This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0046 Worksheet S Peri od: From 09/01/2022 Parts I-III AND SETTLEMENT SUMMARY 08/31/2023 Date/Time Prepared: 1/29/2024 8:15 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 1/29/2024 8: 15 am] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Initial Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(5) Amended

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 TERRE HAUTE REGIONAL HOSPITAL (15-0046) for the cost reporting period beginning 09/01/2022 and ending 08/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR			ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Korenna Power			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	Korenna Power			2
3	Signatory Title	CFO TERRE HAUTE REGIONAL HOSPITAL			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	523, 203	18, 531	0	0	1. 00
2.00	SUBPROVI DER - I PF	0	7, 764	-59		0	2. 00
3.00	SUBPROVI DER - I RF	0	-28, 564	-96		0	3. 00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	502, 403	18, 376	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

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.

	_							<u> 1/29/20</u>	024 8: 1	<u>5 am</u>
	1.00	2.00		3. 00			4. 00			
1. 00 2. 00	Hospital and Hospital Health Care Co Street: 3901 HOSPITAL LANE City: TERRE HAUTE	PO Box: State: IN	Zip Cod	a: 4780	12 Count	ty: VI GO				1.00
2.00	orty. TERRE HAUTE	Component Name	CCN	CBSA			Pavme	nt Syst	em (P.	2.00
			Number	Numbe		Certi fi ed		0, or		
							V	XVIII		
	U	1.00	2. 00	3.00	0 4.00	5. 00	6. 00	7. 00	8.00	
3. 00	Hospital and Hospital-Based Componen Hospital	TERRE HAUTE REGIONAL	150046	4546	0 1	07/01/1966	N	P	0	3.00
3.00	nospi tai	HOSPI TAL	130040	1340		0770171700	´ ' `	'		3.00
4. 00	Subprovi der - IPF	TERRE HAUTE PSYCHIATRIC	15S046	4546	0 4	09/01/1991	N	Р	0	4. 00
5.00	Subprovider - IRF	TERRE HAUTE REHAB UNIT	15T046	4546	0 5	09/01/2006	N	P	0	5. 00
6.00	Subprovider - (Other)									6.00
7. 00	Swing Beds - SNF									7. 00
8.00	Swing Beds - NF				-					8.00
9. 00 10. 00	Hospi tal -Based SNF Hospi tal -Based NF									9.00
11. 00	Hospi tal -Based OLTC									11.00
12. 00	Hospi tal -Based HHA									12.00
13. 00	Separately Certified ASC									13. 00
14.00	Hospi tal -Based Hospi ce									14. 00
15.00	Hospital-Based Health Clinic - RHC									15. 00
16. 00	Hospital-Based Health Clinic - FQHC									16. 00
17. 00	Hospital -Based (CMHC) I									17. 00
18.00	Renal Dialysis									18.00
19. 00	other					From		To	· ·	19. 00
						1. 00		2. (
20. 00	Cost Reporting Period (mm/dd/yyyy)					09/01/2		08/31		20.00
21.00	Type of Control (see instructions)					4				21. 00
				L						
	Inpatient PPS Information				1. 00	2. 00)	3. (00	
22. 00	Does this facility qualify and is it	currently receiving pay	ments for	-	Y	N				22. 00
22.00	di sproporti onate share hospi tal adju				·					22.00
	§412.106? In column 1, enter "Y" fo	r yes or "N" for no. Is	thi s							
	facility subject to 42 CFR Section §		ndment							
00.04	hospital?) In column 2, enter "Y" fo	r yes or "N" for no.	LUOD		.,					00.04
22. 01	Did this hospital receive interim UC this cost reporting period? Enter in				Υ	Y				22. 01
	for the portion of the cost reportin	3								
	1. Enter in column 2, "Y" for yes or									
	cost reporting period occurring on o	r after October 1. (see								
	instructions)									
22. 02	Is this a newly merged hospital that				N	N				22. 02
	determined at cost report settlement 1, "Y" for yes or "N" for no, for th			umn						
	period prior to October 1. Enter in			no						
	for the portion of the cost reportin			,						
22. 03	Did this hospital receive a geograph			o	N	N		N	I	22. 03
	rural as a result of the OMB standar									
	adopted by CMS in FY2015? Enter in c									
	for the portion of the cost reportin in column 2, "Y" for yes or "N" for			er						
	reporting period occurring on or aft									
	Does this hospital contain at least	•	,	as						
	counted in accordance with 42 CFR 41	2.105)? Enter in column	3, "Y" fo	or						
	yes or "N" for no.									
22. 04	Did this hospital receive a geograph									22. 04
	rural as a result of the revised OMB									
	adopted by CMS in FY 2021? Enter in for the portion of the cost reportin									
	in column 2, "Y" for yes or "N" for			-'						
	reporting period occurring on or aft									
	Does this hospital contain at least	100 but not more than 49	9 beds (a	as						
	counted in accordance with 42 CFR 41	2.105)? Enter in column	3, "Y" 1	for						
22.00	yes or "N" for no.	digaid days so II at	and /-: C1	_		2				22.00
23.00	Which method is used to determine Me below? In column 1, enter 1 if date					3 N				23. 00
	if date of discharge. Is the method									
	reporting period different from the									
	reporting period? In column 2, ente									

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. 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.

Ν

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der CC		Period: From 09/01/20 To 08/31/20	022 P 023 D 1	Norksheet S-2 Part I Pate/Time Pre /29/2024 8:1	pared:
				-	-	2. 00 3. 00	
.00 Are costs claimed on line 100 of Worksheet A? If yes	, compl	ete Wkst. D-2,			N		59. 00
			NAHE 413.85 Y/N	Worksheet Line #	Qı	Pass-Through ualification riterion Code	
	(1) (1)		1. 00	2.00		3. 00	
.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustment? Enter "Y" for yes or "N" for no in column	85? (s umn 1. :R) NAHE	see If column 1	N				60.00
and assemble. Effect 1 101 yes of 11 101 he fit dot an	Y/N	I ME	Direct GME	IME		Direct GME	
	1. 00	2. 00	3. 00	4.00		5. 00	
 .00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) .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) .02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, 	N				0. 00	0. 00	61. 00
and primary care FTEs added under section 5503 of ACA). (see instructions) O3 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. 0
.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)05 Enter the difference between the baseline primary							61. 0
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) 1.06 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. 0
jeure er general eurger jr (eee metraetrene)	Pro	ogram Name	Program Code	Unweighted FTE Coun		Unweighted rect GME FTE	
		1. 00	2. 00	3.00		4. 00	
.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		61. 10
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.				C). 00	0. 00	61. 2
						1. 00	
ACA Provisions Affecting the Health Resources and Ser OO Enter the number of FTE residents that your hospital	trai ned			riod for whic	h	0.00	62.00
your hospital received HRSA PCRE funding (see instruction. O1 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC programmer.	Teachi			o your hospit	al	0.00	62. 0°
Teaching Hospitals that Claim Residents in Nonprovide 1.00 Has your facility trained residents in nonprovider se 1.11 "Y" for yes or "N" for no in column 1. If yes, comple	er Setti ettings	ings during this co	ost reporting		r	N	63.00

	Financial Systems		TE REGIONAL HOSPITAL			eu of Form CMS-2	
HOSPI 1	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA Provi der CC		eriod: fom 09/01/2022 0 08/31/2023		pared:
				Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1. 00	2. 00	3. 00	
	Section 5504 of the ACA Base Yea			This base year	is your cost r	reporting	
64. 00	period that begins on or after of Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir 1 + column 2)). (see	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0. 00	0. 000000	64. 00
		Program Name	Program Code	Unweighted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	
				Nonprovi der	Hospi tal	4))	
				Si te			
	T	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	
				FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current		n Nonprovider Setting	sEffective fo	r cost reporti	ng periods	
66 00	beginning on or after July 1, 20 Enter in column 1 the number of		ry care resident	0.00	0. 00	0. 000000	66 00
00.00	FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0.000000	00.00
		Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
				FTEs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
				Si te	nospi tai	7//	
		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

	Financial Systems TERRE HAUTE REGIONAL HOSPI AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provide		l: 15-0046	Peri od: From 09/01 To 08/31	/2022	wof For Workshe Part I Date/Ti 1/29/20	et S-2 me Pre	pared:
						1. C	00	
68. 00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 4906 For a cost reporting period beginning prior to October 1, 2022, did y MAC to apply the new DGME formula in accordance with the FY 2023 IPPS (August 10, 2022)?	ou obt	ain permis	sion from yo		N		68. 00
					1. 00	0 2.00	3. 00	
70.00	Inpatient Psychiatric Facility PPS							70.00
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME te recent cost report filed on or before November 15, 2004? Enter "Y" for 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train resid program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for Column 3: If column 2 is Y, indicate which program year began during (see instructions) Inpatient Rehabilitation Facility PPS	aching or yes lents i	program is or "N" fon a new te	n the most r no. (see aching r no.	N N	N	0	70.00
75. 00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does	it cor	ntain an IR	F	Y			75. 00
76. 00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME te recent cost reporting period ending on or before November 15, 2004? E no. Column 2: Did this facility train residents in a new teaching pro CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3 indicate which program year began during this cost reporting period.	nter " gram i : If o	Y" for yes n accordan column 2 is	or "N" for ce with 42 Y,	N	N	0	76. 00
						1. 0	00	
	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" Is this a LTCH co-located within another hospital for part or all of "Y" for yes and "N" for no.			ng period? E	inter	N N		80. 00 81. 00
	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Did this facility establish a new Other subprovider (excluded unit) u				no.	N		85. 00 86. 00
87. 00	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classif 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	ied ur	nder sectio	n		N		87. 00
				Approved Perman Adjustr (Y/N	ent nent)	Numbe Appro Perma Adjusti	nent ments	
88. 00	Column 1: Is this hospital approved for a permanent adjustment to the amount per discharge? Enter "Y" for yes or "N" for no. If yes, comple 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.	TEFRA	target . 2 and li	1.00 ne)	2.0		88. 00
			Wkst. A Li No.	ne Effective	e Date	Appro Perma Adj ust Amount Di sch	nent ment Per	
89. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line numbe		1.00	2.00)	3. C	00	89. 00
	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amou per discharge. Column 3: Enter the amount of the approved permanent adjustment to th TEFRA target amount per discharge.	ınt		. 00			O	07.00
	ncha taryet amount per urschalge.			V		XI		
	Title V and XIX Services			1.00)	2.0	00	
90. 00	Does this facility have title V and/or XIX inpatient hospital service	s? Ent	er "Y" for	N		Y		90.00
91. 00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost r full or in part? Enter "Y" for yes or "N" for no in the applicable co		either in	N		Y		91. 00
92. 00	On 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.							92. 00
93. 00								93. 00
94. 00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" fapplicable column.	or no	in the	N		N		94. 00
	If line 94 is "Y", enter the reduction percentage in the applicable c Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" f applicable column.			O. 00 N)	O. C		95. 00 96. 00
97. 00	applicable column. If line 96 is "Y", enter the reduction percentage in the applicable c	olumn.		0.00)	0.0	00	

Health Financial Systems TERRE HAUTE REG		011 45 0044	In Lie		_
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CO		Period: From 09/01/2022 To 08/31/2023	Worksheet S Part I Date/Time P 1/29/2024 8	repared:
			V	XI X	
98.00 Does title V or XIX follow Medicare (title XVIII) for the i	nterns and resi	idents nost	1. 00 Y	2. 00 Y	98. 00
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.	for yes or "N"	for no in			
98.01 Does title V or XIX follow Medicare (title XVIII) for the r C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t title XIX.			Y	Y	98. 01
98.02 Does title V or XIX follow Medicare (title XVIII) for the closed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes 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 cri reimbursed 101% of inpatient services cost? Enter "Y" for y 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 CAP outpatient services cost? Enter "Y" for yes or "N" for no i in column 2 for title XIX.			N	N	98. 04
98.05 Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.			Y	Y	98. 05
98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.			Y	Y	98. 06
Rural Providers					
105.00 Does this hospital qualify as a CAH?			N		105. 00
106.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)	-inclusive meti	nod or paymen	I N		106. 00
107.00 Column 1: If line 105 is Y, is this facility eligible for contraining programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded I	nn 1. (see ins you train I&R: PF and/or IRF (tructions) s in an	N		107. 00
Enter "Y" for yes or "N" for no in column 2. (see instruct 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	e CRNA fee sche		N		108. 00
	Physi cal 1.00	Occupati onal	Speech 3.00	Respiratory 4.00	<u> </u>
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N N	N N	N N	109. 00
			·		
110.00 Did this hospital participate in the Rural Community Hospit	al Demonstration	on project (8/	11∩Δ	1.00 N	110. 00
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no. I	f yes,	IN .	110.00
			1.00	2.00	_
			1.00		
111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to of integration prong of the FCHIP demo in which this CAH is particled that apply: "A" for Ambulance services; "B" for a for tele-health services.	cost reporting p column 1 is Y, e articipating in	period? Enter enter the column 2.	1.00 N		111.00
Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to of integration prong of the FCHIP demo in which this CAH is particled that apply: "A" for Ambulance services; "B" for a	cost reporting p column 1 is Y, e articipating in	period? Enter enter the column 2. ; and/or "C"	N	3.00	111.00
Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to of integration prong of the FCHIP demo in which this CAH is particled that apply: "A" for Ambulance services; "B" for a for telle-health services.	cost reporting poolumn 1 is Y, on a ticipating in additional beds;	period? Enter enter the column 2.		3.00	111.00
Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to dintegration prong of the FCHIP demo in which this CAH is particle. The second of the FCHIP demo in which this CAH is particle. The second of the carrier all that apply: "A" for Ambulance services; "B" for a for tele-health services. 112.00 Did this hospital particle in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost in period? Enter "Y" for yes or "N" for no in column 1. If the companies of the second of the current cost in the date the hospital began particle demonstration. In column 3, enter the date the hospital comparticle particle particle pation in the demonstration, if applicable.	cost reporting polyment 1 is Y, our ticipating in additional beds; alth Model reporting column 1 is pating in the	period? Enter enter the column 2. ; and/or "C"	N	3.00	
Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to dintegration prong of the FCHIP demo in which this CAH is particle and that apply: "A" for Ambulance services; "B" for a for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If of "Y", enter in column 2, the date the hospital began participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided.	cost reporting poolumn 1 is Y, our ticipating in additional beds; all th Model reporting column 1 is pating in the based or "N" for no B, or E only) 93" percent (includes	period? Enter enter the column 2. ; and/or "C"	N	3.00	
Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to dintegration prong of the FCHIP demo in which this CAH is particle. The second of the FCHIP demo in which this CAH is particle. The second of the current cost of the second of the services. 112.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost of period? Enter "Y" for yes or "N" for no in column 1. If of "Y", enter in column 2, the date the hospital began participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care	cost reporting poolumn 1 is Y, our ticipating in additional beds; alth Model reporting column 1 is pating in the cased on "N" for no B, or E only) 93" percent (includes ers) based on	period? Enter enter the column 2. ; and/or "C"	N	3.00	112.00
Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to dintegration prong of the FCHIP demo in which this CAH is particle. Integration prong of the FCHIP demo in which this CAH is particle. Integration prong of the FCHIP demo in which this CAH is particle. Integration prong of the FCHIP demo in which this CAH is particle. Integration apply: "A" for Ambulance services; "B" for a for tele-health services. Integration of Ambulance services; "B" for a for tele-health services. Integration of Ambulance services; "B" for a for tele-health services. Integration of Ambulance services; "B" for a for tele-health services. Integration of the Pennsylvania Rural Health (PARHM) demonstration of the current cost in period. In column 2, the date the hospital began particle demonstration. In column 3, enter the date the hospital control of the demonstration. Integration of the Column of the date of the hospital control of the demonstration. In column 1, if column 1 is yes, enter the method used (A, in column 2. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208. 1.	cost reporting poolumn 1 is Y, our ticipating in additional beds; all th Model reporting column 1 is pating in the eased or "N" for no B, or E only) 93" percent (includes ers) based on for yes or	period? Enter enter the column 2. ; and/or "C" 1.00 N	N	3.00	0 115. 00

117. 00 118. 00

117.00 s this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.

118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.

	GIONAL HOSPITAL	ON 45 004/		u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC	JN: 15-0046	Peri od: From 09/01/2022 To 08/31/2023	Worksheet S Part I Date/Time P 1/29/2024 8	repared:
		Premi ums	Losses	Insurance	10 4111
		1.00	2.00	2.00	
118.01 List amounts of malpractice premiums and paid losses:		191, 6	2. 00 504 0	3.00	67 118. 01
			1.00	2.00	
118.02 Are mal practice premiums and paid losses reported in a cos	t center other 1	than the	1. 00 N	2.00	118. 02
Administrative and General? If yes, submit supporting sch and amounts contained therein. 119.00D0 NOT USE THIS LINE	edule listing co	ost centers			119. 00
120.00 Is this a SCH or EACH that qualifies for the Outpatient Ho \$3121 and applicable amendments? (see instructions) Enter "N" for no. Is this a rural hospital with < 100 beds that Hold Harmless provision in ACA §3121 and applicable amendm Enter in column 2, "Y" for yes or "N" for no.	in column 1, "Y' qualifies for th	' for yes or ne Outpatient		N	120. 00
121.00 Did this facility incur and report costs for high cost imp	lantable devices	s charged to	Y		121. 00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as d Act?Enter "Y" for yes or "N" for no in column 1. If column	1 is "Y", enter			5. 00	122. 00
the Worksheet A line number where these taxes are included 123.00Did the facility and/or its subproviders (if applicable) p services, e.g., legal, accounting, tax preparation, bookke management/consulting services, from an unrelated organizator yes or "N" for no.	urchase professi eping, payroll,	and/or	. Y	Y	123. 00
If column 1 is "Y", were the majority of the expenses, i.e professional services expenses, for services purchased fro located in a CBSA outside of the main hospital CBSA? In co "N" for no.	m unrelated orga	ani zati ons			
Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant	center? Enter '	'Y" for yes	N		125. 00
and "N" for no. If yes, enter certification date(s) (mm/dd 126.00 f this is a Medicare-certified kidney transplant program,	enter the certi	fication dat	te		126. 00
in column 1 and termination date, if applicable, in column 127.00 f this is a Medicare-certified heart transplant program,	enter the certif	fication date	9		127. 00
in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare-certified liver transplant program, in column 1 and termination date, if applicable, in column	enter the certif	fication date	e		128. 00
129.00 f this is a Medicare-certified lung transplant program, e in column 1 and termination date, if applicable, in column	nter the certifi	cation date			129. 00
130.00 of this is a Medicare-certified pancreas transplant progradate in column 1 and termination date, if applicable, in c	m, enter the cer	rti fi cati on			130. 00
131.00 If this is a Medicare-certified intestinal transplant prog date in column 1 and termination date, if applicable, in c	ram, enter the d	certi fi cati or	۱		131. 00
132.00 If this is a Medicare-certified islet transplant program, in column 1 and termination date, if applicable, in column		fication date	9		132. 00
133.00 Removed and reserved 134.00 If this is a hospital-based organ procurement organization in column 1 and termination date, if applicable, in column		ne OPO number	-		133. 00 134. 00
All Providers 140.00 Are there any related organization or home office costs as	1-£:1 :- ONC	D. b. 15 1		4.4110.70	140.00
chapter 10? Enter "Y" for yes or "N" for no in column 1. I are claimed, enter in column 2 the home office chain numbe	f yes, and home r. (see instruct	office costs		44H070	140. 00
1.00 2. If this facility is part of a chain organization, enter or	00 Llines 141 thro	uah 143 the i	3.00 name and address	of the	
home office and enter the home office contractor name and	contractor number	er.			
141.00 Name: HOSPITAL CORP. OF AMERICA Contractor's Name: F 142.00 Street: ONE PARK PLAZA PO Box:	PALMETTO	Contract	tor's Number: 1000)1	141. 00 142. 00
· · · · · · · · · · · · · · · · · · ·	ΓΝ	Zi p Code	e: 3720)3	143. 00
				1.00	
144.00 Are provider based physicians' costs included in Worksheet	A?			Y Y	144. 00
			1. 00	2.00	
145.00 If costs for renal services are claimed on Wkst. A, line 7 inpatient services only? Enter "Y" for yes or "N" for no ino, does the dialysis facility include Medicare utilization	n column 1. If o	column 1 is	Y		145. 00
period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previence of the previence of the provience of the previence of the provience of the previence o	ously filed cost	t report?	N		146. 00

Health Financial Systems	TERRE HAUTE	REGIONAL HOSPIT	ĀL		In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE			CCN: 15-0046	From 09	9/01/2022 3/31/2023	Worksheet S- Part I Date/Time Pr 1/29/2024 8:	2 epared:
						1.00	-
147.00 Was there a change in the statisti	cal basis? Enter "Y" f	for ves or "N" 1	for no			1.00 N	147. 00
148.00 Was there a change in the order of						N N	148. 00
149.00 Was there a change to the simplifi				for no.		N	149.00
	v	Part A	Part I	B Ti	tle V	Title XIX	
		1.00	2.00		3. 00	4. 00	
Does this facility contain a provi or charges? Enter "Y" for yes or '					CFR §413	3. 13)	
155.00 Hospi tal		N	N		N	N	155. 00
156.00 Subprovi der - I PF		N	N N		N	N	156. 00
157. 00 Subprovi der - I RF		N	N		N	N	157. 00
158. OO SUBPROVI DER 159. OO SNF		N	l N		N	N	158. 00 159. 00
160.00 HOME HEALTH AGENCY		N	N N		N	N N	160. 00
161. OOCMHC		IN IN	N N		N	N N	161. 00
TOT. GOJOWITO			14		14	1.00	101.00
Mul ti campus						1.00	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has	one or more ca	ampuses in di	fferent CB	SAs?	N	165. 00
	Name	County	State	Zi p Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00	4. 00	5.00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.0	0 166. 00
						1.00	-
Health Information Technology (HI							
167.00 s this provider a meaningful user 168.00 f this provider is a CAH (line 10 reasonable cost incurred for the H	05 is "Y") and is a mea	ningful user (I			the	Y	167. 00 168. 00
168.01 If this provider is a CAH and is rexception under §413.70(a)(6)(ii)	not a meaningful user,	does this provi			shi p	N	168. 01
169.00 If this provider is a meaningful utransition factor. (see instruction	user (line 167 is "Y")				nter the	9. 9	9169. 00
					ji nni ng	Endi ng	
					1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR length period respectively (mm/dd/yyyy)	peginning date and endi	ng date for the	e reporting				170. 00
					1. 00	2.00	
171.00 If line 167 is "Y", does this proving section 1876 Medicare cost plans in "Y" for yes and "N" for no in column 2.	reported on Wkst. S-3, umn 1. If column 1 is y	Pt. I, line 2,	col. 6? Enter		N		0 171. 00

Heal th	Financial Systems TERRE HAUTE REG	IONAL HOSPITAL		In lie	u of Form CMS-	2552-10
	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0046	Peri od:	Worksheet S-2	
				From 09/01/2022 To 08/31/2023	Part II Date/Time Pre	epared:
				V /N	1/29/2024 8: 1	15 am
				Y/N 1. 00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE					
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	l for all NO re	esponses. Ente	er all dates in 1	the	
	COMPLETED BY ALL HOSPITALS					
4 00	Provider Organization and Operation	1				1
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a			N		1.00
		,	Y/N	Date	V/I	
2.00	Has the provider terminated participation in the Medicare F	Program2 If	1.00 N	2. 00	3. 00	2.00
2.00	yes, enter in column 2 the date of termination and in colum					2.00
3. 00	voluntary or "I" for involuntary. Is the provider involved in business transactions, including	a managamant	Y			3. 00
3.00	contracts, with individuals or entities (e.g., chain home of		'			3.00
	or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of directors through ownership, control, or family and other					
	relationships? (see instructions)			_		
			1.00	7ype 2. 00	Date 3.00	
	Financial Data and Reports		1.00	2.00	0.00	
4. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f		N			4. 00
	or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.					
5. 00	Are the cost report total expenses and total revenues differenthose on the filed financial statements? If yes, submit reconstructions are total expenses and total revenues differenthose on the filed financial statements?		N			5. 00
	, , , , , , , , , , , , , , , , , , , ,			Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
6. 00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, is	the provider	~ N		6. 00
7 00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	etructions		N		7. 00
7. 00 8. 00	Were nursing programs and/or allied health programs approve		ved during the	N N		8.00
0.00	cost reporting period? If yes, see instructions.					0.00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	•	cal education	N		9. 00
10. 00	Was an approved Intern and Resident GME program initiated of		he current	N		10. 00
11. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I	& R in an Ann	roved	N		11. 00
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N 1.00	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes				Y	12. 00
13. 00	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.	oolicy change o	during this co	ost reporting	N	13. 00
14.00	If line 12 is yes, were patient deductibles and/or coinsura	nce amounts wa	nived? If yes,	see	N	14. 00
	instructions. Bed Complement					-
15. 00	Did total beds available change from the prior cost reporti	ng period? If	yes, see inst	tructions.	N	15. 00
			T A		t B	
		Y/N 1.00	2.00	Y/N 3. 00	Date 4.00	
	PS&R Data				= 3	
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N	1	N		16. 00
	date of the PS&R Report used in columns 2 and 4 (see					
17. 00	instructions) Was the cost report proposed using the DSVD Depart for	V	12/04/2022	V	12/04/2022	17 00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Y	12/04/2023	Y	12/04/2023	17. 00
	either column 1 or 3 is yes, enter the paid-through date					
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	N	1	N		18. 00
. 5. 00	Report data for additional claims that have been billed	"	1			
	but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N	1	N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.	I	1	I	I	1

Heal th	Financial Systems TERRE HAUTE REG	IONAL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CC	CN: 15-0046	Peri od: From 09/01/2022 To 08/31/2023	Worksheet S-2 Part II Date/Time Pre 1/29/2024 8:1	pared:
		Descri	pti on	Y/N	Y/N	
		C		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 1.00	Date 2.00	Y/N 3. 00	Date	
21. 00	Was the cost report prepared only using the provider's	1.00 N	2.00	3. 00 N	4. 00	21. 00
	records? If yes, see instructions.					
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)			1
22.00	Capital Related Cost	a I notruptions			N	22. 00
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		als made dur	ing the cost	N N	23. 00
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	porting period?	Υ	24. 00		
25. 00	Have there been new capitalized leases entered into during instructions.	If yes, see	N	25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	f yes, see	N	26. 00		
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportin	g period? If	yes, submit	N	27. 00
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit er	ntered into dur	ing the cost	reporti ng	N	28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	eserve Fund)	N	29. 00		
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		debt? If yes	, see	N	30. 00
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is instructions.</pre>	ssuance of new	debt? If yes	, see	N	31. 00
32. 00 33. 00	Purchased Services Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instructions are seeingtructions. Were the requirements of Sec. 2135.2 approximations.	uctions.	•		N	32. 00 33. 00
	no, see instructions. Provider-Based Physicians					-
34. 00	Were services furnished at the provider facility under an a If yes, see instructions.	arrangement wit	h provider-b	ased physicians?	Y	34. 00
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		ts with the	provi der-based	Υ	35. 00
				Y/N	Date	
	U 066: C+-			1. 00	2. 00	
36. 00	Home Office Costs Were home office costs claimed on the cost report?			Y		36. 00
	If line 36 is yes, has a home office cost statement been pr	repared by the	home office?			36.00
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			Υ	12/31/2022	38. 00
39. 00	If line 36 is yes, did the provider render services to other see instructions.			, N		39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	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.	JAMES		WELLS		41. 00
42. 00	Tespectively. Enter the employer/company name of the cost report preparer.	HCA				42. 00
43. 00		615-372-6585		JAMES. WELLS2@HO	CAHEALTHCARE. C	43. 00

Heal th	Financial Systems TERRE HAU	TE REG	IONAL HOSPITAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi der CCN: 15-0046	ri od: om 09/01/2022 08/31/2023	Date/Time Pre	epared:	
					1/29/2024 8:	15 am
			3. 00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/positi	on	REPORTING MANAGER			41.00
	held by the cost report preparer in columns 1, 2, an	d 3,	REI MBURSEMENT			
	respecti vel y.					
42.00	Enter the employer/company name of the cost report					42. 00
	preparer.					
43.00	Enter the telephone number and email address of the	cost				43.00
	report preparer in columns 1 and 2, respectively.					

Health Financial Systems TERRE HAUTE REGIONAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CO Provider CCN: 15-0046

					Т	0 08/31/2023	Date/Time Prep 1/29/2024 8:1	
	·						1/P Days / 0/P	J alli
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH/REH Hours	Title V	
	·	Li ne No.			Avai I abl e			
		1. 00		2. 00	3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		117	42, 705	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3.00
4. 00 5. 00	HMO IRF Subprovider						0	4. 00 5. 00
6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF						0	6. 00
7. 00	Total Adults and Peds. (exclude observation			117	42, 705	0.00	0	7. 00
7.00	beds) (see instructions)			11/	42, 705	0.00	U	7.00
8. 00	INTENSIVE CARE UNIT	31. 00		18	6, 570	0.00	0	8. 00
9. 00	CORONARY CARE UNIT	31.00		10	0, 370	0.00	O	9. 00
10. 00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	NEONATAL INTENSIVE CARE UNIT	35. 00		6	2, 190	0.00	0	12.00
13. 00	NURSERY	43. 00		Ĭ	27 . 70	0.00	0	13. 00
14. 00	Total (see instructions)			141	51, 465	0.00	0	14. 00
15. 00	CAH visits				,		0	15. 00
15. 10	REH hours and visits							15. 10
16.00	SUBPROVI DER - I PF	40. 00		19	6, 935		0	16.00
17.00	SUBPROVI DER - I RF	41. 00		12	4, 380		0	17.00
18.00	SUBPROVI DER							18.00
19. 00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC	00.00					0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00		170			0	26. 25
28. 00	Total (sum of lines 14-26) Observation Bed Days			172			0	27. 00 28. 00
29. 00	Ambul ance Tri ps						U	29. 00
30. 00	Employee discount days (see instruction)							30. 00
31. 00	Employee discount days (see Fristruction)							31. 00
32. 00	Labor & delivery days (see instructions)			0	0			32. 00
32. 00	Total ancillary labor & delivery room			٩	0			32. 00
02.01	outpatient days (see instructions)							32.01
33. 00	LTCH non-covered days			ļ				33. 00
33. 01	LTCH site neutral days and discharges							33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00		o	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

2.00

5.00

8.00

16.00

17.00

18 00

19.00

20.00

21.00

22 00

23.00

24. 00

24. 10

25.00

26.00

26. 25

27.00

28 00

29. 00

30.00

31.00

32.00

32.01

33.00

33.01

SUBPROVIDER - IPF

SUBPROVIDER - IRF

NURSING FACILITY

OTHER LONG TERM CARE

HOME HEALTH AGENCY

RURAL HEALTH CLINIC

Observation Bed Days

LTCH non-covered days

Ambul ance Trips

SKILLED NURSING FACILITY

HOSPICE (non-distinct part)

Total (sum of lines 14-26)

Employee discount days - IRF

AMBULATORY SURGICAL CENTER (D. P.)

FEDERALLY QUALIFIED HEALTH CENTER

Employee discount days (see instruction)

Labor & delivery days (see instructions)

Total ancillary labor & delivery room

LTCH site neutral days and discharges

34.00 Temporary Expansion COVID-19 PHE Acute Care

outpatient days (see instructions)

SUBPROVI DER

HOSPI CE

CMHC - CMHC

Worksheet S-3

Provider CCN: 15-0046 Peri od: From 09/01/2022 Part I 08/31/2023 Date/Time Prepared: 1/29/2024 8:15 am Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 10.00 6.00 7.00 8.00 9.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 12, 927 1.00 4, 206 952 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) 4,340 2,896 2.00 3.00 HMO IPF Subprovider 552 3.00 4.00 HMO IRF Subprovider 199 229 4.00 Hospital Adults & Peds. Swing Bed SNF 0 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 952 7.00 4, 206 12, 927 7.00 beds) (see instructions) INTENSIVE CARE UNIT 3, 069 1, 155 0 8.00 9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 SURGICAL INTENSIVE CARE UNIT 11.00 11.00 NEONATAL INTENSIVE CARE UNIT 12.00 0 165 12.00 13.00 NURSERY 318 13.00 Total (see instructions) 16, 479 378.78 14.00 5, 361 952 0.00 14.00 CAH visits 15.00 15.00 15.10 REH hours and visits 15.10

378

0

1,230

3, 292

88

192

54

0

5,083

2, 111

76

0

0

0

74

11

0

844

0.00

0.00

0.00

0.00

26.84

14.07

0.00

419.69

16.00

17.00

18 00

19.00

20.00

21.00

22 00

23.00

24.00

24. 10

25.00

26.00

26.25

27.00

28 00

29.00

30.00

31.00

32.00

32.01

33.00

33.01

| Period: | Worksheet S-3 | From 09/01/2022 | Part | To 08/31/2023 | Date/Time Prepared: Health Financial Systems TERRE HAUTE REGIONAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CO Provider CCN: 15-0046

				To	08/31/2023	Date/Time Pre 1/29/2024 8:1	
		Full Time	-	Di sch	arges	., _ ,, , _ , _ , _ , _ , _ , _ , _	<u> </u>
	Component	Equi val ents	Title V	Title XVIII	Title XIX	Total All	
	Component	Nonpai d Workers	ii tie v	II tie xviii	II tie xix	Total All Patients	
		11.00	12. 00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA	11.00	12.00	13.00	14.00	13.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	1, 232	192	3, 854	1.00
1.00	8 exclude Swing Bed, Observation Bed and		· ·	1, 202	1,2	0,001	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			895	817		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				15		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						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00 12. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	NEONATAL INTENSIVE CARE UNIT NURSERY						12. 00 13. 00
14. 00	Total (see instructions)	0. 00	0	1, 232	192	3, 854	
15. 00	CAH visits	0.00	Ü	1, 232	172	3, 034	15. 00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVI DER - I PF	0.00	0	56	608	933	16. 00
17. 00	SUBPROVI DER - I RF	0.00	0		6	171	17. 00
18. 00	SUBPROVI DER						18. 00
19.00	1						19. 00
20.00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	0.00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00 28. 00	Total (sum of lines 14-26)	0. 00					27. 00 28. 00
29. 00	Observation Bed Days Ambulance Trips						29. 00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see l'istruction)						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00				0	İ		33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care						34. 00

| Period: | Worksheet S-3 | From 09/01/2022 | Part II | To 08/31/2023 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0046

management and other management and administrative services 13.00 Contract Labor: Physician-Part A - Administrative 14.00 Home office and/or related organization salaries and wage-related costs 14.01 Home office salaries 10,435,183 10,435,183 10,435,183	4 1.00 0 2.00 0 3.00
Non-physic annesthetist Part 2.00	
PART II - WAGE DATA SALARIES Total salaries (see 200.00 30,765,478 0 30,765,478 872,958.00 35.2	2.00
1.00	2.00
Instructions	2.00
A	3.00
A.00 Physician-Part A -	
Administrative	4.00
4.01 Physicians - Part A - Teaching 0 0 0 0 0.00	1
Physician-Part B	
hospital - based RHC and FOHC services	
7.00 Interns & residents (in an approved program) 7.01 Contracted interns and residents (in an approved programs) 8.00 Home office and/or related organization personnel 9.00 SNF	0.00
residents (in an approved programs) 8. 00 Home office and/or related organization personnel 9. 00 SNF	7. 00
8.00 Home office and/or related organization personnel 44.00 0 0 0 0 0 0 0 0 0	7. 01
9.00 SNF	8.00
Instructions OTHER WAGES & RELATED COSTS	9.00
11. 00 Contract Labor: Direct Patient Care 12. 00 Contract Labor: Top Level management and other management and administrative services 13. 00 Contract Labor: Physician-Part A - Administrative 14. 00 Home office and/or related organization salaries and wage-related costs 14. 01 Home office salaries 0 0 0 0 0 0.00 0.00 0.00 0.00 0.00 0.	9 10.00
12. 00 Contract Labor: Top Level management and other management and administrative services 13. 00 Contract Labor: Physician-Part A - Administrative home office and/or related organization salaries and wage-related costs 14. 01 Home office salaries 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11.00
management and other management and administrative services 13.00 Contract Labor: Physician-Part A - Administrative Home office and/or related organization salaries and wage-related costs 14.01 Home office salaries 10,435,183 10,435,183 10,435,183 10,435,183	0 12.00
13. 00 Contract Labor: Physician-Part 256, 121 0 256, 121 1,570.00 163.1 A - Administrative Home office and/or related organization salaries and wage-related costs Home office salaries 10,435,183 0 10,435,183 213,549.80 48.8	72.00
14. 00 Home office and/or related organization salaries and wage-related costs 0 0 0 0 0.00 0.00	3 13.00
wage-related costs 14.01 Home office salaries 10,435,183 0 10,435,183 213,549.80 48.8	14. 00
	7 14. 01
	0 14.02
15.00 Home office: Physician Part A 0 0 0 0.00 0.00 0.00 0.00	15. 00
16.00 Home office and Contract 0 0 0.00 0.00	16. 00
	16. 01
	16. 02
Physicians Part A - Teaching	
17.00 Wage-related costs (core) (see 6,967,485 0 6,967,485 instructions)	17. 00
18.00 Wage-related costs (other) (see instructions)	18. 00
19. 00 Excluded areas 1,017,256 0 1,017,256 20. 00 Non-physician anesthetist Part 0 0 0	19. 00 20. 00
21.00 Non-physician anesthetist Part 0 0 0	21. 00
22.00 Physician Part A - 0 0 0 0 Administrative	22. 00
22. 01 Physician Part A - Teaching 0 0 0	22. 01
23. 00 Physician Part B	23. 00 24. 00
25.00 Interns & residents (in an 0 0 0	25. 00
approved program)	25. 50
(core) 25. 51 Related organization 0 0 0	25. 51
wage-related (core) 25. 52 Home office: Physician Part A 0 0 0	25. 52
- Administrative - wage-related (core)	20.02

In Lieu of Form CMS-2552-10

Period: Worksheet S-3

From 09/01/2022 Part II

To 08/31/2023 Date/Time Prepared:
1/29/2024 8:15 am Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0046

							1/29/2024 8: 1	5 am
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARII							
26. 00	Employee Benefits Department	4. 00	107, 557	l .	107, 557	,		
27.00	Administrative & General	5. 00	3, 599, 364	-209, 233	3, 390, 131	89, 412. 00		27. 00
28. 00	Administrative & General under		46, 786	0	46, 786	65.00	719. 78	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00		29. 00
30.00	Operation of Plant	7. 00	556, 878	0	556, 878			
31.00	Laundry & Linen Service	8. 00	6, 009	0	6, 009	197. 00		
32.00	Housekeepi ng	9. 00	1, 034, 411	0	1, 034, 411	56, 497. 00	18. 31	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0.00	33.00
	(see instructions)							
34.00	Di etary	10. 00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see		992, 675	0	992, 675	37, 852. 00	26. 23	35. 00
	instructions)							
36.00	Cafeteri a	11. 00	0	0	0	0. 00		36.00
37.00	Maintenance of Personnel	12. 00		0	0	0. 00		37.00
38. 00	Nursing Administration	13. 00	492, 596	209, 233	701, 829	9, 834. 00	71. 37	38. 00
39.00	Central Services and Supply	14. 00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15. 00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical	16. 00	0	0	0	0.00	0. 00	41.00
	Records Library							
42.00	Soci al Servi ce	17. 00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provi der CCN: 15-0046 Peri od: From 09/01/2022 To 08/31/2023 1/29/2024 8:15 am Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 31, 804, 939 31, 804, 939 910, 875. 00 34. 92 1.00 instructions) 2.00 Excluded area salaries (see 3, 918, 783 ol 3, 918, 783 127, 264. 00 30. 79 2.00 instructions) 3.00 Subtotal salaries (line 1 27, 886, 156 0 27, 886, 156 783, 611. 00 35.59 3.00 minus line 2)

10, 691, 304

8, 769, 519

47, 346, 979

6, 836, 276

0

0

215, 119. 80

998, 730. 80

218, 450. 00

0.00

49.70

31. 45

47 41

31. 29

4.00

5.00

6.00

7.00

10, 691, 304

8, 769, 519

47, 346, 979

6, 836, 276

4.00

5.00

6.00

7.00

Subtotal other wages & related

Subtotal wage-related costs

Total overhead cost (see

Total (sum of lines 3 thru 5)

costs (see inst.)

(see inst.)

instructions)

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0046	Peri od: Worksheet S-3
		From 09/01/2022 Part IV
		To 00/21/2022 Data/Time Propared:

	To 08/31/2023	Date/Time Prep 1/29/2024 8:15	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETI REMENT COST		1
1.00	401K Employer Contributions	1, 013, 879	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	o	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	o	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	o	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		1
5.00	401K/TSA Plan Administration fees	49, 830	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	o	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	ol	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	o	8. 02
8. 03	Heal th Insurance (Purchased)	3, 972, 227	8. 03
9. 00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	-10, 611	
	Life Insurance (If employee is owner or beneficiary)	35, 027	11. 00
	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
	Disability Insurance (If employee is owner or beneficiary)	328, 020	
	Long-Term Care Insurance (If employee is owner or beneficiary)	020, 020	14. 00
15. 00		-4, 561	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	1
	Noncumulative portion)	Ĭ	
	TAXES		1
17. 00	FICA-Employers Portion Only	1, 995, 645	17. 00
	Medicare Taxes - Employers Portion Only	465, 794	1
	Unemployment Insurance	0	19.00
	State or Federal Unemployment Taxes	62, 147	
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
200	instructions))	Ĭ	
22. 00	Day Care Cost and Allowances	ol	22. 00
23. 00	Tuition Reimbursement	77, 344	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	7, 984, 741	
·	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
	1	'	

llool +b	Financial Cyatama	TERRE HAUTE REGIONAL HOSPITAL	ا ما	eu of Form CMS-2	DEED 10
	Financial Systems AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0046	Period:	Worksheet S-3	
позетт	AL CUNTRACT LABOR AND DENEFTT COST	Provider CCN. 15-0046	From 09/01/2022		
			To 08/31/2023		pared:
				1/29/2024 8: 1	5 am
	Cost Center Description		Contract Labor		
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Ident	ti fi cati on:			
1.00	Total facility's contract labor and benefi	t cost	0	7, 984, 741	1. 00
2.00	Hospi tal		0	6, 967, 485	2. 00
3.00	SUBPROVI DER - I PF		0	435, 088	3. 00
4.00	SUBPROVI DER - I RF		0	266, 796	4. 00
5.00	Subprovider - (Other)		0	0	5. 00
6.00	Swing Beds - SNF		0	0	6. 00
7.00	Swing Beds - NF		0	0	7. 00
8.00	SKILLED NURSING FACILITY				8. 00
9.00	NURSING FACILITY				9. 00
10.00	OTHER LONG TERM CARE I				10.00
11.00	Hospi tal -Based HHA				11. 00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I				12.00
13.00	Hospi tal -Based Hospi ce				13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15.00	Hospital-Based Health Clinic FQHC				15. 00
16.00	Hospi tal -Based-CMHC				16. 00
17.00	RENAL DIALYSIS I		0	0	17. 00
18.00	Other		0	315, 372	18. 00
	•		•		•

Heal th	Financial Systems TERRE HAUTE REGIONAL	HOSPI TAL	In Lie	eu of Form CMS-2	2552-10			
		Provider CCN: 15-0046	Peri od:	Worksheet S-1				
			From 09/01/2022 To 08/31/2023		pared·			
				1/29/2024 8:1				
				1.00				
	Uncompensated and indigent care cost computation							
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div Medicaid (see instructions for each line)	ided by line 202 col	umn 8)	0. 129277	1.00			
2.00	Net revenue from Medicaid	20, 333, 710	2. 00					
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3. 00			
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement	. 3	i cai d?	Y	4. 00			
5. 00 6. 00	If line 4 is no, then enter DSH and/or supplemental payments fr Medicaid charges	oni medicard		0 196, 484, 867	5. 00 6. 00			
7. 00	Medicaid cost (line 1 times line 6)			25, 400, 974	•			
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of	lines 2 and 5; if	5, 067, 264	1			
	< zero then enter zero)							
0.00	Children's Health Insurance Program (CHIP) (see instructions for	r each line)		1 0	0.00			
9. 00 10. 00	Net revenue from stand-alone CHIP Stand-alone CHIP charges			0 0				
11. 00	Stand-alone CHIP cost (line 1 times line 10)			0	•			
12. 00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9	; if < zero then	0	•			
	enter zero)							
12 00	Other state or local government indigent care program (see inst Net revenue from state or local indigent care program (Not incl			1 0	12.00			
13. 00 14. 00	Charges for patients covered under state or local indigent care	-	,	0	13. 00 14. 00			
14.00	10)	program (Not Theraa	cu ili illics o oi		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 ind	igent care program (line 15 minus line	0	16. 00			
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see							
	instructions for each line)	P and State/Tocal III	digent care progra	iiis (see				
17. 00	Private grants, donations, or endowment income restricted to fu	9		1	17. 00			
18. 00 19. 00	Government grants, appropriations or transfers for support of h Total unreimbursed cost for Medicaid, CHIP and state and local		ome (cum of lines	0 5, 067, 264	18. 00 19. 00			
17.00	8, 12 and 16)	Thurgent care progr	allis (Sulli OI TITIES	5,007,204	19.00			
		Uni nsure		Total (col. 1				
		pati ent		+ col . 2)				
	Uncompensated Care (see instructions for each line)	1.00	2. 00	3.00				
20. 00	Charity care charges and uninsured discounts for the entire fac	ility 21,654	, 613 740, 724	22, 395, 337	20.00			
	(see instructions)							
21. 00	Cost of patients approved for charity care and uninsured discou	nts (see 2,799	740, 724	3, 540, 167	21. 00			
22. 00	instructions) Payments received from patients for amounts previously written	off as	0 0	0	22. 00			
22.00	charity care	011 43			22.00			
23. 00	Cost of charity care (line 21 minus line 22)	2, 799	740, 724	3, 540, 167	23. 00			
24 00	Does the amount on line 20 column 2, include charges for patien	t days beyond a Leng	th of stay limit	1. 00 N	24. 00			
24.00	imposed on patients covered by Medicaid or other indigent care		til of Stay IIIII t	IN.	24.00			
25. 00	If line 24 is yes, enter the charges for patient days beyond the stay limit		ram's length of	0	25. 00			
26. 00	Total bad debt expense for the entire hospital complex (see ins			3, 624, 828	26. 00			
27. 00	Medicare reimbursable bad debts for the entire hospital complex	,		161, 416	•			
27. 01	Medicare allowable bad debts for the entire hospital complex (s	ee instructions)		248, 333	•			
28. 00	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt expense.	onco (coo inctructio	nc)	3, 376, 495	1			
29. 00 30. 00	Cost of non-medicare and non-reimbursable medicare bad debt exp Cost of uncompensated care (line 23 column 3 plus line 29)	ense (see INSTRUCTIO	113)	523, 420 4, 063, 587	•			
	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)		9, 130, 851	1			
		,		•				

