Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. In Lieu of Form CMS-2552-10 This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0169 Worksheet S Peri od. From 01/01/2019 Parts I-III AND SETTLEMENT SUMMARY 12/31/2019 Date/Time Prepared: То 6/30/2020 2:16 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 6/30/2020 Time: 2:16 pm use only Manually prepared cost report 2 [ ] If this is an amended report enter the number of times the provider resubmitted this cost report ] Medicare Utilization. Enter "F" for full or "L" for low. 3 Ο Ē 4 [ 

 [1] Cost Report Status
 6. Date Received:

 (1) As Submitted
 7. Contractor No.

 (2) Settled without Audit
 8. [N] Initial Report for this Provider CCN

 (3) Settled with Audit
 9. [N] Final Report for this Provider CCN

 Contractor 5. use only Δ (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OF FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL. CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPITAL OF INDIANA, INC. (15-0169) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations. [X] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature. HOLLY MILLARD (Signed) Officer or Administrator of Provider(s) NETWORK SR VP FINANCE Title (Dated when report is electronically signed.) Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY					_	
1.00	Hospi tal	0	386, 791	167, 882	0	0	1.00
2.00	Subprovider - IPF	0	9, 783	-10		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	396, 574	167, 872	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The 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, 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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	Subprovider - (Other)											6
	Swing Beds - SNF											7
	Swing Beds - NF											8
C	Hospital-Based SNF											9
00	Hospital-Based NF											10
00	Hospital-Based OLTC											11.
00	Hospital-Based HHA											12
00 00	Separately Certified ASC											13
00 00	Hospital-Based Hospice Hospital-Based Health Clinic - RHC											14
00	Hospital - Based Health Clinic - FQHC											16
00	Hospital-Based (CMHC) I											17
00	Renal Dialysis											18
00	Other											19
							From 1.0			To: 2.00	<u> </u>	-
00	Cost Reporting Period (mm/dd/yyyy)						01/01/		12/	/31/2		20
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~~	Inpatient PPS Information					Y	N					1 22
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	Financial Systems COMMUNITY HO AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC		Peri od:	In Lieu	Worksh	eet S-2	
					From 01/ To 12/		Part I Date/T 6/30/2	ime Pre 020 2:1	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid	Out-of State Medicaid paid days	Out-of State Medicaid eligible	Medica HMO da	ys 🛛 Me	)ther di cai d days	
			days		unpai d				1
. 00	If this provider is an IRF, enter the in-state	1.00	2.00	3.00	4.00	5.00	0	6.00	25.
	Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.								
						Rural S 00		f Geogr 00	
. 00	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for		at the beg	ginning of t	the	1			26.
. 00	Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	age) status r "2" for r	ural. If ap		st	1			27.
. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of	periods SC	CH status ir	ı	0			35.
						nni ng: 00	Endi 2.	i ng: 00	-
. 00	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		cript line	36 for numb					36.
. 00	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		r of period	ds MDH statu	ıs	0			37.
. 01	Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)								37.
00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38
						/N 00		/N 00	-
. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet 1 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)	), (ii), or the mileage	(iii)? Ent requiremer	ter in colum nts in	ıme ın	N		N	39.
. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. Ente	r"Y" for y			Y	Ň	Y	40.
						V 1.00	XVIII 2.00	XI X 3.00	-
00	Prospective Payment System (PPS)-Capital	at fam dian	roportionat	to oboro in			-	-	45.
. 00	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst	eption for	extraordi na	ary circumst	ances	N N	Y N	N N	45.
. 00 . 00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS o Is the facility electing full federal capital payment	•		5		N	N N	N N	47. 48.
. 00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you i	mpacted by	CR 11642 (				Y		56
00	GME payment reduction? Enter "Y" for yes or "N" for If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	period duri r yes or "N th of this Y", complet , if appli	ng which re "for no ir cost report e Worksheet cable.	n column 1. ting period? t E-4. lf co	ול column ? Enter א טועשה 2 is	···			57
00	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,			ans' service	es as	N			58
00	Are costs claimed on line 100 of Worksheet A? If yes	s, complete	Wkst. D-2,	Pt. I. NAHE 413.8 Y/N		N heet A he #		hrough ication on Code	
				1.00		00		00	-
). 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C	85? (see umn 1. If	column 1	N	2	00	3.	00	60.

iospi t	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC		eriod: com 01/01/2019 o 12/31/2019	Worksheet S-2 Part I Date/Time Pre 6/30/2020 2:1	pared:
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N			0.00	0.00	61.0
1. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.0
1. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
1.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.0
	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.0
1. 06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.0
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
1. 10	Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	61.1
	specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00		61. 2
						1.00	
- -	ACA Provisions Affecting the Health Resources and Ser			. ,		0.00	
2. 00 2. 01	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	ctions) a Teachi gram. (s	ng Health Cent see instruction	ter (THC) into			62.0 62.0
3. 00	Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, complete	ettings	during this co	67. (see instru	ictions)	N	63.0
				Unweighted FTEs Nonprovider Site	FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Year FTE Residents in No	onprovia	der Settinas	1.00 This base year	2.00 is your cost r	3.00 eporting	
4.00	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	<u>re June</u> ty trair a-primar all nor d non-pr n columr	30, 2010. med residents y care provider imary care a 3 the ratio	0.00	-		64.0

		DATA Provider	Fr	eriod: com 01/01/2019	Worksheet S-2 Part I	
			To	12/31/2019	Date/Time Pre 6/30/2020 2:1	epared
	Program Name	Program Code	Unweighted	Unwei ghted	Ratio (col. 3/	/
			FTES	FTEs in	$(col \cdot 3 + col \cdot$	
			Nonprovider Site	Hospi tal	4))	
	1.00	2.00	3.00	4.00	5.00	
5.00 Enter in column 1, if line 63			0.00	0.00	0 0. 000000	0 65.0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column						
5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						
			Unweighted	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
			FTEs Nonprovider	Hospital	(COI. 1 + COI. 2))	·
			Si te		_,,,	
			1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 20		in Nonprovider Settin	ngsEffective fo	or cost reporti	ing periods	
Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 -	tal. Enter in column	3 the ratio of <u>nstructions)</u>				
		Program Code	Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			FTĔs Nonprovider Site	FTES in Hospital	(col. 3 + col. 4))	
	1.00 FAMILY PRACTICE	2.00 1350	FTĔs Nonprovi der	FTEsin	(col. 3 + col. 4)) 5.00	
7.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00 FAMI LY PRACTI CE	2.00	FTĔs Nonprovi der Si te 3.00	FTES in Hospital	(col. 3 + col. 4)) 5.00	
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00 FAMI LY PRACTI CE	2.00	FTĔs Nonprovi der Si te 3.00	FTES in Hospital	(col . 3 + col . 4)) 5.00 9 0.000000	
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00 FAMI LY PRACTI CE	2.00	FTĚs Nonprovi der Si te 3.00 0.00	FTES in Hospi tal 4.00 1.49	(col . 3 + col . 4)) 5.00 9 0.000000	0 67.0
<pre>name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</pre>	1.00 FAMILY PRACTICE PPS sychiatric Facility of the facility have a pefore November 15, 2 olumn 2: Did this faa FR 412.424 (d)(1)(iiii cate which program y	2.00 1350 (IPF), or does it con an approved GME teach 2004? Enter "Y" for cility train resident )(D)? Enter "Y" for	FTĚs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for n s in a new teach yes or "N" for n	FTES in Hospital 4.00 1.49 1.49 1.00 1.00 rovider? Y he most N o. (see ing o.	(col . 3 + col . 4)) 5.00 9 0.000000 9 0.000000 9 0.000000 9 0.000000	70.
<pre>name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</pre>	1.00 FAMILY PRACTICE PPS sychiatric Facility d the facility have a before November 15, 2 blumn 2: Did this fac FR 412.424 (d)(1)(iii cate which program y ty PPS shabilitation Facili	2.00 1350 (IPF), or does it con an approved GME teach 2004? Enter "Y" for cillity train resident )(D)? Enter "Y" for year began during thi	FTËs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for n s in a new teach yes or "N" for n	FTES in Hospital 4.00 1.49 1.49 1.00 1.00 rovider? Y he most N o. (see ing o.	(col . 3 + col . 4)) 5.00 9 0.000000 9 0.000000 9 0.0000000 9 0.0000000 9 0.0000000 9 0.0000000 9 0.0000000 9 0.0000000 9 0.0000000	

Health Financial Systems COMMUNITY HOSPITAL	OF INDIANA, IN	NC.	In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet S- Part I Date/Time Pr 6/30/2020 2:	repared:
				1.00	
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for ye 81.00 Is this a LTCH co-located within another hospital for part "Y" for yes and "N" for no.			g period? Enter	N N	80. 00 81. 00
TEFRA Providers         85.00       Is this a new hospital under 42 CFR Section §413.40(f)(1)(i         86.00       Did this facility establish a new Other subprovider (exclud				N	85. 00 86. 00
<pre>§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital an extended neoplastic disease care hospit 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.</pre>	al classi fied	under section		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 XIX inpatient hospit	al services? E	nter "Y" for	N	Y	90.00
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through			N	N	91.00
92.00 Full or in part? Enter "Y" for yes or "N" for no in the app 92.00 Are title XIX NF patients occupying title XVIII SNF beds (d instructions) Enter "Y" for yes or "N" for no in the applic	ual certificat			Ν	92.00
93.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.		d XIX? Enter	N	Ν	93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for n	o in the	N	Ν	94.00
95.00 If line 94 is "Y", enter the reduction percentage in the ap 96.00 Does title V or XIX reduce operating cost? Enter "Y" for ye			0. 00 N	0. 00 N	95.00 96.00
<ul> <li>applicable column.</li> <li>97.00 If line 96 is "Y", enter the reduction percentage in the ap</li> <li>98.00 Does title V or XIX follow Medicare (title XVIII) for the i stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y"</li> </ul>	nterns and res	idents post	0. 00 Y	0. 00 N	97.00 98.00
<ul> <li>column 1 for title V, and in column 2 for title XIX.</li> <li>98.01 Does title V or XIX follow Medicare (title XVIII) for the r C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t</li> </ul>				Y	98.01
<ul> <li>title XIX.</li> <li>98.02 Does title V or XIX follow Medicare (title XVIII) for the c bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes</li> </ul>			Y	Y	98. 02
<ul> <li>for title V, and in column 2 for title XIX.</li> <li>98.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y</li> </ul>			N 1	N	98. 03
<pre>for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no i in column 2 for title XIX.</pre>			Ν	N	98.04
98.05 Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in				Y	98.05
<pre>column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.</pre>	reimbursed fo n 1 for title	r Wkst. D, V, and in	Y	Y	98.06
Rural Providers 105.00 Does this hospital qualify as a CAH?	inclucive met	had of norman	N N		105.00
106.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for c		1 5	t N N		106.00
training programs? Enter "Y" for yes or "N" for no in colum Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded I	n 1. (see ins you train I&R PF and/or IRF	tructions) s in an			
Enter "Y" for yes or "N" for no in column 2. (see instruct 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		dul e? See 42	Ν		108.00
	Physi cal 1.00	Occupationa 2.00	I Speech 3.00	Respi ratory 4.00	,
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
				1.00	
110.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no.	lf yes,	N	110.00

Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC			u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CC	F	eriod: rom 01/01/2019 o 12/31/2019		epared:
111.00 If this facility qualifies as a CAH, did it participate in the Frontier Co Health Integration Project (FCHIP) demonstration for this cost reporting p "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, e integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	eriod? Enter enter the column 2.	1.00 N	2.00	111.00
	1.00	2.00	3.00	_
112.00 Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	N			112.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0115.00
116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Ν			116.00
117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1	1		118.00
118.01List amounts of malpractice premiums and paid losses:	1. 00 788, 234	2.00 4 C	3.00	0118.01
		1.00	2.00	-
118.02 Are mal practice premiums and paid losses reported in a cost center other t Administrative and General? If yes, submit supporting schedule listing co and amounts contained therein. 119.00 DO NOT USE THIS LINE		N		118.02
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for th Hold Harmless provision in ACA §3121 and applicable amendments? (see instr Enter in column 2, "Y" for yes or "N" for no.	for yes or Ne Outpatient	N	Ν	119. 00 120. 00
121.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.	charged to	Y		121.00
122.00 Does the cost report contain healthcare related taxes as defined in §1903( Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.		N		122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below.	for no. If	N		125.00
126.00 If this is a Medicare certified kidney transplant center, enter the certified in column 1 and termination date, if applicable, in column 2.	ïcation date			126. 00
127.00 If this is a Medicare certified heart transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2.	cation date			127.00
128.00 If this is a Medicare certified liver transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2.				128.00
129.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2.				129.00
130.00 If this is a Medicare certified pancreas transplant center, enter the cert date in column 1 and termination date, if applicable, in column 2.				130.00
131.00 If this is a Medicare certified intestinal transplant center, enter the ce date in column 1 and termination date, if applicable, in column 2.				131.00
<ul> <li>132.00 If this is a Medicare certified islet transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2.</li> <li>133.00 Removed and reserved</li> </ul>	cation uate			132.00 133.00
133.00 kemoved and reserved 134.00 lf this is an organ procurement organization (OPO), enter the OPO number i and termination date, if applicable, in column 2. All Providers	n column 1			134. 00
<ul> <li>All Providers</li> <li>140.00 Are there any related organization or home office costs as defined in CMS chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home are claimed, enter in column 2 the home office chain number. (see instruct</li> </ul>	office costs	Y		140. 00

Health Financial Systems	COMMUNI TY HOSI	PITAL OF	INDIANA, IN	C.			In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	A	Provider CC	N: 15-016		ri od:	/01/2019	Worksheet S-2 Part I	2
					To		/31/2019		epared:
1.00		2.00					2.00	6/30/2020 2:	16 pm
1.00 If this facility is part of a chain	organization ente	2.00	nes 141 throu	iah 143 t	the nam	e and	3.00	of the	
home office and enter the home offi						c ana	uuui 033	of the	
141.00 Name: COMMUNITY HEALTH NETWORK	Contractor's Na			I ANS Cont	ractor'	s Nur	nber: 0810	1	141.00
142.00 Street: 1500 NORTH RITTER AVENUE	PO Box:	SERV	ICES						142.00
142.00 City: INDIANAPOLIS	State:	IN		Zip	Code:		4621	9-3095	142.00
	prator			p	00001		1021		110100
								1.00	
144.00 Are provider based physicians' cost	s included in Works	heet A?						Y	144.00
					-		1.00	2.00	-
145.00 If costs for renal services are cla	med on Wkst. A, li	ne 74, a	are the costs	for			Y	2.00	145.00
inpatient services only? Enter "Y"									
no, does the dialysis facility incl period? Enter "Y" for yes or "N" fo		ation to	or this cost	reportin	ig				
146.00 Has the cost allocation methodology		revi ousl	y filed cost	report?			Ν		146.00
Enter "Y" for yes or "N" for no in	column 1. (See CMS	Pub. 15							
yes, enter the approval date (mm/dd	/yyyy) in column 2.								
								1.00	-
147.00 Was there a change in the statistic	al basis? Enter "Y"	for yes	s or "N" for	no.				N N	147.00
148.00 Was there a change in the order of			,					N	148.00
149.00 Was there a change to the simplifier	d cost finding meth	od? Ente					+1 - V	N Title VIV	149.00
			Part A 1.00	Part 2.0			tle V 3.00	Title XIX 4.00	-
Does this facility contain a provid	er that qualifies f	or an e							
or charges? Enter "Y" for yes or "N	" for no for each c	componen				ee 42			_
155.00 Hospi tal			N	N N			N	N	155.00 156.00
156.00 Subprovi der – IPF 157.00 Subprovi der – IRF			N N	N N			N N	N N	156.00
158. OO SUBPROVI DER									158.00
159.00 SNF			N	N			N	N	159.00
160.00 HOME HEALTH AGENCY			N	N			N	N	160.00
161.00 CMHC				N			N	N	161.00
								1.00	
Multicampus									
165.00 Is this hospital part of a Multicam Enter "Y" for yes or "N" for no.	ous hospital that h	as one o	or more campu	ises in d	li fferer	nt CB	SAS?	N	165.00
	Name		County	State	Zip(	Code	CBSA	FTE/Campus	
	0		1.00	2.00	3.0	00	4.00	5.00	
166.00 If line 165 is yes, for each								0.0	0166.00
campus enter the name in column 0, county in column 1, state in									
column 2, zip code in column 3,									
CBSA in column 4, FTE/Campus in									
column 5 (see instructions)		<u> </u>							
								1.00	
Health Information Technology (HIT)						Act			
167.00 Is this provider a meaningful user							41	Y	167.00
168.00 If this provider is a CAH (line 105 reasonable cost incurred for the HI				e 167 TS	Y), E	enter	the		168.00
168.01 If this provider is a CAH and is no	t a meaningful user	, does <sup>-</sup>	this provider			hard	shi p		168. 01
exception under §413.70(a)(6)(ii)?									
169.00 If this provider is a meaningful us transition factor. (see instruction		) and is	s not a CAH (	line 105	is "N'	'), ei	nter the	9.9	9169.00
	>)					Bec	ji nni ng	Endi ng	
							1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR be	ginning date and en	ding da	te for the re	eporting					170.00
period respectively (mm/dd/yyyy)									
					F		1.00	2.00	
171.00 If line 167 is "Y", does this provi							Ν		0171.00
section 1876 Medicare cost plans re									
"Y" for yes and "N" for no in colum 1876 Medicare days in column 2. (se		yes, ei							
					1			•	•

IOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0169	Period: From 01/01/2019 To 12/31/2019	6/30/2020 2:	epared:
				Y/N 1.00	Date 2.00	-
	General Instruction: Enter Y for all YES responses. Enter N	lfor all NO re	sponses. Ente			-
	mm/dd/yyyy format.		•			_
	COMPLETED BY ALL HOSPITALS					_
. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1 1.0
	reporting period? If yes, enter the date of the change in c					
			Y/N	Date	V/I	
. 00	Has the provider terminated participation in the Medicare P	)rogram2 lf	1.00 N	2.00	3.00	2.0
. 00	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.0
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and othe relationships? (see instructions)	offices, drug ler or its of the board	Y			3.0
			Y/N	Туре	Date	
			1.00	2.00	3.00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe	for Compiled, Milable in	Y	A		4.00
. 00	those on the filed financial statements? If yes, submit rec					0.0
	Approved Educational Activitian			Y/N 1.00	Legal Oper. 2.00	
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	lfves is th	ne provider is	s N		6.00
	the legal operator of the program?	··· j·, ··- ··				
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		during the	N N		7.0 8.0
. 00	Are costs claimed for Interns and Residents in an approved	graduate medic	al education	Y		9.0
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.		he current	Ν		10. 0
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	Ν		11.0
					Y/N 1.00	-
	Bad Debts				1.00	
2. 00 3. 00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	Y N	12. 0 13. 0
4.00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement			structions.	N	14.0
5.00	Did total beds available change from the prior cost reporti		yes, see inst t A	tructions. Par	N + P	15.0
		Y/N	Date	Y/N	Date	_
		1.00	2.00	3.00	4.00	
4 00	PS&R Data	N		N		14.0
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see	N		N		16.0
7.00	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	Y	06/26/2020	Y	06/26/2020	17.0
8. 00	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	Ν		Ν		18.0
9. 00	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	N		Ν		19. 0

Heal th	Fi nanci al	Systems

In Lieu of Form CMS-2552-10

lealth Fin	nancial Systems COMMUNITY HOSPITAL	. 0F	INDIANA, II	VC.	In Lie	eu of Form CM	S-2552-10
HOSPI TAL 4	AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider C	1	Period: From 01/01/2019 Fo 12/31/2019		repared:
			Descr	iption	Y/N	Y/N	
		-		0	1.00	3.00	
	line 16 or 17 is yes, were adjustments made to PS&R port data for Other? Describe the other adjustments:				N	N	20.00
1			Y/N	Date	Y/N	Date	
			1.00	2.00	3.00	4.00	
21.00 Was	s the cost report prepared only using the provider's		N		N		21.00
rec	cords? If yes, see instructions.						
						1.00	
	IPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT	CHILDRENS H	IOSPI TALS)			
	ital Related Cost					1	
	ve assets been relifed for Medicare purposes? If yes, se						22.00
	ve changes occurred in the Medicare depreciation expense porting period? If yes, see instructions.	due	e to apprais	als made durir	ng the cost		23.00
	re new leases and/or amendments to existing leases enter yes, see instructions	ed i	nto during	this cost repo	orting period?		24.00
25.00 Hav	ve there been new capitalized leases entered into during structions.	the	e cost repor	ting period? I	f yes, see		25.00
26.00 Wer	re assets subject to Sec.2314 of DEFRA acquired during t	he c	cost reporti	ng period? If	yes, see		26.00
	structions. s the provider's capitalization policy changed during th	e co	ost reportir	ng period?lf	yes, submit		27.00
cop	by. Perest Expense						_
28.00 Wer	re new loans, mortgage agreements or letters of credit e	nter	red into dur	ing the cost r	reporting		28.00
	riod? If yes, see instructions. I the provider have a funded depreciation account and/or	bor	nd funds (De	ebt Service Res	serve Fund)		29.00
	eated as a funded depreciation account? If yes, see inst s existing debt been replaced prior to its scheduled mat			debt? If ves.	see		30.00
i ns	structions. s debt been recalled before scheduled maturity without i		5	5			31.00
ins	structions.	SSUC		uebt: 11 yes,	See		
	chased Services /e changes or new agreements occurred in patient care se	nui c	oc furniche	d through cont	tractual		32.00
arr	rangements with suppliers of services? If yes, see instr	ucti	ons.				
	line 32 is yes, were the requirements of Sec. 2135.2 ap see instructions.	plie	ed pertainir	ng to competiti	ve bidding? If		33.00
Pro	vi der-Based Physi ci ans						
34.00 Are	e services furnished at the provider facility under an a	rrar	ngement with	n provider-base	ed physi ci ans?		34.00
	yes, see instructions.						
	line 34 is yes, were there new agreements or amended ex ysicians during the cost reporting period? If yes, see i			nts with the pr	rovi der-based		35.00
	, <u></u>			-	Y/N	Date	
					1.00	2.00	
Hom	ne Office Costs					•	
	re home office costs claimed on the cost report? line 36 is yes, has a home office cost statement been p	repa	ared by the	home office?			36.00 37.00
lf	yes, see instructions. line 36 is yes, was the fiscal year end of the home of		-				38.00
the	e provider? If yes, enter in column 2 the fiscal year en	d of	f the home c	offi ce.			
see	line 36 is yes, did the provider render services to oth e instructions.			5			39.00
	line 36 is yes, did the provider render services to the structions.	hom	ne office?	lf yes, see			40.00
			1.	00	2.	00	_
Cos	t Report Preparer Contact Information						
1.00 Ent	d by the cost report preparer in columns 1, 2, and 3,	SHI	RLEY		BI SHOP		41.00
res	spectively. the employer/company name of the cost report	CON		TU NETWOOV			42.00
pre	eparer.		MUNITY HEAL	. III INLIWUKK			
	ter the telephone number and email address of the cost port preparer in columns 1 and 2, respectively.	317	7-355-4135		SBI SHOP@ECOMMU	NITY.COM	43.00
	· -						

Heal th	Financial Systems	COMMUNI TY HOSPI TAL	OF INDIANA,	INC.	In Lie	u of Form CMS-	2552-10
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMEN	T QUESTI ONNAI RE	Provi der	CCN: 15-0169	Period:	Worksheet S-2	
			_		From 01/01/2019 To 12/31/2019		
				3.00			
	Cost Report Preparer Contact Information	1					
41.00	Enter the first name, last name and the	ti tl e/posi ti on	DIRECTOR REI	MBURSEMENT			41.00
	held by the cost report preparer in col	umns 1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the	cost report					42.00
	preparer.						
43.00	Enter the telephone number and email ad	dress of the cost					43.00
	report preparer in columns 1 and 2, res	oecti vel y.					

	Financial Systems COMMM AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	<u>JNI TY HOSPI TAL</u> AL DATA	Provider CC		Period: From 01/01/2019 To 12/31/2019	u of Form CMS-2 Worksheet S-3 Part I Date/Time Pre	
						6/30/2020 2:10 I/P Days / 0/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Avai I abl e	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00	238	86, 87	0.00	0	1.00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider						2.00 3.00 4.00
5.00 6.00 7.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation		238	86, 87	0.00	0 0 0	5.00 6.00 7.00
8.00 9.00 10.00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	31. 00	24	8, 76	0.00	0	8.00 9.00 10.00
11. 00 12. 00 13. 00	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT NURSERY	35. 00 43. 00	48	17, 52	0.00	0	11.00 12.00 13.00
14.00 15.00	Total (see instructions) CAH visits		310	113, 15	0.00	0	14. 00 15. 00
16.00 17.00 18.00 19.00	SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY	40. 00	18	6, 57	70	0	16.00 17.00 18.00 19.00
20.00 21.00 22.00 23.00	NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)						20.00 21.00 22.00 23.00
24.00 24.10 25.00 26.00	HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	30. 00					24.00 24.10 25.00 26.00
26. 25 27. 00 28. 00 29. 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips	89.00	328			0	26.25 27.00 28.00 29.00
30.00 31.00 32.00 32.01	Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room		0		0		30.00 31.00 32.00 32.01
33.00	LTCH site neutral days and discharges						33. 00 33. 01

PITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICA	AL DATA	Provider CC		Period: From 01/01/2019 Fo 12/31/2019	Worksheet S-3 Part I Date/Time Pre 6/30/2020 2:1	pared
	I/P Days	/ O/P Visits	/ Trips	Full Time I	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	
Mospital 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)	18, 645	2, 470	57, 49	7		1.
0 HMO and other (see instructions)	9, 559	19, 857				2.
00 HMO IPF Subprovider 00 HMO IRF Subprovider	0	0				3. 4.
0 Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.
00 Hospital Adults & Peds. Swing Bed NF		0				6.
0 Total Adults and Peds. (exclude observation beds) (see instructions)	18, 645	2, 470	57, 49	7		7.
O INTENSIVE CARE UNIT	2, 102	0	6, 54	4		8.
OO CORONARY CARE UNI T						9.
00 BURN INTENSIVE CARE UNIT						10.
00 SURGI CAL I NTENSI VE CARE UNI T				_		11.
00 NEONATAL INTENSIVE CARE UNIT	0	1, 717				12.
00 NURSERY	20 747	2, 781 6, 968	7, 38		1, 539. 36	13
00 Total (see instructions) 00 CAH visits	20, 747	0, 908 0		4 4.40	1, 539. 30	14
00 SUBPROVIDER - IPF	2,786	0		5	26.66	
00 SUBPROVIDER - IRF	2,700	0	0, 11.		20.00	17
00 SUBPROVI DER						18
00 SKILLED NURSING FACILITY						19
00 NURSING FACILITY						20
OO OTHER LONG TERM CARE						21
00 HOME HEALTH AGENCY						22
00 AMBULATORY SURGICAL CENTER (D. P. )						23
00 HOSPI CE				_		24
10 HOSPICE (non-distinct part)			40	/		24
00 CMHC - CMHC 00 RURAL HEALTH CLINIC						25 26
25 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0.00	0.00	
00 Total (sum of lines 14-26)	0	0	, i i i i i i i i i i i i i i i i i i i	6. 14		
00 Observation Bed Days		2, 023	7,65		1,000.02	28
00 Ambul ance Trips	0	_,	.,			29
00 Employee discount days (see instruction)			2, 26	5		30
00 Employee discount days - IRF				D		31
00 Labor & delivery days (see instructions)	0	55	1, 39	9		32
01 Total ancillary labor & delivery room			(	D		32
outpatient days (see instructions)						
00 LTCH non-covered days	0					33
01 LTCH site neutral days and discharges	0					

	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	al data	Provider CC	CN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part I Date/Time Pre 6/30/2020 2:1	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 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 14.00 15.00 14.00 20.00 21.00 22.00 23.00 24.00	NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE	0.00	0	4, 5 1, 7 4, 5	16 500 72 2, 824 0 0	17, 426 17, 426 495	1.00 2.00 3.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 20.00 21.00 22.00 23.00 24.00 24.10
25.00 26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.01 33.00	CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0.00 0.00			0		25. 00 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 01 33. 00

	Financial Systems AL WAGE INDEX INFORMATION	COMML	INI TY HOSPI TAL	OF INDIANA, IN Provider CO		In Lie eriod:	worksheet S-3	
						rom 01/01/2019	Part II Date/Time Pre	pared:
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adj usted Sal ari es (col . 2 ± col . 3)		6/30/2020 2:1 Average Hourly Wage (col. 4 ÷ col. 5)	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARI ES							
1.00	Total salaries (see instructions)	200.00	107, 915, 223	-586, 529	107, 328, 694	3, 257, 322. 00	32.95	1.00
2.00	Non-physician anesthetist Part A		C	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part		C	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		357, 850	0	357, 850	1, 968. 00	181. 83	4.00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		C 489, 852	0	-	0. 00 8, 406. 00		1
6.00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		C	0	0	0.00		
7.00	services Interns & residents (in an	21.00	C	0	0	0.00	0.00	7.00
7.01	approved program) Contracted interns and residents (in an approved		C	0	0	0.00	0.00	7. 01
8.00	programs) Home office and/or related		C	0	0	0.00	0.00	8.00
9.00	organization personnel SNF	44.00	C	о	0	0.00		9.00
10. 00	Excluded area salaries (see instructions)		2, 830, 748	-14, 710	2, 816, 038	85, 186. 00	33.06	10.00
11.00	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		2, 048, 742	0	2, 048, 742	20, 502. 00	99. 93	11.00
12.00	Care Contract Labor: Top Level		C	0	0	0.00	0.00	12.00
	management and other management and administrative services							
13.00	Contract Labor: Physician-Part A - Administrative		1, 995, 259					13.00
14.00	Home office and/or related organization salaries and wage-related costs		C	0	0	0.00	0.00	14.00
14. 01 14. 02	Home office salaries Related organization salaries		34, 137, 040	0	34, 137, 040 0	840, 515. 00 0. 00		14.01 14.02
14.02 15.00	Home office: Physician Part A		C	0	0	0.00		15.00
16.00			C	0	0	0.00	0.00	16.00
16. 01	Physicians Part A - Teaching Home office Physicians Part A - Teaching		C	0	0	0.00	0.00	16. 01
16. 02	Home office contract Physicians Part A – Teaching		C	0	0	0.00	0.00	16. 02
17.00	WAGE-RELATED COSTS Wage-related costs (core) (see		26, 681, 540	0	26, 681, 540			17.00
18.00	instructions) Wage-related costs (other) (see instructions)							18.00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		720, 524	0	720, 524			19.00 20.00
20.00	A Non-physician anesthetist Part		C	0	0			21.00
22.00	B Physician Part A -		20, 699	0	20, 699			22.00
22. 01	Administrative Physician Part A - Teaching		C	0	0			22.01
23.00 24.00	Physician Part B Wage-related costs (RHC/FQHC)		89, 327	0	89, 327			23.00 24.00
25.00	Interns & residents (in an approved program)		C	0	0			25.00
25. 50	Home office wage-related (core)		8, 354, 416	0	8, 354, 416			25. 50
25. 51	Related organization wage-related (core)		C	0	0			25. 51
25. 52	Home office: Physician Part A - Administrative -		C	0	0			25. 52
	wage-related (core)							1

HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Peri od:	Worksheet S-3	
						From 01/01/2019	Part II	
						To 12/31/2019	Date/Time Pre 6/30/2020 2:10	
		Wkst. A Line		Recl assi fi cati		Paid Hours	Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.		col. 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A		0	0		0		25.5
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE							
26.00	Employee Benefits Department	4.00	164, 743		101771			
27.00	Administrative & General	5.00	5, 603, 979	-16, 666				
28.00	Administrative & General under		7, 658, 877	0	7, 658, 87	7 86, 237. 00	88. 81	28.0
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0		0 0.00		29.
30.00	Operation of Plant	7.00	3, 183, 469	-22, 842	3, 160, 62			
31.00	Laundry & Linen Service	8.00	0	0		0.00		
32.00	Housekeepi ng	9.00	3, 043, 122	-24, 885				
33.00	Housekeeping under contract (see instructions)		394, 740	0	394, 74	9, 911. 00	39. 83	33. (
34.00	Dietary	10.00	2, 543, 776	-1, 909, 543	634, 23	3 36, 046. 00	17.60	34.
35.00	Dietary under contract (see instructions)		509, 158	0	509, 15	6, 240. 00	81.60	35. (
36.00	Cafeteri a	11.00	0	1, 893, 968	1, 893, 96	8 105, 063. 00	18.03	36.
37.00	Maintenance of Personnel	12.00	0	0		0.00	0.00	37.
38.00	Nursing Administration	13.00	2, 349, 276	-9, 217	2, 340, 05	9 65, 746. 00	35.59	38.
39.00	Central Services and Supply	14.00	0	0		0.00	0.00	39.
10.00	Pharmacy	15.00	6, 880, 207	-1, 896, 268	4, 983, 93	9 119, 105. 00	41.84	40.
1. 00	Medi cal Records & Medi cal Records Library	16.00	377, 831	-7, 963	369, 86	8 9, 246. 00	40.00	41.
42.00	Social Service	17.00	1, 717, 727	-9, 015	1, 708, 71	2 44, 670. 00	38. 25	42.
43.00	Other General Service	18.00	0	0		0.00	0.00	43.

Heal th	Financial Systems	COMM	JNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2019 Fo 12/31/2019		
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)	/	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		115, 988, 146	-586, 529	115, 401, 61	7 3, 351, 304. 00	34.43	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		2, 830, 748	-14, 710	2, 816, 03	85, 186. 00	33.06	2.00
3.00	Subtotal salaries (line 1 minus line 2)		113, 157, 398	-571, 819	112, 585, 57	3, 266, 118. 00	34. 47	3.00
4.00	Subtotal other wages & related costs (see inst.)		38, 181, 041	0	38, 181, 04	1 878, 535. 00	43. 46	4.00
5.00	Subtotal wage-related costs (see inst.)		35, 056, 655	0	35, 056, 65	5 0.00	31.14	5.00
6.00	Total (sum of lines 3 thru 5)		186, 395, 094	-571, 819	185, 823, 27	5 4, 144, 653. 00	44.83	6.00
7.00	Total overhead cost (see instructions)		34, 426, 905	-2, 002, 431	32, 424, 47	4 966, 273. 00	33. 56	7.00

	Financial Systems COMMUNITY HOSPIT. AL WAGE RELATED COSTS	Provi der		15-0169	Peri od:	eu of Form CMS-2 Worksheet S-3	
			00	10 0107	From 01/01/2019		
					To 12/31/2019		
						6/30/2020 2:1	6 pm
						Amount	
						Reported	
						1.00	
	PART IV - WAGE RELATED COSTS Part A - Core List						-
	RETIREMENT COST						-
	401K Employer Contributions					3, 618, 376	1.0
2.00	Tax Sheltered Annuity (TSA) Employer Contribution					3,010,370	
3.00 3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	N N					
	Qualified Defined Benefit Plan Cost (see instructions)	)				3, 219	
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)					3, 219	4.0
	401K/TSA Plan Administration fees					0	5.0
. 00 . 00	Legal / Accounting/Management Fees-Pension Plan					252, 151	6.0
	Employee Managed Care Program Administration Fees						
						0	7.(
. 00	HEALTH AND INSURANCE COST Health Insurance (Purchased or Self Funded)					0	8.
	Health Insurance (Self Funded without a Third Party Admir	al atratar)					
. 01	Health Insurance (Self Funded with a Third Party Administ					-	
. 02	Health Insurance (Seri Funded with a Third Party Administ Health Insurance (Purchased)	trator)				11, 511, 973	
	Prescription Drug Plan Dental, Hearing and Vision Plan					2, 942, 858	
						114, 401	
	Life Insurance (If employee is owner or beneficiary)					64, 635	
	Accident Insurance (If employee is owner or beneficiary)	.)				0	
	Disability Insurance (If employee is owner or beneficiary					900, 600	
	Long-Term Care Insurance (If employee is owner or benefic	crary)				0	
5.00	'Workers' Compensation Insurance					250, 043	
6. 00	Retirement Health Care Cost (Only current year, not the e	extraordinary a	accrua	require	ed by FASB 106.	0	16.0
	Non cumulative portion) TAXES						-
	FICA-Employers Portion Only					7, 693, 134	1 1 7 1
8.00	Medicare Taxes - Employers Portion Only					1, 093, 134	
	Unemployment Insurance						-
	State or Federal Unemployment Taxes						
	OTHER					0	20.
	Executive Deferred Compensation (Other Than Retirement Co	act Poportod or		s 1 throu	iah 1 ahovo (soo	0	21.
1.00	instructions))	UST Reported of	i i i i iie		ign 4 above. (see	0	21.
2 00	Day Care Cost and Allowances					0	22.
	Tuition Reimbursement					157, 703	
	Total Wage Related cost (Sum of lines 1 -23)					27, 509, 093	
	Part B - Other than Core Related Cost					27, 309, 093	24.0
	OTHER WAGE RELATED COSTS (SPECIFY)						25.0

Heal th	Financial Systems	COMMUNI TY	HOSPI TAL OF	I NDI ANA,	INC.		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST			Provi der	CCN: 15-016		eri od:	Worksheet S-3	
							rom 01/01/2019		
							0 12/31/2019		
	Cost Center Description						Contract Labor	6/30/2020 2:10 Benefit Cost	5 pili
	cost center bescription						1.00	2.00	
	PART V - Contract Labor and Benefit Cos	+					1.00	2.00	
	Hospital and Hospital-Based Component I								
1.00	Total facility's contract labor and be		JII.				2, 048, 742	27, 509, 093	1.00
2.00	Hospi tal						2,048,742	26, 788, 569	2.00
3.00	Subprovi der – IPF						2,040,742	507, 455	
4.00	Subprovider - IRF						U	507, 455	4.00
4.00 5.00	Subprovider - (Other)						0	0	4.00 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						Ŭ	0	8.00
9.00	Hospi tal -Based NF								9.00
10.00	Hospi tal -Based OLTC								10.00
11.00	Hospi tal -Based HHA								10.00
12.00	Separately Certified ASC								12.00
13.00	Hospi tal -Based Hospi ce								12.00
14.00	Hospital -Based Health Clinic RHC								14.00
15.00	Hospital - Based Health Clinic FQHC								14.00
16.00	Hospi tal -Based-CMHC								16.00
	Renal Dialysis						0	0	17.00
18.00	Other						0	213, 069	
10.00							۱ V	213,007	10.00

Heal th	Financial Systems COMMUNITY HOSPITAL OF II	NDIANA, INC.		ln Li€	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	rovider CCN: 15-0		eriod: rom 01/01/2019	Worksheet S-1	C
				o 12/31/2019	Date/Time Pre 6/30/2020 2:1	
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by line 202	column	8)	0. 224038	1.00
	Medicaid (see instructions for each line)				24.044.740	
2.00 3.00	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?				91, 861, 742 Y	2.00 3.00
3.00 4.00	If line 3 is yes, does line 2 include all DSH and/or supplementa	al payments from	Medicai	d?	Y Y	3.00 4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fro		mear ear	u.	. 0	5.00
6.00	Medi cai d charges				282, 150, 585	6.00
7.00	Medicaid cost (line 1 times line 6)				63, 212, 453	7.00
8.00	Difference between net revenue and costs for Medicaid program (I < zero then enter zero)		ofline	s 2 and 5; if	0	8.00
0.00	Children's Health Insurance Program (CHIP) (see instructions for	each line)			0	0.00
9.00 10.00	Net revenue from stand-alone CHIP Stand-alone CHIP charges				0	9.00 10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (I	ine 11 minus li	ne 9; if	< zero then	0	12.00
	enter zero)					
12 00	Other state or local government indigent care program (see instr				0	12.00
13.00 14.00	Net revenue from state or local indigent care program (Not inclu Charges for patients covered under state or local indigent care				0	13.00 14.00
14.00	10)			ii i i i ies o oi	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	)			0	15.00
16.00	Difference between net revenue and costs for state or local indi	gent care progra	am (line	15 minus line	0	16.00
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIF	) and state (Leos)	Lindiaa	nt oono progras		
	instructions for each line)	and state/rocar	r i nai gei	nt care program	lis (see	
17.00	Private grants, donations, or endowment income restricted to fur	nding charity ca	re		0	17.00
18.00	Government grants, appropriations or transfers for support of ho				0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	indigent care p	rograms	(sum of lines	0	19.00
			nsured	Insured	Total (col. 1	
			<u>ients</u>	patients	+ col . 2)	
	Uncompensated Care (see instructions for each line)	1	. 00	2.00	3.00	
20.00	Charity care charges and uninsured discounts for the entire faci	lity 28	, 040, 446	3, 703, 331	31, 743, 777	20.00
	(see instructions)			-,,		
21.00	Cost of patients approved for charity care and uninsured discour instructions)		, 282, 125		9, 985, 456	
22. 00	Payments received from patients for amounts previously written of charity care		0		0	
23.00	Cost of charity care (line 21 minus line 22)	6	, 282, 125	3, 703, 331	9, 985, 456	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patient	t days beyond a l	length o	f stay limit	N	24.00
25. 00	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the		program':	s length of	0	25.00
	stay limit					
26.00 27.00	Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex		<b>n</b> c)		25, 766, 464 582, 246	
	Medicare allowable bad debts for the entire hospital complex (se				582, 246 895, 762	
28.00	Non-Medicare bad debt expense (see instructions)				24, 870, 702	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	ense (see instru	ctions)		5, 885, 498	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				15, 870, 954	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus lir	ne 30)			15, 870, 954	31.00

RECLAS	Financial Systems COMMU SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF		DF INDIANA, IN Provider CC	CN: 15-0169 P	eriod: rom 01/01/2019	u of Form CMS-2 Worksheet A	2332-10
					o 12/31/2019	Date/Time Pre 6/30/2020 2:1	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +-	
		1.00	2.00	3.00	4.00	col. 4) 5.00	
	GENERAL SERVICE COST CENTERS						1
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		0	0		22, 320, 308 10, 368, 680	•
3.00	00300 OTHER CAP REL COSTS		0	0	10, 308, 080	0	1
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	164, 743	276, 171	440, 914	-113, 136	327, 778	•
5.00	00500 ADMI NI STRATI VE & GENERAL	5, 603, 979	153,067,373	158, 671, 352		136, 806, 031	5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	3, 183, 469 0	7, 845, 985 984, 338	11, 029, 454 984, 338		10, 842, 093 984, 258	•
9.00	00900 HOUSEKEEPING	3, 043, 122	1, 876, 486	4, 919, 608		4, 895, 168	•
10.00	01000 DI ETARY	2, 543, 776	2, 955, 449	5, 499, 225	-4, 117, 309	1, 381, 916	
11.00		0	0	0	4, 027, 812	4, 027, 812	
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	2, 349, 276	666, 785 2, 054, 637	3, 016, 061 2, 054, 637	-12, 398 -2, 625, 241	3, 003, 663 -570, 604	
15.00	01500 PHARMACY	6, 880, 207	22, 246, 927	29, 127, 134		5, 346, 141	•
16.00	01600 MEDI CAL RECORDS & LI BRARY	377, 831	64, 744	442, 575		442, 495	•
17.00	01700 SOCI AL SERVI CE	1, 717, 727	456, 245	2, 173, 972	-478	2, 173, 494	
19.00 21.00	01900 NONPHYSICIAN ANESTHETISTS 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS	-	-		-	-	
30.00	03000 ADULTS & PEDIATRICS	34, 363, 184	17, 098, 348				•
31.00 35.00	03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	4, 722, 814	2, 258, 675	6, 981, 489		6, 161, 786 8, 930, 785	
40.00	04000 SUBPROVIDER - IPF	6, 427, 147 1, 905, 425	2, 960, 703 690, 649	9, 387, 850 2, 596, 074		2, 573, 226	1
43.00	04300 NURSERY	0	0,0,01,	2,0,0,0,1		2, 221, 741	1
	ANCI LLARY SERVI CE COST CENTERS	1					
50.00	05000 OPERATING ROOM	5, 227, 675	33, 410, 719				
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	2, 429, 083 190, 819	1, 287, 773 79, 833	3, 716, 856 270, 652		3, 434, 427 6, 399, 940	
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 509, 146	2,095,877	5, 605, 023		4, 198, 752	•
55.00	05500 RADI OLOGY-THERAPEUTI C	502, 296	3, 297, 316	3, 799, 612		934, 079	•
57.00	05700 CT SCAN	915, 227	926, 068	1, 841, 295		1, 509, 678	•
58.00 59.00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	485, 303 0	833, 720 1, 935	1, 319, 023 1, 935		902, 534 132	
60.00	06000 LABORATORY	0	10, 853, 469	10, 853, 469		10, 853, 438	•
64.00	06400 I NTRAVENOUS THERAPY	623, 553	312, 944	936, 497		848, 338	•
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	2, 932, 614	1, 724, 089	4, 656, 703	-604, 637 -2, 805, 584	4, 052, 066 6, 664, 167	
67.00	06700 OCCUPATIONAL THERAPY	6, 276, 416 0	3, 193, 335 0	9, 469, 751 0			•
68.00	06800 SPEECH PATHOLOGY	Ő	0	0	322, 226	322, 226	
69.00	06900 ELECTROCARDI OLOGY	31, 938	756, 651	788, 589			
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	992, 982	788, 598	1, 781, 580	-190, 231 20, 558, 640	1, 591, 349 20, 558, 640	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14, 538, 159	14, 538, 159	
73.00	07300 DRUGS CHARGED TO PATIENTS	Ő	0	0	16, 786, 277	16, 786, 277	
73.01	07301 SPECIALTY PHARMACY	0	7, 616, 688			17, 344, 919	
74.00	07400 RENAL DI ALYSI S	1 225 440	1, 388, 040	1, 388, 040		1, 386, 181	
76.00 76.01	03330 ENDOSCOPY 03950 OTHER ANCILLARY SERVICE COST CENTERS	1, 225, 449 0	2, 632, 587 0	3, 858, 036 0	-1, 862, 139 0	1, 995, 897 0	1
76.02	03951 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	1
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.03
76.04	03953 WOUND CARE	189, 246	54, 554	243, 800		225, 202	•
76.06 76.07	03954 I MAGI NG CENTER 03955 BREAST DI AGNOSTI C CENTER	1, 598, 003 0	2, 602, 202 9, 461, 380	4, 200, 205 9, 461, 380		3, 523, 390 9, 447, 294	•
, 5. 07	OUTPATIENT SERVICE COST CENTERS	<u> </u>	, 401, 300	7, 401, 380	14,000	7, 777, 274	, 0. 0/
90.00	09000 CLI NI C	0	0	0	-	0	
90.01	04950 INFUSION CENTER	103, 638	3, 056, 862	3, 160, 500		218, 915	
90.26 91.00	04975 SPINE CENTER 09100 EMERGENCY	192, 075 6, 281, 737	64, 769 3, 388, 440	256, 844 9, 670, 177		256, 362 9, 069, 168	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	5,201,757	5, 555, 440	7, 070, 177	001,009	7, 007, 100	92.00
	SPECIAL PURPOSE COST CENTERS	ł					
	11300 INTEREST EXPENSE		0	0	0		113.00
114.00 118.00	) 11400 UTILIZATION REVIEW-SNF SUBTOTALS (SUM OF LINES 1 through 117)	0 106, 989, 900	0 305 331 364	0	0 14, 623	0 412, 335, 887	114.00
110.UU	NONREIMBURSABLE COST CENTERS	100, 969, 900	305, 331, 364	412, 321, 264	14, 023	412, 333, 887	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100 RESEARCH	О	0	0	0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	95, 996	95, 996 0	0		192.00
	19300 NONPAID WORKERS 07950 HOME OFFICE	0	0	0	0 0		193.00 194.00
	07956 PAVI LLI ONS	0	38, 771	38, 771	-12, 945		194.06
	07958 OTHER NRCC	925, 323	443, 240				

Health Financial Systems CON	MUNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CO		Period: From 01/01/2019	Worksheet A	
					Date/Time Pre 6/30/2020 2:1	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
194. 10 07960 COMMUNI TY REHAB HOSPI TAL	0	0	0	0 0	0	194.10
200.00 TOTAL (SUM OF LINES 118 through 199)	107, 915, 223	305, 909, 371	413, 824, 594	0	413, 824, 594	200. 00

LCLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C	LN: 15-016	od: 01/01/2019	Worksheet A	ł
					12/31/2019		
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation				
	GENERAL SERVICE COST CENTERS	6.00	7.00		 		
00	00100 CAP REL COSTS-BLDG & FIXT	-7, 718, 863	14, 601, 445				1.
00	00200 CAP REL COSTS-MVBLE EQUIP	5, 633, 008					2.
00	00300 OTHER CAP REL COSTS	0	0				3.
00	00400 EMPLOYEE BENEFITS DEPARTMENT	4, 597, 440					4.
00	00500 ADMI NI STRATI VE & GENERAL	-73, 983, 313					5.
00		600, 141					7.
00 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0					8
. 00	01000 DI ETARY	-20, 163					10
. 00	01100 CAFETERI A	-2, 702, 390					11.
	01300 NURSING ADMINISTRATION	5, 065, 167					13.
	01400 CENTRAL SERVICES & SUPPLY	1, 449, 201					14.
. 00	01500 PHARMACY	-98, 632	5, 247, 509				15.
	01600 MEDICAL RECORDS & LIBRARY	2, 686, 293					16
	01700 SOCIAL SERVICE	0					17.
	01900 NONPHYSI CLAN ANESTHETI STS	0	0				19.
	02100 I & R SERVI CES-SALARY & FRI NGES APPRV 02200 I & R SERVI CES-OTHER PRGM COSTS APPRV	483, 306					21.
. 00	INPATIENT ROUTINE SERVICE COST CENTERS	642, 269	642, 269				22
. 00	03000 ADULTS & PEDIATRICS	840, 961	40, 135, 589				30
	03100 I NTENSI VE CARE UNI T	040, 701					31
	02060 NEONATAL INTENSIVE CARE UNIT	-427, 408					35
. 00	04000 SUBPROVI DER – I PF	-261, 326	2, 311, 900				40
. 00	04300 NURSERY	0	2, 221, 741				43
	ANCI LLARY SERVICE COST CENTERS	-					_
	05000 OPERATING ROOM	0					50
	05100 RECOVERY ROOM	0					51
	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	-55, 431	-, ,				52
	05500 RADI OLOGY-THERAPEUTI C	-55, 431					55
. 00	05700 CT SCAN	0					57
	05800 MRI	-11, 627	.,				58
. 00	05900 CARDI AC CATHETERI ZATI ON	200, 458					59
. 00	06000 LABORATORY	-1, 276, 169					60
. 00	06400 I NTRAVENOUS THERAPY	0	848, 338				64
. 00	06500 RESPI RATORY THERAPY	0	.,,				65
. 00	06600 PHYSI CAL THERAPY	-1, 686					66
. 00	06700 OCCUPATIONAL THERAPY	0					67
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	-179, 618					68 69
	07000 ELECTROENCEPHALOGRAPHY	224, 277					70
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0					71
	07200 I MPL. DEV. CHARGED TO PATIENTS	0					72
	07300 DRUGS CHARGED TO PATIENTS	476, 293					73
. 01	07301 SPECIALTY PHARMACY	397, 221	17, 742, 140				73
	07400 RENAL DI ALYSI S	0					74
	03330 ENDOSCOPY	0	1, 995, 897				76
	03950 OTHER ANCI LLARY SERVICE COST CENTERS	0	0				76
	03951 OTHER ANCILLARY SERVICE COST CENTERS 03952 OTHER ANCILLARY SERVICE COST CENTERS		0				76
	03952 UTHER ANCILLARY SERVICE COST CENTERS		225, 202				76
	03954 I MAGI NG CENTER	1	3, 523, 390				76
	03955 BREAST DI AGNOSTI C CENTER	0					76
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0		 		90
	04950 I NFUSI ON CENTER	0	218, 915				90
	04975 SPINE CENTER	0	256, 362				90
	09100 EMERGENCY	871, 200	9, 940, 368				91
. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS			L			92
3 00	11300 INTEREST EXPENSE	0	0				113
	11400 UTI LI ZATI ON REVI EW-SNF						114
8. OC		-62, 569, 391	-				118
	NONREI MBURSABLE COST CENTERS				 		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190
1.00	19100 RESEARCH	0	0				191
	19200 PHYSICIANS' PRIVATE OFFICES	0	95, 996				192
	19300 NONPAI D WORKERS	0	0				193
	07950 HOME OFFICE	0	0				194
	07956 PAVI LLI ONS	0	25, 826				194
	07958 OTHER NRCC 07960 COMMUNITY REHAB HOSPITAL		1, 366, 885				194 194
		ı U	0	1			1194

