PART II - CERTIFICATION

(4) Reopened(5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPITAL OF INDIANA, INC. (150074) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Officer or Administrator of Provider(s)

Title

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
	1.00	2. 00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	-447, 903	-532, 343	27, 131	0	1.00
2.00 Subprovi der - IPF	0	0	0		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
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
200. 00 Total	0	-447, 903	-532, 343	27, 131	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150074 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/27/2015 6:01 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1500 NORTH RITTER AVENUE 1.00 PO Box: 1.00 State: IN 2.00 City: INDIANAPOLIS Zip Code: 46219 County: MARION 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 COMMUNITY HOSPITAL OF 150074 26900 1 07/01/1966 Ν 3.00 NDI ANA, INC. Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2014 12/31/2014 20.00 21.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 N 22.00 Υ share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Ν Υ 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result N N 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23.00 3 Ν 23 00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" "N" fo<u>r no</u>. used in the prior cost reporting period? In column 2 for ves or In-State Out-of Medi cai d Other In-State Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days paid days el i gi bl e unpai d days unpai d 1.00 2.00 3. 00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 1, 176 21 8, 348 8. 664 276 24.00 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. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der (F	eriod: rom 01/01/20 o 12/31/20	014 014	Workshe Part I Date/Ti 5/27/20	me Pre	
			•	<u> </u>	Urban/Rural		Date of	Geogr	
26. 00	Enter your standard geographic classification (not wa	ne) sta	atus at the hea	inning of the	1. 00	1	2. 0	0	26. 00
27. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	rural. ge) sta "2" fo	atus at the end or rural. If ap	of the cost		1			27. 00
35. 00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status in		0			35. 00
					Begi nni ng	J:	Endi r		
36. 00	Enter applicable beginning and ending dates of SCH st	atus. S	Subscript line	36 for number	1. 00		2. 0	U	36. 00
37. 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter in effect in the cost reporting period.	s MDH status		0			37. 00		
38. 00	Enter applicable beginning and ending dates of MDH st of periods in excess of one and enter subsequent date		Subscript line	38 for number					38. 00
					Y/N 1. 00	_	Y/N 2. 0		
39. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii	"Y" for yes	N N		N	0	39. 00		
40. 00	or "N" for no. Does the facility meet the mileage req CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	or "N" adjust er 1. E	for no. (see i tment? Enter "Y Enter "Y" for y	nstructions) " for yes or	N		N		40. 00
	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	(555 .	. 1.5 (1. 0.5 (1. 0.1.5)			V	XVIII	XIX	
	Prospective Payment System (PPS)-Capital					1. 00	2. 00	3. 00	
45. 00	Does this facility qualify and receive Capital paymen	t for d	di sproporti onat	e share in acc	cordance	N	Y	N	45. 00
46. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkst	ces through	N	N	N	46. 00			
47. 00 48. 00	Pt. III. Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment					N N	N N	N N	47. 00 48. 00
56. 00	Teaching Hospitals Is this a hospital involved in training residents in	approve	ed GME programs	? Enter "Y" 1	for yes	Υ			56. 00
57. 00	or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or h of th	r "N" for no in his cost report plete Worksheet	column 1. If ing period? [column 1 Enter "Y"	N			57. 00
58. 00	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, § 2148? If yes, complete Wk			ns' services a	as	N			58. 00
59. 00 60. 00	Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health	, compl	lete Wkst. D-2,			N Y			59. 00 60. 00
	provider-operated criteria under §413.85? Enter "Y"	for yes	s or "N" for no	. (see instrud		<u>'</u>			
		Y/N	IME	Direct GME	IME		Di rect	GME	
		1. 00	2. 00	3. 00	4. 00		5. 0	0	
61. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	Y			25	5. 85		22. 67	61. 00
61. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		21. 42	21. 5	1				61. 01
61. 02	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		25. 65	25. 6	5				61. 02
61. 03	ACA). (see instructions) 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		19. 85	19. 9:	2				61. 03
61. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		25. 65	25. 6	5				61. 04
61. 05	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		5. 80	5. 73	3				61. 05
61. 06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary		0.00	0.00					61. 06
	care or general surgery. (see instructions)	I	ı l		I	1			

Health Financial Systems	COMMUNITY HO	SPITAL OF I	NDIANA, IN	C.	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA	Provi der		eriod: rom 01/01/2014 o 12/31/2014	Worksheet S-2 Part I Date/Time Pre 5/27/2015 6:0	pared:
		Program		Program Code	Unweighted IME FTE Count	Direct GME FTE Count	
		1. (00	2. 00	3. 00	4.00	
61.10 Of the FTEs in line 61.05, speci specialty, if any, and the numbe for each new program. (see instrucolumn 1, the program name, enter program code, enter in column 3, unweighted count and enter in conferment of the FTE unweighted count. 61.20 Of the FTEs in line 61.05, speci program specialty, if any, and the residents for each expanded program structions) Enter in column 1, enter in column 2, the program of 3, the IME FTE unweighted count 4, direct GME FTE unweighted count	er of FTE residents ructions) Enter in er in column 2, the the IME FTE olumn 4, direct GME fy each expanded the number of FTE gram. (see the program name, code, enter in column and enter in column	FAMILY MEDI	CI NE	1350	5. 80		61. 10
						1.00	
ACA Provisions Affecting the Hea							
62.00 Enter the number of FTE resident your hospital received HRSA PCRE			this cost	reporting peri	od for which	0.00	62. 00
62.01 Enter the number of FTE resident during in this cost reporting per Teaching Hospitals that Claim Re	ts that rotated from a eriod of HRSA THC pro	a Teaching H gram. (see i			your hospital	0.00	62. 01
63.00 Has your facility trained reside			ng this co	st reporting p	eriod? Enter	Υ	63. 00
"Y" for yes or "N" for no in col	umn 1. If yes, comple	ete lines 64	-67. (see	Unweighted	Unweighted	Ratio (col. 1/	
				FTEs	FTEs in	(col. 1 + col.	
				Nonprovi der	Hospi tal	2))	
				Si te 1. 00	2.00	3.00	
Section 5504 of the ACA Base Yea	ar FTE Residents in No	onprovider S	Setti nas				
period that begins on or after section 64.00 Enter in column 1, if line 63 is in the base year period, the number resident FTEs attributable to resettings. Enter in column 2 the resident FTEs that trained in year.	s yes, or your facilit nber of unweighted nor otations occurring in e number of unweighted our hospital. Enter in	ty trained r n-primary ca all nonprov d non-primar n column 3 t	esidents re ider y care he ratio	0. 00	0.00	0. 000000	64. 00
of (column 1 divided by (column							
	Program Name	Program	n Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.0	00	3. 00	4.00	5.00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	FAMILY MEDICINE	1350		2.84	21. 91	0. 114747	05. 00

instructions)			
	1.0	00	
Long Term Care Hospital PPS			
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.	0. 00
81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter	N	l 81.	. 00
"Y" for yes and "N" for no.			
TEFRA Providers			
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	I 85.	5. 00
86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section		86.	o. 00
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			

Health Financial Systems COMMUNITY HOSPITAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			In Period:	Lieu of Fo	rm CMS-: eet S-2	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	FI OVI dei	F	From 01/01/2 To 12/31/2	2014 Part I 2014 Date/T	ime Pre 015 6:0	pared:
	<u> </u>		V 1. 00	X	00	-
Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospita	al services? Fr	nter "Y" for	N		Y	90.00
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through t			N		V	91. 00
full or in part? Enter "Y" for yes or "N" for no in the appl 92.00 Are title XIX NF patients occupying title XVIII SNF beds (du	icable column.				V	92. 00
instructions) Enter "Y" for yes or "N" for no in the applica 93.00 Does this facility operate an ICF/MR facility for purposes o	able column.	, ,	N		N	93. 00
"Y" for yes or "N" for no in the applicable column.			N N		V	94. 00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.						
95.00 If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes			N	0. 00	V. 00	95. 00 96. 00
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the app	olicable column	۱.		0. 00	0. 00	97. 00
Rural Providers 105.00 Does this hospital qualify as a Critical Access Hospital (CA	λH)?		N			105. 00
106.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	inclusive meth	nod of payment	N			106. 00
107.00 Column 1: If this facility qualifies as a CAH, is it eligib for I &R training programs? Enter "Y" for yes or "N" for no			N		V	107. 00
instructions) If yes, the GME elimination would not be on Wk the program would be cost reimbursed. If yes complete Wkst.	kst. B, Pt. I,	col. 25 and				
this facility is a CAH, do L&Rs in an approved medical educa CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "	ation program i	train in the				
instructions)						100.00
108.00 s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N	D =:		108. 00
	Physi cal 1.00	Occupational 2.00	Speech 3.00	4.	ratory 00	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	N	N	N		N	109. 00
for yes or "N" for no for each therapy.						
110.00 Did this hospital participate in the Rural Community Hospita		on project (41	OA Demo)for		<u>00</u> N	110. 00
the current cost reporting period? Enter "Y" for yes or "N"	for no.					
Miscellaneous Cost Reporting Information				1.00 2.00	3.00	
115.00 s this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, §2208.1.	If column 2 int for long ter	s "E", enter rm care (inclu	in column des	N	0	115. 00
116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insurno.	•		"N" for	N Y		116. 00 117. 00
118.00 Is the mal practice insurance a claims-made or occurrence pol	icy? Enter 1 i	f the policy	is	1		118. 00
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losses	Insu	rance	
		1. 00	2.00	3.	00	
118.01 List amounts of malpractice premiums and paid losses:		2, 291, 03	8	0	0	118. 01
118.02 Are mal practice premiums and paid losses reported in a cost	center other t	than the	1. 00 N	2.	00	118. 02
Administrative and General? If yes, submit supporting sched						
and amounts contained therein.	· ·					110 00
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen	n column 1, "Y' ualifies for th	for yes or ne Outpatient	N		N	
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	n column 1, "Y' ualifies for th nts? (see inst	' for yes or ne Outpatient ructions)	N Y	ı	V	119. 00 120. 00 121. 00
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	n column 1, "Y' ualifies for th nts? (see instr antable devices	for yes or ne Outpatient ructions) s charged to		1	V	120. 00
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendmenter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no. 17 Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter "P" for this is a Medicare certified kidney transplant center, enter "Y" for this is a Medicare certified kidney transplant center, enter "Y" for this is a Medicare certified kidney transplant center, enter "Y" for this is a Medicare certified kidney transplant center, enter "Y" for this is a Medicare certified kidney transplant center, enter "Y" for this is a Medicare certified kidney transplant center, enter "Y" for this is a Medicare certified kidney transplant center.	n column 1, "Y' ualifies for th nts? (see instr antable devices or yes and "N"	for yes or ne Outpatient ructions) s charged to	Y		N	120. 00
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA \$3121 and applicable amendmenter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	n column 1, "Y' ualifies for th tts? (see instrantable devices or yes and "N" hter the certif	for yes or ne Outpatient ructions) s charged to for no. If	Y		N	120. 00 121. 00 125. 00

OSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der (CCN: 150074		In Lie od: 01/01/2014 12/31/2014	Worksheet : Part I Date/Ti me 5/27/2015	Prepared:
					1. 00	2.00	
28.00 If this is a Medicare certified li			cati on date				128. 0
in column 1 and termination date, 29.00 If this is a Medicare certified Lu			ation date i	n			129. 0
column 1 and termination date, if 30.00 of this is a Medicare certified pa		ontor the cort	i fi cation				130. 0
date in column 1 and termination d			TITCALION				130.0
31.00 If this is a Medicare certified in date in column 1 and termination d			rti fi cati on				131. 0
32.00 <mark>lf this is a Medicare certified is</mark>	slet transplant center, ent	ter the certifi	cation date				132. 0
in column 1 and termination date, 33.00 f this is a Medicare certified ot			cation date				133. 0
in column 1 and termination date,	if applicable, in column 2	2.					124.0
34.00 If this is an organ procurement or and termination date, if applicabl		ne upu number i	n column I				134. 0
All Providers	on home office costs as a	dafinad in CMC	Dub 15 1		Υ		140.6
40.00 Are there any related organization chapter 10? Enter "Y" for yes or "				5	Y		140. 0
are claimed, enter in column 2 the	e home office chain number.		i ons)		3. 00		
If this facility is part of a chai			gh 143 the	name a		of the	
home office and enter the home off 41.00 Name: COMMUNITY HEALTH NETWORK	fice contractor name and contractor's Name: WI			or's N	Number: 0810	11	141. 0
12.00 Street: 1500 N RITTER	PO Box: SE	RVI CES	AN CONTRACT	.01 3 1			142. 0
43.00 City: INDIANAPOLIS	State: IN		Zi p Code	e:	4621	9-3095	143. 0
						1.00	
14.00 Are provider based physicians' cos 15.00 If costs for renal services are cl			octo for in	4 !		Y	144. (145. (
only? Enter "Y" for yes or "N" for		e 74, are the C	0515 101 111	oati en	t services	Ţ	110.0
		e 74, die the C	USIS 101 111	bati en			110.0
only? Enter "Y" for yes or "N" for	no. By changed from the previou	usly filed cost	report?		1.00	2.00	146. 0
only? Enter "Y" for yes or "N" for 46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in	no. By changed from the previou Column 1. (See CMS Pub. 1	usly filed cost	report?		1. 00		
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Health Financial Systems	u of Form CMS-	2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provider CCN: 150074	Peri od:	Worksheet S-2	
			From 01/01/2014	Part I	
			To 12/31/2014	Date/Time Pre	
				5/27/2015 6:0	1 pm
	Endi ng				
			1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR be period respectively (mm/dd/yyyy)	eginning date and ending date	for the reporting	04/01/2014	06/30/2014	170. 00
				1.00	1
171.00 If line 167 is "Y", does this provi	der have any days for indivi	duals enrolled in secti	on 1876	N	171. 00
Medicare cost plans reported on Wks	st. S-3, Pt. I, line 2, col.	6? Enter "Y" for yes a	nd "N" for no.		
(see instructions)		•			

		INITY HOSPITAL OF I				u of Form CMS-	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	STI ONNAI RE	Provi der	CCN: 150074	Peri od: From 01/01/2014 To 12/31/2014	Date/Time Pro	epared:
					Y/N	5/27/2015 6:0 Date	01 pm
					1. 00	2. 00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	onses. Enter N for	all NO re	esponses. Ente	r all dates in t	he	
. 00	Provider Organization and Operation Has the provider changed ownership immediatel	v prior to the bogi	nni ng of	the cost	N		1.00
. 00	reporting period? If yes, enter the date of t	he change in column	1 2. (see	instructions)		V/I	1.00
				1.00	2. 00	3. 00	
. 00	Has the provider terminated participation in yes, enter in column 2 the date of terminatio			N	2.00	51 65	2.00
. 00	voluntary or "I" for involuntary. Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or frelationships? (see instructions)	, chain home office to the provider or , or members of the	es, drug its board	Y			3. 00
	Terationships: (See Tristidetions)			Y/N	Type	Date	
				1.00	2. 00	3. 00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Y A Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.						4.00
. 00	Are the cost report total expenses and total those on the filed financial statements? If y	revenues different		Y			5. 00
					Y/N	Legal Oper.	
	Approved Educational Activities				1.00	2. 00	
. 00	Column 1: Are costs claimed for nursing scho the legal operator of the program?	ol? Column 2: If y	es, is th	ne provider is	, N		6. 00
. 00	Are costs claimed for Allied Health Programs?	If "Y" see instruc	ctions.		Υ		7. 00
. 00	Were nursing school and/or allied health prog	rams approved and/o	or renewed	d during the	N		8. 00
. 00	cost reporting period? If yes, see instruction Are costs claimed for Intern-Resident program		ırrent cos	st report? If	Υ		9. 00
0. 00	yes, see instructions. Was an Intern-Resident program been initiated period? If yes, see instructions.	or renewed in the	current d	cost reporting	N N		10. 00
1. 00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see		in an App	oroved	N		11. 00
						Y/N 1. 00	
	Bad Debts						
	Is the provider seeking reimbursement for bad If line 12 is yes, did the provider's bad deb				st reporting	Y N	12. 00 13. 00
4. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	nd/or co-payments v	vaived? If	fyes, see ins	tructi ons.	N	14. 00
5. 00	Did total beds available change from the prio	r cost reporting pe	eriod? If	f		N	15. 00
		Description	1	Y/N	art A Date	Part B Y/N	
		0		1.00	2. 00	3. 00	
,	PS&R Data						4
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)			N		N	16. 00
	Was the cost report prepared using the PS&R			Υ	04/29/2014	Υ	17. 00

	[TIISTI UCTI OIIS)				
17.00	Was the cost report prepared using the PS&R	Υ	04/29/2014	Y	17. 00
	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)				
18. 00	If line 16 or 17 is yes, were adjustments	N		N	18. 00
	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.				
19. 00	If line 16 or 17 is yes, were adjustments	N		N	19. 00
	made to PS&R Report data for corrections of				
	other PS&R Report information? If yes, see				
	instructions.				
20.00	If line 16 or 17 is yes, were adjustments	N		N	20. 00
	made to PS&R Report data for Other? Describe				
	the other adjustments:				

Health Financial Systems	COMMUNITY HOSPITAL OF I	NDI ANA, I NC.	In Lie	u of Form CMS-2

2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 150074 Peri od: Worksheet S-2 From 01/01/2014 Part II 12/31/2014 Date/Time Prepared: 5/27/2015 6:01 pm Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21.00 Was the cost report prepared only using the Ν 21 00 Ν provider's records? If yes, see instructions 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 22.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost 23.00 23.00 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? 24.00 If ves. see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see 25.00 25.00 instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see 26,00 instructions. 27 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit 27.00 сору Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting 28.00 period? If yes, see instructions. Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see 30.00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual 32.00 arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If 33.00 33.00 no, see instructions. Provi der-Based Physi ci ans Are services furnished at the provider facility under an arrangement with provider-based physicians? 34.00 If yes, see instructions. Iffine 34 is yes, were there new agreements or amended existing agreements with the provider-based 35.00 physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00 Home Office Costs 36, 00 Were home office costs claimed on the cost report? 36, 00 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of 38.00 the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, 39.00 39.00 see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position RONALD HFLMS 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. 42.00 | Enter the employer/company name of the cost report COMMUNITY HEALTH NETWORK 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 317-355-5501 RHELMS@ECOMMUNI TY. COM 43.00 report preparer in columns 1 and 2, respectively.

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 150074 Peri od: Worksheet S-2 From 01/01/2014 To 12/31/2014 Part II Date/Time Prepared: 5/27/2015 6:01 pm Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 16.00 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) 17.00 Was the cost report prepared using the PS&R 04/29/2014 17.00 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) 18.00 | If line 16 or 17 is yes, were adjustments 18.00 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.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of 19.00 other PS&R Report information? If yes, see i nstructi ons. If line 16 or 17 is yes, were adjustments 20.00 made to PS&R Report data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If yes, see 21.00 21.00 instructions. 3.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position REIMBURSEMENT MANAGER 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report 42.00 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 43.00 report preparer in columns 1 and 2, respectively.

Provider CCN: 150074

					To	12/31/2014	Date/Time Prep 5/27/2015 6:0	
							1/P Days / 0/P	ı pili
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	oomponent.	Line Number	140.	or beas	Avai I abl e	Oran nodi S	11 110 1	
		1.00		2.00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		258	80, 393	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7.00	Total Adults and Peds. (exclude observation			258	80, 393	0.00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		12	4, 380	0.00	0	8. 00
9.00	CORONARY CARE UNIT	32. 00		39	8, 766	0. 00	0	9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43. 00					0	
14. 00	Total (see instructions)			309	93, 539	0. 00	0	14.00
15. 00	CAH visits						0	
16. 00	SUBPROVI DER - I PF							16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20. 00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC	88. 00					0	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00		200			0	
27. 00	Total (sum of lines 14-26)			309			0	27. 00
28. 00	Observation Bed Days						0	
29. 00								29. 00
30.00	Employee discount days (see instruction)							30.00
31. 00	1 ' 3							31.00
32. 00	Labor & delivery days (see instructions)			U	U			32. 00
32. 01	Total ancillary labor & delivery room							32. 01
33 00	outpatient days (see instructions) LTCH non-covered days			}				33. 00
33.00	LIGH HOH-covered days			J		I		33.00

33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 150074

Peri od: Worksheet S-3 From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared:

5/27/2015 6:01 pm Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 6.00 7.00 10.00 8.00 9.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 16, 670 8, 035 48, 076 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 6, 921 2 00 HMO and other (see instructions) 2 00 9,600 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 0 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 0 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 0 6.00 7.00 Total Adults and Peds. (exclude observation 16,670 8,035 48,076 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 1, 215 3, 103 8.00 CORONARY CARE UNIT 9.00 3, 334 C 7, 361 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 574 3, 432 13.00 14.00 Total (see instructions) 21, 219 8,609 61, 972 26. 79 2,537.28 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 HOSPI CE 24 00 24 00 24. 10 HOSPICE (non-distinct part) 0 570 24. 10 25. 00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 0 0.00 0.00 26, 00 26, 25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 0 0.00 C 0 26.25 27.00 Total (sum of lines 14-26) 26.79 2, 537. 28 27.00 28.00 Observation Bed Days 300 2, 931 28.00 29.00 29.00 Ambul ance Trips 0 30.00 Employee discount days (see instruction) 284 30.00 31.00 Employee discount days - IRF 31.00 32.00 Labor & delivery days (see instructions) 350 32.00 276 0 Total ancillary labor & delivery room 32.01 0 32.01 outpatient days (see instructions)

33.00 LTCH non-covered days

| Peri od: | Worksheet S-3 | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | Part | Part | Prepared: | Part | Part | Prepared: | Part
 Heal th Financial
 Systems
 COMMUNITY HO

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 150074

				10) 12/31/2014	5/27/2015 6:0	
		Full Time	•	Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12.00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	4, 507	4, 057	13, 156	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			1, 394	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	230. 00	0	4, 507	4, 057	13, 156	14.00
15. 00	CAH visits						15.00
16. 00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	230. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150074 | Period: Worksheet S-3 From 01/01/2014 | Part II

12/31/2014 Date/Time Prepared: 5/27/2015 6:01 pm Adj usted Worksheet A Amount Recl assi fi cati Paid Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col.2 ± col (from Salaries in col. 5) Worksheet A-6) 3) col. 4 6.00 2.00 5.00 1.00 3.00 4.00 PART II - WAGE DATA SALARI ES 1.00 Total salaries (see 200. 00 152, 987, 459 1, 544, 756 154, 532, 215 5, 277, 542. 00 29, 28 1.00 instructions) 2.00 Non-physician anesthetist Part 0.00 0.00 2.00 3.00 Non-physician anesthetist Part 0 0.00 0.00 3.00 4.00 Physician-Part A -0 0.00 0.00 4.00 Admi ni strati ve Physicians - Part A - Teaching 4.01 0.00 0.00 4.01 5.00 Physician-Part B 472, 400 472, 400 3, 715. 00 127. 16 5.00 6.00 Non-physician-Part B 0.00 0.00 6.00 Interns & residents (in an 21 00 725, 020 951, 904 1, 676, 924 7.00 55, 728. 00 30.09 7.00 approved program) 7.01 Contracted interns and 0.00 0.00 7.01 residents (in an approved programs) 8.00 Home office personnel 0.00 0.00 8.00 SNF 44 00 0.00 9 00 0 00 9 00 10.00 Excluded area salaries (see 3, 307, 942 4, 066, 014 7, 373, 956 285, 902. 00 25.79 10.00 instructions) OTHER WAGES & RELATED COSTS 1, 190, 691 1, 190, 691 15, 683. 00 75. 92 11.00 Contract labor: Direct Patient 11.00 Care 12.00 Contract Labor: Top Level 62, 405 O 62, 405 446.00 139. 92 12.00 management and other management and administrative servi ces Contract Labor: Physician-Part 13.00 388, 670 0 388, 670 3, 650.00 106. 48 13.00 A - Administrative 14.00 Home office salaries & 17, 541, 283 0 17, 541, 283 301, 707. 00 58. 14 14.00 wage-related costs Home office: Physician Part A 15.00 0 0.00 0.00 15.00 - Administrative 16.00 Home office and Contract 0 0 0.00 0.00 16.00 Physicians Part A - Teaching WAGE-RELATED COSTS 17.00 Wage-related costs (core) (see 46, 632, 632 0 46, 632, 632 17.00 instructions) Wage-related costs (other) 18.00 18.00 0 (see instructions) 19.00 19 00 Excluded areas 2, 637, 314 2, 637, 314 20.00 Non-physician anesthetist Part 20.00 21.00 Non-physician anesthetist Part 0 21.00 22.00 Physician Part A -C 22.00 Administrative 22.01 Physician Part A - Teaching 22.01 23.00 Physician Part B 23.00 42, 196 42, 196 24.00 Wage-related costs (RHC/FQHC) 24 00 25.00 Interns & residents (in an 362, 171 362, 171 25.00 approved program) OVERHEAD COSTS - DIRECT SALARIES Employee Benefits Department 26.00 4. 00 3, 161, 623 3, 161, 623 94, 311. 00 33. 52 26.00 Administrative & General 19, 910, 437 27.00 5.00 23, 818, 255 -3, 907, 818 675, 060. 00 29.49 27.00 28.00 Administrative & General under 2, 255, 340 2, 255, 340 31, 306. 00 72.04 28.00 contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 Operation of Plant 4, 979, 782 4, 979, 782 7 00 28. 55 30 00 30.00 174, 410. 00 31.00 Laundry & Linen Service 8.00 0.00 0.00 31.00 32.00 Housekeepi ng 9.00 1, 744, 196 1, 744, 196 124, 291. 00 14. 03 32.00 33.00 Housekeeping under contract 494, 154 494, 154 10, 621, 00 46. 53 33.00 (see instructions) 1, 447, 989 28, 620. 00 34 00 34.00 Di etarv 10.00 -911, 181 536, 808 18. 76 Di etary under contract (see 108, 769 108, 769 3, 114. 00 34. 93 35.00 35.00 instructions) 36.00 Cafeteri a 11.00 911, 181 911, 181 67, 040. 00 13. 59 36.00 Maintenance of Personnel 12 00 0.00 37 00 37 00 0 00 38.00 Nursing Administration 13.00 6, 161, 030 C 6, 161, 030 171, 527. 00 35. 92 38.00 2, 558, 318 Central Services and Supply 2, 558, 318 141, 270. 00 18. 11 39.00 39.00 14.00 40.00 Pharmacy 15.00 4, 568, 752 -87, 744 4, 481, 008 94, 869. 00 47. 23 40. 00

Heal th	Financial Systems	COMMU	JNI TY HOSPI TAL	In Lieu of Form CMS-2552-10				
HOSPITAL WAGE INDEX INFORMATION				Provi der		Peri od:	Worksheet S-3	
						From 01/01/2014		
					-	Γo 12/31/2014		
							5/27/2015 6: 0	1 pm
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
41.00	Medical Records & Medical	16. 00	4, 817, 863	0	4, 817, 863	216, 148. 00	22. 29	41. 00
	Records Library							
42.00	Soci al Servi ce	17. 00	3, 651, 270	0	3, 651, 270	97, 943. 00	37. 28	42.00
43.00	Other General Service	18. 00	0	0	(0.00	0. 00	43.00

instructions)

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 150074 Peri od: Worksheet S-3 From 01/01/2014 To 12/31/2014 Part III Date/Time Prepared: 5/27/2015 6:01 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . (from Salaries in col . 5) Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 154, 648, 302 592, 852 155, 241, 154 5, 263, 140. 00 29. 50 1.00 instructions) 2.00 3, 307, 942 4, 066, 014 7, 373, 956 285, 902. 00 25. 79 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 151, 340, 360 -3, 473, 162 147, 867, 198 4, 977, 238. 00 29.71 3.00 minus line 2) 4.00 Subtotal other wages & related 19, 183, 049 19, 183, 049 321, 486. 00 59.67 4.00 costs (see inst.) Subtotal wage-related costs 5.00 46, 632, 632 C 46, 632, 632 0.00 31.54 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 217, 156, 041 -3, 473, 162 213, 682, 879 5, 298, 724. 00 40 33 7.00 Total overhead cost (see 59, 767, 341 -3, 995, 562 55, 771, 779 1, 930, 530. 00 28.89 7.00

Health Financial Systems	COMMUNITY HOSPITAL OF INDIANA, INC.	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150074	Peri od:	Worksheet S-3

	AL WAGE RELATED COSTS	Provider	CCN.	150074	From 01/01/2014 To 12/31/2014	Part IV Date/Time Pre 5/27/2015 6:0	
						Amount	
						Reported	
	l					1. 00	
	PART IV - WAGE RELATED COSTS						
	Part A - Core List						
	RETI REMENT COST					1 001 101	
1.00	401K Employer Contributions					4, 331, 431	
2.00	Tax Sheltered Annuity (TSA) Employer Contribution					0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)					01	3.00
4. 00	Qualified Defined Benefit Plan Cost (see instructions)					18, 316, 812	4. 00
5. 00	PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Plan Administration fees					0	5.00
6. 00	Legal /Accounting/Management Fees-Pension Plan					321, 375	
7. 00	Employee Managed Care Program Administration Fees					321, 373	7.00
7.00	HEALTH AND INSURANCE COST					U	7.00
8. 00	Health Insurance (Purchased or Self Funded)					13, 373, 414	8. 00
9. 00	Prescription Drug Plan					13, 373, 414	1
10. 00							
11. 00						199, 417 105, 036	
12. 00	Accident Insurance (If employee is owner or beneficiary)					103, 030	1
13. 00							
14. 00						1, 306, 458 0	
15. 00						967, 778	
16. 00	Retirement Health Care Cost (Only current year, not the extraor	di narv acc	rual	reaui re	d by FASB 106.	0	1
	Non cumulative portion)					- I	
	TAXES						ĺ
17.00	FICA-Employers Portion Only					10, 807, 528	17. 00
	Medicare Taxes - Employers Portion Only					0	18. 00
19.00	Unemployment Insurance					0	19. 00
20.00	State or Federal Unemployment Taxes					0	20. 00
	OTHER						
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Rep	orted on I	i nes	1 through	gh 4 above. (see	0	21. 00
	instructions))					 -	
	Day Care Cost and Allowances					0	00
	Tuition Reimbursement					-54, 937	
24. 00	00 Total Wage Related cost (Sum of lines 1 -23) 49,6						24. 00
	Part B - Other than Core Related Cost						
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)				l	0	25. 00

Health Financial Systems	COMMUNITY HOSPITAL OF INDIANA, INC.		In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CC	N: 150074	Peri od: From 01/01/2014	Worksheet S-3 Part V

			1011 01/01/2014	I di t v				
		T	o 12/31/2014					
				5/27/2015 6:01	1 pm			
	Cost Center Description		Contract Labor					
			1. 00	2. 00				
	PART V - Contract Labor and Benefit Cost							
	Hospital and Hospital-Based Component Identification:							
1.00	Total facility's contract labor and benefit cost		0	0	1.00			
2.00	Hospi tal		0	0	2.00			
3.00	Subprovi der - I PF				3.00			
4.00	Subprovi der - I RF				4.00			
5.00	Subprovi der - (Other)		0	0	5.00			
6.00	Swing Beds - SNF		0	0	6.00			
7. 00	Swing Beds - NF		0	O	7.00			
8.00	Hospi tal -Based SNF				8.00			
9. 00	Hospi tal -Based NF				9.00			
10.00	Hospi tal -Based OLTC				10.00			
11. 00	Hospi tal -Based HHA				11.00			
12.00	Separately Certified ASC				12.00			
13.00	Hospi tal -Based Hospi ce				13.00			
14.00	Hospital-Based Health Clinic RHC		0	0	14.00			
15. 00	Hospital-Based Health Clinic FQHC		0	0	15.00			
16. 00	Hospi tal -Based-CMHC				16.00			
	Renal Dialysis		0	0	17.00			
18. 00			0	0	18. 00			
	I and the second se		1	- 1				

Heal th	Financial Systems COMMUNITY HOSPITAL OF INDIANA, II	NC.	In Lie	eu of Form CMS-2	2552-10			
	-	CCN: 150074	Peri od:	Worksheet S-10				
	From 01/01/2014 To 12/31/2014 C							
				1. 00				
1 00	Uncompensated and indigent care cost computation	no 202 col.um	- 0)	0.252221	1 00			
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by li Medicaid (see instructions for each line)	ne 202 coi ulli	1 8)	0. 253221	1. 00			
2. 00	Net revenue from Medicaid			91, 685, 721	2. 00			
3. 00	Did you receive DSH or supplemental payments from Medicaid?			γ, 665, 721	3. 00			
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments	from Medicai	d?	N	4. 00			
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			11, 296, 154	5. 00			
6.00	Medi cai d charges			357, 683, 346	6. 00			
7.00	Medicaid cost (line 1 times line 6)			90, 572, 935				
8.00	Difference between net revenue and costs for Medicaid program (line 7 mir	nus sum of li	nes 2 and 5; if	0	8. 00			
	<pre>< zero then enter zero) </pre>	1 1						
0.00	State Children's Health Insurance Program (SCHIP) (see instructions for e	each line)		0	0.00			
9. 00 10. 00	Net revenue from stand-alone SCHIP Stand-alone SCHIP charges			0				
11. 00	Stand-alone SCHIP cost (line 1 times line 10)							
12. 00	Difference between net revenue and costs for stand-alone SCHIP (line 11 m	ninus line 9.	if < zero then	0				
12.00	enter zero)	irrids Trile 7,	11 1 2010 111011		12.00			
	Other state or local government indigent care program (see instructions f	or each line)					
13.00	13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)							
14. 00	4.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 0							
45.00					45.00			
15. 00 16. 00	State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indigent care	nrogram (li	ao 15 minus lino	0	15. 00 16. 00			
10.00	13; if < zero then enter zero)	program (iii	ie io ilitius title	U	16.00			
	Uncompensated care (see instructions for each line)							
17. 00	Private grants, donations, or endowment income restricted to funding char	ity care		0	17. 00			
18. 00	Government grants, appropriations or transfers for support of hospital op	erati ons		0	18. 00			
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent	care program	ms (sum of lines	0	19. 00			
	8, 12 and 16)	1		T (4				
		Uni nsured pati ents	I nsured pati ents	Total (col. 1 + col. 2)				
		1.00	2. 00	3, 00				
20. 00	Total initial obligation of patients approved for charity care (at full	8, 027, 3			20. 00			
	charges excluding non-reimbursable cost centers) for the entire facility		,					
21. 00	Cost of initial obligation of patients approved for charity care (line 1	2, 032, 7	05 440, 339	2, 473, 044	21. 00			
	times line 20)			_	22. 00			
22. 00								
23. 00	Cost of charity care (line 21 minus line 22)	2, 032, 7	05 440, 339	2, 473, 044	23.00			
				1. 00				
24. 00	Does the amount in line 20 column 2 include charges for patient days beyon	ond a Length	of stav limit	N N	24. 00			
50	imposed on patients covered by Medicaid or other indigent care program?		· · · · · · · · · · · · · · · · · · ·					
	If line 24 is "yes," charges for patient days beyond an indigent care pr		th of stay limit	0				
	Total bad debt expense for the entire hospital complex (see instructions)			54, 502, 280				
27 00	Medicare had debts for the entire hospital complex (see instructions)			264 990	1 27 00			

27.00 Medicare bad debts for the entire hospital complex (see instructions)

31.00 |Total unreimbursed and uncompensated care cost (line 19 plus line 30)

30.00 Cost of uncompensated care (line 23 column 3 plus line 29)

28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)

29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)

16, 207, 065 30. 00 16, 207, 065 31. 00

27. 00

28.00

29.00

30.00

264, 990

54, 237, 290

13, 734, 021

	Financial Systems COMM SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	UNITY HOSPITAL (F FXPFNSFS			<u> </u>	eu of Form CMS-: Worksheet A	2552-10
		. Liu Liiolo	1101146	1	From 01/01/2014 To 12/31/2014		
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +-	Pill
						col . 4)	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4. 00	5. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		C		0 17, 014, 657	17, 014, 657	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		C		9, 281, 138		
3.00	00300 OTHER CAP REL COSTS	2 1/1 /22	1/ 402 115	10 5/2 72	0	0	
4. 00 5. 00	OO400	3, 161, 623 23, 818, 255	16, 402, 115 126, 549, 186	1			•
7. 00	00700 OPERATION OF PLANT	4, 979, 782	4, 801, 421				1
8.00	00800 LAUNDRY & LINEN SERVICE	0	820, 773				8.00
9.00	00900 HOUSEKEEPI NG	1, 744, 196	1, 020, 571	1			
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	1, 447, 989	1, 164, 672	2, 612, 66	1 -1, 138, 687 0 1, 672, 857		
13. 00	01300 NURSI NG ADMI NI STRATI ON	6, 161, 030	-2, 345, 734	3, 815, 29			1
14.00	01400 CENTRAL SERVICES & SUPPLY	2, 558, 318	-125, 334	1			1
15.00	01500 PHARMACY	4, 568, 752	11, 787, 329				
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	4, 817, 863 3, 651, 270	-1, 222, 086 -522, 508	I .			
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	3,031,270	-322, 300 C		0 0	0 3, 127, 030	1
19. 00	01900 NONPHYSICIAN ANESTHETISTS	223, 084	767, 490			990, 574	19.00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	725, 020	3, 779, 736				
22. 00 23. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD 02300 EMS TRAINING-ALLIED HEALTH	377, 559	-14, 426		2, 735, 603 64, 105		
23. 01	02301 RADI OLOGY SCHOOL-ALLI ED HEALTH	87, 546	-49, 731				1
23. 02	02302 PHARMACY RESIDENCY-ALLIED HEALTH	0	C		97, 953	97, 953	
23. 03	02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	0	C) (0	0	23. 03
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	25, 266, 002	4, 033, 194	29, 299, 19	6 -4, 006, 226	25, 292, 970	30.00
31. 00	03100 NTENSI VE CARE UNI T	2, 281, 639	644, 255	1			
32.00	03200 CORONARY CARE UNIT	3, 536, 929	901, 294				
43. 00	04300 NURSERY	0	C)	2, 135, 284	2, 135, 284	43.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	2, 205, 035	12, 966, 663	15, 171, 69	8 -10, 607, 768	4, 563, 930	50.00
51. 00	05100 RECOVERY ROOM	821, 148	266, 411	1			
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C		1, 155, 178	1, 155, 178	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 941, 699	1, 706, 915	1			1
55. 00 57. 00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	2, 819, 677 738, 959	3, 757, 166 791, 806				1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	398, 310	544, 538				
59. 00	05900 CARDI AC CATHETERI ZATI ON	909, 929	5, 021, 155	1			1
60.00	06000 LABORATORY	0	9, 642, 483	1			1
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	246, 308 2, 506, 675	104, 584 734, 057				1
66. 00		3, 577, 046	1, 351, 805				
67. 00	06700 OCCUPATI ONAL THERAPY	0	C		938, 142		1
	06800 SPEECH PATHOLOGY	1 (05 04)	E72 222) 2 170 177	298, 676		
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	1, 605, 846 1, 103, 793	572, 323 -52, 208			2, 077, 218 827, 103	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	02, 200 C		6, 366, 624		
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		9, 236, 043		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	70F 474	705 47	46, 025, 938		
74. 00 76. 00	07400 RENAL DI ALYSI S 03330 ENDOSCOPY	285, 778	705, 474 300, 580	1			1
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	15, 035, 042	6, 666, 163	1		20, 086, 864	1
76. 02	03950 NEUROPSYCHI ATRI C SERVI CES	198, 905	112, 711	311, 61	6 -51, 964	259, 652	76. 02
76. 03	03951 LUTHERWOOD PARTNERSHIP	5, 421, 363	3, 404, 532	1			
76. 04 76. 05	03952 WOUND CARE CENTER 03480 ONCOLOGY-CANCER CARE CENTER	445, 430 6, 698, 431	1, 509, 806 51, 814, 722	1			1
76. 06	03953 I MAGI NG CENTERS	1, 132, 806	2, 406, 382	1			1
76. 07	03954 BREAST DIAGNOSTIC CENTER	105, 563	1, 755, 288				
76. 97 76. 98	07697 CARDI AC REHABI LI TATI ON	282, 288	57, 439				1
70. 90	O7698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	<u> </u>		ή	0 1, 149, 180	1, 149, 180	70.90
88. 00	08800 RURAL HEALTH CLINIC	0	C		0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0	0	
90.00	09000 CLINIC	0	60.200	40.30	0 74 200	0 -6 999	
90. 01 90. 02	04950 DI ABETI C CARE CENTER 04951 HEALTHY HEARTS CENTER	1, 123, 560	69, 289 336, 431	1			
90. 04	04953 PALLI ATI VE CARE	458, 589	-165, 852			292, 737	
90.05	04954 I NFUSI ON CENTERS	257, 655	6, 372, 201				
90. 12 91. 00	04961 FAMILY PRACTICE AND MATERNITY CARE 09100 EMERGENCY	2, 760, 019 6, 657, 911	1, 364, 605 3, 613, 085				
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,057,911	3,013,085	10, 270, 99	-772, 383	7, 210, 013	91.00
		ı I		•	1	1	,

lealth Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. In Lieu of Form CMS-2552-10							
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		Peri od:	Worksheet A		
				From 01/01/2014 Fo 12/31/2014	Date/Time Pre 5/27/2015 6:0		
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati			
			+ col. 2)	ons (See A-6)			
					(col. 3 +-		
	1.00	0.00	2.22		col . 4)		
OTHER RELABURABLE AGOT OFFITERS	1. 00	2. 00	3. 00	4. 00	5. 00		
OTHER REIMBURSABLE COST CENTERS		ام				00.00	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0	0	98. 00	
SPECIAL PURPOSE COST CENTERS 118,00 SUBTOTALS (SUM OF LINES 1-117)	150 144 (22	20/ 122 771	427 27 20	1/ /21 502	410 (4E 001	110 00	
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	150, 144, 622	286, 122, 771	436, 267, 39	-16, 621, 502	419, 645, 891	1118.00	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	13, 533	1, 318	14, 85	1 0	14, 851	100 00	
191.00/19100/RESEARCH	484, 548	71, 813				1	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	497, 615	1, 749, 759					
194. 00 07950 HOME OFFI CE	497,013	1, 749, 739		1, 820		194. 00	
194. 01 07951 OCCUPATIONAL HEALTH ONSITE SVCS	0	1, 207, 585		٥			
194. 02 07952 MEDCHECKS	0	20, 460				194. 01	
194. 03 07953 SCHOOL BASED CLINICS	421, 796	98, 524				1	
194. 04 07954 OCCUPATIONAL HEALTH CLINICS	421, 770	21, 798			21, 798		
194. 05 07955 OTHER NONREI MBURSABLE COST CENTERS	0	21, 770	21,77	0		194. 05	
194. 06 07956 PAVI LLI ONS	206, 815	2, 318, 472	2, 525, 28	-312, 093			
194. 07 07957 LI FECHECK	126, 730	53, 252					
194. 08 07958 GROUP HOMES AND MISC. N R CTRS	1, 091, 800	737, 426		1		1	
194. 09 07959 SURGERY CENTER EAST	0	8, 059					
200. 00 TOTAL (SUM OF LINES 118-199)	152, 987, 459	292, 411, 237			l		
		= /2//20/		-1		1-20.00	

 Heal th Financial
 Systems
 COMMUNITY HOSPITAL OF INDIANA, INC.

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CCN: 150074

Peri od: From 01/01/2014 To 12/31/2014

Date/Time Prepared: 5/27/2015 6:01 pm

			5/2//2015 6: 0	I pm
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6. 00	7.00		
GENERAL SERVICE COST CENTERS				
1.00 00100 CAP REL COSTS-BLDG & FLXT	-692, 128	16, 322, 529		1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	4, 594, 044	13, 875, 182		2.00
3.00 00300 OTHER CAP REL COSTS			l .	3. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-61, 638	1	l .	4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	-68, 771, 659		·	5. 00
7. 00 00700 OPERATION OF PLANT	-943, 746			7. 00
				8. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	C			
9. 00 00900 HOUSEKEEPI NG	0		l	9. 00
10. 00 01000 DI ETARY	-107, 792		·	10. 00
11. 00 01100 CAFETERI A	-110, 257	1, 562, 600		11. 00
13.00 O1300 NURSING ADMINISTRATION	-98, 901	3, 623, 954		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	C	2, 421, 975		14.00
15. 00 01500 PHARMACY	-2, 881, 138	4, 947, 649		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	-181, 018	3, 413, 615		16. 00
17. 00 01700 SOCIAL SERVICE				17. 00
18. 00 01850 OTHER GENERAL SERVICE (SPECIFY)	l c		I I	18. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	-990, 574	1		19. 00
	1	1		
21. 00 02100 1 &R SERVI CES-SALARY & FRINGES APPRVD	-234, 802		l	21. 00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	-200, 624	1	·	22. 00
23.00 02300 EMS TRAINING-ALLIED HEALTH	-234, 040		·	23. 00
23. 01 02301 RADI OLOGY SCHOOL-ALLI ED HEALTH	71, 335		·	23. 01
23. 02 02302 PHARMACY RESIDENCY-ALLIED HEALTH	C	97, 953		23. 02
23. 03 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	C	0		23. 03
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	-3, 268, 768	22, 024, 202		30. 00
31.00 03100 INTENSIVE CARE UNIT	C		·	31. 00
32. 00 03200 CORONARY CARE UNIT	177, 931		·	32. 00
43. 00 04300 NURSERY	177, 731		·	43. 00
		2, 133, 204		43.00
ANCI LLARY SERVI CE COST CENTERS		4 5/2 020		FO 00
50. 00 05000 OPERATI NG ROOM	C		·	50.00
51. 00 05100 RECOVERY ROOM	C		·	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	C	1, 155, 178		52. 00
54. OO 05400 RADI OLOGY-DI AGNOSTI C	-215, 405	2, 589, 703		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	-52, 416	5, 897, 094		55.00
57. 00 05700 CT SCAN			l l	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	i c		l l	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	64, 259	1,	l l	59. 00
	1		l l	
	-1, 187, 894		l	60.00
64. 00 06400 I NTRAVENOUS THERAPY	C			64. 00
65. 00 06500 RESPI RATORY THERAPY	C	2, 936, 534		65. 00
66. 00 06600 PHYSI CAL THERAPY	-229, 675	2, 537, 690		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	C	938, 142		67.00
68.00 06800 SPEECH PATHOLOGY	C	298, 676		68. 00
69. 00 06900 ELECTROCARDI OLOGY	36, 801	2, 114, 019		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	28, 804		·	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	20,001	1	·	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS			·	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	_	10,020,700		73. 00
74. 00 07400 RENAL DI ALYSI S	C			74. 00
76. 00 03330 ENDOSCOPY	C			76. 00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	-11, 687, 553	8, 399, 311		76. 01
76. 02 03950 NEUROPSYCHI ATRI C SERVI CES	-25, 256	234, 396		76. 02
76. 03 03951 LUTHERWOOD PARTNERSHIP	-3, 459, 004	3, 890, 644		76. 03
76. 04 03952 WOUND CARE CENTER	-6, 708		·	76. 04
76. 05 03480 ONCOLOGY-CANCER CARE CENTER	-382, 295		·	76. 05
76. 06 03953 I MAGI NG CENTERS	-35, 610			76. 06
76. 07 03954 BREAST DIAGNOSTIC CENTER	-33,010			76. 07
			·	
76. 97 07697 CARDI AC REHABI LI TATI ON	-28, 526		·	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	C	1, 149, 180		76. 98
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	C	0		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	C	0		89. 00
90. 00 09000 CLI NI C	C	0		90. 00
90. 01 04950 DIABETIC CARE CENTER	47, 507	40, 508		90. 01
90. 02 04951 HEALTHY HEARTS CENTER	17,507	1, 388, 117		90. 02
	//1 227			90. 02
90. 04 04953 PALLI ATI VE CARE	41, 327		l .	
90. 05 04954 I NFUSI ON CENTERS	-6	1		90. 05
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE	-268, 301			90. 12
91. 00 09100 EMERGENCY	-2, 220	9, 276, 393		91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS				
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	C	0		98. 00
			·	

 Heal th Financial
 Systems
 COMMUNITY HOSPITAL OF INDIANA, INC.

