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

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	517, 372	-174, 619	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	9, 921	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	527, 293	-174, 619	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer. Mail Stop C4-26-05. Baltimore, Maryland 21244-1850.

Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provi d	er CCN:		Period: From 01/01/ To 12/31/		Workshe Part I Date/Ti 5/26/20	me Pre	pare
	1.00	2.00		3.00		4	4.00			
	Hospital and Hospital Health Care Co		1							
0 0	Street: 1141 ATWOOD STREET City: CORYDON	PO Box: State: IN	Zip Code	A7112	Count	ty: HARRISON				1.
0	CTTY. CORTDON	Component Name	CCN	CBSA	Provi der			nt Syst	em (P	<u></u> .
			Number	Number		Certi fi ed		0, or		
							V	XVIII		1
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Componer			1	1	1			1	
0	Hospi tal	HARRI SON COUNTY	151331	31140	1	12/15/2005	N	0	0	3
0	Subprovider - IPF	HOSPI TAL								4
0	Subprovider - IRF									5
0	Subprovider - (Other)									6
0	Swing Beds - SNF	HARRISON COUNTY SWING	15Z331	15999		08/14/2011	l N	0	0	7
		BEDS								
0	Swing Beds - NF									8
0	Hospital-Based SNF									9
	Hospital-Based NF									10
00	Hospital-Based OLTC									11
	Hospital-Based HHA									12
	Separately Certified ASC Hospital-Based Hospice									13
	Hospital-Based Health Clinic - RHC									15
	Hospital -Based Health Clinic - FQHC									16
	Hospital -Based (CMHC) I									17
	Renal Dialysis									18
00	Other									19
						From:		То		
						1.00		2.0		
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)					01/01/2	022	12/31/	2022	20
00	Type of control (see this fuctions)					9				21
					1.00	2.00		3.0	00	1
	Inpatient PPS Information									
00	Does this facility qualify and is it				N	N				22
	disproportionate share hospital adju			2						
	§412.106? In column 1, enter "Y" fo									
	facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" for		enament							
01	Did this hospital receive interim UC		tal UCPs	for	Ν	N				22
0.	this cost reporting period? Enter in									
	for the portion of the cost reportir	g period occurring prior	r to Octob	er						
	1. Enter in column 2, "Y" for yes or	"N" for no for the port	tion of th	ie						
	cost reporting period occurring on c	r after October 1. (see								
~~	instructions)									
02	Is this a newly merged hospital that				N	N				22
	determined at cost report settlement 1, "Y" for yes or "N" for no, for th									
	period prior to October 1. Enter in	•	1 3	no,						
	for the portion of the cost reportin			- /						
03	Did this hospital receive a geograph	ic reclassification from	m urban to		Ν	N		Ν		22
	rural as a result of the OMB standar									
	adopted by CMS in FY2015? Enter in c									
	for the portion of the cost reportin			er						
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft									
	Does this hospital contain at least			is						
	counted in accordance with 42 CFR 41									
	yes or "N" for no.		-							
										22
04	Did this hospital receive a geograph									
04	rural as a result of the revised OME		r "N" for							
04	rural as a result of the revised OME adopted by CMS in FY 2021? Enter in	column 1, "Y" for yes or								
04	rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir	column 1, "Y" for yes on g period prior to Octobe	er 1. Ente							
04	rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for	column 1, "Y" for yes or g period prior to Octobe no for the portion of th	er 1. Ente ne cost	:						
04	rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft	column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr	er 1. Ente ne cost ructions)							
04	rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least	column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49	er 1. Ente ne cost ructions) 79 beds (a	IS						
04	rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41	column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49	er 1. Ente ne cost ructions) 79 beds (a	IS						
	rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least	column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column	er 1. Ente ne cost ructions) 99 beds (a n 3, "Y" f	is Tor		2 N				23
	rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column dicaid days on lines 24	er 1. Ente ne cost ructions) 99 beds (a n 3, "Y" f and/or 25	is for		2 N				23
	rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method	column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 4 2.105)? Enter in column dicaid days on lines 24 of admission, 2 if censu of identifying the days	er 1. Ente ne cost ructions) 99 beds (a n 3, "Y" f and/or 25 us days, o in this c	is For for 3		2 N				23
	rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date	column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 44 2.105)? Enter in column dicaid days on lines 24 of admission, 2 if censu of identifying the days method used in the prior	er 1. Entene cost ructions) 79 beds (a n 3, "Y" f and/or 25 us days, co in this co r cost	is For for 3		2 N				23

OSPI T	Financial Systems HARRIS AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D/	ON COUNTY H	Provider CC	CN: 15-1331	Period From O	:			rm CMS- eet S-2	
						2/31/		Date/T	ime Pre 023 5:2	
		In-State Medicaid paid days	unpai d days	Out-of State Medicaid paid days	Out-of State Medicai eligibl unpaic	d HI e	edicai MO day	d ( /s Me	)ther di cai d days	
1.00	If this provider is an IPPS hospital, enter the	1.00 C	2.00 0 0	3.00	4.00	0	5.00	0	6.00 (	24.
5. 00	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. 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	c	0 0	o		0		0		25.
	HMO paid and eligible but unpaid days in column 5.				Urba	 n/Rur	al S	Date of	f Geogr	
						1.00			00	
5. 00	Enter your standard geographic classification (not w cost reporting period. Enter "1" for urban or "2" fo		s at the beg	ginning or	Ine		2			26.
7.00 5.00	Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif If this is a sole community hospital (SCH), enter th	r"2" for r ication in	rural. If ap column 2.	ppl i cabl e,			2			27.
	effect in the cost reporting period.						-	End		
	1					gi nni r 1. 00	ig.	Endi 2.	00	
. 00	Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat		script line	36 for numb	ber					36.
. 00	If this is a Medicare dependent hospital (MDH), ente is in effect in the cost reporting period.		er of period	ls MDH statu	s		0			37.
. 01	Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f instructions)									37.
. 00	If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.									38.
						Y/N 1.00			/N 00	-
9. 00	Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)	), (ii), or the mileage ii)? Enter	r (III)? Ent e requiremen in column 2	ter in colur nts in 2 "Y" for ye	nn es	N		1	N	39.
0. 00	Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo	n adjustmer ber 1. Ente	nt? Enter "Y er "Y" for y	/" for yes o ves or "N" 1	or For	Ν		ſ	N	40.
	no in column 2, for discharges on or after October 1		5				V		VIV	
							1.00	XVIII 2.00	-	
. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payme	nt for disp	proporti onat	e share in	accordar	ice	N	N	N	45.
. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks					ıh	Ν	N	N	46.
. 00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS	capital? E	enter "Y for	ves or "N'	' for no.		N	N	N	47.
. 00	<u>Is the facility electing full federal capital paymen</u> Teaching Hospitals	t? Enter "	Y" for yes	or "N" for	no.		Ν	N	N	48.
. 00 . 00	Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after Decembe the instructions. For column 2, if the response to c involved in training residents in approved GME progr and are you are impacted by CR 11642 (or applicable "Y" for yes; otherwise, enter "N" for no in column 2 For cost reporting periods beginning prior to Decemb	"Y <sup>,, f</sup> or yes r 27, 2020, olumn 1 is ams in the CRs) MA dir	s or "N" for under 42 C "Y", or if prior year ect GME pay	no in colu CFR 413.78(k this hospit or penultir yment reduct	umn 1. Fo b)(2), se tal was nate year tion? Ent	e e ; ; ; ; ; ; ;	N			56.
	is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no i residents start training in the first month of this "N" for no in column 2. If column 2 is "Y", complet complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CF which month(s) of the cost report the residents were for yes, enter "Y" for yes in column 1, do not compl If line 56 is yes, did this facility elect cost reim	residents n column 1. cost report e Worksheet applicable R 413.77(e on duty, i ete column	in approved If column ing period? E-4. If co For cost )(1)(iv) ar f the respo 2, and comp	d GME progra 1 is "Y", c 2 Enter "Y" olumn 2 is ' reporting p nd (v), rega onse to line olete Worksh	ams trair did 'for yes 'N", periods ardless c e 56 is " neet E-4.	ned s or of Y"	Ν			58

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC	F	Period: From 01/01/2022 Fo 12/31/2022	5/26/2023 5:2	pared:
					V 1.00	XVIII XIX 0 2.00 3.00	-
9.00	Are costs claimed on line 100 of Worksheet A? If yes	s, comp	lete Wkst. D-2.	Pt. I.	1.00	5 2.00 5.00	59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustment? Enter "Y" for yes or "N" for no in colum	85? (s umn 1. CR) NAHI	see If column 1	1.00 N	2.00	3.00	60. 0
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	1
o1. 01 o1. 02	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 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) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,	N			0.00	0. OC	61. 00 61. 0 <sup>-</sup> 61. 02
1. 03	and primary care FTEs added under section 5503 of ACA). (see instructions) 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) Enter the number of unweighted primary care/or						61.0
1. 06	surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 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) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary						61.0
	care or general surgery. (see instructions)	Pr	ogram Name	Program Code	Unweighted IME	Unweighted	
						Direct GME FTE Count	
			1.00	2.00	3.00	4.00	1
1. 20	Of the FTEs in line 61.05, specify each new program special ty, 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. Of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE				0. 00		61. 1
	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.						
	ACA Provisions Affecting the Health Resources and Ser	rvi ces	Administration	(HRSA)		1.00	
	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc	trai neo			iod for which	0.00	62.00
	Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	a Teachi			your hospital	0.00	62. 0 <sup>.</sup>
3. 00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	er Sett ettings	ings during this co	ost reporting		N	63.0

<u>th Financial Systems</u> PITAL AND HOSPITAL HEALTH CARE COMPL		TA Provider	CCN: 15-1331 F	Period:	u of Form CMS- Worksheet S-2	
FITAL AND HOSFITAL HEALTH CARE COMPL	LA IDENTITICATION DA	TA FIOVIDEI	F	rom 01/01/2022 o 12/31/2022	Part I	epared
			Unweighted	Unweighted	Ratio (col. 1/	
			FTES	FTEs in	(col. 1 + col.	
			Nonprovi der	Hospi tal	2))	
			Site			4
Castion FEOA of the ACA Dasa Very	ETE Decidente in N	annauidan Cattinga	1.00	2.00	3.00	-
Section 5504 of the ACA Base Year period that begins on or after Ju			-mis base year	is your cost r	eporting	
00 Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you	yes, or your facilit per of unweighted nor ations occurring in number of unweighted	ty trained residents n-primary care all nonprovider non-primary care		D 0. OC	0. 000000	5 64.0
of (column 1 divided by (column 1						
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	
			FTES	FTEs in	(col . 3 + col .	
			Nonprovi der Si te	Hospi tal	4))	
	1.00	2.00	3.00	4.00	5.00	-
00 Enter in column 1, if line 63	1.00	2.00	0.0			0 65 0
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)			Unweighted	Unwei ghted	Ratio (col. 1/	
			FTĔs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current		n Nonprovider Settir	igsEffective f	or cost reporti	ng periods	
beginning on or after July 1, 20 Enter in column 1 the number of u FTEs attributable to rotations or	nweighted non-primar curring in all nonpr	ovider settings.	0.0	0. 00	0. 000000	66.
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	al. Enter in column 3	s the ratio of				
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTES	FTEs in	(col. 3 + col.	
			Nonprovi der	Hospi tal	4))	
-	1 00	2.00	Si te	1.00	E 00	-
00 Enter in column 1, the program	1.00	2.00	3.00	4.00	5.00 0.000000	67
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						

Heal th	Financial Systems HARRISON COUNTY HOSPITAL		In Li	eu of Form CMS-	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CO		eriod: rom 01/01/202	Worksheet S-2 2 Part I	2
		T.		2 Date/Time Pre	
				5/26/2023 5:2	21 pm
		070 (4 4 40		1.00	
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49 For a cost reporting period beginning prior to October 1, 2022, did you of MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Fina (August 10, 2022)?	otain permissio	on from your	N	68.00
			1	00 2.00 3.00	_
	Inpatient Psychiatric Facility PPS			00   2.00   3.00	
70.00	ls this facility an Inpatient Psychiatric Facility (IPF), or does it conta Enter "Y" for yes or "N" for no.	ain an IPF subp	provider?	u	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teachir	ng program in 1	the most	0	71.00
	recent cost report filed on or before November 15, 2004? Enter "Y" for ye				
	42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for ye				
	Column 3: If column 2 is Y, indicate which program year began during this	cost reporting	g period.		
	(see instructions) Inpatient Rehabilitation Facility PPS				1
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it co	ontain an IRF	1	1	75.00
76.00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teachin	ng program in 1	the most	0	76.00
	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 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If				
	indicate which program year began during this cost reporting period. (see				
				1.00	-
	Long Term Care Hospital PPS				
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for r Is this a LTCH co-located within another hospital for part or all of the c		neriod? Enter	- N	80.00 81.00
01.00	"Y" for yes and "N" for no.		period: Enter	ÎN .	01.00
9E 00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter	- "V" for yor (	r "N" for po	N	85.00
	Did this facility establish a new Other subprovider (excluded unit) under				86.00
07 00	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	under eastion		N	07.00
87.00	Is this hospital an extended neoplastic disease care hospital classified u 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	under Section		N	87.00
			Approved for Permanent	<ul> <li>Number of Approved</li> </ul>	
			Adjustment	Permanent	
			(Y/N)	Adjustments	4
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFF	RA target	1.00	2.00	0 88.00
	amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete co				
	89. (see instructions) Column 2: Enter the number of approved permanent adjustments.				
			Effective Dat		
		No.		Permanent Adjustment	
				Amount Per	
		1.00	2.00	Di scharge 3.00	-
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	0.00			89.00
	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.				
			V 1.00	2.00	-
	Title V and XIX Services		1		
90.00	Does this facility have title V and/or XIX inpatient hospital services? Er yes or "N" for no in the applicable column.	nter "Y" for	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report		N	N	91.00
92 00	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certificati			N	92.00
	instructions) Enter "Y" for yes or "N" for no in the applicable column.	, ,			
93.00	Does this facility operate an ICF/IID facility for purposes of title V and "Y" for yes or "N" for no in the applicable column.	d XIX? Enter	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no	o in the	N	N	94.00
95.00	applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column	٦.	0.00	0.00	95.00
	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no		N N	N	96.00
97.00	applicable column. If line 96 is "Y", enter the reduction percentage in the applicable column	٦.	0.00	0.00	97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	F	Period: From 01/01/2022 Fo 12/31/2022	Worksheet S-2 Part I Date/Time Pro 5/26/2023 5:2	epared:
			V	XI X	
			1.00	2.00	00.0
98.00 Does title V or XIX follow Medicare (title XVIII) for the ir stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f column 1 for title V, and in column 2 for title XIX.	for yes or "N"	for no in	Y	Y	98.0
98.01 Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti title XIX.			Y	Y	98.0
98.02 Does title V or XIX follow Medicare (title XVIII) for the ca bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of 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 crit reimbursed 101% of inpatient services cost? Enter "Y" for ye			Ν	Ν	98.0
for title V, and in column 2 for title XIX. P8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in			Ν	Ν	98.0
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c			Y	Y	98.0
column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Y	98.0
Rural Providers 105.00Does this hospital qualify as a CAH?			Y		105. 0
106.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)					105.0
107.00 Column 1: If line 105 is Y, is this facility eligible for co training programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded IF	n 1. (see ins you train I&F PF and/or IRF	structions) Rs in an	N		107.0
Enter "Y" for yes or "N" for no in column 2. (see instructi 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		edule? See 42	Ν		108. C
	Physi cal 1.00	Occupational 2.00	Speech 3.00	Respi ratory 4.00	-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	Y	109. 0
				1.00	-
110.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	Y" for yes or	"N" for no. I	f yes,	N	110.0
			1.00	2.00	-
111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ac for tele-health services.	ost reporting Dumn 1 is Y, rticipating ir	period? Enter enter the column 2.	N		111.0
		1.00	2.00	3.00	-
112.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began particip demonstration. In column 3, enter the date the hospital cear	eporting olumn 1 is pating in the	N			112.0
participation in the demonstration, if applicable. 113.00 Did this hospital participate in the Community Health Access Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no.	and Rural				113. 0
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care ( psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	3, or E only) 93" percent (includes	N			0 115. C
116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	5	N			116.0
117.00 Is this facility legally-required to carry malpractice insur "Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or occurrence pol		N	1		117.0
THE SEPTEMENT OF THE		1	1	1	1110.1

alth Financial Systems DSPITAL AND HOSPITAL HEALTH CARE CON	HARRISON COUNTY H			Period: From 01/01/202 To 12/31/202	Worksheet S 2 Part I	repared
			Premi ums	Losses	Insurance	
			1.00	2.00	3.00	-
18.01 List amounts of malpractice pr	emiums and paid losses:		492, 9		0	0 118. 0
				1.00	2.00	_
and amounts contained therein.	aid losses reported in a cost cen Fyes, submit supporting schedule			N	2.00	118.0
"N" for no. Is this a rural ho	s? (see instructions) Enter in col spital with < 100 beds that quali §3121 and applicable amendments?	umn 1, "Y' Fies for th	' for yes or ne Outpatient	N	N	119. ( 120. (
21.00 Did this facility incur and re patients? Enter "Y" for yes or		ole devices	s charged to	Y		121. (
2.00 Does the cost report contain h	ealthcare related taxes as defined or no in column 1. If column 1 is			Y	5. 01	122. (
3.00 Did the facility and/or its su services, e.g., legal, account management/consulting services for yes or "N" for no.	pproviders (if applicable) purcha ng, tax preparation, bookkeeping from an unrelated organization?	payroll, In column	and/or 1, enter "Y"			123. (
professi onal servi ces expenses	ajority of the expenses, i.e., gro for services purchased from unro ne main hospital CBSA? In column : formation	elated orga	ani zati ons			
5.00 Does this facility operate a M	edicare-certified transplant cente		'Y" for yes	N		125. (
and "N" for no. If yes, enter 6.00 If this is a Medicare-certifie	certification date(s) (mm/dd/yyyy) d kidney transplant program, ente		fication date	e		126. (
in column 1 and termination da 7.00 f this is a Medicare-certifie	te, if applicable, in column 2. I heart transplant program, enter					127. (
8.00 If this is a Medicare-certifie	te, if applicable, in column 2. d liver transplant program, enter	the certit	fication date			128.
in column 1 and termination da 9.00 f this is a Medicare-certifie	te, if applicable, in column 2. d lung transplant program, enter	the certifi	cation date			129.
0.00 If this is a Medicare-certifie	te, if applicable, in column 2. d pancreas transplant program, en on date, if applicable, in column		rti fi cati on			130.
1.00 If this is a Medicare-certifie		enter the d	certi fi cati on			131.
2.00 If this is a Medicare-certifie	d islet transplant program, enter te, if applicable, in column 2.	the certi	fication date			132.
3.00 Removed and reserved						133.
4.00 If this is a hospital-based or in column 1 and termination da All Providers	gan procurement organization (OPO) te, if applicable, in column 2.	), enter th	ne OPO number			134.
0.00 Are there any related organiza chapter 10? Enter "Y" for yes	tion or home office costs as definer or "N" for no in column 1. If yes, the home office chain number. (so	and home	office costs	N		140.
1.00	2.00 2.00 chain organization, enter on line	s 141 thro	uah 143 the n	3.00 ame and address	s of the	
home office and enter the home	office contractor name and contr		er.			
1.00Name: 2.00Street:	Contractor's Name: PO Box:		Contracto	or's Number:		141.
3. 00 Ci ty:	State:		Zip Code:			143.
					1.00	-
4.00 Are provider based physicians'	costs included in Worksheet A?				Y	144.
				1.00	2.00	_
	"Y" for yes or "N" for no in coluinclude Medicare utilization for	umn 1. If o	column 1 is	1.00	2.00	145.
5.00 Has the cost allocation method Enter "Y" for yes or "N" for n	ology changed from the previously			Ν		146.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CO	CN: 15-1331	Period	l: )1/01/2022	Worksheet S- Part I	2
					2/31/2022		
						1.00	-
47.00 Was there a change in the statisti						N	147.0
48.00 Was there a change in the order of				_		N	148.0
49.00 Was there a change to the simplifi	ed cost finding method:	Part A	Part E		Fitle V	N Title XIX	149.0
		1, 00	2.00		3.00	4,00	-
Does this facility contain a provi or charges? Enter "Y" for yes or "		an exemption fro	m the appl		f the lowe	er of costs	
55. 00 Hospi tal	IN TOT TO TOT EACT COM			5. (366 4	N	N	155. 0
56.00 Subprovider - IPF		N	N		N	N	156. 0
57.00 Subprovi der – I RF		Ν	N		N	N	157.0
58. 00 SUBPROVI DER							158.0
59. 00 SNF		N	N		N	N	159.0
60. 00 HOME HEALTH AGENCY		N	N		N	N	160. 0
61.00 CMHC			N		N	N	161.0
						1.00	_
Multicampus						1	_
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that has	one or more camp	uses in dif	ferent Cl	BSAs?	N	165. C
	Name	County		Zip Code		FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	
66.00 If line 165 is yes, for each campus enter the name in column						0.0	00166.0
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)							
						1.00	-
Health Information Technology (HI				ment Act			
67.00 Is this provider a meaningful user						Y	167. 0
68.00 If this provider is a CAH (line 10			e 167 is "\	"), ente	r the		168. 0
reasonable cost incurred for the H 68.01 f this provider is a CAH and is r			a aualifiu f	for a hor	dobin		168. 0
exception under §413.70(a)(6)(ii)?					usinp		100.0
69.00 If this provider is a meaningful u	ser (line 167 is "Y") a				enter the	9.9	99169. 0
transition factor. (see instruction	ins)			De	egi nni ng	Endi ng	_
				DE	1.00	2.00	-
70.00 Enter in columns 1 and 2 the EHR b period respectively (mm/dd/yyyy)	eginning date and endir	ng date for the re	eporting		1.00	2.00	170. 0
period respectively (mm/dd/yyyy)							
71 00 lf lips 147 is "V" doos this prov	idan hava any dava fan	individual c. annal	Lodin		1.00 N	2.00	0171.0
71.00 If line 167 is "Y", does this prov section 1876 Medicare cost plans r "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	eported on Wkst. S-3, F mn 1. If column 1 is ye	Pt. I, line 2, col	. 6? Enter		N		

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Period: From 01/01/2022	Worksheet S-2 Part II	2
				To 12/31/2022		
				Y/N	Date	
				1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE					
	General Instruction: Enter Y for all YES responses. Enter N	lfor all NO re	esponses. Ente	r all dates in t	the	
	mm/dd/yyyy format.					-
	COMPLETED BY ALL HOSPITALS					-
. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	boginning of	the cost	N	1	1.0
. 00	reporting period? If yes, enter the date of the change in o			IN		1.0
	reporting period: in yes, enter the date of the enange in t	<u>501 ulli1 2. (300</u>	Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare F	Program? If	N			2. (
	yes, enter in column 2 the date of termination and in colur	nn 3, "V" for				
	voluntary or "I" for involuntary.					
. 00	Is the provider involved in business transactions, includir		N			3.0
	contracts, with individuals or entities (e.g., chain home of					
	or medical supply companies) that are related to the provid					
	officers, medical staff, management personnel, or members of directors through ownership, control, or family and othe					
	relationships? (see instructions)					
-			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
. 00	Column 1: Were the financial statements prepared by a Cert		Y	С		4. (
	Accountant? Column 2: If yes, enter "A" for Audited, "C" 1					
	or "R" for Reviewed. Submit complete copy or enter date ava	ailable in				
~~	column 3. (see instructions) If no, see instructions.					-
. 00	Are the cost report total expenses and total revenues diffe		N			5.0
	those on the filed financial statements? If yes, submit rea	concritation.		Y/N	Legal Oper.	
				1.00	2.00	-
	Approved Educational Activities			1.00	2.00	
. 00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, is	the provider	N		6.0
	the legal operator of the program?	<u> </u>				
. 00	Are costs claimed for Allied Health Programs? If "Y" see in	nstructions.		N		7.0
. 00	Were nursing programs and/or allied health programs approve	ed and/or renew	ed during the	N		8.0
~~	cost reporting period? If yes, see instructions.					
. 00	Are costs claimed for Interns and Residents in an approved	0	cal education	N		9. (
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of		bo curront	N		10.0
5.00	cost reporting period? If yes, see instructions.			IN		10.0
1.00	Are GME cost directly assigned to cost centers other than I	& Rin an Apr	proved	N		11. (
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N	
					1.00	
	Bad Debts					_
					1	
2.00	Is the provider seeking reimbursement for bad debts? If yes				Y	
2.00	If line 12 is yes, did the provider's bad debt collection p			st reporting	Y N	
2.00 3.00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.	oolicy change o	luring this co		N	13. (
2.00 3.00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura	oolicy change o	luring this co			13. (
2.00 3.00 4.00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura instructions.	oolicy change o	luring this co		N	13. (
2.00 3.00 4.00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura instructions. Bed Complement	policy change c ance amounts wa	during this co nived? If yes,	see	N	13. ( 14. (
2.00 3.00 4.00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura instructions.	ng period? If	during this co nived? If yes,	see	N	13. ( 14. (
2.00 3.00 4.00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura instructions. Bed Complement	ng period? If	during this co nived? If yes, yes, see inst	see	N N	12. ( 13. ( 14. ( 15. (
2.00 3.00 4.00 5.00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura instructions. Bed Complement Did total beds available change from the prior cost reporti	oolicy change c ance amounts wa ng period? If Par	during this co nived? If yes, yes, see inst t A	see ructions.	N N N T B	13. ( 14. (
2.00 3.00 4.00 5.00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura instructions. Bed Complement	ng period?lf Y/N	during this co hived? If yes, yes, see inst t A Date	see ructions. Par Y/N	N N t B Date	13. ( 14. (
2.00 3.00 4.00 5.00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura instructions. Bed Complement Did total beds available change from the prior cost reporti PS&R Data Was the cost report prepared using the PS&R Report only?	ng period?lf Y/N	during this co hived? If yes, yes, see inst t A Date	see ructions. Par Y/N	N N t B Date	13. ( 14. (
2.00 3.00 4.00 5.00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura instructions. Bed Complement Did total beds available change from the prior cost reporti PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	ng period? If Par Y/N 1.00	during this co hived? If yes, yes, see inst t A Date	see Puttions. Y/N 3.00	N N t B Date	13. 14. 15.
2.00 3.00 4.00 5.00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura instructions. Bed Complement Did total beds available change from the prior cost reporti PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see	ng period? If Par Y/N 1.00	during this co hived? If yes, yes, see inst t A Date	see Puttions. Y/N 3.00	N N t B Date	13. 14. 15.
2. 00 3. 00 4. 00 5. 00 6. 00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura instructions. Bed Complement Did total beds available change from the prior cost reporti PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)	ng period?lf Par Y/N N	Juring this co aived? If yes, yes, see inst t A Date 2.00	see ructions. Par Y/N 3.00 N	N N t B Date 4.00	13. ( 14. ( 15. ( 16. (
2. 00 3. 00 4. 00 5. 00 6. 00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura instructions. Bed Complement Did total beds available change from the prior cost reporti PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for	ng period? If Par Y/N 1.00	during this co hived? If yes, yes, see inst t A Date	see Puttions. Y/N 3.00	N N t B Date	13. 14. 15. 15.
2.00 3.00 4.00 5.00 6.00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura instructions. Bed Complement Did total beds available change from the prior cost reporti PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	ng period?lf Par Y/N N	Juring this co aived? If yes, yes, see inst t A Date 2.00	see ructions. Par Y/N 3.00 N	N N t B Date 4.00	13. 14. 15. 15.
2.00 3.00 4.00 5.00 6.00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura instructions. Bed Complement Did total beds available change from the prior cost reporti PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	ng period?lf Par Y/N N	Juring this co aived? If yes, yes, see inst t A Date 2.00	see ructions. Par Y/N 3.00 N	N N t B Date 4.00	13.0
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura instructions. Bed Complement Did total beds available change from the prior cost reporti PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	ng period? If Par Y/N 1.00 Y	Juring this co aived? If yes, yes, see inst t A Date 2.00	see ructions. Par Y/N 3.00 N Y	N N t B Date 4.00	13. 14. 15. 16. 17.
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura instructions. Bed Complement Did total beds available change from the prior cost reporti PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	ng period?lf Par Y/N N	Juring this co aived? If yes, yes, see inst t A Date 2.00	see ructions. Par Y/N 3.00 N	N N t B Date 4.00	13. 14. 15. 15.
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura instructions. Bed Complement Did total beds available change from the prior cost reporti 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) 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) If line 16 or 17 is yes, were adjustments made to PS&R	ng period? If Par Y/N 1.00 Y	Juring this co aived? If yes, yes, see inst t A Date 2.00	see ructions. Par Y/N 3.00 N Y	N N t B Date 4.00	13. 14. 15. 16. 17.
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura instructions. Bed Complement Did total beds available change from the prior cost reporti PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 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.	ng period? If Par Y/N 1.00 Y	Juring this co aived? If yes, yes, see inst t A Date 2.00	see ructions. Par Y/N 3.00 N Y	N N t B Date 4.00	13. 14. 15. 16. 17.
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura instructions. Bed Complement Did total beds available change from the prior cost reporti Mas 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) 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) 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	ng period? If Par Y/N 1.00 Y	Juring this co aived? If yes, yes, see inst t A Date 2.00	see ructions. Par Y/N 3.00 N Y	N N t B Date 4.00	13. 14. 15. 16. 17.

Health Financial Systems HARRISON COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-1331 Peri od: Worksheet S-2 From 01/01/2022 Part II Date/Time Prepared: То 12/31/2022 5/26/2023 5:21 pm Description Y/N Y/N 1.00 3.00 0 20.00 |If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 20.00 Report data for Other? Describe the other adjustments: 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 Ν Ν 21.00 records? If yes, see instructions. 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 Ν 22 00 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost Ν 23.00 reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered into during this cost reporting period? 24 00 Ν 24 00 If ves, see instructions 25 00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see Ν 25 00 instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26.00 instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 copy. Interest Expense Were new loans, mortgage agreements or letters of credit entered into during the cost reporting 28.00 28.00 Ν period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Ν 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see 30.00 Ν 30 00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Ν 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual Ν 32 00 arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If 33.00 Ν 33.00 no, see instructions. Provider-Based Physicians 34.00 Were services furnished at the provider facility under an arrangement with provider-based physicians? γ 34 00 If yes, see instructions. 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based Ν 35.00 physicians during the cost reporting period? If yes, see instructions Y/N Date 1.00 2.00 Home Office Costs 36.00 Were home office costs claimed on the cost report? Ν 36.00 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? Ν 37.00 If yes, see instructions. If line 36 is yes , was the fiscal year end of the home office different from that of 38.00 38 00 Ν the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, Ν 39.00 see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see Ν 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information CLINT BRI LL 41.00 Enter the first name, last name and the title/position 41.00 held by the cost report preparer in columns 1, 2, and 3,

42.00 Enter the employer/company name of the cost report preparer.
43.00 Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.

42.00

43.00

Heal th	Financial Systems HARRISON	COUNTY	/ HOSPI TAL	In Lie	In Lieu of Form CMS-2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-1331	Period: From 01/01/2022	Worksheet S-2 Part II		
				To 12/31/2022		pared: <u>1 pm</u>	
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	SE	ENI OR MANAGER			41.00	
	held by the cost report preparer in columns 1, 2, and 3	3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost report					42.00	
	preparer.						
43.00	Enter the telephone number and email address of the cos	st				43.00	
	report preparer in columns 1 and 2, respectively.						

HOSPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC/	HARRISON COUNT	Provider CC	`N· 15_1331	Peri od:	Worksheet S-3	2552-10
100111	AL AND HOST THE HEALTH OAKE COMPLEX STATISTIC			N. 15 1551	From 01/01/2022	Part I	
					To 12/31/2022	Date/Time Prep	
						5/26/2023 5:2 1/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line No.		Avai I abl e			
		1.00	2.00	3.00	4.00	5.00	
1 00	PART I - STATISTICAL DATA	20.00	04	7.4	70.04(.00		1 1 00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	30. 00	21	7,66	55 72, 216. 00	0	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF 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		21	7,66	5 72, 216. 00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	4	1, 46	50 7, 728. 00	0	8.00
9.00	CORONARY CARE UNI T						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00	0.5			0	13.00
14.00	Total (see instructions)		25	9, 12	25 79, 944. 00	0	14.00
15.00	CAH visits					0	15.00
16.00 17.00	SUBPROVIDER - IPF SUBPROVIDER - IRF						16.00 17.00
17.00	SUBPROVIDER - TRF SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P. )						23.00
24.00	HOSPI CE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambul ance 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						32.01
33.00	outpatient days (see instructions) LTCH non-covered days						33.00
33.00 33.01	LTCH non-covered days LTCH site neutral days and discharges						33.00
					i l		00.01

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time I	<u>  5/26/2023_5: 2</u> Equi val ents	1 pm
	Component	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		1
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	854	84	3, 00	99		1.0
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)	700	007				
2.00	HMO and other (see instructions)	793	897				2.0
3.00	HMO I PF Subprovi der	0	0				3.0
4.00	HMO I RF Subprovi der	0	0	_			4.0
5.00	Hospital Adults & Peds. Swing Bed SNF	57	0		57		5.0
6.00	Hospital Adults & Peds. Swing Bed NF		0		0		6.0
7.00	Total Adults and Peds. (exclude observation	911	84	3, 06	6		7.0
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	84	0	32	22		8.0
9.00	CORONARY CARE UNIT						9.0
10.00	BURN INTENSIVE CARE UNIT						10.0
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.0
12.00	OTHER SPECIAL CARE (SPECIFY)						12.0
13.00	NURSERY	0.05	20	69	-	102.07	13.0
14.00	Total (see instructions)	995 0	104	4, 08		493.07	
15.00	CAH visits	0	0		0		15.0
16.00 17.00	SUBPROVI DER – I PF SUBPROVI DER – I RF						16.0
17.00							18.0
19.00	SUBPROVIDER SKILLED NURSING FACILITY						19.0
20.00	NURSING FACILITY						20.0
20.00	OTHER LONG TERM CARE						20.0
22.00	HOME HEALTH AGENCY						21.0
22.00	AMBULATORY SURGICAL CENTER (D. P. )						22.0
24.00	HOSPICE						24.0
24.10	HOSPICE (non-distinct part)				0		24.0
25.00	CMHC - CMHC				0		24. 1
26.00	RURAL HEALTH CLINIC						26.0
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	
27.00	Total (sum of lines 14-26)	0	0		0.00		
28.00	Observation Bed Days		23	90		493.07	27.0
29.00	Ambul ance Trips	1, 545	23	70			29.0
30.00	Employee discount days (see instruction)	1, 545			0		30.0
30.00 31.00	Employee discount days (see fistraction)				0		31.0
31.00	Labor & delivery days (see instructions)	0	0		0		31.0
32.00 32.01	Total ancillary labor & delivery room	U	0		0		32.0
JZ. UI	outpatient days (see instructions)				U		32.0
33.00	LTCH non-covered days	o					33.0
33.00	LTCH non-covered days LTCH site neutral days and discharges	0					33.0
JJ. UI	LETON SILE HEULTAI UAYS AND UI SCHALVES	U			1		1 33.0

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1331	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part I Date/Time Pre 5/26/2023 5:2	pared
		Full Time		Di se	charges		
		Equi val ents	<b></b>		<b>T</b> 1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.	<b>T</b>	
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers 11.00	12.00	13.00	14.00	Patients 15.00	
	PART I – STATISTICAL DATA	11.00	12.00	13.00	14.00	15.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	25	51 22	960	1 1.
	8 exclude Swing Bed, Observation Bed and		0	2.		,00	
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
. 00	HMO and other (see instructions)			17	70 216		2.
. 00	HMO IPF Subprovider				0		3.
. 00	HMO IRF Subprovider				0		4.
. 00	Hospital Adults & Peds. Swing Bed SNF						5.
. 00	Hospital Adults & Peds. Swing Bed NF						6.
. 00	Total Adults and Peds. (exclude observation						7.
	beds) (see instructions)						
. 00	INTENSIVE CARE UNIT						8.
00	CORONARY CARE UNI T						9.
0.00	BURN INTENSIVE CARE UNIT						10.
1.00	SURGICAL INTENSIVE CARE UNIT						11.
2.00	OTHER SPECIAL CARE (SPECIFY)						12.
3.00 4.00	NURSERY	0. 00	0	25	51 22	960	13.
4.00 5.00	Total (see instructions) CAH visits	0.00	U	20	22	900	14.
6.00	SUBPROVIDER - IPF						16.
7.00	SUBPROVIDER - IRF						17.
B. 00	SUBPROVIDER						18.
9.00	SKILLED NURSING FACILITY						19
). 00 ). 00	NURSING FACILITY						20.
1.00	OTHER LONG TERM CARE						21.
2.00	HOME HEALTH AGENCY						22.
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.
1.00	HOSPI CE						24.
4.10	HOSPICE (non-distinct part)						24
5.00	CMHC - CMHC						25.
5.00	RURAL HEALTH CLINIC						26.
5. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26
7.00	Total (sum of lines 14-26)	0. 00					27.
3.00	Observation Bed Days						28
. 00	Ambul ance Trips						29
). 00	Employee discount days (see instruction)						30.
1.00	Employee discount days - IRF						31.
2.00	Labor & delivery days (see instructions)						32.
2. 01	Total ancillary labor & delivery room						32.
2 00	outpatient days (see instructions)						1 22
3.00	LTCH non-covered days				0		33.
3. 01	LTCH site neutral days and discharges				UI I		33.

