Health Financial Systems COMMUNITY HOSPITA				u of Form CMS-2	2552-10
This report is required by law (42 USC 1395g; 42 CFR 413.20(b)).					
payments made since the beginning of the cost reporting period b	eing dee	med overpayments (42	2 USC 1395g).	OMB NO. 0938-0	
				EXPIRES 09-30-	-2025
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICAT	ION Pro	ovider CCN: 15-0169	Peri od:	Worksheet S	
AND SETTLEMENT SUMMARY			From 01/01/2022 To 12/31/2022	Parts I-III Date/Time Prep	arod
			10 12/31/2022	5/25/2023 11: 3	
PART I – COST REPORT STATUS			-		
Provider 1. [X] Electronically prepared cost report			Date: 5/25/202	23 Time: 11:	:31 am
use only 2. [] Manually prepared cost report					
3.[0]If this is an amended report enter the num 4.[F]Medicare Utilization. Enter "F" for full,	nber of t	imes the provider r	esubmitted this co	ost report	
	"L" for				
Contractor 5. [1] Cost Report Status 6. Date Received:			NPR Date:	0	
use only (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N] Initial Repor	t for th	is Provider CCN 12	Contractor's Vendo)r COOLE: Jump 1 is 1. Fr	4 ntor
(3) Settled with Audit 9. [N] Final Report	for this	s Provider CCN	number of tim	ies reopened = (0_9
(4) Reopened					0 7.
(5) Amended					
PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINIST					
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED					
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LA		-			
PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY	OF A KIC	KBACK OR WERE OTHER	WISE ILLEGAL, CRIM	IINAL, CIVIL ANI	D
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.					
CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATO	OR OF PRO	VVI DER(S)			
I HEREBY CERTIFY that I have read the above certification	on statem	ent and that I have	examined the acco	ompanvi ng	
electronically filed or manually submitted cost report a	and submi	tted cost report and	d the Balance Shee	et and	
Statement of Revenue and Expenses prepared by COMMUNITY	HOSPI TAL	OF INDIANA, INC. (15-0169) for the	e cost	
reporting period beginning 01/01/2022 and ending 12/31/2					
report and statement are true, correct, complete and pre					
accordance with applicable instructions, except as noted					
regulations regarding the provision of health care servi			identified in this	s cost	
report were provided in compliance with such laws and re	egulatior	IS.			
SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	HECKBOX		ELECTRONI C		
1	2	SI GI	NATURE STATEMENT		

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

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	622, 988	-6, 389	0	0	1.00
2.00	SUBPROVIDER - IPF	0	1, 041	-8		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	624, 029	-6, 397	0	0	200.00

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

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

SPI 1	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provi d	ler CCN	N: 15-0169	Period: From 01/01/	2022	Workshe Part I	et S-2	2552-
						To 12/31/	2022	Date/Ti 5/25/20	me Pre	pare
	1.00	2.00		3.00			4.00	5725720	25 11.	
	Hospital and Hospital Health Care Co									
00 00	Street: 7150 CLEARVISTA DRIVE City: INDIANAPOLIS	PO Box: State: IN	Zip Cod	o. 1625	56 Count	ty: MARION				1.
00	CITY. INDIANAFOLIS	Component Name	CCN	CBS		1	Pavme	nt Syst	em (P.	Ζ.
			Number	Numb		Certified		0, or	N)	
		1.00					V	XVIII		-
	Hospital and Hospital-Based Componen	1.00	2.00	3.0	0 4.00	5.00	6.00	7.00	8.00	
00	Hospi tal	COMMUNITY HOSPITAL OF	150169	2690	00 1	02/25/2008	N	Р	Р	3.
		INDIANA, INC.								
00	Subprovider - IPF	COMMUNITY MENTAL HEALTH	I 15S169	2690	0 4	01/01/2010	N	P	0	4.
00 00	Subprovider - IRF Subprovider - (Other)									5.
00	Swing Beds - SNF									7.
00	Swing Beds - NF									8.
00	Hospital-Based SNF									9.
. 00										10.
	Hospital -Based OLTC									11.
	Hospital-Based HHA Separately Certified ASC									12.
	Hospi tal -Based Hospi ce									14.
. 00	Hospital-Based Health Clinic - RHC									15.
	Hospital-Based Health Clinic - FQHC									16.
00	Hospital-Based (CMHC) I									17
	Renal Dialysis Other									18
00	other			1		From:		То	:	17.
						1.00		2. (
	Cost Reporting Period (mm/dd/yyyy)					01/01/2	022	12/31/	/2022	20.
. 00	Type of Control (see instructions)					2				21
				F	1.00	2.00		3. (00	1
	Inpatient PPS Information									
. 00	51 5				Y	N				22.
	disproportionate share hospital adjus §412.106? In column 1, enter "Y" for			·						
	facility subject to 42 CFR Section §	412.106(c)(2)(Pickle am	endment							
	hospital?) In column 2, enter "Y" for	r yes or "N" for no.								
. 01	Did this hospital receive interim UCI				Y	Y				22.
	this cost reporting period? Enter in for the portion of the cost reporting									
	1. Enter in column 2, "Y" for yes or									
	cost reporting period occurring on o									
	instructions)									
. 02	Is this a newly merged hospital that				Ν	N				22.
	determined at cost report settlement 1, "Y" for yes or "N" for no, for the			unn						
	period prior to October 1. Enter in o	column 2, "Y" for yes o	r "N" for	no,						
	for the portion of the cost reporting	g period on or after Oc	tober 1.							
. 03	Did this hospital receive a geographi				Ν	N		N		22.
	rural as a result of the OMB standard adopted by CMS in FY2015? Enter in co									
	for the portion of the cost reporting									
	in column 2, "Y" for yes or "N" for									
	reporting period occurring on or after									
	Does this hospital contain at least counted in accordance with 42 CFR 412									
	yes or "N" for no.	z. robje Enter in column	з, т TC	"						
04		ic reclassification fro	m urban to	,						22
	rural as a result of the revised OMB	delineations for stati	stical are	eas						
	adopted by CMS in FY 2021? Enter in a									
	for the portion of the cost reporting in column 2, "Y" for yes or "N" for			er						
	reporting period occurring on or after									
	Does this hospital contain at least			is						
	counted in accordance with 42 CFR 412									
6.5	yes or "N" for no.			.						
. 00	Which method is used to determine Me					3 N				23.
	below? In column 1, enter 1 if date of discharge. Is the method of									
							1			1
	reporting period different from the	method used in the prio	r cost							

	Financial Systems COMMUNITY HC AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC			ri od:		Works	orm CMS- heet S-2	
					To		1/2022 1/2022		I Time Pre 2023 11:	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	St Med eli	t-of tate i cai d gi bl e pai d	Medica HMO da	id	Other edi cai d days	
		1.00	2.00	3.00		. 00	5.00)	6.00	
	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state	3, 558	4, 321			36 0	24,	956	6	25.0
	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.					Lister and (D			5 0	
					H	Urban/R 1. (of Geogr .00	
6. 00	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for		at the beg	inning of	the		1			26.0
	Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban ou enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the	age) status r "2" for r cation in r	ural. If ap column 2.	pl i cabl e,			1			27.0
J. UU	effect in the cost reporting period.		perious 30		'					35.0
					-	Begi nı 1. (di ng: . 00	-
6. 00	Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent date		cript line	36 for numb	ber					36.0
7.00	If this is a Medicare dependent hospital (MDH), enter		r of period	ls MDH statu	JS		0			37.0
7. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)									37.
8. 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. (
					-	<u> </u>			//N . 00	-
9.00	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 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Ent requiremen	er in colur nts in	nn	N			N	39. (
0. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1.	per 1. Ente	r "Y" for y			Y	,		N	40. (
							V 1.00	XVII 2.00	_	-
5. 00	Prospective Payment System (PPS)–Capital Does this facility qualify and receive Capital paymen	at for disp	roporti opat	o chara in	2000	rdanco	N	Y	N	45. (
	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 Wks	eption for	extraordi na	ary circumst	tance	S	N	N	N	45.
7.00 8.00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS o Is the facility electing full federal capital paymen					no.	N	N	N	47.0
6.00	Teaching Hospitals Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after December the instructions. For column 2, if the response to co involved in training residents in approved GME progra and are you are impacted by CR 11642 (or applicable ('Y' for yes ~ 27, 2020, olumn 1 is ams in the CRs) MA dire	or "N" for under 42 C "Y", or if prior year	no in colu CFR 413.78(h this hospitor or penultir	umn 1 b)(2) tal w nate	. For , see as year,	Y	Y		56. (
. 00	"Y" for yes; otherwise, enter "N" for no in column 2. For cost reporting periods beginning prior to Decembe is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no in residents start training in the first month of this of	er 27, 2020 residents n column 1.	in approved If column	IGME progra 1 is "Y", o P Enter "Y'	ams t did 'for	rai ned				57.

	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC		eriod: rom 01/01/2022 p 12/31/2022 V	Part I Date/Time P 5/25/2023 1	<u>1: 31</u>	
					1.0	XVIII XIX 0 2.00 3.0		
9.00	Are costs claimed on line 100 of Worksheet A? If yes	, compl	lete Wkst. D-2,		N			59.0
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Throug Qualificatio Criterion Co	on	
				1.00	2.00	3.00	-	
). 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustment? Enter "Y" for yes or "N" for no in colum	85? (s umn 1. R) NAHI	see If column 1	N			6	50. (
		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	N			0.00		6 00	51. (51. (
	instructions) 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)							51. (
	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or							51. 51.
. 05	surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						6	61.
. 06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						6	51.
		Pr	ogram Name		Unweighted IME FTE Count	Direct GME F Count		
10	Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	00 6	51
	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				0. 00		00 6	
	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.							
						1.00		
2. 00	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct	trai neo			od for which	0.	00 6	52. (
. 01	Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	i Teachi Iram. (s			your hospital	0.	00 6	52. (

Health Financial Syst			OSPITAL OF INDIANA, I			u of Form CMS-	
HOSPI TAL AND HOSPI TAL	. HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA Provider C		eriod: rom 01/01/2022 o 12/31/2022	Date/Time Pre	epared:
				Unweighted	Unweighted	5/25/2023 11: Ratio (col. 1/	
				FTĔs	FTEs in	(col. 1 + col.	
				Nonprovi der	Hospi tal	2))	
				Si te 1.00	2.00	3.00	-
Section 5504 of	f the ACA Base Yea	r FTE Residents in N	lonprovider Settings-				
period that beg	gins on or after J	uly 1, 2009 and befo	ore June 30, 2010.		,		
in the base yea resident FTEs a settings. Ente resident FTEs	ar period, the num attributable to ro er in column 2 the that trained in yo	ber of unweighted no tations occurring in number of unweighte	all nonprovider d non-primary care n column 3 the ratio	0.00	0. 00	0. 000000	0 64.00
		Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	/
		U U		FTĔs	FTEs in	(col. 3 + col.	
				Nonprovi der	Hospi tal	4))	
		1 00	2.00	Si te	4.00	F 00	-
45 00 Entor in colum	a 1 if line 42	1.00	2.00	3.00	4.00 0.00	5.00 0.000000	45.00
is yes, or your trained resider year period, th associated with FTEs for each p program in whice residents. Enter the program cor column 3, the r unweighted prin residents attri rotations occur non-provider se column 4, the r unweighted prin resident FTEs	hts in the base he program name h primary care orimary care ch you trained er in column 2, de. Enter in humber of hary care FTE butable to rring in all ettings. Enter in humber of hary care that trained in Enter in column f (column 3 umn 3 + column			Unwei ghted	Unwei ghted	Ratio (col. 1/	
				FTEs Nonprovider Site 1.00	FTEs in Hospital	(col. 1 + col. 2)) 3.00	_
Section 5504 of	f the ACA Current	Year FTE Residents i	n Nonprovider Setting				
	r after July 1, 20						
Enter in column FTEs that train	ble to rotations on 2 the number of ned in your hospit	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see in	rovider settings. ry care resident 3 the ratio of	0.00	5. 31	0. 000000	66.00
		Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	/
				FTEs	FTEs in	(col. 3 + col.	
				Nonprovi der	Hospi tal	4))	
		1.00	2.00	Si te 3.00	4.00	5.00	-
67.00 Enter in column	n 1, the program	FAMILY PRACTICE	1350	0.10			1 67.00
which you train Enter in column code. Enter in number of unwei care FTE reside to rotations oc non-provider se column 4, then unweighted prin resident FTEs your hospital. 5, the ratio of	are programs in ned residents. n 2, the program column 3, the ghted primary ents attributable ccurring in all ettings. Enter in number of nary care that trained in Enter in column						

	Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0169	Period: From 01/01	/2022	u of Form Workshe Part I	et S-2	
		To 12/31	/2022	Date/Ti 5/25/20		
			-	1.0	0	
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August For a cost reporting period beginning prior to October 1, 2022, did you obtain permi MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 (August 10, 2022)?	ssion from yo		N		68.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF	subprovi dor?	Y			70.00
	Enter "Y" for yes or "N" for no.					
	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" f 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new t program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" f Column 3: If column 2 is Y, indicate which program year began during this cost report (see instructions)	or no. (see eaching or no.	N	N	0	71.00
75.00	<u>Inpatient Rehabilitation Facility PPS</u> Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an I	RF	N			75.00
76.00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program	n the most	N	N	0	76.00
	recent cost reporting period ending on or before November 15, 2004? Enter "Y" for ye no. Column 2: Did this facility train residents in a new teaching program in accorda CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 i indicate which program year began during this cost reporting period. (see instructio	s or "N" for nce with 42 s Y,			0	
			-	1.0	0	
	Long Term Care Hospital PPS				<u> </u>	00.00
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost report "Y" for yes and "N" for no.	ng period? I	Inter	N		80. 00 81. 00
86.00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for y Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Sec		no.	N		85. 00 86. 00
	<pre>§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under secti 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.</pre>	on		Ν		87.00
		Approved Permar Adjustr (Y/M	ent ment I)	Number Appro Permar Adjustr 2.0	ved nent ments	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and I 89. (see instructions)		5	2.0		88.00
	Column 2: Enter the number of approved permanent adjustments. Wkst. A L	ne Effectiv	e Date	Appro	ved	
	No.			Perman Adjust Amount Discha	nent ment Per	
89.00	1.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	2.0	0	3.0		89.00
	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the	2. 00			0	07.00
	TEFRA target amount per discharge.	V		XLX		
	Title V and XIX Services	1.00)	2.0	0	
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" fo	~ N		Y		90.00
91.00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in	N		Ν		91.00
	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see			N		92.00
	instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Ente	~ N		N		93.00
	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N		N		94.00
	applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column.	0.0		0.0	0	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.0	ן נ	0.0	U	97.00

Heal th Financial Systems COMMUNITY HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			In Lie	u of Form CMS	
HUSPITAL AND HUSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		rom 01/01/2022	Worksheet S Part I Date/Time Pu	repared:
			V	5/25/2023 1 XI X	1:31 am
			1.00	2.00	
98.00 Does title V or XIX follow Medicare (title XVIII) for the in stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" 1 column 1 for title V, and in column 2 for title XIX.			Y	N	98.00
98.01 Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti			Y	Y	98. 01
 title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the cabed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of 			Y	Y	98. 02
<pre>for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye </pre>			Ν	Ν	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 in </pre>			Ν	Ν	98. 04
 in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in control 			Y	Y	98. 05
 column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX. 			Y	Y	98.06
column 2 for title XIX. Rural Providers					-
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all-	-inclusive met	hod of payment	N N		105. 00 106. 00
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for co training programs? Enter "Y" for yes or "N" for no in column	n 1. (see ins	tructions)	Ν		107.00
Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded If Enter "Y" for yes or "N" for no in column 2. (see instruct)	PF and/or IRF ons)	unit(s)?			100.00
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.	CRNA Tee Sche	dulle? See 42	N		108.00
	Physi cal	Occupati onal	Speech	Respi ratory	y
	1.00	2.00	3.00	4.00	100.00
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 Hospita Demonstration) for the current cost reporting period? Enter ' complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	'Y" for yes or	"N" for no. If	°yes,	N	110.00
			1.00	2.00	
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this constrained in the the the temperature of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services.	ost reporting olumn 1 is Y, rticipating in	period? Enter enter the column 2.	N		111.00
		1.00			
112.00 Did this hospital participate in the Pennsylvania Rural Heal	th Model	1.00 N	2.00	3.00	112.00
(PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began particip demonstration. In column 3, enter the date the hospital cea participation in the demonstration, if applicable.	eporting olumn 1 is oating in the				
113.00 Did this hospital participate in the Community Health Access Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information					113.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "G for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provider	3, or E only) 93" percent (includes	N			0115.00
the definition in CMS Pub.15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116.00
117.00 Is this facility legally-required to carry malpractice insured "Y" for yes or "N" for no.		Y			117.00
118.00 Is the malpractice insurance a claims-made or occurrence pol if the policy is claim-made. Enter 2 if the policy is occurr		1			118.00

ealth Financial Systems COMMUNITY HOSPITAL O OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C		Period		w of Form CM Worksheet S Part I	
				2/31/2022		repared
		Premi ums	l	osses	I nsurance	
						_
8.01 List amounts of malpractice premiums and paid losses:		1.00	99	2.00 C	3.00	0 118. (
				1.00	2.00	
8.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein.				N	2.00	118. (
 9.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 	column 1, "Y alifies for th	" for yes or he Outpatient		N	N	119. (120. (
1.00 Did this facility incur and report costs for high cost implar	ntable devices	s charged to		Υ		121.
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1				Ν		122. (
the Worksheet A line number where these taxes are included. 3.00 Did the facility and/or its subproviders (if applicable) pure services, e.g., legal, accounting, tax preparation, bookkeepi management/consulting services, from an unrelated organization for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., professional services expenses, for services purchased from under the main hospital CBSA? In column under the main hospital CBSA?	ng, payroll, on? In column greater than unrelated orga	and/or 1, enter "Y" 50% of total anizations				123.
"N" for no. Certified Transplant Center Information						
5.00 Does this facility operate a Medicare-certified transplant ce and "N" for no. If yes, enter certification date(s) (mm/dd/yy 6.00 If this is a Medicare-certified kidney transplant program, er	yyy) below.	3	e	N		125. 126.
in column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare-certified heart transplant program, en		fication date				127.
in column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare-certified liver transplant program, ent in column 1 and termination date, if applicable, in column 2.	ter the certin	fication date				128.
9.00 If this is a Medicare-certified lung transplant program, ente	er the certifi	ication date				129.
in column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare-certified pancreas transplant program, date in column 1 and termination date, if applicable, in colu	enter the cei umn 2.					130.
1.00 f this is a Medicare-certified intestinal transplant program date in column 1 and termination date, if applicable, in colu 2.00 f this is a Medicare-certified islet transplant program, en	umn 2.					131. 132.
in column 1 and termination date, if applicable, in column 2. 3.00 Removed and reserved						133.
4.00 If this is a hospital-based organ procurement organization (<u>in column 1 and termination date, if applicable, in column 2</u> . All Providers		he OPO number				134.
0.00 Are there any related organization or home office costs as de chapter 10? Enter "Y" for yes or "N" for no in column 1. If y are claimed, enter in column 2 the home office chain number.	yes, and home (see instruc	office costs		Y	HB0720	140.
1.00 2.00 If this facility is part of a chain organization, enter on li		ugh 143 the r	ame and	3.00 d address	of the	
home office and enter the home office contractor name and contractor name and contractor is Name: WIS	ntractor numb	er.				141.
2. 00 Street: 1500 NORTH RITTER AVENUE PO Box: 3. 00 City: INDIANAPOLIS State: IN		Zip Code	:	4621	9-3095	142. 143.
					1.00	-
4.00 Are provider based physicians' costs included in Worksheet A?	?				Y	144.
5 00 lf costs for ronal convisos are claimed an What A list 74	are the east	c for		1.00 Y	2.00	1.45
5.00 If costs for renal services are claimed on Wkst. A, line 74, inpatient services only? Enter "Y" for yes or "N" for no in c no, does the dialysis facility include Medicare utilization 1 period? Enter "Y" for yes or "N" for no in column 2.	column 1. lf (for this cost	column 1 is reporting		T		145.
16.00 Has the cost allocation methodology changed from the previous 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.				Ν		146.

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	COMMUNITY HOSPI X IDENTIFICATION DATA			C. N: 15-0169		eri od:	u of Form CMS Worksheet S-	
					Fr Tc	rom 01/01/2022 0 12/31/2022	Date/Time Pr	
							5/25/2023 11	1:31 am
							1.00	-
47.00Was there a change in the statisti	cal basis? Enter "Y" f	or yes or "	N" for	no.			Y	147.0
48.00 Was there a change in the order of	allocation? Enter "Y"	for yes or	"N" fo	or no.			N	148.0
49.00 Was there a change to the simplifi	ed cost finding method						N	149.0
		Part		Part		Title V	Title XIX	_
		1. (2.00		3.00	4.00	_
Does this facility contain a provi or charges? Enter "Y" for yes or '								
55.00Hospital	N TOT TO TOT EACT CON			N N	<u>в. (</u> з	N	N	155.0
56.00 Subprovi der – IPF		N		N N		N	N	156.0
57.00 Subprovider - IRF		N		N N		N	N	157.0
58. 00 SUBPROVI DER								158.0
59.00 SNF		N		N N	1	Ν	N	159. C
60.00 HOME HEALTH AGENCY		N		N		Ν	N	160. C
61.00 CMHC				N		Ν	N	161. C
							1.00	-
Multicampus							1.00	
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that has	s one or mor	e campu	uses in di	ffere	nt CBSAs?	N	165. 0
	Name	Count	у	State	Zip	Code CBSA	FTE/Campus	
	0	1.00		2.00	3.	00 4.00	5.00	
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.0	00 166. C
						I	1.00	_
Health Information Technology (HI						Act		
67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	95 is "Y") and is a mea	ningful use	es or " r (line	'N" for no e 167 is "	Y"), '	enter the	Y	167. C 168. C
68.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)?	ot a meaningful user,	does this p				hardshi p		168. (
69.00 If this provider is a meaningful u transition factor. (see instruction	ser (line 167 is "Y")	and is not a	a CAH ((line 105	is "N			99169. (
						Begi nni ng	Endi ng	_
						1.00	2.00	470
70.00 Enter in columns 1 and 2 the EHR b period respectively (mm/dd/yyyy)	eginning date and endi	ng date for	the re	eporting				170. 0
						1.00	2.00	-
71.00 fline 167 is "Y", does this prov	ider have any davs for	i ndi vi dual :	s enrol	led in		N 1.00	2.00	0171.0
section 1876 Medicare cost plans r "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	eported on Wkst. S-3, mn 1. If column 1 is y	Pt. I, line	2, col	. 6? Ente				

SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider (Period: From 01/01/2022 To 12/31/2022		
					5/25/2023 11	
				Y/N	Date	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE			1.00	2.00	-
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			r all dates in 1	the	
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the			N		1.
	reporting period? If yes, enter the date of the change in c	orumn 2. (see	Y/N	Date	V/I	
			1.00	2.00	3.00	
00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	5	N			2.
00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe relationships? (see instructions)	ffices, drug er or its f the board	Y			3.
			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.	or Compiled,	Y	A	03/25/2021	4.
00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		Ν			5.
				Y/N	Legal Oper.	
				1.00	2.00	
00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column	2: Ifyes, i	s the provider	· N		6.
00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve		wed during the	N N		7.
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	0	cal education	Y		9.
. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.		the current	Ν		10.
. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an Ap	proved	N		11.
					Y/N 1.00	
	Bad Debts					_
	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.			st reporting	Y N	12
. 00	If line 12 is yes, were patient deductibles and/or coinsura instructions.	nce amounts w	aived? If yes,	see	Ν	14
00	Bed Complement Did total beds available change from the prior cost reporti	ng period2 (f	Ves see inst	ructions	N	15
00	bid total beds available change from the piron cost report		rt A		t B	- 13.
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data	N		NI		1/
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 instructions)	N		N		16
00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	07/01/2021	Y	07/01/2021	17.
00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	Ν		N		18
. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Ν		Ν		19

Heal th	Fi nanci al	Systems

COMMUNI TY	HOSPI TAL	0F	I NDI ANA,	INC.

In Lieu of Form CMS-2552-10

)SPI T <i>i</i>					u of Form CM	0 2002
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0169	Period: From 01/01/2022 To 12/31/2022	Date/Time P	repare
					5/25/2023 1	<u>1:31 a</u>
			iption	Y/N	Y/N	
			0	1.00	3.00	
00	If line 16 or 17 is yes, were adjustments made to PS&R			N	N	20.
	Report data for Other? Describe the other adjustments:	V /N	Data	V /N	Data	
		Y/N 1.00	Date 2.00	Y/N	Date 4.00	
00	Was the cost report prepared only using the provider's	N 1.00	2.00	3.00 N	4.00	21.
00	records? If yes, see instructions.	IN IN		IN		21.
			1			
				-	1.00	
1	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	IOSPI TALS)	I		
Ī	Capital Related Cost					
00	Have assets been relifed for Medicare purposes? If yes, see	e instructions				22.
00	Have changes occurred in the Medicare depreciation expense	due to apprais	sals made duri	ing the cost		23.
	reporting period? If yes, see instructions.			-		
00	Were new leases and/or amendments to existing leases entere	ed into during	this cost rep	porting period?		24.
	lf yes, see instructions					
00	Have there been new capitalized leases entered into during	the cost repo	rting period?	If yes, see		25.
~	instructions.	ha agat ''	ng non!10 ! !	E 1/00 055		
00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	ne cost reporti	ng period? In	yes, see		26.
00	Has the provider's capitalization policy changed during the	a cost ranorti,	na neriod2 lf	ves submit		27
00	copy.		ig period: II	ycs, subiii t		27.
	Interest Expense					
	Were new loans, mortgage agreements or letters of credit en	ntered into du	ing the cost	reporting		28
	period? If yes, see instructions.					
00	Did the provider have a funded depreciation account and/or	bond funds (De	ebt Service Re	eserve Fund)		29
	treated as a funded depreciation account? If yes, see inst	ructions				
00	Has existing debt been replaced prior to its scheduled matu	urity with new	debt? If yes,	see		30
	instructions.					
00	Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes,	see		31
ļ	instructions.					_
	Purchased Services	and an a formulation				- 22
00	Have changes or new agreements occurred in patient care set arrangements with suppliers of services? If yes, see instru		ea through cor	ntractual		32
	If line 32 is yes, were the requirements of Sec. 2135.2 app					
00				tivo bidding2 If		22
00	no see instructions	piled pertainin	ng to competin	tive bidding? If		33
ļ	no, see instructions. Provider-Based Physicians		ng to competin	tive bidding? If		33
	Provi der-Based Physi ci ans		<u> </u>			
	Provider-Based Physicians Were services furnished at the provider facility under an a		<u> </u>			
00	Provi der-Based Physi ci ans	arrangement wi	th provider-ba	ased physi ci ans?		34
00	Provider-Based Physicians Were services furnished at the provider facility under an a If yes, see instructions.	arrangement wi	th provider-ba	ased physi ci ans?		34
00	Provider-Based Physicians Were services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended exi	arrangement wi	th provider-ba	ased physi ci ans? provi der-based	Date	34
00	Provider-Based Physicians Were services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in	arrangement wi	th provider-ba	ased physicians? provider-based	Date 2.00	34
00	Provider-Based Physicians Were services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in Home Office Costs	arrangement wi	th provider-ba	ased physi ci ans? provi der-based		34.
00	Provider-Based Physicians Were services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report?	arrangement wi isting agreemen nstructions.	th provider-bants with the p	ased physi ci ans? provi der-based Y/N 1.00		34.35
00	Provider-Based Physicians Were services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu	arrangement wi isting agreemen nstructions.	th provider-bants with the p	ased physi ci ans? provi der-based Y/N 1.00		34.35
00	Provider-Based Physicians Were services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu If yes, see instructions.	arrangement wi isting agreemen nstructions.	th provider-bants with the provider-band the pro	ased physi ci ans? provi der-based Y/N 1.00		34 35 36 37
00	Provider-Based Physicians Were services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office for the set of the home office for the home offi	arrangement wi isting agreemen nstructions. repared by the fice different	th provider-bants with the provider-band the pro	ased physi ci ans? provi der-based Y/N 1.00		34 35 36 37
	Provider-Based Physicians Were services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu If yes, see instructions. If line 36 is yes, was the fiscal year end of the home offi the provider? If yes, enter in column 2 the fiscal year end	arrangement wi isting agreemen nstructions. repared by the fice different d of the home of	th provider-bands with the provider-bands with the provider-band band band band band band band band	ased physi ci ans? provi der-based Y/N 1.00		34 35 36 37 38
	Provider-Based Physicians Were services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu If yes, see instructions. If line 36 is yes, was the fiscal year end of the home offi the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other	arrangement wi isting agreemen nstructions. repared by the fice different d of the home of	th provider-bands with the provider-bands with the provider-band band band band band band band band	ased physi ci ans? provi der-based Y/N 1.00		34 35 36 37 38
000 000 000 000 000 000	Provider-Based Physicians Were services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu If yes, see instructions. If line 36 is yes, was the fiscal year end of the home offi the provider? If yes, enter in column 2 the fiscal year end	arrangement wi isting agreemen nstructions. repared by the fice different d of the home of er chain composi	home office? from that of pents? If yes,	ased physi ci ans? provi der-based Y/N 1.00		34 35 36 37 38 39
000 000 000 000 000 000	Provider-Based Physicians Were services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu If yes, see instructions. If line 36 is yes, was the fiscal year end of the home offi the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions.	arrangement wi isting agreemen nstructions. repared by the fice different d of the home of er chain composi	home office? from that of pents? If yes,	ased physi ci ans? provi der-based Y/N 1.00		34 35 36 37 38 39
000 000 000 000 000 000	Provider-Based Physicians Were services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu If yes, see instructions. If line 36 is yes, was the fiscal year end of the home offi the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the	arrangement wi isting agreemen nstructions. repared by the fice different d of the home of er chain composi	home office? from that of pents? If yes,	ased physi ci ans? provi der-based Y/N 1.00		34 35 36 37 38 39
000 000 000 000 000 000	Provider-Based Physicians Were services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu If yes, see instructions. If line 36 is yes, was the fiscal year end of the home offi the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions.	arrangement wi isting agreemen nstructions. repared by the fice different d of the home of er chain compor home office?	home office? from that of pents? If yes,	ased physi ci ans? provi der-based Y/N 1.00	2.00	34. 35. 36. 37. 38. 39.
	Provider-Based Physicians Were services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu If yes, see instructions. If line 36 is yes, was the fiscal year end of the home offi the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. If line 36 is yes, did the provider render services to the instructions.	arrangement wi isting agreemen nstructions. repared by the fice different d of the home of er chain compor home office?	th provider-bands with the provider-bands with the provider-band band band band band band band band	ased physi ci ans? provi der-based Y/N 1.00	2.00	34. 35. 36. 37. 38. 39. 40.
	Provider-Based Physicians Were services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. If line 36 is yes, did the provider render services to the instructions. If line 36 is yes, did the provider render services to the instructions.	arrangement wi isting agreemen nstructions. repared by the fice different d of the home of er chain compor home office?	th provider-bands with the provider-bands with the provider-band band band band band band band band	ased physi ci ans? provi der-based Y/N 1.00	2.00	34 35 36 37 38 39 40
	Provider-Based Physicians Were services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	arrangement wi isting agreemen nstructions. repared by the fice different d of the home of er chain compor home office?	th provider-bands with the provider-bands with the provider-band band band band band band band band	ased physi ci ans? provi der-based Y/N 1.00	2.00	34 35 36 37 38 39 40
000 000 000 000 000 000 000	Provider-Based Physicians Were services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu If yes, see instructions. If line 36 is yes, was the fiscal year end of the home offi the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	arrangement wir isting agreemen nstructions. repared by the fice different d of the home of er chain compor home office?	th provider-bands with the provider-bands with the provider-band band band band band band band band	ased physi ci ans? provi der-based Y/N 1.00	2.00	34. 35. 36. 37. 38. 39. 40. 41.
	Provider-Based Physicians Were services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu If yes, see instructions. If line 36 is yes, was the fiscal year end of the home offi the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. If line 36 is yes, did the provider render services to the instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report	arrangement wi isting agreemen nstructions. repared by the fice different d of the home of er chain compor home office?	th provider-bands with the provider-bands with the provider-band band band band band band band band	ased physi ci ans? provi der-based Y/N 1.00	2.00	34. 35. 36. 37. 38. 39. 40. 41.
00 00 00 00 00 00 00 00 00	Provider-Based Physicians Were services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu If yes, see instructions. If line 36 is yes, was the fiscal year end of the home offi the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	arrangement wir isting agreemen nstructions. repared by the fice different d of the home of er chain compor home office?	th provider-bands with the provider-bands with the provider-band band band band band band band band	ased physi ci ans? provi der-based Y/N 1.00	2.00	33. 34. 35. 36. 37. 38. 39. 40. 41. 41. 42. 43.

Heal th Finan	cial Systems	COMMUNI TY HOSPI TAL	OF INDIANA,	INC.	In Lie	u of Form CMS-	2552-10
HOSPI TAL AND	HOSPI TAL AND HOSPI TAL HEALTH CARE REIMBURSEMENT QUESTI ONNAI RE			CCN: 15-0169	Period:	Worksheet S-2	
					From 01/01/2022 To 12/31/2022		pared: 31 am
		_					
				3.00			
Cost I	Report Preparer Contact Informatior	I					
41.00 Enter	the first name, last name and the	title/position [DIRECTOR REI	MBURSEMENT			41.00
hel d	by the cost report preparer in colu	imns 1, 2, and 3,					
respe	cti vel y.						
42.00 Enter	the employer/company name of the c	cost report					42.00
prepa	rer.						
43.00 Enter	the telephone number and email add	Iress of the cost					43.00
repor	t preparer in columns 1 and 2, resp	ecti vel y.					

10SPI T	Financial Systems COMMM TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	JNETY HOSPETAL AL DATA	Provider CC		Period: From 01/01/2022	u of Form CMS-2 Worksheet S-3 Part I	
					To 12/31/2022	Date/Time Pre 5/25/2023 11:	
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line No.	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	PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	268	97, 8	20 0.00	0	1 1.00
1.00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	30.00	200	77, 0.	20 0.00	0	1.00
	for the portion of LDP room available beds)						
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider						2.00
1.00	HMO I RF Subprovider						4.00
F. 00 5. 00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
5.00	Hospital Adults & Peds. Swing Bed NF					0	6.0
7.00	Total Adults and Peds. (exclude observation		268	97, 8	0.00	0	
	beds) (see instructions)						
3.00	INTENSIVE CARE UNIT	31.00	24	8, 7	60 0.00	0	8.0
9.00	CORONARY CARE UNIT						9.0
0.00	BURN INTENSIVE CARE UNIT						10.0
1.00	SURGICAL INTENSIVE CARE UNIT	05.00	10	47.5			11.0
2.00	NEONATAL INTENSIVE CARE UNIT	35.00	48	17, 53	20 0.00	0	12.0
3.00	NURSERY Total (see instructions)	43.00	340	104 10	0.00	0	13.0
4.00 5.00	CAH visits		340	124, 10	0. 00	0	14.0
16.00	SUBPROVIDER - IPF	40.00	21	7,6	55	0	16.0
17.00	SUBPROVIDER - IRF	40.00	21	7,00	55	0	17.0
8.00	SUBPROVI DER						18.0
9.00	SKILLED NURSING FACILITY						19.0
20.00	NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE						21.0
2. 00	HOME HEALTH AGENCY						22.0
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
24.00	HOSPICE						24.0
4.10	HOSPICE (non-distinct part)	30.00					24.1
5.00	CMHC - CMHC						25.0
6.00	RURAL HEALTH CLINIC	00.00				0	26.0
26.25 7.00	FEDERALLY QUALIFIED HEALTH CENTER	89.00	361			0	26.2
8.00	Total (sum of lines 14-26) Observation Bed Days	,	301			0	1
9.00	Ambul ance Trips					0	20.0
0.00	Employee discount days (see instruction)						30.0
1.00	Employee discount days - IRF						31.0
32.00	Labor & delivery days (see instructions)		0		0		32.0
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)		-				32.0
3. 00	LTCH non-covered days						33. C
33.01	LTCH site neutral days and discharges						33. C
	Temporary Expansion COVID-19 PHE Acute Care	30.00	0		0	0	

)SPI T <i>I</i>	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC		Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part I Date/Time Pre 5/25/2023 11:	pare
		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	
	PART I – STATISTICAL DATA	6.00	7.00	8.00	9.00	10.00	
00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	15, 418	1, 960	64, 43	37		1.
00 00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider	18, 408 2, 092 0	26, 327 0 0				2. 3. 4.
00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	0	0		0		5.
	Total Adults and Peds. (exclude observation beds) (see instructions)	15, 418	1, 960				7
00 . 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	1, 643	411	7,02			8 9 10 11
00 00	NEONATAL INTENSIVE CARE UNIT NURSERY Total (see instructions)	0 17, 061	873 3, 300 6, 544	7, 61	4 9 6.56	26.86	
00 00	CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER	0 1, 708	0	4, 45	0.00	1, 506. 25	15 16 17 18
00 00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE						19 20 21
00 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE						22 23 24
00	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC			20	00		24 25 26
00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days	0	0 2, 160		0 0.00 6.56		
00 00	Ambulance Trips Employee discount days (see instruction)	0	2, 100	2, 24			29 30
00 01	Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room	0	61	1, 66	0 53 0		31 32 32
00	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges	0 0					33

JSPLL	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0169	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part I Date/Time Pre 5/25/2023 11:	pare
		Full Time		Di s	charges		
		Equivalents	T : 11)/	T	T: 11 - 21 2	T 1 1 411	
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I – STATISTICAL DATA	11.00	12.00	13.00	14.00	15.00	
00	Hospital Adults & Peds. (columns 5, 6, 7 and		(3, 2	74 413	17,007	1 1.
	8 exclude Swing Bed, Observation Bed and					,	
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
00	HMO and other (see instructions)			2, 8	22 3, 637		2.
00	HMO IPF Subprovider				0		3.
00	HMO IRF Subprovider				0		4.
00	Hospital Adults & Peds. Swing Bed SNF						5.
00	Hospital Adults & Peds. Swing Bed NF						6.
00	Total Adults and Peds. (exclude observation						7.
	beds) (see instructions)						
00	INTENSIVE CARE UNIT						8
00	CORONARY CARE UNIT						9
0. 00	BURN INTENSIVE CARE UNIT						10
. 00	SURGICAL INTENSIVE CARE UNIT						11
2.00	NEONATAL INTENSIVE CARE UNIT						12
3.00	NURSERY						13
4.00	Total (see instructions)	0.00	(3, 2	74 413	17,007	14
5.00	CAH visits						15
6. 00	SUBPROVIDER - IPF	0.00	(1.	42 0	400	16
7.00	SUBPROVIDER - IRF						17
3. 00	SUBPROVI DER						18
9.00	SKILLED NURSING FACILITY						19
0. 00	NURSING FACILITY						20
1.00	OTHER LONG TERM CARE						21
2.00	HOME HEALTH AGENCY						22
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23
1.00	HOSPI CE						24
I. 10	HOSPICE (non-distinct part)						24
5.00	CMHC - CMHC						25
5.00	RURAL HEALTH CLINIC						26
5. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26
7.00	Total (sum of lines 14-26)	0.00					27
3. 00	Observation Bed Days						28
0.00	Ambul ance Trips						29
0.00	Employee discount days (see instruction)						30
. 00	Employee discount days - IRF						31
2.00	Labor & delivery days (see instructions)						32
2. 01	Total ancillary labor & delivery room						32
	outpatient days (see instructions)						0.00
3.00	LTCH non-covered days				0		33
3.01	LTCH site neutral days and discharges				0		33
1.00	Temporary Expansion COVID-19 PHE Acute Care			1			L

	Financial Systems AL WAGE INDEX INFORMATION	COMMU	INITY HUSPITAL	OF INDIANA, IN Provider CO		Period:	u of Form CMS-2 Worksheet S-3	
J3PI I	AL WAGE FINDEX FINFORMATION			Provider co	F	rom 01/01/2022	Part II	
						To 12/31/2022	Date/Time Pre 5/25/2023 11:	
		Wkst. A Line	Amount	Reclassificati	Adjusted		Average Hourly	
		Number	Reported	on of Salaries (from Wkst.	Sal ari es (col . 2 ± col .	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				A-6)	3)	col. 4		
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARI ES						r	
. 00	Total salaries (see instructions)	200.00	133, 523, 481	-635, 543	132, 887, 938	3 3, 188, 861. 00	41.67	1.0
. 00	Non-physician anesthetist Part		C	0	(0.00	0.00	2.0
. 00	A Non-physician anesthetist Part			0	(0.00	0.00	3.0
. 00	B		C	0		0.00	0.00	3.0
. 00	Physician-Part A - Administrative		1, 351, 586	0	1, 351, 586	5, 693. 00	237. 41	4.0
. 01	Physicians - Part A - Teaching		C	0	(0.00	0.00	4.0
. 00	Physician and Non		660, 936	0	660, 936	6, 598. 00	100. 17	5. C
. 00	Physician-Part B Non-physician-Part B for		C	0	(0.00	0.00	6.0
	hospital-based RHC and FQHC							
. 00	services Interns & residents (in an	21.00	C	0	(0.00	0.00	7. C
	approved program)		_					
. 01	Contracted interns and residents (in an approved		C	0	(0.00	0.00	7.C
	programs)							
. 00	Home office and/or related organization personnel		C	0	(0.00	0.00	8.0
. 00	SNF	44.00	C	0	(0.00		
0. 00	Excluded area salaries (see instructions)		4, 372, 100	-5, 576	4, 366, 524	108, 460. 00	40. 26	10.0
	OTHER WAGES & RELATED COSTS							
1. 00	Contract Labor: Direct Patient		32, 000, 853	0	32, 000, 853	3 252, 922. 00	126. 52	11. (
2.00	Care Contract Labor: Top Level		C	0	(0.00	0.00	12.0
	management and other							
	management and administrative services							
3.00	Contract Labor: Physician-Part		2, 142, 579	0	2, 142, 579	9 19, 557. 00	109. 56	13.0
4.00	A - Administrative Home office and/or related		C	0	(0.00	0.00	14. (
4.00	organization salaries and		C	0		0.00	0.00	14.0
4. 01	wage-related costs Home office salaries		C	0	(0.00	0.00	14. (
4. 02	Related organization salaries		C	0	(14. (
5.00	Home office: Physician Part A		C	0	(0.00	0.00	15.
6.00	- Administrative Home office and Contract		C	0	(0.00	0.00	16.
	Physicians Part A - Teaching		_					
6. 01	Home office Physicians Part A - Teaching		C	0	(0.00	0.00	16.
6. 02	Home office contract		C	0	(0.00	0.00	16.
	Physicians Part A - Teaching WAGE-RELATED COSTS							-
7.00	Wage-related costs (core) (see		30, 961, 823	0	30, 961, 823	3		17. (
8.00	instructions) Wage-related costs (other)							18. (
	(see instructions)							
9.00 0.00	Excluded areas Non-physician anesthetist Part		1, 086, 732	0	1, 086, 732	2		19.0 20.0
5.00	A		C	0				20.0
1. 00	Non-physician anesthetist Part		C	0	(D		21.0
2.00	Þ Physician Part A -		69, 810	0	69, 810	þ		22.0
	Administrative							
2.01 3.00	Physician Part A - Teaching Physician Part B		80, 908	0	(80, 908			22.
1.00	Wage-related costs (RHC/FQHC)		C	0	()		24.
5.00	Interns & residents (in an approved program)		C	0	(25. (
5. 50	Home office wage-related		C	0	(þ		25.
	(core)		-					
5. 51	Related organization wage-related (core)		C	0	(25. !
5. 52	Home office: Physician Part A		C	0	(þ		25.5
	- Administrative -			1		1	1	1

	Financial Systems	COMMU	JNI TY HOSPI TAL	OF INDIANA, IN			u of Form CMS-2	
HOSPI 1	AL WAGE INDEX INFORMATION			Provider CO	- -	Period: From 01/01/2022 Fo 12/31/2022	Worksheet S-3 Part II Date/Time Pre 5/25/2023 11:	pared:
		Wkst. A Line Number		Reclassificati on of Salaries (from Wkst. A-6)			Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	(0		25.53
	OVERHEAD COSTS - DIRECT SALARIE			-				
26.00	Employee Benefits Department	4.00			169, 500			
27.00	Administrative & General	5.00	4, 709, 371					
28.00	Administrative & General under contract (see inst.)		6, 500, 006	0	6, 500, 000	59, 494. 00	109. 25	28.00
29.00	Maintenance & Repairs	6.00	0	0	(0.00		29.00
30.00	Operation of Plant	7.00	2, 098, 029	-2, 611	2, 095, 418	3 72, 299. 00	28.98	30.00
31.00	Laundry & Linen Service	8.00	0	0	(0.00	0.00	31.00
32.00	Housekeepi ng	9.00	3, 348, 547	-22, 382	3, 326, 16	5 169, 420. 00	19.63	32.00
33.00	Housekeeping under contract (see instructions)		423, 742	0	423, 742	2 8, 861.00	47.82	33.00
34.00	Dietary	10.00	3, 115, 783	-2, 182, 734	933, 049	40, 607. 00	22. 98	34.00
35.00	Dietary under contract (see instructions)		510, 945	0	510, 94	6, 240. 00	81.88	35.00
36.00	Cafeteri a	11.00	0	2, 167, 883	2, 167, 883	92, 869. 00	23. 34	36.00
37.00	Maintenance of Personnel	12.00	0	0	(0.00	0.00	37.00
38.00	Nursing Administration	13.00	2, 550, 857	-11, 005	2, 539, 852	2 61, 488. 00	41.31	38.00
39.00	Central Services and Supply	14.00	838, 089	-1, 834	836, 25	5 27, 857.00	30. 02	39.00
40.00	Pharmacy	15.00	6, 322, 758			125, 370. 00	50. 17	40.00
41.00	Medi cal Records & Medi cal Records Library	16.00	0	0		0.00	0.00	41.00
42.00	Social Service	17.00	1, 939, 757	-11, 550	1, 928, 20	43, 627. 00	44.20	42.00
43.00	Other General Service	18.00				0.00		43.00

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		Peri od:	Worksheet S-3	
						From 01/01/2022 To 12/31/2022		aarad.
						To 12/31/2022	Date/Time Pre 5/25/2023 11:	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)		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		140, 297, 238	-635, 543	139, 661, 69	5 3, 256, 858. 00	42.88	1.00
	instructions)							
2.00	Excluded area salaries (see		4, 372, 100	-5, 576	4, 366, 52	4 108, 460. 00	40. 26	2.00
	instructions)		405 005 400	(00.0/7	105 005 13		10.07	
3.00	Subtotal salaries (line 1		135, 925, 138	-629, 967	135, 295, 17	1 3, 148, 398. 00	42.97	3.00
4.00	minus line 2)		24 142 422		34, 143, 43	2 272, 479. 00	125. 31	4.00
4.00	Subtotal other wages & related costs (see inst.)		34, 143, 432	0	34, 143, 43	2 272, 479.00	125.31	4.00
5.00	Subtotal wage-related costs		31, 031, 633	0	31, 031, 63	3 0.00	22.94	5.00
5.00	(see inst.)		31, 031, 033	0	31, 031, 03	0.00	22. 74	5.00
6.00	Total (sum of lines 3 thru 5)		201, 100, 203	-629, 967	200, 470, 23	6 3, 420, 877. 00	58.60	6.00
7.00	Total overhead cost (see		32, 527, 390					
,.00	instructions)		52, 527, 570	124,775	52, 402, 57	, 047.00	37.47	,.00
		I		1 1	I	i.	I I	

	Financial Systems COMMUNITY HOSPITAL O TAL WAGE RELATED COSTS		CN: 15-0169	Peri od:	u of Form CMS-2 Worksheet S-3	
				From 01/01/2022	Part IV	
				To 12/31/2022	Date/Time Pre	
					5/25/2023 11:	31
					Amount	
					Reported 1.00	+
	PART IV - WAGE RELATED COSTS				1.00	-
	Part A - Core List					1
	RETI REMENT COST					1
00	401K Employer Contributions				5, 097, 432	1
00	Tax Sheltered Annuity (TSA) Employer Contribution				0,077,432	
00	Nonqualified Defined Benefit Plan Cost (see instructions)				0	
00	Qualified Defined Benefit Plan Cost (see instructions)				20, 437	
00	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				20,407	1
00	401K/TSA Plan Administration fees				0	1
00	Legal /Accounting/Management Fees-Pension Plan				252, 985	
00	Employee Managed Care Program Administration Fees				0	
	HEALTH AND INSURANCE COST					1
00	Health Insurance (Purchased or Self Funded)				0	1 .
01	Health Insurance (Self Funded without a Third Party Administr	rator)			0	
02	Health Insurance (Self Funded with a Third Party Administrate				10, 932, 815	
03	Heal th Insurance (Purchased)	,			0	
00	Prescription Drug Plan				4, 083, 483	
. 00	Dental, Hearing and Vision Plan				111, 594	
. 00	Life Insurance (If employee is owner or beneficiary)				58, 503	
. 00	Accident Insurance (If employee is owner or beneficiary)				0	1
. 00	Disability Insurance (If employee is owner or beneficiary)				1, 478, 797	1
. 00	Long-Term Care Insurance (If employee is owner or beneficiary	()			0	1
. 00	'Workers' Compensation Insurance				435, 891	1
. 00	Retirement Health Care Cost (Only current year, not the extra	aordinary acc	rual require	ed by FASB 106.		11
	Noncumulative portion)	3	•	3		
	TAXES					
. 00	FICA-Employers Portion Only				9, 715, 239	1
. 00	Medicare Taxes - Employers Portion Only				0	1 .
. 00	Unemployment Insurance				0	1
. 00	State or Federal Unemployment Taxes				0	2
	OTHER					4
. 00	Executive Deferred Compensation (Other Than Retirement Cost Finstructions))	Reported on I	ines 1 throu	igh 4 above. (see	0	2
. 00	Day Care Cost and Allowances				0	2
. 00	Tuition Reimbursement				12, 097	2
. 00	Total Wage Related cost (Sum of lines 1 -23)				32, 199, 273	2
	Part B - Other than Core Related Cost					
00	OTHER WAGE RELATED COSTS (SPECIFY)					2

Heal th	Financial Systems	COMMUNI TY HOSPI TAL OF	INDIANA, INC.	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0169	Peri od:	Worksheet S-3	
				From 01/01/2022		
				To 12/31/2022	Date/Time Pre 5/25/2023 11:	
	Cost Center Description			Contract Labor		
	cost center bescription			1.00	2.00	
	PART V - Contract Labor and Benefit Co	st		1100	2100	
	Hospital and Hospital-Based Component	I denti fi cati on:				
1.00	Total facility's contract labor and be	nefit cost		32, 000, 853	32, 199, 273	1.00
2.00	Hospi tal			32, 000, 853	31, 112, 541	2.00
3.00	SUBPROVIDER - IPF			0	559, 678	3.00
4.00	SUBPROVIDER - IRF					4.00
5.00	Subprovider - (Other)			0	0	5.00
6.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	7.00
8.00	SKILLED NURSING FACILITY					8.00
9.00	NURSING FACILITY					9.00
10.00	OTHER LONG TERM CARE I					10.00
11.00	Hospital-Based HHA					11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I					12.00
13.00	Hospi tal -Based Hospi ce					13.00
14.00	Hospital-Based Health Clinic RHC					14.00
15.00	Hospital-Based Health Clinic FQHC					15.00
16.00	Hospi tal -Based-CMHC					16.00
17.00	RENAL DIALYSIS I			0	0	17.00
18.00	Other			0	527, 054	18.00
						•

