Health Financ		COMMUNITY HOSPITAL			u of Form CMS-2552-10
	is required by law (42 USC 1395g				FORM APPROVED
	e since the beginning of the cos				OMB NO. 0938-0050
	HOSPITAL HEALTH CARE COMPLEX CO	ST REPORT CERTIFICATION AND	Provider CCN: 150113		Worksheet S
SETTLEMENT S	JMMARY			From 01/01/2015 To 12/31/2015	Parts I-III Date/Time Prepared:
				10 12/31/2013	5/24/2016 4:24 pm
	ST REPORT STATUS				
Provider	<ol> <li>[X] Electronically filed</li> </ol>			Date: 5/24/20	16 Time: 4:24 pm
use only	<ol><li>2. [ ] Manually submitted co</li></ol>				
	3.[0] If this is an amended 4.[F] Medicare Utilization.	report enter the number of Enter "F" for full or "L" f	times the provider re for low.	esubmitted this cost	: report
Contractor	5. [ 1 ] Cost Report Status	6. Date Received:		.NPR Date:	
use only	(1) As Submitted	7. Contractor No.	11	.Contractor's Vendo	r Code: 4
		8. [ N ] Initial Report for 9. [ N ] Final Report for th	is Provider CCN 12		
	<ul><li>(3) Settled with Audit</li><li>(4) Reopened</li></ul>		is novider cell	number of tim	es reopened = 0-9.
	(5) Amended				
PART II - CE					
MISREPRESENT	ATION OR FALSIFICATION OF ANY IN	FORMATION CONTAINED IN THIS	COST REPORT MAY BE PI	UNISHABLE BY CRIMINA	AL, CIVIL AND
	VE ACTION, FINE AND/OR IMPRISONM				
	THROUGH THE PAYMENT DIRECTLY OR		WERE OTHERWISE ILLEG	AL, CRIMINAL, CIVIL	AND ADMINISTRATIVE
ACTION, FINE	S AND/OR IMPRISONMENT MAY RESULT	•			
	CERTIFICATION BY OFFICER OF	R ADMINISTRATOR OF PROVIDER(	S)		
тыс	REBY CERTIFY that I have read th	a above certification state	mont and that T have	avaminad the accomp	anuina
elec	tronically filed or manually sub	mitted cost report and the	Relance Sheet and Sta	tement of Revenue a	any mg
prep	ared by COMMUNITY HOSPITAL ANDER	RSON (150113) for the cost	reporting period bec	1000000000000000000000000000000000000	nd ending
12/3	1/2015 and to the best of my kno	wledge and belief. this rep	ort and statement are	true, correct, com	nlete and
prep	ared from the books and records	of the provider in accordan	ce with applicable in	structions, except	as noted. I
furt	her certify that I am familiar w	with the laws and regulation	s regarding the provi	sion of health care	services,
and	that the services identified in	this cost report were provi	ded in compliance wit	h such laws and reg	ulations.
			LPP	H.	
Encr	yption Information	(Signed)	John D.	Nam	
	Date: 5/24/2016 Time: 4:24 pm		Officer or Admi	nistrator of Provid	er(s)
tdxb	vRny5Vn4vcxpinfj.gmlBSCbw0			1	20 mil 19 mil
uygd	v0c49uFYwvL9o.h5CJaOSJLb9.		VP Financ	e/CFO	
QY5L	1vYFWs0X8nv1		itle	200 0	
PI:	Date: 5/24/2016 Time: 4:24 pm		5-25-	16	
QuOL	Ht5VmWnLZFmjDXiKswI115IPE0				

			Title X	VIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	1
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	291,583	225,644	-1,141,208	-88,015	1.00
2.00	Subprovider - IPF	0	0	0	10 00 U	0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0	~			0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
3.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	291,583	225,644	-1,141,208	-88,015	200.00

Date

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 valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

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Xg.w0y0w7H0M8Nww

	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	A	Provi de	er CCN:	150113	Period: From 01/ To 12/	01/2015 31/2015	Part I Date/T	eet S-2 ïme Pre 016 1:2	pared
	1.00	2.0	00	3.	00			4.00	572472	010 1.2	
	Hospital and Hospital Health Care Co										4
	Street: 1515 NORTH MADISON AVE	PO Box:		. Carla	4/011	0					1.0
00	City: ANDERSON	State: IN Component Nam		p Code: CCN	CBSA	Provi der	ty: MADISO ^ Date		ent Sys	tom (P	2.0
		component wan			lumber	Type	Certifi		T, 0, or		
								V	XVIII		1
		1.00	2	2.00	3.00	4.00	5.00	6.0	0 7.00	8.00	
	Hospital and Hospital-Based Componen						04 (04 (44				
00	•	COMMUNITY HOSPITAL ANDERSON	_   15	50113	26900	1	01/01/19	966 N	P	0	3.0
00	Subprovider - IPF	ANDERSON									4.
	Subprovider - IRF										5.
0	Subprovider - (Other)										6.
	Swing Beds - SNF										7.
	Swing Beds - NF										8.
	Hospi tal -Based SNF Hospi tal -Based NF										9.
	Hospi tal-Based OLTC										11.
	Hospital-Based HHA										12.
	Separately Certified ASC										13.
	Hospi tal -Based Hospi ce										14.
	Hospital-Based Health Clinic - RHC										15.
	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I										16.
	Hospital-Based (CORF) I		1								17.
	Renal Dialysis										18.
00	Other										19.
								om:	T		4
00	Cost Departing Design (mm (dd (uuuu)							00		00	20
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						0170	1/2015 2		/2015	20.
	Inpatient PPS Information							2	-		21.
00	Does this facility qualify and is it	currently receivi	ng paymen	ts for d	i spropo	ortionate		Y		N	22.
	share hospital adjustment, in accord						for				
	yes or "N" for no. Is this facility :				) (2) (Pi	ckle					
	amendment hospital?) In column 2, en Did this hospital receive interim un				cost re	porting		Y		Y	22.
	period? Enter in column 1, "Y" for ye							1		1	22.
	period occurring prior to October 1.										
	portion of the cost reporting period										
	Is this a newly merged hospital that		•					N		N	22.
	determined at cost report settlement' "N" for no, for the portion of the co						es or				
	column 2, "Y" for yes or "N" for no,						r				
	after October 1.		1 110 000	t roport	ing per						
	Did this hospital receive a geograph	c reclassificatio	n from ur	ban to r	ural as	s a resul	t of	N		N	22.
	the OMB standards for delineating sta										
	column 1, "Y" for yes or "N" for no						to to				
	October 1. Enter in column 2, "Y" for reporting period occurring on or afte										
	contain at least 100 but not more that	•									
	412.105)? Enter in column 3, "Y" for	yes or "N" for no	).								
	Which method is used to determine Me							3	3	N	23.
	enter 1 if date of admission, 2 if co										
	of identifying the days in this cost the prior cost reporting period? In										
	the pirtor cost reporting period. In		In-State	In-Stat		ut-of	Out-of	Medi ca	aid (	)ther	
			Medi cai d	Medi cai		tate	State	HMO da	ays   Me	di cai d	
		1	baid days	eligibl			Medi cai d			days	
				unpai days		d days	el i gi bl e unpai d				
		-	1.00	2.00		3. 00	4.00	5.0	0	6.00	1
00	If this provider is an IPPS hospital,	enter the	2, 198		394	0	4.00		, 623		2 24.
	in-state Medicaid paid days in colum	n 1, in-state									
	Medicaid eligible unpaid days in col										
	out-of-state Medicaid paid days in co										
	out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible bu										
	column 5, and other Medicaid days in										1
	If this provider is an IRF, enter the		0		0	o	(		o		25.
						-					1 -
00	Medicaid paid days in column 1, the i	n-state medicalq				1			1		1
00	eligible unpaid days in column 2, ou	t-of-state									
00		t-of-state ate Medicaid									

SPLI	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	A	Provi der	CCN: 150113	Peri od:	1 /2015	Workshe	eet S-2	
					From 01/0 To 12/3	1/2015	Part I Date/Ti		
					Urban/R		<u>5/24/20</u> Date of		
00	Enter your standard geographic classification (not way	(a) ct	atus at the her	inning of t	1. (	20	2. (	00	24
	Enter your standard geographic classification (not wag cost reporting period. Enter "1" for urban or "2" for	rural				1			26.
. 00	Enter your standard geographic classification (not wag reporting period. Enter in column 1, "1" for urban or					1			27.
	the effective date of the geographic reclassification			pricable, e	iter				
00	If this is a sole community hospital (SCH), enter the			H status in		0			35.
	effect in the cost reporting period.	n the cost reporting period. Begi							
					1. (		Endi 2. (		
00	Enter applicable beginning and ending dates of SCH sta periods in excess of one and enter subsequent dates.	itus.	Subscript line	36 for numb	er of				36
00	If this is a Medicare dependent hospital (MDH), enter	the n	umber of period	ls MDH statu	s i s	0			37
00	in effect in the cost reporting period. If line 37 is 1, enter the beginning and ending dates	of MD	Histatus Ifili	ne 37 is an	eater				38
00	than 1, subscript this line for the number of periods								
	subsequent dates.				Y/	'N	Y/	'N	
					1. (		2.0		
00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii)						N	l	39
	"N" for no. Does the facility meet the mileage require								
~~	412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N								10
00	Is this hospital subject to the HAC program reduction for no in column 1, for discharges prior to October 1.						N	I	40
	column 2, for discharges on or after October 1. (see i	nstru	ctions)					VIV	
						V 1.00	2.00	XIX 3.00	1
	Prospective Payment System (PPS)-Capital	_							
00	Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions)	for	di sproporti onat	e share in a	accordance	N	Y	N	45
00	Is this facility eligible for additional payment excep					N	N	N	46
	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst.	L, P	t. III and Wkst	. L-1, Pt.	l through l	Pt.			
	ls this a new hospital under 42 CFR §412.300 PPS capit					N	N	N	47
00	Is the facility electing full federal capital payment? Teaching Hospitals	' Ent	er "Y" for yes	or "N" for i	10.	N	N	N	48
00	Is this a hospital involved in training residents in a	pprov	ed GME programs	? Enter "Y	' for yes d	or N			56
00	"N" for no. If line 56 is yes, is this the first cost reporting pe	rel a d	during which re	oldonto in	annen od Cl	/E N			67
00	programs trained at this facility? Enter "Y" for yes								57
	"Y" did residents start training in the first month of					or			
	yes or "N" for no in column 2. If column 2 is "Y", co complete Wkst. D, Parts III & IV and D-2, Pt. II, if a			. II COLUMN	215 N,				
	If line 56 is yes, did this facility elect cost reimbu			ins' servi ce	s as define	ed N			58
	in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Are costs claimed on line 100 of Worksheet A? If yes,			Pt. I.		N			59
	Are you claiming nursing school and/or allied health c	osts	for a program t	hat meets t		Y			60
	provider-operated criteria under §413.85? Enter "Y" f	Y/N	IME	Direct GMI		E	Di rec	t GME	
	_	1 00	2.00	2.00		20			-
00	Did your hospital receive FTE slots under ACA section	1.00 N	2.00	3.00	4.	0.00	5. (		0 61
	5503? Enter "Y" for yes or "N" for no in column 1.								
01	(see instructions) Enter the average number of unweighted primary care		0.00	0	. 00				61
	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		0.00	0	. 00				61
	FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA).	1							
~~	(see instructions)			0					
03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for		0.00	0	. 00				61
	determining compliance with the 75% test. (see								
04	instructions) Enter the number of unweighted primary care/or surgery	,	0.00	0	. 00				61
	allopathic and/or osteopathic FTEs in the current cost								
05	reporting period.(see instructions). Enter the difference between the baseline primary		0.00	n	. 00				61
	and/or general surgery FTEs and the current year's		0.00	0					
	primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)								
	Enter the amount of ACA §5503 award that is being used	I	0.00	0	. 00				61
06			i .						1

OSPITAL AND HOSPITAL HEALTH CARE COMPLI	EX IDENTIFICATION DA	TA Provi der	Fi To		5/24/2016 1:2	pared:
		Program Name			Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
<ol> <li>1.10 Of the FTEs in line 61.05, special ty, if any, and the number each new program. (see instructio 1, the program name, enter in col code, enter in col umn 3, the IME and enter in col umn 4, direct GME count.</li> <li>1.20 Of the FTEs in line 61.05, specif program special ty, if any, and th residents for each expanded progr instructions) Enter in col umn 1, enter in col umn 2, the program co 3, the IME FTE unweighted count.</li> </ol>	of FTE residents for ns) Enter in column umn 2, the program FTE unweighted count FTE unweighted y each expanded e number of FTE am. (see the program name, de, enter in column			0.00		61. 10
						_
ACA Provisions Affecting the Heal	th Decourage and Ser	avione Administration			1.00	
2.00 Enter the number of FTE residents				od for which	0.00	62.0
your hospital received HRSA PCRE 2.01 Enter the number of FTE residents during in this cost reporting per	that rotated from a iod of HRSA THC prog	n Teaching Health Cen gram. (see instruction		your hospital	0.00	62. 0 <sup>.</sup>
3.00 Has your facility trained residen for yes or "N" for no in column 1	ts in nonprovider se	ettings during this c		period? Enter "	Y'' N	63. 0
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year			This base year	is your cost r	eporting	
period that begins on or after Ju .00 Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1	yes, or your facilit er of unweighted non ations occurring in number of unweighted r hospital. Enter in + column 2)). (see	y trained residents -primary care all nonprovider i non-primary care n column 3 the ratio instructions)	0. OC			
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te		Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
5.00 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 4). (see			0. 00	0.00	0. 000000	

Health Financial Systems		TY HOSPITAL AND	ERSON			n Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COM	PLEX IDENTIFICATION DA	ATA Pr	ovi der		Period: From 01/01 To 12/31		Worksheet S- Part I Date/Time Pr 5/24/2016 1:	epared:
				Unweighted FTEs Nonprovider Site		in tal	Ratio (col. 1 (col. 1 + col 2))	
Section 5504 of the ACA Current	Year FTE Residents in	n Nonprovider	Setti ngs	1.00 sEffective	<u>2.00</u> for cost re		3.00 ng periods	-
beginning on or after July 1, 2 66.00 Enter in column 1 the number of attributable to rotations occur column 2 the number of unweight trained in your hospital. Enter by (column 1 + column 2)). (see	unweighted non-prima ring in all nonprovide ed non-primary care re in column 3 the ratio	er settings. I esident FTEs tl	Enter ir nat		00	0.00	0. 00000	0 66.00
	Program Name	Program C	ode	Unwei ghted FTEs Nonprovi der Si te		in tal	Ratio (col. 3 (col. 3 + col 4))	
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 residen FTEs that trained in your hospital. Enter in column 5, th ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	t	2.00		3.00	4.00	0.00	5.00	0 67.00
						1.00	0 2.00 3.00	_
Inpati ent Psychi atric Facility70.00Is this facility an Inpatient F Enter "Y" for yes or "N" for r71.00If line 70 yes: Column 1: Did t recent cost report filed on or CFR 412.424(d)(1)(iii)(c)) Colu in accordance with 42 CFR 412.4 column 2 is Y, indicate which p instructions)	sychiatric Facility (I o. he facility have an ap before November 15, 20 mn 2: Did this facilit 24 (d)(1)(iii)(D)? Ent	pproved GME tea 004? Enter "Y ty train reside ter "Y" for yes	aching p 'for ye ents in s or "N"	program in the es or "N" for a new teachir for no. Colu	e most no. (see 4 ng program umn 3: lf	N	0	70.00
Inpatient Rehabilitation Facili								
<ul> <li>75.00 Is this facility an Inpatient F subprovider? Enter "Y" for yes</li> <li>76.00 If line 75 yes: Column 1: Did t recent cost reporting period er no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ent which program year began during</li> </ul>	and "N" for no. he facility have an ap ding on or before Nove train residents in a er "Y" for yes or "N"	pproved GME tea ember 15, 2004 new teaching for no. Column	aching p ? Enter program n 3: If	orogram in the "Y" for yes o in accordance column 2 is N	or "N" for e with 42	N	0	75.00
							1.00	-
Long Term Care Hospi tal PPS 80.00 Is this a long term care hospi t 81.00 Is this a LTCH co-located withi "Y" for yes and "N" for no. TEFRA Providers					g period? E	inter	N N	80. 00 81. 00
<ul> <li>85.00 Is this a new hospital under 42</li> <li>86.00 Did this facility establish a r §413.40(f)(1)(ii)? Enter "Y" f</li> </ul>	ew Other subprovider ( or yes and "N" for no.	(excluded unit)	) under	42 CFR Sectio	on		N	85.00 86.00
87.00 Is this hospital a "subclause ( yes or "N" for no.	II) LICH CLASSIFIED U	under section	1886(d)(	(I)(B)(IV)(II)	er Enter "Y	тог	N	87.00
					V 1.00	)	XI X 2.00	-
Title V and XIX Services 90.00 Does this facility have title V	and/or VIV innoti ont	hospital corri	CAS2 Em	tor "V" for y			Y	90.00
or "N" for no in the applicable	column.			-			Y Y	
91.00 Is this hospital reimbursed for or in part? Enter "Y" for yes c	r "N" for no in the ap	pplicable colur	nn.		II N			91.00
92.00 Are title XIX NF patients occup instructions) Enter "Y" for yes	or "N" for no in the	applicable col	umn.	, ,			N	92.00
93.00 Does this facility operate an I for yes or "N" for no in the ap		urposes of titl	e V and	I XIX? Enter '	'Y'' N		N	93.00
94.00 Does title V or XIX reduce capi applicable column.		or yes, and "N'	' for no	o in the	N		Ν	94.00

Heal th Financial Systems         COMMUNITY HOSPI           HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CCN: 150113 Pe	Ir eriod:	n Lieu	u of For Workshe		
NOSTIAL AND NOSTIAL HEALTH CARE CONFLEX IDENTITICATION DATA	FIOVIDEI		om 01/01/		Part I Date/Ti 5/24/20	me Pre	epared:
			V		XI		
95.00 If line 94 is "Y", enter the reduction percentage in the app	olicable colum	2	1.00	0.00	2.0		95.00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			Ν	0.00	Ν		96.00
97.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers		ו.		0.00		0.00	97.00
105.00 Does this hospital qualify as a critical access hospital (C/ 106.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)		nod of payment	N N				105.00 106.00
107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column the GME elimination is not made on Wkst. B, Pt. I, col. 25 a reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see insti	ructions) If ye	N S,				107.00
108.00 Is this a rural hospital qualifying for an exception to the Section §412.113(c). Enter "Y" for yes or "N" for no.							108.00
	Physi cal 1.00	Occupational 2.00	Speech 3.00		Respir 4.(		-
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	<u> </u>				109.00
					1. (	00	
110.00 Did this hospital participate in the Rural Community Hospita current cost reporting period? Enter "Y" for yes or "N" for		on project (410	A Demo)for	the	N		110.00
				1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provider	. If column 2 i for long term	s "E", enter i care (includes	n column 3	N 3		0	115.00
Pub. 15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insur 118.00 s the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	rance? Enter ""	Y" for yes or "		N Y 1			116. 00 117. 00 118. 00
		Premi ums	Losses	5	Insur	ance	
		1.00	2.00		3. (	)()	-
118.01List amounts of malpractice premiums and paid losses:		496, 143		3, 369	0.0		0 118. 01
			1.00		2. (	00	1
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheo amounts contained therein.			N				118.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in for no. Is this a rural hospital with < 100 beds that qualif Harmless provision in ACA §3121 and applicable amendments? ( column 2, "Y" for yes or "N" for no.	n column 1, "Y fies for the Ou	' for yes or "N utpatient Hold	N		N		119.00 120.00
121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	antable device	s charged to	Y				121.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for enter certification date(s) (mm/dd/yyyy) below.	or yes and "N"	for no. If yes	, N				125. 00
126.00 If this is a Medicare certified kidney transplant center, er column 1 and termination date, if applicable, in column 2.							126.00
127.00 If this is a Medicare certified heart transplant center, ent column 1 and termination date, if applicable, in column 2.							127.00
<ul> <li>128.00 If this is a Medicare certified liver transplant center, enter, column 1 and termination date, if applicable, in column 2.</li> <li>129.00 If this is a Medicare certified lung transplant center, enter</li> </ul>							128.00 129.00
column 1 and termination date, if applicable, in column 2. 130.00 f this is a Medicare certified pancreas transplant center,	enter the cer						130. 00
in column 1 and termination date, if applicable, in column 2 131.00 If this is a Medicare certified intestinal transplant center	r, enter the ce	ertification da	te				131.00
in column 1 and termination date, if applicable, in column 2 132.00 If this is a Medicare certified islet transplant center, ent column 1 and termination date, if applicable, in column 2.		cation date in					132.00
133.00 If this is a Medicare certified other transplant center, ent column 1 and termination date, if applicable, in column 2.	ter the certifi	cation date in					133.00
134.00 If this is an organ procurement organization (OPO), enter th	he OPO number i	n column 1 and					134.00

Health Financial Systems	COMMUNI TY HO	SPITAL ANDERSON				In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi de	r CCN: 1501		eri od:	104 10045	Worksheet S-2	
				Fr		/01/2015	Part I Date/Time Pre	pared <sup>.</sup>
							5/24/2016 1:2	
						1.00	2.00	
All Providers 140.00Are there any related organization	or home office costs (	as dofined in Cl	IS Dub 15	1		Y	HB0040	140.00
chapter 10? Enter "Y" for yes or "					re	T		140.00
claimed, enter in column 2 the hom				0010 4				
1.00		2.00				3.00		
If this facility is part of a chai				he nam	ne and	address	of the	
home office and enter the home off 141.00Name: COMMUNITY HEALTH NETWORK	Contractor name and Contractor's Name:			ractor	's Num	ber: 0810	1	141.00
142. 00 Street: 1500 NORTH RITTER AVE	PO Box:	WFJ	Cont	actor	SINUI			141.00
143. 00 City: INDIANAPOLIS	State:	IN	Zip	Code:		4621	9	143.00
			- · ·					
							1.00	
144.00 Are provider based physicians' cos	sts included in Workshee	et A?					Y	144.00
						1 00	2.00	
145.00 If costs for renal services are cl	aimed on Wkst A line	74 are the cos	ts for inn	atient		1.00 Y	2.00	145.00
services only? Enter "Y" for yes o								145.00
dialysis facility include Medicare	e utilization for this o							
for yes or "N" for no in column 2.								
146.00 Has the cost allocation methodolog						Ν		146.00
"Y" for yes or "N" for no in colum enter the approval date (mm/dd/yyy		2, cnapter 40, §	34020) IT Y	es,				
							1.00	
147.00 Was there a change in the statisti							N	147.00
148.00 Was there a change in the order of							N	148.00
149.00 Was there a change to the simplifi	ed cost finding method?					+1 - \/	N T: +I - VIV	149.00
		Part A 1.00	Part 2.0			tle V 3.00	Title XIX 4.00	
Does this facility contain a provi	der that qualifies for							
or charges? Enter "Y" for yes or '								
155.00Hospi tal		N	N			N	N	155.00
156.00 Subprovi der – IPF		N	N			N	N	156.00
157. 00 Subprovi der – IRF 158. 00 SUBPROVI DER		N	N			N	N	157.00
158. 00 S0BPROVI DER 159. 00 SNF		N	N			N	N	158.00 159.00
160.00HOME HEALTH AGENCY		N	N N			N	N	160.00
161.00 CMHC			N			Ν	N	161.00
161. 10 CORF			N			Ν	N	161.10
							1.00	
Multicampus							1.00	
165.00 s this hospital part of a Multica	ampus hospital that has	one or more can	nuses in d	iffere	nt CB	SAs? Ent	er N	165.00
"Y" for yes or "N" for no.			ipueses in a			Line		
	Name	County	State			CBSA	FTE/Campus	
	0	1.00	2.00	3.	00	4.00	5.00	1.1.1.00
166.00 If line 165 is yes, for each campus enter the name in column 0,							0.00	166.00
county in column 1, state in								
column 2, zip code in column 3,								
CBSA in column 4, FTE/Campus in								
column 5 (see instructions)								
							1.00	
Health Information Technology (HI	C) incentive in the Ame	rican Recovery	and Reinves	stment	Act		1.00	
167.00 Is this provider a meaningful user					Act		Y	167.00
168.00 If this provider is a CAH (line 10					enter	the	c	168.00
reasonable cost incurred for the H	HT assets (see instruct	tions)						
168.01 If this provider is a CAH and is r					hards	shi p		168. 01
exception under §413.70(a)(6)(ii)? 169.00 f this provider is a meaningful u					") ^'	tor the	0.25	169.00
transition factor. (see instruction			, (IIIE 105	13 11	), ei		0.25	107.00
					Bec	i nni ng	Endi ng	
						1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR k	eginning date and endir	ng date for the	reporting	peri od	10/	01/2012	09/30/2013	170.00
respectively (mm/dd/yyyy)								l

Health Financial Systems	COMMUNI TY HOSPI TAL	ANDERSON	In Lieu	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provider CCN: 150113	From 01/01/2015	Worksheet S-2 Part I Date/Time Pre 5/24/2016 1:2	pared:
				1.00	
171.00 If line 167 is "Y", does this provide cost plans reported on Wkst. S-3, Pt. instructions)				Ν	171.00

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der	CCN: 150113	Period: From 01/01/2015 To 12/31/2015		
					10 12/31/2013	Date/Time Pr 5/24/2016 1:	26 pm
					Y/N	Date	
					1.00	2.00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format.	OONSES. ENTER N TOR	all nu re	esponses. Ente	er all dates in t	tne	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation						_
0	Has the provider changed ownership immediatel	y prior to the beg	inning of	the cost	N		1
	reporting period? If yes, enter the date of t			instructions)			
				Y/N	Date	V/I	_
0	Has the provider terminated participation in	the Medicare Progr	am? If ves	1.00 N	2.00	3.00	2
	enter in column 2 the date of termination and voluntary or "I" for involuntary.			, iv			
00	Is the provider involved in business transact	tions, including ma	nagement	N			3.
	contracts, with individuals or entities (e.g.			br			
	medical supply companies) that are related to			-			
	officers, medical staff, management personnel directors through ownership, control, or fami						
	relationships? (see instructions)						
				Y/N	Туре	Date	
	Financial Data and Reports			1.00	2.00	3.00	_
0	Column 1: Were the financial statements prep	bared by a Certifie	d Public	Y	A		4
	Accountant? Column 2: If yes, enter "A" for	Audited, "C" for C	ompiled, o	br			
	"R" for Reviewed. Submit complete copy or ent 3. (see instructions) If no, see instructions		in column				
0	Are the cost report total expenses and total		from thos	se N			5
-	on the filed financial statements? If yes, su						
					Y/N	Legal Oper.	_
	Approved Educational Activities				1.00	2.00	_
0	Column 1: Are costs claimed for nursing scho	ol? Column 2: If	yes, is th	ne provider is	s N		6
	the legal operator of the program?						
0	Are costs claimed for Allied Health Programs?			during the c	Y N		7
0	Were nursing school and/or allied health progreporting period? If yes, see instructions.	grams approved and/	or renewed	a during the c	cost N		8
0	Are costs claimed for Interns and Residents i	n an approved grad	uate medio	cal education	Ν		9
	program in the current cost report? If yes, s						
00	Was an approved Intern and Resident GME progr reporting period? If yes, see instructions.	ram initiated or re	newed in 1	the current co	ost N		10.
00	Are GME cost directly assigned to cost center	rs other than I & R	in an App	oroved Teachir	ng N		11
	Program on Worksheet A? If yes, see instructi	ons.					
						Y/N 1.00	
	Bad Debts					Y/N 1.00	
00	Is the provider seeking reimbursement for bac	debts?lfyes, se				1.00 Y	
00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad deb	debts?lfyes, se			ost reporting	1.00	
00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad deb period? If yes, submit copy.	d debts? If yes, se ot collection polic	y change o	during this co		1.00 Y N	13
00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad deb	d debts? If yes, se ot collection polic	y change o	during this co		1.00 Y	13
00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad deb period? If yes, submit copy. If line 12 is yes, were patient deductibles a	d debts? If yes, se ot collection polic and/or co-payments	y change o waived? If	during this co * yes, see ins yes, see inst	ructions.	1.00 Y N N	13. 14.
00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad deb period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	d debts? If yes, se ot collection polic and/or co-payments or cost reporting p	y change o waived? If eriod? If	during this co <sup>≈</sup> yes, see ins yes, see inst	structions.	1.00 Y N N Part B	13
00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad deb period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	d debts? If yes, se ot collection polic and/or co-payments	y change o waived? If eriod? If	during this co * yes, see ins yes, see inst	ructions.	1.00 Y N N	13
00 00 00 00 00 00 00 00 00 00 00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the pric	d debts? If yes, se ot collection polic and/or co-payments or cost reporting p Descriptic	y change o waived? If eriod? If	during this co yes, see inst yes, see inst Pa Y/N 1.00	art A 2.00	1.00 Y N N Part B Y/N 3.00	13 14 15
00 00 00 00 00 00 00 00 00 00 00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the pric PS&R Data Was the cost report prepared using the PS&R	d debts? If yes, se ot collection polic and/or co-payments or cost reporting p Descriptic	y change o waived? If eriod? If	during this co yes, see ins yes, see inst Y/N	structions.	1.00 Y N N Part B Y/N	13 14 15
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00 00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the price PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R	d debts? If yes, se ot collection polic and/or co-payments or cost reporting p Descriptic	y change o waived? If eriod? If	during this co yes, see inst yes, see inst Pa Y/N 1.00	art A 2.00	1.00 Y N N Part B Y/N 3.00	13. 14. 15. 16.
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00 00 00 00 00 00 00 00 00 00 00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the price PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	d debts? If yes, se of collection polic and/or co-payments or cost reporting p Descriptic 0	y change o waived? If eriod? If	yes, see inst yes, see inst Y/N 1.00 Y	art A 2.00	1.00 Y N N Part B Y/N 3.00 Y	13 14 15 16 16
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	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the price PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	d debts? If yes, se of collection polic and/or co-payments or cost reporting p Descriptic 0	y change o waived? If eriod? If	yes, see inst yes, see inst Y/N 1.00 Y	art A 2.00	1.00 Y N N Part B Y/N 3.00 Y	13 14. 15. 16 16 17 18
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Heal th	Financial Systems	COMMUNI TY HOSPI TAL	ANDERSON		In Lie	u of Form CMS	6-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der		Peri od:	Worksheet S	-2
					From 01/01/2015 To 12/31/2015	Part II Date/Time P	repared:
						5/24/2016 1	26 pm
		Descripti			art A	Part B	
		Descripti 0	on	Y/N 1.00	Date 2.00	Y/N 3.00	
21 00	Was the cost report prepared only using the	0		N 1.00	2.00	S.00N	21.00
	provider's records? If yes, see instructions.						
	AND FED DV AAAT DELUDUDAED AND TEEDA HAADI					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	TALS ONLY (EXCEPT O	HILDRENS H	OSPITALS)			_
22 00	Capital Related Cost Have assets been relifed for Medicare purpose	es? If ves see in	structions			N	22.00
	Have changes occurred in the Medicare depreci			als made duri	na the cost	N	23.00
	reporting period? If yes, see instructions.				5		
24.00	Were new leases and/or amendments to existing	g leases entered in	nto during	this cost rep	orting period? I	f N	24.00
25 00	yes, see instructions				I.C	N	25.00
25.00	Have there been new capitalized leases entere instructions.	ed into during the	cost repor	ting period?	TT yes, see	N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acqu	uired during the co	ost reporti	na period? If	ves, see	Ν	26.00
	instructions.	<b>J</b>		5 1	<b>J</b>		
27.00	Has the provider's capitalization policy char	nged during the cos	st reportin	g period?lf	yes, submit copy	/. N	27.00
	Interest Expense						
28.00	Were new loans, mortgage agreements or letter	rs of credit entere	ed into dur	ing the cost	reporting period	1? N	28.00
29 00	If yes, see instructions. Did the provider have a funded depreciation a	account and/or bond	d funds (De	ht Service Re	serve Fund)	Ν	29.00
27.00	treated as a funded depreciation account? If						27.00
30.00	Has existing debt been replaced prior to its	schedul ed maturi ty	y with new	debt? If yes,	see instruction	is. N	30.00
31.00	Has debt been recalled before scheduled matur	rity without issuar	nce of new	debt? If yes,	see instruction	is. N	31.00
22.00	Purchased Services				+	N	
32.00	Have changes or new agreements occurred in pa arrangements with suppliers of services? If			a through con	tractual	N	32.00
33.00	If line 32 is yes, were the requirements of S			ig to competit	ive bidding? If	Ν	33.00
	no, see instructions.		•		5		
	Provi der-Based Physi ci ans			· · · ·		-	
34.00	Are services furnished at the provider facili	ity under an arrang	gement with	provider-bas	ed physicians? I	fΥ	34.00
35 00	yes, see instructions. If line 34 is yes, were there new agreements	or amended existin	na aareemen	ts with the n	rovi der-based	Ν	35.00
00.00	physicians during the cost reporting period?				lovi del based		00.00
		· ·			Y/N	Date	
					1.00	2.00	
24 00	Home Office Costs				V		24.00
	Were home office costs claimed on the cost re If line 36 is yes, has a home office cost sta		ed by the	home office?	IF Y		36.00 37.00
57.00	yes, see instructions.	arement been prepar	ed by the				57.00
38.00	If line 36 is yes, was the fiscal year end of	of the home office	di fferent	from that of	the N		38.00
	provider? If yes, enter in column 2 the fisca						
39.00	If line 36 is yes, did the provider render se	ervices to other ch	nain compon	ents? If yes,	N		39.00
40 00	see instructions. If line 36 is yes, did the provider render se	ervices to the home	office?	lf ves see	N		40.00
40.00	instructions.		onnee:	11 yes, see	14		+0.00
			1.	00	2.	00	
44 00	Cost Report Preparer Contact Information	/ · · · · · · · · · · · · · · · · · · ·			CUEDA		40.00
41.00	Enter the first name, last name and the title by the cost report preparer in columns 1, 2,				SHERA		41.00
	respectively.	and S,					
42.00	Enter the employer/company name of the cost i	report preparerERNS	ST & YOUNG	LLP			42.00
43.00	Enter the telephone number and email address		817519		REX. SHERA@EY. C	MC	43.00
	report preparer in columns 1 and 2, respectiv	vel y.					

	Financial Systems ( AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	COMMUNITY HOSPITA		CCN: 150113	Peri od:	u of Form CMS-2 Worksheet S-2	552-
10521 1	AL AND HUSPITAL HEALTH CARE REIMBURSEMENT QUE:	STIONNALKE	Provi der	CCN: 150113	From 01/01/2015		bared 5 pm
		Part B					
		Date					
		4.00		-			
	PS&R Data	0.1.100.100.1.1					
	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)	04/20/2016					16. (
	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2	2					17. (
	and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes can instructions	5					18. (
	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.						19. (
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:						20. (
	Was the cost report prepared only using the provider's records? If yes, see instructions.						21. (
			3	. 00			
1. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title by the cost report preparer in columns 1, 2,		ECUTIVE DIR	ECTOR			41.
2.00 3.00	respectively. Enter the employer/company name of the cost r Enter the telephone number and email address report preparer in columns 1 and 2, respectiv	of the cost					42. 43.

	Financial Systems ( AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC)	COMMUNITY HOSPI			CCN: 150113	Pe	riod:	u of Form CMS-2 Worksheet S-3	
1103FT I	AL AND HOSFITAL HEALTH CARE COMFLEX STATISTIC	AL DATA	FIC	vi uei	CCN. 150115		om 01/01/2015	Part I	
						То		Date/Time Pre	
								5/24/2016 1:2 /P Days / 0/P	6 pm
								Visits / Trips	
	Component	Worksheet A	No. of	Beds	Bed Days		CAH Hours	Title V	
	Component	Line Number		2000	Avai I abl e		or an initial of		
		1.00	2.0	0	3.00		4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		128	46, 72	20	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 I PF 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			128	46, 72	20	0.00	0	7.00
7.00	beds) (see instructions)			120	40, 72	20	0.00	0	7.00
8.00	INTENSI VE CARE UNI T	31.00		12	4, 38	80	0.00	0	8.00
9.00	CORONARY CARE UNIT	32.00		0	.,	0	0,00	0	9.00
10.00	BURN INTENSIVE CARE UNIT	33.00		0		0	0.00	0	10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T	34.00		0		0	0.00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)			-					12.00
13.00	NURSERY	43.00						0	13.00
14.00	Total (see instructions)			140	51, 10	00	0.00	0	14.00
15.00	CAH visits							0	15.00
16.00	SUBPROVIDER – IPF	40.00		0		0		0	16.00
17.00	SUBPROVIDER – IRF	41.00		0		0		0	17.00
18.00	SUBPROVIDER	42.00		0		0		0	18.00
19.00	SKILLED NURSING FACILITY	44.00		0		0		0	19.00
20.00	NURSING FACILITY	45.00		0		0		0	20.00
21.00	OTHER LONG TERM CARE	46.00		0		0		_	21.00
22.00	HOME HEALTH AGENCY	101.00						0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P. )	115.00		0		~			23.00
24.00 24.10	HOSPICE	116.00 30.00		0		0			24.00 24.10
24.10	HOSPICE (non-distinct part) CMHC - CMHC	99. 00						0	24.10
25.00	CMHC - CORF	99.00 99.10						0	25.00
26.00	RURAL HEALTH CLINIC	88.00						0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00						0	26.25
27.00	Total (sum of lines 14-26)	07.00		140				Ū	27.00
28.00	Observation Bed Days							0	28.00
29.00	Ambul ance Trips							Ū	29.00
30.00	Employee discount days (see instruction)								30.00
31.00	Employee discount days - IRF								31.00
32.00	Labor & delivery days (see instructions)			0		0			32.00
32. 01	Total ancillary labor & delivery room								32.01
	outpatient days (see instructions)								
33.00	LTCH non-covered days								33.00

iospi 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der		eriod: rom 01/01/2015 o 12/31/2015	Worksheet S-3 Part I Date/Time Pre 5/24/2016 1:2	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	9, 095	924	20, 388			1.00
2.00	HMO and other (see instructions)	3, 288	3, 356				2.00
3.00	HMO IPF Subprovider	0	0				3.00
1.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
o. 00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	9, 095	924	20, 388			7.00
3.00	INTENSIVE CARE UNIT	1, 268	0	1, 317			8.00
9.00	CORONARY CARE UNI T	0	0	0			9.00
0.00	BURN INTENSIVE CARE UNIT	0	0	0			10.00
1.00	SURGI CAL I NTENSI VE CARE UNI T	0	0	0			11.00
2.00	OTHER SPECIAL CARE (SPECIFY)	-	-	-			12.00
3.00	NURSERY		1, 939	2, 103			13.00
4.00	Total (see instructions)	10, 363	2, 863	23, 808		1,014.45	
5.00	CAH visits	10, 505	2,000	23,000	0.00	1, 014. 43	15.00
6.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	
7.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	
8.00	SUBPROVI DER	0	0	0	0.00	0.00	
9.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	
20.00	NURSING FACILITY	0	0	0	0.00	0.00	•
21.00	OTHER LONG TERM CARE		0	0	0.00	0.00	
22.00		0	0	0	0.00	0.00	
2.00	HOME HEALTH AGENCY	U	0	0	0.00		
	AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE		0	0		0.00	
24.00		0	0	0	0.00	0.00	
24.10	HOSPICE (non-distinct part)	0	0	237	0.00	0.00	24.10
25.00	CMHC - CMHC	0	0	0	0.00	0.00	
25.10	CMHC - CORF	0	0	0	0.00	0.00	
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00		
27.00	Total (sum of lines 14-26)				0.00	1, 014. 45	
28.00	Observation Bed Days		1, 205	2, 442			28.00
29.00	Ambul ance Tri ps	0					29.00
30.00	Employee discount days (see instruction)			401			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	72	104			32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32. 01
33.00	LTCH non-covered days	0					33.0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTI	CAL DATA	Provi der	CCN: 150113	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part I Date/Time Pre 5/24/2016 1:2	pared:
	Full Time Equivalents		Di s	charges		
Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	Workers 11.00	12.00	13.00	14.00	Patients 15.00	
1 00 Hospital Adults & Pods (columns 5 6 7 and		12.00				1.00
<ol> <li>Hospital Adults &amp; Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)</li> <li>HMO and other (see instructions)</li> <li>HMO and other (see instructions)</li> <li>HMO IPF Subprovider</li> <li>O HMO IRF Subprovider</li> <li>Hospital Adults &amp; Peds. Swing Bed SNF</li> <li>Hospital Adults &amp; Peds. Swing Bed SNF</li> <li>Hospital Adults and Peds. (exclude observation beds) (see instructions)</li> <li>O Total Adults and Peds. (exclude observation beds) (see instructions)</li> <li>O INTENSIVE CARE UNIT</li> <li>O CORONARY CARE UNIT</li> <li>O GURN INTENSIVE CARE UNIT</li> <li>O UTHER SPECIAL CARE (SPECIFY)</li> <li>O UTHER SPECIAL CARE (SPECIFY)</li> <li>O CH visits</li> <li>O SUBPROVIDER - IPF</li> <li>O SUBPROVIDER - IRF</li> <li>O OTHER LONG TERM CARE</li> <li>O HOKE HEALTH AGENCY</li> <li>O AMBULATORY SURGICAL CENTER (D. P.)</li> <li>O CMHC - CORF</li> <li>O RURAL HEALTH CLINIC</li> <li>FEDERALLY QUALIFIED HEALTH CENTER</li> <li>O Total (sum of lines 14-26)</li> <li>O Boservation Bed Days</li> <li>O Ambul ance Trips</li> <li>O OBServation Bed Days</li> <li>O Ambul ance Trips</li> <li>O Deservation Bed Days</li> <li>O Ambul ance Trips</li> <li>O Dason &amp; delivery days (see instructions)</li> <li>O Employee discount days (see instructions)</li> <li>O Employee discount days (see instructions)<!--</td--><td></td><td></td><td>8</td><td>30 0 0 0</td><td>7, 165 7, 165 0 0 0 0</td><td>2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 11. 00 12. 00 13. 00</td></li></ol>			8	30 0 0 0	7, 165 7, 165 0 0 0 0	2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 11. 00 12. 00 13. 00

HOSPI T	Financial Systems AL WAGE INDEX INFORMATION			Provi der	1	Period: From 01/01/2015 Fo 12/31/2015		pared:
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Sal ari es (col . 2 ± col .		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							
1.00	Total salaries (see	200.00	56, 291, 520	C	56, 291, 520	2, 110, 063. 23	26.68	1.00
2.00	instructions) Non-physician anesthetist Part		C	c		0.00	0.00	2.00
	A							
3.00	Non-physician anesthetist Part B		742, 557	0	742, 55	7 9, 479. 70	78.33	3.00
4.00	Physician-Part A -		C	C		0.00	0.00	4.00
4.01	Administrative Physicians - Part A - Teaching		C	0		0.00	0.00	4.01
5.00	Physician-Part B		11, 860	-	11, 860			
6.00	Non-physician-Part B		C	C		0.00		
7.00	Interns & residents (in an approved program)	21.00	C	C		0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved		C	c		0.00	0.00	7.01
8.00	programs) Home office personnel		C	0		0.00	0.00	8.00
9.00	SNF	44.00	C	C		0.00	0.00	
10. 00	Excluded area salaries (see		3, 102, 567	30, 552	3, 133, 119	9 90, 495. 47	34. 62	10.00
	instructions) OTHER WAGES & RELATED COSTS							-
11.00	Contract Labor: Direct Patient		1, 564, 091	C	1, 564, 09	1 16, 423. 79	95. 23	11.00
12.00	Care Contract Labor: Top Level management and other managemen		C	c		0.00	0.00	12.00
12 00	and administrative services		140,400		140.40	1 ( ) 0 ( 7	01.0/	12.00
13.00	Contract Labor: Physician-Part A - Administrative		148, 400	C	148, 400	1, 629. 67	91.06	13.00
14.00	Home office salaries &		1,098,860	C	1, 098, 860	21, 594. 00	50. 89	14.00
15.00	wage-related costs Home office: Physician Part A	_	C	0		0.00	0.00	15.00
101.00	Administrative		c c					
16.00	Home office and Contract Physicians Part A - Teaching WAGE-RELATED COSTS		C	C	(	0.00	0.00	16.00
17.00	Wage-related costs (core) (see		14, 698, 908	C	14, 698, 908	3		17.00
18.00	instructions) Wage-related costs (other) (see	2	C			0		18.00
10.00	instructions)		C					10.00
	Excluded areas		869, 739					19.00
20.00	Non-physician anesthetist Part A		C					20.00
21. 00	Non-physician anesthetist Part B		C	C	(	D		21.00
22.00	Physician Part A -		C	C		C		22.00
22. 01	Administrative Physician Part A - Teaching		C	0		b		22.01
23.00	Physician Part B		211, 485	C	211, 48	5		23.00
24.00 25.00	Wage-related costs (RHC/FQHC) Interns & residents (in an		C	0				24.00 25.00
25.00	approved program)		C					25.00
	OVERHEAD COSTS - DI RECT SALARI E			-		-		
26.00 27.00	Employee Benefits Department Administrative & General	4.00 5.00	2, 710, 920 9, 265, 775					
27.00	Administrative & General under	5.00	9, 265, 775 6, 162, 809		6, 162, 80			
	contract (see inst.)							
29.00 30.00	Maintenance & Repairs Operation of Plant	6.00 7.00	C 1, 926, 783		1, 926, 78	0.00 3 73,208.63		29.00 30.00
30.00	Laundry & Linen Service	8.00	1, 720, 783	57, 413				30.00
32.00	Housekeepi ng	9.00	1, 244, 783			81, 121. 41	14.64	32.00
33.00	Housekeeping under contract (see instructions)		C	0		0.00	0.00	33.00
34.00	Di etary	10.00	1, 310, 281	-829, 487	480, 794	4 30, 839. 25	15. 59	34.00
	Dietary under contract (see		C	C C	1	0.00		
36. 00	instructions) Cafeteria	11.00	~	829, 487	829, 48	53, 206. 00	15 50	36.00
36.00	Maintenance of Personnel	12.00	C.	ozy, 487 0	029,48	0.00		
38.00	Nursing Administration	13.00	1, 026, 371		1, 026, 37	1 23, 188. 03	44.26	38.00
39.00	Central Services and Supply Pharmacy	14.00	836, 657					39.00
	I FLIAL IIIACV	15.00	1, 501, 512	0	1, 501, 512	∠I 4Z,88I.03	35.02	40.00

Health Financial Systems	(	COMMUNI TY HOSP	ITAL ANDERSON		In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Period:	Worksheet S-3	
					From 01/01/2015		narod
						5/24/2016 1:2	
	Worksheet A	Amount	Recl assi fi cati	Adj usted		Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00 Medical Records & Medical Records Library	16.00	1, 174, 141	0	1, 174, 14	47, 882. 13	24. 52	41.00
42.00 Social Service	17.00	0	0	(	0.00	0.00	42.00
43.00 Other General Service	18.00	0	0	(	0.00	0.00	43.00

Heal th	Financial Systems	(	COMMUNI TY HOSP	ITAL ANDERSON		In Lie	u of Form CMS-2	2552-10
HOSPI 1	AL WAGE INDEX INFORMATION			Provi der		Period:	Worksheet S-3	
						From 01/01/2015 To 12/31/2015	Date/Time Prep	
						_	5/24/2016 1:20	
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see instructions	)	61, 699, 912	0	61, 699, 91	2 2, 165, 263. 73	28. 50	1.00
2.00	Excluded area salaries (see		3, 102, 567	30, 552	3, 133, 11	9 90, 495. 47	34.62	2.00
	instructions)							
3.00	Subtotal salaries (line 1 minu	5	58, 597, 345	-30, 552	58, 566, 79	3 2,074,768.26	28. 23	3.00
	line 2)							
4.00	Subtotal other wages & related		2, 811, 351	0	2, 811, 35	1 39, 647. 46	70. 91	4.00
	costs (see inst.)						-	
5.00	Subtotal wage-related costs		14, 698, 908	0	14, 698, 90	в 0.00	25. 10	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		76, 107, 604	-30, 552	76, 077, 05	2 2, 114, 415. 72	35. 98	6.00
7.00	Total overhead cost (see		27, 160, 032		27, 160, 03			
	instructions)		2., 100, 002	j ő	2., 100,00		27.77	
				I	1	I	I I	

Heal th	Financial Systems COMMUN	NITY HOSPITAL AND	ERSON		In Lie	u of Form CMS-2	2552-10
HOSPI 1	AL WAGE RELATED COSTS	Pro	ovider CCI	l: 150113	Period: From 01/01/2015 To 12/31/2015		pared:
						Amount	
						Reported	
						1.00	
	PART IV - WAGE RELATED COSTS						
	Part A - Core List						
1 00	RETIREMENT COST					0	1 00
1.00	401K Employer Contributions					0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution					0	2.00
3.00 4.00	Nonqualified Defined Benefit Plan Cost (see instru Qualified Defined Benefit Plan Cost (see instructi					0	3.00 4.00
4.00	PLAN ADMINISTRATIVE COSTS (Paid to External Organi					2, 996, 428	4.00
5.00	401K/TSA Plan Administration fees	2411011)				0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan					0	6.00
7.00	Employee Managed Care Program Administration Fees					0	7.00
7.00	HEALTH AND INSURANCE COST					0	7.00
8.00	Health Insurance (Purchased or Self Funded)					8, 247, 295	8.00
9.00	Prescription Drug Plan					0, 247, 273	9.00
10.00	Dental, Hearing and Vision Plan					0	10.00
11.00	Life Insurance (If employee is owner or beneficiar	-v)				28, 299	
12.00	Accident Insurance (If employee is owner or benefi					20, 2, ,	12.00
13.00	Disability Insurance (If employee is owner or bene					196, 058	
14.00	Long-Term Care Insurance (If employee is owner or					0	14.00
15.00	'Workers' Compensation Insurance	· · · · · · · · · · · · · · · · · · ·				195, 850	15.00
16.00	Retirement Health Care Cost (Only current year, no	ot the extraordina	ary accrua	I require	d by FASB 106. No		16.00
	cumulative portion)		5	•	3		
	TAXES						
17.00	FICA-Employers Portion Only					3, 973, 523	17.00
18.00	Medicare Taxes - Employers Portion Only					0	18.00
19.00	Unemployment Insurance					89, 034	19.00
20.00	State or Federal Unemployment Taxes					0	20.00
	OTHER						
21.00	Executive Deferred Compensation (Other Than Retire instructions))	ement Cost Reporte	ed on line	s 1 throu	gh 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances					0	22.00
23.00	Tuition Reimbursement					53, 643	
24.00	Total Wage Related cost (Sum of lines 1 -23)					15, 780, 130	24.00
	Part B - Other than Core Related Cost						
25.00	OTHER WAGE RELATED COSTS (SPECIFY)					0	25.00

