| Heal th Financ | | UNITY HOSPITAL OF | | | | u of Form CMS- | |
|----------------------|--|-------------------------|----------------|-----------------------|-------------------------------|--------------------------------|---------|
| | s required by law (42 USC 1395g; 42 CF | | | | | FORM APPROVEI | |
| <u> </u> | e since the beginning of the cost repor HOSPITAL HEALTH CARE COMPLEX COST REPO | <u> </u> | | CCN: 150169 | Peri od: | Worksheet S | -0050 |
| AND SETTLEMEN | | | | | From 01/01/2014 | Parts I-III | |
| | | | | | To 12/31/2014 | Date/Time Pro 5/27/2015 6:0 | |
| | REPORT STATUS | | | | | | |
| Provider use only | 1. [X] Electronically filed cost re | | | | Date: 5/27/20 | 15 Time: | 6:08 pm |
| use only | 2. [] Manually submitted cost report 3. [0] If this is an amended report | enter the number | of times the | e provider re | submitted this c | ost report | |
| | 4. [F] Medicare Utilization. Enter | "F" for full or " | L" for low. | | | | |
| Contractor | | Received: ractor No. | | | PR Date: ontractor's Vende | or Codo: | 4 |
| use only | (2) Settled without Audit 8. [N] | Initial Report f | or this Provi | der CCN 12. [| 0]If line 5, co | olumn 1 is 4: | Enter |
| | | Final Report for | this Provide | er CCN | number of tin | nes reopened = | 0-9. |
| | (4) Reopened (5) Amended | | | | | | |
| | (5) Allended | | | | | | |
| PART II - CER | | | | | | | |
| | TION OR FALSIFICATION OF ANY INFORMATI /E ACTION, FINE AND/OR IMPRISONMENT UNE | | | | | | |
| | PROCURED THROUGH THE PAYMENT DIRECTLY O | | | | | | |
| ADMI NI STRATI V | 'E ACTION, FINES AND/OR IMPRISONMENT MA | AY RESULT. | | | | | |
| | CERTIFICATION BY OFFICER OR ADMINI | STRATOR OF PROVID | NER(S) | | | | |
| | SERTITION DI SITTCER OR ADMINI | | JER(3) | | | | |
| | REBY CERTIFY that I have read the above | | | | | | |
| | tronically filed or manually submitted nses prepared by COMMUNITY HOSPITAL OF | | | | | | |
| | 1/2014 and ending 12/31/2014 and to the | | | | | | |
| | ect, complete and prepared from the boo | | | | | | |
| | ructions, except as noted. I further of | | | | | | |
| | sion of health care services, and that iance with such laws and regulations. | t the services id | entified in t | this cost rep | ort were provide | din | |
| Compr | Tance with such raws and regulations. | | | | | | |
| | | (Si gned | I) | | | | |
| | | | | er or Adminis | strator of Provic | ler(s) | |
| | | | | | | | |
| | | | Title | | | | |
| | | | | | | | |
| | | | Date | | | | |
| | | | bate | | | | |
| | | | Title | | | T I I I VI V | |
| C | Cost Center Description | Title V 1.00 | Part A 2.00 | <u>Part B</u> 3.00 | HI T 4. 00 | <u>Title XIX</u> 5.00 | |
| PART II | I - SETTLEMENT SUMMARY | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 1.00 Hospit | | 0 | -234, 988 | -122, 05 | 5 4, 373 | (| 1.00 |
| | vider - IPF | 0 | 8, 628 | 12 | | (| |
| | vider - IRF | 0 | 0 | | 0 | (| |
| 6.00 Swing | bed - SNF bed - NF | 0 | 0 | | 0 | (| |
| 200.00 Total | | 0 | -226, 360 | -121, 93 | 4, 373 | | 200.00 |
| | ounts represent "due to" or "due from" | | | | | | |
| | the Paperwork Reduction Act of 1995, r | | | | | | |
| | lid OMB control number. The valid OME complete and review the information col | | | | | | |
| | search existing resources, gather the | | | | | | |
| | ents concerning the accuracy of the ti | | | | | | CMS, |
| | Boulevard, Attn: PRA Report Clearance | | | | | | - 004 |
| | send applications, claims, payments, claims, payments, cance Office. Please note that any cor | | | | | | |
| | sociated OMB control number listed on t | | | | | | |
| | regarding where to submit your document | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

| | | | | | | From 01/01/ To 12/31/ | /2014 | Part I Date/Ti 5/27/20 | | |
|----------|--|--|------------|----------------------|---------------|--------------------------|-----------------|------------------------------|----------|--------------|
| | 1.00 | 2.00 | | 3.00 | | | 4.00 | | | |
| 00 | Hospital and Hospital Health Care Con Street: 7150 CLEARVISTA PARKWAY | PO Box: | | | | | | | | 1.00 |
| 00 | City: INDIANAPOLIS | State: IN | Zip Coc | le: 46256 | Count | ty: MARION | | | | 2.0 |
| | | Component Name | CCN | CBSA | Provi der | | | ent Syst | | |
| | | | Number | Number | Туре | Certified | V | , 0, or XVIII | | - |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | _ | | 1 |
| | Hospital and Hospital-Based Componen | t Identification: | | | | | | | | |
| 00 | Hospi tal | COMMUNITY HOSPITAL OF | 150169 | 26900 | 1 | 02/25/2008 | N | P | P | 3.00 |
| 00 | Subprovider - IPF | INDIANA, INC. COMMUNITY MENTAL HEALTH | 15S169 | 26900 | 4 | 01/01/2010 | N | Р | 0 | 4.00 |
| 00 | Subprovi der – IRF | | 100107 | 20,00 | | | | | | 5.00 |
| 00 | Subprovider - (Other) | | | | | | | | | 6.00 |
| 00 | Swing Beds - SNF | | | | | | | | | 7.00 |
| 00 00 | Swing Beds - NF Hospital-Based SNF | | | | | | | | | 8.00 9.00 |
| | Hospi tal -Based NF | | | | | | | | | 10.0 |
| | Hospi tal -Based OLTC | | | | | | | | | 11.00 |
| | Hospi tal -Based HHA | | | | | | | | | 12.0 |
| | Separately Certified ASC Hospital-Based Hospice | | | | | | | | | 13.0 |
| | Hospital - Based Health Clinic - RHC | | | | | | | | | 15.0 |
| | Hospital-Based Health Clinic - FQHC | | | | | | | | | 16.0 |
| | Hospital-Based (CMHC) I Bapal Dialysis | | | | | | | | | 17.0 |
| | Renal Dialysis Other | | | | | | | | | 19.0 |
| | | | 1 | 1 | | From: | | То |): | |
| | | | | | | 1.00 | | 2.0 | | |
| | Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions) | | | | | 01/01/2 | 2014 | 12/31/ | /2014 | 20.0 |
| . 00 | Inpatient PPS Information | | | | | | | | | 1 21.0 |
| 2.00 | Does this facility qualify and is it | | | | | Y | | N | | 22.0 |
| | share hospital adjustment, in accorda | | | | | | | | | |
| | for yes or "N" for no. Is this facili amendment hospital?) In column 2, ent | | | 12.06(C)(| (2) (PI CKI e | | | | | |
| 2. 01 | Did this hospital receive interim und | | | is cost r | reporting | N | | Y | | 22.0 |
| | period? Enter in column 1, "Y" for ye | | | | | | | | | |
| | reporting period occurring prior to (for no for the portion of the cost re | | | | | | | | | |
| | (see instructions) | eporting period occurri | Ig on or a | | LUDEI I. | | | | | |
| 2. 02 | Is this a newly merged hospital that | | | | | N | | Ν | | 22.0 |
| | determined at cost report settlement? or "N" for no, for the portion of the | ? (see instructions) En | ter in co | lumn 1, " Octobor | 'Y" for ye | s | | | | |
| | in column 2, "Y" for yes or "N" for r | | | | | n | | | | |
| | or after October 1. | | | oper trig | , politica o | | | | | |
| 2. 03 | Did this hospital receive a geographi | | | | | | | N | | 22.0 |
| | of the OMB standards for delineating in column 1, "Y" for yes or "N" for r | | | | | | | | | |
| | prior to October 1. Enter in column 2 | | | | | e | | | | |
| | cost reporting period occurring on or | r after October 1. (see | instruct | ions) Doe | es this | | | | | |
| | hospital contain at least 100 but not 42 CFR 412.105)? Enter in column 3, ' | | | in accor | dance wit | h | | | | |
| 3. 00 | Which method is used to determine Med | | | 5 below? | In column | | 3 | Ν | | 23.0 |
| | 1, enter 1 if date of admission, 2 if | | | | | | | | | |
| | method of identifying the days in thi used in the prior cost reporting peri | | | | | | | | | |
| | | In-Sta | | | Dut-of | | <i>l</i> edi ca | id 0 | ther | |
| | | Medica | aid Medi | cai d | State | State H | IMO da | ys Med | li cai d | |
| | | paid d | | · I | | Medicaid eligible | | d | lays | |
| | | | | ard pa ays | id days | unpai d | | | | |
| | | 1.00 | | 00 | 3.00 | 4. 00 | 5.00 | 6 | 5.00 | 1 |
| . 00 | If this provider is an IPPS hospital, | | 084 | 2, 195 | 0 | 6 | 13, | 133 | 454 | 24.0 |
| | in-state Medicaid paid days in column | | | | | | | | | |
| | Medicaid eligible unpaid days in colu out-of-state Medicaid paid days in co | | | | | | | | | |
| | out-of-state Medicaid eligible unpaid | d days in column | | | | | | | | |
| | 4, Medicaid HMO paid and eligible but | t unpaid days in | | | | | | | | |
| . 00 | column 5, and other Medicaid days in If this provider is an IRF, enter the | | 0 | o | 0 | 0 | | 0 | | 25.0 |
| . 00 | Medicaid paid days in column 1, the i | | 0 | | U | | | | | ∠5.0 |
| | Medicaid eligible unpaid days in colu | umn 2, | | | | | | | | |
| | out-of-state Medicaid days in column | 3, out-of-state | | | | | | | | |
| | | | 1 | 1 | 1 | 1 | | 1 | | |
| | Medicaid eligible unpaid days in colu HMO paid and eligible but unpaid days | umn 4, Medicaid | | | | | | | | |

| Heal th | Financial Systems COMMUNITY HO | SPI TAL | OF INDIANA, IN | С. | I | n Lieu | ı of For | m CMS-2 | 2552-10 |
|------------------|---|--------------------------------|---|-------------------------------|----------------------------------|-----------|---|--------------|----------------|
| HOSPI T | AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA | TA | Provi der | F | eriod: rom 01/01/ o 12/31/ | | Workshe Part I Date/Ti 5/27/20 | me Pre | pared: |
| | | | | | Urban/Rur 1.00 | | Date of 2.0 | | - |
| 26.00 | Enter your standard geographic classification (not wa | | | jinning of the | 1.00 | 1 | 2. 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 | age) sta - "2" fo | atus at the end or rural. If ap | | | 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. | | | CH status in | - | 0 | | | 35.00 |
| | | | | | Begi nni 1.00 | | Endi 2. (| | - |
| 36.00 | Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date | | Subscript line | 36 for number | 1.00 | | 2.0 | | 36.00 |
| 37.00 | If this is a Medicare dependent hospital (MDH), enter in effect in the cost reporting period. | | umber of period | ds 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 | | Y/ | | - |
| 39.00 | Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage rec CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes |)? Ente qui remer | er in column 1 nts in accordar | "Y" for yes nce with 42 | 1.00 N | | <u>2. (</u> N | | 39.00 |
| 40.00 | Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. | n adjust per 1. E | tment? Enter "א Enter "Y" for א | (" for yes or | N | | Y | | 40.00 |
| | | | | | | V 1.00 | 2.00 | XI X 3.00 | - |
| 45.00 | Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer | nt for a | di sproporti onat | e share in ac | cordance | N | Y | N | 45.00 |
| 46.00 | with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. | | | | | N | N | N | 46.00 |
| 47. 00 48. 00 | Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals | | | | | N N | N N | N N | 47.00 48.00 |
| 56.00 | Is this a hospital involved in training residents in | approve | ed GME programs | s? Enter "Y" | for yes | Y | | | 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 th of th (", comp | r "N" for no ir nis cost report plete Worksheet | n column 1. lf ing period? | column 1 Enter "Y" | N | | | 57.00 |
| | If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, § 2148? If yes, complete Wk | oursemer st. D-5 | nt for physicia 5. | | as | N | | | 58.00 |
| | Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health | | | | | N Y | | | 59.00 60.00 |
| | provider-operated criteria under §413.85? Enter "Y" | for yes | s or "N" for no | <u>). (see instru</u> | ctions) | | Dimoni | | |
| | | Y/N | IME | Direct GME | IME | | Di rect | | |
| 61.00 | Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in | 1.00 N | 2.00 | 3.00 | 4.00 | 0.00 | 5.0 | | 61.00 |
| 61.01 | column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see | | 0.00 | 0.0 | o | | | | 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 | | 1.76 | 1.7 | 6 | | | | 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 | | 0.00 | 0.0 | o | | | | 61.03 |
| 61. 04 | instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the | | 0.00 | 0.0 | o | | | | 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 | | 0. 00 | 0.0 | o | | | | 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 care or general surgery. (see instructions) | | 0.00 | 0.0 | o | | | | 61.06 |

| HOSPITAL AND HOSPITA | AL HEALTH CARE COMPL | EX IDENTIFICATION DA | TA | 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: |
|---|---|---|--|---|--|--|---|---------|
| | | | Progra | n Name | Program Code | Unweighted IME FTE Count | Unweighted Direct GME FTE Count | |
| | | | 1. | 00 | 2.00 | 3.00 | 4.00 | |
| special ty, if for each new column 1, the program code, unweighted of TE unweighte 51.20 Of the FTEs i program speci- residents for | n line 61.05, speci- any, and the number program. (see instru- program name, enter enter in column 3, unt and enter in co d count. n line 61.05, speci- alty, if any, and ti each expanded prog Enter in column 1, | of FTE residents Juctions) Enter in r in column 2, the the IME FTE umn 4, direct GME fy each expanded he number of FTE ram. (see | | | | 0.00 | | 61. 1 |
| enter in colu 3, the IME FT | | ode, enter in column and enter in column | | | | | | |
| | | | | | | | 1.00 | |
| ACA Provision | s Affecting the Hea | th Resources and Ser | rvices Admi | nistration | (HRSA) | | 1.00 | |
| 2.00 Enter the num | ber of FTE resident: | s that your hospital funding (see instruc | trained in | | | od for which | 0.00 | 62.0 |
| 2.01 Énter the num during in this | ber of FTE residents s cost reporting pe | s that rotated from a riod of HRSA THC prog | a Teaching H gram. (see i | | | your hospital | 0.00 | 62.0 |
| 3.00 Has your faci | lity trained reside | <u>sidents in Nonprovide</u> nts in nonprovider se umn 1. If yes, comple | ettings duri | | | | N | 63.0 |
| | | | | | Unwei ghted FTEs Nonprovi der Si te | Unweighted FTEs in Hospital | Ratio (col. 1/ (col. 1 + col. 2)) | |
| | | | | | 1.00 | 2.00 | 3.00 | 1 |
| | | r FTE Residents in No | | | This base year | is your cost r | eporting | |
| 4.00 Enter in colu in the base y resident FTEs settings. En resident FTEs | nn 1, if line 63 is ear period, the numl attributable to ro ter in column 2 the that trained in you | uly 1, 2009 and befor yes, or your facilit per of unweighted nor tations occurring in number of unweightec ur hospital. Enter in 1 + column 2)). (see | trained u primary ca all nonprov non-priman column 3 | residents are /ider ry care the ratio | 0. 00 | | | |
| | | Program Name | Progra | n Code | Unwei ghted FTEs Nonprovi der Si te | Unweighted FTEs in Hospital | Ratio (col. 3/ (col. 3 + col. 4)) | |
| | | 1.00 | 2. | 00 | 3.00 | 4.00 | 5.00 | |
| year period, associated wi FTEs for each program in wh residents. En the program c col umn 3, the unweighted pr residents att rotations occ non-provider col umn 4, the unweighted pr resident FTEs your hospital | ur facility ents in the base the program name th primary care primary care ich you trained ter in column 2, ode, enter in number of imary care FTE ributable to urring in all settings. Enter in number of | | | | 0. 00 |) 0.00 | 0. 000000 | η 65. Ο |

| Heal th | Financial Systems | COMMUNI TY H | OSPITAL OF I | NDIANA, IN | IC. | I | n Lie | u of Form | n CMS-2 | 2552-10 |
|---------|--|---|---------------|------------|----------------------|------------------------|------------|---------------------|---------|---------|
| HOSPI T | AL AND HOSPITAL HEALTH CARE COMP | LEX IDENTIFICATION DA | ATA | Provi der | | Period: From 01/01, | /2014 | Workshe Part I | et S-2 | |
| | | | | | | To 12/31, | | | | |
| | | | | | Unwei ghted | Unwei gh | ted | Ratio (c | | 7 piii |
| | | | | | FTEs Nonprovi der | FTEs i Hospi t | | (col. 1 2)) | | |
| | | | | | Si te | | | | | |
| | Section 5504 of the ACA Current | Vear FTF Residents i | n Nonnrovi de | er Setting | 1.00 | 2.00 | | 3.0 | | |
| | beginning on or after July 1, 20 | 010 | • | | 1 | | • | | | |
| 66.00 | Enter in column 1 the number of FTEs attributable to rotations of | | | | 0.0 | 00 | 0.00 | 0. | 000000 | 66.00 |
| | Enter in column 2 the number of | unweighted non-prima | ry care resi | dent | | | | | | |
| | FTEs that trained in your hospit (column 1 divided by (column 1 + | | | of | | | | | | |
| | | Program Name | Program | n Code | Unweighted FTEs | Unwei gh FTEs | | Ratio (c (col. 3 | | |
| | | | | | Nonprovi der | | | (201. 3 | | |
| | | 1.00 | 2.0 | 0 | Si te | 4.00 | <u></u> | E 0 | 0 | |
| 67.00 | Enter in column 1, the program | 1.00 FAMILY PRACTICE | 2.0 | 0 | 3.00 | 4.00 | , 1. 89 | 5.0 0. | 000000 | 67.00 |
| | name associated with each of | | | | | | | | | |
| | your primary care programs in which you trained residents. | | | | | | | | | |
| | Enter in column 2, the program code. Enter in column 3, the | | | | | | | | | |
| | number of unweighted primary | | | | | | | | | |
| | care FTE residents attributable to rotations occurring in all | | | | | | | | | |
| | non-provider settings. Enter in | | | | | | | | | |
| | column 4, the number of unweighted primary care | | | | | | | | | |
| | resident FTEs that trained in | | | | | | | | | |
| | your hospital. Enter in column 5, the ratio of (column 3 | | | | | | | | | |
| | divided by (column 3 + column | | | | | | | | | |
| | 4)). (see instructions) | | | | | | | | | |
| | | | | | | | 1.00 | 0 2.00 | 3.00 | |
| 70.00 | Inpatient Psychiatric Facility F Is this facility an Inpatient Ps | | IPF), or doe | s it conta | ain an IPF sul | oprovi der? | Y | | | 70.00 |
| 71 00 | Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th | | nnrouad CME | toophing . | nnannan in th | maat | N | | 0 | 71.00 |
| 71.00 | recent cost report filed on or b | | | | | | | | 0 | 71.00 |
| | 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF | | | | | | | | | |
| | Column 3: If column 2 is Y, ente | er 1, 2, or 3, in col | umn 3. (see | instructio | ons) If this (| cost | | | | |
| | reporting period covers the begi or subsequent academic years of | | | | | ne fifth | | | | |
| | instructions) For cost reporting | g periods beginning o | n or after C | october 1, | 2012, if this | | | | | |
| | reporting period covers the begi teaching program in existence, e | - | | | emic year of | the new | | | | |
| 75 00 | Inpatient Rehabilitation Facili | ty PPS | | | | | | | | 75 00 |
| 75.00 | Is this facility an Inpatient Re subprovider? Enter "Y" for yes | | y (IRF), or | does it co | ontain an IRF | | N | | | 75.00 |
| 76.00 | If line 75 yes: Column 1: Did th | ne facility have an a | | 0. | 0 | | N | | 0 | 76.00 |
| | recent cost reporting period end no. Column 2: Did this facility | | | | | | | | | |
| | CFR 412.424 (d)(1)(iii)(D)? Ente 1, 2, or 3, in column 3. (see ir | | | | | | | | | |
| | of the fourth year, enter 4 in c | | | | | | | | | |
| | teaching program in existence, e on or after October 1, 2012, if | | , | | 51 | 5 5 | | | | |
| | any subsequent academic year of | | | | | | | | | |
| | instructions) | | | | | | | | | |
| | | | | | | | | 1.0 | 0 | |
| 80. 00 | Long Term Care Hospital PPS Is this a long term care hospita | al (LTCH)? Enter "V" | for yes and | N" for a | no | | | N | | 80. 00 |
| | Is this a LTCH co-located within | | | | | g period? E | nter | N | | 81.00 |
| | "Y" for yes and "N" for no. TEFRA Providers | | | | | | | | | |
| | Is this a new hospital under 42 | | | | | | no. | N | | 85.00 |
| 86.00 | Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo | ew Other subprovider or yes and "N" for no | (excluded ur | nit) under | 42 CFR Sectio | on | | | | 86.00 |

| HIGH IAL AND HESH IAL HEALTH CARE COMPLEX LIDENTIFICATION DATA Provider COX 10000 Period | Health Financial Systems COMMUNITY HOSPITAL | OF INDIANA, IN | VC. | In Li | eu of Form CMS | -2552-10 |
|--|---|---|---|-----------------------------|----------------------------|----------------|
| The W and MX Services 1.00 2.00 0.00 Bost this facility have title V and/or NX frough the cost resort of ther in rul or in parts tarter 'Y for yes or 'W for no in the applicable column. N< | HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provi der | | From 01/01/2014 | 4 Part I 4 Date/Time Pr | epared: |
| Differ Use V and XL Services V V N Y </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>_</td> | | | | | | _ |
| bs corr Torm of in the applicable colume. instruction of in the applicable colume. N 91.05 20.00 in the instruction of in the applicable colume. N 92.00 N N 91.05 N N 92.00 N 93.00 <td></td> <td></td> <td></td> <td>1.00</td> <td></td> <td></td> | | | | 1.00 | | |
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| mom "for yos or "N" for no in the applicable form" M 94.00 00 000000000000000000000000000000000000 | | | ion)? (see | | N | 92.00 |
| begin labble colume. 0.00 0.00 95.00 96.00 best this V or NLY relace operating cost? Enter 'Y for yes or 'W for no in the N N 0.00 95.00 96.00 best this V or NLY relace operating cost? Enter 'Y for yes or 'W for no in the N N 0.00 95.00 96.00 best this V, enter the reduction percentage in the applicable colum. 0.00 0.00 0.00 95.00 96.00 boliose this V, enter the reduction percentage in the applicable colum. 0.00 0.00 0.00 0.00 95.00 96.00 boliose this V, enter the reduction would not be constructurations. N N 105.00 97.00 boliose this V, enter the reduction would not be on Rest. 8, PL, i. col. 25 and the program colube cost reisbursteement. N N 106.00 97.00 bolios this a ural heapilal qualifying for an exception to the CRM for social cost reisbursteement. N N N 106.00 107.00 for no for no for each therage provider. Are N N N N 106.00 108.00 fbis revices provided by actid despin applicat? Inter 'Y' for yes or 'W for no. 1.00 2.00 3.00 1.00 2.00 3.00 109.00< | "Y" for yes or "N" for no in the applicable column. | | | N | N | 93.00 |
| 96.00 Does It It V or XIX reduce operating coirt 2 ther "Y" for yes or "N" for no In the not the N N 96.00 97.00 If It inn 64 is "Y", inter the reduction percentage in the applicable colum. 0.00 | | and "N" for no | o in the | N | N | 94.00 |
| 97.00 [1] Time 96 is "Y," enter the reduction percentage in the applicable column. 0.00 0.00 97.00 | 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes | | | | | |
| 105. 00/Des this heapital quality as a Critical Access inspirat (CM)? N 105. 00/D 106. 00/D fits facility qualities as a CM. Is it eligible for cost non-memory of a payment in the cost reinbursteement in the cost re | 97.00 If line 96 is "Y", enter the reduction percentage in the app | plicable colum | n | 0.0 | 0 0.0 | <u>0</u> 97.00 |
| Tor outpatient Services? (see instructions) N 100 0 0 0 0 0 N N N N N N N N N N N N N N N <t< td=""><td>105.00 Does this hospital qualify as a Critical Access Hospital (CA</td><td></td><td>hod of navment</td><td></td><td></td><td></td></t<> | 105.00 Does this hospital qualify as a Critical Access Hospital (CA | | hod of navment | | | |
| Instructions) If yes, "the Odd edit and to would not be on Wkst. B. Pt. I. Col 25 and the program would be cost reinbursed. If yes complete Wkst. D. 2. Pt. II. Col 25 and the structions) Instructions CAP is accluded IP and/or IR emil? Enter "Y" for yes or "N" for no in colum 2. (see Cart's accluded IP and/or IR emil? Enter "Y" for yes or "N" for no in colum 2. (see Cart's accluded IP and/or IR emil? Enter "Y" for yes or "N" for no. 108.00 Interview Physical Occupational Speech Respiratory. 3.00 3.00 Interview Physical Occupational Speech Respiratory. 3.00 3.00 Interview N N N Interview N N N Interview 1.00 2.00 3.00 Interview Interview 1.00 1.00 Interview Interview 1.00 1.00 Interview Interview 1.00 1.00 1.00 Interview Interview 1.00 1.00 1.00 1.00 Interview Interview 1.00 1.00 1.00 1.00 1.00 Interview Interview Interview Interview 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 < | for outpatient services? (see instructions) | | | | N | |
| 106.001s this a rural hospital qualifying for an exception to the CRM Fee schedule? See 42 N 108.00 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Physical 0ccupational Speech Respiratory 100.00 109.001f this hospital qualifies as a CAH or a cost provider, are N N N N 109.00 109.001f this hospital qualifies as a CAH or a cost provider, are N N N N N N 109.00 109.001f this hospital qualifies as a CAH or a cost provider, are N N N N N N N 109.00 106.0021d this hospital qualifies as a CAH or a cost provider, are N N N N N N N 100.00 106.0021d this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for N 110.00 100.00 1.00 2.00 3.00 115.00 100.00 3.00 115.00 100.00 115.00 115.00 115.00 116.00 | for I &R training programs? Enter "Y" for yes or "N" for no instructions) If yes, the GME elimination would not be on W the program would be cost reimbursed. If yes complete Wkst. this facility is a CAH, do I&Rs in an approved medical educa CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or ' | o in column 1. kst. B, Pt. I, D-2, Pt. II. (ation program | (see col. 25 and Column 2: If train in the | 9 | | |
| Physical Occupational Speech Respiratory 100 0.00 2.00 3.00 4.00 107.00 1f this hospital qualifies as a CAH or a cost provider, are thereave. N </td <td>108.00 Is this a rural hospital qualifying for an exception to the</td> <td>CRNA fee schee</td> <td>dul e? See 42</td> <td>Ν</td> <td></td> <td>108.00</td> | 108.00 Is this a rural hospital qualifying for an exception to the | CRNA fee schee | dul e? See 42 | Ν | | 108.00 |
| 109.00[if this hospital qualifies as a CAH or a cost provider, are there were the provided by outside supplier? Enter "Y" N N N N 109.00 therapy services provided by outside supplier? Enter "Y" N N N N 109.00 10.00[if this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for N 110.00 110.00 110.00[if this anall-inclusive rate provider? Enter "Y" for yes or "N" for no. 1.00 2.00 3.00 115.00[is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 N 0 115.00 3 either "33 percent for short term hospitals provider? Enter "Y" for yes or "N" for no. N N 116.00 109.00[is this facility classified as a referral center? Enter "Y" for yes or "N" for no. N 116.00 117.00 110.00[is this facility classified as a referral center? Enter "Y" for yes or "N" for no. N 118.00 118.00 111.00[is this facility classified as a referral center? Enter "Y" for yes or "N" for no. N 118.00 118.00 118.00[is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is 1 118.00 118.00 118.01[List amounts of malpractice premiums and paid losses: 2.026.885 | | | - | | | _ |
| 110.00Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no. 1.00 110.00 Miscellaneous. Cost Reporting Information 1.00 2.00 3.00 Miscellaneous. Cost Reporting Information 1.00 2.00 3.00 115.00 [s this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "92" percent for short term hospital or "98" percent for long term care (Includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, \$2208.1. 0 116.00 116.00 [s this facility classified as a referral center? Enter "Y" for yes or "N" for no. no. N 116.00 116.00 118.00 [s the mal practice insurance a claims-made or occurrence. Premiums Losses Insurance 118.01 [List amounts of mal practice premiums and paid losses: 2,026,885 0 0118.01 118.02 Are mal practice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 118.02 119.00 DON OU USE THIS LINE 100 AS S81 and applicable amendments? (see Instructions) Enter in column 1, "" for yes or "" for yes or "" for no. N 120.00 2 | therapy services provided by outside supplier? Enter "Y" | | | | | 109.00 |
| 110.0001d this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for N 110.00 Inter "Y" for yes or "N" for no. N Inter "Y" for yes or "N" for no. N Inter "Y" for yes or "N" for no. N Inter "Y" for yes or "N" for no. N Inter "Y" for yes or "N" for no. N Inter "Y" for yes or "N" for no. N Inter "Y" for yes or "N" for no. N Inter "Y" for yes or "N" for no. N Inter "Y" for yes o | Tor yes or in tor no tor each therapy. | | 1 | | 1.00 | _ |
| Miscel Laneous Cost Reporting Information 115.00 N 0 115.00 N 0 0 115.00 115.00 N 0 0 115.00 N 0 0 115.00 N 0 0 115.00 N 0 115.00 115.00 N 0 115.00 115.00 115.00 N 115.00 N 115.00 N 115.00 N 115.00 N 115.00 115.00 115.00 115.00 115.00 115.00 115.00 115.00 115.00 115.00 115.00 115.00 115.00 115.00 116.00 116.00 117.00 10.00 10.00 10.00 116.01 117.00 10.00 116.01 116.02 116.02 116.02 116.02 116.02 116.02 116.02 116.02 100 116.02 100.00 118.02 118.02 118.02 | | | on project (4 ⁻ | IOA Demo)for | | 110.00 |
| 115.00 [s this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 N 0 115.00 15.00 [s this an all-inclusive rate provider? Enter "Y" for yes or "N" for no. N 0 115.00 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, §2208.1. N 116.00 116.00 [s this facility classified as a referral center? Enter "Y" for yes or "N" for no. N N 116.00 117.00 [s this facility classified as a referral center? Enter "Y" for yes or "N" for no. N N 116.00 118.00 [s the malpractice insurance a claims-made or occurrence. Premiums Losses Insurance 118.01 [List amounts of malpractice premiums and paid losses: 2,026,885 0 0 0118.01 118.02 [Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 118.02 118.02 119.00 DO NOT USE THIS LINE 119.00 2.00 N 119.00 120.00 [s this a a CH or EACH that qualifies for the 0utpatient Hold Harmless provision in ACA N N 112.00 112.00 119.00 Dose this a Schor EACH that qualifies for | | | | 1. (| 0 2.00 3.00 | _ |
| no. 118.00 Is the mal practice insurance a claims-made or occurrence policy? Enter 1 if the policy is 1 1 118.00 Is the mal practice insurance a claims-made or occurrence. Premiums Losses Insurance 1.00 2.00 3.00 118.01List amounts of mal practice premiums and paid losses: 2,026,885 0 0118.01 1.00 2.00 118.01 1.00 100 100 100 118.01 1.00 100 100 118.01 1.00 100 118.01 1. | 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, §2208.1. | . If column 2 i nt for long te rs) based on tl | is "E", enter rm care (inclu he definition | in column udes in CMS | | |
| claim-made. Enter 2 if the policy is occurrence. Premiums Losses Insurance 1.00 2.00 3.00 118.01List amounts of malpractice premiums and paid losses: 2,026,885 0 0118.01 118.02 Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 118.02 119.000 NOT USE THIS LINE 119.000 N N 119.00 120.001 Is this a SCH or EACH that qualifies for the 0utpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the 0utpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121.00 121.00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no. 121.00 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 125.00 126.00 If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 126.00 126.00 If this is a Medicare certified heart transplant center, enter the certification date 126.00 <t< td=""><td>no.</td><td></td><td></td><td></td><td></td><td></td></t<> | no. | | | | | |
| 18.01 1.00 2.00 3.00 118.01 List amounts of mal practice premiums and paid losses: 2,026,885 0 0118.01 118.02 Are mal practice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. N 118.02 119.00 D0 NOT USE THIS LINE N 119.00 119.00 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA S3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA S3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. | | IICY? Enter II | | | | 118.00 |
| 118. 01 List amounts of mal practice premiums and paid Losses: 2,026,885 0 0 118. 01 118. 02 Are mal practice premiums and paid Losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule Listing cost centers and amounts contained therein. N 118. 02 119. 00 DON TUSE THIS LINE N 118. 02 120. 00 List his a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA N N N 120. 00 List his a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA N | | | | | | |
| 118.02 Are mal practice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. N 118.02 119.00 D0 NOT USE THIS LINE N 118.02 120.00 Is this a SCH or EACH that qualifies for the 0utpatient Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the 0utpatient Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121.00 121.00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no. Y 121.00 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 125.00 125.00 125.00 126.00 If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 126.00 126.00 126.00 127.00 If this is a Medicare certified heart transplant center, enter the certification date 126.00 126.00 126.00 126.00 | 118 01 list amounts of malaractica promiums and paid losses | | | | | 0110 01 |
| 118. 02 Are mal practice premiums and paid losses reported in a cost center other than the N 118. 02 Administrative and General? If yes, submit supporting schedule listing cost centers N 118. 02 and amounts contained therein. 119. 00 NOT USE THIS LINE 119. 00 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA N N 120. 00 § 3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or N N 120. 00 Is this a SCH or EACH that qualifies for the 0utpatient Hold Harmless provision in ACA N N 120. 00 § 3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or N N 120. 00 If this facility incur and report costs for high cost implantable devices charged to Y 121. 00 121. 00 Did this facility operate a transplant center? Enter "Y" for yes and "N" for no. If N N 125. 00 Des this facility operate a transplant center? Enter "Y" for yes and "N" for no. If N 126. 00 126. 00 If this is a Medicare certified kidney transplant center, enter the certification date 126. 00 126. 00 126. 00 If this is a Medicare certified heart transplant center, enter the certification date | | | 2,020,80 | | | 0118.01 |
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| 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA N N 120.00 \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. N N 120.00 121.00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no. Y 121.00 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 125.00 Image: Source the state of t | Administrative and General? If yes, submit supporting scheme | | | | | 110.02 |
| 121.00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no. 121.00 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 125.00 126.00 If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 126.00 127.00 If this is a Medicare certified heart transplant center, enter the certification date 126.00 | 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 amendment | n column 1, "Y ualifies for tl | " for yes or he Outpatient | Ν | Ν | |
| 125. 00Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.125. 00125. 00126. 00< | 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. | antable devices | s charged to | Y | | 121.00 |
| 126.00 If this is a Medicare certified kidney transplant center, enter the certification date126.00in column 1 and termination date, if applicable, in column 2.127.00127.00 If this is a Medicare certified heart transplant center, enter the certification date127.00 | 125.00 Does this facility operate a transplant center? Enter "Y" for | or yes and "N" | for no. If | N | | 125.00 |
| 127.00 If this is a Medicare certified heart transplant center, enter the certification date | 126.00 If this is a Medicare certified kidney transplant center, er | | fication date | | | 126. 00 |
| | 127.00 If this is a Medicare certified heart transplant center, ent | ter the certifi | ication date | | | 127.00 |

| Health Financial Systems | COMMUNI TY HOSPI TAL | _ OF INDIANA, IN | C | In Lie | eu of Form CMS | -2552-10 |
|--|------------------------|------------------|---------------|----------------------------|--------------------|-------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX | DENTIFICATION DATA | Provi der | | Period: From 01/01/2014 | Worksheet S- | 2 |
| | | | | To 12/31/2014 | | |
| | | I | L | | | |
| 128.00 f this is a Medicare certified live | r transplant center e | nter the certifi | cation date | 1.00 | 2.00 | 128.00 |
| in column 1 and termination date, if | applicable, in column | 2. | | | | |
| 129.00 f this is a Medicare certified lung column 1 and termination date, if ap | | ter the certific | ation date in | 1 | | 129.00 |
| 130.00 If this is a Medicare certified panc | reas transplant center | | i fi cati on | | | 130. 00 |
| date in column 1 and termination dat 131.00 If this is a Medicare certified inte | | | rtification | | | 131.00 |
| date in column 1 and termination dat | | | | | | 122.00 |
| 132.00 f this is a Medicare certified isle in column 1 and termination date, if | | | cation date | | | 132.00 |
| 133.00 If this is a Medicare certified othe | | | cation date | | | 133.00 |
| in column 1 and termination date, if 134.00 If this is an organ procurement orga | | | n column 1 | | | 134.00 |
| and termination date, if applicable, All Providers | in column 2. | | | | | - |
| 140.00 Are there any related organization o | r home office costs as | defined in CMS | Pub. 15-1, | Y | | 140.00 |
| chapter 10? Enter "Y" for yes or "N" | | | | | | |
| are claimed, enter in column 2 the h | | 00 | | 3.00 | | |
| If this facility is part of a chain | | | | ame and address | of the | |
| home office and enter the home offic 141.00 Name: COMMUNITY HEALTH NETWORK | Contractor name and | | | or's Number: 081 | 01 | 141.00 |
| | S | SERVI CES | | | | 142.00 |
| 142.00 Street: 1500 NORTH RITTER AVENUE 143.00 City: INDIANAPOLIS | PO Box: State: I | N | Zip Code: | 462 | 19-3095 | 142.00 143.00 |
| | | | | | | |
| 144.00 Are provider based physicians' costs | included in Worksheet | Α? | | | 1.00 Y | 144.00 |
| 145.00 If costs for renal services are clai | med on Worksheet A, li | | osts for inpa | atient services | Ý | 145.00 |
| only? Enter "Y" for yes or "N" for n | 0. | | | | | |
| | | | | 1.00 | 2.00 | |
| 146.00Has the cost allocation methodology Enter "Y" for yes or "N" for no in c | | | | N | | 146.00 |
| the approval date (mm/dd/yyyy) in co | lumn 2. | | 3 | | | |
| 147.00Was there a change in the statistica 148.00Was there a change in the order of a | | | | N N | | 147.00 |
| 148.00 Was there a change to the simplified | | 2 | | N | | 148.00 |
| no. | - | Part A | Part B | Title V | Title XIX | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | |
| Does this facility contain a provide | | | | | | |
| or charges? Enter "Y" for yes or "N" 155.00Hospital | TOT NO TOT EACH COMPO | N | N | N | <u>3. 13)</u> N | 155.00 |
| 56.00 Subprovider - IPF | | N | N | N | N | 156.00 |
| 57.00 Subprovider - IRF 58.00 SUBPROVIDER | | N | Ν | N | N | 157.00 158.00 |
| 159. 00 SNF | | N | Ν | N | N | 159.00 |
| 160.00 HOME HEALTH AGENCY | | Ν | N | N | N | 160.00 |
| 161.00 CMHC | | | N | N | N | 161.00 |
| | | | | | 1.00 | |
| <u>Multicampus</u> 165.00 Is this hospital part of a Multicamp | us hospital that has o | ne or more camp | ses in differ | ent CBSAs? | N | 165.00 |
| Enter "Y" for yes or "N" for no. | | | | | | |
| | Name 0 | County 1.00 | | Code CBSA 3.00 4.00 | FTE/Campus 5.00 | - |
| 66.00 If line 165 is yes, for each | | 1.00 | 2.00 | 4.00 | | 0 166. 00 |
| campus enter the name in column | | | | | | |
| 0, county in column 1, state in column 2, zip code in column 3, | | | | | | |
| CBSA in column 4, FTE/Campus in | | | | | | |
| column 5 (see instructions) | | | | | | |
| | | | | | 1.00 | - |
| Heal th Information Technology (HIT) | incentive in the Ameri | can Recovery and | Reinvestmen | t Act | N N | 1/7 00 |
| 167.00Is this provider a meaningful user u 168.00If this provider is a CAH (line 105 | | | | | Y | 167.00 0168.00 |
| reasonable cost incurred for the HIT | assets (see instructi | ons) | | | | |
| 169.00 If this provider is a meaningful use transition factor. (see instructions | | d is not a CAH (| line 105 is " | 'N"), enter the | 0.5 | 0169.00 |
| |) | | | | 1 | I |

| Health Financial Systems | COMMUNITY HOSPITAL OF | INDIANA, INC. | In Lie | u of Form CMS- | 2552-10 |
|---|------------------------------|----------------------|-----------------|----------------|-------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX | IDENTIFICATION DATA | Provider CCN: 150169 | Peri od: | Worksheet S-2 | |
| | | | From 01/01/2014 | | |
| | | | To 12/31/2014 | Date/Time Pre | |
| | | | | 5/27/2015 6:0 | <u>/ pm</u> |
| | | | Begi nni ng | Endi ng | |
| | | | 1.00 | 2.00 | |
| 170.00 Enter in columns 1 and 2 the EHR beg period respectively (mm/dd/yyyy) | ginning 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 provid Medicare cost plans reported on Wks1 | | | | N | 171.00 |
| (see instructions) | ,, | | | | |

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 150169 Peri od: Worksheet S-2 From 01/01/2014 Part II Date/Time Prepared: То 12/31/2014 5/27/2015 6:07 pm Y/N Date 1.00 2.00 General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) V/I Y/N Date 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If Ν 2 00 yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Υ 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Туре 3.00 1.00 2.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Y А 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different from 5.00 Ν 5.00 those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper 1.00 2.00 Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is Ν 6.00 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 γ 7.00 8.00 Were nursing school and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Intern-Resident programs claimed on the current cost report? If 9.00 Υ 9.00 ves. see instructions. 10.00 Was an Intern-Resident program been initiated or renewed in the current cost reporting γ 10.00 period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved Ν 11.00 Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. Υ 12.00 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. Ν 14.00 Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions. Ν 15.00 Part B Part A Description Y/N Date Y/N 0 1.00 2.00 3.00 PS&R Data Ν 16.00 Ν 16.00 Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through 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 γ 04/29/2014 Υ 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) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional 18.00 Ν Ν 18.00 claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments 19.00 Ν Ν 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 Ν Ν 20.00 made to PS&R Report data for Other? Describe the other adjustments:

| Heal th | Financial Systems COMM | UNITY HOSPITAL | OF INDIANA, IN | NC | Inlie | eu of Form CMS- | 2552-10 |
|---------|---|-----------------|--------------------|-----------------|-----------------|--------------------------------|-----------|
| | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE | | | | Peri od: | Worksheet S-2 | |
| | | | | | rom 01/01/2014 | | |
| | | | | 1 | o 12/31/2014 | Date/Time Pre 5/27/2015 6:0 | |
| | | | | Par | rt A | Part B | |
| | | Dosor | ipti on | Y/N | Date | Y/N | |
| | | | 0 | 1.00 | 2.00 | 3.00 | |
| 21.00 | Was the cost report prepared only using the | | 0 | 1.00 N | 2.00 | N 3.00 | 21.00 |
| 21.00 | Was the cost report prepared only using the provider's records? If yes, see | | | N | | N | 21.00 |
| | instructions. | | | | | | |
| | | | | | | 1.00 | |
| | COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT | | | | | 1.00 | |
| | Completed by cost Refmborsed and terra hospit | ALS UNLT (LACI | LFT CHILDRENS H | IUSFTTALS) | | | - |
| 22.00 | Have assets been relifed for Medicare purpose | s2 If vas so | e instructions | | | 1 | 22.00 |
| | Have changes occurred in the Medicare depreci | | | als made durin | a the cost | | 23.00 |
| 23.00 | reporting period? If yes, see instructions. | ation expense | uue to apprais | | ig the cost | | 23.00 |
| 24.00 | Were new leases and/or amendments to existing | n Leases enter | ed into during | this cost rend | rting period? | | 24.00 |
| 24.00 | If yes, see instructions | g reases enter | cu into uuring | 1113 0031 1000 | a tring period: | | 24.00 |
| 25.00 | Have there been new capitalized leases entered instructions. | ed into during | the cost repor | ting period? I | f yes, see | | 25.00 |
| 26.00 | Were assets subject to Sec. 2314 of DEFRA acqu | uired during t | he cost reporti | na period? If | Ves see | | 26.00 |
| 20.00 | instructions. | an our during t | | ng porrour ri | J007 000 | | 20100 |
| 27.00 | Has the provider's capitalization policy char | naed durina the | e cost reportir | na period? If v | ves. submit | | 27.00 |
| | сору. | .g | | .9 | | | |
| | Interest Expense | | | | | · | |
| 28.00 | Were new loans, mortgage agreements or letter | rs of credit e | ntered into dur | ing the cost r | eporting | | 28.00 |
| | period? If yes, see instructions. | | | 0 | | | |
| 29.00 | Did the provider have a funded depreciation a | account and/or | bond funds (De | ebt Service Res | erve Fund) | | 29.00 |
| | treated as a funded depreciation account? If | yes, see inst | ructions | | | | |
| 30.00 | Has existing debt been replaced prior to its | scheduled mate | urity with new | debt? If yes, | see | | 30.00 |
| | instructions. | | | | | | |
| 31.00 | Has debt been recalled before scheduled matur | rity without is | ssuance of new | debt? If yes, | see | | 31.00 |
| | instructions. | | | | | | _ |
| | Purchased Services | | | | | | |
| 32.00 | Have changes or new agreements occurred in pa | | | ed through cont | ractual | | 32.00 |
| 22.00 | arrangements with suppliers of services? If y | | | | | | 22.00 |
| 33.00 | If line 32 is yes, were the requirements of 5 no, see instructions. | sec. 2135.2 ap | pired pertainin | ig to competiti | ve braarng? Ti | | 33.00 |
| | Provi der-Based Physi ci ans | | | | | | |
| 3/ 00 | Are services furnished at the provider facili | ty under an a | rrangement with | nrovi der_base | d physicians? | 1 | 34.00 |
| 54.00 | If yes, see instructions. | ty under an a | i i angement wi ti | | | | 54.00 |
| 35 00 | If line 34 is yes, were there new agreements | or amended exi | isting agreemer | nts with the pr | ovi der-based | | 35.00 |
| | physicians during the cost reporting period? | | 0 0 | | | | |
| | | | | | Y/N | Date | |
| | | | | | 1.00 | 2.00 | |
| | Home Office Costs | | | | | | |
| 36.00 | Were home office costs claimed on the cost re | eport? | | | | | 36.00 |
| 37.00 | If line 36 is yes, has a home office cost sta | atement been p | repared by the | home office? | | | 37.00 |
| | If yes, see instructions. | | | | | | |
| 38.00 | If line 36 is yes , was the fiscal year end o | | | | | | 38.00 |
| | the provider? If yes, enter in column 2 the f | fiscal year en | d of the home c | offi ce. | | | |
| 39.00 | If line 36 is yes, did the provider render se | ervices to othe | er chain compor | nents? If yes, | | | 39.00 |
| | see instructions. | | | | | | |
| 40.00 | If line 36 is yes, did the provider render se | ervices to the | home office? | lf yes, see | | | 40.00 |
| | instructions. | | | | | | |
| | | | | | | | _ |
| | | | 1. | 00 | 2. | 00 | |
| | Cost Report Preparer Contact Information | | DONIALD | | | | 14.00 |
| 41.00 | Enter the first name, last name and the title | | RONALD | | HELMS | | 41.00 |
| | held by the cost report preparer in columns 1 | i, 2, and 3, | | | | | |
| 12 00 | respectively. | conort | | | | | 42.00 |
| 42.00 | Enter the employer/company name of the cost r preparer. | epui i | COMMUNITY HEAL | NEIWUKK | | | 42.00 |
| 43.00 | Enter the telephone number and email address | of the cost | 317-355-5501 | | RHELMS@ECOMMUN | ITY COM | 43.00 |
| 10.00 | report preparer in columns 1 and 2, respectiv | | 517 555-5501 | | | | J - J. 00 |
| | i sport proportor in containing i and z, respectiv | · · · J · | 1 | | 1 | | 11 |

| OSPI T | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES | STI ONNAI RE | Provider CCN: 150 | Period: | Worksheet S | -2 |
|--------|---|--------------|-----------------------|----------------------------------|------------------------|--------|
| | | | | From 01/01/2014 To 12/31/2014 | Part II Date/Time P | |
| | | | | | 5/27/2015 6 | :07 pm |
| | | Part B | | | | |
| | | | | | | |
| | PS&R Data | 4.00 | | · · · · · · | | - |
| | Was the cost report prepared using the PS&R | | | | | 16. |
| 0.00 | Report only? If either column 1 or 3 is yes, | | | | | 10. |
| | enter the paid-through date of the PS&R | | | | | |
| | Report used in columns 2 and 4 . (see | | | | | |
| | instructions) | | | | | |
| 7 00 | Was the cost report prepared using the PS&R | 04/29/2014 | | | | 17. |
| 7.00 | Report for totals and the provider's records | 04/2//2014 | | | | ''' |
| | for allocation? If either column 1 or 3 is | | | | | |
| | yes, enter the paid-through date in columns | | | | | |
| | 2 and 4. (see instructions) | | | | | |
| 8 00 | If line 16 or 17 is yes, were adjustments | | | | | 18. |
| 0.00 | 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. | | | | | |
| 9.00 | If line 16 or 17 is yes, were adjustments | | | | | 19. |
| | made to PS&R Report data for corrections of | | | | | |
| | other PS&R Report information? If yes, see | | | | | |
| | instructions. | | | | | |
| 0.00 | If line 16 or 17 is yes, were adjustments | | | | | 20. |
| | made to PS&R Report data for Other? Describe | | | | | |
| | the other adjustments: | | | | | |
| 21.00 | Was the cost report prepared only using the | | | | | 21. |
| | provider's records? If yes, see | | | | | |
| | instructions. | | | | | |
| | | | | | | |
| | | | 3.00 | | | |
| | Cost Report Preparer Contact Information | | | - | | |
| 1.00 | Enter the first name, last name and the title | | REIMBURSEMENT MANAGER | | | 41. |
| | held by the cost report preparer in columns 1 | , 2, and 3, | | | | |
| | respectively. | | | | | |
| 2.00 | Enter the employer/company name of the cost r | report | | | | 42. |
| | preparer. Enter the telephone number and email address | 6 H | | | | 43. |
| | | | | | | |

| 10SPI T | Financial Systems COMMM AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC | AL DATA | | Provi der | CCN: 150169 | | eriod: .om 01/01/2014 | Worksheet S Part I | -3 | |
|----------------|--|----------------------------|-----|-----------|--------------------------|----|--------------------------|--------------------------------|------------|----------------|
| | | | | | | Tc | | Date/Time P 5/27/2015 6 | rep :07 | bared: 7 pm |
| | | | | | | | | I/P Days / O. Visits / Trij | /P | |
| | Component | Worksheet A Line Number | No. | of Beds | Bed Days Avai I abl e | | CAH Hours | Title V | | |
| | | 1.00 | 2 | 2.00 | 3.00 | | 4.00 | 5.00 | | |
| 1.00 | Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) | 30.00 | | 218 | | 39 | 0.00 | | 0 | 1.00 |
| 2.00 3.00 | HMO and other (see instructions) HMO IPF Subprovider | | | | | | | | | 2.00 3.00 |
| 4.00 | HMO I RF Subprovider | | | | | | | | | 4.00 |
| 5.00 | Hospital Adults & Peds. Swing Bed SNF | | | | | | | | 0 | 5.00 |
| 5.00 7.00 | Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation | | | 218 | 79, 5 | 20 | 0.00 | | 0 0 | 6.00 7.00 |
| . 00 | beds) (see instructions) | | | 210 | 77, 3 | 37 | 0.00 | | | 7.00 |
| 3. 00 | INTENSIVE CARE UNIT | 31.00 | | 24 | 8, 7 | 60 | 0.00 | | 0 | 8.00 |
| 9.00 | CORONARY CARE UNIT | | | | | | | | | 9.0 |
| 0.00 | BURN INTENSIVE CARE UNIT | | | | | | | | | 10.0 |
| 11.00 | SURGICAL INTENSIVE CARE UNIT | | | | | | | | | 11.00 |
| 12.00 | NEONATAL INTENSIVE CARE UNIT | 35.00 | | 43 | 15, 6 | 95 | 0.00 | | 0 | 12.00 |
| 13.00 | NURSERY | 43.00 | | | | | | | 0 | 13.00 |
| 14.00 | Total (see instructions) | | | 285 | 103, 9 | 94 | 0.00 | | 0 | 14.00 |
| 15.00 | CAH visits | | | | | | | | 0 | 15.00 |
| 16.00 | SUBPROVIDER - IPF | 40.00 | 1 | 18 | 6, 5 | 70 | | | 0 | 16.0 |
| 7.00 | SUBPROVIDER - IRF | 41.00 | | 0 | | 0 | | | 0 | 17.0 |
| 8.00 | SUBPROVIDER | | | | | | | | | 18.0 |
| 9.00 | SKILLED NURSING FACILITY | | | | | | | | | 19.0 |
| 20.00 | NURSING FACILITY | | | | | | | | | 20.0 |
| 21.00 | OTHER LONG TERM CARE | | | | | | | | | 21.0 |
| 22.00 | HOME HEALTH AGENCY | | | | | | | | | 22.0 |
| 23.00 | AMBULATORY SURGICAL CENTER (D. P.) | | | | | | | | | 23.0 |
| 24.00 | HOSPICE | 20.00 | | | | | | | | 24.0 |
| 24.10 | HOSPICE (non-distinct part) | 30.00 | | | | | | | | 24. 1 25. 0 |
| 25.00 26.00 | CMHC - CMHC RURAL HEALTH CLINIC | | | | | | | | | 25.0 |
| 26.25 | FEDERALLY QUALIFIED HEALTH CENTER | | | | | | | | | 26.0 |
| 27.00 | Total (sum of lines 14-26) | | | 303 | | | | | | 20.2 |
| 28.00 | Observation Bed Days | | | 505 | | | | | o | 28.0 |
| 29.00 | Ambul ance Trips | | | | | | | | Ĭ | 29.0 |
| 30.00 | Employee discount days (see instruction) | | | | | | | | | 30.0 |
| 1.00 | Employee discount days - IRF | | | | | | | | | 31.0 |
| 32.00 | Labor & delivery days (see instructions) | | | 0 | | 0 | | | | 32.0 |
| 32.00 | Total ancillary labor & delivery room | | | 0 | | 5 | | | | 32.0 |
| | outpatient days (see instructions) | | | | | | | | | 0 |
| 33 00 | LTCH non-covered days | | | | | | | | | 33.0 |

| SPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC. | AL DATA | Provi der | | Period: From 01/01/2014 Fo 12/31/2014 | | pare |
|---|--------------|--------------|-----------------------|---|-------------------------|----------------|
| | I/P Days | / O/P Visits | / Trips | Full Time I | Equi val ents | |
| Component | Title XVIII | Title XIX | Total All Patients | Total Interns & Residents | Employees On Payroll | |
| | 6.00 | 7.00 | 8.00 | 9.00 | 10,00 | |
| Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) | 18, 408 | 2, 566 | | | | 1. |
| 0 HMO and other (see instructions) 00 HMO IPF Subprovider | 6, 432 0 | 15, 367 C | | | | 2. 3. |
| 00 HMO IRF Subprovider 00 Hospital Adults & Peds. Swing Bed SNF | 0 0 | C | | D | | 4. 5. |
| Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) | 18, 408 | 0 2, 566 | | 2 7 | | 6. 7. |
| 00 INTENSIVE CARE UNIT 00 CORONARY CARE UNIT 00 BURN INTENSIVE CARE UNIT | 2, 140 | C | 5, 16 | 1 | | 8 9 10 |
| 00 SURGI CAL I NTENSI VE CARE UNI T 00 NEONATAL I NTENSI VE CARE UNI T 00 NURSERY | О | 0 1,485 | 1.1, 10 | | | 11 12 13 |
| 00 Total (see instructions) 00 CAH visits | 20, 548 0 | 4, 051 C | 76, 23 | 4 1.89 D | | 15 |
| 00 SUBPROVIDER - IPF 00 SUBPROVIDER - IRF 00 SUBPROVIDER 00 SKILLED NURSING FACILITY | 2, 633 0 | C C | -, | 0.00 0.00 | | |
| 00 NURSING FACILITY 00 OTHER LONG TERM CARE 00 HOME HEALTH AGENCY | | | | | | 20 21 22 |
| 00 AMBULATORY SURGICAL CENTER (D. P.) 00 HOSPICE 10 HOSPICE (non-distinct part) | О | C | 79 | 1 | | 23 24 24 |
| 00 CMHC - CMHC 00 RURAL HEALTH CLINIC 25 FEDERALLY QUALIFIED HEALTH CENTER | | | | | | 25 26 26 |
| 00 Total (sum of lines 14-26)00 Observation Bed Days00 Ambulance Trips | О | 684 | 4, 99 | 1.89 | 1, 320. 20 | 27 28 29 |
| 00 Employee discount days (see instruction) 00 Employee discount days - IRF 00 Labor & delivery days (see instructions) | 0 | 454 | 2, 01 (1, 30 | D | | 30 31 32 |
| .01 Total ancillary labor & delivery room outpatient days (see instructions) | | 454 | | 2 | | 32 |
| 00 LTCH non-covered days | 0 | | | | | 33 |

| | Financial Systems COMMM AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC | JNETY HOSPETAL C AL DATA | | CCN: 150169 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Pre 5/27/2015 6:0 | pared: |
|---|---|-----------------------------|---------|-------------|---|---|--|
| | | Full Time Equivalents | | Di s | charges | | |
| | Component | Nonpaid Workers | Title V | Title XVIII | Title XIX | Total All Patients | |
| | | 11.00 | 12.00 | 13.00 | 14.00 | 15.00 | |
| 1.00 | Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) | | 0 | 4, 3. | 27 3, 241 | 13, 677 | 1.00 |
| 2.00 3.00 4.00 5.00 6.00 7.00 | HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) | | | 1, 3 | 00 0 | | 2.00 3.00 4.00 5.00 6.00 7.00 |
| 8.00 9.00 10.00 11.00 12.00 13.00 | INTENSI VE CARE UNI T CORONARY CARE UNI T BURN INTENSI VE CARE UNI T SURGI CAL INTENSI VE CARE UNI T NEONATAL INTENSI VE CARE UNI T NURSERY | | | | | | 8.00 9.00 10.00 11.00 12.00 13.00 |
| 14.00 15.00 | Total (see instructions) CAH visits | 0.00 | 0 | 4, 3 | 27 3, 241 | 13, 677 | 14.00 15.00 |
| 16.00 17.00 18.00 19.00 20.00 21.00 23.00 24.00 24.00 24.10 25.00 26.25 27.00 28.00 29.00 | SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) | 0. 00 0. 00 0. 00 | 0 0 | 2 | 76 0 0 0 | 348 0 | 16.00 17.00 18.00 19.00 20.00 21.00 23.00 24.10 25.00 26.00 26.00 26.00 26.25 27.00 28.00 29.00 |
| 30.00 31.00 32.00 32.01 | Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days | | | | | | 30. (31. (32. (32. (33. (|

Health Financial Systems In Lieu of Form CMS-2552-10 COMMUNITY HOSPITAL OF INDIANA, INC. HOSPITAL WAGE INDEX INFORMATION Provider CCN: 150169 Peri od: Worksheet S-3 From 01/01/2014 Part II 12/31/2014 Date/Time Prepared: То 5/27/2015 6:07 pm Worksheet A Amount Recl assi fi cati Adj usted Paid Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col.2 ± col (from Salaries in col. 5) Worksheet A-6 3) col. 4 2.00 5.00 6.00 1.00 3.00 4.00 PART II - WAGE DATA SALARI ES 1.00 Total salaries (see 200.00 89, 450, 322 -389,795 89, 060, 527 2, 746, 025. 00 32.43 1.00 instructions) 2.00 Non-physician anesthetist Part 0 C 0 0.00 0.00 2.00 3.00 Non-physician anesthetist Part 0 0 0 0.00 0.00 3.00 4.00 Physician-Part A -0 0 C 0.00 0.00 4.00 Admi ni strati ve 4.01 Physicians - Part A - Teaching 0 С 0 0.00 0.00 4.01 5.00 Physician-Part B 0 0 0.00 0.00 5.00 6.00 Non-physician-Part B 0 0 0.00 0.00 6.00 C 0 Interns & residents (in an 21 00 7.00 C 0 0.00 0.00 7.00 approved program) 7.01 Contracted interns and C 0.00 0.00 7.01 residents (in an approved programs) 8.00 Home office personnel 0 0 0.00 0.00 8.00 44 00 9 00 SNF 0.00 0 00 9 00 \cap C 10.00 Excluded area salaries (see 2, 503, 714 225, 149 2, 728, 863 58, 109. 00 46.96 10.00 instructions) OTHER WAGES & RELATED COSTS 325, 100 0 325, 100 5, 129. 00 63.38 11.00 Contract Labor: Direct Patient 11.00 Care 12.00 Contract Labor: Top Level 0 C 0 0.00 0.00 12.00 management and other management and administrative servi ces Contract Labor: Physician-Part 89.50 13.00 114,833 0 114,833 1,283.00 13.00 A - Administrative 14.00 Home office salaries & 11, 146, 515 0 11, 146, 515 191, 717.00 58.14 14.00 wage-related costs Home office: Physician Part A 15.00 0 С 0 0.00 0.00 15.00 - Administrative 16.00 Home office and Contract 0 С 0 0.00 0.00 16.00 Physicians Part A - Teaching WAGE-RELATED COSTS Wage-related costs (core) (see 28, 413, 615 0 28, 413, 615 17.00 17.00 instructions) Wage-related costs (other) 0 18.00 18.00 0 0 (see instructions) 19.00 19 00 Excluded areas 677,742 0 677, 742 20.00 Non-physician anesthetist Part C С 20.00 0 21.00 Non-physician anesthetist Part 0 C 21.00 22.00 Physician Part A -0 C 0 22.00 Admi ni strati ve 22.01 Physician Part A - Teaching С 22.01 0 23.00 Physician Part B 0 23.00 С 0 24.00 Wage-related costs (RHC/FQHC) 0 0 24 00 C 25.00 Interns & residents (in an 0 25.00 0 (approved program) OVERHEAD COSTS - DIRECT SALARIES Employee Benefits Department 26.00 4.00 327, 784 327, 784 10,009.00 32.75 26.00 Administrative & General 108.93 27.00 11, 205, 703 -26, 559 11, 179, 144 102, 628.00 27.00 5.00 28.00 Administrative & General under 0.00 0.00 28.00 0 contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 Operation of Plant 7 00 2, 378, 951 -10, 574 20. 92 30 00 30 00 2, 368, 377 113, 229. 00 31.00 Laundry & Linen Service 8.00 0.00 0.00 31.00 32.00 Housekeepi ng 9.00 1,930,340 -25, 472 1,904,868 142, 560. 00 13.36 32.00 33.00 Housekeeping under contract 446, 980 446.980 9,911.00 45.10 33.00 (see instructions) 2, 262, 879 19.90 34 00 34.00 Dietarv 10.00 -1, 211, 937 1,050,942 52,811,00 Dietary under contract (see 0.00 35.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 1, 202, 971 1, 202, 971 86, 671.00 13.88 36.00 0 12.00 Maintenance of Personnel 0.00 37 00 37 00 \cap C 0 00 38.00 Nursing Administration 13.00 511,034 -1,828 509, 206 29,654.00 17.17 38.00

0.00

39.29 40.00

0.00

77.264.00

39.00

40.00 Pharmacy

39.00

Central Services and Supply

14.00

15.00

3, 259, 413

-223,836

3,035,577

| Health Financial Systems | COMM | JNI TY HOSPI TAL | OF INDIANA, IN | IC. | In Lie | u of Form CMS-2 | 2552-10 |
|--|-------------|------------------|-------------------|---------------|----------------|--------------------------------|---------|
| HOSPITAL WAGE INDEX INFORMATION | | | Provi der | | Peri od: | Worksheet S-3 | |
| | | | | | rom 01/01/2014 | | |
| | | | | | o 12/31/2014 | Date/Time Pre 5/27/2015 6:0 | |
| | Worksheet A | Amount | Recl assi fi cati | Adj usted | Paid Hours | Average Hourly | |
| | Line Number | Reported | on of Salaries | Sal ari es | Related to | Wage (col. 4 ÷ | |
| | | | (from | (col.2 ± col. | Salaries in | col. 5) | |
| | | | Worksheet A-6) | 3) | col. 4 | | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | |
| 41.00 Medical Records & Medical Records Library | 16.00 | 460, 823 | -4, 860 | 455, 963 | 3 13, 288. 00 | 34. 31 | 41.00 |
| 42.00 Social Service | 17.00 | 1, 806, 039 | -2, 010 | 1, 804, 029 | 52, 380. 00 | 34.44 | 42.00 |
| 43.00 Other General Service | 18.00 | 0 | 0 | (C | 0.00 | 0.00 | 43.00 |

| Heal th | Financial Systems | COMM | JNI TY HOSPI TAL | OF INDIANA, IN | IC. | In Lie | eu of Form CMS-2 | 2552-10 |
|----------|--------------------------------|-------------|------------------|-------------------|---------------|----------------------------|---------------------------|---------|
| HOSPI TA | AL WAGE INDEX INFORMATION | | | Provi der | | Period: From 01/01/2014 | Worksheet S-3 Part III | |
| | | | | | | To 12/31/2014 | Date/Time Pre | |
| | | | | | | _ | 5/27/2015 6:0 | |
| | | Worksheet A | Amount | Recl assi fi cati | Adj usted | Paid Hours | Average Hourly | |
| | | Line Number | Reported | on of Salaries | Sal ari es | Related to | Wage (col. 4 ÷ | |
| | | | | (from | (col.2 ± col. | Salaries in | col. 5) | |
| | | | | Worksheet A-6) | 3) | col. 4 | ŕ | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | |
| | PART III - HOSPITAL WAGE INDEX | SUMMARY | | | | | | |
| 1.00 | Net salaries (see | | 89, 897, 302 | -389, 795 | 89, 507, 50 | 7 2, 755, 936. 00 | 32.48 | 1.00 |
| | instructions) | | | | | | | |
| 2.00 | Excluded area salaries (see | | 2, 503, 714 | 225, 149 | 2, 728, 86 | 3 58, 109. 00 | 46.96 | 2.00 |
| | instructions) | | | | | | | |
| 3.00 | Subtotal salaries (line 1 | | 87, 393, 588 | -614, 944 | 86, 778, 64 | 4 2, 697, 827.00 | 32.17 | 3.00 |
| | minus line 2) | | | | | | | |
| 4.00 | Subtotal other wages & related | | 11, 586, 448 | 0 | 11, 586, 44 | B 198, 129. 00 | 58.48 | 4.00 |
| | costs (see inst.) | | | | | | | |
| 5.00 | Subtotal wage-related costs | | 28, 413, 615 | 0 | 28, 413, 61 | 5 0.00 | 32.74 | 5.00 |
| | (see inst.) | | | | | | | |
| 6.00 | Total (sum of lines 3 thru 5) | | 127, 393, 651 | -614, 944 | 126, 778, 70 | 7 2, 895, 956.00 | 43. 78 | 6.00 |
| | Total overhead cost (see | | 24, 589, 946 | -304, 105 | 24, 285, 84 | 1 690, 405. 00 | 35. 18 | 7.00 |
| | instructions) | | | | | | | |
| | , | | | • | | | | |

| | | F INDIANA, INC. | | eu of Form CMS-2 | |
|--------|--|-------------------------|-------------------------------|------------------|--------|
| HUSPII | AL WAGE RELATED COSTS | Provider CCN: 1501 | 69 Period: From 01/01/2014 | Worksheet S-3 | |
| | | | To 12/31/2014 | | pared: |
| | | | | 5/27/2015 6:0 | 7 pm |
| | | | | Amount | |
| | | | | Reported | |
| | | | | 1.00 | |
| | PART IV - WAGE RELATED COSTS | | | | - |
| | Part A - Core List RETIREMENT COST | | | | - |
| 1 00 | | | | 2 12(020 | 1 1 0 |
| 1.00 | 401K Employer Contributions | | | 2, 126, 930 | |
| 2.00 | Tax Sheltered Annuity (TSA) Employer Contribution | | | 0 | |
| 3.00 | Nonqualified Defined Benefit Plan Cost (see instructions) | | | 0 | |
| 4.00 | Qualified Defined Benefit Plan Cost (see instructions) | | | 1, 687, 399 | 4.0 |
| | PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Plan Administration fees | | | 0 | 5.0 |
| 5.00 | | | | 0 | |
| 6.00 | Legal /Accounting/Management Fees-Pension Plan | | | 39, 107 | |
| 7.00 | Employee Managed Care Program Administration Fees | | | 0 | 7.0 |
| | HEALTH AND INSURANCE COST | | | 17 000 540 | |
| 3.00 | Heal th Insurance (Purchased or Self Funded) | | | 17, 938, 548 | |
| 9.00 | Prescription Drug Plan | | | 0 | 1 |
| 10.00 | Dental, Hearing and Vision Plan | | | 199, 449 | |
| 11.00 | Life Insurance (If employee is owner or beneficiary) | | | 89, 812 | |
| 12.00 | Accident Insurance (If employee is owner or beneficiary) | | | 0 | |
| 13.00 | Disability Insurance (If employee is owner or beneficiary) | | | 417, 204 | 1 |
| 14.00 | Long-Term Care Insurance (If employee is owner or beneficiary | () | | 0 | |
| 15.00 | 'Workers' Compensation Insurance | | internal has EACD 104 | - | |
| 16.00 | Retirement Health Care Cost (Only current year, not the extra Non cumulative portion) | aordinary accruai requ | IFED DY FASE 106. | 0 | 16. C |
| | TAXES | | | | - |
| 17.00 | FICA-Employers Portion Only | | | 6, 553, 950 | 1 17.0 |
| 18.00 | Medicare Taxes - Employers Portion Only | | | 0, 555, 750 | |
| 19.00 | Unemployment Insurance | | | 0 | |
| 20.00 | State or Federal Unemployment Taxes | | | 0 | |
| 20.00 | OTHER | | | 0 | 20.0 |
| 21.00 | Executive Deferred Compensation (Other Than Retirement Cost F | Reported on lines 1 th | prough 4 above (see | 0 | 21.0 |
| | instructions)) | tepor teu on rimes i ti | il ougit 4 above. (See | | 21.0 |
| 22.00 | Day Care Cost and Allowances | | | 0 | 22.0 |
| 23.00 | Tui ti on Rei mbursement | | | 38.957 | |
| 24.00 | Total Wage Related cost (Sum of lines 1 -23) | | | 29, 091, 356 | |
| 00 | Part B - Other than Core Related Cost | | | 27, 87.1, 880 | 1 0 |
| | OTHER WAGE RELATED COSTS (SPECIFY) | | | 0 | 25. C |