	Financial Systems SIFICATIONS	COMM	UNITY HOSPITAL	OF INDIANA, INC Provider CCM	Peri od:	u of Form CMS- Worksheet A-6	
					From 01/01/2019 To 12/31/2019	Date/Time Pre 6/30/2020 2:1	
	Cost Center	I ncreases Li ne #	Salary	Other		0,00,2020 2.1	o pin
	2.00	3.00	4.00	5.00			
. 00	A - Chargeable Medical Suppli MEDICAL SUPPLIES CHARGED TO	es71.00	0	20, 558, 640			1.00
	PATI ENT						
. 00 . 00		0. 00 0. 00	0	0			2.00 3.00
. 00		0.00	0	0			4.00
. 00 . 00		0.00 0.00	0 0	0			5.00 6.00
. 00		0.00	0	0			7.00
. 00		0.00	0	0			8.00
. 00 0. 00		0.00 0.00	0 0	0			9.00 10.00
1. 00		0.00	0	0			11.00
2.00 3.00		0. 00 0. 00	0 0	0			12.00 13.00
4.00		0.00	0	0			14.00
5.00 6.00		0.00 0.00	0 0	0			15.00 16.00
6.00 7.00		0.00	0	0			17.00
3. 00		0.00	0	0			18.00
9.00 ).00		0. 00 0. 00	0 0	0			19.00 20.00
I. 00		0.00	0	0			21.00
2.00 3.00		0. 00 0. 00	0 0	0			22.00 23.00
4. 00		0.00	0	0			23.00
5.00		0.00	0	0			25.00
. 00 . 00		0. 00 0. 00	0	0			26.00 27.00
8. 00		0.00	0	0			28.00
0. 00 0. 00		0. 00 0. 00	0	0			29.00 30.00
. 00		0.00		0			31.00
	TOTALS B - Implantable Device Reclas		0	20, 558, 640			
00	I MPL. DEV. CHARGED TO	72.00		14, 538, 159			1.00
00	PATI ENTS						2.00
00 00							2.00 3.00
			0	14, 538, 159			
00	C - Drugs Charges to Pat DRUGS CHARGED TO PATIENTS	73.00	0	16, 786, 277			1.00
00		0.00	0	0			2.00
00 00		0.00 0.00	0 0	0 0			3.00 4.00
00		0.00	0	0			5.00
00		0.00	0	0			6.00
00 00		0. 00 0. 00	0 0	0			7.00 8.00
00		0.00	0	0			9.00
. 00 . 00		0. 00 0. 00	0	0			10.00 11.00
. 00		0.00	0	0			12.00
. 00		0.00 0.00	0 0	0			13.00 14.00
. 00		0.00	0	0			14.00
o. 00		0.00	0	0			16.00
. 00 . 00		0. 00 0. 00	0	0			17.00 18.00
. 00		0.00	0	0			19.00
). 00 . 00		0.00 0.00	0 0	0			20.00 21.00
2.00		0.00	0	0			22.00
3.00		0.00		0			23.00
	TOTALS D - Depreciation Expense		0	16, 786, 277			
00	CAP REL COSTS-MVBLE EQUIP	2.00	0	14, 824, 925			1.00
00 00		0. 00 0. 00	0	0			2.00 3.00
00		0.00	0	0			4.00
00		0.00 0.00	0 0	0 0			5.00 6.00
00 00		0.00	0	0			7.00
		0.00	0	0			8.00

# COMMUNITY HOSPITAL OF INDIANA, INC. In Lieu of Form CMS-2552-10 Provider CCN: 15-0169 Period: From 01/01/2019 Worksheet A-6

	SEFECATIONS			Provider CCN: 15-0169	From 01/01/2019 To 12/31/2019 Date/Time Pr	
		Increases			6/30/2020 2:	16 pm
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
9.00	2.00	0.00	4.00	0		9.00
10.00		0.00	0	0 0		10.00
11. 00 12. 00		0. 00 0. 00	0	0		11.00 12.00
13.00		0.00	0	0		13.00
14.00 15.00		0. 00 0. 00	0	0 0		14.00 15.00
16.00		0.00	Ö	0		16.00
17. 00 18. 00		0. 00 0. 00	0	0 0		17.00 18.00
19.00		0.00	0	0		19.00
20. 00 21. 00		0.00 0.00	0	0 0		20.00 21.00
21.00		0.00	0	0		21.00
23.00		0.00	0	0		23.00
24.00 25.00		0.00 0.00	0	0 0		24.00 25.00
26.00		0.00	0	0		26.00
27.00 28.00		0. 00 0. 00	0	0 0		27.00 28.00
29.00		0.00	0	0		29.00
30. 00 31. 00		0.00 0.00	0	0 0		30.00 31.00
51.00	TOTALS	0.00		14, 824, 925		51.00
1.00	E - Interest Expense CAP REL COSTS-BLDG & FIXT	1.00	0	13, 426, 889		1.00
1.00	TOTALS			13, 426, 889		
1.00	F - Other Capital Rental CAP REL COSTS-MVBLE EQUIP	2.00	0	4, 231, 784		1.00
2.00	PAVI LLI ONS	194.06	0	6, 348		2.00
3.00 4.00		0. 00 0. 00	0	0 0		3.00 4.00
5.00		0.00	0	0		5.00
6.00 7.00		0. 00 0. 00	0	0 0		6.00 7.00
8.00		0.00	0	0		8.00
9. 00 10. 00		0. 00 0. 00	0	0 0		9.00 10.00
11.00		0.00	0	0		11.00
12.00 13.00		0.00 0.00	0	0 0		12.00 13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0 0		15.00
16. 00 17. 00		0.00 0.00	0	0		16.00 17.00
18.00		0.00	0	0		18.00
19. 00 20. 00		0.00 0.00	0 0	0		19.00 20.00
21.00		0.00	0	0		21.00
22.00 23.00		0.00 0.00	0	0 0		22.00 23.00
24.00		0.00	0	0		24.00
25.00 26.00		0. 00 0. 00	0	0 0		25.00 26.00
27.00		0.00	0	0		27.00
28. 00 29. 00		0.00 0.00	0	0 0		28.00 29.00
27.00	TOTALS		00	4, 238, 132		27.00
1.00	G – STD BENEFIT ADMINISTRATIVE & GENERAL	5.00	0	16, 666		1.00
2.00	OPERATION OF PLANT	7.00	0	22, 842		2.00
3.00 4.00	HOUSEKEEPI NG DI ETARY	9.00 10.00	0	24, 885 15, 575		3.00 4.00
5.00	NURSING ADMINISTRATION	13.00	0	9, 217		5.00
6.00 7.00	PHARMACY MEDI CAL RECORDS & LI BRARY	15.00 16.00	0	19, 610 7, 963		6.00 7.00
7.00 8.00	SOCIAL SERVICE	17.00	0	7, 983 9, 015		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	182, 767		9.00
10. 00 11. 00	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	31.00 35.00	0 0	21, 893 41, 238		10.00 11.00
12.00	SUBPROVI DER – I PF	40.00	0	13, 514		12.00
13.00 14.00	OPERATING ROOM RECOVERY ROOM	50. 00 51. 00	0 0	44, 186 2, 145		13.00 14.00
15.00	RADI OLOGY-DI AGNOSTI C	54.00	0	16, 648		15.00

#### Health Financial Systems RECLASSIFICATIONS

#### COMMUNITY HOSPITAL OF INDIANA, INC.

Provider CCN: 15-0169

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2019

Increases         Increases           Cost Conter         Line #         Salary         Other           2.00         3.00         4.00         5.00           16.00         RADUCOY-THERAPEUTIC         57.00         0         9.832           18.00         INTRAVENOUS THERAPY         66.00         0         24.737         20.00           19.00         RESPIRATORY THERAPY         66.00         0         24.737         20.00           20.00         PHYSICAL THERAPY         66.00         0         24.737         20.00           21.00         ELECTROENCEPHALOGRAPHY         70.00         0         3.817         22.00           22.00         WOUND CARE         76.04         0         10.583         22.00           24.00         MARCH CSCENER         76.06         0         7.422         24.00           26.00         DHKERY         76.06         0         3.719         26.00           26.00         THER WRC         194.08         0         3.719         26.00           21.00         MARERY         0         56.76,697         2.133.844         1.00           10.00         MERERY         66.00         220.355         11.893.968						e Prepared: 0 2:16 pm
2.00         3.00         4.00         5.00           16.00         RADUOSY-THERAPUTIC         55.00         0         6.475           17.00         CT SCAN         57.00         0         9.532         16.00           18.00         INTRAVENUOS THERAPY         64.00         0         383         18.00           19.00         RESTRATORY THERAPY         66.00         0         28.742         20.00           21.00         ELECTROENCEPHANCOGRAPHY         70.00         0         3.817         21.00           22.00         ENDSCOPY         76.04         0         5.239         22.00           23.00         UND CARE         76.04         0         5.239         22.00           23.00         OUND CARE         76.04         0         5.239         22.00           24.00         UNAGINC CENTER         76.06         0         7.942         24.00           25.00         MERGENCY         91.00         0         39.719         25.00           26.00         OTHER NRCC         194.08         0         1.586.945         2.00           1.00         CAFETERIA         1.00         1.893.968         2.133.844         1.00 <td< th=""><th></th><th></th><th>Increases</th><th></th><th></th><th></th></td<>			Increases			
Image: Product Construction         2.00         3.00         4.00         5.00           16.00         RAD LOGY-THERAPEUTIC         55.00         0         6.475         16.00           17.00         CT SCAN         57.00         0         9.532         17.00           18.00         INTRAVENUS THERAPY         65.00         0         28.742         19.00           0.00         PRISPI RATORY THERAPY         65.00         0         24.737         20.00           0.00         ENDESCEPTALORY THERAPY         66.00         0         24.737         21.00           22.00         ENDESCEPTALOGRAPHY         70.00         0         3.817         21.00           22.00         ENDESCEPTATORY THERAPY         76.04         0         10.583         23.00           23.00         WOIND CARE         76.04         0         5.239         23.00           24.00         IMAIN GENTER         76.04         0         5.239         25.00           0         TOTALS         0         1.536.696         685.045         26.00           0         TOTALS         0         1.586.629         1.00         2.00         2.00           1.00         MERERY         43.00		Cost Center	Line #	Salary	Other	
17.00       CT SCAN       57.00       0       9.52       17.00         18.00       INTRAVENUS THERAPY       64.00       0       383       18.00         19.00       RESPIRATORY THERAPY       66.00       0       28.742       19.00         0.00       PHYSI CAL THERAPY       66.00       0       24.737       20.00         0.00       ENDSCOPY       76.00       0       3.817       21.00         22.00       ENDSCOPY       76.04       0       5.239       23.00         24.00       IMAGING CENTER       76.04       0       5.239       23.00         25.00       EMERCINCY       91.00       0       39,719       25.00         26.00       OTHER_NRCC       194.08       0       1.196       26.00         10.00       DELIVERY ROOM & LABOR ROOM       52.00       4,239,401       1.889.887       2.00         10.00       CAFETERIA       11.00       1.893.968       2.133.844       1.00         10.00       COUPATI ONAL THERAPY       67.00       1.287.705       595.315       1.00         20.00       SPECH PATHOLOGY       68.00       220.355       101.871       2.00         10.00       CAFETERIA		2.00	3.00		5.00	
18.00       INTRAVENOUS THERAPY       64.00       0       383       18.00         19.00       RESPIRATORY THERAPY       65.00       0       28.742       19.00         20.00       PHYSICAL THERAPY       66.00       0       24.737       20.00         21.00       ELECTROENCEPHALOGRAPHY       70.00       0       3.817       21.00         23.00       WOUND CARE       76.04       0       5.239       22.00         24.00       MAGIN CENTER       76.04       0       7.942       24.00         26.00       EMERCENCY       91.00       0       3.9,719       25.00         26.00       TOTALS       0       586.529       25.00       26.00         1.00       NURSERY       43.00       1,536.696       685.045       1.00         2.00       DELI VERY ROOM & LABOR ROOM       52.00       4,239.401       1,893.968       2.133.844       1.00         1.00       DELI VERY ROOM & LABOR ROOM       52.00       4,239.401       1.893.968       2.133.844       1.00         2.00       TOTALS       1.00       1.893.968       2.133.844       1.00       2.00         1.00       COCUPATIONAL THERAPY       67.00       1.287.705	16.00	RADI OLOGY-THERAPEUTI C	55.00	0	6, 475	16.00
19.00       RESPIRATORY THERAPY       65.00       0       24.737       19.00         20.00       PHYSICAL THERAPY       66.00       0       24.737       20.00         21.00       ELECTROENCEPHALOGRAPHY       70.00       0       3.817       21.00         22.00       ENDOSCOPY       76.04       0       5.239       22.00         23.00       UNND CARE       76.04       0       5.239       23.00         24.00       OTHER INCC       194.06       0       1.196       26.00         00       OTHER INCC       194.06       0       1.196       26.00         10.00       NURSERY       43.00       1.536.696       685.045       2.00         10.00       NURSERY       52.00       4.239.401       1.889.887       2.00         10.00       DELI VERY ROOM & LABOR ROOM       52.00       4.239.401       1.889.887       2.00         10.01       TOTALS       11.00       1.893.968       2.133.844       2.00         10.00       COLPATI ONAL THERAPY       67.00       1.287.705       595.315       2.00         10.00       SPECH PATHOLOGY       68.00       220.355       101.871       2.00         10.01 CAS </td <td>17.00</td> <td>CT SCAN</td> <td>57.00</td> <td>0</td> <td>9, 532</td> <td>17.00</td>	17.00	CT SCAN	57.00	0	9, 532	17.00
20.00         PHYSICAL THERAPY         66.00         0         24,737         20.00           21.00         ELECTROENCEPHALOGRAPHY         70.00         0         3,817         21.00           22.00         ENDOSCOPY         76.00         0         10.583         22.00           23.00         WOUND CARE         76.04         0         5,239         23.00           24.00         IMAGING CENTER         76.06         0         7,942         24.00           26.00         EMERGENCY         91.00         0         39,719         25.00         42.400           26.00         TOTALS         -         -         0         586,529         1.00         20.00           1.00         NIRSERY         A3.00         1,536,696         685,045         2.00         2.00         2.00           1.00         DELIVERY ROOM & LABOR ROOM         52.00         4.239,401         1.989,887         2.00         2.00           1.00         DECUVERTIN ROM & LABOR ROOM         52.00         4.239,401         1.989,868         2.133,844         1.00           1.00         DCCUPATIONAL THERAPY         67.00         1,287,705         595,315         2.00         2.00         2.00	18.00	INTRAVENOUS THERAPY	64.00	0	383	
21.00         ELECTROENCEPHALOGRAPHY         70.00         0         3.817         22.00           22.00         ENDOSCOPY         76.04         0         5.239         22.00           23.00         WOND CARE         76.04         0         5.239         23.00           24.00         IMAGING CENTER         76.06         0         7.942         24.00           25.00         DIKRGENCY         91.00         0         39.719         25.00           26.00         OTHER NRCC         194.08         0         1.196         25.00           100         NURSERY         43.00         1.536.696         650.045         2.00           1.00         CAFETERIA	19.00	RESPI RATORY THERAPY	65.00	0	28, 742	19.00
22.00         ENDOSCOPY         76.00         0         10,583         22.00           23.00         WOUND CARE         76.04         0         5.239         23.00           24.00         IMAGING CENTER         76.06         0         7,942         24.00           25.00         EMERGENCY         91.00         0         39,719         25.00           26.00         OTHER NRCC         194.08         0         1.196         26.00           TOTALS         0         586,529         0         26.00         26.00           H - Labor and Delivery         1.00         1,893,968         2.133.844         1.00           1.00         DELIVERY ROOM & LABOR ROOM         52.00         4,239,401         1,889,887         2.00           1.00         TOTALS         1         11.00         1,893,968         2.133.844         1.00           1.00         TOTALS         1         1,939,968         2.133.844         1.00         2.00           VICHATIONAL THERAPY         66.00         220,355         101.871         2.00         2.00           100         SPECH PATHOLOGY         68.00         200,359         10.01.871         2.00           101DIN DEPERCIATION	20.00	PHYSICAL THERAPY	66.00	0	24, 737	20.00
23.00         VOUND CARE         76.04         0         5.239         23.00           24.00         IMAGING CENTER         76.06         0         7.942         24.00           26.00         CHERGENCY         91.00         0         39.719         25.00           26.00         OTHER NRCC         194.08         0         1.196         26.00           100         NURSERY         43.00         1.536.696         685.045         26.00           1.00         NURSERY         43.00         1.536.696         685.045         2.01           1.00         CAFETERIA         52.00         4.239.401         1.893.887         2.01           1.01         CAFETERIA         11.00         1.893.968         2.133.844         1.00           1.00         CAFETERIA         1.1.00         1.893.968         2.133.844         1.00           1.01         CAFETERIA         1.1.00         1.893.968         2.133.844         1.00           1.00         CCUPATI ONAL THERAPY         67.00         1.287.705         595.315         2.00           2.00         SPECH PATHOLOGY         68.00         20.355         101.871         2.00           1.00         CAP REL COSTS-BLDG & FLX	21.00	ELECTROENCEPHALOGRAPHY	70.00	0	3, 817	21.00
24.00       IMAGI NG CENTER       76.06       0       7,942       24.00         26.00       DEMERGENCY       91.00       0       39,719       25.00         100       NURSERY       0       586,529       1.00       25.00         H       - Labor and Del i very       0       586,529       1.00       1.00         1.00       NURSERY       43.00       1,536,696       685,045       2.00         1.00       DELI VERY ROM & LABOR ROM       52.00       4,239,401       1.893,844       1.00         1.00       CAFETERIA       11.00       1,893,968       2,133,844       1.00         J       - Therapy       1       1.893,968       2,133,844       1.00         1.00       SPEECH PATHOLOGY       68.00       220,355       101,871       2.00         1.00       SPEECH PATHOLOGY       68.00       220,355       101,871       2.00         1.00       CAP REL COSTS-BLDG & FIXT       1.00       0       8,688,029       1.00         1.00       CAP REL COSTS-BLDG & FIXT       1.00       0       205,390       1.00         0.0       CAP REL COSTS-BLDG & FIXT       1.00       0       205,390       1.00 <td< td=""><td>22.00</td><td>ENDOSCOPY</td><td>76.00</td><td>0</td><td>10, 583</td><td>22.00</td></td<>	22.00	ENDOSCOPY	76.00	0	10, 583	22.00
25.00       EMERGENCY       91.00       0       39,719       25.00         26.00       OTHER NRCC       194.08       0       1.196       26.00         H       Labor and Delivery       0       586.529       1.00       26.00         H       Labor and Delivery       43.00       1,536.696       685,045       2.00         1.00       NURSERY       43.00       1,536.696       685,045       2.00         1.00       CAFETERIA       5,776.097       2,574.932       1.00         1.00       CAFETERIA       1.893.968       2,133.844       1.00         J       TOTALS       1.893.968       2,133.844       1.00         J       TOTALS       68.00       220.355       101.871         J       OCCUPATI ONAL THERAPY       67.00       1,287,705       595,315         2.00       TOTALS       1.00       2.00       8,688,029         1.00       CAP ELE COSTS-BLDG & FIXT       1.00       0       8,688,029         1.00       CAP REL COSTS-BLDG & FIXT       1.00       0       205,390         1.00       CAP REL COSTS-BLDG & FIXT       1.00       0       205,390         1.00       CAP REL COSTS-BLDG & FIXT	23.00	WOUND CARE	76.04	0	5, 239	23.00
26.00         OTHER NRCC         194.08         0         1,196         26.00           TOTALS         0         586,529         100         26.00         1,196         26.00           H         Labor and Delivery         43.00         1,536,666         685,045         1.00         1.00           2.00         DELIVERY ROOM & LABOR ROOM         52.00         4,239,401         1,899,887         2.00           I         - Cafeteria         -         5,776,097         2,574,932         1.00           1.00         CAFETERIA         -         11.00         1,893,968         2,133,844         1.00           J         - Therapy         -         1,893,968         2,133,844         1.00         2.00           SPECH PATHOLOCY         -         67.00         1,287,705         595,315         1.00           2.00         SPECH PATHOLOCY         -         68.00         220,355         101,871         2.00           1.00         CAP REL COSTS-BLD6 & FIXT         1.00         0         8,688,029         1.00           1.00         CAP REL COSTS-BLD6 & FIXT         1.00         0         205,390         1.00           1.00         CAP REL COSTS-BLD6 & FIXT         0	24.00	I MAGI NG CENTER	76.06	0	7, 942	24.00
TOTALS	25.00	EMERGENCY	91.00	0	39, 719	25.00
H - Labor and Delivery       43.00       1,536,696       685,045       1.00         NURSERY       00       4,239,401       1,889,887       2.00         TOTALS       5,776,097       2,574,932       2.00         I - Cafeteria       11.00       1,893,968       2,133,844       1.00         TOTALS       1,893,968       2,133,844       1.00       1.00         J - Therapy       67.00       1,287,705       595,315       1.00         COUPATIONAL THERAPY       67.00       1,287,705       595,315       2.00         1.00       SPECH PATHOLOGY       68.00       220,355       101,871       2.00         TOTALS       1,508,060       697,186       1.00       2.00         K - BUILDING DEPRECIATION       1.00       1.508,060       697,186       1.00         L - Capital Insurance Costs       0       8,688,029       1.00       1.00         TOTALS       0       205,390       1.00       1.00         M - Radiology Support       0       205,390       1.00       2.00         M - Radiology Support       1.00       0       205,390       1.00         M - Radiology Support       0       205,390       2.0692       3.00	26.00	OTHER NRCC	194.08		1, 196	26.00
H - Labor and Delivery       43.00       1,536,696       685,045       1.00         2.00       DELIVERY ROOM & LABOR ROOM       52.00       4,239,401       1.889,887       2.00         TOTALS       5,776,097       2,574,932       2.00       2.00       2.00         I - Cafeteria       1.00       1.893,968       2,133,844       1.00       1.00         J - Therapy       1.893,968       2,133,844       1.00       1.00         J - Therapy       1.893,968       2,133,844       1.00       1.00         COUPATIONAL THERAPY       67.00       1,287,705       595,315       2.00         1.00       SPEECH PATHOLOGY       68.00       220,355       101,871       1.00         TOTALS       1.508,060       697,186       1.00       2.00       1.00         K - BUILDING DEPRECIATION       1.00       0.8,688,029       1.00       1.00         L - Capital Insurance Costs       0       205,390       1.00       1.00         M - Radiology Support       1.00       0.205,390       1.00       2.00         M - Radiology Support       1.00       0.205,390       2.00       2.00         1.00       CAP REL COSTS-BLDG & FIXT       1.00       0.205,390		TOTALS			586, 529	
2.00       DELIVERY ROOM & LABOR ROOM       52.00       4,239,401       1,889,887         TOTALS       5,776,097       2,574,932       1         1.00       CAFETERIA       11.00       1,893,968       2,133,844       1       1.00         0.00       CCUPATIONAL THERAPY       67.00       1,287,705       595,315       1.00       1.00         2.00       SPEECH PATHOLOGY       68.00       220,355       101,871       2.00         TOTALS       1,508,060       697,186       2.00       2.00       2.00         K - BUILDING DEPRECIATION       1.00       0       8,688,029       1.00       2.00         L - Capital Insurance Costs       0       8,688,029       1.00       1.00       1.00         L - Capital Insurance Costs       0       205,390       1.00       1.00       2.00         M - Radiology Support       1.00       0       205,390       1.00       2.00         M - Radiology Support       1       3.73       20,692       3.00       3.00         MRI       58.00       53.373       20,692       3.00       3.00         Mol       SPECIALTY PHARMACY       374,844       145,322       3.00         N - Special t		H - Labor and Delivery	· · ·	· · ·		
TOTALS         5.776,097         2.574,932           I         - Cafeteria         -         <	1.00	NURSERY	43.00	1, 536, 696	685, 045	1.00
1 - Cafeteria       11.00       1,893,968       2,133,844       1.00         1.00       CAFETERIA       11.00       1,893,968       2,133,844       1.00         J - Therapy       1.00       0.00       0CCUPATIONAL THERAPY       67.00       1,287,705       595,315       1.00         2.00       SPEECH PATHOLOGY       68.00       220,355       101,871       2.00       2.00         1.00       CAP REL COSTS-BLDG & FIXT       1,00       0       8,688,029       1.00       1.00         1.00       CAP REL COSTS-BLDG & FIXT       1.00       0       205,390       1.00       1.00         M - Radiology Support       0       205,390       1.00       2.00       1.00       2.00         M - Radiology Support       1.00       0       205,390       1.00       1.00         M - Radiology Support       1.00       0       205,390       1.00       2.00         M - Radiology Support       1.00       1.00       2.00       2.00       3.00       3.73       2.0,692       3.00       3.00         MRI       58.00       53,373       20,692       3.00       3.00       3.00       3.00       3.00       3.00       3.00       3.00 <td< td=""><td>2.00</td><td>DELIVERY ROOM &amp; LABOR ROOM</td><td>52.00</td><td>4, 239, 401</td><td>1, 889, 887</td><td>2.00</td></td<>	2.00	DELIVERY ROOM & LABOR ROOM	52.00	4, 239, 401	1, 889, 887	2.00
1.00       CAFETERIA       11.00       1,893,968       2,133,844       1.00         J - Therapy       1,893,968       2,133,844       1.00       1.00         J - Therapy       0       1,287,705       595,315       1.00         2.00       SPEECH PATHOLOGY       67.00       1,287,705       595,315       1.00         2.00       SPEECH PATHOLOGY       68.00       220,355       101,871       2.00         TOTALS       1,508,060       697,186       1.00       2.00         K - BUI LDI NG DEPRECI ATI ON       1.00       0       8,688,029       1.00         L - Capi tal Insurance Costs       0       8,688,029       1.00       1.00         L - Capi tal Insurance Costs       0       205,390       1.00       1.00         M - Radi ol ogy Support       0       205,390       1.00       2.00         M - Radi ol ogy Support       0       53,373       20,692       3.00       3.00       3.00       3.00       58,00       53,373       20,692       3.00       3.00       3.00       3.00       3.00       3.00       3.00       3.00       3.00       1.876,658       7,851,573       1.00         1.00       SPECI ALTY PHARMACY       73.01		TOTALS		5, 776, 097	2, 574, 932	
TOTALS       1,893,968       2,133,844         J - Therapy       1,00       0CCUPATI ONAL THERAPY       67.00       1,287,705       595,315       1.00         2.00       SPEECH PATHOLOGY       68.00       220,355       101,871       2.00         TOTALS       1,508,060       697,186       2.00         K - BUI LDI NG DEPRECI ATI ON       1.00       0       8,688,029       1.00         L - Capi tal Insurance Costs       0       0,205,390       1.00       1.00         L - Capi tal Insurance Costs       1       0       205,390       1.00         M - Radi ol ogy Support       0       23,373       20,692       1.00         2.00       CT SCAN       57.00       208,692       80,907       2.00         3.00       MRI       58.00       53,373       20,692       3.00         1.00       SECIALTY PHARMACY       73.01       1,876,658       7,851,573       1.00		I - Cafeteria				
J - Therapy       1.00       0CCUPATI ONAL THERAPY       67.00       1,287,705       595,315       1.00         2.00       SPEECH PATHOLOGY       68.00       220,355       101,871       2.00         TOTALS       1,508,060       697,186       2.00       2.00         K - BUI LDI NG DEPRECIATI ON       1,508,060       697,186       1.00         1.00       CAP REL COSTS-BLDG & FIXT       1.00       0       8,688,029       1.00         I.00       CAP REL COSTS-BLDG & FIXT       1.00       0       205,390       1.00         I.00       CAP REL COSTS-BLDG & FIXT       1.00       0       205,390       1.00         M - Radi ol ogy Support       0       205,390       1.00       1.00         0       CT SCAN       57.00       208,692       80,907       2.00         3.00       MRI	1.00	CAFETERI A	11.00	1, 893, 968	2, 133, 844	1.00
1.00       OCCUPATIONAL THERAPY       67.00       1.287,705       595,315       1.00         2.00       SPEECH PATHOLOGY       68.00       220,355       101,871       2.00         TOTALS       1.508,060       697,186       2.00       2.00         K - BUI LDI NG DEPRECI ATI ON       1.00       0       8,688,029       1.00         1.00       CAP REL COSTS-BLDG & FIXT       1.00       0       8,688,029       1.00         L - Capi tal Insurance Costs       0       205,390       1.00       1.00         M - Radi ol ogy Support       0       205,390       1.00         M - Radi ol ogy Support       1.00       0       205,390       1.00         2.00       CT SCAN       57.00       208,692       80,907       2.00         3.00       MRI       58.00       53,373       20,692       3.00       3.00         3.00       MRI       374,844       145,322       3.00       3.00       3.00       1.00         N - Speci al ty Pharmacy       73.01       1.876,658       7.851,573       1.00       1.00         N - Speci al ty Pharmacy       1.876,658       7.851,573       1.00       1.00		TOTALS		1, 893, 968	2, 133, 844	
2.00       SPEECH PATHOLOGY       68.00       220,355       101,871       2.00         TOTALS       1,508,060       697,186       101,871       1.00						
TOTALS       1,508,060       697,186         K - BUI LDI NG DEPRECI ATI ON       1.00       0       8,688,029         1.00       CAP REL COSTS-BLDG & FIXT       1.00       0       8,688,029         L - Capi tal Insurance Costs       0       8,688,029       1.00         1.00       CAP REL COSTS-BLDG & FIXT       1.00       0       205,390         M - Radi ol ogy Support       0       205,390       1.00         1.00       CAT SCAN       55.00       112,779       43,723       1.00         2.00       CT SCAN       57.00       208,692       80,907       2.00         3.00       MRI       58.00       53,373       20,692       3.00         M - Special ty Pharmacy       73.01       1,876,658       7,851,573       1.00         1.00       SPECIALTY PHARMACY       73.01       1,876,658       7,851,573       1.00	1.00	OCCUPATI ONAL THERAPY	67.00	1, 287, 705	595, 315	1.00
K - BUI LDI NG DEPRECI ATI ON       1.00       0       8,688,029       1.00         1.00       CAP REL COSTS-BLDG & FIXT       1.00       0       8,688,029       1.00         L - Capi tal Insurance Costs       0       205,390       1.00       1.00         TOTALS       0       205,390       1.00       1.00         M - Radi ol ogy Support       0       205,390       1.00         2.00       CT SCAN       55.00       112,779       43,723       1.00         2.00       CT SCAN       57.00       208,692       80,907       2.00         3.00       MRI       58.00       53,373       20,692       3.00         M - Special ty Pharmacy       73.01       1,876,658       7,851,573       1.00         1.00       SPECIALTY PHARMACY       73.01       1,876,658       7,851,573       1.00	2.00	SPEECH PATHOLOGY	68.00	220, 355	101, 871	2.00
1.00       CAP REL COSTS-BLDG & FIXT       1.00       0       8,688,029       1.00       1.00         L - Capi tal Insurance Costs       0       8,688,029       1.00 <td></td> <td>TOTALS</td> <td></td> <td>1, 508, 060</td> <td>697, 186</td> <td></td>		TOTALS		1, 508, 060	697, 186	
TOTALS         0         8, 688, 029           L - Capi tal Insurance Costs         1.00         0         205, 390           TOTALS         0         205, 390         1.00           TOTALS         0         205, 390         1.00           M - Radi ol ogy Support         0         205, 390         1.00           1.00         RADI OLOGY-THERAPEUTI C         55.00         112, 779         43, 723         1.00           2.00         CT SCAN         57.00         208, 692         80, 907         2.00         3.00           3.00         MRI         58.00         53, 373         20, 692         3.00         3.00           N - Speci al ty Pharmacy         374, 844         145, 322         1.00         1.00           1.00         SPECI ALTY PHARMACY         73.01         1, 876, 658         7, 851, 573         1.00		K - BUILDING DEPRECIATION				
L - Capi tal Insurance Costs         1.00         0         205, 390         1.00           1.00         CAP REL COSTS-BLDG & FIXT         1.00         0         205, 390         1.00           M - Radi ol ogy Support         0         205, 390         1.00         1.00         205, 390         1.00           1.00         RADI OLOGY-THERAPEUTI C         55.00         112, 779         43, 723         1.00         2.00           2.00         CT SCAN         57.00         208, 692         80, 907         2.00         2.00         3.00         MRI         2.00         53, 373         20, 692         3.00         3.00         3.00         53, 373         20, 692         3.00         3.00         1	1.00	CAP REL COSTS-BLDG & FIXT	1.00		8, 688, 029	1.00
1.00       CAP REL COSTS-BLDG & FIXT       1.00       0       205, 390       1.00         TOTALS       0       205, 390       0       205, 390       1.00         M - Radi ol ogy Support       1.00       0       205, 390       1.00         1.00       RADI OLOGY-THERAPEUTI C       55.00       112, 779       43, 723       1.00         2.00       CT SCAN       57.00       208, 692       80, 907       2.00       2.00         3.00       MRI		TOTALS		0	8, 688, 029	
TOTALS         0         205, 390           M - Radi ol ogy Support         1.00         RADI OLOGY-THERAPEUTI C         55.00         112, 779         43, 723         1.00           2.00         CT SCAN         57.00         208, 692         80, 907         2.00         2.00           3.00         MRI		L - Capital Insurance Costs				
M - Radi ol ogy Support         200,070           1.00         RADI OLOGY-THERAPEUTI C         55.00         112,779         43,723         1.00           2.00         CT SCAN         57.00         208,692         80,907         2.00           3.00         MRI         58.00         53.373         20,692         3.00           TOTALS         374,844         145,322         3.00           N - Special ty Pharmacy         73.01         1,876,658         7,851,573         1.00           SPECIALTY PHARMACY         73.01         1,876,658         7,851,573         1.00	1.00	CAP REL COSTS-BLDG & FIXT	1.00		205, 390	1.00
1.00       RADI OLOGY-THERAPEUTI C       55.00       112,779       43,723       1.00         2.00       CT SCAN       57.00       208,692       80,907       2.00         3.00       MRI       58.00       53.373       20,692       3.00         TOTALS       374,844       145,322       3.00       3.00         N - Special ty Pharmacy       73.01       1,876,658       7,851,573       1.00         SPECIALTY PHARMACY       1,876,658       7,851,573       1.00       1.00		TOTALS		0	205, 390	
2.00       CT SCAN       57.00       208,692       80,907       2.00       3.00         3.00       MRI       58.00       53,373       20,692       3.00       3.00         TOTALS       374,844       145,322       3.00       3.00       3.00         N - Special ty Pharmacy       73.01       1,876,658       7,851,573       1.00         SPECIALTY PHARMACY       1,876,658       7,851,573       1.00						
3. 00       MRI	1.00		55.00	112, 779	43, 723	1.00
TOTALS         374,844         145,322           N - Special ty Pharmacy         1,876,658         7,851,573           1.00         SPECIALTY PHARMACY         1,876,658         7,851,573           TOTALS         1,876,658         7,851,573         1.00	2.00	CT SCAN	57.00	208, 692	80, 907	2.00
N - Special ty Pharmacy           1.00         SPECIALTY PHARMACY         73.01         1,876,658         7,851,573         1.00           TOTALS         1,876,658         7,851,573         1.00	3.00		58.00	53, 373		3.00
1. 00         SPECIALTY_PHARMACY		TOTALS		374, 844	145, 322	
TOTALS 1, 876, 658 7, 851, 573						
	1.00		73.01			1.00
500.00 Grand Total:         Increases         11, 429, 627         107, 255, 827         500.00						
	500.00	Grand Total: Increases		11, 429, 627	107, 255, 827	500.00

In Lieu of Form CMS-2552-10

:		Wor	~ks	she	ee.	t A-	6	

Peri od:	Worksheet A-6 Date/Time Prepared: 6/30/2020 2:16 pm
From 01/01/2019	
To 12/31/2019	Date/Time Prepared:
	6/30/2020 2:16 pm

						6/30/2020	2:16 pm
		Decreases				I	
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1 00	A - Chargeable Medical Suppli						1.00
1.00	ADMINISTRATIVE & GENERAL	5.00 7.00	0	64 67, 206			1.00
2.00	OPERATION OF PLANT DIETARY	10.00	0				3.00
3.00 4.00	NURSING ADMINISTRATION	13.00	0	_,			4.00
4.00 5.00	CENTRAL SERVICES & SUPPLY	14.00	0				5.00
6.00	PHARMACY	14.00	0				6.00
7.00	ADULTS & PEDIATRICS	30.00	0	2, 198, 252			7.00
8.00	INTENSIVE CARE UNIT	30.00	0		-		8.00
9.00	NEONATAL INTENSIVE CARE UNIT	35.00	0		-		9.00
10.00	SUBPROVI DER – I PF	40.00	0				10.00
11.00	OPERATING ROOM	50.00	0				11.00
12.00	RECOVERY ROOM	51.00	0	,,			12.00
13.00	RADI OLOGY-DI AGNOSTI C	54.00	0		-		13.00
14.00	RADI OLOGY-THERAPEUTI C	55.00	0				14.00
15.00	CT SCAN	57.00	0				15.00
16.00	MRI	58.00	0				16.00
17.00	CARDI AC CATHETERI ZATI ON	59.00	0	276			17.00
18.00	LABORATORY	60.00	0	31	0		18.00
19.00	INTRAVENOUS THERAPY	64.00	0	83, 974	0		19.00
20.00	RESPI RATORY THERAPY	65.00	0	468, 668	0		20.00
21.00	PHYSI CAL THERAPY	66.00	0	48, 138	0		21.00
22.00	ELECTROCARDI OLOGY	69.00	0	212	0		22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	78, 045	6 O		23.00
24.00	RENAL DI ALYSI S	74.00	0	1, 859	0		24.00
25.00	ENDOSCOPY	76.00	0	1, 198, 616	0		25.00
26.00	WOUND CARE	76.04	0	18, 238	8 0		26.00
27.00	I MAGI NG CENTER	76.06	0	106, 252	0		27.00
28.00	INFUSION CENTER	90.01	0	8, 782			28.00
29.00	EMERGENCY	91.00	0				29.00
30.00	PAVI LLI ONS	194.06	0				30.00
31.00	OTHER NRCC	1 <u>94.</u> 08	0				31.00
	TOTALS		0	20, 558, 640	)		
	B - Implantable Device Reclas			10.11(.000		Γ	
1.00	OPERATING ROOM	50.00		13, 116, 939			1.00
2.00	RADI OLOGY-THERAPEUTI C	55.00		1, 136, 303			2.00
3.00	ENDOSCOPY	<u>76.</u> 00		284, 917		_	3.00
	C - Drugs Charges to Pat		0	14, 538, 159	,		
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	271	0		1.00
2.00	PHARMACY	14.00	0				2.00
3.00	SOCIAL SERVICE	13.00	0				3.00
4.00	ADULTS & PEDIATRICS	30.00	0		-		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	21, 950			5.00
6.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	2, 063			6.00
7.00	SUBPROVIDER - IPF	40.00	0	185	-		7.00
8.00	OPERATING ROOM	50.00	0				8.00
9.00	RECOVERY ROOM	51.00	0				9.00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	0	106, 060			10.00
11.00	RADI OLOGY-THERAPEUTI C	55.00	0				11.00
12.00	CT SCAN	57.00	0				12.00
13.00	MRI	58.00	0	89, 868	0		13.00
14.00	INTRAVENOUS THERAPY	64.00	0	1, 118	0		14.00
15.00	RESPI RATORY THERAPY	65.00	0	4, 228	0		15.00
16.00	PHYSI CAL THERAPY	66.00	0	5, 751	0		16.00
17.00	ELECTROENCEPHALOGRAPHY	70.00	0	1, 454			17.00
18.00	ENDOSCOPY	76.00	0	3, 931	0		18.00
19.00	WOUND CARE	76.04	0	16	0		19.00
20.00	I MAGI NG CENTER	76.06	0	146, 859			20.00
21.00	INFUSION CENTER	90.01	0	_,,			21.00
22.00	EMERGENCY	91.00	0				22.00
23.00	OTHER_NRCC	<u> </u>	0				23.00
	TOTALS		0	16, 786, 277			
4 95	D - Depreciation Expense	1		. =			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0				1.00
2.00	ADMINI STRATI VE & GENERAL	5.00	0				2.00
3.00	OPERATION OF PLANT	7.00	0				3.00
4.00	HOUSEKEEPING	9.00	0	6, 922			4.00
5.00		10.00	0	00,000			5.00
6.00	NURSING ADMINISTRATION	13.00	0	9,659			6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0				7.00
8.00		15.00	0				8.00
9.00	ADULTS & PEDIATRICS	30.00	0				9.00
10.00	INTENSIVE CARE UNIT	31.00	0	343, 111	0		10.00

#### COMMUNITY HOSPITAL OF INDIANA, INC.

Provi der CCN: 15-0169

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2019 To 12/31/2019 Date/Time Prepared:

					1	o 12/31/2019 Date/Time 6/30/2020	
		Decreases				10,00,2020	2110 pm
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7.00	8.00	9.00	10.00		
11.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	176, 083			11.00
12.00	SUBPROVIDER - IPF	40.00	0	17, 318			12.00
13.00	OPERATING ROOM	50.00	0	1, 219, 704	0		13.00
14.00	RECOVERY ROOM	51.00	0	10, 648			14.00
15.00	RADI OLOGY-DI AGNOSTI C	54.00	0	400, 412	0		15.00
16.00	RADI OLOGY-THERAPEUTI C	55.00	0	578, 937	0		16.00
17.00	CT SCAN	57.00	0	229, 798			17.00
18.00		58.00	0	383, 146	0		18.00
19.00	CARDIAC CATHETERIZATION	59.00	0	1, 527	0		19.00
20. 00 21. 00	I NTRAVENOUS THERAPY RESPI RATORY THERAPY	64.00 65.00	0	2,856			20.00 21.00
21.00	PHYSICAL THERAPY	66.00	0	62, 309 265, 127	0		21.00
22.00	ELECTROCARDI OLOGY	69.00	0	3, 377	0		22.00
24.00	ELECTROENCEPHALOGRAPHY	70.00	0	59, 823	0		24.00
25.00	ENDOSCOPY	76.00	0	364, 320	0		25.00
26.00	WOUND CARE	76.04	0	344	0		26.00
27.00	I MAGI NG CENTER	76.06	0	423, 343	-		27.00
28.00	BREAST DI AGNOSTI C CENTER	76.07	0	14, 086	-		28.00
29.00	INFUSION CENTER	90.01	0	23, 996	0		29.00
30.00	EMERGENCY	91.00	0	202, 442	0		30.00
31.00	PAVI LLI ONS	194.06	0	19, 261	0		31.00
	TOTALS		— — — d	14, 824, 925	<u> </u>		
	E - Interest Expense						
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	<u>13, 426, 8</u> 89	11		1.00
	TOTALS		0	13, 426, 889			
	F - Other Capital Rental						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	111, 622	10		1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	92, 017	0		2.00
3.00	OPERATION OF PLANT	7.00	0	5, 794	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	80			4.00
5.00	HOUSEKEEPING	9.00	0	17, 518	0		5.00
6.00	DI ETARY	10.00	0	952	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	2, 509			7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,032,434	0		8.00
9.00		15.00	0	543, 716			9.00
10.00	MEDI CAL RECORDS & LI BRARY	16.00	0	80			10.00
11.00	SOCIAL SERVICE	17.00	0	36	0		11.00
12.00 13.00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30.00 31.00	0	16, 572 489	0		12.00 13.00
13.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	3, 403	0		14.00
14.00	SUBPROVIDER - IPF	40.00	0	3, 403	0		15.00
16.00	OPERATING ROOM	50.00	0	986, 059	0		16.00
17.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 000	0		17.00
18.00	RADI OLOGY-THERAPEUTI C	55.00	0	672	0		18.00
19.00	MRI	58.00	0	500	0		19.00
20.00	INTRAVENOUS THERAPY	64.00	0	211	0		20.00
21.00	RESPI RATORY THERAPY	65.00	0	69, 432	0		21.00
22.00	PHYSI CAL THERAPY	66.00	0	281, 322			22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	50, 909			23.00
24.00	ENDOSCOPY	76.00	Ő	10, 355			24.00
25.00	I MAGI NG CENTER	76.06	0	361	0		25.00
26.00	INFUSION CENTER	90.01	0	8, 800	0		26.00
27.00	SPINE CENTER	90.26	0	482	0		27.00
28.00	EMERGENCY	91.00	0	41	0		28.00
29.00	OTHER_NRCC	194.08	0	<u> </u>	0		29.00
	TOTALS		0	4, 238, 132			
	G - STD BENEFIT						
1.00	ADMI NI STRATI VE & GENERAL	5.00	16, 666	0			1.00
2.00	OPERATION OF PLANT	7.00	22, 842	0			2.00
3.00	HOUSEKEEPING	9.00	24, 885	0			3.00
4.00	DIETARY	10.00	15, 575	0	-		4.00
5.00	NURSING ADMINISTRATION	13.00	9, 217	0			5.00
6.00	PHARMACY	15.00	19, 610	0	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	7, 963	0	0		7.00
8.00	SOCIAL SERVICE	17.00	9,015	0	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	182, 767	0	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	21, 893	0	0		10.00
11.00	NEONATAL INTENSIVE CARE UNIT	35.00	41, 238	0	0		11.00
12.00	SUBPROVIDER - IPF	40.00	13, 514	0	0		12.00
13.00	OPERATING ROOM	50.00 51.00	44, 186	0	0		13.00
14.00 15.00	RECOVERY ROOM	51.00	2, 145	0			14.00
15.00	RADI OLOGY-DI AGNOSTI C	54.00	16, 648	-	Ű		15.00
16.00 17.00	RADI OLOGY-THERAPEUTI C	55.00	6, 475 0, 522	0			16.00
17.00	CT SCAN	57.00	9, 532	0	0		17.00

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	IS

## COMMUNITY HOSPITAL OF INDIANA, INC. Provider CCN: 15-0169

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2019 To 12/31/2019 Date/Time Prepared:

						To 12/31/2019	Date/Time Prepared: 6/30/2020 2:16 pm
		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	.	
	6.00	7.00	8.00	9.00	10.00	7	
18.00	INTRAVENOUS THERAPY	64.00	383	0	)	0	18.00
19.00	RESPI RATORY THERAPY	65.00	28, 742	0		o	19.00
20.00	PHYSI CAL THERAPY	66.00	24, 737	0		o	20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	3, 817	0		o	21.00
22.00	ENDOSCOPY	76.00	10, 583	0		o	22.00
23.00	WOUND CARE	76.04	5, 239	0		o	23.00
24.00	I MAGI NG CENTER	76.06	7, 942	0		o	24.00
25.00	EMERGENCY	91.00	39, 719	0		o	25.00
26.00	OTHER NRCC	194.08	1, 196	0		o	26.00
	TOTALS	+	586, 529	0		7	
	H - Labor and Delivery	· ·					
1.00	ADULTS & PEDIATRICS	30.00	5, 776, 097	2, 574, 932		0	1.00
2.00		0.00	О			o	2.00
	TOTALS	+	5, 776, 097	2, 574, 932		7	
	I - Cafeteria	· · ·					
1.00	DI ETARY	10.00	1, 893, 968	2, 133, 844		0	1.00
	TOTALS		1, 893, 968	2, 133, 844		7	
	J - Therapy						
1.00	PHYSI CAL THERAPY	66.00	1, 508, 060	697, 186		0	1.00
2.00		0.00	0	0		o	2.00
	TOTALS		1, 508, 060	697, 186		7	
	K - BUILDING DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8, 688, 029		9	1.00
	TOTALS		0	8, 688, 029			
	L - Capital Insurance Costs						
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	205, 390		2	1.00
	TOTALS		0	205, 390			
	M - Radiology Support						
1.00	RADI OLOGY-DI AGNOSTI C	54.00	374, 844	145, 322		o	1.00
2.00		0.00	0	0		0	2.00
3.00		0.00	0	0		0	3.00
	TOTALS		374, 844	145, 322			
	N - Specialty Pharmacy	·					
1.00	PHARMACY	15.00	1, 876, 658	7,851,573		0	1.00
	TOTALS		1, 876, 658	7,851,573			
500.00	Grand Total: Decreases		12, 016, 156	106, 669, 298			500.00
		•	•				·

	Financial Systems COMM ILLATION OF CAPITAL COSTS CENTERS	UNI TY HOSPI TAL	Provider CC			i od:	u of Form CMS-2 Worksheet A-7	
						om 01/01/2019	Part I	
					То	12/31/2019	Date/Time Prep 6/30/2020 2:10	pared: 6 nm
				Acqui si ti on	IS		0/30/2020 2.1	
		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 ASSET	BALANCES						
1.00	Land	2, 705, 851	0		0	0	0	1.00
2.00	Land Improvements	3, 747, 533	611, 299		0	611, 299	0	2.00
3.00	Buildings and Fixtures	320, 765, 033	18, 737, 018		0	18, 737, 018	15, 920, 183	3.00
4.00	Building Improvements	2, 597, 127	622, 401		0	622, 401	0	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	111, 616, 189	8, 774, 121		0	8, 774, 121	30, 164	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	441, 431, 733	28, 744, 839		0	28, 744, 839	15, 950, 347	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	441, 431, 733	28, 744, 839		0	28, 744, 839	15, 950, 347	10.00
	· · · ·	Endi ng Bal ance	Fully					
		Ũ	Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	2, 705, 851	0					1.00
2.00	Land Improvements	4, 358, 832	0					2.00
3.00	Buildings and Fixtures	323, 581, 868	0					3.00
4.00	Building Improvements	3, 219, 528	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	120, 360, 146	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	454, 226, 225	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	454, 226, 225	0					10.00

Health Financial Systems	COMMUNI TY HOSPI TAL	OF INDIANA, IN	NC.	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0169	Peri od:	Worksheet A-7	
				From 01/01/2019		
				To 12/31/2019	Date/Time Pre 6/30/2020 2:10	
		SI	JMMARY OF CAP	ΙΤΑΙ	0/30/2020 2.1	
Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
				instructions)	instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FRO	M WORKSHEET A, COLUM	N 2, LINES 1 a	nd 2			
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 OF	F CAPITAL				
		T + + (4) (	-			
Cost Center Description		Total (1) (sum				
	Capi tal -Rel ate					
	d Costs (see instructions)	through 14)				
	14,00	15.00	-			
PART II - RECONCILIATION OF AMOUNTS FRO			nd 2			
1.00 CAP REL COSTS-BLDG & FIXT		0				1.00
2.00 CAP REL COSTS BEDG & THAT	0	0				2.00
3.00 Total (sum of lines 1-2)	0	0				3.00
· · · · · · · · · · · · · · · · · · ·		0	1			

	UNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO	F	Period: From 01/01/2019 To 12/31/2019		
	COMI	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
PART III - RECONCILIATION OF CAPITAL COSTS CE	1.00	2.00	3.00	4.00	5.00	
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	329, 815, 544 111, 616, 189 441, 431, 733	0	329, 815, 544 111, 616, 189 441, 431, 733 CAPI TAL	0. 252850	0 0 F CAPITAL	1.00 2.00 3.00
Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	1			0 (00 000		
1.00CAP REL COSTS-BLDG & FIXT2.00CAP REL COSTS-MVBLE EQUIP3.00Total (sum of lines 1-2)	0	0		8, 688, 029 11, 769, 904 20, 457, 933	0 4, 231, 784 4, 231, 784	1.00 2.00 3.00
		Ŭ	IMMARY OF CAPIT		4,231,704	3.00
Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE			-	-		
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP	5, 708, 026 0	205, 390 0			14, 601, 445 16, 001, 688	1.00 2.00
3.00 Total (sum of lines 1-2)	5, 708, 026	205, 390	c	0	30, 603, 133	3.00

Health Financial Systems

### COMMUNITY HOSPITAL OF INDIANA, INC.

In Lieu of Form CMS-2552-10

					From 01/01/2019 To 12/31/2019	Date/Time Pre	nar
						6/30/2020 2:10	
				Expense Classification of To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
)0	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1
	COSTS-BLDG & FIXT (chapter 2)						
00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2
0	Investment income - other		0		0.00	0	:
0	(chapter 2) Trade, quantity, and time		0		0.00	0	
0	discounts (chapter 8) Refunds and rebates of	В	-16 705	ADMI NI STRATI VE & GENERAL	5.00	0	Ę
	expenses (chapter 8)		-10, 703				
0	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6
00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7
00	Television and radio service		0		0.00	0	8
00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	Ģ
00	Provider-based physician	A-8-2	-776, 673			0	10
	adjustment Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11
00	Related organization transactions (chapter 10)	A-8-1	1, 916, 367			0	12
	Laundry and linen service		0		0.00		
00 00	Cafeteria-employees and guests Rental of quarters to employee		-2, 652, 289	CAFETERI A	11.00 0.00		
	and others		0				
00	Sale of medical and surgical supplies to other than patients		0		0.00	0	10
00	Sale of drugs to other than patients		0		0.00	0	17
00	Sale of medical records and		0		0.00	0	18
00	abstracts Nursing and allied health		0		0.00	0	19
	education (tuition, fees,		Ū			Ŭ	
00	books, etc.) Vending machines		0		0.00	0	20
00	Income from imposition of		0		0.00	0	
	interest, finance or penalty charges (chapter 21)						
00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22
	repay Medicare overpayments						
00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23
00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66.00		24
00	therapy costs in excess of	A-0-3	0	THISTORE THENAFT	00.00		
00	limitation (chapter 14) Utilization review –		0	UTILIZATION REVIEW-SNF	114.00		25
-	physicians' compensation		Ū				
00	(chapter 21) Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26
00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27
00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	NONPHYSI CI AN ANESTHETI STS	19.00		28
00	Physicians' assistant		0		0.00	0	29
00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30
99	limitation (chapter 14) Hospice (non-distinct) (see		~	ADULTS & PEDIATRICS	30.00		30
	instructions)						
00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31
	CAH HIT Adjustment for		0		0.00	0	32

Health Financial Systems

ADJUSTMENTS TO EXPENSES			Provider CCN: 15-0169	Peri od:	Worksheet A-8	
				From 01/01/2019 To 12/31/2019	Date/Time Pre	nared
				10 12/01/2017	6/30/2020 2:1	
			Expense Classification o			
			To/From Which the Amount is	s to be Adjusted		
Cost Center Description	n Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. (
(3)						
33.01 Misc Revenue	В		EMPLOYEE BENEFITS DEPARTMEN			
33.02 Misc Revenue	В		ADMI NI STRATI VE & GENERAL	5.00	0	
33.03 Misc Revenue	В		OPERATION OF PLANT	7.00	0	
33.04 Misc Revenue	В	-20, 163	DI ETARY	10.00	0	
33.05 Misc Revenue	В	-98, 632	PHARMACY	15.00	0	33.
33.06 Misc Revenue	В	-90	ADULTS & PEDIATRICS	30.00	0	33.
3.07 Misc Revenue	В	-1, 520	NEONATAL INTENSIVE CARE UNI	T 35.00	0	33.
3.08 Misc Revenue	В	-111, 063	RADI OLOGY-DI AGNOSTI C	54.00	0	33.
3.09 Misc Revenue	В	-11, 627	MRI	58.00	0	33.
3.10 Misc Revenue	В	-291	LABORATORY	60.00	0	33.
33.11 Misc Revenue	В	-1, 216	PHYSICAL THERAPY	66.00	0	33.
34.01 00 Non-Allow Interest Expens	e A	-4, 149, 875	CAP REL COSTS-BLDG & FIXT	1.00	11	34.
34.02 LOC Non-Allow Interest Expen	se A	-88, 397	CAP REL COSTS-BLDG & FIXT	1.00	11	34.
34.03 12A Non-Allow Interest Expen	se A	-2, 224, 425	CAP REL COSTS-BLDG & FIXT	1.00	11	34.
34.04 12B Non-Allow Interest Expen	se A	-232,079	CAP REL COSTS-BLDG & FIXT	1.00	11	34.
34.05 50M BMO Non-Allow Interest	А	-77, 368	CAP REL COSTS-BLDG & FIXT	1.00	11	34.
Expense		,				
34.06 16AB Non-Allow Interest	A	-946, 719	CAP REL COSTS-BLDG & FIXT	1.00	11	34.
Expense						
34.07 Non-Allow Debt Issuance	A	76, 650	ADMI NI STRATI VE & GENERAL	5.00	0	34.
Expense						
34.10 HAF Tax Offset	A	-27, 812, 505	ADMI NI STRATI VE & GENERAL	5.00	0	34.
35.00 Bad Debt	A	-23, 329, 999	ADMI NI STRATI VE & GENERAL	5.00	0	35.
35.01 Space Rental Income	В	-59,019	ADMI NI STRATI VE & GENERAL	5.00	0	35.
5.02 Space Rental Income	В	-20, 400	OPERATION OF PLANT	7.00	0	35.
35.03 Investment Income	В		LABORATORY	60.00	0	35.
36.00 Meals of Wheels Cost	A	-50, 101	CAFETERIA	11.00	0	36.
36. 01 Sponsorshi p	A		ADMI NI STRATI VE & GENERAL	5.00	0	
36. 02 Sponsorship	A		PHYSICAL THERAPY	66.00	0	
6.03 Nurse Practitioner Offset	A		NEONATAL INTENSIVE CARE UNI			
6. 04 CARDIAC CATH SHARED SERVICES			CARDI AC CATHETERI ZATI ON	59.00		
36. 05 CARDI AC MONI TORI NG SHARED	A		ELECTROCARDI OLOGY	69.00	0	
SERVICES		201, 770		07.00		
50.00 TOTAL (sum of lines 1 thru 4	9)	-62, 569, 391				50.
(Transfer to Worksheet A,		52, 557, 571				
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 HOSPI TA	L OF INDIANA, INC.	In Lie	eu of Form CMS-	2552-10
STATEM OFFICE	ENT OF COSTS OF SERVICES FROM COSTS	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019		pared:
	Li ne No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount	<u>o piii</u>
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST HOME OFFICE COSTS:					
1.00		I &R SERVICES-SALARY & FRINGE		483, 306		1.00
2.00		I&R SERVICES-OTHER PRGM COST		642, 269		2.00
3.00			7250 CLEARVI STA	229, 551		3.00
3.01			7250 CLEARVI STA	98, 744		3. 01
3.02			7250 CLEARVI STA	452, 520		3. 02
4.00			HOME OFFICE	5, 633, 008		4.00
4.01			HOME OFFICE	4, 734, 250		4.01
4.02			HOME OFFICE	53, 401, 544	0	4.02
4.03			HOME OFFICE	650, 266	0	4.03
4.04	13.00		HOME OFFICE	5, 065, 167	0	4.04
4.05			HOME OFFICE	1, 449, 201	0	4.05
4.06			HOME OFFICE	2, 686, 293		4.06
4.07			HOME OFFICE	840, 998		4.07
4.08	54.00		HOME OFFICE	55, 632		4.08
4.09			HOME OFFICE	22, 152	0	4.09
4.10			HOME OFFICE	260, 718		4.10
4.11			HOME OFFICE	476, 293	0	4.11
4.12	30.00		HOME OFFICE	53	0	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	0	75, 715, 543	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	CPN MEDICAL DIRECTOR	15, 120	0	4.14
4.15	91.00	EMERGENCY	CPN CALL	871, 200	0	4.15
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			78, 068, 285	76, 151, 918	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.

