

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet S Parts I-III Date/Time Prepared: 3/25/2025 3:14 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: 3/25/2025	Time: 3:14 pm
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HARRISON COUNTY HOSPITAL (15-1331) for the cost reporting period beginning 01/01/2024 and ending 12/31/2024 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	199,255	1,728	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	4,735	0	0	5.00
6.00	SWING BED - NF	0			0	6.00
10.00	RURAL HEALTH CLINIC (RHC) I	0		0	0	10.00
200.00	TOTAL	0	203,990	1,728	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet S-2 Part I Date/Time Prepared: 3/25/2025 3:14 pm
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1.00	2.00	3.00	4.00	
Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1141 ATWOOD STREET		PO Box:	1.00
2.00	City: CORYDON		State: IN Zip Code: 47112- County: HARRISON	2.00

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	HARRISON COUNTY HOSPITAL	151331	31140	1	12/15/2005	N	0	0	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	HARRISON COUNTY SWING BEDS	15Z331	15999		08/14/2011	N	0	0	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	HCH ELIZABETH CLINIC	158588	31140		12/27/2024	N	0	0	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2024	12/31/2024		20.00	
21.00	Type of Control (see instructions)					9			21.00	
						1.00	2.00	3.00		

Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				N	N			22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				N	N			22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N			22.02
22.03	Did this hospital receive a geographic redesignation from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015 or FY2025? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N	N		22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.								22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				2	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-1331			Period: From 01/01/2024 To 12/31/2024		Worksheet S-2 Part I Date/Time Prepared: 3/25/2025 3:14 pm		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0		24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00
						Urban/Rural	S	Date of Geogr	
						1.00		2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0		35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.						0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N		40.00
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.								57.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet S-2 Part I Date/Time Prepared: 3/25/2025 3:14 pm
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		V	XVIII	XIX	
		1.00	2.00	3.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00

61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

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

61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20
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						1.00	
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		ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
		Teaching Hospitals that Claim Residents in Nonprovider Settings				
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet S-2
Part I
Date/Time Prepared:
3/25/2025 3:14 pm

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
		1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00		
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
				1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010. Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet S-2 Part I Date/Time Prepared: 3/25/2025 3:14 pm	
			1.00		
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?			68.00	
			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N	75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00
			Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
			1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.			N	0 88.00
			Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge
			1.00	2.00	3.00
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.			0.00	0 89.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y 90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N 91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N 92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N 93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N 94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00 95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N 96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00 97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet S-2 Part I Date/Time Prepared: 3/25/2025 3:14 pm	
		V 1.00	XIX 2.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. 1, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. 1V, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. 1, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. 1 through 1V? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 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
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N
					1.00
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.		N		
					1.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.		N		
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet S-2 Part I Date/Time Prepared: 3/25/2025 3:14 pm
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	632,739	0	0
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N	118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y	121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		Y	5.01
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.		Y	123.00
124.00	Did the hospital incur cost, either directly or through a contract with an outside supplier, to establish and maintain access to no less than a 6-month buffer stock of one or more essential medicines according to 42 CFR 412.113(g)? Enter "Y" for yes or "N" for no.			124.00
Certified Transplant Center Information				
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N	125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		N	140.00
		1.00	2.00	3.00
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name:	Contractor's Name:	Contractor's Number:	
142.00	Street:	PO Box:		
143.00	City:	State:	Zip Code:	
				1.00
144.00	Are provider based physicians' costs included in Worksheet A?		Y	144.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-1331		Period: From 01/01/2024 To 12/31/2024		Worksheet S-2 Part I Date/Time Prepared: 3/25/2025 3:14 pm	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
		1.00					
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00	
		Part A 1.00		Part B 2.00		Title V 3.00	
						Title XIX 4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		155.00	
156.00	Subprovider - IPF	N		N		156.00	
157.00	Subprovider - IRF	N		N		157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N		N		159.00	
160.00	HOME HEALTH AGENCY	N		N		160.00	
161.00	CMHC			N		161.00	
		1.00					
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name 0		County 1.00		State 2.00	
				Zip Code 3.00		CBSA 4.00	
						FTE/Campus 5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00 166.00	
		1.00					
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			9.99		169.00	
		1.00		2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					170.00	
		1.00		2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N				0 171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet S-2 Part II Date/Time Prepared: 3/25/2025 3:14 pm		
			Y/N	Date		
			1.00	2.00		
PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE						
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.						
COMPLETED BY ALL HOSPITALS						
Provider Organization and Operation						
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00	
			Y/N	Date	V/I	
			1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00	
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00	
			Y/N	Type	Date	
			1.00	2.00	3.00	
Financial Data and Reports						
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C		4.00	
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00	
			Y/N	Legal Oper.		
			1.00	2.00		
Approved Educational Activities						
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N			6.00	
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00	
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00	
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00	
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00	
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00	
			Y/N			
			1.00			
Bad Debts						
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00	
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00	
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N	14.00	
Bed Complement						
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00	
			Part A		Part B	
			Y/N	Date	Y/N	Date
			1.00	2.00	3.00	4.00
PS&R Data						
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, in columns 2 and 4, from the PS&R used to prepare this cost report, enter the "Paid Claims Verified Current As Of" date, if present, or the paid-through date. (see instructions)	N		N		
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, in columns 2 and 4, enter the "Paid Claims Verified Current As Of" date, if present, or the paid-through date. (see instructions)	Y	03/10/2025	Y	03/10/2025	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet S-2
Part II
Date/Time Prepared:
3/25/2025 3:14 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet S-2 Part II Date/Time Prepared: 3/25/2025 3:14 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet S-3 Part I Date/Time Prepared: 3/25/2025 3:14 pm
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Component	Worksheet A Line No.	No. of Beds	Bed Days Avai lable	CAH/REH Hours	I/P Days / O/P Vi s i t s / Tri ps		
						Title V	
	1.00	2.00	3.00	4.00	5.00		
PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,686	48,600.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,686	48,600.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,464	3,000.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,150	51,600.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC (RHC)	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet S-3
Part I
Date/Time Prepared:
3/25/2025 3:14 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	478	59	2,025		1.00
2.00	HMO and other (see instructions)	409	883			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	84	0	84		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	103		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	562	59	2,212		7.00
8.00	INTENSIVE CARE UNIT	46	4	125		8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY		48	679		13.00
14.00	Total (see instructions)	608	111	3,016	0.00	482.67
15.00	CAH visits	0	0	0		15.00
15.10	REH hours and visits	0	0	0		15.10
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			0		24.10
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC (RHC)	0	0	0	0.00	0.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	482.67
28.00	Observation Bed Days		18	1,233		28.00
29.00	Ambulance Trips	1,277				29.00
30.00	Employee discount days (see instruction)			0		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	0	0		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00	LTCH non-covered days	0				33.00
33.01	LTCH site neutral days and discharges	0				33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care					34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet S-3 Part I Date/Time Prepared: 3/25/2025 3:14 pm
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Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	161	26	751	1.00
2.00	HMO and other (see instructions)			122	197		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	161	26	751	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC (RHC)	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet S-10 Parts I & II Date/Time Prepared: 3/25/2025 3:14 pm
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				1.00	
PART I - HOSPITAL AND HOSPITAL COMPLEX DATA					
Uncompensated and Indigent Care Cost-to-Charge Ratio					
1.00	Cost to charge ratio (see instructions)			0.270382	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			8,268,524	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			47,244,475	6.00
7.00	Medicaid cost (line 1 times line 6)			12,774,056	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)			4,505,532	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)			0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			4,505,532	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated care cost (see instructions for each line)					
20.00	Charity care charges and uninsured discounts (see instructions)	437,345	791,985	1,229,330	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	118,250	791,985	910,235	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	118,250	791,985	910,235	23.00
				1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
25.01	Charges for insured patients' liability (see instructions)			0	25.01
26.00	Bad debt amount (see instructions)			7,366,794	26.00
27.00	Medicare reimbursable bad debts (see instructions)			236,880	27.00
27.01	Medicare allowable bad debts (see instructions)			364,431	27.01
28.00	Non-Medicare bad debt amount (see instructions)			7,002,363	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)			2,020,864	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			2,931,099	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			7,436,631	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet S-10 Parts I & II Date/Time Prepared: 3/25/2025 3:14 pm
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			1.00		
PART II - HOSPITAL DATA					
Uncompensated and Indigent Care Cost-to-Charge Ratio					
1.00	Cost to charge ratio (see instructions)			1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			5.00	
6.00	Medicaid charges			6.00	
7.00	Medicaid cost (line 1 times line 6)			7.00	
8.00	Difference between net revenue and costs for Medicaid program (see instructions)			8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			9.00	
10.00	Stand-alone CHIP charges			10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)			11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)			12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)			16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			19.00	
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
Uncompensated care cost (see instructions for each line)					
20.00	Charity care charges and uninsured discounts (see instructions)			20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)			21.00	
22.00	Payments received from patients for amounts previously written off as charity care			22.00	
23.00	Cost of charity care (see instructions)			23.00	
			1.00		
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			25.00	
25.01	Charges for insured patients' liability (see instructions)			25.01	
26.00	Bad debt amount (see instructions)			26.00	
27.00	Medicare reimbursable bad debts (see instructions)			27.00	
27.01	Medicare allowable bad debts (see instructions)			27.01	
28.00	Non-Medicare bad debt amount (see instructions)			28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)			29.00	
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet A
Date/Time Prepared:
3/25/2025 3:14 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		1,090,537	1,090,537	124,766	1,215,303	1.00
1.01	00101		647,396	647,396	0	647,396	1.01
1.02	00102		0	0	53,888	53,888	1.02
2.00	00200		741,220	741,220	1,395	742,615	2.00
2.01	00201		0	0	297,451	297,451	2.01
4.00	00400	247,269	191,541	438,810	85,076	523,886	4.00
5.01	00590	1,896,268	6,211,799	8,108,067	-5,257	8,102,810	5.01
5.02	00570	673,788	165,792	839,580	0	839,580	5.02
5.03	00580	487,513	809,104	1,296,617	0	1,296,617	5.03
7.00	00700	363,939	1,540,016	1,903,955	0	1,903,955	7.00
8.00	00800	38,280	214,097	252,377	0	252,377	8.00
9.00	00900	506,172	335,790	841,962	0	841,962	9.00
10.00	01000	606,631	544,282	1,150,913	-751,131	399,782	10.00
11.00	01100	0	0	0	750,971	750,971	11.00
13.00	01300	767,804	301,498	1,069,302	0	1,069,302	13.00
14.00	01400	262,888	1,759,916	2,022,804	-824,492	1,198,312	14.00
16.00	01600	628,587	260,016	888,603	0	888,603	16.00
17.00	01700	393,003	111,021	504,024	0	504,024	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,591,835	2,155,368	5,747,203	-173,392	5,573,811	30.00
31.00	03100	371,467	96,124	467,591	-2,891	464,700	31.00
43.00	04300	0	89	89	155,518	155,607	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	947,470	697,546	1,645,016	-115,893	1,529,123	50.00
53.00	05300	0	1,275,705	1,275,705	-7,206	1,268,499	53.00
54.00	05400	1,248,072	1,235,100	2,483,172	-73,354	2,409,818	54.00
60.00	06000	1,047,457	2,229,754	3,277,211	-115,046	3,162,165	60.00
65.00	06500	0	676,179	676,179	-65,827	610,352	65.00
66.00	06600	427,498	99,048	526,546	-94,935	431,611	66.00
67.00	06700	0	0	0	83,036	83,036	67.00
68.00	06800	0	0	0	11,899	11,899	68.00
69.00	06900	448,212	176,178	624,390	16,852	641,242	69.00
71.00	07100	0	0	0	1,341,505	1,341,505	71.00
72.00	07200	0	0	0	460,141	460,141	72.00
73.00	07300	375,039	3,165,940	3,540,979	533	3,541,512	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
90.00	09000	43,843	10,434	54,277	-5,598	48,679	90.00
90.01	09001	65,753	138,147	203,900	0	203,900	90.01
90.02	09002	803,625	397,106	1,200,731	30,516	1,231,247	90.02
90.03	09003	665,012	332,927	997,939	-350	997,589	90.03
90.04	09004	594,803	277,409	872,212	26,588	898,800	90.04
90.05	09005	638,893	645,955	1,284,848	27,896	1,312,744	90.05
90.06	09006	382,235	202,867	585,102	37,616	622,718	90.06
90.07	09007	1,258,350	663,110	1,921,460	60,836	1,982,296	90.07
90.08	09008	337,963	233,783	571,746	-3,927	567,819	90.08
90.09	09009	155,854	62,709	218,563	-16,255	202,308	90.09
90.10	09010	495,740	174,263	670,003	21,798	691,801	90.10
90.11	09011	1,334,140	1,126,155	2,460,295	-330,725	2,129,570	90.11
91.00	09100	1,992,144	1,383,977	3,376,121	-7,713	3,368,408	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	2,896,429	1,965,910	4,862,339	-431,100	4,431,239	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		99,874	99,874	-99,874	0	113.00
118.00		26,993,976	34,445,682	61,439,658	463,315	61,902,973	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	3,276,018	1,855,578	5,131,596	-260,962	4,870,634	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	309,372	203,899	513,271	-202,353	310,918	194.01
194.02	07952	0	0	0	0	0	194.02
200.00		30,579,366	36,505,159	67,084,525	0	67,084,525	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet A
Date/Time Prepared:
3/25/2025 3:14 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-7,556	1,207,747	1.00
1.01	00101 MOB	0	647,396	1.01
1.02	00102 AMB DEPR	0	53,888	1.02
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	742,615	2.00
2.01	00201 AMB EQUIP	0	297,451	2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	523,886	4.00
5.01	00590 ADMINISTRATIVE & GENERAL	-1,585,697	6,517,113	5.01
5.02	00570 ADMITTING	0	839,580	5.02
5.03	00580 CASHIERING/ACCOUNTS RECEIVABLE	0	1,296,617	5.03
7.00	00700 OPERATION OF PLANT	0	1,903,955	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	252,377	8.00
9.00	00900 HOUSEKEEPING	0	841,962	9.00
10.00	01000 DIETARY	0	399,782	10.00
11.00	01100 CAFETERIA	-133,585	617,386	11.00
13.00	01300 NURSING ADMINISTRATION	0	1,069,302	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	1,198,312	14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-11,162	877,441	16.00
17.00	01700 SOCIAL SERVICE	0	504,024	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-7,798	5,566,013	30.00
31.00	03100 INTENSIVE CARE UNIT	0	464,700	31.00
43.00	04300 NURSERY	0	155,607	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	1,529,123	50.00
53.00	05300 ANESTHESIOLOGY	-1,255,516	12,983	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	2,409,818	54.00
60.00	06000 LABORATORY	-2,815	3,159,350	60.00
65.00	06500 RESPIRATORY THERAPY	835	611,187	65.00
66.00	06600 PHYSICAL THERAPY	0	431,611	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	83,036	67.00
68.00	06800 SPEECH PATHOLOGY	0	11,899	68.00
69.00	06900 ELECTROCARDIOLOGY	0	641,242	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,341,505	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	460,141	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3,541,512	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC (RHC)	0	0	88.00
90.00	09000 CLINIC	0	48,679	90.00
90.01	09001 SENIOR CARE	-20,027	183,873	90.01
90.02	09002 GENERAL SURGERY	-872,210	359,037	90.02
90.03	09003 HARRISON CRAWFORD HEALTHCARE	-576,969	420,620	90.03
90.04	09004 CORYDON MEDICAL ASSOCIATES	-439,733	459,067	90.04
90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	-711,661	601,083	90.05
90.06	09006 OBGYN - DR SAUER	-416,019	206,699	90.06
90.07	09007 FIRST CAPITAL MEDICAL GROUP	-434,221	1,548,075	90.07
90.08	09008 SOUTH HARRISON FAMILY MEDICINE	-266,374	301,445	90.08
90.09	09009 PAIN MANAGEMENT	-190,768	11,540	90.09
90.10	09010 DERMATOLOGY	-441,230	250,571	90.10
90.11	09011 KIDS FIRST	-846,562	1,283,008	90.11
91.00	09100 EMERGENCY	0	3,368,408	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	-17,533	4,413,706	95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE	0	0	113.00
118.00	11800 SUBTOTALS (SUM OF LINES 1 through 117)	-8,236,601	53,666,372	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	4,870,634	192.00
194.00	07950 MARKETING	0	0	194.00
194.01	07951 PHYSICIAN BILLING	0	310,918	194.01
194.02	07952 MOB	0	0	194.02
200.00	20000 TOTAL (SUM OF LINES 118 through 199)	-8,236,601	58,847,924	200.00