Heal th	Financial Systems TI	ERRE HAUTE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der CO	CN: 15-0046 F	eri od:	Worksheet A	
					rom 09/01/2022	Date/Time Pre	narod:
				'	o 08/31/2023	1/29/2024 8: 1	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	
	'			+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col . 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FLXT		3, 106, 924				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2, 913, 579			3, 242, 865	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	107, 557	5, 934, 124			6, 172, 093	4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	3, 599, 364	1, 391, 443			4, 431, 623	5. 00
7.00	00700 OPERATION OF PLANT	556, 878	3, 360, 347	3, 917, 225		3, 913, 095	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	6,009	420, 448			426, 457	8.00
9.00	00900 HOUSEKEEPI NG	1, 034, 411	459, 284			1, 493, 695	9.00
10.00	01000 DI ETARY	0	2, 044, 992			1, 451, 762	10.00
11. 00 13. 00	01100 CAFETERIA 01300 NURSI NG ADMINI STRATI ON	492, 596	750, 057	1, 242, 653		592, 621 1, 476, 470	11. 00 13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	492, 590	742, 222	742, 222		742, 222	16.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	UU	142, 222	142, 222	.	142, 222	10.00
30. 00	03000 ADULTS & PEDI ATRI CS	4, 287, 666	3, 296, 082	7, 583, 748	302, 952	7, 886, 700	30.00
31. 00	03100 I NTENSI VE CARE UNI T	2, 127, 392	1, 017, 636			3, 124, 836	1
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	417, 528	275, 181			692, 332	35. 00
40. 00	04000 SUBPROVI DER - I PF	1, 676, 091	507, 570			2, 183, 381	40.00
41. 00	04100 SUBPROVI DER - I RF	1, 027, 782	409, 252			1, 295, 119	41.00
43. 00	04300 NURSERY	120, 677	38, 267			158, 929	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	2, 862, 843	6, 847, 577	9, 710, 420	-136, 498	9, 573, 922	50.00
51.00	05100 RECOVERY ROOM	204, 335	31, 932	236, 267	-80	236, 187	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	980, 093	119, 274	1, 099, 367	-20	1, 099, 347	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	668, 461	342, 052	1, 010, 513	-15, 226	995, 287	54.00
54.01	03630 ULTRA SOUND	156, 816	44, 275	201, 091	-19, 503	181, 588	54. 01
54. 02	03440 MAMMOGRAPHY	78, 488	18, 022	96, 510	0	96, 510	54. 02
55.00	05500 RADI OLOGY-THERAPEUTI C	557, 901	522, 180	1, 080, 081	-18, 242	1, 061, 839	55. 00
56.00	05600 RADI 0I SOTOPE	41, 853	548, 679	590, 532	-1, 197	589, 335	56. 00
57. 00	05700 CT SCAN	392, 193	153, 325			540, 699	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	146, 049	88, 973			235, 022	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	500, 234	401, 788			883, 196	1
60. 00	06000 LABORATORY	1, 033, 513	1, 702, 797			2, 680, 680	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	58, 055	490, 964			1, 802, 533	
65. 00	06500 RESPI RATORY THERAPY	640, 428	744, 277			1, 318, 671	65.00
66. 00	06600 PHYSI CAL THERAPY	975, 625	166, 784			1, 142, 409	66.00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	408, 720 18, 262	84, 106 7, 802			492, 826 26, 064	69. 00 70. 00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	189, 156	3, 559, 665			3, 978, 654	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	187, 130	2, 374, 182			2, 374, 296	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 130, 211	13, 445, 391	14, 575, 602		13, 554, 506	
74. 00	07400 RENAL DIALYSIS	670	537, 101			537, 311	
76. 00	03950 LI THOTRI PSY		69, 400			69, 400	
	03330 ENDOSCOPY	241, 027	304, 438			537, 442	
	03040 PRISION CLINIC	196, 016	25, 361	221, 377			
	03050 WOUND CARE	81, 228	651, 030			729, 923	
76. 04	03060 OPI C	448, 535	83, 192	531, 727		531, 727	
77.00	07700 ALLOGENEIC HSCT ACQUISITION	o	0	C	o	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	2, 085, 905	5, 119, 413	7, 205, 318	-456, 461	6, 748, 857	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	C	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		29, 550, 568	65, 151, 388	94, 701, 956	169	94, 702, 125	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22				190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	1	0	192.00
	07950 OCCUPATIONAL MEDICINE	774, 390	152, 710	927, 100	-169		
	07951 UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	C	<u> </u>		194. 01
	07952 SI TTERS	440, 520	35, 123	475, 643	0	475, 643	
	07953 UNLICENSED STAFF	0 745 479	0 4E 220 242	04 104 701	' O		194. 03
200.00	TOTAL (SUM OF LINES 118 through 199)	30, 765, 478	65, 339, 243	96, 104, 721	0	96, 104, 721	200.00

Provider CCN: 15-0046

					10	08/31/2023 Date	9/2024 8:15 am
	Cost Center Description		Adjustments	Net Expenses		1,72	,,,2021 0110 0111
	·			For Allocation			
			6. 00	7. 00			
	GENERAL SERVICE COST CENTERS		204 254	0.540.040			
1.00	00100 CAP REL COSTS-BLDG & FIXT		331, 854	3, 510, 263			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P	-	-50, 336	3, 192, 529			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMEN	1	175, 297	6, 347, 390			4.00
5.00	00500 ADMINISTRATIVE & GENERAL		25, 302, 268	29, 733, 891			5.00
7.00	00700 OPERATION OF PLANT		52, 308	3, 965, 403			7. 00 8. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING		0	426, 457 1, 493, 695			9.00
10.00	01000 DI ETARY		0	1, 451, 762			10.00
11. 00	01100 CAFETERI A		-209, 256	383, 365			11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON		1, 089	1, 477, 559			13. 00
16. 00			28, 515	770, 737			16. 00
10.00	INPATIENT ROUTINE SERVICE COST CE	NTERS	20, 010	770,707			10.00
30.00			-1, 739, 868	6, 146, 832			30.00
31.00	03100 INTENSIVE CARE UNIT		-19, 893	3, 104, 943			31.00
35.00	02060 NEONATAL INTENSIVE CARE UNI	Т	-224, 272	468, 060			35. 00
40.00	04000 SUBPROVI DER - I PF		-117, 971	2, 065, 410			40. 00
41.00	04100 SUBPROVI DER - I RF		-48, 171	1, 246, 948			41. 00
43.00	04300 NURSERY		-17	158, 912			43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	1		-4, 861, 984	4, 711, 938			50.00
51. 00	1		0	236, 187			51. 00
52. 00	1		-440	1, 098, 907			52. 00
54. 00	1		-4, 325	990, 962			54.00
54. 01	03630 ULTRA SOUND		-9	181, 579			54. 01
54. 02			-23	96, 487			54. 02
55.00	05500 RADI OLOGY-THERAPEUTI C		1 742	1, 061, 839			55. 00 56. 00
56. 00 57. 00	1		-1, 763 1, 292	587, 572 539, 417			57. 00
58. 00		(MDI)	-1, 282 -45	234, 977			58.00
59. 00	1	(WICT)	-6, 615	876, 581			59.00
60.00	06000 LABORATORY		0, 019	2, 680, 680			60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BL	OOD CELLS	Ö	1, 802, 533			62.00
65. 00	06500 RESPIRATORY THERAPY	000 02220	-104, 281	1, 214, 390			65. 00
66. 00	06600 PHYSI CAL THERAPY		-31, 068	1, 111, 341			66.00
69.00	06900 ELECTROCARDI OLOGY		-11, 548	481, 278			69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY		o	26, 064			70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO	PATI ENTS	o	3, 978, 654			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIE	NTS	0	2, 374, 296			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		0	13, 554, 506			73. 00
74. 00			-20, 877	516, 434			74. 00
76. 00	03950 LI THOTRI PSY		0	69, 400			76. 00
76. 01	03330 ENDOSCOPY		-153, 800	383, 642			76. 01
76. 02			0	221, 285			76. 02
76. 03			-11, 376	718, 547			76. 03
76. 04 77. 00			-30, 747 O	500, 980 0			76. 04 77. 00
77.00	OUTPATIENT SERVICE COST CENTERS		<u>U</u>	U			77.00
91. 00			-3, 677, 085	3, 071, 772			91.00
92. 00	1 1	NCT PART)	0,077,000	0,011,112			92.00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPI OI D TREATMENT PROGRAM		0	0			102. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		hrough 117)	14, 564, 279	109, 266, 404			118. 00
	NONREI MBURSABLE COST CENTERS						
	0 19000 GIFT, FLOWER, COFFEE SHOP &		0	22			190. 00
	0 19200 PHYSICIANS' PRIVATE OFFICES		0	0			192. 00
	0 07950 OCCUPATI ONAL MEDI CI NE		0	926, 931			194. 00
	1 07951 UNOCCUPI ED SPACE/NONALLOWAB	LE MEALS	0	0			194. 01
	2 07952 SI TTERS		0	475, 643			194. 02
	3 07953 UNLI CENSED STAFF	augh 100)	14 5/4 272	110 //0 000			194. 03
200.00	0 TOTAL (SUM OF LINES 118 thr	ougn 199)	14, 564, 279	110, 669, 000			200. 00

Health Financial Systems RECLASSIFICATIONS Peri od: From 09/01/2022 To 08/31/2023 Date/Ti me Prepared: 1/29/2024 8:15 am Provider CCN: 15-0046

					1/29/2024 8:	<u>15 am</u>
	C+ C+	Increases	C-1	0+1		
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
A	- LEASES	3.00	4.00	5. 00		
	AP REL COSTS-MVBLE EQUIP	2. 00	0	323, 682		1.
RE	ESPI RATORY THERAPY	65.00	O	6, 913		2.
) DR	RUGS CHARGED TO PATIENTS	73. 00	0	52, 504		3.
)		0. 00	0	0		4.
)		0.00	0	0		5.
)		0.00	0	0		6.
		0. 00 0. 00	0	0		7. 8.
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00		0.00	o	0		10.
0		0.00	ō	Ō		11.
0		0.00	O	0		12.
00		0. 00	0	0		13.
00		0.00	•	0		14.
0			0	383, 099		
	- PROPERTY INSURANCE		م	77.000		
CA	AP REL COSTS-BLDG & FIXT		0	77, 089		1.
0	- EXECUTIVE COMP.		U	77, 089		-
	- EXECUTIVE COMP. MPLOYEE BENEFITS DEPARTMENT	4.00	ol	126, 189		1.
	JRSING ADMINISTRATION	13. 00	192, 360	13, 327		2.
0	SKSTNE ABIII NI STICKIT GIV		192, 360	139, 516		-
D	- CAFETERI A		1727 000	1077010		
	AFETERI A	11. 00	0	592, 621		1.
0				592, 621		
	- MEDICAL SUPPLIES					
	EDICAL SUPPLIES CHARGED TO	71. 00	0	400, 959		1
	ATI ENTS	0.00		0		1
)		0. 00 0. 00	0	0		3
,		0.00	0	0		4.
		0.00	Ö	o		5
		0.00	o	Ö		6
)		0.00	O	0		7.
)		0.00	O	0		8.
)		0.00	0	0		9.
00		0.00	0	0		10
00		0. 00	0	0		11.
00		0. 00	0	0		12
00		0.00	0	0		13
00		0.00	0	0		14
00		0. 00 0. 00	0	0		15 16
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00		0.00	o	Ö		19
0		0.00	O	0		20
00		0.00	O	0		21
00		0.00		0		22
0	22110		0	400, 959		_
	- DRUG RUGS CHARGED TO PATIENTS	72 00	0	107 572		۱,
	HOLE BLOOD & PACKED RED	73. 00 62. 00	0	187, 573 1, 253, 514		1.
	LOOD CELLS	02.00	o o	1, 233, 314		-
)	1000 02220	0.00	o	0		3
		0.00	o	0		4
)		0.00	O	0		5
)		0.00	o	0		6
)		0.00	O	0		7
)		0.00	0	0		8
)		0.00	•			9
0	IMDI ANTADI E DEVI OEC		0	1, 441, 087		-
	- IMPLANTABLE DEVICES	72 00	0	210, 000		1
	MPL. DEV. CHARGED TO ATLENTS	72. 00	٩	210, 008		1 '
)	III ENTO	0.00	o	0		2
		0.00	ol ol	0		3
0		— — -:- -		210, 008		
Н	- ER BEDHOLD		91	-,		
) AD	DULTS & PEDIATRICS	30.00	229, 150	159, 265		1
11	NTENSIVE CARE UNIT	3100	<u>28, 3</u> 51	1 <u>9, 7</u> 05		2
			257, 501	178, 970		1

Heal th	Financial Systems	TERRE HAUTE REGIONAL HOSPITAL				In Lieu of Form CMS-2552-10		
RECLAS	SIFICATIONS			Provider (CCN: 15-0046	Period: From 09/01/2022 To 08/31/2023	Worksheet A- Date/Time Pr 1/29/2024 8:	epared:
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4. 00	5.00				
-	I - EQUIPMENT PROPERTY TAX							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	<u>5, 6</u> 04				1. 00
	0		0	5, 604				
	J - LOST CHARGES							
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	19, 538				1. 00
	PATI ENTS							
2.00		0.00	0	0				2. 00
	TOTALS		0	19, 538				
	K - CNO CONTRACT SALARY							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	4, 223				1. 00
2.00	NURSING ADMINISTRATION	13. 00	16, 873	47, 580				2. 00
	TOTALS		16, 873	51, 803				
500.00	Grand Total: Increases		466, 734	3, 500, 294				500.00
	•	•			•			•

Provider CCN: 15-0046

Peri od: From 09/01/2022 To 08/31/2023

Date/Time Prepared: 1/29/2024 8:15 am

						1/29/2024 8:	15 am
	2 1 2 1	Decreases	6.1	0.11			
	Cost Center	Li ne #	Sal ary	Other Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
4 00	A - LEASES	F 00		04 540	4.0		4
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	81, 543			1.00
2.00	OPERATION OF PLANT	7.00	0	4, 130			2.00
3.00	DI ETARY	10.00	0	609	0		3. 00
4.00	NURSI NG ADMI NI STRATI ON	13. 00	0	36, 323	l 1		4. 00
5.00	ADULTS & PEDIATRICS	30.00	0	84, 603	0		5. 00
6. 00	INTENSIVE CARE UNIT	31.00	0	62, 639			6. 00
7.00	SUBPROVI DER - I PF	40. 00	0	267	0		7. 00
8.00	OPERATING ROOM	50.00	0	25, 175	l 1		8. 00
9.00	RADI OLOGY-DI AGNOSTI C	54.00	0	9, 153			9. 00
10.00	ULTRA SOUND	54. 01	0	19, 503	0		10.00
11. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	40			11. 00
12.00	LABORATORY	60.00	0	54, 453			12.00
13.00	EMERGENCY	91.00	0	4, 492	l 1		13. 00
14. 00	OCCUPATI ONAL MEDI CI NE	194.00	4	169			14. 00
	0		0	383, 099			4
	B - PROPERTY INSURANCE		ما	77.000	4.0		4
1. 00	ADMI NI STRATI VE & GENERAL		•	77, 089			1. 00
	0		0	77, 089			1
	C - EXECUTIVE COMP.						4
1.00	ADMINISTRATIVE & GENERAL	5. 00	192, 360	139, 516			1.00
2.00		0.00	9	0			2. 00
	0		192, 360	139, 516			_
	D - CAFETERI A		-1				4
1. 00	DI ETARY	10.00	•	59 <u>2, 6</u> 21			1. 00
	0		0	592, 621			_
	E - MEDI CAL SUPPLI ES		-1				4
1.00	ADULTS & PEDIATRICS	30. 00	0	860			1. 00
2.00	INTENSIVE CARE UNIT	31.00	0	4, 905			2. 00
3.00	NEONATAL INTENSIVE CARE UNIT	35. 00	0	377	0		3. 00
4.00	SUBPROVI DER - I PF	40. 00	0	13	0		4. 00
5.00	SUBPROVI DER - I RF	41.00	0	141	0		5. 00
6.00	NURSERY	43.00	0	15	0		6. 00
7.00	OPERATING ROOM	50.00	0	63, 230	o		7.00
8.00	RECOVERY ROOM	51.00	o	80			8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	o	20	o		9. 00
10. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	5, 015			10.00
11. 00	RADI OI SOTOPE	56.00	o	1, 197	l 1		11. 00
12. 00	CT SCAN	57. 00	o	4, 596			12. 00
13. 00	CARDIAC CATHETERIZATION	59. 00	o	2, 769	l 1		13. 00
14. 00		60.00	0		l 1		14. 00
	LABORATORY THERABY			1, 177			
15. 00	RESPIRATORY THERAPY	65.00	0	72, 603	l 1		15. 00
16. 00	I MPL. DEV. CHARGED TO	72. 00	0	209, 894	0		16. 00
47.00	PATI ENTS	70.00		7 /50			47.00
17. 00	DRUGS CHARGED TO PATIENTS	73.00	0	7, 659	l 1		17. 00
18.00	RENAL DI ALYSI S	74.00	0	460	l 1		18. 00
19.00	ENDOSCOPY	76. 01	0	8, 023	0		19. 00
20. 00	PRISION CLINIC	76. 02	0	92			20. 00
21. 00	WOUND CARE	76. 03	0	2, 335			21.00
22. 00	EMERGENCY	<u>91.</u> 00	•	1 <u>5, 4</u> 98			22. 00
	0		0	400, 959			_
	F - DRUG		-				4
1.00	INTENSIVE CARE UNIT	31. 00	0	704	l		1. 00
2.00	SUBPROVI DER - I RF	41. 00	0	141, 774			2. 00
3.00	OPERATING ROOM	50.00	0	36, 293			3. 00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 058			4. 00
5.00	CT SCAN	57.00	0	223	0		5. 00
6.00	CARDIAC CATHETERIZATION	59.00	0	947	0		6. 00
7.00	RESPIRATORY THERAPY	65.00	0	344	0		7. 00
8.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	6, 230	0		8. 00
	PATI ENTS						
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	1, 253, 514	0		9. 00
	0 — — — — — —			1, 441, 087			1
	G - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00		7, 372	0		1. 00
2.00	RADI OLOGY-THERAPEUTI C	55.00		18, 202			2. 00
3.00	MEDICAL SUPPLIES CHARGED TO	71. 00		184, 434			3. 00
	PATI ENTS			., ., .,			
	<u> </u>			210, 008			1
	H - ER BEDHOLD		<u> </u>	, 300			1
1. 00	EMERGENCY	91.00	257, 501	178, 970	0		1.00
2. 00		0.00	257,001	, ,,,	o		2. 00
2. 50	0 — — — — —		257, 501	178, 970			
	1-	1	207,001	175, 776	ı l		1

Heal th	Financial Systems	1	TERRE HAUTE REG	In Lieu of Form CMS-2552-10				
RECLAS	SIFICATIONS			Provi der (Peri od:	Worksheet A-	6
						From 09/01/2022 To 08/31/2023	Date/Time Pr 1/29/2024 8:	epared: 15 am
		Decreases						
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref			
	6. 00	7.00	8. 00	9. 00	10.00			
	I - EQUIPMENT PROPERTY TAX							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5, 604	1	3		1. 00
	0		0	5, 604				
	J - LOST CHARGES							
1.00	OPERATING ROOM	50.00	0	4, 428	3	0		1. 00
2.00	CARDIAC CATHETERIZATION	59. 00	0	15, 110		0		2. 00
	TOTALS		0	19, 538	3			
	K - CNO CONTRACT SALARY							
1.00	ADMINISTRATIVE & GENERAL	5. 00	16, 873	51, 803	3	0		1. 00
2.00		0.00	0	0		0		2. 00
	TOTALS		16, 873	51, 803	3			
500.00	Grand Total: Decreases		466, 734	3, 500, 294				500.00

RECONCILIATION OF CAPITAL COSTS CENTERS Worksheet A-7 Provi der CCN: 15-0046 Peri od: From 09/01/2022 Part I Date/Time Prepared: 1/29/2024 8:15 am 08/31/2023 Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Retirements 5.00 Bal ances 2.00 3.00 4. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1, 262, 718 1.00 0 1.00 2.00 Land Improvements 3, 238, 473 2.00 0 0 0 0 30, 039 30, 039 3.00 Buildings and Fixtures 38, 638, 215 3.00 0 Building Improvements 9, 572, 776 4.00 15, 168 15, 168 0 4.00 5.00 Fixed Equipment 31, 608, 284 3, 512, 258 0 3, 512, 258 5.00 Movable Equipment 54, 195, 962 0 6.00 1, 773, 105 1, 773, 105 326, 454 6.00 0 HIT designated Assets 7.00 7.00 Ω 8.00 Subtotal (sum of lines 1-7) 138, 516, 428 5, 330, 570 5, 330, 570 326, 454 8.00 9.00 Reconciling Items 0 9.00 Total (line 8 minus line 9) 138, 516, 428 10.00 5, 330, 570 0 5, 330, 570 326, 454 10.00 Endi ng Bal ance Fully Depreciated Assets

			N330 t3	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES		
1.00	Land	1, 262, 718	0	1. 00
2.00	Land Improvements	3, 238, 473	0	2. 00
3.00	Buildings and Fixtures	38, 668, 254	0	3. 00
4.00	Building Improvements	9, 587, 944	0	4.00
5.00	Fixed Equipment	35, 120, 542	0	5. 00
6.00	Movable Equipment	55, 642, 613	0	6. 00
7.00	HIT designated Assets	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	143, 520, 544	0	8. 00
9.00	Reconciling Items	0	0	9. 00
10.00	Total (line 8 minus line 9)	143, 520, 544	0	10.00

Heal th	Financial Systems T	ERRE HAUTE REG	ONAL HOSPITAL		In Lieu of Form CMS-2552-1			
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 09/01/2022 Fo 08/31/2023		pared:	
			SL	JMMARY OF CAPI	TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)			
		9. 00	10. 00	11. 00	12. 00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FLXT	2, 457, 739	4, 607	1, 37	7 0	643, 201	1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	2, 781, 448	132, 131		0	0	2. 00	
3.00	Total (sum of lines 1-2)	5, 239, 187	136, 738	1, 37	7 0	643, 201	3. 00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	Other	Total (1) (sum					
	·	Capi tal -Relate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14.00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	IN 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	3, 106, 924			·	1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	2, 913, 579				2. 00	
3. 00	Total (sum of lines 1-2)	0	6, 020, 503				3. 00	

Health Financial Systems	ERRE HAUTE REG	IONAL HOSPITAL		In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C	<u> </u>	Period: From 09/01/2022 To 08/31/2023	1/29/2024 8: 1	pared:	
	COM	PUTATION OF RA	TI OS	ALLOCATION OF	OTHER CAPITAL		
Cost Center Description	Gross Assets	Gross Assets Capitalized Leases		instructions)	Insurance		
	1.00	2.00	3.00	4. 00	5. 00		
PART III - RECONCILIATION OF CAPITAL COSTS C							
1.00 CAP REL COSTS-BLDG & FLXT	87, 877, 931	l .	87, 877, 93 ⁻		0	1.00	
2.00 CAP REL COSTS-MVBLE EQUIP	55, 642, 613		55, 642, 61			2. 00	
3.00 Total (sum of lines 1-2)	143, 520, 544		143, 520, 54		0	3. 00	
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL						
Cost Center Description	Taxes Other Total (sum of Capital-Relate cols. 5 through 7)			Depreciation	Lease		
	6. 00	7.00	8. 00	9. 00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS						
1.00 CAP REL COSTS-BLDG & FLXT	0	0		2, 789, 593	4, 607	1.00	
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		2, 731, 112	455, 813	2.00	
3.00 Total (sum of lines 1-2)	0	0	(5, 520, 705	460, 420	3. 00	
		Sl	JMMARY OF CAPI	TAL			
Cost Center Description	Interest	Insurance (see instructions)		Other Capi tal -Rel ate d Costs (see i nstructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13. 00	14. 00	15. 00		
PART III - RECONCILIATION OF CAPITAL COSTS C							
1.00 CAP REL COSTS-BLDG & FLXT	1, 377	77, 089	637, 59	7 0	3, 510, 263	1.00	
2.00 CAP REL COSTS-MVBLE EQUIP	0		5, 60	4 0	3, 192, 529	2.00	
3.00 Total (sum of lines 1-2)	1, 377	77, 089	643, 20	1 0		3. 00	

From 09/01/2022 08/31/2023 Date/Time Prepared: 1/29/2024 8:15 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) Trade, quantity, and time 4 00 4 00 0 00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay 7.00 0.00 7.00 stations excluded) (chapter 8.00 Tel evi si on and radio servi ce 0.00 8.00 (chapter 21) Parking lot (chapter 21) 9.00 9.00 0.00 -10, 799, 149 A-8-2 10.00 10.00 Provider-based physician adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 A-8-1 26, 111, 430 12.00 transactions (chapter 10) 13 00 Laundry and linen service 0 00 13 00 14.00 Cafeteria-employees and guests В -193, 965 CAFETERI A 11.00 14.00 Rental of quarters to employee 15.00 15.00 0.00 and others Sale of medical and surgical 16.00 0 0.00 16.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents 18.00 Sale of medical records and 0.00 18.00 abstracts Nursing and allied health 19 00 19 00 0 00 education (tuition, fees, books, etc.) 20.00 Vending machines -15, 291 CAFETERI A 11.00 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) 22.00 22.00 Interest expense on Medicare 0.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 23.00 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 24 00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review 0 *** Cost Center Deleted *** 114.00 25.00 physicians' compensation (chapter 21) Depreciation - CAP REL -36, 485 CAP REL COSTS-BLDG & FIXT 26.00 Α 1.00 26.00 COSTS-BLDG & FLXT Depreciation - CAP REL -49, 753 CAP REL COSTS-MVBLE EQUIP 27.00 2.00 27.00 COSTS-MVBLE EQUIP 28.00 0 *** Cost Center Deleted *** 19.00 28.00 Non-physician Anesthetist Physicians' assistant 29 00 29.00 0.00 30.00 Adjustment for occupational A-8-3 0 *** Cost Center Deleted *** 67.00 30.00 therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see 30.99 В -91, 937 ADULTS & PEDIATRICS 30.00 30.99 instructions) 0 *** Cost Center Deleted *** 31.00 Adjustment for speech A-8-3 68.00 31.00 pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 32.00 0.00 Depreciation and Interest 33.00 INTEREST INCOME -22, 521 ADMI NI STRATI VE & GENERAL В 5.00 0 33.00

Heal th	Financial Systems	T	ERRE HAUTE REG	In Lie	In Lieu of Form CMS-2552-10			
ADJUST	MENTS TO EXPENSES				eri od:	Worksheet A-8		
					rom 09/01/2022	D . (T' D		
					o 08/31/2023	Date/Time Pre 1/29/2024 8:1		
				Expense Classification on	Worksheet A	172772024 0. 1	Jaiii	
				To/From Which the Amount is				
					,			
		D 1 (0 1 (0)			T "			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.		
33. 01	OTHER REVENUE	1. 00 B	2.00	3. 00 ADMI NI STRATI VE & GENERAL	4. 00 5. 00	5. 00	33. 01	
33. 01	UNCLAIMED PROPERTY	В	•	ADMINISTRATIVE & GENERAL	5.00		33. 01	
33. 02	PATIENT TELEPHONES	A		EMPLOYEE BENEFITS DEPARTMENT	4.00		33. 02	
33. 04	PATIENT TELEPHONES	A	•	ADMINISTRATIVE & GENERAL	5.00		33. 04	
33. 05	PATIENT TELEVISIONS	Ä	•	CAP REL COSTS-MVBLE EQUIP	2.00		33. 05	
33. 06	PATIENT TELEVISIONS	A		OPERATION OF PLANT	7. 00		33. 06	
33. 07	PATIENT TELEVISIONS	A	•	RADI OLOGY-DI AGNOSTI C	54.00		33. 07	
33. 08	CONSULTI NG SERVI CES	A		ADMINISTRATIVE & GENERAL	5. 00		33. 08	
33. 09	ADMIN TRAVEL	A	•	ADMINISTRATIVE & GENERAL	5. 00	l	33. 09	
33. 10	ADMIN MEALS	A	•	ADMINISTRATIVE & GENERAL	5. 00		33. 10	
33. 11	EMERGENCY NON-ALLOWABLE	Α	-30, 117	EMERGENCY	91.00	0	33. 11	
33. 12	NON-PATIENT GIFTS	A	-19, 312	ADMINISTRATIVE & GENERAL	5.00	0	33. 12	
33. 13	NON-PATIENT GIFTS	A	-903	SUBPROVIDER - IPF	40.00	0	33. 13	
33. 14	ALCOHOL	A		ADMINISTRATIVE & GENERAL	5. 00	l e	00	
33. 15	COUNTRY CLUB DUES	A	•	ADMINISTRATIVE & GENERAL	5. 00	l e	33. 15	
33. 16	BHU NON-ALLOWABLE	A		SUBPROVI DER - I PF	40.00		33. 16	
33. 17	ADMIN NON-ALLOWABLE	Α	•	ADMINISTRATIVE & GENERAL	5. 00	l e	33. 17	
33. 18	CONTRI BUTI ONS	A	•	ADMI NI STRATI VE & GENERAL	5. 00		33. 18	
33. 19	MED STAFF NON-ALLOWABLE	A	•	ADMI NI STRATI VE & GENERAL	5. 00	l e	33. 19	
33. 20	PUBLIC RELATIONS - DEPT. 920	A	•	ADMINISTRATIVE & GENERAL	5.00	l e	33. 20	
33. 21	PHYSICIAN RECRUIT - DEPT. 950	A		ADMINISTRATIVE & GENERAL	5.00	l	33. 21	
33. 22 33. 23	SALES - DEPT. 965 LEGAL FEES	A A		ADMINISTRATIVE & GENERAL	5. 00 5. 00	l	33. 22 33. 23	
33. 23	LOBBYING DUES	A	•	ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5.00		33. 23	
33. 24	MOB ACCOUNTING	A		ADMINISTRATIVE & GENERAL	5.00		33. 24	
33. 23	WOD ACCOUNTING	l A	-1, 440	MADINI STRATI VE & GENERAL	3.00		33. 23	

14, 564, 279

-378 EMPLOYEE BENEFITS DEPARTMENT

172, 540 CAP REL COSTS-BLDG & FIXT

4.00

1.00

33. 26

33. 27

50.00

Α

TOTAL (sum of lines 1 thru 49)

USEFUL LIFE ADJUSTMENT

(Transfer to Worksheet A,

33. 26 MOB ACCOUNTING

33. 27

column 6, line 200.) (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.

Health Financial Systems TERRE HAUTE REGIONAL HOSPITAL STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CO In Lieu of Form CMS-2552-10 Provider CCN: 15-0046 OFFICE COSTS

				To 08/31/2023	Date/Time Pre 1/29/2024 8:1	pared: 5 am
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	
				Allowable Cost	Included in Wks. A, column	
					5 5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTN HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAIMED	
1.00		ADMINISTRATIVE & GENERAL	HPG	103, 833	213, 168	1. 00
2.00	l .	ADMINISTRATIVE & GENERAL	I T&S	1, 708, 529		2. 00
3. 00 4. 00		ADMINISTRATIVE & GENERAL	HOME OFFICE COST HOME OFFICE DIRECT COMP.	1, 821, 754 202, 216		3.00
4. 00		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	ISSC	2, 132, 700		4. 00 4. 01
4. 02		ADMINISTRATIVE & GENERAL	SUPPLY CHAIN	1, 542, 677	1, 525, 495	4. 02
4. 03		ADMINISTRATIVE & GENERAL	PARALLON WORKFORCE SOLUTIONS	260, 713		4. 03
4. 04 4. 05	1	OPERATION OF PLANT	PARALLON WORKFORCE SOLUTIONS PARALLON WORKFORCE SOLUTIONS	138, 324	· ·	4. 04
4. 06		NURSING ADMINISTRATION ADULTS & PEDIATRICS	PARALLON WORKFORCE SOLUTIONS	30, 936 736, 530		4. 05 4. 06
4. 07	1	INTENSIVE CARE UNIT	PARALLON WORKFORCE SOLUTIONS	488, 879		4. 07
4.08		NEONATAL INTENSIVE CARE UNIT		37, 965	1	4. 08
4. 09 4. 10		SUBPROVI DER - I PF SUBPROVI DER - I RF	PARALLON WORKFORCE SOLUTIONS PARALLON WORKFORCE SOLUTIONS	39, 314 124, 219	1	4. 09 4. 10
4. 10		NURSERY	PARALLON WORKFORCE SOLUTIONS	439	1	4. 10
4. 12		OPERATING ROOM	PARALLON WORKFORCE SOLUTIONS	221, 115	230, 111	4. 12
4. 13		DELIVERY ROOM & LABOR ROOM	PARALLON WORKFORCE SOLUTIONS	10, 827	11, 267	4. 13
4. 14 4. 15		RADI OLOGY-DI AGNOSTI C ULTRA SOUND	PARALLON WORKFORCE SOLUTIONS PARALLON WORKFORCE SOLUTIONS	100, 956 216	1	4. 14 4. 15
4. 16		MAMMOGRAPHY	PARALLON WORKFORCE SOLUTIONS	577	600	4. 16
4. 17		RADI OI SOTOPE	PARALLON WORKFORCE SOLUTIONS	43, 331	45, 094	4. 17
4. 18		CT SCAN	PARALLON WORKFORCE SOLUTIONS	31, 497	32, 779	4. 18
4. 19 4. 20		MAGNETIC RESONANCE IMAGING (CARDIAC CATHETERIZATION	PARALLON WORKFORCE SOLUTIONS PARALLON WORKFORCE SOLUTIONS	1, 095 162, 561	1, 140 169, 176	4. 19 4. 20
4. 21		RESPIRATORY THERAPY	PARALLON WORKFORCE SOLUTIONS	375, 524		4. 21
4. 22		RENAL DIALYSIS	PARALLON WORKFORCE SOLUTIONS	513, 037	533, 914	4. 22
4. 23	1	EMERGENCY	PARALLON WORKFORCE SOLUTIONS	898, 281	934, 832	4. 23
4. 24 4. 25		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	PARALLON WORKFORCE SOLUTIONS PARALLON WORKFORCE SOLUTIONS	-1, 090 75, 976		4. 24 4. 25
4. 26		ADMINISTRATIVE & GENERAL	PARALLON WORKFORCE SOLUTIONS	69, 559		4. 26
4. 27		ADMINISTRATIVE & GENERAL	PARALLON MARK-UP	0	947, 409	4. 27
4. 28		ADMINISTRATIVE & GENERAL	PARALLON PAYROLL	20, 673	1	4. 28
4. 29 4. 30	1	ADMINISTRATIVE & GENERAL MEDICAL RECORDS & LIBRARY	CAPITAL DIVISION IT&S HIM	932, 281 588, 810	912, 865 558, 840	4. 29 4. 30
4. 31		MEDICAL RECORDS & LIBRARY	HIM ABSTRACTING	128, 516		4. 31
4. 32		ADMINISTRATIVE & GENERAL	REVENUE INTEGRITY	1, 349	1	4. 32
4. 33		ADMINISTRATIVE & GENERAL	CREDENTI ALI NG	59, 491	58, 708	4. 33
4. 34 4. 35		SUBPROVIDER - IPF ADMINISTRATIVE & GENERAL	BEHAVIORAL HEALTH CREDENTIAL IT&S FEES	161, 101 7, 384	1	4. 34 4. 35
4. 36		ADMINISTRATIVE & GENERAL	CLINICAL IT FEES	74, 835		4. 36
4. 37	l .	ADMINISTRATIVE & GENERAL	PATIENT ACCTING FEES	293, 904	282, 620	4. 37
4. 38 4. 39		ADMINISTRATIVE & GENERAL EMPLOYEE BENEFITS DEPARTMENT	CASE MGMT ALLOCATION HCA HR SERVICES	98, 849 608, 183	1	4. 38 4. 39
4. 40		EMPLOYEE BENEFITS DEPARTMENT		008, 183	13, 880	4. 40
4.41	13. 00	NURSING ADMINISTRATION	CLINICAL EDUCATION	568, 620		4. 41
4. 42		MEDICAL RECORDS & LIBRARY	CANCER REGISTRY-SARAH CANN	28, 607		4. 42
4. 43 4. 44		MEDICAL RECORDS & LIBRARY ADMINISTRATIVE & GENERAL	CANCER REGISTRY-SARAH CANN TRANSFER CTR ALLOCATION	24, 446 311, 894		4. 43 4. 44
4. 45		ADMINISTRATIVE & GENERAL	URS ALLOCATION	66, 895		4. 45
4.46	5. 00	ADMINISTRATIVE & GENERAL	CDI MS-DRGRECON TEAM ALLOC	0	23, 939	4. 46
4.47	l .	ADMINISTRATIVE & GENERAL	SUPPORT SERVICES ALLOCATION	14, 684		4. 47
4. 48 4. 49		OPERATION OF PLANT SUBPROVIDER - IRF	FACILITIES MGMT ALLOCATION IRF ALLOCATION	30, 826 145, 787	21, 509 141, 774	4. 48 4. 49
4. 50		LABORATORY	LAB SERVICES-DEPT 736	182, 975		4. 50
4. 51		ADMINISTRATIVE & GENERAL	CALL CENTER	0	,	4. 51
4.52		ADMINISTRATIVE & GENERAL	PHYSICIAN RECRUITING MALPRACTICE	0 425, 504	46, 512	4. 52
4. 53 4. 54		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	MALPRACTICE GENERAL LIABILITY INSURANCE	425, 504 0	643, 767 20, 356	4. 53 4. 54
4. 55	l .	ADMINISTRATIVE & GENERAL	PHYSICIAN SALES	0	126, 784	4. 55
4. 56		ADMINISTRATIVE & GENERAL	RI CHMOND FSC	7, 700		4. 56
4.57			RESTORATION PLAN EXP.	0	-3, 385 100 427	4. 57
4. 58 4. 59		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	SELF INS_POOLING ADJ. STUDENT LOAN REPAYMENT BENEF		,	4. 58 4. 59
4. 60		ADMINISTRATIVE & GENERAL	INTERCOMPANY INTEREST	0	-28, 706, 544	4. 60
4. 61		ADMINISTRATIVE & GENERAL	HOME OFFICE INTEREST	571, 936		4. 61
4.62		CAP REL COSTS-BLDG & FIXT	POB SPACE	85, 803	1	4. 62
4. 63 4. 64		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	POB SPACE POB SPACE	54, 380 62, 653		4. 63 4. 64
4. 65		CAP REL COSTS-BLDG & FIXT	PAVILLION SPACE	109, 996		4. 65
4.66	5. 00	ADMINISTRATIVE & GENERAL	PAVILLION SPACE	379	0	4. 66

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-0046

Peri od: Worksheet A-8-1 From 09/01/2022 To 08/31/2023 Date/Time Prepared:

Line No. Cost Center Expense I tems Amount of Allowable Cost Included in Wks. A, column 5 1.00 2.00 3.00 4.00 5.00	
Wks. A, colu	ımn
5	
5 1,00 2,00 3,00 4,00 5,00	0 4.6
1.00 2.00 3.00 4.00 5.00	0 4.6
	0 4.6
4.67 7.00 OPERATION OF PLANT PAVILLION SPACE 42,404	-1
4. 68 0. 00 0	0 4.6
4. 69 0. 00 0	0 4.6
4.70 0.00 0	0 4.7
4.71 0.00 0	0 4.7
4. 72 0. 00 0	0 4.7
4. 73 0. 00 0	0 4.7
4. 74 0. 00 0	0 4.7
4. 75 0. 00 0	0 4.7
5.00 TOTALS (sum of lines 1-4). 17,583,355 -8,528,0	75 5.0
Transfer column 6, line 5 to	
Worksheet A-8, column 2,	
line 12.	

The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

			Related Organization(s) and/	or Home Office					
Symbol (1)	Name	Percentage of	Name	Percentage of					
		Ownershi p		Ownershi p					
1. 00	2. 00	3.00	4. 00	5. 00					
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:									

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	В	100.00 PARALLON 100.0	0 6.00
7.00	В	67. 10 HPG 65. 0	2 7.00
8.00	В	100. 00 HCI 100. 0	8.00
9.00	В	100. 00 CAPI TAL DI VI SI 0 100. 0	9.00
10.00	В	100.00 WORKFORCE MGT. 100.0	0 10.00
10. 01	В	100. 00 HCA 100. 0	0 10.01
10. 02	В	100. 00 POB 100. 0	0 10.02
100.00	G. Other (financial or		100.00
	non-financial) specify:		

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.

 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

Health Financial Systems TERRE HAUTE REGIONAL HOSPITAL STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-0046 In Lieu of Form CMS-2552-10

Peri od: Worksheet A-8-1 From 09/01/2022 To 08/31/2023 Date/Time Prepared: 1/29/2024 8:15 am OFFICE COSTS

						1/29/2024 8: 15 am
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6. 00	7. 00				
			ENTS REQUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED C	RGANIZATIONS OR CL	AIMED
1 00	+OME OFFICE COS -109, 335	0				1 00
1. 00 2. 00	-109, 335 -255, 097	0				1.00
3.00	-2, 118, 617	0				3. 00
4. 00	202, 216	0				4. 00
4. 01	106, 458	o				4. 01
4. 02	17, 182	Ö				4. 02
4.03	-10, 609	0				4. 03
4.04	-5, 629	0				4. 04
4.05	-1, 259	0				4. 05
4.06	-29, 970	0				4. 06
4. 07	-19, 893	0				4. 07
4. 08	-1, 544	0				4. 08
4. 09	-1, 600	0				4. 09
4. 10	-5, 054	0				4. 10
4. 11 4. 12	-17 -8, 996	0				4. 11 4. 12
4. 13	-440	0				4. 12
4. 14	-4, 108	0				4. 13
4. 15	-9	O				4. 15
4. 16	-23	0				4. 16
4. 17	-1, 763	0				4. 17
4. 18	-1, 282	0				4. 18
4. 19	-45	0				4. 19
4. 20	-6, 615	0				4. 20
4. 21	-15, 281 -20, 877	0				4. 21
4. 22 4. 23	-36, 551	0				4. 22 4. 23
4. 23	3, 322	0				4. 23
4. 25	5, 282	o				4. 25
4. 26	1, 152	Ö				4. 26
4. 27	-947, 409	0				4. 27
4. 28	-4, 313	0				4. 28
4. 29	19, 416	0				4. 29
4.30	29, 970	0				4. 30
4. 31	-1, 762	0				4. 31
4. 32	0	0				4. 32
4. 33 4. 34	783 4, 013	0				4. 33
4. 35	14,013	0				4. 34 4. 35
4. 36	2, 710	o				4. 36
4. 37	11, 284	O				4. 37
4.38	-25, 508	0				4. 38
4.39	0	0				4. 39
4. 40	-13, 880	0				4. 40
4. 41	2, 348	0				4. 41
4. 42	349	0				4. 42
4. 43 4. 44	-42 -657	0				4. 43 4. 44
4. 44	4, 282	0				4. 44
4. 46	-23, 939	o o				4. 46
4. 47	1, 171	o				4. 47
4.48	9, 317	O				4. 48
4.49	4, 013	О				4. 49
4.50	0	0				4. 50
4. 51	-50, 536	0				4. 51
4.52	-46, 512	0				4. 52
4.53	-218, 263 -20, 356	0				4. 53 4. 54
4. 54 4. 55	-20, 356 -126, 784	0				4. 54
4. 56	-120, 784	0				4. 56
4. 57	3, 385					4. 57
4. 58	198, 437	o				4. 58
4. 59	-14, 202	o				4. 59
4.60	28, 706, 544	0				4. 60
4. 61	571, 936	0				4. 61
4. 62	85, 803	9				4. 62
4. 63	54, 380	0				4. 63
4. 64 4. 65	62, 653 109, 996	0 0 9 0 0 9				4. 64 4. 65
4. 65 4. 66	379	0				4. 65
	577	<u>ا</u>				1 1. 00

Health Financial Systems			TERRE HAUTE REGIONAL HOSPITAL						In Lieu of Form CMS-2552-1				
STATEME OFFICE	NT OF COSTS OF	SERVICES FROM	RELATED	ORGANI ZATI ON	S AND	HOME	Provi der	CCN:	15-0046	Peri	od: 09/01/2022	Worksheet A	N-8-1
OFFICE	C0515									То	08/31/2023		
	Net	Wkst. A-7 Ref						_				172772024). 15 dill
	Adjustments												
	(col. 4 minus												
	col. 5)*												
	6. 00	7. 00											
4.67	42.404												4. 67

4.68

4.69

4 70

4.72

4.73

4.74

4.75

5.00 5.00 The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A. columns 1 and/or 2. the amount allowable should be indicated in column 4 of this part

nas not	been posted to worksheet A,	COI UIIIIS I allu/OI	z, the amount	allowable should b	de indicated i	II COI UIIII 4 OI	tili s pai t.	
	Related Organization(s)							
	and/or Home Office							
	Type of Business							
	6. 00							
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6. 00
7. 00
8. 00
9. 00
10.00
10. 01
10. 02
100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

4.68

4.69

4.70

4.71

4.72

4.73

4.74

4.75

0

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26, 111, 430

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Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT | Peri od: | Worksheet A-8-2 | From 09/01/2022 | To 08/31/2023 | Date/Time Prepared: Provider CCN: 15-0046