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CCN: 150074
 In Lieu of Form CMS-2552-10
Worksheet A

Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6.00	7.00		
SPECIAL PURPOSE COST CENTERS				
118.00 SUBTOTALS (SUM OF LINES 1-117)	-91, 295, 946	328, 349, 945	118. 0	0
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14, 851	190. 0	O
191. 00 19100 RESEARCH	0	553, 052	191. O	O
192.00 19200 PHYSICIANS' PRIVATE OFFICES	39, 341	2, 284, 889	192. 0	O
194.00 07950 HOME OFFICE	0	0	194. 0	O
194. 01 07951 OCCUPATIONAL HEALTH ONSITE SVCS	0	1, 006, 772	194. 0	1
194. 02 07952 MEDCHECKS	0	2, 226	194. 0	2
194.03 07953 SCHOOL BASED CLINICS	0	505, 534	194. 0	3
194.04 07954 OCCUPATIONAL HEALTH CLINICS	0	21, 798	194. 0	4
194.05 07955 OTHER NONREIMBURSABLE COST CENTERS	0	0	194. 0	5
194. 06 07956 PAVI LLI ONS	0	2, 213, 194	194. 0	6
194. 07 07957 LI FECHECK	-134, 145	44, 387	194. 0	7
194.08 07958 GROUP HOMES AND MISC. N_R CTRS	-826, 807	974, 362	194. 0	8
194.09 07959 SURGERY CENTER EAST	0	17, 210, 129	194. 0	9
200.00 TOTAL (SUM OF LINES 118-199)	-92, 217, 557	353, 181, 139	200. 0	0

Health Financial Systems RECLASSIFICATIONS COMMUNITY HOSPITAL OF INDIANA, INC. In Lieu of Form CMS-2552-10 Peri od: From 01/01/2014 To 12/31/2014 Date/Ti me Prepared: 5/27/2015 6:01 pm Provider CCN: 150074

					5/27/2015 6:	O1 pm
		Increases				
	Cost Center	Li ne #	Salary	Other 5		
	2.00	3. 00	4.00	5. 00		
1 00	A - Labor and Delivery Salary	42.00	1 507 00/	0		1 00
1. 00 2. 00	NURSERY DELIVERY ROOM & LABOR ROOM	43. 00 52. 00	1, 597, 996	0		1. 00 2. 00
2.00	TOTALS		86 <u>4, 5</u> 08 2, 462, 504	0		2.00
	B - Labor and Delivery Other		2, 402, 504	U		
1.00	NURSERY	43.00		537, 288		1.00
2. 00	DELIVERY ROOM & LABOR ROOM	52.00		290, 670		2. 00
2.00	BEEL VERN NOOM & ELEON NOOM		0	827, 958		2.00
	C - Chargeable Medical Suppli	es		,		
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	6, 366, 624		1.00
	PATI ENTS					
2.00	LUTHERWOOD PARTNERSHIP	76. 03	0	252		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7. 00		0. 00	0	0		7. 00
8. 00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12. 00 13. 00		0. 00 0. 00	0	0		12. 00 13. 00
14. 00		0.00	o	0		14. 00
15. 00		0.00	o	0		15. 00
16. 00		0.00	0	0		16. 00
17. 00		0.00	o	0		17. 00
18. 00		0.00	0	o		18. 00
19. 00		0. 00	0	Ö		19. 00
20. 00		0. 00	0	Ö		20. 00
21. 00		0.00	o	Ō		21. 00
22. 00		0.00	0	0		22. 00
23.00		0.00	0	0		23. 00
24.00		0.00	0	0		24. 00
25.00		0.00	0	0		25. 00
26.00		0.00	0	0		26. 00
27.00		0.00	0	0		27. 00
28.00		0.00	0	0		28. 00
29.00		0.00	0	0		29. 00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32. 00
33.00		0.00	0	0		33. 00
34.00		0.00	0	0		34. 00
35. 00		0.00	0	0		35. 00
36. 00		0. 00	0	0		36. 00
37. 00		0.00	0	0		37. 00
38. 00	TOTAL C — — — —	0.00	9	0		38. 00
	TOTALS D - Depreciation Expense		0	6, 366, 876		-
1. 00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	13, 830, 615		1.00
2.00	OAI ALL GOSTS-WYDLL LQUIP	0.00	o	13, 630, 613		2.00
3. 00		0.00	0	0		3. 00
4. 00		0.00	0	0		4. 00
5. 00		0.00	0	0		5. 00
6. 00		0.00	o	0		6. 00
7. 00		0.00	0	o		7. 00
8. 00		0.00	Ö	Ö		8. 00
9. 00		0. 00	Ö	Ö		9. 00
10.00		0.00	O	O		10. 00
11. 00		0.00	0	0		11. 00
12.00		0.00	0	0		12. 00
13.00		0.00	0	0		13. 00
14.00		0.00	0	0		14. 00
15.00		0.00	0	0		15. 00
16.00		0.00	0	0		16. 00
17.00		0.00	0	0		17. 00
18.00		0.00	0	0		18. 00
19.00		0.00	0	0		19. 00
20.00		0.00	0	0		20. 00
21.00		0.00	0	0		21. 00
22. 00		0.00	O	0		22. 00
23. 00		0.00	0	0		23. 00
24. 00		0. 00	0	0		24. 00

Health Financial Systems		COMMUNITY HOSPITAL OF INDIANA, INC.				In Lieu of Form CMS-2552-10			
RECLASS	SIFICATIONS			Provi	der CCN	: 150074	Peri od: From 01/01/2014	Worksheet A-	
							To 12/31/2014	Date/Time Pr 5/27/2015 6:	epared: 01 pm
	Cost Center	Increases Line #	Salary	Other					
	2. 00	3.00	4. 00	5. 00					
25. 00 26. 00		0. 00 0. 00	0		0				25. 00 26. 00
27. 00		0.00	О		0				27. 00
28. 00		0.00	0		0				28. 00
29. 00 30. 00		0. 00 0. 00	0		0				29. 00 30. 00
31.00		0.00	o		0				31.00
32. 00 33. 00		0. 00 0. 00	0		0				32. 00 33. 00
34. 00		0.00	o		0				34. 00
35. 00		0.00	0		0				35. 00
36. 00 37. 00		0. 00 0. 00	0		0				36. 00 37. 00
38. 00		0.00	О		Ö				38. 00
39. 00 40. 00		0. 00 0. 00	0		0				39. 00 40. 00
40.00		0.00	0		0				41. 00
42.00		0.00	О		0				42. 00
43. 00 44. 00		0. 00 0. 00	0		0				43. 00 44. 00
45. 00		0.00	0		0				45. 00
46. 00		0.00	O		0				46. 00
47. 00 48. 00		0. 00 0. 00	0		0				47. 00 48. 00
49. 00	L	0.00	0		_ <u>o</u>				49. 00
	TOTALS		0	13, 830,	615				
1.00	E - Radi ol ogy Support Sal ary RADI OLOGY-THERAPEUTI C	55.00	318, 499						1.00
2.00	CT SCAN	57. 00	315, 433						2. 00
3. 00	MAGNETIC RESONANCE IMAGING (MRI)	58. 00	88, 469						3. 00
4.00	IMAGING CENTERS	7606	94, 324						4. 00
	F - Radiology Support Other		816, 725		0				
1.00	RADI OLOGY-THERAPEUTI C	55.00		185,	389				1.00
2.00	CT SCAN	57.00		183,					2. 00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58. 00		51,	495				3. 00
4.00	IMAGING CENTERS	<u>76.</u> 06			903				4. 00
	G - Capital Insurance Costs		0	475,	391				-
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	263,	780				1. 00
	TOTALS		o	263,	780				
1. 00	H - Implantable Device Reclas ADMINISTRATIVE & GENERAL	5.00	ol	33.	269				1.00
2.00	CENTRAL SERVICES & SUPPLY	14. 00	О	1, 034,	915				2. 00
3. 00	I MPL. DEV. CHARGED TO PATIENTS	72.00	0	9, 236,	043				3. 00
4.00	I ATTENTS	0.00	o		0				4. 00
5.00			0	10, 304,	0				5. 00
	I - Interest Expense		U _I	10, 304,	221				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3, 846,					1. 00
	TOTALS J - INTERNS AND RESIDENTS		0	3, 846,	023				
1.00	I&R SERVICES-OTHER PRGM	22.00	592, 852	2, 142,	751				1. 00
2.00	COSTS APPRVD	21 00	1 544 754		0				2.00
2.00	I &R SERVICES-SALARY & FRINGES APPRVD	21. 00	1, 544, 756		0				2. 00
	TOTALS		2, 137, 608	2, 142,	751				
1. 00	K - Other Capital Rental CAP REL COSTS-BLDG & FIXT	1.00	O	5, 856,	352				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	O	2, 499,					2. 00
3. 00 4. 00		0. 00 0. 00	0		0				3. 00 4. 00
4. 00 5. 00		0.00	0		0				5. 00
6.00		0.00	0		0				6. 00
7. 00 8. 00		0. 00 0. 00	0		0				7. 00 8. 00
8. 00 9. 00		0.00	0		0				9. 00
10.00		0.00	0		0				10.00
11. 00 12. 00		0. 00 0. 00	0		0				11. 00 12. 00
13. 00		0.00	o		o				13. 00

Health Financial Systems RECLASSIFICATIONS

Peri od: From 01/01/2014 To 12/31/2014

Date/Time Prepared: 5/27/2015 6:01 pm

		1			5/27/2015 6: 0	ı pm
	Cost Contor	Increases Line #	Callany	Othor		
	Cost Center 2.00	3. 00	Sal ary 4.00	0ther 5.00		
14. 00	2.00	0.00	4.00	5.00		14. 00
15. 00		0.00	ő	0		15. 00
16. 00		0.00	o	0		16. 00
17. 00		0.00	Ö	0		17. 00
18. 00		0.00	Ö	0		18. 00
19. 00		0.00	Ö	0		19. 00
20.00		0.00	O	0		20.00
21.00		0.00	o	0		21.00
22.00		0.00	O	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25. 00		0.00	0	0		25. 00
26. 00		0.00	0	0		26. 00
27. 00		0.00	0	0		27. 00
28. 00		0.00	0	0		28. 00
29. 00		0.00	0	0		29. 00
30. 00 31. 00		0. 00 0. 00	0	0		30. 00 31. 00
32. 00		0.00	0	0		32.00
33. 00		0.00	o	0		33. 00
34. 00		0.00	ő	0		34. 00
35. 00		0.00	Ö	0		35. 00
36. 00		0.00	o	0		36. 00
37. 00		0.00	Ö	0		37. 00
38. 00		0.00	o	0		38. 00
39.00		0.00	0	0		39.00
	TOTALS			8, 355, 377		
	M - Depreciation by CC					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0_	<u>7, 048, 5</u> 02		1. 00
	TOTALS		0	7, 048, 502		
	N - Cafeteria Salary	44.00	044 404			
1. 00	CAFETERI A	<u>11.</u> 00	911, 181	— — ₀		1. 00
	0 - Cafeteria Reclass		911, 181	U		
1.00	CAFETERI A	11. 00		761, 676		1. 00
1.00	ONI ETERNA			761, 676		1.00
	P - Benefit Allocation		<u> </u>	7017070		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		162, 744		1.00
2.00						2.00
			0	162, 744		
	R - Pharm Resident Costs					
1. 00	PHARMACY RESIDENCY-ALLIED	23. 02	87, 744			1. 00
	HEALTH	+	+			
	S - Pharmacy Residency Reclas		87, 744	0		
1. 00	PHARMACY RESIDENCY-ALLIED	23. 02		10, 209		1. 00
1.00	HEALTH	23.02		10, 209		1.00
	<u> </u>	+		_{10, 209}		
	T - Drugs Charges to Pat		-			
1.00	RESPI RATORY THERAPY	65.00	0	232		1.00
2.00	ELECTROCARDI OLOGY	69. 00	0	8, 171		2.00
3.00	DRUGS CHARGED TO PATIENTS	73. 00	0	46, 025, 938		3.00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8. 00 9. 00		0. 00 0. 00	0	0		8. 00 9. 00
10. 00		0.00	0	0		10.00
11. 00		0.00	o	0		11. 00
12. 00		0.00	o	0		12. 00
13. 00		0.00	Ö	0		13. 00
14.00		0.00	0	0		14.00
15.00		0.00	О	0		15.00
16.00		0.00	0	0		16.00
17. 00		0.00	0	0		17. 00
18. 00		0.00	0	0		18. 00
19. 00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21. 00		0.00	0	0		21. 00
22. 00		0.00	0	0		22. 00
23. 00 24. 00		0. 00 0. 00	0	0		23. 00 24. 00
25. 00		0.00	0	0		25. 00
	1	3.30	<u> </u>	٥١	l	

18.00

19.00

20.00

21.00

22.00

23.00 24.00

Health Financial Systems In Lieu of Form CMS-2552-10 COMMUNITY HOSPITAL OF INDIANA, INC. RECLASSI FI CATIONS Provider CCN: 150074 Peri od: Worksheet A-6 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/27/2015 6:01 pm Increases Cost Center 0ther Li ne # Sal ary 2.00 3.00 4.00 5.00 26. 00 0.00 0 26.00 27.00 0.00 27.00 0 28.00 0.00 0 28.00 29.00 0.00 0 29.00 30.00 0.00 0 30.00 TOTALS 46, 034, 341 U - Therapy Salary 1.00 OCCUPATI ONAL THERAPY 67.00 831, 697 0 1.00 2.00 SPEECH PATHOLOGY 68.00 264, 787 0 2.00 1, 096, 484 TOTALS V - Therapy Other OCCUPATIONAL THERAPY 1.00 67.00 106, 445 1.00 2.00 SPEECH PATHOLOGY 68.00 33, 889 2.00 TOTALS ō 140, 334 W - Plant Operations Expense 1.00 OPERATION OF PLANT 7.00 0 237, 276 1.00 2.00 EMS TRAINING-ALLIED HEALTH 23.00 0 297 2.00 0 3.00 **ENDOSCOPY** 76.00 64 3.00 4.00 0.00 0 4.00 0 5.00 0.00 0 5.00 6.00 0.00 0 0 6.00 0 7.00 0.00 0 7.00 8.00 0.00 0 0 8.00 9.00 0.00 0 9.00 0 10.00 0.00 0 10.00 0 11.00 0.00 11.00 12.00 0.00 0 0 12.00 13.00 0.00 0 0 13.00 0 0 0.00 14.00 14.00 0 15.00 0.00 15.00 16.00 0.00 0 0 16.00 17.00 0.00 0 0 17.00 0 0 18.00 0.00 18.00 19.00 0.00 19.00 20.00 0.00 0 0 20.00 0 21.00 0.00 0 21.00 0 22.00 0.00 22.00 23.00 0.00 23.00 0 24.00 0.00 0 24.00 0 25.00 0.00 25.00 ol 0 26.00 0.00 26.00 27.00 0.00 0 0 27.00 28.00 0.00 0 0 28.00 29.00 0.00 0 29.00 TOTALS 237, 637 X - Dietary Food Service Allocation 1.00 DI ETARY 10. 00 582, 102 1.00 2.00 SOCIAL SERVICE 17.00 2.00 3.00 3.00 4.00 4.00 5.00 5 00 6.00 6.00 7.00 7.00 8.00 8.00 9.00 9 00 10.00 10.00 11.00 11.00 12.00 12.00 13.00 13.00 14.00 14.00 15.00 15.00 16.00 16, 00 17.00 17.00

582, 103

18.00

19.00

20.00

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22.00

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24.00

RECLASSI FI CATI ONS Provider CCN: 150074 Peri od: Worksheet A-6 From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/27/2015 6:01 pm Increases Cost Center 0ther Li ne # Sal ary 2.00 3.00 4.00 5.00 Y - ISC LLC Salary Reclass 1.00 SURGERY CENTER EAST 194.09 3, 907, 818 1.00 3, 907, 818 - Reclass ISC LLC Other Expense 1.00 SURGERY CENTER EAST 194.09 13, 294, 252 1.00 13, 294, 252 AA - HYPERBARIC OXYGEN TX SALARY RECLASS 1.00 HYPERBARI C OXYGEN THERAPY 26<u>4, 5</u>85 1.00 0 264, 585 AB - HBOT Other 1.00 HYPERBARIC OXYGEN THERAPY 76. 98 884, 595 1.00 0 884, 595 TOTALS AC - Radiology School Allied Health 1.00 RADI OLOGY SCHOOL-ALLI ED 23. 01 24, 090 1.00 <u>HEALTH</u> ō 24,090 AD - Radiology School Allied Health 1.00 RADI OLOGY SCHOOL-ALLI ED 23.01 1, 843 1.00 HEALTH ō 1, 843 AE - EMS School Allied Health 1.00 EMS TRAINING-ALLIED HEALTH 23.00 46, 362 1.00 46, 362 AF - EMS School Allied Health 1.00 EMS TRAINING-ALLIED HEALTH 23.00 32, 702 1.00 32, 702 AK - IHH Cat Scan Salary Reclass 1.00 81, 507 CT_SCAN_ 57.00 1.00 81, 507

57. 00

11, 836, 608

1<u>6, 4</u>00

16, 400

115, 620, 336

1.00

500.00

AL - IHH Cat Scan Other Reclass

CT_SCAN

500.00 Grand Total: Increases

1.00

Health Financial Systems RECLASSIFICATIONS

Peri od: Worksheet A-6 From 01/01/2014 To 12/31/2014 Date/Time Prepared:

						o 12/31/2014 Date/lime Pr 5/27/2015 6:	
		Decreases	6.1	011	W . A 7 D C		
	Cost Center 6.00	Li ne # 7. 00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - Labor and Delivery Salary		0.00	7.00	10.00		
1.00	ADULTS & PEDIATRICS	30.00	2, 462, 504	0	0		1. 00
2.00		0.00	0_	0	0		2. 00
	TOTALS		2, 462, 504	0			-
1.00	B - Labor and Delivery Other ADULTS & PEDIATRICS	30.00		827, 958			1. 00
2. 00	ADDETS & LEDIATRICS	30.00		021, 730			2. 00
				827, 958			
	C - Chargeable Medical Suppli						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 966			1.00
2. 00 3. 00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5. 00 7. 00	0	48, 178 99, 685			2. 00 3. 00
4. 00	DI ETARY	10.00	o	509			4. 00
5. 00	NURSING ADMINISTRATION	13. 00	Ö	1, 050			5. 00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	126, 256	O		6. 00
7. 00	PHARMACY	15. 00	0	32, 140			7. 00
8. 00	I &R SERVICES-SALARY & FRINGES APPRVD	21. 00	0	5, 170	0		8. 00
9. 00	EMS TRAINING-ALLIED HEALTH	23. 00	0	480	o		9. 00
10. 00	ADULTS & PEDIATRICS	30.00	o	342, 126			10.00
11. 00	INTENSIVE CARE UNIT	31.00	О	103, 861			11. 00
12.00	CORONARY CARE UNIT	32.00	0	64, 471	0		12. 00
13.00	OPERATING ROOM	50.00	0	2, 275, 855			13.00
14. 00 15. 00	RECOVERY ROOM RADIOLOGY-DIAGNOSTIC	51. 00 54. 00	0	54, 956 29, 990			14. 00 15. 00
16. 00	RADI OLOGY-THERAPEUTI C	55.00	0	441, 434			16. 00
17. 00	CT SCAN	57.00	ő	120, 642			17. 00
18. 00	MAGNETIC RESONANCE IMAGING	58. 00	O	2, 990			18. 00
	(MRI)						
19.00	CARDI AC CATHETERI ZATI ON	59.00	0	1, 625, 182			19. 00
20. 00 21. 00	LABORATORY INTRAVENOUS THERAPY	60. 00 64. 00	0	356 67, 871			20.00
22. 00	RESPIRATORY THERAPY	65. 00	o	185, 631			22. 00
23. 00	PHYSI CAL THERAPY	66.00	O	8, 338			23. 00
24.00	ELECTROCARDI OLOGY	69.00	O	20, 198	O		24. 00
25. 00	ELECTROENCEPHALOGRAPHY	70. 00	0	33, 944			25. 00
26. 00	RENAL DIALYSIS	74.00	0	1, 214			26. 00
27. 00 28. 00	ENDOSCOPY PSYCHI ATRI C/PSYCHOLOGI CAL	76. 00 76. 01	0	162, 965 1, 899			27. 00 28. 00
20.00	SERVI CES	70.01	Ĭ	1,077			20.00
29. 00	WOUND CARE CENTER	76. 04	О	58, 792	0		29. 00
30.00	ONCOLOGY-CANCER CARE CENTER	76. 05	0	39, 014			30. 00
31.00	I MAGI NG CENTERS	76.06	0	9, 624			31.00
32. 00 33. 00	BREAST DIAGNOSTIC CENTER CARDIAC REHABILITATION	76. 07 76. 97	0	3, 545			32. 00 33. 00
34. 00	HEALTHY HEARTS CENTER	90. 02	0	2, 025 1, 388			34. 00
35. 00	FAMILY PRACTICE AND	90. 12	o	2, 169			35. 00
	MATERNITY CARE						
36. 00	EMERGENCY	91.00	0	388, 096			36. 00
37. 00	OCCUPATIONAL HEALTH ONSITE	194. 01	0	311	0		37. 00
38. 00	SVCS SCHOOL BASED CLINICS	194. 03	0	2, 555	0		38. 00
00.00	TOTALS		— — ŏ	6, 366, 876			00.00
	D - Depreciation Expense						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38, 280			1. 00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	9, 595, 590			2.00
3. 00 4. 00	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	7. 00 8. 00	0	212, 975 100			3. 00 4. 00
5. 00	HOUSEKEEPI NG	9. 00	o	16, 026			5. 00
6. 00	DI ETARY	10.00	o	32, 386			6. 00
7.00	NURSING ADMINISTRATION	13. 00	0	46, 386			7. 00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	21, 343			8. 00
9.00	PHARMACY	15. 00	0	46, 242			9. 00
10.00	SOCIAL SERVICE	17. 00	0	56 2 170			10.00
11. 00	I&R SERVICES-SALARY & FRINGES APPRVD	21. 00	0	2, 179	0		11. 00
12. 00	EMS TRAINING-ALLIED HEALTH	23. 00	o	14, 243	О		12. 00
13. 00	ADULTS & PEDIATRICS	30.00	O	189, 602			13. 00
14. 00	INTENSIVE CARE UNIT	31.00	О	37, 470			14. 00
15. 00	CORONARY CARE UNIT	32.00	0	28, 179			15. 00
16.00	OPERATING ROOM	50.00	0	602, 819			16.00
17. 00 18. 00	RECOVERY ROOM RADIOLOGY-DIAGNOSTIC	51. 00 54. 00	0	1, 432 342, 156			17. 00 18. 00
19. 00	RADI OLOGY-THERAPEUTI C	55.00	0	246, 203			19. 00
		'	'		· '		•

Peri od: From 01/01/2014 To 12/31/2014

Date/Time Prepared: 5/27/2015 6:01 pm

						5/27/2015 6:0)1 pm
		Decreases		0.11			
	Cost Center	Li ne #	Sal ary	Other 0	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		00.00
20. 00	CT SCAN	57. 00	0	58, 833			20.00
21. 00	MAGNETIC RESONANCE I MAGING	58. 00	0	220, 633	0		21. 00
22.00	(MRI) CARDIAC CATHETERIZATION	59.00		24 477	o		22. 00
22. 00	LABORATORY		0	34, 477			23. 00
23. 00 24. 00	INTRAVENOUS THERAPY	60.00	0	2, 486 539			1
	l control of the cont	64.00	0				24. 00
25. 00	RESPIRATORY THERAPY	65. 00		93, 306			25. 00
26. 00	PHYSI CAL THERAPY	66.00	0	76, 411	0		26. 00
27. 00	ELECTROCARDI OLOGY	69.00	0	42, 316			27. 00
28. 00	ELECTROENCEPHALOGRAPHY	70.00	0	118, 357	0		28. 00
29. 00	RENAL DIALYSIS	74.00	0	503			29. 00
30.00	ENDOSCOPY	76. 00	0	12, 512			30.00
31. 00	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 01	0	139, 444	0		31. 00
22.00	SERVICES	7/ 00	0	1 220			22.00
32. 00	NEUROPSYCHI ATRI C SERVI CES	76. 02	0	1, 329			32.00
33. 00	LUTHERWOOD PARTNERSHIP	76. 03	0	19, 238			33. 00
34.00	WOUND CARE CENTER	76. 04	0	20, 591	0		34. 00
35. 00	ONCOLOGY-CANCER CARE CENTER	76. 05	0	78, 188			35. 00
36. 00	I MAGI NG CENTERS	76. 06	0	492, 893			36. 00
37. 00	CARDIAC REHABILITATION	76. 97	0	4, 157			37. 00
38. 00	HEALTHY HEARTS CENTER	90. 02	0	1, 263			38. 00
39. 00	INFUSION CENTERS	90. 05	0	1, 170			39. 00
40. 00	FAMILY PRACTICE AND	90. 12	0	105, 654	0		40. 00
	MATERNITY CARE						
41.00	EMERGENCY	91.00	0	467, 609	0		41.00
42.00	RESEARCH	191. 00	0	261	0		42.00
43.00	OCCUPATIONAL HEALTH ONSITE	194. 01	0	2, 340	0		43. 00
	SVCS						
44.00	MEDCHECKS	194. 02	0	18, 234	0		44.00
45.00	SCHOOL BASED CLINICS	194. 03	0	778	o		45. 00
46.00	PAVI LLI ONS	194.06	0	312, 093	o		46. 00
47.00	LI FECHECK	194. 07	0	1, 450	o		47. 00
48. 00	GROUP HOMES AND MISC. N_R	194. 08	o	28, 057	1		48. 00
	CTRS						
49.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	1, 826	0		49. 00
	TOTALS			13, 830, 615			
	E - Radiology Support Salary						
1.00	RADI OLOGY-DI AGNOSTI C	54.00	816, 725				1. 00
2.00							2. 00
3.00							3. 00
4.00							4. 00
			816, 725	0			
	F - Radi ol ogy Support Other						
1.00	RADI OLOGY-DI AGNOSTI C	54.00		475, 391			1. 00
2.00							2. 00
3.00							3. 00
4.00							4. 00
			0	475, 391			
	G - Capital Insurance Costs						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	263, 780	12		1. 00
	TOTALS		0	263, 780			
	H - Implantable Device Reclas	SS					
1.00	OPERATING ROOM	50.00	0	7, 024, 887	0		1. 00
2.00	RADI OLOGY-THERAPEUTI C	55. 00	0	159, 033	o		2. 00
3.00	CARDIAC CATHETERIZATION	59. 00	O	3, 041, 487			3. 00
4.00	ENDOSCOPY	76.00	o	17, 052			4. 00
5.00	WOUND CARE CENTER	76. 04	O	61, 768			5. 00
	TOTALS	†	of	10, 304, 227			
	I - Interest Expense						1
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	3, 846, 023	9		1.00
	TOTALS	— — — †		3, 846, 023			
	J - INTERNS AND RESIDENTS				· · · · · · · · · · · · · · · · · · ·		İ
1.00	I &R SERVI CES-SALARY &	21.00	592, 852	3, 687, 507	0		1. 00
	FRINGES APPRVD	250	3,2,002	2, 33., 307			
2.00		0.00	0	Λ	o		2. 00
55	TOTALS — — — —	<u> </u>	592, 852	3, 687, 507	<u> — — </u>		55
	K - Other Capital Rental		3,2,002	5, 557, 507	1		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	169, 296	10		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 725, 112			2.00
3.00	OPERATION OF PLANT	7. 00	0	132, 360			3. 00
4.00	HOUSEKEEPI NG	7. 00 9. 00	0	3, 967			4. 00
	DI ETARY		0				5. 00
5.00		10.00	0	8, 146			
6.00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13.00	0	29, 646 997, 224			6. 00 7. 00
7. 00	POLITICAL SERVICES & SUPPLY	14. 00	ΟĮ	887, 234	0		1.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 150074

| Peri od: | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: 5/27/2015 6:01 pm

						5/27/2015 6:	O1 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref. 10.00		
8. 00	6. 00 PHARMACY	7. 00 15. 00	8. 00	9. 00 344, 779			8. 00
9. 00	MEDICAL RECORDS & LIBRARY	16. 00	0	1, 144			9. 00
10. 00	SOCI AL SERVI CE	17. 00	Ö	1, 649			10.00
11. 00	I &R SERVI CES-SALARY &	21. 00	o	4, 943			11. 00
	FRI NGES APPRVD			·			
12.00	ADULTS & PEDIATRICS	30.00	0	6, 868	0		12. 00
13.00	INTENSIVE CARE UNIT	31. 00	0	63, 159			13. 00
14.00	CORONARY CARE UNIT	32.00	0	52, 628			14. 00
15. 00	OPERATING ROOM RECOVERY ROOM	50.00	0	172, 093			15. 00
16. 00 17. 00	RADI OLOGY-DI AGNOSTI C	51. 00 54. 00	0	948 1, 791			16. 00 17. 00
18. 00	RADI OLOGY-THERAPEUTI C	55.00	0	586			18. 00
19. 00	CT SCAN	57. 00	0	74, 376			19. 00
20. 00	MAGNETIC RESONANCE I MAGING	58.00	o	317	1		20.00
	(MRI)						
21. 00	CARDI AC CATHETERI ZATI ON	59. 00	0	1, 373			21. 00
22.00	LABORATORY	60.00	0	158			22. 00
23. 00	I NTRAVENOUS THERAPY	64. 00	0	389			23. 00
24. 00	RESPIRATORY THERAPY	65. 00	0	18, 904	1		24. 00
25. 00	PHYSI CAL THERAPY	66.00	0	828, 486			25. 00
26. 00 27. 00	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	69. 00 70. 00	0	41, 471 66, 460	0		26. 00 27. 00
28. 00	RENAL DIALYSIS	74.00	0	274			28. 00
29. 00	ENDOSCOPY	76.00	0	421	0		29. 00
30.00	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 01	o	1, 274, 309			30.00
	SERVI CES			.,,			
31.00	NEUROPSYCHIATRIC SERVICES	76. 02	O	50, 150	0		31.00
32.00	LUTHERWOOD PARTNERSHIP	76. 03	0	1, 165, 575	I		32. 00
33.00	ONCOLOGY-CANCER CARE CENTER	76. 05	0	281, 101	1		33. 00
34. 00	I MAGI NG CENTERS	76. 06	0	319, 006	1		34. 00
35. 00	DIABETIC CARE CENTER	90. 01	0	76, 288			35. 00
36.00	HEALTHY HEARTS CENTER I NFUSI ON CENTERS	90. 02	0	68, 837	1		36. 00 37. 00
37. 00 38. 00	FAMILY PRACTICE AND	90. 05 90. 12	0	40, 112 408, 556			38.00
30.00	MATERNITY CARE	70. 12	٥	400, 550			30.00
39. 00	EMERGENCY	91.00	o	32, 465	0		39. 00
	TOTALS			8, 355, 377			
	M - Depreciation by CC						
1. 00	CAP REL COSTS-MVBLE EQUIP	2.00	•	<u>7, 048, 5</u> 02			1. 00
	TOTALS		0	7, 048, 502			
1. 00	N - Cafeteria Salary	10.00	911, 181				1.00
1.00	DI ETARY		911, 181	— — _ō			1.00
	0 - Cafeteria Reclass		711, 101				
1.00	DI ETARY	10.00		761, 676			1.00
				761, 676			
	P - Benefit Allocation						
1.00	I &R SERVICES-SALARY &	21. 00		38, 287			1. 00
	FRI NGES APPRVD						
2. 00	OCCUPATIONAL HEALTH ONSITE	194. 01		124, 457			2. 00
	<u> SVC</u> S	+					
	R - Pharm Resident Costs		٩_	102, 744			
1.00	PHARMACY	15. 00	87, 744				1.00
			87, 744	— — — _ō			
	S - Pharmacy Residency Reclas	S					
1.00	PHARMACY	1500		1 <u>0, 2</u> 09			1. 00
			0	10, 209			
	T - Drugs Charges to Pat						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	253, 164			1.00
2. 00 3. 00	OPERATION OF PLANT NURSING ADMINISTRATION	7. 00 13. 00	0	52 15 140	1		2. 00 3. 00
4.00	CENTRAL SERVICES & SUPPLY	14. 00	0	15, 160 2, 259			4. 00
5.00	PHARMACY	15. 00	0	8, 006, 180	1		5. 00
6. 00	EMS TRAINING-ALLIED HEALTH	23. 00	Ö	533	I I		6. 00
7. 00	ADULTS & PEDIATRICS	30. 00	Ö	7, 845			7. 00
8.00	INTENSIVE CARE UNIT	31.00	0	1, 639	l t		8. 00
9.00	CORONARY CARE UNIT	32.00	0	1, 375			9. 00
10. 00	OPERATING ROOM	50.00	0	481, 845			10. 00
11.00	RECOVERY ROOM	51.00	0	202			11.00
12.00	RADI OLOGY TUEDADEUT C	54.00	0	46, 039	1		12.00
13. 00 14. 00	RADI OLOGY-THERAPEUTI C CT SCAN	55. 00 57. 00	0	271, 736 16	1		13. 00 14. 00
14. 00 15. 00	CARDIAC CATHETERIZATION	57.00 59.00	0	904			15. 00
	1	27.00	٩	,,,,	·		

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: 5/27/2015 6:01 pm Provider CCN: 150074

						5/27/2015 6	: 01 pm
		Decreases					
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
1/ 00	6.00	7. 00	8. 00	9.00	10. 00		16, 00
16. 00 17. 00	INTRAVENOUS THERAPY PHYSICAL THERAPY	64. 00 66. 00	0		0		17. 00
18. 00	ELECTROENCEPHALOGRAPHY	70.00	0		0		18. 00
19. 00	ENDOSCOPY	76. 00	0	17	0		19. 00
20.00	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 01	0	62, 555	0		20. 00
	SERVI CES						
21. 00	LUTHERWOOD PARTNERSHIP	76. 03	0		0		21. 00
22. 00 23. 00	WOUND CARE CENTER ONCOLOGY-CANCER CARE CENTER	76. 04 76. 05	0	59, 919 30, 296, 138	0		22. 00 23. 00
24. 00	I MAGING CENTERS	76. 05 76. 06	0	30, 240, 138	0		24. 00
25. 00	HEALTHY HEARTS CENTER	90. 02	0	122	0		25. 00
26.00	INFUSION CENTERS	90. 05	0	6, 280, 520	0		26. 00
27. 00	FAMILY PRACTICE AND	90. 12	0	118, 598	0		27. 00
	MATERNI TY CARE	04.00					
28. 00	EMERGENCY	91.00	0	-,	0		28. 00
29. 00	OCCUPATIONAL HEALTH ONSITE SVCS	194. 01	Ü	73, 705	U		29. 00
30. 00	SCHOOL BASED CLINICS	194. 03	0	11, 453	0		30. 00
	TOTALS			46, 034, 341			
	U - Therapy Salary						
1.00	PHYSI CAL THERAPY	66. 00	1, 096, 484		0	1	1.00
2. 00		0.00	<u>0</u> 1, 096, 484	<u> </u>	0		2. 00
	V - Therapy Other		1, 090, 484	0			
1.00	PHYSI CAL THERAPY	66. 00	0	140, 334	0		1.00
2.00	<u> </u>	0.00	0		0		2. 00
	TOTALS		0	140, 334			
1. 00	W - Plant Operations Expense EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5, 265	0		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	0		0		2. 00
3.00	HOUSEKEEPI NG	9. 00	0		0		3. 00
4.00	DI ETARY	10.00	0	6, 891	0		4. 00
5.00	NURSING ADMINISTRATION	13. 00	0	199	0		5. 00
6.00	CENTRAL SERVICES & SUPPLY	14. 00	0	8, 832	0		6. 00
7. 00	I &R SERVI CES-SALARY &	21. 00	0	1, 878	0		7. 00
8. 00	FRINGES APPRVD ADULTS & PEDIATRICS	30.00	0	7, 125	0		8. 00
9. 00	INTENSIVE CARE UNIT	31. 00	0		0		9. 00
10.00	CORONARY CARE UNIT	32.00	0	4, 075	0		10. 00
11. 00	OPERATING ROOM	50. 00	0	49, 571	0		11. 00
12.00	RECOVERY ROOM	51.00	0	426	0		12.00
13. 00 14. 00	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	54. 00 55. 00	0	0,0,,	0		13. 00 14. 00
15. 00	MAGNETIC RESONANCE I MAGING	58. 00 58. 00	0	5, 540 881	0		15. 00
13.00	(MRI)	30.00	O	001	Ö		13.00
16.00	CARDIAC CATHETERIZATION	59. 00	0	10, 731	0		16. 00
17. 00	LABORATORY	60.00	0	1, 471	0		17. 00
18. 00	RESPI RATORY THERAPY	65. 00	0	-,			18. 00
19. 00	PHYSI CAL THERAPY	66.00	0	,	0 0		19.00
20. 00 21. 00	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	69. 00 70. 00	0		0		20. 00 21. 00
22. 00	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 01	0		o	1	22.00
	SERVI CES			,			
23. 00	LUTHERWOOD PARTNERSHI P	76. 03	0		0		23. 00
24. 00	ONCOLOGY-CANCER CARE CENTER	76. 05	0	_,	0		24. 00
25. 00 26. 00	I MAGING CENTERS BREAST DIAGNOSTIC CENTER	76. 06 76. 07	0	6, 578 174	0		25. 00 26. 00
27. 00	CARDIAC REHABILITATION	76. 07 76. 97	0	1	0		27. 00
28. 00	FAMILY PRACTICE AND	90. 12	0	1, 571	0		28. 00
	MATERNITY CARE						
29. 00	EMERGENCY	<u>91.</u> 00	0	 	0		29. 00
	TOTALS X - Dietary Food Service Allo	ncation	0	237, 637			
1. 00	ADULTS & PEDIATRICS	30.00		162, 198			1.00
2. 00	INTENSIVE CARE UNIT	31. 00		5, 376			2. 00
3.00	CORONARY CARE UNIT	32. 00		7, 130			3. 00
4.00	OPERATING ROOM	50.00		698			4. 00
5.00	RECOVERY ROOM	51.00		268			5. 00
6.00	RADI OLOGY - DI AGNOSTI C	54. 00 55. 00		3, 677			6.00
7. 00 8. 00	RADI OLOGY-THERAPEUTI C CT SCAN	55. 00 57. 00		6, 689 18			7. 00 8. 00
9. 00	MAGNETIC RESONANCE I MAGING	58. 00		85			9. 00
	(MRI)						
10.00	CARDIAC CATHETERIZATION	59. 00		1, 710			10.00

RECLASSI FI CATIONS Pro

Provi der CCN: 150074 Peri od:

Peri od: Worksheet A-6 From 01/01/2014 To 12/31/2014 Date/Ti me Prepared:

5/27/2015 6:01 pm Decreases 0ther Cost Center Li ne # Sal ary Wkst. A-7 Ref. 10. 00 6.00 7.00 8.00 9.00 PHYSICAL THERAPY 11. 00 11.00 66.00 5, 528 12.00 ELECTROCARDI OLOGY 69.00 932 12.00 ELECTROENCEPHALOGRAPHY 13.00 70.00 2, 347 13.00 PSYCHI ATRI C/PSYCHOLOGI CAL 14.00 76.01 111, 532 14.00 SERVI CES NEUROPSYCHIATRIC SERVICES 15.00 76.02 485 15.00 LUTHERWOOD PARTNERSHIP 76.03 225, 720 16.00 16.00 17.00 WOUND CARE CENTER 76.04 259 17.00 ONCOLOGY-CANCER CARE CENTER 76.05 18.00 26, 929 18.00 19.00 IMAGING CENTERS 76.06 904 19.00 20.00 CARDIAC REHABILITATION 76.97 183 20.00 HEALTHY HEARTS CENTER 90.02 21.00 21.00 264 22.00 FAMILY PRACTICE AND 90.12 384 22.00 MATERNITY CARE 23.00 EMERGENCY 91.00 15, 739 23.00 24.00 RESEARCH 191.00 3.048 24.00 582, 103 Y - ISC LLC Salary Reclass ADMINISTRATIVE & GENERAL 1.00 5. 00 3, 907, 818 1.00 ō 3, 907, 818 Z - Reclass ISC LLC Other Expense 1.00 ADMINISTRATIVE & GENERAL 5.00 13, 294, 252 1.00 13, 294, 252 AA - HYPERBARIC OXYGEN TX SALARY RECLASS 1.00 WOUND CARE CENTER 76.04 264, 585 1.00 264, 585 AB - HBOT Other 1.00 WOUND CARE CENTER 76.04 884, 595 0 1.00 TOTALS 884, 595 AC - Radiology School Allied Health RADI OLOGY-DI AGNOSTI C 1 00 54. 00 24, 090 1.00 24,090 0 AD - Radiology School Allied Health 1.00 RADI OLOGY-DI AGNOSTI C 54. 00 1.843 1.00 ō 1, 843 - EMS School Allied Health 1.00 **EMERGENCY** 46, 362 91.00 1.00 ō 46, 362 AF - EMS School Allied Health 1.00 **EMERGENCY** 91. 00 32, 702 1.00 32, 702 AK - IHH Cat Scan Salary Reclass 1.00 RADI OLOGY-DI AGNOSTI C 54.00 81, 507 1.00 Ō 81, 507 AL - IHH Cat Scan Other Reclass RADI OLOGY-DI AGNOSTI C 1.00 54.00 16, 400 1.00 16, 400 500.00 Grand Total: Decreases 10, 291, 852 117, 165, 092 500.00

9.00

Reconciling Items

10.00 Total (line 8 minus line 9)

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 150074 Peri od: Worksheet A-7 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/27/2015 6:01 pm Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 2, 432, 807 310, 241 310, 241 0 1.00 2.00 Land Improvements 4, 080, 044 0 0 0 0 2.00 3.00 172, 240, 742 83, 565, 959 83, 565, 959 1, 202, 231 3.00 Buildings and Fixtures 4.00 Building Improvements 15, 522, 659 929, 581 929, 581 -78, 287 4.00 5.00 Fixed Equipment 14, 265, 238 0 5.00 0 6.00 Movable Equipment 256, 052, 488 46, 560, 430 46, 560, 430 -3, 764, 146 6.00 0 7.00 HIT designated Assets 516,000 0 7.00 8.00 Subtotal (sum of lines 1-7) 465, 109, 978 131, 366, 211 131, 366, 211 -2, 640, 202 8.00 9.00 Reconciling Items 0 9.00 <u>465, 109, 97</u>8 -2, 640, 202 Total (line 8 minus line 9) 10.00 131, 366, 211 131, 366, 211 10.00 Endi ng Bal ance Fully Depreciated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 2, 743, 048 0 1.00 2.00 Land Improvements 4, 080, 044 0 2. 00 3.00 Buildings and Fixtures 254, 604, 470 0 3.00 0 4.00 Building Improvements 16, 530, 527 4.00 5.00 Fi xed Equipment 14, 265, 238 0 5.00 Movable Equipment 306, 377, 064 0 6.00 6.00 7.00 HIT designated Assets 516,000 0 7.00 Subtotal (sum of lines 1-7) 8.00 599, 116, 391 0 8.00

599, 116, 391

Health Financial Systems COMM	MUNITY HOSPITAL	OF INDIANA, IN	NC.	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od: From 01/01/2014 To 12/31/2014	Worksheet A-7 Part II Date/Time Pre 5/27/2015 6:0	pared:
	SUMMARY OF CAPITAL					
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9. 00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	IN 2, LINES 1 a	ind 2			
1.00 CAP REL COSTS-BLDG & FLXT	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 0	F CAPITAL				
Cost Center Description	0ther	Total (1) (sum				
	Capi tal -Rel ate	of cols. 9				
	d Costs (see	through 14)				
	instructions)					
DADT II DECONCILIATION OF AMOUNTS FROM WOR	14. 00	15. 00				

0 0 0

0 0 0

1. 00 2. 00 3. 00

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2
CAP REL COSTS-BLDG & FIXT
CAP REL COSTS-MVBLE EQUIP
0
0

1. 00 2. 00

3.00 Total (sum of lines 1-2)

Heal th	Financial Systems COMM	UNITY HOSPITAL	OF INDIANA, IN	NC.	In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014 Fo 12/31/2014		pared:
		COMI	PUTATION OF RAT	TI 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	
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE				_		
1.00	CAP REL COSTS-BLDG & FLXT	285, 400, 235		285, 400, 23			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	306, 893, 064		306, 893, 064			2. 00
3.00	Total (sum of lines 1-2)	592, 293, 299		592, 293, 299			3. 00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL						
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	0	(11, 635, 347		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	(11, 376, 157	2, 499, 025	2. 00
3.00	Total (sum of lines 1-2)	0		(23, 011, 504	8, 355, 377	3. 00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
		11.00	12.00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS OF	INTEDS					1

-1, 432, 950

0 -1, 432, 950

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
CAP REL COSTS-BLDG & FIXT -1

CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)

263, 780

263, 780

0 0 0

0 0 0

16, 322, 529 1. 00 13, 875, 182 2. 00 30, 197, 711 3. 00

1.00

2.00

Provider CCN: 150074

Peri od:

From 01/01/2014 12/31/2014 Date/Time Prepared: 5/27/2015 6:01 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) Trade, quantity, and time 4 00 4 00 0 00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay -43, 219 ADMI NI STRATI VE & GENERAL 7.00 Α 5.00 7.00 stations excluded) (chapter 8.00 Tel evi si on and radio servi ce -23, 350 CAP REL COSTS-MVBLE EQUIP 2.00 8.00 Α (chapter 21) Parking lot (chapter 21) 9.00 9.00 0.00 Provider-based physician -2, 061, 150 10.00 10.00 A-8-2 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 A-8-1 9, 107, 369 12.00 transactions (chapter 10) 13 00 Laundry and linen service 0 00 13 00 14.00 Cafeteria-employees and guests В -90, 926 DI ETARY 10.00 14.00 Rental of quarters to employee 15.00 15.00 0.00 and others 16.00 Sale of medical and surgical 0 0.00 16.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents 18.00 Sale of medical records and 0.00 18.00 abstracts Nursing school (tuition, fees, 19.00 19 00 0 00 books, etc.) 20.00 Vending machines 0.00 20.00 Income from imposition of 21.00 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 0 00 22 00 22.00 overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory ORESPIRATORY THERAPY 23.00 23.00 A - 8 - 365.00 therapy costs in excess of limitation (chapter 14) OPHYSICAL THERAPY 66.00 24 00 24.00 Adjustment for physical A-8-3 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review 0 *** Cost Center Deleted *** 114.00 25.00 physicians' compensation (chapter 21) Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 26.00 1.00 26.00 COSTS-BLDG & FLXT 27.00 Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 27.00 COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist -990, 574 NONPHYSI CI AN ANESTHETI STS 19.00 28.00 Α Physicians' assistant 29. 00 29 00 0.00 30.00 Adjustment for occupational A-8-3 OOCCUPATIONAL THERAPY 67.00 30.00 therapy costs in excess of limitation (chapter 14) OADULTS & PEDIATRICS 30. 99 Hospice (non-distinct) (see 30.00 30.99 instructions) 31.00 Adjustment for speech OSPEECH PATHOLOGY 68 00 31.00 A - 8 - 3pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 0.00 32.00 Depreciation and Interest 33.00 Misc Revenue В -61, 835 EMPLOYEE BENEFITS DEPARTMENT 4 00 33 00 O 33.01 Misc Revenue -911, 779 ADMINI STRATI VE & GENERAL В 5.00 0 33.01