RECLASSIFICATIONS

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-6

Date/Time Prepared:
3/25/2025 3:14 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - EKG RECLASS					
1.00	ELECTROCARDIOLOGY	69.00	20,626	21,483	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	O		20,626	21,483	
B - INTEREST RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	99,874	1.00
	O		0	99,874	
C - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	395,827	355,144	1.00
	O		395,827	355,144	
D - NURSERY RECLASS					
1.00	NURSERY	43.00	155,518	0	1.00
	O		155,518	0	
E - AMBULANCE CAPITAL RECLASS					
1.00	AMB DEPR	1.02	0	53,888	1.00
2.00	AMB EQUIP	2.01	0	297,451	2.00
	O		0	351,339	
F - IMPLANTABLE DEVICES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	460,141	1.00
	O		0	460,141	
G - DEPRECIATION RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	24,892	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	1,395	2.00
	O		0	26,287	
H - SPEECH PATHOLOGY					
1.00	SPEECH PATHOLOGY	68.00	9,661	2,238	1.00
2.00	OCCUPATIONAL THERAPY	67.00	67,416	15,620	2.00
	O		77,077	17,858	
I - SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,801,646	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	533	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
	O		0	1,802,179	
J - AMBULANCE WORKERS COMP RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	79,659	1.00
	O		0	79,659	
K - MISCELLANEOUS BENEFITS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,417	1.00
2.00		0.00	0	0	2.00
	O		0	5,417	
L - PROVIDER BASED HOUSEKEEPING RECLASS					
1.00	GENERAL SURGERY	90.02	5,912	2,630	1.00
2.00	CORYDON MEDICAL ASSOCIATES	90.04	7,231	3,216	2.00
3.00	FIRST CAPITAL MEDICAL GROUP	90.07	19,571	8,705	3.00
4.00	SOUTH HARRISON FAMILY MEDICINE	90.08	6,605	2,938	4.00
5.00	HARRISON CRAWFORD HEALTHCARE	90.03	8,073	3,591	5.00
6.00	PAIN MANAGEMENT	90.09	897	399	6.00

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
7.00	ORTHOPEdic SURGERY - DR KLINE	90.05	8,606	3,828	7.00
8.00	DERMATOLOGY	90.10	4,689	2,086	8.00
9.00	OBGYN - DR SAUER	90.06	5,178	2,303	9.00
10.00	KIDS FIRST	90.11	14,216	6,323	10.00
	0		80,978	36,019	
M - PROVIDER BASED BILLING RECLASS					
1.00	GENERAL SURGERY	90.02	12,223	2,480	1.00
2.00	CORYDON MEDICAL ASSOCIATES	90.04	13,424	2,724	2.00
3.00	FIRST CAPITAL MEDICAL GROUP	90.07	33,557	6,810	3.00
4.00	SOUTH HARRISON FAMILY MEDICINE	90.08	9,975	2,024	4.00
5.00	HARRISON CRAWFORD HEALTHCARE	90.03	13,007	2,640	5.00
6.00	PAIN MANAGEMENT	90.09	4,598	933	6.00
7.00	ORTHOPEdic SURGERY - DR KLINE	90.05	11,131	2,259	7.00
8.00	DERMATOLOGY	90.10	10,104	2,051	8.00
9.00	OBGYN - DR SAUER	90.06	17,288	3,508	9.00
10.00	KIDS FIRST	90.11	42,909	8,708	10.00
	0		168,216	34,137	
N - PRACTICE MANAGEMENT RECLASS					
1.00	GENERAL SURGERY	90.02	2,860	5,691	1.00
2.00	CORYDON MEDICAL ASSOCIATES	90.04	3,141	6,250	2.00
3.00	FIRST CAPITAL MEDICAL GROUP	90.07	7,852	15,623	3.00
4.00	SOUTH HARRISON FAMILY MEDICINE	90.08	2,334	4,644	4.00
5.00	HARRISON CRAWFORD HEALTHCARE	90.03	3,044	6,056	5.00
6.00	PAIN MANAGEMENT	90.09	1,076	2,141	6.00
7.00	ORTHOPEdic SURGERY - DR KLINE	90.05	2,605	5,182	7.00
8.00	DERMATOLOGY	90.10	2,364	4,704	8.00
9.00	OBGYN - DR SAUER	90.06	4,045	8,048	9.00
10.00	KIDS FIRST	90.11	10,041	19,977	10.00
	0		39,362	78,316	
500.00	Grand Total: Increases		937,604	3,367,853	500.00

RECLASSIFICATIONS

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-6
Date/Time Prepared:
3/25/2025 3:14 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - EKG RECLASS						
1.00	LABORATORY	60.00	19,845	0	0	1.00
2.00	RESPIRATORY THERAPY	65.00	0	21,483	0	2.00
3.00	EMERGENCY	91.00	679	0	0	3.00
4.00	AMBULANCE SERVICES	95.00	102	0	0	4.00
	O		20,626	21,483		
B - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	99,874	11	1.00
	O		0	99,874		
C - CAFETERIA RECLASS						
1.00	DIETARY	10.00	395,827	355,144	0	1.00
	O		395,827	355,144		
D - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	155,518	0	0	1.00
	O		155,518	0		
E - AMBULANCE CAPITAL RECLASS						
1.00	AMBULANCE SERVICES	95.00	0	351,339	9	1.00
2.00		0.00	0	0	9	2.00
	O		0	351,339		
F - IMPLANTABLE DEVICES RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	460,141	0	1.00
	O		0	460,141		
G - DEPRECIATION RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	26,287	9	1.00
2.00		0.00	0	0	9	2.00
	O		0	26,287		
H - SPEECH PATHOLOGY						
1.00	PHYSICAL THERAPY	66.00	77,077	17,858	0	1.00
2.00		0.00	0	0	0	2.00
	O		77,077	17,858		
I - SUPPLIES RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	824,492	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	17,874	0	2.00
3.00	INTENSIVE CARE UNIT	31.00	0	2,891	0	3.00
4.00	OPERATING ROOM	50.00	0	115,893	0	4.00
5.00	ANESTHESIOLOGY	53.00	0	7,206	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	73,354	0	6.00
7.00	LABORATORY	60.00	0	95,201	0	7.00
8.00	RESPIRATORY THERAPY	65.00	0	44,344	0	8.00
9.00	ELECTROCARDIOLOGY	69.00	0	25,257	0	9.00
10.00	CLINIC	90.00	0	5,598	0	10.00
11.00	GENERAL SURGERY	90.02	0	1,280	0	11.00
12.00	HARRISON CRAWFORD HEALTHCARE	90.03	0	36,761	0	12.00
13.00	CORYDON MEDICAL ASSOCIATES	90.04	0	9,398	0	13.00
14.00	ORTHOPEDIC SURGERY - DR KLINE	90.05	0	5,715	0	14.00
15.00	OBGYN - DR SAUER	90.06	0	2,754	0	15.00
16.00	FIRST CAPITAL MEDICAL GROUP	90.07	0	31,282	0	16.00
17.00	SOUTH HARRISON FAMILY MEDICINE	90.08	0	32,447	0	17.00
18.00	PAIN MANAGEMENT	90.09	0	26,299	0	18.00
19.00	DERMATOLOGY	90.10	0	4,200	0	19.00
20.00	KIDS FIRST	90.11	0	432,899	0	20.00
21.00	EMERGENCY	91.00	0	7,034	0	21.00
	O		0	1,802,179		
J - AMBULANCE WORKERS COMP RECLASS						
1.00	AMBULANCE SERVICES	95.00	0	79,659	0	1.00
	O		0	79,659		
K - MISCELLANEOUS BENEFITS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.01	0	5,257	0	1.00
2.00	DIETARY	10.00	0	160	0	2.00
	O		0	5,417		
L - PROVIDER BASED HOUSEKEEPING RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	80,978	36,019	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
0		80,978	36,019			
M - PROVIDER BASED BILLING RECLASS						
1.00	PHYSICIAN BILLING	194.01	168,216	34,137	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
0		168,216	34,137			
N - PRACTICE MANAGEMENT RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	39,362	78,316	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
0		39,362	78,316			
500.00	Grand Total : Decreases	937,604	3,367,853			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-7
Part I
Date/Time Prepared:
3/25/2025 3:14 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,001,138	0	0	0	0	1.00
2.00	Land Improvements	3,334,019	5,224	0	5,224	0	2.00
3.00	Buildings and Fixtures	42,563,319	176,354	0	176,354	0	3.00
4.00	Building Improvements	4,243,870	0	0	0	0	4.00
5.00	Fixed Equipment	346,074	0	0	0	0	5.00
6.00	Movable Equipment	25,498,242	579,626	0	579,626	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	78,986,662	761,204	0	761,204	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	78,986,662	761,204	0	761,204	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,001,138	0				1.00
2.00	Land Improvements	3,339,243	0				2.00
3.00	Buildings and Fixtures	42,739,673	0				3.00
4.00	Building Improvements	4,243,870	0				4.00
5.00	Fixed Equipment	346,074	0				5.00
6.00	Movable Equipment	26,077,868	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	79,747,866	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	79,747,866	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-7
Part II
Date/Time Prepared:
3/25/2025 3:14 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	953,467	0	0	137,070	0	1.00
1.01	MOB	329,666	73,487	45,621	0	0	1.01
1.02	AMB DEPR	0	0	0	0	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	741,220	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)	2,024,353	73,487	45,621	137,070	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of col.s. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,090,537				1.00
1.01	MOB	198,622	647,396				1.01
1.02	AMB DEPR	0	0				1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	741,220				2.00
2.01	AMB EQUIP	0	0				2.01
3.00	Total (sum of lines 1-2)	198,622	2,479,153				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-7
Part III
Date/Time Prepared:
3/25/2025 3:14 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	53,669,999	0	53,669,999	0.672996	0	1.00
1.01	MOB	0	0	0	0.000000	0	1.01
1.02	AMB DEPR	0	0	0	0.000000	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	26,077,868	0	26,077,868	0.327004	0	2.00
2.01	AMB EQUIP	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	79,747,867	0	79,747,867	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col. s. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	978,359	0	1.00
1.01	MOB	0	0	0	329,666	73,487	1.01
1.02	AMB DEPR	0	0	0	53,888	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	742,615	0	2.00
2.01	AMB EQUIP	0	0	0	297,451	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	2,401,979	73,487	3.00
Cost Center Description		SUMMARY OF CAPITAL			Total (2)		
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	(sum of col. s. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	92,318	137,070	0	0	1,207,747	1.00
1.01	MOB	45,621	0	0	198,622	647,396	1.01
1.02	AMB DEPR	0	0	0	0	53,888	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	742,615	2.00
2.01	AMB EQUIP	0	0	0	0	297,451	2.01
3.00	Total (sum of lines 1-2)	137,939	137,070	0	198,622	2,949,097	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			3.00	4.00	5.00	
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01 Investment income - MOB (chapter 2)			OMOB	1.01	0	1.01
1.02 Investment income - AMB DEPR (chapter 2)			OAMB DEPR	1.02	0	1.02
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01 Investment income - AMB EQUIP (chapter 2)			OAMB EQUIP	2.01	0	2.01
3.00 Investment income - other (chapter 2)			0	0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0	0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0	0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-1,884	ADMINISTRATIVE & GENERAL	5.01	0	7.00
8.00 Television and radio service (chapter 21)			0	0.00	0	8.00
9.00 Parking lot (chapter 21)			0	0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-4,472,275			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0	0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1		0		0	12.00
13.00 Laundry and linen service			0	0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-133,585	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employees and others			0	0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0	0.00	0	16.00
17.00 Sale of drugs to other than patients			0	0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-11,162	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.00
19.01 Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.01
19.02 Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.02
20.00 Vending machines			0	0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0	0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		ORESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00		24.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-8