Heal th	Financial Systems	COMMUNI TY	HOSPI TAL	ANDERSON		In Lie	u of Form CMS-	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST			Provi der	CCN: 15	Peri od:	Worksheet S-3	
						From 01/01/2015		
						To 12/31/2015	Date/Time Pre 5/24/2016 1:2	
	Cost Center Description					 Contract Labor	Benefit Cost	
	cost center bescription					1.00	2,00	
	PART V - Contract Labor and Benefit Cost					 1.00	2.00	
	Hospital and Hospital-Based Component Ident	ification:						1
1.00	Total facility's contract labor and benefit	cost				0	0	1.00
2.00	Hospi tal					0	0	2.00
3.00	Subprovider - IPF					0	0	3.00
4.00	Subprovider - IRF					0	0	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	Hospital-Based SNF					0	0	8.00
9.00	Hospital-Based NF					0	0	9.00
10.00	Hospital-Based OLTC							10.00
11.00	Hospital-Based HHA					0	0	11.00
12.00	Separately Certified ASC					0	0	12.00
13.00	Hospital-Based Hospice					0	0	13.00
14.00	Hospital-Based Health Clinic RHC					0	0	14.00
15.00	Hospital-Based Health Clinic FQHC					0	0	15.00
16.00	Hospital-Based-CMHC					0	0	16.00
16. 10	Hospital-Based-CMHC 10					0	0	16. 10
17.00	Renal Dialysis					0	0	17.00
18.00	Other					0	0	18.00

Heal th	Financial Systems COMMUNITY HOSPITAL A	NDERSON		ln Li€	eu of Form CMS	5-2552-10
			CCN: 150113	Peri od:	Worksheet S	
				From 01/01/2015		
				To 12/31/2015	Date/Time P 5/24/2016 1	
					1 37 247 2010 1	
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by li	ne 202 columr	8)	0. 2666	71 1.00
	Medicaid (see instructions for each line)	-				
2.00	Net revenue from Medicaid				28, 021, 7	78 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 or supplemental	payments <sup>·</sup>	from Medicaid	?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from I	Medi cai d				0 5.00
6.00	Medicaid charges				56, 282, 1	78 6.00
7.00	Medicaid cost (line 1 times line 6)				15, 008, 82	
8.00	Difference between net revenue and costs for Medicaid program (I	ine 7 min	us sum of lir	es 2 and 5; if	<	0 8.00
	zero then enter zero)					
	State Children's Health Insurance Program (SCHIP) (see instruction	ons for ea	ach line)			
9.00	Net revenue from stand-alone SCHIP					0 9.00
10.00						0 10.00
11.00						0 11.00
12.00		line 11 m	inus line 9;	if < zero then		0 12.00
	enter zero)				<u> </u>	_
10.00	Other state or local government indigent care program (see instru			<u>``</u>		
	Net revenue from state or local indigent care program (Not inclu					0 13.00
14.00	- J	program (I	Not included	in lines 6 or 1	ψ)	0 14.00
15.00 16.00	5 1 5	ant one	nrogrom (Lir	a 15 minua lina		0 15.00
16.00	13; if < zero then enter zero)	gent care	program (III	le 15 minus fine		0 16.00
	Uncompensated care (see instructions for each line)				<u> </u>	_
17 00	Private grants, donations, or endowment income restricted to fun	ding char	ity care		25, 6	57 17.00
18.00					107, 72	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local			s (sum of lines		0 19.00
	12 and 16)		p9	(		-
			Uni nsured	Insured	Total (col.	1
			patients	pati ents	+ col. 2)	
			1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (		6, 360, 78	1, 917, 184	8, 277, 9	73 20.00
	charges excluding non-reimbursable cost centers) for the entire					
21.00	Cost of initial obligation of patients approved for charity care	(line 1	1, 696, 23	511, 257	2, 207, 4	95 21.00
22.00	times line 20)					
22.00			1 (0/ 0)			0 22.00
23.00	Cost of charity care (line 21 minus line 22)		1, 696, 23	511, 257	2, 207, 4	25 23.00
					1.00	
24 00	Does the amount in line 20 column 2 include charges for patient	days hevo	nd a length o	f stay limit	1.00	24.00
24.00	imposed on patients covered by Medicaid or other indigent care p		na a rength e	in Stay minit		24.00
25.00			oaram's Lenat	h of stav limit		0 25.00
26.00					8, 627, 3	
27.00					473, 8	
28.00			s line 27)		8, 153, 50	
29.00				28)	2, 174, 30	
30.00				- /	4, 381, 79	
	Total unreimbursed and uncompensated care cost (line 19 plus line	e 30)				31.00

LULAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		Period: From 01/01/2015	Worksheet A	
					o 12/31/2015	Date/Time Pre 5/24/2016 1:2	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		0	C	4, 712, 826	4, 712, 826	1.00
. 00	00200 CAP REL COSTS-MVBLE EQUIP		0	C	3, 620, 090	3, 620, 090	2.00
. 00	00300 OTHER CAP REL COSTS	0 710 000	0	0	0	0	3.00
. 00 . 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	2, 710, 920 9, 265, 775	12, 111, 662 17, 394, 923			14, 701, 700 24, 447, 828	4.00 5.00
. 00	00600 MAI NTENANCE & REPAI RS	0	0	20,000,070	0 0	0	6.00
. 00	00700 OPERATION OF PLANT	1, 926, 783	6, 426, 845	8, 353, 628		7, 418, 503	
. 00 . 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0 1, 244, 783	0 381, 611	1, 626, 394	146, 970 -166, 081	146, 970 1, 460, 313	8.00 9.00
0.00	01000 DI ETARY	1, 310, 281	1, 155, 563				
1.00		0	0	0	1, 561, 028		
3.00 4.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	1, 026, 371 836, 657	142, 419 2, 177, 987			1, 168, 587 2, 904, 033	13.00 14.00
5.00	01500 PHARMACY	1, 501, 512	6, 199, 481				
6.00	01600 MEDICAL RECORDS & LIBRARY	1, 174, 141	460, 835	1, 634, 976	-65	1, 634, 911	16.00
7.00 9.00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0			0	17.00 19.00
0.00	02000 NURSI NG SCHOOL	0	0	c c	0	0	20.00
1.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	C	0	0	21.00
2.00 3.00	02200 I & SERVICES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM-(EMS)	0	0		0 0 63, 986	0 63, 986	22.00 23.00
0.00	INPATIENT ROUTINE SERVICE COST CENTERS						20.00
0.00	03000 ADULTS & PEDIATRICS	11, 451, 419	2, 574, 744				
1.00 2.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	1, 575, 190	704, 754 0	2, 279, 944	-440, 606	1, 839, 338 0	31.00 32.00
3.00	03300 BURN INTENSIVE CARE UNIT	0	0		0	0	33.00
4.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	C	0	0	34.00
0.00	04000 SUBPROVIDER - IPF	0	0	C C	0	0	40.00
1.00 2.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	0			0	41.00
3.00	04300 NURSERY	0	2, 868	2, 868	595, 301	598, 169	
4.00	04400 SKI LLED NURSI NG FACI LI TY	0	0	C	0	0	44.00
5.00 6.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0			0	45.00 46.00
	ANCILLARY SERVICE COST CENTERS			1	-		
0.00 1.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	4, 259, 079	16, 798, 843	21, 057, 922	-14, 970, 206	6, 087, 716 0	50.00 51.00
2.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
3.00	05300 ANESTHESI OLOGY	742, 557	2, 755, 270			3, 435, 160	
4.00	05400 RADI OLOGY - DI AGNOSTI C	2, 390, 849 0	1, 663, 803				
5.00 6.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	248, 272	0 568, 469	-	-		
7.00	05700 CT SCAN	334, 403	514, 360	848, 763	-371, 516	477, 247	57.00
8.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	305, 629	505, 628			511, 290 735, 404	
9.00 0.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	585, 134 2, 031, 214	1, 266, 193 3, 390, 024				59.00 60.00
0. 01	06001 BLOOD LABORATORY	0	0	C		0	60. O
1.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	005 507	0		0	0	61.00
2.00 3.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	205, 527	535, 115 0	740, 642	-515, 637	225,005	62.00 63.00
4.00	06400 I NTRAVENOUS THERAPY	0	0	c c	0	0	64.00
5.00	06500 RESPI RATORY THERAPY	795, 241	268, 788			914, 329	65.00
6.00 7.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 585, 887 317, 673	454, 028 30, 517			1, 913, 344 351, 308	66.00 67.00
8.00	06800 SPEECH PATHOLOGY	178, 201	16, 906				
9.00	06900 ELECTROCARDI OLOGY	431, 013	125, 052				69.00
0.00 1.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	479, 431	267, 201 0	746, 632		694, 564 10, 120, 921	70.00
2.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		10, 120, 921	10, 120, 921	72.00
3.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	5, 598, 680	5, 598, 680	73.00
4.00 5.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	152, 628 0			149, 404	74.00 75.00
5.00	OUTPATIENT SERVICE COST CENTERS		0		<u>''</u> 0	0	, 5.00
8. 00	08800 RURAL HEALTH CLINIC	0	0	C	0	0	
9.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0	C	0	0	89.00
0. 00 0. 01	09001 WOUND/OSTOMY CLINIC	339, 468	0 753, 497	1, 092, 965	-209, 281	0 883, 684	90.00 90.01
0. 02	09002 KIDS PLUS CLINIC	0	0	C	0 0	0	90. 02
0.03		766, 286	-5,051,714				
0. 04	09004 MUNCIE CLINIC 09005 ANTICOAGULATION CLINIC	0 247, 583	125, 657 71, 813			55, 753 272, 231	90.04 90.05

Health Financial Systems	COMMUNI TY HOSPI T	AL ANDERSON		In Lie	eu of Form CMS-:	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		Period:	Worksheet A	
				From 01/01/2015 To 12/31/2015		
Cost Contor Description	Calarian	Othor	Tatal (agl (	Deel eesi fi eeti	5/24/2016 1:2	6 pm
Cost Center Description	Sal ari es	Other	+ col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance	
			+ cor. 2)	UII3 (See A-0)	(col . 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
90.06 09006 PREGNANCY PLUS	133, 951	18, 953	152, 90	4 -922	151, 982	90.06
90. 07 09007 0/P LAB	0	0		0 0	0	90.07
90. 08 09008 0/P LAB	0	0		0 0	0	90.08
90. 09 09009 FORTVILLE CLINIC	0	38, 255	38, 25	5 -35, 300	2, 955	90.09
91. 00 09100 EMERGENCY	2, 787, 723	898, 686	3, 686, 40	9 -601, 517	3, 084, 892	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS	1 T		1			
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0		0 0	0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0 0	0	97.00
99.00 09900 CMHC	0	0		0 0	0	
99.10 09910 CORF	0	0			0	
100.00 10000 I&R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY	0	0		0 0 0 0		100.00 101.00
SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0		106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0 0		107.00
108. 00 10800 LUNG ACQUI SI TI ON	0	0		0 0		108.00
109. 00 10900 PANCREAS ACQUISITION	0	0		0 0		109.00
110.00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0		111.00
113.00 11300 INTEREST EXPENSE		0		0 0		113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		0 0		114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0	0	115.00
116.00 11600 HOSPI CE	0	0		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	53, 188, 953	75, 901, 664	129, 090, 61	7 1, 046, 174	130, 136, 791	118.00
NONREI MBURSABLE COST CENTERS				-		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
190.01 19001 WELLNESS CENTERS	717, 496	425, 613	1, 143, 10	9 -32,056		
190.02 19002 EMPLOYED ORTHO MD	0	0		0 0		190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)	259, 310	42, 257	301, 56		280, 915	
190. 04 19004 SUMMIT CONV. (LTC)	188, 979	73, 779			261, 915	
190. 05 19005 PARKVI EW CONV. (LTC)	281,055	19, 960			301, 015	
190. 06 19006 MONTI CELLO HSE. (ASS' TD LVG.)	113, 174	8, 964			122, 138	
190. 07 19007 NH PARK PLACE (LTC)	29, 885	2, 219		4 U 0 0	32, 104	
190. 08 19008 MADI SON PLACE OF ELWOOD (LTC)	0	0				190. 08 190. 09
190. 09 19009 SPI NE SURGEON 190. 10 19010 CLI NI CAL RESEARCH CENTER	664, 521	241 944	906, 38	7 -41,729	864, 658	
190. 11 19011 ONCOLOGI ST	004, 321	241, 866	900, 30	7 -41,729		190. 10
190. 12 19012 MEDI CAL I NTERNI ST	68,064	61, 280	129, 34	4 -2, 512	126, 832	
190. 13 19013 RHEUMATOLOGY	414, 049	415, 194			799, 358	
191. 00 19100 RESEARCH	414,049	413, 174	027, 24	0 -27,000		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	2, 603, 065	2, 603, 06	-912, 262	1, 690, 803	
192. 01 19201 PHYSI CLANS' PRI VATE OFFICES	0	2, 300, 000	2,000,00	0 0		192.00
192. 02 19202 FOUNDATI ON	196, 440	827, 501	1, 023, 94	1 -347	1, 023, 594	
192. 03 19203 SPOE	0	0	., 020, , 1	o 0		192.02
192. 04 19204 HEALTHY HEART	169, 594	28, 620	198, 21	4 -5, 888	192, 326	
192. 05 19205 VACANT SPACE	0	0		0 0		192.05
192.07 19207 PARK PLACE CENTER	0	538	53	8 0		192.07
193.00 19300 NONPALD WORKERS	0	0		0 0		193.00
200.00 TOTAL (SUM OF LINES 118-199)	56, 291, 520	80, 652, 520	136, 944, 04	0 0	136, 944, 040	200.00

				From 01/C	1/2015		A
						Date/Time 5/24/2016	
	Cost Center Description	Adjustments	Net Expenses			0,21,2010	
		(See A-8) 6.00	For Allocation 7.00				
	GENERAL SERVICE COST CENTERS	·   .= .= .					
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	-65, 471					1.00
2.00	00300 OTHER CAP REL COSTS						3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-2, 990, 877	11, 710, 823				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	-3, 692, 640					5.00
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0 -58, 641	0 7, 359, 862				6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	-58, 641	4.4.4				8.00
9.00	00900 HOUSEKEEPI NG	0					9.00
10.00	01000 DI ETARY	0	872, 336				10.00
11.00 13.00	01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON	-836, 651	724, 377 1, 168, 587				11.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-1, 752					14.00
15.00	01500 PHARMACY	0	1, 869, 614				15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	-7, 207	1, 627, 704				16.00
17.00 19.00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0				17.00
20.00	02000 NURSI NG SCHOOL						20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0				21.00
22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	0				22.00
23.00	02300 PARAMED ED PRGM-(EMS)	177, 330	241, 316				23. 00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	-3, 381	12,067,892				30.00
31.00	03100 I NTENSI VE CARE UNI T	0,001					31.00
32.00	03200 CORONARY CARE UNI T	0	0				32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0				33.00
34.00 40.00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF						34.00 40.00
41.00	04100 SUBPROVIDER - IRF		0				41.00
42.00	04200 SUBPROVI DER	0	0				42.00
43.00		0	598, 169				43.00
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY						44.00 45.00
46.00	04600 OTHER LONG TERM CARE						46.00
	ANCI LLARY SERVI CE COST CENTERS		1				
50.00	05000 OPERATING ROOM	0					50.00
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0				51.00 52.00
53.00	05300 ANESTHESI OLOGY	-3, 375, 403	59, 757				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-323, 449	3, 081, 939				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0					55.00
56.00 57.00							56.00 57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	511, 290				58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	735, 404				59.00
60.00	06000 LABORATORY	0	3, 586, 428				60.00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0				60. 0 <sup>.</sup> 61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		225,005				62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0				64.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	-15, 906	914, 329 1, 897, 438				65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	351, 308				67.00
68.00	06800 SPEECH PATHOLOGY	0	201, 555				68.00
69.00		7,609					69.00
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	18, 422					70.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0					72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	91, 784	5, 690, 464				73.00
74.00	07400 RENAL DI ALYSI S	0					74.00
75.00	07500 ASC (NON-DI STI NCT PART) OUTPATI ENT SERVICE COST CENTERS	0	0				75.00
88. 00	08800 RURAL HEALTH CLINIC	0	0				88. 00
89.00	08900 FEDERALLY QUALI FIED HEALTH CENTER	0	0				89.00
90.00	09000 CLINIC	0					90.00
90.01	09001 WOUND/OSTOMY CLINIC	-501, 241					90.0
90. 02 90. 03	09002 KIDS PLUS CLINIC 09003 ONCOLOGY	-7, 659 -2, 478, 135					90. 02 90. 03
90.03	09004 MUNCI E CLINI C	-2,470,133					90.04
	09005 ANTI COAGULATI ON CLINIC	0					90. 0
90.05 90.06	09006 PREGNANCY PLUS		151, 982				90.00

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON			Inlieu	of Form CMS-	-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O			CCN: 150113	Peri od:	W	orksheet A	2002 10
				From 01/0		. (T) D	
				To 12/3		ate/Time Pro /24/2016 1::	
Cost Center Description	Adjustments	Net Expenses					
		For Allocation					
	6.00	7.00					
90. 08 09008 0/P LAB	0						90.08
90. 09 09009 FORTVILLE CLINIC 91. 00 09100 EMERGENCY	0 -20, 822	2, 955 3, 064, 070					90.09 91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	-20, 022	3,004,070					91.00
OTHER REI MBURSABLE COST CENTERS	<u> </u>						72.00
94.00 09400 HOME PROGRAM DI ALYSI S	0	0					94.00
95. 00 09500 AMBULANCE SERVI CES	0	0					95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0					96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0					97.00
99. 00 09900 CMHC	0	0					99.00
99.10 09910 CORF	0	0					99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0					100.00
101.00 10100 HOME HEALTH AGENCY	0	0					101.00
SPECIAL PURPOSE COST CENTERS	0	0					105.00
106. 00 10600 HEART ACQUISITION	0	0					105.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0					107.00
108. 00 10800 LUNG ACQUI SI TI ON	0	0					108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0					109.00
110.00 11000 INTESTINAL ACQUISITION	0	0					110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0					111.00
113.00 11300 INTEREST EXPENSE	0	0					113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0					114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0					115.00
116.00 11600 HOSPI CE	0	0					116.00
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	-14, 084, 090	116, 052, 701					118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0					190.00
190. 01 19001 WELLNESS CENTERS	0	1, 111, 053					190.01
190.02 19002 EMPLOYED ORTHO MD	0	0					190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)	0	280, 915					190. 03
190.04 19004 SUMMIT CONV. (LTC)	0	261, 915					190. 04
190. 05 19005 PARKVI EW CONV. (LTC)	0	301, 015					190. 05
190.06 19006 MONTI CELLO HSE. (ASS' TD LVG.)	0	122, 138					190.06
190.07 19007 NH PARK PLACE (LTC)	0	32, 104					190.07
190.08 19008 MADI SON PLACE OF ELWOOD (LTC) 190.09 19009 SPI NE SURGEON	0	0					190.08
190. 10 19009 SPINE SURGEON 190. 10 19010 CLINICAL RESEARCH CENTER	0	864, 658					190. 09 190. 10
190. 11 19011 ONCOLOGI ST	0	004, 058					190.10
190. 12 19012 MEDI CAL I NTERNI ST	0	126, 832					190.12
190. 13 19013 RHEUMATOLOGY	0	799, 358					190.13
191. 00 19100 RESEARCH	0	0					191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	1, 690, 803					192.00
192. 01 19201 PHYSI CLANS' PRI VATE OFFI CES	0	0					192.01
192. 02 19202 FOUNDATI ON	0	1, 023, 594					192. 02
192. 03 19203 SPOE	0	0					192.03
192. 04 19204 HEALTHY HEART	0	192, 326					192.04
192. 05 19205 VACANT SPACE	0	0					192.05
192. 07 19207 PARK PLACE CENTER 193. 00 19300 NONPAI D WORKERS	0	538					192. 07 193. 00
200.00 TOTAL (SUM OF LINES 118-199)	-14, 084, 090	122, 859, 950					200.00
		.22, 007, 700	I				

	Financial Systems SIFICATIONS		COMMUNI TY HOSPI		CCN: 150113	Peri od:	u of Form CMS-: Worksheet A-6	
						From 01/01/2015 To 12/31/2015	Date/Time Pre 5/24/2016 1:2	
	Cost Center	I ncreases Li ne #	Salary	Other		_l, ,	0/21/2010 112	0 011
	2.00	3.00	4.00	5.00				
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 25.\ 00\\ 24.\ 00\\ 25.\ 00\\ 24.\ 00\\ 25.\ 00\\ 25.\ 00\\ 24.\ 00\\ 25.\ 00\\ 25.\ 00\\ 26.\ 00\\ 27.\ 00\\ 28.\ 00\\ 30.\ 00\\ 31.\ 00\\ 33.\ 00\\ 34.\ 00\\ 35.\ 00\\ 35.\ 00\\ 36.\ 00\\ 37.\ 00\\ 38.\ 00\\ 39.\ 00\\ 40.\ 00\\ 00\\ 00\\ 00\\ 00\\ 00\\ 00\\ 00\\ 00\\ 00$	A - DEPRECIATION CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	3.00           1.00           2.00           0.00		3, 933, 697 3, 247, 360 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 15. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ 20. \ 00\\ 21. \ 00\\ 22. \ 00\\ 23. \ 00\\ 24. \ 00\\ 25. \ 00\\ 24. \ 00\\ 25. \ 00\\ 26. \ 00\\ 27. \ 00\\ 28. \ 00\\ 29. \ 00\\ 30. \ 00\\ 31. \ 00\\ 32. \ 00\\ 34. \ 00\\ 35. \ 00\\ 34. \ 00\\ 35. \ 00\\ 34. \ 00\\ 35. \ 00\\ 36. \ 00\\ 37. \ 00\\ 38. \ 00\\ 39. \ 00\\ 40. \ 00\\ 40. \ 00\\ 00\\ 00\\ 00\\ 00\\ 00\\ 00\\ 00\\ 00\\ 0$
1 00	TOTALS B - DRUGS & SUPPLIES MEDICAL SUDDLIES CHARCED TO	71.00		7, 181, 057				1 00
1.00	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	71.00	-	10, 120, 921				1.00
2.00	I MPL. DEV. CHARGED TO PATI ENTS	72.00	0	10, 352, 069				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 22.00 23.00 23.00 24.00 25.00	DRUGS CHARGED TO PATIENTS	$\begin{array}{c} 73.\ 00\\ 0.\ 00\ 0.\ 00\\ 0.\ 00\ 0.\ 00\\ 0.\ 00\ 0.\ 00\ 0.\ 00\ 0.\ 00\ 0.\ 00\ 0.\ 00\ 0.\ 00\ 0.\ 00\ 0.\ 0.$		5, 598, 680 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				$\begin{array}{c} 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 15. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ 20. \ 00\\ 21. \ 00\\ 22. \ 00\\ 23. \ 00\\ 24. \ 00\\ 25. \ 00\\ 25. \ 00\\ 26. \ 00\\ 27. \ 00\\ 28. \ 00\\ 29. \ 00\\ 29. \ 00\\ \end{array}$

## COMMUNITY HOSPITAL ANDERSON

Heal th	Financial Systems		COMMUNI TY HOSP	ITAL ANDERSON		In Lieu of	Form CMS-2552-10
	SIFICATIONS			Provi der	CCN: 150113		rksheet A-6
						From 01/01/2015	
							e/Time Prepared: 24/2016 1:26 pm
		Increases				572	
	Cost Center	Li ne #	Salary	Other			
	2.00	3.00	4.00	5.00			
30.00	2100	0.00	0	0.00			30.00
31.00		0.00	0	0			31.00
32.00		0.00	0	0			32.00
33.00		0.00	0	0			33.00
34.00		0.00	0	0			34.00
35.00		0.00	0	0			35.00
36.00		0.00	0	0			36.00
37.00		0.00	0	0			37.00
38.00		0.00	0	0			38.00
39.00		0.00	0	0			39.00
40.00		0.00	0	0			40.00
40.00	TOTALS			26,071,670			40.00
	C - RENT		<u>Ч</u>	20,071,070			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	286, 071			1.00
2.00	CAP REL COSTS-DEDG & TTXT	2.00	0	300, 910			2.00
3.00	CAP REL COSTS-MUBLE EQUIP	0.00	0	300, 910			3.00
4.00		0.00	0	0			4.00
4.00 5.00		0.00	0	0			5.00
6.00		0.00	0	0			6.00
7.00		0.00	0	0			7.00
7.00 8.00		0.00	0	0			8.00
8.00 9.00		0.00	0	0			9.00
			-	0			
10.00		0.00	0	0			10.00
11.00			0	<u>0</u> 0 586, 981			11.00
	TOTALS D - LABOR & DELIVERY		U	280, 981			
1.00	NURSERY	43.00	466, 052	132, 117	[		1.00
1.00	TOTALS	43.00	466, 052	13 <u>2, 1</u> 17 132, 117			1.00
	E - CAFETERIA RECLASS		400, 032	132, 117			
1.00	CAFETERI A	11.00	884, 274	779, 859			1.00
1.00	TOTALS		884, 274	779,859			1.00
	F - SPECIAL MEALS		004, 274	117,037			
1.00	DI ETARY	10.00	54, 787	48, 318			1.00
1.00	TOTALS		54, 787	48, 318			1.00
	G - INTEREST & INSURANCE		54, 707	40, 510			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	1	354, 878			1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00		138, 180			2.00
3.00	CAP REL COSTS-BEDG & TTXT	2.00		71, 820			3.00
5.00							5.00
	H - LAUNDRY		V	504, 070	<u> </u>		
1.00	LAUNDRY & LINEN SERVICE	8.00	57, 413	89, 557			1.00
1.00	TOTALS		57, 413	89, 557			1.00
	I - POB UTILITIES		57,415	07, 337			
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	5, 949			1.00
2.00	LABORATORY	60.00	0	4, 264			2.00
	PHYSICAL THERAPY	66.00	0	10, 539			
3.00 4.00	OCCUPATIONAL THERAPY	67.00	0	7, 272			3.00
	SPEECH PATHOLOGY	68.00	-				
5.00		68.00 69.00	0	8, 746			5.00
6.00			0	14, 383			6.00
7.00	ONCOLOGY	<u> </u>	0	<u>50, 486</u> 101 620			7.00
	J - EMS PARAMED		U	101, 639	I		
1 00	J - EMS PARAMED PARAMED ED PRGM-(EMS)	22.00	20 552	22 424			1.00
1.00	TOTALS	<u>23.00</u>	<u> </u>	<u>33, 434</u> 33, 434			1.00
500 00	Grand Total: Increases		1, 493, 078	35, 589, 510			500.00
500.00	orana rotar. Increases	I I	1, 473, 0/0	55, 567, 510	I		1 300.00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-2552-10
RECLASSI FI CATI ONS	Provider CCN: 150113	Peri od:	Worksheet A-6

			5/24/2016	1:2	26 pm	_
	То	12/31/2015	Date/Time	Pre	epared:	
	From	01/01/2015				
5115		Ju.	WULKSHEEL	- C	,	

		Deerseese				5/24/2016 1:	
		Decreases		0.11		1	
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRECIATION	1					-
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0				1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	1, 536, 17	0 9		2.00
3.00	OPERATION OF PLANT	7.00	0	880, 57	7 0		3.00
4.00	HOUSEKEEPI NG	9.00	0	11, 73	7 0		4.00
5.00	DI ETARY	10.00	0	27, 20	5 0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	20	3 0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	47, 46	8 0		7.00
8.00	PHARMACY	15.00	0	4, 96	5 0		8.00
9.00	ADULTS & PEDIATRICS	30, 00	0				9.00
10.00	INTENSIVE CARE UNIT	31.00	0				10.00
11.00	NURSERY	43.00	0				11.00
12.00	OPERATING ROOM	50.00	0				12.00
13.00	ANESTHESI OLOGY	53.00	0				13.00
14.00	RADI OLOGY-DI AGNOSTI C	54.00	0				14.00
14.00		56.00	0				14.00
	RADI OI SOTOPE						
16.00	CT SCAN	57.00	0				16.00
17.00	MAGNETIC RESONANCE IMAGING	58.00	0	283, 28	8 0		17.00
	(MRI)						
18.00	CARDIAC CATHETERIZATION	59.00	0				18.00
19.00	LABORATORY	60.00	0				19.00
20.00	WHOLE BLOOD & PACKED RED	62.00	0	1, 70	9 0		20.00
	BLOOD CELLS				_		
21.00	RESPI RATORY THERAPY	65.00	0				21.00
22.00	PHYSICAL THERAPY	66.00	0	5, 21	0 0		22.00
23.00	OCCUPATIONAL THERAPY	67.00	0	60	8 0		23.00
24.00	SPEECH PATHOLOGY	68.00	0	1,00	4 0		24.00
25.00	ELECTROCARDI OLOGY	69.00	0	54, 57	6 0		25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	0				26.00
27.00	WOUND/OSTOMY CLINIC	90.01	0				27.00
28.00	ONCOLOGY	90.03	0				28.00
29.00	MUNCIE CLINIC	90.04	0				29.00
30.00	ANTI COAGULATION CLINIC	90.05	0				30.00
30.00	PREGNANCY PLUS	90.05	0				30.00
		90.08 90.09	0				
32.00	FORTVILLE CLINIC						32.00
33.00	EMERGENCY	91.00	0				33.00
34.00	WELLNESS CENTERS	190.01	0				34.00
35.00	NORTHVIEW CONV. (LTC)	190.03	0				35.00
36.00	CLINICAL RESEARCH CENTER	190.10	0				36.00
37.00	MEDICAL INTERNIST	190. 12	0				37.00
38.00	RHEUMATOLOGY	190. 13	0				38.00
39.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	808, 64	7 0		39.00
40.00	HEALTHY_HEART	192.04	0		40		40.00
	TOTALS		0	7, 181, 05	7		
	B - DRUGS & SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	54, 13	3 0		1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	117, 77	1 0		2.00
3.00	OPERATION OF PLANT	7.00	0				3.00
4.00	HOUSEKEEPING	9.00	0				4.00
5.00	DI ETARY	10.00	0				5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0				6.00
7.00	PHARMACY	14.00	0		· · · ·		7.00
	MEDICAL RECORDS & LIBRARY		0				
8.00		16.00					8.00
9.00	ADULTS & PEDIATRICS	30.00	0				9.00
10.00	INTENSIVE CARE UNIT	31.00	0				10.00
11.00	OPERATING ROOM	50.00	0				11.00
12.00	ANESTHESI OLOGY	53.00	0				12.00
13.00	RADI OLOGY-DI AGNOSTI C	54.00	0				13.00
14.00	RADI OI SOTOPE	56.00	0	239, 45	8 0		14.00
15.00	CT SCAN	57.00	0	84, 81	7 0		15.00
16.00	MAGNETIC RESONANCE IMAGING	58.00	0	16, 67	9 0		16.00
	(MRI)						
17.00	CARDIAC CATHETERIZATION	59.00	0	1, 028, 58	7 0		17.00
18.00	LABORATORY	60.00	0	1, 549, 06	8 0		18.00
19.00	WHOLE BLOOD & PACKED RED	62.00	0	513, 92	8 0		19.00
	BLOOD CELLS						
20.00	RESPI RATORY THERAPY	65.00	0	115, 79	7 0		20.00
21.00	PHYSICAL THERAPY	66.00	0				21.00
22.00	OCCUPATI ONAL THERAPY	67.00	0				22.00
23.00	SPEECH PATHOLOGY	68.00	0				23.00
23.00	ELECTROCARDI OLOGY	69.00	0				23.00
24.00 25.00		70.00	0				24.00
	ELECTROENCEPHALOGRAPHY						
26.00	RENAL DIALYSIS	74.00	0				26.00
27.00	WOUND/OSTOMY CLINIC	90.01	0	180, 90	8 0		27.00

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	S

## COMMUNITY HOSPITAL ANDERSON

ANDERSON In Lieu of Form CMS-2552-10 Provider CCN: 150113 Period: Worksheet A-6 From 01/01/2015 Date/Time Prepared:

Decreases         Stary         Other         15/24/2016 1: 26 /m           6         0.00         0.00         0.00         0.00         0.00         0.00           28         00         Accolory         0.00 <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th>Prepared:</th>								Prepared:
c         c.00         7.00         8.00         9.00         10.00           28.00         MARCE CLINIC         00.03         0         29,00         30.00         28.00         30.00         28.00         30.00         28.00         30.00         28.00         30.00         28.00         30.00         28.00         30.00         28.00         30.00         28.00         30.00         28.00         30.00         28.00         30.00         28.00         30.00         30.00         30.00         30.00         30.00         30.00         31.02         32.00         33.00         32.00         33.00         30.00         33.00         30.00         33.00         30.00         33.00         30.00         30.00         30.00 </th <th></th> <th></th> <th>Decreases</th> <th></th> <th></th> <th></th> <th>372472010</th> <th></th>			Decreases				372472010	
28.00         NCULOY         90.03         0         259.044         0         28.00         28.00         28.00         28.00         28.00         29.00         30.00         31.00         30.00         31.00         30.00         31.00         31.00         32.00         33.00         32.00         32.00         33.00         32.00         33.00         39.00         40.00         40.00         40.00         40.00         40.00         40.00         40.00         40.00         40.00         40.00         40.00         40.00         40.0								
29.00         MARCIE CLINIC         90.0d         47         0         29.00           20.00         MATCOGUIATION (LINIC)         90.06         0         107         0         33.00           31.00         PREGNANCY PLUS         90.06         0         107         0         33.00           32.00         BREGREYY         91.00         0         423.241         0         33.00           33.00         MATCHER CUNV (LTC)         190.01         0         31.522         0         33.00           35.00         SIMUT CONC (LTC)         190.04         0         44.47         0         35.00           35.00         SIMUT CONC (LTC)         190.04         0         44.77         0         35.00           36.00         HYSICLANS FRIVATE OFFICES         192.00         0         4.776         0         38.00           37.00         GUNANTION         PLANT         7.00         0         2.60         37.00         38.00           0         PERANCY         15.00         0         28.00         38.00         38.00         38.00         38.00         38.00         38.00         38.00         38.00         38.00         38.00         38.00         38.00								
30. 00         ANTICOAGULATION CLINIC         90. 05         0         40. 297         0         30. 00           31. 00         PREARMARY PLUS         90. 06         0         107         0         33. 00           32. 00         FMERGENCY         91. 00         0         423. 241         0         33. 00           33. 00         MELINESS CENTES         190. 01         0         31. 20         33. 00           34. 00         MRERGENCY         190. 01         0         31. 20         33. 00           34. 00         MRERGENCY         190. 01         0         13. 10         36. 00           35. 00         MSELINESS CENTERS         190. 01         0         1. 31. 00         36. 00           36. 00         MSELINESS CENTERS         190. 01         0         2. 460         0         37. 00           37. 00         MEDICAL, INTERNIST         190. 02         0         34. 00         38. 00         38. 00           39. 00         FUNCTINEST CANST PRIVATE OFFICES         192. 00         0         26. 071. 673         100         30. 00           10. 00         FUNCTINEST NE. FOOM         50. 00         0         30. 00         30. 00         30. 00         30. 00         30.								
31.00       PERGMANCY PLUS       90.06       0       107       0       33.00         32.00       DERGENCY       91.00       0       423.241       0       33.00         33.00       WELLNESS CENTERS       190.01       0       31.252       0       33.00       33.00         34.00       NORTHERS       190.01       0       31.252       0       33.00       33.00         35.00       SUMMIT CONV. (LTC)       190.03       0       423.241       0       34.00         35.00       SUMMIT CONV. (LTC)       190.04       0       43.40       35.00       35.00         37.00       MEDICAL INTENTSIT       192.02       0       4.964       0       37.00         0.00       PERATION TO PLANT       7.00       0       63.9       0       00.00         100       OPERATION OF PLANT       7.00       0       2.00       0       2.00       0       2.00       0       2.00       0       2.00       0       2.00       0       2.00       0       2.00       0       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       <								
$ \begin{array}{c c c c c c c c c c c c c c c c c c c $								
33.00       WELLNESS CENTRES       190.01       0       31.252       0       33.00         34.00       NGRINIT CONV. (LTC)       190.03       0       440       0       34.00       35.00       34.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       36.00       37.00       MEDICAL INTERNIST       190.12       0       2.460       0       36.00       38.00         39.00       FULLNER SECHTER       190.22       0       34.70       38.00       39.00       39.00       39.00       30.00       40.00       1.00       30.00       40.00       1.00       30.00       40.00       30.00       40.00       30.00       40.00       30.00       40.00       30.00       40.00       30.00       40.00       30.00       40.00       30.00       40.00       30.00       40.00       30.00       40.00       30.00       40.0								
34. 00       MORTHYLEW CONV. (LTC)       190. 03       0       490       0       34. 00       34. 00       36. 00       36. 00       0       0       100. 00       11. 121       0       37. 00       36. 00       0       11. 121       0       37. 00       36. 00       37. 00       36. 00       0       1. 121       0       37. 00       37. 00       38. 00       39. 00       39. 00       39. 00       39. 00       39. 00       39. 00       39. 00       39. 00       39. 00       39. 00 <t< td=""><td></td><td></td><td></td><td>-</td><td></td><td></td><td></td><td></td></t<>				-				
35.00         SUMM T CONV. (LTC)         190.04         0         643         0         35.00         Solo         35.00         Solo         36.00         37.00         MEDICAL INTERNIST         190.12         0         2.460         0         37.00				-				
36.00         CLINICAL RESERRCH CENTER         190.10         0         1,121         0         36.00         60.00         37.00         80.00         70.00         80.00         70.00         80.00         70.00         80.00         70.00         80.00         70.00         80.00         70.00         80.00         70.00         80.00         70.00         80.00         70.00				-				
37. 00     MEDI CAL INTERNIST     190. 12     0     2,460     0     33.00       38. 00     PROLINATION     192. 02     0     347     0     38.00       0. 00     HELICAL INTERNIST     192. 04     0     2.6,071,670     347     0       0. 01     HELITY HEART     192. 04     0     2.6,071,670     0     40.00       0. 01     C. RENT     0     2.6,071,670     0     30.00       1.00     OPERATION OF PLANT     7.00     0     6.3     9     2.00       3.00     OPERATION FORMACY     15.00     0     2.0,00     0     3.00       3.00     DEDICAL INTERNACY     60.00     0     3.02,532     0     4.00       0.00     DECISTRCARDEDALOGRAPHY     70.00     0     5.560     0     6.00       0.00     DELICTROBACEPHALOGRAPHY     70.00     0     34,282     0     0.00       0.00     DELICTROBACEPHALOGRAPHY     70.00     0     34,282     0     0.00       0.00     DELICTROBACEPHALOGRAPHY     70.00     0     34,282     0     10.00       0.00     DELICTROBACEPHALOGRAPHY     70.00     0     34,282     0     10.00       1.00     ADULIS & PEDIATRICS				-				
38. 00     PHVS1C1 ABS' PRIVATE OFFICES     192.00     0     1.976     0     38. 00       90. 00     FOLMATION     192.04     0     4.964     0     39. 00       100     DFRAINS     192.04     0     4.964     0     49. 00       100     DFRAINS     192.04     0     2.6071.670     40. 00       100     DFRAINS     FOLMAT     7.00     0     6.3     9     2.00       2.00     PHARMACY     15.00     0     2.00, 408     9     2.00       2.00     PHARMACY     15.00     0     2.00, 408     9     2.00       3.00     DERATING ROOM     50.00     0     2.00, 00     3.00     3.00       3.00     DERATING ROOM     50.00     0     16.027     0     5.00       0.00     ELCTROCARDIOLOGY     69.00     0     3.282     0     10.00       10.00     ELCTROCARDIOLOGY     90.01     3.282     0     10.00       10.00     DLITARY     100.01     3.282     0     10.00       10.00     DLITARY     100.01     3.242     0     10.00       10.00     DLITARY     100.02     2.172     0     11.00       10.01     DITTARY<				-				
99.00         FOURDATION         192.02         0         347         0         40.00         44.114         HEART         192.04         0         26.071.670         0         40.00         40.00           C - RENT         0         26.071.670         0         26.071.670         0         40.00 </td <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td>				-				
40.00       HEALTHY HEAT       192.04       0       4.964       0       40.00         C - RENT       0       26.071.670       0       63       9       1.00         100       PERATION OF PLANT       7.00       0       63       9       2.00       2.000       0       2.000       0       2.000       0       2.000       0       2.000       0       2.000       0       0.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>								
$ \begin{array}{c c c c c c c c c c c c c c c c c c c $								
$ \begin{array}{c c c c c c c c c c c c c c c c c c c $	40.00		172.04					40.00
1.00         OPERATION OF PLANT         7.00         0         6.3         9         1.00           2.00         PHARMACY         15.00         0         280.408         9         3.00           3.00         OPERATING ROM         50.00         0         2.00         3.00         3.00           4.00         LABORATORY         66.00         0         32.532         0         5.00           5.00         PHYSICAL THERAPY         66.00         0         16.927         0         5.00           6.00         RETEROCARDIOLOGY         69.00         0         9.967         0         6.00           0.00         RELETROCENDELLOGEY         69.00         0         32.550         0         7.00           0.00         COLOGY         90.03         0         42.582         0         7.00           10.00         CHELMATCLOGY         190.13         0         24.292         0         10.00           10.00         NELIMATICS         30.00         466.052         132.117         0         1.00           10.00         TEAS         10.00         586.981         1         1.00         1.00           10.01 AS         PEDI ATRICS <t< td=""><td></td><td></td><td>L L</td><td>V</td><td>20,071,070</td><td></td><td></td><td></td></t<>			L L	V	20,071,070			
2.00         PHARMACY         15.00         0         280.08         9         2.00         200.00         0         3.00         0 <t< td=""><td>1.00</td><td></td><td>7.00</td><td>0</td><td>63</td><td></td><td></td><td>1.00</td></t<>	1.00		7.00	0	63			1.00
3. 00         OPERATING ROOM         50. 00         0         2.000         0         3. 00           4. 00         LABORATORY         60. 00         0         32. 532         0         4.00           5. 00         PHYSI CAL THERAPY         66. 00         0         116. 927         0         5. 00         6. 00           6. 00         ELECTROCARD LOGY         69. 00         0         9. 967         0         6. 00           7. 00         ELECTROCARD LOGY         90. 03         0         42. 582         0         8. 00           0.00         FORTVILLE CLINIC         90. 09         0         34. 282         0         9. 00           0.00         CLAWATOLGCY         100. 10         0         38. 268         0         10. 00           0.00         CLAWATOLGY         100. 10         0         38. 428         0         10. 00           10. ABOR & DELIVERY         10. 00         884. 274         779. 859         0         10. 00           11. 00         CAFETERIA         RECLAS         1         10. 00         10. 484. 318         0         1. 00           10. 01         CAFETERIA         RECLAS         1         0         54. 787         48. 318 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
4.00         LABORATORY         60.00         0         32,52         0         4.00           5.00         PHYSICAL THERAPY         66.00         0         116,927         0         5.00           0.00         ELECTROCARDIDLOGY         69.00         0         9,967         0         6.00         7.00           0.00         ELECTROCARDEPHALORGAPHY         70.00         0         34,252         0         8.00         9.00           9.00         FORTVILLE CLINIC         90.09         0         34,252         0         9.00         10.00           11.00         TOTALS         0         28,268         0         10.00         10.00         10.00         11.00         10.00								
5.00         PHYSICAL THERAPY         66.00         0         116.927         0         5.00           0.00         ELECTROCARDIOLOGY         66.00         0         9.967         0         6.00         7.00         7.00         7.00         7.00         8.00         9.00         7.00         8.00         9.00         7.00         8.00         9.00         7.00         8.00         9.00<								
6.00         ELECTROCARDIOLOGY         69.00         0         9.967         0         6.00         7.00           7.00         ELECTROCARDIPLAGGAPHY         70.00         0         5.560         0         7.00           8.00         ONCOLOGY         90.03         0         42.582         0         7.00           9.00         FORTVILLE CLINIC         90.09         0         34.282         0         9.00           10.00         CLINICAL RESEARCH CENTER         190.13         0         24.392         0         11.00           TOTALS         0         256.991         0         11.00         11.00         11.00           TOTALS         0         26.46.052         132.117         0         0         10.00           E         CAFETERIA RECLASS         -         -         466.052         132.117         0         1.00           TOTALS         0         0.00         466.052         132.117         0         1.00         1.00           TOTALS         10.00         884.274         779.859         -         0         1.00           CAFETERIA         11.00         54.787         48.318         0         1.00         2.00		PHYSI CAL THERAPY		0				
7.00         ELECTROENCEPHALOGRAPHY         70.00         0         5.50         0         7.00         8.00         8.00         8.00         8.00         8.00         8.00         8.00         8.00         8.00         8.00         8.00         9.00         8.00         9.00         8.00         9.00 <td></td> <td>ELECTROCARDI OLOGY</td> <td></td> <td>0</td> <td></td> <td>0</td> <td></td> <td></td>		ELECTROCARDI OLOGY		0		0		
9.00         FORTVILLE CLINIC         90.09         0         34,282         0         9.00           10.00         CLINICAL RESEARCH CENTER         190.10         0         38,268         0         10.00	7.00	ELECTROENCEPHALOGRAPHY	70.00	0		0		7.00
9.00         FORTVILLE CLINIC         90.09         0         34,282         0         9.00           10.00         CLINICAL RESEARCH CENTER         190.13         0         24,392         0         10.00         10.00           0         LABOR & DELLVERY         0         586,981         0         10.00         11.00           0         LABOR & DELLVERY         0         24,392         0         0         10.00           11.00         DICTALS         30.00         466,052         132,117         0         0         10.00           10.01         TOTALS         30.00         466,052         132,117         0         0         10.00           10.01         TOTALS         30.00         466,052         132,117         0         1.00           10.02         TOTALS         10.00         884,274         779,859         0         1.00           F - SPECIAL MEALS         50.00         0         354,787         48,318         0         1.00           0         ADMINISTRATIVE & GENERAL         5.00         0         210,000         12         3.00           10.00         ADMINISTRATIVE & GENERAL         5.00         0         210,000         12	8.00	ONCOLOGY	90.03	0	42, 582	0		8.00
10.00       CLINICAL RESEARCH CENTER       190.10       0       38.268       0       10.00         11.00       NHEUMATOLOGY       190.13       0       24.392       0       0         D       - LABOR & DELIVERY       0       566.981       0       11.00         D       - LABOR & DELIVERY       0       0       566.981       0       11.00         I.00       ADUITS & PEDIATRICS       30.00       466.052       132.117       0       0       10.00         E       - CAFETERIA RECLASS       10.00       884.274       779.859       0       1.00         TOTALS       - SPECIAL MEALS       -       -       -       0       1.00         G       - INTEREST & INSURANCE       -       -       -       1.00       2.00         3.00	9.00	FORTVILLE CLINIC	90.09	0				9.00
TOTALS         0         586, 981         1           D         - LABOR & DELIVERY         -         0         -         0         -         0         -         0         -         0         -         0         -         0         -         0         -         0         -         0         -         0         1.00         0         -         -         0         -         0         -         0         -         0         1.00         0         -         -         0         0         -         0         0         -         0         -         0         -         0         0         -         0	10.00	CLINICAL RESEARCH CENTER	190. 10	0	38, 268	0		10.00
D         - LABOR & DELIVERY	11.00	RHEUMATOLOGY	190. 13	0	24, 392	0		11.00
1.00       ADULTS & PEDIATRICS       30.00       466,052       132,117       0         TOTALS       466,052       132,117       0       1.00         E       CAFETERIA RECLASS       10.00       884,274       779,859       0       1.00         TOTALS       884,274       779,859       0       1.00       1.00       1.00         TOTALS       9       884,274       779,859       0       1.00       1.00         TOTALS       9       10.00       54,787       48,318       0       0       1.00         G       INTEREST & INSURANCE       1.00       54,787       48,318       0       1.00       1.00         G       INTEREST & INSURANCE       1.00       0       354,878       11       1.00         100       ADMI NI STRATI VE & GENERAL       5.00       0       354,878       12       3.00         100       HOUSEKEEPING       9.00       57,413       89,557       0       3.00         1       0       0.00       0       0       0       3.00         100       PHYSICIANS' PRIVATE OFFICES       192.00       101,639       0       3.00         1.00       0.00       0<		TOTALS		0	586, 981			
TOTALS		D - LABOR & DELIVERY						
E         CAFETERIA RECLASS         Image: constraint of the second secon	1.00			<u>466, 0</u> 52	13 <u>2, 1</u> 17			1.00
1.00       DIETARY       10.00       884,274       779,859       0       1.00         TOTALS       884,274       779,859       0       1.00       1.00         F - SPECIAL MEALS       11.00       54,787       48,318       0       1.00         G - INTEREST & INSURANCE       54,787       48,318       0       1.00       1.00         1.00       ADMI NI STRATI VE & GENERAL       5.00       0       354,878       11       2.00         2.00       ADMI NI STRATI VE & GENERAL       5.00       0       210,000       12       2.00         3.00       TOTALS       0       564,878       11       1.00       2.00         1.00       HOUSEKEEPING       9.00       57,413       89,557       0       3.00         1.00       HOUSEKEEPING       9.00       57,413       89,557       0       1.00         1.00       PHYSI CI ANS' PRI VATE OFFI CES       192.00       101,639       0       2.00       3.00         0.00       0       0       0       0       0       3.00       3.00       3.00       3.00       3.00       3.00       3.00       3.00       3.00       3.00       3.00       3.00       3.0				466, 052	132, 117			
TOTALS         884, 274         779, 859         1           F - SPECIAL MEALS         11.00         54, 787         48, 318         0           TOTALS         54, 787         48, 318         0         1.00           G - INTEREST & INSURANCE         500         0         354, 878         11         1.00           2.00         ADMI NI STRATI VE & GENERAL         5.00         0         210, 000         12         2.00           3.00         TOTALS         0         564, 878         11         1.00         2.00           1.00         ADMI NI STRATI VE & GENERAL         5.00         0         210, 000         12         2.00           3.00         TOTALS         0         564, 878         11         1.00           H - LAUNDRY         -         0         57, 413         89, 557         0         1.00           1.00         PHYSI CI ANS' PRI VATE OFFI CES         192.00         101, 639         0         2.00         3.00           3.00         0.00         0         0         0         3.00         4.00         3.00         4.00         3.00         4.00         5.00         0.00         0         0         3.00         5.00         5.00<			-			i		
F - SPECIAL MEALS	1.00						<u>)</u>	1.00
1.00       CAFETERIA       11.00       54,787       48,318       0         G - INTEREST & INSURANCE       54,787       48,318       0       1.00         ADMINISTRATIVE & GENERAL       5.00       0       354,878       11       1.00         2.00       ADMINISTRATIVE & GENERAL       5.00       0       210,000       12       2.00         3.00       101ALS       0       564,878       11       1.00       2.00         1.00       ADMINISTRATIVE & GENERAL       5.00       0       210,000       12       2.00         3.00       101ALS       0       564,878       11       1.00       3.00         H - LAUNDRY				884, 274	779, 859			
TOTALS						1	I	
G         - INTEREST & INSURANCE           1.00         ADMI NI STRATI VE & GENERAL         5.00         0         354,878         11         1.00           2.00         ADMI NI STRATI VE & GENERAL         5.00         0         210,000         12         2.00           3.00	1.00		<u> </u>				<u>)</u>	1.00
1.00       ADMI NI STRATI VE & GENERAL       5.00       0       354,878       11       1.00         2.00       ADMI NI STRATI VE & GENERAL       5.00       0       210,000       12       2.00         3.00				54, 787	48, 318			
2.00       ADMI NI STRATI VE & GENERAL       5.00       0       210,000       12       12       2.00         3.00       TOTALS       0       564,878       12       12       3.00         H - LAUNDRY       1.00       HOUSEKEEPING       0       57,413       89,557       0       1.00         1.00       HOUSEKEEPING       9.00       57,413       89,557       0       1.00         1.00       PHYSI CLANS' PRI VATE OFFICES       192.00       101,639       0       2.00         3.00       0.00       0       0       0       3.00         3.00       0.00       0       0       0       3.00         1.00       0.00       0       0       0       2.00         3.00       0.00       0       0       0       3.00         4.00       0.00       0       0       3.00       4.00         5.00       0.00       0       0       0       5.00       6.00         7.00       0       0.00       0       0       7.00       7.00         1.00       EMERGENCY       0       30,552       33,434       0       1.00	1 00		F 00	0	254.070	1		1 00
3.00								
TOTALS         0         564,878         1           H         -         LAUNDRY         1.00         1.00         HOUSEKEEPING         0         57,413         89,557         0         1.00           TOTALS         -         -         57,413         89,557         0         1.00         1.00           1         -         -         57,413         89,557         0         1.00         2.00         1.00         2.00         0.00         0         0         2.00         3.00         0.00         0         0         2.00         3.00         0.00         0         0         0         2.00         3.00         4.00         0.00         0         0         0         0         3.00         4.00         5.00         6.00         5.00         6.00         5.00         6.00         7.00         5.00         6.00         7.00 </td <td></td> <td>ADMINISTRATIVE &amp; GENERAL</td> <td>5.00</td> <td>0</td> <td>210,000</td> <td></td> <td></td> <td></td>		ADMINISTRATIVE & GENERAL	5.00	0	210,000			
H - LAUNDRY         1.00       HOUSEKEEPING       9.00       57,413       89,557       0       1.00         TOTALS       57,413       89,557       0       1.00       1.00       1.00       1.00         1.00       PHYSI CLANS' PRIVATE OFFICES       192.00       101,639       0       2.00       3.00         1.00       0.00       0       0       0       3.00       3.00       2.00         3.00       0.00       0       0       0       3.00       3.00       4.00       3.00         4.00       0.00       0       0       0       0       4.00       5.00         6.00       0.00       0       0       0       0       6.00       7.00         7.00       0.00       0       0       0       0       6.00       7.00         1.00       EMERGENCY       0.00       0       0       0       0       7.00         1.00       EMERGENCY       91.00       30,552       33,434       0       1.00	3.00			+	<u> </u>		2	3.00
1.00       HOUSEKEEPING       9.00       57,413       89,557       0       1.00         TOTALS       57,413       89,557       0       1.00       1.00       1.00         1.00       PHYSI CLANS' PRIVATE OFFICES       192.00       101,639       0       2.00       2.00       3.00       0.00       0       0       2.00       3.00       4.00       2.00       3.00       4.00       2.00       3.00       4.00       5.00       0.00       0       0       0       2.00       3.00       4.00       5.00       6.00       7.00       0       0       0       0       0       7.00       5.00       6.00       7.00				U	504, 878			
TOTALS         57,413         89,557         1           I - POB UTILITIES         1         -         <	1 00	-	9.00	57 413	89 557	0		1 00
I         - POB         UTILITIES           1.00         PHYSI CI ANS' PRI VATE OFFICES         192.00         101, 639         0         2.00           2.00         0.00         0         0         0         2.00         3.00           3.00         0.00         0         0         0         3.00         2.00         3.00           4.00         0.00         0         0         0         0         3.00         4.00           5.00         0.00         0         0         0         0         4.00         5.00         6.00         7.00         6.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         1.	1.00							1.00
1.00       PHYSI CI ANS' PRI VATE OFFICES       192.00       101,639       0       1.00         2.00       0.00       0       0       0       2.00         3.00       0.00       0       0       0       2.00         4.00       0.00       0       0       0       3.00         4.00       0.00       0       0       0       3.00         5.00       0.00       0       0       0       4.00         5.00       0.00       0       0       0       6.00         7.00       0.00       0       0       0       6.00         7.00       0.00       0       0       0       7.00         1.00       EMERGENCY       0.00       30,552       33,434       0       0         1.00       EMERGENCY       91.00       30,552       33,434       0       0       1.00			LI	07,110	07,007	1		
2.00       0.00       0       0       0       0       2.00         3.00       0.00       0       0       0       0       3.00         4.00       0.00       0       0       0       0       3.00         4.00       0.00       0       0       0       4.00         5.00       0.00       0       0       0       5.00         6.00       0.00       0       0       0       6.00         7.00       0.00       0       0       0       6.00         7.00       0.00       0       0       0       7.00         1.00       TOTALS       0.00       30.552       33.434       0       0         1.00       EMERGENCY       91.00       30.552       33.434       0       0       1.00	1.00		192.00		101.639	(		1.00
3.00       0.00       0       0       0       0       3.00         4.00       0.00       0       0       0       0       4.00         5.00       0.00       0       0       0       0       4.00         5.00       0.00       0       0       0       0       5.00         6.00       0.00       0       0       0       6.00       6.00         7.00       0.00       0       0       0       0       7.00         TOTALS       0.00       0       0.101, 639       0       7.00       7.00         J - EMS PARAMED       1.00       30, 552       33, 434       0       0       1.00				0				
4.00       0.00       0       0       0       0       4.00         5.00       0.00       0       0       0       0       5.00         6.00       0.00       0       0       0       6.00       6.00         7.00       0.00       0       0       0       0       6.00         7.00       0.00       0       0       0       7.00         TOTALS       0       101, 639       0       7.00         J - EMS PARAMED       0       30, 552       33, 434       0       1.00         I.00       EMERGENCY       91.00       30, 552       33, 434       0       1.00								
5.00       0.00       0       0       0       0       0       6.00         6.00       0.00       0       0       0       0       0       6.00         7.00       0       0       0       0       0       0       7.00         TOTALS       0       0       0       0       0       0       7.00         J - EMS PARAMED       J - EMS PARAMED       1.00       30,552       33,434       0       0       1.00								
6.00       0.00       0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
7.00								
TOTALS         0         101, 639           J - EMS PARAMED         J         30, 552         33, 434         0           1.00         EMERGENCY         91.00         30, 552         33, 434         0         1.00				-				
J - EMS PARAMED         1.00       EMERGENCY         TOTALS       91.00         30,552       33,434         30,552       33,434		TOTALS					1	
1.00         EMERGENCY         91.00         30.552         33.434         0         1.00           TOTALS         30,552         33,434         0         1.00								
TOTALS 30, 55233, 434	1.00		91.00				)	1.00
500. 00 Grand Total : Decreases         1, 493, 078         35, 589, 510         500. 00				30, 552	33, 434			
	500.00	Grand Total: Decreases		1, 493, 078	35, 589, 510			500.00

