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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0037	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/26/2023 1:33 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/26/2023 Time: 1:33 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HANCOCK REGIONAL HOSPITAL (15-0037) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

		Title V	Title XVIII 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	459,962	24,278	0	-105,843	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		5,468		0	10.00
200.00	TOTAL	0	459,962	29,746	0	-105,843	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 1:33 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2023 1:33 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	169	133	0	0	1,616	39	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	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: 15-0037	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 1:33 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2023 1:33 pm

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

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

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

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

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					1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)					
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?				N	68.00
			1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)		N	N	0	71.00
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.		N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)		N	N	0	76.00
				1.00		
	Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N		81.00
	TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N		87.00
			Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments		
			1.00	2.00		
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.			0		88.00
		Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge		
		1.00	2.00	3.00		
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	0.00		0		89.00
			V	XIX		
			1.00	2.00		
	Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00		97.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2023 1:33 pm

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

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			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: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 1:33 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2023 1:33 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	06/15/2023	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/06/2023	Y	03/06/2023	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II Date/Time Prepared: 5/26/2023 1:33 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0037	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/26/2023 1:33 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2023 1:33 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	81	29,565	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		81	29,565	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	24	8,760	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		105	38,325	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		105				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2023 1:33 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,026	169	4,782			1.00
2.00	HMO and other (see instructions)	2,896	1,749				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,026	169	4,782			7.00
8.00	INTENSIVE CARE UNIT	2,232	0	5,984			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)	3,258	169	10,766	0.00	787.45	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			468			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	115	128	4,738	0.00	4.27	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	791.72	27.00
28.00	Observation Bed Days		0	3,014			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			98			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	39	76			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2023 1:33 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	740	32	2,988	1.00
2.00	HMO and other (see instructions)			565	422		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	740	32	2,988	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part II | Date/Time Prepared: 5/26/2023 1:33 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	67,583,324	-232,573	67,350,751	1,574,157.00	42.79	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		3,818,239	0	3,818,239	26,803.00	142.46	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		122,712	0	122,712	5,864.00	20.93	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		15,170,088	-705,142	14,464,946	257,673.00	56.14	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		3,820,956	0	3,820,956	32,030.00	119.29	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		28,750	0	28,750	482.00	59.65	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		12,249,747	0	12,249,747			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		2,564,462	0	2,564,462			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		461,928	0	461,928			23.00
24.00	Wage-related costs (RHC/FQHC)		43,360	0	43,360			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part II | Date/Time Prepared: 5/26/2023 1:33 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	535,318	-7,445	527,873	19,776.00	26.69	26.00
27.00	Administrative & General	5.00	10,317,386	-217,490	10,099,896	242,412.00	41.66	27.00
28.00	Administrative & General under contract (see inst.)		339,430	0	339,430	1,514.00	224.19	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,294,859	0	1,294,859	36,919.00	35.07	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,991,030	-3,691	1,987,339	97,346.00	20.42	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,688,941	-1,014,813	674,128	30,361.00	22.20	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,006,246	1,006,246	90,848.00	11.08	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,651,180	0	1,651,180	28,595.00	57.74	38.00
39.00	Central Services and Supply	14.00	325,965	0	325,965	8,820.00	36.96	39.00
40.00	Pharmacy	15.00	2,766,947	-17,744	2,749,203	56,219.00	48.90	40.00
41.00	Medical Records & Medical Records Library	16.00	651,654	-2,182	649,472	26,269.00	24.72	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part III Date/Time Prepared: 5/26/2023 1:33 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		63,981,803	-232,573	63,749,230	1,543,004.00	41.32	1.00
2.00	Excluded area salaries (see instructions)		15,170,088	-705,142	14,464,946	257,673.00	56.14	2.00
3.00	Subtotal salaries (line 1 minus line 2)		48,811,715	472,569	49,284,284	1,285,331.00	38.34	3.00
4.00	Subtotal other wages & related costs (see inst.)		3,849,706	0	3,849,706	32,512.00	118.41	4.00
5.00	Subtotal wage-related costs (see inst.)		12,249,747	0	12,249,747	0.00	24.86	5.00
6.00	Total (sum of lines 3 thru 5)		64,911,168	472,569	65,383,737	1,317,843.00	49.61	6.00
7.00	Total overhead cost (see instructions)		21,562,710	-257,119	21,305,591	639,079.00	33.34	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part IV Date/Time Prepared: 5/26/2023 1:33 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	2,980,718	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	6,992,890	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	440,923	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	-31,261	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	455,554	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	4,387,397	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	2,117	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	18,834	22.00
23.00	Tuition Reimbursement	72,324	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	15,319,496	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part V | Date/Time Prepared: 5/26/2023 1:33 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	4,160,386	15,319,496	1.00
2.00	Hospital	4,160,386	15,319,496	2.00
3.00	SUBPROVIDER - IPF	0	0	3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0037 | Component CCN: 15-3987 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/26/2023 1:33 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			224 WEST MAIN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	KNIGHTSTOWN		IN	46148	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)		137632		07/01/2015	4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

	1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	Y	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0 13.00

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		HANCOCK				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0037
Component CCN: 15-3987

Period:
From 01/01/2022
To 12/31/2022

Worksheet S-8
Date/Time Prepared:
5/26/2023 1:33 pm

RHC I

Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-10 | Date/Time Prepared: 5/26/2023 1:33 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.246020	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,361,069	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	65,193,224	6.00
7.00	Medicaid cost (line 1 times line 6)	16,038,837	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	8,677,768	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	8,677,768	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	4,194,400	323,246	4,517,646	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,031,906	323,246	1,355,152	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,031,906	323,246	1,355,152	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,208,205	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	100,388	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	154,443	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,053,762	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	559,322	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,914,474	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	10,592,242	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/26/2023 1:33 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		17,836,043	17,836,043	0	17,836,043	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	535,318	10,947,306	11,482,624	-8,815	11,473,809	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,317,386	27,402,359	37,719,745	-926,695	36,793,050	5.00
7.00	00700	OPERATION OF PLANT	1,294,859	6,646,891	7,941,750	1,377	7,943,127	7.00
9.00	00900	HOUSEKEEPING	1,991,030	894,096	2,885,126	0	2,885,126	9.00
10.00	01000	DIETARY	1,688,941	1,500,887	3,189,828	-1,864,529	1,325,299	10.00
11.00	01100	CAFETERIA	0	0	0	1,864,529	1,864,529	11.00
13.00	01300	NURSING ADMINISTRATION	1,651,180	400,601	2,051,781	0	2,051,781	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	325,965	85,725	411,690	0	411,690	14.00
15.00	01500	PHARMACY	2,766,947	20,359,697	23,126,644	-19,387,129	3,739,515	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	651,654	352,272	1,003,926	4,473	1,008,399	16.00
23.00	02300	PARAMED ED PRGM	91,123	12,536	103,659	-118	103,541	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,775,220	2,049,264	5,824,484	735,578	6,560,062	30.00
31.00	03100	INTENSIVE CARE UNIT	4,288,006	2,569,962	6,857,968	-206,978	6,650,990	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,517,310	5,302,292	9,819,602	-1,733,540	8,086,062	50.00
51.00	05100	RECOVERY ROOM	617,411	95,435	712,846	-26,087	686,759	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,568,254	2,257,871	6,826,125	-471,598	6,354,527	54.00
60.00	06000	LABORATORY	2,025,513	3,983,165	6,008,678	-1,880	6,006,798	60.00
65.00	06500	RESPIRATORY THERAPY	1,917,445	425,295	2,342,740	-46,566	2,296,174	65.00
66.00	06600	PHYSICAL THERAPY	1,329,135	223,154	1,552,289	-12,754	1,539,535	66.00
67.00	06700	OCCUPATIONAL THERAPY	369,968	36,352	406,320	-4,785	401,535	67.00
68.00	06800	SPEECH PATHOLOGY	197,777	22,943	220,720	-941	219,779	68.00
69.00	06900	ELECTROCARDIOLOGY	608,486	781,772	1,390,258	-497,487	892,771	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	233	233	3,476,624	3,476,857	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,728,469	1,728,469	0	1,728,469	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	20,487,386	20,487,386	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	67,699	13,246	80,945	-11	80,934	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	291,014	274,468	565,482	-41,980	523,502	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	462,496	524,044	986,540	-63,308	923,232	90.01
90.02	09002	DIABETES CLINIC	45,945	13,487	59,432	0	59,432	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	99,191	42,182	141,373	-307	141,066	90.04
90.05	09005	PRIME TIME	0	7,900	7,900	0	7,900	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
90.07	04951	ONCOLOGY	2,692,819	71,087	2,763,906	-47,973	2,715,933	90.07
90.08	04950	ANDERSON WOMENS CENTER	468,756	336,922	805,678	-131,014	674,664	90.08
91.00	09100	EMERGENCY	2,847,511	3,730,112	6,577,623	-262,834	6,314,789	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	920,990	155,969	1,076,959	-1,076,959	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	53,425,349	111,084,037	164,509,386	-244,321	164,265,065	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	277,291	277,291	-13,173	264,118	190.01
190.02	19002	PHYSICIAN BUILDING	0	729,029	729,029	0	729,029	190.02
190.03	19003	PRIVATE DUTY	282,320	877,235	1,159,555	0	1,159,555	190.03
190.04	19004	MARKETING	0	0	0	928,763	928,763	190.04
190.05	19005	SPORTS PHYSICALS	318,492	29,403	347,895	0	347,895	190.05
190.06	19006	FOUNDATION	243,521	796,608	1,040,129	0	1,040,129	190.06
190.07	19007	ASC	0	7,588	7,588	-5,265	2,323	190.07
190.08	19008	GATEWAY LOCATION	3,529,380	1,417,541	4,946,921	-148,586	4,798,335	190.08
190.09	19009	HANCOCK OB	4,424,875	2,347,319	6,772,194	-466,168	6,306,026	190.09
190.10	19010	HANCOCK WELLNESS	890,955	279,600	1,170,555	0	1,170,555	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	905,672	460,680	1,366,352	0	1,366,352	190.13
190.14	19014	3 WEST UNIT	207,839	238,985	446,824	-2,362	444,462	190.14
190.15	19015	NEUROLOGY PHYSICIAN	1,248,356	392,688	1,641,044	-106,510	1,534,534	190.15
190.16	19016	THORACI	77,464	14,216	91,680	0	91,680	190.16

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/26/2023 1:33 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
190.17	19017	HANCOCK ENDO	834,071	385,395	1,219,466	-48,879	1,170,587	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	61,476	29,603	91,079	0	91,079	190.19
194.00	07950	OTHER NONREIMBURSABLE	320	427	747	0	747	194.00
194.01	07951	SUBURBAN HOSPICE	0	0	0	107,821	107,821	194.01
194.02	07952	HRH HANCOCK GI	768,891	175,854	944,745	0	944,745	194.02
194.03	07954	HRH NEPHROLOGY	157,235	131,293	288,528	0	288,528	194.03
194.04	07957	HRH SANE	104,239	64,304	168,543	-1,320	167,223	194.04
194.05	07955	HRH RISE	0	379,942	379,942	0	379,942	194.05
194.06	07956	HRH JUSTICE NAVIGATION	102,869	61,068	163,937	0	163,937	194.06
200.00		TOTAL (SUM OF LINES 118 through 199)	67,583,324	120,180,106	187,763,430	0	187,763,430	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/26/2023 1:33 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-805,573	17,030,470		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-6,455,180	5,018,629		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-15,164,786	21,628,264		5.00
7.00	00700	OPERATION OF PLANT	-11,820	7,931,307		7.00
9.00	00900	HOUSEKEEPING	-142,710	2,742,416		9.00
10.00	01000	DIETARY	-736,926	588,373		10.00
11.00	01100	CAFETERIA	-890,026	974,503		11.00
13.00	01300	NURSING ADMINISTRATION	-21,125	2,030,656		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-3,752	407,938		14.00
15.00	01500	PHARMACY	-1,901,299	1,838,216		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-61,206	947,193		16.00
23.00	02300	PARAMED ED PRGM	-39,819	63,722		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-914,959	5,645,103		30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,650,990		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-2,630,841	5,455,221		50.00
51.00	05100	RECOVERY ROOM	0	686,759		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-703,719	5,650,808		54.00
60.00	06000	LABORATORY	-634,720	5,372,078		60.00
65.00	06500	RESPIRATORY THERAPY	-47,718	2,248,456		65.00
66.00	06600	PHYSICAL THERAPY	-60	1,539,475		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	401,535		67.00
68.00	06800	SPEECH PATHOLOGY	0	219,779		68.00
69.00	06900	ELECTROCARDIOLOGY	0	892,771		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,476,857		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,728,469		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,487,386		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	80,934		76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	523,502		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	-304,218	619,014		90.01
90.02	09002	DIABETES CLINIC	0	59,432		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	0	141,066		90.04
90.05	09005	PRIME TIME	-3,615	4,285		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0		90.06
90.07	04951	ONCOLOGY	-1,022,112	1,693,821		90.07
90.08	04950	ANDERSON WOMENS CENTER	-84,900	589,764		90.08
91.00	09100	EMERGENCY	-95,090	6,219,699		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-32,676,174	131,588,891		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	264,118		190.01
190.02	19002	PHYSICIAN BUILDING	0	729,029		190.02
190.03	19003	PRIVATE DUTY	0	1,159,555		190.03
190.04	19004	MARKETING	0	928,763		190.04
190.05	19005	SPORTS PHYSICALS	0	347,895		190.05
190.06	19006	FOUNDATION	0	1,040,129		190.06
190.07	19007	ASC	0	2,323		190.07
190.08	19008	GATEWAY LOCATION	0	4,798,335		190.08
190.09	19009	HANCOCK OB	0	6,306,026		190.09
190.10	19010	HANCOCK WELLNESS	0	1,170,555		190.10
190.11	19011	MORRISTOWN CLINIC	0	0		190.11
190.12	19012	O3PUREMED	0	0		190.12
190.13	19013	MCCORD WELLNESS	0	1,366,352		190.13
190.14	19014	3 WEST UNIT	0	444,462		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	1,534,534		190.15
190.16	19016	THORACI	0	91,680		190.16
190.17	19017	HANCOCK ENDO	0	1,170,587		190.17

