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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1331	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/31/2024 10:04 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/31/2024 Time: 10:04 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 HARRISON COUNTY HOSPITAL (15-1331) 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	Don Duval		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	Don Duval			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	601,364	134,076	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	9,741	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	611,105	134,076	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2024 10:04 am

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

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

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	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.	N	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2024 10:04 am

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

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? 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: 15-1331	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 10:04 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.	N			60.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1331	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 10:04 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1331	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 10:04 am

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

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

		Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
		1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.	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	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00

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		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
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	Y	109.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 10:04 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	530,753	0	0	118.01

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 10:04 am

					1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
					1.00	
	Multicampus					
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00

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

			1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		9.99	169.00
		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2024 10:04 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	C		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/03/2024	Y	04/03/2024	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: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2024 10:04 am

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/31/2024 10:04 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	21	7,665	60,480.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	60,480.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	4,824.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	65,304.00	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						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2024 10:04 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)	684	75	2,520			1.00
2.00	HMO and other (see instructions)	524	872				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	22	0	22			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	16			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	706	75	2,558			7.00
8.00	INTENSIVE CARE UNIT	66	6	201			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		20	720			13.00
14.00	Total (see instructions)	772	101	3,479	0.00	489.54	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						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	489.54	27.00
28.00	Observation Bed Days		29	912			28.00
29.00	Ambulance Trips	1,331					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2024 10:04 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	210	27	878	1.00
2.00	HMO and other (see instructions)			136	224		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	210	27	878	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/31/2024 10:04 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)	0.292011	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	9,133,834	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	46,036,346	6.00
7.00	Medicaid cost (line 1 times line 6)	13,443,119	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	4,309,285	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)	4,309,285	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)	206,889	878,595	1,085,484	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	60,414	878,595	939,009	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)	60,414	878,595	939,009	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)	5,868,767	26.00
27.00	Medicare reimbursable bad debts (see instructions)	328,245	27.00
27.01	Medicare allowable bad debts (see instructions)	504,993	27.01
28.00	Non-Medicare bad debt amount (see instructions)	5,363,774	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	1,743,029	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	2,682,038	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,991,323	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/31/2024 10:04 am

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)		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

		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)				20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)				21.00
22.00	Payments received from patients for amounts previously written off as charity care				22.00
23.00	Cost of charity care (see instructions)				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?		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		25.00
25.01	Charges for insured patients' liability (see instructions)		25.01
26.00	Bad debt amount (see instructions)		26.00
27.00	Medicare reimbursable bad debts (see instructions)		27.00
27.01	Medicare allowable bad debts (see instructions)		27.01
28.00	Non-Medicare bad debt amount (see instructions)		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/31/2024 10:04 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,161,298	1,161,298	129,755	1,291,053	1.00
1.01	00101	MOB		661,648	661,648	0	661,648	1.01
1.02	00102	AMB DEPR		0	0	50,059	50,059	1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		818,780	818,780	3,970	822,750	2.00
2.01	00201	AMB EQUIP		0	0	290,321	290,321	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	242,222	1,298,967	1,541,189	118,004	1,659,193	4.00
5.01	00590	ADMINISTRATIVE & GENERAL	1,871,436	5,976,931	7,848,367	-3,245	7,845,122	5.01
5.02	00570	ADMITTING	648,188	161,321	809,509	0	809,509	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	462,611	979,875	1,442,486	0	1,442,486	5.03
7.00	00700	OPERATION OF PLANT	406,143	1,620,187	2,026,330	0	2,026,330	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	35,110	232,023	267,133	0	267,133	8.00
9.00	00900	HOUSEKEEPING	518,523	326,706	845,229	0	845,229	9.00
10.00	01000	DIETARY	606,498	590,996	1,197,494	-794,298	403,196	10.00
11.00	01100	CAFETERIA	0	0	0	794,298	794,298	11.00
13.00	01300	NURSING ADMINISTRATION	729,012	224,868	953,880	0	953,880	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	258,490	1,583,754	1,842,244	-834,214	1,008,030	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	614,101	224,079	838,180	0	838,180	16.00
17.00	01700	SOCIAL SERVICE	387,564	101,689	489,253	0	489,253	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,617,114	2,033,271	5,650,385	-175,595	5,474,790	30.00
31.00	03100	INTENSIVE CARE UNIT	350,945	106,564	457,509	-5,105	452,404	31.00
43.00	04300	NURSERY	0	355	355	154,570	154,925	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,065,470	710,580	1,776,050	-176,119	1,599,931	50.00
53.00	05300	ANESTHESIOLOGY	0	1,217,184	1,217,184	-11,355	1,205,829	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,114,401	1,195,953	2,310,354	-85,936	2,224,418	54.00
60.00	06000	LABORATORY	982,162	2,186,115	3,168,277	-113,868	3,054,409	60.00
65.00	06500	RESPIRATORY THERAPY	0	666,417	666,417	-59,729	606,688	65.00
66.00	06600	PHYSICAL THERAPY	414,226	91,876	506,102	-94,995	411,107	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	82,242	82,242	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	12,753	12,753	68.00
69.00	06900	ELECTROCARDIOLOGY	510,116	158,988	669,104	27,926	697,030	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,370,780	1,370,780	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	412,009	412,009	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	362,623	3,633,895	3,996,518	-53	3,996,465	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	34,917	15,217	50,134	-9,754	40,380	90.00
90.01	09001	SENIOR CARE	64,401	135,643	200,044	0	200,044	90.01
90.02	09002	GENERAL SURGERY	1,146,723	336,864	1,483,587	49,039	1,532,626	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	710,098	363,149	1,073,247	24,525	1,097,772	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	564,003	277,504	841,507	26,643	868,150	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	1,076,452	389,986	1,466,438	36,161	1,502,599	90.05
90.06	09006	OBGYN - DR SAUER	518,029	270,195	788,224	60,835	849,059	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	1,367,671	650,459	2,018,130	93,853	2,111,983	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	348,929	216,280	565,209	16,073	581,282	90.08
90.09	09009	PAIN MANAGEMENT	156,885	43,557	200,442	1,103	201,545	90.09
90.10	09010	DERMATOLOGY	503,632	142,916	646,548	30,637	677,185	90.10
90.11	09011	KIDS FIRST	1,340,812	999,332	2,340,144	-171,090	2,169,054	90.11
91.00	09100	EMERGENCY	2,005,318	1,013,557	3,018,875	-13,840	3,005,035	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,652,181	1,685,453	4,337,634	-456,220	3,881,414	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		104,885	104,885	-104,885	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,687,006	34,609,317	62,296,323	675,255	62,971,578	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,850,177	1,129,500	2,979,677	-398,278	2,581,399	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	330,303	183,516	513,819	-276,977	236,842	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	29,867,486	35,922,333	65,789,819	0	65,789,819	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/31/2024 10:04 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	-11,672	1,279,381		1.00
1.01	00101	MOB	0	661,648		1.01
1.02	00102	AMB DEPR	0	50,059		1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	822,750		2.00
2.01	00201	AMB EQUIP	0	290,321		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,659,193		4.00
5.01	00590	ADMINISTRATIVE & GENERAL	-1,593,287	6,251,835		5.01
5.02	00570	ADMITTING	0	809,509		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,442,486		5.03
7.00	00700	OPERATION OF PLANT	0	2,026,330		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	267,133		8.00
9.00	00900	HOUSEKEEPING	0	845,229		9.00
10.00	01000	DIETARY	0	403,196		10.00
11.00	01100	CAFETERIA	-151,195	643,103		11.00
13.00	01300	NURSING ADMINISTRATION	0	953,880		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,008,030		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-12,719	825,461		16.00
17.00	01700	SOCIAL SERVICE	0	489,253		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	7,964	5,482,754		30.00
31.00	03100	INTENSIVE CARE UNIT	0	452,404		31.00
43.00	04300	NURSERY	0	154,925		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,599,931		50.00
53.00	05300	ANESTHESIOLOGY	-1,190,620	15,209		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,224,418		54.00
60.00	06000	LABORATORY	-2,773	3,051,636		60.00
65.00	06500	RESPIRATORY THERAPY	-597	606,091		65.00
66.00	06600	PHYSICAL THERAPY	0	411,107		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	82,242		67.00
68.00	06800	SPEECH PATHOLOGY	0	12,753		68.00
69.00	06900	ELECTROCARDIOLOGY	0	697,030		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,370,780		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	412,009		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,996,465		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	40,380		90.00
90.01	09001	SENIOR CARE	-19,498	180,546		90.01
90.02	09002	GENERAL SURGERY	-1,115,308	417,318		90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	-375,226	722,546		90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	-458,508	409,642		90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	-871,724	630,875		90.05
90.06	09006	OBGYN - DR SAUER	-589,898	259,161		90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	-468,196	1,643,787		90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	-185,573	395,709		90.08
90.09	09009	PAIN MANAGEMENT	-189,112	12,433		90.09
90.10	09010	DERMATOLOGY	-454,456	222,729		90.10
90.11	09011	KIDS FIRST	-896,859	1,272,195		90.11
91.00	09100	EMERGENCY	0	3,005,035		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-15,575	3,865,839		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,594,832	54,376,746		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,581,399		192.00
194.00	07950	MARKETING	0	0		194.00
194.01	07951	PHYSICIAN BILLING	0	236,842		194.01
194.02	07952	MOB	0	0		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,594,832	57,194,987		200.00

RECLASSIFICATIONS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/31/2024 10:04 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EKG RECLASS				
1.00	ELECTROCARDIOLOGY	69.00	12,876	21,694	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
	TOTALS		12,876	21,694	
	B - INTEREST RECLASS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	104,885	1.00
	TOTALS		0	104,885	
	C - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	402,290	392,008	1.00
	TOTALS		402,290	392,008	
	D - NURSERY RECLASS				
1.00	NURSERY	43.00	154,570	0	1.00
	TOTALS		154,570	0	
	E - AMBULANCE CAPITAL RECLASS				
1.00	AMB DEPR	1.02	0	50,059	1.00
2.00	AMB EQUIP	2.01	0	290,321	2.00
	TOTALS		0	340,380	
	F - IMPLANTABLE DEVICES RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	412,009	1.00
	TOTALS		0	412,009	
	G - DEPRECIATION RECLASS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	24,870	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	3,970	2.00
	TOTALS		0	28,840	
	H - SPEECH PATHOLOGY				
1.00	SPEECH PATHOLOGY	68.00	10,438	2,315	1.00
2.00	OCCUPATIONAL THERAPY	67.00	67,312	14,930	2.00
	TOTALS		77,750	17,245	
	I - SUPPLIES RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,782,789	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
	TOTALS		0	1,782,789	
	J - AMBULANCE WORKERS COMP RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	115,691	1.00
	TOTALS		0	115,691	
	K - MISCELLANEOUS BENEFITS RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,313	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	1,042	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	3,355	
	L - PROVIDER BASED HOUSEKEEPING RECLASS				
1.00	GENERAL SURGERY	90.02	6,399	8,917	1.00
2.00	CORYDON MEDICAL ASSOCIATES	90.04	9,451	13,170	2.00
3.00	FIRST CAPITAL MEDICAL GROUP	90.07	24,084	33,558	3.00
4.00	SOUTH HARRISON FAMILY MEDICINE	90.08	6,694	9,328	4.00