| HOSPITAL CONTRACT LABOR AND BENEFIT COST Provider CCN: 150169 Period: From 01/01/2014 Period: From 01/01/2014 Period: Part V Cost Center Description Contract Labor and Benefit Cost 1.00 2.00 Hospital and Hospital-Based Component Identification: 1.00 2.00 1.00 Total facility's contract labor and benefit cost 0 0 1.00 2.00 Ubprovider - 1PF 0 0 3.00 3.00 Subprovider - 1RF 0 0 4.00 5.00 Subprovider - 1RF 0 0 5.00 6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 7.00 8.00 Hospital-Based NF 0 0 7.00 9.00 Hospital-Based NF 0 0 1.00 10.00 Hospital-Based HHA 1.00 1.00 1.00 10.00 Hospital-Based HHA 1.00 1.00 1.00 10.00 Hospital-Based Health Clinic RHC 1.00 1.00 | Heal th | Financial Systems | COMMUNI TY HOSPI | TAL OF I | NDIANA, IN | NC. | In Lie | u of Form CMS-2 | 2552-10 |
|---|---------|---|-------------------|----------|------------|-------------|----------------|-----------------|---------|
| To 12/31/2014 Date/Time Prepared: 5/27/2015 6:07 pm PART V - Contract Labor and Benefit Cost 1.00 2.00 PART V - Contract Labor and Benefit Cost 0 0 1.00 Hospital and Hospital-Based Component Identification: 0 0 1.00 1.00 Subprovider - 1PF 0 0 1.00 2.00 4.00 Subprovider - 1RF 0 0 0 3.00 5.00 0 0 4.00 0 2.00 4.00 5.00 0 0 3.00 4.00 0 3.00 5.00 0 0 3.00 5.00 0 0 4.00 0 0 3.00 5.00 0 0 4.00 0 0 4.00 | HOSPI T | AL CONTRACT LABOR AND BENEFIT COST | | | Provi der | CCN: 150169 | | | |
| Cost Center Description Contract Labor Benefit Cost Hospital and Hospital - Based Component Identification: 1.00 2.00 1.00 Total facility's contract labor and benefit cost 0 0 1.00 1.00 Total facility's contract labor and benefit cost 0 0 1.00 1.00 Total facility's contract labor and benefit cost 0 0 1.00 1.00 Subprovider - 1PF 0 0 3.00 3.00 Subprovider - 1RF 0 0 4.00 5.00 Subprovider - (Other) 0 0 5.00 6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 6.00 8.00 Hospital - Based SNF 0 0 6.00 9.00 Hospital - Based NF 0 0 1.00 10.00 Hospital - Based HA 11.00 10.00 11.00 Hospital - Based Health Clinic RHC 10.00 10.00 11.00 Hospital - Based Health Clinic CHC< | | | | | | | | | |
| PART V - Contract Labor and Benefit Cost 1.00 2.00 Hospital and Hospital -Based Component Identification: 0 0 1.00 1.00 Total facility's contract labor and benefit cost 0 0 1.00 2.00 Hospital 0 0 2.00 3.00 3.00 Subprovider - IPF 0 0 3.00 4.00 Subprovider - IRF 0 0 4.00 5.00 Subprovider - (Other) 0 0 5.00 6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 6.00 8.00 Hospital -Based SNF 0 0 7.00 8.00 Hospital -Based NF 0 0 9.00 10.00 Hospital -Based HAA 1 1.00 13.00 11.00 Hospital -Based HAA 1 10.00 13.00 10.00 Hospital -Based HAA 11.00 13.00 13.00 11.00 Hospital -Based Healt | | | | | | | 10 12/31/2014 | | |
| PART V - Contract Labor and Benefit Cost Hospital and Hospital -Based Component I dentification: 1.00 7.00 Total facility's contract labor and benefit cost 0 0 0 1.00 2.00 Hospital 0 0 3.00 Subprovider - IPF 0 0 0 4.00 Subprovider - IRF 0 0 0 3.00 5.00 Subprovider - (Other) 0 | | Cost Center Description | | | | | Contract Labor | | |
| Hospi tal and Hospi tal -Based Component I dentification: 1.00 Total facility's contract labor and benefit cost 0 0 1.00 2.00 Hospi tal 0 0 0 2.00 3.00 Subprovi der - IPF 0 0 3.00 3.00 4.00 Subprovi der - IRF 0 0 4.00 5.00 0 4.00 5.00 Subprovi der - (Other) 0 0 0 5.00 6.00 5.00 6.00 5.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 7.00 8.00 6.00 7.00 8.00 7.00 8.00 9.00 7.00 8.00 9.00 10.00 10.00 10.00 11.00 | | | | | | | 1.00 | 2.00 | |
| 1.00 Total facility's contract labor and benefit cost 0 0 1.00 2.00 Hospital 0 0 2.00 3.00 Subprovider - IPF 0 0 3.00 4.00 Subprovider - IRF 0 0 3.00 5.00 Subprovider - (Other) 0 0 5.00 6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 7.00 8.00 Hospital -Based SNF 0 0 7.00 8.00 Hospital -Based NF 0 0 7.00 9.00 Hospital -Based NF 0 0 11.00 10.00 Hospital -Based NF 10.00 11.00 11.00 12.00 Separatel y Certified ASC 12.00 13.00 14.00 13.00 14.00 Hospital -Based Heal th Clinic RHC 14.00 15.00 15.00 15.00 16.00 Hospital -Based -CMHC 14.00 15.00 15.00 16.00 17.00 Renal Dialysis 0 0 0 <td></td> <td>PART V - Contract Labor and Benefit Cos</td> <td>t</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> | | PART V - Contract Labor and Benefit Cos | t | | | | | | |
| 2.00 Hospital 0 0 2.00 3.00 Subprovider - IPF 0 0 3.00 4.00 Subprovider - IRF 0 0 4.00 5.00 Subprovider - (Other) 0 0 5.00 6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 7.00 8.00 Hospital -Based SNF 0 0 7.00 8.00 Hospital -Based OLTC 1 10.00 11.00 Hospital -Based HHA 11.00 11.00 12.00 13.00 Hospital -Based Health Clinic RHC 13.00 14.00 14.00 Hospital -Based Health Clinic RHC 14.00 15.00 15.00 Hospital -Based-CMHC 15.00 15.00 17.00 Renal Dialysis 0 0 17.00 | | Hospital and Hospital-Based Component I | denti fi cati on: | | | | | | |
| 3.00 Subprovider - IPF 0 0 3.00 4.00 Subprovider - IRF 0 0 4.00 5.00 Subprovider - (Other) 0 0 5.00 6.00 Swing Beds - SNF 0 0 5.00 7.00 Swing Beds - NF 0 0 6.00 8.00 Hospital -Based SNF 0 0 7.00 8.00 Hospital -Based NF 0 0 7.00 9.00 Hospital -Based NF 10.00 10.00 11.00 10.00 11.00 Hospital -Based HHA 11.00 12.00 13.00 13.00 12.00 Separately Certified ASC 13.00 13.00 14.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 16.00 17.00 16.00 17.00 17.00 0 0 17.00 | 1.00 | Total facility's contract labor and ber | efit cost | | | | 0 | 0 | 1.00 |
| 4.00 Subprovider - IRF 0 0 4.00 5.00 Subprovider - (Other) 0 0 5.00 6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 6.00 8.00 Hospital -Based SNF 0 0 7.00 8.00 Hospital -Based SNF 9.00 8.00 9.00 10.00 Hospital -Based OLTC 10.00 10.00 10.00 10.00 11.00 Hospital -Based HHA 11.00 12.00 13.00 13.00 12.00 Separately Certified ASC 13.00 14.00 15.00 13.00 14.00 Hospital -Based Health Clinic RHC 15.00 15.00 15.00 15.00 15.00 Hospital -Based-CMHC 0 0 17.00 77.00 Renal Dialysis 0 0 17.00 | | | | | | | 0 | 0 | 2.00 |
| 5.00 Subprovider - (0ther) 0 0 5.00 6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 7.00 8.00 Hospital -Based SNF 0 0 7.00 9.00 Hospital -Based NF 9.00 9.00 10.00 10.00 11.00 Hospital -Based OLTC 10.00 11.00 12.00 12.00 13.00 Hospital -Based HHA 11.00 12.00 13.00 13.00 14.05 13.00 14.00 15.00 Hospital -Based Heal th Clinic RHC 15.00 15.00 15.00 15.00 15.00 15.00 16.00 16.00 16.00 17.00 | | | | | | | 0 | 0 | 3.00 |
| 6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 7.00 8.00 Hospital -Based SNF 0 0 7.00 9.00 Hospital -Based NF 9.00 9.00 9.00 10.00 Hospital -Based OLTC 10.00 11.00 11.00 Hospital -Based HHA 12.00 12.00 13.00 Hospital -Based Health Clinic RHC 13.00 13.00 15.00 Hospital -Based Health Clinic FOHC 15.00 15.00 16.00 Hospital -Based-CMHC 0 0 17.00 | | | | | | | 0 | 0 | |
| 7.00 Swing Beds - NF 0 7.00 8.00 Hospital -Based SNF 8.00 9.00 Hospital -Based NF 9.00 10.00 Hospital -Based OLTC 10.00 11.00 Hospital -Based HHA 11.00 12.00 Separately Certified ASC 12.00 13.00 Hospital -Based Health Clinic RHC 13.00 15.00 Hospital -Based Health Clinic FOHC 15.00 16.00 Hospital -Based-CMHC 16.00 17.00 Renal Dialysis 0 0 | | | | | | | 0 | 0 | |
| 8.00Hospi tal -Based SNF8.009.00Hospi tal -Based NF9.0010.00Hospi tal -Based OLTC10.0011.00Hospi tal -Based HHA11.0012.00Separatel y Certi fi ed ASC12.0013.00Hospi tal -Based Heal th Clinic RHC13.0014.00Hospi tal -Based Heal th Clinic FQHC15.0016.00Hospi tal -Based-CMHC16.0017.00Renal Dial ysi s00 | | | | | | | 0 | 0 | 6.00 |
| 9.00 Hospital -Based NF 9.00 10.00 Hospital -Based OLTC 10.00 11.00 Hospital -Based HHA 11.00 12.00 Separately Certified ASC 12.00 13.00 Hospital -Based Hospice 13.00 14.00 Hospital -Based Heal th Clinic RHC 15.00 15.00 Hospital -Based-CMHC 15.00 17.00 Renal Dialysis 0 0 | | | | | | | 0 | 0 | |
| 10.00 Hospital -Based OLTC 10.00 11.00 Hospital -Based HHA 11.00 12.00 Separately Certified ASC 12.00 13.00 Hospital -Based Hospice 13.00 14.00 Hospital -Based Health Clinic RHC 14.00 15.00 Hospital -Based Health Clinic FQHC 15.00 16.00 Hospisial -Based-CMHC 16.00 17.00 Renal Dialysis 0 0 | | | | | | | | | |
| 11. 00 Hospital -Based HHA 11. 00 12. 00 Separately Certified ASC 12. 00 13. 00 Hospital -Based Hospice 13. 00 14. 00 Hospital -Based Health Clinic RHC 14. 00 15. 00 Hospital -Based-CMHC 16. 00 17. 00 Renal Dialysis 0 0 | | | | | | | | | |
| 12.00 Separately Certified ASC 12.00 13.00 Hospital-Based Hospice 13.00 14.00 Hospital-Based Health Clinic RHC 14.00 15.00 Hospital-Based Health Clinic FQHC 15.00 16.00 Hospital-Based-CMHC 16.00 17.00 Renal Dialysis 0 0 | | | | | | | | | |
| 13.00 Hospital -Based Hospice 13.00 14.00 Hospital -Based Health Clinic RHC 14.00 15.00 Hospital -Based Health Clinic FOHC 15.00 16.00 Hospital -Based-CMHC 16.00 17.00 Renal Dialysis 0 0 | | | | | | | | | |
| 14.00 Hospital -Based Health Clinic RHC 14.00 15.00 Hospital -Based Health Clinic FOHC 15.00 16.00 Hospital -Based-CMHC 16.00 17.00 Renal Dialysis 0 0 17.00 | | | | | | | | | • |
| 15.00 Hospital -Based Health Clinic FOHC 15.00 16.00 Hospital -Based-CMHC 16.00 17.00 Renal Dialysis 0 0 17.00 | | | | | | | | | |
| 16.00 Hospital -Based-CMHC 16.00 17.00 Renal Dialysis 0 0 17.00 | | | | | | | | | |
| 17.00 Renal Dialysis 0 0 17.00 | | | | | | | | | |
| | | | | | | | | | |
| 18.00 Other 0 0 18.00 | | | | | | | 0 | | |
| | 18.00 | Other | | | | | 0 | 0 | 18.00 |

| Heal th | Financial Systems C | OMMUNITY HOSPITAL OF I | NDIANA, IN | С. | In Lie | u of Form CMS-: | 2552-10 |
|---------|--|--------------------------------|-------------|---------------|-----------------|--------------------------------|---------|
| | AL UNCOMPENSATED AND INDIGENT CARE DATA | | | CCN: 150169 | Period: | Worksheet S-1 | |
| | | | | | From 01/01/2014 | | |
| | | | | | To 12/31/2014 | Date/Time Pre 5/27/2015 6:0 | |
| | | | | | | 572772013 0.0 | |
| | | | | | | 1.00 | |
| | Uncompensated and indigent care cost compu | tation | | | | | |
| 1.00 | Cost to charge ratio (Worksheet C, Part I | line 202 column 3 divi | ded by li | ne 202 column | 8) | 0. 230171 | 1.00 |
| | Medicaid (see instructions for each line) | | | | | | |
| 2.00 | Net revenue from Medicaid | | | | | 41, 149, 892 | 2.00 |
| 3.00 | Did you receive DSH or supplemental paymer | | | | | N | 3.00 |
| 4.00 | If line 3 is "yes", does line 2 include al | | | from Medicaid | ? | | 4.00 |
| 5.00 | If line 4 is "no", then enter DSH or suppl | emental payments from | Medi cai d | | | 0 | 5.00 |
| 6.00 | Medi cai d charges | | | | | 285, 085, 454 | 6.00 |
| 7.00 | Medicaid cost (line 1 times line 6) | Saus Mardi ani di musamuran (1 | | | | 65, 618, 404 | 7.00 |
| 8.00 | Difference between net revenue and costs f < zero then enter zero) | or medicald program (| ine / minu | us sum of fin | es 2 and 5; IT | 24, 468, 512 | 8.00 |
| | State Children's Health Insurance Program | (SCHLP) (see instructi | ons for e | ach line) | | | |
| 9.00 | Net revenue from stand-al one SCHIP | | | | | 0 | 9.00 |
| | Stand-al one SCHIP charges | | | | | 0 | |
| 11.00 | 0 | 10) | | | | 0 | |
| 12.00 | | | (line 11 mi | inus line 9: | if < zero then | 0 | |
| | enter zero) | | | | | | |
| | Other state or local government indigent c | are program (see instr | ructions fo | or each line) | | _ | |
| | Net revenue from state or local indigent of | | | | | 0 | |
| 14.00 | Charges for patients covered under state of | or local indigent care | program (I | Not included | in lines 6 or | 0 | 14.00 |
| | 10) | | | | | | |
| | State or local indigent care program cost | | | | | 0 | |
| 16.00 | Difference between net revenue and costs f | or state or local ind | gent care | program (IIn | e 15 minus line | 0 | 16.00 |
| | 13; if < zero then enter zero) Uncompensated care (see instructions for e | ach line) | | | | | |
| 17 00 | Private grants, donations, or endowment in | | nding chari | ity care | | 0 | 17.00 |
| 18.00 | 5 | | 9 | 5 | | 0 | |
| 19.00 | 0 11 1 | | | | s (sum of lines | 24, 468, 512 | |
| | 8, 12 and 16) | | 5 | 1 1 | | ., | |
| | | | | Uni nsured | Insured | Total (col. 1 | |
| | | | | patients | pati ents | + col. 2) | |
| | | | () () (| 1.00 | 2.00 | 3.00 | |
| 20.00 | Total initial obligation of patients appro | | | 4, 092, 90 | 1, 302, 917 | 5, 395, 821 | 20.00 |
| 21.00 | charges excluding non-reimbursable cost ce Cost of initial obligation of patients app | | | 942, 06 | 8 299, 894 | 1, 241, 962 | 21.00 |
| 21.00 | times line 20) | for the charty card | | 942,00 | 299,094 | 1, 241, 902 | 21.00 |
| 22 00 | Partial payment by patients approved for o | harity care | | | 0 0 | 0 | 22.00 |
| | Cost of charity care (line 21 minus line 2 | | | 942, 06 | 8 299, 894 | 1, 241, 962 | |
| | | | I | | | .,, | |
| | | | | | | 1.00 | |
| 24.00 | Does the amount in line 20 column 2 includ | le charges for patient | days beyor | nd a length o | f stay limit | | 24.00 |
| | imposed on patients covered by Medicaid or | | | | | | |
| | If line 24 is "yes," charges for patient | | | ogram's lengt | h of stay limit | 0 | 20.00 |
| | Total bad debt expense for the entire hosp | | | | | 31, 653, 289 | |
| | Medicare bad debts for the entire hospital | 1 | , | | | 8, 881 | |
| | Non-Medicare and non-reimbursable Medicare | | | | | 31, 644, 408 | |
| | Cost of non-Medicare and non-reimbursable | • | ense (line | i times line | 28) | 7, 283, 625 | |
| 30.00 | | | 20 | | | 8, 525, 587 | |
| 31.00 | Total unreimbursed and uncompensated care | cost (line la bine li | ie 30) | | | 32, 994, 099 | 31.00 |

| | | | | | o 12/31/2014 | 5/27/2015 6:0 | |
|-------------|--|--------------------------|-------------------------------|----------------------------|---------------------------------|--|-----|
| | Cost Center Description | Sal ari es | Other | Total (col. 1 + col. 2) | Reclassificati ons (See A-6) | Reclassified Trial Balance (col. 3 +- col. 4) | |
| orner | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 00 0010 | RAL SERVICE COST CENTERS O CAP REL COSTS-BLDG & FIXT | | 0 | 0 | 17, 396, 595 | 17, 396, 595 | 1 1 |
| | O CAP REL COSTS-MVBLE EQUIP | | 0 | | | | |
| | 0 OTHER CAP REL COSTS | | 0 | - | - | | |
| | 0 EMPLOYEE BENEFITS DEPARTMENT 0 ADMINISTRATIVE & GENERAL | 327, 784 11, 205, 703 | 15, 806, 078 108, 856, 460 | | | | |
| | O OPERATION OF PLANT | 2, 378, 951 | 6, 717, 355 | | | | |
| | O LAUNDRY & LINEN SERVICE | 0 | 789, 738 | 789, 738 | -79 | | |
| | O HOUSEKEEPI NG O DI ETARY | 1, 930, 340 | 975, 703 | | | | |
| | O CAFETERI A | 2, 262, 879 | 434, 808 0 | | | | |
| | O NURSI NG ADMI NI STRATI ON | 511, 034 | 2, 174, 785 | | | | |
| | 0 CENTRAL SERVICES & SUPPLY | 0 | 1, 645, 778 | | | 1, 548, 777 | |
| | O PHARMACY O MEDICAL RECORDS & LIBRARY | 3, 259, 413 460, 823 | 10, 008, 970 2, 798, 027 | | | | |
| | 0 SOCIAL SERVICE | 1, 806, 039 | 770, 047 | | | 2, 575, 695 | |
| | O NONPHYSI CI AN ANESTHETI STS | 0 | 0 | 0 | 0 | 0 | |
| | 0 I & R SERVICES-SALARY & FRINGES APPRVD 0 I & R SERVICES-OTHER PRGM COSTS APPRVD | 0 | 0 | 0 | 0 | 0 | |
| | 0 EMS TRAINING PROGRAM-ALLIED HEALTHEM | 0 | 0 | | - | 32, 961 | |
| . 01 0230 | 1 RADIOLOGY SCHOOL-ALLIED HEALTH | 0 | 41, 687 | 41, 687 | | | |
| | 2 PHARMACY RESIDENCY-ALLIED HEALTH | 0 | 0 | 0 | 223, 260 | 223, 260 | 23 |
| | TI ENT_ROUTI NE_SERVI CE_COST_CENTERS 0 ADULTS & PEDI ATRI CS | 26, 824, 971 | 8,037,482 | 34, 862, 453 | -12, 508, 875 | 22, 353, 578 | 30 |
| | O INTENSIVE CARE UNIT | 3, 299, 245 | 856, 277 | | | | |
| 00 0206 | O NEONATAL INTENSIVE CARE UNIT | 5, 103, 305 | 1, 275, 095 | | | | |
| | 0 SUBPROVIDER - IPF | 1, 090, 831 | 162, 121 | | | | |
| | 0 SUBPROVI DER – I RF 0 NURSERY | 0 | 251 0 | 251 | -251 2, 358, 423 | 0 2, 358, 423 | |
| | LLARY SERVICE COST CENTERS | <u> </u> | 0 | 0 | 2, 330, 423 | 2, 330, 423 | |
| | O OPERATING ROOM | 4, 803, 650 | 30, 179, 499 | | | | |
| | O RECOVERY ROOM | 1, 945, 478 | 506, 953 | | | | |
| | 0 DELIVERY ROOM & LABOR ROOM 0 RADIOLOGY-DIAGNOSTIC | 0 3, 248, 948 | 426, 131 2, 428, 026 | | | | |
| | 0 RADI OLOGY-THERAPEUTI C | 318, 734 | 1, 401, 656 | | | | |
| | O CT SCAN | 710, 198 | 732, 687 | | | | |
| | O MAGNETIC RESONANCE IMAGING (MRI) O LABORATORY | 595, 639 0 | 4, 093, 367 6, 669, 099 | | | | |
| | 0 INTRAVENOUS THERAPY | 290, 956 | 146, 191 | | | | |
| | O RESPI RATORY THERAPY | 2, 692, 750 | 860, 745 | | | 3, 129, 184 | |
| | O PHYSI CAL THERAPY | 4, 182, 549 | 1, 840, 820 | | | | |
| | 0 OCCUPATIONAL THERAPY 0 SPEECH PATHOLOGY | 0 | 0 | 0 | 1, 352, 663 308, 539 | | |
| | 0 ELECTROCARDI OLOGY | 31, 719 | 1, 443, 922 | 1, 475, 641 | -17, 719 | | |
| | 0 ELECTROENCEPHALOGRAPHY | 762, 817 | 838, 938 | | | | |
| | O MEDICAL SUPPLIES CHARGED TO PATIENTS O IMPL. DEV. CHARGED TO PATIENTS | 0 | 0 | 0 | | | |
| | O DRUGS CHARGED TO PATIENTS | 0 | 0 | | 10, 287, 303 | | |
| 00 0740 | O RENAL DI ALYSI S | 0 | 647, 891 | 647, 891 | -6, 312 | 641, 579 | 74 |
| | | 895, 295 | 1, 245, 850 | 2, 141, 145 | | | |
| | 0 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 NEUROPSYCHI ATRI C SERVI CES | 0 | 0 | | 0 | 0 | |
| | 1 OTHER ANCILLARY SERVICES | 0 | 0 | 0 | 0 | 0 | |
| 04 0395 | 2 ANCILLARY SERVICE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 76 |
| | 3 MI SC ANCI LLARY 4 I MAGI NG CENTER | 1 251 (00 | 0 | | 0 | | |
| | 5 BREAST DIAGNOSTIC CENTER | 1, 251, 688 | 2, 840, 182 5, 524, 163 | | | | |
| 08 0395 | 6 BARIATRIC CLINIC | 3, 992 | 5, 979 | | -212 | 9, 759 | |
| | ATLENT SERVICE COST CENTERS | | | - | - | - | |
| | 0 CLINIC 3 PALLIATIVE CARE | 0 | 0 85, 582 | | - | 0 85, 582 | |
| | 5 SPINE CENTER | 175, 739 | 74, 810 | | | | |
| 27 0497 | 6 DIABETIC CARE CENTER | 0 | 2, 347 | 2, 347 | 0 | 2, 347 | 90 |
| | O EMERGENCY | 5, 665, 969 | 2, 248, 988 | 7, 914, 957 | -307, 484 | 7, 607, 473 | |
| | O OBSERVATION BEDS (NON-DISTINCT PART) | <u> </u> | | <u> </u> | | <u> </u> | 92 |
| | O INTEREST EXPENSE | | 0 | 0 | | | 113 |
| 3. 00 | SUBTOTALS (SUM OF LINES 1-117) | 88, 037, 439 | 225, 594, 488 | 313, 631, 927 | 1, 167, 382 | 314, 799, 309 | 118 |
| | EIMBURSABLE COST CENTERS O GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | 0 | 0 | 0 | 190 |
| | 0 RESEARCH | 0 | 24, 233 | | | | |
| | 0 PHYSICIANS' PRIVATE OFFICES | 876, 328 | 7, 042, 136 | | | | |

| Health Financial Systems COMM | UNI TY HOSPI TAL | OF INDIANA, IN | IC. | In Lie | eu of Form CMS-2 | 2552-10 |
|---|------------------|----------------|---------------|--------------------------------|--------------------------------|---------|
| RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O | F EXPENSES | Provi der | | Period: | Worksheet A | |
| | | | | rom 01/01/2014 o 12/31/2014 | Date/Time Pre 5/27/2015 6:0 | |
| Cost Center Description | Sal ari es | Other | | Recl assi fi cati | | |
| | | | + col. 2) | ons (See A-6) | Trial Balance | |
| | | | | | (col. 3 +- | |
| | | | | | col. 4) | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 193.00 19300 NONPALD WORKERS | 0 | 0 | C | 0 0 | 0 | 193.00 |
| 194.0007950 HOME OFFICE | 0 | 0 | C | 0 0 | 0 | 194.00 |
| 194. 06 07956 PAVI LLI ONS | 0 | 2, 683, 781 | 2, 683, 781 | -1, 104, 807 | 1, 578, 974 | 194.06 |
| 194.07 07957 OTHER NONREI MBURSABLE COST CENTERS | 0 | 0 | C | 0 0 | 0 | 194.07 |
| 194.0807958 OTHER NONREIMBURSABLE COST CENTERS | 233, 815 | 1, 134, 036 | 1, 367, 851 | -51, 726 | 1, 316, 125 | 194.08 |
| 194.0907959 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | c | 0 0 | 0 | 194.09 |
| 194. 10 07960 COMMUNI TY REHAB HOSPI TAL | 302, 740 | 44, 675 | 347, 415 | -10, 849 | 336, 566 | 194. 10 |
| 194.1107961 WALGREENS TAKE CARE CLINIC | 0 | 0 | C | 0 | 0 | 194. 11 |
| 200.00 TOTAL (SUM OF LINES 118-199) | 89, 450, 322 | 236, 523, 349 | 325, 973, 671 | 0 | 325, 973, 671 | 200. 00 |

| LASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE | UF EXPENSES | Provider C | JN: 150169 | From 01/01/2014 | Worksheet A | |
|--|---------------------------|--------------------------------|------------|-----------------|------------------------------|----------|
| | | | | To 12/31/2014 | Date/Time Pi 5/27/2015 6: | |
| Cost Center Description | Adjustments (See A-8) | Net Expenses For Allocation | | | | |
| GENERAL SERVICE COST CENTERS | 6.00 | 7.00 | | | | _ |
| 0 00100 CAP REL COSTS-BLDG & FIXT | -9, 690, 557 | 7, 706, 038 | | | | 1. |
| 0 00200 CAP REL COSTS-MVBLE EQUIP | 3, 705, 957 | | | | | 2. |
| 0 00300 OTHER CAP REL COSTS | C | 0 | | | | 3 |
| 0 00400 EMPLOYEE BENEFITS DEPARTMENT | -150, 331 | 15, 836, 773 | | | | 4 |
| 0 00500 ADMINI STRATI VE & GENERAL | -58, 969, 493 | | | | | 5 |
| 0 00700 OPERATION OF PLANT | -113, 127 | | | | | 7 |
| 0 00800 LAUNDRY & LINEN SERVICE | 0 | | | | | 8 |
| 0 00900 HOUSEKEEPI NG 00 01000 DI ETARY | -8, 591 | | | | | 9 |
| 00 01100 CAFETERI A | -54, 869 | | | | | 11 |
| 00 01300 NURSING ADMINISTRATION | -212, 370 | | | | | 13 |
| 00 01400 CENTRAL SERVICES & SUPPLY | 212, 370 | | | | | 14 |
| 00 01500 PHARMACY | -4,974 | | | | | 15 |
| 00 01600 MEDI CAL RECORDS & LI BRARY | C | | | | | 16 |
| 00 01700 SOCIAL SERVICE | C | 2, 575, 695 | | | | 17 |
| 00 01900 NONPHYSICIAN ANESTHETISTS | C | - | | | | 19 |
| 00 02100 I&R SERVICES-SALARY & FRINGES APPRVD | 109, 353 | | | | | 21 |
| 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD | 186, 788 | | | | | 22 |
| 00 02300 EMS TRAINING PROGRAM-ALLIED HEALTHEM | 53, 751 | | | | | 23 |
| 01 02301 RADI OLOGY SCHOOL-ALLI ED HEALTH | -41,687 | | | | | 23 |
| 02 02302 PHARMACY RESIDENCY-ALLIED HEALTH | 246, 750 | 470, 010 | | | | 23 |
| 00 03000 ADULTS & PEDIATRICS | -62, 839 | 22, 290, 739 | | | | 30 |
| 00 03100 INTENSIVE CARE UNIT | 214, 074 | | | | | 31 |
| 00 02060 NEONATAL INTENSIVE CARE UNIT | 214,074 | | | | | 35 |
| 00 04000 SUBPROVIDER - IPF | | | | | | 40 |
| 00 04100 SUBPROVIDER - IRF | C | | | | | 41 |
| 00 04300 NURSERY | C | 2, 358, 423 | | | | 43 |
| ANCILLARY SERVICE COST CENTERS | - | | | | | |
| 00 05000 OPERATI NG ROOM | -37, 298 | | | | | 50 |
| 00 05100 RECOVERY ROOM | C | | | | | 51 |
| 00 05200 DELIVERY ROOM & LABOR ROOM | C | -,, | | | | 52 |
| 00 05400 RADI OLOGY-DI AGNOSTI C | -79, 419 | | | | | 54 |
| 00 05500 RADI OLOGY-THERAPEUTI C | 0 | | | | | 55 |
| 00 05700 CT SCAN | 404 775 | ., | | | | 57 |
| 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 00 06000 LABORATORY | -434, 775 -2, 860, 603 | | | | | 58 |
| 00 06400 INTRAVENOUS THERAPY | -2,860,603 | | | | | 64 |
| 00 06500 RESPIRATORY THERAPY | | | | | | 65 |
| 00 06600 PHYSI CAL THERAPY | -219, 295 | | | | | 66 |
| 00 06700 OCCUPATI ONAL THERAPY | 0 | | | | | 67 |
| 00 06800 SPEECH PATHOLOGY | C | | | | | 68 |
| 00 06900 ELECTROCARDI OLOGY | C | 1, 457, 922 | | | | 69 |
| 00 07000 ELECTROENCEPHALOGRAPHY | C | | | | | 70 |
| 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | C | | | | | 71 |
| 00 07200 I MPL. DEV. CHARGED TO PATIENTS | C | | | | | 72 |
| 00 07300 DRUGS CHARGED TO PATIENTS | C | 10, 287, 303 | | | | 73 |
| 00 07400 RENAL DI ALYSI S | 0 | | | | | 74 |
| | | 1, 268, 151 | | | | 76 |
| 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | | 0 | | | | 76 |
| 02 03950 NEUROPSYCHI ATRI C SERVI CES 03 03951 OTHER ANCI LLARY SERVI CES | | | | | | 76 |
| 03 03951 OTHER ANGILLARY SERVICES 04 03952 ANCILLARY SERVICE COST CENTERS | | | | | | 76 |
| 05 03953 MISC ANCI LLARY | | | | | | 76 |
| 06 03954 I MAGI NG CENTER | -145,050 | 2, 815, 022 | | | | 76 |
| 07 03955 BREAST DI AGNOSTI C CENTER | 000 | | | | | 76 |
| 08 03956 BARI ATRI C CLI NI C | C | | | | | 76 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 00 09000 CLINIC | C | | | | | 90 |
| 24 04973 PALLIATIVE CARE | -85, 582 | | | | | 90 |
| 26 04975 SPI NE CENTER | C | | | | | 90 |
| 27 04976 DI ABETI C CARE CENTER | -2, 347 | 1 1 | | | | 90 |
| 00 09100 EMERGENCY | -121, 803 | 7, 485, 670 | | | | 91 |
| 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) | | | | | | 92 |
| SPECIAL PURPOSE COST CENTERS | 0 | 0 | | | | 113 |
| .00 SUBTOTALS (SUM OF LINES 1-117) | -68, 778, 337 | | | | | 113 |
| NONREI MBURSABLE COST CENTERS | 00,770,337 | 270,020,772 | | | | \dashv |
| . 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | | | | 190 |
| . 00 19100 RESEARCH | 0 | 1 | | | | 191 |
| . 00 19200 PHYSI CLANS' PRI VATE OFFI CES | C | | | | | 192 |
| . 00 19300 NONPALD WORKERS | C | | | | | 193 |
| . 00 07950 HOME OFFICE | | l ol | | | | 194 |

| Health Financial Systems COMM | UNI TY HOSPI TAL | OF INDIANA, INC | C. | In Lie | u of Form CMS-2552-10 |
|---|------------------|-----------------|-------------|----------------------------|--|
| RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O | F EXPENSES | Provi der (| CCN: 150169 | Period: From 01/01/2014 | Worksheet A |
| | | | | To 12/31/2014 | Date/Time Prepared: 5/27/2015 6:07 pm |
| Cost Center Description | Adjustments | Net Expenses | | | |
| | (See A-8) | For Allocation | | | |
| | 6.00 | 7.00 | | | |
| 194. 06 07956 PAVI LLI ONS | 0 | 1, 578, 974 | | | 194.06 |
| 194.0707957 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | | | 194.07 |
| 194.0807958 OTHER NONREIMBURSABLE COST CENTERS | 0 | 1, 316, 125 | | | 194.08 |
| 194.0907959 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | | | 194.09 |
| 194.1007960 COMMUNITY REHAB HOSPITAL | 0 | 336, 566 | | | 194. 10 |
| 194.1107961 WALGREENS TAKE CARE CLINIC | 0 | o | | | 194. 11 |
| 200.00 TOTAL (SUM OF LINES 118-199) | -68, 778, 337 | 257, 195, 334 | | | 200.00 |

| th Financial Systems ASSIFICATIONS | COMMU | NI TY HOSPI TAL | OF INDIANA, INC. Provider CCN: 15 | 14 Date/Time Prepared: |
|--|--|---|---|---|
| Cost Center | Increases Line # | Salary | Other | 5/27/2015 6:07 pm |
| 2.00 A - Labor and Delivery Salary | 3.00 | 4.00 | 5.00 | |
| D NURSERY D DELIVERY ROOM & LABOR ROOM | 43.00 52.00 | 1, 794, 047 <u>4, 838, 7</u> 40 6, 632, 787 | | 1.00 |
| B - Labor and Delivery Other D NURSERY D DELIVERY ROOM & LABOR TOTALS | 43.00 <u>52.</u> 00 | 0 | 564, 376 <u>1, 522, 185</u> 2, 086, 561 | 1.0 |
| C - Chargeable Medical Supplie CENTRAL SERVICES & SUPPLY MEDICAL SUPPLIES CHARGED TO | es 14. 00 71. 00 | 0 | 565, 600 10, 406, 302 | 1. 0 2. 0 |
| PATI ENTS | 0.00 0.00 0.00 0.00 0.00 0.00 0.00 | 0 0 0 0 0 0 | | 3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 0 |
| 00 00 00 00 00 00 00 00 00 00 | 0.00 0.00 0.00 0.00 0.00 0.00 0.00 | | | 10. 0 11. 0 12. 0 13. 0 14. 0 15. 0 16. 0 |
| 00 00 00 00 00 00 00 00 00 00 00 00 | 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0 | | | 17. 0(18. 0(19. 0(20. 0(21. 0(22. 0(23. 0(23. 0(|
| TOTALS | 0.00 | 0 | 10, 971, 902 | 24.0 |
| D - Depreciation Expense CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQ | 2. 00 0. | | 17, 296, 110 0 0 0 0 0 0 0 0 0 0 0 0 0 | 1. 0 2. 0 3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 0 10. 0 11. 0 12. 0 13. 0 14. 0 15. 0 16. 0 17. 0 18. 0 19. 0 20. 0 21. 0 22. 0 23. 0 24. 0 25. 0 26. 0 27. 0 28. 0 29. 0 30. 0 29. 0 29. 0 30. 0 29. 0 29. 0 29. 0 20. 0 29. 0 20. 0 21. 0 25. 0 26. 0 27. 0 28. 0 29. 0 29. 0 20. 0 29. 0 20. |
| RADIOLOGY-THERAPEUTIC CT SCAN MAGNETIC RESONANCE IMAGING (MRI) | 55.00 57.00 58.00 | 48, 441 141, 365 46, 135 | | 1. 0 2. 0 3. 0 |

| CLASS | Financial Systems SFICATIONS | | | OF INDIANA, IN Provider | CCN: 150169 Period: Workshe From 01/01/2014 | <u>m CMS-2552-1</u> eet A-6 me Prepared: |
|----------|---|----------------|--------------------|----------------------------|--|--|
| | | | | | | 15 6:07 pm |
| | Cost Center | Line # | Salary | Other | | |
| | 2.00 | 3.00 | 4.00 | 5.00 | | |
| | F - Radiology Support Other | 55.00 | | 70, 700 | | |
|)0)0 | RADI OLOGY-THERAPEUTI C CT SCAN | 55.00 57.00 | 0 0 | 70, 780 206, 552 | | 1.0 |
| 00 | MAGNETIC RESONANCE IMAGING | 58.00 | 0 | 67, 410 | | 3.0 |
| | (MRI) | | | | | |
| | TOTALS | | 0 | 344, 742 | | |
| 00 | G - Capital Insurance Costs CAP REL COSTS-BLDG & FIXT | 1.00 | 0 | 204, 484 | | 1.0 |
| | TOTALS | | of | 204, 484 | | 1.0 |
| | H - Implantable Device Reclass | | | | | |
| 00 | CENTRAL SERVICES & SUPPLY | 14.00 | | 676, 027 | | 1.0 |
| 00 | I MPL. DEV. CHARGED TO PATI ENTS | 72.00 | | 13, 938, 495 | | 2.0 |
| 00 | I ATTENTS | | | | | 3.0 |
| 00 | | | | | | 4.0 |
| 00 | | | | | | 5.0 |
| 00 | | | | | | 6.0 |
| 00 | \vdash $+$ | + | — — — ₀ | 14, 614, 522 | | 7.0 |
| | I - Interest Expense | | | 11, 014, 022 | | |
| 00 | CAP REL COSTS-BLDG & FIXT | 1.00 | 0 | 8, 658, 883 | | 1.0 |
| | TOTALS | | 0 | 8, 658, 883 | | |
| 00 | J - Other Capital Rental Recla CAP REL COSTS-BLDG & FIXT | 1.00 | 0 | 1, 795, 425 | | 1.0 |
| 00 | CAP REL COSTS-BLDG & FIXT | 2.00 | 0 | 2, 940, 705 | | 2.0 |
| 00 | OPERATION OF PLANT | 7.00 | 0 | 18, 208 | | 3.0 |
| 00 | DI ETARY | 10.00 | 0 | 286 | | 4.0 |
| 00 | RESPI RATORY THERAPY | 65.00 | 0 | 26, 557 | | 5.0 |
| 00 | | 0.00 | 0 | 0 | | 6.0 |
| 0 0 | | 0.00 0.00 | 0 0 | 0 | | 7.0 |
| 0 | | 0.00 | 0 | 0 | | 9.0 |
| 00 | | 0.00 | 0 | 0 | | 10.0 |
| 00 | | 0.00 | 0 | 0 | | 11. C |
| 00 | | 0.00 | 0 | 0 | | 12.0 |
| 00 00 | | 0.00 0.00 | 0 0 | 0 | | 13. C |
| 00 | | 0.00 | 0 | 0 | | 15.0 |
| 00 | | 0.00 | 0 | 0 | | 16.0 |
| 00 | | 0.00 | 0 | 0 | | 17.0 |
| 00 00 | | 0.00 0.00 | 0 0 | 0 | | 18. (19. (|
| 00 | | 0.00 | 0 | 0 | | 20.0 |
| 00 | | 0.00 | 0 | 0 | | 21.0 |
| 00 | | 0.00 | 0 | 0 | | 22.0 |
| 00 | | 0.00 | 0 | 0 | | 23.0 |
| 00 00 | | 0.00 0.00 | 0 | 0 | | 24. 0 25. 0 |
| 00 | | 0.00 | 0 | 0 | | 25.0 |
| 00 | | 0.00 | 0 | 0 | | 27.0 |
| 00 | | 0.00 | 0 | 0 | | 28.0 |
| 00 | | 0.00 | 0 | 0 | | 29.0 |
| | TOTALS K - Depreciation by CC | | 0 | 4, 781, 181 | | |
| 00 | CAP REL COSTS-BLDG & FIXT | 1.00 | 0 | 6, 737, 803 | | 1.0 |
| | TOTALS | | 0 | 6, 737, 803 | | |
| | L - Cafeteria Salary | | | 1 | | |
| 00 | | <u>11.</u> 00 | <u>1, 202, 971</u> | | | 1.0 |
| | M - Cafeteria Reclass | | 1, 202, 971 | 0 | | |
| 00 | CAFETERIA | 11.00 | | 214, 216 | | 1.0 |
| | <u> </u> | | 0 | 214, 216 | | |
| | N - PHARMACY PRECEPTOR SALARY | | | | | |
| 00 | PHARMACY RESIDENCY-ALLIED | 23.02 | 200, 245 | 0 | | 1. C |
| | HEALTH | + | | | | |
| | 0 - Pharmacy Residency Precept | or Reclass | 200, 243 | 0 | | |
| 00 | PHARMACY RESIDENCY-ALLIED | 23. 02 | | 23, 015 | | 1.0 |
| | HEALTH | | ↓ | | | |
| | | | 0 | 23, 015 | | |
| 00 | Q - Drugs Charges to Pat DRUGS CHARGED TO PATIENTS | 73.00 | | 10, 287, 303 | | 1.0 |
| | DRUGG CHARGED TO FATTENTS | 73.00 | | 10, 207, 303 | | 2.0 |
| 0 | 1 | | | | | |

| | Financial Systems SIFICATIONS | COMM | IUNITY HOSPITAL | | CCN: 150169 Period: From O | 1/01/2014 2/31/2014 Date/Time Prepared: |
|---|--|--|--|---|-------------------------------|---|
| | | Increases | | | | 5/27/2015 6:07 pm |
| | Cost Center | Li ne # | Salary | Other | | |
| 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 | 2.00 | 3.00 | 4.00 | 5.00 | | 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 |
| | R - Therapy Salary | (7.00 | 055 070 | | | |
| 1.00 2.00 | OCCUPATIONAL THERAPY SPEECH PATHOLOGY | 67.00 <u>68.</u> 00 | 955, 078 21 <u>7, 8</u> 51 1, 172, 929 | — — | | 1.00 2.00 |
| 1.00 | S - Therapy Other PHYSICAL THERAPY | 66.00 | | 1, 252, 860 | | 1.00 |
| 2.00 | OCCUPATI ONAL THERAPY | 67.00 | | 397, 585 | | 2.00 |
| 3.00 | SPEECH PATHOLOGY | | ↓ | <u> </u> | | 3.00 |
| | T - Plant Operations Expense | | 0 | 1, 741, 133 | | |
| $\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ \end{array}$ | OPERATION OF PLANT | 7.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 | | 883, 896 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 |
| | U - Dietary Food Service Allo | bcati on | 0 | 883, 870 | | |
| $\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$ | DI ETARY | 10.00 0.000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000000 | | 191, 548 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 15.00 |
| 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 | V - STD BENEFIT RECLASS ADMI NI STRATI VE & GENERAL OPERATI ON OF PLANT HOUSEKEEPI NG DI ETARY NURSI NG ADMI NI STRATI ON PHARMACY MEDI CAL RECORDS & LI BRARY SOCI AL SERVI CE ADULTS & PEDI ATRI CS | 5.00 7.00 9.00 10.00 13.00 15.00 16.00 17.00 30.00 | | 26, 559 10, 574 25, 472 8, 966 1, 828 23, 591 4, 860 2, 010 156, 717 | | 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 |

Health Financial Systems RECLASSIFICATIONS

COMMUNITY HOSPITAL OF INDIANA, INC. In Lieu of Form CMS-2552-10 Provider CCN: 150169 Period: From 01/01/2014 Worksheet A-6

| | | | | | Date/Time Prepared: |
|--------|-------------------------------|-----------|--------------------|--------------|-----------------------|
| | | Increases | | | 5/27/2015 6:07 pm |
| | Cost Center | Line # | Salary | Other | |
| | 2.00 | 3.00 | 4.00 | 5.00 | |
| 10.00 | INTENSIVE CARE UNIT | 31.00 | 0 | 16, 458 | 10.00 |
| 11.00 | NEONATAL INTENSIVE CARE UNIT | 35.00 | 0 | 23, 399 | 11.00 |
| 12.00 | SUBPROVIDER - IPF | 40.00 | 0 | 3, 347 | 12.00 |
| 13.00 | RADI OLOGY-DI AGNOSTI C | 54.00 | 0 | 6, 338 | 13.00 |
| 14.00 | RADI OLOGY-THERAPEUTI C | 55.00 | 0 | 7, 439 | 14.00 |
| 15.00 | RESPI RATORY THERAPY | 65.00 | 0 | 15, 849 | 15.00 |
| 16.00 | PHYSI CAL THERAPY | 66.00 | 0 | 13, 045 | 16.00 |
| 17.00 | ELECTROENCEPHALOGRAPHY | 70.00 | 0 | 874 | 17.00 |
| 18.00 | I MAGI NG CENTER | 76.06 | 0 | 3, 907 | 18.00 |
| 19.00 | EMERGENCY | 91.00 | 0 | 37, 962 | 19.00 |
| 20.00 | COMMUNITY REHAB HOSPITAL | 194.10 | 0 | 600 | 20.00 |
| | TOTALS | | | 389, 795 | |
| | W - EMS School Allied Health | · · · | | | |
| 1.00 | EMS TRAINING PROGRAM-ALLIED | 23.00 | 22, 936 | | 1.00 |
| | HEALTHEM | + | | | |
| | | | 22, 936 | 0 | |
| 1 00 | X - EMS School Allied Health | 23.00 | | 10.025 | 1.00 |
| 1.00 | EMS TRAINING PROGRAM-ALLIED | 23.00 | | 10, 025 | 1.00 |
| | | | — — — ₀ | 10, 025 | |
| | Y - Radiology School Allied H | leal th | | | |
| 1.00 | RADI OLOGY SCHOOL-ALLI ED | 23.01 | 5, 915 | | 1.00 |
| | HEALTH | | | | |
| | | | 5, 915 | 0 | |
| | Z - Radiology School Allied H | | | | |
| 1.00 | RADI OLOGY SCHOOL-ALLI ED | 23. 01 | | 453 | 1.00 |
| | HEALTH | | + | | |
| | | | 0 | 453 | |
| 500.00 | Grand Total: Increases | l | 9, 473, 724 | 79, 437, 572 | 500.00 |

| ASS | Financial Systems SEFECATIONS | | | Provi der | | Peri od: | Worksheet A-6 |
|----------|--|------------------|-------------|------------------------|----------------|----------------------------------|-----------------|
| | | | | | | From 01/01/2014 To 12/31/2014 | Date/Time Prepa |
| | | Decreases | | | | · · · · · · · | 5/27/2015 6:07 |
| | Cost Center | Li ne # | Salary | Other | Wkst. A-7 Ref. | | |
| | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | | |
| | A - Labor and Delivery Salary | 20.00 | ((00 707 | | 1 | | |
|)) | ADULTS & PEDIATRICS | 30.00 | 6, 632, 787 | | | | |
| | \vdash $+$ | + | 6, 632, 787 | c |) | - | |
| | B - Labor and Delivery Other | 1 | | | 1 | 1 | |
|) | ADULTS & PEDIATRICS | 30.00 | 0 | 2, 086, 561 | | | |
|) | TOTALS | 0.00 | 0 | 2,086,561 | | | |
| | C - Chargeable Medical Supplie | S | | 2,000,001 | | | |
| D | OPERATION OF PLANT | 7.00 | 0 | 51, 607 | | | |
| 2 | DIETARY | 10.00 | 0 | 2, 256 | | | |
|)) | PHARMACY ADULTS & PEDIATRICS | 15.00 30.00 | 0 | 51, 462 1, 147, 450 | | | |
| 5 | INTENSIVE CARE UNIT | 31.00 | Ő | 180, 702 | | | |
|) | NEONATAL INTENSIVE CARE UNIT | 35.00 | 0 | 109, 006 | | | |
| 2 | SUBPROVIDER - IPF | 40.00 | 0 | 1, 366 | | | |
|) | SUBPROVIDER - IRF OPERATING ROOM | 41.00 50.00 | 0 | 3 7, 169, 544 | | | |
| 00 | RECOVERY ROOM | 51.00 | 0 | 188, 810 | | | 1 |
| 00 | RADI OLOGY-DI AGNOSTI C | 54.00 | 0 | 42, 837 | (| b | 1 |
| 00 | RADI OLOGY-THERAPEUTI C | 55.00 | 0 | 680, 844 | | 2 D | 1 |
| 00 00 | CT SCAN MAGNETIC RESONANCE IMAGING | 57.00 58.00 | 0 | 125, 469 7, 263 | | | 1 |
| 00 | (MRI) | 58.00 | 0 | 7,203 | | | |
| 00 | INTRÁVENOUS THERAPY | 64.00 | 0 | 97, 336 | , (| b | 1 |
| 00 | RESPIRATORY THERAPY | 65.00 | 0 | 290, 143 | | | 1 |
| 00 00 | PHYSI CAL THERAPY ELECTROENCEPHALOGRAPHY | 66.00 70.00 | 0 | 12, 278 48, 992 | | | 1 |
| 00 | RENAL DI ALYSI S | 70.00 | 0 | 6, 177 | | | 1 |
| 00 | ENDOSCOPY | 76.00 | 0 | 524, 083 | | b | 2 |
| 00 | IMAGING CENTER | 76.06 | 0 | 48, 758 | . (| | 2 |
| 00 00 | BREAST DIAGNOSTIC CENTER | 76.07 91.00 | 0 | 771 | | | |
| 00 | OTHER NONREI MBURSABLE COST | 194.08 | 0 | 181, 414 3, 331 | | | |
| | CENTERS | | | | | | |
| | TOTALS | | 0 | 10, 971, 902 | | | |
|) | D - Depreciation Expense EMPLOYEE BENEFITS DEPARTMENT | 4.00 | 0 | 17, 758 | | 9 | |
| 5 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 10, 954, 084 | | | |
|) | OPERATION OF PLANT | 7.00 | О | 99, 598 | . (| o | |
|) | HOUSEKEEPING | 9.00 | 0 | 9, 596 | | | |
|)) | DI ETARY NURSI NG ADMI NI STRATI ON | 10. 00 13. 00 | 0 | 66, 385 853 | | | |
| 5 | CENTRAL SERVICES & SUPPLY | 14.00 | 0 | 69, 769 | | | |
|) | PHARMACY | 15.00 | О | 148, 795 | | b | |
|) | ADULTS & PEDIATRICS | 30.00 | 0 | 719, 378 | | 2 D | |
| 00 00 | INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT | 31.00 35.00 | 0 | 31, 308 191, 954 | | | 1 |
| 00 | SUBPROVIDER - IPF | 40.00 | 0 | 17, 890 | | | 1 |
| 00 | OPERATING ROOM | 50.00 | 0 | 1, 548, 913 | | | 1 |
| 00 | RECOVERY ROOM | 51.00 | 0 | 22, 300 | | | 1 |
| 00 00 | RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C | 54.00 55.00 | 0 | 781, 940 144, 144 | | | 1 |
| 00 | CT SCAN | 57.00 | 0 | 38, 258 | | | 1 |
| 00 | MAGNETIC RESONANCE I MAGING | 58.00 | Ō | 590, 522 | | | 1 |
| | (MRI) | | | | | | |
| 00 | | 60.00 64.00 | 0 | 1,082 | | | 1 |
| 00 00 | I NTRAVENOUS THERAPY RESPI RATORY THERAPY | 65.00 | 0 | 3, 000 145, 229 | | | |
| 00 | PHYSI CAL THERAPY | 66.00 | 0 | 99, 687 | | | |
| 00 | ELECTROCARDI OLOGY | 69.00 | 0 | 17, 719 |) (| כן | 2 |
| 00 | ELECTROENCEPHALOGRAPHY | 70.00 | 0 | 89, 498 | | | 2 |
| 00 00 | ENDOSCOPY I MAGI NG CENTER | 76. 00 76. 06 | 0 | 255, 622 672, 014 | | | |
| 00 | BREAST DIAGNOSTIC CENTER | 76.08 76.07 | 0 | 63, 153 | | | |
| 00 | EMERGENCY | 91.00 | 0 | 56, 267 | | p | |
| 00 | PAVI LLI ONS | 194.06 | 0 | 431, 641 | | | 2 |
| 00 | OTHER NONREI MBURSABLE COST CENTERS | 194.08 | 0 | 7, 753 | (| נ | 3 |
| | TOTALS | +- | - — — † | 17, 296, 110 | | 1 | |
| | E - Radiology Support Salary | | | , , | | | |
| D | RADI OLOGY-DI AGNOSTI C | 54.00 | 235, 941 | | | | |
|) | | | | | | | |

| Heal th | Fi nanci al | Systems |
|---------|-------------|---------|
| RECLAS | SIFICATION | IS |

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

| | | | | | | To 12/31/2014 | Date/Time Prepare 5/27/2015 6:07 pr |
|----------------|---|----------------------|-----------------------------------|---------------------|---------------|---------------|--|
| | Cost Center | Decreases Line # | Salary | Other | Wkst. A-7 Ref | • | |
| | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | <u>·</u> | |
| | 0.00 | 1.00 | 235, 941 | 0 | | | |
| | F - Radiology Support Other | | | | | | |
| 00 | RADI OLOGY-DI AGNOSTI C | 54.00 | 0 | 344, 742 | | 0 | 1 |
| 00 00 | | 0.00 0.00 | 0 | 0 | | 0 | 2 |
| 0 | TOTALS | | 0 | | | | ່ ວ |
| | G - Capital Insurance Costs | | 0 | 544,742 | | | |
| 00 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 204, 484 | 1 | 2 | 1 |
| | TOTALS | | 0 | 204, 484 | | | |
| 0 | H - Implantable Device Reclass | | | 0.400 | | | 1 |
| 0 0 | ADMI NI STRATI VE & GENERAL PHARMACY | 5.00 15.00 | | 9, 600 7 | | | 1 |
| 0 | ADULTS & PEDIATRICS | 30.00 | | , 982 | | | 3 |
| 0 | OPERATING ROOM | 50.00 | | 14, 231, 228 | | | 4 |
| 0 | RADI OLOGY-THERAPEUTI C | 55.00 | | 278, 018 | | | 5 |
| 0 | PHYSICAL THERAPY | 66.00 | | 5, 474 | | | 6 |
| 0 | ENDOSCOPY | | | 89,213 | | _ | 7 |
| | I - Interest Expense | | 0 | 14, 614, 522 | | | |
| 0 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 8, 658, 883 | 1 | 1 | 1 |
| | TOTALS | | o | 8, 658, 883 | | 1 | |
| _ | J - Other Capital Rental Recla | | | | | -1 | |
| 0 | EMPLOYEE BENEFITS DEPARTMENT | 4.00 | 0 | 128, 400 | | 0 | 1 |
| 0 0 | ADMINISTRATIVE & GENERAL LAUNDRY & LINEN SERVICE | 5.00 8.00 | 0 | 239, 842 79 | | 0 | 2 |
| 0 | HOUSEKEEPING | 9.00 | 0 | 1,068 | | 0 | |
| 0 | NURSI NG ADMI NI STRATI ON | 13.00 | 0 | 79 | | 0 | Ę |
| 0 | CENTRAL SERVICES & SUPPLY | 14.00 | 0 | 1, 263, 741 | | 0 | 6 |
| 0 | PHARMACY | 15.00 | 0 | 331, 552 | | 0 | 7 |
| 0 | MEDI CAL RECORDS & LI BRARY | 16.00 | 0 | 178 | | 0 | 8 |
| 0 | SOCIAL SERVICE | 17.00 | 0 | 391 | | 0 | 10 |
| 00 00 | ADULTS & PEDIATRICS INTENSIVE CARE UNIT | 30.00 31.00 | 0 | 23, 844 612 | | 0 | 10 |
| 00 | NEONATAL INTENSIVE CARE UNIT | 35.00 | 0 | 514 | | o | 12 |
| 00 | SUBPROVIDER - IPF | 40.00 | 0 | 482 | | o | 13 |
| 00 | SUBPROVI DER – I RF | 41.00 | 0 | 174 | | o | 14 |
| 00 | OPERATING ROOM | 50.00 | 0 | 1, 223, 143 | | 0 | 15 |
| 00 | RECOVERY ROOM | 51.00 | 0 | 394 | | 0 | 16 |
| 00 00 | RADI OLOGY-DI AGNOSTI C | 54.00 | 0 | 1, 557 | | 0 | 17 |
| 00 | RADI OLOGY-THERAPEUTI C | 55.00 57.00 | 0 | 665 102, 810 | | 0 | 19 |
| 00 | MAGNETIC RESONANCE I MAGI NG | 58.00 | 0 | 68, 339 | | 0 | 20 |
| | (MRI) | | - | , | | | |
| 00 | INTRAVENOUS THERAPY | 64.00 | 0 | 197 | | 0 | 21 |
| 00 | PHYSICAL THERAPY | 66.00 | 0 | 719, 206 | | 0 | 22 |
| | ELECTROENCEPHALOGRAPHY ENDOSCOPY | 70.00 | 0 | 83, 661 | | 0 | 23 |
| 00 00 | I MAGI NG CENTER | 76.00 76.06 | 0 | 713 399, 702 | | 0 | 24 |
| 00 | SPINE CENTER | 90.26 | 0 | 51, 108 | | 0 | 26 |
| 00 | EMERGENCY | 91.00 | 0 | 4, 133 | | 0 | 27 |
| 00 | PAVI LLI ONS | 194.06 | О | 93, 955 | | o | 28 |
| 00 | OTHER NONREI MBURSABLE COST | 194.08 | 0 | 40, 642 | | 0 | 29 |
| | CENTERS | + | | 4, 781, 181 | | - | |
| | K - Depreciation by CC | | U | 4, 781, 181 | | | |
| 0 | CAP REL COSTS-MVBLE EQUI P | 2.00 | 0 | 6, 737, 803 | | 9 | 1 |
| | TOTALS | | 0 | 6, 737, 803 | | | |
| | L - Cafeteria Salary | I | | | | 1 | |
| 0 | <u>DIETARY</u> | <u>10.00</u> | <u>1, 202, 971</u> 1, 202, 971 | | | - | 1 |
| | M - Cafeteria Reclass | | 1, 202, 971 | 0 | | | |
| 0 | DI ETARY | 10.00 | | 214, 216 | | | 1 |
| | | | o | 214, 216 | | 1 | |
| _ | N - PHARMACY PRECEPTOR SALARY | | | | | -1 | |
| 0 | PHARMACY | <u>15.00</u> | 200, 245 | 0 | | o | 1 |
| | TOTALS | ton Doctors | 200, 245 | 0 | | | |
| 0 | 0 - Pharmacy Residency Precept PHARMACY | tor RecLass 15.00 | | 23, 015 | | | 1 |
| ⁱ U | | | | 23,015 23,015 | | + | |
| | Q - Drugs Charges to Pat | | | 20,010 | | | |
| | CENTRAL SERVICES & SUPPLY | 14.00 | | 350 | | | 1 |
| | | | 1 | | | | |
| 00 00 00 | ADULTS & PEDIATRICS | 15.00 30.00 | | 10, 154, 247 430 | | | 2 |

| Heal th | Fi nanci al | Systems |
|---------|-------------|---------|
| RECLAS | SIFICATION | IS |

| | COMMUNI TY | HOSPI TAL | 0F | I NDI ANA, | I NC |
|--|------------|-----------|----|------------|------|
|--|------------|-----------|----|------------|------|

| CLAS | SI FI CATI ONS | | | Provi der | | Period: From 01/01/2014 | Worksheet A-6 |
|--------------|--|------------------|----------------|--------------------|-------------------------|----------------------------|--|
| | | | | | | To 12/31/2014 | Date/Time Prepare 5/27/2015 6:07 pr |
| | | Decreases | | 0.11 | | | |
| | Cost Center 6.00 | Line # 7.00 | Salary 8.00 | 0ther 9.00 | Wkst. A-7 Ref. 10.00 | - | |
| 00 | NEONATAL INTENSIVE CARE UNIT | 35.00 | 0.00 | 48 | | | 5 |
| 00 | OPERATING ROOM | 50.00 | | 459 | | | 6 |
| 00 | RADI OLOGY-DI AGNOSTI C | 54.00 | | 105, 684 | | | 7 |
| 00 | RESPI RATORY THERAPY | 65.00 | | 4, 276 | | | 8 |
| 00 | PHYSI CAL THERAPY | 66.00 | | 839 | | | 9 |
| 00 | | 76.06 | | 243 | | | 10 |
| . 00 . 00 | BARIATRIC CLINIC SPINE CENTER | 76. 08 90. 26 | | 96 9, 197 | | | 11 |
| 00 | EMERGENCY | 90.28 91.00 | | 9, 197 380 | | | 12 |
| 00 | COMMUNITY REHAB HOSPITAL | 194.10 | | 10, 849 | | | 14 |
| | | | o | 10, 287, 303 | | - | |
| 00 | R - Therapy Salary PHYSICAL THERAPY | 66.00 | 1, 172, 929 | | | | 1 |
| 00 | | | | | | | 2 |
| | S - Therapy Other | | 1, 172, 929 | C |) | | |
| 00 | ADULTS & PEDIATRICS | 30.00 | | 1, 741, 133 | : | | 1 |
| 00 | | | | | | | 2 |
| 00 | \vdash $+$ | + | | 1, 741, 133 | · · · · · · · | 4 | 3 |
| | T - Plant Operations Expense | | | | 1 | | |
| 00 | EMPLOYEE BENEFITS DEPARTMENT | 4.00 | 0 | 600 | | | 1 |
| 00 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 127 | | | 2 |
|)0)0 | HOUSEKEEPI NG DI ETARY | 9.00 10.00 | 0 | 18, 790 23, 841 | | | 3 |
| 00 | CENTRAL SERVICES & SUPPLY | 14.00 | 0 | 4, 768 | | | 5 |
| 00 | ADULTS & PEDIATRICS | 30.00 | 0 | 32, 854 | | | 6 |
| 00 | INTENSIVE CARE UNIT | 31.00 | 0 | 1,070 | | | 7 |
| 00 | NEONATAL INTENSIVE CARE UNIT | 35.00 | 0 | 10, 337 | | | 8 |
| 00 | OPERATING ROOM | 50.00 | 0 | 170, 307 | (| | 9 |
| 00 | RADI OLOGY-DI AGNOSTI C | 54.00 | 0 | 1, 702 | | | 10 |
| 00 | RADI OLOGY-THERAPEUTI C | 55.00 | 0 | 279 | | | 11 |
| 00 00 | CT SCAN MAGNETIC RESONANCE IMAGING | 57.00 58.00 | 0 | 955 4, 062 | | | 12 |
| 00 | (MRI) | 58.00 | 0 | 4, 002 | | | 13 |
| . 00 | LABORATORY | 60.00 | 0 | 2, 366 | | | 14 |
| 00 | RESPI RATORY THERAPY | 65.00 | 0 | 10, 252 | | | 15 |
| 00 | PHYSICAL THERAPY | 66.00 | 0 | 3, 752 | | | 16 |
| 00 | ELECTROENCEPHALOGRAPHY RENAL DIALYSIS | 70.00 | 0 | 1, 414 | | | 17 |
| 00 | ENDOSCOPY | 74.00 76.00 | 0 | 135 2, 432 | | | 18 |
| 00 | I MAGI NG CENTER | 76.06 | 0 | 6, 846 | | | 20 |
| . 00 | EMERGENCY | 91.00 | 0 | 7, 796 | | | 20 |
| 00 | PAVI LLI ONS | 194.06 | 0 | 579, 211 | | | 22 |
| | TOTALS | | | 883, 896 | | | |
| 00 | U - Dietary Food Service Alloca ADULTS & PEDIATRICS | ation 30.00 | 0 | 123, 456 | |) | 1 |
| 00 | INTENSIVE CARE UNIT | 31.00 | 0 | 4, 822 | | | 2 |
| 00 | NEONATAL INTENSIVE CARE UNIT | 35.00 | 0 | 4, 404 | | | 3 |
| 00 | SUBPROVI DER – I RF | 41.00 | 0 | 74 | | | 4 |
| 00 | OPERATING ROOM | 50.00 | 0 | 18, 359 | | | 5 |
| 00 | RECOVERY ROOM | 51.00 | 0 | 26 | | | 6 |
| 00 | RADI OLOGY-DI AGNOSTI C | 54.00 | O | 3, 143 | | | 7 |
|)0)0 | CT SCAN MAGNETIC RESONANCE IMAGING | 57.00 58.00 | 0 | 626 167 | | | 8 |
| | (MRI) | | Ĭ | | | | |
| 00 | RESPIRATORY THERAPY | 65.00 | 0 | 968 | | | 10 |
| 00 | PHYSICAL THERAPY | 66.00 | 0 | 819 | | | 11 |
| 00 00 | ELECTROENCEPHALOGRAPHY ENDOSCOPY | 70. 00 76. 00 | 0 | 4, 425 931 | | | 12 |
| 00 | I MAGI NG CENTER | 76.00 | 0 O | 4, 235 | | | 13 |
| 00 | BARI ATRI C CLI NI C | 76.08 | 0 | 4, 235 | | | 15 |
| 00 | SPINE CENTER | 90.26 | 0 | 444 | | | 16 |
| 00 | EMERGENCY | <u>91.</u> 00 | 0 | 2 <u>4,5</u> 33 | | | 17 |
| | TOTALS V - STD BENEFIT RECLASS | | 0 | 191, 548 | | | |
| 00 | ADMI NI STRATI VE & GENERAL | 5.00 | 26, 559 | C | | 0 | 1 |
| 00 | OPERATION OF PLANT | 7.00 | 10, 574 | C | | | 2 |
| 00 | HOUSEKEEPI NG | 9.00 | 25, 472 | C | | | 3 |
| 00 | DI ETARY | 10.00 | 8, 966 | C | | | 4 |
| 00 | NURSING ADMINISTRATION | 13.00 | 1, 828 | C | - | | 5 |
| 00 | PHARMACY | 15. 00 16. 00 | 23, 591 | C | | | 6 |
| 00 | MEDICAL RECORDS & LIBRARY | | 4, 860 | C | | N | 7 |

| ECLASS | SI FI CATI ONS | | | Provi der | CCN: 150169 | Period: From 01/01/2014 To 12/31/2014 | Worksheet Date/Time 5/27/2015 | Prepared |
|--------|--------------------------------|---------------|-------------|------------------|---------------|---|-------------------------------------|----------|
| | | Decreases | | | | | 0/2//2010 | |
| | Cost Center | Line # | Sal ary | Other | Wkst. A-7 Ref | · . | | |
| | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | | | |
| . 00 | ADULTS & PEDIATRICS | 30.00 | 156, 717 | 0 | | 0 | | 9.0 |
| 0.00 | INTENSIVE CARE UNIT | 31.00 | 16, 458 | 0 | | 0 | | 10.0 |
| 1.00 | NEONATAL INTENSIVE CARE UNIT | 35.00 | 23, 399 | 0 | | 0 | | 11.0 |
| 2.00 | SUBPROVIDER - IPF | 40.00 | 3, 347 | 0 | | 0 | | 12.0 |
| 3.00 | RADI OLOGY-DI AGNOSTI C | 54.00 | 6, 338 | 0 | | 0 | | 13. (|
| 4.00 | RADI OLOGY-THERAPEUTI C | 55.00 | 7, 439 | 0 | | 0 | | 14.0 |
| 5.00 | RESPI RATORY THERAPY | 65.00 | 15, 849 | 0 | | 0 | | 15.0 |
| 6.00 | PHYSICAL THERAPY | 66.00 | 13, 045 | 0 | | 0 | | 16. (|
| 7.00 | ELECTROENCEPHALOGRAPHY | 70.00 | 874 | 0 | | 0 | | 17. (|
| 8.00 | I MAGI NG CENTER | 76.06 | 3, 907 | 0 | | 0 | | 18.0 |
| | EMERGENCY | 91.00 | 37, 962 | 0 | | 0 | | 19. (|
| 0.00 | COMMUNITY REHAB HOSPITAL | 194.10 | | 0 | | <u>o</u> | | 20. 0 |
| | TOTALS | | 389, 795 | 0 | | | | |
| | W - EMS School Allied Health | | | | | | | |
| . 00 | EMERGENCY | 91.00 | 22, 936 | | | | | 1. (|
| | | | 22, 936 | 0 | | | | |
| | X - EMS School Allied Health | | | | | | | |
| . 00 | EMERGENCY | | | 1 <u>0, 0</u> 25 | | | | 1. (|
| | | | 0 | 10, 025 | | | | |
| | Y - Radiology School Allied He | | | | | | | |
| . 00 | RADI OLOGY-DI AGNOSTI C | 54.00 | 5, 915 | | | | | 1. (|
| | | | 5, 915 | 0 | | | | |
| | Z - Radiology School Allied He | | | | | | | |
| . 00 | RADI OLOGY-DI AGNOSTIC | <u>54.</u> 00 | | 453 | | 4 | | 1.0 |
| | | | 0 | 453 | | 4 | | |
| 00.00 | Grand Total: Decreases | | 9, 863, 519 | 79, 047, 777 | | | | 500. |

| RECONC | ILIATION OF CAPITAL COSTS CENTERS | | Provi der | CCN: 150169 | Period: From 01/01/2014 To 12/31/2014 | | pared: |
|--------|--|------------------|-------------|----------------|---|---------------|--------|
| | | | | Acqui si ti on | s | | |
| | | Begi nni ng | Purchases | Donati on | Total | Disposals and | |
| | | Bal ances | | | | Retirements | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE | ET BALANCES | | _ | | | |
| 1.00 | Land | 2, 705, 851 | 0 | | 0 0 | 0 | 1.00 |
| 2.00 | Land Improvements | 3, 158, 137 | 0 | | 0 0 | 0 | 2.00 |
| 3.00 | Buildings and Fixtures | 289, 972, 896 | 1, 602, 044 | | 0 1, 602, 044 | 0 | 3.00 |
| 4.00 | Building Improvements | 5, 326, 285 | 3, 117 | | 0 3, 117 | 351, 687 | 4.00 |
| 5.00 | Fixed Equipment | 3, 118, 039 | 0 | | 0 0 | 0 | 5.00 |
| 5.00 | Movable Equipment | 90, 711, 081 | 6, 884, 162 | | 0 6, 884, 162 | 5, 507, 430 | 6.0 |
| 7.00 | HIT designated Assets | 0 | 0 | | 0 0 | 0 | 7.00 |
| 3.00 | Subtotal (sum of lines 1-7) | 394, 992, 289 | 8, 489, 323 | | 0 8, 489, 323 | 5, 859, 117 | 8.00 |
| 9.00 | Reconciling Items | 0 | 0 | | 0 0 | 0 | |
| 10.00 | Total (line 8 minus line 9) | 394, 992, 289 | 8, 489, 323 | | 0 8, 489, 323 | 5, 859, 117 | 10.00 |
| | | Endi ng Bal ance | | | | | |
| | | J | Depreciated | | | | |
| | | | Assets | | | | |
| | | 6.00 | 7.00 | 1 | | | |
| | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE | T BALANCES | | • | | | |
| 1.00 | Land | 2, 705, 851 | 0 | | | | 1.00 |
| 2.00 | Land Improvements | 3, 158, 137 | 0 | | | | 2.0 |
| 3.00 | Buildings and Fixtures | 291, 574, 940 | 0 | | | | 3.0 |
| 4.00 | Building Improvements | 4, 977, 715 | 0 | | | | 4.0 |
| 5.00 | Fixed Equipment | 3, 118, 039 | 0 | | | | 5.0 |
| 5.00 | Movable Equipment | 92, 087, 813 | 0 | | | | 6.00 |
| 7.00 | HIT designated Assets | 0 | 0 | | | | 7.00 |
| 3.00 | Subtotal (sum of lines 1-7) | 397, 622, 495 | 0 | | | | 8.0 |
| 7.00 | Reconciling Items | 0 | 0 | | | | 9.0 |
| 10.00 | Total (line 8 minus line 9) | 397, 622, 495 | 0 | | | | 10.00 |

| Heal th | Financial Systems COMM | UNI TY HOSPI TAL | OF INDIANA, IN | IC. | In Lie | u of Form CMS-2 | 2552-10 |
|---------|---|--------------------------------|----------------|---------------|----------------------------------|-----------------|---------|
| RECON | CILIATION OF CAPITAL COSTS CENTERS | | Provi der | CCN: 150169 | Peri od: | Worksheet A-7 | |
| | | | | | From 01/01/2014 To 12/31/2014 | | arod |
| | | | | | 10 12/31/2014 | 5/27/2015 6:0 | |
| | | | SL | JMMARY OF CAP | I TAL | | |
| | | | | | | | |
| | Cost Center Description | Depreciation | Lease | Interest | Insurance (see | | |
| | | | | | | instructions) | |
| | | 9.00 | 10.00 | 11.00 | 12.00 | 13.00 | |
| | PART II - RECONCILIATION OF AMOUNTS FROM WOR | <u>(SHEET A, COLUN</u> | N 2, LINES 1 a | nd 2 | 1 | | |
| 1.00 | CAP REL COSTS-BLDG & FIXT | 0 | 0 | | 0 0 | 0 | 1.00 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | 0 | 0 | | 0 0 | 0 | 2.00 |
| 3.00 | Total (sum of lines 1-2) | 0 | 0 | | 0 0 | 0 | 3.00 |
| | | SUMMARY O | F CAPITAL | | | | |
| | Cont. Contan Decariation | 0+1 | Tatal (1) (au | | | | |
| | Cost Center Description | | Total (1) (sum | | | | |
| | | Capital-Relate d Costs (see | | | | | |
| | | instructions) | (Infough 14) | | | | |
| | | 14.00 | 15.00 | | | | |
| | PART II - RECONCILIATION OF AMOUNTS FROM WORI | | | nd 2 | | | |
| 1.00 | CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 2.00 | CAP REL COSTS BEDG & TTXT | 0 | 0 | | | | 2.00 |
| 3.00 | Total (sum of lines 1-2) | 0 | | | | | 3.00 |
| 0.00 | | | | 1 | | I I | 0.00 |

| ECONCILIATION OF CAPI | | | OF INDIANA, IN | | eri od: | u of Form CMS-2 Worksheet A-7 | |
|------------------------|----------------------------|---------------|-------------------|-----------------|-------------------|----------------------------------|-------|
| LECONCILIATION OF CAPI | TAL COSTS CENTERS | | FIOVICE | | rom 01/01/2014 | | |
| | | | | | to 12/31/2014 | | pared |
| | | | | | | 5/27/2015 6:07 | |
| | | COM | PUTATION OF RAT | TI OS | ALLOCATION OF | OTHER CAPITAL | |
| | | | | | | | |
| Cost Cente | r Description | Gross Assets | Capi tal i zed | Gross Assets | Ratio (see | Insurance | |
| | | | Leases | for Ratio | instructions) | | |
| | | | | (col. 1 - col. | | | |
| | | | | 2) | | | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| PART III - RECON | CILIATION OF CAPITAL COSTS | CENTERS | | | | | |
| . 00 CAP REL COSTS-BI | _DG & FIXT | 394, 992, 289 | 0 | 394, 992, 289 | 1.000000 | 0 | 1. |
| . 00 CAP REL COSTS-M | /BLE EQUIP | 0 | 0 | C | 0. 000000 | 0 | 2. |
| .00 Total (sum of li | nes 1-2) | 394, 992, 289 | 0 | 394, 992, 289 | 1.000000 | 0 | 3. |
| | | ALLOCA | TION OF OTHER (| CAPI TAL | SUMMARY C | F CAPITAL | |
| | | | | | | | |
| Cost Cente | r Description | Taxes | Other | Total (sum of | Depreciation | Lease | |
| | | | Capi tal -Rel ate | cols. 5 | | | |
| | | | d Costs | through 7) | | | |
| | | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| PART III - RECON | CILIATION OF CAPITAL COSTS | CENTERS | _ | _ | | | |
| . 00 CAP REL COSTS-BI | _DG & FIXT | 0 | 0 | C | 7, 305, 453 | 1, 795, 425 | 1. |
| . 00 CAP REL COSTS-M | /BLE EQUIP | 0 | 0 | c | 14, 264, 264 | 2, 940, 705 | 2. |
| .00 Total (sum of li | nes 1-2) | 0 | 0 | c c | 21, 569, 717 | 4, 736, 130 | 3. |
| | | | SL | JMMARY OF CAPIT | AL | | |
| | | | | | | | |
| Cost Cente | r 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 | |
| | CILIATION OF CAPITAL COSTS | | | | | | |
| . 00 CAP REL COSTS-BI | DG & FIXT | -1, 599, 324 | 204, 484 | C | 0 | 7, 706, 038 | 1. |
| . 00 CAP REL COSTS-M | /BLE FOULP | 0 | 0 | l c | 0 | 17, 204, 969 | 2. |
| .00 CAF KLL 00313-W | | | | | | | |

| | Financial Systems MENTS TO EXPENSES | | | | In Lieu of Form CMS-2552-10 Period: Worksheet A-8 From 01/01/2014 | | |
|----------------|--|-----------------|----------------|------------------------------|---|----------------|----------------|
| | | | | | To 12/31/2014 | | |
| | | | | Expense Classification c | n Worksheet A | 5/27/2015 6:0 | / pm |
| | | | | To/From Which the Amount is | s to be Adjusted | | |
| | | | | | | | |
| | Cost Conton Description | Basi s/Code (2) | Amount | Cost Conton | line # | Wkst. A-7 Ref. | |
| | Cost Center Description | 1.00 | Amount 2.00 | Cost Center 3.00 | 4.00 | 5.00 | |
| 1.00 | Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2) | | 0 | CAP REL COSTS-BLDG & FIXT | 1.00 | 0 | 1.00 |
| 2.00 | Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2) | | 0 | CAP REL COSTS-MVBLE EQUIP | 2.00 | 0 | 2.00 |
| 3.00 | Investment income - other | | 0 | | 0.00 | 0 | 3.00 |
| 4.00 | (chapter 2) Trade, quantity, and time | | 0 | | 0.00 | 0 | 4.00 |
| 5.00 | discounts (chapter 8) Refunds and rebates of | | 0 | | 0.00 | 0 | 5.00 |
| | expenses (chapter 8) | | 0 | | | | |
| 6.00 | Rental of provider space by suppliers (chapter 8) | | 0 | | 0.00 | 0 | 6.00 |
| 7.00 | Telephone services (pay stations excluded) (chapter 21) | A | -29, 853, | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 7.00 |
| 8.00 | Television and radio service | A | -27, 363 | CAP REL COSTS-MVBLE EQUIP | 2.00 | 9 | 8.00 |
| 9.00 | (chapter 21) Parking lot (chapter 21) | | о | | 0.00 | 0 | 9.00 |
| 10.00 | Provider-based physician adjustment | A-8-2 | -99, 629 | | | 0 | 10.00 |
| 11.00 | Sale of scrap, waste, etc. | | 0 | | 0.00 | 0 | 11.00 |
| 12.00 | (chapter 23) Related organization transactions (chapter 10) | A-8-1 | 285, 554 | | | 0 | 12.00 |
| 13.00 14.00 | Laundry and linen service Cafeteria-employees and guests | | 0 | | 0.00 0.00 | | 13.00 14.00 |
| 14.00 | Rental of quarters to employee | | 0 | | 0.00 | | 15.00 |
| 16.00 | and others Sale of medical and surgical supplies to other than | | О | | 0.00 | 0 | 16.00 |
| 17.00 | patients Sale of drugs to other than | | 0 | | 0.00 | 0 | 17.00 |
| 18.00 | | | 0 | | 0.00 | 0 | 18.00 |
| 19.00 | abstracts Nursing school (tuition, fees, | | 0 | | 0.00 | 0 | 19.00 |
| 20.00 | books, etc.) Vending machines | | 0 | | 0.00 | 0 | 20.00 |
| 21.00 | Income from imposition of interest, finance or penalty | | 0 | | 0.00 | | |
| 22.00 | overpayments and borrowings to | | 0 | | 0.00 | 0 | 22.00 |
| 23.00 | repay Medicare overpayments Adjustment for respiratory | A-8-3 | 0 | RESPI RATORY THERAPY | 65.00 | | 23.00 |
| | therapy costs in excess of limitation (chapter 14) | | | | | | |
| 24.00 | Adjustment for physical therapy costs in excess of | A-8-3 | 0 | PHYSICAL THERAPY | 66.00 | | 24.00 |
| 05 00 | limitation (chapter 14) | | | | 111.00 | | 05 00 |
| 25.00 | Utilization review - physicians' compensation | | 0 | *** Cost Center Deleted *** | 114.00 | | 25.00 |
| 26.00 | (chapter 21) Depreciation - CAP REL | | 0 | CAP REL COSTS-BLDG & FIXT | 1.00 | 0 | 26.00 |
| | COSTS-BLDG & FIXT Depreciation - CAP REL | | | CAP REL COSTS-MVBLE EQUIP | 2.00 | | 27.00 |
| | COSTS-MVBLE EQUIP | | | | | | |
| 28.00 29.00 | Non-physician Anesthetist Physicians'assistant | | 0 | NONPHYSI CI AN ANESTHETI STS | 19.00 0.00 | | 28.00 29.00 |
| | Adjustment for occupational therapy costs in excess of | A-8-3 | 0 | OCCUPATI ONAL THERAPY | 67.00 | | 30.00 |
| 30. 99 | limitation (chapter 14) Hospice (non-distinct) (see | | 0 | ADULTS & PEDIATRICS | 30.00 | | 30. 99 |
| 31.00 | instructions) Adjustment for speech | A-8-3 | 0 | SPEECH PATHOLOGY | 68.00 | | 31.00 |
| | pathology costs in excess of | | | | | | |
| 32.00 | limitation (chapter 14) CAH HIT Adjustment for | | 0 | | 0.00 | 0 | 32.00 |
| 33.00 | Depreciation and Interest Misc Revenue | В | | EMPLOYEE BENEFITS DEPARTMEN | | | 33.00 |
| 33. 01 | Misc Revenue | В | -593, 396 | ADMINISTRATIVE & GENERAL | 5.00 | 0 | 33.01 |

| | Financial Systems MENTS TO EXPENSES | COMM | JNITT HUSPITAL | OF INDIANA, INC. Provider CCN: 150169 P | eriod: | u of Form CMS-2 Worksheet A-8 | |
|----------------|---|----------------|--------------------|--|----------------|----------------------------------|----------|
| | | | | | rom 01/01/2014 | | |
| | | | | Expanse Classification on | | 5/27/2015 6:0 | 7 pm |
| | | | | Expense Classification on To/From Which the Amount is | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | Cost Center Description | Basis/Code (2) | Amount | Cost Center | Line # | Wkst. A-7 Ref. | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 3. 02 | Misc Revenue | В | | OPERATION OF PLANT | 7.00 | | |
| | Misc Revenue | B B | | NURSING ADMINISTRATION | 13.00 | | |
| | Misc Revenue Misc Revenue | В | | PHARMACY ADULTS & PEDIATRICS | 15.00 30.00 | | |
| | Mi sc Revenue | В | | OPERATING ROOM | 50.00 | | |
| . 07 | Mi sc Revenue | B | | MAGNETIC RESONANCE I MAGI NG | 58.00 | | |
| . 07 | Mi Se Nevende | D | -434,773 | (MRI) | 50.00 | 0 | |
| 8. 08 | Misc Revenue | В | -213, 370 | PHYSICAL THERAPY | 66.00 | 0 | 33 |
| 3. 13 | Misc Rev 35100 | В | -20,000 | OPERATION OF PLANT | 7.00 | 0 | 33 |
| . 14 | Misc Rev 35100 | В | -1, 323 | DI ETARY | 10.00 | 0 | 33 |
| . 15 | Misc Revenue 35200 | В | -35,960 | EMPLOYEE BENEFITS DEPARTMENT | 4.00 | 0 | 33 |
| | Misc Revenue 35200 | В | | DI ETARY | 10.00 | 0 | 33 |
| | Misc Revenue 35200 | В | | ADULTS & PEDIATRICS | 30.00 | | |
| | Misc Revenue 35200 | В | | RADI OLOGY-DI AGNOSTI C | 54.00 | | |
| . 20 | Leased Equipment CBI | В | | ADMI NI STRATI VE & GENERAL | 5.00 | | |
| . 22 | | В | | ADMI NI STRATI VE & GENERAL | 5.00 | | |
| 8. 24 | Interest Income IHH Building | В | -1, 853, 247 | CAP REL COSTS-BLDG & FIXT | 1.00 | 11 | 33 |
| 3. 26 | Loan Space Rental Income IHH and | В | -145,050 | IMAGING CENTER | 76.06 | 0 | 33 |
| . 27 | OLI Equity Investment Gain/Loss | В | E 244 447 | CAP REL COSTS-BLDG & FIXT | 1 00 | 11 | 33 |
| | 00 Non-Allow Interest Expense | A | | CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT | 1.00 1.00 | | |
| | 00 Non-Allow Interest Expense | A | | ADMINI STRATI VE & GENERAL | 5.00 | | |
| | LOC Non-Allow Interest Expense | A | | ADMINISTRATIVE & GENERAL | 5.00 | 0 | |
| | 92 Non-Allow Interest Expense | A | | CAP REL COSTS-BLDG & FIXT | 1.00 | - | |
| | 92 Non-Allow Interest Expense | A | | ADMI NI STRATI VE & GENERAL | 5.00 | | |
| 1.05 | 12B Non-Allow Interest Expense | A | | CAP REL COSTS-BLDG & FIXT | 1.00 | | |
| . 06 | 12B Non-Allow Interest Expense | A | | ADMI NI STRATI VE & GENERAL | 5.00 | | |
| 1. 07 | 50M BMO Non-Allow Interest Expense | A | | CAP REL COSTS-BLDG & FIXT | 1.00 | | |
| 5.00 | HAF Tax Offset | А | -16, 748, 393 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 35 |
| 5. 01 | Bad Debt Expense | А | -31, 527, 509 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 35 |
| 5. 15 | Medical Director Allocation | А | 131, 839 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 35 |
| 5. 16 | Medical Director Allocation | А | 214, 074 | INTENSIVE CARE UNIT | 31.00 | 0 | 35 |
| . 17 | Pension Adjustment | A | -1, 686, 391 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 35 |
| 5. 18 | | | C | | 0.00 | 0 | 35 |
| . 21 | | | C | | 0.00 | 0 | 35 |
| . 02 | Sponsorshi p | А | | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | |
| | Non Allow Marketing Expense | А | | ADMI NI STRATI VE & GENERAL | 5.00 | | |
| | Meals of Wheels Cost | A | | CAFETERIA | 11.00 | | |
| 5. 06 | EMS Training Allied | A | 53, 751 | EMS TRAINING PROGRAM-ALLIED | 23.00 | 0 | 36 |
| 5. 07 | Health_Expense Onset Patient Phone Cost - | А | 1 1/0 | HEALTHEM CAP REL COSTS-MVBLE EQUIP | 2.00 | 9 | 36 |
| | Depreciation | | | | | | |
| o. 08 | INTERHOSPITAL ALLOCATION PALIATIVE CARE AND DCC | A | | PALLIATIVE CARE | 90.24 | | |
| o. 09 | INTERHOSPITAL ALLOCATION PALIATIVE CARE AND DCC | A | | DIABETIC CARE CENTER | 90.27 | | |
| . 11 | Pharmacy Residency Expense | A | | PHARMACY RESIDENCY-ALLIED | 23.02 | | |
| . 12 | INTERHOSPITAL ALLOCATION ALLIED HEALTH | A | | RADI OLOGY SCHOOL-ALLI ED HEALTH | 23.01 | 0 | |
| . 13 | INTERHOSPITAL ALLOCATION ALLIED HEALTH | A | | EMERGENCY | 91.00 | | |
| 6. 14). 00 | TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.) | | 0 -68, 778, 337 | | 0.00 | 0 | 36 50 |