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/26/2023 1:33 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
190.18	19018	HANCOCK FOOT & ANKLE	0	0		190.18
190.19	19019	HANCOCK RHEUM	0	91,079		190.19
194.00	07950	OTHER NONREIMBURSABLE	0	747		194.00
194.01	07951	SUBURBAN HOSPICE	0	107,821		194.01
194.02	07952	HRH HANCOCK GI	0	944,745		194.02
194.03	07954	HRH NEPHROLOGY	0	288,528		194.03
194.04	07957	HRH SANE	0	167,223		194.04
194.05	07955	HRH RISE	0	379,942		194.05
194.06	07956	HRH JUSTICE NAVIGATION	0	163,937		194.06
200.00		TOTAL (SUM OF LINES 118 through 199)	-32,676,174	155,087,256		200.00

RECLASSIFICATIONS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/26/2023 1:33 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	1,006,246	858,283		1.00
	TOTALS		1,006,246	858,283		
	B - PLANT					
1.00	OPERATION OF PLANT	7.00	0	1,377		1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,473		2.00
3.00	ELECTROCARDIOLOGY	69.00	0	4,400		3.00
4.00	RESPIRATORY THERAPY	65.00	0	2,923		4.00
	TOTALS		0	13,173		
	C - MARKETING					
1.00	MARKETING	190.04	170,201	758,562		1.00
	TOTALS		170,201	758,562		
	E - DRUG RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	20,487,386		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	2,218		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
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
	TOTALS		0	20,489,604		
	F - TERM ETO BENEFIT RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,445		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	47,289		2.00
3.00	HOUSEKEEPING	9.00	0	3,691		3.00
4.00	DIETARY	10.00	0	8,567		4.00
5.00	PHARMACY	15.00	0	17,744		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,182		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	30,477		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	9,680		8.00
9.00	OPERATING ROOM	50.00	0	20,919		9.00
10.00	RECOVERY ROOM	51.00	0	2,584		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10,393		11.00
12.00	LABORATORY	60.00	0	6,189		12.00
13.00	RESPIRATORY THERAPY	65.00	0	5,139		13.00
14.00	WOUND CLINIC	90.01	0	3,807		14.00
15.00	ONCOLOGY	90.07	0	384		15.00
16.00	EMERGENCY	91.00	0	7,543		16.00
18.00	PRIVATE DUTY	190.03	0	801		18.00
19.00	SPORTS PHYSICALS	190.05	0	6,073		19.00
20.00	GATEWAY LOCATION	190.08	0	24,610		20.00
21.00	MCCORD WELLNESS	190.13	0	10,558		21.00
22.00	HANCOCK ENDO	190.17	0	6,174		22.00
23.00	SUBURBAN HOSPICE	194.01	0	324		23.00
	TOTALS		0	232,573		
	G - TRANSITION UNIT RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	826,803	140,018		1.00
2.00	SUBURBAN HOSPICE	194.01	94,187	15,951		2.00
	TOTALS		920,990	155,969		
	H - IMPANTABLE SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,238		1.00
	TOTALS		0	2,238		

RECLASSIFICATIONS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/26/2023 1:33 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	I - MED SUPPLY RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,474,532	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
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
	TOTALS		0	3,474,532	
500.00	Grand Total: Increases		2,097,437	25,984,934	500.00

RECLASSIFICATIONS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/26/2023 1:33 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA					
1.00	DIETARY	10.00	1,006,246	858,283	0	1.00
	TOTALS		1,006,246	858,283		
	B - PLANT					
1.00	PROFESSIONAL BUILDING	190.01	0	13,173	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
	TOTALS		0	13,173		
	C - MARKETING					
1.00	ADMINISTRATIVE & GENERAL	5.00	170,201	758,562	0	1.00
	TOTALS		170,201	758,562		
	E - DRUG RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8,815	0	1.00
2.00	PHARMACY	15.00	0	19,351,455	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	13,616	0	3.00
4.00	INTENSIVE CARE UNIT	31.00	0	23,207	0	4.00
5.00	OPERATING ROOM	50.00	0	8,546	0	5.00
6.00	RECOVERY ROOM	51.00	0	1,302	0	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	339,179	0	7.00
8.00	LABORATORY	60.00	0	318	0	8.00
9.00	RESPIRATORY THERAPY	65.00	0	195	0	9.00
10.00	PHYSICAL THERAPY	66.00	0	2,073	0	10.00
11.00	ELECTROCARDIOLOGY	69.00	0	27,887	0	11.00
12.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	146	0	12.00
13.00	RURAL HEALTH CLINIC	88.00	0	41,660	0	13.00
14.00	WOUND CLINIC	90.01	0	12,206	0	14.00
15.00	ANDIS CLINIC	90.04	0	13	0	15.00
16.00	ONCOLOGY	90.07	0	8,631	0	16.00
17.00	ANDERSON WOMENS CENTER	90.08	0	497	0	17.00
18.00	EMERGENCY	91.00	0	21,488	0	18.00
20.00	ASC	190.07	0	105	0	20.00
21.00	GATEWAY LOCATION	190.08	0	36,425	0	21.00
22.00	HANCOCK OB	190.09	0	449,591	0	22.00
23.00	NEUROLOGY PHYSICIAN	190.15	0	92,277	0	23.00
24.00	HANCOCK ENDO	190.17	0	48,639	0	24.00
25.00	HRH SANE	194.04	0	1,102	0	25.00
26.00	SUBURBAN HOSPICE	194.01	0	231	0	26.00
	TOTALS		0	20,489,604		
	F - TERM ETO BENEFIT RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	7,445	0	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	47,289	0	0	2.00
3.00	HOUSEKEEPING	9.00	3,691	0	0	3.00
4.00	DIETARY	10.00	8,567	0	0	4.00
5.00	PHARMACY	15.00	17,744	0	0	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	2,182	0	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	30,477	0	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	9,680	0	0	8.00
9.00	OPERATING ROOM	50.00	20,919	0	0	9.00
10.00	RECOVERY ROOM	51.00	2,584	0	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	10,393	0	0	11.00
12.00	LABORATORY	60.00	6,189	0	0	12.00
13.00	RESPIRATORY THERAPY	65.00	5,139	0	0	13.00
14.00	WOUND CLINIC	90.01	3,807	0	0	14.00
15.00	ONCOLOGY	90.07	384	0	0	15.00
16.00	EMERGENCY	91.00	7,543	0	0	16.00
18.00	PRIVATE DUTY	190.03	801	0	0	18.00
19.00	SPORTS PHYSICALS	190.05	6,073	0	0	19.00
20.00	GATEWAY LOCATION	190.08	24,610	0	0	20.00
21.00	MCCORD WELLNESS	190.13	10,558	0	0	21.00
22.00	HANCOCK ENDO	190.17	6,174	0	0	22.00
23.00	SUBURBAN HOSPICE	194.01	324	0	0	23.00
	TOTALS		232,573	0		
	G - TRANSITION UNIT RECLASS					
1.00	HOSPICE	116.00	920,990	155,969	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		920,990	155,969		
	H - IMPANTABLE SUPPLY RECLASS					
1.00	GATEWAY LOCATION	190.08	0	2,238	0	1.00
	TOTALS		0	2,238		

RECLASSIFICATIONS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/26/2023 1:33 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	I - MED SUPPLY RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	150	0	1.00
2.00	PHARMACY	15.00	0	35,674	0	2.00
3.00	PARAMED ED PRGM	23.00	0	118	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	217,627	0	4.00
5.00	INTENSIVE CARE UNIT	31.00	0	183,771	0	5.00
6.00	OPERATING ROOM	50.00	0	1,724,994	0	6.00
7.00	RECOVERY ROOM	51.00	0	24,785	0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	132,419	0	8.00
9.00	LABORATORY	60.00	0	1,562	0	9.00
10.00	RESPIRATORY THERAPY	65.00	0	49,294	0	10.00
11.00	PHYSICAL THERAPY	66.00	0	10,681	0	11.00
12.00	OCCUPATIONAL THERAPY	67.00	0	4,785	0	12.00
13.00	SPEECH PATHOLOGY	68.00	0	941	0	13.00
14.00	ELECTROCARDIOLOGY	69.00	0	474,000	0	14.00
15.00	CARDIOPULMONARY	76.01	0	11	0	15.00
16.00	RURAL HEALTH CLINIC	88.00	0	320	0	16.00
17.00	WOUND CLINIC	90.01	0	51,102	0	17.00
18.00	ANDIS CLINIC	90.04	0	294	0	18.00
19.00	ONCOLOGY	90.07	0	39,342	0	19.00
20.00	ANDERSON WOMENS CENTER	90.08	0	130,517	0	20.00
21.00	EMERGENCY	91.00	0	241,346	0	21.00
23.00	ASC	190.07	0	5,160	0	23.00
24.00	GATEWAY LOCATION	190.08	0	109,923	0	24.00
25.00	HANCOCK OB	190.09	0	16,577	0	25.00
26.00	3 WEST UNIT	190.14	0	2,362	0	26.00
27.00	NEUROLOGY PHYSICIAN	190.15	0	14,233	0	27.00
28.00	HANCOCK ENDO	190.17	0	240	0	28.00
29.00	HRH SANE	194.04	0	218	0	29.00
30.00	SUBURBAN HOSPICE	194.01	0	2,086	0	30.00
	TOTALS		0	3,474,532		
500.00	Grand Total: Decreases		2,330,010	25,752,361		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part I | Date/Time Prepared: 5/26/2023 1:33 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,494,664	0	0	0	0	1.00
2.00	Land Improvements	26,217,818	707,863	0	707,863	0	2.00
3.00	Buildings and Fixtures	173,797,167	4,103,858	0	4,103,858	0	3.00
4.00	Building Improvements	235,570	17,621	0	17,621	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	95,936,993	4,025,651	0	4,025,651	43,155	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	298,682,212	8,854,993	0	8,854,993	43,155	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	298,682,212	8,854,993	0	8,854,993	43,155	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,494,664	0	1.00
2.00	Land Improvements	26,925,681	0	2.00
3.00	Buildings and Fixtures	177,901,025	0	3.00
4.00	Building Improvements	253,191	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	99,919,489	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	307,494,050	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	307,494,050	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part II | Date/Time Prepared: 5/26/2023 1:33 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	15,960,705	0	0	1,438,787	436,551	1.00
3.00	Total (sum of lines 1-2)	15,960,705	0	0	1,438,787	436,551	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	17,836,043		1.00
3.00	Total (sum of lines 1-2)	0	17,836,043		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part III | Date/Time Prepared: 5/26/2023 1:33 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	319,973,630	0	319,973,630	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	319,973,630	0	319,973,630	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	15,960,705	-800,866	1.00
3.00	Total (sum of lines 1-2)	0	0	0	15,960,705	-800,866	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	-4,707	1,438,787	436,551	0	17,030,470	1.00
3.00	Total (sum of lines 1-2)	-4,707	1,438,787	436,551	0	17,030,470	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/26/2023 1:33 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,013,259			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	-858,283	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/26/2023 1:33 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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	PHARMACY - MISCELLANEOUS REVENUE	B	0		0.00	0	33.00
33.01	OTHER NON-DEPARTMENTAL - MISCELLANEO	B	0		0.00	0	33.01
33.02	INTERCOMPANY REVENUE	B	0		0.00	0	33.02
33.03	ADMINISTRATION MISCELLANEOUS EXPENSE	A	0		0.00	0	33.03
33.04	DONATIONS	A	0		0.00	0	33.04
33.05	INTEREST EXPENSE	A	0		0.00	0	33.05
33.06	LOBBYING % OF DUES	A	0		0.00	0	33.06
33.07	ADMINISTRATION LEGAL FEES	A	0		0.00	0	33.07
33.08	ADMINISTRATION - CONSULTING	A	0		0.00	0	33.08
33.09	HRH MMO RENTAL INCOME	B	-10,967	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.09
33.10	HRH HUMAN RESOURCES MISCELLANEOUS RE	B	-175,440	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	HRH OTHER REVENUE SALES TAX	B	-2,972	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	HRH OTHER REVENUE MISCELLANEOUS REVE	B	-2,779	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	HRH MED STAFF SERV QA APPLICATION FE	B	-15,400	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	HRH MED STAFF SERV MISCELLANEOUS REV	B	-516	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	HRH MEDICAL DUES MEDICAL STAFF DUES	B	-33,900	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	HRH PAT FIN. SERV. BUSINESS SERV-COP	B	-1,240	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	HRH INFO SERVICES MISCELLANEOUS REVE	B	-94,604	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	HRH ACCOUNTING MISCELLANEOUS REVENUE	B	-71,377	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	HRH ACCOUNTING MANAGEMENT FEES	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	HRH EXEC ADMIN MISCELLANEOUS REVENUE	B	-25,542	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	HRH PURCHASING MISCELLANEOUS REVENUE	B	-83,011	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	HRH COMMUNICATIONS MISCELLANEOUS REV	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	HRH COMMUNICATIONS PHONE LEASE REVEN	B	-98,304	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	HRH COMM EDUCATION EDUCATION SERVICE	B	-1,094	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	HRH HEALTHY 365 MISCELLANEOUS REVENU	B	-1,081	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	HRH GAIN/LOSS GROSS VARIANCE INVENTO	B	9,342	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	HRH PLANT OFFSITE SERVICES	B	-10,340	OPERATION OF PLANT	7.00	0	33.27
33.28	HRH HOUSEKEEPING ENVIRONMENTAL SERVI	B	-142,710	HOUSEKEEPING	9.00	0	33.28
33.29	HRH NUTRITIONAL SER LTACH REVENUE	B	-106,796	DIETARY	10.00	0	33.29
33.30	HRH NUTRITIONAL SER MISCELLANEOUS RE	B	-1,940	DIETARY	10.00	0	33.30
33.31	HRH NUTRITIONAL SER REBATES/REFUNDS	B	0	DIETARY	10.00	0	33.31
33.32	HRH CLINICAL EDUCAT AHA COURSE REVEN	B	-20,609	NURSING ADMINISTRATION	13.00	0	33.32
33.33	HRH CLINICAL EDUCAT EDUCATION SERVIC	B	0	NURSING ADMINISTRATION	13.00	0	33.33
33.34	HRH OTHER REVENUE REBATES/REFUNDS	B	-816	CENTRAL SERVICES & SUPPLY	14.00	0	33.34