			Related Organization(s) and/	or Home Office	
				1	
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

Ternibur					
6.00	В	CHNW	100.00	0.00	6.00
7.00			0.00	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.

Heal th	Financial Syste	ems	COMMUNI TY HOSPI TAL OF	INDIANA, INC.	In Lieu	u of Form CMS-2	552-10
STATEM OFFI CE		SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-01	69 Period: From 01/01/2019 To 12/31/2019	Worksheet A-8- Date/Time Prep	
					10 12/31/2017	6/30/2020 2:16	pm
		Wkst. A-7 Ref.					
	Adj ustments						
	(col. 4 minus						
	col. 5)*						
	6.00	7.00					
			ENTS REQUIRED AS A RESULT OF TRAN	ISACTIONS WITH RELAT	FED ORGANIZATIONS OR (	CLAIMED	
	HOME OFFICE CO						
1.00	483, 306						1.00
2.00	642, 269						2.00
3.00	-16, 340						3.00
3.01	-36, 441						3.01
3.02	397, 221						3.02
4.00	5, 633, 008						4.00
4.01	4, 734, 250	0					4.01
4.02	53, 401, 544	0					4.02
4.03	650, 266	0					4.03
4.04	5, 065, 167	0					4.04
4 05	1 449 201	0					4 05

4.05
4.06
4.07
4.08
4.09
4.10
4.11
4.12
4.13
4.14
4.15
5.00
4 4 4 4

\* 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 the amount allowable should be indi to Workshoot A columns 1 and/or 2

Related Organization(s) and/or Home Office         Type of Business         6.00         B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:	nas no	L been posted to worksheet A,	corumns r and/or 2, the amount arrowable should be indicated in corumn 4 of this part.	
Type of Busi ness 6.00		Related Organization(s)		
6.00		and/or Home Office		
6.00				
6.00				
6.00		Type of Business		
		6.00		
D. INTERRELATIONSHIF TO RELATED ORGANIZATION(3) AND/OR HOME OFFICE.		B. INTERRELATIONSHIP TO RELA	FED 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	6.00
7.00	7.00
8.00	8.00
9.00	9.00
10.00	10.00
7. 00 8. 00 9. 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.

Β. Corporation, partnership, or other organization has financial interest in provider.

Provider has financial interest in corporation, partnership, or other organization. C.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

Health Financial Systems PROVIDER BASED PHYSICIAN ADJUSTMENT COMMUNITY HOSPITAL OF INDIANA, INC. Provider CCN: 15-0169 Period:

In Lieu of Form CMS-2552-10 Worksheet A-8-2

PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (		Period:	Worksheet A-8	8-2
						From 01/01/2019 To 12/31/2019		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	AGGREGATE-ADMI NI STRATI VE &	606, 847	228, 388	378, 459	211, 500	2,080	1.00
		GENERAL						
2.00	35.00	AGGREGATE-NEONATAL INTENSIVE	120, 000	120, 000	0	0	0	2.00
2 00	40.00	CARE UN	2(1,22)	2(1,22)	0	0	0	2 00
3.00 4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	261, 326	261, 326 0		-	0	3.00 4.00
4.00 5.00	0.00				-	-	0	4.00 5.00
5.00 6.00	0.00				-	-	0	5.00 6.00
7.00	0.00			0	0	-	0	7.00
8.00	0.00			0	0	0	0	7.00 8.00
9.00	0.00				3	0	0	9,00
10.00	0.00				0	-	0	10.00
200.00	0.00		988, 173	609, 714	-	-	2,080	
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	200.00
	WRSt. A EINC #	I denti fi er		Unadjusted RCE			of Malpractice	
				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	5.00	AGGREGATE-ADMI NI STRATI VE &	211, 500	10, 575	0	0	0	1.00
		GENERAL						
2.00		AGGREGATE-NEONATAL INTENSIVE	0	0	0	0	0	2.00
2 00		CARE UN		0	0			2 00
3.00 4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0		-	-	-	3.00 4.00
4.00 5.00	0.00				0		0	4.00 5.00
5.00 6.00	0.00			0	0		0	5.00 6.00
7.00	0.00				3		0	7.00
8.00	0.00				0	0	0	8.00
9.00	0.00				0	0	0	9.00
10.00	0.00				0	0	0	10.00
200.00	0.00		211, 500	10, 575	-	-	0	200.00
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		AGGREGATE-ADMI NI STRATI VE &	0	211, 500	166, 959	395, 347		1.00
		GENERAL				100.000		
2.00	35.00	AGGREGATE-NEONATAL INTENSIVE	0	0	0	120, 000		2.00
2 00	10.00	CARE UN		0		2(1.22)		2 00
3.00		AGGREGATE-SUBPROVI DER - I PF	0		0			3.00
4.00	0. 00 0. 00				0	0		4.00
5.00	0.00				0	0		5.00 6.00
6.00 7.00	0.00				0	0		6.00 7.00
7.00 8.00	0.00			0	0	0		7.00 8.00
8.00 9.00	0.00				0	0		8.00 9.00
9.00 10.00	0.00				0	0		9.00 10.00
200.00	0.00		0	211, 500	0	776, 673		200.00
200.00	1	I	. 0	1 211, 300	100, 707	1 7,0,073	I	200.00

T ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F	Period: From 01/01/2019 To 12/31/2019	w of Form CMS- Worksheet B Part I Date/Time Pre	
		CAPI TAL REL	ATED COSTS		6/30/2020 2:1	16 pm
	Net European	BLDG & FIXT			Cultated	
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXI	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
0 00100 CAP REL COSTS-BLDG & FIXT 0 00200 CAP REL COSTS-MVBLE EQUIP	14, 601, 445 16, 001, 688		16, 001, 688			1.
0 00400 EMPLOYEE BENEFITS DEPARTMENT	4, 925, 218		112, 175			4.
0 00500 ADMINISTRATIVE & GENERAL	62, 822, 718		6, 452, 432		69, 968, 006	
0 00700 OPERATION OF PLANT	11, 442, 234					
0 00800 LAUNDRY & LINEN SERVICE	984, 258		79			
0 00900 HOUSEKEEPI NG 00 01000 DI ETARY	4, 895, 168 1, 361, 753		24, 232 16, 291			
00 01100 CAFETERIA	1, 325, 422					
00 01300 NURSI NG ADMI NI STRATI ON	8,068,830		12,065			
00 01400 CENTRAL SERVICES & SUPPLY	878, 597	335, 928	2, 090, 613	3 0	3, 305, 138	14.
00 01500 PHARMACY	5, 247, 509		601, 365			
00 01600 MEDICAL RECORDS & LIBRARY	3, 128, 788		79		3, 152, 117	
00 01700 SOCIAL SERVICE 00 01900 NONPHYSICIAN ANESTHETISTS	2, 173, 494	40, 029 0	36			
00 02100 I &R SERVICES-SALARY & FRINGES APPRV	483, 306	-	(			
00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	642, 269	0	(			
INPATIENT ROUTINE SERVICE COST CENTERS				1		
00 03000 ADULTS & PEDIATRICS	40, 135, 589		788, 777			
00 03100 I NTENSI VE CARE UNI T 00 02060 NEONATAL I NTENSI VE CARE UNI T	6, 161, 786 8, 503, 377		180, 818 174, 405			
00 04000 SUBPROVIDER - IPF	2, 311, 900		17, 572		2, 574, 660	
00 04300 NURSERY	2, 221, 741		46, 015			
ANCI LLARY SERVI CE COST CENTERS						
00 05000 OPERATING ROOM	11,074,938					
00 05100 RECOVERY ROOM 00 05200 DELIVERY ROOM & LABOR ROOM	3, 434, 427 6, 399, 940				3, 925, 992 7, 772, 015	
00 05400 RADI OLOGY-DI AGNOSTI C	4, 143, 321	231, 932	375, 000			
00 05500 RADI OLOGY-THERAPEUTI C	934,079					
00 05700 CT SCAN	1, 509, 678	33, 902	234, 875	5 52, 448	1, 830, 903	
00 05800 MRI	890, 907	120, 915	291, 026			
00 05900 CARDIAC CATHETERIZATION 00 06000 LABORATORY	200, 590		1, 514			
00 06000 LABORATORY 00 06400 I NTRAVENOUS THERAPY	9, 577, 269 848, 338			-		
00 06500 RESPIRATORY THERAPY	4, 052, 066					
00 06600 PHYSI CAL THERAPY	6, 662, 481	22, 543				
00 06700 OCCUPATI ONAL THERAPY	1, 883, 020		55, 336			
00 06800 SPEECH PATHOLOGY	322, 226		.,			
00 06900 ELECTROCARDI OLOGY 00 07000 ELECTROENCEPHALOGRAPHY	605, 382 1, 815, 626		3, 209 109, 790		610, 094 2, 055, 385	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	20, 558, 640		(	0 0		
00 07200 IMPL. DEV. CHARGED TO PATIENTS	14, 538, 159	0	(	0 0		
00 07300 DRUGS CHARGED TO PATIENTS	17, 262, 570		(	0 0	17, 262, 570	
01 07301 SPECIALTY PHARMACY	17, 742, 140			88, 323		
00 07400 RENAL DI ALYSI S 00 03330 ENDOSCOPY	1, 386, 181 1, 995, 897	2, 638 180, 718	350, 323		1 1 -	
01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	330, 323	0 0	2, 304, 114	
02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	C	0	0	
03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	(	0	0	
04 03953 WOUND CARE	225, 202	0	341			
06 03954 I MAGI NG CENTER 07 03955 BREAST DI AGNOSTI C CENTER	3, 523, 390 9, 447, 294		352, 263 13, 966			
OUTPATIENT SERVICE COST CENTERS	7,447,274	0	15, 900	<u> </u>	7,401,200	1 '0
00 09000 CLINIC	0	0	(	0 0	0	90
01 04950 INFUSION CENTER	218, 915	0	32, 517			
26 04975 SPINE CENTER	256, 362	0	478		265, 880	
00 09100 EMERGENCY 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	9, 940, 368	622, 910	169, 089	293, 774	11, 026, 141 0	
SPECIAL PURPOSE COST CENTERS	1			<u> </u>	0	1 12
. 00 11300 I NTEREST EXPENSE						113
. 00 11400 UTI LI ZATI ON REVI EW-SNF						114
. 00 SUBTOTALS (SUM OF LINES 1 through 117)	349, 766, 496	14, 502, 114	15, 988, 527	5, 000, 114	349, 610, 511	1118
NONREI MBURSABLE COST CENTERS	0	85, 617	(	0 0	85, 617	100
. 00 19000 GFFT, FLOWER, COFFEE SHOP & CANTEEN	0	03,017		-		190.
. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	95, 996	0		0	95, 996	
. 00 19300 NONPALD WORKERS	0	0	(	-	0	193.
. 00 07950 HOME OFFICE	0	0	(	0 0		194

Health Financial Systems	COMMUNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2019	Worksheet B	
				To 12/31/2019	Date/Time Pre	pared:
					6/30/2020 2:1	<u>6 pm</u>
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	for Cost			BENEFITS		
	Allocation			DEPARTMENT		
	(from Wkst A					
	col. 7)					
	0	1.00	2.00	4.00	4A	
194. 06 07956 PAVI LLI ONS	25, 826	0	12, 80	3 0	38, 629	194.06
194.0807958 OTHER NRCC	1, 366, 885	13, 714	35	8 43, 493	1, 424, 450	194.08
194.1007960 COMMUNITY REHAB HOSPITAL	0	0		0 0	0	194.10
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	351, 255, 203	14, 601, 445	16, 001, 68	8 5, 043, 607	351, 255, 203	202.00

COST A	Cost Center Description	ADMI NI STRATI VE	Provider CC	F	eriod: rom 01/01/2019 o 12/31/2019 HOUSEKEEPING	Worksheet B Part I Date/Time Pre 6/30/2020 2:1 DIETARY	
	cost center bescription	& GENERAL	PLANT	LINEN SERVICE			
	GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
1.00 2.00 4.00 5.00 7.00	General Service COST Centers         00100       CAP REL COSTS-BLDG & FLXT         00200       CAP REL COSTS-MVBLE EQUIP         00400       EMPLOYEE BENEFLTS DEPARTMENT         00500       ADMLNISTRATIVE & GENERAL         00700       OPERATION OF PLANT	69, 968, 006 3, 367, 430	16, 905, 272				1.00 2.00 4.00 5.00 7.00
8.00 9.00 10.00 11.00 13.00 14.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	257, 867 1, 291, 892 379, 422 452, 888 2, 043, 337 822, 127	71, 905 181, 663 161, 359 470, 330 32, 493 461, 435	1, 366, 456 0 0 0 0 0 0 0 0	6, 667, 257 64, 607 188, 318 13, 010	2, 130, 752 0 0 0	11.00 13.00
15.00 16.00 17.00 19.00 21.00 22.00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS 02100 I &R SERVI CES-SALARY & FRI NGES APPRV 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	1, 553, 907 784, 064 570, 609 0 120, 219 159, 759	224, 758 8, 026 54, 984 0 0 0	0 0 0 0 0	3, 214 22, 015 0 0	0 0 0 0 0	16.00 17.00 19.00 21.00
30. 00 31. 00 35. 00 40. 00 43. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 02060 NEONATAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04300 NURSERY	11, 638, 956 1, 875, 910 2, 449, 285 640, 426 675, 543	6, 222, 185 1, 343, 037 1, 192, 789 214, 486 516, 150		537, 745 477, 587 85, 879	158, 045 281, 481	31.00 35.00 40.00
73.00 73.01 74.00 76.00 76.01 76.02 76.03 76.03	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM 05100 RECOVERY ROOM & LABOR ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06400 INTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07300 SPECI ALTY PHARMACY 07400 RENAL DI ALYSI S 03330 ENDOSCOPY 03950 OTHER ANCI LLARY SERVI CE COST CENTERS 03951 OTHER ANCI LLARY SERVI CE COST CENTERS 03952 OTHER ANCI LLARY SERVI CE COST CENTERS 03953 WOUND CARE 03955 BREAST DI AGNOSTI C CENTER 0400 THEN SERVI CE COST CENTERS	$\begin{array}{c} 3, 525, 968\\ 976, 559\\ 1, 933, 227\\ 1, 218, 085\\ 402, 876\\ 455, 422\\ 330, 379\\ 50, 272\\ 2, 414, 488\\ 262, 096\\ 1, 109, 259\\ 1, 837, 029\\ 497, 226\\ 85, 086\\ 151, 756\\ 511, 261\\ 5, 113, 797\\ 3, 616, 251\\ 4, 293, 926\\ 4, 435, 185\\ 345, 458\\ 642, 78\\ 0\\ 0\\ 0\\ 58, 256\\ 982, 652\\ 2, 353, 413\\ \end{array}$	943, 355 506, 387 1, 423, 926 318, 584 347, 274 46, 569 166, 090 237, 606 192, 474 30, 966 0 0 114, 580 0 114, 580 0 0 3, 624 248, 237 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	52, 135 0 91, 864 72, 265 10, 889 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	202, 755 570, 133 127, 560 139, 047 18, 646 66, 502 0 71, 238 95, 136 77, 066 12, 399 0 0 0 45, 877 0 0 0 45, 877 0 0 0 0 1, 451		$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 52.\ 00\\ 55.\ 00\\ 55.\ 00\\ 57.\ 00\\ 58.\ 00\\ 69.\ 00\\ 64.\ 00\\ 65.\ 00\\ 64.\ 00\\ 65.\ 00\\ 64.\ 00\\ 67.\ 00\\ 67.\ 00\\ 67.\ 00\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 01\\ 74.\ 00\\ 76.\ 01\\ 76.\ 03\\ 76.\ 04\\ 76.\ 06\\ \end{array}$
90. 00 90. 01 90. 26 91. 00 92. 00	09000 CLINIC 04950 INFUSION CENTER 04975 SPINE CENTER 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS	0 63, 755 66, 136 2, 742, 664	0 0 855, 638	0 0 251, 232	0	0 0 0	90. 01 90. 26
	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF	69, 558, 901	16, 768, 830	1, 366, 456	6, 612, 627	2, 130, 752	113. 00 114. 00 118. 00
191.00 192.00 193.00 194.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFICES 19300 NONPALD WORKERS 07950 HOME OFFICE 07956 PAVI LLIONS	21, 297 0 23, 878 0 0 9, 609	117, 605 0 0 0 0 0 0	0 0 0 0 0 0 0	47, 088 0 0 0 0 0 0 0	0 0 0 0	190.00 191.00 192.00 193.00 194.00
194.08	07958 OTHER NRCC 07960 COMMUNITY REHAB HOSPITAL Cross Foot Adjustments	354, 321	18, 837 0 0	0	7, 542 0 0	0 0	194. 08 194. 10 200. 00 201. 00

Health Financial Systems	COMMUNI TY HOSPI TAL	OF INDIANA, IN	NC.	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2019	Worksheet B	
					Date/Time Pre 6/30/2020 2:1	
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5.00	7.00	8.00	9.00	10.00	
202.00 TOTAL (sum lines 118 through 201)	69, 968, 006	16, 905, 272	1, 366, 456	6, 667, 257	2, 130, 752	202.00

COST A	Financial Systems COMMI LLOCATION - GENERAL SERVICE COSTS	UNI TY HOSPI TAL	Provi der CC	N: 15-0169 Pe	eriod: com 01/01/2019	u of Form CMS-2 Worksheet B Part I Date/Time Pre	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	Date/Time Pre 6/30/2020 2:1 MEDICAL	6 pm
			ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	GENERAL SERVICE COST CENTERS 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	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
9.00	00900 HOUSEKEEPI NG						9.00
	01000 DI ETARY						10.00
	01100 CAFETERIA	2, 932, 251	10 202 704				11.00
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	79, 183 0	10, 382, 706 0	4, 773, 456			13.00 14.00
	01500 PHARMACY	197, 958	0	26, 259	8, 339, 937		15.00
	01600 MEDICAL RECORDS & LIBRARY	9, 898	0	1	0	3, 957, 320	16.00
	01700 SOCIAL SERVICE	51, 964	0	51	0	0	17.00
	01900 NONPHYSICIAN ANESTHETISTS 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	19.00 21.00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1				
	03000 ADULTS & PEDIATRICS	1,012,060	5,097,871	224, 773	0	475, 815	
	03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	165, 790 202, 907	835, 104 1, 022, 067	40, 446 43, 240	0	69, 235 225, 959	
	04000 SUBPROVI DER – I PF	66, 811	336, 534	7, 318	0	29, 723	1
	04300 NURSERY	54, 438	274, 213	11, 400	0	24, 491	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	470.4(0)	007 405	070 400			50.00
	05000 OPERATING ROOM 05100 RECOVERY ROOM	178, 162 79, 183	897, 425 0	270, 183 34, 576	0	527, 221 90, 141	50.00 51.00
	05200 DELIVERY ROOM & LABOR ROOM	148, 468	747, 854	34, 370	0	67, 566	1
	05400 RADI OLOGY-DI AGNOSTI C	96, 504	0	14, 349	0	106, 841	1
	05500 RADI OLOGY-THERAPEUTI C	19, 796	0	17, 584	0	93, 520	
	05700 CT SCAN 05800 MRI	34,643	0	1,077	0	194, 755	
	05900 CARDI AC CATHETERI ZATI ON	14, 847 0	0	160 7	0	51, 125 11, 422	59.00
	06000 LABORATORY	0	0	, 148, 713	0	328, 711	60.00
64.00	06400 I NTRAVENOUS THERAPY	19, 796	0	2, 509	0	6, 872	
		94,030	0	24,064	0	71,866	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	37, 117 37, 117	0	13, 889 3, 583	0	75, 025 22, 402	
	06800 SPEECH PATHOLOGY	7, 423	0	613	0	5, 651	68.00
	06900 ELECTROCARDI OLOGY	2, 474	0	38	0	30, 900	
	07000 ELECTROENCEPHALOGRAPHY	37, 117	0	13, 215	0	34, 920	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	2, 064, 709 1, 460, 082	0	196, 799 116, 749	
	07300 DRUGS CHARGED TO PATIENTS	0	0	1, 400, 002	8, 339, 937	315, 826	
73.01	07301 SPECI ALTY PHARMACY	0	0	176, 349	0	51, 047	
	07400 RENAL DIALYSIS	0	0	159	0	10, 700	
	03330 ENDOSCOPY 03950 OTHER ANCILLARY SERVICE COST CENTERS	42,066	0	22, 675 0	0	64, 798 0	76.00 76.01
	03951 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.03
	03953 WOUND CARE	4, 949	0	1,688	0	2, 926	76.04
	03954 I MAGI NG CENTER 03955 BREAST DI AGNOSTI C CENTER	0	0	18, 593 504	0	152, 623 63, 316	
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	0	0	0	90.00
	04950 I NFUSI ON CENTER	4, 949	0	1, 483	0	1, 581	90.01
	04975 SPI NE CENTER 09100 EMERGENCY	0 232, 601	0 1, 171, 638	464 93, 526	0	1, 617 435, 177	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	202,001	1, 171, 030	,5, 520	0	-55, 177	92.00
	SPECIAL PURPOSE COST CENTERS						1
	11300 INTEREST EXPENSE						113.00
114.00 118.00	11400 UTILIZATION REVIEW-SNF SUBTOTALS (SUM OF LINES 1 through 117)	2, 932, 251	10, 382, 706	4, 769, 730	8, 339, 937	3, 957, 320	114.00
110.00	NONREIMBURSABLE COST CENTERS	2,752,251	10, 302, 700	+, 707, 730	0, 007, 707	5, 757, 320	1.10.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19100 RESEARCH	0	о	0	0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	2, 965	0		192.00
	19300 NONPALD WORKERS 07950 HOME OFFICE	0	0	0	0		193.00 194.00
	07956 PAVI LLI ONS	0	0	478	0		194.00
194.08	07958 OTHER NRCC	0	Ō	283	0	0	194. 08
194.10	07960 COMMUNITY REHAB HOSPITAL Cross Foot Adjustments	0	0	0	0		194. 10 200. 00
200.00							

Health Fin	ancial Systems CO	MMUNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-	2552-10
COST ALLOC	ATION - GENERAL SERVICE COSTS		Provider CC		Peri od:	Worksheet B	
					From 01/01/2019 Fo 12/31/2019	Date/Time Pre	
	Cost Center Description	CAFETERIA	NURSING	CENTRAL	PHARMACY	6/30/2020 2:1 MEDI CAL	o pm
			ADMI NI STRATI ON			RECORDS &	
				SUPPLY		LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
201.00	Negative Cost Centers	0	0	(	0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2, 932, 251	10, 382, 706	4, 773, 456	8, 339, 937	3, 957, 320	202.00

	Financial Systems COMM ALLOCATION - GENERAL SERVICE COSTS	IUNI TY HOSPI TAL		NC. CN: 15-0169	Peri od:	u of Form CMS-: Worksheet B	2552-10
					From 01/01/2019 To 12/31/2019	Part I Date/Time Pre	
				I NTERNS	& RESI DENTS	6/30/2020 2:1	
	Cost Center Description	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	Y & FRINGES		Subtotal	
		17.00	19.00	APPRV 21.00	APPRV 22.00	24.00	
	GENERAL SERVICE COST CENTERS	1		ь			
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00 5.00 7.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						4.00 5.00 7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8. 00 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
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	2, 993, 601					16.00
	01900 NONPHYSICIAN ANESTHETISTS	0	C				19.00
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0		603, 5			21.00
22.00	02200 I & R SERVI CES-OTHER PRGM COSTS APPRV I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	L	1	802, 028		22.00
30.00	03000 ADULTS & PEDI ATRI CS	1, 950, 934	C	367, 8	93 488, 895	78, 841, 038	30.00
	03100 I NTENSI VE CARE UNI T	222, 045	C		0 0	12, 854, 842	
	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	395, 466 174, 473			0 0 98 228,437	16, 188, 890 4, 670, 729	
	04000 SUBPROVIDER - TPF	250, 683			98 228, 437 0 0	4, 870, 729	
101.00	ANCI LLARY SERVICE COST CENTERS	200,000		· [	<u> </u>		
50.00	05000 OPERATI NG ROOM	0	C		0 0	20, 947, 363	
51.00	05100 RECOVERY ROOM	0			0 0	5, 815, 593	
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0				12, 786, 503 6, 851, 170	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	2, 650, 639	
57.00	05700 CT SCAN	0	C	)	0 0	2, 582, 015	
58.00 59.00		0			0 0	1, 957, 303	
60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0			0 0	263, 805 12, 847, 866	
64.00	06400 I NTRAVENOUS THERAPY	0	C		0 0	1, 677, 703	
65.00	06500 RESPI RATORY THERAPY	0	C		0 0	6, 028, 237	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0		12, 2	44 16, 271 0 0	9, 420, 218 2, 559, 289	
68.00	06800 SPEECH PATHOLOGY	0			0 0	440, 839	
69.00	06900 ELECTROCARDI OLOGY	0	C		0 0	795, 262	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	C		0 0	2, 812, 355	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 0	27, 933, 945 19, 731, 241	
	07300 DRUGS CHARGED TO PATIENTS	0			0 0	30, 212, 259	
73.01	07301 SPECIALTY PHARMACY	0	C		0 0	22, 493, 044	
	07400 RENAL DI ALYSI S	0	0		0 0	1, 750, 211	
	03330 ENDOSCOPY 03950 OTHER ANCILLARY SERVICE COST CENTERS	0				3, 734, 929 0	
	03951 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0 0	0	76.02
	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	C		0 0	0	76.03
	03953 WOUND CARE	0	0		0 0	302, 022	76.04
	03954 I MAGI NG CENTER 03955 BREAST DI AGNOSTI C CENTER	0			0 0	5, 104, 356 11, 878, 493	
. 5. 57	OUTPATIENT SERVICE COST CENTERS			· L	- 0	. 1, 0, 0, 473	1 0.07
		0	C	)	0 0	0	
	04950 INFUSION CENTER	0			0 0	328, 078	
	04975 SPINE CENTER 09100 EMERGENCY	0		) 51, 4	0 0 90 68, 425	334, 097 17, 271, 125	
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS			1			
	11300 INTEREST EXPENSE						113.00
114.00	) 11400 UTILIZATION REVIEW-SNF ) SUBTOTALS (SUM OF LINES 1 through 117)	2, 993, 601	C	603, 5	25 802, 028	349, 006, 608	114.00
	NONREI MBURSABLE COST CENTERS	2,773,001				017,000,000	1 10.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	)	0 0	271, 607	
	19100 RESEARCH	0	C		0 0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	0			0 0	122, 839	192.00 193.00
	07950 HOME OFFICE	0		Ď	0 0		193.00
194.06	07956 PAVI LLI ONS	0	C	þ	0 0	48, 716	194.06
	07958 OTHER NRCC				0 0	1, 805, 433	1104 00

Health Financial Systems	COMMUNI TY HOSPI TAL	OF INDIANA, IN	NC.	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B	
				rom 01/01/2019 0 12/31/2019		pared.
					6/30/2020 2:1	<u>6 pm</u>
			INTERNS &	RESI DENTS		
Cost Center Description	SOCI AL SERVI CE	NONPHYSI CI AN	SERVI CES-SALAF	SERVI CES-OTHER	Subtotal	
		ANESTHETI STS	Y & FRINGES	PRGM COSTS		
			APPRV	APPRV		
	17.00	19.00	21.00	22.00	24.00	
194.1007960 COMMUNITY REHAB HOSPITAL	0	C	(	0 0	0	194.10
200.00 Cross Foot Adjustments		C	(	0 0	0	200.00
201.00 Negative Cost Centers	0	C	(	0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	2, 993, 601	0	603, 525	802, 028	351, 255, 203	202.00

	Financial Systems COMM LLOCATION - GENERAL SERVICE COSTS	<u>NUNITY HOSPITAL C</u>	Provider CC	Period: From 01/01/	
				To 12/31/	epared: 16 pm
	Cost Center Description	Intern & Residents Cost & Post Stepdown	Total		
		Adjustments 25.00	26.00		
	GENERAL SERVICE COST CENTERS	23.00	20.00		
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
7.00	00700 OPERATION OF PLANT				7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG				8.00
10.00	01000 DI ETARY				10.00
11.00	01100 CAFETERI A				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON				13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY				14.00
	01600 MEDICAL RECORDS & LIBRARY				16.00
	01700 SOCIAL SERVICE				17.00
	01900 NONPHYSI CI AN ANESTHETI STS				19.00
21.00 22.00	02100 I & SERVI CES-SALARY & FRI NGES APPRV 02200 I & SERVI CES-OTHER PRGM COSTS APPRV				21.00
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	I		
	03000 ADULTS & PEDIATRICS	-856, 788	77, 984, 250		30.00
	03100 INTENSIVE CARE UNIT	0	12, 854, 842		31.00
	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	-400, 335	16, 188, 890 4, 270, 394		35.00
	04300 NURSERY	0	4, 941, 149		43.00
	ANCI LLARY SERVICE COST CENTERS	1			
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	20, 947, 363		50.00 51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	5, 815, 593 12, 786, 503		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	6, 851, 170		54.00
	05500 RADI OLOGY-THERAPEUTI C	0	2, 650, 639		55.00
57.00 58.00	05700 CT SCAN 05800 MRI	0	2, 582, 015 1, 957, 303		57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	263, 805		59.00
60.00	06000 LABORATORY	0	12, 847, 866		60.00
64.00	06400 I NTRAVENOUS THERAPY	0	1,677,703		64.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0 -28, 515	6, 028, 237 9, 391, 703		65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	2, 559, 289		67.00
	06800 SPEECH PATHOLOGY	0	440, 839		68.00
		0	795, 262		69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 812, 355 27, 933, 945		70.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	19, 731, 241		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	30, 212, 259		73.00
	07301 SPECIALTY PHARMACY 07400 RENAL DIALYSIS	0	22, 493, 044 1, 750, 211		73.01
	03330 ENDOSCOPY	0	3, 734, 929		76.00
76. 01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.01
	03951 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		76.02
	03952 OTHER ANCILLARY SERVICE COST CENTERS 03953 WOUND CARE	0	0 302, 022		76.03
	03954 I MAGI NG CENTER	0	5, 104, 356		76.06
76. 07	03955 BREAST DI AGNOSTI C CENTER	0	11, 878, 493		76.07
00.00	OUTPATIENT SERVICE COST CENTERS		ol		
	09000 CLINIC 04950 INFUSION CENTER	0	0 328, 078		90.00
	04975 SPI NE CENTER	0	334, 097		90.26
91.00	09100 EMERGENCY	-119, 915	17, 151, 210		91.00
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0			 92.00
113.00	SPECIAL PURPOSE COST CENTERS	[ [			113.00
	11400 UTILIZATION REVIEW-SNF				114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-1, 405, 553	347, 601, 055		 118.00
100 00	NONREI MBURSABLE COST CENTERS		074 (07		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	271, 607 0		190.00 191.00
	19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES	0	122, 839		191.00
193.00	19300 NONPAI D WORKERS	0	0		193.00
	07950 HOME OFFICE	0	0		194.00
	07956 PAVI LLI ONS	0	48, 716		194.06

Health Financial Systems	COMMUNI TY HOSPI TAL (	OF INDIANA, INC.		In Lieu	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN:	15-0169	Peri od:	Worksheet B	
					Part I Date/Time Pre	narod
				10 12/31/2017	6/30/2020 2:1	
Cost Center Description	Intern &	Total		· · · · ·		
	Residents Cost					
	& Post					
	Stepdown					
	Adjustments					
	25.00	26.00				
194.1007960 COMMUNITY REHAB HOSPITAL	0	0				194.10
200.00 Cross Foot Adjustments	0	0				200.00
201.00 Negative Cost Centers	0	0				201.00
202.00 TOTAL (sum lines 118 through 201)	-1, 405, 553	349, 849, 650				202.00

Health Financial Systems         COMN           ALLOCATION OF CAPITAL RELATED COSTS         COMN	<u>IUNI TY HOSPI TAL</u>	Provider C	CN: 15-0169 P F	eriod: rom 01/01/2019 o 12/31/2019	u of Form CMS-: Worksheet B Part II Date/Time Pre 6/30/2020 2:1	pared:
		CAPI TAL REL	ATED COSTS		0/30/2020 2.1	
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS						1 00
1.00       00100       CAP       REL       COSTS-BLDG & FIXT         2.00       00200       CAP       REL       COSTS-MVBLE       EQUIP         4.00       00400       EMPLOYEE       BENEFITS       DEPARTMENT         5.00       00500       ADMINISTRATIVE       & GENERAL         7.00       00700       OPERATION OF       PLANT         8.00       00800       LAUNDRY & LINEN       SERVICE         9.00       00900       HOUSEKEEPING         10.00       01000       DIETARY         11.00       01100       CAFETERIA         13.00       01300       NURSI NG       ADMINISTRATION         14.00       01400       CENTRAL       SERVICES       SUPPLY         15.00       01500       PHARMACY       16.00       01600       MEDICAL       RECORDS       & LI BRARY         17.00       01700       SOCI AL       SERVICE       19.00       01900       NONPHYSICI AN ANESTHETISTS         21.00       021001       I&R SERVICES-OTHER       PRGM COSTS       APPRV         VALUE       NPATIENT       ROUTOR       SERVICES-OTHER       APRV		6, 214 429, 895 1, 858, 178 52, 347 132, 252 117, 470 342, 403 23, 655 335, 928 163, 625 5, 843 40, 029 0 0	6, 452, 432 88, 678 79 24, 232 16, 291 63, 752 12, 065 2, 090, 613 601, 365 79 36 0 0	118, 389 6, 882, 327 1, 946, 856 52, 426 156, 484 133, 761 406, 155 35, 720 2, 426, 541 764, 990 5, 922 40, 065 0 0	118, 389 6, 174 3, 492 0 3, 335 701 2, 093 2, 586 0 5, 507 409 1, 888 0 0 0 0	$\begin{array}{c} 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 19.\ 00\\ 21.\ 00\\ \end{array}$
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	0	4, 529, 797	788, 777	5, 318, 574	31, 360	30.00
31. 00 03100 INTENSIVE CARE UNIT 35. 00 02060 NEONATAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF 43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS		4, 329, 797 977, 741 868, 359 156, 147 375, 761	180, 818 174, 405	1, 158, 559 1, 042, 764	5, 195 5, 195 7, 056 2, 091 1, 698	31.00 35.00 40.00
50. 00 05000 OPERATI NG ROOM	0	686, 769	2, 169, 537	2, 856, 306	5, 728	50.00
51.00       05100       RECOVERY ROOM         52.00       05200       DELI VERY ROOM & LABOR ROOM         54.00       05400       RADI OLOGY-DI AGNOSTI C         55.00       05500       RADI OLOGY-THERAPEUTI C         57.00       05700       CT SCAN         58.00       05900       CARDI AC CATHETERI ZATI ON         60.00       06000       LABORATORY         64.00       06400       INTRAVENOUS THERAPY         65.00       06500       RESPI RATORY THERAPY         66.00       06600       PHYSI CAL THERAPY         66.00       06600       PHYSI CAL THERAPY         67.00       06700       OCCUPATI ONAL THERAPY         68.00       06800       SPEECH PATHOLOGY         69.00       06900       ELECTROCARDI OLOGY         70.00       07000       ELECTROCARDI OLOGY         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS         73.01       07301       SPECI ALTY PHARMACY         74.00       07400       RENAL DI ALYSI S         76.01       03950       OTHER ANCI LLARY SERVICE COST CENTERS         76.02       03951       OTHER ANCI LLARY S		368, 653 1, 036, 628 231, 932 252, 818 33, 902 120, 915 0 129, 527 172, 979 140, 123 22, 543 0 0	8, 691 126, 943 375, 000 404, 113 234, 875 291, 026 1, 514 0 3, 042 130, 621 477, 000 55, 336 9, 469 3, 209 109, 790 0 0 0 0 0 0 0	377, 344 1, 163, 571 606, 932 656, 931 268, 777 411, 941 1, 514 129, 527 176, 021 270, 744 499, 543 55, 336 9, 469	2, 682 4, 895 3, 445 673 1, 231 595 0 0 689 3, 209 5, 242 1, 423 243	$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 52.\ 00\\ 55.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 00\\ 64.\ 00\\ 65.\ 00\\ 64.\ 00\\ 67.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 00\\ 71.\ 00\\ 71.\ 00\\ 73.\ 01\\ 74.\ 00\\ 73.\ 01\\ 74.\ 00\\ 76.\ 01\\ 76.\ 03\\ 76.\ 03\\ \end{array}$
76. 06 03954 I MAGI NG CENTER 76. 07 03955 BREAST DI AGNOSTI C CENTER	0	0	352, 263 13, 966	352, 263 13, 966	1, 757 0	1
OUTPATIENT SERVICE COST CENTERS		0		13, 900	0	,0.0/
90. 00 09000 CLINIC 90. 01 04950 INFUSION CENTER 90. 26 04975 SPINE CENTER 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS	0 0 0	0 0 622, 910	0 32, 517 478 169, 089	0 32, 517 478 791, 999 0	0 115 212 6, 897	90. 01 90. 26
113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVIEW-SNF 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0	14, 502, 114	15, 988, 527	30, 490, 641	117, 368	113. 00 114. 00 118. 00
NONKET MBURSABLE COST CENTERS           190.00         19000         GIFT, FLOWER, COFFEE SHOP & CANTEEN           191.00         19100         RESEARCH           192.00         19200         PHYSI CLANS' PRI VATE OFFICES           193.00         19300         NONPAI D WORKERS           194.00         07950         HOME OFFICE           194.06         07956         PAVI LLI ONS		85, 617 0 0 0 0 0 0	0 0 0 0 12, 803	85, 617 0 0 0 12, 803	0 0 0 0	190. 00 191. 00 192. 00 193. 00 194. 00 194. 06

Health Financial Systems CO	MMUNITY HOSPITAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Period: From 01/01/2019 To 12/31/2019		
		CAPI TAL REI	LATED COSTS			
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	
194.08 07958 OTHER NRCC	0	13, 714	35	8 14, 072	1, 021	194.08
194. 10 07960 COMMUNI TY REHAB HOSPI TAL	0	0		0 0	0	194.10
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00   TOTAL (sum lines 118 through 201)	0	14, 601, 445	16, 001, 68	8 30, 603, 133	118, 389	202.00

$\begin{array}{ccccc} 1.\ 00 & 00 \\ 2.\ 00 & 00 \\ 4.\ 00 & 00 \\ 5.\ 00 & 00 \\ 7.\ 00 & 00 \\ 8.\ 00 & 00 \\ 9.\ 00 & 00 \\ 10.\ 00 & 01 \\ 11.\ 00 & 01 \\ 13.\ 00 & 01 \\ 14.\ 00 & 01 \\ 15.\ 00 & 01 \end{array}$	ENERAL SERVICE COST CENTERS 0100 CAP REL COSTS-BLDG & FIXT 0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING	ADMI NI STRATI VE <u>&amp; GENERAL</u> 5.00 6, 888, 501 331, 528 26, 292	OPERATI ON OF PLANT 7.00	LAUNDRY & LI NEN SERVI CE 8. 00	rom 01/01/2019 5 12/31/2019 HOUSEKEEPI NG 9.00	Part II Date/Time Prep 6/30/2020 2:10 DIETARY 10.00	
$\begin{array}{ccccc} 1.\ 00 & 00 \\ 2.\ 00 & 00 \\ 4.\ 00 & 00 \\ 5.\ 00 & 00 \\ 7.\ 00 & 00 \\ 8.\ 00 & 00 \\ 9.\ 00 & 00 \\ 10.\ 00 & 01 \\ 11.\ 00 & 01 \\ 13.\ 00 & 01 \\ 14.\ 00 & 01 \\ 15.\ 00 & 01 \end{array}$	ENERAL SERVICE COST CENTERS 0100 CAP REL COSTS-BLDG & FIXT 0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING	& GENERAL 5.00 6, 888, 501 331, 528	PLANT	LINEN SERVICE		DI ETARY	6 pm
$\begin{array}{ccccc} 1.\ 00 & 00 \\ 2.\ 00 & 00 \\ 4.\ 00 & 00 \\ 5.\ 00 & 00 \\ 7.\ 00 & 00 \\ 8.\ 00 & 00 \\ 9.\ 00 & 00 \\ 10.\ 00 & 01 \\ 11.\ 00 & 01 \\ 13.\ 00 & 01 \\ 14.\ 00 & 01 \\ 15.\ 00 & 01 \end{array}$	ENERAL SERVICE COST CENTERS 0100 CAP REL COSTS-BLDG & FIXT 0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING	& GENERAL 5.00 6, 888, 501 331, 528	PLANT	LINEN SERVICE			
$\begin{array}{ccccc} 1.\ 00 & 00 \\ 2.\ 00 & 00 \\ 4.\ 00 & 00 \\ 5.\ 00 & 00 \\ 7.\ 00 & 00 \\ 8.\ 00 & 00 \\ 9.\ 00 & 00 \\ 10.\ 00 & 01 \\ 11.\ 00 & 01 \\ 13.\ 00 & 01 \\ 14.\ 00 & 01 \\ 15.\ 00 & 01 \end{array}$	0100 CAP REL COSTS-BLDG & FIXT 0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING	6, 888, 501 331, 528	7.00	8.00	9.00	10.00	
$\begin{array}{ccccc} 1.\ 00 & 00 \\ 2.\ 00 & 00 \\ 4.\ 00 & 00 \\ 5.\ 00 & 00 \\ 7.\ 00 & 00 \\ 8.\ 00 & 00 \\ 9.\ 00 & 00 \\ 10.\ 00 & 01 \\ 11.\ 00 & 01 \\ 13.\ 00 & 01 \\ 14.\ 00 & 01 \\ 15.\ 00 & 01 \end{array}$	0100 CAP REL COSTS-BLDG & FIXT 0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING	331, 528					
$\begin{array}{cccc} 2.\ 00 & 00 \\ 4.\ 00 & 00 \\ 5.\ 00 & 00 \\ 7.\ 00 & 00 \\ 9.\ 00 & 00 \\ 9.\ 00 & 00 \\ 10.\ 00 & 01 \\ 13.\ 00 & 01 \\ 14.\ 00 & 01 \\ 15.\ 00 & 01 \end{array}$	0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING	331, 528			1		1.00
$\begin{array}{cccc} 5.\ 00 \\ 7.\ 00 \\ 8.\ 00 \\ 9.\ 00 \\ 10.\ 00 \\ 11.\ 00 \\ 13.\ 00 \\ 14.\ 00 \\ 15.\ 00 \\ 11 \end{array} \left( \begin{array}{c} 00 \\ 01 \\ 01 \\ 01 \\ 01 \\ 01 \\ 01 \\ 01 $	0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING	331, 528					2.00
7.00008.00009.000010.000111.000113.000114.000115.0001	0700 OPERATI ON OF PLANT 0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING	331, 528					4.00
8.00009.000010.000111.000113.000114.000115.0001	0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING						5.00
9.000010.000111.000113.000114.000115.0001	0900 HOUSEKEEPI NG	, ,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2, 281, 876 9, 706				7.00
10. 000111. 000113. 000114. 000115. 0001		25, 387 127, 189	24, 521	07, 319	311, 529		9.00
13.000114.000115.0001	1000 DI ETARY	37, 355	21, 780	-	3, 019	196, 616	
14.00 01 15.00 01	1100 CAFETERI A	44, 587	63, 485		8, 799	0	•
15.00 01	1300 NURSING ADMINISTRATION	201, 169	4, 386		608	0	
	1400 CENTRAL SERVICES & SUPPLY 1500 PHARMACY	80, 940 152, 984	62, 285 30, 338	0	8, 633 4, 205	0	14.00
16.00 01	1600 MEDICAL RECORDS & LIBRARY	77, 192	1, 083		4, 205	0	
	1700 SOCIAL SERVICE	56, 177	7, 422	0	1, 029	Ő	1
	1900 NONPHYSICIAN ANESTHETISTS	0	0	-	0	0	
	2100 I & R SERVI CES-SALARY & FRINGES APPRV	11, 836	0	-	0	0	
	2200 I & SERVICES-OTHER PRGM COSTS APPRV	15, 729	0	0	0	0	22.00
	3000 ADULTS & PEDIATRICS	1, 145, 923	839, 871	44, 238	116, 408	128, 134	30.00
	3100 I NTENSI VE CARE UNI T	184, 686	181, 283		25, 126	14, 584	
1	2060 NEONATAL INTENSIVE CARE UNIT	241, 136	161, 003		22, 315	25, 974	
	4000 SUBPROVIDER - IPF	63, 051	28, 951		4, 013	11, 459	1
	4300 NURSERY NCI LLARY SERVI CE COST CENTERS	66, 508	69, 670	2, 133	9, 656	16, 465	43.00
	5000 OPERATING ROOM	347, 136	127, 334	3, 339	17, 649	0	50.00
	5100 RECOVERY ROOM	96, 144	68, 352		9, 474	0	51.00
	5200 DELIVERY ROOM & LABOR ROOM	190, 329	192, 202	5, 884	26, 640	0	52.00
	5400 RADI OLOGY-DI AGNOSTI C	119, 922	43,003	4, 628	5, 960	0	54.00
	5500 RADI OLOGY-THERAPEUTI C 5700 CT SCAN	39, 664 44, 837	46, 875		6, 497 871	0	
	5700 CT SCAN 5800 MRI	32, 526	6, 286 22, 419		3, 107	0	
	5900 CARDI AC CATHETERI ZATI ON	4,949	0	0	0	Ő	
	6000 LABORATORY	237, 710	24, 016	0	3, 329	0	60.00
	6400 I NTRAVENOUS THERAPY	25, 804	32, 072	0	4, 445	0	
	6500 RESPI RATORY THERAPY 6600 PHYSI CAL THERAPY	109, 208	25, 980		3, 601 579	0	65.00 66.00
	6700 OCCUPATI ONAL THERAPY	180, 858 48, 953	4, 180 0	0	579	0	67.00
	6800 SPEECH PATHOLOGY	8, 377	0	0	o	0	
69.00 06	6900 ELECTROCARDI OLOGY	14, 941	0	0	0	0	69.00
	7000 ELECTROENCEPHALOGRAPHY	50, 334	15, 466		2, 144	0	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT 7200 IMPL. DEV. CHARGED TO PATIENTS	503, 461 356, 025	0	-	0	0	
	7300 DRUGS CHARGED TO PATIENTS	422, 743	0	0	0	0	
	7301 SPECIALTY PHARMACY	436, 650	0	0	0	Ő	
	7400 RENAL DIALYSIS	34, 011	489		68	0	
	3330 ENDOSCOPY	63, 282	33, 507	1, 977	4, 644	0	
	3950 OTHER ANCILLARY SERVICE COST CENTERS 3951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	
	3952 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	1
	3953 WOUND CARE	5, 735	0	0	0	0	1
	3954 I MAGI NG CENTER	96, 744	0	0	0	0	
	3955 BREAST DI AGNOSTI C CENTER	231, 697	0	0	0	0	76.07
	JTPATI ENT SERVICE COST CENTERS 9000 CLINIC		0			0	90.00
	4950 INFUSION CENTER	6, 277	0	0	0	0	
	4975 SPINE CENTER	6, 511	0	0	0	0	
91.00 09	9100 EMERGENCY	270, 019	115, 494	16, 091	16, 008	0	
	9200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	PECIAL PURPOSE COST CENTERS						112 00
	1300 INTEREST EXPENSE 1400 UTILIZATION REVIEW-SNF						113.00 114.00
114.0011	SUBTOTALS (SUM OF LINES 1 through 117)	6, 848, 224	2, 263, 459	87, 519	308, 977	196, 616	
NO	ONREI MBURSABLE COST CENTERS						
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 097	15, 874	0	2, 200		190.00
		0	0	0	0		191.00
	9200 PHYSICIANS' PRIVATE OFFICES 9300 NONPAID WORKERS	2, 351	0	0	0		192.00 193.00
	7950 HOME OFFICE	0	0	0	0		193.00
	7956 PAVI LLI ONS	946	0	0	Ő		194.06
	7958 OTHER NRCC	34, 883	2, 543	0	352		194. 08
						•	
	7960 COMMUNITY REHAB HOSPITAL Cross Foot Adjustments	0	0	0	0		194. 10 200. 00

Health Financial Systems	COMMUNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2019	Worksheet B	
					Date/Time Pre 6/30/2020 2:1	
Cost Center Description	ADMI NI STRATI VE	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5.00	7.00	8.00	9.00	10.00	
202.00 TOTAL (sum lines 118 through 201)	6, 888, 501	2, 281, 876	87, 51	9 311, 529	196, 616	202.00