RECLASSIFICATIONS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/31/2024 10:04 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
5.00	HARRISON CRAWFORD HEALTHCARE	90.03	8,621	12,013	5.00
6.00	PAIN MANAGEMENT	90.09	958	1,335	6.00
7.00	ORTHOPEDIC SURGERY - DR KLINE	90.05	7,381	10,285	7.00
8.00	DERMATOLOGY	90.10	5,630	7,844	8.00
9.00	OBGYN - DR SAUER	90.06	5,963	8,309	9.00
10.00	KIDS FIRST	90.11	15,078	21,010	10.00
	TOTALS		90,259	125,769	
	M - PROVIDER BASED BILLING RECLASS				
1.00	GENERAL SURGERY	90.02	18,629	3,993	1.00
2.00	CORYDON MEDICAL ASSOCIATES	90.04	16,614	3,561	2.00
3.00	FIRST CAPITAL MEDICAL GROUP	90.07	42,774	9,168	3.00
4.00	SOUTH HARRISON FAMILY MEDICINE	90.08	13,146	2,818	4.00
5.00	HARRISON CRAWFORD HEALTHCARE	90.03	20,082	4,304	5.00
6.00	PAIN MANAGEMENT	90.09	6,144	1,317	6.00
7.00	ORTHOPEDIC SURGERY - DR KLINE	90.05	18,035	3,865	7.00
8.00	DERMATOLOGY	90.10	11,561	2,478	8.00
9.00	OBGYN - DR SAUER	90.06	26,986	5,784	9.00
10.00	KIDS FIRST	90.11	54,103	11,595	10.00
	TOTALS		228,074	48,883	
	N - PRACTICE MANAGEMENT RECLASS				
1.00	GENERAL SURGERY	90.02	3,196	9,335	1.00
2.00	CORYDON MEDICAL ASSOCIATES	90.04	2,850	8,325	2.00
3.00	FIRST CAPITAL MEDICAL GROUP	90.07	7,338	21,434	3.00
4.00	SOUTH HARRISON FAMILY MEDICINE	90.08	2,255	6,587	4.00
5.00	HARRISON CRAWFORD HEALTHCARE	90.03	3,445	10,063	5.00
6.00	PAIN MANAGEMENT	90.09	1,054	3,079	6.00
7.00	ORTHOPEDIC SURGERY - DR KLINE	90.05	3,094	9,037	7.00
8.00	DERMATOLOGY	90.10	1,983	5,793	8.00
9.00	OBGYN - DR SAUER	90.06	4,629	13,522	9.00
10.00	KIDS FIRST	90.11	9,281	27,110	10.00
	TOTALS		39,125	114,285	
500.00	Grand Total: Increases		1,004,944	3,507,833	500.00

RECLASSIFICATIONS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/31/2024 10:04 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EKG RECLASS						
1.00	LABORATORY	60.00	12,100	0	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	21,694	0		2.00
3.00	EMERGENCY	91.00	674	0	0		3.00
4.00	AMBULANCE SERVICES	95.00	102	0	0		4.00
	TOTALS		12,876	21,694			
	B - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	104,885	11		1.00
	TOTALS		0	104,885			
	C - CAFETERIA RECLASS						
1.00	DIETARY	10.00	402,290	392,008	0		1.00
	TOTALS		402,290	392,008			
	D - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	154,570	0	0		1.00
	TOTALS		154,570	0			
	E - AMBULANCE CAPITAL RECLASS						
1.00	AMBULANCE SERVICES	95.00	0	340,380	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	340,380			
	F - IMPLANTABLE DEVICES RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	412,009	0		1.00
	TOTALS		0	412,009			
	G - DEPRECIATION RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	28,840	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	28,840			
	H - SPEECH PATHOLOGY						
1.00	PHYSICAL THERAPY	66.00	77,750	17,245	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		77,750	17,245			
	I - SUPPLIES RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	834,214	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	22,067	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	5,105	0		3.00
4.00	OPERATING ROOM	50.00	0	176,119	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	11,355	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	85,936	0		6.00
7.00	LABORATORY	60.00	0	101,725	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	38,035	0		8.00
9.00	ELECTROCARDIOLOGY	69.00	0	6,644	0		9.00
10.00	DRUGS CHARGED TO PATIENTS	73.00	0	53	0		10.00
11.00	CLINIC	90.00	0	9,754	0		11.00
12.00	GENERAL SURGERY	90.02	0	1,430	0		12.00
13.00	HARRISON CRAWFORD HEALTHCARE	90.03	0	34,003	0		13.00
14.00	CORYDON MEDICAL ASSOCIATES	90.04	0	27,328	0		14.00
15.00	ORTHOPEDIC SURGERY - DR KLINE	90.05	0	15,536	0		15.00
16.00	OBGYN - DR SAUER	90.06	0	4,358	0		16.00
17.00	FIRST CAPITAL MEDICAL GROUP	90.07	0	44,503	0		17.00
18.00	SOUTH HARRISON FAMILY MEDICINE	90.08	0	24,755	0		18.00
19.00	PAIN MANAGEMENT	90.09	0	12,784	0		19.00
20.00	DERMATOLOGY	90.10	0	4,652	0		20.00
21.00	KIDS FIRST	90.11	0	309,267	0		21.00
22.00	EMERGENCY	91.00	0	13,166	0		22.00
	TOTALS		0	1,782,789			
	J - AMBULANCE WORKERS COMP RECLASS						
1.00	AMBULANCE SERVICES	95.00	0	115,691	0		1.00
	TOTALS		0	115,691			
	K - MISCELLANEOUS BENEFITS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.01	0	3,245	0		1.00
2.00	LABORATORY	60.00	0	43	0		2.00
3.00	AMBULANCE SERVICES	95.00	0	47	0		3.00
4.00	PHYSICIAN BILLING	194.01	0	20	0		4.00
	TOTALS		0	3,355			
	L - PROVIDER BASED HOUSEKEEPING RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	90,259	125,769	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
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00

RECLASSIFICATIONS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/31/2024 10:04 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
	TOTALS		90,259	125,769			
	M - PROVIDER BASED BILLING RECLASS						
1.00	PHYSICIAN BILLING	194.01	228,074	48,883	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
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
	TOTALS		228,074	48,883			
	N - PRACTICE MANAGEMENT RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	39,125	114,285	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
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
	TOTALS		39,125	114,285			
500.00	Grand Total: Decreases		1,004,944	3,507,833			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/31/2024 10:04 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,001,138	0	0	0	0	1.00
2.00	Land Improvements	3,310,462	0	23,557	23,557	0	2.00
3.00	Buildings and Fixtures	42,421,847	141,472	0	141,472	0	3.00
4.00	Building Improvements	4,243,870	0	0	0	0	4.00
5.00	Fixed Equipment	346,074	0	0	0	0	5.00
6.00	Movable Equipment	25,239,972	258,270	0	258,270	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	78,563,363	399,742	23,557	423,299	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	78,563,363	399,742	23,557	423,299	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,001,138	0	1.00
2.00	Land Improvements	3,334,019	0	2.00
3.00	Buildings and Fixtures	42,563,319	0	3.00
4.00	Building Improvements	4,243,870	0	4.00
5.00	Fixed Equipment	346,074	0	5.00
6.00	Movable Equipment	25,498,242	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	78,986,662	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	78,986,662	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/31/2024 10:04 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,040,148	0	0	121,150	0	1.00
1.01	MOB	331,803	79,221	54,558	0	0	1.01
1.02	AMB DEPR	0	0	0	0	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	818,780	0	0	0	0	2.00
2.01	AMB EQUIP	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,190,731	79,221	54,558	121,150	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,161,298		1.00
1.01	MOB	196,066	661,648		1.01
1.02	AMB DEPR	0	0		1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	818,780		2.00
2.01	AMB EQUIP	0	0		2.01
3.00	Total (sum of lines 1-2)	196,066	2,641,726		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III Date/Time Prepared: 5/31/2024 10:04 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	53,488,420	0	53,488,420	0.677183	0	1.00
1.01	MOB	0	0	0	0.000000	0	1.01
1.02	AMB DEPR	0	0	0	0.000000	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	25,498,242	0	25,498,242	0.322817	0	2.00
2.01	AMB EQUIP	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	78,986,662	0	78,986,662	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,065,018	0	1.00
1.01	MOB	0	0	0	331,803	79,221	1.01
1.02	AMB DEPR	0	0	0	50,059	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	822,750	0	2.00
2.01	AMB EQUIP	0	0	0	290,321	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	2,559,951	79,221	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	93,213	121,150	0	0	1,279,381	1.00
1.01	MOB	54,558	0	0	196,066	661,648	1.01
1.02	AMB DEPR	0	0	0	0	50,059	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	822,750	2.00
2.01	AMB EQUIP	0	0	0	0	290,321	2.01
3.00	Total (sum of lines 1-2)	147,771	121,150	0	196,066	3,104,159	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/31/2024 10:04 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - MOB (chapter 2)		0	MOB	1.01	0	1.01
1.02	Investment income - AMB DEPR (chapter 2)		0	AMB DEPR	1.02	0	1.02
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - AMB EQUIP (chapter 2)		0	AMB EQUIP	2.01	0	2.01
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,407	ADMINISTRATIVE & GENERAL	5.01	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,964,536			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	-151,195	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-12,719	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
19.02	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.02
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/31/2024 10:04 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	
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - MOB		0	MOB	1.01	0	26.01
26.02	Depreciation - AMB DEPR		0	AMB DEPR	1.02	0	26.02
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - AMB EQUIP		0	AMB EQUIP	2.01	0	27.01
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME - A&G	B	-77,971	ADMINISTRATIVE & GENERAL	5.01	0	33.00
33.02	INTEREST	B	-6,033	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.02
33.03	PROVIDER TAX FEE	A	-1,307,198	ADMINISTRATIVE & GENERAL	5.01	0	33.03
33.04	UNNECESSARY BORROWING	A	-5,639	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.04
33.05	CRNA	A	-1,190,620	ANESTHESIOLOGY	53.00	0	33.05
33.06	LOBBYING FEES	A	-8,608	ADMINISTRATIVE & GENERAL	5.01	0	33.06
33.07	MARKETING EXPENSE	A	-198,103	ADMINISTRATIVE & GENERAL	5.01	0	33.07
33.09	CLINIC RENT - SENIOR CARE	A	-19,498	SENIOR CARE	90.01	0	33.09
33.10	CLINIC RENT - GENERAL SURGERY	B	-18,353	GENERAL SURGERY	90.02	0	33.10
33.11	CLINIC RENT - HARRISON CRAWFORD HEAL	B	-83,071	HARRISON CRAWFORD HEALTHCARE	90.03	0	33.11
33.13	CLINIC RENT - CORYDON MEDICAL ASSOCI	B	-106,132	CORYDON MEDICAL ASSOCIATES	90.04	0	33.13
33.14	CLINIC RENT - ORTHOPEDIC SURGERY - D	A	-96,353	ORTHOPEDIC SURGERY - DR KLINE	90.05	0	33.14
33.15	CLINIC RENT - OBGYN - DR SAUER	B	-38,130	OBGYN - DR SAUER	90.06	0	33.15
33.17	CLINIC RENT - FIRST CAPITAL MEDICAL	B	-133,082	FIRST CAPITAL MEDICAL GROUP	90.07	0	33.17
33.18	CLINIC RENT - SOUTH HARRISON FAMILY	B	-59,067	SOUTH HARRISON FAMILY MEDICINE	90.08	0	33.18
33.19	CLINIC RENT - PAIN MANAGEMENT	A	-5,599	PAIN MANAGEMENT	90.09	0	33.19
33.20	CLINIC RENT - DERMATOLOGY	B	-31,828	DERMATOLOGY	90.10	0	33.20
33.21	CLINIC RENT - KIDS FIRST	B	-79,690	KIDS FIRST	90.11	0	33.21
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,594,832				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/31/2024 10:04 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	17.00	SOCIAL SERVICE	146,621	0	146,621	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,072,314	-7,964	1,080,278	0	0	2.00
3.00	60.00	LABORATORY	27,734	2,773	24,961	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	597	597	0	0	0	4.00
5.00	90.02	GENERAL SURGERY	1,096,955	1,096,955	0	0	0	5.00
6.00	90.03	HARRISON CRAWFORD HEALTHCARE	292,155	292,155	0	0	0	6.00
7.00	90.04	CORYDON MEDICAL ASSOCIATES	352,376	352,376	0	0	0	7.00
8.00	90.05	ORTHOPEDIC SURGERY - DR KLINE	775,371	775,371	0	0	0	8.00
9.00	90.06	OBGYN - DR SAUER	551,768	551,768	0	0	0	9.00
10.00	90.07	FIRST CAPITAL MEDICAL GROUP	335,114	335,114	0	0	0	10.00
11.00	90.08	SOUTH HARRISON FAMILY MEDICINE	126,506	126,506	0	0	0	11.00
12.00	90.09	PAIN MANAGEMENT	183,513	183,513	0	0	0	12.00
13.00	90.10	DERMATOLOGY	422,628	422,628	0	0	0	13.00
14.00	90.11	KIDS FIRST	817,169	817,169	0	0	0	14.00
15.00	91.00	EMERGENCY	354,557	0	354,557	0	0	15.00
16.00	95.00	AMBULANCE SERVICES	15,575	15,575	0	0	0	16.00
200.00			6,570,953	4,964,536	1,606,417		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	17.00	SOCIAL SERVICE	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	90.02	GENERAL SURGERY	0	0	0	0	0	5.00
6.00	90.03	HARRISON CRAWFORD HEALTHCARE	0	0	0	0	0	6.00
7.00	90.04	CORYDON MEDICAL ASSOCIATES	0	0	0	0	0	7.00
8.00	90.05	ORTHOPEDIC SURGERY - DR KLINE	0	0	0	0	0	8.00
9.00	90.06	OBGYN - DR SAUER	0	0	0	0	0	9.00
10.00	90.07	FIRST CAPITAL MEDICAL GROUP	0	0	0	0	0	10.00
11.00	90.08	SOUTH HARRISON FAMILY MEDICINE	0	0	0	0	0	11.00
12.00	90.09	PAIN MANAGEMENT	0	0	0	0	0	12.00
13.00	90.10	DERMATOLOGY	0	0	0	0	0	13.00
14.00	90.11	KIDS FIRST	0	0	0	0	0	14.00
15.00	91.00	EMERGENCY	0	0	0	0	0	15.00
16.00	95.00	AMBULANCE SERVICES	0	0	0	0	0	16.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	17.00	SOCIAL SERVICE	0	0	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	-7,964		2.00
3.00	60.00	LABORATORY	0	0	0	2,773		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	597		4.00
5.00	90.02	GENERAL SURGERY	0	0	0	1,096,955		5.00
6.00	90.03	HARRISON CRAWFORD HEALTHCARE	0	0	0	292,155		6.00
7.00	90.04	CORYDON MEDICAL ASSOCIATES	0	0	0	352,376		7.00
8.00	90.05	ORTHOPEDIC SURGERY - DR KLINE	0	0	0	775,371		8.00
9.00	90.06	OBGYN - DR SAUER	0	0	0	551,768		9.00
10.00	90.07	FIRST CAPITAL MEDICAL GROUP	0	0	0	335,114		10.00
11.00	90.08	SOUTH HARRISON FAMILY MEDICINE	0	0	0	126,506		11.00
12.00	90.09	PAIN MANAGEMENT	0	0	0	183,513		12.00
13.00	90.10	DERMATOLOGY	0	0	0	422,628		13.00
14.00	90.11	KIDS FIRST	0	0	0	817,169		14.00
15.00	91.00	EMERGENCY	0	0	0	0		15.00
16.00	95.00	AMBULANCE SERVICES	0	0	0	15,575		16.00
200.00			0	0	0	4,964,536		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/31/2024 10:04 am