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/26/2023 1:33 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.35	HRH OTHER REVENUE DISCOUNTS EARNED O	B	-2,936	CENTRAL SERVICES & SUPPLY	14.00	0	33.35
33.36	HRH PHARMACY MISCELLANEOUS REVENUE	B	-2,370	PHARMACY	15.00	0	33.36
33.37	HRH PHARMACY REBATES/REFUNDS	B	-650	PHARMACY	15.00	0	33.37
33.38	HRH ASSOCIATE PHARM RETAIL PHARMACY-	B	-1,115,919	PHARMACY	15.00	0	33.38
33.39	HRH ASSOCIATE PHARM HOSPICE PHARMACY	B	-191,916	PHARMACY	15.00	0	33.39
33.40	HRH ASSOCIATE PHARM PHARMACY MEDS TO	B	-5,537	PHARMACY	15.00	0	33.40
33.41	HRH ASSOCIATE PHARM MISCELLANEOUS RE	B	-37,532	PHARMACY	15.00	0	33.41
33.42	HRH HEALTH INFO SER MEDICAL RECORDS-	B	-556	MEDICAL RECORDS & LIBRARY	16.00	0	33.42
33.43	HRH HEALTH INFO SER MISCELLANEOUS RE	B	-60,650	MEDICAL RECORDS & LIBRARY	16.00	0	33.43
33.44	HRH X-RAY SCHOOL TUITION-X-RAY SCHOO	B	-40,275	PARAMED ED PRGM	23.00	0	33.44
33.45	HRH MED/SURG-2 EAST MISCELLANEOUS RE	B	0	ADULTS & PEDIATRICS	30.00	0	33.45
33.46	HRH ANDIS UNIT REBATES/REFUNDS	B	-471	ADULTS & PEDIATRICS	30.00	0	33.46
33.47	HRH SURGERY REBATES/REFUNDS	B	-420	OPERATING ROOM	50.00	0	33.47
33.48	HRH LAB WATER TESTING	B	-68,110	LABORATORY	60.00	0	33.48
33.49	HRH LAB DIRECT TESTS	B	-19,757	LABORATORY	60.00	0	33.49
33.50	HRH LAB MISCELLANEOUS REVENUE	B	-450,603	LABORATORY	60.00	0	33.50
33.51	HRH WATER LAB WATER TESTING	B	0	LABORATORY	60.00	0	33.51
33.52	HRH SLEEP STUDY CLINIC MANAGMENT	B	-45,468	RESPIRATORY THERAPY	65.00	0	33.52
33.53	HRH SLEEP STUDY SLEEP STUDY FEES	B	0	RESPIRATORY THERAPY	65.00	0	33.53
33.54	HRH CATH LAB REBATES/REFUNDS	B	0	ELECTROCARDIOLOGY	69.00	0	33.54
33.55	HRH MED ONCOLOGY MISCELLANEOUS REVEN	B	-185,734	ONCOLOGY	90.07	0	33.55
33.56	HRH E R REBATES/REFUNDS	B	-90	EMERGENCY	91.00	0	33.56
33.57	HRH HOSPICE MISCELLANEOUS REVENUE	B	-178,338	ADULTS & PEDIATRICS	30.00	0	33.57
33.58	MOW	A	-626,822	DIETARY	10.00	0	33.58
33.59	CAFETERIA GUEST MEALS	A	-31,743	CAFETERIA	11.00	0	33.59
33.60	PHYSICIAN RECRUITMENT FEES	A	-44,121	ADMINISTRATIVE & GENERAL	5.00	0	33.60
33.61	DONATIONS & SPONSORSHIPS	A	-217,054	ADMINISTRATIVE & GENERAL	5.00	0	33.61
33.62	ADVERTISING FEE	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.62
33.63	ADVERTISING FEE	A	-4,127,460	ADMINISTRATIVE & GENERAL	5.00	0	33.63
33.64	ADVERTISING FEE	A	-444,617	ADMINISTRATIVE & GENERAL	5.00	0	33.64
33.65	ADVERTISING FEE	A	-2,402	ADULTS & PEDIATRICS	30.00	0	33.65
33.66	ADVERTISING FEE	A	-7,000	OPERATING ROOM	50.00	0	33.66
33.67	ADVERTISING FEE	A	-2,164	RADIOLOGY-DIAGNOSTIC	54.00	0	33.67
33.68	ADVERTISING FEE	A	0	WOUND CLINIC	90.01	0	33.68
33.69	ADVERTISING FEE	A	0	SHELBYVILLE WOUND CLINIC	90.06	0	33.69
33.70	IHA LOBBYING EXPENSE	A	-3,924	ADMINISTRATIVE & GENERAL	5.00	0	33.70
33.71	AHA LOBBYING EXPENSE	A	-6,829	ADMINISTRATIVE & GENERAL	5.00	0	33.71
33.72	PHY OFFICE BLDG DEPR EXPENSE	A	-699,890	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.72
33.73	PHY OFFICE BLDG	A	0	RADIOLOGY-DIAGNOSTIC	54.00	0	33.73
33.74	PHY OFFICE BLDG	A	0	RURAL HEALTH CLINIC	88.00	0	33.74
33.75	INTEREST INCOME	B	-4,707	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.75
33.76	RENTAL PROPERTIES EXPENSE	A	-90,009	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.76
33.77	RENTAL PROPERTIES EXPENSE	A	-250,035	ADMINISTRATIVE & GENERAL	5.00	0	33.77
33.78	RENTAL PROPERTIES EXPENSE	A	-980	OPERATION OF PLANT	7.00	0	33.78
33.79	TELEPHONE SERVICES	A	-50,426	ADMINISTRATIVE & GENERAL	5.00	0	33.79
33.80	HAF EXPENSE	A	-8,604,969	ADMINISTRATIVE & GENERAL	5.00	0	33.80
33.81	SELF INSURANCE CLAIM EXPENSE	A	-6,279,740	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.81
33.82	HHA MISC REVENUE	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.82
33.83	NUTRITIONAL SER CAF SALAD ROBOT	B	-1,368	DIETARY	10.00	0	33.83

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/26/2023 1:33 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.84	PLANT MISCELLANEOUS REVENUE	B	-500	OPERATION OF PLANT	7.00	0	33.84
33.85	PAT FIN SERV EXPENSE REIMBURSEMENT	B	-83,552	ADMINISTRATIVE & GENERAL	5.00	0	33.85
33.86	PURCHASING REBATES AND REFUNDS	B	-1,207	ADMINISTRATIVE & GENERAL	5.00	0	33.86
33.87	HIFI MISCELLANEOUS REVENUE	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.87
33.88	COMM EDUCATION MISCELLANEOUS REVENUE	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.88
33.89	ADVERTISING FEE	B	0	ANDIS CLINIC	90.04	0	33.89
33.90	ADVERTISING FEE	B	0	ANDERSON WOMENS CENTER	90.08	0	33.90
33.91	HRH ACCT ACCRUALS MISCELLANEOUS REVE	B	-368,937	ADMINISTRATIVE & GENERAL	5.00	0	33.91
33.92	HRH NURSING ADMIN MISCELLANEOUS REVE	B	-516	NURSING ADMINISTRATION	13.00	0	33.92
33.93	HRH PHYSICAL THER MISCELLANEOUS REVE	B	-60	PHYSICAL THERAPY	66.00	0	33.93
33.94	HRH GATEWAY PROP MISCELLANEOUS REVEN	B	-1,004	ADMINISTRATIVE & GENERAL	5.00	0	33.94
33.95	HRH MC CORDSVILLE P RENTAL INCOME	B	-150	ADMINISTRATIVE & GENERAL	5.00	0	33.95
33.96	HRH IMMED CARE RAD RENTAL INCOME	B	-3,615	PRIME TIME	90.05	0	33.96
33.97	HRH VACCINE CLINIC CLINIC MANAGMENT	B	-547,375	PHARMACY	15.00	0	33.97
33.98	HRH PAT FIN. SERV. MISCELLANEOUS REV	A	-28	ADMINISTRATIVE & GENERAL	5.00	0	33.98
33.99	HRH 3N MISCELLANEOUS REVENUE	A	0	ADULTS & PEDIATRICS	30.00	0	33.99
34.00	HRH ANDIS UNIT MISCELLANEOUS REVENUE	B	-206	ADULTS & PEDIATRICS	30.00	0	34.00
34.01	HRH X-RAY SCHOOL STUDENT ACTIVITIES	B	1,176	PARAMED ED PRGM	23.00	0	34.01
34.02	HRH X-RAY SCHOOL MISCELLANEOUS REVEN	B	-720	PARAMED ED PRGM	23.00	0	34.02
34.03	HRH SLEEP STUDY MISCELLANEOUS REVENU	B	-2,250	RESPIRATORY THERAPY	65.00	0	34.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-32,676,174				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 5/26/2023 1:33 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	537,995	537,995	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	733,542	733,542	0	0	0	2.00
3.00	50.00	OPERATING ROOM	2,623,421	2,623,421	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	701,555	701,555	0	0	0	4.00
5.00	60.00	LABORATORY	125,000	96,250	28,750	211,500	482	5.00
6.00	90.01	WOUND CLINIC	304,218	304,218	0	0	0	6.00
7.00	90.07	ONCOLOGY	836,378	836,378	0	0	0	7.00
8.00	90.08	ANDERSON WOMENS CENTER	84,900	84,900	0	0	0	8.00
9.00	91.00	EMERGENCY	95,000	95,000	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			6,042,009	6,013,259	28,750		482	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	49,011	2,451	0	0	0	5.00
6.00	90.01	WOUND CLINIC	0	0	0	0	0	6.00
7.00	90.07	ONCOLOGY	0	0	0	0	0	7.00
8.00	90.08	ANDERSON WOMENS CENTER	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			49,011	2,451	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	537,995		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	733,542		2.00
3.00	50.00	OPERATING ROOM	0	0	0	2,623,421		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	701,555		4.00
5.00	60.00	LABORATORY	0	49,011	0	96,250		5.00
6.00	90.01	WOUND CLINIC	0	0	0	304,218		6.00
7.00	90.07	ONCOLOGY	0	0	0	836,378		7.00
8.00	90.08	ANDERSON WOMENS CENTER	0	0	0	84,900		8.00
9.00	91.00	EMERGENCY	0	0	0	95,000		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	49,011	0	6,013,259		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/26/2023 1:33 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	17,030,470	17,030,470				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,018,629	87,569	5,106,198			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	21,628,264	1,456,727	771,754	23,856,745	23,856,745	5.00
7.00	00700	OPERATION OF PLANT	7,931,307	6,619,052	98,940	14,649,299	2,663,140	7.00
9.00	00900	HOUSEKEEPING	2,742,416	35,999	151,853	2,930,268	532,702	9.00
10.00	01000	DIETARY	588,373	333,871	51,510	973,754	177,022	10.00
11.00	01100	CAFETERIA	974,503	0	76,887	1,051,390	191,135	11.00
13.00	01300	NURSING ADMINISTRATION	2,030,656	17,340	126,167	2,174,163	395,248	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	407,938	133,729	24,907	566,574	102,999	14.00
15.00	01500	PHARMACY	1,838,216	260,625	210,067	2,308,908	419,743	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	947,193	63,986	49,626	1,060,805	192,847	16.00
23.00	02300	PARAMED ED PRGM	63,722	32,912	6,963	103,597	18,833	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,645,103	1,073,402	349,529	7,068,034	1,284,919	30.00
31.00	03100	INTENSIVE CARE UNIT	6,650,990	791,899	326,907	7,769,796	1,412,495	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,455,221	455,600	343,569	6,254,390	1,137,004	50.00
51.00	05100	RECOVERY ROOM	686,759	120,481	46,979	854,219	155,291	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,650,808	887,167	348,266	6,886,241	1,251,870	54.00
60.00	06000	LABORATORY	5,372,078	188,177	154,297	5,714,552	1,038,866	60.00
65.00	06500	RESPIRATORY THERAPY	2,248,456	196,223	146,119	2,590,798	470,989	65.00
66.00	06600	PHYSICAL THERAPY	1,539,475	167,750	101,559	1,808,784	328,824	66.00
67.00	06700	OCCUPATIONAL THERAPY	401,535	0	28,269	429,804	78,135	67.00
68.00	06800	SPEECH PATHOLOGY	219,779	0	15,112	234,891	42,702	68.00
69.00	06900	ELECTROCARDIOLOGY	892,771	160,329	46,494	1,099,594	199,898	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,476,857	0	0	3,476,857	632,068	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,728,469	0	0	1,728,469	314,224	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,487,386	0	0	20,487,386	3,724,420	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	80,934	43,247	5,173	129,354	23,516	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	523,502	0	22,236	545,738	99,211	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	619,014	116,215	35,048	770,277	140,031	90.01
90.02	09002	DIABETES CLINIC	59,432	0	3,511	62,943	11,443	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	141,066	16,577	7,579	165,222	30,036	90.04
90.05	09005	PRIME TIME	4,285	0	0	4,285	779	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
90.07	04951	ONCOLOGY	1,693,821	511,783	205,729	2,411,333	438,363	90.07
90.08	04950	ANDERSON WOMENS CENTER	589,764	145,104	35,818	770,686	140,105	90.08
91.00	09100	EMERGENCY	6,219,699	545,631	217,002	6,982,332	1,269,339	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	131,588,891	14,461,395	4,007,870	127,921,488	18,918,197	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	264,118	945,257	0	1,209,375	219,856	190.01
190.02	19002	PHYSICIAN BUILDING	729,029	0	0	729,029	132,532	190.02
190.03	19003	PRIVATE DUTY	1,159,555	15,502	21,511	1,196,568	217,528	190.03
190.04	19004	MARKETING	928,763	0	13,005	941,768	171,207	190.04
190.05	19005	SPORTS PHYSICALS	347,895	0	23,872	371,767	67,585	190.05
190.06	19006	FOUNDATION	1,040,129	66,968	18,607	1,125,704	204,645	190.06
190.07	19007	ASC	2,323	782,292	0	784,615	142,638	190.07
190.08	19008	GATEWAY LOCATION	4,798,335	0	267,799	5,066,134	920,988	190.08
190.09	19009	HANCOCK OB	6,306,026	226,153	338,105	6,870,284	1,248,970	190.09
190.10	19010	HANCOCK WELLNESS	1,170,555	6,589	68,078	1,245,222	226,373	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	1,366,352	0	68,396	1,434,748	260,827	190.13