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. ADJUSTMENTS TO EXPENSES Provider CCN: 150074 Peri od: Worksheet A-8 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/27/2015 6:01 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Cost Center Line # Wkst. A-7 Ref. Amount 1.00 2.00 3.00 4.00 5.00 33.02 Misc Revenue -963, 758 OPERATION OF PLANT 7. 00 33. 02 В -105, 914 NURSING ADMINISTRATION 33.03 Mi sc Revenue В 13.00 0 33.03 33.04 Misc Revenue В -200 PHARMACY 15.00 33.04 33.05 Misc Revenue -181, 018 MEDI CAL RECORDS & LI BRARY 33.05 В 16.00 -117, 349 | &R SERVICES-SALARY & 33.06 Milsc Revenue 21.00 33.06 B FRINGES APPRVD 33.07 Misc Revenue В -10,000 ADULTS & PEDIATRICS 30.00 33.07 -100, 039 RADI OLOGY-DI AGNOSTI C 33.08 Misc Revenue В 54.00 33.08 -52, 416 RADI OLOGY-THERAPEUTI C 33.09 Misc Revenue 55.00 33.09 В 33.10 Misc Revenue В -109, 172 PHYSI CAL THERAPY 66.00 33.10 Misc Revenue -573, 038 PSYCHI ATRI C/PSYCHOLOGI CAL 33.11 33.11 В 76.01 SERVI CES 33. 12 Mi sc Revenue В -882, 383 LUTHERWOOD PARTNERSHIP 33.12 76.03 -35, 610 I MAGING CENTERS 33.13 Misc Revenue R 76.06 0 33.13 33. 14 Mi sc Revenue В -28, 526 CARDIAC REHABILITATION 76.97 33.14 -51, 805 FAMILY PRACTICE AND 33. 15 Misc Revenue В 90.12 33.15 MATERNITY CARE -300 EMERGENCY 33. 16 Misc Revenue В 91.00 0 33, 16 -1, 560 ADMINISTRATIVE & GENERAL 33.17 Misc Rev MACL В 5.00 33.17 33. 18 Misc Rev MACL -20,000 OPERATION OF PLANT 7.00 33.18 В 33 19 Misc Rev MACL В -3, 681 DI ETARY 10.00 33.19 -2, 544, 068 PHARMACY Misc Rev MACL 33.20 15.00 0 33.20 В -34, 757 PSYCHI ATRI C/PSYCHOLOGI CAL 33. 21 Misc Rev MACL В 76.01 33. 21 SERVI CES -13, 185 DI ETARY 33, 22 Misc Revenue - Acct 35200 В 10.00 0 33. 22 Misc Revenue - Acct 35200 Misc Revenue - Acct 35200 -75 ADULTS & PEDIATRICS 33.23 В 30.00 ol 33.23 -115, 366 RADI OLOGY-DI AGNOSTI C 33. 24 В 54.00 0 33. 24 33.25 Leased Equipment CBI В -5, 576, 931 ADMI NI STRATI VE & GENERAL 5.00 0 33.25 33. 26 0.00 0 33. 26 CMH Subsidy В -128, 864 GROUP HOMES AND MISC. N_R 33 27 194.08 33 27 CTRS 33. 28 Purchased Discounts В -99, 139 ADMINI STRATI VE & GENERAL 5.00 0 33. 28 Oper Fund Interest Income -511, 679 ADMINI STRATI VE & GENERAL 33. 29 В 5.00 33. 29 Trustee Fund Interest Income -20, 205 ADMINISTRATI VE & GENERAL 33. 31 В 5.00 0 33. 31 -11, 338, 666 ADMI NI STRATI VE & GENERAL 34.00 HAF Tax Offset Α 5.00 34.00 00 Non-Allow Interest Expense -3,369 CAP REL COSTS-BLDG & FIXT 1.00 11 34.01 34.01 Α -57, 809 ADMINISTRATIVE & GENERAL 34. 02 00 Non-Allow Interest Expense Α 5.00 34.02 -14,653 CAP REL COSTS-BLDG & FIXT LOC Non-Allow Interest Expense 34.03 34.03 Α 1.00 11 -1, 203, 694 CAP REL COSTS-BLDG & FIXT 34.04 12A Non-Allow Interest Expense Α 1.00 11 34 04 12A Non-Allow Interest Expense 57, 765 ADMINI STRATI VE & GENERAL 34.05 34.05 Α 5.00 -54, 799 CAP REL COSTS-BLDG & FIXT 34.06 12B Non-Allow Interest Expense 1.00 11 34.06 Α 12B Non-Allow Interest Expense 34.07 -654 ADMINISTRATIVE & GENERAL 5.00 34.07 Α 0 34.08 50 BMO Loan Non- Allow Α -156, 435 CAP REL COSTS-BLDG & FIXT 1.00 11 34.08 Interest Expense INTERHOSPITAL ALLOCATION 35.00 Α 219, 451 EMS TRAINING-ALLIED HEALTH 23.00 35.00 ALLI ED HEALTH 35.01 INTERHOSPITAL ALLOCATION 71, 335 RADI OLOGY SCHOOL-ALLI ED 23.01 35.01 0 Α ALLIED HEALTH HEALTH -106, 007 ADMINISTRATIVE & GENERAL 36.02 Non Allow Marketing Expense 5.00 36.02 Α 36.03 A-8 Allied Health Program Α -116, 683 EMS TRAINING-ALLIED HEALTH 23.00 36.03 Expense -CHS A-8 Allied Health Program 36.04 -53. 751 FMS TRAINING-ALLIED HEALTH 23.00 36.04 Α Expense -CHN 36.05 A-8 Allied Health Program Α -1. 310 EMS TRAINING-ALLIED HEALTH 23.00 36.05 Expense - CHRH A-8 Allied Health Program 36.06 Α -79, 603 EMS TRAINING-ALLIED HEALTH 23.00 36.06 Expense -CH&V A-8 Allied Health Program -202, 144 EMS TRAINING-ALLIED HEALTH 36.07 23.00 0 36, 07 Α Expense -CH&V |Patient Phone Cost --14, 594 CAP REL COSTS-MVBLE EQUIP 36.08 Α 2.00 36.08 Depreciation 36.09 -336, 870 PHARMACY 15.00 36.09 Pharmacy Residency Α 36, 751 CAP REL COSTS-BLDG & FIXT 36.10 Depreciation Carryforward Α 1.00 36.10 Meals on Wheels Cost -110, 257 CAFETERI A 11.00 0 36.11 36 11 Α 36. 12 Medical Director Allocation 292, 745 ADMINI STRATI VE & GENERAL 5.00 36. 12 Α Medical Director Allocation 177, 931 CORONARY CARE UNIT 32.00 36. 13 Α 36.13 36.14 Medical Director Allocation 64, 259 CARDI AC CATHETERI ZATI ON 59.00 0 36. 14 Α 55, 461 ELECTROCARDI OLOGY Medical Director Allocation 36. 15 Α 69.00 0 36.15

39, 357 DI ABETIC CARE CENTER

90.01

0 36. 16

36.16 Medical Director Allocation

Α

ADJUSTMENTS TO EXPENSES Provider CCN: 150074 Peri od: Worksheet A-8 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/27/2015 6:01 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 36. 18 INTERHOSPITAL ALLOCATION 233, 734 PALLIATIVE CARE 90.04 36. 18 Α PALIATIVE CARE AND DCC 36. 19 INTERHOSPITAL ALLOCATION Α 8,085 DIABETIC CARE CENTER 90.01 36. 19 PALIATIVE CARE AND DCC 36. 20 Gallahue Professional Fee -2, 079, 425 ADULTS & PEDIATRICS 30.00 36. 20 Gallahue Professional Fee -11, 071, 647 PSYCHI ATRI C/PSYCHOLOGI CAL 36. 21 76.01 36. 21 Α SERVI CES -2, 543, 141 LUTHERWOOD PARTNERSHIP 36.22 Gallahue Professional Fee Α 76.03 0 36.22 36. 23 Gallahue Professional Fee -134, 145 LI FECHECK 194.07 36. 23 Α Gallahue Professional Fee 36. 24 -697, 943 GROUP HOMES AND MISC. N_R 194.08 36. 24 Α CTRS Bad Debt Expense 38.00 65 DIABETIC CARE CENTER 90 01 38 00 Α 38. 01 Bad Debt Expense 197 EMPLOYEE BENEFITS DEPARTMENT 4.00 38.01 Α Bad Debt Expense -55, 260, 221 ADMI NI STRATI VE & GENERAL 38.02 Α 5.00 38.02 -197, 186 ADULTS & PEDIATRICS Bad Debt Expense 38. 03 30.00 0 38.03 Α -4, 206 PHYSI CAL THERAPY 38.04 Bad Debt Expense Α 66.00 38 04 38. 05 Bad Debt Expense -12, 770 ELECTROCARDI OLOGY 69.00 0 38.05 Α -8, 111 PSYCHI ATRI C/PSYCHOLOGI CAL 38.06 Bad Debt Expense Α 76.01 38.06 SERVI CES 38 07 Bad Debt Expense -25, 256 NEUROPSYCHIATRIC SERVICES 38. 07 Α 76 02 ol -7, 030 PALLIATIVE CARE 38.08 Bad Debt Expense Α 90.04 0 38.08 38. 09 Bad Debt Expense -6 INFUSION CENTERS 90.05 38.09 Α 38. 10 Bad Debt Expense -216, 496 FAMILY PRACTICE AND 90.12 38. 10 Α MATERNITY CARE -9, 310 PHYSICIANS' PRIVATE OFFICES 38 11 Bad Debt Expense Α 192.00 ol 38 11 38. 12 0.00 0 38. 12 38. 13 0 0.00 38. 13 0 0.00 0 38. 14 38.14 38.15 0 0.00 38. 15 38. 16 38.16 0.00 50.00 TOTAL (sum of lines 1 thru 49) -92, 217, 557 50.00

(Transfer to Worksheet A.

[|] column 6, line 200.) | (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

⁽²⁾ Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

⁽³⁾ Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

				10 12/31/2014	5/27/2015 6:0	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:		la.	1		
1. 00	1		MACL	4, 269, 517	5, 341, 069	
2. 00			MACL I HH	212, 592	328, 934	2. 00
3.00		ADMINISTRATIVE & GENERAL	1400 N RITTER	194, 941	736, 140	
3. 01	II	OPERATION OF PLANT	1400 N RITTER	159, 318	· ·	
3. 02	l e	NURSING ADMINISTRATION	1400 N RITTER	29, 518		
3. 03		ELECTROENCEPHALOGRAPHY	1400 N RITTER	93, 618	· ·	3. 03
3. 04	l e	ONCOLOGY-CANCER CARE CENTER	1400 N RITTER	142, 157	108, 383	3. 04
3. 05	192. 00	PHYSICIANS' PRIVATE OFFICES	1400 N RITTER	48, 651	0	3. 05
3.06	69. 00	ELECTROCARDI OLOGY	1400 N RITTER IHH	34, 346	40, 236	3. 06
4.00	76. 05	ONCOLOGY-CANCER CARE CENTER	1550 E COUNTY LINE	73, 740	27, 734	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	CHNW - HOME OFFICE	704, 071	0	4. 01
4.02	2. 00	CAP REL COSTS-MVBLE EQUIP	CHNW - HOME OFFICE	4, 631, 988	0	4. 02
4.03	5. 00	ADMINISTRATIVE & GENERAL	CHNW - HOME OFFICE	27, 286, 049	21, 665, 939	4.03
4.04	21. 00	I&R SERVICES-SALARY & FRINGE	INTERNS & RESIDENTS	1, 484, 073	1, 601, 526	4.04
4.05	22. 00	I&R SERVICES-OTHER PRGM COST	INTERNS & RESIDENTS	2, 534, 979	2, 735, 603	4.05
5.00	TOTALS (sum of lines 1-4).			41, 899, 558	32, 792, 189	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

nas i	has not been posted to worksheet A, cordinis i ana/or 2, the amount arrowable should be indicated in cordinir 4 or this part.							
				Related Organization(s) and/	or Home Office			
						l		
	Symbol (1)	Name	Percentage of	Name	Percentage of			
			Ownershi p		Ownershi p			
	1. 00	2.00	3.00	4. 00	5. 00			
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:					

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

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

6.00	В	CHNW	100.00	0. 00	6. 00
7.00			0.00	0. 00	7. 00
8.00			0.00	0. 00	8. 00
9.00			0.00	0. 00	9. 00
10.00			0.00	0. 00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

							5/27/2015 6:0	1 pm
	Net	Wkst. A-7 Ref.						
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6. 00	7. 00						
			ENTS REQUIRED AS A	RESULT OF TRANS	SACTIONS WITH RELATED O	ORGANIZATIONS OR C	CLAIMED	
	HOME OFFICE CO							
1. 00	-1, 071, 552	1						1. 00
2.00	-116, 342							2. 00
3.00	-541, 199	l						3. 00
3. 01	40, 012							3. 01
3.02	7, 013							3. 02
3.03	28, 804							3. 03
3.04	33, 774	0						3. 04
3.05	48, 651	0						3. 05
3.06	-5, 890							3. 06
4.00	46, 006	0						4. 00
4. 01	704, 071	9						4. 01
4. 02	4, 631, 988	9						4. 02
4.03	5, 620, 110	0						4. 03
4.04	-117, 453							4. 04
4. 05	-200, 624	0						4. 05
5. 00	9, 107, 369							5. 00

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

Related Organization(s)		
and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	6.00
7.00	7.00
8.00	8.00
9.00	9.00
10.00	10.00
7. 00 8. 00 9. 00 10. 00 100. 00	100.00

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT In Lieu of Form CMS-2552-10 Provider CCN: 150074

					1	o 12/31/2014	Date/Time Pre 5/27/2015 6:0	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
	mot. A Line "	I denti fi er	Remuneration	Component	Component	NOL TIMOGITE	ider Component	
							Hours	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1. 00	5. 00	AGGREGATE-ADMINISTRATIVE &	273, 211	273, 211	0	0	0	1. 00
2.00	20.00	GENERAL	002 002	002 002	0	0	0	2.00
2. 00	30.00	AGGREGATE-ADULTS & PEDI ATRI CS	982, 082	982, 082	0	0	0	2. 00
3. 00	66, 00	AGGREGATE-PHYSICAL THERAPY	116, 297	116, 297	0	0	0	3.00
4. 00		AGGREGATE-LUTHERWOOD	33, 480			0	0	
		PARTNERSHI P		·				
5.00		AGGREGATE-WOUND CARE CENTER	6, 708			0	0	
6. 00	76. 05	AGGREGATE-ONCOLOGY-CANCER	462, 075	462, 075	0	0	0	6. 00
7.00	00.04	CARE CENTE	105 277	105 277		_	_	7.00
7. 00 8. 00		AGGREGATE-PALLIATIVE CARE AGGREGATE-EMERGENCY	185, 377			0	0	
9.00	91.00		1, 920 0			0	0	
10.00	0.00		0	0	0	0	0	
200.00	0.00		2, 061, 150	ľ	-	0	Ö	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	200.00
		I denti fi er	Limit		Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
1.00	1. 00	2.00	8.00	9. 00	12. 00	13. 00	14. 00	4 00
1. 00	5. 00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	0	0	1. 00
2. 00	30. 00	AGGREGATE-ADULTS &	0	0	0	0	0	2.00
		PEDI ATRI CS	_	_			_	
3.00		AGGREGATE-PHYSICAL THERAPY	0		0	0	0	3. 00
4. 00	76. 03	AGGREGATE-LUTHERWOOD	0	0	0	0	0	4. 00
	7. 0.	PARTNERSHI P						
5.00		AGGREGATE-WOUND CARE CENTER AGGREGATE-ONCOLOGY-CANCER	0		0	0	0	
6. 00	76.05	CARE CENTE	0	0	0	U	0	6.00
7. 00	90. 04	AGGREGATE-PALLI ATI VE CARE	0	0	0	0	0	7. 00
8. 00		AGGREGATE-EMERGENCY	0	0	0	0	0	1
9. 00	0. 00		0	0	0	0	0	9. 00
10. 00	0. 00		0	0	0	0	0	10. 00
200.00			0	0	0	0	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	15. 00	16, 00	17. 00	18. 00		
1. 00		AGGREGATE-ADMINISTRATIVE &	0			273, 211		1. 00
		GENERAL						
2.00	30. 00	AGGREGATE-ADULTS &	0	0	0	982, 082		2. 00
		PEDI ATRI CS	_	_	_			
3.00	66. 00	AGGREGATE-PHYSI CAL THERAPY	0	· -	-	116, 297		3. 00
4. 00	/6. 03	AGGREGATE-LUTHERWOOD PARTNERSHI P	0	0	0	33, 480		4. 00
5. 00	76 04	AGGREGATE-WOUND CARE CENTER	0	0	0	6, 708		5. 00
6. 00		AGGREGATE - ONCOLOGY - CANCER	0		0	462, 075		6. 00
5. 50	, 5. 05	CARE CENTE		I		102, 373		0.00
7. 00	90. 04	AGGREGATE-PALLI ATI VE CARE	0	0	0	185, 377		7. 00
8. 00		AGGREGATE-EMERGENCY	0	0	0	1, 920		8. 00
9. 00	0. 00		0	0	0	0		9. 00
10.00	0. 00		0		0	0		10.00
200. 00			0	0	0	2, 061, 150		200. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150074 Peri od: Worksheet B From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/27/2015 6:01 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 16, 322, 529 16, 322, 529 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 13, 875, 182 13, 875, 182 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 19, 196, 873 229, 811 32, 829 19, 459, 513 4.00 00500 ADMINISTRATIVE & GENERAL 63, 468, 085 5 00 48, 920, 125 3, 151, 094 8, 837, 280 2 559 586 5 00 7.00 00700 OPERATION OF PLANT 8, 629, 661 2, 417, 849 192, 015 640, 176 11, 879, 701 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 820, 673 85 820, 758 8.00 00900 HOUSEKEEPI NG 2, 735, 913 321, 807 16, 984 224, 225 3, 298, 929 9.00 9.00 01000 DI ETARY 178, 277 12, 752 69,009 1, 626, 220 10 00 10.00 1, 366, 182 11.00 01100 CAFETERI A 1, 562, 600 417, 607 19, 281 117, 137 2, 116, 625 11.00 01300 NURSING ADMINISTRATION 4, 720, 473 13.00 3, 623, 954 261,000 43, 488 792, 031 13.00 01400 CENTRAL SERVICES & SUPPLY 2, 421, 975 107, 231 771, 851 328, 885 3, 629, 942 14.00 14.00 300, 296 576, 056 15.00 01500 PHARMACY 4, 947, 649 176, 271 6,000,272 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 3, 413, 615 363, 462 972 619, 360 4, 397, 409 16.00 01700 SOCIAL SERVICE 17.00 3, 127, 058 126, 819 715 469, 389 3, 723, 981 17.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 18.00 0 0 0 19 00 01900 NONPHYSICIAN ANESTHETISTS 0 0 28.679 28.679 19 00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 1, 481, 894 6,030 215, 577 1, 787, 776 21.00 84, 275 21.00 22.00 02200 & SERVICES-OTHER PRGM COSTS APPRVD 2, 534, 979 76, 214 2, 611, 193 22.00 02300 EMS TRAINING-ALLIED HEALTH 23.00 193.198 84, 748 12, 100 54.497 344, 543 23.00 23.01 02301 RADI OLOGY SCHOOL-ALLI ED HEALTH 135,083 14, 156 0 14, 351 163, 590 23.01 02302 PHARMACY RESIDENCY-ALLIED HEALTH 97, 953 109, 233 23.02 23.02 0 11, 280 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH 23.03 23.03 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 22, 024, 202 2, 788, 540 92, 823 2, 931, 568 27, 837, 133 30.00 03100 INTENSIVE CARE UNIT 2, 710, 992 31.00 221, 768 85, 486 293, 316 3, 311, 562 31.00 32.00 03200 CORONARY CARE UNIT 4, 458, 296 425, 707 68.646 454, 690 5, 407, 339 32.00 43.00 04300 NURSERY 2, 135, 284 293, 854 48,073 205, 430 2, 682, 641 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 563, 930 697, 362 658, 300 283, 468 6, 203, 060 50.00 05100 RECOVERY ROOM 1.029.327 186, 282 105, 563 51 00 2 022 1, 323, 194 51 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 155, 178 158, 973 26, 007 111, 137 1, 451, 295 52.00 05400 RADI OLOGY-DI AGNOSTI C 3, 644, 540 54.00 2, 589, 703 512, 310 282, 926 259, 601 54.00 05500 RADI OLOGY-THERAPEUTI C 5, 897, 094 213, 262 403, 428 6, 880, 861 55.00 367.077 55.00 05700 CT SCAN 116, 740 146, 025 2, 200, 349 57.00 1, 873, 824 63, 760 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 857, 906 99, 604 188, 704 62, 578 1, 208, 792 58.00 59.00 05900 CARDIAC CATHETERIZATION 1, 279, 479 176, 328 30, 455 116, 976 1, 603, 238 59.00 06000 LABORATORY 193, 947 2, 246 60 00 8, 450, 118 8, 646, 311 60 00 64.00 06400 INTRAVENOUS THERAPY 281, 978 11, 166 788 31, 664 325, 596 64.00 65.00 06500 RESPIRATORY THERAPY 2, 936, 534 65, 520 95, 324 322, 246 3, 419, 624 65.00 66.00 06600 PHYSI CAL THERAPY 2, 537, 690 79, 543 47,696 318, 889 2, 983, 818 66.00 06700 OCCUPATIONAL THERAPY 106, 919 1, 081, 231 938 142 20.761 15, 409 67 00 67 00 68.00 06800 SPEECH PATHOLOGY 298, 676 6, 605 4,906 34, 040 344, 227 68.00 06900 ELECTROCARDI OLOGY 2, 114, 019 26, 685 36, 998 206, 440 2, 384, 142 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 855, 907 48. 411 101, 944 141, 898 1, 148, 160 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 6, 366, 624 C 0 6, 366, 624 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 9, 236, 043 0 0 0 9, 236, 043 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 46, 025, 938 46, 025, 938 73.00 07400 RENAL DIALYSIS 74.00 703.483 0 660 0 704, 143 74.00 03330 ENDOSCOPY 76.00 393, 455 C 10.988 36, 738 441, 181 76.00 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 8, 399, 311 93, 889 133, 452 1, 932, 830 10, 559, 482 76.01 03950 NEUROPSYCHI ATRI C SERVI CES 76.02 234, 396 C 1, 431 25, 570 261, 397 76.02 03951 LUTHERWOOD PARTNERSHIP 3, 890, 644 23, 718 696, 943 4, 611, 305 76 03 76.03 76.04 03952 WOUND CARE CENTER 598, 019 61, 981 10, 390 23, 249 693, 639 76.04 03480 ONCOLOGY-CANCER CARE CENTER 27, 406, 919 76.05 31, 359 67,815 861, 117 28, 367, 210 76.05 03953 I MAGING CENTERS 76.06 2, 823, 761 1.741 420, 308 157.754 3, 403, 564 76.06 03954 BREAST DIAGNOSTIC CENTER 76.07 1, 857, 132 49, 338 0 13.571 1, 920, 041 76.07 76. 97 07697 CARDIAC REHABILITATION 303, 144 74, 036 3, 531 36, 290 417, 001 76.97 07698 HYPERBARIC OXYGEN THERAPY 76.98 1, 149, 180 42, 374 7, 102 34, 014 1, 232, 670 76.98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 89.00 90.00 09000 CLI NI C 0 Ω 0 0 90.00 04950 DIABETIC CARE CENTER 90.01 40,508 73 0 40, 581 90.01 90.02 04951 HEALTHY HEARTS CENTER 1, 388, 117 102, 897 1, 258 144, 439 1, 636, 711 90.02 90.04 04953 PALLIATIVE CARE 334,064 15, 121 C 58, 954 408, 139 90.04 04954 INFUSION CENTERS 994 33, 123 90.05 90.05 308.048 342, 165 04961 FAMILY PRACTICE AND MATERNITY CARE 7, 192 3, 219, 391 90.208 354, 814 3, 671, 605 90.12 90 12 91. 00 09100 EMERGENCY 9, 276, 393 589, 620 424.821 849.948 11, 140, 782 91.00

Health Financial Systems COMM	IUNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-25	552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet B Part I Date/Time Prepa 5/27/2015 6:01	
		CAPI TAL REL	ATED COSTS		0,2,,20,0 0,0,	p
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	for Cost			BENEFITS DEPARTMENT		
	Allocation (from Wkst A			DEPARTMENT		
	col. 7)					
	0	1.00	2. 00	4. 00	4A	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92. 00
OTHER REIMBURSABLE COST CENTERS						
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	328, 349, 945	15, 448, 158	13, 562, 18	2 18, 591, 682	326, 294, 743 1	18. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	14, 851	0		0 1, 740	16, 591 1	
191. 00 19100 RESEARCH	553, 052	43, 907			659, 750 1	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	2, 284, 889	104, 506	· ·	9 63, 971	2, 455, 355 1	
194. 00 07950 HOME OFFICE	1 00/ 770	630, 347		0	630, 347 1	
194. 01 07951 OCCUPATIONAL HEALTH ONSITE SVCS	1, 006, 772	60, 769			1, 069, 686 1	
194. 02 07952 MEDCHECKS 194. 03 07953 SCHOOL BASED CLINICS	2, 226	0	15, 55 78		17, 784 1	
194.04 07954 OCCUPATIONAL HEALTH CLINICS	505, 534 21, 798	0	/8	2 54, 224	560, 540 1 21, 798 1	
194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS	21,790	0		0		94. 04
194. 06 07956 PAVILLI ONS	2, 213, 194	0	265, 12	8 26, 587	2, 504, 909 1	
194. 07 07957 LI FECHECK	44, 387	0	1, 23		61, 911 1	
194.08 07958 GROUP HOMES AND MISC. N R CTRS	974, 362	34, 842			1, 175, 226 1	
194. 09 07959 SURGERY CENTER EAST	17, 210, 129	0.,012	23, 00	0 502, 370	17, 712, 499 1	
200.00 Cross Foot Adjustments	1.,2.0,12,	J		002,070		200.00
201.00 Negative Cost Centers		0		ol ol		201.00
202.00 TOTAL (sum lines 118-201)	353, 181, 139	16, 322, 529	13, 875, 18	2 19, 459, 513	353, 181, 139 2	202.00

Provider CCN: 150074

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2014	Part
To 12/31/2014	Date/Time Prepared:
5/27/2015 6:01 pm	

					0 12/31/2014	5/27/2015 6:0	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		<u> </u>	PLANT 7. 00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	63, 468, 085					4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	2, 602, 510					7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	179, 805	14, 402, 211	1, 000, 563			8.00
9. 00	00900 HOUSEKEEPI NG	722, 703	442, 852		4, 464, 484		9. 00
10.00	01000 DI ETARY	356, 259	245, 335		78, 016	2, 305, 830	10.00
11. 00	01100 CAFETERI A	463, 693	574, 687	0	182, 749	0	11. 00
13.00	01300 NURSING ADMINISTRATION	1, 034, 123	359, 173	2, 596		0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	795, 219	147, 565			0	14. 00
15.00	01500 PHARMACY	1, 314, 492	242, 574	1	,	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	963, 349	500, 175	1	,	0	16.00
17. 00 18. 00	01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICE (SPECIFY)	815, 820	174, 521 0	1	55, 497	0	17. 00 18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	6, 283	0		0	0	19.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	391, 652	115, 974	1	36, 879	0	21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	572, 039	0	ō	0	0	22. 00
23. 00	02300 EMS TRAINING-ALLIED HEALTH	75, 480	116, 625	0	37, 087	0	23. 00
23. 01	02301 RADI OLOGY SCHOOL-ALLI ED HEALTH	35, 838	19, 481	0	6, 195	0	23. 01
23. 02	02302 PHARMACY RESIDENCY-ALLIED HEALTH	23, 930	0	1	0	0	23. 02
23. 03	02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	0	0	0	0	0	23. 03
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	(000 00(0.007.407	100 170	4 000 004	4 700 700	
30. 00 31. 00	03000 ADULTS & PEDIATRICS	6, 098, 336	3, 837, 427	1		1, 788, 793	30.00
31.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	725, 471 1, 184, 597	305, 184 585, 834	1		115, 455 273, 885	31. 00 32. 00
43. 00	04300 NURSERY	587, 692	404, 385			127, 697	43.00
10. 00	ANCILLARY SERVICE COST CENTERS	007,072	101,000	10,022	120, 071	127,077	10.00
50.00	05000 OPERATI NG ROOM	1, 358, 917	959, 669	40, 381	305, 173	0	50.00
51.00	05100 RECOVERY ROOM	289, 875	256, 351	0	81, 519	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	317, 938	218, 770	21, 975	69, 568	0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	798, 417	705, 011	1		0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 507, 404	505, 150			0	55. 00
57. 00	05700 CT SCAN	482, 035				0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	264, 812	137, 070			0	58.00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	351, 225 1, 894, 165	242, 652 266, 899		77, 163 84, 873	0	59. 00 60. 00
64. 00	06400 I NTRAVENOUS THERAPY	71, 329	15, 366	1		0	64.00
65. 00	06500 RESPIRATORY THERAPY	749, 144	90, 164	1		0	65.00
66. 00	06600 PHYSI CAL THERAPY	653, 671	109, 463	1		0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	236, 867	28, 570	1		0	67. 00
68.00	06800 SPEECH PATHOLOGY	75, 410	9, 089	0	2, 890	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	522, 299	36, 722	1	,	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	251, 530				0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 394, 749	0	1 -,	1	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	2, 023, 358	0			0	72.00
74. 00	07400 RENAL DIALYSIS	10, 083, 059 154, 258			0	0	73. 00 74. 00
76. 00	03330 ENDOSCOPY	96, 650			0	0	76.00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 313, 287	129, 204	Ö	41, 087	0	76. 01
76. 02	03950 NEUROPSYCHI ATRI C SERVI CES	57, 265		0	0	0	76. 02
76. 03	03951 LUTHERWOOD PARTNERSHIP	1, 010, 208	0	0	0	0	76. 03
76. 04	03952 WOUND CARE CENTER	151, 957	85, 294		27, 123	0	76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	6, 214, 461	43, 155	1		0	76. 05
76.06	03953 I MAGI NG CENTERS	745, 626	2, 396		762	0	76.06
76. 07 76. 97	03954 BREAST DIAGNOSTIC CENTER 07697 CARDIAC REHABILITATION	420, 627	67, 897		21, 591	0	76. 07 76. 97
	07698 HYPERBARIC OXYGEN THERAPY	91, 353 270, 043	101, 884 58, 313			0	76. 97 76. 98
70. 70	OUTPATIENT SERVICE COST CENTERS	270,043	30, 313	,	10, 545	0	70.70
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	O	0	0	0	89. 00
90.00	09000 CLI NI C	0	O	0	0	0	90.00
90. 01	04950 DIABETIC CARE CENTER	8, 890	0	0	0	0	90. 01
90. 02	04951 HEALTHY HEARTS CENTER	358, 558	141, 601			0	90. 02
90. 04	04953 PALLIATIVE CARE	89, 412	20, 809	0	6, 617	0	90. 04
90. 05	04954 I NFUSION CENTERS	74, 959	0 000	0	0	0	90.05
90. 12	04961 FAMILY PRACTICE AND MATERNITY CARE	804, 346	9, 897	1	3, 147	0	90. 12
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 440, 633	811, 401 İ	169, 077	258, 024	0	91. 00 92. 00
7∠. UU	OTHER REIMBURSABLE COST CENTERS						j 7∠. UU
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	O	0	ol	0	98. 00
. 5. 55	SPECIAL PURPOSE COST CENTERS	<u>, </u>			<u> </u>	<u> </u>	1 3. 50
118.00		57, 578, 028	13, 278, 952	998, 118	4, 081, 851	2, 305, 830	118. 00
	· · · · · ·	· · · · · · · · · · · · · · · · · · ·			· · · · · · · · · · · · · · · · · · ·		

Provider CCN: 150074

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2014 | Part I | To 12/31/2014 | Date/Time Prepared: | 5/27/2015 6:01 pm

					5/2//2015 6:01 pm
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
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 635	0	0	0	0 190. 00
191. 00 19100 RESEARCH	144, 533	60, 422	0	19, 214	0 191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	537, 900	143, 815	0	45, 733	0 192. 00
194.00 07950 HOME OFFICE	138, 091	867, 448	0	275, 846	0 194. 00
194.01 07951 OCCUPATIONAL HEALTH ONSITE SVCS	234, 338	83, 627	0	26, 593	0 194. 01
194. 02 07952 MEDCHECKS	3, 896	0	0	0	0 194. 02
194. 03 07953 SCHOOL BASED CLINICS	122, 799	0	0	0	0 194. 03
194.04 07954 OCCUPATIONAL HEALTH CLINICS	4, 775	0	0	0	0 194. 04
194.05 07955 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194. 05
194. 06 07956 PAVI LLI ONS	548, 755	0	0	0	0 194. 06
194. 07 07957 LI FECHECK	13, 563	0	0	0	0 194. 07
194.08 07958 GROUP HOMES AND MISC. N_R CTRS	257, 459	47, 947	2, 445	15, 247	0 194. 08
194. 09 07959 SURGERY CENTER EAST	3, 880, 313	0	0	0	0 194. 09
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118-201)	63, 468, 085	14, 482, 211	1, 000, 563	4, 464, 484	2, 305, 830 202. 00
		'	•	•	•

Provider CCN: 150074

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2014	Part
To 12/31/2014	Date/Time Prepared:
5/27/2015 6:01 pm	

			10) 12/31/2014	5/27/2015 6:0	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11. 00	13. 00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	13.00	10.00	
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 O0700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						9. 00 10. 00
11. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	3, 337, 754					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	196, 479	6, 427, 060				13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0	4, 619, 651			14. 00
15. 00 01500 PHARMACY	124, 597	О	28, 909	7, 787, 982		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	249, 193	0	3, 570	0	6, 272, 751	16. 00
17.00 01700 SOCIAL SERVICE	112, 616	0	4, 162	0	0	17. 00
18. 00 01850 OTHER GENERAL SERVI CE (SPECI FY)	0	0	0	0	0	18. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	0	10.017	0	0	19.00
21. 00 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD 22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	64, 694	0	10, 817 0	0	0	21. 00 22. 00
23. 00 02300 EMS TRAINING-ALLIED HEALTH	16, 773 16, 773	0	6, 032	0	0	23. 00
23. 01 02301 RADI OLOGY SCHOOL-ALLI ED HEALTH	2, 396	0	91	0	0	23. 00
23. 02 02302 PHARMACY RESIDENCY-ALLIED HEALTH	2, 396	Ö	0	0	ő	23. 02
23. 03 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	0	0	0	0		23. 03
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	766, 751	3, 932, 427	163, 145	0		30. 00
31. 00 03100 I NTENSI VE CARE UNI T	71, 883	368, 665	27, 362	0		31.00
32. 00 03200 CORONARY CARE UNIT	129, 389	0	35, 590	0		32.00
43. 00 04300 NURSERY	57, 506	294, 932	37, 239	0	32, 796	43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	83, 863	430, 109	147, 706	0	233, 465	50.00
51. 00 05100 RECOVERY ROOM	23, 961	430, 109	7, 982	0	45, 218	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	31, 149	159, 755	20, 146	0	60, 622	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	81, 467	0	31, 918	0	146, 203	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	107, 824	0	44, 480	0	270, 863	55. 00
57.00 05700 CT SCAN	33, 545	0	27, 097	0	269, 899	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	16, 773	0	12, 007	0	73, 076	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	28, 753	0	833	0	229, 510	59. 00
60. 00 06000 LABORATORY	0	0	189, 280	0	463, 125	60.00
64. 00 06400 I NTRAVENOUS THERAPY	7, 188	0	442	0	4, 999	64.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	83, 863 19, 169	0	20, 220 10, 828	0	93, 545 79, 640	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	28, 753	0	4, 158	0	18, 240	67.00
68. 00 06800 SPEECH PATHOLOGY	9, 584	ő	1, 324	0	6, 041	68.00
69. 00 06900 ELECTROCARDI OLOGY	62, 298	O	23, 043	0	126, 294	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	35, 941	0	6, 946	0	20, 577	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1, 351, 312	0	253, 049	71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1, 878, 619	0	,	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	7, 787, 982	1, 604, 365	
74. 00 07400 RENAL DI ALYSI S	0 504	0	129	0	11, 569 13, 505	74.00
76. 00 03330 ENDOSCOPY 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	9, 584 234, 817	0	1, 309 75, 957	0	106, 289	76. 00 76. 01
76. 02 03950 NEUROPSYCHI ATRI C SERVI CES	7, 188	0	75, 757 856	0	2, 522	76. 02
76. 03 03951 LUTHERWOOD PARTNERSHIP	0	o	58, 528	0	9, 293	76. 03
76. 04 03952 WOUND CARE CENTER	9, 584	0	1, 595	0	15, 366	76. 04
76.05 03480 ONCOLOGY-CANCER CARE CENTER	198, 876	0	128, 555	0	330, 913	76. 05
76.06 03953 I MAGI NG CENTERS	0	0	12, 288	0	79, 752	76. 06
76. 07 03954 BREAST DIAGNOSTIC CENTER	2, 396	0	12, 555	0	32, 691	
76. 97 07697 CARDI AC REHABI LI TATI ON	14, 377	0	1, 234	0	.,	76. 97
76. 98 O7698 HYPERBARI C OXYGEN THERAPY	7, 188	0	13, 694	0	13, 335	76. 98
OUTPATIENT SERVICE COST CENTERS 88. OO 08800 RURAL HEALTH CLINIC	0	O	O	0	0	00 00
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88. 00 89. 00
90. 00 09000 CLI NI C	0	0	0	0	0	90.00
90. 01 04950 DI ABETI C CARE CENTER	0	o	0	0	ő	90. 01
90. 02 04951 HEALTHY HEARTS CENTER	43, 130	o	16, 654	0	16, 501	90. 02
90. 04 04953 PALLI ATI VE CARE	9, 584	o	216	0	1, 624	90. 04
90. 05 04954 I NFUSI ON CENTERS	0	o	3, 200	0	9, 817	90. 05
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE	74, 279	0	8, 630	0	20, 469	90. 12
91. 00 09100 EMERGENCY	242, 005	1, 241, 172	133, 063	0	714, 923	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)						92. 00
OTHER REI MBURSABLE COST CENTERS 98. 00 O9850 OTHER REI MBURSABLE COST CENTERS	0	0	0	0	0	98. 00
70. 00 JO 7000 JOHIEN NEI MIDDINGADEL COOT CENTERS	١	ı Y	ı o	U		75.00

TOTAL (sum lines 118-201)

202.00

6, 272, 751 202. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150074 Peri od: Worksheet B From 01/01/2014 Part I 12/31/2014 Date/Time Prepared: 5/27/2015 6:01 pm Cost Center Description CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL ADMI NI STRATI ON SERVICES & RECORDS & LI BRARY SUPPLY 11.00 13.00 15.00 16.00 14.00 SPECIAL PURPOSE COST CENTERS
SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 6, 272, 751 118. 00 118.00 3, 318, 585 6, 427, 060 4, 563, 722 7, 787, 982 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2, 396 0 190. 00 0 0 0 0 0 0 0 0 0 0 191. 00 19100 RESEARCH 0 191.00 16, 773 0 959 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 26, 069 0 192. 00 194.00 07950 HOME OFFICE 0 0 194.00 0 0 0 0 0 0 0 194. 01 07951 OCCUPATIONAL HEALTH ONSITE SVCS 0 194, 01 0 2, 268 194. 02 07952 MEDCHECKS 0 194. 02 194. 03 07953 SCHOOL BASED CLINICS 1, 913 0 194. 03 194. 04 07954 OCCUPATIONAL HEALTH CLINICS 0 0 194. 04 0 194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 194. 05 0 0 194. 06 07956 PAVI LLI ONS 0 3, 195 0 194. 06 194. 07 07957 LI FECHECK 58 0 194. 07 194.08 07958 GROUP HOMES AND MISC. N_R CTRS 0 0 194. 08 21, 467 194. 09 07959 SURGERY CENTER EAST 0 0 194. 09 C C 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00

3, 337, 754

6, 427, 060

4, 619, 651

7, 787, 982

Provider CCN: 150074

Cost Center Description	1. 00
SOCIAL SERVICE SPECIFY NONPHYSICIAN ANESTHETISTS Y & FRINGES PRGM COSTS	
ANESTHETISTS Y & FRINGES PRGM COSTS	
17.00	
GENERAL SERVICE COST CENTERS 1. 00	
1. 00	
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	
4. 00	1 2.00
5. 00 00500 ADMINISTRATIVE & GENERAL	
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	4. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	5. 00
9. 00 00900 HOUSEKEEPI NG	7. 00
	8. 00
	9. 00
TO, OUT TO TOUR LIAM (10.00
11. 00 01100 CAFETERI A	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	14. 00
	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	16.00
17. 00 01700 SOCIAL SERVICE 4, 886, 597	17. 00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY) 0 0	18. 00
19.00 01900 NONPHYSI CI AN ANESTHETI STS 0 0 34,963	19. 00
21.00 02100 1 &R SERVI CES-SALARY & FRINGES APPRVD 0 0 2, 407, 792	21. 00
22.00 02200 1&R SERVI CES-0THER PRGM COSTS APPRVD 0 0 0 0 3, 200, 005	22. 00
23. 00 02300 EMS TRAINING-ALLIED HEALTH 0 0 0 0	23. 00
23. 01 02301 RADI 0LOGY SCHOOL-ALLI ED HEALTH O O O O	23. 01
23. 02 02302 PHARMACY RESI DENCY-ALLI ED HEALTH 0 0 0 0	23. 02
23. 03 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH 0 0 0 0	23. 03
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	25.05
30. 00 03000 ADULTS & PEDI ATRI CS 3, 790, 874 0 0 724, 251 962, 545	30. 00
31. 00 03100 I NTENSI VE CARE UNI T 244, 677 0 0 0 0	31.00
32. 00 03200 CORONARY CARE UNI T 580, 427 0 0 0	32. 00
43. 00 04300 NURSERY 270, 619 0 0 0	43. 00
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 0PERATI NG ROOM 0 34, 963 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	52. 00
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 0 0 0 0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C O O O O	55. 00
57. 00 05700 CT SCAN 0 0 0 0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON O O O O	59. 00
60. 00 06000 LABORATORY 0 0 0 0	60.00
64. 00 06400 I NTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 0	64.00
65. 00 06500 RESPI RATORY THERAPY 0 0 0 0	65. 00
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0	67. 00
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0	68. 00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0	73. 00
74. 00 07400 RENAL DI ALYSIS 0 0 0 0	74. 00
76. 00 03330 ENDOSCOPY	76.00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	76. 00
	76. 02
76. 03 03951 LUTHERWOOD PARTNERSHI P	76. 03
76. 04 03952 WOUND CARE CENTER 0 0 0	76. 04
76. 05 03480 ONCOLOGY-CANCER CARE CENTER 0 0 0 0	76. 05
76.06 03953 I MAGI NG CENTERS 0 0 0 0 0	76. 06
76. 07 03954 BREAST DI AGNOSTI C CENTER 0 0 0 0 0	76. 07
76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0	76. 97
76. 98 O7698 HYPERBARI C OXYGEN THERAPY O O O O	76. 98
OUTPATIENT SERVICE COST CENTERS	
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0	89. 00
90. 00 09000 CLI NI C	90. 00
90. 01 04950 DI ABETI C CARE CENTER 0 0 0 0	90.00
90. 02 04951 HEALTHY HEARTS CENTER 0 0 0 0 0 0 0	90. 02
90. 04 04953 PALLI ATI VE CARE 0 0 0 0 0 0	90. 04
90. 05 04954 INFUSION CENTERS	90. 05
90.12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0 0 1,488,352 1,978,050	90. 12
	91. 00
91. 00 09100 EMERGENCY 0 0 0 0	
91. 00 09100 EMERGENCY 0 0 0 0 0 0 0 0 0	92. 00
91. 00 09100 EMERGENCY 0 0 0 0	92.00
91.00 09100 EMERGENCY 0 0 0 0 0 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	98. 00

194. 09 07959 SURGERY CENTER EAST

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

200.00

201.00

202.00

0 194. 09

0 200.00

0 201.00

3, 200, 005 202. 00

0

0

34, 963

0

0

2, 407, 792

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150074 Peri od: Worksheet B From 01/01/2014 Part I Date/Time Prepared: 5/27/2015 6:01 pm 12/31/2014 OTHER GENERAL INTERNS & RESIDENTS SERVI CE (SPECI FY) NONPHYSICIAN SERVICES-SALAR SERVICES-OTHER Cost Center Description SOCIAL SERVICE Y & FRINGES ANESTHETI STS PRGM COSTS 18.00 17.00 19.00 21.00 22.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 4, 886, 597 0 34, 963 2, 212, 603 2, 940, 595 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 191. 00 19100 RESEARCH 0 0 191. 00 0 0 0 0 0 0 0 0 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 195, 189 259, 410 192. 00 194.00 07950 HOME OFFICE 0 0 194. 00 0 194. 01 07951 OCCUPATIONAL HEALTH ONSITE SVCS 0 0 194. 01 0 194. 02 07952 MEDCHECKS 0 0 0 0 194. 02 194. 03 07953 SCHOOL BASED CLINICS 0 0 0 0 0 0 0 0 0 194. 03 01 0 0 194. 04 194. 04 07954 OCCUPATIONAL HEALTH CLINICS 194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 0 194. 05 194. 06 07956 PAVI LLI ONS 0 194.06 194. 07 07957 LI FECHECK 0 0 0 194. 07 0 194.08 07958 GROUP HOMES AND MISC. N_R CTRS 0 194. 08 0

4, 886, 597

Provider CCN: 150074

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2014	Part
To 12/31/2014	Date/Time Prepared:
5/27/2015 6:01 pm	

			'	0 12/31/2014	5/27/2015 6:0	
Cost Center Description	EMS	RADI OLOGY	PHARMACY	PHARMACY	Subtotal	
	TRAI NI NG-ALLI E	SCHOOL-ALLI ED	RESI DENCY-ALLI	RESI DNECY-BTH		
	D HEALTH	HEALTH	ED HEALTH	ALLIED HEALTH		
	23. 00	23. 01	23. 02	23. 03	24. 00	
GENERAL SERVICE COST CENTERS		ı				1 4 00
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11.00
13. 00 01300 NURSING ADMINISTRATION						13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY						14.00
15. 00 01500 PHARMACY						15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY						16.00
17. 00 01700 SOCIAL SERVICE						17. 00
18. 00 01850 OTHER GENERAL SERVICE (SPECIFY)						18.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS						19.00
21. 00 02100 1 &R SERVI CES-SALARY & FRI NGES APPRVD						21.00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD						22. 00
23. 00 02300 EMS TRAINING-ALLIED HEALTH	596, 540	l e				23. 00
23. 01 02301 RADI OLOGY SCHOOL-ALLI ED HEALTH	0	227, 591				23. 01
23. 02 02302 PHARMACY RESI DENCY-ALLI ED HEALTH	0	0				23. 02
23. 03 O2303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	0	0	<u> </u>	0		23. 03
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				ا	E0 0E0 000	00.00
30. 00 03000 ADULTS & PEDI ATRI CS	0		1	-		30.00
31. 00 03100 INTENSIVE CARE UNIT	0			-	5, 382, 764	31.00
32. 00 03200 CORONARY CARE UNIT	0			-	8, 602, 646	32. 00
43. 00 04300 NURSERY	0	0	<u> </u> C	0	4, 664, 723	43. 00
ANCILLARY SERVICE COST CENTERS				ا	0.707.007	
50. 00 05000 OPERATI NG ROOM	0				9, 797, 306	50.00
51. 00 05100 RECOVERY ROOM	0	0		-	2, 028, 100	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0	C	-	2, 351, 218	52.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	227, 591	C	ı	5, 877, 236	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		1	9, 498, 490	55. 00
57. 00 05700 CT SCAN	0	0	C	-	3, 165, 732	57. 00
58. 00 05800 MAGNETI C RESONANCE MAGING (MRI)	0	0		ı	1, 766, 265	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		-	2, 538, 061	1
60. 00 06000 LABORATORY	0	0		0	11, 544, 653	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	429, 806	64.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0	4, 485, 232	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	3, 891, 398	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	1, 406, 904	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	448, 565	1
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	3, 166, 476	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	1, 552, 966	1
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS	0	-		0	9, 368, 740	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1		13, 339, 050	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	135, 559	0	65, 636, 903	
74. 00 07400 RENAL DI ALYSI S	0	0		0	870, 099	74.00
76. 00 03330 ENDOSCOPY	0	0		0	562, 229	76. 00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	13, 460, 123	76. 01
76. 02 03950 NEUROPSYCHI ATRI C SERVI CES	0	0		0	329, 228	
76. 03 03951 LUTHERWOOD PARTNERSHI P	0	0		0	5, 689, 334	76. 03
76. 04 03952 WOUND CARE CENTER	0	0		0	984, 558	
76. 05 03480 ONCOLOGY-CANCER CARE CENTER	0	0		0	35, 301, 938	1
76. 06 03953 I MAGI NG CENTERS	0	0		0	4, 244, 388	1
76. 07 03954 BREAST DI AGNOSTI C CENTER	0	0		0	2, 477, 798	
76. 97 O7697 CARDI AC REHABI LI TATI ON	0			-	666, 076	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	<u> </u>	0	1, 613, 786	76. 98
OUTPATIENT SERVICE COST CENTERS			1	1		
88.00 08800 RURAL HEALTH CLINIC	0	1	1	-	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0) c	이	0	89. 00
90. 00 09000 CLI NI C	0	0	l c	이	0	90.00
90. 01 04950 DI ABETI C CARE CENTER	0	0	l c	이	49, 471	90. 01
90. 02 04951 HEALTHY HEARTS CENTER	0	0	l c	이	2, 262, 120	90. 02
90. 04 04953 PALLI ATI VE CARE	0	0	l c	이	536, 401	1
90. 05 04954 I NFUSI ON CENTERS	0	0	l c	이	430, 141	1
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE	0	0	l c	이	8, 058, 775	1
91. 00 09100 EMERGENCY	596, 540	0	C	이	17, 747, 620	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS			1			00.55
98.00 09850 0THER REIMBURSABLE COST CENTERS	0	0	() C	0	0	98. 00

0 201.00

353, 181, 139 202. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150074 Peri od: Worksheet B From 01/01/2014 Part I 12/31/2014 Date/Time Prepared: 5/27/2015 6:01 pm Cost Center Description EMS RADI OLOGY PHARMACY PHARMACY Subtotal TRAI NI NG-ALLI E SCHOOL-ALLI ED RESI DENCY-ALLI RESI DNECY-BTH HEALTH ALLIED HEALTH D HEALTH ED HEALTH 24.00 23. 00 23. 01 23. 02 23. 03 SPECIAL PURPOSE COST CENTERS
SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 596, 540 227, 591 135, 559 118.00 318, 286, 652 118. 00 22, 622 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 191. 00 19100 RESEARCH 0 0 901, 651 191. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 3, 663, 471 192. 00 194.00 07950 HOME OFFICE 0 1, 911, 732 194. 00 194. 01 07951 OCCUPATIONAL HEALTH ONSITE SVCS 0 0 1, 416, 512 194. 01 0 194. 02 07952 MEDCHECKS 21, 680 194. 02 194. 03 07953 SCHOOL BASED CLINICS 0 685, 252 194. 03 26, 573 194. 04 0 194. 04 07954 OCCUPATIONAL HEALTH CLINICS 0 0 194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 194. 05 0 194. 06 07956 PAVI LLI ONS 0 3, 056, 859 194. 06 194. 07 07957 LI FECHECK 0 75, 532 194. 07 194.08 07958 GROUP HOMES AND MISC. N_R CTRS 0 1, 519, 791 194. 08 0 194. 09 07959 SURGERY CENTER EAST 21, 592, 812 194. 09 C 200.00 Cross Foot Adjustments 0 0 0 200. 00