						-	Γο 08/31/2023	Date/Time Pre 1/29/2024 8:1	
1.00		Wkst Aline#	Cost Center/Physician	Total	Professi onal	Provi der	RCF Amount		3 dili
1.00 30.00 ADULTS & PEDIATRICS 1,017.96 1,017.9							1102 711104111		
1.00									
1.00		1. 00	2.00	3, 00	4.00	5, 00	6, 00		
2.00 35.00 MESTA LINTENSI WE CARE UNIT 242, 309 194, 309 48.000 109, 700 240 2.00 4.00 4.00 50.00 MESTA LINTENSI WE CARE UNIT 129, 158 112, 418 10.740 181, 300 112 3.00 4.00 4.00 4.00 5.00 6.0	1. 00								1. 00
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12.00 91.00 00					_				
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10,948,340 10,675,480 272,860 1,682 200.00 20 20 20 20 20 20						· ·			
Wkst. A Line # Cost Center/Physician Identifier Unadjusted RCE S Percent of Unadjusted RCE Limit Cost of Continuing Education Cost of Cost of Continuing Education Cost of		5.00	ADMINISTRATIVE & GENERAL			· ·	1		
Identifier		Wkst Alino#	Cost Contor/Dhysician						200.00
1.00		WKSt. A LINE #		,					
1.00			ruentiriei	LIIIII					
1.00					LIIIII			I IIIsui ance	
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2.00	1 00								1 00
3.00				ľ				_	
4.00									
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6.00 65. 00 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0									
7. 00				0					
8. 00 69. 00 ELECTROCARDIOLOGY 24, 302 1, 215 0 0 0 0 0 0 9. 00 9. 00 9. 00 0 0 0 0 0				45 202	_			0	
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11.00				24 000	-		0	l "I	
12.00					· ·		0		
13.00								0	
Number N								0	
Wkst. A Line # Cost Center/Physician I dentifier Component Share of col. Limit Disallowance Disallowance Limit Disallowance		5. 00	ADMINISTRATIVE & GENERAL					1	
1.00			0 1 0 1 (5)					0	200.00
Share of col. 14		Wkst. A Line #					Adjustment		
14			Identifier		LIMIT	DI Sai i owance			
1.00									
1.00 30.00 ADULTS & PEDIATRICS 0 0 0 1,617,961 1.00 2.00 35.00 NEONATAL INTENSIVE CARE UNIT 0 19,581 28,419 222,728 2.00 3.00 40.00 SUBPROVI DER - IPF 0 9,762 6,978 119,396 3.00 4.00 41.00 SUBPROVI DER - IRF 0 0 0 47,130 4.00 5.00 50.00 OPERATI NG ROOM 0 0 0 4,852,988 5.00 6.00 65.00 RESPI RATORY THERAPY 0 0 0 89,000 6.00 7.00 66.00 PHYSI CAL THERAPY 0 65,382 30,730 31,068 7.00 8.00 69.00 ELECTROCARDI OLOGY 0 24,302 11,548 11,548 8.00 9.00 76.01 ENDOSCOPY 0 0 0 153,800 9.00 10.00 76.04 OPI C 0 24,099 11,376 11,376 10.00 12.00 91.00 EMERGENCY 0 2,913 30,747		1 00	2.00		1/ 00	17.00	10.00		
2. 00 35. 00 NEONATAL INTENSIVE CARE UNIT 0 19, 581 28, 419 222, 728 2. 00 3. 00 40. 00 SUBPROVI DER - I PF 0 9, 762 6, 978 119, 396 3. 00 4. 00 41. 00 SUBPROVI DER - I RF 0 0 0 47, 130 4. 00 5. 00 50. 00 OPERATI NG ROOM 0 0 0 4, 852, 988 5. 00 6. 00 65. 00 RESPI RATORY THERAPY 0 0 0 89, 000 6. 00 7. 00 66. 00 PHYSI CAL THERAPY 0 0 65, 382 30, 730 31, 068 7. 00 8. 00 69. 00 ELECTROCARDI OLOGY 0 24, 302 11, 548 11, 548 8. 00 9. 00 76. 01 ENDOSCOPY 0 0 0 153, 800 9. 00 10. 00 76. 03 WOUND CARE 0 24, 099 11, 376 11, 376 10. 00 11. 00 76. 04 OPI C 0 2, 913 30, 747 30, 747 11. 00 12. 00 91. 00 EMERGENCY 0 2, 034 2, 966 3, 610, 417 12. 00	1 00								1 00
3. 00				1	_	_			
4. 00									
5. 00 50. 00 OPERATI NG ROOM 0 0 0 4,852,988 5. 00 6. 00 65. 00 RESPI RATORY THERAPY 0 0 0 89,000 6. 00 7. 00 66. 00 PHYSI CAL THERAPY 0 65,382 30,730 31,068 7. 00 8. 00 69. 00 ELECTROCARDI OLOGY 0 24,302 11,548 11,548 8. 00 9. 00 76. 01 ENDOSCOPY 0 0 0 153,800 9. 00 10. 00 76. 03 WOUND CARE 0 24,099 11,376 11,376 10. 00 11. 00 76. 04 OPI C 0 2,913 30,747 30,747 11. 00 12. 00 91. 00 EMERGENCY 0 2,034 2,966 3,610,417 12. 00 13. 00 5. 00 ADMI NI STRATI VE & GENERAL 0 1,118 905 990 13. 00				0	· ·				
6. 00 65. 00 RESPI RATORY THERAPY 0 0 0 0 89,000 6. 00 7. 00 66. 00 PHYSI CAL THERAPY 0 65,382 30,730 31,068 7. 00 8. 00 69. 00 ELECTROCARDI OLOGY 0 24,302 11,548 11,548 8. 00 9. 00 76. 01 ENDOSCOPY 0 0 0 153,800 9. 00 10. 00 76. 03 WOUND CARE 0 24,099 11,376 11,376 10. 00 76. 04 OPI C 0 2,913 30,747 30,747 11. 00 12. 00 91. 00 EMERGENCY 0 2,034 2,966 3,610,417 12. 00 13. 00 5. 00 ADMI NI STRATI VE & GENERAL 0 1,118 905 990 13. 00				0					
7. 00 66. 00 PHYSI CAL THERAPY 0 65, 382 30, 730 31, 068 7. 00 8. 00 69. 00 ELECTROCARDI OLOGY 0 24, 302 11, 548 11, 548 8. 00 9. 00 76. 01 ENDOSCOPY 0 0 0 153, 800 9. 00 10. 00 76. 03 WOUND CARE 0 24, 099 11, 376 11, 376 10. 00 11. 00 76. 04 OPI C 0 2, 913 30, 747 30, 747 11. 00 12. 00 91. 00 EMERGENCY 0 2, 034 2, 966 3, 610, 417 12. 00 13. 00 5. 00 ADMI NI STRATI VE & GENERAL 0 1, 118 905 990 13. 00				0					
8. 00 69. 00 ELECTROCARDI OLOGY 0 24, 302 11, 548 11, 548 8. 00 9. 00 76. 01 ENDOSCOPY 0 0 0 153, 800 9. 00 10. 00 76. 03 WOUND CARE 0 24, 099 11, 376 11, 376 10. 00 11. 00 76. 04 OPI C 0 2, 913 30, 747 30, 747 11. 00 12. 00 91. 00 EMERGENCY 0 2, 034 2, 966 3, 610, 417 12. 00 13. 00 5. 00 ADMI NI STRATI VE & GENERAL 0 1, 118 905 990 13. 00				0	-	_			
9. 00 76. 01 ENDOSCOPY 0 0 0 153, 800 9. 00 10. 00 76. 03 WOUND CARE 0 0 24, 099 11, 376 11, 376 11. 00 76. 04 OPI C 0 2, 913 30, 747 30, 747 11. 00 12. 00 91. 00 EMERGENCY 0 2, 034 2, 966 3, 610, 417 12. 00 13. 00 5. 00 ADMI NI STRATI VE & GENERAL 0 1, 118 905 990 13. 00				0					
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11. 00 76. 04 OPI C 0 2, 913 30, 747 30, 747 11. 00 12. 00 91. 00 EMERGENCY 0 2, 034 2, 966 3, 610, 417 12. 00 13. 00 5. 00 ADMI NI STRATI VE & GENERAL 0 1, 118 905 990 13. 00				0	0	_		1	
12. 00 91. 00 EMERGENCY 0 2, 034 2, 966 3, 610, 417 12. 00 13. 00 5. 00 ADMI NI STRATI VE & GENERAL 0 1, 118 905 990 13. 00				0		· ·			
13. 00 5. 00 ADMI NI STRATI VE & GENERAL 0 1, 118 905 990 13. 00				0					
				0	·				
200.00 0		5. 00	ADMINISTRATIVE & GENERAL	0	· ·				
	200.00			J 0	149, 191	123, 669	10, 799, 149		200.00

Heal th	Financial Systems I	ERRE HAUTE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST A	ILLOCATION - GENERAL SERVICE COSTS		Provi der CC	CN: 15-0046 Pe Fi To	eriod: com 09/01/2022 o 08/31/2023	Worksheet B Part I Date/Time Pre 1/29/2024 8:1	pared:
			CAPI TAL REL	ATED COSTS		172772024 0. 1	Jaiii
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		0	1.00	2. 00	4. 00	4A	
	GENERAL SERVICE COST CENTERS		1.00	2.00	1. 00	17.	
1.00	00100 CAP REL COSTS-BLDG & FLXT	3, 510, 263	3, 510, 263				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	3, 192, 529	0,0.0,200	3, 192, 529			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	6, 347, 390	8, 816	8, 018	6, 364, 224		4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	29, 733, 891	257, 504		703, 751	30, 929, 342	5. 00
7. 00	00700 OPERATION OF PLANT	3, 965, 403	957, 417	870, 752	115, 601	5, 909, 173	1
8.00	00800 LAUNDRY & LINEN SERVICE	426, 457	29, 921	27, 213	1, 247	484, 838	
9. 00	00900 HOUSEKEEPING	1, 493, 695	34, 081	30, 996	214, 731	1, 773, 503	
10.00	01000 DI ETARY	1, 451, 762	58, 606	53, 301	o	1, 563, 669	
11. 00	01100 CAFETERI A	383, 365	30, 941	28, 140	o	442, 446	
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 477, 559	4, 575		145, 691	1, 631, 986	
16. 00	01600 MEDICAL RECORDS & LIBRARY	770, 737	7, 119		0	784, 331	
	INPATIENT ROUTINE SERVICE COST CENTERS		.,	27			1
30.00	03000 ADULTS & PEDI ATRI CS	6, 146, 832	471, 733	429, 034	937, 645	7, 985, 244	30.00
31. 00	03100 INTENSIVE CARE UNIT	3, 104, 943	110, 913	100, 874	447, 506	3, 764, 236	
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	468, 060	4, 439	4, 038	86, 674	563, 211	
40. 00	04000 SUBPROVI DER - I PF	2, 065, 410	98, 985	•	347, 936	2, 602, 356	
41. 00	04100 SUBPROVI DER – I RF	1, 246, 948	90, 079		213, 355	1, 632, 307	
43. 00	04300 NURSERY	158, 912	14, 203		25, 051	211, 083	1
	ANCI LLARY SERVI CE COST CENTERS	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	, = ,	.=,			1
50.00	05000 OPERATI NG ROOM	4, 711, 938	261, 240	237, 594	594, 292	5, 805, 064	50.00
51.00	05100 RECOVERY ROOM	236, 187	14, 293	12, 999	42, 417	305, 896	
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 098, 907	45, 170	41, 082	203, 456	1, 388, 615	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	990, 962	107, 457	97, 731	138, 764	1, 334, 914	
54. 01	03630 ULTRA SOUND	181, 579	7, 408		32, 553	228, 278	
54. 02	03440 MAMMOGRAPHY	96, 487	23, 893		16, 293	158, 404	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 061, 839	38, 466	34, 984		1, 251, 103	
56. 00	05600 RADI OI SOTOPE	587, 572	6, 885		8, 688	609, 407	
57. 00	05700 CT SCAN	539, 417	12, 127	11, 029		643, 988	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	234, 977	12, 461	11, 333		289, 089	
59. 00	05900 CARDI AC CATHETERI ZATI ON	876, 581	17, 379		103, 843	1, 013, 609	
60.00	06000 LABORATORY	2, 680, 680	58, 173	52, 907	214, 545	3, 006, 305	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 802, 533	2, 824		12, 052	1, 819, 978	
65. 00	06500 RESPIRATORY THERAPY	1, 214, 390	14, 455	13, 147	132, 945	1, 374, 937	
66. 00	06600 PHYSI CAL THERAPY	1, 111, 341	9, 086	8, 264	202, 528	1, 331, 219	
69. 00	06900 ELECTROCARDI OLOGY	481, 278	39, 170	35, 624	84, 845	640, 917	
70. 00	07000 ELECTROENCEPHALOGRAPHY	26, 064	4, 385			38, 228	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 978, 654	50, 575	45, 997	39, 267	4, 114, 493	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 374, 296	0	0	0	2, 374, 296	
	07300 DRUGS CHARGED TO PATIENTS	13, 554, 506	32, 989	-	234, 618	13, 852, 116	
	07400 RENAL DI ALYSI S	516, 434	12, 587	11, 448	139	540, 608	1
76. 00	03950 LI THOTRI PSY	69, 400	0	0	0	69, 400	
76. 01	03330 ENDOSCOPY	383, 642	14, 293	12, 999	50, 034	460, 968	
	03040 PRISION CLINIC	221, 285	39, 991	36, 371	40, 691	338, 338	1
76. 03	03050 WOUND CARE	718, 547	29, 740	27, 049		792, 198	1
76. 04	03060 OPI C	500, 980	38, 890	35, 370		668, 350	
	07700 ALLOGENEIC HSCT ACQUISITION	0	00,070	0		0	
77.00	OUTPATIENT SERVICE COST CENTERS	١	<u> </u>	O ₁	٩		77.00
91. 00	09100 EMERGENCY	3, 071, 772	116, 165	105, 650	379, 555	3, 673, 142	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,071,772	110, 100	100, 000	077,000	0, 0, 0, 1, 12	1
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
102 00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
.02.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>	5	٥١		1.02.00
118.00		109, 266, 404	3, 189, 434	2, 900, 740	6, 112, 023	108, 401, 585	118. 00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	22	5, 107	4, 645	O	9 774	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0, 107	1, 545 N	o O		192. 00
	07950 OCCUPATI ONAL MEDI CI NE	926, 931	21, 466	19, 523	160, 754	1, 128, 674	
	07951 UNOCCUPIED SPACE/NONALLOWABLE MEALS	/20, /31	294, 256	267, 621	100, 734	561, 877	
	07952 SITTERS	475, 643	2,7,230 N	207, 021	91, 447	567, 090	
	07953 UNLICENSED STAFF	175,045	0	0	71, 447		194. 02
200.00					٩		200. 00
200.00	1 1		n	Λ	٨		201. 00
202.00		110, 669, 000	3, 510, 263	3, 192, 529	6, 364, 224	110, 669, 000	
202.00	1.0 (Sam. 1.1.55 110 till Sagit 201)		5, 515, 200	3, 1,2, 32,	5, 50 1, 227	, ,	,_02.00

Provider CCN: 15-0046

Peri od: Worksheet B From 09/01/2022 Part I To 08/31/2023 Date/ime Prepared:

				11	0 08/31/2023	1/29/2024 8:1	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE	0.00	10.00	
	GENERAL SERVICE COST CENTERS	5. 00	7. 00	8.00	9. 00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	30, 929, 342					5. 00
7.00	00700 OPERATION OF PLANT	2, 292, 044	8, 201, 217				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	188, 058	107, 319				8. 00
9.00	00900 HOUSEKEEPI NG	687, 905	122, 239			l	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	606, 514 171, 616	210, 205 110, 976				
13. 00	01300 NURSING ADMINISTRATION	633, 013	16, 409			1	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	304, 226	25, 535		· ·	l	1
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0017220	20,000		0,270		1
30.00	03000 ADULTS & PEDIATRICS	3, 097, 308	1, 691, 991	428, 278	548, 380	1, 082, 742	30. 00
31. 00	03100 INTENSIVE CARE UNIT	1, 460, 068	397, 819		128, 935		1
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	218, 458	15, 923			2, 835	1
40.00	04000 SUBPROVI DER - I PF	1, 009, 399	355, 034		115, 068		1
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	633, 138	323, 091				1
43.00	ANCI LLARY SERVI CE COST CENTERS	81, 875	50, 941	10, 415	10, 510	1, 828	43.00
50. 00	05000 OPERATING ROOM	2, 251, 662	937, 005	0	303, 687	0	50.00
51.00	05100 RECOVERY ROOM	118, 651	51, 265	1		i e	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	538, 615	162, 015	0	52, 510	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	517, 785	385, 424	1	,	0	
54. 01	03630 ULTRA SOUND	88, 544	26, 571		8, 612		54. 01
54. 02	03440 MAMMOGRAPHY	61, 442	85, 700	1		l e	
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	485, 277 236, 376	137, 968 24, 694	1		0	
57. 00	05700 CT SCAN	249, 789	43, 497			l	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	112, 132	44, 695		·	l	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	393, 158	62, 333			l	1
60.00	06000 LABORATORY	1, 166, 083	208, 651			l	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	705, 931	10, 130			0	62. 00
65. 00	06500 RESPI RATORY THERAPY	533, 309	51, 847			0	65. 00
66.00	06600 PHYSI CAL THERAPY	516, 352	32, 591			1	
69.00	06900 ELECTROCARDI OLOGY	248, 598	140, 492		·	l	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 828 1, 595, 925	15, 729 181, 401		·		
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	920, 940	101, 401		·	l	
73. 00	07300 DRUGS CHARGED TO PATIENTS	5, 372, 947	118, 323			1	
74.00	07400 RENAL DIALYSIS	209, 690	45, 148	1		l	74. 00
76.00	03950 LI THOTRI PSY	26, 919	0	0	0	0	76. 00
76. 01	03330 ENDOSCOPY	178, 800	51, 265	1		l .	
76. 02	03040 PRISION CLINIC	131, 234	143, 438		46, 489	l e	
76. 03	03050 WOUND CARE	307, 277	106, 672		·		
76. 04 77. 00	03060 OPIC 07700 ALLOGENEIC HSCT ACQUISITION	259, 239 0	139, 489 0	1	·	i e	
77.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	0	0		77.00
91. 00	09100 EMERGENCY	1, 424, 735	416, 655	0	135, 040	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	30, 049, 860	7, 050, 480	780, 215	2, 210, 689	1, 777, 577	118 00
110.00	NONREI MBURSABLE COST CENTERS	30, 047, 800	7,050,460	700,213	2, 210, 009	1,777,377	1118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 791	18, 318	0	5, 937	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0				192. 00
194.00	07950 OCCUPATIONAL MEDICINE	437, 789	76, 994	0	24, 954	0	194. 00
	07951 UNOCCUPIED SPACE/NONALLOWABLE MEALS	217, 940	1, 055, 425	0	342, 067	670, 939	
	07952 SI TTERS	219, 962	0	0	0		194. 02
	07953 UNLI CENSED STAFF	0	0	9	0	0	194. 03
200.00	1 1		^	_	^	_	200. 00 201. 00
201. 00 202. 00		30, 929, 342	8, 201, 217	780, 215	0 2, 583, 647	l .	
202.00	TOTAL (Sum TITIES TTO LIMOUGH 201)	30, 727, 342	0, 201, 217	1 /00, 215	2, 303, 047	2,440,310	1202.00

Period: Worksheet B
From 09/01/2022 Part I
To 09/21/2022 Part I
To 09/21/2022 Part I Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0046

				To	08/31/2023	Date/Time Pre	pared:
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	Subtotal	1/29/2024 8: 1 Intern &	o am
	The state of the s		ADMI NI STRATI ON	RECORDS &		Residents Cost	
				LI BRARY		& Post Stepdown	
						Adjustments	
	CENEDAL CEDILOE COCT CENTEDO	11.00	13.00	16. 00	24. 00	25. 00	
	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00
	00700 OPERATION OF PLANT						5. 00 7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
11. 00	01100 CAFETERI A	761, 006					10. 00 11. 00
13.00	01300 NURSING ADMINISTRATION	20, 806					13. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0	1, 122, 368			16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	133, 903	634, 907	30, 810	15, 633, 563	0	30. 00
31.00	03100 INTENSIVE CARE UNIT	63, 907		18, 584	6, 506, 944	0	31. 00
	02060 NEONATAL INTENSIVE CARE UNIT	12, 378		952	907, 888		35. 00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	49, 688 30, 469		40, 275 5, 716	4, 902, 711 3, 143, 024	0	40. 00 41. 00
	04300 NURSERY	3, 577		994	391, 115		43. 00
50.00	ANCILLARY SERVICE COST CENTERS		1	407 700	0.500.000		
50. 00 51. 00	O5000 OPERATING ROOM O5100 RECOVERY ROOM	84, 869 6, 058		137, 793 14, 191	9, 520, 080 512, 676	0	50. 00 51. 00
	05200 DELIVERY ROOM & LABOR ROOM	29, 055		4, 795	2, 310, 255		52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	19, 817	1	17, 389	2, 400, 246	1	54. 00
54. 01 54. 02	03630 ULTRA SOUND 03440 MAMMOGRAPHY	4, 649 2, 327	0	5, 428 2, 831	362, 082 338, 480	0	54. 01 54. 02
55. 00	05500 RADI OLOGY-THERAPEUTI C	16, 539	0	27, 872	1, 963, 475	0	55. 00
56.00	05600 RADI OI SOTOPE	1, 241	o	21, 386	901, 107	0	56. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	11, 627 4, 330	0	92, 032 12, 632	1, 055, 031 477, 364	0	57. 00 58. 00
59. 00	05900 CARDIAC CATHETERIZATION	14, 829	1	39, 709	1, 616, 126		59. 00
60.00	06000 LABORATORY	30, 638		102, 650	4, 581, 952	0	60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 721	0	7, 913	2, 548, 956	0	62.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	18, 985 28, 922		24, 457 15, 594	2, 082, 408 1, 935, 545	0	65. 00 66. 00
69. 00	06900 ELECTROCARDI OLOGY	12, 117		32, 755	1, 148, 151	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	541	0	1, 156	75, 580		70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	5, 608	0	63, 796 24, 431	6, 020, 016 3, 319, 667	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	33, 505	o	233, 583	19, 648, 823	Ö	73. 00
	07400 RENAL DI ALYSI S	20	1	1, 682	811, 781	0	74. 00
76. 00 76. 01	03950 LI THOTRI PSY 03330 ENDOSCOPY	7, 145	0	1, 447 19, 500	97, 766 734, 293	0	76. 00 76. 01
	03040 PRI SI ON CLI NI C	5, 811		1, 103	681, 766		76. 02
	03050 WOUND CARE	2, 408		6, 948			76. 03
	03060 OPIC 07700 ALLOGENEIC HSCT ACQUISITION	13, 297 0		9, 813 0	1, 204, 184 0	0	76. 04 77. 00
	OUTPATIENT SERVICE COST CENTERS		9	<u> </u>		0	77.00
	09100 EMERGENCY	54, 203	400, 330	102, 151	6, 206, 256		91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS					0	92. 00
	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	724, 990	2, 305, 466	1, 122, 368	105, 289, 387	0	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	37, 820 0		190. 00 192. 00
	07950 OCCUPATIONAL MEDICINE	22, 957		0	1, 691, 368		194. 00
194. 01	07951 UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	O	0	2, 848, 248	0	194. 01
	07952 SI TTERS 07953 UNLI CENSED STAFF	13, 059	2, 066	0	802, 177 0		194. 02 194. 03
200.00			1	U	0		200. 00
201.00	Negative Cost Centers	0	0	0	0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	761, 006	2, 307, 532	1, 122, 368	110, 669, 000	I 0	202. 00

Provider CCN: 15-0046

			То	08/31/2023 Date/Time P	
	Cost Center Description	Total		172772024 0	1. 15 dill
		26.00			
1 00	GENERAL SERVI CE COST CENTERS				1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP				1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL				5. 00
7. 00	00700 OPERATION OF PLANT				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE				8. 00
9.00	00900 HOUSEKEEPI NG				9. 00
10.00	01000 DI ETARY				10. 00
11.00	01100 CAFETERI A				11.00
13. 00 16. 00	01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY				13. 00 16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				10.00
30.00	03000 ADULTS & PEDIATRICS	15, 633, 563			30. 00
31.00	03100 INTENSIVE CARE UNIT	6, 506, 944			31. 00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	907, 888			35. 00
40. 00	04000 SUBPROVI DER - I PF	4, 902, 711			40. 00
41. 00	04100 SUBPROVI DER – I RF	3, 143, 024			41. 00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	391, 115			43. 00
50. 00	05000 OPERATI NG ROOM	9, 520, 080			50.00
51. 00	05100 RECOVERY ROOM	512, 676			51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 310, 255			52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 400, 246			54. 00
54. 01	03630 ULTRA SOUND	362, 082			54. 01
54. 02	03440 MAMMOGRAPHY	338, 480			54. 02
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	1, 963, 475 901, 107			55. 00 56. 00
57. 00	05700 CT SCAN	1, 055, 031			57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	477, 364			58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 616, 126			59. 00
60.00	06000 LABORATORY	4, 581, 952			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 548, 956			62. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	2, 082, 408			65. 00 66. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 935, 545 1, 148, 151			69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	75, 580			70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 020, 016			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3, 319, 667			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	19, 648, 823			73. 00
74. 00	07400 RENAL DI ALYSI S	811, 781			74. 00
76. 00	03950 LI THOTRI PSY	97, 766			76.00
76. 01 76. 02	03330 ENDOSCOPY 03040 PRI SI ON CLI NI C	734, 293 681, 766			76. 01 76. 02
76. 02	03050 WOUND CARE	1, 250, 076			76. 03
76. 04	03060 OPI C	1, 204, 184			76. 04
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0			77. 00
	OUTPATIENT SERVICE COST CENTERS				
	09100 EMERGENCY	6, 206, 256			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				92. 00
102.00	10200 OPI OI D TREATMENT PROGRAM	0			102. 00
.02.00	SPECIAL PURPOSE COST CENTERS	<u> </u>			102.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	105, 289, 387			118. 00
100.00	NONREI MBURSABLE COST CENTERS	07.000			100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	37, 820			190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OCCUPATIONAL MEDICINE	1, 691, 368			192. 00 194. 00
	07951 UNOCCUPIED SPACE/NONALLOWABLE MEALS	2, 848, 248			194. 00
	07952 SI TTERS	802, 177			194. 02
	07953 UNLICENSED STAFF	0			194. 03
200.00	, ,	0			200. 00
201.00		0			201. 00
202.00	TOTAL (sum lines 118 through 201)	110, 669, 000			202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS In Lieu of Form CMS-2552-10 TERRE HAUTE REGIONAL HOSPITAL Worksheet B
Part II
Date/Time Prepared:
1/29/2024 8:15 am Provider CCN: 15-0046 Peri od: From 09/01/2022 To 08/31/2023 CAPITAL RELATED COSTS

Related Costs
1.00
2.00 002000 CAP REL COSTS AWBLE EQUIP
4. 00 00400 EMPLOYEE BERREITS DEPARTMENT 0 8, 816 8, 018 16, 834 16, 834 4. 00
5.00 00500 ADMINISTRATIVE & CENERAL 2, 367, 657 257, 504 234, 196 2, 897, 367 1, 8c1 5, 00
7.00 00700
9.00 00900 HOUSEKEEPI NS
10.00 01000 01ETARY 0 58.606 53.301 111, 907 0 10.00 11
11.00 01000 01000 010000 0100000 0100000000
13.0 01300 NURSI NG ADM IN ISTRATION 38, 445 4, 575 4, 161 47, 181 385 13.0 016.0 016.00 DIOLON ECCORDS & LIBRARY 5, 085 7, 119 6, 475 18, 679 0 16.00 016.00 1000 2000 2000 2001 2000
16.00 16.00 16.00 16.00 16.00 18.679
INPATI ENT ROUTI NE SERVI CE COST CENTERS
33.00 03100 INTENSIVE CARE UNIT 929 110, 913 100, 874 212, 716 1, 184 31.00 35.00 02060 NEOMATAL INTENSIVE CARE UNIT 72 4, 439 4, 038 8, 549 229 35.00 40.00 04000 SUBPROVI DER - IPF 75 98, 985 90, 025 189, 095 920 40.00 41.00 04100 SUBPROVI DER - IPF 236 90, 079 81, 925 172, 240 564 41.00 43.00 43200 NURSERY 1 14, 203 12, 917 27, 121 66 43.00 A0300 NURSERY 1 14, 203 12, 917 27, 121 66 44.00 ANCI LLARY SERVI CE COST CENTERS 75 77, 121 77, 12
35. 00 02600 NEONATAL INTENSIVE CARE UNIT 72
40.00 04000 SUBPROVI DER - I PF 75 98, 985 90, 025 189, 085 920 40, 00 41.00 04100 SUBPROVI DER - I RF 236 90, 079 81, 925 172, 240 564 41.00 43.00 04100 SUBPROVI DER - I RF 236 90, 079 81, 925 172, 240 564 41.00 43.00 04300 NURSERY 1 14, 203 12, 917 27, 121 66 43.00 43.00 05000 OPERATI NG ROOM 420 261, 240 237, 594 499, 254 1, 572 50.00 05000 OPERATI NG ROOM 0 14, 293 12, 999 27, 292 112 51.00 51.00 05000 OPERATI NG ROOM 21 45, 170 41, 082 86, 273 538 52.00 52.00 05200 DELI VERY ROOM 8.1ABOR ROOM 21 45, 170 41, 082 86, 273 538 52.00 54.01 03630 ULTRA SOUND 0 7, 408 6, 738 14, 146 86 54.01 54.01 03440 MAMMOGRAPHY 1 23, 893 21, 731 45, 625 43 54.02 55.00 05500 RADIO LOGY-THERAPEUTI C 0 38, 466 34, 984 73, 450 306 55.00 56.00 05600 RADIO STOPE 82 82 68, 85 6. 262 13, 229 23 56.00 57.00 05700 CT SCAN 60 12, 127 11, 029 23, 216 215 57.00 58.00 05600 CARDI AC CATHETERI ZATI ON 309 17, 379 15, 806 33, 494 275 59.00 59.00 05600 CARDI AC CATHETERI ZATI ON 309 17, 379 15, 806 33, 494 275 59.00 60.00 06000 LEGERRO AGRIPHY 1 14, 455 13, 147 28, 316 352 65.00 66.00 06500 PHYSI CAL THERAPY 0 9, 086 8, 264 17, 350 356 66.00 66.00 06500 PHYSI CAL THERAPY 0 9, 086 8, 264 17, 350 356 66.00 66.00 06500 PHYSI CAL THERAPY 0 9, 086 8, 264 17, 350 356 66.00 66.00 06500 PHYSI CAL THERAPY 0 9, 086 8, 264 17, 350 356 66.00 66.00 06500 PHYSI CAL THERAPY 0 9, 086 8, 264 17, 350 356 66.00 66.00 06500 PHYSI CAL THERAPY 0 9, 086 8, 264 17, 350 356 66.00 66.00 06500 PHYSI CAL THERAPY 0 9, 086 8, 264 17, 350 356 66.00 06500 PHYSI CAL THERAPY 0 9, 086 8, 264 17, 350 356 66.00 0700 0700 0700 0700 0700 0700 07
41.00 04100 SUBPROVI DER - I FF 236 90,079 81,925 172,240 564 41.00 04300 NURSERY 1 14,203 12,917 27,121 66 43.00 04300 NURSERY ROOM 0 14,293 12,999 27,292 112 51.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 21 45,170 41,082 86,273 538 52.00 05200 DELI VERY ROOM & LABOR ROOM 21 45,170 41,082 86,273 538 52.00 05400 RADI DI GOSY-DI AGNOSTI C 191 107,457 97,731 205,379 367 54.00
43.00
50. 00 05000 0FERATI NG ROOM 420 261, 240 237, 594 499, 254 1, 572 50. 00 51. 00 05100 RECOVERY ROOM & LABOR ROOM 0 14, 293 12, 999 27, 292 112 51. 00 51. 00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 21 45, 170 41, 082 86, 273 538 52. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 191 107, 457 97, 731 205, 379 367 54. 00 54. 01 3630 ULTRA SOUND 0 7, 408 6, 738 14, 146 86 54. 01 54. 02 33440 MAMMOGRAPHY 1 23, 893 21, 731 45, 625 43 54. 02 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 38, 466 34, 984 73, 450 306 55. 00 5500 RADI OLOGY-THERAPEUTI C 0 38, 466 34, 984 73, 450 306 55. 00 5500 RADI OLOGY-THERAPEUTI C 0 38, 466 34, 984 73, 450 306 55. 00 5500 RADI OLOGY-THERAPEUTI C 0 38, 466 34, 984 73, 450 306 55. 00 5500 RADI OLOGY-THERAPEUTI C 0 38, 466 34, 984 73, 450 306 55. 00 5500 RADI OLOGY-THERAPEUTI C 0 38, 466 34, 984 73, 450 306 55. 00 5500 RADI OLOGY-THERAPEUTI C 2 11, 029 23, 216 215 57. 00 58. 00 05500 RADI OLOGY-THERAPEUTI C 2 12, 461 11, 333 23, 796 80 58. 00 59. 00 5900 CARDI AC CATHETERI ZATI ON 309 71, 379 15, 806 33, 494 275 59. 00 69. 00 0600 LABORATORY 988 58, 173 52, 907 112, 068 567 60. 00 62. 00 06200 RESPI RATORY THERAPY 9 9, 88 58, 173 52, 907 112, 068 567 60. 00 6500 RESPI RATORY THERAPY 0 9, 086 8, 264 17, 350 536 66. 00 66. 00 0600 DADICAL SUPPLIES CHARGED TO PATI ENTS 0 9, 086 8, 264 17, 350 536 66. 00 69. 00 00 00 00 00 00 00 00
51.00 05100 RECOVERY ROOM 0 14, 293 12, 999 27, 292 112 51.00
52. 00 05200 DELL VERY ROOM & LABOR ROOM 21 45, 170 41, 062 86, 273 538 52. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 191 107, 457 97, 731 205, 379 367 54. 00 03630 ULTRA SOUND 0 7, 408 6, 738 14, 146 86 54. 01 54. 02 03440 MAMMOGRAPHY 1 23, 893 21, 731 45, 625 43 54. 02 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 38, 466 34, 984 73, 450 306 55. 00 05600 RADI OLOGY-THERAPEUTI C 0 38, 466 34, 984 73, 450 306 55. 00 05600 RADI OLOGY-THERAPEUTI C 0 38, 466 34, 984 73, 450 306 55. 00 05600 RADI OLOGY-THERAPEUTI C 0 38, 466 34, 984 73, 450 306 55. 00 05600 RADI OLOGY-THERAPEUTI C 0 21, 127 11, 029 23, 216 215 57. 00 05700 CT SCAN 60 12, 127 11, 029 23, 216 215 57. 00 05700 CT SCAN 60 12, 127 11, 029 23, 216 215 57. 00 05900 CARDI AC CATHETERI ZATI ON 309 17, 379 15, 806 33, 494 275 59. 00 05900 CARDI AC CATHETERI ZATI ON 309 17, 379 15, 806 33, 494 275 59. 00 06000 LABORATORY 988 58, 173 52, 907 112, 068 567 60. 00 06000 LABORATORY 988 58, 173 52, 907 112, 068 567 60. 00 06000 LABORATORY 14, 455 13, 147 28, 316 352 65. 00 06500 RESPI RATORY THERAPY 0 9, 086 8, 264 17, 350 536 66. 00 06000 PHYSI CAL THERAPY 0 9, 086 8, 264 17, 350 536 66. 00 06000 PHYSI CAL THERAPY 0 4, 385 3, 988 8, 373 10 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 50, 575 45, 997 96, 572 104 71. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 73. 00 74
54. 00 05400 RADI OLOGY-DI AGNOSTI C 191 107, 457 97, 731 205, 379 367 54. 00 54. 01 03630 ULTRA SOUND 0 7, 408 6, 738 14, 146 86 54. 01 54. 02 3340 MAMMOGRAPHY 1 23, 893 21, 731 45, 625 43 54. 02 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 38, 466 34, 984 73, 450 306 55. 00 56. 00 65600 RADI OLOGY-THERAPEUTI C 0 38, 466 34, 984 73, 450 306 55. 00 57. 00 05700 CT SCAN 60 12, 127 11, 029 23, 216 215 57, 00 57. 00 05700 CT SCAN 60 12, 127 11, 029 23, 216 215 57, 00 58. 00 05800 MAGNETI C RESONANCE MAGING (MRI) 2 12, 461 11, 333 23, 796 80 58. 00 59. 00 CARDI AC CATHETERI ZATI ON 309 17, 379 15, 806 33, 494 275 59. 00 60. 00 60600 LABORATORY 988 58, 173 52, 907 112, 068 567 60. 00 60600 LABORATORY 988 58, 173 52, 907 112, 068 567 60. 00 60600 LABORATORY 714 14, 455 13, 147 28, 316 352 65. 00 65. 00 65. 00 65. 00 RESPI RATORY THERAPY 0 9, 086 8, 264 17, 350 536 66. 00 66. 00 60600 PIYSI CAL THERAPY 0 4, 385 3, 988 8, 373 10 70. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 4, 385 3, 988 8, 373 10 70. 00 70. 00 07000 RELECTROENCEPHALOGRAPHY 0 4, 385 3, 988 8, 373 10 70. 00 72. 00 07200 MPL. DEV. CHARGED TO PATI ENTS 0 50, 575 45, 997 96, 572 104 71. 00 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 76. 00 76. 00 03300 DRUGS CHARGED TO PATI ENTS 0 14, 293 12, 999 27, 292 132 76. 01 76. 00 03300 RMOS CHARGED TO PATI ENTS 0 39, 991 36, 371 76, 362 108 76. 01 76. 00 76. 00 03050 WOUND CARE 0 29, 740 27, 049 56, 789 45 76. 03 77. 00 00 00 00 00 00 00
54. 01 03630 ULTRA SOUND
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 38, 466 34, 984 73, 450 306 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 82 6, 885 6, 262 13, 229 23 56. 00 57. 00 05700 CT SCAN 60 12, 127 11, 029 23, 216 215 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 2 12, 461 11, 333 23, 796 80 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 309 17, 379 15, 806 33, 494 275 59. 00 60. 00 0600 LABORATORY 988 58, 173 52, 907 112, 068 567 60. 00 60
56. 00 05600 RADI OI SOTOPE 82 6, 885 6, 262 13, 229 23 56. 00 57. 00 05700 CT SCAN 60 12, 127 11, 029 23, 216 215 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 2 12, 461 11, 333 23, 796 80 58. 00 05900 CARDI AC CATHETERI ZATI ON 309 17, 379 15, 806 33, 494 275 59. 00 06. 00 06. 00 06. 000 LABORATORY 988 58, 173 52, 907 112, 068 567 60. 00 06. 00 06. 000 LABORATORY 988 58, 173 52, 907 112, 068 567 60. 00 06. 00 06. 000 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 2, 824 2, 569 5, 393 32 62. 00 06
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06500 LABORATORY 60. 00 06500 LABORATORY 70 06500 NAGNETIC RESONANCE I MAGI NG (MRI) 71. 379 15, 806 33, 494 275 59, 00 10 12, 127 112, 068 567 60, 00 10 12, 127 112, 068 567 60, 00 10 12, 127 112, 068 567 60, 00 10 12, 127 112, 068 567 60, 00 10 12, 127 112, 068 567 60, 00 10 12, 127 112, 068 567 60, 00 10 12, 127 112, 068 567 60, 00 10 12, 127 112, 068 567 60, 00 10 12, 127 112, 068 567 60, 00 10 12, 127 112, 068 567 60, 00 10 12, 127 112, 068 567 60, 00 12, 127 112, 00 1
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 2 12, 461 11, 333 23, 796 80 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 309 17, 379 15, 806 33, 494 275 59. 00 60. 00 06000 LABORATORY 988 58. 173 52, 907 112, 068 567 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 2, 824 2, 569 5, 393 32 62. 00 65. 00 06500 RESPI RATORY THERAPY 714 14, 455 13, 147 28, 316 352 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 9, 086 8, 264 17, 350 536 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0 39, 170 35, 624 74, 794 224 69. 00 70. 00 70.00 ELECTROCARDI OLOGY 0 4, 385 3, 988 8, 373 10 70. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 50, 575 45, 997 96, 572 104 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 32, 989 30, 003 62, 992 620 73. 00 74. 00 07400 RENAL DI ALYSIS 974 12, 587 11, 448 25, 009 0 74. 00 76. 00 03950 LI THOTRI PSY 0 0 0 0 0 0 76. 00 76. 00 03950 LI THOTRI PSY 0 0 0 0 0 76. 00 76. 00 03040 PRI SI ON CLI NI C 0 39, 991 36, 371 76, 362 108 76. 02 76. 03 03050 WOUND CARE 0 29, 740 27, 049 56, 789 45 76. 03 76. 04 03060 OPI C 0 0 0 0 0 0 0 0 0
59.00 05900 CARDI AC CATHETERI ZATI ON 309 17, 379 15, 806 33, 494 275 59.00 60.00 06000 LABORATORY 988 58, 173 52, 907 112, 068 567 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 2, 824 2, 569 5, 393 32 62.00 65.00 06500 RESPI RATORY THERAPY 714 14, 455 13, 147 28, 316 352 65.00 66.00 06600 PHYSI CAL THERAPY 0 9, 086 8, 264 17, 350 536 66.00 69.00 06900 ELECTROCARDI OLOGY 0 39, 170 35, 624 74, 794 224 69.00 70.00 07000 ELECTROENCEPHALLOGRAPHY 0 4, 385 3, 988 8, 373 10 70.00 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 50, 575 45, 997 96, 572 104 71.00 72.00 07200 I IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 72.00 <t< td=""></t<>
62. 00
65. 00
66. 00
69. 00 06900 ELECTROCARDI OLOGY 0 39, 170 35, 624 74, 794 224 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 4, 385 3, 988 8, 373 10 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 50, 575 45, 997 96, 572 104 71. 00 73. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 32, 989 30, 003 62, 992 620 73. 00 74. 00 07400 RENAL DI ALYSI S 974 12, 587 11, 448 25, 009 0 74. 00 76. 00 0 0 0 0 0 76. 00 76. 01 03330 ENDOSCOPY 0 14, 293 12, 999 27, 292 132 76. 01 76. 02 03040 PRI SI ON CLI NI C 0 39, 991 36, 371 76, 362 108 76. 02 76. 03 03050 MOUND CARE 0 29, 740 27, 049 56, 789 45 76. 03 76. 04 03060 OPI C 0 38, 890 35, 370 74, 260 246 76. 04 77. 00 0UTPATI ENT SERVICE COST CENTERS
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 4, 385 3, 988 8, 373 10 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 50, 575 45, 997 96, 572 104 71. 00 72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 32, 989 30, 003 62, 992 620 73. 00 74. 00 07400 RENAL DIALYSIS 974 12, 587 11, 448 25, 009 0 74. 00 76. 00 33950 LI THOTRI PSY 0 0 0 0 0 0 76. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 50,575 45,997 96,572 104 71. 00 72. 00 72. 00 72. 00 73. 00 73. 00 73. 00 73. 00 74. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 32, 989 30, 003 62, 992 620 73. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 75. 00
74. 00 07400 RENAL DI ALYSI S 974 12, 587 11, 448 25, 009 0 74. 00 76. 00 03950 LI THOTRI PSY 0 0 0 0 0 0 76. 00 76. 01 03330 ENDOSCOPY 0 14, 293 12, 999 27, 292 132 76. 01 76. 02 03040 PRI SI ON CLI NI C 0 39, 991 36, 371 76, 362 108 76. 02 76. 03 03050 WOUND CARE 0 29, 740 27, 049 56, 789 45 76. 03 76. 04 03060 OPI C 0 38, 890 35, 370 74, 260 246 76. 04 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
76. 00 03950 LITHOTRIPSY 0 0 0 0 0 0 0 76. 00 76. 01 03330 ENDOSCOPY 0 14, 293 12, 999 27, 292 132 76. 01 76. 02 03040 PRISION CLINIC 0 39, 991 36, 371 76, 362 108 76. 02 76. 03 03050 WOUND CARE 0 29, 740 27, 049 56, 789 45 76. 03 76. 04 03060 OPI C 0 38, 890 35, 370 74, 260 246 76. 04 77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 0 77. 00 OUTPATIENT SERVICE COST CENTERS
76. 01 03330 ENDOSCOPY 0 14, 293 12, 999 27, 292 132 76. 01 76. 02 03040 PRI SI ON CLI NI C 0 39, 991 36, 371 76, 362 108 76. 02 76. 03 03050 WOUND CARE 0 29, 740 27, 049 56, 789 45 76. 03 76. 04 03060 OPI C 0 38, 890 35, 370 74, 260 246 76. 04 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 77. 00 OUTPATI ENT SERVI CE COST CENTERS
76. 02 03040 PRISION CLINIC 0 39, 991 36, 371 76, 362 108 76. 02 76. 03 03050 WOUND CARE 0 29, 740 27, 049 56, 789 45 76. 03 76. 04 77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 0 0 0 0
76. 04 03060 OPI C 0 38, 890 35, 370 74, 260 246 76. 04 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 0
77. 00 O7700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 77. 00 OUTPATIENT SERVICE COST CENTERS
OUTPATIENT SERVICE COST CENTERS
91. 00 09100 EMERGENCY 1, 706 116, 165 105, 650 223, 521 1, 004 91. 00
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 92.00
OTHER REIMBURSABLE COST CENTERS
102. 00 10200 OPI 0I D TREATMENT PROGRAM O O O O 102. 00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 2,422,038 3,189,434 2,900,740 8,512,212 16,167,118.00
NONREI MBURSABLE COST CENTERS
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 5, 107 4, 645 9, 752 0 190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 192. 00
194. 00 07950 OCCUPATI ONAL MEDI CI NE 0 21, 466 19, 523 40, 989 425 194. 00
194. 01 07951 UNOCCUPI ED SPACE/NONALLOWABLE MEALS 0 294, 256 267, 621 561, 877 0 194. 01 194. 02 07952 SI TTERS 0 0 0 0 0 242 194. 02
194. 02 07952 STITERS 0 0 0 0 0 242 194. 02 194. 03 194. 03 07953 UNLI CENSED STAFF 0 0 0 0 0 0 0 194. 03
200.00 Cross Foot Adjustments 0 200.00
201.00 Negative Cost Centers 0 0 0 201.00
202.00 TOTAL (sum lines 118 through 201) 2,422,038 3,510,263 3,192,529 9,124,830 16,834 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0046

Peri od: Worksheet B From 09/01/2022 Part II To 08/31/2023 Date/Time Prepared:

1/29/2024 8:15 am Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 2, 861, 218 5 00 7.00 00700 OPERATION OF PLANT 212, 033 2,043,180 7.00 00800 LAUNDRY & LINEN SERVICE 17, 397 26, 737 101, 271 8.00 8.00 9.00 00900 HOUSEKEEPI NG 63, 637 30, 454 159, 736 9.00 C 01000 DI ETARY 224, 596 10.00 10.00 56, 108 52, 369 0 4.212 11.00 01100 CAFETERI A 15,876 27, 648 0 2, 224 11.00 0 13 00 01300 NURSING ADMINISTRATION 58, 559 4, 088 0 329 0 13.00 01600 MEDICAL RECORDS & LIBRARY 28, 143 16.00 6, 362 0 512 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 286, 527 421, 523 55, 590 33, 904 99.318 30.00 03100 INTENSIVE CARE UNIT 135, 068 99, 109 7, 971 11, 865 31.00 13,046 31.00 02060 NEONATAL INTENSIVE CARE UNIT 20, 209 35.00 3.967 701 319 260 35.00 04000 SUBPROVIDER - IPF 40.00 93, 378 88, 450 21, 608 7, 114 36, 566 40.00 04100 SUBPROVIDER - IRF 41.00 41.00 58, 570 80, 492 8,974 6, 474 14,876 04300 NURSERY
ANCILLARY SERVICE COST CENTERS 1, 352 12<u>,</u> 691 43.00 7,574 1,021 168 43.00 50.00 05000 OPERATING ROOM 208, 297 233, 437 50.00 18,776 0 05100 RECOVERY ROOM 10, 976 12, 772 0 51.00 1,027 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 49.826 52.00 52.00 40, 363 3.246 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 47, 899 96, 021 7, 723 0 54.00 54.01 03630 ULTRA SOUND 8, 191 6, 620 0 532 0 54.01 03440 MAMMOGRAPHY 5, 684 21, 351 0 1, 717 54.02 54.02 0 44, 892 05500 RADI OLOGY-THERAPEUTI C 0 55.00 34, 372 2, 765 0 55.00 0 56.00 05600 RADI 0I S0T0PE 21,867 6, 152 495 0 56.00 05700 CT SCAN 0 57.00 23, 108 10, 837 872 0 57.00 0 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 10.373 0 58.00 11, 135 896 0 05900 CARDIAC CATHETERIZATION 59.00 36, 370 15, 529 1, 249 0 59.00 4, 181 60.00 06000 LABORATORY 107, 872 51, 982 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 65, 304 2, 524 203 0 62.00 06500 RESPIRATORY THERAPY 12, 917 65 00 49 335 0 1, 039 0 65 00 0 06600 PHYSI CAL THERAPY 66.00 47, 767 8, 119 653 0 66.00 06900 ELECTROCARDI OLOGY 22, 997 35, 001 0 2,815 0 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 1.372 3. 919 0 315 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 147, 636 45, 193 3, 635 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 85, 194 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 497, 044 29, 478 2, 371 0 73.00 74 00 07400 RENAL DIALYSIS 19.398 0 905 0 74 00 11, 248 0 03950 LI THOTRI PSY 76.00 2, 490 0 0 76.00 03330 ENDOSCOPY 16, 540 12, 772 1,027 0 76.01 76.01 76.02 03040 PRISION CLINIC 12, 140 35, 735 0 2,874 0 76.02 03050 WOUND CARE 0 28 426 2.137 76.03 76.03 26, 575 0 76.04 03060 OPI C 23, 982 34, 751 2, 795 0 76.04 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 91 00 09100 EMERGENCY 0 91 00 131, 800 103, 802 8.349 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102, 00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 2, 779, 859 1, 756, 495 101, 271 136, 677 163, 053 118. 00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 351 4, 564 367 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192, 00 19, 182 194. 00 07950 OCCUPATIONAL MEDICINE 40, 499 0 1,543 0 194.00 194. 01 07951 UNOCCUPIED SPACE/NONALLOWABLE MEALS 20, 161 262, 939 0 21, 149 61, 543 194. 01 0 194. 02 194. 02 07952 SITTERS 20, 348 C 0 0 194. 03 07953 UNLI CENSED STAFF C 0 0 0 194. 03 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201, 00 C 159, 736 224, 596 202. 00 202.00 TOTAL (sum lines 118 through 201) 2, 861, 218 2.043.180 101, 271

| Period: | Worksheet B | From 09/01/2022 | Part II | To 08/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0046