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/26/2023 1:33 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
190.14	19014	3 WEST UNIT	444,462	428,896	15,881	889,239	161,657	190.14
190.15	19015	NEUROLOGY PHYSICIAN	1,534,534	64,021	95,387	1,693,942	307,947	190.15
190.16	19016	THORACI	91,680	0	5,919	97,599	17,743	190.16
190.17	19017	HANCOCK ENDO	1,170,587	0	63,260	1,233,847	224,305	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	91,079	0	4,697	95,776	17,411	190.19
194.00	07950	OTHER NONREIMBURSABLE	747	0	24	771	140	194.00
194.01	07951	SUBURBAN HOSPICE	107,821	33,397	7,197	148,415	26,981	194.01
194.02	07952	HRH HANCOCK GI	944,745	0	58,751	1,003,496	182,429	194.02
194.03	07954	HRH NEPHROLOGY	288,528	0	12,014	300,542	54,636	194.03
194.04	07957	HRH SANE	167,223	0	7,965	175,188	31,848	194.04
194.05	07955	HRH RISE	379,942	0	0	379,942	69,071	194.05
194.06	07956	HRH JUSTICE NAVIGATION	163,937	0	7,860	171,797	31,231	194.06
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	155,087,256	17,030,470	5,106,198	155,087,256	23,856,745	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 1:33 pm

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	17,312,439					7.00
9.00	00900	HOUSEKEEPING	79,030	3,542,000				9.00
10.00	01000	DIETARY	732,966	61,675	1,945,417			10.00
11.00	01100	CAFETERIA	0	101,632	0	1,344,157		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	44,744	2,614,155	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	293,582	154,164	0	13,660	33,924	14.00
15.00	01500	PHARMACY	572,165	112,453	0	87,539	217,399	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	140,472	135,265	0	40,845	101,438	16.00
23.00	02300	PARAMED ED PRGM	72,253	155,813	0	3,020	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,356,499	1,033,762	775,568	156,580	388,858	30.00
31.00	03100	INTENSIVE CARE UNIT	1,738,500	213,124	1,160,540	155,274	385,616	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,000,205	413,806	0	95,662	237,573	50.00
51.00	05100	RECOVERY ROOM	264,498	152,373	0	17,185	42,678	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,947,647	151,477	0	147,971	367,481	54.00
60.00	06000	LABORATORY	413,116	144,549	0	101,129	251,150	60.00
65.00	06500	RESPIRATORY THERAPY	430,780	110,710	0	76,330	189,564	65.00
66.00	06600	PHYSICAL THERAPY	368,272	128,666	0	45,900	113,992	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	15,192	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	7,103	0	68.00
69.00	06900	ELECTROCARDIOLOGY	351,979	250,876	0	22,499	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	94,942	0	0	4,010	0	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	255,133	0	0	18,046	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	1,902	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	341,396	0	0	4,045	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	93	0	90.06
90.07	04951	ONCOLOGY	1,123,546	0	0	71,464	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	6,776	221,655	0	18,859	0	90.08
91.00	09100	EMERGENCY	1,197,855	0	0	95,069	236,100	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,781,612	3,542,000	1,936,108	1,244,121	2,565,773	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	0	19,482	48,382	190.03
190.04	19004	MARKETING	0	0	0	5,899	0	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	147,019	0	0	9,059	0	190.06
190.07	19007	ASC	1,717,410	0	0	0	0	190.07
190.08	19008	GATEWAY LOCATION	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	496,486	0	0	41,167	0	190.09
190.10	19010	HANCOCK WELLNESS	14,466	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	0	190.13
190.14	19014	3 WEST UNIT	941,579	0	0	7,375	0	190.14
190.15	19015	NEUROLOGY PHYSICIAN	140,548	0	0	4,240	0	190.15
190.16	19016	THORACI	0	0	0	0	0	190.16
190.17	19017	HANCOCK ENDO	0	0	0	5,983	0	190.17

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/26/2023 1:33 pm

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	0	0	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	26	0	194.00
194.01	07951	SUBURBAN HOSPICE	73,319	0	9,309	2,890	0	194.01
194.02	07952	HRH HANCOCK GI	0	0	0	3,915	0	194.02
194.03	07954	HRH NEPHROLOGY	0	0	0	0	0	194.03
194.04	07957	HRH SANE	0	0	0	0	0	194.04
194.05	07955	HRH RISE	0	0	0	0	0	194.05
194.06	07956	HRH JUSTICE NAVIGATION	0	0	0	0	0	194.06
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)	17,312,439	3,542,000	1,945,417	1,344,157	2,614,155	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 1:33 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,164,903					14.00
15.00	01500	PHARMACY	0	3,718,207				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,671,672			16.00
23.00	02300	PARAMED ED PRGM	0	0	0	353,516		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	463,479	0	13,527,699	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	57,871	0	12,893,216	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	609,174	0	9,747,814	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	1,486,244	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	69,547	353,516	11,175,750	54.00
60.00	06000	LABORATORY	0	0	154,324	0	7,817,686	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	3,869,171	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	2,794,438	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	523,131	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	284,696	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	1,924,846	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,164,903	0	79,192	0	5,353,020	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,042,693	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,718,207	0	0	27,930,013	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	0	0	0	251,822	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	644,949	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	1,183,487	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	76,288	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	0	0	540,699	90.04
90.05	09005	PRIME TIME	0	0	0	0	5,064	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	93	90.06
90.07	04951	ONCOLOGY	0	0	0	0	4,044,706	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	0	1,158,081	90.08
91.00	09100	EMERGENCY	0	0	238,085	0	10,018,780	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,164,903	3,718,207	1,671,672	353,516	119,294,386	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	1,429,231	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	861,561	190.02
190.03	19003	PRIVATE DUTY	0	0	0	0	1,481,960	190.03
190.04	19004	MARKETING	0	0	0	0	1,118,874	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	439,352	190.05
190.06	19006	FOUNDATION	0	0	0	0	1,486,427	190.06
190.07	19007	ASC	0	0	0	0	2,644,663	190.07
190.08	19008	GATEWAY LOCATION	0	0	0	0	5,987,122	190.08
190.09	19009	HANCOCK OB	0	0	0	0	8,656,907	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	1,486,061	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	1,695,575	190.13
190.14	19014	3 WEST UNIT	0	0	0	0	1,999,850	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0	0	2,146,677	190.15
190.16	19016	THORACI	0	0	0	0	115,342	190.16
190.17	19017	HANCOCK ENDO	0	0	0	0	1,464,135	190.17

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/26/2023 1:33 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	0	113,187	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	937	194.00
194.01	07951	SUBURBAN HOSPICE	0	0	0	0	260,914	194.01
194.02	07952	HRH HANCOCK GI	0	0	0	0	1,189,840	194.02
194.03	07954	HRH NEPHROLOGY	0	0	0	0	355,178	194.03
194.04	07957	HRH SANE	0	0	0	0	207,036	194.04
194.05	07955	HRH RISE	0	0	0	0	449,013	194.05
194.06	07956	HRH JUSTICE NAVIGATION	0	0	0	0	203,028	194.06
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,164,903	3,718,207	1,671,672	353,516	155,087,256	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 1:33 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
23.00	02300	PARAMED ED PRGM				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	13,527,699		30.00
31.00	03100	INTENSIVE CARE UNIT	0	12,893,216		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	9,747,814		50.00
51.00	05100	RECOVERY ROOM	0	1,486,244		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,175,750		54.00
60.00	06000	LABORATORY	0	7,817,686		60.00
65.00	06500	RESPIRATORY THERAPY	0	3,869,171		65.00
66.00	06600	PHYSICAL THERAPY	0	2,794,438		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	523,131		67.00
68.00	06800	SPEECH PATHOLOGY	0	284,696		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,924,846		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,353,020		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,042,693		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	27,930,013		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	251,822		76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	644,949		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	1,183,487		90.01
90.02	09002	DIABETES CLINIC	0	76,288		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	0	540,699		90.04
90.05	09005	PRIME TIME	0	5,064		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	93		90.06
90.07	04951	ONCOLOGY	0	4,044,706		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	1,158,081		90.08
91.00	09100	EMERGENCY	0	10,018,780		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	119,294,386		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	1,429,231		190.01
190.02	19002	PHYSICIAN BUILDING	0	861,561		190.02
190.03	19003	PRIVATE DUTY	0	1,481,960		190.03
190.04	19004	MARKETING	0	1,118,874		190.04
190.05	19005	SPORTS PHYSICALS	0	439,352		190.05
190.06	19006	FOUNDATION	0	1,486,427		190.06
190.07	19007	ASC	0	2,644,663		190.07
190.08	19008	GATEWAY LOCATION	0	5,987,122		190.08
190.09	19009	HANCOCK OB	0	8,656,907		190.09
190.10	19010	HANCOCK WELLNESS	0	1,486,061		190.10
190.11	19011	MORRISTOWN CLINIC	0	0		190.11
190.12	19012	O3PUREMED	0	0		190.12
190.13	19013	MCCORD WELLNESS	0	1,695,575		190.13
190.14	19014	3 WEST UNIT	0	1,999,850		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	2,146,677		190.15