	Financial Systems	COMMUNI TY HOSPI		CCN: 150113	Peri od:	u of Form CMS-2 Worksheet A-7	
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der		From 01/01/2015		
					To 12/31/2015		pared:
						5/24/2016 1:2	
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL A						
1.00	Land	6, 188, 988			0 135, 000		1.00
2.00	Land Improvements	1, 939, 229	132, 375		0 132, 375		2.00
3.00	Buildings and Fixtures	61, 222, 144	4, 551, 570	1, 513, 49	6, 065, 068	3, 263, 674	3.00
4.00	Building Improvements	0	0		0 0	0	4.00
5.00	Fixed Equipment	18, 972, 454			0 490, 211		5.00
6.00	Movable Equipment	45, 069, 440	3, 163, 340	555, 13	3, 718, 476	1, 073, 807	
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	133, 392, 255	8, 472, 496	2, 068, 63	10, 541, 130	4, 411, 733	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	133, 392, 255		2, 068, 63	10, 541, 130	4, 411, 733	10.00
		Endi ng Bal ance					
			Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL A						
1.00	Land	6, 323, 988					1.00
2.00	Land Improvements	2, 071, 604					2.00
3.00	Buildings and Fixtures	64, 023, 538	25, 233, 397				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	19, 388, 413	9, 386, 355				5.00
6.00	Movable Equipment	47, 714, 109	27, 162, 546				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	139, 521, 652	63, 531, 097				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	139, 521, 652	63, 531, 097				10.00

Heal th	Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150113	Period: From 01/01/2015	Worksheet A-7 Part II	
					To 12/31/2015		pared:
						5/24/2016 1:2	6 pm
			SL	JMMARY OF CAF	91 TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	•	
			10.00	44.00		instructions)	
	DADT IL DEGONOLI LATION OF ANOUNTO FROM WOR	9.00	10.00	11.00	12.00	13.00	
4 00	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES I A	na 2			1 00
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum	-			
		Capi tal -Rel ate					
		d Costs (see					
		instructions)					
		14.00	15.00	1			
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

Heal th	n Financial Systems	COMMUNI TY HOSP	TAL ANDERSON		In Lie	u of Form CMS-2	552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2015 Fo 12/31/2015	Worksheet A-7 Part III Date/Time Prep 5/24/2016 1:26	
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
	Γ	1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C			1			
1.00	CAP REL COSTS-BLDG & FIXT	91, 807, 544		91, 807, 54			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	47, 714, 109		47, 714, 10			2.00
3.00	Total (sum of lines 1-2)	139, 521, 653		139, 521, 65			3.00
		ALLOCA	TION OF OTHER (	CAPITAL	SUMMARY C	F CAPI TAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capital-Relate d Costs	cols.5 through 7)			
		6,00	7.00	8.00	9,00	10,00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	C	)	0 4, 219, 768	-2, 782	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		3, 548, 270	0	2.00
3.00	Total (sum of lines 1-2)	0	0		7, 768, 038	-2, 782	3.00
			SI	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see instructions)	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 & FIXT	292, 189	138, 180	) ()	0 0	4, 647, 355	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	71, 820		0 0	3, 620, 090	2.00
3.00	Total (sum of lines 1-2)	292, 189	210,000		0 0	8, 267, 445	3.00
				-			

ADJUST	Financial Systems MENTS TO EXPENSES				Peri od:	u of Form CMS-2 Worksheet A-8	
					From 01/01/2015 To 12/31/2015		
				Expense Classification or To/From Which the Amount is		5/24/2016 1:20	
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL	В		CAP REL COSTS-BLDG & FIXT	1.00	11	1.0
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		(	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.0
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		(		0.00	0	3.0
. 00	(chapter 2) Trade, quantity, and time	В	-14 031	ADMI NI STRATI VE & GENERAL	5.00	0	4.0
	discounts (chapter 8)		14,001			-	
5.00	Refunds and rebates of expenses (chapter 8)	6	(		0.00	0	5.0
5.00	Rental of provider space by suppliers (chapter 8)		(		0.00	0	6.0
7.00	Telephone services (pay	А	-80, 277	ADMI NI STRATI VE & GENERAL	5.00	0	7.0
3. 00	stations excluded) (chapter 21 Television and radio service	A	-58, 516	OPERATION OF PLANT	7.00	0	8.0
9.00	(chapter 21) Parking lot (chapter 21)		C		0.00	0	9.0
	Provider-based physician adjustment	A-8-2	-9, 427, 012	2		0	
11.00	Sale of scrap, waste, etc.	В	-1, 239	ADMI NI STRATI VE & GENERAL	5.00	0	11.0
12.00	(chapter 23) Related organization	A-8-1	-1, 090, 121			0	12.0
3.00	transactions (chapter 10) Laundry and linen service		ſ		0.00	0	13.0
4.00	Cafeteria-employees and guests	В		CAFETERI A	11.00	0	14.0
5.00	Rental of quarters to employee and others	В	-2, 782	CAP REL COSTS-BLDG & FIXT	1.00	10	15.0
6.00	Sale of medical and surgical supplies to other than patients		(		0.00	0	16.0
7.00	Sale of drugs to other than	3	(		0.00	0	17.0
8.00	patients Sale of medical records and	В	-7, 207	MEDI CAL RECORDS & LI BRARY	16.00	0	18. 0
9.00	abstracts Nursing school (tuition, fees,		(		0.00	0	19.0
	books, etc.) Vending machines		ſ		0.00	0	20.0
	Income from imposition of		(		0.00	0	
	interest, finance or penalty charges (chapter 21)						
22.00	Interest expense on Medicare overpayments and borrowings to		(		0.00	0	22.0
	repay Medicare overpayments		c.		(5.00		
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	l	RESPI RATORY THERAPY	65.00		23.0
24.00	limitation (chapter 14) Adjustment for physical therap	v A-8-3	(	PHYSICAL THERAPY	66.00		24.0
	costs in excess of limitation (chapter 14)						
25.00	Utilization review -		(	UTILIZATION REVIEW-SNF	114.00		25. 0
	physicians' compensation (chapter 21)						
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		(	CAP REL COSTS-BLDG & FIXT	1.00	0	26.0
27.00	Depreciation - CAP REL		(	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.0
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		(	NONPHYSI CI AN ANESTHETI STS	19.00		28.0
	Physicians' assistant Adjustment for occupational	A-8-3	(	) OCCUPATI ONAL THERAPY	0.00 67.00	0	29.0 30.0
0.00	therapy costs in excess of	N O J		COOL ATTOMAL THERAFT	07.00		30.0
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		(	ADULTS & PEDIATRICS	30.00		30.9
1. 00	instructions) Adjustment for speech patholog	v A-8-3	ſ	SPEECH PATHOLOGY	68.00		31.0
	costs in excess of limitation	,					
32.00	(chapter 14) CAH HIT Adjustment for		(		0.00	0	32. C
3. 00	Depreciation and Interest NONREIMBURSABLE PHYSICIAN PTO	А	-11.860	EMPLOYEE BENEFITS DEPARTMEN	4.00	0	33.0
	SOLD PHYSICIAN RECRUITMENT				5.00	0	
	ADVERTISING	A A		ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	5.00	-	33.0 33.0

Heal th	Financial Systems	(	COMMUNI TY HOSP	TAL ANDERSON	In Lie	eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 01/01/2015 To 12/31/2015		norod.
					To 12/31/2015	Date/Time Pre 5/24/2016 1:20	pareu: 6 pm
				Expense Classification or	Worksheet A		
				To/From Which the Amount is			
					-		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
	OUTSIDE SERVICES - SPD	В		CENTRAL SERVICES & SUPPLY	14.00		33.05
33.07	MISC A&G	В	-198, 884	ADMI NI STRATI VE & GENERAL	5.00		33.07
33.08	SEXUAL RESPONSE UNIT	В	-20, 822	EMERGENCY	91.00	0	33.08
33.09	MISC A&P	В	-3, 381	ADULTS & PEDIATRICS	30.00	0	33.09
33.10	MISC EMPLOYEE BENEFITS	В	-30, 434	EMPLOYEE BENEFITS DEPARTMEN	Г 4.00	0	33.10
33.13	MISC OPERATION OF PLANT	В	-125	OPERATION OF PLANT	7.00	0	33.13
33.14	GUEST MEALS	А	-27, 469	CAFETERI A	11.00	0	33.14
33. 15	RADI OLOGY, DI AGNOSTI C	В	-22, 363	RADI OLOGY-DI AGNOSTI C	54.00	0	33.15
33.17	MISC OTHER OPERATING REVENUE	В	-925, 337	ADMI NI STRATI VE & GENERAL	5.00	0	33.17
33. 18	ONCOLOGY SERVICES	В	-522, 327	ONCOLOGY	90.03	0	33. 18
33. 19	ESPRESSO TO GO	В	-65, 277	CAFETERIA	11.00	0	33.19
33. 22	PROCARE ADMINI STRATI ON	В		PHYSICAL THERAPY	66.00		33.22
33.28	HOSPITAL ASSESSMENT FEES (HAF)	В		ADMI NI STRATI VE & GENERAL	5.00		33.28
33. 31	KIDS PLUS	В		KIDS PLUS CLINIC	90.02		33.31
33. 32	EMS PARAMED EXPENSES FROM HO	Ā		PARAMED ED PRGM-(EMS)	23.00	-	33.32
50.00	TOTAL (sum of lines 1 thru 49)		-14, 084, 090			Ŭ	50.00
22.00	(Transfer to Worksheet A,		,				
	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.

Heal th	Financial Systems	COMMUNI TY HOSE	PITAL ANDERSON	In Lie	eu of Form CMS-	2552-10
STATEM	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 150113	Peri od:	Worksheet A-8	-1
OFFICE	COSTS		From 01/01/2015			
				To 12/31/2015	Date/Time Pre 5/24/2016 1:2	
	Line No.	Cost Center	Expense Items	Amount of	Amount	o pili
	Li ne no.	cost center	Expense i tellis	Allowable Cost		
					Wks. A, column	
					5 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED (	ORGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE	0	3, 029, 970	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	81, 387	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2,047,442	350, 000	3.00
4.00	54.00	RADI OLOGY-DI AGNOSTI C	HOME OFFICE	43, 205	0	4.00
4.01	69.00	ELECTROCARDI OLOGY	HOME OFFICE	7,609	0	4.01
4.02	70.00	ELECTROENCEPHALOGRAPHY	HOME OFFICE	18, 422	0	4.02
4.03	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	91, 784	0	4.03
5.00	TOTALS (sum of lines 1-4).			2, 289, 849	3, 379, 970	5.00
	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	A	IN PROHEALTH	100.00		0.00	6.00
7.00	В		0.00	CHN	0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
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 organization.

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 provider.

Health Financial Systems	COMMUNI TY HOSPI TAL AI	NDERSON	In Lieu	J of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANI	ZATIONS AND HOME F	Provider CCN: 150113		Worksheet A-8-1
OFFICE COSTS			From 01/01/2015 To 12/31/2015	Date/Time Prepared:

					5/24/2016 1:2	26 pm
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF TRANS	ACTIONS WITH RELATED (	ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:				
1.00	-3, 029, 970	0	,			1.00
2.00	81, 387	0				2.00
3.00	1, 697, 442	0				3.00
4.00	43, 205	0				4.00
4.01	7,609	0				4.01
4.02	18, 422	0				4.02
4.03	91, 784	0				4.03
5.00	-1, 090, 121					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.

not bee	i posteu to norkaneet A, coru		
	Rel ated Organi zati on(s)		
	and/or Home Office		
	Type of Business		
	6.00		
	6.00		
	B. INTERRELATIONSHIP TO RELAT	ED 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	6.00
7.00	7.00
8.00	8.00
9.00	9.00
10.00	10.00
100.00	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.

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 organization.

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 provider.

Heal th	Financial Syste	ems	COMMUNI TY HOSI	PITAL ANDERSON		In Lie	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provi der	CCN: 150113	Peri od:	Worksheet A-8	3-2
						From 01/01/2015		
						To 12/31/2015	Date/Time Pre 5/24/2016 1:2	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
	intot: A Erno #	I denti fi er	Remuneration	Component	Component		ider Component	
			nomarior a crom	oomportorre	oomponone		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADMI NI STRATI VE & GENERAL	3, 384, 587	3, 236, 187			1,630	1.00
2.00		ANESTHESI OLOGY	3, 375, 403			0 0	0	
3.00		RADI OLOGY-DI AGNOSTI C	344, 291			0 0	0	
4.00	90.01	WOUND/OSTOMY CLINIC	501, 241	501, 241		o o	0	4.00
5.00	90.03	ONCOLOGY	1, 955, 808			o l	0	5.00
6.00	0.00		0			0 0	0	6.00
7.00	0.00		0	c c		o o	0	7.00
8.00	0.00		0	l c		o o	0	8.00
9.00	0.00		0	l c		o o	0	9.00
10.00	0.00		0	l c		o l	0	10.00
200.00			9, 561, 330	9, 412, 930	148, 40	b	1, 630	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships 8	Component	of Mal practi ce	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADMINISTRATIVE & GENERAL	134, 318			0 0		
2.00		ANESTHESI OLOGY	0	-		0 0	0	
3.00		RADI OLOGY-DI AGNOSTI C	0			0 0	, s	
4.00		WOUND/OSTOMY CLINIC	0	-		0 0	0	
5.00		ONCOLOGY	0	-		0 0	2, 755	
6.00	0.00		0	, s		0 0	0	6.00
7.00	0.00		0	C		0	0	
8.00	0.00		0	-		0 0	0	
9.00	0.00		0	-		0 0	0	
10.00	0.00		0	-		0 0	0	
200.00			134, 318			0	2, 755	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adj ustment		
		I denti fi er	Component Share of col.	Limit	Di sal I owance			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		ADMI NI STRATI VE & GENERAL	0					1.00
2.00		ANESTHESI OLOGY	0			3, 375, 403		2.00
3.00		RADI OLOGY-DI AGNOSTI C	0			344, 291		3.00
4.00		WOUND/OSTOMY CLINIC	0	-		501, 241		4.00
5.00		ONCOLOGY	0	-		1, 955, 808		5.00
6.00	0.00		0					6.00
7.00	0.00		0	, s				7.00
8.00	0.00		0	-				8.00
9.00	0.00	4	0	-				9.00
10.00	0.00		0					10.00
200.00			0	-	14,08	9, 427, 012		200.00
	•							

	Financial Systems NLLOCATION - GENERAL SERVICE COSTS	COMMUNI TY HOSPI			Period: Trom 01/01/2015	u of Form CMS-2 Worksheet B Part I	2552-10
					o 12/31/2015		pared: 6 pm
			CAPI TAL REL	ATED COSTS		10/21/2010 112	o piii
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		<u>col.7)</u> 0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	7/1	
1.00	00100 CAP REL COSTS-BLDG & FIXT	4, 647, 355	4, 647, 355				1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	3, 620, 090 11, 710, 823	28, 671	3, 620, 090 38, 382			2.00 4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	20, 755, 188	368, 205			24, 137, 354	5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0	C	0	0	6.00
7.00	00700 OPERATION OF PLANT	7, 359, 862	547,669			8, 499, 049	7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	146, 970 1, 460, 313	56, 816 113, 764	13, 192	12, 620 261, 003	216, 406 1, 848, 272	8.00 9.00
7.00 10.00	01000 DI ETARY	872, 336	170, 350			1, 158, 629	
11.00	01100 CAFETERI A	724, 377	33, 515			940, 227	11. OC
13.00	01300 NURSING ADMINISTRATION	1, 168, 587	43, 696			1, 438, 124	
14.00	01400 CENTRAL SERVICES & SUPPLY	2,902,281	83, 434			3, 191, 731	
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	1, 869, 614 1, 627, 704	52, 662 66, 767	4, 871	330, 056 258, 095	2, 257, 203 1, 952, 566	
17.00	01700 SOCIAL SERVICE	0	0		0	0	17. OC
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	C	0	0	19.00
20.00	02000 NURSI NG SCHOOL	0	0	C	0	0	20.00
21.00 22.00	02100 I & SERVI CES-SALARY & FRI NGES APPRVD 02200 I & SERVI CES-OTHER PRGM. COSTS APPRVD	0	0		0	0	21.00 22.00
22.00	02300 PARAMED ED PRGM-(EMS)	241, 316	0		6, 716	248, 032	
	INPATIENT ROUTINE SERVICE COST CENTERS			-		,	
30.00	03000 ADULTS & PEDIATRICS	12, 067, 892	846, 894			15, 521, 641	
31.00	03100 I NTENSI VE CARE UNI T	1, 839, 338	81, 415	86, 529	346, 252	2, 353, 534	31.00
32.00 33.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0			0	32.00 33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0	0	34.00
40.00	04000 SUBPROVI DER – I PF	0	0	C	0	0	40. OC
41.00	04100 SUBPROVI DER – I RF	0	0	C	0	0	41. OC
42.00	04200 SUBPROVI DER	0	0		0	0	42.00
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	598, 169 0	30, 707	1, 865	102, 446	733, 187 0	43.00 44.00
45.00	04500 NURSING FACILITY	0	0		0	0	45.00
46.00	04600 OTHER LONG TERM CARE	0	0	C	0	0	46.00
50.00	ANCI LLARY SERVICE COST CENTERS	6, 087, 716	366, 727	1,004,800	936, 214	8, 395, 457	50. OC
50.00	05100 RECOVERY ROOM	0,007,718	300,727	1,004,800	930, 214	6, 395, 457 0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	
	05300 ANESTHESI OLOGY	59, 757	4, 466	20, 986		248, 435	
	05400 RADI OLOGY-DI AGNOSTI C	3, 081, 939	316, 660			4, 279, 530	
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	570, 233	24, 352	C 7, 924	0 0 54, 574	0 657, 083	55.00 56.00
57.00	05700 CT SCAN	477, 247	7, 389			583, 561	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	511, 290	15, 370			602, 923	
59.00	05900 CARDI AC CATHETERI ZATI ON	735, 404	61, 036			993, 167	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	3, 586, 428	128, 543	217, 813		4, 379, 277 0	60. 00 60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	225, 005	9, 606	1, 921	45, 178	281, 710	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C	0	0	63. OC
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	0	64.00
65.00	06500 RESPIRATORY THERAPY	914, 329	11, 823			1, 139, 066	
66.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 897, 438 351, 308	23, 794 14, 664			2, 274, 761 436, 485	
	10000000000000000000000000000000000000	201, 555	8, 194			249, 951	
67.00 68.00	06800 SPEECH PATHOLOGY	201, 333				703, 235	
67.00 68.00 69.00	06900 ELECTROCARDI OLOGY	495, 886					
67.00 68.00 69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	495, 886 712, 986				860, 518	70.00
67.00 68.00 69.00 70.00 71.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	495, 886 712, 986 10, 120, 921				860, 518 10, 120, 921	70.00 71.00
67.00 68.00 69.00 70.00 71.00 72.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS	495, 886 712, 986 10, 120, 921 10, 352, 069	25, 173 0 0			860, 518 10, 120, 921 10, 352, 069	70.00 71.00 72.00
67.00 68.00 69.00 70.00 71.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	495, 886 712, 986 10, 120, 921	25, 173 0 0	16, 972 C C C		860, 518 10, 120, 921	70.00 71.00 72.00 73.00
67.00 68.00 69.00 70.00 71.00 72.00 73.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STINCT PART)	495, 886 712, 986 10, 120, 921 10, 352, 069 5, 690, 464	25, 173 0 0 0	16, 972 C C C	105, 387 0 0 0 0 0 0	860, 518 10, 120, 921 10, 352, 069 5, 690, 464	70.00 71.00 72.00 73.00 74.00
67.00 68.00 69.00 70.00 71.00 72.00 73.00 74.00 75.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 0UTPATI ENT SERVI CE COST CENTERS	495, 886 712, 986 10, 120, 921 10, 352, 069 5, 690, 464	25, 173 0 0 0	16, 972 C C C C C C C	105, 387 0 0 0 0 0	860, 518 10, 120, 921 10, 352, 069 5, 690, 464 152, 491 0	70.00 71.00 72.00 73.00 74.00 75.00
67.00 68.00 69.00 70.00 71.00 72.00 73.00 74.00 75.00 88.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C	495, 886 712, 986 10, 120, 921 10, 352, 069 5, 690, 464	25, 173 0 0 0	16, 972 C C C C C C	105, 387 0 0 0 0 0	860, 518 10, 120, 921 10, 352, 069 5, 690, 464 152, 491 0 0	70.00 71.00 72.00 73.00 74.00 75.00
67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 88. 00 89. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C 08900 FEDERALLY QUALI FI ED HEALTH CENTER	495, 886 712, 986 10, 120, 921 10, 352, 069 5, 690, 464	25, 173 0 0 0	16, 972 C C C C C C C	105, 387 0 0 0 0 0	860, 518 10, 120, 921 10, 352, 069 5, 690, 464 152, 491 0	70.00 71.00 72.00 73.00 74.00 75.00 88.00 89.00
67.00 68.00 69.00 70.00 71.00 72.00 73.00 74.00 75.00 88.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C	495, 886 712, 986 10, 120, 921 10, 352, 069 5, 690, 464	25, 173 0 0 0	16, 972 C C C C C C C C C C C C C C C C C C C		860, 518 10, 120, 921 10, 352, 069 5, 690, 464 152, 491 0 0 0	70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 88. 00 89. 00 90. 00
67.00 68.00 69.00 70.00 71.00 72.00 73.00 74.00 75.00 88.00 89.00 90.01 90.01 90.02	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C 08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C	495, 886 712, 986 10, 120, 921 10, 352, 069 5, 690, 464 149, 404 0 0 0 0 0 0	25, 173 0 0 3, 087 0 0 0 0 167, 936 25, 617	16, 972 C C C C C C C C C C C C C C C C C C C	105, 387 0 0 0 0 0 0 0 0 0 74, 620 0	860, 518 10, 120, 921 10, 352, 069 5, 690, 464 152, 491 0 0 0 0 634, 824 17, 958	70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 88. 00 88. 00 89. 00 90. 00 90. 01 90. 02

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2015 To 12/31/2015	Worksheet B Part I Date/Time Pre 5/24/2016 1:2	pared:
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
90. 04       09004       MUNCI E CLINIC         90. 05       09005       ANTI COAGULATI ON CLINIC         90. 06       09006       PREGNANCY PLUS         90. 07       09007       0/P LAB         90. 08       09008       0/P LAB         90. 09       PORTVILLE CLINIC	55, 753 272, 231 151, 982 0 0	24, 434 0 38, 934 0 10 557	14, 83 3, 84 81	2 54, 423	95, 018 330, 496 221, 177 0 0	90. 05 90. 06 90. 07 90. 08
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	2, 955 3, 064, 070	19, 557 127, 278	107, 68	6 606, 070	22, 512 3, 905, 104 0	91.00
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
95. 0009500AMBULANCE SERVICES96. 0009600DURABLE MEDICAL EQUIP-RENTED97. 0009700DURABLE MEDICAL EQUIP-SOLD	0 0 0	0 0 0		0 0 0 0 0 0	0 0 0	95.00 96.00
99. 00 09900 CMHC 99. 10 09910 CORF	0	0		0 0 0 0	0	
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0 0		0 0 0 0		100. 00 101. 00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON	0	0		0 0		106.00 107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0		0 0	0	108.00
109. 00 10900 PANCREAS ACQUISITION 110. 00 11000 INTESTINAL ACQUISITION	0	0		0 0		109.00 110.00
111. 00 11100   SLET ACQUI SI TI ON 113. 00 11300   NTEREST EXPENSE	0	0		0 0		111.00 113.00
114. 00 11400 UTLLIZATION REVIEW-SNF 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P. )	0	0		0	0	114.00 115.00
116. 00 11600 HOSPI CE	0	0	0 500 07		0	116.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	116, 052, 701	4, 255, 750	3, 599, 27	9 11, 095, 883	114, 958, 292	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.01 19001 WELLNESS CENTERS	0 1, 111, 053	19, 804 20, 148	81	0 0 5 157, 717	19, 804 1, 289, 733	190.00
190.02 19002 EMPLOYED ORTHO MD	0	20, 148	01	0 0	0	190. 02
190. 03 19003 NORTHVI EW CONV. (LTC) 190. 04 19004 SUMMI T CONV. (LTC)	280, 915 261, 915	0		0 57,000 0 41,541	337, 915 303, 456	
190. 05 19005 PARKVI EW CONV. (LTC)	301, 015	0		0 61, 780	362, 795	
190. 06 19006 MONTI CELLO HSE. (ASS' TD LVG.)	122, 138	0		0 24, 877	147, 015	
190.07 19007 NH PARK PLACE (LTC) 190.08 19008 MADI SON PLACE OF ELWOOD (LTC)	32, 104 0	0		0 6, 569 0 0		190.07
190. 09 19009 SPI NE SURGEON 190. 10 19010 CLI NI CAL RESEARCH CENTER 190. 11 19011 ONCOLOGI ST	0 864, 658	0 34, 024	2, 63	0 0 0 146, 072	1, 047, 384	190. 09 190. 10 190. 11
190. 12 19012 MEDI CAL I NTERNI ST 190. 13 19013 RHEUMATOLOGY	126, 832 799, 358	0	5 5, 25		141, 852 895, 625	190. 12
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0 304, 591	11, 01	0 0		191.00
192. 01 19201 PHYSI CLANS' PRI VATE OFFI CES 192. 02 19202 FOUNDATI ON	0 1, 023, 594	0 3, 071		0 0 0 43, 181		192.01
192.03 19203 SPOE 192.04 19204 HEALTHY HEART	0 192, 326	0	1, 03	0 0 9 37, 279		192.03
192. 05 19205 VACANT SPACE	0	9, 967		0 0	9, 967	192.05
192.07         19207         PARK PLACE CENTER           193.00         19300         NONPAID WORKERS           200.00         Cross Foot Adjustments	538 0	0 0		0 0	0	192. 07 193. 00 200. 00
201.00Negative Cost Centers202.00TOTAL (sum lines 118-201)	122, 859, 950	0 4, 647, 355	3, 620, 09	0 0 0 11, 777, 876	0	201.00

	Financial Systems	COMMUNI TY HOSP				eu of Form CMS-2	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der	F	eriod: rom 01/01/2015		
				T	o 12/31/2015	Date/Time Pre 5/24/2016 1:2	pared: 6 pm
	Cost Center Description	ADMI NI STRATI VE & GENERAL	MAI NTENANCE & REPAI RS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5.00	6.00	7.00	8.00	9.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			1			1.00
2.00	00200 CAP REL COSTS-BEDG & TTAT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	24, 137, 354					5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0	10 407 417			6.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	1, 937, 367 49, 330		10, 436, 416 160, 137	425, 873		7.00 8.00
9.00	00900 HOUSEKEEPING	421, 315		320, 645			9.00
10.00	01000 DI ETARY	264, 111	0	480, 134	0		
11.00	01100 CAFETERI A	214, 326		94, 462	0	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	327, 822		123, 158		28, 553	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	727, 558 514, 532		235, 161 148, 428	22, 282	31, 890 23, 361	
16.00	01600 MEDICAL RECORDS & LIBRARY	445, 089		148, 428	0	6, 304	
17.00	01700 SOCIAL SERVICE	0		0	0	0	
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21.00 22.00	02100 I & R SERVI CES-SALARY & FRI NGES APPRVD 02200 I & R SERVI CES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	21.00
22.00	02200 PARAMED ED PRGM-(EMS)	56, 539	-		0	0	1
20100	INPATIENT ROUTINE SERVICE COST CENTERS						20100
30.00	03000 ADULTS & PEDI ATRI CS	3, 538, 150				1, 209, 972	
31.00	03100 I NTENSI VE CARE UNI T	536, 490			24, 965		31.00
32.00 33.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0			0	0	34.00
40.00	04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100 SUBPROVI DER – I RF	0	0	0	0	0	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	
43.00 44.00	04300 NURSERY 04400 SKILLED NURSING FACILITY	167, 131 0	0	86, 548 0	0	67, 489 0	1
44.00	04500 NURSING FACILITY	0		0	0	0	
46.00	04600 OTHER LONG TERM CARE	0			0	0	
	ANCILLARY SERVICE COST CENTERS						
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	1, 913, 753		1, 033, 626 0	76, 622	514, 693 0	50.00 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	-	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	56, 631	-	12, 589	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	975, 523	0	892, 511	3, 285	131, 640	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	-	0	0	0	
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	149, 783 133, 023		68, 637 20, 827	3, 647 4, 274	41, 531 0	1
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	133, 023		43, 320			
59.00	05900 CARDI AC CATHETERI ZATI ON	226, 393			3, 514		
60.00	06000 LABORATORY	998, 261		362, 299	525		
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 62.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	64, 216	0	27, 075	0	13 720	61.00 62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	04,210		0	0	0	
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	259, 651		33, 323			1
66.00	06600 PHYSI CAL THERAPY	518, 534		67,063			
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	99, 497 56, 977		41, 330 23, 095		7,046	
69.00	06900 ELECTROCARDI OLOGY	160, 303		70, 951	5, 998		1
70.00	07000 ELECTROENCEPHALOGRAPHY	196, 156		70, 951	0	11, 866	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	2, 307, 074		0	0	0	
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	2, 359, 764		0	0	0	
73.00	07400 RENAL DIALYSIS	1, 297, 147 34, 760		8, 701	0	0	
75.00	07500 ASC (NON-DI STINCT PART)	0			0	-	
	OUTPATIENT SERVICE COST CENTERS	-	1			1	1
88.00	08800 RURAL HEALTH CLINIC	0	-	0	0	0	
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-	0	0	0	89.00 90.00
90.00 90.01	09000 CLINIC 09001 WOUND/OSTOMY CLINIC	144, 709	-	473, 331	8, 752	-	
90.01	09002 KIDS PLUS CLINIC	4, 094		72, 201	0, 732	0	
90.03	09003 ONCOLOGY	0	0	793, 050		742	90. 03
90.04	09004 MUNCI E CLINI C	21,659		68, 868	0	0	
90. 05 90. 06	09005 ANTI COAGULATI ON CLINIC 09006 PREGNANCY PLUS	75, 337		100 704	0	0	
90.06 90.07	09006 PREGNANCY PLUS	50, 418 0		109, 736 0	0	4, 821 0	
90.08	09008 0/P LAB	0	-	-	0		90.08
	· · ·	· · · · · · · · · · · · · · · · · · ·		•			

Health Financial Systems	COMMUNI TY HOSP	ITAL ANDERSON		In Lie	u of Form CMS-2	552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	F	Period: From 01/01/2015 Fo 12/31/2015	Worksheet B Part I Date/Time Prep	pared:
					5/24/2016 1:26	5 pm
Cost Center Description		MAINTENANCE &			HOUSEKEEPI NG	
	& GENERAL 5.00	REPAIRS 6.00	PLANT 7.00	LINEN SERVICE 8.00	9.00	
90. 09 09009 FORTVILLE CLINIC	5, 132		55, 122		0	90.09
91. 00 09100 EMERGENCY	890, 172				179, 104	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DI ALYSI S	0	-			0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0		0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED 97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0				0	96.00 97.00
97.00 109700 DURABLE MEDICAL EQUIP-SOLD 99.00 109900 CMHC					0	97.00 99.00
99. 10 09910 CORF	0				0	99. 00 99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0			o o		100.00
101.00 10100 HOME HEALTH AGENCY	0	c c	(	0 0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0					105.00
106.00 10600 HEART ACQUI SI TI ON	0	0	(	0 0		106.00
107.00 10700 LIVER ACQUISITION	0			0		107.00
108.00 10800 LUNG ACQUISITION 109.00 10900 PANCREAS ACQUISITION						108. 00 109. 00
110. 00 11000   NTESTI NAL ACQUI SI TI ON						1109.00
111. 00 11100   SLET ACQUI SI TI ON						111.00
113.00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P. )	0	0	(	0 0	0	115.00
116. 00 11600 HOSPI CE	0	0	0	0 0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	22, 336, 164	0	9, 332, 672	2 425, 873	2, 535, 640	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	4, 514		55, 81	7 0	0	190. 00
190. 01 19001 WELLNESS CENTERS	293, 996		56, 789		40, 790	
190. 02 19002 EMPLOYED ORTHO MD	0		(	o o		190.02
190. 03 19003 NORTHVI EW CONV. (LTC)	77, 028	C	(	0 0		190. 03
190. 04 19004 SUMMIT CONV. (LTC)	69, 173	C	(	0 0	0	190. 04
190. 05 19005 PARKVI EW CONV. (LTC)	82, 699		(	0 0		190. 05
190.06 19006 MONTI CELLO HSE. (ASS' TD LVG.)	33, 512		(	0 0		190. 06
190.07 19007 NH PARK PLACE (LTC)	8, 816		(	0		190.07
190. 08 19008 MADI SON PLACE OF ELWOOD (LTC) 190. 09 19009 SPI NE SURGEON	0					190. 08 190. 09
190. 10 19010 CLINI CAL RESEARCH CENTER	238, 752		95, 89			190. 09 190. 10
190. 11 19011 ONCOLOGI ST	230, 732		75, 07			190.10
190. 12 19012 MEDI CAL I NTERNI ST	32, 335			0		190.12
190. 13 19013 RHEUMATOLOGY	204, 159			0		190. 13
191. 00 19100 RESEARCH	0	0 0	0	0 0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	457, 363	C	858, 493	3 0	14, 091	
192. 01 19201 PHYSI CLANS' PRI VATE OFFI CES	0	0 0	(	0 0		192. 01
192. 02 19202 FOUNDATI ON	243, 872		8, 655	5 0		192.02
192. 03 19203 SPOE	E2 E74					192. 03 192. 04
192. 04 19204 HEALTHY HEART 192. 05 19205 VACANT SPACE	52, 576 2, 272		28, 093			192.04 192.05
192. 07 19207 PARK PLACE CENTER	123		20,09			192.05 192.07
193. 00 19300 NONPAI D WORKERS	0					193.00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0 0		201.00
202.00   TOTAL (sum lines 118-201)	24, 137, 354	-  O	10, 436, 416	425, 873	2, 590, 521	202.00

COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der		riod: om 01/01/2015 12/31/2015	Worksheet B Part I Date/Time Pre 5/24/2016 1:2	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
1.00 2.00 4.00 5.00 6.00 7.00 8.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						1.00 2.00 4.00 5.00 6.00 7.00 8.00
15.00 16.00 17.00 19.00 20.00 21.00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL 02100 I & SERVI CES-SALARY & FRI NGES APPRVD 02200 I & SERVI CES-OTHER PRGM. COSTS APPRVD	1, 970, 733 0 0 0 0 0 0 0 0 0 0 0	1, 249, 015 20, 188 50, 583 37, 333 41, 687 0 0 0 0 0 0	1, 937, 845 0	4, 259, 205 9, 463 450 0 0 0 0	2, 990, 320 0 0 0 0 0 0 0	9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 19.00 20.00 21.00 22.00
	02300 PARAMED ED PRGM- (EMS)	0	886	0	0	0	23.00
30. 00 31. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	1, 721, 502 234, 329	365, 476 48, 269		164, 986 45, 015	0	30. 00 31. 00
42.00 43.00 44.00	03200 CORONARY CARE UNIT 03200 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY 04400 SKILLED NURSING FACILITY	0 0 0 0 0 0 0 0	0 0 0 0 0 13, 710 0	0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	32.00 33.00 34.00 40.00 41.00 42.00 43.00 44.00
45.00 46.00 50.00	04500 NURSI NG FACI LI TY 04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	000	0 0 133, 246	0 0 460, 512	0 0 622, 888	0 0	45.00 46.00 50.00
51.00 52.00 53.00 54.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	000000000000000000000000000000000000000	0 0 8, 253 65, 181	0 0	0 0 0 116 9, 625	0 0 22, 914 683	51.00 52.00
55.00 56.00 57.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI 0I SOTOPE 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI)	0 0 0	0 5, 525 9, 738 7, 184	0	0 890 12, 022 634	0 45 0 4	55. 00 56. 00
59. 00 60. 00 60. 01	05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0 0 0	15, 551 75, 089 0	0	8, 114 13, 840 0	0 0 0	59.00 60.00 60.01 61.00
62.00 63.00 64.00 65.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 0 0 0	5, 304 0 0 25, 719		140 0 0 1, 411	0 0 0 26	62.00 63.00 64.00 65.00
67.00 68.00 69.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY	0 0 0 0	45, 337 7, 311 5, 016 13, 493	0 0 0	1, 308 49 19 2, 045 822	80 0 0 0	66.00 67.00 68.00 69.00
71.00 72.00 73.00 74.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0 0 0 0	14, 686 0 0 0 0 0	0 0 0 0	823 1, 607, 182 1, 643, 898 0 500 0	11 0 0 2, 965, 254 0 0	72.00 73.00 74.00
89. 00 90. 00 90. 01	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09001 WOUND/OSTOMY CLINIC	0 0 0 0	0 0 0 10, 685	0 0 0 0	0 0 0 16, 387	0 0 0 143	89.00 90.00 90.01
90. 03 90. 04 90. 05	09002 KIDS PLUS CLINIC 09003 ONCOLOGY 09004 MUNCIE CLINIC 09005 ANTICOAGULATION CLINIC 09006 PREGNANCY PLUS 09007 O/P LAB	0 0 0 0 0	0 45, 825 0 7, 247 5, 499		0 29, 339 64 184 31	0 224 0 0 0	90. 03 90. 04 90. 05

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	1	Period: From 01/01/2015 To 12/31/2015		
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI OI	CENTRAL N SERVICES & SUPPLY	PHARMACY	
	10.00	11.00	13.00	14.00	15.00	
90.08 09008 0/P LAB	0	0		0 0	0	90.08
90. 09 09009 FORTVILLE CLINIC	0	0	) (	0 0	0	90.09
91.00 09100 EMERGENCY	14, 194	86, 206		0 65, 910	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
95. 00 09500 AMBULANCE SERVI CES	0	0		0 0	0	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0 0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	97.00
99. 00 09900 CMHC	0	0		0 0	0	99.00
99. 10 09910 CORF	0	0		0 0	0	99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0 0		100.00
101.0010100HOME HEALTH AGENCY	0	0	) (	0 0	0	101.00
SPECIAL PURPOSE COST CENTERS			1			
105.00 10500 KIDNEY ACQUISITION	0	0		0 0		105.00
106.00 10600 HEART ACQUI SI TI ON	0	0		0 0		106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0		107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0		0 0		108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVIEW-SNF		_		_	_	114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		115.00
116.00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 970, 733	1, 170, 227	1, 937, 84	5 4, 257, 333	2, 989, 384	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
190. 01 19000 WELLNESS CENTERS	0	19, 506		0 116		190.00
190. 02 19002 EMPLOYED ORTHO MD	0	19, 500		0 0		190.01
190. 03 19003 NORTHVI EW CONV. (LTC)	0	7 420		0 117		190. 02
190. 04 19004 SUMMIT CONV. (LTC)	0	7, 630 4, 942		0 134		190.03
190. 05 19005 PARKVI EW CONV. (LTC)	0	7, 971		0 10		190.04
190. 06 19006 MONTI CELLO HSE. (ASS' TD LVG.)	0	2, 979				190.05
190. 07 19007 NH PARK PLACE (LTC)	0	891				190.00
190. 08 19008 MADI SON PLACE OF ELWOOD (LTC)	0	071				190.08
190. 09 19009 SPI NE SURGEON	0	0		0 0		190.09
190. 10 19010 CLINICAL RESEARCH CENTER	0	24, 400		311		190.10
190. 11 19011 ONCOLOGI ST	0	21, 100		0 0		190.11
190. 12 19012 MEDI CAL I NTERNI ST	0	2, 288		0 47		190.12
190. 13 19013 RHEUMATOLOGY	0	1, 453	1	0 0		190.12
191. 00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		342		192.00
192. 01 19201 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.01
192. 02 19202 FOUNDATI ON	0	3, 212		0 1		192.02
192. 03 19203 SPOE	0	-,		0 .		192.03
192. 04 19204 HEALTHY HEART	0	3, 516		0 794		192.04
192. 05 19205 VACANT SPACE	0	0		0 0		192.05
192. 07 19207 PARK PLACE CENTER	0	0		o 0		192.07
193. 00 19300 NONPAI D WORKERS	0	0		0 0		193.00
200.00 Cross Foot Adjustments		-		1		200.00
201.00 Negative Cost Centers	0	0	) (	0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	1, 970, 733	1, 249, 015	1, 937, 84	4, 259, 205		
						-