				To	08/31/2023		
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	Subtotal	1/29/2024 8: 1: Intern &	o alli
	· ·		ADMI NI STRATI ON	RECORDS &		Residents Cost	
				LI BRARY		& Post Stepdown	
						Adjustments	
		11.00	13. 00	16. 00	24. 00	25. 00	
	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FLXT						1. 00
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL						5. 00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	404.000					10.00
11. 00 13. 00	01100 CAFETERIA 01300 NURSI NG ADMINI STRATI ON	104, 829 2, 866					11. 00 13. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	2,000	0				16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					_	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	18, 436 8, 804	31, 204 21, 798		1, 852, 627 512, 451	0	30. 00 31. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	1, 705	4, 107	46	40, 092		35. 00
40. 00	04000 SUBPROVI DER - I PF	6, 845	8, 147	1, 929	454, 042	0	40. 00
41.00	04100 SUBPROVI DER - I RF	4, 197	8, 958		355, 619		41.00
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	493	683	48	51, 217	0	43. 00
50. 00	05000 OPERATING ROOM	11, 692	0	6, 600	979, 628	0	50. 00
51.00	05100 RECOVERY ROOM	835		680	53, 694	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4, 003	6, 617	230	191, 096		52.00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	2, 730 640	0 0	833 260	360, 952 30, 475	0	54. 00 54. 01
	03440 MAMMOGRAPHY	321	0	136	74, 877	Ö	54. 02
55. 00	05500 RADI OLOGY-THERAPEUTI C	2, 278	0	1, 335	159, 398	0	55. 00
56. 00 57. 00	05600	171 1, 602	0 0	1, 024 4, 408	42, 961 64, 258	0	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	596	0	605	47, 481	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 043	3, 553	1, 902	94, 415	0	59. 00
60.00	06000 LABORATORY	4, 221	0	4, 916	285, 807	0	60.00
62. 00 65. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPI RATORY THERAPY	237 2, 616	3, 050	379 1, 171	74, 072 98, 796	0	62. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 984	15	747	79, 171	Ö	66. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 669	1, 363	1, 569	140, 432	0	69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	75 773	0	55 3, 056	14, 119 296, 969	0	70. 00 71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1, 170	86, 364	Ö	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 616	0	11, 124	608, 245		73. 00
74. 00	07400 RENAL DIALYSIS 03950 LITHOTRIPSY	3	0	81	56, 644	0	74. 00
76. 00 76. 01	03330 ENDOSCOPY	984	0	69 934	2, 559 59, 681	0	76. 00 76. 01
	03040 PRISION CLINIC	801	755		128, 828		76. 02
	03050 WOUND CARE	332		333	114, 637		
	03060 OPI C 07700 ALLOGENEI C HSCT ACQUI SITION	1, 832 0	3, 381	470 0	141, 717 0		
77.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	<u> </u>	0	0	77.00
	09100 EMERGENCY	7, 467	19, 675	4, 893	500, 511		91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92. 00
	OTHER REIMBURSABLE COST CENTERS 10200 OPI OI D TREATMENT PROGRAM	O	0	0	0	0	102. 00
102.00	SPECIAL PURPOSE COST CENTERS	<u> </u>					102.00
118. 00		99, 867	113, 306	53, 696	8, 053, 835	0	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	0	15, 034	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		13, 034		192. 00
194.00	07950 OCCUPATIONAL MEDICINE	3, 163	0	0	105, 801	0	194. 00
	07951 UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	927, 669		194. 01
	07952 SI TTERS 07953 UNLI CENSED STAFF	1, 799 0	102 0	0	22, 491 0		194. 02 194. 03
200.00				J	0	0	200. 00
201.00		0	0	0	0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	104, 829	113, 408	53, 696	9, 124, 830	I 0	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 09/01/2022 | Part II | To 08/31/2023 | Date/Time Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0046

		10 08/31/2023 Date/Time Prepare 1/29/2024 8:15 ar	ea: m
Cost Center Description	Total	172723213113	
·	26. 00		
GENERAL SERVICE COST CENTERS			
1.00 O0100 CAP REL COSTS-BLDG & FIXT			1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP			2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL			5. 00
7. 00 00700 OPERATION OF PLANT			7. 00
8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING			3. 00 9. 00
10. 00 01000 DI ETARY			9. 00 D. 00
11. 00 01100 CAFETERI A			1. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON			3. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY			5. 00
INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00 03000 ADULTS & PEDIATRICS	1, 852, 627	30	0. 00
31.00 03100 INTENSIVE CARE UNIT	512, 451	31	1. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	40, 092	35	5. 00
40. 00 04000 SUBPROVI DER - 1 PF	454, 042		0. 00
41. 00 04100 SUBPROVI DER - I RF	355, 619		1. 00
43. 00 04300 NURSERY	51, 217	43	3. 00
ANCILLARY SERVICE COST CENTERS	070 (00		
50. 00 05000 OPERATI NG ROOM	979, 628		0.00
51. 00 05100 RECOVERY ROOM	53, 694		1. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	191, 096		2. 00 4. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03630 ULTRA SOUND	360, 952 30, 475		4. 00 4. 01
54. 02 03440 MAMMOGRAPHY	74, 877		4. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	159, 398		5. 00
56. 00 05600 RADI OLGGT THERWI EGTT G	42, 961		5. 00
57. 00 05700 CT SCAN	64, 258		7. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	47, 481		3. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	94, 415	59	9. 00
60. 00 06000 LABORATORY	285, 807	60	0. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	74, 072	62	2. 00
65. 00 06500 RESPI RATORY THERAPY	98, 796	65	5. 00
66. 00 06600 PHYSI CAL THERAPY	79, 171		5. 00
69. 00 06900 ELECTROCARDI OLOGY	140, 432		9. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	14, 119		0. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	296, 969		1. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	86, 364		2. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	608, 245		3. 00 4. 00
74. 00 07400 RENAL DI ALYSI S 76. 00 03950 LI THOTRI PSY	56, 644 2, 559		4. 00 5. 00
76. 00 03330 ENDOSCOPY	59, 681		5. 00 5. 01
76. 02 03040 PRI SI ON CLI NI C	128, 828		5. 02
76. 03 03050 WOUND CARE	114, 637		5. 03
76. 04 03060 OPI C	141, 717		5. 04
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0		7. 00
OUTPATIENT SERVICE COST CENTERS			
91. 00 09100 EMERGENCY	500, 511	91	1. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		92	2. 00
OTHER REIMBURSABLE COST CENTERS			
102.00 10200 OPIOLD TREATMENT PROGRAM	0	102	2. 00
SPECIAL PURPOSE COST CENTERS			
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	8, 053, 835	118	3. 00
NONREI MBURSABLE COST CENTERS	45 00 1		
190. 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN	15, 034		0.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	105 001		2. 00
194. 00 07950 OCCUPATI ONAL MEDI CI NE	105, 801		4. 00
194. 01 07951 UNOCCUPIED SPACE/NONALLOWABLE MEALS 194. 02 07952 SITTERS	927, 669 22, 491		4. 01 4. 02
194. 02 07952 5111ER5 194. 03 07953 UNLI CENSED STAFF	22, 491		4. 02 4. 03
200.00 Cross Foot Adjustments	0		4. 03 D. 00
201.00 Negative Cost Centers	0		1. 00
202.00 TOTAL (sum lines 118 through 201)	9, 124, 830		2. 00
1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		1	-

				Ť	08/31/2023	Date/Time Pre 1/29/2024 8:1	
		CAPITAL RE	LATED COSTS			172772024 0. 1	J dill
	Cost Contor Dosorintion	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Doconci Li ati on	ADMINI STRATI VE	
	Cost Center Description	(SQUARE FEET)		BENEFITS	Reconciliation	ADMINISTRATIVE & GENERAL	
		,	,	DEPARTMENT		(ACCUM. COST)	
				(GROSS			
		1.00	2.00	SALARI ES) 4. 00	5A	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	389, 026	l .				1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	977	389, 026 977				2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	28, 538	1			79, 739, 658	5. 00
7.00	00700 OPERATION OF PLANT	106, 106	1			_,,	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	3, 316	1				8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	3, 777 6, 495	1		0	.,	9. 00 10. 00
11. 00	01100 CAFETERI A	3, 429	1				1
13. 00	01300 NURSING ADMINISTRATION	507	ł				13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	789	789	0	0	784, 331	16. 00
30. 00	03000 ADULTS & PEDIATRICS	52, 280	52, 280	4, 516, 816	0	7, 985, 244	30.00
31. 00	03100 INTENSIVE CARE UNIT	12, 292	12, 292	2, 155, 743			1
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	492	1				35. 00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	10, 970 9, 983					40. 00 41. 00
43. 00	04300 NURSERY	1, 574					43. 00
	ANCILLARY SERVICE COST CENTERS		1				
50. 00 51. 00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM	28, 952 1, 584					50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	5, 006	1				
54. 00	05400 RADI OLOGY-DI AGNOSTI C	11, 909			0		
54. 01	03630 ULTRA SOUND	821	1				1
54. 02 55. 00	03440 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C	2, 648 4, 263	1				54. 02 55. 00
56. 00	05600 RADI OI SOTOPE	763					56.00
57. 00	05700 CT SCAN	1, 344	1, 344	392, 193	0		
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 381	1				58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	1, 926 6, 447	1			.,	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	313	1				1
65. 00	06500 RESPI RATORY THERAPY	1, 602	1				65. 00
66. 00 69. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	1, 007 4, 341				.,,	66. 00 69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	4, 341	1				•
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 605	ł			4, 114, 493	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0 (5)	1	1			
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	3, 656 1, 395					1
76. 00	03950 LI THOTRI PSY	0	1				1
	03330 ENDOSCOPY	1, 584				460, 968	
76. 02 76. 03	03040 PRI SI ON CLI NI C 03050 WOUND CARE	4, 432 3, 296					1
76. 03		4, 310					
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0					1
01 00	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	10.074	10.074	1 000 404		2 (72 142	01 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	12, 874	12, 874	1, 828, 404	0	3, 673, 142	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	353, 470	353, 470	29, 443, 011	-30, 929, 342	77, 472, 243	118 00
110.00	NONREI MBURSABLE COST CENTERS	333, 470	333, 470	27, 443, 011	30, 727, 342		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	566	l .				190. 00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OCCUPATIONAL MEDICINE	2, 379	1				192. 00 194. 00
	07951 UNOCCUPIED SPACE/NONALLOWABLE MEALS	32, 611	1		0	561, 877	
194. 02	07952 SI TTERS	0	0	1	0	567, 090	194. 02
	3 07953 UNLICENSED STAFF	0	0	0	0	0	194. 03
200. 00 201. 00	, ,	1					200. 00 201. 00
202.00		3, 510, 263	3, 192, 529	6, 364, 224		30, 929, 342	•
202 63	Part I)	0.000000	0.00///-	0.007500		0.007070	202 22
203. 00 204. 00		9. 023209	8. 206467	0. 207588 16, 834		0. 387879 2, 861, 218	
20 7. 00	Part II)			10, 034		2,551,210	50

Heal th Fina	ncial Systems T	ERRE HAUTE REGI	IONAL HOSPITAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS			Provi der Co		Period: From 09/01/2022	Worksheet B-1		
					To 08/31/2023	Date/Time Pre 1/29/2024 8:1		
		CAPITAL REL	LATED COSTS					
	Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS	Reconciliation	ADMI NI STRATI VE & GENERAL		
				DEPARTMENT (GROSS SALARI ES)		(ACCUM. COST)		
		1.00	2.00	4.00	5A	5. 00		
205. 00	Unit cost multiplier (Wkst. B, Part			0. 00054	9	0. 035882	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	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0046

				T	08/31/2023	Date/Time Pre 1/29/2024 8:1	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE (PATIENT DAYS)	(SQUARE FOOTAGE)	(MEALS SERVED)	(GROSS SALARI ES)	
		7.00	8. 00	9. 00	10.00	11. 00	
	RAL SERVICE COST CENTERS						
	00 CAP REL COSTS-BLDG & FIXT 00 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
	OO EMPLOYEE BENEFITS DEPARTMENT						4. 00
	OO ADMINISTRATIVE & GENERAL						5. 00
	OO OPERATION OF PLANT	253, 405					7. 00
	OO LAUNDRY & LINEN SERVICE	3, 316	1				8. 00
4	00 HOUSEKEEPI NG 00 DI ETARY	3, 777 6, 495	0				9. 00 10. 00
	00 CAFETERI A	3, 429	ł			25, 670, 492	1
	OO NURSI NG ADMI NI STRATI ON	507	Ö		Ö	701, 829	1
	00 MEDICAL RECORDS & LIBRARY	789	0	789	0	0	16. 00
	ATIENT ROUTINE SERVICE COST CENTERS	F2 200	12 077	E2 200	40.072	4 F1/ O1/	20.00
	00 ADULTS & PEDIATRICS 00 INTENSIVE CARE UNIT	52, 280 12, 292	l			4, 516, 816 2, 155, 743	1
	NEONATAL INTENSIVE CARE UNIT	492	165			417, 528	1
	OO SUBPROVI DER - I PF	10, 970	5, 083	10, 970	15, 048	1, 676, 091	40. 00
4	00 SUBPROVI DER – I RF	9, 983				1, 027, 782	1
	DO NURSERY LLARY SERVICE COST CENTERS	1, 574	318	1, 574	69	120, 677	43. 00
	OO OPERATING ROOM	28, 952	0	28, 952	0	2, 862, 843	50.00
	00 RECOVERY ROOM	1, 584	l e		O	204, 335	1
	DO DELIVERY ROOM & LABOR ROOM	5, 006		-,		980, 093	
	OO RADI OLOGY-DI AGNOSTI C	11, 909	l			668, 461	1
	BO ULTRA SOUND BO MAMMOGRAPHY	821 2, 648	0		0	156, 816 78, 488	1
	00 RADI OLOGY-THERAPEUTI C	4, 263		_,	0	557, 901	1
	00 RADI OI SOTOPE	763	Ö		O	41, 853	1
4	OO CT SCAN	1, 344	0		0	392, 193	1
	MAGNETIC RESONANCE IMAGING (MRI)	1, 381	0	,	0	146, 049	1
	00 CARDI AC CATHETERI ZATI ON 00 LABORATORY	1, 926 6, 447	0	.,	0	500, 234 1, 033, 513	1
4	00 WHOLE BLOOD & PACKED RED BLOOD CELLS	313			- 1	58, 055	1
	00 RESPI RATORY THERAPY	1, 602	Ö		O	640, 428	1
	PHYSI CAL THERAPY	1, 007	0	.,	0	975, 625	1
	OO ELECTROCARDI OLOGY	4, 341	0	.,	0	408, 720	1
1	DO ELECTROENCEPHALOGRAPHY DO MEDICAL SUPPLIES CHARGED TO PATIENTS	486 5, 605	0		0 0	18, 262 189, 156	1
	OO IMPL. DEV. CHARGED TO PATIENTS	0,000	Ö		0	0	1
73. 00 0730	DO DRUGS CHARGED TO PATIENTS	3, 656				1, 130, 211	
4	00 RENAL DIALYSIS	1, 395	i e	,		670	1
4	50 LI THOTRI PSY 80 ENDOSCOPY	0 1, 584	0		0	0 241, 027	
	O PRISION CLINIC	4, 432	1	4, 432	0	196, 016	1
	50 WOUND CARE	3, 296			O	81, 228	1
	OPIC	4, 310	1			448, 535	1
	OO ALLOGENEIC HSCT ACQUISITION PATIENT SERVICE COST CENTERS	0	0	0	0	0	77. 00
	OO EMERGENCY	12, 874	0	12, 874	ol	1, 828, 404	91.00
	OO OBSERVATION BEDS (NON-DISTINCT PART)	.2,071		12,071	,	1,020,101	92.00
	R REIMBURSABLE COST CENTERS						
	OO OPLOLD TREATMENT PROGRAM	0	0	0	0	0	102. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	217, 849	23, 823	210, 756	67, 101	24, 455, 582	118 00
	REI MBURSABLE COST CENTERS	217,017	20,020	210,700	07, 101	21, 100, 002	1110.00
	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	566	0	566	0		190. 00
	OO PHYSICIANS' PRIVATE OFFICES	0	1	_			192. 00
4	50 OCCUPATIONAL MEDICINE 51 UNOCCUPIED SPACE/NONALLOWABLE MEALS	2, 379 32, 611	0	2, 379 32, 611	0 25, 327	774, 390	194. 00
194. 02 0795		32,011	0	32,011	25, 327	440, 520	
	33 UNLICENSED STAFF	0	Ö	0	O		194. 03
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	0 004 047	700 045	2 502 / 47	2 440 544	7/1 00/	201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	8, 201, 217	780, 215	2, 583, 647	2, 448, 516	761, 006	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	32. 364069	32. 750493	10. 489327	26. 491063	0. 029645	203. 00
204. 00	Cost to be allocated (per Wkst. B,	2, 043, 180				104, 829	
205 00	Part II)	0.040000	4 25007/	0 (40544	2 420057	0.004004	205 00
205. 00	Unit cost multiplier (Wkst. B, Part	8. 062903	4. 250976	0. 648511	2. 429956	0. 004084	205.00
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						

Health Financial Systems T	ERRE HAUTE REG	ONAL HOSPITAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provider CO		eri od:	Worksheet B-1		
				rom 09/01/2022			
			1	o 08/31/2023			
					1/29/2024 8: 1	<u>5 am </u>	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A		
	PLANT	LINEN SERVICE	(SQUARE	(MEALS SERVED)	(GROSS		
	(SQUARE FEET)	(PATIENT DAYS)	FOOTAGE)		SALARI ES)		
	7. 00	8. 00	9. 00	10.00	11. 00		
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00	
Parts III and IV)							

In Lieu of Form CMS-2552-10 TERRE HAUTE REGIONAL HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0046 Peri od: Worksheet B-1 From 09/01/2022 08/31/2023 Date/Time Prepared: 1/29/2024 8:15 am Cost Center Description NURSI NG MEDI CAL ADMI NI STRATI ON RECORDS & LI BRARY (DI RECT NURS. (GROSS CHARGES) SALARI ES) 13.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 11, 324, 726 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY 814, 448, 550 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 3 115 977 30 00 22 358 711 31.00 03100 INTENSIVE CARE UNIT 2, 176, 705 13, 486, 438 31.00 02060 NEONATAL INTENSIVE CARE UNIT 35.00 410, 117 691, 101 35.00 04000 SUBPROVIDER - IPF 40 00 813 610 29, 227, 374 40 00 04100 SUBPROVI DER - I RF 41.00 894, 547 4, 147, 867 41.00 04300 NURSERY 68, 179 721, 640 43.00 43.00 ANCILLARY SERVICE COST CENTERS 99, 995, 237 50 00 50 00 05000 OPERATING ROOM 0 51.00 05100 RECOVERY ROOM 0 10, 298, 054 51.00 05200 DELIVERY ROOM & LABOR ROOM 660, 823 3, 479, 756 52.00 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 12, 619, 129 54.00 03630 ULTRA SOUND 0 3, 939, 011 54.01 54 01 54.02 03440 MAMMOGRAPHY 0 2, 054, 088 54.02 05500 RADI OLOGY-THERAPEUTI C 0 20, 226, 420 55.00 55.00 0 05600 RADI OI SOTOPE 15, 519, 570 56, 00 56, 00 05700 CT SCAN 66, 786, 753 57.00 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 9, 167, 187 58.00 05900 CARDI AC CATHETERI ZATI ON 59 00 354, 758 28, 816, 497 59.00 60.00 06000 LABORATORY 74, 491, 771 60.00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 5, 742, 475 62 00 06500 RESPIRATORY THERAPY 304, 618 17, 748, 416 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 1, 493 11, 316, 220 66.00 06900 ELECTROCARDI OLOGY 23, 770, 158 136, 128 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 839, 136 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 46, 296, 392 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 17, 728, 997 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 169, 464, 839 73.00 74.00 07400 RENAL DIALYSIS 0 1, 220, 663 74.00 76.00 03950 LI THOTRI PSY 0 1,050,039 76.00 14, 151, 090 76.01 03330 ENDOSCOPY 0 76.01 76.02 03040 PRISION CLINIC 75, 346 800, 198 76.02 76.03 03050 WOUND CARE 5, 041, 909 76.03 03060 OPI C 337, 585 76.04 7, 121, 260 76.04 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 1, 964, 703 74, 130, 154 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 11, 314, 589 814, 448, 550 118 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 192.00 194. 00 07950 OCCUPATIONAL MEDICINE 0 194 00 0 194. 01 07951 UNOCCUPIED SPACE/NONALLOWABLE MEALS 0 194. 01 194. 02 07952 SI TTERS 194. 02 10, 137 0 194. 03 07953 UNLICENSED STAFF 194. 03 Cross Foot Adjustments l200. 00 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 2, 307, 532 1, 122, 368 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.203761 0.001378 203.00

113, 408

0.010014

53, 696

0.000066

204.00

205.00

Part II)

11)

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

204.00

205.00

Health Financial Systems	TERRE HAUTE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co	CN: 15-0046	Peri od:	Worksheet B-1	
				From 09/01/2022 To 08/31/2023	Date/Time Pre 1/29/2024 8:1	
Cost Center Description	NURSI NG	MEDI CAL				
	ADMI NI STRATI ON	RECORDS &				
		LI BRARY				
	(DI RECT NURS.	(GROSS				
	SALARI ES)	CHARGES)				
	13.00	16.00				
206.00 NAHE adjustment amount to be allocat	ted					206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0046	Peri od: Worksheet C From 09/01/2022 Part I To 08/31/2023 Date/Time Prepared:

NATE Cost Center Description					From 09/01/2022 To 08/31/2023	Part I Date/Time Pre 1/29/2024 8:1	pared: 5 am
Total Cost Content Cost			Title	XVIII	Hospi tal		
INPATIENT ROUTINE SERVICE COST CENTERS Part I, col. Part I,					Costs		
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
NPATI ENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 3.00 3.00 4.00 5.00 3	·	(from Wkst. B,	Ādj .		Di sal I owance		
INPATI ENT ROUTINE SERVICE COST CENTERS 1,000 2,000 3,000 4,000 5,000		Part I, col.					
INPATI ENT ROUTINE SERVICE COST CENTERS		26)					
30.00 03000 ADULTS & PEDIATRICS 15,633,563 15,633,563 0 15,633,563 30.00 310.00 310.00 INTENSIVE CARE UNIT 6,506,944 6,506,944 0 6,506,944 31.00 340.		1. 00	2. 00	3. 00	4. 00	5. 00	
33.00 03100 INTENSIVE CARE UNIT	INPATIENT ROUTINE SERVICE COST CENTERS						
35. 00 02000 NEDONATAL INTENSIVE CARE UNIT 0.907, 888 9.07, 888 28, 419 936, 307 35. 00 41. 00 04100 SUBPROVI DER - I PF 4. 992, 711 4. 902, 711 6. 978 4. 999, 699 40. 00 41. 00 04100 SUBPROVI DER - I RF 3. 143, 024 3. 143, 024 3. 143, 024 3. 143, 024 43. 00 43. 00 44. 00 43. 00 44. 00	30. 00 03000 ADULTS & PEDIATRICS	15, 633, 563		15, 633, 563	0	15, 633, 563	30. 00
40.00 04000 04000 SubPROVIDER - I IPF 4 , 902, 711 4 , 902, 711 4 , 902, 711 6 , 978 4 , 909, 689 40 .00 41.00 04300 SubPROVIDER - I RF 3 , 143, 024 41 .00 04300 NURSERY 391, 115 391	31.00 03100 INTENSIVE CARE UNIT	6, 506, 944		6, 506, 94	1 0	6, 506, 944	31.00
41.00	35.00 02060 NEONATAL INTENSIVE CARE UNIT	907, 888		907, 888	28, 419	936, 307	35. 00
ASON	40. 00 04000 SUBPROVI DER - 1 PF	4, 902, 711		4, 902, 71°	6, 978	4, 909, 689	40.00
ANCILLARY SERVICE COST CENTERS	41. 00 04100 SUBPROVI DER - 1 RF	3, 143, 024		3, 143, 024	1 o	3, 143, 024	41.00
50.00	43. 00 04300 NURSERY	391, 115		391, 11!	5 o	391, 115	43.00
51.00	ANCILLARY SERVICE COST CENTERS						
52. 00 05200 DELIVERY ROOM & LABOR ROOM 2, 310, 255 2, 310, 255 0, 05400 RADI OLOGY-DIAGNOSTIC 2, 400, 246 2, 400, 246 0, 2400, 246 54, 00 54. 01 03630 ULTRA SOUND 362, 082 362, 082 0, 362, 082 54, 01 54. 02 03440 MAMMOGRAPHY 338, 480 338, 480 0, 380, 480 0, 380, 480 0, 490	50. 00 05000 OPERATING ROOM	9, 520, 080		9, 520, 080	0	9, 520, 080	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 2, 400, 246 362, 082 0 362, 082 0 362, 082 54. 01 54. 01 03303 ULTRA SOUND 362, 082 0 362, 082 0 362, 082 54. 01 55. 02 03500 MAMMOGRAPHY 338, 480 338, 480 0 338, 480 54. 02 55. 00 05500 GADI OLOGY-THERAPEUTI C 1, 963, 475 1, 963, 475 0 1, 963, 475 55. 00 57. 00 05500 GADI OLOGY-THERAPEUTI C 1, 963, 475 1, 963, 475 0 1, 963, 475 55. 00 57. 00 05500 CADI OLOGY-THERAPEUTI C 1, 963, 475 1, 963, 475 0 1, 963, 475 55. 00 58. 00 05500 MADI OLOGY-THERAPEUTI C 1, 963, 475 1, 963, 475 0 1, 963, 475 55. 00 58. 00 05500 MADI OLOGY-THERAPEUTI C 1, 963, 475 1, 963, 475 0 1, 963, 475 55. 00 59. 00 05500 MADI CLETT CRESONANCE IMAGI NG (MRI) 477, 364 477, 364 0 4		512, 676		512, 670	0	512, 676	51.00
54. 01 03630 ULTRA SOUND 362, 082 362, 082 0 362, 082 54. 01	52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 310, 255		2, 310, 25!	0	2, 310, 255	52.00
54. 02 03440 MAMMOGRAPHY 338, 480 338, 480 0 338, 480 54. 02 05500 0	54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 400, 246		2, 400, 240	0	2, 400, 246	54.00
55.00 05500 RADI OLOGY-THERAPEUTIC 1, 963, 475 50.00 05500 RADI OLOGY-THERAPEUTIC 1, 963, 475 55.00 05600 05700 CT SCAN 1, 055, 031 1, 055, 031 0 1, 055, 031 57.00 05700 CT SCAN 1, 055, 031 1, 055, 031 0 1, 055, 031 57.00 05700 CT SCAN 1, 055, 031 1, 055, 031 0 1, 055, 031 57.00 05900 CARDI AC CATHETERI ZATI ON 1, 616, 126 1, 616, 126 0 1, 616, 126 0 0.00 06000 LABGRATORY 4, 581, 952 4, 581, 952 0, 4581, 952 0.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 2, 548, 956 2, 548, 956 0 2, 548, 956 0 2, 548, 956 0 2, 082, 408 0	54. 01 03630 ULTRA SOUND	362, 082		362, 082	0	362, 082	54. 01
56.00 05600 RADI OI SOTOPE 901.107 901.107 0 901.107 56.00	54. 02 03440 MAMMOGRAPHY	338, 480		338, 480	ol ol	338, 480	54. 02
57. 00 05700 CT SCAN 1,055,031 1,055,031 1,055,031 0 1,055,031 57. 00	55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 963, 475		1, 963, 47!	0	1, 963, 475	55. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 477, 364 477, 364 1, 616, 126 0 1, 616, 126 59.00 05900 CARDI AC CATHETERIZATION 1, 616, 126 1, 616, 126 0 1, 616, 126 59.00 60.00 06000 LABORATORY 4, 581, 952 4, 581, 952 0 4, 581, 952 0.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 2, 548, 956 2, 548, 956 0 2, 548, 956 62.00 65.00 06500 RESPIRATORY THERAPY 2, 082, 408 0 2, 082, 408 0 2, 082, 408 0 2, 082, 408 65.00 66.00 06600 PKINICAL THERAPY 1, 935, 545 0 1, 935, 545 30, 730 1, 966, 275 66.00 06900 ELECTROCARDIOLOGY 1, 148, 151 1, 148, 151 11, 548 1, 159, 699 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 75, 580 75, 580 0 75, 580 0 75, 580 0 75, 580 0 75, 580 0 75, 580 0 70.00 70.00 MDICAL SUPPLIES CHARGED TO PATIENTS 3, 319, 667 3, 319, 667 0 3, 319, 667 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 319, 667 3, 319, 667 0 3, 319, 667 72.00 73.00 07400 RENAL DI ALYSIS 811, 781 811, 781 0 811,	56. 00 05600 RADI 0I SOTOPE	901, 107		901, 10	0	901, 107	56. 00
59.00 0.5900 CARDI AC CATHETERI ZATI ON 1, 616, 126 1, 616, 126 0 1, 616, 126 59.00 60.00 0.6000 LABORATORY 4, 581, 952 0 4, 581, 952 0 4, 581, 952 0 0.00 62.00 0.6200 WHOLE BLOOD & PACKED RED BLOOD CELLS 2, 548, 956 2, 548, 956 0 2, 548, 956 62.00 0 0 0.00 60.00 0	57.00 05700 CT SCAN	1, 055, 031		1, 055, 03°	0	1, 055, 031	57. 00
60. 00 06000 LABORATORY	58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	477, 364		477, 364	1 0	477, 364	58. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 2, 548, 956 65. 00 06500 RESPI RATORY THERAPY 2, 082, 408 0 2, 082, 402, 402, 402, 402, 402, 402, 402, 40	59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 616, 126		1, 616, 120	0	1, 616, 126	59. 00
65. 00 06500 RESPI RATORY THERAPY 2, 082, 408 0 2, 082, 408 0 2, 082, 408 65. 00 66. 00 06600 PHYSI CAL THERAPY 1, 935, 545 0 1, 935, 545 30, 730 1, 966, 275 66. 00 06900 ELECTROCARDI OLOGY 1, 148, 151 11, 148, 151 11, 1548 1, 159, 699 69. 00 07000 ELECTROENCEPHALOGRAPHY 75, 580 75, 580 0 0 75, 580 0	60. 00 06000 LABORATORY	4, 581, 952		4, 581, 952	0	4, 581, 952	60.00
66. 00 06600 PHYSI CAL THERAPY 1, 935, 545 0 1, 935, 545 30, 730 1, 966, 275 66. 00 69. 00 6900 ELECTROCARDI OLOGY 1, 148, 151 11, 548 1, 159, 699 69. 00 70. 00 70. 00 70. 00 CLECTROENCEPHALOGRAPHY 75, 580 75, 580 75, 580 75, 580 75, 580 75, 580 75, 580 75, 580 70. 00 70. 00 70. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 6, 020, 016 6, 020, 016 0 6, 020, 016 71. 00 72. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 19, 648, 823 19, 648, 823 0 19, 648, 823 0 19, 648, 823 73. 00 74. 00 07400 RENAL DI ALYSI S 811, 781 811, 781 0 811, 781 74. 00 76. 00 03950 LI THOTRI PSY 97, 766 97, 766 0 97, 766 0 97, 766 76. 00 76. 01 03330 ENDOSCOPY 734, 293 734, 293 734, 293 0 734, 293 76. 01 76. 02 03040 PRI SI ON CLI NI C 681, 766 681, 766 681, 766 0 681, 766 0 681, 766 0 681, 766 0 070, 76. 02 0700 ALOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 0	62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 548, 956		2, 548, 956	0	2, 548, 956	62.00
69. 00 06900 ELECTROCARDI OLOGY 1, 148, 151 1, 148, 151 1, 1548 1, 159, 699 69. 00 70. 00 07000 ELECTROENCEPHALLOGRAPHY 75, 580 75, 580 0 75, 580 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 6, 020, 016 6, 020, 016 0 6, 020, 016 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 319, 667 3, 319, 667 0 3, 319, 667 72. 00 07300 DRUGS CHARGED TO PATIENTS 19, 648, 823 19, 648, 823 0 19, 648, 823 73. 00 07300 DRUGS CHARGED TO PATIENTS 19, 648, 823 19, 648, 823 0 19, 648, 823 73. 00 07300 DRUGS CHARGED TO PATIENTS 19, 648, 823 19, 648, 823 0 19, 648, 823 73. 00 07300 DRUGS CHARGED TO PATIENTS 19, 648, 823 19, 648, 823 0 19, 648, 823 73. 00 07300 DRUGS CHARGED TO PATIENTS 19, 648, 823 19, 648, 823 0 19, 648, 823 73. 00 07300 DRUGS CHARGED TO PATIENTS 19, 648, 823 19, 648, 823 0 19, 648, 823 19, 648	65. 00 06500 RESPIRATORY THERAPY	2, 082, 408	0	2, 082, 408	3 o	2, 082, 408	65.00
70. 00	66. 00 06600 PHYSI CAL THERAPY	1, 935, 545	0	1, 935, 54	30, 730	1, 966, 275	66.00
71. 00	69. 00 06900 ELECTROCARDI OLOGY	1, 148, 151		1, 148, 15°	11, 548	1, 159, 699	69. 00
71. 00	70. 00 07000 ELECTROENCEPHALOGRAPHY	75, 580		75, 580	ol	75, 580	70.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 19, 648, 823 19, 648, 823 0 19, 648, 823 73. 00 74. 00 07400 RENAL DIALYSIS 811, 781 0 811, 781 74. 00 76. 00 03950 LI THOTRI PSY 97, 766 97, 766 0 97, 766 76. 00 97, 766	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 020, 016		6, 020, 016	ol ol	6, 020, 016	71. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 19, 648, 823 19, 648, 823 0 19, 648, 823 73. 00 74. 00 07400 RENAL DIALYSIS 811, 781 0 811, 781 74. 00 76. 00 03950 LI THOTRI PSY 97, 766 97, 766 0 97, 766 76. 00 97, 766	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 319, 667		3, 319, 66	7 o	3, 319, 667	72. 00
74. 00 07400 RENAL DIALYSIS 811, 781 0 811, 781 74. 00 76. 00 03950 LI THOTRI PSY 97, 766 97, 766 97, 766 0 97, 766 76. 00 97, 766 76. 00 97, 766 76. 00 97, 766 76. 00 97, 766 76. 00 97, 766 76. 00 734, 293 734, 293 0 734, 293 734, 293 0 734, 293 76. 01 76. 02 76. 03 76. 04 76. 03 76. 04 03060 OPI C 1, 250, 076 1, 250, 076 1, 250, 076 11, 376 1, 261, 452 76. 03 76. 04 03060 OPI C 1, 204, 184 1, 204, 184 30, 747 1, 234, 931 76. 04 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 0							73. 00
76. 01 03330 ENDOSCOPY 734, 293 734, 293 0 734, 293 76. 01 76. 02 03040 PRI SI ON CLI NI C 681, 766 681, 766 0 681, 766 0 681, 766 0 76. 02 76. 03 03050 WOUND CARE 1, 250, 076 1, 250, 076 11, 376 1, 261, 452 76. 03 76. 04 03060 OPI C 1, 204, 184 1, 204, 184 30, 747 1, 234, 931 76. 04 77. 00 OTHOR INTERIOR SERVICE COST CENTERS 091. 00 OPI OUTPATI ENT SERVICE COST CENTERS 092. 00 OSERVATI ON BEDS (NON-DI STI NCT PART) 958, 151 958, 151 958, 151 92. 00 OTHER REI MBURSABLE COST CENTERS 0102. 00 OUTPATI ENT SERVICE COST CENTERS 0 102. 00 OUTPATI ENT SERVICE COST CENTERS 0 104, 247, 538 122, 764 106, 370, 302 200. 00 OUTPATI ENT SERVICE COST CENTERS 0 106, 247, 538 122, 764 106, 370, 302 200. 00 OUTPATI ENT SERVICE COST CENTERS 0 106, 247, 538 122, 764 106, 370, 302 200. 00 OUTPATI ENT SERVICE COST CENTERS 0 106, 247, 538 122, 764 106, 370, 302 200. 00 OUTPATI ENT SERVICE COST CENTERS 0 106, 247, 538 122, 764 106, 370, 302 200. 00 OUTPATI ENT SERVICE COST CENTERS 0 106, 247, 538 122, 764 106, 370, 302 200. 00 OUTPATI ENT SERVICE COST CENTERS 0 106, 247, 538 122, 764 106, 370, 302 200. 00 OUTPATI ENT SERVICE COST CENTERS 0 106, 247, 538 122, 764 106, 370, 302 200. 00 OUTPATI ENT SERVICE COST CENTERS 0 106, 247, 538 122, 764 106, 370, 302 200. 00 OUTPATI ENT SERVICE COST CENTERS 0 106, 247, 538 122, 764 106, 370, 302 200. 00 OUTPATI ENT SERVICE COST CENTERS 0 106, 247, 538 122, 764 106, 370, 302 200. 00 OUTPATI ENT SERVICE COST CENTERS 0 106, 247, 538	74. 00 07400 RENAL DIALYSIS						
76. 01 03330 ENDOSCOPY 734, 293 76. 01 76. 02 03040 PRI SI ON CLI NI C 681, 766 681, 766 681, 766 0 681, 766 0 681, 766 0 681, 766 0 76. 02 76. 03 03050 WOUND CARE 1, 250, 076 1, 250, 076 11, 376 1, 261, 452 76. 03 76. 04 03060 PI C 7. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	76. 00 03950 LI THOTRI PSY	97, 766		97, 760	ol ol	97, 766	76. 00
76. 03 03050 WOUND CARE 1, 250, 076 1, 250, 076 11, 376 1, 261, 452 76. 03 76. 04 77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 0 0 0 0	76. 01 03330 ENDOSCOPY	734, 293					
76. 04 03060 OPI C 1, 204, 184 30, 747 1, 234, 931 76. 04 77. 00 OTTO ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 0 0 0 0	76. 02 03040 PRISION CLINIC	681, 766		681, 766	o o	681, 766	76. 02
77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 0 0 0 0	76. 03 03050 WOUND CARE	1, 250, 076		1, 250, 076	11, 376	1, 261, 452	76. 03
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 0	76. 04 03060 0PI C	1, 204, 184		1, 204, 184	30, 747	1, 234, 931	76. 04
91. 00 09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 958, 151 958, 151 958, 151 92. 00 9	77.00 07700 ALLOGENEIC HSCT ACQUISITION					0	77. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 958, 151 958, 151 92. 00 0THER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 102. 00 200. 00 Subtotal (see instructions) 106, 247, 538 0 106, 247, 538 122, 764 106, 370, 302 200. 00 201. 00 Less Observation Beds 958, 151 958, 151 201. 00 0 0 0 0 0 0 0 0 0	OUTPATIENT SERVICE COST CENTERS	•					
OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102.00 200.00 Subtotal (see instructions) 106, 247, 538 0 106, 247, 538 122, 764 106, 370, 302 200.00 201.00 Less Observation Beds 958, 151 958, 151 958, 151 201.00	91. 00 09100 EMERGENCY	6, 206, 256		6, 206, 250	2, 966	6, 209, 222	91.00
102.00 10200 OPI 0I D TREATMENT PROGRAM 0 0 0 102.00 200.00 Subtotal (see instructions) 106, 247, 538 0 106, 247, 538 122, 764 106, 370, 302 200.00 201.00 Less Observation Beds 958, 151 958, 151 958, 151 958, 151		958, 151		958, 15°		958, 151	92. 00
200.00 Subtotal (see instructions) 106, 247, 538 0 106, 247, 538 122, 764 106, 370, 302 200.00 201.00 Less Observation Beds 958, 151 958, 151							
201.00 Less Observation Beds 958, 151 958, 151 958, 151 958, 151			l		1		ł
	, ,		0				
202.00 Iotal (see instructions) 105, 289, 387 0 105, 289, 387 122, 764 105, 412, 151 202.00		1				· ·	•
	202.00 lotal (see instructions)	105, 289, 387	0	105, 289, 38	/ 122, 764	105, 412, 151	202. 00

From 09/01/2022 Part I Date/Time Prepared: 08/31/2023 1/29/2024 8:15 am Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 21, 443, 334 21, 443, 334 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 13, 486, 438 13, 486, 438 31.00 02060 NEONATAL INTENSIVE CARE UNIT 35.00 691, 101 691, 101 35.00 04000 SUBPROVIDER - IPF 40.00 29, 227, 374 29, 227, 374 40.00 04100 SUBPROVI DER - I RF 41.00 4.147.867 4, 147, 867 41.00 43.00 04300 NURSERY 43.00 721,640 721,640 ANCILLARY SERVICE COST CENTERS 46, 797, 870 99, 995, 237 50.00 05000 OPERATING ROOM 53, 197, 367 0.095205 0.000000 50.00 05100 RECOVERY ROOM 51.00 3, 886, 646 6, 411, 408 10, 298, 054 0.049784 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 3, 377, 463 102, 293 3, 479, 756 0.663913 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 3, 780, 296 8, 838, 833 12, 619, 129 0.190207 0.000000 54.00 03630 ULTRA SOUND 2, 681, 088 3, 939, 011 0.091922 0.000000 54.01 1, 257, 923 54.01 54.02 03440 MAMMOGRAPHY 1, 128 2,052,960 2, 054, 088 0.164784 0.000000 54.02 55.00 05500 RADI OLOGY-THERAPEUTI C 220, 994 20, 005, 426 20, 226, 420 0.097075 0.000000 55.00 56.00 05600 RADI OI SOTOPE 281, 497 15, 238, 073 15, 519, 570 0.058063 0.000000 56.00 05700 CT SCAN 21, 530, 282 45, 256, 471 66, 786, 753 0.015797 57 00 0.000000 57 00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 3, 532, 522 5, 634, 665 9, 167, 187 0.052073 0.000000 58.00 05900 CARDIAC CATHETERIZATION 0.056083 0.000000 59.00 18, 813, 525 10,002,972 28, 816, 497 59.00 06000 LABORATORY 74, 491, 771 0.061510 0.000000 60.00 36, 386, 136 38, 105, 635 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 4, 286, 152 62.00 1, 456, 323 5, 742, 475 0.443878 0.000000 62.00 65.00 06500 RESPIRATORY THERAPY 17, 057, 160 691, 256 17, 748, 416 0.117329 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 11, 113, 274 202, 946 11, 316, 220 0.171042 0.000000 66.00 23, 770, 158 9, 923, 920 69 00 06900 ELECTROCARDI OLOGY 13, 846, 238 0.048302 0 000000 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 552,024 287, 112 839, 136 0.090069 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 28, 846, 209 17, 450, 183 46, 296, 392 0.130032 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 9,044,676 8, 684, 321 17, 728, 997 0.187245 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 88, 659, 380 169, 464, 839 73.00 80, 805, 459 0.115946 0.000000 73.00 74.00 07400 RENAL DIALYSIS 1, 167, 130 53, 533 1, 220, 663 0.665033 0.000000 74.00 03950 LI THOTRI PSY 76.00 1,050,039 1,050,039 0.093107 0.000000 76.00 76 01 03330 ENDOSCOPY 2, 558, 748 11, 592, 342 14, 151, 090 0.051890 0.000000 76 01 03040 PRISION CLINIC 800, 198 76.02 2, 120 798,078 0.851997 0.000000 76.02 76.03 03050 WOUND CARE 60, 428 4, 981, 481 5, 041, 909 0.247937 0.000000 76.03 76.04 03060 OPI C 37, 223 7, 084, 037 7, 121, 260 0.169097 0.000000 76.04 07700 ALLOGENEIC HSCT ACQUISITION 77 00 0.000000 0.000000 77.00 OUTPATIENT SERVICE COST CENTERS 53, 108, 503 74, 130, 154 91.00 21, 021, 651 0.083721 0.000000 09100 EMERGENCY 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 192,626 722, 751 915, <u>3</u>77 1.046728 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 102.00 406, 419, 475 200.00 Subtotal (see instructions) 408, 029, 075 814, 448, 550 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 408, 029, 075 406, 419, 475 814, 448, 550 202.00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0046	From 09/01/2022	Worksheet C Part I Date/Time Prepared:

NPATI ENT ROUTINE SERVICE COST CENTERS 11.00 11.00 13.00 30.00 30.00 ADULTS & PEDI ATRIC SC 30.00 30.00 ADULTS & PEDI ATRIC SC 31.00 31.00 31.00 31.00 31.00 INTENSI VE CARE UNIT 31.50 32.00 32.00 REDATA IL ATTENSI VE CARE UNIT 35.50 02000 REDATA IL ATTENSI VE CARE UNIT 35.50 02000 REDATA IL ATTENSI VE CARE UNIT 34.00 04000 SUBPROVI DER - 1 PF 40.00 41.00 41.00 41.00 041.00 041.00 SUBPROVI DER - 1 PF 41.00 41.00 41.00 041.00 SUBPROVI DER - 1 PF 43.00 04300 NURSERY 43.00 04300 NURSERY 43.00 04300 RECOVERY ROOM 0.049784 55.00 05200 DELI VERY ROOM & LABOR ROOM 0.663913 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.663913 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.643913 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.643913 54.00 05400 RADIO LOCY-THERAPEUTI C 0.997075 54.00 05400 RADIO LOCY-THERAPEUTI C 0.997075 54.00 05400 RADIO LOCY-THERAPEUTI C 0.997075 55.00 05500 RADIO LOCY-THERAPEUTI C 0.997075 56.00 05600 REDSIR RADIO ROOM 0.054083 59.00 05000 MIGNETI E RESONANCE I MAGI NG (MRI) 0.052073 57.00 05700 CT SCAN 59.00 05000 MIGNETI E RESONANCE I MAGI NG (MRI) 0.052073 59.00 05000 MIGNETI E RESONANCE RED BLOOD CELLS 0.443378 60.00 05000 MIGNETI E RESONANCE RED BLOOD CELLS 0.443378 60.00 05000 PRIST CALT HERRAPY 0.173757 66.50 05000 PRIST CALT HERRAPY 0.173757 66.50 0.00 05000 PRIST CALT HERRAPY 0.00 050000					10 00/31/2023	1/29/2024 8:15 am	
INPATI ENT ROUTINE SERVICE COST CENTERS				Title XVIII	Hospi tal		<u></u>
INPATI ENT ROUTINE SERVICE COST CENTERS 11.00 30.00 3000 ADULTS & PEDI ATRI CS 30. 30. 31.00 30300 ADULTS & PEDI ATRI CS 31. 31. 35.00 32000 RODATAL I RITENSI VE CARE UNI T 35. 36.00 32000 RODATAL I RITENSI VE CARE UNI T 35. 40.00 04000 SUBPROVI DER - I PF 40. 40. 41.00 41.00 04100 SUBPROVI DER - I PF 41. 41. 43.00 04300 SUBPROVI DER - I RF 41. 43.00 04300 RUBSERY 43. 43. 44. 44. 44. 45.00 05000 OFERATI NG ROOM 0.049784 55. 60.00 65000 PECOVERY ROOM 0.049784 55. 60.00 65000 PECOVERY ROOM 0.049784 55. 60.00 65000 PECOVERY ROOM 0.049784 55. 60.00 5500 RODATO ADULT CONTROL 54. 60.00 6500 RODATO ADULT CONTROL 60.00 6500 RODATO ADULT CONTROL 60.00 6500 RODATO CONTROL 60.00 RODATO CONTROL 60.00 RODATO CONTROL 60.00 RODATO RODATO CONTROL 60.00 RO		Cost Center Description	PPS Inpatient				
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30.00 03000 ADULTS & PEDI ATRI CS 30.0 31.00 31.00 131.00 14TENSI VE CARE UNI T 35.0 30.0 02000 NEONATAL INTENSI VE CARE UNI T 35.0 35.0 02000 NEONATAL INTENSI VE CARE UNI T 35.0 35.0 04000 04000 SUBPROVI DER - I PF 40.0 41.0 041.00 041.00 SUBPROVI DER - I PF 41.0 41.0 41.0 041.00 O4000 SUBPROVI DER - I PF 43.0 41.0 41.0 04300 NURSERY 43.0 04300 NURSERY 43.0 04300 NURSERY 43.0 04300 NURSERY 50.0 05000 PEDETATI NG ROOM 0.049784 51.0 05000 PEDETATI NG ROOM 0.049784 51.0 05000 PEDETATI NG ROOM 0.049784 51.0 05000 PEDETATI NG ROOM 0.049784 52.0 05200 DELI VERY ROOM & LABOR ROOM 0.049784 54.0 05400 RADIO LABOR ROOM 0.049784 54.0 05500 RADIO LOGY-THERAPEUTI C 0.097075 55.0 05500 RADIO LOGY-THERAPEUTI C 0.097075 55.0 05500 RADIO LOGY-THERAPEUTI C 0.097075 55.0 05500 CT SCAN 0.0500 CT SCAN 0.015797 57.0 05700 CT SCAN 0.0500 CT S			11. 00				
31.00 03100 INTENSIVE CARE UNIT 35.		INPATIENT ROUTINE SERVICE COST CENTERS					
31.0 03100 INTENSIVE CARE UNIT 35.	30.00	03000 ADULTS & PEDI ATRI CS				30.	0. 00
A0. 00 04000 SUBPROVI DER - I PF	31.00	03100 INTENSIVE CARE UNIT				31.	. 00
41.00 04100 SUBPROVI DER - IRF 41.	35.00	02060 NEONATAL INTENSIVE CARE UNIT				35.	5. 00
43.00 04300 NURSERY	40.00	04000 SUBPROVI DER - I PF				40.	0. 00
ANCILLARY SERVICE COST CENTERS 50.00	41.00	04100 SUBPROVI DER - I RF				41.	. 00
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51.00 05100 RECOVERY ROOM & LABOR ROOM 0.049784 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.663913 52.00 05400 RADI OLOGY-DI AGNOSTI C 0.190207 54.01 03630 ULTRA SOUND 0.091922 54.02 03440 MAMDIGRAPHY 0.164784 55.4 0.5500 RADI OLOGY-THERAPEUTI C 0.097075 55.5 0.05500 RADI OLOGY-THERAPEUTI C 0.097075 55.5 0.05500 RADI OLOGY-THERAPEUTI C 0.097075 55.5 0.05500 RADI OLOGY-THERAPEUTI C 0.097075 56.00 05700 CT SCAN 0.015797 57.00 05700 CT SCAN 0.015797 57.00 05700 CT SCAN 0.015797 57.00 05700 CT SCAN 0.05800 MAGNETI C RESONANCE I MAGING (MRI) 0.052073 58.00 0.05800 MAGNETI C RESONANCE I MAGING (MRI) 0.052073 58.00 0.0600 LABORATORY 0.061510 0.0600 0.0000 LABORATORY 0.061510 0.052073 0.06200 MHOLE BLOOD & PACKED RED BLOOD CELLS 0.443878 62.00 0.06200 MHOLE BLOOD & PACKED RED BLOOD CELLS 0.443878 62.00 0.0600 RESPI RATORY THERAPY 0.117329 65.00 0.06500 RESPI RATORY THERAPY 0.173757 0.0700 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.00000000		ANCILLARY SERVICE COST CENTERS	·				
51.00 05100 RECOVERY ROOM & LABOR ROOM 0.049784 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.663913 52.00 05400 RADI OLOGY-DI AGNOSTI C 0.190207 54.01 03630 ULTRA SOUND 0.091922 54.02 03440 MAMDIGRAPHY 0.164784 55.4 0.5500 RADI OLOGY-THERAPEUTI C 0.097075 55.5 0.05500 RADI OLOGY-THERAPEUTI C 0.097075 55.5 0.05500 RADI OLOGY-THERAPEUTI C 0.097075 55.5 0.05500 RADI OLOGY-THERAPEUTI C 0.097075 56.00 05700 CT SCAN 0.015797 57.00 05700 CT SCAN 0.015797 57.00 05700 CT SCAN 0.015797 57.00 05700 CT SCAN 0.05800 MAGNETI C RESONANCE I MAGING (MRI) 0.052073 58.00 0.05800 MAGNETI C RESONANCE I MAGING (MRI) 0.052073 58.00 0.0600 LABORATORY 0.061510 0.0600 0.0000 LABORATORY 0.061510 0.052073 0.06200 MHOLE BLOOD & PACKED RED BLOOD CELLS 0.443878 62.00 0.06200 MHOLE BLOOD & PACKED RED BLOOD CELLS 0.443878 62.00 0.0600 RESPI RATORY THERAPY 0.117329 65.00 0.06500 RESPI RATORY THERAPY 0.173757 0.0700 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.00000000	50.00	05000 OPERATI NG ROOM	0. 095205			50.	0. 00
54. 00	51.00		0. 049784			51.	. 00
54.01 03630 ULTRA SOUND 0.091922 54.	52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 663913			52.	2. 00
54	54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 190207			54.	. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 097075 0. 05600 RADI OLOGY-THERAPEUTI C 0. 058063 55. 0500 05700 CT SCAN 0. 015797 57. 70 05700 CT SCAN 0. 015797 57. 758. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 0. 052073 58. 00 05900 CARDI AC CATHETER ZATI ON 0. 056083 59. 00 05900 CARDI AC CATHETER ZATI ON 0. 056083 59. 00 05900 CARDI AC CATHETER ZATI ON 0. 056083 62. 00 06000 LABORATORY 0. 061510 60. 00 06000 LABORATORY 0. 061510 0. 005608 62. 00 06500 RESPI RATORY THERAPY 0. 117329 65. 00 06500 RESPI RATORY THERAPY 0. 1173257 66. 00 06600 PHYSI CAL THERAPY 0. 0173757 65. 00 06900 ELECTROCARDI OLOGY 0. 048788 69. 00 06900 ELECTROENCEPHALOGRAPHY 0. 090069 0. 07000 ELECTROENCEPHALOGRAPHY 0. 090069 0. 07000 ELECTROENCEPHALOGRAPHY 0. 187245 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 187245 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 187245 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 187245 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 165033 74. 00 07400 RENAL DI ALYSI S 0. 665033 74. 00 07400 RENAL DI ALYSI S 0. 665033 74. 00 07400 RENAL DI ALYSI S 0. 065033 74. 00 07400 RENAL DI ALYSI S 0. 065033 74. 00 07400 RENAL DI ALYSI S 0. 065033 74. 00 07400 RENAL DI ALYSI S 0. 065033 74. 00 07400 RENAL DI ALYSI S 0. 065033 74. 00 07400 RENAL DI ALYSI S 0. 065033 74. 00 07400 RENAL DI ALYSI S 0. 065033 75. 00 07500 07	54.01	03630 ULTRA SOUND	0. 091922			54.	. 01
56. 00 05600 RADI OI SOTOPE 0.058063 56.	54.02	03440 MAMMOGRAPHY	0. 164784			54.	. 02
56. 00 05600 RADI OI SOTOPE 0.058063 56.	55.00	05500 RADI OLOGY-THERAPEUTI C	0. 097075			55.	. 00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.052073 58. 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.056083 59. 60. 00 06000 LABORATORY 0.061510 60. 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.443878 62. 65. 00 06500 RESPI RATORY THERAPY 0.117329 65. 66. 00 06600 PHYSI CAL THERAPY 0.173757 66. 69. 00 06900 ELECTROCARDI OLOGY 0.048788 69. 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.090069 70. 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.130032 71. 72. 00 07200 I IMPL. DEV. CHARGED TO PATI ENTS 0.187245 72. 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.115946 73. 74. 00 07400 RENAL DI ALYSI S 0.665033 74. 76. 01 03330 ENDOSCOPY 0.093107 76. 76. 02 03040 PRI SI ON CLINI C 0.851997 76. 76. 04 03060 OPI C 0.173415 76. 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0.083761 <	56.00		0. 058063				. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.052073 58. 59. 00 05900 CARDIAC CATHETERIZATION 0.056083 59. 60. 00 06000 LABORATORY 0.061510 60. 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.443878 62. 65. 00 06500 RESPI RATORY THERAPY 0.117329 65. 66. 00 06600 PHYSI CAL THERAPY 0.173757 66. 69. 00 06900 ELECTROCARDIOLOGY 0.048788 69. 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.090069 70. 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATIENTS 0.130032 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.187245 72. 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.115946 73. 74. 00 07400 RENAL DIALYSIS 0.665033 74. 76. 01 03330 ENDOSCOPY 0.093107 76. 76. 02 03040 PRISION CLINIC 0.851997 76. 76. 04 03060 OPIC 0.173415 76. 76. 04 03060 OPIC 0.173415 76. 70.	57.00	05700 CT SCAN	0. 015797			57.	. 00
60. 00 06000 LABORATORY 0. 061510 60. 62. 00 66200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 443878 62. 65. 00 06500 RESPI RATORY THERAPY 0. 117329 65. 66. 00 06600 PHYSI CAL THERAPY 0. 173757 66. 00 06900 ELECTROCARDI OLOGY 0. 048788 69. 00 07000 ELECTROCARDI OLOGY 0. 048788 69. 00 07000 ELECTROCARDI OLOGY 0. 090069 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 130032 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 187245 72. 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 115946 73. 74. 00 07400 RENAL DI ALYSI S 0. 665033 74. 74. 00 07400 RENAL DI ALYSI S 0. 065033 74. 76. 00 03330 ENDOSCOPY 0. 051890 76. 76. 01 03330 ENDOSCOPY 0. 051890 76. 76. 02 03040 PRI SI ON CLI NI C 0. 851997 76. 76. 03 03050 WOUND CARE 0. 250193 76. 76. 04 03060 OPI C 0. 773415 76. 01 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0. 000000 77. 0700 INTER REI MBURSABLE COST CENTERS 92. 01 0746728 92. 01	58.00	1					3. 00
62. 00	59.00	05900 CARDI AC CATHETERI ZATI ON	0. 056083			59.	0. 00
65. 00	60.00		1			60.	0. 00
65. 00	62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 443878			62.	2. 00
69. 00 06900 ELECTROCARDI OLOGY 0. 048788 69. 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 090069 70. 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 130032 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 187245 72. 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 115946 73. 74. 00 07400 RENAL DI ALYSI S 0. 065033 74. 76. 00 03950 LI THOTRI PSY 0. 093107 76. 76. 01 03330 ENDOSCOPY 0. 051890 76. 76. 02 03040 PRI SI ON CLI NI C 0. 851997 76. 76. 03 03050 WOUND CARE 0. 250193 76. 76. 04 03060 OPI C 0. 173415 76. 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0. 000000 77. 91. 00 09100 EMERGENCY 0. 083761 91. 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 1. 046728 92. OTHER REI MBURSABLE COST CENTERS	65.00	06500 RESPIRATORY THERAPY	0. 117329			65.	5. 00
70. 00 07000 Carrote C	66.00	06600 PHYSI CAL THERAPY	0. 173757			66.	. 00
71. 00	69.00	06900 ELECTROCARDI OLOGY	0. 048788			69.	0. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 187245 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 115946 73. 00 07400 RENAL DI ALYSIS 0. 665033 74. 00 03950 LI THOTRI PSY 0. 093107 76. 01 03330 ENDOSCOPY 0. 0. 051890 76. 02 03040 PRI SI ON CLI NI C 0. 851997 76. 03 03050 WOUND CARE 0. 250193 76. 04 03060 OPI C 0. 173415 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0. 000000 00TPATIENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 0. 083761 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 1. 046728 0THER REI MBURSABLE COST CENTERS	70.00	07000 ELECTROENCEPHALOGRAPHY	0. 090069			70.	0. 00
73. 00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 130032			71.	. 00
74. 00	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 187245			72.	2. 00
76. 00	73.00	07300 DRUGS CHARGED TO PATIENTS	0. 115946			73.	3. 00
76. 01 03330 ENDOSCOPY 0. 051890 76. 76. 02 03040 PRISION CLINIC 0. 851997 76. 76. 03 03050 WOUND CARE 0. 250193 76. 76. 04 03060 OPI C 0. 173415 76. 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0. 000000 77. 91. 00 09100 EMERGENCY 0. 083761 91. 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1. 046728 92. OTHER REIMBURSABLE COST CENTERS	74.00	07400 RENAL DIALYSIS	0. 665033			74.	. 00
76. 02 03040 PRISION CLINIC 0.851997 76. 03 03050 WOUND CARE 0.250193 76. 76. 04 03060 OPI C 0.173415 76. 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 77. OUTPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY 0.083761 91. 092.00 0BSERVATION BEDS (NON-DISTINCT PART) 1.046728 92. OTHER REIMBURSABLE COST CENTERS	76.00	03950 LI THOTRI PSY	0. 093107			76.	. 00
76. 03 03050 WOUND CARE 0. 250193 76. 76. 04 03060 OPI C 0. 173415 76. 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0. 000000 77. OUTPATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 0. 083761 91. 92. 00 0700 OBSERVATI ON BEDS (NON-DI STI NCT PART) 1. 046728 92. OTHER REI MBURSABLE COST CENTERS	76. 01	03330 ENDOSCOPY	0. 051890			76.	. 01
76. 04	76.02	03040 PRISION CLINIC	0. 851997			76.	. 02
77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0.000000 77.	76.03	03050 WOUND CARE	0. 250193			76.	. 03
OUTPATIENT SERVICE COST CENTERS 91. 00	76.04	03060 0PI C	0. 173415			76.	. 04
91. 00	77.00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77.	. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 1. 046728 92. OTHER REIMBURSABLE COST CENTERS		OUTPATIENT SERVICE COST CENTERS					
OTHER REI MBURSABLE COST CENTERS	91.00	09100 EMERGENCY	0. 083761			91.	. 00
	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 046728			92.	2. 00
103 00 10300 ODI OLD TDEATHENT DDOCDAM		OTHER REIMBURSABLE COST CENTERS					
TOZ. OU TOZOU OPTOTO TREATMENT PROGRAM TOZ.	102.00	10200 OPIOID TREATMENT PROGRAM				102.	2. 00
200.00 Subtotal (see instructions) 200.	200.00	Subtotal (see instructions)				200.	. 00
201.00 Less Observation Beds 201.	201.00	Less Observation Beds					
202.00 Total (see instructions) 202.	202.00	Total (see instructions)				202.	. 00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0046	Peri od:	Worksheet C
		From 09/01/2022	
		To 00/21/2022	Data/Tima Dranarada

				rom 09/01/2022 o 08/31/2023	Part I Date/Time Pre 1/29/2024 8:1	
		Ti tl	e XIX	Hospi tal	Cost	
		·		Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
·	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	15, 633, 563		15, 633, 563	0	15, 633, 563	30.00
31.00 03100 INTENSIVE CARE UNIT	6, 506, 944		6, 506, 944	1	6, 506, 944	
35.00 02060 NEONATAL INTENSIVE CARE UNIT	907, 888		907, 888	28, 419	936, 307	35. 00
40. 00 04000 SUBPROVI DER - 1 PF	4, 902, 711		4, 902, 711	6, 978	4, 909, 689	40. 00
41. 00 04100 SUBPROVI DER - I RF	3, 143, 024		3, 143, 024	0	3, 143, 024	41. 00
43. 00 04300 NURSERY	391, 115		391, 115	0	391, 115	43. 00
ANCILLARY SERVICE COST CENTERS	1					
50. 00 05000 OPERATING ROOM	9, 520, 080		9, 520, 080	0	9, 520, 080	50.00
51.00 05100 RECOVERY ROOM	512, 676	l e	512, 676	1	512, 676	
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 310, 255		2, 310, 255	I	2, 310, 255	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 400, 246		2, 400, 246	I	2, 400, 246	
54. 01 03630 ULTRA SOUND	362, 082		362, 082		362, 082	
54. 02 03440 MAMMOGRAPHY	338, 480		338, 480		338, 480	
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 963, 475		1, 963, 475		1, 963, 475	
56. 00 05600 RADI 0I SOTOPE	901, 107		901, 107	I	901, 107	56. 00
57.00 05700 CT SCAN	1, 055, 031		1, 055, 031		1, 055, 031	1
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	477, 364		477, 364		477, 364	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 616, 126		1, 616, 126	I I	1, 616, 126	
60. 00 06000 LABORATORY	4, 581, 952		4, 581, 952		4, 581, 952	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 548, 956		2, 548, 956		2, 548, 956	
65. 00 06500 RESPI RATORY THERAPY	2, 082, 408				2, 082, 408	
66. 00 06600 PHYSI CAL THERAPY	1, 935, 545	0	1, 935, 545		1, 966, 275	66. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 148, 151		1, 148, 151		1, 159, 699	
70. 00 07000 ELECTROENCEPHALOGRAPHY	75, 580		75, 580	I	75, 580	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 020, 016		6, 020, 016		6, 020, 016	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	3, 319, 667		3, 319, 667	1	3, 319, 667	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	19, 648, 823		19, 648, 823	1	19, 648, 823	
74. 00 07400 RENAL DIALYSIS	811, 781		811, 781	1	811, 781	
76. 00 03950 LI THOTRI PSY	97, 766		97, 766		97, 766	76.00
76. 01 03330 ENDOSCOPY	734, 293		734, 293	1	734, 293	1
76. 02 03040 PRI SI ON CLI NI C	681, 766		681, 766		681, 766	
76. 03 03050 WOUND CARE	1, 250, 076		1, 250, 076		1, 261, 452	76. 03
76. 04 03060 0PI C	1, 204, 184		1, 204, 184	1	1, 234, 931	76. 04
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0)J U	0	77. 00
91.00 OUTPATIENT SERVICE COST CENTERS 91.00 O9100 EMERGENCY	6, 206, 256	T	6, 206, 256	2.0(/	6, 209, 222	01 00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	958, 151		958, 151		6, 209, 222 958, 151	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS	938, 131		958, 151		958, 151	92.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	T 0				0	102. 00
200.00 Subtotal (see instructions)	106, 247, 538			I	106, 370, 302	
201. 00 Less Observation Beds	958, 151		958, 151		958, 151	
202.00 Total (see instructions)	105, 289, 387	0			105, 412, 151	
202. 00 10 tai (300 1113 ti dott 0113)	100, 209, 307	1	100, 207, 307	122, 704	100, 412, 101	1202.00

Date/Time Prepared: 08/31/2023 1/29/2024 8:15 am Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 21, 443, 334 21, 443, 334 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 13, 486, 438 13, 486, 438 31.00 02060 NEONATAL INTENSIVE CARE UNIT 35.00 691, 101 691, 101 35.00 04000 SUBPROVIDER - IPF 40.00 29, 227, 374 29, 227, 374 40.00 04100 SUBPROVI DER - I RF 41.00 4.147.867 4, 147, 867 41.00 43.00 04300 NURSERY 43.00 721,640 721,640 ANCILLARY SERVICE COST CENTERS 46, 797, 870 99, 995, 237 50.00 05000 OPERATING ROOM 53, 197, 367 0.095205 0.000000 50.00 05100 RECOVERY ROOM 51.00 3, 886, 646 6, 411, 408 10, 298, 054 0.049784 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 3, 377, 463 102, 293 3, 479, 756 0.663913 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 3, 780, 296 8, 838, 833 12, 619, 129 0.190207 0.000000 54.00 03630 ULTRA SOUND 2, 681, 088 3, 939, 011 0.091922 0.000000 54.01 1, 257, 923 54.01 54.02 03440 MAMMOGRAPHY 1, 128 2,052,960 2, 054, 088 0.164784 0.000000 54.02 55.00 05500 RADI OLOGY-THERAPEUTI C 220, 994 20, 005, 426 20, 226, 420 0.097075 0.000000 55.00 56.00 05600 RADI OI SOTOPE 281, 497 15, 238, 073 15, 519, 570 0.058063 0.000000 56.00 05700 CT SCAN 21, 530, 282 45, 256, 471 66, 786, 753 0.015797 57 00 0.000000 57 00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 3, 532, 522 5, 634, 665 9, 167, 187 0.052073 0.000000 58.00 05900 CARDIAC CATHETERIZATION 0.056083 0.000000 59.00 18, 813, 525 10,002,972 28, 816, 497 59.00 06000 LABORATORY 74, 491, 771 0.000000 60.00 36, 386, 136 38, 105, 635 0.061510 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 4, 286, 152 62.00 1, 456, 323 5, 742, 475 0.443878 0.000000 62.00 65.00 06500 RESPIRATORY THERAPY 17, 057, 160 691, 256 17, 748, 416 0.117329 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 11, 113, 274 202, 946 11, 316, 220 0.171042 0.000000 66.00 23, 770, 158 9, 923, 920 69 00 06900 ELECTROCARDI OLOGY 13, 846, 238 0.048302 0 000000 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 552,024 287, 112 839, 136 0.090069 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 28, 846, 209 17, 450, 183 46, 296, 392 0.130032 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 9,044,676 8, 684, 321 17, 728, 997 0.187245 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 88, 659, 380 169, 464, 839 73.00 80, 805, 459 0.115946 0.000000 73.00 74.00 07400 RENAL DIALYSIS 1, 167, 130 53, 533 1, 220, 663 0.665033 0.000000 74.00 03950 LI THOTRI PSY 76.00 1,050,039 1,050,039 0.093107 0.000000 76.00 76 01 03330 ENDOSCOPY 2, 558, 748 11, 592, 342 14, 151, 090 0.051890 0.000000 76 01 03040 PRISION CLINIC 800, 198 76.02 2, 120 798,078 0.851997 0.000000 76.02 76.03 03050 WOUND CARE 60, 428 4, 981, 481 5, 041, 909 0.247937 0.000000 76.03 76.04 03060 OPI C 37, 223 7, 084, 037 7, 121, 260 0.169097 0.000000 76.04 07700 ALLOGENEIC HSCT ACQUISITION 77 00 0.000000 0.000000 77.00 OUTPATIENT SERVICE COST CENTERS 53, 108, 503 74, 130, 154 91.00 21, 021, 651 0.083721 0.000000 09100 EMERGENCY 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 192,626 722, 751 915, <u>3</u>77 1.046728 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 102.00 406, 419, 475 200.00 Subtotal (see instructions) 408, 029, 075 814, 448, 550 200.00 201.00 Less Observation Beds 201.00

408, 029, 075

406, 419, 475

814, 448, 550

202.00

202.00

Total (see instructions)

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0046	From 09/01/2022 To 08/31/2023	Worksheet C Part I Date/Time Prepared: 1/29/2024 8:15 am

				To 08/31/2023	Date/Time Prepare 1/29/2024 8:15 am
			Title XIX	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
		Ratio			
	INDATI ENT DOUTING CEDALCE COCT CENTERS	11.00			
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				20
30.00	03000 ADULTS & PEDIATRICS				30.
31.00	03100 I NTENSI VE CARE UNI T				31.
35. 00	02060 NEONATAL INTENSIVE CARE UNIT				35.
40.00	04000 SUBPROVI DER - I PF				40.
41. 00 43. 00	04100 SUBPROVI DER - I RF				41.
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS				43.
50. 00	05000 OPERATING ROOM	0. 000000			F0
51. 00	05100 RECOVERY ROOM	0. 000000			50. 51.
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			
54. 00		0. 000000			52.
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54. 54.
54. 01 54. 02	03630 ULTRA SOUND 03440 MAMMOGRAPHY	0. 000000			54.
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.
56. 00	05600 RADI OLOGT - THERAPEUTI C	0. 000000			56.
57. 00	05700 CT SCAN	0. 000000			50.
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			57.
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.
60.00	06000 LABORATORY	0. 000000			60.
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.
65. 00	06500 RESPIRATORY THERAPY	0. 000000			65.
66. 00	06600 PHYSI CAL THERAPY	0. 000000			66.
69. 00	06900 ELECTROCARDI OLOGY	0. 000000			69.
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.
74.00	07400 RENAL DIALYSIS	0. 000000			74.
76. 00	03950 LI THOTRI PSY	0. 000000			76.
76. 01	03330 ENDOSCOPY	0. 000000			76.
76. 02	03040 PRISION CLINIC	0. 000000			76.
76.03	03050 WOUND CARE	0. 000000			76.
76.04	03060 OPI C	0. 000000			76.
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77.
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0. 000000			91.
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.
	OTHER REIMBURSABLE COST CENTERS				
	10200 OPIOID TREATMENT PROGRAM				102.
200.00					200.
201.00					201.
202.00	Total (see instructions)				202.

<u> </u>	TERRE HAUTE REG	IONAL HOSPITAL			eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co	CN: 15-0046	Period: From 09/01/2022 To 08/31/2023		pared: 5 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 852, 627	l .	1, 852, 62		134. 53	
31.00 INTENSIVE CARE UNIT	512, 451		512, 45			
35.00 NEONATAL INTENSIVE CARE UNIT	40, 092		40, 09	2 165		
40. 00 SUBPROVI DER - I PF	454, 042	0	454, 04	2 5, 083	89. 33	40.00
41. 00 SUBPROVI DER - I RF	355, 619	0	355, 61	9 2, 111	168. 46	
43. 00 NURSERY	51, 217		51, 21	7 318	161.06	43.00
200.00 Total (lines 30 through 199)	3, 266, 048		3, 266, 04	8 24, 517		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	4, 206					30.00
31.00 INTENSIVE CARE UNIT	1, 155					31.00
35.00 NEONATAL INTENSIVE CARE UNIT	0		1			35. 00
40. 00 SUBPROVI DER - I PF	378		•			40. 00
41. 00 SUBPROVI DER - I RF	1, 230		1			41. 00
43. 00 NURSERY	0	_	1			43. 00
200.00 Total (lines 30 through 199)	6, 969	999, 668	B			200. 00

		TERRE HAUTE REG		ON 45 0047		eu of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co	JN: 15-0046	Peri od: From 09/01/2022	Worksheet D Part II	
					To 08/31/2023	Date/Time Pre	
						1/29/2024 8: 1	5 am
		1 2		XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		(from Wkst. B.	(from Wkst. C, Part I, col.		Program Charges	(column 3 x column 4)	
		Part II, col.	8)	2)	. Charges	Corumn 4)	
		· ·	8)	2)			
		26) 1. 00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00	05000 OPERATING ROOM	979, 628	99, 995, 237	0.00979	16, 029, 023	157, 036	50.00
51. 00	05100 RECOVERY ROOM	53, 694				6, 621	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	191, 096				0,021	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	360, 952				38, 458	
54. 00	03630 ULTRA SOUND	30, 475				3, 294	
54. 01	03440 MAMMOGRAPHY	74, 877				3, 294	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	159, 398				762	55.00
56. 00	05600 RADI OLOGI - THERAPEUTI C	42, 961			· ·	234	
57. 00	05700 CT SCAN	64, 258				6, 673	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	47, 481					
59. 00	05900 CARDIAC CATHETERIZATION	94, 415				18, 708	
60.00	06000 LABORATORY	285, 807					
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	74, 072					
65. 00	06500 RESPIRATORY THERAPY	98, 796				l	1
66. 00	06600 PHYSI CAL THERAPY	79, 171					
69.00	06900 ELECTROCARDI OLOGY	140, 432					
70. 00	07000 ELECTROCARDI OLOGI	140, 432					
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	296, 969					
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	86, 364					
73. 00	07300 DRUGS CHARGED TO PATIENTS						
74. 00	07400 RENAL DIALYSIS	608, 245				20, 738	
76. 00	03950 LI THOTRI PSY	56, 644					
		2, 559				0	
76. 01 76. 02	03330 ENDOSCOPY	59, 681				3, 843	1
	03040 PRI SI ON CLI NI C	128, 828				0	
76. 03	03050 WOUND CARE	114, 637				445	
	03060 OPI C	141, 717				i e	
77. 00	07700 ALLOGENEI C HSCT ACQUI SITI ON	0	0	0.00000	0 0	0	77. 00
01 00	OUTPATIENT SERVICE COST CENTERS	F00 544	74 120 154	0.00475	/ 424 000	40.440	01 00
	09100 EMERGENCY	500, 511					91.00

113, 544 4, 901, 331

74, 130, 154 915, 377 744, 730, 796

43, 449 91. 00 5, 915 92. 00 636, 438 200. 00

47, 683 107, 833, 353

0. 124041

92. 00 | 09200 | 085ERVATION BEDS (NON-DISTINCT PART) 200. 00 | Total (lines 50 through 199)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS			Period: From 09/01/2022 To 08/31/2023	Date/Time Pre 1/29/2024 8:1	pared: 5 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Post-Stepdowr Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				_		
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 35. 00 02060 NEONATAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF 41. 00 04100 SUBPROVIDER - IRF	000000000000000000000000000000000000000	_		0 0 0 0 0 0 0 0	0 0 0	31. 00 35. 00 40. 00
43. 00 04300 NURSERY	0			0	0	
200.00 Total (lines 30 through 199)	0			0 0		200.00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	200. 00
	4.00	5.00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			,	Ţ		
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	0		9 0.00	1, 155	31.00
40. 00 04000 SUBPROVI DER - PF	0		5, 08			
41. 00 04100 SUBPROVI DER	0	_	2, 11			
43. 00 04300 NURSERY			1			
200.00 Total (lines 30 through 199)		l c				200.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 35. 00 02060 NEONATAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVI DER - IPF 41. 00 04100 SUBPROVI DER - IRF	000000000000000000000000000000000000000					30.00 31.00 35.00 40.00 41.00
43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0					43.00

Health Financia	l Systems	TERRE	HAUTE REGION	AL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTI ONMENT (THROUGH COSTS	OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE	OTHER PASS	Provider CCN: 15-0046	Peri od: From 09/01/2022 To 08/31/2023	Worksheet D Part IV Date/Time Prepared:

				To 08/31/2023	Date/Time Pre 1/29/2024 8:1	
		Title	xVIII	Hospi tal	PPS	J dili
Cost Center Description	Non Physician		Nursi ng	Allied Health	Allied Health	
· ·	Anestheti st	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2. 00	3A	3. 00	
ANCI LLARY SERVI CE COST CENTERS	1	1				
50. 00 05000 OPERATI NG ROOM	0	0	1	0	0	
51.00 05100 RECOVERY ROOM	0	0	1	0	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0	0	52. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0	1	0	0	54.00
54. 01 03630 ULTRA SOUND	0	0		0	0	54. 01
54. 02 03440 MAMMOGRAPHY	0	0		0	0	54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55. 00
56. 00 05600 RADI 01 SOTOPE	0	0		0	0	56. 00
57. 00 05700 CT SCAN	0	0		0	0	57. 00
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0	0		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
60. 00 06000 LABORATORY	0	0		0	0	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	66. 00
	0	0		0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	70. 00 71. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS					0	73. 00
73. 00 07300 DRUGS CHARGED TO PATTENTS 74. 00 07400 RENAL DIALYSIS				0	0	74.00
74. 00 07400 KENAL DI ALTSI S 76. 00 03950 LI THOTRI PSY	0			0	0	76.00
76. 00 03730 EFF HOTKIFST 76. 01 03330 ENDOSCOPY					0	76. 00
76. 02 03040 PRI SI ON CLI NI C					0	76. 01
76. 03 03050 WOUND CARE	0			0	0	76. 02
76. 04 03060 OPI C	0	0		0	0	76. 03
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	_		0	0	
OUTPATIENT SERVICE COST CENTERS			· '	0	<u> </u>	1 , , . 00
91. 00 09100 EMERGENCY	0	0		0 (0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	Ĭ		ol	Ö	
200.00 Total (lines 50 through 199)	0	0		0	0	200. 00

Heal th	Financial Systems T	ERRE HAUTE REGI	ONAL HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	VICE OTHER PASS			Period: From 09/01/2022 To 08/31/2023	Date/Time Pre 1/29/2024 8:1	pared: 5 am
				XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	_		1			
50.00	05000 OPERATING ROOM	0	0	1	0 99, 995, 237		
51. 00	05100 RECOVERY ROOM	0	0		0 10, 298, 054		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 3, 479, 756		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 12, 619, 129		
54. 01	03630 ULTRA SOUND	0	0		0 3, 939, 011		
54. 02	03440 MAMMOGRAPHY	0	0		0 2, 054, 088		1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 20, 226, 420		
56.00	05600 RADI OI SOTOPE	0	0		0 15, 519, 570		
57. 00	05700 CT SCAN	0	0		0 66, 786, 753		
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 9, 167, 187		
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 28, 816, 497		
60.00	06000 LABORATORY	0	0		0 74, 491, 771	0.000000	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	1	0 5, 742, 475		
65. 00	06500 RESPI RATORY THERAPY	0	0	1	0 17, 748, 416		
66. 00	06600 PHYSI CAL THERAPY	0	0		0 11, 316, 220		
69. 00	06900 ELECTROCARDI OLOGY	0	0	1	0 23, 770, 158		1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	1	0 839, 136		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 46, 296, 392		
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 17, 728, 997		
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 169, 464, 839		
74.00	07400 RENAL DI ALYSI S	0	0	1	0 1, 220, 663		
76. 00	03950 LI THOTRI PSY	0	0		0 1, 050, 039		
76. 01	03330 ENDOSCOPY	0	0	1	0 14, 151, 090		
76. 02	03040 PRISION CLINIC	0	0		0 800, 198		1
76. 03	03050 WOUND CARE	0	0	1	0 5, 041, 909		
76. 04	03060 OPI C	0	0	1	0 7, 121, 260		
77. 00	07700 ALLOGENEI C HSCT ACQUISITION	0	0	1	0 0	0. 000000	77. 00

0 0 0

0.000000

0.000000

0 0 0

74, 130, 154 915, 377 744, 730, 796

0 0

91.00

92.00 200.00

77. 00 07700 ALLOGENEI C HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS
91. 00 09100 EMERGENCY
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
200. 00 Total (lines 50 through 199)

APPORT	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI H COSTS	TERRE HAUTE REGIO RVICE OTHER PASS	Provider CO		Period: From 09/01/2022 To 08/31/2023	u of Form CMS-2 Worksheet D Part IV Date/Time Pre 1/29/2024 8:1	pared:
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpatient Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Pass-Through	Outpatient Program Charges	Outpatient Program Pass-Through	
		(col. 6 ÷ col.	-	Costs (col. 8	3	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						_
50.00	05000 OPERATING ROOM	0. 000000	16, 029, 023		0 12, 891, 420	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	1, 269, 773		0 1, 534, 137	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 344, 497		0 1, 372, 324	0	54.00
54.01	03630 ULTRA SOUND	0. 000000	425, 811		0 466, 642	0	54. 01
54.02	03440 MAMMOGRAPHY	0. 000000	0		0 125, 586	0	54. 02
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	96, 714		0 7, 758, 442	0	55. 00
56.00	05600 RADI OI SOTOPE	0. 000000	84, 496		0 4, 500, 342	0	56. 00
57.00	05700 CT SCAN	0. 000000	6, 936, 405		0 9, 342, 007	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	1, 144, 110		0 982, 608	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	5, 710, 581		0 3, 952, 861	0	59. 00
60.00	06000 LABORATORY	0. 000000	11, 506, 324		0 4, 974, 032	0	60. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	1, 597, 076		0 531, 572	0	62. 00
65.00	06500 RESPI RATORY THERAPY	0. 000000	6, 201, 410		0 109, 989	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	2, 122, 134		0 6, 165	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	4, 934, 982		0 2, 776, 013	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	190, 632		0 4, 888	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	10, 057, 178		0 4, 637, 793	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	3, 274, 684		0 2, 743, 695	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	27, 027, 401		0 28, 840, 798	0	73. 00
74.00	07400 RENAL DI ALYSI S	0. 000000	446, 908		0 48, 774	0	74.00
76.00	03950 LI THOTRI PSY	0. 000000	0		0 251, 446	0	76. 00
76. 01	03330 ENDOSCOPY	0. 000000	911, 367		0 2, 726, 274	0	76. 01
76. 02	03040 PRISION CLINIC	0. 000000	0		0	0	76. 02
76. 03	03050 WOUND CARE	0. 000000	19, 552		0 1, 591, 642	0	76. 03
	03060 OPI C	0. 000000	19, 619		0 2, 514, 778	0	76. 04
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	0. 000000	6, 434, 993		0 6, 519, 612	0	
02 00	00200 ORSEDVATION REDS (NON-DISTINCT DAPT)	0 000000	17 693		02 975	0	02 00

0.000000

6, 434, 993 47, 683 107, 833, 353

0 0 0

92, 875 101, 296, 715

0 91.00 0 92.00 0 200.00

92. 00 | 09200 | 085ERVATION BEDS (NON-DISTINCT PART) 200. 00 | Total (lines 50 through 199)

Health Financial Systems	TERRE HAUTE REGI	ONAL HOSDITAL		Inlie	u of Form CMS-2	2552_10
APPORTI ONMENT OF MEDICAL, OTHER HEALTH SERVICES	THER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0046 Period: From 09/01/20 To 08/31/20				Worksheet D	pared:
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Services (see inst.)	Cost Rei mbursed Servi ces Subj ect To	Cost Reimbursed Services Not Subject To	PPS Services (see inst.)	

			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 095205	12, 891, 420	0	0	1, 227, 328	50.00
51.00 05100 RECOVERY ROOM	0. 049784	1, 534, 137	0	0	76, 375	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 663913	0	0	0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 190207	1, 372, 324	0	0	261, 026	54.00
54.01 03630 ULTRA SOUND	0. 091922	466, 642	0	0	42, 895	54. 01
54. 02 03440 MAMMOGRAPHY	0. 164784	125, 586	0	0	20, 695	54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 097075	7, 758, 442	0	0	753, 151	55. 00
56. 00 05600 RADI OI SOTOPE	0. 058063	4, 500, 342	0	0	261, 303	56. 00
57. 00 05700 CT SCAN	0. 015797	9, 342, 007	0	0	147, 576	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 052073	982, 608	0	0	51, 167	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 056083	3, 952, 861	l 0	0	221, 688	59. 00
60. 00 06000 LABORATORY	0. 061510		l 0	0	305, 953	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 443878			0	235, 953	62. 00
65. 00 06500 RESPIRATORY THERAPY	0. 117329			0	12, 905	
66. 00 06600 PHYSI CAL THERAPY	0. 171042	6, 165	l o	0	1, 054	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 048302			0	134, 087	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 090069			0	440	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 130032			0	603, 061	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 187245			0	513, 743	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 115946			13, 965	3, 343, 975	73. 00
74. 00 07400 RENAL DIALYSIS	0. 665033			0	32, 436	1
76. 00 03950 LI THOTRI PSY	0. 093107	251, 446	0	0	23, 411	76. 00
76. 01 03330 ENDOSCOPY	0. 051890			0	141, 466	
76. 02 03040 PRI SI ON CLI NI C	0. 851997	0	0	0	0	76. 02
76. 03 03050 WOUND CARE	0. 247937	1, 591, 642	l 0	0	394, 627	76. 03
76. 04 03060 OPI C	0. 169097	2, 514, 778		0	425, 241	1
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000		0	0	0	ł
OUTPATIENT SERVICE COST CENTERS			-			
91. 00 09100 EMERGENCY	0. 083721	6, 519, 612	0	0	545, 828	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 046728			0	97, 215	
200.00 Subtotal (see instructions)	1. 5.5720	101, 296, 715		13, 965		1
201.00 Less PBP Clinic Lab. Services-Program		101,270,710	١	13, 703	,, 0, 1, 0, 7	201. 00
Only Charges			Ĭ			
202.00 Net Charges (line 200 - line 201)		101, 296, 715	l o	13, 965	9, 874, 599	202. 00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1		'	, , , , ,	., ., ., .,	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0046 Period: Worksheet D From 09/01/2022 Part V To 08/31/2023 Date/Time Prepare	nancial Systems TERRE HAUTE REGIONAL HOSPITAL	In Lie	eu of Form CMS-2552-10
	VMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0046	From 09/01/2022	Part V
Title XVIII Hospital PPS	Title XVIII	Hospi tal	PPS
Costs	Costs		

				То	08/31/2023	Date/Time Pro 1/29/2024 8:	epared: 15 am
		Title	XVIII		Hospi tal	PPS	
	Cos	sts					
Cost Center Description	Cost	Cost					
	Rei mbursed	Reimbursed					
	Servi ces	Services Not					
	Subject To	Subject To					
	Ded. & Coins.	Ded. & Coins.					
	(see inst.)	(see inst.)					
	6. 00	7. 00					
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0					50. 00
51. 00 05100 RECOVERY ROOM	0	0					51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0					52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0					54. 00
54.01 03630 ULTRA SOUND	0	0					54. 01
54. 02 03440 MAMMOGRAPHY	0	0					54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0					55. 00
56. 00 05600 RADI 01 SOTOPE	0	0					56. 00
57.00 05700 CT SCAN	0	0					57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0					58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0					59. 00
60. 00 06000 LABORATORY	0	0					60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0					62. 00
65. 00 06500 RESPIRATORY THERAPY	0	0					65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0					66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0					69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0					70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0					72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	1, 619	i				73. 00
74. 00 07400 RENAL DI ALYSI S	0	0					74. 00
76. 00 03950 LI THOTRI PSY	0	0					76. 00
76. 01 03330 ENDOSCOPY	0	0					76. 01
76. 02 03040 PRISION CLINIC	0	0					76. 02
76. 03 03050 WOUND CARE	0	0					76. 03
76. 04 03060 OPI C	0	0	1				76. 04
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0					77. 00
OUTPATIENT SERVICE COST CENTERS		^					01.00
91. 00 09100 EMERGENCY	0	0	1				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	1				92.00
200.00 Subtotal (see instructions)	0	1, 619					200. 00
201.00 Less PBP Clinic Lab. Services-Program	0						201. 00
Only Charges (Line 200 Line 201)		1 /10					202 00
202.00 Net Charges (line 200 - line 201)	0	1, 619	1				202. 00

Health Financial Systems T	ERRE HAUTE REG	IONAL HOSPITAL		In lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der Co	CN: 15-0046	Peri od:	Worksheet D	2002 10
				From 09/01/2022 To 08/31/2023	Part II Date/Time Pre 1/29/2024 8:1	pared: 5 am
		Title	XVIII	Subprovi der -	PPS	
		I = o.		I PF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	`	. Charges	column 4)	
	Part II, col.	8)	2)			
	26) 1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50, 00 O5000 OPERATING ROOM	979, 628	99, 995, 237	0.00979	7 0	0	50.00
					0	
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	53, 694				0	
	191, 096					
54. 00 05400 RADI OLOGY - DI AGNOSTI C	360, 952				l e	
54. 01 03630 ULTRA SOUND	30, 475				16	
54. 02 03440 MAMMOGRAPHY	74, 877				0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	159, 398				0	
56. 00 05600 RADI 0I SOTOPE	42, 961				0	
57. 00 05700 CT SCAN	64, 258				26	
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	47, 481				0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	94, 415					
60. 00 06000 LABORATORY	285, 807		0. 00383		l e	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	74, 072				0	
65. 00 06500 RESPIRATORY THERAPY	98, 796				59	1
66. 00 06600 PHYSI CAL THERAPY	79, 171				31	
69. 00 06900 ELECTROCARDI OLOGY	140, 432				32	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	14, 119				0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	296, 969				41	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	86, 364				0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	608, 245				788	
74. 00 07400 RENAL DIALYSIS	56, 644				0	
76. 00 03950 LI THOTRI PSY	2, 559				0	
76. 01 03330 ENDOSCOPY	59, 681				0	
76. 02 03040 PRI SI ON CLI NI C	128, 828				0	1
76. 03 03050 WOUND CARE	114, 637				0	
76. 04 03060 OPI C	141, 717				0	
77. 00 07700 ALLOGENEI C HSCT ACQUISITION	0	0	0.00000	0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	500 511	7	0.05:	100		
91. 00 09100 EMERGENCY	500, 511				l e	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	
200.00 Total (lines 50 through 199)	4, 787, 787	744, 730, 796	I	552, 156	2, 491	200. 00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	FERRE HAUTE REG RVI CE OTHER PAS	S Provider Co	CN: 15-0046 CCN: 15-S046		ri od: om 09/01/2022 08/31/2023	u of Form CMS-2 Worksheet D Part IV Date/Time Pre 1/29/2024 8:1	pared:
		Title	xVIII	Su	ubprovi der - I PF	PPS	<u>3 alli </u>
Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Р		Allied Health	
	1.00	2A	2. 00		3A	3. 00	
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05100 DELI VERY ROOM & LABOR ROOM 05400 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND 03440 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06200 MAGNETI C RESONANCE I MAGI NG (MRI) 06500 RESPI RATORY THERAPY 06500 RESPI RATORY THERAPY 06400 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07400 RENAL DI ALYSI S 07400 RENAL DI ALYSI S 07600 ORIOGO PRISI ON CLI NI C 03050 WOUND CARE 03060 OPI C				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			50. 00 51. 00 52. 00 54. 00 54. 01 54. 02 55. 00 56. 00 57. 00 59. 00 60. 00 62. 00 66. 00 66. 00 67. 00 71. 00 71. 00 72. 00 73. 00 74. 00 76. 01 76. 02 76. 03
77. 00 O7700 ALLOGENEI C HSCT ACQUI SITION OUTPATIENT SERVICE COST CENTERS	0	0		0	0	0	77. 00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 200. 00 Total (lines 50 through 199)	0 0 0			0 0 0	0	0 0 0	91. 00 92. 00 200. 00

Heal th	Financial Systems	TERRE HAUTE REGI	ONAL HOSPITAL		In Li∈	u of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE			CN: 15-0046	Peri od:	Worksheet D	
THROUG	SH COSTS				From 09/01/2022	Part IV	
			·	CCN: 15-S046	To 08/31/2023	Date/Time Pre 1/29/2024 8:1	
			Ti tl e	: XVIII	Subprovi der -	PPS	
		1 444 644		T	I PF		
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of cols.	Outpatient	(from Wkst. C,		
		Education Cost	1, 2, 3, and 4)	Cost (sum of cols. 2, 3,		(col. 5 ÷ col. 7)	
			4)	and 4)	0)	(see	
				and 4)		instructions)	
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	0,00	0.00	7.00	0.00	
50.00	05000 OPERATING ROOM	0	0		0 99, 995, 237	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	O		0 10, 298, 054	0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	o		0 3, 479, 756	0. 000000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	o		0 12, 619, 129	0. 000000	54.00
54.01	03630 ULTRA SOUND	0	0		0 3, 939, 011	0.000000	54. 01
54.02	03440 MAMMOGRAPHY	0	0		0 2, 054, 088	0. 000000	54. 02
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 20, 226, 420	0. 000000	55.00
56.00	05600 RADI OI SOTOPE	0	0		0 15, 519, 570	0. 000000	56. 00
57.00	05700 CT SCAN	0	0		0 66, 786, 753	0. 000000	57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 9, 167, 187	0.000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	•	0 28, 816, 497	0. 000000	
60.00	06000 LABORATORY	0	0		0 74, 491, 771	0. 000000	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 5, 742, 475	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	0	0		0 17, 748, 416	0. 000000	
66. 00	06600 PHYSI CAL THERAPY	0	0		0 11, 316, 220	0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 23, 770, 158	0.000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 839, 136	0.000000	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 46, 296, 392	0.000000	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		0 17, 728, 997	0.000000	
73.00		0	0		0 169, 464, 839	0.000000	
74. 00 76. 00	07400 RENAL DI ALYSI S 03950 LI THOTRI PSY	0			0 1, 220, 663 0 1, 050, 039	0. 000000 0. 000000	
76. 00	03330 ENDOSCOPY				0 14, 151, 090	0. 000000	
76. 01	03040 PRI SI ON CLI NI C				0 14, 151, 090	0. 000000	
76. 02	03050 WOUND CARE	0			0 5, 041, 909	0. 000000	
76. 03	03060 OPI C	0	_	1	0 7, 121, 260	0.000000	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0		l .	0 7, 121, 200	0. 000000	
	OUTPATIENT SERVICE COST CENTERS				<u> </u>	0.00000	1 ,,
91. 00		0	C		0 74, 130, 154	0. 000000	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	-	l .	0 915, 377	0. 000000	
200.00	1 1	0		l .	0 744, 730, 796		200.00

