	Financial Systems report is required by law (42 USC 1395g; 42 CF	COMMUNITY HOSPI FR 413.20(b)). F		ort can result		eu of Form CMS- m FORM APPROVED	
	its made since the beginning of the cost repor					OMB NO. 0938- EXPIRES 05-33	-0050
	AL AND HOSPITAL HEALTH CARE COMPLEX COST REPO	ORT CERTIFICATIO	N Provider CC		Period: From 01/01/2010 To 12/31/2010		
	- COST REPORT STATUS						
Provid					Date: 4/14/2	2017 Time:	8:22 am
use or	 aly 2.[] Manually submitted cost report 3.[0] If this is an amended report 4.[F] Medicare Utilization. Enter ' 		er of times the "L" for low.	e provider re	submitted this	cost report	
Contra		Received:			PR Date:	10	
use or	(2) Settled without Audit 8. [N]	ractor No. Initial Report Final Report fo	for this Provi or this Provide	ider CCN 12.[ontractor's Ven 0]If line 5, c number of ti	dor Code: column 1 is 4: imes reopened =	4 Enter 0-9.
PART J	I - CERTIFICATION						2-2-55
ADMINI PROVID	RESENTATION OR FALSIFICATION OF ANY INFORMATI STRATIVE ACTION, FINE AND/OR IMPRISONMENT UND DED OR PROCURED THROUGH THE PAYMENT DIRECTLY C STRATIVE ACTION, FINES AND/OR IMPRISONMENT MA CERTIFICATION BY OFFICER OR ADMINI	DER FEDERAL LAW. DR INDIRECTLY OF NY RESULT.	FURTHERMORE, A KICKBACK OR	IF SERVICES	IDENTIFIED IN	THIS REPORT WER	E
	I HEREBY CERTIFY that I have read the above electronically filed or manually submitted Expenses prepared by COMMUNITY HOSPITAL AND and ending 12/31/2016 and to the best of my complete and prepared from the books and re except as noted. I further certify that I health care services, and that the services laws and regulations. Encryption Information ECR: Date: 4/14/2017 Time: 8:22 am ivvUyDxuijDQYpkz07JzDkzh:.wFm0 mwzISOtrAqzN.7v9Tzjz.OwIU1Aj. dH8O1V8xd60dJJBD PI: Date: 4/14/2017 Time: 8:22 am SCNTVN.U3miEbjqONP1f7ex1kiolc0 nWCcJOvG494909JAPot:EMEf.5mOiq .85KOk6ENQ0.loNx	cost report and DERSON (15-0113 / knowledge and ecords of the pr am familiar wit	d the Balance S belief, this r rovider in acco th the laws and this cost report ed) Office VP FIN Title	Sheet and Stat st reporting p report and stat ordance with a d regulations ort were provi- or Adminis ANCE/CFO	tement of Reven beriod beginnin tement are tru applicable inst regarding the ided in complia trator of Provi	ue and g 01/01/2016 le, correct, ructions, provision of ince with such	
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
1 00	PART III - SETTLEMENT SUMMARY		E0 201			0 -1.700.257	1 00
1.00 2.00	Hospital Subprovider - IPF	0	58,281	-34,37	0	0 -1,700,257	
3.00	Subprovider - IRF	0	0		0		
4.00	SUBPROVIDER I		, in the second s				4.00
5.00	Swing bed - SNF	0	0		0	0	
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0		0	(C	7.00
8.00	NURSING FACILITY	0				C	
9.00	HOME HEALTH AGENCY I	0	0		0	C	
10.00	RURAL HEALTH CLINIC I	0			0	0	20.00
	FEDERALLY QUALIFIED HEALTH CENTER I	0			0	0	
	CMHC I	0	50 201		-		12.00
200.00	ove amounts represent "due to" or "due from"		58,281	-34,37			200.00
Accord displa	ing to the Paperwork Reduction Act of 1995, n ys a valid OMB control number. The valid OMB	o persons are r control number	equired to res for this info	pond to a col rmation colle	lection of info ction is 0938-0	ormation unless 0050. The time	
	ed to complete and review the information col						
	ctions, search existing resources, gather the ny comments concerning the accuracy of the ti						
	ecurity Boulevard, Attn: PRA Report Clearance						CMS,
	do not send applications, claims, payments,						e PRA
	s Clearance Office. Please note that any cor						

under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPI 7	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX		Y HOSPITAL	ANDERSO Provi der		5-0113	Peri od:		u of For Workshe		
							From 01/01 To 12/31	/2016 /2016	Part I Date/Ti		
	1.00	2.	00	3	. 00			4.00	4/14/20	17 8:1	8 am
4 00	Hospital and Hospital Health Care Co										1 00
1.00 2.00	Street: 1515 NORTH MADISON AVE City: ANDERSON	PO Box: State: I	N Zi	p Code:	46011	Coun	ty: MADISON				1.00 2.00
		Component Na	ime	CCN	CBSA	Provi der	Date	Payme	ent Syst		
			NL	ımber I	Number	Туре	Certified		, 0, or XVIII		
	1	1.00	2	2.00	3.00	4.00	5.00	6.00	_	8.00	
3.00	Hospital and Hospital-Based Componer Hospital	t Identification: COMMUNITY HOSPITA	VI 15	0113	26900	1	01/01/196	6 N	Р	0	3.00
		ANDERSON			20700					Ŭ	
4.00 5.00	Subprovider - IPF Subprovider - IRF										4.00
6.00	Subprovider - (Other)										6.00
7.00 8.00	Swing Beds - SNF Swing Beds - NF										7.00
9.00	Hospital - Based SNF										9.00
10.00	Hospital -Based NF										10.00
11.00 12.00	Hospi tal -Based OLTC Hospi tal -Based HHA										11.00
13.00	Separately Certified ASC										13.00
	Hospital-Based Hospice Hospital-Based Health Clinic - RHC										14.00
	Hospital - Based Health Clinic - FQHC										16.00
	Hospital-Based (CMHC) I Hospital-Based (CORF) I										17.00
	Renal Dialysis										18.00
19.00	Other										19.00
							From 1.0				
	Cost Reporting Period (mm/dd/yyyy)						01/01/		12/31/		20.00
21.00	Type of Control (see instructions) Inpatient PPS Information						2				21.00
22.00	Does this facility qualify and is it								N		22.00
	share hospital adjustment, in accord for yes or "N" for no. Is this facil										
	amendment hospital?) In column 2, er				100(0)(
22. 01	Did this hospital receive interim un period? Enter in column 1, "Y" for y						Y		Y		22.01
	reporting period occurring prior to										
	for no for the portion of the cost r (see instructions)	eporting period o	ccurring o	n or aft	ter Octo	ober 1.					
22. 02	Is this a newly merged hospital that	requires final u	ncompensat	ed care	payment	ts to be	N		N		22.02
	determined at cost report settlement						s				
	or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for						n				
	or after October 1.	•			0	•					
22.03	Did this hospital receive a geograph of the OMB standards for delineating								N		22.03
	in column 1, "Y" for yes or "N" for	no for the portio	n of the c	ost repo	orting p	peri od					
	prior to October 1. Enter in column cost reporting period occurring on c						ie				
	hospital contain at least 100 but no	t more than 499 b	eds (as co				h				
23.00	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me			/or 25 h	nelow? I	n column		3	N		23.00
20.00	1, enter 1 if date of admission, 2 i	f census days, or	3 if date	of disc	charge.	Is the		Ū			20100
	method of identifying the days in the used in the prior cost reporting per										
			In-State	In-Sta	te Ou	ut-of	Out-of	Medi ca		ther	
	used in the piror cost reporting per				id S	State		HMO da	J	i cai d ays	
	Jused fir the piror cost reporting per		Medicaid	Medica		hicaid	Medicaid				
	Jused fir the professor reporting per		Medicaid paid days	el i gi b unpai	d pai		Medicaid eligible			uy5	
	jused fir the professor reporting per		paid days	el i gi b unpai days	d pai	d days	el i gi bl e unpai d	5.00			
24.00	If this provider is an IPPS hospital	, enter the		el i gi b unpai days 2.00	d pai		eligible	<u>5.00</u> 5,		. 00 21	24.00
24.00	lf this provider is an IPPS hospital in-state Medicaid paid days in colum	n 1, in-state	paid days	el i gi b unpai days 2.00	d pai	d days 3.00	el i gi bl e unpai d 4. 00		6	. 00	24.00
24.00	If this provider is an IPPS hospital	n 1, in-state umn 2,	paid days	el i gi b unpai days 2.00	d pai	d days 3.00	el i gi bl e unpai d 4. 00		6	. 00	24.00
24.00	lf this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai	n 1, in-state umn 2, column 3, d days in column	paid days	el i gi b unpai days 2.00	d pai	d days 3.00	el i gi bl e unpai d 4. 00		6	. 00	24.00
24.00	If this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu	n 1, in-state umn 2, column 3, d days in column it unpaid days in	paid days	el i gi b unpai days 2.00	d pai	d days 3.00	el i gi bl e unpai d 4. 00		6	. 00	24.00
	If this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in co out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days ir If this provider is an IRF, enter th	n 1, in-state umn 2, olumn 3, d days in column it unpaid days in o column 6. me in-state	paid days	el i gi b unpai days 2.00	d pai	d days 3.00	el i gi bl e unpai d 4. 00		6	. 00	24.00
	If this provider is an IPPS hospital in-state Medicaid paid days in colur Medicaid eligible unpaid days in col out-of-state Medicaid paid days in co out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days ir If this provider is an IRF, enter th Medicaid paid days in column 1, the	n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state in-state	pai d days <u>1. 00</u> 1, 071	el i gi b unpai days 2.00	d pai	d days 3.00 0	el i gi bl e unpai d 4.00 25		107	. 00	
	If this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in co out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days ir If this provider is an IRF, enter th Medicaid paid days in column 1, the Medicaid eligible unpaid days in col out-of-state Medicaid days in columr	n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state in-state umn 2, 3, out-of-state	pai d days <u>1. 00</u> 1, 071	el i gi b unpai days 2.00	d pai	d days 3.00 0	el i gi bl e unpai d 4.00 25		107	. 00	
	If this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in co out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days ir If this provider is an IRF, enter th Medicaid paid days in column 1, the Medicaid eligible unpaid days in col	n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. ue in-state in-state umn 2, 3, out-of-state umn 4, Medicaid	pai d days <u>1. 00</u> 1, 071	el i gi b unpai days 2.00	d pai	d days 3.00 0	el i gi bl e unpai d 4.00 25		107	. 00	

позетт	Financial Systems COMMUNIT AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		TAL ANDERSON Provider CC		Period: From 01/01/201 To 12/31/201	6 Date/Time	S-2 Prep	ared:
					Urban/Rural	4/14/2017 S Date of Ge		an
26.00	Enter your standard geographic classification (not wa		tus at the her	inning of th	1.00	2.00		26.00
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	rural. nge) sta "2" fo	atus at the end or rural. If ap	of the cost		1		27.00
35.00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status in		0		35.00
					Begi nni ng:	Endi ng:		
36.00	Enter applicable beginning and ending dates of SCH st	atus. S	Subscript line	36 for number	1.00	2.00		36.00
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	es.	·			0		37.00
37. 01	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo							37. 01
38. 00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.							38.00
					Y/N	Y/N		
39.00	Does this facility qualify for the inpatient hospital	pavmer	nt adjustment f	or low volum	1.00 e N	2.00 N		39.00
	hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes)? Ente uiremer or "N"	er in column 1 nts in accordan for no. (see i	"Y" for yes ce with 42 nstructions)				
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.	per 1. E	Enter "Y" for y			N		40.00
							(I X . 00	
45.00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)	nt for a	li sproporti onat	e share in a	ccordance 1	N Y	N	45.00
46.00	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
	Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals					1 1	N N	47.00 48.00
56.00	Is this a hospital involved in training residents in or "N" for no.	approve	ed GME programs	? Enter "Y"	for yes	N		56.00
57.00	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	yes or h of th'	"N" for no in his cost report plete Worksheet	column 1. l [:] ing period?	f column 1 Enter "Y"	N		57.00
58.00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb	oursemer	nt for physicia	ns' services	as 1	N		58.00
59 00	defined in CMS Pub. 15–1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes			P† I	,	N		59.00
	Are you claiming nursing school and/or allied health	costs f	°or a program t	hat meets the	1 e	N		60.00
	provider-operated criteria under §413.85? Enter "Y"	Y/N	<u>s or "N" for no</u> IME	Direct GME	I ME	Direct G	ME	
	1	1.00	2.00	3.00	4.00	5.00		
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.	00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.	00			61.01
51. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of		0.00	0.	oo			61. 02
o1. 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.	00			61. 03
61.04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.	00			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.	00			61.05

OSPI T	AL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	TA	Provider CC		eriod:	Worksheet S-2	
					T	rom 01/01/2016 0 12/31/2016	Part I Date/Time Pre 4/14/2017 8:15	
			Y/N	IME	Direct GME	IME	Direct GME	
			1.00	2.00	3.00	4.00	5.00	
. 06	Enter the amount of ACA §5503 aw used for cap relief and/or FTEs care or general surgery. (see in	that are nonprimary		0.00	0.00			61.
			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1			1.00	2.00	3.00	4.00	1
1. 10	Of the FTEs in line 61.05, speci special ty, if any, and the numbe for each new program. (see instr column 1, the program name, ente program code, enter in column 3, unweighted count and enter in co FTE unweighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE				0.00	0.00	61.
. 20	Of the FTEs in line 61.05, speci program specialty, if any, and t residents for each expanded prog instructions) Enter in column 1, enter in column 2, the program c 3, the IME FTE unweighted count 4, direct GME FTE unweighted cou	he number of FTE ram. (see the program name, ode, enter in column and enter in column				0. 00	0. 00	61.
							1.00	
	ACA Provisions Affecting the Hea Enter the number of FTE resident					ad for which		10
2.00 2.01	your hospital received HRSA PCRE Enter the number of FTE resident	funding (see instructs that rotated from a	cti ons) a Teachi	ng Health Cent	er (THC) into			62. 62.
	during in this cost reporting pe Teaching Hospitals that Claim Re				is)			
3. 00	Has your facility trained reside "Y" for yes or "N" for no in col					eriod? Enter	N	63.
					Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
					Si te			
	Section 5504 of the ACA Base Yea	r FTE Residents in No	onprovi	der Settings1	1.00 This base year	2.00 is your cost r	3.00 eporting	
. 00	period that begins on or after J Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	y trair a-primar all nor non-pr columr	ned residents ry care nprovider rimary care n 3 the ratio	0.00	0.00	0. 000000	64.
		Program Name	Pro	ogram Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00		2.00	3.00	4.00	5.00	
. 00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in				0.00	0.00	0. 000000	65.

	Financial Systems		Y HOSPITAL ANDERSON				of Form		2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	TA Provider C		eriod: rom 01/01/2 o 12/31/2	016 F	Norkshee Part I Date/Tin 4/14/201	ne Prep	
				Unwei ghted FTEs Nonprovi der Si te	Unweighte FTEs in Hospital	ı ((atio (co col. 1 - 2))	⊦ col.	
	Section 5504 of the ACA Current	Year FTE Residents in	n Nonprovider Setting	1.00 gsEffective fo	2.00 pr cost rep	ortino	3.00 g period		
66.00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations o	10 unweighted non-primar ccurring in all nonpr	ry care resident rovider settings.	0.00		0. OO			66.00
	Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	al. Enter in column 3	3 the ratio of						
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighte FTEs in Hospital	ı ((atio (co col. 3 - 4))	⊦ col.	
(7.00		1.00	2.00	3.00	4.00		5.00		(7.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0. 00		0.00	0.0	000000	67.00
					-	1.00	2.00	3.00	
	Inpatient Psychiatric Facility P						2.00	5.00	
70.00	ls this facility an Inpatient Ps Enter "Y" for yes or "N" for no		PF), or does it cont	ain an IPF subp	provi der?	Ν			70.00
71.00	If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions)	e facility have an ap efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	D04? Enter "Y" for y lity train residents)(D)? Enter "Y" for y	ves or "N" for r s in a new teach ves or "N" for r	no. (see ni ng no.	N		0	71.00
75.00	Inpatient Rehabilitation Facilit Is this facility an Inpatient Re		(IRF), or does it c	contain an IRF		N	г т		75.00
	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	and "N" for no. e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	pproved GME teaching ember 15, 2004? Enter new teaching program for no. Column 3: If	program in the "Y" for yes or in accordance column 2 is Y,	"N" for with 42	N		0	76.00
						-	1.00)	
	Long Term Care Hospital PPS Is this a long term care hospita Is this a LTCH co-located within				period? Ent	ter	N N		80. 00 81. 00
	"Y" for yes and "N" for no. TEFRA Providers Is this a new hospital under 42 Did this facility establish a ne					סו.	N		85. 00 86. 00
	§413.40(f)(1)(ii)? Enter "Y" fo Is this hospital a "subclause (I for yes or "N" for no.	r yes and "N" for no.					Ν		87.00
					V		XI X		
	Title V and XIX Services				1.00		2.00	,	
	Does this facility have title V yes or "N" for no in the applica	ble column.			N		Y		90.00
91.00	Is this hospital reimbursed for full or in part? Enter "Y" for y				N		Y		91.00
92.00	Are title XIX NF patients occupy	ing title XVIII SNF b	oeds (dual certificat				Ν		92.00
93.00	instructions) Enter "Y" for yes Does this facility operate an IC	F/IID facility for pu		nd XIX? Enter	N		Ν		93.00
94.00	"Y" for yes or "N" for no in the Does title V or XIX reduce capit applicable column.		or yes, and "N" for n	no in the	N		N		94.00

	AL ANDERSON			n Lieu			2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	CN: 15-0113	Period: From 01/01, To 12/31,		Workshe Part I Date/Ti		
			V		4/14/20 XI X		8 am
			1.00)	2.0		
95.00 If line 94 is "Y", enter the reduction percentage in the appl 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			0. 00 N)	0. 0 N		95.00 96.00
97.00 If line 96 is "Y", enter the reduction percentage in the appl Rural Providers	licable column	ı.	0.00		0.0	0	97.00
105.00 Does this hospital qualify as a critical access hospital (CAH 106.00 If this facility qualifies as a CAH, has it elected the all-i for outpatient services? (see instructions)		nod of paymen	t N				105.00 106.00
107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	1. (see instr 25 and the pr	ructions) lf rogram is cos					107.00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.							108.00
-	Physi cal 1.00	Occupationa 2.00	I Speed 3.00		Respira 4. C		-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Ν	N	N		N		109.00
					1.0	0	-
110.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N" to		on project (4	10A Demo)fo	r	N		110.00
Miscellaneous Cost Reporting Information				1.00	2.00	3.00	-
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" percent psychiatric, rehabilitation and long term hospitals providers	lf column 2 i t for long ter	s "E", enter rm care (incl	in column udes	N		0	115.00
Pub. 15-1, chapter 22, §2208. 1. 116.00 s this facility classified as a referral center? Enter "Y" 1 117.00 s this facility legally-required to carry malpractice insura			"N" for	N Y			116. 00 117. 00
no. 118.00 Is the malpractice insurance a claims-made or occurrence poli claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1 i	f the policy	is	1			118.00
		Premiums	Losse	s	Insura	ance	
		1.00	2.00)	3.0	0	-
118.01 List amounts of malpractice premiums and paid losses:		573, 1		, 7, 450	5.0		0 118. 01
			1.00		2.0	0	-
118.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein.			N	,	2.0	0	118.02
119.00 D0 NOT USE THIS LINE							119.00
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 qua Hold Harmless provision in ACA §3121 and applicable amendment	column 1, "Y alifies for th	' for yes or ne Outpatient			Ν		120.00
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 qua Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implant	column 1, "Y' alifies for th ts? (see instr	' for yes or ne Outpatient ructions)			Ν		120.00
 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 qua Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? If or no in column 1. If column 1 is "Y", enter in column 2 the 	column 1, "Y" alifies for th ts? (see instr ntable devices Enter "Y" for	' for yes or ne Outpatient ructions) s charged to yes or "N"			Ν		
 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 qual Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? If for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 	column 1, "Y" alifies for th ts? (see instr ntable devices Enter "Y" for e Worksheet A	' for yes or ne Outpatient ructions) s charged to yes or "N" line number	YN		N		121. 00 122. 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 qua Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? If or no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. 	column 1, "Y" alifies for th ts? (see instr ntable devices Enter "Y" for e Worksheet A r yes and "N"	' for yes or ne Outpatient ructions) s charged to yes or "N" line number for no. If	Y N N		N		121.00
 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 qual Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? If for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified heart transplant center, enter in column 2. 	column 1, "Y" alifies for th ts? (see instr ntable devices Enter "Y" for e Worksheet A r yes and "N" ter the certifi er the certifi	' for yes or ne Outpatient ructions) s charged to yes or "N" line number for no. If fication date	Y N N		N		121. 00 122. 00 125. 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 qual Hold Harmless provision in ACA \$3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state heal th or similar taxes? If for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 	column 1, "Y" alifies for th ts? (see instr ntable devices Enter "Y" for e Worksheet A worksheet A r yes and "N" ter the certifi er the certifi	' for yes or ne Outpatient ructions) s charged to yes or "N" line number for no. If fication date cation date	Y N N		N		121. 00 122. 00 125. 00 126. 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 qual Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? If for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2. 	column 1, "Y alifies for th ts? (see instr ntable devices Enter "Y" for e Worksheet A r yes and "N" ter the certifi er the certifi	' for yes or ne Outpatient ructions) s charged to yes or "N" line number for no. If fication date cation date	Y N		N		121. 00 122. 00 125. 00 126. 00 127. 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 qual Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state heal th or similar taxes? If for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified panceas transplant center, enter column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified panceas transplant center, enter column 1 and termination date, if applicable, in column 2. 	column 1, "Y" alifies for th ts? (see instr ntable devices Enter "Y" for e Worksheet A worksheet A r yes and "N" ter the certifient or the certifient r the certifient enter the certifient enter the certifient anter the certifient center the certifient	' for yes or ne Outpatient ructions) s charged to yes or "N" line number for no. If fication date cation date cation date i tification	Y N		N		121. 00 122. 00 125. 00 126. 00 127. 00 128. 00 129. 00 130. 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 qualifies for no applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for no applicable amendments? In column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state heal th or similar taxes? If for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter column 1 and termination date, if applicable, in column 2. 	column 1, "Y" alifies for th ts? (see instr ntable devices Enter "Y" for e Worksheet A worksheet A r yes and "N" ter the certifient of the	' for yes or ne Outpatient ructions) s charged to yes or "N" line number for no. If fication date cation date cation date i tification ertification	Y N		N		121. 00 122. 00 125. 00 126. 00 127. 00 128. 00 129. 00

	IDENTIFICATION DATA	Provider CC	N: 15-0113		1/01/2016 2/31/2016	Worksheet S- Part I Date/Time Pr 4/14/2017 8:	repared:
					1.00	2.00	
3.00 If this is a Medicare certified othe in column 1 and termination date, if			cation date				133. 0
I. 00 If this is an organ procurement organ and termination date, if applicable,	nization (OPO), enter th		n column 1				134. 0
All Providers						11000.40	140.0
0.00 Are there any related organization c chapter 10? Enter "Y" for yes or "N" are claimed, enter in column 2 the h	for no in column 1. If	yes, and home	office costs	5	Y	HB0040	140. 0
1.00	2.0	0			3.00		
If this facility is part of a chain				name and	address	of the	
home office and enter the home office	Contractor name and contractor's Name: WP			or's Nu	mber: 0810	1	
2. 00 Street: 1500 NORTH RITTER AVE	PO Box:	5		01 3 110			142.0
3. 00 City: INDIANAPOLIS	State: IN		Zip Code	:	4621	9	143.0
						1.00	_
1.00 Are provider based physicians' costs	included in Workshoot /	12				1.00 Y	144. C
	FIGLAGE TH WULKSHEEL F	1;				I	144. (
					1.00	2.00	-
5.00 If costs for renal services are clai					Y		145.0
inpatient services only? Enter "Y" f no, does the dialysis facility inclu period? Enter "Y" for yes or "N" fo	ide Medicare utilization						
0.00Has the cost allocation methodology Enter "Y" for yes or "N" for no in c	changed from the previou column 1. (See CMS Pub. ?			-	Ν		146. (
yes, enter the approval date (mm/dd/	'yyyy) in column 2.						_
						1.00	-
.00Was there a change in the statistica	I basis? Enter "Y" for	yes or "N" for	no.			N	147.0
3.00Was there a change in the order of a		2				N	148. 0
0.00 Was there a change to the simplified	l cost finding method? Er					N	149.0
		Part A 1.00	Part B 2.00		itle V 3.00	Title XIX 4.00	-
Does this facility contain a provide	er that qualifies for an						
or charges? Enter "Y" for yes or "N"						. 13)	
5.00Hospital		N	N		N	N	155.0
b.00 Subprovider - IPF 7.00 Subprovider - IRF		N N	N		N N	N N	156. 0 157. 0
3. OO SUBPROVI DER		IN	IN		IN .		158.0
9. 00 SNF		N	N		Ν	N	159.0
D. OO HOME HEALTH AGENCY		N	N		Ν	N	160. 0
. 00 CMHC			N		Ν	N	161.0
. 10 CORF			N		N	N	161.1
						1.00	-
Multicampus						1.00	
5.00 Is this hospital part of a Multicamp Enter "Y" for yes or "N" for no.	ous hospital that has one	e or more campu	ises in diffe	erent CB	SAs?	N	165. 0
	Name	County	State Zi	p Code	CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	
b. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.0	00 166. (
	,					1.00	_
	incentive in the Americ	an Recovery and		nt Act			
Health Information Technology (HIT)							- · · - ·
Heal th Information Technology (HIT) 7.00 Is this provider a meaningful user u 8.00 If this provider is a CAH (line 105 reasonable cost incurred for the HIT	nder §1886(n)? Enter ") is "Y") and is a meaning	Y" for yes or " gful user (line		, enter	the	Y	167. (0168. (

Health Financial Systems CO					
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICAT					
	rom 01/01/2016 p 12/31/2016				
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning dateperiod respectively (mm/dd/yyyy)	10/01/2012	09/30/2013	170.00		
					1
			1.00	2.00	
171.00 If line 167 is "Y", does this provider have any section 1876 Medicare cost plans reported on Wk "Y" for yes and "N" for no in column 1. If colu 1876 Medicare days in column 2. (see instruction	st. S-3, Pt. I, line 2, col. 6? En mn 1 is yes, enter the number of se		Ν	C	171.00

HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet S- Part II Date/Time Pr 4/14/2017 8:	epared:
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	snonses Entr	<u> </u>	2.00	
	mm/dd/yyyy format.		Sponses. Ent			
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c	beginning of	the cost	N		1.0
	reporting periods in yes, enter the date of the enange in e	01 unit 2. (300	Y/N	Date	V/I	
			1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.00
3. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and othe relationships? (see instructions)	iffices, drug ler or its if the board	N			3. 00
			Y/N	Туре	Date	
	Financial Data and Danasta		1.00	2.00	3.00	
4.00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled, ilable in	Y	A		4.00
5.00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N	Y/N	Legal Oper.	5.00
				1.00	2.00	
	Approved Educational Activities					
5.00	Column 1: Are costs claimed for nursing school? Column 2:	lf yes, is th	ne provider i	s N		6.00
7.00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	structions		Ν		7.00
3.00	were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		during the	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved		al education	Ν		9.00
10. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.		he current	Ν		10.00
11.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. 0
					Y/N 1.00	-
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	Y N	12. 0 13. 0
4.00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	°yes, see in:	structions.	N	14.0
5.00	Did total beds available change from the prior cost reporti		yes, see ins t A	tructions. Par	N t B	15.0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	_
16.00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	Y	03/30/2017	Y	03/30/2017	16. 0
7.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Ν		Ν		17.0
18.00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18. 0
19.00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19. 0

Heal th	Fi nanci al	Systems

In Lieu of Form CMS-2552-10

<u>Heal th</u>	Financial Systems COMMUNITY HOS	PITAL ANDERSON		In Lie	n Lieu of Form CMS-2552-		
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Period: From 01/01/2016 To 12/31/2016			
		_			4/14/2017		
			iption	Y/N	Y/N		
00.00			0	1.00	3.00		
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00	
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		Ν		21.00	
					1.00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS H	IOSPI TALS)		1.00		
	Capital Related Cost						
22.00	Have assets been relifed for Medicare purposes? If yes, se	ee instructions			N	22.00	
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		als made duri	ng the cost	N	23.00	
24.00	Were new leases and/or amendments to existing leases enter	red into during	this cost rep	orting period?	Ν	24.00	
25. 00	If yes, see instructions Have there been new capitalized leases entered into during	N	25.00				
26.00	instructions. Were assets subject to Sec.2314 of DEFRA acquired during 1	the cost reporti	ng period? If	yes, see	N	26.00	
27.00	instructions. Has the provider's capitalization policy changed during th	ne cost reportir	ng period?lf	yes, submit	N	27.00	
	copy. Interest Expense						
28.00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	entered into dur	ing the cost	reporting	Ν	28.00	
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		ebt Service Re	serve Fund)	Ν	29.00	
30. 00	Has existing debt been replaced prior to its scheduled mat		debt? If yes,	see	N	30.00	
31.00	instructions. Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If yes,	see	N	31.00	
	i nstructi ons. Purchased Servi ces						
32.00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr		ed through con	tractual	Ν	32.00	
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		ng to competit	ive bidding? If	Ν	33.00	
	Provi der-Based Physi ci ans						
	Are services furnished at the provider facility under an a If yes, see instructions.	arrangement with	n provi der-bas	ed physi ci ans?	Y	34.00	
35.00	If line 34 is yes, were there new agreements or amended e>		nts with the p	rovi der-based	Ν	35.00	
	physicians during the cost reporting period? If yes, see i	nstructions.	-	Y/N	Date		
				1, 00	2.00		
	Home Office Costs			1.00	2.00		
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	prepared by the	home office?	Y		36.00 37.00	
	If yes, see instructions.						
	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end	nd of the home o	offi ce.	N		38.00	
39.00	If line 36 is yes, did the provider render services to oth see instructions.	ner chain compor	nents? If yes,	Ν		39.00	
40.00	If line 36 is yes, did the provider render services to the instructions.	e home office?	lf yes, see	Ν		40.00	
		1.	00	2.	00		
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	REX		SHERA		41.00	
42.00	respectively. Enter the employer/company name of the cost report	ERNST & YOUNG	LLP			42.00	
	preparer.			REX SHERA@EY O	ОМ	43.00	
75.00	report preparer in columns 1 and 2, respectively.			NEA. SHENAGET. U		+3.00	
42. 00 43. 00	respectively. Enter the employer/company name of the cost report preparer. Enter the telephone number and email address of the cost	ERNST & YOUNG 3176817519	LLP	REX. SHERA@EY. CI	ОМ		

Heal th	Financial Systems COMMUNITY HOS	PITAL ANDERSON	In Lie	u of Form CMS-	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0113	Peri od:	Worksheet S-2	
			From 01/01/2016 To 12/31/2016		pared: 8 am
		3.00			
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position	EXECUTI VE DI RECTOR			41.00
	held by the cost report preparer in columns 1, 2, and 3,				
	respectively.				
42.00	Enter the employer/company name of the cost report				42.00
	preparer.				
43.00	Enter the telephone number and email address of the cost				43.00
	report preparer in columns 1 and 2, respectively.				

		AL ANDERSON		Non-CMS HFS Wo	
FS SI	upplemental Information	Provider CCN: 15-0113	Period: From 01/01/2016	Worksheet S-2 Part IX	2
			To 12/31/2016	Date/Time Pre	naro
			10 12/31/2010	4/14/2017 8:1	
			Title V	Title XIX	
			1.00	2.00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE				
. 00	Do Title V or XIX follow Medicare (Title XVIII) for the Inter	rns and Residence post	Y	Y	1 1.
	stepdown adjustments on W/S B, Part I, column 25? Enter Y/N i				
	and Y/N in column 2 for Title XIX.				
. 00	Do Title V or XIX follow Medicare (Title XVIII) for the repor	ting of charges on W/S C	Y	Y	2.
	Part I (e.g. net of Physician's component)? Enter Y/N in colu				
	in column 2 for Title XIX.				
. 00	Do Title V or XIX follow Medicare (Title XVIII) for the calcu	ulation of Observation Bee	Y b	Y	3.
	Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for	Title V and Y/N in column	۱		
	2 for Title XIX.				
			Inpati ent	Outpati ent	
			1.00	2.00	
	CRITICAL ACCESS HOSPITALS				
. 00	Does Title V follow Medicare (Title XVIII) for Critical Acces		N	N	4.
	reimbursed 101% of cost? Enter Y or N in column 1 for inpatie	ent and Y or N in column 2	2		
	for outpatient.				
. 00	Does Title XIX follow Medicare (Title XVIII) for Critical Acc			N	5
	reimbursed 101% of cost? Enter Y or N in column 1 for inpatie	ent and Y or N in column 2	2		
	for outpatient.		T 1.1.1.1.1		
			Title V	Title XIX	
	RCE DI SALLOWANCE		1.00	2.00	
. 00	Do Title V or XIX follow Medicare and add back the RCE Disall	awaraa an W/S C Dart I	Y	Y	6
. 00	column 4? Enter Y/N in column 1 for Title V and Y/N in column	· · · · · · · · · · · ·	Ŷ	Ŷ	0
	PASS THROUGH COST				
00	Do Title V or XIX follow Medicare when cost reimbursed (payme	pt system is "0") for	Y	Y	1 7
00	worksheets D, parts I through IV? Enter Y/N in column 1 for T		T	Ţ	'
	2 for Title XIX.				
	RHC				
. 00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Ent	ter Y/N in column 1 for	N	N	8
. 00	Title V and Y/N in column 2 for Title XIX.		i N	14	1

HOSPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	COMMUNITY HOSPI AL DATA	Provi der CC	CN: 15-0113	Peri od:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2016		
					To 12/31/2016	Date/Time Pre 4/14/2017 8:1	
						I/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	128	46, 84	18 0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)						0.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovider						3.00 4.00
4.00	HMO IRF Subprovider					0	
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation		128	14 04	18 0.00	0	6.00 7.00
7.00			128	46, 84	18 0.00	0	7.00
8.00	beds) (see instructions) INTENSIVE CARE UNIT	31.00	12	4, 39	0.00	0	8.00
9.00	CORONARY CARE UNIT	31.00	0	4, 55	0 0.00		9.00
10.00	BURN INTENSIVE CARE UNIT	33.00	0		0 0.00		10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T	34.00	0		0 0.00		11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	54.00	0		0.00	0	12.00
12.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)	45.00	140	51, 24	10 0.00		14.00
15.00	CAH visits		110	01,2	0.00	0	15.00
16.00	SUBPROVIDER - IPF	40, 00	0		0	0	16.00
17.00	SUBPROVI DER – I RF	41.00	0		0	0	17.00
18.00	SUBPROVIDER	42.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY	44.00	0		0	0	19.00
20.00	NURSING FACILITY	45.00	0		0	0	20.00
21.00	OTHER LONG TERM CARE	46.00	0		0		21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	115.00					23.00
24.00	HOSPI CE	116.00	0		0		24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC	99.00				0	25.00
25.10	CMHC - CORF	99. 10				0	25.10
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		140				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00

10SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	F	Period: From 01/01/2016 Fo 12/31/2016		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00 2.00 3.00	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) HMO and other (see instructions) HMO IPF Subprovider	9, 473 3, 789	732 3, 720	21, 568	3		1.00 2.00 3.00
1.00	HMO I RF Subprovi der	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	(0		5.00
5.00	Hospital Adults & Peds. Swing Bed NF	-	0	(6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	9, 473	732	21, 568	3		7.00
3.00	INTENSIVE CARE UNIT	1, 438	0	1, 570	C		8.00
9.00	CORONARY CARE UNIT	0	0	(D		9.00
0.00	BURN INTENSIVE CARE UNIT	0	0	(D		10.0
1.00	SURGICAL INTENSIVE CARE UNIT	0	0	(D		11.0
2.00	OTHER SPECIAL CARE (SPECIFY)						12.0
3.00	NURSERY		1, 780	2, 158			13.0
4.00	Total (see instructions)	10, 911	2, 512	25, 296	6 0.00	1, 062. 18	14.0
15.00	CAH visits	0	0	(D		15.0
6.00	SUBPROVIDER - IPF	0	0	(0.00	0.00	16.0
7.00	SUBPROVIDER - IRF	0	0	(0.00	0.00	17.0
8.00	SUBPROVI DER		0	(0.00	0.00	18. C
9.00	SKILLED NURSING FACILITY	0	0	(0.00	0.00	19. C
20.00	NURSING FACILITY		0	(0.00	0.00	20. C
1.00	OTHER LONG TERM CARE			(0.00	0.00	
2.00	HOME HEALTH AGENCY	0	0	(0.00	0.00	
3.00	AMBULATORY SURGICAL CENTER (D. P.)				0.00	0.00	
4.00	HOSPI CE	0	0	(0.00	
4. 10	HOSPICE (non-distinct part)	0	0	210			24.1
5.00	CMHC - CMHC	0	0	(0.00	
5. 10	CMHC - CORF	0	0	(0.00	0.00	
6.00	RURAL HEALTH CLINIC	0	0	(0.00	0.00	
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0.00	0.00	
7.00	Total (sum of lines 14-26)				0.00	1, 062. 18	
8.00	Observation Bed Days		1, 126	2, 404	1		28.0
9.00	Ambulance Trips	0					29. (
0. 00	Employee discount days (see instruction)			273			30. (
1. 00	Employee discount days - IRF			(31. (
2.00	Labor & delivery days (see instructions)	0	21	93	3		32.0
32.01	Total ancillary labor & delivery room			(32.0
	outpatient days (see instructions)						
3.00	LTCH non-covered days	0					33.

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICA	AL DATA	Provider C	CN: 15-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part I Date/Time Pre 4/14/2017 8:13	pared
	Full Time Equivalents		Di s	scharges		
Component	Nonpai d	Title V	Title XVII	Title XIX	Total All	
	Workers				Patients	
	11.00	12.00	13.00	14.00	15.00	
 Nov 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) Nov HMO and other (see instructions) HMO and other (see instructions) HMO IPF Subprovider HMO HO IPF Subprovider HMO Hospital Adults & Peds. Swing Bed SNF Hospital Adults and Peds. (exclude observation beds) (see instructions) Intensive CARE UNIT CORONARY CARE UNIT SURGICAL INTENSIVE CARE UNIT CORONARY CARE UNIT O Total (see instructions) NURSERY O Total (see instructions) SUBPROVIDER - IPF SO SUBPROVIDER - IRF SO SUBPROVIDER - IRF O SKILLED NURSING FACILITY ON RESING FACILITY ON OTHER LONG TERM CARE O HOME HEALTH AGENCY O AMBULATORY SURGICAL CENTER (D. P.) HOR HOSPICE A MBULATORY SURGICAL CENTER (D. P.) HOR HOSPICE COR CORF O CMHC - CORF O ON RURAL HEALTH CLINIC SE FEDERALLY QUALIFIED HEALTH CENTER O OServation Bed Days O Ambulance Trips O Employee discount days - IRF 	0.00 0.00		2, 5 9 2, 5	52 1, 236 09 0 0 0	7, 047 7, 047 0 0 0 0	2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20.