	Financial Systems COMM TION OF CAPITAL RELATED COSTS	UNITY HUSPITAL	OF INDIANA, IN Provider CC	N: 15-0169 P F	eriod: rom 01/01/2019 o 12/31/2019	u of Form CMS-: Worksheet B Part II Date/Time Pre	
	Cost Center Description	CAFETERI A		CENTRAL	PHARMACY	MEDICAL RECORDS &	6 pm
			ADMI NI STRATI ON	SERVICES & SUPPLY		LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	GENERAL SERVICE COST CENTERS 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	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
11.00		525, 119					11.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	14, 180 0	258, 649 0	2, 578, 399			13.00
14.00	01500 PHARMACY	35, 451	0	2, 578, 377			15.00
	01600 MEDICAL RECORDS & LIBRARY	1, 773	0	1	0	86, 530	16.00
17.00	01700 SOCIAL SERVICE	9, 306	0	27	0	0	17.00
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19.00
21.00 22.00	02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	21.00 22.00
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	0		0			22.00
30.00	03000 ADULTS & PEDI ATRI CS	181, 247		121, 412	0	10, 445	30.00
31.00	03100 I NTENSI VE CARE UNI T	29, 690		21, 847	0	1, 520	31.00
35.00 40.00	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	36, 337 11, 965	25, 461 8, 384	23, 356 3, 953	0	4, 960 652	35.00 40.00
40.00	04300 NURSERY	9,749		6, 158		538	40.00
	ANCI LLARY SERVI CE COST CENTERS			-,	-		
50.00	05000 OPERATING ROOM	31, 906		145, 940		11, 233	
51.00	05100 RECOVERY ROOM	14, 180		18, 676	0	1,979	
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C	26, 588 17, 282	18, 630 0	16, 988 7, 751	0	1, 483 2, 345	
55.00	05500 RADI OLOGY-THERAPEUTI C	3, 545	0	9, 498	0	2,053	
57.00	05700 CT SCAN	6, 204	0	582	0	4, 275	57.00
58.00		2,659	0	86	0	1, 122	58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0	4 80, 328	0	251 7, 216	59.00 60.00
64.00	06400 I NTRAVENOUS THERAPY	3, 545	0	1, 355	0	151	64.00
65.00	06500 RESPI RATORY THERAPY	16, 839	0	12, 998	0	1, 578	
66.00	06600 PHYSI CAL THERAPY	6, 647	0	7, 502	0	1, 647	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	6, 647 1, 329	0	1, 935 331	0	492 124	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	443	0	21	0	678	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	6, 647	0	7, 138	0	767	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1, 115, 264	0	4, 320	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	Ŭ	788, 666	0		72.00
	07300 DRUGS CHARGED TO PATIENTS 07301 SPECIALTY PHARMACY	0	0	0 95, 255		6, 933 1, 121	
	07400 RENAL DIALYSIS	0	0	86		235	
76.00	03330 ENDOSCOPY	7, 533	0	12, 248		1, 422	
	03950 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	76.01
	03951 OTHER ANCI LLARY SERVICE COST CENTERS 03952 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
	03953 WOUND CARE	886	0	912	0	64	76.03
	03954 I MAGI NG CENTER	0	0	10, 043	0	3, 350	
76.07	03955 BREAST DIAGNOSTIC CENTER	0	0	272	0	1, 390	76.07
00.00	OUTPATIENT SERVICE COST CENTERS	~		~			90.00
	09000 CLINIC 04950 INFUSION CENTER	0 886	0	0 801	0	0 35	90.00
	04935 SPINE CENTER	000	0	251	0	35	
91.00	09100 EMERGENCY	41, 655	29, 187	50, 518	0	9, 553	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
112 00	SPECIAL PURPOSE COST CENTERS						112 00
	11300 INTEREST EXPENSE 11400 UTI LI ZATI ON REVI EW-SNF						113.00 114.00
118.00		525, 119	258, 649	2, 576, 387	1, 007, 659	86, 530	
	NONREIMBURSABLE COST CENTERS	I			1		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
	19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES		0	0 1, 601	0		191.00 192.00
	19300 NONPALD WORKERS	0	0	1, 001 0	0		192.00
194.00	07950 HOME OFFICE	0	0	0	0		194.00
194.06	07956 PAVI LLI ONS	0	0	258		0	194.06
	07958 OTHER NRCC	0	0	153	0		194.08
	07960 COMMUNITY REHAB HOSPITAL	0	0	0	0		194. 10 200. 00
200.00	Cross Foot Adjustments						200.00

Health Fin	ancial Systems COM	MUNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS			Provider CC		Period:	Worksheet B	
					From 01/01/2019 Fo 12/31/2019		
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON	SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
201.00	Negative Cost Centers	0	0	(	0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	525, 119	258, 649	2, 578, 399	9 1, 007, 659	86, 530	202.00

	ial Systems COMM F CAPITAL RELATED COSTS	IUNI TY HOSPI TAL		CN: 15-0169	Period: From 01/01/2019	u of Form CMS-: Worksheet B Part II	2002
					To 12/31/2019	Date/Time Pre 6/30/2020 2:1	epared
				I NTERNS &	RESI DENTS	0/30/2020 2.1	
(	Cost Center Description	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	SERVI CES-SALA Y & FRI NGES	RSERVICES-OTHER PRGMCOSTS	Subtotal	
		17.00	19.00	APPRV 21.00	APPRV 22.00	24.00	
GENERA	L SERVICE COST CENTERS	17.00	17.00	21.00	22.00	24.00	
	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP						1.0
	EMPLOYEE BENEFITS DEPARTMENT						4.0
	ADMINISTRATIVE & GENERAL						5. C
	OPERATION OF PLANT						7.0
	LAUNDRY & LINEN SERVICE HOUSEKEEPING						8.0
	DI ETARY						10.0
							11.0
	NURSI NG ADMI NI STRATI ON CENTRAL SERVI CES & SUPPLY						13.0
	PHARMACY						15.0
	MEDICAL RECORDS & LIBRARY						16.0
	SOCIAL SERVICE	115, 914					17.0
	NONPHYSICIAN ANESTHETISTS I&R SERVICES-SALARY & FRINGES APPRV	0	0	11, 83	6		19.0
	I &R SERVICES-SALART & TRINGES AFFRV	0		11,03	15, 729		22.0
	ENT ROUTINE SERVICE COST CENTERS	-		1			
1 1	ADULTS & PEDIATRICS	75, 540				8, 140, 148	
	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	8, 598 15, 313				1, 656, 112 1, 608, 969	
	SUBPROVIDER - IPF	6, 756				316, 012	
3.00 04300 1	NURSERY	9, 707				620, 889	
	ARY SERVICE COST CENTERS	T -		T			
	OPERATING ROOM RECOVERY ROOM	0				3, 568, 927 588, 831	
1 1	DELIVERY ROOM & LABOR ROOM	0				1, 647, 210	
	RADI OLOGY-DI AGNOSTI C	0				811, 268	
	RADI OLOGY-THERAPEUTI C	0				766, 433	
7.00 05700 ( 8.00 05800 1		0				333, 063 474, 455	
	CARDI AC CATHETERI ZATI ON	0				6, 718	
	LABORATORY	0				482, 126	
	INTRAVENOUS THERAPY	0				244, 082	
	RESPI RATORY THERAPY PHYSI CAL THERAPY	0				444, 157 706, 198	
	OCCUPATIONAL THERAPY	0				114, 786	
	SPEECH PATHOLOGY	0				19, 873	
	ELECTROCARDI OLOGY	0				19, 327	
		0				276, 794	
	MEDICAL SUPPLIES CHARGED TO PATIENT	0				1, 623, 045 1, 147, 254	
	DRUGS CHARGED TO PATIENTS	0				1, 437, 335	
	SPECIALTY PHARMACY	0				535, 100	
4.00 07400 I 6.00 03330 I	RENAL DIALYSIS	0				37, 527 656, 996	
	OTHER ANCILLARY SERVICE COST CENTERS	0				030, 770	
6. 02 03951	OTHER ANCILLARY SERVICE COST CENTERS	0				0	76.
	OTHER ANCILLARY SERVICE COST CENTERS	0				0	
6.04 03953 \ 6.06 03954	WOUND CARE I MAGI NG CENTER	0				8, 141 464, 157	
	BREAST DIAGNOSTIC CENTER	0				247, 325	
OUTPAT	IENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	-	•			
0.00 09000		0				0	
	INFUSION CENTER SPINE CENTER	0				40, 631 7, 487	
1.00 09100		0				1, 347, 421	
	OBSERVATION BEDS (NON-DISTINCT PART					., ,	92.
	L PURPOSE COST CENTERS			1			1
	INTEREST EXPENSE UTILIZATION REVIEW-SNF						113. 114.
	SUBTOTALS (SUM OF LINES 1 through 117)	115, 914	r		o o	30, 398, 797	
	MBURSABLE COST CENTERS			· I			
90.0019000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				105, 788	
91.0019100		0				0	191.
	PHYSICIANS' PRIVATE OFFICES NONPAID WORKERS	0				3, 952 0	192.
93.00193001 94.00079501		0					193.
94. 06 07956 1	PAVI LLI ONS	0				14, 007	194.
	OTHER NRCC	0		1		53, 024	194

Health Financial Systems	COMMUNI TY HOSPI TAL	OF INDIANA, I	NC.	In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eriod:	Worksheet B	
				rom 01/01/2019 o 12/31/2019		nared
				0 12/31/2017	6/30/2020 2:1	6 pm
			INTERNS &	RESI DENTS		
					Cultate	
Cost Center Description	SUCIAL SERVICE	ANESTHETI STS	Y & FRINGES	SERVICES-OTHER PRGM COSTS	Subtotal	
		ANESTHETISTS	APPRV	APPRV		
	17.00	19.00	21.00	22.00	24.00	
194. 10 07960 COMMUNI TY REHAB HOSPI TAL	0				0	194.10
200.00 Cross Foot Adjustments		0	11, 836	15, 729	27, 565	200.00
201.00 Negative Cost Centers	0	0	0	0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	115, 914	0	11, 836	15, 729	30, 603, 133	202.00

OCATION OF CAPITAL RELATED COSTS		Provider CC	Period: From 01/01/2019	u of Form CMS-255 Worksheet B Part II
			To 12/31/2019	Date/Time Prepar 6/30/2020 2:16 p
Cost Center Description	Intern &	Total		0/ 30/ 2020 2. 10 p
	Residents Cost			
	& Post Stepdown			
	Adjustments			
	25.00	26.00		
GENERAL SERVICE COST CENTERS	1			
00 00100 CAP REL COSTS-BLDG & FIXT 00 00200 CAP REL COSTS-MVBLE EQUIP				
0 00400 EMPLOYEE BENEFITS DEPARTMENT				
00 00500 ADMINI STRATI VE & GENERAL				
00 00700 OPERATION OF PLANT				-
00 00800 LAUNDRY & LINEN SERVICE				8
00 00900 HOUSEKEEPING				
00 01000 DI ETARY 00 01100 CAFETERIA				1(
00 01300 NURSING ADMINI STRATI ON				1:
00 01400 CENTRAL SERVICES & SUPPLY				14
00 01500 PHARMACY				1
00 01600 MEDICAL RECORDS & LIBRARY				10
00 01700 SOCIAL SERVICE				1
00 01900 NONPHYSICIAN ANESTHETISTS 00 02100 I &R SERVICES-SALARY & FRINGES APPRV				1º 2'
00 02200 I & SERVICES-SALART & PRINCES APPRV				2
INPATIENT ROUTINE SERVICE COST CENTERS				
00 03000 ADULTS & PEDIATRICS	0	8, 140, 148		30
00 03100 I NTENSI VE CARE UNI T	0	1, 656, 112		3
00 02060 NEONATAL INTENSIVE CARE UNIT	0	1, 608, 969		3!
00 04000 SUBPROVIDER - IPF	0	316, 012		40
00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	620, 889		43
00 05000 OPERATING ROOM	0	3, 568, 927		50
00 05100 RECOVERY ROOM	0	588, 831		5
00 05200 DELIVERY ROOM & LABOR ROOM	0	1,647,210		52
00 05400 RADI OLOGY-DI AGNOSTI C	0	811, 268		54
00 05500 RADI OLOGY-THERAPEUTI C	0	766, 433		5
00 05700 CT SCAN 00 05800 MRI	0	333, 063 474, 455		5
00 05900 CARDI AC CATHETERI ZATI ON	0	6, 718		59
00 06000 LABORATORY	0	482, 126		60
00 06400 I NTRAVENOUS THERAPY	0	244, 082		64
00 06500 RESPI RATORY THERAPY	0	444, 157		6
00 06600 PHYSI CAL THERAPY	0	706, 198		60
00 06700 OCCUPATI ONAL THERAPY 00 06800 SPEECH PATHOLOGY	0	114, 786 19, 873		6
00 06900 ELECTROCARDI OLOGY	0	19, 327		64
00 07000 ELECTROENCEPHALOGRAPHY	0	276, 794		70
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 623, 045		7
00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	1, 147, 254		72
00 07300 DRUGS CHARGED TO PATIENTS	0	1, 437, 335		73
01 07301 SPECIALTY PHARMACY 00 07400 RENAL DIALYSIS	0	535, 100 37, 527		7:
00 03330 ENDOSCOPY	0	656, 996		70
01 03950 OTHER ANCI LLARY SERVICE COST CENTERS	0	0000, 770		70
02 03951 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		70
03 03952 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		70
04 03953 WOUND CARE	0	8, 141		70
06 03954 I MAGI NG CENTER	0	464, 157		70
07 03955 BREAST DI AGNOSTI C CENTER OUTPATI ENT SERVI CE COST CENTERS	0	247, 325		70
00 09000 CLINIC	0	0		90
01 04950 INFUSION CENTER	0	40, 631		90
26 04975 SPINE CENTER	0	7, 487		90
00 09100 EMERGENCY	0	1, 347, 421		9'
00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			92
SPECIAL PURPOSE COST CENTERS 3. 00 11300 I NTEREST EXPENSE		1		11:
I. 00 11400 UTI LI ZATI ON REVI EW-SNF				114
3.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	30, 398, 797		118
NONREI MBURSABLE COST CENTERS				
0. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	105, 788		190
. 00 19100 RESEARCH	0	0		19
2. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	3, 952		192
3. 00 19300 NONPALD WORKERS	0	0		19: 194
I. 00 07950 HOME OFFICE I. 06 07956 PAVI LLI ONS	0	0 14, 007		194
		17,00/		117

Health Financial Systems	COMMUNITY HOSPITAL (	OF INDIANA, IN	IC.	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0169	Peri od:	Worksheet B	
				From 01/01/2019		
				To 12/31/2019	Date/Time Pre 6/30/2020 2:1	epared: 6 pm
Cost Center Description	Intern &	Total				
	Residents Cost					
	& Post					
	Stepdown					
	Adjustments					
	25.00	26.00				
194. 10 07960 COMMUNI TY REHAB HOSPI TAL	0	0				194.10
200.00 Cross Foot Adjustments	0	27, 565				200.00
201.00 Negative Cost Centers	0	0				201.00
202.00 TOTAL (sum lines 118 through 201)	0	30, 603, 133				202.00

Heal th	Fi nanci al	S	ystems	
COST A	LLOCATION	_	STATI STI CAL	RA

## COMMUNITY HOSPITAL OF INDIANA, INC. In Lieu of Form CMS-2552-10

	LLOCATION - STATISTICAL BASIS	UNITE HUST TAL	Provider CC	CN: 15-0169 F	Peri od:	Worksheet B-1	
					rom 01/01/2019 o 12/31/2019		pared:
		CAPITAL REI	ATED COSTS			6/30/2020 2:1	6 pm
		-					
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFI TS	Reconciliation	ADMI NI STRATI VE & GENERAL	
		(SQUARE FEET)	(DULLAR VALUE)	DEPARTMENT		(ACCUM. COST)	
				(GROSS		<b>x</b>	
		1.00	2.00	SALARIES) 4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	AC	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	669, 724					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		16, 138, 846				2.00
4.00		285				201 207 107	4.00
5.00 7.00	00500 ADMI NI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT	19, 718 85, 229				281, 287, 197 13, 537, 842	
8.00	00800 LAUNDRY & LINEN SERVICE	2,401					
9.00	00900 HOUSEKEEPI NG	6,066				5, 193, 702	
10.00	01000 DI ETARY	5, 388				1, 525, 364	
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	15, 705 1, 085				1, 820, 715 8, 214, 683	
	01400 CENTRAL SERVICES & SUPPLY	15, 408				3, 305, 138	
	01500 PHARMACY	7, 505			-	6, 247, 063	
	01600 MEDICAL RECORDS & LIBRARY	268	80			3, 152, 117	16.00
	01700 SOCIAL SERVICE	1,836				2, 293, 978	
	01900 NONPHYSI CI AN ANESTHETI STS 02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0	-			0 483, 306	
	02200 I &R SERVICES-SALART & PRINCES APPRV	0	-				
221 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>			, <u>_</u>	012/20/	
	03000 ADULTS & PEDI ATRI CS	207, 768				46, 791, 026	1
	03100 I NTENSI VE CARE UNI T	44, 846				7, 541, 589	
35.00 40.00	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	39, 829 7, 162				9, 846, 687 2, 574, 660	1
	04300 NURSERY	17, 235					
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	31, 500					
	05100 RECOVERY ROOM	16, 909				3, 925, 992	
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	47, 547 10, 638				7, 772, 015 4, 896, 982	
55.00	05500 RADI OLOGY-THERAPEUTI C	11, 596				1, 619, 653	
57.00	05700 CT SCAN	1, 555				1, 830, 903	
58.00	05800 MRI	5, 546				1, 328, 200	
	05900 CARDI AC CATHETERI ZATI ON	0				202, 104	1
60.00 64.00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	5, 941 7, 934				9, 706, 796 1, 053, 688	
65.00	06500 RESPI RATORY THERAPY	6, 427				4, 459, 478	
66. 00	06600 PHYSI CAL THERAPY	1,034				7, 385, 278	
67.00	06700 OCCUPATIONAL THERAPY	0	55, 810			1, 998, 961	
68.00		0				342,066	
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0 3, 826	3, 237 110, 731			610, 094 2, 055, 385	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0,020		-		20, 558, 640	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	14, 538, 159	
	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0 0	17, 262, 570	
	07301 SPECIALTY PHARMACY	0	0	1, 876, 658	0	17, 830, 463	
74.00	07400 RENAL DI ALYSI S 03330 ENDOSCOPY	121 8, 289	0 353, 326	1, 214, 866	0	1, 388, 819 2, 584, 114	
	03950 OTHER ANCILLARY SERVICE COST CENTERS	0, 209	0	1, 214, 000	) ) ) )	2, 364, 114	
	03951 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	c	0	0	
	03952 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	C	0 0	0	
	03953 WOUND CARE	0	344			234, 203	
	03954 I MAGI NG CENTER 03955 BREAST DI AGNOSTI C CENTER	0				3, 950, 488 9, 461, 260	
10.01	OUTPATIENT SERVICE COST CENTERS	0	14, 086		, U	7, 401, 200	_ /0.0/
90.00	09000 CLINIC	0	0	C	0 0	0	90.00
	04950 INFUSION CENTER	0				256, 310	
	04975 SPINE CENTER	0	482			265, 880	
	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	28, 571	170, 538	6, 242, 018	s 0	11, 026, 141	91.00 92.00
7∠. UU	SPECIAL PURPOSE COST CENTERS		<u> </u>	l	<u> </u>		_ 72.00
113.00	11300 I NTEREST EXPENSE						113.00
	11400 UTI LI ZATI ON REVI EW-SNF						114.00
		665, 168	16, 125, 572	106, 239, 824	-69, 968, 006	279, 642, 505	118.00
118.00							
118.00	NONREI MBURSABLE COST CENTERS	2 027			<u> </u>	OF /17	100 00
118. 00 190. 00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 927	0				190.00
118.00 190.00 191.00	NONREI MBURSABLE COST CENTERS	3, 927 0 0				0	190. 00 191. 00 192. 00
118.00 190.00 191.00 192.00 193.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	0	0 0 0	C		0 95, 996 0	191.00

h Financial Systems COM	MUNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
ALLOCATION - STATISTICAL BASIS		Provider CO		Period:	Worksheet B-1	
				From 01/01/2019 To 12/31/2019	Date/Time Pre 6/30/2020 2:1	
	CAPI TAL RE	LATED COSTS				
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	(SQUARE FEET)	(DOLLAR VALUE)			& GENERAL	
			DEPARTMENT		(ACCUM. COST)	
			(GROSS			
	1.00	0.00	SALARI ES)	<b>F A</b>	F 00	
	1.00	2.00	4.00	5A	5.00	101.01
06 07956 PAVI LLI ONS	0	12, 913		0 0	38, 629	
0807958 OTHER NRCC	629	361	924, 12	7 0	1, 424, 450	
10 07960 COMMUNITY REHAB HOSPITAL	0	0	(	0 0	0	194. 10
00 Cross Foot Adjustments						200.00
00 Negative Cost Centers						201.00
Cost to be allocated (per Wkst. B, Part I)	14, 601, 445	16, 001, 688	5, 043, 60	7	69, 968, 006	202.00
00 Unit cost multiplier (Wkst. B, Part I	) 21. 802183	0. 991501	0.04706	4	0. 248742	203.00
Cost to be allocated (per Wkst. B, Part II)			118, 38	9	6, 888, 501	204.00
00 Unit cost multiplier (Wkst. B, Part			0.00110	5	0. 024489	205.00
NAHE adjustment amount to be allocated (per Wkst. B-2)	t					206. 00
00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

	Financial Systems COMM NLLOCATION - STATISTICAL BASIS	UNI TY HOSPI TAL	OF INDIANA, IN Provider C	CN: 15-0169 Pe	<u>In Lie</u> eriod: rom 01/01/2019	u of Form CMS-2 Worksheet B-1	
				Te		Date/Time Pre 6/30/2020 2:1	
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DI ETARY (TOTAL PATI ENT DAYS)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS	1	1				
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 19.\ 00\\ 21.\ 00\\ 22.\ 00\\ \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02100 I&R SERVICES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVICE COST CENTERS	564, 492 2, 401 6, 066 5, 388 15, 705 15, 408 7, 505 268 1, 836 0 0 0	270, 303 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	556, 025 5, 388 15, 705 1, 085 15, 408 7, 505 268 1, 836 0 0 0 0 0	88, 226 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 185 32 0 80 4 21 0 0 0	13.00 14.00 15.00 16.00 17.00 19.00 21.00 22.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	207, 768 44, 846			57, 497 6, 544	409 67	30.00 31.00
31.00	02060 NEONATAL INTENSIVE CARE UNIT	39, 829			11, 655	82	1
40.00	04000 SUBPROVIDER - IPF	7, 162			5, 142	27	40.00
43.00	04300 NURSERY	17, 235	6, 587	17, 235	7, 388	22	43.00
$\begin{array}{c} 50. \ 00\\ 51. \ 00\\ 52. \ 00\\ 54. \ 00\\ 55. \ 00\\ 57. \ 00\\ 59. \ 00\\ 60. \ 00\\ 64. \ 00\\ 65. \ 00\\ 66. \ 00\\ 67. \ 00\\ 68. \ 00\\ 69. \ 00\\ 70. \ 00\\ 71. \ 00\\ 71. \ 00\\ 72. \ 00\\ 73. \ 01\\ 74. \ 00\\ 73. \ 01\\ 74. \ 00\\ 76. \ 01\\ 76. \ 02\\ 76. \ 03\\ 76. \ 04\\ 76. \ 06\\ 76. \ 07\\ \end{array}$	ANCI LLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 05500 CADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 I MPL. DEV. CHARGED TO PATI ENTS 07301 SPECI ALTY PHARMACY 07400 RENAL DI ALYSI S 03330 ENDOSCOPY 03950 OTHER ANCI LLARY SERVICE COST CENTERS 03951 OTHER ANCI LLARY SERVICE COST CENTERS 03952 OTHER ANCI LLARY SERVICE COST CENTERS 03953 WOUND CARE 03955 BREAST DI AGNOSTI C CENTER 0400 DUTPATI ENT SERVICE COST CENTERS	31, 500 16, 909 47, 547 10, 638 11, 596 1, 555 5, 546 0 5, 941 7, 934 6, 427 1, 034 0 0 0 3, 826 0 0 0 0 0 121 8, 289 0 0 0 0 0 0 0 0 0 0 0 0 0	10, 313 0 18, 172 14, 295 2, 154 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31, 500 16, 909 47, 547 10, 638 11, 555 5, 546 0 5, 941 7, 934 6, 427 1, 034 0 0 0 3, 826 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		72 32 60 39 8 14 6 0 0 8 38 15 15 3 1 15 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50. 00 51. 00 52. 00 54. 00 55. 00 57. 00 58. 00 59. 00 60. 00 64. 00 65. 00 66. 00 67. 00 68. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 01 74. 00 73. 01 74. 00 76. 01 76. 02 76. 03 76. 04 76. 04 76. 06 76. 07
90. 01 90. 26 91. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0 0 0 28, 571	0 0 0 49, 697	0 0 0 28, 571	0 0 0	0 2 0 94	90.00 90.01 90.26 91.00 92.00
		559, 936	270, 303	551, 469	88, 226	1, 185	113. 00 114. 00 118. 00
191.00 192.00 193.00 194.00 194.06 194.08	NONREI MBURSABLE COST CENTERS         19000       GIFT, FLOWER, COFFEE SHOP & CANTEEN         19100       RESEARCH         19200       PHYSI CLANS' PRI VATE OFFICES         19300       NONPALD WORKERS         07950       HOME OFFICE         07956       PAVILLIONS         07958       OTHER NRCC         07960       COMMUNITY REHAB HOSPITAL	3, 927 0 0 0 0 0 0 0 629 0		3, 927 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	190. 00 191. 00 192. 00 193. 00 194. 00 194. 06 194. 08 194. 10

		UNITY HOSPITAL	OF INDIANA, IN			u of Form CMS-:	
COST ALL	OCATION - STATISTICAL BASIS		Provider CO		Peri od:	Worksheet B-1	
					From 01/01/2019 To 12/31/2019		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE FEET)	(TOTAL PATI	(MEALS SERVED)	
		(SQUARE FEET)	(POUNDS OF		ENT DAYS)		
			LAUNDRY)				
		7.00	8.00	9.00	10.00	11.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	16, 905, 272	1, 366, 456	6, 667, 257	2, 130, 752	2, 932, 251	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	29. 947762	5. 055275	11. 990930	24. 151067	2, 474. 473418	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	2, 281, 876	87, 519	311, 529	9 196, 616	525, 119	204. 00
205.00	Unit cost multiplier (Wkst. B, Part	4. 042353	0. 323781	0. 560279	2. 228549	443. 138397	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

CUSI P	ALLOCATION - STATISTICAL BASIS		OF INDIANA, IN Provider CO		Peri od:	u of Form CMS-2 Worksheet B-1	
					From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	6/30/2020 2:1 SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED REQUI S. )	RECORDS & LI BRARY	(TOTAL PATI	
		(DIRECT NRSING	(COSTED	KLQUIS.)	(GROSS CHAR	ENT DAYS)	
		HRS)	REQUIS.)	15.00	GES)	17.00	
	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	17.00	
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 4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
3.00 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	01300 NURSING ADMINISTRATION	833	47 500 004				13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	47, 529, 884 261, 467	16, 930, 10	าย		14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	201, 407	10, 930, 10	0 1, 551, 524, 218		16.00
17.00	01700 SOCIAL SERVICE	0	504		0 0	88, 226	17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0		0 0	0	19.00
21.00 22.00	02100 I & SERVI CES-SALARY & FRI NGES APPRV 02200 I & SERVI CES-OTHER PRGM COSTS APPRV	0	0		0 0 0 0	0	21.00 22.00
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0		0 0	0	22.00
30. 00	03000 ADULTS & PEDI ATRI CS	409	2, 238, 086		0 186, 521, 030	57, 497	30. 00
31.00	03100 I NTENSI VE CARE UNI T	67	402, 726		0 27, 140, 503	6, 544	
35.00 40.00	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	82 27	430, 549 72, 867		0 88, 576, 583 0 11, 651, 668	11, 655 5, 142	
40.00	04300 NURSERY	22	113, 511		0 9, 600, 682	7, 388	
	ANCI LLARY SERVICE COST CENTERS		,			.,	
50.00	05000 OPERATING ROOM	72	2, 690, 235		0 206, 913, 833	0	50.00
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0 60	344, 272 313, 151		0 35, 335, 484 0 26, 486, 133	0	51.00 52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	142, 874		0 41, 882, 101	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	175, 086		0 36, 660, 309	0	55. OC
57.00	05700 CT SCAN	0	10, 727		0 76, 344, 460	0	57.00
58.00 59.00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0	1, 593 72		0 20, 041, 330 0 4, 477, 421	0	58.00 59.00
60.00	06000 LABORATORY	0	1, 480, 748		0 128, 855, 828	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	24, 981		0 2, 693, 925	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	239, 603		0 28, 171, 592	0	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	138, 294 35, 672		0 29, 409, 991 0 8, 781, 809	0	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	0	6, 104		0 2, 215, 016	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	379		0 12, 112, 876	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	131, 583		0 13, 688, 767	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	20, 558, 641 14, 538, 159		0 77, 145, 878 0 45, 765, 998	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0			0	
	07301 SPECIALTY PHARMACY	0	1, 755, 926		0 20, 010, 685	0	73.01
	07400 RENAL DI ALYSI S 03330 ENDOSCOPY	0	1, 584		0 4, 194, 423	0	74.00 76.00
	03950 OTHER ANCI LLARY SERVICE COST CENTERS	0	225, 781 0		0 25, 400, 941	0	76.00
	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0	76.02
	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0	76.03
	03953 WOUND CARE 03954 I MAGI NG CENTER	0	16, 812 185, 136		0 1, 146, 994 0 59, 828, 850	0	76.04 76.06
	03955 BREAST DI AGNOSTI C CENTER	0	5, 022		0 24, 820, 012	0	76.00
	OUTPATIENT SERVICE COST CENTERS	· · · · · ·	-,				
	09000 CLINIC	0	0		0 0	0	90.00
	04950 I NFUSI ON CENTER 04975 SPI NE CENTER	0	14, 769 4, 618		0 619, 794 0 633, 756	0	90.01 90.26
	09100 EMERGENCY	94	931, 245		0 170, 590, 727	0	90.20
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
140 0-	SPECIAL PURPOSE COST CENTERS						110 0-
	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF						113.00 114.00
114.00 118.00		833	47, 492, 791	16, 930, 10	08 1, 551, 524, 218	88, 226	
	NONREIMBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 00
	19100 RESEARCH	0	0		0 0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	0	29, 521 0				192.00 193.00
	07950 HOME OFFICE	0	0		0 0		193. 00 194. 00
	07956 PAVI LLI ONS	0	4, 759		0 0		194.06
	07958 OTHER NRCC		2, 813				194. 08

Health Finar	cial Systems COMM	IUNI TY HOSPI TAL	OF INDIANA, IN	VC.	In Lie	u of Form CMS-:	2552-10
COST ALLOCA	FION - STATISTICAL BASIS		Provider C		Period: From 01/01/2019	Worksheet B-1	
					To 12/31/2019	Date/Time Pre 6/30/2020 2:1	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUIS.)	LI BRARY	(TOTAL PATI	
		(DI RECT NRSI NG	•		(GROSS CHAR	ENT DAYS)	
		HRS)	REQUIS.)		GES)		
		13.00	14.00	15.00	16.00	17.00	
	COMMUNITY REHAB HOSPITAL	0	0		0 0	0	194.10
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	10, 382, 706	4, 773, 456	8, 339, 93	3, 957, 320	2, 993, 601	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	12, 464. 232893	0. 100431	0. 4926	0 0.002551	33. 931052	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	258, 649	2, 578, 399	1, 007, 65	86, 530	115, 914	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	310. 503001	0. 054248	0. 05951	9 0.000056	1. 313830	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

	Financial Systems COMM LLOCATION - STATISTICAL BASIS	IUNI TY HOSPI TAL	OF INDIANA, IN Provider C	CN: 15-0169 P	In Lieu eriod: rom 01/01/2019	u of Form CMS-25 Worksheet B-1	552-10
					o 12/31/2019	Date/Time Prepa	
			INTERNS &	RESI DENTS		6/30/2020 2:16	pm
					_		
	Cost Center Description	NONPHYSI CI AN	SERVI CES-SALAR				
		ANESTHETI STS (ASSI GNED	Y & FRI NGES APPRV	PRGM COSTS APPRV			
		TI ME)	(ASSI GNED	(ASSI GNED			
			TIME)	TIME)	-		
	GENERAL SERVICE COST CENTERS	19.00	21.00	22.00			
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	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00
8.00 9.00	00900 HOUSEKEEPING						8.00 9.00
	01000 DI ETARY						10.00
	01100 CAFETERI A						11.00
	01300 NURSING ADMINISTRATION						13.00
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY						14.00 15.00
	01600 MEDICAL RECORDS & LIBRARY						16.00
	01700 SOCIAL SERVICE						17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0					19.00
	02100 I &R SERVICES-SALARY & FRINGES APPRV		61, 466				21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV			61, 466			22.00
30, 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	37, 468	37, 468			30.00
	03100 I NTENSI VE CARE UNI T						31.00
	02060 NEONATAL INTENSIVE CARE UNIT	0	0	C			35.00
	04000 SUBPROVI DER – I PF	0					40.00
43.00	04300 NURSERY		0 0	C			43.00
50.00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	0				50.00
	05100 RECOVERY ROOM						51.00
	05200 DELIVERY ROOM & LABOR ROOM	C					52.00
	05400 RADI OLOGY-DI AGNOSTI C	C	0				54.00
	05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
	05700 CT SCAN 05800 MRI						57.00 58.00
	05900 CARDI AC CATHETERI ZATI ON		0				59.00
	06000 LABORATORY	0	0	C			60.00
	06400 I NTRAVENOUS THERAPY	0	0				64.00
	06500 RESPIRATORY THERAPY						65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY		1, 247				66.00 67.00
	06800 SPEECH PATHOLOGY						68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	C			69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0				71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS						72.00 73.00
	07301 SPECIALTY PHARMACY		0				73.01
74.00	07400 RENAL DI ALYSI S	0	0	C			74.00
	03330 ENDOSCOPY	0	0	C			76.00
	03950 OTHER ANCI LLARY SERVICE COST CENTERS 03951 OTHER ANCI LLARY SERVICE COST CENTERS		0				76. 01 76. 02
	03952 OTHER ANCI LLARY SERVICE COST CENTERS						76.02
	03953 WOUND CARE		0				76.04
76.06	03954 I MAGI NG CENTER	0	0	C			76.06
76.07	03955 BREAST DI AGNOSTI C CENTER	(	00	) C			76.07
00.00	OUTPATIENT SERVICE COST CENTERS						00.00
	09000 CLINIC 04950 INFUSION CENTER						90. 00 90. 01
	04975 SPI NE CENTER						90.26
	09100 EMERGENCY	0	5, 244	5, 244			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
110 00	SPECIAL PURPOSE COST CENTERS	1	1	1	1		12 00
	11300 INTEREST EXPENSE 11400 UTI LI ZATI ON REVI EW-SNF						13.00 14.00
114.00		0	61, 466	61, 466			114.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-	-			90.00
	19100 RESEARCH	0	0				91.00
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS						192.00 193.00
	07950 HOME OFFICE		0				194.00
						'	

Health Financial Systems COMM	IUNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO		Peri od:	Worksheet B-1
		_		From 01/01/2019 To 12/31/2019	Date/Time Prepared: 6/30/2020 2:16 pm
		INTERNS &	RESI DENTS		
Cost Center Description		SERVI CES-SALAR		R	
	ANESTHETI STS	Y & FRINGES	PRGM COSTS		
	(ASSI GNED	APPRV	APPRV		
	TIME)	(ASSI GNED	(ASSI GNED		
		TIME)	TIME)		
	19.00	21.00	22.00		
194. 06 07956 PAVI LLI ONS	C	0		0	194.06
194.08079580THER NRCC	C	0		0	194.08
194. 10 07960 COMMUNI TY REHAB HOSPI TAL	C	0 0		0	194. 10
200.00 Cross Foot Adjustments					200.00
201.00 Negative Cost Centers					201.00
202.00 Cost to be allocated (per Wkst. B,	C	603, 525	802, 02	8	202.00
Part I)					
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	9. 818843	13.04831	9	203.00
204.00 Cost to be allocated (per Wkst. B,	C	11, 836	15, 72	9	204.00
Part II)					
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 192562	0. 25589	8	205.00
11)					
206.00 NAHE adjustment amount to be allocated					206.00
(per Wkst. B-2)					
207.00 NAHE unit cost multiplier (Wkst. D,					207.00
Parts III and IV)					

	ATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 6/30/2020 2:1	
			Title	XVIII	Hospi tal	PPS	
	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	
	INPATIENT ROUTINE SERVICE COST CENTERS		1		-		
	03000 ADULTS & PEDIATRICS	77, 984, 250		77, 984, 25			
	03100 INTENSIVE CARE UNIT	12, 854, 842		12, 854, 84			
	02060 NEONATAL INTENSIVE CARE UNIT	16, 188, 890		16, 188, 89			
	04000 SUBPROVI DER – I PF	4, 270, 394		4, 270, 39			
43.00	04300 NURSERY	4, 941, 149		4, 941, 14	9 0	4, 941, 149	43.00
	ANCI LLARY SERVICE COST CENTERS			00.047.04			
50.00	05000 OPERATI NG ROOM	20, 947, 363		20, 947, 36			
	05100 RECOVERY ROOM	5, 815, 593		5, 815, 59			
	05200 DELIVERY ROOM & LABOR ROOM	12, 786, 503		12, 786, 50			
	05400 RADI OLOGY-DI AGNOSTI C	6, 851, 170		6, 851, 17			
55.00	05500 RADI OLOGY-THERAPEUTI C	2, 650, 639		2, 650, 63			
	05700 CT SCAN 05800 MRI	2, 582, 015		2, 582, 01			
58.00 59.00		1, 957, 303		1, 957, 30			
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	263, 805 12, 847, 866		263, 80 12, 847, 86			
64.00	06400 I NTRAVENOUS THERAPY						
	06500 RESPIRATORY THERAPY	1, 677, 703		1, 677, 70			
66.00	06600 PHYSI CAL THERAPY	6, 028, 237 9, 391, 703					
	06700 OCCUPATI ONAL THERAPY	2, 559, 289					
	06800 SPEECH PATHOLOGY	440, 839		440, 83		_,,	
	06900 ELECTROCARDI OLOGY	795, 262		795, 26			
	07000 ELECTROENCEPHALOGRAPHY	2, 812, 355		2, 812, 35			
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	27, 933, 945		27, 933, 94			
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	19, 731, 241		19, 731, 24			
73.00	07300 DRUGS CHARGED TO PATIENTS	30, 212, 259		30, 212, 25			
	07301 SPECIALTY PHARMACY	22, 493, 044		22, 493, 04			
	07400 RENAL DI ALYSI S	1, 750, 211		1, 750, 21			
	03330 ENDOSCOPY	3, 734, 929		3, 734, 92			
	03950 OTHER ANCILLARY SERVICE COST CENTERS	0,701,727			0 0		
	03951 OTHER ANCI LLARY SERVICE COST CENTERS	0			0 0		
	03952 OTHER ANCI LLARY SERVICE COST CENTERS	0			0 0		1
	03953 WOUND CARE	302,022		302, 02	· · ·	-	
	03954 I MAGI NG CENTER	5, 104, 356		5, 104, 35			
	03955 BREAST DI AGNOSTI C CENTER	11, 878, 493		11, 878, 49			•
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	0			0 0	0	90.00
90.01	04950 INFUSION CENTER	328, 078		328, 07	8 0	328, 078	90.01
90.26	04975 SPI NE CENTER	334, 097		334, 09	7 0	334, 097	90.26
	09100 EMERGENCY	17, 151, 210		17, 151, 21	0 0	17, 151, 210	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	9, 158, 477		9, 158, 47	7	9, 158, 477	92.00
	SPECIAL PURPOSE COST CENTERS		1			1	
	11300 INTEREST EXPENSE						113.00
	11400 UTILIZATION REVIEW-SNF						114.00
200.00		356, 759, 532					
201.00		9, 158, 477		9, 158, 47		9, 158, 477	
202.00	Total (see instructions)	347, 601, 055	0	347, 601, 05	5 0	347, 601, 055	202.00

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 6/30/2020 2:1	epared 16 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Charges Outpati ent	+ 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	470 707 457		470 707 4			
0. 00 03000 ADULTS & PEDIATRICS	173, 787, 457		173, 787, 4			30.0
1.00 03100 INTENSIVE CARE UNIT	27, 140, 503		27, 140, 5			31.0
5. 00 02060 NEONATAL INTENSIVE CARE UNIT	88, 576, 583		88, 576, 5			35.0
0.00 04000 SUBPROVIDER - IPF	11, 651, 668		11, 651, 6			40.0
3. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	9, 600, 682		9, 600, 6	52		43.0
0. 00 05000 OPERATING ROOM	135, 468, 134	71, 445, 699	206, 913, 8	0, 101237	0, 000000	50. C
1. 00 05100 RECOVERY ROOM	19, 850, 715	15, 484, 769			0.000000	
2. 00 05200 DELIVERY ROOM & LABOR ROOM	26, 486, 133	13, 404, 707			0.000000	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	12, 285, 747	29, 596, 354			0.000000	
5. 00 05500 RADI OLOGY THERAPEUTI C	14, 070, 579	22, 589, 730			0.000000	
7. 00 05700 CT SCAN	26, 050, 357	50, 294, 103			0.000000	
8. 00 05800 MRI	5, 285, 954	14, 755, 376			0.000000	
9. 00 05900 CARDI AC CATHETERI ZATI ON	4, 477, 421	11, 700, 070			0.000000	
0. 00 06000 LABORATORY	80, 770, 477	48, 085, 351			0.000000	
4. 00 06400 I NTRAVENOUS THERAPY	1, 204, 800	1, 489, 125			0.000000	
5. 00 06500 RESPI RATORY THERAPY	25, 521, 296	2, 650, 296			0.000000	
6. 00 06600 PHYSI CAL THERAPY	6, 097, 090	23, 312, 901			0.000000	
7. 00 06700 OCCUPATI ONAL THERAPY	5, 422, 496	3, 359, 313			0.000000	
8. 00 06800 SPEECH PATHOLOGY	1, 516, 214	698, 802			0.000000	
9. 00 06900 ELECTROCARDI OLOGY	10, 265, 627	1, 847, 249			0.000000	
0. 00 07000 ELECTROENCEPHALOGRAPHY	1, 330, 528	12, 358, 239			0.000000	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	52, 136, 816	25,009,062			0.000000	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	35, 440, 942	10, 325, 056			0.000000	
3. 00 07300 DRUGS CHARGED TO PATIENTS	77, 808, 216	45, 996, 603			0.000000	
3. 01 07301 SPECIALTY PHARMACY	0	20, 010, 685			0.00000	
4. 00 07400 RENAL DIALYSIS	4, 194, 423	0	4, 194, 4		0. 000000	
6. 00 03330 ENDOSCOPY	6, 241, 098	19, 159, 843			0.00000	
6.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0.000000	0.00000	
6.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0.000000	0.00000	
6.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0.000000	0. 000000	
6.04 03953 WOUND CARE	992, 834	154, 160	1, 146, 9		0.00000	
6.06 03954 I MAGI NG CENTER	523, 953	59, 304, 897	59, 828, 8	0. 085316	0. 000000	76.
6. 07 03955 BREAST DIAGNOSTIC CENTER	18, 564	24, 801, 448	24, 820, 0	0. 478585	0. 000000	76. (
OUTPATIENT SERVICE COST CENTERS			•			
0. 00 09000 CLINIC	0	0	1	0 0.000000	0.00000	90. 0
0.01 04950 INFUSION CENTER	0	619, 794	619, 7	0. 529334	0.00000	90. (
0. 26 04975 SPINE CENTER	0	633, 756	633, 7	56 0. 527170	0.00000	90. 2
1.00 09100 EMERGENCY	39, 236, 042	131, 354, 685	170, 590, 7	0. 100540	0.00000	91. (
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 133, 956	9, 599, 617	12, 733, 5	73 0. 719239	0.00000	92. (
SPECIAL PURPOSE COST CENTERS						
13.00 11300 INTEREST EXPENSE						113.
14.00 11400 UTILIZATION REVIEW-SNF						114.
00.00 Subtotal (see instructions)	906, 587, 305	644, 936, 913	1, 551, 524, 2	18		200.
01.00 Less Observation Beds						201.0
02.00 Total (see instructions)	906, 587, 305	644 936 913	1, 551, 524, 2	18		202.

Health Financial Systems	COMMUNITY HUSPITAL OF	F TINDIANA, TINC.		J OF FORM CMS-2552
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0169	Peri od:	Worksheet C
			From 01/01/2019 To 12/31/2019	Part I Date/Time Prepare
			10 12/31/2017	6/30/2020 2:16 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.
31.00 03100 INTENSIVE CARE UNIT				31.
35.00 02060 NEONATAL INTENSIVE CARE UNIT				35.
40. 00 04000 SUBPROVIDER - IPF				40.
43. 00 04300 NURSERY				43.
ANCI LLARY SERVI CE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 101237			50.
51.00 05100 RECOVERY ROOM	0. 164582			51.
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 482762			52.
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 163582			54.
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 072303			55.
57.00 05700 CT SCAN	0. 033821			57.
58. 00 05800 MRI	0. 097663			58.
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 058919			59.
60. 00 06000 LABORATORY	0. 099707			60.
64.00 06400 I NTRAVENOUS THERAPY	0. 622773			64.
65. 00 06500 RESPI RATORY THERAPY	0. 213983			65.
66. 00 06600 PHYSI CAL THERAPY	0. 319337			66.
67. 00 06700 OCCUPATI ONAL THERAPY	0. 291431			67.
68. 00 06800 SPEECH PATHOLOGY	0. 199023			68.
69. 00 06900 ELECTROCARDI OLOGY	0. 065654			69.
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 205450			70.
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT				71.
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 431133			72.
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 244031			73.
73. 01 07301 SPECIALTY PHARMACY	1. 124052			73.
74. 00 07400 RENAL DI ALYSI S	0. 417271			74.
76. 00 03330 ENDOSCOPY	0. 147039			74.
76.01 03950 OTHER ANCILLARY SERVICE COST CENTER				76.
76. 02 03951 OTHER ANCI LLARY SERVICE COST CENTER				76.
76.03 03952 OTHER ANCILLARY SERVICE COST CENTER				76.
76. 04 03953 WOUND CARE	0. 263316			76.
76.06 03954 I MAGI NG CENTER	0. 085316			76.
76. 07 03955 BREAST DI AGNOSTI C CENTER	0. 478585			
OUTPATIENT SERVICE COST CENTERS	0,000000			
90. 00 09000 CLINIC	0. 000000			90.
90. 01 04950 I NFUSI ON CENTER	0. 529334			90.
90. 26 04975 SPINE CENTER	0. 527170			90.
91.00 09100 EMERGENCY	0. 100540			91.
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0. 719239			92.
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113.
114.00 11400 UTI LI ZATI ON REVI EW-SNF				114.
200.00 Subtotal (see instructions)				200.
201.00 Less Observation Beds				201.
202.00 Total (see instructions)				202.

		IONITI HOSTITAL					2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 6/30/2020 2:1	epared:
						6/30/2020 2:1	6 pm
				e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
30.00	03000 ADULTS & PEDI ATRI CS	78, 841, 038		78, 841, 03	38 0	78, 841, 038	30.00
	03100 I NTENSI VE CARE UNI T	12, 854, 842		12, 854, 84			
	02060 NEONATAL INTENSIVE CARE UNIT	16, 188, 890		16, 188, 89			
40.00	04000 SUBPROVI DER – I PF	4, 670, 729		4, 670, 72		.,	
43.00	04300 NURSERY	4, 941, 149		4, 941, 14	19 0	4, 941, 149	43.00
	ANCI LLARY SERVI CE COST CENTERS	1			1		
	05000 OPERATING ROOM	20, 947, 363		20, 947, 36	03 0		
	05100 RECOVERY ROOM	5, 815, 593		5, 815, 59	03 0	5, 815, 593	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	12, 786, 503		12, 786, 50	03 0	12, 786, 503	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 851, 170		6, 851, 17	0 0	6, 851, 170	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	2, 650, 639		2, 650, 63			
57.00	05700 CT SCAN	2, 582, 015		2, 582, 01		2, 582, 015	
	05800 MRI	1, 957, 303		1, 957, 30			
59.00	05900 CARDI AC CATHETERI ZATI ON	263, 805		263, 80			
60.00	06000 LABORATORY	12, 847, 866		12, 847, 86			
64.00	06400 I NTRAVENOUS THERAPY	1, 677, 703		1, 677, 70		1, 677, 703	
65.00	06500 RESPI RATORY THERAPY	6, 028, 237					
66.00	06600 PHYSI CAL THERAPY	9, 420, 218		., .==,=		., .==,=.=	
67.00	06700 OCCUPATI ONAL THERAPY	2, 559, 289	0	2, 559, 28	39 0	2, 559, 289	67.00
68.00	06800 SPEECH PATHOLOGY	440, 839	0	440, 83	39 0	440, 839	68.00
69.00	06900 ELECTROCARDI OLOGY	795, 262		795, 26	02 0	795, 262	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2, 812, 355		2, 812, 35			
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	27, 933, 945		27, 933, 94			
	07200 I MPL. DEV. CHARGED TO PATIENTS	19, 731, 241		19, 731, 24			
	07300 DRUGS CHARGED TO PATIENTS	30, 212, 259		30, 212, 25			
	07301 SPECIALTY PHARMACY						
		22, 493, 044		22, 493, 04		,,	
	07400 RENAL DI ALYSI S	1, 750, 211		1, 750, 21		.,	
	03330 ENDOSCOPY	3, 734, 929		3, 734, 92	29 0		
	03950 OTHER ANCI LLARY SERVICE COST CENTERS	0			0 0	0	
	03951 OTHER ANCILLARY SERVICE COST CENTERS	0			0 0	0	
	03952 OTHER ANCILLARY SERVICE COST CENTERS	0			0 0	0	
	03953 WOUND CARE	302, 022		302, 02	22 0	302, 022	76.04
76.06	03954 I MAGI NG CENTER	5, 104, 356		5, 104, 35	6 0		76.06
	03955 BREAST DI AGNOSTI C CENTER	11, 878, 493		11, 878, 49		11, 878, 493	
	OUTPATIENT SERVICE COST CENTERS		1		- <u>-</u>		
90 00	09000 CLINIC	0			0 0	0	90.00
	04950 I NFUSI ON CENTER	328, 078		328, 07			
	04975 SPINE CENTER	328,078		334, 09			
	09100 EMERGENCY						
		17, 271, 125		17, 271, 12			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	9, 158, 477	l	9, 158, 47	7/	9, 158, 477	92.00
	SPECIAL PURPOSE COST CENTERS		1			1	
	11300 INTEREST EXPENSE						113.00
	11400 UTI LI ZATI ON REVI EW-SNF						114.00
200.00	Subtotal (see instructions)	358, 165, 085	0	358, 165, 08	35 0	358, 165, 085	200.00
201.00	Less Observation Beds	9, 158, 477		9, 158, 47	7	9, 158, 477	201.00
202.00		349, 006, 608					

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 6/30/2020 2:1	epared: 6 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Inpati ent	Charges Outpatient	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	
INPATIENT ROUTINE SERVICE COST CENTERS	470 707 457		470 707 4			
0.00 03000 ADULTS & PEDIATRICS	173, 787, 457		173, 787, 4			30.0
1.00 03100 I NTENSI VE CARE UNI T 5.00 02060 NEONATAL I NTENSI VE CARE UNI T	27, 140, 503 88, 576, 583		27, 140, 5 88, 576, 5			31.0
0.00 04000 SUBPROVIDER - IPF	11, 651, 668		11, 651, 6			40.0
3. 00 04300 NURSERY	9, 600, 682		9, 600, 6			40.0
ANCI LLARY SERVICE COST CENTERS	7,000,002		7,000,0	52		
0. 00 05000 OPERATI NG ROOM	135, 468, 134	71, 445, 699	206, 913, 8	33 0. 101237	0, 000000	50.0
1.00 05100 RECOVERY ROOM	19, 850, 715	15, 484, 769			0.00000	
2.00 05200 DELIVERY ROOM & LABOR ROOM	26, 486, 133	0			0.00000	52.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	12, 285, 747	29, 596, 354	41, 882, 1	0. 163582	0.00000	54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C	14, 070, 579	22, 589, 730	36, 660, 3	0. 072303	0.00000	55.0
7.00 05700 CT SCAN	26, 050, 357	50, 294, 103	76, 344, 4	60 0. 033821	0.00000	57.0
8. 00 05800 MRI	5, 285, 954	14, 755, 376	20, 041, 3	30 0. 097663	0.00000	58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	4, 477, 421	0	4, 477, 4	0. 058919	0.00000	59.0
0. 00 06000 LABORATORY	80, 770, 477	48,085,351	128, 855, 8	28 0. 099707	0.00000	60.0
4. 00 06400 I NTRAVENOUS THERAPY	1, 204, 800	1, 489, 125	2, 693, 9	25 0. 622773	0.00000	
5. 00 06500 RESPI RATORY THERAPY	25, 521, 296	2, 650, 296			0.00000	65.0
6. 00 06600 PHYSI CAL THERAPY	6, 097, 090	23, 312, 901			0.00000	
7.00 06700 OCCUPATI ONAL THERAPY	5, 422, 496	3, 359, 313			0.00000	
8.00 06800 SPEECH PATHOLOGY	1, 516, 214	698, 802			0.00000	
9.00 06900 ELECTROCARDI OLOGY	10, 265, 627	1, 847, 249			0.00000	
0.00 07000 ELECTROENCEPHALOGRAPHY	1, 330, 528	12, 358, 239			0.00000	
1.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	52, 136, 816	25, 009, 062			0.00000	
22.00 07200 I MPL. DEV. CHARGED TO PATIENTS	35, 440, 942	10, 325, 056			0.00000	
3.00 07300 DRUGS CHARGED TO PATIENTS	77, 808, 216	45, 996, 603			0.00000	
3. 01 07301 SPECIALTY PHARMACY	0	20, 010, 685			0.00000	
74. 00 07400 RENAL DI ALYSI S 76. 00 03330 ENDOSCOPY	4, 194, 423	10 150 042	4, 194, 4 25, 400, 9		0.00000	
6. 01 03350 ENDOSCOPY 6. 01 03950 OTHER ANCI LLARY SERVICE COST CENTERS	6, 241, 098 0	19, 159, 843 0	25, 400, 9	0 0.000000	0. 000000 0. 000000	
6.02 03950 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0 0.000000	0. 000000	
6. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0.000000	0. 000000	
6. 04 03953 WOUND CARE	992, 834	154, 160			0.000000	
6. 06 03954 I MAGI NG CENTER	523, 953	59, 304, 897			0.000000	
76. 07 03955 BREAST DI AGNOSTI C CENTER	18, 564	24, 801, 448			0. 000000	
OUTPATIENT SERVICE COST CENTERS	10/001	21/001/110	21/020/0		0100000	
0.00 09000 CLINIC	0	0		0 0.000000	0.00000	90.0
0. 01 04950 I NFUSION CENTER	0	619, 794			0.000000	
0. 26 04975 SPI NE CENTER	0	633, 756			0.00000	
01.00 09100 EMERGENCY	39, 236, 042	131, 354, 685	170, 590, 7		0.00000	91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 133, 956	9, 599, 617	12, 733, 5	0. 719239	0.00000	92.0
SPECIAL PURPOSE COST CENTERS						
13.00 11300 INTEREST EXPENSE						]113. C
14.00 11400 UTI LI ZATI ON REVI EW-SNF						114. C
200.00 Subtotal (see instructions)	906, 587, 305	644, 936, 913	1, 551, 524, 2	18		200.0
201.00 Less Observation Beds						201.0
202.00 Total (see instructions)	906, 587, 305	644, 936, 913	1, 551, 524, 2	18		202.0

		MUNITY HUSPITAL U			J OI FOI III CMS-2552-
COMPUTATI	ION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0169	Period: From 01/01/2019	Worksheet C Part I
				To 12/31/2019	Date/Time Prepared
					6/30/2020 2:16 pm
			Title XIX	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
		11.00			
	IPATIENT ROUTINE SERVICE COST CENTERS				
	3000 ADULTS & PEDIATRICS				30.
	100 INTENSIVE CARE UNIT				31.
	2060 NEONATAL INTENSIVE CARE UNIT				35.
	000 SUBPROVI DER – I PF				40.
	300 NURSERY				43.
	CILLARY SERVICE COST CENTERS				
	0000 OPERATING ROOM	0. 101237			50.
	100 RECOVERY ROOM	0. 164582			51.
52.00 05	200 DELIVERY ROOM & LABOR ROOM	0. 482762			52.
54.00 05	5400 RADI OLOGY-DI AGNOSTI C	0. 163582			54.
55.00 05	500 RADI OLOGY-THERAPEUTI C	0. 072303			55.
57.00 05	700 CT SCAN	0. 033821			57.
58.00 05	5800 MRI	0. 097663			58.
59.00 05	900 CARDI AC CATHETERI ZATI ON	0. 058919			59.
	000 LABORATORY	0. 099707			60.
	400 INTRAVENOUS THERAPY	0. 622773			64.
	500 RESPI RATORY THERAPY	0. 213983			65.
	600 PHYSI CAL THERAPY	0. 320307			66.
	700 OCCUPATI ONAL THERAPY	0. 291431			67.
	0800 SPEECH PATHOLOGY	0. 199023			68.
	900 ELECTROCARDI OLOGY	0. 065654			69.
	000 ELECTROENCEPHALOGRAPHY	0. 205450			70.
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 362093			70.
	200 IMPL. DEV. CHARGED TO PATIENTS	0. 431133			71.
	300 DRUGS CHARGED TO PATIENTS	0. 244031			72.
	300 SPECIALTY PHARMACY	1. 124052			73.
	400 RENAL DIALYSIS	0. 417271			73.
	330 ENDOSCOPY				
	3350 OTHER ANCI LLARY SERVICE COST CENTERS	0. 147039 0. 000000			76. 76.
	3951 OTHER ANCI LLARY SERVICE COST CENTERS	0. 000000			76.
	3952 OTHER ANCI LLARY SERVICE COST CENTERS	0.000000			76.
	9953 WOUND CARE	0. 263316			76.
	1954 I MAGI NG CENTER	0. 085316			76.
	3955 BREAST DI AGNOSTI C CENTER	0. 478585			
	ITPATIENT SERVICE COST CENTERS	0.000000			
		0. 000000			90.
	1950 I NFUSI ON CENTER	0. 529334			90.
	975 SPINE CENTER	0. 527170			90.
	2100 EMERGENCY	0. 101243			91.
	2200 OBSERVATION BEDS (NON-DISTINCT PART	0. 719239			92.
	CONTRACTOR COST CENTERS	1			
	300 INTEREST EXPENSE				113.
	400 UTI LI ZATI ON REVI EW-SNF				114.
200.00	Subtotal (see instructions)				200.
201.00	Less Observation Beds				201.
202.00	Total (see instructions)				202.