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

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	8,760.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.74	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.37	38.37	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01

			1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		672,242	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)		0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		672,242	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		672,242	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		0	22.00
23.00	Total salary equivalency (see instructions)		672,242	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
	Standard Travel Allowance			
24.00	Therapists (line 3 times column 2, line 11)		0	24.00
25.00	Assistants (line 4 times column 3, line 11)		0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		0	28.00
	Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
	Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)		0	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0	39.00
	Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/31/2024 10:04 am

					Respiratory Therapy	Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.74	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT						
57.00	Salary equivalency amount (from line 23)					672,242	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					672,242	63.00
64.00	Total cost of outside supplier services (from your records)					585,312	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
	LINE 33 CALCULATION						
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					0	100.02
	LINE 34 CALCULATION						
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					0	101.02
	LINE 35 CALCULATION						
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/31/2024 10:04 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	MOB	AMB DEPR	NEW MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,279,381	1,279,381				1.00
1.01	00101	MOB	661,648	0	661,648			1.01
1.02	00102	AMB DEPR	50,059	0	0	50,059		1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	822,750				822,750	2.00
2.01	00201	AMB EQUIP	290,321				0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,659,193	1,971	0	0	1,268	4.00
5.01	00590	ADMINISTRATIVE & GENERAL	6,251,835	198,199	3,784	0	127,459	5.01
5.02	00570	ADMITTING	809,509	0	0	0	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,442,486	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	2,026,330	154,609	0	0	99,427	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	267,133	9,027	0	0	5,805	8.00
9.00	00900	HOUSEKEEPING	845,229	19,336	0	0	12,435	9.00
10.00	01000	DIETARY	403,196	56,264	0	0	36,182	10.00
11.00	01100	CAFETERIA	643,103	28,107	0	0	18,075	11.00
13.00	01300	NURSING ADMINISTRATION	953,880	4,731	0	0	3,042	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,008,030	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	825,461	31,389	0	0	20,186	16.00
17.00	01700	SOCIAL SERVICE	489,253	1,892	0	0	1,217	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,482,754	213,701	0	0	137,429	30.00
31.00	03100	INTENSIVE CARE UNIT	452,404	28,551	0	0	18,361	31.00
43.00	04300	NURSERY	154,925	5,913	0	0	3,803	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,599,931	174,655	0	0	112,318	50.00
53.00	05300	ANESTHESIOLOGY	15,209	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,224,418	91,506	0	0	58,846	54.00
60.00	06000	LABORATORY	3,051,636	48,094	0	0	30,928	60.00
65.00	06500	RESPIRATORY THERAPY	606,091	10,466	0	0	6,731	65.00
66.00	06600	PHYSICAL THERAPY	411,107	35,410	0	0	22,772	66.00
67.00	06700	OCCUPATIONAL THERAPY	82,242	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,753	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	697,030	17,976	0	0	11,560	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,370,780	42,930	0	0	27,607	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	412,009	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,996,465	12,083	0	0	7,770	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	40,380	14,970	0	0	9,627	90.00
90.01	09001	SENIOR CARE	180,546	0	22,068	0	0	90.01
90.02	09002	GENERAL SURGERY	417,318	276	51,356	0	177	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	722,546	296	60,971	0	190	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	409,642	246	84,854	0	158	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	630,875	266	93,272	0	171	90.05
90.06	09006	OBGYN - DR SAUER	259,161	404	30,486	0	260	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	1,643,787	641	106,400	0	412	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	395,709	197	47,225	0	127	90.08
90.09	09009	PAIN MANAGEMENT	12,433	89	23,168	0	57	90.09
90.10	09010	DERMATOLOGY	222,729	177	25,447	0	114	90.10
90.11	09011	KIDS FIRST	1,272,195	808	63,713	0	520	90.11
91.00	09100	EMERGENCY	3,005,035	64,641	0	0	41,569	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,865,839	0	0	50,059	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,376,746	1,269,821	612,744	50,059	816,603	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,032	0	0	5,165	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,581,399	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	236,842	1,528	0	0	982	194.01
194.02	07952	MOB	0	0	48,904	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	57,194,987	1,279,381	661,648	50,059	822,750	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 10:04 am

		Cost Center Description	CAPITAL RELATED COSTS AMB EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	ADMITTING	
			2.01	4.00	4A	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP	290,321					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,662,432				4.00
5.01	00590	ADMINISTRATIVE & GENERAL	0	105,016	6,686,293	6,686,293		5.01
5.02	00570	ADMITTING	0	36,373	845,882	111,977	957,859	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	25,959	1,468,445	194,391	0	5.03
7.00	00700	OPERATION OF PLANT	0	22,791	2,303,157	304,890	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,970	283,935	37,587	0	8.00
9.00	00900	HOUSEKEEPING	0	29,097	906,097	119,948	0	9.00
10.00	01000	DIETARY	0	11,459	507,101	67,130	0	10.00
11.00	01100	CAFETERIA	0	22,575	711,860	94,235	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	40,909	1,002,562	132,718	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,505	1,022,535	135,362	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	34,460	911,496	120,663	0	16.00
17.00	01700	SOCIAL SERVICE	0	21,748	514,110	68,057	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	194,310	6,028,194	798,012	45,148	30.00
31.00	03100	INTENSIVE CARE UNIT	0	19,693	519,009	68,706	3,300	31.00
43.00	04300	NURSERY	0	8,674	173,315	22,943	8,558	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	59,789	1,946,693	257,701	77,091	50.00
53.00	05300	ANESTHESIOLOGY	0	0	15,209	2,013	11,999	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	62,535	2,437,305	322,648	231,896	54.00
60.00	06000	LABORATORY	0	54,435	3,185,093	421,639	156,578	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	623,288	82,510	11,158	65.00
66.00	06600	PHYSICAL THERAPY	0	18,881	488,170	64,623	17,604	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,777	86,019	11,387	3,453	67.00
68.00	06800	SPEECH PATHOLOGY	0	586	13,339	1,766	1,251	68.00
69.00	06900	ELECTROCARDIOLOGY	0	29,348	755,914	100,067	61,312	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,441,317	190,800	8,522	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	412,009	54,541	6,756	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,349	4,036,667	534,370	44,052	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,959	66,936	8,861	955	90.00
90.01	09001	SENIOR CARE	0	3,614	206,228	27,300	956	90.01
90.02	09002	GENERAL SURGERY	0	65,932	535,059	70,831	879	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	41,651	825,654	109,299	4,601	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	33,272	528,172	69,919	4,235	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	62,005	786,589	104,128	2,025	90.05
90.06	09006	OBGYN - DR SAUER	0	31,178	321,489	42,558	196	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	80,910	1,832,150	242,538	9,028	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	20,820	464,078	61,434	2,829	90.08
90.09	09009	PAIN MANAGEMENT	0	9,261	45,008	5,958	623	90.09
90.10	09010	DERMATOLOGY	0	29,337	277,804	36,775	2,491	90.10
90.11	09011	KIDS FIRST	0	79,643	1,416,879	187,565	7,141	90.11
91.00	09100	EMERGENCY	0	112,491	3,223,736	426,755	178,025	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	290,321	148,821	4,355,040	576,516	55,197	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	290,321	1,560,133	54,209,836	6,291,121	957,859	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	13,197	1,747	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	96,562	2,677,961	354,506	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	5,737	245,089	32,445	0	194.01
194.02	07952	MOB	0	0	48,904	6,474	0	194.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	290,321	1,662,432	57,194,987	6,686,293	957,859	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 10:04 am