Date/Time Prepared:
3/25/2025 3:14 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			3.00	4.00			
1.00	2.00	3.00	4.00	5.00			
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01 Depreciation - MOB			0	MOB	1.01	0	26.01
26.02 Depreciation - AMB DEPR			0	AMB DEPR	1.02	0	26.02
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01 Depreciation - AMB EQUIP			0	AMB EQUIP	2.01	0	27.01
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 MISC INCOME - A&G	B	-44,785		ADMINISTRATIVE & GENERAL	5.01	0	33.00
33.01 INTEREST	B	-2,520		NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.01
33.02 PROVIDER TAX FEE	A	-1,307,198		ADMINISTRATIVE & GENERAL	5.01	0	33.02
33.03 UNNECESSARY BORROWING	A	-5,036		NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.03
33.04 CRNA	A	-1,255,516		ANESTHESIOLOGY	53.00	0	33.04
33.05 LOBBYING FEES	A	-9,046		ADMINISTRATIVE & GENERAL	5.01	0	33.05
33.06 MARKETING EXPENSE	A	-222,784		ADMINISTRATIVE & GENERAL	5.01	0	33.06
33.07 CPR AND EMS EDUCATION	B	-7,233		AMBULANCE SERVICES	95.00	0	33.07
33.08 CLINIC RENT - SENIOR CARE	A	-20,027		SENIOR CARE	90.01	0	33.08
33.09 CLINIC RENT - GENERAL SURGERY	B	-70,301		GENERAL SURGERY	90.02	0	33.09
33.10 CLINIC RENT - HARRISON CRAWFORD HEAL	B	-83,462		HARRISON CRAWFORD HEALTHCARE	90.03	0	33.10
33.11 CLINIC RENT - CORYDON MEDICAL ASSOCI	B	-83,462		CORYDON MEDICAL ASSOCIATES	90.04	0	33.11
33.13 CLINIC RENT - ORTHOPEDIC SURGERY - D	A	-121,535		ORTHOPEDIC SURGERY - DR KLINE	90.05	0	33.13
33.14 CLINIC RENT - OBGYN - DR SAUER	B	-41,731		OBGYN - DR SAUER	90.06	0	33.14
33.15 CLINIC RENT - FIRST CAPITAL MEDICAL	B	-145,649		FIRST CAPITAL MEDICAL GROUP	90.07	0	33.15
33.17 CLINIC RENT - SOUTH HARRISON FAMILY	B	-64,645		SOUTH HARRISON FAMILY MEDICINE	90.08	0	33.17
33.18 CLINIC RENT - PAIN MANAGEMENT	A	-10,717		PAIN MANAGEMENT	90.09	0	33.18
33.19 CLINIC RENT - DERMATOLOGY	B	-34,833		DERMATOLOGY	90.10	0	33.19
33.20 CLINIC RENT - KIDS FIRST	B	-87,215		KIDS FIRST	90.11	0	33.20
33.21 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.21
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,236,601					50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT			Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet A-8-2 Date/Time Prepared: 3/25/2025 3:14 pm
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Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours
1.00	2.00	3.00	4.00	5.00	6.00	7.00
1.00	17.00 SOCIAL SERVICE	145,204	0	145,204	0	0
2.00	30.00 ADULTS & PEDIATRICS	1,158,443	7,798	1,150,645	0	0
3.00	60.00 LABORATORY	28,148	2,815	25,333	0	0
4.00	65.00 RESPIRATORY THERAPY	-835	-835	0	0	0
5.00	90.02 GENERAL SURGERY	801,909	801,909	0	0	0
6.00	90.03 HARRISON CRAWFORD HEALTHCARE	493,507	493,507	0	0	0
7.00	90.04 CORYDON MEDICAL ASSOCIATES	356,271	356,271	0	0	0
8.00	90.05 ORTHOPEDIC SURGERY - DR KLINE	590,126	590,126	0	0	0
9.00	90.06 OBGYN - DR SAUER	374,288	374,288	0	0	0
10.00	90.07 FIRST CAPITAL MEDICAL GROUP	288,572	288,572	0	0	0
11.00	90.08 SOUTH HARRISON FAMILY MEDICINE	201,729	201,729	0	0	0
12.00	90.09 PAIN MANAGEMENT	180,051	180,051	0	0	0
13.00	90.10 DERMATOLOGY	406,397	406,397	0	0	0
14.00	90.11 KIDS FIRST	759,347	759,347	0	0	0
15.00	91.00 EMERGENCY	757,192	0	757,192	0	0
16.00	95.00 AMBULANCE SERVICES	10,300	10,300	0	0	0
200.00		6,550,649	4,472,275	2,078,374	0	0

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

Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment
1.00	2.00	15.00	16.00	17.00	18.00
1.00	17.00 SOCIAL SERVICE	0	0	0	0
2.00	30.00 ADULTS & PEDIATRICS	0	0	0	7,798
3.00	60.00 LABORATORY	0	0	0	2,815
4.00	65.00 RESPIRATORY THERAPY	0	0	0	-835
5.00	90.02 GENERAL SURGERY	0	0	0	801,909
6.00	90.03 HARRISON CRAWFORD HEALTHCARE	0	0	0	493,507
7.00	90.04 CORYDON MEDICAL ASSOCIATES	0	0	0	356,271
8.00	90.05 ORTHOPEDIC SURGERY - DR KLINE	0	0	0	590,126
9.00	90.06 OBGYN - DR SAUER	0	0	0	374,288
10.00	90.07 FIRST CAPITAL MEDICAL GROUP	0	0	0	288,572
11.00	90.08 SOUTH HARRISON FAMILY MEDICINE	0	0	0	201,729
12.00	90.09 PAIN MANAGEMENT	0	0	0	180,051
13.00	90.10 DERMATOLOGY	0	0	0	406,397
14.00	90.11 KIDS FIRST	0	0	0	759,347
15.00	91.00 EMERGENCY	0	0	0	0
16.00	95.00 AMBULANCE SERVICES	0	0	0	10,300
200.00		0	0	0	4,472,275

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 15-1331		Period: From 01/01/2024 To 12/31/2024		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 3/25/2025 3:14 pm	
				Respiratory Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.50	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	8,784.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	80.00	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.00	40.00	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					702,720	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					702,720	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					702,720	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					702,720	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 15-1331		Period: From 01/01/2024 To 12/31/2024		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 3/25/2025 3:14 pm	
		Respiratory Therapy				Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	80.00	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					702,720	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					702,720	63.00
64.00	Total cost of outside supplier services (from your records)					590,112	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					0	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					0	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet B
Part I
Date/Time Prepared:
3/25/2025 3:14 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT	MOB	AMB DEPR	NEW MVBLE EQUIP		
		0	1.00	1.01	1.02		2.00
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	1,207,747	1,207,747				1.00	
1.01 00101 MOB	647,396	0	647,396			1.01	
1.02 00102 AMB DEPR	53,888	0	0	53,888		1.02	
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	742,615				742,615	2.00	
2.01 00201 AMB EQUIP	297,451				0	2.01	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	523,886	1,861	0	0	1,144	4.00	
5.01 00590 ADMINISTRATIVE & GENERAL	6,517,113	187,103	3,703	0	115,045	5.01	
5.02 00570 ADMINITTING	839,580	0	0	0	0	5.02	
5.03 00580 CASHIERING/ACCOUNTS RECEIVABLE	1,296,617	0	0	0	0	5.03	
7.00 00700 OPERATION OF PLANT	1,903,955	145,954	0	0	89,744	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	252,377	8,522	0	0	5,240	8.00	
9.00 00900 HOUSEKEEPING	841,962	18,254	0	0	11,224	9.00	
10.00 01000 DIETARY	399,782	53,114	0	0	32,658	10.00	
11.00 01100 CAFETERIA	617,386	26,534	0	0	16,315	11.00	
13.00 01300 NURSING ADMINISTRATION	1,069,302	4,466	0	0	2,746	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	1,198,312	0	0	0	0	14.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	877,441	29,632	0	0	18,220	16.00	
17.00 01700 SOCIAL SERVICE	504,024	1,786	0	0	1,098	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	5,566,013	201,739	0	0	124,045	30.00	
31.00 03100 INTENSIVE CARE UNIT	464,700	26,952	0	0	16,572	31.00	
43.00 04300 NURSERY	155,607	5,582	0	0	3,432	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	1,529,123	164,877	0	0	101,379	50.00	
53.00 05300 ANESTHESIOLOGY	12,983	0	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,409,818	86,383	0	0	53,115	54.00	
60.00 06000 LABORATORY	3,159,350	45,401	0	0	27,916	60.00	
65.00 06500 RESPIRATORY THERAPY	611,187	9,880	0	0	6,075	65.00	
66.00 06600 PHYSICAL THERAPY	431,611	33,428	0	0	20,554	66.00	
67.00 06700 OCCUPATIONAL THERAPY	83,036	0	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	11,899	0	0	0	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	641,242	16,970	0	0	10,434	69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,341,505	40,526	0	0	24,919	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	460,141	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	3,541,512	11,406	0	0	7,013	73.00	
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.00	
90.00 09000 CLINIC	48,679	14,132	0	0	8,689	90.00	
90.01 09001 SENIOR CARE	183,873	0	21,592	0	0	90.01	
90.02 09002 GENERAL SURGERY	359,037	186	50,250	0	114	90.02	
90.03 09003 HARRISON CRAWFORD HEALTHCARE	420,620	195	59,658	0	120	90.03	
90.04 09004 CORYDON MEDICAL ASSOCIATES	459,067	205	83,026	0	126	90.04	
90.05 09005 ORTHOPEDIC SURGERY - DR KLINE	601,083	167	91,263	0	103	90.05	
90.06 09006 OBGYN - DR SAUER	206,699	260	29,829	0	160	90.06	
90.07 09007 FIRST CAPITAL MEDICAL GROUP	1,548,075	502	104,110	0	309	90.07	
90.08 09008 SOUTH HARRISON FAMILY MEDICINE	301,445	149	46,207	0	92	90.08	
90.09 09009 PAIN MANAGEMENT	11,540	65	22,669	0	40	90.09	
90.10 09010 DERMATOLOGY	250,571	149	24,898	0	92	90.10	
90.11 09011 KIDS FIRST	1,283,008	642	62,340	0	395	90.11	
91.00 09100 EMERGENCY	3,368,408	61,022	0	0	37,521	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
OTHER REIMBURSABLE COST CENTERS							
95.00 09500 AMBULANCE SERVICES	4,413,706	0	0	53,888	0	95.00	
SPECIAL PURPOSE COST CENTERS							
113.00 11300 INTEREST EXPENSE						113.00	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	53,666,372	1,198,044	599,545	53,888	736,649	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,582	0	0	4,662	190.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	4,870,634	0	0	0	0	192.00	
194.00 07950 MARKETING	0	0	0	0	0	194.00	
194.01 07951 PHYSICIAN BILLING	310,918	2,121	0	0	1,304	194.01	
194.02 07952 MOB	0	0	47,851	0	0	194.02	
200.00	Cross Foot Adjustments					200.00	
201.00	Negative Cost Centers		0	0	0	201.00	
202.00	TOTAL (sum lines 118 through 201)	58,847,924	1,207,747	647,396	53,888	742,615	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet B
Part I
Date/Time Prepared:
3/25/2025 3:14 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	ADMITTING	
	AMB EQUIP						
	2.01	4.00					
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101	MOB						1.01
1.02 00102	AMB DEPR						1.02
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 00201	AMB EQUIP	297,451					2.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	526,891				4.00
5.01 00590	ADMINISTRATIVE & GENERAL	0	27,328	6,850,292	6,850,292		5.01
5.02 00570	ADMITTING	0	21,863	861,443	113,488	974,931	5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	12,024	1,308,641	172,403	0	5.03
7.00 00700	OPERATION OF PLANT	0	9,838	2,149,491	283,178	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	1,093	267,232	35,206	0	8.00
9.00 00900	HOUSEKEEPING	0	14,211	885,651	116,677	0	9.00
10.00 01000	DIETARY	0	6,559	492,113	64,832	0	10.00
11.00 01100	CAFETERIA	0	12,024	672,259	88,565	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	9,838	1,086,352	143,118	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	6,559	1,204,871	158,732	0	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	14,211	939,504	123,772	0	16.00
17.00 01700	SOCIAL SERVICE	0	4,373	511,281	67,357	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	74,333	5,966,130	786,011	41,996	30.00
31.00 03100	INTENSIVE CARE UNIT	0	5,466	513,690	67,675	2,081	31.00
43.00 04300	NURSERY	0	3,279	167,900	22,119	8,103	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	25,142	1,820,521	239,839	68,441	50.00
53.00 05300	ANESTHESIOLOGY	0	0	12,983	1,710	10,210	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	24,049	2,573,365	339,020	259,870	54.00
60.00 06000	LABORATORY	0	18,583	3,251,250	428,326	164,523	60.00
65.00 06500	RESPIRATORY THERAPY	0	0	627,142	82,621	7,672	65.00
66.00 06600	PHYSICAL THERAPY	0	5,466	491,059	64,693	17,956	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	1,093	84,129	11,083	3,321	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	11,899	1,568	1,128	68.00
69.00 06900	ELECTROCARDIOLOGY	0	7,652	676,298	89,097	52,734	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,406,950	185,354	6,072	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	460,141	60,620	7,238	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	3,279	3,563,210	469,424	41,461	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.00
90.00 09000	CLINIC	0	1,093	72,593	9,564	911	90.00
90.01 09001	SENIOR CARE	0	1,093	206,558	27,212	1,027	90.01
90.02 09002	GENERAL SURGERY	0	6,559	416,146	54,824	658	90.02
90.03 09003	HARRISON CRAWFORD HEALTHCARE	0	7,652	488,245	64,322	3,816	90.03
90.04 09004	CORYDON MEDICAL ASSOCIATES	0	7,652	550,076	72,468	4,294	90.04
90.05 09005	ORTHOPEDIC SURGERY - DR KLINE	0	7,652	700,268	92,255	871	90.05
90.06 09006	OBGYN - DR SAUER	0	3,279	240,227	31,648	462	90.06
90.07 09007	FIRST CAPITAL MEDICAL GROUP	0	19,676	1,672,672	220,361	9,310	90.07
90.08 09008	SOUTH HARRISON FAMILY MEDICINE	0	5,466	353,359	46,552	2,658	90.08
90.09 09009	PAIN MANAGEMENT	0	1,093	35,407	4,665	497	90.09
90.10 09010	DERMATOLOGY	0	4,373	280,083	36,899	2,810	90.10
90.11 09011	KIDS FIRST	0	18,583	1,364,968	179,824	7,032	90.11
91.00 09100	EMERGENCY	0	39,353	3,506,304	461,928	188,481	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	297,451	53,564	4,818,609	634,813	59,298	95.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	297,451	485,351	53,561,312	6,153,823	974,931	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	12,244	1,613	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	37,167	4,907,801	646,564	0	192.00
194.00 07950	MARKETING	0	0	0	0	0	194.00
194.01 07951	PHYSICIAN BILLING	0	4,373	318,716	41,988	0	194.01
194.02 07952	MOB	0	0	47,851	6,304	0	194.02
200.00	Cross Foot Adjustments			0			200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	297,451	526,891	58,847,924	6,850,292	974,931	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet B
Part I
Date/Time Prepared:
3/25/2025 3:14 pm