SPI T	AL WAGE INDEX INFORMATION			Provider CC	F	eriod: rom 01/01/2016 o 12/31/2016		pare
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
00	Total salaries (see	200.00	60, 201, 930	0	60, 201, 930	2, 209, 326. 24	27.25	1.
	instructions)						0.00	
00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.
00	Non-physician anesthetist Part		722, 472	0	722, 472	9, 388. 00	76. 96	3.
00	B Physician-Part A -		0	0	0	0.00	0. 00	4
00	Administrative		0	0	0	0.00	0.00	4
D1	Physicians - Part A - Teaching		0	-	0	0.00		
00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5
00	Non-physician-Part B for		0	0	0	0.00	0.00	6
	hospital-based RHC and FQHC							
00	services Interns & residents (in an	21.00	0	0	0	0.00	0.00	7
	approved program)	21.00	0	0	0	0.00	0.00	
01	Contracted interns and		0	0	0	0.00	0.00	7
	residents (in an approved programs)							
00	Home office and/or related		0	0	0	0.00	0.00	8
0	organization personnel	11.00	0			0.00	0.00	
00 00	SNF Excluded area salaries (see	44.00	3, 209, 156	0	3, 209, 156	0.00 92,771.31	0. 00 34. 59	
	instructions)			_				
00	OTHER WAGES & RELATED COSTS		1 040 05/		1 040 05/	10 710 /0	02.7/	1 1 1
00	Contract Labor: Direct Patient Care		1, 848, 856	0	1, 848, 856	19, 719. 69	93. 76	11
00	Contract Labor: Top Level management and other management and administrative		0	0	0	0.00	0.00	12
00	services Contract Labor: Physician-Part		341, 703	0	341, 703	3, 906. 00	87.48	12
00	A - Administrative		341, 703	0	341,703	3, 900. 00	07.40	13
00	Home office and/or related		0	0	0	0.00	0.00	14
	orgainzation salaries and wage-related costs							
01	Home office salaries		1, 324, 348	0	1, 324, 348	34, 296. 00	38.62	14
02	Related organization salaries		0	-	0			
00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15
00	Home office and Contract		0	0	0	0.00	0.00	16
	Physicians Part A - Teaching							
00	WAGE-RELATED COSTS Wage-related costs (core) (see		15, 410, 572	0	15, 410, 572			17
	instructions)				-, -, -, -			
00	Wage-related costs (other) (see instructions)		0	0	0			18
00	Excluded areas		878, 881	0	878, 881			19
00	Non-physician anesthetist Part		0	0	0			20
00	A Non-physician anesthetist Part		0	0	∩			21
	В		-	_				
00	Physician Part A -		0	0	0			22
01	Administrative Physician Part A - Teaching		Ω	0	n			22
00	Physician Part B		197, 861	0	197, 861			23
00	Wage-related costs (RHC/FQHC)		0	0	0			24
00	Interns & residents (in an approved program)		0	0	0			25
50	Home office wage-related		0	0	0			25
51	Related orgainzation		0	0	0			25
52	wage-related Home office: Physician Part A - Administrative -		181, 808	0	181, 808			25
53	wage-related Home office & Contract		O	0	0			25
	Physicians Part A - Teaching -		Ū					
	wage-related OVERHEAD COSTS - DIRECT SALARIE	c						-
	Employee Benefits Department	4.00	2,911,456	0	2, 911, 456	81, 405. 69	35. 76	26
	Administrative & General	5.00	9, 916, 675					

Heal th	Financial Systems	(COMMUNITY HOSP	ITAL ANDERSON		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 4/14/2017 8:1	pared: 8 am
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		7, 582, 686	0	7, 582, 68	6 140, 803. 58	53.85	28.00
29.00	Maintenance & Repairs	6.00	0	0		0 0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,023,034	0	2, 023, 03	4 77, 109. 06	26. 24	30.00
31.00	Laundry & Linen Service	8.00	0	64, 354	64, 35	4, 051. 00	15.89	31.00
32.00	Housekeepi ng	9.00	1, 395, 271	-64, 354	1, 330, 91	7 83, 785. 64	15.88	32.00
33.00	Housekeeping under contract (see instructions)		0	0		0 0.00	0.00	33.00
34.00	Dietary	10.00	1, 459, 921	-770, 880	689, 04	1 40, 315. 04	17.09	34.00
35.00	Dietary under contract (see instructions)		0	0		0 0.00	0.00	35.00
36.00	Cafeteri a	11.00	0	770, 880	770, 88	0 45, 102. 00	17.09	36.00
37.00	Maintenance of Personnel	12.00	0	0		0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,075,547	0	1, 075, 54	7 23, 821. 71	45. 15	38.00
39.00	Central Services and Supply	14.00	987, 429	0	987, 42	9 64, 280. 58	15.36	39.00
40.00	Pharmacy	15.00	1, 470, 252		1, 470, 25			40.00
41.00	Medi cal Records & Medi cal Records Library	16.00	1, 157, 213		1, 157, 21			
42.00	Social Service	17.00	0	0		0.00	0.00	42.00
43.00	Other General Service	18.00	0	0		0.00	0.00	43.00

Heal th	Financial Systems	(COMMUNI TY HOSP	ITAL ANDERSON		In Lieu of Form CMS-2552-10			
HOSPI	TAL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2016 To 12/31/2016		pared:	
		Worksheet A		Recl assi fi cati	, J		Average Hourly		
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷		
				(from	(col.2 ± col.		col. 5)		
				Worksheet A-6)	,	col. 4			
		1.00	2.00	3.00	4.00	5.00	6.00		
	PART III - HOSPITAL WAGE INDEX	SUMMARY							
1.00	Net salaries (see		67, 062, 144	0	67, 062, 14	4 2, 340, 741. 82	28.65	1.00	
	instructions)								
2.00	Excluded area salaries (see instructions)		3, 209, 156	0	3, 209, 15	6 92, 771. 31	34. 59	2.00	
3.00	Subtotal salaries (line 1		63, 852, 988	0	63, 852, 98	8 2, 247, 970. 51	28, 40	3.00	
0100	minus line 2)		00,002,700		00,002,70	2/2/////0/01	201.10	0.00	
4.00	Subtotal other wages & related		3, 514, 907	0	3, 514, 90	7 57, 921. 69	60. 68	4.00	
	costs (see inst.)								
5.00	Subtotal wage-related costs		15, 592, 380	0	15, 592, 38	0.00	24.42	5.00	
	(see inst.)								
6.00	Total (sum of lines 3 thru 5)		82, 960, 275	0	82, 960, 27	5 2, 305, 892. 20	35. 98	6.00	
7.00	Total overhead cost (see		29, 979, 484	0	29, 979, 48	4 1, 016, 264. 69	29. 50	7.00	
	instructions)								
		-		-					

Heal th	Financial Systems COMMUNITY HOS	SPITAL ANDERSON	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE RELATED COSTS	Provider CCN: 15-0113	Peri od: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part IV Date/Time Pre 4/14/2017 8:1	pared:
				Amount Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				
	RETI REMENT COST				
1.00	401K Employer Contributions			0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			2, 547, 717	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0	6.00
7.00	Employee Managed Care Program Administration Fees			0	7.00
	HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			9, 003, 846	
8.01	Health Insurance (Self Funded without a Third Party Admin			0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administ	rator)		0	8.02
8.03	Heal th Insurance (Purchased)			0	8.03
9.00	Prescription Drug Plan			0	9.00
10.00	Dental, Hearing and Vision Plan			0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)			-4, 232	
12.00	Accident Insurance (If employee is owner or beneficiary)	、 、		0	
13.00	Disability Insurance (If employee is owner or beneficiary			173, 774	
14.00	Long-Term Care Insurance (If employee is owner or benefic	iary)		0	
15.00	'Workers' Compensation Insurance			200, 060	
16.00	Retirement Health Care Cost (Only current year, not the e	xtraordinary accruai require	ed by FASB 106.	0	16.00
	Non cumulative portion) TAXES				
17 00	FICA-Employers Portion Only			4, 395, 844	17.00
18.00	Medicare Taxes - Employers Portion Only			4, 393, 844	18.00
19.00	Unemployment Insurance			57, 179	
	State or Federal Unemployment Taxes			57, 179	
20.00	OTHER			0	20.00
21 00	Executive Deferred Compensation (Other Than Retirement Co	st Reported on Lines 1 throu	inh 4 above (see	0	21.00
21.00	instructions))	st kepol ted on triles i tillot	igii 4 above. (3cc	0	21.00
22.00	Day Care Cost and Allowances			0	22.00
	Tuition Reimbursement			113, 126	
	Total Wage Related cost (Sum of lines 1 -23)			16, 487, 314	
	Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0	25.00

Heal th	Financial Systems	COMMUNI TY HOSPI TAL ANDERSON	In Lie	u of Form CMS-:	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0113	Peri od:	Worksheet S-3	
			From 01/01/2016		
			To 12/31/2016	Date/Time Pre 4/14/2017 8:1	
	Cost Center Description		Contract Labor		
	cost center bescription		1.00	2.00	
	PART V - Contract Labor and Benefit Cost		1.00	2.00	
	Hospital and Hospital-Based Component Ident	i fi cati on:			1
1.00	Total facility's contract labor and benefit		0	0	1.00
2.00	Hospi tal		0	0	2.00
3.00	Subprovider - IPF		0	0	3.00
4.00	Subprovider - IRF		0	0	4.00
5.00	Subprovider - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00	Hospital-Based SNF		0	0	8.00
9.00	Hospital-Based NF		0	0	9.00
10.00	Hospital-Based OLTC				10.00
11.00	Hospital-Based HHA		0	0	11.00
12.00	Separately Certified ASC		0	0	12.00
13.00	Hospital-Based Hospice		0	0	13.00
14.00	Hospital-Based Health Clinic RHC		0	0	14.00
15.00	Hospital-Based Health Clinic FQHC		0	0	15.00
16.00	Hospital-Based-CMHC		0	0	16.00
16. 10	Hospital-Based-CMHC 10		0	0	16. 10
	Renal Dialysis		0	0	
18.00	Other		0	0	18.00

Heal th	Financial Systems COMMUNITY HOSPITA	L ANDERSON		In Lie	u of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider C		Period:	Worksheet S-1	
				From 01/01/2016 To 12/31/2016	Date/Time Pre	parod
				10 12/31/2010	4/14/2017 8: 1	
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by li	ne 202 column	8)	0. 268984	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				56, 955, 751	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplementa		from Medicaid	?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments fro	om Medicaid			0	5.00
6.00	Medi cai d charges				90, 887, 364	6.00
7.00	Medicaid cost (line 1 times line 6)		<u> </u>		24, 447, 247	7.00
8.00	Difference between net revenue and costs for Medicaid program	(line / min	us sum of lin	es 2 and 5; if	0	8.00
	<pre>< zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions f</pre>	For oach lin	0)			
9.00	Net revenue from stand-al one CHIP		e)		0	9.00
10.00	Stand-al one CHIP charges				0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)					
12.00	Difference between net revenue and costs for stand-alone CHIP	(line 11 mi	nus line 9 i	f < zero then	0	
12.00	enter zero)		nus i i ne 🧃 i		0	12.00
	Other state or local government indigent care program (see ins	structions f	or each line)			
13.00	Net revenue from state or local indigent care program (Not ind)	0	13.00
14.00	Charges for patients covered under state or local indigent car				0	14.00
	10)					
15.00	State or local indigent care program cost (line 1 times line '	14)			0	15.00
16.00	Difference between net revenue and costs for state or local in	ndigent care	program (lin	e 15 minus line	0	16.00
	13; if < zero then enter zero)					
	Uncompensated care (see instructions for each line)					
	Private grants, donations, or endowment income restricted to the	9	5		122, 206	
18.00	Government grants, appropriations or transfers for support of			(<u> </u>	62, 284	
19.00	Total unreimbursed cost for Medicaid , CHIP and state and loca 8, 12 and 16)	al indigent	care programs	(sum of lines	0	19.00
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col. 2)	
			1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions	5)	4, 059, 15	9 1, 341, 890	5, 401, 049	20.00
21.00	Cost of patients approved for charity care (line 1 times line	20)	1, 091, 84	9 360, 947	1, 452, 796	21.00
22.00	Partial payment by patients approved for charity care			0 0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		1, 091, 84	9 360, 947	1, 452, 796	23.00
					1.00	
24.00	Does the amount in line 20 column 2 include charges for patier	nt days beyo	nd a length o	f stav limit	1.00 N	24.00
21.00	imposed on patients covered by Medicaid or other indigent care		na a rengen o	i stay i i ilii t		21.00
25.00	If line 24 is "yes," charges for patient days beyond an indig		ogram's lengt	h of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see in			J J	3, 444, 744	
27.00	Medicare bad debts for the entire hospital complex (see instru				474, 764	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (1		s line 27)		2, 969, 980	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex		,	28)	798, 877	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			,	2, 251, 673	
	Total unreimbursed and uncompensated care cost (line 19 plus I	ine 30)			2, 251, 673	

RECEAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C		eriod: rom 01/01/2016	Worksheet A	
				T		Date/Time Pre 4/14/2017 8:1	pared: 8 am
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
	[1.00	2.00	3.00	4.00	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		0	0	4, 829, 689	4, 829, 689	1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT		0	0	3, 766, 392	3, 766, 392	2.00
3.00	00300 OTHER CAP REL COSTS		0	0	0	0	3.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	2, 911, 456 9, 916, 675	12, 363, 827 19, 022, 364		-98, 562 -1, 968, 438	15, 176, 721 26, 970, 601	4.00 5.00
6.00	00600 MAINTENANCE & REPAIRS	9,910,075	19,022,304	20, 939, 039	-1, 900, 430 0	20, 970, 001	6.00
7.00	00700 OPERATION OF PLANT	2, 023, 034	5, 849, 088	7, 872, 122	-1, 115, 998	6, 756, 124	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	187, 821	187, 821	8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 395, 271 1, 459, 921	471, 204 1, 628, 273	1, 866, 475 3, 088, 194	206, 681 -1, 767, 073	1, 659, 794 1, 321, 121	9.00 10.00
11.00	01100 CAFETERI A	0	0 0 0	0	1, 630, 654	1, 630, 654	
13.00	01300 NURSING ADMINISTRATION	1, 075, 547	140, 967		-203	1, 216, 311	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	987, 429 1, 470, 252	880, 722 6, 343, 052	1, 868, 151 7, 813, 304	-123, 681 -6, 025, 015	1, 744, 470 1, 788, 289	
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 470, 252	550, 023		-0, 023, 015 -45	1, 707, 191	16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	0	0	0	0	19.00
20.00	02000 NORSTNG SCHOOL 02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0		0	0	20.00
22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300 PARAMED ED PRGM-(EMS)	0	0	0	0	0	23.00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	12, 769, 507	3, 278, 308	16, 047, 815	-2, 835, 323	13, 212, 492	30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 960, 029	772, 879		-510, 385	2, 222, 523	31.00
32.00	03200 CORONARY CARE UNI T	0	0	0	0	0	32.00
33.00 34.00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	33.00 34.00
40.00	04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100 SUBPROVI DER – I RF	0	0	0	0	0	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	0	2, 868 0	2,868	1, 234, 484 0	1, 237, 352 0	43.00 44.00
45.00	04500 NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
50.00	ANCI LLARY SERVI CE COST CENTERS	4, 388, 557	18, 117, 696	22, 506, 253	-16, 677, 431	5, 828, 822	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		0	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	722, 472 2, 339, 117	2, 230, 957 1, 604, 864		-53, 866 -672, 717	2, 899, 563 3, 271, 264	
	05500 RADI OLOGY-THERAPEUTI C	0	0				
56.00	05600 RADI OI SOTOPE	240, 022	632, 777	872, 799		628, 516	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	361, 443 322, 727	593, 342 460, 276	954, 785 783, 003	-365, 798 -138, 171	588, 987 644, 832	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	815, 790	1, 435, 913		-1, 180, 704	1, 070, 999	59.00
60.00	06000 LABORATORY	2, 044, 051	3, 680, 104	5, 724, 155	-1, 894, 039	3, 830, 116	
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	197, 263	444, 777	642, 040	-422, 244	219, 796	61.00 62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	827, 931 1, 655, 894	305, 913 480, 955	1, 133, 844 2, 136, 849	-188, 951 -124, 348	944, 893 2, 012, 501	65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	328, 976	31, 813		4, 679	365, 468	67.00
68.00	06800 SPEECH PATHOLOGY	199, 138	20, 698		6, 697	226, 533	
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	369, 858 530, 710	274, 987 272, 561		-155, 694 -62, 362	489, 151 740, 909	69.00 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	272, 501	003, 271	-02, 302 11, 331, 606	11, 331, 606	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11, 334, 059	11, 334, 059	72.00
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0 271, 338	0	5, 822, 394 -3, 471	5, 822, 394 267, 867	73.00 74.00
75.00	07400 RENAL DIALYSIS 07500 ASC (NON-DI STINCT PART)	0	∠/1,338 0	271, 338 0	-3,471	267,867	74.00
	OUTPATIENT SERVICE COST CENTERS			· · · · · · · · · · · · · · · · · · ·			
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0	0	0	0	89.00 90.00
90. 01	09001 WOUND/OSTOMY CLINIC	306, 643	871, 031	1, 177, 674	-309, 203	868, 471	90.01
90.02	09002 KIDS PLUS CLINIC	0	0	0	0	0	90.02
90.03	09003 ONCOLOGY 09004 MUNCIE CLINIC	986, 203 0	-5, 922, 909 82, 386		-1, 121, 006 -34, 665	-6, 057, 712 47, 721	90.03 90.04
90.04							, , , , , , +

		COMMUNITY HOSPIT				u of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CO	CN: 15-0113	Period: From 01/01/2016	Worksheet A	
					To 12/31/2016	Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col	1 Reclassi fi cati	4/14/2017 8:1 Recl assi fi ed	8 am
	cost center bescription	Sararres	other	+ col. 2)	ons (See A-6)	Trial Balance	
				, í		(col. 3 +-	
						col. 4)	
00.0(1.00	2.00	3.00	4.00	5.00	00.04
90. 06 90. 07	09006 PREGNANCY PLUS 09007 0/P LAB	-7, 773	1, 933	-5, 84	0 -788 0 0	-6, 628	90.06 90.07
90.07 90.08	09008 0/P LAB	0	0			0	90.07
90.00 90.09	09009 FORTVILLE CLINIC	0	41, 811	41, 81	1 -41,022		90.00
91.00	09100 EMERGENCY	2, 978, 755	968, 633			3, 376, 117	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
	09500 AMBULANCE SERVICES	0	0		0 0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	96.00
	09700 DURABLE MEDICAL EQUIP-SOLD 09900 CMHC	0	0		0 0	0	97.00 99.00
	09910 CORF	0	0			0	99.00 99.10
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0 0		100.00
	10100 HOME HEALTH AGENCY	0	0		0 0		101.00
	SPECIAL PURPOSE COST CENTERS				<u> </u>		
105.00	10500 KIDNEY ACQUISITION	0	0		0 0	0	105.00
106.00	10600 HEART ACQUI SI TI ON	0	0		0 0	0	106.00
	10700 LIVER ACQUISITION	0	0		0 0		107.00
	10800 LUNG ACQUISITION	0	0		0 0		108.00
	10900 PANCREAS ACQUI SI TI ON	0	0		0 0		109.00
	11000 I NTESTI NAL ACQUI SI TI ON	0	0		0 0		110.00
	11100 I SLET ACQUI SI TI ON 11300 I NTEREST EXPENSE	0	0		0 0		111.00
	11400 UTILIZATION REVIEW-SNF	0	0				113.00 114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0				115.00
	11600 HOSPI CE	0	0		0 0		116.00
118.00		56, 992, 774	78, 277, 632	135, 270, 40	1, 201, 211	136, 471, 617	
	NONREI MBURSABLE COST CENTERS						1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 00
	19001 WELLNESS CENTERS	760, 331	388, 734	1, 149, 06	-67, 085		
	19002 EMPLOYED ORTHO MD	0	0		0 0		190.02
	19003 NORTHVI EW CONV. (LTC)	290, 176	58, 823				
	19004 SUMMIT CONV. (LTC) 19005 PARKVIEW CONV. (LTC)	196, 475 288, 218	16, 316 21, 790			212, 791 310, 008	1
	19006 MONTI CELLO HSE. (ASS' TD LVG.)	107, 252	8, 402			115, 654	
	19007 NH PARK PLACE (LTC)	36, 803	2,643			39, 446	
	19008 MADISON PLACE OF ELWOOD (LTC)	0	0		0 0		190.08
190.09	19009 SPI NE SURGEON	0	0		0 0	0	190. 09
190.10	19010 CLINICAL RESEARCH CENTER	639, 562	269, 152	908, 71	4 -41, 684	867, 030	190. 10
	19011 ONCOLOGI ST	0	0		0 0		190. 11
	19012 MEDI CAL I NTERNI ST	83, 696	60, 312				
	19013 RHEUMATOLOGY	437,006	446, 819				
	19014 ROCK STEADY BOXING 19100 RESEARCH	25, 581	36, 899				
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0 2, 553, 005				191.00
	19201 MUNCIE MD OFFICES	0	2, 553, 005				192.00
	19202 FOUNDATION	165, 075	706, 349			871, 424	
	19203 SPOE	0	, 00, 049 N	0,1,42	0 0		192.02
	19204 HEALTHY HEART	178, 981	34, 595	213, 57			
	19205 VACANT SPACE	0	0		0 0		192.05
192.07	19207 PARK PLACE CENTER	0	637	63	7 0		192.07
	19208 RENTAL PROPERTY - 1924 MADISON	0	106, 837				192. 08
200.00	TOTAL (SUM OF LINES 118-199)	60, 201, 930	83, 125, 097	143, 327, 02	.7 0	143, 327, 027	200. 00

CLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN: 15-0113	Period: From 01/01/2016	Worksheet A
			To 12/31/2016	Date/Time Prepa 4/14/2017 8:18
Cost Center Description		Net Expenses For Allocation		
GENERAL SERVICE COST CENTERS	6.00	7.00		
00 00100 CAP REL COSTS-BLDG & FIXT	-134, 326	4, 695, 363		
00 00200 CAP REL COSTS-MVBLE EQUIP	0	3, 766, 392		
00 00300 OTHER CAP REL COSTS	0			
00 00400 EMPLOYEE BENEFITS DEPARTMENT	6, 684, 269			
00 00500 ADMINISTRATIVE & GENERAL 00 00600 MAINTENANCE & REPAIRS	-6, 850, 304	20, 120, 297		
00 00700 OPERATION OF PLANT	-68, 001	-		
00 00800 LAUNDRY & LINEN SERVICE	0			
00 00900 HOUSEKEEPI NG	0			
00 01000 DI ETARY	0	.,		1
00 01100 CAFETERIA 00 01300 NURSING ADMINISTRATION	-813, 885	816, 769 1, 216, 311		1
00 01400 CENTRAL SERVICES & SUPPLY	-1, 451			1
00 01500 PHARMACY	0	1, 788, 289		1
00 01600 MEDICAL RECORDS & LIBRARY	-1, 312	1, 705, 879		1
00 01700 SOCIAL SERVICE	0	-		1
00 01900 NONPHYSI CLAN ANESTHETI STS	0			1
00 02000 NURSI NG SCHOOL 00 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD		0		
00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0			
00 02300 PARAMED ED PRGM-(EMS)	0	0		2
INPATIENT ROUTINE SERVICE COST CENTERS	1	1		
00 03000 ADULTS & PEDIATRICS	-5, 893			
00 03100 I NTENSI VE CARE UNI T 00 03200 CORONARY CARE UNI T	0			
00 03300 BURN INTENSIVE CARE UNIT	0	0		
00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		3
00 04000 SUBPROVIDER - IPF	0	O		4
00 04100 SUBPROVIDER - IRF	0	0		4
00 04200 SUBPROVI DER 00 04300 NURSERY	0			2
00 04300 NURSERY 00 04400 SKILLED NURSING FACILITY		1, 237, 352 0		
00 04500 NURSING FACILITY	0			4
00 04600 OTHER LONG TERM CARE	0	0		4
ANCI LLARY SERVI CE COST CENTERS	-			
00 05000 OPERATING ROOM 00 05100 RECOVERY ROOM	0			Ę
00 05200 DELIVERY ROOM & LABOR ROOM				5
00 05300 ANESTHESI OLOGY	-2, 846, 661			E
00 05400 RADI OLOGY-DI AGNOSTI C	-118, 223	3, 153, 041		5
00 05500 RADI OLOGY-THERAPEUTI C	0	1 1		5
00 05600 RADI 0I SOTOPE 00 05700 CT SCAN	0	628, 516 588, 938		Ę
00 05800 MAGNETIC RESONANCE IMAGING (MRI)	-49			E
00 05900 CARDI AC CATHETERI ZATI ON	0	1,070,999		5
00 06000 LABORATORY	0	3, 830, 116		6
01 06001 BLOOD LABORATORY	0	0		6
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0 219, 796		
00 06300 BLOOD STORING, PROCESSING & TRANS.		0		
00 06400 I NTRAVENOUS THERAPY	0	0		
00 06500 RESPI RATORY THERAPY	0	944, 893		6
00 06600 PHYSI CAL THERAPY	-16, 270			6
00 06700 OCCUPATIONAL THERAPY	0			6
00 06800 SPEECH PATHOLOGY 00 06900 ELECTROCARDI OLOGY	44, 160			
00 07000 ELECTROENCEPHALOGRAPHY	44, 100			
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			
00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			7
00 07300 DRUGS CHARGED TO PATIENTS	345, 896			
00 07400 RENAL DIALYSIS 00 07500 ASC (NON-DISTINCT PART)	0	2011001		
OUTPATIENT SERVICE COST CENTERS	0			
00 08800 RURAL HEALTH CLINIC	0	0		8
00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		8
00 09000 CLINIC	0	0		9
01 09001 WOUND/OSTOMY CLINIC	-512, 454			9
02 09002 KIDS PLUS CLINIC 03 09003 0NC0L0GY	0 -2, 492, 122	0 -8, 549, 834		¢.
04 09004 MUNCIE CLINIC	-2, 492, 122 -21, 150			
05 09005 ANTI COAGULATI ON CLINIC	0			ç
06 09006 PREGNANCY PLUS	0			ç
07 09007 0/P LAB	0	0		C

Heal th Financial Systems	COMMUNI TY HOSPI			orm CMS-2552-1
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CCN: 15	-0113 Period: Works From 01/01/2016	sheet A
				Time Prepared:
		N	4/14/	<u>2017 8:18 am</u>
Cost Center Description	Adjustments	Net Expenses		
	(See A-8) 6.00	For Allocation 7.00		
90. 08 09008 0/P LAB	0.00	7.00		90.08
90. 09 09009 FORTVILLE CLINIC	0	789		90.0
91. 00 09100 EMERGENCY	-21, 352	3, 354, 765		90.0
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	-21, 332	3, 334, 705		92.00
OTHER REIMBURSABLE COST CENTERS				92.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		94.00
95. 00 09500 AMBULANCE SERVICES	0	0		95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		96.0
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.0
99. 00 09900 CMHC	0	0		99.0
99. 10 09910 CORF	0	Ő		99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		100.00
101. 00 10100 HOME HEALTH AGENCY	0	o		101.00
SPECIAL PURPOSE COST CENTERS				10110
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		105.00
106. 00 10600 HEART ACQUI SI TI ON	0	o		106.00
107.00 10700 LIVER ACQUISITION	0	0		107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0		108.0
109.00 10900 PANCREAS ACQUISITION	0	0		109. 0
110.00 11000 INTESTINAL ACQUISITION	0	О		110. 0
111.00 11100 I SLET ACQUI SI TI ON	0	O		111.00
113.00 11300 INTEREST EXPENSE	0	0		113.00
114.00 11400 UTILIZATION REVIEW-SNF	0	O		114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		115.00
116.00 11600 HOSPI CE	0	o		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-6, 829, 128	129, 642, 489		118.00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
190.01 19001 WELLNESS CENTERS	0	1, 081, 980		190. 0
190.02 19002 EMPLOYED ORTHO MD	0	0		190. 0
190. 03 19003 NORTHVI EW CONV. (LTC)	0	328, 837		190. 03
190.04 19004 SUMMIT CONV. (LTC)	0	212, 791		190. 0
190. 05 19005 PARKVI EW CONV. (LTC)	0	310, 008		190. 0
190. 06 19006 MONTI CELLO HSE. (ASS' TD LVG.)	0	115, 654		190. 0
190.07 19007 NH PARK PLACE (LTC)	0	39, 446		190. 0
90.08 19008 MADI SON PLACE OF ELWOOD (LTC)	0	0		190. 0
90. 09 19009 SPI NE SURGEON	0	0		190. 0
90. 10 19010 CLINICAL RESEARCH CENTER	0	867, 030		190. 1
90. 11 19011 ONCOLOGI ST	0	0		190. 1
190. 12 19012 MEDI CAL I NTERNI ST	0	141, 582		190. 1
190. 13 19013 RHEUMATOLOGY	0	856, 356		190. 1
190. 14 19014 ROCK STEADY BOXING	0	53, 417		190. 1
191.00 19100 RESEARCH	0			191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	1,669,516		192.0
192. 01 19201 MUNCIE MD OFFICES	0	4, 402		192.0
192. 02 19202 FOUNDATI ON	0	871, 424		192.0
192. 03 19203 SPOE	0			192.0
192. 04 19204 HEALTHY HEART	0	207, 141		192.0
192. 05 19205 VACANT SPACE	0			192. 0
192. 07 19207 PARK PLACE CENTER	0	637		192.0
192.08 19208 RENTAL PROPERTY - 1924 MADISON 200.00 TOTAL (SUM OF LINES 118-199)	0 -6, 829, 128	95, 189 136, 497, 899		192. 08 200. 00
	- U. 829. [28]	130.47/.077		

Health Financial Systems		COMMUNITY HOSPITAL ANDERSON		In Lieu of Form CMS-2552-10		
COST (CENTERS USED IN COST REPORT	Provider C	CN: 15-0113	Period: Worksheet Not From 01/01/2016	n-CMS W	
				To 12/31/2016 Date/Time Pro		
	Cost Center Description		CMS Code	4/14/2017 8: Standard Label For	<u>18 am</u>	
	obst center bescription		Cinis code	Non-Standard Codes		
			1.00	2.00	_	
	GENERAL SERVICE COST CENTERS		1.00	2.00		
1.00	CAP REL COSTS-BLDG & FIXT		00100		1.00	
2.00	CAP REL COSTS-MVBLE EQUIP		00200		2.00	
3.00 4.00	OTHER CAP REL COSTS EMPLOYEE BENEFITS DEPARTMENT		00300 00400		3.00 4.00	
5.00	ADMI NI STRATI VE & GENERAL		00500		5.00	
6.00	MAINTENANCE & REPAIRS		00600		6.00	
7.00	OPERATION OF PLANT		00700		7.00	
8.00 9.00	LAUNDRY & LINEN SERVICE HOUSEKEEPING		00800		8.00 9.00	
10.00	DI ETARY		01000		10.00	
11.00	CAFETERI A		01100		11.00	
	NURSI NG ADMI NI STRATI ON		01300		13.00	
	CENTRAL SERVICES & SUPPLY PHARMACY		01400 01500		14.00 15.00	
	MEDICAL RECORDS & LIBRARY		01600		16.00	
17.00	SOCI AL SERVI CE		01700		17.00	
	NONPHYSI CI AN ANESTHETI STS		01900		19.00	
	NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRVD		02000 02100		20.00	
21.00	I &R SERVICES-OTHER PRGM. COSTS APPRVD		02200		22.00	
23.00	PARAMED ED PRGM-(EMS)		02300		23.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				-	
30.00 31.00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT		03000 03100		30.00 31.00	
	CORONARY CARE UNIT		03200		32.00	
	BURN INTENSIVE CARE UNIT		03300		33.00	
	SURGICAL INTENSIVE CARE UNIT		03400		34.00	
40.00 41.00	SUBPROVIDER - IPF SUBPROVIDER - IRF		04000 04100		40.00	
	SUBPROVI DER		04100		41.00	
	NURSERY		04300		43.00	
	SKILLED NURSING FACILITY		04400		44.00	
45.00 46.00	NURSING FACILITY OTHER LONG TERM CARE		04500 04600		45.00 46.00	
40.00	ANCI LLARY SERVICE COST CENTERS		04000		40.00	
	OPERATING ROOM		05000		50.00	
	RECOVERY ROOM		05100		51.00	
	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY		05200 05300		52.00 53.00	
54.00	RADI OLOGY-DI AGNOSTI C		05400		54.00	
55.00	RADI OLOGY-THERAPEUTI C		05500		55.00	
	RADI OI SOTOPE		05600		56.00	
57.00 58.00	CT SCAN MAGNETIC RESONANCE IMAGING (MRI)		05700 05800		57.00 58.00	
	CARDI AC CATHETERI ZATI ON		05900		59.00	
	LABORATORY		06000		60.00	
	BLOOD LABORATORY		06001		60.01	
	PBP CLINICAL LAB SERVICES-PRGM ONLY WHOLE BLOOD & PACKED RED BLOOD CELLS		06100 06200		61.00 62.00	
	BLOOD STORING, PROCESSING & TRANS.		06300		63.00	
64.00	INTRAVENOUS THERAPY		06400		64.00	
65.00			06500		65.00	
	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY		06600 06700		66.00 67.00	
	SPEECH PATHOLOGY		06800		68.00	
69.00	ELECTROCARDI OLOGY		06900		69.00	
			07000		70.00	
71.00 72.00	MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS		07100 07200		71.00	
	DRUGS CHARGED TO PATIENTS		07200		73.00	
74.00	RENAL DI ALYSI S		07400		74.00	
75.00	ASC (NON-DI STI NCT PART)		07500		75.00	
88.00	OUTPATIENT SERVICE COST CENTERS		08800		88.00	
	FEDERALLY QUALIFIED HEALTH CENTER		08800		88.00	
	CLINIC		09000		90.00	
	WOUND/OSTOMY CLINIC		09001		90.01	
	KIDS PLUS CLINIC ONCOLOGY		09002 09003		90. 02 90. 03	
	MUNCIE CLINIC		09003		90.03	
	ANTI COAGULATI ON CLI NI C		09005		90.05	

Heal th	Fi nanc	ial S	yst	ems	
COCT			LAL	COCT	DE

leal th	Financial Systems	COMMUNI TY HOSPI TA	L ANDERSON			In Lie	u of Form (<u>_MS-255</u> 2	
COST CE	ENTERS USED IN COST REPORT		Provider CCN:			eriod:	Worksheet	orksheet Non-CMS	
					Fr	rom 01/01/2016 0 12/31/2016	Dato /Time	Dropora	
) 12/31/2010	4/14/2017		
	Cost Center Description			CMS Code		Standard			
	· · · · · · · · · · · · · · · · · · ·					Non-Standa			
				1.00		2. (00		
90.06	PREGNANCY PLUS			09006				90.	
	O/P LAB			09007				90.	
	O/P LAB			09008				90.	
1	FORTVILLE CLINIC			09009				90.	
	EMERGENCY			09100				91.	
E E	OBSERVATION BEDS (NON-DISTINCT PART)			09200				92.	
H	OTHER REIMBURSABLE COST CENTERS								
	HOME PROGRAM DIALYSIS			09400				94.	
	AMBULANCE SERVICES			09500				95.	
	DURABLE MEDICAL EQUIP-RENTED			09600				96.	
	DURABLE MEDICAL EQUIP-SOLD			09700				97.	
	CMHC			09900				99.	
	CORF			09910				99.	
	I&R SERVICES-NOT APPRVD PRGM			10000				100.	
- F	HOME HEALTH AGENCY			10100				101.	
- F	SPECIAL PURPOSE COST CENTERS								
	KIDNEY ACQUISITION			10500				105.	
	HEART ACQUI SI TI ON			10600				106.	
	LIVER ACQUISITION			10700				107.	
	LUNG ACQUISITION			10800				108.	
09.00	PANCREAS ACQUISITION			10900				109.	
10.00	INTESTINAL ACQUISITION			11000				110.	
	I SLET ACQUI SI TI ON			11100				1111.	
	INTEREST EXPENSE			11300				113.	
14.00	UTILIZATION REVIEW-SNF			11400				∥114.	
	AMBULATORY SURGICAL CENTER (D. P.)			11500				115.	
	HOSPI CE			11600				116.	
	SUBTOTALS (SUM OF LINES 1-117)							118.	
H	NONREI MBURSABLE COST CENTERS								
1	GIFT, FLOWER, COFFEE SHOP & CANTEEN			19000				190.	
1	WELLNESS CENTERS			19001				190.	
	EMPLOYED ORTHO MD			19002				190.	
	NORTHVI EW CONV. (LTC)			19003				190.	
	SUMMIT CONV. (LTC)			19004				190.	
	PARKVIEW CONV. (LTC)			19005				190.	
	MONTICELLO HSE. (ASS' TD LVG.)			19006				190.	
	NH PARK PLACE (LTC)			19007				190.	
	MADISON PLACE OF ELWOOD (LTC)			19008				190.	
	SPINE SURGEON			19009				190.	
	CLINICAL RESEARCH CENTER			19010				190.	
	ONCOLOGI ST			19011				190.	
	MEDI CAL I NTERNI ST			19012				190.	
	RHEUMATOLOGY			19013				190.	
	ROCK STEADY BOXING			19014				190.	
	RESEARCH			19100				191.	
	PHYSICIANS' PRIVATE OFFICES			19200				192.	
	MUNCIE MD OFFICES			19201				192.	
	FOUNDATION			19202				192.	
92.03				19203				192.	
92.04	HEALTHY HEART			19204				192.	
92.05	VACANT SPACE			19205				192.	
92.07	PARK PLACE CENTER			19207				192.	
92 08	RENTAL PROPERTY - 1924 MADISON			19208				192.	
12.001	TOTAL (SUM OF LINES 118-199)							200.	

RECLAS	SIFICATIONS			TAL ANDERSON Provider (CCN: 15-0113	Peri od:	u of Form CMS- Worksheet A-6	
						From 01/01/2016 To 12/31/2016	Date/Time Pre 4/14/2017 8:2	
	Cost Center	Increases Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 20.00 21.00 22.00 24.00 25.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 30.00 31.00 32.00 33.00 34.00 5.00 2.00 3.00 4.00 5.00 2.00 3.00 1.00 1.00 1.00 1.00 1.00 <tr< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 14. 00 15. 00 14. 00 15. 00 14. 00 20. 00 21. 00 22. 00 24. 00 22. 00 24. 00 25. 00 26. 00 27. 00 28. 00 27. 00 28. 00 29. 00 31. 00 33. 00 34. 00 35. 00 33. 00 34. 00 35. 00 30. 00 31. 00 20. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 30. 00 31. 00 10. 00 11. 00 20. 00 21. 00 22. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 35. 00 30. 00 31. 00 20. 00 21. 00 22. 00 23. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 20. 00 20.</td></tr<>								1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 14. 00 15. 00 14. 00 15. 00 14. 00 20. 00 21. 00 22. 00 24. 00 22. 00 24. 00 25. 00 26. 00 27. 00 28. 00 27. 00 28. 00 29. 00 31. 00 33. 00 34. 00 35. 00 33. 00 34. 00 35. 00 30. 00 31. 00 20. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 30. 00 31. 00 10. 00 11. 00 20. 00 21. 00 22. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 35. 00 30. 00 31. 00 20. 00 21. 00 22. 00 23. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 20.