Heal th	Financial Systems COMMUNITY HOSPITAL OF I	NDI ANA, INC.	In Lie	eu of Form CMS-:	2552-10
		Provider CCN: 15-0169		Worksheet S-1	
			To 12/31/2022		
				1.00	
	Uncompensated and indigent care cost computation			1.00	
1.00	<u>Cost to charge ratio (Worksheet C, Part I line 202 column 3 div</u> Medicaid (see instructions for each line)	ided by line 202 col	umn 8)	0. 234486	1.00
2.00	Net revenue from Medicaid			102, 586, 190	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement		i cai d?	N	4.00
5.00 6.00	If line 4 is no, then enter DSH and/or supplemental payments fr Medicaid charges	om Medicald		-33, 804, 049 422, 607, 073	
7.00	Medicaid cost (line 1 times line 6)			99, 095, 442	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of	lines 2 and 5; if	30, 313, 301	8.00
	< zero then enter zero)				
9.00	Children's Health Insurance Program (CHIP) (see instructions fo Net revenue from stand-alone CHIP	r each line)		0	9.00
9.00	Stand-al one CHIP charges			0	
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	
12.00	Difference between net revenue and costs for stand-alone CHIP (; if < zero then	0	12.00	
	enter zero)				
13.00	Other state or local government indigent care program (see inst Net revenue from state or local indigent care program (Not incl			0	13.00
14.00	Charges for patients covered under state or local indigent care			0	
	10)				
15.00	State or local indigent care program cost (line 1 times line 14			0	
16.00	Difference between net revenue and costs for state or local ind 13; if < zero then enter zero)	ligent care program (line 15 minus line	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state/local in	digent care progra	ms (see	1
	instructions for each line)				
	Private grants, donations, or endowment income restricted to fu			0	
18. 00 19. 00	Government grants, appropriations or transfers for support of h Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)		ams (sum of lines	0 30, 313, 301	
		Uni nsur		Total (col. 1	
		pati ent		+ col . 2)	
	Uncompensated Care (see instructions for each line)	1.00	2.00	3.00	
20. 00	Charity care charges and uninsured discounts for the entire fac (see instructions)	ility 10, 286	o, 213 2, 482, 026	12, 768, 239	20.00
21.00	Cost of patients approved for charity care and uninsured discou instructions)	nts (see 2, 411	, 973 2, 482, 026	4, 893, 999	21.00
22.00	Payments received from patients for amounts previously written charity care	off as	0 0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	2, 411	, 973 2, 482, 026	4, 893, 999	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patien	t days beyond a leng	th of stay limit	N	24.00
25.00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond th		ram's length of	0	25.00
o./	stay limit			10 ((1 05)	
26.00 27.00	Total bad debt expense for the entire hospital complex (see ins Medicare reimbursable bad debts for the entire hospital complex			19, 661, 854 197, 818	•
27.00	Medicare allowable bad debts for the entire hospital complex (s			304, 335	
28.00	Non-Medicare bad debt expense (see instructions)			19, 357, 519	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see instructio	ns)	4, 645, 584	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus li	no 20)		9, 539, 583	•
31.00	Trotal uniermoursed and uncompensated care cost (Trne 19 plus II	ne 30)		39, 852, 884	31.00

RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF		OF INDIANA, IN Provider CC	CN: 15-0169 P	eriod: rom 01/01/2022	u of Form CMS-2 Worksheet A	2002 10
					o 12/31/2022	Date/Time Pre 5/25/2023 11:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	I	0	0	21, 174, 996	21, 174, 996	1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT		0	0		14, 545, 723	2.00
3.00	00300 OTHER CAP REL COSTS		0	0	-	0	3.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINI STRATI VE & GENERAL	169, 506 4, 709, 371	225, 854 157, 023, 551	395, 360 161, 732, 922		300, 351 141, 236, 674	4.00 5.00
7.00	00700 OPERATION OF PLANT	2, 098, 029	9, 949, 435	12, 047, 464		11, 786, 319	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	О	970, 347	970, 347	-79	970, 268	
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	3, 348, 547 3, 115, 783	2, 255, 098 3, 667, 233	5, 603, 645 6, 783, 016		5, 581, 159 2, 037, 488	9.00 10.00
11.00	01100 CAFETERIA	3, 115, 783	3,007,233	0, 783, 010		2, 037, 488 4, 659, 813	
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 550, 857	660, 888	3, 211, 745	-31, 177	3, 180, 568	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	838, 089	4, 737, 571	5, 575, 660		2, 710, 014	1
15.00 16.00	01600 MEDICAL RECORDS & LIBRARY	6, 322, 758 0	15, 943, 465 0	22, 266, 223 0		8, 623, 001 0	15.00 16.00
17.00	01700 SOCIAL SERVICE	1, 939, 757	614, 507	2, 554, 264	-39	2, 554, 225	1
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	02100 I & R SERVI CES-SALARY & FRI NGES APPRV 02200 I & R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	0	21.00 22.00
22.00	INPATIENT ROUTINE SERVICE COST CENTERS		0	0	0	0	22.00
30.00	03000 ADULTS & PEDIATRICS	46, 586, 179	44, 481, 050	91, 067, 229		76, 063, 850	
31.00 35.00	03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	6, 260, 129 9, 316, 226	5, 205, 490 5, 681, 752	11, 465, 619 14, 997, 978		10, 567, 301 14, 432, 034	31.00 35.00
40.00	04000 SUBPROVIDER - IPF	2, 537, 310	701, 095	3, 238, 405		3, 208, 316	
43.00	04300 NURSERY	0	0	0		3, 391, 628	
	ANCI LLARY SERVI CE COST CENTERS	E 240 020	40, 570, 685	45, 911, 505	22 (10 (17	22.250.020	
50.00 51.00	05100 RECOVERY ROOM	5, 340, 820 3, 659, 593	40, 570, 885 2, 528, 282	45, 911, 505 6, 187, 875		22, 250, 838 5, 859, 587	50.00 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		7, 277, 464	
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 238, 283	2, 620, 140	6, 858, 423		5, 588, 472	54.00
55.00 57.00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	706, 563 1, 396, 651	6, 389, 056 1, 389, 961	7, 095, 619 2, 786, 612		3, 324, 425 2, 587, 740	
58.00	05800 MRI	868, 530	1, 947, 988	2, 816, 518		1, 985, 286	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	4, 988	4, 988		3, 461	59.00
60.00 64.00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	0 546, 846	14, 783, 840 289, 114	14, 783, 840 835, 960		14, 783, 840 713, 741	60.00 64.00
65.00	06500 RESPIRATORY THERAPY	4, 283, 251	3, 912, 826	8, 196, 077		7, 222, 775	65.00
66.00	06600 PHYSI CAL THERAPY	7, 463, 220	3, 594, 193	11, 057, 413		7, 066, 643	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0		2, 311, 488 431, 008	
69.00	06900 ELECTROCARDI OLOGY	43, 858	531,000	574, 858		574, 110	
	07000 ELECTROENCEPHALOGRAPHY	1, 180, 335	1, 064, 910	2, 245, 245		1, 981, 463	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	19, 128, 767	19, 128, 767 12, 602, 121	
	07200 TMPL. DEV. CHARGED TO PATTENTS	0	0	0	12, 602, 121 15, 240, 131	15, 240, 131	72.00
73.01	07301 SPECIALTY PHARMACY	0	0	0	0	0	73.01
74.00	07400 RENAL DI ALYSI S	79, 676	1, 435, 171	1, 514, 847		1, 417, 072	
76.00 76.01	03330 ENDOSCOPY 03950 OTHER ANCILLARY SERVICE COST CENTERS	1, 741, 646	3, 572, 525 0	5, 314, 171 0	-2, 213, 276	3, 100, 895 0	76.00
76.02	03951 OTHER ANCI LLARY SERVICE COST CENTERS	Ő	Ő	0	0	0	1
76.03	03952 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	76.03
76. 04 76. 06	03953 WOUND CARE 03954 I MAGI NG CENTER	554, 055 2, 037, 005	1, 020, 017 2, 897, 033	1, 574, 072 4, 934, 038		1, 366, 936 3, 611, 742	
	03955 BREAST DI AGNOSTI C CENTER	2,037,003	12, 343, 391	12, 369, 415		11, 964, 413	
	OUTPATIENT SERVICE COST CENTERS						
90. 00 90. 01	09000 CLINIC 04950 INFUSION CENTER	0 100, 130	0 1, 795, 492	0 1, 895, 622	0 -1, 746, 910	0 148, 712	90.00 90.01
	04955 SPINE CENTER	217, 743	64, 871	282, 614		282, 614	90.01
91.00	09100 EMERGENCY	7, 411, 921	8, 339, 511	15, 751, 432		15, 178, 964	91.00
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART SPECIAL PURPOSE COST CENTERS						92.00
113.00	11300 I NTEREST EXPENSE		ol	0	0	0	113.00
114.00	11400 UTI LI ZATI ON REVI EW-SNF	О	Ō	0	0	0	114.00
118.00		131, 688, 691	363, 212, 330	494, 901, 021	127, 415	495, 028, 436	118.00
190.00	NONREIMBURSABLE COST CENTERS	0	n	0	0	0	190.00
191.00	19100 RESEARCH	o	o	0	Ő	0	191.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	84, 188	84, 188	0	84, 188	
	19300 NONPALD WORKERS 07950 HOME OFFICE	0	0	0	0		193.00 194.00
	07956 PAVI LLI ONS	0	72, 686	72, 686	-58, 354		194.00
	07958 OTHER NRCC	1, 834, 790	686, 525	2, 521, 315	-69, 061	2, 452, 254	1101 00

Health Financial Systems COM	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 C		Period: From 01/01/2022	Worksheet A	
				Foil 01/01/2022 Fo 12/31/2022		
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	194.10
200.00 TOTAL (SUM OF LINES 118 through 199)	133, 523, 481	364, 055, 729	497, 579, 210	0 0	497, 579, 210	200. 00

CLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C	CN: 15-016	59 Period: From 01/01/2	Workshee	⊧t A
					To 12/31/2	2022 Date/Tim	ne Prepare 23 11:31 a
	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, 883, 621	13, 291, 375				1.
00	00200 CAP REL COSTS-MVBLE EQUIP	3, 322, 187	17, 867, 910				2.
00	00300 OTHER CAP REL COSTS	C	-				3.
00	00400 EMPLOYEE BENEFITS DEPARTMENT	6, 824, 923					4.
00	00500 ADMI NI STRATI VE & GENERAL	-78, 798, 946					5.
00 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	3, 778, 450 C					7.
00	00900 HOUSEKEEPING						9.
	01000 DI ETARY	-111, 734					10.
	01100 CAFETERIA	-2, 581, 355					11.
. 00	01300 NURSING ADMINISTRATION	6, 696, 604					13.
	01400 CENTRAL SERVICES & SUPPLY	1, 733, 180					14.
	01500 PHARMACY	-63, 300					15.
	01600 MEDICAL RECORDS & LIBRARY	2, 519, 449					16.
	01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS						17. 19.
	02100 I &R SERVICES-SALARY & FRINGES APPRV	577, 257	0				21.
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	1, 221, 933					22.
20	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
. 00	03000 ADULTS & PEDI ATRI CS	-7, 570, 329	68, 493, 521				30.
. 00	03100 I NTENSI VE CARE UNI T	C	10, 567, 301				31.
	02060 NEONATAL INTENSIVE CARE UNIT	-671, 751					35.
	04000 SUBPROVIDER - IPF	-248, 484					40.
. 00	04300 NURSERY	C	3, 391, 628				43.
00	ANCI LLARY SERVI CE COST CENTERS	C	22, 250, 838				50.
	05100 RECOVERY ROOM						51.
	05200 DELIVERY ROOM & LABOR ROOM	C					52.
	05400 RADI OLOGY-DI AGNOSTI C	136, 111					54.
. 00	05500 RADI OLOGY-THERAPEUTI C	C	3, 324, 425				55.
	05700 CT SCAN	C	2, 587, 740				57.
	05800 MRI	C	1,700,200				58.
	05900 CARDI AC CATHETERI ZATI ON	168, 519					59.
	06000 LABORATORY						60.
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY						64. 65.
	06600 PHYSI CAL THERAPY	-4, 700					66.
	06700 OCCUPATI ONAL THERAPY	C					67.
. 00	06800 SPEECH PATHOLOGY	C	431, 008				68.
	06900 ELECTROCARDI OLOGY	-66, 915					69.
	07000 ELECTROENCEPHALOGRAPHY	351, 432					70.
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	C					71.
	07200 IMPL. DEV. CHARGED TO PATIENTS	C 295, 646	12,002,121				72.
	07300 DRUGS CHARGED TO PATIENTS 07301 SPECIALTY PHARMACY	293, 040	15, 535, 777				73.
	07400 RENAL DI ALYSI S		1, 417, 072				74.
	03330 ENDOSCOPY		3, 100, 895				76.
	03950 OTHER ANCILLARY SERVICE COST CENTERS	C	0				76.
	03951 OTHER ANCILLARY SERVICE COST CENTERS	C	0				76
	03952 OTHER ANCI LLARY SERVICE COST CENTERS	C	0				76.
	03953 WOUND CARE		1, 366, 936				76.
	03954 I MAGI NG CENTER 03955 BREAST DI AGNOSTI C CENTER		3, 611, 742 11, 964, 413				76. 76.
/	OUTPATIENT SERVICE COST CENTERS		1 1, 704, 413				/0.
. 00	09000 CLINIC	C	0				90.
. 01	04950 INFUSION CENTER	C	148, 712				90.
	04975 SPINE CENTER	C					90.
	09100 EMERGENCY	1, 103, 924	16, 282, 888				91.
. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.
2 00	SPECIAL PURPOSE COST CENTERS						110
	11300 INTEREST EXPENSE 11400 UTI LI ZATI ON REVI EW-SNF						113. 114.
4.00 8.00		-69, 271, 520	-				114.
5.00	NONREI MBURSABLE COST CENTERS	07,271,020	120,700,710				
0. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0				190.
	19100 RESEARCH	C	0				191.
2.00	19200 PHYSICIANS' PRIVATE OFFICES	C	84, 188				192.
	19300 NONPAID WORKERS	C	0				193.
	07950 HOME OFFICE	C	0				194.
	07956 PAVI LLI ONS	C	14, 332				194.
	07958 OTHER NRCC		2, 452, 254				194. 194.
	07960 COMMUNI TY REHAB HOSPI TAL	L C	u ()				1194

	Financial Systems SFFICATIONS	COMM	UNI TY HOSPI TAL	OF INDIANA, INC. Provider CCN: 15-	0169 Period:	eu of Form CMS-2552-10 Worksheet A-6
					From 01/01/2022 To 12/31/2022	
		Increases				5/25/2023 11: 31 am
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	Other		
	A - Chargeable Medical Suppli		4.00	5.00		
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	19, 128, 767		1.00
2.00	PATI ENT	0.00	0	0		2.00
2.00 3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00 5.00		0.00 0.00	0	0		5.00
. 00		0.00	0	0		7.00
00		0.00	0	0		8.00
00 . 00		0.00 0.00	0	0 0		9.00 10.00
. 00		0.00	0	0		11.00
00		0.00	0	0		12.00
00 00		0.00 0.00	0	0 0		13.00 14.00
00		0.00	0	0		15.00
00		0.00	0	0		16.00
00 00		0.00 0.00	0	0 0		17.00 18.00
00		0.00	0	0		19.00
00		0.00	0	0		20.00
00 00		0.00 0.00	0	0 0		21.00 22.00
00		0.00	0	0		23.00
00		0.00	0	0		24.00
00 00		0.00 0.00	0	0		25.00 26.00
00		0.00	0	0		27.00
00		0.00				28.00
	TOTALS B - Implantable Device Reclas		0	19, 128, 767		
C	IMPL. DEV. CHARGED TO	72.00		12, 602, 121		1.00
0	PATI ENTS					2.00
0						3.00
	C - Drugs Charges to Pat		0	12, 602, 121		
0	DRUGS CHARGED TO PATIENTS	73.00	0	15, 240, 131		1.00
0		0.00	0	0		2.00
)		0.00 0.00	0	0		3.00
)		0.00	0	0		5.00
)		0.00	0	0		6.00
)		0.00 0.00	0 0	0 0		7.00
5		0.00	0	Ő		9.00
00		0.00	0	0		10.00
00 00		0.00 0.00	0 0	0 0		11. 00 12. 00
00		0.00	0	0		13.00
00		0.00	0	0		14.00
00 00		0.00 0.00	0	0 0		15.00 16.00
00		0.00	0	0		17.00
00		0.00	0	0		18.00
00 00		0.00 0.00	0	0 0		19.00 20.00
00		0.00	0	0		20.00
00		0.00	О	0		22.00
00 00		0.00 0.00	0	0 0		23.00 24.00
00	TOTALS		0	15, 240, 131		24.00
	D - Depreciation Expense	1				
))	CAP REL COSTS-MVBLE EQUIP	2.00 0.00	0 0	14, 772, 446 0		1.00
)		0.00	0	0		3.00
C		0.00	0	0		4.00
0		0.00 0.00	0	0		5.00
0 0		0.00	0	0		6. 00 7. 00
0		0.00	0	0		8.00
00		0.00 0.00	0	0 0		9.00 10.00
. 00		0.00	U	U		I 10.00

COMMUNITY HOSPITAL OF INDIANA, INC. In Lieu of Form CMS-2552-10 Provider CCN: 15-0169 Period: From 01/01/2022 Worksheet A-6

RECLAS	SEFECATIONS			Provider CCN: 15-0	From 01/01/2022 To 12/31/2022 Dat	e/Time Prepared: 5/2023 11:31 am
	Cost Center	I ncreases Li ne #	Salary	Other		372023 11. 31 am
	2.00	3.00	4.00	5.00		
$\begin{array}{c} 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 25.\ 00\\ 25.\ 00\\ 26.\ 00\\ 27.\ 00\\ 28.\ 00\\ 29.\ 00\\ 30.\ 00\\ 31.\ 00\\ 32.\ 00\\ \end{array}$	T0TALS	0.00 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000000		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 25.\ 00\\ 26.\ 00\\ 27.\ 00\\ 28.\ 00\\ 29.\ 00\\ 30.\ 00\\ 31.\ 00\\ 32.\ 00\\ \end{array}$
1.00	E - Interest Expense CAP REL COSTS-BLDG & FIXT TOTALS	<u> </u>	00	<u>12, 507, 318</u> 12, 507, 318		1.00
$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 14. \ 00\\ 15. \ 00\\ 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ 20. \ 00\\ 21. \ 00\\ 22. \ 00\\ 23. \ 00\\ 24. \ 00\\ 25. \ 00\\ 26. \ 00\\ \end{array}$	F - Other Capital Rental CAP REL COSTS-MVBLE EQUIP	2. 00 0.		8, 105, 037 0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 25.\ 00\\ 26.\ 00\\ \end{array}$
$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ \end{array}$	G - STD BENEFIT ADMI NI STRATI VE & GENERAL OPERATION OF PLANT HOUSEKEEPING DI ETARY NURSING ADMINI STRATION CENTRAL SERVICES & SUPPLY PHARMACY SOCIAL SERVICE ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT SUBPROVIDER - IPF OPERATING ROOM RECOVERY ROOM RADIOLOGY-DIAGNOSTIC CT SCAN INTRAVENOUS THERAPY PHYSICAL THERAPY	$\begin{array}{c} 5.\ 00\\ 7.\ 00\\ 9.\ 00\\ 10.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 17.\ 00\\ 30.\ 00\\ 31.\ 00\\ 35.\ 00\\ 40.\ 00\\ 50.\ 00\\ 51.\ 00\\ 51.\ 00\\ 54.\ 00\\ 57.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ \end{array}$		27, 112 2, 611 22, 382 14, 851 11, 005 1, 834 33, 448 11, 550 196, 190 13, 640 51, 818 5, 576 26, 061 17, 298 28, 410 275 939 32, 875 49, 163		$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 00\\ \end{array}$

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 01/01/2022

					From 01/01/2022 To 12/31/2022 Date/Time P 5/25/2023 1	
		Increases			572572025 1	
	Cost Center	Li ne #	Salary	Other		
	2.00	3.00	4.00	5.00		
20.00	ELECTROENCEPHALOGRAPHY	70.00	0	9, 917		20.00
21.00	ENDOSCOPY	76.00	0	31, 817		21.00
22.00	WOUND CARE	76.04	0	7, 129		22.00
23.00	I MAGI NG CENTER	76.06	0	14, 810		23.00
24.00	BREAST DIAGNOSTIC CENTER	76.07	0	1, 375		24.00
25.00	INFUSION CENTER	90.01	0	5, 753		25.00
26.00	SPINE CENTER	90.26	0	198		26.00
27.00	EMERGENCY	90.20	0	17, 506		20.00
27.00	TOTALS		— — — 0	635, 543		27.00
	H - Labor and Delivery		U	030, 043		_
1 00	NURSERY	43.00	2, 078, 879	0		1 00
1.00				U		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	4, 460, 681	0		2.00
3.00	NURSERY	43.00	0	1, 312, 749		3.00
4.00	DELIVERY ROOM & LABOR ROOM	<u>52.</u> 00		2,816,783		4.00
	TOTALS		6, 539, 560	4, 129, 532		_
	I - Cafeteria					
1.00	CAFETERIA	11.00	2, 167, 883			1.00
2.00	CAFETERI A	<u>11.00</u>		2, 491, 930		2.00
			2, 167, 883	2, 491, 930		
	J - Therapy					
1.00	OCCUPATI ONAL THERAPY	67.00	1, 595, 844	0		1.00
2.00	SPEECH PATHOLOGY	68.00	297, 567	0		2.00
3.00	OCCUPATI ONAL THERAPY	67.00	0	715, 644		3.00
4.00	SPEECH PATHOLOGY		0	<u>133, 4</u> 41		4.00
	TOTALS		1, 893, 411	849, 085		
	K - Building Depreciation					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8, 331, 760		1.00
	TOTALS		0	8, 331, 760		
	L - Capital Insurance Costs					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	335, 918		1.00
	TOTALS	+		335, 918		
	M - Radiology Support	•	· · · · · ·	· · ·		
1.00	RADI OLOGY-THERAPEUTI C	55.00	80, 470	0		1.00
2.00	CT SCAN	57.00	124, 936	0		2.00
3.00	MRI	58.00	40, 349	Ō		3.00
4.00	RADI OLOGY-THERAPEUTI C	55.00	0	55, 032		4.00
5.00	CT SCAN	57.00	0	85, 441		5.00
6.00	MRI	58.00	0	27, 594		6.00
5.00	TOTALS — — — — —		245, 755	168,067		
500 00	Grand Total: Increases		10, 846, 609	99, 297, 655		500.00
500.00		I				1 000.00

In Lieu of Form CMS-2552-10 Worksheet A-6

 Peri od:
 Worksheet A-6

 From 01/01/2022
 Date/Time Prepared:

 To
 12/31/2022
 Date/Time Prepared:

						5/25/2023 1	
		Decreases					
	Cost Center	Li ne # 7.00	<u>Salary</u> 8.00		Wkst. A-7 Ref. 10.00		
	6.00 A - Chargeable Medical Suppli		8.00	9.00	10.00		
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	761	0		1.00
2.00	OPERATION OF PLANT	7.00	0	98, 652	0		2.00
3.00	DI ETARY	10.00	0		0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0		0		4.00
5.00 6.00	PHARMACY ADULTS & PEDIATRICS	15.00 30.00	0		0		5.00 6.00
7.00	INTENSIVE CARE UNIT	31.00	0		0		7.00
8.00	NEONATAL INTENSIVE CARE UNIT	35.00	0		0		8.00
9.00	SUBPROVIDER - IPF	40.00	0		0		9.00
10.00	OPERATING ROOM	50.00	0	8, 935, 780	0		10.00
11.00	RECOVERY ROOM	51.00	0		0		11.00
12.00		54.00 55.00	0		0		12.00
13.00 14.00	RADI OLOGY-THERAPEUTI C CT SCAN	55.00	0	_,,	0		13.00 14.00
15.00	MRI	58.00	0		0		15.00
16.00	INTRAVENOUS THERAPY	64.00	0		0		16.00
17.00	RESPI RATORY THERAPY	65.00	0	673, 422	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	_,	0		18.00
19.00	ELECTROCARDI OLOGY	69.00	0		0		19.00
20. 00 21. 00	ELECTROENCEPHALOGRAPHY RENAL DIALYSIS	70.00 74.00	0		0		20.00 21.00
21.00	ENDOSCOPY	74.00	0		0		21.00
23.00	WOUND CARE	76.04	0	55, 010	0		23.00
24.00	I MAGI NG CENTER	76.06	0		0		24.00
25.00	BREAST DIAGNOSTIC CENTER	76.07	0	5, 537	0		25.00
26.00	INFUSION CENTER	90.01	0		0		26.00
27.00	EMERGENCY	91.00	0		0		27.00
28.00	PAVI LLI ONS	<u> </u>	<u>0</u>		0		28.00
	TOTALS B - Implantable Device Reclas		0	19, 128, 767			-
1.00	OPERATING ROOM	50.00		11, 070, 769			1.00
2.00	RADI OLOGY-THERAPEUTI C	55.00		1, 178, 039			2.00
3.00	ENDOSCOPY			<u> </u>			3.00
			0	12, 602, 121			_
1.00	C - Drugs Charges to Pat ADMINISTRATIVE & GENERAL	5.00	0	154	0		1.00
2.00	OPERATION OF PLANT	7.00	0		0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0		0		3.00
4.00	PHARMACY	15.00	0		0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	70, 032	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0		0		6.00
7.00	NEONATAL INTENSIVE CARE UNIT	35.00	0		0		7.00
8.00	SUBPROVIDER - IPF	40.00	0		0		8.00
9. 00 10. 00	OPERATING ROOM RECOVERY ROOM	50. 00 51. 00	0		0		9.00 10.00
11.00	RADI OLOGY-DI AGNOSTI C	54.00	0		0		11.00
12.00	RADI OLOGY-THERAPEUTI C	55.00	0		-		12.00
13.00	CT SCAN	57.00	0				13.00
14.00	MRI	58.00	0	91, 720	0		14.00
15.00	INTRAVENOUS THERAPY	64.00	0		0		15.00
16.00	RESPI RATORY THERAPY	65.00	0		0		16.00
17.00	PHYSICAL THERAPY	66.00	0	_,	0		17.00
18. 00 19. 00	ELECTROENCEPHALOGRAPHY ENDOSCOPY	70.00 76.00	0		0		18.00 19.00
20.00	WOUND CARE	76.04	0	.,	0		20.00
21.00	I MAGI NG CENTER	76.06	0		0		21.00
22.00	INFUSION CENTER	90.01	0		0		22.00
23.00	EMERGENCY	91.00	0	22, 981	0		23.00
24.00	OTHER NRCC	<u> </u>	<u>0</u>		0		24.00
	TOTALS		0	15, 240, 131			_
1.00	D - Depreciation Expense EMPLOYEE BENEFITS DEPARTMENT	4.00	0	539	9		1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0		0		2.00
3.00	OPERATION OF PLANT	7.00	0		0		3.00
4.00	HOUSEKEEPING	9.00	0		0		4.00
5.00	DI ETARY	10.00	0		0		5.00
6.00	NURSING ADMINISTRATION	13.00	0		0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0		0		7.00
8.00		15.00	0		0		8.00
9. 00 10. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	0	.,	0		9.00 10.00
11.00	NEONATAL INTENSIVE CARE UNIT	35.00	0		-		11.00
12.00	SUBPROVIDER - IPF	40.00	0				12.00
	1						

Heal th	Financial Systems	COMM	UNI TY HOSPI TAL	OF INDIANA, I	NC.	In Lieu of Form CM	S-2552-10
RECLAS	SIFICATIONS			Provider (Period: Worksheet A	-6
						From 01/01/2022 To 12/31/2022 Date/Time P	repared:
						5/25/2023 1	1:31 am
	Cost Center	Decreases Line #	Salary	Other		1	
	6.00	7.00	8.00	9.00	10.00	-	
13.00	OPERATING ROOM	50.00	0	1, 716, 995	j (13.00
14.00	RECOVERY ROOM	51.00	0	4, 836		-	14.00
15.00	RADI OLOGY-DI AGNOSTI C	54.00	0	331, 389		-	15.00
16.00	RADI OLOGY-THERAPEUTI C	55.00	0	610, 037			16.00
17.00 18.00	CT SCAN MRI	57.00 58.00	0	164, 663 660, 151			17.00 18.00
19.00	CARDI AC CATHETERI ZATI ON	59.00	0	1, 527			19.00
20.00	INTRAVENOUS THERAPY	64.00	0	8, 550			20.00
21.00	RESPI RATORY THERAPY	65.00	0	54, 576			21.00
22.00	PHYSICAL THERAPY	66.00	0	259, 248	8 (22.00
23.00	ELECTROCARDI OLOGY	69.00	0	140			23.00
24.00	ELECTROENCEPHALOGRAPHY	70.00	0	65, 962			24.00
25. 00 26. 00	ENDOSCOPY WOUND CARE	76.00 76.04	0	349, 971 43, 101			25.00 26.00
27.00	I MAGI NG CENTER	76.04	0	454, 108			27.00
28.00	BREAST DI AGNOSTI C CENTER	76.07	0	300	-		28.00
29.00	INFUSION CENTER	90.01	0	23, 515	i (29.00
30.00	EMERGENCY	91.00	0	195, 989) (30.00
31.00	PAVI LLI ONS	194.06	0	17, 700			31.00
32.00	OTHER NRCC	194.08		10, 108		2	32.00
	TOTALS E - Interest Expense		0	14, 772, 446			_
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	12, 507, 318	11	1	1.00
1.00	TOTALS		0	12, 507, 318			1.00
	F - Other Capital Rental	Ι		,			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	94, 470) 10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	363, 363			2.00
3.00	OPERATION OF PLANT	7.00	0	22, 048		-	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	79			4.00
5.00 6.00	HOUSEKEEPI NG DI ETARY	9.00 10.00	0	18, 123 1, 189			5.00 6.00
7.00	NURSING ADMINISTRATION	13.00	0	2, 031			7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	2, 558, 479			8.00
9.00	PHARMACY	15.00	0	516, 972			9.00
10.00	SOCIAL SERVICE	17.00	0	39) (10.00
11.00	ADULTS & PEDIATRICS	30.00	0	18, 769			11.00
12.00	INTENSIVE CARE UNIT	31.00	0	313		-	12.00
13.00	SUBPROVIDER - IPF	40.00	0	316			13.00
14. 00 15. 00	OPERATING ROOM RADIOLOGY-DIAGNOSTIC	50.00 54.00	0	1, 848, 601 473			14.00 15.00
16.00	MRI	58.00	0	79			16.00
17.00	RESPI RATORY THERAPY	65.00	0	243, 797			17.00
18.00	PHYSICAL THERAPY	66.00	0	983, 667			18.00
19.00	ELECTROENCEPHALOGRAPHY	70.00	0	175, 316			19.00
20.00	ENDOSCOPY	76.00	0	12, 398			20.00
21.00	WOUND CARE	76.04	0	107, 548			21.00
22.00	I MAGI NG CENTER	76.06	0	577,030			22.00
23.00 24.00	BREAST DIAGNOSTIC CENTER	76.07 90.01	0	399, 165 61, 498			23.00 24.00
24.00	PAVI LLI ONS	194.06	0	40, 501		-	24.00
26.00	OTHER NRCC	194.08	0	58, 773			26.00
	TOTALS		0	8, 105, 037			
	G - STD BENEFIT	I					
1.00	ADMI NI STRATI VE & GENERAL	5.00	27, 112	0		-	1.00
2.00	OPERATION OF PLANT	7.00	2, 611	0		-	2.00
3.00 4.00	HOUSEKEEPI NG DI ETARY	9.00 10.00	22, 382 14, 851	0		-	3.00 4.00
4.00 5.00	NURSING ADMINISTRATION	13.00	14, 851	0		-	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	1, 834	0			6.00
7.00	PHARMACY	15.00	33, 448	0) (7.00
8.00	SOCIAL SERVICE	17.00	11, 550	0) (8.00
9.00	ADULTS & PEDIATRICS	30.00	196, 190	0	-		9.00
10.00	INTENSIVE CARE UNIT	31.00	13, 640	0			10.00
11.00	NEONATAL INTENSIVE CARE UNIT	35.00	51, 818	0		-	11.00
12.00 13.00	SUBPROVIDER - IPF OPERATING ROOM	40.00 50.00	5, 576 26, 061	0		-	12.00 13.00
13.00 14.00	RECOVERY ROOM	50.00	26, 061 17, 298	0	-		13.00
14.00	RADI OLOGY-DI AGNOSTI C	51.00	28, 410	0			14.00
16.00	CT SCAN	57.00	20, 410	0	-		16.00
17.00	INTRAVENOUS THERAPY	64.00	939	0) (-	17.00
18.00	RESPI RATORY THERAPY	65.00	32, 875	0) (18.00
19.00	PHYSICAL THERAPY	66.00	49, 163	0			19.00
20.00	ELECTROENCEPHALOGRAPHY	70.00	9, 917	0		-	20.00
21.00	ENDOSCOPY	76.00	31, 817	0) (וע	21.00

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 01/01/2022 To 12/21/2022 Date (T) 5

						To 12/31/2022	Date/Time Prepared: 5/25/2023 11:31 am
		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00	1	
22.00	WOUND CARE	76.04	7, 129	0) ()	22.00
23.00	I MAGI NG CENTER	76.06	14, 810	0) (23.00
24.00	BREAST DIAGNOSTIC CENTER	76.07	1, 375	0) (24.00
25.00	INFUSION CENTER	90.01	5, 753	0) (b	25.00
26.00	SPINE CENTER	90.26	198	0) (b	26.00
27.00	EMERGENCY	91.00	17, 506	0) (b	27.00
	TOTALS		635, 543	0		1	
	H - Labor and Delivery						
1.00	ADULTS & PEDIATRICS	30.00	6, 539, 560	0) (1.00
2.00		0.00	0	0) (b	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	4, 129, 532	(b	3.00
4.00		0.00	0	0			4.00
	TOTALS		6, 539, 560	4, 129, 532		1	
	I - Cafeteria	· · · · ·		· · ·			
1.00	DI ETARY	10.00	2, 167, 883				1.00
2.00	DI ETARY	10.00		2, 491, 930			2.00
			2, 167, 883	2, 491, 930		1	
	J - Therapy	· · · · · ·		· · ·			
1.00	PHYSICAL THERAPY	66.00	1, 893, 411	0) (1.00
2.00		0.00	0	0) (b	2.00
3.00	PHYSI CAL THERAPY	66.00	0	849, 085	(b	3.00
4.00		0.00	0	0) (b	4.00
	TOTALS		1, 893, 411	849,085	· · · · · · · · · · · · · · · · · · ·	1	
	K - Building Depreciation			· · · · · ·			
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8, 331, 760		9	1.00
	TOTALS			8, 331, 760		1	
	L - Capital Insurance Costs			· · ·			
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	335, 918	12	2	1.00
	TOTALS			335, 918		1	
	M - Radiology Support	· · · · · · · · · · · · · · · · · · ·				1	
1.00	RADI OLOGY-DI AGNOSTI C	54.00	245, 755	0) (2	1.00
2.00		0.00	0	0			2.00
3.00		0.00	0	0			3.00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	168, 067	(4.00
5.00		0.00	0	0			5.00
6.00		0.00	0	0	(6.00
5.00	TOTALS — — — — —		245, 755	168,067	/ ``	1	0.00
500.00	Grand Total: Decreases		11, 482, 152	98, 662, 112		1	500.00
500.00		I			1	1	1000.00

		MUNITY HOSPITAL				eu of Form CMS-	
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	JN: 15-0169	Period: From 01/01/2022	Worksheet A-7 Part I	
					To 12/31/2022		pared:
		_				5/25/2023 11:	
				Acquisition			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
	I	1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASS					1	
1.00	Land	2, 705, 851	0		0 0	0	
2.00	Land Improvements	4, 358, 832			0 0	0	1 2.00
3.00	Buildings and Fixtures	326, 057, 951	6, 383, 717		0 6, 383, 717		0.00
4.00	Building Improvements	3, 525, 194	90, 546		0 90, 546	0	1
5.00	Fixed Equipment	0	0		0 C	0	5.00
6.00	Movable Equipment	126, 202, 139	3, 241, 938		0 3, 241, 938	542, 970	6.00
7.00	HIT designated Assets	0	0		0 0	0	
8.00	Subtotal (sum of lines 1-7)	462, 849, 967	9, 716, 201		0 9, 716, 201	542, 970	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	462, 849, 967	9, 716, 201		0 9, 716, 201	542, 970	10.00
		Endi ng Bal ance	Fully				
			Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASS						
1.00	Land	2, 705, 851	0				1.00
2.00	Land Improvements	4, 358, 832	0				2.00
3.00	Buildings and Fixtures	332, 441, 668	0				3.00
4.00	Building Improvements	3, 615, 740	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	128, 901, 107	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	472, 023, 198	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	472, 023, 198	0				10.00

Heal th	Financial Systems COMM	UNI TY HOSPI TAL	OF INDIANA, I	INC.	In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 15-0169	Peri od:	Worksheet A-7	
					From 01/01/2022 To 12/31/2022	Part II Date/Time Pre	arod
					10 12/31/2022	5/25/2023 11:	
				SUMMARY OF CAP	PI TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1	and 2	1		
1.00	CAP REL COSTS-BLDG & FIXT	0		0	0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0	0 0	0	2.00
3.00	Total (sum of lines 1-2)	0		0	0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (su	m			
	cost center bescription	Capi tal -Rel ate		****			
		d Costs (see					
		i nstructi ons)					
		14.00	15.00	-			
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0		0			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3.00	Total (sum of lines 1-2)	0		0			3.00
			•				

Health Financial Systems COMM	UNI TY HOSPI TAL	OF INDIANA, IN	NC.	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2022 To 12/31/2022		oared: 31 am
	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 C	1.00	2.00	3.00	4.00	5.00	
1.00 CAP REL COSTS-BLOG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	343, 122, 090 128, 901, 109 472, 023, 199	0	343, 122, 090 128, 901, 109 472, 023, 199	0. 273082	0 0 0 E_CAPLTAL	1.00 2.00 3.00
	ALLOCA	TTON OF OTHER C				
Cost Center Description	Taxes	Other Capital-Relate 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		-	-		-	
1.00CAP REL COSTS-BLDG & FIXT2.00CAP REL COSTS-MVBLE EQUIP3.00Total (sum of lines 1-2)	0			8, 331, 760 9, 762, 873 18, 094, 633	0 8, 105, 037 8, 105, 037	1.00 2.00 3.00
		SI	JMMARY OF CAPIT		0,100,007	0.00
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				-		
1.00CAP REL COSTS-BLDG & FIXT2.00CAP REL COSTS-MVBLE EQUIP3.00Total (sum of lines 1-2)	4, 623, 697 0 4, 623, 697	0	C		13, 291, 375 17, 867, 910 31, 159, 285	1.00 2.00 3.00

	Financial Systems	COMML	INI TY HOSPI TAL	OF INDIANA, INC.		u of Form CMS-2	
ADJUSTI	MENTS TO EXPENSES			Provider CCN: 15-0169	Period: From 01/01/2022 To 12/31/2022		pared:
				Expense Classification of To/From Which the Amount is		5/25/2023 11:	31 am
					s to be Aujusted		
		Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	4.00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 3.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0	CAP REL COSTS-MVBLE EQUIP	2.00		
	(chapter 2)		0				
4.00	Trade, quantity, and time discounts (chapter 8)		U		0.00		
5.00	Refunds and rebates of expenses (chapter 8)	В	-24, 277	ADMI NI STRATI VE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter		O		0.00	0	7.00
8.00	21) Television and radio service		0		0.00	0	8.00
9.00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	9.00
10. 00	Provider-based physician adjustment	A-8-2	-1, 323, 180			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	5, 163, 126			0	12.00
	Laundry and linen service		0		0.00		
	Cafeteria-employees and guests Rental of quarters to employee		-2, 464, 351 0	CAFETERI A	11.00 0.00		
16. 00	and others Sale of medical and surgical supplies to other than		O		0.00	0	16.00
17.00	patients Sale of drugs to other than		0		0.00	0	17.00
18.00	patients Sale of medical records and		0		0.00	0	18.00
19.00	abstracts Nursing and allied health		0		0.00	0	19.00
17.00	education (tuition, fees, books, etc.)		0		0.00	0	17.00
	Vending machines		C C		0.00		
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		U		0.00	0	21.00
22. 00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		O		0.00	0	22.00
	Adjustment for respiratory therapy costs in excess of	A-8-3	O	RESPI RATORY THERAPY	65.00		23.00
	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24.00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		O	UTILIZATION REVIEW-SNF	114.00		25.00
26. 00	(chapter 21) Depreciation - CAP REL		O	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		Û	NONPHYSI CI AN ANESTHETI STS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see instructions)		C	ADULTS & PEDIATRICS	30.00		30. 99
	Adjustment for speech pathology costs in excess of	A-8-3	C	SPEECH PATHOLOGY	68.00		31.00
32.00	limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest		C		0.00	0	32.00

ADJUS I	MENTS TO EXPENSES				Period: From 01/01/2022	Worksheet A-8	
				1	o 12/31/2022	Date/Time Pre 5/25/2023 11:	pared: 31 am
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Conton Decorintian		Amount	Cost Center	line #	Wiket A 7 Def	
	Cost Center Description	Basis/Code (2) 1.00	2.00	3. 00	Line # 4.00	<u>Wkst. A-7 Ref.</u> 5.00	
33.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.0
	(3)						
33.01	Misc Revenue	В	-142, 563	EMPLOYEE BENEFITS DEPARTMENT		0	33.0
33.02	Misc Revenue	В	-579, 775	ADMINISTRATIVE & GENERAL	5.00	0	33. (
33.03	Misc Revenue	В	-111, 734	DI ETARY	10.00	0	33.
33.04	Misc Revenue	В	-63, 300	PHARMACY	15.00	0	33.
33.05	Misc Revenue	В	-7,227	ADULTS & PEDIATRICS	30.00	0	33.
33.06	Misc Revenue	В	-1,710	NEONATAL INTENSIVE CARE UNIT	35.00	0	33.
33.07	Misc Revenue	В		RADI OLOGY-DI AGNOSTI C	54.00	0	
33.08	Mi sc Revenue	B		PHYSICAL THERAPY	66.00	0	
33.09	Space Rental Income	B		ADMI NI STRATI VE & GENERAL	5.00	0	
33.10	Space Rental Income	B		OPERATION OF PLANT	7.00	0	
34.00	HAF Tax Offset	A		ADMI NI STRATI VE & GENERAL	5.00	0	
					5.00	11	
34. 01	2018A Non-Allow Interest Expense	A		CAP REL COSTS-BLDG & FIXT			
34.02	PNC Non-Allow Interest Expense	1 1		CAP REL COSTS-BLDG & FIXT	1.00	11	
34. 03	2012A Non-Allow Interest Expense	A		CAP REL COSTS-BLDG & FIXT	1.00	11	34.
34.04	2012B Non-Allow Interest Expense	A	-150, 448	CAP REL COSTS-BLDG & FIXT	1.00	11	34.
34. 05	2022A Non-Allow Interest Expense	A	-50, 279	CAP REL COSTS-BLDG & FIXT	1.00	11	34.
34.06	2016AB Non-Allow Interest Expense	A	-554, 468	CAP REL COSTS-BLDG & FIXT	1.00	11	34.
34. 07	2020A Non-Allow Interest Expense	A	-2, 898, 044	CAP REL COSTS-BLDG & FIXT	1.00	11	34.
34. 08	Non-Allow Debt Issuance Expense	A	-346, 338	ADMI NI STRATI VE & GENERAL	5.00	0	34.
35. 01	Hospitalist Loss	A	-7, 632, 280	ADULTS & PEDIATRICS	30.00	0	35.
35.02	Bad Debt	А		ADMI NI STRATI VE & GENERAL	5.00	0	
35.03	Bad Debt	А		NEONATAL INTENSIVE CARE UNIT		0	35.
35.04	Loss on Assets	A		ADULTS & PEDIATRICS	30.00	0	
35.05	APP	A		NEONATAL INTENSIVE CARE UNIT		0	
35.06	APP	A		ADULTS & PEDIATRICS	30.00	0	
36.00	Meals on Wheels Cost	A		CAFETERIA	11.00	0	
36.00	SHARED SERVICES	A		CAPETERTA CARDIAC CATHETERIZATION	59.00	0	
						0	
36. 02 50. 00	SHARED SERVICES TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,	A	-66, 915 -69, 271, 520	ELECTROCARDI OLOGY	69.00	0	36. 50.

(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 f	Financial Systems	COMMUNI TY HOSPI TAI	L OF INDIANA, INC.	In Lie	eu of Form CMS-:	2552-10
	NT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-0169	Peri od:	Worksheet A-8	-1
OFFICE	COSTS			From 01/01/2022 To 12/31/2022		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column 5	
	1.00	2.00	3.00	4,00	5.00	
	A. COSTS INCURRED AND ADJUSTM					
	HOME OFFICE COSTS:	ENTO RECORDED NO A RECOEL OF			OEM MED	
1.00		I &R SERVICES-SALARY & FRINGE	RESI DENTS	577, 257	0	1.00
2.00	22.00	I&R SERVICES-OTHER PRGM COST	RESI DENTS	1, 221, 933	0	2.00
3.00		CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	3, 322, 187	0	3.00
3.01		EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	6, 967, 486	0	3. 01
3.02		ADMINISTRATIVE & GENERAL	HOME OFFICE	55, 482, 126	79, 641, 013	3. 02
3.03		OPERATION OF PLANT	HOME OFFICE	3, 780, 100	0	3.03
3.04		NURSING ADMINISTRATION	HOME OFFICE	6, 696, 604	0	3.04
3.05		CENTRAL SERVICES & SUPPLY	HOME OFFICE	1, 733, 180	0	3.05
3.06		MEDICAL RECORDS & LIBRARY	HOME OFFICE	2, 519, 449	0	3.06
3.07		ADULTS & PEDIATRICS	HOME OFFICE	167, 996	0	3.07
3.08 3.09		RADI OLOGY-DI AGNOSTI C ELECTROENCEPHALOGRAPHY	HOME OFFICE HOME OFFICE	251,004	0	3.08 3.09
3.09		DRUGS CHARGED TO PATIENTS	HOME OFFICE	351, 432 295, 646	0	3.09 3.10
4.00			CPN MEDICAL DIRECTOR	333, 815	0	4.00
4.00			CPN ED ON CALL	1, 103, 924	0	4.00
	TOTALS (sum of lines 1-4).	Emeridenci		84, 804, 139	79, 641, 013	5.00
	Transfer column 6, line 5 to			07,004,137	, , 041, 013	5.00
	Worksheet A-8, column 2,					
	line 12.					

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

inds not been posted to worksheet A, eordinns i and/or 2, the amount arrowable should be indicated in cordinary or this part.						
				Related Organization(s) and/	or Home Office	
				3 ()		
	Symbol (1)	Name	Percentage of	Name	Percentage of	
	Symbol (1)	Name		Name		
			Ownership		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.

rerinbur	Schone under trette Aviri.				
6.00	В	CHNW	100.00	0.0	0 6.0
7.00			0.00	0.0	0 7.0
8.00			0.00	0.0	0 8.0
9.00			0.00	0.0	0 9.0
10.00			0.00	0.0	0 10.0
100.00	G. Other (financial or				100.0
	non-financial) specify:				

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

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

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

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

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

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

Health Financial Systems	COMMUNI TY HOSPI TAL OF	INDIANA, INC.	In Lieu	of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM REL OFFICE COSTS	LATED ORGANIZATIONS AND HOME		Period: From 01/01/2022	Worksheet A-8-1
				Date/Time Prepared:

					5/25/2023 11	: <u>31 am</u>
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
-	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:				
1.00	577, 257	0				1.00
2.00	1, 221, 933	0				2.00
3.00	3, 322, 187	9				3.00
3.01	6, 967, 486	0				3. 01
3.02	-24, 158, 887	0				3. 02
3.03	3, 780, 100	0				3.03
3.04	6, 696, 604	0				3.04
3.05	1, 733, 180	0				3.05
3.06	2, 519, 449					3.06
3.07	167, 996					3.07
3.08	251,004					3.08
3.09	351, 432					3.09
3.10	295, 646					3, 10
4.00	333, 815					4.00
4.01	1, 103, 924					4.01
5.00	5, 163, 126					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 as not been posted to Worksheet A. columns 1 and/or 2. the amount allowable should be indicated in column 4 of this part

IId	SINUL	been posted to worksheet A,	COLIMITS	i anu/oi	Ζ, Ι	The annount	arrowabre	Shourd	be i	nui cateu	TH COLUM	1 4 01	this part.	
		Rel ated Organi zati on(s)												
		and/or Home Office												
		Type of Business												
		51												
		6, 00	1											
		B. INTERRELATIONSHIP TO RELA	TED ORGAI	VI ZATI ON	(S) AN	VD/OR HOME	E 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
6.00 7.00 8.00 9.00 10.00 100.00	1	100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

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

 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.