0

227, 591

596, 540

0

135, 559

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118-201)

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150074

Peri od: Worksheet B From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared:

5/27/2015 6:01 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 16 00 17. 00 |01700 | SOCIAL SERVICE 17.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 18.00 19. 00 01900 NONPHYSICIAN ANESTHETISTS 19 00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 22.00 23. 00 02300 EMS TRAINING-ALLIED HEALTH 23.00 02301 RADI OLOGY SCHOOL-ALLI ED HEALTH 23 01 23 01 23.02 02302 PHARMACY RESIDENCY-ALLIED HEALTH 23.02 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH 23.03 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS -1, 686, 796 50.372.537 30.00 31.00 03100 INTENSIVE CARE UNIT 5, 382, 764 31.00 03200 CORONARY CARE UNIT 0 32.00 32.00 8,602,646 04300 NURSERY 4, 664, 723 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 9, 797, 306 50.00 05100 RECOVERY ROOM 0 51.00 2,028,100 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 00000 2, 351, 218 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 5.877.236 54 00 05500 RADI OLOGY-THERAPEUTI C 9, 498, 490 55.00 55.00 57.00 05700 CT SCAN 3, 165, 732 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 58.00 1, 766, 265 59.00 05900 CARDIAC CATHETERIZATION 2, 538, 061 59.00 60.00 06000 LABORATORY 00000000000000000000 11, 544, 653 60.00 06400 I NTRAVENOUS THERAPY 429, 806 64.00 64.00 4, 485, 232 06500 RESPIRATORY THERAPY 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 3, 891, 398 66.00 67.00 06700 OCCUPATIONAL THERAPY 1, 406, 904 67.00 06800 SPEECH PATHOLOGY 448, 565 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 3, 166, 476 69.00 07000 ELECTROENCEPHALOGRAPHY 1, 552, 966 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 9.368.740 07200 I MPL. DEV. CHARGED TO PATIENTS 72 00 72 00 13, 339, 050 73.00 07300 DRUGS CHARGED TO PATIENTS 65, 636, 903 73.00 07400 RENAL DIALYSIS 74.00 870, 099 74.00 76. 00 03330 ENDOSCOPY 562, 229 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.01 13, 460, 123 76.01 76.02 03950 NEUROPSYCHI ATRI C SERVI CES 329, 228 76.02 03951 LUTHERWOOD PARTNERSHIP 76. 03 5, 689, 334 76.03 76 04 03952 WOUND CARE CENTER 984, 558 76 04 03480 ONCOLOGY-CANCER CARE CENTER 35, 301, 938 76.05 76.05 4, 244, 388 03953 I MAGING CENTERS 76.06 76.07 03954 BREAST DIAGNOSTIC CENTER 0 0 2, 477, 798 76.07 07697 CARDIAC REHABILITATION 76 97 666, 076 76 97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 1, 613, 786 76.98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 0 0 90.00 09000 CLI NI C Λ 90.00 49, 471 04950 DIABETIC CARE CENTER 90.01 90.01 0 90.02 04951 HEALTHY HEARTS CENTER 2, 262, 120 90.02 90.04 04953 PALLIATIVE CARE 0 536, 401 90.04 04954 INFUSION CENTERS 430, 141 90.05 90.12 04961 FAMILY PRACTICE AND MATERNITY CARE -3.466.402 4.592.373 90. 12 91 00 09100 EMERGENCY 0 17, 747, 620 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00

Hearth Financial Systems	COMMUNITY HOSPITAL C	JE INDIANA, INC.	In Lieu of Form CMS	5-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CCN: 1500	074	repared: : 01 pm
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments 25.00	Total 26. 00		
OTHER REIMBURSABLE COST CENTERS				
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		98. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>		70.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	-5, 153, 198	313, 133, 454		118.00
NONREI MBURSABLE COST CENTERS	3, 133, 170	313, 133, 434		110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEE	N O	22, 622		190. 00
191. 00 19100 RESEARCH	0	901, 651		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	-454, 599	3, 208, 872		192.00
194. 00 07950 HOME OFFICE	-434, 377	1, 911, 732		194. 00
194. 01 07951 OCCUPATIONAL HEALTH ONSITE SVCS	0	1, 416, 512		194. 00
194. 02 07952 MEDCHECKS		21, 680		194. 01
194. 03 07953 SCHOOL BASED CLINICS		685, 252		194. 02
194. 04 07954 OCCUPATIONAL HEALTH CLINICS				194. 03
		26, 573		194. 04
194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS		2 05/ 050		
194. 06 07956 PAVI LLI ONS	0	3, 056, 859		194. 06
194. 07 07957 LI FECHECK	0	75, 532		194. 07
194. 08 07958 GROUP HOMES AND MISC. N_R CTRS	0	1, 519, 791		194. 08
194. 09 07959 SURGERY CENTER EAST	0	21, 592, 812		194. 09
200.00 Cross Foot Adjustments	0	0		200. 00
201.00 Negative Cost Centers	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	-5, 607, 797	347, 573, 342		202. 00

Provider CCN: 150074

Peri od:

From 01/01/2014

ALLOCATION OF CAPITAL RELATED COSTS

Part II

Date/Time Prepared: 12/31/2014 5/27/2015 6:01 pm CAPITAL RELATED COSTS Cost Center Description Directly BLDG & FIXT MVBLE EQUIP Subtotal **EMPLOYEE** Assigned New **BENEFITS** DEPARTMENT Capi tal Related Costs 1.00 2.00 2A 4.00 0 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 229, 811 32, 829 262, 640 262, 640 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 0 0 0 3, 151, 094 8, 837, 280 11, 988, 374 34, 545 5.00 00700 OPERATION OF PLANT 2, 609, 864 7 00 2, 417, 849 192, 015 8, 640 7 00 00800 LAUNDRY & LINEN SERVICE 8.00 85 85 0 8.00 9.00 00900 HOUSEKEEPI NG 321, 807 16, 984 338, 791 3,026 9.00 01000 DI ETARY 00000000000 178, 277 12.752 191, 029 10.00 10 00 931 01100 CAFETERI A 11.00 417, 607 19, 281 436, 888 1, 581 11.00 13.00 01300 NURSING ADMINISTRATION 261, 000 43, 488 304, 488 10, 689 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 107, 231 771, 851 879, 082 4, 439 14.00 01500 PHARMACY 7. 775 300 296 15 00 176, 271 476, 567 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 363, 462 972 364, 434 8, 359 16.00 01700 SOCIAL SERVICE 715 127, 534 6, 335 17.00 126, 819 17.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 C 0 18.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 387 19 00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 84, 275 6,030 90, 305 2, 909 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 1, 029 22.00 22.00 0 02300 EMS TRAINING-ALLIED HEALTH 96, 848 23.00 84.748 12, 100 736 23.00 02301 RADI OLOGY SCHOOL-ALLI ED HEALTH 23.01 14, 156 0 14, 156 194 23 01 0 23.02 02302 PHARMACY RESIDENCY-ALLIED HEALTH 0 152 23.02 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH 23.03 0 0 0 23.03 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 0 2, 788, 540 92.823 2, 881, 363 39.572 03100 INTENSIVE CARE UNIT 0 221, 768 85, 486 307, 254 3, 959 31.00 31.00 03200 CORONARY CARE UNIT 0 32.00 425, 707 68, 646 494, 353 6, 137 32.00 43.00 04300 NURSERY 0 <u>48,</u> 073 341, 927 293, 854 2,773 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 697, 362 1, 355, 662 50.00 0 658, 300 3.826 50.00 51.00 05100 RECOVERY ROOM 0 0 186, 282 2,022 188, 304 1, 425 51.00 05200 DELIVERY ROOM & LABOR ROOM 158, 973 184, 980 1.500 52 00 26,007 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 512, 310 282, 926 795, 236 3, 504 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 00000000000000000000 367, 077 213, 262 580, 339 5, 445 55.00 1, 971 05700 CT SCAN 63, 760 57.00 116, 740 180, 500 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 99,604 188, 704 288, 308 845 58.00 30, 455 59.00 05900 CARDIAC CATHETERIZATION 176, 328 206, 783 1,579 59.00 06000 LABORATORY 193, 947 2, 246 196, 193 60.00 60.00 0 06400 I NTRAVENOUS THERAPY 788 11.954 427 64.00 11, 166 64 00 65.00 06500 RESPIRATORY THERAPY 65, 520 95, 324 160, 844 4, 349 65.00 66.00 06600 PHYSI CAL THERAPY 79, 543 47, 696 127, 239 4, 304 66.00 1, 443 06700 OCCUPATIONAL THERAPY 20, 761 15, 409 36, 170 67.00 67.00 4, 906 06800 SPEECH PATHOLOGY 68.00 6, 605 11, 511 459 68.00 69.00 06900 ELECTROCARDI OLOGY 26, 685 36, 998 63, 683 2,786 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 48, 411 101, 944 150, 355 1, 915 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 71 00 0 C 0 0 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 73.00 0 07400 RENAL DIALYSIS 74.00 660 660 0 74.00 03330 ENDOSCOPY 10 988 10 988 76 00 496 76 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.01 93,889 133, 452 227, 341 26,086 76.01 03950 NEUROPSYCHIATRIC SERVICES 1, 431 76.02 1, 431 345 76.02 76.03 03951 LUTHERWOOD PARTNERSHIP 00000 23, 718 23, 718 9, 406 76.03 03952 WOUND CARE CENTER 61, 981 10, 390 72.371 76.04 314 76.04 76.05 03480 ONCOLOGY-CANCER CARE CENTER 31, 359 67,815 99, 174 11,622 76.05 03953 I MAGING CENTERS 422, 049 76.06 1, 741 420, 308 2, 129 76.06 03954 BREAST DIAGNOSTIC CENTER 49, 338 49, 338 76.07 183 76.07 07697 CARDIAC REHABILITATION 3.531 76.97 74,036 77.567 490 76.97 07698 HYPERBARIC OXYGEN THERAPY 49, 476 459 76. 98 76.98 42, 374 7, 102 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88 00 0 88 00 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 09000 CLI NI C 90.00 0 0 90.00 0 90.01 04950 DIABETIC CARE CENTER 73 90.01 73 0 04951 HEALTHY HEARTS CENTER 90 02 102.897 1, 258 104, 155 1.949 90.02 0 04953 PALLIATIVE CARE 15, 121 796 90.04 90.04 15, 121 90 05 04954 INFUSION CENTERS 0 994 994 447 90.05 04961 FAMILY PRACTICE AND MATERNITY CARE 0 97, 400 7. 192 90. 208 90.12 90.12 4.789 09100 EMERGENCY 91.00 589, 620 424.821 1, 014, 441 11, 471 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00

Health Financial Systems COMM	MUNITY HOSPITAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS			F	Period: From 01/01/2014 To 12/31/2014		
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1.00	2.00	2A	4. 00	
OTHER REIMBURSABLE COST CENTERS						
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	(0	0	98. 00
SPECIAL PURPOSE COST CENTERS	_					
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	15, 448, 158	13, 562, 182	29, 010, 340	250, 928	118. 00
NONREI MBURSABLE COST CENTERS	_	_	_			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0		190.00
191. 00 19100 RESEARCH	0	43, 907		1		191.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	104, 506	1, 989			192. 00
194. 00 07950 HOME OFFICE	0	630, 347	2 145	630, 347		194. 00
194. 01 07951 OCCUPATI ONAL HEALTH ONSI TE SVCS	0	60, 769		1		194. 01 194. 02
194. 02 07952 MEDCHECKS 194. 03 07953 SCHOOL BASED CLINICS	0	0	15, 558			194. 02
194. 04 07954 OCCUPATIONAL HEALTH CLINICS	0	0	782	/82		194. 03
194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS	0	0				194. 04
194. 06 07956 PAVI LLI ONS	0	0	265, 128	265, 128		194. 06
194. 07 07957 LI FECHECK	0	0	1, 232	1		194. 07
194. 08 07958 GROUP HOMES AND MISC. N R CTRS	0	34, 842	25, 666	1		194. 08
194. 09 07959 SURGERY CENTER EAST	0	0.70.2	20,000	0		194. 09
200.00 Cross Foot Adjustments		Ĭ		0	3, 700	200.00
201.00 Negative Cost Centers		o	l	o o	0	201. 00
202.00 TOTAL (sum lines 118-201)	0	16, 322, 529	13, 875, 182	30, 197, 711	262, 640	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150074

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared: | 5/27/2015 6:01 pm

					5/27/2015 6:0	1 pm
Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	<u> </u>	PLANT 7. 00	LINEN SERVICE	9. 00	10.00	
GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2. 00 OO200 CAP REL COSTS-MVBLE EQUIP					ļ	2. 00
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT					ļ	4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	12, 022, 919					5. 00
7. 00 O0700 OPERATION OF PLANT	492, 996	3, 111, 500				7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	34, 061	3, 111, 300	34, 146		ļ	8. 00
9. 00 00900 HOUSEKEEPI NG	136, 902	95, 147		573, 866		9. 00
10. 00 01000 DI ETARY	67, 487	52, 710		10, 028	322, 185	10. 00
11. 00 01100 CAFETERI A	87, 838			23, 491	0	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	195, 895	77, 168		14, 681	0	13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	150, 639			6, 032	0	14. 00
15. 00 01500 PHARMACY	249, 005	52, 117		9, 915	0	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	182, 488	107, 463		20, 445	0	16. 00
17. 00 01700 SOCI AL SERVI CE	154, 541	37, 496		7, 134	0	17. 00
18. 00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0,7,7,0		0	0	18. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	1, 190	Ö	o o	0	0	19. 00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD	74, 191	24, 917		4, 740	0	21. 00
22. 00 02200 &R SERVICES-OTHER PRGM COSTS APPRVD	108, 362	2.,,,,,	o o	0	0	22. 00
23. 00 02300 EMS TRAINING-ALLIED HEALTH	14, 298	25, 057	0	4, 767	0	23. 00
23. 01 02301 RADI OLOGY SCHOOL-ALLI ED HEALTH	6, 789			796	0	23. 01
23. 02 02302 PHARMACY RESI DENCY-ALLI ED HEALTH	4, 533	.,		0	0	23. 02
23. 03 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	0	Ö	o o	ol	0	23. 03
INPATIENT ROUTINE SERVICE COST CENTERS				-1	-	
30. 00 03000 ADULTS & PEDI ATRI CS	1, 155, 213	824, 471	14, 658	156, 856	249, 941	30. 00
31.00 03100 INTENSIVE CARE UNIT	137, 427	65, 569	2, 154	12, 475	16, 132	31. 00
32. 00 03200 CORONARY CARE UNIT	224, 399				38, 269	32.00
43. 00 04300 NURSERY	111, 327	86, 882	1, 386	16, 529	17, 843	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	257, 421	206, 185	1, 378	39, 227	0	50.00
51.00 05100 RECOVERY ROOM	54, 911	55, 077	0	10, 478	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	60, 227	47, 003	750	8, 942	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	151, 245	151, 472	611	28, 818	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	285, 549	108, 531	726	20, 648	0	55. 00
57.00 05700 CT SCAN	91, 312	18, 851	1, 268	3, 587	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	50, 164	29, 449	346	5, 603	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	66, 533	52, 134	160	9, 919	0	59. 00
60. 00 06000 LABORATORY	358, 813	57, 343	0	10, 910	0	60.00
64.00 06400 INTRAVENOUS THERAPY	13, 512	3, 301	0	628	0	64.00
65. 00 06500 RESPIRATORY THERAPY	141, 911	19, 372	2 0	3, 686	0	65.00
66. 00 06600 PHYSI CAL THERAPY	123, 825	23, 518	0	4, 474	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	44, 870	6, 138	0	1, 168	0	67.00
68. 00 06800 SPEECH PATHOLOGY	14, 285	1, 953	0	372	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	98, 940	7, 890	0	1, 501	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	47, 647	14, 313	68	2, 723	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	264, 209	0	103	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	383, 287	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 910, 143	0	0	0	0	73.00
74. 00 07400 RENAL DI ALYSI S	29, 221	0	0	0	0	74.00
76. 00 03330 ENDOSCOPY	18, 309	0	0	0	0	76. 00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	438, 208	27, 760	0	5, 281	0	76. 01
76. 02 03950 NEUROPSYCHI ATRI C SERVI CES	10, 848	0	0	0	0	76. 02
76. 03 03951 LUTHERWOOD PARTNERSHI P	191, 365	0	0	0	0	76. 03
76. 04 03952 WOUND CARE CENTER	28, 785	18, 325	0	3, 486	0	76. 04
76. 05 03480 ONCOLOGY-CANCER CARE CENTER	1, 177, 211	9, 272	172	1, 764	0	76. 05
76.06 03953 I MAGI NG CENTERS	141, 245	515		98	0	76. 06
76. 07 03954 BREAST DIAGNOSTIC CENTER	79, 680	14, 588	0	2, 775	0	76. 07
76. 97 07697 CARDI AC REHABI LI TATI ON	17, 305	21, 890	0	4, 165	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	51, 155	12, 528	0	2, 384	0	76. 98
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90. 00 09000 CLI NI C	0	0	0	0	0	90.00
90. 01 04950 DI ABETI C CARE CENTER	1, 684	0	0	0	0	90. 01
90. 02 04951 HEALTHY HEARTS CENTER	67, 922	30, 423		5, 788	0	90. 02
90. 04 04953 PALLI ATI VE CARE	16, 937	4, 471	0	851	0	90. 04
90.05 04954 INFUSION CENTERS	14, 200	0	0	0	0	90. 05
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE	152, 368	2, 126		405	0	90. 12
91. 00 09100 EMERGENCY	462, 331	174, 329	5, 770	33, 166	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
SPECIAL PURPOSE COST CENTERS	T -		1			
118.00 SUBTOTALS (SUM OF LINES 1-117)	10, 907, 159	2, 852, 980	34, 063	524, 682	322, 185	118. 00

202.00

Negative Cost Centers

TOTAL (sum lines 118-201)

Provider CCN: 150074

Peri od:

34, 146

573, 866

322, 185 202. 00

From 01/01/2014 Part II 12/31/2014 Date/Time Prepared: 5/27/2015 6:01 pm ADMINISTRATIVE OPERATION OF HOUSEKEEPI NG Cost Center Description LAUNDRY & DI ETARY & GENERAL PLANT LINEN SERVICE 9. 00 10.00 5.00 7.00 8.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 689 0 12, 982 0 191. 00 19100 RESEARCH 27, 379 2, 470 0 191.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 101, 895 30, 899 0 5, 879 0 192. 00 194.00 07950 HOME OFFICE 0 35, 457 26, 159 186, 371 0 194.00 194. 01 07951 OCCUPATIONAL HEALTH ONSITE SVCS 0 0 194. 01 44, 391 17, 967 3, 418 194. 02 07952 MEDCHECKS 738 0 194. 02 194. 03 07953 SCHOOL BASED CLINICS 0 0 0 194. 03 23, 262 0 194. 04 07954 OCCUPATIONAL HEALTH CLINICS 0 0 194, 04 0 905 0 194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 0 194. 05 0 194. 06 07956 PAVI LLI ONS 103, 951 0 0 0 0 194. 06 194. 07 07957 LI FECHECK 0 194. 07 2,569 0 0 C 194.08 07958 GROUP HOMES AND MISC. N_R CTRS 0 194. 08 48, 771 10, 301 83 1, 960 194. 09 07959 SURGERY CENTER EAST 735, 051 0 0 194. 09 Cross Foot Adjustments 200.00 200.00 0 201. 00 201.00

12, 022, 919

3, 111, 500

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150074

CEMBRIAL SERVICE COST CENTERS		Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	5/27/2015 6: 0 MEDI CAL	
STATEST STATEST CONTINUES CONTINUES		cost center bescription	CALLIERIA		SERVICES &	FIIANWACT	RECORDS &	
1.00 001000 CAP REL CUSIS-BLEG & FIXT			11. 00	13.00		15.00		
2 00 0000 CAP REL COSTS-WINE EQUIP 4 00 00000 REMINE STRAIN V. A GEMENAL 5 00 00000 REMINE V. A GEMENAL 5 00 00000 REMINE V	1 00							1 1 00
4.00 DOSCORD JURY DETERMENT IS DEPARTMENT								1. 00 2. 00
DOCSON_ARMIN IN STRATI VIT. A GENERAL COURSES OF CONTROL SERVICE COURSES OF CONTROL SERVICE COURSES OF								4.00
0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000								5. 00
9.00 009000 009000 00900								7. 00
10.00 01000 DETARY								8. 00
11.00 0 11000 CAFETERIA								9. 00
13.00 0 1300 MIRSI NG ADMINI STRATI ON			472 246					10.00
14.00 01400 CFRITAM SFRVICES & SUPPLY 0 0 1,071,896 1,071,896 15.00			1	1				11. 00 13. 00
15.00 01500 PIMAMACY 25, 1333 0 6,708 827, 220 34, 813 16. 00 1620 01700 SOCI AL SERVICE 22,716 0 066 0 0 0 18. 19. 19. 19. 19. 19. 19. 19. 19. 19. 19		1	1	1	1 071 896			14.00
16.00 01 100 NEDICAL RECORDS & LIBRARY 50.266 0 828 0 734,283 1 1 0 0 1 7 1 1 1 1 1 1 1 1 1 1 1 1 1 1		1	-	1		827, 220		15.00
18.00 01850 OTHER CRIFFICAL SERVICE (SPECIFY) 0 0 0 0 0 0 0 0 18.	16. 00					0		
19.00 01900 MOMPHYSICI AM AMESTHETISTS 0 0 0 0 19. 22.00 02100 IAS SERVICES-CHIER PROID COSTS APPRVD 3, 383 0 0 0 0 0 22. 23.01 02300 RASSERVICES-CHIER PROID COSTS APPRVD 3, 383 0 1, 400 0 0 0 23. 23.01 02301 RADIOLOGY SCHOOL-ALLIED HEALTH 483 0 21 0 0 0 0 23. 23.01 02301 RADIOLOGY SCHOOL-ALLIED HEALTH 483 0 21 0 0 0 0 23. 23.03 02301 RADIOLOGY SCHOOL-ALLIED HEALTH 483 0 0 0 0 0 0 0 0 0			22, 716	0	966	0		17. 00
21.00 02100 IAS SERVICES-SALARY & FRINCES APPROD 13, 050 0 2, 1510 0 0 22. 23.00 02200 IAS SERVICES-STREPROD 3, 3833 0 1, 400 0 0 0 22. 23.00 02300 IAS TRAIN NG-ALLIED HEALTH 4833 0 211 0 0 0 0 23. 23. 23. 20 02302 PHARMACY RESIDENCY-ALLIED HEALTH 4833 0 0 0 0 0 0 0 23. 23. 20. 20. 2020 PHARMACY RESIDENCY-ALLIED HEALTH 483 0 0 0 0 0 0 0 23. 23. 20. 20. 2020 PHARMACY RESIDENCY-ALLIED HEALTH 0 0 0 0 0 0 0 23. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20				1	0	0		18. 00
22.00 02000 IAS SERVICES-OTHER PROBLOSTS APPRVO 3,385 0 0 0 0 22 23 23 20 02300 BST SERVICES-OTHER PROBLEM 483 0 0 0 0 0 23 23 23 2				1	0	0		19.00
23.00 02300 RMS TRAIN ING-ALLIED HEALTH			1	1		0		21. 00 22. 00
23.0 10 02301 PADIOLOGY SCHOOL-ALLIED HEALTH		1	1	1	-	0		23.00
23.02 02302 PHARMARY RESIDENCY-ALLIED HEALTH 483 0 0 0 0 0 0 23.			1	1		0		23. 01
INPATI ENT ROUTI NE SERVI CE COST CENTERS 154, 665 393, 203 37, 805 0 59, 468 30. 00 30. 00 30.00 03.00 AULTS & PEDIA FIRIC S 154, 665 393, 203 37, 805 0 59, 468 30. 31. 00 30. 00 30.00 AULTS & PEDIA FIRIC S 14, 500 36, 863 6, 349 0 6, 127 31, 32. 00 320.00 CRONARY CARE UNIT 26, 699 0 8, 641 0 3, 840 43. 30. 30. 30. 30. 30. 30. 30. 30. 30. 3						0	0	23. 02
30.00 03000 JAULTS & PEDIATRICS 154,665 394,203 37,855 0 6.727 31.	23. 03	02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	(o	0	0	0	23. 03
31.00 03100 INTENSIVE CARE UNIT 14,500 36,663 6,349 0 6,127 31, 32, 20 03200 CROMARY CARE UNIT 26,099 0 8,641 0 3,840 43, 320 03200 CROMARY CARE UNIT 26,099 0 8,641 0 3,840 43, 320 3,840 44, 34, 320 3,840 44, 34, 320 3,840 44, 34, 320 3,840 44, 34, 320 3,840 44, 34, 320 3,840 44, 34, 320 3,840 44, 34, 320 3,840 44, 34, 320 3,840 44, 34, 320 3,840 44, 34, 320 3,840 44, 34, 320 3,840 44, 34, 320 3,840 44, 34, 320 3,840 44, 34, 320 3,840 44, 34, 340 34, 340 44, 34, 340 34, 340			_					
32 00 03200 COROMARY CARE UNIT 26,099 0 8,258 0 10,959 32,			1	1		-	,	
A3. 00 0.4300 NURSERY 11,600 29,490 8,641 0 3,840 43.						_		
ANCILLARY SERVICE COST CENTERS						_		
50.00 05000 0FECRATING ROOM	43.00	-	11,000	27, 470	0, 041	0	3, 040	43.00
S2 00 OS200 DELIVERY ROOM & LABOR ROOM 6, 283 15, 974 4, 674 0 7, 098 52, 50 00 500 RADIO LOGY-THERAPEUTI C 21, 750 0 10, 321 0 31, 715 54, 55, 70 00 570 OCT SCAN 6, 767 0 00 00, 321 0 31, 715 55, 70 00 570 OCT SCAN 6, 767 0 00 00, 321 0 31, 715 55, 70 00 570 OCT SCAN 6, 767 0 00 0 287 0 31, 603 57, 70 00 570 OCT SCAN 6, 767 0 00 0 28, 786 0 00 00, 85, 750 00 00, 90 00	50.00		16, 916	43, 007	34, 272	0	27, 337	50.00
54.00 OS400 RADI OLOCY-DI AGNOSTIC 16, 433 0 7, 406 0 17, 119 54, 50 0 5500 RADI OLOCY-DI AGNOSTIC 21, 750 0 10, 321 0 31, 715 55, 57.00 OS700 CT SCAN 6, 767 0 6, 287 0 31, 603 57, 580 OS900 MAGNETIC RESONANCE IMAGING (MRI) 3, 383 0 2, 786 0 0 30, 321 0 31, 603 57, 580 OS900 MAGNETIC RESONANCE IMAGING (MRI) 3, 383 0 2, 786 0 0 31, 603 57, 560 0 0 0 0 0 0 0 0 0	51.00		1	1	1, 852	0		
55.00 05500 RADIO LOGY -THERAPEUTI C 21,750 0 10,321 0 31,715 55.70 05700 CTS OOK 5700 CTS OOK 57			1	1		_		
57.00 05700 CT SCAN 6, 767 0 6, 287 0 31, 603 57. 88.00 05800 MAGNETI C RESONANCE IMAGING (MRI) 3, 383 0 2, 786 0 0 0 0 0 193 0 26, 873 59. 60. 00 0 0 0 0 0 0 0 0			1	1		0		
SBO 0 OSBOO MAGNETI C RESONANCE I IMAGI NG (MRI) 3,383 0 2,786 0 8,566 58,			1	1		0		
59.00 05900 CARDI AC CATHETERI ZATI ON 5,800 0 193 0 26,873 59,		1	1	1		0		
60.00 06000 LABOBATORY 0 0 43, 919 0 54, 228 60.			1	1		0		
65.00 06500 RESPI RATORY THERAPY 16, 916 0 4, 692 0 10, 953 65. 66. 00 06600 PHYSI CAL THERAPY 3, 867 0 2, 512 0 9, 325 66. 67. 00 06700 OCCUPATI ONAL THERAPY 5, 800 0 965 0 2, 136 67. 68. 00 06800 SPEECH PATHOLOGY 12, 566 0 5, 347 0 14, 788 69. 00 06900 ELECTROCARDI OLOGY 12, 566 0 5, 347 0 14, 788 69. 00 06900 ELECTROCARDI OLOGY 12, 566 0 5, 347 0 14, 788 69. 00 06900 ELECTROCARDI OLOGY 12, 566 0 5, 347 0 14, 788 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 313, 548 0 29, 630 71. 72. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 435, 889 0 23, 539 72. 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 827, 220 187, 660 73. 74. 00 07400 RENAL DI LALYSI S 0 0 0 304 0 1, 581 76. 76. 00 3030 S. 3550 PSYCHI ATRI C SERVI CES 1, 450 0 17, 625 0 12, 445 76. 00 30 304 0 1, 581 76. 76. 00 303550 PSYCHI ATRI C SERVI CES 1, 450 0 199 0 295 76. 03 03951 ULTHERWOOD PARTINERSHI P 0 0 13, 580 0 1, 088 76. 76. 00 03953 MAGI NO CARDE CENTER 1, 933 0 370 0 1, 799 76. 60 03953 MAGI NO CARDE CENTER 40, 116 0 29, 829 0 38, 747 76. 60 03953 MAGI NO CARDE CENTER 40, 116 0 29, 829 0 38, 747 76. 60 03953 MAGI NO CENTERS 0 0 0 0 0 0 0 0 0		1	1	1		0		
66.00 06600 PHYSI CAL THERAPY 3,867 0 2,512 0 9,325 66. 67.00 06700 0CCUPATI ONAL THERAPY 5,800 0 965 0 2,136 67. 68.00 06800 SPEECH PATHOLOGY 1,933 0 307 0 707 68. 69.00 06900 ELECTROCARDI OLOGY 12,566 0 5,347 0 14,788 69. 70.00 7000 COTORO ELECTROCARDI OLOGY 12,566 0 5,347 0 14,788 69. 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 1,612 0 2,409 70. 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 313,548 0 29,630 71. 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 33,548 0 29,630 71. 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 827,220 187,660 73. 74.00 07400 RENAL DI JALYSI S 0 0 0 30 0 1,355 74. 74.00 07400 RENAL DI JALYSI S 0 0 0 30 0 1,355 74. 76.01 03330 ENDOSCOPY 1,933 0 304 0 1,581 76. 76.01 03350 PSYCHI ATRI C SERVI CES 1,450 0 199 0 295 76. 76.03 03951 LUTHERWOOD PARTHERSH P 0 0 13,580 0 1,088 76. 76.04 03952 WOUND CARE CENTER 1,933 0 370 0 1,799 76. 76.05 03480 ONCOLOGY-CANCER CARE CENTER 40,116 0 29,829 0 38,747 76. 76.07 03954 BREAST DI AGNOSTIC CENTER 483 0 2,913 0 3,828 76. 76.07 03954 BREAST DI AGNOSTIC CENTER 483 0 2,913 0 3,828 76. 76.07 03954 BREAST DI AGNOSTIC CENTER 483 0 2,913 0 3,828 76. 76.07 03954 BREAST DI AGNOSTIC CENTER 483 0 2,913 0 3,828 76. 76.07 03954 BREAST DI AGNOSTIC CENTER 483 0 2,913 0 3,828 76. 76.07 03954 BREAST DI AGNOSTIC CENTER 483 0 2,913 0 3,828 76. 76.09 04900 04900 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	64.00	06400 I NTRAVENOUS THERAPY	1, 450	o o	103	0	585	64. 00
67.00 06700 0CCUPATI ONAL THERAPY 5,800 0 965 0 2,136 67. 80.00 06800 SPEECH PATHOLOGY 1,933 0 307 0 707 68. 80.00 06900 ELECTROCARDI OLOGY 1,933 0 307 0 707 68. 80.00 07000 ELECTROCARDI OLOGY 1,2566 0 5,347 0 14,788 69. 80.00 07000 ELECTROCARDI OLOGY 7,250 0 1,612 0 2,409 70. 80.00 07000 ELECTROCARDI OLOGY 7,250 0 1,612 0 2,409 70. 80.00 07000 ELECTROENCEPHALOGRAPHY 7,250 0 0 313,548 0 29,630 70. 80.00 07000 IMPL DEV. CHARGED TO PATIENTS 0 0 0 313,548 0 29,630 72. 80.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 30 0 1,355 74. 80.00 07400 RENAL DIALYSIS 0 0 0 30 0 1,355 74. 80.00 03300 ENDOSCOPY 1,933 0 304 0 1,581 76. 80.00 03350 PSYCHI ATRI C.YPSYCHOLOGI CAL SERVI CES 1,450 0 199 0 295 76. 80.00 03950 NEUROPSYCHI ATRI C. SERVI CES 1,450 0 199 0 295 76. 80.00 03950 NEUROPSYCHI ATRI C. SERVI CES 1,450 0 199 0 295 76. 80.00 03951 LUTHERWOOD PARTNERSHI P 0 0 13,580 0 1,088 76. 80.00 03952 WOUND CARE CENTER 1,933 0 370 0 1,799 76. 80.00 03953 IMAGING CENTERS 0 0 0 2,851 0 9,338 76. 80.00 03953 IMAGING CENTERS 0 0 0 0 0 0 0 0 0		1	1	1		0		
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70. 00 07000 ELECTROENCEPHALOGRAPHY 7, 250 0 1, 612 0 2, 409 70. 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 313, 548 0 29, 630 71. 72. 00 07200 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 435, 889 0 23, 539 72. 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 827, 220 187, 660 73. 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 30 0 1, 355 74. 76. 00 74						0		
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74. 00 07400 RENAL DIALYSIS 0 0 330 0 1, 355 74. 76. 00 03330 ENDOSCOPY 1, 333 0 304 0 1, 551 76. 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 47, 366 0 17, 625 0 12, 445 76. 76. 02 03950 NEUROPSYCHI ATRI C SERVI CES 1, 450 0 199 0 295 76. 76. 03 03951 LUTHERWOOD PARTNERSHI P 0 0 13, 580 0 1, 088 76. 76. 04 03952 WOUND CARE CENTER 1, 933 0 370 0 1, 799 76. 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 40, 116 0 29, 829 0 38, 747 76. 76. 06 03953 I MAGI NG CENTERS 0 0 0 2, 851 0 9, 338 76. 76. 07 03954 BREAST DI AGNOSTI C CENTER 483 0 2, 913 0 3, 828 76. 76. 97 07697 CARDI AC REHABI LI TATI ON 2, 900 0 286 0 917 76. 76. 98 07698 HYPERBARI C OXYGEN THERAPY 1, 450 0 3, 177 0 1, 561 76. 76. 98 0800 RURAL HEALTH CLI NI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		ol ol	435, 889	0	23, 539	72. 00
76. 00 03330 ENDOSCOPY 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES				이		827, 220	187, 660	
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 47, 366 0 17, 625 0 12, 445 76. 76. 02 03950 NEUROPSYCHI ATRI C SERVI CES 1, 450 0 199 0 295 76. 76. 03 03951 LUTHERWOOD PARTNERSHI P 0 0 0 13, 580 0 1, 088 76. 76. 04 03952 WOUND CARE CENTER 1, 933 0 370 0 1, 799 76. 76. 05 03480 0NCOLOGY-CANCER CARE CENTER 40, 116 0 29, 829 0 38, 747 76. 76. 06 03953 IMAGI NG CENTERS 0 0 0 2, 851 0 9, 338 76. 76. 07 03954 BREAST DI AGNOSTI C CENTER 483 0 2, 913 0 3, 828 76. 76. 97 07697 CARDI AC REHABI LI TATI ON 2, 900 0 286 0 917 76. 90 00PATI ENT SERVI CE COST CENTERS 88. 00 08900 RURAL HEALTH CLI NI C 0 0 0 0 0 0 0 0 88. 89. 90. 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						0		
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76. 03 03951 LUTHERWOOD PARTNERSHIP			1	1		0		76. 01 76. 02
76. 04 03952 WOUND CARE CENTER 1, 933 0 370 0 1, 799 76. 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 40, 116 0 29, 829 0 38, 747 76. 76. 06 03953 I MAGI NG CENTERS 0 0 0, 2, 851 0 9, 338 76. 76. 07 03954 BREAST DI AGNOSTI C CENTER 483 0 2, 913 0 3, 828 76. 76. 97 07697 CARDI AC REHABI LI TATI ON 2, 900 0 286 0 917 76. 76. 98 07698 HYPERBARI C OXYGEN THERAPY 1, 450 0 3, 177 0 1, 561 76. DUTPATI ENT SERVICE COST CENTERS 88. 00 08900 RURAL HEALTH CLINI C 0 0 0 0 0 0 88. 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 89. 90. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 0 90. 90. 01 04950 DI ABETI C CARE CENTER 8, 700 0 3, 864 0 1, 932 90. 90. 02 04951 HEALTHY HEARTS CENTER 8, 700 0 3, 864 0 1, 932 90. 90. 05 04954 I NFUSION CENTERS 0 0 0 743 0 1, 149 90. 90. 12 04961 FAMI LY PRACTI CE AND MATERNI TY CARE 14, 983 0 2, 002 0 2, 397 90. 91. 00 09000 DI MERGENCY 48, 816 124, 105 30, 875 0 83, 711 91. 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS				1		0		
76. 05			1	1		0		76. 04
76. 06			1	1		0		
76. 97		03953 I MAGI NG CENTERS		ol ol		0		1
76. 98 07698 HYPERBARI C OXYGEN THERAPY 1, 450 0 3, 177 0 1, 561 76.			1	1		0		
SECTION SERVICE COST CENTERS SERVICE COST CENTER SERVICE COST CENTERS SERVICE COST			1	1		-		76. 97
88. 00	76. 98		1, 450	<u> 0</u>	3, 177	0	1, 561	76. 98
89. 00	88 00					0	^	88. 00
90. 00				1	0	0		
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90. 02				ol ol	o	0		90. 01
90. 05	90. 02		8, 700	o o	3, 864	0	1, 932	90. 02
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE 14, 983 0 2, 002 0 2, 397 90.		1	1, 933	3 O		0		90. 04
91. 00 09100 EMERGENCY 48,816 124,105 30,875 0 83,711 91.		1	(이		0		
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) 92. OTHER REIMBURSABLE COST CENTERS			1	1		0		90. 12
OTHER REIMBURSABLE COST CENTERS		1	48, 816	124, 105	30, 8/5	0	83, /11	91. 00 92. 00
	7∠. UU							, 7∠.00
	98. 00			ol	0	0	0	98. 00
			•	1	-1	_		

202.00

TOTAL (sum lines 118-201)

734, 283 202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150074 Peri od: Worksheet B From 01/01/2014 Part II 12/31/2014 Date/Time Prepared: 5/27/2015 6:01 pm Cost Center Description CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL ADMI NI STRATI ON SERVICES & RECORDS & SUPPLY LI BRARY 11.00 13.00 15.00 16.00 14.00 SPECIAL PURPOSE COST CENTERS
SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 1, 058, 919 827, 220 118.00 669, 403 642, 642 734, 283 118. 00 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 483 191. 00 19100 RESEARCH 0 191.00 3, 383 0 223 0 0 0 0 0 0 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 6,049 0 192. 00 194.00 07950 HOME OFFICE 0 0 194.00 0 0 0 0 0 0 0 0 0 0 194. 01 07951 OCCUPATIONAL HEALTH ONSITE SVCS 0 194, 01 0 526 194. 02 07952 MEDCHECKS 0 194. 02 194. 03 07953 SCHOOL BASED CLINICS 444 0 194. 03 194. 04 07954 OCCUPATIONAL HEALTH CLINICS 0 0 194. 04 0 194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 194. 05 0 0 194. 06 07956 PAVI LLI ONS 0 741 0 194. 06 194. 07 07957 LI FECHECK 13 0 194. 07 194.08 07958 GROUP HOMES AND MISC. N_R CTRS 0 194. 08 0 4, 981 194. 09 07959 SURGERY CENTER EAST 0 0 194. 09 C C 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 0

673, 269

642, 642

1, 071, 896

827, 220

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150074

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared: 5/27/2015 6:01 pm

						5/27/2015 6:0	1 pm
			OTHER GENERAL		INTERNS &	RESI DENTS	
			SERVI CE				
	Cost Center Description	SOCI AL SERVI CE	(SPECI FY)		SERVI CES-SALAR		
				ANESTHETI STS	Y & FRINGES	PRGM COSTS	
	OFFICE A SERVICE ASST OFFICE	17. 00	18. 00	19. 00	21. 00	22. 00	
	GENERAL SERVICE COST CENTERS			l	1		
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 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14. 00							14. 00
15. 00	+ I						
	1 1						15.00
16.00	+ I	05, 700					16.00
17. 00		356, 722	_				17. 00
18. 00	1 1	0	0				18. 00
19. 00	1	0	0	1, 577			19. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0		212, 622		21. 00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0			112, 774	22. 00
23.00	02300 EMS TRAINING-ALLIED HEALTH	0	0				23. 00
23. 01	02301 RADI OLOGY SCHOOL-ALLI ED HEALTH	ol	0				23. 01
23. 02		o	0				23. 02
23. 03		l ol	0				23. 03
23.03	I NPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>					25.05
30. 00		276, 735	0				30.00
	1 1	1					
31.00	1 1	17, 861	0				31.00
32. 00		42, 371	0				32. 00
43. 00		19, 755	0				43. 00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0				50.00
51.00	05100 RECOVERY ROOM	0	0				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	o	0				54.00
55. 00	1 1	ol	0				55. 00
57.00	1 1	o	0				57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	o	0				58. 00
59. 00			0				59. 00
60. 00	06000 LABORATORY		0				60.00
	1 1	0	0				
64. 00	+ I	0	0				64.00
65. 00		0	0				65. 00
66. 00	l l	0	0				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0				69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0				70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0				72. 00
	07300 DRUGS CHARGED TO PATIENTS	o	0				73. 00
74. 00			0				74. 00
76. 00	1		0				76. 00
76. 00	1		0				76. 01
		0	0				
76. 02	1 1		0				76. 02
76. 03	1 1	0	0				76. 03
76. 04	+ I	0	0				76. 04
76. 05	+ I	0	0				76. 05
76. 06	+ I	0	0				76. 06
	03954 BREAST DIAGNOSTIC CENTER		0				76. 07
76. 97	1 1	0	0				76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0				76. 98
	OUTPATIENT SERVICE COST CENTERS						
88. 00		0	0				88. 00
89. 00		o	0				89. 00
90. 00	+ I	ا م	0				90.00
90. 00	1 1		0				90. 01
90.01	1 1		0				90.01
90. 02	l l		0				90.02
	l l		0				
90. 05	1	0	0				90.05
90. 12	1	0	0				90. 12
91. 00		0	0				91. 00
92. 00	,						92. 00
	OTHER REIMBURSABLE COST CENTERS						
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0				98. 00
		·			<u>.</u>		

200.00

201.00

202.00

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

112, 774 200. 00

112, 774 202. 00

0 201.00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150074 Peri od: Worksheet B From 01/01/2014 Part II Date/Time Prepared: 5/27/2015 6:01 pm 12/31/2014 OTHER GENERAL INTERNS & RESIDENTS SERVI CE SOCIAL SERVICE (SPECI FY) NONPHYSICIAN SERVICES-SALAR SERVICES-OTHER Cost Center Description ANESTHETI STS Y & FRINGES PRGM COSTS 18.00 21.00 22.00 17.00 19.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 356, 722 0 0 0 0 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 191. 00 19100 RESEARCH 191. 00 0 0 0 0 0 0 0 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 00 194.00 07950 HOME OFFICE 0 194. 00 194.01 07951 OCCUPATIONAL HEALTH ONSITE SVCS 194. 01 194. 02 07952 MEDCHECKS 0 194. 02 194. 03 07953 SCHOOL BASED CLINICS 0 194. 03 194. 04 194. 04 07954 OCCUPATIONAL HEALTH CLINICS 194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 194. 05 194. 06 07956 PAVI LLI ONS 194. 06 194. 07 07957 LI FECHECK 0 194. 07 194.08 07958 GROUP HOMES AND MISC. N_R CTRS 194. 08 0 194. 09 07959 SURGERY CENTER EAST 0 194. 09

356, 722

1, 577

1, 577

0

212, 622

212, 622

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150074 Peri od: Worksheet B From 01/01/2014 Part II 12/31/2014 Date/Time Prepared: 5/27/2015 6:01 pm Cost Center Description EMS RADI OLOGY **PHARMACY** PHARMACY Subtotal FRAI NI NG-ALLI E SCHOOL-ALLI ED RESI DENCY-ALLI RESI DNECY-BTH HEALTH ED HEALTH ALLI ED HEALTH D HEALTH 24.00 23.02 23.03 23.00 23.01 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14 00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 18.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22 00 22 00 23.00 02300 EMS TRAINING-ALLIED HEALTH 146, 489 23.00 02301 RADIOLOGY SCHOOL-ALLIED HEALTH 23. 01 26, 624 23.01 02302 PHARMACY RESIDENCY-ALLIED HEALTH 23.02 5.168 23.02 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH 23.03 0 23.03 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 6, 244, 000 30.00 31 00 03100 INTENSIVE CARE UNIT 626, 670 31 00 03200 CORONARY CARE UNIT 32.00 1,004,947 32.00 04300 NURSERY 651, 993 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 985, 231 50.00 51.00 05100 RECOVERY ROOM 322, 175 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 337, 431 52.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 1, 171, 844 54 00 55.00 05500 RADI OLOGY-THERAPEUTI C 1,065,024 55.00 57.00 05700 CT SCAN 342, 146 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 389, 440 58.00 05900 CARDIAC CATHETERIZATION 369, 974 59 00 59 00 06000 LABORATORY 60.00 721, 406 60.00 06400 I NTRAVENOUS THERAPY 31, 960 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 362, 723 65.00 06600 PHYSI CAL THERAPY 299, 064 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 98, 690 67.00 68.00 06800 SPEECH PATHOLOGY 31, 527 68.00 06900 ELECTROCARDI OLOGY 207, 501 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 228, 292 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 607, 490 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 842, 715 72 00 07300 DRUGS CHARGED TO PATIENTS 2, 925, 023 73.00 73.00 07400 RENAL DIALYSIS 74.00 31, 266 74 00 76.00 03330 ENDOSCOPY 33, 611 76.00 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 802, 112 76.01 03950 NEUROPSYCHIATRIC SERVICES 76.02 14.568 76.02 76. 03 03951 LUTHERWOOD PARTNERSHIP 239, 157 76.03 76.04 03952 WOUND CARE CENTER 127, 383 76.04 03480 ONCOLOGY-CANCER CARE CENTER 1, 407, 907 76.05 76.05 76.06 03953 I MAGING CENTERS 578, 225 76.06 03954 BREAST DIAGNOSTIC CENTER 76.07 153, 788 76.07 07697 CARDIAC REHABILITATION 76. 97 125, 520 76. 97 76.98 07698 HYPERBARIC OXYGEN THERAPY 122, 190 76. 98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 89.00 09000 CLINIC 90.00 Ω 90 00 90.01 04950 DIABETIC CARE CENTER 1, 757 90.01 04951 HEALTHY HEARTS CENTER 90.02 224, 867 90.02 90.04 04953 PALLIATIVE CARE 40.349 90.04 04954 INFUSION CENTERS 90.05 17, 533 90.05 90.12 04961 FAMILY PRACTICE AND MATERNITY CARE 276, 470 90.12