Cost Center Description		CASHIERING/AC COUNTS RECEIVABLE	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.03	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 MOB						1.01
1.02	00102 AMB DEPR						1.02
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 AMB EQUIP						2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590 ADMINISTRATIVE & GENERAL						5.01
5.02	00570 ADMITTING						5.02
5.03	00580 CASHIERING/ACCOUNTS RECEIVABLE	1,481,044					5.03
7.00	00700 OPERATION OF PLANT	0	2,432,669				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	23,752	326,190			8.00
9.00	00900 HOUSEKEEPING	0	50,875	0	1,053,203		9.00
10.00	01000 DIETARY	0	148,034	0	66,118	771,097	10.00
11.00	01100 CAFETERIA	0	73,952	0	33,030	0	11.00
13.00	01300 NURSING ADMINISTRATION	0	12,446	0	5,559	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	82,587	0	36,887	0	16.00
17.00	01700 SOCIAL SERVICE	0	4,979	0	2,224	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	63,805	562,264	48,967	251,132	551,952	30.00
31.00	03100 INTENSIVE CARE UNIT	3,161	75,119	44,770	33,551	34,071	31.00
43.00	04300 NURSERY	12,312	15,558	0	6,949	185,074	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	103,984	459,530	25,205	205,246	0	50.00
53.00	05300 ANESTHESIOLOGY	15,513	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	394,631	240,759	55,109	107,534	0	54.00
60.00	06000 LABORATORY	249,965	126,538	400	56,517	0	60.00
65.00	06500 RESPIRATORY THERAPY	11,656	27,538	0	12,299	0	65.00
66.00	06600 PHYSICAL THERAPY	27,281	93,166	0	41,612	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	5,046	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	1,714	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	80,121	47,296	11,076	21,125	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,226	112,951	0	50,449	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	10,997	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	62,993	31,790	0	14,199	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.00
90.00	09000 CLINIC	1,384	39,388	0	17,592	0	90.00
90.01	09001 SENIOR CARE	1,560	0	0	0	0	90.01
90.02	09002 GENERAL SURGERY	999	519	550	232	0	90.02
90.03	09003 HARRISON CRAWFORD HEALTHCARE	5,798	545	0	243	0	90.03
90.04	09004 CORYDON MEDICAL ASSOCIATES	6,524	570	200	255	0	90.04
90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	1,323	467	165	208	0	90.05
90.06	09006 OBGYN - DR SAUER	701	726	979	324	0	90.06
90.07	09007 FIRST CAPITAL MEDICAL GROUP	14,146	1,400	847	625	0	90.07
90.08	09008 SOUTH HARRISON FAMILY MEDICINE	4,038	415	152	185	0	90.08
90.09	09009 PAIN MANAGEMENT	755	182	1,049	81	0	90.09
90.10	09010 DERMATOLOGY	4,269	415	2,012	185	0	90.10
90.11	09011 KIDS FIRST	10,683	1,789	0	799	0	90.11
91.00	09100 EMERGENCY	286,365	170,074	115,200	75,963	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	90,094	0	17,859	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,481,044	2,405,624	324,540	1,041,123	771,097	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21,133	0	9,439	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	1,650	0	0	192.00
194.00	07950 MARKETING	0	0	0	0	0	194.00
194.01	07951 PHYSICIAN BILLING	0	5,912	0	2,641	0	194.01
194.02	07952 MOB	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1,481,044	2,432,669	326,190	1,053,203	771,097	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet B Part I Date/Time Prepared: 3/25/2025 3:14 pm
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11.00	13.00	14.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 MOB						1.01
1.02	00102 AMB DEPR						1.02
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 AMB EQUIP						2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590 ADMINISTRATIVE & GENERAL						5.01
5.02	00570 ADMITTING						5.02
5.03	00580 CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY						10.00
11.00	01100 CAFETERIA	867,806					11.00
13.00	01300 NURSING ADMINISTRATION	27,309	1,274,784				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	18,206	0	1,381,809			14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	39,446	0	2,849	1,225,045		16.00
17.00	01700 SOCIAL SERVICE	12,137	0	413	0	598,391	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	206,333	605,521	26,226	333,801	428,329	30.00
31.00	03100 INTENSIVE CARE UNIT	15,171	48,410	7,375	0	26,440	31.00
43.00	04300 NURSERY	9,103	26,211	29	0	143,622	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	69,789	201,929	83,587	320,538	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	4,254	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	66,754	0	38,616	0	0	54.00
60.00	06000 LABORATORY	51,583	0	391,814	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	9,911	0	0	65.00
66.00	06600 PHYSICAL THERAPY	15,171	0	1,946	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	3,034	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	21,240	59,375	4,533	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	452,762	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	150,787	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	9,103	0	1,100	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.00
90.00	09000 CLINIC	3,034	5,527	16	0	0	90.00
90.01	09001 SENIOR CARE	3,034	7,310	355	241,325	0	90.01
90.02	09002 GENERAL SURGERY	18,206	0	1,414	0	0	90.02
90.03	09003 HARRISON CRAWFORD HEALTHCARE	21,240	0	7,986	0	0	90.03
90.04	09004 CORYDON MEDICAL ASSOCIATES	21,240	0	4,602	0	0	90.04
90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	21,240	0	12,161	0	0	90.05
90.06	09006 OBGYN - DR SAUER	9,103	0	5,561	0	0	90.06
90.07	09007 FIRST CAPITAL MEDICAL GROUP	54,617	0	17,041	0	0	90.07
90.08	09008 SOUTH HARRISON FAMILY MEDICINE	15,171	0	8,140	0	0	90.08
90.09	09009 PAIN MANAGEMENT	3,034	0	713	0	0	90.09
90.10	09010 DERMATOLOGY	12,137	0	2,745	0	0	90.10
90.11	09011 KIDS FIRST	0	0	52,866	0	0	90.11
91.00	09100 EMERGENCY	109,234	320,501	42,155	329,381	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	49,852	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	855,669	1,274,784	1,381,809	1,225,045	598,391	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950 MARKETING	0	0	0	0	0	194.00
194.01	07951 PHYSICIAN BILLING	12,137	0	0	0	0	194.01
194.02	07952 MOB	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	867,806	1,274,784	1,381,809	1,225,045	598,391	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet B Part I Date/Time Prepared: 3/25/2025 3:14 pm
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
1.01	00101				1.01
1.02	00102				1.02
2.00	00200				2.00
2.01	00201				2.01
4.00	00400				4.00
5.01	00590				5.01
5.02	00570				5.02
5.03	00580				5.03
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
16.00	01600				16.00
17.00	01700				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	9,872,467	0	9,872,467	30.00
31.00	03100	871,514	0	871,514	31.00
43.00	04300	596,980	0	596,980	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	3,598,609	0	3,598,609	50.00
53.00	05300	44,670	0	44,670	53.00
54.00	05400	4,075,658	0	4,075,658	54.00
60.00	06000	4,720,916	0	4,720,916	60.00
65.00	06500	778,839	0	778,839	65.00
66.00	06600	752,884	0	752,884	66.00
67.00	06700	106,613	0	106,613	67.00
68.00	06800	16,309	0	16,309	68.00
69.00	06900	1,062,895	0	1,062,895	69.00
71.00	07100	2,223,764	0	2,223,764	71.00
72.00	07200	689,783	0	689,783	72.00
73.00	07300	4,193,280	0	4,193,280	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	0	0	0	88.00
90.00	09000	150,009	0	150,009	90.00
90.01	09001	488,381	0	488,381	90.01
90.02	09002	493,548	0	493,548	90.02
90.03	09003	592,195	0	592,195	90.03
90.04	09004	660,229	0	660,229	90.04
90.05	09005	828,958	0	828,958	90.05
90.06	09006	289,731	0	289,731	90.06
90.07	09007	1,991,019	0	1,991,019	90.07
90.08	09008	430,670	0	430,670	90.08
90.09	09009	46,383	0	46,383	90.09
90.10	09010	341,555	0	341,555	90.10
90.11	09011	1,617,961	0	1,617,961	90.11
91.00	09100	5,605,586	0	5,605,586	91.00
92.00	09200		0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	5,670,525	0	5,670,525	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00					118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	44,429	0	44,429	190.00
192.00	19200	5,556,015	0	5,556,015	192.00
194.00	07950	0	0	0	194.00
194.01	07951	381,394	0	381,394	194.01
194.02	07952	54,155	0	54,155	194.02
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		58,847,924	0	58,847,924	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet B Part II Date/Time Prepared: 3/25/2025 3:14 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	MOB	AMB DEPR	NEW MVBLE EQUIP	
		0	1.00	1.01	1.02	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	MOB					1.01
1.02 00102	AMB DEPR					1.02
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01 00201	AMB EQUIP					2.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,861	0	0	1,144 4.00
5.01 00590	ADMINISTRATIVE & GENERAL	0	187,103	3,703	0	115,045 5.01
5.02 00570	ADMINITTING	0	0	0	0	0 5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0 5.03
7.00 00700	OPERATION OF PLANT	0	145,954	0	0	89,744 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	8,522	0	0	5,240 8.00
9.00 00900	HOUSEKEEPING	0	18,254	0	0	11,224 9.00
10.00 01000	DIETARY	0	53,114	0	0	32,658 10.00
11.00 01100	CAFETERIA	0	26,534	0	0	16,315 11.00
13.00 01300	NURSING ADMINISTRATION	0	4,466	0	0	2,746 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	29,632	0	0	18,220 16.00
17.00 01700	SOCIAL SERVICE	0	1,786	0	0	1,098 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	201,739	0	0	124,045 30.00
31.00 03100	INTENSIVE CARE UNIT	0	26,952	0	0	16,572 31.00
43.00 04300	NURSERY	0	5,582	0	0	3,432 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	164,877	0	0	101,379 50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	86,383	0	0	53,115 54.00
60.00 06000	LABORATORY	0	45,401	0	0	27,916 60.00
65.00 06500	RESPIRATORY THERAPY	0	9,880	0	0	6,075 65.00
66.00 06600	PHYSICAL THERAPY	0	33,428	0	0	20,554 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	16,970	0	0	10,434 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	40,526	0	0	24,919 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	11,406	0	0	7,013 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0 88.00
90.00 09000	CLINIC	0	14,132	0	0	8,689 90.00
90.01 09001	SENIOR CARE	0	0	21,592	0	0 90.01
90.02 09002	GENERAL SURGERY	0	186	50,250	0	114 90.02
90.03 09003	HARRISON CRAWFORD HEALTHCARE	0	195	59,658	0	120 90.03
90.04 09004	CORYDON MEDICAL ASSOCIATES	0	205	83,026	0	126 90.04
90.05 09005	ORTHOPEDIC SURGERY - DR KLINE	0	167	91,263	0	103 90.05
90.06 09006	OBGYN - DR SAUER	0	260	29,829	0	160 90.06
90.07 09007	FIRST CAPITAL MEDICAL GROUP	0	502	104,110	0	309 90.07
90.08 09008	SOUTH HARRISON FAMILY MEDICINE	0	149	46,207	0	92 90.08
90.09 09009	PAIN MANAGEMENT	0	65	22,669	0	40 90.09
90.10 09010	DERMATOLOGY	0	149	24,898	0	92 90.10
90.11 09011	KIDS FIRST	0	642	62,340	0	395 90.11
91.00 09100	EMERGENCY	0	61,022	0	0	37,521 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	53,888	0 95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0 113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	1,198,044	599,545	53,888	736,649 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,582	0	0	4,662 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
194.00 07950	MARKETING	0	0	0	0	0 194.00
194.01 07951	PHYSICIAN BILLING	0	2,121	0	0	1,304 194.01
194.02 07952	MOB	0	0	47,851	0	0 194.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	0	1,207,747	647,396	53,888	742,615 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet B
Part II
Date/Time Prepared:
3/25/2025 3:14 pm

Cost Center Description	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	ADMITTING	
	AMB EQUIP						
	2.01	2A					
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	AMB DEPR					1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	AMB EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,005	3,005		4.00
5.01	00590	ADMINISTRATIVE & GENERAL	0	305,851	156	306,007	5.01
5.02	00570	ADMITTING	0	0	125	5,070	5,195
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	69	7,701	0
7.00	00700	OPERATION OF PLANT	0	235,698	56	12,650	0
8.00	00800	LAUNDRY & LINEN SERVICE	0	13,762	6	1,573	0
9.00	00900	HOUSEKEEPING	0	29,478	81	5,212	0
10.00	01000	DIETARY	0	85,772	37	2,896	0
11.00	01100	CAFETERIA	0	42,849	69	3,956	0
13.00	01300	NURSING ADMINISTRATION	0	7,212	56	6,393	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	37	7,091	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	47,852	81	5,529	0
17.00	01700	SOCIAL SERVICE	0	2,884	25	3,009	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	325,784	425	35,110	227
31.00	03100	INTENSIVE CARE UNIT	0	43,524	31	3,023	11
43.00	04300	NURSERY	0	9,014	19	988	44
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	266,256	143	10,714	370
53.00	05300	ANESTHESIOLOGY	0	0	0	76	55
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	139,498	137	15,144	1,327
60.00	06000	LABORATORY	0	73,317	106	19,134	890
65.00	06500	RESPIRATORY THERAPY	0	15,955	0	3,691	42
66.00	06600	PHYSICAL THERAPY	0	53,982	31	2,890	97
67.00	06700	OCCUPATIONAL THERAPY	0	0	6	495	18
68.00	06800	SPEECH PATHOLOGY	0	0	0	70	6
69.00	06900	ELECTROCARDIOLOGY	0	27,404	44	3,980	285
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	65,445	0	8,280	33
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,708	39
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,419	19	20,969	224
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0
90.00	09000	CLINIC	0	22,821	6	427	5
90.01	09001	SENIOR CARE	0	21,592	6	1,216	6
90.02	09002	GENERAL SURGERY	0	50,550	37	2,449	4
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	59,973	44	2,873	21
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	83,357	44	3,237	23
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	91,533	44	4,121	5
90.06	09006	OBGYN - DR SAUER	0	30,249	19	1,414	2
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	104,921	112	9,844	50
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	46,448	31	2,080	14
90.09	09009	PAIN MANAGEMENT	0	22,774	6	208	3
90.10	09010	DERMATOLOGY	0	25,139	25	1,648	15
90.11	09011	KIDS FIRST	0	63,377	106	8,033	38
91.00	09100	EMERGENCY	0	98,543	224	20,635	1,020
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0			
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	297,451	351,339	305	28,358	321
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	297,451	2,885,577	2,768	274,895	5,195
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,244	0	72	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	212	28,882	0
194.00	07950	MARKETING	0	0	0	0	0
194.01	07951	PHYSICIAN BILLING	0	3,425	25	1,876	0
194.02	07952	MOB	0	47,851	0	282	0
200.00		Cross Foot Adjustments	0	0			200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	297,451	2,949,097	3,005	306,007	5,195

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet B
Part II
Date/Time Prepared:
3/25/2025 3:14 pm