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

| Heal th | Financial Systems | COMMUNI TY HOSPI TAI | L OF II | NDIANA, INC. | In Lie | eu of Form CMS-: | 2552-10 |
|---------|------------------------------------|-------------------------------|---------|------------------------|-----------------|--------------------------------|---------|
| STATEME | ENT OF COSTS OF SERVICES FROM | RELATED ORGANIZATIONS AND HOM | ME | Provider CCN: 150169 | Peri od: | Worksheet A-8 | -1 |
| OFFI CE | COSTS | | | | From 01/01/2014 | | |
| | | | | | To 12/31/2014 | Date/Time Pre 5/27/2015 6:0 | |
| | Line No. | Cost Center | | Expense Items | Amount of | Amount | 7 pm |
| | | | | | Allowable Cost | Included in | |
| | | | | | | Wks. A, column | |
| | | | | | | 5 | |
| | 1.00 | 2.00 | | 3.00 | 4.00 | 5.00 | |
| | A. COSTS INCURRED AND ADJUST | MENTS REQUIRED AS A RESULT OF | TRANS | ACTIONS WITH RELATED C | RGANIZATIONS OR | CLAI MED | |
| | HOME OFFICE COSTS: | | | | | | |
| 1.00 | 22.00 I &R SERVICES-OTHER PRGM COS | | | | 186, 788 | | 1.00 |
| 2.00 | 21.00 | I &R SERVICES-SALARY & FRINGE | I NTERM | NS & RESIDENTS | 109, 353 | 0 | 2.00 |
| 3.00 | 60.00 | LABORATORY | PURCHA | ASED LAB SERVICES | 4, 009, 077 | 6, 869, 680 | 3.00 |
| 4.00 | 1.00 | CAP REL COSTS-BLDG & FIXT | CHNW - | - HOME OFFICE | 567, 650 | 0 | 4.00 |
| 4.01 | 2.00 | CAP REL COSTS-MVBLE EQUIP | CHNW - | - HOME OFFICE | 3, 734, 489 | 0 | 4.01 |
| 4.02 | 5.00 | ADMINISTRATIVE & GENERAL | CHNW - | - HOME OFFICE | 16, 363, 992 | 17, 816, 115 | 4.02 |
| 5.00 | TOTALS (sum of lines 1-4). | | | | 24, 971, 349 | 24, 685, 795 | 5.00 |
| | Transfer column 6, line 5 to | | | | | | |
| | Worksheet A-8, column 2, | | | | | | |
| | line 12. | | | | | | |
| * The | amounts on Lines 1-4 (and sub | scripts as appropriate) are t | transfe | erred in detail to Wor | ksheet A column | 6 lines as | |

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

| | | | Related Organization(s) and/ | or Home Office | | |
|---|------|---------------|------------------------------|----------------|--|--|
| | | | | | | |
| Symbol (1) | Name | Percentage of | Name | Percentage of | | |
| , , , , , , , , , , , , , , , , , , , | | Ownership | | Ownershi p | | |
| 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | | |
| B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE: | | | | | | |

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

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

| 1 CT IIIDUT | | | | | |
|-------------|-------------------------|------|--------|------|--------|
| 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 | G | | | 100.00 |
| | non-financial) specify: | | | | |

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

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

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

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

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

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

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

| Health Financial Systems | COMMUNITY HOSPITAL OF I | NDIANA, INC. | In Lieu | u of Form CMS-2552-10 |
|---|--------------------------------|----------------------|-----------------|--|
| STATEMENT OF COSTS OF SERVICES FROM F OFFICE COSTS | RELATED ORGANIZATIONS AND HOME | Provider CCN: 150169 | From 01/01/2014 | Worksheet A-8-1 Date/Time Prepared: |

| | | | | | | | | 5/27/2015 6:0 | <u>7 pm</u> |
|------|-----------------|-----------------|------------------|-----------------|-----------------|-----------|-----------------|---------------|-------------|
| | Net | Wkst. A-7 Ref. | | | | | | | |
| | Adjustments | | | | | | | | |
| | (col. 4 minus | | | | | | | | |
| | col. 5)* | | | | | | | | |
| | 6.00 | 7.00 | | | | | | | |
| | A. COSTS INCURF | RED AND ADJUSTN | ENTS REQUIRED AS | A RESULT OF TRA | ANSACTIONS WITH | RELATED (| ORGANIZATIONS O | R CLAIMED | |
| | HOME OFFICE COS | STS: | | | | | | | |
| 1.00 | 186, 788 | 0 | | | | | | | 1.00 |
| 2.00 | 109, 353 | 0 | | | | | | | 2.00 |
| 3.00 | -2, 860, 603 | 0 | | | | | | | 3.00 |
| 4.00 | 567, 650 | 9 | | | | | | | 4.00 |
| 4.01 | 3, 734, 489 | 9 | | | | | | | 4.01 |
| 4.02 | -1, 452, 123 | 0 | | | | | | | 4.02 |
| 5.00 | 285, 554 | | | | | | | | 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

| 1103 1101 | been posted to worksheet A, | cordinas r and/or 2, the another arowable should be marcated in cordinary of this part. | |
|-----------|------------------------------|---|--|
| | Rel ated Organi zati on(s) | | |
| | and/or Home Office | | |
| | | | |
| | | | |
| | Type of Business | | |
| | | | |
| | 6.00 | | |
| | B. INTERRELATIONSHIP TO RELA | 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.

| rerinbur | |
|---|--------------|
| 6.00 | 6.00 |
| 7.00 | 7.00 |
| 8.00 | 8.00 9.00 |
| 9.00 | 9.00 |
| 10.00 | 10.00 |
| 6.00 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 organization.

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

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

Health Financial Systems

| COMMUNI TY | HOSPI TAL | 0F | INDLANA. | INC |
|------------|-----------|----|----------|-----|
| | | | | |

INC. In Lieu of Form CMS-2552-10

| Hearth | Financial Syste | enis com | MUNITY HUSPITAL | _ UF LINDIANA, I | NC. | | au of Form CMS- | 2552-10 |
|----------|------------------|---------------------------------|-----------------|------------------|-----------------|----------------------------|------------------|-------------|
| PROVI DE | ER BASED PHYSICI | AN ADJUSTMENT | | Provi der | | Period: From 01/01/2014 | | |
| | | | | | | To 12/31/2014 | 5/27/2015 6:0 | <u>pm 7</u> |
| | Wkst. A Line # | Cost Center/Physician | Total | Professi onal | Provi der | RCE Amount | Physi ci an/Prov | |
| | | I denti fi er | Remuneration | Component | Component | | ider Component | |
| | | | | | | | Hours | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | 7.00 | |
| 1.00 | 5.00 | AGGREGATE-ADMI NI STRATI VE & | 93, 704 | 93, 704 | (| 0 0 | 0 | 1.00 |
| | | GENERAL | | | | | | |
| 2.00 | 66.00 | AGGREGATE-PHYSI CAL THERAPY | 5, 925 | 5, 925 | (| 0 0 | 0 | 2.00 |
| 3.00 | 0.00 | | 0 | 0 | (| o o | 0 | 3.00 |
| 4.00 | 0.00 | | 0 | l o | 0 | ol o | 0 | 4.00 |
| 5.00 | 0.00 | | 0 | 0 | (| 0 | 0 | 5.00 |
| 6.00 | 0.00 | | 0 | 0 | | | 0 | 6.00 |
| 7.00 | 0.00 | | | 0 | (| | 0 | 7.00 |
| 8.00 | 0.00 | | | | | | 0 | 8.00 |
| 9.00 | 0.00 | | 0 | 0 | | | 0 | 9,00 |
| | 0.00 | | 0 | 0 | | | 0 | |
| 10.00 | 0.00 | | | | - | - | 0 | |
| 200.00 | | | 99, 629 | | | | 0 | |
| | Wkst. A Line # | Cost Center/Physician | Unadjusted RCE | | Cost of | Provi der | Physician Cost | |
| | | ldenti fi er | Limit | Unadjusted RCE | | | of Malpractice | |
| | | | | Limit | Conti nui ng | Share of col. | Insurance | |
| | 1.00 | | | | Education | 12 | 14.00 | |
| 1.00 | 1.00 | 2.00 | 8.00 | 9.00 | 12.00 | 13.00 | 14.00 | |
| 1.00 | | AGGREGATE - ADMI NI STRATI VE & | 0 | 0 | (| 0 | 0 | 1.00 |
| | | GENERAL | | | | | _ | |
| 2.00 | | AGGREGATE-PHYSI CAL THERAPY | 0 | 0 | | | 0 | 2.00 |
| 3.00 | 0.00 | | 0 | 0 | | | 0 | 3.00 |
| 4.00 | 0.00 | | 0 | 0 | | | 0 | |
| 5.00 | 0.00 | | 0 | 0 | (| 0 0 | 0 | 5.00 |
| 6.00 | 0.00 | | 0 | 0 | (| 0 0 | 0 | 6.00 |
| 7.00 | 0.00 | | 0 | 0 | (| 0 0 | 0 | 7.00 |
| 8.00 | 0.00 | | 0 | 0 | (| 0 0 | 0 | 8.00 |
| 9.00 | 0.00 | | 0 | 0 | (| 0 0 | 0 | 9.00 |
| 10.00 | 0, 00 | | 0 | l o | 0 | ol o | 0 | 10.00 |
| 200.00 | | | 0 | 0 | (| 0 | 0 | |
| | 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. | | | | | |
| | | | 14 | | | | | |
| | 1.00 | 2.00 | 15.00 | 16.00 | 17.00 | 18.00 | | |
| 1.00 | | AGGREGATE - ADMI NI STRATI VE & | 0 | 0 | (| 93, 704 | | 1.00 |
| 2 00 | | GENERAL | | _ | | E 005 | | 2.00 |
| 2.00 | | AGGREGATE-PHYSICAL THERAPY | | 0 | | | | 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 | (| 0 0 | | 8.00 |
| 9.00 | 0.00 | | 0 | 0 | (| 0 0 | | 9.00 |
| 10.00 | 0.00 | | 0 | 0 | (| 0 0 | | 10.00 |
| 200.00 | | | 0 | | | | | 200.00 |
| | · · | | | | | | | |

| ST A | Financial Systems COMM LLOCATION - GENERAL SERVICE COSTS | <u> </u> | OF INDIANA, IN Provider | CCN: 150169 P | eriod: rom 01/01/2014 | u of Form CMS-2 Worksheet B Part I Date/Time Pre | |
|----------|--|---|----------------------------|---------------------|-------------------------------------|---|------------|
| | | | | | | 5/27/2015 6:0 | 7 pm |
| | | | CAPI TAL REL | LATED COSTS | | | |
| | Cost Center Description | Net Expenses for Cost Allocation (from Wkst A col. 7) | BLDG & FIXT | MVBLE EQUIP | EMPLOYEE BENEFI TS DEPARTMENT | Subtotal | |
| | | 0 | 1.00 | 2.00 | 4.00 | 4A | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 00 | 00100 CAP REL COSTS-BLDG & FIXT | 7, 706, 038 | 7, 706, 038 | | | | 1. |
| 00 | 00200 CAP REL COSTS-MVBLE EQUIP | 17, 204, 969 | | 17, 204, 969 | | | 2. |
| 00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | 15, 836, 773 | | | 15, 866, 617 | | 4. |
| 00 | 00500 ADMINISTRATIVE & GENERAL | 41, 025, 650 | | | 1, 998, 987 | 54, 787, 509 | 5. |
| 00 | 00700 OPERATION OF PLANT | 9, 734, 078 | | | 423, 499 | | 7. |
| 00 | 00800 LAUNDRY & LINEN SERVICE | 789, 659 | | 0 | 0 | 816, 128 | 8. |
| 00 00 | 00900 HOUSEKEEPI NG 01000 DI ETARY | 2, 876, 589 1, 371, 261 | 47, 366 93, 334 | 9, 545 25, 001 | 340, 617 187, 923 | 3, 274, 117 1, 677, 519 | 9. 10. |
| 00 | 01100 CAFETERIA | 1, 362, 318 | | 41, 035 | 215, 108 | 1, 771, 647 | 10. |
| 00 | 01300 NURSI NG ADMI NI STRATI ON | 2, 472, 517 | 41, 882 | 849 | 91, 053 | 2, 606, 301 | 13. |
| | 01400 CENTRAL SERVICES & SUPPLY | 1, 548, 777 | 172,051 | 69, 401 | 0 | 1, 790, 229 | 14. |
| | 01500 PHARMACY | 2, 354, 086 | | | 542, 804 | 3, 127, 267 | 15. |
| | 01600 MEDICAL RECORDS & LIBRARY | 3, 258, 672 | 10, 356 | 0 | 81, 533 | 3, 350, 561 | 16. |
| | 01700 SOCIAL SERVICE | 2, 575, 695 | 17, 260 | 0 | 322, 586 | 2, 915, 541 | 17. |
| | 01900 NONPHYSICIAN ANESTHETISTS | 0 | 0 | 0 | 0 | 0 | 19. |
| 00 | 02100 I & R SERVICES-SALARY & FRINGES APPRVD | 109, 353 | 0 | 0 | 0 | 109, 353 | 21. |
| 00 | 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD | 186, 788 | 0 | 0 | 0 | 186, 788 | 22. |
| | 02300 EMS TRAINING PROGRAM-ALLIED HEALTHEM | 86, 712 | 9, 329 | 0 | 4, 101 | 100, 142 | |
| | 02301 RADIOLOGY SCHOOL-ALLIED HEALTH | 6, 368 | 350 | | | | |
| 02 | 02302 PHARMACY RESIDENCY-ALLIED HEALTH | 470, 010 | 0 | 0 | 35, 807 | 505, 817 | 23. |
| 00 | INPATIENT ROUTINE SERVICE COST CENTERS | 22 200 720 | 1 070 205 | E20 (12 | 2 502 502 | 20 201 120 | 20 |
| 00 00 | 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT | 22, 290, 739 4, 150, 877 | | 539, 612 31, 143 | 3, 582, 582 587, 008 | 28, 391, 138 5, 010, 653 | 30. 31. |
| 00 | 02060 NEONATAL INTENSIVE CARE UNIT | 6, 062, 137 | 455, 439 | 190, 942 | 908, 358 | 7, 616, 876 | 35. |
| 00 | 04000 SUBPROVIDER - IPF | 1, 233, 214 | 125, 505 | | | 1, 570, 972 | 40. |
| 00 | 04100 SUBPROVI DER – I RF | 1, 200, 214 | 120, 000 | 0 | 0 | 1, 370, 772 | 41. |
| 00 | 04300 NURSERY | 2, 358, 423 | 230, 123 | 47, 598 | - | 2, 956, 945 | |
| | ANCI LLARY SERVICE COST CENTERS | | | | | | |
| 00 | 05000 OPERATI NG ROOM | 10, 583, 898 | 351, 826 | 1, 540, 750 | 858, 960 | 13, 335, 434 | 50. |
| 00 | 05100 RECOVERY ROOM | 2, 240, 901 | 146, 096 | 22, 182 | 347, 879 | 2, 757, 058 | 51. |
| | 05200 DELIVERY ROOM & LABOR ROOM | 6, 787, 056 | 620, 663 | 128, 377 | 865, 234 | 8, 401, 330 | |
| 00 | 05400 RADI OLOGY-DI AGNOSTI C | 4, 073, 641 | 128, 410 | | | 5, 497, 988 | |
| 00 | 05500 RADI OLOGY-THERAPEUTI C | 735, 661 | 88, 964 | 147, 174 | 64, 326 | 1, 036, 125 | 55. |
| 00 | 05700 CT SCAN | 1, 522, 684 | 16, 178 | 49, 117 | 152, 271 | 1, 740, 250 | |
| 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 3, 697, 423 | 58, 771 | 591,019 | 114, 758 | 4, 461, 971 | 58. |
| 00 00 | 06000 LABORATORY 06400 I NTRAVENOUS THERAPY | 3, 805, 048 336, 614 | | | 0 52, 027 | 3, 871, 602 393, 821 | |
| | 06500 RESPIRATORY THERAPY | 3, 129, 184 | | | | 3, 823, 145 | |
| | 06600 PHYSI CAL THERAPY | 5, 041, 950 | | 71, 354 | 535, 830 | 5, 649, 134 | |
| 00 | 06700 OCCUPATI ONAL THERAPY | 1, 352, 663 | | 22, 643 | 170, 781 | 1, 546, 087 | 67. |
| 00 | 06800 SPEECH PATHOLOGY | 308, 539 | | 5, 165 | | 352, 659 | |
| 00 | 06900 ELECTROCARDI OLOGY | 1, 457, 922 | 0 | 17, 626 | 5, 672 | 1, 481, 220 | |
| | 07000 ELECTROENCEPHALOGRAPHY | 1, 373, 765 | 17, 293 | | 136, 246 | 1, 616, 330 | |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 10, 406, 302 | 0 | 0 | 0 | 10, 406, 302 | 71. |
| | 07200 IMPL. DEV. CHARGED TO PATIENTS | 13, 938, 495 | 0 | 0 | 0 | 13, 938, 495 | |
| | 07300 DRUGS CHARGED TO PATIENTS | 10, 287, 303 | | 0 | 0 | 10, 287, 303 | |
| | 07400 RENAL DI ALYSI S | 641, 579 | | | 0 | 643, 742 | 74. |
| | | 1, 268, 151 | 91, 356 | 254, 275 | 160, 091 | 1, 773, 873 | |
| | 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | 0 | 0 | 0 | 0 | 76. |
| | 03950 NEUROPSYCHI ATRI C SERVI CES | 0 | 0 | 0 | 0 | 0 | 76. |
| | 03951 OTHER ANCI LLARY SERVICES 03952 ANCI LLARY SERVICE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 76. 76. |
| | 03952 ANCIELARY SERVICE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 76. 76. |
| | 03954 I MAGI NG CENTER | 2, 815, 022 | - | 668, 472 | 223, 121 | 3, 706, 615 | 76. |
| | 03955 BREAST DI AGNOSTI C CENTER | 5, 460, 239 | | 62, 820 | | | |
| | 03956 BARI ATRI C CLI NI C | 9, 759 | | 02,020 | | 10, 473 | 76. |
| | OUTPATIENT SERVICE COST CENTERS | ,,,,,,, | 0 | 0 | , 14 | 10, 170 | |
| 00 | 09000 CLINIC | 0 | 0 | 0 | 0 | 0 | 90. |
| | 04973 PALLI ATI VE CARE | 0 | 0 | 0 | 0 | 0 | 90. |
| | 04975 SPINE CENTER | 189, 800 | 0 | 0 | 31, 425 | 221, 225 | 90. |
| | 04976 DIABETIC CARE CENTER | 0 | 0 | 0 | 0 | 0 | 90. |
| | 09100 EMERGENCY | 7, 485, 670 | 358, 205 | 55, 970 | 1, 002, 265 | | |
| 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | 0 | 92. |
| _ | SPECIAL PURPOSE COST CENTERS | T | | | | | |
| 2 00 | 11300 INTEREST EXPENSE | | | | | | 113. |
| | | | | 14 747 001 | 15 (14 001 | 14E 004 770 | 0.11 |
| 3. 00 | SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS | 246, 020, 972 | 7, 609, 450 | 16, 767, 891 | 15, 614, 081 | 245, 234, 770 | 118. |

| COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150169 Period: From 01/07/2014 To 12/31/2014 Worksheet B Part I Date/Time Prepared: 5/27/2015 6:07 pm Cost Center Description Net Expenses for Cost Al location (from Wkst A col. 7) BLDG & FIXT MVBLE EQUIP MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT Subtotal 191.00 19100 RESEARCH 0 0 44.00 44 192.00 19200 PHYSICIANS' PRIVATE OFFICES 7, 918, 464 9, 700 0 156, 700 8, 804 192.0 193.00 19300 NONRABLE COST CENTERS 0 0 0 0 193.0 194.06 07950 HOME NORKERS 0 0 0 0 193.00 194.06 07950 FIRE NONREI MBURSABLE COST CENTERS 1, 578, 974 0 2, 008, 340 194. 0 0 <t< th=""><th>Health Financial Systems COMM</th><th>IUNI TY HOSPI TAL</th><th>OF INDIANA, IN</th><th>IC.</th><th>In Lie</th><th>u of Form CMS-</th><th>2552-10</th></t<> | Health Financial Systems COMM | IUNI TY HOSPI TAL | OF INDIANA, IN | IC. | In Lie | u of Form CMS- | 2552-10 |
|---|--|--|----------------|-------------|-----------------|-------------------------|---------|
| Cost Center Description Net Expenses for Cost Al Location (from Wkst A col7) BLDG & FIXT MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT Subtotal 191.00 19100 RESEARCH 0 1.00 2.00 4.00 4A 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 7,918,464 9,700 0 156,700 8,084,864 192.0 193.00 19300 NONPAI D WORKERS 0 0 0 193.0 194.00 07956 PAVI LLI ONS 1,578,974 0 429,366 2,008,340 194.0 194.00 07955 OTHER NONREI MBURSABLE COST CENTERS 1,316,125 0 0 0 0 194.00 07959 0THER NONREI MBURSABLE COST CENTERS 1,316,125 0 7,712 41,809 1,365,646 194.00 194.00 07959 0 0 0 0 0 194.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | COST ALLOCATION - GENERAL SERVICE COSTS | | Provi der | | From 01/01/2014 | Part I Date/Time Pre | |
| for Cost Al l ocati on (from Wkst A col . 7) BENEFI TS DEPARTMENT BENEFI TS DEPARTMENT 191.00 19100 RESEARCH 24,233 0 0 4.00 4A 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 7,918,464 9,700 0 156,700 8,084,864 192.0 193.00 19300 NONPAI D WORKERS 0 0 0 193.0 194.06 07956 HOME OFFI CE 0 48,873 0 0 48,873 194.0 0 194.0 194.06 0 2,008,340 194.0 194.00 0 0 0 0 194.0 194.06 0 0 0 0 194.0 194.06 0 2,008,340 194.0 194.00 0 0 0 0 194.0 194.06 1958 0 0 0 0 194.0 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 | | | CAPI TAL REL | _ATED COSTS | | | |
| 191.00 19100 RESEARCH 24, 233 0 0 24, 233 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 7, 918, 464 9, 700 0 156, 700 8, 084, 864 192.0 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.0 194.00 07950 HOME OFFI CE 0 48, 873 0 0 48, 873 194.0 194.06 07956 PAVI LLI ONS 1, 578, 974 0 429, 366 0 2, 008, 340 194.0 194.07 07957 OTHER NONREI MBURSABLE COST CENTERS 1, 578, 974 0 429, 366 0 2, 008, 340 194.0 194.07 07957 OTHER NONREI MBURSABLE COST CENTERS 1, 316, 125 0 7, 712 41, 809 1, 365, 646 194.0 194.09 07959 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194.0 194.10 07960 COMMUNI TY REHAB HOSPI TAL 336, 566 0 <td>Cost Center Description</td> <td>for Cost Allocation (from Wkst A</td> <td>BLDG & FI XT</td> <td>MVBLE EQUIP</td> <td>BENEFI TS</td> <td>Subtotal</td> <td></td> | Cost Center Description | for Cost Allocation (from Wkst A | BLDG & FI XT | MVBLE EQUIP | BENEFI TS | Subtotal | |
| 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 7, 918, 464 9, 700 0 156, 700 8, 084, 864 192.0 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.0 194.00 07950 HOME OFFICE 0 48, 873 0 0 48, 873 194.0 194.06 07956 PAVILLI ONS 1, 578, 974 0 429, 366 0 2, 008, 340 194.0 194.07 07957 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194.0 194.09 07958 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194.0 194.09 07957 OTHER NONREI MBURSABLE COST CENTERS 1, 316, 125 0 7, 712 41, 809 1, 365, 646 194.0 194.09 07959 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194.0 194.10 07960 COMMUNI TY REHAB HOSPI TAL 336, 566 0 0 194.0 194.0 194.11 07960 KMALGREENS TAKE CARE CLINI C 0 0 | | 0 | 1.00 | 2.00 | 4.00 | 4A | |
| 193.00 19300 NONPAID WORKERS 0 0 0 193.00 194.00 07950 HOME OFFICE 0 48,873 0 0 48,873 194.00 194.06 07956 PAVILLIONS 1,578,974 0 429,366 0 2,008,340 194.00 194.07 07957 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194.00 194.08 07958 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194.00 194.09 07959 OTHER NONREI MBURSABLE COST CENTERS 1,316,125 0 7,712 41,809 1,365,646 194.00 194.09 07959 OTHER NONREI MBURSABLE COST CENTERS 1,316,125 0 7,712 41,809 1,365,646 194.00 194.09 07959 OTHER NONREI MBURSABLE COST CENTERS 336,566 0 0 0 194.00 194.10 07960 COMMUNI TY REHAB HOSPITAL 336,566 0 0 0 0 194.10 200.00 Cross Foot Adjustments 0 0 0 | 191. 00 19100 RESEARCH | 24, 233 | 0 | | 0 0 | 24, 233 | 191.00 |
| 194.00 07950 HOME OFFICE 0 48,873 0 0 48,873 194.0 194.06 07956 PAVILLIONS 1,578,974 0 429,366 0 2,008,340 194.0 194.07 07957 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 194.0 194.08 07958 OTHER NONREIMBURSABLE COST CENTERS 1,316,125 0 7,712 41,809 1,365,646 194.0 194.09 07959 OTHER NONREIMBURSABLE COST CENTERS 1,316,125 0 7,712 41,809 1,365,646 194.0 194.09 07959 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 194.0 194.10 07960 COMMUNI TY REHAB HOSPITAL 336,566 0 0 194.1 194.1 194.11 07960 WALGREENS TAKE CARE CLINIC 0 0 0 0 194.1 200.00 Cross Foot Adjustments 0 0 0 0 200.0 201.0 | 192.00 19200 PHYSICIANS' PRIVATE OFFICES | 7, 918, 464 | 9, 700 | | 0 156, 700 | 8, 084, 864 | 192.00 |
| 194.06 07956 PAVILLIONS 1,578,974 0 429,366 0 2,008,340 194.0 194.07 07957 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194.0 194.08 07958 OTHER NONREI MBURSABLE COST CENTERS 1,316,125 0 7,712 41,809 1,365,646 194.0 194.09 07959 OTHER NONREI MBURSABLE COST CENTERS 1,316,125 0 0 0 0 194.0 194.10 07959 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194.0 194.10 07960 COMMUNI TY REHAB HOSPITAL 336,566 0 0 0 194.10 194.11 07961 WALGREENS TAKE CARE CLINIC 0 0 0 0 194.1 200.00 Cross Foot Adjustments 0 | 193.00 19300 NONPALD WORKERS | 0 | 0 | | 0 0 | 0 | 193.00 |
| 194. 07 07957 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194. 0 194. 08 07958 OTHER NONREI MBURSABLE COST CENTERS 1, 316, 125 0 7, 712 41, 809 1, 365, 646 194. 0 194. 09 07959 OTHER NONREI MBURSABLE COST CENTERS 1, 316, 125 0 7, 712 41, 809 1, 365, 646 194. 0 194. 09 07959 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194. 0 194. 10 07960 COMMUNI TY REHAB HOSPITAL 336, 566 0 0 54, 027 390, 593 194. 1 194. 11 07961 WALGREENS TAKE CARE CLI NI C 0 0 0 0 194. 1 200. 00 Cross Foot Adjustments 0 0 0 0 0 200. 0 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 0 | 194.00 07950 HOME OFFICE | 0 | 48, 873 | | 0 0 | 48, 873 | 194.00 |
| 194.08 07958 OTHER NONREI MBURSABLE COST CENTERS 1, 316, 125 0 7, 712 41, 809 1, 365, 646 194.0 194.09 07959 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194.0 194.10 07960 COMMUNI TY REHAB HOSPI TAL 336, 566 0 0 54, 027 390, 593 194.1 194.11 07961 WALGREENS TAKE CARE CLINIC 0 0 0 194.1 200.00 Cross Foot Adjustments 0 0 0 0 200.0 201.00 0 0 0 201.0 0 0 201.0 | 194. 06 07956 PAVI LLI ONS | 1, 578, 974 | 0 | 429, 36 | 6 0 | 2, 008, 340 | 194.06 |
| 194.09 07959 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194.0 194.10 07960 COMMUNI TY REHAB HOSPI TAL 336,566 0 0 54,027 390,593 194.1 194.11 07961 WALGREENS TAKE CARE CLINIC 0 0 0 194.1 200.00 Cross Foot Adjustments 0 0 0 0 200.0 201.00 Negative Cost Centers 0 0 0 0 201.0 | 194.0707957 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | | 0 0 | 0 | 194.07 |
| 194.10 07960 COMMUNITY REHAB HOSPITAL 336,566 0 0 54,027 390,593 194.11 194.11 07961 WALGREENS TAKE CARE CLINIC 0 0 0 194.1 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00 | 194.0807958 OTHER NONREIMBURSABLE COST CENTERS | 1, 316, 125 | 0 | 7, 71 | 2 41, 809 | 1, 365, 646 | 194.08 |
| 194.11 07961 WALGREENS TAKE CARE CLINIC 0 0 0 194.1 200.00 Cross Foot Adjustments 0 0 0 200.0 201.00 Negative Cost Centers 0 0 0 0 201.0 | 194.0907959 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | | 0 0 | 0 | 194.09 |
| 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00 | 194.1007960 COMMUNITY REHAB HOSPITAL | 336, 566 | 0 | | 0 54, 027 | 390, 593 | 194.10 |
| 201.00 Negative Cost Centers 0 0 0 0 0 0 201.0 | 194.1107961 WALGREENS TAKE CARE CLINIC | 0 | 0 | | 0 0 | 0 | 194.11 |
| 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00 | 200.00 Cross Foot Adjustments | | | | | 0 | 200.00 |
| | | | 0 | | 0 0 | 0 | 201.00 |
| 202.00 TOTAL (sum lines 118-201) 257, 195, 334 7, 706, 038 17, 204, 969 15, 866, 617 257, 195, 334 202.0 | 202.00 TOTAL (sum lines 118-201) | 257, 195, 334 | 7, 706, 038 | 17, 204, 96 | 9 15, 866, 617 | 257, 195, 334 | 202.00 |

| ST AL | Financial Systems COM LLOCATION - GENERAL SERVICE COSTS | MUNI TY HOSPI TAL | | CCN: 150169 P | eriod: rom 01/01/2014 o 12/31/2014 | u of Form CMS- Worksheet B Part I Date/Time Pre 5/27/2015 6:0 | pared: |
|-------|--|--------------------------------|-------------------------|----------------------------|--|---|------------|
| | Cost Center Description | ADMI NI STRATI VE & GENERAL | OPERATION OF PLANT | LAUNDRY & LINEN SERVICE | HOUSEKEEPI NG | DI ETARY | |
| | | 5.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| | GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT | | | | | | 1.0 |
| | 00200 CAP REL COSTS MVBLE EQUIP | | | | | | 2.0 |
| 00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.0 |
| | 00500 ADMINISTRATIVE & GENERAL | 54, 787, 509 | | | | | 5.0 |
| | 00700 OPERATION OF PLANT | 3, 054, 380 220, 909 | 14, 338, 520 | | | | 7.0 |
| | 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING | 886, 235 | 65, 436 117, 099 | | | | 8.0 9.0 |
| | 01000 DI ETARY | 454, 069 | 230, 741 | | | 2, 432, 051 | |
| 00 | 01100 CAFETERI A | 479, 548 | 378, 708 | | | 0 | |
| | 01300 NURSI NG ADMI NI STRATI ON | 705, 471 | 103, 542 | | | 0 | |
| | 01400 CENTRAL SERVICES & SUPPLY | 484, 577 | 425, 348 | | | 0 | |
| | 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY | 846, 486 906, 927 | 203, 627 25, 602 | | | 0 | |
| | 01700 SOCI AL SERVI CE | 789, 176 | 42, 670 | | | 0 | 1 |
| | 01900 NONPHYSICIAN ANESTHETISTS | 0 | 0 | | | 0 | 19.0 |
| | 02100 I &R SERVICES-SALARY & FRINGES APPRVD | 29, 600 | 0 | | 0 | 0 | |
| | 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD | 50, 560 | 0 | - | - | 0 | |
| | 02300 EMS TRAINING PROGRAM-ALLIED HEALTHEM 02301 RADIOLOGY SCHOOL-ALLIED HEALTH | 27, 106 2, 105 | 23, 063 864 | | 6, 969 261 | 0 | |
| | 02302 PHARMACY RESIDENCY-ALLIED HEALTH | 136, 914 | 0 | | | 0 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| | 03000 ADULTS & PEDIATRICS | 7, 684, 845 | 4, 890, 558 | | | 1, 586, 010 | |
| | 03100 INTENSIVE CARE UNIT | 1, 356, 279 | | | | 158, 175 | |
| | 02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF | 2, 061, 728 425, 229 | 1, 125, 943 310, 274 | | | 351, 319 95, 622 | |
| | 04100 SUBPROVIDER - IRF | 423, 229 | 310, 274 | | ^{93,734} | 95, 022 | 1 |
| | 04300 NURSERY | 800, 383 | 568, 913 | 39, 645 | 171, 906 | 240, 925 | |
| | ANCI LLARY SERVI CE COST CENTERS | | | 1 | | | |
| | 05000 OPERATING ROOM | 3, 609, 622 | 869, 789 | | | 0 | |
| | 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM | 746, 278 2, 274, 064 | 361, 181 1, 534, 412 | | | 0 | |
| | 05400 RADI OLOGY-DI AGNOSTI C | 1, 488, 190 | 317, 458 | | | 0 | |
| 00 | 05500 RADI OLOGY-THERAPEUTI C | 280, 457 | 219, 939 | 7, 849 | 66, 458 | 0 | 55.0 |
| | 05700 CT SCAN | 471, 049 | 39, 996 | | | 0 | |
| | 05800 MAGNETIC RESONANCE I MAGING (MRI) | 1, 207, 762 | 145, 293 | | | 0 | |
| | 06000 LABORATORY 06400 I NTRAVENOUS THERAPY | 1, 047, 961 106, 599 | 161, 875 5, 428 | | | 0 | |
| | 06500 RESPIRATORY THERAPY | 1, 034, 845 | 175, 108 | | | 0 | 65. |
| | 06600 PHYSI CAL THERAPY | 1, 529, 102 | 0 | C | 0 | 0 | 66. |
| | 06700 OCCUPATIONAL THERAPY | 418, 493 | 0 | C | 0 | 0 | |
| | 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY | 95, 457 400, 935 | 0 | | 0 | 0 | |
| | 07000 ELECTROENCEPHALOGRAPHY | 400, 933 | | | | | |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 2, 816, 767 | 0 | - | 0 | 0 | |
| 00 | 07200 IMPL. DEV. CHARGED TO PATIENTS | 3, 772, 858 | 0 | c c | 0 | 0 | 1 |
| | 07300 DRUGS CHARGED TO PATIENTS | 2, 784, 557 | 0 | C | - | 0 | |
| | 07400 RENAL DI ALYSI S 03330 ENDOSCOPY | 174, 247 480, 150 | | | 1, 616 68, 245 | 0 | |
| | 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 480, 150 | 225, 855 | 21,499 | 00, 243 | 0 | |
| | 03950 NEUROPSYCHI ATRI C SERVI CES | 0 | 0 | C | 0 | 0 | |
| | 03951 OTHER ANCILLARY SERVICES | 0 | 0 | C | 0 | 0 | |
| | 03952 ANCI LLARY SERVICE COST CENTERS | 0 | 0 | C | 0 | 0 | |
| | 03953 MI SC ANCI LLARY 03954 I MAGI NG CENTER | 1,003,303 | 0 | | 0 | 0 | |
| | 03955 BREAST DI AGNOSTI C CENTER | 1, 494, 976 | | | 0 | 0 | |
| | 03956 BARI ATRI C CLI NI C | 2, 835 | 0 | C C | 0 | 0 | |
| [| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| | 09000 CLINIC | 0 | 0 | | | 0 | |
| | 04973 PALLI ATI VE CARE 04975 SPI NE CENTER | 0 59, 881 | 0 | 2, 049 | - | 0 | |
| | 04975 DIABETIC CARE CENTER | 07,081 | 0 | 2,049 | 0 | 0 | |
| | 09100 EMERGENCY | 2, 409, 614 | 885, 561 | 164, 885 | 267, 586 | 0 | |
| 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92. |
| | SPECIAL PURPOSE COST CENTERS | | | 1 | | | |
| | 11300 INTEREST EXPENSE | E1 550 000 | 14 000 700 | 1 100 170 | 4 005 000 | 0 400 054 | 113. |
| 3. 00 | SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS | 51, 550, 036 | 14, 099, 730 | 1, 102, 473 | 4, 205, 298 | 2, 432, 051 | 1118. |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 10, 290 | 93, 982 | 0 | 28, 398 | 0 | 190. |
| . 00 | 19100 RESEARCH | 6, 559 | | | 20,070 | 0 | 191. |
| 2.00 | 19200 PHYSI CLANS' PRI VATE OFFI CES | 2, 188, 403 | | C | 7, 246 | 0 | 192. |
| | 19300 NONPALD WORKERS | 0 | 0 | 0 | 0 | 0 | 193. |
| | 07950 HOME OFFICE | 13, 229 | 120, 826 | - | 36, 509 | | 194. |

| Health Financial Systems COMM | UNI TY HOSPI TAL | OF INDIANA, IN | IC. | In Lie | u of Form CMS- | 2552-10 |
|---|-------------------|----------------|---------------|----------------|----------------|---------|
| COST ALLOCATION - GENERAL SERVICE COSTS | | Provi der | | Peri od: | Worksheet B | |
| | | | | rom 01/01/2014 | | |
| | | | | To 12/31/2014 | | |
| | | | | | 5/27/2015 6:0 | / 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 | |
| 194.07 07957 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | (| 0 0 | 0 | 194.07 |
| 194.0807958 OTHER NONREIMBURSABLE COST CENTERS | 369, 652 | 0 | (| 0 0 | 0 | 194.08 |
| 194.09079590THER NONREIMBURSABLE COST CENTERS | 0 | 0 | | 0 0 | 0 | 194.09 |
| 194. 10 07960 COMMUNI TY REHAB HOSPI TAL | 105, 725 | 0 | | 0 0 | | 194.10 |
| 194.1107961 WALGREENS TAKE CARE CLINIC | 0 | 0 | | 0 0 | 0 | 194. 11 |
| 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) | 54, 787, 509 | 14, 338, 520 | 1, 102, 47 | 3 4, 277, 451 | 2, 432, 051 | 202.00 |

| OST AL | Financial Systems COMM LOCATION - GENERAL SERVICE COSTS | | OF INDIANA, IN Provider | CCN: 150169 P | eriod: rom 01/01/2014 | u of Form CMS-: Worksheet B Part I | |
|--|--|------------------------|-------------------------------|----------------------------------|--------------------------|--|--|
| | | | | | o 12/31/2014 | Date/Time Pre 5/27/2015 6:0 | pare |
| | Cost Center Description | CAFETERI A | NURSI NG ADMI NI STRATI ON | CENTRAL SERVI CES & SUPPLY | PHARMACY | MEDI CAL RECORDS & LI BRARY | |
| | | 11.00 | 13.00 | 14.00 | 15.00 | 16.00 | |
| | GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT | | | | | | 1 1. |
| 00 00 00 00 00 00 00 00 00 00 | 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA | 2 744 226 | | | | | 2. 4. 5. 7. 8. 9. 10. 11. |
| 3.00 4.00 | 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY | 2, 744, 336 37, 484 | 3, 484, 085 0 0 | 2, 828, 679 | | | 13. 14. |
| | 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY | 99, 064 | | 631, 575 10 | 4, 969, 548 0 | 4, 306, 900 | 15. 16. |
| | 01700 SOCIAL SERVICE | 66, 935 | | 599 | 0 | 0 | 17. |
| | 01900 NONPHYSICIAN ANESTHETISTS | C | " | 0 | 0 | 0 | 19. |
| | 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD | | | 0 | 0 | 0 | 21. |
| | 02300 EMS TRAINING PROGRAM-ALLIED HEALTHEM | | | 0 | 0 | 0 | 23. |
| 3. 01 | 02301 RADIOLOGY SCHOOL-ALLIED HEALTH | C | | 0 | 0 | 0 | 23. |
| | 02302 PHARMACY RESIDENCY-ALLIED HEALTH | 8, 032 | 2 0 | 0 | 0 | 0 | 23. |
| | I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS | 891, 575 | 1, 862, 279 | 135, 092 | 208 | 481, 783 | 30. |
| 1.00 | 03100 I NTENSI VE CARE UNI T | 133, 870 | | 30, 331 | 99 | 71, 233 | |
| | 02060 NEONATAL INTENSIVE CARE UNIT | 192, 773 | | 22, 030 | 23 | 293, 672 | |
| | 04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF | 42, 838 | | 2, 567 0 | 0 | 23, 915 0 | 40 |
| | 04300 NURSERY | 74, 967 | | 18, 308 | 0 | 40, 005 | 43. |
| - | ANCI LLARY SERVICE COST CENTERS | 105.455 | 057.04/ | | | 105 0.10 | 1 - 0 |
| | 05000 OPERATING ROOM 05100 RECOVERY ROOM | 195, 450 77, 645 | | 1, 513, 464 20, 043 | | 495, 848 102, 575 | |
| 1 | 05200 DELIVERY ROOM & LABOR ROOM | 198, 128 | 1 1 | 49, 379 | 0 | 107, 898 | |
| | 05400 RADI OLOGY-DI AGNOSTI C | 115, 128 | 1 1 | 34, 515 | | 139, 794 | |
| | 05500 RADI OLOGY-THERAPEUTI C 05700 CT_SCAN | 13, 387 | 1 1 | 68, 290 | 0 | 61, 790 | 55 57 |
| | 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) | 32, 129 | 1 1 | 15, 503 8, 855 | 0 | 227, 211 107, 843 | |
| | 06000 LABORATORY | C | 1 1 | 91, 402 | 0 | 355, 332 | 60 |
| | 06400 I NTRAVENOUS THERAPY | 10, 710 | | 6, 684 | 0 | 5,609 | |
| | 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY | 109, 773 | 1 1 | 31, 005 5, 492 | 2, 066 405 | 116, 310 86, 926 | |
| | 06700 OCCUPATI ONAL THERAPY | 34, 806 | 1 1 | 1, 743 | 0 | 18, 471 | 67 |
| | 06800 SPEECH PATHOLOGY | 8, 032 | | 398 | 0 | 6, 324 | |
| | 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY | 2,677 32,129 | | 44 6, 743 | 0 | 25, 703 | |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 32, 125 | | 0, 743 | 0 | 32, 142 253, 346 | |
| | 07200 IMPL. DEV. CHARGED TO PATIENTS | C | 0 0 | 0 | 0 | 181, 267 | 72 |
| | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | 4, 905, 439 | 307, 199 | |
| | 07400 RENAL DIALYSIS 03330 ENDOSCOPY | 34, 806 | | 710 46, 652 | 0 | 8, 176 52, 188 | |
| . 01 | 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | | 0 | Ő | 0 | 76 |
| | 03950 NEUROPSYCHI ATRI C SERVI CES | 0 | 0 | 0 | 0 | 0 | 76 |
| | 03951 OTHER ANCI LLARY SERVICES 03952 ANCI LLARY SERVICE COST CENTERS | | | 0 | 0 | 0 | 76 76 |
| | 03953 MI SC ANCI LLARY | | Ó | 0 | 0 | 0 | 76 |
| | 03954 I MAGI NG CENTER | C | 0 | 19, 148 | | 191, 389 | 76 |
| | 03955 BREAST DI AGNOSTI C CENTER 03956 BARI ATRI C CLI NI C | | | 1, 344 256 | | 44, 640 278 | |
| | OUTPATIENT SERVICE COST CENTERS | | <u>и</u> 0 | 230 | 40 | 270 | 1 /0 |
| . 00 🛛 | 09000 CLI NI C | C | 0 0 | 0 | 0 | 0 | 90 |
| | 04973 PALLIATIVE CARE | | | 0 | 0 | 2 000 | 90 |
| | 04975 SPINE CENTER 04976 DIABETIC CARE CENTER | | | 683 0 | 4, 443 0 | 3, 009 | 90 90 |
| | 09100 EMERGENCY | 235, 611 | 492, 134 | 57, 268 | 184 | 465, 024 | |
| 0 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE | | | | | | 92 113 |
| 8.00 | SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS | 2, 733, 626 | 3, 484, 085 | 2, 820, 133 | 4, 964, 307 | 4, 306, 900 | 118 |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | | | 0 | 0 | | 190 191 |
| | 19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES | | | 0 4, 438 | 0 | | 191 |
| | 19300 NONPALD WORKERS | | | 4,430 | 0 | 0 | 193 |
| | 07950 HOME OFFICE | | ol ol | 0 | 0 | 0 | 194 |

| Health Financial Systems CON | MUNI TY HOSPI TAL | OF INDIANA, IN | IC. | In Lie | u of Form CMS- | 2552-10 |
|---|-------------------|-------------------|-------------|----------------------------------|----------------|---------|
| COST ALLOCATION - GENERAL SERVICE COSTS | | Provi der | | Period: | Worksheet B | |
| | | | | From 01/01/2014 To 12/31/2014 | | nared |
| | | | | 12/01/2011 | 5/27/2015 6:0 | |
| Cost Center Description | CAFETERI A | NURSI NG | CENTRAL | PHARMACY | MEDI CAL | |
| | | ADMI NI STRATI ON | SERVICES & | | RECORDS & | |
| | | | SUPPLY | | LI BRARY | |
| | 11.00 | 13.00 | 14.00 | 15.00 | 16.00 | |
| 194. 06 07956 PAVI LLI ONS | 0 | 0 | 68 | 3 0 | 0 | 194.06 |
| 194.07 07957 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | (| 0 0 | 0 | 194.07 |
| 194.0807958 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | 3, 376 | 6 0 | 0 | 194.08 |
| 194.0907959 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | (| 0 0 | 0 | 194.09 |
| 194. 10 07960 COMMUNI TY REHAB HOSPI TAL | 10, 710 | 0 | 664 | 1 5, 241 | 0 | 194.10 |
| 194.1107961 WALGREENS TAKE CARE CLINIC | 0 | 0 | (| 0 0 | 0 | 194.11 |
| 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) | 2, 744, 336 | 3, 484, 085 | 2, 828, 679 | 4, 969, 548 | 4, 306, 900 | 202.00 |

| Health Financial Systems COMN COST ALLOCATION - GENERAL SERVICE COSTS COMN | IUNI TY HOSPI TAL | | CCN: 150169 F | <u>In Lie</u> eriod: rom 01/01/2014 | u of Form CMS-2 Worksheet B Part I | 2552-10 |
|--|----------------------|---------------------------------|---------------------------------|---|--|----------------|
| | | | | o 12/31/2014 | | |
| | | | I NTERNS & | RESI DENTS | 0/2//2010 0.0 | |
| Cost Center Description | SOCI AL SERVI CE | NONPHYSI CI AN ANESTHETI STS | SERVI CES-SALAR Y & FRI NGES | SERVI CES-OTHER PRGM COSTS | PROGRAM-ALLI ED | |
| | 17.00 | 19.00 | 21.00 | 22.00 | HEALTHEM 23.00 | |
| GENERAL SERVICE COST CENTERS | | | 1 | 1 | - - | |
| 1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 1.00 2.00 |
| 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| 5.00 00500 ADMINI STRATI VE & GENERAL | | | | | | 5.00 |
| 7.00 00700 OPERATION OF PLANT | | | | | | 7.00 |
| 8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG | | | | | | 8.00 9.00 |
| 10. 00 01000 DI ETARY | | | | | | 10.00 |
| 11. 00 01100 CAFETERIA | | | | | | 11.00 |
| 13.00 01300 NURSING ADMINISTRATION | | | | | | 13.00 |
| 14. 00 01400 CENTRAL SERVICES & SUPPLY | | | | | | 14.00 |
| 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY | | | | | | 15.00 16.00 |
| 17. 00 01700 SOCIAL SERVICE | 3, 827, 814 | | | | | 17.00 |
| 19.00 01900 NONPHYSICIAN ANESTHETISTS | 0 | C |) | | | 19.00 |
| 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD | 0 | C | 138, 953 | | | 21.00 |
| 22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD | 0 | 0 | C | | 457.000 | 22.00 |
| 23. 00 02300 EMS TRAINING PROGRAM-ALLIED HEALTHEM 23. 01 02301 RADIOLOGY SCHOOL-ALLIED HEALTH | 0 | | | - | 157, 280 0 | 23.00 23.01 |
| 23. 02 02302 PHARMACY RESIDENCY-ALLIED HEALTH | 0 | | | - | 0 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | - | | - | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 2, 496, 226 | C | | | 0 | 30.00 |
| 31. 00 03100 I NTENSI VE CARE UNI T | 248, 952 | 0 | | - | 0 | 31.00 |
| 35. 00 02060 NEONATAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF | 552, 943 150, 500 | | | - | 0 | 35.00 40.00 |
| 40.00 04000 SUBPROVIDER - TPP 41.00 04100 SUBPROVIDER - TRF | 150, 500 | | | - | 0 | 40.00 |
| 43. 00 04300 NURSERY | 379, 193 | C | | | 0 | 1 |
| ANCI LLARY SERVI CE COST CENTERS | | | | | | |
| 50. 00 05000 OPERATING ROOM | 0 | 0 | | | 0 | 50.00 |
| 51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | | | - | 0 | 51.00 52.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | | | - | 0 | 54.00 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0 | 0 | | - | 0 | 55.00 |
| 57. 00 05700 CT SCAN | 0 | C | | - | 0 | 57.00 |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | 0 | - | - | 0 | 58.00 |
| 60. 00 06000 LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY | 0 | | | | 0 | 60.00 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 0 | | - | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 0 | | - | 0 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0 | C | C | 0 | 0 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | C | C | 0 | 0 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | | 0 | 0 | 69.00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | | | 0 | 0 | 70.00 |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS | 0 | 0 | C | 0 | 0 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | C | C | 0 | 0 | 73.00 |
| 74. 00 07400 RENAL DI ALYSI S | 0 | 0 | C | 0 | 0 | 74.00 |
| 76. 00 03330 ENDOSCOPY 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | | | 0 | 0 | 76.00 |
| 76. 02 03950 NEUROPSYCHI ATRI C SERVI CES | 0 | 0 | | 0 | 0 | 76.02 |
| 76.03 03951 OTHER ANCI LLARY SERVICES | 0 | 0 | C | 0 | 0 | 76.03 |
| 76.04 03952 ANCI LLARY SERVI CE COST CENTERS | 0 | C | C | 0 | 0 | 76.04 |
| 76. 05 03953 MISC ANCI LLARY | 0 | 0 | C | 0 | 0 | 76.05 |
| 76.06 03954 I MAGI NG CENTER 76.07 03955 BREAST DI AGNOSTI C CENTER | 0 | | | 0 | 0 | 76.06 |
| 76. 08 03956 BARI ATRI C CLI NI C | 0 | | | 0 | 0 | 76.08 |
| OUTPATIENT SERVICE COST CENTERS | 1 - | | | | | |
| 90. 00 09000 CLINIC | 0 | C | C | 0 | 0 | 90.00 |
| 90. 24 04973 PALLI ATI VE CARE | 0 | 0 | C | 0 | 0 | 90.24 |
| 90. 26 04975 SPI NE CENTER 90. 27 04976 DI ABETI C CARE CENTER | | | | 0 | 0 | 90.26 90.27 |
| 90. 27 04976 DTABETTC CARE CENTER 91. 00 09100 EMERGENCY | 0 | | 27, 078 | 46, 253 | - | 1 |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92.00 |
| SPECIAL PURPOSE COST CENTERS | | | | 1 | | |
| 113. 00 11300 INTEREST EXPENSE | 2 0 2 0 4 4 | _ | 100.050 | 007 040 | 157 000 | 113.00 |
| 118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS | 3, 827, 814 | 0 | 138, 953 | 237, 348 | 157, 280 | 118.00 |
| 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | C | C | 0 | 0 | 190.00 |
| 191.00 19100 RESEARCH | 0 | C | | - | | 191.00 |
| 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES | 0 | 0 | C | 0 | 0 | 192.00 |

| Health Financial Systems | COMMUNI TY HOSPI TAL | OF INDIANA, IN | NC. | In Lie | u of Form CMS-2 | 2552-10 |
|---|----------------------|----------------|---------------|------------------|--------------------------------|---------|
| COST ALLOCATION - GENERAL SERVICE COSTS | | Provi der | | Period: | Worksheet B | |
| | | | | From 01/01/2014 | | |
| | | | | Го 12/31/2014 | Date/Time Pre 5/27/2015 6:0 | |
| | | | INTERNS 8 | RESI DENTS | | |
| Cost Center Description | SOCI AL SERVI CE | NONPHYSI CI AN | SERVICES_SALA | RSERVI CES-OTHER | EMS TRAINING | |
| cost center bescription | SUCIAL SERVICE | ANESTHETI STS | Y & FRINGES | | PROGRAM-ALLI ED | |
| | | | | | HEALTHEM | |
| | 17.00 | 19.00 | 21.00 | 22.00 | 23.00 | |
| 193. 00 19300 NONPALD WORKERS | 0 | C | | 0 0 | 0 | 193.00 |
| 194.0007950 HOME OFFICE | 0 | 0 | | 0 0 | 0 | 194.00 |
| 194. 06 07956 PAVI LLI ONS | 0 | C | | 0 0 | 0 | 194.06 |
| 194.07079570THER NONREIMBURSABLE COST CENTERS | 0 | C | | 0 0 | 0 | 194.07 |
| 194.08079580THER NONREIMBURSABLE COST CENTERS | 0 | C | | 0 0 | 0 | 194.08 |
| 194.09079590THER NONREIMBURSABLE COST CENTERS | 0 | C | | 0 0 | 0 | 194.09 |
| 194. 10 07960 COMMUNI TY REHAB HOSPI TAL | 0 | C | | 0 0 | 0 | 194.10 |
| 194.1107961 WALGREENS TAKE CARE CLINIC | 0 | C | | 0 0 | 0 | 194. 11 |
| 200.00 Cross Foot Adjustments | | C | | 0 0 | 0 | 200.00 |
| 201.00 Negative Cost Centers | 0 | C | | 0 0 | 0 | 201.00 |
| 202.00 TOTAL (sum lines 118-201) | 3, 827, 814 | 0 | 138, 95 | 3 237, 348 | 157, 280 | 202.00 |

| | Financial Systems COM LLOCATION - GENERAL SERVICE COSTS | MUNITY HOSPITAL | OF INDIANA, IN Provider | CCN: 150169 P F | In Lie Period: rom 01/01/2014 o 12/31/2014 | u of Form CMS-2 Worksheet B Part I Date/Time Pre 5/27/2015 6:0 | pared: |
|--------------------|--|--|--|-----------------------------|---|--|----------------|
| | Cost Center Description | RADI OLOGY SCHOOL-ALLI ED HEALTH | PHARMACY RESI DENCY-ALLI ED HEALTH | Subtotal | Intern & Residents Cost & Post Stepdown Adjustments | Total | |
| | | 23.01 | 23.02 | 24.00 | 25.00 | 26.00 | |
| 1 00 | GENERAL SERVICE COST CENTERS | 1 | 1 1 | | 1 | | 1 1 00 |
| 2.00 | 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 1.00 |
| | 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL | | | | | | 4.00 |
| | 00700 OPERATION OF PLANT | | | | | | 7.00 |
| | 00800 LAUNDRY & LINEN SERVICE | | | | | | 8.00 |
| | 00900 HOUSEKEEPI NG 01000 DI ETARY | | | | | | 9.00 |
| | 01100 CAFETERIA | | | | | | 11.00 |
| | 01300 NURSI NG ADMI NI STRATI ON | | | | | | 13.00 |
| | 01400 CENTRAL SERVICES & SUPPLY | | | | | | 14.00 |
| | | | | | | | 15.00 |
| | 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE | | | | | | 16.00 17.00 |
| | 01900 NONPHYSI CI AN ANESTHETI STS | | | | | | 19.00 |
| 21.00 | 02100 I&R SERVICES-SALARY & FRINGES APPRVD | | | | | | 21.00 |
| | 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD | | | | | | 22.00 |
| | 02300 EMS TRAINING PROGRAM-ALLIED HEALTHEM 02301 RADIOLOGY SCHOOL-ALLIED HEALTH | 11,006 | | | | | 23.00 23.01 |
| | 02302 PHARMACY RESIDENCY-ALLIED HEALTH | 11,000 | 1 | | | | 23.01 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | 20102 |
| | 03000 ADULTS & PEDIATRICS | C | | 50, 731, 590 | | 50, 428, 620 | |
| | 03100 INTENSIVE CARE UNIT | 0 | | 8, 150, 065 | | 8, 150, 065 | |
| | 02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF | | 0 | 12, 990, 494 2, 805, 150 | | 12, 990, 494 2, 805, 150 | |
| | 04100 SUBPROVI DER – I RF | | - | 2,003,130 | 0 | 2,003,130 | 1 |
| | 04300 NURSERY | 0 | 0 | 5, 291, 190 | 0 | 5, 291, 190 | 43.00 |
| | ANCI LLARY SERVI CE COST CENTERS | - | | | | | 1 = 0 = 00 |
| | 05000 OPERATING ROOM 05100 RECOVERY ROOM | | | 20, 690, 094 4, 173, 917 | | 20, 690, 094 4, 173, 917 | • |
| | 05200 DELIVERY ROOM & LABOR ROOM | | | 13, 135, 788 | | 13, 135, 788 | |
| | 05400 RADI OLOGY-DI AGNOSTI C | 11,006 | - | 7, 816, 686 | | 7, 816, 686 | 1 |
| | 05500 RADI OLOGY-THERAPEUTI C | C | 0 | 1, 754, 295 | | 1, 754, 295 | |
| | 05700 CT SCAN | 0 | 0 | 2, 538, 223 | | 2, 538, 223 | |
| | 05800 MAGNETIC RESONANCE IMAGING (MRI) 06000 LABORATORY | | | 5, 999, 724 5, 577, 085 | | 5, 999, 724 5, 577, 085 | |
| | 06400 I NTRAVENOUS THERAPY | | 0 | 530, 491 | | 530, 491 | |
| 65.00 | 06500 RESPI RATORY THERAPY | C | 0 | 5, 345, 164 | 0 | 5, 345, 164 | 65.00 |
| | 06600 PHYSI CAL THERAPY | C | 0 | 7, 316, 575 | | 7, 316, 575 | |
| | 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY | 0 | | 2, 019, 600 | | 2,019,600 | |
| | 06900 ELECTROCARDI OLOGY | | | 462, 870 1, 910, 579 | | 462, 870 1, 910, 579 | |
| | 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | 2, 180, 520 | | 2, 180, 520 | |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | C | 0 | 13, 476, 415 | | 13, 476, 415 | |
| | 07200 I MPL. DEV. CHARGED TO PATIENTS | 0 | 0 | 17, 892, 620 | | 17, 892, 620 | • |
| | 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS | | 650, 763 | 18, 935, 261 833, 838 | | 18, 935, 261 833, 838 | • |
| | 03330 ENDOSCOPY | 0 | 0 | 2, 703, 266 | | 2, 703, 266 | |
| 76. 01 | 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | o o | 0 | o o | 0 | • |
| | 03950 NEUROPSYCHI ATRI C SERVI CES | 0 | 0 | 0 | 0 | 0 | |
| | 03951 OTHER ANCI LLARY SERVICES | | 0 | 0 | 0 | 0 | |
| | 03952 ANCI LLARY SERVI CE COST CENTERS 03953 MI SC ANCI LLARY | | | 0 | | 0 | |
| | 03954 I MAGI NG CENTER | | o | 4, 920, 572 | 0 | 4, 920, 572 | |
| | 03955 BREAST DI AGNOSTI C CENTER | 0 | 0 | 7, 064, 019 | | 7, 064, 019 | |
| 76.08 | 03956 BARI ATRI C CLI NI C | C | 0 | 13, 888 | 0 | 13, 888 | 76.08 |
| 90.00 | OUTPATIENT SERVICE COST CENTERS | | | | | 0 | 90.00 |
| | 04973 PALLI ATI VE CARE | | | 0 | | 0 | • |
| | 04975 SPI NE CENTER | | 0 | 291, 290 | 0 | 291, 290 | |
| 90. 27 | 04976 DIABETIC CARE CENTER | 0 | 0 | 0 | 0 | 0 | 90.27 |
| | 09100 EMERGENCY | 0 | 0 | 14, 110, 588 | -73, 331 | 14, 037, 257 | |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS | | | | 0 | | 92.00 |
| | 11300 INTEREST EXPENSE | | | | | | 113.00 |
| | | 11,006 | 650, 763 | 241, 661, 857 | -376, 301 | 241, 285, 556 | |
| 118.00 | | | | | | | |
| 118.00 | NONREIMBURSABLE COST CENTERS | | | | | | 100 |
| 118. 00 190. 00 | | | 0 | 170, 685 30, 792 | | 170, 685 30, 792 | |

| Health Financial Systems | COMMUNI TY HOSPI TAL | OF INDIANA, IN | IC. | In Lieu of Form CMS-2552-10 | | | |
|--|----------------------|-----------------|---------------|--------------------------------|---------------------------|---------|--|
| COST ALLOCATION - GENERAL SERVICE COSTS | | Provi der | | eriod: | Worksheet B | | |
| | | | | rom 01/01/2014 o 12/31/2014 | Part Date/Time Pre | harod | |
| | | | 1 | 0 12/31/2014 | 5/27/2015 6:0 | | |
| Cost Center Description | RADI OLOGY | PHARMACY | Subtotal | Intern & | Total | | |
| | | RESI DENCY-ALLI | | Residents Cost | | | |
| | HEALTH | ED HEALTH | | & Post | | | |
| | | | | Stepdown | | | |
| | | | | Adjustments | | | |
| | 23.01 | 23.02 | 24.00 | 25.00 | 26.00 | | |
| 193.00 19300 NONPALD WORKERS | 0 | 0 | C | 0 | 0 | 193.00 | |
| 194.0007950 HOME OFFICE | 0 | 0 | 219, 437 | 0 | 219, 437 | 194.00 | |
| 194. 06 07956 PAVI LLI ONS | 0 | 0 | 2, 552, 023 | 0 | 2, 552, 023 | 194.06 | |
| 194.07079570THER NONREIMBURSABLE COST CENTERS | S 0 | 0 | C | 0 | 0 | 194. 07 | |
| 194.08 07958 OTHER NONREI MBURSABLE COST CENTERS | S 0 | 0 | 1, 738, 674 | . 0 | 1, 738, 674 | 194. 08 | |
| 194.0907959 OTHER NONREIMBURSABLE COST CENTERS | S 0 | 0 | C | 0 | 0 | 194. 09 | |
| 194.1007960 COMMUNITY REHAB HOSPITAL | 0 | 0 | 512, 933 | 0 | 512, 933 | 194. 10 | |
| 194.11 07961 WALGREENS TAKE CARE CLINIC | 0 | 0 | C | 0 | 0 | 194.11 | |
| 200.00 Cross Foot Adjustments | 0 | 0 | C | 0 | 0 | 200.00 | |
| 201.00 Negative Cost Centers | 0 | 0 | C | 0 | 0 | 201.00 | |
| 202.00 TOTAL (sum lines 118-201) | 11, 006 | 650, 763 | 257, 195, 334 | -376, 301 | 256, 819, 033 | 202.00 | |
| | | | | | | | |

| | TION OF CAPITAL RELATED COSTS | | Provi der | F | eriod: rom 01/01/2014 o 12/31/2014 | Worksheet B Part II Date/Time Prep | |
|--|---|--|--|--|---|---|---|
| | | | CAPI TAL RE | LATED COSTS | | 5/27/2015 6:07 | |
| | 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 | |
| ~~ | GENERAL SERVICE COST CENTERS | | | 1 | | | 1 1 |
| 00 00 00 00 | 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE | | 866, 505 1, 027, 490 26, 469 47, 366 93, 334 153, 186 41, 882 172, 051 82, 366 | 10, 896, 367 99, 073 0 9, 545 25, 001 41, 035 849 69, 401 148, 011 0 | 11, 762, 872 1, 126, 563 26, 469 56, 911 118, 335 194, 221 42, 731 241, 452 230, 377 10, 356 | 29, 844 3, 756 796 0 640 353 404 171 0 1, 020 153 606 | 22 4 77 8 99 100 111 133 14 15 16 |
| 00 00 00 00 01 | 01900 NONPHYSI CI AN ANESTHETI STS 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD 02300 EMS TRAI NI NG PROGRAM-ALLI ED HEALTHEM 02301 RADI OLOGY SCHOOL-ALLI ED HEALTH 02302 PHARMACY RESI DENCY-ALLI ED HEALTH INPATI ENT ROUTI NE SERVI CE COST CENTERS | | 0 0 9, 329 350 | 0 0 0 0 0 | 0 0 9, 329 350 | 0 0 8 2 67 | 19 22 23 23 |
| 00 00 00 00 | 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY ANCILLARY SERVICE COST CENTERS | | 241, 625 455, 439 125, 505 0 | 31, 143 190, 942 17, 796 0 | 272, 768 646, 381 143, 301 0 | 6, 762 1, 103 1, 707 365 0 603 | 31 35 40 41 |
| 00 00 00 00 00 00 00 00 00 00 00 00 00 | 05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 05500 RADIOLOGY-THERAPEUTIC 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 06000 LABORATORY 06400 INTRAVENOUS THERAPY 06400 INTRAVENOUS THERAPY 06600 PHYSICAL THERAPY 06600 SEECH PATHOLOGY 06700 OCCUPATIONAL THERAPY 06600 SPEECH PATHOLOGY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07200 RUAL DIALYSIS 03330 ENDOSCOPY 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 03950 NEUROPSYCHIATRIC SERVICES 03952 ANCILLARY SERVICE 03952 ANCILLARY SERVICE 03955 BREAST DIAGNOSTIC CENTER 03956 BARIATRIC CLINIC 0UTPATIENT SERVICE COST CENTERS | | 146, 096 620, 663 128, 410 88, 964 16, 178 58, 771 65, 478 2, 196 70, 830 | 22, 182 128, 377 759, 360 147, 174 49, 117 591, 019 1, 076 2, 984 144, 464 71, 354 22, 643 5, 165 17, 626 89, 026 0 0 0 0 | $\begin{array}{c} 168, 278\\ 749, 040\\ 887, 770\\ 236, 138\\ 65, 295\\ 649, 790\\ 66, 554\\ 5, 180\\ 215, 294\\ 71, 354\\ 22, 643\\ 5, 165\\ 17, 626\\ 106, 319\\ 0\\ 0\\ 2, 163\\ 345, 631\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$ | 1, 614 654 1, 626 1, 008 121 286 216 0 98 899 1, 007 321 73 11 256 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 55555555555555555555555555555555555555 |
| 24 26 27 00 00 3.00 | 09000 CLINIC 04973 PALLIATIVE CARE 04975 SPINE CENTER 04976 DIABETIC CARE CENTER 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE | | 0 0 0 358, 205 | | 0 | | 9(9(9(9 ⁷ 92 |
| 8.00 | SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS | 0 | 7, 609, 450 | 16, 767, 891 | 24, 377, 341 | 29, 369 | 118 |
| | | | | | | | |