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 1:33 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
190.16	19016	THORACI	0	115,342		190.16
190.17	19017	HANCOCK ENDO	0	1,464,135		190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0		190.18
190.19	19019	HANCOCK RHEUM	0	113,187		190.19
194.00	07950	OTHER NONREIMBURSABLE	0	937		194.00
194.01	07951	SUBURBAN HOSPICE	0	260,914		194.01
194.02	07952	HRH HANCOCK GI	0	1,189,840		194.02
194.03	07954	HRH NEPHROLOGY	0	355,178		194.03
194.04	07957	HRH SANE	0	207,036		194.04
194.05	07955	HRH RISE	0	449,013		194.05
194.06	07956	HRH JUSTICE NAVIGATION	0	203,028		194.06
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	155,087,256		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/26/2023 1:33 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	87,569	87,569	87,569		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,456,727	1,456,727	13,261	1,469,988	5.00
7.00	00700	OPERATION OF PLANT	0	6,619,052	6,619,052	1,696	164,101	7.00
9.00	00900	HOUSEKEEPING	0	35,999	35,999	2,603	32,825	9.00
10.00	01000	DIETARY	0	333,871	333,871	883	10,908	10.00
11.00	01100	CAFETERIA	0	0	0	1,318	11,778	11.00
13.00	01300	NURSING ADMINISTRATION	0	17,340	17,340	2,163	24,355	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	133,729	133,729	427	6,347	14.00
15.00	01500	PHARMACY	0	260,625	260,625	3,601	25,864	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	63,986	63,986	851	11,883	16.00
23.00	02300	PARAMED ED PRGM	0	32,912	32,912	119	1,160	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,073,402	1,073,402	5,992	79,176	30.00
31.00	03100	INTENSIVE CARE UNIT	0	791,899	791,899	5,605	87,037	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	455,600	455,600	5,890	70,062	50.00
51.00	05100	RECOVERY ROOM	0	120,481	120,481	805	9,569	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	887,167	887,167	5,971	77,140	54.00
60.00	06000	LABORATORY	0	188,177	188,177	2,645	64,014	60.00
65.00	06500	RESPIRATORY THERAPY	0	196,223	196,223	2,505	29,022	65.00
66.00	06600	PHYSICAL THERAPY	0	167,750	167,750	1,741	20,262	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	485	4,815	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	259	2,631	68.00
69.00	06900	ELECTROCARDIOLOGY	0	160,329	160,329	797	12,318	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	38,948	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	19,362	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	229,443	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	43,247	43,247	89	1,449	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	381	6,113	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	116,215	116,215	601	8,629	90.01
90.02	09002	DIABETES CLINIC	0	0	0	60	705	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	16,577	16,577	130	1,851	90.04
90.05	09005	PRIME TIME	0	0	0	0	48	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0	511,783	511,783	3,527	27,012	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	145,104	145,104	614	8,633	90.08
91.00	09100	EMERGENCY	0	545,631	545,631	3,720	78,216	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	14,461,395	14,461,395	68,739	1,165,676	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	945,257	945,257	0	13,547	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	8,167	190.02
190.03	19003	PRIVATE DUTY	0	15,502	15,502	369	13,404	190.03
190.04	19004	MARKETING	0	0	0	223	10,550	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	409	4,165	190.05
190.06	19006	FOUNDATION	0	66,968	66,968	319	12,610	190.06
190.07	19007	ASC	0	782,292	782,292	0	8,789	190.07
190.08	19008	GATEWAY LOCATION	0	0	0	4,591	56,751	190.08
190.09	19009	HANCOCK OB	0	226,153	226,153	5,797	76,961	190.09
190.10	19010	HANCOCK WELLNESS	0	6,589	6,589	1,167	13,949	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	1,173	16,072	190.13
190.14	19014	3 WEST UNIT	0	428,896	428,896	272	9,961	190.14

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/26/2023 1:33 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
190.15	19015	NEUROLOGY PHYSICIAN	0	64,021	64,021	1,635	18,976	190.15
190.16	19016	THORACI	0	0	0	101	1,093	190.16
190.17	19017	HANCOCK ENDO	0	0	0	1,085	13,822	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	81	1,073	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	9	194.00
194.01	07951	SUBURBAN HOSPICE	0	33,397	33,397	123	1,663	194.01
194.02	07952	HRH HANCOCK GI	0	0	0	1,007	11,241	194.02
194.03	07954	HRH NEPHROLOGY	0	0	0	206	3,367	194.03
194.04	07957	HRH SANE	0	0	0	137	1,962	194.04
194.05	07955	HRH RISE	0	0	0	0	4,256	194.05
194.06	07956	HRH JUSTICE NAVIGATION	0	0	0	135	1,924	194.06
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	17,030,470	17,030,470	87,569	1,469,988	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/26/2023 1:33 pm

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	6,784,849					7.00
9.00	00900	HOUSEKEEPING	30,972	102,399				9.00
10.00	01000	DIETARY	287,254	1,783	634,699			10.00
11.00	01100	CAFETERIA	0	2,938	0	16,034		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	534	44,392	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	115,057	4,457	0	163	576	14.00
15.00	01500	PHARMACY	224,235	3,251	0	1,044	3,692	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	55,052	3,910	0	487	1,723	16.00
23.00	02300	PARAMED ED PRGM	28,317	4,505	0	36	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	923,527	29,886	253,032	1,870	6,603	30.00
31.00	03100	INTENSIVE CARE UNIT	681,328	6,161	378,630	1,852	6,548	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	391,986	11,963	0	1,141	4,034	50.00
51.00	05100	RECOVERY ROOM	103,658	4,405	0	205	725	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	763,294	4,379	0	1,765	6,240	54.00
60.00	06000	LABORATORY	161,903	4,179	0	1,206	4,265	60.00
65.00	06500	RESPIRATORY THERAPY	168,825	3,201	0	911	3,219	65.00
66.00	06600	PHYSICAL THERAPY	144,328	3,720	0	548	1,936	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	181	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	85	0	68.00
69.00	06900	ELECTROCARDIOLOGY	137,943	7,253	0	268	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	37,208	0	0	48	0	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	99,988	0	0	215	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	23	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	133,795	0	0	48	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	1	0	90.06
90.07	04951	ONCOLOGY	440,324	0	0	852	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	2,656	6,408	0	225	0	90.08
91.00	09100	EMERGENCY	469,446	0	0	1,134	4,009	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,401,096	102,399	631,662	14,842	43,570	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	0	232	822	190.03
190.04	19004	MARKETING	0	0	0	70	0	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	57,618	0	0	108	0	190.06
190.07	19007	ASC	673,063	0	0	0	0	190.07
190.08	19008	GATEWAY LOCATION	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	194,576	0	0	491	0	190.09
190.10	19010	HANCOCK WELLNESS	5,669	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	0	190.13
190.14	19014	3 WEST UNIT	369,011	0	0	88	0	190.14
190.15	19015	NEUROLOGY PHYSICIAN	55,082	0	0	51	0	190.15
190.16	19016	THORACI	0	0	0	0	0	190.16
190.17	19017	HANCOCK ENDO	0	0	0	71	0	190.17

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/26/2023 1:33 pm

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	0	0	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	SUBURBAN HOSPICE	28,734	0	3,037	34	0	194.01
194.02	07952	HRH HANCOCK GI	0	0	0	47	0	194.02
194.03	07954	HRH NEPHROLOGY	0	0	0	0	0	194.03
194.04	07957	HRH SANE	0	0	0	0	0	194.04
194.05	07955	HRH RISE	0	0	0	0	0	194.05
194.06	07956	HRH JUSTICE NAVIGATION	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,784,849	102,399	634,699	16,034	44,392	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/26/2023 1:33 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	260,756					14.00
15.00	01500	PHARMACY	0	522,312				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	137,892			16.00
23.00	02300	PARAMED ED PRGM	0	0	0	67,049		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	38,231		2,411,719	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	4,774		1,963,834	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0		0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	50,249		990,925	50.00
51.00	05100	RECOVERY ROOM	0	0	0		239,848	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	5,737		1,751,693	54.00
60.00	06000	LABORATORY	0	0	12,730		439,119	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		403,906	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		340,285	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		5,481	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		2,975	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		318,908	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	260,756	0	6,532		306,236	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		19,362	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	522,312	0		751,755	73.00
76.00	03020	CARDIAC	0	0	0		0	76.00
76.01	03160	CARDIOPULMONARY	0	0	0		82,041	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0		0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0		6,494	88.00
90.00	09000	CLINIC	0	0	0		0	90.00
90.01	09001	WOUND CLINIC	0	0	0		225,648	90.01
90.02	09002	DIABETES CLINIC	0	0	0		788	90.02
90.03	09003	ASTHMA CLINIC	0	0	0		0	90.03
90.04	09004	ANDIS CLINIC	0	0	0		152,401	90.04
90.05	09005	PRIME TIME	0	0	0		48	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0		1	90.06
90.07	04951	ONCOLOGY	0	0	0		983,498	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0		163,640	90.08
91.00	09100	EMERGENCY	0	0	19,639		1,121,795	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0		0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0		0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	260,756	522,312	137,892	0	12,682,400	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0		958,804	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0		8,167	190.02
190.03	19003	PRIVATE DUTY	0	0	0		30,329	190.03
190.04	19004	MARKETING	0	0	0		10,843	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0		4,574	190.05
190.06	19006	FOUNDATION	0	0	0		137,623	190.06
190.07	19007	ASC	0	0	0		1,464,144	190.07
190.08	19008	GATEWAY LOCATION	0	0	0		61,342	190.08
190.09	19009	HANCOCK OB	0	0	0		503,978	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0		27,374	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0		0	190.11
190.12	19012	O3PUREMED	0	0	0		0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0		17,245	190.13
190.14	19014	3 WEST UNIT	0	0	0		808,228	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0		139,765	190.15
190.16	19016	THORACI	0	0	0		1,194	190.16
190.17	19017	HANCOCK ENDO	0	0	0		14,978	190.17

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/26/2023 1:33 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0		0	190.18
190.19	19019	HANCOCK RHEUM	0	0	0		1,154	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	0	0		9	194.00
194.01	07951	SUBURBAN HOSPICE	0	0	0		66,988	194.01
194.02	07952	HRH HANCOCK GI	0	0	0		12,295	194.02
194.03	07954	HRH NEPHROLOGY	0	0	0		3,573	194.03
194.04	07957	HRH SANE	0	0	0		2,099	194.04
194.05	07955	HRH RISE	0	0	0		4,256	194.05
194.06	07956	HRH JUSTICE NAVIGATION	0	0	0		2,059	194.06
200.00		Cross Foot Adjustments				67,049	67,049	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	260,756	522,312	137,892	67,049	17,030,470	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/26/2023 1:33 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
23.00	02300	PARAMED ED PRGM				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,411,719		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,963,834		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	990,925		50.00
51.00	05100	RECOVERY ROOM	0	239,848		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,751,693		54.00
60.00	06000	LABORATORY	0	439,119		60.00
65.00	06500	RESPIRATORY THERAPY	0	403,906		65.00
66.00	06600	PHYSICAL THERAPY	0	340,285		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,481		67.00
68.00	06800	SPEECH PATHOLOGY	0	2,975		68.00
69.00	06900	ELECTROCARDIOLOGY	0	318,908		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	306,236		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	19,362		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	751,755		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	82,041		76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	6,494		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	225,648		90.01
90.02	09002	DIABETES CLINIC	0	788		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	0	152,401		90.04
90.05	09005	PRIME TIME	0	48		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	1		90.06
90.07	04951	ONCOLOGY	0	983,498		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	163,640		90.08
91.00	09100	EMERGENCY	0	1,121,795		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	12,682,400		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	958,804		190.01
190.02	19002	PHYSICIAN BUILDING	0	8,167		190.02
190.03	19003	PRIVATE DUTY	0	30,329		190.03
190.04	19004	MARKETING	0	10,843		190.04
190.05	19005	SPORTS PHYSICALS	0	4,574		190.05
190.06	19006	FOUNDATION	0	137,623		190.06
190.07	19007	ASC	0	1,464,144		190.07
190.08	19008	GATEWAY LOCATION	0	61,342		190.08
190.09	19009	HANCOCK OB	0	503,978		190.09
190.10	19010	HANCOCK WELLNESS	0	27,374		190.10
190.11	19011	MORRISTOWN CLINIC	0	0		190.11
190.12	19012	O3PUREMED	0	0		190.12
190.13	19013	MCCORD WELLNESS	0	17,245		190.13
190.14	19014	3 WEST UNIT	0	808,228		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	139,765		190.15