1, 989, 015

91.00

92 00

0 98.00

09100 EMERGENCY

09200 OBSERVATION BEDS (NON-DISTINCT PART)

OTHER REIMBURSABLE COST CENTERS 98. 00 09850 OTHER REIMBURSABLE COST CENTERS

91.00

92 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150074 Peri od: Worksheet B From 01/01/2014 Part II 12/31/2014 Date/Time Prepared: 5/27/2015 6:01 pm Cost Center Description EMS RADI OLOGY PHARMACY PHARMACY Subtotal TRAI NI NG-ALLI E SCHOOL-ALLI ED RESI DENCY-ALLI RESI DNECY-BTH HEALTH ALLI ED HEALTH D HEALTH ED HEALTH 24.00 23. 00 23. 01 23. 02 23. 03 SPECIAL PURPOSE COST CENTERS
SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 0 0 118.00 0 27, 052, 984 118. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1, 195 190. 00 191. 00 19100 RESEARCH 91, 685 191. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 252, 080 192. 00 194.00 07950 HOME OFFICE 878, 334 194. 00 194. 01 07951 OCCUPATIONAL HEALTH ONSITE SVCS 129, 216 194. 01 194. 02 07952 MEDCHECKS 16, 296 194. 02 194. 03 07953 SCHOOL BASED CLINICS 25, 220 194. 03 905 194. 04 194. 04 07954 OCCUPATIONAL HEALTH CLINICS 194.05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 194. 05 194. 06 07956 PAVI LLI ONS 370, 179 194. 06 194. 07 07957 LI FECHECK 4, 034 194. 07 194.08 07958 GROUP HOMES AND MISC. N_R CTRS 128, 498 194. 08 194. 09 07959 SURGERY CENTER EAST 741, 831 194. 09 200.00 Cross Foot Adjustments 146, 489 5, 168 505, 254 200. 00 26,624 201.00 Negative Cost Centers 0 201.00 30, 197, 711 202. 00 202.00 TOTAL (sum lines 118-201) 146, 489 5, 168 26, 624

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150074
From 01/01/2014
To 12/31/2014
Vorksheet B
Part II
Date/Time Prepared:
5/27/2015 6: 01 pm

				5/27/2015	
	Cost Center Description	Intern &	Total		
		Residents Cost			
		& Post			
		Stepdown			
		Adjustments	24 00		
	GENERAL SERVICE COST CENTERS	25. 00	26. 00		
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP				2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL				5. 00
7. 00	00700 OPERATION OF PLANT				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE				8. 00
9.00	00900 HOUSEKEEPI NG				9. 00
10.00	01000 DI ETARY				10. 00
11.00	01100 CAFETERI A				11. 00
13.00	01300 NURSING ADMINISTRATION				13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY				14. 00
15. 00	01500 PHARMACY				15. 00
	01600 MEDICAL RECORDS & LIBRARY				16. 00
	01700 SOCI AL SERVI CE				17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)				18. 00
	01900 NONPHYSICIAN ANESTHETISTS				19. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD				21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD				22. 00
23. 00	02300 EMS TRAINING-ALLIED HEALTH				23. 00
23. 01	02301 RADI OLOGY SCHOOL-ALLI ED HEALTH				23. 01
23. 02	02302 PHARMACY RESIDENCY-ALLIED HEALTH				23. 02
23. 03	02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH				23. 03
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	6, 244, 000		30.00
31. 00	03100 INTENSIVE CARE UNIT	0	626, 670		31. 00
32. 00	03200 CORONARY CARE UNIT		1, 004, 947		32. 00
43. 00	04300 NURSERY		651, 993		43. 00
10.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	001,770		10.00
50.00	05000 OPERATING ROOM	0	1, 985, 231		50.00
51. 00	05100 RECOVERY ROOM	0	322, 175		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	O	337, 431		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 171, 844		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	1, 065, 024		55. 00
57.00	05700 CT SCAN	0	342, 146		57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	389, 440		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	369, 974		59. 00
60.00	06000 LABORATORY	0	721, 406		60. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	31, 960		64. 00
65. 00	06500 RESPI RATORY THERAPY	0	362, 723		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	299, 064		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	98, 690		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	31, 527		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	207, 501		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	228, 292		70.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	607, 490 842, 715		71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS		2, 925, 023		73. 00
	07400 RENAL DIALYSIS		31, 266		74. 00
	03330 ENDOSCOPY	0	33, 611		76.00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	802, 112		76. 01
	03950 NEUROPSYCHI ATRI C SERVI CES	o	14, 568		76. 02
	1 1	O	239, 157		76. 03
76.04	03952 WOUND CARE CENTER	0	127, 383		76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	0	1, 407, 907		76. 05
76.06	03953 I MAGI NG CENTERS	0	578, 225		76. 06
76. 07	03954 BREAST DIAGNOSTIC CENTER	0	153, 788		76. 07
76. 97	07697 CARDI AC REHABILI TATI ON	0	125, 520		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	122, 190		76. 98
	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC	0	0		88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89. 00
90.00	09000 CLINIC	0	1 757		90.00
	04950 DI ABETI C CARE CENTER	0	1, 757		90. 01
	04951 HEALTHY HEARTS CENTER	0	224, 867		90. 02
	04953 PALLIATIVE CARE	0	40, 349		90. 04
	04954 INFUSION CENTERS 04961 FAMILY PRACTICE AND MATERNITY CARE	0	17, 533 276, 470		90. 05 90. 12
	09100 EMERGENCY		1, 989, 015		90. 12
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1, 707, 013		92. 00
,2.00	10.2301 SECTION SECTION SIGNING! TAKE)	١	ı		1 /2.00

Health Financial Systems	COMMUNITY HOSPITAL OF	- INDIANA, INC.	In Lieu of Form CMS	S-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 150074	Period: Worksheet B From 01/01/2014 Part II To 12/31/2014 Date/Time P 5/27/2015 6	repared: :01 pm
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments 25.00	Total		
OTHER REIMBURSABLE COST CENTERS	20.00	20.00		
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		98. 00
SPECIAL PURPOSE COST CENTERS	-	<u> </u>		75.55
118.00 SUBTOTALS (SUM OF LINES 1-117)	O	27, 052, 984		118. 00
NONREI MBURSABLE COST CENTERS	<u> </u>			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTE	EN O	1, 195		190. 00
191. 00 19100 RESEARCH	o	91, 685		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	o	252, 080		192. 00
194.00 07950 HOME OFFICE	O	878, 334		194. 00
194.01 07951 OCCUPATIONAL HEALTH ONSITE SVCS	O	129, 216		194. 01
194. 02 07952 MEDCHECKS	O	16, 296		194. 02
194. 03 07953 SCHOOL BASED CLINICS	O	25, 220		194. 03
194.04 07954 OCCUPATIONAL HEALTH CLINICS	0	905		194. 04
194.05 07955 OTHER NONREIMBURSABLE COST CENTER	s 0	0		194. 05
194. 06 07956 PAVI LLI ONS	0	370, 179		194. 06
194. 07 07957 LI FECHECK	O	4, 034		194. 07
194.08 07958 GROUP HOMES AND MISC. N_R CTRS	0	128, 498		194. 08
194.09 07959 SURGERY CENTER EAST	0	741, 831		194. 09
200.00 Cross Foot Adjustments	o	505, 254		200. 00
201.00 Negative Cost Centers	o	0		201. 00
202.00 TOTAL (sum lines 118-201)	0	30, 197, 711		202. 00

	Financial Systems COMM LLOCATION - STATISTICAL BASIS	MUNITY HOSPITAL OF			<u> </u>	wof Form CMS-2 Worksheet B-1	
			1101146	F	rom 01/01/2014 o 12/31/2014		
		CAPITAL RELAT	FD COSTS			5/27/2015 6:0	1 pm
	Cost Center Description	BLDG & FIXT N	IVBLE EQUIP OLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4. 00	5A	5. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	862, 468	16, 333, 046				1. 00 2. 00
4. 00 5. 00 7. 00 8. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	12, 143 166, 501 127, 757 0	38, 644 10, 402, 721 226, 029 100	151, 370, 592 19, 910, 437 4, 979, 782	-63, 468, 085 0 0	11, 879, 701 820, 758	4. 00 5. 00 7. 00 8. 00
9. 00 10. 00 11. 00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A	17, 004 9, 420 22, 066	19, 993 15, 011 22, 696	1, 744, 196 536, 808 911, 181	0	1, 626, 220 2, 116, 625	10. 00 11. 00
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	13, 791 5, 666	51, 192 908, 577	6, 161, 030 2, 558, 318		.,	
15.00	01500 PHARMACY	9, 314	353, 491	4, 481, 008			
16. 00 17. 00	O1600 MEDICAL RECORDS & LIBRARY O1700 SOCIAL SERVICE	19, 205 6, 701	1, 144 842	4, 817, 863 3, 651, 270			
	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	000.000	_		18.00
19. 00 21. 00	01900 NONPHYSICIAN ANESTHETISTS 02100 I&R SERVICES-SALARY & FRINGES APPRVD	4, 453	7, 098	223, 084 1, 676, 924			
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0	0	592, 852	0	2, 611, 193	22. 00
23. 00 23. 01	02300 EMS TRAINING-ALLIED HEALTH 02301 RADIOLOGY SCHOOL-ALLIED HEALTH	4, 478 748	14, 243	423, 921 111, 636			1
23. 02	02302 PHARMACY RESIDENCY-ALLIED HEALTH	0	ō	87, 744	0	109, 233	23. 02
23. 03	02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH INPATIENT ROUTINE SERVICE COST CENTERS	0	0	C	0	0	23. 03
30. 00	03000 ADULTS & PEDIATRICS	147, 344	109, 266	22, 803, 498			
31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	11, 718 22, 494	100, 629 80, 806	2, 281, 639 3, 536, 929		1	
43. 00	04300 NURSERY	15, 527	56, 589	1, 597, 996			
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	36, 848	774, 912	2, 205, 035	0	6, 203, 060	50.00
51. 00	05100 RECOVERY ROOM	9, 843	2, 380	821, 148			1
52.00	05200 DELIVERY ROOM & LABOR ROOM	8, 400	30, 614	864, 508			
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	27, 070 19, 396	333, 044 251, 040	2, 019, 377 3, 138, 17 <i>6</i>			
57. 00	05700 CT SCAN	3, 369	137, 420	1, 135, 899			
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	5, 263 9, 317	222, 131 35, 850	486, 779 909, 929			
60.00	06000 LABORATORY	10, 248	2, 644	0.44, 000	0	8, 646, 311	60.00
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	590 3, 462	928 112, 210	246, 308 2, 506, 675			
66. 00	06600 PHYSI CAL THERAPY	4, 203	56, 145	2, 480, 562	. 0	2, 983, 818	66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	1, 097 349	18, 138 5, 775	831, 697 264, 787		1, 081, 231 344, 227	
69. 00	06900 ELECTROCARDI OLOGY	1, 410	43, 552	1, 605, 846		2, 384, 142	69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 558	120, 003 0	1, 103, 793 0		1, 148, 160 6, 366, 624	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	9, 236, 043	72. 00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	777	C	0	46, 025, 938 704, 143	
76. 00	03330 ENDOSCOPY	0	12, 934	285, 778		441, 181	76. 00
76. 01 76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 03950 NEUROPSYCHI ATRI C SERVI CES	4, 961	157, 092 1, 685	15, 035, 042 198, 905		10, 559, 482 261, 397	
76. 03	03951 LUTHERWOOD PARTNERSHIP	O	27, 920	5, 421, 363	0	4, 611, 305	76. 03
76. 04 76. 05	03952 WOUND CARE CENTER 03480 ONCOLOGY-CANCER CARE CENTER	3, 275 1, 657	12, 231 79, 828	180, 845 6, 698, 431		693, 639 28, 367, 210	1
76. 06	03953 I MAGI NG CENTERS	92	494, 762	1, 227, 130		3, 403, 564	
76. 07 76. 97	03954 BREAST DI AGNOSTIC CENTER 07697 CARDI AC REHABILITATION	2, 607 3, 912	0 4, 157	105, 563 282, 288			
76. 98	07698 HYPERBARIC OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	2, 239	8, 360	264, 585			
88. 00	08800 RURAL HEALTH CLINIC	0	0	C		l	
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0	l	89. 00 90. 00
90. 01	04950 DI ABETI C CARE CENTER	o o	86	C	0	40, 581	90. 01
90. 02 90. 04	04951 HEALTHY HEARTS CENTER 04953 PALLI ATI VE CARE	5, 437 799	1, 481 0	1, 123, 560 458, 589		1, 636, 711 408, 139	
90. 05	04954 INFUSION CENTERS	0	1, 170	257, 655		l	
	04961 FAMILY PRACTICE AND MATERNITY CARE 09100 EMERGENCY	380 31, 155	106, 188 500, 074	2, 760, 019 6, 611, 549			
71.00	O / 100 EMERGENOT	1 31, 133	300, 074	5, 611, 549		11, 140, 762	71.00

Health Financial Systems	COMMUNITY HOSPITAL OF I	NDI ANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2014	Worksheet B-1	
					Date/Time Prep 5/27/2015 6:0	
	CAPITAL RELATED	COSTS			3/2//2013 0.0	ı piii

NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 13, 533 0 191. 00 19100 RESEARCH 2, 320 588 484, 548 0 6 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 5, 522 2, 341 497, 615 0 2, 4		
COST Center Description CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET) MVBLE EQUIP (BENEFITS DEPARTMENT (GROSS SALARIES) MVBLE EQUIP (ACCUM. GROSS SALARIES) MVBLE EQUIP (BOSS	1	
Cost Center Description BLDG & FIXT (SQUARE FEET) MVBLE EQUIP (DOLLAR VALUE) BENEFITS BENE	15 6:0	I pm
Course feet Course feet		
Course feet Course feet	RATIVE	
CROSS SALARI ES		
SALARIES	COST)	
1.00 2.00 4.00 5A 5.0		
92. 00		
OTHER REIMBURSABLE COST CENTERS O O O O)	
98. 00		92. 00
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 816, 267 15, 964, 602 144, 619, 937 -63, 468, 085 262, 8		
118. 00 SUBTOTALS (SUM OF LINES 1-117) 816, 267 15, 964, 602 144, 619, 937 -63, 468, 085 262, 8 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 13, 533 0 191. 00 19100 RESEARCH 2, 320 588 484, 548 0 6 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 5, 522 2, 341 497, 615 0 2, 4	0	98. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 13, 533 0 191. 00 19100 RESEARCH 2, 320 588 484, 548 0 6 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 5, 522 2, 341 497, 615 0 2, 4		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 13, 533 0 191. 00 19100 RESEARCH 2, 320 588 484, 548 0 6 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 5, 522 2, 341 497, 615 0 2, 4	26, 658	118. 00
191. 00 19100 RESEARCH 2, 320 588 484, 548 0 6 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 5, 522 2, 341 497, 615 0 2, 4		
192.00 PHYSI CLANS' PRI VATE OFFI CES 5, 522 2, 341 497, 615 0 2, 4		190. 00
		191. 00
194. 00 07950 HOME_OFFLCE 33.307 0 0 0 6		192. 00
		194. 00
		194. 01
		194. 02
		194. 03
		194. 04
194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0		194. 05
		194. 06
		194. 07
		194. 08
		194. 09
200.00 Cross Foot Adjustments		200. 00
201.00 Negative Cost Centers		201. 00
	58, 085	202. 00
Part I)		
		203. 00
204.00 Cost to be allocated (per Wkst. B, Part II) 262,640 12,0	22, 919	204. 00
)41499	205. 00

Health Financial Systems In Lieu of Form CMS-2552-10 COMMUNITY HOSPITAL OF INDIANA, INC. COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 150074 Peri od: Worksheet B-1 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/27/2015 6:01 pm Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A LINEN SERVICE (SQUARE FEET) (TOTAL PATIENT (MEALS SERVED) PLANT (SQUARE FEET) (POUNDS OF DAYS) LAUNDRY) 10.00 7.00 9.00 11.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 556, 067 7 00 00800 LAUNDRY & LINEN SERVICE 211, 999 8.00 8.00 00900 HOUSEKEEPI NG 539, 063 9.00 17.004 9.00 10.00 01000 DI ETARY 9, 420 9, 420 61, 972 10.00 11.00 01100 CAFETERI A 22,066 22, 066 1, 393 11.00 01300 NURSING ADMINISTRATION 13, 791 13.00 13, 791 0 82 13.00 550 14.00 01400 CENTRAL SERVICES & SUPPLY 5,666 C 5,666 0 0 14.00 15.00 01500 PHARMACY 9, 314 9, 314 0 0 0 0 0 0 52 15.00 01600 MEDICAL RECORDS & LIBRARY 19, 205 0 19, 205 104 16.00 16.00 01700 SOCIAL SERVICE 17.00 6,701 C 6, 701 47 17.00 18.00 01850 OTHER GENERAL SERVICE (SPECIFY) 0 18.00 C 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 C 0 19.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 27 21 00 Ω 4 453 21 00 4 453 22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 0 \cap 22.00 02300 EMS TRAINING-ALLIED HEALTH 4, 478 0 4, 478 0 23.00 23.00 02301 RADI OLOGY SCHOOL-ALLI ED HEALTH 0 23. 01 748 0 748 23.01 1 02302 PHARMACY RESIDENCY-ALLIED HEALTH ol 23 02 23 02 0 C 0 1 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH 23.03 0 0 23.03 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 147 344 90, 998 147, 344 48 076 320 30.00 03100 INTENSIVE CARE UNIT 31.00 11, 718 13, 376 11, 718 3, 103 30 31.00 32.00 03200 CORONARY CARE UNIT 22, 494 22, 494 7, 361 54 32.00 26, 633 04300 NURSERY 8, 607 3, 432 43.00 15, 527 15, 527 24 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 36,848 8, 556 36,848 35 50.00 05100 RECOVERY ROOM 9,843 9, 843 0 10 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 8,400 4,656 8, 400 13 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 27, 070 3, 792 27,070 34 54 00 55.00 05500 RADI OLOGY-THERAPEUTI C 19, 396 4,507 19, 396 45 55.00 05700 CT SCAN 7,874 57.00 3, 369 3, 369 14 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 5, 263 2, 150 5. 263 7 58.00 05900 CARDIAC CATHETERIZATION 9, 317 59 00 12 59.00 993 9.317 60.00 06000 LABORATORY 10, 248 10, 248 0 60.00 64.00 06400 I NTRAVENOUS THERAPY 590 590 3 64.00 06500 RESPIRATORY THERAPY 35 65.00 3.462 0 3.462 65.00 06600 PHYSI CAL THERAPY 66.00 4.203 Ω 4.203 8 66.00 67.00 06700 OCCUPATIONAL THERAPY 1,097 0 1,097 12 67.00 68.00 06800 SPEECH PATHOLOGY 349 349 68.00 06900 ELECTROCARDI OLOGY 1.410 69.00 1.410 0 26 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 2,558 425 2,558 15 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 637 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 72.00 C 07300 DRUGS CHARGED TO PATIENTS 73.00 0 C 0 0 73.00 74.00 07400 RENAL DIALYSIS 0 0 74.00 03330 ENDOSCOPY 76.00 0 4 76.00 C 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.01 4.961 0 4.961 98 76.01 76.02 03950 NEUROPSYCHIATRIC SERVICES C C 3 76.02 76.03 03951 LUTHERWOOD PARTNERSHIP 0 0 76.03 03952 WOUND CARE CENTER 3, 275 3, 275 76.04 76.04 03480 ONCOLOGY-CANCER CARE CENTER 76.05 1,657 1,069 1,657 83 76.05 76.06 03953 I MAGING CENTERS 92 92 0 76.06 C 0 03954 BREAST DIAGNOSTIC CENTER 76.07 2,607 2,607 1 76.07 07697 CARDIAC REHABILITATION 3.912 0 3.912 76. 97 76.97 6 07698 HYPERBARI C OXYGEN THERAPY 76. 98 2, 239 0 2, 239 0 3 76. 98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 С 0 0 88.00 0 89 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 Ω 0 0 89 00 90.00 09000 CLI NI C 0 C 0 0 90.00 04950 DIABETIC CARE CENTER 0 0 0 0 90.01 90.01 C 04951 HEALTHY HEARTS CENTER 90.02 5, 437 834 5, 437 18 90.02 04953 PALLIATIVE CARE 90 04 90 04 799 799 C 4 90.05 04954 INFUSION CENTERS 0 C C 0 0 90.05 04961 FAMILY PRACTICE AND MATERNITY CARE 31 90.12 90.12 380 380 91.00 09100 EMERGENCY 31, 155 35, 824 31, 155 ol 101 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS

0

0

0

0

0 98.00

09850 OTHER REIMBURSABLE COST CENTERS

98.00

Heal th Finar	ncial Systems COMM	UNITY HOSPITAL	NITY HOSPITAL OF INDIANA, INC. In Lie			u of Form CMS-	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 01/01/2014 To 12/31/2014		narod:
					10 12/31/2014	5/27/2015 6:0	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE FEET)	(TOTAL PATIENT	(MEALS SERVED)	
		(SQUARE FEET)	(POUNDS OF		DAYS)		
		7.00	LAUNDRY)		10.00	44.00	
CDECL	AL DUDDOCE COCT CENTEDO	7. 00	8. 00	9. 00	10.00	11. 00	
118. 00	AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	509, 866	211, 481	492, 86	2 61, 972	1 205	118. 00
	IMBURSABLE COST CENTERS	309, 800	211, 401	492, 00	2 01, 972	1, 300	1110.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			0	1	190. 00
191, 00 19100	₽ Total Control Contr	2, 320	_	2, 32	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES		5, 522		5, 52		0	192. 00
194.00 07950 HOME OFFICE		33, 307	(33, 30	7 0	0	194. 00
194.01 07951 OCCUPATIONAL HEALTH ONSITE SVCS		3, 211	[c	3, 21	1 0	0	194. 01
194. 02 07952 MEDCHECKS		0	C		0 0		194. 02
194. 03 07953 SCHOOL BASED CLINICS		0	()	0 0		194. 03
194.04 07954 OCCUPATIONAL HEALTH CLINICS		0	C		0		194. 04
194.05 07955 OTHER NONREIMBURSABLE COST CENTERS		0	C		0		194. 05
194. 06 07956 PAVI LLI ONS		0			0		194. 06
194. 07 07957 LI FECHECK		0	[0		194. 07
194.08 07958 GROUP HOMES AND MISC. N_R CTRS 194.09 07959 SURGERY CENTER EAST		1, 841	518	1, 84	0		194. 08 194. 09
200. 00	Cross Foot Adjustments	0	1	ή '	J	U	200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	14, 482, 211	1, 000, 563	4, 464, 48	4 2, 305, 830	3, 337, 754	
202.00	Part 1)	14, 402, 211	1,000,500	7, 404, 40	2, 303, 030	3, 337, 734	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	26. 044004	4. 719659	8. 28193	4 37. 207610	2, 396. 090452	203. 00
204.00	Cost to be allocated (per Wkst. B,	3, 111, 500	34, 146	573, 86	6 322, 185	673, 269	204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	5. 595549	0. 161067	1. 06456	2 5. 198880	483. 323044	205. 00
	[11]						

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 150074 Peri od: Worksheet B-1 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/27/2015 6:01 pm Cost Center Description NURSI NG CENTRAL **PHARMACY** MEDI CAL SOCIAL SERVICE ADMI NI STRATI ON SERVICES & (COSTED RECORDS & **SUPPLY** REQUIS.) LI BRARY (TOTAL PATIENT (DI RECT NURS. (COSTED (GROSS DAYS) CHARGES) HRS.) REQUIS.) 17.00 13.00 14.00 15.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 523 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 30, 203, 052 14.00 15.00 01500 PHARMACY 0 0 189, 008 100 15.00 01600 MEDICAL RECORDS & LIBRARY 1, 236, 602, 543 23, 341 16.00 16 00 0 17.00 01700 SOCIAL SERVICE 27, 208 C 61, 972 17.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 00000 0 0 0 18.00 01900 NONPHYSICIAN ANESTHETISTS 0 19 00 0 19 00 0 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 70, 722 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 0 22.00 22.00 0 0 23.00 02300 EMS TRAINING-ALLIED HEALTH 39, 438 0 23.00 0 02301 RADI OLOGY SCHOOL-ALLI ED HEALTH 0 23 01 23 01 595 0 0 23.02 02302 PHARMACY RESIDENCY-ALLIED HEALTH C 0 0 0 23.02 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH 23.03 0 23.03 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 320 0 100, 113, 895 48 076 30.00 1,066,636 31.00 03100 INTENSIVE CARE UNIT 30 178, 893 0 10, 314, 706 3, 103 31.00 03200 CORONARY CARE UNIT 0 0 18, 449, 127 32.00 232, 685 7, 361 32.00 04300 NURSERY 43.00 24 243, 464 0 6, 464, 871 3, 432 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 35 965, 694 46, 021, 123 0 50.00 05100 RECOVERY ROOM 51.00 52, 185 0 8, 913, 551 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 13 131, 713 0 11, 949, 960 52.00 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 28, 819, 800 54.00 0 208.678 0 54.00 290, 807 05500 RADI OLOGY-THERAPEUTI C 0 53, 393, 097 55.00 55.00 0 57.00 05700 CT SCAN 00000 177, 156 53, 203, 056 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 14, 404, 861 58.00 58.00 78, 503 0 59.00 05900 CARDIAC CATHETERIZATION 5, 444 45, 241, 497 0 59.00 60.00 06000 LABORATORY 1, 237, 502 91, 292, 114 0 60.00 06400 INTRAVENOUS THERAPY 985, 315 64.00 2.892 0 64.00 06500 RESPIRATORY THERAPY 132, 199 0 65.00 18, 439, 795 Λ 65.00 66.00 06600 PHYSI CAL THERAPY 00000000 70, 793 15, 698, 773 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 27, 186 3, 595, 485 0 67.00 06800 SPEECH PATHOLOGY 1, 190, 716 8, 655 0 68.00 0 68.00 69.00 06900 ELECTROCARDI OLOGY 150, 656 0 24, 895, 410 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 45, 415 4, 056, 216 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 8, 834, 816 0 49, 881, 552 71.00 71.00 0 07200 I MPL. DEV. CHARGED TO PATIENTS n 72 00 12, 282, 310 39, 627, 355 0 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 100 316, 361, 038 0 73.00 07400 RENAL DIALYSIS 74.00 00000000 842 0 2, 280, 518 0 74.00 03330 ENDOSCOPY 0 76.00 8.555 76.00 2, 662, 117 0 0 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 496, 605 20, 951, 818 0 76.01 76.02 03950 NEUROPSYCHI ATRI C SERVI CES 5, 598 0 497, 097 0 76.02 03951 LUTHERWOOD PARTNERSHIP 76.03 382, 651 1, 831, 836 0 76.03 76 04 03952 WOUND CARE CENTER 0 3, 028, 986 76 04 10 430 0 03480 ONCOLOGY-CANCER CARE CENTER 0 76.05 840, 489 65, 230, 245 0 76.05 03953 I MAGING CENTERS 80, 338 15, 720, 788 76.06 76.06 0 0 0 76.07 03954 BREAST DIAGNOSTIC CENTER 82, 084 6, 444, 193 0 76.07 07697 CARDIAC REHABILITATION 0 76 97 1 543 134 76. 97 8,067 0 07698 HYPERBARI C OXYGEN THERAPY 76.98 89, 532 2, 628, 612 0 76.98 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 0 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89 00 C 0 90.00 09000 CLI NI C 0 C 0 0 0 90.00 04950 DIABETIC CARE CENTER 0 0 90.01 0 90.01 0 90.02 04951 HEALTHY HEARTS CENTER 108.885 0 3, 252, 632 0 90.02 90.04 04953 PALLIATIVE CARE 0 1, 412 0 320, 158 0 90.04 04954 INFUSION CENTERS 0 20, 923 90.05 1, 935, 184 90.05 90.12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 56, 422 0 4, 034, 846 0 90. 12 91.00 09100 EMERGENCY 91 00 101 869, 959 0 140, 927, 066 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00

Heal th Financi	al Systems COMM	UNITY HOSPITAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-255	52-10
COST ALLOCATIO	DN - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 01/01/2014 To 12/31/2014	Date/Time Prepai	rod:
					10 12/31/2014	5/27/2015 6:01 i	
Co	ost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	·	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUIS.)	LI BRARY	(TOTAL PATIENT	
		(DI RECT NURS.	(COSTED		(GROSS	DAYS)	
		HRS.)	REQUI S.)		CHARGES)		
		13.00	14. 00	15. 00	16. 00	17. 00	
	EIMBURSABLE COST CENTERS	1		T			
	THER REIMBURSABLE COST CENTERS	0	0		0 0	0 9	98. 00
	PURPOSE COST CENTERS	T ===1					
	UBTOTALS (SUM OF LINES 1-117)	523	29, 837, 393	10	00 1, 236, 602, 543	61, 972 11	8. 00
	BURSABLE COST CENTERS			Γ		0 40	
	FFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		90.00
191. 00 19100 RE		0	6, 271		0		91.00
	HYSICIANS' PRIVATE OFFICES	0	170, 441		0		92. 00
194. 00 07950 HC		0	14 007		0		94. 00
	CCUPATIONAL HEALTH ONSITE SVCS	0	14, 827		0		94. 01 94. 02
194. 02 07952 ME		0	10 507		0		94. 02 94. 03
	CHOOL BASED CLINICS	0	12, 507		0		94. 03 94. 04
	CCUPATIONAL HEALTH CLINICS	0	0		0		94. 04 94. 05
	THER NONREIMBURSABLE COST CENTERS	0	20.007		0		
194. 06 07956 PA		0	20, 887		0		94. 06
194. 07 07957 LI		0	377		0		94. 07
	ROUP HOMES AND MISC. N_R CTRS	0	140, 349		0		94. 08
	URGERY CENTER EAST	U U	Ü		U U		94. 09 00. 00
	ross Foot Adjustments						01. 00
	egative Cost Centers	(407 0/0	4 /10 /51	7 707 00	, , , , , , , , , , , , , , , , , , , ,		
	ost to be allocated (per Wkst. B, art I)	6, 427, 060	4, 619, 651	7, 787, 98	6, 272, 751	4, 886, 597 20	12.00
	artı) nit cost multiplier (Wkst. B, Part I)	12, 288. 833652	0 152052	77, 879. 82000	0. 005073	78. 851691 20	13 00
	ost to be allocated (per Wkst. B,	642, 642	1, 071, 896				
	ost to be allocated (per wkst. в, art II)	042, 042	1,0/1,090	021, 22	134, 203	330, 122 20	, -1 . 00
	nit cost multiplier (Wkst. B, Part	1, 228. 760994	0. 035490	8, 272. 20000	0. 000594	5. 756180 20	15 00
203.00		1, 220. 700774	0. 033470	0, 2, 2. 20000	3.000374	3. 730 100 20	.5. 00
1 1	· ,	1		1	ı	1	

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 150074 Peri od: Worksheet B-1 From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/27/2015 6:01 pm OTHER GENERAL INTERNS & RESIDENTS SERVI CE NONPHYSI CI AN SERVI CES-SALAR SERVI CES-OTHER EMS Cost Center Description (SPECIFY) TRAI NI NG-ALLI E (TIME SPENT) **ANESTHETISTS** Y & FRINGES PRGM COSTS (ASSI GNED (ASSI GNED (ASSI GNED D HEALTH TIME) TIME) TIME) (ASSI GNED TIME) 18.00 19. 00 21.00 22. 00 23. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10 00 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 18.00 19 00 01900 NONPHYSICIAN ANESTHETISTS 100 19 00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 53, 352 21.00 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 53, 352 22.00 0 02300 EMS TRAINING-ALLIED HEALTH 23.00 100 23.00 23.01 02301 RADI OLOGY SCHOOL-ALLI ED HEALTH 0 23.01 02302 PHARMACY RESIDENCY-ALLIED HEALTH 0 0 23.02 23.02 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH 23.03 23.03 0 INPATIENT ROUTINE SERVICE COST CENTERS 0 30.00 03000 ADULTS & PEDIATRICS 16, 048 16, 048 0 30.00 03100 INTENSIVE CARE UNIT 0 31.00 0 31.00 0 32.00 03200 CORONARY CARE UNIT 0 0 0 32.00 43.00 04300 NURSERY 0 0 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 100 0 0 0 50.00 0 05100 RECOVERY ROOM 0 0 51 00 0 51.00 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM C 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 000000000000000000000000000 0 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 55.00 0 0 05700 CT SCAN 0 57.00 0 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 06000 LABORATORY 0 0 60 00 0 60 00 06400 I NTRAVENOUS THERAPY 0 64.00 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 66.00 06700 OCCUPATIONAL THERAPY 0 Ω 67 00 67 00 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 06900 ELECTROCARDI OLOGY 0 0 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 07400 RENAL DIALYSIS 0 74.00 0 74.00 0 03330 ENDOSCOPY 0 76.00 0 0 76.00 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 76.01 03950 NEUROPSYCHI ATRI C SERVI CES 0 76 02 0 76.02 03951 LUTHERWOOD PARTNERSHIP Ω 0 76 03 0 76.03 76.04 03952 WOUND CARE CENTER 0 76.04 03480 ONCOLOGY-CANCER CARE CENTER 0 0 0 76.05 76.05 0 0 03953 I MAGING CENTERS 0 76.06 0 0 76.06 0 03954 BREAST DIAGNOSTIC CENTER 76.07 0 0 76.07 76. 97 07697 CARDIAC REHABILITATION 0 0 0 0 0 76.97 07698 HYPERBARIC OXYGEN THERAPY 0 76.98 0 0 0 0 76.98 OUTPATIENT SERVICE COST CENTERS 0 88 00 08800 RURAL HEALTH CLINIC C 0 0 88 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 89.00 000000 0 90.00 09000 CLI NI C 0 0 O 90.00 04950 DIABETIC CARE CENTER 90.01 0 0 0 90.01 90.02 04951 HEALTHY HEARTS CENTER 0 0 0 0 90.02 04953 PALLIATIVE CARE 0 0 0 0 90.04 04954 INFUSION CENTERS 0 90.05 90.05 0 04961 FAMILY PRACTICE AND MATERNITY CARE 0 90.12 90 12 32, 979 32, 979 Λ 91.00 09100 EMERGENCY 100 91.00

	IUNI TY HOSPI TAL				u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 01/01/2014	Worksheet B-1	
				o 12/31/2014	Date/Time Pre 5/27/2015 6:0	
	OTHER GENERAL SERVI CE		INTERNS &	RESI DENTS		
Cost Center Description	(SPECIFY)	NONPHYSICIAN	SERVI CES-SALAR	SERVI CES-OTHER	EMS	
	(TIME SPENT)	ANESTHETI STS	Y & FRINGES		TRAI NI NG-ALLI E	
		(ASSI GNED	(ASSI GNED	(ASSI GNED	D HEALTH	
		TIME)	TIME)	TIME)	(ASSI GNED	
					TIME)	
O2 O0 O0200 ODCEDVATION DEDC (NON DISTINCT DADT)	18. 00	19. 00	21.00	22. 00	23. 00	02.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
SPECIAL PURPOSE COST CENTERS	0		<u></u>	0	0	98.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	0	100	49, 027	49, 027	100	118. 00
NONREI MBURSABLE COST CENTERS		100	47,027	47,027	100	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0		d	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	4, 325	4, 325	0	192. 00
194.00 07950 HOME OFFICE	0	0	C	0	0	194. 00
194.01 07951 OCCUPATIONAL HEALTH ONSITE SVCS	0	0	C	0	0	194. 01
194. 02 07952 MEDCHECKS	0	0	C	0		194. 02
194. 03 07953 SCHOOL BASED CLINICS	0	0	O C	0		194. 03
194.04 07954 OCCUPATIONAL HEALTH CLINICS	0	0	C	0		194. 04
194. 05 07955 OTHER NONREIMBURSABLE COST CENTERS	0	0	C	0		194. 05
194. 06 07956 PAVI LLI ONS	0	0		0		194. 06
194. 07 07957 LI FECHECK	0	0		0		194. 07
194.08 07958 GROUP HOMES AND MISC. N_R CTRS 194.09 07959 SURGERY CENTER EAST	0	0		0		194. 08 194. 09
200.00 Cross Foot Adjustments	0	U	1	0	U	200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	0	34, 963	2, 407, 792	3, 200, 005	596, 540	
Part I)		34, 703	2,401,172	3, 200, 003	370, 340	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	349. 630000	45. 130304	59. 979101	5, 965. 400000	203. 00
204.00 Cost to be allocated (per Wkst. B,	0	1, 577	1			
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	15. 770000	3. 985268	2. 113773	1, 464. 890000	205. 00
11)			1			

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10 Peri od: From 01/01/2014 To 12/31/2014 Date/Ti me Prepared: 5/27/2015 6:01 pm Provi der CCN: 150074

						5/27/2015 6:0	1 pm
	Cost	t Center Description	RADI OLOGY	PHARMACY	PHARMACY		
			SCHOOL-ALLI ED				
			HEALTH	ED HEALTH	ALLI ED HEALTH		
			(ASSI GNED	(ASSI GNED	(ASSI GNED		
			TI ME) 23. 01	TI ME) 23. 02	TIME) 23.03		
	GENERAL SI	ERVICE COST CENTERS	25.01	25. 02	23.03		
1.00		REL COSTS-BLDG & FIXT					1.00
2.00	1 1	REL COSTS-MVBLE EQUIP					2.00
4.00	00400 EMPL	LOYEE BENEFITS DEPARTMENT					4. 00
5.00	00500 ADMI	INISTRATIVE & GENERAL					5. 00
7.00	00700 OPER	RATION OF PLANT					7. 00
8.00	00800 LAUN	NDRY & LINEN SERVICE					8. 00
9.00	00900 HOUS						9. 00
10. 00	01000 DI E1						10.00
11. 00	01100 CAFE						11. 00
13.00	1 1	SING ADMINISTRATION					13. 00
14.00	1 1	TRAL SERVICES & SUPPLY					14.00
15.00	01500 PHAF						15. 00
16. 00 17. 00	1 1	ICAL RECORDS & LIBRARY IAL SERVICE					16. 00 17. 00
18. 00	1 1	ER GENERAL SERVICE (SPECIFY)					18.00
19. 00		PHYSICIAN ANESTHETISTS					19. 00
21. 00	1 1	SERVICES-SALARY & FRINGES APPRVD					21. 00
22. 00	1 1	SERVI CES-OTHER PRGM COSTS APPRVD					22. 00
23. 00	1 1	TRAINING-ALLIED HEALTH					23. 00
23. 01	1 1	I OLOGY SCHOOL-ALLI ED HEALTH	100				23. 01
23. 02	1 1	RMACY RESIDENCY-ALLIED HEALTH	0	100			23. 02
23. 03	1 1	RMACY RESIDNECY-BTH ALLIED HEALTH	O	0			23. 03
		ROUTINE SERVICE COST CENTERS					1
30.00	03000 ADUL	LTS & PEDIATRICS	0	0	0		30. 00
31. 00		ENSIVE CARE UNIT	0	0			31. 00
32. 00	1 1	ONARY CARE UNIT	0	0			32. 00
43. 00	04300 NURS		0	0	0		43. 00
FO 00		SERVI CE COST CENTERS	ما				
50. 00 51. 00		RATING ROOM OVERY ROOM	0 0	0			50. 00 51. 00
52.00	1 1	IVERY ROOM & LABOR ROOM	ol Ol	0	1		52.00
54.00	1 1	I OLOGY-DI AGNOSTI C	100	0	1		54. 00
55. 00	1 1	I OLOGY-THERAPEUTI C	0	0			55. 00
57. 00	05700 CT S		0	0			57. 00
58. 00	1 1	NETIC RESONANCE IMAGING (MRI)	Ö	0	O		58. 00
59. 00	1 1	DI AC CATHETERI ZATI ON	O	0	0		59.00
60.00	06000 LABO		0	0	0		60.00
64.00	06400 I NTF	RAVENOUS THERAPY	0	0	0		64.00
65.00	06500 RESF	PI RATORY THERAPY	0	0	0		65. 00
66. 00		SI CAL THERAPY	0	0	0		66. 00
67. 00	1 1	UPATI ONAL THERAPY	0	0	0		67. 00
68. 00	1 1	ECH PATHOLOGY	0	0	0		68. 00
69. 00		CTROCARDI OLOGY	0	0	0		69. 00
70.00	1 1	CTROENCEPHALOGRAPHY	0	0	i		70.00
		ICAL SUPPLIES CHARGED TO PATIENTS L. DEV. CHARGED TO PATIENTS	U	0			71.00
72. 00 73. 00	1 1	GS CHARGED TO PATTENTS	0	0 100			72. 00 73. 00
		AL DIALYSIS	0	0	1		74.00
	03330 ENDO		0	0	1		76. 00
76. 01		CHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0		76. 01
		ROPSYCHI ATRI C SERVI CES	o	0	Ö		76. 02
76. 03		HERWOOD PARTNERSHIP	0	0	0		76. 03
76.04	03952 WOUN	ND CARE CENTER	o	0	0		76. 04
76. 05	03480 ONC	OLOGY-CANCER CARE CENTER	0	0	0		76. 05
	1 1	GING CENTERS	0	0	0		76. 06
76. 07	1 1	AST DIAGNOSTIC CENTER	0	0			76. 07
76. 97		DI AC REHABI LI TATI ON	0	0			76. 97
76. 98		ERBARI C OXYGEN THERAPY	0	0	0		76. 98
88. 00		T SERVICE COST CENTERS AL HEALTH CLINIC	ما	0	0		88. 00
89.00	1 1	ERALLY QUALIFIED HEALTH CENTER	0	0			89.00
90.00	09000 CLIN		0	0	0		90.00
90. 00		BETIC CARE CENTER	o n	0			90. 01
90. 02		LTHY HEARTS CENTER	o	0	l ő		90. 02
		LIATIVE CARE	o	0	o		90. 04
		USION CENTERS	ō	0	o		90. 05
		ILY PRACTICE AND MATERNITY CARE	o	0	0		90. 12
91. 00	09100 EMEF		0	0	0		91. 00
92. 00	09200 OBSE	ERVATION BEDS (NON-DISTINCT PART)					92.00

205. 00

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 150074 Peri od: Worksheet B-1 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/27/2015 6:01 pm Cost Center Description RADI OLOGY PHARMACY PHARMACY SCHOOL-ALLIED RESIDENCY-ALLI RESI DNECY-BTH HEALTH ED HEALTH ALLI ED HEALTH (ASSI GNED (ASSI GNED (ASSI GNED TIME) TIME) TIME) 23.01 23.02 23.03 OTHER REIMBURSABLE COST CENTERS 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 98.00 98.00 SPECIAL PURPOSE COST CENTERS 100 100 118.00 SUBTOTALS (SUM OF LINES 1-117) 0 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 0 0 191. 00 19100 RESEARCH 191. 00 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192. 00 194.00 07950 HOME OFFICE 0 0 194. 00 194. 01 07951 OCCUPATIONAL HEALTH ONSITE SVCS 194. 02 07952 MEDCHECKS 0 0 194. 01 0 194. 02 0 194. 03 07953 SCHOOL BASED CLINICS 0 194. 03

266, 240000

51.680000

0.000000

205.00

111)

Unit cost multiplier (Wkst. B, Part

Peri od:

COMPUTATION OF RATIO OF COSTS TO CHARGES

From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/27/2015 6:01 pm Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30 00 03000 ADULTS & PEDIATRICS 50.372.537 50. 372. 537 50, 372, 537 03100 INTENSIVE CARE UNIT 5, 382, 764 5, 382, 764 0 5, 382, 764 31.00 31.00 03200 CORONARY CARE UNIT o 32.00 8, 602, 646 8, 602, 646 8, 602, 646 32.00 04300 NURSERY 43.00 4, 664, 723 4, 664, 723 4, 664, 723 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 9, 797, 306 9, 797, 306 9, 797, 306 50.00 05100 RECOVERY ROOM 2, 028, 100 2, 028, 100 0 2, 028, 100 51.00 51.00 2, 351, 218 0 05200 DELIVERY ROOM & LABOR ROOM 2, 351, 218 52 00 2, 351, 218 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 5, 877, 236 5, 877, 236 0 5, 877, 236 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 9, 498, 490 9, 498, 490 0 0 0 9, 498, 490 55.00 57.00 05700 CT SCAN 3, 165, 732 3, 165, 732 3, 165, 732 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 1, 766, 265 1, 766, 265 1, 766, 265 58.00 59.00 05900 CARDIAC CATHETERIZATION 2, 538, 061 2, 538, 061 2, 538, 061 59.00 60.00 06000 LABORATORY 11, 544, 653 11, 544, 653 0 0 0 0 0 0 0 0 0 0 11, 544, 653 60.00 06400 INTRAVENOUS THERAPY 429, 806 429, 806 429, 806 64 00 64 00 4, 485, 232 65.00 06500 RESPIRATORY THERAPY 4, 485, 232 4, 485, 232 65.00 06600 PHYSI CAL THERAPY 3, 891, 398 3, 891, 398 3, 891, 398 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 1, 406, 904 1, 406, 904 1, 406, 904 67.00 06800 SPEECH PATHOLOGY 448 565 448 565 448, 565 68 00 68 00 69.00 06900 ELECTROCARDI OLOGY 3, 166, 476 3, 166, 476 3, 166, 476 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 552, 966 1, 552, 966 1, 552, 966 70.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 9 368 740 9 368 740 9 368 740 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 13, 339, 050 13, 339, 050 13, 339, 050 72.00 07300 DRUGS CHARGED TO PATIENTS 65, 636, 903 65, 636, 903 65, 636, 903 73.00 73.00 74.00 07400 RENAL DIALYSIS 870,099 870,099 0 870, 099 74.00 03330 ENDOSCOPY 76 00 562 229 562 229 562, 229 76 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.01 13, 460, 123 13, 460, 123 13, 460, 123 76.01 329, 228 03950 NEUROPSYCHI ATRI C SERVI CES 329, 228 329, 228 76.02 0 0 0 0 76.02 76.03 03951 LUTHERWOOD PARTNERSHIP 5, 689, 334 5, 689, 334 5, 689, 334 76.03 76.04 03952 WOUND CARE CENTER 984, 558 984, 558 984, 558 76 04 76.05 03480 ONCOLOGY-CANCER CARE CENTER 35, 301, 938 35, 301, 938 35, 301, 938 76.05 03953 I MAGING CENTERS 76.06 4, 244, 388 4, 244, 388 4, 244, 388 76.06 0 76.07 03954 BREAST DIAGNOSTIC CENTER 2.477.798 2, 477, 798 2, 477, 798 76.07 07697 CARDIAC REHABILITATION 666,076 76.97 666,076 666, 076 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 1, 613, 786 1, 613, 786 1, 613, 786 76.98 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0 88.00 88.00 0 08900 FEDERALLY QUALIFIED HEALTH CENTER O 89.00 0 Λ 89 00 90.00 09000 CLI NI C 0 0 0 90.00 0 90. 01 04950 DIABETIC CARE CENTER 49, 471 49, 471 49, 471 90.01 04951 HEALTHY HEARTS CENTER 2, 262, 120 90.02 2, 262, 120 2, 262, 120 90.02 0 90.04 04953 PALLIATIVE CARE 536, 401 536, 401 536, 401 90.04 90.05 04954 INFUSION CENTERS 430, 141 430, 141 0 430, 141 90.05 0 04961 FAMILY PRACTICE AND MATERNITY CARE 4, 592, 373 4, 592, 373 4, 592, 373 90.12 90.12 91.00 09100 EMERGENCY 17, 747, 620 17, 747, 620 17, 747, 620 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2, 894, 538 2, 894, 538 2, 894, 538 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 98.00 09850 OTHER REIMBURSABLE COST CENTERS O 98.00 316, 027, 992 200.00 Subtotal (see instructions) 0 316, 027, 992 0 316, 027, 992 200. 00 201.00 Less Observation Beds 2, 894, 538 2, 894, 538 2, 894, 538 201. 00 202.00 Total (see instructions) 313, 133, 454 313, 133, 454 313, 133, 454 202. 00

Peri od:

COMPUTATION OF RATIO OF COSTS TO CHARGES

Part I

From 01/01/2014 Date/Time Prepared: 12/31/2014 5/27/2015 6:01 pm Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 81, 442, 089 81, 442, 089 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 10, 314, 706 10, 314, 706 31.00 18, 449, 127 03200 CORONARY CARE UNIT 32.00 18, 449, 127 32.00 43.00 04300 NURSERY 6, 464, 871 6, 464, 871 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 35, 999, 349 10, 021, 774 46, 021, 123 0. 212887 0.000000 50.00 51 00 05100 RECOVERY ROOM 5, 720, 253 3, 193, 298 8, 913, 551 0. 227530 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 11, 949, 960 11, 949, 960 0.196755 0.000000 52.00 52.00 21, 667, 501 05400 RADI OLOGY-DI AGNOSTI C 28, 819, 800 0. 203930 54.00 7, 152, 299 0.000000 54 00 55.00 05500 RADI OLOGY-THERAPEUTI C 4, 128, 772 49, 264, 325 53, 393, 097 0.177897 0.000000 55.00 57 00 05700 CT SCAN 14, 627, 488 38, 575, 568 53, 203, 056 0.059503 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 14, 404, 861 58.00 4.069.877 10, 334, 984 0.122616 0.000000 58.00 05900 CARDIAC CATHETERIZATION 59.00 21, 955, 916 23, 285, 581 45, 241, 497 0.056100 0.000000 59.00 06000 LABORATORY 48, 173, 308 43, 118, 806 91, 292, 114 0. 126458 0.000000 60.00 60.00 64.00 06400 INTRAVENOUS THERAPY 963,600 21, 715 985, 315 0.000000 0.436212 64.00 06500 RESPIRATORY THERAPY 16, 139, 553 18, 439, 795 0 243237 65.00 2, 300, 242 0.000000 65 00 66.00 06600 PHYSI CAL THERAPY 2, 966, 404 12, 732, 369 15, 698, 773 0. 247879 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 3, 595, 485 67.00 1, 938, 481 1, 657, 004 0.391297 0.000000 67.00 06800 SPEECH PATHOLOGY 750, 581 1, 190, 716 0.000000 68.00 440, 135 0.376719 68.00 06900 ELECTROCARDI OLOGY 17, 749, 167 69.00 7, 146, 243 24, 895, 410 0.127191 0.000000 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 877, 896 3, 178, 320 4, 056, 216 0.382861 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 16, 274, 344 33, 607, 208 49, 881, 552 0.187820 0.000000 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72 00 21 756 066 17 871 289 39, 627, 355 0 000000 0.336612 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 53, 415, 245 262, 945, 793 316, 361, 038 0.207475 0.000000 73.00 74.00 07400 RENAL DIALYSIS 2, 280, 518 2, 280, 518 0.381536 0.000000 74.00 76.00 03330 ENDOSCOPY 1, 140, 580 1, 521, 537 2, 662, 117 0. 211196 0.000000 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 20, 951, 818 20, 951, 818 76.01 0.642432 0.000000 76.01 76.02 03950 NEUROPSYCHI ATRI C SERVI CES 9,919 487, 178 497, 097 0.662301 0.000000 76.02 76. 03 03951 LUTHERWOOD PARTNERSHIP 1, 831, 836 1, 831, 836 3.105810 0.000000 76.03 76 04 03952 WOUND CARE CENTER 51 460 2, 977, 526 3 028 986 0 325045 0 000000 76 04 03480 ONCOLOGY-CANCER CARE CENTER 76.05 2,077,927 63, 152, 318 65, 230, 245 0.541190 0.000000 76.05 03953 I MAGING CENTERS 83, 739 15, 637, 049 15, 720, 788 0.269986 0.000000 76.06 76.06 76.07 03954 BREAST DIAGNOSTIC CENTER 10, 157 6, 434, 036 6, 444, 193 0.384501 0.000000 76.07 07697 CARDIAC REHABILITATION 2.042 1, 541, 092 76 97 1, 543, 134 0.431638 0.000000 76 97 76.98 07698 HYPERBARIC OXYGEN THERAPY 7, 137 2, 621, 475 2, 628, 612 0.613931 0.000000 76.98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC Э 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89 00 89 00 0 90.00 09000 CLI NI C 0 0 0 0.000000 0.000000 90.00 90.01 04950 DIABETIC CARE CENTER 0 C 0.000000 0.000000 90.01 04951 HEALTHY HEARTS CENTER 27, 026 3, 252, 632 0.695474 90.02 3, 225, 606 0.000000 90.02 1.675426 90.04 04953 PALLIATIVE CARE 320, 158 320 158 0.000000 90 04 90.05 04954 INFUSION CENTERS 1, 935, 184 1, 935, 184 0.222274 0.000000 90.05 90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE 805, 513 3, 229, 333 4, 034, 846 1. 138178 0.000000 90.12 09100 EMERGENCY 28, 127, 841 112, 799, 225 140, 927, 066 0.000000 91.00 91.00 0.125935 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 1, 108, 990 17, 562, 816 18, 671, 806 0.155022 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 0.000000 98.00 200.00 Subtotal (see instructions) 428, 418, 989 808, 183, 554 1, 236, 602, 543 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 428, 418, 989 808, 183, 554 1, 236, 602, 543 202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | 5/27/2015 6:01 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 150074

		Title XVIII	Hospi tal	PPS	т рііі
Cost Center Description	PPS Inpatient	in the Attitude	noopi tui	1.0	
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
32. 00 03200 CORONARY CARE UNIT					32. 00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS	<u> </u>				
50. 00 05000 OPERATING ROOM	0. 212887				50. 00
51.00 05100 RECOVERY ROOM	0. 227530				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 196755				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 203930				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 177897				55. 00
57. 00 05700 CT SCAN	0. 059503				57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 122616				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 056100				59.00
60. 00 06000 LABORATORY	0. 126458				60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 436212				64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 430212				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 247879				66.00
					67.00
	0. 391297				
68. 00 06800 SPEECH PATHOLOGY	0. 376719				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 127191				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 382861				70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 187820				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 336612				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 207475				73. 00
74. 00 07400 RENAL DI ALYSI S	0. 381536				74. 00
76. 00 03330 ENDOSCOPY	0. 211196				76. 00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 642432				76. 01
76. 02 03950 NEUROPSYCHI ATRI C SERVI CES	0. 662301				76. 02
76. 03 03951 LUTHERWOOD PARTNERSHI P	3. 105810				76. 03
76.04 03952 WOUND CARE CENTER	0. 325045				76. 04
76. 05 03480 ONCOLOGY-CANCER CARE CENTER	0. 541190				76. 05
76.06 03953 I MAGI NG CENTERS	0. 269986				76. 06
76. 07 03954 BREAST DI AGNOSTIC CENTER	0. 384501				76. 07
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 431638				76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 613931				76. 98
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC					88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER					89. 00
90. 00 09000 CLI NI C	0. 000000				90.00
90. 01 04950 DIABETIC CARE CENTER	0. 000000				90. 01
90. 02 04951 HEALTHY HEARTS CENTER	0. 695474				90. 02
90. 04 04953 PALLI ATI VE CARE	1. 675426				90. 04
90. 05 04954 INFUSION CENTERS	0. 222274				90. 05
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE	1. 138178				90. 12
91. 00 09100 EMERGENCY	0. 125935				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 155022				92.00
OTHER REIMBURSABLE COST CENTERS	3. 100022				1 00
98. 00 09850 OTHER REI MBURSABLE COST CENTERS	0. 000000				98. 00
200.00 Subtotal (see instructions)	3. 333300				200.00
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)					202. 00
	1				1-32. 00

Peri od:

COMPUTATION OF RATIO OF COSTS TO CHARGES

From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/27/2015 6:01 pm Title XIX Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30 00 03000 ADULTS & PEDIATRICS 50.372.537 50. 372. 537 50, 372, 537 03100 INTENSIVE CARE UNIT 5, 382, 764 5, 382, 764 0 5, 382, 764 31.00 31.00 03200 CORONARY CARE UNIT o 32.00 8, 602, 646 8, 602, 646 8, 602, 646 32.00 04300 NURSERY 43.00 4, 664, 723 4, 664, 723 4, 664, 723 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 9, 797, 306 9, 797, 306 9, 797, 306 50.00 05100 RECOVERY ROOM 2, 028, 100 2, 028, 100 0 2, 028, 100 51.00 51.00 2, 351, 218 0 05200 DELIVERY ROOM & LABOR ROOM 2, 351, 218 52 00 2, 351, 218 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 5, 877, 236 5, 877, 236 0 5, 877, 236 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 9, 498, 490 9, 498, 490 0 0 0 9, 498, 490 55.00 57.00 05700 CT SCAN 3, 165, 732 3, 165, 732 3, 165, 732 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 1, 766, 265 1, 766, 265 1, 766, 265 58.00 59.00 05900 CARDIAC CATHETERIZATION 2, 538, 061 2, 538, 061 2, 538, 061 59.00 60.00 06000 LABORATORY 11, 544, 653 11, 544, 653 0 0 0 0 0 0 0 0 0 0 11, 544, 653 60.00 06400 INTRAVENOUS THERAPY 429, 806 429, 806 429, 806 64 00 64 00 4, 485, 232 65.00 06500 RESPIRATORY THERAPY 4, 485, 232 4, 485, 232 65.00 06600 PHYSI CAL THERAPY 3, 891, 398 3, 891, 398 3, 891, 398 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 1, 406, 904 1, 406, 904 1, 406, 904 67.00 06800 SPEECH PATHOLOGY 448 565 448 565 448, 565 68 00 68 00 69.00 06900 ELECTROCARDI OLOGY 3, 166, 476 3, 166, 476 3, 166, 476 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 552, 966 1, 552, 966 1, 552, 966 70.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 9 368 740 9 368 740 9 368 740 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 13, 339, 050 13, 339, 050 13, 339, 050 72.00 07300 DRUGS CHARGED TO PATIENTS 65, 636, 903 65, 636, 903 65, 636, 903 73.00 73.00 74.00 07400 RENAL DIALYSIS 870,099 870,099 0 870, 099 74.00 03330 ENDOSCOPY 76 00 562 229 562 229 562, 229 76 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.01 13, 460, 123 13, 460, 123 13, 460, 123 76.01 329, 228 03950 NEUROPSYCHI ATRI C SERVI CES 329, 228 329, 228 76.02 0 0 0 0 76.02 76.03 03951 LUTHERWOOD PARTNERSHIP 5, 689, 334 5, 689, 334 5, 689, 334 76.03 76.04 03952 WOUND CARE CENTER 984, 558 984, 558 984, 558 76 04 76.05 03480 ONCOLOGY-CANCER CARE CENTER 35, 301, 938 35, 301, 938 35, 301, 938 76.05 03953 I MAGING CENTERS 76.06 4, 244, 388 4, 244, 388 4, 244, 388 76.06 0 76.07 03954 BREAST DIAGNOSTIC CENTER 2.477.798 2, 477, 798 2, 477, 798 76.07 07697 CARDIAC REHABILITATION 666,076 76.97 666,076 666, 076 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 1, 613, 786 1, 613, 786 1, 613, 786 76.98 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0 88.00 88.00 0 08900 FEDERALLY QUALIFIED HEALTH CENTER O 89.00 0 Λ 89 00 90.00 09000 CLI NI C 0 0 0 90.00 0 90. 01 04950 DIABETIC CARE CENTER 49, 471 49, 471 49, 471 90.01 04951 HEALTHY HEARTS CENTER 2, 262, 120 90.02 2, 262, 120 2, 262, 120 90.02 0 90.04 04953 PALLIATIVE CARE 536, 401 536, 401 536, 401 90.04 90.05 04954 INFUSION CENTERS 430, 141 430, 141 0 430, 141 90.05 0 04961 FAMILY PRACTICE AND MATERNITY CARE 4, 592, 373 4, 592, 373 4, 592, 373 90.12 90.12 91.00 09100 EMERGENCY 17, 747, 620 17, 747, 620 17, 747, 620 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2, 894, 538 2, 894, 538 2, 894, 538 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 98.00 09850 OTHER REIMBURSABLE COST CENTERS O 98.00 316, 027, 992 200.00 Subtotal (see instructions) 0 316, 027, 992 0 316, 027, 992 200. 00 201.00 Less Observation Beds 2, 894, 538 2, 894, 538 2, 894, 538 201. 00 202.00 Total (see instructions) 313, 133, 454 313, 133, 454 313, 133, 454 202. 00

Peri od:

COMPUTATION OF RATIO OF COSTS TO CHARGES

Part I

From 01/01/2014 Date/Time Prepared: 12/31/2014 5/27/2015 6:01 pm Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 81, 442, 089 81, 442, 089 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 10, 314, 706 10, 314, 706 31.00 18, 449, 127 03200 CORONARY CARE UNIT 32.00 18, 449, 127 32.00 43.00 04300 NURSERY 6, 464, 871 6, 464, 871 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 35, 999, 349 10, 021, 774 46, 021, 123 0. 212887 0.000000 50.00 51 00 05100 RECOVERY ROOM 5, 720, 253 3, 193, 298 8, 913, 551 0. 227530 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 11, 949, 960 11, 949, 960 0.196755 0.000000 52.00 52.00 21, 667, 501 05400 RADI OLOGY-DI AGNOSTI C 28, 819, 800 0. 203930 54.00 7, 152, 299 0.000000 54 00 55.00 05500 RADI OLOGY-THERAPEUTI C 4, 128, 772 49, 264, 325 53, 393, 097 0.177897 0.000000 55.00 57 00 05700 CT SCAN 14, 627, 488 38, 575, 568 53, 203, 056 0.059503 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 14, 404, 861 58.00 4.069.877 10, 334, 984 0.122616 0.000000 58.00 05900 CARDIAC CATHETERIZATION 59.00 21, 955, 916 23, 285, 581 45, 241, 497 0.056100 0.000000 59.00 06000 LABORATORY 48, 173, 308 43, 118, 806 91, 292, 114 0. 126458 0.000000 60.00 60.00 64.00 06400 INTRAVENOUS THERAPY 963,600 21, 715 985, 315 0.000000 0.436212 64.00 06500 RESPIRATORY THERAPY 16, 139, 553 18, 439, 795 0 243237 65.00 2, 300, 242 0.000000 65 00 66.00 06600 PHYSI CAL THERAPY 2, 966, 404 12, 732, 369 15, 698, 773 0. 247879 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 3, 595, 485 67.00 1, 938, 481 1, 657, 004 0.391297 0.000000 67.00 06800 SPEECH PATHOLOGY 750, 581 1, 190, 716 0.000000 68.00 440, 135 0.376719 68.00 06900 ELECTROCARDI OLOGY 17, 749, 167 69.00 7, 146, 243 24, 895, 410 0.127191 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 877, 896 3, 178, 320 4, 056, 216 0.382861 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 16, 274, 344 33, 607, 208 49, 881, 552 0.187820 0.000000 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72 00 21 756 066 17 871 289 39, 627, 355 0 000000 0.336612 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 53, 415, 245 262, 945, 793 316, 361, 038 0.207475 0.000000 73.00 74.00 07400 RENAL DIALYSIS 2, 280, 518 2, 280, 518 0.381536 0.000000 74.00 76.00 03330 ENDOSCOPY 1, 140, 580 1, 521, 537 2, 662, 117 0. 211196 0.000000 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 20, 951, 818 20, 951, 818 76.01 0.642432 0.000000 76.01 76.02 03950 NEUROPSYCHI ATRI C SERVI CES 9,919 487, 178 497, 097 0.662301 0.000000 76.02 76. 03 03951 LUTHERWOOD PARTNERSHIP 1, 831, 836 1, 831, 836 3.105810 0.000000 76.03 76 04 03952 WOUND CARE CENTER 51 460 2, 977, 526 3 028 986 0 325045 0 000000 76 04 03480 ONCOLOGY-CANCER CARE CENTER 76.05 2,077,927 63, 152, 318 65, 230, 245 0.541190 0.000000 76.05 03953 I MAGING CENTERS 83, 739 15, 637, 049 15, 720, 788 0.269986 0.000000 76.06 76.06 76.07 03954 BREAST DIAGNOSTIC CENTER 10, 157 6, 434, 036 6, 444, 193 0.384501 0.000000 76.07 07697 CARDIAC REHABILITATION 2.042 1, 541, 092 76 97 1, 543, 134 0.431638 0.000000 76 97 0.000000 76.98 07698 HYPERBARIC OXYGEN THERAPY 7, 137 2, 621, 475 2, 628, 612 0.613931 76.98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC Э 0 0.000000 0.000000 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 89 00 89 00 0 0.000000 90.00 09000 CLI NI C 0 0 0 0.000000 0.000000 90.00 90.01 04950 DIABETIC CARE CENTER 0 0 0.000000 0.000000 90.01 04951 HEALTHY HEARTS CENTER 27, 026 3, 252, 632 90.02 3, 225, 606 0.695474 0.000000 90.02 1.675426 90.04 04953 PALLIATIVE CARE 320, 158 320 158 0.000000 90 04 90.05 04954 INFUSION CENTERS 1, 935, 184 1, 935, 184 0.222274 0.000000 90.05 90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE 805, 513 3, 229, 333 4, 034, 846 1. 138178 0.000000 90.12 09100 EMERGENCY 28, 127, 841 112, 799, 225 140, 927, 066 0.000000 91.00 91.00 0.125935 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 1, 108, 990 17, 562, 816 18, 671, 806 0.155022 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 0.000000 98.00 200.00 Subtotal (see instructions) 428, 418, 989 808, 183, 554 1, 236, 602, 543 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 428, 418, 989 808, 183, 554 1, 236, 602, 543 202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | 5/27/2015 6:01 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES COMMUNITY HOSPITAL OF INDIANA, INC.

Provider CCN: 150074

		Title XIX	Hospi tal	PPS	рш
Cost Center Description	PPS Inpatient	THE XIX	nospi tui	110	
oost conten beschiptron	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31. 00 03100 NTENSI VE CARE UNI T					31. 00
32. 00 03200 CORONARY CARE UNIT					32. 00
43. 00 04300 NURSERY					43. 00
ANCI LLARY SERVI CE COST CENTERS					43.00
	0.212007				EO 00
	0. 212887				50.00
51. 00 05100 RECOVERY ROOM	0. 227530				51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 196755				52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 203930			l l	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 177897			l l	55. 00
57.00 05700 CT SCAN	0. 059503			l l	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 122616				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 056100				59. 00
60. 00 06000 LABORATORY	0. 126458				60.00
64.00 06400 I NTRAVENOUS THERAPY	0. 436212				64.00
65. 00 06500 RESPIRATORY THERAPY	0. 243237				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 247879				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 391297				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 376719				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 127191				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 382861				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT				1	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 336612			1	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 207475				73. 00
74. 00 07400 RENAL DIALYSIS	0. 381536				74.00
76. 00 03330 ENDOSCOPY	0. 211196				76. 00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 642432				76. 01
76. 02 03950 NEUROPSYCHI ATRI C SERVI CES	0. 662301				76. 01
					76. 02
	3. 105810				76. 03 76. 04
	0. 325045				
76. 05 03480 ONCOLOGY-CANCER CARE CENTER	0. 541190				76. 05
76. 06 03953 I MAGI NG CENTERS	0. 269986				76.06
76. 07 03954 BREAST DI AGNOSTI C CENTER	0. 384501			l l	76. 07
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 431638				76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 613931				76. 98
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0. 000000				88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89. 00
90. 00 09000 CLI NI C	0. 000000				90.00
90. 01 04950 DIABETIC CARE CENTER	0. 000000				90. 01
90.02 04951 HEALTHY HEARTS CENTER	0. 695474				90. 02
90. 04 04953 PALLI ATI VE CARE	1. 675426				90.04
90. 05 04954 INFUSION CENTERS	0. 222274				90.05
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE	1. 138178				90. 12
91. 00 09100 EMERGENCY	0. 125935				91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART					92. 00
OTHER REIMBURSABLE COST CENTERS	,				00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0.000000				98. 00
200.00 Subtotal (see instructions)	3. 000000				200.00
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)					202.00
202.00 [10101 (366 111311 0611 0113)	į l			l ²	_02.00

Heal th Financial Systems COMMUNITY HOSPIT CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY In Lieu of Form CMS-2552-10 | Peri od: | Worksheet C | From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared: Provi der CCN: 150074

				10	J 12/31/2014	5/27/2015 6:0	
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
		(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reduction	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 SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	9, 797, 306			0		50. 00
51. 00	05100 RECOVERY ROOM	2, 028, 100			0		51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 351, 218			0	1	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 877, 236			0		54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	9, 498, 490			0		55. 00
57. 00	05700 CT SCAN	3, 165, 732			0		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 766, 265			0		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 538, 061	369, 974		0	1	59. 00
60.00	06000 LABORATORY	11, 544, 653			0		60. 00
64. 00	06400 I NTRAVENOUS THERAPY	429, 806			0		64. 00
65.00	06500 RESPI RATORY THERAPY	4, 485, 232			0		65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 891, 398			0		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 406, 904			0		67. 00
68. 00	06800 SPEECH PATHOLOGY	448, 565			0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	3, 166, 476	207, 501	2, 958, 975	0		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 552, 966	228, 292	1, 324, 674	0		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 368, 740	607, 490	8, 761, 250	0		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	13, 339, 050	842, 715	12, 496, 335	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	65, 636, 903	2, 925, 023	62, 711, 880	0	0	73. 00
74.00	07400 RENAL DIALYSIS	870, 099	31, 266	838, 833	0	0	74. 00
76.00	03330 ENDOSCOPY	562, 229	33, 611	528, 618	0	0	76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	13, 460, 123	802, 112	12, 658, 011	0		76. 01
76. 02	03950 NEUROPSYCHI ATRI C SERVI CES	329, 228	14, 568	314, 660	0	0	76. 02
76. 03	03951 LUTHERWOOD PARTNERSHIP	5, 689, 334	239, 157	5, 450, 177	0	0	76. 03
76. 04	03952 WOUND CARE CENTER	984, 558	127, 383	857, 175	0	0	76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	35, 301, 938	1, 407, 907		0	0	76. 05
76. 06	03953 I MAGI NG CENTERS	4, 244, 388	578, 225	3, 666, 163	0	1	76. 06
76. 07	03954 BREAST DI AGNOSTI C CENTER	2, 477, 798	153, 788	2, 324, 010	0		76. 07
76. 97	07697 CARDI AC REHABI LI TATI ON	666, 076			0		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	1, 613, 786	122, 190	1, 491, 596	0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS	T	T			Г	
88. 00	08800 RURAL HEALTH CLINIC	0	C		0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	1	0		89. 00
90.00	09000 CLI NI C	0	C	`l	0		90. 00
90. 01	04950 DI ABETI C CARE CENTER	49, 471	1, 757		0		90. 01
90. 02	04951 HEALTHY HEARTS CENTER	2, 262, 120			0		90. 02
90. 04	04953 PALLIATIVE CARE	536, 401	40, 349		0	1	90. 04
90. 05	04954 I NFUSI ON CENTERS	430, 141	17, 533	·	0	1	90. 05
90. 12	04961 FAMILY PRACTICE AND MATERNITY CARE	4, 592, 373			0	_	90. 12
91. 00	09100 EMERGENCY	17, 747, 620			0		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 894, 538	358, 795	2, 535, 743	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS	_	-	.11		_	
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0		1	0		98. 00
200.00		247, 005, 322			0		200. 00
201.00		2, 894, 538			0		201. 00
202.00	Total (line 200 minus line 201)	244, 110, 784	18, 525, 374	225, 585, 410	0	J 0	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared: | 5/27/2015 6:01 pm Health Financial Systems COMMUNITY HOSPIT CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF Provi der CCN: 150074 REDUCTIONS FOR MEDICALD ONLY

						5/27/2015 6: 01	l pm
				le XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and	(Worksheet C,	Cost to Charge			
		Operating Cost	Part I, column	Ratio (col. 6			
		Reduction	8)	/ col. 7)			
		6. 00	7. 00	8.00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	9, 797, 306	46, 021, 123	0. 212887			50.00
51. 00	05100 RECOVERY ROOM	2, 028, 100					51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 351, 218					52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C						54. 00
		5, 877, 236					55. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	9, 498, 490					
57. 00	05700 CT SCAN	3, 165, 732					57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 766, 265					58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 538, 061	45, 241, 497				59. 00
60.00	06000 LABORATORY	11, 544, 653					60.00
64. 00	06400 I NTRAVENOUS THERAPY	429, 806					64. 00
65. 00	06500 RESPI RATORY THERAPY	4, 485, 232		•			65.00
66.00	06600 PHYSI CAL THERAPY	3, 891, 398					66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 406, 904	3, 595, 485	0. 391297			67.00
68.00	06800 SPEECH PATHOLOGY	448, 565	1, 190, 716	0. 376719			68.00
69.00	06900 ELECTROCARDI OLOGY	3, 166, 476	24, 895, 410	0. 127191			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 552, 966	4, 056, 216	0. 382861			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 368, 740	49, 881, 552	0. 187820			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	13, 339, 050					72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	65, 636, 903					73. 00
74. 00	07400 RENAL DIALYSIS	870, 099					74. 00
76. 00	03330 ENDOSCOPY	562, 229					76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	13, 460, 123					76. 01
76. 02	03950 NEUROPSYCHI ATRI C SERVI CES	329, 228					76. 02
76. 03	03951 LUTHERWOOD PARTNERSHIP	5, 689, 334					76. 03
76. 04	03952 WOUND CARE CENTER	984, 558					76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	35, 301, 938					76. 05
76. 06	03953 I MAGI NG CENTERS	4, 244, 388					76. 06
76. 07	03954 BREAST DIAGNOSTIC CENTER	2, 477, 798					76. 07
76. 97	07697 CARDI AC REHABI LI TATI ON	666, 076					76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	1, 613, 786					76. 98
70. 70	OUTPATIENT SERVICE COST CENTERS	1,013,700	2,020,012	0.013731			70. 70
88. 00	08800 RURAL HEALTH CLINIC	1 0	0	0.000000			88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		1	•			89. 00
90.00	09000 CLINIC						90.00
90.00	04950 DI ABETI C CARE CENTER	49, 471					90. 00
		•	1				
90. 02	04951 HEALTHY HEARTS CENTER	2, 262, 120					90. 02
90. 04	04953 PALLI ATI VE CARE	536, 401	320, 158				90. 04
90. 05	04954 I NFUSI ON CENTERS	430, 141	1, 935, 184				90. 05
90. 12	04961 FAMILY PRACTICE AND MATERNITY CARE	4, 592, 373					90. 12
91.00	09100 EMERGENCY	17, 747, 620					91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 894, 538	18, 671, 806	0. 155022			92.00
	OTHER REIMBURSABLE COST CENTERS				1		
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0					98. 00
200.00	1 1		1, 119, 931, 750				200. 00
201.00	l l	2, 894, 538					201. 00
202.00	Total (line 200 minus line 201)	244, 110, 784	1, 119, 931, 750				202. 00

Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. In Lieu of Form CMS-29						2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAP	TAL COSTS	Provi der		Peri od:	Worksheet D	
				From 01/01/2014 To 12/31/2014		nared·
					5/27/2015 6:0	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		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	6, 244, 000		-, ,			1
31.00 INTENSIVE CARE UNIT	626, 670		626, 670			
32. 00 CORONARY CARE UNIT	1, 004, 947	l .	1, 004, 94			
43. 00 NURSERY	651, 993		651, 993	3, 432	189. 97	43.00
200.00 Total (lines 30-199)	8, 527, 610	8, 527, 6		64, 903		200.00
Cost Center Description	Inpatient	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	16, 670	2, 040, 575				30.00
31.00 INTENSIVE CARE UNIT	1, 215	245, 381				31. 00
32.00 CORONARY CARE UNIT	3, 334	455, 158				32. 00
43. 00 NURSERY	0	0)			43.00
200.00 Total (lines 30-199)	21, 219	2, 741, 114				200. 00

Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. In Lieu of Form CMS-2552-1								
	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS		Provi der	CCN: 150074	Peri od:	Worksheet D	
						From 01/01/2014	Part II	
						To 12/31/2014	Date/Time Pre	pared:
					201111		5/27/2015 6:0	1 pm
					e XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal			Ratio of Cos		Capital Costs	
		Related Cost				Program	(column 3 x	
		(from Wkst. B,	Part	•	(col . 1 ÷ col	. Charges	column 4)	
		Part II, col.		8)	2)			
		26)						
	T	1.00		2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS				r			
50.00	05000 OPERATING ROOM	1, 985, 231		6, 021, 123				50. 00
51.00	05100 RECOVERY ROOM	322, 175		8, 913, 551			20, 974	
52.00	05200 DELIVERY ROOM & LABOR ROOM	337, 431		1, 949, 960			0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 171, 844	2	8, 819, 800	0. 04066	3, 174, 139	129, 064	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 065, 024	5	3, 393, 097	0. 01994	1, 932, 964	38, 557	55. 00
57.00	05700 CT SCAN	342, 146	5	3, 203, 056	0.00643	6, 156, 787	39, 594	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	389, 440	1	4, 404, 861	0. 02703	1, 658, 190	44, 829	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	369, 974	4	5, 241, 497	0.00817	7, 014, 053	57, 361	59. 00
60.00	06000 LABORATORY	721, 406		1, 292, 114				60.00
64. 00	06400 I NTRAVENOUS THERAPY	31, 960		985, 315				1
65. 00	06500 RESPI RATORY THERAPY	362, 723		8, 439, 795				65. 00
66. 00	06600 PHYSI CAL THERAPY	299, 064		5, 698, 773			•	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	98, 690	1	3, 595, 773 3, 595, 485		· · · · ·	•	67. 00
	06800 SPEECH PATHOLOGY		1				•	•
68. 00		31, 527		1, 190, 716		· ·		68. 00
69.00	06900 ELECTROCARDI OLOGY	207, 501		4, 895, 410		· · · · ·		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	228, 292		4, 056, 216				70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	607, 490		9, 881, 552				71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	842, 715		9, 627, 355				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 925, 023		6, 361, 038				73. 00
74.00	07400 RENAL DIALYSIS	31, 266		2, 280, 518		1, 357, 363		74. 00
76. 00	03330 ENDOSCOPY	33, 611		2, 662, 117			7, 802	76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	802, 112	2	0, 951, 818	0. 03828	34 0	0	76. 01
76. 02	03950 NEUROPSYCHI ATRI C SERVI CES	14, 568		497, 097	0. 02930	06	0	76. 02
76. 03	03951 LUTHERWOOD PARTNERSHIP	239, 157		1, 831, 836	0. 13055	56 0	0	76. 03
76.04	03952 WOUND CARE CENTER	127, 383		3, 028, 986	0. 04205	16, 471	693	76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	1, 407, 907	6	5, 230, 245	0. 02158	55, 862	1, 206	76. 05
76. 06	03953 I MAGI NG CENTERS	578, 225		5, 720, 788				76. 06
76. 07	03954 BREAST DIAGNOSTIC CENTER	153, 788		6, 444, 193				76. 07
76. 97	07697 CARDI AC REHABI LI TATI ON	125, 520		1, 543, 134				76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	122, 190		2, 628, 612	•			76. 98
70.70	OUTPATIENT SERVICE COST CENTERS	122/170		2,020,012	0.0.0.	77.07	002	70.70
88. 00	08800 RURAL HEALTH CLINIC	1 0		0	0.00000	00 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		1	0				89. 00
90.00	09000 CLINIC	0	1	0				90.00
90. 00	04950 DI ABETI C CARE CENTER	1, 757		0				90.00
90. 01				-			1	90.01
	04951 HEALTHY HEARTS CENTER	224, 867		3, 252, 632			•	
90. 04	04953 PALLIATIVE CARE	40, 349		320, 158				90. 04
90. 05	04954 I NFUSI ON CENTERS	17, 533		1, 935, 184			0	90. 05
90. 12	04961 FAMILY PRACTICE AND MATERNITY CARE	276, 470		4, 034, 846			0	90. 12
91. 00	09100 EMERGENCY	1, 989, 015		0, 927, 066				91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	358, 795	1	8, 671, 806	0. 0192	16 492, 880	9, 471	92. 00
	OTHER REIMBURSABLE COST CENTERS							
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	l .	0			1	98. 00
200.00	Total (lines 50-199)	18, 884, 169	1, 11	9, 931, 750		118, 987, 012	2, 095, 570	200. 00

Health Financial Systems COMM	NUNITY HOSPITAL	OF INDIANA, IN	NC.	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provi der		Peri od:	Worksheet D	
				From 01/01/2014		
				Γο 12/31/2014	Date/Time Pre 5/27/2015 6:0	
		Ti tl	e XVIII	Hospi tal	PPS	ТРШ
Cost Center Description	Nursing School	Allied Health		Swi ng-Bed	Total Costs	
· ·		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos-	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	(0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0) (O	0	31.00
32. 00 03200 CORONARY CARE UNIT	0	0) (O	0	32.00
43. 00 04300 NURSERY	0	0) ()	0	43.00
200.00 Total (lines 30-199)	0	0) (O	0	200. 00
Cost Center Description	Total Patient	Per Diem (col.	I npati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	51, 007					30.00
31.00 03100 INTENSIVE CARE UNIT	3, 103	l .				31. 00
32. 00 03200 CORONARY CARE UNIT	7, 361	l .		4 0		32. 00
43. 00 04300 NURSERY	3, 432	0.00) (0		43. 00
200.00 Total (lines 30-199)	64, 903		21, 21	9 0	,	200. 00

 Heal th Financial
 Systems
 COMMUNITY HOSPITAL O

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provi der CCN: 150074 THROUGH COSTS

						5/27/2015 6:0	1 pm
				e XVIII	Hospi tal	PPS	
	Cost Center Description		Nursing School	Allied Health		Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	9	
		1.00	0.00			4)	
	ANGLEL ADV. CEDVI CE. COCT. CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
50. 00	ANCILLARY SERVICE COST CENTERS	1 0		\		0	
	05000 OPERATING ROOM		1			Ŭ	50.00
51. 00	05100 RECOVERY ROOM	0			-	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0		1	ή	0	52.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0		227, 591	0	227, 591 0	54. 00 55. 00
55. 00 57. 00		0				0	55.00
	05700 CT SCAN	0				0	1
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0				0	58.00
60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0				0	59. 00 60. 00
64. 00		0				0	
65. 00	06400 I NTRAVENOUS THERAPY	0				0	64. 00 65. 00
66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0				0	66. 00
67. 00	06700 OCCUPATIONAL THERAPY	0				0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0				0	68. 00
	06900 ELECTROCARDI OLOGY	0				0	69. 00
	07000 ELECTROENCEPHALOGRAPHY					0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS					0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS					0	72.00
	07300 DRUGS CHARGED TO PATIENTS			135, 559		135, 559	73. 00
	07400 RENAL DIALYSIS			133, 339		133, 334	74.00
76. 00	03330 ENDOSCOPY					0	76. 00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES					0	76. 00
	03950 NEUROPSYCHI ATRI C SERVI CES	0				0	76. 02
	03951 LUTHERWOOD PARTNERSHIP	0				0	76. 02
	03952 WOUND CARE CENTER	0				0	76. 04
	03480 ONCOLOGY-CANCER CARE CENTER	0				0	76. 05
	03953 I MAGI NG CENTERS	0				0	76. 06
	03954 BREAST DIAGNOSTIC CENTER	0				0	76. 07
	07697 CARDI AC REHABI LI TATI ON		1	1		0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0		1	0	_	76. 98
70.70	OUTPATIENT SERVICE COST CENTERS	<u> </u>		,	<u>, </u>		70.70
88. 00	08800 RURAL HEALTH CLINIC	0			0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1		0	0	89. 00
90. 00	09000 CLINIC	0	1		0	0	90.00
90. 01	04950 DIABETIC CARE CENTER	0	1		0	0	90. 01
90. 02	04951 HEALTHY HEARTS CENTER	0			0	0	90. 02
	04953 PALLI ATI VE CARE	0			0	0	90. 04
	04954 INFUSION CENTERS	0			0	0	90. 05
	04961 FAMILY PRACTICE AND MATERNITY CARE	0			0	0	90. 12
91. 00	09100 EMERGENCY	0		596, 540	0	596, 540	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						1
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	C) (0	0	98. 00
200.00	Total (lines 50-199)	0	C	959, 690	0	959, 690	200. 00
		•		•	•		-

					10 12/31/2014	5/27/2015 6:0		
				Ti tl	e XVIII	Hospi tal	PPS	· p
	Cost Center Description	Total	Total		Ratio of Cost		Inpati ent	
	'	Outpati ent		Wkst. C,	to Charges	Ratio of Cost	Program	
		Cost (sum of	Part	I, col.	(col. 5 ÷ col.	to Charges	Charges	
		col . 2, 3 and		8)	7)	(col. 6 ÷ col.		
		4)				7)		
		6. 00	7	'. 00	8. 00	9. 00	10. 00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	1	, 021, 123	•		16, 242, 706	50. 00
51. 00	05100 RECOVERY ROOM	0	1	3, 913, 551	•		580, 294	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		, 949, 960			0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	227, 591	1	8, 819, 800			3, 174, 139	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	1	3, 393, 097			1, 932, 964	55. 00
57. 00	05700 CT SCAN	0		3, 203, 056			6, 156, 787	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0		, 404, 861			1, 658, 190	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	1	5, 241, 497	•		7, 014, 053	59. 00
60. 00	06000 LABORATORY	0	91	, 292, 114			19, 292, 612	60. 00
64. 00	06400 I NTRAVENOUS THERAPY	0		985, 315			404, 682	64. 00
65.00	06500 RESPI RATORY THERAPY	0	1	3, 439, 795			6, 592, 596	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	1	, 698, 773			1, 452, 658	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	1	8, 595, 485			963, 351	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	1	, 190, 716			223, 660	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		, 895, 410			3, 263, 240	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		, 056, 216			432, 107	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		, 881, 552			5, 991, 694	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	1	, 627, 355			8, 863, 097	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	135, 559	1	, 361, 038			19, 948, 054	73. 00
74.00	07400 RENAL DI ALYSI S	0	1	2, 280, 518			1, 357, 363	74. 00
76. 00	03330 ENDOSCOPY	0		2, 662, 117			617, 935	76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	20), 951, 818			0	76. 01
76. 02	03950 NEUROPSYCHI ATRI C SERVI CES	0		497, 097			0	76. 02
76. 03	03951 LUTHERWOOD PARTNERSHIP	0	ı	, 831, 836	•		0	76. 03
76. 04	03952 WOUND CARE CENTER	0		3, 028, 986			16, 471	76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	0		, 230, 245			55, 862	76. 05
76. 06	03953 I MAGI NG CENTERS	0	1	, 720, 788	•		19, 657	76. 06
76. 07	03954 BREAST DI AGNOSTI C CENTER	0		, 444, 193			798	76. 07
76. 97	07697 CARDI AC REHABI LI TATI ON	0		, 543, 134			476	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0) 2	2, 628, 612	0. 000000	0. 000000	7, 137	76. 98
	OUTPATIENT SERVICE COST CENTERS	1						
88. 00	08800 RURAL HEALTH CLINIC	0)	0			0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0)	0			0	89. 00
90.00	09000 CLINIC	0)	0			0	90. 00
90. 01	04950 DI ABETI C CARE CENTER	0] _	0			0	90. 01
90. 02	04951 HEALTHY HEARTS CENTER	0] 3	3, 252, 632			5, 243	90. 02
90. 04	04953 PALLI ATI VE CARE	0]	320, 158			0	90. 04
90. 05	04954 INFUSION CENTERS	0	1	, 935, 184			0	90. 05
90. 12	04961 FAMILY PRACTICE AND MATERNITY CARE	0		, 034, 846			0	90. 12
91. 00	09100 EMERGENCY	596, 540	1	, 927, 066			12, 226, 306	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0) 18	<u>8, 671, 806</u>	0. 000000	0.000000	492, 880	92. 00
	OTHER REIMBURSABLE COST CENTERS	-				0.005	_	
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	1	0		0. 000000	0	98. 00
200.00	Total (lines 50-199)	959, 690	լ 1, 119	, 931, 750	1		118, 987, 012	200.00

Health Financial Systems COMMUNITY HOSPITAL OF APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Peri od: Worksheet D From 01/01/2014 Part IV To 12/31/2014 Date/Time Prepared: 5/27/2015 6:01 pm Provi der CCN: 150074 THROUGH COSTS

						5/27/2015 6:01 pm
			Ti tl	e XVIII	Hospi tal	PPS
	Cost Center Description	I npati ent	Outpati ent	Outpati ent		
		Program	Program	Program		
		Pass-Through	Charges	Pass-Through		
		Costs (col. 8	5	Costs (col. 9		
		x col . 10)		x col . 12)		
		11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS	11.00	12.00	13.00		
50. 00	05000 OPERATING ROOM		3, 996, 346	ol		50, 00
51. 00	05100 RECOVERY ROOM			1		51. 00
	1 1	0	625, 619	- 1		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		_		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	25, 066	4, 651, 777			54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	16, 367, 283	1		55. 00
57. 00	05700 CT SCAN	0	10, 064, 355	0		57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	3, 058, 057	0		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	9, 614, 222	0		59.00
60.00	06000 LABORATORY	0	10, 957, 636	0		60.00
64.00	06400 I NTRAVENOUS THERAPY	o	312	0		64.00
65.00	06500 RESPIRATORY THERAPY	ol	684, 694	lo		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	486			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		0	l .		67. 00
68. 00	06800 SPEECH PATHOLOGY		0	_		68. 00
69. 00	06900 ELECTROCARDI OLOGY		-	_		69. 00
		0	7, 341, 771			
70.00	07000 ELECTROENCEPHALOGRAPHY	0	937, 902	1		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 083, 938			71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	3, 032, 378	1		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	8, 538	93, 592, 239			73. 00
74. 00	07400 RENAL DIALYSIS	0	0	_		74.00
76.00	03330 ENDOSCOPY	0	726, 648	1		76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	1, 544, 828	0		76. 01
76. 02	03950 NEUROPSYCHI ATRI C SERVI CES	0	64, 476	0		76. 02
76. 03	03951 LUTHERWOOD PARTNERSHIP	0	0	0		76. 03
76.04	03952 WOUND CARE CENTER	0	1, 628, 103	0		76. 04
76.05	03480 ONCOLOGY-CANCER CARE CENTER	o	20, 622, 718	0		76. 05
76.06	03953 I MAGI NG CENTERS	o	3, 656, 687			76. 06
76. 07	03954 BREAST DIAGNOSTIC CENTER	ol	1, 143, 516	1		76. 07
76. 97	07697 CARDI AC REHABI LI TATI ON	0	731, 145			76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	870, 714	1		76. 98
	OUTPATIENT SERVICE COST CENTERS	-1	2.2,	-1		
88. 00	08800 RURAL HEALTH CLINIC	n ol	0	O		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	- 1		89. 00
90.00	09000 CLINIC		0	- 1		90.00
90.00	04950 DI ABETI C CARE CENTER		0			90.00
	1 1		1 (10 001	1		
90. 02	04951 HEALTHY HEARTS CENTER		1, 618, 001			90. 02
90. 04	04953 PALLIATIVE CARE	0	054 000	_		90. 04
90. 05	04954 I NFUSI ON CENTERS	0	851, 303	1		90. 05
90. 12	04961 FAMILY PRACTICE AND MATERNITY CARE	0	0			90. 12
91. 00	09100 EMERGENCY	51, 754	17, 722, 637			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 741, 705	0		92. 00
	OTHER REIMBURSABLE COST CENTERS					
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	- 1		98.00
200.00	Total (lines 50-199)	85, 358	219, 931, 496	151, 812		200. 00

Peri od:

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Worksheet D From 01/01/2014 Part V Date/Time Prepared: 12/31/2014 5/27/2015 6:01 pm Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 212887 3, 996, 346 850, 770 50.00 51.00 05100 RECOVERY ROOM 0. 227530 625, 619 0 0 51.00 142, 347 05200 DELIVERY ROOM & LABOR ROOM 0 0 52 00 0 196755 52 00 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.203930 4, 651, 777 0 948, 637 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0. 177897 16, 367, 283 0 2, 911, 691 55.00 0 05700 CT SCAN 0.059503 10.064.355 0 598.859 57 00 57 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0.122616 3, 058, 057 0 374, 967 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.056100 9, 614, 222 0 0 539, 358 59.00 60.00 06000 LABORATORY 0. 126458 10, 957, 636 1,537 0 1, 385, 681 60.00 06400 INTRAVENOUS THERAPY 64 00 0 436212 312 136 64 00 0 65.00 06500 RESPIRATORY THERAPY 0.243237 684, 694 0 166, 543 65.00 06600 PHYSI CAL THERAPY 0. 247879 0 0 66.00 486 120 66.00 0 06700 OCCUPATIONAL THERAPY 0.391297 67.00 0 0 67.00 06800 SPEECH PATHOLOGY O 68 00 0.376719 0 68 00 69.00 06900 ELECTROCARDI OLOGY 0.127191 7, 341, 771 0 0 933, 807 69.00 937, 902 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0.382861 0 359, 086 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 083, 938 0 0 203, 585 71.00 0.187820 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 0.336612 3, 032, 378 0 1, 020, 735 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 207475 93, 592, 239 241, 527 19, 418, 050 73.00 436 07400 RENAL DIALYSIS 74.00 0.381536 0 0 0 74.00 03330 ENDOSCOPY 76.00 0.211196 726, 648 0 0 153, 465 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 76.01 0.642432 1, 544, 828 992, 447 76 01 03950 NEUROPSYCHIATRIC SERVICES 0 0 76.02 0.662301 64, 476 42, 703 76.02 0 76. 03 03951 LUTHERWOOD PARTNERSHIP 3. 105810 76.03 0 03952 WOUND CARE CENTER 0. 325045 1, 628, 103 0 529, 207 76.04 76.04 0 76.05 03480 ONCOLOGY-CANCER CARE CENTER 0.541190 20, 622, 718 0 11, 160, 809 76.05 987, 254 03953 I MAGING CENTERS 0. 269986 3, 656, 687 0 76.06 76.06 0 76. 07 03954 BREAST DIAGNOSTIC CENTER 0.384501 1, 143, 516 0 439, 683 76.07 07697 CARDIAC REHABILITATION 76.97 0 0 315, 590 0.431638 731, 145 76.97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0. 613931 870, 714 0 534, 558 76.98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 88.00 0 |08900| FEDERALLY QUALIFIED HEALTH CENTER 89.00 0.000000 0 89.00 90.00 09000 CLI NI C 0.000000 90.00 04950 DIABETIC CARE CENTER 0.000000 0 90.01 90.01 0. 695474 0 04951 HEALTHY HEARTS CENTER 1, 618, 001 0 1, 125, 278 90 02 90 02 0 90.04 04953 PALLIATIVE CARE 1.675426 0 0 90.04 90.05 04954 INFUSION CENTERS 0. 222274 851, 303 0 0 189, 223 90.05 04961 FAMILY PRACTICE AND MATERNITY CARE 0 90.12 90.12 1.138178 0 09100 EMERGENCY 17, 722, 637 2, 231, 900 91.00 0.125935 16 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.155022 2, 741, 705 0 425, 025 92.00 OTHER REIMBURSABLE COST CENTERS 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 98 00 C 0 200.00 Subtotal (see instructions) 219, 931, 496 1, 989 241, 527 48, 981, 514 200. 00 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges Net Charges (line 200 +/- line 201) 219, 931, 496 1, 989 48, 981, 514 202. 00 202.00 241. 527

From 01/01/2014 Part V Date/Time Prepared: 12/31/2014 5/27/2015 6:01 pm Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 52 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 55.00 57.00 05700 CT SCAN 0 0 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 06000 LABORATORY 60.00 194 0 60.00 06400 I NTRAVENOUS THERAPY 0 64 00 64 00 65.00 06500 RESPIRATORY THERAPY 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72 00 Ω 73.00 07300 DRUGS CHARGED TO PATIENTS 50, 111 73.00 07400 RENAL DIALYSIS 74.00 0 74.00 03330 ENDOSCOPY 76.00 0 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.01 0 76.01 76.02 03950 NEUROPSYCHI ATRI C SERVI CES 0 76.02 03951 LUTHERWOOD PARTNERSHIP 76. 03 76.03 76.04 03952 WOUND CARE CENTER 76.04 0 03480 ONCOLOGY-CANCER CARE CENTER 76.05 0 76.05 03953 I MAGING CENTERS 76.06 76.06 03954 BREAST DIAGNOSTIC CENTER 76. 07 0 76.07 07697 CARDIAC REHABILITATION 76.97 76. 97 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 76.98 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 89.00 90.00 09000 CLI NI C 0 90.00 90. 01 04950 DIABETIC CARE CENTER 0 90.01 0 04951 HEALTHY HEARTS CENTER 90 02 90.02 90.04 04953 PALLIATIVE CARE 0 90.04 90.05 04954 INFUSION CENTERS 0 90.05 04961 FAMILY PRACTICE AND MATERNITY CARE 0 90.12 90.12 09100 EMERGENCY 91.00 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 OTHER REIMBURSABLE COST CENTERS 98. 00 09850 OTHER REIMBURSABLE COST CENTERS n 98 00 200.00 Subtotal (see instructions) 286 50, 111 200.00 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges 202.00 Net Charges (line 200 +/- line 201) 286 202. 00 50.111

Provider CCN: 150074

Peri od:

Health Financial Systems	COMMUNITY HOSPITAL	OF INDIANA, II	NC.	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPI	TAL COSTS	Provi der		Peri od:	Worksheet D	
				From 01/01/2014 To 12/31/2014	Part I Date/Time Pre	nared:
				10 12/31/2014	5/27/2015 6:0	
			le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		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	6, 244, 000		0/2:1/00			
31.00 INTENSIVE CARE UNIT	626, 670		626, 67	3, 103		
32. 00 CORONARY CARE UNIT	1, 004, 947		1, 004, 94			
43. 00 NURSERY	651, 993		651, 99	3, 432	189. 97	43.00
200.00 Total (lines 30-199)	8, 527, 610		8, 527, 61	64, 903		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 & PEDI ATRI CS	8, 035	983, 564				30. 00
31.00 INTENSIVE CARE UNIT	0	0)			31.00
32.00 CORONARY CARE UNIT	0	0)			32. 00
43. 00 NURSERY	574	109, 043	s			43.00
200.00 Total (lines 30-199)	8, 609	1, 092, 607	'			200. 00