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	S

COMMUNITY HOSPITAL ANDERSON Provider CCN: 15-0113

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2016

					From 01/01/2016 To 12/31/2016 Date/Time Pro	
		Increases			4/14/2017 8: 1	18 am
	Cost Center	Li ne #	Salary	Other		
	2.00	3,00	4.00	5.00	•	
32.00	2.00	0,00	0	0.00		32.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
37.00		0.00	0	0		37.00
	0		0	28, 488, 059		
	C - RENT	Г				-
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	396, 590		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	445, 678		2.00
4.00		0.00	0	0		4.00
5.00 6.00		0. 00 0. 00	0	0		5.00 6.00
8.00 7.00		0.00	0 0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00		0		14.00
	0 — — — — — —		0	842, 268		
	D - LABOR & DELIVERY	,			F	
1.00	NURSERY	43.00	<u> </u>	27 <u>7,7</u> 18		1.00
			959, 634	277, 718		
1 00	E - CAFETERIA RECLASS	11 00	000.044	001 004		1 00
1.00	<u>CAFETERI</u> A	<u>11.00</u>	80 <u>8, 0</u> 46 808, 046	<u>901, 226</u> 901, 226		1.00
	F - SPECIAL MEALS		808, 040	901, 220		
1.00	DI ETARY	10.00	37, 166	41, 452		1.00
1.00			37, 166	41, 452		1.00
	G - INTEREST & INSURANCE	II		,		1
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	281, 607		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	136, 458		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7 <u>3,5</u> 42		3.00
	0		0	491, 607		
	H - LAUNDRY				I	
1.00	LAUNDRY & LINEN SERVICE	8.00	64, 354	123, 467		1.00
			64, 354	123, 467		
1.00	I – POB UTILITIES ADMINISTRATIVE & GENERAL	5.00	0	6, 016		1.00
2.00	LABORATORY	60.00	0	4, 173		2.00
3.00	PHYSICAL THERAPY	66.00	0	10, 473		3.00
4.00	OCCUPATIONAL THERAPY	67.00	0	7, 226		4.00
5.00	SPEECH PATHOLOGY	68.00	0	8, 691		5.00
6.00	ELECTROCARDI OLOGY	69.00	0	14, 293		6.00
7.00	ONCOLOGY	90.03	0	49, 404		7.00
	0			100, 276		
500.00	Grand Total: Increases		1, 869, 200	38, 528, 279		500.00

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	S

COMMUNITY HOSPITAL ANDERSON

Heal th	Financial Systems		COMMUNI TY HOSP	ITAL ANDERSON		In Lieu of Form CM	S-2552-10
RECLAS	SIFICATIONS			Provi der	CCN: 15-0113	Period: Worksheet A	-6
						From 01/01/2016 To 12/31/2016 Date/Time P	repared:
		Deserves				4/14/2017 8	:18 am
	Cost Center	Decreases Li ne #	Sal ary	Other	 Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00	<u>-</u>	
	A – DEPRECIATION						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	49, 13		9	1.00
2.00 3.00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5.00 7.00	0	1, 372, 815 1, 078, 291		9	2.00 3.00
4.00	HOUSEKEEPI NG	9.00	0	12, 149			4.00
5.00	DI ETARY	10.00	0	133, 612			5.00
6.00	NURSING ADMINISTRATION	13.00	0	203	3 (6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	35, 691			7.00
8.00	PHARMACY	15.00	0	4, 630	-		8.00
9. 00 10. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	0	237, 638 144, 802			9.00 10.00
11.00	NURSERY	43.00	0	2, 868			11.00
12.00	OPERATING ROOM	50.00	0	1,003,415			12.00
13.00	ANESTHESI OLOGY	53.00	0	13, 683			13.00
14.00	RADI OLOGY-DI AGNOSTI C	54.00	0	476, 059			14.00
15.00	RADI OI SOTOPE	56.00	0	12, 300	-		15.00
16.00	CT SCAN	57.00	0	277, 219			16.00
17.00	MAGNETIC RESONANCE IMAGING	58.00	0	121, 391	1		17.00
18.00	CARDI AC CATHETERI ZATI ON	59.00	0	35, 887	7 (18.00
19.00	LABORATORY	60.00	0	297, 21	7 (19.00
20.00	WHOLE BLOOD & PACKED RED	62.00	0	1, 650	0		20.00
01 00	BLOOD CELLS	(5.00		27 (1)			21.00
21. 00 22. 00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65.00 66.00	0	27, 614 4, 987			21.00 22.00
22.00	SPEECH PATHOLOGY	68.00	0	4, 96, 663			22.00
25.00	ELECTROCARDI OLOGY	69.00	0	39, 287	-		25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	0	32, 325			26.00
27.00	WOUND/OSTOMY CLINIC	90.01	0	20, 633			27.00
28.00	ONCOLOGY	90.03	0	819, 332			28.00
29. 00 30. 00		90. 04 90. 05	0	34, 648			29.00 30.00
30.00	ANTICOAGULATION CLINIC PREGNANCY PLUS	90.03	0	7, 558 788	-		30.00
32.00	FORTVILLE CLINIC	90.09	0	6, 105			32.00
33.00	EMERGENCY	91.00	0	119, 872	-		33.00
34.00	WELLNESS CENTERS	190.01	0	30, 699	9 (34.00
35.00	NORTHVIEW CONV. (LTC)	190.03	0	20, 162			35.00
36.00	CLINICAL RESEARCH CENTER	190.10	0	2,00			36.00
38. 00 39. 00	RHEUMATOLOGY PHYSICIANS' PRIVATE OFFICES	190. 13 192. 00	0	3, 073 780, 823			38.00 39.00
40.00	HEALTHY HEART	192.00	0	985			40.00
101 00	0		<u>0</u>	7, 262, 200		5	10100
	B - DRUGS & SUPPLIES	I			1		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	49, 43			1.00
2.00 3.00	ADMINISTRATIVE & GENERAL	5.00 7.00	0 0	110, 032 37, 703			2.00 3.00
4.00	HOUSEKEEPI NG	9.00	0	6, 71			4.00
5.00	DI ETARY	10.00	0	2, 80			5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	87, 990	D (6.00
7.00	PHARMACY	15.00	0	5, 711, 821			7.00
8.00	MEDI CAL RECORDS & LI BRARY	16.00	0	45			8.00
9. 00 10. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	0	1, 360, 333 365, 583	-		9.00 10.00
11.00	OPERATING ROOM	50.00	0	15, 674, 016			11.00
12.00	ANESTHESI OLOGY	53.00	0	40, 183			12.00
13.00	RADI OLOGY-DI AGNOSTI C	54.00	0	196, 658			13.00
14.00	RADI OI SOTOPE	56.00	0	231, 983	-		14.00
15.00	CT SCAN	57.00	0	88, 579		0	15.00
16.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	16, 780		D	16.00
17.00	CARDIAC CATHETERIZATION	59.00	0	1, 144, 817	7		17.00
18.00	LABORATORY	60.00	0	1, 568, 543			18.00
19.00	WHOLE BLOOD & PACKED RED	62.00	0	420, 594			19.00
00.00	BLOOD CELLS		_	150			00.00
20.00	RESPIRATORY THERAPY	65.00	0	150, 749			20.00
21. 00 22. 00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	66.00 67.00	0	12, 578 2, 547			21.00 22.00
22.00	SPEECH PATHOLOGY	68.00	0	1, 33			22.00
24.00	ELECTROCARDI OLOGY	69.00	0	12, 894			24.00
25.00	ELECTROENCEPHALOGRAPHY	70.00	0	24, 47	7 (25.00
26.00	RENAL DIALYSIS	74.00	0	3, 47			26.00
27.00	WOUND/OSTOMY CLINIC	90.01	0	288, 570			27.00
28. 00 29. 00	ONCOLOGY MUNCIE CLINIC	90. 03 90. 04	0 0	351, 078 17			28.00 29.00
27.00		1 70.04	0		1	~I	27.00

	Financial Systems SIFICATIONS		COMMUNITY HOSPI		20N. 1E 0112	In Lie Period:	u of Form CMS-2552-1 Worksheet A-6
RECLAS	STFICATIONS			Provider (CCN: 15-0113	From 01/01/2016	WORKSheet A-6
						To 12/31/2016	Date/Time Prepared: 4/14/2017 8:18 am
		Decreases					4/14/2017 0. 10 dill
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	-	
	6.00	7.00	8.00	9.00	10.00		
30.00	ANTI COAGULATION CLINIC	90.05	0	26, 268		0	30. 0
31.00	EMERGENCY	91.00	0	451, 399		0	31.0
32.00	WELLNESS CENTERS	190.01	0	36, 386		0	32.0
34.00	CLINICAL RESEARCH CENTER	190. 10	0	1, 415		0	34.0
35.00	MEDICAL INTERNIST	190.12	0	2, 426		0	35.0
36.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2, 390		0	36.0
37.00	HEALTHY HEART	<u> </u>	0	<u>5, 450</u>		Ō	37.0
	0		0	28, 488, 059			
	C - RENT	0.00			1		
1.00	DUADUA OV	0.00	0	0		9	1.0
2.00	PHARMACY	15.00	0	308, 564		9	2.0
4.00		60.00	0	32, 452		0	4.0
5.00	RESPI RATORY THERAPY	65.00	0	10, 588		0	5.0
6.00	PHYSI CAL THERAPY	66.00	0	117, 256		0	6.0
7.00	ELECTROCARDI OLOGY	69.00	0	117, 806		0	7.0
8.00	ELECTROENCEPHALOGRAPHY	70.00	0	5, 560		0	8.0
9.00	FORTVILLE CLINIC	90.09	0	34, 917		0	9.0
10.00	CLINICAL RESEARCH CENTER	190.10	0	38, 268		0	10.0
11.00	RHEUMATOLOGY	190.13	0	24, 396		0	11.0
12.00	ROCK STEADY BOXING	190.14	0	9, 063		0	12.0
13.00	MUNCIE MD OFFICES	192.01	0	131, 750		0	13.0
14.00	RENTAL PROPERTY - 1924	192.08	0	11, 648		0	14.0
	MADI SON				<u> </u>	-	
			U	842, 268			
1 00	D - LABOR & DELIVERY ADULTS & PEDIATRICS	20.00	959, 634	277, 718		0	1.0
1.00	ADULIS & PEDIATRICS	<u>30.</u> 00				Ō	1.0
	0 E - CAFETERIA RECLASS		959, 634	277, 718			
1.00	DI ETARY	10.00	808, 046	901, 226		0	1.0
1.00			808, 046	901, 226		Ō	1.0
	F - SPECIAL MEALS	I	000, 040	901, 220	2		
1.00	CAFETERI A	11.00	37, 166	41, 452		0	1.0
1.00			37, 166	41, 452		9	1.0
	G - INTEREST & INSURANCE		37,100	41, 432			
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	281, 607	1	11	1.0
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	210,000		12	2.0
3.00		5.00	0	210,000		12	3. 0
3.00			— — — d	491, 607		12	3.0
	H - LAUNDRY		U	491,007			
1.00	HOUSEKEEPI NG	9.00	64, 354	123, 467		0	1.0
1.00			64, 354	123, 467		<u>q</u>	1.0
	I - POB UTILITIES		04, 334	123, 407			
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	100, 276		0	1.0
2.00		0.00	0	100, 270		0	2.0
3.00		0.00	0	C		0	3.0
4.00		0.00	0	C		0	4.0
4.00 5.00		0.00	0	C		0	5.0
6.00		0.00	0	0		0	6.0
7.00		0.00					7.0
1.00	<u> </u>			100, 276	<u> </u>	4	7.0
500 00	Grand Total: Decreases		1, 869, 200	38, 528, 279		-	500. 0
500.00	pi and iotai. Deciedaea	I I	1,007,200	50, 520, 279	1	I	1 500. 0

COMMUNITY HOSPITAL ANDERSON

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2016 Non-CMS Worksheet To 12/31/2016 Date/Time Prepared: 4/14/2017 8:18 am Provider CCN: 15-0113

		-						4/14/2017 8:1	8 am
			eases	0.11		Decre		0.11	
	Cost Center	Line #		Other	Cost Center	Line #	Salary	Other	
		3.00	4.00	5.00	6.00	7.00	8.00	9.00	
4 00	A - DEPRECIATION	1 00		4 045 004		1 00		10,101	1 00
1.00	CAP REL COSTS-BLDG &	1.00	0	4, 015, 034	EMPLOYEE BENEFITS	4.00	0	49, 131	1.00
2 00	FLXT	2 00	0	2 247 172		F 00	0	1 272 015	2.00
2.00	CAP REL COSTS-MVBLE	2.00	0	3, 247, 172	ADMINISTRATIVE &	5.00	0	1, 372, 815	2.00
2 00		0.00		0	GENERAL	7 00	0	1 070 001	2.00
3.00		0.00			OPERATION OF PLANT	7.00	0	1, 078, 291	3.00
4.00		0.00			HOUSEKEEPING	9.00	-	12, 149	4.00
5.00		0.00			DI ETARY	10.00	0	133, 612	5.00
6.00		0.00	0	0	NURSI NG	13.00	0	203	6.00
7 00		0 00	0	0	ADMINISTRATION	14 00	0	25 401	7 00
7.00		0.00	0	0	CENTRAL SERVICES &	14.00	0	35, 691	7.00
8.00		0.00	0	0	SUPPLY PHARMACY	15.00	0	4 (20	8.00
		0.00				30.00	0	4,630	
9.00					ADULTS & PEDIATRICS			237,638	9.00
10.00		0.00			INTENSIVE CARE UNIT	31.00	0	144, 802	10.00
11.00		0.00			NURSERY	43.00	0	2,868	11.00
12.00		0.00			OPERATING ROOM	50.00	0	1, 003, 415	12.00
13.00		0.00			ANESTHESI OLOGY	53.00	0	13, 683	13.00
14.00		0.00			RADI OLOGY-DI AGNOSTI C	54.00	0	476, 059	
15.00		0.00			RADI OI SOTOPE	56.00	0	12, 300	15.00
16.00		0.00			CT SCAN	57.00	0	277, 219	16.00
17.00		0.00	0	0	MAGNETIC RESONANCE	58.00	0	121, 391	17.00
10.00		0.00		0	IMAGING (MRI)	50.00	0	25 007	10.00
18.00		0.00	0	0	CARDI AC CATHETERI ZATI ON	59.00	0	35, 887	18.00
10.00		0 00	0	0		60,00	0	207 217	10.00
19.00 20.00		0.00			LABORATORY		0	297, 217	19.00
20.00		0.00	U	0	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	1, 650	20.00
21 00		0.00	0	0	RESPIRATORY THERAPY	65,00	0	27 414	21 00
21.00 22.00								27,614	21.00
		0.00 0.00			PHYSICAL THERAPY	66.00	0	4, 987	22.00
24.00					SPEECH PATHOLOGY	68.00	•	663	24.00
25.00		0.00			ELECTROCARDI OLOGY	69.00	0	39, 287	25.00
26.00		0.00	0	0	ELECTROENCEPHALOGRAPH	70.00	0	32, 325	26.00
27 00		0 00	0	0		00 01	0	20 (22	27.00
27.00		0.00			WOUND/OSTOMY CLINIC ONCOLOGY	90.01 90.03	0	20, 633	27.00 28.00
28.00							-	819, 332	
29.00		0.00			MUNCIE CLINIC	90.04	0	34, 648	29.00
30.00		0.00	U	0	ANTI COAGULATI ON CLI NI C	90.05	0	7, 558	30.00
31.00		0.00	о	0	PREGNANCY PLUS	90.06	0	788	31.00
32.00		0.00			FORTVILLE CLINIC	90.00	0	6, 105	32.00
33.00		0.00			EMERGENCY	90.09	0	119, 872	32.00
34.00		0.00			WELLNESS CENTERS	190.01	0	30, 699	34.00
35.00		0.00			NORTHVI EW CONV. (LTC)	190.03	0	20, 162	35.00
36.00		0.00			CLINICAL RESEARCH	190.03	0	20, 102	36.00
30.00		0.00	0	0	CENTER	190.10	0	2,001	30.00
38.00		0.00	О	0	RHEUMATOLOGY	190.13	0	3, 073	38.00
39.00		0.00			PHYSI CLANS' PRI VATE	192.00	0	780, 823	39.00
57.00		0.00	Ŭ		OFFICES	172.00	0	700,023	37.00
40.00		0.00	o		HEALTHY HEART	192.04	0	985	40.00
101.00	0			7, 262, 206			<u> </u>		101 00
	B - DRUGS & SUPPLIES			112021200	10	II	Ŭ	172027200	
1.00	MEDICAL SUPPLIES	71.00	0	11, 331, 606	EMPLOYEE BENEFITS	4.00	0	49, 431	1.00
	CHARGED TO PATIENTS		-		DEPARTMENT			,	
2.00	IMPL. DEV. CHARGED TO	72.00	0	11, 334, 059	ADMINISTRATIVE &	5.00	0	110, 032	2.00
	PATI ENTS				GENERAL				
3.00	DRUGS CHARGED TO	73.00	0	5, 822, 394	OPERATION OF PLANT	7.00	0	37, 707	3.00
	PATI ENTS								
4.00		0.00	0	0	HOUSEKEEPING	9.00	0	6, 711	4.00
5.00		0.00	0	0	DI ETARY	10.00	0	2, 807	5.00
6.00		0.00	0	0	CENTRAL SERVICES &	14.00	0	87, 990	6.00
					SUPPLY				
7.00		0.00	0	0	PHARMACY	15.00	0	5, 711, 821	7.00
8.00		0.00	0	0	MEDICAL RECORDS &	16.00	0	45	8.00
					LI BRARY				
9.00		0.00			ADULTS & PEDIATRICS	30.00	0	1, 360, 333	9.00
10.00		0.00			INTENSIVE CARE UNIT	31.00	0	365, 583	10.00
11.00		0.00	0	0	OPERATING ROOM	50.00	0	15, 674, 016	11.00
12.00		0.00	0		ANESTHESI OLOGY	53.00	0	40, 183	12.00
13.00		0.00	0	0	RADI OLOGY-DI AGNOSTI C	54.00	0	196, 658	13.00
14.00		0.00	0	0	RADI OI SOTOPE	56.00	0	231, 983	14.00
15.00		0.00	0	0	CT SCAN	57.00	0	88, 579	15.00
16.00		0.00	0		MAGNETIC RESONANCE	58.00	0	16, 780	16.00
					IMAGING (MRI)				

In Lieu of Form CMS-2552-10

Provider CCN: 15-0113 Period: Worksheet A-6 From 01/01/2016 Non-CMS Worksheet To 12/31/2016 Date/Time Prepared:

						T		Date/Time Pre 4/14/2017 8:1	
				Decreases					
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
17.00	2.00	3.00	4.00	5.00	6. 00 CARDI AC	7.00	8.00	9.00 1,144,817	17.00
17.00		0.00	Ű	Ũ	CATHETERI ZATI ON	07.00	Ű	1, 111, 017	17.00
18.00		0.00	0	0	LABORATORY	60.00	0	1, 568, 543	18.00
19.00		0.00	0		WHOLE BLOOD & PACKED	62.00	0	420, 594	19.00
					RED BLOOD CELLS	1.5 00		150 710	~~ ~~
20.00		0.00	0		RESPI RATORY THERAPY	65.00	0	150, 749	20.00
21.00 22.00		0.00	0		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	66.00 67.00	0	12, 578 2, 547	21. 00 22. 00
22.00		0.00	0		SPEECH PATHOLOGY	68.00	0	1, 331	23.00
24.00		0.00	Ö		ELECTROCARDI OLOGY	69.00	0	12, 894	24.00
25.00		0.00	0		ELECTROENCEPHALOGRAPH	70.00	0	24, 477	25.00
					Y				
26.00		0.00	0		RENAL DIALYSIS	74.00	0	3, 471	26.00
27.00		0.00	0		WOUND/OSTOMY CLINIC	90.01	0	288, 570	27.00
28. 00 29. 00		0.00 0.00	0		ONCOLOGY MUNCIE CLINIC	90.03 90.04	0	351, 078 17	28. 00 29. 00
29.00 30.00		0.00	0		ANTI COAGULATI ON	90.04	0	26, 268	29.00 30.00
30.00		0.00	0		CLINIC	70.03	0	20, 200	30.00
31.00		0.00	0		EMERGENCY	91.00	0	451, 399	31.00
32.00		0.00	0	0	WELLNESS CENTERS	190.01	0	36, 386	32.00
34.00		0.00	0	0	CLINICAL RESEARCH	190.10	0	1, 415	34.00
					CENTER	100.10			
35.00		0.00	0		MEDICAL INTERNIST	190.12	0	2, 426	35.00
36.00		0.00	0	0	PHYSI CI ANS' PRI VATE OFFI CES	192.00	0	2, 390	36.00
37.00		0.00	0	0	HEALTHY HEART	192.04	0	5, 450	37.00
	0			28, 488, 059				28, 488, 059	
	C – RENT								
1.00	CAP REL COSTS-BLDG &	1.00	0	396, 590		0.00	0	0	1.00
	FIXT				SHA SHA OV	15 00		000 5/1	
2.00	CAP REL COSTS-MVBLE	2.00	0	445, 678	PHARMACY	15.00	0	308, 564	2.00
4.00		0, 00	0	0	LABORATORY	60,00	0	32, 452	4.00
5.00		0.00	0		RESPI RATORY THERAPY	65.00	0	10, 588	5.00
6.00		0.00	0		PHYSI CAL THERAPY	66.00	0	117, 256	6.00
7.00		0.00	0		ELECTROCARDI OLOGY	69.00	0	117, 806	7.00
8.00		0.00	0	0	ELECTROENCEPHALOGRAPH	70.00	0	5, 560	8.00
					Y				
9.00		0.00	0		FORTVILLE CLINIC	90.09	0	34, 917	9.00
10.00		0.00	0	0	CLINICAL RESEARCH CENTER	190.10	0	38, 268	10.00
11.00		0, 00	0	0	RHEUMATOLOGY	190.13	0	24, 396	11.00
12.00		0.00	Ő		ROCK STEADY BOXING	190.14	0	9,063	12.00
13.00		0.00	0		MUNCIE MD OFFICES	192.01	0	131, 750	
14.00		0.00	0	0	RENTAL PROPERTY -	192.08	0	11, 648	14.00
					1924 MADI SON				
	0		0	842, 268	0		0	842, 268	
1 00	D - LABOR & DELIVERY NURSERY	42.00	050 424	277 710		20.00	959, 634	277 710	1 00
1.00		<u>43</u> . <u>00</u>	<u> </u>	277,718	ADULTS & PEDI ATRI CS	30.00	<u> </u>	<u>277, 7</u> 18 277, 718	1.00
	E - CAFETERIA RECLASS	II.	757,054	277,710	0	1 1	757, 054	277,710	
1.00	CAFETERI A	11.00	808, 046	901, 226	DI ETARY	10.00	808, 046	901, 226	1.00
	0		808, 046	901, 226	0		808, 046	901, 226	
	F - SPECIAL MEALS								
1.00	DIETARY	10.00	37,166		CAFETERI A	11.00	37, 166	41, 452	1.00
	U G – INTEREST & INSURAN		37, 166	41, 452	0		37, 166	41, 452	
1.00	CAP REL COSTS-BLDG &	1.00	0	201 607	ADMI NI STRATI VE &	5.00	0	281, 607	1.00
1.00	FIXT	1.00	0		GENERAL	5.00	0	201,007	1.00
2.00	CAP REL COSTS-BLDG &	1.00	0		ADMINI STRATI VE &	5.00	o	210, 000	2.00
	FLXT		-		GENERAL		-		
3.00	CAP REL COSTS-MVBLE	2.00	0	73, 542					3.00
					<u> </u>	L			
			0	491, 607	0		0	491, 607	
1.00	H – LAUNDRY LAUNDRY & LINEN	8.00	64, 354	100 127	HOUSEKEEPI NG	9.00	64, 354	123, 467	1.00
1.00	SERVICE	0.00	04, 334	123, 407	TIOUSENEEFTING	7.00	04, 334	123, 407	1.00
		\vdash $+$	64, 354	123, 467	0	\vdash $+$	64, 354	123, 467	
	I - POB UTILITIES		, - 5 1				, - 5 1		
1.00	ADMI NI STRATI VE &	5.00	0	6, 016	PHYSI CI ANS' PRI VATE	192.00	0	100, 276	1.00
	GENERAL				OFFICES				
2.00	LABORATORY	60.00	0	4, 173		0.00	0	0	2.00
3.00	PHYSICAL THERAPY	66.00	0	10, 473		0.00	0	0	3.00
4.00	OCCUPATIONAL THERAPY	67.00	0	7, 226		0.00	0	0	4.00 5.00
5.00	SPEECH PATHOLOGY	68.00	U	8, 691		0.00	0	0	5.00

Health Financial Systems				COMMUNITY HOSPITAL ANDERSON			In Lieu of Form CMS-2552-10			
RECLASS	SI FI CATI ONS				Provider CCN: 15-0113		Period: Worksheet A- From 01/01/2016 Non-CMS Work To 12/31/2016 Date/Time Pr 4/14/2017 8: 4/14/2017 8:		sheet epared:	
	Increases				Decreases					
	Cost Center	Line #	Sal ary	0ther	Cost Center	Li ne	# Salary	0ther		
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00		
6.00	ELECTROCARDI OLOGY	69.00	0	14, 293		0.0	0 0	0	6.00	
7.00	ONCOLOGY	90.03	0	49, 404		0.0	0 0	0	7.00	
	0		0	100, 276	0		0	100, 276		
500.00	Grand Total:		1, 869, 200	38, 528, 279	Grand Total:		1, 869, 200	38, 528, 279	500.00	
	Increases				Decreases					

Heal th	Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 01/01/2016 To 12/31/2016		pared:
				Acqui si ti ons	8		
		Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES		_			
1.00	Land	6, 323, 988	0		0 0	0	1.00
2.00	Land Improvements	2, 071, 604	0		0 0	103, 759	2.00
3.00	Buildings and Fixtures	64, 023, 539	537, 228	4, 436, 98	4, 974, 216	1, 012, 668	3.00
4.00	Building Improvements	0	0		0 0	0	4.00
5.00	Fixed Equipment	19, 388, 413	1, 240, 615		0 1, 240, 615	855, 261	5.00
6.00	Movable Equipment	47, 714, 109	2, 730, 122	4, 092, 29	6, 822, 415	2, 769, 424	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	139, 521, 653	4, 507, 965	8, 529, 28	31 13, 037, 246	4, 741, 112	
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	139, 521, 653	4, 507, 965	8, 529, 28	31 13, 037, 246	4, 741, 112	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE			1			
1.00	Land	6, 323, 988	0				1.00
2.00	Land Improvements	1, 967, 845	1, 645, 040				2.00
3.00	Buildings and Fixtures	67, 985, 087	22, 017, 625				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	19, 773, 767	9, 161, 041				5.00
6.00	Movable Equipment	51, 767, 100	25, 474, 900				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	147, 817, 787	58, 298, 606				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	147, 817, 787	58, 298, 606				10.00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON			In Lieu of Form CMS-2552-10				
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0113	Peri od:	Worksheet A-7			
				From 01/01/2016				
				To 12/31/2016	Date/Time Pre 4/14/2017 8:1	pared: 8 am		
		SUMMARY OF CAPITAL						
				–				
Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see			
				instructions)	instructions)			
	9.00	10.00	11.00	12.00	13.00			
PART II - RECONCILIATION OF AMOUNTS FROM WOR	RKSHEET A, COLUN	N 2, LINES 1 a	nd 2					
1.00 CAP REL COSTS-BLDG & FLXT	0	0		0 0	0	1.00		
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00		
3.00 Total (sum of lines 1-2)	0	0		0 0	0	3.00		
SUMMARY OF CAPITAL								
	0.11		-					
Cost Center Description	Other	Total (1) (sum						
	Capital -Relate							
	d Costs (see instructions)	through 14)						
	14.00	15.00	-					
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2								
1.00 CAP REL COSTS-BLDG & FIXT						1.00		
2.00 CAP REL COSTS MVBLE EQUIP		0				2.00		
3.00 Total (sum of lines 1-2)		0				3.00		
	1	1 0	1			0.00		

PECONCILIATION OF CAPITAL COSTS CENTERS Provider CN: 15-0113 Period: From 01/01/2016 To m01/2017/2016 Worksheet A-7 Part 111 Date/Time Prepared: 01/2017 8:18 an Cost Center Description COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL Cost Center Description ALLOCATION OF OTHER CAPITAL Cost Center Description Insurance for Ratio (col. 1 - col. 2.00 ALLOCATION OF OTHER CAPITAL (col. 1 - col. 2.00 Insurance for Ratio (col. 1 - col. 2.00 Insurance for Ratio 2.00 Insurance	Heal th	Financial Systems	COMMUNI TY HOSP	ITAL ANDERSON		In Lie	u of Form CMS-2	552-10
Cost Center Description Gross Assets Capitalized Leases Gross Assets for Ratio (col. 1 - col. Ratio (see instructions) Insurance instructions) PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 2.00 3.00 4.00 5.00 1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-BUDG & FIXT COST CENTERS 96,050,687 0 96,050,687 0.649791 0 1.00 2.00 CAP REL COSTS-MUBLE EQUIP 51,767,101 0 51,767,101 0.350209 0 2.00 3.00 Total (sum of lines 1-2) 147,817,788 0 047,817,787,701 0.0000 3.00 0 0 3.00 ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL SUMMARY OF CAPITAL 0 <	RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C		From 01/01/2016	Part III Date/Time Prep	
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS Instructions Instructions 1.00 2.00 3.00 4.00 5.00 1.00 CAP REL COSTS-BLDG & FIXT 96,050,687 0 96,050,687 0.649791 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 51,767,101 0 51,767,101 0.350209 0 2.00 3.00 Total (sum of lines 1-2) 147,817,788 0 147,817,788 1000000 0 3.00 Cost Center Description Taxes Other Capital -Relate d Costs Total (sum of cols.5 d Costs Depreciation Lease 1.00 1.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 4,411,624 0 1.00 1.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 4,411,624 0 1.00 1.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 2.00 1.00 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 2.00			COM	PUTATION OF RA	FI OS	ALLOCATION OF	OTHER CAPI TAL	
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 96,050,687 0 96,050,687 0 96,050,687 0 64,09791 0 1.00 2.00 CAP REL COSTS-BLDG & FIXT 96,050,687 0 96,050,687 0.649791 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 51,767,101 0 51,767,101 0.350209 0 2.00 3.00 Total (sum of lines 1-2) 147,817,788 0 147,817,788 1.000000 0 3.00 Cost Center Description Taxes Other Capital-Relate ocls.5 through 7) Total (sum of capital-Relate ocls.5 through 7) Depreciation Lease 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 4.411,624 0 1.00 2.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 3.692,850 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 3.00 1.00 2.00 3.00 1.00 2.00 3.00 3.00 <td></td> <td>Cost Center Description</td> <td>Gross Assets</td> <td></td> <td>for Ratio (col. 1 - col.</td> <td></td> <td>Insurance</td> <td></td>		Cost Center Description	Gross Assets		for Ratio (col. 1 - col.		Insurance	
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 0 96, 050, 687 0 96, 050, 687 0.649791 0 1.00 1.00 CAP REL COSTS-BLDG & FIXT 96, 050, 687 0 96, 050, 687 0.649791 0 1.00 2.00 CAP REL COSTS-WBLE EQUIP 51, 767, 101 0 51, 767, 101 0 51, 767, 101 0 350209 0 2.00 3.00 Total (sum of lines 1-2) 147, 817, 788 0 147, 817, 788 1.000000 0 3.00 Cost Center Description Taxes Other Total (sum of capital - Relate Cols. 5 through 7) 0 1.00 through 7) 0 1.00 0 0 0 0 0 2.00 2.00 2.00 2.00 2.00 2.00 3.692, 850 0 2.00 2.00 3.692, 850 0 2.00 2.00 0 0 0 3.00 2.00 3.00 1.00 2.00			1 00	2 00		4 00	5.00	
2.00 CAP REL COSTS-MVBLE EQUIP 51, 767, 101 0 51, 767, 101 0. 350209 0 2.00 3.00 Total (sum of lines 1-2) 147, 817, 788 0 147, 817, 788 1.000000 0 3.00 Cost Center Description Taxes Other Capital -Relate d Costs Total (sum of cols. 5 Depreciation Lease 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 1.00 2.00 CAP REL COSTS-MUBLE EQUIP 0 0 0 4.410(ATION OF CAPITAL SUMMARY OF CAPITAL 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 4.411, 624 0 1.00 2.00 CAP REL COSTS-MUBLE EQUIP 0 0 0 4.411, 624 0 1.00 3.00 Total (sum of lines 1-2) 0 0 0 4.411, 624 0 1.00 3.00 Total (sum of lines 1-2) 0 0 0 3.00 1.00 3.00 3.00 Total (sum of lines 1-2) 0 0 0 </td <td></td> <td>PART III - RECONCILIATION OF CAPITAL COSTS C</td> <td></td> <td>2100</td> <td>0100</td> <td></td> <td>0100</td> <td></td>		PART III - RECONCILIATION OF CAPITAL COSTS C		2100	0100		0100	
3.00 Total (sum of lines 1-2) 147, 817, 788 0 147, 817, 788 1.00000 0 3.00 ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL SUMMARY OF CAPITAL SUMMARY OF CAPITAL 0 3.00 Cost Center Description Taxes Other Capital-Relate d Costs Total (sum of cols.5 through 7) Depreciation Lease PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 6.00 7.00 8.00 9.00 10.00 CAP REL COSTS-BLDG & FIXT 0 0 0 3.62.850 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 3.69.800 2.00 CAP REL COSTS-MBLE EQUIP 0 0 0 3.69.800 0 2.00 SUMMARY OF CAPITAL Interest Insurance (see instructions) Taxes (see instructions) 0 0 3.00 11.00 12.00 13.00 14.00 15.00 11.00 14.00 15.00 1.00 CAP REL COSTS-MUBLE AUIP 147,281 136,458 0 0 4,695,36	1.00	CAP REL COSTS-BLDG & FIXT	96, 050, 687	C	96, 050, 68	0. 649791	0	1.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS O O O ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL 1.00 CAP REL COSTS-BLDG & FIXT 0 0 7.00 8.00 9.00 10.00 2.00 CAP REL COSTS-BLDG & FIXT 0 0 0 4.411,624 0 1.00 2.00 CAP REL COSTS-BLDG & FIXT 0 0 0 3.692,850 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 3.00 7.04,474 0 3.00 Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Capital -Relate of Capital -Relate of Capital -Relate of Capital - Relate of Capital -	2.00	CAP REL COSTS-MVBLE EQUIP	51, 767, 101	0	51, 767, 10 ⁻	0. 350209	0	2.00
Cost Center Description Taxes Other Capital-Relate d Costs Total (sum of cols. 5 through 7) Depreciation Lease PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 6.00 7.00 8.00 9.00 10.00 CAP REL COSTS-BLDG & FIXT 0 0 0 4,411,624 0 1.00 2.00 CAP REL COSTS-BLDG & FIXT 0 0 0 2.00 3,692,850 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 3.00 2.00 8,104,474 0 3.00 Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Total (2) (sum of cols. 9 through 14) 0 0 0 1.00 12.00 13.00 14.00 15.00 11.00 12.00 13.04,458 0 0 4,695,363 1.00 2.00 CAP REL COSTS-BLDG & FIXT 147,281 136,458 0 0 4,695,363 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 73,542 0	3.00	Total (sum of lines 1-2)						3.00
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS Capital -Relate d Costs cols. 5 through 7) notesting 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 4,411,624 0 1.00 2.00 CAP REL COSTS-BLDG & FIXT 0 0 0 3,692,850 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 3.00 0 3.00 10.00 3.00 Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) 0 0 10.00 10.00 ACost Center Description 11.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 11.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 147,281 136,458 0 0 4,695,363 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 73,542			ALLOCA	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAP				
6.00 7.00 8.00 9.00 10.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 0 0 0 4,411,624 0 1.00 2.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 3,692,850 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 3.00 4.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00		Cost Center Description		Capi tal -Rel ate	col s. 5	Depreciation	Lease	
1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 4,411,624 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 3,692,850 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 8,104,474 0 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) 0			6.00			9.00	10.00	
2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 3, 692, 850 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 8, 104, 474 0 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see other capital -Relate of cols. 9 through 14) 11.00 12.00 13.00 14.00 15.00 CAP REL COSTS-BLDG & FIXT 1.00 CAP REL COSTS-BLDG & FIXT 147, 281 136, 458 0 0 4, 695, 363 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 73, 542 0 0 3, 766, 392 2.00		PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
3.00 Total (sum of lines 1-2) 0 0 0 0 8,104,474 0 3.00 Summary OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) 0 0 10 10 10 10 10 10 11.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 147,281 136,458 0 0 4,695,363 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 73,542 0 0 3,766,392 2.00	1.00	CAP REL COSTS-BLDG & FIXT	0	C	(4, 411, 624	0	1.00
SUMMARY OF CAPITAL SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see Other Capital -Relate of cols. 9 Interest Instructions) Instructions) Capital -Relate of cols. 9 Of cols. 9 11.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 147,281 136,458 0 0 4,695,363 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 73,542 0 0 3,766,392 2.00	2.00		0	0	(2.00
Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other of cols.9 11.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 2.00 73,542 0 0 4,695,363 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 73,542 0 0 3,766,392 2.00	3.00	Total (sum of lines 1-2)	0	0	(0	3.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 11.00 12.00 13.00 14.00 15.00 1.00 CAP REL COSTS-BLDG & FIXT 147,281 136,458 0 0 4,695,363 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 73,542 0 0 3,766,392 2.00				SI	JMMARY OF CAPI	TAL		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS d Costs (see instructions) through 14) 1.00 12.00 13.00 14.00 15.00 2.00 CAP REL COSTS-BLDG & FIXT 147, 281 136, 458 0 0 4, 695, 363 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 73, 542 0 0 3, 766, 392 2.00		Cost Center Description	Interest	Insurance (see	Taxes (see	Other		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 11.00 12.00 13.00 14.00 15.00 1.00 CAP REL COSTS-BLDG & FIXT 147,281 136,458 0 0 4,695,363 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 73,542 0 0 3,766,392 2.00				instructions)	instructions)			
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 147, 281 136, 458 0 0 4, 695, 363 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 73, 542 0 0 3, 766, 392 2.00							through 14)	
1.00 CAP REL COSTS-BLDG & FIXT 147, 281 136, 458 0 0 4, 695, 363 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 73, 542 0 0 3, 766, 392 2.00				12.00	13.00	14.00	15.00	
2. 00 CAP REL COSTS-MVBLE EQUIP 0 73, 542 0 0 3, 766, 392 2. 00				1		_		
						0 0		
3.00 Total (sum of lines 1-2) 147,281 210,000 0 0 8,461,755 3.00			-			0 0		
	3.00	Total (sum of lines 1-2)	147, 281	210, 000	(0 0	8, 461, 755	3.00

Heal th	Heal th Financial	
AD JUST	MENTS TO	EXPENSES

	Financial Systems	(COMMUNI TY HOSP			u of Form CMS-2	
ADJUST	MENTS TO EXPENSES			F	Period: From 01/01/2016 Fo 12/31/2016	Worksheet A-8 Date/Time Prep 4/14/2017 8:18	pared:
				Expense Classification on To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL	В		CAP REL COSTS-BLDG & FIXT	4.00		1.00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
	COSTS-MVBLE EQUIP (chapter 2)						
3.00	Investment income - other (chapter 2)	_	0		0.00		
4.00	Trade, quantity, and time discounts (chapter 8)	В		ADMI NI STRATI VE & GENERAL	5.00	0	
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7.00	Telephone services (pay stations excluded) (chapter	А	-87, 095	ADMI NI STRATI VE & GENERAL	5.00	0	7.00
8.00	21) Tel evi si on and radi o servi ce	А	-67, 876	OPERATION OF PLANT	7.00	0	8. 00
9.00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-9, 340, 947			0	10. 00
11.00	Sale of scrap, waste, etc. (chapter 23)	В	-466	ADMI NI STRATI VE & GENERAL	5.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	9, 608, 535			0	12.00
13.00	Laundry and linen service		0		0.00		
	Cafeteria-employees and guests Rental of quarters to employee	В	-712, 792 0	CAFETERI A	11.00 0.00	0	
16. 00	and others Sale of medical and surgical supplies to other than		0		0.00	0	
17.00	patients Sale of drugs to other than		0		0.00	0	17.00
18.00	patients Sale of medical records and	В	-1, 312	MEDICAL RECORDS & LIBRARY	16.00	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
20.00	Income from imposition of interest, finance or penalty		0		0.00	0	
22.00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		0	UTILIZATION REVIEW-SNF	114.00		25. 00
26.00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	NONPHYSI CI AN ANESTHETI STS	19.00		28.00
	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00		29. 00 30. 00
30. 99	therapy costs in excess of 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 limitation (chapter 14)						
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	NONREI MBURSABLE PHYSI CI AN PTO SOLD	А	-11, 860	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 00

Heal th	Financial Systems		COMMUNI TY HOSP	TAL ANDERSON	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Period:	Worksheet A-8	
					From 01/01/2016 To 12/31/2016	Date/Time Pre	narod
					10 12/31/2010	4/14/2017 8: 1	8 am
				Expense Classification or	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
	PHYSICIAN RECRUITMENT	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.01
	RADI OLOGY	В		CT SCAN	57.00		33.02
	ADVERTI SI NG	А		ADMI NI STRATI VE & GENERAL	5.00	0	33.03
	MUNCIE CLINIC	В		MUNCIE CLINIC	90.04	0	33.04
	OUTSIDE SERVICES - SPD	В		CENTRAL SERVICES & SUPPLY	14.00	0	33.05
33.07	MISC A&G	В	-202, 690	ADMI NI STRATI VE & GENERAL	5.00	0	33.07
33.08	SEXUAL RESPONSE UNI T	В	-21, 352	EMERGENCY	91.00	0	33.08
33.09	MISC A&P	В	-5, 893	ADULTS & PEDIATRICS	30.00	0	33.09
33.10	MISC EMPLOYEE BENEFITS	В	-27, 554	EMPLOYEE BENEFITS DEPARTMEN	4.00	0	33.10
33.13	MISC OPERATION OF PLANT	В	-125	OPERATION OF PLANT	7.00	0	33.13
33.14	GUEST MEALS	A	-24, 813	CAFETERIA	11.00	0	33.14
33.17	MISC OTHER OPERATING REVENUE	В	-1, 073, 846	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33. 18	ONCOLOGY SERVICES	В	-554,050	ONCOLOGY	90.03	0	33. 18
33.19	ESPRESSO TO GO	В	-76, 280	CAFETERIA	11.00	0	33.19
33. 22	PROCARE ADMINISTRATION	В	-16, 270	PHYSICAL THERAPY	66.00	0	33. 22
33. 28	HOSPITAL ASSESSMENT FEES (HAF)	В	-3, 930, 427	ADMI NI STRATI VE & GENERAL	5.00	0	33. 28
50.00	TOTAL (sum of lines 1 thru 49)		-6, 829, 128				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).