Health Financial Systems	ERRE HAUTE REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der Co	CN: 15-0046	Peri od:	Worksheet D	
THROUGH COSTS		Component (CCN: 15-S046	From 09/01/2022 To 08/31/2023	Part IV Date/Time Pre 1/29/2024 8:1	pared: 5 am
		Title	XVIII	Subprovi der -	PPS	
				I PF		
Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col . 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS	0.000000		<u> </u>	اما		
50. 00 05000 OPERATI NG ROOM	0. 000000	0		0 0	0	1
51. 00 05100 RECOVERY ROOM	0. 000000	0		0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	3, 330		0	0	
54. 01 03630 ULTRA SOUND	0. 000000	2, 105		0	0	54. 01
54. 02 03440 MAMMOGRAPHY	0. 000000	0		0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
56. 00 05600 RADI 0I SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	26, 727		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	7, 696		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	142, 746		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	10, 675		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	4, 498		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	5, 480		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	6, 435		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	219, 575		0 738	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
76. 00 03950 LI THOTRI PSY	0. 000000	0		0 0	0	76.00
76. 01 03330 ENDOSCOPY	0. 000000	0		0 0	0	76, 01
76. 02 03040 PRISION CLINIC	0. 000000	0		0 0	0	76, 02
76. 03 03050 WOUND CARE	0. 000000	0		0 0	0	76. 03
76. 04 03060 OPI C	0. 000000	0		o o	0	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0			0	1
OUTPATIENT SERVICE COST CENTERS	2. 222300			-		1 50
91. 00 09100 EMERGENCY	0. 000000	122, 889		0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		o o	0	
	5. 555500	O	1	-1 9		, ,_, ,

		TERRE HAUTE REGI				u of Form CMS-:	2552-10
APP0RTI	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der CO		Peri od:	Worksheet D	
			0		From 09/01/2022		
			component	CCN: 15-S046	To 08/31/2023	Date/Time Pre 1/29/2024 8:1	
			Title	XVIII	Subprovi der -	PPS	J dili
			11 11 0	XVIII	IPF	110	
			"	Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	·		Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins	. Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0. 095205	0		0	0	50.00
51.00	D5100 RECOVERY ROOM	0. 049784	0		0 0	0	51.00
52.00	D5200 DELIVERY ROOM & LABOR ROOM	0. 663913	0		0 0	0	52. 00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	0. 190207	0		0 0	0	54. 00
54. 01	03630 ULTRA SOUND	0. 091922	0		0 0	0	54. 01
54. 02	D3440 MAMMOGRAPHY	0. 164784	0		0 0	0	54. 02
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 097075	0		0 0	0	55. 00
56.00	05600 RADI OI SOTOPE	0. 058063	0		0 0	0	56.00
57. 00	05700 CT SCAN	0. 015797	0		0 0	0	57. 00
58. 00	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 052073	0		0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 056083	0		0 0	0	59. 00
60.00	06000 LABORATORY	0. 061510	0		0 0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 443878	0		0 0	0	62.00
65. 00	06500 RESPI RATORY THERAPY	0. 117329	0		0 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 171042	0		0 0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0. 048302	0		0 0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 090069	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 130032	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 187245	0		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 115946	738		0 717	86	73. 00
74.00	07400 RENAL DIALYSIS	0. 665033	0		o o	0	74. 00
76.00	03950 LI THOTRI PSY	0. 093107	0		o o	0	76. 00
76. 01	D3330 ENDOSCOPY	0. 051890	0		o o	0	76. 01
76. 02	D3040 PRISION CLINIC	0. 851997	0		o o	0	76. 02
71 00 1	AAAFA WALIND AADE	0.047007			اء ا		7, 00

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86 200. 00 201. 00

86 202. 00

03040 PRISION CLINIC 03050 WOUND CARE

09100 EMERGENCY

07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges

Net Charges (line 200 - line 201)

76. 03

77.00

91.00

200.00

201.00

202.00

76. 04 03060 OPI C

Component CCN: 15-S046 Component CCN: 15-S		Financial Systems T ONMENT OF MEDICAL. OTHER HEALTH SERVICES AND	ERRE HAUTE REG		CN: 15-0046	Period:	u of Form CMS- Worksheet D	2552-10
Cost Cost Cost Cost Cost Cost Cost Cost Rel mbursed Servi ces Not Subject To Ded. & Col ns. (See Inst.) See Inst.) See Inst.) See Inst.) See Inst.) See Inst. See Inst.) See Inst. See Inst.) See Inst. See Inst. See Inst.) See Inst.						From 09/01/2022	Part V Date/Time Pre	pared: 5 am
Cost Center Description				Ti tl e	e XVIII			
Rel inbursed Servi ces Not Subject To Ded. & Col ns. (See inst.)				sts				
Services Subject To Ded. & Coin Subject		Cost Center Description						
Subject To Ded. & Coins Color & Coins								
Ded. & Coi ns. (see i nst.)								
ANCI LLARY SERVI CE COST CENTERS								
ANCILLARY SERVICE COST CENTERS 50.00								
50. 00 05000 0PERATING ROOM 0 0 0 0 0 0 0 0 0			6.00	7.00				
51. 00 05100 RECOVERY ROOM 0 0 0 0 52. 00 052.00 052.00 052.00 052.00 054.00 054.00 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 0								
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0	50.00	05000 OPERATING ROOM	0	C				50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54. 00 54. 00 54. 00 54. 01 36300 ULTRA SOUND 0 0 54. 01 54. 01 54. 01 54. 02 33400 MAMMOGRAPHY 0 0 55. 00 55. 00 55. 00 0 0 55. 00 55. 00 55. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 66. 00 <td< td=""><td>51.00</td><td>05100 RECOVERY ROOM</td><td>0</td><td>C</td><td></td><td></td><td></td><td>51.00</td></td<>	51.00	05100 RECOVERY ROOM	0	C				51.00
54. 01 03630 ULTRA SOUND 0 0 0 54. 01 54. 02 03440 MAMMOGRAPHY 0 0 0 0 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 57. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 58. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 59. 00 05700 CT SCAN 0 0 0 58. 00 05800 MAGNETI C RESONANCE MAGI NG (MRI) 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 60. 00 06900 LABORATORY 0 0 60. 00 06000 LABORATORY 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 67. 00 07000 ELECTROCARDI OLOGY 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 71. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 71. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 71. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 71. 00 07400 RENAL DI ALYSI S 0 0 71. 00 07400 RENAL DI ALYSI S 0 0 71. 00 07500 RENAL DI ALYSI S 0 0 71. 00 07500 RENAL DI ALYSI S 0 0 71. 00 07500 O 0 72. 00 07500 O 0 73. 00 07500 O 0 74. 00 07500 O 0 75. 01 07500 O 0 76. 02 07500 O 0 76. 03 07500 O O 76. 04 07500 O 0 76. 06 07500 O 76. 07 07500 O 77. 07 07500 O 78. 08 07500 O 79. 09 07500 O 79. 00 0			0	C)			
54. 02 03440 MAMMOGRAPHY 0 0 54. 02 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 55. 00 57. 00 05700 CT SCAN 0 0 0 56. 00 59. 00 05900 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 58. 00 60. 00 06000 CARDI AC CATHETRI ZATI ON 0 0 0 59. 00 60. 00 06000 LABORATORY 0 0 0 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 62. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 65. 00 66. 00 06600 PHSI CAL THERAPY 0 0 0 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 66. 00 70. 00 07000 ELECTROSINCEPHALOGRAPHY 0 0 0 70. 00			0	C)			54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 55. 00 56. 00 05600 RADI OLSGY-THERAPEUTI C 0 0 0 57. 00 05700 CT SCAN 0 0 0 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 60. 00 06000 LABORATORY 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 66. 00 06900 PHYSI CAL THERAPY 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 76. 01 03330 ENDOSCOPY 0 0			0	_	•			
56. 00 05600 RADI OI SOTOPE 0 0 56. 00 57. 00 05700 CT SCAN 0 0 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 59. 00 60. 00 06000 LABORATORY 0 0 0 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 62. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 69. 00 70. 00 07000 ELECTROEARDI OLOGY 0 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 83 73. 00 73. 00 07400 RENAL DI ALYSI S 0 0 74. 00 76. 01 03330 ENDOSCOPY			0	_	1			1
57. 00 05700 CT SCAN			0	_	1			
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 59. 00 60. 00 06000 LABORATORY 0 0 60. 00 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 60. 00 65. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 65. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 66. 00 70. 00 07000 ELECTROCNCEPHALOGRAPHY 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 73. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 83 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 74. 00 76. 01			0	_	1			
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 59. 00 60. 00 06000 LABORATORY 0 0 0 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 62. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 83 73. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 74. 00 76. 01 03330 ENDOSCOPY 0 0 0 76. 01 76. 02 03040 PRI SI ON CLINI C 0 0 0 76. 02 76. 04 03060 OPI C 0 0 0 76. 03 76. 04 03060 OPI C 0 0 0 0			0	_	1			
60. 00			0		1			
62. 00			0	_	1			1
65. 00			0	_	1			
66. 00 06600			0		1			1
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	_	1			
70. 00 07000 07000 07000 07000 07100 0			0	_	1			1
71. 00					1			
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73. 00 07300 DRUGS CHARGED TO PATIENTS 0 83 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 0 0				_	1			
74. 00					1			1
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76. 01 03330 ENDOSCOPY 0 0 0 76. 01 76. 02 03040 PRI SI ON CLI NI C 0 0 0 76. 02 76. 03 03050 WOUND CARE 0 0 0 76. 03 76. 04 03060 OPI C 0 0 0 76. 04			0	_	1			
76. 02 03040 PRISION CLINIC 0 0 76. 02 76. 03 03050 WOUND CARE 0 0 0 76. 03 76. 04 03060 OPIC 0 0 0 76. 04			0		1			
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	76. 03	03050 WOUND CARE	0	C				76. 03
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 77. 00	76. 04	03060 OPI C	0	C				76. 04
	77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	C				77. 00

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202. 00

09100 EMERGENCY

91.00

200.00

201.00

202.00

07700 ALLOGENEI C HSCT ACQUISITION
OUTPAILENT SERVICE COST CENTERS

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges
Net Charges (line 200 - line 201)

Health Financial Systems T	ERRE HAUTE REG	IONAL HOSPITAL		In lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 15-0046		Worksheet D	
			CCN: 15-T046	Peri od: From 09/01/2022 To 08/31/2023	Part II Date/Time Pre	pared:
		·			1/29/2024 8:1	<u>5 am</u>
		Title	xVIII	Subprovi der - I RF	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col . 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)	Ŭ	,	
	26)	·				
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	979, 628	99, 995, 237			979	50. 00
51.00 O5100 RECOVERY ROOM	53, 694	10, 298, 054	0. 00521	4 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	191, 096	3, 479, 756	0. 05491	6 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	360, 952	12, 619, 129	0. 02860	92, 580	2, 648	54.00
54. 01 03630 ULTRA SOUND	30, 475	3, 939, 011	0.00773	75, 359	583	54. 01
54. 02 03440 MAMMOGRAPHY	74, 877	2, 054, 088	0. 03645	53 0	0	54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	159, 398				0	55.00
56. 00 05600 RADI OI SOTOPE	42, 961	15, 519, 570	0. 00276	0 8	0	56.00
57. 00 05700 CT SCAN	64, 258		1		128	1
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	47, 481	9, 167, 187	•		32	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	94, 415		l .		629	
60. 00 06000 LABORATORY	285, 807				2, 615	1
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	74, 072		l .		1, 009	
65. 00 06500 RESPIRATORY THERAPY	98, 796		1		953	1
66. 00 06600 PHYSI CAL THERAPY	79, 171				22, 309	
69. 00 06900 ELECTROCARDI OLOGY	140, 432		l .		132	
70. 00 07000 ELECTROENCEPHALOGRAPHY	14, 119	1			77	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	296, 969				3, 074	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	86, 364	1			3,074	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	608, 245				6, 482	
74. 00 07400 RENAL DI ALYSI S	56, 644				3, 001	74.00
76. 00 03950 LI THOTRI PSY	2, 559				3,001	1
76. 01 03330 ENDOSCOPY	59, 681	14, 151, 090			0	
76. 02 03040 PRI SI ON CLI NI C	128, 828	1			0	
76. 03 03050 WOUND CARE	114, 637				0	76. 02
76. 04 03060 OPI C	141, 717				0	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	141,717		•		0	
OUTPATIENT SERVICE COST CENTERS	1 0	0	0.00000	0	0	77.00
91. 00 09100 EMERGENCY	500, 511	74, 130, 154	0.00675	52 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				Ö	92.00
200.00 Total (lines 50 through 199)	4, 787, 787		l .	7, 165, 495	-	200. 00

111 41-	Figure in Contract	TENNE HALITE NECL	LONAL HOCDLTAL			1-1:-	£ [CMC :	2552 40
	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	ERRE HAUTE REGI		CN: 15-0046	Per	riod:	u of Form CMS-2 Worksheet D	2552-10
	H COSTS			CCN: 15-T046		om 09/01/2022	Part IV	
			Title	xVIII	Sı	ubprovi der - I RF	PPS	
	Cost Center Description	Non Physician		Nursi ng			Allied Health	
		Anesthetist Cost	Program Post-Stepdown	Program		Post-Stepdown Adjustments		
		0031	Adjustments			Adj d3 tillorrt3		
		1.00	2A	2.00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATI NG ROOM	0		1	0	0	0	50. 00
51.00	05100 RECOVERY ROOM	0	0		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	
54. 01	03630 ULTRA SOUND	0	0		0	0	0	54. 01
54. 02	03440 MAMMOGRAPHY	0	0		0	0	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	0		0	0	0	56. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	0	1
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60.00	06000 LABORATORY	0	0		0	0	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	0	62.00
65. 00	06500 RESPIRATORY THERAPY	0	0		0	0	Ö	
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	ő	66.00
69. 00	06900 ELECTROCARDI OLOGY	o o	Ö		0	0	Ö	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0	0	0	74. 00
76. 00	03950 LI THOTRI PSY	0	0		0	0	0	76. 00
76. 01	03330 ENDOSCOPY	0	0		0	0	0	
76. 02	03040 PRI SI ON CLI NI C	0	0		0	0	0	76. 02
76. 03	03050 WOUND CARE	0	0		0	0	0	
76. 04	03060 OPI C	0			0	0	0	
77. 00	O7700 ALLOGENEI C HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0		0	0	0	77. 00
91. 00	09100 EMERGENCY	0	0		0	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0		0	92.00
200.00	Total (lines 50 through 199)	0	0		0	0	0	200. 00

Heal th	Financial Systems	TERRE HAUTE REG	ONAL HOSDITAL		In lie	eu of Form CMS-2	2552_10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE			CN: 15-0046	Peri od:	Worksheet D	2332-10
	GH COSTS	AVIOL OTHER THO			From 09/01/2022	Part IV	
			Component	CCN: 15-T046	To 08/31/2023	Date/Time Pre 1/29/2024 8:1	pared: 5 am
			Title	: XVIII	Subprovi der -	PPS	J dili
					I RF		
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
		4.00	F 00	4 00	7.00	instructions)	
	ANCILLARY SERVICE COST CENTERS	4. 00	5. 00	6. 00	7. 00	8. 00	
50. 00	05000 OPERATING ROOM	0	0	1	0 99, 995, 237	0.000000	50.00
50.00	05100 RECOVERY ROOM	0					
51.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 10, 298, 054 0 3, 479, 756		1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0				
54. 00	03630 ULTRA SOUND	0	0				
54. 01	03440 MAMMOGRAPHY	0) 0		0, 707, 011		
55.00	03440 MAMINOGRAPHY 05500 RADI OLOGY-THERAPEUTI C	0	0		0 2, 054, 088 0 20, 226, 420		
56. 00	05600 RADI OI SOTOPE	0	0		0 20, 226, 420		
57. 00	05700 CT SCAN	0	0		0 66, 786, 753		
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 9, 167, 187		1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0				
60.00	06000 LABORATORY		0		0 28, 816, 497 0 74, 491, 771		
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0		0 5, 742, 475		
65. 00	06500 RESPIRATORY THERAPY		0		0 17, 748, 416		
66. 00	06600 PHYSI CAL THERAPY		0		0 11, 316, 220		1
69. 00	06900 ELECTROCARDI OLOGY		0		0 23, 770, 158		
70.00	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY		0		0 23, 770, 136		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0 46, 296, 392		1
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0		0 40, 290, 392		
73. 00	07300 DRUGS CHARGED TO PATIENTS		0		0 169, 464, 839		1
74. 00	07400 RENAL DIALYSIS		0		0 1, 220, 663		
76. 00	03950 LI THOTRI PSY		0		0 1, 050, 039		1
76. 00	03330 ENDOSCOPY		0		0 14, 151, 090		1
76. 01	03040 PRISION CLINIC		0		0 800, 198		
76. 02	03050 WOUND CARE		0		0 5, 041, 909		1
76. 03	03060 OPI C	0	0		0 7, 121, 260		
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	1	0 7, 121, 200	0.000000	
77.00	OUTPATIENT SERVICE COST CENTERS	1 0	0		0 0	0.00000	77.00
91. 00	09100 EMERGENCY	0	0		0 74, 130, 154	0.000000	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	Ö		l .	0 915, 377		
200.00		Ō			0 744, 730, 796		200.00
		•	•	•		•	•

Health Financial Systems 1	ERRE HAUTE REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER		Provi der Co	CN: 15-0046	Peri od:	Worksheet D	
THROUGH COSTS		Component (CCN: 15-T046	From 09/01/2022 To 08/31/2023	Part IV Date/Time Pre 1/29/2024 8:1	
		Title	XVIII	Subprovi der -	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	I RF Outpatient	Outpati ent	
COST CENTER DESCRIPTION	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col . 6 ÷ col .	orial ges	Costs (col.		Costs (col. 9	
	7)		x col . 10)		x col. 12)	
	9, 00	10.00	11.00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 000000	99, 966		0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000	0		o o	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	92, 580		0 0	0	54.00
54. 01 03630 ULTRA SOUND	0. 000000	75, 359		0 0	0	54. 01
54. 02 03440 MAMMOGRAPHY	0. 000000	0	1	0 0	0	54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0. 000000	0		0 0	0	56. 00
57. 00 05700 CT SCAN	0. 000000	133, 117		0 0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	6, 088		0 0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	192, 022		0 0	0	59. 00
60. 00 06000 LABORATORY	0. 000000	681, 598		o o	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	78, 205		0 0	0	62. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	171, 210		0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	3, 188, 869		0 0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	22, 324		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	4, 568		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	479, 216		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	69, 664		0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 806, 036		0 738	0	73. 00
74.00 07400 RENAL DIALYSIS	0. 000000	64, 673		0 0	0	74. 00
76. 00 03950 LI THOTRI PSY	0. 000000	0		0 0	0	76. 00
76. 01 03330 ENDOSCOPY	0. 000000	0		0 0	0	76. 01
76. 02 03040 PRISION CLINIC	0. 000000	0		0	0	76. 02
76. 03 03050 WOUND CARE	0. 000000	0		0	0	76. 03
76. 04 03060 0PI C	0. 000000	0		0	0	1
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON	0. 000000	0		0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	0.000000	^				01 00
91. 00 09100 EMERGENCY	0.000000	0		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 200.00 Total (lines 50 through 199)	0. 000000	7, 165, 495		0 0 738	0	92. 00 200. 00
200.00 Total (Titles 30 tillough 199)	1	7, 100, 495	I	U /38	U	₁ 200.00

Heal th	Financial Systems 1	ERRE HAUTE REG	IONAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPOR1	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	,	CCN: 15-T046	Period: From 09/01/2022 To 08/31/2023	Worksheet D Part V Date/Time Pre 1/29/2024 8:1	pared: 5 am
			Title	XVIII	Subprovi der - I RF	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
			Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(, , , , , , , , , , , , , , , , , , ,	
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2, 00	3.00	4.00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
50. 00	05000 OPERATING ROOM	0. 095205	0		0 0	0	50.00
51. 00	05100 RECOVERY ROOM	0. 049784	0		0 0	Ö	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 663913	0		0 0	0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 190207			0 0	0	54.00
54. 00	03630 ULTRA SOUND	0. 190207			0 0	0	54. 00
	03440 MAMMOGRAPHY	0. 164784	0		0 0	0	
54. 02			0		-1	0	54. 02
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 097075	0		0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0. 058063	0		0	0	56. 00
57. 00	05700 CT SCAN	0. 015797	0		0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 052073	0		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 056083	0		0	0	59. 00
60.00	06000 LABORATORY	0. 061510	0		0	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 443878	0		0	0	62. 00
65.00	06500 RESPI RATORY THERAPY	0. 117329	0		0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 171042	0		0	0	66. 00
69.00	06900 ELECTROCARDI OLOGY	0. 048302	0		0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 090069	0		0 0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 130032	0		0 0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 187245	0		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 115946	738		0 1, 151	86	73. 00
74.00	07400 RENAL DIALYSIS	0. 665033	0		0 0	0	74. 00
76. 00	03950 LI THOTRI PSY	0. 093107	l o		0 0	Ō	76. 00
76. 01	03330 ENDOSCOPY	0. 051890	0		0 0	Ō	76. 01
76. 02	03040 PRI SI ON CLI NI C	0. 851997	1 0		0 0	n n	76. 02
76. 02	03050 WOUND CARE	0. 247937	0		0 0	o o	76. 03
76. 04	03060 OPI C	0. 169097	0		0 0	n	76. 04
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	, o	77. 00
77.00	OUTDATE ENT. CEDVICE. COCT. CENTERS	0.000000		L	<u> </u>	<u> </u>	1 / / . 00

0. 083721

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91.00

86 200. 00 201. 00

86 202. 00

09100 EMERGENCY

91.00

200.00

201.00

202.00

07700 ALLOGENEIC HSCT ACQUISITION
OUTPAILENT SERVICE COST CENTERS

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges

Net Charges (line 200 - line 201)

Health Financial Systems APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	TERRE HAUTE REGI	ONAL HOSPITAL Provider Co	CN: 1E 0044	In Lie	u of Form CMS- Worksheet D	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ID VACCINE COST		CCN: 15-0046 CCN: 15-T046	From 09/01/2022 To 08/31/2023	Part V Date/Time Pre	
		Title	· XVIII	Subprovi der - I RF	PPS	<u>o am</u>
	Cos	sts				
Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins.	Cost Reimbursed Services Not Subject To Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0	1			50.00
51. 00 05100 RECOVERY ROOM	0	0				51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0				52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03630 ULTRA SOUND	U	0				54.00
54. 01 03630 ULTRA SOUND 54. 02 03440 MAMMOGRAPHY	0	0				54. 01 54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
56. 00 05600 RADI 01 SOTOPE	0	0				56. 00
57. 00 05700 CT SCAN	0	0				57. 00
58.00 05800 MAGNETIC RESONANCE MAGING (MRI)		0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	o o	0				59.00
60. 00 06000 LABORATORY	o o	0				60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	Ö	0				62. 00
65. 00 06500 RESPIRATORY THERAPY	ol	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	ol	0				66. 00
69. 00 06900 ELECTROCARDI OLOGY	o	0				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	o	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	133				73. 00
74. 00 07400 RENAL DIALYSIS	0	0	1			74. 00
76. 00 03950 LI THOTRI PSY	o	0				76. 00
76. 01 03330 ENDOSCOPY	0	0				76. 01
76.02 03040 PRISION CLINIC	o	0				76. 02
76. 03 03050 WOUND CARE	0	0				76. 03
76. 04 03060 0PI C	0	0				76. 04
77 OO O77OO ALLOGENELC HSCT ACOULSITION		0	I			77 00

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77.00

91.00

92.00

200.00

201. 00

202. 00

07700| ALLOGENEI C HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS 09100| EMERGENCY

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges
Net Charges (line 200 - line 201)

77. 00

91.00

200.00

201.00

202.00

Heelth Financial Cyatama	TEDDE HAUTE DECL	ONAL HOSDITAL		la li o	u of Form CMC	DEE2 10
Health Financial Systems APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES	TERRE HAUTE REGI S AND VACCINE COST	Provider CC	CN: 15-0046	Peri od: From 09/01/2022	u of Form CMS-2 Worksheet D Part V Date/Time Pre 1/29/2024 8:1	pared:
		Ti tl	e XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Services (see inst.)	Cost Reimbursed Services Subject To	Cost Reimbursed Services Not Subject To	PPS Services (see inst.)	

				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00		0. 095205	l .	·	10, 089, 947	0	
51.00		0. 049784	0	0	1, 316, 312	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 663913	0	0	64, 306	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 190207	0	0	2, 891, 888	0	54.00
54. 01	03630 ULTRA SOUND	0. 091922	0	0	906, 626	0	54. 01
54. 02	03440 MAMMOGRAPHY	0. 164784	0	0	204, 519	0	54. 02
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 097075	0	0	1, 430, 827	0	55.00
56.00	05600 RADI OI SOTOPE	0. 058063	0	0	2, 174, 239	0	56. 00
57.00	05700 CT SCAN	0. 015797	0	0	14, 108, 632	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 052073	0	0	949, 207	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 056083	0	0	1, 039, 429	0	59. 00
60.00	06000 LABORATORY	0. 061510	0	0	12, 614, 114	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 443878	0	0	268, 836	0	62. 00
65.00	06500 RESPI RATORY THERAPY	0. 117329	0	0	179, 310	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 171042	0	0	35, 579	0	66. 00
69.00		0. 048302	0	0	1, 998, 343	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 090069	0	0	194, 880	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 130032	0	0	3, 305, 765	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 187245	0	0		0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 115946	0	0		0	73. 00
74.00	07400 RENAL DIALYSIS	0. 665033	0	l o	2, 291	0	74. 00
76. 00	03950 LI THOTRI PSY	0. 093107	0	0	168, 972	0	76, 00
76. 01	03330 ENDOSCOPY	0. 051890	0	0	1, 610, 496	0	76, 01
76. 02	03040 PRISION CLINIC	0. 851997	0	0	3, 418	0	76, 02
76. 03	03050 WOUND CARE	0. 247937	0	0	1, 437, 266	0	76. 03
76. 04	03060 OPI C	0. 169097	0	0	715, 637	0	76. 04
	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS			_			
91. 00		0. 083721	0	0	24, 794, 588	0	91. 00
92. 00		1. 046728				0	
200. 0			0	1	95, 785, 391	0	200.00
201. 0				l	0	Ü	201. 00
	Only Charges]			
202. 0			0	0	95, 785, 391	0	202. 00
	1 2 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	1	-	'			

Health Financial Systems	TERRE HAUTE REGIONA	AL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0046	From 09/01/2022	Worksheet D Part V Date/Time Prepared

	TONNELVE OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		014. 13 0040	From 09/01/2022 To 08/31/2023	Part V Date/Time Pr 1/29/2024 8:	epared: 15 am
				e XIX	Hospi tal	Cost	
			sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coi ns.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7.00				
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	960, 613				50. 00
	05100 RECOVERY ROOM	0	,				51. 00
	05200 DELIVERY ROOM & LABOR ROOM	0	1,				52. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	550, 057				54. 00
	03630 ULTRA SOUND	0	83, 339	1			54. 01
54. 02	03440 MAMMOGRAPHY	0	33, 701				54. 02
55.00	05500 RADI OLOGY-THERAPEUTI C	0	138, 898				55. 00
56.00	05600 RADI 0I SOTOPE	0	126, 243				56. 00
57.00	05700 CT SCAN	0	222, 874				57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	49, 428				58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	58, 294				59. 00
60.00	06000 LABORATORY	0	775, 894				60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	119, 330)			62. 00
65.00	06500 RESPI RATORY THERAPY	0	21, 038	1			65. 00
66.00	06600 PHYSI CAL THERAPY	0	6, 086	,			66. 00
69.00	06900 ELECTROCARDI OLOGY	0	96, 524				69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	17, 553				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	429, 855				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	227, 310)			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1, 399, 003				73. 00
74.00	07400 RENAL DIALYSIS	0	1, 524				74.00
76.00	03950 LI THOTRI PSY	0	15, 732				76. 00
76. 01	03330 ENDOSCOPY	0	83, 569				76. 01
76. 02	03040 PRISION CLINIC	0	2, 912				76. 02
76. 03	03050 WOUND CARE	0	1				76. 03
	03060 OPI C	0	1				76. 04
	07700 ALLOGENEIC HSCT ACQUISITION	0	1	1			77. 00
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	1 0	2, 075, 828				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
200.00							200. 00
201.00	,		0,001,173				201.00
201.00	Only Charges		1				201.00
202.00		0	8, 081, 193				202. 00
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1		1			

Heal th	Financial Systems TERRE HAUTE REGION	NAI HOSPITAI	Inlie	u of Form CMS-2	2552_10
	ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0046	Peri od:	Worksheet D-1	1002 10
			From 09/01/2022 To 08/31/2023	Date/Time Pre 1/29/2024 8:1	
		Title XVIII	Hospi tal	PPS	o alli
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	excluding newborn)		13, 771	1. 00
2. 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			13, 771	2. 00
3. 00	Private room days (excluding swing-bed and observation bed da		ivate room days,	0	3. 00
	do not complete this line.		-		
4.00	Semi-private room days (excluding swing-bed and observation b		. 21 -6 +6	12, 927	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roreporting period	om days) through Decembe	r 31 or the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private ro	om davs) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	3 ,			
7.00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00
0.00	reporting period	da) -£t Db 3	1 -6 +1+	0	0.00
8. 00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after becember 3	Tor the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	4, 206	9. 00
	newborn days) (see instructions)	3 (4 4 4 5	J	,	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days)	0	10.00
11 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o		com dovo) often	0	11. 00
11. 00	December 31 of the cost reporting period (if calendar year, e		dom days) arter	U	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12. 00
	through December 31 of the cost reporting period		-		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr	ear, enter 0 on this iin	e) days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	am (exertaining swring bea	days)	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 servic	es through December 31 c	f the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
10.00	reporting period	es arter becomber 51 or	the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19. 00
	reporting period	S. D. J. S.			
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of t	he cost	0. 00	20. 00
21. 00	Teportrig perrou Total general inpatient routine service cost (see instruction	(2)		15, 633, 563	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line	0	22. 00
	5 x line 17)		5 1 1		
23. 00	9 11	31 of the cost reportin	g period (line 6	0	23. 00
24.00	x line 18)	ur 21 of the cost reporti	ng paried (line	0	24.00
24. 00	Swing-bed cost applicable to NF type services through Decembe $ 7 \times 1 $ ine 19)	a si or the cost reporti	ing period (iine	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)				
26. 00	Total swing-bed cost (see instructions)	(1) 21 11 2()		0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TIME 21 MINUS TIME 26)		15, 633, 563	27. 00
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		3 - 7	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00

	Cost Contar Decement on	PPS	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	13, 771	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13, 771	
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)	12, 927	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7.00
7.00	reporting period	U	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	4, 206	9. 00
40.00	newborn days) (see instructions)	0	40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	O	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
14 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	14. 00
14. 00 15. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days) Total nursery days (title V or XIX only)	0	1
16. 00	Nursery days (title V or XIX only)	0	
	SWING BED ADJUSTMENT	-	
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
17.00	reporting period	0.00	19.00
20.00	Medical d rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	15, 633, 563	
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)	0	23. 00
	x line 18)	_	
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
25 00	7 x line 19)	0	25 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25. 00
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	15, 633, 563	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00		0	
	Private room charges (excluding swing-bed charges)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	•
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00 0. 00	ı
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	15, 633, 563	1
	27 minus line 36)		ļ
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	4 405 65	00.05
38.00	Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38)	1, 135. 25	ı
39. 00 40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	4, 774, 862 0	1
	Total Program general inpatient routine service cost (line 39 + line 40)	4, 774, 862	

COMI O I	ATION OF INPATIENT OPERATING COST		Provi der CCN:		Peri od:	Worksheet D-1	2552-1
					From 09/01/2022 To 08/31/2023	Date/Time Pre 1/29/2024 8:1	pared:
	Cost Center Description	Total Inpatient Costl	Title XV Total A npatient Days Die	verage Per	Hospi tal Program Days	PPS Program Cost (col. 3 x col. 4)	
42 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00 0 0	5. 00	42.00
42.00	Intensive Care Type Inpatient Hospital Units	0	<u> </u>	0.0	0 0	0	42.00
43. 00 44. 00 45. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	6, 506, 944	3, 069	2, 120. 2	2 1, 155	2, 448, 854	43. 00 44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT Cost Center Description	936, 307	165	5, 674. 5	9 0	0	46. 00 47. 00
		-				1. 00	
48. 00 48. 01	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisition			line 10	column 1)	11, 155, 132 0	48. 00 48. 01
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.01)(see instruction	ons)	·	18, 378, 848	49.00
50. 00	Pass through costs applicable to Program inp.	atient routine s	services (from Wk	kst. D, sum	of Parts I and	758, 695	50.00
51.00	Pass through costs applicable to Program inp. and IV)	·	services (from	Wkst. D, s	um of Parts II	636, 438	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu- medical education costs (line 49 minus line	ding capital rel	ated, non-physic	cian anesth	etist, and	1, 395, 133 16, 983, 715	
F4 00	TARGET AMOUNT AND LIMIT COMPUTATION	- ,				0	F4 00
54. 00 55. 00	Program discharges Target amount per discharge					0 0. 00	
55. 01	Permanent adjustment amount per discharge					0.00	
55. 02 56. 00	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55					0. 00 0	
57. 00	Difference between adjusted inpatient operat		get amount (line	56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	!: FF <i>&</i>	****!			0 0. 00	
59. 00	updated and compounded by the market basket)						
60. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 from	n prior year cost	report, u	pdated by the	0. 00	60.00
61. 00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	ser of 50% of th	ne amount by whic	ch operating	g costs (line	0	61. 00
62. 00	enter zero. (see instructions) Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instrud	ctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Decer	nber 31 of the co	st reporti	ng period (See	0	64.00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	er 31 of the cost	reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line 6	64 plus line 65)((title XVII	l only); for	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31 of t	the cost re	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after De	ecember 31 of the	e cost repo	rting period	0	68.00
	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY,	AND ICF/IID ONL	-Y		0	
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c			(line 37)			70. 00 71. 00
71.00	Program routine service cost (line 9 x line		ne 70 ÷ 1111e 2)				72.00
73. 00	Medically necessary private room cost applic	able to Program		35)			73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient 26, line 45)		,	sheet B, P	art II, column		74. 00 75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	,					76. 00
77. 00 78. 00	Program capital -related costs (line 9 x line						77. 00 78. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovi der records)				79.00
80.00	Total Program routine service costs for comp	arison to the co		ine 78 min	us line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (83.00
84. 00	Program inpatient ancillary services (see in	structions)					84.00
85.00	Utilization review - physician compensation						85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ougn 85)				86.00
87. 00	Total observation bed days (see instructions)				844	
88. 00	Adjusted general inpatient routine cost per					1, 135. 25	88.00

Health Financial Systems T	ERRE HAUTE REG	ONAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 09/01/2022 To 08/31/2023		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	1, 852, 627	15, 633, 563	0. 11850	958, 151	113, 544	90.00
91.00 Nursing Program cost	0	15, 633, 563	0.00000	958, 151	0	91.00
92.00 Allied health cost	0	15, 633, 563	0.00000	958, 151	0	92.00
93.00 All other Medical Education	0	15, 633, 563	0.00000	958, 151	0	93. 00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0046		Worksheet D-1
	Component CCN: 15-S046	From 09/01/2022 To 08/31/2023	
	Title XVIII	Subprovi der -	PPS

		Title XVIII	Subprovi der - I PF	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			5, 083	1. 00
2.00	Inpatient days (including private room days, excluding swing-			5, 083	2.00
3.00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pr	Tvate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		5, 083	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roof		r 31 of the cost	0	5. 00
	reporting period				,
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room	m davs) through December	31 of the cost	0	7. 00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	a the Program (eveluding	swing bod and	378	9. 00
9.00	newborn days) (see instructions)	o the Frogram (excruding	swifig-bed and	370	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days)	0	10. 00
	through December 31 of the cost reporting period (see instruc				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en	nly (including private r	oom days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12. 00
	through December 31 of the cost reporting period	у (зак. н.д. р			
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar you Medically necessary private room days applicable to the Program			0	14. 00
15. 00	Total nursery days (title V or XIX only)	all (excluding swing-bed	uays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	s)		4, 909, 689	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	0	22. 00
	5 x line 17)	•			
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)			_	
25. 00	Swing-bed cost applicable to NF type services after December : x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 909, 689	27. 00
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		<u>, </u>		
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed cr	arges)	0	28. 00 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	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mil	nus lina 33)(saa instruc	etions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x li	, ,		0.00	
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 di	fferential (line	4, 909, 689	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			965. 90	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			365, 110	
40.00	Medically necessary private room cost applicable to the Program general inpatient routine service cost (Line 20)	,		0 265 110	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ 11110 40 <i>)</i>	I	365, 110	41.00

OMPUT.	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0046	Peri od:	Worksheet D-1	2552-1
			Component	CCN: 15-S046	From 09/01/2022 To 08/31/2023		pared:
			Ti +L	e XVIII	Subprovi der -	1/29/2024 8: 1 PPS	<u>5 am</u>
					I PF		
	Cost Center Description	Total Inpatient Cost	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
2. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Unit	0	(0. (00 0	0	42.0
3. 00	INTENSIVE CARE UNIT	0	(0.0	00 0	0	43.0
	CORONARY CARE UNIT						44. C
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. C
	NEONATAL INTENSIVE CARE UNIT	0	(0.0	00 0	0	1
	Cost Center Description					4.00	
8. 00	Program inpatient ancillary service cost (V	Wkst D-3 col 3	line 200)			1. 00 49, 350	48.0
8. 01	Program inpatient cellular therapy acquisit	tion cost (Workshe	et D-6, Part	III, line 10	, column 1)	0	1
9. 00	Total Program inpatient costs (sum of lines	41 through 48.01)(see instru	ctions)		414, 460	49. 0
0. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program in	nnatient routine s	ervices (fro	m Wkst D sur	m of Parts L and	33, 767	50. C
0. 00	III)	ipatront routino s	,c. v. cc3 (11 oi	with the second	ii or rures r una	00,707	00.0
1. 00	Pass through costs applicable to Program ir and IV) $\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \$	npatient ancillary	services (f	om Wkst. D, s	sum of Parts II	2, 491	51.0
2. 00	Total Program excludable cost (sum of lines	s 50 and 51)				36, 258	52.0
	Total Program inpatient operating cost excl	uding capital rel	ated, non-phy	ysician anesth	hetist, and	378, 202	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	9 52)					-
4. 00	Program di scharges					0	54.0
	Target amount per discharge					0.00	
	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	ruse only)				0.00	1
	Target amount (line 54 x sum of lines 55, 5					0.00	1
	Difference between adjusted inpatient opera	ating cost and tar	get amount (ine 56 minus	line 53)	0	
8. 00 9. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost ren	orting period	ending 1996	0.00	
7. 00	updated and compounded by the market basket		the cost rep	or tring period	charrig 1770,	0.00	07.0
0. 00	Expected costs (lesser of line 53 ÷ line 54	1, or line 55 from	prior year	cost report, ι	updated by the	0.00	60.0
1. 00	market basket) Continuous improvement bonus payment (if li 55.01, or line 59, or line 60, enter the Le 53) are less than expected costs (lines 54 enter zero. (see instructions)	esser of 50% of th	ne amount by w	which operatio	ng costs (line	0	61.0
2. 00	Relief payment (see instructions)					0	62.0
	Allowable Inpatient cost plus incentive pay	ment (see instruc	tions)			0	63.0
4. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine co	osts through Decem	her 31 of the	e cost reporti	ing period (See	0	64. 0
4. 00	instructions)(title XVIII only)	313 thi ough beech	10C1 31 01 11N	, cost reporti	riig perrou (see		04.0
5. 00	Medicare swing-bed SNF inpatient routine co	osts after Decembe	er 31 of the o	cost reportino	g period (See	0	65.0
6. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rout</pre>	tine costs (line 6	4 plus line	55)(title XVI	II only); for	0	66.0
	CAH, see instructions	·	·		3,	_	
7.00	Title V or XIX swing-bed NF inpatient routi (line 12 x line 19)	ne costs through	December 31 (or the cost re	aporting period	0	67.0
8. 00	Title V or XIX swing-bed NF inpatient routi	ne costs after De	ecember 31 of	the cost repo	orting period	0	68. 0
9. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	t routine costs (I	ine 67 + line	e 68)		0	69.0
	PART III - SKILLED NURSING FACILITY, OTHER	NURSING FACILITY,	AND ICF/IID	ONLY			
	Skilled nursing facility/other nursing faci Adjusted general inpatient routine service	,		, ,)		70.0
	Program routine service cost (line 9 x line		ne 70 ÷ 11ne	2)			72. 0
3. 00	Medically necessary private room cost appli	cable to Program					73.0
4. 00 5. 00	Total Program general inpatient routine ser Capital-related cost allocated to inpatient	•		•	Part II column		74. 0
5. 00	26, line 45)	routine service	COSTS (TIOIII)	TOT KSHEET B, I	art II, corumii		75.0
	Per diem capital -related costs (line 75 ÷ l						76.0
	Program capital-related costs (line 9 x lir Inpatient routine service cost (line 74 mir						77. (78. (
	Aggregate charges to beneficiaries for exce		ovi der recor	(st			79. (
	Total Program routine service costs for con	•	st limitatio	ו (line 78 mir	nus line 79)		80. (
1. 00 2. 00	Inpatient routine service cost per diem lin Inpatient routine service cost limitation (81. (
3. 00	Reasonable inpatient routine service costs	•					83. 0
4. 00	Program inpatient ancillary services (see i		>				84. 0
	Utilization review - physician compensation Total Program inpatient operating costs (su						85. C
	PART IV - COMPUTATION OF OBSERVATION BED PA					1	1
7. 00	Total observation bed days (see instruction					0] 87. C

Health Financial Systems	T	ERRE HAUTE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OF	PERATING COST		Provider CO		Peri od:	Worksheet D-1	
			Component (From 09/01/2022 To 08/31/2023	Date/Time Pre 1/29/2024 8:1	
			Title	XVIII	Subprovi der -	PPS	
					I PF		
Cost Center Des	scription						
						1. 00	
89.00 Observation bed cost	(line 87 x line 88) (see	e instructions)		-		0	89. 00
Cost Center Des	scri pti on	Cost	Routine Cost	column 1 ÷	Total	Observati on	
			(from line 21)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
		1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERY	VATION BED PASS THROUGH C	OST					
90.00 Capital -related cost		454, 042	4, 909, 689	0. 09247	9 0	0	90.00
91.00 Nursing Program cost		0	4, 909, 689	0. 00000	o o	0	91.00
92.00 Allied health cost		0	4, 909, 689	0. 00000	o o	0	92.00
93.00 All other Medical Ed	ucati on	0	4, 909, 689	0. 00000	0 0	0	93. 00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0046		Worksheet D-1
	Component CCN: 15-T046	From 09/01/2022 To 08/31/2023	
	Title XVIII	Subprovi der -	PPS

		litle XVIII	I RF	PPS	
	Cost Center Description		TRI		
	DADT I ALL DROW DED COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		2, 111	1. 00
2.00	Inpatient days (including private room days, excluding swing-	ped and newborn days)		2, 111	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	ivate room days,	0	3. 00
4 00	do not complete this line.			0.444	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		r 21 of the cost	2, 111 0	4. 00 5. 00
3.00	reporting period	om days) thi dagii becembe	i 31 of the cost	O	3.00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private roor reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roor	m davs) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)			_	
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	1, 230	9. 00
10.00	newborn days) (see instructions)	alv. (i poludi po privoto p	voom dovo)	0	10 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruc-	tions)	ooiii days)	U	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	(only (including privat	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	Conty (including privat	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye			Ü	
14. 00	Medically necessary private room days applicable to the Progra	am (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) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
	reporting period	G			
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period			2.22	
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	5)		3, 143, 024	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	0	
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)	•			
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 143, 024	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		,	_	
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed ch	arges)	0	28. 00 29. 00
30. 00	Semi - pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	22) (+	+:>	0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin		tions)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	10 31)		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	3, 143, 024	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 488. 88	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		1, 831, 322	
40.00	Medically necessary private room cost applicable to the Progra			0	
41. 00	Total Program general inpatient routine service cost (line 39	+ IINE 40)		1, 831, 322	41.00

OMPUT.	Financial Systems ATION OF INPATIENT OPERATING COST		NAL HOSPITAL Provider C	CN: 15-0046	Peri od:	worksheet D-1	
			Component	CCN: 15-T046	From 09/01/2022 To 08/31/2023		pared:
			Ti +1 4	e XVIII	Subprovi der -	1/29/2024 8: 1 PPS	5 am
					l RF		
	Cost Center Description	Total Inpatient Cost	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
2. 00	NURSERY (title V & XIX only)	0		0.	00 0	0	42. 0
3. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	S 0	(0. (00 0	0	43.0
	CORONARY CARE UNIT			,			44.0
	BURN INTENSIVE CARE UNIT						45. C
	SURGICAL INTENSIVE CARE UNIT	o	C	0. (00	0	46. C
7.00	NEONATAL INTENSIVE CARE UNIT Cost Center Description	<u> </u>		η	00	U	47.0
	·					1. 00	
8. 00	Program inpatient ancillary service cost (W Program inpatient cellular therapy acquisit	kst. D-3, col. 3,	line 200)	III lina 10	oolumn 1)	1, 027, 326	
	Total Program inpatient certurar therapy acquisit				COLUMN I)	0 2, 858, 648	
	PASS THROUGH COST ADJUSTMENTS	- U	,	,		27 0007 0 10	
0. 00	Pass through costs applicable to Program in	patient routine s	ervices (from	n Wkst. D, sur	m of Parts I and	207, 206	50. C
1. 00	<pre>III) Pass through costs applicable to Program in</pre>	natient ancillary	services (fr	om Wkst D	sum of Parts II	44, 990	51.0
00	and IV)	patront unorridry	301 11 003 (11	om mot. D _i :	Jun Or Turts II	74, 770] 31.0
2. 00	Total Program excludable cost (sum of lines					252, 196	1
3. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		aτed, non-phy	sıcıan anestl	netist, and	2, 606, 452	53.0
	TARGET AMOUNT AND LIMIT COMPUTATION	UL)			_		1
	Program di scharges					0	
	Target amount per discharge Permanent adjustment amount per discharge					0. 00 0. 00	1
	Adjustment amount per discharge (contractor	use only)				0.00	1
	Target amount (line 54 x sum of lines 55, 59					0	1
	Difference between adjusted inpatient opera	ting cost and tar	get amount (I	ine 56 minus	line 53)	0	
8. 00 9. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost rong	orting ported	anding 1006	0.00	
7. 00	updated and compounded by the market basket		the cost repo	n tring perrou	enaring 1770,	0.00	37. 0
0. 00	Expected costs (lesser of line 53 ÷ line 54)		prior year o	cost report, u	updated by the	0.00	60.0
1. 00	market basket) Continuous improvement bonus payment (if lime 55.01, or line 59, or line 60, enter the less) are less than expected costs (lines 54:	sser of 50% of th	e amount by w	which operatio	ng costs (line	0	61. 0
	enter zero. (see instructions)		g	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-,,		
	Relief payment (see instructions)		±:>			0	1
3. 00	Allowable Inpatient cost plus incentive pays PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instruc	tions)			0	63.0
4. 00	Medicare swing-bed SNF inpatient routine co	sts through Decem	ber 31 of the	e cost reporti	ng period (See	0	64. (
F 00	instructions) (title XVIII only)	ata aftan Dagamba	5 21 of +bo o	ant manamtin	a norted (Coo		45.0
5. 00	Medicare swing-bed SNF inpatient routine communications)(title XVIII only)	sts after Decembe	r 31 or the c	cost reporting	g perroa (see	0	65.0
6. 00	Total Medicare swing-bed SNF inpatient rout	ine costs (line 6	4 plus line 6	55)(title XVI	<pre>II only); for</pre>	0	66.0
7. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routing	no costs through	Docombon 21	of the east =	oporting period	0	67.0
7.00	(line 12 x line 19)	ne costs through	December 31 (of the cost is	eporting perrou	0	07.0
8. 00	Title V or XIX swing-bed NF inpatient routi	ne costs after De	cember 31 of	the cost repo	orting period	0	68.0
9. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (L	ine 67 + line	- 68)		0	69.0
00	PART III - SKILLED NURSING FACILITY, OTHER N]
	Skilled nursing facility/other nursing faci	,		` ')		70.0
	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne 70 ÷ line	2)			71.0
	Medically necessary private room cost applic		(line 14 x li	ne 35)			73. 0
4. 00	Total Program general inpatient routine serv	vice costs (line	72 + line 73))			74.0
5. 00	Capital-related cost allocated to inpatient	routine service	costs (from V	Vorksheet B, I	Part II, column		75.0
6. 00	26, line 45) Per diem capital-related costs (line 75 ÷ 1)	ine 2)					76. (
7. 00	Program capital-related costs (line 9 x line	e 76)					77. (
	Inpatient routine service cost (line 74 min		ovi dos sees	46)			78. (
	Aggregate charges to beneficiaries for exceptional Program routine service costs for company to the cost of the co			*.	nus line 79)		79. 0
	Inpatient routine service cost per diem lim			. (, , ,		81. (
2. 00	Inpatient routine service cost limitation (line 9 x line 81)					82. (
3.00	Reasonable inpatient routine service costs	•)				83.0
4. 00 5. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		s)				84. C
	Total Program inpatient operating costs (sur						86.0
7 0-	PART IV - COMPUTATION OF OBSERVATION BED PAS						-
7. 00	Total observation bed days (see instructions	S)				0	87.0