Cost Center Description		CASHIERING/AC COUNTS RECEIVABLE	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.03	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 MOB						1.01
1.02	00102 AMB DEPR						1.02
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 AMB EQUIP						2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590 ADMINISTRATIVE & GENERAL						5.01
5.02	00570 ADMITTING						5.02
5.03	00580 CASHIERING/ACCOUNTS RECEIVABLE	7,770					5.03
7.00	00700 OPERATION OF PLANT	0	248,404				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	2,425	17,766			8.00
9.00	00900 HOUSEKEEPING	0	5,195	0	39,966		9.00
10.00	01000 DIETARY	0	15,116	0	2,509	106,330	10.00
11.00	01100 CAFETERIA	0	7,551	0	1,253	0	11.00
13.00	01300 NURSING ADMINISTRATION	0	1,271	0	211	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	8,433	0	1,400	0	16.00
17.00	01700 SOCIAL SERVICE	0	508	0	84	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	337	57,414	2,667	9,529	76,111	30.00
31.00	03100 INTENSIVE CARE UNIT	17	7,671	2,438	1,273	4,698	31.00
43.00	04300 NURSERY	65	1,589	0	264	25,521	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	549	46,923	1,373	7,788	0	50.00
53.00	05300 ANESTHESIOLOGY	82	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,037	24,584	3,002	4,081	0	54.00
60.00	06000 LABORATORY	1,319	12,921	22	2,145	0	60.00
65.00	06500 RESPIRATORY THERAPY	61	2,812	0	467	0	65.00
66.00	06600 PHYSICAL THERAPY	144	9,513	0	1,579	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	27	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	9	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	423	4,829	603	802	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	49	11,534	0	1,914	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	58	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	332	3,246	0	539	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.00
90.00	09000 CLINIC	7	4,022	0	668	0	90.00
90.01	09001 SENIOR CARE	8	0	0	0	0	90.01
90.02	09002 GENERAL SURGERY	5	53	30	9	0	90.02
90.03	09003 HARRISON CRAWFORD HEALTHCARE	31	56	0	9	0	90.03
90.04	09004 CORYDON MEDICAL ASSOCIATES	34	58	11	10	0	90.04
90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	7	48	9	8	0	90.05
90.06	09006 OBGYN - DR SAUER	4	74	53	12	0	90.06
90.07	09007 FIRST CAPITAL MEDICAL GROUP	75	143	46	24	0	90.07
90.08	09008 SOUTH HARRISON FAMILY MEDICINE	21	42	8	7	0	90.08
90.09	09009 PAIN MANAGEMENT	4	19	57	3	0	90.09
90.10	09010 DERMATOLOGY	23	42	110	7	0	90.10
90.11	09011 KIDS FIRST	56	183	0	30	0	90.11
91.00	09100 EMERGENCY	1,511	17,367	6,274	2,883	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	475	0	973	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	7,770	245,642	17,676	39,508	106,330	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,158	0	358	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	90	0	0	192.00
194.00	07950 MARKETING	0	0	0	0	0	194.00
194.01	07951 PHYSICIAN BILLING	0	604	0	100	0	194.01
194.02	07952 MOB	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	7,770	248,404	17,766	39,966	106,330	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet B Part II Date/Time Prepared: 3/25/2025 3:14 pm
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11.00	13.00	14.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 MOB						1.01
1.02	00102 AMB DEPR						1.02
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 AMB EQUIP						2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590 ADMINISTRATIVE & GENERAL						5.01
5.02	00570 ADMITTING						5.02
5.03	00580 CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY						10.00
11.00	01100 CAFETERIA	55,678					11.00
13.00	01300 NURSING ADMINISTRATION	1,752	16,895				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	1,168	0	8,296			14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	2,531	0	17	65,843		16.00
17.00	01700 SOCIAL SERVICE	779	0	2	0	7,291	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	13,236	8,025	157	17,941	5,219	30.00
31.00	03100 INTENSIVE CARE UNIT	973	642	44	0	322	31.00
43.00	04300 NURSERY	584	347	0	0	1,750	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	4,478	2,676	502	17,228	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	26	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,283	0	232	0	0	54.00
60.00	06000 LABORATORY	3,310	0	2,352	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	59	0	0	65.00
66.00	06600 PHYSICAL THERAPY	973	0	12	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	195	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	1,363	787	27	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,722	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	905	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	584	0	7	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.00
90.00	09000 CLINIC	195	73	0	0	0	90.00
90.01	09001 SENIOR CARE	195	97	2	12,971	0	90.01
90.02	09002 GENERAL SURGERY	1,168	0	8	0	0	90.02
90.03	09003 HARRISON CRAWFORD HEALTHCARE	1,363	0	48	0	0	90.03
90.04	09004 CORYDON MEDICAL ASSOCIATES	1,363	0	28	0	0	90.04
90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	1,363	0	73	0	0	90.05
90.06	09006 OBGYN - DR SAUER	584	0	33	0	0	90.06
90.07	09007 FIRST CAPITAL MEDICAL GROUP	3,504	0	102	0	0	90.07
90.08	09008 SOUTH HARRISON FAMILY MEDICINE	973	0	49	0	0	90.08
90.09	09009 PAIN MANAGEMENT	195	0	4	0	0	90.09
90.10	09010 DERMATOLOGY	779	0	16	0	0	90.10
90.11	09011 KIDS FIRST	0	0	317	0	0	90.11
91.00	09100 EMERGENCY	7,008	4,248	253	17,703	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	299	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	54,899	16,895	8,296	65,843	7,291	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950 MARKETING	0	0	0	0	0	194.00
194.01	07951 PHYSICIAN BILLING	779	0	0	0	0	194.01
194.02	07952 MOB	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	55,678	16,895	8,296	65,843	7,291	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet B Part II Date/Time Prepared: 3/25/2025 3:14 pm
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
1.01	00101				1.01
1.02	00102				1.02
2.00	00200				2.00
2.01	00201				2.01
4.00	00400				4.00
5.01	00590				5.01
5.02	00570				5.02
5.03	00580				5.03
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
16.00	01600				16.00
17.00	01700				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	552,182	0	552,182	30.00
31.00	03100	64,667	0	64,667	31.00
43.00	04300	40,185	0	40,185	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	359,000	0	359,000	50.00
53.00	05300	239	0	239	53.00
54.00	05400	194,325	0	194,325	54.00
60.00	06000	115,516	0	115,516	60.00
65.00	06500	23,087	0	23,087	65.00
66.00	06600	69,221	0	69,221	66.00
67.00	06700	741	0	741	67.00
68.00	06800	85	0	85	68.00
69.00	06900	40,547	0	40,547	69.00
71.00	07100	89,977	0	89,977	71.00
72.00	07200	3,710	0	3,710	72.00
73.00	07300	44,339	0	44,339	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	0	0	0	88.00
90.00	09000	28,224	0	28,224	90.00
90.01	09001	36,093	0	36,093	90.01
90.02	09002	54,313	0	54,313	90.02
90.03	09003	64,418	0	64,418	90.03
90.04	09004	88,165	0	88,165	90.04
90.05	09005	97,211	0	97,211	90.05
90.06	09006	32,444	0	32,444	90.06
90.07	09007	118,821	0	118,821	90.07
90.08	09008	49,673	0	49,673	90.08
90.09	09009	23,273	0	23,273	90.09
90.10	09010	27,804	0	27,804	90.10
90.11	09011	72,140	0	72,140	90.11
91.00	09100	177,669	0	177,669	91.00
92.00	09200		0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	382,070	0	382,070	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		2,850,139	0	2,850,139	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	14,832	0	14,832	190.00
192.00	19200	29,184	0	29,184	192.00
194.00	07950	0	0	0	194.00
194.01	07951	6,809	0	6,809	194.01
194.02	07952	48,133	0	48,133	194.02
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		2,949,097	0	2,949,097	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
3/25/2025 3:14 pm

Cost Center Description		CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	AMB DEPR (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	AMB EQUIP (SQUARE FEET)	
		1.00	1.01	1.02	2.00	2.01	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	129,816					1.00
1.01	00101 MOB	0	34,270				1.01
1.02	00102 AMB DEPR	0	0	11,032			1.02
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP				129,816		2.00
2.01	00201 AMB EQUIP				0	11,032	2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	200	0	0	200	0	4.00
5.01	00590 ADMINISTRATIVE & GENERAL	20,111	196	0	20,111	0	5.01
5.02	00570 ADMINITTING	0	0	0	0	0	5.02
5.03	00580 CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.03
7.00	00700 OPERATION OF PLANT	15,688	0	0	15,688	0	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	916	0	0	916	0	8.00
9.00	00900 HOUSEKEEPING	1,962	0	0	1,962	0	9.00
10.00	01000 DIETARY	5,709	0	0	5,709	0	10.00
11.00	01100 CAFETERIA	2,852	0	0	2,852	0	11.00
13.00	01300 NURSING ADMINISTRATION	480	0	0	480	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	3,185	0	0	3,185	0	16.00
17.00	01700 SOCIAL SERVICE	192	0	0	192	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	21,684	0	0	21,684	0	30.00
31.00	03100 INTENSIVE CARE UNIT	2,897	0	0	2,897	0	31.00
43.00	04300 NURSERY	600	0	0	600	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	17,722	0	0	17,722	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	9,285	0	0	9,285	0	54.00
60.00	06000 LABORATORY	4,880	0	0	4,880	0	60.00
65.00	06500 RESPIRATORY THERAPY	1,062	0	0	1,062	0	65.00
66.00	06600 PHYSICAL THERAPY	3,593	0	0	3,593	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	1,824	0	0	1,824	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,356	0	0	4,356	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,226	0	0	1,226	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.00
90.00	09000 CLINIC	1,519	0	0	1,519	0	90.00
90.01	09001 SENIOR CARE	0	1,143	0	0	0	90.01
90.02	09002 GENERAL SURGERY	20	2,660	0	20	0	90.02
90.03	09003 HARRISON CRAWFORD HEALTHCARE	21	3,158	0	21	0	90.03
90.04	09004 CORYDON MEDICAL ASSOCIATES	22	4,395	0	22	0	90.04
90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	18	4,831	0	18	0	90.05
90.06	09006 OBGYN - DR SAUER	28	1,579	0	28	0	90.06
90.07	09007 FIRST CAPITAL MEDICAL GROUP	54	5,511	0	54	0	90.07
90.08	09008 SOUTH HARRISON FAMILY MEDICINE	16	2,446	0	16	0	90.08
90.09	09009 PAIN MANAGEMENT	7	1,200	0	7	0	90.09
90.10	09010 DERMATOLOGY	16	1,318	0	16	0	90.10
90.11	09011 KIDS FIRST	69	3,300	0	69	0	90.11
91.00	09100 EMERGENCY	6,559	0	0	6,559	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	11,032	0	11,032	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	128,773	31,737	11,032	128,773	11,032	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	815	0	0	815	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950 MARKETING	0	0	0	0	0	194.00
194.01	07951 PHYSICIAN BILLING	228	0	0	228	0	194.01
194.02	07952 MOB	0	2,533	0	0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,207,747	647,396	53,888	742,615	297,451	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	9.303530	18.891042	4.884699	5.720520	26.962563	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)						204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
3/25/2025 3:14 pm

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

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet B-1 Date/Time Prepared: 3/25/2025 3:14 pm			
Cost Center	Description	EMPLOYEE BENEFITS DEPARTMENT (PAID FTES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	ADMINING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
		4.00	5A.01	5.01	5.02	5.03	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	AMB DEPR					1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	AMB EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	482				4.00
5.01	00590	ADMINISTRATIVE & GENERAL	25	-6,850,292	51,997,632		5.01
5.02	00570	ADMINING	20	0	861,443	195,323,283	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	11	0	1,308,641	0	5.03
7.00	00700	OPERATION OF PLANT	9	0	2,149,491	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1	0	267,232	0	8.00
9.00	00900	HOUSEKEEPING	13	0	885,651	0	9.00
10.00	01000	DIETARY	6	0	492,113	0	10.00
11.00	01100	CAFETERIA	11	0	672,259	0	11.00
13.00	01300	NURSING ADMINISTRATION	9	0	1,086,352	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6	0	1,204,871	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13	0	939,504	0	16.00
17.00	01700	SOCIAL SERVICE	4	0	511,281	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	68	0	5,966,130	8,414,279	30.00
31.00	03100	INTENSIVE CARE UNIT	5	0	513,690	416,868	31.00
43.00	04300	NURSERY	3	0	167,900	1,623,584	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	23	0	1,820,521	13,712,791	50.00
53.00	05300	ANESTHESIOLOGY	0	0	12,983	2,045,731	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22	0	2,573,365	52,053,503	54.00
60.00	06000	LABORATORY	17	0	3,251,250	32,963,888	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	627,142	1,537,140	65.00
66.00	06600	PHYSICAL THERAPY	5	0	491,059	3,597,603	66.00
67.00	06700	OCCUPATIONAL THERAPY	1	0	84,129	665,408	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	11,899	226,038	68.00
69.00	06900	ELECTROCARDIOLOGY	7	0	676,298	10,565,913	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,406,950	1,216,624	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	460,141	1,450,176	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3	0	3,563,210	8,307,129	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	0	88.00
90.00	09000	CLINIC	1	0	72,593	182,529	90.00
90.01	09001	SENIOR CARE	1	0	206,558	205,784	90.01
90.02	09002	GENERAL SURGERY	6	0	416,146	131,777	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	7	0	488,245	764,621	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	7	0	550,076	860,396	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	7	0	700,268	174,432	90.05
90.06	09006	OBGYN - DR SAUER	3	0	240,227	92,501	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	18	0	1,672,672	1,865,448	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	5	0	353,359	532,539	90.08
90.09	09009	PAIN MANAGEMENT	1	0	35,407	99,573	90.09
90.10	09010	DERMATOLOGY	4	0	280,083	562,971	90.10
90.11	09011	KIDS FIRST	17	0	1,364,968	1,408,866	90.11
91.00	09100	EMERGENCY	36	0	3,506,304	37,764,134	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	49	0	4,818,609	11,881,037	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	444	-6,850,292	46,711,020	195,323,283	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	12,244	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	34	0	4,907,801	0	192.00
194.00	07950	MARKETING	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	4	0	318,716	0	194.01
194.02	07952	MOB	0	0	47,851	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	526,891		6,850,292	974,931	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1,093.134855		0.131742	0.004991	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	3,005		306,007	5,195	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
3/25/2025 3:14 pm

Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT (PAID FTES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	ADMITTING (GROSS CHARGES)	CASHIERING/AC COUNTS RECEIVABLE (GROSS CHARGES)	
		4.00	5A.01	5.01	5.02	5.03	
205.00	Unit cost multiplier (Wkst. B, Part II)	6.234440		0.005885	0.000027	0.000040	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
3/25/2025 3:14 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (HOURS OF SERVICE)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	AMB DEPR					1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	AMB EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	ADMINISTRATIVE & GENERAL					5.01
5.02	00570	ADMITTING					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
7.00	00700	OPERATION OF PLANT	93,817				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	916	148,311			8.00
9.00	00900	HOUSEKEEPING	1,962	0	90,939		9.00
10.00	01000	DIETARY	5,709	0	5,709	2,829	10.00
11.00	01100	CAFETERIA	2,852	0	2,852	0	286 11.00
13.00	01300	NURSING ADMINISTRATION	480	0	480	0	9 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	6 14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,185	0	3,185	0	13 16.00
17.00	01700	SOCIAL SERVICE	192	0	192	0	4 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	21,684	22,264	21,684	2,025	68 30.00
31.00	03100	INTENSIVE CARE UNIT	2,897	20,356	2,897	125	5 31.00
43.00	04300	NURSERY	600	0	600	679	3 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	17,722	11,460	17,722	0	23 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,285	25,057	9,285	0	22 54.00
60.00	06000	LABORATORY	4,880	182	4,880	0	17 60.00
65.00	06500	RESPIRATORY THERAPY	1,062	0	1,062	0	0 65.00
66.00	06600	PHYSICAL THERAPY	3,593	0	3,593	0	5 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	1 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	1,824	5,036	1,824	0	7 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,356	0	4,356	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,226	0	1,226	0	3 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0 88.00
90.00	09000	CLINIC	1,519	0	1,519	0	1 90.00
90.01	09001	SENIOR CARE	0	0	0	0	1 90.01
90.02	09002	GENERAL SURGERY	20	250	20	0	6 90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	21	0	21	0	7 90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	22	91	22	0	7 90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	18	75	18	0	7 90.05
90.06	09006	OBGYN - DR SAUER	28	445	28	0	3 90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	54	385	54	0	18 90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	16	69	16	0	5 90.08
90.09	09009	PAIN MANAGEMENT	7	477	7	0	1 90.09
90.10	09010	DERMATOLOGY	16	915	16	0	4 90.10
90.11	09011	KIDS FIRST	69	0	69	0	0 90.11
91.00	09100	EMERGENCY	6,559	52,379	6,559	0	36 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	8,120	0	0	0 95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	92,774	147,561	89,896	2,829	282 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	815	0	815	0	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	750	0	0	0 192.00
194.00	07950	MARKETING	0	0	0	0	0 194.00
194.01	07951	PHYSICIAN BILLING	228	0	228	0	4 194.01
194.02	07952	MOB	0	0	0	0	0 194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,432,669	326,190	1,053,203	771,097	867,806 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.929938	2.199365	11.581423	272.568752	3,034.286713 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	248,404	17,766	39,966	106,330	55,678 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.647750	0.119789	0.439481	37.585719	194.678322 205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-1331			Period: From 01/01/2024 To 12/31/2024		Worksheet B-1 Date/Time Prepared: 3/25/2025 3:14 pm	
Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (HOURS OF SERVICE)		
		7.00	8.00	9.00	10.00	11.00		
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)							206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)							207.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet B-1 Date/Time Prepared: 3/25/2025 3:14 pm
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Cost Center Description		NURSING ADMINISTRATIVE (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME STUDY)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		13.00	14.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
1.01	00101					1.01
1.02	00102					1.02
2.00	00200					2.00
2.01	00201					2.01
4.00	00400					4.00
5.01	00590					5.01
5.02	00570					5.02
5.03	00580					5.03
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300	14,299				13.00
14.00	01400	0	4,216,724			14.00
16.00	01600	0	8,695	3,325		16.00
17.00	01700	0	1,260	0	2,829	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	6,792	80,032	906	2,025	30.00
31.00	03100	543	22,506	0	125	31.00
43.00	04300	294	89	0	679	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	2,265	255,075	870	0	50.00
53.00	05300	0	12,983	0	0	53.00
54.00	05400	0	117,840	0	0	54.00
60.00	06000	0	1,195,658	0	0	60.00
65.00	06500	0	30,244	0	0	65.00
66.00	06600	0	5,939	0	0	66.00
67.00	06700	0	0	0	0	67.00
68.00	06800	0	0	0	0	68.00
69.00	06900	666	13,834	0	0	69.00
71.00	07100	0	1,381,641	0	0	71.00
72.00	07200	0	460,141	0	0	72.00
73.00	07300	0	3,357	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	0	0	0	0	88.00
90.00	09000	62	49	0	0	90.00
90.01	09001	82	1,084	655	0	90.01
90.02	09002	0	4,315	0	0	90.02
90.03	09003	0	24,370	0	0	90.03
90.04	09004	0	14,042	0	0	90.04
90.05	09005	0	37,111	0	0	90.05
90.06	09006	0	16,970	0	0	90.06
90.07	09007	0	52,001	0	0	90.07
90.08	09008	0	24,841	0	0	90.08
90.09	09009	0	2,175	0	0	90.09
90.10	09010	0	8,377	0	0	90.10
90.11	09011	0	161,327	0	0	90.11
91.00	09100	3,595	128,640	894	0	91.00
92.00	09200					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	0	152,128	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
118.00						118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	0	0	0	192.00
194.00	07950	0	0	0	0	194.00
194.01	07951	0	0	0	0	194.01
194.02	07952	0	0	0	0	194.02
200.00						200.00
201.00						201.00
202.00		1,274,784	1,381,809	1,225,045	598,391	202.00
203.00		89.151969	0.327697	368.434586	211.520325	203.00
204.00		16,895	8,296	65,843	7,291	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1
Date/Time Prepared:
3/25/2025 3:14 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME STUDY)	SOCIAL SERVICE (TOTAL PATIENT DAYS)		
		13.00	14.00	16.00	17.00		
205.00	Unit cost multiplier (Wkst. B, Part II)	1.181551	0.001967	19.802406	2.577236		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet C
Part I
Date/Time Prepared:
3/25/2025 3:14 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	9,872,467		9,872,467	0	0 30.00
31.00	03100 INTENSIVE CARE UNIT	871,514		871,514	0	0 31.00
43.00	04300 NURSERY	596,980		596,980	0	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3,598,609		3,598,609	0	0 50.00
53.00	05300 ANESTHESIOLOGY	44,670		44,670	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,075,658		4,075,658	0	0 54.00
60.00	06000 LABORATORY	4,720,916		4,720,916	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	778,839	0	778,839	0	0 65.00
66.00	06600 PHYSICAL THERAPY	752,884	0	752,884	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	106,613	0	106,613	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	16,309	0	16,309	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	1,062,895		1,062,895	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,223,764		2,223,764	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	689,783		689,783	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,193,280		4,193,280	0	0 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC (RHC)	0		0	0	0 88.00
90.00	09000 CLINIC	150,009		150,009	0	0 90.00
90.01	09001 SENIOR CARE	488,381		488,381	0	0 90.01
90.02	09002 GENERAL SURGERY	493,548		493,548	0	0 90.02
90.03	09003 HARRISON CRAWFORD HEALTHCARE	592,195		592,195	0	0 90.03
90.04	09004 CORYDON MEDICAL ASSOCIATES	660,229		660,229	0	0 90.04
90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	828,958		828,958	0	0 90.05
90.06	09006 OBGYN - DR SAUER	289,731		289,731	0	0 90.06
90.07	09007 FIRST CAPITAL MEDICAL GROUP	1,991,019		1,991,019	0	0 90.07
90.08	09008 SOUTH HARRISON FAMILY MEDICINE	430,670		430,670	0	0 90.08
90.09	09009 PAIN MANAGEMENT	46,383		46,383	0	0 90.09
90.10	09010 DERMATOLOGY	341,555		341,555	0	0 90.10
90.11	09011 KIDS FIRST	1,617,961		1,617,961	0	0 90.11
91.00	09100 EMERGENCY	5,605,586		5,605,586	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,632,233		3,632,233	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	5,670,525		5,670,525	0	0 95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	56,444,164	0	56,444,164	0	0 200.00
201.00	Less Observation Beds	3,632,233		3,632,233		0 201.00
202.00	Total (see instructions)	52,811,931	0	52,811,931	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet C
Part I
Date/Time Prepared:
3/25/2025 3:14 pm

		Title XVIII			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,441,771		6,441,771		30.00
31.00	03100	INTENSIVE CARE UNIT	416,868		416,868		31.00
43.00	04300	NURSERY	1,623,584		1,623,584		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,658,280	11,054,511	13,712,791	0.262427	50.00
53.00	05300	ANESTHESIOLOGY	328,404	1,717,327	2,045,731	0.021836	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,050,111	51,003,392	52,053,503	0.078297	54.00
60.00	06000	LABORATORY	2,584,222	30,379,666	32,963,888	0.143215	60.00
65.00	06500	RESPIRATORY THERAPY	460,151	1,076,989	1,537,140	0.506681	65.00
66.00	06600	PHYSICAL THERAPY	339,780	3,257,823	3,597,603	0.209274	66.00
67.00	06700	OCCUPATIONAL THERAPY	255,474	409,934	665,408	0.160222	67.00
68.00	06800	SPEECH PATHOLOGY	75,369	150,669	226,038	0.072152	68.00
69.00	06900	ELECTROCARDIOLOGY	435,680	10,130,233	10,565,913	0.100597	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	594,663	621,961	1,216,624	1.827815	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	112,080	1,338,096	1,450,176	0.475655	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,208,861	7,098,268	8,307,129	0.504781	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0		88.00
90.00	09000	CLINIC	0	182,529	182,529	0.821837	90.00
90.01	09001	SENIOR CARE	0	205,784	205,784	2.373270	90.01
90.02	09002	GENERAL SURGERY	0	131,777	131,777	3.745327	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	764,621	764,621	0.774495	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	860,396	860,396	0.767355	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	174,432	174,432	4.752328	90.05
90.06	09006	OBGYN - DR SAUER	0	92,501	92,501	3.132193	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	1,865,448	1,865,448	1.067314	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	532,539	532,539	0.808711	90.08
90.09	09009	PAIN MANAGEMENT	0	99,573	99,573	0.465819	90.09
90.10	09010	DERMATOLOGY	0	562,971	562,971	0.606701	90.10
90.11	09011	KIDS FIRST	0	1,408,866	1,408,866	1.148414	90.11
91.00	09100	EMERGENCY	245,637	37,518,497	37,764,134	0.148437	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,944	1,969,564	1,972,508	1.841429	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	11,881,037	11,881,037	0.477275	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	18,833,879	176,489,404	195,323,283		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	18,833,879	176,489,404	195,323,283		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet C Part I Date/Time Prepared: 3/25/2025 3:14 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC (RHC)			88.00
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 SENIOR CARE	0.000000		90.01
90.02	09002 GENERAL SURGERY	0.000000		90.02
90.03	09003 HARRISON CRAWFORD HEALTHCARE	0.000000		90.03
90.04	09004 CORYDON MEDICAL ASSOCIATES	0.000000		90.04
90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	0.000000		90.05
90.06	09006 OBGYN - DR SAUER	0.000000		90.06
90.07	09007 FIRST CAPITAL MEDICAL GROUP	0.000000		90.07
90.08	09008 SOUTH HARRISON FAMILY MEDICINE	0.000000		90.08
90.09	09009 PAIN MANAGEMENT	0.000000		90.09
90.10	09010 DERMATOLOGY	0.000000		90.10
90.11	09011 KIDS FIRST	0.000000		90.11
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet C
Part I
Date/Time Prepared:
3/25/2025 3:14 pm

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		9,872,467	0	9,872,467	30.00	
31.00	03100 INTENSIVE CARE UNIT		871,514	0	871,514	31.00	
43.00	04300 NURSERY		596,980	0	596,980	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		3,598,609	0	3,598,609	50.00	
53.00	05300 ANESTHESIOLOGY		44,670	0	44,670	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		4,075,658	0	4,075,658	54.00	
60.00	06000 LABORATORY		4,720,916	0	4,720,916	60.00	
65.00	06500 RESPIRATORY THERAPY	0	778,839	0	778,839	65.00	
66.00	06600 PHYSICAL THERAPY	0	752,884	0	752,884	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	106,613	0	106,613	67.00	
68.00	06800 SPEECH PATHOLOGY	0	16,309	0	16,309	68.00	
69.00	06900 ELECTROCARDIOLOGY		1,062,895	0	1,062,895	69.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		2,223,764	0	2,223,764	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		689,783	0	689,783	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		4,193,280	0	4,193,280	73.00	
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC (RHC)		0	0	0	88.00	
90.00	09000 CLINIC		150,009	0	150,009	90.00	
90.01	09001 SENIOR CARE		488,381	0	488,381	90.01	
90.02	09002 GENERAL SURGERY		493,548	0	493,548	90.02	
90.03	09003 HARRISON CRAWFORD HEALTHCARE		592,195	0	592,195	90.03	
90.04	09004 CORYDON MEDICAL ASSOCIATES		660,229	0	660,229	90.04	
90.05	09005 ORTHOPEDIC SURGERY - DR KLINE		828,958	0	828,958	90.05	
90.06	09006 OBGYN - DR SAUER		289,731	0	289,731	90.06	
90.07	09007 FIRST CAPITAL MEDICAL GROUP		1,991,019	0	1,991,019	90.07	
90.08	09008 SOUTH HARRISON FAMILY MEDICINE		430,670	0	430,670	90.08	
90.09	09009 PAIN MANAGEMENT		46,383	0	46,383	90.09	
90.10	09010 DERMATOLOGY		341,555	0	341,555	90.10	
90.11	09011 KIDS FIRST		1,617,961	0	1,617,961	90.11	
91.00	09100 EMERGENCY		5,605,586	0	5,605,586	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		3,632,233	0	3,632,233	92.00	
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES		5,670,525	0	5,670,525	95.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE					113.00	
200.00	Subtotal (see instructions)		56,444,164	0	56,444,164	200.00	
201.00	Less Observation Beds		3,632,233		3,632,233	201.00	
202.00	Total (see instructions)		52,811,931	0	52,811,931	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet C
Part I
Date/Time Prepared:
3/25/2025 3:14 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,441,771		6,441,771		30.00
31.00	03100	INTENSIVE CARE UNIT	416,868		416,868		31.00
43.00	04300	NURSERY	1,623,584		1,623,584		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,658,280	11,054,511	13,712,791	0.262427	50.00
53.00	05300	ANESTHESIOLOGY	328,404	1,717,327	2,045,731	0.021836	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,050,111	51,003,392	52,053,503	0.078297	54.00
60.00	06000	LABORATORY	2,584,222	30,379,666	32,963,888	0.143215	60.00
65.00	06500	RESPIRATORY THERAPY	460,151	1,076,989	1,537,140	0.506681	65.00
66.00	06600	PHYSICAL THERAPY	339,780	3,257,823	3,597,603	0.209274	66.00
67.00	06700	OCCUPATIONAL THERAPY	255,474	409,934	665,408	0.160222	67.00
68.00	06800	SPEECH PATHOLOGY	75,369	150,669	226,038	0.072152	68.00
69.00	06900	ELECTROCARDIOLOGY	435,680	10,130,233	10,565,913	0.100597	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	594,663	621,961	1,216,624	1.827815	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	112,080	1,338,096	1,450,176	0.475655	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,208,861	7,098,268	8,307,129	0.504781	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	0.000000	88.00
90.00	09000	CLINIC	0	182,529	182,529	0.821837	90.00
90.01	09001	SENIOR CARE	0	205,784	205,784	2.373270	90.01
90.02	09002	GENERAL SURGERY	0	131,777	131,777	3.745327	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	764,621	764,621	0.774495	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	860,396	860,396	0.767355	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	174,432	174,432	4.752328	90.05
90.06	09006	OBGYN - DR SAUER	0	92,501	92,501	3.132193	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	1,865,448	1,865,448	1.067314	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	532,539	532,539	0.808711	90.08
90.09	09009	PAIN MANAGEMENT	0	99,573	99,573	0.465819	90.09
90.10	09010	DERMATOLOGY	0	562,971	562,971	0.606701	90.10
90.11	09011	KIDS FIRST	0	1,408,866	1,408,866	1.148414	90.11
91.00	09100	EMERGENCY	245,637	37,518,497	37,764,134	0.148437	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,944	1,969,564	1,972,508	1.841429	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	11,881,037	11,881,037	0.477275	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	18,833,879	176,489,404	195,323,283		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	18,833,879	176,489,404	195,323,283		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet C Part I Date/Time Prepared: 3/25/2025 3:14 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC (RHC)	0.000000		88.00
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 SENIOR CARE	0.000000		90.01
90.02	09002 GENERAL SURGERY	0.000000		90.02
90.03	09003 HARRISON CRAWFORD HEALTHCARE	0.000000		90.03
90.04	09004 CORYDON MEDICAL ASSOCIATES	0.000000		90.04
90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	0.000000		90.05
90.06	09006 OBGYN - DR SAUER	0.000000		90.06
90.07	09007 FIRST CAPITAL MEDICAL GROUP	0.000000		90.07
90.08	09008 SOUTH HARRISON FAMILY MEDICINE	0.000000		90.08
90.09	09009 PAIN MANAGEMENT	0.000000		90.09
90.10	09010 DERMATOLOGY	0.000000		90.10
90.11	09011 KIDS FIRST	0.000000		90.11
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet D Part II Date/Time Prepared: 3/25/2025 3:14 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	359,000	13,712,791	0.026180	154,079	4,034	50.00
53.00	05300 ANESTHESIOLOGY	239	2,045,731	0.000117	20,655	2	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	194,325	52,053,503	0.003733	223,690	835	54.00
60.00	06000 LABORATORY	115,516	32,963,888	0.003504	525,792	1,842	60.00
65.00	06500 RESPIRATORY THERAPY	23,087	1,537,140	0.015019	162,268	2,437	65.00
66.00	06600 PHYSICAL THERAPY	69,221	3,597,603	0.019241	108,899	2,095	66.00
67.00	06700 OCCUPATIONAL THERAPY	741	665,408	0.001114	84,973	95	67.00
68.00	06800 SPEECH PATHOLOGY	85	226,038	0.000376	7,562	3	68.00
69.00	06900 ELECTROCARDIOLOGY	40,547	10,565,913	0.003838	212,165	814	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	89,977	1,216,624	0.073956	251,983	18,636	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	3,710	1,450,176	0.002558	60,960	156	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	44,339	8,307,129	0.005337	300,316	1,603	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC (RHC)	0	0	0.000000	0	0	88.00
90.00	09000 CLINIC	28,224	182,529	0.154627	0	0	90.00
90.01	09001 SENIOR CARE	36,093	205,784	0.175393	0	0	90.01
90.02	09002 GENERAL SURGERY	54,313	131,777	0.412158	0	0	90.02
90.03	09003 HARRISON CRAWFORD HEALTHCARE	64,418	764,621	0.084248	0	0	90.03
90.04	09004 CORYDON MEDICAL ASSOCIATES	88,165	860,396	0.102470	0	0	90.04
90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	97,211	174,432	0.557300	0	0	90.05
90.06	09006 OBGYN - DR SAUER	32,444	92,501	0.350742	0	0	90.06
90.07	09007 FIRST CAPITAL MEDICAL GROUP	118,821	1,865,448	0.063696	0	0	90.07
90.08	09008 SOUTH HARRISON FAMILY MEDICINE	49,673	532,539	0.093276	0	0	90.08
90.09	09009 PAIN MANAGEMENT	23,273	99,573	0.233728	0	0	90.09
90.10	09010 DERMATOLOGY	27,804	562,971	0.049388	0	0	90.10
90.11	09011 KIDS FIRST	72,140	1,408,866	0.051204	0	0	90.11
91.00	09100 EMERGENCY	177,669	37,764,134	0.004705	7,836	37	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	203,158	1,972,508	0.102995	1,856	191	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	2,014,193	174,960,023		2,123,034	32,780	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet D
Part IV
Date/Time Prepared:
3/25/2025 3:14 pm