(2) basis for adjustment (see first detroits).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	COMMUNI TY HOSE	PITAL ANDERSON	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Peri od:	Worksheet A-8	3-1
OFFICE	COSTS			From 01/01/2016 To 12/31/2016		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
1.00		EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE	0	2, 761, 115	1.00
2.00		EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	9, 484, 798	2, 701, 115	2.00
2.00		ADMINISTRATIVE & GENERAL	HOME OFFICE		250.004	2.00
				2, 578, 009	350, 004	
4.00		RADI OLOGY-DI AGNOSTI C	HOME OFFICE	266, 791	0	4.00
4.01		ELECTROCARDI OLOGY	HOME OFFICE	44, 160	0	4.01
4.02	0.00			0	0	4.02
4.03	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	345, 896	0	4.03
5.00	TOTALS (sum of lines 1-4).			12, 719, 654	3, 111, 119	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

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

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

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

6.00	A	IN PROHEALTH	100.00		0.00	6.00
7.00	В		0.00	CHN	0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

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

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

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

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

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

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

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

Health Financial Systems	COMMUNI TY HOSPI TA	L ANDERSON	u of Form CMS-2552-10	
STATEMENT OF COSTS OF SERVICES FR	COM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0113	Period: From 01/01/2016	Worksheet A-8-1
			To 12/31/2016	Date/Time Prepared: 4/14/2017 8:18 am

					4/14/2017 8:	18 am
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED C	RGANIZATIONS OR CLAIMED	
	HOME OFFICE COS	STS:				
1.00	-2, 761, 115	0				1.00
2.00	9, 484, 798	0				2.00
3.00	2, 228, 005	0				3.00
4.00	266, 791	0				4.00
4.01	44, 160	0				4.01
4.02	0	0				4. 02
4.03	345, 896	0				4.03
5.00	9, 608, 535					5.00

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

Related Organization(s) and/or Home Office		
 Type of Business		
6.00		
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00 7.00 8.00 9.00 10.00 100.00		6.00
7.00	7	7.00 8.00
8.00	3	8.00
9.00	ç	9.00 0.00
10.00		
100.00	100	0. 00

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

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

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

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

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

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

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

Heal th	Financial Syste	ems	COMMUNI TY HOSE	PITAL ANDERSON		Inli	eu of Form CMS-	2552-10
	R BASED PHYSIC	I AN ADJUSTMENT		Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet A-8	3-2 epared:
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professi onal Component	Provider Component	RCE Amount	Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADMI NI STRATI VE & GENERAL	4,000,449		341, 703			1.00
2.00		ANESTHESI OLOGY	2, 846, 661	2, 846, 661	(
3.00		RADI OLOGY-DI AGNOSTI C	385, 014		(
4,00	90.01	WOUND/OSTOMY CLINIC	512, 454		(0	4.00
5.00		ONCOLOGY	1, 938, 072		(0	5.00
6.00	0.00		0	0	(0	
7.00	0.00		0	0	(0	7.00
8.00	0.00		0	0	(ol o	0	8.00
9.00	0.00		0	0	(0 0	0	9.00
10.00	0.00		0	0	(ol o	0	10.00
200.00			9, 682, 650	9, 340, 947	341, 703	3	3, 906	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADMINISTRATIVE & GENERAL	397, 173		(-	, i i i i i i i i i i i i i i i i i i i	
2.00		ANESTHESI OLOGY	0	0	(0	
3.00		RADI OLOGY-DI AGNOSTI C	0		(0	
4.00		WOUND/OSTOMY CLINIC	0	0	(0	
5.00		ONCOLOGY	0	0	(0	
6.00	0. 00 0. 00		0	0	(0	
7.00 8.00	0.00		0	0			0	
8.00 9.00	0.00		0	0			0	
9.00 10.00	0.00		0	0			0	
200.00	0.00		397, 173	19, 859	(0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	WRSt. A EINC #	I denti fi er	Component	Limit	Di sal I owance	Aujustillerre		
		Tudinti Troi	Share of col.	Er ini t	bi Sui i Suidice			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00	1	
1.00	5.00	ADMI NI STRATI VE & GENERAL	0	397, 173	(3, 658, 746		1.00
2.00	53.00	ANESTHESI OLOGY	0	0	(2, 846, 661		2.00
3.00		RADI OLOGY-DI AGNOSTI C	0	0	(385, 014		3.00
4.00		WOUND/OSTOMY CLINIC	0	0	(512, 454		4.00
5.00		ONCOLOGY	0	0	(1, 938, 072		5.00
6.00	0.00		0	0	(0		6.00
7.00	0.00		0	0	(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		(10.00
200.00			0	397, 173	(9, 340, 947	1	200.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	COMMUNI TY HOSPI	Provider CO	CN: 15-0113	Peri od:	u of Form CMS-2 Worksheet B	2552-10
					From 01/01/2016 To 12/31/2016	Part I Date/Time Pre 4/14/2017 8:13	pared:
			CAPI TAL REL	ATED COSTS		4/14/2017 0.10	
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		for Cost			BENEFI TS		
		Allocation (from Wkst A			DEPARTMENT		
		col. 7)					
	CENEDAL CEDVICE COCT CENTERC	0	1.00	2.00	4.00	4A	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	4, 695, 363	4, 695, 363				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P	3, 766, 392	., ,	3, 766, 392	2		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	21, 860, 990	26, 379				4.00
5.00 6.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	20, 120, 297	408, 612	917, 939	9 3, 793, 307	25, 240, 155 0	5.00 6.00
7.00	00700 OPERATION OF PLANT	6, 688, 123	493, 603	230, 759	9 773, 847	8, 186, 332	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	187, 821	55, 484	(0 24, 617	267, 922	8.00
9.00	00900 HOUSEKEEPI NG	1, 659, 794	111, 097	13, 700		2, 293, 691	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	1, 321, 121 816, 769	172, 900 32, 729			1, 808, 025 1, 166, 792	
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 216, 311	42, 672			1, 670, 636	
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 743, 019	81, 479		2 377, 709	2, 211, 429	
15.00	01500 PHARMACY	1, 788, 289	51, 427	4, 908		2, 407, 022	
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	1, 705, 879 0	65, 202 0		0 442,655 0 0	2, 213, 736 0	16.00 17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0		0 0	0	19.00
20.00	02000 NURSI NG SCHOOL	0	0	(0 0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0		0 0	0	21.00 22.00
22.00 23.00	02200 I & R SERVICES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM-(EMS)	0	0		0 0	0	
20100	INPATIENT ROUTINE SERVICE COST CENTERS						20100
30.00	03000 ADULTS & PEDIATRICS	13, 206, 599	833, 647	231, 210		18, 788, 940	
31.00 32.00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	2, 222, 523	79, 506	98, 639	9 749, 746	3, 150, 414 0	31.00 32.00
33.00	03300 BURN I NTENSI VE CARE UNI T	0	0		0 0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0		0 C	0	34.00
40.00	04000 SUBPROVIDER - IPF	0	0	(0 0	0	
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	0			0	41.00
43.00	04300 NURSERY	1, 237, 352	29, 987	1, 939	9 367, 077	1, 636, 355	
44.00	04400 SKILLED NURSING FACILITY	0	0		0 0	0	44.00
45.00 46.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0			0	45.00 46.00
40.00	ANCI LLARY SERVICE COST CENTERS	0	0		5 0	0	40.00
50.00	05000 OPERATING ROOM	5, 828, 822	355, 245	983, 522	2 1, 678, 702	8, 846, 291	
51.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	51.00
	05300 ANESTHESI OLOGY	52, 902	4, 362	15, 994	4 276, 359	349, 617	
	05400 RADI OLOGY-DI AGNOSTI C	3, 153, 041	309, 238			4, 770, 065	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	(0 0	0	55.00
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	628, 516 588, 938	23, 781 7, 216	14, 378 17, 322		758, 488 751, 734	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	644, 832	15, 010			804, 697	
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 070, 999	59, 606			1, 483, 254	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	3, 830, 116	125, 530		1 781, 886 0 0	4, 952, 383 0	60.00 60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		5	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	219, 796	9, 381	1, 929	9 75, 457	306, 563	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 944, 893	0 11, 546	32, 278	0 8 316,699	0 1, 305, 416	
66. 00	06600 PHYSI CAL THERAPY	1, 996, 231	34, 060			2, 668, 563	
67.00	06700 OCCUPATI ONAL THERAPY	365, 468	14, 320		0 125, 839	505, 627	67.00
68.00	06800 SPEECH PATHOLOGY	226, 533	6, 751			310, 132	
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	533, 311 740, 909	24, 583 24, 583			745, 294 1, 003, 328	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 331, 606	24, 303	(0 200,000	11, 331, 606	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	11, 334, 059	0		0 0	11, 334, 059	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6, 168, 290			0 0	6, 168, 290	
74.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	267,867	3, 015 0			270, 882 0	1
	OUTPATIENT SERVICE COST CENTERS	. 0		· · · · · · · · · · · · · · · · · · ·			
75.00	OUTPATTENT SERVICE CUST CENTERS						
75.00 88.00	08800 RURAL HEALTH CLINIC	0	0	(0 0	0	
75.00 88.00 89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	89.00
75.00 88.00	08800 RURAL HEALTH CLINIC	0 0 0 356, 017	0 0 0 163, 294		0 0		89. 00 90. 00
75.00 88.00 89.00 90.00 90.01 90.02	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0 0 163, 294 25, 016	((5, 05)	0 0 0 0 6 117, 296 0 0	0	89.00 90.00 90.01 90.02

Health Fin	ancial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-	2552-10
COST ALLOC	CATION - GENERAL SERVICE COSTS		Provider CO		eriod: om 01/01/2016	Worksheet B Part I	
				To		Date/Time Pre	pared:
			CAPI TAL REL	ATED COSTS		4/14/2017 8:1	8 am
	Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A					
		<u>col.7)</u>	1.00	2.00	4.00	4A	
	D4 MUNCIE CLINIC	26, 571	23, 862	347	0	50, 780	1
	05 ANTI COAGULATI ON CLINI C 06 PREGNANCY PLUS	297,038	0	3, 995	98, 943	399, 976	1
	07 0/P LAB	-6, 628	38, 021 0	817 0	0	32, 210 0	1
	08 0/P LAB	0	0	0	0	0	1
	09 FORTVILLE CLINIC	789	19, 099		0	19, 888	
	00 EMERGENCY 00 OBSERVATION BEDS (NON-DISTINCT PART)	3, 354, 765	124, 295	118, 513	1, 139, 427	4, 737, 000 0	1
	ER REIMBURSABLE COST CENTERS					0	72.00
	DO HOME PROGRAM DI ALYSI S	0	0	0	0	0	
	00 AMBULANCE SERVI CES 00 DURABLE MEDI CAL EQUI P-RENTED	0	0	0	0	0	
	00 DURABLE MEDICAL EQUIP-KENTED	0	0	0	0	0	1
99.00 099	ро смнс	0	0	0	0	0	99.00
		0	0	0	0	0	
	00 I &R SERVICES-NOT APPRVD PRGM 00 HOME HEALTH AGENCY	0	0	0	0		100.00 101.00
	CIAL PURPOSE COST CENTERS				0		
	DO KIDNEY ACQUISITION	0	0	0	0		105.00
	00 HEART ACQUI SI TI ON 00 LI VER ACQUI SI TI ON	0	0	0	0		106.00 107.00
	DO LUNG ACQUISITION	0	0	0	0		108.00
	DO PANCREAS ACQUISITION	0	0	0	0		109.00
	DO I NTESTI NAL ACQUI SI TI ON DO I SLET ACQUI SI TI ON	0	0	0	0		110.00 111.00
	00 INTEREST EXPENSE	0	0	0	0	0	113.00
	00 UTILIZATION REVIEW-SNF						114.00
	00 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115.00
116.00116 118.00	SUBTOTALS (SUM OF LINES 1-117)	0 129, 642, 489	0 4, 181, 314	0 3, 715, 782	0 20, 690, 038		116.00
	REIMBURSABLE COST CENTERS	127,012,107	1, 101, 011	0, 110, 102	20, 070, 000	127,000,270	
	00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19, 339		0		190.00
	01 WELLNESS CENTERS 02 EMPLOYED ORTHO MD	1, 081, 980	19, 676	35, 884	290, 840	1, 428, 380	190.01
	03 NORTHVI EW CONV. (LTC)	328, 837	0	0	110, 998	439, 835	
	D4 SUMMIT CONV. (LTC)	212, 791	0	0	75, 155	287, 946	
	05 PARKVIEW CONV. (LTC) 06 MONTICELLO HSE. (ASS'TD LVG.)	310, 008 115, 654	0	0	110, 249 41, 026	420, 257 156, 680	
	07 NH PARK PLACE (LTC)	39, 446	0	0	14, 078		
190.08 190	08 MADISON PLACE OF ELWOOD (LTC)	0	0	0	0	0	190. 08
	09 SPINE SURGEON	0	0	0	0		190.09
	10 CLI NI CAL RESEARCH CENTER 11 ONCOLOGI ST	867,030	33, 227	2, 339	244, 644	1, 147, 240 0	190. 10
	12 MEDICAL INTERNIST	141, 582	0	0	32, 015	173, 597	
	13 RHEUMATOLOGY	856, 356	0	2, 784	167, 163	1, 026, 303	
	14 ROCK STEADY BOXING DO RESEARCH	53, 417	16, 148	0	9, 785		190. 14 191. 00
	DO PHYSI CI ANS' PRI VATE OFFI CES	1, 669, 516	297, 451	8, 452	0	1, 975, 419	
192.01 192	01 MUNCIE MD OFFICES	4, 402	92, 127	0	0		192.01
192.02 192 192.03 192	02 FOUNDATION	871, 424	2, 999	0	63, 144	937, 567	192.02 192.03
	04 HEALTHY HEART	207, 141	0	1, 151	0 68, 463	276, 755	
192.05 192	05 VACANT SPACE	0	9, 734	0	0		192.05
	07 PARK PLACE CENTER	637	0	0	0		192.07
192.08 192 200.00	08 RENTAL PROPERTY - 1924 MADISON Cross Foot Adjustments	95, 189	23, 348	0	0	118, 537 0	192.08 200.00
200.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	136, 497, 899	4, 695, 363	3, 766, 392	21, 917, 598	136, 497, 899	202.00

	Financial Systems	COMMUNI TY HOSPI				-		u of Form CMS-2	2552-10
COST /	ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN	: 15-0113	Fr	riod: om 01/01/2016	Worksheet B Part I	
						То		4/14/2017 8:1	pared: 8 am
	Cost Center Description	ADMI NI STRATI VE M & GENERAL	AI NTENANCE REPAI RS	& (OPERATION O PLANT		LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5.00	6.00		7.00		8.00	9.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT								1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP								2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	05 040 455							4.00
5.00 6.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	25, 240, 155		0					5.00 6.00
7.00	00700 OPERATION OF PLANT	1, 736, 018		0	9, 922, 3	50			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	56, 816		0	146, 1		470, 894		8.00
9.00	00900 HOUSEKEEPING	486, 407		0	292, 6		23, 282	3, 096, 030	9.00
10.00 11.00	01000 DI ETARY 01100 CAFETERI A	383, 415 247, 433		0	455, 4 86, 2		0	103, 400 0	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	354, 280		0	112, 4		0	19, 227	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	468, 962		0	214, 6		2, 374	30, 336	14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	510, 440 469, 451		0	135, 4 171, 7		87 0	25, 209 4, 273	15.00 16.00
17.00	01700 SOCIAL SERVICE	409, 431		0	171,7	0	0	4, 273	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0		0		0	0	0	19.00
20.00	02000 NURSI NG SCHOOL	0		0		0	0	0	20.00
21.00 22.00	02100 I & R SERVI CES-SALARY & FRI NGES APPRVD 02200 I & R SERVI CES-OTHER PRGM. COSTS APPRVD	0		0		0	0	0	21.00 22.00
23.00	02300 PARAMED ED PRGM-(EMS)	0		0		0	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00		3, 984, 490		0	2, 195, 9		165, 531	1, 566, 387	30.00
31.00 32.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	668, 086 0		0	209, 4	34 0	25, 365 0	177, 746 0	31.00 32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0		0		0	0	0	33.00
34.00	03400 SURGI CAL INTENSI VE CARE UNI T	0		0		0	0	0	34.00
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0		0		0	0	0	40.00
41.00	04200 SUBPROVIDER - TRF	0		0		0	0	0	41.00
43.00	04300 NURSERY	347,010		0	78, 9	92	0	21, 364	43.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	0		0		0	0	0	44.00
45.00 46.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0		0		0 0	0	0	45.00 46.00
40.00	ANCI LLARY SERVICE COST CENTERS	0		<u> </u>		0	0	0	40.00
50.00	05000 OPERATING ROOM	1, 875, 971		0	935, 7		151, 483	532, 384	50.00
51.00	05100 RECOVERY ROOM	0		0		0 0	0	0	51.00
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	74, 141		0	11, 4	-	0	0	52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 011, 554		0	814, 5		13, 448	79, 473	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0		0	() ()	0	0	0	55.00
56.00 57.00	05600 RADI 0I SOTOPE 05700 CT SCAN	160, 847 159, 415		0	62, 6 19, 0		1, 583 17, 049	18, 373 0	
58.00		170, 646		0	39, 5		7, 188	2, 564	
59.00	05900 CARDI AC CATHETERI ZATI ON	314, 543		0	157, 0		1, 604	15, 382	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	1, 050, 217		0	330, 6	68 0	1, 409	33, 327 0	60.00 60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0				U	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	65, 011		0	24, 7	11	0	7, 691	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0		0	0	0	63.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	276, 830		0	30, 4	0 14	0	0 23, 927	64.00 65.00
66.00	06600 PHYSI CAL THERAPY	565, 903		0	89, 7		305		66.00
67.00	06700 OCCUPATI ONAL THERAPY	107, 225		0	37, 7		0	7, 264	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	65, 768 158, 049		0	17, 7 64, 7		0 3, 001	5, 555 1, 709	68.00 69.00
70.00		212, 769		0	64, 7		4, 755		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 403, 014		0		0	0	0	71.00
72.00		2, 403, 535		0		0	0	0	72.00
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	1, 308, 066 57, 444		0	7, 9	41	0	0	73.00 74.00
75.00		0		0	.,	0	0	0	75.00
00	OUTPATIENT SERVICE COST CENTERS					-			00
88.00 89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0		0 0	0	0	88.00 89.00
90. 00	09000 CLINIC	0		0		0	0	0	90.00
90.01	09001 WOUND/OSTOMY CLINIC	136, 073		0	430, 1		1, 456	57, 255	90.01
90.02		5, 305		0	65, 8		0 124	0	90.02
90. 03 90. 04	09003 ONCOLOGY 09004 MUNCIE CLINIC	0 10, 769		0	723, 8 62, 8		9, 134 0	0	90.03 90.04
90. 04 90. 05	09005 ANTI COAGULATI ON CLINIC	84, 820		0	02,0	0	0	0	90.04
90.06	09006 PREGNANCY PLUS	6, 831		0	100, 1		0	0	90.06
90. 07 90. 08	09007 0/P LAB 09008 0/P LAB	0		0		0 0	0	0	90.07 90.08
7U. U8	UTUUUUUT LAD	0		Ч		U	0	0	J 20.08

Heal th Financial Systems	COMMUNI TY HOSPI T				u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F	eriod: rom 01/01/2016	Worksheet B Part I	
			T	b 12/31/2016	Date/Time Prep 4/14/2017 8:18	
Cost Center Description	ADMI NI STRATI VE M & GENERAL	AI NTENANCE & REPAI RS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	5.00	6.00	7.00	8.00	9.00	
90. 09 09009 FORTVILLE CLINIC	4, 218	0	50, 310	0	0	90.09
91.00 09100 EMERGENCY	1, 004, 542	0	327, 415	41, 217	290, 547	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINC	PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	0	0	0	96.00 97.00
99. 00 09900 CMHC	0	0	0	0	0	
99. 10 09910 CORF	0	0	0	0	0	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0	Ō	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 10600 HEART ACQUI SI TI ON	0	0	0	0		106.00
107.00 10700 LI VER ACQUI SI TI ON	0	0	0	0		107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0	0	0		108.00
109. 00 10900 PANCREAS ACQUI SI TI ON	0	0	0	0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON 111. 00 11100 I SLET ACQUI SI TI ON	0	0	0	0		110.00
113. 00 11300 I NTEREST EXPENSE	0	0	0	0		113.00
114. 00 11400 UTI LI ZATI ON REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.	P.) 0	0	0	0		115.00
116.00 11600 HOSPI CE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	23, 406, 314	0	8, 568, 253	470, 271	3, 070, 393	118.00
NONREI MBURSABLE COST CENTERS					-	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & C/		0	50, 943	0		190.00
190. 01 19001 WELLNESS CENTERS 190. 02 19002 EMPLOYED ORTHO MD	302, 907 0	0	51, 830 0	0	24, 782	190.01
190. 03 19003 NORTHVI EW CONV. (LTC)	93, 273	0	0	0		190.02
190. 04 19004 SUMMIT CONV. (LTC)	61,063	0	0	0		190.03
190. 05 19005 PARKVI EW CONV. (LTC)	89, 121	0	0	o		190.05
190. 06 19006 MONTI CELLO HSE. (ASS' TD LVG.)	33, 226	0	0	0	0	190.06
190.07 19007 NH PARK PLACE (LTC)	11, 350	0	0	0	0	190. 07
190.08 19008 MADISON PLACE OF ELWOOD (LTC)	0	0	0	0		190. 08
190. 09 19009 SPI NE SURGEON	0	0	0	0		190.09
190. 10 19010 CLINICAL RESEARCH CENTER	243, 287	0	87, 525	0		190.10
190. 11 19011 ONCOLOGI ST	0	0	0	0		190.11
190. 12 19012 MEDI CAL I NTERNI ST 190. 13 19013 RHEUMATOLOGY	36, 814	0	0	0		190. 12 190. 13
190. 14 19014 ROCK STEADY BOXING	217, 641 16, 827	0	42, 537	0		190. 13
191. 00 19100 RESEARCH	10, 827	0	42, 007 N	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	418, 913	0	783, 540	17		192.00
192.01 19201 MUNCIE MD OFFICES	20, 470	0	242, 678	0		192.01
192. 02 19202 FOUNDATI ON	198, 823	0	7, 899	0	0	192.02
192. 03 19203 SPOE	0	0	0	0		192.03
192.04 19204 HEALTHY HEART	58, 689	0	0	606		192.04
192. 05 19205 VACANT SPACE	2,064	0	25, 641	0		192.05
TOT ATTOTATIONAR DIACE CENTED	135	0	0	0		192.07
192.07 19207 PARK PLACE CENTER		~	/4 504			
192.08 19208 RENTAL PROPERTY - 1924 MADI SOM	N 25, 137	0	61, 504	0		192.08
	N 25, 137	0	61, 504	0		192.08 200.00 201.00

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	COMMUNI TY HOSPI	TAL ANDERSON Provider CO		ri od:	u of Form CMS-: Worksheet B	2552-10
				Fr To	om 01/01/2016 12/31/2016		
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	4/14/2017 8:1 PHARMACY	8 am
		10.00	11.00	13.00	SUPPLY 14.00	15.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00 4.00 5.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						1.00 2.00 4.00 5.00
6.00 7.00 8.00 9.00 10.00	00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY	2, 750, 289					6.00 7.00 8.00 9.00 10.00
11.00	01100 CAFETERIA	2,730,207	1, 500, 440				11.00
13.00	01300 NURSING ADMINISTRATION	0	23, 628				13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	63, 758	0	2, 991, 489	3, 131, 068	14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	43, 114 46, 934	-	9, 727 340	3, 131, 008	16.00
17.00	01700 SOCI AL SERVI CE	0	0	0	0	0	17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
20.00 21.00	02000 NURSI NG SCHOOL 02100 I & SERVI CES-SALARY & FRI NGES APPRVD	0	0	0	0	0	20.00
21.00	02200 I &R SERVICES-SALART & TRINGES APPRVD	0	0	0	0	0	21.00
23.00	02300 PARAMED ED PRGM-(EMS)	0	0	0	0	0	23.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	2 407 222	420 520	1 205 200	100 111	17	20.00
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	2, 407, 223 336, 104	439, 529 66, 789		128, 111 35, 994	17 0	30.00 31.00
32.00	03200 CORONARY CARE UNI T	0	0	0	0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 40.00	03400 SURGI CAL INTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF	0	0	0	0	0	34.00 40.00
40.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	40.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43.00	04300 NURSERY	0	31, 202	98, 341	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0	0	0	0	44.00
45.00 46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	45.00 46.00
	ANCI LLARY SERVICE COST CENTERS						
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	416	154, 210 0	486, 033 0	425, 208 0	0	50.00
51.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	51.00 52.00
53.00	05300 ANESTHESI OLOGY	0	9, 312	0	97	20, 892	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	72, 766	0	4, 819	429	54.00
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0 6, 326	0	0 645	0	55.00 56.00
57.00		0	11, 970	0	7, 662	0	57.00
58.00		0	9, 575		399	30	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	24, 615	0	6, 862	0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	84, 861 0	0	7, 892	0	60. 00 60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	Ū	0	Ū	J. J	Ũ	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	6, 224	0	83	0	
63.00 64.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	63.00 64.00
65.00	06500 RESPIRATORY THERAPY	0	31, 403	0	1, 028	23	
66.00	06600 PHYSI CAL THERAPY	0	53, 151	0	697	51	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	8, 601	0	10	0	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	6, 245 13, 872		9 1, 085	0 12	68.00 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	18, 950		565	11	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1, 140, 330	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	1, 140, 596	0	
73.00 74.00		0	0	0	0 346	3, 101, 058 0	73.00
75.00	07500 ASC (NON-DI STINCT PART) OUTPATI ENT SERVICE COST CENTERS	0	0		0	0	75.00
88.00 89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88.00 89.00
89.00 90.00	09000 CLINIC	0	0	0	0	0	
90.01	09001 WOUND/OSTOMY CLINIC	o	10, 185	0	14, 510	208	90. 01
90.02	09002 KIDS PLUS CLINIC	0	0	0	0	0	90.02
90. 03 90. 04	09003 ONCOLOGY 09004 MUNCIE CLINIC	0	59, 966 0	0	18, 390 7	189 0	90. 03 90. 04
90.04 90.05	09005 ANTI COAGULATI ON CLINIC	0	8, 269	0	, 118	0	90.04 90.05
90.06	09006 PREGNANCY PLUS	o o	0	0	11	0	90.06
90.07	09007 0/P LAB	0	0	0	0	0	90.07

Heal th	Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2016 Fo 12/31/2016		
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI OI	SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
90.08	09008 0/P LAB	0	C		0 0	0	
90.09	09009 FORTVILLE CLINIC	0	C		0 0	0	
91.00	09100 EMERGENCY	6, 546	102, 970		0 44, 789	36	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DI ALYSI S	0	C		0 0	0	
95.00	09500 AMBULANCE SERVICES	0	C		0 0	0	
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0 0	0	
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	C		0 0	0	
99.00	09900 CMHC	0	C		0 0	0	
99.10	09910 CORF	0	C		0 0	0	
	10000 I &R SERVICES-NOT APPRVD PRGM	0	C		0 0		100.00
101.00	10100 HOME HEALTH AGENCY	0	C		0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS			1			-
	10500 KIDNEY ACQUISITION	0	C		0 0		105.00
	10600 HEART ACQUI SI TI ON	0	C		0 0		106.00
	10700 LIVER ACQUISITION	0	C		0 0		107.00
	10800 LUNG ACQUISITION	0	C		0 0		108.00
	10900 PANCREAS ACQUISITION	0	C		0 0		109.00
	11000 INTESTINAL ACQUISITION	0	C		0 0		110.00
	11100 I SLET ACQUI SI TI ON	0	C		0 0	0	111.00
	11300 INTEREST EXPENSE						113.00
	11400 UTI LI ZATI ON REVI EW-SNF						114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	C		0 0		115.00
		0			0 0 0 0 0 0		116.00
118.00		2, 750, 289	1, 408, 425	2, 180, 17	5 2, 990, 330	3, 122, 960	118.00
100.00	NONREI MBURSABLE COST CENTERS			J		0	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190.00
	19001 WELLNESS CENTERS	0	24, 043		76		190.01
	19002 EMPLOYED ORTHO MD	0			0		190.02
	19003 NORTHVI EW CONV. (LTC)	0	8, 797		31		190.03
	19004 SUMMIT CONV. (LTC)	0	5,667		0		190.04
	19005 PARKVI EW CONV. (LTC)	0	8, 300		13		190. 05 190. 06
	19006 MONTICELLO HSE. (ASS'TD LVG.) 19007 NH PARK PLACE (LTC)	0	3, 116 1, 131				190.08
	19007 NH PARK PLACE (LTC) 19008 MADISON PLACE OF ELWOOD (LTC)	0	1, 131				190.07
	19009 SPINE SURGEON	0					190.08
	19009 SFINE SURGEON	0	26, 807		202		190. 09
	19011 ONCOLOGI ST	0	20,007		0 0		190.10
	19012 MEDICAL INTERNIST	0	3, 674		43		190.12
	19013 RHEUMATOLOGY	0	1, 659				190. 12
	19014 ROCK STEADY BOXING	0	1,033				190.13
	19100 RESEARCH	0	1, 015 C				191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0			255		192.00
	19201 MUNCIE MD OFFICES	0			0 0		192.00
	19201 MONCTE MD OFFICES		3, 632				192.01
	19202 FOUNDATION 19203 SPOE		3, 032 r				192.02
	19203 SPOE		4, 176		539		192.03
	19204 HEALTHY HEART		4, 1/0		039		192.04
	19205 VACANT SPACE						192.05
	19207 PARK PLACE CENTER 19208 RENTAL PROPERTY - 1924 MADI SON						192.07
200.00		0		´ ``		0	200.00
200.00		_	r r			Λ	200.00
201.00		2, 750, 289	1, 500, 440	2, 180, 17	2, 991, 489		
202.00	1 1017E (3000 11103 110-201)	2,130,207	1, 500, 440	۲ <u>ک</u> , ۱۵۵, ۱۸	2, 771, 407	J 5, 151, 000	1202.00

	Financial Systems	COMMUNI TY HOSP		N 15 0112 5		u of Form CMS-2	2552-10
CUSTA	ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2016	Worksheet B Part I	
					o 12/31/2016	Date/Time Pre 4/14/2017 8:1	
						INTERNS &	
						RESI DENTS	
	Cost Center Description	MEDI CAL RECORDS &	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	NURSING SCHOOL	SERVICES-SALAR Y & FRINGES	
		LIBRARY		ANESTHETTSTS		T & TRINGLS	
		16.00	17.00	19.00	20.00	21.00	
1 00	GENERAL SERVICE COST CENTERS		1				1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8.00 9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSING ADMINISTRATION						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	2, 906, 489	,				15.00 16.00
17.00	01700 SOCIAL SERVICE	2, 700, 107					17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	C	0	C			19.00
20.00	02000 NURSI NG SCHOOL	C	0		0	-	20.00
21.00	02100 I & R SERVICES-SALARY & FRINGES APPRVD		0			0	21.00
22.00 23.00	02200 I & SERVI CES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM-(EMS)		-				22.00 23.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS						20.00
30.00	03000 ADULTS & PEDI ATRI CS	311, 855				0	30.00
31.00	03100 INTENSIVE CARE UNIT	C	-			0	31.00
32.00 33.00	03200 CORONARY CARE UNIT		0		-	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT					0	33.00 34.00
40.00	04000 SUBPROVIDER - IPF		0		0	0	40.00
41.00	04100 SUBPROVI DER – I RF	C	0	C	0 0	0	41.00
42.00	04200 SUBPROVI DER	C	0	C	0	0	42.00
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY					0	43.00 44.00
45.00	04500 NURSING FACILITY		-		-	0	45.00
46.00	04600 OTHER LONG TERM CARE	C	0	C	0 0	0	46.00
50.00	ANCI LLARY SERVICE COST CENTERS	004 504				0	50.00
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	224, 536			-	0	50.00 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	C	0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	95, 636	0	C	0	0	54.00
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE					0	55.00 56.00
57.00	05700 CT SCAN		0			0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	C	0	C	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	C	0	C	0 0	0	59.00
60.00	06000 LABORATORY	0	0	C	0	0	60.00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0	0	60.01 61.00
62.00		0	0	C	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	C	0	C	0 0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	C	0	C	0	0	64.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		0			0	65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY		0			0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
	06900 ELECTROCARDI OLOGY	C	0	C	0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY		0		0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS					0	71.00
			0		0	0	73.00
74.00	07400 RENAL DI ALYSI S	(C	0	с (0 0	0	74.00
	07500 ASC (NON-DI STI NCT PART)	C	0	C	0 0	0	75.00
75.00	OUTPATIENT SERVICE COST CENTERS		0	C	0	0	88.00
		r	. 0	, [,]	1 0		
88. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER		0	C	0	0	89.00
88. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC		0	C C		0	90.00
88. 00 89. 00 90. 00 90. 01	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09001 WOUND/OSTOMY CLINIC	0 0 0 1, 197, 522				0	90. 00 90. 01
88.00 89.00 90.00 90.01 90.02	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09001 WOUND/OSTOMY CLINIC 09002 KIDS PLUS CLINIC					0	90. 00 90. 01 90. 02
88. 00 89. 00 90. 00 90. 01	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09001 WOUND/OSTOMY CLINIC 09002 KIDS PLUS CLINIC 09003 ONCOLOGY					0	90. 00 90. 01

	Financial Systems LOCATION - GENERAL SERVICE COSTS	COMMUNI TY HOSPI	Provi der CC	CN: 15-0113 P	eri od:	u of Form CMS-2 Worksheet B	2002-10
				F	rom 01/01/2016 o 12/31/2016	Part I	pared: 8 am
						I NTERNS & RESI DENTS	
	Cost Center Description	MEDI CAL S RECORDS & LI BRARY	OCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	NURSI NG SCHOOL		
		16.00	17.00	19.00	20.00	21.00	
1	09006 PREGNANCY PLUS 09007 0/P LAB	0	0	0	0	0	90.06 90.07
	09008 0/P LAB	0	0	0	0	0	90.07
	09009 FORTVILLE CLINIC	0	0	0	0	0	90.09
	09100 EMERGENCY	798, 349	0	0	0	0	91.00
	09200 OBSERVATION_BEDS_(NON-DISTINCT_PART) OTHER_REIMBURSABLE_COST_CENTERS						92.00
	09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.00
	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
	09600 DURABLE MEDI CAL EQUI P-RENTED 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	0	0	0	96.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00 99.00
	09910 CORF	0	0	0	0	0	99.10
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00
	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	105.00
	10600 HEART ACQUI SI TI ON	0	0	0	0		106.00
	10700 LIVER ACQUISITION	0	0	0	0		107.00
	10800 LUNG ACQUISITION 10900 PANCREAS ACQUISITION	0	0	0	0		108.00 109.00
	11000 INTESTINAL ACQUISITION	0	0	0	0	-	1109.00
	11100 I SLET ACQUI SI TI ON	0	0	0	0		111.00
	11300 INTEREST EXPENSE						113.00
	11400 UTI LI ZATI ON REVI EW-SNF			0			114.00
1	11500 AMBULATORY SURGI CAL CENTER (D. P.) 11600 HOSPI CE	0	0	0	0		115.00 116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	2, 627, 898	0	0	0		118.00
	NONREI MBURSABLE COST CENTERS		-				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 WELLNESS CENTERS	0	0	0	0		190. 00 190. 01
	19002 EMPLOYED ORTHO MD	0	0	0	0		190.01
	19003 NORTHVI EW CONV. (LTC)	0	0	0	0		190. 03
	19004 SUMMIT CONV. (LTC)	0	0	0	0	-	190. 04
	19005 PARKVIEW CONV. (LTC) 19006 MONTICELLO HSE. (ASS'TD LVG.)	0	0	0	0		190. 05 190. 06
	19007 NH PARK PLACE (LTC)	0	0	0	0	-	190.07
	19008 MADISON PLACE OF ELWOOD (LTC)	0	0	0	0		190. 08
	19009 SPINE SURGEON	0	0	0	0		190.09
	19010 CLINI CAL RESEARCH CENTER 19011 ONCOLOGI ST	0	0	0	0		190. 10 190. 11
	19012 MEDICAL INTERNIST	0	0	0	0		190.11
	19013 RHEUMATOLOGY	0	0	0	0		190.13
	19014 ROCK STEADY BOXING	0	0	0	0		190. 14
	19100 RESEARCH	270 501	0	0	0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES 19201 MUNCIE MD OFFICES	278, 591 0	0	0	0		192. 00 192. 01
	19202 FOUNDATI ON	0	0	0	0		192.02
	19203 SPOE	0	0	0	0		192.03
	19204 HEALTHY HEART	0	0	0	0		192.04
192.04			0	0	0	0	192.05
192. 04 192. 05	19205 VACANT SPACE	0	0	0	0	0	192.07
192. 04 192. 05 192. 07		0	0 0	0	0		192. 07 192. 08
192. 04 192. 05 192. 07 192. 08 200. 00	19205 VACANT SPACE 19207 PARK PLACE CENTER 19208 RENTAL PROPERTY - 1924 MADISON Cross Foot Adjustments	0	0 0	0 0 0	0 0 0	0 0	192. 08 200. 00
192. 04 192. 05 192. 07 192. 08	19205 VACANT SPACE 19207 PARK PLACE CENTER 19208 RENTAL PROPERTY - 1924 MADI SON	0 0 0 2, 906, 489	0 0 0 0	0 0 0 0 0	0 0 0 0	0 0 0	192. 08

	Financial Systems	COMMUNI TY HOSPI		ON 15 0112		u of Form CMS-	2552-10
CUST P	LLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2016		
					To 12/31/2016	Date/Time Pre 4/14/2017 8:1	
		I NTERNS &				1 47 147 2017 0.1	
		RESI DENTS					
	Cost Center Description	SERVICES-OTHER	PARAMED ED	Subtotal	Intern &	Total	
		PRGM. COSTS	PRGM-(EMS)		Residents Cost & Post		
					Stepdown		
					Adjustments		
	GENERAL SERVICE COST CENTERS	22.00	23.00	24.00	25.00	26.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS						6.00
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						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY						14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY						16.00
17.00	01700 SOCIAL SERVICE						17.00
	01900 NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000 NURSI NG SCHOOL						20.00
21.00 22.00	02100 I & R SERVICES-SALARY & FRINGES APPRVD 02200 I & R SERVICES-OTHER PRGM. COSTS APPRVD	0					21.00 22.00
	02300 PARAMED ED PRGM-(EMS)	0	0				22.00
20100	INPATIENT ROUTINE SERVICE COST CENTERS	1 1		1			20100
30.00	03000 ADULTS & PEDI ATRI CS	0	0	31, 373, 35	6 0	31, 373, 356	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0			4, 880, 435	
32.00 33.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0		0 0	0	32.00 33.00
33.00 34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0			0	33.00
40.00	04000 SUBPROVI DER – I PF	0	0		0 0	0	40.00
41.00	04100 SUBPROVI DER – I RF	0	0)	0 0	0	41.00
42.00	04200 SUBPROVI DER	0	0		0 0	0	42.00
43.00	04300 NURSERY	0	0	2, 213, 26	4 0	2, 213, 264	
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0		0 0	0	44.00 45.00
46.00	04600 OTHER LONG TERM CARE	0	0		0 0	0	
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0			13, 632, 311	50.00
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0 0 0	0	51.00 52.00
	05300 ANESTHESI OLOGY	0	0				
	05400 RADI OLOGY-DI AGNOSTI C	0	0	6, 862, 77		6, 862, 778	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0	1, 008, 91		1, 008, 910	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	966, 83		966, 839	
58.00 59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	1, 034, 63 2, 003, 27		1, 034, 637 2, 003, 272	
60.00	06000 LABORATORY	0	0	6, 460, 75		6, 460, 757	
60. 01	06001 BLOOD LABORATORY	0	0		0 0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		_		0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	410, 28	3 0	410, 283	
63.00 64.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY	0	0			0	63.00 64.00
65.00	06500 RESPI RATORY THERAPY	0	0	1, 669, 04	1 0	1, 669, 041	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	3, 386, 08		3, 386, 082	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	666, 44		666, 449	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	405, 49		405, 493	
69.00		0	0	987, 77		987, 778	
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1, 344, 44 14, 874, 95		1, 344, 443 14, 874, 950	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	14, 878, 19		14, 878, 190	1
	07300 DRUGS CHARGED TO PATIENTS	0	0	10, 577, 41		10, 577, 414	
74.00	07400 RENAL DIALYSIS	0	0	336, 61	3 0	336, 613	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.00
<u>go 00</u>	OUTPATIENT SERVICE COST CENTERS	0			0	0	88 00
88.00 89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	88.00 89.00
90.00	09000 CLINIC	0	0		0 0	0	1
90. 01	09001 WOUND/OSTOMY CLINIC	0	0	2, 489, 01		2, 489, 019	90. 01
90.02	09002 KIDS PLUS CLINIC	0	0	96, 21		96, 218	
90.03	09003 ONCOLOGY	0	0	-6, 952, 51	1 0	-6, 952, 511	90.03