Heal th Financi	al Systems	TERRE HAUTE REGI	ONAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION O	F INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
			Component (From 09/01/2022 To 08/31/2023		
			Title	XVIII	Subprovi der -	PPS	
		_			I RF		
C	cost Center Description						
						1.00	
89.00 Observa	ation bed cost (line 87 x line 88) (se	e instructions)				0	89. 00
C	cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
			(from line 21)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
		1.00	2. 00	3.00	4. 00	5. 00	
COMPUTA	ATION OF OBSERVATION BED PASS THROUGH	COST			<u> </u>		
90.00 Capi tal	-related cost	355, 619	3, 143, 024	0. 11314	5 0	0	90.00
91.00 Nursi no	g Program cost	0	3, 143, 024	0. 00000	o o	0	91.00
92.00 Allied	heal th cost	0	3, 143, 024	0. 00000	o o	0	92.00
93.00 All oth	ner Medical Education	0	3, 143, 024	0.00000	0 0	0	93. 00

		HAUTE REGIONAL			u of Form CMS-2	
COMPUI	ATION OF INPATIENT OPERATING COST	1	Provider CCN: 15-0046	Peri od: From 09/01/2022	Worksheet D-1	
				To 08/31/2023		
			Title XIX	Hospi tal	1/29/2024 8: 1 Cost	<u>5 am</u>
	Cost Center Description			noopi tai	3031	
					1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS					+
1. 00	Inpatient days (including private room days and s	swing-bed days,	excluding newborn)		13, 771	1.00
2. 00	Inpatient days (including private room days, excl				13, 771	
3. 00	Private room days (excluding swing-bed and observ	vation bed days	s). If you have only pr	rivate room days,	0	3.00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and c	observation hed	l days)		12, 927	4.00
5. 00	Total swing-bed SNF type inpatient days (including			er 31 of the cost	12, 727	
	reporting period	5 1	,,,,			
. 00	Total swing-bed SNF type inpatient days (includir		n days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on the Total swing-bed NF type inpatient days (including		days) through December	31 of the cost	0	7.00
. 00	reporting period	ig private room	days) through becember	31 Of the cost	O	/. 00
. 00	Total swing-bed NF type inpatient days (including		days) after December 3	31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on the				050	
. 00	Total inpatient days including private room days newborn days) (see instructions)	applicable to	the Program (excluding	g swing-bed and	952	9.00
0. 00	Swing-bed SNF type inpatient days applicable to t	title XVIII onl	y (including private m	room days)	0	10.00
	through December 31 of the cost reporting period					
1. 00	Swing-bed SNF type inpatient days applicable to t December 31 of the cost reporting period (if cale			room days) after	0	11.00
12. 00	Swing-bed NF type inpatient days applicable to ti			e room davs)	0	12.00
	through December 31 of the cost reporting period					
13. 00	Swing-bed NF type inpatient days applicable to ti				0	13.00
14. 00	after December 31 of the cost reporting period (i Medically necessary private room days applicable				0	14.00
15. 00	Total nursery days (title V or XIX only)	to the rrogram	(exercaring suring bea	uays)	318	
16. 00	Nursery days (title V or XIX only)				0	16. 00
17.00	SWING BED ADJUSTMENT				0.00	17.00
17. 00	Medicare rate for swing-bed SNF services applicate reporting period	ble to services	through December 31 (or the cost	0. 00	17.00
8. 00	Medicare rate for swing-bed SNF services applicate	ble to services	after December 31 of	the cost	0. 00	18.00
	reporting period					
9. 00	Medicaid rate for swing-bed NF services applicable reporting period	le to services	through December 31 of	the cost	0. 00	19.00
20. 00	Medicaid rate for swing-bed NF services applicabl	le to services	after December 31 of 1	he cost	0. 00	20.00
	reporting period					
21. 00	Total general inpatient routine service cost (see				15, 633, 563	1
22. 00	Swing-bed cost applicable to SNF type services th 5×1 ine 17)	hrough December	31 of the cost report	ing period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services af	fter December 3	31 of the cost reportir	na period (line 6	0	23. 00
	x line 18)			.9		
24. 00	Swing-bed cost applicable to NF type services thr	rough December	31 of the cost reporti	ng period (line	0	24.00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services aft	tar Dacambar 31	of the cost reporting	neriod (line 8	0	25. 00
.5. 50	x line 20)	to. December 31	o. the cost reporting	, por roa (11110 0	o l	25.00
26. 00	Total swing-bed cost (see instructions)				0	
27. 00	General inpatient routine service cost net of swi	ing-bed cost (I	ine 21 minus line 26)		15, 633, 563	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (exclud	dina swina-bod	and observation had ob	narnes)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges		and object valued bed of	iai gos)	0	
30. 00	Semi -private room charges (excluding swing-bed ch	harges)			0	30.00
31. 00	General inpatient routine service cost/charge rat	•	line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ l	1100 21			0 00	32.00

5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)		
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	952	9. 00
	newborn days) (see instructions)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	_	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
40.00	through December 31 of the cost reporting period		40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
14.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	14 00
	Medically necessary private room days applicable to the Program (excluding swing-bed days)	- 1	14. 00
15. 00	Total nursery days (title V or XIX only)	318	
16. 00	Nursery days (title V or XIX only)	U	16. 00
17 00	SWING BED ADJUSTMENT	0.00	17. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17.00
18. 00	reporting period Medicare rate for swing had SNE services applicable to services after December 21 of the cost	0.00	18. 00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
19.00	reporting period	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
20.00	reporting period	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	15, 633, 563	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	
22.00	5 x line 17)	J	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
	7 x line 19)		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	15, 633, 563	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
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	15, 633, 563	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
	Adjusted general inpatient routine service cost per diem (see instructions)	1, 135. 25	
	Program general inpatient routine service cost (line 9 x line 38)	1, 080, 758	
	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, 080, 758	41. 00

	Financial Systems TI ATION OF INPATIENT OPERATING COST	ERRE HAUTE REGI	ONAL HOSPITAL Provider CC	N: 15-0046	Peri od:	wof Form CMS-2 Worksheet D-1	
					From 09/01/2022 To 08/31/2023		pared:
	Cost Center Description	Total Inpatient Cost	Title Total Inpatient Days	e XIX Average Per Diem (col. 1 col. 2)	Hospital Program Days	Cost Program Cost (col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1. 00 391, 115	2.00	3. 00 1, 229. 9	4.00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	391, 115	310	1, 229. 9	0	0	42.00
43. 00 44. 00 45. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	6, 506, 944	3, 069	2, 120. 2	0	0	43. 00 44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	907, 888	165	5, 502. 3	5 0	0	46. 00
	Cost Center Description					1. 00	
48. 00 48. 01	Program inpatient ancillary service cost (Wks Program inpatient cellular therapy acquisition			II lino 10	column 1)	7, 970, 240 0	1
49. 00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	11 through 48.0	1)(see instruct	ti ons)	·	9, 050, 998	49. 00
50. 00	Pass through costs applicable to Program inpa	ntient routine	services (from	Wkst. D, sum	of Parts I and	0	50.00
51.00	Pass through costs applicable to Program inpa and IV)		y services (fro	om Wkst. D, s	um of Parts II	0	51.00
52. 00 53. 00	Total Program excludable cost (sum of lines 5 Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5	ling capital re	lated, non-phys	sician anesth	etist, and	0	
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00	Target amount per discharge					0.00	55. 00
55. 01 55. 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor u	ico only)				0. 00 0. 00	1
56. 00	Target amount (line 54 x sum of lines 55, 55.					0.00	1
57. 00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (li	ne 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54, c	or line EE from	the cost repor	sting poriod	anding 1004	0 0. 00	58. 00 59. 00
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,		•	0.	0	0.00	
61. 00	market basket) Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x	ser of 50% of t	he amount by wh	nich operatin	g costs (line	0	61.00
62. 00	enter zero. (see instructions) Relief payment (see instructions)	00), 01 1 % 01	the target and	Junt (Title 30), otherwise	0	62.00
63. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	s through Dece	mber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	s after Decemb	er 31 of the co	ost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routir CAH, see instructions	ne costs (line	64 plus line 65	5)(title XVII	I only); for	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	costs through	December 31 of	f the cost re	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	costs after D	ecember 31 of 1	the cost repo	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU	RSING FACILITY	, AND ICF/IID (NLY		0	
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co						70. 00 71. 00
71.00	Program routine service cost (line 9 x line 7	,	THE 70 - TITLE 2	-)			71.00
73. 00	Medically necessary private room cost applica	nble to Program		ne 35)			73.00
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r 26, line 45)	•		orksheet B, P	art II, column		74. 00 75. 00
76. 00	Per diem capital-related costs (line 75 ÷ lir						76. 00
77.00	Program capital-related costs (line 9 x line	,					77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovi der records	5)			78. 00 79. 00
80.00	Total Program routine service costs for compa	rison to the c			us line 79)		80.00
81.00	Inpatient routine service cost per diem limit		`				81.00
82. 00 83. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s		* .				82. 00 83. 00
84. 00	Program inpatient ancillary services (see ins		~ <i>,</i>				84. 00
85. 00	Utilization review - physician compensation (see instructio					85. 00
86. 00	Total Program inpatient operating costs (sum		rough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					844	87. 00
88. 00	Adjusted general inpatient routine cost per o	liem (line 27 ÷	line 2)			1, 135. 25	1
89.00	Observation bed cost (line 87 x line 88) (see	e instructions)				958, 151	89.00

Health Financial Systems	TERRE HAUTE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 09/01/2022 To 08/31/2023	Date/Time Pre	pared:
					1/29/2024 8: 1	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 852, 627	15, 633, 563	0. 11850	3 958, 151	113, 544	90. 00
91.00 Nursing Program cost	0	15, 633, 563	0.00000	0 958, 151	0	91.00
92.00 Allied health cost	0	15, 633, 563	0.00000	0 958, 151	0	92.00
93.00 All other Medical Education	0	15, 633, 563	0.00000	0 958, 151	0	93. 00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0046	Peri od: From 09/01/2022	Worksheet D-1
	Component CCN: 15-S046		
	Title XIX	Subprovi der -	Cost

		II tie xix	I PF	COST	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		5, 083	1. 00
2.00	Inpatient days (including private room days, excluding swing-b			5, 083	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	s). If you have only pri	vate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		5, 083	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room		31 of the cost	0, 000	5. 00
	reporting period	3 ,			
6. 00	Total swing-bed SNF type inpatient days (including private room	om days) after December 3	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
7.00	reporting period	r days) through become	31 of the cost	O	7.00
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 31	of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)			2 222	0.00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	swing-bed and	3, 292	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days)	0	10. 00
	through December 31 of the cost reporting period (see instruct	i ons)			
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Comy (Therdaing private	, room days)	O	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13.00
14 00	after December 31 of the cost reporting period (if calendar ye	· · · · · · · · · · · · · · · · · · ·	,	0	14 00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	dii (excluding swing-bed o	iays)	-	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	the cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0.00	18. 00
	reporting period				
19. 00	Medical drate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20. 00
	reporting period			2.22	
21. 00	Total general inpatient routine service cost (see instructions			4, 902, 711	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost reporti	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reportin	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)			_	
26. 00	Total swing-bed cost (see instructions)	(1.1 0.1 1.1 0.1)		0	
27. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		4, 902, 711	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	irges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 + line 3)	- line 28)		0. 000000 0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruct	i ons)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	and arivate ream east -!! f	forential (1:	4 002 711	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	anu private room cost dit	recential (TIME	4, 902, 711	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see			964. 53	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program			3, 175, 233 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39)			3, 175, 233	
				'	

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST		Provi der (CCN: 15-0046	Peri od:	Worksheet D-1	2552-1
			Component	CCN: 15-S046	From 09/01/2022 To 08/31/2023		pared:
			Ti +	le XIX	Subprovi der -	1/29/2024 8:1 Cost	5 am
					l PF		
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Pers Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
2. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Unit	0		0. (00 0	0	42. 0
3. 00	INTENSIVE CARE UNIT	0		0. 0	00 00	0	43.0
4. 00	CORONARY CARE UNIT						44.0
5. 00 5. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 0 46. 0
7. 00	NEONATAL INTENSIVE CARE UNIT	0		0.0	00	0	
	Cost Center Description	·		•		4.00	
3. 00	Program inpatient ancillary service cost (W	lkst D-3 col 3	line 200)			1. 00 437, 366	48. 0
	Program inpatient cellular therapy acquisit	ion cost (Workshe	et D-6, Part	III, line 10,	column 1)	0	
9. 00	Total Program inpatient costs (sum of lines	41 through 48.0°	I)(see instru	ctions)		3, 612, 599	49. 0
0. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program in	natient routine «	services (fro	m Wkst D sur	n of Parts I and	0	50.0
3. 00	III)	patrent routine s	services (110	iii wkst. b, sai	ii Or Tarts r and		30.0
1. 00	Pass through costs applicable to Program in and IV) $$		/ services (f	rom Wkst. D, s	sum of Parts II	0	
2. 00 3. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost excl		ated non nh	vei ei an anoeti	notict and	0	
J. 00	medical education costs (line 49 minus line		atea, non-pn		ocist, and] 33.0
1 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 0
	Target amount per discharge					0.00	
5. 01	Permanent adjustment amount per discharge					0.00	55.0
	Adjustment amount per discharge (contractor					0.00	
5. 00 7. 00	Target amount (line 54 x sum of lines 55, 5 Difference between adjusted inpatient opera		rget amount (line 56 minus	line 53)	0 0	
3. 00	Bonus payment (see instructions)	9	g (0	1
9. 00	Trended costs (lesser of line 53 ÷ line 54,		the cost rep	orting period	endi ng 1996,	0.00	59.0
0. 00	updated and compounded by the market basket Expected costs (lesser of line 53 ÷ line 54		n prior year	cost report, (updated by the	0.00	60. C
1. 00	market basket) Continuous improvement bonus payment (ifli	ne 53 ÷ line 54 i	s less than	the lowest of	lines 55 plus	0	61. 0
	55.01, or line 59, or line 60, enter the le 53) are less than expected costs (lines 54 enter zero. (see instructions)						
	Relief payment (see instructions)					0	
3. 00	Allowable Inpatient cost plus incentive pay PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instruc	ctions)			0	63. C
4. 00	Medicare swing-bed SNF inpatient routine co	sts through Decer	mber 31 of th	e cost reporti	ng period (See	0	64.0
- 00	instructions)(title XVIII only)		21 -6 +1				/
5. 00	Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	sts after Decembe	er 31 or the	cost reporting	g period (See	0	65.0
5. 00	Total Medicare swing-bed SNF inpatient rout	ine costs (line 6	64 plus line	65)(title XVI	I only); for	0	66.0
7. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31	nf the cost r	enorting period	0	67. 0
, . 00	(line 12 x line 19)	costs till ough	Pecelinet 31	or the cost It	Sporting period		37.0
3. 00	Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)	ne costs after De	ecember 31 of	the cost repo	orting period	0	68. 0
9. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER					0	69. 0
	Skilled nursing facility/other nursing faci	lity/ICF/IID rout	ine service	cost (line 37))		70. C
1. 00 2. 00	Adjusted general inpatient routine service Program routine service cost (line 9 x line		ne 70 ÷ line	2)			71. C
	Medically necessary private room cost appli		(line 14 x l	ine 35)			73.0
4. 00	Total Program general inpatient routine ser	vice costs (line	72 + line 73)			74.0
5. 00	Capital-related cost allocated to inpatient 26, line 45)		costs (from	Worksheet B, I	Part II, column		75.0
5. 00 7. 00	Per diem capital-related costs (line 75 ÷ l Program capital-related costs (line 9 x lin						76. 0 77. 0
	Inpatient routine service cost (line 74 min						78.0
9. 00	Aggregate charges to beneficiaries for exce	ss costs (from pr		*.			79.0
). 00 I. 00	Total Program routine service costs for com	•	ost limitatio	n (line 78 mi	nus line 79)		80. C
. 00	Inpatient routine service cost per diem lim Inpatient routine service cost limitation ()				81.0
3. 00	Reasonable inpatient routine service costs	(see instructions					83.0
4. 00	Program inpatient ancillary services (see i))				84.0
5. 00 5. 00	Utilization review - physician compensation Total Program inpatient operating costs (su						85. 0 86. 0
	PART IV - COMPUTATION OF OBSERVATION BED PA		g 00)]
7. 00	Total observation bed days (see instruction					0	87.0

Health Fin	nancial Systems	TERRE HAUTE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATIO	ON OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
			Component (CCN: 15-S046	From 09/01/2022 To 08/31/2023	Date/Time Pre 1/29/2024 8:1	
			Ti tl	e XIX	Subprovi der -	Cost	
					I PF		
	Cost Center Description						
						1. 00	
89.00 Obs	servation bed cost (line 87 x line 88) (se	e instructions)				0	89. 00
	Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
			(from line 21)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
		1.00	2. 00	3.00	4. 00	5. 00	
COM	IPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Cap	oital-related cost	454, 042	4, 902, 711	0. 09261	0 0	0	90.00
91. 00 Nur	rsing Program cost	0	4, 902, 711	0. 00000	0 0	0	91.00
92. 00 AI I	ied health cost	0	4, 902, 711	0. 00000	0	0	92.00
93. 00 AII	other Medical Education	0	4, 902, 711	0. 00000	0	0	93. 00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0046	Peri od: From 09/01/2022	Worksheet D-1
	Component CCN: 15-T046	To 08/31/2023	Date/Time Prepared: 1/29/2024 8:15 am
	Title XIX	Subprovi der -	Cost

		II tie xix	I RF	COST	
	Cost Center Description		-		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		2, 111	1.00
2.00	Inpatient days (including private room days, excluding swing-b			2, 111	2. 00
3. 00	Private room days (excluding swing-bed and observation bed day	(s). If you have only pri	vate room days,	0	3. 00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		2, 111	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	
	reporting period			ا	,
6.00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after December 3	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
	reporting period	, .,			
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 31	of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (eycluding	swing_hed and	88	9. 00
7. 00	newborn days) (see instructions)	the rrogram (excruding	Swifig-bed and	00	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11 00	through December 31 of the cost reporting period (see instruct				11 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)	oom days) arter	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ve			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra	· · · · · · · · · · · · · · · · · · ·	<i>'</i>	0	14. 00
15. 00	Total nursery days (title V or XIX only)	(ener daring eniring bed e	,		15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWING BED ADJUSTMENT			2.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions			3, 143, 024	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost reporti	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
20.00	x line 20)	or or the cost reporting	perrou (rriie o		20.00
26. 00	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		3, 143, 024	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	rges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)	and executation sed end	900)	Ö	
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	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruct	ions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin			0. 00	1
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 a	and private room cost dif	ferential (line	3, 143, 024	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 488. 88	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			131, 021	
40.00	Medically necessary private room cost applicable to the Program general inpatient routine service cost (Line 20)			121 021	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ 11116 40)	ļ	131, 021	41.00

COMPUI	ATION OF INPATIENT OPERATING COST		Pi	rovider C	CN: 15-0046	Peri od:	Worksheet D-1	
			Co	omponent	CCN: 15-T046	From 09/01/2022 To 08/31/2023		pared:
				Ti +1	le XIX	Subprovi der -	1/29/2024 8:1 Cost	5 am
					_	IRF		
	Cost Center Description	Total Inpatient Cost		Fotal ient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00		2. 00	3.00	4. 00	5. 00	
12.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units		0	C	0. (00 0	0	42. 0
13. 00	INTENSIVE CARE UNIT		o	C	0. (00 0	0	43.0
4. 00	CORONARY CARE UNIT							44. 0
15. 00 16. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT							45. 0 46. 0
17. 00	NEONATAL INTENSIVE CARE UNIT		o	C	0.0	00 0	0	1
	Cost Center Description	•					4.00	
18. 00	Program inpatient ancillary service cost (Wk	st D-3 col	3 lin	e 200)			1. 00 216, 483	48. 0
8. 01	Program inpatient cellular therapy acquisiti	on cost (Works	sheet D	-6, Part	III, line 10	, column 1)	0	1
9. 00	Total Program inpatient costs (sum of lines	41 through 48.	01) (se	e instruc	ctions)		347, 504	49. 0
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	servi	ces (from	n Wkst D su	m of Parts L and	0	50.0
0. 00	III)	atrent routine	301 11	CC3 (110II	i wkst. D, sui	iii or rarts r and		30.00
51. 00	Pass through costs applicable to Program inp and IV)		ary ser	vices (fr	om Wkst. D,	sum of Parts II	0	
52. 00 53. 00	Total Program excludable cost (sum of lines		l a t a d	non nh	veieian anaeti	hotist and	0	
3.00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		егатео	, non-pny	jarcian anesti	netist, and		J 33. U
4 00	TARGET AMOUNT AND LIMIT COMPUTATION							
4. 00 5. 00	Program discharges Target amount per discharge						0.00	
5. 01	Permanent adjustment amount per discharge						0.00	1
	Adjustment amount per discharge (contractor						0.00	
6. 00 7. 00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat			amount (I	ine 56 minus	line 53)	0 0	
8. 00	Bonus payment (see instructions)	riig cost and t	tui go t	amourt (i	The co minds	11116 00)	ő	1
9. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 fro	om the	cost repo	orting period	endi ng 1996,	0.00	59. 0
0. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line 55 fr	om pri	or vear o	cost report.	updated by the	0.00	60.0
1. 00	market basket) Continuous improvement bonus payment (if lin	e 53 ÷ line 54	4 is le	ss than t	the lowest of	lines 55 plus	0	
	55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)							
2. 00	Relief payment (see instructions)						0	62.0
3. 00	Allowable Inpatient cost plus incentive paym	ent (see instr	ruction	s)			0	63.0
4. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dec	cember	31 of the	e cost report	ina period (See	0	64. C
	instructions)(title XVIII only)	· ·			•		_	
5. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decem	mber 31	of the c	cost reporting	g period (See	0	65. C
6. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	e 64 pl	us line 6	55)(title XVI	II only); for	0	66.0
7. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	a costs throug	nh Doco	mhar 21 c	of the cost r	enorting period	0	67. C
7.00	(line 12 x line 19)	e costs throug	gii bece	aliber 31 C	n the cost is	eportring perrou	0	07.0
8. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after	Decemb	er 31 of	the cost repo	orting period	0	68. 0
9. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N						0	69.0
	Skilled nursing facility/other nursing facil	,			,)		70.0
1. 00 2. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		(line 7	0 ÷ line	2)			71. C
3. 00	Medically necessary private room cost applic		am (lin	e 14 x li	ne 35)			73. C
4. 00	Total Program general inpatient routine serv	•				D+ 11 '		74.0
5. 00	Capital-related cost allocated to inpatient 26, line 45)	routine servic	ce cost	s (from V	vorksheet B, I	Part II, column		75. C
6. 00	Per diem capital-related costs (line 75 ÷ li							76. C
7. 00	Program capital -related costs (line 9 x line							77.0
8. 00 9. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		provi d	er record	(ab			78. C
0. 00	Total Program routine service costs for comp	•	•		*.	nus line 79)		80.0
1. 00	Inpatient routine service cost per diem limi		24)					81.0
2. 00 3. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (· ·					82. C
4. 00	Program inpatient ancillary services (see in	structions)	ŕ					84. 0
5. 00	Utilization review - physician compensation			05)				85. 0
6. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS			85)			<u> </u>	86.0
7. 00	Total observation bed days (see instructions						0	1
8.00	Adjusted general inpatient routine cost per	diem (line 27	÷ line	2)			0.00	88. (

Health Financial S	Systems T	ERRE HAUTE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INF	PATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
			Component (From 09/01/2022 To 08/31/2023	Date/Time Pre 1/29/2024 8:1	
			Ti tl	e XIX	Subprovi der -	Cost	
					I RF		
Cost	Center Description						
						1. 00	
89.00 Observation	n bed cost (line 87 x line 88) (se	e instructions)				0	89. 00
Cost	Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
			(from line 21)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
		1.00	2.00	3.00	4. 00	5. 00	
COMPUTATI ON	OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capi tal -rel	ated cost	355, 619	3, 143, 024	0. 11314	5 0	0	90.00
91.00 Nursing Pro	ogram cost	0	3, 143, 024	0. 00000	0 0	0	91.00
92.00 Allied heal		0	3, 143, 024	0. 00000	0 0	0	92.00
93.00 All other N	Medical Education	0	3, 143, 024	0.00000	0 0	0	93. 00

IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0046	Peri From To	od: 09/01/2022 08/31/2023	Worksheet D-3 Date/Time Pre 1/29/2024 8:1	pared
	Ti tl e	XVIII	H	Hospi tal	PPS	
Cost Center Description		Ratio of Cos To Charges	st	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1. 00		2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		l				
0.00 03000 ADULTS & PEDI ATRI CS				6, 764, 288		30.
. 00 03100 I NTENSI VE CARE UNI T				5, 094, 688		31.
0.00 02060 NEONATAL INTENSIVE CARE UNIT				0		35.
0. 00 04000 SUBPROVI DER - 1 PF				0		40.
. 00 04100 SUBPROVI DER - I RF				0		41.
04300 NURSERY						43.
ANCILLARY SERVICE COST CENTERS						
0.00 05000 OPERATING ROOM		0. 0952		16, 029, 023	1, 526, 043	1
.00 05100 RECOVERY ROOM		0. 0497		1, 269, 773	63, 214	1
05200 DELIVERY ROOM & LABOR ROOM		0. 6639		0	0	
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1902		1, 344, 497	255, 733	1
. 01 03630 ULTRA SOUND		0. 0919		425, 811	39, 141	1
O2 03440 MAMMOGRAPHY		0. 1647		0	0	
6. 00 05500 RADI OLOGY-THERAPEUTI C		0. 0970		96, 714	9, 389	
. 00 05600 RADI 0I SOTOPE		0. 0580		84, 496	4, 906	
7. 00 05700 CT SCAN		0. 0157	97	6, 936, 405	109, 574	
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 0520	73	1, 144, 110	59, 577	
0. 00 05900 CARDI AC CATHETERI ZATI ON		0. 0560		5, 710, 581	320, 267	59.
0. 00 06000 LABORATORY		0. 0615		11, 506, 324	707, 754	60.
06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 4438	78	1, 597, 076	708, 907	62.
6. 00 06500 RESPI RATORY THERAPY		0. 1173	29	6, 201, 410	727, 605	65.
0. 00 06600 PHYSI CAL THERAPY		0. 1737	57	2, 122, 134	368, 736	66.
0. 00 06900 ELECTROCARDI OLOGY		0. 0487	88	4, 934, 982	240, 768	69.
0. 00 07000 ELECTROENCEPHALOGRAPHY		0. 0900	69	190, 632	17, 170	70.
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1300	32	10, 057, 178	1, 307, 755	71.
07200 MPL. DEV. CHARGED TO PATIENTS		0. 1872	45	3, 274, 684	613, 168	72.
07300 DRUGS CHARGED TO PATIENTS		0. 1159	46	27, 027, 401	3, 133, 719	73.
. 00 07400 RENAL DI ALYSI S		0. 6650	33	446, 908	297, 209	74.
. 00 03950 LI THOTRI PSY		0. 0931	07	0	0	76.
0. 01 03330 ENDOSCOPY		0. 0518		911, 367	47, 291	
0.02 03040 PRISION CLINIC		0. 8519	97	o	0	76.
0. 03 03050 WOUND CARE		0. 2501	93	19, 552	4, 892	76.
o. 04 03060 0PI C		0. 1734	15	19, 619	3, 402	76.
07700 ALLOGENEIC HSCT ACQUISITION		0.0000	00	0	0	77.
OUTPATIENT SERVICE COST CENTERS						
. 00 09100 EMERGENCY		0. 0837	61	6, 434, 993	539, 001	91.
.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 0467	28	47, 683	49, 911	92.
0.00 Total (sum of lines 50 through 94 and 96 through 98)				107, 833, 353	11, 155, 132	200.
11.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)			o		201.
Net charges (line 200 minus line 201)				107, 833, 353		202.

NPATIENT ANCILLARY SERVICE COST APPORTIONME			Peri od: From 09/01/2022	Worksheet D-3	
	Component	CCN: 15-S046	To 08/31/2023	Date/Time Pre 1/29/2024 8:1	
	Ti tl	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description		Ratio of Cost To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			1
0.00 03000 ADULTS & PEDIATRICS 1.00 03100 INTENSIVE CARE UNIT					30.
5. 00 02060 NEONATAL INTENSIVE CARE UNIT					35.
0. 00 04000 SUBPROVI DER - I PF			2, 159, 526		40.
1. 00 04100 SUBPROVI DER - I RF			2, 107, 020		41.
3. 00 04300 NURSERY					43.
ANCILLARY SERVICE COST CENTERS					
O. OO O5000 OPERATING ROOM		0. 09520		0	
1.00 05100 RECOVERY ROOM		0. 04978		0	
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 66391		0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 19020			
4. 01 03630 ULTRA SOUND		0. 09192		l	
4. 02 03440 MAMMOGRAPHY		0. 16478		0	
5. 00 05500 RADI OLOGY-THERAPEUTI C 6. 00 05600 RADI OI SOTOPE		0. 09707 0. 05806			
7. 00 05700 CT SCAN		0. 03800		422	
B. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 05207		0	
9. 00 05900 CARDI AC CATHETERI ZATI ON		0. 05608		l e	
0. 00 06000 LABORATORY		0. 06151		l .	
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD (LLS	0. 44387	8 0	0	62
5. 00 06500 RESPIRATORY THERAPY		0. 11732	9 10, 675	1, 252	65
6. 00 06600 PHYSI CAL THERAPY		0. 17375		782	
9. 00 06900 ELECTROCARDI OLOGY		0. 04878		l	
0. 00 07000 ELECTROENCEPHALOGRAPHY	1170	0. 09006		0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATI	NIS	0. 13003		l	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 18724		0	
3.00 07300 DRUGS CHARGED TO PATIENTS 4.00 07400 RENAL DIALYSIS		0. 11594 0. 66503		25, 459 0	
6. 00 03950 LI THOTRI PSY		0. 09310		0	
6. 01 03330 ENDOSCOPY		0. 05189		0	
6. 02 03040 PRI SI ON CLI NI C		0.85199		Ö	
6. 03 03050 WOUND CARE		0. 25019		Ō	
6. 04 03060 OPI C		0. 17341		0	1
7.00 07700 ALLOGENEIC HSCT ACQUISITION		0.00000	0 0	0	77.
OUTPATIENT SERVICE COST CENTERS					
1.00 09100 EMERGENCY		0. 08376		1	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT F	,	1. 04672		0	
Total (sum of lines 50 through 9			552, 156	49, 350	
01.00 Less PBP Clinic Laboratory Servi	as_program only charges (line 61)	1	0		201

NPATII	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider Component	CN: 15-0046 CCN: 15-T046	Peri od: From 09/01/2022 To 08/31/2023		pared:
		Titl∈	xVIII	Subprovi der - I RF	PPS	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		T		Т	٠
	03000 ADULTS & PEDIATRICS					30.0
	03100 I NTENSI VE CARE UNIT					31.0
	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF					35. 0 40. 0
	04100 SUBPROVIDER - TPF			2, 396, 317		41. 0
	04300 NURSERY			2, 370, 317		43. 0
	ANCI LLARY SERVI CE COST CENTERS					1 .0.0
	05000 OPERATING ROOM		0. 0952	05 99, 966	9, 517	50. c
51. 00	05100 RECOVERY ROOM		0. 0497	84 0	0	51.0
2. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 6639	13 0	0	52. (
	05400 RADI OLOGY-DI AGNOSTI C		0. 1902	07 92, 580		
	03630 ULTRA SOUND		0. 0919			
	03440 MAMMOGRAPHY		0. 1647			
	05500 RADI OLOGY-THERAPEUTI C		0. 0970			
	05600 RADI OI SOTOPE		0.0580			
	05700 CT SCAN		0.0157	-		1
	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION		0. 0520 0. 0560			
	06000 LABORATORY		0.0300			
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 4438			
	06500 RESPI RATORY THERAPY		0. 1173			
	06600 PHYSI CAL THERAPY		0. 1737			1
9. 00	06900 ELECTROCARDI OLOGY		0. 0487	88 22, 324	1, 089	69.
	07000 ELECTROENCEPHALOGRAPHY		0. 0900	69 4, 568	411	70. (
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1300			
2. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1872			
	07300 DRUGS CHARGED TO PATIENTS		0. 1159			1
	07400 RENAL DIALYSIS		0. 6650			
	03950 LI THOTRI PSY 03330 ENDOSCOPY		0.0931		1	
	03040 PRI SI ON CLI NI C		0. 0518 0. 8519			
	03050 WOUND CARE		0. 8519			
	03060 OPI C		0. 2301			1
	07700 ALLOGENEIC HSCT ACQUISITION		0.0000			
	OUTPATIENT SERVICE COST CENTERS		2. 2000	,		1
	09100 EMERGENCY		0. 0837	61 0	0	91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 0467			
200.00	Total (sum of lines 50 through 94 and 96 through 98)			7, 165, 495	1, 027, 326	200.
201.00	Less PBP Clinic Laboratory Services-Program only char	ges (line 61)		0		201.
202.00	Net charges (line 200 minus line 201)			7, 165, 495		202.

Health Financial Systems TERRE HAU' INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	TE REGIONAL HOSPITAL Provider CCI	N: 15-0046	Peri od:	u of Form CMS-2 Worksheet D-3	
THE THE TWO LETTER SERVICE GOOT THE OWN COMMENT	11011461 001		From 09/01/2022		
			To 08/31/2023	Date/Time Pre 1/29/2024 8:1	
	Title	XIX	Hospi tal	Cost	J dili
Cost Center Description		Ratio of Cos		Inpati ent	
· ·		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			4, 927, 261		30.00
31. 00 03100 INTENSIVE CARE UNIT			2, 832, 783		31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT			507, 018		35.00
40. 00 04000 SUBPROVI DER - PF			0		40.00
41. 00 04100 SUBPROVI DER - I RF			407 170		41.00
43. 00 04300 NURSERY			486, 179		43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 O5000 OPERATI NG ROOM	T	0. 09520	9, 449, 030	899, 595	50.00
51. 00 05100 RECOVERY ROOM		0. 04978		39, 477	1
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 66391		1, 575, 460	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 19020		1, 373, 400	1
54. 01 03630 ULTRA SOUND		0. 09192		23, 299	
54. 02 03440 MAMMOGRAPHY		0. 16478		23, 277	1
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 09707		0	
56. 00 05600 RADI OI SOTOPE		0. 05806		1, 737	
57. 00 05700 CT SCAN		0. 01579		65, 923	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 05207		39, 424	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 05608	3, 336, 057	187, 096	59.00
60. 00 06000 LABORATORY		0. 06151	0 6, 888, 429	423, 707	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 44387	754, 658	334, 976	62.00
65. 00 06500 RESPIRATORY THERAPY		0. 11732	4, 315, 212	506, 300	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 17104	2 835, 987	142, 989	66.00
69. 00 06900 ELECTROCARDI OLOGY		0. 04830	2, 416, 065	116, 701	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 09006	9 117, 312	10, 566	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 13003	4, 216, 909	548, 333	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 18724		257, 921	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 11594		2, 138, 808	1
74. 00 07400 RENAL DI ALYSI S		0. 66503		140, 187	
76. 00 03950 LI THOTRI PSY		0. 09310		0	
76. 01 03330 ENDOSCOPY		0. 05189		22, 733	
76. 02 03040 PRI SI ON CLI NI C		0. 85199		1, 806	
76. 03 03050 WOUND CARE		0. 24793		9, 274	1
76. 04 03060 0PI C		0. 16909		0	

0.000000

0. 083721

1.046728

4, 185, 110

66, 108, 908

66, 108, 908

350, 382

0 92.00

7, 970, 240 200. 00 201. 00

77. 00 0

91.00

202. 00

07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
200.00 Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)

Net charges (line 200 minus line 201)

09100 EMERGENCY

77. 00

91.00

202.00

NPATIENT A	NCILLARY SERVICE COST APPORTIONMENT	Provider Component	CN: 15-0046 CCN: 15-S046	Fro To	iod: m 09/01/2022 08/31/2023	Worksheet D-3 Date/Time Pre 1/29/2024 8:1	pare
		Ti tl	e XIX	Su	ıbprovi der - I PF	Cost	
	Cost Center Description		Ratio of Cos To Charges	st	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00		2. 00	3. 00	
	TIENT ROUTINE SERVICE COST CENTERS	<u> </u>					
	O ADULTS & PEDIATRICS						30.
	O INTENSIVE CARE UNIT						31.
	O NEONATAL INTENSIVE CARE UNIT						35.
	O SUBPROVI DER - I PF				18, 775, 468		40.
	O SUBPROVI DER – I RF						41.
	O NURSERY LLARY SERVICE COST CENTERS						43.
	O OPERATING ROOM		0. 0952	05	0	0	50.
	O RECOVERY ROOM		0.0932		0	0	
	O DELIVERY ROOM & LABOR ROOM		0. 6639		0	0	
- 1	O RADI OLOGY-DI AGNOSTI C		0. 1902		30, 015	5, 709	
	O ULTRA SOUND		0. 0919		6, 778	623	
	O MAMMOGRAPHY		0. 1647		0	0	
	RADI OLOGY-THERAPEUTI C		0. 0970		O	0	
5. 00 0560	O RADI OI SOTOPE		0. 0580	63	О	0	56.
7. 00 0570	O CT SCAN		0. 0157	97	205, 198	3, 242	57.
3. 00 0580	O MAGNETIC RESONANCE IMAGING (MRI)		0. 0520	73	15, 851	825	58.
	O CARDI AC CATHETERI ZATI ON		0. 0560		0	0	
	0 LABORATORY		0. 0615		1, 368, 710	84, 189	
	O WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 4438		9, 460	4, 199	
	O RESPI RATORY THERAPY		0. 1173		89, 788	10, 535	1
	O PHYSI CAL THERAPY		0. 1710		8, 122	1, 389	
	O ELECTROCARDI OLOGY		0.0483		41, 384	1, 999	
	O ELECTROENCEPHALOGRAPHY O MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 0900 0. 1300		0 4, 691	0 610	
	O I MPL. DEV. CHARGED TO PATIENTS		0. 1300		4, 071	010	
	O DRUGS CHARGED TO PATIENTS		0. 1072		1, 865, 826	216, 335	1
	O RENAL DI ALYSI S		0. 6650		0	0	
	0 LI THOTRI PSY		0. 0931		Ö	0	
	O ENDOSCOPY		0. 0518		0	0	76
- 1	O PRISION CLINIC		0. 8519		0	0	76
03050	O WOUND CARE		0. 2479	37	0	0	76.
03060	O OPI C		0. 1690	97	0	0	76
	O ALLOGENEIC HSCT ACQUISITION		0.0000	00	0	0	77.
	ATLENT SERVICE COST CENTERS						
	O EMERGENCY		0. 0837		1, 286, 550	107, 711	91.
	O OBSERVATION BEDS (NON-DISTINCT PART)		1. 0467	28	0	0	
00.00	Total (sum of lines 50 through 94 and 96 through 98)	(1)			4, 932, 373	437, 366	
01.00	Less PBP Clinic Laboratory Services-Program only charge	es (IINe 61)	1		0		201.

NPATI E	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider Component	CN: 15-0046 CCN: 15-T046	Peri od: From 09/01/2022 To 08/31/2023		pared:
		Ti tl	e XIX	Subprovi der - I RF	Cost	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1		·	4
	03000 ADULTS & PEDI ATRI CS					30. C
	03100 I NTENSI VE CARE UNI T					31.0
	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF					35.0
	04100 SUBPROVI DER - TPF			567, 453		40.0
	04300 NURSERY			507, 453		43. 0
	ANCI LLARY SERVI CE COST CENTERS		l		l .	1 75. \
	05000 OPERATING ROOM		0. 0952	05 32, 277	3, 073	50.
	05100 RECOVERY ROOM		0. 0497			
2.00	05200 DELIVERY ROOM & LABOR ROOM		0. 6639	13 C	0	52.
4.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1902	07 7, 137	1, 358	54.
4. 01	03630 ULTRA SOUND		0. 0919		83	54.
	03440 MAMMOGRAPHY		0. 1647			
	05500 RADI OLOGY-THERAPEUTI C		0. 0970		-	
	05600 RADI OI SOTOPE		0. 0580		1	
	05700 CT SCAN		0. 0157	· ·		1
	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION		0. 0520 0. 0560		825 0	
	06000 LABORATORY		0.0560			
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 4438			
	06500 RESPIRATORY THERAPY		0. 1173			
	06600 PHYSI CAL THERAPY		0. 1710			
	06900 ELECTROCARDI OLOGY		0. 0483	· ·		
0.00	07000 ELECTROENCEPHALOGRAPHY		0.0900	69 C	0	70.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1300	32 45, 837	5, 960	71.
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1872		0	
	07300 DRUGS CHARGED TO PATIENTS		0. 1159	· ·		1
	07400 RENAL DI ALYSI S		0. 6650	· ·		
	03950 LI THOTRI PSY		0. 0931		-	
	03330 ENDOSCOPY		0. 0518		-	
	03040 PRISION CLINIC 03050 WOUND CARE		0.8519			1
	03060 OPLC		0. 2479 0. 1690			
	03000 OFFC 07700 ALLOGENEIC HSCT ACQUISITION		0. 1890			1
	OUTPATIENT SERVICE COST CENTERS		0.000	00,		1 ′′′
	09100 EMERGENCY		0. 0837	21 165	14	91.
4	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 0467		0	
00.00	Total (sum of lines 50 through 94 and 96 through 98)			1, 561, 922		
201.00	Less PBP Clinic Laboratory Services-Program only char	ges (line 61)		C		201.
02.00	Net charges (line 200 minus line 201)			1, 561, 922		202.