Health Financial Systems COMM	/UNI TY HOSPI TAL	OF INDIANA, IN	VC.	In Lie	u of Form CMS-2	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 15-0169		Period: From 01/01/2019 To 12/31/2019	Date/Time Prepared: 6/30/2020 2:16 pm	
			e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost			Operating Cost	
		(Wkst. B, Part			Reducti on	
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	00.047.0/0	0.5/0.007	47.070.44		0	50.00
50. 00 05000 OPERATING ROOM	20, 947, 363				0	50.00
51.00 05100 RECOVERY ROOM	5, 815, 593				0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	12, 786, 503				0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 851, 170				0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 650, 639				0	55.00
57.00 05700 CT SCAN	2, 582, 015				0	57.00
58. 00 05800 MRI	1, 957, 303				0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	263, 805	6, 718	257, 08	37 0	0	59.00
60. 00 06000 LABORATORY	12, 847, 866	482, 126	12, 365, 74	40 0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	1, 677, 703	244, 082	1, 433, 62	21 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	6, 028, 237	444, 157	5, 584, 08	30 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	9, 420, 218	706, 198	8, 714, 02	20 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	2, 559, 289		2, 444, 50	03 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	440, 839				0	68.00
69. 00 06900 ELECTROCARDI OLOGY	795, 262				0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 812, 355				0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	27, 933, 945				0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	19, 731, 241	1, 147, 254			0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	30, 212, 259				0	73.00
73. 01 07301 SPECIALTY PHARMACY	22, 493, 044				0	73.01
74. 00 07400 RENAL DIALYSIS	1, 750, 211				0	74.00
76. 00 03330 ENDOSCOPY	3, 734, 929				0	76.00
					-	
76. 01 03950 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0 0	0	76.01
76.02 03951 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0 0	0	76.02
76.03 03952 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0 0	0	76.03
76.04 03953 WOUND CARE	302, 022				0	76.04
76.06 03954 I MAGI NG CENTER	5, 104, 356				0	76.06
76. 07 03955 BREAST DI AGNOSTI C CENTER	11, 878, 493	247, 325	11, 631, 16	58 0	0	76.07
OUTPATIENT SERVICE COST CENTERS			1		0	00.00
90. 00 09000 CLINIC	0	-		0 0	0	90.00
90. 01 04950 I NFUSI ON CENTER	328, 078				0	90.01
90. 26 04975 SPI NE CENTER	334,097				0	90.26
91. 00 09100 EMERGENCY	17, 271, 125				0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	9, 158, 477	955, 980	8, 202, 49	97 0	0	92.00
SPECIAL PURPOSE COST CENTERS	1		1			
113.00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
200.00 Subtotal (sum of lines 50 thru 199)	240, 668, 437					200.00
201.00 Less Observation Beds	9, 158, 477					201.00
202.00  Total (line 200 minus line 201)	231, 509, 960	18, 056, 667	213, 453, 29	93 0	0	202.00

	ATION OF OUTPATIENT SERVICE COST TO CHARGE RA ONS FOR MEDICAID ONLY	ATIOS NET OF	Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet C Part II Date/Time Prepare 6/30/2020 2:16 pm
				e XIX	Hospi tal	PPS
	Cost Center Description	Cost Net of	Total Charges	Outpati ent		
		Capital and	(Worksheet C,			
			Part I, column		6	
		Reduction	8)	/ col. 7)		
		6.00	7.00	8.00		
	ANCI LLARY SERVI CE COST CENTERS					
	05000 OPERATI NG ROOM	20, 947, 363				50.
	05100 RECOVERY ROOM	5, 815, 593				51.
	05200 DELIVERY ROOM & LABOR ROOM	12, 786, 503				52.
	05400 RADI OLOGY-DI AGNOSTI C	6, 851, 170				54.
	05500 RADI OLOGY-THERAPEUTI C	2, 650, 639	36, 660, 309	0. 07230	03	55.
57.00	05700 CT SCAN	2, 582, 015	76, 344, 460	0. 0338	21	57.
58.00	05800 MRI	1, 957, 303	20, 041, 330	0. 0976	63	58.
59.00	05900 CARDI AC CATHETERI ZATI ON	263, 805	4, 477, 421	0. 0589	19	59.
60.00	06000 LABORATORY	12, 847, 866	128, 855, 828	0. 09970	07	60.
64.00	06400 INTRAVENOUS THERAPY	1, 677, 703	2, 693, 925	0. 6227	73	64.
	06500 RESPI RATORY THERAPY	6, 028, 237	28, 171, 592	0. 2139	83	65.
66.00	06600 PHYSI CAL THERAPY	9, 420, 218	29, 409, 991	0. 3203	07	66.
67.00	06700 OCCUPATI ONAL THERAPY	2, 559, 289			31	67.
	06800 SPEECH PATHOLOGY	440, 839				68.
	06900 ELECTROCARDI OLOGY	795, 262				69.
	07000 ELECTROENCEPHALOGRAPHY	2, 812, 355				70.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	27, 933, 945				71.
	07200 I MPL. DEV. CHARGED TO PATIENTS	19, 731, 241				72.
	07300 DRUGS CHARGED TO PATIENTS	30, 212, 259				73.
	07301 SPECIALTY PHARMACY	22, 493, 044				73.
	07400 RENAL DIALYSIS	1, 750, 211				74.
	03330 ENDOSCOPY	3, 734, 929				74.
	03950 OTHER ANCI LLARY SERVICE COST CENTERS	3, 734, 727				76.
	03951 OTHER ANCI LLARY SERVICE COST CENTERS	0				76.
	03952 OTHER ANCI LLARY SERVICE COST CENTERS	0				76.
	03953 WOUND CARE	302, 022	-			76.
	03954 I MAGI NG CENTER					
		5, 104, 356				76.
	03955 BREAST DI AGNOSTI C CENTER	11, 878, 493	24, 820, 012	0. 4785	85	
	OUTPATIENT SERVICE COST CENTERS			0.0000	00	
	09000 CLINIC	0	-			90.
	04950 I NFUSI ON CENTER	328,078				90.
	04975 SPINE CENTER	334,097				90.
	09100 EMERGENCY	17, 271, 125				91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART	9, 158, 477	12, 733, 573	0. 7192	37	92.
	SPECIAL PURPOSE COST CENTERS	1	1	1		140
	11300 INTEREST EXPENSE					113.
	11400 UTI LI ZATI ON REVI EW-SNF		1 040 7/7 005			114.
200.00			1, 240, 767, 325			200.
201.00	Less Observation Beds	9, 158, 477	-			201.
202.00	Total (line 200 minus line 201)	231, 509, 960	1, 240, 767, 325	1		202.

Health Financial Systems	COMMUNI TY HOSPI TAL	OF INDIANA, IN	NC.	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE	CAPITAL COSTS	Provider C		Period: From 01/01/2019 To 12/31/2019		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTER	RS					
30. 00 ADULTS & PEDIATRICS	8, 140, 148	0	8, 140, 14	8 65, 148	124.95	30.00
31.00 INTENSIVE CARE UNIT	1, 656, 112		1, 656, 11	2 6, 544	253.07	31.00
35.00 NEONATAL INTENSIVE CARE UNIT	1, 608, 969		1, 608, 96	9 11, 655	138.05	35.00
40.00 SUBPROVIDER - IPF	316, 012	0	316, 01	2 5, 142	61.46	40.00
43.00 NURSERY	620, 889		620, 88	9 7, 388	84.04	43.00
200.00 Total (lines 30 through 199)	12, 342, 130		12, 342, 13	0 95, 877		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTER	RS					
30. 00 ADULTS & PEDIATRICS	18, 645	2, 329, 693				30.00
31.00 INTENSIVE CARE UNIT	2, 102	531, 953				31.00
35.00 NEONATAL INTENSIVE CARE UNIT	0	0				35.00
40. 00 SUBPROVIDER - IPF	2, 786	171, 228				40.00
43.00 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	23, 533	3, 032, 874	L .			200. 00

	MUNITY HOSPITAL				u of Form CMS-2	2552-1
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provider C	CN: 15-0169	Peri od:	Worksheet D	
				From 01/01/2019 To 12/31/2019	Part II Date/Time Pre	narod
				10 12/31/2019	6/30/2020 2:1	6 nm
		Title	XVIII	Hospi tal	PPS	o piii
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B.		$(col \cdot 1 \div col$		column 4)	
	Part II, col.	8)	2)			
	26)		,			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		•				
50. 00 05000 OPERATI NG ROOM	3, 568, 927	206, 913, 833	0.0172	48 44, 190, 169	762, 192	1 50. 00
51.00 05100 RECOVERY ROOM	588, 831			4, 962, 874	82, 701	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 647, 210					52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	811, 268					
55. 00 05500 RADI OLOGY-THERAPEUTI C	766, 433					
57. 00 05700 CT SCAN	333,063					
58. 00 05800 MRI	474, 455					
59. 00 05900 CARDI AC CATHETERI ZATI ON	6, 718					
50. 00 06000 LABORATORY	482, 126					
54. 00 06400 I NTRAVENOUS THERAPY	244, 082					
55. 00 06500 RESPI RATORY THERAPY	444, 157					
56. 00 06600 PHYSI CAL THERAPY	706, 198				62, 328	
57. 00 06700 OCCUPATI ONAL THERAPY	114, 786					
68. 00 06800 SPEECH PATHOLOGY	19, 873					
59. 00 06900 ELECTROCARDI OLOGY	19, 327				7,016	
70.00 07000 ELECTROENCEPHALOGRAPHY	276, 794					
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	1, 623, 045				208, 601	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 147, 254					
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 437, 335					
73. 01 07301 SPECIALTY PHARMACY	535, 100				-	
74. 00 07400 RENAL DIALYSIS	37, 527					
76.00 03330 ENDOSCOPY	656, 996					76.0
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	-				76.0
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	-				76.0
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	-	0.0000		0	76.0
76.04 03953 WOUND CARE	8, 141				2, 957	
76.06 03954 I MAGI NG CENTER	464, 157				346	
76. 07 03955 BREAST DIAGNOSTIC CENTER	247, 325	24, 820, 012	0.0099	65 1, 419	14	76.0
OUTPATIENT SERVICE COST CENTERS	1	I				
90. 00 09000 CLINIC	0	-				90.00
90.01 04950 INFUSION CENTER	40, 631	619, 794			0	90.0
90. 26 04975 SPINE CENTER	7,487	633, 756	0. 0118	14 0	0	90.2
91. 00 09100 EMERGENCY	1, 347, 421	170, 590, 727	0.0078	99 15, 012, 435	118, 583	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	955, 980	12, 733, 573	0. 0750	76 1, 216, 555	91, 334	92.00
200.00 Total (lines 50 through 199)	19,012,647	1, 240, 767, 325		185, 842, 349	2, 613, 328	200 00

Health Financial Systems COM	IMUNI TY HOSPI TAL	OF INDIANA, IN	NC.	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	ASS THROUGH COS			Period: From 01/01/2019 Fo 12/31/2019	Date/Time Pre 6/30/2020 2:1	pared: 6 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School		Allied Health	All Other	
	Post-Stepdown		Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	)	0 0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0		0 0	0	31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0	0		0	0	
40. 00 04000 SUBPROVI DER - I PF	0				0	
43. 00 04300 NURSERY	0	0			0	1
200.00 Total (lines 30 through 199)	0			0	-	200.00
Cost Center Description	Swing-Bed	Total Costs	Tatal Dationt		Inpati ent	200.00
cost center bescription	Adjustment	(sum of cols.		Per Diem (col.		
			Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)	( 00	7.00	0.00	
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0	0	(5.44)	0.00	40.445	0.0.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	65, 14			
31.00 03100 I NTENSI VE CARE UNI T		0	6, 54			
35.00 02060 NEONATAL INTENSIVE CARE UNIT		0	11, 65			
40. 00 04000 SUBPROVIDER - IPF	0	0	5, 14			
43. 00 04300 NURSERY		0	7, 38			
200.00 Total (lines 30 through 199)		0	95, 87	7	23, 533	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0					35.00
40. 00 04000 SUBPROVIDER - IPF	0					40.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00
	1 0	I				

	MUNITY HOSPITAL		NC.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS			Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 6/30/2020 2:1	
	-		e XVIII	Hospi tal	PPS	
Cost Center Description				Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments	2.00	Adjustments	2.00	
ANCI LLARY SERVICE COST CENTERS	1.00	2A	2.00	3A	3.00	
50. 00 05000 OPERATING ROOM	0	0	)	0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0			0 0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0				0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	c c			0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	c c			0	55.00
57. 00 05700 CT SCAN	0			0 0	0	57.00
58. 00 05800 MRI	0			0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C C		0 0	0	59.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
54.00 06400 INTRAVENOUS THERAPY	0	C		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	Ċ		0 0	0	65.00
56. 00 06600 PHYSI CAL THERAPY	0	Ċ		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		o o	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C	)	0 0	0	73.00
73. 01 07301 SPECIALTY PHARMACY	0	C		0 0	0	73.01
74. 00 07400 RENAL DIALYSIS	0	C		0 0	0	74.00
76. 00 03330 ENDOSCOPY	0	C		0 0	0	76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	C		0 0	0	
76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	C	)	0 0	0	76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	C	)	0 0	0	76.03
76. 04 03953 WOUND CARE	0	C	)	0 0	0	76.04
76.06 03954 I MAGI NG CENTER	0	C	)	0 0	0	76.06
76. 07 03955 BREAST DI AGNOSTI C CENTER	0	C	)	0 0	0	76.07
		C	J	0 0		
90. 00 09000 CLINIC	0			0	-	90.00
90. 01 04950 I NFUSI ON CENTER	0			0 0	0	90.01
90. 26 04975 SPINE CENTER	0					1 10.20
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0					1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (lines 50 through 199)	0			0 0	-	200.00
	1 0		1	0 0	1 0	1200.00

Health Financial Systems COM	MUNITY HOSPITAL	OF INDIANA, IN	NC.	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2019 To 12/31/2019		pared <sup>.</sup>
				10 12/01/2017	6/30/2020 2:1	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
	4.00	F 00	( 00	7.00	instructions)	
ANCI LLARY SERVI CE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
50. 00 05000 OPERATI NG ROOM	0	0		206, 913, 833	0. 000000	50.00
51. 00 05100 RECOVERY ROOM	0	-		35, 335, 484		1
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			26, 486, 133		1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			41, 882, 101		•
55. 00 05500 RADI OLOGY - DI AGNOSTI C	0	0		36, 660, 309		•
57. 00  05700 CT SCAN	0			76, 344, 460		
58. 00  05800 MRI	0	0		20, 041, 330		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 4, 477, 421		
60. 00 06000 LABORATORY	0			128, 855, 828		
64. 00 06400 I NTRAVENOUS THERAPY	0			2, 693, 925		
65. 00 06500 RESPIRATORY THERAPY	0			2, 093, 925		
66. 00 06600 PHYSI CAL THERAPY	0			28, 171, 592		
67. 00 06700 OCCUPATI ONAL THERAPY	0			29, 409, 991 0 8, 781, 809		
68. 00 06800 SPEECH PATHOLOGY	0			2, 215, 016		
69. 00 06900 ELECTROCARDI OLOGY	0			12, 112, 876		
70. 00 07000 ELECTROEARDFOLOGT	0			13, 688, 767		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			77, 145, 878		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	, °		45, 765, 998		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0			123, 804, 819		
73. 01 07301 SPECIALTY PHARMACY	0			20, 010, 685		
74. 00 07400 RENAL DI ALYSI S	0	0		4, 194, 423		
76. 00 03330 ENDOSCOPY	0	0		25, 400, 941		
76. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 20,100,711	0. 000000	
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0. 000000	
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0. 000000	
76.04 03953 WOUND CARE	0	0		1, 146, 994		
76.06 03954 I MAGI NG CENTER	0	0		59, 828, 850		
76. 07 03955 BREAST DI AGNOSTI C CENTER	0			24, 820, 012		1
OUTPATI ENT SERVICE COST CENTERS	· · · · ·					
90. 00 09000 CLINIC	0	0		0 0	0.000000	90.00
90. 01 04950 INFUSION CENTER	0	0		619, 794		
90. 26 04975 SPI NE CENTER	0	0		633, 756		
91.00 09100 EMERGENCY	0	-		170, 590, 727		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0 12, 733, 573		
200.00 Total (lines 50 through 199)	0	0		0 1, 240, 767, 325		200.00
			•		•	

		MUNITY HOSPITAL (					u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	Provider C	CN: 15-0169	Peri		Worksheet D	
THROUG	GH COSTS				To	1 01/01/2019 12/31/2019	Part IV Date/Time Pre	narod
					10	12/ 31/ 2019	6/30/2020 2:1	6 pm
			Title	XVIII		Hospi tal	PPS	<u>o p</u>
	Cost Center Description	Outpati ent	Inpati ent	I npati ent		Outpatient	Outpati ent	
		Ratio of Cost	Program	Program		Program	Program	
		to Charges	Charges	Pass-Throug	h	Charges	Pass-Through	
		(col. 6 ÷ col.	Ũ	Costs (col.	8	Ũ	Costs (col. 9	
		7)		x col. 10)			x col. 12)	
		9.00	10.00	11.00		12.00	13.00	
	ANCI LLARY SERVICE COST CENTERS				·			
50.00	05000 OPERATING ROOM	0.000000	44, 190, 169		0	16,044,379	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	4, 962, 874		0	2, 581, 190	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0,000000	3, 781, 948		0	5, 333, 392	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	6, 110, 345		0	10, 446, 818	0	55.00
57.00	05700 CT SCAN	0. 000000	9, 690, 643		õ	10, 046, 667	0	57.00
58.00	05800 MRI	0. 000000	1, 656, 514		0	3, 387, 761	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	2, 540, 199		0	0,007,701	0	59.00
60.00	06000 LABORATORY	0. 000000	26, 495, 078		0	8, 667, 086	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	397, 926		0	468, 211	0	64.00
65.00	06500 RESPI RATORY THERAPY	0.000000	6, 113, 643		0	354, 296	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	2, 595, 691		0	113, 715	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0.000000			0		0	67.00
			1, 888, 608		0	27,627		
68.00		0. 000000	540, 726		0	7, 317	0	68.00
69.00		0. 000000	4, 396, 112		-	429, 942	-	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	319, 595		0	2, 760, 800	0	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0. 000000	9, 914, 981		0	5, 315, 183	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	13, 827, 324		0	3, 426, 807	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	25, 425, 446		0	14, 645, 826	0	73.00
73.01	07301 SPECIALTY PHARMACY	0. 000000	0		0	0	0	73.01
74.00	07400 RENAL DI ALYSI S	0. 000000	1, 758, 152		0	0	0	74.00
76.00	03330 ENDOSCOPY	0. 000000	2, 544, 825		0	5, 622, 571	0	76.00
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0	0	0	76.01
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0	0	0	76.02
76.03	03952 OTHER ANCI LLARY SERVICE COST CENTERS	0. 000000	0		0	0	0	76.03
76.04	03953 WOUND CARE	0. 000000	416, 603		0	66, 778	0	76.04
76.06	03954 I MAGI NG CENTER	0. 000000	44, 538		0	16, 776, 310	0	76.06
76.07	03955 BREAST DI AGNOSTI C CENTER	0. 000000	1, 419		0	2, 619, 919	0	76.07
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0. 000000	0		0	0	0	90.00
90. 01	04950 INFUSION CENTER	0. 000000	0		0	13, 496	0	90.01
90.26	04975 SPI NE CENTER	0. 000000	0		0	388	0	90.26
91.00	09100 EMERGENCY	0. 000000	15, 012, 435		0	17, 016, 068	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	1, 216, 555		0	5, 385, 052	0	92.00
200.00	Total (lines 50 through 199)	1 1	185, 842, 349	1	0	131, 557, 599	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERV	ICES AND VACCINE COST	Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pre 6/30/2020 2:1	pared: 6 pm
		Title	× XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS			1	-		
50. 00 05000 OPERATI NG ROOM	0. 101237			0 0	1	
51.00 05100 RECOVERY ROOM	0. 164582			0 0	424, 817	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 482762			0 0	0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 163582			0 0	872, 447	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 072303			0 0	755, 336	
57.00 05700 CT SCAN	0. 033821	10, 046, 667		0 0	339, 788	
58.00 05800 MRI	0. 097663			0 0	330, 859	
59.00 05900 CARDIAC CATHETERIZATION	0. 058919			0 0	0	59.00
60. 00 06000 LABORATORY	0. 099707			0 0	864, 169	
64.00 06400 INTRAVENOUS THERAPY	0. 622773			0 0	291, 589	
65. 00 06500 RESPI RATORY THERAPY	0. 213983	354, 296		0 0	75, 813	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 319337	113, 715		0 0	36, 313	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 291431	27,627		0 0	8, 051	67.00
68.00 06800 SPEECH PATHOLOGY	0. 199023	7, 317		0 0	1, 456	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 065654	429, 942		0 0	28, 227	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 205450	2, 760, 800		0 0	567, 206	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	I ENT 0. 362093	5, 315, 183		0 0	1, 924, 591	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 431133	3, 426, 807		0 0	1, 477, 410	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 244031	14, 645, 826		0 70, 267	3, 574, 036	73.00
73.01 07301 SPECIALTY PHARMACY	1. 124052	0		0 0	0	73.01
74.00 07400 RENAL DIALYSIS	0. 417271	0		0 0	0	
76. 00 03330 ENDOSCOPY	0. 147039	5, 622, 571		0 0	826, 737	76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CE	NTERS 0. 000000	0		0 0	0	76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CE				0 0	0	
76.03 03952 OTHER ANCILLARY SERVICE COST CE	NTERS 0. 000000	0		0 0	0	76.03
76.04 03953 WOUND CARE	0. 263316	66, 778		0 0	17, 584	76.04
76.06 03954 I MAGI NG CENTER	0. 085316	16, 776, 310		0 0	1, 431, 288	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0. 478585	2, 619, 919		0 0	1, 253, 854	76.07
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90.01 04950 INFUSION CENTER	0. 529334			0 0	7, 144	
90. 26 04975 SPI NE CENTER	0. 527170	388		0 0	205	90.26
91. 00 09100 EMERGENCY	0. 100540			0 114	1, 710, 795	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	PART 0. 719239	5, 385, 052		0 0	3, 873, 139	92.00
200.00 Subtotal (see instructions)		131, 557, 599		0 70, 381	22, 317, 139	200.00
201.00 Less PBP Clinic Lab. Services-F	rogram			0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 20		131, 557, 599	1	0 70, 381	22, 317, 139	1

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provider CCN:	15-0169	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pr 6/30/2020 2:	epared: 16 pm
		Title XV	/111	Hospi tal	PPS	
	Cost	ts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
		Services Not				
	Subject To Ded. & Coins.	Subject To Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATING ROOM	0	0				50.00
51.00 05100 RECOVERY ROOM	0	o				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	o				55.00
57.00 05700 CT SCAN	0	o				57.00
58. 00 05800 MRI	0	o				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	o				59.00
50. 00 06000 LABORATORY	0	o				60.00
64.00 06400 INTRAVENOUS THERAPY	0	o				64.00
65. 00 06500 RESPI RATORY THERAPY	0	o				65.00
66. 00 06600 PHYSI CAL THERAPY	0	o				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
58.00 06800 SPEECH PATHOLOGY	0	0				68.00
59. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	17, 147				73.00
73. 01 07301 SPECIALTY PHARMACY	0	0				73.01
74. 00 07400 RENAL DI ALYSI S	0	0				74.00
76.00 03330 ENDOSCOPY	0	0				76.00
76. 01 03950 OTHER ANCI LLARY SERVICE COST CENTERS	0	0				76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS 76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0				76.02
76.04 03953 WOUND CARE	0	0				76.03
76. 06 03954 I MAGI NG CENTER	0	0				76.04
76. 07 03955 BREAST DIAGNOSTIC CENTER	0	0				76.07
OUTPATIENT SERVICE COST CENTERS	UU	0				/0.0/
90. 00 09000 CLINIC	0	0				90.00
90. 01 04950 INFUSION CENTER	0	0				90.01
90. 26 04975 SPI NE CENTER	0	o				90.26
91. 00 09100 EMERGENCY	0	11				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
200.00 Subtotal (see instructions)	0	17, 158				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	17, 158				202.00

51.00       05100       RECOVERY ROOM       588,831       35,335,484       0.016664       0       0       51.00         52.00       05200       DELI VERY ROOM & LABOR ROOM       1,647,210       26,486,133       0.062191       0       52.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       811,268       41,882,101       0.019370       34,272       664       54.00         55.00       05500       RADI OLOGY-THERAPEUTI C       766,433       36,660,309       0.020906       0       0       55.00         57.00       05700       CT SCAN       333,063       76,344,460       0.004363       85,336       372       57.00         58.00       05800       MRI       474,455       20,041,330       0.023674       7,409       175       58.00         59.00       05900       CARDI AC CATHETERI ZATI ON       6,718       4,477,421       0.001500       0       0       59.00	Health Financial Systems COM	MUNITY HOSPITAL	OF INDIANA, IN	VC.	In Lie	eu of Form CMS-:	2552-10
Component CCN: 15-5169         To         12/31/201         Date/Time Prepared: 6/30/2022;16 pm           Cost Center Description         Capital Related Cost (from Wst: B, 20)         Total Charges (From Wst: C, 20)         Ratio of Cost (cost)         Inpatient (colum 3 x) (colum 4)         Capital (colum 3 x) (colum 4)           MACILLARY SERVICE COST CENTERS         1.00         3.00         4.00         5.00           05000 (DPERATING ROOM 52.00         3.568,927         20,913,833         0.017248         0         0         5.00           50.00         05000 (DPERATING ROOM 52.00         3.568,927         20,913,833         0.002791         0         0         5.00           50.00         05000 (DPERATING ROOM 52.00         5.58,484         0.016664         0         0         5.00           50.00         05000 (DELIVERY ROM & LABOR ROOM 55.00         811,258,414,820,101         0.02970         64,272         664,530           50.00         05000 (RAI) CACY-INAROSTIC         813,853,854,440         0.016664         0         0.55.00           50.00         05000 (RAI) CACY-INAROSTIC         813,856,872         0.030,043         85,336         372,57           50.00         05000 (RAI) CACY-INAROSTIC         813,47,471         0.001500         0.02976         55.00           50	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provider C				
Cost Center Description         Capital Related Cost (From Wkst. C. Description         Total Charges (Col. 1 + col. 2)         Ratio of Cost (Col. 1 + col. 2)         Inpatient Pregram (Col. 1 + col. 2)         Capital Costs (Col. 1 + col. 2)           MCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           05000 (DPERATING ROOM 52.00         3.566,927         206,913,833         0.017248         0         0         50.00           05000 (DPERATING ROOM 52.00         5.00         5.00         50.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
Cost Center Description         Capital Related Charges (from Wkst. C, 26)         Ratio of Cost (from Wkst. C, 26)         Inpatient (col. 1 + col. 8)         Capital Cost Costs (col. 1 + col. 8)         Capital Costs (col. 1 + col. 8)         Capital (col. 2 + col. 8)         Capi			Component	LCN: 15-5169	10 12/31/2019		
Cost Center Description         Capital Related Cost (from Wkst. C. part II, col. 2)         Total Charges To Col. Capital Cost (col. Int Applient Program Charges         Capital Cost Col. Int Col. 2)         Capital Cost Col. Int Col. 2)         Col. Capital Cost (col. Int Applient Program Charges           MCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           05000 (PECNTING ROOM         5.86, 927         206, 913, 833         0.017248         0         0.0520           51.00         05200 (PECNTING ROOM         5.86, 927         206, 913, 833         0.017248         0         0         5.00           52.00         05200 (PECNERY ROOM         5.86, 927         206, 913, 833         0.016604         0         0         5.00           55.00         05200 (PECNERY ROOM         5.88, 831         35, 354, 444         0.016604         0         0         5.50           05300 (CL SCAN         333, 063         76, 344, 450         0.023674         7, 409         175         58.00           50.00         05000 (CL RODIAC CATHERERIZATION         6, 718         4, 477, 421         0.0015766         19, 527         3.386         3726         59.00         0.003742         851, 356         65.00           60.00         060000 (CL ARDIAC CATHERERIZATION <t< td=""><td></td><td></td><td>Title</td><td>XVIII</td><td>Subprovider -</td><td></td><td></td></t<>			Title	XVIII	Subprovider -		
Cost Center Description         Capital Related Charges (from Wkst. C, 26)         Total Charges (rom Wkst. C, 20)         Inpatient to Charges (col. 1 + col. 8)         Capital core         Capital Costs (col. 1 + col. 8)         Inpatient Col. 1 + col. 8)         Capital Costs (col. 0 cost (col. 1 + col. 8)         Capital Costs (col. 0 cost (col. 0 cost (c			ii tie			115	
ANCI LLARY SERVICE COST CENTERS         Part 1, col. 26)         Part 1, col. 8)         Col. 2)         Charges         Col umn 4)           ANCI LLARY SERVICE COST CENTERS         0         3.00         4.00         5.00           0         05000 (DPRATI NG ROOM         3,568,927         206,913,833         0.017248         0         0         50.00           51.00         05100 (RECOVERY ROOM         1,647,210         26,486,133         0.062191         0         0         52.00           05200 (RADI LOGY-THERAPEUTI C         766,433         36,660,090         0.004363         85,336         372         25,70           55.00         05500 (RADI LOGY-THERAPEUTI C         766,433         36,660,090         0.004363         85,336         372         57.00           50.00         05500 (RADI LOGY-THERAPEUTI C         766,433         36,660,090         0.004363         85,336         372         57.00           50.00         05600 (RADI LOGY-THERAPEUTI C         7.06,718         477,421         0.004363         85,336         372         57.00           50.00         05600 (RESPI RATORY THERAPY         442,126         128,855,828         0.003742         851,356         37.18         66.00         66.00         66.00         66.00         66.00 <td>Cost Center Description</td> <td>Capi tal</td> <td>Total Charges</td> <td>Ratio of Cos</td> <td></td> <td>Capital Costs</td> <td></td>	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
Part II, col         8)         2)         3         4           26)         2.00         3.00         4.00         5.00           50.00         05000 OPERATING ROOM         3,568,927         206,913,833         0.017248         0         0         50.00           51.00         05100 RECOVERY ROOM         LBOR ROOM         1,647,210         26,486,133         0.017248         0         0         52.00           52.00         05200 RADI LOGY-THERAPEUTIC         766,433         36,660,309         0.020906         0         0.55.0           50.00         05700 CT SCAN         333,063         76,344,460         0.024306         35,336         372         57.00           50.00         05500 MRI         .474,455         20,041,330         0.02374         7.409         175.58.00           50.00         05500 MRI         .474,455         20,041,330         0.03570         0         0.55.00           64.00         0.6400 INTRAVENOUS THERAPEY         4847,455         28.55.828         0.03701         51.116         66.60           65.00         06500 RESPI RATORY THERAPY         444,157         28.857.829         0.090605         22.741         2.066         61.00         60.00         66.00         66.0		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
26)         1.00         2.00         3.00         4.00         5.00           ANCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           51.00         05000 OPERATINE ROOM         3.568,927         206,913,833         0.017248         0         0         55.00           52.00         052000 DELIVERY ROOM & LABOR ROOM         1,647,210         26,486,133         0.012644         0         0         52.00           55.00         05500 RADI LOGY-DI AGNOSTIC         811,268         41,862,101         0.019370         34,272         664         54.00           55.00         05500 RADI LOGY-THERAPEUTIC         766,433         36,636,09         0.02906         0         0         55.00           50.00         05500 CARDI AC CATHETERIZATION         6,718         4,477,421         0.015700         0         9590           0.6000 LABORATORY         482,126         128,853,828         0.003742         851,356         3,186         60.00           66.00         06600 PHYSICAL THERAPY         244,082         2,693,925         0.09605         22,741         2,066 4.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
I. OC         2. OO         3. OO         4. OO         5. OO           ANCILLARY SERVICE COST CENTERS         50. OO         550. OO		Part II, col.	8)	2)	Ŭ		
ANCI LLARY SERVICE COST CENTERS         200           00         00         00000         OPERATI NG ROOM         3, 568, 927         206, 913, 833         0, 017248         0 </td <td></td> <td>26)</td> <td></td> <td></td> <td></td> <td></td> <td></td>		26)					
50.00         05000         0FERTING ROM         3, 568, 927         206, 913, 833         0.017248         0         0         50.00           51.00         05100         RECOVERY ROOM         1, 647, 210         26, 486, 133         0.652191         0         0         55.00           52.00         05200         RADI OLGOY- DI AGNOSTIC         811, 268         41, 882, 101         0.017370         34, 272         664         55.0           50.00         05500         RADI OLGOY- DI AGNOSTIC         766, 433         36, 660, 309         0.02096         0         0.55.0           50.00         05500         CARDI AC CATHETERI ZATI ON         6, 718         4, 477, 421         0.001500         0         0.59.00           60.00         06600         LINRAVENOUS THERAPY         244, 082         2, 693, 925         0.90605         2, 741         2, 060         464         66.00         6600         19, 572         308         65.00         6500         0.6000         100000         1, 251         66.00         6600         11, 847, 809         0.013071         51.116         66.80         67.00         0.6000         14, 878         67.00         0.02097         6, 506         58         68.00         65.00         6500         6		1.00	2.00	3.00	4.00	5.00	
51.00       05100       RECOVERY ROOM       588, 831       353, 484       0.016664       0       51.00         52.00       05200       DELIVERY ROOM & LABOR ROOM       1, 647, 210       26, 486, 133       0.02191       0       0       52.00         52.00       05200       RADI DLOGY-THERAPEUTI C       766, 433       36, 600, 309       0.023096       0       0       55.00         55.00       05500       CTSCAN       333, 063       76, 344, 460       0.004363       85, 336       372       57.00         57.00       05700       CARDI AC CATHETERI ZATI ON       6, 718       4, 477, 410       0.015500       0       0       0       59.00         60.00       CABORATORY       482, 126       128, 855, 828       0.03742       851, 356       3.186       60.00         61.00       06400       INTRAVENOUS THERAPY       244, 082       2, 693, 925       0.090605       22, 741       2.060       64.00         61.00       06500       RESH RATORY THERAPY       706, 198       29, 409, 991       0.024012       52, 109       1, 251       66.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00			_				
52.00         05200         DELUVERY ROM & LABOR ROM         1, 647, 210         24, 46, 133         0, 062101         0         52.00           54.00         05400         RADI OLOGY-DI AGNOSTI C         811, 268         41, 882, 101         0, 019370         34, 272         664         54.00           55.00         05500         RADI OLOGY-DI AGNOSTI C         766, 433         36, 660, 309         0, 020976         0         0         55.00           50.00         05500         RADI OLOGY-DI AGNOSTI C         766, 433         36, 660, 309         0, 0203674         7, 409         175         58.00           50.00         05900         CARDI AC CATHETERIZATI ON         6, 718         4,477, 421         0,001500         0         0590         6400         INTRAVENUS THERAPY         448,157         28,955,828         0,003742         851,356         3,186         60.00           66.00         06600         INTRAVENUS THERAPY         444,157         28,171,592         0,013071         51,116         65.06         68.00           66.00         06600         PHYSI CAL THERAPY         144,784         871,386         0,013071         51,116         66.00         66.00         66.00         66.00         66.00         66.00         66.00	50.00 05000 OPERATING ROOM	3, 568, 927	206, 913, 833	0. 01724	18 0	0	50.00
54.00       05400       RADI OLOGY-DIACNOSTI C       811, 248       41, 882, 101       0.019370       34, 272       664       54.00         55.00       05500       RADI OLOGY-THERAPEUTI C       766, 433       36, 660, 309       0.020906       0       0       55.00         57.00       05700       CT SCAN       333, 063       76, 344, 460       0.004363       53.336       372       57.00         58.00       05800       KRI       474, 455       20, 041, 330       0.023674       7, 409       175       58.00         60.00       06000       LABORATORY       482, 126       128, 855, 828       0.003742       851, 356       3, 186       60.00         65.00       06500       RESPI RATORY THERAPY       444, 157       28, 171, 52       0.015766       19, 527       308       65.00         66.00       06600       RESPI RATONAL THERAPY       706, 198       29, 409, 991       0.024012       52, 109       1, 251       66.06         67.00       06700       0CEUPATI TOAL THERAPY       114, 766       8, 781       89       0.013071       51, 116       66.86       67.00         68.00       06800       SPEECH PATHOLOGY       19, 327       12, 112, 876       0.001596	51.00 05100 RECOVERY ROOM	588, 831	35, 335, 484	0. 01666	64 0	0	51.00
55.00       05500       RADI OLOGY-THERAPEUTIC       766,433       36,660,309       0.020906       0       0       55.00         57.00       05700       CT SCAN       333,063       76,344,460       0.004363       85,336       372       57.00         58.00       DS800       MRI       474,455       20,041,330       0.023674       7,409       175       58.00         59.00       DS900       LABDATORY       6,718       4,477,421       0.001500       0       0       59.00       60.00       60.00       0.0001       LBRATORY       851,356       60.00       60.00       65.00       64.00       0.6500       RESPI RATORY THERAPY       444,157       28,171,592       0.015766       19,527       308       65.00         66.00       06600       PHYSI CAL THERAPY       706,198       29,409,991       0.024012       52,109       1,251       66.00         67.00       06700       OCEPATI ONAL THERAPY       114,786       8,781,809       0.013071       51,116       688       67.00         60.00       06800       PHTHOLOGY       19,827       12,112,876       0.020211       1,811       37       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI	52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 647, 210	26, 486, 133	0.06219	0	0	52.00
55. 00       05500       RADI 0L CGY-THERAPEUTI C       766, 433       36, 660, 309       0. 020906       0       0       55. 00         57. 00       05700       CT SCAN       333, 063       76, 344, 460       0. 004363       85, 336       372       57. 00         58. 00       05800       MRI       474, 455       20, 041, 330       0. 023674       7, 409       175       58. 00         59. 00       0ABD (ACATHETERI ZATI ON       6, 718       4, 477, 421       0. 001500       0       0       59. 00         60. 00       06400       INTRAVENOUS THERAPY       482, 126       128, 855, 828       0. 003766       19, 527       308       65. 00         66. 00       06600       RESPI RATORY       THERAPY       706, 198       29, 409, 971       0. 024012       52, 109       1, 251       66. 00         67. 00       06700       OCUPATI ONAL THERAPY       114, 786       8, 781, 809       0. 013071       51, 116       66. 87. 00         69. 00       06000       SPECEH PATHOLOGR       19, 327       12, 112, 876       0. 001506       20, 156       32       69. 00         71. 00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       1, 147, 254       457, 698       0. 021039       <	54. 00 05400 RADI OLOGY-DI AGNOSTI C	811, 268	41, 882, 101	0. 01937	70 34, 272	664	54.00
58. 00       05800       NRI       474, 455       20, 041, 330       0.023674       7, 409       175       58. 00         59. 00       05900       CARDI AC CATHETERI ZATI 0N       6, 718       4, 477, 421       0.001500       0       0       59. 00         60. 00       06000       LABORATORY       422, 126       128, 855, 828       0.003742       851, 356       63. 186       60. 00         64. 00       06400       INTRAVENOUS THERAPY       444, 157       28, 171, 592       0.015766       19, 527       308       65. 00         65. 00       06600       PHYSI CAL THERAPY       706, 198       29, 409, 991       0.024012       52, 109       1, 251       66. 00         67. 00       06700       0CUPATI ONAL THERAPY       114, 786       8, 781, 809       0.013071       51, 116       668       67. 00         69. 00       6900       ELECTROCARDI OLOGY       19, 873       22, 215, 016       0.008972       6, 506       58       68. 00         70. 00       07000       ELECTROCARDI OLOGY       19, 327       12, 112, 876       0.001596       20, 156       32       69. 00       72. 00       73. 00       73. 00       73. 00       73. 00       73. 00       73. 00       73. 00	55. 00 05500 RADI OLOGY-THERAPEUTI C	766, 433	36, 660, 309	0. 02090		0	55.00
58. 00       05800       NRI       474, 455       20, 041, 330       0.023674       7, 409       175       58. 00         59. 00       05900       CARDI AC CATHETERI ZATI 0N       6, 718       4, 477, 421       0.001500       0       0       59. 00         60. 00       06000       LABORATORY       422, 126       128, 855, 828       0.003742       851, 356       63. 186       60. 00         64. 00       06400       INTRAVENOUS THERAPY       444, 157       28, 171, 592       0.015766       19, 527       308       65. 00         65. 00       06600       PHYSI CAL THERAPY       706, 198       29, 409, 991       0.024012       52, 109       1, 251       66. 00         67. 00       06700       0CUPATI ONAL THERAPY       114, 786       8, 781, 809       0.013071       51, 116       668       67. 00         69. 00       6900       ELECTROCARDI OLOGY       19, 873       22, 215, 016       0.008972       6, 506       58       68. 00         70. 00       07000       ELECTROCARDI OLOGY       19, 327       12, 112, 876       0.001596       20, 156       32       69. 00       72. 00       73. 00       73. 00       73. 00       73. 00       73. 00       73. 00       73. 00						372	57.00
59.00       CARDI AC CATHETERI ZATI 0N       6,718       4,477,421       0.001500       0       0       59.00         60.00       06000       LABORATORY       482,126       128,855,828       0.003742       851,356       3,186       60.00         64.00       06400       INTRAVENUS THERAPY       244,082       22,855,828       0.003742       851,356       3,186       60.00         65.00       06500       RESPI RATORY THERAPY       4444,157       28,171,592       0.015766       19,527       308       65.00         66.00       06000       PHYSI CAL THERAPY       706,198       29,409,991       0.024012       52,109       1,251       66.06         67.00       0COUPOT IONAL THERAPY       114,786       8,781,809       0.013071       151,116       66.86       70.00         68.00       06900       ELECTROCARDI LOGY       19,873       2,215,016       0.001596       20,156       32       69.07         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       1,623,045       77,145,878       0.021039       70.356       1,480       71.07         73.00       07300       DRUS CHARGED TO PATI ENTS       1,437,335       123,804,819       0.011610       499,111       5,757						175	58.00
60.00       06000       LABORATORY       482, 126       128, 855, 828       0.003742       851, 356       3, 186       60.00         64.00       064001       INTRAVENOUS THERAPY       244, 082       2, 693, 925       0.090605       22, 741       2, 060       64.00         65.00       065000       RESPI RATORY THERAPY       444, 157       28, 171, 592       0.015766       19, 527       308       65.00         66.00       06700       OCCUPATI ONAL THERAPY       706, 198       29, 409, 991       0.024012       52, 109       1, 251       66.00         67.00       06700       OCCUPATI ONAL THERAPY       114, 786       8, 781, 809       0.013071       51, 116       6688       67.00         69.00       06800       SPEECH PATHOLOGY       19, 873       2, 215, 016       0.000872       6, 506       58       68.00       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       1, 623, 045       77, 145, 878       0.021039       70, 356       1, 440       71.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.01       73.01       73.01       73.01       73.01       73.01       73.01       73.01       73.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td>						-	
64.00       06400       INTRAVENOUS THERAPY       244,082       2,693,925       0.090605       22,741       2,060       64.00         65.00       065000       RESPI RATORY THERAPY       444,157       28,171,592       0.015766       19,527       308       65.00         66.00       06600       PNS1 CAL THERAPY       706,198       29,409,991       0.024012       52,109       1,251       66.00         67.00       06700       0CCUPATI ONAL THERAPY       114,786       8,781,809       0.013071       51,116       66.80       67.00         68.00       068000       ELECTROCARDI OLOGY       19,327       12,112,876       0.001596       20,156       32.69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       276,794       13,688,767       0.020221       1,811       37       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       1,447,254       45,765,998       0.021039       70,356       1,440       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       1,437,335       123,804,819       0.011610       499,111       5,757       73.00       73.00       73.00       73.00       73.00       73.00       73.00       74.00       74.00						-	
65:00       06500       RESPI RATORY THERAPY       444, 157       28, 171, 592       0.015766       19, 527       308       65.00         66:00       06600       PHYSI CAL THERAPY       706, 198       29, 409, 991       0.024012       52, 109       1, 251       66.00         067:00       0C0/DO OCCUPATI ONAL THERAPY       114, 786       8, 781, 809       0.013071       51, 116       666.06       68.00         068:00       SPEECH PATHOLOGY       19, 873       2, 215, 016       0.008972       6, 506       58       68.00         06:00       06000       ELECTROCARDI OLOGY       19, 327       12, 112, 876       0.001596       20, 156       32.69.00       67.00         0:00       07000       IMPL. DEV. CHARGED TO PATI ENT       1, 623, 045       77, 145, 878       0.021039       70, 356       1, 480       77.00       73.00         73.00       07300       IMPL. DEV. CHARGED TO PATI ENTS       1, 437, 335       123, 804, 819       0.011610       499, 111       5, 75       73.00         74.00       07400       RENAL DI ALYP HARMACY       535, 100       20, 01685       0.026741       0       0       74.00         76.01       03950       OTHER ANCI LLARY SERVI CE COST CENTERS       0       0.0000							
66.00       06600       PHYSI CAL THERAPY       706, 198       29, 409, 991       0.024012       52, 109       1, 251       66.00         67.00       0CCUPATI ONAL THERAPY       114, 786       8, 781, 809       0.013071       51, 116       668       67.00         68.00       06900       ELECTROCARDI OLOGY       19, 873       2, 215, 016       0.008972       6, 506       58       68.00         69.00       06900       ELECTROCARDI OLOGY       19, 873       2, 215, 016       0.001596       20, 156       32       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       276, 794       13, 688, 767       0.021203       70, 356       1, 480       71.00         71.00       07100       IBDI CAL SUPPLI ES CHARGED TO PATI ENTS       1, 147, 254       45, 765, 998       0.025068       0       0       72.00         73.00       07300       RUGS CHARGED TO PATI ENTS       1, 437, 335       123, 804, 819       0.011610       499, 111       5, 795       73.00         73.01       07301       SPECI ALTY PHARMACY       535, 100       20,010, 685       0.026741       0       74.00       76.00         76.02       03950       OTHER ANCI LLARY SERVICE COST CENTERS       0       0.0000000							
67.00       06700       0CCUPATI 0NAL THERAPY       114,786       8,781,809       0.013071       51,116       668       67.00         68.00       06800       SPEECH       PATHOLOGY       19,873       2,215,016       0.008972       6,506       58       68.00         69.00       06900       ELECTROCARDI 0LOGY       19,873       2,215,016       0.008972       6,506       58       68.00         70.00       07000       ELECTROENCEPHALOGRAPHY       276,794       13,688,767       0.020221       1,811       37       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       1,623,045       77,145,878       0.021039       70,356       1,480       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       1,447,335       123,804,819       0.011610       499,111       5,795       73.00         73.01       07301       SPECI ALTY PHARMACY       535,100       20,010,685       0.025665       0       0       74.00         74.00       03305       NDMSCOPY       656,996       25,400,941       0.025865       0       0       76.00       76.00       0       0.000000       0       76.00       0       0.0000000       0       76.00<							
68.00         06800         SPEECH PATHOLOGY         19,873         2,215,016         0.008972         6,506         58         68.00           69.00         06900         ELECTROCARDI OLOGY         19,327         12,112,876         0.001596         20,156         32         69.00           70.00         07000         ELECTROENCEPHALOGRAPHY         276,794         13,688,767         0.021039         70.356         1,480         77.00           71.00         07100         MEDL CAL SUPPLIES CHARGED TO PATIENT         1,623,045         77,145,878         0.021039         70,356         1,480         77.00           73.00         07300         DRUGS CHARGED TO PATIENTS         1,147,254         45,765,998         0.025068         0         73.00           73.01         07300         DRUGS CHARGED TO PATIENTS         1,437,335         123,804,819         0.011610         499,111         5,795         73.00           74.00         07400         RENAL DI ALYSI S         37,527         4,194,423         0.008947         0         0         74.00           76.01         03950         OTHER ANCI LLARY SERVICE COST CENTERS         0         0         0.000000         0         76.00           76.02         03951         OTHER ANCI							
69.00       06900       ELECTROCARDIOLOGY       19,327       12,112,876       0.001596       20,156       32       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       276,794       13,688,767       0.020221       1,811       37       70.00         71.00       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       1,623,045       77,145,878       0.021039       70,356       1,480       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       1,147,254       45,765,998       0.025068       0       0       72.00         73.00       07301       SPECI ALTY PHARMACY       535,100       20,010,685       0.026741       0       0       73.00         74.00       07400       RENAL DI ALYSI S       37,527       4,194,423       0.008947       0       76.00         76.01       03950       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0.000000       0       76.00         76.02       03951       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0.0000000       0       76.00         76.04       03952       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0.0000000       0       76.00         76.02       03954<							
70.00       07000       ELECTROENCEPHALOGRAPHY       276,794       13,688,767       0.020221       1,811       37       70.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       1,623,045       77,145,878       0.021039       70,356       1,480       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATIENTS       1,147,254       45,765,998       0.025068       0       0       72.00         73.01       07300       DRUGS CHARGED TO PATIENTS       1,437,335       123,804,819       0.011610       499,111       5,795       73.00         74.00       07400       RENAL DI ALYSI S       37,527       4,194,423       0.008947       0       0       74.00         76.00       03330       ENDOSCOPY       656,996       25,400,941       0.025865       0       0       76.00         76.02       03950       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0.000000       0       76.00         76.04       03953       WOUND CARE       8,141       1,146,994       0.007098       0       76.00         76.07       03954       IMAGI NG CENTER       247,325       24,820,012       0.009965       0       76.00							
71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       1,623,045       77,145,878       0.021039       70,356       1,480       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       1,147,254       45,765,998       0.025068       0       0       72.00         73.00       DRUGS CHARGED TO PATIENTS       1,437,335       123,804,819       0.011610       499,111       5,795       73.00         74.00       O7400       RENAL DIALYSIS       37,527       4,194,423       0.008947       0       74.00         76.00       03305       ENDOSCOPY       656,996       25,400,941       0.025865       0       0       76.00         76.01       03950       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0.000000       0       76.00         76.02       03951       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0.000000       0       76.00         76.04       03953       WOUND CARE       8,141       1,146,994       0.007098       0       76.00         76.07       03955       BREAST DI AGNOSTIC CENTER       247,325       24,820,012       0.009965       0       76.00         76.07       03955       BREAST DI AGNOSTIC CE							
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       1,147,254       45,765,998       0.025068       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       1,437,335       123,804,819       0.011610       499,111       5,795       73.00         73.01       07301       SPECI ALTY PHARMACY       535,100       20,010,685       0.026741       0       0       73.00         74.00       07400       RENAL DI ALYSI S       37,527       4,194,423       0.008947       0       74.00         76.00       03305       ENDOSCOPY       656,996       25,400,941       0.025865       0       0       76.00         76.02       03950       OTHER ANCI LLARY SERVI CE COST CENTERS       0       0       0.000000       0       76.00         76.02       03951       OTHER ANCI LLARY SERVI CE COST CENTERS       0       0       0.0000000       0       76.02         76.03       03952       OTHER ANCI LLARY SERVI CE COST CENTERS       0       0       0.0000000       0       76.02         76.04       03953       WOUND CARE       8,141       1,146,994       0.00758       0       76.02         76.07       03955       BREAST DI AGNOSTI C CENT							
73.00       07300       DRUGS CHARGED TO PATIENTS       1,437,335       123,804,819       0.011610       499,111       5,795       73.00         73.01       07301       SPECIALTY PHARMACY       535,100       20,010,685       0.026741       0       73.00         74.00       07400       RENAL DIALYSIS       37,527       4,194,423       0.008947       0       74.00         76.00       03330       ENDOSCOPY       656,996       25,400,941       0.025865       0       0       76.00         76.02       03950       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0.000000       0       76.00         76.03       03952       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0.000000       0       76.00         76.04       03953       WOUND CARE       8,141       1,146,994       0.007098       0       76.00         76.05       03954       IMAGI NG CENTER       464,157       59,828,850       0.007758       0       76.00         76.07       03955       BREAST DI AGNOSTI C CENTER       247,325       24,820,012       0.009965       0       76.00         70.01       04950       INFUSI ON CENTER       40,631       619,794       0							
73. 01       07301       SPECI ALTY PHARMACY       535, 100       20, 010, 685       0. 026741       0       73. 0         74. 00       07400       RENAL DI ALYSI S       37, 527       4, 194, 423       0. 008947       0       0       74. 00         76. 00       0330       ENDOSCOPY       656, 996       25, 400, 941       0. 025865       0       0       76. 00         76. 01       03950       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0. 000000       0       76. 00         76. 02       03951       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0. 000000       0       76. 00         76. 04       03952       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0. 000000       0       76. 00         76. 04       03952       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0. 000000       0       76. 00         76. 04       03953       WOUND CARE       8, 141       1, 146, 994       0. 007798       0       0       76. 00         76. 04       03955       BREAST DI AGNOSTI C CENTER       464, 157       59, 828, 850       0. 007758       0       0       76. 00         76. 07       03955       BREAST DI							
74.00       07400       RENAL DI ALYSI S       37, 527       4, 194, 423       0.008947       0       0       74.00         76.00       0330       ENDOSCOPY       656, 996       25, 400, 941       0.025865       0       0       76.00         76.01       03950       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0.000000       0       76.00         76.02       03951       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0.000000       0       76.00         76.03       03952       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0.000000       0       76.00         76.04       03953       WOUND CARE       8, 141       1, 146, 994       0.007098       0       76.00         76.04       03954       IMAGI NG CENTER       464, 157       59, 828, 850       0.007758       0       0       76.00         76.07       03955       BREAST DI AGNOSTI C CENTER       247, 325       24, 820, 012       0.009965       0       76.00         70.01       04950       I NFUSI ON CENTER       40, 631       619, 794       0.065556       0       0       90.00         90.26       04975       SPI NE CENTER       7, 487							
76. 00       03330       ENDOSCOPY       656, 996       25, 400, 941       0. 025865       0       0       76. 00         76. 01       03950       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0. 000000       0       76. 00         76. 02       03951       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0. 000000       0       76. 00         76. 03       03952       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0. 000000       0       76. 00         76. 04       03953       WOUND CARE       8, 141       1, 146, 994       0. 007098       0       76. 00         76. 06       03954       IMAGI NG CENTER       464, 157       59, 828, 850       0. 007758       0       0       76. 00         76. 07       03955       BREAST DI AGNOSTI C CENTER       247, 325       24, 820, 012       0. 009965       0       76. 00         76. 07       03950       I NFUSI ON CENTER       406, 631       619, 794       0. 065556       0       0       90. 00         90. 01       04950       I NFUSI ON CENTER       7, 487       633, 756       0. 011814       0       0       90. 02         90. 26       04975       SPI NE CENTER						-	
76. 01       03950       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0.000000       0       76. 00         76. 02       03951       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0.000000       0       76. 00         76. 03       03952       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0.000000       0       76. 00         76. 04       03953       WOUND CARE       8, 141       1, 146, 994       0.007098       0       76. 00         76. 04       03954       I MAGI NG CENTER       464, 157       59, 828, 850       0.007758       0       76. 00         76. 07       03955       BREAST DI AGNOSTIC CENTER       247, 325       24, 820, 012       0.009965       0       76. 00         76. 07       03955       BREAST DI AGNOSTIC CENTER       247, 325       24, 820, 012       0.009965       0       0       76. 00         00100       CLINIC       0       0       0.000000       0       0       90. 00         90. 00       OPOOO       CLINIC       0       0       0.005556       0       0       90. 00         90. 10       04905       INFUSION CENTER       7, 487       633, 756       0.011814 <td< td=""><td></td><td></td><td></td><td></td><td></td><td>-</td><td></td></td<>						-	
76. 02       03951       0THER ANCI LLARY SERVICE COST CENTERS       0       0       0.000000       0       76. 00         76. 03       03952       0THER ANCI LLARY SERVICE COST CENTERS       0       0       0.000000       0       76. 00         76. 04       03953       WOUND CARE       8, 141       1, 146, 994       0.007098       0       76. 00         76. 04       03954       I MAGI NG CENTER       464, 157       59, 828, 850       0.007758       0       0       76. 00         76. 07       03955       BREAST DI AGNOSTIC CENTER       247, 325       24, 820, 012       0.009965       0       0       76. 00         00000       CLINIC       0       0       0.005556       0       0       90. 00         90. 00       OUTPATIENT SERVICE COST CENTER       40, 631       619, 794       0.065556       0       90. 00       90. 00         90. 01       04950       INFUSION CENTER       7, 487       633, 756       0.011814       0       90. 02       90. 02         91. 00       09100       EMERGENCY       1, 347, 421       170, 590, 727       0.007899       377, 837       2, 985       91. 00         92. 00       09200       0BSERVATI ON BEDS (NON-DI STI NCT							
76.03       03952       OTHER ANCI LLARY SERVICE COST CENTERS       0       0.000000       0       76.02         76.04       03953       WOUND CARE       8,141       1,146,994       0.007098       0       76.02         76.05       03954       I MAGI NG CENTER       464,157       59,828,850       0.007758       0       0       76.02         76.07       03955       BREAST DI AGNOSTI C CENTER       247,325       24,820,012       0.009965       0       76.02         0UTPATIENT SERVICE COST CENTER       0       0       0.000000       0       90.00       76.02         00000       CLINIC       0       0       0.000000       0       90.02       90.00		-	-				
76. 04       03953       WOUND CARE       8, 141       1, 146, 994       0. 007098       0       76. 04         76. 06       03954       I MAGI NG CENTER       464, 157       59, 828, 850       0. 007758       0       0       76. 04         76. 07       03955       BREAST DI AGNOSTI C CENTER       247, 325       24, 820, 012       0. 009965       0       0       76. 04         0UTPATI ENT SERVICE COST CENTER       247, 325       24, 820, 012       0. 009965       0       0       76. 04         90. 00       09000       CLINIC       0       0. 000000       0       90. 00       90. 00         90. 01       04950       INFUSI ON CENTER       40, 631       619, 794       0. 065556       0       90. 00       90. 02         90. 26       04975       SPI NE CENTER       7, 487       633, 756       0. 011814       0       0       90. 20         91. 00       09100       EMERGENCY       1, 347, 421       170, 590, 727       0. 007899       377, 837       2, 985       91. 00         92. 00       09200       0BSERVATION BEDS (NON-DI STINCT PART       0       12, 733, 573       0. 000000       0       0       92. 00		-	-				
76. 06       03954       I MAGI NG CENTER       464, 157       59, 828, 850       0.007758       0       76. 07         03955       BREAST DI AGNOSTI C CENTER       247, 325       24, 820, 012       0.009965       0       76. 07         0UTPATI ENT SERVICE COST CENTER       247, 325       24, 820, 012       0.009965       0       76. 07         90. 00       09000       CLINIC       0       0.000000       0       90. 00         90. 01       04950       INFUSI ON CENTER       40, 631       619, 794       0.065556       0       90. 00         90. 26       04975       SPINE CENTER       7, 487       633, 756       0.011814       0       0       90. 20         91. 00       09100       EMERGENCY       1, 347, 421       170, 590, 727       0.007899       377, 837       2, 985       91. 00         92. 00       09200       0BSERVATI ON BEDS (NON-DI STI NCT PART       0       12, 733, 573       0.000000       0       0       92. 00		-	-				
76. 07       03955       BREAST DI AGNOSTI C CENTER       247, 325       24, 820, 012       0.009965       0       76. 0         OUTPATI ENT SERVICE COST CENTER       0       0       0.000000       0       0.000000       0       90. 00         90. 00       09000       CLINIC       0       0       0.000000       0       90. 00         90. 01       04950       INFUSION CENTER       40, 631       619, 794       0.065556       0       90. 00         90. 26       04975       SPINE CENTER       7, 487       633, 756       0.011814       0       0       90. 02         91. 00       09100       EMERGENCY       1, 347, 421       170, 590, 727       0.007899       377, 837       2, 985       91. 00         92. 00       09200       0BSERVATI ON BEDS (NON-DI STI NCT PART       0       12, 733, 573       0.000000       0       0       92. 00							
OUTPATI ENT SERVICE COST CENTERS           90.00         09000         CLINIC         0         0.000000         0         90.00         90.00           90.01         04950         INFUSION CENTER         40, 631         619, 794         0.065556         0         90.00         90.00           90.26         04975         SPINE CENTER         7, 487         633, 756         0.011814         0         90.20         90.20           91.00         09100         EMERGENCY         1, 347, 421         170, 590, 727         0.007899         377, 837         2, 985         91.00           92.00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART         0         12, 733, 573         0.000000         0         0         92.00							
90.00         OPODO         CLINIC         0         0.00000         0.000000         0         90.00         90.00           90.01         04950         INFUSION CENTER         40,631         619,794         0.065556         0         90.00         90.00           90.26         04975         SPINE CENTER         7,487         633,756         0.011814         0         90.20           91.00         09100         EMERGENCY         1,347,421         170,590,727         0.007899         377,837         2,985         91.00           92.00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART         0         12,733,573         0.000000         0         92.00		247, 325	24, 820, 012	0.00998	05 0	0	/6.0/
90. 01       04950       INFUSION CENTER       40, 631       619, 794       0. 065556       0       90. 0'         90. 26       04975       SPINE CENTER       7, 487       633, 756       0. 011814       0       90. 2'         91. 00       09100       EMERGENCY       1, 347, 421       170, 590, 727       0. 007899       377, 837       2, 985       91. 0'         92. 00       09200       0BSERVATION BEDS (NON-DISTINCT PART       0       12, 733, 573       0. 000000       0       92. 0'		-		0.0000			00.00
90. 26       04975       SPI NE_CENTER       7, 487       633, 756       0. 011814       0       0       90. 24         91. 00       09100       EMERGENCY       1, 347, 421       170, 590, 727       0. 007899       377, 837       2, 985       91. 00         92. 00       09200       OBSERVATI ON_BEDS_(NON-DI STINCT_PART       0       12, 733, 573       0. 000000       0       0       92. 00		-	-				
91. 00 09100 EMERGENCY 1, 347, 421 170, 590, 727 0. 007899 377, 837 2, 985 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 12, 733, 573 0. 000000 0 0 92. 00							
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 12, 733, 573 0. 000000 0 92. 00							
200.00    Total (Tines 50 through 199)   18,056,667  1,240,767,325    2,099,643  19,071 200.00		-				-	
	200.00  lotal (lines 50 through 199)	18, 056, 667	1, 240, 767, 325	I	2, 099, 643	19, 071	J200. 00