Heal th	Financial Systems HARRISON COUNTY H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN	l: 15-1331	Period:	Worksheet S-1	0
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 5:2	
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by line	e 202 columr	18)	0. 274577	1.00
	Medicaid (see instructions for each line)	*				
2.00	Net revenue from Medicaid				8, 428, 849	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement		from Medica	ni d?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr	om Medicaid			0	5.00
6.00	Medicaid charges				45, 952, 402	6.00
7.00 8.00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program (	lino 7 minur	cum of lin	voc 2 and E. if	12, 617, 473 4, 188, 624	7.00
0.00	<pre>&lt; zero then enter zero)</pre>		s sum of fff		4, 100, 024	0.00
	Children's Health Insurance Program (CHIP) (see instructions fo	or each line)	)			
9.00	Net revenue from stand-alone CHIP				0	9.00
10.00	Stand-alone CHIP charges				0	10.00
	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 minu	us line 9; i	f < zero then	0	12.00
	enter zero)					
13.00	Other state or local government indigent care program (see inst Net revenue from state or local indigent care program (Not incl				0	13.00
	Charges for patients covered under state or local indigent care					14.00
14.00	10)				Ŭ	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 inc		orogram (lir	ne 15 minus line	0	16.00
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state/	/local indig	jent care program	ns (see	
17.00	instructions for each line) Private grants, donations, or endowment income restricted to fu	nding charit	ty care		0	17.00
	Government grants, appropriations or transfers for support of h					
	Total unreimbursed cost for Medicaid , CHIP and state and local			s (sum of lines	4, 188, 624	
	8, 12 and 16)					
			Uni nsured	Insured	Total (col. 1	
		_	patients	patients	+ col . 2)	
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00	
20.00	Charity care charges and uninsured discounts for the entire fac	ility	481, 60	1, 208, 917	1, 690, 517	20.00
20.00	(see instructions)		101, 00	1,200,717	1,070,017	20.00
21.00	Cost of patients approved for charity care and uninsured discou	unts (see	132, 23	1, 208, 917	1, 341, 153	21.00
	instructions)					
22.00	Payments received from patients for amounts previously written	off as		0 0	0	22.00
22.00	charity care Cost of charity care (line 21 minus line 22)		132, 23	36 1, 208, 917	1, 341, 153	22.00
23.00	cost of charity care (the 21 minus the 22)		132, 23	1, 208, 917	1, 341, 153	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patier	nt days beyor	nd a length	of stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care		5	5		
25.00	If line 24 is yes, enter the charges for patient days beyond the	ne indigent o	care program	n's length of	0	25.00
	stay limit					
	Total bad debt expense for the entire hospital complex (see ins				6, 627, 366	
	Medicare reimbursable bad debts for the entire hospital complex				547, 542 842, 373	
	Medicare allowable bad debts for the entire hospital complex (s Non-Medicare bad debt expense (see instructions)		uns)		5, 784, 993	•
	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see ir	nstructione)		1, 883, 257	
	Cost of uncompensated care (line 23 column 3 plus line 29)		13 11 46 11 0113)		3, 224, 410	
	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			7, 413, 034	

Heal th	Financial Systems	HARRI SON COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O		Provider C		eriod:	Worksheet A	
				T	rom 01/01/2022 p 12/31/2022	Date/Time Pre 5/26/2023 5:2	
	Cost Center Description	Sal ari es	Other		Reclassi fi cati	Reclassi fi ed	
				+ col. 2)	ons (See A-6)	Trial Balance (col. 3 +-	
						col . 4)	
		1.00	2.00	3.00	4.00	5.00	
1 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT		1 502 1/0	1 502 1/0	1/0 700	1 745 000	1.00
1.00 1.01	00100 New CAP REL COSTS-BEDG & FIXT		1, 583, 169 628, 857		162, 720 0	1, 745, 889 628, 857	1.00
1.02	00102 AMB DEPR		020,007		57, 611	57, 611	1.02
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		1, 016, 239	1, 016, 239		1, 020, 209	2.00
2.01	00201 AMB EQUIP	221 224	0	0	325, 544	325, 544	2.01
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00590 ADMINISTRATIVE & GENERAL	231, 236 1, 912, 233	953, 132 5, 854, 383		184, 068 -2, 676	1, 368, 436 7, 763, 940	4.00 5.01
5.02	00570 ADMI TTI NG	593, 700	162, 221		-263	755, 658	5.02
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	404, 327	811, 467		0	1, 215, 794	5.03
7.00	00700 OPERATION OF PLANT	322, 562	1, 497, 438			1, 820, 000	7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	37, 219 516, 595	237, 717 320, 005		0	274, 936 836, 600	8.00 9.00
10.00	01000 DI ETARY	511, 124	526, 173		-579, 641	457, 656	10.00
11.00	01100 CAFETERI A	0	0	0	579, 641	579, 641	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	774, 236	257,056		0	1, 031, 292	13.00
14.00 16.00	01400 CENTRAL SERVICES & SUPPLY 01600 MEDICAL RECORDS & LIBRARY	226, 947 621, 022	2, 464, 557 280, 593		-1, 861, 792 0	829, 712 901, 615	14.00 16.00
17.00	01700 SOCIAL SERVICE	383, 415	86, 820			470, 235	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS		· · ·				
30.00	03000 ADULTS & PEDIATRICS	4, 491, 116	1, 829, 960			6, 100, 949	30.00
31.00 43.00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	525, 732 0	158, 790 114		-3, 555 156, 987	680, 967 157, 101	31.00 43.00
43.00	ANCI LLARY SERVICE COST CENTERS	0		114	130, 707	137, 101	43.00
50.00	05000 OPERATING ROOM	1, 064, 629	719, 095	1, 783, 724	-123, 262	1, 660, 462	50.00
53.00	05300 ANESTHESI OLOGY	0	1, 223, 186			1, 206, 759	53.00
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	1, 146, 239 989, 755	1, 095, 830 2, 120, 284			2, 143, 673 2, 937, 913	54.00 60.00
65.00	06500 RESPIRATORY THERAPY	0,733	629, 196			576, 199	65.00
66.00	06600 PHYSI CAL THERAPY	390, 488	77, 293		-52, 369	415, 412	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	-	42, 847	42, 847	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0 484, 034	0 169, 575	, °	9, 495 26, 003	9, 495 679, 612	68.00 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	404, 034	325		2, 000, 335	2, 000, 660	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		1, 017, 388	1, 017, 388	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	356, 118	2, 112, 207		-941	2, 467, 384	73.00
77.00	07700 ALLOGENEI C HSCT ACQUI SI TI ON OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	77.00
90.00	09000 CLINIC	33, 810	18, 331	52, 141	-13, 930	38, 211	90.00
90.01	09001 SENI OR CARE	88, 600	144, 994	233, 594	-33	233, 561	90. 01
		856, 228	321, 734			1, 177, 006	
90. 03 90. 04	09003 HARRI SON CRAWFORD HEALTHCARE 09004 CORYDON MEDI CAL ASSOCI ATES	633, 774 571, 025	317, 001 263, 754			938, 619 816, 857	90. 03 90. 04
90.04 90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	1, 218, 667	462, 845		-139, 823	1, 541, 689	90.04 90.05
90.06	09006 OBGYN - DR SAUER	506, 123	253, 565			754, 920	90.06
90.07	09007 FIRST CAPITAL MEDICAL GROUP	1, 226, 936	569, 989			1, 760, 742	90.07
90. 08 90. 09	09008 SOUTH HARRISON FAMILY MEDICINE 09009 PAIN MANAGEMENT	424, 592	237, 012		-40, 166 5, 160	621, 438	90. 08 90. 09
90.09 90.10	09009 PATN MANAGEMENT 09010 DERMATOLOGY	156, 885 484, 549	28, 457 140, 651		-5, 160 -4, 717	180, 182 620, 483	90. 09 90. 10
90.11	09011 KIDS FIRST	1, 269, 556	1, 031, 360			1, 960, 128	90.11
91.00	09100 EMERGENCY	2, 281, 914	821, 278	3, 103, 192	-17, 148	3, 086, 044	91.00
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	2, 334, 456	1, 693, 410	4, 027, 866	-581, 487	3, 446, 379	95.00
	10200 OPI OI D TREATMENT PROGRAM	2,001,100	0		0		102.00
	SPECIAL PURPOSE COST CENTERS						
	SUBTOTALS (SUM OF LINES 1 through 117)	20 040 042	137,850				113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	28, 069, 842	33, 257, 913	61, 327, 755	28, 950	61, 356, 705	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	1, 698, 831	977, 783	2, 676, 614		2, 647, 774	
	07950 MARKETING 07951 PHYSICIAN BILLING	0 388, 371	0 214, 063	0 602, 434	0 -110	0 602, 324	194.00
	207951 PHYSICIAN BILLING	388, 371	214, 063		-110		194. 01 194. 02
200.00		30, 157, 044	34, 449, 759	-	-	64, 606, 803	

	inancial Systems IFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	HARRISON COUN F EXPENSES	Provi der CCN: 15-1331	Period: Work	Form CMS-2552 sheet A
					/Time Prepare
	Cost Center Description	Adjustments	Net Expenses	5720	0/2023 5:21 pm
		(See A-8) 6.00	For Allocation 7.00		
G	ENERAL SERVICE COST CENTERS	0.00	7.00		
	0100 NEW CAP REL COSTS-BLDG & FIXT	-13, 734	1, 732, 155		1.
	0101 MOB	0	628, 857		1.
	0102 AMB DEPR	0	57, 611		1.
	0200 NEW CAP REL COSTS-MVBLE EQUIP 0201 AMB EQUIP	0	1, 020, 209 325, 544		2.
	0400 EMPLOYEE BENEFITS DEPARTMENT	0	1, 368, 436		4.
	0590 ADMINISTRATIVE & GENERAL	-1, 569, 113	6, 194, 827		5.
	0570 ADMI TTI NG	0	755, 658		5.
	0580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	1, 215, 794		5.
	0700 OPERATION OF PLANT	0	1, 820, 000		7.
	0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING	0	274, 936 836, 600		8.
	1000 DI ETARY	0	457, 656		10.
	1100 CAFETERIA	-123,025	456, 616		11.
. 00  0	1300 NURSING ADMINISTRATION	0	1, 031, 292		13.
	1400 CENTRAL SERVICES & SUPPLY	0	829, 712		14.
	1600 MEDI CAL RECORDS & LI BRARY	-23,046	878, 569		16.
	11700 SOCIAL_SERVICE NPATIENT ROUTINE SERVICE COST CENTERS	0	470, 235		
	3000 ADULTS & PEDIATRICS	-973, 001	5, 127, 948		30.
	3100 I NTENSI VE CARE UNI T	0	680, 967		31.
. 00 0	4300 NURSERY	0	157, 101		43.
	NCI LLARY SERVICE COST CENTERS	-			
	5000 OPERATING ROOM	0	1, 660, 462		50.
	5300 ANESTHESI OLOGY 5400 RADI OLOGY-DI AGNOSTI C	-1, 190, 620	16, 139 2, 143, 673		53. 54.
	6000 LABORATORY	-2, 547	2, 935, 366		60.
	6500 RESPI RATORY THERAPY	0	576, 199		65.
	6600 PHYSI CAL THERAPY	0	415, 412		66.
	6700 OCCUPATIONAL THERAPY	0	42, 847		67.
		0	9, 495		68.
	6900 ELECTROCARDI OLOGY 7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	679, 612 2, 000, 660		69. 71.
	7200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 017, 388		72.
	7300 DRUGS CHARGED TO PATIENTS	0	2, 467, 384		73.
. 00 0	7700 ALLOGENEIC HSCT ACQUISITION	0	0		77.
	UTPATIENT SERVICE COST CENTERS				
		0	38, 211		90.
	9001 SENI OR CARE	-24, 906			90.
	9002 GENERAL SURGERY 9003 HARRI SON CRAWFORD HEALTHCARE	-811, 791 -333, 165	365, 215 605, 454		90.
	9004 CORYDON MEDICAL ASSOCIATES	-422, 321	394, 536		90.
. 05 0	9005 ORTHOPEDIC SURGERY - DR KLINE	-1, 080, 876			90
	19006 OBGYN - DR SAUER	-555, 433	199, 487		90
	9007 FIRST CAPITAL MEDICAL GROUP	-339, 824	1, 420, 918		90
	9008 SOUTH HARRISON FAMILY MEDICINE	-265, 702	355, 736		90
	9009 PAI N MANAGEMENT 9010 DERMATOLOGY	-207, 265 -433, 803	-27, 083 186, 680		90. 90.
	9011 KIDS FIRST	-433, 803 -849, 639	1, 110, 489		90.
	9100 EMERGENCY	0	3, 086, 044		91.
00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART)				92.
	THER REIMBURSABLE COST CENTERS				
	19500 AMBULANCE SERVICES	-16, 463	3, 429, 916		95.
	0200 OPI OI D TREATMENT PROGRAM PECIAL PURPOSE COST CENTERS	0	0		102.
	1300 INTEREST EXPENSE	0	0		113.
3.00	SUBTOTALS (SUM OF LINES 1 through 117)	-9, 236, 274			118.
	ONREI MBURSABLE COST CENTERS				
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.
	9200 PHYSI CI ANS' PRI VATE OFFI CES	0	2, 647, 774		192.
	7950 MARKETING	0			194.
	7951 PHYSICIAN BILLING 17952 MOB	0	602, 324		194. 194.
7. UZIU	TOTAL (SUM OF LINES 118 through 199)	-9, 236, 274	55, 370, 529		200.

SSI FI CATI ONS			Y HOSPITAL Provider C	CN: 15-1331	Period: From 01/01/2022	u of Form CM Worksheet A	
					To 12/31/2022	Date/Time P 5/26/2023 5	repar
	Increases					572072023 3	
Cost Center 2.00	Li ne # 3.00	Salary 4.00	0ther 5.00				
A - SUPPLIES							
MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3, 017, 723				1
PATTENTS	0.00	0	0				2
	0.00	0	0				3
	0.00 0.00	0	0				2
	0.00	0	0				
	0.00	0	0				
	0.00 0.00	0	0				
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	0.00 0.00	0	0				1
	0.00	Ő	0				1
	0.00	0	0				2
	0.00 0.00	0	0				2
	0.00	0	0				2
	0.00	0	0				2
<u> </u>	0.00	0	<u>0</u> 0 3,017,723				2
B - IMPLANTABLE DEVICES		0	3,017,723				
IMPL. DEV. CHARGED TO	72.00	0	1,017,388				
PATI ENT	+		1,017,388				
C - AMBULANCE CAPITAL		9	1,017,300				
AMB DEPR	1.02	0	57, 611				
AMB EQUI P		0	<u>325, 544</u> 383, 155				
D - INTEREST	I	Y	000, 100				
NEW CAP REL COSTS-BLDG &	1.00	0	137, 850				
FIXT	+		137, 850				
E - EKG			1077000				
ELECTROCARDI OLOGY	69.00	13, 016	21, 947				
	0.00 0.00	0	0 0				
	0.00	0	0				
		13, 016	21, 947				_
F - NURSERY NURSERY	43.00	156, 987	0				
		156, 987	<u> </u>				
G - THERAPY	(0.00	7 007	4 5 ( 0				
SPEECH PATHOLOGY OCCUPATI ONAL THERAPY	68.00 67.00	7, 927 35, 769	1, 568 7, 078				
0		43, 696	8, 646				
H - CAFETERIA	44.00	005 (4)	004 005				
CAFETERI A	<u>11.00</u>	28 <u>5, 6</u> 16 285, 616	<u>294, 025</u> 				
I - DEPRECIATION RECLASS	I	200,010	271,020				
NEW CAP REL COSTS-BLDG &	1.00	0	24, 870				
FIXT NEW CAP REL COSTS-MVBLE	2.00	0	3, 970				
EQUI P							
O J – AMBULANCE WORKERS COMP		0	28, 840				_
EMPLOYEE BENEFITS DEPARTMENT	4.00	0	151, 033				-
0			151, 033				
K - MI SCELLANEOUS BENEFI TS	4.00		22.025				<b>—</b>
EMPLOYEE BENEFITS DEPARTMENT	4.00 0.00	0	33, 035 0				
	0.00	0	0				:
	0.00	0	0				
	0.00 0.00	0	0				
	0.00	0	0				
		-	33, 035				1

Heal th	Financial Systems		HARRI SON COUN	NTY HOSPITAL		In Lieu	u of Form CMS-25	52-10
RECLASS	SEFECATIONS			Provider (	CCN: 15-1331	Period: From 01/01/2022	Worksheet A-6	
							Date/Time Prepa 5/26/2023 5:21	ared: pm
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
500.00	Grand Total: Increases		499, 315	5, 093, 642			50	00.00

CLAS	SIFICATIONS			Provi der	CCN: 15-1331	Peri od:	Worksheet A-	-6
						From 01/01/2022 To 12/31/2022	Date/Time Pr	epared
		D					5/26/2023 5:	
	Cost Center	Decreases Line #	Salary	Other	 Wkst. A-7 Ref	-		
	6.00	7.00	8.00	9.00	10.00	<u>.</u>		
	A – SUPPLIES							
00	CENTRAL SERVICES & SUPPLY	14.00	0	1, 861, 79		0		1.
00	ADULTS & PEDIATRICS	30.00	0	37, 99		0		2.
00	INTENSIVE CARE UNIT	31.00	0	3, 55		0		3.
00	OPERATING ROOM	50.00	0	123, 26		0		4.
00	ANESTHESI OLOGY	53.00	0	16, 42		0		5
00	RADI OLOGY-DI AGNOSTI C	54.00	0	98, 39		0		6
00 00	LABORATORY RESPI RATORY THERAPY	60.00 65.00	0	155, 17 31, 050		0		8
00	PHYSICAL THERAPY	66.00	0	2		0		9
. 00	ELECTROCARDI OLOGY	69.00	0	8, 96		0		10
. 00	DRUGS CHARGED TO PATIENTS	73.00	0	94		0		11
. 00	CLINIC	90.00	0	13, 93		0		12
. 00	SENI OR CARE	90.01	o	3		0		13
. 00	GENERAL SURGERY	90.02	0	95		0		14
. 00	HARRISON CRAWFORD HEALTHCARE	90.03	0	12, 15	6	0		15
. 00	CORYDON MEDICAL ASSOCIATES	90.04	0	17, 92	2	0		16
. 00	ORTHOPEDIC SURGERY - DR	90.05	0	139, 82	3	0		17
	KLINE							
. 00	OBGYN - DR SAUER	90.06	0	4, 76		0		18
. 00	FIRST CAPITAL MEDICAL GROUP	90.07	0	36, 18		0		19
. 00	SOUTH HARRISON FAMILY	90.08	0	40, 16	6	0		20
00		00.00		F 4/4		0		01
. 00	PAIN MANAGEMENT	90.09	0	5, 16		0		21
. 00 . 00	DERMATOLOGY KIDS FIRST	90. 10 90. 11	0	4, 71 340, 78		0		22
. 00	EMERGENCY	90. 11 91. 00	0	16, 44		0		23
. 00	AMBULANCE SERVICES	95.00	0	47, 10				24
. 00				3,017,72				20
	B - IMPLANTABLE DEVICES			0,017,72	5			
00	MEDI CAL SUPPLI ES CHARGED TO	71.00	0	1,017,38	8	0		1.
	PATI ENTS							
	0		0	1,017,38	8			
	C - AMBULANCE CAPITAL	05.00			-1			
00	AMBULANCE SERVICES	95.00	0	383, 15		9		1.
00		0.00	0		0	9		2.
	D - INTEREST		V	303, 13	5			
00	INTEREST EXPENSE	113.00	0	137, 850	1 C	1		1.
	0		o	137, 85				
	E – EKG							
00	LABORATORY	60.00	12, 261			0		1
00	RESPI RATORY THERAPY	65.00		21, 94	7	0		2
00	EMERGENCY	91.00	662			0		3
00	AMBULANCE_SERVICES	95.00	93		<u> </u>	Q		4
	0		13, 016	21, 94	7			_
00	F - NURSERY	20.00	154 007			0		1
00	ADULTS & PEDIATRICS	<u>30.</u> 00	<u>156, 987</u>		<u> </u>	Q		1
	0		156, 987		J			-
00	PHYSICAL THERAPY	66,00	43, 696	8, 64	6	0		1
00		0.00	-3, 070	0, 04	0	0		2.
20			43, 696	8, 64		7		
	H – CAFETERIA		-,	2, 31.				1
00	DI ETARY	10.00	285, 616	294, 02	5	0		1.
	0		285, 616	294, 02				
	I - DEPRECIATION RECLASS							
00	PHYSICIANS' PRIVATE OFFICES	192.00	0	28, 84	0	9		1
00		0.00	이	(	<u> </u>	9		2
	0		0	28, 84				
~~	J - AMBULANCE WORKERS COMP	05.05		454.55				
00	AMBULANCE_SERVICES	95.00	0	151,03		Ō		1
			0	151, 03	5			-
00	K - MISCELLANEOUS BENEFITS	E OA		0.77	/	0		
00	ADMI NI STRATI VE & GENERAL	5.01	0	2,67		0		1
00		5.02	U O	26		0		2
00	ADULTS & PEDIATRICS	30.00	o	25, 14				3
00		60.00	0	4, 69				4
00		91.00	U U	40				5
00 00	AMBULANCE SERVICES	95.00	U U	10		0		6
1111	PHYSICIAN_BILLING	1 <u>94.</u> 01	U	110		띡		7
00				33, 03				

Health Financial Systems	HARRI SON COUN				u of Form CMS-2	
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-1331	Period: From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
					5/26/2023 5:2	1 pm
			Acqui si ti on			
	Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPI		2.00	3.00	4.00	5.00	
1.00 Land	3, 001, 138	0		0 0	0	1.00
2.00 Land Improvements	3, 355, 876	0		0 0	45, 414	2.00
3.00 Buildings and Fixtures	37, 464, 364	4,957,483		0 4, 957, 483		3.00
4.00 Building Improvements	857, 272	3, 386, 598		0 3, 386, 598		4.00
5.00 Fixed Equipment	346,074	0,000,0,0		0 0	0	5.00
5.00 Movable Equipment	28, 128, 109	0		0 0	2, 888, 137	6.00
7.00 HIT designated Assets	0	0		0 0	0	7.00
3.00 Subtotal (sum of lines 1-7)	73, 152, 833	8, 344, 081		0 8, 344, 081	2, 933, 551	8.00
9.00 Reconciling Items	0	0		0 0	0	9.00
10.00 Total (line 8 minus line 9)	73, 152, 833	8, 344, 081		0 8, 344, 081	2, 933, 551	10.00
	Endi ng Bal ance	Fully				
	-	Depreci ated				
		Assets				
	6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPI						
1.00 Land	3, 001, 138	0				1.00
2.00 Land Improvements	3, 310, 462	0				2.00
3.00 Buildings and Fixtures	42, 421, 847	0				3.0
4.00 Building Improvements	4, 243, 870	0				4.00
5.00 Fixed Equipment	346, 074	0				5.00
5.00 Movable Equipment	25, 239, 972	0				6.0
7.00 HIT designated Assets	0	0				7.0
3.00 Subtotal (sum of lines 1-7)	78, 563, 363	0				8.0
9.00 Reconciling Items	0	0				9.00
10.00  Total (line 8 minus line 9)	78, 563, 363	0				10.00

Heal th	Financial Systems	HARRI SON COUN	TY_HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider CC	F	Period: From 01/01/2022 Fo 12/31/2022		
			SUMMARY OF CAPITAL				
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	1, 475, 646	0	(	0 107, 523	0	1.00
1.01	MOB	302, 681	77, 663	61, 572	2 0	0	1.01
1.02	AMB DEPR	0	0	(	0 0	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1, 016, 239	0	(	0 0	0	2.00
2.01	AMB EQUIP	0	0	(	0 0	0	2.01
3.00	Total (sum of lines 1-2)	2, 794, 566		61, 572	2 107, 523	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
	1	14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1, 583, 169				1.00
1.01	MOB	186, 941	628, 857				1.01
1.02	AMB DEPR	0	0				1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1, 016, 239				2.00
2.01	AMB EQUIP	0	0				2.01
3.00	Total (sum of lines 1-2)	186, 941	3, 228, 265				3.00

Health Financial Systems	HARRI SON COUN	ITY HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2022 To 12/31/2022	Date/Time Prep 5/26/2023 5:2	pared:
	COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COST		-				
1.00 NEW CAP REL COSTS-BLDG & FLXT 1.01 MOB 1.02 AMB DEPR	53, 323, 391 0 0			1 0. 678731 0 0. 000000 0 0. 000000	0	1. 00 1. 01 1. 02
2.00 NEW CAP REL COSTS-MVBLE EQUIP 2.01 AMB EQUIP	25, 239, 972 0		20,20,,,,	2 0. 321269 0 0. 000000		2. 00 2. 01
3.00 Total (sum of lines 1-2)	78, 563, 363					3.00
	ALLOCA	TION OF OTHER (			OF CAPITAL	
Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum o cols. 5 through 7)	f Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COST		-	1		_	
1.00 NEW CAP REL COSTS-BLDG & FLXT 1.01 MOB 1.02 AMB DEPR	0	-		0 1, 500, 516 0 302, 681 0 57, 611	77, 663	1.00 1.01 1.02
2. 00 NEW CAP REL COSTS-MVBLE EQUIP 2. 01 AMB EQUIP	0	, s		0 1, 020, 209 0 325, 544	0	2. 00 2. 01
3.00 Total (sum of lines 1-2)	0	, s		0 3, 206, 561		3.00
		SI	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d 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 COST		407.500	1		1 700 155	1.00
1.00 NEW CAP REL COSTS-BLDG & FLXT 1.01 MOB	124, 116 61, 572			0 0 0 186, 941	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1.00 1.01
1.02 AMB DEPR	01, 572			0 180, 941	57, 611	1.01
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	-		0 0	1, 020, 209	2.00
2.01 AMB EQUIP	0	, s		0 0	325, 544	2.01
3.00  Total (sum of lines 1-2)	185, 688	107, 523		0 186, 941	3, 764, 376	3.00

ADJUST	Financial Systems MENTS TO EXPENSES				Period: From 01/01/2022	Worksheet A-8	
					To 12/31/2022	Date/Time Pre 5/26/2023 5:2	pared: 1 pm
				Expense Classification or To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - MOB (chapter 2)		0	МОВ	1.01	0	1.01
1.02	Investment income - AMB DEPR		0	AMB DEPR	1.02	0	1. 02
2.00	(chapter 2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter		C	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	2) Investment income - AMB EQUIP		C	AMB EQUIP	2. 01	0	2. 01
3.00	(chapter 2) Investment income - other		0		0.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of		0		0.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter	А	-3, 173	ADMI NI STRATI VE & GENERAL	5.01	0	7.00
8.00	21) Television and radio service (chapter 21)		O		0.00	0	8.00
9. 00 10. 00	Parking lot (chapter 21) Provider-based physician	A-8-2	0 -5, 654, 857		0.00	0 0	9. 00 10. 00
11.00	adjustment Sale of scrap, waste, etc. (chapter 23)		C		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00 14.00	Laundry and linen service Cafeteria-employees and guests	В	122 025	CAFETERI A	0.00 11.00	0	
15.00	Rental of quarters to employee and others	В	-123, 025 0		0.00	0	
16.00	Sale of medical and surgical supplies to other than patients		C		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	В	-23, 046	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19. 00	Nursing and allied health education (tuition, fees,		C		0.00	0	19.00
19. 01	books, etc.) Nursing and allied health education (tuition, fees,		O		0.00	0	19. 01
19. 02	books, etc.) Nursing and allied health education (tuition, fees,		O		0.00	0	19. 02
20.00	books, etc.) Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty		0		0.00	0	21.00
22.00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		C		0.00	0	22.00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	O	RESPI RATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of	A-8-3	O	PHYSI CAL THERAPY	66.00		24.00
25. 00	limitation (chapter 14) Utilization review -		O	*** Cost Center Deleted ***	114.00		25.00
	physicians' compensation (chapter 21) Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-BLDG &	1.00	0	26.00
26.00							

	Financial Systems		HARRI SON COUNT			u of Form CMS-	
ADJUSI	MENTS TO EXPENSES			Provider CCN: 15-1331	Period: From 01/01/2022 To 12/31/2022	Worksheet A-8 Date/Time Pre 5/26/2023 5:2	pared:
				Expense Classification o	n Worksheet A	572672023 5:2	
			r	o/From Which the Amount is			
					,		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
26.02	Depreciation - AMB DEPR		0 A	MB DEPR	1.02	0	26.0
27.00	Depreciation - NEW CAP REL		ON	EW CAP REL COSTS-MVBLE	2.00	0	27.0
	COSTS-MVBLE EQUIP		E	QUI P			
27.01	Depreciation - AMB EQUIP		OA	MB EQUIP	2.01	0	27.0
28.00	Non-physician Anesthetist		0 *	** Cost Center Deleted ***	19.00		28.0
29.00	Physicians' assistant		0		0.00	0	29.0
30.00	Adjustment for occupational	A-8-3	olo	CCUPATI ONAL THERAPY	67.00		30.0
	therapy costs in excess of						
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		OA	DULTS & PEDIATRICS	30.00		30.9
	instructions)						
31.00	Adjustment for speech	A-8-3	0 5	PEECH PATHOLOGY	68.00		31.0
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32. C
	Depreciation and Interest						
	MISC INCOME - A&G	В		DMINISTRATIVE & GENERAL	5.01	0	
33.01	MISC INCOME - LABORATORY	В		ABORATORY	60.00	-	
33.02	INTEREST	В		EW CAP REL COSTS-BLDG &	1.00	11	33.0
				I XT			
33.03	PROVIDER TAX FEE	A		DMI NI STRATI VE & GENERAL	5.01	0	
33.04	UNNECESSARY BORROWING	A		EW CAP REL COSTS-BLDG &	1.00	11	33.0
				IXT		_	
33.05	CRNA	A		NESTHESI OLOGY	53.00		
33.06		A		DMI NI STRATI VE & GENERAL	5.01	0	
	MARKETING EXPENSE	A		DMI NI STRATI VE & GENERAL	5.01	0	1 00.0
	CLINIC RENT - SENIOR CARE	В		ENI OR CARE	90.01	0	
	CLINIC RENT - GENERAL SURGERY	В		ENERAL SURGERY	90.02		
33. 10		В	-74, 957H	ARRISON CRAWFORD HEALTHCAF	E 90.03	0	33.1
	CRAWFORD HEAL		05 7/10				
33. 11	CLINIC RENT - CORYDON MEDICAL	В	-95, 7660	ORYDON MEDICAL ASSOCIATES	90.04	0	33. 1
00.40	ASSOCI	P	111 (00)		00.05		
33. 12		В		RTHOPEDIC SURGERY - DR	90.05	0	33.1
22 12	SURGERY - D	D			00.0/		
33.13	CLINIC RENT - OBGYN - DR SAUER			BGYN - DR SAUER	90.06		
33.14	CLINIC RENT - FIRST CAPITAL	В	- 120, 083 F	IRST CAPITAL MEDICAL GROUP	90.07	0	33.1
33. 15	MEDICAL CLINIC RENT - SOUTH HARRISON	В	E2 200	OUTH HARRISON FAMILY	90.08	0	22.
JJ. 15	FAMILY	Ď		EDICINE	90.08		33.1
22 14	CLINIC RENT - PAIN MANAGEMENT	В		AIN MANAGEMENT	90.09	0	33. 1
	CLINIC RENT - PAIN MANAGEMENT	В			90.09		
		В		ERMATOLOGY			
	CLINIC RENT - KIDS FIRST	В		IDS FIRST	90.11	0	33.1
5U. UU	TOTAL (sum of lines 1 thru 49)		-9, 236, 274				50. C
	(Transfer to Worksheet A, column 6, line 200.)						1

(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.
(2) distinguished and can be applied on the set of an advectment of the set of a set of