| Health Financial Systems COMM | UNITY HOSPITAL | OF INDIANA, IN | IC. | In Lieu of Form CMS-2552-10 | | | |
|--|-------------------------|----------------|--------------|-----------------------------|-------------------------|---------|--|
| ALLOCATION OF CAPITAL RELATED COSTS | | Provi der | | Period: From 01/01/2014 | Worksheet B Part II | | |
| | | | | To 12/31/2014 | | | |
| | | CAPI TAL REL | LATED COSTS | | | | |
| Cost Center Description | Directly | BLDG & FIXT | MVBLE EQUIP | Subtotal | EMPLOYEE | | |
| | Assigned New Capital | | | | BENEFI TS DEPARTMENT | | |
| | Rel ated Costs | | | | DELYNTHIENT | | |
| | 0 | 1.00 | 2.00 | 2A | 4.00 | | |
| 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES | 0 | 9, 700 | (| 9, 700 | 294 | 192.00 | |
| 193.00 19300 NONPALD WORKERS | 0 | 0 | (| 0 0 | 0 | 193.00 | |
| 194.0007950 HOME OFFICE | 0 | 48, 873 | (| 48, 873 | 0 | 194.00 | |
| 194. 06 07956 PAVI LLI ONS | 0 | 0 | 429, 360 | 6 429, 366 | 0 | 194.06 | |
| 194.0707957 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | (| 0 0 | 0 | 194.07 | |
| 194.0807958 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | 7, 71 | 2 7, 712 | 79 | 194.08 | |
| 194.0907959 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | (| 0 0 | 0 | 194.09 | |
| 194. 10 07960 COMMUNI TY REHAB HOSPI TAL | 0 | 0 | (| 0 0 | 102 | 194.10 | |
| 194.1107961WALGREENS TAKE CARE CLINIC | 0 | 0 | (| 0 0 | 0 | 194. 11 | |
| 200.00 Cross Foot Adjustments | | | | 0 | | 200.00 | |
| 201.00 Negative Cost Centers | | 0 | | 0 0 | 0 | 201.00 | |
| 202.00 TOTAL (sum lines 118-201) | 0 | 7, 706, 038 | 17, 204, 969 | 24, 911, 007 | 29, 844 | 202.00 | |

| LLOCA | TION OF CAPITAL RELATED COSTS | | Provi der | | eriod: rom 01/01/2014 o 12/31/2014 | Worksheet B Part II Date/Time Pre | |
|----------------|--|----------------------|--------------------|---------------|--|---|------------------|
| | Cost Center Description | ADMI NI STRATI VE | OPERATION OF | LAUNDRY & | HOUSEKEEPI NG | 5/27/2015 6: 0 DI ETARY | 7 pm |
| | · | & GENERAL 5.00 | PLANT 7.00 | LINEN SERVICE | 0.00 | 10.00 | |
| | GENERAL SERVICE COST CENTERS | 5.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| . 00 | 00100 CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| . 00 | 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| . 00 . 00 | 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINI STRATI VE & GENERAL | 11, 766, 628 | | | | | 4.00 5.00 |
| . 00 | 00700 OPERATION OF PLANT | 655, 981 | 1, 783, 340 | | | | 7.00 |
| . 00 | 00800 LAUNDRY & LINEN SERVICE | 47, 444 | 8, 139 | | | | 8.00 |
| . 00 | 00900 HOUSEKEEPI NG | 190, 334 | 14, 564 | 0 | 262, 449 | | 9.00 |
| D. 00 1. 00 | 01000 DI ETARY 01100 CAFETERI A | 97, 519 102, 991 | 28, 698 47, 101 | 0 | 4, 278 7, 021 | 249, 183 0 | |
| | 01300 NURSI NG ADMI NI STRATI ON | 151, 512 | 12, 878 | | 1, 920 | 0 | |
| 4.00 | 01400 CENTRAL SERVICES & SUPPLY | 104,071 | 52, 902 | 0 | 7, 886 | 0 | |
| | 01500 PHARMACY | 181, 797 | 25, 326 | 0 | 3, 775 | 0 | 15.00 |
| | 01600 MEDI CAL RECORDS & LI BRARY | 194, 778 | 3, 184 | 0 | 475 | 0 | |
| | 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS | 169, 489 | 5, 307 | 0 | 791 0 | 0 | |
| | 02100 I &R SERVICES-SALARY & FRINGES APPRVD | 6, 357 | | 0 | 0 | 0 | |
| | 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD | 10, 859 | 0 | 0 | 0 | 0 | |
| | 02300 EMS TRAINING PROGRAM-ALLIED HEALTHEM | 5, 822 | 2, 868 | 0 | 428 | 0 | |
| | 02301 RADI OLOGY SCHOOL-ALLI ED HEALTH | 452 | 107 | 0 | 16 | 0 | |
| 3. 02 | 02302 PHARMACY RESIDENCY-ALLIED HEALTH | 29, 405 | 0 | 0 | 0 | 0 | 23. 02 |
| D. 00 | INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS | 1, 650, 514 | 608, 259 | 39, 532 | 90, 667 | 162, 500 | 30.00 |
| | 03100 I NTENSI VE CARE UNI T | 291, 284 | 74, 295 | | 11,075 | 16, 206 | 1 |
| | 02060 NEONATAL INTENSIVE CARE UNIT | 442, 792 | 140, 038 | | 20, 875 | 35, 995 | |
| 0. 00 | 04000 SUBPROVI DER – I PF | 91, 325 | 38, 590 | 0 | 5, 752 | 9, 797 | |
| | 04100 SUBPROVIDER - IRF | 171 00(| 0 | 0 | 0 | 0 | |
| 3.00 | 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS | 171, 896 | 70, 758 | 2, 951 | 10, 548 | 24, 685 | 43.00 |
| D. 00 | 05000 OPERATI NG ROOM | 775, 229 | 108, 179 | 3, 686 | 16, 126 | 0 | 50.00 |
| 1. 00 | 05100 RECOVERY ROOM | 160, 276 | 44, 922 | 0 | 6, 696 | 0 | 51.00 |
| 2.00 | 05200 DELIVERY ROOM & LABOR ROOM | 488, 395 | 190, 841 | 7, 958 | 28, 448 | 0 | |
| 4.00 5.00 | 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C | 319, 615 60, 233 | 39, 484 27, 355 | 4, 884 584 | 5, 886 4, 078 | 0 | |
| 7.00 | 05700 CT SCAN | 101, 166 | 4, 974 | 0 | 4,078 | 0 | |
| B. 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 259, 388 | 18, 071 | 0 | 2, 694 | 0 | |
| D. 00 | 06000 LABORATORY | 225, 068 | 20, 133 | 0 | 3, 001 | 0 | 60.00 |
| 4.00 | 06400 I NTRAVENOUS THERAPY | 22, 894 | 675 | | 101 | 0 | 64.00 |
| 5.00 6.00 | 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY | 222, 251 328, 401 | 21, 779 | 0 | 3, 246 | 0 | |
| 7.00 | 06700 OCCUPATIONAL THERAPY | 89, 879 | | 0 | 0 | 0 | |
| B. 00 | 06800 SPEECH PATHOLOGY | 20, 501 | 0 | 0 | 0 | 0 | 1 |
| | 06900 ELECTROCARDI OLOGY | 86, 108 | 0 | | 0 | 0 | |
| | 07000 ELECTROENCEPHALOGRAPHY | 93, 962 | 5, 317 | 0 | 793 | 0 | |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS | 604, 950 810, 287 | 0 | 0 | 0 | 0 | |
| | 07300 DRUGS CHARGED TO PATIENTS | 598, 032 | 0 | 0 | 0 | 0 | |
| | 07400 RENAL DIALYSIS | 37, 423 | 665 | 0 | 99 | 0 | |
| | 03330 ENDOSCOPY | 103, 121 | 28, 090 | 1, 600 | 4, 187 | 0 | |
| | 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | 0 | 0 | 0 | 0 | |
| | 03950 NEUROPSYCHI ATRI C SERVI CES 03951 OTHER ANCI LLARY SERVI CES | 0 | | | 0 | 0 | |
| | 03952 ANCI LLARY SERVI CE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 1 |
| | 03953 MI SC ANCI LLARY | 0 | 0 | 0 | 0 | 0 | |
| | 03954 I MAGI NG CENTER | 215, 477 | 0 | 0 | 0 | 0 | |
| | 03955 BREAST DIAGNOSTIC CENTER | 321, 072 | 0 | 0 | 0 | 0 | |
| 6. 08 | 03956 BARI ATRI C CLI NI C OUTPATI ENT SERVI CE COST CENTERS | 609 | 0 | 0 | 0 | 0 | 76.08 |
| D. 00 | 09000 CLINIC | 0 | 0 | 0 | 0 | 0 | 90.00 |
| | 04973 PALLIATIVE CARE | 0 | 0 | 0 | 0 | 0 | |
| | 04975 SPI NE CENTER | 12, 860 | 0 | 152 | 0 | 0 | |
| | 04976 DI ABETI C CARE CENTER | 0 | 0 | 0 | 0 | 0 | |
| | 09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) | 517, 506 | 110, 141 | 12, 272 | 16, 418 | 0 | 91.00 |
| 2.00 | SPECIAL PURPOSE COST CENTERS | | | | | | /2.00 |
| 13.00 | 11300 INTEREST EXPENSE | | | | | | 113.00 |
| 18.00 | | 11, 071, 325 | 1, 753, 640 | 82, 052 | 258, 022 | 249, 183 | 118.00 |
| 90 00 | NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 2, 210 | 11, 689 | 0 | 1, 742 | 0 | 190. 00 |
| | 19100 RESEARCH | 1, 409 | 0 | 0 | 1, 742 | | 191.00 |
| | 19200 PHYSI CLANS' PRI VATE OFFI CES | 469, 997 | 2, 983 | 0 | 445 | | 192.00 |
| 72.00 | | | - | | | | 400.00 |
| 93.00 | 19300 NONPAI D WORKERS 07950 HOME OFFI CE | 0 2, 841 | 0 15, 028 | 0 | 0 2, 240 | | 193.00 194.00 |

| Health Financial Systems 0 | COMMUNITY HOSPITAL | OF INDIANA, IN | IC. | In Lie | u of Form CMS- | 2552-10 |
|--|--------------------|----------------|---------------|--------------------------------|----------------|-----------|
| ALLOCATION OF CAPITAL RELATED COSTS | | Provi der | | eriod: | Worksheet B | |
| | | | | rom 01/01/2014 o 12/31/2014 | | |
| 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 | |
| 194.07 07957 OTHER NONREI MBURSABLE COST CENTERS | 0 | 0 | C | 0 | (| 0 194. 07 |
| 194.08 07958 OTHER NONREI MBURSABLE COST CENTERS | 79, 389 | 0 | C | 0 | (| 194.08 |
| 194.0907959 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | C | 0 | (| 194.09 |
| 194.10 07960 COMMUNI TY REHAB HOSPI TAL | 22, 706 | 0 | c | 0 | (| 194. 10 |
| 194.11 07961 WALGREENS TAKE CARE CLINIC | 0 | 0 | c | 0 | (| 194. 11 |
| 200.00 Cross Foot Adjustments | | | | | | 200.00 |
| 201.00 Negative Cost Centers | 0 | 0 | c | 0 | (| 201.00 |
| 202.00 TOTAL (sum lines 118-201) | 11, 766, 628 | 1, 783, 340 | 82, 052 | 262, 449 | 249, 183 | 3 202. 00 |

| ALLOCA | TION OF CAPITAL RELATED COSTS | | Provi der | | eriod: com 01/01/2014 0 12/31/2014 | Worksheet B Part II Date/Time Pre | narod. |
|----------------|---|-----------------|-------------------------------|---|--|---|-----------------|
| | | | | | | 5/27/2015 6:0 | pared: 17 pm |
| | Cost Center Description | CAFETERI A | NURSI NG ADMI NI STRATI ON | CENTRAL SERVI CES & SUPPLY | PHARMACY | MEDI CAL RECORDS & LI BRARY | |
| | | 11.00 | 13.00 | 14.00 | 15.00 | 16.00 | |
| 1.00 | GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT | | 1 | | | | 1.00 |
| 2.00 | 00200 CAP REL COSTS BEDG & THAT | | | | | | 2.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| 5.00 | 00500 ADMINI STRATI VE & GENERAL | | | | | | 5.00 |
| 7.00 8.00 | 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE | | | | | | 7.00 |
| 8.00 9.00 | 00900 HOUSEKEEPING | | | | | | 9.00 |
| 10.00 | 01000 DI ETARY | | | | | | 10.00 |
| 11.00 | 01100 CAFETERI A | 351, 738 | | | | | 11.00 |
| 13.00 | 01300 NURSI NG ADMI NI STRATI ON | 4, 804 | | 10/ 211 | | | 13.00 |
| 14.00 15.00 | 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY | 12, 697 | | 406, 311 90, 719 | 545, 711 | | 14.00 15.00 |
| 16.00 | 01600 MEDICAL RECORDS & LIBRARY | 2,059 | | , | 0 | 211, 006 | |
| 17.00 | 01700 SOCIAL SERVICE | 8, 579 | | 86 | 0 | 0 | |
| | 01900 NONPHYSICIAN ANESTHETISTS | 0 | 0 | 0 | 0 | 0 | |
| 21.00 | 02100 I &R SERVICES-SALARY & FRINGES APPRVD | 0 | 0 | 0 | 0 | 0 | |
| 22.00 23.00 | 02200 I & SERVI CES-OTHER PRGM COSTS APPRVD 02300 EMS TRAINING PROGRAM-ALLIED HEALTHEM | | | 0 | 0 | 0 | |
| 23.00 | 02301 RADI OLOGY SCHOOL-ALLI ED HEALTH | | 0 | 0 | 0 | 0 | |
| | 02302 PHARMACY RESIDENCY-ALLIED HEALTH | 1, 029 | 0 | 0 | 0 | 0 | |
| 00.55 | I NPATI ENT ROUTI NE SERVI CE COST CENTERS | | | | | | 0.0 |
| 30.00 | 03000 ADULTS & PEDIATRICS | 114, 271 | | 19, 405 | 23 | 23, 567 | |
| 31.00 35.00 | 03100 I NTENSI VE CARE UNI T 02060 NEONATAL I NTENSI VE CARE UNI T | 17, 158 24, 707 | | 4, 357 3, 164 | 11 3 | 3, 485 14, 366 | |
| 40.00 | 04000 SUBPROVIDER - IPF | 5, 491 | | 369 | 0 | 1, 170 | |
| 41.00 | 04100 SUBPROVI DER – I RF | 0 | 0 | 0 | 0 | 0 | 1 |
| 43.00 | 04300 NURSERY | 9, 608 | 0 | 2, 630 | 0 | 1, 957 | 43.00 |
| | ANCI LLARY SERVICE COST CENTERS | 05.054 | | 017.005 | | | 1 = 0 = 0 = 0 |
| 50.00 51.00 | 05000 OPERATING ROOM 05100 RECOVERY ROOM | 25, 051 | | 217, 395 2, 879 | 24 0 | 24, 580 5, 018 | |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 25, 394 | | 7,093 | 0 | 5, 278 | |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 14, 756 | | 4, 958 | 5, 606 | 6, 838 | |
| 55.00 | 05500 RADI OLOGY-THERAPEUTI C | 1, 716 | | 9, 809 | 0 | 3, 023 | 55.00 |
| 57.00 | 05700 CT SCAN | 4, 118 | | 2, 227 | 0 | 11, 114 | |
| 58.00 60.00 | 05800 MAGNETIC RESONANCE I MAGING (MRI) 06000 LABORATORY | 3, 088 | 0 | 1, 272 13, 129 | 0 | 5, 275 17, 382 | |
| 64. 00 | 06400 I NTRAVENOUS THERAPY | 1, 373 | - | 13, 129 960 | 0 | 274 | |
| 65.00 | 06500 RESPI RATORY THERAPY | 14,070 | - | 4, 453 | 227 | 5, 690 | |
| 66.00 | 06600 PHYSI CAL THERAPY | 5, 834 | . 0 | 789 | 45 | 4, 252 | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 4, 461 | 0 | 250 | 0 | 904 | |
| 68.00 69.00 | 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY | 1, 029 | | 57 | 0 | 309 1, 257 | |
| | 07000 ELECTROCARDI OLOGI | 4, 118 | | 969 | 0 | 1, 237 | |
| | 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 12, 393 | |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 8, 867 | 72.00 |
| | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | 538, 670 | 15, 027 | |
| | 07400 RENAL DIALYSIS | 0 | 0 | 102 | 0 | 400 | |
| 76.00 76.01 | 03330 ENDOSCOPY 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 4, 461 | 0 | 6, 701 0 | 0 | 2, 553 0 | 1 |
| | 03950 NEUROPSYCHI ATRI C SERVI CES | | 0 | 0 | 0 | 0 | |
| 76.03 | 03951 OTHER ANCI LLARY SERVICES | | o o | 0 | Ō | 0 | 1 |
| 76.04 | 03952 ANCI LLARY SERVI CE COST CENTERS | 0 | 0 | 0 | О | 0 | |
| | 03953 MI SC ANCI LLARY | 0 | 0 | 0 | 0 | 0 | |
| | 03954 I MAGI NG CENTER 03955 BREAST DI AGNOSTI C CENTER | 0 | 0 | 2, 750 193 | 13 | 9, 362 2, 184 | |
| 76.07 76.08 | 03955 BREAST DIAGNOSTIC CENTER | | | 37 | 5 | 2, 184 14 | 1 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | |] |
| 90.00 | 09000 CLI NI C | 0 | 0 | 0 | 0 | 0 | |
| 90.24 | 04973 PALLIATIVE CARE | 0 | 0 | 0 | 0 | 0 | |
| | 04975 SPINE CENTER | 0 | 0 | 98 | 488 | 147 | |
| | 04976 DI ABETI C CARE CENTER 09100 EMERGENCY | 30, 198 | 30, 230 | 8, 226 | 20 | 0 22, 748 | |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 30,170 | 30, 200 | 0,220 | 20 | 22, , 40 | 92.00 |
| | SPECIAL PURPOSE COST CENTERS | • • | · · · | | 1 | | |
| | 11300 INTEREST EXPENSE | | | | | | 113.00 |
| 118.00 | SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS | 350, 365 | 214, 016 | 405, 084 | 545, 135 | 211, 006 | 1118.00 |
| 190. 00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | | 0 | n | 0 | 190.00 |
| | 19100 RESEARCH | | 0 | 0 | 0 | | 191.00 |
| 192.00 | 19200 PHYSI CLANS' PRI VATE OFFI CES | 0 | 0 | 637 | О | 0 | 192.00 |
| | 19300 NONPALD WORKERS | 0 | 0 | 0 | 0 | | 193.00 |
| 194.00 | 07950 HOME OFFICE | 0 | ן 0 | 0 | 0 | 0 | 194.00 |

| Health Financial Systems COM | MUNITY HOSPITAL | OF INDIANA, IN | IC. | In Lie | u of Form CMS- | 2552-10 |
|---|-----------------|-------------------|------------|----------------------------------|----------------|---------|
| ALLOCATION OF CAPITAL RELATED COSTS | | Provi der | | Period: | Worksheet B | |
| | | | | From 01/01/2014 To 12/31/2014 | | |
| Cost Center Description | CAFETERI A | NURSI NG | CENTRAL | PHARMACY | MEDI CAL | |
| | | ADMI NI STRATI ON | SERVICES & | | RECORDS & | |
| | | | SUPPLY | | LI BRARY | |
| | 11.00 | 13.00 | 14.00 | 15.00 | 16.00 | |
| 194. 06 07956 PAVI LLI ONS | 0 | 0 | 1 | 0 0 | 0 | 194.06 |
| 194.0707957 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | | 0 0 | 0 | 194.07 |
| 194.08 07958 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | 48 | 5 0 | 0 | 194.08 |
| 194.0907959 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | | 0 0 | 0 | 194.09 |
| 194. 10 07960 COMMUNI TY REHAB HOSPI TAL | 1, 373 | 0 | 9 | 5 576 | 0 | 194.10 |
| 194.11 07961 WALGREENS TAKE CARE CLINIC | 0 | 0 | | 0 0 | 0 | 194.11 |
| 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) | 351, 738 | 214, 016 | 406, 31 | 1 545, 711 | 211, 006 | 202.00 |

| LOCA | Financial Systems COM TION OF CAPITAL RELATED COSTS | MUNI TY HOSPI TAL | | CCN: 150169 F | Period: | worksheet B | 200. |
|------|--|-------------------|---------------------------------|---------------|----------------------------------|----------------|------|
| | | | | | From 01/01/2014 Fo 12/31/2014 | Date/Time Pre | |
| | | | | I NTERNS & | RESIDENTS | 5/27/2015 6:0 | 0/ p |
| | | | | | | | |
| | Cost Center Description | SOCI AL SERVI CE | NONPHYSI CI AN ANESTHETI STS | Y & FRINGES | RSERVICES-OTHER PRGM COSTS | PROGRAM-ALLIED | |
| | | | | | | HEALTHEM | |
| | | 17.00 | 19.00 | 21.00 | 22.00 | 23.00 | |
| 00 | GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT | | | 1 | | | |
| 00 | 00200 CAP REL COSTS-BEDG & TTAT | | | | | | |
| 00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | |
| 00 | 00500 ADMINI STRATI VE & GENERAL | | | | | | 5 |
| 00 | 00700 OPERATION OF PLANT | | | | | | 1 |
| 00 | 00800 LAUNDRY & LINEN SERVICE | | | | | | 8 |
| 00 | 00900 HOUSEKEEPI NG | | | | | | 0 |
| | 01000 DI ETARY | | | | | | 10 |
| . 00 | | | | | | | 1 |
| | 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY | | | | | | 1: |
| | 01500 PHARMACY | | | | | | 1 |
| | 01600 MEDICAL RECORDS & LIBRARY | | | | | | 10 |
| | 01700 SOCI AL SERVI CE | 202, 118 | | | | | 17 |
| . 00 | 01900 NONPHYSI CI AN ANESTHETI STS | 0 | C | | | | 19 |
| . 00 | 02100 I &R SERVICES-SALARY & FRINGES APPRVD | 0 | | 6, 357 | 7 | | 2 |
| | 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD | 0 | | | 10, 859 | | 22 |
| | 02300 EMS TRAINING PROGRAM-ALLIED HEALTHEM | 0 | | | | 18, 455 | |
| | 02301 RADI OLOGY SCHOOL-ALLI ED HEALTH | 0 | | | | | 2 |
| . 02 | 02302 PHARMACY RESIDENCY-ALLIED HEALTH | 0 | | | | | 2: |
| . 00 | I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS | 131, 807 | | 1 | | | 30 |
| | 03100 I NTENSI VE CARE UNI T | 13, 145 | | | | | 3 |
| | 02060 NEONATAL INTENSIVE CARE UNIT | 29, 197 | | | | | 3! |
| | 04000 SUBPROVIDER - IPF | 7,947 | | | | | 40 |
| . 00 | 04100 SUBPROVI DER – I RF | 0 | | | | | 4 |
| . 00 | 04300 NURSERY | 20, 022 | | | | | 43 |
| | ANCI LLARY SERVI CE COST CENTERS | | | 1 | 1 | | |
| | 05000 OPERATING ROOM | 0 | | | | | 50 |
| . 00 | 05100 RECOVERY ROOM | 0 | | | | | 5 |
| | 05200 DELIVERY ROOM & LABOR ROOM | 0 | | | | | 52 |
| | 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C | 0 | | | | | 5! |
| . 00 | 05700 CT SCAN | 0 | | | | | 5 |
| . 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | | | | | 58 |
| | 06000 LABORATORY | 0 | | | | | 60 |
| . 00 | 06400 I NTRAVENOUS THERAPY | 0 | | | | | 64 |
| . 00 | 06500 RESPI RATORY THERAPY | 0 | | | | | 65 |
| . 00 | 06600 PHYSI CAL THERAPY | 0 | | | | | 6 |
| | 06700 OCCUPATIONAL THERAPY | 0 | | | | | 6 |
| | | 0 | | | | | 6 |
| | | 0 | | | | | 6 |
| | 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | | | | | 7 |
| | 07200 I MPL. DEV. CHARGED TO PATIENTS | 0 | | | | | 7 |
| | 07300 DRUGS CHARGED TO PATIENTS | 0 | | | | | 7 |
| | 07400 RENAL DI ALYSI S | 0 | | 1 | | | 7 |
| . 00 | 03330 ENDOSCOPY | 0 | | | | | 70 |
| | 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | | | | | 7 |
| | 03950 NEUROPSYCHI ATRI C SERVI CES | 0 | | | | | 7 |
| | 03951 OTHER ANCI LLARY SERVICES | 0 | | | | | 70 |
| | 03952 ANCI LLARY SERVICE COST CENTERS | 0 | | | | | 70 |
| | 03953 MISC ANCI LLARY 03954 I MAGI NG CENTER | 0 | | | | | 70 |
| | 03955 BREAST DIAGNOSTIC CENTER | 0 | | | | | 7 |
| | 03956 BARI ATRI C CLI NI C | 0 | | | | | 76 |
| 55 | OUTPATIENT SERVICE COST CENTERS | | | | <u> </u> | | 1 `` |
| . 00 | 09000 CLINIC | 0 | | | | | 90 |
| | 04973 PALLI ATI VE CARE | 0 | | | | | 90 |
| | 04975 SPI NE CENTER | 0 | | | | | 90 |
| | 04976 DIABETIC CARE CENTER | 0 | | | | | 90 |
| | 09100 EMERGENCY | 0 | | | | | 9 |
| . 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | 1 |
| | 11300 INTEREST EXPENSE | 202 112 | - | | | _ | 113 |
| 8.00 | | 202, 118 | C |) (| 0 0 | 0 | 118 |
| 0 00 | NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | | I | | | 190 |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | | | | | 190 |
| | 19200 PHYSICIANS' PRIVATE OFFICES | 0 | | | 1 | 1 | 19: |

| Health Financial Systems | COMMUNI TY HOSPI TAL | OF INDIANA, IN | NC. | In Lie | eu of Form CMS-2 | 2552-10 |
|--|----------------------|----------------|----------------|------------------|--------------------------------|---------|
| ALLOCATION OF CAPITAL RELATED COSTS | | Provi der | CCN: 150169 | Peri od: | Worksheet B | |
| | | | | From 01/01/2014 | | |
| | | | | To 12/31/2014 | Date/Time Pre 5/27/2015 6:0 | |
| | | | I NTERNS | RESI DENTS | | |
| | | | | | | |
| Cost Center Description | SOCI AL SERVI CE | NONPHYSI CI AN | SERVI CES-SALA | RSERVI CES-OTHER | EMS TRAINING | |
| | | ANESTHETI STS | Y & FRINGES | PRGM COSTS | PROGRAM-ALLI ED | |
| | | | | | HEALTHEM | |
| | 17.00 | 19.00 | 21.00 | 22.00 | 23.00 | |
| 193.00 19300 NONPALD WORKERS | 0 | | | | | 193.00 |
| 194.0007950 HOME OFFICE | 0 | | | | | 194.00 |
| 194. 06 07956 PAVI LLI ONS | 0 | | | | | 194.06 |
| 194.07079570THER NONREIMBURSABLE COST CENTERS | 0 | | | | | 194. 07 |
| 194.08 07958 OTHER NONREI MBURSABLE COST CENTERS | 0 | | | | | 194.08 |
| 194.0907959 OTHER NONREIMBURSABLE COST CENTERS | 0 | | | | | 194. 09 |
| 194.1007960 COMMUNITY REHAB HOSPITAL | 0 | | | | | 194. 10 |
| 194.1107961 WALGREENS TAKE CARE CLINIC | 0 | | | | | 194. 11 |
| 200.00 Cross Foot Adjustments | | 0 | 6, 35 | 7 10, 859 | 18, 455 | 200. 00 |
| 201.00 Negative Cost Centers | 0 | 0 | | 0 0 | 0 | 201.00 |
| 202.00 TOTAL (sum lines 118-201) | 202, 118 | 0 | 6, 35 | 7 10, 859 | 18, 455 | 202.00 |
| | | | | | | |

| | Financial Systems COMM FION OF CAPITAL RELATED COSTS | <u>MUNI TY HOSPI TAL</u> | | CCN: 150169 P F | eriod: rom 01/01/2014 o 12/31/2014 | of Form CMS-2 Worksheet B Part II Date/Time Pre | pared: |
|------------------------------|--|--|--|-------------------------------------|--|--|--------------------------------------|
| | Cost Center Description | RADI OLOGY SCHOOL-ALLI ED HEALTH | PHARMACY RESI DENCY-ALLI ED HEALTH | Subtotal | Intern & Residents Cost & Post Stepdown | 5/27/2015 6:0 Total | 7 pm |
| | | 23.01 | 23.02 | 24.00 | Adjustments 25.00 | 26.00 | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 2.00 4.00 5.00 7.00 | 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT | | | | | | 1.00 2.00 4.00 5.00 7.00 |
| 9.00 10.00 | 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA | | | | | | 8.00 9.00 10.00 11.00 |
| 13.00 14.00 | 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY | | | | | | 13.00 14.00 15.00 |
| 16.00 17.00 | 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS | | | | | | 16.00 17.00 19.00 |
| 22.00 | 02100 I &R SERVICES-SALARY & FRINGES APPRVD 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 02300 EMS TRAINING PROGRAM-ALLIED HEALTHEM | | | | | | 21.00 22.00 23.00 |
| 23. 02 | 02301 RADIOLOGY SCHOOL-ALLIED HEALTH 02302 PHARMACY RESIDENCY-ALLIED HEALTH | 927 | 30, 501 | | | | 23. 0 ² 23. 02 |
| 30. 00 | I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS | | | 5, 479, 518 | | 5, 479, 518 | |
| 35. 00 40. 00 | 03100 I NTENSI VE CARE UNI T 02060 NEONATAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF | | | 728, 240 1, 386, 215 309, 603 | 0 | 728, 240 1, 386, 215 309, 603 | 35.00 40.00 |
| 43.00 | 04100 SUBPROVI DER - I RF 04300 NURSERY NICLL ADV SEDVILCE COST CENTERS | | | 0 593, 379 | | 0 593, 379 | 41.00 43.00 |
| 50.00 | ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05100 RECOVERY ROOM | | | 3, 086, 446 398, 675 | | 3, 086, 446 398, 675 | |
| 52.00 54.00 | 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC | | | 1, 504, 073 1, 290, 805 | 0 | 1, 504, 073 1, 290, 805 | 52.00 54.00 |
| 57.00 | 05500 RADIOLOGY-THERAPEUTIC 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) | | | 343, 057 189, 922 939, 794 | 0 | 343, 057 189, 922 939, 794 | 55.00 57.00 58.00 |
| 4.00 | 06000 LABORATORY 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY | | | 345, 267 31, 555 487, 909 | 0 | 345, 267 31, 555 487, 909 | |
| 6.00 | 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY | | | 411, 682 118, 458 | 0 | 411, 682 118, 458 | 66.0 |
| 9.00 | 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY | | | 27, 134 105, 351 213, 306 | 0 | 27, 134 105, 351 213, 306 | 69.0 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS | | | 617, 343 819, 154 | 0 | 617, 343 819, 154 | 71.0 |
| 74.00 | 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 03330 ENDOSCOPY | | | 1, 151, 729 40, 852 | 0 | 1, 151, 729 40, 852 | 74.0 |
| 6. 01 | 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 03950 NEUROPSYCHI ATRI C SERVI CES | | | 496, 645 0 0 | 0 | 496, 645 0 0 | 76.0 |
| 76.04 | 03951 OTHER ANCI LLARY SERVICES 03952 ANCI LLARY SERVICE COST CENTERS | | | 0 | 0 | 0 0 | |
| 76.06 | 03953 MISC ANCILLARY 03954 IMAGING CENTER 03955 BREAST DIAGNOSTIC CENTER | | | 0 896, 493 386, 269 | | 0 896, 493 386, 269 | |
| 6. 08 | 03956 BARIATRIC CLINIC OUTPATIENT SERVICE COST CENTERS | | | 666 | | 666 | |
| 0. 24 | 09000 CLINIC 04973 PALLIATIVE CARE | | | 0 | 0 | 0 0 | |
| 0. 27 1. 00 | 04975 SPINE CENTER 04976 DIABETIC CARE CENTER 09100 EMERGENCY 02200 OBSERVATION REDS (NON DISTINCT DART) | | | 13, 804 0 1, 163, 817 | 0 0 | 13, 804 0 1, 163, 817 | 90. 2 91. 0 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117) | | | 22 577 1/1 | 0 | 23 577 141 | 92.0 113.0 |
| 90.00 | NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | C | | 23, 577, 161 53, 656 | | 23, 577, 161 53, 656 | 190. O |
| | 19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES | | | 1, 409 484, 056 | | 1, 409 484, 056 | |

| Health Financial Systems | COMMUNI TY HOSPI TAL | OF INDIANA, IN | NC. | In Lie | u of Form CMS-2 | 2552-10 |
|--|--|--|-------------|---|--|---------|
| ALLOCATION OF CAPITAL RELATED COSTS | | Provi der | | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Pre 5/27/2015 6:0 | |
| Cost Center Description | RADI OLOGY SCHOOL-ALLI ED HEALTH | PHARMACY RESI DENCY-ALLI ED HEALTH | Subtotal | Intern & Residents Cost & Post Stepdown Adjustments | Total | |
| | 23.01 | 23.02 | 24.00 | 25.00 | 26.00 | |
| 193.00 19300 NONPALD WORKERS | | | (| 0 0 | 0 | 193.00 |
| 194.0007950 HOME OFFICE | | | 68, 98 | 2 0 | 68, 982 | 194.00 |
| 194. 06 07956 PAVI LLI ONS | | | 546, 12 | 7 0 | 546, 127 | 194.06 |
| 194.07079570THER NONREIMBURSABLE COST CENTERS | | | (| 0 0 | 0 | 194.07 |
| 194.0807958 OTHER NONREIMBURSABLE COST CENTERS | | | 87, 66 | 5 0 | 87, 665 | 194.08 |
| 194.0907959 OTHER NONREIMBURSABLE COST CENTERS | | | (| 0 0 | 0 | 194.09 |
| 194.1007960 COMMUNI TY REHAB HOSPI TAL | | | 24, 85 | 2 0 | 24, 852 | 194.10 |
| 194.1107961 WALGREENS TAKE CARE CLINIC | | | (| 0 0 | 0 | 194. 11 |
| 200.00 Cross Foot Adjustments | 927 | 30, 501 | 67, 09 | 9 0 | 67, 099 | 200. 00 |
| 201.00 Negative Cost Centers | 0 | 0 | (| 0 0 | 0 | 201.00 |
| 202.00 TOTAL (sum lines 118-201) | 927 | 30, 501 | 24, 911, 00 | 7 0 | 24, 911, 007 | 202.00 |

| ST ALLOCAT | ION - STATISTICAL BASIS | | Provi der | | Period: From 01/01/2014 | Worksheet B-1 | |
|------------|--|-------------------|----------------|-------------------|----------------------------|--------------------------------|-------|
| | | | | | o 12/31/2014 | Date/Time Pre 5/27/2015 6:0 | |
| | | CAPI TAL RE | LATED COSTS | | | 0.0 | Ť |
| | Cost Center Description | BLDG & FIXT | MVBLE EQUIP | EMPLOYEE | Reconci l i ati on | ΔΠΜΙ ΝΙ ΣΤΡΛΤΙ νε | |
| | cost center bescription | | (DOLLAR VALUE) | | Reconciliation | & GENERAL | |
| | | (00001112 1 221) | | DEPARTMENT | | (ACCUM. COST) | |
| | | | | (GROSS | | | |
| | | 1.00 | 2.00 | SALARIES) 4.00 | 5A | 5.00 | + |
| GENERA | L SERVICE COST CENTERS | 1.00 | 2.00 | 4.00 | DA | 5.00 | - |
| | CAP REL COSTS-BLDG & FIXT | 705, 430 |) | | | | 1 1 |
| | CAP REL COSTS-MVBLE EQUIP | | 17, 296, 112 | | | | 2 |
| | EMPLOYEE BENEFITS DEPARTMENT | 1, 115 | | | | | 4 |
| | ADMINISTRATIVE & GENERAL | 79, 322 | | | | | |
| | OPERATION OF PLANT LAUNDRY & LINEN SERVICE | 94,059 | | 2, 368, 377 C | | 11, 284, 140 816, 128 | |
| | HOUSEKEEPING | 4, 336 | | | - | 3, 274, 117 | |
| | DI ETARY | 8, 544 | | | | 1, 677, 519 | |
| | CAFETERI A | 14, 023 | | | | 1, 771, 647 | |
| | NURSI NG ADMI NI STRATI ON | 3, 834 | | | | 2, 606, 301 | |
| | CENTRAL SERVICES & SUPPLY PHARMACY | 15, 750 7, 540 | | | - | 1, 790, 229 3, 127, 267 | |
| | MEDICAL RECORDS & LIBRARY | 948 | | | | 3, 350, 561 | |
| | SOCIAL SERVICE | 1, 580 | | | - | 2, 915, 541 | |
| | NONPHYSICIAN ANESTHETISTS | C | | | | 0 | |
| 1 1 | I&R SERVICES-SALARY & FRINGES APPRVD | C | | C | - | 109, 353 | |
| | I &R SERVICES-OTHER PRGM COSTS APPRVD | 0 | | | | 186, 788 | |
| | EMS TRAINING PROGRAM-ALLIED HEALTHEM RADIOLOGY SCHOOL-ALLIED HEALTH | 854 | | , | | 100, 142 7, 776 | |
| | PHARMACY RESIDENCY-ALLIED HEALTH | C | | | | 505, 817 | |
| | ENT ROUTINE SERVICE COST CENTERS | | | 200,210 | | 000,017 | 1 - 1 |
| | ADULTS & PEDIATRICS | 181, 090 | 542, 471 | 20, 035, 467 | 0 | 28, 391, 138 | 30 |
| | INTENSIVE CARE UNIT | 22, 119 | | | | 5, 010, 653 | |
| | NEONATAL INTENSIVE CARE UNIT | 41, 692 | | | | 7, 616, 876 | |
| | SUBPROVI DER – I PF SUBPROVI DER – I RF | 11, 489 | 17,890 | 1,087,484 | | 1, 570, 972 0 | |
| | NURSERY | 21,066 | 47,850 | | | 2, 956, 945 | |
| | ARY SERVICE COST CENTERS | 21,000 | 1,1,000 | 1 17771017 | | 2,700,710 | 1 |
| | OPERATING ROOM | 32, 207 | | | | 13, 335, 434 | |
| 1 1 | RECOVERY ROOM | 13, 374 | | | | 2, 757, 058 | |
| | DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC | 56, 817 | | | | 8, 401, 330 5, 497, 988 | |
| | RADI OLOGY - THERAPEUTI C | 8, 144 | | | | 1, 036, 125 | |
| | CT SCAN | 1, 481 | | | | 1, 740, 250 | |
| | MAGNETIC RESONANCE IMAGING (MRI) | 5,380 | | | | 4, 461, 971 | |
| | | 5, 994 | | | - | 3, 871, 602 | |
| | I NTRAVENOUS THERAPY RESPI RATORY THERAPY | 201 6, 484 | | | | 393, 821 3, 823, 145 | |
| | PHYSICAL THERAPY | 0,484 | 71, 732 | | | 5, 649, 134 | |
| | OCCUPATIONAL THERAPY | C | 22, 763 | | | 1, 546, 087 | |
| 00 06800 | SPEECH PATHOLOGY | C | 5, 192 | 217, 851 | 0 | 352, 659 | 68 |
| | ELECTROCARDI OLOGY | C | 17, 719 | | | 1, 481, 220 | |
| | ELECTROENCEPHALOGRAPHY | 1, 583 | 89, 498 | | | 1, 616, 330 | |
| | MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS | | | | | 10, 406, 302 13, 938, 495 | |
| | DRUGS CHARGED TO PATIENTS | |) (| | | 10, 287, 303 | |
| | RENAL DIALYSIS | 198 | c c | | 0 | 643, 742 | |
| | ENDOSCOPY | 8, 363 | 255, 622 | 895, 295 | 0 | 1, 773, 873 | |
| | PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | C | | | 0 | 0 | |
| | NEUROPSYCHI ATRI C SERVI CES OTHER ANCI LLARY SERVI CES | | | | | 0 | |
| | ANCILLARY SERVICES | | | | | | |
| | MISC ANCILLARY | | | | 0 | 0 | |
| | IMAGING CENTER | C | 672, 014 | 1, 247, 781 | 0 | 3, 706, 615 | |
| 1 1 | BREAST DIAGNOSTIC CENTER | C | 63, 153 | | 0 0 | 5, 523, 059 | |
| | | C |) C | 3, 992 | 0 | 10, 473 | 76 |
| | TENT SERVICE COST CENTERS | | | | 0 | 0 | 90 |
| | PALLIATIVE CARE | | | | | 0 | |
| | SPINE CENTER | |) (| 175, 739 | | 221, 225 | |
| | DIABETIC CARE CENTER | | |) C |) Ö | 0 | |
| 00 09100 | EMERGENCY | 32, 791 | 56, 267 | 5, 605, 071 | 0 | 8, 902, 110 | |
| | OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92 |
| | L PURPOSE COST CENTERS | | 1 | 1 | | | 4 |
| | INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117) | 696, 588 | 16 856 710 | 87, 320, 460 | _51 797 EOO | 190, 447, 261 | 113 |
| | SUBTOTALS (SUM OF LINES 1-117) MBURSABLE COST CENTERS | 090, 388 | 16, 856, 718 | y 07, 320, 460 | -54, 787, 509 | 170, 447, 201 | -1116 |
| | INDER OUT OUTLEND | | | | | | 4E |

| COST ALLOCATION - STATISTICAL BASIS | | Provi der | | Period: From 01/01/2014 | Worksheet B-1 | |
|--|------------------------------|-------------------------------|---|----------------------------|---|----------------|
| | | | | To 12/31/2014 | Date/Time Pre 5/27/2015 6:0 | pared: 7 pm |
| | CAPI TAL REI | LATED COSTS | | | | |
| Cost Center Description | BLDG & FIXT (SQUARE FEET) | MVBLE EQUIP (DOLLAR VALUE) | EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES) | Reconci I i ati on | ADMI NI STRATI VE & GENERAL (ACCUM. COST) | |
| | 1.00 | 2.00 | 4.00 | 5A | 5.00 | |
| 191. 00 19100 RESEARCH | 0 | 0 | (| 0 0 | 24, 233 | 191.00 |
| 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES | 888 | 0 | 876, 328 | з О | 8, 084, 864 | 192.00 |
| 193. 00 19300 NONPAI D WORKERS | 0 | 0 | (| 0 0 | | 193. 0 |
| 194. 00 07950 HOME OFFICE | 4,474 | 0 | (| 0 0 | 48, 873 | |
| 194. 06 07956 PAVI LLI ONS | 0 | 431, 641 | (| 0 0 | 2, 008, 340 | |
| 194.07 07957 OTHER NONREI MBURSABLE COST CENTERS | 0 | 0 | (| 0 0 | | 194. 0 |
| 194.08 07958 OTHER NONREI MBURSABLE COST CENTERS | 0 | 7, 753 | 233, 81 | 5 0 | 1, 365, 646 | |
| 194.0907959 OTHER NONREI MBURSABLE COST CENTERS | 0 | 0 | (| 0 0 | - | 194. 0 |
| 194. 10 07960 COMMUNI TY REHAB HOSPI TAL | 0 | 0 | 302, 140 | 0 0 | 390, 593 | |
| 194. 11 07961 WALGREENS TAKE CARE CLINIC | 0 | 0 | (| 0 0 | 0 | 194.1 |
| 200.00 Cross Foot Adjustments | | | | | | 200. 0 |
| 201.00 Negative Cost Centers | 7 70/ 000 | 17 004 040 | 45 0// /4 | _ | E 4 303 500 | 201.00 |
| 202.00 Cost to be allocated (per Wkst. B, Part I) | 7, 706, 038 | 17, 204, 969 | 15, 866, 61 | | 54, 787, 509 | |
| 203.00 Unit cost multiplier (Wkst. B, Part I) | 10. 923888 | 0. 994730 | 0. 178814 | 4 | 0. 270679 | 203.00 |
| 204.00 Cost to be allocated (per Wkst. B, Part II) | | | 29, 84 | 4 | 11, 766, 628 | 204.00 |
| 205.00 Unit cost multiplier (Wkst. B, Part | | | 0.000330 | 5 | 0. 058133 | 205. 0(|

| Health Financial Systems COMM COST ALLOCATION - STATISTICAL BASIS COMM | IUNI TY HOSPI TAL | | CCN: 150169 P | eriod: rom 01/01/2014 | u of Form CMS-2 Worksheet B-1 | |
|---|--|--|---|----------------------------------|---|---|
| Cost Center Description | OPERATION OF | LAUNDRY & | HOUSEKEEPI NG | 0 12/31/2014 | Date/Time Pre 5/27/2015 6:0 CAFETERIA | |
| | PLANT (SQUARE FEET) | LINEN SERVICE (POUNDS OF | | (TOTAL PATIENT DAYS) | | |
| | 7.00 | LAUNDRY) 8.00 | 9.00 | 10.00 | 11.00 | |
| GENERAL SERVICE COST CENTERS | Ť | l . | 1 | | | |
| 1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DIETARY 11.00 01100 CAFETERIA 13.00 01300 NURSI NG 14.00 01400 CENTRAL SERVICES 5.00 01500 PHARMACY | 530, 934 2, 423 4, 336 8, 544 14, 023 3, 834 15, 750 7, 540 | 242, 713 | 524, 175 8, 544 14, 023 3, 834 15, 750 | 79, 354 0 0 0 | 1, 025 14 0 37 | 1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 |
| 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 17.00 01700 SOCI AL SERVI CE 19.00 01900 NONPHYSI CI AN ANESTHETI STS 21.00 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD 22.00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD 23.00 02300 EMS TRAI NI NG PROGRAM-ALLI ED HEALTHEM 23.01 02301 RADI OLOGY SCHOOL-ALLI ED HEALTH 23.02 02302 PHARMACY RESI DENCY-ALLI ED HEALTH | 7, 540 948 1, 580 0 0 0 854 32 0 | 0 0 0 0 0 0 0 0 0 | 948 1,580 0 0 0 0 854 32 | | 37 6 255 0 0 0 0 0 3 | 15.00 16.00 17.00 19.00 21.00 22.00 23.00 23.01 23.02 |
| INPATIENT ROUTINE SERVICE COST CENTERS | - | - | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 35. 00 02060 NEONATAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF 41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY | 181, 090 22, 119 41, 692 11, 489 0 21, 066 | 18, 273 6, 673 0 0 | 22, 119 41, 692 11, 489 C | 5, 161 11, 463 3, 120 0 | 333 50 72 16 0 28 | 35.00 40.00 41.00 |
| ANCI LLARY SERVICE COST CENTERS | 32, 207 | 10, 904 | 32, 207 | ol | 73 | 50.00 |
| 51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 54.00 05400 RADI OLOGY-DI AGNOSTI C 55.00 05500 RADI OLOGY-THERAPEUTI C 57.00 05700 CT SCAN 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 60.00 06000 LABORATORY 64.00 06400 I NTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY | 13, 374 56, 817 11, 755 8, 144 1, 481 5, 380 5, 994 201 6, 484 0 0 | 23, 541 | 56, 817 11, 755 8, 144 1, 481 5, 380 5, 994 201 6, 484 | | 29 74 43 5 12 9 0 4 41 17 13 3 | |
| 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S | 0 0 1,583 0 0 0 0 198 | | 1, 583 C C C C C C C C C C C C C C C C C C C | 0 0 0 | 1 12 0 0 0 0 0 | 69.00 70.00 71.00 72.00 73.00 74.00 |
| 76.00 03330 ENDOSCOPY 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.02 03950 NEUROPSYCHI ATRI C SERVI CES 76.03 03951 OTHER ANCI LLARY SERVI CES 76.04 03952 ANCI LLARY SERVI CE COST CENTERS 76.05 03953 MI SC ANCI LLARY 76.06 03954 I MAGI NG CENTER 76.07 03955 BREAST DI AGNOSTI C CENTER 76.08 03956 BARI ATRI C CLI NI C 0UTPATI ENT SERVI CE COST CENTERS 0017ATI ENT SERVI CE COST CENTERS | 8,363 0 0 0 0 0 0 0 0 0 0 | 4,733 0 0 0 0 0 0 0 0 0 | 8, 363 C C C C C C C C C C C C C C | | 13 0 0 0 0 0 0 0 0 0 0 | 76. 00 76. 01 76. 02 76. 03 76. 04 76. 05 76. 06 76. 07 76. 08 |
| 90. 00 09000 CLI NI C | 0 | 0 | C | 0 | 0 | 90.00 |
| 90. 24 04973 PALLI ATI VE CARE 90. 26 04975 SPI NE CENTER 90. 27 04976 DI ABETI C CARE CENTER 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) SPECI AL PURPOSE COST CENTERS | 0 0 0 32, 791 | 0 451 0 36, 300 | C | 0 0 0 | 0 0 0 88 | 90. 24 90. 26 90. 27 91. 00 92. 00 |
| 113. 00 11300 INTEREST EXPENSE 118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS | 522, 092 | 242, 713 | 515, 333 | 79, 354 | 1, 021 | 113. 00 118. 00 |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 3, 480 | 0 | 3, 480 | 0 | | 190. 00 |
| 191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 193. 00 19300 NONPALD WORKERS | 0 888 0 | 0 0 0 | C 888 C | | 0 | 191. 00 192. 00 193. 00 |

| | UNI TY HOSPI TAL | OF INDIANA, IN | | | u of Form CMS-2 | 2552-10 |
|--|------------------|----------------|---------------|--------------------------------|--------------------------------|---------|
| COST ALLOCATION - STATISTICAL BASIS | | Provi der | | eriod: | Worksheet B-1 | |
| | | | | rom 01/01/2014 o 12/31/2014 | Date/Time Pre 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) | | |
| | | LAUNDRY) | | | | |
| | 7.00 | 8.00 | 9.00 | 10.00 | 11.00 | |
| 194.0007950 HOME OFFICE | 4,474 | 0 | 4, 474 | 0 | 0 | 194.00 |
| 194. 06 07956 PAVI LLI ONS | 0 | 0 | C | 0 | 0 | 194.06 |
| 194.0707957OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | C | 0 | 0 | 194.07 |
| 194.0807958 OTHER NONREI MBURSABLE COST CENTERS | 0 | 0 | C | 0 | 0 | 194.08 |
| 194.0907959 OTHER NONREI MBURSABLE COST CENTERS | 0 | 0 | C | 0 | 0 | 194.09 |
| 194.1007960 COMMUNITY REHAB HOSPITAL | 0 | 0 | C | 0 | 4 | 194.10 |
| 194.1107961 WALGREENS TAKE CARE CLINIC | 0 | 0 | C | 0 | 0 | 194.11 |
| 200.00 Cross Foot Adjustments | | | | | | 200.00 |
| 201.00 Negative Cost Centers | | | | | | 201.00 |
| 202.00 Cost to be allocated (per Wkst. B, Part I) | 14, 338, 520 | 1, 102, 473 | 4, 277, 451 | 2, 432, 051 | 2, 744, 336 | 202.00 |
| 203.00 Unit cost multiplier (Wkst. B, Part I) | 27.006219 | 4. 542291 | 8. 160349 | 30. 648121 | 2,677.400976 | 203.00 |
| 204.00 Cost to be allocated (per Wkst. B, Part II) | 1, 783, 340 | 82, 052 | 262, 449 | 249, 183 | 351, 738 | 204.00 |
| 205.00 Unit cost multiplier (Wkst. B, Part | 3. 358873 | 0. 338062 | 0. 500690 | 3. 140144 | 343. 159024 | 205. 00 |

| | Financial Systems COM LLOCATION - STATISTICAL BASIS | MUNITY HOSPITAL | | CCN: 150169 F | Period: | u of Form CMS-2 Worksheet B-1 | |
|---------------|---|-------------------|------------------------------|-----------------------|--|-----------------------------------|----------------|
| | | | | | From 01/01/2014 To 12/31/2014 | | |
| | Cost Center Description | NURSI NG | CENTRAL | PHARMACY | MEDI CAL | 5/27/2015 6:0 SOCI AL SERVI CE | |
| | | ADMI NI STRATI ON | SERVICES & SUPPLY | (COSTED REQUI S.) | RECORDS & LI BRARY | (TOTAL PATIENT | |
| | | (DI RECT NURS. | (COSTED | REQUIS.) | (GROSS | DAYS) | |
| | | HRS.) | REQUIS.) | 15.00 | CHARGES) | 17.00 | |
| | GENERAL SERVICE COST CENTERS | 13.00 | 14.00 | 15.00 | 16.00 | 17.00 | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 2.00 4.00 | 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 2.00 4.00 |
| 4.00 5.00 | 00500 ADMINISTRATIVE & GENERAL | | | | | | 4.00 |
| 7.00 | 00700 OPERATION OF PLANT | | | | | | 7.00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | | | | | | 8.00 |
| 9.00 10.00 | 00900 HOUSEKEEPI NG 01000 DI ETARY | | | | | | 9.00 10.00 |
| | 01100 CAFETERI A | | | | | | 11.00 |
| | 01300 NURSI NG ADMI NI STRATI ON | 623 | | | | | 13.00 |
| | 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY | 0 | 46, 203, 048 10, 315, 969 | 10, 286, 953 | 2 | | 14.00 15.00 |
| | 01600 MEDICAL RECORDS & LIBRARY | 0 | 168 | 10, 200, 730 | | | 16.00 |
| | 01700 SOCIAL SERVICE | 0 | 9, 788 | (| 0 0 | 79, 354 | 17.00 |
| | 01900 NONPHYSICIAN ANESTHETISTS | 0 | 0 | (| 0 | 0 | 19.00 |
| | 02100 I & R SERVI CES-SALARY & FRI NGES APPRVD 02200 I & R SERVI CES-OTHER PRGM COSTS APPRVD | 0 | 0 | | ט וי ח (כ | 0 | 21.00 22.00 |
| 23.00 | 02300 EMS TRAINING PROGRAM-ALLIED HEALTHEM | 0 | 0 | (| 0 | 0 | 23.00 |
| | 02301 RADI OLOGY SCHOOL-ALLI ED HEALTH | 0 | 0 | 0 | 0 | 0 | 23.01 |
| 23. 02 | 02302 PHARMACY RESIDENCY-ALLIED HEALTH | 0 | 0 | (| 0 0 | 0 | 23. 02 |
| 30.00 | 03000 ADULTS & PEDIATRICS | 333 | 2, 206, 563 | 430 | 117, 250, 663 | 51, 749 | 30.00 |
| 31.00 | 03100 I NTENSI VE CARE UNI T | 50 | 495, 426 | 205 | 5 17, 335, 927 | 5, 161 | 31.00 |
| | 02060 NEONATAL INTENSIVE CARE UNIT | 72 | 359, 827 | 48 | | | |
| | 04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF | 16 0 | 41, 930 0 | | | 3, 120 0 | 40.00 |
| | 04300 NURSERY | 0 | 299, 038 | (| | 7, 861 | |
| | ANCI LLARY SERVI CE COST CENTERS | | | | 100 700 405 | | |
| | 05000 OPERATING ROOM 05100 RECOVERY ROOM | 64 0 | 24, 720, 711 327, 372 | 459 | | 0 | 50.00 51.00 |
| | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 806, 539 | (| | 0 | 52.00 |
| | 05400 RADI OLOGY-DI AGNOSTI C | 0 | 563, 759 | 105, 684 | | 0 | 54.00 |
| | 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN | 0 | 1, 115, 425 253, 218 | | | 0 | 55.00 57.00 |
| | 05800 MAGNETIC RESONANCE I MAGING (MRI) | 0 | 144, 631 | (| | 0 | 58.00 |
| | 06000 LABORATORY | 0 | 1, 492, 937 | (| 86, 476, 587 | 0 | 60.00 |
| | 06400 INTRAVENOUS THERAPY | 0 | 109, 176 | (| | 0 | 64.00 |
| | 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY | 0 | 506, 421 89, 698 | 4, 276 839 | | 0 | 65.00 66.00 |
| | 06700 OCCUPATI ONAL THERAPY | 0 | 28, 465 | (| | 0 | |
| | 06800 SPEECH PATHOLOGY | 0 | 6, 493 | | .,, | 0 | 68.00 |
| | 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY | 0 | 717 110, 141 | | 0,200,020 | 0 | 69.00 70.00 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 61, 656, 352 | 0 | 71.00 |
| | 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 0 | (| 44, 114, 734 | 0 | 72.00 |
| | 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS | 0 | 0 11 507 | 10, 154, 247 | | 0 | 73.00 74.00 |
| | 03330 ENDOSCOPY | 0 | 11, 597 762, 009 | | ., , , , , , , , , , , , , , , , , , , | | 76.00 |
| 76. 01 | 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | 0 | (| 0 0 | 0 | 76.01 |
| | 03950 NEUROPSYCHI ATRI C SERVI CES | 0 | 0 | (| 0 | 0 | 76.02 |
| | 03951 OTHER ANCILLARY SERVICES 03952 ANCILLARY SERVICE COST CENTERS | 0 | 0 | | 0 וע ח ((| 0 | 76.03 76.04 |
| | 03953 MISC ANCI LLARY | 0 | 0 | | o o | 0 | 76.04 |
| | 03954 I MAGI NG CENTER | 0 | 312, 761 | 243 | | | 76.06 |
| | 03955 BREAST DI AGNOSTI C CENTER 03956 BARI ATRI C CLI NI C | 0 | 21, 955 4, 174 | 96 | | 0 | 76.07 76.08 |
| , 0. 00 | OUTPATIENT SERVICE COST CENTERS | 0 | 4, 174 | 90 | 67, 545 | 0 | /0.08 |
| | 09000 CLI NI C | 0 | 0 | (| | 0 | 90.00 |
| | 04973 PALLIATIVE CARE 04975 SPINE CENTER | 0 | 11 151 | 0 10 | - | 0 | 90.24 90.26 |
| | 04975 SPINE CENTER 04976 DIABETIC CARE CENTER | 0 | 11, 151 0 | 9, 197 (| 7 732, 310 0 0 | 0 | 90.26 |
| 91.00 | 09100 EMERGENCY | 88 | 935, 399 | 380 | 113, 172, 177 | 0 | 91.00 |
| 92.00 | 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) | | | | | | 92.00 |
| 113 00 | SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE | | | | | | 113.00 |
| 118.00 | | 623 | 46, 063, 458 | 10, 276, 104 | 1, 048, 287, 429 | 79, 354 | |
| | NONREI MBURSABLE COST CENTERS | | - | | | - | 100 0- |
| 100 07 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | | 0 0 | ı 0 | 190.00 |
| | 19100 RESEARCH | 0 | 0 | (| - | | 191.00 |

| | UNI TY HOSPI TAL | | - | | u of Form CMS-2 | 2552-10 |
|--|-------------------|-------------|------------|----------------------------|--------------------------------|----------------|
| COST ALLOCATION - STATISTICAL BASIS | | Provi der | | Period: From 01/01/2014 | Worksheet B-1 | |
| | | | | To 12/31/2014 | Date/Time Pre 5/27/2015 6:0 | pared: 7 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) | |
| | HRS.) | REQUIS.) | | CHARGES) | | |
| | 13.00 | 14.00 | 15.00 | 16.00 | 17.00 | |
| 193. 00 19300 NONPALD WORKERS | 0 | 0 | | 0 0 | | 193.00 |
| 194. 00 07950 HOME OFFICE | 0 | 0 | | 0 0 | | 194.00 |
| 194. 06 07956 PAVI LLI ONS | 0 | 1, 112 | | 0 0 | 0 | 194.06 |
| 194.0707957OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | | 0 0 | 0 | 194.07 |
| 194.08079580THER NONREIMBURSABLE COST CENTERS | 0 | 55, 139 | | 0 0 | 0 | 194.08 |
| 194.09079590THER NONREIMBURSABLE COST CENTERS | 0 | 0 | | 0 0 | 0 | 194.09 |
| 194.1007960 COMMUNITY REHAB HOSPITAL | 0 | 10, 852 | 10, 84 | 9 0 | 0 | 194.10 |
| 194.1107961 WALGREENS TAKE CARE CLINIC | 0 | 0 | | 0 0 | 0 | 194.11 |
| 200.00 Cross Foot Adjustments | | | | | | 200.00 |
| 201.00 Negative Cost Centers | | | | | | 201.00 |
| 202.00 Cost to be allocated (per Wkst. B, | 3, 484, 085 | 2, 828, 679 | 4, 969, 54 | 8 4, 306, 900 | 3, 827, 814 | 202.00 |
| Part I) | | | | | | |
| 203.00 Unit cost multiplier (Wkst. B, Part I) | 5, 592. 431782 | 0.061223 | 0. 48309 | 2 0. 004109 | 48. 237190 | 203.00 |
| 204.00 Cost to be allocated (per Wkst. B, Part II) | 214, 016 | 406, 311 | 545, 71 | 1 211, 006 | 202, 118 | 204.00 |
| 205.00 Unit cost multiplier (Wkst. B, Part | 343. 524880 | 0. 008794 | 0. 05304 | 9 0. 000201 | 2. 547042 | 205.00 |

| Form TUTUEND Extra construction Extra construction Extra construction Cost: 0mHer Description VIORENVSICIALIN STREPT CTS CONTERPORTS CTS CHIER PIRSTAILING ALCENTERTS V AT THE REST PROVIDE COST CHIER PIRSTAILING (VIEW) INCENT COST CHIER PIRSTAILING (VIEW) | | Financial Systems COMM LLOCATION - STATISTICAL BASIS | UNI TY HOSPI TAL | OF INDIANA, IN Provider | CCN: 150169 P | eriod: | u of Form CMS- Worksheet B-1 | |
|---|--------|---|------------------|---------------------------------|------------------------------|--------------------------------|---------------------------------|---------|
| Loss Center Description INTERS A RESIDENTS LIST NUM INC. SPRICE-ALL DI (ASSI MARC) VIII PLACE 1 Cost Center Description NUM PROJECULE (ASSI MARC) SPRICE-ALL DI (ASSI MARC) SPRICE-ALL DI (ASSI MARC) SPRICE-ALL DI (ASSI MARC) 1 OTION OF REL COST CENTRE 1 SPRICE-ALL DI (ASSI MARC) SPRICE-ALL DI (ASSI MARC) SPRICE-ALL DI (ASSI MARC) 1 OTION OF REL COST CENTRE 1 0 23.00 23.01 1 OTION OF REL COST CENTRE 1 0 0 0 0 0 OTION OF REL COST CENTRE 1 0 1 0 | | | | | | rom 01/01/2014 o 12/31/2014 | | |
| THE THE <td></td> <td>Cost Center Description</td> <td>ANESTHETI STS</td> <td>SERVI CES-SALAR Y & FRI NGES</td> <td>SERVICES-OTHER PRGM COSTS</td> <td>PROGRAM-ALLI ED</td> <td>RADI OLOGY SCHOOL-ALLI ED</td> <td></td> | | Cost Center Description | ANESTHETI STS | SERVI CES-SALAR Y & FRI NGES | SERVICES-OTHER PRGM COSTS | PROGRAM-ALLI ED | RADI OLOGY SCHOOL-ALLI ED | |
| Image: 19.00 21.00 22.00 23.00 23.01 PAREAL SERVICE CONT DEVERSE 0.00000 0.0000 | | | | | · · | (ASSI GNED | (ASSI GNED | |
| 1.00 DOTOD CAP HEL COSTS-MELGA # LIXI 1.00 2.00 DOZOD CAP HEL COSTS-MELGA # LIXI 2.00 4.00 DOYOD EPRLOYTE BERFETTS DEPARTMENT 2.00 7.00 DOZOD CAPREL COSTS-MELGA # LIXI 3.00 7.00 DOZOD CAPREL COSTS-MELGA # LIXI 1.100 7.00 DOZOD CAPREL COSTS-MELGA # LIXI # LIXI 1.100 7.00 DOZOD CAPREL COSTS # LIXI # LIXI# LIXI# # LIXI# # LIXI# # LIXI# LIXI# LIXI# # LIXI# # LIXI# # LIXI# LIXI# # LIXI# # LIXI# # LIXI# # LIX | | CENERAL CERVICE COST CENTERS | 19.00 | 21.00 | 22.00 | | | |
| 4.00 00400 ENFLOYEE ENFERTS DEPARTMENT 4.00 7.00 00400 ENFLOYEE ENFERTS DEPARTMENT 5.00 7.00 00400 ENFLOYEE AT LINK STRATUS 6.00 7.00 00400 ENFLOYEE AT LINK STRATUS 6.00 7.00 00400 ENFLOYEE AT LINK STRATUS 6.00 7.00 01400 DEFENSION 10.00 7.00 01400 DEFENSION 11.00 7.00 01400 DEFENSION 3.941 7.00 01400 DEFENSION 11.00 7.00 01400 DEFENSION 3.941 7.00 01400 DEFENSION 3.941 7.00 DEFENSION 3.941 3.941 7.00 DEFENSION 3.941 3.941 7.00 | 1.00 | | | | | | | 1.00 |
| 5.00 000000 LAMIN ISTRATIVE & CREATERL 5.00 000000 1.00 | | | | | | | | |
| 7.00 00700 | | | | | | | | |
| 9.00 00000 PROJECTED NG 00000 PETAPY 0000 00000 PETAPY 0000 0000 PETAPY 0000 0000 0000 0000 0000 0000 0000 0 | 7.00 | 00700 OPERATION OF PLANT | | | | | | 7.00 |
| 10.00 01000 DETARY 10.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<> | | | | | | | | |
| 11.00 01100 CAFTERIA 11.00 13.00 01300 CAFTERIA 11.00 14.00 OHADO CENTRAL SERVICES & SUPPLY 13.00 15.00 01300 OTADO CENTRAL SERVICE 13.00 17.00 01700 OCALL SERVICE 11.00 13.00 17.00 01700 OCALL SERVICE 0 17.00 17.00 17.00 01700 OCALL SERVICE 0 17.00 1 | | | | | | | | |
| 14.00 01400 CENTRAL SERVICES & LIBRARY 14.00 15.00 01500 INFARMACY 15.00 16.00 01500 INFARMACY 15.00 17.00 01700 INFARMACY 15.00 17.00 01700 INFARMACY 16.00 17.00 01700 INFART FINISES 22.00 02200 INFART FINISES 17.00 23.00 02300 FINISES APRILED 22.00 23.01 02300 FINISES 3.713 3.941 00 23.00 23.02 02300 FINISES 3.173 3.73 0 30.00 23.00 03000 AULES AFENTRE COST CENTRES 0 | | | | | | | | |
| 15:00 01500 PHARAKCY 15:00 15:00 17:00 0700 SCRUICE SCRUICE 16:00 17:00 0700 SCRUICE SCRUICE 16:00 10:00 DTODI (SCRUICES-SALARY & FEN NERS APPRYD) 3,941 3,941 10:00 21:00 DTODI (AB SERVICE SCRUICES-SALARY & FEN NERS APPRYD) 3,941 3,941 23:01 D2301 ADDI (SCRUICES-SALARY & FEN NERS APPRYD) 3,941 00 22:00 23:01 D2301 ADDI (SCRUICES-SALARY & FEN NERS APPRYD) 3,941 00 00 23:01 23:01 D2301 ADDI (SCRUICES-SALARY & FEN NERS APPRYD) 3,941 0 00< | | | | | | | | |
| 16 00 01000 UPCICLERCORDS & LLBRARY 17.00 17 00 01700 01700 01700 17.00 18 00 01900 MOMPHYSICLAN ARESTHETSTS 0 17.00 22 00 02001 AR SERVICES-SALARY & FINCES APPRVD 3.941 3.941 22 00 02001 AR SERVICES-SALARY & FINCES APPRVD 3.941 3.941 23 00 02001 AR SERVICES-SALARY & FINCES APPRVD 3.941 3.941 23 00 02000 AR SERVICES-SALED #ALTH 0 0 23.02 10 001 010000Y SOMENCE COST CENTERES 3.173 3.173 0 | | | | | | | | • |
| 19:00 01900 NONPHYSICIAN AMESTRETISTS 0 19:00 19:00 19:00 19:00 19:00 19:00 19:00 19:00 19:00 19:00 19:00 19:00 19:00 19:00 19:00 19:00 19:00 19:00 22:00 10:00 10:00 10:00 10:00 10:00 10:00 22:00 10:00 23:00 10:00 23:00 10:00 10:00 23:00 23:00 23:00 23:00 23:00 23:00 23:00 23:00 23:00 23:00 23:00 23:00 00:00 | | | | | | | | • |
| 21.00 02100 148 SERVICES-SALARY & FRINCES APPRVD 3.941 21.00 22.00 22.00 02200 148 SERVICES-SALARY & FRINCES APPRVD 3.941 0 22.00 23.00 02300 EMS TRAINING PROCEMA-ALLED HEALTHEW 0 0 23.00 13.00 02300 FMS TRAINING PROCEMA-ALLED HEALTHEW 0 0 0 23.00 13.00 03000 ADULTS & PEDIATRICS 3.173 0 | | | | | | | | • |
| 22.00 02200 [1AR SERVICES-OTHER PROX 22.00 23.00 < | | | C | | | | | • |
| 23.00 02300 [EAS TRAIN IN G. PROGRAM-ALLIED HEALTH 0 00 23.01 02301 [PARAMECY RESI DENCY-ALLIED HEALTH 0 00 0 23.01 02301 [PARAMECY RESI DENCY-ALLIED HEALTH 0 0 0 23.01 02301 [PARAMECY RESI DENCY-ALLIED HEALTH 0 | | | | 3, 741 | 3, 941 | | | • |
| 23. 12 223.02 PHARMARY RESIDENCY-ALLIED HEALTH 0 0 23. 02 10. 00 03000 ADULTS & PEDIATRICS COST CENTERS 3. 173 3. 173 0 | 23.00 | 02300 EMS TRAINING PROGRAM-ALLIED HEALTHEM | | | | | | • |
| INPATI ENT. ROUTI NE. SERVICE COST CENTERS | | | | | | | | |
| 30.00 03000 ADULTS A PEDIATRICS 3.173 0 0 0 0 31.00 03100 INTENSI VE CARE UNIT 0 </td <td>23.02</td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td>0</td> <td>23.02</td> | 23.02 | | | | | 0 | 0 | 23.02 |
| 15. 00 02060 MEDIATAL INTENSIVE CARE UNIT 0 | 30.00 | | | 3, 173 | 3, 173 | 0 | 0 | 30.00 |
| 40.00 Q4000 SUBPROV DER - I PF 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<> | | | | | | | | |
| 11.00 04100 SUBPRIVIDER - IRF 0 0 0 1 0 ANCILLARY SERVICE COST CENTERS | | | | - | | | | |
| ANCI LLARY SERVICE COST CENTERS 000 0000 OPERAT IN ROOM 0 < | | | | - | - | - | | |
| 50. 00 O <td>43.00</td> <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>43.00</td> | 43.00 | | | 0 | 0 | 0 | 0 | 43.00 |
| 51:00 0 0 0 0 0 0 0 0 0 0 0 0 51:00 52:00 52:00 52:00 52:00 52:00 52:00 52:00 52:00 52:00 55:00 56:00 66:00 66:00 66:00 66:00 66:00 66:00 67:00 66:00 67:00 66:00 67:00 60:00 66:00 67:00 60:00 66:00 67:00 60:00 67:00 60:00 6 | 50 00 | | 0 | | 0 | 0 | 0 | 50.00 |
| 54.00 0s400 | | | | | | | | |
| 55.00 0 <td></td> <td></td> <td>0</td> <td>-</td> <td></td> <td></td> <td></td> <td></td> | | | 0 | - | | | | |
| 57.00 05700 CT SCAN 0 0 0 0 57.00 58.00 05000 MADRETIC RESONANCE I MAGING (MRI) 0 0 0 0 66.00 06400 0000 0 0 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 0 66.00 06500 RESPI RATORY THERAPY 0 0 0 0 0 67.00 05000 CLECTROCACADIOLOGY 0 0 0 0 0 68.00 068000 SEPECH PATHOLOGY 0 0 0 0 0 70.00 07000 ELECTROCACADIOLOGY 0 0 0 0 0 71.00 07000 ELECTROCACADIOLOGY 0 0 0 0 0 73.00 07300 DRUCH SCHARGED TO PATIENTS 0 0 0 0 0 73.00 07400 RENAL DIALYSIS 0 0 0 0 0 0 76.01 03330 ENDOSCOPY 0 0 0 | | | | - | | | | |
| 60:00 IABORATORY 0 | | | 0 | | | | | |
| 64.00 INTRAVENDUS THERAPY 0 0 0 0 65.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 0 65.00 66.00 06600 PHYSICAL THERAPY 0 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 66.00 68.00 06800 SPECEL PATHOLOCY 0 0 0 0 68.00 68.00 06900 ELECTROCARDIOLOGY 0 0 0 0 71.00 77.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 72.00 73.00 73.00 73.00 73.00 73.00 73.00 74.00 0 0 0 74.00 74.00 74.00 0 0 0 0 74.00 74.00 74.00 74.00 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 76.00 76.00 | | | C | 0 | | 0 | | |
| 65:00 66:00 RESPI RATORY THERAPY 0 <td< td=""><td></td><td></td><td></td><td></td><td>-</td><td>0</td><td></td><td></td></td<> | | | | | - | 0 | | |
| 67.00 06700 0CCUPATIONAL THERAPY 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<> | | | | | | | | |
| 68.00 06800 SPECH PATHOLOGY 0 <td></td> <td></td> <td>c</td> <td>0</td> <td></td> <td>0</td> <td></td> <td>•</td> | | | c | 0 | | 0 | | • |
| 69.00 06900 ELECTROCARDIOLOGY 0< | | | | | 0 | 0 | | • |
| 71.00 07100 MEDI CAL 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 07000 RENAL DI ALYSI S 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 74.00 76.01 03300 RENDSCOPY 0 0 0 0 76.00 76.02 0350 PSYCHIATRI C SERVICES 0 0 0 76.01 76.03 03951 OTHER ANCI LLARY SERVICES 0 0 0 76.02 76.03 03951 OTHER ANCI LLARY SERVICES 0 0 0 76.03 76.04 03952 ANCI LLARY SERVICE COST CENTERS 0 0 0 76.04 76.05 03953 MISC ANGL LLARY SERVICE 0 0 0 76.05 76.06 03954 IMAGI NG CENTER 0 0 0 0 76.07 76.08 03955< | | | | | 0 | 0 | - | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 74.00 ORANG LDIALYSIS 0 0 0 0 73.00 74.00 ORANG DIALS CHARGED TO PATIENTS 0 0 0 0 73.00 74.00 ORANG DIALS CHARGED TO PATIENTS 0 0 0 0 73.00 74.00 ORANG DIALS CHARGED TO PATIENTS 0 0 0 0 74.00 76.01 0350 NEUROPSYCHIATRI C/PSYCHOLOGI CAL SERVICES 0 0 0 76.01 76.02 03951 OTHER ANCILLARY SERVICES 0 0 0 76.03 76.03 03952 NILLARY SERVICE COST CENTERS 0 0 0 76.04 76.04 03952 MISC ANCILLARY SERVICE COST CENTER 0 0 0 76.05 76.05 03953 MISC ANCILLARY SERVICE COST CENTER 0 0 0 76.05 76.06 03954 IAAGING CENTER < | 70.00 | | c | 0 | 0 | 0 | 0 | |
| 73.00 O7300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 74.00 O7400 RENAL DI ALYSIS 0 0 0 0 74.00 76.00 0330 ENDOSCOPY 0 0 0 0 74.00 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 76.01 76.02 03950 NEUROPSYCHI ATRI C SERVI CES 0 0 0 76.02 76.03 03951 OTHER ANCI LLARY SERVI CES 0 0 0 76.03 03952 MOLLARY SERVI CE COST CENTERS 0 0 0 0 76.04 76.04 03954 MILARY SERVI CE COST CENTERS 0 0 0 76.05 76.05 03953 MI SC ANCI LLARY SERVI CE COST CENTER 0 0 0 76.06 76.06 03954 BRI ATRI C CLINIC 0 0 0 76.07 76.08 03955 BREAST DI AGNOSTI C CENTER 0 0 0 0 0 70.24 04973 PALLIATI VE CA | | | | 0 | 0 | 0 | - | |
| 76.00 03330 ENDOSCOPY 0 0 0 76.00 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 76.01 76.02 03950 NEUROPSYCHI ATRI C SERVI CES 0 0 0 0 76.02 76.03 03951 OTHER ANCI LLARY SERVI CES 0 0 0 76.03 76.04 03952 ANCI LLARY SERVI CE COST CENTERS 0 0 0 76.04 76.05 03953 MISC ANCI LLARY 0 0 0 76.05 76.06 03954 I MAGING CENTER 0 0 0 76.06 76.07 03955 BREAST DI AGNOSTI C CENTER 0 0 0 76.06 76.08 03956 BARI ATRI C CLI NI C 0 0 0 0 76.07 76.08 03956 BARI ATRI C CLI NI C 0 0 0 0 90.00 76.09 0 0 0 0 0 0 0 76.07 76.08 03956 BARI ATRI C CLI NI C <td></td> <td></td> <td></td> <td></td> <td>0</td> <td>0</td> <td>-</td> <td></td> | | | | | 0 | 0 | - | |
| 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 OTHER ANCI LLARY SERVI CES 0 0 0 0 76. 02 76. 04 03952 ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 76. 04 76. 05 03953 MISC ANCI LLARY SERVICE 0 0 0 76. 04 76. 06 03954 IMAGI NG CENTER 0 0 0 0 76. 05 76. 06 03954 IMAGI NG CENTER 0 0 0 0 76. 06 76. 07 03955 BREAST DI AGNOSTI C CENTER 0 0 0 0 76. 07 76. 08 03956 BARIATI C CLI NI C 0 0 0 0 76. 08 090.00 CLI NI C 0 0 0 0 0 90. 02 90. 24 04973 PALLI ATI VE CARE 0 0 0 | 74.00 | 07400 RENAL DI ALYSI S | c | 0 | 0 | 0 | 0 | 74.00 |
| 76. 02 03950 NEUROPSYCHI ATRI C SERVI CES 0 0 0 0 76. 02 76. 03 03951 OTHER ANCI LLARY SERVI CES 0 0 0 0 76. 03 76. 04 03952 ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 76. 03 76. 05 03953 MI SC ANCI LLARY SERVI CE 0 0 0 76. 05 76. 06 03954 I MAGI NG CENTER 0 0 0 0 76. 06 76. 07 03955 BREAST DI AGNOSTI C CENTER 0 0 0 0 76. 07 76. 08 03956 JARI ATRI C CLI NI C 0 0 0 0 0 76. 07 76. 08 03955 BREAST DI AGNOSTI C CENTER 0 0 0 0 0 76. 07 76. 08 03956 JARI ATRI C CLI NI C 0 <t< td=""><td></td><td></td><td></td><td></td><td>0</td><td>0</td><td>-</td><td></td></t<> | | | | | 0 | 0 | - | |
| 76.03 03951 OTHER ANCI LLARY SERVICES 0 0 0 76.03 76.04 03952 ANCI LLARY SERVICE COST CENTERS 0 0 0 0 76.04 76.05 03952 ANCI LLARY SERVICE COST CENTERS 0 0 0 0 76.04 76.06 03954 INSC ANCI LLARY 0 0 0 0 76.05 76.06 03954 IMAGING CENTER 0 0 0 0 76.05 76.07 03955 BRAST DI AGNOSTI C CENTER 0 0 0 76.07 76.08 03956 BARI ATRI C CLI NI C 0 0 0 0 76.08 090.00 09000 CLI NI C 0 0 0 0 90.00 90.24 04973 PALLI ATI VE CARE 0 0 0 90.26 90.26 90.26 90.26 90.26 90.26 90.26 90.26 90.26 90.26 90.26 90.26 90.26 90.26 90.26 90.26 90.26 90.26 90.27 90.26 90.27 | | | | | | 0 | | |
| 76.05 03953 MI SC ANCI LLARY 0 0 0 0 76.05 76.06 03954 IMAGI NG CENTER 0 0 0 0 76.06 76.07 03955 BREAST DI AGNOSTI C CENTER 0 0 0 0 0 76.07 76.08 03956 BARI ATRI C CLI NI C 0 0 0 0 0 76.07 76.08 03956 BARI ATRI C CLI NI C 0 0 0 0 0 76.07 76.08 03956 BARI ATRI C CLI NI C 0 0 0 0 0 76.08 00TPATI ENT SERVICE COST CENTER 0 0 0 0 0 90.00 90.00 09000 CLI NI C 0 0 0 0 90.00 90.24 90.24 04973 PALLI ATI VE CARE 0 0 0 0 90.24 90.25 91NE CENTER 0 0 0 0 90.27 91.00 09100 EMERGENCY 0 76.8 76.8 100 91.00 | | | C | 0 | 0 | 0 | 0 | |
| 76.06 03954 I MAGI NG CENTER 0 0 0 0 76.06 76.07 03955 BREAST DI AGNOSTI C CENTER 0 0 0 0 0 76.07 76.08 03956 BARI ATRI C CLINI C 0 0 0 0 0 0 76.08 03956 BARI ATRI C CLINI C 0 0 0 0 0 0 0 76.08 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 0 0 90.00 90.24 90.24 90.24 90.24 90.26 90.27 91.00 90.26 90.27 91.00 90.00 90.00 90.00 90.00 92.00 | | | 0 | 0 | 0 | 0 | | |
| 76. 07 03955 BREAST DI AGNOSTI C CENTER 0 0 0 0 76. 07 76. 08 03956 BARI ATRI C CLI NI C 0 0 0 0 0 0 76. 07 76. 08 03956 BARI ATRI C CLI NI C 0 0 0 0 0 0 0 76. 08 00 0 0000 CLI NI C 0 <th0< th=""> 0</th0<> | | | | | | 0 | - | |
| OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 0 0 0 90.00 90.24 04973 PALLI ATI VE CARE 0 0 0 0 0 90.00 90.24 04973 PALLI ATI VE CARE 0 0 0 0 90.24 90.26 04975 SPI NE CENTER 0 0 0 0 90.26 90.27 04976 DI ABETI C CARE CENTER 0 0 0 0 90.27 91.00 09100 EMERGENCY 0 768 768 100 0 91.00 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 768 768 100 0 91.00 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART) 92.00 92.00 92.00 92.00 92.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 100 100 118.00 | | | | | 0 | 0 | - | |
| 90.00 09000 CLINIC 0 0 0 0 0 0 90.00 90.24 04973 PALLIATIVE CARE 0 0 0 0 0 90.24 90.26 04975 SPINE CENTER 0 0 0 0 90.24 90.27 04976 DIABETIC CARE CENTER 0 0 0 0 90.27 91.00 09100 EMERGENCY 0 768 768 100 0 91.00 92.00 OSEEVATION BEDS (NON-DISTINCT PART) 0 768 768 100 0 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 11300 11300 113.00 100 100 113.00 100 100 118.00 NOREL MBURSABLE COST CENTERS | 76.08 | | C | 0 | 0 | 0 | 0 | 76.08 |
| 90. 24 04973 PALLI ATI VE CARE 0 0 0 0 90. 24 90. 26 04975 SPI NE CENTER 0 0 0 0 90. 26 90. 27 04976 DI ABETI C CARE CENTER 0 0 0 0 90. 26 90. 27 04976 DI ABETI C CARE CENTER 0 0 0 0 90. 27 91. 00 09100 EMERGENCY 0 768 768 100 0 91. 00 92. 00 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 768 768 100 0 92. 00 SPECIAL PURPOSE COST CENTERS 113. 00 1300 INTEREST EXPENSE 113.00 1300 JUSTI NCT PARTS 100 100 118. 00 118. 00 SUBTOTALS (SUM OF LINES 1-117) 0 3, 941 3, 941 100 100 118. 00 | 90 00 | | | | | 0 | 0 | 90.00 |
| 90. 26 04975 SPI NE CENTER 0 0 0 0 0 90. 26 90. 27 04976 DI ABETI C CARE CENTER 0 0 0 0 90. 27 91. 00 09100 EMERGENCY 0 768 768 100 0 91. 00 92. 00 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 768 768 100 0 92. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 3, 941 3, 941 100 100 118. 00 118. 00 NONREI MBURSABLE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 0 3, 941 3, 941 100 100 118. 00 | | | | | | 0 | | |
| 91.00 09100 EMERGENCY 0 768 768 100 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 768 768 100 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 11300 100 113.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 0 3,941 3,941 100 100 118.00 | 90.26 | 04975 SPI NE CENTER | 0 | | 0 | 0 | 0 | 90. 26 |
| 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 0 3,941 3,941 100 100 NONREI MBURSABLE COST CENTERS Interest Interest Interest Interest Interest | | | | | 0 | 0 | 0 | • |
| SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1-117) 0 3, 941 100 100 118.00 NONREIMBURSABLE COST CENTERS Interest expenses | | | | /68 | /68 | 100 | 0 | |
| 118.00 SUBTOTALS (SUM OF LINES 1-117) 0 3,941 3,941 100 118.00 NONREI MBURSABLE COST CENTERS | | SPECIAL PURPOSE COST CENTERS | I | 1 | I | 1 | | |
| NONREIMBURSABLE COST CENTERS | | | | 2.011 | 2.011 | 100 | 100 | • |
| | 118.00 | | <u> </u> | <u>ال</u> 3, 941 | 1 3, 941 | 100 | 100 | 118.00 |
| | 190.00 | | C | 0 | 0 | 0 | 0 | 190. 00 |