Heal th	Fi nanci a	l Systems	
		DUVELCLAN	

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

	R BASED PHYSIC				CCN: 15-0169	Peri od:	Worksheet A-8	
FROVIDE	K DAJED FIIIJIC	TAN ADJUSTMENT		FIOVICEI		From 01/01/2022		5-2
						To 12/31/2022	Date/Time Pre	epared:
							5/25/2023 11:	31 am
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
	intot. A Erno "	I denti fi er	Remuneration	Component	Component		ider Component	
		luentitien	Reliquier at 1 011	component	component			
-	1.00	0.00	0.00	4.00	5 00	(00	Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	AGGREGATE-ADMI NI STRATI VE &	918, 078	918, 078	C	0	0	1.00
		GENERAL						
2.00	30.00	AGGREGATE-ADULTS &	4, 118	4, 118	C	0	0	2.00
		PEDI ATRI CS						
3.00	35.00	AGGREGATE-NEONATAL INTENSIVE	152, 500	152, 500	0	0	0	3.00
5.00	33.00		152, 500	152, 500			0	5.00
		CARE UN						
4.00		AGGREGATE-SUBPROVIDER - IPF	248, 484	248, 484		0	0	4.00
5.00	0.00		C	0	C	0	0	5.00
6.00	0.00		C	0	C	0	0	6.00
7.00	0,00			0	0	0	0	7.00
8.00	0.00			0	0	0	0	8.00
				0			0	
9.00	0.00			ں 1	C	0	0	9.00
10.00	0.00		C	0	C	0	0	10.00
200.00			1, 323, 180	1, 323, 180	C		0	200.00
	Wkst. A Line #	Cost Center/Physician		5 Percent of	Cost of	Provi der	Physician Cost	
	intot. A Erno "	I denti fi er	Limit	Unadjusted RCE			of Malpractice	
		luentinei						
				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 &	C	0	C	0	0	1.00
		GENERAL						
2.00	30.00	AGGREGATE-ADULTS &		0	C	0	0	2.00
2.00	30.00	PEDIATRI CS					0	2.00
0.00	05.00							0.00
3.00	35.00	AGGREGATE-NEONATAL INTENSIVE		0	C	0	0	3.00
		CARE UN						
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	C	0	C	0	0	4.00
5.00	0.00		l c	0	C	0	0	5.00
6.00	0.00			0	0	0	0	6.00
7.00	0.00			0	0	0	0	7.00
				0		-	0	
8.00	0.00			y 0	C	0	0	8.00
9.00	0.00		C	0	C	0	0	9.00
10.00	0.00		C	0	C	0	0	10.00
200.00				0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		200.00
	WKSL A LINE #					Aujustment		
		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	5.00	AGGREGATE - ADMI NI STRATI VE &	C	0	C	918, 078		1.00
	3.00	GENERAL	Ĭ	l °	Ŭ			
2 00	20.00	AGGREGATE-ADULTS &		0	0	1 110		2 00
2.00	30.00			' U		4, 118		2.00
		PEDI ATRI CS						
3.00	35.00	AGGREGATE-NEONATAL INTENSIVE	[C	0	C	152, 500		3.00
		CARE UN						
4.00	40.00	AGGREGATE-SUBPROVI DER – I PF	0	0	C	248, 484		4.00
5.00	0.00			0	-			5.00
6.00	0.00			0	-	0		6.00
7.00	0.00		[C	0	-	-		7.00
8.00	0.00		[C	0	C	0		8.00
9.00	0.00		l c	0	C	0		9.00
10.00	0.00			0		0		10.00
	0.00					-		200.00
200.00	I	I	I C	ıj U	n C	1, 323, 180		200.00

T ALLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod: rom 01/01/2022 o 12/31/2022	Worksheet B Part I Date/Time Pre 5/25/2023 11:	
		CAPI TAL REL	ATED COSTS		572572025 11.	
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
0 00100 CAP REL COSTS-BLDG & FIXT	13, 291, 375					1.
0 00200 CAP REL COSTS-MVBLE EQUIP 0 00400 EMPLOYEE BENEFITS DEPARTMENT	17, 867, 910 7, 125, 274		17, 867, 910 94, 682	7, 225, 758		2.
0 00500 ADMI NI STRATI VE & GENERAL	62, 437, 728		4, 156, 617	254, 921	67, 282, 044	
0 00700 OPERATION OF PLANT	15, 564, 769		122, 521	114, 083	17, 473, 172	
0 00800 LAUNDRY & LINEN SERVICE	970, 268		79	0	1, 008, 342	
0 00900 HOUSEKEEPING	5, 581, 159		22, 409	181, 090	5, 944, 646	
00 01000 DI ETARY 00 01100 CAFETERI A	1, 925, 754 2, 078, 458		19, 194 57, 455	50, 799 118, 028	2, 109, 140 2, 544, 887	
00 01300 NURSI NG ADMI NI STRATI ON	9, 877, 172	53, 170	31, 069	138, 280	10, 099, 691	
00 01400 CENTRAL SERVICES & SUPPLY	4, 443, 194		2, 649, 328	45, 529	7, 464, 580	
00 01500 PHARMACY	8, 559, 701	143, 835	590, 185	342, 415	9, 636, 136	
00 01600 MEDI CAL RECORDS & LI BRARY	2, 519, 449		0	0	2, 524, 909	
00 01700 SOCIAL SERVICE 00 01900 NONPHYSICIAN ANESTHETISTS	2, 554, 225	25, 891 0	39 0	104, 979 0	2, 685, 134 0	1
00 02100 I &R SERVICES-SALARY & FRINGES APPRV	577, 257	0	0	0	577, 257	
00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	1, 221, 933	0	0	0	1, 221, 933	
INPATIENT ROUTINE SERVICE COST CENTERS						
00 03000 ADULTS & PEDI ATRI CS	68, 493, 521	4, 953, 127	792, 808		76, 409, 111	
00 03100 INTENSIVE CARE UNIT	10, 567, 301	423, 382	181, 951	340, 084	11, 512, 718	
00 02060 NEONATAL INTENSIVE CARE UNIT 00 04000 SUBPROVIDER - IPF	13, 760, 283 2, 959, 832		114, 512 7, 826	504, 391 137, 838	15, 170, 095 3, 251, 378	
00 04300 NURSERY	3, 391, 628		31, 341	113, 182	3, 837, 630	
ANCILLARY SERVICE COST CENTERS					· · ·	
00 05000 OPERATING ROOM	22, 250, 838				26, 621, 094	
00 05100 RECOVERY ROOM	5, 859, 587	334, 879	4,819	198, 301	6, 397, 586	
00 05200 DELIVERY ROOM & LABOR ROOM 00 05400 RADIOLOGY-DIAGNOSTIC	7, 277, 464 5, 724, 583		67, 249 309, 136	242, 857 215, 822	8, 234, 485 6, 553, 068	
00 05500 RADI OLOGY-THERAPEUTI C	3, 324, 425		433, 999	42, 849	3, 956, 552	
00 05700 CT SCAN	2, 587, 740		166, 144	82, 826	2, 886, 581	
00 05800 MRI	1, 985, 286		548, 432	49, 483	2, 662, 399	
00 05900 CARDI AC CATHETERI ZATI ON 00 06000 LABORATORY	171, 980		1, 522	0	173, 502	
00 06400 INTRAVENOUS THERAPY	14, 783, 840 713, 741	122, 744 4, 073	0 8, 521	0 29, 721	14, 906, 584 756, 056	
00 06500 RESPI RATORY THERAPY	7, 222, 775		297, 347	231, 407	7, 882, 168	
00 06600 PHYSI CAL THERAPY	7, 061, 943		1, 171, 791	300, 566	8, 555, 322	
00 06700 OCCUPATI ONAL THERAPY	2, 311, 488		56, 343	86, 884	2, 454, 715	
00 06800 SPEECH PATHOLOGY	431,008		10, 506	16, 201	457, 715	
00 06900 ELECTROCARDI OLOGY 00 07000 ELECTROENCEPHALOGRAPHY	507, 195 2, 332, 895		0 240, 448	2, 388 63, 722	519, 525 2, 726, 182	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	19, 128, 767	0	0	00,722	19, 128, 767	
00 07200 IMPL. DEV. CHARGED TO PATIENTS	12, 602, 121	0	0	0	12, 602, 121	
00 07300 DRUGS CHARGED TO PATIENTS	15, 535, 777	0	0	0	15, 535, 777	
01 07301 SPECIALTY PHARMACY 00 07400 RENAL DIALYSIS	0	0	0	0	1 422 050	
00 07400 RENAL DI ALYSI S 00 03330 ENDOSCOPY	1, 417, 072 3, 100, 895		338, 369	4, 338 93, 090	1, 433, 059 3, 700, 851	
01 03950 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0, 700, 001	
02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	
03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	
04 03953 WOUND CARE	1, 366, 936		150, 131	29, 777	1, 546, 844	
06 03954 IMAGING CENTER 07 03955 BREAST DIAGNOSTIC CENTER	3, 611, 742 11, 964, 413	0	959, 305 397, 792	110, 096 1, 342	4, 681, 143 12, 363, 547	
OUTPATIENT SERVICE COST CENTERS	11, 704, 413	0	577, 772	1, 342	12, 303, 347	1 /0.
00 09000 CLI NI C	0	0	0	0	0	90.
01 04950 INFUSION CENTER	148, 712		84, 721	5, 138	238, 571	
26 04975 SPI NE CENTER	282, 614		0	11,844	294, 458	
00 09100 EMERGENCY 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	16, 282, 888	559, 777	163, 481	402, 582	17, 408, 728 0	1
SPECIAL PURPOSE COST CENTERS	1				0	1 12.
. 00 11300 I NTEREST EXPENSE						113.
. 00 11400 UTI LI ZATI ON REVI EW-SNF	105 354 511	40 101 0	47 744 617	7 405 015	105 100 5	114.
. 00 SUBTOTALS (SUM OF LINES 1 through 117)	425, 756, 916	13, 191, 200	17, 741, 265	7, 125, 865	425, 430, 203	1118.
NONREI MBURSABLE COST CENTERS . 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	90, 733	0	0	90, 733	190
. 00 19100 RESEARCH	0	90, 733	0	0		190.
. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	84, 188	-	0	0	84, 188	192.
. 00 19300 NONPALD WORKERS	0	0	0	0		193.
. 00 07950 HOME OFFICE			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 CO		Period: From 01/01/2022	Worksheet B	
				To 12/31/2022		pared:
					5/25/2023 11:	31 am
		CAPI TAL REL	LATED COSTS			
					.	
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	for Cost Allocation			BENEFI TS DEPARTMENT		
	(from Wkst A			DEPARTMENT		
	col. 7)					
	0	1.00	2.00	4.00	4A	
194. 06 07956 PAVI LLI ONS	14, 332	0	58, 00	1 0	72, 333	194.06
194.08 07958 OTHER NRCC	2, 452, 254	9, 442	68, 64	4 99, 893	2, 630, 233	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)	428, 307, 690	13, 291, 375	17, 867, 91	0 7, 225, 758	428, 307, 690	202.00

CUST	ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 01/01/2022 o 12/31/2022		epared:
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPING	5/25/2023 11: DI ETARY	31 am
		& GENERAL 5.00	PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	5.00	7.00	0.00	7.00	10.00	
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	67, 282, 044					5.00
7.00	00700 OPERATION OF PLANT	3, 256, 370					7.00
3.00	00800 LAUNDRY & LINEN SERVICE	187, 919					8.00
9.00	00900 HOUSEKEEPING	1, 107, 868					9.00
0.00	01000 DI ETARY 01100 CAFETERI A	393, 068 474, 275	210, 231 539, 412			2, 788, 315 0	
3.00	01300 NURSI NG ADMI NI STRATI ON	1, 882, 219	98, 577				
4.00	01400 CENTRAL SERVICES & SUPPLY	1, 391, 129	605, 384				
15.00	01500 PHARMACY	1, 795, 829	266, 669				
6.00	01600 MEDI CAL RECORDS & LI BRARY	470, 552	10, 123			0	
7.00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	500, 412 0	48, 002				
9.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	107, 580	0		-		
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	227, 724	0		-		
	INPATIENT ROUTINE SERVICE COST CENTERS						
0. 00	03000 ADULTS & PEDIATRICS	14, 239, 764					
31.00	03100 INTENSIVE CARE UNIT	2, 145, 556	784, 949				
5.00 0.00	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	2, 827, 160 605, 940	1, 466, 343 270, 465				
13.00	04300 NURSERY	715, 196					
	ANCILLARY SERVICE COST CENTERS						-
50.00	05000 OPERATING ROOM	4, 961, 214	1, 152, 642			C	
1.00	05100 RECOVERY ROOM	1, 192, 280	620, 864				
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C	1, 534, 612	1, 199, 379				
54.00	05500 RADI OLOGY-THERAPEUTI C	1, 221, 256 737, 359	562, 739 287, 886				
57.00	05700 CT SCAN	537,955	92, 461			C	
58.00	05800 MRI	496, 175	146, 833			C	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	32, 335	0		-		
60.00	06000 LABORATORY	2, 778, 051	227, 567				
54.00 55.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	140, 902 1, 468, 952	7, 550 242, 204			0	
56.00	06600 PHYSI CAL THERAPY	1, 594, 404	38, 975				
57.00	06700 OCCUPATI ONAL THERAPY	457, 471	0				
58.00	06800 SPEECH PATHOLOGY	85, 302	0	0			
59.00	06900 ELECTROCARDI OLOGY	96, 821	18, 433				
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	508, 062 3, 564, 914	165, 224 0				
	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 348, 582	0				
	07300 DRUGS CHARGED TO PATIENTS	2, 895, 310					
73.01	07301 SPECIALTY PHARMACY	0	0	0	0	C	
74.00	07400 RENAL DI ALYSI S	267,071	21, 597		7, 795		
76.00 76.01	03330 ENDOSCOPY 03950 OTHER ANCI LLARY SERVICE COST CENTERS	689, 705	312, 394	46, 273	112, 748 0		
76. 02	03951 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0	0	C C	
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	C	76.0
76.04	03953 WOUND CARE	288, 276	0	0	0	C	
76.06	03954 I MAGI NG CENTER	872, 397	0	0	0	0	
76. 07	03955 BREAST DI AGNOSTI C CENTER OUTPATI ENT SERVI CE COST CENTERS	2, 304, 120	0	0	0	0) 76.0 ⁻
90.00	09000 CLINIC	0	0	0	0	C	90.00
90. 00 90. 01	04950 I NFUSI ON CENTER	44, 461	0	0	0		
90. 26	04975 SPI NE CENTER	54, 876	0	0	0	C	90. 2
91.00	09100 EMERGENCY	3, 244, 360	1, 037, 825	198, 205	374, 567	C	
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92.00
113 00	SPECIAL PURPOSE COST CENTERS						113.00
	11400 UTI LI ZATI ON REVI EW-SNF						114.00
18.00		66, 745, 784	20, 543, 819	1, 266, 704	7, 282, 101	2, 788, 315	
	NONREIMBURSABLE COST CENTERS						4
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	16, 909	168, 218				190.0
	19100 RESEARCH	15 (00	0	0	0		191.0
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	15, 690		0	0		192. 0 193. 0
	07950 HOME OFFICE	0 0	0	n 0	0		193.0
	07956 PAVI LLI ONS	13, 480	0	0	0		194.0
94.08	07958 OTHER NRCC	490, 181	17, 505	0	6, 318	C	194. 0
	07960 COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.1
200.00	5	0	-	-	-	-	200.00
01.00			0	0	0		1001 C

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: From 01/01/2022	Worksheet B Part I	
					Date/Time Pre 5/25/2023 11:	
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)	67, 282, 044	20, 729, 542	1, 266, 704	4 7, 349, 132	2, 788, 315	202.00

	Financial Systems COMMI LLOCATION - GENERAL SERVICE COSTS	UNITE HUSFITAL	OF INDIANA, IN Provider CC	CN: 15-0169	Period: From 01/01/2022 Fo 12/31/2022	u of Form CMS-: Worksheet B Part I Date/Time Pre	pared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	PHARMACY	5/25/2023 11: MEDI CAL RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 19.\ 00\\ 21.\ 00\\ 22.\ 00\\ \end{array}$	GENERAL SERVICE COST CENTERS 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 DI ETARY 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-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	3, 753, 256 95, 260 41, 279 190, 521 0 66, 682 0 0	12, 211, 325 0 0	9, 720, 864 46, 16 (8	4 7 12, 031, 567 0 0	3, 009, 238 0 0 0 0	1.00 2.00 4.00 5.00 7.00 8.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 19.00 21.00 22.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 2/5 400	(220 005	F00 17		400 500	20.00
30. 00 31. 00 35. 00 40. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04300 NURSERY ANCILLARY SERVICE COST CENTERS	1, 365, 400 200, 047 314, 359 85, 734 69, 858	925, 504 1, 454, 868 395, 914	582, 17: 99, 55 173, 04 16, 400 29, 788	1 0 7 0 0 0	423, 522 62, 401 213, 779 19, 938 19, 366	40.00
50.00	05000 OPERATI NG ROOM	187, 345	875, 840	1, 679, 708	3 0	444, 901	50.00
$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 54.\ 00\\ 55.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 00\\ 64.\ 00\\ 65.\ 00\\ \end{array}$	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 05500 RADIOLOGY-THERAPEUTIC 05700 CT SCAN 05800 MRI 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY	120, 663 149, 241 123, 838 25, 403 47, 630 28, 578 0 0 15, 877 114, 312	0 697, 495 0 0 0 0 0 0 0 0 0 0	61, 24 63, 91 31, 72 85, 29 39, 95 9, 30 61 434, 69 7, 68 82, 97	1 0 7 0 5 0 5 0 6 0 7 0 0 0 0 0 0 0 5 0	80, 490 41, 554 74, 935 86, 281 159, 818 51, 694 7, 565 174, 659 2, 548 67, 508	$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 54.\ 00\\ 55.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 00\\ 64.\ 00\\ 65.\ 00\\ \end{array}$
73. 00 73. 01	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 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 07301 SPECI ALTY PHARMACY 27400 FENAL DE LAUXELS	47,630 53,981 9,526 3,175 41,279 0 0 0 0		22, 53(5, 45(1, 01) 28, 06(3, 517, 76(2, 317, 53((0, 72)	3 0 3 0 5 0 2 0 4 0 0 0 0 12, 031, 567 0 0	44, 506 13, 843 4, 010 18, 599 25, 349 117, 056 75, 192 202, 844 0	67.00 68.00 69.00 70.00 71.00 72.00 73.00 73.01
76.00 76.01 76.02 76.03 76.04 76.06	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 03954 I MAGI NG CENTER 03955 BREAST DI AGNOSTI C CENTER 04700 CONTRACTOR	3, 175 66, 682 0 0 22, 227 0 0	0 0 0	8, 72 93, 24 ((19, 81 31, 99 1, 01	D 0 D 0 D 0 D 0 1 0 3 0	8, 325 57, 315 0 0 9, 911 104, 855 52, 885	76.00 76.01 76.02 76.03 76.04 76.06
90.00	09000 CLINIC	0	0	(0 0	0	90.00
90. 26 91. 00	04950 I NFUSI ON CENTER 04975 SPI NE CENTER 09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	6, 351 0 257, 203	0	1, 69 78! 223, 189	5 0	972 809 341, 808	
113.00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11400 UTI LI ZATI ON REVI EW-SNF	3, 753, 256	12, 211, 325	9, 717, 23(0 12, 031, 567	3, 009, 238	113.00 114.00
190.00 191.00 192.00 193.00 194.00 194.06 194.08	NONRE MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES 19300 NONPAI D WORKERS 07950 HOME OFFI CE 07956 PAVI LLI ONS 07958 OTHER NRCC 07960 COMMUNI TY REHAB HOSPI TAL			(((((((((((((((((((D 0 D 0 P 0 D 0 D 0 D 0 S 0	0 0 0 0 0 0 0 0 0 0	190.00 191.00 192.00 193.00 194.00 194.06 194.08 194.10 200.00

Health Financial Systems	s COMM	UNI TY HOSPI TAL	OF INDIANA,	NC.	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS			Provi der		Peri od:	Worksheet B	
					From 01/01/2022		
					To 12/31/2022		
						5/25/2023 11:	<u>31 am</u>
Cost Center	Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI C	N SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
201.00 Negative Co	st Centers	0		0	0 0	0	201.00
202.00 TOTAL (sum	lines 118 through 201)	3, 753, 256	12, 211, 32	5 9, 720, 86	12, 031, 567	3, 009, 238	202.00

Health Financial Systems CON COST ALLOCATION - GENERAL SERVICE COSTS CON	MUNITY HOSPITAL		NC. CN: 15-0169	Period:	u of Form CMS-: Worksheet B	2552-10
				From 01/01/2022 To 12/31/2022	Part I Date/Time Pre	pared:
			I NTERNS	& RESI DENTS	5/25/2023 11:	
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	1			1 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 001000 DIETARY 11.00 01100 CAFETERIA 13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS & LIBRARY 17.00 01700 SOCI AL SERVICE 19.00 01900 NONPHYSICIAN ANESTHETISTS 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	3, 317, 642 0 0 0	(684, 8	37 1, 449, 657		$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 21.\ 00\\ 21.\ 00\\ 22.\ 00\\ \end{array}$
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	2, 806, 801) 355, 9	90 753, 557	118, 793, 695	30.00
31. 00 03100 I NTENSI VE CARE UNI T 35. 00 02060 NEONATAL I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF 43. 00 04300 NURSERY	312, 717 0 198, 124			0 0 0 0 0 0 0 0 0 0	16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459	31.00 35.00 40.00
	0		247.4	10 502 722	27 141 014	50.00
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 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 05800 MRI 59.00 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 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROCARDI OLOGY 70.00 07000 ELECTROCARDI OLOGY 70.00 07000 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 73.00 07300				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	37, 161, 816 8, 697, 203 12, 411, 240 8, 846, 379 5, 298, 723 3, 797, 772 3, 447, 982 214, 012 18, 603, 685 933, 338 9, 945, 535 10, 392, 271 2, 985, 468 557, 571 663, 291 3, 553, 790 26, 328, 501 17, 343, 425 30, 665, 498 0 1, 749, 749 5, 079, 208 0 0 1, 887, 069 5, 690, 388 14, 721, 571	$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 54.\ 00\\ 55.\ 00\\ 57.\ 00\\ 58.\ 00\\ 69.\ 00\\ 64.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 66.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 01\\ 74.\ 00\\ 73.\ 01\\ 74.\ 00\\ 76.\ 01\\ 76.\ 02\\ 76.\ 03\\ 76.\ 04\\ 76.\ 06\\ \end{array}$
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			57, 4 ⁻	0 0 0 0 18 121, 541	0 292, 052 350, 928 24, 462, 480	
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 114.00 11400 UTI LI ZATI ON REVIEW-SNF 118.00 SUBTOTALS (SUM OF LI NES 1 through 117) NONDEL MENUESABLE COST CENTERS) 3, 317, 642	(684, 8	37 1, 449, 657	424, 637, 555	113. 00 114. 00 118. 00
NONREI MBURSABLE COST CENTERS 190.00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 193.00 19300 NONPAI D WORKERS 194.00 07950 HOME OFFI CE 194.06 07958 OTHER NRCC				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	100, 227 0	191. 00 192. 00 193. 00 194. 00 194. 06

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 01/01/2022 o 12/31/2022		pared.
					5/25/2023 11:	
			I NTERNS &	RESI DENTS		
Cost Center Description	SOCI AL SERVI CE	NONPHYSI CI AN	SERVI CES-SALAR	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	C	0	0	194.10
200.00 Cross Foot Adjustments		C	C	0	0	200.00
201.00 Negative Cost Centers	0	C	C	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	3, 317, 642	C	684, 837	1, 449, 657	428, 307, 690	202.00

ST ALLOCATION - GENERA		NUNITY HOSPITAL (Provider CCN:		In Lieu of F od: Works 01/01/2022 Part	sheet B
				To	12/31/2022 Date/	' Time Prepare 2023 11:31 a
Cost Center	Description	Intern & Residents Cost & Post Stepdown	Total		37237	<u>2023 11. 31 a</u>
		Adjustments 25.00	26.00			
GENERAL SERVICE CO	OST CENTERS	25.00	20.00			
00 00100 CAP REL COST						1.
00 00200 CAP REL COST 00 00400 EMPLOYEE BEN						2.
00400 EMPLOYEE BEN 000500 ADMINI STRATI						4.
00 00700 OPERATION OF						7.
00 00800 LAUNDRY & LI						8.
00 00900 HOUSEKEEPI NG						9.
00 01000 DI ETARY						10.
00 01100 CAFETERIA						11.
00 01300 NURSING ADMI						13.
00 01400 CENTRAL SERV	ICES & SUPPLY					14.
00 01500 PHARMACY 00 01600 MEDICAL RECO						15.
00 01600 MEDI CAL RECO 00 01700 SOCI AL SERVI						16. 17.
00 01900 NONPHYSI CI AN						17.
	-SALARY & FRINGES APPRV					21.
	-OTHER PRGM COSTS APPRV					22.
	SERVICE COST CENTERS	1 1	I.			
00 03000 ADULTS & PED		-1, 109, 547	117, 684, 148			30.
00 03100 INTENSIVE CA		0	16, 665, 540			31.
00 02060 NEONATAL INT		0	22, 191, 468			35.
00 04000 SUBPROVI DER	- IPF	0	5, 121, 448			40.
00 04300 NURSERY	COCT CENTERC	0	5, 784, 459			43.
ANCI LLARY SERVICE 00 05000 OPERATING RC		-771, 151	36, 390, 665			50.
00 05100 RECOVERY ROC		-771, 151	8, 697, 203			51.
00 05200 DELIVERY ROC		0	12, 411, 240			52.
00 05400 RADI OLOGY-DI		0	8, 846, 379			54.
00 05500 RADI OLOGY-TH		0	5, 298, 723			55.
00 05700 CT SCAN		0	3, 797, 772			57.
00 05800 MRI		0	3, 447, 982			58.
. 00 05900 CARDI AC CATH	ETERI ZATI ON	0	214, 012			59.
00 06000 LABORATORY		0	18, 603, 685			60.
. 00 06400 I NTRAVENOUS		0	933, 338			64.
. 00 06500 RESPI RATORY		0	9, 945, 535			65.
. 00 06600 PHYSI CAL THE . 00 06700 OCCUPATI ONAL		-74, 837	10, 317, 434 2, 985, 468			66. 67.
00 06800 SPEECH PATHO		0	557, 571			68.
00 06900 ELECTROCARDI		0	663, 291			69.
00 07000 ELECTROENCEP		0	3, 553, 790			70.
	LIES CHARGED TO PATIENT	0	26, 328, 501			71.
.00 07200 IMPL. DEV. C	HARGED TO PATIENTS	0	17, 343, 425			72.
00 07300 DRUGS CHARGE		0	30, 665, 498			73
01 07301 SPECIALTY PH		0	0			73
00 07400 RENAL DIALYS	IS	0	1, 749, 749			74
00 03330 ENDOSCOPY		0	5, 079, 208			76
1 1	ARY SERVICE COST CENTERS	0	0			76
1 1	ARY SERVICE COST CENTERS ARY SERVICE COST CENTERS					76. 76.
03 03952 0THER ANCILL 04 03953 WOUND CARE	ANT SERVICE COST CENTERS		1, 887, 069			76
06 03954 I MAGI NG CENT	ER	0	5, 690, 388			76
07 03955 BREAST DI AGN		0	14, 721, 571			76
OUTPATI ENT SERVI CE		· · ·				
00 09000 CLINIC		0	0			90.
01 04950 INFUSION CEN		0	292, 052			90.
26 04975 SPI NE CENTER		0	350, 928			90.
00 09100 EMERGENCY	DEDC (NON DICTINCT DADT	-178, 959	24, 283, 521			91.
	BEDS (NON-DISTINCT PART	0				92
SPECIAL PURPOSE CO 00 11300 INTEREST EXP		1				112
. 00 11300 INTEREST EXF . 00 11400 UTI LI ZATI ON						113. 114.
	UM OF LINES 1 through 117)	-2, 134, 494	422, 503, 061			114.
NONREI MBURSABLE CO		-2, 134, 474	422, 303, 001			
	, COFFEE SHOP & CANTEEN	0	336, 573			190.
. 00 19100 RESEARCH	, tone onor a onitreen		000, 0, 0			191.
2. 00 19200 PHYSI CI ANS'	PRIVATE OFFICES	0	100, 227			192.
3. 00 19300 NONPAI D WORK		0	0			193.
4. 00 07950 HOME OFFICE		0	ō			194.
4. 06 07956 PAVI LLI ONS		0	86, 859			194.
4.08 07958 OTHER NRCC			3, 146, 476			194.

Health Financial Systems	COMMUNITY HOSPITAL (OF INDIANA, INC		In Lieu	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN	N: 15-0169	Peri od:	Worksheet B	
				From 01/01/2022 To 12/31/2022	Part I Date/Time Pre	narod
				10 12/31/2022	5/25/2023 11:	31 am
Cost Center Description	Intern &	Total				
	Residents Cost					
	& Post					
	Stepdown					
	Adj ustments					
	25.00	26.00				
194. 10 07960 COMMUNI TY REHAB HOSPI TAL	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)	-2, 134, 494	426, 173, 196				202.00

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	COMMUNI TY HOSPI TAL	OF INDIANA, IN Provider C	CN: 15-0169 P	In Lie eriod: rom 01/01/2022	u of Form CMS-: Worksheet B Part II	2552-10
			T		Date/Time Pre 5/25/2023 11:	
		CAPI TAL RE	LATED COSTS		0/20/2020 111	
Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	Related Costs 0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS			1			
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 001000 DIETARY 11.00 01100 CAFETERIA 13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 17.00 01700 SOCIAL SERVICE 9.00 01900 NONPHYSICIAN ANESTHETISTS 21.00 02100 I&R SERVICES-SALARY & FRINGES A 22.00 02200 I&R SERVICES-OTHER PRGM COSTS A	PPRV 0	5, 802 432, 778 1, 671, 799 37, 995 159, 988 113, 393 290, 946 53, 170 326, 529 143, 835 5, 460 25, 891 0 0	4, 156, 617 122, 521 79 22, 409 19, 194 57, 455 31, 069 2, 649, 328 590, 185 0 39 0 0	100, 484 4, 589, 395 1, 794, 320 38, 074 182, 397 132, 587 348, 401 84, 239 2, 975, 857 734, 020 5, 460 25, 930 0 0	100, 484 3, 544 1, 586 0 2, 518 706 1, 641 1, 923 633 4, 761 0 1, 460 0 0	7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 19.00 21.00
INPATI ENT ROUTI NE SERVI CE COST CENTER 30.00 03000 ADULTS & PEDI ATRI CS 31.00 03100 INTENSI VE CARE UNI T 35.00 02060 NEONATAL INTENSI VE CARE UNI T 40.00 04000 SUBPROVI DER - I PF 43.00 04300 NURSERY		4, 953, 127 423, 382 790, 909 145, 882 301, 479	181, 951 114, 512 7, 826	5, 745, 935 605, 333 905, 421 153, 708 332, 820	30, 182 4, 729 7, 013 1, 917 1, 574	31.00 35.00 40.00
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM 54.00 05400 RADI OLOGY-DI AGNOSTI C 55.00 05500 RADI OLOGY-THERAPEUTI C 57.00 05700 CT SCAN 58.00 05800 MRI 59.00 05900 CARDI AC CATHETERI ZATI ON 60.00 064000 INTRAVENOUS THERAPY 65.00 06400 INTRAVENOUS THERAPY 66.00 06600 PHYSI CAL THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCUPATI ONAL THERAPY 68.00 06800 SPECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 69.00 06900 ELECTROCARDI OLOGY 70.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 73.00 07300 DRUGS CHARGED TO PATI ENTS 73.01 07301 SPECI ALTY PHARMACY 74.00 074	I ENT 0 1 ENT 0 1 ENT 0 1 ENT 0 0 0 0 0 0 0 0 0 0 0 0 0 0	621, 706 334, 879 646, 915 303, 527 155, 279 49, 871 79, 198 0 122, 744 4, 073 130, 639 21, 022 0 0 0	3, 459, 193 4, 819 67, 249 309, 136 433, 999 166, 144 548, 432 1, 522 0 8, 521 297, 347 1, 171, 791 56, 343 10, 506 0 240, 448 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4, 080, 899 339, 698 714, 164 612, 663 589, 278 216, 015 627, 630 1, 522 122, 744 12, 594 427, 986 1, 192, 813 56, 343 10, 506 9, 942 329, 565 0 0 0 11, 649 506, 866 0 0 150, 131 959, 305 397, 792	4, 023 2, 757 3, 377 3, 001 596 1, 152 688 0 0 413 3, 218 4, 179 1, 208 225 33 886 0 0 0 60 1, 294 0 0 60 1, 294 0 0 414 1, 531 19	$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 54.\ 00\\ 55.\ 00\\ 55.\ 00\\ 55.\ 00\\ 59.\ 00\\ 60.\ 00\\ 64.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 00\\ 71.\ 00\\ 73.\ 00\\ 73.\ 01\\ 74.\ 00\\ 73.\ 01\\ 74.\ 00\\ 76.\ 01\\ 76.\ 02\\ 76.\ 03\\ 76.\ 04\\ 76.\ 06\\ \end{array}$
90.00 09000 CLINIC 00000 CLINIC 90.01 04950 INFUSION CENTER 90.26 04975 SPINE CENTER 91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT SPECIAL PURPOSE COST CENTERS	0 0 0 PART	0 0 559, 777	0 84, 721 0 163, 481	0 84, 721 0 723, 258 0	0 71 165 5, 598	90. 01 90. 26
113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 118. 00 SUBTOTALS (SUM OF LI NES 1 throu NONREI MBURSABLE COST CENTERS	gh 117) 0	13, 191, 200	17, 741, 265	30, 932, 465	99, 095	113. 00 114. 00 118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CAN 191.00 19100 RESEARCH 192.00 19200 PHYSICIANS' PRIVATE OFFICES 193.00 19300 NONPAID WORKERS 194.00 07950 HOME OFFICE 194.06 07956 PAVILLIONS	TEEN 0 0 0 0 0 0 0 0 0	90, 733 0 0 0 0 0 0 0	0 0 0 0 0 58, 001	90, 733 0 0 0 0 58, 001	0 0 0 0	190.00 191.00 192.00 193.00 194.00 194.06

Health Financial Systems CC	MMUNITY HOSPITAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Period: From 01/01/2022 To 12/31/2022		
		CAPI TAL REL	ATED COSTS			
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	
194.08 07958 OTHER NRCC	0	9, 442	68, 64	4 78, 086	1, 389	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	13, 291, 375	17, 867, 91	0 31, 159, 285	100, 484	202.00

	Financial Systems COMM TION OF CAPITAL RELATED COSTS	NUNITY HOSPITAL C	Provider C	CN: 15-0169 F	Period:	u of Form CMS-2 Worksheet B	2552-10
					From 01/01/2022 Fo 12/31/2022	Part II Date/Time Pre	pared:
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	5/25/2023 11: DI ETARY	<u>31 am</u>
	bost benter beschiption	& GENERAL	PLANT	LINEN SERVICE			
	GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
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	4, 592, 939	0.010.000				5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	222, 294 12, 828	2, 018, 200 6, 858				7.00 8.00
9.00	00900 HOUSEKEEPING	75, 628	28, 878				9.00
10.00	01000 DI ETARY	26, 832	20, 468			183, 581	•
	01100 CAFETERI A	32, 376	52, 516			0	
13.00	01300 NURSI NG ADMI NI STRATI ON	128, 488	9, 597	(.,	0	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	94, 964 122, 591	58, 939 25, 963			0	14.00 15.00
	01600 MEDICAL RECORDS & LIBRARY	32, 122	986			0	16.00
	01700 SOCIAL SERVICE	34, 160	4, 673	(0	
	01900 NONPHYSICIAN ANESTHETISTS	0	0			0	
	02100 I &R SERVICES-SALARY & FRINGES APPRV	7, 344	0	(0	
22.00	02200 I & R SERVICES-OTHER PRGM COSTS APPRV I NPATI ENT ROUTI NE SERVICE COST CENTERS	15, 545	0	(0 0	0	22.00
30.00	03000 ADULTS & PEDIATRICS	972, 050	894, 053	30, 186	5 130, 524	155, 314	30.00
31.00	03100 I NTENSI VE CARE UNI T	146, 465	76, 422	3, 464	11, 157	17, 304	31.00
	02060 NEONATAL INTENSIVE CARE UNIT	192, 994	142, 761	1, 942		0	35.00
	04000 SUBPROVIDER - IPF 04300 NURSERY	41, 364 48, 822	26, 332 54, 418			10, 963 0	1
43.00	ANCI LLARY SERVI CE COST CENTERS	40, 022	54, 410	1,220	7,944	0	43.00
50.00	05000 OPERATI NG ROOM	338, 674	112, 220	2, 36	7 16, 383	0	50.00
51.00	05100 RECOVERY ROOM	81, 390	60, 446			0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	104, 759	116, 770			0	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	83, 368 50, 335	54, 787 28, 028	3, 453 732		0	54.00 55.00
57.00	05700 CT SCAN	36, 723	9,002	(0	57.00
58.00	05800 MRI	33, 871	14, 295			0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 207	0	(0	
60.00	06000 LABORATORY	189, 642	22, 156	(0	60.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	9, 619 100, 277	735 23, 581			0	64.00 65.00
66. 00	06600 PHYSI CAL THERAPY	108, 841	3, 795			0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	31, 229	0	(0	67.00
	06800 SPEECH PATHOLOGY	5, 823	0			0	68.00
		6, 609	1, 795			0	69.00
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	34, 682 243, 356	16, 086 0			0	70.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	160, 324	0			0	
	07300 DRUGS CHARGED TO PATIENTS	197, 646	0	(0 0	0	73.00
	07301 SPECIALTY PHARMACY	0	0	(-	0	
	07400 RENAL DI ALYSI S 03330 ENDOSCOPY	18, 231 47, 082	2, 103 30, 414	2, 110	0 307 0 4, 440	0	74.00
	03950 OTHER ANCI LLARY SERVICE COST CENTERS	47,002	0	2,110		0	76.01
	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	(0 0	0	76.02
	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		0	76.03
	03953 WOUND CARE 03954 I MAGI NG CENTER	19, 679	0			0	
	03955 BREAST DIAGNOSTIC CENTER	59, 554 157, 289	0			0	76.06
	OUTPATIENT SERVICE COST CENTERS					-	
	09000 CLINIC	0	0	(0	
	04950 I NFUSI ON CENTER	3,035	0			0	
	04975 SPINE CENTER 09100 EMERGENCY	3, 746 221, 474	0 101, 041	9, 038) 0 3 14,751	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	221,474	101, 041	7,030	14,751	0	92.00
	SPECIAL PURPOSE COST CENTERS				ц		
	11300 I NTEREST EXPENSE						113.00
	11400 UTI LI ZATI ON REVI EW-SNF	A EE4 222	2 000 110	E7 7//	204 701		114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	4, 556, 332	2,000,118	57, 760	286, 781	183, 581	1118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 154	16, 378	(2, 391	0	190. 00
190.00	Troop of the transmission of the office of t	1		(0	191.00
191.00	19100 RESEARCH	0	0				
191. 00 192. 00	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0 1, 071	0	(•
191. 00 192. 00 193. 00	19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	0 1,071 0	0	(0 0	0	193.00
191.00 192.00 193.00 194.00	19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS 07950 HOME OFFICE	0 0	000000000000000000000000000000000000000		0 0	0 0	193. 00 194. 00
191.00 192.00 193.00 194.00 194.06	19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	0 1,071 0 920 33,462	0 0 0 0 1, 704	(0 0	0 0 0	192.00 193.00 194.00 194.06 194.08
191.00 192.00 193.00 194.00 194.06 194.08 194.10	19100 RESEARCH 19200 PHYSICLANS' PRIVATE OFFICES 19300 NONPALD WORKERS 07950 HOME OFFICE 07956 PAVILLIONS 07958 OTHER NRCC 07960 COMMUNITY REHAB HOSPITAL	0 0 920	0 0 0	(0 0 0 0 0 0 0 249	0 0 0 0 0	193. 00 194. 00 194. 06 194. 08 194. 10
191.00 192.00 193.00 194.00 194.06 194.08	19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS 07950 HOME OFFICE 07956 PAVILLIONS 07958 OTHER NRCC 07960 COMMUNITY REHAB HOSPITAL Cross Foot Adjustments	0 0 920	0 0 0		0 0 0 0 0 249 0 0	0 0 0 0	193. 00 194. 00 194. 06 194. 08

Health Financial Systems	COMMUNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Period: From 01/01/2022	Worksheet B	
					Date/Time Pre 5/25/2023 11:	
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)	4, 592, 939	2, 018, 200	57, 76	289, 421	183, 581	202.00

	Financial Systems COMM TION OF CAPITAL RELATED COSTS	UNI TY HOSPI TAL	OF INDIANA, IN Provider CC	CN: 15-0169 P	eriod: rom 01/01/2022	u of Form CMS-: Worksheet B Part II Date/Time Pre 5/25/2023 11:	pared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 4. \ 00\\ 5. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 11. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 19. \ 00\\ 21. \ 00\\ 22. \ 00\end{array}$	GENERAL SERVICE COST CENTERS 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 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02100 I & SERVICES-SALARY & FRINGES APPRV 02200 I & SERVICES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVICE COST CENTERS	442, 601 11, 234 4, 868 22, 467 0 7, 863 0 0 0 0 0 0 0	236, 882 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 143, 866 14, 931 0 28 0 0 0 0	928, 523 0 0 0 0 0 0	38, 712 0 0 0 0 0	17.00 19.00 21.00
30.00	03000 ADULTS & PEDIATRI CS	161, 014	122, 969	188, 283	0	5, 326	30.00
31.00 35.00 40.00 43.00	03100 I NTENSI VE CARE UNI T 02060 NEONATAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	23, 590 37, 071 10, 110 8, 238		32, 196 55, 966 5, 304 9, 634	0 0 0 0	785 2, 688 251 244	35.00 40.00
50.00	05000 OPERATING ROOM	22, 093	16, 990	543, 242	0	6, 463	50.00
$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 54.\ 00\\ 55.\ 00\\ 57.\ 00\\ 58.\ 00\\ 60.\ 00\\ 64.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 73.\ 01\end{array}$	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 05500 RADIOLOGY-THERAPEUTIC 05700 CT SCAN 05800 MRI 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06400 INTRAVENOUS THERAPY 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06600 SPEECH PATHOLOGY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 SPECH ARGED TO PATIENTS 07301 SPECIALTY PHARMACY	14, 229 17, 599 14, 604 2, 996 5, 617 3, 370 0 0 1, 872 13, 480 5, 617 6, 366 1, 123 374 4, 868 0 0 0 0	0 13, 530 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	19, 806 20, 672 10, 261 27, 586 12, 922 3, 011 197 140, 585 2, 484 26, 836 7, 287 1, 765 329 27 9, 076 1, 137, 691 749, 524 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 012 523 942 1, 085 2, 010 650 95 2, 196 32 849 560 174 50 234 319 1, 472 946	$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 54.\ 00\\ 55.\ 00\\ 57.\ 00\\ 59.\ 00\\ 60.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 00\\ 71.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ \end{array}$
76. 03 76. 04	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 03954 I MAGI NG CENTER 03955 BREAST DI AGNOSTI C CENTER 04700 CENTER 04700 CENTER 04700 CENTER 04700 CENTER 04700 CENTER	374 7, 863 0 0 0 2, 621 0 0	0 0 0 0 0 0 0	2, 823 30, 155 0 0 0 6, 407 10, 347 330	0 0 0 0 0 0 0 0	105 721 0 0 125 1, 319 665	76.00 76.01 76.02 76.03 76.04 76.06
90.00	09000 CLINIC	0	0	0	0	0	90.00
90. 01 90. 26 91. 00	04950 INFUSION CENTER 04975 SPINE CENTER 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	749 0 30, 331	0 0 23, 232	549 254 72, 183	0 0 0	12 10 4, 298	90. 01 90. 26
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	442, 601	236, 882	3, 142, 691	928, 523	38, 712	113. 00 114. 00 118. 00
191.00 192.00 193.00 194.00 194.06 194.08	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS 07950 HOME OFFICE 07956 PAVILLIONS 07958 OTHER NRCC 07960 COMMUNITY REHAB HOSPITAL	0 0 0 0 0 0 0	0 0 0 0 0 0	0 0 113 0 0 338 724 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	190.00 191.00 192.00 193.00 194.00 194.06 194.08 194.10 200.00

Health Financial Systems	COMMUNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Peri od:	Worksheet B	
				rom 01/01/2022		
				o 12/31/2022		
					5/25/2023 11:	<u>31 am</u>
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	C	0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201) 442,601	236, 882	3, 143, 866	928, 523	38, 712	202.00

	n Financial Systems COMM ATION OF CAPITAL RELATED COSTS	IUNI TY HOSPI TAL		CN: 15-0169	Period: From 01/01/2022	u of Form CMS-: Worksheet B Part II	2002 1
					To 12/31/2022	Date/Time Pre	pared:
				I NTERNS &	RESI DENTS	5/25/2023 11:	
	Cost Center Description	SOCI AL SERVI CE	NONPHYSI CI AN	SERVICES-SALA	RSERVI CES-OTHER	Subtotal	
			ANESTHETI STS	Y & FRINGES	PRGM COSTS	oub to tu.	
		17.00	19.00	APPRV 21.00	APPRV 22.00	24.00	
	GENERAL SERVICE COST CENTERS			1			
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
5.00	00500 ADMINISTRATIVE & GENERAL						5.0
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.0
9.00 9.00	00900 HOUSEKEEPI NG						9.0
10.00							10.0
11.00 13.00							11.0
14.00	01400 CENTRAL SERVICES & SUPPLY						14.0
15.00							15.0
16.00 17.00		74, 796					16.0
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0	C	D			19.0
21.00		0		7, 34			21.0
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVICE COST CENTERS	0			15, 545		22.0
30. 00	03000 ADULTS & PEDIATRICS	63, 279				8, 499, 115	30. 0
31.00		7,050				946, 448 1, 394, 920	
35.00 40.00		4, 467				1, 394, 920 266, 552	
43.00	04300 NURSERY	0				471, 226	
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	0		1		5, 143, 354	50.0
50.00		0				528, 163	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0				1, 011, 071	52.0
54.00 55.00		0				791, 077 704, 728	1
57.00		0				284, 755	
58.00		0				685, 602	
59.00 60.00		0				4, 021 480, 558	59.0 60.0
64. 00		0				27, 856	
65.00		0				599, 670	1
66.00 67.00		0				1, 323, 646 97, 085	
68. 00		0				18, 056	
69.00		0				19, 276	
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				397, 830 1, 382, 519	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0				910, 794	
	07300 DRUGS CHARGED TO PATIENTS	0				1, 128, 720	
	07301 SPECIALTY PHARMACY 07400 RENAL DI ALYSI S	0				0 35, 652	
76.00	03330 ENDOSCOPY	0				630, 945	
	03950 OTHER ANCI LLARY SERVICE COST CENTERS	0				0	
	03951 OTHER ANCILLARY SERVICE COST CENTERS 03952 OTHER ANCILLARY SERVICE COST CENTERS	0				0	76.0
76.04	03953 WOUND CARE	0				179, 377	
	03954 I MAGI NG CENTER	0				1, 032, 056	
/0.0/	03955 BREAST DI AGNOSTI C CENTER OUTPATI ENT SERVI CE COST CENTERS	0				556, 095	76.0
	09000 CLI NI C	0				0	
	04950 I NFUSI ON CENTER 04975 SPI NE CENTER	0				89, 137	
	09100 EMERGENCY	0				4, 175 1, 205, 204	
	09200 OBSERVATION BEDS (NON-DISTINCT PART					,, = 3 .	92.0
112 0	SPECIAL PURPOSE COST CENTERS						1112 0
	0 11400 UTILIZATION REVIEW-SNF						113.0
118.0	0 SUBTOTALS (SUM OF LINES 1 through 117)	74, 796	(0 0	30, 849, 683	
100.0	NONREI MBURSABLE COST CENTERS					110 / [/	1100 0
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 19100 RESEARCH	0				110, 656 0	190. 0
192.0	0 19200 PHYSI CI ANS' PRI VATE OFFI CES	0				1, 184	192.0
	0 19300 NONPALD WORKERS	0					193.0
	0 07950 HOME_OFFI CE 6 07956 PAVI LLI ONS					0 59, 259	194.0
	8 07958 OTHER NRCC	0		1		115, 614	

Health Financial Systems	COMMUNI TY HOSPI TAL	OF INDIANA, II	NC.	In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B	
				rom 01/01/2022 To 12/31/2022		pared: <u>31 am</u>
			INTERNS &	RESI DENTS		
Cost Center Description	SOCI AL SERVI CE			SERVI CES-OTHER	Subtotal	
		ANESTHETI STS	Y & FRINGES	PRGM COSTS		
	17.00	10.00	APPRV	APPRV	04.00	
	17.00	19.00	21.00	22.00	24.00	
194.10 07960 COMMUNITY REHAB HOSPITAL	0				0	194.10
200.00 Cross Foot Adjustments		C	7, 344	1 15, 545	22, 889	200. 00
201.00 Negative Cost Centers	0	C	(0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	74, 796	C	7, 344	15, 545	31, 159, 285	202.00

ALLOCATION OF CAPITAL RELATED COSTS	MUNITY HOSPITAL O	Provider CCN: 1	From 01/01/2022 Part I	neet B
Cost Contor Deceription	Intern &	Total	10 12/31/2022 Date/1 5/25/2	1 me Prepared: 2023 11:31 am
Cost Center Description	Residents Cost & Post	Total		
	Stepdown Adjustments			
	25.00	26.00		
GENERAL SERVICE COST CENTERS	1			1.00
2.00 00200 CAP REL COSTS-BEDG & TTXT				2.00
00 00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
. 00 00500 ADMI NI STRATI VE & GENERAL . 00 00700 OPERATI ON OF PLANT				5.00
. 00 00800 LAUNDRY & LI NEN SERVI CE				8.00
. 00 00900 HOUSEKEEPI NG				9.00
0. 00 01000 DI ETARY 1. 00 01100 CAFETERI A				10.00
3. 00 01300 NURSI NG ADMI NI STRATI ON				13.00
4.00 01400 CENTRAL SERVICES & SUPPLY				14.00
5. 00 01500 PHARMACY 6. 00 01600 MEDICAL RECORDS & LIBRARY				15.00
7. 00 01700 SOCIAL SERVICE				17.00
9.00 01900 NONPHYSICIAN ANESTHETISTS				19.00
1.00 02100 I & SERVICES-SALARY & FRINGES APPRV 2.00 02200 I & SERVICES-OTHER PRGM COSTS APPRV				21.00
INPATIENT ROUTINE SERVICE COST CENTERS				22.00
30. 00 03000 ADULTS & PEDIATRICS	0	8, 499, 115		30.00
1.00 03100 INTENSIVE CARE UNIT 35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	946, 448		31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF	0	1, 394, 920 266, 552		40.00
13. 00 04300 NURSERY	0	471, 226		43.00
		E 142 2E4		FO. 00
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM	0	5, 143, 354 528, 163		50.00
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	1, 011, 071		52.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	791,077		54.00
5. 00 05500 RADI OLOGY-THERAPEUTI C 7. 00 05700 CT SCAN	0	704, 728 284, 755		55.00 57.00
i8. 00 05800 MRI	0	685, 602		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	4, 021		59.00
0. 00 06000 LABORATORY 4. 00 06400 I NTRAVENOUS THERAPY	0	480, 558 27, 856		60.00 64.00
55.00 06500 RESPIRATORY THERAPY	0	599, 670		65.00
66.00 06600 PHYSI CAL THERAPY	0	1, 323, 646		66.00
07.00 06700 OCCUPATIONAL THERAPY 08.00 06800 SPEECH PATHOLOGY	0	97, 085 18, 056		67.00 68.00
9. 00 06900 ELECTROCARDI OLOGY	0	19, 276		69.00
0.00 07000 ELECTROENCEPHALOGRAPHY	0	397, 830		70.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 382, 519		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	910, 794 1, 128, 720		72.00
3.01 07301 SPECIALTY PHARMACY	0	0		73. 01
4.00 07400 RENAL DIALYSIS	0	35, 652		74.00
76.00 03330 ENDOSCOPY 76.01 03950 OTHER ANCI LLARY SERVICE COST CENTERS	0	630, 945 0		76.00 76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76. 02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	170 277		76.03
76. 04 03953 WOUND CARE 76. 06 03954 I MAGI NG CENTER	0	179, 377 1, 032, 056		76.04 76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	556, 095		76.07
OUTPATIENT SERVICE COST CENTERS		0		
20. 00 09000 CLINIC 20. 01 04950 INFUSION CENTER		0 89, 137		90. 00 90. 01
20. 26 04975 SPI NE CENTER	0	4, 175		90.26
	0	1, 205, 204		91.00
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS	0			92.00
13. 00 11300 I NTEREST EXPENSE				113.00
14.00 11400 UTI LI ZATI ON REVIEW-SNF				114.00
18.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	30, 849, 683		118.00
NONREI MBURSABLE COST CENTERS 90. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	110, 656		190.00
91. 00 19100 RESEARCH	0	0		191.00
92. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	1, 184		192.00
193. 00 19300 NONPALD WORKERS 194. 00 07950 HOME OFFICE	0	0		193.00 194.00
194. 06 07956 PAVI LLI ONS	0	59, 259		194.00
194. 08 07958 OTHER NRCC	0	115, 614		194.08

Health Financial Systems	COMMUNITY HOSPITAL C	DF 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 01/01/2022	Part II	nored.
				To 12/31/2022	Date/Time Pre 5/25/2023 11:	31 am
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	22, 889				200.00
201.00 Negative Cost Centers	0	0				201.00
202.00 TOTAL (sum lines 118 through 201)	0	31, 159, 285				202.00

Heal th Financial	Systems
COST ALLOCATION	- STATISTICAL BASIS

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

 Provider CCN: 15-0169
 Period: From 01/01/2022
 Worksheet B-1

USI ALLUCATION - STATISTICAL BASIS		Provider CC	F	From 01/01/2022 o 12/31/2022		pared
	CAPI TAL REL	ATED COSTS			572572025 11.	
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
	1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS			1		1	
. 00 00100 CAP REL COSTS-BLDG & FIXT	584, 199					1.0
. 00 00200 CAP REL COSTS-MVBLE EQUIP		17, 929, 586				2.0
. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	255	95, 009				4.0
. 00 00500 ADMINI STRATI VE & GENERAL	19, 022	4, 170, 968				
. 00 00700 OPERATION OF PLANT	73, 481	122, 944		3 0	,	
. 00 00800 LAUNDRY & LINEN SERVICE	1, 670	79		-	.,	
. 00 00900 HOUSEKEEPI NG	7,032	22, 486				
0. 00 01000 DI ETARY	4, 984	19, 260			2, 109, 140	
1. 00 01100 CAFETERI A	12, 788	57, 653				
3. 00 01300 NURSI NG ADMI NI STRATI ON	2, 337	31, 176			10, 099, 691	
4. 00 01400 CENTRAL SERVICES & SUPPLY	14, 352	2,658,473			.,	
5.00 01500 PHARMACY	6, 322	592, 222	6, 289, 310	0	9, 636, 136	
6. 00 01600 MEDI CAL RECORDS & LI BRARY	240	0		0	2, 524, 909	
7. 00 01700 SOCIAL SERVICE	1, 138	39			2, 685, 134	
9.00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	-	-	0	
1.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0				
2. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	C	0 0	1, 221, 933	22. (
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 0. 00 03000 ADULTS & PEDI ATRI CS	217, 706	795, 545	39, 850, 429	0	76, 409, 111	30. 0
1. 00 03100 INTENSIVE CARE UNIT	18,609	182, 579				
	34, 763	114, 907				
0.00 04000 SUBPROVIDER - IPF	6, 412	7,853				
3. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	13, 251	31, 449	2, 078, 879	0	3, 837, 630	43.0
0. 00 05000 OPERATING ROOM	27, 326	3, 471, 134	5, 314, 759	0	26, 621, 094	50.0
1. 00 05100 RECOVERY ROOM	14, 719	4, 836				
2.00 05200 DELIVERY ROOM & LABOR ROOM	28, 434	67, 481				
4. 00 05400 RADI OLOGY - DI AGNOSTI C	13, 341	310, 203			6, 553, 068	
5. 00 05500 RADI OLOGY-THERAPEUTI C	6, 825	435, 497			3, 956, 552	
7. 00 05700 CT SCAN	2, 192	166, 718				
8. 00 05800 MRI	3, 481	550, 325				
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	1, 527				
0. 00 06000 LABORATORY	5, 395	1, 02,		0		
4. 00 06400 I NTRAVENOUS THERAPY	179	8, 550	-	-	, ,	
5. 00 06500 RESPIRATORY THERAPY	5,742	298, 373				
6. 00 06600 PHYSI CAL THERAPY	924	1, 175, 836			.,	
7. 00 06700 OCCUPATI ONAL THERAPY	0	56, 537			2, 454, 715	
8.00 06800 SPEECH PATHOLOGY	0	10, 542			457, 715	
9. 00 06900 ELECTROCARDI OLOGY	437	0				
0. 00 07000 ELECTROENCEPHALOGRAPHY	3, 917	241, 278				
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0 0	19, 128, 767	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C C	0 0	12, 602, 121	72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	0 0	15, 535, 777	73. (
3. 01 07301 SPECIALTY PHARMACY	0	0	C	0 0	0	73. (
4. 00 07400 RENAL DIALYSIS	512	0	79, 676	0	1, 433, 059	
6. 00 03330 ENDOSCOPY	7,406	339, 537			3, 700, 851	
6.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	C	0 0	0	
6.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	C	0 0	0	76.
6.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	C	0	0	76.
6.04 03953 WOUND CARE	0	150, 649	546, 926	0	1, 546, 844	76.
6. 06 03954 I MAGI NG CENTER	0	962, 616	2, 022, 195	5 O	4, 681, 143	76.
6. 07 03955 BREAST DI AGNOSTI C CENTER	0	399, 165	24, 649	0	12, 363, 547	76.
OUTPATIENT SERVICE COST CENTERS	-				1	
0. 00 09000 CLINIC	0	0	C	0 0		
0.01 04950 INFUSION CENTER	0	85, 013			238, 571	
0. 26 04975 SPI NE CENTER	0	0	217, 545		294, 458	1
1.00 09100 EMERGENCY	24, 604	164, 045	7, 394, 415	0	17, 408, 728	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. (
SPECIAL PURPOSE COST CENTERS	1 1		1		1	1
13. 00 11300 INTEREST EXPENSE						113. (
14. 00 11400 UTI LI ZATI ON REVIEW-SNF	F70 70/	17 000 500	100 000 / 10	(7 000 0	250 440 450	114.
18.00 SUBTOTALS (SUM OF LINES 1 through 117)	579, 796	17, 802, 504	130, 883, 642	-67, 282, 044	358, 148, 159	1118.
NONREI MBURSABLE COST CENTERS	2.000	2	-		00 700	1100
90.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 988	0		0		
91. 00 19100 RESEARCH	0	0				191. (
92. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	84, 188	
93.00 19300 NONPALD WORKERS	0	()	1 C	ע 0	1 0	193. (
94. 00 07950 HOME OFFICE	0			0	-	194.