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT         Provider CCN: 15-1331         Period: From 01/4 To 12/2           WKst. A Line #         Cost Center/Physician Identifier         Total Remuneration         Provider CCN: 15-1331         Provider Component         RCE An Component           1.00         2.00         3.00         4.00         5.00         6.0           2.00         30.00 ADULTS & PEDIATRICS         973.001         153.952         0         153.952           2.00         30.00 ADULTS & PEDIATRICS         973.001         975.231         0         0           3.00         60.00 LABORATORY         20.970         2.9971         18.873         0           4.00         90.02/CENERAL SURGERY         795.231         0         0         0           5.00         90.04/CORYDON MEDICAL ASSOCIATES         326.555         326.555         0         0           7.00         90.06/DEGYN - NR SAUER         521.027         521.027         0         0           9.00         90.07FIRST CAPITAL MEDICAL GROUP         219.741         219.741         0         0           11.00         90.09/PAIN MANAGEMENT         181.117         181.117         181.117         0         170.943           12.00         95.00/AMBULANCE SERVICES         16.	11/2022 11/2022 Date/Ti 5/26/20 Dount Physiciar ider Comp Hour 0 0 0 0 0 0 0 0 0 0 0 0 0	ponent         1           0         0         1.1           0         2.1         0         3.1           0         0         3.1         0         4.1           0         0         3.1         0         4.1         0         5.1         0         6.1         0         7.1         0         8.1         0         9.1         0         10.1         0         12.1         0         13.1         0         12.1         0         13.1         0         14.1         0         15.1         0         200.1         15.1         0         200.1         10.1 </th
To         12/2           WKst. A Line #         Cost Center/Physician Identifier         Total Remuneration         Professional Component         Provider Component         RCE An Component           1.00         17.00 SOCIAL SERVICE         153,952         0         153,952         0         153,952           2.00         30.00 (ABULTS & PEDIATRICS         973,001         973,001         0         0           3.00         60.00 (JABORATORY         20,970         2.097         18,873         0           4.00         90.02 (GENERAL SURGERY         795,231         0         5         0           5.00         90.03 (JARRISON CRAWFORD HEALTHCARE         258,208         208         0         0           6.00         90.04 (CORYDON MEDICAL ASSOCIATES         326,555         326,555         0         0           7.00         90.05 (DETHOFEDIC SURGERY - DR KLINE         211,027         521,027         0         0           9.00         90.06 (DERMATICAL SENTIAL WEDICAL GROUP         219,741         219,741         0         0           11.00         90.09 (PAIN MANAGEMENT         181,117         181,117         0         0         0         0         0           12.00         90.00 (DERMAGENCY         170,943 </td <td>B1/2022         Date/Ti           5726/20           ount         Physiciar           ider Comp           0         7.00           0         14.0</td> <td>023         5: 21         pm           in/Proviponent        </td>	B1/2022         Date/Ti           5726/20           ount         Physiciar           ider Comp           0         7.00           0         14.0	023         5: 21         pm           in/Proviponent
Identifier         Remuneration         Component         Component           1.00         2.00         3.00         4.00         5.00         6.00           1.00         17.00 SOCIAL SERVICE         153,952         0         153,952         0           3.00         60.00 LABORATORY         273,001         0         0         0         0           4.00         90.02 GENERAL SURGERY         20,970         2,097         18,873         0           5.00         90.03 GENERAL SURGERY         206,970         2,097         18,873         0           5.00         90.04 CORTOON MEDI CAL ASSOCI ATES         326,555         326,555         0<	Physiciar ider Comp Hour 0 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	n/Prov ponent rs 0 0 0 1 0 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 0 1 0 0 1 0 0 1 0 0 1 0 0 0 1 0 0 0 1 0 0 0 1 0 0 0 1 0 0 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0
1.00         2.00         3.00         4.00         5.00         6.0           1.00         17.00 SOCIAL SERVICE         153,952         0         0         0         0	Hour           0         7.00           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         14.0	rs         0           00         0           0         1           0         2           0         3           0         4           0         5           0         6           0         7           0         8           0         7           0         8           0         10           0         12           0         13           0         14           0         200           0         15           0         200           0         1           0         2           0         1           0         2           0         1           0         2           0         1           0         2           0         3           0         1           0         2           0         3           0         4           0         5
1.00         17.00         SOCIAL SERVICE         153,952         0         153,952           2.00         30.00         ADDADUTS & PEDIATRICS         973,001         0         0           3.00         60.00         LABORATORY         20,970         2,097         18,873           4.00         90.02         GENERAL SURGERY         795,231         795,231         795,231           5.00         90.03         HARRISON CRAWFORD HEALTHCARE         258,208         258,208         0           6.00         90.04         CORYDON MEDICAL ASSOCIATES         326,555         326,555         0           7.00         90.05         ORTHOPEDIC SURGERY - DR         966,196         966,196         0           8.00         90.06         BEGYN - DR SAUER         521,027         521,027         0           10.00         90.08         SOUTH HARRISON FAMILY         212,404         212,404         0           11.00         90.09         PAIN MANAGEMENT         181,117         181,117         0         170,943         0         170,943         0         170,943         0         170,943         0         170,943         0         170,943         0         170,943         0         170,943         0	0 7.00 0 0 0 0 0 0 0 0 0 0 0 0	00     0       0     1.       0     2.       0     3.       0     4.       0     5.       0     6.       0     7.       0     8.       0     9.       0     10.       0     11.       0     12.       0     13.       0     14.       0     200.       In Cost     200.       0     1.       0     2.       00     1.       0     3.       0     3.       0     3.       0     3.       0     3.       0     3.
2.00         30.00         30.00         40.00         973.001         973.001         973.001         0           3.00         60.00         LABORATORY         20.970         2.097         18.873           4.00         90.02         GENERAL SURGERY         795.231         795.231         0           5.00         90.03         HARRI SON CRAWFORD HEALTHCARE         258.208         256.555         0           6.00         90.04         CONTHOPEDIC SURGERY - DR         966.196         966.196         0           8.00         90.05         ORTHOPEDIC SURGERY - DR         966.196         966.196         0           8.00         90.05         OSTHOPEDIC SURGERY - DR         966.196         966.196         0           9.00         90.07 FIRST CAPI TAL MEDICAL GROUP         219.741         219.741         0         0           10.00         90.09 PAIN MANAGEMENT         181.117         181.1177         0         12.00         90.00         170.943         0         170.943         0         170.943         0         170.943         0         170.943         0         170.943         0         12.00         13.4           10.00         17.00         2.00         8.00         9.00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 2.1 0 3.1 0 4.1 0 5.1 0 6.1 0 7.1 0 8.1 0 9.1 0 10.1 0 11.1 0 12.1 0 13.1 0 14.1 0 15.1 0 15.1 0 15.1 0 14.1 0 15.1 0 0 15.1 0 0 5.1 0 0 0 5.1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
3.00         60.00 LABORATORY         20.970         2.097         18,873           4.00         90.02 GENERAL SURGERY         795,231         795,231         0           5.00         90.03 HARRI SON CRAWFORD HEALTHCARE         258,208         258,208         0           6.00         90.05 ORTHOPEDI C SURGERY - DR         266,555         326,555         326,555         0           7.00         90.05 ORTHOPEDI C SURGERY - DR         966,196         0         0         0           8.00         90.06 (DBGYN - DR SAUER         521,027         521,027         0           9.00         90.07 FIRST CAPITAL MEDI CAL GROUP         219,741         219,741         0           10.00         90.08 SOUTH HARRI SON FAMI LY         212,404         212,404         0           MEDI CI NE         777,733         777,733         0         170,943         0           11.00         90.09 PAI N MANAGEMENT         181,117         181,117         0         170,943         0         170,943           15.00         95.00 AMBULANCE SERVI CES         16,463         16,463         0         243,768           11.00         17.00 SOCI AL SERVI CE         0         0         0         12.00         13.4 <t< td=""><td>0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td><td>0 3.1 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 0 10. 0 11. 0 12. 0 13. 0 14. 0 15. 0 200. 0 14. 0 200. 0 1. 0 2. 0 3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 0 10. 0 1. 0 12. 0 13. 0 14. 0 200. 0 1. 0 14. 0 200. 0 1. 0 14. 0 2. 0 14. 0 2. 0 15. 0 14. 0 2. 0 15. 0 14. 0 15. 0 200. 0 14. 0 200. 0 14. 0 200. 0 14. 0 200. 0 14. 0 200. 0 14. 0 200. 0 15. 0 2. 0 3. 0 15. 0 2. 0 3. 0 15. 0 2. 0 3. 0 3.</td></t<>	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 3.1 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 0 10. 0 11. 0 12. 0 13. 0 14. 0 15. 0 200. 0 14. 0 200. 0 1. 0 2. 0 3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 0 10. 0 1. 0 12. 0 13. 0 14. 0 200. 0 1. 0 14. 0 200. 0 1. 0 14. 0 2. 0 14. 0 2. 0 15. 0 14. 0 2. 0 15. 0 14. 0 15. 0 200. 0 14. 0 200. 0 14. 0 200. 0 14. 0 200. 0 14. 0 200. 0 14. 0 200. 0 15. 0 2. 0 3. 0 15. 0 2. 0 3. 0 15. 0 2. 0 3. 0 3.
4.00       90.02 GENERAL SURGERY       795,231       795,231       0         5.00       90.03 HARRI SON CRAWFORD HEALTHCARE       258,208       258,208       0         6.00       90.04 CORYDON MEDI CAL ASSOCI ATES       326,555       326,555       0         7.00       90.05 ORTHOPEDI C SURGERY - DR       966,196       0       0         8.00       90.06 OBGYN - DR SAUER       521,027       521,027       0         9.00       90.07 FIRST CAPITAL MEDI CAL GROUP       219,741       219,741       0         10.00       90.08 SOUTH HARRI SON FAMI LY       212,404       212,404       0         MEDI CI NE       11.00       90.00 OP AI N MANAGEMENT       181,117       181,117       0         12.00       90.10 DERMATOLOGY       405,084       405,084       0       0         13.00       90.11 K IDS FI RST       777,733       777,733       0       790,943         14.00       91.00 EMERGENCY       170,943       0       170,943       0       170,943         15.00       95.00 AMBULANCE SERVICES       16,463       10,463       0       0       12,00       13.1         10.00       17.00 SOCI AL SERVICE       0       0       0       0       0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 4, 1 0 5, 0 0 6, 0 0 7, 1 0 8, 0 0 10, 1 0 12, 0 0 12, 0 0 12, 0 0 12, 0 0 14, 0 0 15, 0 0 20, 0 0 1, 1 0 2, 0 0 3, 1 0 4, 1 0 2, 1 0 2, 1 0 3, 1 0 1, 1 0 2, 1 0 4, 1 0 3, 1 0 2, 1 0 4, 1 0 3, 1 0 2, 1 0 4, 1 0 3, 1
5.00         90.03 HARRI SON CRAWFORD HEALTHCARE         258,208         258,208         0           6.00         90.04 (CORYDON MEDI CAL ASSOCI ATES         326,555         0         1           7.00         90.05 ORTHOPEDI C SURGERY - DR         966,196         9         9           8.00         90.06 (BGYN - DR SAUER         521,027         521,027         0           9.00         90.07 FIRST CAPITAL MEDI CAL GROUP         219,741         219,741         0           10.00         90.08 SOUTH HARRISON FAMILY         212,404         212,404         0           11.00         90.09 PALN MANAGEMENT         181,117         181,117         0           13.00         90.10 (ERMATOLOGY         405,084         0         170,943           15.00         95.00 AMBULANCE SERVICES         16,463         16,463         0           200.00         12.00         17.0943         0         170,943         0           1.00         17.00 SOCIAL SERVICES         16,463         16,463         0         12.00           2.00         8.00         9.00         12.00         13.4           1.00         17.00 SOCIAL SERVICE         0         0         0         12.00           1.00         0	nent of Malpra f col. Insura 00 14.0 0	0 5.0 0 6.0 0 7.0 0 8.0 0 9.0 0 10.0 0 11.0 0 12.0 0 13.0 0 14.0 0 200.0 0 14.0 0 200.0 0 1.0 0 2.0 0 3.0 0 4.0 0 3.0 0 4.0 0 3.0 0 5.0 0 3.0 0 3.0 0 3.0 0 4.0 0 5.0 0 5.0 0 5.0 0 7.0 0 7.0 0 8.0 0 9.0 0 10.0 0 0 0 0 0 0 0
6.00       90.04 (CORYDON MEDI CAL ASSOCI ATES 7.00       326,555       326,555       326,555       0         7.00       90.05 (ORTHOPEDI C SURGERY - DR KLINE       966,196       921,027       521,027       0         8.00       90.06 (DBGYN - DR SAUER       521,027       521,027       0         9.00       90.07 [FIRST CAPI TAL MEDI CAL GROUP       219,741       219,741       0         10.00       90.08 [SOUTH HARRI SON FAMILY       212,404       0       0         11.00       90.09 [PAI N MANAGEMENT       181,117       181,117       0         12.00       90.10 [DERMATOLOGY       405,084       0       170,943         13.00       90.11 [k1DS FI RST       777,733       777,733       0         15.00       95.00 AMBULANCE SERVICES       16,463       16,463       0         200.00       2.00       8.00       9.00       12.00       Share o         1.00       17.00 SOCIAL SERVICE       0       0       0       13.10         2.00       8.00       9.00       12.00       13.10         2.00       2.00       8.00       9.00       12.00       13.10         2.00       3.00       60.00 [LABORATORY       0       0       0	nent of Malpra f col. Insura 00 14.0 0	0 6. 0 7. 0 8. 0 9. 0 10. 0 11. 0 12. 0 13. 0 14. 0 200. 0 14. 0 200. 0 14. 0 200. 0 14. 0 200. 0 14. 0 200. 0 14. 0 2. 0 2. 0 3. 0 4. 0 3. 0 4. 0 5. 0 3. 0 4. 0 5. 0 5.
7.00         90.05         ORTHOPEDIC SURGERY - DR KLINE         966, 196         0           8.00         90.06/D6GYN - DR SAUER         521, 027         521, 027         0           9.00         90.07/FIRST CAPITAL MEDICAL GROUP         219, 741         219, 741         0           10.00         90.08/SOUTH HARRISON FAMILY         212, 404         212, 404         0           MEDICINE         11:00         90.09/PAIN MANAGEMENT         181, 117         181, 117         0           12.00         90.01/DERMATOLOCY         405, 084         405, 084         0         0           13.00         90.11/KIDS FIRST         777, 733         777, 733         0         0         170, 943         0         170, 943         0         170, 943         0         170, 943         0         170, 943         0         170, 943         0         170, 943         0         170, 943         0         170, 943         0         170, 943         0         170, 943         0         170, 943         0         170, 943         0         170, 943         0         170, 943         0         170, 943         0         170, 943         0         170, 943         0         18, 00         0         0         0         0	nent of Malpra f col. Insura 00 14.0 0	0 7.1 0 8. 0 9. 0 10. 0 11. 0 12. 0 13. 0 14. 0 200. 0 14. 0 200. 0 15. 0 200. 0 1. 0 200. 0 1. 0 200. 0 3. 0 4. 0 3. 0 4. 0 2. 0 3. 0 4. 0 2. 0 3. 0 3. 0 2. 0 3. 0 2. 0 3. 0 2. 0 3. 0 2. 0 3. 0 3. 0 2. 0 3. 0 3. 0 3. 0 2. 0 3. 0 3.
8.00         90.06         0BGYN         - DR SAUER         521,027         521,027         0           9.00         90.07 FIRST CAPITAL MEDICAL GROUP         219,741         219,741         0         0         0           10.00         90.08 SOUTH HARRISON FAMILY         212,404         212,404         0         0           11.00         90.09 PAIN MANAGEMENT         181,117         181,117         0         0           12.00         90.11 KIDS FIRST         777,733         777,733         0         0           13.00         90.11 KIDS FIRST         777,733         777,733         0         0           14.00         95.00 AMBULANCE SERVICES         16,463         16,463         0         0           200.00         95.00 AMBULANCE SERVICES         10entifier         Unadjusted RCE         Limit         Cost of         Memberships & Compo         Compo           1.00         17.00 SOCIAL SERVICE         0         0         0         0         13.0           1.00         2.00         8.00         9.00         12.00         13.1           1.00         2.00         8.00         9.00         12.00         13.1           0         0         0         0	nent of Malpra f col. Insura 00 14.0 0	0 9,1 0 10.1 0 11.1 0 12. 0 13.1 0 14.1 0 200.1 n Cost actice 0 0 1.1 0 2.1 0 2.5 0 4.1 0 4.1 0 3.1 0 10.1 0 12.1 0 200.1 0 12.1 0 200.1 0 12.1 0 200.1 0 2.1 0 3.1 0 2.1 0 3.1 0 2.1 0 3.1 0 2.1 0 3.1 0 2.1 0 3.1 0 3.1
9.00         90.07         FIRST CAPITAL MEDICAL GROUP MEDICINE         219,741         219,741         0           10.00         90.08SOUTH HARRISON FAMILY MEDICINE         212,404         212,404         0           11.00         90.09 PAIN MANAGEMENT         181,117         181,117         0           12.00         90.10 DERMATOLOGY         405,084         405,084         0           13.00         90.11 KIDS FIRST         777,733         0         0           14.00         91.00EMERGENCY         170,943         0         170,943           15.00         95.00 AMBULANCE SERVICES         16,463         0         5,9564,857           200.00         5,998,625         5,654,857         343,768           100         2.00         8.00         9.00         12.00         13.0           1.00         2.00         8.00         9.00         12.00         13.0           1.00         17.00 SOCIAL SERVICE         0         0         0         0           1.00         17.00 SOCIAL SERVICE         0         0         0         0         13.0           1.00         17.00 SOCIAL SERVICE         0         0         0         0         0         13.0 <tr< td=""><td>nent of Malpra f col. Insura 00 14.0 0</td><td>0 9,1 0 10.1 0 11.1 0 12. 0 13.1 0 14.1 0 200.1 n Cost actice 0 0 1.1 0 2.1 0 2.5 0 4.1 0 4.1 0 3.1 0 10.1 0 12.1 0 200.1 0 12.1 0 200.1 0 12.1 0 200.1 0 2.1 0 3.1 0 2.1 0 3.1 0 2.1 0 3.1 0 2.1 0 3.1 0 2.1 0 3.1 0 3.1</td></tr<>	nent of Malpra f col. Insura 00 14.0 0	0 9,1 0 10.1 0 11.1 0 12. 0 13.1 0 14.1 0 200.1 n Cost actice 0 0 1.1 0 2.1 0 2.5 0 4.1 0 4.1 0 3.1 0 10.1 0 12.1 0 200.1 0 12.1 0 200.1 0 12.1 0 200.1 0 2.1 0 3.1 0 2.1 0 3.1 0 2.1 0 3.1 0 2.1 0 3.1 0 2.1 0 3.1 0 3.1
10.00         90.08         SOUTH HARRI SON FAMILY MEDI CI NE MEDI CI NE         212,404         212,404         0           11.00         90.09         PAIN MANAGEMENT         181,117         181,117         0           12.00         90.10         DERMATOLOGY         405,084         0         0           13.00         90.11         KIDS FIRST         777,733         777,733         0           14.00         91.00         EMERGENCY         170,943         0         170,943           15.00         95.00         AMBULANCE SERVICES         16,463         16,463         0           200.00         5,998,625         5,654,857         343,768         Compoint Composition Composite Composite Composition Composite Composition Composite Composit	nent of Malpra f col. Insura 00 14.0 0	0 10.1 0 11.1 0 12.1 0 13.1 0 14.1 0 200.1 11.1 0 200.1 0 20.1 0 2.1 0 2.1 0 2.1 0 2.1 0 4.1 0 2.1 0 3.1 0 2.1 0 1.1 0 2.1 0 1.1 0 200.1 0 1.1 0 200.1 0 2.1 0 1.1 0 2.1 0 1.1 0 2.0 0 1.1 0 2.0 0 1.1 0 2.0 0 1.1 0 2.0 0 1.1 0 2.0 0 1.1 0 2.0 0 2.0 0 1.1 0 2.0 0 1.1 0 2.0 0 2.0 0 2.0 0 1.1 0 2.0 0 3.5 0 2.0 0 5.5 0 5
11.00         90.09         PAIN MANAGEMENT         181,117         181,117         181,117         0           12.00         90.10         DERMATOLOGY         405,084         405,084         0           13.00         90.11         KIDS FIRST         777,733         777,733         0           14.00         91.00         EMERGENCY         170,943         0         170,943         0           15.00         95.00         AMBULANCE SERVICES         16,463         16,463         0         0           200.00	nent of Malpra f col. Insura 00 14.0 0	0 12.1 0 13.1 0 14.0 0 200.1 in Cost ance 0 0 1.1 0 2.0 0
12.00       90.10       DERMATOLOGY       405,084       405,084       0         13.00       90.11       KI DS FIRST       777,733       777,733       0         14.00       91.00       EMERGENCY       170,943       0       170,943         15.00       95.00       AMBULANCE SERVICES       16,463       16,463       0         200.00       5.998,625       5,654,857       343,768       Provi         Wkst. A Line #       Cost Center/Physician       Unadjusted RCE       5       Percent of       Cost of       Provi         1.00       2.00       8.00       9.00       12.00       13.4         1.00       2.00       8.00       9.00       12.00       13.4         1.00       17.00 \$001AL SERVICE       0       0       0       12.00       13.4         1.00       17.00 \$001AL SERVICE       0       0       0       0       12.00       13.4         1.00       9.00 \$00 \$00 \$00 \$00 \$00 \$00 \$00 \$00 \$00	nent of Malpra f col. Insura 00 14.0 0	0 12.1 0 13.1 0 14.0 0 200.1 in Cost ance 0 0 1.1 0 2.0 0
13.00       90.11       KIDS FIRST       777,733       777,733       0         14.00       91.00       EMERGENCY       170,943       0       170,943         15.00       95.00       AMBULANCE SERVICES       16,463       16,463       0         200.00       5,998,625       5,654,857       343,768         Wkst. A Line #       Cost Center/Physician Identifier       Unadjusted RCE       5 Percent of Unadjusted RCE       Cost of Education       Provi         1.00       17.00       SOCIAL SERVICE       0       0       0       0       Share o         1.00       17.00       SOCIAL SERVICE       0       0       0       0       0       Share o       12         1.00       17.00       SOCIAL SERVICE       0       0       0       0       0       12         1.00       17.00       SOCIAL SERVICE       0       0       0       0       0       12         1.00       17.00       SOCIAL SERVICE       0       0       0       0       0       12         1.00       10.00       ARARISON CRAWFORD HEALTHCARE       0       0       0       0       0       0         1.00       90.06 <td>nent of Malpra f col. Insura 00 14.0 0</td> <td>0 13.1 0 14.0 0 200.1 in Cost ance 0 0 1.1 0 2.0 0 3.1 0 4.1 0 3.1</td>	nent of Malpra f col. Insura 00 14.0 0	0 13.1 0 14.0 0 200.1 in Cost ance 0 0 1.1 0 2.0 0 3.1 0 4.1 0 3.1
14.00         91.00         EMERGENCY         170,943         0         170,943         0           15.00         95.00         AMBULANCE SERVICES         16,463         16,463         0         343,768           200.00         Wkst. A Line #         Cost Center/Physician Identifier         Unadjusted RCE         5 Percent of Unadjusted RCE         Cost of Cost of Limit         Provi           1.00         2.00         8.00         9.00         12.00         13.4           1.00         17.00 SOCI AL SERVICE         0         0         0         0           2.00         30.00 ADULTS & PEDIATRICS         0         0         0         0         12.00         13.4           1.00         90.02 GENERAL SURGERY         0         0         0         0         0         0         12.00         13.4           1.00         0.04 CORYDON MEDI CAL ASSOCIATES         0	nent of Malpra f col. Insura 00 14.0 0	0 14. 0 200. 15. 0 200. 16. 0 200. 0 20. 0 1. 0 2. 0 3. 0 4. 0 5.
15.00         95.00         AMBULANCE SERVICES         16,463         16,463         0           200.00         5,998,625         5,654,857         343,768         Provi           Identifier         Identifier         Unadjusted RCE         5 Percent of         Cost of         Provi           Identifier         Identifier         Unadjusted RCE         5 Percent of         Cost of         Composition           1.00         2.00         8.00         9.00         12.00         13.0           1.00         17.00 SOCIAL SERVICE         0         0         0         0           2.00         8.00         9.00         12.00         13.0           1.00         17.00 SOCIAL SERVICE         0         0         0         0           2.00         8.00         9.00         12.00         13.0         1.0         1.00         1.00         0         0         0         0         0         0         1.0         1.00         0         0         0         0         0         0         0         0         0         1.0         1.0         1.0         0         0         0         0         0         0         0         0         0         0 <td>nent of Malpra f col. Insura 00 14.0 0</td> <td>0 15. 0 200. in Cost ance 0 0 1. 0 2. 0 3. 0 4. 0 5.</td>	nent of Malpra f col. Insura 00 14.0 0	0 15. 0 200. in Cost ance 0 0 1. 0 2. 0 3. 0 4. 0 5.
Wkst. A Line #         Cost Center/Physician Identifier         Unadjusted RCE Limit         5 Percent of Unadjusted RCE Limit         Cost of Memberships & Continuing Education         Provi Composition           1.00         2.00         8.00         9.00         12.00         12.00         12.00         12.00         13.00           1.00         17.00         SOCIAL SERVICE         0         0         0         12.00         13.00           1.00         17.00         SOCIAL SERVICE         0         0         0         12.00         13.00           2.00         30.00         ADULTS & PEDIATRICS         0         0         0         0         0         13.00           3.00         60.00         LABORATORY         0	nent of Malpra f col. Insura 00 14.0 0	n Cost actice ance 00 0 1. 0 2. 0 3. 0 4. 0 0 5.
Identifier         Limit         Unadjusted RCE Limit         Memberships & Continuing Education         Composition Share of 200           1.00         2.00         8.00         9.00         12.00         12.00         12.00         12.00         12.00         12.00         13.00           1.00         17.00         SOCIAL SERVICE         0         0         0         0         12.00         13.00           2.00         30.00         ADULTS & PEDIATRICS         0         0         0         0         0         13.00           3.00         60.00         LABORATORY         0 <t< td=""><td>nent of Malpra f col. Insura 00 14.0 0</td><td>oractice           ance           00           0           0           0           0           0           0           0           0           0           0           0           0           0</td></t<>	nent of Malpra f col. Insura 00 14.0 0	oractice           ance           00           0           0           0           0           0           0           0           0           0           0           0           0           0
Limit         Continuing Education         Share of Education           1.00         2.00         8.00         9.00         12.00         12.00           1.00         17.00         SOCIAL SERVICE         0         0         0         12.00           1.00         17.00         SOCIAL SERVICE         0         0         0         12.00         13.00           1.00         17.00         SOCIAL SERVICE         0         0         0         0         12.00         13.00           2.00         30.00         ADULTS & PEDIATRICS         0	f col . Insura	ance 00 0 1.1 0 2.1 0 3.1 0 4.1 0 5.1
Image: 1.00         2.00         8.00         9.00         12.00         13.0           1.00         17.00         SOCIAL SERVICE         0         0         0         13.0           1.00         17.00         SOCIAL SERVICE         0         0         0         13.0           1.00         17.00         SOCIAL SERVICE         0         0         0         13.0           2.00         30.00         ADULTS & PEDIATRICS         0         0         0         0           3.00         60.00         LABORATORY         0         0         0         0           4.00         90.02         GENERAL SURGERY         0         0         0         0           5.00         90.03         HARRI SON CRAWFORD HEALTHCARE         0         0         0         0           6.00         90.04         CORYDON MEDI CAL ASSOCI ATES         0         0         0         0           7.00         90.05         ORTHOPEDI C SURGERY - DR         0         0         0         0           8.00         90.06         060FGYN - DR SAUER         0         0         0         0           9.00         90.07         FIRST CAPITAL MEDI CAL GROUP <td< td=""><td>0 14.0</td><td>00 0 1. 0 2. 0 3. 0 4. 0 5.</td></td<>	0 14.0	00 0 1. 0 2. 0 3. 0 4. 0 5.
1.00         2.00         8.00         9.00         12.00         13.1           1.00         17.00         SOCI AL SERVI CE         0	0	0 1. 0 2. 0 3. 0 4. 0 5.
2.00       30.00       ADULTS & PEDIATRICS       0       0       0         3.00       60.00       LABORATORY       0       0       0         4.00       90.02       GENERAL SURGERY       0       0       0         5.00       90.03       HARRI SON CRAWFORD HEALTHCARE       0       0       0         6.00       90.04       CORYDON MEDI CAL ASSOCIATES       0       0       0         7.00       90.05       ORTHOPEDI C SURGERY - DR       0       0       0         8.00       90.06       OBGYN - DR SAUER       0       0       0         8.00       90.06       OBGYN - DR SAUER       0       0       0         90.00       90.07       FI RST CAPI TAL MEDI CAL GROUP       0       0       0         10.00       90.08       SOUTH HARRI SON FAMILY       0       0       0         11.00       90.09       PAI N MANAGEMENT       0       0       0         12.00       90.10       DERMATOLOGY       0       0       0	-	0 2. 0 3. 0 4. 0 5.
3. 00       60. 00       LABORATORY       0       0       0         4. 00       90. 02       GENERAL SURGERY       0       0       0         5. 00       90. 03       HARRI SON CRAWFORD HEALTHCARE       0       0       0         6. 00       90. 04       CORYDON MEDI CAL ASSOCI ATES       0       0       0         7. 00       90. 05       ORTHOPEDI C SURGERY - DR       0       0       0         8. 00       90. 06       OBGYN - DR SAUER       0       0       0         9. 00       90. 07       FIRST CAPI TAL MEDI CAL GROUP       0       0       0         10. 00       90. 08       SOUTH HARRI SON FAMI LY       0       0       0         11. 00       90. 09       PAI N MANAGEMENT       0       0       0         12. 00       90. 10       DERMATOLOGY       0       0       0	0 0 0	0 3. 0 4. 0 5.
4.00       90.02       GENERAL SURGERY       0       0       0         5.00       90.03       HARRI SON CRAWFORD HEALTHCARE       0       0       0         6.00       90.04       CORYDON MEDI CAL ASSOCI ATES       0       0       0         7.00       90.05       ORTHOPEDI C SURGERY - DR       0       0       0         8.00       90.06       OBGYN - DR SAUER       0       0       0         9.00       90.07       FI RST CAPI TAL MEDI CAL GROUP       0       0       0         10.00       90.08       SOUTH HARRI SON FAMI LY       0       0       0         11.00       90.09       PAI N MANAGEMENT       0       0       0         12.00       90.10       DERMATOLOGY       0       0       0	0	0 4. 0 5.
5.00       90.03 HARRI SON CRAWFORD HEALTHCARE       0       0       0         6.00       90.04 CORYDON MEDI CAL ASSOCI ATES       0       0       0         7.00       90.05 ORTHOPEDI C SURGERY - DR       0       0       0         8.00       90.06 OBGYN - DR SAUER       0       0       0         9.00       90.07 FI RST CAPI TAL MEDI CAL GROUP       0       0       0         10.00       90.08 SOUTH HARRI SON FAMI LY       0       0       0         11.00       90.09 PAI N MANAGEMENT       0       0       0         12.00       90.10 DERMATOLOGY       0       0       0	0	0 5.
7.00         90.05         ORTHOPEDIC SURGERY - DR KLINE         0         0         0           8.00         90.06         OBGYN - DR SAUER         0         0         0         0           90.01         90.07         FIRST CAPITAL MEDICAL GROUP         0         0         0         0           90.02         90.03         SOUTH HARRISON FAMILY MEDICINE         0         0         0         0           11.00         90.09         PAIN MANAGEMENT         0         0         0         0           12.00         90.10         DERMATOLOGY         0         0         0         0		0 6.
KLI NE         KLI NE           8. 00         90. 06 (DBGYN - DR SAUER         0         0         0           9. 00         90. 07 FI RST CAPI TAL MEDI CAL GROUP         0         0         0           10. 00         90. 08 SOUTH HARRI SON FAMI LY MEDI CI NE         0         0         0           11. 00         90. 09 PAI N MANAGEMENT         0         0         0           12. 00         90. 10 DERMATOLOGY         0         0         0	0	
8.00         90.06         OBGYN - DR SAUER         0         0         0           9.00         90.07         FLRST CAPITAL MEDICAL GROUP         0         0         0         0           10.00         90.08         SOUTH HARRISON FAMILY         0         0         0         0           11.00         90.09         PALN MANAGEMENT         0         0         0         0           12.00         90.10         DERMATOLOGY         0         0         0         0	0	0 7.
9. 00         90. 07         FIRST CAPITAL MEDICAL GROUP         0         0         0         0           10. 00         90. 08         SOUTH HARRI SON FAMILY         0         0         0         0           11. 00         90. 09         PAI N MANAGEMENT         0         0         0         0           12. 00         90. 10         DERMATOLOGY         0         0         0         0	0	0 8.
MEDICINE         0<	o	0 9.
11. 00         90. 09         PAI N         MANAGEMENT         0         0         0           12. 00         90. 10         DERMATOLOGY         0         0         0         0	0	0 10.
12.00 90.10 DERMATOLOGY 0 0 0		0 11
	0	0 11. 0 12.
	0	0 13.
14.00 91.00 EMERGENCY 0 0 0	0	0 14.
15. 00 95. 00 AMBULANCE SERVICES 0 0 0	0	0 15.
200.00         0         0         0           Wkst. A Line #         Cost Center/Physician         Provider         Adjusted RCE         RCE         Adjust	0 mont	0 200.
Wkst. A Line # Cost Center/Physician Provider Adjusted RCE RCE Adjust Identifier Component Limit Disallowance	ment	
Share of col.		
1.00         2.00         15.00         16.00         17.00         18.0           1.00         17.00         SOCI AL SERVICE         0 <td>0</td> <td>1.</td>	0	1.
	73, 001	2.
3.00 60.00 LABORATORY 0 0 0	2, 097	3.
	95, 231	4.
	58, 208	5.
	26, 555 66, 196	6. 7.
KLINE	00, 170	/.
8.00 90.06 OBGYN - DR SAUER 0 0 0 5	21, 027	8.
	19, 741	9.
10. 00 90. 08 SOUTH HARRISON FAMILY 0 0 0 2 MEDICINE	12, 404	10.
	81, 117	11.
	05, 084	12.
		13.
14.00 91.00 EMERGENCY 0 0 0	77, 733	14.
15. 00 95. 00 AMBULANCE SERVICES 0 0 0 200. 00 0 5, 6	77, 733 0	ar
	77, 733	15. 200.

REASON	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	HARRI SON COUNT FURNI SHED BY	TY HOSPITAL Provider CC		In Lie Period: From 01/01/2022 To 12/31/2022 Respiratory Therapy	u of Form CMS- Worksheet A-8 Parts I-VI Date/Time Pre 5/26/2023 5:2 Cost	-3 pared:
						1.00	
1.00 2.00 3.00 4.00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervis Number of unduplicated days in which therapy	sor or therapis assistant was o	t was on provid			52 780 0 0	2.00
5.00 6.00	nor therapist was on provider site (see inst Number of unduplicated offsite visits - super Number of unduplicated offsite visits - thera assistant and on which supervisor and/or ther instructions)	rvisors or thera apy assistants	(include only	visits made by		0 0	5.00 6.00
7.00 8.00	Standard travel expense rate Optional travel expense rate per mile	Supervi sors	Therapists	Assi stants	Ai des	5.50 0.00 Trai nees	
	1	1.00	2.00	3.00	4.00	5.00	
9.00 10.00 11.00	Total hours worked AHSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	0. 00 0. 00 34. 83	8, 760. 00 69. 66 34. 83	0.00 0.00 0.00	0.00	0.00 0.00	
12.00 12.01 13.00 13.01	Number of travel hours (provider site) Number of travel hours (offsite) Number of miles driven (provider site) Number of miles driven (offsite)	0	0				12.00 12.01 13.00 13.01
						1.00	
14.00 15.00 16.00 17.00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1, Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 ar	16 for all	0 610, 222 0 610, 222	15.00 16.00			
18. 00 19. 00 20. 00	others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, li Total allowance amount (sum of lines 17-19 fo		0 0 610, 222	19.00			
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete	n line 2, make r					
21. 00 22. 00	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine	ainees (line 17 line 9 for all	others)	n of columns '	l and 2, line 9	0.00	21.00 22.00
23.00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW		,	JTATION - PROV	/I DER SI TE	610, 222	•
24.00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	
26. 00 27. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3				and 4 for all	0	26.00 27.00
28.00	others) Total standard travel allowance and standard					0	
	27) Optional Travel Allowance and Optional Travel						
29.00 30.00	Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3,		d 2, line 12 )			0	29.00 30.00
31.00	Subtotal (line 29 for respiratory therapy or	sum of lines 20				0	31.00
32.00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)	s 1 and 2, line	13 for respira	atory therapy	or sum of	0	32.00
33.00	Standard travel allowance and standard travel					0	33.00
34. 00 35. 00	Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	expense (sum o	of lines 31 and	d 32)	CES OUTSI DE PRO	0 0 VIDER SITE	34.00 35.00
24 00	Standard Travel Expense					0	24.00
36.00 37.00	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)					0 0	
38. 00 39. 00	Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur		d 6)			0	
40.00	Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0		2, line 10)			0	40.00
41.00	Assistants (column 3, line 12.01 times column		<i>,</i>			0	41.00
42.00 43.00	Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sur Total Travel Allowance and Travel Expense - C			e of the foll	wing three line	0 0 25 44 45	
	or 46, as appropriate.						
44.00	Standard travel allowance and standard travel	expense (sum o	or lines 38 and	a 39 - see ins	structions)	0	44.00

	ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	FURNI SHED BY	Provider C	CN: 15-1331	Period: From 01/01/2022 To 12/31/2022	Worksheet A-8 Parts I-VI Date/Time Pre 5/26/2023 5:2	pared:
					Respi ratory Therapy	Cost	
						1.00	
5.00	Optional travel allowance and standard travel					0	45.00
6.00	Optional travel allowance and optional travel		of lines 42 an			0	46.00
		Therapists 1.00	Assi stants 2.00	Ai des 3.00	Trai nees 4.00	<u> </u>	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
7.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0. 00	0.00	0. (	0.00	0.00	47.00
	Overtime rate (see instructions)	0. 00	0.00				48.00
	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0.00	0.00	0. (	0.00		49.00
0. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0.00	0.0	0.00	0.00	50.00
	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0.0	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	69.66	0.00	0.0	0.00		52.00
	(see instructions) Overtime cost limitation (line 51 times line	0	0.00		0 0		53.00
4.00	52) Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.00
5.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55.00
6. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3	O	0		0 0	0	56.00
	for all others.)						
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT			(10,000	1 57 00
8.00 9.00 0.00 1.00 2.00 3.00 4.00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION	i your records)	44, 45, or 46	)		610, 222 0 0 0 0 610, 222 558, 473 0	58.00 59.00 60.00 61.00 62.00 63.00
00. 01 00. 02	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27	sum of lines 2 therapy or su	4 and 25 for a m of lines 3 a	II others nd 4 for all	others	0	100. 00 100. 01 100. 02
01.00 01.01 01.02	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION				others	0	101. 00 101. 01 101. 02
02.00	Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line 13 for all others Line 35 = sum of lines 31 and 32				umns 1-3, line		102. 00 102. 01

	inancial Systems OCATION - GENERAL SERVICE COSTS	HARRI SON COUN	Provi der CCN		riod: om 01/01/2022	u of Form CMS-2 Worksheet B Part I Date/Time Pre	pared:
				CAPITAL REL	ATED COSTS	5/26/2023 5:2	
	Cost Center Description	Net Expenses	NEW BLDG &	МОВ	AMB DEPR	NEW MVBLE	
	Cost center bescription	for Cost Allocation (from Wkst A col. 7)	FIXT	WOB	AWD DEFR	EQUI P	
		0	1.00	1.01	1.02	2.00	
	ENERAL SERVICE COST CENTERS D100 NEW CAP REL COSTS-BLDG & FIXT	1, 732, 155	1, 732, 155		I		1.00
1.01 00	О101 МОВ	628, 857	0	628, 857			1.00
	D102 AMB DEPR	57,611	0	0	57, 611	1 020 200	1.02 2.00
	D200 NEW CAP REL COSTS-MVBLE EQUIP D201 AMB EQUIP	1, 020, 209 325, 544				1, 020, 209 0	2.00
4.00 00	D400 EMPLOYEE BENEFITS DEPARTMENT	1, 368, 436	2, 770	0	0	1, 632	4.00
	D590 ADMI NI STRATI VE & GENERAL D570 ADMI TTI NG	6, 194, 827 755, 658	278, 569 0	3, 597 0	0	164, 072 0	5.01 5.02
	D580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 215, 794	0	0	0	0	5.02
	0700 OPERATION OF PLANT	1, 820, 000	151, 273	0	0	89, 097	7.00
	D800 LAUNDRY & LINEN SERVICE D900 HOUSEKEEPING	274, 936	12,688	0	0	7,473	8.00
	1000 DI ETARY	836, 600 457, 656	27, 177 79, 079	0	0	16, 007 46, 576	9.00 10.00
	1100 CAFETERI A	456, 616	39, 505	0	0	23, 268	
	1300 NURSING ADMINISTRATION	1, 031, 292	6, 649	0	0	3, 916	
	1400 CENTRAL SERVICES & SUPPLY 1600 MEDICAL RECORDS & LIBRARY	829, 712 878, 569	0 44, 117	0 0	0	0 25, 984	14.00 16.00
	1700 SOCIAL SERVICE	470, 235	2, 660	0	0	25, 984	
IN	NPATIENT ROUTINE SERVICE COST CENTERS	· · ·		-			
	3000 ADULTS & PEDIATRICS	5, 127, 948	300, 357	0	0	176, 906	30.00
	3100 I NTENSI VE CARE UNI T 4300 NURSERY	680, 967 157, 101	40, 128 8, 311	0	0 0	23, 635 4, 895	31.00 43.00
	NCI LLARY SERVI CE COST CENTERS						101.00
	5000 OPERATING ROOM	1, 660, 462	245, 478	0	0	144, 582	50.00
	5300 ANESTHESI OLOGY 5400 RADI OLOGY-DI AGNOSTI C	16, 139 2, 143, 673	0 128, 612	0	0	0 75, 750	53.00 54.00
	5000 LABORATORY	2, 935, 366	67, 596	0	0	39, 813	60.00
	5500 RESPI RATORY THERAPY	576, 199	14, 710	0	0	8, 664	65.00
	6600 PHYSI CAL THERAPY 5700 OCCUPATI ONAL THERAPY	415, 412 42, 847	49, 769 0	0	0	29, 313 0	66.00 67.00
	5800 SPEECH PATHOLOGY	42, 847 9, 495	0	0	0	0	68.00
	5900 ELECTROCARDI OLOGY	679, 612	25, 265	0	0	14, 881	
	7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	2,000,660	60, 338	0	0	35, 538	
	7200 IMPL. DEV. CHARGED TO PATIENT 7300 DRUGS CHARGED TO PATIENTS	1, 017, 388 2, 467, 384	0 16, 982	0 0	0	0 10, 002	72.00
	7700 ALLOGENEIC HSCT ACQUISITION	2,407,304	10, 902	0	0	10, 002	1
	JTPATIENT SERVICE COST CENTERS						
	9000 CLINIC 9001 SENIOR CARE	38, 211 208, 655	10, 527	0 20, 974	0	6, 200 0	90.00 90.01
	9002 GENERAL SURGERY	365, 215	0	13, 946	0	0	90.01
90.03 09	9003 HARRI SON CRAWFORD HEALTHCARE	605, 454	0	63, 124	0	0	90.03
	POO4 CORYDON MEDICAL ASSOCIATES	394, 536	0	80, 649	0	0	90.04
	9005 ORTHOPEDIC SURGERY – DR KLINE 9006 OBGYN – DR SAUER	460, 813 199, 487	0	96, 576 28, 975	0	0	90.05 90.06
	9007 FIRST CAPITAL MEDICAL GROUP	1, 420, 918	Ö	101, 128	0	0	90.07
	9008 SOUTH HARRISON FAMILY MEDICINE	355, 736	0	44, 884	0	0	90.08
	9009 PALN MANAGEMENT 9010 DERMATOLOGY	-27, 083 186, 680	0	22, 020 24, 185	0	0	90.09 90.10
	9011 KIDS FIRST	1, 110, 489	0	60, 555	0	0	90.10
91.00 09	9100 EMERGENCY	3, 086, 044	101, 380	0	0	59, 711	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	THER REIMBURSABLE COST CENTERS 9500 AMBULANCE SERVICES	3, 429, 916	0	0	57, 611	0	95.00
	D200 OPI OI D TREATMENT PROGRAM	0	Ő	Ő	0		102.00
	PECIAL PURPOSE COST CENTERS	i					
118.00	1300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) DNREIMBURSABLE COST CENTERS	52, 120, 431	1, 713, 940	560, 613	57, 611	1, 009, 481	113. 00 118. 00
190.0019	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11, 289	0	0		190. 00
	9200 PHYSI CLANS' PRI VATE OFFI CES	2, 647, 774	o	0	0		192.00
	7950 MARKETING 7951 PHYSICIAN BILLING	0 602, 324	0 6, 926	0	0		194.00 194.01
194.0107		002, 324	0, 720	68, 244	o		194.01
200.00	Cross Foot Adjustments		1				200.00
201.00	Negative Cost Centers	EF 270 522		0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	55, 370, 529	1, 732, 155	628, 857	57, 611	1, 020, 209	1202. UO