Health Financial Systems COMM	IUNI TY HOSPI TAL O	)FINDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provider C	CN: 15-0169	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2019	Part IV	
		Component	CCN: 15-S169	To 12/31/2019	Date/Time Pre 6/30/2020 2:1	pared: 6 pm
		Title	XVIII	Subprovider -	PPS	
				IPF		
Cost Center Description			Nursing Scho	ol Allied Health	Allied Health	
	Anesthetist P	Post-Stepdown		Post-Stepdown		
		Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1 1					
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	-	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58. 00 05800 MRI	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
64.00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
73. 01 07301 SPECIALTY PHARMACY	0	0		0 0	0	73.01
74. 00 07400 RENAL DI ALYSI S	0	0		0 0	0	74.00
76. 00 03330 ENDOSCOPY	0	0		0 0	0	76.00
76.01 03950 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0 0	0	76.01
76. 02 03951 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0 0	0	76.02
76. 03 03952 OTHER ANCI LLARY SERVICE COST CENTERS	0	0			0	76.02
76.04 03953 WOUND CARE	0	0		0 0	0	76.04
76. 06 03954 I MAGI NG CENTER	0	0		0 0	0	76.04
76. 07 03955 BREAST DI AGNOSTI C CENTER	0	0		0 0	0	76.07
OUTPATIENT SERVICE COST CENTERS	U U	0		0 0	0	/0.0/
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 04950 I NFUSI ON CENTER	0	0		0 0	-	90.00
90. 26 04975 SPI NE CENTER	0	0			0	90.26
91. 00 09100 EMERGENCY	0	0			0	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0	0	91.00
200.00 Total (lines 50 through 199)	0	0		0 0	-	200.00
	I O	0	I	с <sub>1</sub> 0	0	200.00

Health Financial Systems CO	MMUNI TY HOSPI TAL	OF INDIANA, I	NC.	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	ERVICE OTHER PAS	S Provider C		Period:	Worksheet D	
THROUGH COSTS		Component		From 01/01/2019 To 12/31/2019		narod
		component	CCN. 15-3109	10 12/31/2019	6/30/2020 2:1	
		Title	e XVIII	Subprovider -	PPS	<u> </u>
				I PF		
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
	4.00	5.00	(	7.00	instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS		0	J		0.000000	F0 00
50. 00 05000 OPERATING ROOM				206, 913, 833		
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM		0		0 35, 335, 484		
	0			26, 486, 133		
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C				0 41, 882, 101	0.00000	
				0 36, 660, 309		
57. 00 05700 CT SCAN				0 76, 344, 460		•
58. 00   05800   MRI 59. 00   05900   CARDI AC   CATHETERI ZATI ON				20, 041, 330 4 477 421		
				., ., .,	0.00000	
60. 00  06000  LABORATORY 64. 00  06400  I NTRAVENOUS_THERAPY				120,000,020		
65. 00 06500 RESPIRATORY THERAPY				2, 693, 925 28, 171, 592		
66. 00 06600 PHYSI CAL THERAPY				29, 409, 991	0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY				8, 781, 809		
68. 00 06800 SPEECH PATHOLOGY				2, 215, 016		
69. 00 06900 ELECTROCARDI OLOGY				12, 112, 876		
70. 00 07000 ELECTROENCEPHALOGRAPHY				13, 688, 767		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT				77, 145, 878		
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0		45, 765, 998		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		123, 804, 819		
73. 01 07301 SPECIALTY PHARMACY	0	0		20, 010, 685		
74. 00 07400 RENAL DI ALYSI S	0	0		4, 194, 423		
76. 00 03330 ENDOSCOPY	0	0		25, 400, 941	0.000000	
76. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0		
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	C		0 0	0.000000	
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	C		0 0	0.000000	
76.04 03953 WOUND CARE	0	C		0 1, 146, 994		
76. 06 03954 I MAGI NG CENTER	0	C		59, 828, 850	0.000000	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0		24, 820, 012	0.000000	76.07
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	C	) ()	0 C		
90. 01 04950 INFUSION CENTER	0	0		0 619, 794	0.000000	90.01
90. 26 04975 SPI NE CENTER	0	0		0 633, 756	0.000000	90.26
91. 00 09100 EMERGENCY	0	0		0 170, 590, 727		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0 12, 733, 573	0.000000	92.00
200.00 Total (lines 50 through 199)			'l '	0 1, 240, 767, 325		200.00

Health Financial Systems COM	MUNITY HOSPITAL O	F_INDIANA, IN	NC.	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	Provider C	CN: 15-0169	Peri od:	Worksheet D	
THROUGH COSTS		Component (	CCN: 15-S169	From 01/01/2019 To 12/31/2019		
		Title	e XVIII	Subprovider -	PPS	o pii
				I PF		
Cost Center Description	Outpatient	Inpati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	5	Pass-Through	
	(col. 6 ÷ col. 7)		Costs (col. x col. 10)	8	Costs (col. 9	
	9.00	10.00	11.00	12.00	x col. 12) 13.00	
ANCI LLARY SERVI CE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
50. 00 05000 OPERATI NG ROOM	0.000000	0		0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	34, 272			0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	34, 272			0	55.00
57. 00 05700 CT SCAN	0. 000000	85, 336			0	57.00
58. 00 05800 MRI	0. 000000	7, 409			0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	7,409			0	59.00
60. 00 06000 LABORATORY	0. 000000	851, 356			0	60.00
64. 00 06400 INTRAVENOUS THERAPY	0. 000000	22, 741			0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	19, 527			0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				0	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	52, 109			-	66.00
	0. 000000	51, 116 6, 506			0	67.00
	0. 000000				-	68.00
	1	20, 156			0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	1, 811			0	70.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0. 000000	70, 356			0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	0			0	72.00
	0. 000000	499, 111			0	73.00
73. 01 07301 SPECI ALTY PHARMACY 74. 00 07400 RENAL DI ALYSI S	0. 000000 0. 000000	0			0	
76. 00 03330 ENDOSCOPY	0. 000000	0			0	76.00
		0			0	
	0.000000	0			0	76.01 76.02
		0			0	
76. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS 76. 04 03953 WOUND CARE	0. 000000 0. 000000	0			0	76.03
		0			-	
76.06 03954 I MAGI NG CENTER	0. 000000	0			0	
76. 07 03955 BREAST DI AGNOSTI C CENTER	0. 000000	0		0 0	0	76.07
	0.000000			0		00.00
90. 00 09000 CLINIC	0. 000000	0		0 0	-	
90. 01 04950 INFUSION CENTER	0. 000000	0			0	
90. 26 04975 SPI NE CENTER	0. 000000	0		0	0	
91.00 09100 EMERGENCY	0. 000000	377, 837 0		-	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0			-	
200.00   Total (lines 50 through 199)	1 I	2, 099, 643	I	u U	'I U	200. 00

Heal th	Financial Systems COM	MUNITY HOSPITAL			In Lie	u of Form CMS-:	2552-10
APPORTI	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-0169	Peri od:	Worksheet D	
			Component	CON. 15 6140	From 01/01/2019 To 12/31/2019		nored.
			component	CCN: 15-S169	10 12/31/2019	6/30/2020 2:1	6 pm
			Title	e XVIII	Subprovider -	PPS	<u>o p</u>
					I PF		
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	ANCI LLARY SERVICE COST CENTERS	0 101007			0		50.00
	05000 OPERATI NG ROOM	0. 101237			0 0	0	
	05100 RECOVERY ROOM	0. 164582			0 0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 482762	0		0 0	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 163582	0		0 0	0	54.00
	05500 RADI OLOGY-THERAPEUTI C	0. 072303			0 0	0	55.00
	05700 CT SCAN	0. 033821	0		0 0	0	57.00
	05800 MRI	0. 097663			0 0	0	58.00
	05900 CARDI AC CATHETERI ZATI ON	0. 058919			0 0	0	59.00
	06000 LABORATORY	0. 099707	0		0 0	0	60.00
	06400 I NTRAVENOUS THERAPY	0. 622773			0 0	0	64.00
	06500 RESPI RATORY THERAPY	0. 213983			0 0	0	65.00
	06600 PHYSI CAL THERAPY	0. 319337	0		0 0	0	66.00
	06700 OCCUPATI ONAL THERAPY	0. 291431	0		0 0	0	67.00
	06800 SPEECH PATHOLOGY	0. 199023			0 0	0	68.00
	06900 ELECTROCARDI OLOGY	0. 065654			0 0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0. 205450			0 0	0	70.00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0. 362093			0 0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 431133			0 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 244031	0		0 3, 339	0	73.00
	07301 SPECIALTY PHARMACY	1. 124052	0		0 0	0	73.01
	07400 RENAL DIALYSIS	0. 417271	0		0 0	0	74.00
		0. 147039			0 0	0	76.00
	03950 OTHER ANCI LLARY SERVICE COST CENTERS	0. 000000			0 0	0	76.01
	03951 OTHER ANCI LLARY SERVICE COST CENTERS	0. 000000			0 0	0	76.02
	03952 OTHER ANCI LLARY SERVICE COST CENTERS	0.00000			0	0	76.03
	03953 WOUND CARE	0. 263316			0 0	0	76.04
	03954 I MAGI NG CENTER	0. 085316			0 0	0	76.06
	03955 BREAST_DIAGNOSTIC_CENTER	0. 478585	C	1	0 0	0	76.07
	09000 CLINIC	0. 000000	C		0 0	0	90.00
	04950 INFUSION CENTER	0. 529334			0 0	0	90.00
	04950 SPINE CENTER	0. 529334			0 0	0	90.01
	09100 EMERGENCY	0. 327170			0 0	0	90.20
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 719239			0 0	0	91.00
92.00 200.00	Subtotal (see instructions)	0. / 19239			0 3, 339	-	200.00
200.00	Less PBP Clinic Lab. Services-Program				0 3, 339	0	200.00
201.00	Only Charges				0		201.00
202.00	Net Charges (line 200 - line 201)		C		0 3, 339	n	202.00
202.00		Į.		Т	5, 557	0	1202.00

	UNI TY HOSPI TAL	OF INDIANA, IN	NC.	In Lie	u of Form CMS-	2552-1
PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0169	Peri od:	Worksheet D	
		Component	CCN: 15-S169	From 01/01/2019 To 12/31/2019	Part V Date/Time Pre 6/30/2020 2:1	
		Title	e XVIII	Subprovider -	PPS	
	Cos	sts		I PF		
Cost Center Description	Cost	Cost	1			
	Reimbursed	<b>Reimbursed</b>				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS		0	1			1 50 0
0. 00 05000 OPERATING ROOM	0	0				50.00
1.00 05100 RECOVERY ROOM	0	0				51.0
2. 00 05200 DELIVERY ROOM & LABOR ROOM 4. 00 05400 RADIOLOGY-DIAGNOSTIC	0	0	•			52.0
4. 00  05400  RADI OLOGY-DI AGNOSTI C 5. 00  05500  RADI OLOGY-THERAPEUTI C	0	0				54.0
7. 00 05700 CT SCAN	0	0				57.0
8. 00 05800 MRI	0	0				58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.0
0. 00 06000 LABORATORY	0	0	•			60.0
4. 00 06400 INTRAVENOUS THERAPY	0	0				64.0
5. 00 06500 RESPIRATORY THERAPY	0	0				65.0
6. 00 06600 PHYSI CAL THERAPY	0	0				66.0
7. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.0
8. 00 06800 SPEECH PATHOLOGY	0	0				68.0
9. 00 06900 ELECTROCARDI OLOGY	0	0				69.0
0. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	•			70.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.0
2.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	0	815				73.0
3. 01 07301 SPECIALTY PHARMACY	0	0				73.0
4. 00 07400 RENAL DIALYSIS	0	0				74.0
6. 00 03330 ENDOSCOPY	0	0				76. C
6.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0				76. C
6.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0				76. C
6.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0				76.0
6.04 03953 WOUND CARE	0	0				76.0
6.06 03954 I MAGI NG CENTER	0	0				76.0
6.07 03955 BREAST DIAGNOSTIC CENTER	0	0				76.0
OUTPATIENT SERVICE COST CENTERS	1		1			
0. 00 09000 CLINIC	0	0				90.0
0. 01 04950 INFUSION CENTER	0	0	•			90.0
0. 26 04975 SPINE CENTER	0	0				90.2
1.00 09100 EMERGENCY	0	0				91.0
	0	0				92.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		045				1000 0
00.00 Subtotal (see instructions)	0	815				
	0 0	815				200. 00 201. 00

Health Financial Systems	COMMUNI TY HOSPI TAL				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CA	API TAL COSTS	Provider C		Period: From 01/01/2019 To 12/31/2019		pared: 6 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	i					
30. 00 ADULTS & PEDIATRICS	8, 140, 148	0	8, 140, 14	8 65, 148	124.95	30.00
31.00 INTENSIVE CARE UNIT	1, 656, 112		1, 656, 112	2 6, 544	253.07	31.00
35.00 NEONATAL INTENSIVE CARE UNIT	1, 608, 969		1, 608, 96	9 11, 655	138.05	35.00
40. 00 SUBPROVIDER - IPF	316, 012	0	316, 01	2 5, 142	61.46	40.00
43.00 NURSERY	620, 889		620, 88	9 7, 388	84.04	43.00
200.00 Total (lines 30 through 199)	12, 342, 130		12, 342, 13	0 95, 877		200.00
Cost Center Description	I npati ent	Inpatient			•	
·	Program days	Program				
	0 9	Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	2, 470	308, 627				30.00
31.00 INTENSIVE CARE UNIT	0	0				31.00
35.00 NEONATAL INTENSIVE CARE UNIT	1, 717	237, 032				35.00
40. 00 SUBPROVIDER - IPF	0	0				40.00
43.00 NURSERY	2, 781	233, 715				43.00
200.00 Total (lines 30 through 199)	6, 968	779, 374	1			200.00

	MUNITY HOSPITAL				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C	CN: 15-0169	Peri od:	Worksheet D	
				From 01/01/2019	Part II	
				To 12/31/2019	Date/Time Pre 6/30/2020 2:1	pared:
		Ti +1	e XIX	Hospi tal	PPS	o pili
Cost Center Description	Capi tal	Total Charges	Patio of Cos	t Inpatient	Capital Costs	
obst denter beschiption		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B.		(col. 1 ÷ col		column 4)	
	Part II, col.	8)	2)	. ondriges		
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
50. 00 05000 OPERATING ROOM	3, 568, 927	206, 913, 833	0. 01724	18 2, 374, 707	40, 959	50. 00
51. 00 05100 RECOVERY ROOM	588, 831				6, 939	•
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 647, 210					
	811, 268		0.0193		11, 665	
55. 00 05500 RADI OLOGY-THERAPEUTI C	766, 433				6, 740	
57. 00 05700 CT SCAN	333, 063					
58. 00 05800 MRI	474, 455					
59. 00 05900 CARDI AC CATHETERI ZATI ON	6, 718		0.00150			
60. 00 06000 LABORATORY	482, 126					
64.00 06400 INTRAVENOUS THERAPY	244, 082	2, 693, 925				
65. 00 06500 RESPI RATORY THERAPY	444, 157		0. 01576			
66. 00 06600 PHYSI CAL THERAPY	706, 198	29, 409, 991	0. 0240	12 156, 664	3, 762	66.00
67.00 06700 OCCUPATI ONAL THERAPY	114, 786	8, 781, 809	0.0130	71 306, 274	4, 003	67.00
68.00 06800 SPEECH PATHOLOGY	19, 873	2, 215, 016	0.0089	72 99, 121	889	68.00
69. 00 06900 ELECTROCARDI OLOGY	19, 327	12, 112, 876	0.00159	96 436, 492	697	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	276, 794	13, 688, 767	0. 02022	125, 440	2, 537	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 623, 045	77, 145, 878	0. 02103	1, 335, 639	28, 101	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 147, 254	45, 765, 998	0. 02506	58 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 437, 335	123, 804, 819	0. 0116	10 4, 131, 775	47, 970	73.00
73.01 07301 SPECIALTY PHARMACY	535, 100					
74.00 07400 RENAL DIALYSIS	37, 527				1, 193	74.00
76. 00 03330 ENDOSCOPY	656, 996		0. 02586			
76. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0000,770	20,100,71	0. 00000			
76. 02 03951 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0. 00000		0	
76. 03 03952 OTHER ANCI LLARY SERVICE COST CENTERS	0	, o	0.00000		0	•
76. 04 03953 WOUND CARE	8, 141	, o			-	
76. 06 03954 I MAGI NG CENTER	464, 157					76.02
76. 07 03955 BREAST DI AGNOSTI C CENTER	247, 325	24, 820, 012	0.00996	000000000000000000000000000000000000000	0	76.07
			0.0000			
90. 00 09000 CLINIC	0	-			-	
90. 01 04950 INFUSION CENTER	40, 631				-	
90. 26 04975 SPI NE CENTER	7,487				0	
91.00 09100 EMERGENCY	1, 347, 421					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	955, 982					
200.00 Total (lines 50 through 199)	19, 012, 649	1, 240, 767, 325		21, 241, 601	287, 147	200.00

Health Financial Systems	COMMUNI TY HOSPI TAL	OF INDIANA, IN	NC.	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OT	HER PASS THROUGH COS <sup>-</sup>		F	Period: From 01/01/2019 Fo 12/31/2019	Date/Time Pre 6/30/2020 2:1	epared: 6 pm
			e XIX	Hospi tal	PPS	
Cost Center Description		Nursing School		Allied Health	All Other	
	Post-Stepdown		Post-Stepdown		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	(	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	(	0 0	0	31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	0	0	0 0	0	35.00
40. 00 04000 SUBPROVI DER – I PF	0	0	0	0 0	0	40.00
43. 00 04300 NURSERY	0	0	(	0	0	
200.00 Total (lines 30 through 199)	0	0		0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	200100
	Adjustment	(sum of cols.	Days	$5 \div col. 6$	Program Days	
	Amount (see	1 through 3,	bajo			
		minus col. 4)				
	4.00	5.00	6,00	7.00	8,00	
INPATIENT ROUTINE SERVICE COST CENTERS		0100	0.00	1100	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0	65, 148	3 0.00	2, 470	30.00
31. 00 03100 I NTENSI VE CARE UNI T		0	6, 544			
35. 00 02060 NEONATAL INTENSIVE CARE UNIT		0	11, 655			
40. 00 04000 SUBPROVIDER - 1 PF	0	0	5, 142			
43. 00 04300 NURSERY	0	0	7, 388			
200.00 Total (lines 30 through 199)		0	95, 877			200.00
Cost Center Description	I npati ent	0	93, 677	/	0, 900	200.00
cost center bescription	Program					
	Pass-Through					
	Cost (col. 7 x					
	cost (col. 7 x					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	9.00					
	0					30.00
	0					30.00
31.00 03100 I NTENSI VE CARE UNI T	0					
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0					35.00
40. 00 04000 SUBPROVIDER - IPF	0					40.00
						43.00
43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0					200.00

ealth Financial Systems COM PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE		OF INDIANA, II S Provider C	CN: 15-0169	Peri od:	u of Form CMS-2 Worksheet D	2002 1
HROUGH COSTS				From 01/01/2019 To 12/31/2019	Part IV Date/Time Pre 6/30/2020 2:1	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description				Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments	2.00	Adjustments	2.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2A	2.00	3A	3.00	
0. 00 05000 OPERATING ROOM	0	0		0 0	0	50.0
1. 00 05100 RECOVERY ROOM	0	0		0 0	0	
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	
7. 00 05700 CT SCAN	0	C	)	0 0	0	57.0
8. 00 05800 MRI	0	C		0 0	0	58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	C	)	0 0	0	59.0
0. 00 06000 LABORATORY	0	C	)	0 0	0	60.0
4. 00 06400 I NTRAVENOUS THERAPY	0	C		0 0	0	64.0
5. 00 06500 RESPI RATORY THERAPY	0	C	)	0 0	0	65. C
6. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.0
7. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.0
8.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	
9. 00 06900 ELECTROCARDI OLOGY	0	C		0 0	0	0 / 0
0.00 07000 ELECTROENCEPHALOGRAPHY	0	C		0 0	0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	1
3. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
3. 01 07301 SPECIALTY PHARMACY 4. 00 07400 RENAL DIALYSIS	0	0		0 0	0	
6. 00 03330 ENDOSCOPY	0	0		0 0	0	
6. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0	
6. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0			0	
6. 03 03952 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0 0	0	
6. 04 03953 WOUND CARE	0	0		0 0	0	
6. 06 03954 I MAGI NG CENTER	0	0		0 0	0	
6. 07 03955 BREAST DI AGNOSTI C CENTER	0	0		0 0	0	
OUTPATIENT SERVICE COST CENTERS			1			1
0. 00 09000 CLINIC	0	C		0 0	0	90. C
0. 01 04950 INFUSION CENTER	0	C	)	0 0	0	90. C
0. 26 04975 SPI NE CENTER	0	C	)	0 0	0	90.2
1.00 09100 EMERGENCY	0	C		0 0	0	91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92. C
00.00 Total (lines 50 through 199)	0	0		0 0	0	200.0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS       Provider CCN: 15-0169       Period: From 01/01/2019 To 12/31/2019       Worksheet D Part IV Date/Time P 6/30/2020 2         Title XIX       Hospital       PPS         Cost Center Description       All Other Medical Education Cost       Total Cost (sum of cols. 4)       Total Outpatient Cost (sum of cols. 2, 3, 8)       Total Charges (rom Wkst. C, Part I, col. 8)       Ratio of Cos to Charges (col. 5 + co 7)	repared: :16 pm
To     12/31/2019     Date/Time P       Title XIX     Hospital     PP       Cost Center Description     All Other     Total Cost     Total Charges     Ratio of Cost       Medical     (sum of cols.     Outpatient     (from Wkst. C, to Charges     to Cost (sum of Part I, col.     (col. 5 + col)	:16 pm
6/30/2020 2       Title XIX     6/30/2020 2       Title XIX     Hospital     PPS       Cost Center Description     All Other     Total Cost     Total Cost     PPS       Cost Center Description     All Other     Total Cost     Total     Total Charges     Ratio of Cost       Medical     (sum of cols.     Outpatient     (from Wkst. C,     to Charges       Education Cost     1, 2, 3, and     Cost (sum of     Part I, col.     (col. 5 ÷ col)	:16 pm
Title XIXHospitalPPSCost Center DescriptionAll Other MedicalTotal Cost (sum of cols.Total OutpatientTotal Charges (from Wkst. C, to ChargesEducation Cost1, 2, 3, and CostCost (sum of Cost (sum of Cost (sum ofPart I, col.(col. 5 ÷ col	
Cost Center DescriptionAll OtherTotal CostTotalTotal ChargesRatio of CostMedical(sum of cols.Outpatient(from Wkst. C, (from Wkst. C, (col. 5 ÷ col))to Charges	t
Medical (sum of cols. Outpatient (from Wkst. C, to Charges Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ co	
Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ co	
and 4) (see	
instructions	
4.00 5.00 6.00 7.00 8.00	
ANCI LLARY SERVICE COST CENTERS	
50. 00 05000 OPERATING ROOM 0 0 0 206, 913, 833 0.0000	50.00
51. 00 05100 RECOVERY ROOM 0 0 0 35, 335, 484 0.0000	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 26, 486, 133 0.0000	
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 0 0 0 41, 882, 101 0. 0000	
55.00 05500 RADI 0L0GY-THERAPEUTI C 0 0 0 0 0 0 0 0 0 00000	
57. 00 05700 CT SCAN 0 0 0 76, 344, 460 0.0000	
58. 00 05800 MRI 0 0 0 20, 041, 330 0. 0000	
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 4, 477, 421 0.0000	
60. 00 06000 LABORATORY 0 0 0 128, 855, 828 0.0000	
64. 00 06400 I NTRAVENOUS THERAPY 0 0 0 2, 693, 925 0.0000	
65. 00 06500 RESPIRATORY THERAPY 0 0 0 28, 171, 592 0.0000	
66. 00 06600 PHYSI CAL THERAPY 0 0 0 29, 409, 991 0.0000	
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 8, 781, 809 0.0000	
68. 00 06800 SPEECH PATHOLOGY 0 0 0 2, 215, 016 0.0000	
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 12, 112, 876 0.0000	
70. 00 07000 ELECTROEARDIOLOGY 0 0 0 12, 112, 878 0.0000	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 77, 145, 878 0.0000	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 45, 765, 998 0.0000	
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 123, 804, 819 0.0000	
76. 00         03330         ENDOSCOPY         0         0         25, 400, 941         0.0000           76. 01         03950         OTHER         ANCI LLARY         SERVICE         COST         0         0         0         0         0.0000	
76. 02         03951         OTHER         ANCI LLARY         SERVI CE         COST         CENTERS         0         0         0         0.0000           76. 03         03952         OTHER         ANCI LLARY         SERVI CE         COST         CENTERS         0         0         0         0.00000	
76. 04         03953         WOUND_CARE         0         0         1, 146, 994         0. 0000           76. 06         03954         I MAGI NG_CENTER         0         0         0         59, 828, 850         0. 0000	
	76.07
	00 00 00
90. 00 09000 CLINIC 0 0 0 0.0000	
90. 01 04950 I NFUSI ON CENTER 0 0 0 619, 794 0. 0000	
90. 26 04975 SPI NE CENTER 0 0 0 633, 756 0. 0000	
91. 00 09100 EMERGENCY 0 0 170, 590, 727 0. 0000	
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 12, 733, 573 0.0000 200. 00 Total (lines 50 through 199) 0 0 0 1.240, 767, 325	
200.00        Total (lines 50 through 199)       0       0       0       1, 240, 767, 325	200.00

Health Financial Systems COM	MUNITY HOSPITAL O	)FINDIANA, IN	NC.	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA	RVICE OTHER PASS	Provider C	CN: 15-0169	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2019	Part IV	
				To 12/31/2019	Date/Time Pre 6/30/2020 2:1	
		Ti †I	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.	5	Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.000000	2, 374, 707		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	416, 407		0 0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	578, 375		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	602, 217		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	322, 391		0 0	0	55.00
57.00 05700 CT SCAN	0. 000000	1, 215, 313		0 0	0	57.00
58. 00 05800 MRI	0. 000000	328, 109		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	218, 580		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	4, 030, 856	•	0 0	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	77, 412		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	2, 059, 098		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	156, 664		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	306, 274		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	99, 121		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	436, 492		0 0		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	125, 440		0 0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	1, 335, 639		0 0	-	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	4, 131, 775		0 0	0	73.00
73.01 07301 SPECI ALTY PHARMACY	0. 000000	0		0 0	0	73.01
74.00 07400 RENAL DIALYSIS	0. 000000	133, 333		0 0	0	74.00
76.00 03330 ENDOSCOPY	0. 000000	239, 626		0 0	0	76.00
76. 01 03950 OTHER ANCI LLARY SERVICE COST CENTERS	0. 000000	0	0	0 0	0	76.01
76. 02 03951 OTHER ANCI LLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76.02
76. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76.03
76. 04 03953 WOUND CARE	0. 000000	46, 925		0 0	0	76.04
76.06 03954 I MAGI NG CENTER	0. 000000	6, 095		0 0		76.06
76. 07 03955 BREAST DI AGNOSTI C CENTER	0. 000000	0		0 0	0	76.07
OUTPATIENT SERVICE COST CENTERS	0.000000		1			
90. 00 09000 CLINIC	0.000000	0	1	0 0		90.00
90. 01 04950 I NFUSI ON CENTER	0. 000000	0		0 0	-	90.01
90. 26 04975 SPINE CENTER	0. 000000	0		0 0	-	90.26
91.00 09100 EMERGENCY	0. 000000	1, 920, 647		0 0	-	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0. 000000	80, 105		0 0	0	92.00
200.00   Total (lines 50 through 199)		21, 241, 601	I	0 0	0	200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALT	H SERVICES AN	D VACCINE COST	Provider C	CN. 15-0189	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pre 6/30/2020 2:1	pared:
			Ti †I	e XIX	Hospi tal	PPS	
			11.01	Charges	nospi tai	Costs	
Cost Center Description		Cost to Charge	PPS Reimbursed		Cost	PPS Services	
			Services (see		Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	()	
		Part I, col. 9	· · ·	Subject To	Subject To		
				Ded. & Coi ns	. Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM		0. 101237	0	1, 723, 93		0	
51.00 05100 RECOVERY ROOM		0. 164582	0			0	
52.00 05200 DELIVERY ROOM & LABOR ROO	MC	0. 482762	0		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 163582	0	1, 172, 84	17 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 072303	0	467, 98	39 0	0	55.00
57.00 05700 CT SCAN		0. 033821	C	2, 682, 60	)9 0	0	57.00
58. 00 05800 MRI		0. 097663	C	236, 60	02 0	0	58.00
59.00 05900 CARDI AC CATHETERI ZATI ON		0. 058919	C		0 0	0	59.00
60. 00 06000 LABORATORY		0. 099707	C	2, 829, 7	4 0	0	60.00
64.00 06400 INTRAVENOUS THERAPY		0. 622773	C	15, 91	2 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 213983	C	102, 62	28 0	0	65.00
66.00 06600 PHYSI CAL THERAPY		0. 320307	C	211, 07	6 0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY		0. 291431	C	63, 26	0	0	67.00
68.00 06800 SPEECH PATHOLOGY		0. 199023	C	35, 96	6 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 065654	C	66, 31	0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 205450	C	161, 31	3 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED	TO PATIENT	0. 362093	0	434, 68	37 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PAT		0. 431133	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	5	0. 244031	0		2 0	0	
73.01 07301 SPECIALTY PHARMACY		1. 124052	C		0 0	0	73.01
74.00 07400 RENAL DIALYSIS		0. 417271	0		0 0	0	74.00
76. 00 03330 ENDOSCOPY		0. 147039	0	244, 17	0 0	0	
76.01 03950 OTHER ANCILLARY SERVICE (		0. 000000	0		0 0	0	
76.02 03951 OTHER ANCILLARY SERVICE (		0. 000000	C		0 0	0	
76.03 03952 OTHER ANCILLARY SERVICE (	COST CENTERS	0. 000000	C		0 0	0	
76.04 03953 WOUND CARE		0. 263316	C			0	
76.06 03954 I MAGI NG CENTER		0. 085316	C			0	
76. 07 03955 BREAST DI AGNOSTI C CENTER	-	0. 478585	C	176, 22	23 0	0	76.07
OUTPATIENT SERVICE COST CENTER	5			1			1
90. 00 09000 CLINIC		0. 000000			0 0	0	
90. 01 04950 I NFUSI ON CENTER		0. 529334	0		0 0	0	
90. 26 04975 SPI NE CENTER		0. 527170	0		0 0	0	
91.00 09100 EMERGENCY	TINGT DART	0. 101243	0			0	
92.00 09200 OBSERVATION BEDS (NON-DIS		0. 719239	0			0	
200.00 Subtotal (see instruction			C	23, 308, 52		0	200.00
		1		1	0 0		201.00
201.00 Less PBP Clinic Lab. Serv Only Charges	n ces-i i ogi alli				0		

APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0169	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pro 6/30/2020 2:	
			Ti t	e XIX	Hospi tal	PPS	
		Cos			nosprear	110	
	Cost Center Description	Cost	Cost	1			
		Reimbursed	<b>Reimbursed</b>				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)	_			
		6.00	7.00				
	ANCI LLARY SERVICE COST CENTERS	174 504		1			
	05000 OPERATING ROOM	174, 526	(				50.00
	05100 RECOVERY ROOM	73, 126	(				51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	(				52.00
	05400 RADI OLOGY-DI AGNOSTI C	191, 857	(				54.00
	05500 RADI OLOGY-THERAPEUTI C	33, 837					55.00
	05700 CT SCAN	90, 729					57.00
		23, 107	(				58.00 59.00
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	282, 148	(				60.00
	06400 I NTRAVENOUS THERAPY	9, 910	(				64.00
	06500 RESPIRATORY THERAPY	21,961	(	•			65.00
	06600 PHYSI CAL THERAPY	67,609	(				66.00
	06700 OCCUPATI ONAL THERAPY	18, 436	(				67.00
	06800 SPEECH PATHOLOGY	7, 158					68.00
	06900 ELECTROCARDI OLOGY	4, 354	(				69.00
	07000 ELECTROENCEPHALOGRAPHY	33, 142					70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	157, 397	(				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	(				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	303, 634	(				73.00
73.01	07301 SPECIALTY PHARMACY	0	(				73.01
74.00	07400 RENAL DIALYSIS	0	(				74.00
76.00	03330 ENDOSCOPY	35, 904	(	D			76.00
76. 01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	(				76.01
	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	(				76.02
	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	(				76.03
	03953 WOUND CARE	1,065	(				76.04
	03954 I MAGI NG CENTER	46, 418	(				76.06
	03955 BREAST DI AGNOSTI C CENTER	84, 338	(				76.07
	OUTPATIENT SERVICE COST CENTERS	-1		1			
		0	(	•			90.00
	04950 INFUSION CENTER	0	(	•			90.01
	04975 SPINE CENTER	0	(				90.26
	09100 EMERGENCY	1, 056, 604					91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	7,351	(				92.00
200.00		2, 724, 611	(	D			200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0					201.00
202.00		2, 724, 611		0			202.00