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.03	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,662,836					5.03
7.00	00700	OPERATION OF PLANT	0	2,608,047				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	25,464	346,986			8.00
9.00	00900	HOUSEKEEPING	0	54,542	0	1,080,587		9.00
10.00	01000	DIETARY	0	158,705	4,929	67,837	805,702	10.00
11.00	01100	CAFETERIA	0	79,283	0	33,889	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	13,344	0	5,704	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	88,540	0	37,845	0	16.00
17.00	01700	SOCIAL SERVICE	0	5,337	0	2,281	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	78,382	602,791	63,391	257,659	590,052	30.00
31.00	03100	INTENSIVE CARE UNIT	5,729	80,534	55,187	34,423	47,064	31.00
43.00	04300	NURSERY	14,858	16,679	0	7,129	168,586	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	133,839	492,654	28,018	210,580	0	50.00
53.00	05300	ANESTHESIOLOGY	20,831	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	402,482	258,114	50,248	110,328	0	54.00
60.00	06000	LABORATORY	271,837	135,659	0	57,986	0	60.00
65.00	06500	RESPIRATORY THERAPY	19,372	29,523	0	12,619	0	65.00
66.00	06600	PHYSICAL THERAPY	30,562	99,882	0	42,694	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,995	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,171	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	106,444	50,705	13,261	21,674	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,795	121,092	0	51,760	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	11,729	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,479	34,082	0	14,568	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,659	42,227	0	18,049	0	90.00
90.01	09001	SENIOR CARE	1,659	0	0	0	0	90.01
90.02	09002	GENERAL SURGERY	1,526	778	380	333	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	7,988	834	0	356	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	7,352	695	110	297	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	3,516	751	74	321	0	90.05
90.06	09006	OBGYN - DR SAUER	340	1,140	926	487	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	15,674	1,807	592	772	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	4,911	556	516	238	0	90.08
90.09	09009	PAIN MANAGEMENT	1,082	250	986	107	0	90.09
90.10	09010	DERMATOLOGY	4,325	500	2,264	214	0	90.10
90.11	09011	KIDS FIRST	12,398	2,280	0	974	0	90.11
91.00	09100	EMERGENCY	309,072	182,334	106,435	77,937	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	95,829	0	18,401	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,662,836	2,581,082	345,718	1,069,061	805,702	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22,656	0	9,684	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,268	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	4,309	0	1,842	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,662,836	2,608,047	346,986	1,080,587	805,702	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 10:04 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	14.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	919,267					11.00
13.00	01300	NURSING ADMINISTRATION	27,408	1,181,736				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,278	0	1,177,175			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	40,410	0	2,160	1,201,114		16.00
17.00	01700	SOCIAL SERVICE	12,284	0	500	0	602,569	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	207,101	541,516	29,956	56,619	441,289	30.00
31.00	03100	INTENSIVE CARE UNIT	20,026	52,362	7,978	4,138	35,198	31.00
43.00	04300	NURSERY	9,325	24,383	4	10,733	126,082	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	72,959	190,769	55,949	96,679	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	4,274	15,047	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	63,425	0	34,923	290,695	0	54.00
60.00	06000	LABORATORY	46,746	0	327,786	196,361	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	6,628	13,994	0	65.00
66.00	06600	PHYSICAL THERAPY	14,676	0	1,199	22,077	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,929	0	0	4,331	0	67.00
68.00	06800	SPEECH PATHOLOGY	448	0	0	1,568	0	68.00
69.00	06900	ELECTROCARDIOLOGY	24,449	63,928	2,839	76,890	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	396,158	10,687	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	115,769	8,473	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,073	0	2,329	55,245	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,614	4,220	327	1,198	0	90.00
90.01	09001	SENIOR CARE	2,630	6,877	387	1,199	0	90.01
90.02	09002	GENERAL SURGERY	23,732	0	2,050	1,102	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	34,044	0	9,268	5,770	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	20,474	0	4,359	5,311	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	26,930	0	15,545	2,540	0	90.05
90.06	09006	OBGYN - DR SAUER	13,151	0	7,744	246	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	60,944	0	16,745	11,322	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	16,618	0	6,005	3,548	0	90.08
90.09	09009	PAIN MANAGEMENT	1,943	0	330	781	0	90.09
90.10	09010	DERMATOLOGY	12,524	0	2,231	3,124	0	90.10
90.11	09011	KIDS FIRST	0	0	33,564	8,955	0	90.11
91.00	09100	EMERGENCY	113,847	297,681	50,828	223,259	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	39,340	69,222	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	899,988	1,181,736	1,177,175	1,201,114	602,569	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,089	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	8,190	0	0	0	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	919,267	1,181,736	1,177,175	1,201,114	602,569	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 10:04 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	AMB DEPR					1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	AMB EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	ADMINISTRATIVE & GENERAL					5.01
5.02	00570	ADMITTING					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	9,740,110	0	9,740,110		30.00
31.00	03100	INTENSIVE CARE UNIT	933,654	0	933,654		31.00
43.00	04300	NURSERY	582,595	0	582,595		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,562,932	0	3,562,932		50.00
53.00	05300	ANESTHESIOLOGY	69,373	0	69,373		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,202,064	0	4,202,064		54.00
60.00	06000	LABORATORY	4,799,685	0	4,799,685		60.00
65.00	06500	RESPIRATORY THERAPY	799,092	0	799,092		65.00
66.00	06600	PHYSICAL THERAPY	781,487	0	781,487		66.00
67.00	06700	OCCUPATIONAL THERAPY	114,114	0	114,114		67.00
68.00	06800	SPEECH PATHOLOGY	20,543	0	20,543		68.00
69.00	06900	ELECTROCARDIOLOGY	1,277,483	0	1,277,483		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,235,131	0	2,235,131		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	609,277	0	609,277		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,807,865	0	4,807,865		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	146,046	0	146,046		90.00
90.01	09001	SENIOR CARE	247,236	0	247,236		90.01
90.02	09002	GENERAL SURGERY	636,670	0	636,670		90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	997,814	0	997,814		90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	640,924	0	640,924		90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	942,419	0	942,419		90.05
90.06	09006	OBGYN - DR SAUER	388,277	0	388,277		90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	2,191,572	0	2,191,572		90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	560,733	0	560,733		90.08
90.09	09009	PAIN MANAGEMENT	57,068	0	57,068		90.09
90.10	09010	DERMATOLOGY	342,252	0	342,252		90.10
90.11	09011	KIDS FIRST	1,669,756	0	1,669,756		90.11
91.00	09100	EMERGENCY	5,189,909	0	5,189,909		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	5,209,545	0	5,209,545		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	53,755,626	0	53,755,626		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	47,284	0	47,284		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,044,824	0	3,044,824		192.00
194.00	07950	MARKETING	0	0	0		194.00
194.01	07951	PHYSICIAN BILLING	291,875	0	291,875		194.01
194.02	07952	MOB	55,378	0	55,378		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	57,194,987	0	57,194,987		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/31/2024 10:04 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	MOB	AMB DEPR	NEW MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,971	0	0	1,268	4.00
5.01	00590	ADMINISTRATIVE & GENERAL	0	198,199	3,784	0	127,459	5.01
5.02	00570	ADMITTING	0	0	0	0	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	0	154,609	0	0	99,427	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,027	0	0	5,805	8.00
9.00	00900	HOUSEKEEPING	0	19,336	0	0	12,435	9.00
10.00	01000	DIETARY	0	56,264	0	0	36,182	10.00
11.00	01100	CAFETERIA	0	28,107	0	0	18,075	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,731	0	0	3,042	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	31,389	0	0	20,186	16.00
17.00	01700	SOCIAL SERVICE	0	1,892	0	0	1,217	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	213,701	0	0	137,429	30.00
31.00	03100	INTENSIVE CARE UNIT	0	28,551	0	0	18,361	31.00
43.00	04300	NURSERY	0	5,913	0	0	3,803	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	174,655	0	0	112,318	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	91,506	0	0	58,846	54.00
60.00	06000	LABORATORY	0	48,094	0	0	30,928	60.00
65.00	06500	RESPIRATORY THERAPY	0	10,466	0	0	6,731	65.00
66.00	06600	PHYSICAL THERAPY	0	35,410	0	0	22,772	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	17,976	0	0	11,560	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	42,930	0	0	27,607	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	12,083	0	0	7,770	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	14,970	0	0	9,627	90.00
90.01	09001	SENIOR CARE	0	0	22,068	0	0	90.01
90.02	09002	GENERAL SURGERY	0	276	51,356	0	177	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	296	60,971	0	190	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	246	84,854	0	158	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	266	93,272	0	171	90.05
90.06	09006	OBGYN - DR SAUER	0	404	30,486	0	260	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	641	106,400	0	412	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	197	47,225	0	127	90.08
90.09	09009	PAIN MANAGEMENT	0	89	23,168	0	57	90.09
90.10	09010	DERMATOLOGY	0	177	25,447	0	114	90.10
90.11	09011	KIDS FIRST	0	808	63,713	0	520	90.11
91.00	09100	EMERGENCY	0	64,641	0	0	41,569	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	50,059	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,269,821	612,744	50,059	816,603	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,032	0	0	5,165	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	1,528	0	0	982	194.01
194.02	07952	MOB	0	0	48,904	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,279,381	661,648	50,059	822,750	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/31/2024 10:04 am

		Cost Center Description	CAPITAL RELATED COSTS AMB EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	ADMITTING	
			2.01	2A	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,239	3,239			4.00
5.01	00590	ADMINISTRATIVE & GENERAL	0	329,442	204	329,646		5.01
5.02	00570	ADMITTING	0	0	71	5,521	5,592	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	50	9,585	0	5.03
7.00	00700	OPERATION OF PLANT	0	254,036	44	15,033	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	14,832	4	1,853	0	8.00
9.00	00900	HOUSEKEEPING	0	31,771	57	5,914	0	9.00
10.00	01000	DIETARY	0	92,446	22	3,310	0	10.00
11.00	01100	CAFETERIA	0	46,182	44	4,646	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,773	79	6,544	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	28	6,674	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	51,575	67	5,949	0	16.00
17.00	01700	SOCIAL SERVICE	0	3,109	42	3,356	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	351,130	387	39,326	260	30.00
31.00	03100	INTENSIVE CARE UNIT	0	46,912	38	3,388	19	31.00
43.00	04300	NURSERY	0	9,716	17	1,131	49	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	286,973	116	12,706	444	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	99	69	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	150,352	121	15,908	1,407	54.00
60.00	06000	LABORATORY	0	79,022	106	20,789	903	60.00
65.00	06500	RESPIRATORY THERAPY	0	17,197	0	4,068	64	65.00
66.00	06600	PHYSICAL THERAPY	0	58,182	37	3,186	102	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	7	561	20	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1	87	7	68.00
69.00	06900	ELECTROCARDIOLOGY	0	29,536	57	4,934	354	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	70,537	0	9,407	49	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,689	39	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,853	40	26,347	254	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	24,597	4	437	6	90.00
90.01	09001	SENIOR CARE	0	22,068	7	1,346	6	90.01
90.02	09002	GENERAL SURGERY	0	51,809	128	3,492	5	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	61,457	81	5,389	27	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	85,258	65	3,447	24	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	93,709	120	5,134	12	90.05
90.06	09006	OBGYN - DR SAUER	0	31,150	61	2,098	1	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	107,453	157	11,958	52	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	47,549	40	3,029	16	90.08
90.09	09009	PAIN MANAGEMENT	0	23,314	18	294	4	90.09
90.10	09010	DERMATOLOGY	0	25,738	57	1,813	14	90.10
90.11	09011	KIDS FIRST	0	65,041	155	9,248	41	90.11
91.00	09100	EMERGENCY	0	106,210	219	21,041	1,026	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	290,321	340,380	289	28,425	318	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	290,321	3,039,548	3,040	310,162	5,592	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,197	0	86	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	188	17,479	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	2,510	11	1,600	0	194.01
194.02	07952	MOB	0	48,904	0	319	0	194.02
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	290,321	3,104,159	3,239	329,646	5,592	202.00