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	HARRI SON COUNT	Provider CCI		Period: From 01/01/2022	u of Form CMS-: Worksheet B Part I	
					To 12/31/2022	Date/Time Pre	pared:
		CAPI TAL				5/26/2023 5:2	1 pm
		RELATED COSTS					
	Cost Center Description	AMB EQUIP	EMPLOYEE	Subtotal	ADMI NI STRATI VE	ADMI TTI NG	
			BENEFITS		& GENERAL		
		2.01	DEPARTMENT 4.00	4A	5. 01	5.02	
	GENERAL SERVICE COST CENTERS	2.01	4.00	47	5.01	5.02	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 MOB						1.01
1.02	00102 AMB DEPR						1.02
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	205 544					2.00
2.01 4.00	00201 AMB EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	325, 544 0	1, 372, 838				2.01 4.00
5.01	00590 ADMI NI STRATI VE & GENERAL	0	87, 724	6, 728, 789	6, 728, 789		5.01
5.02	00570 ADMI TTI NG	0	27, 236	782, 894		891, 195	
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	18, 549	1, 234, 343	3 170, 752	0	5.03
7.00	00700 OPERATION OF PLANT	0	14, 798	2, 075, 168		0	•
8.00	00800 LAUNDRY & LINEN SERVICE	0	1, 707	296, 804		0	8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	23, 699 10, 345	903, 483 593, 656		0	9.00 10.00
11.00	01100 CAFETERI A	0	13, 103	532, 492		0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	35, 518	1, 077, 375		0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	10, 411	840, 123		0	14.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	28, 489	977, 159		0	16.00
17.00	01700 SOCIAL SERVICE	0	17, 589	492, 050	68, 067	0	17.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	198, 818	5, 804, 029	802, 878	43, 938	30.00
30.00	03100 I NTENSI VE CARE UNI T	0	24, 118	768, 848		43, 938 4, 304	31.00
43.00	04300 NURSERY	0	7, 202	177, 509		6, 969	•
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	48, 840	2, 099, 362		68, 281	50.00
53.00	05300 ANESTHESI OLOGY	0		16, 139		12, 443	•
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	52, 584 44, 843	2, 400, 619 3, 087, 618		193, 690 135, 326	•
65.00	06500 RESPI RATORY THERAPY	0	0	599, 573		14, 377	
66.00	06600 PHYSI CAL THERAPY	0	15, 909	510, 403		16, 301	
67.00	06700 OCCUPATI ONAL THERAPY	0	1, 641	44, 488		1, 722	67.00
68.00	06800 SPEECH PATHOLOGY	0	364	9,859		922	•
69.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	22, 802 0	742, 560 2, 096, 536		54, 793 21, 115	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1, 017, 388		15, 275	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	16, 337	2, 510, 705		41, 387	73.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	(	0 0	0	77.00
~~ ~~	OUTPATIENT SERVICE COST CENTERS		4 554				
90. 00 90. 01	09000 CLINIC 09001 SENIOR CARE	0	1, 551 4, 065	56, 489 233, 694		729 1, 744	•
	09002 GENERAL SURGERY	0	39, 279	418, 440		987	
90.03	09003 HARRI SON CRAWFORD HEALTHCARE	0	29,074	697, 652		4, 552	•
90.04	09004 CORYDON MEDICAL ASSOCIATES	0	26, 196	501, 381	69, 358	4, 233	
90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	0	55, 906	613, 295		4, 895	
90.06	09006 OBGYN - DR SAUER	0	23, 218	251, 680		1, 465	•
90. 07 90. 08	09007 FIRST CAPITAL MEDICAL GROUP 09008 SOUTH HARRISON FAMILY MEDICINE	0	56, 286	1, 578, 332 420, 098		9, 526 3, 348	•
90.08 90.09	09009 PALN MANAGEMENT	0	19, 478 7, 197	420, 098 2, 134		563	1
90.10	09010 DERMATOLOGY	0	22, 229	233, 094		3, 522	
90.11	09011 KIDS FIRST	0	58, 241	1, 229, 285		10, 464	1
91.00	09100 EMERGENCY	0	104, 652	3, 351, 787		163, 089	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			(			92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	325, 544	107, 089	3, 920, 160	542, 291	51 235	95.00
	10200 OPI OI D TREATMENT PROGRAM	0	0	3, 720, 100			102.00
	SPECIAL PURPOSE COST CENTERS				· · · · ·		
	11300 INTEREST EXPENSE						113.00
118.00		325, 544	1, 277, 087	51, 927, 493	6, 252, 501	891, 195	118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	17, 938	3 2, 481	0	190.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFICES	0	77, 934	2, 725, 708			190.00
	07950 MARKETI NG	0	0	_,0, , 00	0		194.00
194.01	07951 PHYSI CLAN BILLING	0	17, 817	631, 146		0	194. 01
	07952 MOB	0	0	68, 244		0	194. 02
200.00				(		-	200.00
201.00 202.00		0 325, 544	0 1, 372, 838	( 55, 370, 529	, v	0 891, 195	201.00
202.00		525, 544	1, 572, 030	55, 570, 525	0, 120, 109	071, 170	1202.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	HARRI SON COUNTY	Provider C		eriod:	u of Form CMS-2 Worksheet B	2552-10
				FI Te	rom 01/01/2022 o 12/31/2022	Part I Date/Time Pre	pared:
	Cost Center Description	CASHI ERI NG/ACC OUNTS RECEI VABLE	DPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	5/26/2023 5: 2 DI ETARY	
		5.03	7.00	8.00	9.00	10.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01 1. 02 2. 00 2. 01 4. 00	00101 MOB 00102 AMB DEPR 00200 NEW CAP REL COSTS-MVBLE EQUI P 00201 AMB EQUI P 00201 AMB EQUI P 00400 EMPLOYEE BENEFI TS DEPARTMENT						1. 01 1. 02 2. 00 2. 01 4. 00
5.01 5.02 5.03 7.00 8.00	00590 ADMI NI STRATI VE & GENERAL 00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE	1, 405, 095 0 0	2, 362, 234 23, 064				5. 01 5. 02 5. 03 7. 00 8. 00
9.00	00900 HOUSEKEEPI NG	0	49, 400		1, 077, 865		9.00
10.00	01000 DI ETARY	0	143, 745			891, 706	10.00
11.00		0	71, 809		33, 803	0	11.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	0	12, 086 0		5, 689 0	0	13.00
	01600 MEDICAL RECORDS & LIBRARY	0	80, 194		37, 750	0	16.00
	01700 SOCIAL SERVICE	0	4, 834		2, 276	0	17.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	69, 274	545, 973			665, 957	30.00
31.00	03100 I NTENSI VE CARE UNI T	6, 786	72, 942		34, 336	71, 266	31.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	10, 987	15, 107	0	7, 111	154, 483	43.00
50.00	05000 OPERATI NG ROOM	107, 653	446, 216	29, 072	210, 047	0	50.00
53.00	05300 ANESTHESI OLOGY	19, 618	0		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	305, 395	233, 784	48, 781	110, 049	0	54.00
60.00	06000 LABORATORY	213, 357	122, 872	0	57, 839	0	60.00
65.00	06500 RESPI RATORY THERAPY	22, 667	26, 740		12, 587	0	65.00
66.00	06600 PHYSI CAL THERAPY	25, 701	90, 467		42, 586	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	2,716	0		0	0	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	1, 454 86, 387	0 45, 926	0 9, 048	0 21, 619	0	68.00 69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	33, 291	109, 678		51, 629	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	24, 083	0		01,027	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	65, 251	30, 869	0	14, 531	0	73.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS	1		1			
90.00		1, 149	19, 136			0	90.00
90. 01 90. 02	09001 SENI OR CARE 09002 GENERAL SURGERY	2, 750 1, 556	0	24 420	0	0	90.01 90.02
	09003 HARRI SON CRAWFORD HEALTHCARE	7, 177	0		0	0	90.02
	09004 CORYDON MEDICAL ASSOCIATES	6, 673	0	152	-	0	•
90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	7, 718	0	47		0	90.05
90.06	09006 OBGYN - DR SAUER	2, 310	0	897	0	0	90.06
90.07	09007 FIRST CAPITAL MEDICAL GROUP	15, 019	0	738	0	0	90.07
90.08	09008 SOUTH HARRISON FAMILY MEDICINE	5, 278	0	181	0	0	90.08
90. 09 90. 10	09009 PALN MANAGEMENT 09010 DERMATOLOGY	888 5, 552	0	1, 339 1, 955	0	0	90.09 90.10
	09011 KIDS FIRST	16, 498	0	1, 955	0	0	90.10
91.00	09100 EMERGENCY	257, 129	184, 282	, s	86, 747	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	80, 778	0			0	
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113.00
112 00		1, 405, 095	2, 329, 124	359, 714	1, 062, 279	891, 706	
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS				0.440	0	190.00
118.00 190.00	NONREIMBURSABLE COST CENTERS	0	20, 521	0	9, 660		
118.00 190.00 192.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	20, 521 0	0 1, 212	9, 880	0	192.00
118.00 190.00 192.00 194.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 MARKETI NG	0 0 0	0	1, 212 0	0 0	0 0	192. 00 194. 00
118.00 190.00 192.00 194.00 194.01	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 MARKETI NG 07951 PHYSI CI AN BILLI NG	0 0 0 0	20, 521 0 0 12, 589	1, 212 0	9, 880 0 5, 926	0 0 0	192. 00 194. 00 194. 01
118.00 190.00 192.00 194.00 194.01 194.02	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 MARKETI NG 07951 PHYSI CI AN BILLI NG 07952 MOB	0 0 0 0	0	1, 212 0	0 0	0 0 0 0	192. 00 194. 00 194. 01 194. 02
118.00 190.00 192.00 194.00 194.01	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 MARKETING 07951 PHYSICIAN BILLING 07952 MOB Cross Foot Adjustments	000000000000000000000000000000000000000	0	1, 212 0	0 0	0 0 0	192. 00 194. 00 194. 01

Heal th	Financial Systems	HARRI SON COUN	NTY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2022	Worksheet B Part I	
					To 12/31/2022	Date/Time Pre	pared:
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	MEDI CAL	5/26/2023 5: 2 SOCI AL SERVI CE	
	bost benter bescription	OALETERIA	ADMI NI STRATI ON	SERVICES &	RECORDS &	SOUTHE SERVICE	
		11.00	10.00	SUPPLY	LIBRARY	47.00	
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	16.00	17.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 MOB						1.01
1.02	00102 AMB DEPR						1.02
2.00 2.01	00200 NEW CAP REL COSTS-MVBLE EQUIP 00201 AMB EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590 ADMI NI STRATI VE & GENERAL						5.01
5.02	00570 ADMI TTI NG						5.02
5.03 7.00	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00700 OPERATI ON OF PLANT						5.03 7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	711, 766					11.00
13.00	01400 CENTRAL SERVICES & SUPPLY	22, 192 13, 097		969, 43	8		13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	31, 998		1, 47			16.00
17.00	01700 SOCIAL SERVICE	8, 694	0	17	7 0	576, 098	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS	4(0.0/4	574 400	10.11	1 (0.001	400.050	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNI T	162, 061 23, 348		19, 11 6, 51		430, 250 46, 042	•
43.00	04300 NURSERY	6, 715		2		40, 042 99, 806	
	ANCILLARY SERVICE COST CENTERS					,	
50.00	05000 OPERATING ROOM	54, 212		33, 00		0	
53.00	05300 ANESTHESI OLOGY	40 503	-	2, 56		0	
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	48, 587 35, 356		22, 11 223, 18		0	
65.00	06500 RESPI RATORY THERAPY	00,000		6, 50		0	65.00
66.00	06600 PHYSI CAL THERAPY	11, 074	0	75	0 23, 114	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	1, 134			0 2, 442	0	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	245 18, 078		3, 68	0 1, 308 5 77, 692	0	68.00 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	18, 078		352, 42		0	•
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	C		179, 24		0	
73.00	07300 DRUGS CHARGED TO PATIENTS	7, 938		2, 93		0	
77.00	07700 ALLOGENEIC HSCT ACQUISITION	C	0		0 0	0	77.00
90.00	OUTPATIENT SERVICE COST CENTERS	1, 201	4, 254	11	6 1, 033	0	90.00
90.01	09001 SENI OR CARE	3, 135		39		0	1
90. 02	09002 GENERAL SURGERY	13, 164		1, 05		0	90.02
90.03	09003 HARRI SON CRAWFORD HEALTHCARE	20, 480		5, 34		0	
	09004 CORYDON MEDICAL ASSOCIATES 09005 ORTHOPEDIC SURGERY - DR KLINE	15, 276 22, 014		3, 52 5, 31		0	
90. 05 90. 06	09006 OBGYN - DR SAUER	7, 516		6, 25		0	
90.07	09007 FIRST CAPITAL MEDICAL GROUP	39, 492		9, 60		0	•
90.08	09008 SOUTH HARRISON FAMILY MEDICINE	13, 764		4, 61		0	90.08
90.09	09009 PALN MANAGEMENT	1,001		24		0	
90. 10 90. 11	09010 DERMATOLOGY 09011 KIDS FIRST	8, 450 C		1, 74 23, 90		0	90.10
91.00	09100 EMERGENCY	88, 723	-	30, 24		0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	,-=-				_	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	C		23, 36			95.00
102.00	10200 OPI OI D TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	C	0 0		0 0	0	102.00
113.00	11300 I NTEREST EXPENSE						113.00
118.00		678, 945	1, 266, 380	969, 43	8 1, 263, 746	576, 098	
	NONREI MBURSABLE COST CENTERS		<b></b> _				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	10.051	-		0 0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES 07950 MARKETI NG	10, 851					192.00 194.00
	07951 PHYSI CI AN BILLI NG	21, 970	o o		o o		194.00
194.02	07952 MOB	C			0 0	0	194.02
200.00							200.00
201.00 202.00		C 711, 766	0 1, 266, 380	969, 43	0 0 8 1, 263, 746		201.00
202.00		/11,/00	η i, 200, 300	707,43	i, 203, 740	J 570, 090	1202. UU

Heal th	Financial Systems	HARRI SON COUN	ITY HOSPITAL		In Lie	u of Form CMS-25	552-10
	LLOCATION - GENERAL SERVICE COSTS		Provider CO	CN: 15-1331	Peri od:	Worksheet B	
					From 01/01/2022 To 12/31/2022	Part I Date/Time Prepa	ared:
	Cast Contor Description	Subtotal	Intern &	Total		5/26/2023 5:21	pm
	Cost Center Description	Subtotal	Residents Cost	Total			
			& Post				
			Stepdown Adjustments				
		24.00	25.00	26.00			
4 00	GENERAL SERVICE COST CENTERS	[	1	[			4 00
1.00 1.01	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 MOB						1.00 1.01
1.02	00102 AMB DEPR						1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01							2.01
4.00 5.01	00400 EMPLOYEE BENEFI TS DEPARTMENT 00590 ADMI NI STRATI VE & GENERAL						4.00 5.01
5.02	00570 ADMI TTI NG						5.02
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.03
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8.00 9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00 16.00	01400 CENTRAL SERVICES & SUPPLY 01600 MEDICAL RECORDS & LIBRARY						14.00 16.00
	01700 SOCIAL SERVICE						17.00
	INPATIENT ROUTINE SERVICE COST CENTERS		1	1			
30.00	03000 ADULTS & PEDIATRICS	9, 513, 274					30.00
31.00 43.00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	1, 296, 407 536, 934					31.00 43.00
40.00	ANCI LLARY SERVI CE COST CENTERS	000,704	10		54		43.00
50.00	05000 OPERATI NG ROOM	3, 627, 133		3, 627, 1			50.00
53.00	05300 ANESTHESI OLOGY	70, 643		70, 6			53.00
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	3, 969, 836 4, 494, 561		3, 969, 8 4, 494, 5			54.00 60.00
65.00	06500 RESPI RATORY THERAPY	785, 775		785, 7			65.00
66.00	06600 PHYSI CAL THERAPY	791, 002		791, 0			66.00
67.00	06700 OCCUPATI ONAL THERAPY	58,656		58, 6			67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	15, 152 1, 226, 553		15, 1 1, 226, 5			68.00 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 984, 634		2, 984, 6			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1, 398, 389		1, 398, 3	89		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 079, 616		3, 079, 6			73.00
77.00	07700 ALLOGENEI C HSCT ACQUI SI TI ON OUTPATI ENT SERVI CE COST CENTERS	C	0	<u> </u>	0		77.00
90.00	09000 CLINIC	100, 929	0	100, 9	29		90.00
	09001 SENI OR CARE	287,655					90. 01
	09002 GENERAL SURGERY	494, 902					90.02
90. 03 90. 04	09003 HARRI SON CRAWFORD HEALTHCARE 09004 CORYDON MEDI CAL ASSOCI ATES	838, 173 606, 597		838, 1 606, 5			90. 03 90. 04
90. 04 90. 05	09005 ORTHOPEDIC SURGERY - DR KLINE	745,069		745, 0			90.04 90.05
90.06	09006 OBGYN – DR SAUER	307, 012		307, 0			90.06
90.07	09007 FIRST CAPITAL MEDICAL GROUP	1, 884, 554		1, 884, 5			90.07
90. 08 90. 09	09008 SOUTH HARRISON FAMILY MEDICINE 09009 PAIN MANAGEMENT	510, 146 7, 268		510, 1 7, 2			90. 08 90. 09
90.09 90.10	09010 DERMATOLOGY	291, 553		291, 5			90.09 90.10
90.11	09011 KIDS FIRST	1, 465, 042		1, 465, 0			90.11
91.00	09100 EMERGENCY	5, 271, 408		5, 271, 4	08		91.00
92.00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REIMBURSABLE COST CENTERS		0				92.00
95.00	09500 AMBULANCE SERVICES	4, 709, 603	0	4, 709, 6	03		95.00
	10200 OPI OI D TREATMENT PROGRAM	C			0		02.00
440 -	SPECIAL PURPOSE COST CENTERS		1				40.07
113.00 118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	51 240 174	0	51 240 A	76		13.00 18.00
118.00	NONREIMBURSABLE COST CENTERS	51, 368, 476	<u>1</u> 0	51, 368, 4	70	I	10.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	50, 600	0	50, 6	00	11	90.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	3, 114, 829		3, 114, 8		10	92.00
	07950 MARKETING		0	750.0	0		94.00
	07951 PHYSICIAN BILLING 07952 MOB	758, 940 77, 684		758, 9 77, 6			94. 01 94. 02
200.00		77, 084 C		,,,,,	0		200.00
201.00	Negative Cost Centers	C	0		0	20	201.00
202.00	TOTAL (sum lines 118 through 201)	55, 370, 529	0	55, 370, 5	29	20	202.00

Heal th	n Financial Systems ATION OF CAPITAL RELATED COSTS	HARRISON COUNT	Provider CCN	I: 15-1331 Pe	riod: om 01/01/2022	<u>of Form CMS-:</u> Worksheet B Part II	2552-10
				То		Date/Time Pre 5/26/2023 5:2	
				CAPITAL REL	ATED COSTS		
	Cost Center Description	Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	MOB	AMB DEPR	NEW MVBLE EQUIP	
	GENERAL SERVICE COST CENTERS	0	1.00	1.01	1.02	2.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 1.02 2.00 2.01 4.00 5.01 5.02	00101 MOB 00102 AMB DEPR 00200 NEW CAP REL COSTS-MVBLE EQUIP 00201 AMB EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00590 ADMINISTRATIVE & GENERAL 00570 ADMITING	0 0	2, 770 278, 569 0	0 3, 597 0	0	1, 632 164, 072 0	5. 01
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	0	0	0	
7.00	00700 OPERATION OF PLANT	0	151, 273	0	0	89, 097	
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	12, 688 27, 177	0	0	7, 473 16, 007	
10.00	01000 DI ETARY	0	79, 079	0	0	46, 576	10.00
11.00 13.00		0	39, 505 6, 649	0	0	23, 268 3, 916	
13.00		0	0, 049	0	0	3, 910	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	44, 117	0	0	25, 984	16.00
17.00	01700 SOCIAL SERVICE	0	2, 660	0	0	1, 566	17.00
30.00		0	300, 357	0	0	176, 906	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	40, 128	0	О	23, 635	31.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	8, 311	0	0	4, 895	43.00
50.00		0	245, 478	0	0	144, 582	50.00
53.00		0	0	0	О	0	53.00
54.00		0	128, 612	0	0	75, 750 39, 813	
60.00 65.00		0	67, 596 14, 710	0	0	39, 813 8, 664	
66.00		0	49, 769	Ö	Ő	29, 313	
67.00		0	0	0	0	0	
68.00 69.00		0	0 25, 265	0	0	0 14, 881	
71.00		0	60, 338	0	0	35, 538	
72.00		0	0	0	0	0	
73.00 77.00		0	16, 982 0	0	0	10, 002 0	
77.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>	0	U	0	//.00
90.00	09000 CLI NI C	0	10, 527	0	0	6, 200	
	09001 SENI OR CARE	0	0	20, 974	0	0	
90. 02 90. 03		0	0	13, 946 63, 124	0	0	
90.04		0	o	80, 649	Ő	0	
90.05		0	0	96, 576	0	0	
90. 06 90. 07		0	0	28, 975 101, 128	0	0	
90.08		0	o	44, 884	Ő	0	90.08
90.09		0	0	22, 020	0	0	
90. 10 90. 11		0	0	24, 185 60, 555	0	0	
91.00		0	101, 380	00, 333	0	59, 711	
92.00							92.00
95.00	OTHER REI MBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES	0	0	0	57, 611	0	95.00
	0 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0		102.00
	SPECIAL PURPOSE COST CENTERS						
113.00 118.00	0 11300 INTEREST EXPENSE 0 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	1, 713, 940	560, 613	57, 611	1, 009, 481	113.00 118.00
	019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11, 289	0	0	6, 649	190. 00
	0 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.00			0	0	0	0	194.00
192.00 194.00	0 07950 MARKETI NG	0	6 926	0	n		
192.00 194.00 194.01		0	6, 926 0	0 68, 244	0	4, 079	194. 01 194. 02
192.00 194.01 194.01 194.02 200.00	0 07950 MARKETING 1 07951 PHYSICIAN BILLING 2 07952 MOB 0 Cross Foot Adjustments	0	6, 926 0	0 68, 244	0 0	4, 079 0	194. 01 194. 02 200. 00
192.00 194.00 194.01 194.02	0 07950 MARKETING 1 07951 PHYSICIAN BILLING 2 07952 MOB 0 Cross Foot Adjustments 0 Negative Cost Centers	0	6, 926 0 1, 732, 155	0 68, 244 0 628, 857	0 0 57, 611	4, 079 0	194. 01 194. 02 200. 00 201. 00

	Financial Systems TION OF CAPITAL RELATED COSTS	HARRI SON COUNT	Y HOSPIIAL Provider CC	N: 15-1331 F	Period:	u of Form CMS-2 Worksheet B	2552-10
				F	rom 01/01/2022 o 12/31/2022	Part II Date/Time Pre	pared:
		CAPI TAL				5/26/2023 5: 2	1 pm
	Cost Center Description	RELATED COSTS AMB EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMI NI STRATI VE & GENERAL	ADMI TTI NG	
		2.01	2A	4.00	5. 01	5.02	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.00	00101 MOB						1.00
1.02	00102 AMB DEPR						1. 02
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 4.00	00201 AMB EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0	4, 402	4, 402			2.01 4.00
4.00 5.01	00590 ADMINI STRATI VE & GENERAL	0	446, 238	4, 402			5.01
5.02	00570 ADMI TTI NG	0	0	87		7, 274	5.02
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	59		0	
7.00	00700 OPERATION OF PLANT	0	240, 370	47		0	7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	20, 161 43, 184	5 76		0	8.00 9.00
10.00	01000 DI ETARY	0	125, 655	33		0	10.00
11.00	01100 CAFETERI A	0	62, 773	42		0	11.00
	01300 NURSI NG ADMI NI STRATI ON	0	10, 565	114		0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	33		0	14.00
	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	0	70, 101 4, 226	91 56		0	16.00 17.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	4, 220	50	4, 517	0	17.00
30.00	03000 ADULTS & PEDI ATRI CS	0	477, 263	645	53, 271	360	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	63, 763	77		35	
43.00		0	13, 206	23	3 1, 630	57	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	0	390, 060	157	19, 272	559	50.00
53.00	05300 ANESTHESI OLOGY	0	0,000	(0)		102	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	204, 362	168		1, 563	
60.00	06000 LABORATORY	0	107, 409	144		1, 108	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	23, 374 79, 082	( 51		118 133	
67.00	06700 OCCUPATIONAL THERAPY	0	19,082	51		133	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	1		8	68.00
69.00	06900 ELECTROCARDI OLOGY	0	40, 146	73		449	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	95, 876	(		173	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0 26, 984	( 52		125 339	72.00
	07700 ALLOGENEIC HSCT ACQUISITION	0	20, 704	(		0	77.00
	OUTPATIENT SERVICE COST CENTERS						
		0	16, 727	5		6	90.00
	09001 SENI OR CARE 09002 GENERAL SURGERY	0	20, 974 13, 946	13 126		14	
	09003 HARRI SON CRAWFORD HEALTHCARE	0	63, 124	93		37	
	09004 CORYDON MEDICAL ASSOCIATES	0	80, 649	84		35	
90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	0	96, 576	179		40	
	09006 OBGYN - DR SAUER 09007 FIRST CAPITAL MEDICAL GROUP	0	28, 975 101, 128	74 180		12	90.06 90.07
90. 07 90. 08	09008 SOUTH HARRISON FAMILY MEDICINE	0	44, 884	62		78 27	90.07
	09009 PALN MANAGEMENT	0	22, 020	23		5	90.09
90.10	09010 DERMATOLOGY	0	24, 185	71	2, 140	29	90.10
	09011 KIDS FIRST	0	60, 555	187		86	90.11
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	161, 091 0	335	30, 769	1, 335	91.00 92.00
92.00	OTHER REIMBURSABLE COST CENTERS		U.		1		92.00
95.00	09500 AMBULANCE SERVICES	325, 544	383, 155	343	3 35, 987	419	95.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0		0 0	0	102.00
112 00	SPECIAL PURPOSE COST CENTERS				1		112 00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	325, 544	3, 667, 189	4, 095	414, 912		113.00 118.00
110.00	NONREI MBURSABLE COST CENTERS	020,011	0,007,107	1,070		7,271	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17, 938	(			190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	250	25, 022		192.00
192.00			0	(	ן 0	0	194.00
192.00 194.00	07950 MARKETI NG	0	11 005	C -	7 5 704	<u>_</u>	10/ 01
192.00 194.00 194.01	07950 MARKETING 07951 PHYSICIAN BILLING	0	11, 005 68, 244	57			194. 01 194. 02
192.00 194.00 194.01	07950 MARKETING 07951 PHYSICIAN BILLING 07952 MOB	0	11, 005 68, 244 0	57	7 5, 794 0 626	0	194. 01 194. 02 200. 00
192.00 194.00 194.01 194.02	07950 MARKETING 07951 PHYSICIAN BILLING 07952 MOB Cross Foot Adjustments Negative Cost Centers	0 0 0 325, 544		57 ( 4, 402	0 626 0 0	0 0	194. 02

From         10.7012/2022         Pert 11		Financial Systems	HARRI SON COUNT				u of Form CMS-	2552-10
Cost Center Description         ZASH EPH NARC OFENATION OF PLANT         LANNEY K         HUBBEREFIN         DIFERSY DIFERSY           1.00         DOTOTING OF ILLING STRUCT         5.03         7.00         6.00         9.00         10.00           1.01         DOTOTING OF ILLIONIS TRUCT         5.03         7.00         6.00         9.00         10.00           1.01         DOTOTING OF ILLIONIS TRUCT         5.03         7.00         6.00         9.00         10.00           1.01         DOTOTING OF ILLIONIS TRUCT         5.03         7.00         10.00         10.00         10.00           1.01         DOTOTING OF ILLIONIS TRUCT         0.00         1.00         0.00         10.00	ALLOCA	ITON OF CAPITAL RELATED COSTS		Provider C			Worksheet B Part II	
Loss Center Bescription         DABIE IN KC/ACC OPE NATION OF RCOT Male         LABBER # 100         HEADE KIVE KIVE KIVE KIVE KIVE KIVE KIVE KIV							Date/Time Pre	pared:
OUNTS BYOLINABLE         PLANT         LINEN SERVICE           OUNTS BYOLINABLE         5.04         7.00         8.00         9.00         10.00           1.01         COUNTS BYOLINABLE         5.03         7.00         8.00         9.00         10.00           1.01         COUNTS BYOLINABLE         5.03         7.00         8.00         9.00         10.00           1.01         COUNTS BYOLINABLE         5.03         COUNTS BYOLINABLE         S.037         T.03         0.		Cost Center Description	CASHI ERI NG/ACC	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		
Soal         7,00         8,00         9,00         10,00           1.00         00100 [H2 ACP HEL COSTS-HELD & FIXT			OUNTS	PLANT				
Determining         Determining         Determining           1.00         000001 MB         CANTER         0.01           1.01         00001 MB         CANTER         0.01           2.00         000001 MB         CANTER         0.01           2.01         000001 MB         CANTER         0.01           2.01         000001 MB         CANTER         0.01           2.01         000001 MB         CANTER         0.01           0.01         000001 MB         CANTER         0.01           0.000001 MB         CANTER         CANTER         0.01           0.000001 MB         CANTER         CANTER         0.01           0.000001 MDS         CANTER         0.01         0.00           0.000001 MDS         CANTER         0.01         0.00           0.000001 MDS         CANTER         1.00         0.00         0.00           0.000001 MDS         CANTER         S.577         150.622         0.00           1.000         0.00001 MDS         S.426         0.00001         0.00001           0.010000         CANTER         S.4261         0.5.371         150.622           1.000         0.0000         0.0000         0.0000 <th></th> <th></th> <th></th> <th>7.00</th> <th>8.00</th> <th>0.00</th> <th>10.00</th> <th></th>				7.00	8.00	0.00	10.00	
1.00         ODION LEW CAP REL COSTS-BUDG & FLXT           1.01         ODION LEW CAP REL COSTS-MPLE EQUIP           1.02         ODION LEW CAP REL COSTS-MPLE EQUIP           1.03         ODION LEW CAP REL COSTS-MPLE EQUIP           1.04         ODION LEW CAP REL COSTS-MPLE EQUIP           1.05         ODIONO LEW CAP REL EN LANCE           1.06         ODIONO LEW ENT NOT           1.00         DIONO LEW ENT NOT NOT NOT           1.00         DIONO LEW ENT NOT NOT NOT NOT NOT NOT NOT NOT NOT N		GENERAL SERVICE COST CENTERS	5.05	7.00	0.00	9.00	10.00	
1.42 00102 AUB DERR 2.01 00207 AUB DERR 2.01 00207 AUB EDUT P 2.01								1.00
2.00 00200 NPN CAP PRI COSTS-WINE FOULP 4.00 00200 ENFLOYCE BENEFITS CEPARATENT 5.02 00270 ADM ITING 5.02 00270 ADM ITING 5.02 00270 ADM ITING 5.02 00270 ADM ITING 5.00 00200 CANDERS EVENTS 5.00 00200 CANTERS FOR UNCE 5.00								1.01
2.01 00001 ABB FOUP P 5.01 00000 APB VTFF BRFETTS 0 FPARTMENT 5.01 00000 APB VTFF BRFETTS 0 FPARTMENT 7.00 00000 APB VTFFF BRFETTS 0 FPARTMENT 7.00 00000 APB VTFFFF APB VTFFFF APB VTFFFF 7.00 0 APB VTFFFF APB VTFFFF APB VTFFFF 7.00 0 APB VTFFFF APB VTFFFF APB VTFFFF 7.00 0 APB VTFFFF APB VTFFFFF APB VTFFFFFFFFFFFFFFFFFFFFFFFFFFFFFFFFFFFF								1.02
4.00 00400 EXPLOYEE BENEFITS DEPARTMENT 5.02 00570 ADMITTIN C 5.02 00570 ADMITTIN C 5.02 00570 ADMITTIN C 5.02 00570 ADMITTIN C 5.00 00570 ADMITTIN STATION 5.00 00570 ADMITTIN STATION 5.00 00570 ADMITTIN C 5.00 00500 ADMI								2.00
5.01         00550 AMM INTERTIVE & GENERAL         11, 300           5.03         00550 AMM ITTIS         11, 300           5.03         00560 CASHI FRINCA ACCOUNTS BFC1 VABLE         11, 300           5.03         00560 CASHI FRINCA ACCOUNTS BFC1 VABLE         11, 300           5.03         00560 CASHI FRINCA ACCOUNTS BFC1 VABLE         11, 300           5.03         00560 CASHI FRINCA ACCOUNTS BFC1 VABLE         11, 300           5.03         00560 CASHI FRINCA ACCOUNTS BFC1 VABLE         11, 300           5.03         001000 LAUNDAY AL INFN SCAPUCE         0         2, 531           5.01         011000 CAFETENIA         0         7, 888         3, 77           5.01         011000 CAFETENIA         0         8, 808         0         1, 790           10.00         010000 INTERSING ADMINISTRATION         0         8, 808         0         1, 990           11.00         01400 CENTRAL SERVICE COST CENTFES         5, 513         0         120         0         0           11.00         01400 CENTRAL SERVICE COST CENTERS         5, 518         11, 164         0         1, 158         11, 2, 650           10.00         01400 MINTERSIV         550         5, 60, 77         3, 436         0         0         0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>4.00</td>								4.00
5.02         00507 (AMM TTING         11.300         1           7.00         00700 (DEPARTING OF PLANT         0         259,467         56,980           7.00         00700 (DEPARTING OF PLANT         0         2,533         25,424         56,980           9.00         00700 (DEPARTING OF PLANT         0         5,77         150,822         56,980           9.00         00700 (DEPARTING         0         1,37         0         56,980         56,980           13.00         01300 (NURSI & ADM IN STRATION         0         1,37         0         0         0         0         0           10.00         014000 (NURSI & ADM IN STRATION         0         1,37         0         1,307         0         0         0           10.00         014000 (SCILLA SERVICE CaS & SUPPLY         0         8,808         0         1,990         0           10.01         01300 SILTS & PEDIATRICS         5563         59,970         5,381         13,586         112,639           31.00         03000 INFLSI INE SILTS & PEDIATRICS         5633         1,657         3,436         5,818         0           0.00         00000 SECILLA SERVICE COST CENTERS         89         0         0         0         0								5.01
7.00         00/0000         00/00000         00/00000         00/00000         00/00000         00/000000         <	5.02							5. 02
8.00         00000         LANIDRY & LINEN SERVICE         0         2, 033         25, 244           0.00         00000         0055KCEP1 MOUSENCEP1 MO								5.03
9.00         00000 HOUSEKEEPING         0         5.426         0         6.980           11.00         011000 CAFETRIA         0         7.888         0         1.787         0           11.00         011000 CAFETRIA         0         7.888         0         1.787         0           11.00         01400 CAFETRIA         0         7.888         0         1.787         0           11.00         01400 CAFETRIA         CRORES & LIBRARY         0         8.808         0         1.996         0           11.00         01400 CANTRAL SERVICES & SUPPLY         0         8.801         1.996         0         0         0           10.00         03100 INTERSIVE CARE UNITS         5.53         8.012         4.709         1.815         112.654           10.00         03500 MRESTRES IOLOCY         155         0			0					7.00
10. 00         01000         DIETARY         0         15,789         318         3,577         150,822           13. 00         01300         NURSIN ADMINISTRATION         0         1,327         0         301         0           14. 00         01400         DIADO, CENTRAL, SERVICE SA, SUPPLY         0         0         0         0         0         0         0           16. 00         DIADO, MERSINA, RECORDS & LIBRARY         0         8,805         0         1,202         0			0					8.00 9.00
11.00       01100       CARETERIA       0       7, 888       0       1, 787       0         13.00       01300       UNESING ADMINISTRATION       0       1, 287       0       301       0       0000       0			0				150, 822	
14.00       0       0       0       0       0       0       0         16.00       01700       SCI.AL.SERVICES & LIBRARY       0       8.00B       0       1.996       0         17.00       01700       SCI.AL.SERVICE       0       5.31       0       1.20       0         18.00       10.00       3000       ADULTS & FEDUATRICS       5.63       59,970       5.381       1.3.586       1.12.639         10.00       03000       JUNESNIK CASE LONG TENTES       89       1.659       0       3.76       26.129         AMACILLARY SERVICE COST CENTERS       50.00       5000       0			0					1
16. 00         01600 [NED1CAL, RECORDS & LI BRARY         0         8,808         0         1,996         0           INPATE ENT ROUTINE SERVICE COST CENTERS         5         531         0         120         0           0.00         03000 [NITESN VE CARE UNIT         55         53,81         13,566         112,639           31. 00         03100 [NITESN VE CARE UNIT         55         53,81         13,566         112,639           ANCILLARY SERVICE COST CENTERS			0	1, 327			0	
17.00         0         1200         0         1200         0           INPATE RET NOUTINE SERVICE COST CENTERS         563         59,970         5,381         13,586         112,639           10.00         03000 ADULTS & PEDIATRICS         563         59,970         5,381         13,586         112,639           10.00         03000 INTESSIVE CADE UNIT         555         8,012         4.709         1,815         12,200           ARCILLARY SERVICE COST CENTERS         9         1,659         0         376         26,129           ARCILLARY SERVICE COST CENTERS         0         0         0         0         0         0           50.00         05000 OPE-RATING ROOM         874         49,012         2,048         11,104         0           51.00         05000 ARSINE SICIOCY         159         0			0			-		
INPART ENT ROUTI NE SERVICE COST CENTERS         Impact         <			0					
30: 00     03000 ADULTS & PEDIATRICS     563     563     59, 970     5, 381     13, 586     112, 634       43: 00     0300 INTENSIVE CARE UNIT     55     8, 012     4, 709     1, 815     12, 054       43: 00     0300 ONRESERY     89     1, 659     0     376     26, 129       ANCILLARY SERVICE COST CENTERS     874     49, 012     2, 048     11, 104     0       0     05000 OFEARI ING ROOM     1, 733     13, 496     0     0     0       0     05400 RADICLOCY -DI AGNOSTI C     2, 459     25, 679     3, 436     5, 818     0       0.0     06500 RESPI RATORY THERAPY     12, 937     0     665     0     0     0     0     0       0.0     06500 RESPI RATORY THERAPY     229     9, 937     0     2, 251     0     0     0     0       0.0     06700 QCUPATI ONAL THERAPY     12     0     0     0     0     0     0       72. 00     06700 QCUPATI ONAL THERAPY     702     5, 044     637     1, 143     0       73. 00     07300 QT200 URDCA CANEGED TO PATIENTS     7250     1, 2, 447     0     2     0       73. 00     07300 URDCA CANEGED TO PATIENTS     5530     3, 91     0     766 <td>17.00</td> <td></td> <td>0</td> <td>531</td> <td></td> <td>120</td> <td>0</td> <td>17.00</td>	17.00		0	531		120	0	17.00
31.00       03100   INTERSIVE CARE UNIT       55       8,012       4,709       1,815       12,054         A00       04300 (NRSSERY       B9       1,669       0       376       26,129         A00       05300 (ARESTRVICE COST CENTERS       5       0       05000 (Second) (ARESTRVICE COST CENTERS       26,129         A00       04300 (ARESTRVICE COST CENTERS       159       0       0       0       0         05300 (ARESTRVICE COST CENTERS       159       0       0       0       0       0       0         06000 (ARDORNOW THERAPY       1,733       13,496       0       3,058       0 <td>30, 00</td> <td></td> <td>563</td> <td>59, 970</td> <td>5, 381</td> <td>13, 586</td> <td>112, 639</td> <td>30.00</td>	30, 00		563	59, 970	5, 381	13, 586	112, 639	30.00
ANCI LLARY SERVICE COST CENTERS           00         05300 OPERATI NG ROOM         874         49, 012         2, 048         11, 104         0           53. 00         05300 ANESTHESI OLOGY         159         0         0, 0         0         0           64. 00         05400 ANESTHESI OLOGY         1, 733         13, 496         3, 436         3, 058         0           65. 00         06500 CH2BORATORY         11, 733         13, 496         3, 436         3, 058         0           66. 00         06600 CH2BORATORY         12, 937         0         665         0								
50. 00         550.00         550.00         550.00         550.00         550.00         560.00         570.00<	43.00		89	1, 659	C	376	26, 129	43.00
53. 00         05300         NESTHESI 0.0GY         159         0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1 - 0 - 00</td>								1 - 0 - 00
54. 00         05400         RADIOLOGY-DI AGRADTIC         2, 459         25, 679         3, 436         5, 818         0           00         06500         HESPIRATORY THERAPY         1, 733         13, 496         3, 058         0           06.00         06600         PHYSI CAL THERAPY         209         9, 937         0         2, 251         0           06.00         06600         PHYSI CAL THERAPY         209         9, 937         0         2, 251         0           06.00         06000         SPEECH PATHOLOGY         12         0         0         0         0         0           071.00         07100 MEDI CAL, SUPPLIES CHARGED TO PATIENTS         270         12, 047         0, 729         0						-		1
60.00         06000         LABORATORY         1,7.33         13,496         0         3,058         0           65.00         06500         PRSPIR ATORY THERAPY         184         2,937         0         2,251         0           66.00         06600         PRSVI CAL THERAPY         209         9,937         0         2,251         0           66.00         06000         SPECH PATHOLOGY         12         0         0         0         0           67.00         06000         PECCI RACCARDI OLOGY         12         0         0         0         0         0         0           69.00         06000         DEDICAL SUPPLIES CHARGED TO PATIENTS         2700         12,047         0         2,729         0         7         0					-	-		1
65.00         06500         PKSPI RATORY THERAPY         184         2,937         0         665         0           66.00         06600         PMSI CAL THERAPY         209         9,937         0         2,251         0           67.00         06700         OCCUPATI ONAL THERAPY         22         0         0         0         0           68.00         06600         SPEECH PATHOLOCY         12         0         0         0         0         0           71.00         07100         NEDICAL SUPPLIES CHARGED TO PATI ENTS         702         12,047         0         2,729         0           72.00         07200         INPL_DEV. CHARGED TO PATI ENTS         530         3,391         0         768         0           073.00         07300         RUGS CHARGED TO PATI ENTS         530         3,391         0         768         0           0.00         09000         CLLOGENEI CAST CENTERS         9         2,102         0         476         0           0.01         09001         SENI RC CARE         9         2,102         0         2         0         0         0         0         0         0         0         0         0         0								
67.00         06700         00CUPATIONAL THERAPY         22         0         0         0         0           68.00         66000         SPECCH PATHOLOCY         12         0         0         0         0           69.00         66000         ELECTROCARDIOLOGY         12         0         0         0         0         0           69.00         60000         ELECTROCARDIOLOGY         702         5,044         637         1,143         0           71.00         07100         MCDICAL SUPPLIES CHARGED TO PATIENTS         270         12,047         0         2,729         0           73.00         073000         RUGOS CHARGED TO PATIENTS         530         3,391         0         768         0	65.00	06500 RESPI RATORY THERAPY					0	65.00
68:00         06800         SPECCH PATHOLOCY         12         0         0         0         0           69:00         06900         LECTROCARD IOLOCY         702         5,044         637         1,143         0           71:00         0720.01         IMPL. DEV. CHARGED TO PATIENTS         270         12,047         0         2,729         0           72:00         0720.01         IMPL. DEV. CHARGED TO PATIENTS         533         3,391         0         768         0           70:00         OTOO DEUGS CHARGED TO PATIENTS         533         3,391         0         768         0           00         0700         ALLOGENEI C HSCT ACOUISITION         0				9, 937			0	
69:00         06900         ELECTROCARDI OLOGY         702         5,044         637         1,143         0           71:00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         270         12,047         0         2,729         0           72:00         07200         IMPL. DEV. CHARGED TO PATI ENTS         533         3,391         0         768         0           70:00         07000         ALCGENET CHSCT ACOUST TO         0						-	-	67.00
71.00       VOIO       VEDICAL SUPPLIES CHARGED TO PATIENTS       270       12,047       0       2,729       0         72.00       07200       IMPL. DEV. CHARGED TO PATIENT       196       0       0       0       0         73.00       07300       DRUGS CHARGED TO PATIENTS       530       3,391       0       768       0         007300       DRUGS CHARGED TO PATIENTS       530       3,391       0       768       0         007300       DRUGS CHARGED TO PATIENTS       530       3,391       0       768       0         00700       ALLOCENEI C HSCT ACQUISITION       0       0       0       0       0       0         009001       CLINI C       CENTRES       9       2,102       0       476       0         90.01       09002       GENERAL SURGERY       13       0       30       0				0		-		68.00 69.00
72.00         O7200         IMPL         DEV.         CHARGED TO PATIENT         196         0         0         0         0           73.00         07300         DRUGS CHARGED TO PATIENTS         530         3,391         0         768         0           001700         ALLOGENEIC HSCT ACQUISITION         0								
77.00         0700         ALLGGENELC HSCT ACQUISITION         0         0         0         0           0UTPATLENT SERVICE COST CENTERS         0 </td <td></td> <td></td> <td>1</td> <td></td> <td></td> <td></td> <td></td> <td></td>			1					
OUTPATIENT SERVICE COST CENTERS           90.00         09000         CLINIC         9         2,102         0         476         0           90.01         09001         SENIOR CARE         222         0         2         0         0         0           90.02         GENERAL SURCERY         13         0         30         0         0           90.03         Og003         KARRI SON CRAWFORD HEALTHCARE         58         0         0         0         0           90.04         Og004         CONDOS HARRI SON CRAWFORD HEALTHCARE         53         0         0         0         0         0           90.05         ORTHOPEDI C SURGERY - DR KLINE         63         0         3         0         0         0           90.06         Og006         OBGYON - DR SAUER         19         0         63         0         0         0           90.08         SOUTH HARRI SON FAMI LY MEDI CI NE         43         0         13         0         0         0           90.09         PAI N. MANAGEMENT         7         0         94         0         0         0         0         0         0         0         0         0         0         0 <td></td> <td></td> <td></td> <td>3, 391</td> <td></td> <td></td> <td></td> <td></td>				3, 391				
90.00         09000         CLINIC         9         2, 102         0         476         0           90.01         09001         SENIOR CARE         22         0         2         0         0           90.02         09002         GURCARAL SURGERY         13         0         30         0         0           90.01         09003         HARRI SON CRAWFORD HEALTHCARE         58         0         0         0         0           90.05         09005         ORTHOPEDIC SURGERY - DR KLINE         63         0         3         0         0           90.06         09005         ORTHOPEDIC SURGERY - DR KLINE         63         0         3         0         0           90.07         09005         DRTHOPEDIC SURGERY - DR KLINE         63         0         3         0         0           90.08         09008         SOUTH HARI SON FAMILY MEDICINE         43         0         13         0 <td>77.00</td> <td></td> <td>0</td> <td>0</td> <td>C</td> <td>0</td> <td>0</td> <td>77.00</td>	77.00		0	0	C	0	0	77.00
90.01         09001         SENIOR CARE         22         0         2         0         0           90.02         09002         GENRAL SURGERY         13         0         30         0         0           90.02         09003         HARRI SON CRAWFORD HEALTHCARE         58         0         0         0         0           90.04         09004         CORYDON MEDI CAL ASSOCIATES         54         0         11         0         0           90.05         ORTHOPEDI C SURGERY - DR KLINE         63         0         3         0         0           90.06         09006         DBGKPN - DR SAUER         19         0         63         0         0           90.07         FIRST CAPITAL MEDI CAL GROUP         122         0         52         0         0           90.08         SOUTH HARRI SON FAMILY MEDI CI NE         43         0         13         0	00.00		0	2 102		47/	0	
90.02       GENERAL SURGERY       13       0       30       0       0         90.02       GENERAL SURGERY       13       0       30       0       0       0         90.03       HARRI SON CRAWFORD HEALTHCARE       58       0								1
90.03         09003         HARRI SON CRAWFORD HEALTHCARE         58         0				0			-	
90.05         09005         ORTHOPEDIC SURGERY - DR KLINE         63         0         3         0         0           90.05         09005         OBGYN - DR SAUER         19         0         63         0         0           90.05         09007         FIRST CAPITAL MEDICAL GROUP         122         0         52         0         0           90.08         09008         SOUTH HARRISON FAMILY MEDICINE         43         0         13         0         0           90.09         99009         PAIN MANAGEMENT         7         0         94         0         0           90.10         DERMATOLOGY         45         0         138         0         0         0           90.11         09101         DERMATOLOGY         45         0         138         0				0			0	90.03
90.06         09006         0BGYN - DR SAUER         19         0         63         0         0           90.07         09007         FIRST CAPITAL MEDICAL GROUP         122         0         52         0         00           90.08         09008         SOUTH HARRISON FAMILY MEDICINE         43         0         13         0         0           90.09         PAIN MANAGEMENT         7         0         94         0         0           90.10         09010         DERMATOLOGY         45         0         138         0         0           90.11         09110         DERRATOLOGY         2,088         20,242         7,056         4,586         0           91.00         09200         DBSERVATION BEDS (NON-DI STINCT PART)         2,088         20,242         7,056         4,586         0           92.00         09200         OBSERVATION BEDS (NON-DI STINCT PART)         2,088         20,242         7,056         4,586         0			1	0		0	Ŭ	1 /0.01
90.07         09007         FIRST CAPITAL MEDICAL GROUP         122         0         52         0         0           90.08         09008         SOUTH HARRISON FAMILY MEDICINE         43         0         113         0         0           90.09         PAIN MANAGEMENT         7         0         94         0         0           90.10         DERMATOLOGY         45         0         138         0         0           90.11         09010         DERMATOLOGY         2,088         20,242         7,056         4,586         0           91.00         09100         DERMATOLOGY         2,088         20,242         7,056         4,586         0           92.00         OBSERVATI ON BEDS (NON-DI STINCT PART)         2,088         20,242         7,056         4,586         0           92.00         OBSERVATION BEDS (NON-DI STINCT PART)         2,088         20,242         7,056         4,586         0				0				
90.08         09008         SOUTH HARRISON FAMILY MEDICINE         43         0         13         0         0           90.09         90009         PAIN MANAGEMENT         7         0         94         0         0           90.09         09009         PAIN MANAGEMENT         7         0         94         0         0           90.10         DERMATOLOGY         45         0         138         0         0           90.11         O9010         DERMATOLOGY         134         0         0         0         0           91.00         09100         EMERGENCY         2,088         20,242         7,056         4,586         0           92.00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART)         2,088         20,242         7,056         4,586         0           92.00         OPS00         AMBURANCE SERVI CES         656         0         1,348         0				0				
90.09         09009         PAIN MANAGEMENT         7         0         94         0         0           90.10         09010         DERMATOLOGY         45         0         138         0         0           90.11         09011         KIDS FIRST         134         0 </td <td></td> <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td>1</td>				0				1
90.10         OPO10         DERMATOLOGY         45         O         138         O         O           90.11         OPO10         EMERGENCY         134         0			1	0				1
91.00         09100         EMERGENCY         2,088         20,242         7,056         4,586         0           92.00         OBSERVATI ON BEDS (NON-DI STI NCT PART)         0			45	0	138	0	0	90.10
92.00         O9200         OBSERVATI ON BEDS (NON-DI STI NCT PART)         Image: Constraint of the state of t				0	-	-	0	
OTHER         REI MBURSABLE         COST         CENTERS           95.00         09500         AMBULANCE         SERVICES         656         0         1, 348         0         0           102.00         10200         OPIOID         TREATMENT         PROGRAM         0<			2,088	20, 242	7, 056	4, 586	0	
95.00         09500         AMBULANCE SERVICES         656         0         1, 348         0         0           102.00         0PI 0I D TREATMENT PROGRAM         0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>92.00</td>								92.00
102.00         10200         OPI OI D TREATMENT PROGRAM         0         1           113.00         11300         INTEREST EXPENSE         SUBTOTALS (SUM OF LINES 1 through 117)         11,390         255,830         25,339         56,156         150,822         1			656	0	1 348	0	0	95.00
SPECIAL PURPOSE COST CENTERS           113.00         INTEREST EXPENSE           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         11,390         255,830         25,339         56,156         150,822         1           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         11,390         255,830         25,339         56,156         150,822         1           190.00         190000         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         2,254         0         511         01           192.00         19200         PHYSI CI ANS' PRI VATE OFFI CES         0         0         85         0         01           194.00         07950         MARKETI NG         0         1,383         0         313         01           194.02         07952         MOB         0         0         0         0         0         0         0           194.02         07952         MOB         0								102.00
118.00         SUBTOTALS (SUM OF LINES 1 through 117)         11,390         255,830         25,339         56,156         150,822         1           NONREI MBURSABLE COST CENTERS								
NONREL MBURSABLE COST CENTERS           190.00         19000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         2,254         0         511         01           192.00         19200         PHYSI CI ANS' PRI VATE OFFICES         0         0         85         0         01           194.00         07950         MARKETI NG         0         0         0         0         0         0         1           194.01         07951         PHYSI CI AN BI LLI NG         0         1, 383         0         313         0         1           194.02         07952         MOB         0         0         0         0         0         1           200.00         Cross Foot Adj ustments         0         0         0         0         2         2         0         0         0         0         0         0         2           201.00         Negati ve Cost Centers         0								113.00
190.00         19000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         2,254         0         511         01           192.00         19200         PHYSICIANS' PRIVATE OFFICES         0         0         85         0         01           194.00         07950         MARKETING         0         0         0         0         01           194.01         07951         PHYSICIAN BILLING         0         1,383         0         313         01           194.02         07952         MOB         0         0         0         0         0           200.00         Cross Foot Adjustments         0         0         0         0         0         20           201.00         Negative Cost Centers         0 <td< td=""><td></td><td></td><td>11, 390</td><td>255, 830</td><td>25, 339</td><td>56, 156</td><td>150, 822</td><td>1118.00</td></td<>			11, 390	255, 830	25, 339	56, 156	150, 822	1118.00
192.00       192.00       PHYSICIANS' PRIVATE OFFICES       0       0       85       0       0         194.00       07950       MARKETING       0       0       0       0       0       0       1         194.01       07951       PHYSICIAN BILLING       0       1,383       0       313       0       1         194.02       07952       MOB       0       0       0       0       0       0       0       1         194.02       07952       MOB       0       0       0       0       0       0       1       1       1       0				2 254		<b>F11</b>	0	190. 00
194.00       07950       MARKETING       0       0       0       0       1         194.01       07951       PHYSICIAN BILLING       0       1,383       0       313       0       1         194.02       07952       MOB       0       0       0       0       0       0       1         200.00       Cross Foot Adjustments       0 </td <td></td> <td></td> <td>0</td> <td>2, 204 N</td> <td></td> <td></td> <td></td> <td>190.00</td>			0	2, 204 N				190.00
194.01       07951       PHYSICIAN BILLING       0       1,383       0       313       0       1         194.02       07952       MOB       0       0       0       0       0       0       1         200.00       Cross Foot Adjustments       0 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td>194.00</td>			0	0				194.00
200.00         Cross Foot Adjustments         2<	194.01	07951 PHYSICIAN BILLING	0	1, 383	C	313	0	194.01
201.00 Negative Cost Centers 0 0 0 0 0			0	0	C	0	0	194.02
201.00 Integrative cost centers 0 0 0 0 0 0 202 202.00 TOTAL (sum Lines 118 through 201) 11, 390 259, 467 25, 424 56, 980 150, 822 2				~	_	_	_	200.00
202,001 [10the (30m 11n03 110 through 2017 ] [1, 370] 237,407] 23,424] 30,700[ 130,022]2			11 200	0 250 167	25 424	56 020	0 150 822	201.00
	202.00	TOTAL (Sum TITIES TTO THE OUGH 201)	1 1, 370	237,407	1 25,424	50, 760	1 130, 622	1202.00