Heal th	Financial Systems COMM	MUNITY HOSPITAL	OF IN	IDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS		Provi der	CCN: 150074	Peri od:	Worksheet D	
						From 01/01/2014 To 12/31/2014	Part II	
						To 12/31/2014	Date/Time Pre	pared:
				 .			5/27/2015 6:0	1 pm
		0 111	I +		le XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal			Ratio of Cos		Capital Costs	
		Related Cost		Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part		(col . 1 ÷ col	. Charges	column 4)	
		Part II, col.		8)	2)			
		26)						
	ANOLILIADY CERVICE COCT CENTERS	1.00		2. 00	3.00	4. 00	5. 00	
F0 00	ANCILLARY SERVICE COST CENTERS	4 005 004			0.04040	1 000 050	FF 040	F0 00
50.00	05000 OPERATING ROOM	1, 985, 231		6, 021, 123				
51.00	05100 RECOVERY ROOM	322, 175		8, 913, 551	0. 03614		13, 739	
52.00	05200 DELIVERY ROOM & LABOR ROOM	337, 431		1, 949, 960			13, 735	ł
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 171, 844		8, 819, 800		•	31, 645	
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 065, 024		3, 393, 097	0. 01994			
57. 00	05700 CT SCAN	342, 146	5	3, 203, 056	0. 00643	1 1, 652, 315	10, 626	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	389, 440	1	4, 404, 861	0. 02703	5 449, 089	12, 141	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	369, 974	4	5, 241, 497	0. 00817	8 974, 230	7, 967	59. 00
60.00	06000 LABORATORY	721, 406		1, 292, 114			46, 789	
64. 00	06400 I NTRAVENOUS THERAPY	31, 960		985, 315				
65. 00	06500 RESPI RATORY THERAPY	362, 723		8, 439, 795				
66. 00	06600 PHYSI CAL THERAPY	299, 064		5, 698, 773			5, 270	
67. 00	06700 OCCUPATI ONAL THERAPY	98, 690		3, 595, 775 3, 595, 485			5, 270 5, 072	
			l .			·		l
68. 00	06800 SPEECH PATHOLOGY	31, 527	1	1, 190, 716		•	· ·	68. 00
69. 00	06900 ELECTROCARDI OLOGY	207, 501		4, 895, 410		•	5, 021	•
70.00	07000 ELECTROENCEPHALOGRAPHY	228, 292		4, 056, 216		•	7, 366	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	607, 490	4	9, 881, 552	0. 01217	9 2, 232, 944	27, 195	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	842, 715	3	9, 627, 355	0. 02126	6 1, 066, 498	22, 680	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 925, 023	31	6, 361, 038	0. 00924	6, 536, 331	60, 435	73.00
74.00	07400 RENAL DIALYSIS	31, 266		2, 280, 518	0. 01371	0 247, 410	3, 392	74. 00
76. 00	03330 ENDOSCOPY	33, 611		2, 662, 117	0. 01262	6 100, 692	1, 271	76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	802, 112		0, 951, 818			0	76. 01
76. 02	03950 NEUROPSYCHI ATRI C SERVI CES	14, 568		497, 097			0	76. 02
76. 03	03951 LUTHERWOOD PARTNERSHIP	239, 157		1, 831, 836			0	76. 03
76. 04	03952 WOUND CARE CENTER	127, 383	1	3, 028, 986			1, 004	
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	1, 407, 907	1	5, 230, 245		•	234	
76. 06	03953 I MAGI NG CENTERS	578, 225		5, 230, 243 5, 720, 788			0	76.06
76. 07	03954 BREAST DIAGNOSTIC CENTER	153, 788		6, 444, 193			0	76.00
	07697 CARDIAC REHABILITATION						_	
76. 97		125, 520		1, 543, 134			0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	122, 190		2, 628, 612	0. 04648	5 0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS	_						
88. 00	08800 RURAL HEALTH CLINIC	0		0				
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0. 00000		-	89. 00
90.00	09000 CLI NI C	0		0			0	90. 00
90. 01	04950 DIABETIC CARE CENTER	1, 757		0	0. 00000	0	0	90. 01
90. 02	04951 HEALTHY HEARTS CENTER	224, 867		3, 252, 632	0. 06913	4 236	16	90. 02
90. 04	04953 PALLI ATI VE CARE	40, 349		320, 158	0. 12602	8 0	0	90. 04
90. 05	04954 I NFUSI ON CENTERS	17, 533		1, 935, 184			0	90. 05
90. 12	04961 FAMILY PRACTICE AND MATERNITY CARE	276, 470		4, 034, 846			0	90. 12
91. 00	09100 EMERGENCY	1, 989, 015		0, 927, 066			-	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	358, 795		8, 671, 806				
72.00	OTHER REIMBURSABLE COST CENTERS	330, 793	<u>'</u>	0, 071, 000	0.01921	0 177, 333	3, 440	, ,2.00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0		0	0.00000	0 0	0	98. 00
200.00		18, 884, 169	l .	0 0 031 750		29, 413, 452	-	
200.00	11000 (11103 30 177)	10,004,109	', ' '	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	I	27, 410, 402	1 737, 003	1200.00

Health Financial Systems COMM	NUNITY HOSPITAL	OF INDIANA, II	NC.	In Li€	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provi der		Peri od:	Worksheet D	
				From 01/01/2014		
				To 12/31/2014		
		Ti +	le XIX	Hospi tal	5/27/2015 6: 0 PPS	т рііі
Cost Center Description	Nursing School			Swi ng-Bed	Total Costs	
cost center bescription	inul Si lig School	Cost	Medi cal	Adjustment	(sum of cols.	
		COST	Education Cos		1 through 3,	
			Education cos	instructions)	minus col. 4)	
	1. 00	2.00	3.00	4. 00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS					0	20.00
	0				0	
31. 00 03100 I NTENSI VE CARE UNI T	0			J	0	31.00
32. 00 03200 CORONARY CARE UNIT	0)		0	32. 00
43. 00 04300 NURSERY	0	0)	J	0	43. 00
200.00 Total (lines 30-199)	0	0		0	0	200. 00
Cost Center Description		Per Diem (col.		Inpati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	51, 007	l .		5 0		30. 00
31.00 03100 INTENSIVE CARE UNIT	3, 103			0		31. 00
32. 00 03200 CORONARY CARE UNIT	7, 361	0.00		0)	32.00
43. 00 04300 NURSERY	3, 432	0.00	57	4 0)	43.00
200.00 Total (lines 30-199)	64, 903		8, 60	9 0	ı	200. 00

 Heal th Financial
 Systems
 COMMUNITY HOSPITAL O

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provi der CCN: 150074 THROUGH COSTS

					5/27/2015 6:0	1 pm
			le XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Allied Health	All Other	Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost		
					4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	1)	ή	0	50. 00
51. 00 05100 RECOVERY ROOM	0	0	1		0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0) (,	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	227, 591	0	227, 591	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0) (0	0	55.00
57. 00 05700 CT SCAN	0	0) (0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0) (0	0	59. 00
60. 00 06000 LABORATORY	0	0)	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0) (0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0	0) (0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0) (0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0) (0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0) (0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0) (0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0) (0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0) (0	0	71. 00
72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0	0) (0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	135, 559	0	135, 559	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0) (0	0	74.00
76. 00 03330 ENDOSCOPY	0	0) (0	0	76.00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0) (0	0	76. 01
76. 02 03950 NEUROPSYCHI ATRI C SERVI CES	0	0) (0	0	76. 02
76. 03 03951 LUTHERWOOD PARTNERSHIP	0	0) (0	0	76. 03
76.04 03952 WOUND CARE CENTER	0	0) (0	0	76. 04
76.05 03480 ONCOLOGY-CANCER CARE CENTER	0	0) (0	0	76. 05
76.06 03953 I MAGING CENTERS	0	0) (0	0	76. 06
76.07 03954 BREAST DIAGNOSTIC CENTER	0	0) (0	0	76. 07
76. 97 07697 CARDIAC REHABILITATION	0	0) (0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0) (0	0	76. 98
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0)	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0) (0	0	89. 00
90. 00 09000 CLI NI C	0	0) (0	0	90.00
90. 01 04950 DIABETIC CARE CENTER	0	0) (0	0	90. 01
90.02 04951 HEALTHY HEARTS CENTER	0	0) (0	0	90. 02
90. 04 04953 PALLI ATI VE CARE	0	0) (0	0	90. 04
90.05 04954 INFUSION CENTERS	0	0) (0	0	90. 05
90.12 04961 FAMILY PRACTICE AND MATERNITY CARE	0	0) (0	0	90. 12
91. 00 09100 EMERGENCY	0	0	596, 540	0	596, 540	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0)	0	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	C) (0		98. 00
200.00 Total (lines 50-199)	0		959, 690	0	959, 690	200. 00
	•		•	'		

Health Financial Systems COMMUNITY HOSPITAL OF APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS COMMUNITY HOSPITAL OF INDIANA, INC. In Lieu of Form CMS-2552-10 Peri od: Worksheet D From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/27/2015 6:01 pm Provi der CCN: 150074 THROUGH COSTS

						5/2//2015 6:0	ı pm
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	Inpati ent	
	·	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
		Cost (sum of	Part I, col.	(col. 5 ÷ col.	to Charges	Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.	,	
		4)	,	,	7)		
		6.00	7.00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS	•		•			
50.00	05000 OPERATI NG ROOM	0	46, 021, 123	0.000000	0.000000	1, 280, 050	50. 00
51.00	05100 RECOVERY ROOM	0				380, 111	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	11, 949, 960			486, 424	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	227, 591				778, 267	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	53, 393, 097	•		498, 258	55. 00
57. 00	05700 CT SCAN	0	53, 203, 056			1, 652, 315	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	14, 404, 861			449, 089	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	45, 241, 497			974, 230	59. 00
60.00	06000 LABORATORY		91, 292, 114			5, 921, 176	60.00
64. 00	06400 I NTRAVENOUS THERAPY		985, 315			134, 599	64. 00
65. 00	06500 RESPIRATORY THERAPY		18, 439, 795			1, 866, 468	65. 00
66. 00	06600 PHYSI CAL THERAPY		15, 698, 773			276, 624	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	3, 595, 485			184, 792	67. 00
68. 00	06800 SPEECH PATHOLOGY					59, 948	68. 00
	1	0	1, 190, 716				
69. 00	06900 ELECTROCARDI OLOGY	0	24, 895, 410			602, 404	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	4, 056, 216	0.000000	0.000000	130, 877	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	49, 881, 552			2, 232, 944	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	105 550	39, 627, 355			1, 066, 498	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	135, 559				6, 536, 331	73. 00
74.00	07400 RENAL DI ALYSI S	0	_, _,			247, 410	74.00
76. 00	03330 ENDOSCOPY	0	_, _,			100, 692	76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	20, 951, 818			0	76. 01
76. 02	03950 NEUROPSYCHI ATRI C SERVI CES	0	497, 097			0	76. 02
76. 03	03951 LUTHERWOOD PARTNERSHIP	0	1, 831, 836			0	76. 03
76. 04	03952 WOUND CARE CENTER	0	3, 028, 986			23, 884	76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	0	65, 230, 245			10, 849	76. 05
76. 06	03953 I MAGI NG CENTERS	0	15, 720, 788			0	76. 06
76. 07	03954 BREAST DI AGNOSTI C CENTER	0	6, 444, 193			0	76. 07
76. 97	07697 CARDI AC REHABI LI TATI ON	0	1, 543, 134			0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	2, 628, 612	0.000000	0. 000000	0	76. 98
00.00	OUTPATIENT SERVICE COST CENTERS			0.00000	0.000000		00.00
88. 00	08800 RURAL HEALTH CLINIC	0	Ĭ			0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	89. 00
90.00	09000 CLINIC	0	0			0	90.00
90. 01	04950 DI ABETI C CARE CENTER	0	0	0.000000		0	90. 01
90. 02	04951 HEALTHY HEARTS CENTER	0	3, 252, 632			236	90. 02
90. 04	04953 PALLI ATI VE CARE	0	320, 158			0	90. 04
90. 05	04954 INFUSION CENTERS	0	1, 935, 184			0	90. 05
90. 12	04961 FAMILY PRACTICE AND MATERNITY CARE	0	4, 034, 846			0	90. 12
91. 00	09100 EMERGENCY	596, 540					91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	18, 671, 806	0.000000	0.000000	179, 333	92. 00
	OTHER REIMBURSABLE COST CENTERS						
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0			0. 000000		98. 00
200.00	Total (lines 50-199)	959, 690	1, 119, 931, 750)		29, 413, 452	200. 00

Peri od: Worksheet D From 01/01/2014 Part IV To 12/31/2014 Date/Time Prepared: 5/27/2015 6:01 pm Provi der CCN: 150074 THROUGH COSTS

Cost Center Description							5/27/2015 6:01	pm
Program Pass-Through Cost's (col. a x col. 10) x col. 10)				Ti t	le XIX	Hospi tal	PPS	
Program Pass-Through Costs (col. a x col. 10) 20 20 20 20 20 20 20		Cost Center Description	I npati ent	Outpati ent	Outpati ent			
Pass-Through Costs (col. 8 x.col. 10)		·	Program	Program	Program			
Costs (col. 8 x col. 12) x col. 12)								
AMCILLARY SERVICE COST CENTERS			9	5				
ANCILLARY SERVICE COST CENTERS								
ANCILLARY SERVICE COST CENTERS				12 00				
50.00 050000 0FEATT NG ROOM		ANCILLARY SERVICE COST CENTERS	11.00	12.00	13.00			
51.00 05100 ECOUPERY ROOM	EO 00							-0.00
52.00 05200 05200 05200 05200 0510 05400 0540 05400 05400 05400 05400 05400 05400 05400 05400 05400 05400 05400 05400 05400 05400 05400 05400 0570 05700		l l	1 1					
54.00 05400 RADIOLOGY-DIAGNOSTIC 0.1 54.00 55.00 55.00 05500 RADIOLOGY-THERAPEUTIC 0.0 0.0 0.0 55.00 05500 RADIOLOGY-THERAPEUTIC 0.0 0.0 0.0 0.0 0.0 55.00 05900 CARDIOLOGY-THERAPEUTIC 0.0 0.		l l	١					
55. 00 05.500 RADI OLOGY-THERAPEUTI C			١				•	
57. 00 05700 CT SCAN 0 0 0 0 57. 00 58. 00 05900 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 0 59. 00 05900 05900 CARDIAC CATHETERIZATION 0 0 0 0 59. 00 05900 05900 CARDIAC CATHETERIZATION 0 0 0 0 60. 00 05900 05		l l	6, 146	-	_		l l	
SB 00 OSB00 MAGNETI C RESONANCE I MAGI NG (MRI)			0	0	0		•	
59.00 0.05900 CARDIAC CATHETERI ZATION 0 0 0 0 0 0 0 0 0	57. 00	05700 CT SCAN	0	0	0		5	57. 00
60.00 0.0000 LABORATORY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0		5	58. 00
64.00 06400 INTRAVENOUS THERAPY 0 0 0 64.00 06.50 06	59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0		5	59. 00
65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 0 0	60.00	06000 LABORATORY	0	0	0		1 6	50.00
65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 0 0	64.00	06400 I NTRAVENOUS THERAPY	ol	0	0		1 6	54. 00
66. 00 06600 06700 06CUPATI ONAL THERAPY 0 0 0 0 067. 00 06700 06CUPATI ONAL THERAPY 0 0 0 0 0 068.00 06800 SPECEH PATHOLOGY 0 0 0 0 0 068.00 06800 SPECEH PATHOLOGY 0 0 0 0 0 0 0 0 0	65. 00		0	0	0		1 6	55. 00
67. 00 06700 05CUPATI ONAL THERAPY 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 68. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0			0	0	Ō		_ ·	
68. 00 06800 06900			0	-	_			
69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		I I		_	_			
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 71. 00 0710 07		l l		-	_			
171.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0			0	-	_			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 2,798 0 0 0 73. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 0 0 0			0		_		•	
73. 00 07300 DRUGS CHARGED TO PATIENTS 2,798 0 0 0 74. 00 74. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 74. 00 0 0 0 0 0 0 0 0 0			0	-	_			
74. 00 07400 RENAL DI ALYSI S 0 0 0 74. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 01 76. 02 03950 PSYCHI ATRI C SERVI CES 0 0 0 0 0 76. 01 76. 02 76. 03 03951 LUTHERWOOD PARTNERSHI P 0 0 0 0 0 0 76. 04 76. 05 76. 03 76. 04 76. 05 76. 04 76. 05 76. 04 76. 05 76. 04 76. 05 76. 04 76. 05 76. 04 76. 05 76. 04 76. 05 76. 04 76. 05 76. 04 76. 05 76. 07 76. 0			0	•	1			
76. 00 03330 ENDOSCOPY 76. 01 03350 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 76. 01 76. 02 03550 PSYCHI ATRI C SERVI CES 0 0 0 0 76. 02 76. 03 03951 LUTHERWOOD PARTNERSHI P 0 0 0 0 76. 02 76. 04 03952 WOUND CARE CENTER 0 0 0 0 0 76. 03 76. 04 03952 WOUND CARE CENTER 0 0 0 0 0 76. 04 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 0 0 0 0 0 76. 05 76. 06 03953 IMAGI NG CENTERS 0 0 0 0 0 76. 05 76. 07 03954 BREAST DI AGNOSTI C CENTER 0 0 0 0 0 76. 07 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76. 98 0017PATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			2, 798					
76. 01		l l	0	-	_			
76. 02 03950 NEUROPSYCHI ATRI C SERVI CES 0 0 0 0 76. 02 76. 03 03951 LUTHERWOOD PARTNERSHI P 0 0 0 0 76. 04 76. 04 03952 WOUND CARE CENTER 0 0 0 0 76. 04 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 0 0 0 0 0 76. 05 76. 06 03953 I MAGI NG CENTERS 0 0 0 0 0 76. 07 76. 07 03954 BREAST DI AGNOSTI C CENTER 0 0 0 0 0 76. 07 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 76. 98 0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 0 0 9000 CLI NI C 0 0 0 9000 CLI NI C 0 0 0 9000 CLI NI C 0 0 0 9000 CLI NI C 0 0 0 9000 CLI NI C 0 0 0 9000 CLI NI C 0 0 0 90. 01 90. 01 04950 DI ABETI C CARE CENTER 0 0 0 0 0 90. 02 90. 04 04953 PALLI ATI VE CARE 0 0 0 0 0 90. 02 90. 05 04954 I NFUSI ON CENTERS 90. 00 09100 EMERGENCY 14, 137 0 0 990. 05 90. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 990. 00 098. 00 09800 THER REI MBURSABLE COST CENTERS			0				•	
76. 03 03951 LUTHERWOOD PARTNERSHIP			0	0	0		l l	
76. 04 03952 WOUND CARE CENTER 0 0 0 0 76. 04 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 0 0 0 0 76. 05 76. 06 03953 I MAGING CENTERS 0 0 0 0 76. 05 76. 07 03954 BREAST DI AGNOSTIC CENTER 0 0 0 0 76. 07 76. 97 07697 CARDI AC REHABILITATION 0 0 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 76. 98 0UTPATI ENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 99. 00 90. 01 04950 DI ABETI C CARE CENTER 0 0 0 0 99. 00 90. 01 04950 DI ABETI C CARE CENTER 0 0 0 0 99. 01 90. 02 04951 HEALTH YEARTS CENTER 0 0 0 0 99. 02 90. 04 04953 PALLIATIVE CARE 0 0 0 0 99. 02 90. 05 04954 INFUSION CENTERS 0 0 0 0 99. 02 90. 01 04950 OLIABTI C CARE CENTER 0 0 0 0 0 99. 02 90. 02 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0 0 0 99. 02 91. 00 09100 EMERGENCY 14,137 0 0 0 99. 02 91. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 99. 00 0THER REIMBURSABLE COST CENTERS	76. 02	03950 NEUROPSYCHI ATRI C SERVI CES	0	0	0		7	76. 02
76. 05	76. 03	03951 LUTHERWOOD PARTNERSHIP	0	0	0		7	76. 03
76. 06	76.04	03952 WOUND CARE CENTER	0	0	0		7	76. 04
76. 07	76.05	03480 ONCOLOGY-CANCER CARE CENTER	0	0	0		7	76. 05
76. 97 76. 98 76. 97 76. 98 76	76.06	03953 I MAGI NG CENTERS	0	0	0		7	76. 06
76. 97 76. 98 76. 97 76. 98 76	76. 07	03954 BREAST DIAGNOSTIC CENTER	ol	0	o		1 7	76. 07
76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 0		l l	0	0	0		l l	
SECTION SERVICE COST CENTERS SECTION S			0		1		l l	
88. 00			-1	-				
89. 00	88 00		0	0	0		۶ ا	38 00
90. 00 09000 CLINIC 0 0 0 0 0 90. 00 90. 00 90. 01 90. 00 90. 01 90. 01 90. 01 90. 02 90. 01 90. 02 90. 04 90. 04 90. 04 90. 04 90. 05 90. 05 90. 05 90. 05 90. 12 90. 04 90. 05 90. 12 90. 05 90. 12 90. 06 90. 06 90. 07 90. 07 90. 08 90			ا					
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98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 98. 00	92.00		0	0	0		ç	92.00
200.00 Total (lines 50-199) 23,081 0 0 200.00	98. 00	09850 OTHER REIMBURSABLE COST CENTERS	1				5	98. 00
	200.00	Total (lines 50-199)	23, 081	0	0		20	00.00

APPORT	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST	Provi der	CCN: 150074	From 01/01/2014 To 12/31/2014		pared:
			Ti +	le XIX	Hospi tal	5/27/2015 6: 0 PPS	ТРШ
			1110	Charges	nospi tai	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	cost center bescription	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(See Hist.)	
		Part I, col. 9		Subject To	Subject To		
		art 1, cor. 7		Ded. & Coins			
				(see inst.)	(see inst.)		
		1. 00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00	05000 OPERATING ROOM	0. 212887		d	0 995, 518	0	50.00
51. 00	05100 RECOVERY ROOM	0. 212667		l .	0 87, 164	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 227330			0 87, 104	0	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	· I			-		54.00
		0. 203930			-, ,		
55. 00	O5500 RADI OLOGY-THERAPEUTI C	0. 177897	l ~		0 3, 305, 513	0	55. 00
57. 00	05700 CT SCAN	0. 059503	0		0 4, 237, 534	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 122616	0	•	0 904, 726	l	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 056100	0	•	0 1, 148, 527	0	59. 00
60.00	06000 LABORATORY	0. 126458	0		0 4, 410, 176	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 436212	0)	0 2, 787	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 243237	0		0 217, 621	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 247879	0)	0 519, 174	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 391297	0)	0 174, 966	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 376719	l 0	1	0 143, 188	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 127191	l o)	0 788, 717	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 382861	1	,	0 137, 357	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 187820		1	0 861, 936	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 336612			0 0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 207475		1	0 1, 312, 265	Ö	73.00
74. 00	07400 RENAL DIALYSIS	0. 381536			0 1, 312, 203	0	74.00
76. 00	03330 ENDOSCOPY	0. 331330		1	0 87, 222	0	
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1		1	0 0 0	ľ	76. 01
76. 01		0. 642432 0. 662301			0 0	0	76. 01
	03950 NEUROPSYCHI ATRI C SERVI CES	1			0 0	0	
76. 03	03951 LUTHERWOOD PARTNERSHIP	3. 105810	Ĭ		-		76. 03
76. 04	03952 WOUND CARE CENTER	0. 325045	0		0 224, 269	0	76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	0. 541190	0	1	0 16, 585, 247	0	76. 05
76. 06	03953 I MAGI NG CENTERS	0. 269986	0	1	0 491, 162	0	76. 06
76. 07	03954 BREAST DIAGNOSTIC CENTER	0. 384501	0		0 246, 991	0	76. 07
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 431638			0 73, 024	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 613931	0		0 0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0. 000000				0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90.00	09000 CLI NI C	0. 000000	0)	0	0	90.00
90. 01	04950 DI ABETI C CARE CENTER	0. 000000	0)	0	0	90. 01
90.02	04951 HEALTHY HEARTS CENTER	0. 695474	0	1	0 47, 761	0	90. 02
90. 04	04953 PALLI ATI VE CARE	1. 675426	l o)	0 0	0	90. 04
90. 05	04954 INFUSION CENTERS	0. 222274		,	0 615, 258	0	90. 05
90. 12	04961 FAMILY PRACTICE AND MATERNITY CARE	1. 138178		1	0 0	0	90. 12
91. 00	09100 EMERGENCY	0. 125935			0 15, 230, 332		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 155022		l .	0 2, 417, 723	l e	
7Z. UU	OTHER REIMBURSABLE COST CENTERS	0. 100022		1	0, 417,723	0	72.00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000		1	0 0	0	98. 00
200.00		0.000000		1	0 57, 556, 261	l e	200.00
200.00	,			1		l	200.00
201. UC	3				0	l	201.00
202.00	Only Charges (Line 200 . (Line 201)			l	0 57, 556, 261	_	202. 00
202. UL	Net Charges (line 200 +/- line 201)	1	0	1	0 57, 556, 261	, 0	1202.00

202. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 150074 Peri od: Worksheet D From 01/01/2014 Part V Date/Time Prepared: 12/31/2014 5/27/2015 6:01 pm Title XIX Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 211, 933 50.00 51.00 05100 RECOVERY ROOM 0 0 0 19,832 51.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 52 00 Ω 05400 RADI OLOGY-DI AGNOSTI C 54.00 467, 021 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 588, 041 55.00 57.00 05700 CT SCAN 252, 146 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 110, 934 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 64, 432 59.00 06000 LABORATORY 60.00 557, 702 60.00 06400 I NTRAVENOUS THERAPY 64 00 1 216 64 00 06500 RESPIRATORY THERAPY 65.00 52, 933 65.00 06600 PHYSI CAL THERAPY 128, 692 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 68, 464 67.00 68.00 06800 SPEECH PATHOLOGY 53, 942 68 00 69.00 06900 ELECTROCARDI OLOGY 100, 318 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 52, 589 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 161, 889 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 272, 262 73.00 07400 RENAL DIALYSIS 74.00 74.00 03330 ENDOSCOPY 76.00 18, 421 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.01 Ω 76.01 76.02 03950 NEUROPSYCHI ATRI C SERVI CES 76.02 0 03951 LUTHERWOOD PARTNERSHIP 76. 03 76.03 76.04 03952 WOUND CARE CENTER 72, 898 76.04 03480 ONCOLOGY-CANCER CARE CENTER 76.05 8, 975, 770 76.05 03953 I MAGING CENTERS 132, 607 76.06 76.06 03954 BREAST DIAGNOSTIC CENTER 76. 07 94, 968 76.07 07697 CARDIAC REHABILITATION 76.97 76. 97 31, 520 76. 98 07698 HYPERBARIC OXYGEN THERAPY 76.98 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 000000000 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 89.00 90.00 09000 CLI NI C 0 90.00 90. 01 04950 DIABETIC CARE CENTER 90.01 04951 HEALTHY HEARTS CENTER 90 02 90 02 33, 217 90.04 04953 PALLIATIVE CARE 90.04 90.05 04954 INFUSION CENTERS 136, 756 90.05 04961 FAMILY PRACTICE AND MATERNITY CARE 90.12 90.12 09100 EMERGENCY 91.00 1, 918, 032 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 374, 800 92.00 OTHER REIMBURSABLE COST CENTERS 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 98 00 200.00 Subtotal (see instructions) 0 14, 953, 335 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00

0

14, 953, 335

Only Charges

Net Charges (line 200 +/- line 201)

202.00

Health Financial Systems	COMMUNITY HOSPITAL OF I	NDI ANA, INC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150074	Peri od: From 01/01/2014	Worksheet D-1	
			To 12/31/2014	Date/Time Pre 5/27/2015 6:0	
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
LAIDATI ENT. DAVC					1

DRI 1- ALL PROVIDED COMPONENTS 1.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 1.01 Inpatient days (including private room days, secluding swing-bed days, excluding newborn) 1.02 Inpatient days (including private room days, secluding swing-bed and newborn days) 1.00 Private room days (uncluding swing-bed and observation bed days) 1.01 Private room days (excluding swing-bed and observation bed days) 1.02 Private room days (excluding swing-bed and observation bed days) 1.03 Private room days (excluding swing-bed and observation bed days) 1.05 Private room days (excluding swing-bed and observation bed days) 1.06 Private room days (excluding swing-bed and observation bed days) 1.07 Private room days (excluding swing-bed and observation bed days) 1.08 Private room days (excluding swing-bed) 1.09 Private room days (excluding swing-bed) 1.00 Priv			Title XVIII	Hospi tal	PPS			
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do not complete this line. 48.076 4.00 Semi-private room days (excluding swing-bed and observation bed days) 10x1 Swing-bed SW Type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SW Type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SW Type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Total swing-bed SW Type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total swing-bed SW Type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SW Type inpatient days applicable to the Program (excluding private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SW Type inpatient days applicable to title sWill only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SW Type inpatient days applicable to title SW IVI only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed NF Type inpatient days applicable to title SW Or XX only (including private room days) 11.00 Swing-bed NF Type inpatient days applicable to title SW Or XX only (including private room days) 12.00 Swing-bed NF Type inpatient days applicable to title SW Or XX only (including private room days) 13.00 Swing-bed NF Type inpatient days applicable to swing-bed SW SW or on days after December 31 of the cost reporting period (including private room days) 14.00 Swing-bed NF Type inpatient days applicable to swing-bed SW SW SW SW SW SW SW SW SW S				vato room dave	•			
Semi_private room days (excluding swing-ded and observation bed days) Ale	3.00). IT you have only pir	vate room days,	O	3.00		
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Total swing-bed SNF type Inpatient days (Including private room days) after December 31 of the cost ropering period (if calendar year, enter 0 on this line)	5.00		days) through December	31 of the cost	0	5. 00		
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Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERNTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) O Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) O Semi-private room charges (excluding swing-bed charges) O Semi-private room charges (excluding swing-bed charges) O Semi-private room charges (excluding swing-bed charges) O Semi-private room per diem charge (line 29 + line 3) O Average private room per diem charge (line 30 + line 4) O Average per diem private room charge differential (line 32 minus line 33)(see instructions) O Average per diem private room cost differential (line 34 x line 31) O Average per diem private room cost differential (line 3 x line 35) O Average per diem private room cost differential (line 3 x line 35) O Average per diem private room cost differential (line 3 x line 35) O Average per diem private room cost differential (line 3 x line 35) O Average per diem private room cost differential (line 3 x line 35) O Average per diem private room cost differential (line 3 x line 35) O Average per diem private room cost differential (line 3 x line 35) O Average per diem private room cost differential (line 3 x line 35) O Average per diem private room cost differential (line 3 x line 35) O Average per diem private room cost differential (line 3 x line 35) O Average per diem private room cost differential (line 3 x line 35) O Average per diem private room cost differential (line 3 x line 35) O Average per diem private room cost differential (line 3 x line 35) O Average per diem private room cost differential (line 3 x line 35) O Average per diem private room cost differential (line 3 x line 35) O Average per diem private room cost differential (line 3 x line 31) O Average per diem private room cost differential (line 3 x line 31) O Average per diem priva	25. 00		of the cost reporting	period (line 8	0	25. 00		
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 50, 372, 537 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 029. 00 Private room charges (excluding swing-bed charges) 030. 00 Semi-private room charges (excluding swing-bed charges) 030. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.000000 31. 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 32. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34. 00 Average per diem private room cost differential (line 34 x line 31) 0.00 35. 00 Average per diem private room cost differential (line 34 x line 35) 0.00 Average per diem private room cost differential (line 3 x line 35) 0.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROCRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 987. 56 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00	26 00	1			0	26 00		
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 90.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 50, 372, 537) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 987.56 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28.00 28.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 20.00 20.00 31.00 20.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 33.00 Average per diem private room per diem (see instructions) 90.00 32.00 32.00 32.00 33.00 Average per diem private room cost differential (line 3 x line 31) 90.00 35.00 36.00 36.00 37.00 General inpatient routine service cost per diem (see instructions) 987.56 38.00 987.56 38.00 987.56 38.00		,	ine 21 minus line 26)		50, 372, 537			
29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 50, 372, 537) 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 30. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		PRIVATE ROOM DIFFERENTIAL ADJUSTMENT						
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 50, 372, 537) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 30.00 0.00 30.00 0.00 32.00 0.00 33.00 0.00 33.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 0			and observation bed cha	irges)				
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 50, 372, 537) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 987.56 38.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 .0000000000000000000000000000000000								
32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 50, 372, 537) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.00 0.00 32.00 0.00 33.00 0.00 34.00 0.00 35.00 0.00 36.00 0.00		, , , , , , , , , , , , , , , , , , , ,	line 28)					
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 50, 372, 537) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			11116 20)					
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 50, 372, 537 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 987.56 38.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		Average semi-private room per diem charge (line 30 ÷ line 4)						
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 50, 372, 537 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 987.56 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			, ,	i ons)				
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 20, 372, 537 27.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 987.56 38.00 16, 462, 625 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			31)					
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 987.56 38.00 Program general inpatient routine service cost (line 9 x line 38) 16, 462, 625 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , , ,	d nrivate room cost dif	ferential (line				
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 987.56 38.00 Program general inpatient routine service cost (line 9 x line 38) 16, 462, 625 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37.00		u private room cost arr	rerential (TIME	50, 512, 531	37.00		
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 987.56 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 987.56 38.00 16,462,625 39.00				,				
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 16,462,625 39.00 40.00								
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			•					
		1	,					

Heal th	Financial Systems COMM	UNITY HOSPITAL	OF INDIANA	LN	IC.	In lie	eu of Form CMS-:	2552-10
	ATION OF INPATIENT OPERATING COST	ON TT HOST TAL			CCN: 150074	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Pre	pared:
			-	Ti +L	e XVIII	Hospi tal	5/27/2015 6: 0 PPS	1 pm
	Cost Center Description	Total	Total	11 (1	Average Per	Program Days	Program Cost	
	cost center bescription	Inpatient Cost		าลงร			(col. 3 x col.	
		,	,	,-	col . 2)		4)	
		1.00	2.00		3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	0)	0	0. C	0 0	0	42. 00
	Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	5, 382, 764	- 3,	103	1, 734. 7			43.00
44. 00	CORONARY CARE UNIT	8, 602, 646	7,	361	1, 168. 6	8 3, 334	3, 896, 379	44. 00
45. 00	BURN INTENSIVE CARE UNIT							45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT							46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)		L					47. 00
	Cost Center Description						1 00	
48. 00	Program inpatient ancillary service cost (Wks	r+ D 2 col 3	2 Line 200	<u> </u>			1. 00 21, 727, 260	48. 00
49. 00	Total Program inpatient costs (sum of lines 4				ne)		44, 193, 925	
47.00	PASS THROUGH COST ADJUSTMENTS	+1 thi ough 40)	(See Thistruc	5110	113)		44, 173, 723	47.00
50.00	Pass through costs applicable to Program inpa	atient routine	services (1	from	Wkst. D, sum	of Parts I and	2, 741, 114	50.00
- 4 00						6.5	0 400 000	
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	ry services	(fr	om Wkst. D, s	um of Parts II	2, 180, 928	51.00
52.00	Total Program excludable cost (sum of lines !	50 and 51)					4, 922, 042	52. 00
53.00	Total Program inpatient operating cost exclude	ding capital re	elated, non-	-phy	sician anesth	etist, and	39, 271, 883	53.00
	medical education costs (line 49 minus line 5	52)						
	TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program di scharges						0	54.00
55. 00	Target amount per discharge						0.00	
56.00	Target amount (line 54 x line 55)						0	56.00
57. 00	Difference between adjusted inpatient operati	ng cost and ta	arget amoun	τ (Ι	ine 56 minus	line 53)	0	57. 00
58. 00	Bonus payment (see instructions)	anting nonind	anding 100	,	ndatad and aa	manumdad by +ba	0 0. 00	58. 00 59. 00
59. 00	Lesser of lines 53/54 or 55 from the cost repmarket basket	borting period	ending 1996	o, u	puateu anu co	iipourided by the	0.00	59.00
60. 00	Lesser of lines 53/54 or 55 from prior year	cost report, um	odated by th	ne m	arket basket		0.00	60.00
61.00	If line 53/54 is less than the lower of lines					the amount by	0	61.00
	which operating costs (line 53) are less than	n expected cost	ts (lines 54	4 x	60), or 1% of	the target		
	amount (line 56), otherwise enter zero (see i	nstructions)						
62. 00	Relief payment (see instructions)						0	62.00
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	uctions)				0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	te through Doc	ombor 21 of	tho	cost roporti	ng poriod (Soo	0	64. 00
04.00	instructions)(title XVIII only)	is through beck	siliber 31 Of	the	cost reporti	ng period (see	U	04.00
65. 00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	per 31 of th	ne c	ost reporting	period (See	0	65. 00
	instructions)(title XVIII only)					p = 1	_	
66. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus lir	ne 6	5)(title XVII	l only). For	0	66. 00
47.00	CAH (see instructions)	a acata theaugh	n Dooombon 1	21 .	f +b2 222+ 52	namting paried		(7.00
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	i becember :	31 0	The cost re	portring period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine	e costs after [December 31	of	the cost repo	rting period	0	68. 00
	(line 13 x line 20)				•	0 .		
69. 00	Total title V or XIX swing-bed NF inpatient i		•				0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NU							
70.00	Skilled nursing facility/other nursing facili	•						70.00
71. 00 72. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 1		The 70 ÷ 11	ne	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applications	•	m (line 14 s	v Ii	ne 35)			73.00
74. 00	Total Program general inpatient routine servi				116 33)			74.00
75. 00	Capital -related cost allocated to inpatient	•		,	orksheet B P	art II column		75. 00
70.00	26, line 45)	041110 001 11 01		J	0. 1.01.001 27 .	ar c , oor a		70.00
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	Inpatient routine service cost (line 74 minus	s line 77)						78. 00
79. 00	Aggregate charges to beneficiaries for excess				•			79. 00
80. 00	Total Program routine service costs for compa		cost limitat	ti on	(line 78 min	us line 79)		80.00
81.00	Inpatient routine service cost per diem limit		• `					81.00
82.00	Inpatient routine service cost limitation (li		*					82.00
~ ~ (III)	Reasonable inpatient routine service costs (s	SEE THSTELICTION	15.1					83.00

83.00

84.00 85. 00

86.00

87.00

2, 931

84.00

85.00 86.00

83.00 Reasonable inpatient routine service costs (see instructions)

Program inpatient ancillary services (see instructions)
Utilization review - physician compensation (see instructions)
Total Program inpatient operating costs (sum of lines 83 through 85)
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

Health Financial Systems COMM	MUNITY HOSPITAL	OF INDIANA, IN	IC.	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 Fo 12/31/2014	Date/Time Pre 5/27/2015 6:0	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	6, 244, 000	50, 372, 537	0. 12395	5 2, 894, 538	358, 795	90.00
91.00 Nursing School cost	0	50, 372, 537	0. 000000	2, 894, 538	0	91.00
92.00 Allied health cost	0	50, 372, 537	0. 000000	2, 894, 538	0	92.00
93.00 All other Medical Education	0	50, 372, 537	0. 000000	2, 894, 538	0	93. 00

Health Financial Systems	COMMUNITY HOSPITAL OF I	INDIANA, INC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150074	Peri od: From 01/01/2014	Worksheet D-1	
			To 12/31/2014	Date/Time Prep 5/27/2015 6:0	
		Title XIX	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00 Inpatient days (including private room	1.00 Inpatient days (including private room days and swing-bed days, excluding newborn)				
2.00 Inpatient days (including private room days, excluding swing-bed and newborn days)					2. 00

	III tie XIX Hospital	PPS	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	51, 007	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	51, 007 0	2. 00 3. 00
3.00	In value from days, (excitating swing-bed and observation bed days). It you have only private room days, I do not complete this line.	٥	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	48, 076	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period	اِ	
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	8, 035	9. 00
	newborn days)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	O	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period	_	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13. 00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	3, 432	
16. 00	Nursery days (title V or XIX only)	574	16. 00
17.00	SWING BED ADJUSTMENT	0.00	17.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	50, 372, 537	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6)	0	23. 00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
20.00	In the 20)		20.00
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	50, 372, 537	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00		0	
30.00	Semi - pri vate room charges (excluding swing-bed charges)	0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00 0. 00	33. 00 34. 00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	50, 372, 537	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	987. 56	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	7, 935, 045	39. 00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	7, 935, 045	41.00

33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	50, 372, 537	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	987. 56	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	7, 935, 045	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	7, 935, 045	41.00

OMPUT	ATION OF INPATIENT OPERATING COST		Provi der		Peri od: From 01/01/2014	Worksheet D-1	
					To 12/31/2014	Date/Time Pre 5/27/2015 6:0	
				le XIX	Hospi tal	PPS	<u> </u>
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
2. 00	NURSERY (title V & XIX only)	4, 664, 723	3, 432	1, 359. 1	9 574	780, 175	42.00
3. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	5, 382, 764	3, 103	1, 734. 7	0 0	0	43. 00
. 00	CORONARY CARE UNIT	8, 602, 646	1			0	
. 00	BURN INTENSIVE CARE UNIT	0,002,010	,,,,,,	1, 100.0			45. 0
. 00	SURGICAL INTENSIVE CARE UNIT						46.0
. 00	OTHER SPECIAL CARE (SPECIFY)						47. 0
	Cost Center Description					1.00	
3. 00	Program inpatient ancillary service cost (Wks	s+ D 2 col 3	2 line 200)			1. 00 5, 174, 117	48. 00
0. 00	Total Program inpatient costs (sum of lines 4			ns)		13, 889, 337	
. 00	PASS THROUGH COST ADJUSTMENTS	+1 till odgil +0) (See Thistruction	713)		13,007,337	1 47.0
00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sum	of Parts I and	1, 092, 607	50.0
	111)						
00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	457, 086	51.0
00	and IV) Total Program excludable cost (sum of lines !	50 and 51)				1, 549, 693	52.0
. 00	Total Program inpatient operating cost excluding		lated non-phy	sician anesth	etist and	12, 339, 644	
00	medical education costs (line 49 minus line §		rated, non priy	isi ci an ancstri	ctrst, and	12, 337, 044	55. 0
	TARGET AMOUNT AND LIMIT COMPUTATION	,					
	Program di scharges					0	
00	Target amount per discharge					0.00	1
00							
.00	00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 00 Bonus payment (see instructions)						
. 00							58. 0 59. 0
. 00	market basket	oor tring porrou	5.1dg	.paaroa ana oo	pouridou by the	0.00	0,, 0
. 00	Lesser of lines $53/54$ or 55 from prior year of					0.00	1
. 00	If line 53/54 is less than the lower of lines					0	61.0
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		is (lines 54 x	60), or 1% of	the target		
. 00	Relief payment (see instructions)	ilisti ucti olis)				0	62.0
. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ıcti ons)			Ö	
	PROGRAM INPATIENT ROUTINE SWING BED COST		·				1
. 00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64.0
00	instructions)(title XVIII only)		04 6 11				
. 00	Medicare swing-bed SNF inpatient routine cosinstructions) (title XVIII only)	ts after Decemb	er 31 or the c	cost reporting	period (See	0	65.0
. 00	Total Medicare swing-bed SNF inpatient routing	ne costs (line	64 plus line 6	55)(title XVII	I only). For	0	66.0
	CAH (see instructions)	`	·	, ,	3,		
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	n December 31 c	of the cost re	porting period	0	67.0
00	(line 12 x line 19)						
. 00	Title V or XIX swing-bed NF inpatient routine	e costs arter L	ecember 31 or	the cost repo	rting period	0	68. 0
. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient (routine costs (line 67 + line	48)		0	69.0
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU						07.0
. 00	Skilled nursing facility/other nursing facili						70.0
. 00	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71.0
. 00	Program routine service cost (line 9 x line 7		(1) 44 11	05)			72.0
. 00	Medically necessary private room cost applicational Program general inpatient routine servi		•				73.0
. 00	Capital -related cost allocated to inpatient i	•			art II column		75.0
. 00	26, line 45)	Satino Sci Vi Ce	. 20213 (11011111	.c. Ronoct D, T	a. c ii, coi uiill		, 5. 0
. 00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76.0
. 00	Program capital-related costs (line 9 \times line						77. C
. 00	Inpatient routine service cost (line 74 minus						78. C
. 00	Aggregate charges to beneficiaries for excess				us lino 70)		79.0
. 00	Total Program routine service costs for comparing the routine service cost per diem limit		JOST TIMITATION	ı (ııne /ö min	us IIIle /9)		80. C
$\Omega\Omega$, 01.6
. 00	Inpatient routine service cost limitation (li)				82.0

Inpatient routine service cost limitation (line 9 x line 81)

Reasonable inpatient routine service costs (see instructions)

Program inpatient ancillary services (see instructions)
Utilization review - physician compensation (see instructions)
Total Program inpatient operating costs (sum of lines 83 through 85)
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

83.00

84.00 85. 00

86.00

83.00

84.00

85.00 86.00

Health Financial Systems COMM	MUNITY HOSPITAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014	Date/Time Prep 5/27/2015 6:0	
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	6, 244, 000	50, 372, 537	0. 12395	6 2, 894, 538	358, 795	90.00
91.00 Nursing School cost	0	50, 372, 537	0.00000	2, 894, 538	0	91.00
92.00 Allied health cost	0	50, 372, 537	0.00000	2, 894, 538	0	92.00
93.00 All other Medical Education	0	50, 372, 537	0. 00000	2, 894, 538	0	93. 00

Heal	th Financial Systems	COMMUNITY HOSPITAL OF IN	NDI ANA,	INC.	In Lie	eu of Form CMS-2552-10
	-					

Health Financial Systems COMMUNITY HOSPITAL OF I	NDI ANA, II	NC.	In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150074	Peri od:	Worksheet D-3	
			From 01/01/2014	D 1 /T' D	
			To 12/31/2014	Date/Time Pre 5/27/2015 6:0	
	Ti +I	e XVIII	Hospi tal	PPS	т рііі
Cost Center Description	11 (1	Ratio of Cos		Inpati ent	
cost center bescription		To Charges	Program	Program Costs	
		10 charges	Charges	(col. 1 x col.	
			onal ges	2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				5.55	
30. 00 03000 ADULTS & PEDI ATRI CS			26, 744, 995		30.00
31. 00 03100 NTENSI VE CARE UNI T			4, 044, 246		31. 00
32. 00 03200 CORONARY CARE UNI T			8, 054, 946	l	32. 00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 21288	16, 242, 706	3, 457, 861	50.00
51. 00 05100 RECOVERY ROOM		0. 22753			
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 19675		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 20393		l	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 17789		343, 868	
57. 00 05700 CT SCAN		0. 05950		366, 347	57. 00
58.00 05800 MAGNETIC RESONANCE MAGING (MRI)		0. 1226		1	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 05610		393, 488	
60. 00 06000 LABORATORY		0. 12645			
64.00 06400 I NTRAVENOUS THERAPY		0. 4362			64.00
65. 00 06500 RESPI RATORY THERAPY		0. 24323			
66. 00 06600 PHYSI CAL THERAPY		0. 24787			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 39129		376, 956	
68. 00 06800 SPEECH PATHOLOGY		0. 3767		l	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 12719			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 38286		165, 437	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 18782		1, 125, 360	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 3366		2, 983, 425	1
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 20747			
74. 00 07400 RENAL DI ALYSI S		0. 38153		l	
76. 00 03330 ENDOSCOPY		0. 21119		1	
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 64243		0	76. 01
76. 02 03950 NEUROPSYCHI ATRI C SERVI CES		0. 66230		Ō	76. 02
76. 03 03951 LUTHERWOOD PARTNERSHI P		3. 1058		o o	76. 03
76. 04 03952 WOUND CARE CENTER		0. 32504		5, 354	76. 04
76. 05 03480 ONCOLOGY-CANCER CARE CENTER		0. 54119		30, 232	76. 05
76. 06 03953 I MAGI NG CENTERS		0. 26998		5, 307	
76. 07 03954 BREAST DIAGNOSTIC CENTER		0. 38450			76. 07
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 43163			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 61393		4, 382	76. 98
OUTPATIENT SERVICE COST CENTERS			,		
88. 00 08800 RURAL HEALTH CLINIC		0.00000	00	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	89. 00
90. 00 09000 CLI NI C		0.00000		0	90.00
90. 01 04950 DI ABETI C CARE CENTER		0.00000		0	90. 01
90. 02 04951 HEALTHY HEARTS CENTER		0. 69547			
90. 04 04953 PALLI ATI VE CARE		1. 67542		0	1
90. 05 04954 NFUSION CENTERS		0. 22227		o o	
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE		1. 13817		Ö	90. 12
91. 00 09100 EMERGENCY		0. 12593			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 15502		l	1
OTHER REIMBURSABLE COST CENTERS		0. 10002	, 1,2,300	, , , , , , , ,	1 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		0.00000	00	0	98. 00
200.00 Total (sum of lines 50-94 and 96-98)		3. 25000	118, 987, 012		
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201. 00
202.00 Net Charges (line 200 minus line 201)			118, 987, 012		202. 00
, , , , , , , , , , , , , , , , , , , ,		•		•	•