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		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.03	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	9,635					5.03
7.00	00700	OPERATION OF PLANT	0	269,113				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,628	19,317			8.00
9.00	00900	HOUSEKEEPING	0	5,628	0	43,370		9.00
10.00	01000	DIETARY	0	16,376	274	2,723	115,151	10.00
11.00	01100	CAFETERIA	0	8,181	0	1,360	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,377	0	229	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,136	0	1,519	0	16.00
17.00	01700	SOCIAL SERVICE	0	551	0	92	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	451	62,199	3,529	10,340	84,331	30.00
31.00	03100	INTENSIVE CARE UNIT	33	8,310	3,072	1,382	6,726	31.00
43.00	04300	NURSERY	86	1,721	0	286	24,094	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	770	50,835	1,560	8,452	0	50.00
53.00	05300	ANESTHESIOLOGY	120	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,379	26,634	2,797	4,428	0	54.00
60.00	06000	LABORATORY	1,565	13,998	0	2,327	0	60.00
65.00	06500	RESPIRATORY THERAPY	112	3,046	0	506	0	65.00
66.00	06600	PHYSICAL THERAPY	176	10,306	0	1,714	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	35	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	12	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	613	5,232	738	870	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	85	12,495	0	2,077	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	68	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	440	3,517	0	585	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10	4,357	0	724	0	90.00
90.01	09001	SENIOR CARE	10	0	0	0	0	90.01
90.02	09002	GENERAL SURGERY	9	80	21	13	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	46	86	0	14	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	42	72	6	12	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	20	77	4	13	0	90.05
90.06	09006	OBGYN - DR SAUER	2	118	52	20	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	90	186	33	31	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	28	57	29	10	0	90.08
90.09	09009	PAIN MANAGEMENT	6	26	55	4	0	90.09
90.10	09010	DERMATOLOGY	25	52	126	9	0	90.10
90.11	09011	KIDS FIRST	71	235	0	39	0	90.11
91.00	09100	EMERGENCY	1,779	18,814	5,926	3,128	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	552	0	1,024	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,635	266,330	19,246	42,907	115,151	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,338	0	389	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	71	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	445	0	74	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	9,635	269,113	19,317	43,370	115,151	202.00

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		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	14.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	60,413					11.00
13.00	01300	NURSING ADMINISTRATION	1,801	17,803				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,267	0	7,969			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,656	0	15	70,917		16.00
17.00	01700	SOCIAL SERVICE	807	0	3	0	7,960	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,611	8,157	203	3,341	5,829	30.00
31.00	03100	INTENSIVE CARE UNIT	1,316	789	54	244	465	31.00
43.00	04300	NURSERY	613	367	0	633	1,666	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,795	2,874	379	5,704	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	29	888	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,168	0	236	17,199	0	54.00
60.00	06000	LABORATORY	3,072	0	2,219	11,586	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	45	826	0	65.00
66.00	06600	PHYSICAL THERAPY	964	0	8	1,303	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	192	0	0	256	0	67.00
68.00	06800	SPEECH PATHOLOGY	29	0	0	93	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,607	963	19	4,537	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,682	631	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	784	500	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	662	0	16	3,260	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	106	64	2	71	0	90.00
90.01	09001	SENIOR CARE	173	104	3	71	0	90.01
90.02	09002	GENERAL SURGERY	1,560	0	14	65	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	2,237	0	63	340	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	1,346	0	30	313	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	1,770	0	105	150	0	90.05
90.06	09006	OBGYN - DR SAUER	864	0	52	14	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	4,005	0	113	668	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	1,092	0	41	209	0	90.08
90.09	09009	PAIN MANAGEMENT	128	0	2	46	0	90.09
90.10	09010	DERMATOLOGY	823	0	15	184	0	90.10
90.11	09011	KIDS FIRST	0	0	227	528	0	90.11
91.00	09100	EMERGENCY	7,482	4,485	344	13,173	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	266	4,084	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	59,146	17,803	7,969	70,917	7,960	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	729	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	538	0	0	0	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	60,413	17,803	7,969	70,917	7,960	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/31/2024 10:04 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	AMB DEPR					1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	AMB EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	ADMINISTRATIVE & GENERAL					5.01
5.02	00570	ADMITTING					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	583,094	0	583,094		30.00
31.00	03100	INTENSIVE CARE UNIT	72,748	0	72,748		31.00
43.00	04300	NURSERY	40,379	0	40,379		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	375,608	0	375,608		50.00
53.00	05300	ANESTHESIOLOGY	1,205	0	1,205		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	225,629	0	225,629		54.00
60.00	06000	LABORATORY	135,587	0	135,587		60.00
65.00	06500	RESPIRATORY THERAPY	25,864	0	25,864		65.00
66.00	06600	PHYSICAL THERAPY	75,978	0	75,978		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,071	0	1,071		67.00
68.00	06800	SPEECH PATHOLOGY	229	0	229		68.00
69.00	06900	ELECTROCARDIOLOGY	49,460	0	49,460		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	97,963	0	97,963		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,080	0	4,080		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	54,974	0	54,974		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	30,378	0	30,378		90.00
90.01	09001	SENIOR CARE	23,788	0	23,788		90.01
90.02	09002	GENERAL SURGERY	57,196	0	57,196		90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	69,740	0	69,740		90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	90,615	0	90,615		90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	101,114	0	101,114		90.05
90.06	09006	OBGYN - DR SAUER	34,432	0	34,432		90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	124,746	0	124,746		90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	52,100	0	52,100		90.08
90.09	09009	PAIN MANAGEMENT	23,897	0	23,897		90.09
90.10	09010	DERMATOLOGY	28,856	0	28,856		90.10
90.11	09011	KIDS FIRST	75,585	0	75,585		90.11
91.00	09100	EMERGENCY	183,627	0	183,627		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	375,338	0	375,338		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,015,281	0	3,015,281		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,010	0	16,010		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,467	0	18,467		192.00
194.00	07950	MARKETING	0	0	0		194.00
194.01	07951	PHYSICIAN BILLING	5,178	0	5,178		194.01
194.02	07952	MOB	49,223	0	49,223		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	3,104,159	0	3,104,159		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 10:04 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	AMB DEPR (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	AMB EQUIP (SQUARE FEET)	
			1.00	1.01	1.02	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	129,817					1.00
1.01	00101	MOB	0	34,270				1.01
1.02	00102	AMB DEPR	0	0	11,032			1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				129,817		2.00
2.01	00201	AMB EQUIP				0	11,032	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	200	0	0	200	0	4.00
5.01	00590	ADMINISTRATIVE & GENERAL	20,111	196	0	20,111	0	5.01
5.02	00570	ADMITTING	0	0	0	0	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	15,688	0	0	15,688	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	916	0	0	916	0	8.00
9.00	00900	HOUSEKEEPING	1,962	0	0	1,962	0	9.00
10.00	01000	DIETARY	5,709	0	0	5,709	0	10.00
11.00	01100	CAFETERIA	2,852	0	0	2,852	0	11.00
13.00	01300	NURSING ADMINISTRATION	480	0	0	480	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,185	0	0	3,185	0	16.00
17.00	01700	SOCIAL SERVICE	192	0	0	192	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,684	0	0	21,684	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,897	0	0	2,897	0	31.00
43.00	04300	NURSERY	600	0	0	600	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,722	0	0	17,722	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,285	0	0	9,285	0	54.00
60.00	06000	LABORATORY	4,880	0	0	4,880	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,062	0	0	1,062	0	65.00
66.00	06600	PHYSICAL THERAPY	3,593	0	0	3,593	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,824	0	0	1,824	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,356	0	0	4,356	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,226	0	0	1,226	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,519	0	0	1,519	0	90.00
90.01	09001	SENIOR CARE	0	1,143	0	0	0	90.01
90.02	09002	GENERAL SURGERY	28	2,660	0	28	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	30	3,158	0	30	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	25	4,395	0	25	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	27	4,831	0	27	0	90.05
90.06	09006	OBGYN - DR SAUER	41	1,579	0	41	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	65	5,511	0	65	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	20	2,446	0	20	0	90.08
90.09	09009	PAIN MANAGEMENT	9	1,200	0	9	0	90.09
90.10	09010	DERMATOLOGY	18	1,318	0	18	0	90.10
90.11	09011	KIDS FIRST	82	3,300	0	82	0	90.11
91.00	09100	EMERGENCY	6,559	0	0	6,559	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	11,032	0	11,032	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	128,847	31,737	11,032	128,847	11,032	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	815	0	0	815	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	155	0	0	155	0	194.01
194.02	07952	MOB	0	2,533	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,279,381	661,648	50,059	822,750	290,321	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.855265	19.306916	4.537618	6.337768	26.316262	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 10:04 am

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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 10:04 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
			4.00	5A.01	5.01	5.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	29,625,264					4.00
5.01	00590	ADMINISTRATIVE & GENERAL	1,871,436	-6,686,293	50,508,694			5.01
5.02	00570	ADMITTING	648,188	0	845,882	184,087,467		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	462,611	0	1,468,445	0	184,087,467	5.03
7.00	00700	OPERATION OF PLANT	406,143	0	2,303,157	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	35,110	0	283,935	0	0	8.00
9.00	00900	HOUSEKEEPING	518,523	0	906,097	0	0	9.00
10.00	01000	DIETARY	204,208	0	507,101	0	0	10.00
11.00	01100	CAFETERIA	402,290	0	711,860	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	729,012	0	1,002,562	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	258,490	0	1,022,535	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	614,101	0	911,496	0	0	16.00
17.00	01700	SOCIAL SERVICE	387,564	0	514,110	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,462,544	0	6,028,194	8,677,287	8,677,287	30.00
31.00	03100	INTENSIVE CARE UNIT	350,945	0	519,009	634,250	634,250	31.00
43.00	04300	NURSERY	154,570	0	173,315	1,644,884	1,644,884	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,065,470	0	1,946,693	14,816,649	14,816,649	50.00
53.00	05300	ANESTHESIOLOGY	0	0	15,209	2,306,081	2,306,081	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,114,401	0	2,437,305	44,559,713	44,559,713	54.00
60.00	06000	LABORATORY	970,062	0	3,185,093	30,093,712	30,093,712	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	623,288	2,144,622	2,144,622	65.00
66.00	06600	PHYSICAL THERAPY	336,476	0	488,170	3,383,375	3,383,375	66.00
67.00	06700	OCCUPATIONAL THERAPY	67,312	0	86,019	663,732	663,732	67.00
68.00	06800	SPEECH PATHOLOGY	10,438	0	13,339	240,358	240,358	68.00
69.00	06900	ELECTROCARDIOLOGY	522,992	0	755,914	11,783,934	11,783,934	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,441,317	1,637,928	1,637,928	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	412,009	1,298,484	1,298,484	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	362,623	0	4,036,667	8,466,616	8,466,616	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	34,917	0	66,936	183,612	183,612	90.00
90.01	09001	SENIOR CARE	64,401	0	206,228	183,680	183,680	90.01
90.02	09002	GENERAL SURGERY	1,174,947	0	535,059	168,914	168,914	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	742,246	0	825,654	884,333	884,333	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	592,918	0	528,172	813,897	813,897	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	1,104,962	0	786,589	389,221	389,221	90.05
90.06	09006	OBGYN - DR SAUER	555,607	0	321,489	37,642	37,642	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	1,441,867	0	1,832,150	1,735,164	1,735,164	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	371,024	0	464,078	543,726	543,726	90.08
90.09	09009	PAIN MANAGEMENT	165,041	0	45,008	119,728	119,728	90.09
90.10	09010	DERMATOLOGY	522,806	0	277,804	478,801	478,801	90.10
90.11	09011	KIDS FIRST	1,419,274	0	1,416,879	1,372,476	1,372,476	90.11
91.00	09100	EMERGENCY	2,004,644	0	3,223,736	34,215,871	34,215,871	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,652,079	0	4,355,040	10,608,777	10,608,777	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,802,242	-6,686,293	47,523,543	184,087,467	184,087,467	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	13,197	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,720,793	0	2,677,961	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	102,229	0	245,089	0	0	194.01
194.02	07952	MOB	0	0	48,904	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,662,432		6,686,293	957,859	1,662,836	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.056115		0.132379	0.005203	0.009033	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	3,239		329,646	5,592	9,635	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000109		0.006527	0.000030	0.000052	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 10:04 am