Cost Center Description		Title XVIII					Hospital		
		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	Cost		
		1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.00	
90.00	09000	CLINIC	0	0	0	0	0	90.00	
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01	
90.02	09002	GENERAL SURGERY	0	0	0	0	0	90.02	
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	0	0	0	0	90.03	
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	0	0	0	0	90.04	
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	0	0	0	0	90.05	
90.06	09006	OBGYN - DR SAUER	0	0	0	0	0	90.06	
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	0	0	0	0	90.07	
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	0	0	0	0	90.08	
90.09	09009	PAIN MANAGEMENT	0	0	0	0	0	90.09	
90.10	09010	DERMATOLOGY	0	0	0	0	0	90.10	
90.11	09011	KIDS FIRST	0	0	0	0	0	90.11	
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00	
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet D Part IV Date/Time Prepared: 3/25/2025 3:14 pm
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Cost Center Description	Title XVIII			Hospital	Cost	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)		
	All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)				
	4.00	5.00	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	13,712,791	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,045,731	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	52,053,503	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	32,963,888	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,537,140	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,597,603	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	665,408	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	226,038	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	10,565,913	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,216,624	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,450,176	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,307,129	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0.000000	88.00
90.00	09000	CLINIC	0	0	0	182,529	0.000000	90.00
90.01	09001	SENIOR CARE	0	0	0	205,784	0.000000	90.01
90.02	09002	GENERAL SURGERY	0	0	0	131,777	0.000000	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	0	0	764,621	0.000000	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	0	0	860,396	0.000000	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	0	0	174,432	0.000000	90.05
90.06	09006	OBGYN - DR SAUER	0	0	0	92,501	0.000000	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	0	0	1,865,448	0.000000	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	0	0	532,539	0.000000	90.08
90.09	09009	PAIN MANAGEMENT	0	0	0	99,573	0.000000	90.09
90.10	09010	DERMATOLOGY	0	0	0	562,971	0.000000	90.10
90.11	09011	KIDS FIRST	0	0	0	1,408,866	0.000000	90.11
91.00	09100	EMERGENCY	0	0	0	37,764,134	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,972,508	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0			95.00
200.00		Total (lines 50 through 199)	0	0	0	174,960,023		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet D Part IV Date/Time Prepared: 3/25/2025 3:14 pm
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Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	154,079	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	20,655	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	223,690	0	0	0	54.00
60.00	06000 LABORATORY	0.000000	525,792	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	162,268	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	108,899	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	84,973	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	7,562	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	212,165	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	251,983	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000	60,960	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	300,316	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC (RHC)	0.000000	0	0	0	0	88.00
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	09001 SENIOR CARE	0.000000	0	0	0	0	90.01
90.02	09002 GENERAL SURGERY	0.000000	0	0	0	0	90.02
90.03	09003 HARRISON CRAWFORD HEALTHCARE	0.000000	0	0	0	0	90.03
90.04	09004 CORYDON MEDICAL ASSOCIATES	0.000000	0	0	0	0	90.04
90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	0.000000	0	0	0	0	90.05
90.06	09006 OBGYN - DR SAUER	0.000000	0	0	0	0	90.06
90.07	09007 FIRST CAPITAL MEDICAL GROUP	0.000000	0	0	0	0	90.07
90.08	09008 SOUTH HARRISON FAMILY MEDICINE	0.000000	0	0	0	0	90.08
90.09	09009 PAIN MANAGEMENT	0.000000	0	0	0	0	90.09
90.10	09010 DERMATOLOGY	0.000000	0	0	0	0	90.10
90.11	09011 KIDS FIRST	0.000000	0	0	0	0	90.11
91.00	09100 EMERGENCY	0.000000	7,836	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	1,856	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		2,123,034	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet D Part V Date/Time Prepared: 3/25/2025 3:14 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.262427	0	2,075,612	0	0
53.00 05300 ANESTHESIOLOGY	0.021836	0	322,244	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.078297	0	9,958,036	0	0
60.00 06000 LABORATORY	0.143215	0	5,362,839	0	0
65.00 06500 RESPIRATORY THERAPY	0.506681	0	323,459	0	0
66.00 06600 PHYSICAL THERAPY	0.209274	0	756,175	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.160222	0	92,989	0	0
68.00 06800 SPEECH PATHOLOGY	0.072152	0	30,556	0	0
69.00 06900 ELECTROCARDIOLOGY	0.100597	0	2,794,833	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.827815	0	140,626	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.475655	0	381,621	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.504781	0	2,510,292	41,563	0
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC (RHC)					88.00
90.00 09000 CLINIC	0.821837	0	39,018	0	0
90.01 09001 SENIOR CARE	2.373270	0	159,816	0	0
90.02 09002 GENERAL SURGERY	3.745327	0	3,420	0	0
90.03 09003 HARRISON CRAWFORD HEALTHCARE	0.774495	0	1,729	373	0
90.04 09004 CORYDON MEDICAL ASSOCIATES	0.767355	0	857	92	0
90.05 09005 ORTHOPEDIC SURGERY - DR KLINE	4.752328	0	274	0	0
90.06 09006 OBGYN - DR SAUER	3.132193	0	162	77	0
90.07 09007 FIRST CAPITAL MEDICAL GROUP	1.067314	0	4,151	366	0
90.08 09008 SOUTH HARRISON FAMILY MEDICINE	0.808711	0	2,376	153	0
90.09 09009 PAIN MANAGEMENT	0.465819	0	100	0	0
90.10 09010 DERMATOLOGY	0.606701	0	7,071	5	0
90.11 09011 KIDS FIRST	1.148414	0	9,840	6,443	0
91.00 09100 EMERGENCY	0.148437	0	6,029,131	1,609	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.841429	0	458,952	0	0
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0.477275		0		95.00
200.00	Subtotal (see instructions)	0	31,466,179	50,681	0
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0	201.00
202.00	Net Charges (line 200 - line 201)	0	31,466,179	50,681	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet D Part V Date/Time Prepared: 3/25/2025 3:14 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	544,697	0	50.00
53.00	05300 ANESTHESIOLOGY	7,037	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	779,684	0	54.00
60.00	06000 LABORATORY	768,039	0	60.00
65.00	06500 RESPIRATORY THERAPY	163,891	0	65.00
66.00	06600 PHYSICAL THERAPY	158,248	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	14,899	0	67.00
68.00	06800 SPEECH PATHOLOGY	2,205	0	68.00
69.00	06900 ELECTROCARDIOLOGY	281,152	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	257,038	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	181,520	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,267,148	20,980	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC (RHC)			88.00
90.00	09000 CLINIC	32,066	0	90.00
90.01	09001 SENIOR CARE	379,287	0	90.01
90.02	09002 GENERAL SURGERY	12,809	0	90.02
90.03	09003 HARRISON CRAWFORD HEALTHCARE	1,339	289	90.03
90.04	09004 CORYDON MEDICAL ASSOCIATES	658	71	90.04
90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	1,302	0	90.05
90.06	09006 OBGYN - DR SAUER	507	241	90.06
90.07	09007 FIRST CAPITAL MEDICAL GROUP	4,430	391	90.07
90.08	09008 SOUTH HARRISON FAMILY MEDICINE	1,921	124	90.08
90.09	09009 PAIN MANAGEMENT	47	0	90.09
90.10	09010 DERMATOLOGY	4,290	3	90.10
90.11	09011 KIDS FIRST	11,300	7,399	90.11
91.00	09100 EMERGENCY	894,946	239	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	845,128	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0		95.00
200.00	Subtotal (see instructions)	6,615,588	29,737	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	6,615,588	29,737	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet D Part V Date/Time Prepared: 3/25/2025 3:14 pm
		Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.262427	0	101,791	0	0 50.00
53.00	05300 ANESTHESIOLOGY	0.021836	0	58,343	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.078297	0	922,922	0	0 54.00
60.00	06000 LABORATORY	0.143215	0	604,148	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	0.506681	0	26,712	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.209274	0	35,377	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.160222	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.072152	0	2,993	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.100597	0	122,070	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.827815	0	267	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.475655	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.504781	0	56,396	0	0 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC (RHC)					88.00
90.00	09000 CLINIC	0.821837	0	7,697	0	0 90.00
90.01	09001 SENIOR CARE	2.373270	0	0	0	0 90.01
90.02	09002 GENERAL SURGERY	3.745327	0	4,875	0	0 90.02
90.03	09003 HARRISON CRAWFORD HEALTHCARE	0.774495	0	11,000	0	0 90.03
90.04	09004 CORYDON MEDICAL ASSOCIATES	0.767355	0	4,019	0	0 90.04
90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	4.752328	0	8,376	0	0 90.05
90.06	09006 OBGYN - DR SAUER	3.132193	0	61,075	0	0 90.06
90.07	09007 FIRST CAPITAL MEDICAL GROUP	1.067314	0	18,761	0	0 90.07
90.08	09008 SOUTH HARRISON FAMILY MEDICINE	0.808711	0	4,356	0	0 90.08
90.09	09009 PAIN MANAGEMENT	0.465819	0	2,214	0	0 90.09
90.10	09010 DERMATOLOGY	0.606701	0	2,736	0	0 90.10
90.11	09011 KIDS FIRST	1.148414	0	57,171	0	0 90.11
91.00	09100 EMERGENCY	0.148437	0	997,017	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.841429	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.477275	0	284,920		95.00
200.00	Subtotal (see instructions)		0	3,395,236	0	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 - line 201)		0	3,395,236	0	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet D Part V Date/Time Prepared: 3/25/2025 3:14 pm
		Title XIX	Hospital	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	26,713	0	50.00
53.00	05300	ANESTHESIOLOGY	1,274	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,262	0	54.00
60.00	06000	LABORATORY	86,523	0	60.00
65.00	06500	RESPIRATORY THERAPY	13,534	0	65.00
66.00	06600	PHYSICAL THERAPY	7,403	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	216	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12,280	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	488	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,468	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC (RHC)			88.00
90.00	09000	CLINIC	6,326	0	90.00
90.01	09001	SENIOR CARE	0	0	90.01
90.02	09002	GENERAL SURGERY	18,258	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	8,519	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	3,084	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	39,805	0	90.05
90.06	09006	OBGYN - DR SAUER	191,299	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	20,024	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	3,523	0	90.08
90.09	09009	PAIN MANAGEMENT	1,031	0	90.09
90.10	09010	DERMATOLOGY	1,660	0	90.10
90.11	09011	KIDS FIRST	65,656	0	90.11
91.00	09100	EMERGENCY	147,994	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	135,985		95.00
200.00		Subtotal (see instructions)	892,325	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	892,325	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Prepared: 3/25/2025 3:14 pm
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,445 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,258 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			2,025 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			84 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			103 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			478 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			84 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			266.32 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			9,872,467 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			27,431 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			274,882 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			9,597,585 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			9,597,585 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			2,945.85 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,408,116 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,408,116 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1331		Period: From 01/01/2024 To 12/31/2024		Worksheet D-1	
		Title XVIII		Hospital		Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	871,514	125	6,972.11	46	320,717	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					919,961	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					2,648,794	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00	55.02
55.03	CAR T-cell amount paid as an interim payment					0	55.03
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					247,451	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					247,451	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,233	87.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1331		Period: From 01/01/2024 To 12/31/2024		Worksheet D-1 Date/Time Prepared: 3/25/2025 3:14 pm	
Cost Center Description		Title XVIII		Hospital		Cost	
						1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,945.85	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,632,233	89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	552,182	9,872,467	0.055932	3,632,233	203,158	90.00
91.00	Nursing Program cost	0	9,872,467	0.000000	3,632,233	0	91.00
92.00	Allied health cost	0	9,872,467	0.000000	3,632,233	0	92.00
93.00	All other Medical Education	0	9,872,467	0.000000	3,632,233	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Prepared: 3/25/2025 3:14 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,445 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,258 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			2,025 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			84 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			103 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			59 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			679 15.00
16.00	Nursery days (title V or XIX only)			48 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			266.32 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			9,872,467 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			27,431 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			274,882 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			9,597,585 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			9,597,585 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			2,945.85 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			173,805 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			173,805 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Prepared: 3/25/2025 3:14 pm	
Title XIX			Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	596,980	679	879.20	48	42,202	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	871,514	125	6,972.11	4	27,888	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					62,543	48.00
48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00 Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					306,438	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
55.01 Permanent adjustment amount per discharge					0.00	55.01
55.02 Adjustment amount per discharge (contractor use only)					0.00	55.02
55.03 CAR T-cell amount paid as an interim payment					0	55.03
56.00 Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					1,233	87.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1331		Period: From 01/01/2024 To 12/31/2024		Worksheet D-1 Date/Time Prepared: 3/25/2025 3:14 pm	
Cost Center Description		Title XIX		Hospital		Cost	
						1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,945.85	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,632,233	89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	552,182	9,872,467	0.055932	3,632,233	203,158	90.00
91.00	Nursing Program cost	0	9,872,467	0.000000	3,632,233	0	91.00
92.00	Allied health cost	0	9,872,467	0.000000	3,632,233	0	92.00
93.00	All other Medical Education	0	9,872,467	0.000000	3,632,233	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet D-3 Date/Time Prepared: 3/25/2025 3:14 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		832,978	30.00
31.00	03100	INTENSIVE CARE UNIT		152,026	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.262427	154,079	50.00
53.00	05300	ANESTHESIOLOGY	0.021836	20,655	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.078297	223,690	54.00
60.00	06000	LABORATORY	0.143215	525,792	60.00
65.00	06500	RESPIRATORY THERAPY	0.506681	162,268	65.00
66.00	06600	PHYSICAL THERAPY	0.209274	108,899	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.160222	84,973	67.00
68.00	06800	SPEECH PATHOLOGY	0.072152	7,562	68.00
69.00	06900	ELECTROCARDIOLOGY	0.100597	212,165	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.827815	251,983	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.475655	60,960	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.504781	300,316	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC (RHC)	0.000000	0	88.00
90.00	09000	CLINIC	0.821837	0	90.00
90.01	09001	SENIOR CARE	2.373270	0	90.01
90.02	09002	GENERAL SURGERY	3.745327	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0.774495	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.767355	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	4.752328	0	90.05
90.06	09006	OBGYN - DR SAUER	3.132193	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	1.067314	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0.808711	0	90.08
90.09	09009	PAIN MANAGEMENT	0.465819	0	90.09
90.10	09010	DERMATOLOGY	0.606701	0	90.10
90.11	09011	KIDS FIRST	1.148414	0	90.11
91.00	09100	EMERGENCY	0.148437	7,836	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.841429	1,856	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)		2,123,034	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		2,123,034	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1331 Component CCN: 15-Z331	Period: From 01/01/2024 To 12/31/2024	Worksheet D-3 Date/Time Prepared: 3/25/2025 3:14 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.262427	0	50.00
53.00	05300	ANESTHESIOLOGY	0.021836	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.078297	12,118	54.00
60.00	06000	LABORATORY	0.143215	12,110	60.00
65.00	06500	RESPIRATORY THERAPY	0.506681	1,441	65.00
66.00	06600	PHYSICAL THERAPY	0.209274	41,874	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.160222	30,615	67.00
68.00	06800	SPEECH PATHOLOGY	0.072152	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.100597	1,363	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.827815	4,921	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.475655	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.504781	17,600	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC (RHC)	0.000000	0	88.00
90.00	09000	CLINIC	0.821837	0	90.00
90.01	09001	SENIOR CARE	2.373270	0	90.01
90.02	09002	GENERAL SURGERY	3.745327	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0.774495	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.767355	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	4.752328	0	90.05
90.06	09006	OBGYN - DR SAUER	3.132193	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	1.067314	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0.808711	0	90.08
90.09	09009	PAIN MANAGEMENT	0.465819	0	90.09
90.10	09010	DERMATOLOGY	0.606701	0	90.10
90.11	09011	KIDS FIRST	1.148414	0	90.11
91.00	09100	EMERGENCY	0.148437	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.841429	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)		122,042	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		122,042	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet D-3 Date/Time Prepared: 3/25/2025 3:14 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		425,227		30.00
31.00	03100 INTENSIVE CARE UNIT		18,464		31.00
43.00	04300 NURSERY		152,337		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.262427	63,016	16,537	50.00
53.00	05300 ANESTHESIOLOGY	0.021836	5,670	124	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.078297	26,669	2,088	54.00
60.00	06000 LABORATORY	0.143215	119,705	17,144	60.00
65.00	06500 RESPIRATORY THERAPY	0.506681	11,896	6,027	65.00
66.00	06600 PHYSICAL THERAPY	0.209274	2,992	626	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.160222	4,335	695	67.00
68.00	06800 SPEECH PATHOLOGY	0.072152	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.100597	13,228	1,331	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.827815	93	170	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.475655	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.504781	35,265	17,801	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC (RHC)	0.000000	0	0	88.00
90.00	09000 CLINIC	0.821837	0	0	90.00
90.01	09001 SENIOR CARE	2.373270	0	0	90.01
90.02	09002 GENERAL SURGERY	3.745327	0	0	90.02
90.03	09003 HARRISON CRAWFORD HEALTHCARE	0.774495	0	0	90.03
90.04	09004 CORYDON MEDICAL ASSOCIATES	0.767355	0	0	90.04
90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	4.752328	0	0	90.05
90.06	09006 OBGYN - DR SAUER	3.132193	0	0	90.06
90.07	09007 FIRST CAPITAL MEDICAL GROUP	1.067314	0	0	90.07
90.08	09008 SOUTH HARRISON FAMILY MEDICINE	0.808711	0	0	90.08
90.09	09009 PAIN MANAGEMENT	0.465819	0	0	90.09
90.10	09010 DERMATOLOGY	0.606701	0	0	90.10
90.11	09011 KIDS FIRST	1.148414	0	0	90.11
91.00	09100 EMERGENCY	0.148437	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.841429	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)		282,869	62,543	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		282,869		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1331 Component CCN: 15-Z331	Period: From 01/01/2024 To 12/31/2024	Worksheet D-3 Date/Time Prepared: 3/25/2025 3:14 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.262427	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.021836	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.078297	0	0	54.00
60.00	06000 LABORATORY	0.143215	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.506681	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.209274	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.160222	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.072152	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.100597	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.827815	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.475655	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.504781	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC (RHC)	0.000000	0	0	88.00
90.00	09000 CLINIC	0.821837	0	0	90.00
90.01	09001 SENIOR CARE	2.373270	0	0	90.01
90.02	09002 GENERAL SURGERY	3.745327	0	0	90.02
90.03	09003 HARRISON CRAWFORD HEALTHCARE	0.774495	0	0	90.03
90.04	09004 CORYDON MEDICAL ASSOCIATES	0.767355	0	0	90.04
90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	4.752328	0	0	90.05
90.06	09006 OBGYN - DR SAUER	3.132193	0	0	90.06
90.07	09007 FIRST CAPITAL MEDICAL GROUP	1.067314	0	0	90.07
90.08	09008 SOUTH HARRISON FAMILY MEDICINE	0.808711	0	0	90.08
90.09	09009 PAIN MANAGEMENT	0.465819	0	0	90.09
90.10	09010 DERMATOLOGY	0.606701	0	0	90.10
90.11	09011 KIDS FIRST	1.148414	0	0	90.11
91.00	09100 EMERGENCY	0.148437	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.841429	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet E Part B Date/Time Prepared: 3/25/2025 3:14 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			6,645,325 1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)			0 2.00
3.00	OPPTS or REH payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
4.01	Outlier reconciliation amount (see instructions)			0 4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			6,645,325 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (see instructions)			6,711,778 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			57,579 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			5,210,193 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			1,444,006 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
28.50	REH facility payment amount (see instructions)			0 28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)			1,444,006 30.00
31.00	Primary payer payments			846 31.00
32.00	Subtotal (line 30 minus line 31)			1,443,160 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			343,083 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			223,004 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			176,980 36.00
37.00	Subtotal (see instructions)			1,666,164 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.75	N95 respirator payment adjustment amount (see instructions)			0 39.75
39.97	Demonstration payment adjustment amount before sequestration			0 39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			1,666,164 40.00
40.01	Sequestration adjustment (see instructions)			33,323 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
40.03	Sequestration adjustment-PARHM pass-throughs			0 40.03
41.00	Interim payments			1,631,113 41.00
41.01	Interim payments-PARHM			0 41.01
42.00	Tentative settlement (for contractors use only)			0 42.00
42.01	Tentative settlement-PARHM (for contractor use only)			0 42.01
43.00	Balance due provider/program (see instructions)			1,728 43.00
43.01	Balance due provider/program-PARHM (see instructions)			0 43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			120,079 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet E Part B Date/Time Prepared: 3/25/2025 3:14 pm
		Title XVIII	Hospital	Cost
				1.00
94.00	Total (sum of lines 91 and 93)			0 94.00
				1.00
200.00	MEDICARE PART B ANCILLARY COSTS Part B Combined Billed Days			0 200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet E-1
Part I
Date/Time Prepared:
3/25/2025 3:14 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,842,032		1,631,113	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	10/14/2024	391,000		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		391,000		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,233,032		1,631,113		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		199,255		1,728		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		2,432,287		1,632,841		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1331
Component CCN: 15-Z331