| COST ALLOCATION - STATISTICAL BASIS | | Provi der | | Period: From 01/01/2014 | Worksheet B-1 | |
|---|----------------|-----------------|----------------|----------------------------|-----------------------------|----------------|
| | | | | To 12/31/2014 | Date/Time Pre 5/27/2015 6:0 | pared: 7 pm |
| | | I NTERNS & | RESI DENTS | | | |
| Cost Center Description | NONPHYSI CI AN | SERVI CES-SALAR | SERVI CES-OTHE | R EMS TRAINING | RADI OLOGY | |
| • | ANESTHETI STS | Y & FRINGES | PRGM COSTS | PROGRAM-ALLI ED | SCHOOL-ALLI ED | |
| | (ASSI GNED | (ASSI GNED | (ASSI GNED | HEALTHEM | HEALTH | |
| | TIME) | TIME) | TIME) | (ASSI GNED | (ASSI GNED | |
| | | | | TIME) | TIME) | |
| | 19.00 | 21.00 | 22.00 | 23.00 | 23.01 | |
| 191. 00 19100 RESEARCH | 0 | 0 | | 0 0 | | 191.00 |
| 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES | 0 | 0 | | 0 0 | | 192.0 |
| 193.00 19300 NONPALD WORKERS | 0 | 0 | | 0 0 | | 193.0 |
| 194.0007950 HOME OFFICE | 0 | 0 | | 0 0 | | 194.0 |
| 194. 06 07956 PAVI LLI ONS | 0 | 0 | | 0 0 | | 194.0 |
| 194.07079570THER NONREIMBURSABLE COST CENTERS | 0 | 0 | | 0 0 | 0 | 194.0 |
| 94.08079580THER NONREIMBURSABLE COST CENTERS | 0 | 0 | | 0 0 | | 194. C |
| 94.09079590THER NONREIMBURSABLE COST CENTERS | 0 | 0 | | 0 0 | | 194. C |
| 194.1007960COMMUNITY REHAB HOSPITAL | 0 | 0 | | 0 0 | | 194.1 |
| 194.1107961WALGREENS TAKE CARE CLINIC | 0 | 0 | | 0 0 | 0 | 194.1 |
| 200.00 Cross Foot Adjustments | | | | | | 200. C |
| 201.00 Negative Cost Centers | | | | | | 201. C |
| 202.00 Cost to be allocated (per Wkst. B, Part I) | 0 | 138, 953 | 237, 34 | 8 157, 280 | 11, 006 | 202.0 |
| 203.00 Unit cost multiplier (Wkst. B, Part I) | 0. 000000 | 35. 258310 | 60. 22532 | 4 1, 572. 800000 | 110.060000 | 203.0 |
| 204.00 Cost to be allocated (per Wkst. B, Part II) | 0 | 6, 357 | 10, 85 | 9 18, 455 | 927 | 204. 0 |
| 205.00 Unit cost multiplier (Wkst. B, Part | 0. 000000 | 1. 613042 | 2. 75539 | 2 184. 550000 | 9. 270000 | 205. 0 |

| Health Financial Systems COM COST ALLOCATION - STATISTICAL BASIS COM | MUNITY HOSPITAL O | F INDIANA, INC. Provider CCN: 150169 | In Lieu Period: | u of Form CMS-2552-10 Worksheet B-1 |
|---|--|---|----------------------------------|--|
| | | | From 01/01/2014 To 12/31/2014 | Date/Time Prepared: |
| Cost Center Description | PHARMACY RESI DENCY-ALLI ED HEALTH (ASSI GNED TI ME) 23. 02 | | | 5/27/2015 6:07 pm |
| GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT | | | | 1.00 |
| 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMI NI STRATI VE & GENERAL 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVICE 9.00 00900 HOUSEKEEPING 01000 DI ETARY 11.00 01100 CAFETERIA 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY LI BRARY | | | | 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 |
| 17. 00 01700 SOCIAL SERVICE 19. 00 01900 NONPHYSICIAN ANESTHETISTS 21. 00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 22. 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 23. 00 C2300 EMS TRAINING PROGRAM-ALLIED HEALTHEM 23. 01 02201 RADIOLOGY SCHOOL-ALLIED HEALTH | | | | 17.00 19.00 21.00 22.00 23.00 23.01 |
| 23. 02 02302 PHARMACY RESIDENCY-ALLIED HEALTH | 100 | | | 23. 02 |
| INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 INTENSI VE CARE UNI T 35. 00 02060 NEONATAL INTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - IPF | 0 0 0 0 | | | 30. 00 31. 00 35. 00 40. 00 |
| 41.00 04100 SUBPROVIDER - IRF | 0 | | | 41.00 |
| 43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS | | | | 43.00 |
| 50. 00 05000 0PERATI NG ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C 57. 00 05700 CT SCAN 50. 00 05700 CT SCAN | | | | 50. 00 51. 00 52. 00 54. 00 55. 00 57. 00 |
| 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 60. 00 06000 LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY | | | | 58.00 60.00 64.00 65.00 66.00 67.00 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSI S | 0 0 0 0 100 | | | 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 |
| 76.00 03330 ENDOSCOPY 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.02 03950 NEUROPSYCHI ATRI C SERVI CES 76.03 03951 OTHER ANCI LLARY SERVI CES 76.04 03952 ANCI LLARY SERVI CE COST CENTERS 76.05 03953 MI SC ANCI LLARY | | | | 76. 00 76. 01 76. 02 76. 03 76. 04 76. 05 |
| 76. 0603954I MAGI NG CENTER76. 0703955BREAST DI AGNOSTI C CENTER76. 0803956BARI ATRI C CLI NI C0UTPATI ENT SERVI CE COST CENTERS | 000 | | | 76. 06 76. 07 76. 08 |
| 90. 00 09000 CLINIC 90. 24 04973 PALLIATIVE CARE 90. 26 04975 SPINE CENTER 90. 27 04976 DIABETIC CARE CENTER 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | 90.00 90.24 90.26 90.27 91.00 92.00 |
| SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS | 100 | | | 113. 00 118. 00 |
| 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES | 0 0 0 | | | 190. 00 191. 00 192. 00 |

| Health Financial Systems COMM | UNITY HOSPITAL OF | INDIANA, INC. | In Lieu | u of Form CMS-2552-10 |
|--|-------------------|----------------------|----------------------------------|--|
| COST ALLOCATION - STATISTICAL BASIS | | Provider CCN: 150169 | Peri od: | Worksheet B-1 |
| | | | From 01/01/2014 To 12/31/2014 | Date/Time Prepared: 5/27/2015 6:07 pm |
| Cost Center Description | PHARMACY | | | |
| | RESI DENCY-ALLI | | | |
| | ED HEALTH | | | |
| | (ASSI GNED | | | |
| | TIME) | | | |
| | 23.02 | | | |
| 193. 00 19300 NONPALD WORKERS | 0 | | | 193.00 |
| 194. 00 07950 HOME OFFICE | 0 | | | 194.00 |
| | 0 | | | 194.06 |
| 194. 07 07957 OTHER NONREI MBURSABLE COST CENTERS | 0 | | | 194.07 |
| 194. 08 07958 OTHER NONRELIMBURSABLE COST CENTERS | 0 | | | 194.08 |
| 194. 09 07959 OTHER NONREI MBURSABLE COST CENTERS | 0 | | | 194.09 |
| 194. 10 07960 COMMUNITY REHAB HOSPITAL | 0 | | | 194.10 |
| 194. 11 07961 WALGREENS TAKE CARE CLINIC | 0 | | | 194. 11 |
| 200.00 Cross Foot Adjustments | | | | 200. 00 201. 00 |
| 201.00 Negative Cost Centers | (50 7(2) | | | |
| 202.00 Cost to be allocated (per Wkst. B, Part I) | 650, 763 | | | 202.00 |
| 203.00 Unit cost multiplier (Wkst. B, Part I) | 6, 507. 630000 | | | 203.00 |
| 204.00 Cost to be allocated (per Wkst. B, | 30, 501 | | | 203.00 |
| Part II) | 30, 301 | | | 204.00 |
| 205.00 Unit cost multiplier (Wkst. B, Part | 305. 010000 | | | 205.00 |
| | 303.010000 | | | 200.00 |
| | I I | | | I |

| Heal th Financial | | I Syst | Systems | | | | |
|-------------------|--|--------|---------|----|-------|----|----|
| COMPLIT | | OF | PATIO | 0F | 27200 | ΤO | CH |

| | | IUNI IT HUSFITAL | | | | | 2552-10 |
|----------------|--|------------------|---------------|--------------|---|---|----------------|
| COMPUT | ATION OF RATIO OF COSTS TO CHARGES | | Provi der | CCN: 150169 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Pre 5/27/2015 6:0 | pared: 7 pm |
| | | | Ti †I | e XVIII | Hospi tal | PPS | , bii |
| | | | | | Costs | 110 | |
| | Cost Center Description | Total Cost | Therapy Limit | Total Costs | RCE | Total Costs | |
| | cost center bescription | (from Wkst. B, | Adj. | | Di sal I owance | | |
| | | Part I, col. | Auj. | | DI Sal I Owalice | | |
| | | 26) | | | | | |
| | | 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 | 50, 428, 620 | | 50, 428, 62 | 0 0 | 50, 428, 620 | 30, 00 |
| 30.00 | 03100 I NTENSI VE CARE UNI T | 8, 150, 065 | | 8, 150, 06 | | 8, 150, 065 | |
| 31.00 | 02060 NEONATAL INTENSIVE CARE UNIT | 12, 990, 494 | | 12, 990, 49 | | 12, 990, 494 | |
| 35.00 40.00 | | | | | | | |
| | 04000 SUBPROVIDER - IPF | 2, 805, 150 | | 2, 805, 15 | 0 0 | 2, 805, 150 | |
| 41.00 | 04100 SUBPROVIDER - IRF | 0 | | F 001 10 | 0 0 | 0 | |
| 43.00 | 04300 NURSERY | 5, 291, 190 | | 5, 291, 19 | 0 0 | 5, 291, 190 | 43.00 |
| | ANCI LLARY SERVICE COST CENTERS | 1 | 1 | | | | |
| 50.00 | 05000 OPERATING ROOM | 20, 690, 094 | | 20, 690, 09 | | | |
| 51.00 | 05100 RECOVERY ROOM | 4, 173, 917 | | 4, 173, 91 | | | |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 13, 135, 788 | | 13, 135, 78 | | 13, 135, 788 | |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 7, 816, 686 | | 7, 816, 68 | | | |
| 55.00 | 05500 RADI OLOGY-THERAPEUTI C | 1, 754, 295 | | 1, 754, 29 | | | |
| 57.00 | 05700 CT SCAN | 2, 538, 223 | | 2, 538, 22 | | _,, | |
| 58.00 | 05800 MAGNETIC RESONANCE I MAGING (MRI) | 5, 999, 724 | | 5, 999, 72 | 4 0 | 5, 999, 724 | 58.00 |
| 60.00 | 06000 LABORATORY | 5, 577, 085 | | 5, 577, 08 | 5 0 | 5, 577, 085 | 60.00 |
| 64.00 | 06400 INTRAVENOUS THERAPY | 530, 491 | | 530, 49 | 1 0 | 530, 491 | 64.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 5, 345, 164 | 0 | 5, 345, 16 | 4 0 | 5, 345, 164 | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 7, 316, 575 | 0 | 7, 316, 57 | 5 0 | 7, 316, 575 | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 2,019,600 | | 2,019,60 | | 2, 019, 600 | |
| 68.00 | 06800 SPEECH PATHOLOGY | 462, 870 | | 462, 87 | | 462, 870 | |
| 69.00 | 06900 ELECTROCARDI OLOGY | 1, 910, 579 | | 1, 910, 57 | | 1, 910, 579 | |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 2, 180, 520 | | 2, 180, 52 | | 2, 180, 520 | |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 13, 476, 415 | | 13, 476, 41 | | | |
| 72.00 | 07200 I MPL. DEV. CHARGED TO PATIENTS | 17, 892, 620 | | 17, 892, 62 | | | |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 18, 935, 261 | | 18, 935, 26 | | 18, 935, 261 | |
| 74.00 | 07400 RENAL DI ALYSI S | 833, 838 | | 833, 83 | | 833, 838 | |
| 76.00 | 03330 ENDOSCOPY | 2, 703, 266 | | 2, 703, 26 | | 2, 703, 266 | |
| 76.00 | 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 2,703,200 | | 2,703,20 | 0 0 | 2, 703, 200 | |
| 76.01 | 03950 NEUROPSYCHI ATRI C SERVI CES | 0 | | | 0 0 | 0 | |
| 76.02 | 03951 OTHER ANCI LLARY SERVICES | 0 | | | 0 0 | | |
| 76.03 76.04 | 03951 OTHER ANCILLARY SERVICES 03952 ANCILLARY SERVICE COST CENTERS | 0 | | | 0 0 | | |
| 76.04 76.05 | | 0 | | | 0 0 | - | |
| | 03953 MI SC ANCI LLARY | 1 000 570 | | 4 000 57 | 0 0 | 0 | |
| 76.06 | 03954 I MAGI NG CENTER | 4, 920, 572 | | 4, 920, 57 | | 4, 920, 572 | |
| 76.07 | 03955 BREAST DI AGNOSTI C CENTER | 7,064,019 | | 7, 064, 01 | | 7,064,019 | |
| 76.08 | 03956 BARI ATRI C CLI NI C | 13, 888 | | 13, 88 | 8 0 | 13, 888 | 76.08 |
| ~~ ~~ | OUTPATIENT SERVICE COST CENTERS | 1 | | | | | |
| 90.00 | 09000 CLINIC | 0 | | | 0 0 | 0 | |
| 90.24 | 04973 PALLIATIVE CARE | 0 | | | 0 0 | 0 | |
| 90.26 | 04975 SPINE CENTER | 291, 290 | | 291, 29 | 0 0 | 291, 290 | |
| 90.27 | 04976 DIABETIC CARE CENTER | 0 | | | 0 0 | 0 | |
| 91.00 | 09100 EMERGENCY | 14, 037, 257 | | 14, 037, 25 | | 14, 037, 257 | |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 4, 438, 268 | | 4, 438, 26 | 8 | 4, 438, 268 | 92.00 |
| | SPECIAL PURPOSE COST CENTERS | 1 | 1 | | 1 | | |
| | 11300 INTEREST EXPENSE | | | | | | 113.00 |
| 200.00 | | 245, 723, 824 | | | | | |
| 201.00 | Less Observation Beds | 4, 438, 268 | | 4, 438, 26 | | 4, 438, 268 | 201.00 |
| 202.00 | Total (see instructions) | 241, 285, 556 | 0 | 241, 285, 55 | 6 0 | 241, 285, 556 | 202.00 |
| | | | | | | | |

| COMPUT | Financial Systems COMM ATION OF RATIO OF COSTS TO CHARGES | UNI TY HOSPI TAL | | CCN: 150169 | Period: From 01/01/2014 | u of Form CMS-2 Worksheet C Part I | |
|------------------|--|---|------------------------------|-----------------|----------------------------|--|-----------------|
| | | | | | To 12/31/2014 | Date/Time Pre 5/27/2015 6:0 | pared:)7 pm |
| | | | | e XVIII | Hospi tal | PPS | |
| | Cost Center Description | Inpatient | <u>Charges</u> Outpatient | Total (col. | 6 Cost or Other | TEFRA | |
| | cost center bescription | inpatrent | outpatrent | + col. 7 | Ratio | Inpatient | |
| | | | | | Ratio | Ratio | |
| | | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 | 03000 ADULTS & PEDI ATRI CS | 94, 440, 486 | | 94, 440, 48 | | | 30.00 |
| 31.00 | 03100 I NTENSI VE CARE UNI T | 17, 335, 927 | | 17, 335, 92 | 27 | l | 31.00 |
| 35.00 | 02060 NEONATAL INTENSIVE CARE UNIT | 71, 470, 515 | | 71, 470, 51 | 15 | l | 35.00 |
| 40.00 | 04000 SUBPROVI DER – I PF | 5, 820, 250 | | 5, 820, 25 | 50 | l | 40.00 |
| 41.00 | 04100 SUBPROVIDER - IRF | 0 | | | 0 | l | 41.00 |
| 43.00 | 04300 NURSERY | 9, 735, 925 | | 9, 735, 92 | 25 | L | 43.00 |
| | ANCI LLARY SERVICE COST CENTERS | | | | | | 4 |
| 50.00 | 05000 OPERATING ROOM | 85, 146, 285 | 35, 651, 840 | | | 0.000000 | |
| 51.00 | 05100 RECOVERY ROOM | 14, 599, 179 | 10, 364, 265 | | | 0.00000 | |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 26, 258, 849 | 0 | 26, 258, 84 | | 0.00000 | |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 10, 457, 301 | 23, 564, 090 | | | 0.00000 | |
| 55.00 | 05500 RADI OLOGY-THERAPEUTI C | 6, 431, 059 | 8, 606, 702 | | | 0.00000 | |
| 57.00 | 05700 CT SCAN | 18, 919, 757 | 36, 376, 232 | | | 0.00000 | |
| 58.00 | 05800 MAGNETIC RESONANCE I MAGING (MRI) | 5, 417, 150 | 20, 828, 500 | | | 0.00000 | |
| 60.00 | 06000 LABORATORY | 57, 770, 485 | 28, 706, 102 | | | 0.00000 | |
| 64.00 | 06400 I NTRAVENOUS THERAPY | 1, 206, 908 | 158, 037 | | | 0.00000 | |
| 65.00 | 06500 RESPI RATORY THERAPY | 23, 032, 308 | 5, 273, 757 | | | 0.00000 | |
| 66.00 | 06600 PHYSI CAL THERAPY | 5, 084, 051 | 16, 070, 920 | | | 0.00000 | |
| 67.00 | 06700 OCCUPATIONAL THERAPY | 3, 525, 012 | 970, 243 | | | 0.00000 | |
| 68.00 | 06800 SPEECH PATHOLOGY | 1,020,654 | 518, 319 | | | 0.00000 | |
| 69.00 | 06900 ELECTROCARDI OLOGY | 5, 275, 608 | 979, 720 | | | 0.00000 | |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 1,025,446 | 6, 796, 926 | | | 0.00000 | |
| 71.00 | 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS | 45, 964, 229 | 15, 692, 123 | | | 0.00000 | |
| 72.00 | 07200 I MPL. DEV. CHARGED TO PATIENTS | 38, 414, 305 | 5, 700, 429 | | | 0.00000 | |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 60, 320, 374 | 14, 442, 176 | | | 0.000000 | |
| 74.00 | 07400 RENAL DI ALYSI S | 1, 989, 829 | 0 | 1, 989, 82 | | 0.000000 | |
| 76.00 | 03330 ENDOSCOPY | 2, 550, 837 | 10, 150, 109 | | | 0.00000 | |
| 76.01 | 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | 0 | | 0 0.000000 | 0.000000 | |
| 76.02 | 03950 NEUROPSYCHI ATRI C SERVI CES | 0 | 0 | | 0 0.000000 | 0.000000 | |
| 76.03 | 03951 OTHER ANCI LLARY SERVICES | , i i i i i i i i i i i i i i i i i i i | 0 | | 0 0.000000 | 0.000000 | |
| 76.04 | 03952 ANCI LLARY SERVICE COST CENTERS | 0 | 0 | | 0 0.000000 | 0.000000 | |
| 76.05 | 03953 MISC ANCI LLARY | 0 | 0 | | 0.000000 | 0.000000 | |
| 76.06 | 03954 I MAGI NG CENTER | 287, 123 | 46, 290, 911 | | | 0.000000 | |
| 76.07 | 03955 BREAST DI AGNOSTI C CENTER | 22, 808 0 | 10, 841, 159 | | | 0.000000 | |
| 76. 08 | 03956 BARIATRIC CLINIC OUTPATIENT SERVICE COST CENTERS | 0 | 67, 545 | 67, 54 | 0. 205611 | 0. 000000 | 76.08 |
| 90.00 | 09000 CLINIC | 0 | 0 | | 0 0.000000 | 0. 000000 | 90.00 |
| 90.00 | 04973 PALLIATIVE CARE | 0 | 0 | | | | |
| 90. 24 90. 26 | 04975 SPINE CENTER | 0 | 732, 310 | 732, 31 | 0.000000 | 0. 000000 0. 000000 | |
| 90.26 | 04975 SPINE CENTER | 0 | 132,310 | 132,3 | 0 0. 000000 | 0.000000 | |
| 90.27 | 09100 EMERGENCY | 26, 266, 790 | 86, 905, 387 | 113, 172, 17 | | 0.000000 | |
| 91.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 1, 506, 037 | 21, 304, 140 | | | 0.000000 | |
| 7Z. UU | SPECIAL PURPOSE COST CENTERS | 1, 000, 037 | 21, 304, 140 | 22,010,17 | 0. 194374 | 0.00000 | 72.00 |
| 113 00 | 11300 INTEREST EXPENSE | | | | | | 1113.00 |
| 200.00 | | 641, 295, 487 | 406 991 942 | 1, 048, 287, 42 | | l | 200.00 |
| | | 071,273,407 | 400, 771, 74Z | 1,070,207,42 | - 1 | 1 | |
| 200.00 | Less Observation Beds | | | | | 1 | 201.00 |

| | | IMUNITY HOSPITAL OF | INDIANA, INC. | In Lieu | u of Form CMS-2552-1 |
|----------------|---|------------------------|----------------------|----------------------------|--------------------------|
| COMPUT | FATION OF RATIO OF COSTS TO CHARGES | | Provider CCN: 150169 | Period: From 01/01/2014 | Worksheet C Part I |
| | | | | To 12/31/2014 | Date/Time Prepared: |
| | | | Title XVIII | Hospi tal | 5/27/2015 6:07 pm PPS |
| | Cost Center Description | PPS Inpatient | | | |
| | | Ratio 11.00 | | | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | 11.00 | | | |
| 30.00 | 03000 ADULTS & PEDI ATRI CS | | | | 30.0 |
| 31.00 | 03100 I NTENSI VE CARE UNI T | | | | 31.0 |
| 35.00 | 02060 NEONATAL INTENSIVE CARE UNIT | | | | 35.0 |
| 40.00 | 04000 SUBPROVI DER – I PF | | | | 40.0 |
| 41.00 | 04100 SUBPROVI DER – I RF | | | | 41.0 |
| 43.00 | 04300 NURSERY | | | | 43.0 |
| | ANCI LLARY SERVI CE COST CENTERS | | | | |
| 50.00 | 05000 OPERATING ROOM | 0. 171278 | | | 50.0 |
| 51.00 | 05100 RECOVERY ROOM | 0. 167201 | | | 51.0 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0. 500242 | | | 52.0 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 0. 229758 | | | 54.0 |
| 55.00 | 05500 RADI OLOGY-THERAPEUTI C | 0. 116659 | | | 55.0 |
| 57.00 | 05700 CT SCAN | 0. 045902 | | | 57.0 |
| 58.00 | 05800 MAGNETIC RESONANCE I MAGING (MRI) | 0. 228599 | | | 58.0 |
| 60.00 | 06000 LABORATORY | 0. 064492 | | | 60.0 |
| 64.00 | 06400 I NTRAVENOUS THERAPY | 0. 388654 | | | 64.0 |
| 65.00 | 06500 RESPI RATORY THERAPY | 0. 188835 | | | 65.0 |
| 66.00 | 06600 PHYSI CAL THERAPY | 0. 345856 | | | 66.0 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 0. 449274 | | | 67.0 |
| 68.00 | 06800 SPEECH PATHOLOGY | 0. 300766 | | | 68.0 |
| 69.00 | | 0. 305432 | | | 69.0 |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 0. 278754 | | | 70.0 |
| 71.00 | 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS | 0. 218573 | | | 71.0 |
| 72.00 73.00 | 07200 I MPL. DEV. CHARGED TO PATIENTS | 0. 405593 | | | 72. 0 73. 0 |
| 74.00 | 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS | 0. 253272 0. 419050 | | | 73.0 |
| 76.00 | 03330 ENDOSCOPY | 0. 212840 | | | 74.0 |
| 76.00 | 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0. 212840 | | | 76.0 |
| 76.01 | 03950 NEUROPSYCHI ATRI C SERVI CES | 0.000000 | | | 76.0 |
| 76.02 | 03951 OTHER ANCI LLARY SERVICES | 0.000000 | | | 76.0 |
| 76.03 | 03952 ANCI LLARY SERVICE COST CENTERS | 0.000000 | | | 76.0 |
| 76.05 | 03953 MISC ANCI LLARY | 0. 000000 | | | 76.0 |
| 76.06 | 03954 I MAGI NG CENTER | 0. 105641 | | | 76.0 |
| 76.07 | 03955 BREAST DI AGNOSTI C CENTER | 0. 650225 | | | 76.0 |
| 76.08 | 03956 BARI ATRI C CLI NI C | 0. 205611 | | | 76.0 |
| /01/00 | OUTPATIENT SERVICE COST CENTERS | 01200011 | | | |
| 90.00 | 09000 CLI NI C | 0.000000 | | | 90.0 |
| 90.24 | 04973 PALLI ATI VE CARE | 0. 000000 | | | 90.2 |
| 90.26 | 04975 SPI NE CENTER | 0. 397769 | | | 90.2 |
| 90.27 | 04976 DI ABETI C CARE CENTER | 0. 000000 | | | 90.2 |
| 91.00 | 09100 EMERGENCY | 0. 124035 | | | 91.0 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 194574 | | | 92.0 |
| | SPECIAL PURPOSE COST CENTERS | | | | |
| 113.00 | 11300 INTEREST EXPENSE | | | | 113.0 |
| 200.00 | Subtotal (see instructions) | | | | 200. 0 |
| 201.00 | | | | | 201.0 |
| 202.00 |) Total (see instructions) | | | | 202.0 |

| | Financial Systems COMM ATION OF RATIO OF COSTS TO CHARGES | MUNI TY HOSPI TAL | Provi der | CCN: 150169 | Period: | Worksheet C | |
|------------------|--|----------------------------|---------------|--------------------------|---------------------------------------|---------------------------------|----------------|
| 01 | | | | | From 01/01/2014 | Part I | |
| | | | | | To 12/31/2014 | Date/Time Prep 5/27/2015 6:0 | |
| | | | Ti t | le XIX | Hospi tal | PPS | 7 piii |
| | | | | | Costs | | |
| | Cost Center Description | Total Cost | Therapy Limit | Total Costs | RCE | Total Costs | |
| | | (from Wkst. B, | Adj . | | Di sal I owance | | |
| | | Part I, col. | | | | | |
| | | 26) | 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 | 50, 428, 620 | | 50, 428, 62 | 0 0 | 50, 428, 620 | 30.00 |
| 31.00 | 03100 I NTENSI VE CARE UNI T | 8, 150, 065 | | 8, 150, 06 | | 8, 150, 065 | |
| 35.00 | 02060 NEONATAL INTENSIVE CARE UNIT | 12, 990, 494 | | 12, 990, 49 | 4 0 | 12, 990, 494 | 35.00 |
| 40.00 | 04000 SUBPROVIDER - IPF | 2, 805, 150 | | 2, 805, 15 | 0 0 | 2, 805, 150 | 40.00 |
| 41.00 | 04100 SUBPROVIDER - IRF | 0 | | | 0 0 | 0 | 41.00 |
| 43.00 | 04300 NURSERY | 5, 291, 190 | | 5, 291, 19 | 0 0 | 5, 291, 190 | 43.00 |
| | ANCI LLARY SERVI CE COST CENTERS | 1 | | 1 | | | |
| | 05000 OPERATI NG ROOM | 20, 690, 094 | | 20, 690, 09 | | 20, 690, 094 | |
| | 05100 RECOVERY ROOM | 4, 173, 917 | | 4, 173, 91 | | 4, 173, 917 | 51.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 13, 135, 788 | | 13, 135, 78 | | 13, 135, 788 | |
| | 05400 RADI OLOGY - DI AGNOSTI C | 7, 816, 686 | | 7, 816, 68 | | 7, 816, 686 | |
| 55.00 57.00 | 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN | 1, 754, 295 2, 538, 223 | | 1, 754, 29 2, 538, 22 | | 1, 754, 295 2, 538, 223 | 55.00 57.00 |
| 57.00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 5, 999, 724 | | 5, 999, 72 | | 2, 538, 223 5, 999, 724 | |
| 60.00 | 06000 LABORATORY | 5, 577, 085 | | 5, 577, 08 | | 5, 577, 085 | 60.00 |
| 64.00 | 06400 I NTRAVENOUS THERAPY | 530, 491 | | 530, 49 | | 530, 491 | 64.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 5, 345, 164 | 0 | | | 5, 345, 164 | |
| 66.00 | 06600 PHYSI CAL THERAPY | 7, 316, 575 | 0 | | | 7, 316, 575 | |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 2,019,600 | 0 | | | 2,019,600 | |
| 68.00 | 06800 SPEECH PATHOLOGY | 462, 870 | 0 | 462, 87 | 0 0 | 462, 870 | 68.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 1, 910, 579 | | 1, 910, 57 | 9 0 | 1, 910, 579 | 69.00 |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 2, 180, 520 | | 2, 180, 52 | 0 0 | 2, 180, 520 | 70.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 13, 476, 415 | | 13, 476, 41 | | 13, 476, 415 | 71.00 |
| | 07200 IMPL. DEV. CHARGED TO PATIENTS | 17, 892, 620 | | 17, 892, 62 | 0 0 | 17, 892, 620 | 72.00 |
| | 07300 DRUGS CHARGED TO PATIENTS | 18, 935, 261 | | 18, 935, 26 | | 18, 935, 261 | 73.00 |
| | 07400 RENAL DIALYSIS | 833, 838 | | 833, 83 | | 833, 838 | |
| | 03330 ENDOSCOPY | 2, 703, 266 | | 2, 703, 26 | | 2, 703, 266 | |
| | 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | | | 0 0 | 0 | 76.01 |
| 76. 02 76. 03 | 03950 NEUROPSYCHI ATRI C SERVI CES 03951 OTHER ANCI LLARY SERVI CES | 0 | | | 0 0 0 0 | 0 | 76.02 76.03 |
| | 03952 ANCI LLARY SERVICE COST CENTERS | 0 | | | | 0 | 76.03 |
| 76.04 | 03953 MI SC ANCI LLARY | 0 | | | 0 0 | 0 | 76.04 |
| 76.06 | 03954 I MAGI NG CENTER | 4, 920, 572 | | 4, 920, 57 | - | 4, 920, 572 | |
| 76.07 | 03955 BREAST DI AGNOSTI C CENTER | 7,064,019 | | 7, 064, 01 | | 7,064,019 | |
| 76.08 | 03956 BARI ATRI C CLI NI C | 13, 888 | | 13, 88 | | 13, 888 | |
| | OUTPATIENT SERVICE COST CENTERS | | | | · · · · · · · · · · · · · · · · · · · | | 1 |
| 90.00 | 09000 CLI NI C | 0 | | | 0 0 | 0 | 90.00 |
| 90.24 | 04973 PALLIATIVE CARE | 0 | | | 0 0 | 0 | 90. 24 |
| | 04975 SPINE CENTER | 291, 290 | | 291, 29 | | 291, 290 | |
| | 04976 DI ABETI C CARE CENTER | 0 | | | 0 0 | 0 | 90. 27 |
| 91.00 | 09100 EMERGENCY | 14,037,257 | | 14, 037, 25 | | 14,037,257 | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 4, 438, 268 | | 4, 438, 26 | Ö | 4, 438, 268 | 92.00 |

245, 723, 824

241, 285, 556

4, 438, 268

245, 723, 824

241, 285, 556

4, 438, 268

0

0

113.00

245, 723, 824 200. 00

4, 438, 268 201. 00 241, 285, 556 202. 00

0

0

SPECIAL PURPOSE COST CENTERS

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

113.00 11300 INTEREST EXPENSE

200.00

201.00

202.00

| | Financial Systems COMM TATION OF RATIO OF COSTS TO CHARGES | UNI TY HOSPI TAL | | CCN: 150169 | Period: | u of Form CMS- Worksheet C | 2552-10 |
|--------|---|---|---------------|---|----------------------------------|--|----------|
| COMPUT | ATTON OF RATIO OF COSTS TO CHARGES | | Provi der | CCN: 150169 | From 01/01/2014 To 12/31/2014 | Part I Date/Time Pre 5/27/2015 6:0 | epared: |
| | | _ | Tit | le XIX | Hospi tal | PPS | |
| | | | Charges | | | | |
| | Cost Center Description | I npati ent | Outpati ent | Total (col. + col. 7) | 6 Cost or Other Ratio | TEFRA Inpatient | |
| | | 6,00 | 7.00 | 8,00 | 9,00 | Rati o 10.00 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | 0.00 | 7.00 | 0.00 | 9.00 | 10.00 | - |
| 30.00 | 03000 ADULTS & PEDIATRICS | 94, 440, 486 | | 94, 440, 48 | 36 | | 30.00 |
| 31.00 | 03100 I NTENSI VE CARE UNI T | 17, 335, 927 | | 17, 335, 92 | 27 | | 31.00 |
| 35.00 | 02060 NEONATAL INTENSIVE CARE UNIT | 71, 470, 515 | | 71, 470, 51 | | | 35.00 |
| 40.00 | 04000 SUBPROVIDER - IPF | 5, 820, 250 | | 5, 820, 25 | | | 40.00 |
| 41.00 | 04100 SUBPROVIDER - IRF | 0 | | | 0 | | 41.00 |
| 43.00 | 04300 NURSERY | 9, 735, 925 | | 9, 735, 92 | 25 | | 43.00 |
| 101 00 | ANCI LLARY SERVI CE COST CENTERS | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | -0 | | 1 101 00 |
| 50.00 | 05000 OPERATI NG ROOM | 85, 146, 285 | 35, 651, 840 | 120, 798, 12 | 0. 171278 | 0.00000 | 50.00 |
| 51.00 | 05100 RECOVERY ROOM | 14, 599, 179 | 10, 364, 265 | | | 0.000000 | |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 26, 258, 849 | 0 | 26, 258, 84 | | 0.000000 | |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 10, 457, 301 | 23, 564, 090 | 34, 021, 39 | | 0. 000000 | |
| 55.00 | 05500 RADI OLOGY-THERAPEUTI C | 6, 431, 059 | 8, 606, 702 | 15, 037, 76 | | 0.000000 | |
| 57.00 | 05700 CT SCAN | 18, 919, 757 | 36, 376, 232 | 55, 295, 98 | | 0.000000 | |
| 58.00 | 05800 MAGNETIC RESONANCE I MAGING (MRI) | 5, 417, 150 | 20, 828, 500 | 26, 245, 65 | | 0.000000 | |
| 60.00 | 06000 LABORATORY | 57, 770, 485 | 28, 706, 102 | 86, 476, 58 | | 0. 000000 | |
| 64.00 | 06400 I NTRAVENOUS THERAPY | 1, 206, 908 | 158, 037 | 1, 364, 94 | | 0.000000 | |
| 65.00 | 06500 RESPI RATORY THERAPY | 23, 032, 308 | 5, 273, 757 | 28, 306, 06 | | 0. 000000 | |
| 66.00 | 06600 PHYSI CAL THERAPY | 5, 084, 051 | 16, 070, 920 | | | 0. 000000 | |
| 67.00 | 06700 OCCUPATIONAL THERAPY | 3, 525, 012 | 970, 243 | 4, 495, 25 | | 0. 000000 | |
| | 06800 SPEECH PATHOLOGY | 1, 020, 654 | 518, 319 | | | 0.000000 | |
| 68.00 | | | | | | | |
| 69.00 | | 5, 275, 608 | 979, 720 | 6, 255, 32 | | 0.000000 | |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 1,025,446 | 6, 796, 926 | 7, 822, 37 | | 0.00000 | |
| 71.00 | 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS | 45, 964, 229 | 15, 692, 123 | 61, 656, 35 | | 0.00000 | |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENTS | 38, 414, 305 | 5, 700, 429 | | | 0.00000 | |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 60, 320, 374 | 14, 442, 176 | | | 0.00000 | |
| 74.00 | 07400 RENAL DI ALYSI S | 1, 989, 829 | 0 | 1, 989, 82 | | 0.00000 | |
| 76.00 | 03330 ENDOSCOPY | 2, 550, 837 | 10, 150, 109 | 12, 700, 94 | | 0.000000 | |
| 76. 01 | 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | 0 | | 0 0. 000000 | 0.000000 | |
| 76. 02 | 03950 NEUROPSYCHI ATRI C SERVI CES | 0 | 0 | | 0 0. 000000 | 0.000000 | |
| 76.03 | 03951 OTHER ANCI LLARY SERVICES | 0 | 0 | | 0 0. 000000 | 0.000000 | |
| 76.04 | 03952 ANCI LLARY SERVI CE COST CENTERS | 0 | 0 | | 0 0. 000000 | 0. 000000 | |
| 76.05 | 03953 MISC ANCI LLARY | 0 | 0 | | 0 0. 000000 | 0.00000 | |
| 76.06 | 03954 I MAGI NG CENTER | 287, 123 | 46, 290, 911 | 46, 578, 03 | 0. 105641 | 0.00000 | 76.06 |
| 76.07 | 03955 BREAST DIAGNOSTIC CENTER | 22, 808 | 10, 841, 159 | 10, 863, 96 | 67 0. 650225 | 0.00000 | 76.07 |
| 76.08 | 03956 BARI ATRI C CLI NI C | 0 | 67, 545 | 67, 54 | 45 0. 205611 | 0.00000 | 76.08 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90.00 | 09000 CLI NI C | 0 | 0 | | 0 0. 000000 | 0.00000 | 90.00 |
| 90. 24 | 04973 PALLI ATI VE CARE | 0 | 0 | | 0 0. 000000 | 0. 000000 | |
| 90.26 | 04975 SPINE CENTER | 0 | 732, 310 | 732, 31 | 0. 397769 | 0.000000 | 90.26 |
| 90. 27 | 04976 DI ABETI C CARE CENTER | 0 | 0 | | 0 0.000000 | 0. 000000 | 90.27 |
| 91.00 | 09100 EMERGENCY | 26, 266, 790 | 86, 905, 387 | 113, 172, 17 | 0. 124035 | 0. 000000 | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 1, 506, 037 | 21, 304, 140 | 22, 810, 17 | 0. 194574 | 0. 000000 | 92.00 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | |
| 113.00 | 11300 INTEREST EXPENSE | | | | | | 113.00 |
| 200.00 | Subtotal (see instructions) | 641, 295, 487 | 406, 991, 942 | 1, 048, 287, 42 | 29 | | 200.00 |
| | Less Observation Beds | | | | | | 201.00 |
| 201.00 | | | | | | | 201.00 |

| Health Financial Systems | COMMUNITY HOSPITAL OF | INDIANA, INC. | In Lieu | u of Form CMS-: | 2552-10 |
|--|--------------------------|----------------------|----------------------------------|--------------------------------|---------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provider CCN: 150169 | Peri od: | Worksheet C | |
| | | | From 01/01/2014 To 12/31/2014 | Part I | narod |
| | | | 10 12/31/2014 | Date/Time Pre 5/27/2015 6:0 | i7 nm |
| | | Title XIX | Hospi tal | PPS | 7 pm |
| Cost Center Description | PPS Inpatient | | | | |
| | Ratio | | | | |
| | 11.00 | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS | | | | | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | | | | | 31.00 |
| 35.00 02060 NEONATAL INTENSIVE CARE UNIT | | | | | 35.00 |
| 40. 00 04000 SUBPROVIDER - IPF | | | | | 40.00 |
| 41.00 04100 SUBPROVIDER - IRF | | | | | 41.00 |
| 43.00 04300 NURSERY | | | | | 43.00 |
| ANCI LLARY SERVI CE COST CENTERS | | | | | |
| 50.00 05000 OPERATI NG ROOM | 0. 171278 | | | | 50. OC |
| 51.00 05100 RECOVERY ROOM | 0. 167201 | | | | 51.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0. 500242 | | | | 52.00 |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C | 0. 229758 | | | | 54. OC |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0. 116659 | | | | 55.00 |
| 57. 00 05700 CT SCAN | 0. 045902 | | | | 57.00 |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0. 228599 | | | | 58.00 |
| 60. 00 06000 LABORATORY | 0. 064492 | | | | 60.00 |
| 64. 00 06400 I NTRAVENOUS THERAPY | 0. 388654 | | | | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0. 188835 | | | | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0. 345856 | | | | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0. 449274 | | | | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 0. 300766 | | | | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0. 305432 | | | | 69.00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 0. 278754 | | | | 70.00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIE | | | | | 71.00 |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS | 0. 405593 | | | | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 0. 403373 | | | | 73.00 |
| 74. 00 07400 RENAL DIALYSIS | 0. 233272 | | | | 74.00 |
| 76. 00 03330 ENDOSCOPY | | | | | 76.00 |
| | 0. 212840 S 0. 000000 | | | | |
| | | | | | 76.01 |
| 76. 02 03950 NEUROPSYCHI ATRI C SERVI CES 76. 03 03951 OTHER ANCI LLARY SERVI CES | 0. 000000 | | | | 76.02 |
| | 0. 000000 | | | | 76.03 |
| | 0. 000000 | | | | 76.04 |
| 76. 05 03953 MISC ANCI LLARY | 0. 000000 | | | | 76.05 |
| 76. 06 03954 I MAGI NG CENTER | 0. 105641 | | | | 76.06 |
| 76. 07 03955 BREAST DI AGNOSTI C CENTER | 0. 650225 | | | | 76.07 |
| 76. 08 03956 BARI ATRI C CLI NI C | 0. 205611 | | | | 76.08 |
| OUTPATIENT SERVICE COST CENTERS | 0,000000 | | | | |
| 90. 00 09000 CLINIC | 0. 000000 | | | | 90.00 |
| 90. 24 04973 PALLI ATI VE CARE | 0. 000000 | | | | 90.24 |
| 90. 26 04975 SPINE CENTER | 0. 397769 | | | | 90.26 |
| 90. 27 04976 DIABETIC CARE CENTER | 0. 000000 | | | | 90.27 |
| 91.00 09100 EMERGENCY | 0. 124035 | | | | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PA | RT) 0. 194574 | | | | 92.00 |
| SPECIAL PURPOSE COST CENTERS | 1 | | | | |
| 113.00 11300 INTEREST EXPENSE | | | | | 113.00 |
| 200.00 Subtotal (see instructions) | | | | | 200.00 |
| 201.00 Less Observation Beds | | | | | 201.00 |
| 202.00 Total (see instructions) | | | | | 202.00 |

| | | MUNITY HOSPITAL | | | In Lie | u of Form CMS-2 | 2552-10 |
|--------------------|---|-----------------|----------------|--------------|---|--|----------------|
| | ON OF OUTPATIENT SERVICE COST TO CHARGE R/ S FOR MEDICAID ONLY | ATIOS NET OF | | | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part II Date/Time Pre 5/27/2015 6:0 | pared: 7 pm |
| | | - | | le XIX | Hospi tal | PPS | |
| | Cost Center Description | Total Cost | Capital Cost | | | Operating Cost | |
| | | | (Wkst. B, Part | | | Reduction | |
| | | I, col. 26) | II col. 26) | Cost (col. 1 | - | Amount | |
| | | | | col. 2) | | | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | CILLARY SERVICE COST CENTERS | 1 | | | - | - | |
| | DOO OPERATING ROOM | 20, 690, 094 | 3, 086, 446 | | | 0 | 50. OC |
| | 100 RECOVERY ROOM | 4, 173, 917 | 398, 675 | | | 0 | 51.OC |
| | 200 DELIVERY ROOM & LABOR ROOM | 13, 135, 788 | 1, 504, 073 | | | 0 | 52.00 |
| | 400 RADI OLOGY-DI AGNOSTI C | 7, 816, 686 | 1, 290, 805 | | | 0 | 54.00 |
| | 500 RADI OLOGY-THERAPEUTI C | 1, 754, 295 | 343, 057 | | | 0 | 55.00 |
| | 700 CT SCAN | 2, 538, 223 | 189, 922 | | | 0 | 57.00 |
| | BOO MAGNETIC RESONANCE IMAGING (MRI) | 5, 999, 724 | 939, 794 | | | 0 | 58.00 |
| 60.00 060 | DOO LABORATORY | 5, 577, 085 | 345, 267 | 5, 231, 81 | | 0 | 60.00 |
| 64.00 064 | 400 INTRAVENOUS THERAPY | 530, 491 | 31, 555 | 498, 93 | 36 0 | 0 | 64.00 |
| 65.00 065 | 500 RESPI RATORY THERAPY | 5, 345, 164 | 487, 909 | 4, 857, 25 | 55 0 | 0 | 65.00 |
| 66.00 066 | 500 PHYSI CAL THERAPY | 7, 316, 575 | 411, 682 | 6, 904, 89 | 93 0 | 0 | 66.00 |
| 67.00 067 | 700 OCCUPATI ONAL THERAPY | 2,019,600 | 118, 458 | 1, 901, 14 | 12 0 | 0 | 67.00 |
| 58. 00 068 | BOO SPEECH PATHOLOGY | 462, 870 | 27, 134 | 435, 73 | 36 0 | 0 | 68.00 |
| 69.00 069 | POO ELECTROCARDI OLOGY | 1, 910, 579 | 105, 351 | 1, 805, 22 | 28 0 | 0 | 69.00 |
| | DOO ELECTROENCEPHALOGRAPHY | 2, 180, 520 | 213, 306 | | | 0 | 70.00 |
| | 100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 13, 476, 415 | 617, 343 | | | 0 | 71.0 |
| | 200 IMPL. DEV. CHARGED TO PATIENTS | 17, 892, 620 | 819, 154 | | | 0 | 72.0 |
| | 300 DRUGS CHARGED TO PATIENTS | 18, 935, 261 | 1, 151, 729 | | | 0 | 73.0 |
| | 400 RENAL DI ALYSI S | 833, 838 | 40, 852 | | - | 0 | 74.0 |
| | 330 ENDOSCOPY | 2, 703, 266 | 496, 645 | | | 0 | 76.0 |
| | 550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 2,703,200 | 470, 043 | 2,200,02 | 0 0 | 0 | 76.0 |
| | PSO NEUROPSYCHI ATRI C SERVI CES | 0 | 0 | | 0 0 | 0 | 76.0 |
| | 951 OTHER ANCILLARY SERVICES | 0 | 0 | | 0 0 | 0 | 76.0 |
| | | 0 | 0 | | | 0 | 76.0 |
| | 952 ANCI LLARY SERVICE COST CENTERS | 0 | 0 | | 0 0 | - | |
| | 953 MISC ANCI LLARY | 0 | 0 | 4 004 0- | 0 0 79 0 | 0 | 76.0 |
| | 954 I MAGI NG CENTER | 4, 920, 572 | 896, 493 | | | 0 | 76.0 |
| | 955 BREAST DI AGNOSTI C CENTER | 7,064,019 | 386, 269 | | | 0 | 76.0 |
| | 956 BARIATRIC CLINIC | 13, 888 | 666 | 13, 22 | 22 0 | 0 | 76.0 |
| | IPATIENT SERVICE COST CENTERS | - | - | 1 | _ | _ | |
| | | 0 | 0 | | 0 0 | 0 | 90.00 |
| | 973 PALLIATIVE CARE | 0 | 0 | | 0 0 | 0 | 90. 24 |
| | 975 SPINE CENTER | 291, 290 | 13, 804 | 277, 48 | | 0 | 90.20 |
| | 976 DIABETIC CARE CENTER | 0 | 0 | | 0 0 | 0 | 90.27 |
| | 100 EMERGENCY | 14, 037, 257 | 1, 163, 817 | | | 0 | 91.00 |
| | 200 OBSERVATION BEDS (NON-DISTINCT PART) | 4, 438, 268 | 482, 258 | 3, 956, 01 | 0 0 | 0 | 92.00 |
| | ECIAL PURPOSE COST CENTERS | 1 | | | | | |
| | 300 INTEREST EXPENSE | | | | | | 113.00 |
| | Subtotal (sum of lines 50 thru 199) | 166, 058, 305 | 15, 562, 464 | 150, 495, 84 | 1 0 | 0 | 200.00 |
| 200. 00 | | 100/000/000 | 10/002/101 | 100/170/0 | | | • |
| 200. 00 201. 00 | Less Observation Beds | 4, 438, 268 | | | | 0 | 201.00 |

| ALCULATION OF OUTPATIENT SERVICE COST TO CHARGE R EDUCTIONS FOR MEDICAID ONLY | ATIOS NET OF | | CCN: 150169 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part II Date/Time Prep 5/27/2015 6:07 | oared: 7 pm |
|--|----------------|---------------|-------------|---|--|----------------|
| | _ | | le XIX | Hospi tal | PPS | |
| Cost Center Description | Cost Net of | Total Charges | Outpati ent | | | |
| | Capital and | (Worksheet C, | | | | |
| | Operating Cost | | · · | 6 | | |
| | Reduction | 8) | / col. 7) | | | |
| | 6.00 | 7.00 | 8.00 | | | |
| ANCI LLARY SERVI CE COST CENTERS | 1 | | | | | |
| 0.00 05000 OPERATING ROOM | 20, 690, 094 | | | | | 50.00 |
| 1.00 05100 RECOVERY ROOM | 4, 173, 917 | 24, 963, 444 | | | | 51.00 |
| 2.00 05200 DELIVERY ROOM & LABOR ROOM | 13, 135, 788 | | | | | 52.00 |
| 4. 00 05400 RADI OLOGY-DI AGNOSTI C | 7, 816, 686 | | | | | 54.00 |
| 5. 00 05500 RADI OLOGY-THERAPEUTI C | 1, 754, 295 | 15, 037, 761 | 0. 1166 | | | 55.00 |
| 7.00 05700 CT SCAN | 2, 538, 223 | | | | | 57.00 |
| 8.00 05800 MAGNETIC RESONANCE IMAGING (MRI) | 5, 999, 724 | 26, 245, 650 | 0. 22859 | 99 | | 58.0 |
| 0. 00 06000 LABORATORY | 5, 577, 085 | 86, 476, 587 | 0.06449 | 92 | | 60.0 |
| 4.00 06400 INTRAVENOUS THERAPY | 530, 491 | 1, 364, 945 | 0. 3886 | 54 | | 64.0 |
| 5. 00 06500 RESPI RATORY THERAPY | 5, 345, 164 | 28, 306, 065 | 0. 18883 | 35 | | 65.0 |
| 6. 00 06600 PHYSI CAL THERAPY | 7, 316, 575 | 21, 154, 971 | 0. 3458 | 56 | | 66.0 |
| 7.00 06700 OCCUPATIONAL THERAPY | 2, 019, 600 | 4, 495, 255 | 0. 4492 | 74 | | 67.0 |
| 8.00 06800 SPEECH PATHOLOGY | 462, 870 | 1, 538, 973 | 0.30076 | 66 | | 68.0 |
| 9. 00 06900 ELECTROCARDI OLOGY | 1, 910, 579 | | | | | 69.0 |
| 0.00 07000 ELECTROENCEPHALOGRAPHY | 2, 180, 520 | | | | | 70.0 |
| 1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 13, 476, 415 | | | | | 71.0 |
| 2.00 07200 I MPL. DEV. CHARGED TO PATIENTS | 17, 892, 620 | | | | | 72.0 |
| 3. 00 07300 DRUGS CHARGED TO PATIENTS | 18, 935, 261 | 74, 762, 550 | | | | 73.0 |
| 4. 00 07400 RENAL DIALYSIS | 833, 838 | 1, 989, 829 | | | | 74.0 |
| 6. 00 03330 ENDOSCOPY | 2, 703, 266 | 12, 700, 946 | | | | 76.0 |
| 6. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 2, 703, 200 | 12,700,740 | 0. 00000 | | | 76.0 |
| 6. 02 03950 NEUROPSYCHI ATRI C SERVI CES | 0 | 0 | 0.00000 | | | 76.0 |
| | 0 | 0 | | | | |
| 6. 03 03951 OTHER ANCI LLARY SERVI CES 6. 04 03952 ANCI LLARY SERVI CE COST CENTERS | 0 | | 0.0000 | | | 76.0 76.0 |
| 6. 05 03952 ANGI LLARY SERVICE COST CENTERS 6. 05 03953 MISC ANCI LLARY | 0 | | | | | |
| | | 0 | 0.0000 | | | 76.0 |
| 6. 06 03954 I MAGI NG CENTER | 4, 920, 572 | | | | | 76.0 |
| 6.07 03955 BREAST DIAGNOSTIC CENTER | 7,064,019 | | | | | 76.0 |
| 6. 08 03956 BARI ATRI C CLI NI C | 13, 888 | 67, 545 | 0. 2056 | | | 76. 0 |
| OUTPATIENT SERVICE COST CENTERS | | 0 | 0.0000 | 20 | | |
| 0. 00 09000 CLINIC | 0 | 0 | | | | 90.0 |
| 0. 24 04973 PALLI ATI VE CARE | 0 | 0 | | | | 90.2 |
| 0. 26 04975 SPINE CENTER | 291, 290 | 732, 310 | | | | 90.2 |
| 0. 27 04976 DI ABETI C CARE CENTER | 0 | 0 | 0.0000 | | | 90.2 |
| 1.00 09100 EMERGENCY | 14, 037, 257 | | | | | 91.0 |
| 2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 4, 438, 268 | 22, 810, 177 | 0. 1945 | 74 | | 92.0 |
| SPECIAL PURPOSE COST CENTERS | 1 | | | - | | |
| 13.00 11300 INTEREST EXPENSE | | | | | | 113.0 |
| 00.00 Subtotal (sum of lines 50 thru 199) | 166, 058, 305 | 849, 484, 326 | | | | 200. 0 |
| 01.00 Less Observation Beds | 4, 438, 268 | | | | | 201. 0 |
| 02.00 Total (line 200 minus line 201) | 161, 620, 037 | 849, 484, 326 | | | | 202.0 |

| Health Financial Systems | COMMUNI TY HOSPI TAL | OF INDIANA, IN | NC. | In Lie | u of Form CMS- | 2552-10 |
|---|----------------------|----------------|---------------|---|----------------|----------------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CA | PLTAL COSTS | Provi der | | Period: From 01/01/2014 To 12/31/2014 | | pared: 7 pm |
| | | Ti tl | e XVIII | Hospi tal | PPS | |
| Cost Center Description | Capi tal | Swing Bed | Reduced | Total Patient | Per Diem (col. | |
| | Related Cost | Adjustment | Capi tal | Days | 3 / col. 4) | |
| | (from Wkst. B, | | Related Cost | | | |
| | Part II, col. | | (col. 1 - col | | | |
| | 26) | | 2) | | | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 ADULTS & PEDIATRICS | 5, 479, 518 | 0 | 5, 479, 51 | 8 56, 743 | 96.57 | 30.00 |
| 31.00 INTENSIVE CARE UNIT | 728, 240 | | 728, 24 | 0 5, 161 | 141.10 | 31.00 |
| 35.00 NEONATAL INTENSIVE CARE UNIT | 1, 386, 215 | | 1, 386, 21 | 5 11, 463 | 120. 93 | 35.00 |
| 40.00 SUBPROVIDER - IPF | 309, 603 | 0 | 309, 60 | 3 3, 120 | 99.23 | 40.00 |
| 41.00 SUBPROVIDER - IRF | 0 | 0 | | 0 0 | 0.00 | 41.00 |
| 43.00 NURSERY | 593, 379 | | 593, 37 | 9 7, 861 | 75.48 | 43.00 |
| 200.00 Total (lines 30-199) | 8, 496, 955 | | 8, 496, 95 | 5 84, 348 | | 200.00 |
| Cost Center Description | I npati ent | Inpati ent | | | | |
| | Program days | Program | | | | |
| | | Capital Cost | | | | |
| | | (col. 5 x col. | | | | |
| | | 6) | | | | |
| | 6.00 | 7.00 | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 ADULTS & PEDIATRICS | 18, 408 | 1, 777, 661 | | | | 30.00 |
| 31.00 INTENSIVE CARE UNIT | 2, 140 | 301, 954 | | | | 31.00 |
| 35.00 NEONATAL INTENSIVE CARE UNIT | 0 | 0 | | | | 35.00 |
| 40. 00 SUBPROVIDER - IPF | 2,633 | 261, 273 | | | | 40.00 |
| 41.00 SUBPROVIDER - IRF | 0 | 0 |) | | | 41.00 |
| 43.00 NURSERY | 0 | 0 | | | | 43.00 |
| 200.00 Total (lines 30-199) | 23, 181 | 2, 340, 888 | | | | 200.00 |

| | | JUNI TY HOSPI TAL | | | | u of Form CMS- | 2552-10 |
|-----------|---|-------------------|----------------|-------------|------------------------------|----------------------|---------|
| APPORTI 0 | NMENT OF INPATIENT ANCILLARY SERVICE CAPITA | AL COSTS | Provi der | CCN: 150169 | Peri od: | Worksheet D | |
| | | | | | From 01/01/2014 | Part II | |
| | | | | | To 12/31/2014 | Date/Time Pre | |
| | | | T; +I | Title XVIII | | 5/27/2015 6:0 PPS | n pili |
| | Cost Center Description | Capi tal | Total Charges | | Hospital t Inpatient | Capital Costs | |
| | cost center bescription | | (from Wkst. C, | | | (column 3 x | |
| | | (from Wkst. B, | | | | column 4) | |
| | | Part II, col. | 8) | 2) | i. charges | | |
| | | 26) | 0) | 2) | | | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | NCI LLARY SERVI CE COST CENTERS | 1.00 | 2.00 | 5.00 | 4.00 | 5.00 | |
| | 5000 OPERATING ROOM | 3, 086, 446 | 120, 798, 125 | 0. 0255 | 50 32, 920, 568 | 841, 121 | 50.00 |
| | 5100 RECOVERY ROOM | 3,080,440 | | | | 15, 110 | |
| | 5200 DELIVERY ROOM & LABOR ROOM | | | | | | 1 |
| | | 1, 504, 073 | | | | - | |
| | 5400 RADI OLOGY-DI AGNOSTI C 5500 RADI OLOGY-THERAPEUTI C | 1, 290, 805 | | | | | |
| | | 343, 057 | | | | | |
| | 5700 CT SCAN | 189, 922 | | | | | |
| | 5800 MAGNETIC RESONANCE IMAGING (MRI) | 939, 794 | | | | | |
| | 6000 LABORATORY | 345, 267 | | | | | |
| | 6400 I NTRAVENOUS THERAPY | 31, 555 | | | | | |
| | 6500 RESPI RATORY THERAPY | 487, 909 | | | | | |
| | 6600 PHYSI CAL THERAPY | 411, 682 | 21, 154, 971 | | | 47, 143 | |
| 67.00 06 | 6700 OCCUPATI ONAL THERAPY | 118, 458 | 4, 495, 255 | 0. 0263 | 52 1, 470, 844 | 38, 760 | 67.00 |
| | 6800 SPEECH PATHOLOGY | 27, 134 | 1, 538, 973 | 0. 0176 | 31 387, 887 | 6, 839 | 68.00 |
| 69.00 06 | 6900 ELECTROCARDI OLOGY | 105, 351 | 6, 255, 328 | 0. 0168 | 42 2, 644, 450 | 44, 538 | 69.00 |
| 70.00 07 | 7000 ELECTROENCEPHALOGRAPHY | 213, 306 | 7, 822, 372 | 0. 0272 | 69 443, 307 | 12, 089 | 70.00 |
| 71.00 07 | 7100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 617, 343 | 61, 656, 352 | 0. 0100 | 13 9, 658, 708 | 96, 713 | 71.00 |
| 72.00 07 | 7200 IMPL. DEV. CHARGED TO PATIENTS | 819, 154 | 44, 114, 734 | 0. 0185 | 69 14, 215, 954 | 263, 976 | 72.00 |
| 73.00 07 | 7300 DRUGS CHARGED TO PATIENTS | 1, 151, 729 | 74, 762, 550 | 0. 0154 | 05 25, 726, 533 | 396, 317 | 73.00 |
| 74.00 07 | 7400 RENAL DIALYSIS | 40, 852 | 1, 989, 829 | 0. 0205 | | | 74.00 |
| 76.00 03 | 3330 ENDOSCOPY | 496, 645 | 12, 700, 946 | 0. 0391 | | | 76.00 |
| 76.01 03 | 3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | | | | | 76.01 |
| | 3950 NEUROPSYCHI ATRI C SERVI CES | 0 | 0 | | | 0 | 76.02 |
| | 3951 OTHER ANCILLARY SERVICES | 0 | 0 | | | 0 | 76.03 |
| | 3952 ANCI LLARY SERVICE COST CENTERS | 0 | | | | - | |
| | 3953 MI SC ANCI LLARY | 0 | - | | | 0 | |
| | 3954 I MAGI NG CENTER | 896, 493 | | 1 | | | |
| | 3955 BREAST DIAGNOSTIC CENTER | 386, 269 | | | | | |
| | 3956 BARIATRIC CLINIC | 666 | | | | | |
| | JTPATIENT SERVICE COST CENTERS | 000 | 07, 545 | 0.0098 | 00 0 | 0 | 70.00 |
| | 9000 CLINIC | 0 | C | 0.0000 | 0 00 | 0 | 90.00 |
| | 4973 PALLI ATI VE CARE | | | | | | |
| | | - | | | | | |
| | 4975 SPINE CENTER | 13, 804 | | | | | |
| | 4976 DIABETIC CARE CENTER | 0 | | | | 0 | |
| | 9100 EMERGENCY | 1, 163, 817 | | | | | |
| 92.00 09 | 9200 OBSERVATION BEDS (NON-DISTINCT PART) Total (lines 50-199) | 482, 258 | | | 42 582, 622 152, 638, 663 | | |
| 200.00 | | | | | | | |

| Health Financial Systems C | OMMUNI TY HOSPI TAL | OF INDIANA, II | NC. | In Lie | eu of Form CMS- | 2552-10 |
|--|---------------------|----------------|---------------|---|-----------------|------------------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER | PASS THROUGH COS | | <u> </u> | Period: From 01/01/2014 To 12/31/2014 | | epared:)7 pm |
| | | Ti tl | e XVIII | Hospi tal | PPS | |
| Cost Center Description | Nursing School | Allied Health | All Other | Swing-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 | C | 0 |) (| 0 0 | 0 | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | C | 0 | | 0 | 0 | 31.00 |
| 35.00 02060 NEONATAL INTENSIVE CARE UNIT | C | c c | | 0 | 0 | 35.00 |
| 40. 00 04000 SUBPROVIDER - IPF | C | o c | | 0 0 | 0 | 40.00 |
| 41.00 04100 SUBPROVIDER - IRF | C | o c | | 0 0 | 0 | 41.00 |
| 43.00 04300 NURSERY | C | | | 0 | l o | 43.00 |
| 200.00 Total (lines 30-199) | C | | | 0 | 0 | 200.00 |
| Cost Center Description | Total Patient | Per Diem (col. | Inpati ent | 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 & PEDI ATRI CS | 56, 743 | 0.00 | 18, 40 | 8 0 | | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | 5, 161 | 0.00 | 2, 14 | 0 0 | | 31.00 |
| 35.00 02060 NEONATAL INTENSIVE CARE UNIT | 11, 463 | | | 0 0 | | 35.00 |
| 40. 00 04000 SUBPROVIDER - IPF | 3, 120 | | | 3 0 | | 40.00 |
| 41. 00 04100 SUBPROVIDER - IRF | C | | | 0 0 | | 41.00 |
| 43. 00 04300 NURSERY | 7,861 | | | 0 0 | | 43.00 |
| 200.00 Total (lines 30-199) | 84, 348 | | 23, 18 | 1 0 | | 200.00 |
| | | Т | 20,10 | | 1 | |

| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 150169 Period: From 01/01/2014 Worksheet D From 01/01/2014 THROUGH COSTS Title XVIII Hospital PPS Cost Center Description Non Physician Anesthetist Cost Nursing School AIIIed Health AIIOHER Medical Education Cost Morksheet D Hospital ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 50.00 05000 QPERATING ROOM 0 <t< th=""><th>552-10</th></t<> | 552-10 |
|--|--------|
| Interview To 12/31/2014 Date/Time Prepside Title XVIII Hospital PPS Cost Cost Cost All lied Health All Other Medical Education Cost Total Cost (sum of col 1 50.00 | |
| Cost Center Description Non Physician Anesthetist Cost Nursing School Allied Health Cost All Other Medical clucation Cost Total Cost (sum of col 1 4) ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 S0.00 05000 PERATING ROOM 0 0 0 0 0 0 50.00 05000 PERATING ROOM 0 | |
| Cost Center Description Non Physical an Nursing School All i de Walth Hospital Ford Cost (sum of col 1 through col.) ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 50.00 05100 (RECOVERY ROOM 0 | ared: |
| Cost Center Description Non Physician Anesthetist Cost Nursing School Allied Health Education Cost Allied Health Medical Education Cost Allied Health Medical Education Cost ANCILLARY SERVICE COST CENTERS 0 | рш |
| Anesthetist Cost Anesthetist Cost Medical Education Cost (sum of col 1 through col.) 4) 50.00 05000 OPERATI NG ROOM 0 | |
| Image: And Links Service Cost Centers Cost Education Cost through col. ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 OPERATING ROOM 0 | |
| ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 OPERATI NG ROOM 0 < | |
| Inclusion Inclusion <t< td=""><td></td></t<> | |
| ANCI LLARY SERVI CE COST CENTERS 50.00 05000 OPERATI NG ROOM 0 | |
| 50.00 05000 0PERATI NG ROOM 0 | |
| 51.00 05100 RECOVERY ROOM 0 0 0 0 0 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 55.00 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 57.00 05700 CT SCAN 0< | |
| 54.00 05400 RADI 0LOGY-DI AGNOSTI C 0 11,006 0 11,006 55.00 05500 RADI 0LOGY-THERAPEUTI C 0 0 0 0 57.00 05700 CT SCAN 0 | 51.00 |
| 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 57.00 05700 CT SCAN 0 0 0 0 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 60.00 CABORATORY 0 0 0 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 66.00 PHYSI CAL THERAPY 0 | 52.00 |
| 57.00 05700 CT SCAN 0 0 0 0 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 60.00 0.6000 LABORATORY 0 0 0 0 0 64.00 0.6400 INTRAVENOUS THERAPY 0 0 0 0 0 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 0 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 | 54.00 |
| 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 60.00 06000 LABORATORY 0 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 0 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 70.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 55.00 |
| 60.00 06000 LABORATORY 0 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 66.00 06600 PHYSI CAL THERAPY 0 | 57.00 |
| 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 0 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 67.00 06700 0CUPATI ONAL THERAPY 0 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 | 58.00 |
| 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 </td <td>60.00</td> | 60.00 |
| 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 <t< td=""><td>64.00</td></t<> | 64.00 |
| 67.00 06700 0CCUPATIONAL THERAPY 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 < | 65.00 |
| 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 | 66.00 |
| 69.00 06900 ELECTROCARDI OLOGY 0 </td <td>67.00</td> | 67.00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 | 68.00 |
| 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 74.00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 74.00 07400 RENAL DI ALYSI S 0 <t< td=""><td>69.00</td></t<> | 69.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 650, 763 0 650, 763 0 | 70.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS 0 650, 763 0 650, 763 74.00 07400 RENAL DI ALYSI S 0 < | 71.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS 0 650, 763 0 650, 763 74.00 07400 RENAL DI ALYSI S 0 < | 72.00 |
| 74.00 07400 RENAL DI ALYSI S 0 <td>73.00</td> | 73.00 |
| 76.00 03330 ENDOSCOPY 0 | 74.00 |
| 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 | 76.00 |
| 76. 02 03950 NEUROPSYCHI ATRI C SERVI CES 0 | 76.01 |
| 76. 03 03951 OTHER ANCI LLARY SERVICES 0 | 76.02 |
| 76.04 03952 ANCI LLARY SERVICE COST CENTERS 0 | 76.02 |
| 76. 05 03953 MISC ANCILLARY 0 0 0 0 0 | 76.03 |
| | 76.04 |
| | 76.05 |
| 76.06 03954 I MAGI NG CENTER 0 0 0 0 0 0 | |
| | 76.07 |
| 76. 08 03956 BARI ATRI C CLI NI C 0 0 0 0 0 | 76.08 |
| OUTPATIENT SERVICE COST CENTERS | ~~ ~~ |
| | 90.00 |
| 90. 24 04973 PALLI ATI VE CARE 0 0 0 0 0 0 | 90.24 |
| 90. 26 04975 SPINE CENTER 0 0 0 0 0 | 90.26 |
| 90. 27 04976 DI ABETI C CARE CENTER 0 0 0 0 0 | 90.27 |
| 91. 00 09100 EMERGENCY 0 157, 280 0 157, 280 | 91.00 |
| 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 | 92.00 |
| 200.00 Total (lines 50-199) 0 819,049 0 819,049 | 200.00 |