CDST_ALIOLATION EPRIFAL SPREAL SPREAL SPREAL December 18 Reviewert 8 Reviewer	Heal th	Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	eu of Form CMS-:	2552-10
To 12/31/2016 Deter/Time Program Internet & RESUBATIS Internet & RESUBATIS Subtotal Internet & Resuberts Total 00.01 00001 00001 22.00 23.00 24.00 26.00 26.00 00.01 00001 22.00 23.00 24.00 26.00 26.00 00.01 00001 00001 124.412 0 124.712 0 0 00.01 00001 PROVE 0 0 0 124.412 0 124.712 0 0 00.01 00001 PROVE 0 </td <td></td> <td></td> <td></td> <td>Provider CC</td> <td>CN: 15-0113</td> <td></td> <td></td> <td></td>				Provider CC	CN: 15-0113			
Cast Center Description HTERMS & Instant PAUMUL 15 PROM (ESS) Subtorial PROM (ESS) Intern & Residue (SS) Intern & Residue (SS) 90:04 0000 PROM (ESS) 22.00 24.00 24.00 24.00 24.00 24.00 20.00 10.4.11 0.10 10.9.21 0.00 10.9.21 0.00 10.9.21 0.00 10.9.21 0.00 10.9.21 0.00 10.9.21 0.00 10.9.21 0.00 10.9.21 0.00							Date/Time Pre	pared:
PROM PROM COST PROM PROM Read dents Cost 90. 04 00004 MULTE CLINIC 20.00 23.00 24.40 37.00 26.00 90. 05 00005 MULTE CLINIC 0 0 0 44.01 90.04 90. 06 00005 MULTE CLINIC 0 0 0 0 49.18 0 69.00 74.418 0 64.91,189 0 69.00 74.418 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 7.353.411 0 17.353.411 90.05 90.06 90.06 00000 INTER REMORESARE CONT CENTERS 0 0 0 7.353.411 90.05 90.00 7.353.411 90.05 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00			RESI DENTS					
Image: constraint of the set of		Cost Center Description			Subtotal	Residents Cost	Total	
00.04 00004 (MINCLE CLINIC 0 0 124, 412 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>Stepdown</td><td></td><td></td></t<>						Stepdown		
90.05 9005 APTICACULATION CLINIC 0 493,183 0 493,183 0 05 00.07 90.07 9007	00.04		22.00	23.00				00.04
00.06 PRECENSEY PLIS 0 139,207 0 139,207 0 0.0 0 <th< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td></td></th<>			0	0				
90.08 99008 (o/P LAB 0 7.4.416 0 0	90.06	09006 PREGNANCY PLUS	0	0			139, 207	
90.00 90000 FORTVLLE CLINIC 0 7,4,410 90.00 7,353,411 0 7,353,411 91.00 97.00 91.00 90200 BESERVATION BEDS (NON-DISTINCT PART) 0 7,353,411 0 7,353,411 0 7,353,411 92.00 0FTRE REMBRASALE COST CENTERS 0 0 0 0 0 0 0 0 0 94.00 94.00 94.00 94.00 94.00 94.00 95.00			0	0		0 0		1
91 D0 0910D EXERCISENCY 0 7, 353, 411 0			0	0	74 4		-	
OTHER RELAURSABLE COST CENTERS 96.00 09500 AMBULANCE SENVICES 0			0	0				
94.00 09400 HOME PROGRAM DIALYSIS 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>0</td><td></td><td>92.00</td></t<>						0		92.00
99 500 09500 ANBLANCE SERVICES 0 </td <td></td> <td></td> <td></td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>01 00</td>				0		0 0	0	01 00
97.00 09700 DURALE MEDICAL EQUIP-SOLD 0 0 0 0 0 0 97.00 99.00 99.00 00000 CMHC 0 0 0 99.10 00.00 0 0 0 0 0 0 0 99.10 00.00 <			0	0			-	
99.00 0 0 0 </td <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>-</td> <td></td>			0	0		0 0	-	
99. 10 0 99910 CORF 0			0	0		0 0	-	
100. col 10000 (AR SERVI CES-NOT APPRVD PRGM 0 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>-</td> <td></td>			0	0		0 0	-	
SPECIAL PURPOSE COST CENTERS 05. 00 10500 (KIDW X ACQUISITION 0	100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0 0		100. 00
105. 00 105. 00 106 (0) 0	101.00		0	0		0 0	0	101.00
106. C00 TOGO HART ACQUI SI TI ON 0	105.00		0	0		0 0	0	105.00
108. 00 108. 00 <			0	-				
109. 00 109. 00 00 0			0	0		0 0		
110.00 INTESTI NAL ACQUISITION 0 111.00 111.			0	0				
113 00 11300 INTEREST EXPENSE 113.00 114.00 114.00 UTI LIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 <td< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td></td><td></td></td<>			0	0		0 0		
114 00 11400 UTI LI ZATI ON REVIEW-SNF 114.00 115.00 11500 ANBULATORY SURGI CAL CENTER (D. P.) 0			0	0		0 0	0	
115 00 115 00 MBULATORY SURGI CAL CENTER (D. P.) 0 115.00 0 0 0 0 0 0 124, 256, 199 0 124, 256, 199 0 124, 256, 199 0 124, 256, 199 0 124, 256, 199 0 124, 256, 199 0 124, 256, 199 0 0 124, 256, 199 0 124, 256, 199 0 130, 00 190, 00								
118. 00 SUBTOTALS (SUM OF LINES 1-117) 0 0 124, 256, 199 124, 256, 199 118. 00 NORE MBURSABLE COST CENTERS 0 0 74, 383 0 74, 383 190. 00 190. 00 1900.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 74, 383 190. 00 190. 02 PMPLOYED ORTHO MD 0 0 0 1, 832, 136 0 1, 832, 136 190. 02 190. 03 INORTHVI EW CONV. (LTC) 0 0 549, 507 0 549, 507 190. 04 190.04 19005 PARKVIEW CONV. (LTC) 0 0 517, 691 0 517, 691 190. 61 190. 06 190.06 19005 PARKVIEW CONV. (LTC) 0 0 0 0 190. 06 190.08 190.080 190.080 190.080 190.080 190.080 190.080 190.080 190.090 190.09 190.09 190.09 190.09 190.09 190.09 190.09 190.09 190.09 190.09 190.00 190.09 190			0	0		0 0	0	
NONRE INDURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 74, 383 0 74, 383 190.00 190.01 IVELLNESS CENTERS 0 0 1, 832, 136 0 1, 832, 136 0 1, 832, 136 0 1, 832, 136 0 1, 832, 136 0 1, 832, 136 0 1, 90, 02 190.02 19002 EMPLOYED ORTHO MD 0 0 0 1, 90, 02 1, 90, 04 1, 90, 04 1, 90, 04 1, 90, 04 1, 90, 04 1, 90, 04 1, 90, 04 1, 90, 04 1, 90, 04 1, 90, 04 1, 90, 04 1, 90, 04 1, 90, 04 1, 90, 04 1, 90, 04 1, 90, 04 1, 90, 05 1, 90, 04			-	0	404.05/ 4/	0 0		
190.00 00 0 FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 74,383 190.00 190.01 190.01 WELLNESS CENTERS 0 0 1,832,136 0 1,832,136 0 1,832,136 0 1,832,136 0 1,832,136 0 1,90.02 190.02 190.02 EMPLOYED ORTHO MD 0 0 0 0 0 0 0 0 0 190.02 190.02 190.02 190.02 190.05	118.00		0	0	124, 256, 19	99 0	124, 256, 199	118.00
1900. 02 19002 EMPLOYED ORTHO MD 0 <td< td=""><td>190.00</td><td></td><td>0</td><td>0</td><td>74, 38</td><td>33 0</td><td>74, 383</td><td>190. 00</td></td<>	190.00		0	0	74, 38	33 0	74, 383	190. 00
190.03 19003 NORTHVI EW CONV. (LTC) 0 549,507 0 549,507 190.03 190.04 19004 SUMMI T CONV. (LTC) 0 0 354,676 0 354,676 0 354,676 0 577,691 190.05 190.05 190.05 190.05 190.05 190.05 190.05 190.05 190.07 19005 PARKVI EW CONV. (LTC) 0 0 193.022 0 193.022 190.06 190.07 190.07 190.07 NH PARK PLACE (LTC) 0 0 0 0 0 0 0 190.08 190.08 MADI SON PLACE OF ELWODD (LTC) 0 0 0 0 0 0 190.09 191.02 190.02 190.09 NR TEXPLACE CENTER 0 0 190.09 0 0 0 0 0 190.09 190.02 190.02 190.02 190.02 190.02 190.02 190.02 190.09 0 190.02 190.09 0 190.02 190.09 0 190.02 190.02 190.02 190.02 190.02 190.02 190.02 190.02			0	0	1, 832, 13	36 0		
190.04 19004 SUMMI T CONV. (LTC) 0 354,676 0 354,676 190.04 190.05 19005 PARKVI EW CONV. (LTC) 0 0 517,691 0 517,691 0 517,691 190.05 190.07 190.07 190.07 190.07 190.07 190.07 190.07 190.07 190.07 190.07 190.07 190.07 190.06 190.08 190.08 190.09 919009 SPI KE SURGEON 0 0 0 0 0 0 190.09 190.09 SPI KE SURGEON 0 190.09 SPI KE SURGEON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 190.09 SPI KE SURGEON 0 0 1, 505, 661 0 0 190.14 190.14 Not Ke SURMAT SUREON 0 0 1, 214, 547			0	0	549 50	0 0		
190.06 190.06 MONTI CELLO HSE. (ASS' TD LVG.) 0 193,022 0 193,022 190.06 190.07 19008 MADI SON PLACE (LTC) 0 0 66,005 0 66,005 0 10 0 12 190.12 190.12 190.12 190.13 RHEUMATOLOGY 0 0 1, 245, 603 0 1, 245, 603 190.13 190.14 190.4 ROCK STEADY BOXING 0 0 0 0 0 0 0 <t< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td></td></t<>			0	0				
190.07 19007 NH PARK PLACE (LTC) 0 0 66,005 0 66,005 190.07 190.08 19009 NH PARK PLACE OF ELWOOD (LTC) 0 190.07 190.09 190.09 190.09 SPI NE SURGEON 0 190.09 190.09 190.09 190.09 190.09 190.09 190.09 190.09 190.09 190.09 190.09 190.09 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td></td>			0	0				
190.08 19008 MADI SON PLACE OF ELWOOD (LTC) 0 0 0 0 190.08 190.09 19009 SPI NE SURGEON 0 0 0 0 190.09 190.10 19010 CLI NI CAL RESEARCH CENTER 0 0 0 0 190.09 190.11 19011 OKOLOGI ST 0 0 0 0 0 190.12 190.12 19012 MEDI CAL INTERNIST 0 0 214,547 0 214,547 190.13 190.14 19014 ROCK STEADY BOXING 0 0 139,727 0 139,727 190.14 190.00 <			0	0				
190.10 CLINICAL RESEARCH CENTER 0 0 1,505,061 190.10 190.11 19011 ONCOLOGIST 0 0 0 0 190.11 190.12 19012 MEDICAL INTERNIST 0 0 214,547 0 214,547 190.12 190.13 RHEUMATOLOGY 0 0 1,245,603 0 1,245,603 190.13 190.14 190.14 19014 ROCK STEADY BOXING 0 0 139,727 0 139,727 190.14 191.00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 3,457,590 192.01 192.01 192.01 19202 FOUNDATI ON 0 0 1,147,921 0 1,20.02 192.01 1,147,921 192.02 192.02 192.01 1,147,921 192.02 192.02 1,147,921 0 1,147,92.01 192.02 192.03 192.03 192.03 192.03 192.03 1,245,603 0 0 0 0 1			0	0	00,00			
190.11 19011 ONCOLOGI ST 0 0 0 190.11 190.12 19012 MEDI CAL INTERNIST 0 0 214,547 0 214,547 190.12 190.13 19013 RHEUMATOLOGY 0 0 1,245,603 0 1,245,603 1,245,603 190.13 190.14 19014 ROCK STEADY BOXING 0 0 139,727 0 139,727 190.14 191.00 RESEARCH 0 0 0 191.00 192.00 19200 HYSI CLANS' PRI VATE OFFICES 0 0 3,457,590 0 3,457,590 192.01 192.01 192.01 19201 MUNCLE MD OFFICES 0 0 0 192.02 19202 FOUNDATI ON 0 0 1,147,921 192.02 192.03 192.04 192.04 192.04 192.03 SPOE 0 0 0 0 0 192.05 192.04 192.04 192.04 192.05 192.04 192.04 192.05 192.04 192.04 192.05 192.04 192.05 192.05 192.04			0	0	1 505 0	0 0		
190.12 I9012 MEDI CAL INTERNIST 0 214, 547 190.12 190.13 19013 RHEUMATOLOGY 0 1, 245, 603 0 1, 245, 603 190.13 190.14 19014 ROCK STEADY BOXING 0 0 139, 727 0 139, 727 190.14 191.00 19200 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 359, 677 0 359, 677 192.00 192.01 19201 MUNCI E MD OFFI CES 0 0 11, 147, 921 192.02 192.02 FOUNDATI ON 0 0 0 1, 147, 921 192.02 192.03 SPOE 0 0 0 340, 765 0 192.03 192.04 19205 VACANT SPACE 0 0 340, 765 192.04 192.05 192.05 19205 VACANT SPACE 0 0 340, 765 192.05 192.05 192.07 19207 PARK PLACE CENTER 0 0 772 <			0	0	1, 505, 06			
190.14 19014 ROCK STEADY BOXING 0 139,727 190.14 191.00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 3,457,590 3,457,590 192.00 192.01 19201 MUNCI E MD OFFICES 0 0 359,677 0 359,677 192.01 192.02 19202 FOUNDATI ON 0 0 1,147,921 0 1,147,921 192.02 192.03 19203 SPOE 0 0 0 0 192.03 192.04 19204 HEALTHY HEART 0 0 141,147,921 192.02 192.05 19205 VACANT SPACE 0 0 340,765 192.04 192.07 19207 PARK PLACE CENTER 0 0 37,439 0 37,439 192.05 192.07 19207 PARK PLACE CENTER 0 0 772 0 772 192.07 192.08 19208 RENTAL PROPERTY - 1924 MADI SON 0			0	0	214, 54	47 O		
191.00 19100 RESEARCH 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 3, 457, 590 0 3, 457, 590 192.00 192.01 19201 MUNCI E MD OFFI CES 0 0 359, 677 0 359, 677 192.01 192.02 FOUNDATI ON 0 0 0 1, 147, 921 0 1, 147, 921 192.02 192.03 19203 SPOE 0 0 0 0 0 192.03 192.04 19204 HEALTHY HEART 0 0 0 0 192.04 192.05 19205 VACANT SPACE 0 0 340, 765 192.04 192.07 19207 PARK PLACE CENTER 0 0 37, 439 192.05 192.07 19207 PARK PLACE CENTER 0 0 772 0 772 192.07 192.08 19208 RENTAL PROPERTY - 1924 MADI SON 0 0 205, 178 0 205, 178 200.00 Cross Foot Adj ustments 0 <td< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td></td></td<>			0	0				
192.0019200PHYSICIANS' PRIVATE OFFICES03, 457, 590192.00192.0119201MUNCIE MD OFFICES00359, 6770359, 677192.01192.0219202FOUNDATION001, 147, 92101, 147, 921192.02192.0319203SPOE000000192.03192.0419204HEALTHY HEART00340, 7650340, 765192.04192.0519205VACANT SPACE0037, 439192.05192.05192.0819208RENTAL PROPERTY - 1924 MADI SON00205, 1780205, 178192.08200.00Kogative Cost Centers000000201.00201.00Negative Cost Centers00000201.00			0	0	139, 72			
192.01 MUNCLE MD OFFICES 0 359, 677 0 359, 677 192.01 192.02 FOUNDATION 0 0 1, 147, 921 0 1, 147, 921 192.02 192.03 I9203 SPOE 0 0 0 0 0 192.03 192.04 19204 HEALTHY HEART 0 0 340, 765 0 340, 765 192.04 192.05 19205 VACANT SPACE 0 0 37, 439 0 37, 439 192.05 192.07 19207 PARK PLACE CENTER 0 0 772 0 772 192.07 192.08 19208 RENTAL PROPERTY - 1924 MADISON 0 0 205, 178 192.08 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			0	0	3, 457, 59	0 0	-	
192.03 SPOE 0 0 0 192.03 192.04 19204 HEALTHY HEART 0 0 340,765 0 340,765 192.04 192.05 19205 VACANT SPACE 0 0 37,439 0 37,439 192.05 192.07 19207 PARK PLACE CENTER 0 0 772 0 772 192.07 192.08 RENTAL PROPERTY - 1924 MADI SON 0 0 205,178 0 200.00 200.00 Cross Foot Adjustments 0 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00			0	0				
192.04 19204 HEALTHY HEART 0 0 340, 765 0 340, 765 192.04 192.05 19205 VACANT SPACE 0 0 37, 439 0 37, 439 192.05 192.07 19207 PARK PLACE CENTER 0 0 772 0 772 192.07 192.08 19208 RENTAL PROPERTY - 1924 MADI SON 0 0 205, 178 192.08 200.00 Cross Foot Adj ustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			0	0	1, 147, 92	21 0		
192.05 VACANT SPACE 0 37, 439 0 37, 439 192.05 192.07 19207 PARK PLACE CENTER 0 0 772 0 772 192.07 192.08 19208 RENTAL PROPERTY - 1924 MADI SON 0 0 205, 178 0 205, 178 192.08 200.00 Cross Foot Adjustments 0 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			0	0	340, 76	5 0 55 0		
192.08 RENTAL PROPERTY - 1924 MADI SON 0 205, 178 0 205, 178 192.08 200.00 Cross Foot Adjustments 0 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00	192.05	19205 VACANT SPACE	0	0	37, 43	39 0	37, 439	192.05
200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			0	0				
201.00 Negative Cost Centers 0 </td <td></td> <td></td> <td>0</td> <td>0</td> <td>205, 1.</td> <td></td> <td></td> <td></td>			0	0	205, 1.			
202. 00 T0TAL (sum lines 118-201) 0 0 136, 497, 899 0 136, 497, 899 202. 00	201.00	Negative Cost Centers	0	0		0 0	0	201.00
	202.00	TOTAL (sum lines 118-201)	0	0	136, 497, 89	99 0	136, 497, 899	202.00

Heal th	Financial Systems	COMMUNITY HOSPITAL ANDERSON		In Lieu of Form CMS	-2552-10
	LLOCATION STATISTICS	Provi der C	CN: 15-0113	Period: Worksheet No From 01/01/2016	n-CMS W
				To 12/31/2016 Date/Time Pr 4/14/2017 8:	
	Cost Center Description		Stati sti cs	Statistics Description	
			Code		
			1.00	2.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT		1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP		2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT		3	GROSS SALARIES	4.00
5.00	ADMI NI STRATI VE & GENERAL		-5	ACCUM. COST	5.00
6.00	MAINTENANCE & REPAIRS		4	SQUARE FEET	6.00
7.00	OPERATION OF PLANT		1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE		8	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING		9	HOURS OF SERVICE	9.00
10.00	DI ETARY		10	MEALS SERVED	10.00
11.00	CAFETERIA		11	MAN HOURS	11.00
13.00	NURSING ADMINISTRATION		13	DI RECT NURS. HRS.	13.00
14.00	CENTRAL SERVICES & SUPPLY		14	COSTED REQUIS.	14.00
15.00	PHARMACY		15	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY		16	TIME SPENT	16.00
17.00	SOCIAL SERVICE		17	TIME SPENT	17.00
19.00	NONPHYSICIAN ANESTHETISTS		19	ASSIGNED TIME	19.00
20.00	NURSING SCHOOL		20	ASSIGNED TIME	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD		21	ASSIGNED TIME	21.00
	I&R SERVICES-OTHER PRGM. COSTS APPRVD		22	ASSIGNED TIME	22.00
23.00	PARAMED ED PRGM-(EMS)		23	ASSIGNED TIME	23.00

	Financial Systems TION OF CAPITAL RELATED COSTS	COMMUNI TY HOSPI	TAL ANDERSON Provider CO	1	In Lie Period: From 01/01/2016 To 12/31/2016	u of Form CMS-: Worksheet B Part II Date/Time Pre 4/14/2017 8:1	pared:
			CAPI TAL REL	LATED COSTS		4/14/2017 8.1	
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS	1 1		1			
1.00 2.00 4.00 5.00 6.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	0 0 0	26, 379 408, 612 0			56, 608 9, 798 0	1.00 2.00 4.00 5.00 6.00
7.00 8.00 9.00	00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0 0 0	493, 603 55, 484 111, 097	13, 70	0 55, 484 0 124, 797	1, 999 64 1, 315	7.00 8.00 9.00
	01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	000000000000000000000000000000000000000	172, 900 32, 729 42, 672 81, 479	23 9, 22	0 32, 729 7 42, 909 2 90, 701	623 820 1, 063 976	13.00 14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0 0 0	51, 427 65, 202 0 0		8 56, 335 0 65, 202 0 0 0 0	1, 453 1, 143 0 0	15.00 16.00 17.00 19.00
	02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM-(EMS)	000000000000000000000000000000000000000	0 0 0 0			0 0 0	20.00 21.00 22.00 23.00
201.00	INPATIENT ROUTINE SERVICE COST CENTERS					Ŭ	20100
30. 00 31. 00 32. 00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	0 0 0	833, 647 79, 506 0			11, 662 1, 937 0	30.00 31.00 32.00
33.00 34.00 40.00	03300 BURN I NTENSI VE CARE UNI T 03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF	0 0 0	0 0 0		0 0 0 0 0 0	0 0 0	33.00 34.00 40.00
41.00 42.00 43.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER 04300 NURSERY	0 0 0	0 0 29, 987	1, 93	0 0 0 0 9 31, 926	0 0 948	41.00 42.00 43.00
44.00 45.00 46.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0 0 0	0 0 0		0 0 0 0 0 0	0 0 0	44.00 45.00 46.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	355, 245		2 1, 338, 767 0 0	4, 336 0	50.00 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	4, 362		4 20, 356	714	
	05400 RADI OLOGY-DI AGNOSTI C	0	309, 238	413, 03	2 722, 270		54.00
	05500 RADI OLOGY-THERAPEUTI C	0	0	14.07	0 0	0	1
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	0	23, 781 7, 216			237 357	56.00 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	15, 010			319	1
59.00	05900 CARDI AC CATHETERI ZATI ON	0	59, 606	40, 59	5 100, 201	806	59.00
60.00	06000 LABORATORY	0	125, 530	214, 85	1 340, 381	2, 020	
61. 00 62. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0 9, 381	1, 92	0 0 0 9 11, 310	0 195	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0 11, 546	32, 27	0 0 8 43, 824	0 818	64.00 65.00
66. 00	06600 PHYSI CAL THERAPY	0	34, 060			1, 636	
	06700 OCCUPATI ONAL THERAPY	0	14, 320		0 14, 320	325	1
68.00	06800 SPEECH PATHOLOGY	0	6, 751			197	68.00
		0	24, 583			365	1
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	24, 583	34, 83	0 59, 413	524 0	70.00
	07200 I MPL. DEV. CHARGED TO PATTENTS	0	0			0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74.00	07400 RENAL DI ALYSI S	0	3, 015	1	0 3, 015	0	74.00
	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		0			0	75.00 88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
90.00	09000 CLI NI C	0	0		0 0	0	1
90.01	09001 WOUND/OSTOMY CLINIC	0	163, 294			303	
90. 02 90. 03	09002 KIDS PLUS CLINIC 09003 ONCOLOGY	0	25, 016 274, 776		0 25, 016 7 408, 593	0 974	90. 02 90. 03
	09004 MUNCI E CLINIC	0	23, 862			0	

ALLOCAT	TION OF CAPITAL RELATED COSTS		Provider CC	1	Period: From 01/01/2016 Fo 12/31/2016		epared 8 am
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	2.00	2A	4.00	00 0
	09005 ANTI COAGULATI ON CLINIC 09006 PREGNANCY PLUS	0	0 38, 021	3, 99! 81		256 0	
	09007 0/P LAB	0	00,021		0 0	0	
	09008 0/P LAB	0	0	(0 0	0	
	09009 FORTVILLE CLINIC	0	19, 099	(.,,,,,,	0	90.0
	09100 EMERGENCY	0	124, 295	118, 513		2, 943	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.0
-	OTHER REIMBURSABLE COST CENTERS						
	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0	0			0	
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	(0	
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	(0	0	
	09900 CMHC	0	0	(0	0	
9.10	09910 CORF	0	0	(o o	0	99. ⁻
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0	(-		100.
	10100 HOME HEALTH AGENCY	0	0	(0 0	0	101. (
	SPECIAL PURPOSE COST CENTERS		0			0	105 (
	10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION	0	0				105. 106.
	10700 LIVER ACQUISITION	0	0	(107.
	10800 LUNG ACQUISITION	0	0	(108.
	10900 PANCREAS ACQUI SI TI ON	0	0	(0		109.
	11000 INTESTINAL ACQUISITION	0	0	(o o	0	110.
	11100 I SLET ACQUI SI TI ON	0	0	(0 0	0	111. (
	11300 INTEREST EXPENSE						113. (
	11400 UTI LI ZATI ON REVIEW-SNF					0	114. (
	11500 AMBULATORY SURGICAL CENTER (D. P.) 11600 HOSPICE	0	0	(115. (116. (
18.00		0	4, 181, 314	3, 715, 782	J J	53, 437	
	NONREI MBURSABLE COST CENTERS		.,				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19, 339		0 19, 339		190. (
	19001 WELLNESS CENTERS	0	19, 676	35, 884	4 55, 560		190.
	19002 EMPLOYED ORTHO MD	0	0	(0 0		190.
	19003 NORTHVI EW CONV. (LTC)	0	0	(190.
	19004 SUMMI T CONV. (LTC) 19005 PARKVI EW CONV. (LTC)	0	0	(190. 190.
	19006 MONTI CELLO HSE. (ASS' TD LVG.)	0	0	(190.
	19007 NH PARK PLACE (LTC)	0	0	(0 0		190.
	19008 MADISON PLACE OF ELWOOD (LTC)	0	0	(0 0		190.
	19009 SPI NE SURGEON	0	0	(0 0		190.
	19010 CLINICAL RESEARCH CENTER	0	33, 227	2, 339	9 35, 566		190.
	19011 ONCOLOGI ST	0	0	(0		190.
	19012 MEDI CAL I NTERNI ST 19013 RHEUMATOLOGY	0	0	2 70	0 0		190. 190.
	19013 RHEUMATOLOGY 19014 ROCK STEADY BOXING	0	16, 148	2, 784	4 2, 784 D 16, 148		190. 190.
-	19100 RESEARCH	0	10, 140	(191.
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	297, 451	8, 452	305, 903		192.
92.01	19201 MUNCIE MD OFFICES	0	92, 127	(92, 127	0	192.
	19202 FOUNDATI ON	0	2, 999	(2, 999		192. (
	19203 SPOE	0	0	(0		192.
0.7 U/	19204 HEALTHY HEART	0	0	1, 15			192.
	19205 VACANT SPACE 19207 PARK PLACE CENTER	0	9, 734		9,734		192. 192.
92.05		0	0				
92.05 92.07			22 210	()	()	
92.05 92.07 92.08	19208 RENTAL PROPERTY - 1924 MADISON	0	23, 348	(23, 348 0	0	192. 200.
92.05 92.07	19208 RENTAL PROPERTY - 1924 MADISON Cross Foot Adjustments	0	23, 348 0		0 23, 348 0 0 0		200. 201.

	Financial Systems TION OF CAPITAL RELATED COSTS	COMMUNI TY HOSPI	TAL ANDERSON Provider CCM	N: 15 0112 D	In Lie eriod:	u of Form CMS-2 Worksheet B	2552-10
ALLUCA	TION OF CAPITAL RELATED COSTS		Provider con		rom 01/01/2016	Part II	pared:
	Cost Center Description	ADMI NI STRATI VE M & GENERAL	REPAI RS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	GENERAL SERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 6.00	00500 ADMI NI STRATI VE & GENERAL	1, 336, 349	0				5.00
7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	91, 916	0	818, 277			6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	3,008	0	12,053	70, 609		8.00
9.00	00900 HOUSEKEEPI NG	25, 754	0	24, 134		179, 491	9.00
10.00	01000 DI ETARY	20, 301	0	37, 560	0	5, 995	
11.00		13, 101	0	7, 110	0	0	11.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	18, 758 24, 830	0	9, 270 17, 700	0 356	1, 115 1, 759	13.00 14.00
14.00	01500 PHARMACY	24, 830	0	11, 172	13	1, 757	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	24, 856	0	14, 164	0	248	16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
20.00	02000 NURSING SCHOOL	0	0	0	0	0	20.00
21.00 22.00	02100 I & R SERVI CES-SALARY & FRI NGES APPRVD 02200 I & R SERVI CES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	21.00 22.00
22.00	02300 PARAMED ED PRGM-(EMS)	0	0	0	0	0	22.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	4	0				20.00
30.00	03000 ADULTS & PEDIATRICS	210, 938	0	181, 099		90, 809	30.00
31.00	03100 INTENSIVE CARE UNIT	35, 373	0	17, 272	3, 803	10, 305	31.00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 34.00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	33.00 34.00
40.00	04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43.00	04300 NURSERY	18, 373	0	6, 514	0	1, 239	43.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	0	0	0	0	0	44.00
45.00 46.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0	0	0	0	45.00 46.00
40.00	ANCI LLARY SERVICE COST CENTERS	0	ų	0	0	0	40.00
50.00	05000 OPERATI NG ROOM	99, 326	0	77, 172	22, 714	30, 865	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	3, 925 53, 558	0	948 67, 177		0 4, 607	53.00 54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	55, 558	0	07, 177	2,018	4,007	55.00
56.00	05600 RADI OI SOTOPE	8, 516	0	5, 166	237	1,065	
57.00	05700 CT SCAN	8, 440	0	1, 568		0	
	05800 MAGNETIC RESONANCE I MAGING (MRI)	9, 035	0	3, 261	1, 078		1
59.00	05900 CARDI AC CATHETERI ZATI ON	16, 654	0	12, 948		892	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	55, 605 0	0	27, 270 0	211 0	1, 932 0	60. 00 60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	3, 442	0	2, 038	0	446	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	14,657	0	2, 508 7, 399		1, 387	65.00
66.00 67.00	06700 OCCUPATI ONAL THERAPY	29, 963 5, 677	0	7, 399 3, 111	46	446	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	3, 482	0	1, 467	0	322	
69.00	06900 ELECTROCARDI OLOGY	8, 368	0	5, 340			69.00
	07000 ELECTROENCEPHALOGRAPHY	11, 265	0	5, 340	713	2, 279	1
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	127, 231	0	0	0	0	71.00
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	127, 259 69, 258	0	0	0	0	72.00 73.00
74.00	07400 RENAL DI ALYSI S	3, 041	0	655	0	0	74.00
75.00	07500 ASC (NON-DI STINCT PART)	0	0	039	0	0	75.00
	OUTPATIENT SERVICE COST CENTERS					. <u> </u>	
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	õ	0	0	0	89.00
90. 00 90. 01	09000 CLINIC 09001 WOUND/OSTOMY CLINIC		0	0	0	0 3, 319	90.00 90.01
90.01 90.02	09002 KIDS PLUS CLINIC	7, 205 281	0	35, 473 5, 434		3, 319	90.01
90.02 90.03	09003 ONCOLOGY	0	0	59, 691	1, 370	0	90.02
90.04	09004 MUNCIE CLINIC	570	Ō	5, 184	0	0	90.04
90.05	09005 ANTI COAGULATI ON CLINIC	4, 491	0	0	0	0	90.05
90.06	09006 PREGNANCY PLUS	362	0	8, 260	0	0	90.06
90. 07 90. 08	09007 0/P LAB 09008 0/P LAB	0	0	0	0	0	90. 07 90. 08
7U. UØ	UTUUUUUF LAD	0	U	0	0	0	J 70. UO

Health Financial Systems	COMMUNI TY HOSPI T	AL ANDERSON			In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre	
Cost Center Description	ADMI NI STRATI VE M		8 (OPERATION OF	LAUNDRY &	4/14/2017 8: 1 HOUSEKEEPI NG	8 am
	& GENERAL	REPAI RS		PLANT	LINEN SERVICE		
	5.00	6.00	_	7.00	8.00	9.00	
90. 09 09009 FORTVILLE CLINIC	223		0	4, 14		0	90.09
91.00 09100 EMERGENCY	53, 187		0	27,00	1 6, 180	16, 844	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)							92.00
0THER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S	0		0		0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0		0		0 0	0	94.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0		0			0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0		0		0 0	0	97.00
99. 00 09900 CMHC	0		0		0 0	0	99.00
99. 10 09910 CORF	0		0		0 0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0		0		0 0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0		0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS							
105.00 10500 KIDNEY ACQUISITION	0		0		0 0		105.00
106.00 10600 HEART ACQUI SI TI ON	0		0		0 0		106.00
107. 00 10700 LI VER ACQUI SI TI ON	0		0		0 0		107.00
108.00 10800 LUNG ACQUI SI TI ON	0		0		0 0		108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0		0		0 0		109.00
110. 00 11000 INTESTINAL ACQUISITION	0		0		0 0		110.00
111. 00 11100 I SLET ACQUI SI TI ON 113. 00 11300 I NTEREST EXPENSE	0		9		0 0	0	111.00 113.00
114. 00 11400 UTILIZATION REVIEW-SNF							114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0		0		0	0	115.00
116. 00 11600 HOSPI CE	0		0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 239, 255		0	706, 60	8 70, 515	178, 004	
NONREI MBURSABLE COST CENTERS			-		-		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	217		0	4, 20	1 0	0	190. 00
190.01 19001 WELLNESS CENTERS	16, 038		0	4, 27	4 0		190. 01
190.02 19002 EMPLOYED ORTHO MD	0		0		0 0		190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)	4, 938		0		0 0		190.03
190. 04 19004 SUMMIT CONV. (LTC)	3, 233		0		0 0		190.04
190. 05 19005 PARKVI EW CONV. (LTC)	4,719		0		0 0		190. 05 190. 06
190.06 19006 MONTI CELLO HSE. (ASS' TD LVG.) 190.07 19007 NH PARK PLACE (LTC)	1, 759 601		0		0 0		190.06
190. 08 19008 MADI SON PLACE OF ELWOOD (LTC)	0		0				190.07
190. 09 19009 SPI NE_SURGEON	0		0		0 0		190.09
190. 10 19010 CLINI CAL RESEARCH CENTER	12, 881		0	7, 21	8 0		190.10
190. 11 19011 ONCOLOGI ST	0		0		0 0		190. 11
190. 12 19012 MEDI CAL I NTERNI ST	1, 949		0		0 0	0	190. 12
190. 13 19013 RHEUMATOLOGY	11, 523		0		0 0	0	190. 13
190.14 19014 ROCK STEADY BOXING	891		0	3, 50	8 0		190. 14
191. 00 19100 RESEARCH	0		0		0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	22, 180		0	64, 61			192.00
192. 01 19201 MUNCIE MD OFFICES	1,084		0	20, 01			192.01
192. 02 19202 FOUNDATI ON	10, 527		0	65			192.02
192. 03 19203 SP0E 192. 04 19204 HEALTHY HEART	2 107				0 0 0 91		192.03
192. 04 19204 HEALTHY HEART 192. 05 19205 VACANT SPACE	3, 107 109			2, 11			192. 04 192. 05
192. 05 19205 VACANT SPACE 192. 07 19207 PARK PLACE CENTER	109		0	2, 11			192.05
192. 08 19207 PARK PLACE CENTER 192. 08 19208 RENTAL PROPERTY - 1924 MADI SON	1, 331		0	5, 07	2 0		192.07
200.00 Cross Foot Adjustments	1,001		ĭ	5,07			200.00
201.00 Negative Cost Centers	0		0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	1, 336, 349		0	818, 27	7 70, 609		
							•

Heal th	Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	F	eriod: rom 01/01/2016	Worksheet B Part II	
					o 12/31/2016	Date/Time Pre 4/14/2017 8:1	pared: 8 am
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BEBG & TTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6.00
7.00 8.00	00800 LAUNDRY & LINEN SERVICE						7.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY	310, 231					10.00
11.00		0	53, 760				11.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	847 2, 284				13.00
15.00	01500 PHARMACY	0	1, 545			99, 456	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	1, 682		16	0	16.00
17.00	01700 SOCIAL SERVICE	0	0	0 0	0	0	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL	0	0		0	0	19.00
20.00 21.00	02000 NURSING SCHOOL 02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0	U		0	0	20.00
21.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	0		0	0	22.00
23.00	02300 PARAMED ED PRGM-(EMS)	0	C	C	0	0	23.00
~~ ~~	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	074 504		1	5.00/		
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	271, 534 37, 912	15, 748 2, 393			1 0	30.00
32.00	03200 CORONARY CARE UNIT	37, 912	2, 393			0	31.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	C		0	0	33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	C) C	0	0	34.00
40.00	04000 SUBPROVIDER - IPF	0	C	C	0	0	40.00
41.00	04100 SUBPROVIDER - IRF	0	0		-	0	41.00
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	0	0 1, 118		-	0	42.00
43.00	04400 SKILLED NURSING FACILITY	0	1, 118			0	43.00
45.00	04500 NURSING FACILITY	0	0		-	0	45.00
46.00	04600 OTHER LONG TERM CARE	0	0) C	0	0	46.00
50.00	ANCI LLARY SERVICE COST CENTERS	47	5, 525	16, 489	19, 702	0	50.00
51.00	05100 RECOVERY ROOM	47	5, 525			0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	334		4	664	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	2, 607		223	14	54.00
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0 227		0 30	0	55.00 56.00
57.00	05700 CT SCAN	0	429		355	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	343			1	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	882		318	0	59.00
60.00	06000 LABORATORY	0	3, 041		366	0	60.00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	C		0	0	60.01 61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	223		4	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	C	C	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	1, 125		48	1	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	1, 904 308		32 0	2	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	0	224		0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	497		50	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	679		26	0	70.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	C		52, 838	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		52, 845	08 502	72.00
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DI ALYSI S	0	Ŭ		0 16	98, 502 0	73.00
75.00	07500 ASC (NON-DI STINCT PART)	0	0			0	75.00
	OUTPATIENT SERVICE COST CENTERS				_		1
88.00	08800 RURAL HEALTH CLINIC	0	0			0	88.00
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89.00 90.00
90.00 90.01	09001 WOUND/OSTOMY CLINIC	0	365		672	7	90.00
90.02	09002 KIDS PLUS CLINIC	0	0		0	0	90.02
90.03	09003 ONCOLOGY	0	2, 149) C	852	6	90.03
90.04	09004 MUNCIE CLINIC	0	0		0	0	90.04
90.05	09005 ANTI COAGULATI ON CLINIC 09006 PREGNANCY PLUS	0	296		5	0	90.05
90. 06 90. 07	09006 PREGNANCY PLUS 09007 0/P LAB	0	0		0	0	90.06 90.07
.0.07	1	- V	0	п С	<u> </u>	0	