End         End <th></th> <th>Financial Systems LLOCATION - GENERAL SERVICE COSTS</th> <th>COMMUNI TY HOSP</th> <th></th> <th>CCN: 150112</th> <th></th> <th>worksheet B</th> <th>2552-10</th>		Financial Systems LLOCATION - GENERAL SERVICE COSTS	COMMUNI TY HOSP		CCN: 150112		worksheet B	2552-10
Cost Conter Description         MEDICAL ELEBRAN         COLL SERVICE NUMPRISTOLAN INDESIDE SCHOOL ELEBRANCE         MONRESIDE SCHOOL ELEBRANCE           10.00         10.00         10.00         10.00         20.00         21.00           10.00         10.00         10.00         10.00         20.00         21.00           10.00         00000         SERVICE COST CONTESS FUNCTION IN PUANT CONTESS FUNCTION IN PUANT CONTESS FUNCTI	CUST A	LLUCATION - GENERAL SERVICE CUSIS		Provi der	1		Part I Date/Time Pre	
Cost Contor: Description         MEDICAL RECORDS A LIANY         MEDICAL RECORDS A LIANY         MURENT SCIAN NURSING SCHOOL SERVICES-SALAR ARES HELINSING SCHOOL SERVICES. NUMBER 1:00         District Cost Canters         Provide Cost Cost Cost Canters           1:00         Ditol Cost MELL Cost Canters         1:00         10:00         19:00         19:00         10:00           0:000000         ADM IN STRATTUE & COST CANTERS         1:00         10:00								
Image: Strawtor Cost Charters         Dot of Cast PET Charte		Cost Center Description	RECORDS &	SOCI AL SERVI CE			SERVI CES-SALAR	
1.00         DOTOD (CAP NIT COSTS: NIT NG & IT IXT           2.00         DOSOC DEPULCYSE EXPERTS DEPARTMENT           4.00         DOROD (EMPLOYEE EXPERTS DEPARTMENT           6.00         DOROD (MPLOYEE EXPERTS DEPARTMENT           6.00         DOROD (MPLOYEE EXPERTS DEPARTMENT           6.00         DOROD (MPLOYEE EXPERTS DEPARTMENT           6.00         DOROD (MURRY & LINE SPANCE)           7.00         DOROD (MURRY & LINE SPANCE)           7.0				17.00	19.00	20.00	21.00	
2 00 00000 CAP FEE, COSTS-MURLE EQUIP 4 10 00000 CAP FEE, COSTS-MURLE EQUIP 4 10 00000 CANNON 5 ASTRUE 5 GENERAL 10 00000 CANNON 5 ASTRUE 5 GENERAL 10 00000 CANNON 5 ASTRUE 5 ASTRUE 5 10 00000 CANNON 5 ASTRUE 5 10 00000 CANNON 5 ASTRUE 5 10 0000 CANNON 5 ASTRUE 5 10 00000 CANNON 5 ASTRUE 5 10 0000 CANNON 5 ASTRUE 5 10 0000 CANNON 5 ASTRUE 5 10 0000 CANNON 5 10 0000			1	1	I		I	
4 00 00000 EPPLOYCE ENFERTS DEPARTMENT 5 00 00000 AUM INTERVICE & GENERAL 6 00 00000 AUM INTERVICE & GENERAL 6 00 00000 AUM INTERVICE & SUPPLY 9 00 00000 AUGENEET IN STRUCES & SUPPLY 9 00 10000 AUGENEET IN STRUCES & SUPPLY 10 00 10100 CAFETERIA 11 00 10100 CAFETERIA 10 00 10000 AUGENEET AND STRUCES & SUPPLY 10 00 10100 CAFETERIA 10 00 1000 CAFETERIA 10 00 00 CAFETERIA 10 00 CAF								1.00
6 00 00000 MINITENENCE & REPAIRS  8 00 00000 LAUROPY & LINEN SERVICE 9 9 00000 LAUROPY & LINEN SERVICE 9 9 0000 00000 LAUROPY & LINEN SERVICE 9 9 0000 0000 LAUROPY & LINEN SERVICE 9 9 0000 0000 CAFETERIA  11.00 01000 CAFETERIA  13.00 01000 CAFETERIA  14.00 01000 CAFETERIA  15.00 000 CA								4.00
7.00         00700         DPERATION OF PLANT								5.00
0.00         00000 (LAURINEY & LINEN SERVICE								6.00
9.00 00000 000500 000500 000500 000500 000500 000000								7.00
11.00       01100       CAFETERIA <ul> <li>13.00</li> <li>01300</li> <li>01400</li> <li>CENTRARACY</li> <li>2, 634, 280</li> <li>01000</li> <li>0000</li> <li>0000</li> <li>0000</li> <li>0000</li> <li>00000</li> <li>00000</li> <li>00000</li> <li>00000</li> <li>00000</li> <li>00000</li> <li>00000</li> <li>00000</li> <li>00000</li> <li>000000</li> <li>000000</li> <li>000000</li> <li>000000</li> <li>00000000</li> <li>000000000000000000</li> <li>000000000000000000000000000000000000</li></ul>								9.00
13.00         01300         NURSING ADMINISTICATION         01300         014000         01400         014000         014000         0	10.00	01000 DI ETARY						10.00
14 00       01400       CFNTEAL SERVICES & SUPPLY         15.00       01500       HISMANCY       2, 634, 280         17.00       01700       01600       HEINAMACY       2, 634, 280         17.00       01700       01700       01700       01700       01700         17.00       01700       NERSIN S.SADOL*       0       0       0         17.00       01700       NERSIN S.SADOL*       0       0       0         18.00       01700       NERSIN S.SADOL*       0       0       0       0         10.00       01700       NERSIN S.SADOL*       0       0       0       0       0         11.00       01700       NERSIN S.SADOL*       0       0       0       0       0       0       0       0         11.00       0100       DITOL*       NERSIN S.SADOL*       0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>11.00</td></td<>								11.00
15: 00         01: SDD [HARMACY         2, 634, 280         0         0           17: 00         01: 700         SOCIAL SERVICE         0         0         0         0           17: 00         01: 700         SOCIAL SERVICE         0								13.00
17.00         01700         SOCIAL SERVICE         0         0           17.00         01700         SOCIAL SERVICES         0         0         0         0           20.00         02000         NURSING SCHOL         0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>15.00</td>								15.00
19.00         01900         NORMENTS CLAN ARESTHETISTS         0         0         0           21.00         02000         INESING SCHOLE         0         0         0         0           21.00         02000         INES REVICES-SALARY & FRI NGES APPRVD         0         0         0         0           23.00         02000         INES REVICES-SALARY & FRI NGES APPRVD         0         0         0         0           INPATILENT MOUTINE SERVICE COST CENTERES         0 <td< td=""><td>16.00</td><td>01600 MEDICAL RECORDS &amp; LIBRARY</td><td>2, 634, 280</td><td></td><td></td><td></td><td></td><td>16.00</td></td<>	16.00	01600 MEDICAL RECORDS & LIBRARY	2, 634, 280					16.00
20. 00         02000         NURSI NG SCHOL         0         0         0           21. 00         02001         IAR SERVICES-SALARY & TRI NCES APPRVD         0         0         0         0           22. 00         022001         IAR SERVICES-CITHER PROM. COSTS APPRVD         0         0         0         0         0           00         02000         IAR SERVICES-CITHER PROM. COSTS APPRVD         0         0         0         0         0           00         02000         IAR SERVICES-COST CENTERS         0				, s				17.00
21.00       02100   AR SERVICES-SALARY & FRINCES APPVD       0       0         23.00       02300   FARAMED ED PRCM- (EVS)       0       0       0         IMPATTER ROUTINE SERVICE COSTS APPRVD       0       0       0       0         100       03000 (ADULTS & PEDIATRICS       699,580       0       0       0       0         30.00       03000 (ADULTS & PEDIATRICS       699,580       0       0       0       0       0         31.00       03200 (DRWANTY CARE UNIT       0       0       0       0       0       0       0       0         31.00       03400 (SURGICAL, INTERSIVE CARE UNIT       0 <td></td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td></td> <td>19.00</td>						0		19.00
23.00         00         0         0           IMPART LET ROUTINE SERVICE COST CENTERS         0 <td></td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td>0</td> <td></td>						0	0	
INPART LENT ROUTINE SERVICE (OST CENTERS         Impart Lent ROUTINE SERVICE (OST CENTERS           0.00         03000 INTESNEY LECARE UNIT         0 <t< td=""><td>22.00</td><td>02200 I &amp;R SERVICES-OTHER PRGM. COSTS APPRVD</td><td>-</td><td>-</td><td></td><td></td><td></td><td>22.00</td></t<>	22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	-	-				22.00
30.00         03000 ADULTS & PEDIATRICS         699,580         0         0         0         0           31.00         03200 COROMARY CARE UNIT         0 <td>23.00</td> <td></td> <td>C</td> <td>0 0</td> <td></td> <td></td> <td></td> <td>23.00</td>	23.00		C	0 0				23.00
31.00       03100 INTERNIVE CARE UNIT       0       0       0         33.00       03300 BURN INTERSIVE CARE UNIT       0       0       0       0         34.00       03400 COROMARY CARE UNIT       0<	30 00		699 580			0 0	0	30.00
33. 00         033.00         BURN INTENSIVE CARE UNIT         0         0         0         0         0           40. 00         03000         SUBGICAL INTENSIVE CARE UNIT         0         <								
34. 00         03400         SUBJECAL INTENSIVE CARE LINIT         0         0         0         0         0         0           41. 00         Oddoo SUBPROV DER - 1 RF         0			C	0 0		0 0		
40.00         04000         SUBPROV DER - 1 PF         0         0         0         0         0           41.00         04700         SUBPROV DER - 1 RF         0         0         0         0         0           43.00         04300         SUBPROV DER - 1 RF         0         0         0         0         0         0           43.00         04300         SUBPROV DER - 1 RF         0 <td></td> <td></td> <td>C</td> <td></td> <td></td> <td>0 0</td> <td></td> <td></td>			C			0 0		
41.00         Q4100         SUBPROVI DER         I.F.F         0         0         0         0         0           42.00         Q4300         SUBPROVI DER         0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
43.00         Q4300         NURSERY         0         0         0         0         0           44.00         Q4600         SKILLED NURSING FACILITY         0<						0 0	-	
44.00       [A4.00]       [A4.00]       [A4.00]       [A4.00]       [A4.00]       [A6.00]       [A6.00]       [A6.00]       [A6.01]       [A6.00]			C	0 0		0 0		
45.00         04500         NURSING FACILLTY         0         0         0         0         0           A6.00         OBOOD OTHER LONG TERM CARE         0			C			0 0	-	
46.00         0         0         0         0         0         0           ANGLLARY SERVICE COST CENTERS			-	-				
50.00         05000         05000         <			C				-	
51:00         OS100         RECOVERY ROM         O	50.00		145 700					50.00
52.00         DELIVERY ROOM & LABOR ROOM         0 <th< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></th<>								
54.00       0500       RADI OLOGY-DI AGNOSTI C       43,422       0       0       0       0         55.00       0500       RADI OLOGY-THERAPEUTI C       0       0       0       0       0         56.00       05600       RADI OLOGY-THERAPEUTI C       0       0       0       0       0       0         57.00       05700       CT SCAN       0 <t< td=""><td></td><td></td><td></td><td>-</td><td></td><td>0 0</td><td>-</td><td></td></t<>				-		0 0	-	
55.00         05500         RADI OLOGY-THERAPEUTI C         0 <t< td=""><td></td><td></td><td>C</td><td>0 0</td><td></td><td>0 0</td><td></td><td></td></t<>			C	0 0		0 0		
56.00         05600         RADI 01 SOTOPE         0			43, 422	0		0 0	-	
57.00       05700       CT SCAN       0							-	
59:00       05900       CARDIAC CATHETERIZATION       0			C			0 0		
60.00         06000         LABORATORY         270, 183         0 <td></td> <td></td> <td>C</td> <td>0 0</td> <td></td> <td>0 0</td> <td>-</td> <td></td>			C	0 0		0 0	-	
60.01         06001         BLOOD         LABORATORY         0         0         0         0           61.00         06100         PBP         CLINICAL         LAB         SERVICES-PRGM         ONLY         0         0         0         0           62.00         06200         WHOLE         BLOOD         & PACKED         REDOD         CELIS         0 <td< td=""><td></td><td></td><td>-</td><td>-</td><td></td><td>0 0</td><td>-</td><td></td></td<>			-	-		0 0	-	
61.00       06100       PBP CLINICAL LAB SERVICES-PRGM ONLY       0       0         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0       0       0       0         63.00       0.000       STORING, PROCESSING & TRANS.       0       0       0       0       0         64.00       0.6400       INTRAVENOUS THERAPY       0			270, 183			0 0	-	1
63.00       06300       BLOOD STORING, PROCESSING & TRANS.       0       0       0       0         64.00       06400       INTRAVENOUS THERAPY       0       0       0       0       0         65.00       06500       RESPIRATORY THERAPY       0       0       0       0       0       0       0         66.00       06600       PHYSICAL THERAPY       0								61.00
64.00         06400         INTRAVENOUS THERAPY         0         0         0         0         0           65.00         06500         RESPI RATORY THERAPY         0			C	0		0 0	-	
65.00       06500       RESPI RATORY THERAPY       0       0       0       0         66.00       06600       PHYSI CAL THERAPY       0       0       0       0       0         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0       0       0       0         68.00       SPEECH PATHOLOGY       0								
66.00         06600         PHYSI CAL THERAPY         0         0         0         0         0           67.00         0CCUPATI ONAL THERAPY         0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td>0 0</td><td>-</td><td></td></td<>						0 0	-	
68.00         06800         SPEECH PATHOLOGY         0 <td>66.00</td> <td>06600 PHYSI CAL THERAPY</td> <td>C</td> <td></td> <td></td> <td>0 0</td> <td>0</td> <td>66.00</td>	66.00	06600 PHYSI CAL THERAPY	C			0 0	0	66.00
69.00         06900         ELECTROCARDIOLOGY         0 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>0 0</td> <td>-</td> <td></td>			0			0 0	-	
70.00         07000         ELECTROENCEPHALOGRAPHY         0 <th< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>-</td><td></td></th<>							-	
71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0						o o	-	1
73.00         07300         DRUGS CHARGED TO PATIENTS         0	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C			0 0		71.00
74.00         07400         RENAL DI ALYSI S         0 <td></td> <td></td> <td></td> <td></td> <td></td> <td>0 0</td> <td></td> <td></td>						0 0		
75.00         07500         ASC (NON-DI STINCT PART)         0         <							-	
OUTPATI ENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC         0         0         0         0           89.00         08900         FEDERALLY QUALI FIED HEALTH CENTER         0						o o		
89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0		OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		1		-	1
90. 00         09000         CLINIC         0						0 0		
90. 01         09001         WOUND/OSTOMY CLINIC         585, 396         0							-	
90. 02         09002         KI DS PLUS CLINIC         0 </td <td></td> <td></td> <td>585.396</td> <td></td> <td></td> <td>0 N</td> <td></td> <td>1</td>			585.396			0 N		1
	90.02		0			0 0	-	
			C	0		0 0		
90. 05 09005 ANTI COAGULATI ON CLINIC 0 0 0 0 0 0							0	

Health Financial Systems	COMMUNI TY HOSP	ITAL ANDERSON		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	F	eriod: rom 01/01/2015 o 12/31/2015	Worksheet B Part I Date/Time Pre 5/24/2016 1:2	pared: 6 pm
Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	NURSI NG SCHOOL	I NTERNS & RESI DENTS SERVI CES-SALAR Y & FRI NGES	
	16.00	17.00	19.00	20.00	21.00	
90. 06 09006 PREGNANCY PLUS	0	C	C	0	0	
90. 07 09007 0/P LAB	0	C	C	0	0	
90. 08 09008 0/P LAB	0	C	C	0	0	
90. 09 09009 FORTVILLE CLINIC	001 200			0	0	90.09
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	881, 308			0	0	91.00 92.00
OTHER REIMBURSABLE COST CENTERS						92.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	C	C	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0			0	0	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	C C	C	0	0	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	C	C	0	0	97.00
99. 00 09900 CMHC	0	C	C	0	0	99.00
99. 10 09910 CORF	0	C	C	0	0	99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	C	C	0		100.00
101.00 10100 HOME HEALTH AGENCY	0	C	C	0	0	101.00
SPECIAL PURPOSE COST CENTERS						105 00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	C	C	0		105.00
106. 00 10600 HEART ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON	0			0		106.00 107.00
108. 00 10800 LUNG ACQUISITION	0			0		107.00
109. 00 10900 PANCREAS ACQUISITION				0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0			0	-	110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	C C	C	0		111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	C	C	0		115.00
116.00 11600 H0SPI CE	0	C	C	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	2, 595, 682	C	C	0	0	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	C	0	0	190.00
190. 01 19001 WELLNESS CENTERS				0		190.00
190. 02 19002 EMPLOYED ORTHO MD	0			0		190.02
190. 03 19003 NORTHVI EW CONV. (LTC)	0	C C	C	0		190.03
190. 04 19004 SUMMIT CONV. (LTC)	0	C	C	0	0	190.04
190. 05 19005 PARKVI EW CONV. (LTC)	0	C	C	0	0	190. 05
190.06 19006 MONTI CELLO HSE. (ASS' TD LVG.)	0	C	C	0	-	190.06
190.07 19007 NH PARK PLACE (LTC)	0	C	C	0		190. 07
190.08 19008 MADI SON PLACE OF ELWOOD (LTC)	0	C	C	0		190.08
190. 09 19009 SPINE SURGEON	0			0		190.09
190. 10 19010 CLI NI CAL RESEARCH CENTER 190. 11 19011 ONCOLOGI ST	0			0		190. 10 190. 11
190. 12 19012 MEDI CAL I NTERNI ST	0			0		190. 11
190. 13 19013 RHEUMATOLOGY				0		190. 12
191. 00 19100 RESEARCH	0			0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	38, 598	C	c c	0		192.00
192. 01 19201 PHYSI CLANS' PRI VATE OFFI CES	0	C	C	0		192.01
192. 02 19202 FOUNDATI ON	0	C	C	0		192. 02
192. 03 19203 SP0E	0	C	C	0		192.03
192. 04 19204 HEALTHY HEART	0	C	C	0		192.04
192. 05 19205 VACANT SPACE	0	C	C C	0		192.05
192. 07 19207 PARK PLACE CENTER				0		192.07
193.0019300NONPAIDWORKERS200.00Cross Foot Adjustments				0		193.00 200.00
201.00 Negative Cost Centers		· · · ·		0		200.00
202.00 TOTAL (sum lines 118-201)	2, 634, 280			0		201.00
	2,001,200			. 0	. 0	

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	COMMUNI TY HOSPI	TAL A		CCN: 150113	In Lie Period:	u of Form CMS- Worksheet B	2552-10
						From 01/01/2015 To 12/31/2015	Part I Date/Time Pre	pared:
		INTERNS &					5/24/2016 1:2	6 pm
	Cost Center Description	RESIDENTS SERVICES-OTHER PRGM. COSTS		AMED ED M-(EMS)	Subtotal	Intern & Residents Cost & Post	Total	
						Stepdown Adjustments		
	GENERAL SERVICE COST CENTERS	22.00	2	23.00	24.00	25.00	26.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT							1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP							2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINI STRATIVE & GENERAL							4.00 5.00
6.00	00600 MAI NTENANCE & REPAI RS							6.00
7.00	00700 OPERATION OF PLANT							7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG							8.00 9.00
10.00	01000 DI ETARY							10.00
11.00	01100 CAFETERI A							11.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY							13.00 14.00
14.00	01500 PHARMACY							15.00
16.00	01600 MEDICAL RECORDS & LIBRARY							16.00
17.00 19.00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS							17.00 19.00
20.00	02000 NURSI NG SCHOOL							20.00
21.00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD							21.00
22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0		205 457				22.00
23.00	02300 PARAMED ED PRGM-(EMS) I NPATI ENT ROUTI NE SERVI CE COST CENTERS			305, 457				23.00
30.00	03000 ADULTS & PEDI ATRI CS	0		0			27, 095, 466	1
31.00	03100 I NTENSI VE CARE UNI T	0		0	3, 741, 98		3, 741, 980	1
32.00 33.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0		0		0 0	0	
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0		0		0 0	0	
40.00	04000 SUBPROVIDER - IPF	0		0		0 0	0	
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0		0			0	
43.00	04300 NURSERY	0		0	1, 115, 44	17 0	1, 115, 447	
44.00	04400 SKILLED NURSING FACILITY	0		0		0 0	0	
45.00 46.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0		0		0 0	0	
101 00	ANCILLARY SERVICE COST CENTERS			Ŭ	1			
50.00	05000 OPERATING ROOM	0		0	13, 267, 29		13, 267, 298	
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0		0		0 0	0 0	
53.00	05300 ANESTHESI OLOGY	0		0	348, 93			
	05400 RADI OLOGY-DI AGNOSTI C	0		0	6, 401, 40	0 0	6, 401, 400	
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0		0	927, 14	0 0 11 0	0 927, 141	
57.00	05700 CT SCAN	0		0	763, 44		763, 445	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0		0	795, 12		795, 124	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0		0	1, 424, 33 6, 114, 67		1, 424, 333 6, 114, 677	1
60. 01	06001 BLOOD LABORATORY	0		0		0 0	0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0	202.1/	0	0	61.00
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0		0	392, 16	0 0	392, 165 0	1
64.00	06400 I NTRAVENOUS THERAPY	0		0		0 0	0	
65.00	06500 RESPI RATORY THERAPY	0		0	1, 477, 13		1, 477, 130	1
66.00 67.00	06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY	0		0	2, 923, 20 592, 18		2, 923, 202 592, 185	
68.00	06800 SPEECH PATHOLOGY	0		0	341, 73		341, 733	
69.00	06900 ELECTROCARDI OLOGY	0	ļ	0	958, 99		958, 992	
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	1, 155, 01 14, 035, 17		1, 155, 011 14, 035, 177	
72.00	07200 I MPL. DEV. CHARGED TO PATTENTS	0		0	14, 355, 73		14, 355, 731	
	07300 DRUGS CHARGED TO PATIENTS	0		0	9, 952, 86	5 0	9, 952, 865	73.00
74.00 75.00	07400 RENAL DIALYSIS	0		0	196, 45	52 0 0 0	196, 452 0	
75.00	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0		0	I	0 0	0	75.00
88.00	08800 RURAL HEALTH CLINIC	0		0		0 0	0	
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0		0		0 0	0	
90.00 90.01	09001 WOUND/OSTOMY CLINIC	0		0	1, 905, 00	05 0	1, 905, 005	
90. 02	09002 KIDS PLUS CLINIC	0	l	0	94, 25	53 0	94, 253	90. 02
90.03	09003 0NCOLOGY	0		0	-6, 296, 67	0 0	-6, 296, 676	90.03

	nancial Systems OCATION - GENERAL SERVICE COSTS	COMMUNITY HOSPI		CCN: 150113	Period:	u of Form CMS-2 Worksheet B	2002-10
SUGT ALL	CONTROL - GENERAL SERVICE (USIS			1	From 01/01/2015 To 12/31/2015	Part I	
	Cost Center Description	I NTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	PARAMED ED PRGM-(EMS)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		22.00	23.00	24.00	25.00	26.00	
	2004 MUNCIE CLINIC	0	0	185, 60		185, 609	
	2005 ANTI COAGULATI ON CLINI C	0	0	413, 26		413, 264	
	2006 PREGNANCY PLUS 2007 0/P LAB	0	0	391, 68		391, 682 0	
	2008 0/P LAB	0	0			0	
	2009 FORTVILLE CLINIC	0	0	82, 76	6 0	82, 766	
	P100 EMERGENCY	0	305, 457	6, 726, 48		6, 726, 488	
92.00 09	200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	HER REIMBURSABLE COST CENTERS	1 1					
	2400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	
	2500 AMBULANCE SERVICES	0	0		0 0	0	
	2600 DURABLE MEDICAL EQUIP-RENTED 2700 DURABLE MEDICAL EQUIP-SOLD	0	0			0	
	P900 CMHC	0	0		0 0	0	
	2910 CORF	0	0		0 0	0	
100.0010	0000 I&R SERVICES-NOT APPRVD PRGM	0	0		0 0	0	100.00
	0100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
	PECIAL PURPOSE COST CENTERS						1405 00
	0500 KIDNEY ACQUISITION 0600 HEART ACQUISITION	0	0				105.00 106.00
	0700 LIVER ACQUISITION	0	0				107.00
	0800 LUNG ACQUISITION	0	0		0 0		108.00
	0900 PANCREAS ACQUI SI TI ON	0	0		0 0		109.00
110. 00 11	1000 INTESTINAL ACQUISITION	0	0		0 0	0	110.00
	100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
	300 I NTEREST EXPENSE						113.00
	400 UTILIZATION REVIEW-SNF 500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0	0	114.00 115.00
	1600 HOSPICE	0	0				116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	305, 457	111, 878, 28	3 0	111, 878, 283	
	NREIMBURSABLE COST CENTERS						
	2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	80, 13		80, 135	
	2001 WELLNESS CENTERS	0	0	1, 700, 95	1 0	1, 700, 951	
	2002 EMPLOYED ORTHO MD	0	0	422.40	0 0		190.02
	2003 NORTHVIEW CONV. (LTC) 2004 SUMMIT CONV. (LTC)	0	0	422, 69 377, 70		422, 690 377, 705	
	2005 PARKVI EW CONV. (LTC)	0	0	453, 47		453, 475	
190. 06 19	2006 MONTICELLO HSE. (ASS'TD LVG.)	0	0	183, 50		183, 506	
	2007 NH PARK PLACE (LTC)	0	0	48, 38	0 0	48, 380	
	2008 MADISON PLACE OF ELWOOD (LTC)	0	0		0 0		190. 08
	2009 SPINE SURGEON	0	0	1 404 74	0 0		190.09
	2010 CLINICAL RESEARCH CENTER 2011 ONCOLOGIST	0	0	1, 406, 74	4 0	1, 406, 744	190.10
	PO12 MEDICAL INTERNIST	0	0	177, 43	7 0	177, 437	
	PO13 RHEUMATOLOGY	0	0	1, 101, 23		1, 101, 237	
	2100 RESEARCH	0	0		0 0	0	191.00
	2200 PHYSICIANS' PRIVATE OFFICES	0	0	3, 375, 29	8 0	3, 375, 298	
	2201 PHYSI CLANS' PRI VATE OFFI CES	0	0	4 005	0 0		192.01
	2202 FOUNDATION	0	0	1, 325, 58		1, 325, 586	
		0	0	287, 53		0 287, 530	192.03
192.03 19		(1)	0	207,03		207, 530	
192. 03 19 192. 04 19	204 HEALTHY HEART	0	0	40 33	2 ∩l	40 332	1192 05
192. 03 19 192. 04 19 192. 05 19	2204 HEALTHY HEART 2205 VACANT SPACE	0	0	40, 33 66		40, 332 661	
192. 03 19 192. 04 19 192. 05 19 192. 07 19	204 HEALTHY HEART	0	0 0 0	40, 33. 66		661	192. 05 192. 07 193. 00
192. 03 19 192. 04 19 192. 05 19 192. 07 19 193. 00 19 200. 00	2204 HEALTHY HEART 2205 VACANT SPACE 2207 PARK PLACE CENTER 2300 NONPAID WORKERS Cross Foot Adjustments		0 0 0 0			661 0 0	192. 07 193. 00 200. 00
192. 03 19 192. 04 19 192. 05 19 192. 07 19	2204 HEALTHY HEART 2205 VACANT SPACE 2207 PARK PLACE CENTER 2300 NONPAID WORKERS		0 0 0 0 305, 457	66	1 0 0 0 0 0 0 0 0 0	661 0 0	192.07 193.00 200.00 201.00

	Financial Systems TION OF CAPITAL RELATED COSTS		TAL ANDERSON Provi der	1	Period: From 01/01/2015 To 12/31/2015	u of Form CMS-: Worksheet B Part II Date/Time Pre	pared:
				LATED COSTS		5/24/2016 1:2	6 pm
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs	1.00	2.00	24	4.00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	2A	4.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP				(7.959	(7.050	2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	0	28, 671 368, 205			67, 053 11, 591	1
6.00	00600 MAI NTENANCE & REPAI RS	0	300, 203	777,17	0 1, 343, 400	0	
7.00	00700 OPERATION OF PLANT	0	547, 669			2, 410	
8.00	00800 LAUNDRY & LINEN SERVICE	0	56, 816		D 56, 816	72	1
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	113, 764 170, 350			1, 485 601	1
11.00	01100 CAFETERI A	0	33, 515		D 33, 515	1, 038	
13.00	01300 NURSING ADMINISTRATION	0	43, 696			1, 284	
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	83, 434 52, 662			1, 047 1, 878	
	01600 MEDICAL RECORDS & LIBRARY	0	66, 767		0 66, 767	1, 878	
17.00	01700 SOCIAL SERVICE	0	C		0 0	0	
	01900 NONPHYSI CI AN ANESTHETI STS	0	0		0 0	0	
20.00 21.00	02000 NURSING SCHOOL 02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0			0	
22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	0		0 0	0	1
23.00	02300 PARAMED ED PRGM-(EMS)	0	0		0 0	38	23.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS		0.44 0.04	102.00	1 020 000	10 7/7	20.00
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	846, 894 81, 415			13, 767 1, 971	
	03200 CORONARY CARE UNI T	0	01, 110		0 0	0	
33.00	03300 BURN INTENSIVE CARE UNIT	0	C		0 0	0	
34.00 40.00	03400 SURGI CAL INTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	0	0			0	
40.00	04100 SUBPROVIDER - IRF	0				0	1
42.00	04200 SUBPROVI DER	0	C	)	0 0	0	1
43.00	04300 NURSERY	0	30, 707			583	1
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0			0	
46.00	04600 OTHER LONG TERM CARE	0	0		0 0	0	1
	ANCI LLARY SERVI CE COST CENTERS			1			
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	366, 727	1, 004, 80	0 1, 371, 527	5, 328 0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	1
53.00	05300 ANESTHESI OLOGY	0	4, 466				53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	316, 660	355, 38	4 672, 044		54.00
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	24, 352	7, 92	4 32, 276	0 311	
	05700 CT SCAN	0	7, 389				57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	15, 370			382	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	61, 036 128, 543			732 2, 541	
	06001 BLOOD LABORATORY	0	120, 543	217,01	0 0	2, 341	1
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0		61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	9, 606			257	1
	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0			0	
65.00	06500 RESPI RATORY THERAPY	0	11, 823	38, 10	7 49, 930	995	
66.00	06600 PHYSI CAL THERAPY	0	23, 794	4, 92	6 28, 720	1, 984	
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	14, 664 8, 194			397 223	
	06900 ELECTROCARDI OLOGY	0	25, 173			539	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	25, 173				70.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0			0	
	07400 RENAL DIALYSIS	0	3, 087		3, 087	0	1
	07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	
00.00	OUTPATIENT SERVICE COST CENTERS		~	1		-	
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER					0	
	09000 CLINIC	0	C			0	1
00 04	09001 WOUND/OSTOMY CLINIC	0	167, 936			425	90.01
			· · ·				0 0 0
	09002 KIDS PLUS CLINIC 09003 ONCOLOGY	0	25, 617 281, 372		25, 617 8 368, 370	0 959	

	Financial Systems TION OF CAPITAL RELATED COSTS	COMMUNI TY HOSPI		CCN: 150113 P	eriod:	u of Form CMS-2 Worksheet B	2552-10
ALLUCAT	TION OF CAPITAL RELATED COSTS		Provider	F	rom 01/01/2015 o 12/31/2015	Part II Date/Time Prej 5/24/2016 1:20	pared:
			CAPI TAL REL	ATED COSTS		372472010 1.2	
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	09005 ANTI COAGULATI ON CLINI C	0	0	3, 842		310	
	09006 PREGNANCY PLUS 09007 0/P LAB	0	38, 934	816	39, 750	168 0	90.06
	09008 0/P LAB	0	0	0	0	0	90.07
	09009 FORTVILLE CLINIC	0	19, 557	0	19, 557	0	90.09
	09100 EMERGENCY	0	127, 278	107, 686		3, 449	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
(	OTHER REIMBURSABLE COST CENTERS						
	09400 HOME PROGRAM DI ALYSI S	0	0	0		0	94.00
	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
	09700 DURABLE MEDICAL EQUIP-SOLD 09900 CMHC	0	0	0	0	0	97.00
	09910 CORF	0	0	0	0	0	99.00
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0	-	100. 00
	10100 HOME HEALTH AGENCY	0	0	0	0		101.00
	SPECIAL PURPOSE COST CENTERS				• •		
105.00	10500 KIDNEY ACQUISITION	0	0	0	0		105.00
	10600 HEART ACQUI SI TI ON	0	0	0	0		106.00
	10700 LIVER ACQUISITION	0	0	0	0		107.00
	10800 LUNG ACQUI SI TI ON	0	0	0	0		108.00
	10900 PANCREAS ACQUI SI TI ON	0	0	0	0		109.00
	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION	0	0	0	0		110.00 111.00
	11300 I NTEREST EXPENSE	0	Ű	0	0	0	113.00
	11400 UTI LI ZATI ON REVI EW-SNF						114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115.00
	11600 HOSPI CE	0	0	0	0		116.00
118.00		0	4, 255, 750	3, 599, 279	7, 855, 029	63, 172	118.00
	NONREI MBURSABLE COST CENTERS		10.004		10.001	-	1.00.01
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 WELLNESS CENTERS	0	19,804	0 815			190. 00 190. 01
	19002 EMPLOYED ORTHO MD	0	20, 148 0	015			190. 02
	19003 NORTHVI EW CONV. (LTC)	0	0	0	0		190. 03
	19004 SUMMIT CONV. (LTC)	0	o	0	0		190.04
	19005 PARKVI EW CONV. (LTC)	0	0	0	0	352	190. 05
	19006 MONTICELLO HSE. (ASS'TD LVG.)	0	0	0	0		190. 06
	19007 NH PARK PLACE (LTC)	0	0	0	0	-	190. 07
	19008 MADISON PLACE OF ELWOOD (LTC)	0	0	0	0		190.08
	19009 SPI NE SURGEON	0	24 024	0	0		190.09
	19010 CLINICAL RESEARCH CENTER 19011 ONCOLOGIST	0	34, 024	2, 630	36, 654		190. 10 190. 11
	19012 MEDI CAL I NTERNI ST	0	0	58	58		190. 12
	19013 RHEUMATOLOGY	0	0	5, 252			190. 13
191.00	19100 RESEARCH	0	o	0	0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	304, 591	11, 017	315, 608		192.00
192. 01	19201 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 01
	19202 FOUNDATION	0	3, 071	0	3, 071		192.02
	19203 SPOE	0	0	0	0		192.0
197 (14)	19204 HEALTHY HEART	0		1, 039			192.04
	19205 VACANT SPACE	0	9, 967	0	9, 967		192. 05 192. 0
192.05	10207 DADK DIACE CENTED			()	0	0	1172. U.
192. 05 192. 07	19207 PARK PLACE CENTER	0		0 0	0		192 00
192. 05 192. 07 193. 00	19300 NONPAI D WORKERS	0	0	0	0	0	
192. 05 192. 07	19300 NONPAID WORKERS Cross Foot Adjustments	0	0	0	0	0	193.00 200.00 201.00

	Financial Systems	COMMUNITY HOSPIT				u of Form CMS-2	2552-10
ALLOCA	ITION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2015 To 12/31/2015	Date/Time Pre	pared:
	Cost Center Description	ADMI NI STRATI VE M	AINTENANCE &	OPERATION OF	LAUNDRY &	5/24/2016 1:2 HOUSEKEEPI NG	6 pm
		& GENERAL 5.00	REPAI RS 6.00	PLANT 7.00	LI NEN SERVICE 8.00	9.00	
	GENERAL SERVICE COST CENTERS		0.00		0.00	7100	
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 ADMI NI STRATI VE & GENERAL	1, 356, 991					5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0	00/ 07			6.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	108, 915 2, 773	0	826, 97 12, 68			7.00 8.00
9.00	00900 HOUSEKEEPING	23, 686	0	25, 40			9.00
10.00	01000 DI ETARY	14, 848	0			4, 652	10.00
11.00		12,049	0			0	11.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	18, 430 40, 902	0	9, 75 18, 63		1, 957 2, 186	13.00 14.00
15.00	01500 PHARMACY	28, 926	0	11, 76		1, 601	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	25, 022	0	14, 91		432	16.00
17.00 19.00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0		0 0	0	17.00 19.00
20.00	02000 NURSI NG SCHOOL	0	0		0 0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0		0 0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	0		0 0	0	22.00
23.00	02300 PARAMED ED PRGM-(EMS) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	3, 179	0		0 0	0	23.00
30.00	03000 ADULTS & PEDIATRICS	198, 940	0	189, 14	2 38, 065	82, 947	30.00
31.00	03100 I NTENSI VE CARE UNI T	30, 161	0	18, 18		7,067	31.00
32.00 33.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0		0 0	0	32.00 33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0 0	0	34.00
40.00	04000 SUBPROVI DER – I PF	0	0		0 0	0	40.00
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	0		0 0	0	41.00 42.00
42.00	04300 NURSERY	9, 396	0	6, 85	-	4, 626	42.00
44.00	04400 SKILLED NURSING FACILITY	0	0		0 0	0	44.00
45.00	04500 NURSING FACILITY	0	0		0 0	0	45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0		0 0	0	46.00
50.00	05000 OPERATING ROOM	107, 588	0	81, 90	13, 017	35, 283	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0 3, 184	0	99	0 0 8 0	0	52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	54, 842	0	70, 72			54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	8, 421 7, 478	0	5, 43		2, 847 0	56.00 57.00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	7, 726	0	3, 43			
59.00	05900 CARDI AC CATHETERI ZATI ON	12, 727	0	13, 63	2 597	381	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	56, 120 0	0	28, 70	8 89 0 0	1, 042 0	60. 00 60. 01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0 0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	3, 610	0	2, 14	5 0	941	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0		0 0 0 0	0	63.00 64.00
64.00 65.00	06500 RESPIRATORY THERAPY	14, 597	0	2, 64	-	0 1, 068	
66.00	06600 PHYSI CAL THERAPY	29, 151	0	5, 31			
67.00	06700 OCCUPATIONAL THERAPY	5, 594	0	3, 27			
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	3, 203 9, 012	0	1, 83 5, 62		458 203	
	07000 ELECTROENCEPHALOGRAPHY	11, 028	0	5, 62		813	
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	129, 700	0		0 0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	132, 662 72, 923	0		0 0	0	72.00 73.00
74.00	07400 RENAL DIALYSIS	1, 954	0	68	9 0	0	74.00
	07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.00
00 00	OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	88.00
88.00 89.00	08800 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	88.00 89.00
90.00	09000 CLI NI C	0	0		0 0	0	90.00
90.01	09001 WOUND/OSTOMY CLINIC	8, 135	0	37, 50			1
90. 02 90. 03	09002 KIDS PLUS CLINIC 09003 ONCOLOGY	230	0	5, 72 62, 84		0 51	90.02 90.03
90. 03 90. 04	09004 MUNCIE CLINIC	1, 218	0	5, 45		0	90.03
90.05	09005 ANTI COAGULATI ON CLINIC	4, 235	0		0 0	0	90.05
90. 06 90. 07	09006 PREGNANCY PLUS 09007 0/P LAB	2,834	0	8, 69	0 0	330 0	90.06 90.07
	09008 0/P LAB	0	0		0 0		1

Health Financial Systems	COMMUNI TY HOSP	ITAL ANDERSON		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	F	Period: From 01/01/2015 To 12/31/2015		
Cost Contor Description		MAINTENANCE &	OPERATION OF	LAUNDRY &	5/24/2016 1:20 HOUSEKEEPI NG	6 pm
Cost Center Description	& GENERAL	REPAIRS	PLANT	LINEN SERVICE	HUUSEKEEPING	
	5.00	6.00	7.00	8.00	9.00	
90. 09 09009 FORTVILLE CLINIC	288	C	4, 368	3 0	0	90.09
91. 00 09100 EMERGENCY	50, 044	. C	28, 426	6, 846	12, 278	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS					0	04.00
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES		-			0	94.00 95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED					0	93.00 96.00
97. 00 09700 DURABLE MEDICAL EQUITERENTED					0	90.00 97.00
99. 00 09900 CMHC	C			0	Ő	99.00
99. 10 09910 CORF	C	C	) (	0 0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	C	C	) (	0 0	0	100. 00
101.00 10100 HOME HEALTH AGENCY	C	C	) (	0 0	0	101. 00
SPECIAL PURPOSE COST CENTERS		1	1			
105.00 10500 KI DNEY ACQUI SI TI ON	C					105.00
106. 00 10600 HEART ACQUI SI TI ON	C	C		0		106.00
107.00 10700 LIVER ACQUISITION 108.00 10800 LUNG ACQUISITION						107.00 108.00
109. 00 10900 PANCREAS ACQUISITION						108.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON				0		110,00
111.00 11100 I SLET ACQUI SI TI ON	Ċ			0		111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	C	C	) (	0 0		115.00
116.00 11600 HOSPI CE	0			0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 255, 731	C	739, 514	1 72, 350	173, 822	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	254		4, 423	3 0	0	190. 00
190. 01 19001 WELLNESS CENTERS	16, 528		., .=.			190.00
190. 02 19002 EMPLOYED ORTHO MD	C		) ()			190.02
190.03 19003 NORTHVI EW CONV. (LTC)	4, 330	C	) (	0 0	0	190. 03
190. 04 19004 SUMMI T CONV. (LTC)	3, 889	C	) (	0 0	0	190. 04
190. 05 19005 PARKVI EW CONV. (LTC)	4, 649		) (	0 0		190. 05
190.06 19006 MONTI CELLO HSE. (ASS' TD LVG.)	1, 884		) (	0 0		190.06
190. 07 19007 NH PARK PLACE (LTC)	496			0		190.07
190.08 19008 MADISON PLACE OF ELWOOD (LTC) 190.09 19009 SPINE SURGEON	0					190. 08 190. 09
190. 10 19010 CLINICAL RESEARCH CENTER	13, 422		7, 599			190.09
190. 11 19011 ONCOLOGI ST	10, 122		) ,, 0, 1	0		190.11
190. 12 19012 MEDI CAL I NTERNI ST	1, 818	C		0 0		190. 12
190. 13 19013 RHEUMATOLOGY	11, 477	C	) (	0 0	0	190. 13
191. 00 19100 RESEARCH	C	C	) (	0 0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	25, 712	C C	68, 026	6 0		192.00
192. 01 19201 PHYSI CLANS' PRI VATE OFFI CES		C		0		192.01
192. 02 19202 FOUNDATI ON	13, 710		686			192. 02 192. 03
192. 03 19203  SPOE 192. 04 19204  HEALTHY_HEART	2, 956					192.03 192.04
192. 05 19205 VACANT SPACE	128		2, 226			192.04 192.05
192.07 19207 PARK PLACE CENTER	7		) 2, 220			192.03
193. 00 19300 NONPALD WORKERS	C			0		193.00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	C	C	0 0	0 0		201. 00
202.00   TOTAL (sum lines 118-201)	1, 356, 991	C	826, 974	1 72, 350	177, 584	202.00

Heal th	Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der		eriod: rom 01/01/2015	Worksheet B Part II	
				To		Date/Time Pre	pared:
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	5/24/2016 1:2 PHARMACY	o pm
				ADMI NI STRATI ON	SERVICES &		
		10.00	11.00	13.00	SUPPLY 14.00	15.00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	13.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY	238, 753	F 4 007				10.00
11.00 13.00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	0	54, 087 874				11.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	2, 190		174, 283		14.00
15.00		0	1, 617		387	103, 703	1
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	1, 805 0		18 0	0	
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	C		0	0	1
20.00	02000 NURSING SCHOOL	0	0	0	0	0	
21.00 22.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	21.00
23.00	02300 PARAMED ED PRGM-(EMS)	0	38	0	0	0	
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	208, 558	15, 827	49, 687	6, 751	0	30.00
30.00	03100 I NTENSI VE CARE UNI T	208, 358	2, 090		1, 842	0	31.00
32.00	03200 CORONARY CARE UNI T	0	0		0	0	
33.00 34.00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	33.00 34.00
40.00	04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100 SUBPROVI DER – I RF	0	0	-	0	0	
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	0	0 594		0	0	42.00
43.00	04400 SKI LLED NURSI NG FACI LI TY	0	594 C		0	0	
45.00	04500 NURSING FACILITY	0	C	-	0	0	45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	C	0	0	0	46.00
50.00	05000 OPERATING ROOM	86	5, 770	18, 115	25, 489	0	50.00
51.00	05100 RECOVERY ROOM	0	0	-	0	0	51.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0 357	Ŭ	0 5	0 795	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	2, 823		394	24	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	0	239 422		36 492	2	•
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	311		26	0	1
59.00	05900 CARDI AC CATHETERI ZATI ON	0	673		332	0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	3, 252 0		566 0	0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	230 0		6	0	
64.00	06400 INTRAVENOUS THERAPY	0	0		0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	1, 114		58	1	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	1, 963 317		54	3	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	0	217		2	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	584	0	84	0	69.00
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	636 0		34	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	65, 766 67, 262	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C	0	0	102, 832	
74.00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0	0	0	20 0	0	
75.00	OUTPATIENT SERVICE COST CENTERS				0	0	, 5.00
88.00	08800 RURAL HEALTH CLINIC	0	C		0	0	
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	
90.00 90.01	09001 WOUND/OSTOMY CLINIC	0	463		671	5	90.00
90.02	09002 KIDS PLUS CLINIC	0	0		0	0	
90. 03 90. 04	09003 ONCOLOGY 09004 MUNCI E CLINIC	0	1, 984	0	1, 201	8	90.03 90.04
90.04 90.05	09005 ANTI COAGULATI ON CLINIC	0	314	0	8	0	90.04
90.06	09006 PREGNANCY PLUS	0	238		1	0	90.06
90.07	09007 0/P LAB	0	C	0	0	0	90.07

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	F	eriod: rom 01/01/2015 o 12/31/2015		
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
	10.00	11.00	13.00	14.00	15.00	
90.08 09008 0/P LAB	0	0	0	0	0	90.08
90. 09 09009 FORTVILLE CLINIC	0	0	0	0	0	90.09
91. 00 09100 EMERGENCY	1, 720	3, 733	0	2, 697	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS	1 1					
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0			0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
99.00 09900 CMHC	0	0	0	0	0	99.00
99.10 09910 CORF	0	0	0	0	0	99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0	0	105.00
106. 00 10600 HEART ACQUISITION	0	0		0		105.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0		107.00
108. 00 10800 LUNG ACQUISITION	0	0	0	0		108.00
109. 00 10900 PANCREAS ACQUI SI TI ON	0	0	0	0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0	0	0		111.00
113. 00 11300 I NTEREST EXPENSE		-			-	113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115.00
116. 00 11600 HOSPI CE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	238, 753	50, 675	76, 228	174, 206	103, 670	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		-		190. 00
190.01 19001 WELLNESS CENTERS	0	845	0	5		190. 01
190.02 19002 EMPLOYED ORTHO MD	0	0	0	0		190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)	0	330	0	5		190.03
190. 04 19004 SUMMIT CONV. (LTC)	0	214	0	5		190.04
190. 05 19005 PARKVI EW CONV. (LTC)	0	345		0		190.05
190.06 19006 MONTI CELLO HSE. (ASS' TD LVG.)	0	129	0	0		190.06
190.07 19007 NH PARK PLACE (LTC)	0	39		0		190.07
190. 08 19008 MADI SON PLACE OF ELWOOD (LTC)	0	0		0		190. 08 190. 09
190. 09 19009 SPI NE SURGEON 190. 10 19010 CLI NI CAL RESEARCH CENTER	0	1, 057		13		190. 09
190. 11 19011 ONCOLOGI ST	0	1,037		13		190. 10
190. 12 19012 MEDI CAL I NTERNI ST	0	99		2		190. 12
190. 13 19013 RHEUMATOLOGY	0	63		0		190.12
191. 00 19100 RESEARCH	0	0		0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	14		192.00
192. 01 19201 PHYSI CLANS' PRI VATE OFFI CES	0	0	0			192.01
192. 02 19202 FOUNDATI ON	0	139		-		192.02
192. 03 19203 SPOE	0	0	0			192.03
192. 04 19204 HEALTHY HEART	0	152	0	33	0	192.04
192. 05 19205 VACANT SPACE	0	0	0	0		192.05
192.07 19207 PARK PLACE CENTER	0	0	0	0		192.07
193. 00 19300 NONPAI D WORKERS	0	0	0	0	0	193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00   TOTAL (sum lines 118-201)	238, 753	54, 087	76, 228	174, 283	103, 703	202.00

	Financial Systems TON OF CAPITAL RELATED COSTS	COMMUNI TY HOSP		Provi der	CCN: 150	113 F	Period:	eu of Form CMS-2 Worksheet B	2002-1
						F	rom 01/01/2015 o 12/31/2015	Part II	
								INTERNS &	
	Cost Center Description	MEDI CAL RECORDS &	SOCI AL	SERVI CE	NONPHYS ANESTH		NURSI NG SCHOOL	RESIDENTS SERVICES-SALAR Y & FRINGES	
		LI BRARY 16.00	1	7.00	19.	00	20.00	21.00	
0	GENERAL SERVICE COST CENTERS	10.00	1 1	7.00	1 17.	00	20.00	21.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT								1.00
1	00200 CAP REL COSTS-MVBLE EQUIP								2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT								4.00
1	00500 ADMINISTRATIVE & GENERAL								5.0
1	00600 MAINTENANCE & REPAIRS								6.0
	00700 OPERATION OF PLANT								7.0
1	00800 LAUNDRY & LINEN SERVICE								8.0
	00900 HOUSEKEEPI NG								9.0
	01000 DI ETARY 01100 CAFETERI A								10.0
	01300 NURSING ADMINISTRATION								13.0
	01400 CENTRAL SERVICES & SUPPLY								14.0
	01500 PHARMACY								15.0
	01600 MEDICAL RECORDS & LIBRARY	110, 425	5						16.0
	01700 SOCIAL SERVICE	C		0					17.0
9.00	01900 NONPHYSICIAN ANESTHETISTS	C	b	0		C	)		19.0
20.00	02000 NURSING SCHOOL	C		0			0		20.0
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	C		C				0	21.0
22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	C		0					22.0
	02300 PARAMED ED PRGM-(EMS)	C	)	0					23.0
	INPATIENT ROUTINE SERVICE COST CENTERS		1		1		Т	1	
1	03000 ADULTS & PEDIATRICS	29, 325		0					30.0
1	03100 I NTENSI VE CARE UNI T	C	2	0					31.0
1	03200 CORONARY CARE UNIT		2	0					32.0
1	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT			0					33.0 34.0
	04000 SUBPROVIDER - IPF			0					40.0
	04100 SUBPROVIDER - IRF		Ś	0					41.0
	04200 SUBPROVI DER	0		0					42.0
	04300 NURSERY			Ő					43.0
	04400 SKILLED NURSING FACILITY			0					44.0
1	04500 NURSING FACILITY	C		0					45.0
16.00	04600 OTHER LONG TERM CARE	0	)	0					46.0
-	ANCILLARY SERVICE COST CENTERS	_							
	05000 OPERATING ROOM	4,854		0					50.0
	05100 RECOVERY ROOM	0	2	0					51.0
	05200 DELIVERY ROOM & LABOR ROOM		2	0					52.0
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	1, 820		0					53.0 54.0
	05500 RADI OLOGY-THERAPEUTI C	1, 020		0					55.0
	05600 RADI OLOGI - MERAFLUTI C		Ś	0					56.0
	05700 CT SCAN		Ś	0					57.0
	05800 MAGNETIC RESONANCE IMAGING (MRI)			0					58.0
	05900 CARDI AC CATHETERI ZATI ON			Ő					59.0
1	06000 LABORATORY	11, 326		0					60.0
	06001 BLOOD LABORATORY	C		0					60.0
1.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY								61.0
52.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	C		0					62.0
	06300 BLOOD STORING, PROCESSING & TRANS.	C		0					63.0
	06400 I NTRAVENOUS THERAPY	0	P	0	2				64.0
	06500 RESPI RATORY THERAPY	0	2	C	2				65.0
1	06600 PHYSI CAL THERAPY	C	2	C	2				66.0
	06700 OCCUPATI ONAL THERAPY	C	2	0	2				67.0
	06800 SPEECH PATHOLOGY	0	2	0	2				68.0
1			2	0	2				69.0
1	07000 ELECTROENCEPHALOGRAPHY		2	0	2				70.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS		(	0	()				71. C
1	07200 TMPL. DEV. CHARGED TO PATTENTS 07300 DRUGS CHARGED TO PATTENTS		Ś	0	Ś				72.0
1	07400 RENAL DIALYSIS			0	á				74.0
1	07500 ASC (NON-DI STINCT PART)			0					75.0
	DUTPATIENT SERVICE COST CENTERS		1	0	.1		1	1	1 . 5. 5
	08800 RURAL HEALTH CLINIC	0		C					88. 0
	08900 FEDERALLY QUALIFIED HEALTH CENTER	C		0					89.0
	09000 CLINIC		þ	0					90.0
	09001 WOUND/OSTOMY CLINIC	24, 539		0					90.0
	09002 KIDS PLUS CLINIC	C	þ	0					90.0
	09003 ONCOLOGY	0	þ	0					90.0
	09004 MUNCIE CLINIC		)	0					90.0
1	09005 ANTI COAGULATI ON CLINIC		1	-					90.0

		cial Systems F CAPITAL RELATED COSTS	COMMUNI TY HOSP		CCN: 150113 F	In Lie Period:	worksheet B	2552-10
ALLUCAT	ITON U	F CAPITAL RELATED COSTS		Provider	F	From 01/01/2015 To 12/31/2015	Part II	
							I NTERNS & RESI DENTS	
		Cost Center Description	MEDI CAL	SOCIAL SERVICE		NURSING SCHOOL	SERVI CES-SALAR	!
			RECORDS & LI BRARY		ANESTHETI STS		Y & FRINGES	
00.06	0000		16.00	17.00	19.00	20.00	21.00	00.0(
		PREGNANCY PLUS O/P LAB	0	0				90.06
		O/P LAB	0	0				90.08
		FORTVILLE CLINIC	0	0				90.09
		EMERGENCY	36, 943	0				91.00
		OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS						92.00
		HOME PROGRAM DI ALYSI S	0	0				94.00
		AMBULANCE SERVICES	0	0				95.00
		DURABLE MEDICAL EQUIP-RENTED DURABLE MEDICAL EQUIP-SOLD	0	0				96.00 97.00
99.00								97.00
99.10			0	0				99.10
		I&R SERVICES-NOT APPRVD PRGM	0	0				100.00
-		HOME HEALTH AGENCY	0	0				101.00
		AL PURPOSE COST CENTERS KIDNEY ACQUISITION	0	0				105.00
		HEART ACQUISITION	0					106.00
107.00	10700	LIVER ACQUISITION	0	0				107.00
		LUNG ACQUISITION	0	0				108.00
		PANCREAS ACQUISITION INTESTINAL ACQUISITION	0					109.00
		I SLET ACQUI SI TI ON	0	0				111.00
		INTEREST EXPENSE						113.00
		UTI LI ZATI ON REVI EW-SNF						114.00
		AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE	0					115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	108, 807			o o	0	118.00
H		MBURSABLE COST CENTERS				-	-	
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-				190.00
		WELLNESS CENTERS EMPLOYED ORTHO MD	0	0				190. 01 190. 02
		NORTHVI EW CONV. (LTC)	0	0				190.02
		SUMMIT CONV. (LTC)	0	0	)			190.04
		PARKVIEW CONV. (LTC)	0	0				190.05
		MONTICELLO HSE. (ASS'TD LVG.) NH PARK PLACE (LTC)	0	0				190.06 190.07
		MADISON PLACE OF ELWOOD (LTC)						190.07
		SPINE SURGEON	0	0				190.09
		CLINICAL RESEARCH CENTER	0	0				190. 10
		ONCOLOGI ST	0	0				190.11
		MEDI CAL INTERNI ST RHEUMATOLOGY	0	0				190. 12 190. 13
		RESEARCH		0				190.13
		PHYSICIANS' PRIVATE OFFICES	1, 618	0				192.00
		PHYSICIANS' PRIVATE OFFICES	0	0				192.01
		FOUNDATI ON	0	0				192.02
192.03 192.04		HEALTHY HEART						192.03 192.04
1		VACANT SPACE	0	0				192.04
	19207	PARK PLACE CENTER	0	0				192.07
		NANDALD WARKERS			1	1		400.00
193.00		NONPAI D WORKERS	0	0		-	-	193.00
		NONPAID WORKERS Cross Foot Adjustments Negative Cost Centers	0	0	(			200. 00 201. 00