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

Heal th	Fi nan	cial Systems COMMUNITY HOSPITAL OF I	NDI ANA, II	NC.	In Li€	eu of Form CMS-	2552-10
INPATI	ENT AN	ICILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150074	Peri od:	Worksheet D-3	
					From 01/01/2014		narod:
					To 12/31/2014	5/27/2015 6:0	
			Ti t	le XIX	Hospi tal	PPS	. p
		Cost Center Description		Ratio of Cos	· ·	Inpatient	
		'		To Charges	•	Program Costs	
					Charges	(col. 1 x col.	
						2)	
				1.00	2. 00	3. 00	
		ENT ROUTINE SERVICE COST CENTERS		,			
30. 00		ADULTS & PEDI ATRI CS			13, 247, 193		30.00
31. 00		INTENSIVE CARE UNIT			1, 494, 492	1	31.00
32.00		CORONARY CARE UNIT			1, 857, 259	l e	32.00
43. 00		NURSERY ADV. CEDVI CE COST. CENTERS			298, 185	1	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM		0. 2128	87 1, 280, 050	272, 506	50.00
51. 00	1	RECOVERY ROOM		0. 2128		•	
52. 00	1	DELIVERY ROOM & LABOR ROOM		0. 2273		1	
54. 00	1	RADI OLOGY-DI AGNOSTI C		0. 2039		•	1
55. 00	1	RADI OLOGY-THERAPEUTI C		0. 1778		•	1
57. 00	1	CT SCAN		0. 0595		•	
58. 00		MAGNETIC RESONANCE IMAGING (MRI)		0. 1226			
59. 00		CARDI AC CATHETERI ZATI ON		0. 0561			1
60.00	1	LABORATORY		0. 1264			
64. 00	1	INTRAVENOUS THERAPY		0. 4362			
65. 00		RESPI RATORY THERAPY		0. 2432		1	1
66.00	1	PHYSI CAL THERAPY		0. 2478			
67. 00		OCCUPATI ONAL THERAPY		0. 3912			
68. 00		SPEECH PATHOLOGY		0. 3767			
69.00		ELECTROCARDI OLOGY		0. 1271		1	
70.00	07000	ELECTROENCEPHALOGRAPHY		0. 3828		1	70. 00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1878	20 2, 232, 944	419, 392	71. 00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0. 3366	1, 066, 498	358, 996	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0. 2074	75 6, 536, 331	1, 356, 125	73. 00
74.00		RENAL DI ALYSI S		0. 3815	36 247, 410	94, 396	74. 00
76.00	03330	ENDOSCOPY		0. 2111	96 100, 692	21, 266	76. 00
76. 01	1	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 6424		0	
76. 02	1	NEUROPSYCHI ATRI C SERVI CES		0. 6623			
76. 03		LUTHERWOOD PARTNERSHIP		3. 1058		0	76. 03
76. 04	1	WOUND CARE CENTER		0. 3250		•	
76. 05		ONCOLOGY-CANCER CARE CENTER		0. 5411		1	
76. 06	1	I MAGI NG CENTERS		0. 2699		_	
76. 07	1	BREAST DI AGNOSTI C CENTER		0. 3845			1
76. 97 76. 98	1	CARDI AC REHABI LI TATI ON		0. 4316			
70. 90		HYPERBARIC OXYGEN THERAPY TIENT SERVICE COST CENTERS		0. 6139	31 0	0	70.90
88. 00		RURAL HEALTH CLINIC		0.0000	00 0	0	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER		0.0000		1	89. 00
90.00		CLINIC		0.0000		1	1
90. 01	1	DI ABETI C CARE CENTER		0.0000			
		HEALTHY HEARTS CENTER		0. 6954		•	1
		PALLI ATI VE CARE		1. 6754		1	1
90. 05		INFUSION CENTERS		0. 2222		Ö	1
90. 12		FAMILY PRACTICE AND MATERNITY CARE		1. 1381		0	1
91. 00		EMERGENCY		0. 1259		1	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)		0. 1550		1	
		REIMBURSABLE COST CENTERS]
98. 00	09850	OTHER REIMBURSABLE COST CENTERS		0.0000	00 0	0	98. 00
200.00		Total (sum of lines 50-94 and 96-98)			29, 413, 452	5, 174, 117	
201.00		Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0)	201. 00
202.00)	Net Charges (line 200 minus line 201)		1	29, 413, 452	1	202. 00

	ATION OF REIMBURSEMENT SETTLEMENT		CCN: 150074	Peri od: From 01/01/2014	Worksheet E Part A	
				To 12/31/2014	Date/Time Pre 5/27/2015 6:0	
		Ti tl	e XVIII	Hospi tal	PPS	
			0	1. 00	2. 00	
1. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments		I	O		1.00
1. 01	DRG amounts other than outlier payments for discharges occurrin	g prior		22, 838, 307		1. 01
1. 02	to October 1 (see instructions) DRG amounts other than outlier payments for discharges occurrin	a on or		12, 583, 100		1. 02
1.02	after October 1 (see instructions)	g on or		12, 363, 100		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for			0		1. 03
1.04	discharges occurring prior to October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for			0		1. 04
0.00	discharges occurring on or after October 1 (see instructions)			740 404		
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			710, 421 0		2. 00
2.02	Outlier payment for discharges for Model 4 BPCI (see instructio	ns)		o		2. 02
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost report	ina		11, 722, 222 246. 68		3. 00 4. 00
4.00	period (see instructions)	i rig		240.00		4.00
	Indirect Medical Education Adjustment		1	0.4.00		
5. 00	FTE count for allopathic and osteopathic programs for the most cost reporting period ending on or before 12/31/1996. (see instr			21. 09		5. 00
6.00	FTE count for allopathic and osteopathic programs which meet th	е		0. 00		6. 00
	criteria for an add-on to the cap for new programs in accordanc CFR 413.79(e)	e with 42				
7.00	MMA Section 422 reduction amount to the IME cap as specified un	der 42		2. 21		7. 00
7 01	CFR §412. 105(f)(1)(iv)(B)(1)			0.00		7 01
7. 01	ACA Section 5503 reduction amount to the IME cap as specified u CFR $\S412.105(f)(1)(iv)(B)(2)$ If the cost report straddles July			0.00		7. 01
	then see instructions.					
8. 00	Adjustment (increase or decrease) to the FTE count for allopath osteopathic programs for affiliated programs in accordance with			-2.77		8. 00
	413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67					
8. 01	(August 1, 2002). The amount of increase if the hospital was awarded FTE cap slot	e undor		7. 73		8. 01
0.01	section 5503 of the ACA. If the cost report straddles July 1, 2			7.73		0.01
0.00	instructions.			0.00		0.00
8. 02	The amount of increase if the hospital was awarded FTE cap slot closed teaching hospital under section 5506 of ACA. (see instru			0.00		8. 02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines			23. 84		9. 00
10. 00	and 8,02) (see instructions) FTE count for allopathic and osteopathic programs in the curren	t vear		25. 65		10.00
	from your records	. Joan				
11. 00 12. 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)			0. 00 23. 84		11. 00
13. 00	Total allowable FTE count for the prior year.			20. 79		13. 00
14. 00	Total allowable FTE count for the penultimate year if that year	ended on		21. 49		14. 00
15. 00	or after September 30, 1997, otherwise enter zero. Sum of lines 12 through 14 divided by 3.			22. 04		15. 00
	Adjustment for residents in initial years of the program			0.00		16. 00
17. 00	Adjusted relief evenes of the sount	е		0.00		17. 00
18. 00 19. 00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).		•	22. 04 0. 089347		18. 00 19. 00
20.00	Prior year resident to bed ratio (see instructions)			0. 098030		20. 00
21. 00 22. 00	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)		•	0. 089347 2, 244, 508		21. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			2, 244, 300		22. 01
22.00	Indirect Medical Education Adjustment for the Add-on for Section		he MMA	0.00		22.00
23. 00	Number of additional allopathic and osteopathic IME FTE residen slots under 42 Sec. 412.105 (f)(1)(iv)(C).	т сар		0.00		23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)			1. 81		24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the lo line 23 or line 24 (see instructions)	wer of		0.00		25. 00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000		26. 00
27. 00	IME payments adjustment factor. (see instructions)			0. 000000		27. 00
28. 00 28. 01	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)		•	0		28. 00 28. 01
29. 00	Total IME payment (sum of lines 22 and 28)			2, 244, 508		29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0		29. 01
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A pat	ient days		11. 82		30.00
24 22	(see instructions)	,				21 00
31. 00 32. 00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			29. 53 41. 35		31.00
33. 00	Allowable disproportionate share percentage (see instructions)			23. 33		33. 00
34. 00	Disproportionate share adjustment (see instructions)			2, 065, 953		34. 00

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150074	Period: From 01/01/2014 To 12/31/2014		pared:
		Title XVIII	Hospi tal	PPS	трш
			Prior to	On/After	
			October 1	October 1	
		0	1. 00	2. 00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		9, 046, 380, 143	7, 647, 644, 885	35. 00
35. 01	Factor 3 (see instructions)		0. 000547382	0. 000604583	35. 01
35. 02	Hospital uncompensated care payment (If line 34 is zero,		4, 951, 826	4, 623, 640	35. 02
	enter zero on this line) (see instructions)				
35. 03	Pro rata share of the hospital uncompensated care payment		3, 703, 693	1, 165, 412	35. 03
	amount (see instructions)				
36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		4, 869, 105		36. 00
	Additional payment for high percentage of ESRD beneficiary of	discharges (lines 40 throug	h 46)		1
40.00	Total Medicare discharges on Worksheet S-3, Part I		0		40.00
	excluding discharges for MS-DRGs 652, 682, 683, 684 and				
	685 (see instructions)				
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652,		0		41.00
	682, 683, 684 an 685. (see instructions)				
41.01	Total ESRD Medicare covered and paid discharges excluding		0		41.01
	MS-DRGs 652, 682, 683, 684 an 685. (see instructions)				
42.00	Divide line 41 by line 40 (if less than 10%, you do not		0.00		42.00
	qualify for adjustment)				1
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43.00
	682, 683, 684 an 685. (see instructions)				1
44.00	Ratio of average length of stay to one week (line 43		0.000000		44.00
	divided by line 41 divided by 7 days)				
45.00	Average weekly cost for dialysis treatments (see		0.00		45.00
	instructions)				
46.00	Total additional payment (line 45 times line 44 times line		0		46.00
	41.01)				
47.00	Subtotal (see instructions)		45, 311, 394		47.00
48.00	Hospital specific payments (to be completed by SCH and		0		48.00
	MDH, small rural hospitals only (see instructions)				
49.00	Total payment for inpatient operating costs (see		45, 311, 394		49.00
	instructions)				
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I		3, 232, 231		50.00
	and Pt. II, as applicable)				
51.00	Exception payment for inpatient program capital (Wkst. L,		0		51.00
	Pt. III, see instructions)				
52.00	Direct graduate medical education payment (from Wkst. E-4,		397, 607		52.00
	line 49 see instructions).		, , , , , , , , , , , , , , , , , , , ,		
53.00	Nursing and Allied Health Managed Care payment		94, 970		53.00
54.00	Special add-on payments for new technologies		15, 961		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		0		55.00
	line 69)				
56.00	Cost of physicians' services in a teaching hospital (see		0		56.00
	intructions)				
57.00	Routine service other pass through costs (from Wkst. D,		0		57.00
	Pt. III, column 9, lines 30 through 35).				
58. 00	Ancillary service other pass through costs from Wkst. D,		85, 358		58.00
	Pt. IV, col. 11 line 200)				
59. 00	Total (sum of amounts on lines 49 through 58)		49, 137, 521		59.00
60. 00	Primary payer payments		21, 696		60.00
61. 00	Total amount payable for program beneficiaries (line 59		49, 115, 825		61.00
300	minus line 60)		. , , 110, 323		550
62. 00	Deductibles billed to program beneficiaries		3, 839, 808		62.00
63. 00	Coinsurance billed to program beneficiaries		98, 448		63.00
64. 00	Allowable bad debts (see instructions)		80, 401		64.00
65. 00	Adjusted reimbursable bad debts (see instructions)		52, 261		65.00
66. 00					1
50.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		20, 686		66.00
47 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		45 220 920		47 00
67.00			45, 229, 830		67.00
68. 00	Credits received from manufacturers for replaced devices		0		68.00
60 00	for applicable to MS-DRGs (see instructions)				60.00
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and				69.00
70.00	96). (For SCH see instructions)				70.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				1
70. 50	RURAL DEMONSTRATION PROJECT		0		70.50
70. 89	Pioneer ACO demonstration payment adjustment amount (see		0		70. 89
70.00	instructions)		_[70.5-
70. 90	HSP bonus payment HVBP adjustment amount (see		0		70. 90
70.01	instructions)		_		70 0-
70. 91	HSP bonus payment HRR adjustment amount (see instructions)		0		70. 91
70. 92	Bundled Model 1 discount amount (see instructions)		0		70. 92
	HVBP payment adjustment amount (see instructions)		-113, 972	I	70. 93
70. 93	, ,		0 700		1 70 0.
70. 93 70. 94	HRR adjustment amount (see instructions) Recovery of accelerated depreciation		-3, 780 0		70. 94 70. 95

Health Financial Systems	COMMUNITY HOSPITAL OF INDIANA, INC.	In Lieu of Form CMS-2552-1
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150074	Peri od: Worksheet E

Title XVIII	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150074	Peri od: From 01/01/2014 To 12/31/2014	Date/Time Pre 5/27/2015 6:0	
October 1 Octo			Title XVIII	Hospi tal	PPS	
1.90 Low volume adjustment for federal fiscal year (yyyy)				Prior to	On/After	
10.96 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1) (Enter in column 0 the corresponding federal year for the period prior to 10/1) (Enter in column 0 the corresponding federal year for the period prior to 10/1) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1) (Enter in column 0 the provider (line 67 minus lines 68 plus/minus 10 period ending on or after 10/1) (Enter in payments 10 period ending on or after 10/1) (Enter in payments 10 period ending on a period ending on or after 10/1) (Enter in payments 10 period ending on adjustment (see instructions) (Enter in payments 10 period ending on adjustment (see instructions) (Enter in payments 10 period ending on adjustment (see instructions) (Enter in payments 10 period ending on adjustment (see instructions) (Enter in payments 10 period ending on adjustment 10 period ending on adjustment 20 period ending				October 1	October 1	
CENTER IN COLUMN 0 the corresponding federal year for the period prior to 10/1) 10.97 Low volume adjustment for federal fiscal year (yyyy) 0 0 70.97 10.98 Low Volume Payment-1 0 0 70.98 10.99 Low Volume Payment-1 0 0 70.98 10.99 Low Volume Payment-1 0 70.99 10.99 Low Volume Payment-1 0 70.99 10.99 Low Volume Payment-1 0 70.99 10.99 Low Volume Payment amount (see instructions) 0 70.99 10.99 Low Volume Payment amount (see instructions) 0 70.99 10.90 Low Volume Payment amount (see instructions) 0 70.99 10.90 Low Volume Payment 0 70.99 10.90 Low Volume 0 70.9			0	1. 00	2. 00	
period prior to 10/1)	70. 96	Low volume adjustment for federal fiscal year (yyyy)		0 0		70. 96
10.97 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1) 10.07 10.		(Enter in column 0 the corresponding federal year for the				
10.97 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1) 10.07 10.		period prior to 10/1)				
CEnter In column 0 the corresponding federal year for the period ending on or after 10/1) 10 20 170,98	70. 97			0 0		70. 97
period ending on or after 10/1) 70,98 Nov Yol ume Payment-3 0 70,98 70,99 HAC adjustment amount (see instructions) 0 70,98 70,99 HAC adjustment amount (see instructions) 0 70,99 71,00 70,99 71,00						
70.98 Low Volume Payment-3 0 70.98 70.99 ARC adjustment amount (see instructions) 0 70.99 71.00 Amount due provider (line 67 minus lines 68 plus/minus 45,112,078 71.00 71.01 Sequestration adjustment (see instructions) 902,242 71.01 72.00 Interim payments 44,657,739 72.00 73.00 Totative settlement (for contractor use only) 0 73.00 74.00 Bal ance due provider (Program) (line 71 minus lines 71.01, 72.01 74.00 72. and 73) 74.00 75.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2 70.08 75.00 Operating outlier amount from Wkst. E. Pt. A. line 2 (see instructions) 90.00 70.00 Operating outlier amount from Wkst. E. Pt. A. line 2 (see instructions) 90.00 70.00 Capital outlier from Wkst. L. Pt. I, line 2 0 91.00 70.00 Protested amount (see instructions) 93.00 70.00 Capital outlier reconciliation adjustment amount (see 0 93.00 70.00 Protested (see 0 93.00 94.00 70.00 Protested (see 0 93.00 70.00 Protested (see 0 93.00 94.00 70.00 Protested (see 0 93.00 94.00 70.00 Protested (see 0 95.00 70.00 Protested (see 0 95.00 70.00 Protested (see 0 95.00 70.00 Protested (see 0 0 0 0 70.00 Protested (see 0 0 0 0 0 70.00 Protested (see 0 0 0 0 0 70.00 Protested (see 0 0 0 0 0 0 70.00 Protested (see 0 0 0 0 0 0 0 70.00 Protested (see 0 0 0 0 0 0 0 0 0						
70. 99 HAC adjustment amount (see instructions) 10. 99 Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70) 45, 112, 078 71. 00 1 lines 69 & 70) 71. 01 Sequestration adjustment (see instructions) 902, 242 71. 01 72. 00 1 lines 69 & 70) 72. 00 73. 00 74. 00 75. 00 7	70. 98			0		70. 98
17.00 Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70) 10 10 10 10 10 10 10				0		
Lines 69 & 70 Sequestration adjustment (see instructions) Sequestration adjustment (see instructions) 902, 242 71.01 72.00 Interim payments 44,657,739 72.00 73.00 Tentative settlement (for contractor use only) 0 73.00 73.00 74.00 8al ance due provider (Program) (line 71 minus lines 71.01, 72. and 73) 74.00 75.00				45 112 078		
71. 01 Sequestration adjustment (see instructions) 902, 242 71. 01 72. 00 Interim payments 44, 657, 739 72. 00 73. 00 Tentative settlement (for contractor use only) 0 73. 00 74. 00 Bal ance due provider (Program) (line 71 minus lines 71. 01, 72. and 73) 73. 75. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115. 2	71.00			10, 112, 070		71.00
1. 1. 1. 1. 1. 1. 1. 1.	71 01			902 242		71 01
73.00 Tentative settlement (for contractor use only) 73.00 Relative settlement (for contractor use only) 73.00 74.				· ·		
74.00 Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73) 75.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) 90.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions) 91.00 Capital outlier from Wkst. L, Pt. I, line 2 92.00 Operating outlier reconciliation adjustment amount (see instructions) 93.00 Capital outlier reconciliation adjustment amount (see instructions) 94.00 The rate used to calculate the time value of money (see instructions) 95.00 Time value of money for operating expenses (see instructions) 96.00 Time value of money for capital related expenses (see instructions) 97.00 Time value of money for capital related expenses (see instructions) 98.00 Time value of money for capital related expenses (see instructions) 99.00 Time value of money for capital related expenses (see instructions) 90.00 Time value of money for capital related expenses (see instructions) 90.00 Time value of money for capital related expenses (see instructions) 90.00 Time value of money for capital related expenses (see instructions) 90.00 Time value of money for capital related expenses (see instructions) 90.00 Time value of money for Capital related expenses (see instructions) 90.00 Time value of money for Capital related expenses (see instructions) 90.00 Time value of money for Capital related expenses (see instructions) 90.00 Time value of money for Capital related expenses (see instructions) 90.00 Time value of money for Capital related expenses (see instructions) 90.00 Time value of money for Capital related expenses (see instructions) 90.00 Time value of money for Capital related expenses (see instructions) 90.00 Time value of money for Capital related expenses (see instructions) 90.00 Time value of money for Capital related expenses (see instructions) 91.00 Time value of money for Capital related expenses (see instructions) 92.00 Time value of money for Capital related expenses				14,007,737		
72, and 73) 75.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) 90.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions) 90.00 Capital outlier from Wkst. L, Pt. I, line 2 0 91.00 92.00 Operating outlier reconciliation adjustment amount (see instructions) 93.00 Capital outlier reconciliation adjustment amount (see instructions) 94.00 The rate used to calculate the time value of money (see instructions) 95.00 Time value of money for operating expenses (see instructions) 96.00 Time value of money for capital related expenses (see instructions) 96.00 Time value of money for capital related expenses (see instructions) 96.00 Time value of money for capital related expenses (see instructions) 96.00 Time value of money for capital related expenses (see instructions) 96.00 Operating expenses (see instructions) 96.00 Operating expenses (see instructions) 96.00 Operating expenses (see instructions) Operating expenses (see instructions) Operating expense Operatin				447 003		
75.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	74.00			-447, 903		74.00
accordance with CMS Pub. 15-2, chapter 1, \$115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) 90.00 90.00 10.00	75. 00			3, 939, 638		75. 00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) 90. 00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions) 91. 00 Capital outlier from Wkst. L, Pt. I, line 2 0 91. 00 92. 00 Operating outlier reconciliation adjustment amount (see instructions) 0 92. 00 93. 00 Operating outlier reconciliation adjustment amount (see instructions) 0 93. 00 Operating outlier reconciliation adjustment amount (see instructions) 0 94. 00 Operating outlier reconciliation adjustment amount (see instructions) 0 94. 00 Operating outlier reconciliation adjustment amount (see instructions) 0 94. 00 Operating outlier reconciliation adjustment amount (see instructions) 0 94. 00 Operating outlier reconciliation adjustment amount (see instructions) 0 94. 00 Operating outlier reconciliation adjustment factor (see instructions) Operating outlier factor (see instructions) Operating outlier factor (se						
90. 00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions) 90. 00 91. 00 91. 00 92. 00 92. 00 92. 00 92. 00 92. 00 93. 00 93. 00 93. 00 93. 00 94. 00 94. 00 94. 00 94. 00 94. 00 95. 00 9		TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
91.00 Capital outlier from Wkst. L, Pt. I, line 2 0 91.00 92.00 Operating outlier reconciliation adjustment amount (see instructions) 93.00 Capital outlier reconciliation adjustment amount (see instructions) 93.00 Operating outlier reconciliation adjustment amount (see instructions) 94.00 The rate used to calculate the time value of money (see instructions) 95.00 Time value of money for operating expenses (see instructions) 0 95.00 Operations Opera	90.00			0		90.00
92. 00 Operating outlier reconciliation adjustment amount (see instructions) 93. 00 Capital outlier reconciliation adjustment amount (see instructions) 94. 00 The rate used to calculate the time value of money (see instructions) 95. 00 Time value of money for operating expenses (see instructions) 96. 00 Time value of money for capital related expenses (see instructions) 96. 00 Time value of money for capital related expenses (see O 96. 00 HSP Bonus Payment Amount Prior to 10/1 On/After 10/1		instructions)				
92. 00 Operating outlier reconciliation adjustment amount (see instructions) 93. 00 Capital outlier reconciliation adjustment amount (see instructions) 94. 00 The rate used to calculate the time value of money (see instructions) 95. 00 Time value of money for operating expenses (see instructions) 96. 00 Time value of money for capital related expenses (see instructions) 96. 00 Time value of money for capital related expenses (see O 96. 00 HSP Bonus Payment Amount Prior to 10/1 On/After 10/1	91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
1				0		92.00
101.00 HSP adjustment for HSP Bonus Payment 102.00 HVBP adjustment for HSP Bonus payment 103.00 HRR adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 0.000 0.0000 103.00 103.00 HRR adjustment factor (see instructions) 0.0000 0.0000 103.0						
94. 00 The rate used to calculate the time value of money (see instructions) 95. 00 Time value of money for operating expenses (see instructions) 96. 00 Time value of money for capital related expenses (see instructions) Prior to 10/1 On/After 10/1	93.00	Capital outlier reconciliation adjustment amount (see		0		93.00
101.00 HVBP adj ustment factor (see instructions) 102.00 HRR adj ustment for HSP Bonus Payment 103.00 HRR adj ustment factor (see instructions) 0.0000 0.0000 103.00		instructions)				
95. 00 Time value of money for operating expenses (see instructions) 96. 00 96	94.00	The rate used to calculate the time value of money (see		0.00		94.00
1 instructions 1 instructions 2 96.00		instructions)				
96. 00 Time value of money for capital related expenses (see instructions) Prior to 10/1	95.00	Time value of money for operating expenses (see		0		95. 00
Instructions Prior to 10/1 On/After 10/1 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00		instructions)				
Prior to 10/1 0n/After 10/1 1.00 2.00	96.00	Time value of money for capital related expenses (see		0		96.00
1.00 2.00		instructions)				
HSP Bonus Payment Amount 100.00 HSP bonus amount (see instructions) 0 0 100.00 HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 0 0 0 101.00 102.00 HVBP adjustment for HSP Bonus payment (see instructions) 0 0 0 102.00 HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 0.0000 0.0000 103.00				Prior to 10/1	On/After 10/1	
100.00 HSP bonus amount (see instructions) 0 0 100.00 HVBP Adj ustment for HSP Bonus Payment 101.00 HVBP adj ustment factor (see instructions) 0 0 101.00 102.00 HVBP adj ustment amount for HSP bonus payment (see instructions) 0 0 102.00 HRR Adj ustment for HSP Bonus Payment 103.00 HRR adj ustment factor (see instructions) 0.0000 0.0000 103.00				1. 00	2. 00	
HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment for HSP Bonus Payment 105.00 HRR adjustment factor (see instructions) 106.000 0.0000 103.00						
101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment for HSP Bonus Payment 105.00 HRR adjustment factor (see instructions) 106.000 0.0000 103.00				0	0	100. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) 102.00 HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 0.0000 103.00						
HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 0.0000 0.0000 103.00	101.00	HVBP adjustment factor (see instructions)		0		
103.00 HRR adjustment factor (see instructions) 0.0000 0.0000 103.00	102.00	HVBP adjustment amount for HSP bonus payment (see instruction	ons)	0	0	102. 00
		HRR Adjustment for HSP Bonus Payment				
104.00 HRR adjustment amount for HSP bonus payment (see instructions) 0 104.00	103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103. 00
	104.00	HRR adjustment amount for HSP bonus payment (see instruction	ns)	0	0	104.00

Health Financial Systems	COMMUNITY HOSPITAL OF INDIANA, INC.		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN:	150074	From 01/01/2014	Worksheet E Part B Date/Time Prepared:

			To 12/31/2014	Date/Time Pre	pared:
		Title XVIII	Hospi tal	5/27/2015 6: 0 PPS	1 pm
				1 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			50, 397	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		48, 829, 702	2. 00
3.00	PPS payments			40, 322, 540	
4. 00 5. 00	Outlier payment (see instructions) Enter the hospital specific payment to cost ratio (see instruct	i one)		379, 248 0. 000	1
6. 00	Line 2 times line 5	10113)		0.000	1
7. 00	Sum of line 3 plus line 4 divided by line 6			0.00	1
8.00	Transitional corridor payment (see instructions)			0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		151, 812	
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			50, 397	10.00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			30, 371	11.00
	Reasonable charges				
12. 00	Ancillary service charges			243, 516	1
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, co	I. 4)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13) Customary charges			243, 516	14. 00
15. 00	Aggregate amount actually collected from patients liable for pa	vment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for			0	1
	had such payment been made in accordance with 42 CFR §413.13(e)		-		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only	if line 10 exceeds li	no 11) (coo	243, 516 193, 119	
17.00	instructions)	II IIIle 16 exceeds II	ile II) (See	173, 117	19.00
20.00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20.00
	instructions)				
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see Interns and residents (see instructions)	instructions)		50, 397	
	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	22. 00 23. 00
	Total prospective payment (sum of lines 3, 4, 8 and 9)	oti olis)		40, 853, 600	1
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for			8, 049, 216	1
27. 00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) pl CAH, see instructions)	us the sum of fines 22	2 and 23} (101	32, 854, 781	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		441, 261	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29)			33, 296, 042	
	Primary payer payments Subtotal (line 30 minus line 31)			10, 086 33, 285, 956	
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)		33, 203, 730	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	-/		0	33. 00
	Allowable bad debts (see instructions)			327, 276	1
	Adjusted reimbursable bad debts (see instructions)			212, 729	1
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see instru Subtotal (see instructions)	CTI ONS)		236, 814 33, 498, 685	1
	MSP-LCC reconciliation amount from PS&R			-331	1
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	1
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruc	ctions)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			33, 499, 016 669, 980	
41. 00	Interim payments			33, 361, 379	
42.00	Tentative settlement (for contractors use only)			0	1
43.00	Balance due provider/program (see instructions)			-532, 343	
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115.2 TO BE COMPLETED BY CONTRACTOR				1
90. 00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0	
94. UU	Total (sum of lines 91 and 93)			Ü	94. 00

Health Financial Systems COMMUNITY
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED In Lieu of Form CMS-2552-10 COMMUNITY HOSPITAL OF INDIANA, INC. Worksheet E-1 Part I Date/Time Prepared: 5/27/2015 6:01 pm Provider CCN: 150074 Peri od: From 01/01/2014 To 12/31/2014 Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3. 00 4.00 1.00 Total interim payments paid to provider 44, 446, 839 33, 117, 079

3.00 Lis	ite "NONE" or enter a zero st separately each retroactive lump sum adjustment ount based on subsequent revision of the interim rate					
pay	r the cost reporting period. Also show date of each yment. If none, write "NONE" or enter a zero. (1)					3. 00
	JUSTMENTS TO PROVIDER	08/04/2014	210, 900	08/04/2014	244, 300	3. 01
3. 02			0		0	3. 02
3. 03			0		0	3. 03
3. 04			0		0	3. 04
3. 05			0		0	3. 05
	ovider to Program					i
	JUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3. 54 3. 99 Sub	btotal (sum of lines 3.01-3.49 minus sum of lines		210, 900		244, 300	3. 54 3. 99
	50-3. 98)		210, 900		244, 300	J. 77
	tal interim payments (sum of lines 1, 2, and 3.99)		44, 657, 739		33, 361, 379	4. 00
	ransfer to Wkst. E or Wkst. E-3, line and column as					ì
	propri ate)					i
	BE COMPLETED BY CONTRACTOR					Ì
	st separately each tentative settlement payment after					5. 00
wri	sk review. Also show date of each payment. If none, ite "NONE" or enter a zero. (1)					1
	ogram to Provider NTATIVE TO PROVIDER		0			F 04
5. 01 TEN 5. 02	NTATI VE TO PROVIDER		0		0	5. 01 5. 02
5. 02			0			5. 02
	ovider to Program		0		0	3.03
	NTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		o	5. 52
	btotal (sum of lines 5.01-5.49 minus sum of lines 50-5.98)		0		0	5. 99
	termined net settlement amount (balance due) based on e cost report. (1)					6. 00
	TTLEMENT TO PROVIDER		О		o	6. 01
4	TTLEMENT TO PROGRAM		447, 903		532, 343	6. 02
7. 00 Tot	tal Medicare program liability (see instructions)		44, 209, 836		32, 829, 036	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	and of Company to the)	1. 00	2. 00	0.00
8. 00 Nan	me of Contractor					8. 00

Heal th	Financial Systems COMMUNITY HOSPITAL OF	INDIANA, INC.	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150074	Peri od: From 01/01/2014	Worksheet E-1 Part II	
			To 12/31/2014	Date/Time Pre	
				5/27/2015 6: 0	1 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	14	13, 156	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-	12		21, 219	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			6, 921	3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-	12		58, 540	4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			1, 236, 602, 543	5. 00
6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20			9, 766, 348		
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I			0	7. 00	
	line 168			_	
8. 00	Calculation of the HIT incentive payment (see instructions)			1, 066, 239	8. 00
9. 00	Sequestration adjustment amount (see instructions)			21, 325	
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		1, 044, 914	
	I NPATI ENT HOSPI TAL SERVI CES UNDER PPS & CAH	333 111311 4311 3113)		170117711	
30. 00	Initial/interim HIT payment adjustment (see instructions)			1, 017, 783	30. 00
	Other Adjustment (specify)			0	31. 00
	Palance due provider (line 9 (or line 10) minus line 20 and li	no 21) (soo instruction	6)	27 121	

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

27, 131 32. 00

DIRECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der	CCN: 150074	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS			From 01/01/2014	Doto/Time Dro	no 50 d
				To 12/31/2014	Date/Time Prep 5/27/2015 6:0	
		Ti tl	e XVIII	Hospi tal	PPS	
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
. 00	Unweighted resident FTE count for allopathic and osteopathic pending on or before December 31, 1996.	J	•		24. 75	1.0
. 00	Unweighted FTE resident cap add-on for new programs per 42 CFR		1) (see instr	ructions)	0.00	1
. 00 . 01	Amount of reduction to Direct GME cap under section 422 of MMA Direct GME cap reduction amount under ACA §5503 in accordance		\$412.70 (m)	(500	2. 07 0. 00	1
. 01	instructions for cost reporting periods straddling 7/1/2011)	WI til 42 CIN	3413.77 (111).	(366	0.00	J. C
. 00	Adjustment (plus or minus) to the FTE cap for allopathic and o GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	steopathi c	programs due	to a Medicare	-4. 60	4.0
. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see instrateddling 7/1/2011)	uctions for	cost reporti	ng peri ods	7. 64	4.0
. 02	ACA Section 5506 number of additional direct GME FTE cap slots periods straddling $7/1/2011$)	•			0. 00	
. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plu 4.02 plus applicable subscripts		·		25. 72	5.0
0. 00	Unweighted resident FTE count for allopathic and osteopathic p records (see instructions)	rograms for	the current	year from your	25. 65	
7. 00	Enter the lesser of line 5 or line 6		Primary Care	e Other	25. 65 Total	7.0
			1.00	2.00	3. 00	
. 00	Weighted FTE count for physicians in an allopathic and osteopa	thi c	25. <i>6</i>	0.00	25. 65	8. C
. 00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherwimultiply line 8 times the result of line 5 divided by the amount		25. <i>6</i>	0.00	25. 65	9. (
	6.					
0.00	Weighted dental and podiatric resident FTE count for the curre	nt year	05.4	0.00		10.0
1. 00 2. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting	year (see	25. <i>6</i> 23. 4	1		11. (12. (
2.00	instructions)	year (see	23.4	0.00		12. (
3. 00	Total weighted resident FTE count for the penultimate cost replyear (see instructions)	orti ng	20. 4	0.00		13. (
4. 00	Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	23. 1			14. (
5. 00	Adjustment for residents in initial years of new programs		0.0	1		15. (
6. 00	Adjustment for residents displaced by program or hospital clos	ure	0.0	1		16. (
7. 00 8. 00	Adjusted rolling average FTE count Per resident amount		23. 1 78, 428. 0			17. (18. (
	Approved amount for resident costs		1, 818, 74		1, 818, 747	
7. 00	The first additional to the state of the sta		1,010,7		1,010,717	17.
					1. 00	
	Additional unweighted allopathic and osteopathic direct GME FT Sec. 413.79(c)(4)		cap slots rec	eived under 42	0. 00	
1. 00	Direct GME FTE unweighted resident count over cap (see instruc				0. 00	
2. 00	Allowable additional direct GME FTE Resident Count (see instru				0.00	
	Enter the locally adjustment national average per resident amo	unt (see in	structions)		0.00	1
	Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)				1, 818, 747	24.0
3. 00	Total direct own amount (sum of Tries 17 and 24)		Inpatient Par	t Managed care	1,010,747	23. (
			1. 00	2. 00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD					
	Inpatient Days (see instructions)		21, 21			26. (
7. 00	Total Inpatient Days (see instructions)		58, 89			27. (
8. 00	, , , , , , , , , , , , , , , , , , , ,		0. 36031			28. (
9. 00	Program di rect GME amount		655, 32			29. (
30. 00	Reduction for direct GME payments for Medicare Advantage			30, 202		30.0
	Net Program direct GME amount		I	1	838, 868	L 31. '

Heal th	Financial Systems COMMUNITY HOSPITAL OF I	NDI ANA, INC.	In Lie	u of Form CMS-2	2552-10
DI REC	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der CCN: 150074	Peri od:	Worksheet E-4	
MEDI CA	AL EDUCATION COSTS		From 01/01/2014 To 12/31/2014	Date/Time Prep 5/27/2015 6:0	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE EDUCATION COSTS)	`		CAL	
32. 00	Renal dialysis direct medical education costs (from Wkst. B, Pt and 94)	. I, sum of col. 20 an	d 23, lines 74	0	32. 00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I,	col. 8, sum of lines	74 and 94)	2, 280, 518	33.00
34.00	Ratio of direct medical education costs to total charges (line	32 ÷ line 33)	ĺ	0.000000	34.00
	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 3			0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII O	NLY			
	Part A Reasonable Cost				
37. 00				44, 193, 925	
38. 00				0	38. 00
	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	39.00
	Primary payer payments (see instructions)	111		21, 696	
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus Part B Reasonable Cost	line 40)		44, 172, 229	41.00
42.00	Reasonable cost (see instructions)		T	49, 031, 911	12 00
	Primary payer payments (see instructions)			10, 086	
44. 00				49, 021, 825	
45. 00	· · · · · · · · · · · · · · · · · · ·			93, 194, 054	
46. 00	, ,	41 ÷ line 45)		0. 473981	
	Ratio of Part B reasonable cost to total reasonable cost (line			0. 526019	
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART				1
48. 00	Total program GME payment (line 31)			838, 868	48. 00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		397, 607	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		441, 261	50.00

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

Provider CCN: 150074 Period: From 01/0

Peri od: Worksheet G From 01/01/2014 To 12/31/2014 Date/Time Prepared:

			10 12/31/2014	5/27/2015 6:0	pared: 1 pm	
		General Fund	Speci fi c	Endowment Fund		, piii
			Purpose Fund	2.22	4.00	
	CURRENT ASSETS	1.00	2. 00	3. 00	4. 00	
1.00	Cash on hand in banks	94, 336, 474		0	0	1.00
2.00	Temporary investments	0	1	o o	0	
3.00	Notes receivable	23, 261, 725		0	0	1
4.00	Accounts receivable	92, 424, 700	(0	0	4.00
5.00	Other recei vable	13, 108, 846	(0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-29, 864, 890		0	0	
7.00	Inventory	7, 764, 298	(0	0	
8.00	Prepaid expenses	8, 872, 864	(0	0	
9. 00 10. 00	Other current assets Due from other funds	10, 057, 392			0	
11. 00	Total current assets (sum of lines 1-10)	219, 961, 409			_	1
11.00	FIXED ASSETS	217, 701, 407		<u> </u>	0	111.00
12. 00	Land	2, 743, 049	(0	0	12. 00
13.00	Land improvements	4, 080, 044		0	0	1
14.00	Accumulated depreciation	0	(0	0	14. 00
15. 00	Bui I di ngs	264, 158, 593	(0	0	15. 00
16. 00	Accumulated depreciation	0	(0	0	16. 00
17. 00	Leasehold improvements	21, 005, 882	(0	0	
18.00	Accumulated depreciation	14 2/5 220	(0	0	
20. 00	Fixed equipment Accumulated depreciation	14, 265, 238			0	
	Automobiles and trucks	0			0	1
22. 00	Accumulated depreciation	0			0	1
	Major movable equipment	303, 024, 910		1	ő	1
	Accumul ated depreciation	-379, 195, 962		0	0	1
25. 00	Mi nor equi pment depreci abl e	0	(0	0	25. 00
26. 00	Accumulated depreciation	0	(0	0	26. 00
	HIT designated Assets	0	(0	0	
	Accumulated depreciation	0	(0	0	
	Mi nor equi pment-nondepreci abl e	0	(0	
30. 00	Total fixed assets (sum of lines 12-29)	230, 081, 754		0	0	30.00
31. 00	OTHER ASSETS Investments	349, 277, 925		0	0	31.00
32. 00	Deposits on Leases	0 0			0	
33. 00	Due from owners/officers	0		0	Ō	
34. 00	Other assets	-23, 606, 243	(0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	325, 671, 682	(0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	775, 714, 845	(0	0	36. 00
	CURRENT LI ABI LI TI ES	1		-1 -		ļ
	Accounts payable	49, 872, 131	(
38. 00 39. 00	Salaries, wages, and fees payable	35, 538, 296		0	0	38. 00 39. 00
40.00	Payroll taxes payable Notes and Loans payable (short term)	12, 989, 720 18, 765, 358			0	1
41. 00	Deferred income	10, 703, 330			0	1
42. 00	Accel erated payments	0	· `			42. 00
	Due to other funds	0	(0	0	1
44.00	Other current liabilities	34, 705, 544	(0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	151, 871, 049	(0	0	45. 00
	LONG TERM LIABILITIES	1				
46.00	Mortgage payable	0	(0	0	
47. 00	Notes payable	565, 474, 979	(0	0	
48. 00 49. 00	Unsecured Loans Other Long term Liabilities	206, 724, 957			0	
50.00	Total long term liabilities (sum of lines 46 thru 49	772, 199, 936			0	
51. 00	Total liabilites (sum of lines 45 and 50)	924, 070, 985		o o		
	CAPI TAL ACCOUNTS	.,				
52.00	General fund balance	-148, 356, 140				52. 00
53. 00	Specific purpose fund		(53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
E4 00	Governing body created - endowment fund balance			0	_	56.00
56. 00	Plant fund balance - invested in plant	1			0	
57. 00						
	Plant fund balance - reserve for plant improvement,				0	30.00
57. 00 58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion	-148, 356, 140		0		
57. 00	Plant fund balance - reserve for plant improvement,	-148, 356, 140 775, 714, 845		0 0		59. 00

17.00

18.00

19.00

0

0

STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 150074 Peri od: Worksheet G-1 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/27/2015 6:01 pm General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period -101, 067, 393 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 95, 873, 668 2.00 3.00 Total (sum of line 1 and line 2) -5, 193, 725 0 3.00 4.00 0 0 4.00 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 0 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) -5, 193, 725 11.00 11.00 0 OTHER FUND BALANCE ACTIVITY 12.00 143, 162, 415 0 12.00 13.00 13.00 14.00 0 14.00 0 0 0 0 15.00 15.00 0 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 143, 162, 415 18.00 Fund balance at end of period per balance 19.00 -148, 356, 140 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 4.00 4.00 5.00 0 5.00 0 6.00 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 0 0 Subtotal (line 3 plus line 10) 11.00 12.00 OTHER FUND BALANCE ACTIVITY 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00

0

17.00

18.00

19.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

From 01/01/2014 Parts I & II Date/Time Prepared: 12/31/2014 5/27/2015 6:01 pm Cost Center Description Inpati ent Outpati ent Total 1.00 2. 00 3.00 PART I - PATIENT REVENUES General Inpatient Routine Services 1.00 Hospi tal 96, 119, 815 96, 119, 815 1.00 2.00 SUBPROVIDER - IPF 2.00 SUBPROVIDER - IRF 3.00 3.00 4.00 SUBPROVI DER 4.00 5.00 Swing bed - SNF 0 0 5.00 Swing bed - NF 6.00 0 6.00 SKILLED NURSING FACILITY 7.00 7.00 8.00 NURSING FACILITY 8.00 9.00 OTHER LONG TERM CARE 9.00 10.00 Total general inpatient care services (sum of lines 1-9) 96, 119, 815 96, 119, 815 10 00 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT 10, 747, 369 10, 747, 369 11.00 12.00 CORONARY CARE UNIT 15, 053, 893 15, 053, 893 12.00 BURN INTENSIVE CARE UNIT 13 00 13 00 SURGICAL INTENSIVE CARE UNIT 14.00 14.00 15.00 OTHER SPECIAL CARE (SPECIFY) 15.00 Total intensive care type inpatient hospital services (sum of lines 25, 801, 262 16, 00 25, 801, 262 16, 00 11 - 15) 17.00 121, 921, 077 Total inpatient routine care services (sum of lines 10 and 16) 121, 921, 077 17.00 18.00 Ancillary services 311, 838, 228 907, 833, 613 1, 219, 671, 841 18.00 19.00 Outpatient services 0 19.00 RURAL HEALTH CLINIC 20.00 0 0 0 20.00 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 Λ 21.00 22. 00 HOME HEALTH AGENCY 22.00 AMBULANCE SERVICES 23.00 23.00 CMHC 24.00 24.00 25.00 AMBULATORY SURGICAL CENTER (D. P.) 25.00 26.00 HOSPI CE 26.00 27.00 OTHER (SPECIFY) 27.00 433, 759, 305 907, 833, 613 1, 341, 592, 918 28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 28.00 G-3, line 1) PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200) 29.00 445, 398, 696 29.00 0 30.00 ADD (SPECIFY) 30.00 0 31.00 31.00 32.00 32.00 0 33.00 33.00 0 34.00 34.00 35.00 35.00 36.00 Total additions (sum of lines 30-35) 0 36.00 0 DEDUCT (SPECIFY) 37.00 37.00 0 38.00 38.00 39.00 0 39.00 40.00 0 40.00 0 41.00 41.00 Total deductions (sum of lines 37-41) 42.00 42.00 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 445, 398, 696 43.00 to Wkst. G-3, line 4)

Provider CCN: 150074

Peri od:

Health Financial Systems	COMMUNITY HOSPITAL OF I	NDI ANA, INC.	In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 150074	Peri od: From 01/01/2014	Worksheet G-3	
			To 12/31/2014	Date/Time Pre 5/27/2015 6:0	
				1 00	

STATE	IENI OF KEVENUES AND EXPENSES	Provider CCN: 150074	From 01/01/2014	worksneet G-3	
			To 12/31/2014	Date/Time Prep 5/27/2015 6:0	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line :	28)		1, 341, 592, 918	1. 00
2.00	Less contractual allowances and discounts on patients' accounts			830, 970, 276	
3.00	Net patient revenues (line 1 minus line 2)			510, 622, 642	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43))		445, 398, 696	
5.00	Net income from service to patients (line 3 minus line 4)			65, 223, 946	5. 00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			531, 884	7. 00
8.00	Revenues from telephone and other miscellaneous communication se	ervi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10. 00
11. 00	Rebates and refunds of expenses			0	
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			107, 792	
15. 00	Revenue from rental of living quarters			0	
16. 00	Revenue from sale of medical and surgical supplies to other than	n patients		0	16. 00
17. 00	Revenue from sale of drugs to other than patients			200	
18. 00	Revenue from sale of medical records and abstracts			136, 102	
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			135, 250	22. 00
23.00	Governmental appropriations			0	23.00
24.00	OTHER (SPECIFY)			29, 738, 494	24.00
25.00	Total other income (sum of lines 6-24)			30, 649, 722	25.00
26. 00	Total (line 5 plus line 25)			95, 873, 668	26. 00
27. 00	OTHER EXPENSES (SPECIFY)			0	27. 00
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)			95, 873, 668	29. 00

	Financial Systems COMMUNITY HOSPITAL OF			u of Form CMS-2	2002-IC
CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 150074	Peri od: From 01/01/2014	Worksheet L Parts I-III	
			To 12/31/2014	Date/Time Pre	
		Title XVIII	Hospi tal	5/27/2015 6: 0 PPS	ı pm
		TITLE VIII	поѕрі таі	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			2, 831, 991	
1. 01	Model 4 BPCI Capital DRG other than outlier			0	
2.00	Capital DRG outlier payments			42, 276	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	
3.00	Total inpatient days divided by number of days in the cost rep	orting period (see inst	ructions)	162. 12	
4.00	Number of interns & residents (see instructions)			22. 04	
5. 00	Indirect medical education percentage (see instructions)			3. 91	
6. 00	Indirect medical education adjustment (multiply line 5 by the			110, 731	
7. 00	Percentage of SSI recipient patient days to Medicare Part A pa	tient days (Worksheet E	, part A line	11. 82	7.00
0.00	30) (see instructions)			00.50	
8.00	Percentage of Medicaid patient days to total days (see instructions)			29. 53	
9.00	Sum of lines 7 and 8			41. 35	
10.00	Allowable disproportionate share percentage (see instructions)	1 1 01)		8. 73	
11.00				247, 233 3, 232, 231	
12. 00	Total prospective capital payments (sum of fines 1, 1.01, 2, 2	OI, 6 and II)		3, 232, 231	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	
2.00	Program inpatient ancillary capital cost (see instructions)			0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4.00	Capital cost payment factor (see instructions)			0	
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	1.00
2.00	Program inpatient capital costs for extraordinary circumstance:	s (see instructions)		0	
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	
4.00	Applicable exception percentage (see instructions)			0. 00	
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	
6.00	Percentage adjustment for extraordinary circumstances (see ins			0. 00	
7.00	Adjustment to capital minimum payment level for extraordinary	circumstances (line 2 x	line 6)	0	
8.00	Capital minimum payment level (line 5 plus line 7)			0	
9.00	Current year capital payments (from Part I, line 12, as applications)			0	
10.00	Current year comparison of capital minimum payment level to ca	1 3 1	,	0	1
11. 00	Carryover of accumulated capital minimum payment level over ca	oital payment (from pri	or year	0	11. 0
12 00	Worksheet L, Part III, line 14)			0	12.0

0 12.00 0 13.00

14.00

0 15.00 0 16.00 0 17.00

12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)
13.00 Current year exception payment (if line 12 is positive, enter the amount on this line)
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)