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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 10:04 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (HOURS OF SERVICE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT	93,818					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	916	191,773				8.00
9.00	00900	HOUSEKEEPING	1,962	0	90,940			9.00
10.00	01000	DIETARY	5,709	2,724	5,709	3,441		10.00
11.00	01100	CAFETERIA	2,852	0	2,852	0	30,756	11.00
13.00	01300	NURSING ADMINISTRATION	480	0	480	0	917	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	645	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,185	0	3,185	0	1,352	16.00
17.00	01700	SOCIAL SERVICE	192	0	192	0	411	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,684	35,035	21,684	2,520	6,929	30.00
31.00	03100	INTENSIVE CARE UNIT	2,897	30,501	2,897	201	670	31.00
43.00	04300	NURSERY	600	0	600	720	312	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,722	15,485	17,722	0	2,441	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,285	27,771	9,285	0	2,122	54.00
60.00	06000	LABORATORY	4,880	0	4,880	0	1,564	60.00
65.00	06500	RESPIRATORY THERAPY	1,062	0	1,062	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,593	0	3,593	0	491	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	98	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	15	68.00
69.00	06900	ELECTROCARDIOLOGY	1,824	7,329	1,824	0	818	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,356	0	4,356	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,226	0	1,226	0	337	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,519	0	1,519	0	54	90.00
90.01	09001	SENIOR CARE	0	0	0	0	88	90.01
90.02	09002	GENERAL SURGERY	28	210	28	0	794	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	30	0	30	0	1,139	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	25	61	25	0	685	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	27	41	27	0	901	90.05
90.06	09006	OBGYN - DR SAUER	41	512	41	0	440	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	65	327	65	0	2,039	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	20	285	20	0	556	90.08
90.09	09009	PAIN MANAGEMENT	9	545	9	0	65	90.09
90.10	09010	DERMATOLOGY	18	1,251	18	0	419	90.10
90.11	09011	KIDS FIRST	82	0	82	0	0	90.11
91.00	09100	EMERGENCY	6,559	58,825	6,559	0	3,809	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	10,170	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	92,848	191,072	89,970	3,441	30,111	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	815	0	815	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	701	0	0	371	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	155	0	155	0	274	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,608,047	346,986	1,080,587	805,702	919,267	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.799004	1.809358	11.882417	234.147632	29.889030	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	269,113	19,317	43,370	115,151	60,413	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.868458	0.100728	0.476908	33.464400	1.964267	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 10:04 am

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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 10:04 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)		
			13.00	14.00	16.00	17.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	15,121					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,189,440				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,687	184,087,467			16.00
17.00	01700	SOCIAL SERVICE	0	1,779	0	3,441		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,929	106,610	8,677,287	2,520		30.00
31.00	03100	INTENSIVE CARE UNIT	670	28,393	634,250	201		31.00
43.00	04300	NURSERY	312	14	1,644,884	720		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,441	199,116	14,816,649	0		50.00
53.00	05300	ANESTHESIOLOGY	0	15,209	2,306,081	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	124,286	44,559,713	0		54.00
60.00	06000	LABORATORY	0	1,166,555	30,093,712	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	23,588	2,144,622	0		65.00
66.00	06600	PHYSICAL THERAPY	0	4,266	3,383,375	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	663,732	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	240,358	0		68.00
69.00	06900	ELECTROCARDIOLOGY	818	10,102	11,783,934	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,409,896	1,637,928	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	412,009	1,298,484	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,288	8,466,616	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	54	1,162	183,612	0		90.00
90.01	09001	SENIOR CARE	88	1,379	183,680	0		90.01
90.02	09002	GENERAL SURGERY	0	7,294	168,914	0		90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	32,984	884,333	0		90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	15,513	813,897	0		90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	55,324	389,221	0		90.05
90.06	09006	OBGYN - DR SAUER	0	27,561	37,642	0		90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	59,592	1,735,164	0		90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	21,371	543,726	0		90.08
90.09	09009	PAIN MANAGEMENT	0	1,175	119,728	0		90.09
90.10	09010	DERMATOLOGY	0	7,941	478,801	0		90.10
90.11	09011	KIDS FIRST	0	119,450	1,372,476	0		90.11
91.00	09100	EMERGENCY	3,809	180,890	34,215,871	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	140,006	10,608,777	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,121	4,189,440	184,087,467	3,441		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	MARKETING	0	0	0	0		194.00
194.01	07951	PHYSICIAN BILLING	0	0	0	0		194.01
194.02	07952	MOB	0	0	0	0		194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,181,736	1,177,175	1,201,114	602,569		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	78.151974	0.280986	0.006525	175.114502		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	17,803	7,969	70,917	7,960		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.177369	0.001902	0.000385	2.313281		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 10:04 am

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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 10:04 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,740,110		9,740,110	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	933,654		933,654	0	0	31.00
43.00	04300	NURSERY	582,595		582,595	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,562,932		3,562,932	0	0	50.00
53.00	05300	ANESTHESIOLOGY	69,373		69,373	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,202,064		4,202,064	0	0	54.00
60.00	06000	LABORATORY	4,799,685		4,799,685	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	799,092	0	799,092	0	0	65.00
66.00	06600	PHYSICAL THERAPY	781,487	0	781,487	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	114,114	0	114,114	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	20,543	0	20,543	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,277,483		1,277,483	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,235,131		2,235,131	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	609,277		609,277	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,807,865		4,807,865	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	146,046		146,046	0	0	90.00
90.01	09001	SENIOR CARE	247,236		247,236	0	0	90.01
90.02	09002	GENERAL SURGERY	636,670		636,670	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	997,814		997,814	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	640,924		640,924	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	942,419		942,419	0	0	90.05
90.06	09006	OBGYN - DR SAUER	388,277		388,277	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	2,191,572		2,191,572	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	560,733		560,733	0	0	90.08
90.09	09009	PAIN MANAGEMENT	57,068		57,068	0	0	90.09
90.10	09010	DERMATOLOGY	342,252		342,252	0	0	90.10
90.11	09011	KIDS FIRST	1,669,756		1,669,756	0	0	90.11
91.00	09100	EMERGENCY	5,189,909		5,189,909	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,570,673		2,570,673		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,209,545		5,209,545	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	56,326,299	0	56,326,299	0	0	200.00
201.00		Less Observation Beds	2,570,673		2,570,673		0	201.00
202.00		Total (see instructions)	53,755,626	0	53,755,626	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 10:04 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,009,121		7,009,121			30.00
31.00	03100	INTENSIVE CARE UNIT	634,250		634,250			31.00
43.00	04300	NURSERY	1,644,884		1,644,884			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,062,948	11,753,701	14,816,649	0.240468	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	409,435	1,896,646	2,306,081	0.030083	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,630,843	42,928,870	44,559,713	0.094302	0.000000	54.00
60.00	06000	LABORATORY	3,590,407	26,503,305	30,093,712	0.159491	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	703,848	1,440,774	2,144,622	0.372603	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	361,504	3,021,871	3,383,375	0.230979	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	287,915	375,817	663,732	0.171928	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	94,088	146,270	240,358	0.085468	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	381,481	11,402,453	11,783,934	0.108409	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	791,785	846,143	1,637,928	1.364609	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	273,105	1,025,379	1,298,484	0.469222	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,598,333	6,868,283	8,466,616	0.567861	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	183,612	183,612	0.795406	0.000000	90.00
90.01	09001	SENIOR CARE	0	183,680	183,680	1.346015	0.000000	90.01
90.02	09002	GENERAL SURGERY	0	168,914	168,914	3.769196	0.000000	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	884,333	884,333	1.128324	0.000000	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	2,058	811,839	813,897	0.787476	0.000000	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	134	389,087	389,221	2.421295	0.000000	90.05
90.06	09006	OBGYN - DR SAUER	0	37,642	37,642	10.314994	0.000000	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	1,735,164	1,735,164	1.263035	0.000000	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	543,726	543,726	1.031279	0.000000	90.08
90.09	09009	PAIN MANAGEMENT	0	119,728	119,728	0.476647	0.000000	90.09
90.10	09010	DERMATOLOGY	0	478,801	478,801	0.714811	0.000000	90.10
90.11	09011	KIDS FIRST	0	1,372,476	1,372,476	1.216601	0.000000	90.11
91.00	09100	EMERGENCY	379,087	33,836,784	34,215,871	0.151681	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,668,166	1,668,166	1.541018	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	10,608,777	10,608,777	0.491060	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,855,226	161,232,241	184,087,467			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,855,226	161,232,241	184,087,467			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 10:04 am