Health Financial Systems COMM	UNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 11:	pared: 31 am
	CAPI TAL REI	ATED COSTS				
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation		
	(SQUARE FEET)	(DOLLAR VALUE)			& GENERAL	
			DEPARTMENT		(ACCUM. COST)	
			(GROSS SALARI ES)			
	1,00	2.00	4, 00	5A	5.00	
194. 06 07956 PAVI LLI ONS	0	58, 201		0 0	72, 333	194.06
194.08 07958 OTHER NRCC	415	68, 881	1, 834, 79	0 0	2, 630, 233	194.08
194.10 07960 COMMUNI TY REHAB HOSPI TAL	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)	13, 291, 375	17, 867, 910	7, 225, 75	8	67, 282, 044	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	22. 751451	0. 996560	0. 05444	4	0. 186364	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			100, 48	4	4, 592, 939	204.00
205.00 Unit cost multiplier (Wkst. B, Part			0. 00075	7	0. 012722	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

CUST F	ILLOCATION - STATISTICAL BASIS		Provider C	F	Period: From 01/01/2022 To 12/31/2022	Worksheet B-1 Date/Time Pre	pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (PATI ENT DAYS)	5/25/2023 11: CAFETERI A (ONSI TE FTES)	
		7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS			1			
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 19.\ 00\\ 21.\ 00\\ 22.\ 00\\ \end{array}$	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 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02100 I & RSERVICES-SALARY & FRINGES APPRV 02200 I & RSERVICES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVICE COST CENTERS	491, 441 1, 670 7, 032 4, 984 12, 788 2, 337 14, 352 6, 322 240 1, 138 0 0 0	241, 141 0 0 0 0 0 0 0 0 0 0 0 0	482, 739 4, 984 12, 788 2, 337 14, 352	74,550 0	1, 182 30 13 60 0 21 0 0 0 0	13.00 14.00 15.00 16.00 17.00 19.00 21.00
30.00	03000 ADULTS & PEDIATRICS	217, 706	126, 023	217, 706	63, 071	430	30. 00
31.00 35.00 40.00 43.00	03100 I NTENSI VE CARE UNI T 02060 NEONATAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	18, 609 34, 763 6, 412 13, 251	8, 108 2, 556	34, 763 6, 412	3 0 2 4, 452	63 99 27 22	35.00 40.00
50.00	05000 OPERATI NG ROOM	27, 326	9, 883	27, 326	0	59	50.00
$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 54.\ 00\\ 55.\ 00\\ 55.\ 00\\ 57.\ 00\\ 58.\ 00\\ 60.\ 00\\ 64.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 70.\ 00\\ 71.\ 00\\ 70.\ 00\\ 71.\ 00\\ 73.\ 00\\ 73.\ 00\\ 73.\ 00\\ 73.\ 00\\ 73.\ 00\\ 73.\ 00\\ 73.\ 00\\ 74.\ 00\\ 76.\ 01\\ 76.\ 02\\ 76.\ 03\\ 76.\ 04\\ 76.\ 04\\ 76.\ 06\\ 76.\ 07\\ \end{array}$	05100 RECOVERY ROOM 05200 DELIVERY 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 06400 INTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06600 SPEECH PATHOLOGY 066900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 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 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 03954 I MAGI NG CENTER 03955 BREAST DI AGNOSTI C CENTER 0400 DENTER SERVICE COST CENTER 0400 DENTER DEVICE COST CENTER 0400 CARE	27, 326 14, 719 28, 434 13, 341 6, 825 2, 192 3, 481 0 5, 395 179 5, 742 924 0 0 0 437 3, 917 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 10, 981 14, 414 3, 054 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	14, 719 28, 434 13, 341 6, 825 2, 192 3, 481 0 5, 395 179 5, 742 924 0 0 437 3, 917 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		38 47 39 8 15 9 0 0 5 36 15 17 3 1 13 0 0 0 0 0 1 1 21 0 0 0 0 7 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 52.\ 00\\ 54.\ 00\\ 55.\ 00\\ 55.\ 00\\ 59.\ 00\\ 60.\ 00\\ 64.\ 00\\ 65.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ 71.\ 00\\ 73.\ 01\\ 74.\ 00\\ 76.\ 01\\ 76.\ 02\\ 76.\ 03\\ 76.\ 04\\ 76.\ 06\\ 76.\ 07\\ \end{array}$
90. 01 90. 26 91. 00	09000 CLINIC 04950 INFUSION CENTER 04975 SPINE CENTER 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0 0 0 24, 604	0 0 0 37, 732	C C C 24, 604		0 2 0 81	90. 01 90. 26
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	487, 038	241, 141	478, 336	74, 550	1, 182	113. 00 114. 00 118. 00
191.00 192.00 193.00 194.00 194.06	NONKEI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 19300 NONPAI D WORKERS 07950 HOME OFFI CE 07950 PAVI LLI ONS 07958 OTHER NRCC 07960 COMMUNI TY REHAB HOSPI TAL	3, 988 0 0 0 0 0 415 0	0 0 0 0 0	3, 988 C C C C C C C C C C C C C C C C C C		0 0 0 0 0 0	190. 00 191. 00 192. 00 193. 00 194. 00 194. 06 194. 08 194. 10

Heal th F	inancial Systems COMM	UNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-	2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provider CO		eriod:	Worksheet B-1	
					rom 01/01/2022 o 12/31/2022	Date/Time Pre 5/25/2023 11:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE FEET)	(PATIENT DAYS)	(ONSITE FTES)	
		(SQUARE FEET)	(POUNDS OF				
			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)	20, 729, 542	1, 266, 704	7, 349, 132	2, 788, 315	3, 753, 256	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	42. 181141	5. 252960	15. 223821	37.401945	3, 175. 343486	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	2, 018, 200	57, 760	289, 421	183, 581	442, 601	204.00
205.00	Unit cost multiplier (Wkst. B, Part	4. 106698	0. 239528	0. 599539	2. 462522	374. 450931	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	UNI TY HOSPI TAL	OF INDIANA, IN Provider CO		Period:	u of Form CMS-: Worksheet B-1	
					From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	5/25/2023 11: SOCI AL SERVI CE	
		ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED	RECORDS &		
		(DIRECT NRSING	(COSTED	REQUIS.)	LI BRARY (GROSS CHAR	(PATIENT DAYS)	
		HRS)	REQUIS.)		GES)		
	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	17.00	
00	00100 CAP REL COSTS-BLDG & FIXT						1.0
00	00200 CAP REL COSTS-MVBLE EQUIP						2.0
00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.0 7.0
00	00800 LAUNDRY & LINEN SERVICE						8.0
00	00900 HOUSEKEEPI NG						9.0
D. 00							10.0
1.00 3.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	1, 722, 851					11.0 13.0
4.00	01400 CENTRAL SERVICES & SUPPLY	0	52, 859, 590				14.0
5.00	01500 PHARMACY	0	251, 046	15, 311, 52			15.0
5.00 7.00	01600 MEDICAL RECORDS & LIBRARY	0	0 471		0 1, 801, 824, 242		16.0 17.0
7.00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	471			74, 550 0	19.0
1.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0 0	0	21.0
2.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	22.0
D. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	894, 347	3, 165, 698		0 253, 605, 859	63, 071	30. C
1.00	03100 I NTENSI VE CARE UNI T	130, 576	541, 330		0 253, 805, 859		31.0
5.00	02060 NEONATAL INTENSIVE CARE UNIT	205, 262	940, 986		0 128, 011, 663		35.0
0. 00	04000 SUBPROVI DER – I PF	55, 858	89, 181		0 11, 938, 916		
3.00	04300 NURSERY	45, 862	161, 982		0 11, 596, 548	0	43. C
D. 00	ANCI LLARY SERVI CE COST CENTERS	123, 569	9, 133, 810		0 266, 293, 567	0	50.0
1.00	05100 RECOVERY ROOM	0	333, 013		0 48, 197, 591		51.0
2.00	05200 DELIVERY ROOM & LABOR ROOM	98, 407	347, 566		0 24, 882, 878		52.0
4.00	05400 RADI OLOGY - DI AGNOSTI C	0	172, 515		0 44, 871, 365 0 51, 665, 440		54.C
5.00 7.00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	0	463, 815 217, 270		0 51, 665, 440 0 95, 699, 114		57.0
3.00	05800 MRI	0	50, 618		0 30, 954, 241		58. C
9.00	05900 CARDI AC CATHETERI ZATI ON	0	3, 316		0 4, 529, 880		59. C
0. 00 4. 00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	0	2, 363, 734		0 104, 586, 078 0 1, 525, 783		60.0 64.0
4.00 5.00	06500 RESPI RATORY THERAPY	0	41, 761 451, 201		0 1, 525, 783 0 40, 424, 116		65. C
5.00	06600 PHYSI CAL THERAPY	0	122, 513		0 26, 650, 403		66.0
7.00	06700 OCCUPATI ONAL THERAPY	0	29, 678		0 8, 289, 242		67.0
3.00 9.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	5, 534 462		0 2, 401, 031 0 11, 136, 874		68.0 69.0
	07000 ELECTROENCEPHALOGRAPHY	0	402 152, 592		0 15, 178, 797		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	19, 128, 765		0 70, 093, 476		
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	12, 602, 121		0 45, 025, 034		
	07300 DRUGS CHARGED TO PATIENTS 07301 SPECIALTY PHARMACY	0	0	15, 311, 52	29 121, 463, 382 0 0		73. (73. (
	07400 RENAL DI ALYSI S	0	47, 457		0 4, 985, 128	-	74.0
	03330 ENDOSCOPY	0	507, 012		0 34, 320, 169		76. (
	03950 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0 0	0	76. (76. (
	03951 OTHER ANCI LLARY SERVICE COST CENTERS 03952 OTHER ANCI LLARY SERVICE COST CENTERS	0	0			0	76.0
	03953 WOUND CARE	0	107, 728		0 5, 934, 641		76.0
	03954 I MAGI NG CENTER	0	173, 968		0 62, 787, 404	0	76.0
5. 07	03955 BREAST DI AGNOSTI C CENTER	0	5, 543		0 31, 667, 909	0	76.0
0, 00	OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	90.0
	04950 I NFUSI ON CENTER	0	9, 230		0 582, 151		90.0
	04975 SPI NE CENTER	0	4, 271		0 484, 132		90.2
1.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	168, 970	1, 213, 643		0 204, 675, 480	0	91. (92. (
2.00	SPECIAL PURPOSE COST CENTERS						92.0
13.00	11300 I NTEREST EXPENSE						113. (
	11400 UTI LI ZATI ON REVI EW-SNF					_	114. (
18.00		1, 722, 851	52, 839, 830	15, 311, 52	29 1, 801, 824, 242	74, 550	118. (
0 nr	NONREIMBURSABLE COST CENTERS		0		0 0	0	190.
	19100 RESEARCH	0	0		0 0		191.
92.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	1, 896		0 0	0	192. (
	19300 NONPALD WORKERS	0	0		0 0		193. (
	07950 HOME OFFICE 07956 PAVILLIONS	0			0 0		194. (
	07958 OTHER NRCC	0	5, 687		U U	0	194. (

Heal th Fina	ncial Systems COMM	UNI TY HOSPI TAL	OF INDIANA, IN	NC.	In Lie	u of Form CMS-	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provider C		Peri od:	Worksheet B-1	
					From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 11:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	
		ADMI NI STRATI ON		(COSTED	RECORDS &		
			SUPPLY	REQUIS.)		(PATIENT DAYS)	
		(DI RECT NRSI NG	•		(GROSS CHAR		
		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)	12, 211, 325	9, 720, 864	12, 031, 56	3, 009, 238	3, 317, 642	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	7. 087859	0. 183900	0. 78578	0. 001670	44. 502240	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	236, 882	3, 143, 866	928, 52	3 38, 712	74, 796	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 137494	0. 059476	0.06064	.2 0. 000021	1.003300	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	UNI TY HOSPI TAL	OF INDIANA, I Provider C		In Lie Period:	u of Form CMS-2 Worksheet B-1	552-10
				F	From 01/01/2022 o 12/31/2022	Date/Time Prep	ared:
				RESIDENTS	1 12/01/2022	5/25/2023 11: 3	
				RESTDENTS			
	Cost Center Description	NONPHYSI CI AN ANESTHETI STS	SERVICES-SALAF Y & FRINGES	RSERVICES-OTHEF PRGM COSTS	2		
		(ASSI GNED	APPRV	APPRV			
		TI ME)	(ASSI GNED	(ASSI GNED			
		19.00	TIME) 21.00	TIME) 22.00	-		
1 00	GENERAL SERVICE COST CENTERS						1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
	01100 CAFETERIA 01300 NURSING ADMINISTRATION						11.00 13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY						15.00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE						16.00 17.00
	01900 NONPHYSICIAN ANESTHETISTS	0					19.00
	02100 I &R SERVICES-SALARY & FRINGES APPRV		65, 600				21.00
22.00	02200 I & SERVICES-OTHER PRGM COSTS APPRV I NPATI ENT ROUTI NE SERVICE COST CENTERS			65, 600)		22.00
30.00	03000 ADULTS & PEDIATRICS	0	34, 100	34, 100)		30.00
31.00	03100 I NTENSI VE CARE UNI T	C)		31.00
	02060 NEONATAL INTENSIVE CARE UNIT	0					35.00
40.00 43.00	04000 SUBPROVI DER – I PF 04300 NURSERY						40.00 43.00
10.00	ANCI LLARY SERVI CE COST CENTERS						10.00
	05000 OPERATING ROOM	(50.00
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM						51.00 52.00
	05400 RADI OLOGY-DI AGNOSTI C						54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0			D		55.00
57.00 58.00	05700 CT SCAN						57.00
	05800 MRI 05900 CARDI AC CATHETERI ZATI ON						58.00 59.00
60.00	06000 LABORATORY	0			b		60.00
	06400 INTRAVENOUS THERAPY	0					64.00
66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		2,300				65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	0					67.00
	06800 SPEECH PATHOLOGY	0					68.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY						69.00 70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0					71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0					72.00
	07300 DRUGS CHARGED TO PATIENTS 07301 SPECIALTY PHARMACY				5		73.00 73.01
	07400 RENAL DI ALYSI S				-		74.00
	03330 ENDOSCOPY	(5		76.00
	03950 OTHER ANCILLARY SERVICE COST CENTERS 03951 OTHER ANCILLARY SERVICE COST CENTERS						76. 01 76. 02
	03952 OTHER ANCI LLARY SERVICE COST CENTERS				-		76.02
76.04	03953 WOUND CARE	c			5		76.04
	03954 I MAGI NG CENTER 03955 BREAST DI AGNOSTI C CENTER						76.06 76.07
70.07	OUTPATIENT SERVICE COST CENTERS						70.07
	09000 CLI NI C	0) (90.00
	04950 INFUSION CENTER						90.01
	04975 SPI NE CENTER 09100 EMERGENCY		5, 500	5, 500			90.26 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		3, 300				92.00
110 00	SPECIAL PURPOSE COST CENTERS			1			110 00
	11300 I NTEREST EXPENSE 11400 UTI LI ZATI ON REVI EW-SNF						113.00 114.00
114.00		C	65, 600	65, 600	D		118.00
	NONREI MBURSABLE COST CENTERS			1	l		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH						190.00 191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES						191.00
193.00	19300 NONPAI D WORKERS	0				1	193.00
194.00	07950 HOME OFFICE	() (ון	1	194.00

Health Financial Systems COMM	UNI TY HOSPI TAL	OF INDIANA, I	NC.	In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Peri od:	Worksheet B-1
				From 01/01/2022 To 12/31/2022	Date/Time Prepared: 5/25/2023 11:31 am
		INTERNS &	RESI DENTS		
Cost Center Description	NONPHYSI CI AN	SERVI CES-SALAR	SERVI CES-OTHE	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	0	0		0	194.06
194.08 07958 0THER NRCC	0	0		0	194.08
194. 10 07960 COMMUNI TY REHAB HOSPI TAL	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,	0	684, 837	1, 449, 65	7	202.00
Part I)					
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000			-	203.00
204.00 Cost to be allocated (per Wkst. B,	0	7, 344	15, 54	5	204.00
Part II)					
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 111951	0. 23696	6	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00 NAHE unit cost multiplier (Wkst. D,					207.00
Parts III and IV)					

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0169	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/25/2023 11:	pared: 31 am
		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				-		
30. 00 03000 ADULTS & PEDI ATRI CS	117, 684, 148		117, 684, 14		117, 684, 148	
31.00 03100 I NTENSI VE CARE UNI T	16, 665, 540		16, 665, 54		16, 665, 540	
35.00 02060 NEONATAL INTENSIVE CARE UNIT	22, 191, 468		22, 191, 46		22, 191, 468	
40. 00 04000 SUBPROVIDER - IPF	5, 121, 448		5, 121, 44		5, 121, 448	
43. 00 04300 NURSERY	5, 784, 459		5, 784, 45	9 0	5, 784, 459	43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	26 200 665		24 200 44	5 0	24 200 445	
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	36, 390, 665 8, 697, 203		36, 390, 66 8, 697, 20		36, 390, 665 8, 697, 203	
52.00 05200 DELIVERY ROOM & LABOR ROOM	12, 411, 240		12, 411, 24		12, 411, 240	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 846, 379		8, 846, 37		8, 846, 379	
55. 00 05500 RADI OLOGY-THERAPEUTI C	5, 298, 723		5, 298, 72		5, 298, 723	
57. 00 05700 CT SCAN	3, 797, 772		3, 797, 77		3, 797, 772	
58. 00 05800 MRI	3, 447, 982		3, 447, 98		3, 447, 982	
59. 00 05900 CARDI AC CATHETERI ZATI ON	214, 012		214, 01		214, 012	
60. 00 06000 LABORATORY	18, 603, 685		18, 603, 68		18, 603, 685	
64. 00 06400 I NTRAVENOUS THERAPY	933, 338		933, 33		933, 338	•
65. 00 06500 RESPI RATORY THERAPY	9, 945, 535				9, 945, 535	
66. 00 06600 PHYSI CAL THERAPY	10, 317, 434				10, 317, 434	
67.00 06700 OCCUPATI ONAL THERAPY	2, 985, 468		2, 985, 46		2, 985, 468	
68.00 06800 SPEECH PATHOLOGY	557, 571	0	557, 57		557, 571	
69. 00 06900 ELECTROCARDI OLOGY	663, 291		663, 29		663, 291	
70.00 07000 ELECTROENCEPHALOGRAPHY	3, 553, 790		3, 553, 79	0 0	3, 553, 790	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	26, 328, 501		26, 328, 50	1 0	26, 328, 501	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	17, 343, 425		17, 343, 42	5 0	17, 343, 425	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	30, 665, 498		30, 665, 49	8 0	30, 665, 498	73.00
73. 01 07301 SPECI ALTY PHARMACY	0			0 0	0	73.01
74.00 07400 RENAL DIALYSIS	1, 749, 749		1, 749, 74		1, 749, 749	
76.00 03330 ENDOSCOPY	5, 079, 208		5, 079, 20	8 0	5, 079, 208	
76.01 03950 OTHER ANCI LLARY SERVICE COST CENTERS	0			0 0	0	
76. 02 03951 OTHER ANCI LLARY SERVICE COST CENTERS	0			0 0	0	
76. 03 03952 OTHER ANCI LLARY SERVICE COST CENTERS	0			0 0	0	
76. 04 03953 WOUND CARE	1,887,069		1, 887, 06		1, 887, 069	
76.06 03954 I MAGI NG CENTER	5, 690, 388		5, 690, 38		5, 690, 388	
76. 07 03955 BREAST DI AGNOSTI C CENTER	14, 721, 571		14, 721, 57	0	14, 721, 571	76.07
OUTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC	0		1	0 0	0	90.00
90. 00 04950 NFUSI ON CENTER	292, 052		292, 05		292, 052	
90. 26 04975 SPINE CENTER	350, 928		350, 92		350, 928	•
91. 00 09100 EMERGENCY	24, 283, 521		24, 283, 52		24, 283, 521	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	14, 401, 607		14, 401, 60		14, 401, 607	
SPECIAL PURPOSE COST CENTERS	14,401,007		14,401,00	/	14, 401, 007	72.00
113. 00 11300 I NTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
200.00 Subtotal (see instructions)	436, 904, 668	0	436, 904, 66	8 0	436, 904, 668	
201.00 Less Observation Beds	14, 401, 607		14, 401, 60		14, 401, 607	
202.00 Total (see instructions)	422, 503, 061	0				
						-

MPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: Worksher From 01/01/2022 Part I To 12/31/2022 Date/Ti 5/25/20 5/25/20		me Prepared:)23 11:31 am	
			XVIII	Hospi tal	PPS		
Cost Center Description	I npati ent	Charges Outpati ent	+ col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio		
	6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS			00/ 105 0/			1	
0. 00 03000 ADULTS & PEDIATRICS	236, 135, 291		236, 135, 29			30.	
00 03100 INTENSIVE CARE UNIT	37, 365, 950		37, 365, 95			31.	
5. 00 02060 NEONATAL INTENSIVE CARE UNIT	128, 011, 663		128, 011, 66			35.	
0.00 04000 SUBPROVIDER - IPF	11, 938, 916		11, 938, 91			40.	
3. 00 04300 NURSERY	11, 596, 548		11, 596, 54	18		43.	
ANCI LLARY SERVI CE COST CENTERS	450.004.470	440.007.004	044 000 54	7 0 40//5/		1 50	
0. 00 05000 OPERATING ROOM	153, 296, 473	112, 997, 094			0.00000		
0. 00 05100 RECOVERY ROOM	23, 549, 968	24, 647, 623			0.00000		
2. 00 05200 DELIVERY ROOM & LABOR ROOM	24, 882, 878	0	24, 882, 87		0.00000		
I. 00 05400 RADI OLOGY-DI AGNOSTI C	13, 259, 008	31, 612, 357			0.00000		
5. 00 05500 RADI OLOGY-THERAPEUTI C	21, 278, 270	30, 387, 170	51, 665, 44		0.00000		
7. 00 05700 CT SCAN	32, 373, 208	63, 325, 906			0.00000		
3. 00 05800 MRI	6, 585, 581	24, 368, 660			0.00000		
0. 00 05900 CARDI AC CATHETERI ZATI ON	4, 529, 880	0	4, 529, 88		0.00000		
0. 00 06000 LABORATORY	64, 275, 054	40, 311, 024			0.00000		
I. 00 06400 I NTRAVENOUS THERAPY	1, 486, 812	38, 971	1, 525, 78		0.00000		
5. 00 06500 RESPI RATORY THERAPY	37, 507, 715	2, 916, 401	40, 424, 11		0.00000		
5. 00 06600 PHYSI CAL THERAPY	4, 601, 149	22, 049, 254			0.00000		
7. 00 06700 OCCUPATI ONAL THERAPY	4, 539, 742	3, 749, 500	8, 289, 24		0.00000		
3. 00 06800 SPEECH PATHOLOGY	1, 564, 526	836, 505	2, 401, 03	0. 232221	0.00000	68.	
P. 00 06900 ELECTROCARDI OLOGY	9, 145, 876	1, 990, 998	11, 136, 87	0. 059558	0.00000	69.	
0. 00 07000 ELECTROENCEPHALOGRAPHY	1, 432, 526	13, 746, 271	15, 178, 79	0. 234129	0.00000	70.	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	43, 122, 893	26, 970, 583	70, 093, 47	0. 375620	0.00000) 71.	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	25, 953, 815	19, 071, 219	45, 025, 03	0. 385195	0.00000	72.	
3. 00 07300 DRUGS CHARGED TO PATIENTS	90, 755, 141	30, 708, 241	121, 463, 38	0. 252467	0.00000	73.	
3. 01 07301 SPECIALTY PHARMACY	0	0		0 0.000000	0.00000	73.	
I. 00 07400 RENAL DIALYSIS	4, 985, 128	0	4, 985, 12	0. 350994	0.00000	74.	
5. 00 03330 ENDOSCOPY	7, 818, 414	26, 501, 755	34, 320, 16	0. 147995	0.00000	76.	
5. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0.000000	0.00000	76.	
0. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0.000000	0.00000	76.	
0. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0.000000	0.00000		
0. 04 03953 WOUND CARE	1,096,374	4, 838, 267	5, 934, 64		0.00000		
5. 06 03954 I MAGI NG CENTER	414, 565	62, 372, 839			0.000000		
5. 07 03955 BREAST DI AGNOSTI C CENTER	26, 043	31, 641, 866			0. 000000		
OUTPATIENT SERVICE COST CENTERS						1	
0. 00 09000 CLINIC	0	0		0 0.000000	0.00000	90.	
0. 01 04950 INFUSION CENTER	148	582,003			0. 000000		
0. 26 04975 SPI NE CENTER	310	483, 822	484, 13		0. 000000		
00 09100 EMERGENCY	49, 498, 388	155, 177, 092			0. 000000		
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 295, 688	14, 174, 880			0. 000000		
SPECIAL PURPOSE COST CENTERS	5, 275, 000	11, 174, 000	1, 4, 6, 50	0.024000	0.000000	· / / · ·	
3. 00 11300 I NTEREST EXPENSE						113.	
4. 00 11400 UTILI ZATION REVIEW-SNF						114.	
00.00 Subtotal (see instructions)	1, 056, 323, 941	745 500 201	1, 801, 824, 24	12		200.	
10.00 Less Observation Beds	1,000, 323, 941	745, 500, 301	1,001,024,24	12		200.	
12.00 Total (see instructions)	1, 056, 323, 941	745 500 201	1, 801, 824, 24	10		201.	

nour tri	Financial Systems C	OMMUNI TY HOSPI TAL	OF TINDI ANA,	TNC.	III LI EL	u of Form CMS-	2552-1
COMPUTA	ATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 15-0169	Peri od:	Worksheet C	
					From 01/01/2022	Part I	norod.
					To 12/31/2022	Date/Time Pre 5/25/2023 11:	
			Ti 1	tle XVIII	Hospi tal	PPS	51 4111
	Cost Center Description	PPS Inpatient					
		Ratio					
		11.00					
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS						30. 0
	03100 I NTENSI VE CARE UNI T						31.00
	02060 NEONATAL INTENSIVE CARE UNIT						35.0
	04000 SUBPROVIDER - IPF						40.0
	04300 NURSERY						43.0
	ANCI LLARY SERVI CE COST CENTERS						45.0
	05000 OPERATING ROOM	0. 136656					50.0
	05100 RECOVERY ROOM	0. 180449					51.0
							52.0
	05200 DELIVERY ROOM & LABOR ROOM	0. 498786					
	05400 RADI OLOGY-DI AGNOSTI C	0. 197150					54.0
	05500 RADI OLOGY-THERAPEUTI C	0. 102558					55.0
	05700 CT SCAN	0. 039685					57. C
	05800 MRI	0. 111390					58.0
	05900 CARDI AC CATHETERI ZATI ON	0. 047245					59.0
	06000 LABORATORY	0. 177879					60. C
	06400 INTRAVENOUS THERAPY	0. 611711					64. C
	06500 RESPI RATORY THERAPY	0. 246030					65.0
6.00	06600 PHYSI CAL THERAPY	0. 387140					66. C
57.00	06700 OCCUPATI ONAL THERAPY	0. 360162					67.0
58.00	06800 SPEECH PATHOLOGY	0. 232221					68. C
59.00	06900 ELECTROCARDI OLOGY	0. 059558					69.0
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 234129					70.0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 375620					71.0
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 385195					72.0
	07300 DRUGS CHARGED TO PATIENTS	0. 252467					73.0
	07301 SPECIALTY PHARMACY	0. 000000					73.0
	07400 RENAL DI ALYSI S	0. 350994					74.0
	03330 ENDOSCOPY	0. 147995					76.0
	03950 OTHER ANCILLARY SERVICE COST CENTERS						76.0
-	03951 OTHER ANCI LLARY SERVICE COST CENTERS						76.0
	03952 OTHER ANCI LLARY SERVICE COST CENTERS						76.0
	03953 WOUND CARE	0. 317975					76.0
	03954 I MAGI NG CENTER	0.090629					76.0
	03955 BREAST DI AGNOSTI C CENTER	0. 464873					76.0
	OUTPATIENT SERVICE COST CENTERS	0.404073					/0.0
		0,00000					
	09000 CLINIC	0.00000					90.0
	04950 I NFUSI ON CENTER	0. 501677					90.0
	04975 SPINE CENTER	0. 724860					90.2
	09100 EMERGENCY	0. 118644					91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 824335					92.0
	SPECIAL PURPOSE COST CENTERS	1					
	11300 INTEREST EXPENSE						113.0
	11400 UTILIZATION REVIEW-SNF						114.0
200.00	Subtotal (see instructions)						200.0
	Less Observation Beds						201.0
201.00 202.00	Total (see instructions)						202.00

In Lieu of Form CMS-2552-10 Worksheet C

I NF 30. 00 030 31. 00 033 35. 00 020 40. 00 040 43. 00 052 51. 00 052 51. 00 052 51. 00 052 52. 00 052 54. 00 055 57. 00 057 58. 00 058 60. 00 050	ON OF RATIO OF COSTS TO CHARGES Cost Center Description Cost Center Description PATIENT ROUTINE SERVICE COST CENTERS DOO ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT DOO SUBPROVIDER - IPF 300 NURSERY CILLARY SERVICE COST CENTERS DOO OPERATING ROOM 100 RECOVERY ROOM 200 DELIVERY ROOM & LABOR ROOM 400 RADIOLOGY-THERAPEUTIC 500 RADIOLOGY-THERAPEUTIC 500 CT SCAN 800 MRI 900 CARDIAC CATHETERIZATION	Total Cost (from Wkst. B, Part I, col. 26) 1.00 118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240 8, 846, 379 5, 298, 723 3, 797, 772	Therapy Limit Adj. 2.00	F		5/25/2023 11: PPS Total Costs 5.00 118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203	31 am 30.00 31.00 35.00 40.00 43.00 50.00
30.00 030 31.00 031 35.00 022 40.00 040 50.00 043 50.00 050 51.00 052 54.00 052 57.00 052 57.00 055 58.00 058 59.00 056 60.00 050	PATI ENT ROUTI NE SERVI CE COST CENTERS DOO ADULTS & PEDI ATRI CS 100 I NTENSI VE CARE UNI T DOO NEONATAL I NTENSI VE CARE UNI T DOO SUBPROVI DER - I PF DOO NURSERY CI LLARY SERVI CE COST CENTERS DOO OPERATI NG ROOM 100 RECOVERY ROOM 200 DELI VERY ROOM & LABOR ROOM 400 RADI OLOGY-DI AGNOSTI C 500 RADI OLOGY-THERAPEUTI C 700 CT SCAN 800 MRI	(from Wkst. B, Part I, col. 26) 1.00 118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240 8, 846, 379 5, 298, 723 3, 797, 772	Therapy Limit Adj. 2.00	e XIX Total Costs 3.00 118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240	Image: Tope of the second state of the seco	Date/Time Pre 5/25/2023 11: PPS Total Costs 5. 00 118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203	31 am 30.00 31.00 35.00 40.00 43.00 50.00
30.00 030 31.00 031 35.00 022 40.00 040 50.00 043 50.00 050 51.00 052 54.00 052 57.00 052 57.00 055 58.00 058 59.00 056 60.00 050	PATI ENT ROUTI NE SERVI CE COST CENTERS DOO ADULTS & PEDI ATRI CS 100 I NTENSI VE CARE UNI T DOO NEONATAL I NTENSI VE CARE UNI T DOO SUBPROVI DER - I PF DOO NURSERY CI LLARY SERVI CE COST CENTERS DOO OPERATI NG ROOM 100 RECOVERY ROOM 200 DELI VERY ROOM & LABOR ROOM 400 RADI OLOGY-DI AGNOSTI C 500 RADI OLOGY-THERAPEUTI C 700 CT SCAN 800 MRI	(from Wkst. B, Part I, col. 26) 1.00 118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240 8, 846, 379 5, 298, 723 3, 797, 772	Therapy Limit Adj. 2.00	e XIX Total Costs 3.00 118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240	Hospi tal Costs RCE Di sal I owance 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5/25/2023 11: PPS Total Costs 5.00 118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203	31 am 30.00 31.00 35.00 40.00 43.00 50.00
30.00 030 31.00 031 35.00 022 40.00 040 50.00 043 50.00 050 51.00 052 54.00 052 57.00 052 57.00 055 58.00 058 59.00 056 60.00 050	PATI ENT ROUTI NE SERVI CE COST CENTERS DOO ADULTS & PEDI ATRI CS 100 I NTENSI VE CARE UNI T DOO NEONATAL I NTENSI VE CARE UNI T DOO SUBPROVI DER - I PF DOO NURSERY CI LLARY SERVI CE COST CENTERS DOO OPERATI NG ROOM 100 RECOVERY ROOM 200 DELI VERY ROOM & LABOR ROOM 400 RADI OLOGY-DI AGNOSTI C 500 RADI OLOGY-THERAPEUTI C 700 CT SCAN 800 MRI	(from Wkst. B, Part I, col. 26) 1.00 118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240 8, 846, 379 5, 298, 723 3, 797, 772	Therapy Limit Adj. 2.00	Total Costs 3.00 118, 793, 695 16, 665, 540 22, 191, 466 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240	Costs RCE Di sal I owance 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PPS Total Costs 5.00 118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203	30.00 31.00 35.00 40.00 43.00 50.00
30.00 030 31.00 031 35.00 022 40.00 040 50.00 043 50.00 050 51.00 052 54.00 052 57.00 052 57.00 055 58.00 058 59.00 056 60.00 050	PATI ENT ROUTI NE SERVI CE COST CENTERS DOO ADULTS & PEDI ATRI CS 100 I NTENSI VE CARE UNI T DOO NEONATAL I NTENSI VE CARE UNI T DOO SUBPROVI DER - I PF DOO NURSERY CI LLARY SERVI CE COST CENTERS DOO OPERATI NG ROOM 100 RECOVERY ROOM 200 DELI VERY ROOM & LABOR ROOM 400 RADI OLOGY-DI AGNOSTI C 500 RADI OLOGY-THERAPEUTI C 700 CT SCAN 800 MRI	(from Wkst. B, Part I, col. 26) 1.00 118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240 8, 846, 379 5, 298, 723 3, 797, 772	Therapy Limit Adj. 2.00	Total Costs 3.00 118, 793, 695 16, 665, 540 22, 191, 466 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240	Costs RCE Di sal I owance 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PPS Total Costs 5.00 118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203	30.00 31.00 35.00 40.00 43.00 50.00
30.00 030 31.00 031 35.00 022 40.00 040 50.00 043 50.00 050 51.00 052 54.00 052 57.00 052 57.00 055 58.00 058 59.00 056 60.00 050	PATI ENT ROUTI NE SERVI CE COST CENTERS DOO ADULTS & PEDI ATRI CS 100 I NTENSI VE CARE UNI T DOO NEONATAL I NTENSI VE CARE UNI T DOO SUBPROVI DER - I PF DOO NURSERY CI LLARY SERVI CE COST CENTERS DOO OPERATI NG ROOM 100 RECOVERY ROOM 200 DELI VERY ROOM & LABOR ROOM 400 RADI OLOGY-DI AGNOSTI C 500 RADI OLOGY-THERAPEUTI C 700 CT SCAN 800 MRI	(from Wkst. B, Part I, col. 26) 1.00 118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240 8, 846, 379 5, 298, 723 3, 797, 772	Adj . 2.00	3.00 118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240	RCE Di sal I owance 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5. 00 118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203	31.00 35.00 40.00 43.00 50.00
30.00 030 31.00 031 35.00 022 40.00 040 50.00 043 50.00 050 51.00 052 54.00 052 57.00 052 57.00 055 58.00 058 59.00 056 60.00 050	PATI ENT ROUTI NE SERVI CE COST CENTERS DOO ADULTS & PEDI ATRI CS 100 I NTENSI VE CARE UNI T DOO NEONATAL I NTENSI VE CARE UNI T DOO SUBPROVI DER - I PF DOO NURSERY CI LLARY SERVI CE COST CENTERS DOO OPERATI NG ROOM 100 RECOVERY ROOM 200 DELI VERY ROOM & LABOR ROOM 400 RADI OLOGY-DI AGNOSTI C 500 RADI OLOGY-THERAPEUTI C 700 CT SCAN 800 MRI	(from Wkst. B, Part I, col. 26) 1.00 118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240 8, 846, 379 5, 298, 723 3, 797, 772	Adj . 2.00	3.00 118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240	RCE Di sal I owance 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5. 00 118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203	31.00 35.00 40.00 43.00 50.00
30.00 030 31.00 031 35.00 022 40.00 040 50.00 043 50.00 050 51.00 052 54.00 052 57.00 052 57.00 055 58.00 058 59.00 056 60.00 050	PATI ENT ROUTI NE SERVI CE COST CENTERS DOO ADULTS & PEDI ATRI CS 100 I NTENSI VE CARE UNI T DOO NEONATAL I NTENSI VE CARE UNI T DOO SUBPROVI DER - I PF DOO NURSERY CI LLARY SERVI CE COST CENTERS DOO OPERATI NG ROOM 100 RECOVERY ROOM 200 DELI VERY ROOM & LABOR ROOM 400 RADI OLOGY-DI AGNOSTI C 500 RADI OLOGY-THERAPEUTI C 700 CT SCAN 800 MRI	(from Wkst. B, Part I, col. 26) 1.00 118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240 8, 846, 379 5, 298, 723 3, 797, 772	Adj . 2.00	3.00 118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240	Di sal I owance	5. 00 118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203	31.00 35.00 40.00 43.00 50.00
30.00 030 31.00 031 35.00 022 40.00 040 50.00 043 50.00 050 51.00 052 54.00 052 57.00 052 57.00 055 58.00 058 59.00 056 60.00 050	000 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT 000 SUBPROVIDER - IPF 000 SUBPROVIDER - IPF 000 OPERATING ROOM 100 RECOVERY ROOM 100 RECOVERY ROOM 000 DELIVERY ROOM & LABOR ROOM 100 RADIOLOGY-DIAGNOSTIC 000 CT SCAN 800 MRI	Part I, col. 26) 1.00 118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240 8, 846, 379 5, 298, 723 3, 797, 772	2.00	118, 793, 695 16, 665, 540 22, 191, 466 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240	4.00 4.00 0 0 0 0 0 0 0 0 0 0 0 0	118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203	31.00 35.00 40.00 43.00 50.00
30.00 030 31.00 031 35.00 022 40.00 040 50.00 043 50.00 050 51.00 052 54.00 052 57.00 052 57.00 055 58.00 058 59.00 056 60.00 050	000 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT 000 SUBPROVIDER - IPF 000 SUBPROVIDER - IPF 000 OPERATING ROOM 100 RECOVERY ROOM 100 RECOVERY ROOM 000 DELIVERY ROOM & LABOR ROOM 100 RADIOLOGY-DIAGNOSTIC 000 CT SCAN 800 MRI	26) 1.00 118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240 8, 846, 379 5, 298, 723 3, 797, 772		118, 793, 695 16, 665, 540 22, 191, 466 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240		118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203	31.00 35.00 40.00 43.00 50.00
30.00 030 31.00 031 35.00 022 40.00 040 50.00 043 50.00 050 51.00 052 54.00 052 57.00 052 57.00 055 58.00 058 59.00 056 60.00 050	000 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT 000 SUBPROVIDER - IPF 000 SUBPROVIDER - IPF 000 OPERATING ROOM 100 RECOVERY ROOM 100 RECOVERY ROOM 000 DELIVERY ROOM & LABOR ROOM 100 RADIOLOGY-DIAGNOSTIC 000 CT SCAN 800 MRI	1.00 118,793,695 16,665,540 22,191,468 5,121,448 5,784,459 37,161,816 8,697,203 12,411,240 8,846,379 5,298,723 3,797,772		118, 793, 695 16, 665, 540 22, 191, 466 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240		118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203	31.00 35.00 40.00 43.00 50.00
30.00 030 31.00 031 35.00 022 40.00 040 50.00 043 50.00 050 51.00 052 54.00 052 57.00 052 57.00 055 58.00 058 59.00 056 60.00 050	000 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT 000 SUBPROVIDER - IPF 000 SUBPROVIDER - IPF 000 OPERATING ROOM 100 RECOVERY ROOM 100 RECOVERY ROOM 000 DELIVERY ROOM & LABOR ROOM 100 RADIOLOGY-DIAGNOSTIC 000 CT SCAN 800 MRI	118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240 8, 846, 379 5, 298, 723 3, 797, 772		118, 793, 695 16, 665, 540 22, 191, 466 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240		118, 793, 695 16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203	31.00 35.00 40.00 43.00 50.00
30.00 030 31.00 031 35.00 022 40.00 040 50.00 043 50.00 050 51.00 052 54.00 052 57.00 052 57.00 055 58.00 058 59.00 056 60.00 050	000 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT 000 SUBPROVIDER - IPF 000 SUBPROVIDER - IPF 000 OPERATING ROOM 100 RECOVERY ROOM 100 RECOVERY ROOM 000 DELIVERY ROOM & LABOR ROOM 100 RADIOLOGY-DIAGNOSTIC 000 CT SCAN 800 MRI	16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240 8, 846, 379 5, 298, 723 3, 797, 772		16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240		16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203	31.00 35.00 40.00 43.00 50.00
30.00 030 31.00 031 35.00 022 40.00 040 50.00 043 50.00 050 51.00 052 54.00 052 57.00 052 57.00 055 58.00 058 59.00 056 60.00 050	000 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT 000 SUBPROVIDER - IPF 000 SUBPROVIDER - IPF 000 OPERATING ROOM 100 RECOVERY ROOM 100 RECOVERY ROOM 000 DELIVERY ROOM & LABOR ROOM 100 RADIOLOGY-DIAGNOSTIC 000 CT SCAN 800 MRI	16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240 8, 846, 379 5, 298, 723 3, 797, 772		16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240		16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203	31.00 35.00 40.00 43.00 50.00
31.00 031 35.00 020 40.00 040 43.00 050 50.00 050 51.00 051 52.00 052 54.00 055 57.00 055 58.00 058 59.00 056 60.00 056	100 INTENSIVE CARE UNIT 100 NEONATAL INTENSIVE CARE UNIT 100 SUBPROVIDER - IPF 100 NURSERY 100 OPERATING ROOM 100 RECOVERY ROOM 100 RECOVERY ROOM & LABOR ROOM 100 RADIOLOGY-DIAGNOSTIC 100 RADIOLOGY-THERAPEUTIC 100 CT SCAN 100 MRI	16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240 8, 846, 379 5, 298, 723 3, 797, 772		16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240		16, 665, 540 22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203	31.00 35.00 40.00 43.00 50.00
35.00 020 40.00 040 43.00 043 50.00 055 51.00 052 54.00 055 57.00 055 58.00 058 59.00 056 69.00 056	060 NEONATAL INTENSIVE CARE UNIT 000 SUBPROVIDER - IPF 300 NURSERY CILLARY SERVICE COST CENTERS 000 OPERATING ROOM 100 RECOVERY ROOM 200 DELIVERY ROOM & LABOR ROOM 400 RADIOLOGY-DIAGNOSTIC 500 RADIOLOGY-THERAPEUTIC 500 CT SCAN 800 MRI	22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240 8, 846, 379 5, 298, 723 3, 797, 772		22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240	3 0 3 0 0 0 5 0 3 0	22, 191, 468 5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203	35. 00 40. 00 43. 00 50. 00
40.00 040 43.00 043 ANC 050 50.00 050 51.00 052 52.00 052 55.00 055 57.00 057 58.00 058 59.00 056 60.00 050	000 SUBPROVIDER - IPF 300 NURSERY CILLARY SERVICE COST CENTERS 000 OPERATING ROOM 100 RECOVERY ROOM 200 DELIVERY ROOM & LABOR ROOM 400 RADIOLOGY-DIAGNOSTIC 500 RADIOLOGY-THERAPEUTIC 500 CT SCAN 800 MRI	5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240 8, 846, 379 5, 298, 723 3, 797, 772		5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240	3 0 0 0 3 0	5, 121, 448 5, 784, 459 37, 161, 816 8, 697, 203	40.00 43.00 50.00
43.00 043 50.00 050 51.00 051 52.00 052 54.00 054 55.00 055 57.00 055 58.00 055 59.00 055 60.00 056	300 NURSERY CI LLARY SERVICE COST CENTERS 000 OPERATING ROOM 100 RECOVERY ROOM 200 DELIVERY ROOM & LABOR ROOM 400 RADIOLOGY-DIAGNOSTIC 500 RADIOLOGY-THERAPEUTIC 700 CT SCAN 800 MRI	5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240 8, 846, 379 5, 298, 723 3, 797, 772		5, 784, 459 37, 161, 816 8, 697, 203 12, 411, 240	2 0 5 0 3 0	5, 784, 459 37, 161, 816 8, 697, 203	43.00 50.00
ANC 50. 00 050 51. 00 051 52. 00 052 54. 00 054 55. 00 055 57. 00 055 58. 00 056 59. 00 056 60. 00 060	CI LLARY SERVICE COST CENTERS DOO OPERATING ROOM 100 RECOVERY ROOM 200 DELIVERY ROOM & LABOR ROOM 400 RADIOLOGY-DIAGNOSTIC 500 RADIOLOGY-THERAPEUTIC 700 CT SCAN 800 MRI	37, 161, 816 8, 697, 203 12, 411, 240 8, 846, 379 5, 298, 723 3, 797, 772		37, 161, 816 8, 697, 203 12, 411, 240	5 O 3 O	37, 161, 816 8, 697, 203	50.00
50.00 050 51.00 051 52.00 052 54.00 054 55.00 055 57.00 057 58.00 058 59.00 059 60.00 060	000 OPERATING ROOM 100 RECOVERY ROOM 200 DELIVERY ROOM & LABOR ROOM 400 RADIOLOGY-DIAGNOSTIC 500 RADIOLOGY-THERAPEUTIC 700 CT SCAN 800 MRI	8, 697, 203 12, 411, 240 8, 846, 379 5, 298, 723 3, 797, 772		8, 697, 203 12, 411, 240	3 0	8, 697, 203	
50.00 050 51.00 051 52.00 052 54.00 054 55.00 055 57.00 057 58.00 058 59.00 059 60.00 060	000 OPERATING ROOM 100 RECOVERY ROOM 200 DELIVERY ROOM & LABOR ROOM 400 RADIOLOGY-DIAGNOSTIC 500 RADIOLOGY-THERAPEUTIC 700 CT SCAN 800 MRI	8, 697, 203 12, 411, 240 8, 846, 379 5, 298, 723 3, 797, 772		8, 697, 203 12, 411, 240	3 0	8, 697, 203	
51.00 051 52.00 052 54.00 054 55.00 055 57.00 057 58.00 058 59.00 059 60.00 060	100 RECOVERY ROOM 200 DELIVERY ROOM & LABOR ROOM 400 RADIOLOGY-DIAGNOSTIC 500 RADIOLOGY-THERAPEUTIC 700 CT SCAN 800 MRI	8, 697, 203 12, 411, 240 8, 846, 379 5, 298, 723 3, 797, 772		8, 697, 203 12, 411, 240	3 0	8, 697, 203	
52.00 052 54.00 054 55.00 057 57.00 057 58.00 058 59.00 059 60.00 060	200 DELIVERY ROOM & LABOR ROOM 400 RADIOLOGY-DIAGNOSTIC 500 RADIOLOGY-THERAPEUTIC 700 CT SCAN 800 MRI	12, 411, 240 8, 846, 379 5, 298, 723 3, 797, 772		12, 411, 240			1 31.00
54.00 054 55.00 055 57.00 057 58.00 058 59.00 059 60.00 060	400 RADI OLOGY-DI AGNOSTI C 500 RADI OLOGY-THERAPEUTI C 700 CT SCAN 800 MRI	8, 846, 379 5, 298, 723 3, 797, 772			0		
55.00 055 57.00 057 58.00 058 59.00 059 60.00 060	500 RADI OLOGY-THERAPEUTI C 700 CT SCAN 800 MRI	5, 298, 723 3, 797, 772					
57.00 057 58.00 058 59.00 059 60.00 060	700 CT_SCAN 800 MRI	3, 797, 772				8, 846, 379	
58.00 058 59.00 059 60.00 060	BOO MRI			5, 298, 723	3 0	5, 298, 723	55.00
58.00 058 59.00 059 60.00 060	BOO MRI			3, 797, 772	2 0	3, 797, 772	
59.00 059 60.00 060		3, 447, 982		3, 447, 982		3, 447, 982	
60.00 060							
		214, 012		214, 012		214, 012	
64 00 064	000 LABORATORY	18, 603, 685		18, 603, 685			
04.00 00-	400 INTRAVENOUS THERAPY	933, 338		933, 338	3 0	933, 338	64.00
65.00 065	500 RESPI RATORY THERAPY	9, 945, 535	0	9, 945, 535	5 0	9, 945, 535	65.00
66.00 066	600 PHYSI CAL THERAPY	10, 392, 271	0	10, 392, 271		10, 392, 271	
	700 OCCUPATI ONAL THERAPY	2, 985, 468		2, 985, 468		2, 985, 468	
			0				
	800 SPEECH PATHOLOGY	557, 571	0	557, 571		557, 571	
	900 ELECTROCARDI OLOGY	663, 291		663, 291	0	663, 291	69.00
70.00 070	000 ELECTROENCEPHALOGRAPHY	3, 553, 790		3, 553, 790	0 0	3, 553, 790	70.00
71.00 071	100 MEDICAL SUPPLIES CHARGED TO PATIENT	26, 328, 501		26, 328, 501	l o	26, 328, 501	71.00
72.00 072	200 IMPL. DEV. CHARGED TO PATIENTS	17, 343, 425		17, 343, 425			
					-		
	300 DRUGS CHARGED TO PATIENTS	30, 665, 498		30, 665, 498		30, 665, 498	
	301 SPECIALTY PHARMACY	0		(, o	0	
	400 RENAL DI ALYSI S	1, 749, 749		1, 749, 749	9 0	1, 749, 749	74.00
76.00 033	330 ENDOSCOPY	5,079,208		5, 079, 208	3 0	5, 079, 208	76.00
76.01 039	950 OTHER ANCILLARY SERVICE COST CENTERS	0		(0 0	0	76.01
	951 OTHER ANCI LLARY SERVICE COST CENTERS	0		(0	1
		0					
	952 OTHER ANCILLARY SERVICE COST CENTERS	0				0	
	953 WOUND CARE	1, 887, 069		1, 887, 069		1, 887, 069	
76.06 039	954 IMAGING CENTER	5, 690, 388		5, 690, 388	3 0	5, 690, 388	76.06
76.07 039	955 BREAST DI AGNOSTI C CENTER	14, 721, 571		14, 721, 571	0	14, 721, 571	76.07
	TPATIENT SERVICE COST CENTERS		1	., , , .			
		0		(0 0	0	90.00
90.01 049	950 I NFUSI ON CENTER	292, 052		292, 052		,	
	975 SPINE CENTER	350, 928		350, 928		350, 928	
	100 EMERGENCY	24, 462, 480		24, 462, 480	0 0	24, 462, 480	91.00
92.00 092	200 OBSERVATION BEDS (NON-DISTINCT PART	14, 401, 607		14, 401, 607	7	14, 401, 607	92.00
	ECIAL PURPOSE COST CENTERS		•		· ·		1
	300 INTEREST EXPENSE						113.00
	400 UTILIZATION REVIEW-SNF					1	
							114.00
200.00	Subtotal (see instructions)	439, 039, 162	0	439, 039, 162			
201.00	Less Observation Beds	14, 401, 607		14, 401, 607	7	14, 401, 607	201.00
202.00	Total (see instructions)	424, 637, 555	0	424, 637, 555	5 0	424, 637, 555	202.00