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	F	Period: From 01/01/2016 To 12/31/2016		
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	PHARMACY	
	10.00	11.00	13.00	14.00	15.00	
90. 08 09008 0/P LAB	0	0		-	0	90.08
90. 09 09009 FORTVILLE CLINIC	0	C		-	0	
91. 00 09100 EMERGENCY	738	3, 689		2, 075	1	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS	1 1		1			
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0			0	
95.00 09500 AMBULANCE SERVICES	0	C		-	0	
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C	0 0	0 0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0) (0 0	0	
99.00 09900 CMHC	0	0		0	0	
99.10 09910 CORF	0	0		0	0	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		-		100.00
101.00 10100 HOME HEALTH AGENCY	0	C) (0 0	0	101.00
SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON					0	105 00
106. 00 10600 HEART ACQUISTITION	0	0				105.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		-		106.00 107.00
108. 00 10800 LUNG ACQUISITION	0	0				107.00
109. 00 10900 PANCREAS ACQUISITION	0	0				108.00
	0	0			-	
110. 00 11000 I NTESTI NAL ACQUI SI TI ON 111. 00 11100 I SLET ACQUI SI TI ON	0	0				110.00 111.00
113. 00 11300 I NTEREST EXPENSE	0	U		0	0	113.00
114. 00 11400 UTI LI ZATI ON REVIEW-SNF						114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115.00
116. 00 11600 HOSPI CE	0	0				116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	310, 231	50, 464	73, 962	138, 552		118.00
NONREI MBURSABLE COST CENTERS	010,201	00, 101	1 10, 702	100,002	,,,,,,,	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C) (0 0	0	190.00
190.01 19001 WELLNESS CENTERS	0	861				190.01
190.02 19002 EMPLOYED ORTHO MD	0	C		0 0		190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)	0	315		1	240	190. 03
190.04 19004 SUMMIT CONV. (LTC)	0	203		0 0	0	190. 04
190. 05 19005 PARKVI EW CONV. (LTC)	0	297	() 1	0	190. 05
190. 06 19006 MONTI CELLO HSE. (ASS' TD LVG.)	0	112	(0 0	0	190.06
190.07 19007 NH PARK PLACE (LTC)	0	41	(0 0	0	190. 07
190.08 19008 MADISON PLACE OF ELWOOD (LTC)	0	C) (0 0	0	190. 08
190. 09 19009 SPI NE SURGEON	0	C) (0 0	0	190. 09
190. 10 19010 CLINICAL RESEARCH CENTER	0	960) () 9	0	190. 10
190. 11 19011 ONCOLOGI ST	0	0		0 0		190. 11
190. 12 19012 MEDI CAL I NTERNI ST	0	132		2		190. 12
190. 13 19013 RHEUMATOLOGY	0	59		0 0		190. 13
190. 14 19014 ROCK STEADY BOXING	0	36		0 0		190. 14
191. 00 19100 RESEARCH	0	0		-		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00
192.01 19201 MUNCIE MD OFFICES	0	0		-		192.01
192. 02 19202 FOUNDATI ON	0	130				192.02
192. 03 19203 SPOE	0	0		-		192.03
192. 04 19204 HEALTHY HEART	0	150				192.04
192. 05 19205 VACANT SPACE	0	0				192.05
192. 07 19207 PARK PLACE CENTER	0	0				192.07
192. 08 19208 RENTAL PROPERTY - 1924 MADI SON	0	C		ן ע	0	192.08
200.00 Cross Foot Adjustments		~			_	200. 00 201. 00
201.00Negative Cost Centers202.00TOTAL (sum lines 118-201)	310, 231	53, 760	73, 962			201.00
202.00 101AL (SUII 11185 110-201)	310, 231	55,700	'I 13,902	138, 606	77, 430	1202. UU

	I Financial Systems ATION OF CAPITAL RELATED COSTS	COMMUNI TY HOSP	Provider C	CN: 15-0113	Peri od:	worksheet B	2002-1
ALLOO	THON OF CATTINE RELATED COSTS			F	From 01/01/2016	Part II	
				1	Fo 12/31/2016	Date/Time Pre 4/14/2017 8:1	
						INTERNS &	
						RESI DENTS	
	Cost Center Description	MEDI CAL RECORDS &	SOCI AL SERVI CE	ANESTHETI STS	NURSING SCHOOL	SERVICES-SALAR Y & FRINGES	
		LIBRARY		ANESTHEITSTS			
		16.00	17.00	19.00	20.00	21.00	
	GENERAL SERVICE COST CENTERS		1		1		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
4.00 5.00	00500 ADMINI STRATI VE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00 11.00	01000 DI ETARY 01100 CAFETERI A						10.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00							14.00
15.00							15.00
16.00		107, 311					16.00
17.00 19.00							17.00
20.00					0		20.00
21.00			0		0	0	
22.00		C	0)			22.00
23.00		C	0				23.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	11 514					
30.00 31.00		11, 514					30.00
32.00			-				32.00
33.00		C	0				33.00
34.00		C	0				34.00
40.00		C	0				40.00
41.00 42.00							41.00
43.00							42.00
44.00		C	0				44.00
45.00		C	0				45.00
46.00		C	0				46.00
50.00	ANCI LLARY SERVI CE COST CENTERS	8, 290	0				50.00
51.00		0,270	0				51.00
52.00		C	0)			52.00
53.00	05300 ANESTHESI OLOGY	C	0				53.00
54.00		3, 531	0				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE						55.00
57.00							57.00
58.00		C	0				58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	C	0				59.00
60.00		C	0				60.00
60.01		C	0				60.0
61.00 62.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				61.00
	06300 BLOOD STORI NG, PROCESSI NG & TRANS.		0				63.00
	06400 I NTRAVENOUS THERAPY	C	0				64.00
	06500 RESPI RATORY THERAPY	C	0				65.00
66.00		C C	0				66.00
67.00 68.00			0				67.00 68.00
	06900 ELECTROCARDI OLOGY						69.00
	07000 ELECTROENCEPHALOGRAPHY		o o				70.0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0				71.0
	07200 I MPL. DEV. CHARGED TO PATIENTS	C	0				72.0
	07300 DRUGS CHARGED TO PATIENTS	C	0				73.0
74.00 75.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)						74.00
, 5. 00	OUTPATIENT SERVICE COST CENTERS			1		1	1 / 5. 0
88. 00		C	0				88.00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	C	0				89.00
	09000 CLINIC	C	0				90.00
90.01		44, 214	0				90.0
90. 02 90. 03	09002 KIDS PLUS CLINIC 09003 ONCOLOGY		0				90.02
90. 03 90. 04							90.0
	09005 ANTI COAGULATI ON CLINIC	1	0	1	1	1	90.0

Heal th Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	COMMUNI TY HOSP	Provider C	CN: 15_0113	Period:	worksheet B	2552-10
ALLOCATION OF CAPITAL RELATED COSTS			F	From 01/01/2016 Fo 12/31/2016	Part II	epared: 8 am
Cost Center Description	RECORDS &	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	NURSI NG SCHOOL	I NTERNS & RESI DENTS	
	LI BRARY 16.00	17.00	19.00	20.00	21.00	
90.06 09006 PREGNANCY PLUS 90.07 09007 0/P LAB 90.08 09008 0/P LAB 90.09 09009 FORTVILLE CLINIC 91.00 09100 EMERGENCY 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART)	0 0 0 29, 476	0 0 0				90.06 90.07 90.08 90.09 91.00 92.00
OTHER REI MBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DI ALYSI S 95.00 09500 AMBULANCE SERVI CES 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 99.00 09900 CMHC 99.10 09910 CORF 100.00 10000 I & R SERVI CES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY						94. 00 95. 00 96. 00 97. 00 99. 00 99. 10 100. 00 101. 00
SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 106.00 10600 HEART ACQUI SI TI ON 107.00 10700 LI VER ACQUI SI TI ON 108.00 10800 LUNG ACQUI SI TI ON 109.00 10900 PANCREAS ACQUI SI TI ON 110.00 11000 INTESTI NAL ACQUI SI TI ON 111.00 11100 I SLET ACQUI SI TI ON 113.00 1NTEREST EXPENSE 114.00 11400 UTI LI ZATI ON REVI EW-SNF 115.00 11500 AMBULATORY SURGI CAL CENTER 116.00 10600 HOSPI CE SUBTOTALS (SUM OF LI NES 1-117) NONREI MBURSABLE COST CENTERS 1170	0 0 0 0 0 0 0 0 0 97, 025				0	105.00 106.00 107.00 108.00 110.00 111.00 113.00 114.00 115.00 116.00 118.00
Instruct indicidual construction 190.00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 190.01 19001 WELLNESS CENTERS 190.02 19002 EMPLOYED ORTHO MD 190.03 19003 NORTHVI EW CONV. (LTC) 190.05 19005 PARKVI EW CONV. (LTC) 190.06 19006 MONTI CELLO HSE. (ASS' TD LVG.) 190.07 19007 NH PARK PLACE (LTC) 190.08 19008 MADI SON PLACE OF ELWOOD (LTC) 190.09 19009 SPI NE SURGEON 190.10 19010 CLI NI CAL RESEARCH CENTER 190.11 19010 CLI NI CAL RESEARCH CENTER 190.12 19012 MEDI CAL I NTERNI ST 190.13 19013 RHEUMATOLOGY 190.14 19014 ROCK STEADY BOXI NG 191.00 19200 PHYSI CLANS' PRI VATE OFFI CES 192.01 19200 PHYSI CLANS' PRI VATE OFFI CES 192.02 19202 FOUNDATI ON 192.03 SPOE 192.04 192.04 19204 HEALTHY HEAR	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	190. 00 190. 01 190. 02 190. 03 190. 04 190. 05 190. 06 190. 07 190. 08 190. 09 190. 10 190. 10 190. 11 190. 12 190. 13 190. 14 191. 00 192. 01 192. 01 192. 02 192. 03 192. 04 192. 05 192. 07 192. 08 200. 00 201. 00 202. 00

	Financial Systems TION OF CAPITAL RELATED COSTS	COMMUNI TY HOSPI	TAL ANDERSON Provider C	CN: 15 0112 D	In Lie eriod:	u of Form CMS-: Worksheet B	2552-10
ALLOUP	TION OF CAPITAL RELATED COSTS		Provider C	F	rom 01/01/2016 o 12/31/2016	Part II Date/Time Pre	
		INTERNS &				4/14/2017 8:1	
	Cost Center Description	RESI DENTS SERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	Total	
		PRGM. COSTS	PRGM-(EMS)		Residents Cost & Post		
					Stepdown		
		22.00	23.00	24.00	Adjustments 25.00	26.00	
	GENERAL SERVICE COST CENTERS	22.00	20.00	21.00	20.00	20.00	
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
11.00	01100 CAFETERI A						11.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13.00 14.00
15.00	01500 PHARMACY						15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE						16.00 17.00
	01900 NONPHYSICIAN ANESTHETISTS						19.00
20. 00 21. 00	02000 NURSING SCHOOL 02100 I &R SERVICES-SALARY & FRINGES APPRVD						20.00 21.00
21.00	02200 I &R SERVICES-SALART & FRINGES APPRVD	0					21.00
23.00	02300 PARAMED ED PRGM-(EMS)		0				23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS			1, 935, 922	0	1, 935, 922	30.00
31.00	03100 I NTENSI VE CARE UNI T			295, 949		295, 949	•
32.00 33.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT			0	0	0	
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T			0		0	34.00
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF				0	0	40.00
42.00	04200 SUBPROVI DER			0	0	0	42.00
43.00 44.00	04300 NURSERY 04400 SKILLED NURSING FACILITY			63, 454		63, 454 0	43.00 44.00
45.00	04500 NURSI NG FACI LI TY				-	0	
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS			0	0	0	46.00
50.00	05000 OPERATING ROOM			1, 623, 233		1, 623, 233	50.00
51.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM					0	
	05300 ANESTHESI OLOGY			26, 945		26, 945	•
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C			858, 314	0	858, 314 0	54.00 55.00
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE			53, 637		53, 637	•
57.00	05700 CT SCAN			38, 243		38, 243	
58.00 59.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON			50, 621 132, 942		50, 621 132, 942	•
60.00				430, 826		430, 826	•
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0	0	0	60.01 61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			17, 658	0	17, 658	
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY				0	0	63.00 64.00
65.00	06500 RESPI RATORY THERAPY			64, 368	0	64, 368	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY			80, 351 24, 162		80, 351 24, 162	
68.00	06800 SPEECH PATHOLOGY			13, 117		13, 117	1
69.00				85, 675		85, 675	
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			80, 239 180, 069		80, 239 180, 069	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS			180, 104	0	180, 104	72.00
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS			167, 760 6, 727		167, 760 6, 727	1
75.00	07500 ASC (NON-DISTINCT PART)			0,727		0,727	1
88.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC			0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			0		0	89.00
90. 00 90. 01	09000 CLINIC 09001 WOUND/OSTOMY CLINIC			0 260, 126	0	0 260, 126	90.00 90.01
90. 02	09002 KIDS PLUS CLINIC			30, 731	0	30, 731	90.02
90. 03	09003 ONCOLOGY			473, 635	0	473, 635	90.03

Heal th	Fi nan	cial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	eu of Form CMS-:	2552-10
		OF CAPITAL RELATED COSTS				Peri od:	Worksheet B	
						From 01/01/2016 To 12/31/2016	Date/Time Pre	pared:
							4/14/2017 8:1	8 am
			I NTERNS & RESI DENTS					
		Cost Center Description	SERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	Total	
			PRGM. COSTS	PRGM-(EMS)		Residents Cost		
						& Post Stepdown		
						Adjustments		
			22.00	23.00	24.00	25.00	26.00	
		MUNCIE CLINIC			29, 96		29, 963	•
		ANTICOAGULATION CLINIC PREGNANCY PLUS			9, 04		9, 043 47, 461	
		0/P LAB				0 0	0	
90.08	09008	0/P LAB				0 0	0	1
		FORTVILLE CLINIC			23, 47		23, 471	90.09
		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)			384, 94	2 0	384, 942	91.00 92.00
72.00		REIMBURSABLE COST CENTERS			1			/2.00
94.00		HOME PROGRAM DI ALYSI S				0 0	0	94.00
		AMBULANCE SERVICES				0 0	-	
		DURABLE MEDICAL EQUIP-RENTED DURABLE MEDICAL EQUIP-SOLD					0	
	09900					0 0	0	
99. 10						0 0	0	99.10
		I &R SERVICES-NOT APPRVD PRGM				0 0		100.00
101.00		HOME HEALTH AGENCY AL PURPOSE COST CENTERS				0 0	0	101.00
105.00		KI DNEY ACQUI SI TI ON				0 0	0	105.00
		HEART ACQUISITION				0 0		106.00
		LIVER ACQUISITION				0 0		107.00
		LUNG ACQUISITION PANCREAS ACQUISITION						108.00 109.00
		INTESTINAL ACQUISITION				0 0		110.00
		I SLET ACQUI SI TI ON				0 0	0	111.00
		INTEREST EXPENSE						113.00
		UTILIZATION REVIEW-SNF AMBULATORY SURGICAL CENTER (D. P.)				0 0	0	114.00 115.00
		HOSPI CE				0 0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	7, 669, 68	8 0	7, 669, 688	118.00
100 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN			23.75	7 0	22 757	190.00
		WELLNESS CENTERS			78, 92			190.00
		EMPLOYED ORTHO MD				0 0		190. 02
		NORTHVI EW CONV. (LTC)			5, 78			190.03
		SUMMIT CONV. (LTC) PARKVIEW CONV. (LTC)			3, 63 5, 30			190. 04 190. 05
		MONTICELLO HSE. (ASS' TD LVG.)			1, 97			190.06
		NH PARK PLACE (LTC)			67	8 0		190. 07
		MADISON PLACE OF ELWOOD (LTC) SPINE SURGEON				0 0		190.08
		CLINICAL RESEARCH CENTER			57, 26	6 0		190. 09 190. 10
		ONCOLOGI ST			0,720	0 0		190. 11
		MEDICAL INTERNIST			2, 17			190. 12
		RHEUMATOLOGY			14, 79			190.13
		ROCK STEADY BOXING RESEARCH			20, 60			190. 14 191. 00
		PHYSI CLANS' PRI VATE OFFI CES			403, 05	1 0	403, 051	•
		MUNCIE MD OFFICES			113, 22		113, 224	
192.02 192.03		FOUNDATI ON			14, 47			192. 02 192. 03
		HEALTHY HEART			4, 70	1 0		192.03
		VACANT SPACE			11, 95			192.05
		PARK PLACE CENTER				7 0		192.07
192.08 200.00		RENTAL PROPERTY - 1924 MADISON	0		29, 75	1 0 0 0		192.08 200.00
200.00		Cross Foot Adjustments Negative Cost Centers	0	0		0 0		200.00
202.00		TOTAL (sum lines 118-201)	0					

	Financial Systems LLOCATION - STATISTICAL BASIS	COMMUNI TY HOSP	ITAL ANDERSON Provider CO	CN: 15-0113 P	In Lie Period:	eu of Form CMS-2 Worksheet B-1	2552-10
				F	rom 01/01/2016 o 12/31/2016		pared:
		CAPITAL RE	LATED COSTS			4/14/2017 8:1	8 am
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFI TS	Reconciliation	ADMI NI STRATI VE & GENERAL	
				DEPARTMENT (GROSS		(ACCUM. COST)	
		1.00	2.00	SALARIES) 4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS			4.00		3.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	292, 802					1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	1,645	3, 222, 147 25, 861	57, 298, 247			2.00 4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	25, 481				119, 021, 745	5.00
6.00	00600 MAINTENANCE & REPAIRS	C	, o	C	0 0	0	6.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	30, 781 3, 460		2, 023, 034 64, 354			7.00 8.00
8.00 9.00	00900 HOUSEKEEPING	6, 928					9.00
10.00	01000 DI ETARY	10, 782		630, 434		1, 808, 025	
11.00	01100 CAFETERI A	2,041		829, 487		1, 166, 792	
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	2, 661 5, 081		1, 075, 547 987, 429		1, 670, 636 2, 211, 429	
15.00	01500 PHARMACY	3, 207					
	01600 MEDICAL RECORDS & LIBRARY	4,066	0	1, 157, 213		2, 213, 736	
	01700 SOCIAL SERVICE	C	0	C	0	0	
19.00 20.00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL					0	19.00 20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	C	0	C C	0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	C	0	C	0	0	22.00
23.00	02300 PARAMED ED PRGM-(EMS) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	C	0 0	C	0 0	0	23.00
30.00	03000 ADULTS & PEDIATRICS	51, 986	197, 805	11, 809, 873	0	18, 788, 940	30.00
31.00	03100 I NTENSI VE CARE UNI T	4, 958	84, 386			-,,	
32.00	03200 CORONARY CARE UNIT	C	0	C	0	0	32.00
33.00 34.00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT					0	33.00 34.00
40.00	04000 SUBPROVI DER – I PF		0	0	0	0	40.00
41.00	04100 SUBPROVI DER – I RF	C	0	C	0 0	0	41.00
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	1,870	0 0 1,659	0 959, 634	0	0 1, 636, 355	42.00 43.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	1, 0/C	0	939, 034 C			
45.00	04500 NURSING FACILITY	C C	0	C	-	-	
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	C	0 0	C	0 0	0	46.00
50.00	05000 OPERATI NG ROOM	22, 153	8 841, 402	4, 388, 557	0	8, 846, 291	50.00
51.00	05100 RECOVERY ROOM	C	0	c		0	51.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	272	0 0				
54.00	05400 RADI OLOGY-DI AGNOSTI C	19, 284					
55.00	05500 RADI OLOGY-THERAPEUTI C	C C	0	C	0 0	0	55.00
56.00	05600 RADI OI SOTOPE	1,483				758, 488	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	450		361, 443 322, 727		751, 734 804, 697	
59.00	05900 CARDI AC CATHETERI ZATI ON	3, 717				1, 483, 254	
60.00	06000 LABORATORY	7,828				4, 952, 383	
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	C	0	C	0	0	60. 01 61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	585	1, 650	197, 263	0	306, 563	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	C	0	C	0 0	0	63.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	720	0 0 27,614	0 827, 931	0	1 205 416	64.00 65.00
66.00	06600 PHYSI CAL THERAPY	2, 124				1, 305, 416 2, 668, 563	
67.00	06700 OCCUPATI ONAL THERAPY	893		328, 976		505, 627	
68.00	06800 SPEECH PATHOLOGY	421		199, 138		310, 132	
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	1, 533 1, 533		369, 858 530, 710		745, 294 1, 003, 328	
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	, 555 C	0	0330, 710		11, 331, 606	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	C	0	C	0	11, 334, 059	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	6, 168, 290	
74.00 75.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	188				270, 882	
	OUTPATIENT SERVICE COST CENTERS			1	-		
88.00	08800 RURAL HEALTH CLINIC	C	0	C	0		88.00
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC					0	89.00 90.00
90.00 90.01	09001 WOUND/OSTOMY CLINIC	10, 183	4, 325	306, 643	0	641, 663	
90.02	09002 KIDS PLUS CLINIC	1, 560	0	C	0	25, 016	90. 02
90.03	09003 ONCOLOGY	17, 135	5 114, 480	986, 203	7, 764, 001	0	90.03

ST ALLOCATION - STATISTICAL BASIS		ITAL ANDERSON Provider CC		eriod:	wof Form CMS- Worksheet B-1	
			F	rom 01/01/2016		
			T	0 12/31/2016	Date/Time Pre 4/14/2017 8:1	par
	CAPITAL RE	LATED COSTS			4/14/2017 0.1	
	0, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,					
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation		
	(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS		& GENERAL	
			DEPARTMENT		(ACCUM. COST)	
			(GROSS SALARI ES)			
	1.00	2.00	4.00	5A	5.00	-
04 09004 MUNCIE CLINIC	1, 488		0		50, 780	90
05 09005 ANTI COAGULATI ON CLINIC	C	3, 418	258, 663	0	399, 976	9
06 09006 PREGNANCY PLUS	2, 371	699	0	0	32, 210	
07 09007 0/P LAB	C	0	0	0	0	90
08 09008 0/P LAB 09 09009 FORTVILLE CLINIC	1, 191	0	0	0	0 19, 888	90
00 09100 EMERGENCY	7, 751		2, 978, 755	0	4, 737, 000	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	101,000	2, 770, 700		1, 101, 000	9
OTHER REIMBURSABLE COST CENTERS	1				I	
00 09400 HOME PROGRAM DI ALYSI S	C	0	0	0	0	9
00 09500 AMBULANCE SERVICES	C	0	0	0	0	9
00 09600 DURABLE MEDICAL EQUIP-RENTED	C	0	0	0	0	9
00 09700 DURABLE MEDICAL EQUIP-SOLD 00 09900 CMHC		0	0	0	0	9
10 09910 CORF		0	0	0	0	9
0. 00 10000 I &R SERVICES-NOT APPRVD PRGM		0	0	0	0	
. 00 10100 HOME HEALTH AGENCY	C	0	0	0		10
SPECIAL PURPOSE COST CENTERS	1			1	L	
0. 00 10500 KI DNEY ACQUI SI TI ON	C	0	0		-	10
. 00 10600 HEART ACQUI SI TI ON . 00 10700 LI VER ACQUI SI TI ON	C	0	0	0		10 10
. 00 10800 LUNG ACQUISITION		0	0	0		10
. 00 10900 PANCREAS ACQUI SI TI ON		0	0	0		10
. 00 11000 I NTESTI NAL ACQUI SI TI ON	C	0	0	0		11
. 00 11100 I SLET ACQUI SI TI ON	C	0	0	0	0	11
3. 00 11300 I NTEREST EXPENSE						11
I. 00 11400 UTI LI ZATI ON REVIEW-SNF						11
5. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 5. 00 11600 HOSPI CE		0	0	0		11!
3.00 SUBTOTALS (SUM OF LINES 1-117)	260, 746	3, 178, 849	54, 089, 091	-17, 476, 154		
NONREI MBURSABLE COST CENTERS						
0.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 206		0			
01 19001 WELLNESS CENTERS	1, 227	30, 699	760, 331	0	1, 428, 380	
0. 02 19002 EMPLOYED ORTHO MD 0. 03 19003 NORTHVI EW CONV. (LTC)		0	0 290, 176	0		19
. 04 19003 NORTHVIEW CONV. (LTC)		0	196, 475		439, 835 287, 946	
. 05 19005 PARKVI EW CONV. (LTC)		0	288, 218		420, 257	
0. 06 19006 MONTI CELLO HSE. (ASS' TD LVG.)	C	0	107, 252		156, 680	
0. 07 19007 NH PARK PLACE (LTC)	C	0	36, 803	0	53, 524	19
0. 08 19008 MADISON PLACE OF ELWOOD (LTC)	C	0	0	0		19
0.09 19009 SPINE SURGEON		0	(20 5(2	0		19
0. 10 19010 CLI NI CAL RESEARCH CENTER 0. 11 19011 ONCOLOGI ST	2,072	2, 001	639, 562	0	1, 147, 240	19
. 12 19012 MEDI CAL I NTERNI ST		0	83, 696	0	173, 597	
. 13 19013 RHEUMATOLOGY		2, 382	437, 006		1, 026, 303	
. 14 19014 ROCK STEADY BOXING	1,007		25, 581		79, 350	
. 00 19100 RESEARCH	C	0	0		0	19
00 19200 PHYSI CLANS' PRI VATE OFFI CES	18, 549		0	0	1, 975, 419	
. 01 19201 MUNCIE MD OFFICES	5,745		0	0	96, 529	
. 02 19202 FOUNDATI ON . 03 19203 SPOE	187 C		165, 075	0	937, 567	19
. 03 19203 SPOE . 04 19204 HEALTHY HEART		985	178, 981	0	276, 755	
. 05 19205 VACANT SPACE	607		0	0	9, 734	
. 07 19207 PARK PLACE CENTER	0	Ő	0	0	637	
. 08 19208 RENTAL PROPERTY - 1924 MADI SON	1, 456	0	0	0	118, 537	
0.00 Cross Foot Adjustments						20
. 00 Negative Cost Centers	4 /05 0/0	0.777.000	01 017 500			20
2.00 Cost to be allocated (per Wkst. B, Part I)	4, 695, 363	3, 766, 392	21, 917, 598		25, 240, 155	20
3.00 Unit cost multiplier (Wkst. B, Part I)	16. 035966	1. 168908	0. 382518		0. 212063	20
4.00 Cost to be allocated (per Wkst. B,			56, 608		1, 336, 349	
Part II)						
0.00 Unit cost multiplier (Wkst. B, Part			0. 000988		0. 011228	20
	1	1		1	1	1

	n Financial Systems ALLOCATION - STATISTICAL BASIS	COMMUNI TY HOSP	Provi der CC		eri od:	u of Form CMS-2 Worksheet B-1	
					rom 01/01/2016 o 12/31/2016	Date/Time Pre	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	4/14/2017 8:1 DI ETARY	8 am
		REPAI RS (SQUARE FEET)	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(HOURS OF SERVICE)	(MEALS SERVED)	
			· · · ·	LAUNDRY)		10.00	
	GENERAL SERVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.0
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.0
5.00	00500 ADMI NI STRATI VE & GENERAL						5.0
6.00	00600 MAINTENANCE & REPAIRS	0					6.0
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	234, 895 3, 460	717, 456			7.0
9.00	00900 HOUSEKEEPING	0	6, 928	35, 473			9.0
10.00		0	10, 782	C		118, 897	10.0
11.00		0	2,041	C	-	0	11.0
13.00 14.00		0	2, 661 5, 081	C 3, 617		0	13.0 14.0
15.00		0	3, 207	132		0	15.0
16.00		0	4, 066	C	-	0	16. 0
17.00 19.00		0	0	C	0	0	17.0 19.0
20.00		0	0		0	0	20.0
21.00		0	0	C	0	0	21.0
22.00		0	-	C	-	0	22.0
23.00	02300 PARAMED ED PRGM-(EMS) INPATIENT ROUTINE SERVICE COST CENTERS	0	0	C	0	0	23.0
30. 00		0	51, 986	252, 203	3, 666	104, 066	30.0
31. 00	03100 I NTENSI VE CARE UNI T	0	4, 958	38, 646	416	14, 530	31.0
32.00		0	0	C	0	0	32.0
33.00 34.00		0	0		0	0	33.0 34.0
40.00		0	0	C	0	0	40.0
41.00		0	0	C	-	0	41.0
42.00		0	0	C	0	0	42.0
43.00 44.00		0	1, 870 0			0	43.0 44.0
45.00		0	°	C	0	0	45.0
46.00		0	0	C	0	0	46.0
50.00	ANCI LLARY SERVI CE COST CENTERS	0	22, 153	230, 800	1, 246	18	50.0
51.00		0		230, 000		0	51.0
52.00		0	0	C	0	0	52.0
53.00		0	272	20, 490	0	0	53.0
54.00 55.00		0	19, 284 0	20, 489 0		0	54.0 55.0
56.00		0	1, 483	2, 412	43	0	
57.00		0		25, 976		0	57.0
58.00 59.00		0	936 3, 717			0	58.0 59.0
50. 00		0	7, 828			0	60.0
60. 01		0	0	C	0	0	60.0
61.00			FOF		10	0	61.0 62.0
62.00 63.00		0	585 0		18 0	0	63.0
64.00		0	0	C	0	0	64.0
65.00		0	720	C		0	65.0
66.00 67.00			2, 124 893	464		0	66. 0 67. 0
68.00		0	421	C	13	0	68.0
69.00	06900 ELECTROCARDI OLOGY	0	1, 533		4	0	69.0
70.00		0	1, 533	7, 245	92	0	70.0 71.0
71.00 72.00			0			0	71.0
	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73.0
74.00		0		C	-	0	
75.00	07500 ASC (NON-DI STINCT PART) OUTPATI ENT SERVICE COST CENTERS	0	0	C	0	0	75.0
38. 00		0	0	C	0	0	88. 0
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C		0	89.0
90.00		0	0	C	0	0	90.0
90.01		0	10, 183 1, 560	2, 219	134	0	90.0 90.0
90. 02 90. 03			1, 560	13, 916	-	0	90.0
90.04	09004 MUNCIE CLINIC	0	1, 488	C	0	0	90.0
90.05		0	0	C	0	0	90. 0 90. 0
	09006 PREGNANCY PLUS	0	2, 371	C	0	0	

ST ALLOCATION - STATISTICAL BASIS		Provider C		Peri od:	Worksheet B-1	
				From 01/01/2016 To 12/31/2016		nar
	-	,	,'	1	4/14/2017 8:1	
Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY (MEALS SERVED)	
	REPAI RS (SQUARE FEET)	PLANT (SQUARE FEET)	(POUNDS OF	(HOURS OF SERVICE)	(MEALS SERVED)	
	(000) 112 1221)	(000,	LAUNDRY)			
	6.00	7.00	8.00	9.00	10.00	
07 09007 0/P LAB 08 09008 0/P LAB	0	0		-	-	90
. 09 09009 FORTVILLE CLINIC		1, 191			0	90
. 00 09100 EMERGENCY	0	7, 751		680	-	
. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
. 00 09400 HOME PROGRAM DI ALYSI S . 00 09500 AMBULANCE SERVI CES	0	0				94
. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0			0	96
. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	97
. 00 09900 CMHC	0	0	(c	0 0	0	99
. 10 09910 CORF	0	0	0	0 0	0	
D. OO 10000 I &R SERVICES-NOT APPRVD PRGM 1. OO 10100 HOME HEALTH AGENCY	0	0		-		100
SPECIAL PURPOSE COST CENTERS	0	0	1 <u> </u>	<u> </u>	1 0	10
5. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0 0	0	10
6.00 10600 HEART ACQUI SI TI ON	0	0	0	0 0		106
7.00 10700 LIVER ACQUISITION	0	0	C	0 0		10
8. 00 10800 LUNG ACQUISITION	0	0		0		108
9.00 10900 PANCREAS ACQUISITION 0.00 11000 INTESTINAL ACQUISITION						100
1. 00 11100 I SLET ACQUI SI TI ON		0				11
3. 00 11300 I NTEREST EXPENSE				_		113
4.00 11400 UTILIZATION REVIEW-SNF						114
5.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	C			115
6.00 11600 HOSPI CE	0	0		0		116
8. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0	202, 839	716, 506	5 7, 186	118, 897	1118
0.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1, 206	0	0 0	0	190
0.01 19001 WELLNESS CENTERS	0	1, 227	c	58	0	190
0.02 19002 EMPLOYED ORTHO MD	0	0	C	0 0		190
0. 03 19003 NORTHVI EW CONV. (LTC)	0	0		0		190
0. 04 19004 SUMMI T_CONV. (LTC) 0. 05 19005 PARKVI EW_CONV. (LTC)						190 190
0. 06 19006 MONTI CELLO HSE. (ASS' TD LVG.)		0				190
0.07 19007 NH PARK PLACE (LTC)	0	0	0	0 0		190
0.08 19008 MADISON PLACE OF ELWOOD (LTC)	0	0	C	0 0		190
0. 09 19009 SPI NE SURGEON	0	0	0	0		190
0. 10 19010 CLINI CAL RESEARCH CENTER 0. 11 19011 ONCOLOGI ST		2,072				190 190
0. 12 19012 MEDICAL INTERNIST		0				190
D. 13 19013 RHEUMATOLOGY	0	0	0	0 0		190
0.14 19014 ROCK STEADY BOXING	0	1, 007	(c	0 0	0	190
1.00 19100 RESEARCH	0	0	C	-		19
2. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	18, 549				192
2. 01 19201 MUNCLE MD OFFLCES 2. 02 19202 FOUNDATION		5, 745 187		-		192 192
2. 03 19203 SP0E		0		-		19:
2. 04 19204 HEALTHY HEART	0	0				19
2. 05 19205 VACANT SPACE	0	607			0	19:
2. 07 19207 PARK PLACE CENTER	0	0	(0		192
2. 08 19208 RENTAL PROPERTY - 1924 MADI SON	0	1, 456	C	0 0	0	192
0.00 Cross Foot Adjustments 1.00 Negative Cost Centers						200 20 ⁷
2.00 Cost to be allocated (per Wkst. B,	C	9, 922, 350	470, 894	3, 096, 030	2, 750, 289	
Part I)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		2,0,0,000	2,700,207	[⁻
3.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000					
4.00 Cost to be allocated (per Wkst. B,	0	818, 277	70, 609	9 179, 491	310, 231	204
Part II)	0,000000	2 402507	0.000417	24 771044	2 600240	201
5.00 Unit cost multiplier (Wkst. B, Part	0. 000000	3. 483586	0. 098416	24.771046	2. 609242	1205

	Financial Systems LLOCATION - STATISTICAL BASIS	COMMUNI TY HOSP	Provi der CC	CN: 15-0113	Period:	u of Form CMS-2 Worksheet B-1	
					From 01/01/2016 To 12/31/2016	Date/Time Pre 4/14/2017 8:1	
	Cost Center Description	CAFETERIA (MAN HOURS)	NURSI NG ADMI NI STRATI ON (DI RECT NURS.	CENTRAL SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			HRS.)	REQUIS.)			
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	16.00	
$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 16. \ 00\\ 17. \ 00\\ 19. \ 00\\ 20. \ 00\\ 21. \ 00\\ 22. \ 00\\ 23. \ 00\\ \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERI A 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I& SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM-(EMS)	1, 512, 753 23, 822 64, 281 43, 468 47, 319 C C C C C C C C C C C C C C C C C C C	697, 407 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29, 726, 23 96, 65 3, 38	54 5, 878, 737	34, 950 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ \end{array}$
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	443, 137	443, 137	1, 273, 02	29 32	3, 750	30.00
31. 00 32. 00 33. 00 34. 00 40. 00 41. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T 03300 BURN I NTENSI VE CARE UNI T 03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	67, 337 C C C C C C C		357, 67			31.00 32.00 33.00 34.00 40.00 41.00
42.00 43.00 44.00 45.00 46.00	04200 SUBPROVI DER 04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY 04500 NURSI NG FACI LI TY 04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	C 31, 458 C C C	0		0 0 0 0 0 0 0 0 0 0	0 0 0 0	42.00 43.00 44.00 45.00 46.00
50.00 51.00 52.00	ANCI LLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	155, 475 C		4, 225, 24	47 O O O O O	2, 700 0 0	50.00 51.00 52.00
53.00 54.00 55.00 56.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	9, 388 73, 363 0 6, 378	0 0 0	95 47, 88 6, 4	59 39, 225 32 806 0 0 10 8	0 1, 150 0 0	53.00 54.00 55.00 56.00
58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 BLOOD LABORATORY	12, 068 9, 654 24, 817 85, 557	- 0 0 0	76, 14 3, 96 68, 19 78, 42	59 56 91 0		57.00 58.00 59.00 60.00 60.01
61.00 62.00 63.00 64.00	06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	6, 275 C C 31, 661	0	82 10, 2	0 0 0 0	0 0 0 0	61.00 62.00 63.00 64.00 65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	53, 587 53, 587 8, 672 6, 296 13, 986		6, 92 10	29 95 01 0 39 0	0 0 0 0	66.00 67.00 68.00 69.00
71.00 72.00 73.00 74.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 0UTPATIENT SERVICE COST CENTERS	19, 105 C C C C C C C	1	5, 6 11, 331, 34 11, 334, 05 3, 44	43 0 59 0 0 5, 822, 394	0 0 0 0 0 0	70.00 71.00 72.00 73.00 74.00 75.00
90. 01 90. 02 90. 03	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	C C 10, 269 C 60, 458	0	144, 18 182, 73 1, 16	0 0 36 354 74 0	0 0 14, 400 0 0 0	88.00 89.00 90.00 90.01 90.02 90.03 90.03 90.04 90.05