Heal th	Financial Systems	HARRI SON COUN	ITY HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2022	Worksheet B	
					To 12/31/2022	Date/Time Pre	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	MEDI CAL	5/26/2023 5: 2 SOCI AL SERVI CE	
	cost center bescription	CALLIERIA	ADMI NI STRATI ON	SERVICES &	RECORDS &	SUCIAL SERVICE	
		11.00	10.00	SUPPLY	LIBRARY	17.00	
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	16.00	17.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 MOB						1.01
1.02 2.00	00102 AMB DEPR						1.02
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00201 AMB EQUIP						2.00 2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590 ADMI NI STRATI VE & GENERAL						5.01
5.02							5.02
5.03 7.00	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00700 OPERATI ON OF PLANT						5.03 7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY 01100 CAFETERI A	סבר בב					10.00
11.00 13.00	01300 NURSI NG ADMI NI STRATI ON	77, 378 2, 413					11.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 424		9, 16	9		14.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	3, 479		1			16.00
17.00	01700 SOCIAL SERVICE	945	0		2 0	10, 397	17.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	17, 617	11, 157	18	1 4, 611	7, 765	30.00
31.00	03100 I NTENSI VE CARE UNI T	2, 538		6		831	31.00
43.00	04300 NURSERY	730			0 731	1, 801	43.00
	ANCI LLARY SERVICE COST CENTERS	F 00.	0.700				
50.00 53.00	05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY	5, 894 C		31 2		0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 282		20			
60.00	06000 LABORATORY	3, 844		2, 11		0	•
65.00	06500 RESPI RATORY THERAPY	C		6		0	65.00
66.00	06600 PHYSI CAL THERAPY	1,204	1 1		7 1, 711 0 181	0	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	123 27			0 181 0 97	0	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	1, 965		3		0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C		3, 33		0	
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0 863		1, 69		0	
73.00	07700 ALLOGENEIC HSCT ACQUISITION	003 (			8 4, 344 0 0	0	•
	OUTPATIENT SERVICE COST CENTERS				<u> </u>		1
90.00	09000 CLI NI C	131			1 76		•
90. 01 90. 02	09001 SENI OR CARE 09002 GENERAL SURGERY	341			4 183	0	
90. 02 90. 03	09002 GENERAL SURGERY 09003 HARRI SON CRAWFORD HEALTHCARE	1, 431 2, 226		1 5			
	09004 CORYDON MEDICAL ASSOCIATES	1, 661			3 444	0	•
90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	2, 393		5			
90.06	09006 OBGYN - DR SAUER	817			9 154	0	
90. 07 90. 08	09007 FIRST CAPITAL MEDICAL GROUP 09008 SOUTH HARRISON FAMILY MEDICINE	4, 293 1, 496		9 4		0	90.07
90.09	09009 PALN MANAGEMENT	109			2 59	0	
90. 10	09010 DERMATOLOGY	919	0	1		0	90.10
90.11	09011 KIDS FIRST	0	-	22			
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	9,645	6, 108	28	6 17, 117	0	91.00 92.00
72.00	OTHER REIMBURSABLE COST CENTERS		II				72.00
95.00	09500 AMBULANCE SERVICES	C	0	22	1 5, 377	0	95.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0		0 0	0	102.00
112 00	SPECIAL PURPOSE COST CENTERS						112 00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	73, 810	24, 610	9, 16	9 93, 459	10 397	113.00 118.00
5. 50	NONREI MBURSABLE COST CENTERS				, , , , , , , , , , , , , , , , , , , ,		]
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C			0 0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	1, 180	0		0 0		192.00
	07950 MARKETING 07951 PHYSICIAN BILLING	2, 388	0		0 0		194. 00 194. 01
	07952 MOB	2, 380	0		o o		194.01
200.00	Cross Foot Adjustments						200. 00
201.00		0	0	0.11	0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	77, 378	24, 610	9, 16	9 93, 459	10,397	202.00

Heal th	Financial Systems	HARRI SON COUN	ITY HOSPI TAL		In Lieu	of Form CMS-2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	CN: 15-1331		Vorksheet B Part II
					To 12/31/2022 [	Date/Time Prepared:
	Cost Center Description	Subtotal	Intern &	Total		5/26/2023 5:21 pm
			Residents Cost			
			& Post Stepdown			
			Adjustments		_	
	GENERAL SERVICE COST CENTERS	24.00	25.00	26.00		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101 MOB					1. 01
1.02 2.00	00102 AMB DEPR 00200 NEW CAP REL COSTS-MVBLE EQUIP					1. 02 2. 00
2.00	00200 NEW CAP REL COSTS-MVBEL EDUTP					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 5.02	00590 ADMI NI STRATI VE & GENERAL 00570 ADMI TTI NG					5. 01 5. 02
5.02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE					5. 03
7.00	00700 OPERATION OF PLANT					7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG					8.00 9.00
10.00	01000 DI ETARY					10.00
11.00	01100 CAFETERI A					11.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY					13.00 14.00
16.00	01600 MEDICAL RECORDS & LIBRARY					16.00
17.00	01700 SOCIAL SERVICE					17.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	765,009	0	765, 00	10	30.00
30.00	03100 I NTENSI VE CARE UNI T	103,068				30.00
43.00	04300 NURSERY	46, 893				43.00
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	490, 190	0	490, 19	20	50.00
53.00	05300 ANESTHESI OLOGY	490, 190				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	291, 267	0	291, 26	57	54.00
60.00		175, 449	0	175, 44		60.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	34, 353 99, 270	-			65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	753		75	53	67.00
68.00		236	0			68.00
69.00 71.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	64, 007 135, 891	0	64, 00 135, 89		69.00 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	12, 959	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	60, 347	0			73.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0		0	77.00
90.00	09000 CLINIC	20, 135	0	20, 13	35	90.00
	09001 SENI OR CARE	23, 914				90.01
	09002 GENERAL SURGERY 09003 HARRI SON CRAWFORD HEALTHCARE	19, 509 72, 471	0			90. 02 90. 03
90.04	09004 CORYDON MEDICAL ASSOCIATES	87, 574	0	87, 5		90.04
90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	105, 448		105, 44		90. 05
90. 06 90. 07	09006 OBGYN - DR SAUER 09007 FIRST CAPITAL MEDICAL GROUP	32, 483 121, 433		32, 48 121, 43		90.06 90.07
90.08	09008 SOUTH HARRI SON FAMILY MEDICINE	50, 776		50, 7		90.08
90.09	09009 PAIN MANAGEMENT	22, 339		22, 33		90. 09
90. 10 90. 11	09010 DERMATOLOGY 09011 KI DS FI RST	27, 913 73, 571	0	27, 9 <sup>2</sup> 73, 51		90. 10 90. 11
91.00	09100 EMERGENCY	260, 658	0			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
95 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	427, 506	0	427, 50	16	95.00
	10200 OPI OI D TREATMENT PROGRAM	427, 300			0	102.00
	SPECIAL PURPOSE COST CENTERS		I	1		
113.00 118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	3, 627, 161	0	3, 627, 16	1	113.00 118.00
. 10. 00	NONREI MBURSABLE COST CENTERS	5, 027, 101	0		· · ·	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	20, 868	0	20, 86		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES 07950 MARKETI NG	26, 537 0	0	26, 53	0	192.00 194.00
	07951 PHYSI CI AN BILLI NG	20, 940	0	20, 94	i0	194.00
194.02	07952 MOB	68, 870	0	68, 87	0	194. 02
200.00 201.00	3	0	0		0	200. 00 201. 00
201.00		0 3, 764, 376	-		76	201.00
				•		

	Financial Systems LLOCATION - STATISTICAL BASIS	HARRI SON COUNT	Y HOSPITAL Provider CCN		eri od:	u of Form CMS-: Worksheet B-1	
				Fr To	om 01/01/2022 12/31/2022	Date/Time Pre	
			CAPI	TAL RELATED CO	STS	5/26/2023 5:2	
	Cost Center Description	NEW BLDG & FIXT (SQUARE FEET) 1.00	MOB (SQUARE FEET) 1.01	AMB DEPR (SQUARE FEET) 1.02	NEW MVBLE EQUI P (SQUARE FEET) 2.00	AMB EQUIP (SQUARE FEET) 2.01	
	GENERAL SERVICE COST CENTERS				2.00	2.01	
	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 MOB 00102 AMB DEPR 00200 NEW CAP REL COSTS-MVBLE EQUIP 00201 AMB EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00590 ADMINISTRATIVE & GENERAL 00570 ADMINISTRATIVE & GENERAL 00570 ADMINISTRATIVE & GENERAL 00580 CASHIERING/ACCOUNTS RECEIVABLE 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	125, 051 0 0 200 20, 111 0 0 10, 921 916 1, 962 5, 709 2, 852 480 0	34, 270 0 196 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11, 032 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	125, 051 0 200 20, 111 0 10, 921 916 1, 962 5, 709 2, 852 480 0	11, 032 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00 1.01 1.02 2.00 2.01 4.00 5.01 5.02 5.03 7.00 8.00 9.00 10.00 11.00 13.00 14.00
	01600 MEDICAL RECORDS & LIBRARY	3, 185	0	0	3, 185	0	16. 00
17.00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	192	0	0	192	0	17.00
30.00	03000 ADULTS & PEDIATRICS	21, 684	0	0	21, 684	0	30.00
	03100 I NTENSI VE CARE UNI T 04300 NURSERY	2, 897 600	0	0 0	2, 897 600	0 0	31.00 43.00
43.00	ANCI LLARY SERVI CE COST CENTERS	800	0	0	800	0	43.00
50.00	05000 OPERATING ROOM	17, 722	0	0	17, 722	0	50.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 9, 285	0 0	0 0	0 9, 285	0	53.00 54.00
60.00	06000 LABORATORY	4, 880	0	0	4, 880	0	60.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 062 3, 593	0	0	1, 062 3, 593	0	65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0 1, 824	0	0	0 1, 824	0	68.00 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 356	0	0	4, 356	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0 1, 226	0	0	0 1, 226	0	72.00
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	•
90.00	OUTPATIENT SERVICE COST CENTERS	760	0	0	760	0	90.00
90.01	09001 SENI OR CARE	0	1, 143	0	0	0	90.01
90. 02 90. 03	09002 GENERAL SURGERY 09003 HARRI SON CRAWFORD HEALTHCARE	0	760 3, 440	0	0	0	90.02
90.04	09004 CORYDON MEDICAL ASSOCIATES	0	4, 395	0	0	0	90.04
90. 05 90. 06	09005 ORTHOPEDIC SURGERY - DR KLINE 09006 OBGYN - DR SAUER	0	5, 263 1, 579	0	0	0	90.05
90. 07	09007 FIRST CAPITAL MEDICAL GROUP	0	5, 511	0	0	0	90.07
90. 08 90. 09	09008 SOUTH HARRISON FAMILY MEDICINE 09009 PAIN MANAGEMENT	0	2, 446 1, 200	0	0	0	90.08
90. 09 90. 10	09010 DERMATOLOGY	0	1, 200	0	0	0	90.09
	09011 KIDS FIRST	0	3, 300	0	0	0	90.11
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	7, 319	0	0	7, 319	0	91.00 92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	0	11, 032	0	11, 032	95.00
	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0		102.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113. OC
118.00		123, 736	30, 551	11, 032	123, 736	11, 032	
	NONREI MBURSABLE COST CENTERS						1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFICES	815 0	0 0	0 0	815 0		190. 00 192. 00
194.00	07950 MARKETI NG	0	Ō	Ō	0	0	194.00
	07951 PHYSICIAN BILLING 07952 MOB	500 0	0 3, 719	0	500 0		194.01 194.02
200.00	Cross Foot Adjustments		5,717	0	U U	0	200.00
201.00 202.00		1 720 155	620 057	57 411	1 020 200	325, 544	201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1, 732, 155	628, 857	57, 611	1, 020, 209	325, 544	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	13.851589	18. 350073	5. 222172	8. 158343	29.509065	1203 00

Health Fir	nancial Systems	HARRI SON COUN	TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2022	Worksheet B-1	
					To 12/31/2022	Date/Time Pre 5/26/2023 5:2	
			CAP	ITAL RELATED	COSTS		
	Cost Center Description	NEW BLDG & FIXT	MOB (SQUARE	AMB DEPR (SQUARE	NEW MVBLE EQUIP	AMB EQUI P (SQUARE	
		(SQUARE FEET)	FEET)	FEET)	(SQUARE FEET)	FEET)	
		1.00	1.01	1.02	2.00	2.01	
204.00	Cost to be allocated (per Wkst. B, Part II)						204.00
205.00	Unit cost multiplier (Wkst. B, Part						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

	Financial Systems ALLOCATION - STATISTICAL BASIS	HARRI SON COUN	Provider CC		ri od:	u of Form CMS-2 Worksheet B-1	
				Fr	com 01/01/2022 12/31/2022	Date/Time Pre 5/26/2023 5:2	
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM COST)	ADMI TTI NG (GROSS CHARGES)	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES)	
		4.00	5A. 01	5.01	5. 02	5.03	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT				I		1.00
1.00 1.01 1.02 2.00 2.01 4.00 5.01 5.02 5.03 7.00 8.00 9.00 10.00 11.00 13.00 14.00 14.00 13.00 14.00 14.00 14.00 15.02 1.01 1.02 1.01 1.02 1.02 1.02 1.01 1.02 1.02 1.01 1.02 1.01 1.02 1.01 1.02 1.01 1.02 1.01 1.02 1.01 1.02 1.01 1.02 1.01 1.02 1.01 1.02 1.01 1.02 1.01 1.02 1.01 1.02 1.01 1.02 1.01 1.02 1.01 1.02 1.01 1.02 1.01 1.02 1.01 1.02 1.00 1.	00101 MOB 00102 AMB DEPR 00200 NEW CAP REL COSTS-MVBLE EQUIP 00201 AMB EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00590 ADMINISTRATIVE & GENERAL 00570 ADMINISTRATIVE & GENERAL 005700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	29, 925, 808 1, 912, 233 593, 700 404, 327 322, 562 37, 219 516, 595 225, 508 285, 616 774, 236 226, 947 621, 022 383, 415	-6, 728, 789 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	48, 641, 740 782, 894 1, 234, 343 2, 075, 168 296, 804 903, 483 593, 656 532, 492 1, 077, 375 840, 123 977, 159 492, 050	187, 082, 080 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	187, 082, 080 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1. \ 00\\ 1. \ 01\\ 1. \ 02\\ 2. \ 00\\ 2. \ 01\\ 4. \ 00\\ 5. \ 01\\ 5. \ 02\\ 5. \ 03\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 13. \ 00\\ 14. \ 00\\ 14. \ 00\\ 16. \ 00\\ 17. \ 00\end{array}$
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	4, 334, 129	0	5, 804, 029	9, 222, 961	9, 222, 961	30.00
30.00	03100 I NTENSI VE CARE UNI T	4, 334, 124	0	768, 848	903, 538	903, 538	
43.00	04300 NURSERY	156, 987	0	177, 509	1, 462, 745	1, 462, 745	
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	1,064,629	0	2, 099, 362	14, 332, 742	14, 332, 742	50.00
53.00	05300 ANESTHESI OLOGY	1, 004, 029	0	2, 099, 382	2, 611, 890	2, 611, 890	•
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 146, 239	0	2, 400, 619	40, 670, 059	40, 670, 059	54.00
60.00	06000 LABORATORY	977, 494	0	3, 087, 618	28, 405, 883	28, 405, 883	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0 346, 792	0	599, 573 510, 403	3, 017, 896 3, 421, 755	3, 017, 896 3, 421, 755	
67.00	06700 OCCUPATI ONAL THERAPY	35, 769	0	44, 488	361, 551	361, 551	67.00
68.00	06800 SPEECH PATHOLOGY	7, 927	0	9, 859	193, 617	193, 617	
69.00	06900 ELECTROCARDI OLOGY	497, 050	0	742, 560	11, 501, 410	11, 501, 410	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	2, 096, 536 1, 017, 388	4, 432, 259 3, 206, 393	4, 432, 259 3, 206, 393	
73.00	07300 DRUGS CHARGED TO PATIENTS	356, 118	0	2, 510, 705	8, 687, 426	8, 687, 426	
77.00	07700 ALLOGENEI C HSCT ACQUI SI TI ON	0	0	0	0	0	77.00
90.00	OUTPATIENT SERVICE COST CENTERS	33, 810	0	56, 489	152, 996	152, 996	90.00
90.00 90.01		88,600	0	233, 694	366, 182	366, 182	
90. 02	09002 GENERAL SURGERY	856, 228	0		207, 169	207, 169	
90.03	09003 HARRI SON CRAWFORD HEALTHCARE	633, 774	0	697, 652	955, 476	955, 476	
90. 04 90. 05	09004 CORYDON MEDICAL ASSOCIATES 09005 ORTHOPEDIC SURGERY - DR KLINE	571, 025 1, 218, 667	0	501, 381 613, 295	888, 440 1, 027, 597	888, 440 1, 027, 597	90.04 90.05
90.06	09006 OBGYN - DR SAUER	506, 123	0	251, 680	307, 593	307, 593	
90.07	09007 FIRST CAPITAL MEDICAL GROUP	1, 226, 936	0	1, 578, 332	1, 999, 568	1, 999, 568	
90. 08 90. 09	09008 SOUTH HARRISON FAMILY MEDICINE 09009 PAIN MANAGEMENT	424, 592 156, 885	0	420, 098 2, 134	702, 712 118, 227	702, 712 118, 227	90.08 90.09
90.09 90.10	09010 DERMATOLOGY	484, 549	0	233, 094	739, 238	739, 238	
90.11	09011 KIDS FIRST	1, 269, 556	0	1, 229, 285	2, 196, 552	2, 196, 552	90.11
91.00	09100 EMERGENCY	2, 281, 252	0	3, 351, 787	34, 233, 616	34, 233, 616	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	2, 334, 363	0	3, 920, 160	10, 754, 589	10, 754, 589	95.00
	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
440.00	SPECIAL PURPOSE COST CENTERS						110.00
118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	27, 838, 606	-6, 728, 789	45, 198, 704	187, 082, 080	187, 082, 080	113.00 118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	17, 938	0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	1, 698, 831	0	2, 725, 708	0		192.00 194.00
	07950 MARKETING 07951 PHYSICIAN BILLING	0 388, 371	0	631, 146	0		194.00
194.02	07952 MOB	0	0	68, 244	0		194. 02
200.00	5						200.00
201.00		1 270 020		6 720 700	001 105	1 105 005	201.00
202. UL	Part I)	1, 372, 838		6, 728, 789	891, 195	1, 405, 095	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 045875		0. 138334	0. 004764	0. 007511	
204.00	Cost to be allocated (per Wkst. B,	4, 402		446, 519	7, 274	11 200	204.00

Heal th Fi	nancial Systems	HARRISON COUN	TY HOSPI TAL		In Lie	eu of Form CMS-	2552-10
COST ALLC	CATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2022	Worksheet B-1	
					To 12/31/2022		
	Cost Center Description	EMPLOYEE	Reconciliation	ADMI NI STRATI V	E ADMITTING	CASHI ERI NG/ACC	
		BENEFITS		& GENERAL	(GROSS	OUNTS	
		DEPARTMENT		(ACCUM COST)	CHARGES)	RECEI VABLE	
		(GROSS				(GROSS	
		SALARI ES)				CHARGES)	
		4.00	5A. 01	5.01	5. 02	5.03	
205.00	Unit cost multiplier (Wkst. B, Part	0. 000147		0. 00918	0 0. 000039	0. 000061	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

	Financial Systems	HARRISON COUN		^N+ 15 1221 Ir		u of Form CMS-2	
LUSI A	LLOCATION - STATISTICAL BASIS		Provider CO	F	Period: From 01/01/2022 Fo 12/31/2022	Worksheet B-1 Date/Time Pre	
		ODEDATION OF				5/26/2023 5:2	1 pm
	Cost Center Description	OPERATION OF PLANT (SQUARE	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPING (SQUARE FEET)	DI ETARY (TOTAL PATI ENT DAYS)	CAFETERI A (HOURS OF SERVI CE)	
		FEET)	LAUNDRY)				
	GENERAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00	11.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 1.02	00101 MOB 00102 AMB DEPR						1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 4.00							2.01
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00590 ADMINISTRATIVE & GENERAL						4.00 5.01
5.02	00570 ADMI TTI NG						5. 02
5.03 7.00	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00700 OPERATI ON OF PLANT	93, 819					5.03 7.00
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	93, 819	199, 533				8.00
9.00	00900 HOUSEKEEPI NG	1, 962	0	90, 941			9.00
10.00 11.00	01000 DI ETARY 01100 CAFETERI A	5, 709	2, 497	5, 709		22,000	10.00
13.00	01300 NURSING ADMINISTRATION	2, 852 480	0	2, 852 480		32, 009 998	
	01400 CENTRAL SERVICES & SUPPLY	0	0	(		589	
16.00	01600 MEDICAL RECORDS & LIBRARY	3, 185	0			1, 439	
17.00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	192	0	192	2 0	391	17.00
30.00	03000 ADULTS & PEDIATRICS	21, 684	42, 229	21, 684	1 3, 009	7, 288	30.00
31.00	03100 INTENSIVE CARE UNIT	2, 897	36, 955			1, 050	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	600	0	600	698	302	43.00
50.00	05000 OPERATING ROOM	17, 722	16, 072	17, 722	2 0	2, 438	50.00
53.00	05300 ANESTHESI OLOGY	0	0	(	0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 285				2, 185	
60.00 65.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	4,880 1,062	0	.,		1, 590 0	•
66.00	06600 PHYSI CAL THERAPY	3, 593	0	3, 593		498	
67.00	06700 OCCUPATI ONAL THERAPY	0	0	-		51	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0 1, 824	0 5, 002	-		11 813	68.00 69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 356	0			015	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	-		0	
	07300 DRUGS CHARGED TO PATIENTS 07700 ALLOGENEIC HSCT ACQUISITION	1, 226 0	0			357	•
77.00	OUTPATIENT SERVICE COST CENTERS	0	0		<u>,                                    </u>	0	1 77.00
	09000 CLI NI C	760	0			54	90.00
	09001 SENI OR CARE	0	13			141	•
	09002 GENERAL SURGERY 09003 HARRI SON CRAWFORD HEALTHCARE	0	232			592 921	90.02 90.03
90.04	09004 CORYDON MEDICAL ASSOCIATES	0	84	(	o o	687	90.04
90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	0	26		0	990	•
90. 06 90. 07	09006 OBGYN - DR SAUER 09007 FIRST CAPITAL MEDICAL GROUP	0	496 408			338 1, 776	
90.07 90.08	09008 SOUTH HARRISON FAMILY MEDICINE	0	100			619	
90.09	09009 PALN MANAGEMENT	0	740		0 0	45	
90. 10 90. 11	09010 DERMATOLOGY 09011 KIDS FIRST	0	1, 081			380	90.10
	09100 EMERGENCY	7, 319	55, 383	7, 319		3, 990	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
05 00	OTHER REIMBURSABLE COST CENTERS	0	10 577				
	09500 AMBULANCE SERVICES 10200 OPIOID TREATMENT PROGRAM	0	10, 577			0	95.00 102.00
102.00	SPECIAL PURPOSE COST CENTERS		0				102.00
	11300 INTEREST EXPENSE	00 504	100.0/0		1 000	00 500	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	92, 504	198, 863	89, 626	4, 029	30, 533	1118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	815	0	815	5 0	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	670				192.00
	07950 MARKETING 07951 PHYSICIAN BILLING	0 500	0	500			194.00 194.01
	07951 PHYSICIAN BILLING 07952 MOB	500 0	0 0	500			194.01
200.00	Cross Foot Adjustments					0	200.00
201.00		0.040.05	0/0.053	1 077 5	001 -5	744 741	201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2, 362, 234	360, 926	1, 077, 865	891, 706	711, 766	202.00
203.00		25. 178631	1. 808854	11. 852355	5 221. 321916	22. 236434	203.00
204.00	Cost to be allocated (per Wkst. B,	259, 467	25, 424				204.00
	Part II)	1	1	1	1		1