	Financial Systems TION OF CAPITAL RELATED COSTS	COMMUNI TY HOSPI		CCN: 150113	In Lie Period: From 01/01/2015	u of Form CMS- Worksheet B Part II	2552-10
					To 12/31/2015	Date/Time Pre	
	· · · · · · · · · · · · · · · · · · ·	INTERNS &				5/24/2016 1:2	6 pm
		RESI DENTS					
	Cost Center Description	SERVICES-OTHER	PARAMED ED	Subtotal	Intern &	Total	
		PRGM. COSTS	PRGM-(EMS)		Residents Cost & Post		
					Stepdown		
					Adjustments		
	GENERAL SERVICE COST CENTERS	22.00	23.00	24.00	25.00	26.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 6.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						5.00 6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00							15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE						16.00 17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS						19.00
20.00	02000 NURSI NG SCHOOL						20.00
21.00 22.00	02100 I & R SERVI CES-SALARY & FRI NGES APPRVD 02200 I & R SERVI CES-OTHER PRGM. COSTS APPRVD	0					21.00
22.00	02200 PARAMED ED PRGM-(EMS)	0	3, 255	5			22.00
	INPATIENT ROUTINE SERVICE COST CENTERS		-,				
30.00	03000 ADULTS & PEDIATRICS			1, 871, 99		1, 871, 997	30.00
31.00 32.00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT			268, 45		268, 450 0	31.00 32.00
32.00	03300 BURN INTENSIVE CARE UNIT				0 0	0	1
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T				0 0	0	
40.00	04000 SUBPROVIDER - IPF				0 0	0	
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER				0 0	0	
42.00	04300 NURSERY			56, 49	-	56, 493	
44.00	04400 SKILLED NURSING FACILITY				0 0	0	44.00
45.00	04500 NURSING FACILITY				0 0	0	
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS				0 0	0	46.00
50.00	05000 OPERATI NG ROOM			1, 668, 96	01 0	1, 668, 961	50.00
51.00	05100 RECOVERY ROOM				0 0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY			31, 72	0 0	0	52.00 53.00
53.00 54.00	05400 RADI OLOGY-DI AGNOSTI C			815, 24	5 5	815, 242	
55.00	05500 RADI OLOGY-THERAPEUTI C				0 0	0	55.00
56.00	05600 RADI OI SOTOPE			50, 19		50, 191	1
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)			43, 99		43, 993 36, 756	1
59.00	05900 CARDI AC CATHETERI ZATI ON			158, 21		158, 215	
60.00	06000 LABORATORY			450, 00		450, 000	
60.01	06001 BLOOD LABORATORY				0 0	0	1
61.00 62.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			18, 71	6 0	18, 716	61.00 62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.			,	0 0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY				0 0	0	1
65.00	06500 RESPIRATORY THERAPY			70, 80		70, 805	1
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY			68, 57 25, 49		68, 575 25, 494	1
68.00	06800 SPEECH PATHOLOGY			15, 15		15, 157	
69.00	06900 ELECTROCARDI OLOGY			129, 66	0 8	129, 668	
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY			60, 87		60, 878	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS			195, 46		195, 466 199, 924	
	07300 DRUGS CHARGED TO PATIENTS			175, 75		175, 755	
74.00	07400 RENAL DI ALYSI S			5, 75		5, 750	
75.00	07500 ASC (NON-DI STI NCT PART)				0 0	0	75.00
88.00	OUTPATIENT SERVICE COST CENTERS			1	0 0	0	88.00
89.00	08900 FEDERALLY QUALI FIED HEALTH CENTER				0 0	0	
90.00	09000 CLINIC				0 0	0	90.00
90. 01 90. 02	09001 WOUND/OSTOMY CLINIC 09002 KIDS PLUS CLINIC			253, 10		253, 102 31, 568	1
	09002 KIDS PEUS CEINIC 09003 ONCOLOGY			435, 41		435, 414	1
	1	ı		1 100,41	0	100, 114	

	nancial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-	2552-10
ALLOCATI	ON OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2015 To 12/31/2015	Date/Time Pre	pared:
	Cost Center Description	I NTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	PARAMED ED PRGM-(EMS)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	5/24/2016 1:2	<u>o pm</u>
		22.00	23.00	24.00	25.00	26.00	
90.05         09           90.06         09           90.07         09           90.08         09           90.09         09           91.00         09           92.00         09	2004 MUNCLE CLINIC 2005 ANTI COAGULATI ON CLINIC 2006 PREGNANCY PLUS 2007 0/P LAB 2008 0/P LAB 2009 FORTVILLE CLINIC 2009 FORTVILLE CLINIC 2000 OBSERVATION BEDS (NON-DISTINCT PART) HER REIMBURSABLE COST CENTERS			45, 94 8, 70 52, 01 24, 21 381, 10	9 0 6 0 0 0 0 0 3 0	45, 943 8, 709 52, 016 0 24, 213 381, 100	90. 05 90. 06 90. 07 90. 08 90. 09
94. 00 09 95. 00 09 96. 00 09 97. 00 09 99. 00 09 99. 10 09 100. 00 10 101. 00 10	1400       HOME PROGRAM DI ALYSI S         12500       AMBULANCE SERVI CES         12600       DURABLE MEDI CAL EQUI P-RENTED         12700       DURABLE MEDI CAL EQUI P-SOLD         12900       CMHC         12910       CORF         1000       I &R SERVI CES-NOT APPRVD PRGM         1100       HOME HEALTH AGENCY         12012       FOR SECONT CENTERS				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		95.00 96.00 97.00 99.00
106. 00 10 107. 00 10 108. 00 10 109. 00 10 110. 00 11 111. 00 11 113. 00 11 114. 00 11 115. 00 11	9500       KI DNEY ACQUI SI TI ON         9600       HEART ACQUI SI TI ON         9700       LI VER ACQUI SI TI ON         9800       LUNG ACQUI SI TI ON         9800       LUNG ACQUI SI TI ON         9000       PANCREAS ACQUI SI TI ON         9000       INTESTI NAL ACQUI SI TI ON         9001       INTESTI NAL ACQUI SI TI ON         9001       INTERSTI RAL ACQUI SI TI ON         9001       INTEREST EXPENSE         400       UTI LI ZATI ON REVI EW-SNF         500       AMBULATORY SURGI CAL CENTER (D. P. )         600       HOSPI CE					0 0 0 0 0 0 0	105.00         106.00         107.00         108.00         109.00         110.00         111.00         113.00         114.00         115.00         116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	C	7, 650, 27	1 0		
190. 00 190. 01 190. 02 190. 03 190. 04 190. 05 190. 06 190. 06 190. 07 190. 07 190. 08 190. 07 190. 08 190. 07 190. 08 190. 07 190. 08 190. 07 190. 10 190. 10 190. 12 190. 12 191. 00 192. 01 192. 02 19 192. 02 19 192. 03 19 192. 04 19 192. 05 19 192. 07 19 192. 07 19 19 19 19 19 19 19 19 19 19	WREI MBURSABLE COST CENTERS         0000       GIFT, FLOWER, COFFEE SHOP & CANTEEN         0001       WELLNESS CENTERS         0002       EMPLOYED ORTHO MD         0003       NORTHVI EW CONV. (LTC)         0004       SUMMI T CONV. (LTC)         0005       PARKVI EW CONV. (LTC)         0006       MONTI CELLO HSE. (ASS' TD LVG.)         0007       NH PARK PLACE (LTC)         0008       MADI SON PLACE OF ELWOOD (LTC)         00909       SPI NE SURGEON         0010       CLI NI CAL RESEARCH CENTER         0011       ONCOLOGI ST         0012       MEDI CAL INTERNI ST         013       RHEUMATOLOGY         0100       RESEARCH         0201       PHYSI CI ANS' PRI VATE OFFI CES         0202       POUNDATI ON         0203       SPOE         0204       HEALTHY HEART         0205       VACANT SPACE         0207       PARK PLACE CENTER         0207       PARK PLACE CENTER         0207       PARK PLACE CENTER         0208       RODE         0209       SPOE         0204       HEALTHY HEART         0205       VACANT SPACE         0207	0 0 0	3, 255 0 3, 255	59, 57 2, 09 17, 31 411, 94 17, 85 4, 39 12, 32 3, 25	$\begin{array}{cccccccccccccccccccccccccccccccccccc$	46, 536 0 4, 989 4, 344 5, 346 2, 155 572 0 0 59, 576 0 2, 094 17, 310 0 411, 944 0 17, 852 0 4, 392 12, 321 7 0 3, 255 0	192. 01 192. 02 192. 03 192. 04 192. 05 192. 07 193. 00 200. 00 201. 00

	Financial Systems LLOCATION - STATISTICAL BASIS	COMMUNI TY HOSP		CCN: 150113 P	In Lie eriod:	eu of Form CMS-: Worksheet B-1	
					rom 01/01/2015 o 12/31/2015	Date/Time Pre	
		CAPI TAL RE	LATED COSTS			5/24/2016 1:2	6 pm
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	SALARIES) 4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS			4.00	37	3.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	283, 015					1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 746	3, 220, 717 34, 148				2.00 4.00
5.00	00500 ADMINI STRATI VE & GENERAL	22, 423				105, 888, 452	
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	C 33, 352	0 C 149, 448		0	0 8, 499, 049	
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	3, 460		1, 926, 783 57, 413		216, 406	
9.00	00900 HOUSEKEEPI NG	6, 928		1, 187, 370	0	1, 848, 272	
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	10, 374 2, 041				1, 158, 629 940, 227	
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 041				1, 438, 124	
14.00	01400 CENTRAL SERVICES & SUPPLY	5, 081				3, 191, 731	14.00
15.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	3, 207				2, 257, 203	
16.00 17.00	01700 SOCIAL SERVICE	4,066		1, 174, 141 0		1, 952, 566 0	
19.00	01900 NONPHYSICIAN ANESTHETISTS	C	0	0	0	0	
20.00 21.00	02000 NURSING SCHOOL 02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	
21.00	02200 I &R SERVICES-SALARY & FRINGES APPRVD					0	21.00 22.00
23.00	02300 PARAMED ED PRGM-(EMS)	C	0	30, 552	0	248, 032	
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	51, 574	170, 902	10, 985, 367	0	15, 521, 641	30.00
31.00	03100 I NTENSI VE CARE UNI T	4, 958					
32.00	03200 CORONARY CARE UNI T	C	0	0	0		32.00
33.00 34.00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	
40.00	04000 SUBPROVIDER - IPF				0	0	40.00
41.00	04100 SUBPROVI DER – I RF	C	0	0	0	0	41.00
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	C 1,870			0	0	42.00 43.00
43.00	04400 SKILLED NURSING FACILITY	1, 8/C	1,659 0	466, 052 0	0	733, 187 0	
45.00	04500 NURSING FACILITY	C	0	0			
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	C	0 0	0 0	0	0	46.00
50.00	05000 OPERATI NG ROOM	22, 333	893, 946	4, 259, 079	0	8, 395, 457	50.00
51.00	05100 RECOVERY ROOM	C	0	0	0		
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	272	18, 671	742, 557	0		
54.00	05400 RADI OLOGY-DI AGNOSTI C	19, 284			-	,	
55.00	05500 RADI OLOGY-THERAPEUTI C	C		0	0	0	55.00
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	1,483 450				657, 083 583, 561	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	936				602, 923	
59.00	05900 CARDI AC CATHETERI ZATI ON	3, 717					
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	7,828	193, 784 0	2, 031, 214	0	4, 379, 277 0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	585	1, 709	205, 527	0	281, 710	
63.00 64.00	06400 I NTRAVENOUS THERAPY				0		63.00 64.00
65.00	06500 RESPI RATORY THERAPY	720	33, 903	795, 241	0		65.00
66.00	06600 PHYSI CAL THERAPY	1,449				2, 274, 761	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	893 499				436, 485 249, 951	
69.00	06900 ELECTROCARDI OLOGY	1, 533				703, 235	
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 533	15, 100	479, 431	0	860, 518	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS				0	10, 120, 921 10, 352, 069	
	07300 DRUGS CHARGED TO PATIENTS	C	c c	0	0	5, 690, 464	
74.00	07400 RENAL DIALYSIS	188		0			
75.00	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	C	0 0	0 0	0	0	75.00
88.00	08800 RURAL HEALTH CLINIC	C	C	0	C	0	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90. 00 90. 01	09000 CLINIC 09001 WOUND/OSTOMY CLINIC	10, 227	8, 741	339, 468		0 634, 824	90.00 90.01
90. 02	09002 KIDS PLUS CLINIC	1, 560	C	0	0	17, 958	90. 02
90.03	09003 ONCOLOGY	17,135	77,400	766, 286	7, 165, 856	0	90.03

	Financial Systems LLOCATION - STATISTICAL BASIS	COMMUNI TY HOSP		CCN: 150113 P	eri od:	u of Form CMS-2 Worksheet B-1	
				F	rom 01/01/2015		
					o 12/31/2015	Date/Time Pre 5/24/2016 1:2	
		CAPI TAL REI	ATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconci l i ati on		
	cost center bescription		(DOLLAR VALUE)	BENEFITS	Reconciliation	& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS		<b>、</b>	
				SALARI ES)			<u> </u>
0.04		1.00	2.00	4.00	5A	5.00	00
	09004 MONCHE CEINIC	1, 488	13, 195 3, 418	247, 583	0	95, 018 330, 496	
	09006 PREGNANCY PLUS	2, 371	726	133, 951	0	221, 177	
	09007 0/P LAB	0	0	0	0	0	90
0. 08	09008 0/P LAB	0	0	0	0	0	90
	09009 FORTVILLE CLINIC	1, 191		0	0	22, 512	
	09100 EMERGENCY	7, 751	95, 806	2, 757, 171	0	3, 905, 104	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	)					92
	09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94
	09500 AMBULANCE SERVICES	0	0	0	0	0	95
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97
	09900 CMHC	0	0	0	0	0	99
	09910 CORF	0	0	0	0	0	99
	10000 I &R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	0	0	0	0		100
01.00	SPECIAL PURPOSE COST CENTERS		0	0	0	0	101
05.00	10500 KIDNEY ACQUISITION	0	0	0	0	0	105
06.00	10600 HEART ACQUI SI TI ON	0	0	0	0	0	106
	10700 LIVER ACQUISITION	0	0	0	0		107
	10800 LUNG ACQUI SI TI ON	0	0	0	0		108
	10900 PANCREAS ACQUI SI TI ON	0	0	0	0		109
	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION	0	0	0	0		110
	11300 I NTEREST EXPENSE		0	0	0	0	113
	11400 UTI LI ZATI ON REVI EW-SNF						114
15.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115
1	11600 HOSPI CE	0	0	0	0		116
18.00	SUBTOTALS         SUBTOTALS <thsub< th="">         SUB         SUB</thsub<>	259, 167	3, 202, 201	50, 478, 033	-16, 971, 498	97, 986, 794	1118
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 206	0	0	0	19, 804	1190
	19001 WELLNESS CENTERS	1, 227		717, 496	-	1, 289, 733	
	19002 EMPLOYED ORTHO MD	0	0	0	0		190
	19003 NORTHVI EW CONV. (LTC)	0	0	259, 310	0	337, 915	
	19004 SUMMIT CONV. (LTC)	0	0	188, 979	0	303, 456	
	19005 PARKVI EW CONV. (LTC)	0	0	281, 055	0	362, 795	
	19006 MONTICELLO HSE. (ASS'TD LVG.) 19007 NH PARK PLACE (LTC)	0	0	113, 174 29, 885	-	147, 015 38, 673	
	19008 MADISON PLACE OF ELWOOD (LTC)	0	0	0			190
	19009 SPI NE SURGEON	0	0	0	0	0	190
	19010 CLINICAL RESEARCH CENTER	2,072	2, 340	664, 521	0	1, 047, 384	
	19011 ONCOLOGI ST	0	0	0	0		190
	19012 MEDI CAL I NTERNI ST 19013 RHEUMATOLOGY	0	52	68, 064		141, 852	
	19013 RHEDMATOLOGT	0	4, 673	414, 049	0	895, 625	190
	19200 PHYSICIANS' PRIVATE OFFICES	18, 549	9, 802	0	0	2, 006, 411	
	19201 PHYSI CLANS' PRI VATE OFFICES	0	0	0	0		192
	19202 FOUNDATI ON	187	0	196, 440	0	1, 069, 846	
	19203 SPOE	0	0	0	0		192
	19204 HEALTHY HEART	0	924	169, 594	0	230, 644	
	19205 VACANT SPACE 19207 PARK PLACE CENTER	607	0	0	0	9, 967 538	
1	19207 PARK PLACE CENTER				0		192
20.00				0		0	200
01.00							201
02.00		Part 4,647,355	3, 620, 090	11, 777, 876		24, 137, 354	
				0.0105		0 0070-1	0.0.0
203.00			1. 124001	0. 219816		0. 227951	
04.00		Part		67, 053		1, 356, 991	204
					1		

	Financial Systems	COMMUNI TY HOSP		CCN: 150112 D		u of Form CMS-2	2552-10
CUST A	LLOCATION - STATISTICAL BASIS		Provi der	F	eriod: rom 01/01/2015 o 12/31/2015	Worksheet B-1 Date/Time Pre	
	Cost Center Description	MAI NTENANCE & REPAI RS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	5/24/2016 1:20 DI ETARY (MEALS SERVED)	<u>6 pm</u>
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS		1	1	1		1 00
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	258, 846 33, 352 3, 460 6, 928 10, 374 2, 661 5, 081 3, 207 4, 066 0	225, 494 3, 460 6, 928 10, 374 2, 041 2, 661 5, 081 3, 207 4, 066	712, 868 484 0 0 0 37, 298 0 0 0	6, 986 183 0 77	69, 560 0 0 0 0 0 0 0	11. 00 13. 00 14. 00 15. 00 16. 00 17. 00
19.00 20.00 21.00 22.00 23.00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM-(EMS)		-	-		0 0 0 0	19.00 20.00 21.00 22.00 23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	51, 574	51, 574	375, 047	3, 263	60, 763	30. 00
31.00 32.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	4, 958	4, 958	41, 789		8, 271 0	31.00 32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	C C	0	0	0	33.00
34.00 40.00	03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	0	0	0	0	0	34.00 40.00
41.00	04100 SUBPROVI DER – I RF	0	c c	0	0	0	41.00
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	0	, o		0 182	0	42.00 43.00
43.00	04400 SKI LLED NURSI NG FACI LI TY	0	1,870	0	0	0	43.00 44.00
45.00	04500 NURSING FACILITY	0	C		0	0	45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	C	0	0	0	46.00
50.00	05000 OPERATI NG ROOM	22, 333	22, 333	128, 258	1, 388	25	50.00
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	51.00 52.00
53.00	05300 ANESTHESI OLOGY	272	-		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	19, 284				0	54.00
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0			-	0	55.00 56.00
57.00	05700 CT SCAN	450	450	7, 154	0	0	57.00
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	936 3, 717				0	58.00 59.00
60.00	06000 LABORATORY	7,828				0	60.00
60.01	06001 BLOOD LABORATORY	0	C	0	0	0	60.01
61.00 62.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	585	585	о	37	0	61.00 62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0		-	0	0	63.00 64.00
64.00 65.00	06500 RESPIRATORY THERAPY	0 720			-	0	64.00 65.00
66.00	06600 PHYSI CAL THERAPY	1, 449	1, 449	4, 636	36	0	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	893				0	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	1, 533				0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 533	1, 533	0	32	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	71.00 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	-	0	0	0	73.00
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	188			0	0	74.00 75.00
75.00	OUTPATIENT SERVICE COST CENTERS					0	73.00
88. 00 89. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00 89. 00
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0	0	0	0 0	90.00
90.01	09001 WOUND/OSTOMY CLINIC	10, 227			83	0	90.01
90. 02 90. 03	09002 KIDS PLUS CLINIC 09003 ONCOLOGY	1, 560 17, 135			0	0	90. 02 90. 03
90.04	09004 MUNCIE CLINIC	1, 488	1, 488	0	0	0	90.04
90.05	09005 ANTI COAGULATI ON CLINI C	0	-	-	0	0	90.05
90.06	09006 PREGNANCY PLUS	2, 371	2, 371	0	13	0	90.06

	ncial Systems TION - STATISTICAL BASIS	COMMUNI TY HOSP		CCN: 150113	Period:	u of Form CMS-2 Worksheet B-1	2002-10
CUST ALLOCA	TION - STATISTICAL BASIS		TTOVICE		From 01/01/2015		
					To 12/31/2015	Date/Time Pre 5/24/2016 1:20	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	o piii
		REPAI RS	PLANT	LINEN SERVICE	(HOURS OF	(MEALS SERVED)	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF	SERVI CE)		
		6.00	7.00	LAUNDRY) 8.00	9.00	10.00	
90.07 09007	0/P LAB	0.00	7.00			0	90.07
90.08 09008	O/P LAB	0			0 0	0	90.08
90.09 09009	FORTVILLE CLINIC	1, 191	1, 19	(	0 0	0	90.09
	EMERGENCY	7, 751	7, 75	67, 454	4 483	501	91.00
	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	REIMBURSABLE COST CENTERS	0				0	
	HOME PROGRAM DIALYSIS AMBULANCE SERVICES					0	94.00 95.00
	DURABLE MEDICAL EQUIP-RENTED					0	96.00
	DURABLE MEDICAL EQUIP-SOLD	0			0 0	0	97.00
99.00 09900		0			0 0	0	99.00
99.10 09910	CORF	0	(		0 0	0	99.10
	I&R SERVICES-NOT APPRVD PRGM	0	(		0 0		100. 00
	HOME HEALTH AGENCY	0	(	) (	0 0	0	101.00
	AL PURPOSE COST CENTERS		1			-	
	KIDNEY ACQUISITION HEART ACQUISITION	0					105.00
	LIVER ACQUISITION	0					106.00 107.00
	LUNG ACQUISITION						107.00
	PANCREAS ACQUISITION	0					100.00
	INTESTINAL ACQUISITION	0			0 0		110.00
	I SLET ACQUI SI TI ON	0			0 0		111.00
113.00 11300	INTEREST EXPENSE						113.00
114.00 11400	UTILIZATION REVIEW-SNF						114.00
	AMBULATORY SURGICAL CENTER (D. P.)	0	(		0 0		115.00
116.0011600		0	(		0 0		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	234, 998	201, 640	5 712, 868	6, 838	69, 560	118.00
	IMBURSABLE COST CENTERS	1, 206	1, 200		0 0	0	190.00
	WELLNESS CENTERS	1, 200			110		190.00
	EMPLOYED ORTHO MD	1,227	1,22				190.02
	NORTHVIEW CONV. (LTC)	0			0 0		190.03
	SUMMIT CONV. (LTC)	0			0 0		190.04
190.05 19005	PARKVIEW CONV. (LTC)	0	(		0 0	0	190.05
	MONTICELLO HSE. (ASS'TD LVG.)	0	(		0 0		190.06
	NH PARK PLACE (LTC)	0	(		0 0		190. 07
	MADISON PLACE OF ELWOOD (LTC)	0	(		0 0		190.08
	PSPINE SURGEON	2,072	2,072				190. 09 190. 10
190. 11 19010		2,072	2,072				190.10
	MEDICAL INTERNIST	0					190.12
	RHEUMATOLOGY	0			0 0		190.13
191.0019100		0			0 0		191.00
	PHYSICIANS' PRIVATE OFFICES	18, 549	18, 549		38		192.00
192.01 19201	PHYSICIANS' PRIVATE OFFICES	0	(		0 0	0	192.01
192.02 19202		187	18	7 (	0 0		192. 02
192.03 19203		0	(		0 0		192.03
	HEALTHY HEART	0	(	) (	0		192.04
192.04 19204			60	/  (	0 0		192.05
192.04 19204 192.05 19205		607					
192. 04 19204 192. 05 19205 192. 07 19207	PARK PLACE CENTER	607	(				
192. 04 19204 192. 05 19205 192. 07 19207 193. 00 19300	PARK PLACE CENTER NONPAID WORKERS	607 0 0			0 0 0 0		193.00
192. 04 192. 05 192. 07 192. 07 193. 00 193. 00 200. 00	PARK PLACE CENTER NONPAID WORKERS Cross Foot Adjustments	607 0 0	(		0 0 0 0		193. 00 200. 00
192. 04 19204 192. 05 19205 192. 07 19207 193. 00 19300 200. 00 201. 00	PARK PLACE CENTER NONPAID WORKERS Cross Foot Adjustments Negative Cost Centers	0		) ( ) ( ) 425.87'	0 0 0 2,590 521	0	193. 00 200. 00 201. 00
192. 04 19204 192. 05 19205 192. 07 19207 193. 00 19300	PARK PLACE CENTER NONPAID WORKERS Cross Foot Adjustments	0		) ) 6 425, 873	0 0 0 0 3 2, 590, 521		192. 07 193. 00 200. 00 201. 00 202. 00
192.04         19204           192.05         19205           192.07         19207           193.00         19300           200.00         201.00           202.00         203.00	PARK PLACE CENTER NONPAID WORKERS Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part	0	10, 436, 410			0	193. 00 200. 00 201. 00 202. 00
192. 04 19204 192. 05 19205 192. 07 19207 193. 00 19300 200. 00 201. 00 202. 00	PARK PLACE CENTER NONPAID WORKERS Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part	0 0 : 0 0. 000000	10, 436, 410	0. 597408	3 370. 816061	0 1, 970, 733	193. 00 200. 00 201. 00 202. 00 203. 00
192.04         19204           192.05         19205           192.07         19207           193.00         19300           200.00         201.00           202.00         203.00	PARK PLACE CENTER NONPAID WORKERS Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I)	0 0 0.000000 0	( 10, 436, 410 46. 28245 826, 974	0. 597408 72, 350	3 370. 816061 0 177, 584	0 1, 970, 733 28. 331412 238, 753	193. 00 200. 00 201. 00 202. 00 203. 00 204. 00

	Financial Systems LLOCATION - STATISTICAL BASIS	COMMUNI TY HOSP		CCN: 150113	Peri od:	u of Form CMS-2 Worksheet B-1	2002 10
					From 01/01/2015 To 12/31/2015	Date/Time Pre 5/24/2016 1:2	
	Cost Center Description	CAFETERIA (MAN HOURS)	NURSI NG ADMI NI STRATI ON (DI RECT NURS. HRS.)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	<u>o pin</u>
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS	1	1	l			
$\begin{array}{c} 1. 00\\ 2. 00\\ 4. 00\\ 5. 00\\ 6. 00\\ 7. 00\\ 8. 00\\ 9. 00\\ 10. 00\\ 11. 00\\ 11. 00\\ 13. 00\\ 14. 00\\ 15. 00\\ 14. 00\\ 15. 00\\ 17. 00\\ 19. 00\\ 20. 00\\ 21. 00\\ 22. 00\\ 23. 00\end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I &R SERVICES-SALARY & FRINGES APPRVD 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM-(EMS)	1, 434, 624 23, 188 58, 100 42, 881 47, 882 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	644, 025 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26, 821, 46 59, 59 2, 83	5, 646, 006	81, 900 0 0 0 0 0 0 0	1.00 2.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 13.00 14.00 15.00 14.00 15.00 17.00 19.00 20.00 21.00 22.00 23.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	419, 789	410 790	1 029 04	8 0	21, 750	20.00
<ol> <li>30. 00</li> <li>31. 00</li> <li>32. 00</li> <li>33. 00</li> <li>34. 00</li> <li>40. 00</li> </ol>	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	419,789 55,442 C C C C C C		1, 038, 96 283, 47	-	21, 750 0 0 0 0 0	30.00 31.00 32.00 33.00 34.00 40.00
41.00 42.00 43.00 44.00 45.00 46.00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER 04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY 04500 NURSI NG FACI LI TY 04500 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	C C 15, 747 C C C C	0		0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	41.00 42.00 43.00 44.00 45.00 46.00
50.00	05000 OPERATI NG ROOM	153, 047	153, 047	3, 922, 52	0 0	3, 600	50. OC
51.00 52.00 53.00 54.00 55.00	05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	9, 480 74, 867		73 60, 61	0 0 0 0 2 43, 263	0 0 1, 350 0	
56.00	05600 RADI OI SOTOPE	6, 346	0	5, 60	Ŭ Ŭ	0	56.00
57.00	05700 CT SCAN	11, 185		75, 70		0	57.00
58.00 59.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	8, 251 17, 862		3, 99 51, 09		0	58.00 59.00
60.00	06000 LABORATORY 06001 BLOOD LABORATORY	86, 247	0	87, 15		8, 400	60.00
60. 01 61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0 0	0	60.01 61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	6, 092	-	88		0	62.00
63.00 64.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY				0 0	0	63.00 64.00
	06500 RESPI RATORY THERAPY	29, 541	0	8, 88		0	65.00
66.00	06600 PHYSI CAL THERAPY	52,074		8, 23		0	66.00
67.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	8, 397 5, 761		30		0	67.00 68.00
<u>60 00</u>		່ 3,701		12, 88		0	69.00
68.00 69.00		15, 498	0				
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	15, 498 16, 868		5, 18		0	
69. 00 70. 00 71. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0	5, 18 10, 120, 92	2 0	0	71.00
69.00 70.00 71.00 72.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	16, 868	0	5, 18 10, 120, 92 10, 352, 06	22 0 99 0	0 0	71.00 72.00
69.00 70.00 71.00 72.00 73.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	16, 868	0	5, 18 10, 120, 92 10, 352, 06	22 0 99 0 0 5, 598, 680	0	70.00 71.00 72.00 73.00 74.00
69.00 70.00 71.00 72.00 73.00 74.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	16, 868	0	5, 18 10, 120, 92 10, 352, 06	22 0 99 0 0 5, 598, 680	0 0 0	71.00 72.00 73.00
69.00 70.00 71.00 72.00 73.00 74.00 75.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 0UTPATI ENT SERVI CE COST CENTERS	16, 868 C C C C C C C		5, 18 10, 120, 92 10, 352, 06	22 0 99 0 0 5, 598, 680 11 0 0 0	0 0 0 0	71.00 72.00 73.00 74.00 75.00
69.00 70.00 71.00 72.00 73.00 74.00 75.00 88.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C	16, 868		5, 18 10, 120, 92 10, 352, 06	22 0 9 0 0 5, 598, 680 11 0 0 0	000000000000000000000000000000000000000	71.00 72.00 73.00 74.00 75.00
69.00 70.00 71.00 72.00 73.00 74.00 75.00 88.00 88.00 89.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 0UTPATI ENT SERVI CE COST CENTERS	16, 868 C C C C C C C		5, 18 10, 120, 92 10, 352, 06	22 0 99 0 0 5, 598, 680 11 0 0 0	0 0 0 0	71.00 72.00 73.00 74.00 75.00
69.00 70.00 71.00 72.00 73.00 74.00 75.00 88.00 88.00 89.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C 08900 FEDERALLY QUALI FI ED HEALTH CENTER	16, 868 C C C C C C C		5, 18 10, 120, 92 10, 352, 06	22 0 99 0 0 5, 598, 680 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	71.00 72.00 73.00 74.00 75.00 88.00 89.00
69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 88. 00 89. 00 90. 00 90. 01 90. 02	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STINCT PART) 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLINI C 08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C 09001 WOUND/OSTOMY CLI NI C	16, 868 C C C C C C C C C C C C C C C C C C		5, 18 10, 120, 92 10, 352, 06 3, 15	12 0 19 0 0 5, 598, 680 11 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 18, 200 0	71.00 72.00 73.00 74.00 75.00 88.00 89.00 90.00 90.00 90.00
69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 88. 00 89. 00 90. 00 90. 01 90. 02 90. 03	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C 08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C 09001 WOUND/OSTOMY CLI NI C	16, 868 C C C C C C C C C C C C C C C C C C		5, 18 10, 120, 92 10, 352, 06 3, 15	12 0 19 0 0 5, 598, 680 11 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 18, 200	71. 0 72. 0 73. 0 74. 0 75. 0 88. 0 89. 0 90. 0 90. 0

	Financial Systems LOCATION - STATISTICAL BASIS	COMMUNI TY HOSP			Period:	u of Form CMS-2 Worksheet B-1	
				1	From 01/01/2015 To 12/31/2015	Date/Time Pre	
						5/24/2016 1:2	
	Cost Center Description	CAFETERIA (MAN HOURS)	NURSI NG ADMI NI STRATI ON (DI RECT NURS. HRS.)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (TI ME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
	D9006 PREGNANCY PLUS	6, 316	0	190		0	90.06
	09007 0/P LAB	C	0	(	0	0	90.07
1	D9008 0/P LAB D9009 FORTVI LLE CLI NI C					0	90.08
	D9100 EMERGENCY	99, 017	0	415, 05	5 0	27, 400	•
H	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0	0			0	94.00 95.00
	09600 DURABLE MEDICAL EQUIP-RENTED		0			0	96.00
	D9700 DURABLE MEDICAL EQUIP-SOLD		0		0 0	0	97.00
	D9900 СМНС	C	0	(	0 0	0	99.00
	09910 CORF	C	0	(	0 0	0	
	10000 I &R SERVICES-NOT APPRVD PRGM	C	0	(	- -		100.00
-	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	C	0	(	0 0	0	101.00
	10500 KIDNEY ACQUISITION	0	0	(	0 0	0	105.00
	10600 HEART ACQUI SI TI ON		0				106.00
	10700 LIVER ACQUISITION	C	0	(	0 0	0	107.00
	10800 LUNG ACQUISITION	C	0	(	0 0		108.00
	10900 PANCREAS ACQUI SI TI ON	C	0	(	0 0		109.00
	11000 INTESTINAL ACQUISITION		0	(	0		110.00
	11100 I SLET ACQUI SI TI ON 11300 I NTEREST EXPENSE		0		0	0	111. 00 113. 00
	11400 UTI LI ZATI ON REVI EW-SNF						114. OC
	11500 AMBULATORY SURGICAL CENTER (D. P.)	c	0	(	0 0	0	115. OC
1	11600 HOSPI CE	C	0	(	0 0		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1, 344, 128	644, 025	26, 809, 682	2 5, 644, 238	80, 700	1118.00
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	(	0 0	0	190.00
	19001 WELLNESS CENTERS	22, 405		730			190.01
190. 02 <sup>-</sup>	19002 EMPLOYED ORTHO MD	c c	1	(	0 0	0	190. 02
	19003 NORTHVIEW CONV. (LTC)	8, 764		739			190. 03
	19004 SUMMIT CONV. (LTC)	5,676		843			190.04
	19005 PARKVIEW CONV. (LTC) 19006 MONTICELLO HSE. (ASS'TD LVG.)	9, 156 3, 422		62			190. 05 190. 06
	19007 NH PARK PLACE (LTC)	1, 023					190.07
	19008 MADISON PLACE OF ELWOOD (LTC)	C			0 0		190.08
	19009 SPI NE SURGEON	C	0	(	0 0	0	190. 09
	19010 CLINICAL RESEARCH CENTER	28, 026		1, 958			190.10
	19011 ONCOLOGI ST	0	, v		0		190.11
	19012 MEDI CAL I NTERNI ST	2,628		294	1,728		190. 12 190. 13
	19013  RHEUMATOLOGY 19100  RESEARCH	1,669					190.13
	19200 PHYSI CLANS' PRI VATE OFFI CES		0	2, 15	2 0		192.00
	19201 PHYSI CLANS' PRI VATE OFFI CES	C	0	(	0 0		192. 01
	19202 FOUNDATI ON	3, 689	0	!	5 0		192. 02
	19203 SPOE	C	0	(	5		192.03
	19204 HEALTHY HEART	4,038	0	5, 002			192.04
	19205 VACANT SPACE 19207 PARK PLACE CENTER						192.05 192.07
	19300 NONPAID WORKERS		0				193.00
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part	1, 249, 015	1, 937, 845	4, 259, 20	5 2, 990, 320	2, 634, 280	202.00
02 00	)   nit cost multiplior (West R Part L)	0 070/00	2 000050	0 150700	0 50425	22 14/501	202 00
203.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part	0. 870622 54, 087		0. 158798 174, 283		32. 164591 110, 425	
.04.00	(11)	54,007	10,220	1/4,20	103,703	110, 420	204.00

	Financial Systems LLOCATION - STATISTICAL BASIS	COMMUNI TY HOSPI		CCN: 150113 F	In Lie Period:	u of Form CMS- Worksheet B-1	
0001 7	LECONTON - STATISTICAL DASIS		11001dei	F	rom 01/01/2015		
					Го 12/31/2015	5/24/2016 1:2	
					INTERNS &	RESI DENTS	
	Cost Center Description	SOCI AL SERVI CE	NONPHYSI CI AN	NURSING SCHOOL	SERVI CES-SALAR	SERVI CES-OTHER	2
		(TIME SPENT)	ANESTHETI STS	(ASSI GNED	Y & FRI NGES	PRGM. COSTS	
			(ASSIGNED TIME)	TIME)	(ASSI GNED TI ME)	(ASSIGNED TIME)	
		17.00	19.00	20.00	21.00	22.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS BEDG & TTAT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 6.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						5.00
7.00	00700 OPERATI ON OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00 11.00	01000 DI ETARY 01100 CAFETERI A						10.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY						15.00
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	394					16.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	C	þ			19.00
20.00	02000 NURSI NG SCHOOL	0		(	D		20.00
21.00 22.00	02100 I & SERVI CES-SALARY & FRI NGES APPRVD 02200 I & SERVI CES-OTHER PRGM. COSTS APPRVD	0			0	0	21.00
23.00	02300 PARAMED ED PRGM-(EMS)	0				0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1		T			
30.00 31.00	03000 ADULTS & PEDIATRICS	394	C			0	
31.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	0				0	
33.00	03300 BURN I NTENSI VE CARE UNI T	0	C		0 0	0	
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	C	) (	0 0	0	
40.00 41.00	04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF	0	C			0	
42.00	04200 SUBPROVI DER	0	C			0	
43.00	04300 NURSERY	0	C		0 0	0	
44.00	04400 SKILLED NURSING FACILITY	0	C		0 0	0	
45.00 46.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	C			0	
101 00	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	C		0 0	0	
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	C			0	
53.00	05300 ANESTHESI OLOGY	0	C			0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C		0	0	
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	0	C C			0	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	C	) (	0 0	0	1
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0				0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		C				61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0 0	0	
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	C			0	
65.00	06500 RESPIRATORY THERAPY	0	C			0	1
66.00	06600 PHYSI CAL THERAPY	0	C		o o	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	C			0	
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY					0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	C			0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.00
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0	C			0	
73.00	07300 DRUGS CHARGED TO PATTENTS 07400 RENAL DIALYSIS	0	0			0	
75.00	07500 ASC (NON-DI STI NCT PART)	0	C			0	1
	OUTPATIENT SERVICE COST CENTERS	-				-	00.07
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER		C			0	
88.00 89.00		0	C	1		-	
	09000 CLINIC	0	C		0 0	0	90.00
89. 00 90. 00 90. 01	09000 CLINIC 09001 WOUND/OSTOMY CLINIC	0	C		0	0	90.01
89. 00 90. 00	09000 CLI NI C	000000000000000000000000000000000000000				-	90. 01 90. 02

OST AI	LLOCAT	ION - STATISTICAL BASIS		Provi der	F	Period: From 01/01/2015 To 12/31/2015	Worksheet B-1 Date/Time Pre 5/24/2016 1:2	pared:
				· ·		INTERNS &	RESI DENTS	
		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	ANESTHETI STS (ASSI GNED TI ME)	NURSI NG SCHOOL (ASSI GNED TI ME)	SERVI CES-SALAR Y & FRI NGES (ASSI GNED TI ME)	PRGM. COSTS (ASSIGNED TIME)	
	00005		17.00	19.00	20.00	21.00	22.00	00.05
		ANTI COAGULATI ON CLINI C	0	0			0	90.05
		PREGNANCY PLUS	0	0	C	0	0	90.06 90.07
		O/P LAB O/P LAB	0			0	0	90.07
		FORTVILLE CLINIC	0		c c	0	0	90.09
		EMERGENCY	0	C	C	0	0	91.00
2.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER	REIMBURSABLE COST CENTERS						
		HOME PROGRAM DI ALYSI S	0				0	94.00
		AMBULANCE SERVICES	0	0	-		0	95.00
		DURABLE MEDICAL EQUIP-RENTED	0	0	C	0	0	96.00
		DURABLE MEDICAL EQUIP-SOLD	0			0	0	97.00 99.00
	09900 09910		0			0	0	99.00
		I&R SERVICES-NOT APPRVD PRGM	0					100.00
		HOME HEALTH AGENCY	0		-	-		101.00
		AL PURPOSE COST CENTERS						
05.00	10500	KIDNEY ACQUISITION	0	0	C	0 0	0	105.00
06.00	10600	HEART ACQUI SI TI ON	0	C	C	0 0	0	106.00
		LIVER ACQUISITION	0	0	C	0 0		107.00
		LUNG ACQUISITION	0	0	C	0 0		108.00
		PANCREAS ACQUISITION	0	0	C	0		109.00
		INTESTINAL ACQUISITION	0	0		0		110.00
		I SLET ACQUI SI TI ON I NTEREST EXPENSE	0			0	0	111.00 113.00
		UTILIZATION REVIEW-SNF						114. OC
		AMBULATORY SURGICAL CENTER (D. P. )	0	0	0	0	0	115. OC
		HOSPI CE	0	0	C C	0		116.00
18.00		SUBTOTALS (SUM OF LINES 1-117)	394	0	C	0	0	118.00
		MBURSABLE COST CENTERS			1			
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190.00
		WELLNESS CENTERS	0	0	C	0		190.01
		EMPLOYED ORTHO MD	0			0		190. 02 190. 03
		NORTHVI EW CONV. (LTC) SUMMI T CONV. (LTC)	0			0		190. 03
		PARKVI EW CONV. (LTC)	0					190.05
		MONTI CELLO HSE. (ASS' TD LVG.)	0			0		190.06
		NH PARK PLACE (LTC)	0		c c	o o		190. 0
90. 08	19008	MADISON PLACE OF ELWOOD (LTC)	0	0	C	0	0	190. 0
		SPI NE SURGEON	0	0	C	0		190. 0
		CLINICAL RESEARCH CENTER	0	0				190. 1
		ONCOLOGI ST	0	0	-	-		190.1
		MEDICAL INTERNIST	0	0	-	-		190.1
		RHEUMATOLOGY RESEARCH	0			-		190. 1 191. 0
		PHYSICIANS' PRIVATE OFFICES						191.0
		PHYSICIANS' PRIVATE OFFICES	0					192.0
		FOUNDATION	0		c c			192.0
	19203		0		c c	0		192.0
		HEALTHY HEART	0	0	C	0		192. 0
		VACANT SPACE	0	0	C	0		192. 0
		PARK PLACE CENTER	0	0	C	0		192.0
	19300	NONPAI D WORKERS	0	0	C	0	0	193.0
0.00		Cross Foot Adjustments						200.0
01.00		Negative Cost Centers	0	0	c c		0	201.0
02.00		Cost to be allocated (per Wkst. B, Part	. 0				0	202. 0
03. 00		Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0.000000	0. 000000	0.000000	203 01
04.00		Cost to be allocated (per Wkst. B, Part		1 0.00000	0.000000	0		203.00
		11)					Ũ	
05.00		Unit cost multiplier (Wkst. B, Part II)	0. 000000	0. 000000	0. 000000	0. 000000	0.000000	205 0

	Financial Systems LLOCATION - STATISTICAL BASIS	COMMUNI TY HOSPI TAL	Provi der CCN: 150113	Peri od:	u of Form CMS-2552- Worksheet B-1
				From 01/01/2015 To 12/31/2015	Date/Time Prepared
	Cost Center Description	PARAMED ED			5/24/2016 1:26 pm
		PRGM-(EMS)			
		(ASSI GNED			
		TIME) 23.00			
	GENERAL SERVICE COST CENTERS	20.00			
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.0
2.00	00200 CAP REL COSTS-MVBLE EQUI P				2.
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.0
5.00 6.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS				5.0
7.00	00700 OPERATION OF PLANT				7.0
8.00	00800 LAUNDRY & LINEN SERVICE				8.0
9.00	00900 HOUSEKEEPI NG				9.0
10.00	01000 DI ETARY				10.
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION				11.
14.00	01400 CENTRAL SERVICES & SUPPLY				13.0
15.00	01500 PHARMACY				15.0
16.00	01600 MEDI CAL RECORDS & LI BRARY				16.
17.00	01700 SOCI AL SERVI CE				17.0
19.00	01900 NONPHYSI CLAN ANESTHETI STS				19.
20.00	02000 NURSI NG SCHOOL 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD				20.
22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD				22.
23.00	02300 PARAMED ED PRGM-(EMS)	100			23.
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	0			30.
31.00 32.00	03100 I NTENSI VE CARE UNI T	0			31.0
32.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0			32.
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0			34.
40.00	04000 SUBPROVI DER – I PF	0			40.
41.00	04100 SUBPROVI DER – I RF	0			41.
42.00	04200 SUBPROVI DER	0			42.
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	0			43.0
45.00	04500 NURSING FACILITY	0			45.0
46.00	04600 OTHER LONG TERM CARE	0			46.0
	ANCI LLARY SERVI CE COST CENTERS	1 1			
50.00	05000 OPERATING ROOM	0			50.0
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0			51.0
53.00	05300 ANESTHESI OLOGY	0			53.
54.00	05400 RADI OLOGY-DI AGNOSTI C	0			54.
55.00	05500 RADI OLOGY-THERAPEUTI C	0			55.0
56.00	05600 RADI OI SOTOPE	0			56.
57.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			57.0
	05900 CARDI AC CATHETERI ZATI ON	0			59.0
	06000 LABORATORY	0			60.
60. 01	06001 BLOOD LABORATORY	0			60.
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				61.0
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0			62.
64.00	06400 I NTRAVENOUS THERAPY	0			64.
65.00	06500 RESPI RATORY THERAPY	o o			65.
66.00	06600 PHYSI CAL THERAPY	0			66.
	06700 OCCUPATI ONAL THERAPY	0			67.
		0			68.
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0			69. ( 70. (
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	Ő			71.0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			72.
	07300 DRUGS CHARGED TO PATIENTS	0			73.
	07400 RENAL DIALYSIS	0			74.0
15.00	07500 ASC (NON-DI STI NCT PART) OUTPATI ENT SERVICE COST CENTERS	0			75.0
88. 00		0			88. (
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			89.
90.00	09000 CLI NI C	0			90.
	09001 WOUND/OSTOMY CLINIC	0			90.
	09002 KIDS PLUS CLINIC	0			90.
	09003 ONCOLOGY 09004 MUNCIE CLINIC	0			90.0
	09005 ANTI COAGULATI ON CLINIC	0			90.0
90.05					