Cost Center Description CAFETERIA (MAN HOURS) NURSING ADMINISTRATION (DI RECT NURS.) CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) PHARMACY MEDICAS RECUIS.) 90.06 09006 PREGNANCY PLUS 0 0 11.00 13.00 14.00 15.00 16.00 90.06 09006 PREGNANCY PLUS 0 0 0 11.00 13.00 144.00 15.00 16.00 90.08 09008 0/P LAB 0	e Prepared: 7 8:18 am L & Y ENT) 0 90.06 0 90.07 0 90.08 0 90.09 9.600 91.00 92.00 0 94.00 0 95.00 0 96.00 0 97.00
Cost Center Description CAFETERIA (MAN HOURS) NURSI NG ADMI NI STRATI ON (IN RECUIS.) CENTRAL SERVI CES & SUPPLY (COSTED HRS.) PHARMACY (COSTED REQUIS.) PHARMACY (COSTED REQUIS.) PHARMACY (COSTED REQUIS.) 90.06 09006 PREGNANCY PLUS 0 0 11.00 13.00 14.00 15.00 16.00 90.06 09006 PREGNANCY PLUS 0 </td <td>7 8: 18 am k % ENT) 0 90. 06 0 90. 07 0 90. 08 0 90. 09 90. 00 91. 00 92. 00 0 94. 00 0 95. 00 0 96. 00 0 97. 00</td>	7 8: 18 am k % ENT) 0 90. 06 0 90. 07 0 90. 08 0 90. 09 90. 00 91. 00 92. 00 0 94. 00 0 95. 00 0 96. 00 0 97. 00
Cost Center Description CAFETERIA (MAN HOURS) NURSING ADMINISTRATION (DI RECT NURS. HRS.) CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) PHARMACY (COSTED REQUIS.) MEDICA RECORDS LIBRAR (TI ME SPE 90.06 09006 PREGNANCY PLUS 0 11.00 13.00 14.00 15.00 16.00 90.07 09007 0/P LAB 0 0 0 0 0 90.08 09008 0/P LAB 0 0 0 0 0 90.09 90009 FORTVI LLE CLINIC 0 0 0 0 0 0 91.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 103, 815 0 445, 067 67 59 92.00 092000 OBSERVATION BEDS (NON-DI STINCT PART) 0	L & Y ENT) 0 90.06 0 90.07 0 90.08 0 90.09 9.600 91.00 92.00 0 94.00 0 95.00 0 96.00 0 97.00
Image: Problem in the second	Y NT)
Image: Problem in the system in the	ENT) 0 90.06 0 90.07 0 90.08 0 90.09 9.600 91.00 92.00 0 94.00 0 95.00 0 96.00 0 97.00
Image: Normal State State Image: State State Image: State State Image: State	0 90.06 0 90.07 0 90.07 0 90.08 0 90.09 9.600 91.00 92.00 0 94.00 0 95.00 0 96.00 0 97.00
90. 06 09006 PREGNANCY PLUS 0 111 0 90. 07 09007 0/P LAB 0	0 90.06 0 90.07 0 90.08 0 90.09 9,600 91.00 92.00 0 94.00 0 95.00 0 96.00 0 97.00
90.07 09007 0/P LAB 0 <	0 90.07 0 90.08 0 90.09 9,600 91.00 92.00 0 94.00 0 95.00 0 96.00 0 97.00
90.08 09008 0/P LAB 0	0 90.08 0 90.09 9,600 91.00 92.00 0 94.00 0 95.00 0 96.00 0 97.00
91.00 09100 EMERGENCY 103,815 0 445,067 67 92 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0	9, 600 91.00 92.00 0 94.00 95.00 0 96.00 97.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REI MBURSABLE COST CENTERS 94.00 O9400 HOME PROGRAM DI ALYSI S O O O 95.00 O9500 AMBULANCE SERVICES O O O O 96.00 O9600 DURABLE MEDI CAL EQUI P-RENTED O O O O 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD O O O 99.00 O9900 CMHC O O O	92.00 0 94.00 0 95.00 0 96.00 0 97.00
OTHER REI MBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DI ALYSI S 0 0 0 95.00 09500 AMBULANCE SERVI CES 0 0 0 0 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 99.00 09900 CMHC 0 0 0 0 0	0 94.00 0 95.00 0 96.00 0 97.00
95.00 09500 AMBULANCE SERVICES 0 0 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 99.00 09900 CMHC 0 0 0 0	0 95.00 0 96.00 0 97.00
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0<	0 96.00 0 97.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 <th< td=""><td>0 97.00</td></th<>	0 97.00
99. 00 09900 CMHC 0 0 0	
	0 99.00
	0 99.10
100.00 0 0 0 0 0 0 101.00 HOME HEALTH AGENCY 0 0 0 0 0	0 100.00
SPECIAL PURPOSE COST CENTERS	
105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0	0 105. 00
106.00 HEART ACQUISITION 0	0 106.00 0 107.00
108. 00 10800 LUNG ACQUI SI TI ON	0 108.00
109. 00 10900 PANCREAS ACQUISITION 0 0 0	0 109.00
110.00 11000 I NTESTI NAL ACQUI SI TI ON 0 0 0 0	0 110.00
111. 00 11100 I SLET ACQUI SI TI ON 0 0 0 0 113. 00 11300 I NTEREST EXPENSE	0 111.00 113.00
114. 00 11400 UTI LI ZATI ON REVIEW-SNF	114.00
115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0	0 115.00
116.00 HOSPI CE 0 0 0 0 118.00 SUBTOTALS (SUM OF LINES 1-117) 1, 419, 983 697, 407 29, 714, 712 5, 863, 514 31	0 116.00
NONREI MBURSABLE COST CENTERS	, 000 118.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0	0 190. 00
190.01 WELLNESS CENTERS 24, 240 0 760 222 190.02 EMPLOYED ORTHO 0 0 0 0	0 190. 01 0 190. 02
190. 02 19002 EMPLOTED OKTHO MD 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 190. 02
190.04 SUMMIT CONV. (LTC) 5,714 0 0 0	0 190. 04
190. 05 19005 PARKVI EW CONV. (LTC) 8, 368 0 129 0	0 190. 05
190.06 MONTI CELLO HSE. (ASS' TD LVG.) 3, 142 0 0 0 190.07 19007 NH PARK PLACE (LTC) 1, 140 0 0 0	0 190.06
190. 08 19008 MADI SON PLACE OF ELWOOD (LTC) 0 0 0	0 190.08
190. 09 19009 SPI NE_SURGEON 0 0 0	0 190. 09
190.10 CLINICAL RESEARCH CENTER 27,027 0 2,005 0 190.11 19011 0NC0L0GI ST 0 0 0 0 0	0 190. 10 0 190. 11
190. 11/1901 I ONCOLOGI ST 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 190. 12
190.13 THEUMATOLOGY 1, 673 0 0 0	0 190. 13
190. 14 19014 ROCK STEADY BOXING 1, 021 0 0 0	0 190. 14
191.00 RESEARCH 0 0 0 0 192.00 PHYSI CI ANS' PRI VATE OFFI CES 0 0 2, 533 0 33	0 191.00
192. 01 19201 MUNCI E MD OFFICES 0 0 0 0	0 192.01
192. 02 19202 FOUNDATI ON 3, 662 0 0 0	0 192. 02
192. 03 19203 SPOE 0 0 0 0	0 192.03
192.04 19204 HEALTHY HEART 4, 210 0 5, 360 0 192.05 19205 VACANT SPACE 0 0 0 0	0 192.04 0 192.05
192. 07 19207 PARK PLACE CENTER 0 0 0 0	0 192.07
192. 08 19208 RENTAL PROPERTY - 1924 MADI SON 0 0 0	0 192. 08
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	200.00 201.00
	5, 489 202. 00
Part I)	
	51345 203.00
204.00 Cost to be allocated (per Wkst. B, Part II) 53,760 73,962 138,606 99,456 107	7, 311 204. 00
205.00 Unit cost multiplier (Wkst. B, Part 0.035538 0.106053 0.004663 0.016918 3.07	70415 205. 00

	Financial Systems	COMMUNI TY HOSPI		ON 15 0110		eu of Form CMS-	
CUSTA	ALLOCATION - STATISTICAL BASIS		Provider C	1	Period: From 01/01/2016		
					To 12/31/2016	Date/Time Pre 4/14/2017 8:1	
					INTERNS &	RESI DENTS	
	Cast Castas Description						
	Cost Center Description	SOCI AL SERVI CE	ANESTHETI STS	NURSING SCHOU	L SERVI CES-SALAR Y & FRI NGES	PRGM. COSTS	
		(TIME SPENT)	(ASSI GNED	(ASSI GNED	(ASSI GNED	(ASSI GNED	
		17.00	TIME)	TIME)	TIME)	TIME)	
	GENERAL SERVICE COST CENTERS	17.00	19.00	20.00	21.00	22.00	-
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 6.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						5.00 6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00							15.00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	449					16.00 17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	C				19.00
20.00	02000 NURSI NG SCHOOL	0			0		20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0			0		21.00
22.00 23.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM-(EMS)	0				C	22.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	0		1			23.00
30.00	03000 ADULTS & PEDIATRICS	449	C		0 0	-	
31.00 32.00	03100 I NTENSI VE CARE UNI T	0	C		0 0		
32.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	C C				
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	C		0 0	C	
40.00	04000 SUBPROVI DER – I PF	0	C		0 0	C	
41.00	04100 SUBPROVIDER - IRF	0	C		0 0		1
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	0	C C				
44.00	04400 SKILLED NURSING FACILITY	0	C		0 0	C	
45.00	04500 NURSING FACILITY	0	C		0 0		
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	C		0 0	C	46.00
50.00	05000 OPERATING ROOM	0	C)	0 0	C	50.00
51.00	05100 RECOVERY ROOM	0	C		0 0	C	
52.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	C		0 0	C	
53.00 54.00	05300 ANESTHESTOLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	C C		0 0) 53.00) 54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C		0 0	C	
56.00		0	C		0 0	C	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 0		
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C		0 0		
60.00	06000 LABORATORY	0	C		0 0	C	1
60.01	06001 BLOOD LABORATORY	0	C		0 0	C	
61.00 62.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0 0	C	61.00 62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0 0		
64.00		0	C		0 0	C	
65.00	06500 RESPIRATORY THERAPY	0	C		0 0	0	1
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0					
68.00	06800 SPEECH PATHOLOGY	0	C		o o		1
69.00	06900 ELECTROCARDI OLOGY	0	C		0 0	C	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	C		0 0	0	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0					
	07300 DRUGS CHARGED TO PATIENTS	0	C		0 0		1
74.00	07400 RENAL DI ALYSI S	0	C		0 0	C	74.00
75.00	07500 ASC (NON-DI STI NCT PART)	0	C		0 0	C	75.00
88.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	C		0 0	C C	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		o o		
90.00	09000 CLI NI C	0	C		0 0	C	90.00
	09001 WOUND/OSTOMY CLINIC	0	C		0 0	0	
90. 02 90. 03	09002 KIDS PLUS CLINIC 09003 ONCOLOGY	0					
	09004 MUNCI E CLINIC	0	C		0 0	-	90.04

. 05 09 06 09 07 09 00 00	Cost Center Description Cost Center Description ANTICOAGULATION CLINIC Cost Center Description ANTICOAGULATION CLINIC Cool PREGNANCY PLUS COSTON O/P LAB COSTON CONTRACTION COSTON CONTRACTION CONTRACTION BEDS (NON-DISTINCT PART) HER REIMBURSABLE COST CENTERS AMBULANCE SERVICES COSTON DURABLE MEDICAL EQUIP-RENTED CONTRACT CORF CONTRACT CORF CONTRACT	SOCI AL SERVI CE (TI ME SPENT) 17.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Provi der CC NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME) 19.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	F Ti	eri od: rom 01/01/2016 o 12/31/2016 INTERNS & SERVI CES-SALAR Y & FRI NGES (ASSI GNED TI ME) 21.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4/14/2017 8: 18 RESI DENTS
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0. 00 100 1. 00 10 SPI 5. 00 100 6. 00 100 7. 00 100 8. 00 100 9. 00 100 9. 00 100 9. 00 110 1. 00 111 3. 00 111 6. 00 111 6. 00 111 6. 00 119 0. 01 199 0. 02 199 0. 03 199 0. 04 199 0. 04 199 0. 05 1	000 I &R SERVICES-NOT APPRVD PRGM 100 HOME HEALTH AGENCY ECIAL PURPOSE COST CENTERS 500 KIDNEY ACQUISITION 600 HEART ACQUISITION 700 LIVER ACQUISITION 800 LUNG ACQUISITION 900 PANCREAS ACQUISITION 900 INTESTINAL ACQUISITION 100 I SLET ACQUISITION 100 INTEREST EXPENSE		0	0	0	
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5.00 10 6.00 10 7.00 10 8.00 10 9.00 10 9.00 10 0.00 11 1.00 11 3.00 11 4.00 11 5.00 11 6.00 11 0.00 19 0.01 19 0.03 19 0.0	500 KIDNEY ACQUISITION 600 HEART ACQUISITION 700 LIVER ACQUISITION 800 LUNG ACQUISITION 900 PANCREAS ACQUISITION 900 INTESTINAL ACQUISITION 100 ISLET ACQUISITION 300 INTEREST EXPENSE					0 1 0 1 0 1 0 1
6.00 10. 7.00 10 8.00 10. 9.00 10. 1.00 11. 3.00 11. 5.00 11. 5.00 11. 6.00 11. 8.00 11. 0.00 19. 0.01 19. 0.02 19. 0.03 19. 0.04 19. 0.05 19	600 HEART ACQUISITION 700 LIVER ACQUISITION 800 LUNG ACQUISITION 900 PANCREAS ACQUISITION 000 INTESTINAL ACQUISITION 100 ISLET ACQUISITION 300 INTEREST EXPENSE					0 1 0 1 0 1 0 1
7. 00 10 8. 00 10 9. 00 10 0. 00 11 1. 00 11 3. 00 11 5. 00 11 5. 00 11 6. 00 11 8. 00 NOI 0. 01 19 0. 02 19 0. 03 19 0. 03 19 0. 04 19	700 LIVER ACQUISITION 800 LUNG ACQUISITION 900 PANCREAS ACQUISITION 000 INTESTINAL ACQUISITION 100 ISLET ACQUISITION 300 INTEREST EXPENSE		0 0 0 0 0	0 0 0 0 0	000000000000000000000000000000000000000	0 1 0 1 0 1
8. 00 100 9. 00 10 0. 00 11 1. 00 11 3. 00 11 4. 00 11 6. 00 11 6. 00 11 8. 00 NOI 0. 01 19 0. 02 19 0. 03 19 0. 03 19 0. 03 19	800 LUNG ACQUISITION 900 PANCREAS ACQUISITION 000 INTESTINAL ACQUISITION 100 ISLET ACQUISITION 300 INTEREST EXPENSE	000000000000000000000000000000000000000	0 0 0 0	0 0 0 0	0	0 1 0 1
9. 00 10° 0. 00 111° 1. 00 111° 3. 00 11° 4. 00 11° 5. 00 11° 6. 00 11° 8. 00 0. 00 19° 0. 01 19° 0. 02 19° 0. 02 19° 0. 03 19° 0. 03 19° 0. 04 19°	900 PANCREAS ACQUISITION 000 INTESTINAL ACQUISITION 100 ISLET ACQUISITION 300 INTEREST EXPENSE	0	0	0	0	0 1
0. 00 111 1. 00 111 3. 00 111 4. 00 111 5. 00 111 6. 00 111 8. 00 NOI 0. 00 199 0. 03 199 0. 04 199	000 INTESTINAL ACQUISITION 100 ISLET ACQUISITION 300 INTEREST EXPENSE	0	0	0		
3. 00 111 4. 00 111 5. 00 111 6. 00 111 8. 00 0. 00 199 0. 01 199 0. 02 199 0. 03 199 0. 04 199	300 INTEREST EXPENSE	0	0		0	
4. 00 111 5. 00 111 6. 00 111 8. 00 0. 00 199 0. 01 199 0. 02 199 0. 03 199 0. 04 199				0	0	0 1
5.00111 6.00111 8.00 0.00199 0.01199 0.02199 0.02199 0.03199 0.04199						1
6.00111 8.00 NOI 0.00199 0.01199 0.02199 0.02199 0.03199	400 UTILIZATION REVIEW-SNF 500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	01
8.00 NOI 0.00 199 0.01 199 0.02 199 0.03 199 0.04 199	600 HOSPI CE	0	0	0	0	01
0.0019 0.0119 0.0219 0.0319 0.0319	SUBTOTALS (SUM OF LINES 1-117)	449	0	0	0	0 1
0. 01 19 0. 02 19 0. 03 19 0. 03 19	NREIMBURSABLE COST CENTERS					
0. 02 19 0. 03 19 0. 04 19	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	01
0. 03 19 0. 04 19	001 WELLNESS CENTERS 002 EMPLOYED ORTHO MD	0	0	0	0	01
0.04 19	003 NORTHVI EW CONV. (LTC)	0	0	0	0	0 1
0 05 19	004 SUMMIT CONV. (LTC)	0	0	0	0	0 1
0.0017	005 PARKVIEW CONV. (LTC)	0	0	0	0	0 1
	006 MONTI CELLO HSE. (ASS' TD LVG.)	0	0	0	0	01
	007 NH PARK PLACE (LTC) 008 MADISON PLACE OF ELWOOD (LTC)	0	0	0	0	01
1	009 SPINE SURGEON		0	0	0	01
	010 CLINICAL RESEARCH CENTER	0	0	0	0	01
	011 ONCOLOGI ST	0	0	0	0	0 1
	012 MEDI CAL I NTERNI ST	0	0	0	0	01
	013 RHEUMATOLOGY 014 ROCK STEADY BOXING	0	0	0	0	01
	100 RESEARCH	0	0	0	0	01
	200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	01
2.01 19	201 MUNCIE MD OFFICES	0	0	0	0	0 1
	202 FOUNDATION	0	0	0	0	0 1
	203 SPOE	0	0	0	0	01
	204 HEALTHY HEART 205 VACANT SPACE		0	0	0	01
	205 VACANT SPACE 207 PARK PLACE CENTER	0	0	0	0	01
	208 RENTAL PROPERTY - 1924 MADI SON	0	0	0	0	0 1
0.00	Cross Foot Adjustments					2
1.00	Negative Cost Centers					2
2.00	Cost to be allocated (per Wkst. B,	0	0	0	0	0 2
3.00	Part I) Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0.00000	0. 000000	0. 000000 2
4.00		0.00000	0.00000	0.00000	0.00000	0.0000002
		J S	Ĭ	j j	Ŭ	
5.00	Cost to be allocated (per Wkst. B, Part II)					0. 000000 2

-	Financial Systems ALLOCATION - STATISTICAL BASIS	COMMUNI TY HOSPI T	Provider CCN: 15-0113	Peri od:	u of Form CMS-2552-1 Worksheet B-1
				From 01/01/2016 To 12/31/2016	Date/Time Prepared:
	Cost Center Description	PARAMED ED			4/14/2017 8:18 am
		PRGM-(EMS)			
		(ASSI GNED			
		TI ME) 23.00			
	GENERAL SERVICE COST CENTERS	20.00			
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.0
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2.0
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL				4. 0 5. 0
6.00	00600 MAINTENANCE & REPAIRS				6.0
7.00	00700 OPERATION OF PLANT				7.0
8.00	00800 LAUNDRY & LINEN SERVICE				8.0
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY				9.0 10.0
11.00	01100 CAFETERI A				11.0
13.00	01300 NURSING ADMINISTRATION				13. 0
14.00	01400 CENTRAL SERVICES & SUPPLY				14.0
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY				15. 0 16. 0
17.00	01700 SOCIAL SERVICE				17.0
	01900 NONPHYSI CI AN ANESTHETI STS				19.0
20.00	02000 NURSI NG SCHOOL				20.0
21.00 22.00					21.0
22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM-(EMS)	0			22. 0 23. 0
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				20.0
30.00	03000 ADULTS & PEDIATRICS	0			30. 0
31.00	03100 I NTENSI VE CARE UNI T	0			31.0
32.00 33.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0			32. 0 33. 0
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0			34.0
40.00	04000 SUBPROVIDER - IPF	0			40. 0
41.00	04100 SUBPROVI DER – I RF	0			41.0
42.00		0			42.0
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	0			43. 0 44. 0
45.00	04500 NURSING FACILITY	0			45.0
46.00	04600 OTHER LONG TERM CARE	0			46.0
F0.00	ANCI LLARY SERVI CE COST CENTERS	0			FO 0
50.00 51.00	05100 RECOVERY ROOM	0			50. 0 51. 0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			52.0
53.00	05300 ANESTHESI OLOGY	0			53.0
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0			54.0
	05500 RADI OLOGY - THERAPEOTIC	0			55. 0 56. 0
	05700 CT SCAN	0			57.0
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0			58. 0
	05900 CARDI AC CATHETERI ZATI ON	0			59.0
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0			60. 0 60. 0
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				61.0
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			62.0
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0			63.0
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0			64. 0 65. 0
	06600 PHYSI CAL THERAPY	0			66. 0
67.00		0			67.0
	06800 SPEECH PATHOLOGY	0			68.0
		0			69.0
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				70. 0 71. 0
	07200 I MPL. DEV. CHARGED TO PATIENTS	0			72.0
73.00	07300 DRUGS CHARGED TO PATIENTS	0			73.0
	07400 RENAL DI ALYSI S	0			74.0
/5.00	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0			75.0
88.00	08800 RURAL HEALTH CLINIC	0			88. 0
89.00		0			89.0
90.00	09000 CLINIC	0			90. 0
	09001 WOUND/OSTOMY CLINIC	0			90.0
90.02	09002 KI DS PLUS CLI NI C 09003 ONCOLOGY	0			90. 0 90. 0
	09004 MUNCIE CLINIC	0			90.0
90.05	09005 ANTI COAGULATI ON CLINIC	0			90.0
	09006 PREGNANCY PLUS				90.0

	Financial Systems LLOCATION - STATISTICAL BASIS	COMMUNITY HOSPIT	Provider CCN: 15-0113	Period: Workshe	m CMS-2552-10 2et B-1
0031 7	LEUCATION - STATISTICAL DASIS			From 01/01/2016 To 12/31/2016 Date/Ti	me Prepared:
	Cost Center Description	PARAMED ED PRGM- (EMS) (ASSI GNED TI ME) 23.00		4/14/20)17 8:18 am
90.07	09007 0/P LAB	23.00			90.07
90.08	09008 0/P LAB	0			90.08
90.09	09009 FORTVILLE CLINIC	0			90.09
	09100 EMERGENCY	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				92.00
94.00	09400 HOME PROGRAM DI ALYSI S	0			94.00
95.00	09500 AMBULANCE SERVI CES	0			95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0			96.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0			97.00
	09900 CMHC 09910 CORF	0			99.00 99.10
	10000 I &R SERVICES-NOT APPRVD PRGM	0			100.00
	10100 HOME HEALTH AGENCY	0			101.00
405 00	SPECIAL PURPOSE COST CENTERS				105.00
	10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION	0			105.00 106.00
	10700 LIVER ACQUISITION	0			107.00
	10800 LUNG ACQUISITION	0			108.00
	10900 PANCREAS ACQUISITION	0			109.00
	11000 I NTESTI NAL ACQUI SI TI ON	0			110.00
	11100 I SLET ACQUI SI TI ON 11300 I NTEREST EXPENSE	0			111.00 113.00
	11400 UTILIZATION REVIEW-SNF				114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0			115.00
116.00	11600 HOSPI CE	0			116.00
118.00		0			118.00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190.00
	19001 WELLNESS CENTERS	0			190.00
	19002 EMPLOYED ORTHO MD	0			190. 02
	19003 NORTHVIEW CONV. (LTC)	0			190. 03
	19004 SUMMIT CONV. (LTC)	0			190. 04 190. 05
	19005 PARKVIEW CONV. (LTC) 19006 MONTICELLO HSE. (ASS'TD LVG.)	0			190.05
	19007 NH PARK PLACE (LTC)	0			190.07
	19008 MADISON PLACE OF ELWOOD (LTC)	0			190. 08
	19009 SPINE SURGEON	0			190.09
	19010 CLI NI CAL RESEARCH CENTER 19011 ONCOLOGI ST	0			190. 10 190. 11
	19012 MEDICAL INTERNIST	0			190.12
	19013 RHEUMATOLOGY	0			190. 13
	19014 ROCK STEADY BOXING	0			190.14
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0			191.00 192.00
192.00	19201 MUNCIE MD OFFICES	0			192.00
	19202 FOUNDATION	0			192.02
192.03	19203 SPOE	0			192.03
	19204 HEALTHY HEART	0			192.04
	19205 VACANT SPACE 19207 PARK PLACE CENTER	0			192.05 192.07
	19207 PARK PLACE CENTER 19208 RENTAL PROPERTY - 1924 MADISON	0			192.07
200.00					200.00
201.00	Negative Cost Centers				201.00
202.00		0			202.00
203.00	Part I) Unit cost multiplier (Wkst. B, Part I)	0. 000000			203.00
		0			203.00
204.00	1 I I I I I I I I I I I I I I I I I I I	-			
	Part II)				
204.00 205.00		0. 000000			205.00

Cost Center Description Total Cost (Train West 1) (Train West 1) (Sol.) Total Cost (Train West 1) (Sol.) Total Cost (Sol.) Total Cost (Sol.) <thtotal cost<br="">(S</thtotal>		Financial Systems ATION OF RATIO OF COSTS TO CHARGES	COMMUNI TY HOSP	ITAL ANDERSON Provider C	F	In Lie Period: Trom 01/01/2016 To 12/31/2016		pared:
Total Cost: Total Cost: Total Cost: Total Cost: Total Cost: Total Cost: 000 200 2.00 2.00 2.00 4.00 4.00 000 00000 4.00 2.00 3.00 4.00 6.00 000 00000 4.00 4.00 6.00 4.00 6.00 000000 00000 4.00 0 0.00				Title	2 XVIII	Hospi tal		<u>8 am</u>
Image: state of the second s								
MANTI ENT ROUTINE SAMPLIATING 31, 373, 386		Cost Center Description	(from Wkst. B, Part I, col.		Total Costs		Total Costs	
30.00 30.00 AUULTS & FED ATRICS 91,373,356 91,373,356 91,373,356 91,373,356 90,00 30.00 30.00 SUBAL MERSINE CARE UNIT 4,880,452 4,880,452 4,880,453 91,373,356 90,00 93,00 94,00 96,00 96,00 96,00			1.00	2.00	3.00	4.00	5.00	
31 00 0 D3100 (DRINEN VIC CARE LWI IT 4, BBD, 435 1, BDD, 445 1,	20.00		21 272 254	1	21 272 254		21 272 254	20.00
32.00 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 02000 0200 0200								
31.00 BOSON BLARN INTERSIVE CARE UNIT 0			4,000,400					
40.00 00000 SUBPROVIDER - IPF 0<			C		0	0		
11 00 0 0 0 0 0 0 10 12 00 044000 NURSERY Explore 2,213,264 2,213,264 2,213,264 42.00 14 00 044000 NURSERY Explore 0 0 0 44.00 14 00 044000 NURSERY Explore 0 0 0 0 0 44.00 14 00 044000 NURSERY Explore 0	34.00	03400 SURGI CAL INTENSI VE CARE UNI T	C		0	0	0	34.00
42.00 04200 SUBPROVIDER 0			C		0	0		1
43. 00 00 4300 NURSERY 2.213.264 2.213.264 0 2.213.264 42.00 43. 00 04500 NURSENC 2.213.264 0 0 2.213.264 0 2.213.264 42.00 45. 00 04500 00 0						0		1
44.00 04+00 SKILLEEN MIRSIN & FACILITY 0 0 0 0 0 0 44.00 65.00 46.00 0			2 213 264		2 213 264	. 0		1
45. 00 04500 WREST LAS FACLE LTY 0			2, 210, 201		0	0		1
MACLILARY SERVICE COST CENTERS 1 51.00 065000 (PERATING ROOM 13, 632, 311 0 13, 632, 311 0	45.00		C		0	0	0	45.00
90. 00 00000 0PEAR1 IN & ROOM 13, 632, 311 0 13, 633, 613 0	46.00		C		0	0	0	46.00
51.00 65100 FECUVERY ROM 0 0 0 51.00 0520	E0 00		12 422 211		12 422 211	0	12 422 211	50.00
52. 00 05200 DELVERY NOM & LABOR ROW 0 0 0 0 52. 00 05300								1
53. 00 05300 AMESTHESI OLGXY 445, 549 465, 549 0 446, 549 0 646, 549 0 65, 500 660, 778 0 6, 862, 778 0 6, 862, 778 0 6, 862, 778 0 6, 862, 778 0 6, 862, 778 0 6, 862, 778 0 6, 862, 778 0 6, 862, 778 0 6, 862, 778 0 6, 862, 778 0 6, 862, 778 0 6, 862, 778 0 6, 862, 778 0 6, 862, 778 0 6, 862, 778 0 76, 00 0 <th< td=""><td></td><td></td><td>C</td><td></td><td>0</td><td>0</td><td>-</td><td>•</td></th<>			C		0	0	-	•
55. 00 05500 RADI CLOV-THERAPEUTIC 0 0 0 55. 00 05500 RADI CLOV-THERAPEUTIC 0 0 55. 00 05500 RADI CLOV-THERAPEUTIC 0 0 0 55. 00 0 05500 RADI CLOV-THERAPEUTIC 0 <th< td=""><td>53.00</td><td>05300 ANESTHESI OLOGY</td><td>465, 549</td><td></td><td>465, 549</td><td>0</td><td>465, 549</td><td>53.00</td></th<>	53.00	05300 ANESTHESI OLOGY	465, 549		465, 549	0	465, 549	53.00
56.00 6600 [RADI I STOPE 1,008,910 1,008,910 6 1,008,910 56.00 57.00 56.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 57.00 50.00 50.00 50.00 50.00 50.00 5			6, 862, 778					
57. 00 657.00 657.00 657.00 657.00 657.00 657.00 657.00 657.00 657.00 657.00 657.00 657.00 657.00 657.00 657.00 657.00 657.00 657.00 66.01 66.01 66.01 66.01 66.01 66.01 66.01 66.01 66.01 66.01 66.01 66.00 66.00 66.00 66.00 66.01 66.			1 000 010		, o	0	-	
58. 00 05800 (MAGHETIC RESONANCE LIMAEI NG (MR1) 1, 034, 637 1, 034, 637 0 1, 034, 637 2, 003, 272 2, 003, 272 2, 003, 272 2, 003, 272 5, 00 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1</td>								1
59.0 0 5900 (CARDIAC CATHETERI ZATION 2,003,272 2,003,272 0 2,003,272 0 2,003,272 0 2,003,272 0 0,001 0								
60.01 bc00 BLOD LAB SERVICES-PREM ONL 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
61.00 66100 PRP CLINICAL LAB SERVICES-PREX NONLY 0 0 0 0 </td <td></td> <td></td> <td>6, 460, 757</td> <td></td> <td>6, 460, 757</td> <td>0</td> <td>6, 460, 757</td> <td></td>			6, 460, 757		6, 460, 757	0	6, 460, 757	
62.00 b6200 WHOLE BLOOD & PACKED RED BLOOD CELLS 410,283 410,283 cl 0			C		0	0	-	
63. 00 000500 PLODE STORING, PROCESSING & TRANS. 0 <td></td> <td></td> <td>410 292</td> <td></td> <td>410 292</td> <td>0</td> <td></td> <td></td>			410 292		410 292	0		
64.00 00 0 <td></td> <td></td> <td>410, 203</td> <td></td> <td>410, 283</td> <td>0</td> <td></td> <td>1</td>			410, 203		410, 283	0		1
66.00 06600 PHYSICAL THERAPY 3.386,082 0 3.386,082 0 8.336,082 0 66.449 0 66.6449 0 66.743 0 987.778 69.00 987.778 69.00 987.778 69.00 14.874.950 0 14.874.950 0 14.874.950 0 14.874.950 0 14.874.950 0 336.613 0 336.613 0 336.613 0 336.613 0 336.613 0 336.613 0 0 0			C		0	0	-	
67. 00 067.00 0CUPATIONAL THERAPY 666, 449 0 666, 449 0 666, 449 0 666, 449 0 666, 449 67. 00 69. 00 06900 FLECT PROCARDIOLOGY 987, 778 970, 778 987, 778 970, 778 987, 778 971, 781 990, 714, 4874, 950 14, 874, 950	65.00		1, 669, 041	0	1, 669, 041	0	1, 669, 041	65.00
68. 00 06800 SPEECH PATHOLOGY 405, 493 0 405, 493 0 405, 493 0 405, 493 0 405, 493 0 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 778 0 987. 778 0 987. 778 0 987. 778 0 987. 778 0 987. 778 0 1344, 443 1.344, 443 1.344, 443 0.1344, 453 70. 00 71. 00 14, 878, 190 14, 878, 190 14, 878, 190 14, 878, 190 14, 878, 190 14, 878, 190 14, 878, 190 14, 878, 190 14, 878, 190 14, 878, 190 14, 878, 190 14, 878, 190 14, 878, 190 14, 878, 190 14, 878, 190 14, 878, 190 13, 336, 613 0 336, 613 0 336, 613 0 336, 613 0 336, 613 0								1
69.00 06900 ELECTROCARD OLOGY 987,778 977,78								1
70.00 07000 ELECTROENCEPHALOGRAPHY 1,344,443 1,344,443 0 1,344,443 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 14,878,190 14,878,190 14,878,190 14,878,190 71.00								
72.00 072.00 IMPL DEV. CHARGED TO PATIENTS 14, 878, 190 0 14, 878, 190 10, 577, 414 0 10, 577, 414 0 10, 577, 414 0 0, 336, 613 0 336, 613 0 336, 613 0 336, 613 0 336, 613 0 336, 613 0 336, 613 0 336, 613 0 336, 613 0 336, 613 0 336, 613 0 336, 613 0 336, 613 0								
73.00 DRUGS CHARGED TO PATIENTS 10, 577, 414 10, 577, 414 0 10, 577, 414 73.00 74.00 O7600 RENAL DIAYSIS 336, 613 0 336, 613 0 336, 613 0 336, 613 0 0 336, 613 0 0 336, 613 0 <								
74.00 0 07400 RENAL DIALYSIS 336, 613 0 336, 613 0 336, 613 74.00 75.00 0								
75.00 0750 ASC (NON-DISTINCT PART) 0 0 0 75.00 0UTPATI ENT SERVICE COST CENTERS 0 0 0 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 89.00 00.00 09000 CLINIC 0<								
OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 90.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 90.00 90.00 0								
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 </td <td>/0/00</td> <td></td> <td></td> <td>1</td> <td></td> <td></td> <td></td> <td>10100</td>	/0/00			1				10100
90.00 09000 CLINIC 0 0 0 0 90.00 90.01 09001 VUND/OSTOWY CLINIC 2, 489, 019 2, 489, 019 0 2, 489, 019 0 2, 489, 019 0 2, 489, 019 0 2, 489, 019 0 0 90.01 90.02 90.02 124, 412 124, 412 124, 412 124, 412 0 124, 413 0 493, 183 0 493, 183 0 493, 183 0 590.06 9005 NTCOAGULATI ON CLINIC 493, 183 493, 183 0 493, 183 0 590.06 9005 90.06 9006 9006 9006 9006 9007 0 139, 207 0 139, 207 90.06 90.07 90			C		0	0	-	
90.01 09001 WOUND/OSTOMY CLINIC 2,489,019 2,489,019 0 2,489,019 90.01 90.02 09002 KIDS PLUS CLINIC 96,218 96,218 0 96,218 0 00.02 90.03 0NCOLOGY 0 0 0 0 0 90.03 90.04 09004 MUNCI E CLINIC 124,412 124,412 0 124,412 90.04 90.05 09005 ANTI COAGULATI ON CLINIC 493,183 493,183 0 433,183 0 433,183 0 0.05 90.06 09006 PRECNANCY PLUS 139,207 0			C		0	0	-	1
90. 02 09002 KLDS PLUS CLINIC 96,218 96,218 96,218 96,218 90.02 90. 03 09003 0NCOLOGY 0<			2 490 010		2 490 010	0	-	
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90.05 09005 ANTI COAGULATI ON CLINIC 493, 183 493, 183 0 493, 183 90.05 90.06 09006 PREGNANCY PLUS 139, 207 0 139, 207 0								
90.06 09006 PREGNANCY PLUS 139,207 139,207 0 139,207 0								
90.07 09007 0/P LAB 0								1
90.08 09008 0/P LAB 0 0 0 90.08 90.08 90.09 FORTVILLE CLINIC 74,416 74,416 74,416 0 74,416 90.09 90.09 90.09 FORTVILLE CLINIC 74,416 74,416 74,416 90.09 90.08 90.09 90.08 90.09 FORTVILLE CLINIC 74,416 90.09 7,353,411 7,353,411 0 7,353,411 91.00 92.00 ØSERVATION BEDS (NON-DISTINCT PART) 3,146,235 3,146,235 3,146,235 3,146,235 0 3,146,235 0 94.00 94.00 94.00 94.00 94.00 94.00 95.00 95.00 96.00 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 94.00 95.00 96.00 96.00 97.00 9			139, 207		139, 207	0		1
90.09 09009 FORTVILLE CLINIC 74,416 74,416 74,416 0 74,416 90.09 91.00 09100 EMERGENCY 7,353,411 0 7,353,411 0 7,353,411 0 7,353,411 91.00 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART) 3,146,235 3,146,235 3,146,235 92.00 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 96.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 100.00 100.00 100.00 101.00 10						0	-	1
92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 3, 146, 235 3, 146, 235 92.00 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 94.00 94.00 94.00 95.00 0 0 0 94.00 95.00 0 0 0 0 94.00 95.00 95.00 0 0 0 95.00 95.00 0 0 0 0 95.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 99.00 99.10 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 101.0			74, 416		74, 416	0	-	1
OTHER REI MBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 94.00 95.00 09500 AMBULANCE SERVI CES 0 0 0 0 95.00 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 95.00 97.00 09700 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 97.00 97.00 09700 CMHC 0 0 0 97.00 97.00 99.00 09900 CMHC 0 0 0 99.00 99.10 09910 CORF 0 0 0 100.00 100.00 10000 I & R SERVI CES-NOT APPRVD PRGM 0 0 0 100.00 101.00 HOME HEALTH AGENCY 0 0 0 101.00 101.00 IOTOO IASENT ACQUI SI TI ON								1
94.00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 94.00 95.00 09500 AMBULANCE SERVICES 0 0 0 0 95.00 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 96.00 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 97.00 99.00 09900 CMHC 0 0 0 0 0 99.00 99.10 09910 CORF 0 0 0 0 0 99.10 100.00 10000 I&R SERVI CES-NOT APPRVD PRGM 0 0 0 100.00 100.00 101.00 101.00 0 101.00 0 101.00 0 101.00 0 0 0 0 0 101.00 101.00 101.00 0 0 0 0 101.00 101.00 101.00 0 0 101.00 101.00 101.00 101.00 101.00 101.00 101.00 0 0 101.00	92.00		3, 146, 235		3, 146, 235		3, 146, 235	92.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 97.00 99.00 09900 CMHC 0 0 0 0 99.00 99.10 09910 CORF 0 0 0 0 99.10 100.00 1000 I & R SERVICES-NOT APPRVD PRGM 0 0 0 100.00 101.00 HOME HEALTH AGENCY 0 0 0 101.00 101.00 101.00 100.00 101.00 101.00 101.00 101.00 101.00 0 0 101.00		09400 HOME PROGRAM DI ALYSI S	C		0	0	0	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 97.00 99.00 09900 CMHC 0 0 0 99.00 99.10 09910 CORF 0 0 0 99.00 99.10 100.00 I & R SERVICES-NOT APPRVD PRGM 0 0 0 100.00 101.00 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUISITION 0 0 105.00 105.00 105.00 105.00 105.00 105.00 0 105.00 <td< td=""><td></td><td></td><td>C</td><td>)</td><td>0</td><td>0</td><td>-</td><td>1</td></td<>			C)	0	0	-	1
99.00 09900 CMHC 0 0 99.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td>-</td> <td>1</td>						0	-	1
99.10 09910 CORF 0 0 99.10 100.00 10000 I & R SERVI CES-NOT APPRVD PRGM 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 5 0 0 0 105.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 0 0 0 105.00 106.00 106.00 107.00 0 0 0 107.00 0 0 0 107.00						0	-	
100.00 100.00 1 & R SERVICES-NOT APPRVD PRGM 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 105.00 105.00 105.00 105.00 105.00 106.00 0 0 105.00 106.00 106.00 0 0 105.00 107.00 0 0 0 107.00 0 0 0 107.00 0 0 0 107.00 0 0 0 107.00 0								
SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 0 0 105.00 106.00 10600 HEART ACQUI SI TI ON 0 0 0 106.00 107.00 10700 LI VER ACQUI SI TI ON 0 0 0 107.00	100.00	10000 I&R SERVICES-NOT APPRVD PRGM	C		0			
105.00 10500 KI DNEY ACQUI SI TI ON 0 0 105.00 106.00 10600 HEART ACQUI SI TI ON 0 0 0 106.00 107.00 10700 LI VER ACQUI SI TI ON 0 0 0 107.00	101.00	10100 HOME HEALTH AGENCY	C		0		0	101. 00
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107.00 10700 LIVER ACQUISITION 0 0 107.00					-			
					-			
			C					

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CC		Peri od:	Worksheet C	
				From 01/01/2016		norod.
				To 12/31/2016	Date/Time Pre 4/14/2017 8:1	
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
109.00 10900 PANCREAS ACQUISITION	0			0		109.00
110.00 11000 INTESTINAL ACQUISITION	0			0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0			0		111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0			0	0	115.00
116. 00 11600 HOSPI CE	0			0	0	116.00
200.00 Subtotal (see instructions)	134, 354, 945	0	134, 354, 94	5 0	134, 354, 945	200.00
201.00 Less Observation Beds	3, 146, 235		3, 146, 23	5	3, 146, 235	201.00
202.00 Total (see instructions)	131, 208, 710	0	131, 208, 71	0 0	131, 208, 710	202.00