Health Financial Systems COMMU COMPUTATION OF RATIO OF COSTS TO CHARGES				CN: 15-0169	From 01/01/2022 Part To 12/31/2022 Date/		ksheet C t I :e/Time Prepared: 25/2023 11:31 am	
				e XIX	Hospi tal	PPS		
Cost Center D	lescription	I npati ent	<u>Charges</u> Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o		
		6.00	7.00	8.00	9.00	10.00		
	SERVICE COST CENTERS					1	1	
0.00 03000 ADULTS & PEDI		236, 135, 291		236, 135, 2			30.	
I. 00 03100 I NTENSI VE CAR		37, 365, 950		37, 365, 9			31.	
5. 00 02060 NEONATAL INTE		128, 011, 663		128, 011, 6			35.	
0.00 04000 SUBPROVI DER -	1 PF	11, 938, 916		11, 938, 9			40.	
3. 00 04300 NURSERY		11, 596, 548		11, 596, 5	48		43.	
ANCI LLARY SERVICE (450.004.470	440 007 004	0// 000 5		0.00000	1 50	
0.00 05000 OPERATING ROC		153, 296, 473	112, 997, 094					
I. 00 05100 RECOVERY ROOM		23, 549, 968	24, 647, 623					
2. 00 05200 DELIVERY ROOM		24, 882, 878	0	21,002,0				
1. 00 05400 RADI OLOGY-DI A		13, 259, 008	31, 612, 357					
5. 00 05500 RADI OLOGY-THE	RAPEUTIC	21, 278, 270	30, 387, 170					
7.00 05700 CT SCAN		32, 373, 208	63, 325, 906					
3. 00 05800 MRI		6, 585, 581	24, 368, 660					
9. 00 05900 CARDI AC CATHE	TERI ZATI ON	4, 529, 880	C	4, 527, 0				
0.00 06000 LABORATORY		64, 275, 054	40, 311, 024					
1.00 06400 INTRAVENOUS T		1, 486, 812	38, 971			0.00000		
5. 00 06500 RESPI RATORY T		37, 507, 715	2, 916, 401					
5. 00 06600 PHYSI CAL THER		4, 601, 149	22, 049, 254					
7.00 06700 0CCUPATI ONAL		4, 539, 742	3, 749, 500					
3.00 06800 SPEECH PATHOL		1, 564, 526	836, 505			0.00000		
9. 00 06900 ELECTROCARDI C		9, 145, 876	1, 990, 998					
0.00 07000 ELECTROENCEPH		1, 432, 526	13, 746, 271					
I. 00 07100 MEDICAL SUPPL	IES CHARGED TO PATIENT	43, 122, 893	26, 970, 583	70, 093, 4	76 0. 375620	0. 000000) 71.	
2.00 07200 IMPL. DEV. CH	IARGED TO PATI ENTS	25, 953, 815	19, 071, 219	45, 025, 0	0. 385195	0. 000000) 72.	
3. 00 07300 DRUGS CHARGED	TO PATIENTS	90, 755, 141	30, 708, 241	121, 463, 3	82 0. 252467	0. 000000) 73.	
3. 01 07301 SPECIALTY PHA	RMACY	0	C		0 0.000000	0. 000000) 73.	
1.00 07400 RENAL DIALYSI	S	4, 985, 128	0	4, 985, 1	0. 350994	0.00000	74.	
5. 00 03330 ENDOSCOPY		7, 818, 414	26, 501, 755	34, 320, 1	69 0. 147995	0. 000000	76.	
5.01 03950 OTHER ANCILLA	RY SERVICE COST CENTERS	0	0		0 0.000000	0. 000000	76.	
	RY SERVICE COST CENTERS	0	0		0 0.000000	0. 000000	76.	
5.03 03952 OTHER ANCILLA	RY SERVICE COST CENTERS	0	0)	0 0.000000	0. 000000	76.	
5. 04 03953 WOUND CARE		1, 096, 374	4, 838, 267	5, 934, 6	0. 317975	0. 000000	76.	
5. 06 03954 I MAGI NG CENTE	R	414, 565	62, 372, 839	62, 787, 4	0. 090629	0. 000000	76.	
5. 07 03955 BREAST DI AGNO	STIC CENTER	26, 043	31, 641, 866	31, 667, 9	0. 464873	0. 000000	76.	
OUTPATIENT SERVICE	COST CENTERS							
0. 00 09000 CLINIC		0	0		0 0.000000	0.00000	90.	
D. 01 04950 INFUSION CENT	ER	148	582, 003	582, 1	0. 501677	0. 000000	90.	
0. 26 04975 SPINE CENTER		310	483, 822					
I. 00 09100 EMERGENCY		49, 498, 388	155, 177, 092					
2.00 09200 OBSERVATION E	EDS (NON-DISTINCT PART	3, 295, 688	14, 174, 880					
SPECIAL PURPOSE COS							1	
13. 00 11300 I NTEREST EXPE							113.	
14. 00 11400 UTI LI ZATI ON F							114.	
	instructions)	1, 056, 323, 941	745,500,301	1,801,824,2	42		200.	
01.00 Less Observat		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,,	.,			200.	
D2.00 Total (see in		1,056,323,941	745 500 301	1,801,824,2	12		202	

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0169	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/25/2023 11:	pared:
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient			I	
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 I NTENSI VE CARE UNI T					31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT					35.00
40. 00 04000 SUBPROVIDER - IPF					40.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATI NG ROOM	0. 139552				50.00
51.00 05100 RECOVERY ROOM	0. 180449				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 498786				52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 197150				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 102558				55.00
57.00 05700 CT SCAN	0. 039685				57.00
58. 00 05800 MRI	0. 111390				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 047245				59.00
60. 00 06000 LABORATORY	0. 177879				60.00
64.00 06400 INTRAVENOUS THERAPY	0. 611711				64.00
65. 00 06500 RESPI RATORY THERAPY	0. 246030				65.00
66.00 06600 PHYSI CAL THERAPY	0. 389948				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 360162				67.00
68.00 06800 SPEECH PATHOLOGY	0. 232221				68.00
69.00 06900 ELECTROCARDI OLOGY	0. 059558				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 234129				70.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0. 375620				71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 385195				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 252467				73.00
73. 01 07301 SPECIALTY PHARMACY	0.00000				73.01
74.00 07400 RENAL DI ALYSI S	0.350994				74.00
76.00 03330 ENDOSCOPY 76.01 03950 OTHER ANCI LLARY SERVICE COST CENTERS	0. 147995				76.00
	0.00000				76.01 76.02
76. 02 03951 OTHER ANCI LLARY SERVICE COST CENTERS 76. 03 03952 OTHER ANCI LLARY SERVICE COST CENTERS	0. 000000 0. 000000				76.02
76. 04 03953 WOUND CARE	0. 317975				76.03
76. 06 03954 I MAGI NG CENTER	0. 090629				76.04
76. 07 03955 BREAST DI AGNOSTI C CENTER	0. 464873				76.07
OUTPATIENT SERVICE COST CENTERS	0.404073				/0.0/
90. 00 09000 CLINIC	0.000000				90.00
90. 01 04950 I NFUSI ON CENTER	0. 501677				90.01
90. 26 04975 SPI NE CENTER	0. 724860				90.26
91. 00 09100 EMERGENCY	0. 119518				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 824335				92.00
SPECIAL PURPOSE COST CENTERS	01 02 1000				1 12:00
113. 00 11300 I NTEREST EXPENSE					113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF					114.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems COMM	IUNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA REDUCTIONS FOR MEDICAID ONLY	TIOS NET OF	Provider CC		Period: From 01/01/2022 To 12/31/2022	Worksheet C Part II Date/Time Pre 5/25/2023 11:	pared: 31 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost	Operating Cos	st Capital	Operating Cost	
		(Wkst. B, Part			Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS				-	-	
50. 00 05000 OPERATI NG ROOM	37, 161, 816				0	50.00
51.00 05100 RECOVERY ROOM	8, 697, 203				0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	12, 411, 240		11, 400, 16		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 846, 379		8,055,30		0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	5, 298, 723				0	55.00
57.00 05700 CT SCAN	3, 797, 772		3, 513, 01		0	57.00
58. 00 05800 MRI	3, 447, 982		2, 762, 38		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	214, 012	4, 021	209, 99		0	59.00
60. 00 06000 LABORATORY	18, 603, 685	480, 558	18, 123, 12	27 0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	933, 338	27, 856	905,48	32 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	9, 945, 535	599, 670	9, 345, 86	5 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	10, 392, 271	1, 323, 646	9, 068, 62	25 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	2, 985, 468	97, 085	2, 888, 38	33 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	557, 571	18, 056	539, 51		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	663, 291	19, 276	644, 01		0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	3, 553, 790		3, 155, 96	-	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	26, 328, 501	1, 382, 519	24, 945, 98		0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	17, 343, 425				0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	30, 665, 498		29, 536, 77		0	73.00
73. 01 07301 SPECIALTY PHARMACY	00,000,470	1, 120, 720	27, 550, 71	0 0	0	73.00
74. 00 07400 RENAL DI ALYSI S	1, 749, 749	-	1, 714, 09		0	74.00
76.00 03330 ENDOSCOPY	5, 079, 208		4, 448, 26		0	76.00
76.01 03950 OTHER ANCI LLARY SERVICE COST CENTERS	5, 079, 208	030, 945	4, 440, 20	0 0	0	76.00
		-		0 0	0	
76. 02 03951 OTHER ANCI LLARY SERVICE COST CENTERS 76. 03 03952 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0 0		76.02
	0	Ű	1 707 //	-	0	
76.04 03953 WOUND CARE	1,887,069		1, 707, 69		0	76.04
76.06 03954 I MAGI NG CENTER	5, 690, 388		4, 658, 33		0	76.06
76. 07 03955 BREAST DI AGNOSTI C CENTER	14, 721, 571	556, 095	14, 165, 47	76 0	0	76.07
OUTPATIENT SERVICE COST CENTERS					0	00.00
90. 00 09000 CLINIC	0	-		0 0	0	90.00
90. 01 04950 INFUSION CENTER	292, 052		202, 91		0	90.01
90. 26 04975 SPI NE CENTER	350, 928		346, 75		0	90.26
91.00 09100 EMERGENCY	24, 462, 480		23, 257, 27		0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	14, 401, 607	1, 040, 084	13, 361, 52	23 0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	070 100 5		050 171 -	-	-	114.00
200.00 Subtotal (sum of lines 50 thru 199)	270, 482, 552					200.00
201.00 Less Observation Beds	14, 401, 607					201.00
202.00 Total (line 200 minus line 201)	256, 080, 945	19, 271, 422	236, 809, 52	23 0	0	202.00

	TION OF OUTPATIENT SERVICE COST TO CHARGE RA	ATIOS NET OF	Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet C Part II Date/Time Prepa 5/25/2023 11:31	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and	(Worksheet C,	Cost to Char	ge		
			Part I, column		6		
		Reduction	8)	/ col. 7)			
		6.00	7.00	8.00			
	NCI LLARY SERVI CE COST CENTERS	1	I	1			
	05000 OPERATING ROOM	37, 161, 816					50.00
	05100 RECOVERY ROOM	8, 697, 203					51.00
	05200 DELIVERY ROOM & LABOR ROOM	12, 411, 240					52.0
	05400 RADI OLOGY-DI AGNOSTI C	8, 846, 379					54.00
	05500 RADI OLOGY-THERAPEUTI C	5, 298, 723				Į	55.00
	05700 CT SCAN	3, 797, 772	95, 699, 114	0. 0396	85		57.0
58.00 C	05800 MRI	3, 447, 982	30, 954, 241	0. 1113	90	1	58.0
59.00 C	05900 CARDI AC CATHETERI ZATI ON	214, 012	4, 529, 880	0. 0472	45	Į	59.0
50.00 C	06000 LABORATORY	18, 603, 685	104, 586, 078	0. 1778	79		60.0
64.00 C	06400 I NTRAVENOUS THERAPY	933, 338	1, 525, 783	0. 6117	11		64.0
5. 00 C	06500 RESPI RATORY THERAPY	9, 945, 535	40, 424, 116	0. 2460	30		65.0
6. 00 C	06600 PHYSI CAL THERAPY	10, 392, 271	26, 650, 403	0. 3899	48		66.0
7. 00 C	06700 OCCUPATI ONAL THERAPY	2, 985, 468					67.0
	06800 SPEECH PATHOLOGY	557, 571					68.0
	06900 ELECTROCARDI OLOGY	663, 291					69.0
	07000 ELECTROENCEPHALOGRAPHY	3, 553, 790					70.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	26, 328, 501					71.0
	7200 IMPL. DEV. CHARGED TO PATIENTS	17, 343, 425					72.0
	7300 DRUGS CHARGED TO PATIENTS	30, 665, 498					73.0
	07301 SPECIALTY PHARMACY	0					73.0
	07400 RENAL DI ALYSI S	1, 749, 749	-				74.0
	3330 ENDOSCOPY	5, 079, 208					76.0
	3350 OTHER ANCILLARY SERVICE COST CENTERS	5, 079, 208					76.0
	3951 OTHER ANCILLARY SERVICE COST CENTERS	0	-				76.0
		0					76.0
	03952 OTHER ANCILLARY SERVICE COST CENTERS						
	03953 WOUND CARE	1,887,069					76.0
	03954 I MAGI NG CENTER	5, 690, 388					76.0
	03955 BREAST DI AGNOSTI C CENTER	14, 721, 571	31, 667, 909	0.4648	/3		76. C
	DUTPATIENT SERVICE COST CENTERS			0.0000	20		~~ ~
		0					90.0
	04950 I NFUSI ON CENTER	292, 052					90.0
	04975 SPI NE CENTER	350, 928					90.2
	09100 EMERGENCY	24, 462, 480					91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART	14, 401, 607	17, 470, 568	0.8243	35		92.0
	PECIAL PURPOSE COST CENTERS			1			40.5
	1300 INTEREST EXPENSE						113.0
	1400 UTI LI ZATI ON REVI EW-SNF						114.0
200.00	Subtotal (sum of lines 50 thru 199)		1, 376, 775, 874				200. 0
201.00	Less Observation Beds	14, 401, 607					201.00
202.00	Total (line 200 minus line 201)	256, 080, 945	1, 376, 775, 874			20	202.0

Health Financial Systems	COMMUNI TY HOSPI TAL	OF INDIANA, I	NC.	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE	CAPITAL COSTS	Provider C		Period: From 01/01/2022 To 12/31/2022		pared: 31 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTER	RS					
30. 00 ADULTS & PEDIATRICS	8, 499, 115	0	8, 499, 11	5 73, 422	115.76	30.00
31.00 INTENSIVE CARE UNIT	946, 448		946, 44	B 7, 027	134.69	31.00
35.00 NEONATAL INTENSIVE CARE UNIT	1, 394, 920		1, 394, 920	0 13, 571	102.79	35.00
40.00 SUBPROVIDER - IPF	266, 552	0	266, 55	2 4, 452	59.87	40.00
43.00 NURSERY	471, 226		471, 22	6 7, 614	61.89	43.00
200.00 Total (lines 30 through 199)	11, 578, 261		11, 578, 26	1 106, 086		200.00
Cost Center Description	I npati ent	Inpati 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	15, 418	1, 784, 788				30.00
31.00 INTENSIVE CARE UNIT	1, 643	221, 296				31.00
35.00 NEONATAL INTENSIVE CARE UNIT	0	0				35.00
40.00 SUBPROVIDER - IPF	1, 708	102, 258				40.00
43.00 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	18, 769	2, 108, 342	2			200. 00

		UNI TY HOSPI TAL			In Lie	u of Form CMS-2	2552-10
APPORTI ONM	IENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0169	Period:	Worksheet D	
					From 01/01/2022	Part II	
					To 12/31/2022	Date/Time Pre 5/25/2023 11:	pared:
			T: +1 o	× XVIII	Hospi tal	972572023 TT: PPS	31 200
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
	cost center bescription			to Charges			
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)	2.00	2.00	4.00	E 00	
4101		1.00	2.00	3.00	4.00	5.00	
	LLARY SERVICE COST CENTERS	E 440.054		0.0400		005.04/	
	DO OPERATING ROOM	5, 143, 354				805, 916	•
	DO RECOVERY ROOM	528, 163				61, 896	
	DO DELIVERY ROOM & LABOR ROOM	1, 011, 071				0	
	DO RADI OLOGY-DI AGNOSTI C	791, 077	44, 871, 365			59, 498	•
	DO RADI OLOGY-THERAPEUTI C	704, 728				82, 719	55.00
57.00 0570	DO CT SCAN	284, 755	95, 699, 114	0.0029	76 9, 706, 158	28, 886	57.00
58.00 0580	DO MRI	685, 602	30, 954, 241	0. 0221	1, 963, 154	43, 482	58.00
59.00 0590	DO CARDI AC CATHETERI ZATI ON	4, 021	4, 529, 880	0.0008	38 1, 365, 601	1, 213	59.00
	DO LABORATORY	480, 558	104, 586, 078	0.0045	95 15, 669, 794	72, 003	60.00
64.00 0640	DO INTRAVENOUS THERAPY	27,856	1, 525, 783	0. 0182	57 280, 789	5, 126	64.00
65.00 0650	DO RESPI RATORY THERAPY	599, 670			7, 431, 545	110, 240	
	DO PHYSI CAL THERAPY	1, 323, 646					•
	DO OCCUPATI ONAL THERAPY	97,085					
	DO SPEECH PATHOLOGY	18,056				2,964	•
	DO ELECTROCARDI OLOGY	19, 276				4, 428	•
	DO ELECTROENCEPHALOGRAPHY	397,830					
	DO MEDICAL SUPPLIES CHARGED TO PATIENT	1, 382, 519				150, 437	•
	DO I MPL. DEV. CHARGED TO PATIENTS	910, 794				201, 917	
	DO DRUGS CHARGED TO PATIENTS	1, 128, 720					•
	DI SPECIALTY PHARMACY	1, 120, 720				192, 545	•
	DO RENAL DIALYSIS	-	-				74.00
1		35, 652					
		630, 945					
	50 OTHER ANCILLARY SERVICE COST CENTERS	0				0	
	51 OTHER ANCI LLARY SERVICE COST CENTERS	0	-			0	
	52 OTHER ANCILLARY SERVICE COST CENTERS	0	-	0.0000		0	
	53 WOUND CARE	179, 377		0. 0302		9, 505	
	54 I MAGI NG CENTER	1, 032, 056				633	•
	55 BREAST DIAGNOSTIC CENTER	556, 095	31, 667, 909	0.0175	50 0	0	76.07
OUTF	PATIENT SERVICE COST CENTERS						
	DO CLINIC	0	0	0.0000	0 00	0	90.00
90.01 0495	50 INFUSION CENTER	89, 137	582, 151	0. 1531	17 0	0	90.01
90.26 0497	75 SPINE CENTER	4, 175	484, 132	0. 00863	24 0	0	90.26
91.00 0910	DO EMERGENCY	1, 205, 204	204, 675, 480	0.0058	38 14, 569, 900	85, 788	91.00
92.00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART	1,040,084	17, 470, 568	0. 0595	1, 101, 311	65, 564	92.00

Health Financial Systems	COMMUNI TY HOSPI TAL	OF INDIANA IN	NC.	Inlie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTH		S Provider C	CN: 15-0169 F F T	veriod: rom 01/01/2022 o 12/31/2022	Worksheet D Part III Date/Time Pre 5/25/2023 11:	pared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	20	2.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 35. 00 02060 NEONATAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF 43. 00 04300 NURSERY 200. 00 Total (lines 30 through 199)	0 0 0 0 0 0					31.00 35.00 40.00
Cost Center Description		Total Costs (sum of cols. 1 through 3, minus col. 4)	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
INFAILENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 31.00 03100 INTENSI VE CARE UNI T 35.00 02060 NEONATAL INTENSI VE CARE UNI T 40.00 04000 SUBPROVI DER - I PF 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0	0 0 0 0 0 0	7, 027 13, 571 4, 452 7, 614	0.00 0.00 0.00 0.00	0	31.00 35.00 40.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		100, 000	1	18, 787	200.00
INFAILENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDI ATRICS 31.00 03100 INTENSI VE CARE UNIT 35.00 02060 NEONATAL INTENSI VE CARE UNIT 40.00 04000 SUBPROVI DER - IPF 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0 0 0 0 0 0					30. 00 31. 00 35. 00 40. 00 43. 00 200. 00

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	ERVICE OTHER PASS	6 Provider C	CN: 15-0169	Period: From 01/01/2022	Worksheet D 2 Part IV	
HROUGH COSTS				To 12/31/2022	2 Date/Time Pre	pared
					5/25/2023 11:	31 am
Cost Center Description	Non Physician	Nursing	XVIII Nursing	Hospital	PPS Allied Health	
cost center bescription	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown	i i ogi am	Adjustments		
	0001	Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
0.00 05000 OPERATING ROOM	0	0		0 (0 0	50. C
1.00 05100 RECOVERY ROOM	0	0		0 (0 0	51.C
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 (0 0	52. C
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 (0 0	54. C
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 (0 0	55. C
7.00 05700 CT SCAN	0	0		0 (0 0	57. C
8. 00 05800 MRI	0	0		0 (0 0	58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 (0 0	59.0
0. 00 06000 LABORATORY	0	0		0 (0 0	60.0
4.00 06400 INTRAVENOUS THERAPY	0	0		0 (0 0	64.0
5. 00 06500 RESPI RATORY THERAPY	0	0		0 (0 0	65.0
6. 00 06600 PHYSI CAL THERAPY	0	0		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	68.0
9. 00 06900 ELECTROCARDI OLOGY	0	0		0 (0 0	69.0
0. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 (0 0	70.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 (0 0	71. (
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 (0 0	72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 (0 0	73.0
3. 01 07301 SPECIALTY PHARMACY	0	0		0 (0 0	73.0
4. 00 07400 RENAL DIALYSIS	0	0		0 (0 0	74.
6. 00 03330 ENDOSCOPY	0	0		0 (0 0	76.
6.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 (0 0	76.
6.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 (0 0	76.0
6.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 (0 0	76.0
6.04 03953 WOUND CARE	0	0		0 (0 0	76.0
6.06 03954 I MAGI NG CENTER	0	0		0 (0 0	76.0
6. 07 03955 BREAST DI AGNOSTI C CENTER	0	0		0 (0 0	76.0
OUTPATIENT SERVICE COST CENTERS						
D. 00 09000 CLINIC	0	0		0 (0 0	90. (
D. 01 04950 INFUSION CENTER	0	0		0 (0 0	90.
D. 26 04975 SPI NE CENTER	0	0		0 (0 0	90.
1.00 09100 EMERGENCY	0	0		0 (0 0	91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.
00.00 Total (lines 50 through 199)	0	0		0	0 0	200. (

APPORT IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CON: 15-0169 Period: To 12/31/2022 Worksheet D Part I W Date/Time Prepared: 5/2/2027 THROUGH COSTS TITLE XVIII Hospital For 1/2/31/2022 Worksheet D Part I W Date/Time Prepared: 5/2/2027 Worksheet D Part I W Date/Time Prepared: 5/2/2027 Cost Center Description AII Other Education Cost 4/3 Title XVIII Hospital For 0/2/3/2022 Ratio of Cost	Health Financial Systems COM	MUNITY HOSPITAL	OF INDIANA, IN	NC.	In Lie	eu of Form CMS-:	2552-10
And Terminal Status To 12/31/2022 Date of Time Prepared: 5/25/2023 11:31 and 5/25/2023 11:31		RVICE OTHER PASS	S Provider C				
Initial cost Title XVIII Hospital PPS Cost Center Description AI 1 Other Medical Education Cost Total Cost (sum of cols. (sum of cols. (see instructions)) Total Charges (col. 5 + col. (see instructions)) MCI LLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 05000 (DFEATI NG ROOM (see instructions)) 0 0 0 266.293.567 0.0000000 50.00 05000 (DFEATI NG ROOM (see Cols. (see cols.)) 0 0 24.822.878 0.0000000 50.00 05000 CFT SCAN 0 0 0 44.97.365 0.000000 55.00 05000 MRI 0 0 0 44.822.878 0.000000 55.00 05000 MRI 0 0 0 0 44.822.878 0.000000 55.00 06000 CARDIACCATHERERIZATION 0 0 0 0 57.25.783 0.000000 56.00 06000 DESP	THROUGH COSTS					Date/Time Pre	pared:
Cost Center Description All Other Medication Cost Education Cost Total (sum of cols. education Cost (sum of cols. education Cost Total (sum of cols. education (sum of cols. education) Total (sum of cols. education) Cols. (sum of cols. education) Total (sum of cols. education) Cols. (sum of cols. (sum of cols. education) Cols. (sum of cols. (sum of cols. education) Cols. (sum of cols. (sum						5/25/2023 11:	31 am
Medical Education Costi 4) (sum of cols, 4) Outpatient Costi (sum of cols, 2, 3, and 4) (From Wkst, C, elistructions) (to Charges) (see instructions) MOLLLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 0.00 05000 DPERATINE ROOM 0 0 266, 293, 567 0.0000000 50.00 5.00 05000 DPERATINE ROOM 0 0 266, 293, 567 0.0000000 50.00 5.00 05000 DPERATINE ROOM 0 0 248, 197, 591 0.000000 50.00 50.00 05400 RADILOGY-THERAPEUTIC 0 0 0 44, 871, 365 0.0000000 55.00 50.00 05700 CT SCAN 0 0 0 14, 560, 988.0 0.000000 56.00 50.00 05900 CABDIA CATHETERIZATION 0 0 1, 557, 783 0.0000000 56.00 50.00 05600 CHEPINATERAPEUTIC 0 0 1, 557, 783 0.000000 56.00 50.00 05900 CABDIA CATHETERIZATION 0 0 1, 557, 783 0.000000 66.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
Education Cost 1, 2, 3, and 4) Cost (sum of cost (s. 2, 3, and 4) Part 1, col. Col. 5, e col. 7) (see Col. 5, e col. 7) (see 50.00 05000 (DERATING ROOM 0 0 0 0 8, 197, 591 0.000000 51.00 51.00 51.00 0.0000000 51.00 51.00 0.0000000 51.00 51.00 0.00000000000000000000000000000000000	Cost Center Description						
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ANCI LLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 50.00 05000 (PERATING ROM 0 0 266,293,567 0.000000 (St.000 51.00 51.00 05000 (PECOVERY ROM 0 0 266,293,567 0.000000 (St.000 51.00 52.00 05200 (PEL) VERY ROM 0 0 24.832,878 0.000000 (St.000 52.00 54.00 05500 (RAI) OLCY-THERAPEUTI C 0 0 0 44.871,356 0.000000 (St.000 55.00 55.00 05500 (RAI) OLCY-THERAPEUTI C 0 0 0 95,699,114 0.000000 (St.000 57.00 59.00 05500 (RAI) OLCY-THERAPEUTI C 0 0 0 44.871,356 0.000000 (St.000 57.00 59.00 05500 (RAI) CLACTHETERIZATI ON 0 0 0 44.871,856 0.000000 (St.000 57.00 50.00 06600 (RESPI RATORY 0 0 0 0.424,11 0.000000 (St.0000 57.00 50.00 06600 (RESPI RATORY 0 0		Education Cost					
ANCI LLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 NOT LLARY SERVICE COST CENTERS 0 0 0 0.00 0 266, 293, 567 0.000000 51.00 51.00 05100 (PECATI NR ROM 0 0 0 24, 882, 878 0.000000 51.00 52.00 05200 (PELI VERY ROM 0 0 0 24, 882, 878 0.000000 51.00 52.00 05200 (PELI VERY ROM 0 0 0 24, 882, 878 0.000000 51.00 55.00 05500 (PELI VERY ROM 0 0 0 51.665, 440 0.000000 55.00 57.00 05500 (RI) 0 0 0 30, 954, 241 0.000000 57.00 58.00 05600 MRI 0 0 0 1, 825, 838 0.000000 57.00 60.00 06600 LABORATORY 0 0 0 1, 825, 788 0.0000000 67.00 65.00 REATORY THERAPY 0 0 0 1,			4)		8)		
VALULARY SERVICE COST CENTERS V 50.00 05000 (DPEATING ROM 0 0 0 0.000000 51.00 05100 081.07.00 68.00 7.00 8.00 51.00 51.00 05100 RECOVERY ROM 0 0 0 48.197.591 0.000000 51.00 52.00 05200 DELI VERY ROM & LABOR ROM 0 0 0 44.817.365 0.000000 52.00 55.00 05500 RADI LOCY-THERAPEUTIC 0 0 0 44.877.365 0.000000 55.00 50.00 05500 CARDI AC CATHETERIZATION 0 0 0 30.954.241 0.000000 58.00 59.00 06500 LABOR ACORY 0 0 0 14.557.833 0.000000 64.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 24.650.433 0.000000 65.00 66.00 06500 RESPI RATORY THERAPY 0 0 24.650.433 0.000000 64.00 67.00 0.0700 CUPATIONAL THERAPY <td< td=""><td></td><td></td><td></td><td>and 4)</td><td></td><td></td><td></td></td<>				and 4)			
ANCI LLARY SERVICE COST CENTERS 0 <t< td=""><td></td><td>4.00</td><td>5.00</td><td>6.00</td><td>7 00</td><td></td><td></td></t<>		4.00	5.00	6.00	7 00		
50. 00 050.00 050.00 0266.293.567 0.000000 50. 00 51. 00 05100 REOVERY ROM 0 0 48.197.591 0.000000 51. 00 52. 00 DELI VERY ROM 0 0 0 24.882.878 0.000000 54. 00 55. 00 DS500 (RADI 0LOGY-DI AGNOSTI C 0 0 0 14.871.365 0.000000 54. 00 55. 00 DS500 (RADI 0LOGY-DI AGNOSTI C 0 0 0 95.09 14.0 0.000000 55. 00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 56.07 80.0 0.000000 55.00 55.00 56.07 80.0 0.000000 55.00 56.07 80.0 0.000000 56.07 80.0 0.000000 58.00 80.000000 58.00 80.000 56.078 0.000000 59.00 64.00 14.856.078 0.000000 65.00 66.00 66.00 65.00 66.00 66.00	ANCILLARY SERVICE COST CENTERS	4.00	5.00	0.00	7.00	8.00	
51. 00 651.00 RECOVERY ROM 0 0 48. 197, 591 0. 000000 51. 00 52. 00 65200 DELIVERY ROM & LABOR ROM 0 0 24. 482, 878 0. 000000 52. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 44. 871, 365 0. 000000 54. 00 55. 00 OS500 CTSCAN 0 0 0 95. 699, 114 0. 000000 57. 00 58. 00 OS600 CARI AC CATHETERI ZATI ON 0 0 0 45. 29, 880 0. 000000 68. 00 60. 00 G6000 LABORATORY 0 0 0 14. 525, 783 0. 000000 64. 00 66. 00 PKSPI RATORY THERAPY 0 0 0 42. 4116 0. 000000 65. 00 66. 00 PKSPI RATORY THERAPY 0 0 0 28. 589, 242 0.000000 67. 00 67. 00 G6500 RESPI RATORY THERAPY 0 0 0 28. 59, 242 0.000000 <td< td=""><td></td><td>0</td><td>0</td><td></td><td>0 266 293 567</td><td>0,00000</td><td>50 00</td></td<>		0	0		0 266 293 567	0,00000	50 00
52.00 OS200 DEL IVERY ROM & LABOR ROM 0 0 24.82, 878 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 44.871, 365 0.000000 54.00 55.00 DS500 RADI OLOGY-THERAPEUTI C 0 0 51.655, 440 0.000000 55.00 50.00 DS500 RADI OLOGY-THERAPEUTI C 0 0 0,95,97,91 0.000000 55.00 50.00 DS500 RADI AC CATHETERI ZATI ON 0 0 0 4,529,880 0.000000 64.00 64.00 D6500 RADRATORY 0 0 0 1,525,783 0.000000 64.00 65.00 06500 PHERAPY 0 0 0 4,424,116 0.000000 65.00 66.00 06600 PHTOLOGY 0 0 2,401.031 0.000000 68.00 69.00 OS700 CLEPATIONAL, THERAPY 0 0 1,136,874 0.00000 69.00 70.00 OT			-				•
54.00 OS400 RADIOLOGY-DIAGNOSTLC O 44.871.365 0.000000 54.00 55.00 05500 RADIOLOGY-THERAPEUTIC O O 51.00 50.00 51.00 50.00 51.00 51.00 50.00 51.00 52.00 52.00 52.00 60.00 104.586.078 0.000000 59.00 50.00 50.00 50.00 50.00 50.00 60.00 64.00 64.00 64.00 64.00 64.00 65.00			0				•
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57.00 CT SCAN 0 0 95,699,114 0.000000 57.00 58.00 05800 MRI 0 0 30,954,241 0.000000 58.00 59.00 65900 CARDIAC CATHETERIZATION 0 0 30,954,241 0.000000 58.00 60.00 0 044,529,880 0.000000 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 66.00 0 15.52,783 0.000000 65.00 65.00 0.000000 65.00 65.00 0.000000 65.00 66.00 66.00 0 2.6650,403 0.000000 66.00 66.00 66.00 66.00 68.09 59.242 0.000000 67.00 68.09 59.00 68.00 69.00 0 0 11.136.874 0.000000 68.00 69.00 70.00 11.136.874 0.000000 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 <td< td=""><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td>•</td></td<>		0	0				•
58.00 05900 MRI 0 0 30.95, 241 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 4, 529, 880 0.000000 59.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 14, 586, 078 0.000000 64.00 64.00 06500 RESPI RATORY THERAPY 0 0 0 40, 424, 116 0.000000 65.00 65.00 06500 PHYSI CAL THERAPY 0 0 0 26, 650, 403 0.000000 67.00 67.00 06700 CCUPATI ONAL THERAPY 0 0 0 2, 401, 031 0.000000 68.00 68.00 06900 ELECTROCARDI OLOGY 0 0 11, 136, 874 0.000000 70.00 70.00 07000 ELECTROCARDI OLOGY 0 0 11, 136, 874 0.000000 71.00 71.00 07100 MEL'S LECTROCARDI OLOGY 0 0 11, 136, 874 0.000000 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 121, 463,		0	0				
59.00 CARDI AC CATHETERI ZATI ON 0 0 4, 529, 880 0.000000 59.00 60.00 CABDRATORY 0 0 0 104, 586, 078 0.000000 64.00 64.00 O6400 INTRAVENOUS THERAPY 0 0 104, 586, 078 0.000000 64.00 65.00 O6500 RESPI RATORY THERAPY 0 0 40, 424, 116 0.000000 65.00 66.00 O6700 OCUPATI ONAL THERAPY 0 0 26, 650, 403 0.000000 67.00 67.00 O6700 OCUPATI ONAL THERAPY 0 0 0 26, 650, 403 0.000000 68.00 69.00 O6900 ELECTROCARDI OLOGY 0 0 11, 136, 874 0.000000 70.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 45, 525, 634 0.000000 72.00 73.00 ORUGS CHARGED TO PATI ENTS 0 0 44, 985, 128 0.000000 73.00 73.01 O7300 RUGS CHARG		0	0				•
60.00 06000 LABORATORY 0 0 104, 586, 078 0.000000 60.00 64.00 04400 INTRAVENOUS THERAPY 0 0 1,525, 783 0.000000 64.00 65.00 06500 RSSP RATORY THERAPY 0 0 0 44.00 0.424, 116 0.000000 65.00 66.00 06600 PHYSI CAL. THERAPY 0 0 0 26, 650, 403 0.000000 66.00 67.00 06700 0CUPATI ONAL THERAPY 0 0 0 24, 401, 031 0.000000 68.00 69.00 06800 SPEECH PATHOLOGY 0 0 11, 136, 874 0.000000 69.00 71.00 07100 INPL. DEV. CHARGED TO PATI ENT 0 0 0 15, 178, 797 0.000000 71.00 72.00 07200 INPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0.00000 73.00 73.01 07301 SPECI ALTY PHARIMACY 0 0 0 0 <		0	0				
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66.00 06600 PHYSI CAL THERAPY 0 0 26,650,403 0.000000 66.00 67.00 06700 0CCUPATI 0NAL THERAPY 0 0 0 8,289,242 0.000000 67.00 68.00 06800 SPEECK PATHOLOGY 0 0 0 2,401,031 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 11,136,874 0.000000 69.00 70.00 O7000 ELECTROEACEPHALOGRAPHY 0 0 0 15,178,797 0.000000 70.00 71.00 07200 IMPL AEV. CHARGED TO PATI ENTS 0 0 45,025,034 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 45,025,034 0.000000 73.00 73.01 07301 SPECI ALTY PHARMACY 0 0 0 45,025,034 0.000000 73.00 73.01 07400 RENAL DI ALTY SIS 0 0 0 0.000000 74.00 76.00 03305 ENDSCOPY 0 0 0 0		0	0				•
67.00 06700 0CCUPATIONAL THERAPY 0 0 8,289,242 0.000000 67.00 68.00 06800 SPECH PATHOLOGY 0 0 2,401,031 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 11,136,874 0.000000 70.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 15,178,797 0.000000 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 45,025,034 0.000000 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 12,463,382 0.000000 73.00 73.01 07301 SPECIALTY PHARMACY 0 0 0 0.000000 74.00 74.00 07400 RENAL DIALYSIS 0 0 0 0.000000 74.00 76.01 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.01 76.04 03953 O		0	0				•
68.00 06800 SPEECH PATHOLOGY 0 0 2,401,031 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 11,136,874 0.000000 69.00 70.00 OTOO ELECTROCARDI OLOGY 0 0 11,136,874 0.000000 69.00 71.00 OTIO MELCAL SUPPLIES CHARGED TO PATI ENT 0 0 70.093,476 0.000000 71.00 72.00 O7200 INPL. DEV. CHARGED TO PATI ENTS 0 0 45,025,034 0.000000 73.00 73.01 O7300 DRUGS CHARGED TO PATI ENTS 0 0 0.000000 73.01 74.00 O7400 RENAL DI ALYSI S 0 0 0.000000 74.00 76.01 03330 ENDSCOPY 0 0 0.000000 76.01 76.02 03951 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0.000000 76.02 76.04 03952 OTHER ANCI LLARY SERVICE COST CENTERS 0 0		0	0				•
69.00 06900 ELECTROCARDIOLOGY 0 0 11, 136, 874 0.000000 69.00 70.00 07000 ELECTROCARDIOLOGY 0 0 15, 178, 797 0.000000 70.00 71.00 07000 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 70.00, 93, 476 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 45, 025, 034 0.000000 73.00 73.00 07301 DRUGS CHARGED TO PATIENTS 0 0 0 0.000000 73.00 73.01 07301 SPECIALTY PHARMACY 0 0 0 0.000000 74.00 74.00 ORANO RENAL DI ALYSI S 0 0 0 4.985, 128 0.000000 76.01 76.00 03301 ENDSCOPY 0 0 0 0.000000 76.02 76.01 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.02 76.04 03952 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.02		0	0				•
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 15, 178, 797 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 70.093, 476 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 45, 025, 034 0.000000 73.00 73.01 07300 DRUGS CHARGED TO PATIENTS 0 0 121, 463, 382 0.000000 73.01 74.00 07400 RENAL DI ALYSI S 0 0 0 0.000000 74.00 76.00 03301 ENDOSCOPY 0 0 0 0.000000 76.00 76.01 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.00 76.02 03951 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.02 76.04 03952 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.02 76.05 03954 IMAGI NG CENTER 0 0 0 0.000000 76.04 <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td>•</td>		0	0				•
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 70,093,476 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 45,025,034 0.000000 72.00 73.00 07301 SPECIALTY PHARMACY 0 0 0 0.000000 73.01 74.00 07400 RENAL DI ALYSI S 0 0 0 0.000000 73.01 74.00 07400 RENAL DI ALYSI S 0 0 0 0.000000 74.00 76.00 03330 ENDOSCOPY 0 0 0 0.000000 76.00 76.01 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.02 76.02 03951 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.02 76.04 03952 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.03 76.04 03953 WOUND CARE 0 0 0 0 0.000000 76.04 76.0		0	0				•
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 121,463,382 0.00000 73.00 73.01 07301 SPECIALTY PHARMACY 0 0 0 0.00000 73.01 74.00 07400 RENAL DI ALYSI S 0 0 0 4.985,128 0.00000 74.00 76.00 03330 ENDOSCOPY 0 0 0 34,320,169 0.000000 76.00 76.01 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.00 76.02 03951 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.01 76.04 03952 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.02 76.04 03953 WOUND CARE 0 0 0 0.000000 76.03 76.04 03954 IMAGI NG CENTER 0 0 0 0.000000 76.04 76.07 03955 BREAST DI AGNOSTIC CENTER 0 0 0 0.000000 76.07 <t< td=""><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td>•</td></t<>		0	0				•
73.01 07301 SPECIALTY PHARMACY 0 0 0 0.000000 73.01 74.00 07400 RENAL DI ALYSI S 0 0 0 4,985,128 0.000000 74.00 76.00 03330 ENDOSCOPY 0 0 0 34,320,169 0.000000 76.00 76.01 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.01 76.02 03951 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.02 76.03 03952 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.02 76.03 03952 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.03 76.04 03953 WOUND CARE 0 0 0 0.000000 76.03 76.04 03954 IMAGI NG CENTER 0 0 0 0.000000 76.04 76.05 03955 BREAST DI AGNOSTI C CENTER 0 0 0 0.000000 76.07	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 45, 025, 034	0.000000	72.00
74.00 07400 RENAL DI ALYSI S 0 0 4, 985, 128 0.000000 74.00 76.00 0330 ENDOSCOPY 0 0 0 34, 320, 169 0.000000 76.00 76.01 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.01 76.02 03951 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.02 76.03 03952 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.03 76.04 03953 WOUND CARE 0 0 0 0.000000 76.03 76.04 03954 IMAGI NG CENTER 0 0 0 62, 787, 404 0.000000 76.06 76.04 03955 BREAST DI AGNOSTI C CENTER 0 0 0 31, 667, 909 0.000000 76.07 70.00 09000 CLI NI C 0 0 0 0 0.000000 76.07 70.01 04950 I INFUSI ON CENTER 0 0 0 0.000000 90.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 121, 463, 382	0. 000000	73.00
76.00 03330 ENDOSCOPY 0 0 34, 320, 169 0.000000 76.00 76.01 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.01 76.02 03951 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.02 76.03 03952 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.03 76.04 03953 WOUND CARE 0 0 0 0.000000 76.03 76.04 03954 I MAGI NG CENTER 0 0 0 0.000000 76.04 76.06 03955 BREAST DI AGNOSTI C CENTER 0 0 0 0.000000 76.04 76.07 03955 BREAST DI AGNOSTI C CENTER 0 0 0 31, 667, 909 0.000000 76.07 70.00 090000 CLI NI C 0 0 0 0 0.000000 76.07 90.00 090000 CLI NI C	73.01 07301 SPECIALTY PHARMACY	0	0)	0 0	0.000000	73.01
76.01 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.01 76.02 03951 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.02 76.03 03952 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.03 76.04 03953 WOUND CARE 0 0 0 0.000000 76.04 76.04 03953 WOUND CARE 0 0 0 0.000000 76.04 76.04 03953 WOUND CARE 0 0 0 0.000000 76.04 76.05 03954 IMAGI NG CENTER 0 0 0 62,787,404 0.000000 76.06 76.07 03955 BREAST DI AGNOSTI C CENTER 0 0 0 31,667,909 0.000000 76.07 0 0 0 0 0 0 0 0.000000 76.07 0 0 0 0 0 0 0 0 0.000000 76.07 0 <	74.00 07400 RENAL DI ALYSI S	0	0		0 4, 985, 128	0.000000	74.00
76.02 03951 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.02 76.03 03952 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.03 76.04 03953 WOUND CARE 0 0 0 0.000000 76.04 76.04 03953 WOUND CARE 0 0 0 5,934,641 0.000000 76.04 76.06 03954 IMAGI NG CENTER 0 0 0 62,787,404 0.000000 76.06 76.07 03955 BREAST DI AGNOSTI C CENTER 0 0 0 31,667,909 0.000000 76.07 0 0 0 0 0 0 0.000000 76.07 0 0 0 0 0 0 0.000000 76.07 0 0 0 0 0 0 0.000000 76.07 0 0 0 0 0 0 0.000000 76.07 0 0 0 0 0 0 <td< td=""><td>76.00 03330 ENDOSCOPY</td><td>0</td><td>0</td><td></td><td>0 34, 320, 169</td><td>0.000000</td><td>76.00</td></td<>	76.00 03330 ENDOSCOPY	0	0		0 34, 320, 169	0.000000	76.00
76.03 03952 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0.000000 76.03 76.04 03953 WOUND CARE 0 0 0 5,934,641 0.000000 76.04 76.06 03954 IMAGI NG CENTER 0 0 0 62,787,404 0.000000 76.06 76.07 03955 BREAST DI AGNOSTI C CENTER 0 0 0 31,667,909 0.000000 76.07 0UTPATI ENT SERVI CE COST CENTERS 0 0 0 0.000000 76.07 76.07 90.00 09000 CLI NI C 0 0 0 0.00000 90.01 90.01 04950 INFUSION CENTER 0 0 0 0.00000 90.01 90.02 04955 SPI NE CENTER 0 0 0 0.00000 90.01 90.101 CENTER 0 0 0 0 0.00000 90.01 90.26 04975 SPI NE CENTER 0 0 0 204,675,480 0.000000 90.26 91.00 09100	76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0)	0 0	0.000000	76.01
76. 04 03953 WOUND CARE 0 0 5, 934, 641 0.00000 76. 04 76. 06 03954 I MAGI NG CENTER 0 0 0 62, 787, 404 0.000000 76. 06 76. 07 03955 BREAST DI AGNOSTI C CENTER 0 0 0 31, 667, 909 0.000000 76. 07 OUTPATI ENT SERVICE COST CENTER OUTO 0 0 0 0 0.000000 90. 00 90. 00 09000 CLI NI C 0 0 0 0.000000 90. 01 90. 01 04950 I NEUSI ON CENTER 0 0 0 582, 151 0.000000 90. 01 90. 26 04975 SPI NE CENTER 0 0 484, 132 0.000000 90. 26 91. 00 09100 EMERGENCY 0 0 204, 675, 480 0.000000 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 0 17, 470, 568 0.000000 92. 00	76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0)	0 0	0.000000	76.02
76.06 03954 I MAGI NG CENTER 0 0 62, 787, 404 0.00000 76.06 76.07 03955 BREAST DI AGNOSTI C CENTER 0 0 0 31, 667, 909 0.000000 76.06 70.00 OUTPATI ENT SERVICE COST CENTER 0 0 0 0.000000 76.07 70.00 OPODO CLINIC 0 0 0 0.000000 90.00 90.01 04950 INFUSION CENTER 0 0 0 90.01 90.26 04975 SPI NE CENTER 0 0 0 484, 132 0.000000 90.26 91.00 09100 EMERGENCY 0 0 0 204, 675, 480 0.000000 91.00 92.00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 17, 470, 568 0.000000 92.00	76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0.000000	76.03
76. 07 03955 BREAST DI AGNOSTI C CENTER 0 0 31, 667, 909 0.000000 76. 07 OUTPATI ENT SERVI CE COST CENTERS 0 0 0 0.000000 90. 00 90. 00 90. 00 0 0.000000 90. 01 90. 26 91. 00 91. 00 90. 26 90. 20 000000 91. 00 91. 00 90. 00 91. 00 92. 00 92.00 0BSERVATI 0N BEDS (NON-DI STI NCT PART 0 0 17, 470, 568 0.000000 92. 00	76.04 03953 WOUND CARE	0	0		0 5, 934, 641	0.000000	76.04
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 0.00 90.00 90.01 04950 INFUSION CENTER 0 0 0 582,151 0.00000 90.01 90.26 04975 SPINE CENTER 0 0 0 484,132 0.000000 90.26 91.00 09100 EMERGENCY 0 0 0 204,675,480 0.000000 91.00 92.00 0BSERVATI ON BEDS (NON-DI STINCT PART 0 0 17,470,568 0.000000 92.00		0	0		0 62, 787, 404	0.000000	76.06
90.00 09000 CLINIC 0 0 0 0.00 90.00 90.01 04950 INFUSION CENTER 0 0 0 582,151 0.000000 90.01 90.26 04975 SPINE CENTER 0 0 0 484,132 0.000000 90.26 91.00 09100 EMERGENCY 0 0 0 204,675,480 0.000000 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 17,470,568 0.000000 92.00		0	0		0 31, 667, 909	0.000000	76.07
90.01 04950 INFUSION CENTER 0 0 582,151 0.00000 90.01 90.26 04975 SPINE CENTER 0 0 0 484,132 0.00000 90.26 91.00 09100 EMERGENCY 0 0 0 204,675,480 0.00000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 17,470,568 0.000000 92.00		-1			_		
90. 26 04975 SPI NE CENTER 0 0 484, 132 0.00000 90. 26 91. 00 09100 EMERGENCY 0 0 0 204, 675, 480 0.000000 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 17, 470, 568 0.000000 92. 00							
91.00 09100 EMERGENCY 0 0 204, 675, 480 0.000000 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 17, 470, 568 0.000000 92.00							
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 17, 470, 568 0. 000000 92. 00		-	-				•
200.00 Iotal (lines 50 through 199) 0 0 0 1, 376, 775, 874 200.00							•
	200.00 Total (lines 50 through 199)	0	0	1	0 1, 376, 775, 874	l	200. 00