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/26/2023 1:33 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
190.16	19016	THORACI	0	1,194		190.16
190.17	19017	HANCOCK ENDO	0	14,978		190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0		190.18
190.19	19019	HANCOCK RHEUM	0	1,154		190.19
194.00	07950	OTHER NONREIMBURSABLE	0	9		194.00
194.01	07951	SUBURBAN HOSPICE	0	66,988		194.01
194.02	07952	HRH HANCOCK GI	0	12,295		194.02
194.03	07954	HRH NEPHROLOGY	0	3,573		194.03
194.04	07957	HRH SANE	0	2,099		194.04
194.05	07955	HRH RISE	0	4,256		194.05
194.06	07956	HRH JUSTICE NAVIGATION	0	2,059		194.06
200.00		Cross Foot Adjustments	0	67,049		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	17,030,470		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 1:33 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	491,065					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,525	66,826,042				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	42,004	10,099,896	-23,856,745	131,230,511		5.00
7.00	00700	OPERATION OF PLANT	190,857	1,294,859	0	14,649,299	227,387	7.00
9.00	00900	HOUSEKEEPING	1,038	1,987,339	0	2,930,268	1,038	9.00
10.00	01000	DIETARY	9,627	674,128	0	973,754	9,627	10.00
11.00	01100	CAFETERIA	0	1,006,246	0	1,051,390	0	11.00
13.00	01300	NURSING ADMINISTRATION	500	1,651,180	0	2,174,163	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,856	325,965	0	566,574	3,856	14.00
15.00	01500	PHARMACY	7,515	2,749,203	0	2,308,908	7,515	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,845	649,472	0	1,060,805	1,845	16.00
23.00	02300	PARAMED ED PRGM	949	91,123	0	103,597	949	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,951	4,574,386	0	7,068,034	30,951	30.00
31.00	03100	INTENSIVE CARE UNIT	22,834	4,278,326	0	7,769,796	22,834	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,137	4,496,391	0	6,254,390	13,137	50.00
51.00	05100	RECOVERY ROOM	3,474	614,827	0	854,219	3,474	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,581	4,557,861	0	6,886,241	25,581	54.00
60.00	06000	LABORATORY	5,426	2,019,324	0	5,714,552	5,426	60.00
65.00	06500	RESPIRATORY THERAPY	5,658	1,912,306	0	2,590,798	5,658	65.00
66.00	06600	PHYSICAL THERAPY	4,837	1,329,135	0	1,808,784	4,837	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	369,968	0	429,804	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	197,777	0	234,891	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,623	608,486	0	1,099,594	4,623	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,476,857	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,728,469	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	20,487,386	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	1,247	67,699	0	129,354	1,247	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	291,014	0	545,738	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	3,351	458,689	0	770,277	3,351	90.01
90.02	09002	DIABETES CLINIC	0	45,945	0	62,943	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	478	99,191	0	165,222	4,484	90.04
90.05	09005	PRIME TIME	0	0	0	4,285	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
90.07	04951	ONCOLOGY	14,757	2,692,435	0	2,411,333	14,757	90.07
90.08	04950	ANDERSON WOMENS CENTER	4,184	468,756	0	770,686	89	90.08
91.00	09100	EMERGENCY	15,733	2,839,968	0	6,982,332	15,733	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	416,987	52,451,895	-23,856,745	104,064,743	181,012	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	27,256	0	0	1,209,375	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	729,029	0	190.02
190.03	19003	PRIVATE DUTY	447	281,519	0	1,196,568	0	190.03
190.04	19004	MARKETING	0	170,201	0	941,768	0	190.04
190.05	19005	SPORTS PHYSICALS	0	312,419	0	371,767	0	190.05
190.06	19006	FOUNDATION	1,931	243,521	0	1,125,704	1,931	190.06
190.07	19007	ASC	22,557	0	0	784,615	22,557	190.07
190.08	19008	GATEWAY LOCATION	0	3,504,770	0	5,066,134	0	190.08
190.09	19009	HANCOCK OB	6,521	4,424,875	0	6,870,284	6,521	190.09
190.10	19010	HANCOCK WELLNESS	190	890,955	0	1,245,222	190	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	895,114	0	1,434,748	0	190.13

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 1:33 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
190.14	19014	3 WEST UNIT	12,367	207,839	0	889,239	12,367	190.14
190.15	19015	NEUROLOGY PHYSICIAN	1,846	1,248,356	0	1,693,942	1,846	190.15
190.16	19016	THORACI	0	77,464	0	97,599	0	190.16
190.17	19017	HANCOCK ENDO	0	827,897	0	1,233,847	0	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	61,476	0	95,776	0	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	320	0	771	0	194.00
194.01	07951	SUBURBAN HOSPICE	963	94,187	0	148,415	963	194.01
194.02	07952	HRH HANCOCK GI	0	768,891	0	1,003,496	0	194.02
194.03	07954	HRH NEPHROLOGY	0	157,235	0	300,542	0	194.03
194.04	07957	HRH SANE	0	104,239	0	175,188	0	194.04
194.05	07955	HRH RISE	0	0	0	379,942	0	194.05
194.06	07956	HRH JUSTICE NAVIGATION	0	102,869	0	171,797	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	17,030,470	5,106,198		23,856,745	17,312,439	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	34.680684	0.076410		0.181793	76.136450	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		87,569		1,469,988	6,784,849	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001310		0.011202	29.838333	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 1:33 pm

		Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING	375,765					9.00
10.00	01000	DIETARY	6,543	10,031				10.00
11.00	01100	CAFETERIA	10,782	0	867,895			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	28,890	679,659		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,355	0	8,820	8,820	100	14.00
15.00	01500	PHARMACY	11,930	0	56,522	56,522	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,350	0	26,373	26,373	0	16.00
23.00	02300	PARAMED ED PRGM	16,530	0	1,950	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	109,670	3,999	101,100	101,100	0	30.00
31.00	03100	INTENSIVE CARE UNIT	22,610	5,984	100,257	100,257	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	43,900	0	61,767	61,767	0	50.00
51.00	05100	RECOVERY ROOM	16,165	0	11,096	11,096	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,070	0	95,542	95,542	0	54.00
60.00	06000	LABORATORY	15,335	0	65,297	65,297	0	60.00
65.00	06500	RESPIRATORY THERAPY	11,745	0	49,285	49,285	0	65.00
66.00	06600	PHYSICAL THERAPY	13,650	0	29,637	29,637	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	9,809	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	4,586	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	26,615	0	14,527	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	100	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	0	2,589	0	0	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	11,652	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	1,228	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	2,612	0	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	60	0	0	90.06
90.07	04951	ONCOLOGY	0	0	46,143	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	23,515	0	12,177	0	0	90.08
91.00	09100	EMERGENCY	0	0	61,384	61,384	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	375,765	9,983	803,303	667,080	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	12,579	12,579	0	190.03
190.04	19004	MARKETING	0	0	3,809	0	0	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	0	0	5,849	0	0	190.06
190.07	19007	ASC	0	0	0	0	0	190.07
190.08	19008	GATEWAY LOCATION	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	0	0	26,581	0	0	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	0	190.13
190.14	19014	3 WEST UNIT	0	0	4,762	0	0	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	2,738	0	0	190.15

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 1:33 pm

		Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
190.16	19016	THORACI	0	0	0	0	0	190.16
190.17	19017	HANCOCK ENDO	0	0	3,863	0	0	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	0	0	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	0	17	0	0	194.00
194.01	07951	SUBURBAN HOSPICE	0	48	1,866	0	0	194.01
194.02	07952	HRH HANCOCK GI	0	0	2,528	0	0	194.02
194.03	07954	HRH NEPHROLOGY	0	0	0	0	0	194.03
194.04	07957	HRH SANE	0	0	0	0	0	194.04
194.05	07955	HRH RISE	0	0	0	0	0	194.05
194.06	07956	HRH JUSTICE NAVIGATION	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,542,000	1,945,417	1,344,157	2,614,155	1,164,903	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.426104	193.940484	1.548755	3.846274	11,649.030000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	102,399	634,699	16,034	44,392	260,756	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.272508	63.273751	0.018475	0.065315	2,607.560000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 1:33 pm

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	PARAMED ED PRGM (ASSIGNED TIME)		
			15.00	16.00	23.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,293			16.00
23.00	02300	PARAMED ED PRGM	0	0	100		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	913	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	114	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0		40.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,200	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	137	100		54.00
60.00	06000	LABORATORY	0	304	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	156	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	0	0		73.00
76.00	03020	CARDIAC	0	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	0	0		76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	WOUND CLINIC	0	0	0		90.01
90.02	09002	DIABETES CLINIC	0	0	0		90.02
90.03	09003	ASTHMA CLINIC	0	0	0		90.03
90.04	09004	ANDIS CLINIC	0	0	0		90.04
90.05	09005	PRIME TIME	0	0	0		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0		90.06
90.07	04951	ONCOLOGY	0	0	0		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0		90.08
91.00	09100	EMERGENCY	0	469	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	3,293	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0		190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0		190.02
190.03	19003	PRIVATE DUTY	0	0	0		190.03
190.04	19004	MARKETING	0	0	0		190.04
190.05	19005	SPORTS PHYSICALS	0	0	0		190.05
190.06	19006	FOUNDATION	0	0	0		190.06
190.07	19007	ASC	0	0	0		190.07
190.08	19008	GATEWAY LOCATION	0	0	0		190.08
190.09	19009	HANCOCK OB	0	0	0		190.09
190.10	19010	HANCOCK WELLNESS	0	0	0		190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0		190.11
190.12	19012	O3PUREMED	0	0	0		190.12
190.13	19013	MCCORD WELLNESS	0	0	0		190.13
190.14	19014	3 WEST UNIT	0	0	0		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0		190.15

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 1:33 pm

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	PARAMED ED PRGM (ASSIGNED TIME)		
			15.00	16.00	23.00		
190.16	19016	THORACI	0	0	0		190.16
190.17	19017	HANCOCK ENDO	0	0	0		190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0		190.18
190.19	19019	HANCOCK RHEUM	0	0	0		190.19
194.00	07950	OTHER NONREIMBURSABLE	0	0	0		194.00
194.01	07951	SUBURBAN HOSPICE	0	0	0		194.01
194.02	07952	HRH HANCOCK GI	0	0	0		194.02
194.03	07954	HRH NEPHROLOGY	0	0	0		194.03
194.04	07957	HRH SANE	0	0	0		194.04
194.05	07955	HRH RISE	0	0	0		194.05
194.06	07956	HRH JUSTICE NAVIGATION	0	0	0		194.06
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,718,207	1,671,672	353,516		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	37,182.070000	507.644094	3,535.160000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	522,312	137,892	67,049		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5,223.120000	41.874279	670.490000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 1:33 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,527,699		13,527,699	0	13,527,699	30.00
31.00	03100	INTENSIVE CARE UNIT	12,893,216		12,893,216	0	12,893,216	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,747,814		9,747,814	0	9,747,814	50.00
51.00	05100	RECOVERY ROOM	1,486,244		1,486,244	0	1,486,244	51.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,175,750		11,175,750	0	11,175,750	54.00
60.00	06000	LABORATORY	7,817,686		7,817,686	0	7,817,686	60.00
65.00	06500	RESPIRATORY THERAPY	3,869,171	0	3,869,171	0	3,869,171	65.00
66.00	06600	PHYSICAL THERAPY	2,794,438	0	2,794,438	0	2,794,438	66.00
67.00	06700	OCCUPATIONAL THERAPY	523,131	0	523,131	0	523,131	67.00
68.00	06800	SPEECH PATHOLOGY	284,696	0	284,696	0	284,696	68.00
69.00	06900	ELECTROCARDIOLOGY	1,924,846		1,924,846	0	1,924,846	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,353,020		5,353,020	0	5,353,020	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,042,693		2,042,693	0	2,042,693	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,930,013		27,930,013	0	27,930,013	73.00
76.00	03020	CARDIAC	0		0	0	0	76.00
76.01	03160	CARDIOPULMONARY	251,822		251,822	0	251,822	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	644,949		644,949	0	644,949	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	1,183,487		1,183,487	0	1,183,487	90.01
90.02	09002	DIABETES CLINIC	76,288		76,288	0	76,288	90.02
90.03	09003	ASTHMA CLINIC	0		0	0	0	90.03
90.04	09004	ANDIS CLINIC	540,699		540,699	0	540,699	90.04
90.05	09005	PRIME TIME	5,064		5,064	0	5,064	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	93		93	0	93	90.06
90.07	04951	ONCOLOGY	4,044,706		4,044,706	0	4,044,706	90.07
90.08	04950	ANDERSON WOMENS CENTER	1,158,081		1,158,081	0	1,158,081	90.08
91.00	09100	EMERGENCY	10,018,780		10,018,780	0	10,018,780	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,229,923		5,229,923		5,229,923	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	124,524,309	0	124,524,309	0	124,524,309	200.00
201.00		Less Observation Beds	5,229,923		5,229,923		5,229,923	201.00
202.00		Total (see instructions)	119,294,386	0	119,294,386	0	119,294,386	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 1:33 pm