Heal th Fi	nancial Systems	HARRISON COUN	TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2022	Worksheet B-1	
					To 12/31/2022	Date/Time Pre 5/26/2023 5:2	
	Cost Center Description	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE	(TOTAL PATIENT	(HOURS OF	
		(SQUARE	(POUNDS OF	FEET)	DAYS)	SERVICE)	
		FEET)	LAUNDRY)				
		7.00	8.00	9.00	10.00	11.00	
205.00	Unit cost multiplier (Wkst. B, Part	2. 765613	0. 127418	0. 62656	0 37.434103	2. 417383	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

	ncial Systems TION – STATISTICAL BASIS	HARRI SON COUNT	TY HOSPITAL Provider CC	F	In Lie eriod: rom 01/01/2022 o 12/31/2022	u of Form CMS-2552-10 Worksheet B-1 Date/Time Prepared:
GENER	Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS) 13.00	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S. ) 14. 00	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16. 00	SOCI AL SERVI CE (TOTAL PATI ENT DAYS) 17.00	5/26/2023 5:21 pm
1.00         00100           1.01         00101           1.02         00102           2.00         00200           2.01         00201           4.00         00400           5.01         00590           5.02         00570           8.00         00800           9.00         00900           11.00         01100           13.00         01300           14.00         01400           17.00         01700	NEW CAP REL COSTS-BLDG & FIXT MOB AMB DEPR NEW CAP REL COSTS-MVBLE EQUIP AMB EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL ADMITTING CASHIERING/ACCOUNTS RECEIVABLE OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	16, 076 0 0 0	5, 502, 486 8, 350 1, 006	187, 082, 080 0	4, 029	1.00 1.01 1.02 2.00 2.01 4.00 5.01 5.02 5.03 7.00 8.00 9.00 10.00 11.00 13.00 14.00 14.00 17.00
30.00         03000           31.00         03100           43.00         04300	I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS I NTENSIVE CARE UNIT NURSERY	7, 288 1, 050 302	108, 472 36, 978 114	9, 222, 961 903, 538 1, 462, 745	3, 009 322 698	30. 00 31. 00 43. 00
50.00         05000           53.00         05300           54.00         05400           60.00         06000           65.00         06500           66.00         06600           67.00         06700           68.00         06800           69.00         06900           71.00         07100           73.00         07300           77.00         07700	LARY SERVICE COST CENTERS OPERATING ROOM ANESTHESIOLOGY RADIOLOGY-DIAGNOSTIC LABORATORY RESPIRATORY THERAPY PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS ALLOGENEIC HSCT ACQUISITION TLENT SEDVICE COST CENTEDS	2, 438 0 0 0 0 0 0 0 0 813 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	187, 345 14, 568 125, 502 1, 266, 802 36, 915 4, 259 0 20, 917 2, 000, 335 1, 017, 388 16, 660 0	14, 332, 742 2, 611, 890 40, 670, 059 28, 405, 883 3, 017, 896 3, 421, 755 361, 551 193, 617 11, 501, 410 4, 432, 259 3, 206, 393 8, 687, 426 0		50.00 53.00 54.00 60.00 65.00 66.00 67.00 68.00 69.00 71.00 72.00 73.00 77.00
90.00         09000           90.01         09001           90.02         09002           90.03         09003           90.04         09004           90.05         09005           90.06         09007           90.07         09007           90.08         09008           90.09         09009           90.10         09010           90.11         09010           91.00         09100           92.00         09200	TI ENT SERVICE COST CENTERS CLINIC SENIOR CARE GENERAL SURGERY HARRISON CRAWFORD HEALTHCARE CORYDON MEDICAL ASSOCIATES ORTHOPEDIC SURGERY - DR KLINE OBGYN - DR SAUER FIRST CAPITAL MEDICAL GROUP SOUTH HARRISON FAMILY MEDICINE PAIN MANAGEMENT DERMATOLOGY KIDS FIRST EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS	54 141 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	661 2, 267 5, 973 30, 363 19, 997 30, 191 35, 473 54, 507 26, 199 1, 414 9, 880 135, 682 171, 680	152, 996 366, 182 207, 169 955, 476 888, 440 1, 027, 597 307, 593 1, 999, 568 702, 712 118, 227 739, 238 2, 196, 552 34, 233, 616	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	90.00 90.01 90.02 90.03 90.04 90.05 90.06 90.07 90.08 90.09 90.10 90.11 91.00 92.00
95.00 09500 102.00 10200	AMBULANCE SERVICES OPIOID TREATMENT PROGRAM	0	132, 588 0	10, 754, 589 0	0	95. 00 102. 00
113. 00 11300 118. 00 NONRE	AL PURPOSE COST CENTERS INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	16, 076	5, 502, 486	187, 082, 080	4, 029	113. 00 118. 00
192.00 19200 194.00 07950	PHYSICIAN BILLING MOB Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B,	0 0 0 0 1, 266, 380	0 0 0 969, 438	0 0 0 0 1, 263, 746	0 0 0 0 576, 098	190.00 192.00 194.00 194.01 194.02 200.00 201.00 202.00
203.00 204.00	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	78. 774571 24, 610	0. 176182 9, 169	0. 006755 93, 459	142. 987838 10, 397	203. 00 204. 00

Health Financial Systems	HARRISON COUNT	TY HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2022	Worksheet B-1	
				To 12/31/2022	Date/Time Pre 5/26/2023 5:2	
Cost Center Description	NURSI NG	CENTRAL	MEDI CAL	SOCIAL SERVICE		
	ADMI NI STRATI ON	SERVICES &	RECORDS &			
		SUPPLY	LI BRARY	(TOTAL PATIENT		
	(DI RECT	(COSTED	(GROSS	DAYS)		
	NRSING HRS)	REQUIS.)	CHARGES)			
	13.00	14.00	16.00	17.00		
205.00 Unit cost multiplier (Wkst. B, Part	1. 530853	0. 001666	0. 00050	2. 580541		205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/26/2023 5:2	pared
		Title	XVIII	Hospi tal	Cost	i pii
				Costs	·	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.540.074	1	0.540.07			
D. 00 03000 ADULTS & PEDIATRICS	9, 513, 274		9, 513, 27		0	
1. 00 03100 I NTENSI VE CARE UNI T	1, 296, 407		1, 296, 40		0	
3. 00 04300 NURSERY	536, 934		536, 93	4 0	0	43. (
ANCILLARY SERVICE COST CENTERS	2 ( )7 1 ) )		2 ( )7 1 2	3 0	0	50. (
D. 00  05000  OPERATI NG ROOM 3. 00  05300  ANESTHESI OLOGY	3, 627, 133 70, 643		3, 627, 13 70, 64		0	
4. 00  05300  ANESTHESTOLOGY 4. 00  05400  RADI OLOGY-DI AGNOSTI C	3, 969, 836		3, 969, 83		0	
2. 00  06000  LABORATORY	4, 494, 561		4, 494, 56		0	
5. 00 06500 RESPI RATORY THERAPY	785, 775	0			0	
6. 00 06600 PHYSI CAL THERAPY	791,002				0	
7. 00 06700 OCCUPATI ONAL THERAPY	58, 656		58, 65		0	
B. 00 06800 SPEECH PATHOLOGY	15, 152		15, 15		0	
9. 00 06900 ELECTROCARDI OLOGY	1, 226, 553		1, 226, 55		0	
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 984, 634		2, 984, 63		0	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENT	1, 398, 389		1, 398, 38		0	
3. 00 07300 DRUGS CHARGED TO PATIENTS	3, 079, 616		3, 079, 61		0	
7. 00 07700 ALLOGENEIC HSCT ACQUISITION	0			0 0	0	
OUTPATIENT SERVICE COST CENTERS					-	
D. 00 09000 CLINIC	100, 929		100, 92	9 0	0	1 90.
0. 01 09001 SENI OR CARE	287,655		287,65		0	90.
0. 02 09002 GENERAL SURGERY	494, 902		494, 90		0	
D. 03 09003 HARRI SON CRAWFORD HEALTHCARE	838, 173		838, 17		0	90.
D. 04 09004 CORYDON MEDICAL ASSOCIATES	606, 597		606, 59		0	90.
D. 05 09005 ORTHOPEDIC SURGERY - DR KLINE	745,069		745,06		0	90.
D. 06 09006 0BGYN - DR SAUER	307,012		307, 01	2 0	0	90.
D. 07 09007 FIRST CAPITAL MEDICAL GROUP	1, 884, 554		1, 884, 55	4 0	0	90.
D. 08 09008 SOUTH HARRISON FAMILY MEDICINE	510, 146		510, 14	6 0	0	90.
D. 09 09009 PALN MANAGEMENT	7, 268		7, 26	8 0	0	90.
D. 10 09010 DERMATOLOGY	291, 553		291, 55	3 0	0	90.
D. 11 09011 KIDS FIRST	1, 465, 042		1, 465, 04		0	
1.00 09100 EMERGENCY	5, 271, 408		5, 271, 40		0	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 168, 099		2, 168, 09	9	0	92.
OTHER REIMBURSABLE COST CENTERS						
5. 00 09500 AMBULANCE SERVICES	4, 709, 603		4, 709, 60		0	
02.00 10200 OPI OI D TREATMENT PROGRAM	0			0	0	102.
SPECIAL PURPOSE COST CENTERS	1	I.		1		
13.00 11300 INTEREST EXPENSE						113.
00.00 Subtotal (see instructions)	53, 536, 575					200.
01.00 Less Observation Beds	2, 168, 099		2, 168, 09			201.
02.00 Total (see instructions)	51, 368, 476	0	51, 368, 47	6 0	0	202.

COMPUTATION OF RATIO OF	s COSTS TO CHARGES		Provider C	CN: 15-1331	Peri od:	Worksheet C	
					From 01/01/2022	Part I	norod.
					To 12/31/2022	Date/Time Pre 5/26/2023 5:2	
			Title	XVIII	Hospi tal	Cost	
			Charges				
Cost Center	Description	Inpatient	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
				+ col. 7)	Rati o	Inpati ent	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
	E SERVICE COST CENTERS						
30.00 03000 ADULTS & PE		7, 330, 760		7, 330, 70			30.00
31.00 03100 I NTENSI VE 0	CARE UNIT	903, 538		903, 53			31.00
43.00 04300 NURSERY		1, 462, 745		1, 462, 74	45		43.0
ANCI LLARY SERVI CE							
50.00 05000 OPERATING F		2, 735, 250	11, 597, 492			0.00000	
53.00 05300 ANESTHESI OL		451, 704	2, 160, 186			0.00000	
54.00 05400 RADI OLOGY-E	DI AGNOSTI C	1, 362, 328	39, 307, 731	40, 670, 0		0.00000	
60.00 06000 LABORATORY		3, 561, 149	24, 844, 734	28, 405, 88		0.00000	
65. 00 06500 RESPI RATORY		802, 287	2, 215, 609			0.00000	
66.00 06600 PHYSI CAL TH		560, 490	2,861,265			0.00000	
67.00 06700 OCCUPATI ONA		221, 536	140, 015			0.00000	
68.00 06800 SPEECH PATH		90, 768	102, 849			0.00000	
69.00 06900 ELECTROCARE		517, 952	10, 983, 458			0.00000	
	PPLIES CHARGED TO PATIENTS	1, 492, 563	2, 939, 696			0.00000	
	CHARGED TO PATIENT	1, 119, 534	2,086,859			0.00000	
73.00 07300 DRUGS CHARG		2, 196, 922 0	6, 490, 504 0		26 0. 354491 0 0. 000000	0. 000000 0. 000000	
77.00 07700 ALLOGENEI C OUTPATI ENT SERVIO		U	0		0 0.00000	0.00000	//.0
90. 00 09000 CLINIC	CE COST CENTERS	2,000	150, 996	152, 99	0. 659684	0. 000000	90.00
90. 01 09001 SENI OR CARE	-	2,000	366, 182			0.000000	
90. 02 09002 GENERAL SUF		750	206, 419			0.000000	
	AWFORD HEALTHCARE	250	955, 226			0.000000	
90. 04 09004 CORYDON MEE		200	888, 240			0.000000	
	SURGERY - DR KLINE	1,500	1, 026, 097	1, 027, 59		0. 000000	
90. 06 09006 0BGYN - DR		250	307, 343			0. 000000	
90.07 09007 FIRST CAPIT		375	1, 999, 193			0. 000000	
	SON FAMILY MEDICINE	350	702, 362			0. 000000	
90. 09 09009 PALN MANAGE		50	118, 177			0. 000000	
90. 10 09010 DERMATOLOGY		3, 500	735, 738			0. 000000	
90. 11 09011 KIDS FIRST		350	2, 196, 202			0.000000	
91.00 09100 EMERGENCY		465, 486	33, 768, 130			0.000000	
	I BEDS (NON-DISTINCT PART)	0	1, 892, 201	1, 892, 20		0.000000	
OTHER REIMBURSABI							
95.00 09500 AMBULANCE S		0	10, 754, 589	10, 754, 58	0. 437916	0.00000	95.0
102.00 10200 OPI OI D TREA		0	0		0		102.0
SPECIAL PURPOSE (	COST CENTERS						1
113.00 11300 INTEREST EX							113.0
200.00 Subtotal (s	see instructions)	25, 284, 587	161, 797, 493	187, 082, 08	30		200. 0
201.00 Less Observ	vation Beds						201.00
202.00 Total (see	instructions)	25, 284, 587	161, 797, 493	187, 082, 08	30		202.00

Health Financial Systems	HARRI SON COUNT	( HOSPI TAL	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1331	Peri od:	Worksheet C	
			From 01/01/2022 To 12/31/2022	Part I Date/Time Pre	narod
			10 12/31/2022	5/26/2023 5:2	1 pm
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	1				1 20 00
30. 00 03000 ADULTS & PEDIATRICS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATI NG ROOM	0.000000				50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000				77.00
OUTPATIENT SERVICE COST CENTERS	0.000000				1
90. 00 09000 CLINIC	0.000000				90.00
90. 01 09001 SENI OR CARE	0. 000000				90.01
90. 02 09002 GENERAL SURGERY	0. 000000				90.02
90. 03 09003 HARRI SON CRAWFORD HEALTHCARE	0. 000000				90.03
90. 04 09004 CORYDON MEDICAL ASSOCIATES	0. 000000				90.04
90. 05 09005 ORTHOPEDIC SURGERY - DR KLINE	0. 000000				90.05
90. 06 09006 0BGYN - DR SAUER	0. 000000				90.06
90.07 09007 FIRST CAPITAL MEDICAL GROUP	0. 000000				90.07
90.08 09008 SOUTH HARRISON FAMILY MEDICINE	0. 000000				90.08
90. 09 09009 PALN MANAGEMENT	0. 000000				90.09
90. 10 09010 DERMATOLOGY	0. 000000				90.10
90. 11 09011 KIDS FIRST	0. 000000				90.11
91.00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS	·				
95. 00 09500 AMBULANCE SERVICES	0. 000000				95.00
102.00 10200 OPI OI D TREATMENT PROGRAM					102.00
SPECIAL PURPOSE COST CENTERS	1				110.00
113.00 11300 INTEREST EXPENSE					113.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00  Total (see instructions)	1				202.00

OMPUTATION OF RATIO OF COSTS TO CHARGES	5		Provider C	CN: 15-1331	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre	pared:
				e XIX	Hospi tal	5/26/2023 5:2 Cost	1 pm
					Costs	0031	
Cost Center Description	(from Part	al Cost Wkst. B, I, col. 26)	Therapy Limit Adj.		B RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CE				1	-		
0. 00 03000 ADULTS & PEDI ATRI CS		9, 513, 274		9, 513, 2		9, 513, 274	
1.00 03100 INTENSIVE CARE UNIT		1, 296, 407		1, 296, 4		1, 296, 407	
3. 00 04300 NURSERY		536, 934		536, 9	34 0	536, 934	43.0
ANCI LLARY SERVICE COST CENTERS					[ -		
0.00 05000 OPERATING ROOM		3, 627, 133		3, 627, 1		3, 627, 133	
3. 00 05300 ANESTHESI OLOGY		70, 643		70, 6		70, 643	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		3, 969, 836		3, 969, 8		3, 969, 836	
0. 00 06000 LABORATORY		4, 494, 561		4, 494, 5		4, 494, 561	
5. 00 06500 RESPI RATORY THERAPY		785, 775	(			785, 775	
6. 00 06600 PHYSI CAL THERAPY		791, 002	0			791, 002	
7.00 06700 OCCUPATI ONAL THERAPY		58, 656	(	58,6		58, 656	
8.00 06800 SPEECH PATHOLOGY		15, 152	(	15, 1	52 0	15, 152	68.0
9. 00 06900 ELECTROCARDI OLOGY		1, 226, 553		1, 226, 5		1, 226, 553	69.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO	PATI ENTS	2,984,634		2, 984, 6	34 0	2, 984, 634	71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIE	T	1, 398, 389		1, 398, 3	89 0	1, 398, 389	
3.00 07300 DRUGS CHARGED TO PATIENTS		3, 079, 616		3, 079, 6	16 0	3, 079, 616	73.0
7.00 07700 ALLOGENEIC HSCT ACQUISITION		0			0 0	0	77.0
OUTPATIENT SERVICE COST CENTERS							
0. 00 09000 CLINIC		100, 929		100, 9	29 0	100, 929	90.0
0. 01 09001 SENI OR CARE		287, 655		287, 6	55 0	287, 655	90.0
0. 02 09002 GENERAL SURGERY		494, 902		494, 9	02 0	494, 902	90.0
0. 03 09003 HARRI SON CRAWFORD HEALTHCAR	E	838, 173		838, 1	73 0	838, 173	90.0
0. 04 09004 CORYDON MEDICAL ASSOCIATES		606, 597		606, 5	97 0	606, 597	90.0
0. 05 09005 ORTHOPEDIC SURGERY - DR KLI	NE	745,069		745, 0	69 0	745, 069	90.0
0.06 09006 0BGYN - DR SAUER		307,012		307, 0	12 0	307, 012	90. C
0.07 09007 FIRST CAPITAL MEDICAL GROUP		1, 884, 554		1, 884, 5	54 0	1, 884, 554	90.0
0.08 09008 SOUTH HARRISON FAMILY MEDIC	NE	510, 146		510, 1	46 0	510, 146	90. C
0.09 09009 PALN MANAGEMENT		7, 268		7, 2	68 0	7, 268	90. C
0. 10 09010 DERMATOLOGY		291, 553		291, 5	53 0	291, 553	90.1
0. 11 09011 KIDS FIRST		1, 465, 042		1, 465, 0	42 0	1, 465, 042	90.1
1.00 09100 EMERGENCY		5, 271, 408		5, 271, 4	0 80	5, 271, 408	91. C
2.00 09200 OBSERVATION BEDS (NON-DISTI	NCT PART)	2, 168, 099		2, 168, 0	99	2, 168, 099	92.0
OTHER REIMBURSABLE COST CENTERS							1
5. 00 09500 AMBULANCE SERVICES		4, 709, 603		4, 709, 6	03 0	4, 709, 603	95.0
02.00 10200 OPI OI D TREATMENT PROGRAM		0			0		102.0
SPECIAL PURPOSE COST CENTERS							1
13.00 11300 I NTEREST EXPENSE							113. C
00.00 Subtotal (see instructions)	5	3, 536, 575	C	53, 536, 5	75 0	53, 536, 575	
01.00 Less Observation Beds		2, 168, 099		2, 168, 0		2, 168, 099	
		, , . , ,		_,	76 0	51, 368, 476	

COMPUTATI O	N OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1331	Peri od:	Worksheet C	
					From 01/01/2022	Part I	narad
					To 12/31/2022	Date/Time Pre 5/26/2023 5:2	
			Titl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
	TI ENT ROUTI NE SERVI CE COST CENTERS	· · · · · ·					
	0 ADULTS & PEDIATRICS	7, 330, 760		7, 330, 76			30.00
	O INTENSIVE CARE UNIT	903, 538		903, 53			31.00
	0 NURSERY	1, 462, 745		1, 462, 74	45		43.00
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	2, 735, 250	11, 597, 492			0.00000	
	0 ANESTHESI OLOGY	451, 704	2, 160, 186			0.00000	
	0 RADI OLOGY-DI AGNOSTI C	1, 362, 328	39, 307, 731	40, 670, 0		0.00000	
	O LABORATORY	3, 561, 149	24, 844, 734	28, 405, 88		0.00000	
	0 RESPI RATORY THERAPY	802, 287	2, 215, 609			0.00000	
	0 PHYSI CAL THERAPY	560, 490	2,861,265			0.00000	
	O OCCUPATIONAL THERAPY	221, 536	140, 015			0.00000	
	O SPEECH PATHOLOGY	90, 768	102, 849			0.00000	
	0 ELECTROCARDI OLOGY	517, 952	10, 983, 458			0.00000	
	0 MEDI CAL SUPPLIES CHARGED TO PATIENTS	1, 492, 563	2, 939, 696			0.00000	
	O IMPL. DEV. CHARGED TO PATIENT	1, 119, 534	2,086,859			0.00000	
	O DRUGS CHARGED TO PATIENTS	2, 196, 922	6, 490, 504			0.00000	
	O ALLOGENEIC HSCT ACQUISITION	0	0		0 0.000000	0.00000	77.0
	ATLENT SERVICE COST CENTERS	0.000	450.00/	450.00	0 (50/04	0,000000	
		2,000	150, 996	152, 99		0.00000	
	1 SENI OR CARE	0	366, 182			0.00000	
	2 GENERAL SURGERY	750	206, 419			0.00000	
	3 HARRI SON CRAWFORD HEALTHCARE	250 200	955, 226			0.00000	
	04 CORYDON MEDICAL ASSOCIATES 05 ORTHOPEDIC SURGERY - DR KLINE	1, 500	888, 240 1, 026, 097	888, 44 1, 027, 59		0. 000000 0. 000000	
	16 OBGYN - DR SAUER	250				0. 000000	
	7 FIRST CAPITAL MEDICAL GROUP	375	307, 343 1, 999, 193			0. 000000	
	18 SOUTH HARRISON FAMILY MEDICINE	375				0. 000000	
	9 PAIN MANAGEMENT		702, 362			0. 000000	
	0 DERMATOLOGY	50 3, 500	118, 177			0. 000000	
	1 KIDS FIRST	3, 500	735, 738			0. 000000	
	0 EMERGENCY	465, 486	2, 196, 202 33, 768, 130			0. 000000	
	0 OBSERVATION BEDS (NON-DISTINCT PART)	403, 480	1, 892, 201	1, 892, 20		0. 000000	
	R REIMBURSABLE COST CENTERS	0	1,092,201	1, 092, 20	1. 145606	0.00000	92.00
	0 AMBULANCE SERVICES	0	10, 754, 589	10, 754, 58	0. 437916	0. 000000	95.0
	0 OPI OI D TREATMENT PROGRAM	0	10, 754, 589		0.437910	0.000000	102.0
	IAL PURPOSE COST CENTERS	U U	0	I			102.0
	00 INTEREST EXPENSE	[ [					113. 0
200.00	Subtotal (see instructions)	25, 284, 587	161, 797, 493	187, 082, 08	30		200.0
200.00		23, 204, 307	101, 171, 473	107,002,00			200.0
201.00	Less Observation Beds						

Heal th	Financial Systems	HARRI SON COUNTY	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1331	Peri od: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/26/2023 5:2	
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient Ratio 11.00		<u> </u>		
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
30.00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 I NTENSI VE CARE UNI T					31.00
43.00	04300 NURSERY					43.00
101.00	ANCI LLARY SERVI CE COST CENTERS					101.00
50.00	05000 OPERATING ROOM	0.000000				50.00
53.00	05300 ANESTHESI OLOGY	0. 000000				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60.00	06000 LABORATORY	0. 000000				60.00
65.00	06500 RESPIRATORY THERAPY	0. 000000				65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000				68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000				77.00
/// 00	OUTPATIENT SERVICE COST CENTERS	01000000				1
90.00	09000 CLINIC	0. 000000				90.00
90.01	09001 SENI OR CARE	0. 000000				90.01
90.02	09002 GENERAL SURGERY	0. 000000				90.02
90.03	09003 HARRI SON CRAWFORD HEALTHCARE	0. 000000				90.03
90.04	09004 CORYDON MEDICAL ASSOCIATES	0. 000000				90.04
90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	0. 000000				90.05
90.06	09006 OBGYN - DR SAUER	0. 000000				90.06
90.07	09007 FIRST CAPITAL MEDICAL GROUP	0. 000000				90.07
90.08	09008 SOUTH HARRISON FAMILY MEDICINE	0. 000000				90.08
90.09	09009 PALN MANAGEMENT	0. 000000				90.09
90.10	09010 DERMATOLOGY	0. 000000				90.10
90.11	09011 KIDS FIRST	0. 000000				90.11
91.00	09100 EMERGENCY	0. 000000				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVI CES	0. 000000				95.00
102.00	10200 OPIOID TREATMENT PROGRAM					102.00
	SPECIAL PURPOSE COST CENTERS					
	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)					200.00
201.00						201.00
202.00	Total (see instructions)	1				202.00

ealth Financial Systems PPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	HARRISON COUN AL COSTS	Provider C	CN: 15-1331	Period:	u of Form CMS-: Worksheet D	2002
				From 01/01/2022	Part II	
				To 12/31/2022	Date/Time Pre 5/26/2023 5:2	pared
	_		e XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			1			-
D. 00 05000 OPERATING ROOM	490, 190					
3. 00 05300 ANESTHESI OLOGY	1, 739					
4. 00 05400 RADI OLOGY-DI AGNOSTI C	291, 267					
D. 00 06000 LABORATORY	175, 449					
5. 00 06500 RESPI RATORY THERAPY	34, 353					
6. 00 06600 PHYSI CAL THERAPY	99, 270					
7.00 06700 OCCUPATIONAL THERAPY	753				150	
3. 00 06800 SPEECH PATHOLOGY	236					
9. 00 06900 ELECTROCARDI OLOGY	64,007					
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	135, 891					
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	12, 959					
3.00 07300 DRUGS CHARGED TO PATIENTS	60, 347					
7.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.0000	0 00	0	77.
OUTPATIENT SERVICE COST CENTERS			1			-
D. 00 09000 CLINIC	20, 135					
D. 01 09001 SENI OR CARE	23, 914					
D. 02 09002 GENERAL SURGERY	19, 509				62	
D. 03 09003 HARRI SON CRAWFORD HEALTHCARE	72, 471					
D. 04 09004 CORYDON MEDICAL ASSOCIATES	87, 574					
D. 05 09005 ORTHOPEDIC SURGERY - DR KLINE	105, 448					
D. 06 09006 OBGYN - DR SAUER	32, 483					
D. 07 09007 FIRST CAPITAL MEDICAL GROUP	121, 433					
D. 08 09008 SOUTH HARRISON FAMILY MEDICINE	50, 776					
D. 09 09009 PALN MANAGEMENT	22, 339					
D. 10 09010 DERMATOLOGY	27, 913					
D. 11 09011 KIDS FIRST	73, 571					
1. 00 09100 EMERGENCY	260, 658					
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	174, 348	1, 892, 201	0. 0921	40 0	0	92.
OTHER REIMBURSABLE COST CENTERS	1	I.	1			
5. 00 09500 AMBULANCE SERVICES						95.
00.00 Total (lines 50 through 199)	2, 459, 033	166, 630, 448	8	4, 001, 343	52, 832	200.

ealth Financial Systems	HARRI SON COUN	TY HOSPITAL			In Lieu	u of Form CMS-2	2552-10
PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE HROUGH COSTS	RVICE OTHER PASS	6 Provider C	CN: 15-1331	Period: From 01/0 To 12/3	1/2022 1/2022	Worksheet D Part IV Date/Time Pre 5/26/2023 5:2	pared: 1 pm
			XVIII	Hospi t		Cost	
Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown	Nursing Program	Allied H Post-Ste Adjustm	pdown	Allied Health	
		Adjustments					
	1.00	2A	2.00	3A		3.00	
ANCI LLARY SERVICE COST CENTERS		0	1				50.00
	0	, i i i i i i i i i i i i i i i i i i i		0	0	0	50.00
3. 00 05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 00 06000 LABORATORY	0	0		0	0	0	54.00
	0	0		0	0	0	60.00
5. 00 06500 RESPI RATORY THERAPY 6. 00 06600 PHYSI CAL THERAPY	0	0		0	0	-	65.00
	0	0		0	0	0	66.00
7. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
8. 00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
9.00 06900 ELECTROCARDI OLOGY 1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	69.00
	0	0		0	0	0	71.00
	0	0		0	0	0	
3. 00 07300 DRUGS CHARGED TO PATIENTS 7. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS	0	0		0	U	0	//.00
0. 00 09000 CLINIC	0	0		0	0	0	90.00
0. 01 09001 SENI OR CARE	0	-		0	0	0	90.01
0. 02 09002 GENERAL SURGERY	0	0		0	0	0	90.02
0. 03 09003 HARRI SON CRAWFORD HEALTHCARE	0	0		0	0	0	90.03
0. 04 09004 CORYDON MEDICAL ASSOCIATES	0	0		0	0	0	90.04
0. 05 09005 ORTHOPEDIC SURGERY - DR KLINE	0	0		0	0	0	90.05
0. 06 09006 0BGYN - DR SAUER	0	0		0	0	0	90.06
0.07 09007 FIRST CAPITAL MEDICAL GROUP	0	0		0	0	0	90.07
0. 08 09008 SOUTH HARRI SON FAMILY MEDICINE	0	0		0	0	0	90.08
0. 09 09009 PALN MANAGEMENT	0	0		0	0	0	90.09
0. 10 09010 DERMATOLOGY	0	0		0	0	0	90.10
0. 11 09011 KIDS FIRST	0	0		0	0	0	90.11
1. 00 09100 EMERGENCY	0	0		0	o	0	91.00
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	-		0	J	0	92.00
OTHER REI MBURSABLE COST CENTERS			1	- 1			1
		l.	1	1	1		1
5. 00 09500 AMBULANCE SERVICES							95.00

Health Financial Systems	HARRISON COUN	TY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE	RVICE OTHER PASS	S Provider C	CN: 15-1331	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2022 To 12/31/2022	Part IV Date/Time Pre	narod
				10 12/31/2022	5/26/2023 5:2	1 nm
		Title	× XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum o	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	-					
50.00 O5000 OPERATING ROOM	0	C		0 14, 332, 742		
53. 00 05300 ANESTHESI OLOGY	0	0		0 2, 611, 890		
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 40, 670, 059		
60. 00 06000 LABORATORY	0	0		0 28, 405, 883		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 3, 017, 896		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 3, 421, 755	0. 000000	
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 361, 551	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 193, 617		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 11, 501, 410		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 4, 432, 259		
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 3, 206, 393		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 8, 687, 426		
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0. 000000	77.00
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLINIC	0	-		0 152, 996		
90. 01 09001 SENI OR CARE	0	0		0 366, 182		90.01
90. 02 09002 GENERAL SURGERY	0	0		0 207, 169		
90. 03 09003 HARRI SON CRAWFORD HEALTHCARE	0	0		0 955, 476		
90. 04 09004 CORYDON MEDICAL ASSOCIATES	0	0		0 888, 440		
90. 05 09005 ORTHOPEDIC SURGERY - DR KLINE	0	0		0 1, 027, 597		
90. 06 09006 OBGYN - DR SAUER	0	0		0 307, 593		
90.07 09007 FIRST CAPITAL MEDICAL GROUP	0	0		0 1, 999, 568		
90.08 09008 SOUTH HARRISON FAMILY MEDICINE	0	0		0 702, 712		
90. 09 09009 PALN MANAGEMENT	0	0		0 118, 227		90.09
90. 10 09010 DERMATOLOGY	0	0		0 739, 238		
90. 11 09011 KI DS FI RST	0	0		0 2, 196, 552		
91.00 09100 EMERGENCY	0	C		0 34, 233, 616		91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	0	0		0 1, 892, 201	0.000000	92.00
OTHER REI MBURSABLE COST CENTERS			1			0.5.05
95. 00 09500 AMBULANCE SERVICES						95.00
200.00  Total (lines 50 through 199)	0	0	1	0 166, 630, 448	l	200.00

Health Financial Systems	HARRI SON COUNT	Y HOSPI TAL			In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE	RVICE OTHER PASS	Provider C	CN: 15-1331	Peri		Worksheet D	
THROUGH COSTS				To	n 01/01/2022 12/31/2022	Part IV Date/Time Pre	pared:
						5/26/2023 5:2	
			XVIII		Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	(	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program		Program	Program	
	to Charges	Charges	Pass-Throug		Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8		Costs (col. 9	
	7)	10.00	x col. 10)		10.00	x col. 12)	
ANCI LLARY SERVI CE COST CENTERS	9.00	10.00	11.00		12.00	13.00	
50. 00 05000 OPERATING ROOM	0.000000	350, 643		0	0	0	50.00
53. 00 05300 OPERATING ROOM 53. 00 05300 ANESTHESI OLOGY	0.000000	63, 441		0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.000000	275, 221		0	0	0	53.00
60. 00 06000 LABORATORY	0.000000	742, 426		0	0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0.000000	307,630		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	215, 581		0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0.000000	71, 951		0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0.000000	12,053		0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000	258, 813		0	0	0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	493, 560		0	0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0.000000	435, 027		0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0.000000	750, 414		0	0	0	73.00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0,000000	0,00,111		0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS	0.000000		<u> </u>				
90. 00 09000 CLINIC	0.000000	1, 704		0	0	0	90.00
90. 01 09001 SENI OR CARE	0. 000000	0		0	0	0	90.01
90. 02 09002 GENERAL SURGERY	0, 000000	657		0	o	0	90.02
90. 03 09003 HARRI SON CRAWFORD HEALTHCARE	0.000000	162		0	0	0	90.03
90. 04 09004 CORYDON MEDICAL ASSOCIATES	0.000000	148		0	0	0	90.04
90. 05 09005 ORTHOPEDIC SURGERY - DR KLINE	0. 000000	1, 372		0	0	0	90.05
90. 06 09006 0BGYN - DR SAUER	0. 000000	242		0	0	0	90.06
90.07 09007 FIRST CAPITAL MEDICAL GROUP	0.000000	369		0	0	0	90.07
90.08 09008 SOUTH HARRISON FAMILY MEDICINE	0. 000000	235		0	0	0	90.08
90. 09 09009 PALN MANAGEMENT	0. 000000	13		0	0	0	90.09
90. 10 09010 DERMATOLOGY	0.000000	3, 249		0	0	0	90.10
90. 11 09011 KIDS FIRST	0. 000000	298		0	0	0	90.11
91.00 09100 EMERGENCY	0. 000000	16, 134		0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0		0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS	<u>_</u>		<u>.</u>				
95. 00 09500 AMBULANCE SERVICES							95.00
200.00  Total (lines 50 through 199)		4,001,343		0	0	0	200.00

Health Financial Systems	HARRI SON COUN	TY HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST	Provider C		Peri od:	Worksheet D	
				From 01/01/2022		nored.
				To 12/31/2022	Date/Time Pre 5/26/2023 5:2	pared:
		Title	× XVIII	Hospi tal	Cost	
			Charges	nospi tui	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	· · · · · · · · · · · · · · · · · · ·	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	(	
	Part I, col. 9	· · · ·	Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 253066	C	2, 049, 79	95 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 027047	/ C	391, 48	37 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 097611	C	9, 189, 06	02 0	0	54.00
60. 00 06000 LABORATORY	0. 158226	C	5, 682, 10	3 3	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 260372	2 C	727, 53	36 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 231169	c c	700, 25	68 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 162234	C C	43, 05	50 O	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 078258	C C	27, 53	31 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 106644	C C	3, 191, 80	04 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 673389	c c	479, 11	7 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 436125	i C	498, 87	/8 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 354491	C	3, 227, 98	35 17, 575	0	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	C		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 659684		30, 51	1 0	0	90.00
90. 01 09001 SENI OR CARE	0. 785552	2 C	215, 51	3 0	0	90.01
90. 02 09002 GENERAL SURGERY	2. 388881	C	11, 69	09 0	0	90.02
90. 03 09003 HARRI SON CRAWFORD HEALTHCARE	0. 877231	C	5, 51	9 143	0	90.03
90. 04 09004 CORYDON MEDICAL ASSOCIATES	0. 682766	c C	69, 98	30 76	0	90.04
90. 05 09005 ORTHOPEDIC SURGERY - DR KLINE	0. 725060		24, 29		0	90.05
90. 06 09006 0BGYN - DR SAUER	0. 998111		4, 51		0	90.06
90. 07 09007 FIRST CAPITAL MEDICAL GROUP	0. 942481				0	90.07
90.08 09008 SOUTH HARRISON FAMILY MEDICINE	0. 725967		1 1 20		-	90.08
90. 09 09009 PALN MANAGEMENT	0. 061475		18		0	90.09
90. 10 09010 DERMATOLOGY	0. 394397		57, 94		0	90.10
90. 11 09011 KIDS FIRST	0. 666974					90.11
91.00 09100 EMERGENCY	0. 153983					91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	1. 145808	3 C	657, 67	/8 0	0	92.00
OTHER REI MBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0. 437916			0		95.00
200.00 Subtotal (see instructions)		C	33, 889, 77		0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges					_	000 00
202.00   Net Charges (line 200 - line 201)	I	C	33, 889, 77	26, 935	0	202.00

	Financial Systems	HARRISON COUN		CN. 1E 1001		u of Form CMS	-2002-
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CN: 15-1331	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Pr 5/26/2023 5:	epared 21 pm
				e XVIII	Hospi tal	Cost	_
			sts	_			
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.) 7.00	-			
	ANCI LLARY SERVI CE COST CENTERS	6.00	7.00				_
50.00	05000 OPERATING ROOM	518, 733	(				50.0
	05300 ANESTHESI OLOGY	10, 589					53.0
	05400 RADI OLOGY-DI AGNOSTI C	896, 954					53.0
	06000 LABORATORY						60.0
5. 00 5. 00	06500 RESPI RATORY THERAPY	899, 057					65.0
		189, 430	-				
6.00	06600 PHYSI CAL THERAPY	161, 878	(				66.
57.00	06700 OCCUPATI ONAL THERAPY	6, 984	(				67.
	06800 SPEECH PATHOLOGY	2, 155	(				68.
	06900 ELECTROCARDI OLOGY	340, 387	(				69.
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	322, 632	(				71.
	07200 I MPL. DEV. CHARGED TO PATIENT	217, 573	( ))				72.0
	07300 DRUGS CHARGED TO PATIENTS	1, 144, 292	6, 230	1			73.0
7.00	07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0					77.(
90.00	09000 CLINIC	20, 128	(				90. (
	09001 SENI OR CARE	169, 297					90.0
	09002 GENERAL SURGERY	27, 948					90.0
	09003 HARRI SON CRAWFORD HEALTHCARE	4, 841	125				90.
	09004 CORYDON MEDICAL ASSOCIATES	47, 780	52				90.
	09005 ORTHOPEDIC SURGERY - DR KLINE	17,612	(				90.
	09006 OBGYN - DR SAUER	4, 509	146	1			90.
	09007 FIRST CAPITAL MEDICAL GROUP	6, 714	32	1			90.
	09008 SOUTH HARRISON FAMILY MEDICINE	5, 265	123				90.
	09009 PALN MANAGEMENT	11	(				90.
	09010 DERMATOLOGY	22, 853					90.
	09011 KIDS FIRST	10, 496	3, 87				90.
	09100 EMERGENCY	1, 012, 164	410				91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	753, 573	410				92.
2.00	OTHER REIMBURSABLE COST CENTERS	155,575		1			72.0
95.00	09500 AMBULANCE SERVICES	0					95. (
200.00		6, 813, 855	11, 290				200.0
200.00 201.00		0, 013, 033	11,290	1			200.0
	Only Charges	0					201.0
		1	1				202.0