Period:
From 01/01/2024
To 12/31/2024

Worksheet E-1
Part I
Date/Time Prepared:
3/25/2025 3:14 pm

		Title XVIII		Swing Beds - SNF		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		229,732		0		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	10/14/2024	43,200		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		43,200		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		272,932		0		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		4,735		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		277,667		0		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
			0	1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet E-1 Part II Date/Time Prepared: 3/25/2025 3:14 pm
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (see instructions)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (see instructions)			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPSS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet E-2
		Component CCN: 15-Z331	Date/Time Prepared: 3/25/2025 3:14 pm	
		Title XVIII	Swing Beds - SNF	Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	249,926	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	35,448	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	84	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	285,374	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	285,374	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	285,374	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,040	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	283,334	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	283,334	0	19.00
19.01	Sequestration adjustment (see instructions)	5,667	0	19.01
19.02	Demonstration payment adjustment amount after sequestration	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	272,932	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	4,735	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
Comparison of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet E-2
		Component CCN: 15-Z331	Date/Time Prepared: 3/25/2025 3:14 pm	
		Title XIX	Swing Beds - SNF	Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0		3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (see instructions)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0		19.25
20.00	Interim payments	0		20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0		21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	0		22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
Comparison of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet E-3 Part V Date/Time Prepared: 3/25/2025 3:14 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			2,648,794 1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0 2.00
3.00	Organ acquisition			0 3.00
3.01	Cellular therapy acquisition cost (see instructions)			0 3.01
4.00	Subtotal (sum of lines 1 through 3.01)			2,648,794 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2,675,282 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2,675,282 19.00
20.00	Deductibles (exclude professional component)			205,600 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			2,469,682 22.00
23.00	Coinurance			1,632 23.00
24.00	Subtotal (line 22 minus line 23)			2,468,050 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			21,348 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			13,876 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			2,220 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2,481,926 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 29.50
29.98	Recovery of accelerated depreciation.			0 29.98
29.99	Demonstration payment adjustment amount before sequestration			0 29.99
30.00	Subtotal (see instructions)			2,481,926 30.00
30.01	Sequestration adjustment (see instructions)			49,639 30.01
30.02	Demonstration payment adjustment amount after sequestration			0 30.02
30.03	Sequestration adjustment-PARHM			0 30.03
31.00	Interim payments			2,233,032 31.00
31.01	Interim payments-PARHM			0 31.01
32.00	Tentative settlement (for contractor use only)			0 32.00
32.01	Tentative settlement-PARHM (for contractor use only)			0 32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)			199,255 33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)			0 33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			7,472 34.00

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

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet G
Date/Time Prepared:
3/25/2025 3:14 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	85,396	0	0	0	1.00
2.00	Temporary investments	10,314	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	32,136,861	0	0	0	4.00
5.00	Other receivable	3,015,316	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-27,215,475	0	0	0	6.00
7.00	Inventory	1,348,329	0	0	0	7.00
8.00	Prepaid expenses	1,457,413	0	0	0	8.00
9.00	Other current assets	-96,559	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	10,741,595	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,001,138	0	0	0	12.00
13.00	Land improvements	3,339,243	0	0	0	13.00
14.00	Accumulated depreciation	-2,809,120	0	0	0	14.00
15.00	Buildings	42,739,673	0	0	0	15.00
16.00	Accumulated depreciation	-30,155,906	0	0	0	16.00
17.00	Leasehold improvements	4,243,870	0	0	0	17.00
18.00	Accumulated depreciation	-2,920,113	0	0	0	18.00
19.00	Fixed equipment	346,074	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	26,077,868	0	0	0	23.00
24.00	Accumulated depreciation	-23,338,654	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	20,524,073	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	4,180,588	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	96,559	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,277,147	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	35,542,815	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,907,337	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,947,265	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,953,579	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,808,181	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	4,457,474	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,457,474	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	14,265,655	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	21,277,158				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	21,277,158	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	35,542,813	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet G-1

Date/Time Prepared:
3/25/2025 3:14 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		25,673,539		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-4,396,381				2.00
3.00	Total (sum of line 1 and line 2)		21,277,158		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		21,277,158		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		21,277,158		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-1331

Period:
From 01/01/2024
To 12/31/2024

Worksheet G-2
Parts I & II
Date/Time Prepared:
3/25/2025 3:14 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	6,246,698		6,246,698	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,246,698		6,246,698	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	435,058		435,058	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	435,058		435,058	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,681,756		6,681,756	17.00
18.00	Ancillary services	11,665,661	135,134,560	146,800,221	18.00
19.00	Outpatient services	81,142	43,386,286	43,467,428	19.00
20.00	RURAL HEALTH CLINIC (RHC)	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	11,881,037	11,881,037	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	18,428,559	190,401,883	208,830,442	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		67,084,525		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		67,084,525		43.00

STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet G-3 Date/Time Prepared: 3/25/2025 3:14 pm
			1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)		208,830,442	1.00
2.00	Less contractual allowances and discounts on patients' accounts		152,143,947	2.00
3.00	Net patient revenues (line 1 minus line 2)		56,686,495	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)		67,084,525	4.00
5.00	Net income from service to patients (line 3 minus line 4)		-10,398,030	5.00
OTHER INCOME				
6.00	Contributions, donations, bequests, etc		129,638	6.00
7.00	Income from investments		2,520	7.00
8.00	Revenues from telephone and other miscellaneous communication services		0	8.00
9.00	Revenue from television and radio service		0	9.00
10.00	Purchase discounts		0	10.00
11.00	Rebates and refunds of expenses		0	11.00
12.00	Parking lot receipts		0	12.00
13.00	Revenue from laundry and linen service		0	13.00
14.00	Revenue from meals sold to employees and guests		133,585	14.00
15.00	Revenue from rental of living quarters		0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients		0	17.00
18.00	Revenue from sale of medical records and abstracts		11,162	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)		0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen		0	20.00
21.00	Rental of vending machines		0	21.00
22.00	Rental of hospital space		237,918	22.00
23.00	Governmental appropriations		35,620	23.00
24.00	OTHER OPERATING INCOME		5,451,206	24.00
24.01	MOB		0	24.01
24.02	MISC INCOME		0	24.02
24.03	IGT		0	24.03
24.04	MISC INCOME		0	24.04
24.50	COVID-19 PHE Funding		0	24.50
25.00	Total other income (sum of lines 6-24)		6,001,649	25.00
26.00	Total (line 5 plus line 25)		-4,396,381	26.00
27.00	OTHER EXPENSES (SPECIFY)		0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)		0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)		-4,396,381	29.00

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1331	Period: From 01/01/2024 To 12/31/2024	Worksheet S Parts I-III Date/Time Prepared: 3/25/2025 3:14 pm
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PART I - COST REPORT STATUS

Provider use only 1. Electronically prepared cost report Date: 3/25/2025 Time: 3:14 pm
 2. Manually prepared cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HARRISON COUNTY HOSPITAL (15-1331) for the cost reporting period beginning 01/01/2024 and ending 12/31/2024 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1	Don Duval	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name		Don Duval	2
3	Signatory Title		CFO	3
4	Date		03/26/2025 07:57:16 AM (PT)	4

Encryption Information
 ECR: Date: 3/25/2025 Time: 3:14 pm
 eN98mXlIGtRomCyug0v7Cwj 4l cczT0
 rtp5: 086mBs4: p4600. 7Sy: 7DDXv8U
 rsxk1WG8gy0XzaQM

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	199,255	1,728	0	0 1.00
2.00	SUBPROVIDER - IPF	0	0	0	0	0 2.00
3.00	SUBPROVIDER - IRF	0	0	0	0	0 3.00
5.00	SWING BED - SNF	0	4,735	0	0	0 5.00
6.00	SWING BED - NF	0	0	0	0	0 6.00
10.00	RURAL HEALTH CLINIC (RHC) I	0	0	0	0	0 10.00
200.00	TOTAL	0	203,990	1,728	0	0 200.00

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