| | UNITY HOSPITAL | | VC. | In Lie | eu of Form CMS-: | 2552-10 |
|---|-----------------|----------------|---------------------|---|--------------------------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF | RVICE OTHER PAS | S Provi der | | Period: | Worksheet D | |
| THROUGH COSTS | | | | From 01/01/2014 | Part IV | |
| | | | | To 12/31/2014 | Date/Time Pre 5/27/2015 6:0 | |
| | | Ti +I | e XVIII | Hospi tal | PPS | 7 pili |
| Cost Center Description | Total | Total Charges | | | Inpatient | |
| cost center bescription | Outpatient | (from Wkst. C, | | Ratio of Cost | Program | |
| | Cost (sum of | | $(col. 5 \div col.$ | to Charges | Charges | |
| | col . 2, 3 and | 8) | 7) | $(col. 6 \div col.$ | l ondriges | |
| | 4) | | | 7) | | |
| | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| ANCI LLARY SERVI CE COST CENTERS | 0.00 | 1.00 | 0.00 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 10100 | |
| 50. 00 05000 OPERATING ROOM | 0 | 120, 798, 125 | 0,00000 | 0. 000000 | 32, 920, 568 | 50.00 |
| 51. 00 05100 RECOVERY ROOM | 0 | | | | | 51.00 |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM | 0 | | | | 0 | 52.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 11,006 | | | | 4, 265, 813 | |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0 | | | | 3, 258, 618 | |
| 57. 00 05700 CT SCAN | | | | | | • |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) | | | | | 2, 159, 260 | • |
| 60. 00 06000 LABORATORY | | | | | | • |
| 64. 00 06400 INTRAVENOUS THERAPY | | | | | 493, 970 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | | ., | | | | |
| 66. 00 06600 PHYSI CAL THERAPY | | | | | 2, 422, 547 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | | | | | 1, 470, 844 | 67.00 |
| | | .,, | | | | • |
| 68. 00 06800 SPEECH PATHOLOGY | - | ., | | | | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | | | | | • |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 0 | | | | 443, 307 | 70.00 |
| 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS | 0 | | | | | |
| 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS | 0 | | | | | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 650, 763 | | | | 25, 726, 533 | |
| 74.00 07400 RENAL DIALYSIS | 0 | | | | 1, 073, 535 | |
| 76. 00 03330 ENDOSCOPY | 0 | | | | 1, 237, 653 | |
| 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | | 0.00000 | | 0 | 76.01 |
| 76. 02 03950 NEUROPSYCHI ATRI C SERVI CES | 0 | - | 0.00000 | | 0 | 76.02 |
| 76.03 03951 OTHER ANCI LLARY SERVICES | 0 | - | 0.00000 | | 0 | 76.03 |
| 76.04 03952 ANCILLARY SERVICE COST CENTERS | 0 | - | 0.00000 | | 0 | 76.04 |
| 76. 05 03953 MISC ANCI LLARY | 0 | | 0.00000 | | 0 | 76.05 |
| 76. 06 03954 I MAGI NG CENTER | 0 | | | | | 76.06 |
| 76. 07 03955 BREAST DIAGNOSTIC CENTER | 0 | | | | | 76.07 |
| 76.08 03956 BARIATRIC CLINIC | 0 | 67, 545 | 0.00000 | 0.00000 | 0 | 76.08 |
| OUTPATIENT SERVICE COST CENTERS | - | | | | | |
| 90. 00 09000 CLI NI C | 0 | C | | | 0 | 90.00 |
| 90. 24 04973 PALLI ATI VE CARE | 0 | C | 0.00000 | 0. 000000 | 0 | 90.24 |
| 90. 26 04975 SPI NE CENTER | 0 | 732, 310 | 0.00000 | 0. 000000 | 0 | 90.26 |
| 90. 27 04976 DIABETIC CARE CENTER | 0 | C | 0. 000000 | 0. 000000 | 0 | 90. 27 |
| 91.00 09100 EMERGENCY | 157, 280 | 113, 172, 177 | 0. 001390 | 0. 001390 | 11, 237, 413 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | | | 0. 000000 | 582, 622 | 92.00 |
| 200.00 Total (lines 50-199) | 819, 049 | 849, 484, 326 | | | 152, 638, 663 | 200.00 |
| • | | | | | - | |

| ADDODT | | | OF INDIANA, IN | | Daue! a | | u of Form CMS | -2552-10 |
|--------|--|------------------|----------------|-------------|---------------|------------------|------------------------|----------|
| | IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS | RVICE UTHER PASS | Provi der | CCN: 150169 | Perio From | a: 01/01/2014 | Worksheet D Part IV | |
| TIKUUG | 1 (0313 | | | | | 12/31/2014 | Date/Time Pr | |
| | | | | | | | 5/27/2015 6: | 07 pm |
| | | | | e XVIII | | ospi tal | PPS | _ |
| | Cost Center Description | I npati ent | Outpati ent | Outpati ent | | | | |
| | | Program | Program | Program | | | | |
| | | Pass-Through | Charges | Pass-Throug | | | | |
| | | Costs (col. 8 | | Costs (col. | 9 | | | |
| | | x col. 10) | 40.00 | x col. 12) | | | | |
| | | 11.00 | 12.00 | 13.00 | | | | |
| | ANCI LLARY SERVICE COST CENTERS | | | | 0 | | | - 50.00 |
| | 05000 OPERATING ROOM | 0 | 7, 974, 417 | | 0 | | | 50.00 |
| | 05100 RECOVERY ROOM | 0 | 790, 811 | | 0 | | | 51.00 |
| | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | | 0 | | | 52.00 |
| | 05400 RADI OLOGY-DI AGNOSTI C | 1, 382 | 4, 569, 845 | 1, 4 | | | | 54.00 |
| | 05500 RADI OLOGY-THERAPEUTI C | 0 | 4, 108, 541 | | 0 | | | 55.00 |
| | 05700 CT SCAN | 0 | 7, 720, 002 | | 0 | | | 57.00 |
| | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | 3, 421, 072 | | 0 | | | 58.00 |
| | 06000 LABORATORY | 0 | 5, 988, 637 | | 0 | | | 60.00 |
| | 06400 I NTRAVENOUS THERAPY | 0 | 46, 130 | | 0 | | | 64.00 |
| | 06500 RESPI RATORY THERAPY | 0 | 1, 646, 274 | | 0 | | | 65.00 |
| | 06600 PHYSI CAL THERAPY | 0 | 0 | | 0 | | | 66.00 |
| | 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | 0 | | | 67.00 |
| 68.00 | 06800 SPEECH PATHOLOGY | 0 | 0 | | 0 | | | 68.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0 | 247, 300 | | 0 | | | 69.00 |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 0 | 1, 132, 840 | | 0 | | | 70.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 384, 401 | | 0 | | | 71.00 |
| | 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 765, 300 | | 0 | | | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 223, 924 | 4, 483, 982 | 39, 0 | 29 | | | 73.00 |
| 74.00 | 07400 RENAL DIALYSIS | 0 | 0 | | 0 | | | 74.00 |
| 76.00 | 03330 ENDOSCOPY | 0 | 3, 775, 446 | | 0 | | | 76.00 |
| 76.01 | 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | 0 | | 0 | | | 76.01 |
| 76. 02 | 03950 NEUROPSYCHI ATRI C SERVI CES | 0 | 0 | | 0 | | | 76. 02 |
| | 03951 OTHER ANCI LLARY SERVICES | 0 | 0 | | 0 | | | 76.03 |
| | 03952 ANCI LLARY SERVICE COST CENTERS | 0 | 0 | | 0 | | | 76.04 |
| | 03953 MI SC ANCI LLARY | 0 | 0 | | 0 | | | 76.05 |
| | 03954 I MAGI NG CENTER | 0 | 9, 893, 643 | | 0 | | | 76.06 |
| | 03955 BREAST DI AGNOSTI C CENTER | 0 | 661, 359 | | 0 | | | 76.07 |
| | 03956 BARI ATRI C CLI NI C | 0 | 0 | | 0 | | | 76.08 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 90.00 | 09000 CLINIC | 0 | 0 | | 0 | | | 90.00 |
| | 04973 PALLIATIVE CARE | 0 | 0 | | 0 | | | 90.24 |
| | 04975 SPINE CENTER | 0 | 0 | | 0 | | | 90.26 |
| | 04976 DI ABETI C CARE CENTER | 0 | 0 | | 0 | | | 90.27 |
| | 09100 EMERGENCY | 15,620 | 12, 531, 552 | 17, 4 | - | | | 91.00 |
| | | 13, 020 | 1, 968, 252 | | 0 | | | 92.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | | |

| APPORTI ONME | INT OF MEDICAL, OTHER HEALTH SERVICES ANI | O VACCINE COST | Provi der | CCN: 150169 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Pre 5/27/2015 6:0 | pared: 7 pm |
|--------------|---|----------------|----------------|--------------|---|---|----------------|
| | | | Titl | e XVIII | Hospi tal | PPS | |
| | | | | Charges | | Costs | |
| | Cost Center Description | | PPS Reimbursed | | Cost | PPS Services | |
| | | Ratio From | Services (see | Reimbursed | Reimbursed | (see inst.) | |
| | | Worksheet C, | inst.) | Servi ces | Services Not | | |
| | | Part I, col. 9 | | Subject To | | | |
| | | | | Ded. & Coins | | | |
| | | 1.00 | 0.00 | (see inst.) | | | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | LARY SERVICE COST CENTERS | 0. 171278 | 7 074 417 | 1 | 0 0 | 1 245 042 | 50.00 |
| | | | | | | 1, 365, 842 | |
| | D RECOVERY ROOM | 0. 167201 | | | 0 0 | 132, 224 | |
| | D DELIVERY ROOM & LABOR ROOM | 0. 500242 | | | | 1 040 050 | |
| | D RADI OLOGY-DI AGNOSTI C | 0. 229758 | | | | 1, 049, 958 | |
| | D RADI OLOGY-THERAPEUTI C | 0. 116659 | | | | 479, 298 | |
| | D CT SCAN | 0. 045902 | | | 0 0 | 354, 364 | |
| | D MAGNETIC RESONANCE IMAGING (MRI) | 0. 228599 | | | 0 0 | 782, 054 | |
| | | 0. 064492 | | | 41 0 | 386, 219 | |
| | DINTRAVENOUS THERAPY | 0. 388654 | | | 0 0 | 17, 929 | |
| | D RESPI RATORY THERAPY | 0. 188835 | | | 0 0 | 310, 874 | |
| | D PHYSI CAL THERAPY | 0. 345856 | | | 0 0 | 0 | |
| | O OCCUPATI ONAL THERAPY | 0. 449274 | | | 0 0 | 0 | |
| | D SPEECH PATHOLOGY | 0. 300766 | | | 0 0 | 0 | |
| | D ELECTROCARDI OLOGY | 0. 305432 | | | 0 0 | 75, 533 | 1 |
| | D ELECTROENCEPHALOGRAPHY | 0. 278754 | | | 0 0 | 315, 784 | 1 |
| | D MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 218573 | | | 0 0 | 84, 020 | 1 |
| | DIMPL. DEV. CHARGED TO PATIENTS | 0. 405593 | | | 0 0 | 310, 400 | |
| | D DRUGS CHARGED TO PATIENTS | 0. 253272 | | | 0 111, 506 | 1, 135, 667 | |
| | D RENAL DI ALYSI S | 0. 419050 | | | 0 0 | 0 | 1 |
| | DENDOSCOPY | 0. 212840 | | | 0 0 | 803, 566 | |
| | D PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0. 000000 | | | 0 0 | 0 | |
| | D NEUROPSYCHI ATRI C SERVI CES | 0. 000000 | | | 0 0 | 0 | |
| | 1 OTHER ANCI LLARY SERVICES | 0. 000000 | | | 0 0 | 0 | |
| | 2 ANCILLARY SERVICE COST CENTERS | 0. 000000 | | | 0 0 | 0 | |
| | 3 MI SC ANCI LLARY | 0. 000000 | | | 0 0 | 0 | |
| | 4 I MAGI NG CENTER | 0. 105641 | | | 0 0 | 1, 045, 174 | |
| | 5 BREAST DI AGNOSTI C CENTER | 0. 650225 | | | 0 0 | 430, 032 | |
| | | 0. 205611 | 0 | | 0 0 | 0 | 76.08 |
| | ATIENT SERVICE COST CENTERS | 0. 000000 | 0 | | 0 0 | 0 | 00.00 |
| | | | | | - | | |
| | 3 PALLIATIVE CARE | 0.00000 | | | 0 0 | 0 | |
| | 5 SPINE CENTER | 0. 397769 | | | 0 0 | 0 | |
| | 6 DI ABETI C CARE CENTER | 0. 000000 | | | 0 0 | 0 | |
| | D EMERGENCY | 0. 124035 | | | 0 0 | 1, 554, 351 | |
| | DOBSERVATION BEDS (NON-DISTINCT PART) | 0. 194574 | | | 0 0 | 382, 971 | |
| 200.00 | Subtotal (see instructions) | | 72, 109, 804 | 3 | 41 111, 506 | 11, 016, 260 | |
| 201.00 | Less PBP Clinic Lab. Services-Program Only Charges | | | | 0 0 | | 201.00 |
| | | | | | | | |
| 202.00 | Net Charges (line 200 +/- line 201) | | 72, 109, 804 | | 41 111, 506 | 11, 016, 260 | 202 00 |

| APPORTIONMENT OF MEDICAL, OTHER HEALTH S | ERVICES AND VACCINE COST | Provi der | CCN: 150169 | Peri od: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Pre 5/27/2015 6:0 | epared: D7 pm |
|---|--|--|-------------|--|---|------------------|
| | | Ti tl | e XVIII | Hospi tal | PPS | |
| | | sts | | | | |
| Cost Center Description | Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00 | Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00 | - | | | |
| ANCI LLARY SERVICE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | | D C | | | | 50.00 |
| 51.00 05100 RECOVERY ROOM | | D C | | | | 51.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | | D C | 1 | | | 52.00 |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C | |) C | | | | 54.00 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | | D C | | | | 55.00 |
| 57.00 05700 CT SCAN | | | 1 | | | 57.00 |
| 58.00 05800 MAGNETIC RESONANCE I MAGING (| | | 1 | | | 58.00 |
| | 22 | | 1 | | | 60.00 |
| 64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY | | | • | | | 64.00 65.00 |
| 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY | | | 1 | | | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | | | • | | | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | | | 1 | | | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | | | | | | 69.00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | | | | | | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO | PATI ENTS (| ol c | | | | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIEN | TS | o c | | | | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | (| 28, 241 | | | | 73.00 |
| 74.00 07400 RENAL DIALYSIS | (|) C | | | | 74.00 |
| 76.00 03330 ENDOSCOPY | | o C | 1 | | | 76.00 |
| 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SE | |) C | | | | 76.01 |
| 76. 02 03950 NEUROPSYCHI ATRI C SERVI CES | | | | | | 76.02 |
| 76. 03 03951 OTHER ANCI LLARY SERVICES | | | | | | 76.03 |
| 76.04 03952 ANCI LLARY SERVICE COST CENTE | | | | | | 76.04 |
| 76. 05 03953 MI SC ANCI LLARY 76. 06 03954 I MAGI NG CENTER | | | | | | 76.05 |
| 76. 07 03955 BREAST DIAGNOSTIC CENTER | | | | | | 76.06 |
| 76. 08 03956 BARI ATRI C CLI NI C | | | | | | 76.08 |
| OUTPATIENT SERVICE COST CENTERS | | | 1 | | | /0.00 |
| 90. 00 09000 CLINIC | (| | | | | 90.00 |
| 90. 24 04973 PALLIATIVE CARE | | | 1 | | | 90.24 |
| 90. 26 04975 SPI NE CENTER | | | | | | 90.26 |
| 90. 27 04976 DIABETIC CARE CENTER | | o c | | | | 90.27 |
| 91.00 09100 EMERGENCY | (| o c | | | | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTIN | CT PART) (| | | | | 92.00 |
| 200.00 Subtotal (see instructions) | 22 | | | | | 200.00 |
| 201.00 Less PBP Clinic Lab. Service | s-Program (| ו | | | | 201.00 |
| Only Charges | | | | | | |

| Cost Center Description Capital Related Cost (from Wkst. B, Part I, col. 26) Total Charges (from Wkst. C, Part I, col. 26) Ratio of Cost to Charges 2) Inpatient Program (col um Charges 2) Capital Copital Col um Charges 2) Capital Copital Col um Charges 2) Capital Col um Charges 2) Capital Col um Charges 2) Capital Copital Charges 2) ANCI LLARY SERVICE COST CENTERS Cost Cost Cost Cost Cost Cost Cost Cost | Prepare 6:07 pr PS sts x | pm |
|--|--------------------------------------|--------|
| Title XVIII Subprovider - IPF Cost Center Description Capital Related Cost (from Wkst. B, Part II, col. 26) Total Charges (from Wkst. C, 8) Ratio of Cost to Charges Inpatient Program Capital C (col um second col um | PS Ists X | |
| ANCI LLARY SERVICE COST CENTERS Rel ated Cost (from Wkst. C, from Wkst. C, | x | |
| ANCI LLARY SERVICE COST CENTERS Generation 3,086,446 120,798,125 0.025550 65,088 1 50.00 05000 0PERATI NG ROOM 3,086,446 120,798,125 0.025550 65,088 1 | | |
| Part II, col. 8) 2) 26) 1.00 2.00 3.00 4.00 5.00 50.00 05000 0PERATING ROOM 3,086,446 120,798,125 0.025550 65,088 1 51.00 05100 RECOVERY ROOM 398,675 24,963,444 0.015970 50,730 | .) | |
| 26) 1 26) 1 26) 1 26) 1 26) 1 26) 1 26) 1 26) 1 200 3 00 4 00 5 00 50.00 05000 0PERATI NG ROOM 3,086,446 120,798,125 0.025550 65,088 1 51.00 05100 RECOVERY ROOM 398,675 24,963,444 0.015970 50,730 1 | | |
| I.00 2.00 3.00 4.00 5.00 ANCI LLARY SERVICE COST CENTERS 50.00 05000 0PERATI NG ROOM 3,086,446 120,798,125 0.025550 65,088 1 51.00 05100 RECOVERY ROOM 398,675 24,963,444 0.015970 50,730 | | |
| ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM 3, 086, 446 120, 798, 125 0. 025550 65, 088 1 51. 00 05100 RECOVERY ROOM 398, 675 24, 963, 444 0. 015970 50, 730 | | |
| 50. 00 05000 0PERATI NG ROOM 3, 086, 446 120, 798, 125 0. 025550 65, 088 1 51. 00 05100 RECOVERY ROOM 398, 675 24, 963, 444 0. 015970 50, 730 | | |
| 51. 00 05100 RECOVERY ROOM 398, 675 24, 963, 444 0. 015970 50, 730 | 663 50 | 50.00 |
| | | 51. OC |
| | | 52. OC |
| | | 54. OC |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C 343, 057 15, 037, 761 0. 022813 0 | | 55. OC |
| 57. 00 05700 CT SCAN 189, 922 55, 295, 989 0. 003435 76, 219 | | 57. OC |
| 58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 939, 794 26, 245, 650 0. 035808 10, 389 | | 58. OC |
| | | 50. OC |
| 64. 00 06400 NTRAVENOUS THERAPY 31, 555 1, 364, 945 0. 023118 20, 216 | | 64. OC |
| 65. 00 06500 RESPI RATORY THERAPY 487, 909 28, 306, 065 0. 017237 39, 091 | | 65. OC |
| | | 66. OC |
| | | 67. OC |
| 68. 00 06800 SPEECH PATHOLOGY 27, 134 1, 538, 973 0. 017631 10, 512 | | 68. OC |
| 69. 00 06900 ELECTROCARDI 0LOGY 105, 351 6, 255, 328 0. 016842 13, 440 | | 69. OC |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY 213, 306 7, 822, 372 0. 027269 10, 304 | | 70.00 |
| 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 617, 343 61, 656, 352 0. 010013 29, 559 | | 71.00 |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 819, 154 44, 114, 734 0. 018569 0 | 0 72 | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS 1, 151, 729 74, 762, 550 0. 015405 905, 247 13 | 945 73 | 73.00 |
| 74. 00 07400 RENAL DI ALYSI S 40, 852 1, 989, 829 0. 020530 0 | 0 74 | 74.OC |
| 76. 00 03330 ENDOSCOPY 496, 645 12, 700, 946 0. 039103 0 | 0 76 | 76. OC |
| 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0.000000 0 | 0 76 | 76. 01 |
| 76. 02 03950 NEUROPSYCHI ATRI C SERVI CES 0 0 0.000000 0 | 0 76 | 76. 02 |
| 76. 03 03951 OTHER ANCI LLARY SERVICES 0 0 0.000000 0 | 0 76 | 76.03 |
| 76. 04 03952 ANCI LLARY SERVICE COST CENTERS 0 0 0.000000 0 | 0 76 | 76.04 |
| 76. 05 03953 MISC ANCI LLARY 0 0 0.000000 0 | 0 76 | 76.05 |
| 76. 06 03954 I MAGI NG CENTER 896, 493 46, 578, 034 0. 019247 0 | 0 76 | 76.06 |
| 76. 07 03955 BREAST DI AGNOSTI C CENTER 386, 269 10, 863, 967 0. 035555 0 | 0 76 | 76.07 |
| 76. 08 03956 BARI ATRI C CLINI C 666 67, 545 0. 009860 0 | 0 76 | 76.08 |
| OUTPATIENT SERVICE COST CENTERS | | |
| 90.00 09000 CLINIC 0 0 0.000000 0 | | 90. OC |
| 90. 24 04973 PALLI ATI VE CARE 0 0 0. 00000 0 | | 90.24 |
| 90. 26 04975 SPI NE CENTER 13, 804 732, 310 0. 018850 0 | | 90.26 |
| 90. 27 04976 DI ABETI C CARE CENTER 0 0 0.000000 0 | | 90.27 |
| | | 91. OC |
| 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 22, 810, 177 0. 000000 0 | | 92.00 |
| 200. 00 Total (lines 50-199) 15,080,206 849,484,326 2,269,783 28 | , 761 200 | JU. UC |

| | MUNI TY HOSPI TAL | | | | u of Form CMS- | 2552-10 |
|--|-------------------|----------------|--------------|----------------------------|------------------------|-----------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE | RVICE OTHER PASS | Provi der | CCN: 150169 | Period: From 01/01/2014 | Worksheet D Part IV | |
| THROUGH COSTS | | Component | | To 12/31/2014 | | |
| | | Ti tl | e XVIII | Subprovider - IPF | PPS | |
| Cost Center Description | Non Physician | Nursing School | Allied Healt | n 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 | |
| ANCI LLARY SERVI CE COST CENTERS | | | | 0 | | 50.00 |
| 50. 00 05000 OPERATING ROOM | 0 | 0 | | 0 0 | 0 | |
| 51.00 O5100 RECOVERY ROOM | 0 | 0 | | 0 0 | 0 | |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | 11.00 | 0 0 | 0 | |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | 11, 00 | 6 0 | 11, 006 | 1 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0 | 0 | | 0 0 | 0 | |
| 57. 00 05700 CT SCAN | 0 | 0 | | 0 0 | 0 | |
| 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) | 0 | 0 | | 0 0 | 0 | |
| 60. 00 06000 LABORATORY | 0 | 0 | | 0 0 | 0 | |
| 64. 00 06400 I NTRAVENOUS THERAPY | 0 | 0 | | 0 0 | 0 | 000 |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 0 | | 0 0 | 0 | |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 0 | | 0 0 | 0 | |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | 0 0 | 0 | |
| 68. 00 06800 SPEECH PATHOLOGY | 0 | 0 | | 0 0 | 0 | 00.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 0 | 0 | |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | | 0 0 | 0 | |
| 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS | 0 | 0 | | 0 0 | 0 | |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS | 0 | 0 | (50.7/ | 0 0 | 0 | |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 650, 76 | | 650, 763 | |
| 74. 00 07400 RENAL DI ALYSI S | 0 | 0 | | 0 0 | 0 | |
| 76. 00 03330 ENDOSCOPY | 0 | 0 | | 0 0 | 0 | |
| 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 02 03950 NEUROPSYCHI ATRI C SERVI CES | 0 | 0 | | 0 0 | 0 | 1 1 01 01 |
| | 0 | 0 | | 0 0 | 0 | |
| | 0 | 0 | | 0 0 | | |
| 76. 04 03952 ANCI LLARY SERVICE COST CENTERS | 0 | 0 | | 0 0 | 0 | |
| 76. 05 03953 MISC ANCILLARY 76. 06 03954 I MAGI NG CENTER | 0 | 0 | | 0 0 | 0 | |
| | 0 | 0 | | 0 0 | | 1 |
| 76. 07 03955 BREAST DI AGNOSTI C CENTER 76. 08 03956 BARI ATRI C CLINI C | 0 | 0 | | 0 0 | - | 1 |
| OUTPATIENT SERVICE COST CENTERS | 0 | 0 | I | 0 0 | 0 | 70.00 |
| 90. 00 09000 CLINIC | 0 | 0 | | 0 0 | 0 | 90.00 |
| 90. 24 04973 PALLI ATI VE CARE | 0 | 0 | | 0 0 | | |
| 90. 26 04975 SPINE CENTER | 0 | 0 | | 0 0 | | |
| 90. 27 04976 DI ABETI C CARE CENTER | 0 | 0 | | 0 0 | 0 | 1 |
| 91. 00 09100 EMERGENCY | 0 | 0 | 157, 28 | | 157, 280 | |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | 137,20 | | 0 | 1 |
| 200.00 Total (lines 50-199) | 0 | 0 | 819, 04 | 0 0 | | 1 |
| 200.00 [10tal (11163 30-177) | ı V | 0 | I 017, 04 | 0 | 1 017,049 | 1200.00 |

| Health Financial Systems COM | MUNITY HOSPITAL | OF INDIANA, II | NC. | In Lie | u of Form CMS-: | 2552-10 |
|--|-----------------|----------------|---------------|----------------------------------|---|----------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE | RVICE OTHER PAS | S Provi der | | Peri od: | Worksheet D | |
| THROUGH COSTS | | Componen | | From 01/01/2014 To 12/31/2014 | Part IV Date/Time Pre 5/27/2015 6:0 | |
| | | Ti tl | e XVIII | Subprovider - IPF | PPS | |
| Cost Center Description | Total | Total Charges | Ratio of Cos | t Outpatient | Inpati ent | |
| | Outpati ent | (from Wkst. C, | to Charges | Ratio of Cost | Program | |
| | Cost (sum of | | (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 | |
| ANCI LLARY SERVI CE COST CENTERS | - | | | | | |
| 50.00 05000 OPERATI NG ROOM | 0 | | | | 65, 088 | |
| 51.00 05100 RECOVERY ROOM | 0 | | | | 50, 730 | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | | | | 0 | 52.00 |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C | 11,006 | | | | 41, 854 | |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0 | | | | 0 | 55.00 |
| 57.00 05700 CT SCAN | 0 | | | | 76, 219 | |
| 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) | 0 | | | | 10, 389 | |
| 60. 00 06000 LABORATORY | 0 | | | | 637, 293 | |
| 64. 00 06400 I NTRAVENOUS THERAPY | 0 | ., | | | 20, 216 | |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | | | | 39, 091 | |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | | | | 92, 353 | |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0 | ., | | | 55, 968 | |
| 68.00 06800 SPEECH PATHOLOGY | 0 | | | | 10, 512 | |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | | | | 13, 440 | |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 0 | | | | 10, 304 | |
| 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS | 0 | | | | 29, 559 | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | | | | 0 | |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 650, 763 | | | | 905, 247 | 73.00 |
| 74. 00 07400 RENAL DI ALYSI S | 0 | | | | 0 | |
| 76. 00 03330 ENDOSCOPY | 0 | | | | 0 | |
| 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | | | | 0 | |
| 76. 02 03950 NEUROPSYCHI ATRI C SERVI CES 76. 03 03951 OTHER ANCI LLARY SERVI CES | 0 | | | | 0 | |
| | | - | | | - | |
| 76. 04 03952 ANCI LLARY SERVI CE COST CENTERS 76. 05 03953 MI SC ANCI LLARY | | | | | 0 | |
| | 0 | | | | 0 | |
| 76. 06 03954 I MAGI NG CENTER | 0 | | | | | |
| 76. 07 03955 BREAST DI AGNOSTI C CENTER | 0 | | | | 0 | |
| 76. 08 03956 BARI ATRI C CLI NI C | 0 | 67, 545 | 0.00000 | 0.00000 | 0 | 76.08 |
| | | | 0,00000 | 0 000000 | 0 | |
| 90. 00 09000 CLINIC 90. 24 04973 PALLIATIVE CARE | 0 | | | | 0 | |
| | 0 | | | | 0 | |
| 90. 26 04975 SPINE CENTER | 0 | | | | 0 | |
| 90. 27 04976 DI ABETI C CARE CENTER 91. 00 09100 EMERGENCY | - | - | | | | |
| 91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 157, 280 | | | | 211, 520 0 | |
| 200.00 Total (lines 50-199) | 819,049 | | | 0.00000 | 2, 269, 783 | |
| 200.00 10tal (11165 30-199) | 019,049 | 047,404,320 | 'I | I | 2,207,183 | I200. 00 |

| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY | SERVICE OTHER PASS | 6 Provi der | CCN: 150169 | Period: From 01/01/2014 | Worksheet D Part IV | |
|--|---------------------|-------------|---------------------|----------------------------|------------------------------|--------|
| THROUGH COSTS | | Componen | t CCN: 15S169 | | Date/Time Pr 5/27/2015 6: | |
| | | Ti tl | e XVIII | Subprovider - IPF | PPS | · |
| Cost Center Description | I npati ent | Outpati ent | Outpati ent | | | |
| | Program | Program | Program | | | |
| | Pass-Through | Charges | Pass-Throug | | | |
| | Costs (col. 8 | | Costs (col. | | | |
| | x col. 10) 11.00 | 12.00 | x col. 12) 13.00 | | | |
| ANCI LLARY SERVI CE COST CENTERS | 11.00 | 12.00 | 13.00 | | | |
| 50. 00 05000 OPERATI NG ROOM | 0 | C | | 0 | | 50.00 |
| 51.00 05100 RECOVERY ROOM | 0 | C | | 0 | | 51.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | C | | 0 | | 52.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 14 | C | | 0 | | 54.00 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0 | C | | 0 | | 55.00 |
| 57. 00 05700 CT SCAN | 0 | C | D | 0 | | 57.00 |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | C | D | 0 | | 58.00 |
| 50. 00 06000 LABORATORY | 0 | C | | 0 | | 60.00 |
| 54.00 06400 INTRAVENOUS THERAPY | 0 | C | | 0 | | 64.00 |
| 55. 00 06500 RESPI RATORY THERAPY | 0 | C | | 0 | | 65.00 |
| 56. 00 06600 PHYSI CAL THERAPY | 0 | C | | 0 | | 66.00 |
| 57.00 06700 OCCUPATI ONAL THERAPY | 0 | C | D | 0 | | 67.00 |
| 58.00 06800 SPEECH PATHOLOGY | 0 | C | D | 0 | | 68.00 |
| 59. 00 06900 ELECTROCARDI OLOGY | 0 | C | D | 0 | | 69.00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 0 | C | D | 0 | | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | | C | D | 0 | | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | C | | 0 | | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 7, 879 | C | | 0 | | 73.00 |
| 74. 00 07400 RENAL DI ALYSI S | 0 | C | | 0 | | 74.00 |
| 76.00 03330 ENDOSCOPY | 0 | C | | 0 | | 76.00 |
| 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | C | | 0 | | 76.01 |
| 76. 02 03950 NEUROPSYCHI ATRI C SERVI CES | 0 | 0 | | 0 | | 76.02 |
| 76. 03 03951 OTHER ANCI LLARY SERVICES | 0 | 0 | | 0 | | 76.03 |
| 76. 04 03952 ANCI LLARY SERVICE COST CENTERS | Ű | | | 0 | | 76.04 |
| 76. 05 03953 MISC ANCI LLARY | 0 | | | 0 | | 76.05 |
| 76.06 03954 I MAGI NG CENTER | Ű | | | 0 | | 76.06 |
| 76. 07 03955 BREAST DI AGNOSTI C CENTER | 0 | | | 0 | | 76.07 |
| 76. 08 03956 BARI ATRI C CLI NI C OUTPATI ENT SERVI CE COST CENTERS | 0 | L C | <u>/</u> | 0 | | 76.08 |
| PO. 00 09000 CLINIC | 0 | C | | 0 | | 90.00 |
| 20. 24 04973 PALLIATIVE CARE | 0 | | | 0 | | 90.24 |
| 20. 26 04975 SPINE CENTER | 0 | | | 0 | | 90.24 |
| 20. 27 04976 DIABETIC CARE CENTER | 0 | 0 | | õ | | 90.20 |
| 71. 00 09100 EMERGENCY | 294 | 775 | | 1 | | 91.00 |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART | | 0 | | 0 | | 92.00 |
| 200.00 Total (lines 50-199) | 8, 187 | 775 | | 1 | | 200.00 |

| PPORT | Financial Systems COMM TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | | OF INDIANA, II Provider | | Peri od: | u of Form CMS- Worksheet D | 2002 1 |
|-------|---|----------------|----------------------------|--------------|----------------------|--------------------------------|------------------|
| | | | | | From 01/01/2014 | Part V | |
| | | | Component | CCN: 15S169 | To 12/31/2014 | Date/Time Pre 5/27/2015 6:0 | epared:)7 pm |
| | | | Ti tl | e XVIII | Subprovider - IPF | PPS | - |
| | | | | Charges | | Costs | |
| | Cost Center Description | Cost to Charge | PPS Reimbursed | | Cost | PPS Services | |
| | | Ratio From | Services (see | Reimbursed | Reimbursed | (see inst.) | |
| | | Worksheet C, | inst.) | Servi ces | Services Not | | |
| | | Part I, col. 9 | | Subject To | Subject To | | |
| | | | | Ded. & Coins | | | |
| | | 1.00 | 2.00 | (see inst.) | (see inst.) | F 00 | |
| | ANCI LLARY SERVI CE COST CENTERS | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 0.00 | 05000 OPERATING ROOM | 0. 171278 | | 1 | 0 0 | 0 | 50.0 |
| 1.00 | 05100 RECOVERY ROOM | 0. 167201 | | | 0 0 | 0 | |
| 2.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0. 500242 | | | 0 0 | 0 | |
| 4.00 | 05400 RADI OLOGY - DI AGNOSTI C | 0. 229758 | | | 0 0 | 0 | |
| 5.00 | 05500 RADI OLOGY-THERAPEUTI C | 0. 116659 | | | 0 0 | 0 | |
| 7.00 | 05700 CT SCAN | 0. 045902 | | | 0 0 | 0 | |
| 8.00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0. 228599 | | | 0 0 | 0 | |
| 0.00 | 06000 LABORATORY | 0. 064492 | | | 0 0 | 0 | |
| 4.00 | 06400 I NTRAVENOUS THERAPY | 0. 388654 | | | 0 0 | 0 | |
| 5.00 | 06500 RESPI RATORY THERAPY | 0. 188835 | | | 0 0 | 0 | |
| 6.00 | 06600 PHYSI CAL THERAPY | 0. 345856 | | | 0 0 | 0 | |
| 7.00 | 06700 OCCUPATI ONAL THERAPY | 0. 449274 | | | 0 0 | 0 | |
| 8.00 | 06800 SPEECH PATHOLOGY | 0. 300766 | | | 0 0 | 0 | |
| 9.00 | 06900 ELECTROCARDI OLOGY | 0. 305432 | | | 0 0 | 0 | |
| 0.00 | 07000 ELECTROENCEPHALOGRAPHY | 0. 278754 | | | 0 0 | 0 | |
| 1.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 218573 | | | 0 0 | 0 | |
| 2.00 | 07200 IMPL. DEV. CHARGED TO PATIENTS | 0. 405593 | C | | 0 0 | 0 | 72.0 |
| 3.00 | 07300 DRUGS CHARGED TO PATIENTS | 0. 253272 | | | 0 2, 321 | 0 | 73.0 |
| 4.00 | 07400 RENAL DIALYSIS | 0. 419050 | c c | | 0 0 | 0 | 74.0 |
| 6.00 | 03330 ENDOSCOPY | 0. 212840 | 0 0 | | 0 0 | 0 | 76.0 |
| 6. 01 | 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0. 000000 | 0 | | 0 0 | 0 | 76.0 |
| 6. 02 | 03950 NEUROPSYCHI ATRI C SERVI CES | 0. 000000 | 0 | | 0 0 | 0 | 76.0 |
| 6. 03 | 03951 OTHER ANCILLARY SERVICES | 0. 000000 | 0 | | 0 0 | 0 | 76.0 |
| 6. 04 | 03952 ANCI LLARY SERVI CE COST CENTERS | 0. 000000 | 0 0 | | 0 0 | 0 | 76.0 |
| 6. 05 | 03953 MISC ANCI LLARY | 0. 000000 | | | 0 0 | 0 | |
| 6.06 | 03954 I MAGI NG CENTER | 0. 105641 | 0 | | 0 0 | 0 | 76. 0 |
| 6. 07 | 03955 BREAST DI AGNOSTI C CENTER | 0. 650225 | | | 0 0 | 0 | |
| 6. 08 | 03956 BARI ATRI C CLI NI C | 0. 205611 | 0 | | 0 0 | 0 | 76.0 |
| | OUTPATIENT SERVICE COST CENTERS | T | - | 1 | - | - | 1 |
| 0.00 | 09000 CLINIC | 0. 000000 | | | 0 0 | 0 | |
| 0.24 | 04973 PALLIATIVE CARE | 0. 000000 | | | 0 0 | 0 | |
| 0.26 | 04975 SPINE CENTER | 0. 397769 | | | 0 0 | 0 | |
| D. 27 | 04976 DI ABETI C CARE CENTER | 0.00000 | | | 0 0 | 0 | 1 |
| 1.00 | 09100 EMERGENCY | 0. 124035 | | | 0 0 | 96 | |
| 2.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 194574 | | | 0 0 | 0 | 1 |
| 00.00 | | | 775 | | 0 2, 321 | 96 | 200.0 |
| 01.00 | 5 | | | | 0 0 | | 201.0 |
| | Only Charges | 1 | | | 0 2, 321 | | 202.0 |

| | | | OF INDIANA, II | | | u of Form CMS- | 2552-1 |
|------------------|---|---------------------|---------------------|---------------|----------------------------|-----------------------|---------|
| PPORI | FIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | VACCINE CUST | Provi der | CCN: 150169 | Period: From 01/01/2014 | Worksheet D Part V | |
| | | | Component | t CCN: 15S169 | To 12/31/2014 | Date/Time Pre | epared: |
| | | | | | | 5/27/2015 6:0 | 07 pm |
| | | | liti | e XVIII | Subprovider - IPF | PPS | |
| | | Cos | sts | | | | |
| | Cost Center Description | Cost | Cost |] | | | |
| | | Reimbursed | Reimbursed | | | | |
| | | Servi ces | Services Not | | | | |
| | | Subject To | Subject To | | | | |
| | | | Ded. & Coins. | | | | |
| | | (see inst.) 6.00 | (see inst.) 7.00 | - | | | |
| | ANCI LLARY SERVI CE COST CENTERS | 0.00 | 7.00 | | | | - |
| 0.00 | 05000 OPERATI NG ROOM | 0 | C | | | | 50.0 |
| 1.00 | 05100 RECOVERY ROOM | 0 | | 1 | | | 51.0 |
| 2.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | | 1 | | | 52.0 |
| 4.00 | 05400 RADI OLOGY-DI AGNOSTI C | 0 | | - | | | 54.0 |
| 5.00 | 05500 RADI OLOGY-THERAPEUTI C | 0 | | - | | | 55. C |
| 7.00 | 05700 CT SCAN | 0 | | | | | 57.0 |
| 3.00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | | - | | | 58.0 |
| D. 00 | 06000 LABORATORY | 0 | | - | | | 60.0 |
| 4.00 | 06400 I NTRAVENOUS THERAPY | 0 | | | | | 64.0 |
| 5.00 | 06500 RESPI RATORY THERAPY | 0 | | | | | 65.0 |
| 6.00 | 06600 PHYSI CAL THERAPY | 0 | | | | | 66.0 |
| 7.00 | 06700 OCCUPATI ONAL THERAPY | 0 | | | | | 67.0 |
| 8.00 | 06800 SPEECH PATHOLOGY | 0 | C |) | | | 68.0 |
| 9.00 | 06900 ELECTROCARDI OLOGY | 0 | C |) | | | 69.0 |
| D. 00 | 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | | | | 70.0 |
| 1.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | | | 71. (|
| 2.00 | 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 0 | | | | 72.0 |
| 3.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 588 | | | | 73.0 |
| 4.00 | 07400 RENAL DI ALYSI S | 0 | 0 | | | | 74.0 |
| 6.00 | 03330 ENDOSCOPY | 0 | C | | | | 76.0 |
| 6. 01 | 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | 0 | | | | 76.0 |
| 5. 02 | 03950 NEUROPSYCHI ATRI C SERVI CES | 0 | 0 | | | | 76.0 |
| 5. 03 | 03951 OTHER ANCILLARY SERVICES | 0 | 0 | | | | 76. (|
| 5. 04 | 03952 ANCI LLARY SERVI CE COST CENTERS | 0 | 0 | | | | 76.0 |
| 5. 05 | 03953 MISC ANCILLARY | 0 | 0 | | | | 76.0 |
| 6. 06 | 03954 I MAGI NG CENTER | 0 | C | | | | 76.0 |
| 6. 07 | 03955 BREAST DI AGNOSTI C CENTER | 0 | 0 | | | | 76.0 |
| 6. 08 | 03956 BARI ATRI C CLI NI C | 0 | 0 | | | | 76.0 |
| | OUTPATIENT SERVICE COST CENTERS | 0 | | 1 | | | |
|). 00). 24 | 09000 CLINIC 04973 PALLIATIVE CARE | 0 | | | | | 90.0 |
|). 24). 26 | | | | 1 | | | 90.2 |
|). 26 | 04975 SPI NE CENTER 04976 DI ABETI C CARE CENTER | 0 | | 1 | | | 90. |
| 1.00 | 09100 EMERGENCY | | | | | | 90. 4 |
| 2.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | | 1 | | | 91. |
| 2.00)0.00 | | 0 | 588 | | | | 200. (|
| DU. UC D1. OC | | 0 | 300 | | | | 200.0 |
| 51.00 | Only Charges | 0 | | | | | 201.0 |
| | Net Charges (line 200 +/- line 201) | 0 | 588 | | | | 202.0 |

| Health Financial Systems | COMMUNI TY HOSPI TAL | OF INDIANA, IN | NC. | In Lie | u of Form CMS- | 2552-10 |
|--|----------------------|----------------|---------------|---|----------------|----------------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAI | PITAL COSTS | Provi der | | Period: From 01/01/2014 To 12/31/2014 | | pared: 7 pm |
| | | Tit | le XIX | Hospi tal | PPS | |
| Cost Center Description | Capi tal | Swing Bed | Reduced | Total Patient | Per Diem (col. | |
| | Related Cost | Adjustment | Capi tal | Days | 3 / col. 4) | |
| | (from Wkst. B, | | Related Cost | | | |
| | Part II, col. | | (col. 1 - col | | | |
| | 26) | | 2) | | | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 ADULTS & PEDIATRICS | 5, 479, 518 | 0 | 5, 479, 51 | 8 56, 743 | 96.57 | 30.00 |
| 31.00 INTENSIVE CARE UNIT | 728, 240 | | 728, 24 | 0 5, 161 | 141.10 | 31.00 |
| 35.00 NEONATAL INTENSIVE CARE UNIT | 1, 386, 215 | | 1, 386, 21 | 5 11, 463 | 120.93 | 35.00 |
| 40. 00 SUBPROVIDER - IPF | 309, 603 | 0 | 309, 60 | 3 3, 120 | 99.23 | 40.00 |
| 41.00 SUBPROVIDER - IRF | 0 | 0 |) | 0 0 | 0.00 | 41.00 |
| 43.00 NURSERY | 593, 379 | | 593, 37 | 9 7, 861 | 75.48 | 43.00 |
| 200.00 Total (lines 30-199) | 8, 496, 955 | | 8, 496, 95 | 5 84, 348 | | 200.00 |
| Cost Center Description | I npati ent | I npati ent | | | | |
| | Program days | Program | | | | |
| | | Capital Cost | | | | |
| | | (col. 5 x col. | | | | |
| | | 6) | | | | |
| | 6.00 | 7.00 | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 ADULTS & PEDIATRICS | 2, 566 | 247, 799 | | | | 30.00 |
| 31.00 INTENSIVE CARE UNIT | 0 | 0 | | | | 31.00 |
| 35.00 NEONATAL INTENSIVE CARE UNIT | 0 | 0 | | | | 35.00 |
| 40.00 SUBPROVIDER - IPF | 0 | 0 | | | | 40.00 |
| 41.00 SUBPROVIDER - IRF | 0 | 0 | | | | 41.00 |
| 43.00 NURSERY | 1, 485 | 112, 088 | | | | 43.00 |
| 200.00 Total (lines 30-199) | 4, 051 | 359, 887 | | | | 200.00 |

| | Financial Systems COM TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | | OF INDIANA, IN Provider | CCN: 150169 | Peri od: | u of Form CMS-: Worksheet D | 2002-10 |
|--------|--|----------------|----------------------------|---------------|-----------------|--------------------------------|---------|
| | TORMENT OF THEAT ANOTELART SERVICE OATTA | 12 00010 | riovidei | 0010. 100107 | From 01/01/2014 | Part II | |
| | | | | | To 12/31/2014 | Date/Time Pre | epared: |
| | | | | | | 5/27/2015 6:0 | , pm |
| | | | Tit | le XIX | Hospi tal | PPS | |
| | Cost Center Description | Capi tal | Total Charges | Ratio of Cos | t Inpatient | Capital Costs | |
| | | Related Cost | (from Wkst. C, | to Charges | Program | (column 3 x | |
| | | (from Wkst. B, | Part I, col. | (col. 1 ÷ col | . Charges | column 4) | |
| | | Part II, col. | 8) | 2) | | | |
| | | 26) | | | | | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 | 05000 OPERATING ROOM | 3, 086, 446 | 120, 798, 125 | 0. 02555 | 2, 936, 787 | 75, 035 | 50.00 |
| 51.00 | 05100 RECOVERY ROOM | 398, 675 | 24, 963, 444 | 0. 01597 | 70 526, 258 | 8, 404 | 51.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 1, 504, 073 | 26, 258, 849 | 0. 05727 | 79 545, 055 | 31, 220 | 52.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 1, 290, 805 | 34, 021, 391 | 0. 03794 | 1 534, 674 | 20, 286 | 54.00 |
| 55.00 | 05500 RADI OLOGY-THERAPEUTI C | 343,057 | | | 345, 371 | 7, 879 | 55.00 |
| 57.00 | 05700 CT SCAN | 189, 922 | 55, 295, 989 | 0.00343 | 891, 369 | 3, 062 | 57.00 |
| | 05800 MAGNETIC RESONANCE I MAGING (MRI) | 939, 794 | | | | | |
| 60.00 | 06000 LABORATORY | 345, 267 | | | | | |
| 64.00 | 06400 I NTRAVENOUS THERAPY | 31, 555 | | | | 1, 762 | |
| 65.00 | 06500 RESPI RATORY THERAPY | 487, 909 | | | | | |
| 66.00 | 06600 PHYSI CAL THERAPY | 411, 682 | | | | 3,073 | |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 118, 458 | | | | 4, 297 | |
| | 06800 SPEECH PATHOLOGY | 27, 134 | | | | | |
| | 06900 ELECTROCARDI OLOGY | | | | | | |
| | 07000 ELECTROENCEPHALOGRAPHY | 105, 351 | | | | | |
| | | 213, 306 | | | | | |
| | 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS | 617, 343 | | | | | |
| | 07200 I MPL. DEV. CHARGED TO PATIENTS | 819, 154 | | | | 0 | |
| | 07300 DRUGS CHARGED TO PATIENTS | 1, 151, 729 | | | | 62, 528 | |
| | 07400 RENAL DI ALYSI S | 40, 852 | | | | 2, 748 | |
| | 03330 ENDOSCOPY | 496, 645 | | | | | |
| | 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | 0 | | | 0 | |
| | 03950 NEUROPSYCHI ATRI C SERVI CES | 0 | 0 | 0.0000 | | 0 | |
| | 03951 OTHER ANCI LLARY SERVICES | 0 | 0 | 0.0000 | | 0 | |
| | 03952 ANCILLARY SERVICE COST CENTERS | 0 | 0 | | | 0 | |
| | 03953 MISC ANCILLARY | 0 | - | 0.0000 | | 0 | |
| | 03954 I MAGI NG CENTER | 896, 493 | | | | 0 | |
| | 03955 BREAST DIAGNOSTIC CENTER | 386, 269 | | | | 34 | |
| 76. 08 | 03956 BARI ATRI C CLI NI C | 666 | 67, 545 | 0.00986 | 0 0 | 0 | 76.08 |
| | OUTPATIENT SERVICE COST CENTERS | T | I | 1 | | | |
| | 09000 CLI NI C | 0 | 0 | 0.0000 | 0 00 | 0 | 90.00 |
| 90. 24 | 04973 PALLIATIVE CARE | 0 | 0 | 0.0000 | 0 0 | 0 | 90.24 |
| | 04975 SPINE CENTER | 13, 804 | 732, 310 | | | 0 | 90.26 |
| 90. 27 | 04976 DI ABETI C CARE CENTER | 0 | 0 | 0.0000 | 0 0 | 0 | 90.27 |
| | 09100 EMERGENCY | 1, 163, 817 | 113, 172, 177 | 0. 01028 | 1, 211, 075 | 12, 455 | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 482, 258 | | | | | |
| /2.00 | | | | | | | |

| Health Financial Systems | COMMUNI TY HOSPI TAL | OF INDIANA, IN | VC. | In Lie | eu of Form CMS- | 2552-10 |
|---|---------------------------------------|----------------|----------------|---|-----------------|----------------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OT | HER PASS THROUGH COS | TS Provi der | F | Period: From 01/01/2014 Fo 12/31/2014 | | pared: 7 pm |
| | | Tit | le XIX | Hospi tal | PPS | |
| Cost Center Description | Nursing School | Allied Health | All Other | Swing-Bed | Total Costs | |
| | | Cost | Medi cal | Adj ustment | (sum of cols. | |
| | | | Education Cost | 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 & PEDI ATRI CS | 0 | 0 | (| 0 0 | 0 | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | 0 | 0 | (| D | 0 | 31.00 |
| 35.00 02060 NEONATAL INTENSIVE CARE UNIT | 0 | 0 | | D | 0 | 35.00 |
| 40. 00 04000 SUBPROVIDER - IPF | 0 | 0 | | 0 0 | 0 | 40.00 |
| 41.00 04100 SUBPROVIDER - IRF | 0 | 0 | | 0 0 | 0 | 41.00 |
| 43. 00 04300 NURSERY | 0 | 0 | |) | l o | 43.00 |
| 200.00 Total (lines 30-199) | 0 | 0 | | 0 | 0 | 200.00 |
| Cost Center Description | Total Patient | Per Diem (col. | Inpati ent | I npati ent | | |
| | Days | 5 ÷ col. 6) | Program Days | | | |
| | , , , , , , , , , , , , , , , , , , , | Í Í | | Pass-Through | | |
| | | | | Cost (col. 7 x | | |
| | | | | col. 8) | | |
| | 6.00 | 7.00 | 8.00 | 9.00 | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | · | <u>.</u> | | |
| 30. 00 03000 ADULTS & PEDIATRICS | 56, 743 | 0.00 | 2, 566 | 6 0 | | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | 5, 161 | 0.00 | | 0 0 | | 31.00 |
| 35.00 02060 NEONATAL INTENSIVE CARE UNIT | 11, 463 | | | 0 0 | | 35.00 |
| 40. 00 04000 SUBPROVIDER - IPF | 3, 120 | | | 0 0 | | 40.00 |
| 41. 00 04100 SUBPROVIDER - IRF | 0 | | | 0 0 | | 41.00 |
| 43. 00 04300 NURSERY | 7, 861 | | | 0 | | 43.00 |
| 200.00 Total (lines 30-199) | 84, 348 | | 4,05 | | | 200.00 |
| | 01,010 | 1 | 1 1,00 | | 1 | |

| | MUNITY HOSPITAL | | IC. | In Lie | u of Form CMS-2 | 2552-10 |
|---|------------------|-----------------|---------|-----------------|----------------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE | RVICE OTHER PASS | 5 Provi der | | Period: | Worksheet D | |
| THROUGH COSTS | | | | From 01/01/2014 | Part IV | |
| | | | | To 12/31/2014 | Date/Time Pre | pared: |
| | | T: + | le XIX | Hospi tal | 5/27/2015 6:0 PPS | 7 pili |
| Cost Center Description | Non Physician | | | | Total Cost | |
| cost center bescription | Anesthetist | NULSTING SCHOOL | | Medical | (sum of col 1 | |
| | Cost | | | Education Cost | | |
| | CUST | | | Luucation Cost | 4) | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| ANCI LLARY SERVI CE COST CENTERS | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 50. 00 05000 OPERATING ROOM | 0 | 0 | | 0 0 | 0 | 50.00 |
| 51. 00 05100 PERATING ROOM | 0 | 0 | | 0 0 | | |
| | 0 | 0 | | 0 0 | 0 | 51.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | | - | - | 52.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | 11, 00 | | 11,006 | |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0 | 0 | | 0 0 | 0 | 55.00 |
| 57.00 05700 CT SCAN | 0 | 0 | | 0 0 | 0 | |
| 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) | 0 | 0 | | 0 0 | 0 | 58.00 |
| 60. 00 06000 LABORATORY | 0 | 0 | | 0 0 | 0 | 60.00 |
| 64.00 06400 INTRAVENOUS THERAPY | 0 | 0 | | 0 0 | 0 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 0 | | 0 0 | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 0 | | 0 0 | 0 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | 0 0 | 0 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 0 | | 0 0 | 0 | 68.00 |
| 69.00 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 0 | 0 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | | 0 0 | 0 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 0 0 | 0 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 0 | | 0 0 | 0 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 650, 76 | 3 0 | 650, 763 | 73.00 |
| 74.00 07400 RENAL DIALYSIS | 0 | 0 | | 0 0 | 0 | |
| 76.00 03330 ENDOSCOPY | 0 | 0 | | 0 0 | 0 | 76.00 |
| 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | 0 | | 0 0 | 0 | 76.01 |
| 76. 02 03950 NEUROPSYCHI ATRI C SERVI CES | 0 | 0 | | 0 0 | 0 | 76.02 |
| 76. 03 03951 OTHER ANCI LLARY SERVICES | 0 | 0 | | | 0 | 76.02 |
| 76. 04 03952 ANCI LLARY SERVICE COST CENTERS | 0 | 0 | | | 0 | 76.04 |
| 76. 05 03953 MI SC ANCI LLARY | 0 | 0 | | | 0 | 76.05 |
| 76. 06 03954 I MAGI NG CENTER | 0 | 0 | | 0 0 | 0 | 76.06 |
| 76. 07 03955 BREAST DI AGNOSTI C CENTER | 0 | 0 | | 0 0 | 0 | 76.07 |
| | 0 | 0 | | 0 0 | 0 | |
| 76. 08 03956 BARI ATRI C CLI NI C | 0 | 0 | | 0 0 | 0 | 76.08 |
| | 0 | | 1 | | 0 | 00.00 |
| 90. 00 09000 CLINIC | 0 | 0 | | 0 0 | 0 | |
| 90. 24 04973 PALLI ATI VE CARE | 0 | 0 | | 0 0 | 0 | 90.24 |
| 90. 26 04975 SPINE CENTER | 0 | 0 | | 0 | 0 | 90.26 |
| 90. 27 04976 DI ABETI C CARE CENTER | 0 | 0 | | 0 | 0 | |
| 91.00 09100 EMERGENCY | 0 | 0 | | | 157, 280 | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | 1 | 0 0 | 0 | 92.00 |
| 200.00 Total (lines 50-199) | 0 | 0 | | | 819, 049 | |