Health Financial Systems	HARRI SON COUN				u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-1331	Period: From 01/01/2022	Worksheet D Part V	
				To 12/31/2022	Date/Time Pre	
					5/26/2023 5:2	1 pm
· · · · · · · · · · · · · · · · · · ·			e XIX	Hospi tal	Cost	
			Charges	0.1	Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From Worksheet C.	Services (see inst.)	Reimbursed Services	Reimbursed Services Not	(see inst.)	
	Part I, col. 9	· · · ·	Subject To	Subject To		
			Ded. & Coins	-		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 253066	C	116, 87	'9 O	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 027047	0	99, 38	85 O	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 097611	0	585, 21	6 0	0	54.00
60. 00 06000 LABORATORY	0. 158226	C	434, 23	8 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 260372	0	45, 82	2 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 231169	0	13, 97	1 0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0. 162234	0	37	5 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 078258	0	6, 52	27 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 106644	0	56, 09	06 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 673389	C	40, 60	04 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 436125	C	)	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 354491	0	114, 35	i3 0	0	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS	1	1	1			
90. 00 09000 CLINIC	0. 659684			0 0	-	
90. 01 09001 SENI OR CARE	0. 785552			0 0	-	
90. 02 09002 GENERAL SURGERY	2. 388881	0	-,		-	90.02
90. 03 09003 HARRI SON CRAWFORD HEALTHCARE	0. 877231				0	
90. 04 09004 CORYDON MEDI CAL ASSOCI ATES	0. 682766				0	90.04
90. 05 09005 ORTHOPEDIC SURGERY - DR KLINE	0. 725060		20,00		0	90.05
90. 06 09006 0BGYN - DR SAUER	0. 998111	0	0,,0,		0	90.06
90. 07 09007 FIRST CAPITAL MEDICAL GROUP	0. 942481	0		0 0	0	
90. 08 09008 SOUTH HARRI SON FAMILY MEDICINE	0. 725967	0		0 0	0	90.08
90. 09 09009 PALN MANAGEMENT	0. 061475			0 0	0	
90. 10 09010 DERMATOLOGY	0. 394397	0		0 0	0	90.10
90. 11 09011 KIDS FIRST	0. 666974			0 0	0	•
91.00 09100 EMERGENCY	0. 153983					91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	1. 145808	C	1	0 0	0	92.00
95. 00 09500 AMBULANCE SERVICES	0. 437916	0	295, 93	4		95.00
200.00 Subtotal (see instructions)	0. 43/910				_	200.00
201.00 Less PBP Clinic Lab. Services-Program			2,031,7	0 0		200.00
Only Charges						201.00
202.00 Net Charges (line 200 - line 201)		c c	2, 631, 71	9 0	0	202.00
	T		1 2,001,7	1	1 0	1-02.00

Heal th	Financial Systems	HARRI SON COUN	NTY H	IOSPI TAL		In Lie	u of Form CMS	-2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		Provider CC		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Pr 5/26/2023 5:	21 pm
				Ti tl	e XIX	Hospi tal	Cost	
			<u>sts</u>					
	Cost Center Description	Cost		Cost				
		Reimbursed		eimbursed				
		Servi ces		rvices Not				
		Subject To		ubject To				
		Ded. & Coins.		. & Coi ns.				
		(see inst.)	(S	<u>ee inst.)</u>				
		6.00		7.00				_
	ANCI LLARY SERVICE COST CENTERS	00.570						
50.00	05000 OPERATING ROOM	29, 578		0				50.00
53.00	05300 ANESTHESI OLOGY	2, 688		0				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	57, 124		0				54.00
60.00	06000 LABORATORY	68, 708		0				60.00
65.00	06500 RESPI RATORY THERAPY	11, 931		0				65.00
66.00	06600 PHYSI CAL THERAPY	3, 230		0				66.00
67.00	06700 OCCUPATI ONAL THERAPY	61		0				67.00
68.00	06800 SPEECH PATHOLOGY	511		0				68.00
	06900 ELECTROCARDI OLOGY	5, 982		0				69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	27, 342		0				71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	1	0				72.00
	07300 DRUGS CHARGED TO PATIENTS	40, 537		0				73.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	)	0				77.00
	OUTPATIENT SERVICE COST CENTERS	i						
90.00	09000 CLI NI C	0	1	0				90.00
90.01	09001 SENI OR CARE	0	1	0				90.01
90.02	09002 GENERAL SURGERY	9, 018		0				90.02
90. 03	09003 HARRI SON CRAWFORD HEALTHCARE	12, 782		0				90.03
90.04	09004 CORYDON MEDICAL ASSOCIATES	2, 596	b l	0				90.04
90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	20, 349	9	0				90.05
90.06	09006 OBGYN - DR SAUER	37, 508	3	0				90.06
90.07	09007 FIRST CAPITAL MEDICAL GROUP	0		0				90.07
90.08	09008 SOUTH HARRISON FAMILY MEDICINE	0		0				90.08
90.09	09009 PAIN MANAGEMENT	0		0				90.09
90.10	09010 DERMATOLOGY	0		0				90.10
90.11	09011 KIDS FIRST	0		0				90.11
91.00	09100 EMERGENCY	113, 105	5	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0				92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVI CES	129, 594	ł					95.00
200.00	Subtotal (see instructions)	572, 644	1	0				200.00
201.00	Less PBP Clinic Lab. Services-Program	0	D					201.00
	Only Charges							
202.00	Net Charges (line 200 - line 201)	572, 644	t	0				202.00

INPUI	Financial Systems HARRISON COUNTY ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1331	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2022 To 12/31/2022	Date/Time Pre	pare
		Title XVIII	Hospi tal	5/26/2023 5:2 Cost	1 pm
	Cost Center Description		- Hospi tui		
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS			0.074	
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			3, 971 3, 914	1.
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	had dave)		3, 009	4
00	Total swing-bed SNF type inpatient days (including private ro	5 7	er 31 of the cost	3, 009 57	
	reporting period				
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roo	om days) through December	- 31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private roo	om davs) after December ?	R1 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)			0	
00	Total inpatient days including private room days applicable t newborn days) (see instructions)	to the Program (excluding	g swing-bed and	854	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private m	room days)	57	10
. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of		coom days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, e		oom days) arter	0	
. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	IX only (including privat	te room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI	IX only (including privat	te room days)	0	13
00	after December 31 of the cost reporting period (if calendar y				
. 00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 (	of the cost		1 17
. 00	reporting period	C			''
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost		18
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	250.44	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	as after December 31 of t	the cost	250. 44	20
. 00	reporting period		the cost	230.44	20
. 00	Total general inpatient routine service cost (see instruction	2		9, 513, 274	
2.00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	per 31 of the cost report	ting period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reportin	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	na period (line	0	24
	7 x line 19)	•	0 1 1		
6. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	g period (line 8	0	25
. 00	Total swing-bed cost (see instructions)			136, 554	
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		9, 376, 720	27
8. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	28
. 00	Private room charges (excluding swing-bed charges)			0	
. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷line 28)		0 0. 000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	32
. 00 . 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	inus line 33)(see instruc	stions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x li	, ,	50101137	0.00	
5.00	Private room cost differential adjustment (line 3 x line 35)	and private rest i "	fforontial (1)	0	36
5. 00 5. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	TTERENTIAL (line	9, 376, 720	37
5.00			1		
. 00 . 00	27 minus Line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
. 00 . 00 . 00	27 minus Line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			2 305 60	2.2
5. 00 5. 00	27 minus Line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	e instructions)		2, 395. 69 2, 045, 919	

From 01/07/2021         Entry Interference         Entry Interference           Cost Center Mescription         1001         Namage interference         Exception           1:00         1:00         0 <td< th=""><th></th><th>Financial Systems ATION OF INPATIENT OPERATING COST</th><th>HARRI SON COUN</th><th>TY HOSPITAL Provider C</th><th></th><th>eriod:</th><th>u of Form CMS-: Worksheet D-1</th><th></th></td<>		Financial Systems ATION OF INPATIENT OPERATING COST	HARRI SON COUN	TY HOSPITAL Provider C		eriod:	u of Form CMS-: Worksheet D-1	
Cost Center Description         Total nature of Cost 200         Total 200         Cost 200         Average Peri Cost 200         Program Cost Cost 200         Cost 200         Average Peri Cost 200         Av					Т	0 12/31/2022		
42.00         UNESTEW (11 He V & XIX only)         0         <		Cost Center Description	Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
Intensist Carr Type Inpatient Heightan Units         Init         Ini	42.00	NURSERY (title V & XIX only)						42.00
44.00       CORONARY CASE UNIT       44.00         44.00       Coronal Properties (Coronal Coronal Corona Coronal Coronal Coronal Coronal Coronal Coronal Coronal Coronal		Intensive Care Type Inpatient Hospital Units						
45 col BURN INTENSIVE CARE UNIT       45 col         46 col SURCIAL INTENSIVE CARE (INTERLIC)       45 col         47 col       SURCIAL INTENSIVE CARE (SPECIP)         48 col Forgram Inpatient ancillary service cost (Matt. D-3, col. 3, line 200)       1, col, col, col, col, col, col, col, col			1, 296, 407	322	4, 026. 11	84	338, 193	
42.00       Differs SPECIAL CARE (SPECIFY)       47.00         43.00       Direct Center Description       1.00         48.00       Program inpatitiont ancillary source cost (Werk, D.3, col. 3, line, 200)       1.00         49.01       Program inpatitiont ancillary source cost (Werk, D.3, col. 5, Line, 200)       1.00         49.05       Total Program inpatitiont costs (sour of lines of line 50, col. 5, Line, 200)       3, 665, 807         50.00       Pass through costs applicable to Program inpatient ancillary services (from West, D, sum of Parts II       0         51.00       Total Program excludable cost (sum of lines 50 and 51)       0       52.00         52.00       Total Program excludable cost (sum of lines 50 and 51)       0       52.00         53.00       Program excludable cost (sum of lines 50 and 51)       0       52.00         53.00       Program excludable cost (sum of lines 50 and 50.22)       0.00       55.00         54.00       Program excludable cost (sum of lines 50 and target amount (line 56 an and target amount (line 57 s sum of lines 55, col. 1 and 55, col. 20)       0.00       55.00         55.01       Target amount (line 54 s sum of lines 55, col. 1 and 55, col. 1 and 55, col. 20)       0.00       55.00         56.02       Total Program inscritters of subscritters of subscritters of subscritters of subscritters of subscritters of subscritters of subscriters of subscritters of s								
Cost Conter Description         1.00           45.00         Program input end (i) using the event (Mark shout D-6, Part 111, Time 10, column 1)         1.201, 697, 48.00           45.00         Program input end (i) using the event (Mark shout D-6, Part 111, Time 10, column 1)         3.38, pp1 49.00           46.00         Program input end (i) using the event (Mark shout D-6, Part 111, Time 10, column 1)         3.38, pp1 49.00           47.00         Program input end (i) using the event (Mark shout D-6, Part 111, Time 10, column 1)         5.100           47.01         Program input end (i) using the event (Mark shout D-6, Part 111, Column 1)         0.00           47.01         Program input end (i) using the event (Mark shout D-6, Part 111, Column 1)         0.00           47.01         Program input end (i) using the event (Mark shout D-6, Part 111, Column 1)         0.00           47.01         Program input end (i) using the event (Mark shout D-6, Part 111, Column 1)         0.00           47.01         Program input end (i) using the event (Mark shout D-6, Part 111, Column 1)         0.00           47.01         Program input end (i) using the event (Mark shout D-6, Part 111, Column 1)         0.00           47.01         Program input end (i) using the event (Mark shout D-6, Part 111, Column 1)         0.00           47.01         Program input end (i) (I								1
48.00       Program inpatient anciliary service cost (West, 0-3, col. 3, line 200)       1, 201, 665       48.01         48.00       Program inpatient costs (sum of lines 41 through 8.01) (see instructions)       3, 685, 607       49.00         40.00       Possibility (see instructions)       3, 685, 607       49.00         40.00       Possibility (see instructions)       3, 685, 607       49.00         40.00       Possibility (see instructions)       5, 600       51.00         40.01       Possibility (see instructions)       51.00       51.00         40.01       Possibility (see instructions)       0.05.00       55.00       50.00       55.00       50.00       55.00	47.00	· · · · · · · · · · · · · · · · · · ·						47.00
48.01       Program inpatient cellular therapy acquisition cost (Workheet D-6, Part III, Line 10, colum 1)       3, 585, 607         49.00       Testal Program inpatient costs (sum of lines 41 through 48.01)(see instructions)       3, 585, 607         50.00       Pass Through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts I and on and 10)       51.00         52.00       Testal Program inpatient operating cost occluding capital related, non-physician anesthetist, and on 53.00       53.00         53.00       Testal Program inpatient applicable to Program inpatient accluding to accluding capital related, non-physician anesthetist, and on 54.00       54.00         54.00       Porgram indicate accuration operating cost occluding capital related, non-physician anesthetist, and on 55.00       54.00         55.01       Darget amount (per discharges       0.00       55.01         55.02       Darget amount (per discharge       0.00       55.01         56.01       Derget amount (per discharge       0.00       55.02         57.02       Darget amount (per discharge       0.00       56.00         58.00       Brons paynent discharges       0.00       56.00         50.01       Darget amount (per discharges       0.00       56.00         50.01       Darget amount (per discharges       0.00       56.00         50.01       Darget	48.00	Dragram inpatient encillant convice cost (W/	+ D 2 col 2	) Line 200)	_			49.00
49:00       Total Program inpatient costs (sum of lines 4.1 through 4.01)(see instructions)       3, 585, 807       49.00         ANS. THROUGH COST. ADJOINTING       Sum of Parts 1 and 10.01       50.00       Pass through costs applicable to Program inpatient routine services (from Wkst. 0, sum of Parts 1 and 10.01       51.00         51.00       Total Program excludeble cost (sum of lines 50 and 51)       52.00       52.00         52.00       Total Program excludeble cost (sum of lines 50 and 51)       52.00         53.00       Total Program excludeble cost (sum of lines 50 and 51)       52.00         53.00       Torget amount (line Sinchrege       0.01         54.00       Torget amount (line Sinchrege       0.00         55.01       Target amount (line 53 sum of lines 55, 50, and 55.02)       0.00         56.00       Torget amount (line 54 sum of lines 55, fo1, and 55.02)       0.00         57.00       Difference between all scharge (contractor use only)       0.00         58.00       Torget amount (line 53, line 54, or line 55 from the cost reporting period ending 1996, 0.00       0.00         59.01       Torget amount (line 53, line 54, or line 55 from prior year cost reporting period (see 10.00       0.00         59.01       Target amount (line 53, line 54, or line 55 from prior year cost reporting period (see 10.00       0.00         61.00       Continuous inprovement bo					III, line 10,	column 1)		1
90.00       Pass through costs applicable to Program inpatient routine services (from Wist. D. sum of Parts I and Pass through costs applicable to Program inpatient ancillary services (from Wist. D. sum of Parts II       0       51.00         51.00       Pess through costs applicable cost (sum of Films 50 and 51)       0       52.00         53.00       Total Program inpatient operating cost oxcluding capital related, non-physician anesthetist, and medication costs (line 49 and scharge       0       53.00         54.00       Program films films in the 52)       0       0.00       55.00       0       54.00       55.00       55.00       56.00       55.00       56.00       55.00       55.00       56.00       55.00       56.00       55.00       56.00 <td< td=""><td></td><td>Total Program inpatient costs (sum of lines 4</td><td></td><td></td><td></td><td></td><td>3, 585, 807</td><td>1</td></td<>		Total Program inpatient costs (sum of lines 4					3, 585, 807	1
111)       111       111         111)       111       111       111         1110       111       111       111       111         1110       111       111       111       111       111         1110       111	50 00		atient routine	services (from	Wkst D sum	of Parts L and	0	50.00
and IV)       and IV)       and IV)         20.0 Total Program excludeble cost (sum of lines 50 and 51)       53.00         53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medication costs (line 40 mins line 22)       54.00         54.00 Program discharges       0.00         55.01 Program discharges       0.00         56.02 Program discharges       0.00         56.03 Program discharges       0.00         56.04 Adjustent anount per discharge contractor use only)       0.00         56.04 Adjustent anount per discharge contractor use only)       0.00         56.07 Di Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0.00         58.00 Bonus payment (see instructions)       0.00         59.01 Freded costs (lessor of line 53 - line 54, or line 54 is less than the lowest or lines 55 plus of 50.01 the merket basket)       0.00         60.00       Expected costs (lessor of 100 to 51 will be amount by which operating cost line 55, oflice 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 55, otherwise entructions)       0         61.00       Main addit linguitant routine costs through December 31 of the cost reporting period (See 10 structions)       0         62.00       Main addit linguitant routine costs through December 31 of the cost reporting period (See 10 structions)       0         64.00		111)						
52.00       Total Program excludable cost (sum of Lines 50 and 51)       0       52.00       Total Program institution operating capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)       0 <td>51.00</td> <td>5 11 5 1</td> <td>atient ancillar</td> <td>ry services (fr</td> <td>om Wkst. D, su</td> <td>m of Parts II</td> <td>0</td> <td>51.00</td>	51.00	5 11 5 1	atient ancillar	ry services (fr	om Wkst. D, su	m of Parts II	0	51.00
medical education costs (line 49 minus line 52)         1           TARGET AMMART AND LINT COMPUTATION         54.00         54.00         Forgram discharges         0         54.00         55.00         55.00         55.00         55.00         55.00         0.00         59.00         0.00         59.00         0.00         59.00         0.00         59.00         0.00         59.00         0.00         59.00         0.00         50.01         0.00         50.00         0.00         50.00         0.00         50.00         0.00         50.00         0.00         50.00         0.00         50.00         0.00         50.00         0.00         50.00         0.00         60.00         0.00	52.00		50 and 51)				0	52.00
TARGET AMOUNT AND LIMIT COMPUTATION       0         51:00       Target amount per discharge       0         51:01       Target amount per discharge       0.00         55:02       Target amount per discharge       0.00         55:03       Perment adjustment amount per discharge       0.00         55:04       Target amount (inc 54, son of lines 55, 55.01, and 55.02)       0       0.00         56:05       Difference between adjusted inputient operating cost and farget amount (line 56 minus line 53)       0       58.00         57:00       Difference between adjusted inputient operating cost and farget amount (line 56 minus line 53)       0       58.00         59:00       Ternded costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the nerket basket)       0.00       0         60:00       Continuous inprovement borus 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 54 and 16.00       0 <td< td=""><td>53.00</td><td></td><td></td><td>elated, non-phy</td><td>sician anesthe</td><td>tist, and</td><td>0</td><td>53.00</td></td<>	53.00			elated, non-phy	sician anesthe	tist, and	0	53.00
55.00       Target amount per discharge       0.00       55.00       0.00       55.01       0.00       0.00       0.00       0.00<			52)					-
55.01       Permanent adjustment amount per discharge (contractor use only)       0.00       55.02         55.02       Adjustment amount per discharge (contractor use only)       0.00       55.01         50.00       Trenece between adjusted inpotient operating cost and target amount (line 56 minus line 53)       0.00       55.02         50.00       Difference between adjusted inpotient operating cost and target amount (line 56 minus line 53)       0.00       55.00         50.00       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       Cost invasi imp 50 minus payment (frine 54 + line 54, is less than the lowest of lines 55 plus of the amount by which operating costs (line of 1.00       0.10.00       61.00         62.00       Relief payment (see instructions)       0       62.00       62.00       62.00       62.00       62.00       63.00         63.00       Milowalbe Inpatient cost plus incentive payment (see instructions)       0       64.00       66.00       65.00         64.00       Medicare swing-bed SK inpatient routine costs after December 31 of the cost reporting period (See instructions)       0       65.00         65.00       Total medicare swing-bed KF inpatient routine costs after December 31 of the cost reporting period (See instructions)       64.00       64.00         66.00								
55. 02       Adjustment amount per discharge (centractor use only)       0.00       55. 00         50. 00       Target amount (in Fe 54 x sum of lines 55, 50. 0, and 55. 02)       0.00       56. 00         57. 00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0       57. 00         59. 00       Trended costs (lesser of line 53 + line 54, or line 55 from the cost report, updated by the market basket)       0.00       60. 00         60. 00       Expected costs (lesser of line 53 + line 54, or line 56 rise amount (line 56), otherwise expected costs (lesser of line 53 + line 54, is less than the lowest of lines 55 plus 50, or line 60, enter the lesser of 50% of the amount by which operating costs (line 55, 00, enter the lesser of 50% of the amount by which operating costs (line 50, otherwise expected costs (lines 54 x 40), or line 60 enter the lines 51 enter the lesser of 50% of the amount by which operating costs (line 50, otherwise expected costs (lines 54 x 40), or line 60 enter the lines 51 enter 51 e								1
57.00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0       57.00         58.00       Borus payment (see instructions)       0       57.00         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 lines 54 + line 54 is less than the lowest of lines 55 plus 53 are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enstructions       0       62.00         62.00       Ref payment (see instructions)       0       63.00       0       66.00         64.00       Medicare swing-bed SWF inpatient routine costs through December 31 of the cost reporting period (See instructions)       136,554       64.00         65.00       Medicare swing-bed SWF inpatient routine costs through December 31 of the cost reporting period (See instructions)       136,554       66.00         66.00       Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (See instructions)       67.00       67.00         67.00       Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (See instructions) </td <td></td> <td></td> <td>use only)</td> <td></td> <td></td> <td></td> <td></td> <td></td>			use only)					
58.00       Bonus payment (see instructions)       0       58.00       0 <td></td> <td></td> <td></td> <td></td> <td>ing E( minug l</td> <td>ing (2)</td> <td>-</td> <td>1</td>					ing E( minug l	ing (2)	-	1
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 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       63.00         64.00       Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tile XVIII only)       0       63.00         65.00       Finder swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See (Sing and set in true) (Sing and set in the cost reporting period (See (Sing and set in the cost reporting period (See (Sing and set in the cost reporting period (See (Sing and set in the cost reporting period (See (Sing and set in the cost reporting period (See (Sing and set in the cost reporting period (See (Sing and set in the cost set in the cost reporting period (See (Sing and set in the cost reporting period (See (Sing and set in the cost reporting period (See (Sing and set in the cost reporting period (See (Sing and set in the cost reporting period (See (Sing and set in the cost reporting period (See (Sing and set in the cost reporting period (See (Sing and set in the cost reporting period (See (Sing and set in the cost reporting period (See (Sing and			ng cost and ta	irget amount (i	The so minus i	The 53)	-	
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 53) are less than expected costs (line lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line s54 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       63.00         64.00       Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)       136.554       64.00         65.00       Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See (line 12 x line 19)       136.554       66.00         60.01       Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (See (line 14 v II x) swing-bed NF inpatient routine costs after December 31 of the cost reporting period (See (line 11 title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0       67.00         60.00       Total title V or XIX swing-bed NF inpatient routine costs (line 7 + line 2)       70.00       71.00         70.00       Title V or XIX swing-bed NF inpatient routine costs (line 7 + line 68)       0       69.00         70.00       Skilled nursing facility/OFLID routine service cost (lin		Trended costs (lesser of line 53 ÷ line 54, d	or line 55 from	n the cost repo	rting period e	ndi ng 1996,	0.00	59.00
market basket)       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         63.00       PROGRAM INPATIENT ROUTINE SWING BED COST       0       63.00         64.00       Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) it let XVII in only).       0       65.00         65.00       Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions)       136, 554       64.00         66.00       Total Medicare swing-bed NF inpatient routine costs after December 31 of the cost reporting period (See CAH)       0       65.00         67.00       Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (See CAH)       0       67.00         68.00       Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (See CAH)       0       67.00         69.00       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0       67.00         70.00       Skilled nursing facility/other nursing facility/Othr/ID Total heads       70.00       71.00         70.00       <	60 00		or line 55 fro	m prior vear c	ost report up	dated by the	0.00	60 00
55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line factor)       55.01, or line 59, or line 60, enter the lesser of 50% of the amount (line 56), otherwise enter zero. (see instructions)       0         62.00       Relief payment (see instructions)       0       62.00         63.00       Allowable Inpatient cost plus incentive payment (see instructions)       0       62.00         64.00       Medicare swing-bed SWF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)       136,554       64.00         65.00       Medicare swing-bed SWF inpatient routine costs (line 64 plus line 65) (title XVIII only); for 136,554       66.00       65.00         66.00       Total Medicare swing-bed SWF inpatient routine costs after December 31 of the cost reporting period (See (line 12 × line 19)       0       67.00         68.00       Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0       68.00         70.00       Skiled nursing facility/toter nursing facility/tof/LID routine service cost (line 71)       70.00         70.00       Skiled nursing facility/toter nursing facility/tof/LID routine service cost (line 70 + line 2)       71.00         71.00       Adjusted general inpatient routine service costs (line 72 + line 2)       70.00         70.00       Relied nursing facility/toter nursing facility/tof/LID routine service cost (line 71.10 outin 70.00       73.00		market basket)		. ,		5		
62:00       Relief payment (see instructions)       0       62:00       62:00       0       62:00       63:00       64:00       Medicare swing-bed SMF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tilt & XUII only)       63:00       64:00         64:00       Medicare swing-bed SMF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tilt & XUII only)       64:00       64:00         65:00       Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(tilt & XVIII only); for CAH, see instructions       64:00       65:00         66:00       Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)       67:00       67:00         67:00       Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)       67:00       68:00         68:00       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0       68:00         69:00       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0       69:00         70:00       Total title V or XIX swing-bed NF inpatient routine costs (line 7 + line 68)       0       69:00         70:00       Total title V or XIX swing-bed NF inpatient routine costs (line 7 + line 73)       71:00       71:00         71:00       Aggr	61.00	55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 $\times$	ser of 50% of t	he amount by w	hich operating	costs (line	0	61.00
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83.00Reasonable inpatient routine service costs (see instructions)83.0084.00Program inpatient ancillary services (see instructions)84.0085.00Utilization review - physician compensation (see instructions)85.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)85.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST90587.00Total observation bed days (see instructions)90588.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)2,395.69				)				
85.00Utilization review - physician compensation (see instructions)85.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)86.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST87.0087.00Total observation bed days (see instructions)90588.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)2,395.69		•						
86.00Total Program inpatient operating costs (sum of lines 83 through 85)86.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST87.0087.00Total observation bed days (see instructions)90588.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)2,395.69								1
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST87.00Total observation bed days (see instructions)90587.0088.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)2,395.6988.00								1
88.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)2, 395.6988.00		PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST	~ /				
				line 2)				1
		, , , , , , , , , , , , , , , , , , ,						

Health Financial Systems	HARRISON COUN	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 5:2	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	765,009	9, 513, 274	0. 08041	5 2, 168, 099	174, 348	90.00
91.00 Nursing Program cost	0	9, 513, 274	0.00000	0 2, 168, 099	0	91.00
92.00 Allied health cost	0	9, 513, 274	0.00000	0 2, 168, 099	0	92.00
93.00 All other Medical Education	0	9, 513, 274	0. 00000	0 2, 168, 099	0	93.00

	Financial Systems HARRISON COUNTY ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1331	Peri od: From 01/01/2022	u of Form CMS-2 Worksheet D-1	
			To 12/31/2022	Date/Time Prep 5/26/2023 5:2	
	Cost Center Description	Title XIX	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATI ENT DAYS				
00	Inpatient days (including private room days and swing-bed day			3, 971	1. 2.
00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		rivate room davs.	3, 914 0	2. 3.
	do not complete this line.			0.000	
00 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	3, 009 57	4. 5.
00	reporting period	<u> </u>		0,	0.
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6.
00	Total swing-bed NF type inpatient days (including private roo	om days) through December	r 31 of the cost	0	7.
~~	reporting period				0
00	Total swing-bed NF type inpatient days (including private roc reporting period (if calendar year, enter 0 on this line)	om days) arter December s	31 OF THE COST	0	8.
00	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	84	9.
. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII c	anly (including privato y	coom dovic)	0	10.
. 00	through December 31 of the cost reporting period (see instruc		oom uays)	0	10.
. 00	Swing-bed SNF type inpatient days applicable to title XVIII c	only (including private m	room days) after	0	11.
. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12.
. 00	through December 31 of the cost reporting period	in grand and grand and grand		0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
. 00	Medically necessary private room days applicable to the Progr			0	14
. 00	Total nursery days (title V or XIX only)	, <u> </u>	5,	698	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			20	16
. 00	Medicare rate for swing-bed SNF services applicable to servic	 ces through December 31 d	of the cost		17
	reporting period		+h+		10
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	tes after December 31 of	the cost		18
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	250.44	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	the cost	250.44	20
	reporting period				
. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting pariod (line	9, 513, 274	21 22
. 00	5 x line 17)	Jei Si Oi the Cost report	ting period (inte	0	22
. 00	Swing-bed cost applicable to SNF type services after December	<sup>-</sup> 31 of the cost reportir	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	na period (line	0	24
	7 x line 19)	•	51 (		
. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	g period (line 8	0	25
. 00	Total swing-bed cost (see instructions)			136, 554	26
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		9, 376, 720	27
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be		narges)	0	28
	Private room charges (excluding swing-bed charges)		lar goo)	0	29
. 00	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	31
	Average private room per diem charge (line 29 ÷ line 3)			0.00	32
. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	nuc line 22) (or i	ations)	0.00	33
. 00 . 00	Average per diem private neem change d'ff	, ,	50005)	0.00	34
. 00 . 00 . 00	Average per diem private room charge differential (line 32 mi	no 21)		0.00	35
. 00 . 00 . 00 . 00	Average per diem private room cost differential (line 34 x li	ne 31)		^	
. 00 . 00 . 00 . 00			fferential (line	0 9, 376, 720	36 37
. 00 . 00 . 00 . 00 . 00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36)		fferential (line	-	
. 00 . 00 . 00 . 00 . 00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	and private room cost di	fferential (line	-	
. 00 . 00 . 00 . 00 . 00 . 00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di JUSTMENTS	fferential (line	-	37 38
2. 00 3. 00 3. 00 5. 00 5. 00 7. 00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	and private room cost di JUSTMENTS e instructions) e 38)	fferential (line	9, 376, 720	37 38

	Financial Systems ATION OF INPATIENT OPERATING COST	HARRI SON COUNT	Provider C	CN: 15-1331	Period:	worksheet D-1	
					From 01/01/2022 To 12/31/2022		
	Cost Center Description	Total Inpatient Costl	Total			Cost Program Cost (col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
42.00	NURSERY (title V & XIX only)	536, 934	698				42.00
43.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	1, 296, 407	322	4, 026. 1	11 0	0	43.00
44.00	CORONARY CARE UNI T	1, 270, 407	522	4, 020.	0		44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGI CAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description			1			47.00
40,00						1.00	10.00
48.00 48.01	Program inpatient ancillary service cost (Wks Program inpatient cellular therapy acquisition			III line 10	column 1)	76, 819 0	•
49.00	Total Program inpatient costs (sum of lines 4				001 dilli 1)	293, 442	
F0 00	PASS THROUGH COST ADJUSTMENTS				f. Danta I. and		
50.00	Pass through costs applicable to Program inpa	itient routine s	services (trom	IWKST. D, SUN	I OT Parts I and	0	50.00
51.00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	0	51.00
52.00	and IV) Total Program excludable cost (sum of lines {	(0, and, 51)				0	52.00
53.00	Total Program inpatient operating cost exclude		lated, non-phy	sician anesth	netist, and	0	53.00
	medical education costs (line 49 minus line 5	52)					
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55.00	Target amount per discharge					0.00	
55.01	Permanent adjustment amount per discharge					0.00	•
55.02 56.00	Adjustment amount per discharge (contractor u Target amount (line 54 x sum of lines 55, 55.					0.00	55.02 56.00
57.00	Difference between adjusted inpatient operati		rget amount (I	ine 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 updated and compounded by the market basket)	or line 55 from	the cost repo	orting period	ending 1996,	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 from	m prior year c	ost report, ι	updated by the	0.00	60.00
61.00	market basket) Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less	ng costs (İine	0	61.00			
	53) are less than expected costs (lines 54 x enter zero. (see instructions)	60), 01 I % 01	the target an	iount (inte se	b), otherwise		
62.00	Relief payment (see instructions)					0	
63.00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63.00
64.00	Medicare swing-bed SNF inpatient routine cost	s through Decer	mber 31 of the	e cost reporti	ng period (See	0	64.00
45 00	instructions)(title XVIII only)	c ofter Decemb	ar 21 of the $c$	act reporting	n pariod (Saa	0	65.00
65.00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	s arter Decembe		σειτεροιτιτίς	j period (see	0	05.00
66.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line d	64 plus line 6	o5)(title XVII	I only); for	0	66.00
67.00	CAH, see instructions Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	of the cost re	eporting period	0	67.00
	(line 12 x line 19)	5					
68.00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after De	ecember 31 of	the cost repo	orting period	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient i	routine costs (I	line 67 + line	e 68)		0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU						1 70 00
70.00 71.00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co						70.00
72.00	Program routine service cost (line 9 x line 3						72.00
73.00 74.00	Medically necessary private room cost applica Total Program general inpatient routine servi	0	•				73.00
75.00	Capital -related cost allocated to inpatient i				Part II, column		75.00
7/ 00	26, line 45)	2)					7/ 00
76.00 77.00	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						76.00
78.00	Inpatient routine service cost (line 74 minus						78.00
79.00	Aggregate charges to beneficiaries for excess	• •		· · · · · · · · · · · · · · · · · · ·	$u_{\rm c}$ lips 70)		79.00
80.00 81.00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		JST THE CATION	ι (iine /δ mir	1US III (7)		80.00 81.00
82.00	Inpatient routine service cost limitation (li	ne 9 x line 81)					82.00
83.00 84.00	Reasonable inpatient routine service costs (see ins		s)				83.00
84.00 85.00	Program inpatient ancillary services (see ins Utilization review - physician compensation		ns)				84.00 85.00
86.00	Total Program inpatient operating costs (sum	of lines 83 th					86.00
87.00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					905	87.00
88.00	Adjusted general inpatient routine cost per o		line 2)			2, 395. 69	
89.00	Observation bed cost (line 87 x line 88) (see	e instructions)				2, 168, 099	89.00

Health Financial Systems	HARRISON COUN	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 5:2	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	765,009	9, 513, 274	0. 08041	5 2, 168, 099	174, 348	90.00
91.00 Nursing Program cost	0	9, 513, 274	0.00000	0 2, 168, 099	0	91.00
92.00 Allied health cost	0	9, 513, 274	0.00000	0 2, 168, 099	0	92.00
93.00 All other Medical Education	0	9, 513, 274	0. 00000	0 2, 168, 099	0	93.00

Health Financial Systems	HARRISON COUNTY HOSPITA	۹L			In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provid	ler C	CN: 15-1331	Pe	eri od:	Worksheet D-3	
					om 01/01/2022		
				To	12/31/2022	Date/Time Pre	
						5/26/2023 5:2	1 pm
		Title	XVIII	Ι.,	Hospi tal	Cost	
Cost Center Description			Ratio of Cos		Inpati ent	Inpati ent	
			To Charges		Program	Program Costs	
					Charges	(col. 1 x col.	
						2)	
			1.00		2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDIATRICS					1, 311, 204		30.00
31. 00 03100 I NTENSI VE CARE UNI T					245, 196		31.00
43. 00 04300 NURSERY							43.00
ANCILLARY SERVICE COST CENTERS			1				
50.00 05000 OPERATI NG ROOM			0. 2530	66	350, 643	88, 736	50.00
53.00 05300 ANESTHESI OLOGY			0. 0270	47	63, 441	1, 716	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C			0. 0976	11	275, 221	26, 865	54.00
60. 00 06000 LABORATORY			0. 1582	26	742, 426	117, 471	60.00
65. 00 06500 RESPI RATORY THERAPY			0. 2603	72	307, 630	80, 098	65.00
66. 00 06600 PHYSI CAL THERAPY			0. 2311		215, 581	49, 836	66.00
67.00 06700 OCCUPATI ONAL THERAPY			0. 1622		71, 951	11, 673	
68.00 06800 SPEECH PATHOLOGY			0.0782		12,053	943	68.00
69. 00 06900 ELECTROCARDI OLOGY			0. 1066		258, 813	27,601	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0.6733		493, 560	332, 358	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT			0. 4361		435, 027	189, 726	
73. 00 07300 DRUGS CHARGED TO PATIENTS			0. 3544		750, 414	266, 015	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION			0.0000		/ 50, 414	200, 015	77.00
OUTPATIENT SERVICE COST CENTERS			0.0000	00	0	0	//.00
90. 00 09000 CLINIC			0.6596	0 1	1, 704	1, 124	90.00
90. 01 09001 SENI OR CARE			0. 7855		1, 704	1, 124	90.00
90. 02 09002 GENERAL SURGERY			2. 3888		-		
					657	1, 569	90.02
90. 03 09003 HARRI SON CRAWFORD HEALTHCARE			0.8772		162	142	90.03
90. 04 09004 CORYDON MEDICAL ASSOCIATES			0.6827		148	101	90.04
90. 05 09005 ORTHOPEDIC SURGERY - DR KLINE			0.7250		1, 372	995	90.05
90. 06 09006 0BGYN - DR SAUER			0. 9981		242	242	90.06
90. 07 09007 FIRST CAPITAL MEDICAL GROUP			0.9424		369	348	90.07
90. 08 09008 SOUTH HARRISON FAMILY MEDICINE			0. 7259		235	171	90.08
90. 09 09009 PALN MANAGEMENT			0.0614		13	1	90.09
90. 10 09010 DERMATOLOGY			0. 3943		3, 249	1, 281	90.10
90. 11  09011  KI DS FI RST			0. 6669	74	298	199	90.11
91. 00 09100 EMERGENCY			0. 1539		16, 134	2, 484	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			1. 1458	80	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95. 00 09500 AMBULANCE SERVICES							95.00
200.00 Total (sum of lines 50 through 94 and	96 through 98)				4, 001, 343	1, 201, 695	200.00
201.00 Less PBP Clinic Laboratory Services-Pr	ogram only charges (line	61)			0		201.00
202.00 Net charges (line 200 minus line 201)					4, 001, 343		202.00

Health Financial Systems HAR	RISON COUNTY HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1331	Peri od:	Worksheet D-3	;
	Component	CCN: 15-Z331	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 5:2	
	Title	e XVIII	Swing Beds - SNF		
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS		1	- i		
50. 00 05000 OPERATI NG ROOM		0. 2530		0	
53. 00 05300 ANESTHESI OLOGY		0. 0270			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 0976		0	
60. 00 06000 LABORATORY		0. 1582			
65. 00 06500 RESPI RATORY THERAPY		0. 2603	72 502	131	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 2311	69 26, 716	6, 176	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 1622			67.00
68.00 06800 SPEECH PATHOLOGY		0. 0782	58 3, 282	257	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 1066	44 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 6733	89 13, 006	8, 758	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 4361		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0.3544		3, 882	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0.0000	00 00	0	77.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0. 6596			
90. 01 09001 SENI OR CARE		0. 7855			
90. 02 09002 GENERAL SURGERY		2. 3888			90.02
90. 03 09003 HARRI SON CRAWFORD HEALTHCARE		0. 8772			
90. 04 09004 CORYDON MEDICAL ASSOCIATES		0. 6827			90.04
90. 05 09005 ORTHOPEDIC SURGERY - DR KLINE		0. 7250			90.05
90. 06 09006 0BGYN - DR SAUER		0. 9981			90.06
90. 07 09007 FIRST CAPITAL MEDICAL GROUP		0. 9424			
90. 08 09008 SOUTH HARRISON FAMILY MEDICINE		0. 7259			
90. 09 09009 PALN MANAGEMENT		0.0614			
90. 10 09010 DERMATOLOGY		0. 3943			
90. 11 09011 KIDS FIRST		0. 6669			
91. 00 09100 EMERGENCY		0. 1539			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 1458	08 0	0	92.00
OTHER REIMBURSABLE COST CENTERS		I		1	
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96 th			73, 822	22, 332	
201.00 Less PBP Clinic Laboratory Services-Program	only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		1	73, 822	1	202.00