Title XVIII | Hospital | Cost

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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 10:04 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,740,110		9,740,110	0	9,740,110	30.00
31.00	03100	INTENSIVE CARE UNIT	933,654		933,654	0	933,654	31.00
43.00	04300	NURSERY	582,595		582,595	0	582,595	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,562,932		3,562,932	0	3,562,932	50.00
53.00	05300	ANESTHESIOLOGY	69,373		69,373	0	69,373	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,202,064		4,202,064	0	4,202,064	54.00
60.00	06000	LABORATORY	4,799,685		4,799,685	0	4,799,685	60.00
65.00	06500	RESPIRATORY THERAPY	799,092	0	799,092	0	799,092	65.00
66.00	06600	PHYSICAL THERAPY	781,487	0	781,487	0	781,487	66.00
67.00	06700	OCCUPATIONAL THERAPY	114,114	0	114,114	0	114,114	67.00
68.00	06800	SPEECH PATHOLOGY	20,543	0	20,543	0	20,543	68.00
69.00	06900	ELECTROCARDIOLOGY	1,277,483		1,277,483	0	1,277,483	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,235,131		2,235,131	0	2,235,131	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	609,277		609,277	0	609,277	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,807,865		4,807,865	0	4,807,865	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	146,046		146,046	0	146,046	90.00
90.01	09001	SENIOR CARE	247,236		247,236	0	247,236	90.01
90.02	09002	GENERAL SURGERY	636,670		636,670	0	636,670	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	997,814		997,814	0	997,814	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	640,924		640,924	0	640,924	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	942,419		942,419	0	942,419	90.05
90.06	09006	OBGYN - DR SAUER	388,277		388,277	0	388,277	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	2,191,572		2,191,572	0	2,191,572	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	560,733		560,733	0	560,733	90.08
90.09	09009	PAIN MANAGEMENT	57,068		57,068	0	57,068	90.09
90.10	09010	DERMATOLOGY	342,252		342,252	0	342,252	90.10
90.11	09011	KIDS FIRST	1,669,756		1,669,756	0	1,669,756	90.11
91.00	09100	EMERGENCY	5,189,909		5,189,909	0	5,189,909	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,570,673		2,570,673		2,570,673	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,209,545		5,209,545	0	5,209,545	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	56,326,299	0	56,326,299	0	56,326,299	200.00
201.00		Less Observation Beds	2,570,673		2,570,673		2,570,673	201.00
202.00		Total (see instructions)	53,755,626	0	53,755,626	0	53,755,626	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 10:04 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,009,121		7,009,121			30.00
31.00	03100	INTENSIVE CARE UNIT	634,250		634,250			31.00
43.00	04300	NURSERY	1,644,884		1,644,884			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,062,948	11,753,701	14,816,649	0.240468	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	409,435	1,896,646	2,306,081	0.030083	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,630,843	42,928,870	44,559,713	0.094302	0.000000	54.00
60.00	06000	LABORATORY	3,590,407	26,503,305	30,093,712	0.159491	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	703,848	1,440,774	2,144,622	0.372603	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	361,504	3,021,871	3,383,375	0.230979	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	287,915	375,817	663,732	0.171928	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	94,088	146,270	240,358	0.085468	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	381,481	11,402,453	11,783,934	0.108409	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	791,785	846,143	1,637,928	1.364609	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	273,105	1,025,379	1,298,484	0.469222	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,598,333	6,868,283	8,466,616	0.567861	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	183,612	183,612	0.795406	0.000000	90.00
90.01	09001	SENIOR CARE	0	183,680	183,680	1.346015	0.000000	90.01
90.02	09002	GENERAL SURGERY	0	168,914	168,914	3.769196	0.000000	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	884,333	884,333	1.128324	0.000000	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	2,058	811,839	813,897	0.787476	0.000000	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	134	389,087	389,221	2.421295	0.000000	90.05
90.06	09006	OBGYN - DR SAUER	0	37,642	37,642	10.314994	0.000000	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	1,735,164	1,735,164	1.263035	0.000000	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	543,726	543,726	1.031279	0.000000	90.08
90.09	09009	PAIN MANAGEMENT	0	119,728	119,728	0.476647	0.000000	90.09
90.10	09010	DERMATOLOGY	0	478,801	478,801	0.714811	0.000000	90.10
90.11	09011	KIDS FIRST	0	1,372,476	1,372,476	1.216601	0.000000	90.11
91.00	09100	EMERGENCY	379,087	33,836,784	34,215,871	0.151681	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,668,166	1,668,166	1.541018	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	10,608,777	10,608,777	0.491060	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,855,226	161,232,241	184,087,467			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,855,226	161,232,241	184,087,467			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 10:04 am

Title XIX | Hospital | Cost

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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/31/2024 10:04 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	375,608	14,816,649	0.025350	424,877	10,771	50.00
53.00	05300	ANESTHESIOLOGY	1,205	2,306,081	0.000523	63,088	33	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	225,629	44,559,713	0.005064	399,892	2,025	54.00
60.00	06000	LABORATORY	135,587	30,093,712	0.004505	787,497	3,548	60.00
65.00	06500	RESPIRATORY THERAPY	25,864	2,144,622	0.012060	226,896	2,736	65.00
66.00	06600	PHYSICAL THERAPY	75,978	3,383,375	0.022456	199,320	4,476	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,071	663,732	0.001614	152,908	247	67.00
68.00	06800	SPEECH PATHOLOGY	229	240,358	0.000953	20,066	19	68.00
69.00	06900	ELECTROCARDIOLOGY	49,460	11,783,934	0.004197	321,426	1,349	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	97,963	1,637,928	0.059809	326,467	19,526	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,080	1,298,484	0.003142	155,736	489	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	54,974	8,466,616	0.006493	452,693	2,939	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	30,378	183,612	0.165447	0	0	90.00
90.01	09001	SENIOR CARE	23,788	183,680	0.129508	0	0	90.01
90.02	09002	GENERAL SURGERY	57,196	168,914	0.338610	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	69,740	884,333	0.078862	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	90,615	813,897	0.111335	2,058	229	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	101,114	389,221	0.259786	134	35	90.05
90.06	09006	OBGYN - DR SAUER	34,432	37,642	0.914723	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	124,746	1,735,164	0.071893	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	52,100	543,726	0.095820	0	0	90.08
90.09	09009	PAIN MANAGEMENT	23,897	119,728	0.199594	0	0	90.09
90.10	09010	DERMATOLOGY	28,856	478,801	0.060267	0	0	90.10
90.11	09011	KIDS FIRST	75,585	1,372,476	0.055072	0	0	90.11
91.00	09100	EMERGENCY	183,627	34,215,871	0.005367	10,008	54	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	153,893	1,668,166	0.092253	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,097,615	164,190,435		3,543,066	48,476	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/31/2024 10:04 am

Title XVIII | Hospital | Cost

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/31/2024 10:04 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	14,816,649	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,306,081	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	44,559,713	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	30,093,712	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,144,622	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,383,375	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	663,732	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	240,358	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	11,783,934	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,637,928	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,298,484	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,466,616	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	183,612	0.000000	90.00
90.01	09001	SENIOR CARE	0	0	0	183,680	0.000000	90.01
90.02	09002	GENERAL SURGERY	0	0	0	168,914	0.000000	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	0	0	884,333	0.000000	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	0	0	813,897	0.000000	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	0	0	389,221	0.000000	90.05
90.06	09006	OBGYN - DR SAUER	0	0	0	37,642	0.000000	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	0	0	1,735,164	0.000000	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	0	0	543,726	0.000000	90.08
90.09	09009	PAIN MANAGEMENT	0	0	0	119,728	0.000000	90.09
90.10	09010	DERMATOLOGY	0	0	0	478,801	0.000000	90.10
90.11	09011	KIDS FIRST	0	0	0	1,372,476	0.000000	90.11
91.00	09100	EMERGENCY	0	0	0	34,215,871	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,668,166	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	164,190,435		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/31/2024 10:04 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	424,877	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	63,088	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	399,892	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	787,497	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	226,896	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	199,320	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	152,908	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	20,066	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	321,426	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	326,467	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	155,736	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	452,693	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0.000000	0	0	0	0	90.01
90.02	09002	GENERAL SURGERY	0.000000	0	0	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0.000000	0	0	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.000000	2,058	0	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.000000	134	0	0	0	90.05
90.06	09006	OBGYN - DR SAUER	0.000000	0	0	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0.000000	0	0	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0.000000	0	0	0	0	90.08
90.09	09009	PAIN MANAGEMENT	0.000000	0	0	0	0	90.09
90.10	09010	DERMATOLOGY	0.000000	0	0	0	0	90.10
90.11	09011	KIDS FIRST	0.000000	0	0	0	0	90.11
91.00	09100	EMERGENCY	0.000000	10,008	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		3,543,066	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 10:04 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.240468	0	2,114,342	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.030083	0	341,317	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.094302	0	9,143,599	0	0	54.00
60.00	06000	LABORATORY	0.159491	0	5,399,315	5	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.372603	0	456,833	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.230979	0	545,781	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.171928	0	114,978	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.085468	0	32,412	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108409	0	3,096,970	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.364609	0	204,571	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.469222	0	347,300	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.567861	0	2,549,381	46,193	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.795406	0	42,605	0	0	90.00
90.01	09001	SENIOR CARE	1.346015	0	82,246	0	0	90.01
90.02	09002	GENERAL SURGERY	3.769196	0	2,103	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	1.128324	0	2,758	629	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.787476	0	27,246	237	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	2.421295	0	461	0	0	90.05
90.06	09006	OBGYN - DR SAUER	10.314994	0	0	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	1.263035	0	6,020	739	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	1.031279	0	1,484	378	0	90.08
90.09	09009	PAIN MANAGEMENT	0.476647	0	129	0	0	90.09
90.10	09010	DERMATOLOGY	0.714811	0	5,925	0	0	90.10
90.11	09011	KIDS FIRST	1.216601	0	11,219	9,148	0	90.11
91.00	09100	EMERGENCY	0.151681	0	5,749,245	2,570	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.541018	0	397,032	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.491060		0			95.00
200.00		Subtotal (see instructions)		0	30,675,272	59,899	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	30,675,272	59,899	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 10:04 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	508,432	0		50.00
53.00	05300	ANESTHESIOLOGY	10,268	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	862,260	0		54.00
60.00	06000	LABORATORY	861,142	1		60.00
65.00	06500	RESPIRATORY THERAPY	170,217	0		65.00
66.00	06600	PHYSICAL THERAPY	126,064	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	19,768	0		67.00
68.00	06800	SPEECH PATHOLOGY	2,770	0		68.00
69.00	06900	ELECTROCARDIOLOGY	335,739	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	279,159	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	162,961	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,447,694	26,231		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	33,888	0		90.00
90.01	09001	SENIOR CARE	110,704	0		90.01
90.02	09002	GENERAL SURGERY	7,927	0		90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	3,112	710		90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	21,456	187		90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	1,116	0		90.05
90.06	09006	OBGYN - DR SAUER	0	0		90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	7,603	933		90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	1,530	390		90.08
90.09	09009	PAIN MANAGEMENT	61	0		90.09
90.10	09010	DERMATOLOGY	4,235	0		90.10
90.11	09011	KIDS FIRST	13,649	11,129		90.11
91.00	09100	EMERGENCY	872,051	390		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	611,833	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	6,475,639	39,971		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,475,639	39,971		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 10:04 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.240468	0	56,659	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.030083	0	59,850	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.094302	0	729,475	0	0	54.00
60.00	06000	LABORATORY	0.159491	0	486,139	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.372603	0	61,537	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.230979	0	27,012	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.171928	0	5,184	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.085468	0	458	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108409	0	127,268	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.364609	0	1,734	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.469222	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.567861	0	81,447	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.795406	0	9,408	0	0	90.00
90.01	09001	SENIOR CARE	1.346015	0	0	0	0	90.01
90.02	09002	GENERAL SURGERY	3.769196	0	6,476	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	1.128324	0	17,313	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.787476	0	3,943	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	2.421295	0	9,157	0	0	90.05
90.06	09006	OBGYN - DR SAUER	10.314994	0	37,223	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	1.263035	0	10,725	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	1.031279	0	5,657	0	0	90.08
90.09	09009	PAIN MANAGEMENT	0.476647	0	696	0	0	90.09
90.10	09010	DERMATOLOGY	0.714811	0	2,272	0	0	90.10
90.11	09011	KIDS FIRST	1.216601	0	52,968	0	0	90.11
91.00	09100	EMERGENCY	0.151681	0	829,344	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.541018	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.491060	0	337,550			95.00
200.00		Subtotal (see instructions)		0	2,959,495	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	2,959,495	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 10:04 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	13,625	0		50.00
53.00	05300	ANESTHESIOLOGY	1,800	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	68,791	0		54.00
60.00	06000	LABORATORY	77,535	0		60.00
65.00	06500	RESPIRATORY THERAPY	22,929	0		65.00
66.00	06600	PHYSICAL THERAPY	6,239	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	891	0		67.00
68.00	06800	SPEECH PATHOLOGY	39	0		68.00
69.00	06900	ELECTROCARDIOLOGY	13,797	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,366	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	46,251	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	7,483	0		90.00
90.01	09001	SENIOR CARE	0	0		90.01
90.02	09002	GENERAL SURGERY	24,409	0		90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	19,535	0		90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	3,105	0		90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	22,172	0		90.05
90.06	09006	OBGYN - DR SAUER	383,955	0		90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	13,546	0		90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	5,834	0		90.08
90.09	09009	PAIN MANAGEMENT	332	0		90.09
90.10	09010	DERMATOLOGY	1,624	0		90.10
90.11	09011	KIDS FIRST	64,441	0		90.11
91.00	09100	EMERGENCY	125,796	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	165,757			95.00
200.00		Subtotal (see instructions)	1,092,252	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	1,092,252	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 10:04 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,470	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,432	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,520	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	22	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	16	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)	684	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)	22	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	266.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	266.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,740,110	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)	4,261	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)	66,273	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9,673,837	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	9,673,837	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,818.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,928,004	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)	1,928,004	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 10:04 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	933,654	201	4,645.04	66	306,573	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,239,912	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	3,474,489	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)	62,012	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	62,012	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)	912	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,818.72	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 10:04 am