| 51:00 05100 RECOVERY ROOM 0 24, 963, 444 0.000000 526, 258 51.00 52:00 05200 DELI VERY ROOM & LABOR ROOM 0 26, 258, 849 0.0000324 0.000324 534, 674 54.00 05:00 RADI LOGY-THERAPEUTI C 0 15, 037, 761 0.000000 0.000000 845, 371 55.00 57.00 D5700 CT SCAN 0 55, 2989 0.000000 0.000000 843, 371 56.00 60.00 06400 INTRAVENUS THERAPY 0 86, 476, 587 0.000000 0.000000 76, 231 64.00 06400 INTRAVENUS THERAPY 0 1, 364, 945 0.000000 0.000000 1, 573, 380 65.00 06.00 06600 INTRAVENUS THERAPY 0 21, 154, 971 0.000000 0.000000 163, 051 67.00 067.00 06700 ELCTROCARD IDLOGY 0 1, 538, 973 0.000000 0.000000 163, 051 67.00 06.00 06900 ELECTROCARD IDLOGY 0 6, 255, 32 0.000000 0.000000 20, 050 69.00 071.00 </th <th>Health Financial Systems</th> <th>COMMUNI TY HOSPI TAL</th> <th>OF INDIANA, II</th> <th>NC.</th> <th>In Lie</th> <th>u of Form CMS-2</th> <th>2552-10</th> | Health Financial Systems | COMMUNI TY HOSPI TAL | OF INDIANA, II | NC. | In Lie | u of Form CMS-2 | 2552-10 |
|--|---|----------------------|----------------|-----------|----------------|--------------------------|----------------|
| Cost Center Description Total Outpatient (cost Cost Center Description Description (cost Cost Center Description) Province (cost Cost Center Description) 50:00 05000 Description 0 120.798.125 0.000000 0.000000 0.000000 0.000000 526.85 52.00 51:00 05000 Ratio art Cost Center Description 0 120.798.125 0.000000 0.000000 0.000000 526.85 52.00 52:00 05200 Ratio art Center Description 0 120.798.125 0.000000 0.000000 526.85 52.00 51:00 05500 Ratio art Center Description 0 120.798.125 0.000000 0.000000 0.000000 526.85 52.00 51:00 05500 Ratio art Center Description 0 120.798.125 0.0000000 0.000000 0.000000< | | SERVICE OTHER PAS | S Provi der | F | rom 01/01/2014 | Part IV Date/Time Pre | pared: 7 pm |
| Cost Center Description Total Outpatient (cost (sum of cost (sum of e) Total Outpatient (cost (sum of e) Total (cost (sum of e) Total (cost (sum of e) Total (cost (sum of e) Outpatient (col. Inpatient (col. < | | | Ti t | le XIX | Hospi tal | | |
| Outpatient Outpatient (from Wisch Sum of col. 2, 3 and 4) Cost (sum of col. 2, 3 and 4) Cost (sum of col. 2, 3 and 8) Ratio of Cost (col. 5 + col. 7) Ratio of Cost (col. 6 + col. 7) Ratio of Cost (col. 6 + col. 7) Program Charges 40 7.00 8.00 9.00 10.00 50.00 05000 (DEFRATING ROOM 0 120,798,125 0.000000 0.000000 2,936,787 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 24,963,444 0.000000 0.000000 546,055 55,00 50.00 05500 RADIOLOGY-THERAPEUTIC 11,006 34,021,991 0.000000 0.000000 546,055 57,00 51.00 05500 RADIOLOGY-THERAPEUTIC 0 55,298 0.000000 0.000000 190,516 55,00 60.00 06000 LINGRAVENUS THERAPY 0 26,245,687 0.000000 0.000000 7,231 64.00 61.00 06000 PHYSICAL THERAPY 0 28,245,687 0.000000 1,557,380 65.00 63.00 06000 OPHYSICAL THERAPY 0 24,965,528 0.000000 0.000000 | Cost Center Description | Total | | | | | |
| Cost (sum of col. 2, 3 and 4) Part I, col. (sol. 5, + col. 7) to charges (col. 6, + col. 7) Charges (col. 6, + col. 7) Charges (col. 6, + col. 7) Charges (col. 6, + col. 7) ANCILLARY SERVICE COST CENTERS 0 0.000000 0.000000 2.936, 787 50.00 50.00 05000 OPERATING ROOM 0 120, 798, 125 0.000000 0.000000 2.936, 787 50.00 52.00 05200 DELI VERY ROM & LABOR ROOM 0 26, 258, 849 0.000000 0.000000 546, 555 52.00 55.00 05500 RAD ILOGY-THERAPEUTI C 11,006 15,037,761 0.000000 0.000000 343, 31,345 55.00 56.00 05600 CHABOR TORY 0 86,476,567 0.000000 0.000000 3,31,475 60.00 66.00 06000 RESPI RATORY 0 86,476,587 0.000000 0.000000 3,31,475 60.00 66.00 060000 RESPI RATORY 0 1,364,945 0.000000 0.000000 1,57,806 60.00 66.00 060000 RESPI RATORY THERAPY 0 21,154,971 0.0000000 0. | | | | | | | |
| col. 2, 3 and 8) 7) (col. 6 + col. 6.00 7.00 8.00 9.00 10.00 50.00 05000 OPERATING ROOM 0 120,798,125 0.000000 0.000000 526,258 55.00 51.00 05100 RECOVERY ROOM 0 24,663,444 0.000000 0.000000 526,255 51.00 52.00 05200 DELVIEW ROM & LABOR ROOM 0 26,258,849 0.000000 0.000000 534,675 52.00 55.00 05500 RADI CLOGY-THERAPEUTIC 11,006 34,021,391 0.000324 0.000000 845,371 55.00 56.00 05500 MAGNETIC RESONANCE I MAGING (MRI) 0 26,245,650 0.000000 0.000000 3.31,475 60.00 66.00 064000 INTRAVENUS THERAPY 0 13,364,945 0.000000 0.000000 76,231 64.00 66.00 066000 PHYSI CLA THERAPY 0 28,366,065 0.000000 1.557,380 65.00 66.00 066000 DELECTRORACEIDI OLOGY | | | | | | J | |
| 4) 7) 7) ANCILLARY SERVICE COST CENTERS 6.00 7.00 8.00 9.00 10.00 50.00 05000 OPERATING ROM 0 120,798,125 0.000000 0.000000 2,936,787 50.00 51.00 05100 RECOVERY ROM 0 24,963,444 0.000000 0.000000 542,258 51.00 52.00 05200 DELIVERY ROM & LABOR ROM 0 24,963,444 0.000000 0.000000 545,055 52.00 54.00 05500 RADI LOGY-THERAPEUTI C 11.006 34,021,371 0.000000 0.000000 345,371 55.00 55.00 05000 CT SCAN 0 55,255,999 0.000000 0.000000 190,516 58.00 60.00 06000 LABORATORY 0 26,245,650 0.000000 0.000000 1,557,380 65.00 61.00 06400 INTRAVENOUS THERAPY 0 1,364,945 0.000000 0.000000 1,557,380 65.00 63.00 065000 OSPECH PATHORY 0 1,358,973 0.000000 0.000000 < | | col. 2, 3 and | 8) | 7) | | 5 | |
| ANCILLARY SERVICE COST CENTERS 50.00 OSOOO OPERATI NG ROOM 0 120, 798, 125 0.000000 2.936, 785 50.00 51.00 DS100 RECOVERY ROOM 0 22, 96, 125 0.000000 2.936, 785 51.00 51.00 DS100 RECOVERY ROOM 0 26, 258, 849 0.000000 0.000000 526, 258 51.00 51.00 OSD00 RADI OLCOY-THERAPEUTI C 11, 006 34, 021, 391 0.000234 0.000000 843, 637, 375 55.00 50.00 OSD00 CT SCAN 0 55, 295, 989 0.000000 0.000000 849, 369, 57.00 60.00 O6000 LABORATORY 0 86, 476, 587 0.000000 0.000000 3.331, 475 60.00 66.00 O6000 LABORATORY 0 1, 364, 945 0.000000 0.000000 15, 57, 586 65.00 67.00 OCODOL LECTROCARDI THERAPY 0 21, 154, 971 0.000000 1.057, 386 65.00 66.00 O6000 SPECH PATHOLOCY 0 1, 538, 973 0.000000 0.000000 | | | | , | 7) | | |
| 50. 00 OFGOOL OPERATING ROOM 0 120, 798, 125 0. 000000 2, 936, 787 50. 00 51. 00 OSTOD RECOVERY ROOM 0 24, 963, 444 0. 000000 0. 000000 526, 258 51. 00 52.00 DS200 DELI VERY ROOM & LABOR ROOM 0 26, 258, 849 0. 000324 0. 000324 534, 674 54. 00 55.00 DS500 RAD LOCGY -THERAPEUTIC 0 15, 03, 7751 0. 000000 0. 000000 343, 371 55. 00 56.00 DS500 OKAD LOCGY -THERAPEUTIC 0 15, 525, 959 0. 000000 0. 000000 1000000 1051637, 761 0. 000000 0. 000000 1050, 156 68. 00 0. 000000 1000000 1000000 1050, 156 68. 00 0. 000000 0. 000000 10, 573, 801 66. 00 66. 00 66. 00 66. 00 66. 00 0. 000000 1, 534, 945 0. 000000 1, 553, 897 0. 000000 1, 553, 896 60. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 | | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| 51.00 05100 RECOVERY ROOM 0 24, 963, 444 0.000000 0.000000 526, 258 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 26, 258, 849 0.000000 0.000000 546, 055 52.00 55.00 OS500 RADIOLOGY-DIAGNOSTIC 11, 006 34, 021, 391 0.000324 0.000324 534, 674 54.00 57.00 OS700 (CT SCAN 0 55, 295, 989 0.000000 0.000000 843, 371 55.00 60.00 06400 LABORATORY 0 86, 476, 587 0.000000 0.000000 76, 231 64.00 64.00 06400 INTRAVENUS THERAPY 0 1, 364, 945 0.000000 0.000000 1, 557, 380 65.00 65.00 06500 RESPI RATORY THERAPY 0 21, 154, 971 0.000000 0.000000 163, 051 67.00 67.00 06700 OCUPATI ONAL THERAPY 0 1, 338, 973 0.000000 0.000000 163, 051 67.00 68.00 06800 SPECH PATHOLOGY 0 6, 255, 328 0.0000000 0.0000000 62 | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 52.00 D5200 DELIVERY ROOM & LABOR ROOM 0 26, 258, 849 0.000000 0.000000 545, 055 52.00 54.00 05500 RADI OLGY-THERAPEUTI C 11,006 34, 021, 391 0.000324 0.000000 345, 371 55.00 55.00 05500 RADI OLGY-THERAPEUTI C 0 15,037, 761 0.000000 0.000000 891,349 57.00 56.00 05500 MASON TE C RESONANCE I MAGING (MRI) 0 26,245,650 0.000000 0.000000 3,331,475 60.00 64.00 06400 INTRAVENOUS THERAPY 0 1,364,945 0.000000 0.000000 1,557,380 65.00 65.00 06500 RESPI RATORY THERAPY 0 21,154,971 0.000000 0.000000 157,910 66.00 64.00 06600 PHYSI CAL THERAPY 0 21,154,971 0.000000 0.000000 157,910 66.00 65.00 06500 EECR CARDI OLOGY 0 4,255 0.000000 0.000000 62,055 69.00 60.00 069.00 EECR CARDI OLOGY 0 61,656,352 0.000000 | | C | 120, 798, 125 | | | 2, 936, 787 | 50.00 |
| 54.00 05400 RADI 0L0GY-DI AGNOSTI C 11,006 34,021,391 0.000324 0.000324 534,674 54.00 55.00 05500 RADI 0L0GY-THERAPEUTI C 0 15,037,761 0.000000 0.000000 345,371 55.00 57.00 05700 CT SCAN 0 55,29,989 0.000000 0.000000 190,516 58.00 60.00 Gobool LABRATORY 0 26,245,650 0.000000 0.000000 3,331,475 60.00 64.00 06400 INTRAVENOUS THERAPY 0 28,306,065 0.000000 0.000000 1,557,380 65.00 65.00 06500 RESPI RATORY THERAPY 0 21,154,971 0.000000 0.000000 15,57,901 66.00 66.00 06600 PIST LAT THERAPY 0 1,588,973 0.000000 0.000000 163,051 67.00 67.00 CCUPATI ONAL THERAPY 0 7,822,372 0.000000 0.000000 62,065 68.00 68.0 06900 ELECTROCARDI 0LOGY 0 6,255,328 0.000000 0.000000 183,313 71.00 </td <td>51.00 05100 RECOVERY ROOM</td> <td>C</td> <td>24, 963, 444</td> <td>0. 000000</td> <td>0. 000000</td> <td>526, 258</td> <td>51.00</td> | 51.00 05100 RECOVERY ROOM | C | 24, 963, 444 | 0. 000000 | 0. 000000 | 526, 258 | 51.00 |
| 55:00 05500 RADI OLOGY-THERAPEUTI C 15, 037, 761 0.000000 0.000000 345, 371 55. 00 57:00 05700 CT SCAN 0 55, 295, 989 0.000000 0.000000 891, 369 57. 00 58:00 06500 HAGNETI C RESONANCE I MAGING (MRI) 0 26, 245, 650 0.000000 0.000000 3, 331, 475 60. 00 64:00 06400 INTRAVENOUS THERAPY 0 1, 364, 945 0.000000 0.000000 7, 231 64. 00 65:00 06500 RESPI RATORY THERAPY 0 21, 154, 971 0.000000 0.000000 163, 051 67. 00 66:00 06600 PHYSI CAL THERAPY 0 4, 495, 255 0.000000 0.000000 163, 051 67. 00 67:00 066800 SPEECH PATHOLOGY 0 1, 538, 973 0.000000 0.000000 163, 051 67. 00 69:00 066900 ELECTROCARDI OLOGY 0 6, 255, 328 0.000000 0.000000 1, 843, 313 71. 00 71:00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 650, 763 74, 762, 550 <t< td=""><td>52.00 05200 DELIVERY ROOM & LABOR ROOM</td><td>C</td><td>26, 258, 849</td><td>0. 000000</td><td>0. 000000</td><td>545, 055</td><td>52.00</td></t<> | 52.00 05200 DELIVERY ROOM & LABOR ROOM | C | 26, 258, 849 | 0. 000000 | 0. 000000 | 545, 055 | 52.00 |
| 57.00 05700 CT SCAN 0 55,295,989 0.000000 0.000000 891,369 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 26,245,650 0.000000 0.000000 190,516 58.00 64.00 06400 INTRAVENOUS THERAPY 0 8.6476,557 0.000000 0.000000 76,221 64.00 65.00 05600 RESP RATORY THERAPY 0 28.306,065 0.000000 0.000000 1,57,901 66.00 66.00 06600 PHYSI CAL THERAPY 0 21,154,971 0.000000 0.000000 163,051 67.00 67.00 06700 0CUPATI ONAL THERAPY 0 4,495,255 0.000000 0.000000 62,055 69.00 69.00 06900 ELECTROCARDI OLOGY 0 7,822,372 0.000000 0.000000 68,836 70.00 70.00 07000 RELCARGED TO PATI ENTS 0 44,114,734 0.000000 0.000000 18,843,313 71.00 71.00 07400 RENAL DI ALVIS S 0 1,989,829 0.000000 0.000000 <t< td=""><td>54.00 05400 RADI OLOGY-DI AGNOSTI C</td><td>11,006</td><td>34, 021, 391</td><td>0.000324</td><td>4 0.000324</td><td>534, 674</td><td>54.00</td></t<> | 54.00 05400 RADI OLOGY-DI AGNOSTI C | 11,006 | 34, 021, 391 | 0.000324 | 4 0.000324 | 534, 674 | 54.00 |
| 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 26, 245, 650 0.000000 0.000000 190, 516 58.00 60.00 06000 LABORATORY 0 86, 476, 587 0.000000 0.000000 3, 331, 475 60.00 64.00 06400 INTRAVENOUS THERAPY 0 1, 364, 945 0.000000 0.000000 1, 557, 380 65.00 65.00 06500 RESPI RATORY THERAPY 0 21, 154, 971 0.000000 0.000000 1, 557, 380 65.00 66.00 06700 0CCUPATI 0NAL THERAPY 0 4, 495, 255 0.000000 0.000000 62, 065 68.00 69.00 06900 ELECTROCARDI 0LOGY 0 1, 538, 973 0.000000 0.000000 68, 836 70.00 70.00 07100 RELCTROCARDI 0LOGY 0 7, 822, 372 0.000000 0.000000 1, 843, 313 71.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 61, 656, 352 0.000000 0.000000 1, 843, 313 71.00 72.00 07200 IMPL. MARGED TO PATI ENTS 650, 76 | 55. 00 05500 RADI OLOGY-THERAPEUTI C | C | 15, 037, 761 | 0.00000 | 0. 000000 | | 55.00 |
| 60.00 6400 LABORATORY 0 86.476,587 0.000000 0.000000 3,331,475 60.00 64.00 06400 INTRAVENUS THERAPY 0 1,364,945 0.000000 0.000000 76,231 64.00 65.00 06500 RESPIRATORY THERAPY 0 28.306,065 0.000000 0.000000 1,557,380 65.00 66.00 06600 PHYSI CAL THERAPY 0 21,154,971 0.000000 0.000000 163,051 67.00 67.00 0CCUPATI 0NAL THERAPY 0 4,495,255 0.000000 0.000000 62,055 69.00 69.00 06900 ELECTROCARDI 0LOGY 0 6,255,328 0.000000 0.000000 68,836 70.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 7.822,372 0.000000 0.000000 68,836 70.00 71.00 MDI L. BEV. CHARGED TO PATI ENTS 0 44,114,734 0.000000 0.000000 0.000000 13,874 74.00 73.00 07300 DRUS CHARGED TO PATI ENTS 650,753 74,762,550 0.008704 0.008704 4,058, | 57.00 05700 CT SCAN | C | 55, 295, 989 | 0. 000000 | 0. 000000 | 891, 369 | 57.00 |
| 64.00 06400 INTRAVENUIS THERAPY 0 1,364,945 0.000000 0.000000 76,231 64.00 65.00 06500 RESPI RATORY THERAPY 0 28,306,065 0.000000 0.000000 1,557,380 65.00 66.00 06600 PHYSI CAL THERAPY 0 21,154,971 0.000000 0.000000 163,051 67.00 67.00 06700 0CCUPATI ONAL THERAPY 0 4,495,255 0.000000 0.000000 220,550 68.00 68.00 SPEECH PATHOLOGY 0 6,255,328 0.000000 0.000000 220,550 69.00 0.07000 ELECTROCARDI OLOGY 0 7,822,372 0.000000 0.000000 183,313 71.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 44,114,734 0.000000 0.000000 12,203 72.00 07300 DRUGS CHARGED TO PATI ENTS 650,763 74,762,550 0.008704 4,058,934 73.00 74.00 07300 DRUACS CHARGED TO PATI ENTS 0 0.000000 0.000000 126,438 76.00 0.3330 | 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) | C | 26, 245, 650 | 0. 000000 | 0. 000000 | 190, 516 | 58.00 |
| 65.00 06500 RESPI RATORY THERAPY 0 28, 306, 065 0.000000 0.000000 1, 557, 380 65.00 66.00 06600 PHYSI CAL THERAPY 0 21, 154, 971 0.000000 0.000000 163, 051 67.00 67.00 0C020ATI (DNAL THERAPY 0 4, 495, 255 0.000000 0.000000 62.065 68.00 68.00 06900 ELECTROCARDI 0LOGY 0 6, 255, 328 0.000000 0.000000 68, 836 70.00 70.00 OTOOL ELECTROCARDI 0LOGY 0 7, 822, 372 0.000000 0.000000 68, 836 70.00 71.00 OTOOL ILECTROCARDED TO PATI ENTS 61, 656, 352 0.000000 0.000000 1, 538, 973 71.00 72.00 07200 IMPL DEV CHARGED TO PATI ENTS 61, 656, 352 0.000000 0.000000 0.000000 72.00 73.00 OT300 DRUGS CHARGED TO PATI ENTS 650, 763 74, 762, 550 0.008704 0.008704 4, 058, 934 73.00 74.00 O7400 RENAL DI ALYSI S 0 1, 999, 829 0.000000 | 60. 00 06000 LABORATORY | C | 86, 476, 587 | 0. 000000 | 0. 000000 | 3, 331, 475 | 60.00 |
| 66.00 06600 PHYSI CAL THERAPY 0 21, 154, 971 0.000000 0.000000 157, 901 66.00 67.00 06700 0CUPATI ONAL THERAPY 0 4, 495, 255 0.000000 0.000000 62.065 68.00 68.00 SPEECH PATHOLOGY 0 1, 538, 973 0.000000 0.000000 62.065 68.00 069.00 ELECTROCARDI OLOGY 0 6, 255, 328 0.000000 0.000000 320, 550 69.00 70.00 07000 ELECTROCREPHALOGRAPHY 0 7, 822, 372 0.000000 0.000000 1, 843, 313 71.00 71.00 OT100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 61, 656, 352 0.000000 0.000000 0.000000 72.00 73.00 O7300 DRUGS CHARGED TO PATI ENTS 650, 763 74, 762, 550 0.008704 4, 058, 934 73.00 74.00 07400 RENAL DI ALYSI S 0 1, 989, 829 0.000000 0.000000 126, 438 76.01 76.01 03550 PSYCHI ATRI C PSYCHOLOGI CAL SERVI CES 0 0 0.000000 0.0000000 76.0 | 64.00 06400 INTRAVENOUS THERAPY | C | 1, 364, 945 | 0. 000000 | 0. 000000 | 76, 231 | 64.00 |
| 67.00 06700 0CCUPATI ONAL THERAPY 0 4, 495, 255 0.000000 0.000000 68.00 68.00 0.6800 SPEECH PATHOLOGY 0 1, 538, 973 0.000000 0.000000 62.065 68.00 69.00 06900 ELECTROCARDI OLOGY 0 6, 255, 328 0.000000 0.000000 320, 550 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 7, 822, 372 0.000000 0.000000 1, 843, 313 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 61, 656, 352 0.000000 0.000000 0 020000 0.000000 0 72.00 73.00 O7300 RUGS CHARGED TO PATI ENTS 650, 763 74, 762, 555 0.008704 4, 058, 934 73.00 74.00 07400 RENAL DI ALYSI S 0 12, 700, 946 0.000000 0.000000 126, 438 76.00 75.01 03550 PSYCHI ATRI C SERVI CES 0 0 0.000000 0 76.01 76.02 03950 NEUROPSYCHI ATRI C SERVI CES 0 0 0.0000000 0 76.02 | 65. 00 06500 RESPI RATORY THERAPY | C | 28, 306, 065 | 0. 000000 | 0. 000000 | 1, 557, 380 | 65.00 |
| 68.00 06800 SPEECH PATHOLOGY 0 1, 538, 973 0.000000 0.000000 62, 065 68.00 69.00 06900 ELECTROCARDI OLOGY 0 6, 255, 328 0.000000 0.000000 320, 550 69.00 70.00 OT000 ELECTROCARDI OLOGY 0 7, 822, 372 0.000000 0.000000 68, 836 70.00 71.00 OT100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 61, 656, 352 0.000000 0.000000 1, 843, 313 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 44, 114, 734 0.000000 0.008704 4, 058, 934 73.00 74.00 07400 RENAL DI ALYSI S 0 1, 989, 829 0.000000 0.000000 126, 438 76.00 76.00 03330 ENDOSCOPY 0 12, 700, 946 0.000000 0.000000 166, 63 76.01 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0.000000 0.000000 76.02 76.03 03951 OTHEQ ANCI LLARY SERVI CES 0 0 0.0000000 0.00 | 66. 00 06600 PHYSI CAL THERAPY | C | 21, 154, 971 | 0.00000 | 0. 000000 | 157, 901 | 66.00 |
| 69.00 06900 ELECTROCARDI OLOGY 0 6, 255, 328 0.000000 0.000000 320, 550 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 7, 822, 372 0.000000 0.000000 68, 836 70.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 61, 656, 352 0.000000 0.000000 1, 843, 313 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 44, 114, 734 0.000000 0.000000 1, 843, 313 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 650, 763 74, 762, 550 0.008704 4, 058, 934 73.00 74.00 07400 RENAL DI ALYSI S 0 1, 989, 829 0.000000 0.000000 126, 438 76.00 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES 0 0 0.000000 0.000000 76.01 76.03 03951 OTHER ANCI LLARY SERVICES 0 0 0.000000 0.000000 76.03 76.04 03952 ANCI LLARY SERVI CE COST CENTERS 0 0 0.000000 0.000000 | 67.00 06700 OCCUPATI ONAL THERAPY | C | 4, 495, 255 | 0. 000000 | 0. 000000 | 163, 051 | 67.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY 0 7,822,372 0.000000 0.000000 68,836 70.00 71.00 O7000 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 61,656,352 0.000000 0.000000 1,843,313 71.00 72.00 07300 DRUGS CHARGED TO PATI ENTS 0 44,114,734 0.000000 0.000000 0 72.00 73.00 07300 RENAL DI ALYSI S 650,763 74,762,550 0.008704 0.088704 4,058,934 73.00 74.00 07400 RENAL DI ALYSI S 0 1,989,829 0.000000 0.000000 133,874 74.00 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0.000000 0.000000 76.01 76.02 03950 NEUROPSYCHI ATRI C/SERVI CES 0 0 0.000000 0.000000 76.02 76.04 03952 ANCI LLARY SERVI CE 0 0 0.000000 0.000000 0 76.02 76.04 03954 IMAGI NG CENTER | 68.00 06800 SPEECH PATHOLOGY | C | 1, 538, 973 | 0. 000000 | 0. 000000 | 62, 065 | 68.00 |
| 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 61, 656, 352 0.000000 0.000000 1, 843, 313 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 44, 114, 734 0.000000 0.000000 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 650, 763 74, 762, 550 0.008704 0.008704 4, 058, 934 73.00 74.00 07400 RENAL DI ALYSI S 0 1, 989, 829 0.000000 0.000000 126, 438 76.00 76.00 03330 ENDOSCOPY 0 12, 700, 946 0.000000 0.000000 0 76.00 76.01 03550 PSYCHI ATRI C /PSYCHOLOGI CAL SERVI CES 0 0 0.000000 0.000000 0 76.00 76.02 03951 OTHER ANCI LLARY SERVI CES 0 0 0.000000 0.000000 76.02 76.04 03952 ANCI LLARY SERVI CE COST CENTERS 0 0 0.000000 0.000000 76.05 76.05 03953 II AGI NG CENTER 0 0 0.000000 0.000000 | 69.00 06900 ELECTROCARDI OLOGY | C | 6, 255, 328 | 0. 000000 | 0. 000000 | 320, 550 | 69.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 44, 114, 734 0.000000 0.000000 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 650, 763 74, 762, 550 0.008704 0.008704 4, 058, 934 73.00 74.00 07400 RENAL DI ALYSI S 0 1, 989, 829 0.000000 0.000000 133, 874 74.00 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 12, 700, 946 0.000000 0.000000 126, 438 76.00 76.02 03950 NEUROPSYCHI ATRI C SERVI CES 0 0 0.000000 0.000000 0 76.01 76.03 03951 OTHER ANCI LLARY SERVI CES 0 0 0.000000 0.000000 0 76.02 76.04 03952 ANCI LLARY SERVI CE COST CENTERS 0 0 0.000000 0.000000 0 76.04 76.05 03953 MI SC ANCI LLARY SERVI CE COST CENTER 0 0 0.000000 0.000000 0 76.04 76.06 03954 I MAGI NG CENTER 0 0.863, 967 0 | 70.00 07000 ELECTROENCEPHALOGRAPHY | C | 7, 822, 372 | 0. 000000 | 0. 000000 | 68, 836 | 70.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 44, 114, 734 0.000000 0.000000 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 650, 763 74, 762, 550 0.008704 0.008704 4, 058, 934 73.00 74.00 07400 RENAL DI ALYSI S 0 1, 989, 829 0.000000 0.000000 133, 874 74.00 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 12, 700, 946 0.000000 0.000000 126, 438 76.00 76.02 03950 NEUROPSYCHI ATRI C SERVI CES 0 0 0.000000 0.000000 0 76.01 76.03 03951 OTHER ANCI LLARY SERVI CES 0 0 0.000000 0.000000 0 76.02 76.04 03952 ANCI LLARY SERVI CE COST CENTERS 0 0 0.000000 0.000000 0 76.04 76.05 03953 MI SC ANCI LLARY SERVI CE COST CENTER 0 0 0.000000 0.000000 0 76.04 76.06 03954 I MAGI NG CENTER 0 0.863, 967 0 | 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | S C | 61, 656, 352 | 0. 000000 | 0. 000000 | 1, 843, 313 | 71.00 |
| 74.00 07400 RENAL DI ALYSI S 0 1,989,829 0.000000 0.000000 133,874 74.00 76.00 03330 ENDOSCOPY 0 12,700,946 0.000000 0.000000 126,438 76.00 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0.000000 0.000000 0 76.01 76.02 03950 NEUROPSYCHI ATRI C SERVI CES 0 0 0.000000 0.000000 0 76.02 76.03 03951 OTHER ANCI LLARY SERVI CES 0 0 0.000000 0.000000 0 76.03 76.04 03952 ANCI LLARY SERVI CE COST CENTERS 0 0 0.000000 0.000000 0 76.03 76.05 03953 MI SC ANCI LLARY SERVI CE COST CENTERS 0 0 0.000000 0.000000 0 76.04 76.06 03954 I MAGI NG CENTER 0 46,578,034 0.000000 0.000000 76.04 76.07 03955 BRAST DI AGNOSTI C CENTER 0 10,863,967 0.000000 0.0000000 90.00 | 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | C | | | 0. 000000 | 0 | 72.00 |
| 74.00 07400 RENAL DI ALYSI S 0 1,989,829 0.000000 0.000000 133,874 74.00 76.00 03330 ENDOSCOPY 0 12,700,946 0.000000 0.000000 126,438 76.00 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0.000000 0.000000 0 76.01 76.02 03950 NEUROPSYCHI ATRI C SERVI CES 0 0 0.000000 0.000000 0 76.02 76.03 03951 OTHER ANCI LLARY SERVI CES 0 0 0.000000 0.000000 0 76.03 76.04 03952 ANCI LLARY SERVI CE COST CENTERS 0 0 0.000000 0.000000 0 76.03 76.05 03953 MI SC ANCI LLARY SERVI CE COST CENTERS 0 0 0.000000 0.000000 0 76.04 76.06 03954 I MAGI NG CENTER 0 46,578,034 0.000000 0.000000 76.04 76.07 03955 BRAST DI AGNOSTI C CENTER 0 10,863,967 0.000000 0.0000000 90.00 | 73.00 07300 DRUGS CHARGED TO PATIENTS | 650, 763 | 74, 762, 550 | 0. 008704 | 0. 008704 | 4, 058, 934 | 73.00 |
| 76.00 03330 ENDOSCOPY 0 12,700,946 0.000000 0.000000 126,438 76.00 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0.000000 0.000000 0 76.01 76.02 03950 NEUROPSYCHI ATRI C SERVI CES 0 0 0.000000 0.000000 0 76.02 76.03 03951 OTHER ANCI LLARY SERVI CES 0 0 0.000000 0.000000 0 76.03 76.04 03952 ANCI LLARY SERVI CE COST CENTERS 0 0 0.000000 0.000000 0 76.03 76.04 03952 ANCI LLARY SERVI CE COST CENTERS 0 0 0.000000 0.000000 0 76.04 76.05 03953 MISC ANCI LLARY 0 0 0.000000 0.000000 0 76.04 76.06 03954 I MAGI NG CENTER 0 46, 578, 034 0.000000 0.000000 76.07 76.07 03955 BARI ATRI C CLI NI C <td< td=""><td>74.00 07400 RENAL DIALYSIS</td><td>C</td><td>1, 989, 829</td><td>0. 000000</td><td>0. 000000</td><td></td><td>74.00</td></td<> | 74.00 07400 RENAL DIALYSIS | C | 1, 989, 829 | 0. 000000 | 0. 000000 | | 74.00 |
| 76. 02 03950 NEUROPSYCHI ATRI C SERVI CES 0 0 0.00000 0.000000 0 76. 02 76. 03 03951 OTHER ANCI LLARY SERVI CES 0 0 0.000000 0.000000 0 76. 03 76. 04 03952 ANCI LLARY SERVI CE COST CENTERS 0 0 0.000000 0.000000 0 76. 04 76. 05 03953 MI SC ANCI LLARY SERVI CE COST CENTERS 0 0 0.000000 0.000000 0 76. 04 76. 06 03954 I MAGI NG CENTER 0 46, 578, 034 0.000000 0.000000 0 76. 06 76. 07 03955 BREAST DI AGNOSTI C CENTER 0 46, 578, 034 0.000000 0.000000 949 76. 07 76. 08 03956 BARI ATRI C CLI NI C 0 67, 545 0.000000 0.000000 949 76. 07 76. 08 03956 BARI ATRI C CLI NI C 0 67, 545 0.000000 0.000000 90. 00 90. 00 09000 CLI NI C | 76.00 03330 ENDOSCOPY | C | | | 0. 000000 | 126, 438 | 76.00 |
| 76. 03 03951 OTHER ANCI LLARY SERVICES 0 0 0.00000 0.00000 0 76. 03 76. 04 03952 ANCI LLARY SERVICE COST CENTERS 0 0 0.000000 0.000000 0 76. 04 76. 05 03953 MI SC ANCI LLARY SERVICE COST CENTERS 0 0 0.000000 0.000000 0 76. 04 76. 05 03953 MI SC ANCI LLARY 0 0 0.000000 0.000000 0 76. 04 76. 06 03954 I MAGI NG CENTER 0 46, 578, 034 0.000000 0.000000 0 76. 06 76. 07 03955 BREAST DI AGNOSTIC CENTER 0 10, 863, 967 0.000000 0.000000 949 76. 07 76. 08 03956 BARI ATRI C CLI NI C 0 67, 545 0.000000 0.000000 949 76. 07 76. 08 04973 PALLI ATI VE CARE 0 0 0.000000 90. 00 90. 00 90. 26 04975 SPI NE CENTER 0 | 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | C | 0 | 0. 000000 | 0. 000000 | 0 | 76.01 |
| 76. 04 03952 ANCI LLARY SERVICE COST CENTERS 0 0 0.000000 0.000000 0 76. 04 76. 05 03953 MI SC ANCI LLARY 0 0 0.000000 0.000000 0 76. 04 76. 06 03954 I MAGI NG CENTER 0 46, 578, 034 0.000000 0.000000 0 76. 06 76. 07 03955 BREAST DI AGNOSTI C CENTER 0 46, 578, 034 0.000000 0.000000 949 76. 07 76. 08 03956 BRAI ATRI C CLI NI C 0 67, 545 0.000000 0.000000 90 90 90 90 90 90 90. 00 90.000 90.24 <t< td=""><td>76. 02 03950 NEUROPSYCHI ATRI C SERVI CES</td><td>C</td><td>0</td><td>0. 000000</td><td>0. 000000</td><td>0</td><td>76.02</td></t<> | 76. 02 03950 NEUROPSYCHI ATRI C SERVI CES | C | 0 | 0. 000000 | 0. 000000 | 0 | 76.02 |
| 76.05 03953 MI SC ANCI LLARY 0 0 0.000000 0.000000 0 76.05 76.06 03954 I MAGI NG CENTER 0 46,578,034 0.000000 0.000000 0 76.06 76.07 03955 BREAST DI AGNOSTI C CENTER 0 10,863,967 0.000000 0.000000 949 76.07 76.08 03956 BARI ATRI C CLI NI C 0 67,545 0.000000 0.000000 949 76.07 00TPATIENT SERVICE COST CENTERS 0 0 0.000000 0.000000 0 90.00 90.00 09000 CLI NI C 0 0 0.000000 0.000000 90.02 90.24 04973 PALLI ATI VE CARE 0 0 0.000000 0.000000 90.24 90.26 04975 SPI NE CENTER 0 732,310 0.000000 0.000000 90.26 | 76.03 03951 OTHER ANCI LLARY SERVICES | C | 0 | 0. 000000 | 0. 000000 | 0 | 76.03 |
| 76. 06 03954 I MAGI NG CENTER 0 46, 578, 034 0.000000 0.000000 949 76. 06 76. 07 03955 BREAST DI AGNOSTI C CENTER 0 10, 863, 967 0.000000 0.000000 949 76. 07 76. 08 03956 BARI ATRI C CLI NI C 0 67, 545 0.000000 0.000000 0 76. 08 0UTPATI ENT SERVICE COST CENTERS 0 0 0.000000 0.000000 0 90. 00 90. 00 09000 CLI NI C 0 0 0.000000 0.000000 0 90. 00 90. 24 04973 PALLI ATI VE CARE 0 0 0.000000 0.000000 0 90. 24 90. 26 04975 SPI NE CENTER 0 732, 310 0.000000 0.000000 0 90. 26 | 76.04 03952 ANCILLARY SERVICE COST CENTERS | C | 0 | 0. 000000 | 0. 000000 | 0 | 76.04 |
| 76. 07 03955 BREAST DI AGNOSTI C CENTER 0 10, 863, 967 0.00000 0.00000 949 76. 07 76. 08 03956 BARI ATRI C CLI NI C 0 67, 545 0.00000 0.000000 0 76. 08 0UTPATI ENT SERVI CE COST CENTERS 0 0 0.000000 0.000000 0 90. 00 90. 00 09000 CLI NI C 0 0 0.000000 0.000000 0 90. 00 90. 24 04973 PALLI ATI VE CARE 0 0 0.000000 0.000000 0 90. 24 90. 26 04975 SPI NE CENTER 0 732, 310 0.000000 0.000000 0 90. 26 | 76. 05 03953 MISC ANCI LLARY | C | 0 | 0. 000000 | 0. 000000 | 0 | 76.05 |
| 76.08 03956 BARI ATRI C CLINI C 0 67,545 0.00000 0.000000 76.08 OUTPATI ENT SERVICE COST CENTERS 0 0 0.000000 0.000000 0 90.00 90.00 09000 CLINIC 0 0 0.000000 0 90.00 90.00 90.24 04973 PALLIATI VE CARE 0 0 0.000000 0.000000 0 90.24 90.26 04975 SPI NE CENTER 0 732,310 0.000000 0.000000 0 90.26 | 76.06 03954 I MAGI NG CENTER | C | 46, 578, 034 | 0. 000000 | 0. 000000 | 0 | 76.06 |
| 76.08 03956 BARI ATRI C CLINI C 0 67,545 0.00000 0.000000 76.08 OUTPATI ENT SERVICE COST CENTERS 0 0 0.000000 0.000000 0 90.00 90.00 09000 CLINIC 0 0 0.000000 0 90.00 90.00 90.24 04973 PALLIATI VE CARE 0 0 0.000000 0.000000 0 90.24 90.26 04975 SPI NE CENTER 0 732,310 0.000000 0.000000 0 90.26 | 76.07 03955 BREAST DI AGNOSTI C CENTER | C | 10, 863, 967 | 0. 000000 | 0. 000000 | 949 | 76.07 |
| 90.00 09000 CLINIC 0 0.00000 0.000000 0 90.00 90.24 04973 PALLIATIVE CARE 0 0 0.000000 0 90.24 90.26 04975 SPINE CENTER 0 732,310 0.000000 0 90.26 | 76.08 03956 BARIATRIC CLINIC | C | 67, 545 | | | 0 | 76.08 |
| 90. 24 04973 PALLIATIVE CARE 0 0.000000 0.000000 0 90. 24 90. 26 04975 SPINE CENTER 0 732, 310 0.000000 0 90. 24 | OUTPATIENT SERVICE COST CENTERS | | | • | | | 1 |
| 90. 26 04975 SPI NE CENTER 0 732, 310 0. 000000 0. 000000 0 90. 26 | 90. 00 09000 CLINIC | C | 0 | 0. 000000 | 0. 000000 | 0 | 90.00 |
| | 90. 24 04973 PALLI ATI VE CARE | C | 0 | 0. 000000 | 0. 000000 | 0 | 90.24 |
| | 90. 26 04975 SPI NE CENTER | C | 732, 310 | 0. 000000 | 0. 000000 | 0 | 90.26 |
| 90. 27 04970 DTABETTC CARE CENTER 0 0 0. 000000 0. 000000 0 90. 27 | 90. 27 04976 DI ABETI C CARE CENTER | C | 0 0 | | | 0 | 90.27 |
| | | 157, 280 | 113, 172, 177 | 0. 001390 | | 1, 211, 075 | 91.00 |
| 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 22, 810, 177 0.000000 0.000000 180, 319 92. 00 | 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART |) (| 22, 810, 177 | 0. 000000 | 0. 000000 | 180, 319 | 92.00 |
| 200. 00 Total (lines 50-199) 819,049 849,484,326 19,262,421 200. 00 | 200.00 Total (lines 50-199) | 819, 049 | 849, 484, 326 | | | 19, 262, 421 | 200. 00 |

| APPORT IONNERT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 150169 Period: Tron 01/01/2014 Port 1/ms Period: Port 01/01/2014 Port 1/ms Period: Port 01/01/2014 Port 1/ms Period: Port 01/01/2014 Port 1/ms Period: Port | Health Financial Systems COMM | IUNI TY HOSPI TAL | OF INDIANA, II | VC. | In Li | eu of Form CMS- | -2552-10 | |
|--|---|------------------------------|----------------|-------------|-----------|-----------------|----------------|-------|
| Instrument To 12/31/2014 Date/Time Prepared: 5/21/2014 Date/Time Prepared: 5/21/2014 Cost: Center Description Inpatient Program Pass-Through Costs (col. 8 Outpatient Charges Outpatient Program Pass-Through Costs (col. 9 Not x col. 10 Not x col. 10 0.00 00000PERATIK ROW A 0000PERATIK ROW A 000 0 5000 0.00 05000 DEFARTIK ROW A 0 0 0 5000 0.00 05000 DEFARTIK ROW A 0 0 0 5000 0.00 05000 DEFARTIK ROW A 0 0 0 5000 0.00 05000 DELVIEXP ROM GOBELVIEXP ROM A 0 0 0 5500 0.00 05000 CT SXM A LABOR ROM GOB CT SXM 0 0 0 5500 0.00 00000 CT SXM 0 0 0 0 5500 0.00 00000 CT SXM SXM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | VICE OTHER PASS | 6 Provi der | CCN: 150169 | | | | |
| Cost Center Description Inpatient Program Costs (col. 8 x col. 0) Outpatient Program Charges Outpatient Program Charges Hospital PPS MACILLARY SERVICE COST CENTERS x col. 0) x col. 0) x col. 120 x <td></td> <td></td> <td></td> <td></td> <td></td> <td>1 Date/Time Pr</td> <td></td> | | | | | | 1 Date/Time Pr | | |
| Cost Center Description Inpatient Program Pass.Through Costs (col. 9 x. col. 10) Outpatient Program (Carges) Outpatient Program Costs (col. 9 x. col. 12) ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 50.00 05000 OPERATING ROOM 0 0 0 0 0 50.00 05000 OPERATING ROOM 0 0 0 0 0 0 50.00 50.00 05000 OPERATING ROOM 0 0 0 0 50.00 55.00 50.00 05400 RADILOGY-THERAPEUTIC 173 0 0 55.00 55. | | | Tit | le XIX | Hospi tal | | <u>or pili</u> | |
| Program Pass. Through Costs (col. 8) Program (Charges) Program Pass. Through Costs (col. 9) Program Pass. Through Costs (col. 2) ANCLLLARY SERVICE COST CENTERS 0 0 50.00 0 0 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 51.00 51.00 51.00 51.00 52.00 60.00 52.00 60.00 52.00 52.00 55.00 60.00 55.00 60.00 55.00 55.00 55.00 60.00 55.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.0 | Cost Center Description | I npati ent | | | | | | |
| Costs (col. 8 Costs (col. 9 Costs (col. 9 11.00 12.00 13.00 50.00 05000 (PERATING ROM 0 0 0 0 50.00 51.00 52.00 53.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 56.00 55.00 58.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> | | | | | | | | |
| x col. 100 x col. 12.00 13.00 ANCILLARY SERVICE COST CENTERS 11.00 12.00 13.00 S0 00 DS000 PEEDATINE ROOM 0 0 0 S1 00 DS000 PEEDATINE ROOM 0 0 0 50.00 S2 00 DS200 DELU VERY PROM & LABOR ROOM 0 0 0 52.00 S2 00 DS200 DELU VERY PROM & LABOR ROOM 0 0 0 52.00 S4 00 DS400 RADI OLGGY-THERAPEUTIC 173 0 0 55.00 S5 00 DS500 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 66.00 S6 00 DS600 RESPI RATORY THERAPY 0 0 0 66.00 66.00 DELSTRY THERAPY 0 0 0 66.00 67.00 DELOTRY THERAPY 0 0 0 66.00 67.00 DELOTROENCEPHALDEGARAPY 0 0 0 66.00 67.00 DELOTROENCEPHALDEGARAPY 0 0 0 71.00 | | Pass-Through | Charges | Pass-Throug | h | | | |
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| 52:00 OS200 DELIVERY ROMA & LABOR ROM 0 0 52:00 54:00 OS400 RADIOLOGY-JHARNAFLITIC 173 0 54:00 55:00 DS500 RADIOLOGY-JHARNAFLITIC 0 0 55:00 57:00 DS700 CT SCAN 0 0 0 58:00 DS600 MACNETI C RESONANCE I MAGING (MRI) 0 0 0 60:00 OGONO LABORATORY 0 0 0 66:00 60:00 OGONO LINTRAVENUS THERAPY 0 0 0 66:00 66:00 61:00 OG700 OCLIPATI ONAL THERAPY 0 0 0 66:00 66:00 OG700 OCLIPATI ONAL THERAPY 0 0 0 68:00 69:00 OG700 OCLIPATI ONAL THERAPY 0 0 0 68:00 70:00 OCCUPATI ONAL THERAPY 0 0 0 70:00 70:00 OCCUPATI ONAL THERAPY 0 0 70:00 70:00 70:00 OCCUPATI ONAL THERAPY 0 0 | | | | | - | | 1 | |
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| 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 76. 01 76. 02 03950 NEUROPSYCHI ATRI C SERVI CES 0 0 0 76. 03 03951 OTHER ANCI LLARY SERVI CES 0 0 0 76. 04 03952 ANCI LLARY SERVI CE COST CENTERS 0 0 0 76. 05 03953 MI SC ANCI LLARY SERVI CE 0 0 0 76. 04 03952 ANCI LLARY SERVI CE 0 0 0 76. 04 76. 05 03953 MI SC ANCI LLARY SERVI CE 0 0 0 76. 05 76. 06 03954 IMAGI NG CENTER 0 0 0 76. 06 76. 07 03955 BREAST DI AGNOSTI C CENTER 0 0 0 76. 07 76. 08 03956 BARI ATRI C CLI NI C 0 0 0 76. 08 0117 0118 0119 0 0 0 0 76. 08 0290.00 CLI NI C 0 0 0 0 0 90. 20 | 74.00 07400 RENAL DIALYSIS | 0 | C | | 0 | | 74.00 | |
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| OUTPATIENT SERVICE COST CENTERS 0 <t< td=""><td>76.07 03955 BREAST DI AGNOSTI C CENTER</td><td>0</td><td>0</td><td></td><td>0</td><td></td><td>76.07</td></t<> | 76.07 03955 BREAST DI AGNOSTI C CENTER | 0 | 0 | | 0 | | 76.07 | |
| 90. 00 09000 CLINIC 0 0 90. 00 90. 24 04973 PALLIATIVE CARE 0 0 0 90. 24 90. 26 04975 SPINE CENTER 0 0 0 90. 26 90. 27 04976 DI ABETI C CARE CENTER 0 0 0 90. 27 91. 00 09100 EMERGENCY 1, 683 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 92. 00 | 76.08 03956 BARIATRIC CLINIC | 0 | 0 | | 0 | | 76.08 | |
| 90. 24 04973 PALLI ATI VE CARE 0 0 90. 24 90. 26 04975 SPI NE CENTER 0 0 90. 26 90. 27 04976 DI ABETI C CARE CENTER 0 0 90. 27 91. 00 09100 EMERGENCY 1, 683 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 92. 00 | OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 90. 26 04975 SPI NE CENTER 0 0 90. 26 90. 27 04976 DI ABETI C CARE CENTER 0 0 90. 27 91. 00 09100 EMERGENCY 1, 683 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 92. 00 | 90. 00 09000 CLINIC | 0 | 0 | | 0 | | 90.00 | |
| 90. 27 04976 DI ABETI C CARE CENTER 0 0 90. 27 91. 00 09100 EMERGENCY 1, 683 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 92. 00 | 90. 24 04973 PALLI ATI VE CARE | 0 | C | | 0 | | 90.24 | |
| 91.00 09100 EMERGENCY 1,683 0 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00 92.00 | 90. 26 04975 SPINE CENTER | 0 | C | | 0 | | 90. 26 | |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00 | 90. 27 04976 DIABETIC CARE CENTER | 0 | C | | 0 | | 90.27 | |
| | 91. 00 09100 EMERGENCY | 1, 683 | C | | 0 | | 91.00 | |
| 200.00 Total (lines 50-199) 37, 185 0 0 200.00 | 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | C | | | | 92.00 | |
| | 200.00 Total (lines 50-199) | 37, 185 | C | | 0 | | 200. 00 | |

| APPORTI ONMENT OF | MEDICAL, OTHER HEALTH SERVICES AND | D VACCINE COST | Provi der | CCN: 150169 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Pre 5/27/2015 6:0 | pared: 7 pm |
|--------------------|--|------------------------|----------------|--------------|---|---|----------------|
| | | | Tit | le XIX | Hospi tal | PPS | |
| | | | | Charges | | Costs | |
| Cost | t Center Description | Cost to Charge | PPS Reimbursed | Cost | Cost | PPS Services | |
| | | Ratio From | Services (see | Reimbursed | Reimbursed | (see inst.) | |
| | | Worksheet C, | inst.) | Servi ces | Services Not | | |
| | | Part I, col. 9 | | Subject To | Subject To | | |
| | | | | Ded. & Coins | | | |
| | | | | (see inst.) | | | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | SERVICE COST CENTERS | 0 171070 | | 1 226 2 | | 0 | 1 50 00 |
| | RATING ROOM | 0. 171278 | | | | 0 | |
| | OVERY ROOM | 0. 167201 0. 500242 | 0 | | 57 0 0 0 | 0 | |
| | VERY ROOM & LABOR ROOM | | | | - | 0 | |
| | OLOGY-DI AGNOSTI C OLOGY-THERAPEUTI C | 0. 229758 | | | | | |
| | | 0. 116659 | - | | | 0 | |
| 57.00 05700 CT S | | 0. 045902 | | | | 0 | |
| | NETIC RESONANCE IMAGING (MRI) | 0. 228599 | 0 | | | 0 | |
| 60.00 06000 LAB | | 0. 064492 | 0 | | | 0 | 1 |
| | RAVENOUS THERAPY | 0. 388654 | 0 | | | 0 | |
| | PIRATORY THERAPY | 0. 188835 | 0 | | | 0 | |
| | SI CAL THERAPY | 0. 345856 | | | | 0 | |
| | | 0. 449274 | 0 | | | 0 | |
| | ECH PATHOLOGY CTROCARDI OLOGY | 0. 300766 | | | | 0 | |
| | CTROENCEPHALOGRAPHY | 0. 305432 0. 278754 | | | | 0 | |
| | | | | | | 0 | |
| | CAL SUPPLIES CHARGED TO PATIENTS DEV. CHARGED TO PATIENTS | 0. 218573 0. 405593 | | | 0 0 | 0 | |
| | GS CHARGED TO PATTENTS | 0. 253272 | | | - | 0 | |
| | AL DIALYSIS | 0. 253272 | - | | | 0 | |
| 76.00 03330 END | | 0. 212840 | | | - | 0 | 1 |
| | CHIATRIC/PSYCHOLOGICAL SERVICES | 0. 212840 | | | 0 0 | 0 | 1 |
| | ROPSYCHI ATRI C SERVI CES | 0. 000000 | 0 | | 0 0 | 0 | |
| | ER ANCI LLARY SERVICES | 0. 000000 | | | 0 0 | 0 | |
| | LLARY SERVICE COST CENTERS | 0. 000000 | | | 0 0 | 0 | |
| | C ANCI LLARY | 0. 000000 | | | 0 0 | 0 | |
| | GING CENTER | 0. 105641 | 0 | | - | 0 | 1 |
| | AST DI AGNOSTI C CENTER | 0. 650225 | - | , . | | 0 | |
| | ATRIC CLINIC | 0. 205611 | 0 | | 0 0 | 0 | |
| | T SERVICE COST CENTERS | | - | | | | |
| 90.00 09000 CLIM | | 0. 000000 | 0 | | 0 0 | 0 | 90.00 |
| 90. 24 04973 PALI | LIATIVE CARE | 0. 000000 | 0 | | 0 0 | 0 | 90.24 |
| 90. 26 04975 SPI M | | 0. 397769 | | | 0 0 | 0 | 1 |
| | BETIC CARE CENTER | 0. 000000 | | | 0 0 | 0 | |
| 91.00 09100 EMER | | 0. 124035 | 0 | 6, 376, 8 | 20 0 | 0 | 91.00 |
| | ERVATION BEDS (NON-DISTINCT PART) | 0. 194574 | 0 | | | 0 | 92.00 |
| | total (see instructions) | | 0 | 17, 340, 2 | 73 0 | 0 | 200.00 |
| 201.00 Less | s PBP Clinic Lab. Services-Program | | | | 0 0 | | 201.00 |
| | | 1 | 1 | 1 | | | 1 |
| | / Charges Charges (line 200 +/- line 201) | | 0 | 17, 340, 2 | 73 0 | | 202.00 |

| Health Financial Systems | COMMUNI TY HOSPI TAL | | | | u of Form CMS-2552- |
|--|----------------------|---------------|-------------|---|---|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICE | S AND VACCINE COST | Provi der | CCN: 150169 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared |
| | | т; + | | Hocpital | 5/27/2015 6:07 pm PPS |
| | Cor | sts | le XIX | Hospital | PP5 |
| Cost Center Description | Cost | Cost | - | | |
| cost center bescription | Reimbursed | Reimbursed | | | |
| | Servi ces | Servi ces Not | | | |
| | Subject To | Subject To | | | |
| | Ded. & Coins. | Ded. & Coins. | | | |
| | (see inst.) | (see inst.) | | | |
| | 6.00 | 7.00 |] | | |
| ANCI LLARY SERVI CE COST CENTERS | | | | | |
| 50.00 OPERATING ROOM | 211, 757 | | | | 50.0 |
| 51.00 05100 RECOVERY ROOM | 13, 705 | | | | 51.0 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | - | • | | 52.0 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 266, 338 | | | | 54.0 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 54, 834 | | 1 | | 55.0 |
| 57.00 05700 CT SCAN | 74, 414 | C | • | | 57.0 |
| 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) | 133, 825 | | 1 | | 58.0 |
| 60. 00 06000 LABORATORY | 106, 329 | | • | | 60. (|
| 64. 00 06400 I NTRAVENOUS THERAPY | 5, 231 | C | | | 64. |
| 65. 00 06500 RESPI RATORY THERAPY | 27, 296 | | 1 | | 65.0 |
| 66. 00 06600 PHYSI CAL THERAPY | 62, 567 | C | | | 66. |
| 67.00 06700 OCCUPATI ONAL THERAPY | 14,062 | | | | 67. |
| 68. 00 06800 SPEECH PATHOLOGY | 12, 866 | | 1 | | 68. |
| 69. 00 06900 ELECTROCARDI OLOGY | 4, 558 | | • | | 69. |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 36, 181 | C | • | | 70. |
| 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIEN | TS 79, 567 | | • | | 71. |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS | 185, 899 | - | • | | 72.0 |
| 74. 00 07400 RENAL DIALYSIS | 100, 099 | | | | 73.0 |
| 74. 00 07400 RENAL DIALISIS 76. 00 03330 ENDOSCOPY | 43, 284 | | 1 | | 74. |
| 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | | - | • | | 76. |
| 76. 02 03950 NEUROPSYCHI ATRI C SERVI CES | 0 | | | | 76. |
| 76. 03 03951 OTHER ANCI LLARY SERVICES | 0 | | 1 | | 76. |
| 76. 04 03952 ANCI LLARY SERVICE COST CENTERS | 0 | - | • | | 76. |
| 76. 05 03953 MISC ANCI LLARY | 0 | - | • | | 76. |
| 76.06 03954 I MAGI NG CENTER | 75, 838 | | | | 76. |
| 76.07 03955 BREAST DIAGNOSTIC CENTER | 68, 092 | c c | | | 76.0 |
| 76.08 03956 BARIATRIC CLINIC | 0 | | | | 76.0 |
| OUTPATIENT SERVICE COST CENTERS | | | | | |
| 90. 00 09000 CLINIC | 0 | C | | | 90. |
| 90. 24 04973 PALLI ATI VE CARE | 0 | C | | | 90. : |
| 90. 26 04975 SPI NE CENTER | 0 | C | | | 90. : |
| 90. 27 04976 DI ABETI C CARE CENTER | 0 | | • | | 90. : |
| 91.00 09100 EMERGENCY | 790, 949 | | | | 91.0 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR | | C | • | | 92. |
| 200.00 Subtotal (see instructions) | 2, 555, 353 | | | | 200. (|
| 201.00 Less PBP Clinic Lab. Services-Prog | ram O | | | | 201. (|
| Only Charges | | - | | | |
| 202.00 Net Charges (line 200 +/- line 201 |) 2, 555, 353 | C | 4 | | 202. |

Health Financial Systems COMPUTATION OF INPATIENT OPERATING COST In Lieu of Form CMS-2552-10 Worksheet D-1 COMMUNITY HOSPITAL OF INDIANA, INC. Provider CCN: 150169 Peri od: From 01/01/2014 To 12/31/2014 Title XVIII Hospi tal Cost Center Description _

Date/Time Prepared: 5/27/2015 6:07 pm PPS

| | Cost Center Description | 1.00 | |
|----------------|--|-------------------|-------|
| | PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS | | |
| 1.00 | Inpatient days (including private room days and swing-bed days, excluding newborn) | 56, 743 | 1.00 |
| 2.00 | Inpatient days (including private room days, excluding swing-bed days, excluding newborn) | 56, 743 | 2.00 |
| 2.00 3.00 | Private room days (excluding 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, | 50, 743 | 3.00 |
| 3.00 | do not complete this line. | 0 | 3.00 |
| 4.00 | Semi-private room days (excluding swing-bed and observation bed days) | 51, 749 | 4.00 |
| 5.00 | Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost | 01, 717 | 5.00 |
| 0.00 | reporting period | 0 | 0.00 |
| 6.00 | Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost | 0 | 6.00 |
| | reporting period (if calendar year, enter 0 on this line) | | |
| 7.00 | Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost | 0 | 7.00 |
| | reporting period | | |
| 8.00 | Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost | 0 | 8.00 |
| | reporting period (if calendar year, enter 0 on this line) | | |
| 9.00 | Total inpatient days including private room days applicable to the Program (excluding swing-bed and | 18, 408 | 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) | 0 | 11 00 |
| 11.00 | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | 0 | 11.00 |
| 12.00 | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) | 0 | 12.00 |
| 12.00 | through December 31 of the cost reporting period | 0 | 12.00 |
| 13.00 | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) | 0 | 13.00 |
| 101.00 | after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | 0 | 10100 |
| 14.00 | Medically necessary private room days applicable to the Program (excluding swing-bed days) | 0 | 14.00 |
| 15.00 | Total nursery days (title V or XIX only) | 0 | 15.00 |
| 16.00 | Nursery days (title V or XIX only) | 0 | 16.00 |
| | SWING BED ADJUSTMENT | | |
| 17.00 | Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost | 0.00 | 17.00 |
| | reporting period | | |
| 18.00 | Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost | 0.00 | 18.00 |
| | reporting period | | |
| 19.00 | Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost | 0.00 | 19.00 |
| 00.00 | reporting period | 0.00 | |
| 20.00 | Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost | 0.00 | 20.00 |
| 21.00 | reporting period | 50, 428, 620 | 21.00 |
| 21.00 | Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line | 50, 428, 820 0 | |
| 22.00 | 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 |
| 201.00 | | 0 | 20100 |
| 24.00 | Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line | 0 | 24.00 |
| | 7 x line 19) | | |
| 25.00 | Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 | 0 | 25.00 |
| | x line 20) | | |
| 26.00 | Total swing-bed cost (see instructions) | 0 | |
| 27.00 | General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) | 50, 428, 620 | 27.00 |
| | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | | |
| 28.00 | | 0 | 28.00 |
| 29.00 | Private room charges (excluding swing-bed charges) | 0 | 29.00 |
| 30.00 | Semi-private room charges (excluding swing-bed charges) | 0 | |
| 31.00 | General inpatient routine service cost/charge ratio (line 27 ÷ line 28) | 0.00000 | |
| 32.00 | Average private room per diem charge (line 29 ÷ line 3) | 0.00 | |
| 33.00 | Average semi-private room per diem charge (line 30 ÷ line 4) | 0.00 | |
| 34.00 | Average per diem private room charge differential (line 32 minus line 33)(see instructions) | 0.00 | |
| 35.00 | Average per diem private room cost differential (line 34 x line 31) | 0.00 | |
| 36.00 | Private room cost differential adjustment (line 3 x line 35) | 0 | 36.00 |
| 37.00 | General inpatient routine service cost net of swing-bed cost and private room cost differential (line | 50, 428, 620 | 37.00 |
| | 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY | | |
| | | | |
| 38.00 | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) | 888.72 | 38.00 |
| 38.00 39.00 | Program general inpatient routine service cost (line 9 x line 38) | 16, 359, 558 | |
| 40.00 | Medically necessary private room cost applicable to the Program (line 14 x line 35) | 10, 359, 558 | 40.00 |
| | Total Program general inpatient routine service cost (line 39 + line 40) | 16, 359, 558 | |
| | | | |

| | FATION OF INPATIENT OPERATING COST | | 1. ovr dor | CCN: 150169 | Period: From 01/01/2014 | Worksheet D-1 | I |
|----------|---|-------------------------|-------------------------|--|----------------------------|--------------------------------------|------|
| | | | | | To 12/31/2014 | | |
| | | | | e XVIII | Hospi tal | PPS | |
| | 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 | |
| 00 | NURSERY (title V & XIX only) | 0 | 0 | 0. (| 0 0 | , C |) 42 |
| | Intensive Care Type Inpatient Hospital Units | | | | | | |
| 00 | | 8, 150, 065 | 5, 161 | 1, 579. ⁻ | 16 2, 140 | 3, 379, 402 | |
| 00 | | | | | | | 44 |
| 00 | BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT | | | | | | 45 |
| | NEONATAL INTENSIVE CARE UNIT | 12, 990, 494 | 11, 463 | 1, 133. 2 | 25 0 | o c | |
| 00 | Cost Center Description | 12, 770, 171 | 11, 100 | 1,100.1 | 0 0 | | |
| | | | | | | 1.00 | |
| 00 | Program inpatient ancillary service cost (Wks | | | | | 30, 247, 597 | |
| 00 | | 11 through 48)(| see instructio | ns) | | 49, 986, 557 | 49 |
| 00 | PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa | atient routine | services (from | Wkst D sur | of Parts 1 and | 2, 079, 615 | 5 50 |
| 00 | | | 301 11 003 (11 0 | intot. D, Su | | 2,077,010 | |
| 00 | Pass through costs applicable to Program inpa | atient ancillar | ry services (fr | om Wkst. D, s | sum of Parts II | 2, 776, 263 | 3 51 |
| | and IV) | | | | | | |
| 00 | Total Program excludable cost (sum of lines 5 | | | | | 4, 855, 878 | |
| 00 | Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5 | | eraτeα, non-phy | sıcıan anestr | ietist, and | 45, 130, 679 | 9 53 |
| | TARGET AMOUNT AND LIMIT COMPUTATION |) | | | | 1 | - |
| 00 | | | | | | C | 54 |
| 00 | 5 | | | | | 0.00 | 55 |
| 00 | Target amount (line 54 x line 55) | | | | | 0 | |
| 00 | Difference between adjusted inpatient operati | ng cost and ta | irget amount (I | ine 56 minus | line 53) | 0 | |
| 00 | Bonus payment (see instructions) | | | | | 0 | |
| 00 | Lesser of lines 53/54 or 55 from the cost rep market basket | borting period | ending 1996, u | poated and co | ompounded by the | 0.00 |) 59 |
| 00 | Lesser of lines 53/54 or 55 from prior year of | cost report. up | dated by the m | arket basket | | 0.00 | 60 |
| 00 | If line 53/54 is less than the lower of lines | | | | the amount by | 0 | |
| | which operating costs (line 53) are less than | | s (lines 54 x | 60), or 1% of | the target | | |
| | amount (line 56), otherwise enter zero (see i | nstructions) | | | | _ | |
| 00 | | | | | | 0 | |
| 00 | Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST | ent (see instru | ictions) | | | 0 |) 63 |
| 00 | Medicare swing-bed SNF inpatient routine cost | ts through Dece | mber 31 of the | cost reporti | na period (See | 0 | 64 |
| | instructions)(title XVIII only) | | | | | | |
| 00 | Medicare swing-bed SNF inpatient routine cost | ts after Decemb | er 31 of the c | ost reporting | period (See | 0 |) 65 |
| ~ ~ | instructions)(title XVIII only) | | | | | | |
| 00 | Total Medicare swing-bed SNF inpatient routir CAH (see instructions) | ne costs (line | 64 plus line 6 | 5)(title XVII | I only). For | 0 | 66 |
| 00 | Title V or XIX swing-bed NF inpatient routine | e costs through | December 31 o | f the cost re | porting period | 0 | 67 |
| | (line 12 x line 19) | | | | | | |
| 00 | Title V or XIX swing-bed NF inpatient routine | e costs after D | ecember 31 of | the cost repo | orting period | C | 68 (|
| ~ ~ | (line 13 x line 20) | | | (2) | | | |
| . 00 | Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU | | | , | | 0 | 0 69 |
| 00 | | | | | | | 70 |
| 00 | Adjusted general inpatient routine service co | | | | | | 71 |
| 00 | 3 0 1 | | | | | | 72 |
| 00 | Medically necessary private room cost applica | | | ne 35) | | | 73 |
| 00 | Total Program general inpatient routine servi | • | | | | | 74 |
| 00 | Capital-related cost allocated to inpatient r | routine service | e costs (from W | orksheet B, F | art II, column | | 75 |
| 00 | 26, line 45) Per diem capital-related costs (line 75 ÷ lir | ne 2) | | | | | 76 |
| 00 | Program capital-related costs (line 9 x line | , | | | | | 77 |
| 00 | 0 1 | | | | | | 78 |
| 00 | Aggregate charges to beneficiaries for excess | | orovi der record | s) | | | 79 |
| 00 | 5 | | ost limitation | (line 78 mir | nus line 79) | | 80 |
| 00 | | | ` | | | | 81 |
| 00 | | | · . | | | | 82 |
| 00 00 | Reasonable inpatient routine service costs (s | | 15) | | | | 83 |
| 00 | Program inpatient ancillary services (see ins Utilization review - physician compensation (| | uns) | | | | 84 |
| 00 | 1.5 1 | | | | | | 86 |
| | PART IV - COMPUTATION OF OBSERVATION BED PASS | | / | | | , | 1 - |
| 00 | Total observation bed days (see instructions) | | | | | 4, 994 | 1 87 |
| . 00 | | | | | | | 1 |
| 00 | Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see | • | , | | | 888.72 4,438,268 | |

| Health Financial Systems COMM | IUNI TY HOSPI TAL | OF INDIANA, IN | IC. | In Lie | u of Form CMS-2 | 2552-10 |
|---|-------------------|----------------|------------|----------------------------|-----------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provi der | | Period: From 01/01/2014 | Worksheet D-1 | |
| | | | | To 12/31/2014 | | |
| | | Titl | e XVIII | Hospi tal | PPS | |
| Cost Center Description | Cost | Routine Cost | column 1 ÷ | Total | Observati on | |
| | | (from line 27) | column 2 | Observati on | Bed Pass | |
| | | | | Bed Cost (from | Through Cost | |
| | | | | line 89) | (col. 3 x col. | |
| | | | | | 4) (see | |
| | | | | | instructions) | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST | | | | | |
| 90.00 Capital-related cost | 5, 479, 518 | 50, 428, 620 | 0. 108659 | 9 4, 438, 268 | 482, 258 | 90.00 |
| 91.00 Nursing School cost | 0 | 50, 428, 620 | 0.00000 | 4, 438, 268 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 50, 428, 620 | 0.00000 | 0 4, 438, 268 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | 50, 428, 620 | 0.00000 | | | 93.00 |

| MPUT | ATION OF INPATIENT OPERATING COST | Provider CCN: 150169 Component CCN: 15S169 Title XVIII | Subprovi der – | Worksheet D-1 Date/Time Pre 5/27/2015 6:0 PPS | pare |
|------|--|--|------------------|--|-------|
| | Cost Center Description | | I PF | 1.00 | |
| | PART I - ALL PROVIDER COMPONENTS | | | 1.00 | |
| | INPATIENT DAYS | | | | |
| | Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-bed | 5 , | | 3, 120 3, 120 | |
| | Private room days (excluding swing-bed and observation bed days) | | vate room davs. | 3, 120 | |
| | do not complete this line. | , | | | |
| 00 | Semi-private room days (excluding swing-bed and observation bed | | | 3, 120 | 4 |
| 00 | Total swing-bed SNF type inpatient days (including private room reporting period | days) through December | r 31 of the cost | 0 | 5 |
| 00 | Total swing-bed SNF type inpatient days (including private room | days) after December 3 | 31 of the cost | 0 | 6 |
| | reporting period (if calendar year, enter 0 on this line) | | | _ | |
| 00 | Total swing-bed NF type inpatient days (including private room or reporting period | days) through December | 31 of the cost | 0 | 7 |
| 00 | Total swing-bed NF type inpatient days (including private room o | davs) after December 3 | 1 of the cost | 0 | 8 |
| | reporting period (if calendar year, enter 0 on this line) | - | | - | |
| 00 | Total inpatient days including private room days applicable to room days) | the Program (excluding | swing-bed and | 2, 633 | 9 |
| . 00 | newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only | v (including private r | oom days) | 0 | 10 |
| | through December 31 of the cost reporting period (see instruction | ons) | 5 | 0 | |
| . 00 | Swing-bed SNF type inpatient days applicable to title XVIII only | | oom days) after | 0 | 11 |
| . 00 | December 31 of the cost reporting period (if calendar year, enter Swing-bed NF type inpatient days applicable to titles V or XIX of | | e room days) | 0 | 12 |
| . 00 | through December 31 of the cost reporting period | only (the during private | c room days) | 0 | '2 |
| . 00 | Swing-bed NF type inpatient days applicable to titles V or XIX (| | | 0 | 13 |
| . 00 | after December 31 of the cost reporting period (if calendar year Medically necessary private room days applicable to the Program | | | 0 | 14 |
| | Total nursery days (title V or XIX only) | (excluding swing-bed | uays) | 0 | |
| . 00 | Nursery days (title V or XIX only) | | | 0 | 16 |
| | SWING BED ADJUSTMENT Madi care rate for swing had SNE convises applieshle to convises | through December 21 of | f the cost | 0.00 | 1 1 7 |
| . 00 | Medicare rate for swing-bed SNF services applicable to services reporting period | through becember 31 o | the cost | 0.00 | |
| . 00 | Medicare rate for swing-bed SNF services applicable to services | after December 31 of | the cost | 0.00 | 18 |
| . 00 | reporting period | through December 21 of | the east | 0.00 | 10 |
| . 00 | Medicaid rate for swing-bed NF services applicable to services reporting period | thi ough beceniber 31 01 | the cost | 0.00 | 19 |
| . 00 | Medicaid rate for swing-bed NF services applicable to services a | after December 31 of t | ne cost | 0.00 | 20 |
| . 00 | reporting period | | | 2, 805, 150 | 21 |
| | Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December | 31 of the cost report | ng period (line | 2, 805, 150 | |
| | 5 x line 17) | | | - | |
| . 00 | Swing-bed cost applicable to SNF type services after December 3 | 1 of the cost reporting | g period (line 6 | 0 | 23 |
| . 00 | x line 18) Swing-bed cost applicable to NF type services through December 3 | 31 of the cost reportio | na period (line | 0 | 24 |
| | 7 x line 19) | - | | | |
| . 00 | Swing-bed cost applicable to NF type services after December 31 | of the cost reporting | period (line 8 | 0 | 25 |
| . 00 | x line 20) Total swing-bed cost (see instructions) | | | 0 | 26 |
| | General inpatient routine service cost net of swing-bed cost (li | ine 21 minus line 26) | | 2, 805, 150 | |
| | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | and abcomuction had ab | - | 0 | |
| | General inpatient routine service charges (excluding swing-bed a Private room charges (excluding swing-bed charges) | and observation bed cha | arges) | 0 | |
| | Semi -private room charges (excluding swing-bed charges) | | | 0 | |
| | General inpatient routine service cost/charge ratio (line 27 ÷ l | line 28) | | 0.000000 | |
| | Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) | | | 0.00 0.00 | |
| | Average per diem private room charge differential (line 32 minus | s line 33)(see instruc | tions) | 0.00 | |
| | Average per diem private room cost differential (line 34 x line | | | 0.00 | 35 |
| | Private room cost differential adjustment (line 3 x line 35) | d polyate ''' | Fforonti -1 (1) | 0 | |
| . 00 | General inpatient routine service cost net of swing-bed cost and 27 minus line 36) | a private room cost di | rrerential (line | 2, 805, 150 | 37 |
| | PART II - HOSPITAL AND SUBPROVIDERS ONLY | | | | |
| | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST | | | | |
| | Adjusted general inpatient routine service cost per diem (see in | | | 899.09 2 367 304 | |
| | Program general inpatient routine service cost (line 9 x line 38 Medically necessary private room cost applicable to the Program | | | 2, 367, 304 0 | |
| | Total Program general inpatient routine service cost (line 39 + | . , | | 2, 367, 304 | |

| | ATION OF INPATIENT OPERATING COST | | Provider | - CCN: 150169 | Period: From 01/01/2014 | | |
|--------------|--|-------------------------|------------------------|-----------------------|----------------------------|--------------------------------|--------------|
| | | | Componer | nt CCN: 15S169 | To 12/31/2014 | | |
| | | | Ti t | le XVIII | Subprovider - IPF | PPS | <u> </u> |
| | Cost Center Description | Total Inpatient Cost | Total Inpatient Day | | Program Days | Program Cost (col. 3 x col. | |
| | | 1.00 | 2.00 | <u>col.2)</u> 3.00 | 4.00 | 4) 5.00 | |
| 00 | NURSERY (title V & XIX only) | 0 | | | 00 0 | | 3 42 |
| 00 | Intensive Care Type Inpatient Hospital Units | 0 | [| 0 0 | 00 0 | 1 | 0 43 |
| . 00 . 00 | I NTENSI VE CARE UNI T CORONARY CARE UNI T | 0 | | 0 0. | 00 0 | | 0 43 44 |
| | BURN I NTENSI VE CARE UNI T | | | | | | 45 |
| 00 | SURGICAL INTENSIVE CARE UNIT | | | | | | 46 |
| 00 | NEONATAL INTENSIVE CARE UNIT Cost Center Description | 0 | | 0 0. | 00 0 | | 2 47 |
| | | | | | | 1.00 | |
| | Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines 4 | | | ons) | | 420, 655 2, 787, 959 | |
| | PASS THROUGH COST ADJUSTMENTS | | · | | | | |
| . 00 | Pass through costs applicable to Program inpa | atient routine | services (fro | om Wkst. D, su | m of Parts I and | 261, 273 | 3 50 |
| . 00 | <pre>III) Pass through costs applicable to Program inpa</pre> | atient ancillar | y services (f | rom Wkst. D, | sum of Parts II | 36, 948 | 8 51 |
| 00 | and IV) | | - | | | | |
| . 00 . 00 | Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclud | | lated non-ph | ivsician anest | hetist and | 298, 221 2, 489, 738 | |
| | medical education costs (line 49 minus line ! | | | | | 2, 107, 130 | ` |
| . 00 | TARGET AMOUNT AND LIMIT COMPUTATION Program discharges | | | | | | 5₄ |
| . 00 | Target amount per discharge | | | | | 0.00 | |
| . 00 | Target amount (line 54 x line 55) | | | | | C | |
| . 00 . 00 | Difference between adjusted inpatient operati | ing cost and ta | arget amount (| line 56 minus | line 53) | 0 | 0 57 0 58 |
| 00 | Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep | porting period | endi na 1996. | updated and c | ompounded by the | | |
| | market basket | 0.1 | C I | | . , | | |
| . 00 . 00 | Lesser of lines 53/54 or 55 from prior year of lines 53/54 is less than the lower of lines | | | | | 0.00 | |
| . 00 | which operating costs (line 53) are less than | | | | | | |
| | amount (line 56), otherwise enter zero (see i | | | | 5 | | |
| . 00 | Relief payment (see instructions) Allowable Inpatient cost plus incentive payme | ant (and instru | (ationa) | | | | 0 62 0 63 |
| . 00 | PROGRAM INPATIENT ROUTINE SWING BED COST | | ictions) | | | | <u>)</u> 63 |
| . 00 | Medicare swing-bed SNF inpatient routine cos | ts through Dece | ember 31 of th | ne cost report | ing period (See | C | D 64 |
| . 00 | instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos | ts after Decemb | per 31 of the | cost reportin | a period (See | | 0 65 |
| . 00 | instructions)(title XVIII only) | | | | g period (see | | |
| . 00 | Total Medicare swing-bed SNF inpatient routin | ne costs (line | 64 plus line | 65)(title XVI | II only). For | C | D 66 |
| . 00 | CAH (see instructions) Title V or XIX swing-bed NF inpatient routing | e costs through | December 31 | of the cost r | eporting period | (| 0 67 |
| | (line 12 x line 19) | | | | | | |
| . 00 | Title V or XIX swing-bed NF inpatient routine (line 13 x line 20) | e costs after L | ecember 31 of | the cost rep | orting period | C | 2 68 |
| . 00 | Total title V or XIX swing-bed NF inpatient | | | | | c | 2 69 |
| 00 | PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili | | | | | 1 | |
| . 00 . 00 | Adjusted general inpatient routine service of | 2 | | | | | 70 |
| . 00 | Program routine service cost (line 9 x line | 71) | | | | | 72 |
| . 00 . 00 | Medically necessary private room cost applica Total Program general inpatient routine servi | 0 | • | | | | 73 |
| 00 | Capital-related cost allocated to inpatient | • | | | Part II, column | | 75 |
| 00 | 26, line 45) | | , | | | | |
| . 00 . 00 | Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line | | | | | | 76 |
| 00 | Inpatient routine service cost (line 74 minus | | | | | | 78 |
| 00 | Aggregate charges to beneficiaries for excess | • • | | | | | 79 |
| 00 00 | Total Program routine service costs for compa Inpatient routine service cost per diem limit | | cost limitatio | on (line 78 mi | nus Line 79) | | 80 |
| 00 | Inpatient routine service cost per drem find Inpatient routine service cost limitation (li | |) | | | | 82 |
| . 00 | Reasonable inpatient routine service costs (| see instructior | | | | | 83 |
| . 00 | Program inpatient ancillary services (see ins | | | | | | 84 |
| . 00 . 00 | Utilization review - physician compensation Total Program inpatient operating costs (sum | | | | | | 85 |
| | PART IV - COMPUTATION OF OBSERVATION BED PASS | S THROUGH COST | | | | | |
| . 00 | Total observation bed days (see instructions) | | | | | | 0 87 0 88 |
| | Adjusted general inpatient routine cost per o | diam (1: | | | | 0.00 | |

| Health Financial Systems COMM | IUNI TY HOSPI TAL | OF INDIANA, I | NC. | In Lie | eu of Form CMS-2 | 2552-10 |
|---|-------------------|----------------|------------|----------------------------|------------------|----------------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provi der | | Period: From 01/01/2014 | Worksheet D-1 | |
| | | Component | | To 12/31/2014 | | pared: 7 pm |
| | | Titl | e XVIII | Subprovider - IPF | 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 | 309, 603 | 2, 805, 150 | 0. 11036 | 9 0 | 0 | 90.00 |
| 91.00 Nursing School cost | 0 | 2, 805, 150 | 0. 00000 | 0 0 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 2, 805, 150 | 0. 00000 | 0 0 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | 2, 805, 150 | 0.00000 | 0 0 | 0 | 93.00 |

Health Financial Systems

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

In Lieu of Form CMS-2552-10

| lear th | Financial Systems COMMUNITY HOSPITAL OF | INDIANA, INC. | In Lie | u of Form CMS-2 | 2552-1 |
|----------------------------|--|-------------------------|----------------------------------|-----------------|--------|
| COMPUT | ATION OF INPATIENT OPERATING COST | Provider CCN: 150169 | Peri od: | Worksheet D-1 | |
| | | | From 01/01/2014 To 12/31/2014 | Date/Time Pre | nared |
| | | | 10 12/31/2014 | 5/27/2015 6:0 | |
| | | Title XIX | Hospi tal | PPS | |
| | Cost Center Description | | | | |
| | | | | 1.00 | |
| | PART I - ALL PROVIDER COMPONENTS | | | | - |
| | INPATIENT DAYS | | | 54 740 | |
| . 00 | Inpatient days (including private room days and swing-bed days, | | | 56, 743 | |
| 2.00 | Inpatient days (including private room days, excluding swing-be | | | 56, 743 | |
| 8.00 | Private room days (excluding swing-bed and observation bed days do not complete this line. | s). If you have only p | rivate room days, | 0 | 3.0 |
| 1.00 | Semi-private room days (excluding swing-bed and observation bed | (ave) | | 51, 749 | 4.0 |
| 5.00 | Total swing-bed SNF type inpatient days (including private room | | er 31 of the cost | 0 | |
| . 00 | reporting period | augus) thi bugh become | | 0 | 0.0 |
| . 00 | Total swing-bed SNF type inpatient days (including private room | n days) after December | 31 of the cost | 0 | 6.0 |
| | reporting period (if calendar year, enter 0 on this line) | 5 / | | | |
| . 00 | Total swing-bed NF type inpatient days (including private room | days) through December | r 31 of the cost | 0 | 7.0 |
| | reporting period | | | | |
| 3.00 | Total swing-bed NF type inpatient days (including private room | days) after December 3 | 31 of the cost | 0 | 8.0 |
| | reporting period (if calendar year, enter 0 on this line) | | | 0.544 | |
| 9.00 | Total inpatient days including private room days applicable to newborn days) | the Program (excluding | y swing-bed and | 2, 566 | 9.00 |
| 10.00 | Swing-bed SNF type inpatient days applicable to title XVIII onl | v (including private) | coom days) | 0 | 10.00 |
| . 5. 50 | through December 31 of the cost reporting period (see instructi | | com dayo) | 0 | |
| 11.00 | Swing-bed SNF type inpatient days applicable to title XVIII onl | | room days) after | 0 | 11.0 |
| | December 31 of the cost reporting period (if calendar year, ent | ter 0 on this line) | <i>,</i> | | |
| 12.00 | Swing-bed NF type inpatient days applicable to titles V or XIX | only (including priva- | te room days) | 0 | 12.0 |
| | through December 31 of the cost reporting period | | | _ | |
| 13.00 | Swing-bed NF type inpatient days applicable to titles V or XIX | | | 0 | 13.0 |
| 4.00 | after December 31 of the cost reporting period (if calendar yea Medically necessary private room days applicable to the Program | ar, enter 0 on this iii | le) davs) | 0 | 14.0 |
| 14.00 | Total nursery days (title V or XIX only) | i (excluding swing-bed | uays) | 7, 861 | |
| 6.00 | Nursery days (title V or XIX only) | | | 1, 485 | |
| | SWING BED ADJUSTMENT | | | ., | |
| 17.00 | Medicare rate for swing-bed SNF services applicable to services | s through December 31 d | of the cost | 0.00 | 17.0 |
| | reporting period | | | | |
| 18.00 | Medicare rate for swing-bed SNF services applicable to services | s after December 31 of | the cost | 0.00 | 18.0 |
| 19.00 | reporting period | through December 21 a | E the cost | 0.00 | 19.0 |
| 19.00 | Medicaid rate for swing-bed NF services applicable to services reporting period | thi ough becember 31 0 | the cost | 0.00 | 19.0 |
| 20. 00 | Medicaid rate for swing-bed NF services applicable to services | after December 31 of | the cost | 0.00 | 20.0 |
| | reporting period | | | | |
| 21.00 | Total general inpatient routine service cost (see instructions) | | | 50, 428, 620 | |
| 22.00 | Swing-bed cost applicable to SNF type services through December | - 31 of the cost repor | ting period (line | 0 | 22.0 |
| 22.00 | 5 x line 17) | 1 of the cost report. | a noried (line (| 0 | 22.0 |
| 23.00 | Swing-bed cost applicable to SNF type services after December 3 x line 18) | al of the cost reportin | ig period (Tine 6 | 0 | 23.0 |
| 24.00 | Swing-bed cost applicable to NF type services through December | 31 of the cost reporti | ng period (line | 0 | 24.0 |
| - 1. 00 | 7 x line 19) | | ng period (inne | 0 | 21.0 |
| 25.00 | Swing-bed cost applicable to NF type services after December 31 | l of the cost reporting | g period (line 8 | 0 | 25.0 |
| | x line 20) | | | | |
| 26.00 | Total swing-bed cost (see instructions) | | | 0 | |
| 27.00 | General inpatient routine service cost net of swing-bed cost (I | ine 21 minus line 26) | | 50, 428, 620 | 27.0 |
| 28.00 | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed | and observation bod of | pargos) | 0 | 28.0 |
| 29.00 | Private room charges (excluding swing-bed charges) | and observation bed ci | lai yes) | 0 | |
| 30.00 | Semi-private room charges (excluding swing bed charges) | | | 0 | |
| 1.00 | General inpatient routine service cost/charge ratio (line 27 ÷ | line 28) | | 0.00000 | |
| 2.00 | Average private room per diem charge (line 29 ÷ line 3) | / | | 0.00 | |
| 3.00 | Average semi-private room per diem charge (line 30 ÷ line 4) | | | 0.00 | |
| 4.00 | Average per diem private room charge differential (line 32 minu | | ctions) | 0.00 | |
| 35.00 | Average per diem private room cost differential (line 34 x line | e 31) | | 0.00 | |
| 36.00 | Private room cost differential adjustment (line 3 x line 35) | | CC | 0 | |
| 37.00 | General inpatient routine service cost net of swing-bed cost ar | na private room cost di | TTERENTIAL (Line | 50, 428, 620 | 37.0 |
| | 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY | | | | 1 |
| | PART IT - HOSPITAL AND SUBPROVIDERS UNLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS | STMENTS | | | 1 |
| | PROBLEM TREATER OF ERATING COST DEFORE TASS THROUGH COST ADJUS | | | 888.72 | 38.0 |
| 38.00 | Adjusted general inpatient routine service cost per diem (see i | nstructions) | 1 | 000.721 | |
| | Adjusted general inpatient routine service cost per diem (see i Program general inpatient routine service cost (line 9 x line 3 | | | 2, 280, 456 | 1 |
| 38. 00 39. 00 40. 00 | | 38) | | | 39.0 |

| | ATION OF INPATIENT OPERATING COST | | FIOVICEI | F | Period: From 01/01/2014 | | |
|----------|---|-------------------------|-------------------------|--|----------------------------|--------------------------------------|------------|
| | | | | 1 | o 12/31/2014 | Date/Time Pre 5/27/2015 6:0 | |
| | | | | | Hospi tal | PPS | |
| | Cost Center Description | Total Inpatient Cost | Total Inpatient Days | Average Per Diem (col. 1 ÷ col. 2) | Program Days | Program Cost (col. 3 x col. 4) | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 00 | NURSERY (title V & XIX only) | 5, 291, 190 | 7, 861 | 673.09 | 1, 485 | 999, 539 | 42 |
| ~~ | Intensive Care Type Inpatient Hospital Units | 0.450.045 | F 4/4 | 4 570 4/ | | | 1 40 |
| 00 00 | I NTENSI VE CARE UNI T CORONARY CARE UNI T | 8, 150, 065 | 5, 161 | 1, 579. 16 | 0 | 0 | 43 |
| 00 | BURN INTENSIVE CARE UNIT | | | | | | 45 |
| 00 | SURGICAL INTENSIVE CARE UNIT | | | | | | 46 |
| 00 | NEONATAL INTENSIVE CARE UNIT | 12, 990, 494 | 11, 463 | 1, 133. 25 | j 0 | 0 | 47 |
| | Cost Center Description | | | | | 1.00 | |
| 00 | Program inpatient ancillary service cost (Wks | st D-3 col 3 | Line 200) | | | 1.00 3,613,298 | 48 |
| 00 | Total Program inpatient costs (sum of lines | | | ns) | | 6, 893, 293 | |
| | PASS THROUGH COST ADJUSTMENTS | | | | | | |
| 00 | Pass through costs applicable to Program inpa | atient routine | services (from | Wkst. D, sum | of Parts I and | 359, 887 | 50 |
| 00 |) Dess through costs applicable to Drogram input | ationt ancillar | w convioos (fr | om Wkat D a | m of Dorte II | 252 521 | E 1 |
| 00 | Pass through costs applicable to Program inpa and IV) | atrent dictriar | y SELVICES (TE | UM WASE. D, SU | m ui raits II | 352, 521 | 51 |
| 00 | Total Program excludable cost (sum of lines ! | 50 and 51) | | | | 712, 408 | 52 |
| 00 | Total Program inpatient operating cost exclud | | lated, non-phy | sician anesthe | tist, and | 6, 180, 885 | 53 |
| | medical education costs (line 49 minus line ! | 52) | | | | | |
| 00 | TARGET AMOUNT AND LIMIT COMPUTATION Program di scharges | | | | | 0 | 54 |
| 00 | Target amount per discharge | | | | | | 55 |
| 00 | Target amount (line 54 x line 55) | | | | | 0 | 56 |
| 00 | Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) | | | | | 0 | |
| 00 00 | Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the | | | | | 0.00 | |
| 00 | market basket | porting period | ending 1996, u | ipuated and com | pounded by the | 0.00 | יכ ןי |
| 00 | Lesser of lines 53/54 or 55 from prior year of | cost report, up | dated by the m | arket basket | | 0.00 | 60 |
| 00 | If line 53/54 is less than the lower of lines | | | | | 0 | 61 |
| | which operating costs (line 53) are less than | | s (lines 54 x | 60), or 1% of | the target | | |
| 00 | amount (line 56), otherwise enter zero (see i Relief payment (see instructions) | Instructions) | | | | 0 | 62 |
| 00 | Allowable Inpatient cost plus incentive payme | ent (see instru | ictions) | | | 0 | |
| | PROGRAM INPATIENT ROUTINE SWING BED COST | | | | | | |
| 00 | Medicare swing-bed SNF inpatient routine cos | ts through Dece | mber 31 of the | e cost reportir | g period (See | 0 | 64 |
| 00 | instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos | ts after Decemh | er 31 of the c | ost reporting | neriod (See | 0 | 65 |
| 00 | instructions)(title XVIII only) | | | 1 5 | | | |
| 00 | Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For | | | | | | 66 |
| ~~ | CAH (see instructions) | | December 21 | £ +b + | | | |
| 00 | Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) | e costs through | December 31 d | or the cost rep | orting period | 0 | 67 |
| 00 | Title V or XIX swing-bed NF inpatient routine | e costs after D | ecember 31 of | the cost repor | ting period | 0 | 68 |
| | (line 13 x line 20) | | | | | | |
| 00 | Total title V or XIX swing-bed NF inpatient | | | , | | 0 | 69 |
| 00 | PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili | | | | | | 70 |
| 00 | Adjusted general inpatient routine service of | | | | | | 71 |
| 00 | Program routine service cost (line 9 x line | 71) | | | | | 72 |
| 00 | Medically necessary private room cost applicable to Program (line 14 x line 35) | | | | | | 73 |
| 00 00 | Total Program general inpatient routine servi | • | | | rt II column | | 74 |
| 00 | Capital-related cost allocated to inpatient (26, line 45) | Service | | NULLER B, Pa | ntin, corumn | | / ' |
| 00 | Per diem capital-related costs (line 75 ÷ lin | ne 2) | | | | | 76 |
| 00 | Program capital-related costs (line 9 x line 76) | | | | | | 77 |
| 00 | Inpatient routine service cost (line 74 minus | | | - > | | | 78 |
| 00 00 | Aggregate charges to beneficiaries for excess Total Program routine service costs for compa | • • | | · . | s line 70) | | 80 |
| 00 | Inpatient routine service cost per diem limi | | ost i i mitati Off | | 13 IIIC /7) | | 81 |
| 00 | Inpatient routine service cost limitation (li | |) | | | | 82 |
| 00 | Reasonable inpatient routine service costs (s | | | | | | 83 |
| 00 | Program inpatient ancillary services (see ins | | | | | | 84 |
| 00 | Utilization review - physician compensation | | | | | | 85 |
| 00 | Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS | | n ougir 85) | | | <u> </u> | 86 |
| 00 | Total observation bed days (see instructions) | | | | | 4, 994 | 87 |
| | Adjusted general inpatient routine cost per o | | line 2) | | | 888. 72 | |
| 00 00 | | • | , | | | 4, 438, 268 | |

| Health Financial Systems COMM | IUNITY HOSPITAL OF INDIANA, INC. | | | In Lieu of Form CMS-2552- | | | |
|---|----------------------------------|----------------|------------|----------------------------|----------------|-------|--|
| COMPUTATION OF INPATIENT OPERATING COST | | Provi der | | Period: From 01/01/2014 | Worksheet D-1 | | |
| | | | | To 12/31/2014 | | | |
| | | Tit | 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 | 5, 479, 518 | 50, 428, 620 | 0. 108659 | 4, 438, 268 | 482, 258 | 90.00 | |
| 91.00 Nursing School cost | 0 | 50, 428, 620 | 0.00000 | 4, 438, 268 | 0 | 91.00 | |
| 92.00 Allied health cost | 0 | 50, 428, 620 | 0.00000 | 4, 438, 268 | 0 | 92.00 | |
| 93.00 All other Medical Education | 0 | 50, 428, 620 | 0.00000 | | | 93.00 | |