Health Financial Systems	HARRISON COUNTY HOSPITAL		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1331	Period:	Worksheet D-3	
			From 01/01/2022		
			To 12/31/2022		
	T; +1	e XIX	Hospi tal	5/26/2023 5:2 Cost	I pm
Cost Center Description		Ratio of Cos		1	
cost center bescription		To Charges	Program	Inpatient Program Costs	
		10 charges	Charges	(col. 1 x col.	
			onal ges	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			447, 771		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
43. 00 04300 NURSERY			111, 380		43.00
ANCI LLARY SERVI CE COST CENTERS		1	111,000	L	10.00
50. 00 05000 OPERATI NG ROOM		0. 2530	56 17, 354	4, 392	50.00
53. 00 05300 ANESTHESI OLOGY		0. 02704			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.0276		4, 325	
60. 00 06000 LABORATORY		0. 15822			
65. 00 06500 RESPI RATORY THERAPY		0. 2603		0	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 23110		-	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 16223			67.00
68. 00 06800 SPEECH PATHOLOGY		0. 07825		0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 10664		-	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 67338		5, 530	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 43612		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 3544		32, 024	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0. 00000			
OUTPATIENT SERVICE COST CENTERS		0.00000		0	//.00
90. 00 09000 CLINIC		0.65968	34 0	0	90.00
90. 01 09001 SENI OR CARE		0. 7855			90.00
90. 02 09002 GENERAL SURGERY		2. 38888	-		90.01
90. 02 09002 GENERAL SURGERT 90. 03 09003 HARRI SON CRAWFORD HEALTHCARE		0. 87723			90.02
90. 03 09003 HARRISON CRAWFORD HEALTHCARE 90. 04 09004 CORYDON MEDICAL ASSOCIATES		0. 68276			90.03
90. 05 09005 ORTHOPEDIC SURGERY - DR KLINE		0. 7250			90.04
90. 05 09005 OKTHOPEDIC SURGERT - DR KLINE 90. 06 09006 OBGYN - DR SAUER		0. 9981			90.05
90.06 09006 0BGYN - DR SAUER 90.07 09007 FIRST CAPITAL MEDICAL GROUP		0. 9981			90.08
90. 07 09007 FIRST CAPITAL MEDICAL GROUP 90. 08 09008 SOUTH HARRISON FAMILY MEDICINE		0. 94248			90.07
				0	
90. 09 09009 PALN MANAGEMENT 90. 10 09010 DERMATOLOGY		0.0614		-	90.09
		0. 39439	-	-	90.10
90. 11 09011 KIDS FIRST		0. 6669		0	90.11
91.00 09100 EMERGENCY		0. 15398			91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		1. 14580	0 0	0	92.00
95. 00 09500 AMBULANCE SERVICES		1			
	through (19)		257 457	74 010	95.00 200.00
200.00 Total (sum of lines 50 through 94 and 96			357, 457	/0, 819	
201.00 Less PBP Clinic Laboratory Services-Prog	ram only charges (rine 61)		257 457		201.00
202.00 Net charges (line 200 minus line 201)		I	357, 457	I	202.00

Health Financial Systems	HARRISON COUNTY HOSPITA	L			In Lie	u of Form CMS-	2552-1
INPATIENT ANCILLARY SERVICE COST APPORTIONME	NT Provide	er CCI	N: 15-1331		ri od:	Worksheet D-3	;
	Compone	ent C	CN: 15-Z331	Fr To	com 01/01/2022 12/31/2022	Date/Time Pre 5/26/2023 5:2	
		Title		Swi	ing Beds - SNF		i piii
Cost Center Description			Ratio of Cos		Inpati ent	Inpati ent	
cost center bescription			To Charges		Program	Program Costs	
			ro onarges	·	Charges	$(col. 1 \times col.$	
					ondi ges	2)	
		F	1.00		2.00	3.00	<u> </u>
INPATIENT ROUTINE SERVICE COST CENTER	S		1100		2100	0100	
30. 00 03000 ADULTS & PEDIATRICS	2						30.0
31. 00 03100 I NTENSI VE CARE UNI T							31.0
43. 00 04300 NURSERY							43.0
ANCI LLARY SERVICE COST CENTERS		I					
50. 00 05000 OPERATING ROOM		- T	0. 2530	166	0	0	50.0
53. 00 05300 ANESTHESI OLOGY			0. 2530		0	0	
54. 00 05400 RADI OLOGY - DI AGNOSTI C			0.0270		0	0	
60. 00 06000 LABORATORY			0. 1582		0	0	
65. 00 06500 RESPIRATORY THERAPY			0. 2603		0	0	
66. 00 06600 PHYSI CAL THERAPY			0. 2803		0	0	
67. 00 06700 OCCUPATIONAL THERAPY			0. 2311		0	0	
					0	0	
			0.0782		-	-	
69. 00 06900 ELECTROCARDI OLOGY	ENTO		0. 1066		0	0	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT	ENIS		0.6733		0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT			0. 4361		0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS			0.3544		0	0	
77.00 07700 ALLOGENEIC HSCT ACQUISITION			0.0000	000	0	0	77.0
OUTPATIENT SERVICE COST CENTERS			0 (50)	0.4			
90. 00 09000 CLINIC			0.6596		0	0	
90. 01 09001 SENI OR CARE			0. 7855		0	0	
90. 02 09002 GENERAL SURGERY			2.3888		0	0	
90. 03 09003 HARRI SON CRAWFORD HEALTHCARE			0.8772		0	0	
90. 04 09004 CORYDON MEDI CAL ASSOCI ATES			0. 6827		0	0	
90. 05 09005 ORTHOPEDIC SURGERY - DR KLINE			0. 7250		0	0	
90. 06 09006 OBGYN - DR SAUER			0. 9981		0	0	
90. 07 09007 FIRST CAPITAL MEDICAL GROUP			0.9424		0	0	
90. 08 09008 SOUTH HARRISON FAMILY MEDICINE			0. 7259		0	0	
90. 09 09009 PALN MANAGEMENT			0. 0614		0	0	
90. 10 09010 DERMATOLOGY			0. 3943		0	0	
90. 11 09011 KIDS FIRST			0. 6669		0	0	
91.00 09100 EMERGENCY			0. 1539		0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	PART)		1. 1458	808	0	0	92.0
OTHER REIMBURSABLE COST CENTERS							
95. 00 09500 AMBULANCE SERVICES							95.0
200.00 Total (sum of lines 50 through	$\lambda$ and $06$ through $08$				0	0	200. 0
					9	0	200.0
	ces-Program only charges (line 6	61)			0	0	200.0

	Financial         Systems         HARRISON         COUNTY         HOSPI           ATI ON OF         REI MBURSEMENT         SETTLEMENT         Prov	TAL vider CCN: 15-1331	In Lie Period:	u of Form CMS-2 Worksheet E	2552-10
			From 01/01/2022 To 12/31/2022	Part B Date/Time Prep	
		Title XVIII	Hospi tal	5/26/2023 5:2 Cost	<u>i pm</u>
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions)	N		6, 825, 145 0	1.00
2.00 3.00	OPPS payments	)		0	
4.00	Outlier payment (see instructions)			0	4.00
4.01 5.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructions	-)		0 0. 000	4.01 5.00
5.00 6.00	Line 2 times line 5	5)		0.000	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00 9.00	Transitional corridor payment (see instructions)	al 12 line 200		0	
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, co Organ acquisitions	JI. 13, TINE 200		0	9.00 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			6, 825, 145	
	COMPUTATION OF LESSER OF COST OR CHARGES				
12.00	Reasonable charges Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69	7)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for paymer	t for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payr			0	16.00
17 00	had such payment been made in accordance with 42 CFR §413.13(e)			0,000000	17 00
17.00 18.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 0	17.00
19.00	Excess of customary charges over reasonable cost (complete only if	line 18 exceeds li	ne 11) (see	0	19.00
20.00	instructions)		10) (		20.00
20.00	Excess of reasonable cost over customary charges (complete only if instructions)	line ii exceeds ii	ne 18) (see	0	20.00
21.00	Lesser of cost or charges (see instructions)			6, 893, 396	21.00
22.00	Interns and residents (see instructions)	202)		0	
23.00 24.00	Cost of physicians' services in a teaching hospital (see instruction Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	uns)		0	23.00 24.00
21100	COMPUTATI ON OF REI MBURSEMENT SETTLEMENT				2.11.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			95, 950	
26.00 27.00	Deductibles and Coinsurance amounts relating to amount on line 24 ( Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus			5, 492, 219 1, 305, 227	
27100	instructions)		2 and 20] (000	1,000,227	27100
28.00 29.00	Direct graduate medical education payments (from Wkst. E-4, line 50	))		0	28.00 29.00
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			1, 305, 227	
31.00	Primary payer payments			1, 241	31.00
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			1, 303, 986	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
34.00	Allowable bad debts (see instructions)			795, 451	
35.00 36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructio	one)		517, 043 432, 652	
37.00	Subtotal (see instructions)			1, 821, 029	
38.00	MSP-LCC reconciliation amount from PS&R			0	
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			0	39.00 39.50
39. 50 39. 75	N95 respirator payment adjustment amount (see instructions)			0	
39. 97	Demonstration payment adjustment amount before sequestration			0	
39. 98 39. 99	Partial or full credits received from manufacturers for replaced de	evices (see instruc	ctions)	0	39. 98 39. 99
40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			1, 821, 029	
40. 01	Sequestration adjustment (see instructions)			22, 945	
40.02	Demonstration payment adjustment amount after sequestration			0	
40. 03 41. 00	Sequestration adjustment-PARHM or CHART pass-throughs Interim payments			1, 972, 703	40. 03 41. 00
41.01	Interim payments-PARHM or CHART			.,,	41.01
42.00	Tentative settlement (for contractors use only)			0	
42.01 43.00	Tentative settlement-PARHM or CHART (for contractor use only) Balance due provider/program (see instructions)			-174, 619	42.01 43.00
43.01	Balance due provider/program-PARHM (see instructions)			,	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance wi	th CMS Pub. 15-2,	chapter 1,	278, 408	44.00
	\$115.2 TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	
91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00 0	
93.00					

Health Financial Systems	HARRISON COUNTY HOSPITAL	In Lie	u of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1331	Period: From 01/01/2022	Worksheet E	
			Date/Time Pre 5/26/2023 5:2	pared: 1 pm
	Title XVIII	Hospi tal	Cost	
			1.00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200. 00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CC		Period: From 01/01/2022 To 12/31/2022		
		Title	XVIII	Hospi tal	Cost	•
		I npati ent	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2, 784, 78	2	1, 972, 703	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider			_		
3.01 3.02 3.03 3.04	ADJUSTMENTS TO PROVIDER			0 0 0	0 0 0	3.0 <sup>°</sup> 3.02 3.03
3.04				0	0	3.0
5.05	Provider to Program	II		0	0	5.0.
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.5
3.52				0	0	3.5
3.53				0	0	3.5
3.54				0	0	3.5
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.9
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2, 784, 78	2	1, 972, 703	4.0
	TO BE COMPLETED BY CONTRACTOR	1 1				
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) Program to Provider					5.0
5. 01	TENTATI VE TO PROVIDER			0	0	5.0
5.01				0	0	5.0
5.03				0	0	5.0
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5.5
5. 51				0	0	5.5
5. 52				0	0	5.5
. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5.9
. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.0
. 01	SETTLEMENT TO PROVIDER		517, 37		0	6.0
b. 02	SETTLEMENT TO PROGRAM			0	174, 619	6.0
7.00	Total Medicare program liability (see instructions)		3, 302, 15		1, 798, 084	7.0
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C		Period: From 01/01/2022		
		Component	CCN: 15-Z331	To 12/31/2022	2 Date/Time Pre 5/26/2023 5:2	pared: 1 pm
		Title	XVIII	Swing Beds - SN		
		Inpatien	it Part A	Pa	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00	Total interim payments paid to provider 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,		148, 5	32 0	0	
3.00	write "NONE" or enter a zero 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
0.01	Program to Provider		1			
3. 01 3. 02	ADJUSTMENTS TO PROVIDER			0	0	
3.02				0	0	
3.04				0	0	3.04
3.05				0	0	3.05
	Provider to Program	1				1
3.50 3.51	ADJUSTMENTS TO PROGRAM			0	0	
3.51				0	0	3.5
3.53				0	0	
3.54				0	0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		148, 5	32	0	4.00
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after		1			5.00
3. 00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
- 01	Program to Provider		1	0	0	
5.01 5.02	TENTATI VE TO PROVI DER			0	0	5.0 <sup>2</sup>
5.03				0	0	•
	Provider to Program					1
5.50	TENTATI VE TO PROGRAM			0	0	5.5
5.51 5.52				0	0	
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	
	5. 50-5. 98)			0	0	0.7
. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.0
. 01	SETTLEMENT TO PROVIDER		9,9		0	
5.02	SETTLEMENT TO PROGRAM			0	0	
7.00	Total Medicare program liability (see instructions)		158, 4		0	7.0
			0	Contractor Number 1.00	NPR Date (Mo/Day/Yr) 2.00	
8.00	Name of Contractor		5	1.00	2.00	8.00

2.00Medicare days (see instructions)2.003.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 23.004.00Total inpatient days (see instructions)4.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2004.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 205.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I7.008.00Calculation of the HIT incentive payment (see instructions)8.009.00Sequestration adjustment amount (see instructions)9.0010.00Calculation of the HIT incentive payment after sequestration (see instructions)9.0010.00Initial/interim HIT payment adjustment (see instructions)30.0031.00Other Adjustment (specify)30.00	Heal th	Financial Systems HARRISON CO	DUNTY HOSPITAL	In Lie	u of Form CMS-	2552-10		
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION       1.00         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 days (see instructions)       3.00         5.00       Total hospital charges from Wkst. S-3, Pt. I, col. 6. line 2       3.00         6.00       Total hospital charges from Wkst C, Pt. I, col. 8 line 200       4.00         6.00       Total hospital charges from Wkst. S-10, col. 3 line 20       5.00         7.00       CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I       7.00         8.00       Calculation of the HIT incentive payment (see instructions)       9.00         9.00       Sequestration adjustment amount (see instructions)       9.00         10.00       IniPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       10.00         30.00       Other Adjustment (specify)       30.00	CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1331 Period: From 01/01/2022 To 12/31/2022						
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 141.002.00Medicare days (see instructions)2.003.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 23.004.00Total inpatient days (see instructions)3.005.00Total hospital charges from Wkst. C, Pt. I, col. 8 line 2004.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 205.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I7.001.00Calculation of the HIT incentive payment (see instructions)8.009.00Sequestration adjustment amount (see instructions)9.0010.00Calculation of the HIT incentive payment after sequestration (see instructions)9.0010.00Initial/interim HIT payment adjustment (see instructions)10.0031.00Other Adjustment (specify)31.00			Title XVIII	Hospi tal	Cost			
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 141.002.00Medicare days (see instructions)2.003.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 23.004.00Total inpatient days (see instructions)3.005.00Total hospital charges from Wkst. C, Pt. I, col. 8 line 2004.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 205.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I7.001.00Calculation of the HIT incentive payment (see instructions)8.009.00Sequestration adjustment amount (see instructions)9.0010.00Calculation of the HIT incentive payment after sequestration (see instructions)9.0010.00Initial/interim HIT payment adjustment (see instructions)10.0031.00Other Adjustment (specify)31.00								
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 141.002.00Medicare days (see instructions)2.003.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 23.004.00Total inpatient days (see instructions)3.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2004.006.00Total hospital charges from Wkst S. S-10, col. 3 line 205.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I7.001 line 1688.00Calculation of the HIT incentive payment (see instructions)8.009.00Sequestration adjustment amount (see instructions)9.0010.00INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH10.0031.00Other Adjustment (specify)31.00					1.00			
1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 141.002.00Medicare days (see instructions)2.003.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 23.004.00Total inpatient days (see instructions)3.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2004.006.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2005.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 205.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I7.001 ine 1688.00Calculation of the HIT incentive payment (see instructions)8.009.00Sequestration adjustment amount (see instructions)9.0010.00Calculation of the HIT incentive payment after sequestration (see instructions)10.0030.00Initial/interim HIT payment adjustment (see instructions)30.0031.00Other Adjustment (specify)30.00								
2.00Medicare days (see instructions)2.003.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 23.004.00Total inpatient days (see instructions)4.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2004.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 205.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I7.001ine 1688.00Calculation of the HIT incentive payment (see instructions)8.009.00Sequestration adjustment amount (see instructions)9.0010.00Calculation of the HIT incentive payment after sequestration (see instructions)9.0010.00Initial/interim HIT payment adjustment (see instructions)30.0031.00Other Adjustment (specify)30.00						-		
3.00       Medicare HM0 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       5.00         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)       8.00         10.00       Calculation of the HIT incentive payment after sequestration (see instructions)       10.00         1NPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       30.00         31.00       Other Adjustment (specify)       31.00			Nkst. S-3, Pt. I col. 15 line	e 14		1.00		
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       5.00         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         1NPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       30.00         31.00       Other Adjustment (specify)       31.00						2.00		
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)       9.00         10.00       INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       10.00         30.00       Initial/interim HIT payment adjustment (see instructions)       30.00         31.00       Other Adjustment (specify)       31.00						3.00		
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       6.00         8.00       Calculation of the HIT incentive payment (see instructions)       8.00         9.00       Sequestration adjustment amount (see instructions)       8.00         10.00       Calculation of the HIT incentive payment after sequestration (see instructions)       9.00         10.00       INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       10.00         30.00       Initial/interim HIT payment adjustment (see instructions)       30.00         31.00       Other Adjustment (specify)       31.00	4.00					4.00		
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)       8.00         10.00       Calculation of the HIT incentive payment after sequestration (see instructions)       9.00         10.00       INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       9.00         30.00       Initial/interim HIT payment adjustment (see instructions)       30.00         31.00       Other Adjustment (specify)       31.00	5.00					5.00		
I ine 168       I ine 168       8.00       Cal cul ation of the HIT incentive payment (see instructions)       8.00         9.00       Sequestration adjustment amount (see instructions)       9.00       9.00         10.00       Cal cul ation of the HIT incentive payment after sequestration (see instructions)       9.00         10.00       INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       9.00         30.00       Initial /interim HIT payment adjustment (see instructions)       30.00         31.00       Other Adjustment (specify)       31.00	6.00	Total hospital charity care charges from Wkst. S-10, col	. 3 line 20			6.00		
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       0ther Adjustment (specify)       31.00	7.00		of certified HIT technology	Wkst. S-2, Pt. I		7.00		
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       31. 00	8.00	Calculation of the HIT incentive payment (see instruction	ns)			8.00		
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	9.00	Sequestration adjustment amount (see instructions)				9.00		
30.00Initial/interim HIT payment adjustment (see instructions)30.0031.00Other Adjustment (specify)31.00	10.00	Calculation of the HIT incentive payment after sequestra	tion (see instructions)			10.00		
31.00 Other Adjustment (specify) 31.00								
	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	32.00	Balance due provider (line 8 (or line 10) minus line 30 a	and line 31) (see instruction	ns)		32.00		

alth Financial Sy LCULATION OF REIM	BURSEMENT SETTLEMENT - SWING BEDS	COUNTY HOSPITAL Provider CCN: 15-1331	Peri od:	u of Form CMS-2 Worksheet E-2	
		Component CCN: 15-Z331	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 5:2	
		Title XVIII	Swing Beds - SNF		- piii
			Part A	Part B	
COMPUTATION	F NET COST OF COVERED SERVICES		1.00	2.00	
	itine services - swing bed-SNF (see instruc	tions)	137, 920	0	1.
	itine services - swing bed-NF (see instruct				2.
	vices (from Wkst. D-3, col. 3, line 200, for		22, 555	0	3.
instructions	6 and 7, line 202, for Part B) (For CAH a	na swing-bea pass-thiough, see			
	allied health payment-PARHM or CHART (see in	nstructions)			3.
	for interns and residents not in approved	teaching program (see		0.00	4.
instructions 00 Program days			57	0	5.
5 5	esidents not in approved teaching program	(see instructions)	0,	0	
	eview - physician compensation - SNF option	nal method only	0		7.
	of lines 1 through 3 plus lines 6 and 7)		160, 475	0	
	payments (see instructions) ne 8 minus line 9)		160, 475	0	
	billed to program patients (exclude amounts	applicable to physician	0	0	11.
professi onal	· · · · · · · · · · · · · · · · · · ·				
	ne 10 minus line 11) Aillad ta pragnam patienta (fram provider n		160, 475	0	
	billed to program patients (from provider ro n professional services)	ecolids) (exclude collisurance	0	0	13.
	3 costs (line 12 x 80%)			0	14.
	e instructions)		160, 475	0	
	IENTS (SEE INSTRUCTIONS) (SPECIFY) lemonstration payment adjustment (see instru	uctions)	0	0	16
	ty hospital demonstration project (§410A D		0		16
	see instructions)	smonser att ony paymente	0		
	payment adjustment amount before sequestra	ation	0	0	
	l debts (see instructions) nbursable bad debts (see instructions)		0	0	17
,	l debts for dual eligible beneficiaries (se	e instructions)	0	0	
.00 Total (see i	0	,	160, 475	0	19
	n adjustment (see instructions)		2, 022	0	
	n payment adjustment amount after sequestra n adjustment-PARHM or CHART pass-throughs	tion)	0	0	19. 19.
	for non-claims based amounts (see instruct	ti ons)	0	0	
.00 Interim paym			148, 532	0	
	ents-PARHM or CHART				20
	tlement (for contractor use only) tlement-PARHM or CHART (for contractor use		0	0	21
	provider/program (line 19 minus lines 19.01	57	9, 921	0	
	provider/program-PARHM or CHART (see instru		.,	-	22.
	ounts (nonallowable cost report items) in a	ccordance with CMS Pub. 15-2,	0	0	23.
<u>chapter 1, §</u> Rural Communi	15.2 ty Hospital Demonstration Project (§410A De	emonstration) Adjustment			-
	first year of the current 5-year demonstrat				200
	Act? Enter "Y" for yes or "N" for no.	•			
Cost Reimburs	ement ng-bed SNF inpatient routine service costs	(from West D 1 Dt 11 lipo			201.
	II hospital))	(ITOIN WKSt. D-1, Ft. II, IIIe			201
2.00 Medicare swi	ng-bed SNF inpatient ancillary service cost	s (from Wkst. D-3, col. 3, lin	e		202.
	(III swing-bed SNF))				202
	<sup>c</sup> lines 201 and 202) ng-bed SNF discharges (see instructions)				203 204
	f Demonstration Target Amount Limitation (1	V/A in first year of the curre	nt 5-year demonst	ration	204
period)	-	-	-		
	ng-bed SNF target amount	20E times line 204)			205
	ng-bed SNF inpatient routine cost cap (line Medicare Part A Swing-Bed SNF Inpatient Re				206
	pursement under the §410A Demonstration (see				207
8.00 Medicare swi	ng-bed SNF inpatient service costs (from Wk	-	1		208.
and 3)	Medicare swing hed SNE DDS navments (con	instructions)			209.
0.00 Reserved for	Medicare swing-bed SNF PPS payments (see i future use				209.
Comparision (	f PPS versus Cost Reimbursement				1
5.00 Total adjust	nent to Medicare swing-bed SNF PPS payment	(line 209 plus line 210) (see			215

LCULATION OF REIMBURSEMENT	SETTLEMENT - SWING BEDS		Period:	Worksheet E-2	
			From 01/01/2022 To 12/31/2022	Date/Time Prep 5/26/2023 5:21	
		Title XIX	Swing Beds - SNF	Cost	pi
·			Part A	Part B	
			1.00	2.00	
00 Inpatient routine serv	ices - swing bed-SNF (see instru	uctions)	0		1
1 .	ices - swing bed-NF (see instru		0		2
1 1	<b>a</b> .	for Part A, and sum of Wkst. D,	0		2
5		and swing-bed pass-through, see	0		5
instructions)		and sinning bed pass through, see			
-	Ith payment-PARHM or CHART (see	instructions)			3
00 Per diem cost for inte	rns and residents not in approve	ed teaching program (see	0.00		4
instructions)					
00 Program days			0		5
	not in approved teaching program	. ,	0		6
	hysician compensation - SNF opti	3	0		7
-	1 through 3 plus lines 6 and 7	)	0		8
00 Primary payer payments .00 Subtotal (line 8 minus			0		9 10
	program patients (exclude amoun	ts applicable to physician	0		11
professional services		ts applicable to physicial	0		
2.00 Subtotal (line 10 minu			0		12
	program patients (from provider	records) (exclude coinsurance	0		13
for physician professi					
.00 80% of Part B costs (I	ine 12 x 80%)		0		14
.00 Subtotal (see instruct	i ons)		0		15
. 00 OTHER ADJUSTMENTS (SEE	INSTRUCTIONS) (SPECIFY)		0		16
.50 Pioneer ACO demonstrat	ion payment adjustment (see ins <sup>.</sup>	tructions)			16
	al demonstration project (§410A	Demonstration) payment			16
adjustment (see instru					
	adjustment amount before seques	tration	0		16
7.00 Allowable bad debts (s 7.01 Adjusted reimbursable			0		17 17
5	bad debts (see instructions) r dual eligible beneficiaries (s	coo instructions)	0		18
.00 Total (see instruction	5	see mistractions)	0		19
. 01 Sequestration adjustme			0		19
, , , , , , , , , , , , , , , , , , , ,	adjustment amount after sequesti	ration)	0		19
	nt-PARHM or CHART pass-throughs	-			19
1 3	claims based amounts (see instru		0		19
.00 Interim payments			0		20
.01 Interim payments-PARHM	or CHART				20
	for contractor use only)		0		21
	ARHM or CHART (for contractor us	5.			21
	rogram (line 19 minus lines 19.0		0		22
	rogram-PARHM or CHART (see inst				22
	allowable cost report items) in	accordance with CMS Pub. 15-2,	0		23
chapter 1, §115.2	al Demonstration Project (§410A	Domonstration) Adjustment			
	of the current 5-year demonstra				200
	er "Y" for yes or "N" for no.	atton period ander the 213t		1	200
Cost Reimbursement			1 1		
1.00 Medicare swing-bed SNF	inpatient routine service costs	s (from Wkst. D-1, Pt. II, line		,	201
66 (title XVIII hospit					
		sts (from Wkst. D-3, col. 3, line	2		202
200 (title XVIII swing					~~~
3.00 Total (sum of lines 20	discharges (see instructions)				203 204
		(N/A in first year of the curren	t 5 year demonst		204
peri od)	ration larget Anount Ermitation	(WA IN THISE year of the curren	it 5-year demonst		
5.00 Medicare swing-bed SNF	target amount				205
	inpatient routine cost cap (lin	ne 205 times line 204)			206
<u> </u>	Part A Swing-Bed SNF Inpatient				
7.00 Program reimbursement	under the §410A Demonstration (s	see instructions)		,	207
8.00 Medicare swing-bed SNF	inpatient service costs (from N	Wkst. E-2, col. 1, sum of lines 1		-	208
and 3)					_
	swing-bed SNF PPS payments (see	e instructions)			209
0.00 Reserved for future us					210
Comparision of PPS ver		t (1) == 200 =1			04 F
instructions)	dicare swing-bed SNF PPS paymen <sup>-</sup>	t (TTHE 204 plus TINE 210) (See		2	215

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1331	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part V Date/Time Pre 5/26/2023 5:2	pare
		Title XVIII	Hospi tal	Cost	трп
				1.00	
~ ~	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARI	<u>E PART A SERVICES – COST</u>	REIMBURSEMENT	0.505.007	
. 00	Inpatient services			3, 585, 807	
00	Nursing and Allied Health Managed Care payment (see instruct Organ acquisition	ions)		0	
00 01	Cellular therapy acquisition cost (see instructions)			0	
00	Subtotal (sum of lines 1 through 3.01)			3, 585, 807	4
00	Primary payer payments			0,000,007	
00	Total cost (line 4 less line 5). For CAH (see instructions)			3, 621, 665	
	COMPUTATION OF LESSER OF COST OR CHARGES		•		
	Reasonabl e charges				
00	Routine service charges			0	7
00	Ancillary service charges			0	
00	Organ acquisition charges, net of revenue			0	
). 00	Total reasonable charges			0	10
. 00	Customary charges	normant for convious on		0	1 1 1
. 00	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable for			0	
. 00	had such payment been made in accordance with 42 CFR 413.13(	1 5	ni a charye basi s	0	12
. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)	6)		0.000000	13
. 00	Total customary charges (see instructions)			0.0000000	
. 00	Excess of customary charges over reasonable cost (complete o	nlyifline 14 exceeds li	ne 6) (see	0	15
	instructions)	5	, ,		
5.00	Excess of reasonable cost over customary charges (complete o	nly if line 6 exceeds lir	ne 14) (see	0	16
	instructions)			_	
. 00	Cost of physicians' services in a teaching hospital (see ins	tructions)		0	17
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Direct graduate medical education payments (from Worksheet E	-4 line 49)		0	118
. 00	Cost of covered services (sum of lines 6, 17 and 18)	-, THE -7)		3, 621, 665	
. 00	Deductibles (exclude professional component)			301, 648	
. 00	Excess reasonable cost (from line 16)			0	
2. 00	Subtotal (line 19 minus line 20 and 21)			3, 320, 017	22
3.00	Coinsurance			6, 224	23
. 00	Subtotal (line 22 minus line 23)			3, 313, 793	24
. 00	Allowable bad debts (exclude bad debts for professional serv	ices) (see instructions)		46, 922	
. 00	Adjusted reimbursable bad debts (see instructions)			30, 499	
. 00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		12, 506	
8.00	Subtotal (sum of lines 24 and 25, or line 26)			3, 344, 292	
9.00 9.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructio	20)		0	
9. 50 9. 98	Recovery of accel erated depreciation.	ns)		0	
. 90	Demonstration payment adjustment amount before sequestration			0	
	Subtotal (see instructions)			3, 344, 292	
. 01	Sequestration adjustment (see instructions)			42, 138	
	Demonstration payment adjustment amount after sequestration				30
. 03	Sequestration adjustment-PARHM or CHART				30
. 00	Interim payments			2, 784, 782	31
. 01	Interim payments-PARHM or CHART				31
. 00	Tentative settlement (for contractor use only)			0	
2. 01	Tentative settlement-PARHM or CHART (for contractor use only				32
	Balance due provider/program (line 30 minus lines 30.01, 30.		2 21 01	517, 372	
B. 00	183130000000000000000000000000000000000	anu 26, minus lines 30.0	ມລ, ລາ.ບາ, and		33
. 00 . 01	Balance due provider/program-PARHM or CHART (lines 2, 3, 18,				
	32.01) Protested amounts (nonallowable cost report items) in accord	ance with CMS Dub 15 2	chanter 1	16, 423	34

	Financial Systems HARRISON COUN SHEET (If you are nonproprietary and do not maintain	Provider C		eriod:	u of Form CMS-2 Worksheet G	
	pe accounting records, complete the General Fund column			rom 01/01/2022 o 12/31/2022	Date/Time Pre 5/26/2023 5:2	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
C	UDDENT ACCETC	1.00	2.00	3.00	4.00	
	URRENT ASSETS Cash on hand in banks	1, 195, 526	C	0	0	1 1
	Femporary investments	640, 135		-	0	
	Notes receivable	040, 133		-	0	
	Accounts receivable	27, 919, 665	-	-	0	
	Other receivable	2, 388, 974		0	0	
	Allowances for uncollectible notes and accounts receivable	-22, 205, 463	c c	0	0	
00 1	nventory	1, 369, 026	C	0	0	1
DO F	Prepaid expenses	1, 364, 825	C	0	0	8
	Other current assets	1, 153, 765		-	0	
	Due from other funds	0	C	-	0	
	Total current assets (sum of lines 1-10)	13, 826, 453	C	0	0	11
	I XED ASSETS	0.001.100				1
	Land	3,001,138			0	
	and improvements	3, 310, 462		-	0	
	Accumulated depreciation	-2, 642, 838		-	0	
	Buildings Accumulated depreciation	42, 421, 847		-	0	
	_easehold improvements	-27, 917, 775 4, 243, 870		-	0	
	Accumulated depreciation	-2, 669, 545			0	
	Fixed equipment	346, 074		-	0	
	Accumul ated depreciation	0,074			0	
	Automobiles and trucks	0		0	0	
	Accumul ated depreciation	0		0	0	
	Major movable equipment	25, 239, 972	c c	0	0	
00 A	Accumulated depreciation	-22, 749, 626	c c	0	0	24
00 N	Ninor equipment depreciable	0	C	0	0	25
00 A	Accumulated depreciation	0	C	0	0	26
00	HT designated Assets	0	C	0	0	27
. 00 A	Accumul ated depreciation	0	C	0	0	28
	li nor equi pment-nondepreci abl e	0	C		0	
	Fotal fixed assets (sum of lines 12-29)	22, 583, 579	C	0	0	30
	THER ASSETS		-		-	1
	nvestments	4, 849, 275			0	
	Deposits on Leases	0	0	-	0	
	Due from owners/officers Other assets	-1, 153, 765	-	0	0	
	Total other assets (sum of lines 31-34)	3, 695, 510		0	0	
	Fotal assets (sum of lines 11, 30, and 35)	40, 105, 542		-	0	
	URRENT LIABILITIES	40, 100, 342		0	0	1
	Accounts payable	2, 887, 995	l c	0	0	37
	Salaries, wages, and fees payable	3, 141, 859		-	0	
	Payroll taxes payable	0	c		0	
	Notes and loans payable (short term)	0	c	0	0	40
	Deferred income	0	C	0	0	
. 00 A	Accelerated payments	0				42
00 [	Due to other funds	0	C	0	0	43
	Other current liabilities	1, 395, 671			0	
	Total current liabilities (sum of lines 37 thru 44)	7, 425, 525	C	0	0	45
	ONG TERM LIABILITIES					١.,
	Nortgage payable	0	C	0	0	
	lotes payable	5, 463, 633		0	0	1
	Jnsecured Loans	0		0	0	
	Other long term liabilities Fotal long term liabilities (sum of lines 46 thru 49)	5, 463, 633			0	
	Fotal liabilities (sum of lines 45 and 50)	5, 463, 633		-	0	
	APITAL ACCOUNTS	12,007,100		0	0	1 1
	General fund balance	27, 216, 384				52
	Specific purpose fund	_,, _, 0, 004	l c			53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion					
. 00 T	Total fund balances (sum of lines 52 thru 58)	27, 216, 384	c	0	0	
	Fotal liabilities and fund balances (sum of lines 51 and	40, 105, 542			0	60

Heal th	Financial Systems	HARRI SON COUNT	Y HOSPITAL		In	Lieu of Form CMS-	2552-10
	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-1331	Period: From 01/01/2 To 12/31/2	Worksheet G-1	epared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance		22, 609, 486 -5, 393, 102 27, 216, 384 0 27, 216, 384 0 27, 216, 384 0 27, 216, 384	3.00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ \end{array}$
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0	0 0 0 0 0		0 0 0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	N: 15-1331	Period: From 01/01/2022 To 12/31/2022	Worksheet G-2 Parts I & II Date/Time Pre	pared:
	Cost Center Description		Inpati ent	Outpati ent	5/26/2023 5:2 Total	i pm
	cost center bescription	-	1.00	2,00	3.00	
	PART I - PATIENT REVENUES		1.00	2.00	0.00	
	General Inpatient Routine Services					1
1.00	Hospi tal		7, 359, 02	25	7, 359, 025	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE		7 050 00		7 050 005	9.00
10.00	Total general inpatient care services (sum of lines 1-9)		7, 359, 02	25	7, 359, 025	10.00
11.00	Intensive Care Type Inpatient Hospital Services		938, 97	70	938, 978	1 11. 00
12.00	CORONARY CARE UNIT		930, 9,	0	930, 970	12.00
12.00	BURN INTENSIVE CARE UNIT					12.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	Flines	938, 97	78	938, 978	1
10.00	11-15)	TTHES	700, 71		,00, ,,0	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 10	5)	8, 298, 00	03	8, 298, 003	17.00
18.00	Ancillary services	·	16, 624, 55		176, 584, 482	
19.00	Outpatient services			0 8, 320	8, 320	19.00
20.00	RURAL HEALTH CLINIC			0 0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES			0 10, 754, 589	10, 754, 589	
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.00
26.00	HOSPI CE					26.00
27.00	OTHER (SPECIFY)		04 000 F	0 0	0	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	3 TO WKST.	24, 922, 55	57 170, 722, 837	195, 645, 394	28.00
	G-3, line 1) PART II - OPERATING EXPENSES	l				-
29.00	Operating expenses (per Wkst. A, column 3, line 200)			64, 606, 803		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECI FY)			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 4	17)(transfer		64, 606, 803		43.00

Heal th	Financial Systems	HARRI SON COUNTY	HOSPI TAL	In Lie	u of Form CMS-2	2552-10		
STATE	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-1331 Period:							
	From 01/01/2022 To 12/31/2022							
1					1.00	1 00		
1.00	Total patient revenues (from Wkst. G-2, Part				195, 645, 394	1.00		
2.00 3.00	Less contractual allowances and discounts or	patients account	S		138, 963, 456	2.00 3.00		
3.00 4.00	Net patient revenues (line 1 minus line 2) Less total operating expenses (from Wkst. G-	2 Part II line /	2)		56, 681, 938 64, 606, 803	3.00 4.00		
4.00 5.00	Net income from service to patients (line 3				-7, 924, 865	4.00 5.00		
5.00	OTHER I NCOME				-7, 724, 003	5.00		
6.00	Contributions, donations, bequests, etc				3, 218	6.00		
7.00	Income from investments				35, 888	7.00		
8.00	Revenues from telephone and other miscellane	ous communication	servi ces		0	8.00		
9.00	Revenue from television and radio service				0	9.00		
10.00	Purchase di scounts				0	10.00		
11.00	Rebates and refunds of expenses				0	11.00		
12.00	Parking lot receipts				0	12.00		
13.00	Revenue from Laundry and Linen service				0	13.00		
14.00	Revenue from meals sold to employees and gue	ests			123, 025	14.00		
15.00	Revenue from rental of living quarters				0	15.00		
16.00	Revenue from sale of medical and surgical su		an patients		0	16.00		
17.00	Revenue from sale of drugs to other than pat				0	17.00		
18.00	Revenue from sale of medical records and abs				23, 046	18.00		
	Tuition (fees, sale of textbooks, uniforms,	,			0	19.00		
20.00	Revenue from gifts, flowers, coffee shops, a	and canteen			0	20.00		
21.00	Rental of vending machines				0	21.00		
22.00	Rental of hospital space				213, 978			
23.00	Governmental appropriations				34, 285			
24.00 24.50	MISC INCOME COVID-19 PHE Funding				2, 098, 323 0	24.00 24.50		
24.50	Total other income (sum of lines 6-24)				2, 531, 763			
					-5, 393, 102			
	OTHER EXPENSES (SPECIFY)				-3, 373, 102	27.00		
	Total other expenses (sum of line 27 and sub	oscripts)			0	28.00		
	Net income (or loss) for the period (line 26				-5, 393, 102			