	COMMUNITY HOSPITA			of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150113	From 01/01/2015 To 12/31/2015 [	Vorksheet B-1 Date/Time Prepared: 5/24/2016 1:26 pm
Cost Center Description	PARAMED ED PRGM-(EMS) (ASSI GNED TI ME) 23.00			//24/2010 1.20 piii
90.07         09007         0/P         LAB           90.08         09008         0/P         LAB           90.09         09009         FORTVI LLE         CLINIC           91.00         09100         EMERGENCY           92.00         09SERVATI ON BEDS (NON-DI STINCT PART)           OTHER REI MBURSABLE COST CENTERS	0 0 0 100			90. 07 90. 08 90. 09 91. 00 92. 00
94. 00       09400       HOME       PROGRAM       DI ALYSI S         95. 00       09500       AMBULANCE       SERVI CES         96. 00       09600       DURABLE       MEDI CAL       EQUI P-RENTED         97. 00       09700       DURABLE       MEDI CAL       EQUI P-SOLD         99. 00       09900       CMHC         99. 10       09910       CORF         100. 00       I & SERVI CES-NOT       APPRVD       PRGM         101. 00       10100       HOME       HEALTH       AGENCY	0 0 0 0 0 0 0 0			94.00 95.00 96.00 97.00 99.00 99.10 100.00 101.00
SPECIAL PURPOSE COST CENTERS           105.00         10500         KI DNEY         ACQUI SI TI ON           106.00         10600         HEART         ACQUI SI TI ON           107.00         10700         LI VER         ACQUI SI TI ON           108.00         10800         LINGE ACQUI SI TI ON           109.00         10900         PANCREAS         ACQUI SI TI ON           110.00         11000         INTESTI NAL         ACQUI SI TI ON           111.00         1100         INTESTI NAL         ACQUI SI TI ON           111.00         11100         ISLET         ACQUI SI TI ON           111.00         11100         INTERST         EXPENSE           114.00         INTEREST         EXPENSE           114.00         INTELEXTION         REVIEW-SNF           115.00         11600         HOSPI CE           118.00         SUBTOTALS         (SUM OF LINES 1-117)	0 0 0 0 0 0 0 0 0 0 0 0 0 0			105. 00 106. 00 107. 00 108. 00 109. 00 110. 00 111. 00 113. 00 114. 00 115. 00 116. 00 118. 00
NONREI MBURSABLE COST CENTERS           190. 00         OI 19000         GI FT, FLOWER, COFFEE SHOP & CANTEEN           190. 01         19001         WELLNESS CENTERS           190. 02         19002         EMPLOYED ORTHO MD           190. 03         19003         NORTHVI EW CONV. (LTC)           190. 04         19004         SUMMI T CONV. (LTC)           190. 05         19005         PARKVI EW CONV. (LTC)           190. 06         19006         MONTI CELLO HSE. (ASS' TD LVG.)           190. 07         19006         MONTI CELLO HSE. (ASS' TD LVG.)           190. 08         19006         MONTI CELLO HSE. (LTC)           190. 08         19007         NH PARK PLACE (LTC)           190. 09         19007         CLI NI CAL RESEARCH CENTER           190. 11         19010         RESEARCH           192. 01         19204         PHYSI CLI ANS' PRI VATE OFFI CES           192. 01         1920	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			190. 00 190. 01 190. 02 190. 03 190. 04 190. 05 190. 06 190. 07 190. 08 190. 09 190. 10 190. 11 190. 12 190. 13 191. 00 192. 01 192. 01 192. 02 192. 03 192. 04 192. 05 192. 07 193. 00 200. 00 201. 00 202. 00
1)203.00204.00205.00205.00	3, 054. 570000 3, 255 32. 550000			203. 00 204. 00 205. 00
	32, 00000			1203.00

	Financial Systems ATION OF RATIO OF COSTS TO CHARGES	COMMUNI TY HOSP	I TAL ANDERSON Provi der	F	In Lie Period: From 01/01/2015 Fo 12/31/2015	u of Form CMS-: Worksheet C Part I Date/Time Pre 5/24/2016 1:2	pared:
			Titl	e XVIII	Hospi tal	PPS	1
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	27, 095, 466	1	27, 095, 466	5 0	27, 095, 466	30.00
	03100 INTENSIVE CARE UNIT	3, 741, 980		3, 741, 980		3, 741, 980	
	03200 CORONARY CARE UNIT	0		(		0	32.00
	03300 BURN INTENSIVE CARE UNIT	0		(	0 0	0	33.00
	03400 SURGI CAL INTENSI VE CARE UNI T	0			0	0	34.00
	04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF					0	40.00
	04200 SUBPROVI DER	0				0	42.00
	04300 NURSERY	1, 115, 447	,	1, 115, 447	7 0	1, 115, 447	43.00
	04400 SKILLED NURSING FACILITY	0			0 0	0	44.00
	04500 NURSING FACILITY	0		(		0	45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	<u> </u>	(	0 0	0	46.00
50.00	05000 OPERATING ROOM	13, 267, 298		13, 267, 298	3 0	13, 267, 298	50.00
51.00	05100 RECOVERY ROOM	0		(	0 0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	52.00
	05300 ANESTHESI OLOGY	348, 938		348, 938		348, 938	
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	6, 401, 400		6, 401, 400		6, 401, 400 0	54.00 55.00
	05600 RADI OI SOTOPE	927, 141		927, 14	-	927, 141	1
	05700 CT SCAN	763, 445		763, 445		763, 445	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	795, 124		795, 124		795, 124	
	05900 CARDI AC CATHETERI ZATI ON	1, 424, 333		1, 424, 333		1, 424, 333	
	06000 LABORATORY 06001 BLOOD LABORATORY	6, 114, 677		6, 114, 67		6, 114, 677 0	60.00 60.01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					0	61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	392, 165		392, 165	5 0	392, 165	62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0			0 0	0	63.00
	06400 I NTRAVENOUS THERAPY	0		)	0 0	0	64.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 477, 130				1, 477, 130 2, 923, 202	
	06700 OCCUPATIONAL THERAPY	592, 185				592, 185	
	06800 SPEECH PATHOLOGY	341, 733		341, 733		341, 733	
	06900 ELECTROCARDI OLOGY	958, 992		958, 992		958, 992	
	07000 ELECTROENCEPHALOGRAPHY	1, 155, 011		1, 155, 01		1, 155, 011	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	14, 035, 177 14, 355, 731		14, 035, 17 14, 355, 73		14, 035, 177 14, 355, 731	
	07300 DRUGS CHARGED TO PATIENTS	9, 952, 865		9, 952, 865		9, 952, 865	
	07400 RENAL DIALYSIS	196, 452		196, 452		196, 452	
	07500 ASC (NON-DISTINCT PART)	0		(	0 0	0	75.00
	OUTPATIENT SERVICE COST CENTERS		1			0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER					0	89.00
	09000 CLINIC	0			0 0	0	90.00
	09001 WOUND/OSTOMY CLINIC	1, 905, 005		1, 905, 005		1, 905, 005	90.01
	09002 KIDS PLUS CLINIC	94, 253		94, 253		94, 253	
	09003 ONCOLOGY 09004 MUNCIE CLINIC	0 185, 609		185, 609		0 185, 609	
	09005 ANTI COAGULATI ON CLINI C	413, 264		413, 264		413, 264	
90.06	09006 PREGNANCY PLUS	391, 682		391, 682		391, 682	90.06
	09007 0/P LAB	0		(	0 0	0	90.07
		0			0	0	90.08
	09009 FORTVILLE CLINIC 09100 EMERGENCY	82, 766 6, 726, 488		82, 766 6, 726, 488		82, 766 6, 726, 488	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	2, 898, 263		2, 898, 263	3	2, 898, 263	92.00
	09400 HOME PROGRAM DI ALYSI S	0			0	0	94.00
	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED					0	95.00 96.00
	09700 DURABLE MEDICAL EQUIP-SOLD				o o	0	97.00
99.00	09900 СМНС	0		(	ן ב	0	99.00
	09910 CORF	0		(		0	
	10000 I &R SERVICES-NOT APPRVD PRGM	0					100.00
	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	/	. (	)	0	101.00
	10500 KI DNEY ACQUI SI TI ON	0		(		0	105.00
		0		0	D		106.00
106.00	10600 HEART ACQUISITION 10700 LIVER ACQUISITION	0					107.00

Health Financial Systems	COMMUNI TY HOSPI	ITAL ANDERSON		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150113	Period: From 01/01/2015 To 12/31/2015		
		Titl	e XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
	<u>26)</u> 1.00	2.00	3.00	4,00	5.00	
109.00       10900       PANCREAS ACQUISITION         110.00       1000       INTESTINAL ACQUISITION         111.00       11100       ISLET ACQUISITION         111.00       11100       ISLET ACQUISITION         113.00       11300       INTEREST EXPENSE         114.00       11400       UTILIZATION REVIEW-SNF         115.00       11500       AMBULATORY SURGICAL CENTER (D. P. )         116.00       HOSPICE         200.00       Subtotal (see instructions)         201.00       Less Observation Beds	0 0 0 121, 073, 222 2, 898, 263		121, 073, 2: 2, 898, 20		0 0 0	1
202.00 Total (see instructions)	118, 174, 959		118, 174, 9		118, 174, 959	

	Financial Systems ATION OF RATIO OF COSTS TO CHARGES	COMMUNI TY HOSPI	Provi der	CCN: 150113 e XVIII	Peri od: From 01/01/2015 To 12/31/2015 Hospi tal	u of Form CMS- Worksheet C Part I Date/Time Pre 5/24/2016 1:2 PPS	pared:
			Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
~~ ~~	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			00.001.00			0.00
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	32, 291, 904 8, 450, 081		32, 291, 90 8, 450, 08			30.00
32.00	03200 CORONARY CARE UNIT	8, 450, 081		0, 450, 00	0		32.00
33.00	03300 BURN I NTENSI VE CARE UNI T	0			0		33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0			0		34.00
40.00	04000 SUBPROVI DER – I PF	0			0		40.00
41.00	04100 SUBPROVIDER - IRF	0			0		41.00
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	1, 949, 313		1, 949, 31	0		42.00
43.00	04400 SKI LLED NURSI NG FACI LI TY	1, 949, 313		1, 949, 3	0		43.00
45.00	04500 NURSI NG FACI LI TY	0			0		45.00
46.00	04600 OTHER LONG TERM CARE	0			0		46.00
	ANCI LLARY SERVI CE COST CENTERS	I I		1			
50.00	05000 OPERATING ROOM	24, 053, 610	34, 309, 292			0.00000	
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0.000000 0 0.000000	0. 000000 0. 000000	
52.00	05300 ANESTHESI OLOGY	1, 845, 784	1, 320, 461	3, 166, 24		0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 138, 165	16, 828, 219			0. 000000	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C		0 0.000000	0. 000000	
56.00	05600 RADI OI SOTOPE	766, 130	11, 108, 147			0.00000	
57.00	05700 CT SCAN	5, 757, 136	21, 520, 161			0.00000	
58.00 59.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	1, 551, 489 3, 022, 585	9, 737, 039 6, 713, 036			0. 000000 0. 000000	
60.00	06000 LABORATORY	9, 085, 729	26, 910, 240			0.000000	
60.01	06001 BLOOD LABORATORY	0	, , C	)	0 0.000000	0. 000000	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	C		0 0.000000	0. 000000	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	934, 797	575, 022	1, 509, 81		0.00000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0 0.000000	0.00000	
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	2, 968, 398	575, 697	3, 544, 09	0 0. 000000 95 0. 416786	0. 000000 0. 000000	
66.00	06600 PHYSI CAL THERAPY	1, 570, 794	5, 764, 714			0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	863, 109	845, 484			0.00000	
68.00	06800 SPEECH PATHOLOGY	402, 368	304, 202			0.00000	
69.00		2, 505, 699	6, 825, 618			0.00000	
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	754, 194 25, 947, 169	3, 594, 829 18, 784, 876			0. 000000 0. 000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	28, 866, 668	6, 959, 585			0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	30, 174, 961	22, 567, 945			0. 000000	
	07400 RENAL DIALYSIS	337, 399	C	337, 39	0. 582254	0. 000000	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	C	)	0 0.000000	0. 000000	75.00
88.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0		1	0		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89.00
90.00	09000 CLINIC	0	C		0 0.000000	0. 000000	
90. 01	09001 WOUND/OSTOMY CLINIC	0	5, 519, 381	5, 519, 38		0. 000000	90.01
90.02	09002 KIDS PLUS CLINIC	0	0		0 0.000000	0.00000	
90. 03 90. 04	09003 ONCOLOGY 09004 MUNCIE CLINIC	0	9, 026, 233	9, 026, 23	0. 000000 0. 000000	0. 000000 0. 000000	
90.04 90.05	09005 ANTI COAGULATI ON CLINIC	0	1, 058, 064	1, 058, 06		0. 000000	
90.06	09006 PREGNANCY PLUS	0	., 000, 001	)	0 0.000000	0. 000000	
90. 07	09007 0/P LAB	0	C		0 0.000000	0. 000000	
90. 08	09008 0/P LAB	0	C		0 0.000000	0. 000000	
90.09	09009 FORTVILLE CLINIC	0	0		0 0.00000	0.00000	
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 121, 960 0	29, 578, 987 6, 362, 076			0. 000000 0. 000000	
12.00	OTHER REIMBURSABLE COST CENTERS	, U	0, 302, 070	6, 362, 07	0. 400000	0.00000	1 /2.00
94.00	09400 HOME PROGRAM DI ALYSI S	0	C	)	0 0.000000	0. 000000	94.00
95.00	09500 AMBULANCE SERVICES	0	C		0 0.000000	0. 000000	
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0 0.00000	0.00000	
97.00	09700 DURABLE MEDICAL EQUIP-SOLD 09900 CMHC	0	C		0 0.000000	0. 000000	97.00 99.00
	09900 CMHC 09910 CORF	0	C C		0		99.00
	10000 I &R SERVICES-NOT APPRVD PRGM	0	C.		0		100.00
	10100 HOME HEALTH AGENCY	0	C		0		101.00
	SPECIAL PURPOSE COST CENTERS			1			
	10500 KI DNEY ACQUI SI TI ON	0	C		0		105.00
	10600 HEART ACQUISITION 10700 LIVER ACQUISITION	0	C		0		106.00
	10700 LIVER ACQUISITION	0	C C		0		107.00
108 00					<b>T</b> (		

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 01/01/2015	Worksheet C	
				To 12/31/2015	Date/Time Pre	
		T: ±1		11	5/24/2016 1:2	26 pm
			e XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
110.00 11000 INTESTINAL ACQUISITION	0	0		0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0		111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P. )	0	0		0		115.00
116.00 11600 HOSPI CE	0	0		0		116.00
200.00 Subtotal (see instructions)	196, 359, 442	246, 789, 308	443, 148, 75	0		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	196, 359, 442	246, 789, 308	443, 148, 75	0		202.00

	Financial Systems TATION OF RATIO OF COSTS TO CHARGES	COMMUNI TY HOSPI TAL	ANDERSON Provider CCN: 150113	In Lie Period: From 01/01/2015 To 12/31/2015	
			Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient Ratio			
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT				30.00
32.00	03200 CORONARY CARE UNI T				32.00
33.00	03300 BURN I NTENSI VE CARE UNI T				33.00
34.00 40.00	03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF				34.00 40.00
41.00	04100 SUBPROVI DER – I RF				41.00
42.00	04200 SUBPROVI DER				42.00
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY				43.00 44.00
45.00	04500 NURSI NG FACI LI TY				45.00
46.00	04600 OTHER LONG TERM CARE				46.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0. 227324			50.00
51.00	05100 RECOVERY ROOM	0. 000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0. 110206 0. 305317			53.00 54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.00
56.00	05600 RADI OI SOTOPE	0. 078080			56.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 027988 0. 070436			57.00 58.00
59.00	05900 CARDIAC CATHETERIZATION	0. 146301			59.00
60.00	06000 LABORATORY	0. 169871			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
61.00 62.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000 0. 259743			61.00 62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
64.00	06400 I NTRAVENOUS THERAPY	0.000000			64.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0. 416786 0. 398500			65. 00 66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 346592			67.00
68.00	06800 SPEECH PATHOLOGY	0. 483651			68.00
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0. 102771 0. 265579			69.00 70.00
70.00		0. 313761			70.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 400704			72.00
73.00 74.00		0. 188705 0. 582254			73.00 74.00
75.00	07500 ASC (NON-DI STINCT PART)	0. 000000			74.00
	OUTPATIENT SERVICE COST CENTERS				
88.00 89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER				88. 00 89. 00
90.00	09000 CLINIC	0. 000000			90.00
90.01	09001 WOUND/OSTOMY CLINIC	0. 345148			90.01
90.02		0. 000000			90. 02 90. 03
90. 03 90. 04	09003 UNCOLUGY 09004 MUNCIE CLINIC	0.000000			90.03
90.05	09005 ANTI COAGULATI ON CLINIC	0. 390585			90.05
90.06	09006 PREGNANCY PLUS 09007 0/P LAB	0.000000			90.06
90. 07 90. 08		0.000000			90. 07 90. 08
90.09	09009 FORTVILLE CLINIC	0. 000000			90.09
91.00		0. 178417			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0. 455553			92.00
94.00	09400 HOME PROGRAM DI ALYSI S	0. 000000			94.00
95.00		0. 000000			95.00
96.00 97.00		0.000000			96.00 97.00
	09900 CMHC	0.00000			99.00
	09910 CORF				99.10
	D 10000 I & R SERVI CES-NOT APPRVD PRGM D 10100 HOME HEALTH AGENCY				100. 00 101. 00
101.00	SPECIAL PURPOSE COST CENTERS				101.00
	10500 KIDNEY ACQUISITION				105.00
	D 10600 HEART ACQUI SI TI ON D 10700 LI VER ACQUI SI TI ON				106. 00 107. 00
	10700 LIVER ACQUISITION				108.00
109.00	0 10900 PANCREAS ACQUISITION				109.00
	D 11000 I NTESTI NAL ACQUI SI TI ON D 11100 I SLET ACQUI SI TI ON				110. 00 111. 00
111.00	ITTOUTSELT ACQUISITION				

Health Financial Systems	COMMUNI TY HOSPI TAL	ANDERSON	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150113	Period:	Worksheet C
			From 01/01/2015 To 12/31/2015	Part I Date/Time Prepared:
				5/24/2016 1:26 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
113.00 11300 INTEREST EXPENSE				113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF				114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)				115.00
116. 00 11600 HOSPI CE				116.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	COMMUNI TY HOSP			In Lie Period: From 01/01/2015 To 12/31/2015	u of Form CMS-2 Worksheet C Part I Date/Time Pre 5/24/2016 1:2	pared:
		Tit	le XIX	Hospi tal	Cost	1
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	07.005.444	[	07.005.44	(	07.005.444	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	27, 095, 466 3, 741, 980		27, 095, 46 3, 741, 98	-	27, 095, 466 3, 741, 980	
32. 00 03200 CORONARY CARE UNIT	3, 741, 900		3, 741, 90	0 0	3, 741, 700	1
33. 00 03300 BURN INTENSIVE CARE UNIT	0			0 0	0	
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0			0 0	0	34.00
40. 00 04000 SUBPROVIDER - IPF	0			0 0	0	1
41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER	0			0 0	0	
43. 00 04300 NURSERY	1, 115, 447		1, 115, 44	7 0	1, 115, 447	1
44. 00 04400 SKI LLED NURSING FACILITY	0		1, 110, 11	0 0	0	
45.00 04500 NURSING FACILITY	0			0 0	0	45.00
46.00 O4600 OTHER LONG TERM CARE	0			0 0	0	46.00
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM	13, 267, 298		12 247 20	8 0	13, 267, 298	50.00
51. 00 05100 RECOVERY ROOM	13, 267, 298		13, 267, 29	8 U 0 0	13, 267, 298	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	1
53. 00 05300 ANESTHESI OLOGY	348, 938		348, 93		348, 938	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 401, 400		6, 401, 40		6, 401, 400	
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	927, 141		927, 14	0 0 1 0	0 927, 141	
57. 00 05700 CT SCAN	763, 445		763, 44		763, 445	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	795, 124		795, 12		795, 124	
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 424, 333		1, 424, 33	3 0	1, 424, 333	59.00
60. 00 06000 LABORATORY	6, 114, 677		6, 114, 67		6, 114, 677	
60. 01 06001 BLOOD LABORATORY	0			0 0	0	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	392, 165		392, 16	5 0	0 392, 165	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0			0 0	0	1
64.00 06400 INTRAVENOUS THERAPY	0			0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	1, 477, 130				1, 477, 130	
66. 00 06600 PHYSI CAL THERAPY	2, 923, 202				2, 923, 202	
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	592, 185 341, 733		592, 18 341, 73		592, 185 341, 733	
69. 00 06900 ELECTROCARDI OLOGY	958, 992		958, 99		958, 992	
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 155, 011		1, 155, 01		1, 155, 011	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 035, 177		14, 035, 17		14, 035, 177	
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS	14, 355, 731		14, 355, 73		14, 355, 731	
73.00 07300 DRUGS CHARGED TO PATTENTS 74.00 07400 RENAL DIALYSIS	9, 952, 865 196, 452		9, 952, 86 196, 45	-	9, 952, 865 196, 452	
75. 00 07500 ASC (NON-DI STINCT PART)	0			0 0		
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0			0 0	0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0				0	
90. 01 09001 WOUND/OSTOMY CLINIC	1, 905, 005		1, 905, 00	5 0	1, 905, 005	1
90. 02 09002 KIDS PLUS CLINIC	94, 253		94, 25		94, 253	
90. 03 09003 ONCOLOGY	0			0 0	0	90.03
90. 04 09004 MUNCIE CLINIC	185, 609		185, 60		185, 609	
90. 05 09005 ANTI COAGULATI ON CLINIC 90. 06 09006 PREGNANCY PLUS	413, 264		413, 26		413, 264	
90. 06 09006 PREGNANCY PLUS 90. 07 09007 0/P LAB	391, 682		391, 68		391, 682 0	
90. 08 09008 0/P LAB	0			0 0	0	1
90. 09 09009 FORTVILLE CLINIC	82, 766		82, 76	6 0	82, 766	90.09
91.00 09100 EMERGENCY	6, 726, 488		6, 726, 48		6, 726, 488	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	2, 898, 263		2, 898, 26	3	2, 898, 263	92.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0			0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0			0 0	0	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0			0 0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0			0 0	0	
99. 00 09900 CMHC 99. 10 09910 CORF	0			0	0	
100.00 10000 I & R SERVICES-NOT APPRVD PRGM				0		100.00
101. 00 10100 HOME HEALTH AGENCY	0			0		101.00
SPECIAL PURPOSE COST CENTERS						
		1		0	0	105.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0			-		
105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON	0			0	0	106.00 107.00

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150113	Peri od: From 01/01/2015 To 12/31/2015		
		Tit	le XIX	Hospi tal	Cost	o pili
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
	26) 1.00	2.00	3.00	4,00	5.00	
109.00       10900       PANCREAS ACQUI SITION         110.00       11000       INTESTINAL ACQUI SITION         111.00       1100       ISLET ACQUI SITION         113.00       11300       INTEREST EXPENSE         114.00       11400       UTI LI ZATION REVIEW-SNF         115.00       11500       AMBULATORY SURGICAL CENTER (D. P. )         116.00       11600       HOSPI CE         200.00       Subtotal (see instructions)         201.00       Less Observation Beds         202.00       Total (see instructions)	0 0 0 121, 073, 222 2, 898, 263 118, 174, 959		121, 073, 2: 2, 898, 24 118, 174, 9	53	0 0	201.00

INPATI ENT ROUTI NE SERVI CE COST CENTERS         30.00         7.00         8.00           30.00         03000 ADULTS & PEDIATRICS         32.291,904         32.291,904           32.00         03200 CARDIARY CARE UNIT         8.450.081         8.450.081           32.00         03200 CARDIARY CARE UNIT         0         8.450.081           40.00         SUBRE CALE INTERSI VE CARE UNIT         0         0           41.00         SUBRE CALE INTERSI VE CARE UNIT         0         0           42.00         SUBRE CALE INTERSI VE CARE UNIT         0         0           43.00         SUBRE CALE INTERSI VE CARE UNIT         0         0           44.00         O44000 SKILEED NURSING FACLE ITY         0         0         0           45.00         O4600 UNRSING FACLE ITY         0         0         0         0           46.00         SOBOR OFTHER COST CENTERS         24.053.610         34.309,292         58.362.900         0	Peri od: From 01/01/2015 To 12/31/2015 Hospi tal		pared:
INPATIENT ROUTINE SERVICE COST CENTERS         6.00         7.00         8.00           30.00         03000         AAULTS & PEDLATRICS         32.291,904         32.291,904           31.00         03200         CORMANY CARE UNIT         6.450,001         6.450,001           32.00         03200         CORMARY CARE UNIT         6.450,001         6.450,001           32.00         03200         CORMARY CARE UNIT         0         6.70,000           40.00         SUBPROVIDER         1.PF         0         6.70,000           41.00         PATOMANDER         1.PF         0         6.70,000           42.00         04200         SUBPROVIDER         1.PF         0         0           43.00         04200         SUBPROVIDER         1.PF         0         0           44.00         04400         SKILLEN NURSING FACILITY         1.949,31         1.949,31         1.949,31           45.00         06500         DPECONET ROOM         0         0         0         0           50.00         05000         DPECONET ROOM         1.845,781         1.220,41         1.914,74,272           51.00         05100         DPECONET ROOM         0         0         1.924,972		0031	
INPART ENT ROUTI NE SERVICE COST CENTERS         32, 291, 904         32, 291, 904           0.01         03000 INTESN PE CARE UNIT         8, 450, 081         8, 450, 081           03100 OUROLSA, PEAR UNIT         0         0         0           03100 OUROLAR, UNERSERV         0         0         0           04000 SUBROXIDER - IPENSIVE CARE UNIT         0         0         0           04000 SUBROXIDER - IPENSIVE CARE UNIT         0         0         0           04000 SUBROXIDER - IPENSIVE CARE UNIT         0         0         0           04000 SUBROXIDER - IPE         0         0         0         0           04200 OURSERV         0         0         0         0         0           04400 SKILLED NURSING FACILITY         1         949, 31         1, 949, 31         1, 949, 31           04600 OHECONURSING FACILITY         0         0         0         0         0           04600 OHECONURSING FACILITY         0         1         0.041, 001, 010, 010, 010, 010, 010, 010,	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
30:00         03000 ADULTS & PEDIATRICS         32, 291, 904         32, 291, 904         32, 291, 906           31:00         03300 (INTENSIVE CARE UNIT         8, 450, 081         8, 450, 081         8, 450, 081           31:00         03300 (DIRNENSIVE CARE UNIT         0	9.00	10.00	
31.00       03100   INTENSI VE CARE UNIT       B. 450.081       B. 450.081         33.00       03300 BURN INTENSI VE CARE UNIT       0       0         40.00       03400 SUBROXID ER       0       0         41.00       04100 SUBROXID ER       0       0         42.00       04200 SUBROXID ER       0       0         42.00       04200 SUBROXID ER       0       0         43.00       04200 SUBROXID ER       0       0         44.00       04400 SKILLED NURSING FACILITY       0       0         45.00       04500 OHSENG CALL INTRU CARE       0       0       0         50.00       05000 OFECANTING ROOM       0       0       0       0       0         51.00       05100 OECONTERY ROOM & LABOR ROOM       0       0       1       1.045, 724       1.320, 461       3.166, 244         51.00       05400 RADIOLOGY-THRAPEUTIC       7.68, 118       11.61, 828, 219       20.90, 240       35, 995, 996       0       11.041, 21, 520, 461       3.166, 244       3.166, 244         55.00       05500 RADIOLOGY-THRAPEUTIC       7.68, 118       11.320, 461       3.166, 244       1.320, 461       3.169, 997       11.284, 217       277, 29       25, 56, 673, 326       1.33, 33, 99 <td></td> <td></td> <td></td>			
32. 00       03200 CORONARY CARE UNIT       0       0         34. 00       03400 SURGI CAL INTENSI VE CARE UNIT       0       0         41. 00       04000 SURGI CAL INTENSI VE CARE UNIT       0       0         42. 00       04200 SUBROXI DER - I PF       0       0         43. 00       04300 SUBROXI DER - I PF       0       0         44. 00       04400 SUBROXI DER       1.949, 313       1.949, 313         45. 00       04500 INUESING FACILITY       0       0         46. 00       04600 OHEAD ING RACE       0       0         50. 00       05500 OHEAD ING ROOM       24, 053, 610       34, 309, 292       58, 362, 902         51. 00       05500 OHEAD ING ROOM       0       0       0       0         52. 00       05500 RADI CLOCY - NAGNOSTIC       1, 413, 41, 11, 74, 11, 77, 27, 79       0       0       0         55. 00       05500 RADI CLOCY - NAGNOSTIC       4, 138, 169       9, 737, 709       11, 288, 279       20, 966, 389       575, 731       11, 108, 147       11, 108, 147       11, 108, 147       11, 287, 277, 79       15, 251, 130       11, 108, 147       11, 287, 277, 79       15, 285       6, 713, 336       6, 713, 336       73, 595, 597       3, 544, 99       737, 797       15, 290, 96 <td></td> <td></td> <td>30.00 31.00</td>			30.00 31.00
33.00       03300 BURH INTENSIVE CARE UNIT       0         40.00       04000 SUBFORCU INTENSIVE CARE UNIT       0         40.00       04000 SUBFORVI DER - 1 PF       0         41.00       04100 SUBFORVI DER - 1 FF       0         42.00       04200 SUBFORVI DER - 1 FF       0         42.00       04300 SUBFORVI DER - 1 FF       0         43.00       04300 NURSE INF FACI LI TY       0         46.00       04600 ONLESI NE FACI LI TY       0         46.00       055000 OPERATI NE ROM       24,053,410       34,309,292         50.00       055000 OPERATI NE ROM       0       0       0         50.00       055000 ANESTHES IOLOGY       1,445,784       1,320,461       3,166,244         50.00       055000 ARADIOLOGY-THERAPEUTI C       0       0       0       0         50.00       056000 RADIOLOGY-THERAPEUTI C       1,51,489       9,737,039       1,187,427,729         50.00       056000 RADIOLOGY-THERAPEUTI C       1,020,112,277,29       25,011,220,161       27,72,72         51.00       055000 ARADIOLOGY-THERAPEUTI C       9,065,729       26,910,240       35,995,96         60.10       060000 LABORATORY       9,065,729       26,910,240       35,995,96         61.00<	0		31.00
34.00       04000 SURGICAL INTENSIVE CARE UNIT       0         41.00       04000 SUBPROVIDER - IFF       0         41.00       04000 SUBPROVIDER - IFF       0         43.00       04000 SUBPROVIDER       1,949,313         43.00       04000 SUBPROVIDER       0         45.00       04500 NURSING FACILITY       0         45.00       04500 PTHER LORG TERN CARE       0         46.00       04600 OPTHER LORG TERN CARE       0         47.01 LARY SERVICE COST CENTERS       0       0         50.00       05000 PELATINE ROM       24,053,010       34,309,292         51.00       05000 PELATINES NGOM       0       0       0         52.00       05200 ARESTOLES NOM       1,845,784       1,320,461       1,162,217         53.00       05500 RADIOLOCY-THERAPEUTIC       0       0       0       0         55.00       05500 RADIOLOCY-THERAPEUTIC       0       0       0       0       0         59.00       05000 CARDIA CATHETERI TATIN N       3,202,585       6,713,039       11,388,52       9       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <t< td=""><td>0</td><td></td><td>33.00</td></t<>	0		33.00
41:00       04100 SUBPROVI DER - 1 RF       0       0         43:00       04300 NURSERY       1,949,313       1,949,313         43:00       04500 NURSI MG FACI LI TY       0       0         45:00       04500 NURSI MG FACI LI TY       0       0         64:00       04500 PHER LORG FROM       24,053,610       34,309,292       58,362,900         70:00       05000 PHER LORG FROM AL LABOR ROOM       0       0       0       0         71:00       05100 RECOVERY ROOM       0	0		34.00
42:00         04200 SUBPROVIDER         0         0         0         0           44:00         04400 SKILLED NURSING FACLEITY         0	0		40.00
43. 00       04300       NURSERY       1,949,313       1,949,313         43. 00       04500       NURSI NG FACI LI TY       0         45. 00       04500       NURSI NG FACI LI TY       0         64. 00       04600       DTHEE LONG REM CARE       0         65. 00       05100       DERVICE COST CENTERS       58,362,900         65. 00       0500       DELIVEP ROM & LABOR ROM       0       0         65. 00       0500       DELIVEP ROM & LABOR ROM       0       0       0         65. 00       05500 RADI DLGY-THERAPUTI C       4,133,165       16,828,219       20,966,38         65. 00       05500 RADI DLGY-THERAPUTI C       76,6130       11, 108,147       11, 874, 27         77. 00       05700 CT SCAN       5,757,136       21,520,611       27, 277, 29         80. 00       05800 CABOLAC CATHETERI ZATI ON       3,022,585       6,713,303       13,392,59,900         00       05900 CABOLAC CATHETERI ZATI ON       3,022,585       6,713,303       1,595,697         60. 00       06000 LABORATORY       9,085,729       26,910,240       35,995,696         60. 00       06000 LABORATORY       9,085,729       26,910,240       35,995,696         61. 00       06000 FESPI	0		41.00
44.00       04400       SKILLED       NURSING FACILITY       0         46.00       04600       OTHER       0       0         A6.01       04600       OTHER       0       0         50.00       05000       OPERATING ROOM       24,053,610       34,309,222       58,362,900         51.00       05100       DELOVEPY ROOM       24,053,610       34,309,222       58,362,900         52.00       05200       DELIVEPY ROOM       4,480R ROOM       0       0       0         55.00       05500       RADI DLGY-THERAPEUTI C       4,138,165       16,828,219       20,966,38         55.00       05500       RADI DLGY-THERAPEUTI C       766,130       11,108,147       12,727,29         50.00       05600       RADI DLACY-THERAPEUTI C       3,022,585       6,713,039       11,288,521         50.00       05600       RADI DLAC CATHETERI ZATION       3,022,585       6,713,039       11,288,521         50.00       06000       LAROKATORY       9,085,729       0       0       0         60.00       06000       PROLINICAL LAB SERVICES-PRGM ONLY       0       0       0       0         61.00       06000       PROLINICAL LAS SERVICES-PRGM ONLY       0	0		42.00
45. 00         04500         NURSI NG FACILITY         0         0         0           46. 00         04600         OTHEE LORG REMI CARE         0	0		43.00
ANCILLARY SERVICE COST CENTERS           0.00         05000 OPERATINE ROOM         24,053,610         34,309,292         58,362,900           51.00         05100 RECOVERY ROOM         0         0         0         0           53.00         05300 ANESTHESI OLOGY         1,845,784         1,320,461         3,165,240           54.00         05400 ANESTHESI OLOGY         4,138,165         16,828,219         20,966,38           55.00         05500 RADI OLOGY-THERAPEUTI C         766,130         11,108,147         11,874,27           57.00         05700 CARDI ACCONTIC ELIMERIA TON         3,022,585         6,713,036         9,737,039         11,288,523           59.00         05600 MAGNETIC RESINARCE IMAGI NG (MRI)         1,551,489         9,737,039         11,288,523         26,910,240         35,995,66         0           60.00         06000 LABORATORY         0 </td <td>0</td> <td></td> <td>45.00</td>	0		45.00
50. 00         05000 (DPERATI NG ROOM         24, 053, 610         34, 309, 292         58, 362, 90           51. 00         05100 (DECOVERY ROOM         0         0         0         0           52. 00         05200 (DELUVERY ROOM         1, 845, 784, 1, 330, 461         3, 166, 244         1, 381, 165         16, 828, 219         20, 966, 38           55. 00         05500 (RADI OLGGY - DI AGNOSTI C         4, 138, 165         16, 828, 219         20, 966, 38           55. 00         05500 (RADI OLGGY - THERAPEUTI C         0<	0		46.00
51. 00         051.00         RECOVERY ROOM         Labor ROOM         0         0           53. 00         05300         PALSTHESI OL OCY         1, 845, 784         1, 320, 461         3, 166, 244           54. 00         05400         RADI OLOGY - DI AGNOSTI C         4, 138, 165         16, 828, 219         20, 966, 38           55. 00         05500         RADI OLOGY - THERAPEUTI C         766, 130         11, 108, 147         11, 874, 27           57. 00         05700         CATOR CATHETERIZATION         3, 22, 585         6, 713, 039         9, 735, 62           50. 00         05600         CARDI AC CATHETERIZATION         3, 22, 585         6, 713, 036         9, 735, 62           60. 00         06000         LABORATORY         9, 085, 729         26, 910, 240         35, 995, 964           61. 00         06100         PBOR LINGRE RED BLODO CELLS         934, 797         575, 022         1, 509, 81           63. 00         06300         BLODD LABORATORY         0         0         0         0           64. 00         06400         INTRAVENUS THERAPY         2, 968, 398         575, 697         3, 544, 092           65. 00         06500         PASI ILAL THERAPY         2, 505, 699         6, 525, 618         9, 333, 317     <			
52. 00         052.00         DEJ UPERY PROM & LABOR ROOM         0         0         0           53.00         05300         ARDI OLOGY         1, 845, 784         1, 320, 461         3, 166, 242           54.00         05400         RADI OLOGY-DI AGNOSTI C         4, 138, 165         16, 828, 219         20, 966, 38           55.00         05500         RADI OLOGY-THERAPCUTI C         0         0         0         0           55.00         05500         RADI OLOGY-THERAPCUTI C         0         0         0         0         0           56.00         05600         MADI CATHETERI ZATI ON         3, 022, 585         6, 713, 036         97, 735, 62         6, 97, 335, 62         6, 97, 33, 64         9, 065, 729         26, 910, 240         9, 06         0	0. 227324 0. 000000		
53. 00       OS300       ANESTHESI OLOGY       1, 845, 784       1, 320, 461       3, 166, 243         54. 00       OS500       RADI OLOGY-THERAPEUTI C       0       0       0       0         55. 00       OS500       RADI OLOGY-THERAPEUTI C       4, 133, 165       16, 828, 219       0       966, 38         57. 00       OS700       CT SCAN       5, 757, 136       21, 520, 161       17, 277, 297       29         58. 00       OS600       CARDI AC CHIETERI ZATI ON       3, 22, 585       6, 713, 036       11, 874, 27         59. 00       OS500       CARDI AC CATHETERI ZATI ON       3, 22, 585       6, 713, 036       9, 735, 626         60. 01       OGOD CARDI AC CATHETERI ZATI ON       3, 022, 585       6, 713, 036       11, 508, 143         61. 00       OGOD HILOD BLABORATORY       0       0       0       0       0       0         63. 00       OG400       NHOLE BLOOD LABORATORY       0 <t< td=""><td>0 0.000000</td><td></td><td></td></t<>	0 0.000000		
54. 00       05400       RADI OLOGY-DI AGNOSTI C       4, 138, 165       16, 828, 219       20, 966, 383         55. 00       05500       RADI OLOGY-THERAPEUTI C       0       0       0         56. 00       0500       RADI OLOGY-THERAPEUTI C       766, 130       11, 108, 147       11, 874, 277         57. 00       05000       CATRETCR ZATION       3, 022, 585       6, 713, 036       97, 277, 297       29       26, 910, 240       35, 995, 964         60. 00       CADD LABORATORY       9, 085, 729       26, 910, 240       35, 995, 964       0			
56. 00       05600       RADI DI SOTOPE       76.6, 130       11, 108, 147       11, 874, 277, 297         57. 00       05700       CT SCAN       5, 757, 136       21, 520, 161       27, 277, 297         59. 00       05900       LARDIAC CATHETERI ZATI DN       3, 022, 585       6, 713, 036       9, 735, 632         50. 00       06000       LABORATORY       9, 085, 729       26, 910, 240       35, 995, 964         60. 00       06000       LABORATORY       0       0       0       0         61. 00       06100       LABORATORY       0       0       0       0         62. 00       06200       HHOLE BLOOD & PACKED RED BLOOD CELLS       934, 797       575, 022       1, 509, 817         63. 00       06300       INTRAVENUSU THERAPY       2, 968, 398       575, 697       3, 544, 09         64. 00       06400       INTRAVENUSU THERAPY       2, 688, 308       544, 441       1, 708, 557         67. 00       066700       OCEPATI ONAL THERAPY       2, 505, 649       6, 825, 518       9, 331, 31         70. 00       07000       HECTROCARDI DOGY       402, 368       304, 202       766, 577         70. 00       O7000       HECTROCARDI DOGAPHY       754, 194       3, 544, 294			
57. 00       05700 (CT SCAN       5,757, 136       21, 220, 161       27, 277, 29         58. 00       05800 MAGNETI C RESONANCE I MAGI NG (MRI )       1, 551, 489       9, 737, 039       11, 286, 523         50. 00       05900 (CARDI AC CATHETERI ZATI ON       3, 022, 585       6, 713, 036       9, 735, 62         60. 00       06000 I LADO LABORATORY       9, 085, 729       26, 910, 240       35, 995, 96         61. 00       06100 PB CLI NI CAL LAB SERVI (CES-PRGM ONLY       0       0       0       0         64. 00       06400 WHOLE BLODO & PACKED RED BLODO CELLS       934, 797       575, 622       1, 509, 811         65. 00       06500 RESPI RATORY THERAPY       2, 968, 398       575, 697       3, 544, 09         66. 00       06600 PESPI RATORANT THERAPY       1, 570, 794       5, 764, 714       7, 335, 500         66. 00       06600 SPECCH PATHOLOGY       402, 368       304, 202       776, 57         71. 00       00 CODO OLALAT THERAPY       754, 194       3, 594, 829       4, 44, 732, 044         72. 00       07200 I IMPL. DEV. CHARGED TO PATI ENTS       25, 866, 66       6, 959, 585       35, 826, 25         73. 00       07000 REGUETROECHALAGRAPHY       754, 194       35, 748, 876       44, 732, 044         74. 000       10000 E	0 0. 000000		
58. 00       05800       MAGNETIC RESONANCE I MAGING (MRI )       1, 551, 489       9, 737, 039       11, 288, 522         59. 00       05900       CARDIAC CATHETERIZATION       3, 022, 585       6, 713, 036       9, 735, 622         60. 00       06000 LABORATORY       0       0       0       0       0       0         61. 00       06100 PBP CLIN ICAL LAB SERVICES-PRGM ONLY       0			•
59.00         0s900         CARDI AC CATHETERI ZATI ON         3, 022, 585         6, 713, 036         9, 735, 622           60.00         06000         LABORATORY         9, 085, 729         26, 910, 240         35, 995, 963           60.00         06001         BLODD LABORATORY         0         0         0         0           61.00         06001         BLODD LABORATORY         0 </td <td></td> <td></td> <td>•</td>			•
60.00         0c6000         LABDRATORY         9,085,729         26,910,240         35,995,964           60.01         0c6001         BLODD LABDRATORY         0 <t< td=""><td></td><td>0. 000000</td><td></td></t<>		0. 000000	
61.00         06100         PBP CLINICAL LAB SERVICES-PRGM ONLY         0         0           62.00         06200         WHOLE BLOOD & PACKED RED BLOOD CELLS         934, 797         575, 022         1, 509, 813           63.00         06300         BLOOD STORING, PROCESSING & TRANS.         0         0         0         0           64.00         06400         INTRAVENOUS THERAPY         2,968,398         575,697         3,544,092           65.00         06600         PHYSICAL THERAPY         863,109         845,484         1,703,55,00           67.00         06700         CCUPATI ONAL THERAPY         863,109         845,484         1,733,55,00           68.00         06800         SPECEL PATHOLOGY         402,368         304,202         706,577           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         25,847,169         18,784,876         44,732,044           72.00         07200         IMPL.         DEV. CHARGED TO PATI ENTS         28,866,668         6,959,855         35,826,255           73.00         07300         DRUGS CHARGED TO PATI ENTS         28,866,668         6,959,855         35,826,255           74.00         07400         REARL DI ALYSIS         30,174,961         22,567,945         35,742,900 </td <td></td> <td>0.000000</td> <td></td>		0.000000	
62.00         06200         MPOLE BLOOD & PACKED RED BLOOD CELLS         934, 797         575, 022         1, 509, 81           63.00         06300         BLOOD STORING, PROCESSING & TRANS.         0         0         0           64.00         06400         INTRAVENOUS THERAPY         2, 968, 398         575, 697         3, 544, 099           65.00         065000         PESPI RATORY THERAPY         2, 968, 398         575, 697         3, 544, 099           66.00         066000         PECIA THERAPY         1, 570, 794         5, 764, 714         7, 335, 500           67.00         06700         OCCUPATIONAL THERAPY         863, 109         845, 484         1, 708, 593           68.00         068000         PECCH PATHOLOGY         2, 505, 699         6, 825, 618         9, 331, 317           70.00         07000         ELECTROENCEPHALOGRAPHY         754, 194         3, 594, 829         4, 349, 023           71.00         07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS         28, 866, 668         6, 959, 585         35, 826, 257           73.00         07300 DRUSC CHARGED TO PATI ENTS         337, 399         0         337, 399           75.00         07500 ASC (NON-DI STI NCT PART)         0         0         0         0           00000	0 0.000000		
63.00         IG300         BLOOD STORING, PROCESSING & TRANS.         0         0           64.00         INTRAVENOUS THERAPY         2,968,398         575,697         3,544,099           66.00         06500         RESPIRATORY THERAPY         1,570,794         5,764,714         7,335,500           67.00         6600         OCOUDATIONAL THERAPY         863,109         845,484         1,708,592           68.00         06600         SPEECH PATHOLOGY         402,368         304,202         706,576           69.00         06600         ELECTROCARDIOLOGY         2,505,699         6,825,618         9,331,317           71.00         07000         ELECTROCARDIOLOGY         2,574,194         18,784,876         44,732,044           72.00         07300         DRUS CHARGED TO PATIENTS         28,866,668         6,995,855         35,826,255           73.00         07300         DRUS CHARGED TO PATIENTS         30,74,961         22,557,945,512,742,90           74.00         07400         RENAL DIALYSIS         337,399         0         337,399           75.00         07500 ASC (NON-DI STINCT PART)         0         0         0         0           75.00         08900 RIPAL HEALTH CLINIC         0         0         0	0 0.000000		
64.00         06400         INTRAVENOUS THERAPY         0         0         0           65.00         06500         RESPI RATORY THERAPY         2,968,398         575,697         3,544,092           66.00         06600         PHYSI CAL THERAPY         1,570,794         5,764,714         7,335,500           67.00         0CCUPATI ONAL THERAPY         863,109         845,484         1,708,592           68.00         06800         SPECH PATHOLOGY         402,368         304,202         706,577           70.00         06900         ELECTROCARDI OLOGY         2,505,699         6,825,618         9,331,31           71.00         07000         MEDI CAL SUPPLIES CHARGED TO PATIENTS         28,866,668         6,959,585         35,826,253           73.00         07300         REUS CHARGED TO PATIENTS         28,866,668         6,959,585         35,826,253           73.00         07400         REVAL DIALYSIS         30,174,961         22,567,945         52,742,900           75.00         07500         ASC (NON-DI STINCT PART)         0         0         0         0         0           00         08000         REAULTH CLINIC         0         0         0         0         0         0         0         0 <td></td> <td></td> <td></td>			
65.00       06500       RESPI RATORY THERAPY       2, 968, 398       575, 697       3, 544, 092         66.00       06600       PHYSI CAL THERAPY       1, 570, 794       5, 764, 714       7, 335, 500         68.00       06800       SPEECH PATHOLOGY       402, 368       304, 202       706, 57         69.00       06900       ELECTROENCEPHALOGRAPHY       2, 505, 699       6, 825, 618       9, 331, 317         71.00       07000       ELECTROENCEPHALOGRAPHY       754, 194       3, 594, 829       4, 349, 022         71.00       07000       ELECTROENCEPHALOGRAPHY       754, 194       18, 784, 876       44, 732, 044         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       28, 866, 668       6, 959, 985       35, 826, 255         73.00       07300       DRUS CHARGED TO PATI ENTS       30, 174, 961       22, 567, 945       52, 742, 90         75.00       07500       ASC (NON-DI STINCT PART)       0       0       0       0         00100       07900       KIPAL HEALTH CLINIC       0 <td>0 0.000000 0 0.000000</td> <td></td> <td></td>	0 0.000000 0 0.000000		
66.00       06600       PHYSI CAL THERAPY       1, 570, 794       5, 764, 714       7, 335, 500         67.00       06700       OCCUPATI IONAL THERAPY       863, 109       845, 484       1, 708, 590         68.00       06800       SPEECH PATHOLOGY       2, 505, 699       6, 825, 618       9, 331, 311         70.00       07000       ELECTROCARDI OLOGY       2, 505, 699       6, 825, 618       9, 331, 311         71.00       07100       MPL       LECTROCARDI PATHENTS       25, 947, 169       18, 784, 876       44, 732, 043         72.00       07200       IMPL       DEV. CHARGED TO PATI ENTS       28, 866, 668       6, 959, 585       35, 826, 255         73.00       07300       DRUGS CHARGED TO PATI ENTS       301, 749, 961       22, 567, 945       52, 742, 900         74.00       07400       RENAL DI ALYSIS       337, 399       0       337, 399         75.00       08800       RUGAL HEALTH CLINIC       0       0       0         88.00       08800       RUL HEALTH CLINIC       0 <td></td> <td></td> <td>•</td>			•
68.00       06800       SPEECH PATHOLOGY       402,368       304,202       706,57         69.00       06900       ELECTROCARDIOLOGY       2,505,699       6,825,618       9,331,31         71.00       07000       ELECTROCARDIOLOGY       25,947,169       18,784,876       44,732,043         71.00       07100       IMPL. DEV. CHARGED TO PATIENTS       28,866,668       6,959,585       35,826,253         73.00       07400       RENAL DIALYSIS       30,174,961       22,567,945       52,742,900         74.00       07400       RENAL DIALYSIS       337,399       0       337,399       0         00       0400       RENAL DIALYSIS       337,399       0       0       0       0         00       07500       ASC (NON-DISTINCT PART)       0       0       0       0       0         00       08800       REBRALLY QUALIFIED HEALTH CENTER       0 <td< td=""><td></td><td></td><td></td></td<>			
69.00       06900       ELECTROCARDIOLOGY       2, 505, 699       6, 825, 618       9, 331, 31         70.00       OTOOO ELECTROCENCEPHALOGRAPHY       754, 194       3, 594, 829       4, 349, 023         71.00       OTOOO MEDICAL SUPPLIES CHARGED TO PATIENTS       25, 947, 169       18, 784, 876       44, 732, 044         72.00       07200       IMPL.       DEV. CHARGED TO PATIENTS       28, 866, 668       6, 959, 585       35, 826, 253         73.00       OTOOO REJCS CHARGED TO PATIENTS       30, 174, 961       22, 567, 945       52, 742, 900         75.00       07500 ASC (NON-DISTINCT PART)       0       0       0       0         00       07500 ASC (NON-DISTINCT PART)       0       0       0       0       0         00       08900 FUBCRALLY QUALIFIED HEALTH CENTER       0			
70.00       07000       ELECTROENCEPHALOGRAPHY       754, 194       3, 594, 829       4, 349, 023         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       25, 947, 169       18, 784, 876       44, 732, 04         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       28, 866, 668       6, 959, 585       35, 826, 255         73.00       07400       RENAL DI ALYSI S       337, 399       0       337, 399         75.00       07500       ASC (NON-DI STI NCT PART)       0       0       0         00000       CUTPATI ENT SERVICE COST CENTERS       337, 399       0       0       0         88.00       08800       RURAL HEALTH CLINIC       0       0       0       0       0         90.01       09001       FEDERALLY QUALI FIED HEALTH CENTER       0 <td></td> <td>0. 000000</td> <td>•</td>		0. 000000	•
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       25, 947, 169       18, 784, 876       44, 732, 043         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       28, 866, 668       6, 959, 585       35, 826, 253         73.00       07400       RENAL DI ALYSI S       30, 739       0       337, 399       0       337, 399         75.00       07500       ASC (NON-DI STI NCT PART)       0       0       0       0         0UTPATIENT SERVICE COST CENTERS       0       0       0       0       0       0       0         88.00       08800       RURAL HEALTH CLINIC       0		0.000000	
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       28,866,668       6,959,585       35,826,253         73.00       07300       DRUGS CHARGED TO PATIENTS       30,174,961       22,567,945       52,742,900         74.00       07400       RENAL DI ALYSI S       30,174,961       22,567,945       52,742,900         00       07500       ASC (NON-DISTINCT PART)       0       0       0       0         00       00       0       0       0       0       0       0       0         88.00       0800       RURAL HEALTH CLINIC       0			
74.00       07400       RENAL DIALYSIS       337, 399       0       337, 399         75.00       07500       ASC (NON-DISTINCT PART)       0       0       0         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0       0         88.00       08800       RURAL HEALTH CLINIC       0			
75.00       O7500       ASC (NON-DI STINCT PART)       O       O         0UTPATI ENT SERVICE COST CENTERS         88.00       08800       RURAL HEALTH CLINIC       O       O       O         90.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       O       O       O         90.01       09000       CLINIC       O       O       O       O         90.02       09002       KIDS PLUS CLINIC       O       O       O       O       O         90.03       09003       MCOLOGY       O			
OUTPATI ENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC         0         0         0           89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0			
88.00         08800         RURAL HEALTH CLINIC         0         0         0           89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0	0 0.00000	0. 000000	75.00
89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0         0         0           90.00         09000         CLINIC         0	0 0.00000	0.00000	88.00
90.01       09001       WOUND/OSTOMY CLINIC       0       5,519,381       5,519,381         90.02       VIDS PLUS CLINIC       0       0       0         90.03       09002       KIDS PLUS CLINIC       0       0       0         90.04       09004       MUNCLE CLINIC       0       0       0       0         90.05       09005       ANTI COAGULATION CLINIC       0       1,058,064       1,058,064         90.05       09007       O/P LAB       0       0       0       0         90.06       09009       FREGNANCY PLUS       0       0       0       0         90.07       09007       O/P LAB       0       0       0       0       0         90.08       09009       FORTVI LLE CLINIC       0	0 0.000000		
90.02         09002         KI DS PLUS CLINIC         0         0         0           90.03         09003         0NCOLOGY         0         9, 026, 233         9, 00         0	0 0.000000		
90.03         09003         0NCOLOGY         0         9,026,233         9,00         9,00         9,00         9,00         9,00         9,00         9,00			
90. 04         09004         MUNCI E CLINIC         0	0 0. 000000 3 0. 000000		
90.05         09005         ANTI COAGULATI ON CLINIC         0         1,058,064         1,058,064         1,058,064         1,058,064         1,058,064         1,058,064         1,058,064         1,058,064         1,058,064         1,058,064         0	0 0.000000		•
90. 07         09007         0/P LAB         0         0           90. 08         09008         0/P LAB         0         0         0           90. 09         90009         FORTVI LLE CLINIC         0         0         0         0           91. 00         09100         EMERGENCY         8, 121, 960         29, 578, 987         37, 700, 94           92. 00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART)         0         6, 362, 076         6, 362, 076           07HER         REI MBURSABLE         COST CENTERS         0         0         0         0           94. 00         09500         AMBULANCE SERVI CES         0			
90.08         09008         0/P LAB         0         0           90.09         PORTVILLE CLINIC         0         0         0           91.00         09009         FORTVILLE CLINIC         0         0         0           92.00         09200         DBSERVATION BEDS (NON-DISTINCT PART)         0         6, 362, 076         6, 362, 076           92.00         09200         DBSERVATION BEDS (NON-DISTINCT PART)         0         6, 362, 076         6, 362, 076           0         09400         HOME PROGRAM DIALYSIS         0         0         0         0           94.00         09400         IMBULANCE SERVICES         0         0         0         0           95.00         09500         AMBULANCE SERVICES         0         0         0         0           96.00         09400         IMABLE MEDICAL EQUIP-RENTED         0         0         0         0           97.00         09700         DURABLE MEDICAL EQUIP-SOLD         0	0 0.000000		
90.09         09009         FORTVILLE CLINIC         0         0         0           91.00         09100         EMERGENCY         8, 121, 960         29, 578, 987         37, 700, 94         37, 700, 94           92.00         09200   0BSERVATION BEDS (NON-DISTINCT PART)         0         6, 362, 076         6, 362, 076         6, 362, 076           01.00         09400   HOME PROGRAM DI ALYSI S         0	0 0.00000		•
91.00         09100         EMERGENCY         8, 121, 960         29, 578, 987         37, 700, 94           92.00         OBSERVATI ON BEDS (NON-DI STI NCT PART)         0         6, 362, 076         6, 362, 076         6, 362, 076           94.00         O9400         HOME PROGRAM DI ALYSI S         0         0         0         0           95.00         09500         AMBULANCE SERVI CES         0 <td>0 0.000000 0 0.000000</td> <td></td> <td></td>	0 0.000000 0 0.000000		
92.00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART)         0         6, 362, 076         6, 362, 076           0THER         REI MBURSABLE         COST CENTERS         0			
OTHER         REI MBURSABLE         COST         CENTERS           94.00         09400         HOME         PROGRAM         DI ALYSI S         0			
95.00         09500         AMBULANCE SERVICES         0 </td <td></td> <td>r</td> <td>1</td>		r	1
96.00         09600         DURABLE         MEDICAL         EQUIP-RENTED         0         <	0 0.000000		
97.00         09700         DURABLE MEDI CAL EQUI P-SOLD         0         0         0           99.00         09900         CMHC         0	0 0. 000000 0 0. 000000		
99.00         09900         CMHC         0         0         0           99.10         09910         CORF         0         0         0           100.00         10000         I & R SERVI CES-NOT APPRVD PRGM         0         0         0           101.00         10100         HOME HEALTH AGENCY         0         0         0         0           SPECIAL PURPOSE COST CENTERS	0 0.000000		
99. 10         09910         CORF         0         0         0           100. 00         10000         I & R SERVI CES-NOT APPRVD PRGM         0         0         0         0           101. 00         10100         HOME HEALTH AGENCY         0	0		99.00
101.00         10100         HOME         HEALTH         AGENCY         0	0		99.10
SPECIAL PURPOSE COST CENTERS	0		100.00
	0	I	101.00
	0		105.00
	0		106.00
	0		107.00
	0		108.00 109.00