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0046	Peri od: From 09/01/2022 To 08/31/2023	Worksheet E Part A Date/Time Prepared: 1/29/2024 8:15 am
	T		000

	Title XVIII Hospital	PPS	<u> </u>
	DADT A LINDATIENT HOSDITAL SEDVICES HINDED LDDS	1. 00	
1.00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments	0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see	800, 463	1. 01
	instructions)	•	
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see	11, 593, 092	1. 02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October	0	1. 03
1.03	1 (see instructions)	O	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after	0	1. 04
	October 1 (see instructions)		
2.00	Outlier payments for discharges. (see instructions)	0	2. 00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2. 01 2. 02
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	52, 041	2. 02
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	466, 608	2. 04
3.00	Managed Care Simulated Payments	8, 756, 186	3. 00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	138. 45	4. 00
F 00	Indirect Medical Education Adjustment	0.00	F 00
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)	0.00	5. 00
5. 01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5. 01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for	0.00	6. 00
	new programs in accordance with 42 CFR 413.79(e)	0.00	
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of	0.00	6. 26
7. 00	the CAA 2021 (see instructions) MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the	0.00	7. 01
	cost report straddles July 1, 2011 then see instructions.		
7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural	0. 00	7. 02
	track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)		
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for	0.00	8. 00
0.00	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,	0.00	0.00
	1998), and 67 FR 50069 (August 1, 2002).		
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost	0. 00	8. 01
8. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital	0.00	8. 02
0.02	under § 5506 of ACA. (see instructions)	0.00	0.02
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see	0.00	8. 21
	instructions)		
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or	0. 00	9. 00
10. 00	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10. 00
11. 00	FTE count for residents in dental and podiatric programs.		11. 00
12.00	Current year allowable FTE (see instructions)	0.00	
13.00	Total allowable FTE count for the prior year.		13. 00
14. 00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,	0.00	14. 00
15 00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.	0.00	15. 00
	Adjustment for residents in initial years of the program (see instructions)		16. 00
	Adjustment for residents displaced by program or hospital closure		17. 00
18.00	Adjusted rolling average FTE count	0.00	18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).	0. 000000	
	Prior year resident to bed ratio (see instructions)	0.000000	
21. 00 22. 00	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)	0.000000	21. 00 22. 00
22. 00	IME payment adjustment - Managed Care (see instructions)	0	
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105	0.00	23. 00
	(f)(1)(iv)(c).		
24. 00	IME FTE Resident Count Over Cap (see instructions)	0.00	
25. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25. 00
26. 00	Resident to bed ratio (divide line 25 by line 4)	0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)	0. 000000	
28. 00	IME add-on adjustment amount (see instructions)	0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)	0	28. 01
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29. 00 29. 01
∠7. U l	Disproportionate Share Adjustment	0	∠7. U I
30. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	6. 85	30. 00
31.00	Percentage of Medicaid patient days (see instructions)	23. 57	
32.00	Sum of lines 30 and 31	30. 42	
33.00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)	14. 31 443, 380	
J4. UU	prisprisportionate share adjustment (see mistractions)	443, 300	34.00

	Financial Systems TERRE HAUTE REG ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046	Period:	u of Form CMS-2 Worksheet E	∠၁၁∠-1
ONLOGE	ATTON OF RETWINDINGSEMENT SETTEMBERT	11 0V1 del CON. 13 0040	From 09/01/2022 To 08/31/2023	Part A	pared:
				1/29/2024 8: 1	
		Title XVIII	Hospital	PPS On/After 10/1	
			1. 00	2. 00	
25 00	Uncompensated Care Payment Adjustment		7 100 000 710	/ 074 402 450	1 25 0
35. 00 35. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		0. 000180454	6, 874, 403, 459 0. 000176746	
35. 02	Hospital UCP, including supplemental UCP (If line 34 is zer	ro, enter zero on this lin			•
35. 03	(see instructions) Pro rata share of the hospital UCP, including supplemental	UCP (see instructions)	106, 671	1, 115, 158	35. 0
36. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03))	1, 221, 829		36. 0
10. 00	Additional payment for high percentage of ESRD beneficiary Total Medicare discharges (see instructions)	discharges (lines 40 thro	ugh 46)		40. 0
10. 00	Total meareure discharges (see That detroils)		Before 1/1	On/After 1/1	40.0
	I=		1. 00	1. 01	
41. 00 41. 01	Total ESRD Medicare discharges (see instructions) Total ESRD Medicare covered and paid discharges (see instru	uctions)	0	0	
12. 00	Divide line 41 by line 40 (if less than 10%, you do not qua		0.00	0	42. 0
13.00	Total Medicare ESRD inpatient days (see instructions)		0		43.0
14. 00	Ratio of average length of stay to one week (line 43 divided days)	ed by line 41 divided by /	0. 000000		44.0
45. 00 46. 00	Average weekly cost for dialysis treatments (see instruction Total additional payment (line 45 times line 44 times line	· ·	0.00	0.00	45. 0 46. 0
47. 00	Subtotal (see instructions)	41.01)	14, 577, 413		47. 0
18. 00	Hospital specific payments (to be completed by SCH and MDH,	, small rural hospitals	0		48. 0
	only. (see instructions)			Amount	
				1. 00	
19.00	Total payment for inpatient operating costs (see instruction	· ·	`	14, 577, 413	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I Exception payment for inpatient program capital (Wkst. L, I		•	1, 060, 761 0	1
52. 00	Direct graduate medical education payment (from Wkst. E-4,	· · · · · · · · · · · · · · · · · · ·		0	52.0
3.00	Nursing and Allied Health Managed Care payment			0	
54. 00 54. 01	Special add-on payments for new technologies Islet isolation add-on payment			24, 476 0	
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	e 69)		0	1
55. 01	Cellular therapy acquisition cost (see instructions)	ntructions)		0	
56. 00 57. 00	Cost of physicians' services in a teaching hospital (see in Routine service other pass through costs (from Wkst. D, Pt.	*	through 35).	0	
8. 00	Ancillary service other pass through costs from Wkst. D, P	t. IV, col. 11 line 200)	,	0	
9. 00 0. 00	Total (sum of amounts on lines 49 through 58)			15, 662, 650 0	1
1. 00	Primary payer payments Total amount payable for program beneficiaries (line 59 mi)	nus line 60)		15, 662, 650	
2. 00	Deductibles billed to program beneficiaries	,		1, 345, 376	62. 0
3. 00 4. 00	Coinsurance billed to program beneficiaries			8, 712 99, 153	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			64, 449	
6. 00	Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		17, 287	66. (
7.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	or applicable to MC DDCs (oss imptrustions)	14, 373, 011	1
9. 00 9. 00	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96)	• •		0	1
0. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.0
0.50	Rural Community Hospital Demonstration Project (§410A Demon		instructions)	0	
0. 75 0. 87	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration			0	1
0. 88	SCH or MDH volume decrease adjustment (contractor use only))		0	70.8
70.89	Pioneer ACO demonstration payment adjustment amount (see in			_	70.8
70. 90 70. 91	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions))		0	1
70. 92				0	
	LIVED			0	70. 9
70. 93 70. 94	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			-68, 698	1

Heal th	Financial Systems TERRE HAUTE REGION.	AI HOSPITAI		Inlie	u of Form CMS-2	2552_10
	ATION OF REIMBURSEMENT SETTLEMENT	Provi der Co	CN: 15-0046	Peri od: From 09/01/2022 To 08/31/2023	Worksheet E Part A Date/Time Pre 1/29/2024 8:1	pared:
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column 0		0	0	70. 96
70. 97	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or after			0	0	70. 97
70. 98	Low Volume Payment-3	10/1)		0	0	
70. 99	HAC adjustment amount (see instructions)				0	
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	59 & 70)			14, 304, 313	1
71. 01	Sequestration adjustment (see instructions)				286, 086	1
71. 02	Demonstration payment adjustment amount after sequestration				0	
71. 03	Sequestration adjustment-PARHM pass-throughs				12 405 024	71. 03
72.00	Interim payments				13, 495, 024	1
72. 01 73. 00	Interim payments-PARHM				0	72. 01
73. 00	Tentative settlement (for contractor use only) Tentative settlement-PARHM (for contractor use only)				Ü	73. 00 73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02) 72 and			523, 203	•
74. 00	73) Balance due provider/program-PARHM (see instructions)	z, 72, anu			523, 203	74. 00
75. 00	Protested amounts (nonallowable cost report items) in accordan	aco with			1, 535, 624	1
75.00	CMS Pub. 15-2, chapter 1, §115.2	ice wi tii			1, 333, 624	75.00
	TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	of 2.03			0	90. 00
	plus 2.04 (see instructions)				_	
91.00	Capital outlier from Wkst. Ĺ, Pt. I, line 2				0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instru	ucti ons)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instruct	tions)			0	93. 00
94.00	The rate used to calculate the time value of money (see instru	ıcti ons)			0.00	94. 00
95.00	Time value of money for operating expenses (see instructions)				0	95. 00
96.00	Time value of money for capital related expenses (see instruct	tions)			0	96. 00
				Prior to 10/1		
				1. 00	2. 00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100. 00
101 00	HVBP Adjustment for HSP Bonus Payment			0.000000000	0.000000000	101 00
	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions	-)		0.0000000000	0. 0000000000	101.00
102.00	HRR Adjustment for HSP Bonus Payment	5)		U U	U	102.00
103 00	HRR adjustment factor (see instructions)			0.0000	0.0000	103 00
	HRR adjustment amount for HSP bonus payment (see instructions)	1		0.0000		104. 00
101.00	Rural Community Hospital Demonstration Project (§410A Demonstr		stment	<u> </u>		101.00
200.00	Is this the first year of the current 5-year demonstration per					200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	9 49)				201. 00
	Medicare discharges (see instructions)	•				202. 00
	Case-mix adjustment factor (see instructions)			<u> </u>		203. 00
	Computation of Demonstration Target Amount Limitation (N/A in	first year	of the currer	nt 5-year demonst	rati on	
	peri od)					
	Medicare target amount					204. 00
	Case-mix adjusted target amount (line 203 times line 204)					205. 00
206. 00	Medicare inpatient routine cost cap (line 202 times line 205)					206. 00
	Adjustment to Medicare Part A Inpatient Reimbursement					007.00

208. 00 209. 00

210. 00 211. 00

212. 00 213. 00 218. 00

207.00 Program reimbursement under the §410A Demonstration (see instructions)

208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)

213.00 Low-volume adjustment (see instructions)
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)

211.00 Total adjustment to Medicare IPPS payments (see instructions)

Comparision of PPS versus Cost Reimbursement

212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)

209.00 Adjustment to Medicare IPPS payments (see instructions)

(line 212 minus line 213) (see instructions)

210.00 Reserved for future use

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0046	Peri od: From 09/01/2022 Part B To 08/31/2023 Date/Time Prepared: 1/29/2024 8:15 am

		1/29/2024 8: 1	5 am
	Title XVIII Hospital	PPS	
		1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
1.00	Medical and other services (see instructions)	1, 619	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	9, 874, 599	
3.00	OPPS or REH payments	11, 235, 679	
4.00	Outlier payment (see instructions)	38, 006	
4. 01 5. 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructions)	0.000	4. 01 5. 00
6. 00	Line 2 times line 5	0.000	6.00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	
8.00	Transitional corridor payment (see instructions)	0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	
10.00	Organ acqui si ti ons	0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES	1, 619	11. 00
	Reasonable charges		1
12. 00	Ancillary service charges	13, 965	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13. 00
14.00	Total reasonable charges (sum of lines 12 and 13)	13, 965	14. 00
45.00	Customary charges		45.00
15. 00 16. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebas had such payment been made in accordance with 42 CFR §413.13(e)	15	16.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17. 00
18.00	Total customary charges (see instructions)	13, 965	1
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	12, 346	19. 00
	instructions)		
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20. 00
21. 00	Lesser of cost or charges (see instructions)	1, 619	21.00
22. 00	Interns and residents (see instructions)	0	1
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)	11, 273, 685	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	1	
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1, 946, 991	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see		1
27.00	instructions)	7, 320, 313	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28. 00
28. 50	REH facility payment amount		28. 50
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	9, 328, 313	1
31. 00 32. 00	Primary payer payments Subtotal (line 30 minus line 31)	3, 698 9, 324, 615	1
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	7,021,010	02:00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33. 00
	Allowable bad debts (see instructions)	137, 020	1
35. 00	Adjusted reimbursable bad debts (see instructions)	89, 063	
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	89, 798 9, 413, 678	
38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R	-449	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)		39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)	0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration	0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	0 414 127	
40.00	Subtotal (see instructions)	9, 414, 127	
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration	188, 283	40. 01 40. 02
40. 02	Sequestration adjustment-PARHM pass-throughs		40. 02
41. 00	Interim payments	9, 207, 313	
41. 01	Interim payments-PARHM		41. 01
42. 00	Tentative settlement (for contractors use only)	0	1
42. 01	Tentative settlement-PARHM (for contractor use only)	40 501	42. 01
43. 00 43. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)	18, 531	43. 00 43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	398, 201	44. 00
00	\$115. 2	3,0,201]
	TO BE COMPLETED BY CONTRACTOR		1
90. 00	Original outlier amount (see instructions)	0	1
91.00	Outlier reconciliation adjustment amount (see instructions)	0	
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)	0.00	92. 00 93. 00
94.00	,	0	
	Total Control of the second of	1	

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046	Peri od:	Worksheet E	
		From 09/01/2022		
		To 08/31/2023	Date/Time Pre	pared:
			1/29/2024 8: 1	5 am
	Title XVIII	Hospi tal	PPS	
			1. 00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200. 00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046	Peri od: From 09/01/2022	Worksheet E Part B
	Component CCN: 15-S046	To 08/31/2023	Date/Time Prepared: 1/29/2024 8:15 am
	Title XVIII	Subprovi der -	PPS

	If the XVIII Subprovider -	PPS	
		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
1.00	Medical and other services (see instructions)	83	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)	86	2.00
3. 00 4. 00	OPPS or REH payments Outlier payment (see instructions)	114	3. 00 4. 00
4. 01	Outlier reconciliation amount (see instructions)		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 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions	0	9. 00 10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)	83	11. 00
00	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12. 00	Ancillary service charges	717	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) Customary charges	717	14. 00
15. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15. 00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17. 00
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	717 634	18. 00 19. 00
19.00	instructions)	034	19.00
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.00
	instructions)		
21. 00	Lesser of cost or charges (see instructions)	83	21.00
22. 00 23. 00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instructions)	0	22. 00 23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	114	24. 00
2 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		21100
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	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	197	27. 00
28. 00	instructions) Direct graduate medical education payments (from Wkst. E-4, line 50)	o	28. 00
28. 50	REH facility payment amount		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)	197	30.00
31. 00 32. 00	Primary payer payments Subtatal (Line 30 minus Line 31)	0 197	31. 00 32. 00
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	197	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33. 00
34.00	Allowable bad debts (see instructions)	0	34.00
35. 00	, , , , , , , , , , , , , , , , , , ,	0	35. 00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37. 00 38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R	197 0	37. 00 38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)		39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)	0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration	0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39. 98
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)	197	39. 99 40. 00
40. 01	Sequestration adjustment (see instructions)	4	40. 01
40. 02	Demonstration payment adjustment amount after sequestration	0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs		40. 03
41.00	Interim payments	252	
41. 01 42. 00	Interim payments-PARHM Tentative settlement (for contractors use only)	o	41. 01 42. 00
42. 00	Tentative settlement (for contractor use only)		42. 00
43. 00	Balance due provider/program (see instructions)	-59	43. 00
43. 01	Balance due provider/program-PARHM (see instructions)		43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	44. 00
	\$115. 2		
90 00	TO BE COMPLETED BY CONTRACTOR 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	
93. 00	Time Value of Money (see instructions)	0	93. 00

Health Financial Systems	TERRE HAUTE REGIONA	AL HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0046	Peri od:	Worksheet E	
			From 09/01/2022		
		Component CCN: 15-S046	To 08/31/2023	Date/Time Pre	pared:
				1/29/2024 8:1	5 am
		Title XVIII	Subprovi der -	PPS	
			I PF		
				1.00	
94.00 Total (sum of lines 91 and 93)				0	94.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					200. 00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lieu of Form CMS-		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046	Peri od:	Worksheet E	
	Component CCN: 15-T046	From 09/01/2022		
	Component Con. 13 1040	10 00/31/2023	1/29/2024 8: 15 am	
	Title XVIII	Subprovi der -	PPS	

	If the XVIII Subprovider	- PPS	
		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
1. 00	Medical and other services (see instructions)	133	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)	86	2.00
3. 00 4. 00	OPPS or REH payments Outlier payment (see instructions)	115	3. 00 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 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)	0.00	7. 00 8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		9. 00
10. 00	Organ acqui si ti ons	0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)	133	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges		
12. 00	Ancillary service charges	1, 151	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)	1, 151	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for payment for services on a charge basis	. 0	15. 00
16. 00	, , , , , , , , , , , , , , , , , , , ,		16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	
18. 00 19. 00	Total customary charges (see instructions)	1, 151 1, 018	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,016	19.00
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20. 00
21. 00	instructions)	133	21. 00
	Lesser of cost or charges (see instructions) Interns and residents (see instructions)	133	21.00
	Cost of physicians' services in a teaching hospital (see instructions)	Ö	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	115	24. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)		25. 00
26. 00	Deductibles and Coinsurance amounts (for CAH, see instructions)		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	248	
00 00	instructions)		00.00
28. 00 28. 50	Direct graduate medical education payments (from Wkst. E-4, line 50) REH facility payment amount	0	28. 00 28. 50
	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)	248	30. 00
31.00	Primary payer payments	0	31.00
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	248	32. 00
33. 00		0	33. 00
	Allowable bad debts (see instructions)	0	34.00
	Adjusted reimbursable bad debts (see instructions)	0	35. 00
	Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions)	0 248	36. 00 37. 00
	MSP-LCC reconciliation amount from PS&R	0	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)		39. 50
39. 75 39. 97	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration	0	39. 75 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)	248	40.00
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration	5 0	40. 01 40. 02
40. 03			40. 03
41. 00	Interim payments	339	41.00
	Interim payments-PARHM		41. 01
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)	0	42. 00 42. 01
42. 01	Balance due provider/program (see instructions)	-96	
43. 01	Balance due provider/program-PARHM (see instructions)		43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR		
90. 00		0	90. 00
	Original outlier amount (see instructions)	0	
	Outlier reconciliation adjustment amount (see instructions)	0	91. 00
92. 00	Outlier reconciliation adjustment amount (see instructions)	0 0. 00	91. 00

Health Financial Systems	TERRE HAUTE REGION	AL HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0046	Peri od:	Worksheet E	
			From 09/01/2022		
		Component CCN: 15-T046	To 08/31/2023	Date/Time Pre	pared:
				1/29/2024 8:1	5 am
		Title XVIII	Subprovi der -	PPS	
			I RF		
				1.00	
94.00 Total (sum of lines 91 and 93)				0	94.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					200. 00

Health Financial Systems TERRE ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 09/01/2022 Part I
To 08/31/2023 Date/Ti me Prepared: 1/29/2024 8:15 am Provider CCN: 15-0046

Title XVIII						1/29/2024 8: 1	<u>am</u>
mm/dd/yyyy							
1.00			Inpatien	t Part A	Par	⁻t B	
1.00							
Interim payments payable on Individual bills, either subtited or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.			1. 00		3. 00		
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 Use 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)				13, 495, 024			
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero (1 write "NONE" or enter a zero (1 write "NONE" or enter a zero (1)	2.00			0		0	2.00
write "NONE" or enter a zero							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
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)							
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00						3.00
Bayment. If none, write "NONE" or enter a zero. (1) Program to Provider 0		amount based on subsequent revision of the interim rate					
Program to Provider							
ADJUSTMENTS TO PROVIDER							
3.02 3.02 3.03 3.04 3.05 3.03 3.04 3.05 3.03 3.04 3.05	3 01			0			3 ∩1
3.03 0		ADJUSTIMENTS TO TROVIDER		_			
3. 04 0 0 0 3. 04 3. 05							
3.05				_			
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3 . 50				_			
3. 50 ADJUSTMENTS TO PROGRAM		Provider to Program					
3.52 3.53 3.54 3.99 3.50-3.98	3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.53 3.54 3.54 3.59 3.59 3.50-3.98 3.50-	3.51			0		0	3. 51
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 13,495,024 9,207,313 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	3.52			0		0	3. 52
3. 99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.05-3.98) 3. 50-3.98) 4. 00 Total interim payments (sum of lines 1, 2, and 3.99) 13, 495, 024 9, 207, 313 4. 00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	3.53			0		0	3. 53
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR				0			
13, 495, 024 9, 207, 313 4. 00	3. 99			0		0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR				40 405 004		0.007.040	
appropriate TO BE COMPLETED BY CONTRACTOR	4.00			13, 495, 024		9, 207, 313	4.00
TO BE COMPLETED BY CONTRACTOR							
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	5 00						5 00
Write "NONE" or enter a zero. (1) Program to Provider S. 01 TENTATIVE TO PROVIDER O O S. 02 S. 03 O O S. 02 S. 03 O O S. 50 S. 50 O O S. 50 O O S. 50 S.	0.00						0.00
Program to Provider							
Solition	Program to Provider						
Description	5.01	TENTATI VE TO PROVI DER		0		0	5. 01
Provider to Program	5.02			0		0	5. 02
TENTATI VE TO PROGRAM 0	5.03			0		0	5. 03
5.51 0							
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.52 0		TENTATI VE TO PROGRAM		_			
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 523,203 18,531 6.01 6.02 SETTLEMENT TO PROGRAM 0 0 0 6.02 7.00 Total Medicare program liability (see instructions) 14,018,227 9,225,844 7.00 Contractor Number (Mo/Day/Yr) 0 1.00 2.00				_			
5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) O 1.00 2.00		Cubtatal (aum af linna F 01 F 40 minus aum af linna		ŭ		ı "	
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5. 99			U		0	5. 99
the cost report. (1) SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) Number (Mo/Day/Yr) 0 1.00 2.00	6 00						6 00
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	0.00						0.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6, 01			523, 203		18. 531	6, 01
7.00 Total Medicare program liability (see instructions) 14,018,227 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				0		0	
Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				14, 018, 227		9, 225, 844	
0 1.00 2.00					Contractor		
8.00 Name of Contractor 8.00			()	1. 00	2. 00	
	8. 00	Name of Contractor					8. 00

Title XVIII

		Title	XVIII	Subprovi der - I PF	PPS	
		Inpatien	t Part A	Par	t 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		248, 192		252	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3. 00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		l ol	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 3. 99			0			3. 54
3. 99	3. 50-3. 98)		U			3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		248, 192		252	4. 00
1. 00	(transfer to Wkst. E or Wkst. E-3, line and column as		210, 172		202	1. 00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
E 04	Program to Provider					F 04
5. 01	TENTATIVE TO PROVIDER		0		0	5. 01
5. 02 5. 03			0		0	5. 02 5. 03
5.03	Provider to Program		0		0	5.05
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51	12.17.11.72		0		l ol	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
,	the cost report. (1)					,
6. 01	SETTLEMENT TO PROVIDER		7, 764		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		255 054		59 193	6. 02
7. 00	Total Medicare program liability (see instructions)		255, 956	Contractor	NPR Date	7. 00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
				•	•	

Health Financial Systems	TERRE HAUTE REGIO	NAL HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FO	R SERVICES RENDERED	Provider CCN: 15-0046	Peri od: From 09/01/2022	Worksheet E-1 Part I

		Title	XVIII	Subprovi der - I RF	PPS	
		Inpatien	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		2, 471, 913		339	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
2 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3. 00
3. 00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVI DER		0		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3. 05			0		0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 50	ADJUSTMENTS TO PROGRAM		0			3. 50
3. 52			0			3. 52
3. 53			0		اة	3. 53
3. 54			0		l ol	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 471, 913		339	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5. 03			0		0	5. 03
F F0	Provi der to Program		0		0	F F0
5. 50 5. 51	TENTATIVE TO PROGRAM		0			5. 50 5. 51
5. 51			0			5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0			5. 99
0. ,,	5. 50-5. 98)		· ·			0. ,,
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		28, 564		96	6. 02
7. 00	Total Medicare program liability (see instructions)		2, 443, 349		243	7. 00
				Contractor	NPR Date	
		()	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor			1.00	2. 50	8. 00
	1 · · · · · · · · · · · · · · · · · · ·			I .	!	

Heal th	Financial Systems TERRE HAUTE REGION	NAL HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-0046	Peri od: From 09/01/2022 To 08/31/2023	Worksheet E-1 Part II Date/Time Pre 1/29/2024 8:1	epared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			1.00	
	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 l				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
0 00	Calculation of the HLT incentive newment (see instructions)				8.00
8.00	Calculation of the HIT incentive payment (see instructions)				9. 00
9. 00 10. 00	Sequestration adjustment amount (see instructions)	(see instructions)			10.00
10.00	Calculation of the HIT incentive payment after sequestration INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	(See Tristructions)			10.00
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31. 00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	s)		32. 00
			·		

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0046	Peri od: From 09/01/2022	Worksheet E-3
	Component CCN: 15-S046		
	Title XVIII	Subprovi der - I PF	PPS

	I PF			
			1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS			
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		332, 792	1. 00
2.00	Net IPF PPS Outlier Payments		0	2. 00
3.00	Net IPF PPS ECT Payments		0	3. 00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before Novem	ber	0.00	4. 00
	15, 2004. (see instructions)			
4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced program or hospital closure, that would not be counted without a temporary cap adjustment under		0.00	4. 01
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)	42		
5.00	New Teaching program adjustment. (see instructions)		0.00	5. 00
6. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a	"new	0.00	6. 00
0.00	teaching program" (see instuctions)	11011	0.00	0.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a	"new	0.00	7. 00
	teaching program" (see instuctions)			
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8. 00
9.00	Average Daily Census (see instructions)		13. 926027	9. 00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		332, 792	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	İ	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)	İ		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		332, 792	16.00
17.00	Primary payer payments		0	17. 00
18.00	Subtotal (line 16 less line 17).		332, 792	18.00
19.00	Deducti bl es		50, 716	19.00
20.00	Subtotal (line 18 minus line 19)		282, 076	20.00
21.00	Coi nsurance		28, 800	21. 00
22.00	Subtotal (line 20 minus line 21)		253, 276	22. 00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		12, 160	23. 00
24.00	Adjusted reimbursable bad debts (see instructions)		7, 904	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1, 556	25. 00
26.00	Subtotal (sum of lines 22 and 24)		261, 180	26. 00
27.00	Direct graduate medical education payments (see instructions)		0	27. 00
28.00	Other pass through costs (see instructions)		0	28. 00
29.00	Outlier payments reconciliation		0	29. 00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30. 50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30. 50
30. 98	Recovery of accelerated depreciation.		0	30. 98
30. 99	Demonstration payment adjustment amount before sequestration		0	30. 99
31.00	Total amount payable to the provider (see instructions)		261, 180	31.00
31. 01	Sequestration adjustment (see instructions)		5, 224	31. 01
31. 02	Demonstration payment adjustment amount after sequestration		0	31. 02
32.00	Interim payments		248, 192	32.00
33.00	Tentative settlement (for contractor use only)	İ	0	33. 00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		7, 764	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,		0	35.00
	§115. 2			
	TO BE COMPLETED BY CONTRACTOR			
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		0	50.00
	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53. 00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 202	3 (THE	END OF	
	THE COVID-19 PHE)			
	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020	.	0. 000000	
99. 01	Calculated Teaching Adjustment Factor for the current year. (see instructions)		0. 000000	99. 01

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0046	Peri od: From 09/01/2022	Worksheet E-3
	Component CCN: 15-T046		
	Title XVIII	Subprovi der - I RF	PPS

	IRF		
		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS	1.00	
1.00	Net Federal PPS Payment (see instructions)	2, 137, 419	1. 00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0265	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	113, 283	3. 00
4.00	Outlier Payments	250, 067	4. 00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0. 00	5. 01
6.00	New Teaching program adjustment. (see instructions)	0. 00	6. 00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0. 00	7. 00
8. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0. 00	8. 00
9. 00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9. 00
10.00	Average Daily Census (see instructions)	5. 783562	
11. 00	Teaching Adjustment Factor (see instructions)	0. 000000	
12. 00	Teaching Adjustment (see instructions)	0	12. 00
13. 00	Total PPS Payment (see instructions)	2, 500, 769	13. 00
14. 00	Nursing and Allied Health Managed Care payments (see instruction)	0	14. 00
15. 00	Organ acqui si ti on (DO NOT USE THIS LINE)	Ĭ	15. 00
16. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	16. 00
17. 00	Subtotal (see instructions)	2, 500, 769	
18. 00	Primary payer payments	2, 300, 709	18. 00
	Subtotal (line 17 less line 18).	_	
19.00	· · · · · · · · · · · · · · · · · · ·	2, 500, 769	
20.00	Deductibles	4, 756	
21. 00	Subtotal (line 19 minus line 20)	2, 496, 013	
22. 00	Coi nsurance	2, 800	
23. 00	Subtotal (line 21 minus line 22)	2, 493, 213	
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24. 00
25. 00	Adjusted reimbursable bad debts (see instructions)	0	25. 00
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26. 00
27. 00	Subtotal (sum of lines 23 and 25)	2, 493, 213	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28. 00
29. 00	Other pass through costs (see instructions)	0	29. 00
30. 00	Outlier payments reconciliation	0	30.00
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31. 50
31. 98	Recovery of accelerated depreciation.	0	31. 98
31. 99	Demonstration payment adjustment amount before sequestration	o	31. 99
32. 00	Total amount payable to the provider (see instructions)	2, 493, 213	32. 00
32. 01	Sequestration adjustment (see instructions)	49, 864	32. 01
32. 02	Demonstration payment adjustment amount after sequestration	0	32. 02
33. 00	Interim payments	2, 471, 913	33.00
34. 00	Tentative settlement (for contractor use only)	o	34.00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-28, 564	35. 00
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36. 00
	TO BE COMPLETED BY CONTRACTOR		
50. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4	250, 067	50. 00
51. 00	Outlier reconciliation adjustment amount (see instructions)	230, 007	51. 00
52. 00	The rate used to calculate the Time Value of Money		52. 00
53. 00	Time Value of Money (see instructions)	0.00	53. 00
55.00	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE THE COVID-19 PHE)		33.00
99. 00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0. 000000	ga nr
	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0. 000000	
, 7. U I	paradiated reaching haj astillent ractor for the current year. (See Histiactions)	0.000000	77. UI

Health Financial Systems	TERRE HAUTE REGIONAL H	UOSDI TAI	In Lio	ı of Form CMS-2	0552 10
CALCULATION OF REIMBURSEMENT SETTLEMENT		ovi der CCN: 15-0046		Worksheet E-3	
				Date/Time Prep 1/29/2024 8:15	oared: 5 am
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
			1. 00	2. 00	
PART VII - CALCULATION OF REIMBURSEMENT - A	LL OTHER HEALTH SERVICE	CES FOR TITLES V OR XI	X SERVICES		

		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE	S FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		9, 050, 998		1.00
2.00	Medical and other services			8, 081, 193	2. 00
3.00	Organ acquisition (certified transplant programs only)		O		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		9, 050, 998	8, 081, 193	4. 00
5.00	Inpatient primary payer payments		o		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		9, 050, 998	8, 081, 193	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		, , , , , ,		
	Reasonable Charges				
8.00	Routine service charges		8, 753, 241		8. 00
9. 00	Ancillary service charges		66, 108, 908	95, 785, 391	9. 00
10.00	Organ acquisition charges, net of revenue		00, 100, 700	,0,,00,0,,	10.00
11. 00	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		74, 862, 149	95, 785, 391	12. 00
12.00	CUSTOMARY CHARGES		74,002,147	73, 703, 371	12.00
13. 00	Amount actually collected from patients liable for payment for ser	vices on a charge	O	0	13. 00
13.00	basis	vices on a charge		O	13.00
14. 00	Amounts that would have been realized from patients liable for pay	mont for sorvices on	0	0	14. 00
14.00	a charge basis had such payment been made in accordance with 42 CF		٩	U	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	K 3415. 15(e)	0.000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		74, 862, 149	95, 785, 391	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only if	Line 16 exceeds	65, 811, 151	87, 704, 198	
17.00	line 4) (see instructions)	Title to exceeds	03, 611, 131	07, 704, 190	17.00
18. 00	Excess of reasonable cost over customary charges (complete only if	Line 4 eveneds Line	0	0	18. 00
16.00	16) (see instructions)	Title 4 exceeds fille	۷	U	16.00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instructi	one)	0	0	20.00
		ons)	0 050 000	-	
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	Lated for DDC provide	9, 050, 998	8, 081, 193	21. 00
22.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be comp	reted for PPS provide	0	0	22 00
			· -1	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		9, 050, 998	8, 081, 193	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30. 00	Excess of reasonable cost (from line 18)		0	0	30. 00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		9, 050, 998	8, 081, 193	
32.00	Deducti bl es		0	0	32. 00
33.00	Coinsurance		0	0	33. 00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		9, 050, 998	8, 081, 193	36. 00
37.00	TO ZERO OUT MEDICALD SETTLEMENT		1, 905, 240	-1, 009, 540	37.00
38. 00	Subtotal (line 36 ± line 37)		10, 956, 238	7, 071, 653	38. 00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		10, 956, 238	7, 071, 653	40.00
41. 00	Interim payments		10, 956, 238	7, 071, 653	
42. 00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance w	ith CMS Pub 15-2	o	0	43. 00
10.00	chapter 1, §115.2			O	10.00
	10.00p.co. 17 3.10.2		1		ı

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0046	Peri od: From 09/01/2022	Worksheet E-3
	Component CCN: 15-S046		Date/Time Prepared: 1/29/2024 8:15 am
	Title XIX	Subprovi der -	Cost

	· ·	TETO XIX	IPF	0031	
			Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FO	R TITLES V OR XI)	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				İ
1.00	Inpatient hospital/SNF/NF services		3, 612, 599		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant programs only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		3, 612, 599	0	4.00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		3, 612, 599	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routine service charges		18, 775, 468		8.00
9. 00	Ancillary service charges		4, 932, 373	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		o		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		23, 707, 841	0	•
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for service	s on a charge	0	0	13.00
	basis	3			
14.00	Amounts that would have been realized from patients liable for payment	for services on	0	0	14. 00
	a charge basis had such payment been made in accordance with 42 CFR §4	13. 13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		23, 707, 841	0	16. 00
17.00	Excess of customary charges over reasonable cost (complete only if lir	e 16 exceeds	20, 095, 242	0	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only if lir	ne 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	1
20. 00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		3, 612, 599	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complete	d for PPS provide			
	Other than outlier payments		0	0	
23. 00	Outlier payments		0	0	23. 00
	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		3, 612, 599	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0 (40 500	0	
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		3, 612, 599	0	31.00
32.00	Deducti bl es		0	0	
	Coinsurance		0	0	
34. 00	Allowable bad debts (see instructions)		0	0	34.00
35. 00	Utilization review		2 (12 500	0	35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		3, 612, 599	0	
	TO ZERO OUT MEDICALD SETTLEMENT		-942, 854	0	
38. 00			2, 669, 745	Ü	38. 00
39. 00 40. 00	Direct graduate medical education payments (from Wkst. E-4)		2, 669, 745	0	39. 00 40. 00
40.00				0	
41.00	Interim payments Relance due provider/program (Line 40 minus Line 41)		2, 669, 745	0	
42.00	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accordance with	CMS Dub 15 2	0	0	1
43.00	chapter 1, §115.2	UNIS FUD 13-2,	١	U	43. 00
	Chapter 1, 3113.2		1		ı

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0046	Peri od: From 09/01/2022	Worksheet E-3
	Component CCN: 15-T046		Date/Time Prepared: 1/29/2024 8:15 am
	Title XIX	Subprovi der -	Cost

		II tie xix	I RF	COST	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	1020 1011 111220 1 011 111 1	. 02.111 020		
1.00	Inpatient hospital/SNF/NF services		347, 504		1. 00
2. 00	Medical and other services		0177001	0	2. 00
3.00	Organ acquisition (certified transplant programs only)		0	_	3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		347, 504	0	4. 00
5. 00	Inpatient primary payer payments		0	-	5. 00
6.00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		347, 504	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		3.1.7.5.	-	
	Reasonable Charges				
8.00	Routine service charges		567, 453		8. 00
9. 00	Ancillary service charges		1, 561, 922	0	9. 00
10. 00	Organ acquisition charges, net of revenue		0	· ·	10.00
11. 00	Incentive from target amount computation		o		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		2, 129, 375	0	12. 00
	CUSTOMARY CHARGES			-	
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basis			-	
14.00	Amounts that would have been realized from patients liable for	payment for services on	0	0	14.00
	a charge basis had such payment been made in accordance with 42				
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		2, 129, 375	0	16. 00
17.00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	1, 781, 871	0	17. 00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18.00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instru	ıcti ons)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16		347, 504	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c	completed for PPS provide	ers.		
22. 00	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0		24.00
25. 00	Capital exception payments (see instructions)		0		25.00
26. 00	Routine and Ancillary service other pass through costs		0	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		347, 504	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		347, 504	0	31. 00
32. 00	Deducti bl es		0	0	32.00
33. 00	Coinsurance		0	0	33. 00
34. 00	Allowable bad debts (see instructions)		0	0	34. 00
35. 00	Utilization review		0		35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	347, 504	0	36. 00
37. 00	TO ZERO OUT MEDICALD SETTLEMENT		-19, 729	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		327, 775	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		327, 775	0	40. 00
41. 00	Interim payments		327, 775	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance	ce wrth CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2		1		

Health Financial Systems TERRE HAUTE REGIONAL HOSPITAL In Lieu			u of Form CMS-2	552-10	
OUTLI E	R RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0046	Peri od:	Worksheet E-5	
			From 09/01/2022 To 08/31/2023	Date/Time Prep 1/29/2024 8:15	
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)					1.00
2.00 Capital outlier from Wkst. L, Pt. I, line 2					2.00
3.00 Operating outlier reconciliation adjustment amount (see instructions)				0	3.00
4.00 Capital outlier reconciliation adjustment amount (see instructions)				0	4.00
5.00 The rate used to calculate the time value of money (see instructions)				0.00	5.00
6.00 Time value of money for operating expenses (see instructions)					6.00
7.00 Time value of money for capital related expenses (see instructions)					7.00

Health Financial Systems

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

Provi der CCN: 15-0046

| Peri od: | Worksheet G | From 09/01/2022 | To 08/31/2023 | Date/Time Prepared: 1/29/2024 8:15 am

oni y)					1/29/2024 8: 1	5 am
		General Fund		Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	12, 439			0	
2.00	Temporary investments Notes receivable		0	0	0	2. 00 3. 00
3. 00 4. 00	Accounts recei vable	23, 733, 550	0	0	0	
5. 00	Other recei vable	77, 050	l .	0	0	
6. 00	Allowances for uncollectible notes and accounts receivable	-4, 768, 567	l .	0	0	
7.00	Inventory	6, 983, 278	0	0	0	7. 00
8.00	Prepai d expenses	528, 459	l .	-	0	1
9.00	Other current assets	110 504	0	-	0	
10. 00 11. 00	Due from other funds Total current assets (sum of Lines 1 10)	112, 584			0	1
11.00	Total current assets (sum of lines 1-10) FIXED ASSETS	26, 678, 793	0	U	0] 11.00
12. 00	Land	1, 262, 718	0	0	0	12. 00
13.00	Land improvements	3, 238, 473	1		0	
14.00	Accumulated depreciation	-3, 154, 404	0	0	0	14. 00
15. 00	Bui I di ngs	38, 668, 254	1	_	0	
16.00	Accumulated depreciation	-30, 808, 801	1	_	0	1
17. 00 18. 00	Leasehold improvements	9, 587, 944 -8, 456, 409	1		0	17. 00 18. 00
19. 00	Accumulated depreciation Fixed equipment	35, 120, 542	1	_	0	
20. 00	Accumulated depreciation	-26, 830, 764	1		0	1
21. 00	Automobiles and trucks	0	1	_	0	1
22. 00	Accumulated depreciation	0	0	0	0	22. 00
23. 00	Major movable equipment	47, 459, 727	1		0	1
24. 00	Accumulated depreciation	-41, 168, 662	1	0	0	
25. 00	Minor equipment depreciable	8, 182, 886	1	0	0	25. 00
26. 00 27. 00	Accumulated depreciation HIT designated Assets	-6, 134, 491	0	0	0	
28. 00	Accumulated depreciation		0	0	0	1
29. 00	Mi nor equi pment-nondepreci abl e	709, 904		-	0	1
30.00	Total fixed assets (sum of lines 12-29)	27, 676, 917	l .	0	0	1
	OTHER ASSETS					
31. 00	Investments	3, 063, 197	1		0	1
32.00	Deposits on Leases	0	0	0	0	32.00
33.00	Due from owners/officers	2 472 140	0	0	0	1
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)	2, 472, 140 5, 535, 337	1	_	0	
36. 00	Total assets (sum of lines 11, 30, and 35)	59, 891, 047	1		0	1
	CURRENT LI ABI LI TI ES		-			
37.00	Accounts payable	2, 828, 749	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	2, 510, 907		0	0	
39. 00	Payroll taxes payable	4, 787, 141		0	0	1
40. 00 41. 00	Notes and Loans payable (short term)	275, 764	0	0	0	40. 00 41. 00
41.00	Deferred income Accel erated payments		0	U	U	41.00
43. 00	Due to other funds		0	0	0	1
44. 00	Other current liabilities	27, 078			0	
45.00	Total current liabilities (sum of lines 37 thru 44)	10, 429, 639	0	0	0	45. 00
	LONG TERM LIABILITIES	T	1			
46. 00	Mortgage payable	0	0		0	
47. 00	Notes payable	487, 301	1		0	1
48. 00 49. 00	Unsecured Loans Other Long term Liabilities	-319, 205, 374 121, 702	1	0	0	1
50.00	Total long term liabilities (sum of lines 46 thru 49)	-318, 596, 371	1	_	0	1
51. 00	Total liabilities (sum of lines 45 and 50)	-308, 166, 732	1		0	
	CAPI TAL ACCOUNTS					
52.00	General fund balance	368, 057, 779	1			52. 00
53. 00	Specific purpose fund		0			53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00 56. 00	Donor created - endowment fund balance - unrestricted					55. 00 56. 00
57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	1
	replacement, and expansion					
59. 00	Total fund balances (sum of lines 52 thru 58)	368, 057, 779	1		0	1
60. 00	Total liabilities and fund balances (sum of lines 51 and	59, 891, 047	0	0	0	60. 00
	[59]	I	I	l l	l	I

Provider CCN: 15-0046

| Peri od: | Worksheet G-1 | From 09/01/2022 | To 08/31/2023 | Date/Ti me Prepared:

					To 08/31/2023	Date/Time Prep 1/29/2024 8:1	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	J Cili
		1.00	2. 00	3.00	4. 00	5. 00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) FEDERAL TAX LIABILITY ENTRY XFR 252001 FROM 25704 Total deductions (sum of lines 12-17)	0 0 0 0 0 0 0 0 2, 943, 911 637, 316 0 0	2. 00 355, 066, 603 16, 572, 403 371, 639, 006 0 371, 639, 006		4.00 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 16. 00 17. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		368, 057, 779		0		19. 00
		Endowment Fund	PI ant				
1 00	TE 11.1	6.00	7. 00	8. 00			4 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) FEDERAL TAX LIABILITY ENTRY XFR 252001 FROM 25704 Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0	0 0 0 0 0		0 0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

Health Financial Systems TER STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0046

			-	Го 08/31/2023	Date/Time Pre 1/29/2024 8:1		
	Cost Center Description		Inpatient	Outpati ent	Total	O dill	
			1.00	2. 00	3. 00		
PART I - PATIENT REVENUES							
	General Inpatient Routine Services						
1.00	Hospi tal		22, 200, 35	3	22, 200, 353	1. 00	
2.00	SUBPROVI DER - I PF		29, 227, 37	1	29, 227, 374	2. 00	
3.00	SUBPROVI DER - I RF		4, 147, 86	7	4, 147, 867	3. 00	
4.00	SUBPROVI DER					4. 00	
5.00	Swing bed - SNF				0		
6.00	Swing bed - NF		(D	0		
7.00	SKILLED NURSING FACILITY					7. 00	
8. 00	NURSING FACILITY					8. 00	
9.00	OTHER LONG TERM CARE					9.00	
10. 00			55, 575, 59	1	55, 575, 594	10. 00	
11 00	Intensive Care Type Inpatient Hospital Services						
11. 00 12. 00	INTENSIVE CARE UNIT		13, 474, 64:	2	13, 474, 642	11. 00 12. 00	
12.00	BURN INTENSIVE CARE UNIT					13.00	
14. 00	SURGICAL INTENSIVE CARE UNIT					14.00	
15. 00	NEONATAL INTENSIVE CARE UNIT		691, 10 ⁻	1	691, 101	ł	
16. 00	Total intensive care type inpatient hospital services (sum of	lines	14, 165, 74		14, 165, 743	•	
10.00	11-15)	111163	14, 103, 74.		14, 105, 745	10.00	
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		69, 741, 33	7	69, 741, 337	17. 00	
18. 00	Ancillary services		317, 097, 04		670, 577, 059	1	
19. 00	Outpatient services		21, 021, 65		74, 130, 154		
20. 00	RURAL HEALTH CLINIC		2.702.700		0	20.00	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER			0	0		
22. 00	HOME HEALTH AGENCY				_	22. 00	
23. 00	AMBULANCE SERVICES					23. 00	
24.00	CMHC					24. 00	
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00	
26.00	HOSPI CE					26. 00	
27.00	CCUPATI ONAL MEDI CI NE			315, 429	315, 429	27. 00	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	407, 860, 03	406, 903, 947	814, 763, 979	28. 00	
	G-3, line 1)						
	PART II - OPERATING EXPENSES			+			
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			96, 104, 721		29. 00	
30. 00	ADD (SPECIFY)					30. 00	
31. 00						31. 00	
32.00						32. 00	
33.00			(33.00	
34.00						34.00	
35. 00	T		(35. 00	
36.00	Total additions (sum of lines 30-35)		,	0		36.00	
37. 00 38. 00	DEDUCT (SPECIFY)					37. 00 38. 00	
39.00						39.00	
40.00)			40.00	
41. 00)			41.00	
42.00	Total deductions (sum of lines 37-41)		·	<u></u>		42.00	
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer			96, 104, 721		43.00	
10. 00	to Wkst. G-3, line 4)			70, 101, 721		.5. 55	
	1		1	1	ı	1	

Health Financial Systems TERRE HAUTE REGIONAL HOSPITAL In Lieu of Form CMS-2552-10						
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-0046 Period:	Worksheet G-3					
From 09/01/2022 To 08/31/2023	Date/Time Pre 1/29/2024 8:1					
	1.00	4 00				
1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	814, 763, 979	1.00				
2.00 Less contractual allowances and discounts on patients' accounts	702, 425, 666	1				
3.00 Net patient revenues (line 1 minus line 2)	112, 338, 313					
4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43)	96, 104, 721					
5.00 Net income from service to patients (line 3 minus line 4)	16, 233, 592	5. 00				
OTHER INCOME 6.00 Contributions, donations, bequests, etc	0	6. 00				
7.00 Income from investments	0	7.00				
8.00 Revenues from telephone and other miscellaneous communication services	0					
9.00 Revenue from television and radio service	0	•				
10.00 Purchase di scounts	0	10.00				
11.00 Rebates and refunds of expenses	0	11. 00				
12.00 Parking Lot receipts	0					
13.00 Revenue from Laundry and Linen service	0	•				
14.00 Revenue from meals sold to employees and quests	193, 965					
15.00 Revenue from rental of living quarters	· ·	15. 00				
16.00 Revenue from sale of medical and surgical supplies to other than patients		16. 00				
17.00 Revenue from sale of drugs to other than patients	-	17. 00				
18.00 Revenue from sale of medical records and abstracts	-	18. 00				
19.00 Tuition (fees, sale of textbooks, uniforms, etc.)	0	1				
20.00 Revenue from gifts, flowers, coffee shops, and canteen	0	20.00				
21.00 Rental of vending machines	15, 291					
22.00 Rental of hospital space	0					
23.00 Governmental appropriations	0	l				
24. 00 OTHER INCOME	129, 559					
24.50 COVI D-19 PHE Funding	0	1				
25.00 Total other income (sum of lines 6-24)	338, 815					
26.00 Total (line 5 plus line 25)	16, 572, 407					
27. 00 ROUNDING	4	27. 00				
28.00 Total other expenses (sum of line 27 and subscripts)	4	28. 00				
29.00 Net income (or loss) for the period (line 26 minus line 28)	16, 572, 403	29. 00				

Heal th	Financial Systems TERRE HAUTE REGION	NAL HOSPITAL	In Lie	eu of Form CMS-2	2552-10		
	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0046	Peri od: From 09/01/2022 To 08/31/2023	Worksheet L Parts I-III	pared:		
	Title XVIII Hospital						
	DART I FILLY PROSPECTIVE METHOD			1.00			
	PART I - FULLY PROSPECTIVE METHOD						
1.00	CAPITAL FEDERAL AMOUNT Capital DRG other than outlier						
1. 00	Model 4 BPCI Capital DRG other than outlier				1. 00 1. 01		
2. 00	Capital DRG outlier payments			76, 294			
2. 01	Model 4 BPCI Capital DRG outlier payments			0			
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)			44. 48			
4.00	Number of interns & residents (see instructions)			0.00			
5.00	Indirect medical education percentage (see instructions)			0.00	5. 00		
6.00					6. 00		
	1.01) (see instructions)						
7.00	Percentage of SSI recipient patient days to Medicare Part A p	oatient days (Worksheet E	E, part A line	6. 85	7. 00		
0.00	30) (see instructions)			00.57	0.00		
8.00	Percentage of Medicaid patient days to total days (see instru	ictions)		23.57			
9.00	Sum of lines 7 and 8	-)		30. 42 6. 35			
10. 00 11. 00	Allowable disproportionate share percentage (see instructions Disproportionate share adjustment (see instructions)	>)		58, 781			
12. 00	' '			1, 060, 761			
12.00	Total prospective capital payments (see mistractions)			1, 000, 701	12.00		
				1. 00			
	PART II - PAYMENT UNDER REASONABLE COST						
1.00	Program inpatient routine capital cost (see instructions)			0			
2. 00 3. 00	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2)			0			
4. 00	Capital cost payment factor (see instructions)			0			
5.00	Total inpatient program capital cost (line 3 x line 4)						
3.00	The street program capital cost (Time 5 x Time 4)				3.00		
				1. 00			
4 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS				4 00		
1.00	Program inpatient capital costs (see instructions)	ana (ana i natruatiana)		0			
2. 00 3. 00	Program inpatient capital costs for extraordinary circumstance	ces (see instructions)					
4. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)		0.00				
5.00	Capital cost for comparison to payments (line 3 x line 4)		0.00				
6. 00	Percentage adjustment for extraordinary circumstances (see in	nstructions)		0.00			
7. 00	Adjustment to capital minimum payment level for extraordinary		(line 6)	0.00			
8. 00	Capital minimum payment level (line 5 plus line 7)	y erreamstances (Trie 2)	11110 0)	Ö			
9. 00	Current year capital payments (from Part I, line 12, as appli	cabl e)		Ö			
10.00	Current year comparison of capital minimum payment level to c		less line 9)	0			
11. 00	Carryover of accumulated capital minimum payment level over of			0			
12.00	Worksheet L, Part III, line 14)		- 11)		10.00		
12.00				0			
13.00							
14. 00	(if line 12 is negative, enter the amount on this line)	capital payment for the f	orrowing period	0	14. 00		
15. 00	Current year allowable operating and capital payment (see ins	structions)		0	15. 00		
16. 00				0			
	Current year exception offset amount (see instructions)				17. 00		
	, , , , , , , , , , , , , , , , , , , ,		'				