| | cial Systems COMMUNITY HOSPITAL OF | Provi der | | 150140 | Perio | od. | Worksheet D-3 | 2552-10 |
|------------------|--|-----------|-------|----------|-------|--------------------------|--------------------------------|---------|
| NPATIENT AP | ICILLARY SERVICE CUST APPORTIONMENT | Provider | CCN: | 150109 | | 01/01/2014 | worksneet D-3 | |
| | | | | | То | 12/31/2014 | Date/Time Pre 5/27/2015 6:0 | |
| | | Ti tl | e XVI | 11 | H | ospi tal | PPS | |
| | Cost Center Description | | | o of Cos | t I | npati ent | Inpati ent | |
| | | | 10 | Charges | | Program | Program Costs | |
| | | | | | | Charges | (col. 1 x col. | |
| | | | | 1.00 | | 2.00 | 2) 3.00 | |
| I NPAT | I ENT ROUTI NE SERVI CE COST CENTERS | | | 1.00 | | 2.00 | 5.00 | |
| | ADULTS & PEDIATRICS | | | | | 29, 532, 548 | | 30. 00 |
| 31.00 03100 | INTENSIVE CARE UNIT | | | | | 7, 557, 405 | | 31.00 |
| 35.00 02060 | NEONATAL INTENSIVE CARE UNIT | | | | | 0 | | 35.00 |
| 10.00 04000 | SUBPROVIDER - IPF | | | | | 0 | | 40.00 |
| 41.00 04100 | SUBPROVIDER – IRF | | | | | 0 | | 41.00 |
| | NURSERY | | | | | | | 43.00 |
| | LARY SERVICE COST CENTERS | | - | | | | | |
| | OPERATING ROOM | | | 0. 1712 | | 32, 920, 568 | 5, 638, 569 | |
| | RECOVERY ROOM | | | 0.16720 | | 946, 121 | 158, 192 | |
| | DELIVERY ROOM & LABOR ROOM | | | 0.50024 | | 0 | 0 | |
| | RADI OLOGY-DI AGNOSTI C | | | 0. 22975 | | 4, 265, 813 | 980, 105 | |
| | RADI OLOGY-THERAPEUTI C | | | 0. 11665 | | 3, 258, 618 | 380, 147 | |
| | CT SCAN | | | 0.04590 | | 7, 770, 085 | 356, 662 | |
| | MAGNETIC RESONANCE IMAGING (MRI) | | | 0. 22859 | | 2, 159, 260 | 493, 605 | |
| | LABORATORY I NTRAVENOUS THERAPY | | | 0.06449 | | 21, 873, 340 493, 970 | 1, 410, 655 191, 983 | |
| | RESPIRATORY THERAPY | | | 0. 18883 | | 493,970 | 1, 470, 189 | |
| | PHYSICAL THERAPY | | | 0. 34585 | | 2, 422, 547 | 837, 852 | |
| | OCCUPATIONAL THERAPY | | | 0. 4492 | | 1, 470, 844 | 660, 812 | |
| | SPEECH PATHOLOGY | | | 0. 30076 | | 387, 887 | 116, 663 | |
| | ELECTROCARDI OLOGY | | | 0.30543 | | 2, 644, 450 | 807, 700 | |
| | ELECTROENCEPHALOGRAPHY | | | 0. 27875 | | 443, 307 | 123, 574 | |
| | MEDICAL SUPPLIES CHARGED TO PATIENTS | | | 0. 21857 | | 9, 658, 708 | 2, 111, 133 | 1 |
| | IMPL. DEV. CHARGED TO PATIENTS | | | 0.40559 | | 14, 215, 954 | 5, 765, 891 | |
| | DRUGS CHARGED TO PATIENTS | | | 0.25327 | | 25, 726, 533 | 6, 515, 810 | |
| | RENAL DI ALYSI S | | | 0.41905 | 50 | 1, 073, 535 | | |
| | ENDOSCOPY | | | 0. 21284 | | 1, 237, 653 | 263, 422 | |
| 76.01 03550 | PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | | | 0.0000 | 00 | 0 | 0 | 76.0 |
| 76.02 03950 | NEUROPSYCHI ATRI C SERVI CES | | | 0.0000 | 00 | 0 | 0 | 76.02 |
| 76.03 03951 | OTHER ANCILLARY SERVICES | | | 0.0000 | 00 | 0 | 0 | 76.03 |
| 76.04 03952 | ANCI LLARY SERVI CE COST CENTERS | | | 0.0000 | 00 | 0 | 0 | 76.04 |
| | MISC ANCILLARY | | | 0.0000 | | 0 | 0 | |
| | I MAGI NG CENTER | | | 0. 10564 | 41 | 62, 346 | 6, 586 | 76.06 |
| | BREAST DIAGNOSTIC CENTER | | | 0.65022 | | 1, 516 | 986 | |
| | BARIATRIC CLINIC | | | 0.2056 | 11 | 0 | 0 | 76.08 |
| | TI ENT SERVICE COST CENTERS | | - | | | | - | |
| | | | | 0.0000 | | 0 | 0 | |
| | PALLIATIVE CARE | | | 0.0000 | | 0 | 0 | |
| | SPINE CENTER | | | 0.39776 | | 0 | 0 | 1 |
| | DI ABETI C CARE CENTER | | | 0.0000 | | 11 227 412 | 1 202 022 | |
| | EMERGENCY | | | 0. 12403 | | 11, 237, 413 | | |
| | OBSERVATION BEDS (NON-DISTINCT PART) | | | 0. 1945 | | 582, 622 | | |
| | Total (sum of lines 50-94 and 96-98) | | 1 | | | 152, 638, 663 | 30, 247, 597 | 1200. U |
| 200.00 201.00 | Less PBP Clinic Laboratory Services-Program only charges | (lino 61) | | | | 0 | | 201.00 |

| NPATIENT ANCILLARY SERVICE | COMMUNITY HOSPIT | | CCN: 150169 | Peri od: | Worksheet D-3 | <u>2552-</u> 1 |
|--|---------------------------------------|------------------|---------------|----------------------|--------------------------------|-------------------|
| | | 0 | + CON 1501/0 | From 01/01/2014 | | |
| | | Componen | t CCN: 15S169 | To 12/31/2014 | Date/Time Pre 5/27/2015 6:0 | pared)7 pm |
| | | Ti tl | e XVIII | Subprovider - IPF | PPS | |
| Cost Center Des | scription | | Ratio of Cos | | Inpati ent | |
| | | | To Charges | Program | Program Costs | |
| | | | | Charges | (col. 1 x col. | |
| | | | 1.00 | 2.00 | 2) 3.00 | |
| INPATIENT ROUTINE SE | RVICE COST CENTERS | | 1.00 | 2.00 | 3.00 | |
| 0. 00 03000 ADULTS & PEDIA | | | | 0 | | 30. |
| 1.00 03100 INTENSIVE CARE | UNI T | | | 0 | | 31. |
| 5.00 02060 NEONATAL INTENS | | | | 0 | | 35. |
| 0. 00 04000 SUBPROVI DER - 1 | | | | 4, 932, 096 | | 40. |
| 1.00 04100 SUBPROVIDER - | RF | | | 0 | | 41. |
| 3. 00 04300 NURSERY | | | | | | 43. |
| 0.00 OSOOO OPERATING ROOM | ST CENTERS | | 0 1710 | 70 / E 000 | 11 140 | 50. |
| 1.00 05100 RECOVERY ROOM | | | 0. 1712 | | | |
| 2.00 05200 DELIVERY ROOM & | | | 0. 5002 | | | |
| 4. 00 05400 RADI OLOGY-DI AGI | | | 0. 2297 | | | |
| 5. 00 05500 RADI OLOGY-THER | | | 0. 1166 | | 0 | |
| 7. 00 05700 CT SCAN | | | 0.04590 | | | |
| B. 00 05800 MAGNETIC RESON | ANCE IMAGING (MRI) | | 0. 2285 | | | |
| D. 00 06000 LABORATORY | | | 0.0644 | 92 637, 293 | 41, 100 | 60. |
| 4. 00 06400 INTRAVENOUS TH | RAPY | | 0. 3886 | 54 20, 216 | 7, 857 | 64. |
| 5. 00 06500 RESPI RATORY THI | | | 0. 1888 | | | |
| 6. 00 06600 PHYSI CAL THERAI | | | 0.3458 | | | |
| 7. 00 06700 OCCUPATI ONAL TH | | | 0. 4492 | | | |
| 8.00 06800 SPEECH PATHOLO | | | 0.3007 | | | |
| 9.00 06900 ELECTROCARDI OLO | | | 0.3054 | | | |
| | ES CHARGED TO PATIENTS | | 0. 2787 | | | |
| 2.00 07200 IMPL. DEV. CHAI | | | 0. 2185 | | 0,401 | |
| 3. 00 07300 DRUGS CHARGED | | | 0. 2532 | | | |
| 4. 00 07400 RENAL DIALYSIS | | | 0. 4190 | | 0 | |
| 5. 00 03330 ENDOSCOPY | | | 0. 2128 | | 0 | 76. |
| 6. 01 03550 PSYCHI ATRI C/PS | CHOLOGI CAL SERVI CES | | 0.0000 | 0 00 | 0 | 76. |
| 6. 02 03950 NEUROPSYCHI ATR | | | 0.0000 | 0 00 | 0 | 76. |
| 6.03 03951 OTHER ANCI LLAR | | | 0.0000 | | 0 | |
| 5. 04 03952 ANCI LLARY SERV | CE COST CENTERS | | 0.0000 | | - | |
| 6. 05 03953 MISC ANCILLARY | | | 0.0000 | | | |
| 6. 06 03954 I MAGI NG CENTER | | | 0. 1056 | | | |
| 6. 07 03955 BREAST DI AGNOS | | | 0.6502 | | | |
| 5. 08 03956 BARIATRIC CLIN OUTPATIENT SERVICE C | | | 0.2056 | 11 0 | 0 | 76. |
| 0. 00 09000 CLINIC | JUL VENTERU | | 0.0000 | 0 00 | 0 | 90. |
| 0. 24 04973 PALLI ATI VE CARI | | | 0.0000 | | | |
| 0. 26 04975 SPI NE CENTER | | | 0. 3977 | | | |
| 0. 27 04976 DI ABETI C CARE (| CENTER | | 0.0000 | | 0 | |
| 1.00 09100 EMERGENCY | | | 0. 1240 | | 26, 236 | 91. |
| | OS (NON-DISTINCT PART) | | 0. 1945 | 74 0 | 0 | |
| | ines 50-94 and 96-98) | | | 2, 269, 783 | 420, 655 | 200. |
| | c Laboratory Services-Program only cl | narges (line 61) | | 0 | | 201. |
| 02.00 Net Charges (Li | ne 200 minus line 201) | | | 2, 269, 783 | 1 | 202. |

| | nancial Systems COMMUNITY HOSPITAL OF IN ANCILLARY SERVICE COST APPORTIONMENT | | CCN: 150169 | Po | ri od: | u of Form CMS-2 Worksheet D-3 | |
|-----------|--|---------|-------------|-----|---------------------|----------------------------------|--------|
| | ANGLEART SERVICE CUST AFFORTIONWEIVI | rovidei | CCN. 150109 | | om 01/01/2014 | Date/Time Prej 5/27/2015 6:0 | pared: |
| | | Ti t | le XIX | | Hospi tal | PPS | 7 pm |
| | Cost Center Description | | Ratio of Co | st | Inpatient | Inpati ent | |
| | | | To Charges | s | Program | Program Costs | |
| | | | | | Charges | (col. 1 x col. | |
| | | | 1.00 | | 0.00 | 2) | |
| | ATI ENT ROUTI NE SERVI CE COST CENTERS | | 1.00 | | 2.00 | 3.00 | |
| | 100 ADULTS & PEDIATRICS | | 1 | - | 4, 386, 543 | | 30.00 |
| | 00 I NTENSI VE CARE UNI T | | | | 1, 409, 610 | | 31.00 |
| | 160 NEONATAL INTENSIVE CARE UNIT | | | | 7, 932, 849 | | 35.00 |
| | 000 SUBPROVI DER – I PF | | | | 0 | | 40.00 |
| | 00 SUBPROVI DER – I RF | | | | 0 | | 41.00 |
| | 000 NURSERY | | | | 467, 295 | | 43.00 |
| | I LLARY SERVICE COST CENTERS | | | | | | 1 |
| 50.00 050 | OO OPERATING ROOM | | 0. 1712 | 278 | 2, 936, 787 | 503, 007 | 50.00 |
| | OO RECOVERY ROOM | | 0. 1672 | 201 | 526, 258 | 87, 991 | 51.00 |
| | 200 DELIVERY ROOM & LABOR ROOM | | 0. 5002 | | 545, 055 | 272, 659 | |
| | 00 RADI OLOGY-DI AGNOSTI C | | 0. 2297 | | 534, 674 | 122, 846 | |
| | 00 RADI OLOGY-THERAPEUTI C | | 0. 1166 | | 345, 371 | 40, 291 | |
| | OO CT SCAN | | 0.0459 | | 891, 369 | 40, 916 | |
| | MAGNETIC RESONANCE I MAGI NG (MRI) | | 0. 2285 | | 190, 516 | 43, 552 | |
| | DOO LABORATORY | | 0.0644 | | 3, 331, 475 | 214, 853 | |
| | 00 INTRAVENOUS THERAPY | | 0. 3886 | | 76, 231 | 29, 627 | |
| | 00 RESPI RATORY THERAPY | | 0. 1888 | | 1, 557, 380 | 294, 088 | |
| | 00 PHYSI CAL THERAPY | | 0.3458 | | 157, 901 | 54, 611 | |
| | OO OCCUPATIONAL THERAPY | | 0.4492 | | 163, 051 | 73, 255 | • |
| | 00 SPEECH PATHOLOGY 00 ELECTROCARDI OLOGY | | 0. 3007 | | 62, 065 | 18, 667 97, 906 | |
| | 100 ELECTROEARDI OLOGY 100 ELECTROENCEPHALOGRAPHY | | 0. 3052 | | 320, 550 68, 836 | 97, 908 19, 188 | |
| | 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS | | 0. 2185 | | 1, 843, 313 | 402, 898 | |
| | 200 IMPL. DEV. CHARGED TO PATIENTS | | 0. 2183 | | 1, 043, 313 | 402, 898 | |
| | 00 DRUGS CHARGED TO PATIENTS | | 0. 2532 | | 4, 058, 934 | 1, 028, 014 | |
| | 100 RENAL DI ALYSI S | | 0. 4190 | | 133, 874 | 56, 100 | |
| | ISO ENDOSCOPY | | 0. 2128 | | 126, 438 | 26, 911 | |
| | 150 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | | 0.0000 | | 0 | 20, , 0 | |
| | 50 NEUROPSYCHI ATRI C SERVI CES | | 0.0000 | | ō | 0 | |
| | 51 OTHER ANCI LLARY SERVICES | | 0.0000 | | 0 | 0 | 1 |
| | 52 ANCI LLARY SERVICE COST CENTERS | | 0.0000 | | 0 | 0 | 76.04 |
| 76.05 039 | 953 MI SC ANCI LLARY | | 0.0000 | 000 | 0 | 0 | 76.05 |
| 76.06 039 | 1 MAGI NG CENTER | | 0. 1056 | 641 | 0 | 0 | 76.06 |
| 76.07 039 | 955 BREAST DI AGNOSTI C CENTER | | 0.6502 | 225 | 949 | 617 | 76.07 |
| 76.08 039 | 56 BARIATRIC CLINIC | | 0.2056 | 611 | 0 | 0 | 76.08 |
| | PATIENT SERVICE COST CENTERS | | | | | | |
| | DOD CLINIC | | 0.0000 | | 0 | 0 | |
| | 73 PALLI ATI VE CARE | | 0.0000 | | 0 | 0 | |
| | 175 SPI NE_CENTER | | 0. 397 | | 0 | 0 | |
| | 176 DI ABETI C CARE CENTER | | 0.0000 | | 0 | 0 | |
| | 00 EMERGENCY | | 0. 1240 | | 1, 211, 075 | | |
| | OO OBSERVATION BEDS (NON-DISTINCT PART) | | 0. 1945 | 574 | 180, 319 | 35, 085 | |
| 200.00 | Total (sum of lines 50-94 and 96-98) | | | | 19, 262, 421 | 3, 613, 298 | |
| 201.00 | Less PBP Clinic Laboratory Services-Program only charges (I | ıne 61) | | | 0 | | 201.00 |
| 202.00 | Net Charges (line 200 minus line 201) | | 1 | | 19, 262, 421 | | 202.00 |

| _CUL4 | ATION OF REIMBURSEMENT SETTLEMENT | Provi der | CCN: 150169 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time P | |
|-------|--|------------|-------------|---|--------------------------------------|--------|
| | | Ti +I | e XVIII | Hospi tal | 5/27/2015 6 PPS | :07 pm |
| | | | | | | |
| - | PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS | | 0 | 1.00 | 2.00 | |
| | DRG Amounts Other than Outlier Payments | | | 0 | | 1. |
| | DRG amounts other than outlier payments for discharges occurrin to October 1 (see instructions) | g prior | | 29, 153, 747 | | 1 |
| 02 | DRG amounts other than outlier payments for discharges occurrin | g on or | | 9, 809, 589 | | 1 |
| | after October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for | | | 0 | | 1 |
| | discharges occurring prior to October 1 (see instructions) | | | 0 | | ' |
| | DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions) | | | 0 | | 1 |
| | Outlier payments for discharges. (see instructions) | | | 1, 886, 105 | | 2 |
| | Outlier reconciliation amount | ` | | 0 | | 2 |
| | Outlier payment for discharges for Model 4 BPCI (see instructio Managed Care Simulated Payments | ns) | | 0 12, 069, 854 | | 2 |
| | Bed days available divided by number of days in the cost report | ng | | 269.07 | | 4 |
| | period (see instructions) Indirect Medical Education Adjustment | | | | | _ |
| | FTE count for allopathic and osteopathic programs for the most | recent | | 0.00 | | 5 |
| | cost reporting period ending on or before 12/31/1996. (see instr | | | | | |
| | FTE count for allopathic and osteopathic programs which meet th criteria for an add-on to the cap for new programs in accordanc | | | 0.00 | | 6 |
| | CFR 413.79(e) | | | | | |
| | MMA Section 422 reduction amount to the IME cap as specified un CFR 412. 105(f)(1)(iv)(B)(1) | der 42 | | 0.00 | | 7 |
| | ACA Section 5503 reduction amount to the IME cap as specified u | nder 42 | | 0.00 | | 7 |
| | CFR 412.105(f)(1)(iv)(B)(2) If the cost report straddles July | 1, 2011 | | | | |
| | then see instructions. Adjustment (increase or decrease) to the FTE count for allopath | c and | | 0.87 | | 6 |
| | osteopathic programs for affiliated programs in accordance with | 42 CFR | | | | |
| | 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 (August 1, 2002). | FR 50069 | | | | |
| 01 | The amount of increase if the hospital was awarded FTE cap slot | s under | | 0.00 | | 6 |
| | section 5503 of the ACA. If the cost report straddles July 1, 2 instructions. | 011, see | | | | |
| | The amount of increase if the hospital was awarded FTE cap slot | s from a | | 0.00 | | 6 |
| | closed teaching hospital under section 5506 of ACA. (see instru | | | 0.07 | | |
| | Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines and 8,02) (see instructions) | (8, 8,01 | | 0.87 | | Ģ |
| | FTE count for allopathic and osteopathic programs in the curren | t year | | 1.89 | | 10 |
| | from your records FTE count for residents in dental and podiatric programs. | | | 0.00 | | 11 |
| 00 | Current year allowable FTE (see instructions) | | | 0.87 | | 12 |
| | Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year | andod an | | 1.20 1.19 | | 13 |
| 00 | or after September 30, 1997, otherwise enter zero. | ended on | | 1.19 | | 14 |
| | Sum of lines 12 through 14 divided by 3. | | | 1.09 | | 15 |
| | Adjustment for residents in initial years of the program Adjusment for residents displaced by program or hospital closur | è | | 0. 00 0. 00 | | 16 |
| | Adjusted rolling average FTE count | - | | 1.09 | | 18 |
| | Current year resident to bed ratio (line 18 divided by line 4). Prior year resident to bed ratio (see instructions) | | | 0. 004051 0. 004890 | | 19 |
| | Enter the lesser of lines 19 or 20 (see instructions) | | | 0. 004890 | | 21 |
| | IME payment adjustment (see instructions) | | | 112, 936 | | 22 |
| | IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for Sectio | 1 422 of t | he MMA | 0 | | 22 |
| 00 | Number of additional allopathic and osteopathic IME FTE residen | | | 0.00 | | 23 |
| | slots under 42 Sec. 412.105 (f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions) | | | 1.02 | | 24 |
| | If the amount on line 24 is greater than -0-, then enter the lo | wer of | | 0.00 | | 25 |
| | line 23 or line 24 (see instructions) | | | 0,000000 | | 1.07 |
| | Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions) | | | 0.000000 | | 26 |
| 00 | IME add-on adjustment amount (see instructions) | | | 0 | | 28 |
| | IME add-on adjustment amount - Managed Care (see instructions) Total IME payment (sum of lines 22 and 28) | | | 0 112, 936 | | 28 |
| | Total IME payment - Managed Care (sum of lines 22.01 and 28.01) | | | 0 | | 29 |
| | Disproportionate Share Adjustment | | | | | |
| 00 | Percentage of SSI recipient patient days to Medicare Part A pat (see instructions) | ent days | | 3.36 | | 30 |
| | Percentage of Medicaid patient days (see instructions) | | | 24.98 | | 31 |
| | Sum of lines 30 and 31 | | | 28.34 | | 32 |
| | Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) | | | 12. 60 1, 227, 345 | | 33 |

| CUL | Financial Systems COMMUNITY HOSPITAL | Provi der CCN: 150169 | Period: From 01/01/2014 To 12/31/2014 | | pare |
|----------|---|----------------------------|---|------------------------------|------------|
| | | Title XVIII | Hospital Prior to October 1 | PPS On/After October 1 | . pm |
| | Uncompensated Care Adjustment | 0 | 1.00 | 2.00 | |
| 00 | Total uncompensated care amount (see instructions) | | 9, 046, 380, 143 | 7, 647, 644, 885 | 35. |
| 01 | Factor 3 (see instructions) | | 0. 000434617 | | |
| 02 | Hospital uncompensated care payment (If line 34 is zero, | | 3, 931, 711 | 3, 720, 209 | 35. |
| ~~ | enter zero on this line) (see instructions) | | 2 040 704 | 007 (07 | 25 |
| 03 | Pro rata share of the hospital uncompensated care payment amount (see instructions) | | 2, 940, 704 | 937, 697 | 35. |
| 00 | Total uncompensated care (sum of columns 1 and 2 on line | | 3, 878, 401 | | 36. |
| | 35.03) | | | | |
| | Additional payment for high percentage of ESRD beneficiary of | discharges (lines 40 throu | | | 1 40 |
| 00 | Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and | | 0 | | 40. |
| | 685 (see instructions) | | | | |
| 00 | Total ESRD Medicare discharges excluding MS-DRGs 652, | | 0 | | 41. |
| | 682, 683, 684 an 685. (see instructions) | | | | |
| 01 | Total ESRD Medicare covered and paid discharges excluding | | 0 | | 41. |
| 00 | MS-DRGs 652, 682, 683, 684 an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not | | 0.00 | | 42 |
| 00 | qualify for adjustment) | | 0.00 | | 42 |
| 00 | Total Medicare ESRD inpatient days excluding MS-DRGs 652, | | 0 | | 43 |
| | 682, 683, 684 an 685. (see instructions) | | | | |
| 00 | Ratio of average length of stay to one week (line 43 | | 0. 000000 | | 44 |
| 00 | divided by line 41 divided by 7 days) Average weekly cost for dialysis treatments (see | | 0.00 | | 45 |
| 00 | instructions) | | 0.00 | | 45 |
| 00 | Total additional payment (line 45 times line 44 times line | | 0 | | 46 |
| | 41.01) | | | | |
| 00 | Subtotal (see instructions) | | 46, 068, 123 | | 47 |
| 00 | Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions) | | 0 | | 48 |
| 00 | Total payment for inpatient operating costs (see | | 46, 068, 123 | | 49 |
| | instructions) | | 10,000,120 | | |
| 00 | Payment for inpatient program capital (from Wkst. L, Pt. I | | 3, 570, 707 | | 50 |
| | and Pt. II, as applicable) | | | | |
| 00 | Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions) | | 0 | | 51 |
| 00 | Direct graduate medical education payment (from Wkst. E-4, | | 37, 219 | | 52 |
| | line 49 see instructions). | | | | |
| | Nursing and Allied Health Managed Care payment | | 49, 770 | | 53 |
| 00 | Special add-on payments for new technologies | | 0 | | 54 |
| 00 | Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69) | | 0 | | 55 |
| 00 | Cost of physicians' services in a teaching hospital (see | | 0 | | 56 |
| | intructions) | | - | | |
| 00 | Routine service other pass through costs (from Wkst. D, | | 0 | | 57 |
| ~~ | Pt. III, column 9, lines 30 through 35). | | 240.02/ | | - |
| 00 | Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) | | 240, 926 | | 58 |
| 00 | Total (sum of amounts on lines 49 through 58) | | 49, 966, 745 | | 59 |
| 00 | Primary payer payments | | 26, 896 | | 60 |
| 00 | Total amount payable for program beneficiaries (line 59 | | 49, 939, 849 | | 61 |
| 00 | minus line 60) Deductibles billed to program beneficiaries | | 2 541 004 | | 62 |
| 00 00 | Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries | | 3, 541, 924 169, 824 | | 62 |
| 00 | Allowable bad debts (see instructions) | | -117, 963 | | 64 |
| 00 | Adjusted reimbursable bad debts (see instructions) | | -76, 676 | | 65 |
| 00 | Allowable bad debts for dual eligible beneficiaries (see | | -168, 681 | | 66 |
| 00 | instructions) Subtotal (line 61 plus line 65 minus lines 62 and 63) | | 46, 151, 425 | | 67 |
| 00 00 | Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices | | 40, 131, 425 | | 68 |
| | for applicable to MS-DRGs (see instructions) | | | | |
| 00 | Outlier payments reconciliation (sum of lines 93, 95 and | | 0 | | 69 |
| | 96). (For SCH see instructions) | | - | | |
| 00 50 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT | | 0 | | 70 70 |
| 50 89 | Pioneer ACO demonstration payment adjustment amount (see | | 0 | | 70 |
| ~ ′ | instructions) | | | | '' |
| 90 | HSP bonus payment HVBP adjustment amount (see | | 0 | | 70 |
| ~ | instructions) | | - | | |
| 91 92 | HSP bonus payment HRR adjustment amount (see instructions) | | 0 | | 70 |
| 92 93 | Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions) | | -29, 827 | | 70 70 |
| | HRR adjustment amount (see instructions) | | -43, 814 | | 70 |
| | Recovery of accel erated depreciation | | 0 | | 70 |

| CALCUL | ATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150169 | | | Date/Time Pre 5/27/2015 6:0 | |
|----------|--|----------------------|---|-----------------------|--------------------------------|---------|
| | | Title XVIII | | Hospi tal | PPS | |
| | | | | Prior to October 1 | On/After October 1 | |
| | | 0 | - | 1.00 | 2.00 | |
| 70. 96 | Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the | | 0 | 0 | | 70.96 |
| | period prior to 10/1) | | | | | |
| 70. 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) | | 0 | 0 | | 70.97 |
| 70. 98 | Low Volume Payment-3 | | | 0 | | 70 00 |
| 70.98 | HAC adjustment amount (see instructions) | | | 6, 657 | | 70.98 |
| 70.99 | Amount due provider (line 67 minus lines 68 plus/minus | | | 46, 071, 127 | | 71.00 |
| | lines 69 & 70) | | | | | |
| | Sequestration adjustment (see instructions) | | | 921, 423 | | 71.01 |
| | Interim payments | | | 45, 384, 692 | | 72.00 |
| | Tentative settlement (for contractor use only) | | | 0 | | 73.00 |
| 74.00 | Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73) | | | -234, 988 | | 74.00 |
| 75.00 | Protested amounts (nonallowable cost report items) in | | | 2, 126, 227 | | 75.00 |
| | accordance with CMS Pub. 15-2, chapter 1, §115.2 | | | | | 1 |
| | TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) | | | | | |
| 90.00 | Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions) | | | 0 | | 90.00 |
| 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 | Capital outlier reconciliation adjustment amount (see instructions) | | | 0 | | 93.00 |
| 94.00 | The rate used to calculate the time value of money (see instructions) | | | 0.00 | | 94.00 |
| 95.00 | Time value of money for operating expenses (see instructions) | | | 0 | - | 95.00 |
| 96.00 | Time value of money for capital related expenses (see instructions) | | | 0 | | 96.00 |
| | | | | Prior to 10/1 | On/After 10/1 | |
| | | | | 1.00 | 2.00 | |
| | HSP Bonus Payment Amount | | | | | |
| 100.00 | HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment | | | 0 | 0 | 100. 00 |
| 101 00 | HVBP adjustment factor (see instructions) | | | 0 | 0 | 101.00 |
| | HVBP adjustment amount for HSP bonus payment (see instruction | ns) | | 0 | | 102.00 |
| . 52. 00 | HRR Adjustment for HSP Bonus Payment | no <i>y</i> | | 0 | 0 | 1.02.00 |
| 103.00 | HRR adjustment factor (see instructions) | | | 0.0000 | 0,0000 | 103.00 |
| | HRR adjustment amount for HSP bonus payment (see instruction | | | 0.0000 | | 104.00 |

| ALCUL | ATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150169 | Peri od: | Worksheet E | |
|----------------|---|--------------------------|----------------------------------|-----------------------|-------|
| | | | From 01/01/2014 To 12/31/2014 | | |
| | | Title XVIII | Hospi tal | PPS | |
| | | | | 4.00 | |
| | PART B - MEDICAL AND OTHER HEALTH SERVICES | | | 1.00 | - |
| 00 | Medical and other services (see instructions) | | | 28, 263 | 1 |
| 00 | Medical and other services reimbursed under OPPS (see instruct | i ons) | | 10, 958, 331 | |
| 00 | PPS payments | | | 10, 900, 747 | |
| 00 | Outlier payment (see instructions) | | | 67, 113 | |
| 00 00 | Enter the hospital specific payment to cost ratio (see instruc Line 2 times line 5 | (trons) | | 0. 000 0 | |
| 00 | Sum of line 3 plus line 4 divided by line 6 | | | 0.00 | |
| 00 | Transitional corridor payment (see instructions) | | | 0.00 | |
| 00 | Ancillary service other pass through costs from Wkst. D, Pt. I | V, col. 13, line 200 | | 57, 929 | 9 |
| 0. 00 | Organ acquisitions | | | 0 | 10 |
| I. 00 | | | | 28, 263 | 11 |
| | COMPUTATION OF LESSER OF COST OR CHARGES | | | | - |
| 2.00 | Reasonable charges Ancillary service charges | | | 111 047 | 1 1 1 |
| 3.00 | 5 | ol 4) | | 111, 847 0 | |
| I. 00 | | | | 111, 847 | |
| | Customary charges | | | | |
| 5.00 | Aggregate amount actually collected from patients liable for p | | | 0 | 15 |
| 5.00 | | | n a chargebasis | 0 | 16 |
| 7 00 | had such payment been made in accordance with 42 CFR §413.13(e | 2) | | 0,000000 | 17 |
| 7.00 8.00 | Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions) | | | 0. 000000 111, 847 | |
| 9.00 | Excess of customary charges over reasonable cost (complete onl | vifline 18 exceeds li | ne 11) (see | 83, 584 | |
| . 00 | instructions) | | | 00,001 | |
| 0. 00 | Excess of reasonable cost over customary charges (complete onl | y if line 11 exceeds li | ne 18) (see | 0 | 20 |
| | instructions) | | | | |
| 1.00 | Lesser of cost or charges (line 11 minus line 20) (for CAH see | e instructions) | | 28, 263 | |
| 2.00 3.00 | Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instr | suctions) | | 0 | |
| 4.00 | Total prospective payment (sum of lines 3, 4, 8 and 9) | uctions) | | 11, 025, 789 | |
| | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | 11/020/707 | 1 - 1 |
| 5.00 | Deductibles and coinsurance (for CAH, see instructions) | | | 0 | 25 |
| 6. 00 | Deductibles and Coinsurance relating to amount on line 24 (for | | | 2, 549, 392 | |
| 7.00 | Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) p | olus the sum of lines 22 | and 23} (for | 8, 504, 660 | 27 |
| 0 00 | CAH, see instructions) | Po E0) | | 7, 792 | 28 |
| 8.00 9.00 | Direct graduate medical education payments (from Wkst. E-4, li ESRD direct medical education costs (from Wkst. E-4, line 36) | The SO) | | 1, 192 | 29 |
| 0.00 | Subtotal (sum of lines 27 through 29) | | | 8, 512, 452 | |
| 1.00 | Primary payer payments | | | 2, 474 | |
| 2.00 | Subtotal (line 30 minus line 31) | | | 8, 509, 978 | 32 |
| | ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC | ES) | | - | |
| | Composite rate ESRD (from Wkst. 1-5, line 11) | | | 120 (05 | |
| 4.00 5.00 | Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) | | | 130, 685 84, 945 | |
| 6.00 | | uctions) | | 114, 733 | |
| 7.00 | Subtotal (see instructions) | , | | 8, 594, 923 | |
| | MSP-LCC reconciliation amount from PS&R | | | -160 | |
| | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | | 0 | |
| 9.50 | | | | 0 | |
| 9.98 | Partial or full credits received from manufacturers for replace | ea devices (see instruc | tions) | 0 | |
| 9.99 0.00 | RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) | | | 0 8, 595, 083 | |
| D. 00 D. 01 | Sequestration adjustment (see instructions) | | | 171, 902 | |
| 1.00 | Interim payments | | | 8, 545, 236 | |
| 2.00 | Tentative settlement (for contractors use only) | | | 0 | 42 |
| 3. 00 | Balance due provider/program (see instructions) | | | -122, 055 | |
| 4.00 | Protested amounts (nonallowable cost report items) in accordan | ice with CMS Pub. 15-2, | chapter 1, | 0 | 44 |
| | §115.2 | | | | 1 |
| | TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) | | | 0 | 90 |
| | Outlier reconciliation adjustment amount (see instructions) | | | 0 | |
| | The rate used to calculate the Time Value of Money | | | 0.00 | |
| | Time Value of Money (see instructions) | | | 0 | |
| | Total (sum of lines 91 and 93) | | | | 94 |

| UALUUL | | vider CCN: 150169 ponent CCN: 15S169 | Period: From 01/01/2014 To 12/31/2014 | | |
|------------------|---|---|---|----------------------|--------------|
| | | Title XVIII | Subprovi der – I PF | 5/27/2015 6:0 PPS | 7 pm |
| | | | | 1.00 | |
| 1.00 | PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions) | | | 588 | 1.00 |
| 2.00 | Medical and other services reimbursed under OPPS (see instructions) | | | 95 | |
| 3.00 | PPS payments | | | 366 | |
| 4.00 5.00 | Outlier payment (see instructions) Enter the hospital specific payment to cost ratio (see instructions) |) | | 0.000 | |
| 6.00 | Line 2 times line 5 |) | | 0.000 | • |
| 7.00 | Sum of line 3 plus line 4 divided by line 6 | | | 0.00 | |
| 8.00 9.00 | Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV, col | l 13 line 200 | | 0 | 8.00 9.00 |
| 10.00 | Organ acquisitions | 1. 10, 1110 200 | | 0 | • |
| 11.00 | Total cost (sum of lines 1 and 10) (see instructions) | | | 588 | 11.00 |
| | COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges | | | | - |
| 12.00 | Ancillary service charges | | | 2, 321 | 12.00 |
| 13.00 | Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4) |) | | 0 | |
| 14.00 | Total reasonable charges (sum of lines 12 and 13) Customary charges | | | 2, 321 | 14.00 |
| 15.00 | Aggregate amount actually collected from patients liable for payment | | | 0 | 15.00 |
| 16.00 | Amounts that would have been realized from patients liable for payment | ent for services o | n a chargebasis | 0 | 16.00 |
| 17.00 | had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000) | | | 0. 000000 | 17.00 |
| 18.00 | Total customary charges (see instructions) | | | 2, 321 | |
| 19.00 | Excess of customary charges over reasonable cost (complete only if l | line 18 exceeds li | ne 11) (see | 1, 733 | 19.00 |
| 20.00 | instructions) Excess of reasonable cost over customary charges (complete only if I | line 11 exceeds li | ne 18) (see | 0 | 20.00 |
| | instructions) | | | | |
| 21.00 22.00 | Lesser of cost or charges (line 11 minus line 20) (for CAH see instr Interns and residents (see instructions) | | 588 0 | | |
| 22.00 | Cost of physicians' services in a teaching hospital (see instruction | 0 | | | |
| 24.00 | Total prospective payment (sum of lines 3, 4, 8 and 9) | | 367 | 24.00 | |
| 25.00 | COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions) | | | 0 | 25.00 |
| 26.00 | Deductibles and Coinsurance relating to amount on line 24 (for CAH, | see instructions) | | 0 | |
| 27.00 | Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus | he sum of lines 22 | and 23} (for | 955 | 27.00 |
| 28.00 | CAH, see instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) |) | | 0 | 28.00 |
| 29.00 | ESRD direct medical education costs (from Wkst. E-4, line 36) |) | | 0 | |
| 30.00 | Subtotal (sum of lines 27 through 29) | | | 955 | • |
| 31.00 32.00 | Primary payer payments Subtotal (line 30 minus line 31) | | | 0 955 | |
| 52.00 | ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) | | | 733 | 52.00 |
| | Composite rate ESRD (from Wkst. I-5, line 11) | | | 0 | |
| 34.00 35.00 | Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) | | | 0 | |
| 36.00 | Allowable bad debts for dual eligible beneficiaries (see instruction | ns) | | 0 | • |
| 37.00 | Subtotal (see instructions) | | | 955 | |
| 38.00 39.00 | MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | | 0 | • |
| 39.50 | Pioneer ACO demonstration payment adjustment (see instructions) | | | 0 | |
| 39. 98 | Partial or full credits received from manufacturers for replaced dev | vices (see instruc | tions) | 0 | • |
| 39. 99 40. 00 | RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) | | | 0 955 | • |
| 40.00 | Sequestration adjustment (see instructions) | | | 19 | 1 |
| 41.00 | Interim payments | | | 814 | |
| 42.00 43.00 | Tentative settlement (for contractors use only) Balance due provider/program (see instructions) | | 0 122 | | |
| 43.00 | Protested amounts (nonallowable cost report items) in accordance with | th CMS Pub. 15-2, | chapter 1, | 0 | 1 |
| | §115. 2 | | • | | |
| 90. 00 | TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) | | | 0 | 90.00 |
| 90.00 91.00 | Outlier reconciliation adjustment amount (see instructions) | | | 0 | |
| 92.00 | The rate used to calculate the Time Value of Money | | | 0.00 | 92.00 |
| 93.00 | Time Value of Money (see instructions) | | | 0 | 93.00 |

| NALY: | SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provi der | CCN: 150169 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I Date/Time Prep 5/27/2015 6:0 | pared |
|--------------|--|------------|----------------------|---|--|----------------|
| | | Ti tl | e XVIII | Hospi tal | PPS | |
| | | Inpatien | t Part A | Par | tВ | |
| | | mm/dd/yyyy | Amount | mm/dd/yyyy | Amount | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | |
| . 00 . 00 | Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate | | 45, 276, 8 | 92 0 | 8, 466, 036 0 | 1. 2. 3. |
| | for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider | | | | | |
| 01 | ADJUSTMENTS TO PROVIDER | 08/01/2014 | 107, 8 | | 79, 200 | 3. |
| 02 03 | | | | 0 | 0 | 3. 3. |
| 03 | | | | 0 | 0 | 3. |
| 05 | | | | 0 | 0 | 3. |
| | Provider to Program | 1 | | - | | |
| 50 | ADJUSTMENTS TO PROGRAM | | | 0 | 0 | 3. |
| 51 52 | | | | 0 | 0 | 3 |
| 53 | | | | 0 | 0 | 3 |
| 54 | | | | 0 | 0 | 3. |
| 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) | | 107, 8 | | 79, 200 | 3. |
| 00 | Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) | | 45, 384, 6 | 92 | 8, 545, 236 | 4. |
| 00 | TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after | | | | | 5 |
| 00 | desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) | | | | | |
| | Program to Provider | 1 | | | | |
| 01 02 | TENTATI VE TO PROVI DER | | | 0 0 | 0 | 5 |
| 03 | | | | 0 | 0 | 5 |
| | Provider to Program | 1 | | | | |
| 50 | TENTATI VE TO PROGRAM | | | 0 | 0 | 5 |
| 51 52 | | | | 0 | 0 | 5 |
| 99 99 | Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98) | | | 0 | 0 | |
| 00 | Determined net settlement amount (balance due) based on the cost report. (1) | | | | | 6 |
| 01 | SETTLEMENT TO PROVIDER | | | 0 | 0 | 6 |
|)2)0 | SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions) | | 234, 9 45, 149, 7 | | 122, 055 8, 423, 181 | 6 |
| 50 | | | 40, 149, 7 | Contractor | NPR Date | |
| | | | | Number | (Mo/Day/Yr) | |
| | | (|) | 1.00 | 2.00 | |

| VALYS | SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | | CCN: 150169 CCN: 15S169 | Period: From 01/01/2014 To 12/31/2014 | | pared 7 pm |
|----------------------------|--|------------|----------------------------|---|-------------------------|------------------------------|
| | | Ti tl | e XVIII | Subprovider - IPF | PPS | <u>, bui</u> |
| | | Inpatien | t Part A | | t B | |
| | | mm/dd/yyyy | Amount | mm/dd/yyyy | Amount | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | |
| 00 00 | Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero | | 2, 140, 0 | 91 0 | 814 0 | 1. (2. (|
| 00 | List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider | | | | | 3. (|
| 01 | ADJUSTMENTS TO PROVIDER | | | 0 | 0 | 3. (|
| 02 03 04 05 | | | | 0 0 0 0 | 0 0 0 | 3. (3. (3. (3. (|
| 05 | Provider to Program | | | U | 0 | 5.1 |
| 50 | ADJUSTMENTS TO PROGRAM | | | 0 | 0 | 3. |
| 51 52 53 54 99 | Subtotal (sum of lines 3.01–3.49 minus sum of lines | | | 0 0 0 0 0 | 0 0 0 0 | 3. 3. 3. 3. 3. |
| 00 | 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR | | 2, 140, 0 | 91 | 814 | 4. |
| 00 | List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider | | | | | 5. |
| 01 | TENTATI VE TO PROVI DER | | | 0 | 0 | 5. |
| 02 03 | | | | 0 0 | 0 | 5. 5. |
| | Provider to Program | | | | | 0. |
| 50 | TENTATI VE TO PROGRAM | | | 0 | 0 | 5. |
| 51 | | | | 0 | 0 | 5. |
| 52 | | | | 0 | 0 | 5. |
| 99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) | | | 0 | 0 | 5. |
| 00 | Determined net settlement amount (balance due) based on the cost report. (1) | | | | | 6. |
| 01 | SETTLEMENT TO PROVIDER | | 8, 6 | 28 | 122 | 6. |
| 02 | SETTLEMENT TO PROGRAM | | | 0 | 0 | 6. |
| 00 | Total Medicare program liability (see instructions) | | 2, 148, 7 | | 936 | 7. |
| | | | | Contractor Number | NPR Date (Mo/Day/Yr) | |
| | | (|) | 1.00 | 2.00 | |

| Heal th | Financial Systems COMMUNITY HOSPITAL OF I | NDI ANA, INC. | In Lie | u of Form CMS-2 | 2552-10 | | | |
|---------|--|------------------------|------------------|-----------------------|---------|--|--|--|
| CALCUL | ATION OF REIMBURSEMENT SETTLEMENT FOR HIT | Provider CCN: 150169 | Period: | Worksheet E-1 | | | | |
| | | | From 01/01/2014 | | | | | |
| | | | To 12/31/2014 | Date/Time Pre | | | | |
| | | | | 5/27/2015 6: 0 PPS | / pm | | | |
| | Title XVIII Hospital | | | | | | | |
| | | | | 1.00 | | | | |
| | TO DE CONDUCTED DV CONTRACTOR FOR NON CTANDARD COCT DEPORTS | | | 1.00 | | | | |
| | TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS | | | | | | | |
| | HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION | | | 13, 677 | 1.00 | | | |
| | 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8–12 | | | | | | | |
| 2.00 | 20, 548 6, 432 | 2.00 3.00 | | | | | | |
| 3.00 | 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 | | | | | | | |
| 4.00 | Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-1 | 2 | | 68, 373 | 4.00 | | | |
| 5.00 | Total hospital charges from Wkst C, Pt. I, col. 8 line 200 | | | 1, 048, 287, 429 | 5.00 | | | |
| 6.00 | Total hospital charity care charges from Wkst. S-10, col. 3 lin | e 20 | | 5, 395, 821 | 6.00 | | | |
| 7.00 | CAH only - The reasonable cost incurred for the purchase of cer | tified HIT technology | Wkst. S-2, Pt. I | 0 | 7.00 | | | |
| | line 168 | | | | | | | |
| 8.00 | Calculation of the HIT incentive payment (see instructions) | | | 893, 461 | 8.00 | | | |
| 9.00 | Sequestration adjustment amount (see instructions) | | | 17, 869 | 9,00 | | | |
| 10.00 | Calculation of the HIT incentive payment after sequestration (s | ee instructions) | | 875, 592 | 10.00 | | | |
| | INPATIENT HOSPITAL SERVICES UNDER PPS & CAH | | | , . | | | | |
| 30, 00 | Initial/interim HIT payment adjustment (see instructions) | | | 871, 219 | 30.00 | | | |
| 31.00 | Other Adjustment (specify) | | | 0 | 31.00 | | | |
| 32.00 | 5 (1 5) | e 31) (see instruction | s) | 4, 373 | | | | |
| 02.00 | | | | 1, 0, 0 | 02.00 | | | |

| | | Companyant CCN, 1EC1(0 | From 01/01/2014 | | |
|--------------|--|--------------------------|----------------------|--------------------------------|--------------|
| | | Component CCN: 15S169 | To 12/31/2014 | Date/Time Pre 5/27/2015 6:0 | pare 7 pm |
| | | Title XVIII | Subprovider - IPF | PPS | <u>, bu</u> |
| | | | | 1.00 | |
| | PART II - MEDICARE PART A SERVICES - IPF PPS | | | | |
| 00 | Net Federal IPF PPS Payments (excluding outlier, ECT, and medic | cal education payments) | | 2, 353, 144 |] 1. |
| 00 | Net IPF PPS Outlier Payments | | | 41, 773 | 2 |
| 00 | Net IPF PPS ECT Payments | | | 7, 302 | |
| 00 | Unweighted intern and resident FTE count in the most recent cos | st report filed on or be | efore November | 0.00 | 4 |
| 01 | 15, 2004. (see instructions) | | | 0.00 | |
| 01 | Cap increases for the unweighted intern and resident FTE count program or hospital closure, that would not be counted without | | | 0.00 | 4 |
| | CFR §412. 424(d) (1) (iii) (F) (1) or (2) (see instructions) | | lient under 42 | | |
| 00 | New Teaching program adjustment. (see instructions) | | | 0.00 | 5 |
| 00 | Current year's unweighted FTE count of I&R excluding FTEs in th | ne new program growth pe | eriod of a "new | 0.00 | |
| | teaching program" (see instuctions) | | | | |
| 00 | Current year's unweighted I&R FTE count for residents within th | ne new program growth pe | eriod of a "new | 0.00 | 7 |
| | teaching program" (see instuctions) | | | | |
| 00 | Intern and resident count for IPF PPS medical education adjustm | nent (see instructions) | | 0.00 | |
| 00 | Average Daily Census (see instructions) | | | 8.547945 | |
| . 00 | Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to th | ne power of .5150 -1}. | | 0.00000 | |
| . 00 | Teaching Adjustment (line 1 multiplied by line 10). | | | 0 | |
| . 00 | Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11) | - > | | 2, 402, 219 | |
| . 00 | Nursing and Allied Health Managed Care payment (see instruction | 1) | | 0 | |
| | Organ acquisition (DO NOT USE THIS LINE) | uctions) | | 0 | 14 |
| . 00 | Cost of physicians' services in a teaching hospital (see instru Subtotal (see instructions) | | | 2, 402, 219 | |
| | Primary payer payments | | | 2,402,219 | |
| | Subtotal (line 16 less line 17). | | | 2, 402, 219 | |
| | Deducti bl es | | | 217, 536 | |
| | Subtotal (line 18 minus line 19) | | | 2, 184, 683 | |
| . 00 | Coinsurance | | | 912 | |
| . 00 | Subtotal (line 20 minus line 21) | | | 2, 183, 771 | 22 |
| . 00 | Allowable bad debts (exclude bad debts for professional service | es) (see instructions) | | 941 | 23 |
| . 00 | Adjusted reimbursable bad debts (see instructions) | | | 612 | 24 |
| . 00 | Allowable bad debts for dual eligible beneficiaries (see instru | uctions) | | -458 | 25 |
| . 00 | Subtotal (sum of lines 22 and 24) | | | 2, 184, 383 | |
| | Direct graduate medical education payments (from Wkst. E-4, lir | ne 49) | | 0 | |
| | Other pass through costs (see instructions) | | | 8, 187 | |
| | Outlier payments reconciliation | | | 0 | |
| . 00 . 50 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) | | | 0 | 30 |
| | Recovery of Accel erated Depreciation | | | 0 | |
| . 00 | Total amount payable to the provider (see instructions) | | | 2, 192, 570 | |
| . 01 | Sequestration adjustment (see instructions) | | | 43, 851 | |
| | Interim payments | | | 2, 140, 091 | |
| | Tentative settlement (for contractor use only) | | | | 33 |
| | Balance due provider/program (line 31 minus lines 31.01, 32 and | 33) | | 8, 628 | |
| 5.00 | Protested amounts (nonallowable cost report items) in accordance | | chapter 1, | 0 | |
| | §115. 2 | | | | 1 |
| | TO BE COMPLETED BY CONTRACTOR | | | | |
| | Original outlier amount from Worksheet E-3, Part II, line 2 | | | 41, 773 | |
| | Outlier reconciliation adjustment amount (see instructions) | | | 0 | |
| 2.00 | The rate used to calculate the Time Value of Money Time Value of Money (see instructions) | | | 0.00 | 52 53 |

| | Financial Systems COMMUNITY HOSPITAL OF GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT | | CCN: 150169 | Period: From 01/01/2014 | u of Form CMS-2 Worksheet E-4 | |
|---|---|-------------|----------------------|----------------------------|----------------------------------|-------------------|
| MEDI CA | L EDUCATION COSTS | | | To 12/31/2014 | Date/Time Pre 5/27/2015 6:0 | |
| | | Ti tl | e XVIII | Hospi tal | PPS | 7 pm |
| | | | | | 1.00 | |
| | COMPUTATION OF TOTAL DIRECT GME AMOUNT | | | | 1.00 | |
| . 00 | Unweighted resident FTE count for allopathic and osteopathic pr ending on or before December 31, 1996. | rograms for | cost reporti | ng periods | 0.00 | 1.0 |
| 2. 00 5. 00 | Unweighted FTE resident cap add-on for new programs per 42 CFR Amount of reduction to Direct GME cap under section 422 of MMA | uctions) | 0.00 0.00 | 2. C 3. C | | |
| . 01 | Direct GME cap reduction amount under ACA §5503 in accordance v | with 42 CFR | 8 §413.79 (m). | (see | 0.00 | 3.0 |
| . 00 | instructions for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and os GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)) | steopathi c | programs due | to a Medicare | 1.68 | 4. (|
| . 01 | ACA Section 5503 increase to the Direct GME FTE Cap (see instru stradding 7/1/2011) | uctions for | cost reporti | ng periods | 0.00 | 4. (|
| . 02 | ACA Section 5506 number of additional direct GME FTE cap slots periods straddling 7/1/2011) | (see inst | ructions for | cost reporting | 0.00 | 4.0 |
| 6. 00 | FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus 4.02 plus applicable subscripts | s or minus | line 4 plus l | ines 4.01 and | 1.68 | 5. (|
| . 00 | Unweighted resident FTE count for allopathic and osteopathic pr records (see instructions) | rograms for | the current | year from your | 1.89 | 6. (|
| . 00 | Enter the Lesser of Line 5 or Line 6 | | | Others | 1.68 | 7.(|
| | | | Primary Care 1.00 | e Other 2.00 | <u> </u> | |
| . 00 | Weighted FTE count for physicians in an allopathic and osteopat | thi c | 1.8 | | 1.89 | 8. (|
| . 00 | program for the current year. If line 6 is less than 5 enter the amount from line 8, otherwis multiply line 8 times the result of line 5 divided by the amoun | | 1.6 | 0.00 | 1.68 | 9. |
| 0. 00 | 6. Weighted dental and podiatric resident FTE count for the currer | nt year | | 0.00 | | 10. |
| 1.00 2.00 | Total weighted FTE count Total weighted resident FTE count for the prior cost reporting | vear (see | 1.6 | | | 11. |
| 3.00 | Total weighted resident FTE count for the penultimate cost reporting | 5 | 1.1 | | | 13. |
| | year (see instructions) | 0 | | | | |
| 4.00 5.00 | Rolling average FTE count (sum of lines 11 through 13 divided b Adjustment for residents in initial years of new programs | by 3). | 1.4 | | | 14. 15. |
| 6.00 | Adjustment for residents displaced by program or hospital closu | ure | 0.0 | | | 16. |
| 7.00 | Adjusted rolling average FTE count | | 1.4 | 2 0.00 | | 17.0 |
| 8.00 | Per resident amount | | 80, 383. 6 | | | 18. |
| 9.00 | Approved amount for resident costs | | 114, 14 | 5 0 | 114, 145 | 19. (|
| | | | | | 1.00 | |
| 0. 00 | Additional unweighted allopathic and osteopathic direct GME FTE Sec. 413.79(c)(4) | E resident | cap slots rec | eived under 42 | 0.00 | 20. (|
| 1. 00 | Direct GME FTE unweighted resident count over cap (see instruct | | | | 0. 21 | |
| 2.00 | Allowable additional direct GME FTE Resident Count (see instruc | | | | 0.00 | |
| 3.00 | Enter the locally adjustment national average per resident amount time 22 time 22 | unt (see in | istructions) | | 0.00 | |
| | Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24) | | | | 0 114, 145 | 24. 25. |
| | | | · · · | t Managed care | | |
| | | | A 1.00 | 2.00 | 3.00 | |
| | COMPUTATION OF PROGRAM PATIENT LOAD | | 1 | | | |
| | Inpatient Days (see instructions) Total Inpatient Days (see instructions) | | 23, 18 | | | 26. |
| | LIGTAL INPATIONT NAVE (COO INSTRUCTIONS) | | 72, 79 | 72, 793 | | 27.0 |
| 27.00 | | | | | | 1 20 4 |
| 27. 00 28. 00 | Ratio of inpatient days to total inpatient days | | 0. 31845 | 0. 088360 | | 28.0 |
| 26.00 27.00 28.00 29.00 30.00 | | | | 0. 088360 | | 28. 29. 30. |

| Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. In Lie | eu of Form CMS-2 | 2552-10 |
|---|----------------------------------|---------|
| DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT Provider CCN: 150169 Period: | Worksheet E-4 | |
| MEDICAL EDUCATION COSTS | | |
| To 12/31/2014 | Date/Time Prep 5/27/2015 6:07 | |
| Title XVIII Hospital | PPS | |
| | | |
| | 1.00 | |
| DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMED | | |
| EDUCATION COSTS) | | |
| 32.00 Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 | 0 | 32.00 |
| and 94) | | |
| 33.00 Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) | 1, 989, 829 | |
| 34.00 Ratio of direct medical education costs to total charges (line 32 ÷ line 33) | 0. 000000 | |
| 35.00 Medicare outpatient ESRD charges (see instructions) | 0 | 35.00 |
| 36.00 Medicare outpatient ESRD direct medical education costs (line 34 x line 35) | 0 | 36.00 |
| APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY | | |
| Part A Reasonable Cost | | |
| 37.00 Reasonable cost (see instructions) | 52, 774, 516 | |
| 38.00 Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69) | 0 | 38.00 |
| 39.00 Cost of physicians' services in a teaching hospital (see instructions) | 0 | 39.00 |
| 40.00 Primary payer payments (see instructions) | 26, 896 | |
| 41.00 Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) | 52, 747, 620 | 41.00 |
| Part B Reasonable Cost | | |
| 42.00 Reasonable cost (see instructions) | 11, 045, 207 | |
| 43.00 Primary payer payments (see instructions) | 2, 474 | 43.00 |
| 44.00 Total Part B reasonable cost (line 42 minus line 43) | 11, 042, 733 | |
| 45.00 Total reasonable cost (sum of lines 41 and 44) | 63, 790, 353 | |
| 46.00 Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) | 0. 826890 | |
| 47.00 Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) | 0. 173110 | 47.00 |
| ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B | | |
| 48.00 Total program GME payment (line 31) | 45, 011 | |
| 49.00 Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions) | 37, 219 | |
| 50.00 Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions) | 7,792 | 50.00 |

| | Financial Systems COMMUNITY HOSPITAL E SHEET (If you are nonproprietary and do not maintain Community | | CCN: 150169 F | Peri od: | u of Form CMS-2 Worksheet G | 2002 |
|----------|---|--------------------------------------|---------------|--------------------------------|--------------------------------|------|
| nd-t | ype accounting records, complete the General Fund column onl | y) | | rom 01/01/2014 o 12/31/2014 | Date/Time Pre | pare |
| | | General Fund | Specific | Endowment Fund | 5/27/2015 6:0 Plant Fund | 7 pm |
| | | | Purpose Fund | | | |
| | CURRENT ASSETS | 1.00 | 2.00 | 3.00 | 4.00 | |
| 00 | Cash on hand in banks | 1, 562, 257 | 0 | 0 0 | 0 | 1 1 |
| 00 | Temporary investments | 0 | | - | 0 | |
| 00 | Notes receivable | 0 | C | 0 0 | 0 | 3 |
| 00 | Accounts receivable | 226, 641, 968 | | 0 0 | 0 | |
| 00 | Other receivable | 1, 056, 477 | | 0 | 0 | |
| 00 | Allowances for uncollectible notes and accounts receivable | -175, 362, 612 | | 0 | 0 | |
|)0)0 | Inventory Prepaid expenses | 4, 014, 430 16, 454 | | | 0 | |
| 00 | Other current assets | 0 | | - | 0 | |
| 00 | Due from other funds | 0 | C | 0 0 | 0 | 10 |
| 00 | Total current assets (sum of lines 1-10) | 57, 928, 974 | (C | 0 0 | 0 | 11 |
| | FI XED ASSETS | | | 1 | | |
| 00 | Land | 2, 705, 851 | | | 0 | |
| 00 | Land improvements | 3, 158, 137 | | | 0 | |
| 00 00 | Accumulated depreciation Buildings | 293, 409, 404 | | | 0 | |
| 00 | Accumulated depreciation | 293, 409, 404 | | | 0 | |
| 00 | Leasehold improvements | 4, 977, 715 | | 0 0 | 0 | |
| 00 | Accumulated depreciation | 0 | C | 0 | 0 | |
| 00 | Fixed equipment | 3, 118, 039 | 0 | 0 0 | 0 | 19 |
| 00 | Accumulated depreciation | 0 | C | - | 0 | |
| 00 | Automobiles and trucks | 0 | 0 | 0 | 0 | |
| 00 00 | Accumulated depreciation Major movable equipment | 92, 404, 082 | | 0 | 0 | |
| 00 | Accumulated depreciation | -199, 684, 624 | | | 0 | |
| 00 | Mi nor equipment depreciable | 0 | | | 0 | |
| 00 | Accumulated depreciation | 0 | 0 | 0 0 | 0 | |
| 00 | HIT designated Assets | 0 | C | 0 0 | 0 | 27 |
| 00 | Accumulated depreciation | 0 | C | - | 0 | |
| 00 | Minor equipment-nondepreciable | 0 | C | - | 0 | |
| 00 | Total fixed assets (sum of lines 12-29) | 200, 088, 604 | | 0 0 | 0 | 30 |
| 00 | OTHER ASSETS Investments | 0 | 0 | 0 0 | 0 | 31 |
| 00 | Deposits on Leases | | | | 0 | |
| 00 | Due from owners/officers | 0 | | | 0 | |
| 00 | Other assets | 973, 563, 853 | 0 | 0 0 | 0 | 34 |
| 00 | Total other assets (sum of lines 31-34) | 973, 563, 853 | | | 0 | 35 |
| 00 | Total assets (sum of lines 11, 30, and 35) | 1, 231, 581, 431 | (| 0 0 | 0 | 36 |
| | CURRENT LI ABI LI TI ES | | | | | |
| 00 00 | Accounts payable | 80, 969 | | | 0 | |
| 00 | Salaries, wages, and fees payable Payroll taxes payable | | | | 0 | |
| 00 | | 0 | | 0 | 0 | |
| 00 | Deferred income | 0 | 0 | 0 0 | 0 | |
| 00 | Accelerated payments | 0 | | | | 42 |
| 00 | Due to other funds | 0 | C | 0 0 | 0 | |
| 00 | Other current liabilities | 627, 962 | | | 0 | |
| 00 | Total current liabilities (sum of lines 37 thru 44) | 708, 931 | | 0 0 | 0 | 45 |
| 00 | LONG TERM LI ABI LI TI ES | 0 | 0 | 0 0 | 0 | 46 |
| 00 00 | Mortgage payable Notes payable | | | | 0 | |
| 00 | Unsecured Loans | 0 | | | 0 | |
| 00 | Other long term liabilities | 12, 117, 866 | | 0 0 | 0 | |
| 00 | Total long term liabilities (sum of lines 46 thru 49 | 12, 117, 866 | | 0 0 | 0 | 50 |
| 00 | Total liabilites (sum of lines 45 and 50) | 12, 826, 797 | 0 | 0 0 | 0 | 51 |
| | CAPI TAL ACCOUNTS | | | | | 1 |
| 00 | General fund balance | 1, 218, 754, 634 | | | | 52 |
| 00 | Specific purpose fund | | 0 | ^ _ | | 53 |
| 00 00 | Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted | | | | | 54 |
| 00 | Governing body created - endowment fund balance - unrestricted | | | 0 | | 56 |
| 00 | Plant fund balance - invested in plant | | | | 0 | |
| | Plant fund balance - reserve for plant improvement, | | | | 0 | |
| | | 1 | 1 | 1 | l | 1 |
| 00 | replacement, and expansion | | | | | |
| | replacement, and expansion Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and | 1, 218, 754, 634 1, 231, 581, 431 | | 0 | 0 | |

| | | UNI TY HOSPI TAL | | | | | u of Form CMS- | |
|---|--|---|---|-------------|---|-------------------------------------|---|---|
| STATEM | ENT OF CHANGES IN FUND BALANCES | | Provi der | CCN: 150169 | | iod: om 01/01/2014 12/31/2014 | Worksheet G-1 Date/Time Pre 5/27/2015 6:0 | pared: |
| | | General | l Fund | Speci al | Purp | oose Fund | Endowment Fund | |
| | | 1.00 | 2.00 | 3,00 | | 4.00 | 5.00 | |
| $\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$ | Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) OTHER FUND BALANCE ACTIVITY Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18) | 76, 446, 438 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 1, 001, 434, 621 140, 874, 537 1, 142, 309, 158 76, 446, 438 1, 218, 755, 596 1, 218, 755, 596 | | 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 0 0 0 0 0 0 | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 |
| | | Endowment Fund | PI ant | Fund | _ | | | - |
| | | 6.00 | 7.00 | 8.00 | | | | |
| 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 | Fund balances at beginning of period Net income (Ioss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) OTHER FUND BALANCE ACTIVITY | 0 | 0 0 0 0 0 0 | | 0 | | | 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 |
| 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 | Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) | 0 | 0 0 0 0 0 0 0 | | 0 | | | 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 |
| 18. 00 19. 00 | Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18) | 0 | | | 0 0 | | | 18.00 19.00 |

| STATE | Financial Systems COMMUNITY HOSPITAL OF I ENT OF PATIENT REVENUES AND OPERATING EXPENSES | | CCN: 150169 | | ri od: | Worksheet G-2 | 2552-10 |
|----------------|--|-----------|-------------|----------|-----------------------------|---|----------------|
| | | | | Fr To | om 01/01/2014 12/31/2014 | Parts I & II Date/Time Prep 5/27/2015 6:0 | |
| | Cost Center Description | | I npati ent | | Outpati ent | Total | |
| | · | | 1.00 | | 2.00 | 3.00 | |
| | PART I – PATIENT REVENUES | | | | | | |
| | General Inpatient Routine Services | | | | | | |
| 1.00 | Hospi tal | | 140, 152, 5 | | | 140, 152, 596 | 1.00 |
| 2.00 | SUBPROVIDER - IPF | | -1, 2 | | | -1, 230 | |
| 3.00 | SUBPROVIDER - IRF | | 5, 821, 4 | 80 | | 5, 821, 480 | |
| 4.00 | SUBPROVIDER | | | ~ | | 0 | 4.00 |
| 5.00 6.00 | Swing bed - SNF Swing bed - NF | | | 0 0 | | 0 | 5.00 6.00 |
| 7.00 | SKILLED NURSING FACILITY | | | 0 | | 0 | 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) | | 145, 972, 8 | 346 | | 145, 972, 846 | |
| | Intensive Care Type Inpatient Hospital Services | | 110/ //2/0 | , | | 110/ 1/2/010 | |
| 11.00 | INTENSIVE CARE UNIT | | 18, 239, 4 | 109 | | 18, 239, 409 | 11.00 |
| 12.00 | CORONARY CARE UNIT | | | | | | 12.00 |
| 13.00 | BURN INTENSIVE CARE UNIT | | | | | | 13.00 |
| 14.00 | SURGI CAL I NTENSI VE CARE UNI T | | | | | | 14.00 |
| 15.00 | NEONATAL INTENSIVE CARE UNIT | | 73, 923, 6 | 93 | | 73, 923, 693 | 15.00 |
| 16.00 | Total intensive care type inpatient hospital services (sum of li | nes | 92, 163, 1 | 02 | | 92, 163, 102 | 16.00 |
| | 11-15) | | | | | | |
| 17.00 | Total inpatient routine care services (sum of lines 10 and 16) | | 238, 135, 9 | | | 238, 135, 948 | |
| 18.00 | Ancillary services | | 419, 674, 7 | | 423, 839, 788 | 843, 514, 569 | • |
| 19.00 | Outpatient services | | | 0 | 0 | 0 | 19.00 |
| 20.00 | RURAL HEALTH CLINIC | | | 0 0 | 0 | 0 | |
| 21.00 22.00 | FEDERALLY QUALIFIED HEALTH CENTER HOME HEALTH AGENCY | | | 0 | 0 | 0 | 21.00 22.00 |
| 22.00 | AMBULANCE SERVICES | | | | | | 22.00 |
| 24.00 | CMHC | | | | | | 23.00 |
| 25.00 | AMBULATORY SURGICAL CENTER (D. P.) | | | | | | 25.00 |
| 26.00 | HOSPICE | | | | | | 26.00 |
| 27.00 | OTHER (SPECIFY) | | | 0 | o | 0 | 27.00 |
| 28.00 | Total patient revenues (sum of lines 17-27)(transfer column 3 to | o Wkst. | 657, 810, 7 | 29 | 423, 839, 788 | 1, 081, 650, 517 | 28.00 |
| | G-3, line 1) | | | | | | |
| | PART II - OPERATING EXPENSES | | | | | | |
| 29.00 | Operating expenses (per Wkst. A, column 3, line 200) | | | | 325, 973, 671 | | 29.00 |
| 30.00 | ADD (SPECIFY) | | | 0 | | | 30.00 |
| 31.00 | | | | 0 | | | 31.00 |
| 32.00 | | | | 0 | | | 32.00 |
| 33.00 | | | | 0 0 | | | 33.00 |
| 34.00 35.00 | | | | 0 | | | 34.00 35.00 |
| 35.00 | Total additions (sum of lines 20.25) | | | 0 | 0 | | 35.00 |
| 36.00 | Total additions (sum of lines 30-35) DEDUCT (SPECIFY) | | | 0 | 0 | | 36.00 |
| 38.00 | | | | 0 | | | 38.00 |
| 39.00 | | | | 0 | | | 39.00 |
| 40.00 | | | | 0 | | | 40.00 |
| 41.00 | | | | 0 | | | 41.00 |
| 42.00 | Total deductions (sum of lines 37-41) | | | - | 0 | | 42.00 |
| 43.00 | Total operating expenses (sum of lines 29 and 36 minus line 42) | (transfer | | | 325, 973, 671 | | 43.00 |
| | to Wkst. G-3, line 4) | | | | | | |

| | Financial Systems COMMUNITY HOSPITAL OF | | | u of Form CMS-2 | |
|--------|--|----------------------|----------------------------------|------------------|-------|
| STATEN | ENT OF REVENUES AND EXPENSES | Provider CCN: 150169 | Peri od: | Worksheet G-3 | |
| | | | From 01/01/2014 To 12/31/2014 | Date/Time Pre | nared |
| | | | 10 12/01/2011 | 5/27/2015 6:0 | 7 pm |
| | | | | | |
| | | | | 1.00 | |
| 1.00 | Total patient revenues (from Wkst. G-2, Part I, column 3, line | | | 1, 081, 650, 517 | 1.00 |
| 2.00 | Less contractual allowances and discounts on patients' accounts | S | | 674, 196, 742 | 2.00 |
| 3.00 | Net patient revenues (line 1 minus line 2) | | | 407, 453, 775 | 3.00 |
| 4.00 | Less total operating expenses (from Wkst. G-2, Part II, line 43 | 3) | | 325, 973, 671 | 4.00 |
| 5.00 | Net income from service to patients (line 3 minus line 4) | | | 81, 480, 104 | 5.00 |
| | OTHER INCOME | | | | |
| 6.00 | Contributions, donations, bequests, etc | | | 0 | 6.00 |
| 7.00 | Income from investments | | | 35, 017, 333 | 7.00 |
| 8.00 | Revenues from telephone and other miscellaneous communication s | servi ces | | 0 | |
| 9.00 | Revenue from television and radio service | | | 0 | |
| 10.00 | Purchase di scounts | | | 0 | 10.00 |
| 11.00 | Rebates and refunds of expenses | | | 0 | 11.00 |
| 12.00 | Parking lot receipts | | | 0 | 12.00 |
| 13.00 | Revenue from Laundry and Linen service | | | 0 | 13.00 |
| 14.00 | Revenue from meals sold to employees and guests | | | | 14.00 |
| 15.00 | Revenue from rental of living quarters | | | 0 | 15.00 |
| | Revenue from sale of medical and surgical supplies to other that | an patients | | 0 | 16.00 |
| | Revenue from sale of drugs to other than patients | | | | 17.00 |
| | Revenue from sale of medical records and abstracts | | | 0 | 18.00 |
| | Tuition (fees, sale of textbooks, uniforms, etc.) | | | 0 | 19.00 |
| 20.00 | Revenue from gifts, flowers, coffee shops, and canteen | | | 0 | 20.00 |
| 21.00 | Rental of vending machines | | | 0 | 21.00 |
| 22.00 | Rental of hospital space | | | 4, 389, 891 | 22.00 |
| 23.00 | Governmental appropriations | | | 0 | 23.00 |
| 24.00 | OTHER (SPECIFY) | | | 19, 973, 644 | |
| 25.00 | Total other income (sum of lines 6-24) | | | 59, 394, 433 | |
| | Total (line 5 plus line 25) | | | 140, 874, 537 | |
| | OTHER EXPENSES (SPECIFY) | | | 0 | 27.00 |
| | 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) | | | 140, 874, 537 | 29.00 |

| CALCUL | ATION OF CAPITAL PAYMENT | Provider CCN: 150169 | Peri od: | Worksheet L | |
|--------|--|-------------------------|-----------------|--------------------------------|-------|
| | | | From 01/01/2014 | | |
| | | | To 12/31/2014 | Date/Time Pre 5/27/2015 6:0 | |
| | | Title XVIII | Hospi tal | PPS | 7 рш |
| | | | | | |
| | | | | 1.00 | |
| | PART I - FULLY PROSPECTIVE METHOD | | | | |
| ~~~ | CAPITAL FEDERAL AMOUNT | | | 0 444 050 | |
| 1.00 | Capital DRG other than outlier | | | 3, 114, 950 | |
| 1.01 | Model 4 BPCI Capital DRG other than outlier | | | 0 | 1.0 |
| 2.00 | Capital DRG outlier payments | | | 266, 679 | |
| 2.01 | Model 4 BPCI Capital DRG outlier payments | | | 0 | 2.0 |
| 3.00 | Total inpatient days divided by number of days in the cost rep | orting period (see inst | ructions) | 196.41 | 3.0 |
| 1.00 | Number of interns & residents (see instructions) | | | 1.09 | |
| 5.00 | Indirect medical education percentage (see instructions) | | 、 、 | 0.16 | |
| . 00 | Indirect medical education adjustment (multiply line 5 by the | | | 4, 984 | 6.0 |
| . 00 | Percentage of SSI recipient patient days to Medicare Part A pa 30) (see instructions) | tient days (Worksheet E | , part A line | 3.36 | 7.0 |
| . 00 | Percentage of Medicaid patient days to total days (see instruc | tions) | | 24.98 | 8.0 |
| . 00 | Sum of lines 7 and 8 | | | 28.34 | 9. (|
| 0.00 | Allowable disproportionate share percentage (see instructions) | | | 5.91 | 10.0 |
| 1.00 | Disproportionate share adjustment (line 10 times the sum of li | nes 1 and 1.01) | | 184, 094 | 11. (|
| 2.00 | Total prospective capital payments (sum of lines 1, 1.01, 2, 2 | . 01, 6 and 11) | | 3, 570, 707 | 12.0 |
| | | | · | 1.00 | |
| | PART II - PAYMENT UNDER REASONABLE COST | | | | |
| . 00 | Program inpatient routine capital cost (see instructions) | | | 0 | 1.0 |
| . 00 | Program inpatient ancillary capital cost (see instructions) | | | 0 | 2.0 |
| . 00 | Total inpatient program capital cost (line 1 plus line 2) | | | 0 | 3.0 |
| . 00 | Capital cost payment factor (see instructions) | | | 0 | 4.0 |
| . 00 | Total inpatient program capital cost (line 3 x line 4) | | | 0 | 5. (|
| | | | · | 1.00 | |
| | PART III - COMPUTATION OF EXCEPTION PAYMENTS | | | | |
| . 00 | Program inpatient capital costs (see instructions) | | | 0 | |
| . 00 | Program inpatient capital costs for extraordinary circumstance | s (see instructions) | | 0 | |
| . 00 | Net program inpatient capital costs (line 1 minus line 2) | | | 0 | |
| . 00 | Applicable exception percentage (see instructions) | | | 0.00 | |
| . 00 | Capital cost for comparison to payments (line 3 x line 4) | | | 0 | |
| . 00 | Percentage adjustment for extraordinary circumstances (see ins | | | 0.00 | |
| . 00 | Adjustment to capital minimum payment level for extraordinary | circumstances (line 2 x | line 6) | 0 | |
| . 00 | Capital minimum payment level (line 5 plus line 7) | | | 0 | 8. (|
| . 00 | Current year capital payments (from Part I, line 12, as applic | | | 0 | 9. (|
| 0.00 | Current year comparison of capital minimum payment level to ca | | | 0 | 10. 0 |
| 1.00 | Carryover of accumulated capital minimum payment level over ca | pital payment (from pri | or year | 0 | 11. (|
| | Worksheet L, Part III, line 14) | | - | | |
| | Net comparison of capital minimum payment level to capital pay | | | | 12. |

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 0 0 12.00 13.00 0 14.00 15.00 Current year allowable operating and capital payment (see instructions)
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) 0 15.00 0 16.00 0 17.00