Health Financial Systems COM	MUNITY HOSPITAL C	DF_INDIANA, II	NC.	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0169	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2022	Part IV	norod.
				To 12/31/2022	Date/Time Pre 5/25/2023 11:	pared: 31 am
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.	5	Costs (col.		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	41, 724, 895		0 20, 834, 986	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	5, 648, 457		0 5, 393, 065	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, 374, 791		0 4, 278, 840	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	6,064,467		0 10, 374, 125	0	55.00
57.00 05700 CT SCAN	0. 000000	9, 706, 158		0 9, 284, 137		57.00
58. 00 05800 MRI	0.000000	1, 963, 154		0 6, 662, 806		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000	1, 365, 601		0 0		59.00
60. 00 06000 LABORATORY	0.000000	15, 669, 794		0 5, 629, 896	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	280, 789		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	7, 431, 545		0 224, 358		65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 535, 569		0 89, 343		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 245, 549		0 19, 457		67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	394, 147		0 6, 356		68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	2, 558, 307	1	0 323, 414		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	434, 580		0 2, 249, 726		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	7, 627, 091	1	0 5, 207, 013		71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	9, 981, 566		0 4, 837, 594		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0.000000	20, 719, 143		0 8, 501, 344		73.00
73. 01 07301 SPECIALTY PHARMACY	0. 000000	20, 717, 110	1	0 0		73.01
74. 00 07400 RENAL DIALYSIS	0, 000000	1, 408, 158		0 0	0	74.00
76. 00 03330 ENDOSCOPY	0. 000000	2, 509, 730		0 5, 927, 098	-	76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	2,007,700	1	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	76.03
76. 04 03953 WOUND CARE	0. 000000	314, 484		0 1, 212, 276		76.04
76. 06 03954 I MAGI NG CENTER	0. 000000	38, 541	1	0 13, 676, 361		76.04
76. 07 03955 BREAST DI AGNOSTI C CENTER	0. 000000	30, 341 C		0 2, 940, 559		76.07
OUTPATIENT SERVICE COST CENTERS	0.000000	0	1	2, 740, 337	0	/0.0/
90. 00 09000 CLINIC	0.000000	C		0 0	0	90.00
90. 01 04950 INFUSION CENTER	0.000000	0	1	0 211, 850		90.00
90. 26 04975 SPINE CENTER	0.000000	0		0 211, 850		90.26
90. 28 04975 SPINE CENTER 91. 00 09100 EMERGENCY	0.000000	14, 569, 900		0 16, 138, 959		90.28
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1, 101, 311		0 495, 476		91.00
200.00 Total (lines 50 through 199)	0.000000	157, 667, 727		0 124, 519, 039		200.00
	I I	137,007,727	I	0 124, 517, 039	1 0	1200. 00

APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Pre 5/25/2023 11:	pared: 31 am
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
Cost Center D	escription	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	
ANCILLARY SERVICE C					-		
50.00 05000 OPERATI NG ROO		0. 136656			0 0		•
51.00 05100 RECOVERY ROOM		0. 180449	5, 393, 065		0 0	973, 173	•
52.00 05200 DELIVERY ROOM		0. 498786	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI A		0. 197150			0 0	843, 573	•
55. 00 05500 RADI OLOGY-THE	RAPEUTI C	0. 102558			0 0	1, 063, 950	
57.00 05700 CT SCAN		0. 039685			0 0	368, 441	57.00
58.00 05800 MRI		0. 111390	6, 662, 806		0 0	742, 170	
59. 00 05900 CARDI AC CATHE	TERI ZATI ON	0. 047245	0		0 0	0	59.00
60. 00 06000 LABORATORY		0. 177879	5, 629, 896		0 0	1, 001, 440	
64.00 06400 INTRAVENOUS T	HERAPY	0. 611711	0		0 0	0	64.00
65. 00 06500 RESPI RATORY T	HERAPY	0. 246030	224, 358		0 0	55, 199	65.00
66. 00 06600 PHYSI CAL THER	APY	0. 387140	89, 343		0 0	34, 588	66.00
67.00 06700 0CCUPATI ONAL	THERAPY	0. 360162	19, 457		0 0	7, 008	67.00
68.00 06800 SPEECH PATHOL	OGY	0. 232221	6, 356		0 0	1, 476	68.00
69. 00 06900 ELECTROCARDI 0	LOGY	0. 059558	323, 414		0 0	19, 262	69.00
70.00 07000 ELECTROENCEPH	ALOGRAPHY	0. 234129	2, 249, 726		0 0	526, 726	70.00
71.00 07100 MEDICAL SUPPL	IES CHARGED TO PATIENT	0. 375620	5, 207, 013		0 0	1, 955, 858	71.00
72.00 07200 IMPL. DEV. CH	ARGED TO PATIENTS	0. 385195	4, 837, 594		0 0	1, 863, 417	72.00
73.00 07300 DRUGS CHARGED	TO PATIENTS	0. 252467	8, 501, 344		0 320, 409	2, 146, 309	73.00
73. 01 07301 SPECIALTY PHA	RMACY	0. 000000	0		0 0	0	73.01
74.00 07400 RENAL DIALYSI	S	0. 350994	0		0 0	0	74.00
76.00 03330 ENDOSCOPY		0. 147995	5, 927, 098		0 0	877, 181	76.00
76.01 03950 OTHER ANCILLA	RY SERVICE COST CENTERS	0. 000000	0		0 0	0	76.01
76.02 03951 OTHER ANCILLA	RY SERVICE COST CENTERS	0. 000000	0		0 0	0	76.02
76.03 03952 OTHER ANCILLA	RY SERVICE COST CENTERS	0. 000000	0		0 0	0	76.03
76.04 03953 WOUND CARE		0. 317975	1, 212, 276		0 0	385, 473	76.04
76.06 03954 I MAGI NG CENTE	R	0. 090629	13, 676, 361		0 0	1, 239, 475	76.06
76. 07 03955 BREAST DI AGNO	STIC CENTER	0. 464873	2, 940, 559		0 0	1, 366, 986	76.07
OUTPATIENT SERVICE	COST CENTERS						1
90. 00 09000 CLINIC		0. 000000	0		0 0	0	90.00
90.01 04950 INFUSION CENT	ER	0. 501677	211, 850		0 0	106, 280	90.01
90. 26 04975 SPINE CENTER		0. 724860	0		0 0	0	90.26
91.00 09100 EMERGENCY		0. 118644	16, 138, 959		0 0	1, 914, 791	91.00
92.00 09200 OBSERVATION B	EDS (NON-DISTINCT PART	0. 824335			0 0	408, 438	92.00
200.00 Subtotal (see	instructions)	1	124, 519, 039		0 320, 409	20, 748, 440	200.00
	ic Lab. Services-Program	1			0 0		201.00
Only Charges	3						
202.00 Net Charges (line 200 – line 201)		124, 519, 039	1	0 320, 409	20, 748, 440	1202 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	O VACCINE COST	Provider CCN	15-0169	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Pre 5/25/2023 11:	epared: 31 am
		Title X	VIII	Hospi tal	PPS	
	Cost	ts				
Cost Center Description	Subject To	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00				
ANCI LLARY SERVI CE COST CENTERS	0100	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
50. 00 05000 OPERATING ROOM	0	0				50.00
51. 00 05100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
57. 00 05700 CT SCAN	0	0				57.00
58. 00 05800 MRI	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
50. 00 06000 LABORATORY	0	0				60.00
54.00 06400 INTRAVENOUS THERAPY	0	0				64.00
55. 00 06500 RESPI RATORY THERAPY	0	0				65.00
56. 00 06600 PHYSI CAL THERAPY	0	0				66.00
57.00 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 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 73. 01 07301 SPECIALTY PHARMACY	0	80, 893				73.00
74. 00 07400 RENAL DIALYSIS	0	0				73.01
76. 00 03330 ENDOSCOPY	0	0				76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0				76.01
76.02 03951 OTHER ANCI LLARY SERVICE COST CENTERS	0	0				76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0				76.03
76. 04 03953 WOUND CARE	0	0				76.04
76. 06 03954 I MAGI NG CENTER	0	Ő				76.06
76. 07 03955 BREAST DIAGNOSTIC CENTER	0	o				76.07
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0				90.00
20. 01 04950 INFUSION CENTER	0	0				90.01
20. 26 04975 SPINE CENTER	0	0				90.26
91.00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
200.00 Subtotal (see instructions)	0	80, 893				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	80, 893				202.00

	COMMUNITY HOSPITAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAP	PLTAL COSTS	Provider CO	CN: 15-0169	Peri od:	Worksheet D	
		Component	CON. 15 \$140	From 01/01/2022	Part II	norod.
		component (CCN: 15-S169	To 12/31/2022	Date/Time Pre 5/25/2023 11:	
		Title	XVIII	Subprovider -	PPS	
				IPF		
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)	-		
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	5, 143, 354				0	50.00
51.00 05100 RECOVERY ROOM	528, 163		0. 01095		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 011, 071				0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	791, 077	44, 871, 365	0. 01763		385	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	704, 728				0	55.00
57.00 05700 CT SCAN	284, 755		0.00297		230	57.00
58. 00 05800 MRI	685, 602		0. 02214		62	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	4, 021	4, 529, 880	0. 00088	38 0	0	59.00
60. 00 06000 LABORATORY	480, 558	104, 586, 078			1, 753	60.00
64.00 06400 INTRAVENOUS THERAPY	27, 856	1, 525, 783	0. 01825	57 5, 509	101	64.00
65. 00 06500 RESPI RATORY THERAPY	599, 670	40, 424, 116	0. 01483	4, 563	68	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 323, 646	26, 650, 403	0. 04966	30, 280	1, 504	66.00
67.00 06700 OCCUPATI ONAL THERAPY	97, 085	8, 289, 242			270	67.00
68.00 06800 SPEECH PATHOLOGY	18, 056	2, 401, 031	0.00752	1, 462	11	68.00
59. 00 06900 ELECTROCARDI OLOGY	19, 276	11, 136, 874	0.00173	26, 954	47	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	397, 830	15, 178, 797	0. 0262	2, 460	64	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 382, 519	70, 093, 476			0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	910, 794		0. 02022		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 128, 720	121, 463, 382	0.00929		2, 714	73.00
73. 01 07301 SPECI ALTY PHARMACY	0	0	0.0000	0 0	0	73.0
74. 00 07400 RENAL DIALYSIS	35, 652	4, 985, 128			0	74.00
76. 00 03330 ENDOSCOPY	630, 945	34, 320, 169	0. 01838		0	76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS		0	0.0000		0	76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS		0	0.0000		0	76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS		0	0.0000		0	76.03
76.04 03953 WOUND CARE	179, 377	5, 934, 641	0. 03022		0	76.04
76.06 03954 I MAGI NG CENTER	1, 032, 056	62, 787, 404	0. 01643		0	76.06
76. 07 03955 BREAST DIAGNOSTIC CENTER	556, 095	31, 667, 909	0. 01756	50 0	0	76.07
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0				0	90.00
90.01 04950 INFUSION CENTER	89, 137	582, 151			0	90.01
90. 26 04975 SPINE CENTER	4, 175		0. 00862	24 0	0	90.26
91. 00 09100 EMERGENCY	1, 205, 204	204, 675, 480			1, 631	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	17, 470, 568	0.0000	0 0	0	92.00
200.00 Total (lines 50 through 199)		1, 376, 775, 874		1, 146, 837		200. 00

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE HROUGH COSTS	RVICE OTHER PASS	Component (CCN: 15-S169	Period: From 01/01/202 To 12/31/202		
		Title	XVIII	Subprovider - IPF	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program		Allied Health	
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						1
D. 00 05000 OPERATING ROOM	0	0		-		
1.00 05100 RECOVERY ROOM 2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		-		52.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0		
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0		55.0
7. 00 05700 CT SCAN	0	0		0		
B. 00 05800 MRI	0	0		0		58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0 0	
D. 00 06000 LABORATORY	0	0		0		
4. 00 06400 INTRAVENOUS THERAPY	0	0		0	0 0	
5. 00 06500 RESPI RATORY THERAPY	0	0		0	0 0	65.0
6. 00 06600 PHYSI CAL THERAPY	0	0		0	o o	66.0
7.00 06700 OCCUPATI ONAL THERAPY	0	0		0	o o	67.0
B. 00 06800 SPEECH PATHOLOGY	0	0		0	0 0	68.0
9. 00 06900 ELECTROCARDI OLOGY	0	0		0	0 0	69. C
D. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0 0	
1.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0	0 0	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0 0	
3. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0 0	
3. 01 07301 SPECIALTY PHARMACY	0	0		0	0 0	
4. 00 07400 RENAL_DI ALYSI S 6. 00 03330 ENDOSCOPY	0	0		0		
6.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0		
6. 02 03951 OTHER ANCIELARY SERVICE COST CENTERS	0	0		0		
6. 03 03952 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0		
6. 04 03953 WOUND CARE	0	0		0		
6. 06 03954 I MAGI NG CENTER	0	0		-		
6. 07 03955 BREAST DI AGNOSTI C CENTER	0	0		0	0 0	76.0
OUTPATIENT SERVICE COST CENTERS					•	
D. 00 09000 CLINIC	0	0		0	0 0	90.0
D. 01 04950 INFUSION CENTER	0	0		-	0 0	
D. 26 04975 SPINE CENTER	0	0		0	0 0	90.2
1.00 09100 EMERGENCY	0	0		0	0 0	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	
00.00 Total (lines 50 through 199)	0	0		0	0 0	200. 0

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 PAS	S Provider C		Period:	Worksheet D	
THROUGH COSTS		Component		rom 01/01/2022	Part IV	narad
		component	CCN: 15-S169	Го 12/31/2022	Date/Time Pre 5/25/2023 11:	31 am
		Title	e XVIII	Subprovider -	PPS	
				IPF		
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	-	-				
50. 00 05000 OPERATING ROOM	0	0		266, 293, 567		1
51.00 05100 RECOVERY ROOM	0	0		48, 197, 591	0.000000	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		24, 882, 878		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		44, 871, 365		
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		51, 665, 440		1
57. 00 05700 CT SCAN	0	0		95, 699, 114		
	0	0		30, 954, 241		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		., 02,, 000		
	0	0		104, 586, 078		1
64. 00 06400 INTRAVENOUS THERAPY	0	0		., 020, ,00		
65. 00 06500 RESPI RATORY THERAPY	0	0		40, 424, 116		
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0			20/000/100		
68. 00 06800 SPEECH PATHOLOGY	0	0		0 8, 289, 242 2, 401, 031	0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		11, 136, 874		
70. 00 07000 ELECTROEARDFOLOGT	0	0		15, 178, 797		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			70, 093, 476		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			45, 025, 034		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0			121, 463, 382		
73. 01 07301 SPECIALTY PHARMACY	0			0		
74. 00 07400 RENAL DI ALYSI S	0			4, 985, 128		
76. 00 03330 ENDOSCOPY	0	0		34, 320, 169		
76. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0 0	0. 000000	
76. 02 03951 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0	0. 000000	
76. 03 03952 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0	0.000000	
76. 04 03953 WOUND CARE	0	0		5, 934, 641		
76.06 03954 I MAGI NG CENTER	0	0		62, 787, 404		
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0		31, 667, 909		1
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0	0) (0 0	0.00000	90.00
90. 01 04950 INFUSION CENTER	0	0) (582, 151	0.000000	90.01
90. 26 04975 SPINE CENTER	0	0) (484, 132	0.000000	90.26
91. 00 09100 EMERGENCY	0	0) (204, 675, 480	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		17, 470, 568	0.00000	92.00

	MUNITY HOSPITAL O				u of Form CMS-2	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 01/01/2022 To 12/31/2022	Part IV Date/Time Pre	pared:
		T: +1 -		Culture and share	5/25/2023 11:	31 am
		IITIe	e XVIII	Subprovider - IPF	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	h Charges	Pass-Through	
	(col. 6 ÷ col.	-	Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
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	21, 837		0 275	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
57. 00 05700 CT SCAN	0. 000000	77, 396		0 0	0	57.00
58. 00 05800 MRI	0. 000000	2, 815		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	2,010		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	381, 524		0 49	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	5, 509		0 0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	4, 563		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	30, 280		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	23, 027		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	1, 462		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	26, 954		0 0	0	69.00
	0. 000000			0 0	0	
		2, 460		0 0		70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0. 000000	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	292, 071		0 0	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	0		0 0	0	74.00
76.00 03330 ENDOSCOPY	0.000000	0		0 0	0	76.00
76. 01 03950 OTHER ANCI LLARY SERVICE COST CENTERS	0.000000	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	0.00000	0		0 0	0	76.03
76.04 03953 WOUND CARE	0. 000000	0		0 0	0	76.04
76.06 03954 I MAGI NG CENTER	0. 000000	0		0 0	0	76.06
76. 07 03955 BREAST DIAGNOSTIC CENTER	0. 000000	0		0 0	0	76.07
OUTPATIENT SERVICE COST CENTERS			1			4
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90.01 04950 INFUSION CENTER	0. 000000	0		0 0	0	90.01
90. 26 04975 SPI NE CENTER	0. 000000	0		0 0	0	90.26
91. 00 09100 EMERGENCY	0. 000000	276, 939		0 1,070	0	91.00
			1			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0 0 1, 394	0	92.00 200.00

Heal th Financia		UNITY HOSPITAL			In Lie	u of Form CMS-	2552-10
APPORTI ONMENT	OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0169	Peri od:	Worksheet D	
			Component	CCN: 15-S169	From 01/01/2022 To 12/31/2022	Part V Date/Time Pre	narod
			component	CCN. 15-5109	10 12/31/2022	5/25/2023 11:	
			Title	e XVIII	Subprovider -	PPS	
					I PF		
				Charges		Costs	
Со	ost Center Description	Cost to Charge			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			
		1.00	2.00	(see inst.)	(see inst.)	F 00	
		1.00	2.00	3.00	4.00	5.00	
	RY SERVICE COST CENTERS PERATING ROOM	0. 136656	C		0 0	0	50.00
	ECOVERY ROOM	0. 180449			0 0	0	
	ELIVERY ROOM & LABOR ROOM	0. 498786			0 0	0	
	ADI OLOGY-DI AGNOSTI C	0. 498788			0 0	54	
	ADI OLOGY - THERAPEUTI C	0. 197150		1	0 0		
					0 0	0	
		0. 039685			0 0	-	
58.00 05800 MR		0. 111390			-	0	
	ARDIAC CATHETERIZATION	0. 047245				0	
		0. 177879			0	9	
	NTRAVENOUS THERAPY	0. 611711	0		0 0	0	
	ESPI RATORY THERAPY	0. 246030			0 0	0	
	HYSI CAL THERAPY	0. 387140			0 0	0	
		0. 360162			0 0	0	
	PEECH PATHOLOGY LECTROCARDI OLOGY	0. 059558	-			0	
					0 0	0	
	LECTROENCEPHALOGRAPHY EDICAL SUPPLIES CHARGED TO PATIENT	0. 234129 0. 375620	-		0 0	0	
	MPL. DEV. CHARGED TO PATIENT	0. 375620			0 0	0	
						0	
	RUGS CHARGED TO PATIENTS	0. 252467 0. 000000				0	
	PECIALTY PHARMACY ENAL DIALYSIS	0. 350994			0 0	0	
76.00 03330 EN		0. 350994			0 0	0	
	THER ANCILLARY SERVICE COST CENTERS	0. 147993			0 0	0	
	THER ANCI LLARY SERVICE COST CENTERS	0.000000			0 0	0	
	THER ANCI LLARY SERVICE COST CENTERS	0.000000				0	
	OUND CARE	0. 317975			0 0	0	
	MAGING CENTER	0. 090629			0 0	0	
	REAST DI AGNOSTI C CENTER	0. 464873			0 0	0	•
	ENT SERVICE COST CENTERS	0.404073		1	0 0	0	/0.0/
90.00 09000 CL		0.000000	C		0 0	0	90.00
	VFUSION CENTER	0. 501677			0 0	0	
	PINE CENTER	0. 724860			0 0	0	
91.00 09100 EM		0. 118644			0 0	127	
	BSERVATION BEDS (NON-DISTINCT PART	0. 824335			0 0	0	
	ubtotal (see instructions)	0.024000	1, 394		0 1, 996	-	200.00
	ess PBP Clinic Lab. Services-Program		1, 374		0 1, 990	190	200.00
	nly Charges						201.00
	et Charges (line 200 - line 201)		1, 394		0 1, 996	190	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	VACCINE COST	OF INDIANA, II Provider C		Peri od:	u of Form CMS Worksheet D	
			CCN: 15-S169	From 01/01/2022 To 12/31/2022	Part V Date/Time Pr	
		Title	e XVIII	Subprovi der -	5/25/2023 11 PPS	:31 am
			1	I PF		
	Cos		-			
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Services Subject To	Services Not Subject To				
	Ded. & Coins.	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	C				50.00
51.00 05100 RECOVERY ROOM	0	C				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C				52.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C				55.0
57.00 05700 CT SCAN	0	C				57.0
58. 00 05800 MRI	0	C				58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	C				59.0
0. 00 06000 LABORATORY	0	C				60.0
54.00 06400 INTRAVENOUS THERAPY	0	C				64.0
55. 00 06500 RESPI RATORY THERAPY	0	0				65.0
56. 00 06600 PHYSI CAL THERAPY	0	0	1			66.0
57. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.0
58.00 06800 SPEECH PATHOLOGY	0	C				68.0
59. 00 06900 ELECTROCARDI OLOGY	0	C				69.0
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	1			70.0
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	0	0				71.0
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	0	504				73.0
3. 01 07301 SPECIALTY PHARMACY	0	0	•			73.0
4. 00 07400 RENAL DI ALYSI S 6. 00 03330 ENDOSCOPY	0	0	•			74.0
76.00 03330 ENDOSCOPY 76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0					76.0
6.02 03950 OTHER ANCILLARY SERVICE COST CENTERS	0					76.0
6. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS	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	0	0	1			- /0.0
0. 00 09000 CLINIC	0	C				90.0
0. 01 04950 INFUSION CENTER	0	C				90.0
20. 26 04975 SPI NE CENTER	0	C C				90.2
01. 00 09100 EMERGENCY	0	Ő				91.0
22. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	Ő				92.0
200.00 Subtotal (see instructions)	0	504				200. 0
201.00 Less PBP Clinic Lab. Services-Program	0					201.0
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	504				202.0

Health Financial Systems	COMMUNI TY HOSPI TAL	OF INDIANA, IN	NC.	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAP	PLTAL COSTS	Provider C		Period: From 01/01/2022 To 12/31/2022		pared: 31 am
		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						
30. 00 ADULTS & PEDIATRICS	8, 499, 115	0	8, 499, 11	5 73, 422	115.76	30.00
31.00 INTENSIVE CARE UNIT	946, 448		946, 44	8 7, 027	134.69	31.00
35.00 NEONATAL INTENSIVE CARE UNIT	1, 394, 920		1, 394, 92	0 13, 571	102.79	35.00
40.00 SUBPROVIDER - IPF	266, 552	0	266, 55	2 4, 452	59.87	40.00
43.00 NURSERY	471, 226		471, 22	6 7,614	61.89	43.00
200.00 Total (lines 30 through 199)	11, 578, 261		11, 578, 26	1 106, 086		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00			-	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 960	226, 890				30.00
31.00 INTENSIVE CARE UNIT	411	55, 358				31.00
35.00 NEONATAL INTENSIVE CARE UNIT	873	89, 736	,			35.00
40.00 SUBPROVIDER - IPF	0	0				40.00
43.00 NURSERY	3, 300	204, 237				43.00
200.00 Total (lines 30 through 199)	6, 544	576, 221				200.00

	MUNI TY HOSPI TAL				u of Form CMS-	2552-1
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL CUSIS	Provider C	JN: 15-0169	Period: From 01/01/2022	Worksheet D Part II	
				To 12/31/2022		nared
				10 12/31/2022	5/25/2023 11:	31 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
·	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)	-		
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	5, 143, 354	266, 293, 567	0. 01931	5 2, 620, 851	50, 622	50.00
51.00 05100 RECOVERY ROOM	528, 163	48, 197, 591	0. 01095	524, 069	5, 743	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 011, 071	24, 882, 878	0. 04063	366, 437	14, 889	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	791, 077	44, 871, 365	0. 01763	540, 208	9, 524	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	704, 728	51, 665, 440	0. 01364	0 554, 712	7, 566	55.0
57. 00 05700 CT SCAN	284, 755	95, 699, 114	0. 00297	6 1, 357, 839	4, 041	57.0
58. 00 05800 MRI	685, 602					58.0
59. 00 05900 CARDI AC CATHETERI ZATI ON	4,021					
0. 00 06000 LABORATORY	480, 558					60.0
54.00 06400 INTRAVENOUS THERAPY	27,856					
55. 00 06500 RESPIRATORY THERAPY	599, 670					•
56. 00 06600 PHYSI CAL THERAPY	1, 323, 646					
57. 00 06700 OCCUPATI ONAL THERAPY	97,085					•
58. 00 06800 SPEECH PATHOLOGY	18, 056					•
59. 00 06900 ELECTROCARDI OLOGY	19, 276					
70. 00 07000 ELECTROENCEPHALOGRAPHY	397, 830					
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 382, 519					
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	910, 794					
73. 00 07300 DRUGS CHARGED TO PATIENTS					37, 892	
73. 01 07300 DRUGS CHARGED TO PATTENTS	1, 128, 720					
	35, 652					
76.00 03330 ENDOSCOPY	630, 945				4, 325	
76. 01 03950 OTHER ANCI LLARY SERVICE COST CENTERS	0	-	0100000		-	
76.02 03951 OTHER ANCI LLARY SERVICE COST CENTERS	0	0			0	
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.00000		0	
76.04 03953 WOUND CARE	179, 377		0. 03022		1, 557	
76.06 03954 I MAGI NG CENTER	1, 032, 056				-	
76. 07 03955 BREAST DI AGNOSTI C CENTER	556, 095	31, 667, 909	0.01756	0 0	0	76.0
OUTPATIENT SERVICE COST CENTERS	T		1			
20. 00 09000 CLINIC	0					
90.01 04950 INFUSION CENTER	89, 137				-	
90. 26 04975 SPINE CENTER	4, 175				°	
91. 00 09100 EMERGENCY	1, 205, 204	204, 675, 480			13, 012	91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 040, 084	17, 470, 568	0. 05953	185, 641	11, 052	92.0
200.00 Total (lines 50 through 199)	20, 311, 506	1, 376, 775, 874		20, 249, 693	250, 504	200.0

Health Financial Systems CO	MMUNI TY HOSPI TAL	OF INDIANA, II	NC.	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS		F	Period: From 01/01/2022 Fo 12/31/2022	Date/Time Pre 5/25/2023 11:	epared: 31 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown	-	Adj ustments		Education Cost	
	Adjustments		-			
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	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	35.00
40. 00 04000 SUBPROVIDER - IPF	0			0 0	0	40.00
43. 00 04300 NURSERY	0	0		o o	0	43.00
200.00 Total (lines 30 through 199)	0			0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
· ·	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,		í í		
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS		•		·	•	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	73, 422	0.00	1, 960	30.00
31.00 03100 INTENSIVE CARE UNIT		0	7,02	0.00	411	31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT			13, 57	0.00	873	35.00
40. 00 04000 SUBPROVIDER - IPF	0	0	4,452			40.00
43. 00 04300 NURSERY			7,614	0.00	3, 300	43.00
200.00 Total (lines 30 through 199)			106, 086			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 & PEDI ATRI CS	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				1

	Financial Systems COMM FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF		OF INDIANA, IN Provider CO		Peri od:	eu of Form CMS-2 Worksheet D	2552-10
	GH COSTS	WICE OTHER TASS		311. 13-0109	From 01/01/2022		
1111000	SIT 66515				To 12/31/2022	Date/Time Pre	pared:
						5/25/2023 11:	31 am
	· · · · · · · · · · · · · · · · · · ·	. <u>.</u>		e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
		1.00	Adjustments 2A	2.00	3A	3.00	
	ANCI LLARY SERVI CE COST CENTERS	1.00	ZA	2.00	3A	3.00	
50.00	05000 OPERATING ROOM	0	0	1	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		0 0	0	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	52.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	54.00
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 ELECTROEARDI OLOGI	0	0		0 0	0	70.00
70.00	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
73.00	07301 SPECIALTY PHARMACY	0	0		0 0	0	73.00
	07400 RENAL DIALYSIS	0	0		0 0		
74.00 76.00		0	0		0 0	0	74.00
	03330 ENDOSCOPY	0	0		0 0	0	76.00
76.01	03950 OTHER ANCI LLARY SERVICE COST CENTERS	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	0	0		0 0	0	76.04
76.06	03954 I MAGI NG CENTER	0	0		0 0	0	76.06
76.07	03955 BREAST DI AGNOSTI C CENTER	0	0		0 0	0	76.07
00 00	OUTPATI ENT SERVI CE COST CENTERS		0		0	0	00.00
90.00 90.01		0	0		0 0		90.00 90.01
90.01	04950 I NFUSI ON CENTER 04975 SPI NE CENTER	0	0			-	90.01
		0	0			0	
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	~		0	0	92.00
200.00) Total (lines 50 through 199)	0	0		0 0	0	200.00

Health Financial Systems COM	MUNITY HOSPITAL	OF INDIANA, IN	NC.	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET	RVICE OTHER PAS	S Provider C		Period: From 01/01/2022	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2022	Date/Time Pre	pared:
					5/25/2023 11:	31 am
Cast Contor Description	All Other	Total Cost	e XIX Total	Hospi tal	PPS Ratio of Cost	
Cost Center Description	Medical	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost	•	Cost (sum of		$(col. 5 \div col.$	
		4)	col s. 2, 3,	8)	7)	
			and 4)	0)	(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS	!			_		
50. 00 05000 OPERATI NG ROOM	0	0		0 266, 293, 567	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0		0 48, 197, 591	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 24, 882, 878	0. 000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 44, 871, 365	0. 000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 51, 665, 440	0.000000	55.00
57.00 05700 CT SCAN	0	0		0 95, 699, 114	0.000000	57.00
58. 00 05800 MRI	0	0		0 30, 954, 241	0. 000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 4, 529, 880	0. 000000	59.00
60. 00 06000 LABORATORY	0	0		0 104, 586, 078	0. 000000	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 1, 525, 783		64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 40, 424, 116		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 26, 650, 403		
67.00 06700 OCCUPATIONAL THERAPY	0	0		0 8, 289, 242		
68.00 06800 SPEECH PATHOLOGY	0	0		0 2, 401, 031	0.000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 11, 136, 874		
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 15, 178, 797	0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 70, 093, 476		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 45, 025, 034	0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 121, 463, 382		
73.01 07301 SPECIALTY PHARMACY	0	0		0 0	0.000000	
74.00 07400 RENAL DIALYSIS	0	0		4, 985, 128		
76.00 03330 ENDOSCOPY	0	0		0 34, 320, 169		
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0.000000	
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0.000000	
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0.000000	
76.04 03953 WOUND CARE	0	0		5, 934, 641	0.000000	
76. 06 03954 I MAGI NG CENTER	0	0		62, 787, 404		
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0		0 31, 667, 909		1
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 0	0.000000	90.00
90. 01 04950 INFUSION CENTER	0	0		0 582, 151		
90. 26 04975 SPI NE CENTER	0	0		0 484, 132		
91.00 09100 EMERGENCY	0	0		0 204, 675, 480		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0 17, 470, 568		
200.00 Total (lines 50 through 199)	0			0 1, 376, 775, 874		200.00
	•		•			

		MUNITY HOSPITAL C	DF_INDIANA, IN	IC.	In Lie	u of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	Provider C	CN: 15-0169	Peri od:	Worksheet D	
THROUC	GH COSTS				From 01/01/2022 To 12/31/2022	Part IV Date/Time Pre	narodi
					10 12/31/2022	5/25/2023 11:	31 am
			Titl	e XIX	Hospi tal	PPS	<u>01 am</u>
	Cost Center Description	Outpatient	Inpati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Throug		Pass-Through	
		(col. 6 ÷ col.	Ũ	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 SERVI CE COST CENTERS			•		•	
50.00	05000 OPERATING ROOM	0. 000000	2, 620, 851		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	524, 069	1	0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	366, 437		0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0.000000	540, 208		0 0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0.000000	554, 712		0 0	0	55.00
57.00	05700 CT SCAN	0.000000	1, 357, 839		0 0	0	1
58.00	05800 MRI	0.000000	209, 121		0 0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0.000000	39, 857		0 0	0	
60.00	06000 LABORATORY	0.000000	2, 598, 820		0 0	-	
64.00	06400 I NTRAVENOUS THERAPY	0.000000	57, 725		0 0	0	
65.00	06500 RESPI RATORY THERAPY	0.000000	2, 496, 990		0 0	0	
66.00	06600 PHYSI CAL THERAPY	0.000000	127, 423		0 0	0	
67.00	06700 OCCUPATI ONAL THERAPY	0.000000	172, 579		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0, 000000	51,877		0 0	0	
69.00	06900 ELECTROCARDI OLOGY	0.000000	294, 314		0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	86, 994		0 0	, s	
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1, 122, 028		0 0		
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	1, 122, 020		0 0		
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	4, 077, 451		0 0		
73.00	07301 SPECIALTY PHARMACY	0.000000	4,077,431		0 0	-	
74.00	07400 RENAL DI ALYSI S	0.000000	268, 125		0 0	0	
76.00	03330 ENDOSCOPY	0.000000	235, 267		0 0	0	
76.00	03950 OTHER ANCI LLARY SERVICE COST CENTERS	0.000000	235, 207			0	
76.01	03951 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0				
			0		0 0	-	
76.03 76.04	03952 OTHER ANCILLARY SERVICE COST CENTERS 03953 WOUND CARE	0.00000	U 51 514			0	76.03
		0.00000	51, 514		0	, s	
76.06	03954 I MAGI NG CENTER	0.00000	0		0 0	0	
76.07	03955 BREAST DI AGNOSTI C CENTER	0.000000	0		0 0	0	76.07
00.00		0.000000	^	1	0		00.00
90.00		0.00000	0		0 0		
90.01	04950 I NFUSI ON CENTER	0.00000	0		0 0		
90.26	04975 SPINE CENTER	0.00000	0		0 0		
91.00	09100 EMERGENCY	0.00000	2, 209, 851		0 0		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	185, 641		0 0		
200.00	Total (lines 50 through 199)		20, 249, 693	I	0 0	0	200.00

APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-0169	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Pre 5/25/2023 11:	pared: 31 am
			Titl	e XIX	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	. Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	0. 139552				0	
	O RECOVERY ROOM	0. 180449		256, 80		0	
	O DELIVERY ROOM & LABOR ROOM	0. 498786	0		0 0	0	52.00
	0 RADI OLOGY-DI AGNOSTI C	0. 197150				0	
55.00 0550	0 RADI OLOGY-THERAPEUTI C	0. 102558	0	703, 36	0 8	0	55.00
57.00 0570	O CT SCAN	0. 039685	0	2, 288, 61	8 0	0	57.00
58.00 0580	0 MRI	0. 111390	0	228, 03	80 0	0	58.00
59.00 0590	O CARDI AC CATHETERI ZATI ON	0. 047245	0		0 0	0	59.00
50.00 0600	0 LABORATORY	0. 177879	0	1, 247, 55	5 0	0	60.00
54.00 0640	O INTRAVENOUS THERAPY	0. 611711	0	12	27 0	0	64.00
55.00 0650	O RESPI RATORY THERAPY	0. 246030	0	102, 20	0 8	0	65.00
56.00 0660	O PHYSI CAL THERAPY	0. 389948	0	119, 58	37 0	0	66.00
57.00 0670	O OCCUPATIONAL THERAPY	0. 360162	0	37, 56	07 0	0	67.00
58.00 0680	O SPEECH PATHOLOGY	0. 232221	0	28, 89	07 0	0	68.00
59.00 0690	O ELECTROCARDI OLOGY	0. 059558	0	43, 53	38 0	0	69.00
70.00 0700	OELECTROENCEPHALOGRAPHY	0. 234129	0	135, 78	39 0	0	70.00
71.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 375620	0	301, 48	39 0	0	71.00
72.00 0720	OIMPL. DEV. CHARGED TO PATIENTS	0. 385195	0		0 0	0	72.00
73.00 0730	O DRUGS CHARGED TO PATIENTS	0. 252467	0	503, 21	4 0	0	73.00
73.01 0730	1 SPECIALTY PHARMACY	0. 000000	0		0 0	0	73.01
74.00 0740	O RENAL DIALYSIS	0. 350994	0		0 0	0	74.00
	O ENDOSCOPY	0. 147995	0	359, 19	0 8	0	76.00
76.01 0395	O OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76.01
	1 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76.02
	2 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000			0 0	0	76.03
76.04 0395	3 WOUND CARE	0. 317975	0	159, 83	31 0	0	76.04
76.06 0395	4 I MAGI NG CENTER	0. 090629	l o	408, 55	53 0	0	76.06
	5 BREAST DI AGNOSTI C CENTER	0. 464873				0	
	ATIENT SERVICE COST CENTERS						
	O CLINIC	0. 000000	0		0 0	0	90.00
	O INFUSION CENTER	0. 501677	l o	37	0 0	0	90.01
	5 SPI NE CENTER	0. 724860	-		0 0	0	
	0 EMERGENCY	0. 119518		7, 795, 04		0	
	O OBSERVATION BEDS (NON-DISTINCT PART	0. 824335			0 0	0	
200.00	Subtotal (see instructions)	1.121000	o o				200.00
201.00	Less PBP Clinic Lab. Services-Program	1	Ĭ		0 0	j v	201.00
	Only Charges						
	Net Charges (line 200 - line 201)	1	0	17, 088, 31	6 0		202.00

	MUNITY HOSPITAL C			u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	O VACCINE COST	Provider CCN: 15-01	69 Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/25/2023 11:31 am
		Title XIX	Hospi tal	PPS
	Cost	S		
Cost Center Description	Cost	Cost		
	Reimbursed	Reimbursed		
		Services Not		
	Subject To	Subject To		
		Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00		
50. 00 05000 0PERATING ROOM	187, 805	0		50.00
51.00 05100 RECOVERY ROOM	46, 340	o		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	154, 999	О		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	72, 136	О		55.00
57.00 05700 CT SCAN	90, 824	o		57.00
58. 00 05800 MRI	25, 400	О		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	o		59.00
60. 00 06000 LABORATORY	221, 914	0		60.00
64.00 06400 INTRAVENOUS THERAPY	78	0		64.00
65. 00 06500 RESPI RATORY THERAPY	25, 146	o		65.00
66. 00 06600 PHYSI CAL THERAPY	46, 633	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	13, 530	0		67.00
68.00 06800 SPEECH PATHOLOGY	6, 710	0		68.00
69. 00 06900 ELECTROCARDI OLOGY	2, 593	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	31, 792	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	113, 245	0		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	127, 045	0		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	53, 160	0		76.00
76. 01 03950 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		76.01
76. 02 03951 OTHER ANCI LLARY SERVICE COST CENTERS 76. 03 03952 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		76.02
76. 04 03953 WOUND CARE	50, 822	0		76.03
76. 06 03954 I MAGI NG CENTER	37, 027	0		76.04
76. 07 03955 BREAST DI AGNOSTI C CENTER	109, 966	0		76.00
OUTPATIENT SERVICE COST CENTERS	109, 900	0		/0.0/
90. 00 09000 CLINIC	0	0		90.00
90. 01 04950 I NFUSION CENTER	190	0		90.00
90. 26 04975 SPI NE CENTER		0		90. 26
91. 00 09100 EMERGENCY	931, 648	0		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	2, 349, 003	Ő		200.00
201.00 Less PBP Clinic Lab. Services-Program	0	-		201.00
Only Charges				
202.00 Net Charges (line 200 - line 201)	2, 349, 003	o		202.00

In Lieu of Form CMS-2552-10

	ATION OF INPATIENT OPERATING COST	i der CCN: 15-0169	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1	pared
		Title XVIII	Hospi tal	5/25/2023 11: PPS	31 am
	Cost Center Description		nospital	FF3	
			-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
. 00	Inpatient days (including private room days and swing-bed days, exc			73, 422	
. 00	Inpatient days (including private room days, excluding swing-bed an			73, 422	
. 00	Private room days (excluding swing-bed and observation bed days). I	r you nave only pr	ivate room days,	0	3.0
. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed day	(s)		64, 437	4.0
. 00	Total swing-bed SNF type inpatient days (including private room day	· ·	r 31 of the cost	04, 437	
	reporting period	-,		-	
00	Total swing-bed SNF type inpatient days (including private room day	/s) after December	31 of the cost	0	6. (
	reporting period (if calendar year, enter 0 on this line)			_	
00	Total swing-bed NF type inpatient days (including private room days	s) through December	31 of the cost	0	7.0
00	reporting period) after December 2	1 of the cost	0	8.0
00	Total swing-bed NF type inpatient days (including private room days reporting period (if calendar year, enter 0 on this line)	s) al tel December 3	I UI LINE COST	0	0.1
. 00	Total inpatient days including private room days applicable to the	Program (excluding	swing-bed and	15, 418	9.0
	newborn days) (see instructions)	- J - C J			
0. OO	Swing-bed SNF type inpatient days applicable to title XVIII only (i		oom days)	0	10. (
	through December 31 of the cost reporting period (see instructions)				
1.00	Swing-bed SNF type inpatient days applicable to title XVIII only (i		oom days) after	0	11.0
2. 00	December 31 of the cost reporting period (if calendar year, enter C Swing-bed NF type inpatient days applicable to titles V or XIX only		e room dave)	0	12.
2.00	through December 31 of the cost reporting period		e room days)	0	12.
3.00	Swing-bed NF type inpatient days applicable to titles V or XIX only	/ (including privat	e room days)	0	13.
	after December 31 of the cost reporting period (if calendar year, e				
	Medically necessary private room days applicable to the Program (ex	cluding swing-bed	days)	0	
5.00	Total nursery days (title V or XIX only)			0	
b. 00	Nursery days (title V or XIX only)			0	16.
7 00	SWING BED ADJUSTMENT	augh Dagamhan 21 a	f the east	0.00	1 1 7
7.00	Medicare rate for swing-bed SNF services applicable to services thr reporting period	ough becember 31 o	i the cost	0.00	17.
3. 00	Medicare rate for swing-bed SNF services applicable to services aft	er December 31 of	the cost	0.00	18.
9.00	reporting period Medicaid rate for swing-bed NF services applicable to services thro	ough December 31 of	the cost	0.00	19.
	reporting period			0.00	
0. 00	Medicaid rate for swing-bed NF services applicable to services after reporting period	er December 31 of t	ne cost	0.00	20.
1.00	Total general inpatient routine service cost (see instructions)			117, 684, 148	21
2.00	Swing-bed cost applicable to SNF type services through December 31	of the cost report	ing period (line	0	
	5 x line 17)			-	
3.00	Swing-bed cost applicable to SNF type services after December 31 of	f the cost reportin	g period (line 6	0	23.
	x line 18)			_	
4. 00	Swing-bed cost applicable to NF type services through December 31 c	of the cost reporti	ng period (line	0	24.
5.00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of	the cost reporting	period (line 8	0	25.
5.00	x line 20)	the cost reporting	period (inic o	0	20.
5.00	Total swing-bed cost (see instructions)			0	26.
7.00	General inpatient routine service cost net of swing-bed cost (line	21 minus line 26)		117, 684, 148	27.
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
3.00	General inpatient routine service charges (excluding swing-bed and	observation bed ch	arges)	0	
9.00).00	Private room charges (excluding swing-bed charges)			0	
. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line	28)		0.000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)	, 20)		0.00	
. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
. 00	Average per diem private room charge differential (line 32 minus li	ne 33)(see instruc	tions)	0.00	
. 00	Average per diem private room cost differential (line 34 x line 31)	1		0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0	
7.00	General inpatient routine service cost net of swing-bed cost and pr	rivate room cost di	fferential (line	117, 684, 148	37.
	27 minus line 36)				-
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMEN	ITS			+
3. 00	Adjusted general inpatient routine service cost per diem (see instr			1, 602. 85	38
9.00	Program general inpatient routine service cost per diem (see Hist) Program general inpatient routine service cost (line 9 x line 38)			24, 712, 741	
	Medically necessary private room cost applicable to the Program (li	ne 14 x line 35)		0	
). 00	Incarcar y necessary private ream ever apprivation to the frequency			0	1 40.

COMPUT	Financial Systems COMM ATION OF INPATIENT OPERATING COST		Provider C		Peri od:	worksheet D-1		
					From 01/01/2022 To 12/31/2022			
		-		XVIII	Hospi tal	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		
42.00	NURSERY (title V & XIX only)	0	0	0.	0 00	0	42.00	
43.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	16, 665, 540	7, 027	2, 371.	64 1, 643	3, 896, 605	43.00	
44.00	CORONARY CARE UNIT	10, 000, 040	1,021	2, 371.	1,043	3, 070, 003	44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT	22 101 4/0	10 571	1 () 5			46.00	
47.00	NEONATAL INTENSIVE CARE UNIT Cost Center Description	22, 191, 468	13, 571	1, 635.	21 0	0	47.00	
	·					1.00		
48.00	Program inpatient ancillary service cost (Wks					30, 399, 384		
48. 01 49. 00	Program inpatient cellular therapy acquisition Total Program inpatient costs (sum of lines 4				column I)	0 59, 008, 730		
47.00	PASS THROUGH COST ADJUSTMENTS	1 through 40.01		(1013)		37,000,730	49.00	
50.00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	Wkst. D, sur	n of Parts I and	2, 006, 084	50.00	
E1 00) Dess through costs applieship to Drogram input	tiont ancillary	convious (fr	om Wkat D	sum of Dorte II	2, 143, 213	E1 00	
51.00	Pass through costs applicable to Program inpa and IV)	attent and traig	Services (II	UNI WKSL. D, S	Sum OF Parts II	2, 143, 213	51.00	
52.00	Total Program excludable cost (sum of lines !	50 and 51)				4, 149, 297	52.00	
53.00	Total Program inpatient operating cost exclud		ated, non-phy	si ci an anestl	netist, and	54, 859, 433	53.00	
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	o2)					-	
54.00	Program di scharges					0	54.00	
55.00	Target amount per discharge					0.00		
55.01	Permanent adjustment amount per discharge					0.00	•	
55.02 56.00	Adjustment amount per discharge (contractor u Target amount (line 54 x sum of lines 55, 55.					0.00	56.00	
57.00	Difference between adjusted inpatient operati		get amount (I	ine 56 minus	line 53)	0		
58.00	Bonus payment (see instructions)					0	58.00	
59.00	Trended costs (lesser of line 53 ÷ line 54, or updated and compounded by the market basket)	or line 55 from	the cost repo	rting period	endi ng 1996,	0.00	59.00	
60.00								
	market basket)							
61.00	Continuous improvement bonus payment (if line 55.01 , or line 59 , or line 60 , enter the less 53) are less than expected costs (lines 54×10^{-10}	ser of 50% of th	e amount by w	hich operatiı	ng costs (İine	0	61.00	
62.00	enter zero. (see instructions) Relief payment (see instructions)					0	62.00	
63.00	Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)			0		
	PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts through Decem	ber 31 of the	cost report	ng period (See	0	64.00	
65.00	Medicare swing-bed SNF inpatient routine cost	ts after Decembe	r 31 of the c	ost reporting	g period (See	0	65.00	
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	4 plus line 6	5)(title XVI	I only); for	0	66.00	
47 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routine	costs through	Docombor 21 o	f the cost r	porting ported		47.00	
67.00	(line 12 x line 19)	e costs through	December 31 0	i the cost re	eporting period	0	67.00	
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after De	cember 31 of	the cost repo	orting period	0	68.00	
69.00	Total title V or XIX swing-bed NF inpatient I PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00	
70.00	Skilled nursing facility/other nursing facili)		70.00	
71.00	Adjusted general inpatient routine service co	ost per diem (li					71.00	
72.00 73.00	Program routine service cost (line 9 x line 7 Medically necessary private room cost applica		(line 14 v li	ne 35)			72.00	
74.00	Total Program general inpatient routine servi						74.00	
75.00	Capital-related cost allocated to inpatient i	routine service	costs (from Ŵ	orksheet B, I	Part II, column		75.00	
74 00	26, line 45)	2)					74 00	
76.00 77.00	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						76.00	
78.00	Inpatient routine service cost (line 74 minus						78.00	
79.00	Aggregate charges to beneficiaries for excess	• •		· · · · · · · · · · · · · · · · · · ·			79.0	
BO. 00 B1. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		st limitation	(IINE /8 mii	ius line /9)		80.00	
B2.00	Inpatient routine service cost per drem frim						82.00	
33.00	Reasonable inpatient routine service costs (s	see instructions)				83.00	
84.00	Program inpatient ancillary services (see ins						84.00	
85.00 86.00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85.00 86.00	
20.00	PART IV - COMPUTATION OF OBSERVATION BED PASS						33.00	
87.00	Total observation bed days (see instructions)					8, 985		
88.00	Adjusted general inpatient routine cost per o	nem (line 27 ÷	LINE 2)			1, 602. 85	88.00	

Health Financial Systems COM	MUNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022		
		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, 499, 115	117, 684, 148	0. 07222	0 14, 401, 607	1, 040, 084	90.00
91.00 Nursing Program cost	0	117, 684, 148	0.00000	0 14, 401, 607	0	91.00
92.00 Allied health cost	0	117, 684, 148	0.00000	0 14, 401, 607	0	92.00
93.00 All other Medical Education	0	117, 684, 148	0.00000			93.00

IMPU I	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0169 Component CCN: 15-S169 Title XVIII	Peri od: From 01/01/2022 To 12/31/2022 Subprovi der - I PF	Worksheet D-1 Date/Time Prep 5/25/2023 11: PPS	pare		
	Cost Center Description	1		1.00			
	PART I - ALL PROVIDER COMPONENTS						
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	s excluding newborn)		4, 452	1 1.		
00 00	Inpatient days (including private room days, excluding swing-bed days, excluding newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,						
00 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	4, 452 0	4		
00	reporting period Total swing-bed SNF type inpatient days (including private roo	3.		0	6		
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roor reporting period	m days) through December	31 of the cost	0	7		
00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	-		0	8		
00	Total inpatient days including private room days applicable to newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or		0	1, 708 0			
. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or	tions) nly (including private r	3 /	0			
. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period		e room days)	0	12		
. 00	Swing-bed NF type inpatient days applicable to titles V or XI fter December 31 of the cost reporting period (if calendar y			0	13		
. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)			0 0	15		
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16		
	Medicare rate for swing-bed SNF services applicable to service reporting period	C		0.00			
. 00 . 00	Medicare rate for swing-bed SNF services applicable to service reporting period Medicaid rate for swing-bed NF services applicable to services			0. 00 0. 00			
	reporting period Medicaid rate for swing-bed NF services applicable to services	5		0.00			
. 00 . 00	reporting period Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		ing period (line	5, 121, 448 0			
. 00	5 x line 17) 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-bed cost applicable to NF type services through December 7 x line 19)	r 31 of the cost reporti	ng period (line	0	24		
. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0			
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		0 5, 121, 448			
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0			
. 00 . 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29		
	General inpatient routine service cost/charge ratio (line 27 -	÷line 28)		0.000000			
. 00	Average private room per diem charge (line 29 ÷ line 3)	/		0.00			
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00			
	Average per diem private room charge differential (line 32 min		tions)	0.00			
	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00			
00 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minut line 24)	and private room cost di	fferential (line	0 5, 121, 448	36 37		
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY						
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 150 07	1 20		
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 150. 37 1, 964, 832			
	Medically necessary private room cost applicable to the Progra			1, 964, 832 0			
	Image and a second second second solution of the second se			0	1 10		