In Lieu of Form CMS-2552-10

From 01/07/2019 To 12/31/2019         Description           0         This XVIII         Hospital         POS           0         The XVIII         Hospital         POS           100         The XVIII         Most I - ALL REGNORE COMPONENTS         For XVIIII         POS           100         The XVIIII MANS         For XVIIII         POS         For XVIIII         For XVIIII           100         Inputted days (including private room days, excluding sking-bed and observation bed days)         For XVIIII         For XVIIII         For XVIIIII         For XVIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII		THATCHAI SYSTEMS COMMUNITY HUSPITAL OF				2552-10
Interview         Title XVIII         Programmed.         District Time Proscont Time Programmed.	COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0169	Period: From 01/01/2019	Worksheet D-1	
The XHII         Hospital         PPS           000         1000         1.00         1.00         1.00           1001         Impattent days (including private room days and saing-bed days, excluding neetorm)         66.141         .00           1001         Impattent days (including private room days, excluding saing bed and neetorm days)         67.141         .00           1001         Trapattent days (including private room days, excluding saing bed and neetorm days)         67.141         .00           1001         Trapattent days (including private room days, excluding private room days)         167.041         .00					Date/Time Pre	pared:
Cost Center Description         1.00           IMMI Exit DMS         1.00           IMMI Exit DMS         1.00           Impatted DMS						6 pm
PART 1 - ALL PROVIDER COMPONENTS         1.00           1.00         Impartial CAMS         Impartial CAMS         1.00           1.00         Impartial cass, Circulating perivate room days, excitating mesharm)         6.6,116         1.00           3.00         Private room days, (excluding swing-bed and observation bed days)         1.7 you have only private room days, (excluding swing-bed and observation bed days)         5.7,497         4.8           3.00         Private room days (excluding swing-bed and observation bed days)         1.7 you have only private room days, for the cost of the cost reporting period (incellender yser, enter 0 on this line)         5.00           7.00         Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost of the cost reporting period (incellender yser, enter 0 on this line)         6.00           7.00         Total swing-bed SMF type inpatient days applicable to title XVII and y (including private room days)         10.60           8.00         String-bed SMF type inpatient days applicable to title XVII and y (including private room days)         10.00           9.00         Total indepartient days applicable to title XVII and y (including private room days)         10.00           9.00         Total swing-bed SMF type inpatient days applicable to title XVII and y (including private room days)         10.00           10.00         String-bed SMF type inpatient days applicable to title XVII and y (including private room days)			litle XVIII	Hospital	PPS	
PART I - ALL PROVIDER CONFORMS           IMPART INFORMS         Construction         65.148         1.0           Impact Infl days (including private room days and swing-bed days, excluding neederin)         65.148         1.0           1.00         Impact Infl days (including private room days and swing-bed days). If you have only private room days.         65.148         1.0           1.00         Impact Infl days (including private room days). If you have only private room days.         57.04         77.44           5.00         Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period.         67.00         7.00           6.00         Total swing-bed KT type inpatient days (including private room days) after December 31 of the cost reporting period.         0         7.00           1.00         Total swing-bed KT type inpatient days (including private room days) after December 31 of the cost reporting period.         0         0           0.00         Total swing-bed KT type inpatient days applicable to title XVII only (including private room days).         0         0         0           0.00         Swing-bed SWT type inpatient days applicable to title XVII only (including private room days).         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <td></td> <td>Cost Center Description</td> <td></td> <td></td> <td>1 00</td> <td></td>		Cost Center Description			1 00	
IMPARTNENT DAYS         Important days (including private room days, and swing-bed days, excluding nextorm)         65.148         2.00           10         Inpatterin days (including private room days, accluding seing-bed and nonstorm days)         65.148         2.00           10         Department days (including private room days, accluding seing-bed and nonstorm days)         65.148         2.00           10         Seen-private room days (excluding seing-bed and observation bed days)         10.0         55.00           10         Total seing-bed MF type inpattent days (including private room days) after December 31 of the cost reporting period         6.00           10         Total seing-bed MF type inpattent days (including private room days) after December 31 of the cost reporting period         6.00           10         Total seing-bed MF type inpattent days (including private room days) after December 31 of the cost reporting period         8.00           10         Total seing-bed MF type inpattent days applicable to the Program (excluding private room days)         10.00           10.00         Saing-bed MF type inpattent days applicable to title XVIII only (including private room days)         11.00           10.00         Saing-bed MF type inpattent days applicable to title XVI only (including private room days)         11.00           10.00         Saing-bed MF type inpattent days applicable to title XVI only (including private room days)         11.00 <td< td=""><td></td><td></td><td></td><td></td><td>1.00</td><td></td></td<>					1.00	
1.00       Inpatient days (including private room days, acculating newborn)       65,148       1.00         2.00       Inpatient days (including private room days, acculating swing-bed and newborn days)       65,148       1.00         3.00       Private room days (acculating swing-bed and observation bed days)       17 you have only private room days       57,047       4.00         3.00       Private room days (acculating swing-bed and observation bed days)       17 you have only private room days       57,047       4.00         5.00       Total sking-bed SW type inpatient days (including private room days) after December 31 of the cost       0       5.00         6.00       Total sking-bed SW type inpatient days (including private room days) after December 31 of the cost       0       7.00         reporting period       (1' calendar year, enter 0 on this 1 ine)       0       8.00         0.100       Sing-bed SW type inpatient days applicable to tille XVIII only (including private room days) after December 31 of the cost       0       10.00         1.00       Sing-bed SW type inpatient days applicable to tille XVII only (including private room days) after December 31 of the cost       0       10.00         1.00       Sing-bed SW type inpatient days applicable to tille XVII only (including private room days)       110       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10						
2.00       Injestient days (including private room days, oxcluding swing-bed and networks in the days). If you have only private room days, oxcluding swing-bed and observation bed days). If you have only private room days, oxcluding swing-bed and beservation bed days). If you have only private room days, oxcluding swing-bed swing-leader to a the swing-bed swing-be	1 00		excluding newborn)		65 148	1 00
3.00       Private room days (excluding swing-bed and observation bed days). If you have only private room days.       0       3.00         4.00       Seni private room days (excluding swing-bed and observation bed days).       157,497       4.00         5.00       Total swing-bed SW type inpatient days (including private room days) through December 31 of the cost       0       6.00         7.00       Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost       0       6.00         8.00       Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost       0       6.00         0.00       Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost       0       6.00         0.00       Total swing-bed SW type inpatient days applicable to the Norgan (excluding swing-bed and the system)       10.00         0.01       Swing-bed SW type inpatient days applicable to the Norgan (excluding private room days) after       11.00         0.02       Swing-bed SW type inpatient days applicable to the Norgan (excluding swing-bed days)       11.00         1.00       Swing-bed SW type inpatient days applicable to the Norgan (excluding swing-bed days)       11.00         1.00       Swing-bed SW type inpatient days applicable to the Norgan (excluding swing-bed days)       12.00         1.00       Swing-bed SW type inpatient days applicable to						2.00
do not complete this line.       5.00         Observation construction of the cost regarding period in the cost regarding period.       5.00         5.00       Total sering-beriod.       5.00         6.00       Including period.       6.00         6.01       Including period.       6.00         7.00       Total series.       6.00         7.01       Total series.       6.00         7.00       Total series.       7.00				ivate room davs.		3.00
4.00       Seni private room days (excluding saing bed and observation bed days)       57,497       4.00         5.00       Total saing bed SM (spe inpatient days (including private room days) after December 31 of the cost       5.0         6.00       Total saing bed SM (spe inpatient days (including private room days) after December 31 of the cost       6.00         7.00       Total saing bed MF type inpatient days (including private room days) after December 31 of the cost       0.00         8.00       Total saing bed MF type inpatient days (including private room days) after December 31 of the cost       0.00         9.00       Total saing bed MF type inpatient days (including private room days) after December 31 of the cost       0.00         9.00       Total saing bed SMF type inpatient days applicable to the trict XVIII only (including private room days) after       0.10         10.00       Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after       0.10         11.00       Swing-bed MF type inpatient days applicable to title SV or XX only (including private room days)       0       1.00         13.00       Swing-bed MF type inpatient days applicable to title SV or XX only (including private room days)       0       1.00         14.00       Medically necessary private room days applicable to services through December 31 of the cost       0.00       1.00         14.00       Medically necessary private room days	0.00		, i jou liato cili j pi	vato voom aajo,	0	0.00
reporting period       6.00         Total sing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       7.00         8.00       Total sing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       7.00         9.00       Total sing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       8.00         9.00       Total inpatient days including private room days applicable to the Program (excluding swing-bed and news)       18.045         9.00       Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days)       01.00         11.00       Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days)       11.00         12.00       Swing-bed NF type inpatient days applicable to title XV or XIX only (including private room days)       01.20         13.00       Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed aver and swing-bed NF type inpatient days applicable to the Program (excluding swing-bed aver and swing-bed NF type inpatient days applicable to the Program (excluding swing-bed aver and swing-bed NF type inpatient days applicable to the Program (excluding swing-bed aver and swing-bed NF type inpatient days applicable to the Program (excluding swing-bed aver and swing-bed NF type inpatient days applicable to the Program (excluding swing-bed aver and swing-bed aver and ty	4.00		I days)		57, 497	4.00
6.00       Total sering-bed SNF type Inpatient days (Including private room days) after becember 31 of the cost       0.00         7.00       Total sering-bed WF type Inpatient days (Including private room days) after December 31 of the cost       0.00         8.00       Total sering-bed WF type Inpatient days (Including private room days) after December 31 of the cost       0.00         9.00       Total Inpatient days (Including private room days) after December 31 of the cost       0.00         100       Swing-bed SNF type Inpatient days applicable to title XVII only (Including private room days) after       0.00         100       Swing-bed SNF type Inpatient days applicable to title XVII only (Including private room days)       0.10         100       Swing-bed SNF type Inpatient days applicable to title XVI only (Including private room days)       0.10         100       Swing-bed SNF type Inpatient days applicable to titles VI on XX only (Including private room days)       0.10         110.00       Swing-bed SNF type Inpatient days applicable to titles VI on XX only (Including private room days)       0.10         110.00       Swing-bed SNF type Inpatient days applicable to titles VI on XX only (Including private room days)       0.10         110.00       Swing-bed SNF type Inpatient days applicable to the Program (excluding swing-bed days)       0.10         110.00       Swing-bed SNF type Inpatient days applicable to SNF type Inpatient days applicable to SNF type Inpatient days applicable to	5.00	Total swing-bed SNF type inpatient days (including private room	n days) through Decembe	r 31 of the cost	0	5.00
reporting period         (1 calendar year, enter 0 on this line)         7.00           Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost         0.70           Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost         0.70           Total swing-bed NF type inpatient days applicable to the Program (excluding swing-bed and         18.645           10.00         Swing-bed NF type inpatient days applicable to tille XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)         0.10.00           11.00         Swing-bed NF type inpatient days applicable to tille XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)         0.10.00           13.00         Swing-bed NF type inpatient days applicable to tille XVIII only (including private room days)         0.10.00           13.00         Swing-bed NF type inpatient days applicable to tille XVIII only (including private room days)         0.10.00           10.00         Norservidays (tille V or XX anly)		reporting period				
7.00       Total swing-bed NF type inpatient days (including private room days) through Becember 31 of the cost reporting period (realendar year, enter 0 on this line)       0       7.00         8.00       Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (realendar year, enter 0 on this line)       0       0         9.00       Total inpatient days including private room days applicable to the Program (excluding private room days) through December 31 of the cost reporting period (ise instructions)       0       0         10.00       Swing-bed NF type inpatient days applicable to the VX only (including private room days)       0       1       0         11.00       Swing-bed NF type inpatient days applicable to the VX only (including private room days)       0       1       0         12.00       Swing-bed NF type inpatient days applicable to the Program (excluding private room days)       0       1       0         13.00       Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)       0       1       0         14.00       Medi care rate for swing-bed SNF services applicable to services after December 31 of the cost       0.00       1       0         15.00       Medi care rate for swing-bed SNF services applicable to services after December 31 of the cost       0.00       1       0       1       0       1       0       1       0	6.00		n days) after December	31 of the cost	0	6.00
reporting period report						
8.00       Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar years, enter 0 on this line)       0       8.00         9.00       Total inpatient days including private room days applicable to the Program (excluding private room days)       0	7.00		days) through December	31 of the cost	0	7.00
reporting beried (if calendar year, enter 0 on this line)         1						
9.00       Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)       18,645       9,00         10.00       Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after to cost reporting period (ical endar year, enter 0 on this line)       0       10,00         11.00       Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after 0       12,00         12.00       Swing-bed NF type inpatient days applicable to title XVIII only (including private room days)       0       12,00         12.00       Swing-bed NF type inpatient days applicable to title XVIII only (including private room days)       0       12,00         12.00       Swing-bed NF type inpatient days applicable to title XVIII only (including private room days)       0       14,00         12.00       Swing-bed NF type inpatient days applicable to title XVIII only (including private room days)       0       14,00         15.00       Notare rate for swing-bed SWF services applicable to services through becember 31 of the cost       0.00       16,00         15.00       Notare rate for swing-bed SW F services applicable to services after December 31 of the cost       0.00       16,00         10.00       Medicaid rate for swing-bed SW F services applicable to services after December 31 of the cost       0.00       10,00         10.00       Medicaid	8.00		days) after December 3	1 of the cost	0	8.00
newborn days) (see instructions)       0       0.0	0 00		the Dreaman (avaluding	owing had and	10 (45	0.00
10.00       Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days)       0       10.00         11.00       Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (inclaiding ryger, enter 0 on this line)       0       10.00         12.00       Swing-bed MF type inpatient days applicable to title SV or XIX only (including private room days)       0       10.00         13.00       Swing-bed MF type inpatient days applicable to titles V or XIX only (including private room days)       0       13.00         14.00       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0       14.00         15.00       Total nursery days (title V or XIX only)       0       15.00         16.00       Medically necessary private room days applicable to services through December 31 of the cost       0.00         17.00       Medical care rate for swing-bed SWF services applicable to services after December 31 of the cost       0.00         18.00       reporting period       0.00       18.00         17.00       Medical rate for swing-bed NF services applicable to services after December 31 of the cost       0.00         18.00       reporting period       0.00       18.00         17.00       Medical rate for swing-bed NF services after December 31 of the cost reporting period (line 3 <td>9.00</td> <td></td> <td>the Program (excluding</td> <td>swing-bed and</td> <td>18, 045</td> <td>9.00</td>	9.00		the Program (excluding	swing-bed and	18, 045	9.00
through December' 31 of the cost reporting period (see instructions)       11.00         Descripted SMF type inpatient days applicable to title XVIII only (including private room days) after       0         10.0 Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days)       0         10.0 Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days)       0         10.0 Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days)       0         10.0 Wordcare rate for swing-bed SWF services applicable to the Program (excluding swing-bed days)       0         10.0 Wordcare rate for swing-bed SWF services applicable to services through December 31 of the cost       0.00         10.0 Wordcare rate for swing-bed SWF services applicable to services after December 31 of the cost       0.00         10.0 Wordcare rate for swing-bed SWF services applicable to services after December 31 of the cost       0.00         10.0 Wordcare rate for swing-bed SWF services applicable to services after December 31 of the cost       0.00         10.0 Wordcare rate for swing-bed SWF services applicable to services after December 31 of the cost       0.00         10.0 Wordcare rate for swing-bed SWF services applicable to services after December 31 of the cost       0.00         10.0 Mordcare rate for swing-bed SWF services after December 31 of the cost       0.00         10.0 Mordcare rate for swing-bed SWF services after December 31 of the cost	10 00		v (including private r	nom davs)	0	10 00
11.00       Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period       0       11.00         12.00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period       0       12.00         13.00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period       0       13.00         14.00       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0       14.00         15.00       Nursery days (title V or XIX only)       0       16.00         16.00       Nursery days (title V or XIX only)       0       16.00         17.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00       17.00         18.00       Medicald rate for swing-bed NF services applicable to services after December 31 of the cost       0.00       18.00         19.00       Medicald rate for swing-bed NF type services after December 31 of the cost       0.00       10.00       10.00         20.00       Medicald rate for swing-bed NF type services after December 31 of the cost reporting period (line 5 x line 17)       20.00       10.00       10.00       20.00       10.00       20.00       20.	10.00			oom days)	0	10.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)         12.00           200 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)         0         12.00           100 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)         0         13.00           100 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)         0         14.00           100 Wedicater rate for swing-bed SMF services applicable to services through December 31 of the cost         0.00         16.00           101 No Wedicater rate for swing-bed SMF services applicable to services after December 31 of the cost         0.00         17.00           101 No Wedicater rate for swing-bed SMF services applicable to services after December 31 of the cost         0.00         19.00           102 No Wedicater rate for swing-bed SMF services applicable to services after December 31 of the cost         0.00         19.00           103 No Medicater rate for swing-bed SMF services applicable to services after December 31 of the cost         0.00         20.00           103 No Medicater rate for swing-bed SMF services applicable to services after December 31 of the cost         0.00         20.00           104 Nedicater rate for swing-bed SMF services applicable to services after December 31 of the cost         0.00         20.00           105 No Mign-bed Cost applicable to SMF type services after December 31 of the	11 00			oom days) after	0	11.00
12.00       Swing-bed NF type inpatient days applicable to itles V or XIX only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       12.00         13.00       Swing-bed NF type inpatient days applicable to itles V or XIX only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       13.00         14.00       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0       14.00         15.00       Total nursery days (title V or XIX only)       0       16.00         16.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00       17.00         17.00       Medicaid rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00       18.00         18.00       Medicaid rate for swing-bed NF services sthrough December 31 of the cost reporting period (line 5 x line 17)       0.00       19.00         20.00       Medicaid rate for swing-bed SNF type services through December 31 of the cost reporting period (line 6 x line 20)       0.20       0.00       20.00         21.00       Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 20)       0.20       0.00       0.00       0.00       0.00       0.00       0.00       0				oom aago) ar tor	0	
13:00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if called ary ear, enter 0 on this line)       0       13.00         14:00       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0       14.00         15:00       Total nursery days (title V or XIX only)       0       15.00       0         17:00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00       18.00         18:00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00       18.00         19:00       Medical d rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00       19.00         20:00       Medical d rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x line 17)       0.00       19.00         21:00       Total general inpatient routine service sets through December 31 of the cost reporting period (line 6 x line 18)       0.20.00         22:00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)       0.20.00         23:00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 10)       0.20.00	12.00			e room days)	0	12.00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0         14.00       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0         15.00       Total nursery days (it le V or XIX only)       0         16.00       Nursery days (it le V or XIX only)       0         17.00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       0.00         18.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00         19.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00         10.01       Medicaid rate for swing-bed NF services cast (see instructions)       77, 984, 250       21.00         22.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 13)       23.00         23.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20)       23.00         24.00       Swing-bed cost senstructions)       77, 984, 250       27.00         25.00       Swing-bed cost senstructions)       77, 984, 250       27.00         26.00       Friendail inpatient routine service cost retor swing-bed cost (line 21 minus line 20) <td< td=""><td></td><td>through December 31 of the cost reporting period</td><td><u> </u></td><td>3 /</td><td></td><td></td></td<>		through December 31 of the cost reporting period	<u> </u>	3 /		
14.00       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0       14.00         15.00       Total nursery days (title V or XIX only)       0       15.00         16.00       Nursery days (title V or XIX only)       0       16.00         17.00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       0.00       18.00         18.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (aid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x line 17)       0.00       19.00         20.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x line 17)       77.984,250       21.00         21.00       Total general inpatient routine services after December 31 of the cost reporting period (line 5 x line 18)       77.984,250       21.00         22.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 7 x line 18)       22.00       20.00         24.00       Swing-bed cost (see instructions)       77.984,250       21.00       22.00         25.00       Swing-bed cost (see instructions)       77.984,250       22.00       20.00         26.00       Total swing-bed cost (see instructions)	13.00				0	13.00
15:00       Total nursery days (tile V or XIX only)       0       15:00       <		after December 31 of the cost reporting period (if calendar yea	nr, enter O on this lin	e)		
16.00       Nursery days (title V or XIX only)       0       16.00         SWING BED ADJUSTIONT       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00         17.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00         10.00       Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00         10.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00         10.00       King-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)       0         21.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)       0         23.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)       0         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0         25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0         26.00       Total swing-bed cost (see instructions)       77, 984,250       27.00         27.00       General inpatient routine service cost repo			n (excluding swing-bed	days)	-	14.00
SWING BED ADJUSTMENT           17.00         Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period         0.00         17.00           18.00         Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period         0.00         18.00           19.00         Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period         0.00         18.00           20.00         Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period         0.00         20.00           21.00         Total general inpatient routine service cost (see instructions)         77,984,250         21.00           22.00         Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)         0.20         0           20.00         Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19)         0.20         0           20.00         Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)         0         0         0.26.00           21.00         Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)         0         0.26.00           20.00         Swing-bed cost (see instructions) </td <td></td> <td></td> <td></td> <td></td> <td>-</td> <td>15.00</td>					-	15.00
17.00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       0.00       17.00         18.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00       18.00         19.00       Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00       18.00         20.00       Medicare for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00       18.00         21.00       Total general inpatient routine service cost (see instructions)       77.984,250       21.00         22.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 5 x line 17)       0       22.00         23.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)       0       24.00         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0       0       26.00         25.00       Swing-bed cost (see instructions)       77.984,250       27.00       28.00       6eneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       77.984,250       27.00       28.00       29.00       0       0       29.00       0	16.00				0	16.00
reporting period       reporting period       0.0       0.0       18.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost       0.00       18.00         19.00       Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost       0.00       19.00         20.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost       0.00       20.00         21.00       Total general inpatient routine service cost (see instructions)       77,984,250       21.00         22.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)       77,984,250       21.00         23.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 7 x line 19)       0       23.00         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0       25.00         25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0       26.00         70.00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       77,984,250       27.00         80.00       Semi-private room charges (excluding swing-bed charges)       0       0       0       0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td></td<>						
18. 00       Medicarer <sup>o</sup> rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00       18. 00         19. 00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00       19. 00         20. 00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00       18. 00         21. 00       Total general inpatient routine service cost (see instructions)       77, 984, 250       21. 00         22. 00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 18)       77, 984, 250       21. 00         23. 00       Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 18)       0       26. 00         24. 00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0       26. 00         25. 00       Swing-bed cost (see instructions)       77, 984, 250       27. 00         26. 00       Total swing-bed cost (see instructions)       77, 984, 250       27. 00         27. 00       General inpatient routine service cost charges (excluding swing-bed and observation bed charges)       0       0         28. 00       Forster com charges (excluding swing-bed charges)       0       0 <td>17.00</td> <td><b>o</b> 11</td> <td>s through December 31 o</td> <td>f the cost</td> <td>0.00</td> <td>17.00</td>	17.00	<b>o</b> 11	s through December 31 o	f the cost	0.00	17.00
reporting period019. 00Medicaid arate for swing-bed NF services applicable to services through December 31 of the cost0.0020. 00Medicaid arate for swing-bed NF services applicable to services after December 31 of the cost0.0020. 00Total general inpatient routine service cost (see instructions)77,984,25021. 00Total general inpatient routine services after December 31 of the cost reporting period (line 5 x line 17)77,984,25022. 00Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 20)22. 0024. 00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)024. 0025. 00Swing-bed cost (see instructions)024. 0026. 00Total swing-bed cost (see instructions)026. 0027. 00FRIVATE ROOM DIFFERENTIAL ADJUSTMENT024. 0028. 00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)77, 984, 25029. 00Private room charges (excluding swing-bed charges)0000. 00Semi-private room charges (excluding swing-bed charges)00.0000. 00Semi-private room charges (excluding swing-bed charges)00.0001. 00Average per diem private room cost differential (line 32 minus line 33) (see instructions)0.0030. 0003. 00Average per diem private room cost differential (line 3 x line 35)0030. 0003. 00Average per diem private room cost differential (line 3 x	10.00		efter Desember 21 ef	+ +	0.00	10.00
19.00       Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period       0.00       19.00         20.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00       20.00         21.00       Total general inpatient routine service cost (see instructions)       77,984,250       21.00         22.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)       0       23.00         23.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)       0       23.00         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0       24.00         25.00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       77.984,250       27.00         26.00       Total swing-bed cost (see instructions)       0       26.00       70.984,250       27.00         29.00       Private room charges (excluding swing-bed charges)       0       26.00       77.984,250       27.00         29.00       Private room charges (excluding swing-bed charges)       0       28.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00 <td>18.00</td> <td></td> <td>arter December 31 or</td> <td>the cost</td> <td>0.00</td> <td>18.00</td>	18.00		arter December 31 or	the cost	0.00	18.00
reporting period1.1020.00Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period0.0020.0021.00Total general inpatient routine service cost (see instructions)77,984,25021.0022.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)022.0023.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)023.0024.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)024.0025.00Swing-bed cost (see instructions)026.007.01Cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)026.0026.00Total swing-bed cost (see instructions)026.007.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)77,984,25027.0029.00General inpatient routine service cost charges (excluding swing-bed charges)028.0029.00Orivate room charges (excluding swing-bed charges)00020.00Average private room charge (line 29 + line 3)00.00000031.00Average perivate room charge differential (line 32 minus line 33) (see instructions)0031.00Average perivate room cost differential (line 32 minus line 33)00032.00Average perivate room cost Bifferential (li	10 00		through December 21 of	the cost	0.00	10 00
20.00       Medical d'atte for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00       20.00         21.00       Total general inpatient routine service cost (see instructions)       77,984,250       21.00         22.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)       0.00       22.00         23.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)       0.00       24.00         25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0.00       0.00       0.00         26.00       Total swing-bed cost (see instructions)       0.00       0.00       0.00       0.00         27.00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       77,984,250       27.00         28.00       General inpatient routine service cost charges (excluding swing-bed and observation bed charges)       0.00       0.00       0.00         29.00       Private room charges (excluding swing-bed charges)       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       <	19.00		thi ough becember 31 of	the cost	0.00	19.00
reporting period77,984,25021.00Total general inpatient routine service cost (see instructions)77,984,25022.00Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)77,984,25023.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 7 x line 19)023.0024.00Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)024.0025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)026.0026.00Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT026.0028.00General inpatient routine service cost/charge still (line 30 + line 3) 0.000000.0029.00Private room charges (excluding swing-bed charges) 0.0000000.0031.00General inpatient routine service cost/charge ratio (line 32 + line 28) 0.00000032.00Average per diem private room charge (line 30 + line 3) 0.000000033.00Average per diem private room charge differential (line 34 x line 31) 0.0000000037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 34 x line 31) 0.0000000 <td< td=""><td>20 00</td><td></td><td>after December 31 of t</td><td>he cost</td><td>0 00</td><td>20 00</td></td<>	20 00		after December 31 of t	he cost	0 00	20 00
21.00Total general inpatient routine service cost (see instructions)77,984,25021.0022.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)22.0022.0023.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)23.0024.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)24.0025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)26.0026.00Total swing-bed cost (see instructions)026.00Total swing-bed cost (see instructions)026.00Total swing-bed cost (see instructions)027.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)77,984,25028.00Private room charges (excluding swing-bed charges)028.00Semi-private room charges (excluding swing-bed charges)020.00Semi-private room charges (excluding swing-bed charges)020.00Average per livate room per diem charge (line 29 + line 3)0.00020.01Average per diem private room cost differential (line 3 x line 31)0.0020.02Average per diem private room cost differential (line 3 x line 35)027.01Private room cost differential (line 3 x line 35)027.02Adjusted general inpatient routine service cost (line 9 x line 38)22, 38, 62429.00Private general inpatient routin	201.00				0100	20100
22.00Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)022.0023.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line x line 18)023.0024.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line x line 20)024.0025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)024.0025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)025.0026.00Total swing-bed cost (see instructions) PRIVATE ROUM DIFFERENTIAL ADJUSTMENT0026.0028.00General inpatient routine service charges (excluding swing-bed and observation bed charges) 0028.0029.00Private room charges (excluding swing-bed charges) 00029.0030.00Semi-private room charges (excluding swing-bed charges) 0000031.00General inpatient routine service cost/charge ratio (line 27 + line 28) 00000033.00Average per diem private room per diem charge (line 30 + line 31) 000030.0030.0035.00Average per diem private room cost differential (line 34 x line 31) 000035.004.00Average per diem private room cost differential (line 34 x line 31) 00035.005.00A	21.00				77, 984, 250	21.00
23.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)       0       23.00         24.00       Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 29)       0       24.00         25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0       25.00         26.00       Total swing-bed cost (see instructions)       0       0       26.00         27.00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       77,984,250       27.00         28.00       General inpatient routine service charges (excluding swing-bed charges)       0       0       28.00         29.00       Private room charges (excluding swing-bed charges)       0	22.00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	22.00
x line 18)       x line 18)       24.00         Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line       0       24.00         25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8       0       25.00         26.00       Total swing-bed cost (see instructions)       0       0       26.00         26.00       Total swing-bed cost (see instructions)       0       0       26.00         27.00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       77,984,250       27.00         28.00       General inpatient routine service cost net of swing-bed and observation bed charges)       0       28.00         29.00       Private room charges (excluding swing-bed charges)       0       0       30.00         30.00       Semi-private room charges (excluding swing-bed rating s)       0       0       29.00         31.00       General inpatient routine service cost/charge ratio (line 27 + line 28)       0.000000       31.00         32.00       Average per diem private room charge (line 29 + line 3)       0.00       32.00       0.00       32.00         33.00       Average per diem private room cost differential (line 34 x line 31)       0.00       32.00       33.00       0.00       33.00		5 x line 17)		•		
24.00Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)024.0025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)026.0026.00Total swing-bed cost (see instructions)0026.00Beneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)77,984,25027.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.00Semi-private room charges (excluding swing-bed charges)029.00Private room charges (excluding swing-bed charges)030.00Semi-private room charges (excluding swing-bed charges)031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.00Average per diem private room per diem charge (line 30 + line 4)0.0033.00Average per diem private room cost differential (line 32 minus line 33) (see instructions)0.0035.00Average per diem private room cost differential (line 34 x line 31)0.0035.00Average per diem private room cost differential (line 34 x line 35)037.00PRT 11 - HOSPITAL AND SUBPROVI DERS ONLYPROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS1,197.0338.00Adj usted general inpatient routine service cost per diem (see instructions)1,197.0339.00Program general inpatient routine service cost per diem (see instructions)2,318.6239.00Program general in	23.00	Swing-bed cost applicable to SNF type services after December 3	31 of the cost reportin	g period (line 6	0	23.00
7 x line 19)       7 x line 19)       25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       25.00         26.00       Total swing-bed cost (see instructions)       0       26.00         27.00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       77,984,250       27.00         28.00       General inpatient routine service charges (excluding swing-bed and observation bed charges)       0       28.00         29.00       Private room charges (excluding swing-bed charges)       0       29.00         30.00       Semi-private room charges (excluding swing-bed charges)       0       00.00       30.00         31.00       General inpatient routine service cost/charge ratio (line 27 + line 28)       0.000000       31.00         32.00       Average private room per diem charge (line 30 + line 4)       0.00       32.00         33.00       Average per diem private room cost differential (line 32 minus line 33) (see instructions)       0.00       35.00         35.00       Average per diem private room cost differential (line 3 x line 31)       0.00       35.00       0         36.00       Private room cost differential adjustment (line 3 x line 35)       0       36.00       37.00         37.00       General inpatient routine service cost per diem (see instructions						
25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0       25.00         27.00       Total swing-bed cost (see instructions)       0       0       26.00         27.00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       77, 984, 250       27.00         28.00       Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges)       0       28.00         29.00       Private room charges (excluding swing-bed charges)       0       29.00         30.00       Semi-private room charges (excluding swing-bed charges)       0       30.00         31.00       General inpatient routine service cost/charge ratio (line 27 + line 28)       0.00000       31.00         32.00       Average per ivate room per diem charge (line 30 + line 4)       0.00       32.00         34.00       Average per diem private room cost differential (line 32 minus line 33) (see instructions)       0.00       34.00         35.00       Average per diem private room cost differential adjustment (line 3 x line 35)       0       0.30.00       35.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 35)       0       0       36.00         37.00       General inpatient routine service cost ne	24.00		31 of the cost reporti	ng period (line	0	24.00
x line 20)x line 20x line 20 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
26.00Total swing-bed cost (see instructions)026.0027.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)77,984,25027.00PRIVATE ROOM DIFFERENTIAL ADJUSTMENTPRIVATE ROOM DIFFERENTIAL ADJUSTMENT028.0028.00General inpatient routine service charges (excluding swing-bed and observation bed charges)029.0029.00Private room charges (excluding swing-bed charges)030.0030.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.0032.00Average private room per diem charge (line 30 + line 3)0.0032.0034.00Average per diem private room cost differential (line 34 x line 31)0.0033.0035.00Private room cost differential djustment (line 3 x line 35)0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37, 984, 25037.0038.00Adjusted general inpatient routine service cost per diem (see instructions)1, 197.0338.00Adjusted general inpatient routine service cost per diem (see instructions)1, 197.0338.00Adjusted general inpatient routine service cost per diem (see instructions)1, 197.0339.00Program general inpatient routine service cost per diem (see instructions)2, 318, 62439.00Program general inpatient routine service cost (line 9 x line 38)2, 318, 62439.00Medically necessary pr	25.00		or the cost reporting	period (line 8	0	25.00
27. 00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)77, 984, 25027. 00PRIVATE ROOM DIFFERENTIAL ADJUSTMENT28. 00General inpatient routine service charges (excluding swing-bed charges)028. 0029. 00Private room charges (excluding swing-bed charges)029. 00029. 0030. 00Semi-private room charges (excluding swing-bed charges)0029. 0031. 00General inpatient routine service cost/charge ratio (line 27 + line 28)0. 00000031. 0032. 00Average private room per diem charge (line 29 + line 3)0. 0032. 0033. 00Average per diem private room cost differential (line 30 + line 4)0. 0032. 0034. 00Average per diem private room cost differential (line 34 x line 31)0. 0034. 0035. 00Private room cost differential djustment (line 3 x line 35)0. 0035. 0037. 00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 34 x line 31)0. 0036. 00Private room cost differential adjustment (line 3 x line 35)036. 0037. 00Adjusted general inpatient routine service cost per diem (see instructions)1, 197. 0338. 0038. 00Adjusted general inpatient routine service cost (line 9 x line 38)22, 318, 62439. 0090. 00Program general inpatient routine service cost (line 9 x line 38)22, 318, 62439. 0090. 00Medically necessary private room cost applicable to the Program (line 14 x line 35)040. 00<	24 00				0	24 00
PRI VATE ROOM DI FFERENTIAL ADJUSTMENT       28.00         General inpatient routine service charges (excluding swing-bed and observation bed charges)       0         29.00       Private room charges (excluding swing-bed charges)       0         30.00       Semi-private room charges (excluding swing-bed charges)       0         31.00       General inpatient routine service cost/charge ratio (line 27 ÷ line 28)       0.000000 31.00         32.00       Average private room per diem charge (line 29 ÷ line 3)       0.000000 31.00         33.00       Average semi-private room charge differential (line 30 ÷ line 4)       0.000         34.00       Average per diem private room cost differential (line 34 × line 31)       0.000         35.00       Average per diem private room cost differential adjustment (line 3 × line 35)       0.000         37.00       General inpatient routine service cost per diem (see instructions)       0.00         36.00       Private room cost differential adjustment (line 3 × line 35)       0.00         37.00       General inpatient routine service cost per diem (see instructions)       1.197.03         38.00       Adjusted general inpatient routine service cost (per diem (see instructions)       1.197.03         38.00       Adjusted general inpatient routine service cost (per diem (see instructions)       2.2,318,624         39.00       Program general inpatient rout			ing 21 minus ling 26)			
28.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.0029.00Private room charges (excluding swing-bed charges)029.0030.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0.00000031.0032.00Average private room per diem charge (line 29 ÷ line 3)0.0032.0033.00Average per diem private room per diem charge (line 30 ÷ line 4)0.0032.0034.00Average per diem private room cost differential (line 32 minus line 33) (see instructions)0.0034.0035.00Average per diem private room cost differential (line 3 x line 31)0.0035.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 77, 984, 25037.0037.00PART 11 - HOSPITAL AND SUBPROVIDERS ONLY77.0138.0038.00Adjusted general inpatient routine service cost per diem (see instructions)1, 197.0339.00Program general inpatient routine service cost (line 9 x line 38)22, 318, 62440.00Medically necessary private room cost applicable to the Program (line 14 x line 35)40.00	27.00		The 21 minus The 20)		77, 704, 230	27.00
29.00Private room charges (excluding swing-bed charges)029.0030.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0.00000031.0032.00Average private room per diem charge (line 29 ÷ line 3)0.0032.0033.00Average per diem private room charge differential (line 30 ÷ line 4)0.0032.0034.00Average per diem private room cost differential (line 34 x line 31)0.0034.0035.00Average per diem private room cost differential (line 3 x line 35)0.0035.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 77, 984, 250)37.0027.minus line 36)PART 11 - HOSPI TAL AND SUBPROVI DERS ONLY9.00PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS1, 197.0338.00Adjusted general inpatient routine service cost per diem (see instructions)1, 197.0339.00Program general inpatient routine service cost (line 9 x line 38)22, 318, 62440.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0	28 00		and observation bed ch	arges)	0	28 00
30.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0.00000031.0032.00Average private room per diem charge (line 29 ÷ line 3)0.0032.0033.00Average semi-private room per diem charge (line 30 ÷ line 4)0.0033.0034.00Average per diem private room cost differential (line 32 minus line 33) (see instructions)0.0034.0035.00Average per diem private room cost differential (line 3 x line 31)0.0035.0036.00Private room cost differential adjustment (line 3 x line 35)0.36.0036.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 77, 984, 250)37.0027 minus line 36)PART 11 - HOSPI TAL AND SUBPROVI DERS ONLY38.0078.00Adjusted general inpatient routine service cost per diem (see instructions)1, 197.0339.00Program general inpatient routine service cost per diem (see instructions)22, 318, 62439.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0				ul ges)		
31.00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0.00000031.0032.00Average private room per diem charge (line 29 ÷ line 3)0.0032.0033.00Average semi-private room per diem charge (line 30 ÷ line 4)0.0033.0034.00Average per diem private room charge differential (line 34 x line 33) (see instructions)0.0033.0035.00Average per diem private room cost differential (line 3 x line 35)0.0034.0036.00Private room cost differential adjustment (line 3 x line 35)0.0035.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 77, 984, 250)37.0027 minus line 36)PART 11 - HOSPITAL AND SUBPROVIDERS ONLY0.00PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS1, 197.0338.00Adjusted general inpatient routine service cost per diem (see instructions)1, 197.0339.00Program general inpatient routine service cost per diem (see instructions)22, 318, 62439.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0						30.00
32.00Average private room per diem charge (line 29 ÷ line 3)0.0032.0033.00Average semi-private room per diem charge (line 30 ÷ line 4)0.0033.0034.00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0.0034.0035.00Average per diem private room cost differential (line 34 x line 31)0.0035.0036.00Private room cost differential adjustment (line 3 x line 35)0.0036.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 77, 984, 250)37.0027 minus line 36)PART II - HOSPITAL AND SUBPROVIDERS ONLY38.00Adjusted general inpatient routine service cost per diem (see instructions)1, 197.0338.00Adjusted general inpatient routine service cost per diem (see instructions)1, 197.0339.00Program general inpatient routine service cost (line 9 x line 38)22, 318, 62440.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0			line 28)		-	
33.00       Average semi-private room per diem charge (line 30 ÷ line 4)       0.00       33.00         34.00       Average per diem private room charge differential (line 32 minus line 33) (see instructions)       0.00       34.00         35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       34.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0       36.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 77, 984, 250)       37.00         27 minus line 36)       PART II - HOSPITAL AND SUBPROVIDERS ONLY       37.00         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       1, 197.03         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       1, 197.03         39.00       Program general inpatient routine service cost (line 9 x line 38)       22, 318, 624         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00			/			
34.00       Average per diem private room charge differential (line 32 minus line 33) (see instructions)       0.00       34.00         35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       35.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0       0       36.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 77, 984, 250)       37.00       36.00         27 minus line 36)       PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       38.00       38.00         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       1, 197.03       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       22, 318, 624       39.00         40.000       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00						
36.00       Private room cost differential adjustment (line 3 x line 35)       0       36.00       37.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)       0       37.00       37.00         PART 11 - HOSPITAL AND SUBPROVIDERS ONLY       PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       1,197.03       38.00         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       1,197.03       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       22,318,624       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00	34.00		us line 33)(see instruc	tions)		
37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 77, 984, 250 27 minus line 36)       37.00         PART II - HOSPITAL AND SUBPROVIDERS ONLY       PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       38.00         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       1, 197.03       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       22, 318, 624       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00	35.00	Average per diem private room cost differential (line 34 x line	e 31)		0.00	35.00
27 minus line 36)         PART II - HOSPITAL AND SUBPROVIDERS ONLY         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS         38.00       Adjusted general inpatient routine service cost per diem (see instructions)         39.00       Program general inpatient routine service cost (line 9 x line 38)         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)		<b>3</b>			-	36.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       1,197.03       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       22,318,624       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00	37.00		nd private room cost di	fferential (line	77, 984, 250	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS38.00Adjusted general inpatient routine service cost per diem (see instructions)1,197.0338.0039.00Program general inpatient routine service cost (line 9 x line 38)22,318,62439.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00						
38.00Adjusted general inpatient routine service cost per diem (see instructions)1,197.0338.0039.00Program general inpatient routine service cost (line 9 x line 38)22,318,62439.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00			THENTO			
39.00Program general inpatient routine service cost (line 9 x line 38)22,318,62439.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00	20.00				4 407 00	20.00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
			-			
	+1.00	Total Trogram general inpatient routine service cost (TINE 39 4		I	22, 310, 024	1 41.00

WPUI	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0169	Period: From 01/01/2019	Worksheet D-1	1
					To 12/31/2019	Date/Time Pre	
			Title	XVIII	Hospi tal	6/30/2020 2: PPS	16 pn
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days		÷	(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	+
00	NURSERY (title V & XIX only)	0	0				) 42
	Intensive Care Type Inpatient Hospital Units						
00	INTENSIVE CARE UNIT	12, 854, 842	6, 544	1, 964. 3	37 2, 102	4, 129, 106	
00	CORONARY CARE UNIT						44
00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45
	NEONATAL INTENSIVE CARE UNIT	16, 188, 890	11, 655	1, 389. (	01 0		) 47
	Cost Center Description						
						1.00	
00 00	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines 4			nc)		32, 391, 600	
00	PASS THROUGH COST ADJUSTMENTS			115)		58, 839, 330	J 49
00	Pass through costs applicable to Program inpa	atient routine :	services (from	Wkst. D, sur	n of Parts I and	2, 861, 646	5 50
00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	2, 613, 328	3 51
00	and IV) Total Program excludable cost (sum of lines {	50 and 51)				5, 474, 974	4 52
00	Total Program inpatient operating cost exclude	,	lated, non-phy	sician anesth	netist, and	53, 364, 356	
	medical education costs (line 49 minus line 8	52)					
~~	TARGET AMOUNT AND LIMIT COMPUTATION						
00 00	Program discharges Target amount per discharge					0.00	) 54 ) 55
00	Target amount (line 54 x line 55)						5 56
00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus	line 53)		57
00	Bonus payment (see instructions)					0	
00	Lesser of lines 53/54 or 55 from the cost rep	porting period	ending 1996, u	pdated and co	ompounded by the	0.00	59
00	market basket Lesser of lines 53/54 or 55 from prior year of	rost report up	dated by the m	arket basket		0.00	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	f the target		
00	amount (line 56), otherwise enter zero (see i	nstructions)					
. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)				) 62 ) 63
00	PROGRAM INPATIENT ROUTINE SWING BED COST						
00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the	cost reporti	ng period (See	(	64
~~	instructions)(title XVIII only)						
00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts atter Decembe	er 31 of the c	ost reporting	g period (See		) 65
00	Total Medicare swing-bed SNF inpatient routin	ne costs (line (	64 plus line 6	5)(title XVII	l only). For	0	0 66
	CAH (see instructions)			, ,	3,		
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 c	f the cost re	eporting 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 ren	orting period		68 (
. 00	(line 13 x line 20)		ecember 51 01	the cost rept	bitting period		
. 00	Total title V or XIX swing-bed NF inpatient i					(	) 69
~~	PART III - SKILLED NURSING FACILITY, OTHER NU		•			1	
. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co				)		70
. 00	Program routine service cost (line 9 x line 3			-)			72
00	Medically necessary private room cost applica		(line 14 x li	ne 35)			73
00	Total Program general inpatient routine servi	•			·		74
. 00	Capital-related cost allocated to inpatient i	routine service	costs (from W	orksheet B, F	art II, column		75
00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
00	Program capital -related costs (line 9 x line	,					77
	Inpatient routine service cost (line 74 minus						78
00	Aggregate charges to beneficiaries for excess	• •					79
00 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		UST IIMITATION	(IINE /8 mir	ius i i ne 79)		80
00	Inpatient routine service cost per drem finm		)				82
00	Reasonable inpatient routine service costs (s		•				83
00	Program inpatient ancillary services (see ins	structions)					84
00	Utilization review - physician compensation						85
00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)				86
. 00	Total observation bed days (see instructions)					7,651	1 87
	5 .		1100 2)				
. 00	Adjusted general inpatient routine cost per o	arem (rrne z/ ÷	rine z)			1, 197. 03	

Health Financial Systems COM	UNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2019	Worksheet D-1	
				Foil 01/01/2019 Fo 12/31/2019	Date/Time Pre 6/30/2020 2:1	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	8, 140, 148	77, 984, 250	0. 104382	9, 158, 477	955, 980	90.00
91.00 Nursing School cost	0	77, 984, 250	0.00000	9, 158, 477	0	91.00
92.00 Allied health cost	0	77, 984, 250	0.00000	9, 158, 477	0	92.00
93.00 All other Medical Education	0	77, 984, 250	0.00000	9, 158, 477	0	93.00

MPUT		ovider CCN: 15-0169 omponent CCN: 15-S169 Title XVIII	Peri od: From 01/01/2019 To 12/31/2019 Subprovi der - I PF	Worksheet D-1 Date/Time Prep 6/30/2020 2:10 PPS	pare
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days, e	excluding newborn)		5, 142	1.
00	Inpatient days (including private room days, excluding swing-bed			5, 142	2.
00	Private room days (excluding swing-bed and observation bed days).	. If you have only pr	vate room days,	0	3.
00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed o	davs)		5, 142	4
00	Total swing-bed SNF type inpatient days (including private room of		r 31 of the cost	0,142	
	reporting period				
00	Total swing-bed SNF type inpatient days (including private room or reporting period (if calendar year, enter 0 on this line)	days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private room da	ays) through December	31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private room da reporting period (if calendar year, enter 0 on this line)	ays) after December 3	1 of the cost	0	8
00	Total inpatient days including private room days applicable to th	he Program (excluding	swing-bed and	2, 786	9
	newborn days) (see instructions)				
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instruction		oom days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days) after	0	11
	December 31 of the cost reporting period (if calendar year, enter				
2.00	Swing-bed NF type inpatient days applicable to titles V or XIX on through December 31 of the cost reporting period	nly (including privat	e room days)	0	12
8.00	Swing-bed NF type inpatient days applicable to titles V or XIX or	nly (including privat	e room days)	0	13
	after December 31 of the cost reporting period (if calendar year,	, enter 0 on this lin	e)		
	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT		1	-	
. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 o	f the cost	0.00	17
3. 00	Medicare rate for swing-bed SNF services applicable to services a	after December 31 of	the cost	0.00	18
	reporting period				
0. 00	Medicaid rate for swing-bed NF services applicable to services the reporting period	hrough December 31 of	the cost	0.00	19
0. 00	Medicaid rate for swing-bed NF services applicable to services at	fter December 31 of t	ne cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 3	21 of the cost report	na poriod (lino	4, 270, 394 0	
. 00	5 x line 17)	ST OF THE COST TEPOLT	ng period (inne	0	22
8.00	Swing-bed cost applicable to SNF type services after December 31	of the cost reportin	g period (line 6	0	23
. 00	x line 18) Swing bod cost applicable to NE type services through December 2	1 of the cost reporti	a poriod (line	0	24
. 00	Swing-bed cost applicable to NF type services through December 3' $7 \times 1$ ine 19)	I OI THE COST TEPOLT	ig period (inne	0	24
6.00	Swing-bed cost applicable to NF type services after December 31 of	of the cost reporting	period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost (lin	ne 21 minus line 26)		4, 270, 394	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed an	nd 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 ÷ li	ine 28)		0. 000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus	line 33)(see instruc	tions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x line 3			0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0	36
. 00	General inpatient routine service cost net of swing-bed cost and 27 minus Line 26)	private room cost di	fferential (line	4, 270, 394	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTM				1
	Adjusted general inpatient routine service cost per diem (see ins			830.49	
	Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program			2, 313, 745 0	
	Total Program general inpatient routine service cost (line 39 + 1	, ,		2, 313, 745	

MPUT	Financial Systems COMM ATION OF INPATIENT OPERATING COST	UNI TY HOSPI TAL		CCN: 15-0169	Peri od:	eu of Form CMS- Worksheet D-1	
			Component	CCN: 15-S169	From 01/01/2019 To 12/31/2019	Date/Time Pre	
			Ti tl	e XVIII	Subprovider -	6/30/2020 2: PPS	τορι
	Cost Center Description	Total Inpatient Cost	Total	Average Per	IPF Program Days	Program Cost (col. 3 x col.	
				col . 2)		4)	
00	NURSERY (title V & XIX only)	1.00	2.00	3.00 0 0.	4.00 00 0	5.00	) 42
	Intensive Care Type Inpatient Hospital Units						
00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0		0 0.	00 0	0 0	43
. 00	BURN INTENSIVE CARE UNIT						45
00	SURGI CAL I NTENSI VE CARE UNI T						46
. 00	NEONATAL INTENSIVE CARE UNIT Cost Center Description	0		0 0.	00 0		0 47
						1.00	
00	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines			ons)		332, 231 2, 645, 976	
00	PASS THROUGH COST ADJUSTMENTS						
00	Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D, su	m of Parts I and	171, 228	3 50
00	)  Pass through costs applicable to Program inpa	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	19, 071	1 51
00	and IV)	50 and $51$				100,000	
. 00 . 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated, non-ph	ysician anest	hetist, and	190, 299 2, 455, 677	
-	medical education costs (line 49 minus line		· · F.				
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						54
00	Target amount per discharge					0.00	55
00 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and to	raat amount (	lino E4 minuc	Lino E2)		
00	Bonus payment (see instructions)	ing cost and ta	rget amount (	TTHE 50 III Hus	TTHE 55)		
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and c	ompounded by the	0.00	59
. 00	market basket Lesser of lines 53/54 or 55 from prior year o	cost report up	dated by the	market basket		0.00	0 60
. 00	If line 53/54 is less than the lower of line					(	
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% o	f the target		
. 00	Relief payment (see instructions)	instructions)				0	62
. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)				) 63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost report	ing period (See		0 64
	instructions)(title XVIII only)	0			0 1		
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the	cost reportin	g period (See		65
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66
00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost r	eporting period		67
. 00	(line 12 x line 19)	e costs through	December 51	of the cost i	eporting period		
. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost rep	orting period	0	68
. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient n	routine costs (	line 67 + lin	e 68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER NU				、 、	1	
. 00 . 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	2		•	)		70
. 00	Program routine service cost (line 9 x line			_)			72
. 00	Medically necessary private room cost applicate	0	•				73
. 00 . 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				Part II, column		74
	26, line 45)						
. 00 . 00	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						76
00	Inpatient routine service cost (line 74 minus	s line 77)					78
00	Aggregate charges to beneficiaries for excess				nus lino 70)		79
00 00	Total Program routine service costs for compa Inpatient routine service cost per diem limi				nus IIIe /4)		80
00	Inpatient routine service cost limitation (I	ine 9 x line 81					82
. 00	Reasonable inpatient routine service costs (		s)				83
. 00 . 00	Program inpatient ancillary services (see in: Utilization review - physician compensation		ns)				85
. 00	Total Program inpatient operating costs (sum	of lines 83 th					86
00	PART IV - COMPUTATION OF OBSERVATION BED PASS						0
. 00 . 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			0.00	
	Observation bed cost (line 87 x line 88) (see					1	88 0

Health Financial Systems COMM	IUNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2019	Worksheet D-1	
		Component (		To 12/31/2019		pared: 6 pm
		Title	XVIII	Subprovider - IPF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	316, 012	4, 270, 394	0.07400	0	0	90.00
91.00 Nursing School cost	0	4, 270, 394	0.00000	0 0	0	91.00
92.00 Allied health cost	0	4, 270, 394	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 270, 394	0.00000	0 0	0	93.00

			-			 
COMMUNI TY	HOSPI TAL	0F	INDI	ANA,	INC.	

In Lieu of Form CMS-2552-10

	inancial Systems COMMUNITY HOSPITAL OF TION OF INPATIENT OPERATING COST	Provider CCN: 15-0169	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2019 To 12/31/2019	Date/Time Pre	pared
		Title XIX	Hospi tal	6/30/2020 2: 1 PPS	<u>6 pm</u>
	Cost Center Description		noopi tui		
				1.00	
	ART I - ALL PROVIDER COMPONENTS				-
	NPATLENT DAYS npatient days (including private room days and swing-bed day:	s excluding newborn)		65, 148	1.0
	npatient days (including private room days, excluding swing-l			65, 148	
	rivate room days (excluding swing-bed and observation bed day		rivate room days,	0	
	o not complete this line.		-		
	emi-private room days (excluding swing-bed and observation be			57, 497	
	otal swing-bed SNF type inpatient days (including private roo reporting period	om days) through Decembe	er 31 of the cost	0	5.
	otal swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6.
r	eporting period (if calendar year, enter 0 on this line)	5			
	otal swing-bed NF type inpatient days (including private room	m days) through December	- 31 of the cost	0	7.
	eporting period	n dave) ofter December (	1 of the east	0	
	otal swing-bed NF type inpatient days (including private room eporting period (if calendar year, enter 0 on this line)	li days) al ter becember .	si of the cost	0	8.
	otal inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	2, 470	9.
	ewborn days) (see instructions)	0	, <u> </u>		
	wing-bed SNF type inpatient days applicable to title XVIII on	5 6 5 1	room days)	0	10.
	hrough December 31 of the cost reporting period (see instruc wing-bed SNF type inpatient days applicable to title XVIII o		soom dave) after	0	11.
	ecember 31 of the cost reporting period (if calendar year, e		oom days) arter	0	
	wing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12.
	hrough December 31 of the cost reporting period				
	wing-bed NF type inpatient days applicable to titles V or XIX			0	13.
. 00 M	fter December 31 of the cost reporting period (if calendar ye ledically necessary private room days applicable to the Progra	ear, enter U on this lin am (excluding swing-bed	ne) davs)	0	14.
	otal nursery days (title V or XIX only)	an (exer during swring bed	uuys)	7, 388	
	lursery days (title V or XIX only)			2, 781	
	NING BED ADJUSTMENT				
	ledicare rate for swing-bed SNF services applicable to service	es through December 31 d	of the cost	0.00	17.
	eporting period Ledicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18.
	eporting period		110 0031	0.00	10.
. OO M	edicaid rate for swing-bed NF services applicable to services	s through December 31 of	f the cost	0.00	19.
	eporting period			0.00	
	ledicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of 1	ine cost	0.00	20.
	otal general inpatient routine service cost (see instructions	s)		78, 841, 038	21.
	wing-bed cost applicable to SNF type services through December		ting period (line	0	
	x line 17)				
	wing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23.
	: line 18) wing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	na period (line	0	24.
	x line 19)		ng period (inic	0	27.
. 00 SI	wing-bed cost applicable to NF type services after December 3	31 of the cost reporting	g period (line 8	0	25.
	line 20)				
	iotal swing-bed cost (see instructions)	(line 21 minute line 24)		70 041 020	
	eneral inpatient routine service cost net of swing-bed cost RIVATE ROOM DIFFERENTIAL ADJUSTMENT	(The 21 minus The 26)		78, 841, 038	27.
	eneral inpatient routine service charges (excluding swing-bed	d and observation bed ch	narges)	0	28.
	rivate room charges (excluding swing-bed charges)		5 /	0	
	emi-private room charges (excluding swing-bed charges)			0	
	eneral inpatient routine service cost/charge ratio (line 27 -	÷line 28)		0.000000	
	verage private room per diem charge (line 29 ÷ line 3) verage semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
	verage per diem private room charge differential (line 32 min	nus line 33)(see instru	ctions)	0.00	
	verage per diem private room cost differential (line 34 x lin	, ,	/	0.00	
	rivate room cost differential adjustment (line 3 x line 35)			0	
	eneral inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	78, 841, 038	37.
	7 minus line 36) ART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	ROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			1
	djusted general inpatient routine service cost per diem (see			1, 210. 18	38.
	rogram general inpatient routine service cost (line 9 x line			2, 989, 145	
	ledically necessary private room cost applicable to the Progra			0	
. 00 T	otal Program general inpatient routine service cost (line 39	+ line 40)		2, 989, 145	1 41

IPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0169	Period: From 01/01/2019		
					To 12/31/2019	Date/Time Pre 6/30/2020 2:1	
	Cast Contan Description	Tatal		e XIX	Hospital	PPS	
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	-
00	NURSERY (title V & XIX only)	4, 941, 149	7, 388				42
	Intensive Care Type Inpatient Hospital Unit						
00	INTENSIVE CARE UNIT	12, 854, 842	6, 544	1, 964. 3	37 0	0	
00	CORONARY CARE UNIT						44
00	BURN INTENSIVE CARE UNIT						45
00 00	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	16, 188, 890	11, 655	1, 389. (	01 1, 717	2, 384, 930	46
00	Cost Center Description	10, 100, 070	11,000	1, 307. (	,,,,,	2, 304, 730	<u>, + /</u>
						1.00	
00	Program inpatient ancillary service cost (W					3, 748, 048	
00	Total Program inpatient costs (sum of lines	s 41 through 48)(s	ee instructio	ns)		10, 982, 084	49
00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program in	nationt routine s	ervices (from	Wkst D sur	n of Parts L and	779, 374	50
00				WK31. D, 30		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
00	Pass through costs applicable to Program ir	npatient ancillary	services (fr	om Wkst. D, s	sum of Parts II	287, 147	51
	and IV)	50 1 5 1					
00	Total Program excludable cost (sum of lines	,	atad says of		atiot cod	1, 066, 521	
00	Total Program inpatient operating cost excl medical education costs (line 49 minus line		ateu, non-pny	sician anestr	ietist, and	9, 915, 563	3 53
	TARGET AMOUNT AND LIMIT COMPUTATION					1	
00	Program di scharges					0	54
00	Target amount per discharge					0.00	55
00	Target amount (line 54 x line 55)					0	
00	Difference between adjusted inpatient opera	ating cost and tar	get amount (I	ine 56 minus	line 53)	0	
00 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost r	concreting portiod o	nding 1006 u	ndatod and co	mounded by the	0.00	
00	market basket	eporting period e	nunng 1990, u		hipourided by the	0.00	/ 37
00	Lesser of lines 53/54 or 55 from prior year	- cost report, upd	ated by the m	arket basket		0.00	60
00	If line 53/54 is less than the lower of lin					0	61
	which operating costs (line 53) are less th		(lines 54 x	60), or 1% of	f the target		
00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	e instructions)				0	62
00	Allowable Inpatient cost plus incentive pay	ment (see instruc	tions)				
00	PROGRAM INPATIENT ROUTINE SWING BED COST						
00	Medicare swing-bed SNF inpatient routine co	sts through Decem	ber 31 of the	cost reporti	ng period (See	C	64
~ ~	instructions)(title XVIII only)						
00	Medicare swing-bed SNF inpatient routine co	osts after Decembe	r 31 of the c	ost reporting	g period (See	0	65
00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rout	ine costs (line 6	4 nlus line 6	5)(title XVII	lonly) For	0	66
00	CAH (see instructions)				r onry). For		
00	Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 o	f the cost re	eporting period	0	67
00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routi	na agata aftar Da	combon 21 of	the east rang	sting posied		
00	(line 13 x line 20)	ne costs after De	cemper 31 01	the cost repo	bring period		68
00	Total title V or XIX swing-bed NF inpatient	routine costs (I	ine 67 + line	68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER					1	
00	Skilled nursing facility/other nursing faci	2					70
00 00	Adjusted general inpatient routine service Program routine service cost (line 9 x line		ne /U ÷ IIne	2)			71
00	Medically necessary private room cost appli		(line 14 x li	ne 35)			73
00	Total Program general inpatient routine ser	5	•	,			74
00	Capital-related cost allocated to inpatient			orksheet B, F	Part II, column		75
	26, line 45)						
00	Per diem capital-related costs (line 75 ÷ l						76
00 00	Program capital-related costs (line 9 x lin Inpatient routine service cost (line 74 mir						77
00	Aggregate charges to beneficiaries for exce		ovider record	s)			79
00	Total Program routine service costs for com	• •		· · · · · · · · · · · · · · · · · · ·	nus line 79)		80
00	Inpatient routine service cost per diem lim	•			,		81
00	Inpatient routine service cost limitation (	• ,					82
00	Reasonable inpatient routine service costs	•	)				83
00	Program inpatient ancillary services (see i		- )				84
00 00	Utilization review - physician compensation Total Program inpatient operating costs (su						85
00	PART IV - COMPUTATION OF OBSERVATION BED PA					1	- 00
00	Total observation bed days (see instruction					7, 651	87
	Adjusted general inpatient routine cost per		line 2)			1, 210. 18	
00 00	Observation bed cost (line 87 x line 88) (s					9, 259, 087	