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 01/01/2015 To 12/31/2015		enared.
				10 12/01/2010	5/24/2016 1:2	
		Ti t	le XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0		111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0		115.00
116. 00 11600 HOSPI CE	0	0		0		116.00
200.00 Subtotal (see instructions)	196, 359, 442	246, 789, 308	443, 148, 75	0		200.00
201.00 Less Observation Beds						201.00
202.00   Total (see instructions)	196, 359, 442	246, 789, 308	443, 148, 75	0		202.00

	I Financial Systems FATION OF RATIO OF COSTS TO CHARGES	COMMUNI TY HOSPI TAL	ANDERSON Provider CCN: 150113	In Lie Period: From 01/01/2015	u of Form CMS-2552-10 Worksheet C Part I
				To 12/31/2015	Date/Time Prepared: 5/24/2016 1:26 pm
	Cost Center Description	PPS Inpatient	Title XIX	Hospi tal	Cost
		Rati o 11.00			
20.00	INPATIENT ROUTINE SERVICE COST CENTERS				20.00
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNI T				30.00 31.00
32.00	03200 CORONARY CARE UNI T				32.00
33.00	03300 BURN I NTENSI VE CARE UNI T				33.00
34.00 40.00	03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF				34.00 40.00
41.00	04100 SUBPROVI DER – I RF				40.00
42.00	04200 SUBPROVI DER				42.00
43.00	04300 NURSERY				43.00
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY				44.00 45.00
46.00	04600 OTHER LONG TERM CARE				46.00
	ANCI LLARY SERVI CE COST CENTERS				
50.00 51.00	05000 OPERATING ROOM	0. 000000			50.00
51.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0. 000000 0. 000000			51.00 52.00
53.00	05300 ANESTHESI OLOGY	0. 000000			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
55.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0. 000000			55.00
56.00 57.00	05700 CT SCAN	0. 000000 0. 000000			56.00 57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0. 000000			60. 00 60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000 0. 000000			61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
64.00 65.00	06400 I NTRAVENOUS THERAPY	0. 000000			64.00
66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0. 000000 0. 000000			65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000			68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000			69.00
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 000000 0. 000000			70.00 71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
74.00 75.00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0. 000000 0. 000000			74.00 75.00
75.00	OUTPATIENT SERVICE COST CENTERS	0.000000			/5.00
88.00	08800 RURAL HEALTH CLINIC	0. 000000			88.00
89.00		0. 000000			89.00
90. 00 90. 01	09000 CLINIC 09001 WOUND/OSTOMY CLINIC	0. 000000 0. 000000			90. 00 90. 01
90.01	09002 KIDS PLUS CLINIC	0. 000000			90.02
90.03	09003 ONCOLOGY	0. 000000			90. 03
90.04		0. 000000			90.04
90. 05 90. 06	09005 ANTI COAGULATI ON CLINIC 09006 PREGNANCY PLUS	0. 000000 0. 000000			90. 05 90. 06
90.00 90.07	09007 0/P LAB	0. 000000			90.07
90.08	09008 0/P LAB	0. 000000			90.08
90.09	09009 FORTVILLE CLINIC	0. 000000			90.09
91.00 92.00	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 000000 0. 000000			91.00 92.00
.2.00	OTHER REIMBURSABLE COST CENTERS				/2.00
94.00	09400 HOME PROGRAM DI ALYSI S	0. 000000			94.00
95.00 96.00		0. 000000 0. 000000			95.00 96.00
98.00 97.00		0. 000000			98.00
	09900 CMHC				99.00
	09910 CORF				99.10
	D 10000 I & R SERVICES-NOT APPRVD PRGM D 10100 HOME HEALTH AGENCY				100. 00 101. 00
101.00	SPECIAL PURPOSE COST CENTERS				101.00
	10500 KI DNEY ACQUI SI TI ON				105.00
	10600 HEART ACQUI SI TI ON				106.00
	D 10700 LIVER ACQUISITION D 10800 LUNG ACQUISITION				107.00 108.00
	D 10900 PANCREAS ACQUISITION				109.00
110.00	11000 INTESTINAL ACQUISITION				110.00
111.00	DI11100 I SLET ACQUI SI TI ON				111.00

Health Financial Systems	COMMUNI TY HOSPI T	TAL ANDERSON	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150113	Period:	Worksheet C
			From 01/01/2015 To 12/31/2015	Part I Date/Time Prepared:
				5/24/2016 1:26 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
113.00 11300 INTEREST EXPENSE				113.00
114.00 11400 UTILIZATION REVIEW-SNF				114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)				115.00
116.00 11600 HOSPI CE				116.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der	CCN: 150113	Period: From 01/01/2015 To 12/31/2015		pared: 6 pm
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cos (col. 1 - co 2)	l.	3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT 32. 00 CORONARY CARE UNIT 33. 00 BURN INTENSIVE CARE UNIT 34. 00 SUBPROVIDER - IPF 41. 00 SUBPROVIDER - IRF 42. 00 SUBPROVIDER 43. 00 NURSERY 44. 00 SKILLED NURSING FACILITY 45. 00 NURSING FACILITY 200. 00 Total (lines 30-199) Cost Center Description		Inpatient Program Capital Cost (col. 5 x col. 6)	1, 871, 9 268, 4 56, 4 2, 196, 9	50         1, 317           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           93         2, 103           0         0           0         0		31.00 32.00 33.00 34.00 40.00 41.00 42.00
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 SURGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 42.00 SUBPROVIDER - IRF 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30-199)	9, 095 1, 268 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	258, 456 C C C C C C C C C C C C C C C C C C C				30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 00 200. 00

Health Financial Systems	COMMUNI TY HOSP	ITAL ANDERSON		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provi der	CCN: 150113	Period: From 01/01/2015 To 12/31/2015		pared:
			e XVIII	Hospi tal	972472016 1:2 PPS	o pili
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,				column 4)	
	Part II, col.	8)	2)			
	26)		, í			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 668, 961	58, 362, 902	0. 02859	96 10, 025, 817	286, 698	50.00
51.00 05100 RECOVERY ROOM	0	0	0.0000	0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.0000	0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	31, 720	3, 166, 245	0.0100	411, 097	4, 118	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	815, 242	20, 966, 384	0. 03888	2, 447, 241	95, 156	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		0.0000		0	55.00
56. 00 05600 RADI OI SOTOPE	50, 191	11, 874, 277			1, 872	
57.00 05700 CT SCAN	43, 993				5, 023	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	36, 756				2, 410	
59. 00 05900 CARDI AC CATHETERI ZATI ON	158, 215					59.00
60. 00 06000 LABORATORY	450,000				59, 554	60.00
60. 01 06001 BLOOD LABORATORY	430,000	00, 770, 707	0.0000		0	60.01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0.00000	0	0	61.00
	10 714	1 500 010	0.0123	243, 625	2 0 2 0	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	18, 716				3, 020	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.0000		0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0		0.0000		0	64.00
65. 00 06500 RESPI RATORY THERAPY	70, 805				43, 276	65.00
66. 00 06600 PHYSI CAL THERAPY	68, 575				8, 365	66.00
67.00 06700 OCCUPATI ONAL THERAPY	25, 494				6, 889	67.00
68.00 06800 SPEECH PATHOLOGY	15, 157				5, 314	68.00
69.00 06900 ELECTROCARDI OLOGY	129, 668				23, 538	
70.00 07000 ELECTROENCEPHALOGRAPHY	60, 878					
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	195, 466					
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	199, 924					
73.00 07300 DRUGS CHARGED TO PATIENTS	175, 755				47, 594	
74.00 07400 RENAL DIALYSIS	5, 750	337, 399			2, 672	
75.00 07500 ASC (NON-DISTINCT PART)	0	C	0.0000	00 0	0	75.00
OUTPATIENT SERVICE COST CENTERS	1					
88.00 08800 RURAL HEALTH CLINIC	0		0.0000		0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.0000	0 0	0	89.00
90. 00 09000 CLINIC	0	0	0.0000	0 0	0	90.00
90. 01 09001 WOUND/OSTOMY CLINIC	253, 102	5, 519, 381	0. 0458	57 0	0	90.01
90. 02 09002 KIDS PLUS CLINIC	31, 568	0	0.0000	0 0	0	90.02
90. 03 09003 0NCOLOGY	0	C	0.0000	0 0	0	90.03
90.04 09004 MUNCIE CLINIC	45, 943	0	0.0000	0 0	0	90.04
90.05 09005 ANTICOAGULATION CLINIC	8, 709	1, 058, 064	0.00823	31 0	0	90.05
90. 06 09006 PREGNANCY PLUS	52, 016	C	0.0000		0	90.06
90. 07 09007 0/P LAB	0	C	0.0000		0	90.07
90. 08 09008 0/P LAB	0	0	0.0000		0	
90. 09 09009 FORTVILLE CLINIC	24, 213	-			0	
91. 00 09100 EMERGENCY	381, 100					91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	200, 238				0	
OTHER REIMBURSABLE COST CENTERS	200,200	5,002,070	0.0014			1
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0.0000	00 0	0	94.00
95. 00 09500 AMBULANCE SERVICES		Ĭ	0.00000		l	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0	0.0000	0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD			0.0000		0	•
200.00 Total (lines 50-199)	5, 218, 155	391, 431, 219		71, 782, 932		
200.00   10tal (11163 30-177)	1 5,210,100	371,431,217	I	11,102,732	1 770,414	1200.00

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTH		S Provi der	F	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part III Date/Time Pre 5/24/2016 1:2	pared:
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Cost	Medical Education Cost	instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00       03000       ADULTS & PEDIATRICS         31. 00       03100       INTENSIVE CARE UNIT         32. 00       03200       CORONARY CARE UNIT         33. 00       03300       BURN INTENSIVE CARE UNIT         34. 00       03400       SURGICAL INTENSIVE CARE UNIT         40. 00       04000       SUBPROVIDER - IPF         41. 00       04100       SUBPROVIDER - IRF         42. 00       04200       SUBPROVIDER         43. 00       04300       NURSERY         44. 00       04400       SKILLED NURSING FACILITY		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	42.00
200.00 Total (lines 30-199)	0	0			0	200.00
Cost Center Description	Total Patient F Days 6.00	Per Diem (col. 5 ÷ col. 6) 7.00	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00		
ADJULTS         PEDIATRICS           30.00         03000         ADULTS         PEDIATRICS           31.00         03100         INTENSIVE CARE UNIT           32.00         03200         CORONARY CARE UNIT           33.00         03300         BURN INTENSIVE CARE UNIT           33.00         03400         SURGICAL INTENSIVE CARE UNIT           34.00         03400         SUBGICAL INTENSIVE CARE UNIT           40.00         04000         SUBPROVIDER - IPF           41.00         04100         SUBPROVIDER - IRF           42.00         04200         SUBPROVIDER           43.00         04300         NURSERY           44.00         04400         SKILLED           45.00         04500         NURSING           45.00         04500         NURSING           45.00         04500         NURSING           45.00         04500         NURSING           45.00         04500         NURSING	22, 830 1, 317 0 0 0 0 0 0 2, 103 0 0 26, 250	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	1, 268	3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		30.00 31.00 32.00 33.00 34.00 40.00 41.00 42.00 43.00 44.00 45.00 200.00

Heal th	Financial Systems	COMMUNI TY HOSP	TAL ANDERSON		In Lie	eu of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS	RVICE OTHER PASS	S Provi der		Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Pre 5/24/2016 1:2	
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Allied Health		Total Cost	
		Anestheti st			Medi cal	(sum of col 1	
		Cost			Education Cost		
		1.00	2.00	3.00	4.00	4)	
	ANCI LLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50.00	05000 OPERATI NG ROOM	0	C	)	0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	( C		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	)	0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	)	0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	( C	)	0 0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	( C	)	0 0	0	55.00
56.00	05600 RADI OI SOTOPE	0	( C		0 0	0	
57.00	05700 CT SCAN	0	C		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	C	)	0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C	)	0 0	0	
60.00	06000 LABORATORY	0	C	)	0 0	0	
60.01	06001 BLOOD LABORATORY	0	0	)	0 0	0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		)	0 0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		)	0 0	0	
64.00	06400 I NTRAVENOUS THERAPY	0			0 0	0	
65.00		0			0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0			0 0	0	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0			0 0	0	
69.00	06900 ELECTROCARDI OLOGY	0			0 0	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0			0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	0			0 0	0	
74.00	07400 RENAL DIALYSIS	0			0 0	0	
75.00	07500 ASC (NON-DI STINCT PART)	0			0 0		
	OUTPATIENT SERVICE COST CENTERS		-			-	
88.00	08800 RURAL HEALTH CLINIC	0	C	)	0 0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	( C		0 0	0	89.00
90.00	09000 CLINIC	0	( C		0 0	0	90.00
90.01	09001 WOUND/OSTOMY CLINIC	0	0	)	0 0	0	90.01
90. 02	09002 KIDS PLUS CLINIC	0	C		0 0	0	90.02
90.03	09003 ONCOLOGY	0	C		0 0	0	90.03
90.04	09004 MUNCIE CLINIC	0	( C		0 0	0	90.04
90.05	09005 ANTI COAGULATI ON CLINIC	0	( C		0 0	0	
90.06	09006 PREGNANCY PLUS	0	C	)	0 0	0	
90.07	09007 0/P LAB	0	C	)	0 0	0	90.07
90.08	09008 0/P LAB	0	C	)	0 0	0	
	09009 FORTVILLE CLINIC	0	C	)	0 0	Ű Ő	
	09100 EMERGENCY	0					
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	C	<u>и</u>	0 0	0	92.00
94.00	OTHER REIMBURSABLE COST CENTERS	0	C	1	0 0	0	04 00
	09500 AMBULANCE SERVICES				0		94.00 95.00
	09600 DURABLE MEDICAL EQUIP-RENTED		r		0 0	0	
	09700 DURABLE MEDICAL EQUIP-RENTED	0			0 0		1
200.00		0		305, 45			
200.00		1 0	i C	1 505,45	. 0	1 505, 457	

		COMMUNI TY HOSP			In Lie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provi der		Period:	Worksheet D	
THROUG	COSTS				From 01/01/2015 To 12/31/2015	Part IV Date/Time Pre	narad
					To 12/31/2015	5/24/2016 1:2	6 nm
			Ti tl	e XVIII	Hospi tal	PPS	<u>o p</u>
	Cost Center Description	Total	Total Charges			Inpati ent	
		Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of		(col. 5 ÷ col.		Charges	
		col. 2, 3 and	8)	7)	(col. 6 ÷ col.	-	
		4)			7)		
		6.00	7.00	8.00	9.00	10.00	
	ANCI LLARY SERVI CE COST CENTERS	1	1	1	-		
50.00	05000 OPERATING ROOM	0					50.00
51.00	05100 RECOVERY ROOM	0	0				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000	0. 000000	0	52.00
53.00	05300 ANESTHESI OLOGY	0	3, 166, 245	0.00000	0. 000000	411, 097	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	20, 966, 384	0.00000	0. 000000	2, 447, 241	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0.00000	0. 000000	0	55.00
56.00	05600 RADI OI SOTOPE	0	11, 874, 277	0.00000	0. 000000	442, 850	56.00
57.00	05700 CT SCAN	0	27, 277, 297	0.00000	0. 000000	3, 114, 201	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	11, 288, 528	0.00000	0. 000000	740, 067	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	9, 735, 621	0.00000	0. 000000	1, 291, 746	59.00
60.00	06000 LABORATORY	0	35, 995, 969	0.00000	0. 000000	4, 763, 932	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0.00000	0. 000000	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1, 509, 819	0.00000	0. 000000	243, 625	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0					63.00
64.00	06400 I NTRAVENOUS THERAPY	0	c c				64.00
65.00	06500 RESPI RATORY THERAPY	0	3, 544, 095				•
66.00	06600 PHYSI CAL THERAPY	0					•
67.00	06700 OCCUPATI ONAL THERAPY	0		1			
68.00	06800 SPEECH PATHOLOGY	0					
69.00	06900 ELECTROCARDI OLOGY						69.00
70.00	07000 ELECTROENCEPHALOGRAPHY						•
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS						
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS			1			
73.00	07300 DRUGS CHARGED TO PATIENTS						73.00
74.00	07400 RENAL DI ALYSI S						•
	07500 ASC (NON-DISTINCT PART)			1			75.00
70.00	OUTPATIENT SERVICE COST CENTERS	ŬŬ	<u> </u>	0.00000	0.000000		/0.00
88.00	08800 RURAL HEALTH CLINIC	0	C	0.00000	0. 000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000 CLINIC			1		0	90.00
90.01	09001 WOUND/OSTOMY CLINIC			1		0	90.01
90.02	09002 KIDS PLUS CLINIC			0. 000000		0	90.02
90.02	09003 ONCOLOGY		-			0	90.03
90. 03 90. 04	09004 MUNCIE CLINIC		7, 020, 233	0.00000		0	90.03
90.04 90.05	09005 ANTI COAGULATI ON CLINIC		1, 058, 064			0	90.04
90.05 90.06	09006 PREGNANCY PLUS			0.00000		0	90.05
90.08 90.07	09007 0/P LAB		-	1		-	90.08
	09008 0/P LAB						•
							90.08 90.09
	09009 FORTVILLE CLINIC	205 457					
91.00	09100 EMERGENCY	305, 457					1
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	6, 362, 076	0.00000	0. 000000	0	92.00
04.00	OTHER REIMBURSABLE COST CENTERS	-		0.00000			04.00
	09400 HOME PROGRAM DI ALYSI S	0	C	0.00000	0. 000000	0	
95.00	09500 AMBULANCE SERVICES	_	_	0.00000	0 000000	_	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0.00000			
	09700 DURABLE MEDICAL EQUIP-SOLD	205 457		0.00000	0. 000000		
200.00	Total (lines 50-199)	305, 457	400, 457, 452			71, 782, 932	1200. OO

	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	Provi der	CCN: 150113	Period: From 01/01/2015	Worksheet D Part IV	
					To 12/31/2015	Date/Time Pre 5/24/2016 1:2	
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Inpati ent	Outpati ent	Outpati ent			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8		Costs (col.	9		
		x col. 10) 11.00	12.00	x col. 12) 13.00			
	ANCI LLARY SERVI CE COST CENTERS	11.00	12.00	13.00			
0.00	05000 OPERATI NG ROOM	0	12, 098, 138		0		50.00
1.00	05100 RECOVERY ROOM	0	0	1	0		51.00
2.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52.00
3.00	05300 ANESTHESI OLOGY	0	354, 530		0		53.00
4.00	05400 RADI OLOGY-DI AGNOSTI C	0	7, 597, 258		0		54.0
5.00	05500 RADI OLOGY-THERAPEUTI C	0	0	1	0		55.00
6.00	05600 RADI OLSOTOPE	0	3, 728, 125		0		56.0
7.00	05700 CT SCAN	0	7, 088, 616		0		57.0
8.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	2, 995, 959		0		58.0
9.00	05900 CARDI AC CATHETERI ZATI ON	0	2, 993, 939		0		59.0
0.00	06000 LABORATORY	0	3, 785, 217		0		60.0
0.00	06001 BLOOD LABORATORY	0	3,785,217	1	0		60.0
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0		
1.00		0	1// 701		0		61.0
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	166, 731	1	0		62.0
3.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	1	0		63.0
4.00	06400 I NTRAVENOUS THERAPY	0	0		0		64.0
5.00	06500 RESPI RATORY THERAPY	0	1, 708, 868	1	0		65.0
6.00	06600 PHYSI CAL THERAPY	0	1, 526		0		66.0
7.00	06700 OCCUPATI ONAL THERAPY	0	1, 294		0		67.00
8.00	06800 SPEECH PATHOLOGY	0	2, 094		0		68.0
9.00	06900 ELECTROCARDI OLOGY	0	2, 954, 848		0		69.0
0.00	07000 ELECTROENCEPHALOGRAPHY	0	1,055,550	1	0		70.0
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5, 112, 825		0		71.0
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 457, 010		0		72.0
3.00	07300 DRUGS CHARGED TO PATIENTS	0	8, 104, 536	•	0		73.0
4.00	07400 RENAL DIALYSIS	0	0		0		74.0
5.00	07500 ASC (NON-DI STINCT PART)	0	0		0		75.0
	OUTPATIENT SERVICE COST CENTERS	- <u>1</u>					
8.00	08800 RURAL HEALTH CLINIC	0	0		0		88.0
9.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89.0
0.00	09000 CLINIC	0	0		0		90.0
0. 01	09001 WOUND/OSTOMY CLINIC	0	0		0		90.0
0. 02	09002 KIDS PLUS CLINIC	0	0		0		90.0
0.03	09003 ONCOLOGY	0	0		0		90.0
0.04	09004 MUNCIE CLINIC	0	0		0		90.0
0.05	09005 ANTI COAGULATI ON CLINIC	0	0	)	0		90.0
0. 06	09006 PREGNANCY PLUS	0	0		0		90.0
0. 07	09007 0/P LAB	0	0		0		90.0
0. 08	09008 0/P LAB	0	0		0		90.0
	09009 FORTVILLE CLINIC	0	0		0		90.0
	09100 EMERGENCY	27, 221	5, 623, 734	45, 5	63		91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 289, 788		0		92.0
	OTHER REIMBURSABLE COST CENTERS		_, _c, , , 00				1.2.0
4,00	09400 HOME PROGRAM DI ALYSI S	0	0		0		94.0
	09500 AMBULANCE SERVICES		0				95.0
	09600 DURABLE MEDICAL EQUIP-RENTED	0	Ω		0		96.0
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		õ		97.0
	Total (lines 50-199)	- V	0	1	~		1

alth Financial Systems PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES	COMMUNITY HOSP AND VACCINE COST	Provi der	  - 	Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 5/24/2016 1:2	pared:
		Ti tl	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0 227224	12 000 120			0 750 107	
0.00 05000 OPERATING ROOM	0. 227324			0 0	2, 750, 197	50.00
1.00 05100 RECOVERY ROOM	0. 000000			0 0	0	51.00
2.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			0 0	0	52.00
3. 00 05300 ANESTHESI OLOGY	0. 110206			0 0	39, 071	53.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 305317		1	0 0	2, 319, 572	54.00
5. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000		(	0 0	0	55.00
6. 00 05600 RADI OI SOTOPE	0. 078080		(	0 0	291, 092	56.00
7.00 05700 CT SCAN	0. 027988			0 0	198, 396	57.00
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 070436	2, 995, 959	(	0 0	211, 023	58.00
9. 00 05900 CARDI AC CATHETERI ZATI ON	0. 146301	2, 164, 276	. (	0 0	316, 636	59.00
0. 00 06000 LABORATORY	0. 169871	3, 785, 217	6, 30	7 0	642, 999	60.00
0. 01 06001 BLOOD LABORATORY	0. 000000			0 0	0	60.01
1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				o o		61.00
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL				0 0	43, 307	62.00
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			0 0	0	63.00
4. 00 06400 INTRAVENOUS THERAPY	0. 000000			0 0	0	64.00
5. 00 06500 RESPI RATORY THERAPY	0. 416786		1	0 0	712, 232	65.00
6. 00 06600 PHYSI CAL THERAPY	0. 398500			0 0	608	66.00
7. 00 06700 OCCUPATI ONAL THERAPY	0. 346592			0 0	448	67.00
				0 0		
8. 00 06800 SPEECH PATHOLOGY 9. 00 06900 ELECTROCARDI OLOGY	0. 483651			-	1,013	
	0. 102771	2, 954, 848		0 0	303, 673	
0. 00 07000 ELECTROENCEPHALOGRAPHY	0. 265579			0 0	280, 332	
1. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT				0 0	1, 604, 205	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 400704			0 0	984, 534	72.00
3. 00 07300 DRUGS CHARGED TO PATIENTS	0. 188705			0 135, 388		73.00
4. 00 07400 RENAL DIALYSIS	0. 582254			0 0	0	74.00
5. 00 07500 ASC (NON-DI STINCT PART)	0. 000000	0	<u> </u> (	0 0	0	75.00
OUTPATIENT SERVICE COST CENTERS		1	1			
8.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89.00
0. 00 09000 CLINIC	0. 000000			0 0	0	90.00
0.01 09001 WOUND/OSTOMY CLINIC	0. 345148		(	0 0	0	90.01
0.02 09002 KIDS PLUS CLINIC	0. 000000		(	0 0	0	90.02
0. 03 09003 0NC0L0GY	0. 000000		(	0 0	0	90.03
0.04 09004 MUNCIE CLINIC	0. 000000	0		0 0	0	90.04
0.05 09005 ANTI COAGULATI ON CLINIC	0. 390585			0 0	0	90.05
0. 06 09006 PREGNANCY PLUS	0. 000000	0	) (	0 0	0	90.06
0.07 09007 0/P LAB	0. 000000	0	) (	0 0	0	90.07
0.08 09008 0/P LAB	0. 000000	0	) (	0 0	0	90.08
0.09 09009 FORTVILLE CLINIC	0. 000000	0	) (	0 0	0	90.09
1.00 09100 EMERGENCY	0. 178417	5, 623, 734	. (	0 0	1,003,370	91.00
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0 0	1, 043, 120	92.00
OTHER REI MBURSABLE COST CENTERS			•		, , 0	1
4. 00 09400 HOME PROGRAM DI ALYSI S	0. 000000		(	C		94.00
	0. 000000		1	0		95.00
	0. 000000			0 0	0	96.00
5.00 09500 AMBULANCE SERVICES 6.00 09600 DURABLE MEDICAL FOULP-RENTED				-		
6. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		∩	) (		1 1	
6. 00 09600 DURABLE MEDICAL EQUIP-RENTED 7. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000		6 30	-	0 14 275 194	97.00 200.00
6.00 09600 DURABLE MEDICAL EQUIP-RENTED 7.00 09700 DURABLE MEDICAL EQUIP-SOLD 00.00 Subtotal (see instructions)	0. 000000	0 69, 290, 923		-		200. 0
6.00       09600       DURABLE MEDICAL EQUIP-RENTED         7.00       09700       DURABLE MEDICAL EQUIP-SOLD         00.00       Subtotal (see instructions)         01.00       Less PBP Clinic Lab. Services-Progr	0. 000000			-		
6.00 09600 DURABLE MEDICAL EQUIP-RENTED 7.00 09700 DURABLE MEDICAL EQUIP-SOLD 00.00 Subtotal (see instructions)	0. 000000		6, 30	7 135, 388 0 0	14, 275, 194	200. 0 201. 0

ealth Financial Systems PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider (	CCN: 150113	Peri od: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Pre 5/24/2016 1:2	
		Title	× XVIII	Hospi tal	PPS	
Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00				
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00				-
050.00         05000         OPERATI NG ROOM           51.00         05100         RECOVERY ROOM           52.00         05200         DELI VERY ROOM & LABOR ROOM           53.00         05300         ANESTHESI OLOGY           64.00         05400         RADI OLOGY-DI AGNOSTI C           55.00         05500         RADI OLOGY-THERAPEUTI C           66.00         05600         RADI OL SOTOPE						50.00 51.00 52.00 53.00 54.00 55.00 56.00
NO. 00       100 (0500)       NADIO STOPLE         57. 00       05700)       CT       SCAN         58. 00       05800       MAGNETIC       RESONANCE I MAGING (MRI)         59. 00       05900)       CARDIAC       CATHETERIZATION         50. 00       06000       LABORATORY         50. 01       06001       BLOOD       LABORATORY         51. 00       06100       PBP       CLINICAL       LAB       SERVICES-PRGM       ONLY	0 0 0 1,071 0	0 0 0 0 0				57.00 57.00 58.00 59.00 60.00 60.01 61.00
52.00         06200         WHOLE BLOOD & PACKED RED BLOOD CELLS           53.00         06300         BLOOD STORING, PROCESSING & TRANS.           54.00         06400         INTRAVENOUS THERAPY           55.00         06500         RESPIRATORY THERAPY           56.00         06600         PHYSICAL THERAPY           57.00         06700         OCCUPATI ONAL THERAPY		0 0 0 0 0 0				62.00 63.00 64.00 65.00 66.00 67.00
18.00       06800       SPEECH PATHOLOGY         19.00       06900       ELECTROCARDI OLOGY         10.00       07000       ELECTROENCEPHALOGRAPHY         11.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS         12.00       07200       IMPL.       DEV.         13.00       07300       DRUGS       CHARGED TO PATIENTS         14.00       07400       RENAL DI ALYSI S		0 0 0 25, 548 0				68. 0 69. 0 70. 0 71. 0 72. 0 73. 0 74. 0
5.00 07500 ASC (NON-DISTINCT PART)	0	0				75.0
OUTPATIENT SERVICE COST CENTERS						
38.00         08800         RURAL         HEALTH         CLINIC           39.00         08900         FEDERALLY         QUALIFIED         HEALTH         CENTER           20.00         09000         CLINIC         20.00         09001         WOUND/OSTOMY         CLINIC           20.01         09001         WOUND/OSTOMY         CLINIC         20.01         209002         KIDS         PLUS         CLINIC         20.03         09003         ONCOLOGY         20.04         09004         MUNCIE         CLINIC         20.04		0 0 0 0 0 0 0				88. 00 89. 00 90. 00 90. 01 90. 02 90. 03 90. 04
0. 05 09005 ANTI COAGULATI ON CLI NI C 0. 06 09006 PREGNANCY PLUS 0. 07 09007 0/P LAB 0. 08 09008 0/P LAB 0. 09 0909 FORTVI LLE CLI NI C 1. 00 09100 EMERGENCY 2. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)		0 0 0 0 0 0 0				90. 05 90. 07 90. 07 90. 08 90. 09 91. 00 92. 00
OTHER         REI MBURSABLE         COST         CENTERS           4.00         09400         HOME         PROGRAM         DI ALYSI S           5.00         09500         AMBULANCE         SERVI CES           6.00         09600         DURABLE         MEDI CAL         EQUI P-RENTED           7.00         09700         DURABLE         MEDI CAL         EQUI P-SOLD           00.00         Subtotal         (see instructions)         01.00           01.00         Less PBP Clinic Lab.         Services-Program	0 0 0 1,071	0 0 25, 548				94. 0 95. 0 96. 0 97. 0 200. 0 201. 0
Only Charges202.00Net Charges (line 200 +/- line 201)	1, 071	25, 548				202. 0

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 150113	From 01/01/2015 To 12/31/2015	Norksheet D-1 Date/Time Pre 5/24/2016 1:2	pare
		Title XVIII	Hospi tal	PPS	.o piii
	Cost Center Description			1 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	-
	INPATIENT DAYS		1		
00 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			22, 830 22, 830	
00	Private room days (excluding swing-bed and observation bed day		ivate room davs. d		
	not complete this line.				
00	Semi-private room days (excluding swing-bed and observation be		24 6 11 1	20, 388	
00	Total swing-bed SNF type inpatient days (including private roo reporting period	om days) through Decembe	er 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)			_	_
00	Total swing-bed NF type inpatient days (including private roor	m days) through December	31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private roor	m davs) after December 3	1 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	9, 095	9
. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	nom days) through	0	10
. 00	December 31 of the cost reporting period (see instructions)	ing (mendaring private i	oom days) through	0	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11
00	December 31 of the cost reporting period (if calendar year, en			0	112
. 00	Swing-bed NF type inpatient days applicable to titles V or XLX through December 31 of the cost reporting period	x only (including privat	e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	X only (including privat	e room days) after	0	13
~~	December 31 of the cost reporting period (if calendar year, er				
	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT			-	
. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to service period	es after December 31 of	the cost reporting	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to services period	s through December 31 of	the cost reporting	g 0.00	19
	Medicaid rate for swing-bed NF services applicable to services period		he cost reporting	0.00	
. 00	Total general inpatient routine service cost (see instructions			27, 095, 466	
. 00	Swing-bed cost applicable to SNF type services through December x line 17)	er 31 of the cost report	ing period (line 5	0	22
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6 x	0	23
00	line 18) Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line 7	x 0	24
	line 19)				
. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8 x	0	25
. 00	line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		27, 095, 466	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		· 1		
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27 -	÷line 28)		0. 000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32
	Average semi-private room per diem charge (line 30 ÷ line 4)	nuo lino 22) ( i	uti ana)	0.00	
	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	
	Private room cost differential adjustment (line 3 x line 35)			0.00	
	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line 2		
. 00	minus line 36)				-
. 00	PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			1, 186. 84	38
. 00 . 00		instructions) 38)		1, 186. 84 10, 794, 310 0	39