43. 00 44. 00 45. 00 46. 00 47. 00 48. 01 48. 01 49. 00 50. 00 51. 00	Cost Center Description Inp. NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT NIT Program inpatient ancillary service cost (Wkst. Program inpatient cellular therapy acquisition c Total Program inpatient costs (sum of lines 41 t PASS THROUGH COST ADJUSTMENTS		Ti tl e	col. 2) 3.00 0. 0 0.		5/25/2023 11: PPS Program Cost (col. 3 x col. 4) 5.00	31 am 42.00 43.00 44.00
43. 00 44. 00 45. 00 46. 00 47. 00 48. 01 48. 01 49. 00 50. 00 51. 00	Inp. NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT Cost Center Description Program inpatient ancillary service cost (Wkst. Program inpatient cellular therapy acquisition c Total Program inpatient costs (sum of lines 41 t	atient Cost In 1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Total pati ent Days 2.00 0 0	Average Per Diem (col. 1 col. 2) 3.00 0. 0.	+ Program Days + 4.00 00 0	PPS Program Cost (col. 3 x col. 4) 5.00 C) 42.00 43.00 44.00
43. 00 44. 00 45. 00 46. 00 47. 00 48. 01 48. 01 49. 00 50. 00 51. 00	Inp. NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT Cost Center Description Program inpatient ancillary service cost (Wkst. Program inpatient cellular therapy acquisition c Total Program inpatient costs (sum of lines 41 t	atient Cost In 1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	patient Days 2.00 C	Di em (col. 1 col. 2) 3.00 0.	+ Program Days + 4.00 00 0	(col. 3 x col. 4) 5.00 0) 42.00) 43.00 44.00
43. 00 44. 00 45. 00 46. 00 47. 00 48. 01 48. 01 49. 00 50. 00 51. 00	NURSERY (title V & XIX only) Intensi ve Care Type Inpatient Hospital Units INTENSI VE CARE UNIT CORONARY CARE UNIT BURN INTENSI VE CARE UNIT SURGI CAL INTENSI VE CARE UNIT Cost Center Description Program inpatient ancillary service cost (Wkst. Program inpatient cellular therapy acquisition c Total Program inpatient costs (sum of lines 41 t	1.00 0 0 0 0	2.00 0	col. 2) 3.00 0. 0 0.	4.00 00 0	4) 5.00 0) 42.00) 43.00 44.00
43. 00 44. 00 45. 00 46. 00 47. 00 48. 01 48. 01 49. 00 50. 00 51. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT Cost Center Description Program inpatient ancillary service cost (Wkst. Program inpatient cellular therapy acquisition c Total Program inpatient costs (sum of lines 41 t	0 0 0 D-3, col. 3,	C	0.	00 0	C	43.00 44.00
43. 00 44. 00 45. 00 46. 00 47. 00 48. 01 48. 01 49. 00 50. 00 51. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT Cost Center Description Program inpatient ancillary service cost (Wkst. Program inpatient cellular therapy acquisition c Total Program inpatient costs (sum of lines 41 t	0 0 D-3, col. 3,	C	0.			43.00 44.00
44. 00 45. 00 46. 00 47. 00 48. 01 48. 01 49. 00 50. 00 51. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT Cost Center Description Program inpatient ancillary service cost (Wkst. Program inpatient cellular therapy acquisition c Total Program inpatient costs (sum of lines 41 t	0 D-3, col. 3,	-		00 0		44. OC
46. 00 47. 00 48. 00 48. 01 49. 00 50. 00 51. 00	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT Cost Center Description Program inpatient ancillary service cost (Wkst. Program inpatient cellular therapy acquisition c Total Program inpatient costs (sum of lines 41 t	D-3, col. 3,	C	0.			
47.00 48.00 48.01 49.00 50.00 51.00	NEONATAL INTENSIVE CARE UNIT Cost Center Description Program inpatient ancillary service cost (Wkst. Program inpatient cellular therapy acquisition c Total Program inpatient costs (sum of lines 41 t	D-3, col. 3,	C	0.			45.00
48. 01 49. 00 50. 00 51. 00	Program inpatient ancillary service cost (Wkst. Program inpatient cellular therapy acquisition c Total Program inpatient costs (sum of lines 41 t				00 0	C	46.00
48. 01 49. 00 50. 00 51. 00	Program inpatient cellular therapy acquisition c Total Program inpatient costs (sum of lines 41 t					1.00	
49.00 50.00 51.00	Total Program inpatient costs (sum of lines 41 t					209, 180	
50. 00 51. 00					, column 1)	0 2, 174, 012	48.01 49.00
51.00		, ,					
	Pass through costs applicable to Program inpatie	ent routine se	rvices (from	n Wkst. D, su	m of Parts I and	102, 258	50.00
	Pass through costs applicable to Program inpatie	ent ancillary	services (fr	rom Wkst. D,	sum of Parts II	8, 840	51.00
	and IV) Total Program excludable cost (sum of lines 50 a	and 51)				111, 098	52.00
53.00	Total Program inpatient operating cost excluding medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION		ted, non-phy	vsi ci an anest	hetist, and	2, 062, 914	
54.00	Program di scharges					C	
	Target amount per discharge Permanent adjustment amount per discharge					0.00	
	Adjustment amount per discharge (contractor use					0.00	
	Target amount (line 54 x sum of lines 55, 55.01, Difference between adjusted inpatient operating		et amount (I	ine 56 minus	line 53)		
	Bonus payment (see instructions)					0	
59.00	Trended costs (lesser of line 53 ÷ line 54, or l updated and compounded by the market basket)	INE 55 Trom t	ne cost repo	orting period	ending 1996,	0.00	59.00
	Expected costs (lesser of line 53 ÷ line 54, or market basket)	line 55 from	prior year c	cost report,	updated by the	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 55.01, or line 59, or line 60, enter the lesser 53) are less than expected costs (lines 54 x 60) enter zero. (see instructions)	of 50% of the	amount by w	hich operati	ng costs (line	С	61.00
62.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payment	(coo instruct	i onc)				
Ī	PROGRAM INPATIENT ROUTINE SWING BED COST	•				-	
	Medicare swing-bed SNF inpatient routine costs t instructions)(title XVIII only)	hrough Decemb	er 31 of the	e cost report	ing period (See	C	64.00
65.00	Medicare swing-bed SNF inpatient routine costs a	after December	31 of the c	cost reportin	g period (See	C	65.00
	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine c	costs (line 64	plus line 6	5)(title XVI	ll only); for	0	66.00
67.00	CAH, see instructions Title V or XIX swing-bed NF inpatient routine co	osts through D	ecember 31 c	of the cost r	eporting period	C	67.00
	(line 12 x line 19)	0					
	Title V or XIX swing-bed NF inpatient routine co (line 13 x line 20)				or tring period	C	
	Total title V or XIX swing-bed NF inpatient rout PART III - SKILLED NURSING FACILITY, OTHER NURSI			,		0	69.00
70.00	Skilled nursing facility/other nursing facility/	'ICF/IID routi	ne service c	cost (line 37)		70.00
1	Adjusted general inpatient routine service cost Program routine service cost (line 9 x line 71)	per diem (lin	e 70 ÷ line	2)			71.00
1	Medically necessary private room cost applicable	e to Program (line 14 x li	ne 35)			73.00
74.00	Total Program general inpatient routine service	costs (line 7	2 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient rout 26, line 45)	ine service c	osts (from W	vorкsheet B,	Part II, column		75.00
1	Per diem capital-related costs (line 75 ÷ line 2 Program capital-related costs (line 9 x line 76)						76.00
	Inpatient routine service cost (line 74 minus li						78.00
79.00	Aggregate charges to beneficiaries for excess co	osts (from pro					79.00
1	Total Program routine service costs for comparis		t limitatior	n (line 78 mi	nus line 79)		80.00
	Inpatient routine service cost per diem limitati Inpatient routine service cost limitation (line						81.00
1	Reasonable inpatient routine service cost film tation (file						83.00
84.00	Program inpatient ancillary services (see instru	ictions)					84.00
	Utilization review - physician compensation (see Total Program inpatient operating costs (sum of						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS TH					l	
	Total observation bed days (see instructions) Adjusted general inpatient routine cost per diem	. (lino 27 · ·	ine 2)			0	87.00

Health Financial Systems COMM	UNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
		Component (CCN: 15-S169	From 01/01/2022 To 12/31/2022		pared: 31 am
		Title	XVIII	Subprovider - IPF	PPS	
Cost Center Description		·				
					1.00	
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)				0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from		
				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				i	·	
90.00 Capital-related cost	266, 552				0	
91.00 Nursing Program cost	0	5, 121, 448			0	
92.00 Allied health cost	0	5, 121, 448	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	5, 121, 448	0.00000	0 0	0	93.00

In Lieu of Form CMS-2552-10

	Financial Systems COMMUNITY HOSPITAL OF	INDIANA, INC.	In Lie	u of Form CMS-2	2552-
JMPU I.	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0169	Peri od:	Worksheet D-1	
			From 01/01/2022 To 12/31/2022	Data/Tima Dray	noro
			10 12/31/2022	Date/Time Prep 5/25/2023 11:3	
		Title XIX	Hospi tal	PPS	
	Cost Center Description				
			-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed day	rs, excluding newborn)		73, 422	1.
00	Inpatient days (including private room days, excluding swing-			73, 422	2.
00	Private room days (excluding swing-bed and observation bed da	ys). If you have only p	rivate room days,	0	3.
	do not complete this line.				
00	Semi-private room days (excluding swing-bed and observation b			64, 437	4.
00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	er 31 of the cost	0	5.
00	reporting period Total swing-bed SNF type inpatient days (including private ro	om davc) after December	21 of the cost	0	6.
00	reporting period (if calendar year, enter 0 on this line)	on days) at ter becenber	ST OF THE COST	0	
00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7
00	reporting period				
00	Total swing-bed NF type inpatient days (including private roo	m days) after December (31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)	5.7			
00	Total inpatient days including private room days applicable t	o the Program (excluding	g swing-bed and	1, 960	9.
	newborn days) (see instructions)				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10
	through December 31 of the cost reporting period (see instruc				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		to room dave)	0	12
. 00	through December 31 of the cost reporting period	x only (meruding priva	le room uays)	0	'2
. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te room days)	0	13
. 00	after December 31 of the cost reporting period (if calendar y			0	''
. 00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14
	Total nursery days (title V or XIX only)	· 5 5	5 /	7, 614	15
. 00	Nursery days (title V or XIX only)			3, 300	16
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 o	of the cost	0.00	17
	reporting period				
8. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18
00	reporting period	s through December 21 of	E the cost	0.00	10
0. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	is through becember 31 of	the cost	0.00	19
0. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	the cost	0.00	20
	reporting period			0.00	20
. 00	Total general inpatient routine service cost (see instruction	is)		118, 793, 695	21
. 00	Swing-bed cost applicable to SNF type services through Decemb		ting period (line	0	
	5 x line 17)				
3.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23
	x line 18)				
1.00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	0	24
	7 x line 19)	04 C H H H			0.5
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25
5.00	x line 20) Total swing-bed cost (see instructions)			0	26
7.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		118, 793, 695	
. 00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT		I	110, 773, 073	21
. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28
. 00	Private room charges (excluding swing-bed charges)		5 /	0	
. 00	Semi -private room charges (excluding swing-bed charges)			0	30
. 00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	31
. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32
. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
. 00	Average per diem private room charge differential (line 32 mi	, .	ctions)	0.00	
	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0	
. 00 . 00		and private room cost di	fferential (line	118, 793, 695	37
5. 00 5. 00	General inpatient routine service cost net of swing-bed cost		I		
. 00 . 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)				
. 00 . 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	·			
. 00 . 00 . 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS		1 617 0/	20
. 00 . 00 . 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see	USTMENTS instructions)		1, 617. 96 3 171 202	
5.00 5.00 7.00 8.00	General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS e instructions) e 38)		1, 617. 96 3, 171, 202 0	39

	Financial Systems COMM TATION OF INPATIENT OPERATING COST	UNITY HOSPITAL C	Provider CC		Period: From 01/01/2022	eu of Form CMS-: Worksheet D-1	
					To 12/31/2022		
	Cost Center Description	Total	Ti tl Total	e XIX Average Per	Hospital Program Days	PPS Program Cost	
		Inpatient Cost		Diem (col. 1	5	(col. 3 x col.	
		1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00	
42.00	NURSERY (title V & XIX only)	5, 784, 459	7, 614	759.7	71 3, 300	2, 507, 043	42.00
43.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	16, 665, 540	7, 027	2, 371. 6	54 411	974, 744	43.00
44.00	CORONARY CARE UNI T						44.00
45.00 46.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.00
	NEONATAL INTENSIVE CARE UNIT	22, 191, 468	13, 571	1, 635. 2	21 873	1, 427, 538	
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wks					4, 172, 584	
48.01 49.00	Program inpatient cellular therapy acquisition Total Program inpatient costs (sum of lines 4				column 1)	0 12, 253, 111	
47.00	PASS THROUGH COST ADJUSTMENTS	1 thi ough 40.01	<u>) (see mistrue</u>			12, 233, 111	47.00
50.00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	Wkst. D, sum	n of Parts I and	576, 221	50.00
51.00	<pre>III) Pass through costs applicable to Program inpa</pre>	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	250, 504	51.00
F2 00	and IV)	50 and 51)				02/ 725	E2 00
52.00 53.00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclud		ated, non-phy	sician anesth	netist, and	826, 725 11, 426, 386	
	medical education costs (line 49 minus line 5	52)					
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program di scharges					0	54.00
55.00	Target amount per discharge					0.00	
55.01 55.02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor u					0.00	•
56.00	Target amount (line 54 x sum of lines 55, 55.					0.00	56.00
57.00	Difference between adjusted inpatient operati	ng cost and tar	get amount (I	ine 56 minus	line 53)	0	
58.00 59.00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54, o	or line 55 from	the cost repo	rting period	endi na 1996.	0.00	58.00 59.00
	updated and compounded by the market basket)			0.1	0		
60.00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 from	i prior year c	ost report, ι	updated by the	0.00	60.00
61.00	Continuous improvement bonus payment (if line 55.01 , or line 59 , or line 60 , enter the less 53) are less than expected costs (lines 54×10^{-10}	ser of 50% of th	e amount by w	hich operatir	ng costs (İine	0	61.00
62.00	enter zero. (see instructions) Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)			0	•
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Decem	ber 31 of the	cost reporti	ng period (See	0	64.00
	instructions)(title XVIII only)	5			3 · · · ·		
65.00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts after Decembe	er 31 of the c	ost reporting	g period (See	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	4 plus line 6	5)(title XVII	I only); for	0	66.00
67.00	CAH, see instructions Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	f the cost re	porting period	0	67.00
	(line 12 x line 19)	5					
68.00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after De	ecember 31 of	the cost repo	orting period	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient n					0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili				1		70.00
71.00	Adjusted general inpatient routine service co	ost per diem (li					71.00
72.00 73.00	Program routine service cost (line 9 x line 7 Medically necessary private room cost applica		(line 14 x li	ne 35)			72.00
74.00	Total Program general inpatient routine servi						74.00
75.00	Capital-related cost allocated to inpatient (26, line 45)	routine service	costs (from W	orksheet B, F	Part II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76.00
77.00	Program capital -related costs (line 9 x line						77.00
78.00 79.00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		ovider record	s)			78.00
80.00	Total Program routine service costs for compa	arison to the co		· · · ·	nus line 79)		80.00
81.00 82.00	Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li						81.00 82.00
83.00	Reasonable inpatient routine service costs (s						83.00
84.00 85.00	Program inpatient ancillary services (see ins		e)				84.00 85.00
85.00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85.00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PASS	5 THROUGH COST	-			0.005	1
87.00 88.00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per o		line 2)			8, 985 1, 617. 96	
89.00		•				14, 537, 371	

Health Financial Systems COM	MUNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2022	Worksheet D-1	
				To 12/31/2022		
		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, 499, 115	118, 793, 695	0. 07154	5 14, 537, 371	1, 040, 076	90.00
91.00 Nursing Program cost	0	118, 793, 695	0.00000	0 14, 537, 371	0	91.00
92.00 Allied health cost	0	118, 793, 695	0.00000	0 14, 537, 371	0	92.00
93.00 All other Medical Education	0	118, 793, 695	0.00000	14, 537, 371	0	93.00

	ancial Systems COMMUNITY HOSPITAL OF				u of Form CMS-	
INPATIENT A	ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0169	Peri od:	Worksheet D-3	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 11:	
		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	
	TI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	3.00	
	0 ADULTS & PEDI ATRI CS			36, 693, 630		30.00
	O INTENSIVE CARE UNIT			9, 010, 004		31.00
	O NEONATAL INTENSIVE CARE UNIT			0		35.00
	0 SUBPROVIDER - IPF			384		40.00
43.00 0430	NURSERY					43.00
	LLARY SERVICE COST CENTERS					
	O OPERATI NG ROOM	-	0. 1366		5, 701, 957	50.00
	O RECOVERY ROOM		0. 18044	5, 648, 457	1, 019, 258	51.00
	DO DELIVERY ROOM & LABOR ROOM		0. 49878	36 0	0	52.00
	0 RADI OLOGY-DI AGNOSTI C		0. 1971		665, 340	
	0 RADI OLOGY-THERAPEUTI C		0. 1025		621, 960	
	DO CT SCAN		0. 03968		385, 189	•
	0 MRI		0. 11139		218, 676	•
	O CARDI AC CATHETERI ZATI ON		0.04724		64, 518	
	O LABORATORY		0. 1778		2, 787, 327	•
	0 INTRAVENOUS THERAPY		0. 6117		171, 762	
	0 RESPIRATORY THERAPY		0. 24603		1, 828, 383	
	0 PHYSI CAL THERAPY		0. 38714		594, 480	
	0 OCCUPATIONAL THERAPY		0.36010		448, 599	•
	0 SPEECH PATHOLOGY		0. 23222		91, 529	•
			0.0595		152, 368	•
	0 ELECTROENCEPHALOGRAPHY 00 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 23412 0. 37562		101, 748	1
	0 IMPL. DEV. CHARGED TO PATIENTS		0. 3750		2, 864, 888 3, 844, 849	1
	0 DRUGS CHARGED TO PATIENTS		0. 25246		5, 230, 900	
	SPECIALTY PHARMACY		0. 00000		0, 230, 700	73.00
	0 RENAL DI ALYSI S		0. 3509		494, 255	•
	IO ENDOSCOPY		0. 1479		371, 427	76.00
	O OTHER ANCI LLARY SERVICE COST CENTERS		0. 00000		0, 1, 12,	76.01
	1 OTHER ANCILLARY SERVICE COST CENTERS		0.0000		0	
	2 OTHER ANCILLARY SERVICE COST CENTERS		0.0000		0	76.03
	3 WOUND CARE		0.3179		99, 998	•
76.06 0395	4 I MAGI NG CENTER		0. 09062	38, 541	3, 493	76.06
76.07 0395	5 BREAST DIAGNOSTIC CENTER		0. 4648		0	76.07
	ATIENT SERVICE COST CENTERS					
			0.0000		0	
	O INFUSION CENTER		0. 5016		0	90.01
	5 SPINE CENTER		0. 72486		0	90.26
	0 EMERGENCY		0. 11864		1, 728, 631	
	0 OBSERVATION BEDS (NON-DISTINCT PART		0. 82433		907, 849	
200.00	Total (sum of lines 50 through 94 and 96 through 98)	(1.)		157, 667, 727	30, 399, 384	•
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)			157, 667, 727		202.00

Heal th Financial Systems COMMUNITY HOSPITAL OF INDI		CN: 15-0169	Peri od:	u of Form CMS-2552- Worksheet D-3	
Co	mnonent	CCN: 15-S169	From 01/01/2022 To 12/31/2022		
	component			5/25/2023 11:31	
	Title		Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cos		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					30
. 00 03100 I NTENSI VE CARE UNI T					31
. 00 02060 NEONATAL INTENSIVE CARE UNIT					35
00 04000 SUBPROVI DER - I PF			4, 524, 266		40
					43
ANCI LLARY SERVI CE COST CENTERS		0. 1366	56 0	0	50
. 00 IOS100 RECOVERY ROOM		0. 1300		0	
00 05200 DELIVERY ROOM & LABOR ROOM		0. 1804		0	
00 05400 RADI OLOGY-DI AGNOSTI C		0. 1971		4, 305	
00 05500 RADI OLOGY-THERAPEUTI C		0. 1025		0	
00 05700 CT SCAN		0. 0396		3, 071	
00 05800 MRI		0. 1113		314	
00 05900 CARDI AC CATHETERI ZATI ON		0.0472		0	
00 06000 LABORATORY		0. 1778		67, 865	60
00 06400 I NTRAVENOUS THERAPY		0. 6117	11 5, 509	3, 370	64
00 06500 RESPI RATORY THERAPY		0. 2460	30 4, 563	1, 123	65
00 06600 PHYSI CAL THERAPY		0. 3871	40 30, 280	11, 723	66
00 06700 OCCUPATI ONAL THERAPY		0. 3601		8, 293	67
00 06800 SPEECH PATHOLOGY		0. 2322		340	
00 06900 ELECTROCARDI OLOGY		0. 0595		1, 605	
00 07000 ELECTROENCEPHALOGRAPHY		0. 2341		576	
00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0. 3756		0	
00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.3851		0	
00 07300 DRUGS CHARGED TO PATIENTS		0. 2524		73, 738	
01 07301 SPECIALTY PHARMACY 00 07400 RENAL DI ALYSI S		0.0000		0	
00 03330 ENDOSCOPY		0. 3509		0	
01 03330 ENDUSCOPY 01 03950 OTHER ANCILLARY SERVICE COST CENTERS		0. 1479		0	
02 03951 OTHER ANCI LLARY SERVICE COST CENTERS		0.0000		0	
03 03952 OTHER ANGI LLARY SERVICE COST CENTERS		0.0000		0	
04 03953 WOUND CARE		0. 3179		0	
06 03954 I MAGI NG CENTER		0.0906		0	
07 03955 BREAST DI AGNOSTI C CENTER		0. 4648		0	
OUTPATIENT SERVICE COST CENTERS					1
00 09000 CLINIC		0.0000		0	
01 04950 I NFUSI ON CENTER		0. 5016		0	
26 04975 SPINE CENTER		0. 7248		0	
. 00 09100 EMERGENCY		0. 1186		32, 857	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 8243		0	
0.00 Total (sum of lines 50 through 94 and 96 through 98)			1, 146, 837	209, 180	
1.00 Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)		0		201
2.00 Net charges (line 200 minus line 201)		1	1, 146, 837		202

Ieal th Financial Systems COMMUNITY HOSPITAL OF I NPATIENT ANCILLARY SERVICE COST APPORTIONMENT F				Peri od:	u of Form CMS-2552-10 Worksheet D-3	
INPAILE	ENT ANGTELART SERVICE COST APPORTIONMENT	Provi der CCN: 15-0169		From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 11:	pared:
		Title 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	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00	03000 ADULTS & PEDIATRICS			7, 980, 059		30.00
	03100 I NTENSI VE CARE UNI T			2, 639, 178		31.00
	02060 NEONATAL INTENSIVE CARE UNIT			6, 925, 512		35.00
	04000 SUBPROVI DER – I PF			530, 139		40.00
	04300 NURSERY			4, 711, 282		43.00
	ANCI LLARY SERVI CE COST CENTERS					
	05000 OPERATING ROOM		0. 1395		365, 745	50.00
	05100 RECOVERY ROOM		0. 1804		94, 568	
	05200 DELIVERY ROOM & LABOR ROOM		0.4987		182, 774	•
	05400 RADI OLOGY-DI AGNOSTI C		0. 1971		106, 502	
	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN		0. 1025		56, 890	
	05700 CT SCAN 05800 MRI		0. 0396		53, 886 23, 294	
	05800 CARDI AC CATHETERI ZATI ON		0. 1113		1, 883	
	06000 LABORATORY		0. 0472		462, 276	
	06400 INTRAVENOUS THERAPY		0. 6117		35, 311	
	06500 RESPI RATORY THERAPY		0. 2460		614, 334	
	06600 PHYSI CAL THERAPY		0. 3899		49, 688	
	06700 OCCUPATI ONAL THERAPY		0. 3601		62, 156	
	06800 SPEECH PATHOLOGY		0. 2322		12,047	
	06900 ELECTROCARDI OLOGY		0.0595		17, 529	
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 2341		20, 368	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3756	20 1, 122, 028	421, 456	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 3851	95 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 2524	67 4, 077, 451	1, 029, 422	73.00
	07301 SPECI ALTY PHARMACY		0.0000		0	73.01
	07400 RENAL DI ALYSI S		0. 3509		94, 110	
	03330 ENDOSCOPY		0. 1479		34, 818	
	03950 OTHER ANCILLARY SERVICE COST CENTERS		0.0000		0	76.01
	03951 OTHER ANCI LLARY SERVICE COST CENTERS		0.0000		0	76.02
	03952 OTHER ANCI LLARY SERVICE COST CENTERS		0.0000		0	76.03
	03953 WOUND CARE 03954 I MAGI NG CENTER		0. 3179		16, 380 0	
	03955 BREAST DI AGNOSTI C CENTER		0. 0400		0	
	OUTPATIENT SERVICE COST CENTERS		0.4040	/3	0	,0.0/
	09000 CLINIC		0.0000	00 0	0	90.00
	04950 INFUSION CENTER		0. 5016		0	90.01
	04975 SPI NE CENTER		0. 7248		0	90.26
	09100 EMERGENCY		0. 1195		264, 117	
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 8243		153, 030	
200.00	Total (sum of lines 50 through 94 and 96 through 98)			20, 249, 693	4, 172, 584	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges	6 (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		1	20, 249, 693		202.00

Instructions) Instructions 0.496,394 1.02 DBS for field Specific oursets of the source of the sourc	Heal th	Financial Systems COMMUNITY HOSPITAL OF	FINDIANA, INC.	In Lie	u of Form CMS-2	2552-10
It is AVII. Height Id HPS 0 PMT A - HWATLENT HOSPITAL SERVICES UNDER LPPS 1.00 1.01 DBG Accounts Other Hum Outlier payments for discharges occurring or for to account (see 26,203,B46 1.00 1.01 DBG Accounts Other Hum Outlier payments for discharges occurring or or active occurring prior to active 0 1.00 1.02 DBG Accounts Other Hum Outlier payment for World 4 MPCI for discharges occurring or or after occuber 1 (see 1.00 1.00 1.04 DBG Accounts Other Hum Outlier payment for World 4 MPCI for discharges occurring or or after occuber 1 (see Instructions) 0 2.00 2.03 Duttier payments for discharges occurring or after Occuber 1 (see Instructions) 0 2.00 2.04 Duttier payments for discharges for Koold 4 KPCI for Dischard 1 (see Instructions) 1.000,742 2.00 2.05 Duttier payments for discharges occurring or after Occuber 1 (see Instructions) 2.92,82 2.00 2.06 Duttier payments for discharges occurring or after Occuber 1 (see Instructions) 3.44,84 4.00 2.00 Duttier payments for discharges occurring or after Occuber 1 (see Instructions) 3.44,84 4.00 2.00 Duttier payments for dischar	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0169	From 01/01/2022	Part A	pared:
Description 1.00 Description 1.00 100			Title XVIII		5/25/2023 11:	
Def A LINKTINE TOGETIAL SERVICES LINDER LEPS. 10 BXG anounts Other than Outliner payments for discharges occurring prior to October 1 (see instructions) 26, 203, 846 1 110 DXG anounts Other than Outliner payments for discharges occurring prior to October 1 (see instructions) 26, 203, 846 1 27, 203, 846 1 20, 203, 846 1 20, 203, 846 1 20, 203, 846 1 20, 203, 846 1 20, 203, 846 1 20, 203, 846 1 20, 203, 846 1 20, 203, 846 1 20, 203, 846 1 20, 203, 846 1 20, 203, 846 1 20, 203, 846 1 20, 203, 846 1 20, 203, 846 1 20, 203, 203, 203, 203, 203, 203, 203, 2				•	1 00	
101 BKG amounts other than outlier payments for discharges occurring on or after October 1 (see 22,203,84 1.01 102 BKG amounts of them outlier payments for discharges occurring on or after October 1 (see 9,496,394 1.02 103 BKG for forbard specific operating payment for Model 4 BPC1 for discharges occurring on or after 0 1.04 104 BKG for forbard specific operating payment for Model 4 BPC1 for discharges cocurring on or after 2.00 105 DHI for forbard specific operating payment for Model 4 BPC1 for discharges cocurring on or after 2.00 105 DHI for forbard specific operating payment for discharges cocurring on or after 2.00 106 DHI for forbard specific operating payment for discharges cocurring on or after 2.00 100 DHI for recentil idling amount for discharges cocurring on or after forbard specific operating payments for discharges forbards for the cost reparting pariod (see instructions) 3.00 100 DHI for recentil idling on the cost respecting pariod ending on or after forbard specific operating payment for discharges courring on or after forbard specific operating payment for discharges forbards specific operating payment for discharges forbards specific operating payment for discharges forbards specific operating payment for discharges forbards specific operating payment for discharges forbards specific operating payment for discharges forbards specific operating payment for discharges forbardspayment forbards specific op						
1.02 B&& anounts other than outlier payment for discharges occurring on or after Oxtober 1 (see Instructions) 9,496,394 1.02 1.03 B&& for Federal specific operating payment for Model 4 BPCI for discharges occurring on a after Oxtober 1 (see instructions) 1.03 0 D& for for redural specific operating payment for Model 4 BPCI for discharges occurring on a after Oxtober 1 (see instructions) 2.00 0 Outlier propends for discharges (see instructions) 2.01 0.00 Outlier propends for discharges occurring on or after Oxtober 1 (see instructions) 3.09 273 0.00 Outlier payments for discharges occurring on or after Oxtober 1 (see instructions) 3.00 272 0.00 Defining regression for discharges occurring on or after Oxtober 1 (see instructions) 3.00 27 0.00 TFE count for all opathic and ostopathic programs for the cost resporting period oxtoper 0 0.00 0.00 0.01 TFE count for all opathic and ostopathic programs that meet the cap-bail for given outber 0 0.00 0.00 0.02 Ref advace on 422 requiring the model of the model outber 1 0.00 and 0.00 0.00 0.00 0.03 TFE count for all opathic and ostopathic programs that meet the cap-bail for given outber 0.00 0.00 0.00 0.04 TFE count for all opathic and ostopathic programs that meet the cap-bail for given outbe		DRG amounts other than outlier payments for discharges occurr	ing prior to October 1 (see	-	
1.33 R06 for fuderal specific operating payment for Model 4 BPCI for discharges occurring prior to 0 cluber i (see instructions) 1.04 1.40 R06 for fuderal specific operating payment for Model 4 BPCI for discharges occurring on or after 0. 1.04 0.00 Outlier reconciliation mount 0.01 0.01 Currier payments for discharges for Model 4 BPCI (see instructions) 0.02 0.01 Dutlier payments for discharges for Model 4 BPCI (see instructions) 1.04 0.02 Dutlier payments for discharges for Model 4 BPCI (see instructions) 1.04 0.01 Dutlier payments for discharges for Model 4 BPCI (see instructions) 1.04 0.02 Dutlier payments for discharges for Model 4 BPCI (see instructions) 1.04 0.01 Eff count for dispathic and ostemating on an first Dutlier (see instructions) 3.04 0.01 Eff count for dispathic programs for the most recent cost reporting period ending on one of the Count for all opathic and ostemating the under 3.02 (for the Cap-bail ding indow closed under 5127 of 0.00 0.00 0.01 Eff count for all opathic and ostemating the Cap assectified under 3.2 (FG 8412.1067(1)(4)(4)(6)(2) 0.00 7.00 0.02 Cast for 4.22 for 4.12 (for (1)(4)(4)(6)(2) 0.00 7.00 7.00 7.00 7.00 7.00 7.00 <td>1.02</td> <td>DRG amounts other than outlier payments for discharges occurr</td> <td>ing on or after October</td> <td>1 (see</td> <td>9, 496, 394</td> <td>1. 02</td>	1.02	DRG amounts other than outlier payments for discharges occurr	ing on or after October	1 (see	9, 496, 394	1. 02
Colour 1 (see instructions) 2.00 Duilier reconciliation amount 0 Duilier repayments for discharges occurring on or after October 1 (see instructions) 314.81 Duilier repayments for discharges occurring on or after October 1 (see instructions) 0.00 Duilier repayments for discharges occurring on or after October 1 (see instructions) 0.00 Duilier repayments for discharges occurring on or after October 1 (see instructions) 0.00 Duilier repayments for discharges occurring on or after October 1 (see instructions) 0.00 Duilier repayments for discharges occurring on or after October 1 (see instructions) 0.00 Duilier repayments for dinstruction discharges occuring o	1.03	DRG for federal specific operating payment for Model 4 BPCl f 1 (see instructions)	5 5			1.03
2.01 Outlier reconctinition amount 0		October 1 (see instructions)	or di scharges occurri ng	on or after	0	1.04
2.03 Outliner payments for discharges accurring prior to October 1 (see instructions) 1,000,742 2.03 3.00 Managed Caro Simulated Payments 32,630,609 3.00 3.00 The degree shull able of Used by number of days in the cost reporting period (see instructions) 312,630,609 3.00 5.00 The count for all opathic and ostepaptic programs for the most recent cost reporting period ending on perform 1/23/1966, (see instructions) 0.00 5.00 5.01 The count for all opathic and ostepaptic programs for the CAA 2021 (see instructions) 0.00 0.00 5.01 The count for all opathic and ostepaptic programs that neet the cap-building window cleased under 5127 of 0.00 0.00 </td <td>2.01</td> <td>Outlier reconciliation amount</td> <td>tions)</td> <td></td> <td></td> <td>2.01</td>	2.01	Outlier reconciliation amount	tions)			2.01
3.00 Managed Carle Simulated Payments 32, 630, 609 3.00 3.00 Managed Carle Simulated Payments 314, 44 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 314, 44 5.00 FTE cauling the and estepathic programs for the most resent cost reporting period ending on 0.00 5.00 5.01 FTE cauling the and estepathic programs for the CAA 2021 (see instructions) 0.00 6.00 6.01 FTE cauling the and estepathic programs that neet the criteria for an add on to the cap for new programs in accordance with 42 CFR 413.77(c) 0.00 6.00 6.01 FTE cauling the and estepathic programs that neet the criteria for an add ont cost he cap for the CAA 2021 (see instructions) 0.00 7.00 6.02 FTE cauling the top instructions instructions instructions in scordance with 43, 75(b) 0.00 7.00 7.03 Add stardance of decrease) to the hospital's runal track programs for the CAA 117 the cost report strade scordance with 42 CFR 413, 75(b), 413, 76(c)(2)(iv), 64 FR 26340 (May 12, 1986), and 67 FR 50050 (August 1, 202). 8.00 8.00 affiliated programs in accordance with 42 CFR 413, 75(b), 413, 76(c)(2)(iv), 64 FR 26340 (May 12, 1986), and 67 FR 50050 (August 1, 202). 8.00 8.01 track programs in accordance with 42 CFR 413, 75(b), 413, 76(c)(2)(iv), 64 FR 26340					-	2.02
4.00 Bed asys avail table divided by number of days in the cost reporting period (see instructions) 314.88 4.00 5.00 FIE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/10% (see instructions) 0.00 5.00 5.01 FTE cap adjustment for qual fing heapt tal programs that nee the criteria for an add-on to the cap for one programs in accordance with AZ (FR 413.79(c)) 0.00 6.00 6.26 Rural track programs in the cost of the CAA 201 (see instructions) 0.00 7.00 7.00 MAA Section 422 reduction amount to the IME cop as specified under 42 CFR 9412.105(f)(1)(iv)(8)(2)(1) 0.00 7.00 7.02 Adjustment (increase or decrease) to the HE count for all lopathic and osteopathic programs for artificated programs in accordance with 413.75(b) and 5F R 4005 (August 10, 2022) (see instructions) 0.00 7.02 8.01 Adjustment (increase if the hospital was avaride FTE cap slots from a closed teaching hospital under 5 5500 of the CAA 201 (see 0.00 8.01 9.02 The amount of increase if the hospital was avaride FTE cap slots from a closed teaching hospital under 5 5500 of the CAA 201 (see 0.00 8.01 9.00 FTE count for relopathic and osteopathic programs. In the current year from your records 3.97 10.00 9.01 The amount of incresase if the hospital was avaride FTE cap slots from a c			1 (see instructions)			
5.00 FTE count for allopathic and esteopathic programs for the most recent cost reporting period ending on or before 12/31/396 (see instructions) 0.00 5.00 5.01 FTE cap adjustment for qualifing hospitals under \$131 of the CA 2021 (see instructions) 0.00 5.01 5.01 FTE cap adjustment for qualifing hospitals under \$131 of the CA 2021 (see instructions) 0.00 5.01 5.01 FTE cap adjustment for qualifing hospitals under \$131 of the CA 2021 (see instructions) 0.00 5.01 6.02 Hue Cont for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for under \$200 (for under \$20		Bed days available divided by number of days in the cost repo	orting period (see instru	uctions)		
5.01 FTE cap adjustment for qualiting hospitals under \$131 of the CAA 2021 (see instructions) 0.00 5.01 6.00 FTE count for allopabilic and ostopabilic programs that meet the riterial for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 0.00 6.00 6.0 Rural track programs finat meet the cap-building window closed under \$127 of the CAA 2021 (see instructions) 0.00 7.00 7.01 ACA 5503 reduction amount to to the IME cap as specified under 42 CFR \$412.105(F)(1)(iv)(B)(2) If the 0.00 7.00 7.02 Adjustment (increase or decrease) to the hospital's rural track programs in accordance with 42.57R \$412.105(F)(1)(iv)(B)(2) IF the 0.00 7.00 7.03 Adjustment (increase or decrease) to the hospital's rural track programs in accordance with 42.57R \$405(My) 12. 0.00 7.00 8.00 Adjustment (increase or decrease) to the FIE count for allopathic and ostopathic programs for 4.54 8.00 7.01 8.01 The amount of increase if the hospital was awarded FIE cap slots under \$2503 of the ACA.11' the cost regort stradidis 0.00 8.01 8.01 8.01 The amount of increase if the hospital was awarded FIE cap slots under \$26 of the CAA 2021 (see 0.00 8.01 8.01 The amount of increase if the hospital was awarded FIE cap slots under \$2.67 fm accoad cance (see instructions) 0.00 8.02	5.00	FTE count for allopathic and osteopathic programs for the mos	st recent cost reporting	period ending on	0.00	5.00
6.26 Bural track program FTE cap limitation adjustment after the cap-building window closed under \$127 of the CA 2021 (see instructions) 0.00 6.26 7.00 MAA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(i)(i)(2)(1) 0.00 7.00 7.01 MAA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(i)(2)(2) If the cost report straddles July 1, 2011 then see instructions. 0.00 7.00 7.03 MAA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(i)(2)(2) If the cost report straddles July 1, 2011, see instructions. 0.00 7.00 7.04 MA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(i)(2)(2) If the cost report straddles July 1, 2011, see instructions. 0.00 7.00 8.00 Med FR 4005 (Mugut 10, 2022) (see instructions) 100 pathid and scheapthic programs for report straddles July 1, 2011, see instructions. 0.00 8.01 8.01 The amount of increase if the hospital was awarded FTE cap slots under § 250 of the CAA 2021 (see Instructions). 0.00 8.01 9.00 Sum of lines 5 and 5.01, puis line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus line 6.20 through 6.49,		FTE cap adjustment for qualifing hospitals under §131 of the				5. 01 6. 00
7.00 MAA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(8)(2) IF the Cost report stradides July 1, 2011 then see instructions. 0.00 7.00 7.01 MCA § 503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(8)(2) IF the Cost report stradides July 1, 2011 then see instructions. 0.00 7.00 7.04 Missioned (increase or decrease) to the hospital's rural track programs in accordance with 413.75(b) and 87 R4907 (August 10, 2022) (see instructions) 0.00 7.02 8.00 Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for report stradides July 1, 2011 see instructions. 4.54 8.00 8.01 The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions). 0.00 8.01 8.02 The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions). 0.00 8.21 9.00 Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/inus lines 1.02, plus/inus lines 6.26 through 8.27 (see instructions). 3.97 10.00 10.00 FTE count for relidents in dential and podal arcle programs. 2.561 10.00 8.51 10.00 10.01 FTE count for relidents in dential and podal arcle program frem your records 3.97	6.26	Rural track program FTE cap limitation adjustment after the c	cap-building window close	ed under §127 of	0.00	6. 26
cost report straddles July 1, 2011 then see instructions. Cost		MMA Section 422 reduction amount to the IME cap as specified				7.00
and B7 FF 49075 (August 10, 2022) (see instructions) A. 54 S. 04 Augustnent (increase or decrease) to the FE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413, 75(b), 413, 79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 65 FR 50069 (August 1, 2002). 8.01 8.01 The amount of increase If the hospital was awarded FE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions). 0.00 8.01 8.02 The amount of increase If the hospital was awarded FE cap slots under § 160 the CAA 2021 (see instructions). 0.00 8.21 9.03 Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus lines 8.01 through 8.27 (see instructions). 4.54 9.00 9.00 Current year allowable FTE count for the programs in the current year from your records 3.97 11.00 10.00 FTE count for residents in admital and podiatric programs. 2.59 11.00 12.00 Current year allowable FTE count for the prol year. 6.51 14.00 13.00 Total allowable FTE count for the prol year. 6.51 15.00 14.00 Current year residents in indial and podiatric program (see instructions) 6.51 15.00 14.00 Current year residents di splaced by program or hospital closure 0.00 </td <td></td> <td>cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the hospital's rural tra</td> <td>ack program FTE limitatio</td> <td>on(s) for rural</td> <td></td> <td></td>		cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the hospital's rural tra	ack program FTE limitatio	on(s) for rural		
1998), and 67 FE 50069 (August 1, 2022). 8.11 The mount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 0.00 8.10 8.2 The mount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) 0.00 8.10 9.0 Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 8.47 (see instructions) 4.54 9.00 0.00 FTE count for allopathic and osteopathic programs in the current year from your records 3.97 10.00 11.00 OT FTE count for residents in dental and podiatric programs. 2.59 11.00 12.00 Current year allowable FTE count for the prior year. 6.52 6.52 12.00 13.00 Total allowable FTE count for the prior year. 6.54 15.00 14.40 15.00 Sum of lines 12 through 14 divided by 3. 6.54 15.00 17.00 16.00 Adjustment for residents in initial years of the program (see instructions) 0.00 6.54 18.00 10.00 Derter year resident to bed ratio (see instructions) 0.00 6.54 18.00 10.00 Total allowable FTE count for the prior year. 6.54 15.00 0.00 10.00 Adjustment for residents in initial years of the program (see instructions) 0.00 0.	8.00	and 87 FR 49075 (August 10, 2022) (see instructions) Adjustment (increase or decrease) to the FTE count for allopa	athic and osteopathic pro	ograms for	4.54	8.00
report straddles July 1, 2011, see instructions. 8.02 Ro The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions) 8.00 8.21 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions) 8.21 9.00 Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus line 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) 3.97 10.00 FTE count for rail opathic and osteopathic programs. 2.55 11.00 12.00 Current year allowable FTE (see instructions) 6.56 12.00 13.00 Total allowable FTE count for the prior year. 6.54 15.00 14.00 The count for residents in initial years of the program (see instructions) 0.00 6.54 15.00 Sum of lines 12 through 14 divided by 3. 6.54 15.00 16.00 Adjustment for residents in initial years of the program (see instructions) 0.00 16.00 19.00 Current year resident bed ratio (see instructions) 0.02772 19.00 10.00 Current year resident to bed ratio (see instructions) 0.02772 10.00 10.00 Current year resident to	8.01	1998), and 67 FR 50069 (August 1, 2002).			0.00	8.01
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33.00Allowable disproportionate share percentage (see instructions)20.3833.00						
			:)			
		Disproportionate share adjustment (see instructions)	<i>,</i> ,			

	Financial Systems COMMUNITY HOSPITAL OF			u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0169	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Pre 5/25/2023 11:3	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
	Uncompensated Care Payment Adjustment		_		
35.00	Total uncompensated care amount (see instructions)			6, 874, 403, 459	
35.01	Factor 3 (see instructions)		0. 000277862	0.000369054	
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, e	enter zero on this line)	1, 998, 388	2, 537, 024	35. 02
35.03	(see instructions)	(and instructions)	1, 494, 684	(20, 470	35.03
36.00	Pro rata share of the hospital UCP, including supplemental UCP Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	(see This tructions)	2, 134, 154		36.00
30.00	Additional payment for high percentage of ESRD beneficiary disc	charges (Lines 40 throug			50.00
40.00	Total Medicare discharges (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instruction	ons)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify		0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by	y line 41 divided by 7	0.000000		44.00
	days)				
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.0	U1)	0		46.00
47.00	Subtotal (see instructions)	all rural bearitals	41, 426, 285		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, sma only. (see instructions)	an rurai nospitais	0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			41, 794, 587	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and	Pt. II, as applicable)		3, 143, 112	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. I			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line	e 49 see instructions).		239, 171	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			386, 743	
54. 01 55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	54.01 55.00
55. 00 55. 01	Cellular therapy acquisition cost (see instructions))		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intrud	ctions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III	-	rouah 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IN		5 ,	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			45, 563, 613	59.00
60.00	Primary payer payments			11, 906	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus l	line 60)		45, 551, 707	61.00
62.00	Deductibles billed to program beneficiaries			3, 636, 820	
63.00	Coinsurance billed to program beneficiaries			221, 626	63.00
64.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			136, 085	
65.00 66.00	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		88, 455 31, 713	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			41, 781, 716	
68.00	Credits received from manufacturers for replaced devices for ap	pplicable to MS-DRGs (se	e instructions)	0	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (F			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		,	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstra	ation) adjustment (see i	nstructions)	0	70. 50
70. 75	N95 respirator payment adjustment amount (see instructions)			0	70. 75
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instru	uctions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0	70.90
70. 91 70. 92	Bundled Model 1 discount amount (see instructions)			0	70. 91 70. 92
70.92	HVBP payment adjustment amount (see instructions)			0	70.92
70.93	HRR adjustment amount (see instructions)			-46, 705	
	Recovery of accel erated depreciation			40, 705	
				-	

	NT F	Provider CC		Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prep 5/25/2023 11:3	
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1.00	
	al fiscal year (yyyy) (Enter in o	column O		0	0	70.96
the corresponding federal year				0	0	70.07
	ral fiscal year (yyyy) (Enter in o for the period ending on or afte			0	0	70.97
0.98 Low Volume Payment-3	To the period ending on or arter	10/1)			0	70, 98
0.99 HAC adjustment amount (see inst	ructions)				324, 782	70.99
	nus lines 68 plus/minus lines 69	& 70)			41, 410, 229	71.00
.01 Sequestration adjustment (see i	•	,			521, 769	71.01
1.02 Demonstration payment adjustmer	nt amount after sequestration				0	71.02
1.03 Sequestration adjustment-PARHM	or CHART pass-throughs					71.03
2.00 Interim payments					40, 265, 472	72.00
2.01 Interim payments-PARHM or CHART					-	72.01
3.00 Tentative settlement (for contr					0	73.00
	CHART (for contractor use only)	70			(22,000	73.01
	ine 71 minus lines 71.01, 71.02,	72, and			622, 988	74.00
73) 4.01 Balance due provider/program-PA	ARHM or CHART (see instructions)					74.01
1 1 5	e cost report items) in accordance	e with			691, 376	75.00
CMS Pub. 15-2, chapter 1, §115.	· · · ·	o			0,1,0,0	/0/00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
	/kst. E, Pt. A, line 2, or sum of	2.03			0	90.00
plus 2.04 (see instructions)					-	
1.00 Capital outlier from Wkst. L, F					0	91.00
	on adjustment amount (see instruct				0	92.00 93.00
· · ·	adjustment amount (see instruction time value of money (see instruction	· ·				93.00
5.00 Time value of money for operati	5 .	(10113)			0.00	95.00
6.00 Time value of money for capital	0	ons)			Ő	96.00
				Prior to 10/1	On/After 10/1	
				1.00	2.00	
HSP Bonus Payment Amount						
00.00 HSP bonus amount (see instructi				0	0	100.00
HVBP Adjustment for HSP Bonus P 01.00 HVBP adjustment factor (see ins				0.000000000	0.000000000	101 00
02.00 HVBP adjustment amount for HSP				0.0000000000000000000000000000000000000		101.00
HRR Adjustment for HSP Bonus Pa				<u> </u>	0	102.00
03.00 HRR adjustment factor (see inst				0.0000	0.0000	103.00
04.00 HRR adjustment amount for HSP b				0		104.00
Rural Community Hospital Demons	tration Project (§410A Demonstrat	tion) Adjus	stment			
00.00 Is this the first year of the c	tration Project (§410A Demonstration period					200. 00
00.00 Is this the first year of the c Century Cures Act? Enter "Y" fo	tration Project (§410A Demonstration period					200.00
00.00 Is this the first year of the c Century Cures Act? Enter "Y" fo Cost Reimbursement	tration Project (§410A Demonstrat current 5-year demonstration perio pr yes or "N" for no.	od under t				
00.00 Is this the first year of the c Century Cures Act? Enter "Y" fo Cost Reimbursement 01.00 Medicare inpatient service cost	tration Project (§410A Demonstrat current 5-year demonstration perio or yes or "N" for no. cs (from Wkst. D-1, Pt. II, line	od under t				200. 00
00.00 Is this the first year of the c Century Cures Act? Enter "Y" fo Cost Reimbursement 01.00 Medicare inpatient service cost 02.00 Medicare discharges (see instru	tration Project (§410A Demonstrat current 5-year demonstration perio or yes or "N" for no. cs (from Wkst. D-1, Pt. II, line uctions)	od under t				201. 00 202. 00
 00.00 Is this the first year of the c Century Cures Act? Enter "Y" for Cost Reimbursement 01.00 Medicare inpatient service cost 02.00 Medicare discharges (see instruct) 03.00 Case-mix adjustment factor (see 	tration Project (§410A Demonstration current 5-year demonstration period or yes or "N" for no. (s (from Wkst. D-1, Pt. II, line citions) e instructions)	od under t 49)	he 21st	t 5-year demonst		
00.00 Is this the first year of the c Century Cures Act? Enter "Y" for Cost Reimbursement 01.00 Medicare inpatient service cost 02.00 Medicare discharges (see instru 03.00 Case-mix adjustment factor (see Computation of Demonstration Ta	tration Project (§410A Demonstrat current 5-year demonstration perio or yes or "N" for no. cs (from Wkst. D-1, Pt. II, line uctions)	od under t 49)	he 21st	t 5-year demonst		201. 00 202. 00
 00.00 Is this the first year of the c Century Cures Act? Enter "Y" for Cost Reimbursement 01.00 Medicare inpatient service cost 02.00 Medicare discharges (see instruct) 03.00 Case-mix adjustment factor (see Computation of Demonstration Taperiod) 	tration Project (§410A Demonstration current 5-year demonstration period or yes or "N" for no. (s (from Wkst. D-1, Pt. II, line citions) e instructions)	od under t 49)	he 21st	t 5-year demonst	ration	201. 00 202. 00 203. 00
 00.00 Is this the first year of the c Century Cures Act? Enter "Y" for Cost Reimbursement 01.00 Medicare inpatient service cost 02.00 Medicare discharges (see instruct) 03.00 Case-mix adjustment factor (see Computation of Demonstration Taperiod) 04.00 Medicare target amount 	tration Project (§410A Demonstrat current 5-year demonstration perio or yes or "N" for no. (from Wkst. D-1, Pt. II, line (ctions) (instructions) rget Amount Limitation (N/A in fi	od under t 49)	he 21st	t 5-year demonst	ration	201. 00 202. 00
 00.00 Is this the first year of the c Century Cures Act? Enter "Y" for Cost Reimbursement 01.00 Medicare inpatient service cost 02.00 Medicare discharges (see instru 03.00 Case-mix adjustment factor (see Computation of Demonstration Ta period) 04.00 Medicare target amount 05.00 Case-mix adjusted target amount 06.00 Medicare inpatient routine cost 	tration Project (§410A Demonstration current 5-year demonstration period or yes or "N" for no. (s (from Wkst. D-1, Pt. II, line citions) (e instructions) (rget Amount Limitation (N/A in fi (line 203 times line 204) (c cap (line 202 times line 205)	od under t 49)	he 21st	t 5-year demonst	ration	201. 00 202. 00 203. 00 204. 00
 10.00 Is this the first year of the c Century Cures Act? Enter "Y" for Cost Reimbursement 10.00 Medicare inpatient service cost 12.00 Medicare discharges (see instruitation) 13.00 Case-mix adjustment factor (see Computation of Demonstration Taperiod) 14.00 Medicare target amount 15.00 Case-mix adjusted target amount 16.00 Medicare inpatient routine cost Adjustment to Medicare Part A I 	tration Project (§410A Demonstration current 5-year demonstration period or yes or "N" for no. (s (from Wkst. D-1, Pt. II, line citions) e instructions) rget Amount Limitation (N/A in fi (line 203 times line 204) cap (line 202 times line 205) npatient Reimbursement	49) rst year o	he 21st	t 5-year demonst	ration	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
 10.00 Is this the first year of the c Century Cures Act? Enter "Y" for Cost Reimbursement 10.00 Medicare inpatient service cost 200 Medicare discharges (see instru- 3.00 Case-mix adjustment factor (see Computation of Demonstration Taperiod) 40.00 Medicare target amount 15.00 Case-mix adjusted target amount 16.00 Medicare inpatient routine cost Adjustment to Medicare Part A I 17.00 Program reimbursement under the 	tration Project (§410A Demonstration current 5-year demonstration period or yes or "N" for no. (s (from Wkst. D-1, Pt. II, line distructions) e instructions) rget Amount Limitation (N/A in fi (line 203 times line 204) cap (line 202 times line 205) npatient Reimbursement e §410A Demonstration (see instruct	49) rst year o	he 21st	t 5-year demonst	ration	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00
 10.00 Is this the first year of the c Century Cures Act? Enter "Y" fo Cost Reimbursement 11.00 Medicare inpatient service cost 200 Medicare di scharges (see instruitation) 200 Case-mix adjustment factor (see Computation of Demonstration Taperiod) 400 Medicare target amount 500 Case-mix adjusted target amount 600 Medicare inpatient routine cost Adjustment to Medicare Part A I 700 Program reimbursement under the 800 Medicare Part A inpatient servi 	tration Project (§410A Demonstration period current 5-year demonstration period or yes or "N" for no. (s (from Wkst. D-1, Pt. II, line - uctions) e instructions) rget Amount Limitation (N/A in fi (line 203 times line 204) cap (line 202 times line 205) npatient Reimbursement e §410A Demonstration (see instruction ce costs (from Wkst. E, Pt. A, line)	49) rst year o	he 21st	t 5-year demonst	rati on	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
 00.00 Is this the first year of the c Century Cures Act? Enter "Y" for Cost Reimbursement 01.00 Medicare inpatient service cost 02.00 Medicare discharges (see instruction) 03.00 Case-mix adjustment factor (see Computation of Demonstration Taperiod) 04.00 Medicare target amount 05.00 Case-mix adjusted target amount 06.00 Medicare inpatient routine cost Adjustment to Medicare Part A I 07.00 Program reimbursement under the 08.00 Medicare Part A inpatient servi 09.00 Adjustment to Medicare IPPS pay 	tration Project (§410A Demonstration period current 5-year demonstration period or yes or "N" for no. (s (from Wkst. D-1, Pt. II, line - uctions) e instructions) rget Amount Limitation (N/A in fi (line 203 times line 204) cap (line 202 times line 205) npatient Reimbursement e §410A Demonstration (see instruction ce costs (from Wkst. E, Pt. A, line)	49) rst year o	he 21st	t 5-year demonst	rati on	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
 0.00 Is this the first year of the c Century Cures Act? Enter "Y" for Cost Reimbursement 1.00 Medicare inpatient service cost 2.00 Medicare discharges (see instruction) 3.00 Case-mix adjustment factor (see Computation of Demonstration Taperiod) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount 6.00 Medicare inpatient routine cost Adjustment to Medicare Part A I 7.00 Program reimbursement under the 8.00 Medicare Part A inpatient servi 9.00 Adjustment to Medicare IPPS pay 0.00 Reserved for future use 	tration Project (§410A Demonstration period current 5-year demonstration period or yes or "N" for no. (s (from Wkst. D-1, Pt. II, line - instructions) (s instructions) (rget Amount Limitation (N/A in fine) (s (line 203 times line 204) (s cap (line 202 times line 205) (npatient Reimbursement (s §410A Demonstration (see instructions) (s casts (from Wkst. E, Pt. A, line) (s casts (see instructions)	49) rst year o	he 21st	t 5-year demonst	ration	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
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 00.00 Is this the first year of the c Century Cures Act? Enter "Y" for Cost Reimbursement 01.00 Medicare inpatient service cost 02.00 Medicare discharges (see instru- Computation of Demonstration Taperiod) 04.00 Medicare target amount 05.00 Case-mix adjusted target amount 06.00 Medicare inpatient routine cost Adjustment to Medicare Part A I 07.00 Program reimbursement under the 08.00 Medicare Part A inpatient service 09.00 Adjustment to Medicare IPPS pay 10.00 Total adjustment to Medicare IF Comparision of PPS versus Cost 	tration Project (§410A Demonstration period current 5-year demonstration period or yes or "N" for no. (s (from Wkst. D-1, Pt. II, line of cutions) (e instructions) (rget Amount Limitation (N/A in fi cutions) (line 203 times line 204) (cap (line 202 times line 205) (npatient Reimbursement (cutotation (see instructions)) (see instructions) (see instructions) (see instructions) (see instructions) (see instructions) (see instructions)	49) rst year o ctions) ine 59)	he 21st	t 5-year demonst	ration	201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00
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 00.00 Is this the first year of the c Century Cures Act? Enter "Y" for Cost Reimbursement 01.00 Medicare inpatient service cost 02.00 Medicare discharges (see instruction) 03.00 Case-mix adjustment factor (see Computation of Demonstration Taperiod) 04.00 Medicare target amount 05.00 Case-mix adjusted target amount 06.00 Medicare inpatient routine cost Adjustment to Medicare Part A I 07.00 Program reimbursement under the Medicare Part A inpatient servi 09.00 Adjustment to Medicare IPPS pay 00.00 Reserved for future use 01.00 Total adjustment to Medicare IF 	tration Project (§410A Demonstration period current 5-year demonstration period or yes or "N" for no. (s (from Wkst. D-1, Pt. II, line - ductions) e instructions) rget Amount Limitation (N/A in fi cap (line 203 times line 204) cap (line 202 times line 205) npatient Reimbursement e §410A Demonstration (see instruc- ce costs (from Wkst. E, Pt. A, line ments (see instructions) PPS payments (see instructions) Reimbursement art A IPPS payments (from line 21) cructions)	ctions) i ne 59)	he 21st	t 5-year demonst	rati on	201. 0 202. 0 203. 0 205. 0 206. 0 207. 0 208. 0 209. 0 210. 0 211. 0