Health Financial Systems COM	UNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 01/01/2019 To 12/31/2019	Date/Time Pre 6/30/2020 2:1	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	8, 140, 148	78, 841, 038	0. 103248	9, 259, 087	955, 982	90.00
91.00 Nursing School cost	0	78, 841, 038	0.00000	9, 259, 087	0	91.00
92.00 Allied health cost	0	78, 841, 038	0.00000	9, 259, 087	0	92.00
93.00 All other Medical Education	0	78, 841, 038	0.00000	9, 259, 087	0	93.00

	nancial Systems COMMUNITY HOSPITAL O	FINDIANA, II	VC.	In Lie	u of Form CMS-2	2552-10
I NPATI ENT	ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0169	Peri od:	Worksheet D-3	1
				From 01/01/2019 To 12/31/2019	Date/Time Pre 6/30/2020 2:1	
		Titl€	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2) 3.00	
IND	PATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	DOO ADULTS & PEDIATRICS		1	38, 988, 921		30.00
	100 I NTENSI VE CARE UNI T			8, 684, 298		31.00
	D60 NEONATAL INTENSIVE CARE UNIT			0,001,270		35.00
	DOO SUBPROVIDER - IPF			0		40.00
	300 NURSERY			_		43.00
	CILLARY SERVICE COST CENTERS					
	DOO OPERATING ROOM		0. 1012	37 44, 190, 169	4, 473, 680	50.00
51.00 051	100 RECOVERY ROOM		0. 1645	4, 962, 874	816, 800	51.00
52.00 052	200 DELIVERY ROOM & LABOR ROOM		0. 4827	52 0	0	52.00
54.00 054	400 RADI OLOGY-DI AGNOSTI C		0. 1635	3, 781, 948	618, 659	54.00
55.00 055	500 RADI OLOGY-THERAPEUTI C		0.0723	03 6, 110, 345	441, 796	55.00
57.00 057	700 CT SCAN		0. 0338	9, 690, 643	327, 747	57.00
58.00 058	300 MRI		0.0976	53 1, 656, 514	161, 780	58.00
	200 CARDI AC CATHETERI ZATI ON		0. 0589	19 2, 540, 199	149, 666	59.00
	DOO LABORATORY		0. 09970			
	400 I NTRAVENOUS THERAPY		0. 6227		247, 818	64.00
	500 RESPI RATORY THERAPY		0. 2139		1, 308, 216	
	500 PHYSI CAL THERAPY		0. 3193		828, 900	
	700 OCCUPATI ONAL THERAPY		0. 2914		550, 399	
	BOO SPEECH PATHOLOGY		0. 1990		107, 617	
	900 ELECTROCARDI OLOGY		0.0656		288, 622	
	DOO ELECTROENCEPHALOGRAPHY		0. 2054		65, 661	
	100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.3620		3, 590, 145	
	200 IMPL. DEV. CHARGED TO PATIENTS		0. 4311		5, 961, 416	
	300 DRUGS CHARGED TO PATIENTS		0.2440		6, 204, 597	
	301 SPECIALTY PHARMACY		1. 1240		0	
	400 RENAL DI ALYSI S		0. 4172		733, 626	
	330 ENDOSCOPY		0. 1470		374, 189 0	
	250 OTHER ANCILLARY SERVICE COST CENTERS 251 OTHER ANCILLARY SERVICE COST CENTERS		0.0000		0	
	252 OTHER ANCILLARY SERVICE COST CENTERS		0.0000		0	
	952 OTHER ANGILLART SERVICE COST CENTERS		0. 2633		109, 698	
	253 WOUND CARL 254 I MAGI NG CENTER		0. 0853		3, 800	
	255 BREAST DI AGNOSTI C CENTER		0. 4785		679	
	TPATIENT SERVICE COST CENTERS		0.4703	1,417	0//	/0.0/
			0.0000	0 00	0	90.00
	950 INFUSION CENTER		0. 5293		0	
	975 SPINE CENTER		0. 5271		0	
	100 EMERGENCY		0. 1005		1, 509, 350	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART		0. 7192		874, 994	
92.00 092	200 OBSERVATION BEDS (NON-DISTINCT FART					
92.00 200.00	Total (sum of lines 50 through 94 and 96 through 98)			185, 842, 349	32, 391, 600	
		s (line 61)				

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	rovider C	CN: 15-0169	Peri od:	Worksheet D-3	
	maaaat	CCN. 15 51/0	From 01/01/2019 To 12/31/2019	Data (Tima Dra	
	mponent	CCN: 15-S169	To 12/31/2019	Date/Time Pre 6/30/2020 2:1	6 pm
	Titl€	e XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cos	st Inpatient	Inpati ent	
		To Charges	0	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
. 00 03000 ADULTS & PEDIATRICS			0		30
. 00 03100 INTENSIVE CARE UNIT			0		31
. 00 02060 NEONATAL INTENSIVE CARE UNIT			0		35
00 04000 SUBPROVIDER - IPF			6, 323, 290		40
. 00 04300 NURSERY					43
ANCI LLARY SERVICE COST CENTERS		0 1010	27		1 - 0
00 05000 OPERATING ROOM		0. 1012		0	
. 00 05100 RECOVERY ROOM		0. 1645		0	
. 00 05200 DELIVERY ROOM & LABOR ROOM . 00 05400 RADIOLOGY-DIAGNOSTIC		0.4827		0	
. 00 05400 RADI OLOGY-DI AGNOSTI C . 00 05500 RADI OLOGY-THERAPEUTI C		0. 1635		5, 606 0	
. 00 05700 CT SCAN		0.0723		2, 886	
00 05800 MRI		0.0338		724	
00 05900 CARDI AC CATHETERI ZATI ON		0.0589		0	
. 00 06000 LABORATORY		0.0997		84, 886	
00 06400 I NTRAVENOUS THERAPY		0. 6227		14, 162	
00 06500 RESPI RATORY THERAPY		0. 2139		4, 178	
. 00 06600 PHYSI CAL THERAPY		0. 3193		16, 640	66
. 00 06700 OCCUPATI ONAL THERAPY		0. 2914	31 51, 116	14, 897	67
. 00 06800 SPEECH PATHOLOGY		0. 1990	23 6, 506	1, 295	68
. 00 06900 ELECTROCARDI OLOGY		0.0656	54 20, 156	1, 323	69
. 00 07000 ELECTROENCEPHALOGRAPHY		0. 2054		372	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3620		25, 475	
. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4311		0	
00 07300 DRUGS CHARGED TO PATIENTS		0. 2440		121, 799	
01 07301 SPECIALTY PHARMACY		1. 1240		0	
. 00 07400 RENAL DI ALYSI S		0. 4172		0	
00 03330 ENDOSCOPY		0. 1470		0	
01 03950 OTHER ANCILLARY SERVICE COST CENTERS 02 03951 OTHER ANCILLARY SERVICE COST CENTERS		0.0000		0	
. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS		0.0000		0	
. 04  03953 WOUND CARE		0. 0000		0	
. 06  03954   MAGING CENTER		0. 2033		0	
. 07 03955 BREAST DI AGNOSTI C CENTER		0. 4785			
OUTPATIENT SERVICE COST CENTERS		0.1703	001 0	<u></u>	1
. 00 09000 CLINIC		0.0000	00 0	0	90
. 01 04950 I NFUSI ON CENTER		0. 5293		0	
. 26 04975 SPI NE CENTER		0. 5271		0	
. 00 09100 EMERGENCY		0. 1005		37, 988	91
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 7192	39 0	0	92
0.00 Total (sum of lines 50 through 94 and 96 through 98)			2, 099, 643	332, 231	200
1.00 Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)		0		201
2.00 Net charges (line 200 minus line 201)			2, 099, 643		202

leal th Financial Systems COMMUNITY HOSPITAL OF IN NPATIENT ANCILLARY SERVICE COST APPORTIONMENT Pr					u of Form CMS-2552-10	
INPAILENT	ANGILLARY SERVICE CUSI APPORTIUNMENT	Provider CCN: 15-0169		Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Pre 6/30/2020 2:1	pared:
		Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS				•	
30.00 0300	0 ADULTS & PEDIATRICS			7, 467, 126		30. 00
31.00 0310	O INTENSIVE CARE UNIT			2, 022, 237		31.00
35.00 0206	NO NEONATAL INTENSIVE CARE UNIT			14, 065, 021		35.00
40.00 0400	O SUBPROVIDER - IPF			440, 685		40.00
43.00 0430	NURSERY			487, 754		43.00
	LLARY SERVICE COST CENTERS					
	O OPERATING ROOM		0. 1012		240, 408	
	O RECOVERY ROOM		0. 1645	82 416, 407	68, 533	51.00
	O DELIVERY ROOM & LABOR ROOM		0. 4827	62 578, 375	279, 217	52.00
54.00 0540	0 RADI OLOGY-DI AGNOSTI C		0. 1635	82 602, 217	98, 512	54.00
	0 RADI OLOGY-THERAPEUTI C		0. 0723			
	DO CT SCAN		0. 0338	21 1, 215, 313	41, 103	57.00
58.00 0580	DO MRI		0. 0976	63 328, 109	32, 044	58.00
	O CARDI AC CATHETERI ZATI ON		0. 0589			
	0 LABORATORY		0. 0997	07 4, 030, 856	401, 905	60.00
	0 INTRAVENOUS THERAPY		0. 6227	73 77, 412	48, 210	64.00
	0 RESPI RATORY THERAPY		0. 2139	83 2, 059, 098	440, 612	
	0 PHYSI CAL THERAPY		0. 3203		50, 181	66.00
	0 OCCUPATI ONAL THERAPY		0. 2914			
	0 SPEECH PATHOLOGY		0. 1990	23 99, 121	19, 727	
	0 ELECTROCARDI OLOGY		0.0656		28, 657	
	0 ELECTROENCEPHALOGRAPHY		0. 2054			
	0 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3620			
	0 IMPL. DEV. CHARGED TO PATIENTS		0. 4311		0	
	0 DRUGS CHARGED TO PATIENTS		0. 2440			73.00
	1 SPECIALTY PHARMACY		1. 1240		0	73.0
	0 RENAL DI ALYSI S		0. 4172			
76.00 0333	IO ENDOSCOPY		0. 1470			76.0
	O OTHER ANCI LLARY SERVICE COST CENTERS		0.0000			76.0
	1 OTHER ANCILLARY SERVICE COST CENTERS		0.0000			
	2 OTHER ANCILLARY SERVICE COST CENTERS		0.0000		-	76.0
	3 WOUND CARE		0. 2633			
	4 I MAGI NG CENTER		0.0853			
	5 BREAST DI AGNOSTI C CENTER		0. 4785	85 0	0	76.0
	ATIENT SERVICE COST CENTERS		0.0000	00 0	^	
			0.0000			
	O INFUSION CENTER		0. 5293			90.0
	5 SPINE CENTER		0. 5271		-	90.2
	0 EMERGENCY		0. 1012			
	0 OBSERVATION BEDS (NON-DISTINCT PART		0. 7192			
200.00	Total (sum of lines 50 through 94 and 96 through 98)	(1)		21, 241, 601	3, 748, 048	
201.00	Less PBP Clinic Laboratory Services-Program only charges (	(IINE 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		I	21, 241, 601		202. 0

ALCUL	Financial Systems         COMMUNITY HOSPITAL OF IN           ATION OF REIMBURSEMENT SETTLEMENT         PI	rovider CCN: 15-0169	Period: From 01/01/2019	u of Form CMS-2 Worksheet E Part A	
			To 12/31/2019	Date/Time Pre 6/30/2020 2:1	
		Title XVIII	Hospi tal	PPS	
				1.00	
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 occurring instructions)	31, 974, 009	1.(		
02	DRG amounts other than outlier payments for discharges occurring instructions)	10, 288, 911	1. (		
03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)			0	
04	DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	di scharges occurri ng	on or after	0	1. (
00 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2. ( 2. (
02	Outlier payment for discharges for Model 4 BPCI (see instruction	is)		0	2.0
03	Outlier payments for discharges occurring prior to October 1 (se	848, 647	2.0		
04	Outlier payments for discharges occurring on or after October 1	(see instructions)		153, 891	2.0
00	Managed Care Simulated Payments			17, 526, 950	3.
00	Bed days available divided by number of days in the cost reporti	ng period (see instru	ctions)	287.92	4.
00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most r	ecent cost reporting	period ending on	0.00	5.
00	or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs that meet the new programs in accordance with 42 CFR 413.79(e)	criteria for an add-o	n to the cap for	0.00	6.
00	MMA Section 422 reduction amount to the IME cap as specified und	ler 42 CFR §412.105(f)	(1)(iv)(B)(1)	0.00	7.
01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.				7.
00	Adjustment (increase or decrease) to the FTE count for allopathi affiliated programs in accordance with 42 CFR 413.75(b), 413.79(	3.49	8.		
01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots	under § 5503 of the	ACA. If the cost	0.00	8.
02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots	from a closed teachi	ng hospi tal	0.00	8.
00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines instructions)	3.49	9.		
). 00	FTE count for allopathic and osteopathic programs in the current	year from your recor	ds	3.49	10.
. 00	FTE count for residents in dental and podiatric programs.	2.65	11.		
2.00	Current year allowable FTE (see instructions)				12.
8.00	Total allowable FTE count for the prior year.			5.39	13.
. 00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ended on or after Sep	tember 30, 1997,	4.94	14.
5.00	Sum of lines 12 through 14 divided by 3.			5.49	15.
b. 00	justment for residents in initial years of the program				16.
. 00	ijustment for residents displaced by program or hospital closure				17.
. 00	ijusted rolling average FTE count				18.
. 00	urrent year resident to bed ratio (line 18 divided by line 4).				19.
. 00 . 00	rior year resident to bed ratio (see instructions) nter the lesser of lines 19 or 20 (see instructions)				20.
. 00	IME payment adjustment (see instructions)			0. 019068 438, 140	
. 01	IME payment adjustment - Managed Care (see instructions)			181, 702	
. 00	Indirect Medical Education Adjustment for the Add-on for § 422 o Number of additional allopathic and osteopathic IME FTE resident		FR 412 105	0.00	
. 00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			0.00	
. 00	If the amount on line 24 is greater than -0-, then enter the low instructions)	0.00			
. 00	Resident to bed ratio (divide line 25 by line 4)			0.000000	
. 00	IME payments adjustment factor. (see instructions)			0.00000	
. 00	IME add-on adjustment amount (see instructions)			0	28.
. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28.
. 00 . 01	Total IME payment ( sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			438, 140 181, 702	
. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A pati	ent days (see instruc	tions)	3.66	30.
. 00	Percentage of Medicaid patient days (see instructions)	Chi uaya (See Histiluc	(10113)	3. 66 30. 99	
2.00	Sum of Lines 30 and 31			34.65	
3.00	Allowable disproportionate share percentage (see instructions)			17.80	
-	Disproportionate share adjustment (see instructions)			1, 880, 701	

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0169	Period: From 01/01/2019	Worksheet E Part A	
			To 12/31/2019	Date/Time Prep 6/30/2020 2:10	pare 6 pm
		Title XVIII	Hospi tal	PPS	<u>o p.</u>
			Prior to 10/1		
			1.00	2.00	
	Uncompensated Care Adjustment		0 070 070 447	0.050.500.00/	1 05
	Total uncompensated care amount (see instructions)		8, 272, 872, 447		
5.01	Factor 3 (see instructions)	r zara an this line) (as	0.000343050		
5. 02	Hospital uncompensated care payment (If line 34 is zero, enter instructions)	r zero on this line) (se	e 2, 838, 009	412, 446	35.
5. 03	Pro rata share of the hospital uncompensated care payment amou	unt (see instructions)	2, 122, 675	103, 675	35
	Total uncompensated care (sum of columns 1 and 2 on line 35.03	, , ,	2, 226, 350		36
. 00	Additional payment for high percentage of ESRD beneficiary dis				
. 00	Total Medicare discharges on Worksheet S-3, Part I excluding of		0		1 40
	652, 682, 683, 684 and 685 (see instructions)	<u>j</u>			
. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68	83, 684 an 685. (see	0		41
	instructions)				
. 01	Total ESRD Medicare covered and paid discharges excluding MS-I	DRGs 652, 682, 683, 684	0		41
	an 685. (see instructions)				
. 00	Divide line 41 by line 40 (if less than 10%, you do not qualit		0.00		42
. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682	2, 683, 684 an 685. (see	0		43
. 00	instructions) Ratio of average length of stay to one week (line 43 divided b	by line 41 divided by 7	0.00000		44
. 00	days)	by The 41 divided by /	0.000000		44
. 00	Average weekly cost for dialysis treatments (see instructions)	)	0.00		45
. 00	Total additional payment (line 45 times line 44 times line 41.		0		46
. 00	Subtotal (see instructions)		47, 810, 649		47
. 00	Hospital specific payments (to be completed by SCH and MDH, sr	mall rural hospitals	0		48
	only. (see instructions)				
				Amount	
				1.00	
. 00	Total payment for inpatient operating costs (see instructions)			47, 992, 351	
. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and			3, 826, 018	
. 00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	-
. 00	Direct graduate medical education payment (from Wkst. E-4, lin Nursing and Allied Health Managed Care payment	The 49 see Tristructions).		147, 930 0	
. 00	Special add-on payments for new technologies			0	
. 01	Islet isolation add-on payment			0	
. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69	9)		0	
. 00	Cost of physicians' services in a teaching hospital (see intru			0	
. 00	Routine service other pass through costs (from Wkst. D, Pt. II	-	nrough 35).	0	
3. 00	Ancillary service other pass through costs from Wkst. D, Pt. I		5 /	0	58
. 00	Total (sum of amounts on lines 49 through 58)			51, 966, 299	59
. 00	Primary payer payments			14, 465	60
. 00	Total amount payable for program beneficiaries (line 59 minus	line 60)		51, 951, 834	
. 00	Deductibles billed to program beneficiaries			4, 167, 352	
. 00	Coinsurance billed to program beneficiaries			148, 670	
	Allowable bad debts (see instructions)			360, 001	
	Adjusted reimbursable bad debts (see instructions)			234,001	
	Allowable bad debts for dual eligible beneficiaries (see instructional content of the second content of the se	ructions)		81, 413	
. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	applicable to MS DDC- (-	o instruction-	47, 869, 813	
. 00	Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	
. 00 . 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		<i>)</i>	0	
. 50	Rural Community Hospital Demonstration Project (§410A Demonstr	ration) adjustment (see	instructions)	0	
. 87	Demonstration payment adjustment amount before sequestration			0	
. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	
). 89	Pioneer ACO demonstration payment adjustment amount (see inst	ructions)			70
	HSP bonus payment HVBP adjustment amount (see instructions)	/		0	
). 90	HSP bonus payment HRR adjustment amount (see instructions)			0	
				0	
. 91	Bundled Model 1 discount amount (see instructions)			· Ui	1 / (
). 91 ). 92	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)			-350, 672	
. 91 . 92 . 93					70

	Financial Systems COMMUNITY HOSPITAL OF ATION OF REIMBURSEMENT SETTLEMENT	Provider C		Peri od:	u of Form CMS-2 Worksheet E	
				From 01/01/2019 To 12/31/2019	Part A Date/Time Pre	
		Ti +L c	XVIII	Hocni tal	6/30/2020 2:1 PPS	6 pr
		<u> </u>		Hospi tal (yyyy)	Amount	
				0	1. 00	
. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column O		0	0	70
. 97	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or af			0	0	70
98	Low Volume Payment-3				0	70
99	HAC adjustment amount (see instructions)				504, 514	70
00	Amount due provider (line 67 minus lines 68 plus/minus lines (	69 & 70)			46, 417, 060	
01	Sequestration adjustment (see instructions)				928, 341	
02	Demonstration payment adjustment amount after sequestration				0	71
03	Sequestration adjustment-PARHM pass-throughs					71
00	Interim payments				45, 101, 928	72
01	Interim payments-PARHM					72
00	Tentative settlement (for contractor use only)				0	73
01	Tentative settlement-PARHM (for contractor use only)					73
00	Balance due provider/program (line 71 minus lines 71.01, 71.02 73)	2, 72, and			386, 791	74
01	Balance due provider/program-PARHM (see instructions)					74
00	Protested amounts (nonallowable cost report items) in accordan	nce with			842, 499	75
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum o	of 2.03			0	90
~ ~	plus 2.04 (see instructions)					
00	Capital outlier from Wkst. L, Pt. I, line 2				0	91
00	Operating outlier reconciliation adjustment amount (see instru				0	92
00	Capital outlier reconciliation adjustment amount (see instruc				0	93
	The rate used to calculate the time value of money (see instru	uctions)			0.00	
00	Time value of money for operating expenses (see instructions)	+!)			0	
. 00	Time value of money for capital related expenses (see instruction	tions)		Prior to 10/1		96
				1.00	2.00	
	UCD Design Designed American					
	HSP Bonus Payment Amount			1.00	2.00	
	HSP bonus amount (see instructions)			0		100
	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment				0	
. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			0.000000000	0.000000000	101
. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions	s)			0.000000000	101
. 00 2. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment	s)		0.0000000000000000000000000000000000000	0.000000000 0	101 102
. 00 2. 00 8. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)			0.0000000000000000000000000000000000000	0.0000000000 0.0000000000 0 0.0000	101 102 103
1.00 2.00 3.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)	)		0.0000000000000000000000000000000000000	0.0000000000 0.0000000000 0 0.0000	101 102 103
1.00 2.00 3.00 4.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr	) ration) Adju		0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0.0000 0	101 102 103 104
2.00 2.00 3.00 4.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per	) ration) Adju		0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0.0000 0	101 102 103 104
. 00 2. 00 3. 00 4. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions, Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.	) ration) Adju		0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0.0000 0	101 102 103 104
2.00 2.00 3.00 4.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	) ration) Adju riod under t		0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0.0000 0	101 102 103 104 200
1.00 2.00 3.00 4.00 0.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	) ration) Adju riod under t		0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0.0000 0	101 102 103 104 200
1.00 2.00 3.00 4.00 0.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions)	) ration) Adju riod under t		0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0.0000 0	101 102 103 104 200 201 202
1.00 2.00 3.00 4.00 0.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	) ration) Adju riod under t e 49)	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.000000000 0 0.0000 0.0000 0	101 102 103 104 200 201 202
. 00 2. 00 3. 00 4. 00 0. 00 2. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	) ration) Adju riod under t e 49)	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.000000000 0 0.0000 0.0000 0	101 102 103 104 200 201 202
1.00 2.00 3.00 4.00 0.00 2.00 3.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)	) ration) Adju riod under t e 49)	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.000000000 0 0.0000 0 0.0000 0	101 102 103 104 200 201 202 203
1.00 2.00 3.00 4.00 0.00 1.00 2.00 3.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount	) ration) Adju riod under t e 49)	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.0000000000 0 0.0000 0 0.0000 0	101 102 103 104 200 201 202 203
. 00 . 00 . 00 . 00 . 00 . 00 . 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	) ration) Adju riod under t e 49)	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.0000000000 0 0.0000 0 0.0000 0	101 102 103 104 200 201 202 203 204 204
. 00 . 00 . 00 . 00 . 00 . 00 . 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	) ration) Adju riod under t e 49)	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.0000000000 0 0.0000 0 0.0000 0	101 102 103 104 200 201 202 203 204 204
1. 00 2. 00 3. 00 4. 00 5. 00 5. 00 5. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	) ration) Adju riod under t e 49) first year	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.000000000 0 0.0000 0	101 102 103 104 200 201 202 203 203 204
1. 00 2. 00 3. 00 4. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 5. 00 7. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare inpatient routine cost cap (line 202 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instruction (see instruction)	) ration) Adju riod under t e 49) first year ructions)	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.0000000000 0 0.0000 0	101 102 103 104 200 201 202 203 204 205 206
1. 00 2. 00 4. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 5. 00 7. 00 3. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	) ration) Adju riod under t e 49) first year ructions)	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.0000000000 0 0.0000 0	101 102 103 104 200 201 202 203 204 205 206 207 208
1. 00 2. 00 3. 00 4. 00 5. 00 4. 00 5. 00 4. 00 5. 00 7. 00 3. 00 9. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare IPPS payments (see instructions)	) ration) Adju riod under t e 49) first year ructions)	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.0000000000 0 0.0000 0	101 102 103 104 200 201 202 203 204 205 206 207 208 207 208
1.00 2.00 4.00 5.00 5.00 5.00 5.00 7.00 3.00 7.00 3.00 7.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare IPPS payments (see instructions) Redicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	) ration) Adju riod under t e 49) first year ructions)	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.000000000 0 0.0000 0	101 102 103 104 200 201 202 203 204 205 206 207 208 207 208 209 210
1.00 2.00 4.00 5.00 5.00 5.00 5.00 7.00 3.00 7.00 3.00 7.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	) ration) Adju riod under t e 49) first year ructions)	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.000000000 0 0.0000 0	101 102 103 104 200 201 202 203 204 205 206 207 208 207 208 209 210
1. 00 2. 00 3. 00 4. 00 0. 00 1. 00 2. 00 3. 00 5. 00 5. 00 7. 00 3. 00 7. 000	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Curres Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	) ration) Adju riod under t e 49) first year first year ructions) line 59)	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.000000000 0 0.0000 0	101 102 103 104 200 201 202 203 204 205 206 207 208 207 208 209 210 211
1. 00 2. 00 3. 00 4. 00 0. 00 1. 00 2. 00 3. 00 5. 00 5. 00 5. 00 7. 00 7. 00 0. 00 1. 00 2. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 203)	) ration) Adju riod under t e 49) first year first year ructions) line 59)	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.0000000000 0 0.0000 0	101 102 103 104 200 201 202 203 204 205 206 207 208 209 210 211 212
1. 00 2. 00 3. 00 4. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 0. 00 1. 00 2. 00 3. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Curres Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	) ration) Adju riod under t e 49) first year ructions) line 59) 211)	he 21st of the currer	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.0000000000 0 0.0000 0	102

	Financial Systems         COMMUNITY HOSPITAL OF           ATION OF REIMBURSEMENT SETTLEMENT         Image: Community Hospital Community	INDIANA, INC. Provider CCN: 15-0169	In Lie Period: From 01/01/2019	u of Form CMS-2 Worksheet E Part B	2552-10
			To 12/31/2019	Date/Time Pre	
		Title XVIII	Hospi tal	6/30/2020 2:10 PPS	6 pm
	· · · · · · · · · · · · · · · · · · ·		nospi tui	113	
				1.00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			17, 158	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		22, 317, 139	
3.00	OPPS payments			18, 602, 655	
4.00	Outlier payment (see instructions)			32, 992	
4.01 5.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instruct	tions)		0 0. 000	
6.00	Line 2 times line 5	(TOHS)		0.000	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	1
8.00	Transitional corridor payment (see instructions)			0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IN	/, col. 13, line 200		0	
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 17, 158	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			17, 130	11.00
	Reasonable charges				
12.00	Ancillary service charges	(0)		70, 381	
13.00 14.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lir	ne 69)		0 70, 381	
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			70, 301	14.00
15.00	Aggregate amount actually collected from patients liable for pa	ayment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for			0	16.00
17 00	had such payment been made in accordance with 42 CFR §413.13(e)	)		0,000000	47.00
17.00 18.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 70, 381	
19.00	Excess of customary charges over reasonable cost (complete only	vifline 18 exceeds l	ine 11) (see		19.00
	instructions)	,			
20.00	Excess of reasonable cost over customary charges (complete only	y if line 11 exceeds l	ine 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)			17, 158	21 00
21.00	Interns and residents (see instructions)			17, 138	1
23.00	Cost of physicians' services in a teaching hospital (see instru	uctions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			18, 635, 647	24.00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	<u>,</u>		0	1 25 00
25.00 26.00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line		ructions)	0 3, 489, 180	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl	-		15, 163, 625	1
	instructions)		2 (		
28.00	Direct graduate medical education payments (from Wkst. E-4, lir	ne 50)		53, 741	
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 15, 217, 366	
31.00	Primary payer payments				31.00
32.00	Subtotal (line 30 minus line 31)			15, 213, 733	1
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	ES)			
33.00	Composite rate ESRD (from Wkst. 1-5, line 11)				33.00
34.00 35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			520, 407 338, 265	
36.00	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		318, 018	
37.00	Subtotal (see instructions)			15, 551, 998	37.00
38.00	MSP-LCC reconciliation amount from PS&R				38.00
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)	)		0	39.00 39.50
39.30 39.97	Demonstration payment adjustment amount before sequestration	,		0	
39.98	Partial or full credits received from manufacturers for replace	ed devices (see instru	ctions)	0	
39.99	RECOVERY OF ACCELERATED DEPRECIATION	·		0	
40.00	Subtotal (see instructions)			15, 551, 748	
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			311, 035 0	1
40. 02	Sequestration adjustment-PARHM pass-throughs			0	40.02
41.00	Interim payments			15, 072, 831	1
41.01	Interim payments-PARHM				41.01
42.00	Tentative settlement (for contractors use only)			0	
42. 01 43. 00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			167, 882	42.01
43.00	Balance due provider/program-PARHM (see instructions)			107,002	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance §115.2	ce with CMS Pub. 15-2,	chapter 1,	0	44.00
	TO BE COMPLETED BY CONTRACTOR				1
90.00	Original outlier amount (see instructions)			0	
91.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money				91.00
02 00				0.00	92.00
92. 00 93. 00	Time Value of Money (see instructions)			0	93.00

ALCUL	Financial Systems         COMMUNITY HOSPITAL 0           ATI ON OF REIMBURSEMENT SETTLEMENT	F INDIANA, INC. Provider CCN: 15-0169	Period: From 01/01/2019	u of Form CMS-2 Worksheet E Part B	
		Component CCN: 15-S169	To 12/31/2019	Date/Time Pre 6/30/2020 2:10	
		Title XVIII	Subprovider - IPF	PPS	0 011
				1.00	
. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			815	1.0
. 00	Medical and other services reimbursed under OPPS (see instruc	ctions)		013	
. 00	OPPS payments			269	
. 00 . 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	
. 00	Enter the hospital specific payment to cost ratio (see instru	uctions)		0. 000	
. 00	Line 2 times line 5			0	
. 00 . 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0. 00 0	
. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	
0. 00	Organ acquisitions			0	
1. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			815	11.0
	Reasonabl e charges			0.000	
2.00 3.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		3, 339	12.0
4.00	Total reasonable charges (sum of lines 12 and 13)			3, 339	
5.00	Customary charges Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15. (
6. 00	Amounts that would have been realized from patients liable for	or payment for services o		0	16. (
7.00	had such payment been made in accordance with 42 CFR §413.13 Ratio of line 15 to line 16 (not to exceed 1.000000)	(e)		0, 000000	17 (
8.00	Total customary charges (see instructions)			3, 339	
9.00	Excess of customary charges over reasonable cost (complete or	nly if line 18 exceeds li	ne 11) (see	2, 524	19. (
0. 00	instructions) Excess of reasonable cost over customary charges (complete or	nly if line 11 exceeds li	ne 18) (see	0	20. (
1. 00	instructions) Lesser of cost or charges (see instructions)			015	21.
2.00	Interns and residents (see instructions)			015	
3.00	Cost of physicians' services in a teaching hospital (see inst	tructions)		0	
4.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			269	24.
5.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instruction	าร)		0	25.0
6. 00	Deductibles and Coinsurance amounts relating to amount on lir	-		0	
7.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	plus the sum of lines 22	2 and 23] (see	1, 084	27.0
8.00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. (
9.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	)		0	
0.00 1.00	Subtotal (sum of lines 27 through 29) Primary payer payments			1, 084	30. ( 31. (
2.00	Subtotal (line 30 minus line 31)			1, 084	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
3.00 4.00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0	
5.00	Adjusted reimbursable bad debts (see instructions)			0	
6.00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		0	
7.00 8.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			1, 084 0	
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
9.50	Pioneer ACO demonstration payment adjustment (see instruction	าร)			39.
9.97	Demonstration payment adjustment amount before sequestration	and doubless (see instruc	tiono)		39.
9. 98 9. 99	Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION	aced devices (see instruc	(TIONS)	0	
0.00	Subtotal (see instructions)			1, 084	40.
0.01	Sequestration adjustment (see instructions)				40.
0. 02 0. 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40. 40.
1.00	Interim payments			1, 072	
	Interim payments-PARHM				41.
2.00 2.01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42. 42.
3.00	Balance due provider/program (see instructions)			-10	42.
3. 01 4. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub 15.2	chapter 1	0	43.
<b>⊣</b> . UU	§115. 2	ande with GWB FUD. 13-2,		0	44.
0. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.
1.00	Outlier reconciliation adjustment amount (see instructions)				91.
2.00 3.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92. 93.
	Total (sum of lines 91 and 93)				93.

ANALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-0169	Period: From 01/01/2019 To 12/31/2019		bared: 5 pm
		Title	xvi i	Hospi tal	PPS	•
		Inpatien	it Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		45, 101, 92	28 0	15, 072, 831 0	1.00 2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
3.01	ADJUSTMENTS TO PROVIDER			0	0	3.01
3.02				0	0	3.02
3.03				0	0	3.03
3.04				0	0	3.04
3.05	Provider to Program			0	0	3. 05
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.5
3.52				0	0	3.52
3.53				0	0	3.5
3.54 3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3.54 3.99
3.77	3. 50-3. 98)			0	0	3. 7
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		45, 101, 92	28	15, 072, 831	4.00
	TO BE COMPLÉTED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.00
5.01	TENTATI VE TO PROVIDER			0	0	5. O´
5.02				0	0	5.02
5.03				0	0	5.03
	Provider to Program					
5.50 5.51	TENTATI VE TO PROGRAM			0	0	5.50 5.5
5.51 5.52				0	0	5.5 5.5
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5.9
5.00 5.01	Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER		386, 79	21	167, 882	6. 00 6. 0
5. 01 6. 02	SETTLEMENT TO PROVIDER		300, /	0	107, 002	6.02
7.002	Total Medicare program liability (see instructions)		45, 488, 7	-	15, 240, 713	7.0
-			· · · ·	Contractor Number	NPR Date (Mo/Day/Yr)	
		(	C	1.00	2.00	

IALYS	IS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component C	CN: 15-0169 CCN: 15-S169	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part I Date/Time Prep 6/30/2020 2:16	pared
		Title	XVIII	Subprovider - IPF	PPS	
		I npati en	t Part A		тв	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2, 393, 3	83 0	1, 072 0	1. ( 2. (
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) Program to Provider					3. (
01	ADJUSTMENTS TO PROVIDER			0	0	3.0
02 03 04				0 0 0	0 0 0	3. ( 3. ( 3. (
05				0	0	3. (
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51 52 53 54				0 0 0	0 0 0	3. 3. 3. 3.
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2, 393, 3	83	1, 072	4.
00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.
01	Program to Provider TENTATIVE TO PROVIDER			0	0	5.
02 03	TENTATIVE TO PROVIDER			0	0	5. 5.
	Provider to Program					
50 51	TENTATIVE TO PROGRAM			0	0 0	5. 5.
52 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0 0	5. 5.
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
01	SETTLEMENT TO PROVIDER		9, 7	83	0	6.
02	SETTLEMENT TO PROGRAM			0	10	6.
00	Total Medicare program liability (see instructions)		2, 403, 1		1, 062	7.
				Contractor Number	NPR Date (Mo/Day/Yr)	

Heal th	Financial Systems COMMUNITY HOSPITAL OF	INDIANA, INC.	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0169	Peri od:	Worksheet E-1	
			From 01/01/2019		
			To 12/31/2019	Date/Time Pre 6/30/2020 2:1	
		Title XVIII	Hospi tal	PPS	
			nospi tui	110	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				1
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)		`		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	IS)		32.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0169	Period: From 01/01/2019	Worksheet E-3 Part II	
		Component CCN: 15-S169	To 12/31/2019	Date/Time Pre 6/30/2020 2:1	pare 6 nm
		Title XVIII	Subprovider -	PPS	0 011
			-	1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS				
00	Net Federal IPF PPS Payments (excluding outlier, ECT, and med	lical education payments)		2, 691, 061	1.
00	Net IPF PPS Outlier Payments			625	2.
00	Net IPF PPS ECT Payments	ant report filed on or b	oforo Novembor	0	3
00	Unweighted intern and resident FTE count in the most recent c 15, 2004. (see instructions)	cost report filled on or b	erore wovelliber	0.00	4
01	Cap increases for the unweighted intern and resident FTE cour	t for residents that wer	e displaced by	0.00	4
01	program or hospital closure, that would not be counted without			0.00	4
	CFR §412. 424(d) (1) (i i i ) (F) (1) or (2) (see instructions)				
00	New Teaching program adjustment. (see instructions)			0.00	5
00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	eriod of a "new	0.00	6
	teaching program" (see instuctions)				
00	Current year's unweighted I&R FTE count for residents within	the new program growth p	eriod of a "new	0.00	7
	teaching program" (see instuctions)				
00	Intern and resident count for IPF PPS medical education adjus	stment (see instructions)		0.00	8
00	Average Daily Census (see instructions)			14.087671	9
. 00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to	the power of .5150 -1}.		0.00000	
00	Teaching Adjustment (line 1 multiplied by line 10).			0	11
00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11) Nursing and Allied Health Managed Care payment (see instructi	<b>ab</b> )		2, 691, 686 0	13
. 00	Organ acquisition (DO NOT USE THIS LINE)	011)		0	14
. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	15
. 00	Subtotal (see instructions)			2, 691, 686	16
. 00	Primary payer payments			2,071,000	17
. 00	Subtotal (line 16 less line 17).			2, 691, 686	
. 00	Deducti bl es			205, 916	
. 00	Subtotal (line 18 minus line 19)			2, 485, 770	20
. 00	Coinsurance			43, 540	21
. 00	Subtotal (line 20 minus line 21)			2, 442, 230	22
00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		15, 354	23
. 00	Adjusted reimbursable bad debts (see instructions)			9, 980	
. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	25
00	Subtotal (sum of lines 22 and 24)			2, 452, 210	
00	Direct graduate medical education payments (see instructions)			0	27
00	Other pass through costs (see instructions)			0	28
. 00	Outlier payments reconciliation			0	29
00 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	30
. 99	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	15)		0	30
. 99	Total amount payable to the provider (see instructions)			2, 452, 210	
. 01	Sequestration adjustment (see instructions)			49, 044	31
. 02	Demonstration payment adjustment amount after sequestration			0	
. 00	Interim payments			2, 393, 383	
. 00	Tentative settlement (for contractor use only)			0	33
. 00	Balance due provider/program (line 31 minus lines 31.01, 31.0	)2, 32 and 33)		9, 783	
. 00	Protested amounts (nonallowable cost report items) in accorda §115.2	ance with CMS Pub. 15-2,	chapter 1,	0	35
	TO BE COMPLETED BY CONTRACTOR				
. 00	Original outlier amount from Worksheet E-3, Part II, line 2			625	50
. 00	Outlier reconciliation adjustment amount (see instructions)			0	51
2. 00	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0	5

	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider C		Period: From 01/01/2019	Worksheet E-4	
	L EDUCATION COSTS		-	To 12/31/2019	Date/Time Prep 6/30/2020 2:10	
		Title	e XVIII	Hospi tal	PPS	
					1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT		· ·			
. 00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs for	cost reporti	ng periods	0.00	1. (
. 00	Unweighted FTE resident cap add-on for new programs per 42 CF	R 413.79(e)(	1) (see instru	uctions)	0.00	2.0
. 00	Amount of reduction to Direct GME cap under section 422 of MM			,	0.00	
. 01	Direct GME cap reduction amount under ACA §5503 in accordance	with 42 CFF	R §413.79 (m).	(see	0.00	3.
. 00	instructions for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and		programs due	to a Medicare	3.49	4.
. 01	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f) ACA Section 5503 increase to the Direct GME FTE Cap (see inst stradding 74(2021)		cost reporti	ng periods	0.00	4.
. 02	straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap slot	s (see inst	ructions for a	cost reporting	0.00	4.
. 02	periods straddling 7/1/2011)	3 (300 113)		sost reporting	0.00	
. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl	us or minus	line 4 plus li	nes 4.01 and	3.49	5.
. 00	4.02 plus applicable subscripts Unweighted resident FTE count for allopathic and osteopathic	programs for	the current of	war from your	3.49	6.
. 00	records (see instructions)	programs ror	the current	year rrom your	5.47	0.
. 00	Enter the lesser of line 5 or line 6		1		3. 49	7.
			Primary Care		Total	
. 00	Weighted FTE count for physicians in an allopathic and osteop	athi c	1.00	2.00 9 2.00	3.00	8.
. 00	program for the current year.	atm c		2.00	5.47	0.
. 00	If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo		1.4	9 2.00	3.49	9.
0. 00	6. Weighted dental and podiatric resident FTE count for the curr	ent vear		2.65		10.
0. 01	Unweighted dental and podiatric resident FTE count for the cu	5		0.00		10.
1. 00	Total weighted FTE count		1.4			11.
2.00	Total weighted resident FTE count for the prior cost reportin instructions)	ig year (see	1.2	7 4.12		12.
3. 00	Total weighted resident FTE count for the penultimate cost re year (see instructions)	porting	1.4.	2 3.12		13.
4.00	Rolling average FTE count (sum of lines 11 through 13 divided	l by 3).	1.3	9 3.96		14.
5.00	Adjustment for residents in initial years of new programs		0.0			15.
5.01	Unweighted adjustment for residents in initial years of new p		0.0			15. 16.
6. 00 6. 01	Adjustment for residents displaced by program or hospital clo Unweighted adjustment for residents displaced by program or h		0.0			16.
0.01	closure			0,00		
7.00	Adjusted rolling average FTE count		1.3			17.
8.00 9.00	Per resident amount Approved amount for resident costs		95, 610. 2 132, 89		F11 F1F	18. 19.
9.00			132, 09	8 378, 617	511, 515	19.
					1.00	
0. 00	Additional unweighted allopathic and osteopathic direct GME F	TE resident	cap slots rec	eived under 42	0.00	20.
	Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instru	uctions)			0.00	21
1 00		· ·			0.00	
	5					
2.00	Allowable additional direct GME FTE Resident Count (see instr Enter the locality adjustment national average per resident a		nstructions)		0.00	
2.00 3.00 4.00	Allowable additional direct GME FTE Resident Count (see instr Enter the locality adjustment national average per resident a Multiply line 22 time line 23		nstructions)		0	
2.00 3.00 4.00	Allowable additional direct GME FTE Resident Count (see instr Enter the locality adjustment national average per resident a			t Managed Care	0 511, 515	
2.00 3.00 4.00	Allowable additional direct GME FTE Resident Count (see instr Enter the locality adjustment national average per resident a Multiply line 22 time line 23		Inpatient Par	t Managed Care	0 <u>511, 515</u> Total	
2.00 3.00 4.00	Allowable additional direct GME FTE Resident Count (see instr Enter the locality adjustment national average per resident a Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)		Inpatient Par	t Managed Care	0 511, 515	
2.00 3.00 4.00 5.00	Allowable additional direct GME FTE Resident Count (see instr Enter the locality adjustment national average per resident a Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24) COMPUTATION OF PROGRAM PATIENT LOAD		Inpatient Par A 1.00	2.00	0 <u>511, 515</u> Total	25.
2.00 3.00 4.00 5.00	Allowable additional direct GME FTE Resident Count (see instr Enter the locality adjustment national average per resident a Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)		Inpati ent Par A 1.00 23,53	2. 00 3 9, 559	0 <u>511, 515</u> Total	25. 26.
2.00 3.00 4.00 5.00 6.00 7.00	Allowable additional direct GME FTE Resident Count (see instr Enter the locality adjustment national average per resident a Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24) COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions)		Inpatient Par A 1.00	2.00 3 9,559 7 82,237	0 <u>511, 515</u> Total	25. 26. 27.
22.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00	Allowable additional direct GME FTE Resident Count (see instr Enter the locality adjustment national average per resident a Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24) COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions) Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount		Inpati ent Par A 1.00 23,53 82,23	2.00 3 9,559 7 82,237 1 0.116237 6 59,457	0 <u>511, 515</u> Total	25. 26. 27. 28. 29.
23.00 24.00 25.00	Allowable additional direct GME FTE Resident Count (see instr Enter the locality adjustment national average per resident a Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24) COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions) Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days		I npati ent Par A 1.00 23,53 82,23 0.28616	2.00 3 9,559 7 82,237 1 0.116237	0 511, 515 Total 3. 00	25. 26. 27. 28. 29. 29.

Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. In Li	eu of Form CMS-2	2552-10
DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT Provider CCN: 15-0169 Period:	Worksheet E-4	
MEDICAL EDUCATION COSTS From 01/01/201 To 12/31/201		arad
10 12/31/201	6/30/2020 2:10	
Ti tle XVIII Hospi tal	PPS	<u> </u>
	1.00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAME	I CAL	
EDUCATI ON COSTS)		
32.00 Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74	0	32.00
and 94)		
33.00 Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	4, 194, 423	
34.00 Ratio of direct medical education costs to total charges (line 32 + line 33)		
35.00 Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00 Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
Part A Reasonable Cost	1 (1 (25 00)	
37.00 Reasonable cost (see instructions)		
38.00 Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	0	38.00
39.00 Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00 Primary payer payments (see instructions)	14, 465	40.00
41.00 Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost	61, 470, 841	41.00
42.00 Reasonable cost (see instructions)	22, 335, 112	12 00
43.00 Primary payer payments (see instructions)	22, 335, 112	
44.00 Total Part B reasonable cost (line 42 minus line 43)	22, 331, 479	
45. 00 Total reasonable cost (sum of lines 41 and 44)	83, 802, 320	
46.00 Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0. 733522	46.00
47. 00 Ratio of Part B reasonable cost to total reasonable cost (line 44 + line 45)	0. 266478	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B	0.200470	.,
48.00 Total program GME payment (line 31)	201, 671	48.00
49.00 Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	147, 930	
50. 00 Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	53, 741	

	Financial Systems COMMUNITY HOSPITAL E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	CN: 15-0169	Period: From 01/01/2019	u of Form CMS- Worksheet G	
ly)	ype accounting records, comprete the General Fund cordinin			To 12/31/2019	Date/Time Pre 6/30/2020 2:1	epare 6 pm
		General Fund	Specific Purpose Fund	Endowment Fund		
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	8, 600		o c	0	1.
00	Temporary investments	0		0 0	0	
00	Notes receivable	0	(	o o	0	3.
00	Accounts receivable	2, 189, 246, 593		0 0	0	
00	Other receivable	-206, 080, 811		0 0	0	
00	Allowances for uncollectible notes and accounts receivable			0 0	0	
00 00	Inventory Prepaid expenses	6, 017, 967 4, 364, 170			0	
00	Other current assets	4, 304, 170			0	-
. 00	Due from other funds	0			0	
00	Total current assets (sum of lines 1-10)	1, 994, 143, 907		0 0	0	
00	FI XED ASSETS		· · · · · · · · · · · · · · · · · · ·			1
00	Land	2, 705, 851	(	0 0	0	12
00	Land improvements	4, 358, 832		0 0	0	13
00	Accumulated depreciation	0		0 C	0	
00	Buildings	323, 581, 869		0 0	0	
. 00	Accumulated depreciation	0		0 0	0	
. 00	Leasehold improvements Accumulated depreciation	4, 293, 978			0	
. 00	Fixed equipment	120, 791, 132			0	
. 00	Accumulated depreciation	120,791,132			0	
	Automobiles and trucks	103, 991		0 0	0	
. 00	Accumulated depreciation	0	(	0 0	0	
. 00	Major movable equipment	0		o c	0	23
. 00	Accumulated depreciation	-239, 815, 613		0 0	0	
00	Minor equipment depreciable	0		0 C	0	
. 00	Accumulated depreciation	0		0 0	0	
. 00	HIT designated Assets	0		0 0	0	
. 00 . 00	Accumulated depreciation Minor equipment-nondepreciable	316, 270			0	
. 00	Total fixed assets (sum of lines 12-29)	216, 336, 310			0	
. 00	OTHER ASSETS	210, 330, 310	· · · · · ·		0	
. 00	Investments	0	(	0 0	0	31
. 00	Deposits on Leases	0	(	o c	0	32
. 00	Due from owners/officers	0		0 0	0	33
. 00	Other assets	-938, 300, 419		0 0	0	
. 00	Total other assets (sum of lines 31-34)	-938, 300, 419		0 0	0	
. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	1, 272, 179, 798	[(	0 0	0	36
. 00	Accounts payable	3, 139, 370	(	0 0	0	37
00	Salaries, wages, and fees payable	0	(	0 0	0	38
00	Payroll taxes payable	0		0 C	0	
. 00	Notes and Loans payable (short term)	0		0 0	0	
. 00	Deferred income	0	(	0 0	0	
. 00	Accelerated payments Due to other funds	0		o c	0	42
. 00 . 00	Other current liabilities	2, 367, 508			0	
. 00	Total current liabilities (sum of lines 37 thru 44)	5, 506, 878		0 0	0	
	LONG TERM LIABILITIES	0,000,070	· · · · ·			
. 00	Mortgage payable	0	(	0 0	0	46
. 00	Notes payable	0		o c	0	47
. 00	Unsecured Loans	996, 634		0 0	0	48
. 00	Other long term liabilities	0		0 C	0	
. 00	Total long term liabilities (sum of lines 46 thru 49)	996, 634		0 0	0	
00	Total liabilities (sum of lines 45 and 50)	6, 503, 512	(	0 0	0	51
00	CAPI TAL ACCOUNTS General fund balance	1, 265, 676, 286				52
00	Specific purpose fund	1, 205, 070, 200		0		53
00	Donor created - endowment fund balance - restricted		'	0		54
. 00	Donor created - endowment fund balance - unrestricted			0		55
. 00	Governing body created - endowment fund balance			0		56
. 00	Plant fund balance - invested in plant				0	
. 00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion					
. 00 . 00	Total fund balances (sum of lines 52 thru 58)	1, 265, 676, 286		0 0	0	
	Total liabilities and fund balances (sum of lines 51 and	1, 272, 179, 798	1 (	0	0	60

Heal th	Financial Systems COMM	UNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
STATEN	ENT OF CHANGES IN FUND BALANCES		Provider CC		Period: From 01/01/2019 To 12/31/2019	Worksheet G-1 Date/Time Pre 6/30/2020 2:1	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance		1, 153, 575, 583 112, 100, 703 1, 265, 676, 286 1, 265, 676, 286 1, 265, 676, 286 0 1, 265, 676, 286			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund	_		
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	00	0 0 0 0 0 0 0		0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19.00

	Financial Systems COMMUNITY HOSPITAL 0				eu of Form CMS-2	
STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
					6/30/2020 2:1	6 pm
	Cost Center Description		Inpatient	Outpatient	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES General Inpatient Routine Services					-
1.00	Hospi tal		163, 816, 6	27	163, 816, 637	1.00
2.00	SUBPROVIDER - IPF		11, 649, 0		11, 649, 028	2.00
3.00	SUBPROVIDER - IRF		11, 049, 0	20	11, 049, 020	3.00
4.00	SUBPROVIDER					4.00
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY			-		7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		175, 465, 6	65	175, 465, 665	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT		27, 406, 3	18	27, 406, 318	11.00
12.00	CORONARY CARE UNI T					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	NEONATAL INTENSIVE CARE UNIT		92, 781, 1		92, 781, 176	
16.00	Total intensive care type inpatient hospital services (sum of	f lines	120, 187, 4	94	120, 187, 494	16.00
17 00	11-15)					17 00
17.00	Total inpatient routine care services (sum of lines 10 and 10	)	295, 653, 1		295, 653, 159	
18.00	Ancillary services Outpatient services		603, 787, 9			18.00
19.00 20.00	RURAL HEALTH CLINIC					19.00 20.00
20.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0		20.00
21.00	HOME HEALTH AGENCY			0	0	21.00
23.00	AMBULANCE SERVICES					23.00
24.00	CMHC					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.00
26.00	HOSPI CE					26.00
27.00	PROFESSIONAL FEES			0 66,030	66, 030	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	3 to Wkst.	899, 441, 0		1, 598, 326, 163	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES		-		-	
29.00	Operating expenses (per Wkst. A, column 3, line 200)			413, 824, 594	Ļ	29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECI FY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00 41.00				0		40.00
41.UU	Total deductions (sum of lines 37-41)			0		41.00
42 00						
42.00 43.00	Total operating expenses (sum of lines 29 and 36 minus line 4	l2)(transfer		413, 824, 594		43.00

	Financial Systems COMMUNITY HOSPITAL OF			u of Form CMS-2	
STATEM	TATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-0169 Period:			Worksheet G-3	
			From 01/01/2019 To 12/31/2019	Date/Time Pre	narod
			10 12/31/2019	6/30/2020 2: 10	
					·
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir	ne 28)		1, 598, 326, 163	1.00
2.00	Less contractual allowances and discounts on patients' accour	nts		1, 077, 403, 105	2.00
3.00	Net patient revenues (line 1 minus line 2)			520, 923, 058	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		413, 824, 594	
5.00	Net income from service to patients (line 3 minus line 4)			107, 098, 464	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			1, 275, 878	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			16, 705	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			2, 652, 289	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other t	than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			79, 419	22.00
23.00	Governmental appropriations			0	23.00
24.00	MI SC REVENUE			977, 949	24.00
25.00	Total other income (sum of lines 6–24)			5, 002, 240	25.00
26.00	Total (line 5 plus line 25)			112, 100, 704	26.00
27.00	ROUNDING			1	27.00
28.00	Total other expenses (sum of line 27 and subscripts)			1	28.00
20.00	Net income (or loss) for the period (line 26 minus line 28)			112, 100, 703	20 00

Health Financial Systems	COMMUNI TY HOSPI TAL OF	INDIANA, INC.	In Lie	u of Form CMS-2	552-10
CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0169	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prep 6/30/2020 2:10	
		Title XVIII	Hospi tal	PPS	
				1 00	

		1.00			
	PART I - FULLY PROSPECTIVE METHOD	1.00			
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier	3, 422, 108	1.00		
1.01	Model 4 BPCI Capital DRG other than outlier	0			
2.00	Capital DRG outlier payments	130, 826			
2.00	Model 4 BPCI Capital DRG outlier payments	0	1		
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	217.42			
4.00	Number of interns & residents (see instructions)	5.49			
5.00	Indirect medical education percentage (see instructions)	0.71			
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and	24, 297			
	1.01) (see instructions)				
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	3.66	7.00		
8.00	Percentage of Medicaid patient days to total days (see instructions)	30. 99	8.00		
9.00	Sum of Lines 7 and 8	34.65	9.00		
10.00	Allowable disproportionate share percentage (see instructions)	7.27	10.00		
11.00	Disproportionate share adjustment (see instructions)	248, 787	11.00		
12.00	Total prospective capital payments (see instructions)	3, 826, 018	12.00		
		1.00			
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)	0	1.00		
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00		
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00		
4.00	Capital cost payment factor (see instructions)	0	4.00		
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00		
		1.00			
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)	0	1.00		
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00		
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00		
4.00	Applicable exception percentage (see instructions)	0.00	4.00		
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00		
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00		
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	ol	7.00		
8.00	Capital minimum payment level (line 5 plus line 7)	ol	8.00		
9.00	Current year capital payments (from Part I, line 12, as applicable)	o	9.00		
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	Ő			
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00		
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00		
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0			
	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0			
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00		
	Current year operating and capital costs (see instructions)	0			
	Current year exception offset amount (see instructions)	0			
17.00	Content year exception offset amount (see first actions)	U U	17.00		