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	COMMUNI TY HOSPI			Period: From 01/01/2015	u of Form CMS Worksheet D-	
					To 12/31/2015	Date/Time Pr 5/24/2016 1:	
			Titl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)	Program Days ÷	Program Cost (col. 3 x col 4)	
00		1.00	2.00	3.00	4.00	5.00	0 42
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	0 0		0 42
8. 00	INTENSIVE CARE UNIT	3, 741, 980	1, 317	2, 841. 2	9 1, 268	3, 602, 75	6 43
. 00	CORONARY CARE UNIT	0	0	0.0	0 0		0 44
6.00	BURN INTENSIVE CARE UNIT	0	0	010			0 45
. 00	SURGICAL INTENSIVE CARE UNIT	0	0	0.0	0 0		0 46
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
00			)     === 200)			1.00	E 40
. 00 . 00	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines A			ns)		18, 430, 98 32, 828, 05	
. 00	PASS THROUGH COST ADJUSTMENTS			113)		32, 020, 03	47
. 00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D, sum	of Parts I and	1, 004, 24	6 50
~~							
. 00	Pass through costs applicable to Program inpa IV)	atient ancillar	ry services (fr	om Wkst. D, si	um of Parts II a	ind 805, 63	5 51
2. 00	Total Program excludable cost (sum of lines !	50 and 51)				1, 809, 88	1 52
3. 00	Total Program inpatient operating cost exclude		elated, non-phy	sician anesth	etist, and medio		
	education costs (line 49 minus line 52)						_
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						0 54
. 00	Target amount per discharge						0 54
. 00	Target amount (line 54 x line 55)						0 56
00	Difference between adjusted inpatient operati	ing cost and ta	arget amount (I	ine 56 minus	ine 53)		0 57
. 00	Bonus payment (see instructions)						0 58
. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period	ending 1996, u	pdated and cor	npounded by the	0.0	0 59
. 00	market basket Lesser of lines 53/54 or 55 from prior year of	cost report un	dated by the m	arket hasket		0.0	0 60
. 00	If line 53/54 is less than the lower of lines				the amount by		0 61
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	the target amou	int	
	(line 56), otherwise enter zero (see instruc	tions)					
. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ont (coo instru	uctions)				0 62
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST						0 03
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	cost reporti	ng period (See		0 64
	instructions)(title XVIII only)						
6.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the c	ost reporting	period (See		0 65
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVII)	only) For CA	1	0 66
	(see instructions)				0111 971 1 01 01		
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	n December 31 c	f the cost re	porting period		0 67
3. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	o costs after D	locombor 21 of	the cost repo	sting poriod (Li	<b>n</b> 0	0 68
5. 00	13 x line 20)		ecember 31 01	the cost repo	ting period (n	ne	0 00
9.00	Total title V or XIX swing-bed NF inpatient	`	•	,			0 69
~~~	PART III - SKILLED NURSING FACILITY, OTHER NU						
. 00 . 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co						70
. 00	Program routine service cost (line 9 x line		The 70 - The	2)			72
. 00	Medically necessary private room cost applica		n (line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine servi						74
. 00	Capital-related cost allocated to inpatient	routine service	e costs (from W	orksheet B, Pa	art II, column 2	26,	75
. 00	line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
. 00	Program capital -related costs (line 9 x line	,					77
00	Inpatient routine service cost (line 74 minus	,					78
. 00	Aggregate charges to beneficiaries for excess						79
00	Total Program routine service costs for compa		cost limitation	(line 78 min	us line 79)		80
. 00 . 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (li						81
. 00	Reasonable inpatient routine service cost frim tatron (in						83
. 00	Program inpatient ancillary services (see ins		,				84
. 00	Utilization review - physician compensation		ons)				85
. 00	Total Program inpatient operating costs (sum		nrough 85)				86
	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					2, 44	2 87
7 00							21 0/
7.00 3.00	Adjusted general inpatient routine cost per o		line 2)			1, 186. 8	

Health Financial Systems	COMMUNI TY HOSP	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2015	Worksheet D-1	
				Fo 12/31/2015	Date/Time Pre 5/24/2016 1:2	
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	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, 871, 997	27, 095, 466	0.069089	2, 898, 263	200, 238	90.00
91.00 Nursing School cost	0	27, 095, 466	0.00000	2, 898, 263	0	91.00
92.00 Allied health cost	0	27, 095, 466	0.00000	2, 898, 263	0	92.00
93.00 All other Medical Education	0	27, 095, 466	0.00000			93.00

)MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 150113	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Pre 5/24/2016 1:2	pared
		Title XIX	Hospi tal	Cost	1
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				_
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	excluding newborn)		22, 830	1 1.
00	Inpatient days (including private room days and swing bed days Inpatient days (including private room days, excluding swing-b			22, 830	
00	Private room days (excluding swing-bed and observation bed day		ivate room days,		
	not complete this line.		-		
00	Semi-private room days (excluding swing-bed and observation be		- 21 -6 +6+	20, 388	
00	Total swing-bed SNF type inpatient days (including private roo reporting period	m days) through Decembe	er 31 of the cost	0	5.
00	Total swing-bed SNF type inpatient days (including private roo	m davs) after December	31 of the cost	0	6.
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7.
	reporting period			_	
00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	1 of the cost	0	8.
00	Total inpatient days including private room days applicable to	the Program (evoluding	swing_bed and	924	9
50	newborn days)	the riogram (excrualing	Sarrig bed and	724	<b>_</b>
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on	ly (including private r	room days) through	0	10
	December 31 of the cost reporting period (see instructions)				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on		oom days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XIX		o room dave)	0	12
. 00	through December 31 of the cost reporting period	only (the during privat	e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days) afte	r 0	13
	December 31 of the cost reporting period (if calendar year, en	ter 0 on this line)	•		
	Medically necessary private room days applicable to the Progra	m (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only)			2, 103	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			1, 939	16
. 00	Medicare rate for swing-bed SNF services applicable to service	s through December 31 c	of the cost	0.00	1 17
. 00	reporting period			0.00	
. 00	Medicare rate for swing-bed SNF services applicable to service	s after December 31 of	the cost reportin	g 0.00	18
00	period	thursuph December 21 of			10
. 00	Medicaid rate for swing-bed NF services applicable to services period	through becember 31 of	the cost reporti	ng 0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost reporting	0.00	20
	peri od				
				27, 095, 466	
. 00	Swing-bed cost applicable to SNF type services through Decembe x line 17)	r 31 of the cost report	ing period (line	5 0	22
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	a period (line 6	x 0	23
	line 18)		.9		
. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line 7	x 0	24
00	line 19) Swing had east applicable to NE type convises often December 2	1 of the east reporting	noried (line 0)	0	25
. 00	Swing-bed cost applicable to NF type services after December 3 line 20)	Tor the cost reporting	period (inne 8 x	0	25
. 00	Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost (	line 21 minus line 26)		27, 095, 466	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	Line 29)		0 0.000000	
	Average private room per diem charge (line 29 ÷ line 3)	111le 20)		0.000000	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 min	us line 33)(see instruc	tions)	0.00	
	Average per diem private room cost differential (line 34 x lin	e 31)		0.00	
	, , , , , , , , , , , , , , , , , , ,	· · ·		0	
. 00	General inpatient routine service cost net of swing-bed cost a	nd private room cost di	fferential (line	27 27, 095, 466	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU:	STMENTS			1
. 00	Adjusted general inpatient routine service cost per diem (see			1, 186. 84	38
	Program general inpatient routine service cost (line 9 x line	-		1, 096, 640	
	Medically necessary private room cost applicable to the Progra			0	
		+ line 40)			41

MPUT	ATION OF INPATIENT OPERATING COST		Provi der		eriod: rom 01/01/2015	Worksheet D-1	1
				T	o 12/31/2015		
	Cost Center Description	Total	Ti t Total	le XIX Average Per	Hospital Program Days	Cost Program Cost	
		Inpatient Cost				(col . 3 x col . 4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	1, 115, 447	2, 103	530. 41	1, 939	1, 028, 465	5 42.
00	INTENSIVE CARE UNIT	3, 741, 980	1, 317	2, 841. 29	0	(	0 43
. 00	CORONARY CARE UNI T	0	0			(	0 44
. 00	BURN INTENSIVE CARE UNIT	0	0	0.00			0 45
00	SURGI CAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	0	0.00	0		0 46 47
. 00	Cost Center Description						47
00	Program inpatient ancillary service cost (Wks		line 200)			1.00	4 40
00 00	Total Program inpatient costs (sum of lines			ns)		1, 943, 224 4, 068, 329	
00	PASS THROUGH COST ADJUSTMENTS		300 111311 4011 0	113)		1,000,02	
00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D, sum (	of Parts I and	(	0 50
. 00	<pre>III) Pass through costs applicable to Program inpa</pre>	ationt ancillar	v sorvicos (fr	om Wkst D su	m of Darte II d	and (	0 51
. 00	IV)		y services (II	UNI WKSt. D, Su	III UI FAILS II A		
. 00	Total Program excludable cost (sum of lines !						0 52
. 00	Total Program inpatient operating cost exclud	ding capital re	lated, non-phy	sician anesthe	tist, and medic	al (	0 53
	education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION					1	_
. 00	Program di scharges					(	0 54
00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)				·		0 56
. 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ing cost and ta	rget amount (i	ine 56 minus i	i ne 53)		0 57 0 58
. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period	ending 1996, u	pdated and com	pounded by the		
	market basket	0.1	0				
. 00 . 00	Lesser of lines 53/54 or 55 from prior year of lines 53/54 is less than the lower of lines				he amount by	0.00	0 60 0 61
. 00	which operating costs (line 53) are less that						
	(line 56), otherwise enter zero (see instruct				<u>.</u>		
. 00	Relief payment (see instructions)	ant (and instru	ati ana)				0 62 0 63
. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru				[(	0 63
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reportin	g period (See	(	0 64
~ ~	instructions)(title XVIII only)						
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the c	ost reporting j	period (See		0 65
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVIII	only). For CAH	<b>H</b> (	0 66
	(see instructions)				•		
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	f the cost rep	orting period	(	0 67
. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repor	tina period (li	ne (	0 68
	13 x line 20)				5 J		
. 00	Total title V or XIX swing-bed NF inpatient	· · · · · · · · · · · · · · · · · · ·		/		(	0 69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili					1	70
. 00	Adjusted general inpatient routine service of						71
. 00	Program routine service cost (line 9 x line	· ·					72
. 00 . 00	Medically necessary private room cost applica						73
. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient	•			rt II. column 2	26.	75
	line 45)						
. 00	Per diem capital-related costs (line 75 ÷ lin	,					76
00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77
00	Aggregate charges to beneficiaries for excess		rovi der record	s)			79
00	Total Program routine service costs for compa	• •			s line 79)		80
00	Inpatient routine service cost per diem limi						81
00	Inpatient routine service cost limitation (li		* .				82
	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see ins		3)				83
	Utilization review - physician compensation		ns)				85
. 00		of lines 02 th	rough 85)				86
. 00 . 00	Total Program inpatient operating costs (sum		rough 05)				
. 00 . 00 . 00 . 00	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST				2 442	2 07
. 00 . 00		S THROUGH COST				2, 442 1, 186. 84	

Health Financial Systems	COMMUNI TY HOSP	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2015	Worksheet D-1	
				To 12/31/2015	Date/Time Pre 5/24/2016 1:2	
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	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, 871, 997	27, 095, 466	0. 06908	2, 898, 263	200, 238	90.00
91.00 Nursing School cost	0	27, 095, 466	0.00000	2, 898, 263	0	91.00
92.00 Allied health cost	0	27, 095, 466	0.00000	2, 898, 263	0	92.00
93.00 All other Medical Education	0	27, 095, 466	0.00000			93.00

Health Financial Systems         COMMUNITY HOSP           INPATIENT ANCILLARY SERVICE COST APPORTIONMENT         COMMUNITY HOSP	ITAL ANDERSON	CCN: 150113	Period:	u of Form CMS- Worksheet D-3	
	11 OVI del	001. 100110	From 01/01/2015 To 12/31/2015	Date/Time Pre	epared:
	Ti tl	e XVIII	Hospi tal	5/24/2016 1:2 PPS	
Cost Center Description		Ratio of Cos To Charges	Program	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1	10 (40 507		1 20 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT			13, 640, 527 3, 622, 194		30.00
32. 00 03200 CORONARY CARE UNI T			0,022,171		32.00
33.00 03300 BURN INTENSIVE CARE UNIT			0		33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT			0		34.00
40. 00 04000 SUBPROVIDER - IPF			0		40.00
41. 00 04100 SUBPROVIDER - IRF 42. 00 04200 SUBPROVIDER			0		41.00
43. 00   04300  NURSERY			0		42.00
ANCI LLARY SERVI CE COST CENTERS					10.00
50. 00 05000 OPERATI NG ROOM		0. 2273	24 10, 025, 817	2, 279, 109	50.00
51.00 O5100 RECOVERY ROOM		0.0000		0	1
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		0	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1102 0. 3053	-	45, 305 747, 184	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.0000		0	1
56. 00 05600 RADI OI SOTOPE		0.0780		34, 578	1
57. 00 05700 CT SCAN		0. 0279		87, 160	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0704		52, 127	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1463		188, 984	1
60. 00 06000 LABORATORY		0. 1698		809, 254	
60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2597		63, 280	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000		00,200	1
64.00 06400 I NTRAVENOUS THERAPY		0.0000		0	1
65. 00 06500 RESPI RATORY THERAPY		0. 4167		902, 841	
66. 00 06600 PHYSI CAL THERAPY		0. 3985		356, 594	
67. 00 06700 OCCUPATIONAL THERAPY		0.3465		160, 027	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY		0. 4836		119, 816 174, 083	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 2655		58, 869	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3137		3, 530, 284	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.4007	04 13, 564, 470	5, 435, 337	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1887		2, 695, 418	
74. 00 07400 RENAL DI ALYSI S		0. 5822		91, 295	
75. 00 07500 ASC (NON-DI STI NCT PART) OUTPATI ENT SERVI CE COST CENTERS		0.0000	0 0	0	75.00
88. 00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
90. 00 09000 CLI NI C		0.0000		0	
90. 01 09001 WOUND/OSTOMY CLINIC		0.3451		0	
90. 02 09002 KIDS PLUS CLINIC 90. 03 09003 0NC0L0GY		0.0000		0 0	
90. 04 09004 MUNCIE CLINIC		0.0000		0	1
90. 05 09005 ANTI COAGULATI ON CLINIC		0. 3905		0	1
90. 06 09006 PREGNANCY PLUS		0.0000		0	1
90. 07 09007 0/P LAB		0.0000	0 00	0	
90. 08 09008 0/P LAB		0.0000		0	
90. 09 09009 FORTVILLE CLINIC		0.0000		0	
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)		0. 1784 0. 4555		599, 440 0	1
OTHER REIMBURSABLE COST CENTERS		0.4000	0	0	1 12.00
94. 00 09400 HOME PROGRAM DI ALYSI S		0.0000	0 00	0	94.00
95. 00 09500 AMBULANCE SERVICES					95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0.0000		0	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD 200.00 Total (sum of lines 50-94 and 96-98)		0.0000	00 0 71, 782, 932	0 18, 430, 985	
		1	1 1. 102. 932	10 4.10 985	
201.00 Less PBP Clinic Laboratory Services-Program only char	mes (line 61)		0	107 1007 700	201.00

	Financial Systems COMMUNITY HOSPITAL ENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150113	Peri od:	u of Form CMS- Worksheet D-3	
				From 01/01/2015 To 12/31/2015	Date/Time Pre	pared:
					5/24/2016 1:2	26 pm
	Cost Center Description		Ratio of Cos	Hospital st Inpatient	Cost Inpatient	
	oust benter beschiption		To Charges		Program Costs	
			J		(col. 1 x col.	
			1.00	0.00	2)	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30.00	03000 ADULTS & PEDI ATRI CS			2, 143, 177		30.00
	03100 I NTENSI VE CARE UNI T			510, 016		31.00
32.00	03200 CORONARY CARE UNIT			0		32.00
33.00	03300 BURN I NTENSI VE CARE UNI T			0		33.00
34.00 40.00	03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF			0		34.00
40.00	04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF			0		40.00
41.00	04200 SUBPROVIDER - TRF			0		41.00
43.00	04300 NURSERY			416, 755		43.00
101 00	ANCI LLARY SERVICE COST CENTERS			110,700	I	101.00
50.00	05000 OPERATING ROOM		0. 2273			1
51.00	05100 RECOVERY ROOM		0.0000			
52.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY		0.0000		0 23, 103	
53.00 54.00	05300 ANESTHESTOLOGY 05400 RADI OLOGY-DI AGNOSTI C		0. 1102			
55.00	05500 RADI OLOGY-THERAPEUTI C		0. 0000			
56.00	05600 RADI OI SOTOPE		0.0780		-	
57.00	05700 CT SCAN		0. 0279			
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0704			
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 1463	01 222, 226	32, 512	59.00
60.00	06000 LABORATORY		0. 1698	71 503, 335	85, 502	60.00
60. 01	06001 BLOOD LABORATORY		0.0000	00 0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2597			
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		0.0000			
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY		0.0000		-	
66.00	06600 PHYSI CAL THERAPY		0. 4187			
67.00	06700 OCCUPATI ONAL THERAPY		0. 3465			
68.00	06800 SPEECH PATHOLOGY		0. 4836			
69.00	06900 ELECTROCARDI OLOGY		0. 1027			
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 2655	79 26, 754	7, 105	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3137			
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4007		0	
	07300 DRUGS CHARGED TO PATIENTS		0. 1887			
	07400 RENAL DI ALYSI S		0. 5822			
	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS		0.0000	00 0	0	75.00
	08800 RURAL HEALTH CLINIC		0.0000	00 0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000	00 0	0	89.00
90.00	09000 CLI NI C		0.0000	00 0	0	90.00
	09001 WOUND/OSTOMY CLINIC		0. 3451		-	
90.02	09002 KIDS PLUS CLINIC		0.0000		0	
	09003 ONCOLOGY		0.0000			
	09004 MUNCIE CLINIC		0.0000			
90. 05 90. 06	09005 ANTI COAGULATI ON CLINIC 09006 PREGNANCY PLUS		0. 3905			
90.00 90.07	09007 0/P LAB		0.0000		-	
90.07 90.08	09008 0/P LAB		0.0000			
90.09	09009 FORTVILLE CLINIC		0.0000		0	
91.00	09100 EMERGENCY		0. 1784			
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		0. 4555		0	
04.00	OTHER REIMBURSABLE COST CENTERS		0.0000	00 0	2	04.00
	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES		0.0000	00 0	0	
95.00 96.00	09500 DURABLE MEDICAL EQUIP-RENTED		0.0000	00 0	0	95.00 96.00
98.00 97.00	09700 DURABLE MEDICAL EQUIP-RENTED		0.0000		0	
200.00	Total (sum of lines 50-94 and 96-98)		0.0000	9, 677, 756		
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)	1	0		201.00
	Net Charges (line 200 minus line 201)		1	9, 677, 756	I	202.00

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150113	Period: From 01/01/2015	Worksheet E Part A	
				To 12/31/2015		
		Titl	e XVIII	Hospi tal	PPS	
			0	1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0		1.
01	DRG amounts other than outlier payments for discharges occurrin	g prior to		17, 535, 949		1.
02	October 1 (see instructions) DRG amounts other than outlier payments for discharges occurrin	a on or		6, 006, 662		1.
	after October 1 (see instructions)	0		0,000,002		
03	DRG for federal specific operating payment for Model 4 BPCI for occurring prior to October 1 (see instructions)	di scharge	s	0		1.
)4	DRG for federal specific operating payment for Model 4 BPCI for	di scharge	s	0		1
00	occurring on or after October 1 (see instructions) Outlier payments for discharges. (see instructions)			1, 961, 773		2
01	Outlier reconciliation amount			0		2
)2	Outlier payment for discharges for Model 4 BPCI (see instructio	ns)		0		2
00	Managed Care Simulated Payments Bed days available divided by number of days in the cost report	ing period	8	132.66		4
	(see instructions)					_
00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	recent cos	t	0.00		5
	reporting period ending on or before 12/31/1996. (see instructio					
00	FTE count for allopathic and osteopathic programs which meet th for an add-on to the cap for new programs in accordance with 42			0.00		6
	413. 79(e)					
00	MMA Section 422 reduction amount to the IME cap as specified un $\frac{1}{1}$ (1)(iv)(B)(1)	der 42 CFR	2	0.00		7
01	ACA Section 5503 reduction amount to the IME cap as specified u		R	0.00		7
	412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2 see instructions.	011 then				
00	Adjustment (increase or decrease) to the FTE count for allopath	ic and		0.00		8
	osteopathic programs for affiliated programs in accordance with $413.75(b)$ $412.70(c)(2)(iv)$ $64.50,25240$ (May 12, 1008) and 67					
	413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 (August 1, 2002).	FK 20009				
01	The amount of increase if the hospital was awarded FTE cap slot			0.00		6
	section 5503 of the ACA. If the cost report straddles July 1, 2 instructions.	UTI, See				
02	The amount of increase if the hospital was awarded FTE cap slot			0.00		8
00	closed teaching hospital under section 5506 of ACA. (see instru Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines			0.00		9
	and 8,02) (see instructions)	• • •				
00	FTE count for allopathic and osteopathic programs in the curren your records	t year fro	m	0.00		10
	FTE count for residents in dental and podiatric programs.			0.00		11
00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.			0.00 0.00		12
00	Total allowable FTE count for the penultimate year if that year	ended on		0.00		14
00	or after September 30, 1997, otherwise enter zero.			0.00		15
00 00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program			0. 00 0. 00		15
	Adjustment for residents displaced by program or hospital closu	re		0.00		17
	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).			0. 00 0. 000000		18
00	Prior year resident to bed ratio (see instructions)			0.00000		20
	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)			0.000000		21
	IME payment adjustment - Managed Care (see instructions)			0		22
00	Indirect Medical Education Adjustment for the Add-on for Sectio Number of additional allopathic and osteopathic IME FTE residen		1	0.00		23
	under 42 Sec. 412.105 (f)(1)(iv)(C).	t cap 510t				
	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter the lo	wor of lin		0.00 0.00		24
00	23 or line 24 (see instructions)		c	0.00		25
00 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000 0. 000000		26
	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)			0.000000		28
	IME add-on adjustment amount - Managed Care (see instructions)			0		28
	Total IME payment ( sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0		29
	Disproportionate Share Adjustment					
00	Percentage of SSI recipient patient days to Medicare Part A pat (see instructions)	ient days		4.68		30
00	Percentage of Medicaid patient days (see instructions)			25.88		31
	Sum of Lines 30 and 31			30.56		32
	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)			14. 43 849, 299		33

ALCUL	Financial Systems COMMUNITY HOSPITAL ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150113	Peri od: From 01/01/2015 To 12/31/2015		pared:
				5/24/2016 1:2	
		Title XVIII	Hospital Prior to	PPS On/After	
		0	0ctober 1 1.00	0ctober 1 2.00	
	Uncompensated Care Adjustment	0	1.00	2.00	
5.00	Total uncompensated care amount (see instructions)		7, 647, 644, 885		
5. 01 5. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero,		0. 000152969 1, 169, 849	0. 000150915 966, 783	
0. 02	enter zero on this line) (see instructions)		1, 107, 047	700, 703	33.0
5. 03	Pro rata share of the hospital uncompensated care payment		874, 983	243, 016	35.0
5.00	amount (see instructions) Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1, 117, 999		36. 0
	Additional payment for high percentage of ESRD beneficiary disc	charges (lines 40 throug			
). 00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.0
I. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682,		0		41.0
I. 01	683, 684 an 685. (see instructions) Total ESRD Medicare covered and paid discharges excluding		0		41.0
1.01	MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.0
2.00	Divide line 41 by line 40 (if less than 10%, you do not		0.00		42.0
3.00	qualify for adjustment) Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43.0
	682, 683, 684 an 685. (see instructions)				
1.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.00000		44.0
5.00	Average weekly cost for dialysis treatments (see		0.00		45.0
5.00	instructions) Total additional payment (line 45 times line 44 times line		0		46.0
5. 00	41.01)		0		40.0
7.00	Subtotal (see instructions)		27, 471, 682		47.0
3. 00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.0
9.00	Total payment for inpatient operating costs (see		27, 471, 682		49.0
). 00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I		2, 109, 138		50.0
. 00	and Pt. II, as applicable)		2, 107, 130		30.0
I. 00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.0
2.00	Direct graduate medical education payment (from Wkst. E-4,		0		52.0
	line 49 see instructions).		0		E2 0
1.00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies		11, 113		53.0 54.0
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line		0		55. C
5 00	69) Cost of physicians' services in a teaching hospital (see		0		56. C
	intructions)		0		
7.00	Routine service other pass through costs (from Wkst. D, Pt. 111, column 9, lines 30 through 35).		0		57.C
3. 00	Ancillary service other pass through costs from Wkst. D, Pt.		27, 221		58. C
9.00	IV, col. 11 line 200) Total (cum of amounts on lines 40 through 59)		20 610 154		59.0
). 00	Total (sum of amounts on lines 49 through 58) Primary payer payments		29, 619, 154 26, 082		60.0
I. 00	Total amount payable for program beneficiaries (line 59		29, 593, 072		61.0
2.00	minus line 60) Deductibles billed to program beneficiaries		2, 289, 096		62.0
3.00	Coinsurance billed to program beneficiaries		60, 033		63. C
4.00 5.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)		181, 869 118, 215		64.C
	Allowable bad debts for dual eligible beneficiaries (see		58, 168		66. C
1 00	instructions)		07 0/0 450		47 0
7.00 3.00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for		27, 362, 158 0		67.C
	applicable to MS-DRGs (see instructions)				
9.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.0
0. 00			0		70. C
). 50 ). 89	RURAL DEMONSTRATION PROJECT		0		70.5
J. 07	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		/0.8
	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.9
	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)		0		70.9
). 92 ). 93	HVBP payment adjustment amount (see instructions)		105, 524		70.9
). 94	HRR adjustment amount (see instructions) Recovery of accelerated depreciation		-353, 280		70.9 70.9

	Financial Systems COMMUNITY HOSPITA ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150113	Do	ri od:	u of Form CMS- Worksheet E	2002-1
JALCUL	ATTON OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150113		om 01/01/2015	Part A Date/Time Pre	epared:
		Title XVIII		Hospi tal	5/24/2016 1:2 PPS	26 pm
				Prior to	On/After	
				October 1	October 1	
		0		1,00	2.00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter		0	0		70.9
	in column 0 the corresponding federal year for the period			-		
	prior to 10/1)					
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter		0	0		70.9
	in column 0 the corresponding federal year for the period					
	ending on or after 10/1)					
70. 98	Low Volume Payment-3			0		70.9
	HAC adjustment amount (see instructions)			0		70.9
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines			27, 114, 402		71.0
	69 & 70)					
71.01	Sequestration adjustment (see instructions)			542, 288		71.0
	Interim payments			26, 280, 531		72.0
73.00	Tentative settlement (for contractor use only)			0		73.0
74.00	Balance due provider (Program) (line 71 minus lines 71.01,			291, 583		74.0
	72, and 73)					
75.00	Protested amounts (nonallowable cost report items) in			4, 685, 614		75.0
	accordance with CMS Pub. 15-2, chapter 1, §115.2					-
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see			0		90.0
1 00	instructions)			0		01 0
	Capital outlier from Wkst. L, Pt. I, line 2			0		91.0
72.00	Operating outlier reconciliation adjustment amount (see instructions)			0		92.0
93.00	Capital outlier reconciliation adjustment amount (see			0		93.0
73.00	instructions)			0		93.0
00 10	The rate used to calculate the time value of money (see			0.00		94.0
/4.00	instructions)			0.00		74.0
95 00	Time value of money for operating expenses (see			0		95.0
/0.00	instructions)			0		,0.0
96.00	Time value of money for capital related expenses (see			0		96.0
	instructions)					
				Prior to 10/1	On/After 10/1	
				1.00	2.00	
	HSP Bonus Payment Amount					
	HSP bonus amount (see instructions)			0	C	0 100. 0
	HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)			0.000000000	0.000000000	0 101. 0
	HVBP adjustment amount for HSP bonus payment (see instructions	s)		0	C	102.0
	HRR Adjustment for HSP Bonus Payment					
	HRR adjustment factor (see instructions)			0.0000	0.0000	103. 0
104 00	HRR adjustment amount for HSP bonus payment (see instructions)	)	1	0	C C	104.0

W VO	LUME CALCULATION EXHIBIT 4					Period: From 01/01/2015 To 12/31/2015	Date/Time Prep 5/24/2016 1:20	pared:
		W/S E, Part A line O	Amounts (from E, Part A) 1.00	Titl Pre/Post Entitlement 2.00	e XVIII Period Prior to 10/01 3.00	Hospi tal Peri od On/After 10/01 4.00	PPS Total (Col 2 through 4) 5.00	
00	DRG amounts other than outlier	1.00	0	0		0 0	0	1.00
01	payments DRG amounts other than outlier payments for discharges	1. 01	17, 535, 949	0	17, 535, 94	9 0	17, 535, 949	1. 01
02	occurring prior to October 1 DRG amounts other than outlier payments for discharges	1. 02	6, 006, 662	0		6, 006, 662	6, 006, 662	1. 02
03	occurring on or after October DRG for Federal specific operating payment for Model 4 BPCI occurring prior to Octobe	1.03	0	0		0 0	0	1. 03
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1.04	0	0		0 0	0	1.04
00	October 1 Outlier payments for discharges (see instructions)		1, 961, 773	0	1, 406, 73	1 555, 042	1, 961, 773	
01	Outlier payments for discharges for Model 4 BPCI	s 2.02	0	0		0 0	0	2. 01
00	Operating outlier reconciliation	2. 01	0	0		0 0	0	3.00
00	Managed care simulated payments		0	0		0 0	0	4.00
00	Indirect Medical Education Adju Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0.00000	0 0. 000000		5.00
00	A, line 21 (see instructions) IME payment adjustment (see	22.00	0	0		o o	0	6.00
01	instructions) IME payment adjustment for managed care (see instructions	22.01	0	0		o o	0	6. 01
~ ~	Indirect Medical Education Adju	ustment for the						
00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 000000	0. 00000	0.000000		7.00
00	IME adjustment (see instructions)	28.00	0	0		0 0	0	8.00
01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0		0 0	0	8. 0′
00	Total IME payment (sum of line	s 29.00	0	0		o o	0	9.00
01	6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0		0 0	0	9. 0
	Disproportionate Share Adjustme							
0. 00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1443	0. 1443	0. 144	3 0. 1443		10. 00
. 00	Disproportionate share adjustment (see instructions)	34.00	849, 299	0	632, 60	9 216, 690	849, 299	11.00
. 01	Uncompensated care payments Additional payment for high per	36.00	1, 117, 999		874, 98	3 243, 178	1, 118, 161	11. 01
2. 00	Total ESRD additional payment	46.00	0	0 O		0 0	0	12.00
8. 00	(see instructions) Subtotal (see instructions)	47.00	27, 471, 682	0	20, 450, 11	0 7, 021, 572	27, 471, 682	
. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	48.00	0	0		0 0	0	14.00
5. 00	(see instructions) Total payment for inpatient operating costs (see instructions)	49.00	27, 471, 682	0	20, 450, 11	0 7, 021, 572	27, 471, 682	15.00
o. 00	Payment for inpatient program capital	50.00	2, 109, 138	0	1, 573, 81	3 535, 325	2, 109, 138	16.00
. 00	Special add-on payments for nei technologies	v 54.00	11, 113	0	9, 52	5 1, 588	11, 113	17.00
7. 01 7. 02	Net organ aquisition cost Credits received from manufacturers for replaced	55.00 68.00	0	0			0 0	
3. 00	devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see		0	0		o o	0	18.00
	instructions) SUBTOTAL			0	22, 033, 44	8 7, 558, 485	29, 591, 933	

	Financial Systems		COMMUNI TY HOSPI TAI		CCN: 150113	Period:	u of Form CMS-2	2332-1
LUW VU	DLUME CALCULATION EXHIBIT 4			Provi der (	CCN: 150113	From 01/01/2015 To 12/31/2015		pared:
				Title	e XVIII	Hospi tal	PPS	o piii
		W/S L, line	(Amounts from					
			L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1, 884, 143	0	1, 402, 38	35 481, 759	1, 884, 144	20.0
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0 0	0	20.0
21.00	Capital DRG outlier payments	2.00	104, 598	0	104, 59	98 22, 782	127, 380	21.0
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	0	21.0
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0. 0000	0.000	0.0000		22. 0
23.00	Indirect medical education adjustment (see instructions)	6.00	О	0		0 0	0	23.0
24. 00	Al lowable di sproporti onate share percentage (see i nstructi ons)	10.00	0. 0639	0. 0639	0.063	39 0. 0639		24.0
25.00	Disproportionate share adjustment (see instructions)	11.00	120, 397	0	89, 61	13 30, 784	120, 397	25.0
26. 00	Total prospective capital payments (see instructions)	12.00	2, 109, 138	0	1, 573, 81	13 535, 325	2, 109, 138	26.0
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.0000	0. 000000		27.0
28.00	Low volume adjustment (transfe amount to Wkst. E, Pt. A, line					0	0	28.0
9.00	Low volume adjustment (transfe amount to Wkst. E, Pt. A, line					0	0	29.0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 0

)SPI 1	TAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Exhibi Date/Time Prep 5/24/2016 1:20 PPS	pared:
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	e XVIII Period to 10/01	Hospi tal Peri od on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
00	DRG amounts other than outlier payments	1.00					1.0
01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	17, 535, 949			17, 535, 949	1.0
02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6, 006, 662		6, 006, 662	6, 006, 662	1.0
03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0		0	0	1. C
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.0
00	Outlier payments for discharges (see instructions)	2.00	1, 961, 773	1, 406, 73	555, 042	1, 961, 773	2.0
01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2.0
00	Operating outlier reconciliation	2.01	0		0 0	0	3.0
00	Managed care simulated payments	3.00	0		0 0	0	4.0
00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0.00000	0 0. 000000		5. (
00	IME payment adjustment (see instructions)	22.00	0		0 0	0	6. (
01	IME payment adjustment for managed care (see instructions)	22.01	0		0 0	0	6.
	Indirect Medical Education Adjustment for the						_
00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000			7.
00 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28.00 28.01	0		0 0 0 0	0	8. 8.
00 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 00 29. 01	0		0 0 0 0	0 0	9. 9.
	Disproportionate Share Adjustment	22.00	0 1442	0.144	0 1 4 4 2		10
0. 00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1443				10.
. 00 . 01	Disproportionate share adjustment (see instructions) Uncompensated care payments	34.00 36.00	849, 299 1, 117, 999				
. 01	Additional payment for high percentage of ESR			074, 90	243,170	1, 110, 101	11.
. 00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12.
. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	47.00 48.00	27, 471, 682 0	20, 450, 11	0 7, 021, 572 0 0	27, 471, 682 0	
. 00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	27, 471, 682	20, 450, 11	0 7, 021, 572	27, 471, 682	15.
. 00		50.00	2, 109, 138	1, 596, 59	5 512, 543	2, 109, 138	16.
. 00	Special add-on payments for new technologies	54.00	11, 113			11, 113	17.
. 01	Net organ aquisition cost	55.00	0		0 0	0	
. 02	replaced devices for applicable MS-DRGs	68.00	0		0 0	0	
. 00	amount (see instructions)	93.00	0		0 0		18.
. 00	SUBTOTAL			22, 056, 23	7, 535, 703	29, 591, 933	19.

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5					2552-10
			CCN: 150113	Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 5/24/2016 1:2	pared:
			e XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3.00	4.00	
20.00 Capital DRG other than outlier	1.00	1, 884, 143				20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1.01	0	.,	0 0	0	•
21.00 Capital DRG outlier payments	2.00	104, 598	104, 59	28 0	104, 598	
21.01 Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	
22.00 Indirect medical education percentage (see	5.00	0,0000	0.000	0, 0000	-	22.00
instructions)						
23.00 Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0. 0639	0. 063	0. 0639		24.00
25.00 Disproportionate share adjustment (see instructions)	11.00	120, 397	89, 6	30, 784	120, 397	25.00
26.00 Total prospective capital payments (see instructions)	12.00	2, 109, 138	1, 596, 59	95 512, 543	2, 109, 138	26.00
	Wkst. E, Pt.	(Amt. from				
	A, line	Wkst. E, Pt.				
	0	A) 1.00	2.00	3.00	4.00	
27.00	0	1.00	2.00	3.00	4.00	27.00
28.00 Low volume adjustment prior to October 1	70, 96	0		0	0	
29.00 Low volume adjustment on or after October 1	70.98	0		0	0	
30. 00 HVBP payment adjustment (see instructions)	70.97	105, 524	69, 3	57 36, 167	-	
30. 01 HVBP payment adjustment for HSP bonus paymen		105, 524	09, 3	57 50, 107	105, 524	
(see instructions)	10.90	0		0 0	0	30.01
31.00 HRR adjustment (see instructions)	70, 94	-353, 280	-242, 12	-111, 153	-353, 280	31.00
31.01 HRR adjustment for HSP bonus payment (see	70.94	-303, 200	-242, 12	-111,100	-353, 280	
instructions)	70.91	0		0 0		31.01
					(Amt. to Wkst.	
					E, Pt. A)	
	0	1.00	2.00	3.00	4.00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	02.00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150113	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prep 5/24/2016 1:20	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			26, 619	1.00
2.00 3.00	Medical and other services reimbursed under OPPS (see instruct PPS payments	ions)		14, 229, 631 13, 765, 827	2.00 3.00
4.00	Outlier payment (see instructions)			48, 549	
5.00	Enter the hospital specific payment to cost ratio (see instruc	tions)		0.000	5.00
6.00	Line 2 times line 5			0	6.00
7.00 8.00	Sum of line 3 plus line 4 divided by line 6 Transitional corridor payment (see instructions)			0.00 0	7.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. 1	V. col. 13. line 200		45, 563	
10.00	Organ acqui si ti ons			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			26, 619	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12.00	Ancillary service charges			141, 695	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li	ne 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			141, 695	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for p	aumont for convisor on	a charge basis	0	15.00
	Amounts that would have been realized from patients liable for	5	U U		16.00
	such payment been made in accordance with 42 CFR §413.13(e)				
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.00000	
18.00 19.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete onl)	viflipo 19 ovecede li	no 11) (coo	141, 695	1
19.00	instructions)	y IT THE TO EXCEEDS IT	lie II) (See	115, 076	19.00
20.00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds li	ne 18) (see	0	20.00
04 00	instructions)			04 440	01 00
	Lesser of cost or charges (line 11 minus line 20) (for CAH see Interns and residents (see instructions)	Instructions)		26, 619 0	21.00 22.00
	Cost of physicians' services in a teaching hospital (see instr	uctions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			13, 859, 939	24.00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	1 25 00
	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for	CAH. see instructions)		0 2, 968, 423	25.00 26.00
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p			10, 918, 135	
	instructions)	>		_	
	Direct graduate medical education payments (from Wkst. E-4, li ESRD direct medical education costs (from Wkst. E-4, line 36)	ne 50)		0	28.00 29.00
	Subtotal (sum of lines 27 through 29)			10, 918, 135	
	Primary payer payments			8, 969	
32.00	Subtotal (line 30 minus line 31)	>		10, 909, 166	32.00
22 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICI Composite rate ESRD (from Wkst. I-5, line 11)	ES)		0	33.00
	Allowable bad debts (see instructions)			547, 134	
	Adjusted reimbursable bad debts (see instructions)			355, 637	
	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		402, 939	
	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			11, 264, 803 351	37.00 38.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions			0	39.50
	Partial or full credits received from manufacturers for replace	ed devices (see instruc	tions)	0	39.98
	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 11, 264, 452	39.99 40.00
40.00	Sequestration adjustment (see instructions)			225, 289	
41.00	Interim payments			10, 813, 519	41.00
	Tentative settlement (for contractors use only)			0	
43.00 44.00	Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub 15_?	chapter 1 8115	225, 644 0	1
. <del>т</del> . 00	TO BE COMPLETED BY CONTRACTOR	<u> </u>	Shaptor 1, 3110.4	0	
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92.00 93.00
	Total (sum of lines 91 and 93)				94.00

NALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 150113	Period: From 01/01/2019 To 12/31/2019		pared: 6 pm
		Ti tl	e XVIII	Hospi tal	PPS	
		I npati er	t Part A	Pa	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00	Total interim payments paid to provider		26, 280, 5		10, 813, 519	1.0
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	0	2.0
8. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3. 0
	Program to Provider					
8.01	ADJUSTMENTS TO PROVIDER			0	0	3.0
3. 02				0	0	3.0
3.03 3.04				0	0	3.0 3.0
3.04 3.05				0	0	3.0
. 00	Provider to Program			0		0.0
8.50	ADJUSTMENTS TO PROGRAM			0	0	3.5
8.51				0	0	3.5
8.52				0	0	3.5
3.53				0	0	3.5
8.54 8.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3.5 3.9
0.99	3. 50-3. 98)			0	0	3.9
1.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		26, 280, 5	31	10, 813, 519	4.0
	TO BE COMPLETED BY CONTRACTOR					
6. 00	List separately each tentative settlement payment after des review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	k				5. C
01	Program to Provider TENTATIVE TO PROVIDER		1	0	0	БС
5. 01 5. 02				0	0	5.C 5.C
5.03				0	0	5.0
	Provider to Program					
. 50	TENTATI VE TO PROGRAM			0	0	5.5
5.51				0	0	5.5
. 52 . 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.5 5.9
. 77	5. 50-5. 98)			0		o. 9
. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. C
. 01	SETTLEMENT TO PROVIDER		291, 5		225, 644	6.0
. 02	SETTLEMENT TO PROGRAM			0	0	6.0
. 00	Total Medicare program liability (see instructions)		26, 572, 1		11, 039, 163	7.0
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
. 00	Name of Contractor					8. (

Heal th	Financial Systems COMMUNITY HOS	SPITAL ANDERSON	In Lie	u of Form CMS-2	2552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150113	Period: From 01/01/2015	Worksheet E-1 Part II		
			To 12/31/2015		pared:	
				5/24/2016 1:2		
		Title XVIII	Hospi tal	PPS		
				1.00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORT					
1.00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULA		1/	7, 165	1.00	
2.00						
3.00	S · · · ·					
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines	1, 8-12		3, 288 21, 705	3.00 4.00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 20			443, 148, 750	5.00	
6.00	Total hospital charity care charges from Wkst. S-10, col.	3 line 20		8, 277, 973	6.00	
7.00	CAH only - The reasonable cost incurred for the purchase	of certified HIT technology	Wkst. S-2, Pt. I	0	7.00	
	line 168					
8.00	Calculation of the HIT incentive payment (see instruction	IS)		513, 233		
9.00	Sequestration adjustment amount (see instructions)			10, 265		
10.00	Calculation of the HIT incentive payment after sequestrat	lon (see Instructions)		502, 968	10.00	
30, 00	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH Initial/interim HIT payment adjustment (see instructions)			1, 644, 176	30.00	
30.00	Other Adjustment (specify)			1, 044, 170	31.00	
32.00	Balance due provider (line 8 (or line 10) minus line 30 a	and line 31) (see instruction	s)	-1, 141, 208		
52.00			-,	1, 111, 200	02.00	

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150113	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part VII Date/Time Pre 5/24/2016 1:2	pare
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI COMPUTATION OF NET COST OF COVERED SERVICES	CES FOR TITLES V OR X	IX SERVICES		+
00	Inpatient hospital/SNF/NF services		4, 068, 329		1 1.
00	Medical and other services		4,000,327	0	
00	Organ acquisition (certified transplant centers only)		0	0	3.
00	Subtotal (sum of lines 1, 2 and 3)		4, 068, 329	0	
00	Inpatient primary payer payments		0		5.
00	Outpatient primary payer payments			0	6.
00	Subtotal (line 4 less sum of lines 5 and 6)		4, 068, 329	0	7.
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				-
00	Routine service charges		3, 069, 947		8.
00	Ancillary service charges		9, 677, 756	0	
00	Organ acquisition charges, net of revenue		0		10.
	Incentive from target amount computation Total reasonable charges (sum of lines 8 through 11)		12 747 702	0	11.
00	CUSTOMARY CHARGES		12, 747, 703	0	12.
00	Amount actually collected from patients liable for payment for s	services on a charge h	asis 0	0	13.
	Amounts that would have been realized from patients liable for p			0	
00	charge basis had such payment been made in accordance with 42 Cl			0	
00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15.
00	Total customary charges (see instructions)		12, 747, 703	0	
00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds li		0	17.
00	4) (see instructions) Excess of reasonable cost over customary charges (complete only		0	18.	
	16) (see instructions)				
	Interns and Residents (see instructions)		0	0	
00	Cost of physicians' services in a teaching hospital (see instruc		0	0	
00	Cost of covered services (enter the lesser of line 4 or line 16)		4, 068, 329	0	21.
00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provi			1
	Other than outlier payments		0	0	
00	Outlier payments Program capital payments		0	0	23.
00	Capital exception payments (see instructions)		0		24.
00	Routine and Ancillary service other pass through costs		0	0	
00	Subtotal (sum of lines 22 through 26)		0	0	
	Customary charges (title V or XIX PPS covered services only)		0	0	
00	Titles V or XIX (sum of lines 21 and 27)		4, 068, 329	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
00	Excess of reasonable cost (from line 18)		0	0	30.
00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		4, 068, 329	0	31.
	Deducti bl es		0	0	
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
	Utilization review	>	0		35.
00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	33)	4, 068, 329	0	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
00	Subtotal (line 36 ± line 37)		4, 068, 329	0	
	Direct graduate medical education payments (from Wkst. E-4)		0	0	39
00	Total amount payable to the provider (sum of lines 38 and 39)		4,068,329	0	
	Interim payments Balance due provider/program (line 40 minus line 41)		4, 156, 344 -88, 015	0	
00	Protested amounts (nonallowable cost report items) in accordance	with CMS Dub 15-2	-88,015	0	
50	chapter 1, §115.2	5 WI (II 0W5 100 10-2,	0	0	-3

	Financial Systems COMMUNITY HOSPI E SHEET (If you are nonproprietary and do not maintain fund-		CCN: 150113 P	eriod:	u of Form CMS- Worksheet G	2002
ccoun	ting records, complete the General Fund column only)			rom 01/01/2015 o 12/31/2015	Date/Time Pre	
		General Fund	Specific Purpose Fund	Endowment Fund	5/24/2016 1:2 Plant Fund	<u>26 pm</u>
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS	00.404.040				
. 00 . 00	Cash on hand in banks	32, 424, 810		0	0	
. 00	Temporary investments Notes receivable			0	0	
. 00	Accounts receivable	1, 165, 813	-	0	0	
. 00	Other receivable	45, 715		0	0	
. 00	Allowances for uncollectible notes and accounts receivable	-27, 938, 192	C	0	0	6.0
. 00	Inventory	2, 610, 971		0	0	
. 00	Prepaid expenses	290, 261		0	0	
. 00 D. 00	Other current assets Due from other funds	99, 575, 945 1, 202, 790		0	0	
1.00	Total current assets (sum of lines 1-10)	109, 378, 113		0	0	
1.00	FI XED ASSETS	107, 370, 113		<u> </u>	0	- · · · ·
2.00	Land	6, 323, 988	C	0	0	12. (
3.00	Land improvements	2,071,604	C	0	0	13.0
4.00	Accumulated depreciation	-1, 845, 393	1	0	0	
	Buildings	110, 306, 192		0	0	
6.00	Accumulated depreciation Leasehold improvements	-31, 655, 686		0	0	
7.00 8.00	Accumulated depreciation			0	0	
	Fixed equipment	19, 388, 413	-	0	0	
	Accumulated depreciation	-12, 932, 260		0	0	
	Automobiles and trucks	836, 727		0	0	
2.00	Accumulated depreciation	-617, 324	C	0	0	22.
	Major movable equipment	14, 818, 201		0	0	
	Accumulated depreciation	-11, 287, 010		0	0	
	Minor equipment depreciable	32, 059, 181		0	0	
6.00 7.00	Accumulated depreciation HIT designated Assets	-22, 950, 132		0	0	
7.00 B.00	Accumulated depreciation			0	0	
	Mi nor equi pment-nondepreci abl e	0		0	0	
	Total fixed assets (sum of lines 12-29)	104, 516, 501	C	-	0	
1 00	OTHER ASSETS					1 21
1.00 2.00	Investments Dependents	0		0	0	
2.00 3.00	Deposits on leases Due from owners/officers			0	0	
4.00	Other assets			0	0	
5.00	Total other assets (sum of lines 31-34)	0	c c	0	0	
	Total assets (sum of lines 11, 30, and 35)	213, 894, 614	C	0	0	36.
	CURRENT LI ABI LI TI ES	1				
	Accounts payable	4, 850, 892	1		0	
	Salaries, wages, and fees payable	8, 049, 890			0	
	Payroll taxes payable Notes and Loans payable (short term)	258, 984 1, 613, 304			0	
1.00	Deferred income	1, 013, 304		0	0	
2.00	Accel erated payments	0		Ŭ	0	42.
3.00	Due to other funds	976, 534	C	0	0	
4.00	Other current liabilities	1, 408, 507		0	0	44.
5.00	Total current liabilities (sum of lines 37 thru 44)	17, 158, 111	C C	0	0	45.
	LONG TERM LIABILITIES	1	1	1		
6.00	Mortgage payable	0	-		0	
7.00 3.00	Notes payable Unsecured Loans	0	0	0	0	
9.00 9.00	Other long term liabilities	6, 855, 559		0	0	
). 00	Total long term liabilities (sum of lines 46 thru 49	6, 855, 559		0	0	
1.00	Total liabilites (sum of lines 45 and 50)	24, 013, 670		-	0	
	CAPI TAL ACCOUNTS					
2.00	General fund balance	189, 880, 943				52.
8.00	Specific purpose fund		C			53.
1.00	Donor created - endowment fund balance - restricted			0		54.
5.00	Donor created - endowment fund balance - unrestricted			0		55.
5.00	Governing body created - endowment fund balance			0	~	56.
7.00 8.00	Plant fund balance - invested in plant				0	
8.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.
0 00	Total fund balances (sum of lines 52 thru 58)	189, 880, 943	C	0	0	59.
9.00						

Heal th	Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	eu of Form CMS-2	552-10
	ENT OF CHANGES IN FUND BALANCES			CCN: 150113	Period: From 01/01/2015 To 12/31/2015	Worksheet G-1	bared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	<u>, piii</u>
		1.00	0.00	0.00	1.00	5.00	
1.00	Fund balances at beginning of period	1.00	2.00 166,061,534	3.00	4.00	5.00	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		23, 819, 406		0		2.00
3.00	Total (sum of line 1 and line 2)		189, 880, 940		0		3.00
4.00	Additions (credit adjustments) (specify)	0			0	0	4.00
5.00		0			0	0	5.00
6.00		0			0	0	6.00
7.00 8.00		0			0	0	7.00 8.00
9.00		0			0	0	9,00
10.00	Total additions (sum of line 4–9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		189, 880, 940		0		11.00
12.00	Deductions (debit adjustments) (specify)	0			0	0	12.00
13.00		0			0	0	13.00
14.00 15.00		0			0	0	14.00 15.00
16.00		0			0	0	16.00
17.00		0			0	0	17.00
	Total deductions (sum of lines 12-17)		0		0	_	18.00
19.00	Fund balance at end of period per balance		189, 880, 940		0		19.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)				0		19.00
19.00		Endowment Fund	189, 880, 940 Pl ant		0		19.00
19.00	sheet (line 11 minus line 18)	6.00					
1.00	sheet (line 11 minus line 18) Fund balances at beginning of period		Pl ant	Fund	0		1.00
1.00 2.00	Sheet (line 11 minus line 18) Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	6.00	Pl ant	Fund	0		1.00 2.00
1.00 2.00 3.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6.00	PI ant 7.00	Fund			1.00 2.00 3.00
1.00 2.00 3.00 4.00	Sheet (line 11 minus line 18) Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	6.00	Pl ant	Fund	0		1.00 2.00 3.00 4.00
1.00 2.00 3.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6.00	PI ant 7.00 0	Fund 8. 00	0		1.00 2.00 3.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6.00	PI ant 7.00 0 0	Fund 8. 00	0		1.00 2.00 3.00 4.00 5.00 6.00 7.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6.00	Pl ant 7.00 0 0 0 0 0 0 0	Fund 8. 00	0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Sheet (line 11 minus line 18) 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)	6.00	Pl ant 7.00 0 0 0 0 0	Fund 8. 00	0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	sheet (line 11 minus line 18)         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)	6.00	Pl ant 7.00 0 0 0 0 0 0 0	Fund 8. 00	0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	sheet (line 11 minus line 18)         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)	6.00	PI ant 7.00 0 0 0 0 0 0 0 0 0	Fund 8. 00	0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	sheet (line 11 minus line 18)         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)	6.00	Pl ant 7.00 0 0 0 0 0 0 0	Fund 8. 00	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
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	sheet (line 11 minus line 18)         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)	6.00	PI ant 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0	Fund 8. 00	0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ \end{array}$	sheet (line 11 minus line 18)         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)	6.00	Pl ant 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Fund 8.00	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
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	sheet (line 11 minus line 18)         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)	6.00	Pl ant 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Fund 8.00	0		$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	sheet (line 11 minus line 18)         Fund balances at beginning of period         Net income (loss) (from Wkst. G-3, line 29)         Total (sum of line 1 and line 2)         Additions (credit adjustments) (specify)         Total additions (sum of line 4-9)         Subtotal (line 3 plus line 10)         Deductions (debit adjustments) (specify)	6.00 0 0 0	Pl ant 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Fund 8.00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$	sheet (line 11 minus line 18)         Fund balances at beginning of period         Net income (loss) (from Wkst. G-3, line 29)         Total (sum of line 1 and line 2)         Additions (credit adjustments) (specify)         Total additions (sum of line 4-9)         Subtotal (line 3 plus line 10)         Deductions (debit adjustments) (specify)         Total deductions (sum of lines 12-17)	6.00	Pl ant 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Fund 8.00			$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	sheet (line 11 minus line 18)         Fund balances at beginning of period         Net income (loss) (from Wkst. G-3, line 29)         Total (sum of line 1 and line 2)         Additions (credit adjustments) (specify)         Total additions (sum of line 4-9)         Subtotal (line 3 plus line 10)         Deductions (debit adjustments) (specify)	6.00 0 0 0	Pl ant 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Fund 8.00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$

	Financial Systems COMMUNITY HOSPIT					u of Form CMS-2	
STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 150113	Perio From To	od: 01/01/2015 12/31/2015	Worksheet G-2 Parts I & II Date/Time Pre 5/24/2016 1:2	pared:
	Cost Center Description		Inpatient	0	utpatient	Total	
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						
	General Inpatient Routine Services						
1.00	Hospi tal		33, 080, 0	46		33, 080, 046	1.00
2.00	SUBPROVIDER - IPF			0		0	2.00
3.00	SUBPROVIDER - IRF			0		0	3.00
4.00	SUBPROVI DER			0		0	
5.00	Swing bed - SNF			0		0	
6.00	Swing bed - NF			0		0	
7.00	SKILLED NURSING FACILITY			0		0	
8.00	NURSING FACILITY			0		0	
9.00	OTHER LONG TERM CARE			0		0	
10.00	Total general inpatient care services (sum of lines 1-9)		33, 080, 0	46		33, 080, 046	10.00
11 00	Intensive Care Type Inpatient Hospital Services		0 5 4 0 5	10		0 540 510	1 1 1 00
11.00 12.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T		8, 560, 5			8, 560, 512	1
12.00	BURN INTENSIVE CARE UNIT			0 0		0	
13.00	SURGI CAL I NTENSI VE CARE UNI T			0		0	
14.00	OTHER SPECIAL CARE (SPECIFY)			0		0	14.00
16.00	Total intensive care type inpatient hospital services (sum o	f lines 11-15	) 8, 560, 5	12		8, 560, 512	
17.00	Total inpatient routine care services (sum of lines 10 and 1		41, 640, 5			41, 640, 558	
18.00	Ancillary services	0)	148, 466, 2		206, 317, 449	354, 783, 737	
19.00	Outpatient services		8, 415, 3		40, 330, 510	48, 745, 847	•
20.00	RURAL HEALTH CLINIC		6, 116, 6	0	0,000,010	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	
22.00	HOME HEALTH AGENCY			-	0	0	
23.00	AMBULANCE SERVICES			0	0	0	
24.00	СМНС				0	0	24.00
24.10	CORF			0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D. P. )			0	0	0	25.00
26.00	HOSPI CE			0	0	0	26.00
27.00	NURSERY, NRCC AND OTHER		2, 016, 7	64	7, 879, 257	9, 896, 021	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column	3 to Wkst.	200, 538, 9	47	254, 527, 216	455, 066, 163	28.00
	G-3, line 1)						
	PART II - OPERATING EXPENSES						
29.00	Operating expenses (per Wkst. A, column 3, line 200)				136, 944, 040		29.00
30.00	ADD (SPECIFY)			0			30.00
31.00				0			31.00
32.00				0			32.00
33.00 34.00				0 0			33.00 34.00
				0			•
35.00 36.00	Total additions (sum of lines 30-35)			0	0		35.00
37.00	DEDUCT (SPECIFY)			0	0		37.00
37.00				0			37.00
38.00				0			39.00
40.00				0			40.00
40.00				0			41.00
42.00	Total deductions (sum of lines 37-41)			J	0		42.00
	Total operating expenses (sum of lines 29 and 36 minus line	42)(transfer			136, 944, 040		43.00
43.00							

Heal th	Financial Systems C	OMMUNITY HOSPITAL ANDER	SON	In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES		Prov	ider CCN: 150113	Period: From 01/01/2015 To 12/31/2015	Worksheet G-3 Date/Time Pre	hared:
				10 12/31/2013	5/24/2016 1:20	
					1.00	
1.00	Total patient revenues (from Wkst. G-2, Part	455, 066, 163	1.00			
2.00	Less contractual allowances and discounts on	287, 559, 546	2.00			
3.00	Net patient revenues (line 1 minus line 2)	167, 506, 617 136, 944, 040	3.00			
4.00						4.00
5.00	Net income from service to patients (line 3 m	inus line 4)			30, 562, 577	5.00
	OTHER I NCOME					
6.00	Contributions, donations, bequests, etc				0 62, 689	6.00
7.00						7.00
8.00	Revenues from telephone and other miscellaneous communication services					8.00
9.00						9.00
10.00						10.00
11.00					0	11.00
12.00	5				0	12.00
13.00 14.00	5				0 743, 905	13.00 14.00
15.00	Revenue from rental of living quarters	alian to other then noti	anto		2, 782 0	15. 00 16. 00
16. 00 17. 00	5 11 1					17.00
17.00						
19.00	Tuition (fees, sale of textbooks, uniforms, e				7, 207 0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and				0	20.00
21.00	Rental of vending machines	a canteen			0	
22.00	5				0	22.00
23.00					0	23.00
24.00						24.00
24.01						
24.02	GENERAL OTHER OPERATING REVENUE				-6, 626, 672 7, 530, 146	
25.00	Total other income (sum of lines 6-24)				1, 884, 184	
26.00	Total (line 5 plus line 25)				32, 446, 761	
27.00	BAD DEBT				8, 627, 355	
28.00	Total other expenses (sum of line 27 and subs	cripts)			8, 627, 355	
	Net income (or loss) for the period (line 26)				23, 819, 406	

Health Financial Systems         COMMUNITY HOSPITAL           CALCULATION OF CAPITAL PAYMENT         COMMUNITY HOSPITAL		Provider CCN: 150113	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prep 5/24/2016 1:20			
		Title XVIII	Hospi tal	PPS	o pii		
				1.00			
	PART I - FULLY PROSPECTIVE METHOD						
CAPITAL FEDERAL AMOUNT				1, 884, 143			
	Capital DRG other than outlier						
.01 Model 4 BPCI Capital DRG other 1	than outlier			0 104, 598			
	Capital DRG outlier payments				2.0		
	Model 4 BPCI Capital DRG outlier payments						
	Total inpatient days divided by number of days in the cost reporting period (see instructions)				3.0		
	Number of interns & residents (see instructions)						
	Indirect medical education percentage (see instructions)						
	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and						
1.01)(see instructions) .00 Percentage of SSI recipient pati	ant dave to Madi care Dart A r	ationt dave (Warksheat F	nort A Line 20)	4 40	7.0		
.00 Percentage of SSI recipient pati (see instructions)	ent days to medicare part a pa	attent days (worksheet E	, part A Trie 30)	4.68	/.(		
00 Percentage of Medicaid patient of	25.88	8.					
00 Sum of Lines 7 and 8	30.56						
Allowable disproportionate share percentage (see instructions)				6.39			
Dipspoportionate share adjustment (see instructions)				120, 397			
2.00 Total prospective capital paymer				2, 109, 138			
			-	1.00			
PART II - PAYMENT UNDER REASONAE	ILE COST						
.00 Program inpatient routine capita	Program inpatient routine capital cost (see instructions)				1 1.0		
00 Program inpatient ancillary capi	Program inpatient ancillary capital cost (see instructions)				2.		
00 Total inpatient program capital	Total inpatient program capital cost (line 1 plus line 2)				3.		
.00 Capital cost payment factor (see	Capital cost payment factor (see instructions)				4.		
00 Total inpatient program capital	cost (line 3 x line 4)			0	5.		
			_				
PART III - COMPUTATION OF EXCEPT				1.00			
00 Program inpatient capital costs				0	1 1.		
00 Program inpatient capital costs	. ,	os (soo instructions)		0	2.		
00 Net program inpatient capital costs				0			
00 Applicable exception percentage				0.00			
00 Capital cost for comparison to p	. ,			0.00	5.		
	Percentage adjustment for extraordinary circumstances (see instructions)				6.		
	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)						
Capital minimum payment level (line 5) lus line 7)				0			
Current year capital payments (from Part I, line 12, as applicable)				Ő			
	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)				10.		
	Carryover of accumulated capital minimum payment level over capital payment (from prior year Workshee						
.00 Net comparison of capital minimu	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)				12.		
	Current year exception payment (if line 12 is positive, enter the amount on this line)				13.		
.00 Carryover of accumulated capital	minimum payment level over ca	apital payment for the f	ollowing period (	if 0	14.		
line 12 is negative, enter the a							
00 Comment of a standard to an area the	and conital novement (coo inc	tructions)		0	15.		
				Ŭ,			
<ul> <li>6.00 Current year allowable operating</li> <li>6.00 Current year operating and capit</li> <li>7.00 Current year exception offset and</li> </ul>	tal costs (see instructions)			0	16.		