Ittls X011 Hespital PS 0 PART A. MPACAL MAD OTHER MAD IN SERVICES 1.00 1.00 10 Notical and other services (see instructions) 50,744,440 2.00 2.00 Notical and other services (see instructions) 16,744,460 2.00 10 Duttler record lation amount (see instructions) 0.00,744,460 2.00 10 Duttler record lation amount (see instructions) 0.00,744,460 2.00 10 Duttler record lation amount (see instructions) 0.00,750 0.00,750 10 Duttler threspital segment (see instructions) 0.00,750 0.00,750 11 Dute 2 threspital in threspital segment (see instructions) 0.00,750 0.00,750 10 Dute 2 threspital in threspital segment (see instructions) 0.00,750 0.00,750 10 Dute 2 threspital in threspital segment (see instructions) 0.00,750 0.00,750 11 Dute 3 threspital segment (see instructions) 0.00,750 0.00,750 10 Dute 3 threspital segment (see instructions) 0.00,750 0.00,750 10 Dute 3 threspital segment (see inst		Financial Systems COMMUNITY HOSPITAL OF ATION OF REIMBURSEMENT SETTLEMENT	INDIANA, INC. Provider CCN: 15-0169	In Lie Period: From 01/01/2022 To 12/31/2022		pared:
Dest n APPE CAL <			Title XVIII	Hospi tal		
Dest n MBT Control Mark (Control Mark (Contro) Mark (Control Mark (Contro) <td></td> <td></td> <td></td> <td></td> <td>1 00</td> <td></td>					1 00	
2.00 Nedical and other services relations (one instructions) 20. Hit 400 2.00 0.00 OVER propents 16.00 20.01 20.04 30.00 0.00 OVER propents 23.03 4.00 0.00 50.00 23.03 4.00 0.00 50.00		PART B - MEDICAL AND OTHER HEALTH SERVICES				
4.81 Duttlef recondition 0.0 <td>2.00</td> <td>Medical and other services reimbursed under OPPS (see instruct</td> <td>tions)</td> <td></td> <td>20, 748, 440</td> <td>1.00 2.00 3.00</td>	2.00	Medical and other services reimbursed under OPPS (see instruct	tions)		20, 748, 440	1.00 2.00 3.00
6.00 Line 2 times 1: nes 3: 4, and 4.01, divided by line 6 0.6.00 0.00						4. 00 4. 01
8.00 Transitional corritor payment (see instructions) 0			ctions)			5.00 6.00
10.00 Organ acquisitions 0 10.00 00 10.00 Outget acquisitions 80.993 11.00 Outget acquisitions 80.993 12.00 Acquisitions 80.993 13.00 Arguin acquisition charges (from Mkst. 0.4, Pt. 111. col. 4, line 69) 320.407 13.00 Arguin acquisition charges (from Mkst. 0.4, Pt. 111. col. 4, line 69) 320.407 14.00 Total resonable charges (sum of lines 12 and 13) 320.407 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 16.00 Acquisition of the second control (State 1.4, Pt. 111. col. 4, line 69) 0.000000 16.00 Acquisition of the second control (State 1.4, Pt. 111. col. 4, line 69) 0.000000 17.00 Exclose of customary charges (see instructions) 0.0000000 18.00 Total customary charges (see instructions) 0.0000000 10.00 Exclose of reasonable cost over customary charges (see instructions) 0.200 10.00 Exclose of reasonable cost over customary charges (see instructions) 0.200 10.00 Exclose of reasonable cost over customary charges (see instructions) 0.200 10.00 <						7.00 8.00
COMMUNITION OF LESSE OF COST OF ChaRefs Decisional e charges 320, 149 12.00 Ancillary service charges (rem Rest, D-4, Pt. 111, col. 4, line 69) 320, 149 13.00 Organ equals it on charges (sem of lines 12 and 13) 320, 499 14.00 Destinant, charges (sem of lines 12 and 13) 320, 499 15.00 Agregate amount a cutually coll cated from patients liable for payment for services on a charge basis on darge (see instructions) 15, 00 16.00 Amounts that would have been realized from patients liable for payment for services on a charge basis on darge (see instructions) 0, 000000 10.00 Ratio of line 15 to line 16 (not to exceed 1,000000) 0, 000000 10.00 Ratio of line 15 to line 16 (not to exceed 1,000000) 0, 000000 10.00 Resceeds in estimations) 0, 000000 10.00 Resceeds in estimations) 0, 000000 10.00 Resceeds in estimations) 0, 00000000000000000000000000000000000			IV, col. 13, line 200		-	9.00 10.00
Reasonable charges 12.00 12.00 Ancillary service charges 0 13.00 0 0.00 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 0.00 13.00 0 220.000 14.00 13.00 220.000 15.00 0 13.00 220.000 15.00 0 15.00 0 0.000000 15.00 0 0.000000 15.00 0 0.000000 15.00 0 0.000000 15.00 0 0.000000 16.00 0.000000 16.00 0.000000 16.00 0 0.000000 16.00 0 0.000000 16.00 0 0.000000 16.00 0 0.000000 16.00 0 0.000000 16.00 0 0.000000 16.00 0 0.000000 16.00 0 0.000000 16.00 0 0.000000 16.00 0 0.000000 10.000000 0 0.00	11.00				80, 893	11.00
12.00 Anciliary service charges 320.409 12.00 13.00 Organ acquisition charges (cam of lines 12 and 13) 0320.409 0320.409 14.00 Extension acquisition charges (sum of lines 12 and 13) 0320.409 0320.409 15.00 Aggregate anount actual by collected fram patients 1 lable for payment for services on a chargebasis 0 15.00 Casto of Line 15 to line 16 (not to exceed 1.000000) 030.401 0.000000 15.00 Excess of customary charges (see instructions) 0.000000 0.000000 15.00 Excess of customary charges (see instructions) 0.20.00 0.00000 15.00 Excess of customary charges (see instructions) 0.20.00 0.00000 15.00 Deductibles and Coinsurance anounts (for CAI, see instructions) 0.21.00 0.22.00 15.00 Deductibles and Coinsurance anounts (for CAI, see instructions) 0.24.00 10.802.22.00 15.00 Deductibles and Coinsurance anounts (for CAI, see instructions) 2.909.932.20 13.764.22.27.00 15.00 Deductibles and Coinsurance anounts (for CAI, see instructions) 13.764.22.27.00 13.755.22.30.00 13.755.22.30.00						
14:00 Iotal reasonable charges (sum of lines 12 and 13) 320.409 14:00 05:00 Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been rade in accordance with 42 CFR 431,13(e) 0 15:00 10:00 Aggregate amount actually collected from patients liable for payment for services on a charge basis in for the first the acceed in accordance with 42 CFR 431,13(e) 0 0.000000 17:00 11:00 Destination for the first the acceed in accordance with 42 CFR 431,13(e) 0 0.000000 17:00 12:00 Excess of reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 20:00 10 20:00 10 12:00 Lesser of cost or charges (see instructions) 0 <td></td> <td>Ancillary service charges</td> <td></td> <td></td> <td></td> <td></td>		Ancillary service charges				
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR \$413.13(e) 0 16.00 16.00 Amounts that would have been realized from patients liable for payment for services on a charge basis of line 15 to line 16 (not to exceed 1.000000) 0.000000 17.00 17.00 Ratio of line 15 to line 16 (not be exceed 1.000000) 0.000000 0.000000 0.000000 18.00 Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 18) (see instructions) 0.0000000000000 0.000000000000000000000		Total reasonable charges (sum of lines 12 and 13)	ine 69)		-	
16.00 Andouris that would have been read in accordance with 42 CFR §413.13(e) 0 16.00 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0.00000017.00 18.00 18.00 Total customary charges (see instructions) 0.0000017.00 220,010 18.00 19.00 Excess of resonable cost over customary charges (see instructions) 0.0000017.00 230,01 0.0000017.00 230,01 0.0000017.00 230,01 0.0000017.00 230,01 0.0000017.00 230,01 0.0000017.00 230,00 0.00000017.00 230,00 0.0000017.000	15.00		payment for services on	a charge basis	0	15.00
18.00 Total customery charges (see instructions) 320,409 18.00 19.00 Excess of customery charges over reasonable cost (complete only if line 11 exceeds line 11) (see instructions) 20,00 10.01 Excess of reasonable cost over customery charges (complete only if line 11 exceeds line 18) (see instructions) 20,00 10.01 Exses of reasonable cost over customery charges (complete only if line 11 exceeds line 18) (see instructions) 20,00 20.01 Excess of reasonable cost over customery charges (complete only if line 11 exceeds line 18) (see instructions) 20,00 20.01 Interms and residents (see instructions) 20,00 20,00 20.01 Extension of physic lans servic cust in teaching hospital (see instructions) 0 23,00 20.01 Extension of insurance amounts (frc GM, see instructions) 0 0 24,00 20.00 Direct graduate medical education payments (frc mWisst, E-4, line 36) 0 23,00 0 28,00 20.00 Direct graduate medical education costs (frc mWisst, E-4, line 36) 0 23,00 0 23,00 0 23,00 0 23,00 13,755,62 30,00 0 23,00 0 2	16.00	Amounts that would have been realized from patients liable for	r payment for services o		0	16.00
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40.02Demonstration payment adjustment amount after sequestration040.0240.03Sequestration adjustment-PARHM or CHART pass-throughs13,683,26441.0041.00Interim payments13,683,26441.0041.01Interim payments-PARHM or CHART41.0142.00Tentative settlement (for contractors use only)042.0143.00Bal ance due provider/program (see instructions)-6,38943.0043.01Bal ance due provider/program (see instructions)-6,38943.0044.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.21,01144.0090.00Original outlier amount (see instructions)090.0091.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0093.0093.00Time Value of Money (see instructions)093.00						
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41. 01Interim payments-PARHM or CHART41. 0142. 00Tentative settlement (for contractors use only)042. 01Tentative settlement-PARHM or CHART (for contractor use only)42. 0143. 00Bal ance due provider/program (see instructions)-6, 38943. 01Bal ance due provider/program-PARHM (see instructions)-6, 38944. 00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.21, 01144. 00Original outlier amount (see instructions)090. 00Original outlier amount (see instructions)091. 00Outlier reconciliation adjustment amount (see instructions)092. 00The rate used to calculate the Time Value of Money0. 0093. 00Time Value of Money (see instructions)093. 00Time Value of Money (see instructions)093. 00093. 00						40.03
42.00Tentative settlement (for contractors use only)042.0042.01Tentative settlement-PARHM or CHART (for contractor use only)42.0143.00Balance due provider/program (see instructions)-6,38943.01Balance due provider/program-PARHM (see instructions)-6,38944.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.21,01144.00Original outlier amount (see instructions)090.00Original outlier amount (see instructions)091.00Outlier reconciliation adjustment amount (see instructions)092.00The rate used to calculate the Time Value of Money0.0093.00Time Value of Money (see instructions)093.00Time Value of Money (see instructions)0					13, 683, 264	
42.01 Tentative settlement-PARHM or CHART (for contractor use only) 42.01 43.00 Balance due provider/program (see instructions) -6,389 43.01 Balance due provider/program-PARHM (see instructions) -6,389 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 1,011 1,011 44.00 TO BE COMPLETED BY CONTRACTOR 90.00 90.00 Original outlier amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 92.00 The rate used to calculate the Time Value of Money 0.00 93.00 Time Value of Money (see instructions) 0					0	
43.01 Balance due provider/program-PARHM (see instructions) 43.01 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 1,011 44.00 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 90.00 Original outlier amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 92.00 The rate used to calculate the Time Value of Money 0.00 93.00 Time Value of Money (see instructions) 0						42.01
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2 1,011 44.00 90.00 Original outlier amount (see instructions) 0 90.00 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00					-6, 389	
TO BE COMPLETED BY CONTRACTOR90.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00		Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	chapter 1,	1, 011	43.01 44.00
91.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00						
92.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00		o				
93.00 Time Value of Money (see instructions) 0 93.00					-	91.00 92.00
						92.00 93.00

Health Financial Systems	COMMUNITY HOSPITAL OF	INDIANA, INC.	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169	Peri od:	Worksheet E	
			From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
				5/25/2023 11:	
		Title XVIII	Hospi tal	PPS	
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

	Financial Systems COMMUNITY HOSPITAL OF ATION OF REIMBURSEMENT SETTLEMENT	FINDIANA, INC. Provider CCN: 15-0169	Peri od:	u of Form CMS-2 Worksheet E	2552-10
		Component CCN: 15-S169	From 01/01/2022 To 12/31/2022	Part B Date/Time Pre	
		Title XVIII	Subprovider -	5/25/2023 11: PPS	31 am
			I PF	1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruc	tions)		504 190	1.00 2.00
2.00	OPPS payments	(TOHS)		556	
4.00	Outlier payment (see instructions)			0	
4.01 5.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instru	uctions)		0 0. 000	
6.00	Line 2 times line 5			0.000	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	IV col 12 lino 200		0	
9.00 10.00	Organ acquisitions	TV, COL. 13, THE 200		0	
11.00	Total cost (sum of lines 1 and 10) (see instructions)			504	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				-
12.00	Ancillary service charges			1, 996	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			1, 996	14.00
15.00	Aggregate amount actually collected from patients liable for			0	15.00
16.00	Amounts that would have been realized from patients liable fo		on a chargebasis	0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13(Ratio of line 15 to line 16 (not to exceed 1.000000)	()		0. 000000	17.00
18.00	Total customary charges (see instructions)				18.00
19.00	Excess of customary charges over reasonable cost (complete on instructions)	ly if line 18 exceeds li	ne 11) (see	1, 492	19.00
20.00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds li	ne 18) (see	0	20.00
04 00	instructions)			504	01.00
21.00 22.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			504	21.00
23.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			556	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instruction	is)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on lin			16	
27.00	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, 044	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 1, 044	
30.00	Primary payer payments			1, 044	30.00 31.00
32.00	Subtotal (line 30 minus line 31)			1, 044	32.00
33.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI Composite rate ESRD (from Wkst. 1-5, line 11)	CES)		0	33.00
34.00	Allowable bad debts (see instructions)			0	
35.00	Adjusted reimbursable bad debts (see instructions)			0	
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (see instructions)	ructions)		0 1, 044	
38.00	MSP-LCC reconciliation amount from PS&R			0	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`		0	
39. 50 39. 75	Pioneer ACO demonstration payment adjustment (see instruction N95 respirator payment adjustment amount (see instructions)	IS)		0	39.50 39.75
39.97	Demonstration payment adjustment amount before sequestration			0	
39.98	Partial or full credits received from manufacturers for repla	ced devices (see instruc	tions)	0	
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 1.044	39.99 40.00
40. 01	Sequestration adjustment (see instructions)			14	40. 0 ⁻
40.02	Demonstration payment adjustment amount after sequestration			0	
40. 03 41. 00	Sequestration adjustment-PARHM or CHART pass-throughs Interim payments			1, 038	40.0
41.01	Interim payments-PARHM or CHART				41.0
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM or CHART (for contractor use only)			0	42.0 42.0
42.01	Balance due provider/program (see instructions)			-8	42.0
43.01	Balance due provider/program-PARHM (see instructions)				43. 0 [.]
44.00	Protested amounts (nonallowable cost report items) in accorda §115.2	nce with CMS Pub. 15-2,	chapter 1,	0	44.00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	
91.00 92.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money				91.00 92.00
	Time Value of Money (see instructions)			0.00	
94.00	Total (sum of lines 91 and 93)			0	94.0

Health Financial Systems	COMMUNI TY HOSPI TAL OF	INDIANA, INC.	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169	Period:	Worksheet E	
			From 01/01/2022		
		Component CCN: 15-S169	To 12/31/2022	Date/Time Pre 5/25/2023 11:	apared:
		Title XVIII	Subprovider -	PPS	
			I PF		
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					200.00

ANALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2022 To 12/31/2022		
		Title	XVIII	Hospi tal	PPS	
		I npati en	t 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 3.00	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 List separately each retroactive lump sum adjustment		40, 265, 47	0	13, 683, 264 0	1.00 2.00 3.00
	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	3.01
3.02				0	0	3. 02
3.03 3.04				0	0	3.03 3.04
3.04				0	0	3.02
0.00	Provider to Program	I				0.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.5
3.52 3.53				0	0	3.52 3.53
3.53				0	0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		40, 265, 47	2	13, 683, 264	4.00
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.00
5.00	desk review. Al so show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.00
5.01	TENTATI VE TO PROVI DER			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	5.5 5.5
5. 52				0	0	5.5
. 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5.9
. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.0
5. 01	SETTLEMENT TO PROVIDER		622, 98		0	6.0
5. 02 7. 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		40, 888, 46	0	6, 389 13, 676, 875	6. 0 7. 0
. 00	Total meancare program franchity (see fistructions)		40, 888, 46	Contractor Number	NPR Date (Mo/Day/Yr)	7.0
)	1.00	2.00	

NALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider Concernent	CN: 15-0169 CCN: 15-S169	Period: From 01/01/2022 To 12/31/2022		pared: 31 am
		Title	XVIII	Subprovider -	PPS	<u>un</u>
		Inpatien	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00	Total interim payments paid to provider 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		1, 523, 7	0	1, 038 0	1.0 2.0
. 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. C
. 01	ADJUSTMENTS TO PROVIDER			0	0	3.0
. 02 . 03 . 04 . 05	AUSUSTMILINTS TO PROVIDER			0 0 0	0	3. 0 3. 0 3. 0 3. 0 3. 0
. 05	Provider to Program		I	0		0.0
. 50	ADJUSTMENTS TO PROGRAM			0	0	3.5
. 51 . 52 . 53 . 54 . 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0 0 0 0 0	0 0 0 0	3. 5 3. 5 3. 5 3. 5 3. 5
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		1, 523, 7	83	1, 038	4.
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.
01	TENTATI VE TO PROVIDER			0	0	5.
02 03				0 0	0 0	5. 5.
	Provider to Program		1			
50 51 52	TENTATI VE TO PROGRAM			0 0 0	000000000000000000000000000000000000000	5. 5. 5.
99 00	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on			0	0	5. 6.
01	the cost report. (1) SETTLEMENT TO PROVIDER		1, 0	41	0	6.
02 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		1, 524, 8	0 24 Contractor	8 1,030 NPR Date	6. 7.
)	Number 1.00	MPR Date (Mo/Day/Yr) 2.00	

Heal th	Financial Systems COMMUNITY HOSPITAL C	OF INDIANA, INC.	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0169	Period: From 01/01/2022	Worksheet E-1 Part II	
			To 12/31/2022		
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				-
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO				-
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 (see instructions)				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days (see instructions)				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of line 168 $$	certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		· · · · · · · · · · · · · · · · · · ·		1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruction	is)		32.00
			-		

ALCOL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 11:	pared:
		Title XVIII	Subprovider - IPF	PPS	
				1.00	
. 00	PART II - MEDICARE PART A SERVICES - IPF PPS Net Federal IPF PPS Payments (excluding outlier, ECT, and medi	cal oducation paymonts)		1, 733, 842	1.0
. 00	Net IPF PPS Outlier Payments	cal education payments)		1, 733, 842	
. 00	Net IPF PPS ECT Payments			0	3.0
. 00	Unweighted intern and resident FTE count in the most recent co	ost report filed on or b	efore November	0.00	4.0
. 01	15, 2004. (see instructions) Cap increases for the unweighted intern and resident FTE count	t for residents that wer	e displaced by	0.00	4.0
. 01	program or hospital closure, that would not be counted without			0.00	4.0
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
. 00	New Teaching program adjustment. (see instructions)			0.00	5.0
. 00	Current year's unweighted FTE count of I&R excluding FTEs in teaching program" (see instuctions)	the new program growth p	eriod of a "new	0.00	6.0
. 00	Current year's unweighted I&R FTE count for residents within t	the new program growth p	eriod of a "new	0.00	7.0
	teaching program" (see instuctions)				
. 00	Intern and resident count for IPF PPS medical education adjust	tment (see instructions)		0.00	
. 00 0. 00	Average Daily Census (see instructions) Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to 1	the nower of $5150 -1$		12. 197260 0. 000000	
1.00	Teaching Adjustment (line 1 multiplied by line 10).	the power of 19100 19.		0.000000	
2.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1, 733, 842	
3.00	Nursing and Allied Health Managed Care payment (see instruction	on)		0	
4.00	Organ acquisition (DO NOT USE THIS LINE)			0	14.0
5.00 6.00	Cost of physicians' services in a teaching hospital (see inst Subtotal (see instructions)	ructions)		0 1, 733, 842	
7.00	Primary payer payments			1, 733, 042	1
8.00	Subtotal (line 16 less line 17).			1, 733, 842	18. C
9.00	Deducti bl es			133, 600	
0.00 1.00	Subtotal (line 18 minus line 19) Coinsurance			1, 600, 242 59, 517	
2.00	Subtotal (line 20 minus line 21)			1, 540, 725	
3.00	Allowable bad debts (exclude bad debts for professional servic	ces) (see instructions)		5, 472	
4.00	Adjusted reimbursable bad debts (see instructions)			3, 557	
5.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		1,632	
6.00 7.00	Subtotal (sum of lines 22 and 24)			1, 544, 282 0	
8.00	Direct graduate medical education payments (see instructions) Other pass through costs (see instructions)			0	
9.00	Outlier payments reconciliation			0	
0. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
0.50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	
0. 98 0. 99	Recovery of accelerated depreciation. Demonstration payment adjustment amount before sequestration			0	
1.00	Total amount payable to the provider (see instructions)			1, 544, 282	
1.01	Sequestration adjustment (see instructions)			19, 458	
	Demonstration payment adjustment amount after sequestration			0	
2.00	Interim payments			1, 523, 783	1
3.00 4.00	Tentative settlement (for contractor use only) Balance due provider/program (line 31 minus lines 31.01, 31.02	2^{2} 32 and 33)		0 1, 041	
5.00	Protested amounts (nonallowable cost report items) in accordar		chapter 1.	1, 041	1
	§115. 2		1		
0.00	TO BE COMPLETED BY CONTRACTOR				1 50 0
0.00	Original outlier amount from Worksheet E-3, Part II, line 2 Outlier reconciliation adjustment amount (see instructions)			0	50.0
1.00	The rate used to calculate the Time Value of Money			0.00	
3.00	Time Value of Money (see instructions)			0.00	
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND			PHE	
9.00	Teaching Adjustment Factor for the cost reporting period immed	P 1 1 P E 1		0.000000	99.0

Heal th	Financial Systems COMMUNITY HOSPITAL OF INE	IANA, INC.		In Lie	u of Form CMS-2	2552-10
		ovider CCN: 15-0169		od: 01/01/2022	Worksheet E-4	
MEDICA	L EDUCATION COSTS		To	12/31/2022	Date/Time Pre	
		Title XVIII		Hospi tal	5/25/2023 11: 3 PPS	<u>31 am</u>
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
1.00	Unweighted resident FTE count for allopathic and osteopathic prog	rams for cost repo	rting p	eri ods	0.00	1.00
1.01	ending on or before December 31, 1996. FTE cap adjustment under §131 of the CAA 2021 (see instructions)				0.00	1.01
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 41	3.79(e)(1) (see in	structi	ons)	0.00	
2.26	Rural track program FTE cap limitation adjustment after the cap-b	uilding window clo	sed und	ler §127 of		2.26
3.00	the CAA 2021 (see instructions) Amount of reduction to Direct GME cap under section 422 of MMA				0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance wit	h 42 CFR §413.79 (m). (se	e	0.00	
3. 02	instructions for cost reporting periods straddling 7/1/2011)	TE limitation(a) f		l trook		2.02
3.02	Adjustment (increase or decrease) to the hospital's rural track F programs with a rural track Medicare GME affiliation agreement in					3. 02
	49075 (August 10, 2022) (see instructions)					
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and oste GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	opathic programs d	ue to a	Medicare	4.54	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instruct	ions for cost repo	rting p	eri ods	0.00	4.01
4 02	straddling 7/1/2011)	ooo instructions f		reporting	0.00	4. 02
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (periods straddling 7/1/2011)	see instructions i	or cost	reporting	0.00	4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots	under §126 of the	CAA 202	1 (see		4. 21
5.00	instructions) FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2	26 through 2 49	minus I	ines 3 and	4.54	5.00
5.00	3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4		in nus i			5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic prog	rams for the curre	nt year	from your	3.97	6.00
7.00	records (see instructions) Enter the lesser of line 5 or line 6				3. 97	7.00
1100		Primary C	are	Other	Total	
0.00	Weighted FTF count for short-inter in an allocation and actors this	1.00	1.04	2.00	3.00	0.00
8.00	Weighted FTE count for physicians in an allopathic and osteopathi program for the current year.	c	1.24	2.73	3.97	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise		1.24	2.73	3.97	9.00
	multiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, 20					
	if Worksheet S-2, Part I, line 68, is "Y", see instructions.	22, 01				
	Weighted dental and podiatric resident FTE count for the current			2.59		10.00
10. 01 11. 00	Unweighted dental and podiatric resident FTE count for the curren Total weighted FTE count		1.24	2.59 5.32		10. 01 11. 00
12.00	Total weighted resident FTE count for the prior cost reporting ye		1.30	5. 76		12.00
	instructions)					10.00
13.00	Total weighted resident FTE count for the penultimate cost report year (see instructions)	ing	0. 87	6.06		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by	3).	1.14	5.71		14.00
			0 00	0.00		15.00
15.00	Adjustment for residents in initial years of new programs		0.00			
15.01	Unweighted adjustment for residents in initial years of new progr	ams	0.00	0.00		15.01
15. 01 16. 00	Unweighted adjustment for residents in initial years of new progr Adjustment for residents displaced by program or hospital closure	ams	0. 00 0. 00	0.00 0.00		15. 01 16. 00
15.01	Unweighted adjustment for residents in initial years of new progr	ams	0.00	0.00		15.01
15. 01 16. 00 16. 01 17. 00	Unweighted adjustment for residents in initial years of new progr Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospi closure Adjusted rolling average FTE count	ams tal	0. 00 0. 00 0. 00 1. 14	0. 00 0. 00 0. 00 5. 71		15. 01 16. 00 16. 01 17. 00
15. 01 16. 00 16. 01 17. 00 18. 00	Unweighted adjustment for residents in initial years of new progr Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospi closure Adjusted rolling average FTE count Per resident amount	ams tal	0. 00 0. 00 0. 00 1. 14	0.00 0.00 0.00		15. 01 16. 00 16. 01 17. 00 18. 00
15. 01 16. 00 16. 01 17. 00	Unweighted adjustment for residents in initial years of new progr Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospi closure Adjusted rolling average FTE count	ams tal 110, 50	0. 00 0. 00 0. 00 1. 14	0. 00 0. 00 0. 00 5. 71	756, 988	15. 01 16. 00 16. 01 17. 00 18. 00 18. 01
15. 01 16. 00 16. 01 17. 00 18. 00 18. 01	Unweighted adjustment for residents in initial years of new progr Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospi closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021	ams tal 110, 50	0.00 0.00 0.00 1.14 9.20	0.00 0.00 0.00 5.71 110,509.20		15. 01 16. 00 16. 01 17. 00 18. 00 18. 01
15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00	Unweighted adjustment for residents in initial years of new progr Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospi closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs	ams tal 110, 50 125	0.00 0.00 1.14 9.20	0.00 0.00 5.71 110,509.20 631,008	1.00	15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00
15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00 20. 00	Unweighted adjustment for residents in initial years of new progr Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospi closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FTE r Sec. 413.79(c)(4)	ams tal 110, 50 125 esident cap slots	0.00 0.00 1.14 9.20	0.00 0.00 5.71 110,509.20 631,008	1.00 0.00	15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00 20. 00
15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00 20. 00 21. 00	Unweighted adjustment for residents in initial years of new progr Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospi closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FTE r Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instruction	ams tal 110, 50 125 esi dent cap slots ns)	0.00 0.00 1.14 9.20	0.00 0.00 5.71 110,509.20 631,008	1.00 0.00 0.00	15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00 20. 00 21. 00
15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00 20. 00 21. 00 22. 00	Unweighted adjustment for residents in initial years of new progr Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospi closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FTE r Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instruction Allowable additional direct GME FTE Resident Count (see instruction)	ams tal 110, 50 125 esi dent cap slots ns) ons)	0. 00 0. 00 0. 00 1. 14 19. 20 5, 980	0.00 0.00 5.71 110,509.20 631,008	1.00 0.00 0.00 0.00	15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00 20. 00 21. 00 22. 00
15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00 20. 00 21. 00 22. 00 23. 00	Unweighted adjustment for residents in initial years of new progr Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospi closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FTE r Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instruction	ams tal 110, 50 125 esi dent cap slots ns) ons)	0. 00 0. 00 0. 00 1. 14 19. 20 5, 980	0.00 0.00 5.71 110,509.20 631,008	1.00 0.00 0.00	15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00 20. 00 21. 00 22. 00 23. 00

	Financial Systems COMMUNITY HOSPITAL OF GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT		CN: 15-0169	Peri od:	u of Form CMS-2 Worksheet E-4	
MEDI CA	L EDUCATION COSTS			From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 11:	
		Title	e XVIII	Hospi tal	PPS	
				rt Managed Care	Total	
			A 1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	3.00	
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part 13.02, column 2)	X, line	18, 7	69 20, 500		26.00
27.00	Total Inpatient Days (see instructions)		91, 1	50 91, 150		27.00
28.00	Ratio of inpatient days to total inpatient days		0. 2059	0. 224904		28.00
29.00	Program direct GME amount		155, 8		326, 124	29.00
29. 01	Percent reduction for MA DGME			3.26		29.01
30.00	Reduction for direct GME payments for Medicare Advantage			5, 550	5, 550	
31.00	Net Program direct GME amount				320, 574	31.00
					1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE			GRAM AND PARAMED		
	EDUCATION COSTS)				I OAL	
32.00	Renal dialysis direct medical education costs (from Wkst. B,	Pt. I, sum o	of col. 20 and	d 23, lines 74	0	32.00
	and 94)					
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.			74 and 94)	4, 985, 128	
34.00	Ratio of direct medical education costs to total charges (line	e 32 ÷ line	33)		0.00000	
35.00	Medicare outpatient ESRD charges (see instructions)				0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII		35)		0	36.00
	Part A Reasonable Cost	UNLY				
37.00	Reasonable cost (see instructions)				61, 182, 742	37.00
38.00	Organ acquisition and HSCT acquisition costs (see instructions	s)			01, 102, 742	38.00
39.00	Cost of physicians' services in a teaching hospital (see inst				0	39.00
40.00	Primary payer payments (see instructions)				11, 906	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus	s line 40)			61, 170, 836	41.00
	Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)				20, 830, 027	42.00
43.00	Primary payer payments (see instructions)				10, 185	
44.00	Total Part B reasonable cost (line 42 minus line 43)				20, 819, 842	
45.00	Total reasonable cost (sum of lines 41 and 44)		(5)		81, 990, 678	
46.00	Ratio of Part A reasonable cost to total reasonable cost (lin				0.746071	
47.00	Ratio of Part B reasonable cost to total reasonable cost (line		45)		0. 253929	47.00
48.00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAI Total program GME payment (line 31)	τι Ď			320, 574	48.00
48.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instru	uctions)		239, 171	
	Part B Medicare GME payment (line 40 x 48) (title XVIII only)				81, 403	
55.00		(300 113110		l	51,405	00.00

Health Financial Systems	COMMUNI TY HOSPI TAL OF	INDIANA, I	NC.	In Lieu	u of Form CMS-2	552-10
OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Г	Provider (CCN: 15-0169	Period:	Worksheet E-5	
				From 01/01/2022 To 12/31/2022	Date/Time Prep 5/25/2023 11:3	
		Ti tl	e XVIII		PPS	
					1.00	
TO BE COMPLETED BY CONTRACTOR						
1.00 Operating outlier amount from Wkst. E,	Pt. A, line 2, or sum (of 2.03 plu	ıs 2.04 (see ir	nstructions)	0	1.00
2.00 Capital outlier from Wkst. L, Pt. I, li	ne 2				0	2.00
3.00 Operating outlier reconciliation adjust	ment amount (see instru	uctions)			0	3.00
4.00 Capital outlier reconciliation adjustme	ent amount (see instruc	tions)			0	4.00
5.00 The rate used to calculate the time val	ue of money (see instru	uctions)			0.00	5.00
6.00 Time value of money for operating expen	ses (see instructions)				0	6.00
7.00 Time value of money for capital related		tions)			0	7.00
	-					

	Financial Systems COMMUNITY HOSPITAL E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	1	Period: From 01/01/2022	Worksheet G	
ly)	······································			To 12/31/2022	Date/Time Pre 5/25/2023 11:	
		General Fund	Specific Purpose Fund		Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	8, 600		0 0	0	1.
00	Temporary investments	0		0 0	0	2.
00	Notes receivable	0		0 0	0	
00	Accounts receivable	361, 147, 936		0 0	0	
00	Other receivable	-272, 367, 019		0 0	0	
00 00	Allowances for uncollectible notes and accounts receivable	919, 766			0	6
00	Inventory Prepaid expenses	5, 739, 540			0	8
00	Other current assets	-262		0 0	0	9
. 00	Due from other funds	0		0 0	0	10
	Total current assets (sum of lines 1-10)	95, 448, 561		0 0	0	11
	FIXED ASSETS					
00	Land	2, 705, 851		0 0	0	12
00	Land improvements	4, 358, 832		0 C	0	13
	Accumulated depreciation	0		0 0	0	14
	Buildings	332, 441, 667		0 0	0	15
00	Accumulated depreciation				0	16
	Leasehold improvements Accumulated depreciation	3, 615, 740			0	17
	Fixed equipment	128, 564, 909			0	19
	Accumulated depreciation	0		0 0	0	20
	Automobiles and trucks	19, 930		0 0	0	21
	Accumulated depreciation	0		o o	0	22
	Major movable equipment	0		0 0	0	23
	Accumulated depreciation	-277, 690, 699		0 0	0	24
	Minor equipment depreciable	0		0 0	0	25
	Accumulated depreciation	0		0 0	0	26
	HIT designated Assets Accumulated depreciation	0			0	27
	Mi nor equi pment-nondepreci abl e	316, 270		0 0	0	20
	Total fixed assets (sum of lines 12-29)	194, 332, 500		0 0	0	
	OTHER ASSETS				-	1
. 00	Investments	0		0 0	0	31
	Deposits on Leases	0		0 0	0	32
	Due from owners/officers	0		0 0	0	33
	Other assets	1, 319, 077, 746		0 0	0	34
	Total other assets (sum of lines 31-34)	1, 319, 077, 746		0 0	0	35
00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	1, 608, 858, 807		0 0	0	36
.00	Accounts payable	2, 917, 654		0 0	0	37
	Salaries, wages, and fees payable	2, 717, 034		0 0	0	38
	Payroll taxes payable	0		0 0	0	
	Notes and Loans payable (short term)	0		o o	0	40
	Deferred income	0		o o	0	41
	Accelerated payments	0				42
	Due to other funds	0		0 0	0	
	Other current liabilities	5, 333, 675		0 0	0	
. 00	Total current liabilities (sum of lines 37 thru 44)	8, 251, 329		0 0	0	45
. 00	LONG TERM LIABILITIES Mortgage payable	0		0 0	0	46
. 00	Notes payable				0	40
	Unsecured Loans	0		0 0	0	
	Other long term liabilities	3, 822, 293		0 0	0	
00	Total long term liabilities (sum of lines 46 thru 49)	3, 822, 293		o o	0	50
00	Total liabilities (sum of lines 45 and 50)	12, 073, 622		0 0	0	51
	CAPI TAL ACCOUNTS					ł.,
00	General fund balance	1, 596, 785, 185				52
00	Specific purpose fund			0		53
00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54 55
. 00	Governing body created - endowment fund balance			0		56
. 00	Plant fund balance - invested in plant			0	0	
. 00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				0	
		1	1	1		1
. 00	Total fund balances (sum of lines 52 thru 58)	1, 596, 785, 185		0 0	0	59

		UNI TY HOSPI TAL					u of Form Cl		552-10
STATEM	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0169		eriod: com 01/01/2022 o 12/31/2022	Worksheet Date/Time 5/25/2023	Prep	
		General	Fund	Speci al	Pui	rpose Fund	Endowment F		1 Gill
1 00	Fund halances at beginning of pariod	1.00	2.00	3.00		4.00	5.00		1.00
1.00 2.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		1, 513, 400, 347 83, 384, 835			0			2.00
3.00	Total (sum of line 1 and line 2)		1, 596, 785, 182			0			3.00
4.00	ROUNDI NG	3	1,0,0,,00,102		0	0		0	4.00
5.00		0			0			0	5.00
6.00		0			0			0	6.00
7.00		0			0			0	7.00
8.00		0			0			0	8.00
9.00		0			0			0	9.00
10.00	Total additions (sum of line 4-9)		3			0			10.00
11. 00 12. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	1, 596, 785, 185		0	0		0	11. 00 12. 00
12.00	beductions (debit adjustments) (specify)	0			0			0	12.00
14.00		0			0			o	14.00
15.00		Ő			0			Ő	15.00
16.00		0			0			0	16.00
17.00		0			0			0	17.00
18.00	Total deductions (sum of lines 12-17)		0			0			18.00
19.00	Fund balance at end of period per balance		1, 596, 785, 185			0			19.00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund				-	
1 00	Fund halanage at heginning of namind	6.00	7.00	8.00	0				1 00
1.00 2.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			0				1.00 2.00
3.00	Total (sum of line 1 and line 2)	0			0				2.00
4.00	ROUNDI NG	Ŭ	0		Ŭ				4.00
5.00			0						5.00
6.00			0						6.00
7.00			0						7.00
8.00			0						8.00
9.00			0						9.00
10.00	Total additions (sum of line 4-9)	0			0				10.00
11.00	Subtotal (line 3 plus line 10)	0	0		0				11.00 12.00
12.00 13.00	Deductions (debit adjustments) (specify)		0						12.00
14.00			0						14.00
14.00			0						15.00
16.00			0						16.00
17.00			0						17.00
18.00	Total deductions (sum of lines 12–17)	0			0				18.00
19.00	Fund balance at end of period per balance	0			0				19.00
	sheet (line 11 minus line 18)								
17.00					0				17.0

	ENT OF PATIENT REVENUES AND OPERATING EXPENSES Cost Center Description	Provider CCI		Period: From 01/01/2022	Worksheet G-2	
1.00	Cost Center Description			To 12/31/2022		pared:
1.00			Inpati ent	Outpati ent	Total	
1.00		F	1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services					
2.00	Hospi tal		204, 832, 44		204, 832, 447	1.00
	SUBPROVIDER - IPF		11, 919, 61	8	11, 919, 618	
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVIDER					4.00
5.00	Swing bed - SNF			0	0	5.00
6.00 7.00	Swing bed - NF			0	0	6.00 7.00
8.00	SKILLED NURSING FACILITY NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		216, 752, 06	5	216, 752, 065	1
	Intensive Care Type Inpatient Hospital Services	I	210//02/00		210//02/000	10100
11.00	INTENSIVE CARE UNIT		37, 608, 42	7	37, 608, 427	11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
	NEONATAL INTENSIVE CARE UNIT		135, 328, 28		135, 328, 281	15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	172, 936, 70	8	172, 936, 708	16.00
47.00	11-15)		000 (00 7		000 (00 770	17.00
17.00 18.00	Total inpatient routine care services (sum of lines 10 and 16)		389, 688, 77		389, 688, 773	
	Ancillary services Outpatient services		652, 043, 58	4 811, 218, 560 0 0	1, 463, 262, 144	18.00 19.00
	RURAL HEALTH CLINIC			0 0		
	FEDERALLY QUALIFIED HEALTH CENTER			0 0		
	HOME HEALTH AGENCY			0		22.00
23.00	AMBULANCE SERVICES					23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE					26.00
27.00	PROFESSIONAL FEES			0 948, 209		27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	1,041,732,35	7 812, 166, 769	1, 853, 899, 126	28.00
ł	G-3, line 1)					
29.00	PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200)			497, 579, 210		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECI FY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00	Total deductions (our of lines 27 (1)			0		41.00
42.00 43.00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42	(transfor		497, 579, 210		42.00 43.00
43.00	to Wkst. G-3, line 4)			471, 317, 210		43.00

Health Financial Systems COMMUNITY HC	OSPITAL OF INDIANA, INC.	In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0169	Period: From 01/01/2022	Worksheet G-3	
		To 12/31/2022		
			5/25/2023 11:	31 am
			1.00	
1.00 Total patient revenues (from Wkst. G-2, Part I, colu	mn 3. line 28)		1, 853, 899, 126	1.00
2.00 Less contractual allowances and discounts on patient			1, 288, 697, 019	
3.00 Net patient revenues (line 1 minus line 2)			565, 202, 107	3.00
4.00 Less total operating expenses (from Wkst. G-2, Part	II. line 43)		497, 579, 210	
5.00 Net income from service to patients (line 3 minus li			67, 622, 897	5.00
OTHER INCOME	,			
6.00 Contributions, donations, bequests, etc			660	6.00
7.00 Income from investments			0	7.00
8.00 Revenues from telephone and other miscellaneous comm	unication services		0	8.00
9.00 Revenue from television and radio service			0	9.00
10.00 Purchase di scounts			24, 277	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, 464, 351	
15.00 Revenue from rental of living quarters			0	15.00
16.00 Revenue from sale of medical and surgical supplies t	o other than patients		0	16.00
17.00 Revenue from sale of drugs to other than patients			0	17.00
18.00 Revenue from sale of medical records and abstracts			0	18.00
19.00 Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00 Revenue from gifts, flowers, coffee shops, and cante	en		0	20.00
21.00 Rental of vending machines			0	21.00
22.00 Rental of hospital space			22, 950	
23.00 Governmental appropriations			0	23.00
24.00 MISC REVENUE			1, 246, 143	
24. 50 COVI D-19 PHE Fundi ng			12, 003, 557	
25.00 Total other income (sum of lines 6-24)			15, 761, 938	
26.00 Total (line 5 plus line 25)			83, 384, 835	
27.00 OTHER EXPENSES (SPECIFY)			0	27.00
28.00 Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00 Net income (or loss) for the period (line 26 minus l	ine 28)		83, 384, 835	29.00

Health Financial Systems	COMMUNI TY HOSPI TAL OF	INDIANA, INC.	In Lie	u of Form CMS-:	2552-10
CALCULATION OF CAPITAL PAYMENT		Provi der CCN: 15-0169	Period: From 01/01/2022 To 12/31/2022	Worksheet L Parts I-III Date/Time Pre 5/25/2023 11:	pared: 31 am
		Title XVIII	Hospi tal	PPS	
				1.00	
PART I - FULLY PROSPECTIVE METHO	D				-
CAPITAL FEDERAL AMOUNT				0 700 100	1 00
1.00 Capital DRG other than outlier 1.01 Model 4 BPCL Capital DRG other	han outlion			2, 703, 128	
				0 204, 541	1.01 2.00
 Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments 				204, 541	1
3.00 Total inpatient days divided by		porting period (see inst	tructions)	243.67	3.00
4.00 Number of interns & residents (sol tring period (see this		6.54	
5.00 Indirect medical education perce	,			0.76	
6.00 Indirect medical education adjust		sum of lines 1 and 1.0	1. columns 1 and	20, 544	
1.01) (see instructions)			.,		
7.00 Percentage of SSI recipient pat	ent days to Medicare Part A pa	atient days (Worksheet B	E, part A line	3.67	7.00
30) (see instructions)	5	5 .			
8.00 Percentage of Medicaid patient	lays to total days (see instruc	ctions)		34.11	8.00
9.00 Sum of lines 7 and 8				37.78	9.00
10.00 Allowable disproportionate share	e percentage (see instructions))		7.95	
11.00 Disproportionate share adjustme	nt (see instructions)			214, 899	11.00
12.00 Total prospective capital payment	nts (see instructions)			3, 143, 112	12.00

	1.00	
PART II - PAYMENT UNDER REASONABLE COST		
Program inpatient routine capital cost (see instructions)	0	1.00
Program inpatient ancillary capital cost (see instructions)	0	2.00
Total inpatient program capital cost (line 1 plus line 2)	0	3.00
Capital cost payment factor (see instructions)	0	4.00
Total inpatient program capital cost (line 3 x line 4)	0	5.00
	1.00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS		
Program inpatient capital costs (see instructions)	0	1.00
Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
Net program inpatient capital costs (line 1 minus line 2)	0	3.00
Applicable exception percentage (see instructions)	0.00	4.00
Capital cost for comparison to payments (line 3 x line 4)	0	5.00
Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
Capital minimum payment level (line 5 plus line 7)	0	8.00
Current year capital payments (from Part I, line 12, as applicable)	0	9.00
Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
Carryover of accumulated capital minimum payment level over capital payment (from prior year	0	11.00
Worksheet L, Part III, line 14)		
Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
Carryover of accumulated capital minimum payment level over capital payment for the following period	0	14.00
	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART 111 - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicable) Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payment (from prior year Worksheet L, Part III, line 14)	PART 11 - PAYMENT UNDER REASONABLE COST 0 Program inpatient routine capital cost (see instructions) 0 Program inpatient ancillary capital cost (see instructions) 0 Total inpatient program capital cost (line 1 plus line 2) 0 Capital cost payment factor (see instructions) 0 Total inpatient program capital cost (line 3 x line 4) 0 PART 111 - COMPUTATION OF EXCEPTION PAYMENTS 0 Program inpatient capital costs (see instructions) 0 Program inpatient capital costs (line 1 minus line 2) 0 Program inpatient capital costs (line 1 minus line 2) 0 Program inpatient capital costs (line 1 minus line 2) 0 Applicable exception percentage (see instructions) 0 Net program inpatient for extraordinary circumstances (see instructions) 0 Applicable exception percentage (see instructions) 0 Applicable exception percentage (see instructions) 0 Adj ustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 0 Capital minimum payment level for extraordinary circumstances (line 8 less line 9) 0 Current year comparison of capital minimum payment level over capital payments (line 8 less line 9) 0 Carryover of accu

0 15.00 0 16.00 0 17.00

14.00	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)	
15.00	Current year allowable operating and capital payment (see instructions)	
16.00	Current year operating and capital costs (see instructions)	
17.00	Current year exception offset amount (see instructions)	