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		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	9,891,661		9,891,661			30.00
31.00	03100	INTENSIVE CARE UNIT	14,819,151		14,819,151			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,444,209	38,151,582	45,595,791	0.213788	0.000000	50.00
51.00	05100	RECOVERY ROOM	805,630	1,948,852	2,754,482	0.539573	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,764,721	85,441,888	89,206,609	0.125279	0.000000	54.00
60.00	06000	LABORATORY	8,128,201	53,544,211	61,672,412	0.126761	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,208,389	1,876,097	5,084,486	0.760976	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	603,735	4,677,425	5,281,160	0.529133	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	498,621	891,645	1,390,266	0.376281	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	275,976	509,007	784,983	0.362678	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,184,535	12,148,455	15,332,990	0.125536	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	400,869	1,240,565	1,641,434	3.261185	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,475,092	7,437,449	8,912,541	0.229193	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,710,262	104,777,546	116,487,808	0.239768	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0.000000	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0	415,811	415,811	0.605616	0.000000	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	732,939	732,939			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CLINIC	2,655	6,384,095	6,386,750	0.185303	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	15,274	15,274	4.994631	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	49,492	49,492	10.924978	0.000000	90.04
90.05	09005	PRIME TIME	0	0	0	0.000000	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0.000000	0.000000	90.06
90.07	04951	ONCOLOGY	10,755	5,587,801	5,598,556	0.722455	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	1,106	4,041,590	4,042,696	0.286463	0.000000	90.08
91.00	09100	EMERGENCY	6,079,286	64,974,670	71,053,956	0.141002	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	433,776	17,312,952	17,746,728	0.294698	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	72,738,630	412,159,346	484,897,976			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	72,738,630	412,159,346	484,897,976			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 1:33 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.213788	50.00
51.00	05100	RECOVERY ROOM	0.539573	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.125279	54.00
60.00	06000	LABORATORY	0.126761	60.00
65.00	06500	RESPIRATORY THERAPY	0.760976	65.00
66.00	06600	PHYSICAL THERAPY	0.529133	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.376281	67.00
68.00	06800	SPEECH PATHOLOGY	0.362678	68.00
69.00	06900	ELECTROCARDIOLOGY	0.125536	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3.261185	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.229193	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.239768	73.00
76.00	03020	CARDIAC	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0.605616	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CLINIC	0.185303	90.01
90.02	09002	DIABETES CLINIC	4.994631	90.02
90.03	09003	ASTHMA CLINIC	0.000000	90.03
90.04	09004	ANDIS CLINIC	10.924978	90.04
90.05	09005	PRIME TIME	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	90.06
90.07	04951	ONCOLOGY	0.722455	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.286463	90.08
91.00	09100	EMERGENCY	0.141002	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.294698	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		SPECIAL PURPOSE COST CENTERS		
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 1:33 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,527,699		13,527,699	0	13,527,699	30.00
31.00	03100	INTENSIVE CARE UNIT	12,893,216		12,893,216	0	12,893,216	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,747,814		9,747,814	0	9,747,814	50.00
51.00	05100	RECOVERY ROOM	1,486,244		1,486,244	0	1,486,244	51.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,175,750		11,175,750	0	11,175,750	54.00
60.00	06000	LABORATORY	7,817,686		7,817,686	0	7,817,686	60.00
65.00	06500	RESPIRATORY THERAPY	3,869,171	0	3,869,171	0	3,869,171	65.00
66.00	06600	PHYSICAL THERAPY	2,794,438	0	2,794,438	0	2,794,438	66.00
67.00	06700	OCCUPATIONAL THERAPY	523,131	0	523,131	0	523,131	67.00
68.00	06800	SPEECH PATHOLOGY	284,696	0	284,696	0	284,696	68.00
69.00	06900	ELECTROCARDIOLOGY	1,924,846		1,924,846	0	1,924,846	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,353,020		5,353,020	0	5,353,020	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,042,693		2,042,693	0	2,042,693	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,930,013		27,930,013	0	27,930,013	73.00
76.00	03020	CARDIAC	0		0	0	0	76.00
76.01	03160	CARDIOPULMONARY	251,822		251,822	0	251,822	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	644,949		644,949	0	644,949	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	1,183,487		1,183,487	0	1,183,487	90.01
90.02	09002	DIABETES CLINIC	76,288		76,288	0	76,288	90.02
90.03	09003	ASTHMA CLINIC	0		0	0	0	90.03
90.04	09004	ANDIS CLINIC	540,699		540,699	0	540,699	90.04
90.05	09005	PRIME TIME	5,064		5,064	0	5,064	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	93		93	0	93	90.06
90.07	04951	ONCOLOGY	4,044,706		4,044,706	0	4,044,706	90.07
90.08	04950	ANDERSON WOMENS CENTER	1,158,081		1,158,081	0	1,158,081	90.08
91.00	09100	EMERGENCY	10,018,780		10,018,780	0	10,018,780	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,229,923		5,229,923		5,229,923	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	124,524,309	0	124,524,309	0	124,524,309	200.00
201.00		Less Observation Beds	5,229,923		5,229,923		5,229,923	201.00
202.00		Total (see instructions)	119,294,386	0	119,294,386	0	119,294,386	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 1:33 pm

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	9,891,661		9,891,661			30.00
31.00	03100	INTENSIVE CARE UNIT	14,819,151		14,819,151			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,444,209	38,151,582	45,595,791	0.213788	0.000000	50.00
51.00	05100	RECOVERY ROOM	805,630	1,948,852	2,754,482	0.539573	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,764,721	85,441,888	89,206,609	0.125279	0.000000	54.00
60.00	06000	LABORATORY	8,128,201	53,544,211	61,672,412	0.126761	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,208,389	1,876,097	5,084,486	0.760976	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	603,735	4,677,425	5,281,160	0.529133	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	498,621	891,645	1,390,266	0.376281	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	275,976	509,007	784,983	0.362678	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,184,535	12,148,455	15,332,990	0.125536	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	400,869	1,240,565	1,641,434	3.261185	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,475,092	7,437,449	8,912,541	0.229193	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,710,262	104,777,546	116,487,808	0.239768	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0.000000	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0	415,811	415,811	0.605616	0.000000	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	732,939	732,939	0.879949	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CLINIC	2,655	6,384,095	6,386,750	0.185303	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	15,274	15,274	4.994631	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	49,492	49,492	10.924978	0.000000	90.04
90.05	09005	PRIME TIME	0	0	0	0.000000	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0.000000	0.000000	90.06
90.07	04951	ONCOLOGY	10,755	5,587,801	5,598,556	0.722455	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	1,106	4,041,590	4,042,696	0.286463	0.000000	90.08
91.00	09100	EMERGENCY	6,079,286	64,974,670	71,053,956	0.141002	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	433,776	17,312,952	17,746,728	0.294698	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	72,738,630	412,159,346	484,897,976			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	72,738,630	412,159,346	484,897,976			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 1:33 pm

Title XIX | Hospital | Cost

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part I Date/Time Prepared: 5/26/2023 1:33 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,411,719	0	2,411,719	7,796	309.35	30.00
31.00	INTENSIVE CARE UNIT	1,963,834		1,963,834	5,984	328.18	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
200.00	Total (lines 30 through 199)	4,375,553		4,375,553	13,780		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	1,026	317,393		30.00
31.00	INTENSIVE CARE UNIT	2,232	732,498		31.00
40.00	SUBPROVIDER - IPF	0	0		40.00
200.00	Total (lines 30 through 199)	3,258	1,049,891		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 5/26/2023 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	990,925	45,595,791	0.021733	2,403,615	52,238	50.00
51.00	05100	RECOVERY ROOM	239,848	2,754,482	0.087076	218,498	19,026	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,751,693	89,206,609	0.019636	2,999,366	58,896	54.00
60.00	06000	LABORATORY	439,119	61,672,412	0.007120	4,607,010	32,802	60.00
65.00	06500	RESPIRATORY THERAPY	403,906	5,084,486	0.079439	1,285,852	102,147	65.00
66.00	06600	PHYSICAL THERAPY	340,285	5,281,160	0.064434	250,732	16,156	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,481	1,390,266	0.003942	213,059	840	67.00
68.00	06800	SPEECH PATHOLOGY	2,975	784,983	0.003790	127,598	484	68.00
69.00	06900	ELECTROCARDIOLOGY	318,908	15,332,990	0.020799	1,333,262	27,731	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	306,236	1,641,434	0.186566	159,051	29,674	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,362	8,912,541	0.002172	698,544	1,517	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	751,755	116,487,808	0.006454	4,414,328	28,490	73.00
76.00	03020	CARDIAC	0	0	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	82,041	415,811	0.197304	0	0	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,494	732,939	0.008860	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	225,648	6,386,750	0.035331	0	0	90.01
90.02	09002	DIABETES CLINIC	788	15,274	0.051591	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	152,401	49,492	3.079306	0	0	90.04
90.05	09005	PRIME TIME	48	0	0.000000	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	1	0	0.000000	0	0	90.06
90.07	04951	ONCOLOGY	983,498	5,598,556	0.175670	10,721	1,883	90.07
90.08	04950	ANDERSON WOMENS CENTER	163,640	4,042,696	0.040478	0	0	90.08
91.00	09100	EMERGENCY	1,121,795	71,053,956	0.015788	3,680,066	58,101	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	932,391	17,746,728	0.052539	433,776	22,790	92.00
200.00		Total (lines 50 through 199)	9,239,238	460,187,164		22,835,478	452,775	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part III Date/Time Prepared: 5/26/2023 1:33 pm

Title XVIII | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	7,796	0.00	1,026	30.00
31.00	03100	INTENSIVE CARE UNIT		0	5,984	0.00	2,232	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00
200.00		Total (lines 30 through 199)		0	13,780		3,258	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/26/2023 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	353,516	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	0	0	0	0	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	0	0	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0	0	0	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	353,516	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/26/2023 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	45,595,791	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,754,482	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	353,516	353,516	89,206,609	0.003963	54.00
60.00	06000	LABORATORY	0	0	0	61,672,412	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,084,486	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,281,160	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,390,266	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	784,983	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	15,332,990	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,641,434	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	8,912,541	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	116,487,808	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0	0	0	415,811	0.000000	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	732,939	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND CLINIC	0	0	0	6,386,750	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	0	0	15,274	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	0	0	49,492	0.000000	90.04
90.05	09005	PRIME TIME	0	0	0	0	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0.000000	90.06
90.07	04951	ONCOLOGY	0	0	0	5,598,556	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	4,042,696	0.000000	90.08
91.00	09100	EMERGENCY	0	0	0	71,053,956	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	17,746,728	0.000000	92.00
200.00		Total (lines 50 through 199)	0	353,516	353,516	460,187,164		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/26/2023 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	2,403,615	0	5,886,071	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	218,498	0	305,618	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.003963	2,999,366	11,886	19,766,501	78,335	54.00
60.00	06000	LABORATORY	0.000000	4,607,010	0	5,803,312	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,285,852	0	1,872,639	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	250,732	0	30,970	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	213,059	0	12,717	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	127,598	0	7,844	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,333,262	0	2,990,260	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	159,051	0	248,639	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	698,544	0	1,629,436	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	4,414,328	0	31,273,443	0	73.00
76.00	03020	CARDIAC	0.000000	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.000000	0	0	164,049	0	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.000000	0	0	476,056	0	90.01
90.02	09002	DIABETES CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	PRIME TIME	0.000000	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0.000000	10,721	0	1,719,641	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.000000	0	0	138,358	0	90.08
91.00	09100	EMERGENCY	0.000000	3,680,066	0	8,837,944	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	433,776	0	4,630,454	0	92.00
200.00		Total (lines 50 through 199)		22,835,478	11,886	85,793,952	78,335	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/26/2023 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.213788	5,886,071	0	0	1,258,371	50.00
51.00	05100	RECOVERY ROOM	0.539573	305,618	0	0	164,903	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.125279	19,766,501	0	0	2,476,327	54.00
60.00	06000	LABORATORY	0.126761	5,803,312	50	0	735,634	60.00
65.00	06500	RESPIRATORY THERAPY	0.760976	1,872,639	0	0	1,425,033	65.00
66.00	06600	PHYSICAL THERAPY	0.529133	30,970	0	0	16,387	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.376281	12,717	0	0	4,785	67.00
68.00	06800	SPEECH PATHOLOGY	0.362678	7,844	0	0	2,845	68.00
69.00	06900	ELECTROCARDIOLOGY	0.125536	2,990,260	0	0	375,385	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3.261185	248,639	0	0	810,858	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.229193	1,629,436	0	0	373,455	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.239768	31,273,443	0	5,791	7,498,371	73.00
76.00	03020	CARDIAC	0.000000	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.605616	164,049	0	0	99,351	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.185303	476,056	0	0	88,215	90.01
90.02	09002	DIABETES CLINIC	4.994631	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	10.924978	0	0	0	0	90.04
90.05	09005	PRIME TIME	0.000000	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0.722455	1,719,641	0	0	1,242,363	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.286463	138,358	0	0	39,634	90.08
91.00	09100	EMERGENCY	0.141002	8,837,944	0	0	1,246,168	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.294698	4,630,454	0	0	1,364,586	92.00
200.00		Subtotal (see instructions)		85,793,952	50	5,791	19,222,671	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		85,793,952	50	5,791	19,222,671	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/26/2023 1:33 pm

Title XVIII | Hospital | PPS

		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	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	6	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,388		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	0		76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	0		90.01
90.02	09002	DIABETES CLINIC	0	0		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	0	0		90.04
90.05	09005	PRIME TIME	0	0		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0		90.06
90.07	04951	ONCOLOGY	0	0		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0		90.08
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	6	1,388		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6	1,388		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 1:33 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,796	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,796	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)	4,782	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,026	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	13,527,699	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	13,527,699	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	13,527,699	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,735.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,780,325	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)	1,780,325	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 1:33 pm

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	12,893,216	5,984	2,154.61	2,232	4,809,090	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)	5,388,186	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)	11,977,601	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)	1,049,891	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	464,661	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,514,552	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	10,463,049	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	3,014	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,735.21	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 1:33 pm