Title XVIII | Hospital | Cost

	Cost Center Description						
						1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,570,673	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	583,094	9,740,110	0.059865	2,570,673	153,893	90.00
91.00	Nursing Program cost	0	9,740,110	0.000000	2,570,673	0	91.00
92.00	Allied health cost	0	9,740,110	0.000000	2,570,673	0	92.00
93.00	All other Medical Education	0	9,740,110	0.000000	2,570,673	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 10:04 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)	3,470	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,432	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,520	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	22	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	16	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)	75	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)	720	15.00
16.00	Nursery days (title V or XIX only)	20	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	266.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	266.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,740,110	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)	4,261	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)	66,273	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9,673,837	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	9,673,837	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,818.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	211,404	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)	211,404	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 10:04 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)	582,595	720	809.16	20	16,183	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	933,654	201	4,645.04	6	27,870	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)	88,171	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)	343,628	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)	912	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,818.72	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 10:04 am

Title XIX | Hospital | Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,570,673	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	583,094	9,740,110	0.059865	2,570,673	153,893	90.00
91.00	Nursing Program cost	0	9,740,110	0.000000	2,570,673	0	91.00
92.00	Allied health cost	0	9,740,110	0.000000	2,570,673	0	92.00
93.00	All other Medical Education	0	9,740,110	0.000000	2,570,673	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/31/2024 10:04 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,122,079		30.00
31.00	03100	INTENSIVE CARE UNIT		208,215		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.240468	424,877	102,169	50.00
53.00	05300	ANESTHESIOLOGY	0.030083	63,088	1,898	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.094302	399,892	37,711	54.00
60.00	06000	LABORATORY	0.159491	787,497	125,599	60.00
65.00	06500	RESPIRATORY THERAPY	0.372603	226,896	84,542	65.00
66.00	06600	PHYSICAL THERAPY	0.230979	199,320	46,039	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.171928	152,908	26,289	67.00
68.00	06800	SPEECH PATHOLOGY	0.085468	20,066	1,715	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108409	321,426	34,845	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.364609	326,467	445,500	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.469222	155,736	73,075	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.567861	452,693	257,067	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.795406	0	0	90.00
90.01	09001	SENIOR CARE	1.346015	0	0	90.01
90.02	09002	GENERAL SURGERY	3.769196	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	1.128324	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.787476	2,058	1,621	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	2.421295	134	324	90.05
90.06	09006	OBGYN - DR SAUER	10.314994	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	1.263035	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	1.031279	0	0	90.08
90.09	09009	PAIN MANAGEMENT	0.476647	0	0	90.09
90.10	09010	DERMATOLOGY	0.714811	0	0	90.10
90.11	09011	KIDS FIRST	1.216601	0	0	90.11
91.00	09100	EMERGENCY	0.151681	10,008	1,518	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.541018	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,543,066	1,239,912	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)		3,543,066		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3

Component CCN: 15-Z331 | Date/Time Prepared: 5/31/2024 10:04 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.240468	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.030083	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.094302	0	0	54.00
60.00	06000	LABORATORY	0.159491	1,813	289	60.00
65.00	06500	RESPIRATORY THERAPY	0.372603	2,490	928	65.00
66.00	06600	PHYSICAL THERAPY	0.230979	11,181	2,583	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.171928	10,233	1,759	67.00
68.00	06800	SPEECH PATHOLOGY	0.085468	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108409	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.364609	84	115	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.469222	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.567861	4,983	2,830	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.795406	0	0	90.00
90.01	09001	SENIOR CARE	1.346015	0	0	90.01
90.02	09002	GENERAL SURGERY	3.769196	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	1.128324	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.787476	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	2.421295	0	0	90.05
90.06	09006	OBGYN - DR SAUER	10.314994	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	1.263035	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	1.031279	0	0	90.08
90.09	09009	PAIN MANAGEMENT	0.476647	0	0	90.09
90.10	09010	DERMATOLOGY	0.714811	0	0	90.10
90.11	09011	KIDS FIRST	1.216601	0	0	90.11
91.00	09100	EMERGENCY	0.151681	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.541018	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		30,784	8,504	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)		30,784		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/31/2024 10:04 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		472,516		30.00
31.00	03100	INTENSIVE CARE UNIT		39,159		31.00
43.00	04300	NURSERY		85,100		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.240468	75,867	18,244	50.00
53.00	05300	ANESTHESIOLOGY	0.030083	8,924	268	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.094302	68,111	6,423	54.00
60.00	06000	LABORATORY	0.159491	118,370	18,879	60.00
65.00	06500	RESPIRATORY THERAPY	0.372603	45,692	17,025	65.00
66.00	06600	PHYSICAL THERAPY	0.230979	3,317	766	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.171928	3,364	578	67.00
68.00	06800	SPEECH PATHOLOGY	0.085468	458	39	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108409	18,597	2,016	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.364609	1,255	1,713	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.469222	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.567861	38,395	21,803	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.795406	0	0	90.00
90.01	09001	SENIOR CARE	1.346015	0	0	90.01
90.02	09002	GENERAL SURGERY	3.769196	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	1.128324	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.787476	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	2.421295	0	0	90.05
90.06	09006	OBGYN - DR SAUER	10.314994	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	1.263035	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	1.031279	0	0	90.08
90.09	09009	PAIN MANAGEMENT	0.476647	0	0	90.09
90.10	09010	DERMATOLOGY	0.714811	0	0	90.10
90.11	09011	KIDS FIRST	1.216601	0	0	90.11
91.00	09100	EMERGENCY	0.151681	2,748	417	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.541018	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		385,098	88,171	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)		385,098		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/31/2024 10:04 am

Title XIX | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.240468	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.030083	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.094302	0	0	54.00
60.00	06000	LABORATORY	0.159491	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.372603	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.230979	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.171928	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.085468	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108409	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.364609	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.469222	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.567861	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.795406	0	0	90.00
90.01	09001	SENIOR CARE	1.346015	0	0	90.01
90.02	09002	GENERAL SURGERY	3.769196	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	1.128324	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.787476	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	2.421295	0	0	90.05
90.06	09006	OBGYN - DR SAUER	10.314994	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	1.263035	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	1.031279	0	0	90.08
90.09	09009	PAIN MANAGEMENT	0.476647	0	0	90.09
90.10	09010	DERMATOLOGY	0.714811	0	0	90.10
90.11	09011	KIDS FIRST	1.216601	0	0	90.11
91.00	09100	EMERGENCY	0.151681	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.541018	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1331	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/31/2024 10:04 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,515,610	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,515,610	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	6,580,766	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	67,290	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,005,806	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,507,670	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)	1,507,670	30.00
31.00	Primary payer payments	295	31.00
32.00	Subtotal (line 30 minus line 31)	1,507,375	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)	487,697	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	317,003	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	247,518	36.00
37.00	Subtotal (see instructions)	1,824,378	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,824,378	40.00
40.01	Sequestration adjustment (see instructions)	36,488	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	1,653,814	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)	134,076	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: 15-1331	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/31/2024 10:04 am
	Title XVIII	Hospital	Cost

			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: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I Date/Time Prepared: 5/31/2024 10:04 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,325,646		1,653,814	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	09/18/2023	287,900		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		287,900		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,613,546		1,653,814	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		601,364		134,076	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,214,910		1,787,890	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2024 10:04 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		60,056		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		60,056		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		9,741		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		69,797		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1331	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/31/2024 10:04 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/31/2024 10:04 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	62,632	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	8,589	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	22	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	71,221	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	71,221	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	71,221	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	71,221	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	71,221	0	19.00
19.01	Sequestration adjustment (see instructions)	1,424	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	60,056	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	9,741	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/31/2024 10:04 am

Title XIX | Swing Beds - SNF | Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1331	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 5/31/2024 10:04 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,474,489	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	3,474,489	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,509,234	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,509,234	19.00
20.00	Deductibles (exclude professional component)	239,956	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,269,278	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,269,278	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	17,296	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	11,242	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	7,632	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,280,520	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	3,280,520	30.00
30.01	Sequestration adjustment (see instructions)	65,610	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	2,613,546	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	601,364	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-1331	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/31/2024 10:04 am
	Title XVIII		Cost

		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: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/31/2024 10:04 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	823,473	0	0	0	1.00
2.00	Temporary investments	10,245	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	28,090,781	0	0	0	4.00
5.00	Other receivable	2,890,436	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-22,707,187	0	0	0	6.00
7.00	Inventory	1,338,440	0	0	0	7.00
8.00	Prepaid expenses	1,459,309	0	0	0	8.00
9.00	Other current assets	157,974	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)	12,063,471	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,001,138	0	0	0	12.00
13.00	Land improvements	3,334,019	0	0	0	13.00
14.00	Accumulated depreciation	-2,741,484	0	0	0	14.00
15.00	Buildings	42,563,319	0	0	0	15.00
16.00	Accumulated depreciation	-29,067,603	0	0	0	16.00
17.00	Leasehold improvements	4,243,870	0	0	0	17.00
18.00	Accumulated depreciation	-2,796,117	0	0	0	18.00
19.00	Fixed equipment	346,074	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	25,498,242	0	0	0	23.00
24.00	Accumulated depreciation	-23,704,002	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)	20,677,456	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,618,774	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	-152,149	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,466,625	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	36,207,552	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,636,213	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,548,055	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	583,265	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,767,533	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	4,114,337	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,114,337	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	10,881,870	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	25,325,682				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)	25,325,682	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	36,207,552	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/31/2024 10:04 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		29,140,003		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-3,814,321				2.00
3.00	Total (sum of line 1 and line 2)		25,325,682		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)		25,325,682		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)		25,325,682		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/31/2024 10:04 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,977,680		6,977,680	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,977,680		6,977,680	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	657,987		657,987	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)	657,987		657,987	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	7,635,667		7,635,667	17.00
18.00	Ancillary services	14,847,507	160,472,415	175,319,922	18.00
19.00	Outpatient services	0	10,192	10,192	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	10,608,777	10,608,777	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	22,483,174	171,091,384	193,574,558	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		65,789,819		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)		65,789,819		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1331	Period: From 01/01/2023 To 12/31/2023	Worksheet G-3 Date/Time Prepared: 5/31/2024 10:04 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	193,574,558	1.00
2.00	Less contractual allowances and discounts on patients' accounts	138,573,858	2.00
3.00	Net patient revenues (line 1 minus line 2)	55,000,700	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	65,789,819	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-10,789,119	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	51,000	6.00
7.00	Income from investments	6,259	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	151,195	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	12,719	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	213,507	22.00
23.00	Governmental appropriations	31,801	23.00
24.00	OTHER OPERATING INCOME	6,508,317	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	6,974,798	25.00
26.00	Total (line 5 plus line 25)	-3,814,321	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-3,814,321	29.00