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	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	5,229,923	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,411,719	13,527,699	0.178280	5,229,923	932,391	90.00
91.00	Nursing Program cost	0	13,527,699	0.000000	5,229,923	0	91.00
92.00	Allied health cost	0	13,527,699	0.000000	5,229,923	0	92.00
93.00	All other Medical Education	0	13,527,699	0.000000	5,229,923	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 1:33 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,796	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,796	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)	4,782	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	169	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	13,527,699	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	13,527,699	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	13,527,699	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,735.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	293,250	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)	293,250	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 1:33 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	12,893,216	5,984	2,154.61	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	189,205	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)	482,455	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	3,014	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,735.21	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0037	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/26/2023 1:33 pm
	Title XIX	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	5,229,923	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,411,719	13,527,699	0.178280	5,229,923	932,391	90.00
91.00	Nursing Program cost	0	13,527,699	0.000000	5,229,923	0	91.00
92.00	Allied health cost	0	13,527,699	0.000000	5,229,923	0	92.00
93.00	All other Medical Education	0	13,527,699	0.000000	5,229,923	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/26/2023 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		943,223		30.00
31.00	03100	INTENSIVE CARE UNIT		5,770,851		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.213788	2,403,615	513,864	50.00
51.00	05100	RECOVERY ROOM	0.539573	218,498	117,896	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.125279	2,999,366	375,758	54.00
60.00	06000	LABORATORY	0.126761	4,607,010	583,989	60.00
65.00	06500	RESPIRATORY THERAPY	0.760976	1,285,852	978,503	65.00
66.00	06600	PHYSICAL THERAPY	0.529133	250,732	132,671	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.376281	213,059	80,170	67.00
68.00	06800	SPEECH PATHOLOGY	0.362678	127,598	46,277	68.00
69.00	06900	ELECTROCARDIOLOGY	0.125536	1,333,262	167,372	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3.261185	159,051	518,695	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.229193	698,544	160,101	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.239768	4,414,328	1,058,415	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.605616	0	0	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.185303	0	0	90.01
90.02	09002	DIABETES CLINIC	4.994631	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	10.924978	0	0	90.04
90.05	09005	PRIME TIME	0.000000	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	0	0	90.06
90.07	04951	ONCOLOGY	0.722455	10,721	7,745	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.286463	0	0	90.08
91.00	09100	EMERGENCY	0.141002	3,680,066	518,897	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.294698	433,776	127,833	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		22,835,478	5,388,186	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		22,835,478		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/26/2023 1:33 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		289,560		30.00
31.00	03100	INTENSIVE CARE UNIT		227,038		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.213788	136,555	29,194	50.00
51.00	05100	RECOVERY ROOM	0.539573	17,418	9,398	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.125279	56,892	7,127	54.00
60.00	06000	LABORATORY	0.126761	151,904	19,256	60.00
65.00	06500	RESPIRATORY THERAPY	0.760976	37,633	28,638	65.00
66.00	06600	PHYSICAL THERAPY	0.529133	5,371	2,842	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.376281	4,430	1,667	67.00
68.00	06800	SPEECH PATHOLOGY	0.362678	3,073	1,115	68.00
69.00	06900	ELECTROCARDIOLOGY	0.125536	36,829	4,623	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3.261185	6,404	20,885	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.229193	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.239768	194,939	46,740	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.605616	0	0	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.879949	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.185303	183	34	90.01
90.02	09002	DIABETES CLINIC	4.994631	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	10.924978	0	0	90.04
90.05	09005	PRIME TIME	0.000000	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	0	0	90.06
90.07	04951	ONCOLOGY	0.722455	9	7	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.286463	0	0	90.08
91.00	09100	EMERGENCY	0.141002	125,380	17,679	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.294698	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		777,020	189,205	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)		777,020		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Date/Time Prepared: 5/26/2023 1:33 pm

Title XVIII | Hospital | PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	4,825,248	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,772,584	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	64,781	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	95.46	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	1.45	30.00
31.00	Percentage of Medicaid patient days (see instructions)	17.89	31.00
32.00	Sum of lines 30 and 31	19.34	32.00
33.00	Allowable disproportionate share percentage (see instructions)	5.32	33.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0037	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/26/2023 1:33 pm
	Title XVIII	Hospital	PPS

			1.00	
34.00	Disproportionate share adjustment (see instructions)		87,751	34.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	1,311,318	891,326	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	980,794	224,663	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	1,205,457		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	7,955,821		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		7,955,821	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		510,925	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		11,071	53.00
54.00	Special add-on payments for new technologies		139,240	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
55.01	Cellular therapy acquisition cost (see instructions)		0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		11,886	58.00
59.00	Total (sum of amounts on lines 49 through 58)		8,628,943	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		8,628,943	61.00
62.00	Deductibles billed to program beneficiaries		867,096	62.00
63.00	Coinsurance billed to program beneficiaries		5,057	63.00
64.00	Allowable bad debts (see instructions)		51,626	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		33,557	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		36,620	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		7,790,347	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)		0	70.75
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		0	70.93
70.94	HRR adjustment amount (see instructions)		-28,997	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Date/Time Prepared: 5/26/2023 1:33 pm

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2022	718,442	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2023	126,175	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		8,605,967	71.00
71.01	Sequestration adjustment (see instructions)		108,435	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM or CHART pass-throughs			71.03
72.00	Interim payments		8,037,570	72.00
72.01	Interim payments-PARHM or CHART			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM or CHART (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		459,962	74.00
74.01	Balance due provider/program-PARHM or CHART (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		102,764	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/26/2023 1:33 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,825,248	0	4,825,248		4,825,248	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,772,584	0		1,772,584	1,772,584	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	64,781	0	64,781		64,781	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0532	0.0532	0.0532	0.0532		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	87,751	0	64,176	23,575	87,751	11.00
11.01	Uncompensated care payments	36.00	1,205,457	0	980,794	224,663	1,205,457	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	7,955,821	0	5,934,999	2,020,822	7,955,821	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,955,821	0	5,934,999	2,020,822	7,955,821	15.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/26/2023 1:33 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	510,925	0	379,255	131,670	510,925	16.00
17.00	Special add-on payments for new technologies	54.00	139,240	0	137,097	2,143	139,240	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	6,451,351	2,154,635	8,605,986	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	491,371	0	359,701	131,670	491,371	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	19,554	0	19,554	0	19,554	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	510,925	0	379,255	131,670	510,925	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.111363	0.058560		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			718,442		718,442	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				126,175	126,175	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/26/2023 1:33 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,825,248	4,825,248		4,825,248	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,772,584		1,772,584	1,772,584	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	64,781	64,781		64,781	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0532	0.0532	0.0532		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	87,751	64,176	23,575	87,751	11.00
11.01	Uncompensated care payments	36.00	1,205,457	980,794	224,663	1,205,457	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	7,955,821	5,934,999	2,020,822	7,955,821	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,955,821	5,934,999	2,020,822	7,955,821	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	510,925	379,255	131,670	510,925	16.00
17.00	Special add-on payments for new technologies	54.00	139,240	137,097	2,143	139,240	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			6,451,351	2,154,635	8,605,986	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/26/2023 1:33 pm

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	491,371	359,701	131,670	491,371	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	19,554	19,554	0	19,554	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	510,925	379,255	131,670	510,925	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	718,442	718,442		718,442	28.00
29.00	Low volume adjustment on or after October 1	70.97	126,175		126,175	126,175	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-28,997	-1,489	-27,508	-28,997	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part B Date/Time Prepared: 5/26/2023 1:33 pm

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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,394	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	19,144,336	2.00
3.00	OPPS payments	13,185,669	3.00
4.00	Outlier payment (see instructions)	67,387	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	78,335	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,394	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	5,841	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)	5,841	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)	5,841	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	4,447	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)	1,394	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)	13,331,391	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,280,246	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)	11,052,539	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	11,052,539	30.00
31.00	Primary payer payments	2,939	31.00
32.00	Subtotal (line 30 minus line 31)	11,049,600	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)	102,817	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	66,831	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	65,194	36.00
37.00	Subtotal (see instructions)	11,116,431	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-180	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)	11,116,611	40.00
40.01	Sequestration adjustment (see instructions)	140,070	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs		40.03
41.00	Interim payments	10,952,263	41.00
41.01	Interim payments-PARHM or CHART		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	24,278	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
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0037	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/26/2023 1:33 pm
	Title XVIII	Hospital	PPS

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I Date/Time Prepared: 5/26/2023 1:33 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		8,037,570		10,833,664	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	12/31/2022	118,599	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		118,599	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)		8,037,570		10,952,263	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		459,962		24,278	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		8,497,532		10,976,541	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0037	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 5/26/2023 1:33 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-3 Part VII | Date/Time Prepared: 5/26/2023 1:33 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	482,455		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	482,455	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	482,455	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	516,598		8.00
9.00	Ancillary service charges	777,020	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,293,618	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,293,618	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	811,163	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	482,455	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	482,455	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	482,455	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	482,455	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	482,455	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	482,455	0	40.00
41.00	Interim payments	588,298	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-105,843	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0037	Period: From 01/01/2022 To 12/31/2022	Worksheet E-5 Date/Time Prepared: 5/26/2023 1:33 pm
	Title XVIII		PPS

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G | Date/Time Prepared: 5/26/2023 1:33 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	9,859,312	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	18,262,348	0	0	0	4.00
5.00	Other receivable	19,342,089	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	6,046,112	0	0	0	7.00
8.00	Prepaid expenses	2,541,080	0	0	0	8.00
9.00	Other current assets	112,023,032	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)	168,073,973	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	29,420,345	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	189,252,280	0	0	0	15.00
16.00	Accumulated depreciation	-197,881,721	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	100,005,799	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	120,796,703	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	37,967,002	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	37,967,002	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	326,837,678	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	10,585,826	0	0	0	37.00
38.00	Salaries, wages, and fees payable	7,715,544	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	6,521,160	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	24,822,530	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	802,091	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	802,091	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	25,624,621	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	301,213,057				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)	301,213,057	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	326,837,678	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-1 | Date/Time Prepared: 5/26/2023 1:33 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		339,225,123		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-38,012,066				2.00
3.00	Total (sum of line 1 and line 2)		301,213,057		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)		301,213,057		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)		301,213,057		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/26/2023 1:33 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	8,435,211		8,435,211	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	8,435,211		8,435,211	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	14,798,340		14,798,340	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)	14,798,340		14,798,340	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	23,233,551		23,233,551	17.00
18.00	Ancillary services	48,100,020	430,259,615	478,359,635	18.00
19.00	Outpatient services	0	27,422	27,422	19.00
20.00	RURAL HEALTH CLINIC	0	739,513	739,513	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	991,280	1,227,818	2,219,098	26.00
27.00	OTHER PROFESSIONAL FEES	8,450	2,847,349	2,855,799	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	72,333,301	435,101,717	507,435,018	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		187,763,430		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)		187,763,430		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-3 | Date/Time Prepared: 5/26/2023 1:33 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	507,435,018	1.00
2.00	Less contractual allowances and discounts on patients' accounts	358,558,001	2.00
3.00	Net patient revenues (line 1 minus line 2)	148,877,017	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	187,763,430	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-38,886,413	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-16,384,612	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	15,021,943	24.00
24.01	OTHER NON-OPERATING INCOME	2,660,503	24.01
24.50	COVID-19 PHE Funding	145,186	24.50
25.00	Total other income (sum of lines 6-24)	1,443,020	25.00
26.00	Total (line 5 plus line 25)	-37,443,393	26.00
27.00	OTHER EXPENSES	568,673	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	568,673	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-38,012,066	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0037	Period: From 01/01/2022 To 12/31/2022	Worksheet L Parts I-III Date/Time Prepared: 5/26/2023 1:33 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	491,371	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	19,554	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	29.97	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	510,925	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0037 | Component CCN: 15-3987 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/26/2023 1:33 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	7,076	0	7,076	0	7,076	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	161,225	0	161,225	0	161,225	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	29,345	0	29,345	0	29,345	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	93,368	0	93,368	0	93,368	9.00
10.00	Subtotal (sum of lines 1 through 9)	291,014	0	291,014	0	291,014	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	58,566	58,566	-320	58,246	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	58,566	58,566	-320	58,246	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	291,014	58,566	349,580	-320	349,260	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	41,660	41,660	-41,660	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	41,660	41,660	-41,660	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	174,242	174,242	0	174,242	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	174,242	174,242	0	174,242	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	291,014	274,468	565,482	-41,980	523,502	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0037 | Component CCN: 15-3987 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/26/2023 1:33 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	7,076		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	161,225		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	29,345		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	93,368		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	291,014		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	58,246		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	58,246		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	349,260		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	174,242		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	174,242		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	523,502		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0037 | Component CCN: 15-3987 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 5/26/2023 1:33 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	1	0		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	1.19	4,738	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.19	4,738		1	4,738	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.19	4,738			4,738	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					349,260	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					349,260	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					174,242	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					121,447	15.00
16.00	Total overhead (sum of lines 14 and 15)					295,689	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					295,689	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					295,689	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					644,949	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0037 Component CCN: 15-3987	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/26/2023 1:33 pm
	Title XVIII	RHC I	Cost

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	644,949	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	16,313	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	628,636	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	4,738	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	4,738	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	132.68	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2022 through 12/31/2022)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	113.00	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	113.00	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	115	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	12,995	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	12,995	16.00
16.01	Total program charges (see instructions)(from contractor's records)		14,455	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,788	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,607	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		4,431	16.04
16.05	Total program cost (see instructions)	0	6,038	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		5,849	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		1,364	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		6,038	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,166	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		11,204	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		11,204	26.00
26.01	Sequestration adjustment (see instructions)		141	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		5,595	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		5,468	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0037 | Component CCN: 15-3987 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 5/26/2023 1:33 pm

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	291,014	291,014	291,014	291,014	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.004108	0.015354	0.010303	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,195	4,468	2,998	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	145	28	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	1,340	4,496	2,998	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	349,260	349,260	349,260	349,260	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	295,689	295,689	295,689	295,689	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.003837	0.012873	0.008584	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	1,135	3,806	2,538	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	2,475	8,302	5,536	0	10.00
11.00	Total number of injections/infusions (from your records)	61	228	153	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	40.57	36.41	36.18	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	20	62	58	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	811	2,257	2,098	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		16,313	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		5,166	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0037 Component CCN: 15-3987	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 5/26/2023 1:33 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		5,595	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		5,595	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		5,468	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		11,063	7.00

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