	Financial Systems ATION OF RATIO OF COSTS TO CHARGES	COMMUNI TY HOSPI	Provider C	F	Period: From 01/01/2016 To 12/31/2016 Hospital	u of Form CMS- Worksheet C Part I Date/Time Pre 4/14/2017 8:1 PPS	pared:
			Charges			PP3	
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS			07.050.70			
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	37, 953, 796 9, 699, 564		37, 953, 796 9, 699, 564			30.00 31.00
32.00	03200 CORONARY CARE UNIT	9, 099, 504		9, 099, 302	*		32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0					33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0		(b		34.00
40.00	04000 SUBPROVI DER – I PF	0		(40.00
41.00	04100 SUBPROVIDER - IRF	0		(0		41.00
42.00	04200 SUBPROVI DER 04300 NURSERY	0 E 207 800		5, 307, 809)		42.00
43.00 44.00	04400 SKILLED NURSING FACILITY	5, 307, 809		5, 307, 809			43.00
45.00	04500 NURSI NG FACI LI TY	0					45.00
46.00	04600 OTHER LONG TERM CARE	0		(þ		46.00
	ANCILLARY SERVICE COST CENTERS			I.			
50.00	05000 OPERATING ROOM	24, 907, 118	37, 546, 113			0.00000	
51.00	05100 RECOVERY ROOM	0	C			0.000000	
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0 1, 815, 463	1, 408, 823		0.000000	0. 000000 0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 491, 592	18, 039, 689			0. 000000	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C			0.000000	
56.00	05600 RADI OI SOTOPE	738, 039	11, 996, 757			0.000000	1
57.00	05700 CT SCAN	6, 391, 848	23, 972, 767			0.00000	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 753, 930	10, 383, 010			0.00000	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	6, 891, 444 9, 704, 203	14, 200, 749 28, 438, 387			0. 000000 0. 000000	
60.00	06001 BLOOD LABORATORY	9,704,203	20, 430, 307			0. 000000	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	C			0. 000000	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	917, 450	544, 829	1, 462, 279	0. 280578	0.000000	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C) (0. 000000	0.000000	
64.00	06400 I NTRAVENOUS THERAPY	0	1 050 075		0.000000	0.00000	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	3, 211, 776 1, 765, 187	1, 852, 375 6, 390, 178			0. 000000 0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	950, 488	778, 164			0. 000000	
68.00	06800 SPEECH PATHOLOGY	563, 822	420, 005			0. 000000	
69.00	06900 ELECTROCARDI OLOGY	2, 769, 544	7, 549, 254	10, 318, 798	0. 095726	0.000000	
	07000 ELECTROENCEPHALOGRAPHY	1, 738, 371	3, 705, 455			0.00000	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	27, 353, 961	18, 873, 663 7, 853, 687			0. 000000 0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	30, 545, 488 17, 990, 154	19, 278, 184			0.000000	
	07400 RENAL DIALYSIS	402, 311	C			0. 000000	
75.00	07500 ASC (NON-DISTINCT PART)	0	C			0.000000	
	OUTPATIENT SERVICE COST CENTERS	1 1		1	1		
88.00	08800 RURAL HEALTH CLINIC	0	C)		88.00
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0			0. 000000	0. 000000	89.00 90.00
	09001 WOUND/OSTOMY CLINIC	0	5, 886, 833	5, 886, 833		0. 000000	
90. 02	09002 KIDS PLUS CLINIC	0	C) (0. 000000	0.000000	
90. 03	09003 ONCOLOGY	661, 617	24, 459, 556	25, 121, 173	0. 000000	0.000000	
90.04		0	000 000		0.00000	0.00000	
90. 05 90. 06	09005 ANTI COAGULATI ON CLINI C	0	888, 852	888, 852		0.00000	
90.06 90.07	09006 PREGNANCY PLUS 09007 0/P LAB	0	C C		0.000000 0.000000	0. 000000 0. 000000	
90.07	09008 0/P LAB	0	C.		0. 000000	0. 000000	1
90.09	09009 FORTVILLE CLINIC	0	C		0. 000000	0.000000	
	09100 EMERGENCY	8, 142, 246	29, 227, 228			0.000000	91.00
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	7, 431, 464	7, 431, 464	0. 423367	0.00000	92.00
94.00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S		~		0. 000000	0.00000	94.00
	09500 AMBULANCE SERVICES	0	C		0. 000000	0. 000000	
	09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0.000000	0. 000000	
97.00	09700 DURABLE MEDI CAL EQUI P-SOLD	0	C) (0. 000000	0.000000	97.00
	09900 CMHC	0	C				99.00
		0	C				99.10
	10000 I &R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	0					100.00
101.00	SPECIAL PURPOSE COST CENTERS	0		<u>''</u>	<u> </u>		
105.00	10500 KIDNEY ACQUISITION	0	C				105.00
106.00	10600 HEART ACQUI SI TI ON	0	C)			106.00
107 00	10700 LIVER ACQUISITION	0	C				107.00
	10800 LUNG ACQUISITION						108.00

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2016	Worksheet C Part I	
				To 12/31/2016		
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpatient	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
110.00 11000 INTESTINAL ACQUISITION	0	0		0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0		111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0		115.00
116. 00 11600 HOSPI CE	0	0		0		116.00
200.00 Subtotal (see instructions)	206, 667, 221	281, 126, 022	487, 793, 24	3		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	206, 667, 221	281, 126, 022	487, 793, 24	3		202.00

	Financial Systems	COMMUNI TY HOSPI T	Provi der CCN: 15-0113	Peri od:	u of Form CMS Worksheet C	
				From 01/01/2016 To 12/31/2016	Part I Date/Time Pr 4/14/2017 8:	
	Cost Center Description	PPS Inpatient	Title XVIII	Hospi tal	PPS	
	Cost Center Description	Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
0.00	03000 ADULTS & PEDIATRICS					30.
1.00	03100 I NTENSI VE CARE UNI T					31.
2.00 3.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT					32.
l. 00	03400 SURGICAL INTENSIVE CARE UNIT					34.
). 00	04000 SUBPROVIDER - IPF					40.
. 00	04100 SUBPROVIDER - IRF					41.
2. 00	04200 SUBPROVI DER					42.
8. 00	04300 NURSERY					43.
. 00	04400 SKILLED NURSING FACILITY					44.
5.00	04500 NURSING FACILITY					45.
o. 00	O4600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS					46.
). 00	05000 OPERATING ROOM	0. 218280				50.
1.00	05100 RECOVERY ROOM	0. 000000				51.
2.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.
. 00	05300 ANESTHESI OLOGY	0. 144388				53.
. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 304589				54.
. 00	05500 RADI OLOGY-THERAPEUTI C	0.000000				55.
. 00	05600 RADI OI SOTOPE	0.079225				56.
. 00 . 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 031841 0. 085247				57.
. 00	05900 CARDI AC CATHETERI ZATI ON	0. 094977				59.
. 00	06000 LABORATORY	0. 169384				60.
. 01	06001 BLOOD LABORATORY	0.000000				60.
. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000				61.
. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 280578				62.
. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.
. 00	06400 I NTRAVENOUS THERAPY	0.000000				64.
6.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0. 329580				65.
5.00 7.00	06700 OCCUPATIONAL THERAPY	0. 415197 0. 385531				66. 67.
3.00	06800 SPEECH PATHOLOGY	0. 412159				68.
9.00	06900 ELECTROCARDI OLOGY	0. 095726				69.
). 00	07000 ELECTROENCEPHALOGRAPHY	0. 246967				70.
. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 321776				71.
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 387461				72.
3.00	07300 DRUGS CHARGED TO PATIENTS	0. 283818				73.
. 00 . 00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0. 836698 0. 000000				74.
. 00	OUTPATIENT SERVICE COST CENTERS	0.000000				- 75.
. 00	08800 RURAL HEALTH CLINIC					88.
. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER					89.
. 00	09000 CLI NI C	0. 000000				90.
. 01	09001 WOUND/OSTOMY CLINIC	0. 422811				90.
. 02	09002 KIDS PLUS CLINIC	0.000000				90.
. 03		0. 000000				90.
. 04 . 05	09004 MUNCIE CLINIC 09005 ANTICOAGULATION CLINIC	0. 000000 0. 554854				90.
. 05	09006 PREGNANCY PLUS	0. 000000				90.
. 00	09007 0/P LAB	0. 000000				90.
. 08	09008 0/P LAB	0. 000000				90.
. 09	09009 FORTVI LLE CLI NI C	0. 000000				90.
. 00	09100 EMERGENCY	0. 196776				91.
. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 423367				92.
00	OTHER REIMBURSABLE COST CENTERS	0.000000				
. 00	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0. 000000 0. 000000				94. 95.
	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000				96.
	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000				97.
	09900 CMHC					99.
	09910 CORF					99.
	10000 I &R SERVICES-NOT APPRVD PRGM					100.
1.00	0 10100 HOME HEALTH AGENCY					101.
г <u>с</u>	SPECIAL PURPOSE COST CENTERS	1				10-
	10500 KIDNEY ACQUISITION					105.
	0 10600 HEART ACQUI SI TI ON 0 10700 LI VER ACQUI SI TI ON					106. 107.
	0 10700 LIVER ACQUISITION					107.
	10900 PANCREAS ACQUISITION					108.
	11000 I NTESTI NAL ACQUI SI TI ON					110.
0.00	11100 I SLET ACQUI SI TI ON	1				111.

Health Financial Systems	COMMUNITY HOSPIT	AL ANDERSON	In Lieu	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0113	Peri od:	Worksheet C	
			From 01/01/2016 To 12/31/2016		pared:
				4/14/2017 8:1	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
113.00 11300 INTEREST EXPENSE					113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)					115.00
116. 00 11600 HOSPI CE					116.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

	Financial Systems ATION OF RATIO OF COSTS TO CHARGES	COMMUNI TY HOSP	ITAL ANDERSON Provider C	F	In Lie eriod: rom 01/01/2016 o 12/31/2016	Worksheet C Part I Date/Time Pre 4/14/2017 8:1	pared:
			Titl	e XIX	Hospi tal	Cost	
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	01.070.057	1	01.070.054		04 070 05/	
	03000 ADULTS & PEDIATRICS	31, 373, 356		31, 373, 356		31, 373, 356	
	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	4, 880, 435		4, 880, 435	0	4, 880, 435 0	1
	03300 BURN I NTENSI VE CARE UNI T			0	0	0	
	03400 SURGI CAL I NTENSI VE CARE UNI T	C		0	0	0	
40.00	04000 SUBPROVI DER – I PF	C)	0	0	0	
41.00	04100 SUBPROVI DER – I RF	C		0	0	0	41.00
	04200 SUBPROVI DER			0	0	0	
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	2, 213, 264	-	2, 213, 264	0	2, 213, 264 0	
	04500 NURSING FACILITY				0	0	
	04600 OTHER LONG TERM CARE	C		0		0	
	ANCI LLARY SERVI CE COST CENTERS						
	05000 OPERATING ROOM	13, 632, 311		13, 632, 311	0	13, 632, 311	
	05100 RECOVERY ROOM	C		0	0	0	51.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	465, 549		0 465, 549	0	0 465, 549	52.00 53.00
53.00 54.00	05400 RADI OLOGY -DI AGNOSTI C	6, 862, 778		6, 862, 778		6, 862, 778	
	05500 RADI OLOGY-THERAPEUTI C	0,002,770		0,002,770	0	0,002,770	
56.00	05600 RADI OI SOTOPE	1,008,910		1, 008, 910	0	1, 008, 910	56.00
57.00	05700 CT SCAN	966, 839		966, 839	0	966, 839	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 034, 637		1, 034, 637		1, 034, 637	
59.00	05900 CARDI AC CATHETERI ZATI ON	2,003,272		2,003,272		2,003,272	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	6, 460, 757		6, 460, 757	0	6, 460, 757	60. 00 60. 01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	410, 283		410, 283	0	410, 283	
	06300 BLOOD STORING, PROCESSING & TRANS.	C		0	0	0	1
64.00	06400 I NTRAVENOUS THERAPY	C		0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	1, 669, 041				1, 669, 041	
66.00	06600 PHYSI CAL THERAPY	3, 386, 082		3, 386, 082		3, 386, 082	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	666, 449 405, 493		666, 449 405, 493		666, 449 405, 493	
69.00	06900 ELECTROCARDI OLOGY	987, 778		987, 778		987, 778	1
	07000 ELECTROENCEPHALOGRAPHY	1, 344, 443		1, 344, 443		1, 344, 443	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 874, 950		14, 874, 950	0	14, 874, 950	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	14, 878, 190		14, 878, 190		14, 878, 190	1
	07300 DRUGS CHARGED TO PATIENTS	10, 577, 414		10, 577, 414		10, 577, 414	
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	336, 613	5	336, 613 0		336, 613 0	1
75.00	OUTPATIENT SERVICE COST CENTERS		/	0	0	0	75.00
88.00	08800 RURAL HEALTH CLINIC	C)	0	0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	C		0	0	0	
	09000 CLI NI C	C	D	0	0	0	
	09001 WOUND/OSTOMY CLINIC	2, 489, 019		2, 489, 019		2, 489, 019	
	09002 KIDS PLUS CLINIC 09003 ONCOLOGY	96, 218		96, 218	0	96, 218 0	1
	09003 UNCOLOGY 09004 MUNCIE CLINIC	124, 412		124, 412	0	124, 412	
	09005 ANTI COAGULATI ON CLINIC	493, 183		493, 183		493, 183	
90.06	09006 PREGNANCY PLUS	139, 207		139, 207		139, 207	90.06
	09007 0/P LAB	C	D	0	0	0	
	09008 0/P LAB	C)	0	0	0	
	09009 FORTVILLE CLINIC 09100 EMERGENCY	74,416		74, 416		74, 416	1
	09100 EMERGENCI 09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 353, 411 3, 146, 235		7, 353, 411 3, 146, 235		7, 353, 411 3, 146, 235	
,2.00	OTHER REIMBURSABLE COST CENTERS	1 0, 140, 200	<u> </u>	0,110,200		5, 170, 233	12.00
94.00	09400 HOME PROGRAM DI ALYSI S	C)	0	0	0	94.00
	09500 AMBULANCE SERVI CES	C		0	0	0	
	09600 DURABLE MEDICAL EQUIP-RENTED	C		0	0	0	
	09700 DURABLE MEDICAL EQUIP-SOLD			0	0	0	
	09900 CMHC 09910 CORF					0	
	10000 I &R SERVICES-NOT APPRVD PRGM						100.00
	10100 HOME HEALTH AGENCY			0			101.00
	SPECIAL PURPOSE COST CENTERS			· · · · · · · · · · · · · · · · · · ·			1
	10500 KIDNEY ACQUISITION	C)	0			105. 00
	10600 HEART ACQUI SI TI ON	C C		0			106.00
	10700 LIVER ACQUISITION 10800 LUNG ACQUISITION						107.00 108.00
100.00			1	I 0	1	0	100.00

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-0113	Period:	Worksheet C	
				From 01/01/2016 To 12/31/2016		narod
				10 12/31/2010	4/14/2017 8:1	8 am
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)				5.00	
	1.00	2.00	3.00	4.00	5.00	
109.00 10900 PANCREAS ACQUISITION	0			0		109.00
110.00 11000 INTESTINAL ACQUISITION	0			0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0			0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0			0	0	115.00
116. 00 11600 HOSPI CE	0			0	0	116.00
200.00 Subtotal (see instructions)	134, 354, 945	0	134, 354, 94	15 0	134, 354, 945	200.00
201.00 Less Observation Beds	3, 146, 235		3, 146, 23	35	3, 146, 235	201.00
202.00 Total (see instructions)	131, 208, 710	0	131, 208, 71	0 0	131, 208, 710	202.00

COMPUT	ATION OF RATIO OF COSTS TO CHARGES			 -	Period: From 01/01/2016 Fo 12/31/2016	Worksheet C Part I Date/Time Pre 4/14/2017 8:1	
			Charges	e XIX	Hospi tal	Cost	
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				-		
30.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	37, 953, 796		37, 953, 790			30.00
31.00 32.00	03200 CORONARY CARE UNIT	9, 699, 564		9, 699, 564	+		31.00 32.00
33.00	03300 BURN I NTENSI VE CARE UNI T	0					33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0					34.00
40.00	04000 SUBPROVI DER – I PF	0					40.00
41.00	04100 SUBPROVIDER - IRF	0		(D		41.00
42.00	04200 SUBPROVI DER 04300 NURSERY	0 5 207 000		5, 307, 80			42.00
43.00 44.00	04400 SKI LLED NURSI NG FACI LI TY	5, 307, 809		5, 307, 80			43.00 44.00
45.00	04500 NURSI NG FACI LI TY	0					45.00
46.00	04600 OTHER LONG TERM CARE	0		(D		46.00
	ANCI LLARY SERVI CE COST CENTERS	1					
50.00	05000 OPERATING ROOM	24, 907, 118	37, 546, 113			0.000000	
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0		0.000000 0.000000	0. 000000 0. 000000	
53.00	05300 ANESTHESI OLOGY	1, 815, 463	1, 408, 823			0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 491, 592	18, 039, 689			0.000000	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0. 000000	0.00000	
56.00	05600 RADI OI SOTOPE 05700 CT SCAN	738,039	11, 996, 757 23, 972, 767			0.00000	
57.00 58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	6, 391, 848 1, 753, 930	10, 383, 010			0. 000000 0. 000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	6, 891, 444	14, 200, 749			0. 000000	
60.00	06000 LABORATORY	9, 704, 203	28, 438, 387			0.000000	
60. 01	06001 BLOOD LABORATORY	0	0	(0. 000000	0.00000	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0)	0.000000	0.000000	
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	917, 450	544, 829	1, 462, 279	9 0. 280578 0 0. 000000	0. 000000 0. 000000	
64.00	06400 I NTRAVENOUS THERAPY	0	0			0. 000000	
65.00	06500 RESPI RATORY THERAPY	3, 211, 776	1, 852, 375	5, 064, 15		0. 000000	
66.00	06600 PHYSI CAL THERAPY	1, 765, 187	6, 390, 178	8, 155, 36	5 0. 415197	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	950, 488	778, 164			0.00000	
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	563, 822 2, 769, 544	420, 005 7, 549, 254			0. 000000 0. 000000	
	07000 ELECTROENCEPHALOGRAPHY	1, 738, 371	3, 705, 455			0. 000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	27, 353, 961	18, 873, 663			0. 000000	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	30, 545, 488	7, 853, 687			0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	17, 990, 154	19, 278, 184			0.00000	
	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	402, 311	0		0. 836698 0. 000000	0. 000000 0. 000000	
/ 5. 00	OUTPATIENT SERVICE COST CENTERS	0		1	0.000000	0.00000	/ 5.00
88.00	08800 RURAL HEALTH CLINIC	0	C) (0. 000000	0. 000000	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	(0. 000000	0.00000	
90.00	09000 CLINIC 09001 WOUND/OSTOMY CLINIC	0	C 004 022	E 004 025	0.000000	0.00000	
90. 01 90. 02	09002 KIDS PLUS CLINIC	0	5, 886, 833	5, 886, 83	3 0. 422811 0 0. 000000	0. 000000 0. 000000	
90.03	09003 ONCOLOGY	661, 617	24, 459, 556	25, 121, 17		0. 000000	
90. 04	09004 MUNCIE CLINIC	0	C) (0. 000000	0.000000	
90. 05	09005 ANTI COAGULATI ON CLINIC	0	888, 852	888, 852		0.000000	
90.06	09006 PREGNANCY PLUS	0	0		0.000000	0.00000	
90. 07 90. 08	09007 0/P LAB 09008 0/P LAB	0	0		0.000000 0.000000	0. 000000 0. 000000	
90.00	09009 FORTVILLE CLINIC	0	0		0.000000	0. 000000	
	09100 EMERGENCY	8, 142, 246	29, 227, 228	37, 369, 47		0. 000000	
	09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REI MBURSABLE COST CENTERS	0	7, 431, 464	7, 431, 464		0. 000000	
	09400 HOME PROGRAM DI ALYSI S	0	0	1	0.000000	0.000000	
	09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED	0			0.000000 0.000000	0. 000000 0. 000000	
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0. 000000	0. 000000	
99.00	09900 CMHC	0	0				99.00
	09910 CORF	0	C				99.10
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0				100.00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	C	<u>n</u> ()		101.00
105.00	10500 KI DNEY ACQUI SI TI ON	0	C				105.00
	10600 HEART ACQUI SI TI ON	0	C		Ď		106.00
107.00	10700 LIVER ACQUISITION	0	0		-		107.00 108.00
	10800 LUNG ACQUISITION		0				

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	eu of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0113	Period: From 01/01/2016	Worksheet C Part I	
				To 12/31/2016		
		Titl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
110.00 11000 INTESTINAL ACQUISITION	0	0		0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0		111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115.00
116.00 11600 HOSPI CE	0	0		0		116.00
200.00 Subtotal (see instructions)	206, 667, 221	281, 126, 022	487, 793, 24	13		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	206, 667, 221	281, 126, 022	487, 793, 24	13		202.00

IPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepar
		Title XIX	Hospi tal	4/14/2017 8:18 a Cost
Cost Center Description	PPS Inpatient			0031
	Ratio			
	11.00			
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 00 03000 ADULTS & PEDI ATRI CS				30
00 03100 I NTENSI VE CARE UNI T				31
00 03200 CORONARY CARE UNI T				32
00 03300 BURN INTENSIVE CARE UNIT				33
00 03400 SURGICAL INTENSIVE CARE UNIT				34
00 04000 SUBPROVI DER – I PF				40
00 04100 SUBPROVIDER - IRF				41
00 04200 SUBPROVI DER				42
				43
00 04400 SKILLED NURSING FACILITY 00 04500 NURSING FACILITY				44
00 04600 OTHER LONG TERM CARE				46
ANCI LLARY SERVICE COST CENTERS				
00 05000 OPERATI NG ROOM	0.000000			50
00 05100 RECOVERY ROOM	0. 000000			51
00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52
00 05300 ANESTHESI OLOGY	0. 000000			53
00 05400 RADI OLOGY - DI AGNOSTI C	0. 000000			54
00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55
00 05600 RADI 0I SOTOPE 00 05700 CT SCAN	0. 000000 0. 000000			56
00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58
00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59
00 06000 LABORATORY	0. 000000			60
01 06001 BLOOD LABORATORY	0. 000000			60
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62
00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63
00 06400 I NTRAVENOUS THERAPY	0. 000000			64
00 06500 RESPI RATORY THERAPY 00 06600 PHYSI CAL THERAPY	0. 000000 0. 000000			65
00 06700 OCCUPATIONAL THERAPY	0.000000			67
00 06800 SPEECH PATHOLOGY	0. 000000			68
00 06900 ELECTROCARDI OLOGY	0. 000000			69
00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71
00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72
00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73
00 07400 RENAL DI ALYSI S	0. 000000			74
00 07500 ASC (NON-DI STI NCT PART) 0UTPATI ENT SERVICE COST CENTERS	0. 000000			75
00 08800 RURAL HEALTH CLINIC	0. 000000			88
00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89
00 09000 CLINIC	0. 000000			90
01 09001 WOUND/OSTOMY CLINIC	0. 000000			90
02 09002 KIDS PLUS CLINIC	0. 000000			90
	0. 000000			90
04 09004 MUNCIE CLINIC	0. 000000			90
05 09005 ANTI COAGULATI ON CLINIC 06 09006 PREGNANCY PLUS	0. 000000 0. 000000			90
07 09007 0/P LAB	0. 000000			90
08 09008 0/P LAB	0. 000000			90
09 09009 FORTVILLE CLINIC	0. 000000			90
00 09100 EMERGENCY	0. 000000			91
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92
OTHER REIMBURSABLE COST CENTERS				
00 09400 HOME PROGRAM DI ALYSI S	0. 000000			94
	0. 000000			95
00 09600 DURABLE MEDICAL EQUIP-RENTED 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000 0. 000000			96
00 09900 CMHC	0.00000			99
10 09910 CORF				99
0. 00 10000 I &R SERVICES-NOT APPRVD PRGM				100
I. 00 10100 HOME HEALTH AGENCY				101
SPECIAL PURPOSE COST CENTERS				
5. 00 10500 KIDNEY ACQUISITION				105
5. 00 10600 HEART ACQUI SI TI ON				106
7. 00 10700 LIVER ACQUISITION				107
3. 00 10800 LUNG ACQUI SI TI ON				108
2. 00 10900 PANCREAS ACQUISITION D. 00 11000 INTESTINAL ACQUISITION				109
J. GOLLIGUOLINILGIINAL ACQUISTITUN				L L L L L L L L L L L L L L L L L L L

Health Financial Systems	COMMUNI TY HOSPI TA	AL ANDERSON	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0113	Period: From 01/01/2016	Worksheet C Part I	
			To 12/31/2016	Date/Time Pre	
				4/14/2017 8:1	<u>8 am</u>
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
113.00 11300 INTEREST EXPENSE					113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)					115.00
116. 00 11600 HOSPI CE					116.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL (COSTS	Disautialaus C(
			CN: 15-0113	Period: From 01/01/2016 To 12/31/2016	4/14/2017 8:1	pared: 8 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cos			
	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	1, 935, 922	0	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		80.76	
31. 00 INTENSIVE CARE UNIT	295, 949		295, 9	49 1, 570	188.50	31.00
32. 00 CORONARY CARE UNI T	0			0 0	0.00	32.00
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	34.00
40. 00 SUBPROVIDER - IPF	0	0		0 0	0.00	40.00
41.00 SUBPROVIDER - IRF	0	0		0 0	0.00	41.00
42. 00 SUBPROVI DER	0	0		0 0	0.00	42.00
43.00 NURSERY	63, 454		63, 4	54 2, 158	29.40	43.00
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	44.00
45.00 NURSING FACILITY	0			0 0	0.00	45.00
200.00 Total (lines 30-199)	2, 295, 325		2, 295, 3	25 27, 700		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	9, 473	765, 039				30.00
31.00 INTENSIVE CARE UNIT	1, 438	271, 063				31.00
32.00 CORONARY CARE UNIT	0	0				32.00
33.00 BURN INTENSIVE CARE UNIT	0	0				33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0				34.00
40. 00 SUBPROVI DER – I PF	0	0				40.00
41. 00 SUBPROVI DER – I RF	О	0				41.00
42. 00 SUBPROVI DER	0	0				42.00
43.00 NURSERY	0	0				43.00
44.00 SKILLED NURSING FACILITY	О	0				44.00
45.00 NURSING FACILITY	0	0				45.00
200.00 Total (lines 30-199)	10, 911	1,036,102				200.00

	Financial Systems TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	COMMUNI TY HOSPI	Provider C	°N· 15_0113	Peri od:	u of Form CMS-2 Worksheet D	2002-
FFURI	TONIMENT OF THEATTENT ANGLEART SERVICE CAFTI	12 00313	FIOVIDEI C	CN. 15-0115	From 01/01/2016 To 12/31/2016	Part II	
			Title	× XVIII	Hospi tal	PPS	0 ani
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,		$(col \cdot 1 + col$		column 4)	
		Part II, col.	8)	2)	. ondriges		
		26)	0)	2)			
		1.00	2.00	3.00	4.00	5.00	
	ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
0. 00	05000 OPERATING ROOM	1, 623, 233	62, 453, 231	0.02599	11, 124, 482	289, 136	1 50. O
1.00	05100 RECOVERY ROOM	0	0	0.00000		0	51.0
2.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000		0	52.0
3.00	05300 ANESTHESI OLOGY	26, 945	3, 224, 286				
4.00	05400 RADI OLOGY-DI AGNOSTI C	858, 314					54.0
			22, 531, 281				
5.00	05500 RADI OLOGY-THERAPEUTI C	0	0			0	55.0
6.00	05600 RADI OI SOTOPE	53, 637	12, 734, 796			1, 393	
7.00	05700 CT SCAN	38, 243	30, 364, 615				
8.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	50, 621	12, 136, 940			3, 306	58.0
9.00	05900 CARDI AC CATHETERI ZATI ON	132, 942	21, 092, 193				59. C
0.00	06000 LABORATORY	430, 826	38, 142, 590	0. 01129	95 4, 915, 159	55, 517	60. C
0. 01	06001 BLOOD LABORATORY	0	0	0.0000	0 0	0	60. C
1.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.0
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	17, 658	1, 462, 279	0. 01207	76 377, 124	4, 554	62.0
3.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.0
4.00	06400 I NTRAVENOUS THERAPY	0	0			0	64.0
5.00	06500 RESPI RATORY THERAPY	64, 368	5, 064, 151			-	
	06600 PHYSI CAL THERAPY	80, 351					
6.00			8, 155, 365				66.0
7.00	06700 OCCUPATI ONAL THERAPY	24, 162	1, 728, 652				67.C
8.00	06800 SPEECH PATHOLOGY	13, 117	983, 827				
9.00	06900 ELECTROCARDI OLOGY	85, 675	10, 318, 798				
0. 00	07000 ELECTROENCEPHALOGRAPHY	80, 239					
1. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	180, 069	46, 227, 624				71.0
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	180, 104	38, 399, 175	0.00469	14, 050, 410	65, 896	72.0
3.00	07300 DRUGS CHARGED TO PATIENTS	167, 760	37, 268, 338	0.00450	6, 933, 379	31, 207	73.0
4.00	07400 RENAL DIALYSIS	6, 727	402, 311	0. 01672	209, 733	3, 507	74.0
5.00	07500 ASC (NON-DISTINCT PART)	0	0	0.00000	0 0	0	75.0
	OUTPATIENT SERVICE COST CENTERS			•			
8.00	08800 RURAL HEALTH CLINIC	0	C	0.0000	0 0	0	88. (
9.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C				89.0
0.00	09000 CLINIC	0	0	0.00000			90.0
0.01	09001 WOUND/OSTOMY CLINIC	260, 126	5, 886, 833				90.0
0. 02	09002 KIDS PLUS CLINIC	30, 731	3, 000, 000				90.0
0.02	09003 ONCOLOGY	0	0	0.00000			90.0
0. 03 0. 04	09004 MUNCIE CLINIC	29, 963	0	0.00000		0	90.
0.05	09005 ANTI COAGULATI ON CLINI C	9,043	888, 852				90.
D. 06	09006 PREGNANCY PLUS	47, 461	0				90.
	09007 0/P LAB	0	0				
	09008 0/P LAB	0	C	0.00000		-	
	09009 FORTVILLE CLINIC	23, 471	0			0	
1.00	09100 EMERGENCY	384, 942	37, 369, 474	0. 01030	3, 526, 407	36, 326	
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	194, 142	7, 431, 464	0. 02612	0	0	92. (
	OTHER REIMBURSABLE COST CENTERS						1
4.00	09400 HOME PROGRAM DI ALYSI S	0	0	0.0000	0 0	0	94.
	09500 AMBULANCE SERVICES		, i i i i i i i i i i i i i i i i i i i			Ű	95.
				0. 00000	0	0	
	1096001DURABLE MEDICAL FOULP-RENIED	()	(
6.00	09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD	0		0.00000		0	

Health Financial Systems	COMMUNI TY HOSPI				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	R PASS THROUGH COST	TS Provider C	F	Period: From 01/01/2016 To 12/31/2016		pared: 8 am
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng School	Allied Health	All Other	Swing-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cost	Amount (see	1 through 3,	
					minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	-		-	-	-	
30. 00 03000 ADULTS & PEDI ATRI CS	0				-	
31.00 03100 INTENSIVE CARE UNIT	0				0	
32.00 03200 CORONARY CARE UNI T	0	-			0	
33.00 03300 BURN INTENSIVE CARE UNIT	0	(C	0)	0	
34.00 03400 SURGI CAL INTENSI VE CARE UNI T	0	(C) C)	0	34.00
40. 00 04000 SUBPROVIDER - IPF	0	0	C	0	0	40.00
41.00 04100 SUBPROVIDER - IRF	0	0	0 0	0	0	41.00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42.00
43. 00 04300 NURSERY	0	(C	ol c)	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0			0	44.00
45.00 04500 NURSING FACILITY	0				0	•
200.00 Total (lines 30-199)	0	0) c)	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	I npati ent	Inpati ent	PSA Adj.	
	Days	5 ÷ col. 6)	Program Days	Program	Nursing School	
		· · · · · ·		Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	23, 972	0.00	9, 473	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	1, 570	0.00	1, 438	0	0	31.00
32. 00 03200 CORONARY CARE UNI T	0	0.00	c c	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0.00	ol c	0	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0.00	ol c	0	0	34.00
40. 00 04000 SUBPROVIDER - IPF	0	0.00			0	•
41. 00 04100 SUBPROVI DER – I RF	0				0	
42. 00 04200 SUBPROVI DER	0			-	0	
43. 00 04300 NURSERY	2, 158				0	
44. 00 04400 SKILLED NURSING FACILITY	2, 130				0	•
45. 00 04500 NURSING FACILITY	0			-	0	
200.00 Total (lines 30-199)	27,700		10, 911	-		200.00
Cost Center Description	PSA Adj .	PSA Adj. All	10, 911	0	0	200.00
cost center bescription	Allied Health					
	Cost	Education Cost				
	12.00	13.00	-			
INPATIENT ROUTINE SERVICE COST CENTERS	12.00	10.00	1			
30. 00 03000 ADULTS & PEDIATRICS	0	0)			30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
32. 00 03200 CORONARY CARE UNI T	0					32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0					32.00
	0		1			34.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T	0					
40. 00 04000 SUBPROVIDER - IPF						40.00
41. 00 04100 SUBPROVIDER - IRF	0	-	•			41.00
42. 00 04200 SUBPROVI DER	0	0				42.00
43.00 04300 NURSERY	0		ן ע			43.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
45. 00 04500 NURSI NG FACI LI TY	0					45.00
200.00 Total (lines 30-199)	0	0	ון			200.00

	Financial Systems	COMMUNITY HOSPI		0145 0440		u of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS	RVICE OTHER PASS	Provider C	JN: 15-0113	Period: From 01/01/2016 To 12/31/2016		
			Title	XVIII	Hospi tal	PPS	<u>o un</u>
	Cost Center Description	Non Physician	Nursing School	Allied Healt	h All Other	Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	U U	
		1.00	2.00	3.00	4.00	4) 5.00	
	ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50.00	05000 OPERATI NG ROOM	0	0		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
	05300 ANESTHESI OLOGY	0	0		0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	
	05600 RADI OI SOTOPE 05700 CT SCAN	0	0		0 0	0	56.00 57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	57.00
58.00 59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
	06000 LABORATORY	0	0		0 0	0	
60.01	06001 BLOOD LABORATORY	0	0		0 0	-	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		о - С		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
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
	06800 SPEECH PATHOLOGY	0	0		0 0	0	
	06900 ELECTROCARDI OLOGY	0	0		0 0	0	1
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0 0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0		0 0 0 0	0	1
	07500 ASC (NON-DI STI NCT PART)	0	0		0 0		1
70.00	OUTPATIENT SERVICE COST CENTERS				0 0	0	/0.00
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	1	0 0	0	89.00
90.00	09000 CLI NI C	0	0		0 0	0	90.00
90. 01	09001 WOUND/OSTOMY CLINIC	0	0		0 0	0	90.01
90. 02	09002 KIDS PLUS CLINIC	0	0		0 0	0	90. 02
	09003 ONCOLOGY	0	0		0 0	0	90.03
90.04	09004 MUNCIE CLINIC	0	0		0 0	0	90.04
	09005 ANTI COAGULATI ON CLINI C	0	0		0 0	0	
90.06	09006 PREGNANCY PLUS	0	0		0 0	0	
	09007 0/P LAB 09008 0/P LAB	0	0		0 0	0	90.07 90.08
	09009 FORTVILLE CLINIC	0	0		0 0		
	09100 EMERGENCY	0	0		0 0	e e e e e e e e e e e e e e e e e e e	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0		
/2:00	OTHER REIMBURSABLE COST CENTERS				0 0		12.00
94.00	09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
	09500 AMBULANCE SERVI CES						95.00
06 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	96.00
	09700 DURABLE MEDICAL EQUIP-SOLD Total (lines 50-199)	0	0		0 0 0 0		97.00 200.00

APPORT IDMENT OF IMPATIENT/QUITPATENT ANCILLARY SERVICE OTHER PASS TROUGH COSTS Provider COL: 15-0113 Provider COL: 15-013 Provider COL: 15-013 Provider COL: 15-013 Provider COL: 15-013 Provider COL: 15-013 Provider COL: 15-013 Provid COL: 15-013 Provider COL: 15-013 Provider COL: 15-013 P	Health Financial Systems	COMMUNI TY HOSP			In Lie	eu of Form CMS-2	2552-10
Interview Total Total Total Total Total Autor 20:12:13:18:18:10 Cost Center Description Intal Intal Cost Contract Dutpatient Cost (sum of el. 2, 3 and a) Cost Cost Stall or Cost To Charges Intal Cost Cost Stall or Cost To Charges Intal Charg		RVICE OTHER PAS	S Provider C	CN: 15-0113	Period:	Worksheet D	
Tella Tella <th< td=""><td>THROUGH COSTS</td><td></td><td></td><td></td><td></td><td>Part IV</td><td>narod</td></th<>	THROUGH COSTS					Part IV	narod
Cost Center Description Total Outpatient Cost Stand Cost St					0 12/31/2010	4/14/2017 8:1	8 am
Outpatient Crown Wist, C. (Part I, col.) To Charges Rati or of Cost Program All 1.0 0 7 0 8.00 7.00 10.00 0 0.00 0.0 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.52.00 0.0 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.52.00 0.0 0.000000 <td></td> <td></td> <td>Title</td> <td>xviii</td> <td>Hospi tal</td> <td></td> <td></td>			Title	xviii	Hospi tal		
Outpatient Crown Wist, C. (Part I, col.) To Charges Rati or of Cost Program All 1.0 0 7 0 8.00 7.00 10.00 0 0.00 0.0 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.52.00 0.0 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.52.00 0.0 0.000000 <td>Cost Center Description</td> <td>Total</td> <td>Total Charges</td> <td>Ratio of Cost</td> <td>Outpati ent</td> <td>Inpati ent</td> <td></td>	Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	Inpati ent	
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4) 70 70 10.00 ACCILLARY SERVICE COST CENTERS 0 0.00 05.000 0.000000 0.000000 0.000000 0.000000 0.000000 0.52.00 51.00 05.000 DELVERY ROM 0 0.000000 0.000000 0.000000 0.000000 0.52.00 51.00 DELVERY ROM & LABOR ROM 0 0.000000 0.000000 0.000000 152.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 0.000000 0.000000 0.000000 0.000000 2.54.33 55.00 56.00 DEGOD (LOCY THERPEUTIC 0 12.734,796 0.000000 0.000000 0.20000 3.271.33 57.00 58.00 DEBOD (ARANTORY 0 12.196,793 0.000000 0.000000 0.000000 2.796,13 59.00 60.00 LABORATORY 0 31.42,590 0.000000 0.000000 2.310,415 59.00 61.00 DEADATORY 0 31.42,590 0.000000 0.00000				(col. 5 ÷ col.		Charges	
MCILLARY SERVICE COST CENTERS 0.00 0.00 0.00000 0.000000 1.24,482 50.00 0.000000 1.24,482 50.00 0.000000 0.000000 0.000000 1.24,482 50.00 50.00 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 1.24,482 50.00 50.00 05200 DELIVERY ROM & LABOR ROM 0 0.000000 0.000000 0.000000 0.43,544 53.00 50.00 05200 RADILOS/THERAPEUTIC 0 1.244,746 0.000000 0.000000 2.546,352 54.00 50.00 DS600 RADILOS/THERAPEUTIC 0 1.243,746 0.000000 0.000000 2.354,355 55.00 59.00 DS600 RADILOS/THERAPEUTIC 0 1.243,746 0.000000 0.000000 2.766,134 59.00 60.00 DS600 RADILOS/THERAPUTIC 0 21,92,193 0.000000 0.000000 2.766,134 59.00 61.00 DE50			8)	7)			
ANCILLARY SERVICE COST CENTRES 00 05000 (DPERATI IN CROM 0 62,453,231 0.000000 0.000000 11,124,482 50.00 51.00 05100 (RECOVERY ROM 0 0 0.000000 0.000000 0.000000 0.52.00 53.00 05300 (RADI COV-THERAPEUTIC 0 0 0.000000 0.000000 0.535.00 0.000000 0.000000 0.555.00 0.000000 0.000000 0.000000 0.556.00 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
50. 00 5000 [OPERATING ROOM 0 62, 452, 231 0.000000 0.000000 11, 24, 452 50. 00 51. 00 51.00 05200 [DELUFEW ROM & LABOR ROM 0 0.000000 0.000000 0.51.00 52. 00 05200 [DELUFEW ROM & LABOR ROM 0 0.000000 0.000000 0.453.5 51.00 53.00 05300 [DELUFEW ROM & LABOR ROM 0 2.24, 266 0.000000 0.000000 2.453.52 54.00 55.00 55.00 0.000000 0.000000 0.000000 0.520.0 55.00 55.00 0.000000		6.00	7.00	8.00	9.00	10.00	
51.00 65100 RECOVERY ROOM 0 0 0.000000 0.000000 0.51.00 52.00 05200 05200 05200 05200 05200 05200 05200 05200 05200 0.000000 0.000000 0.55.00 0.000000 25.63.50 0.000000 25.63.50 0.000000 0.000000 25.63.50 0.000000 0.000000 25.63.50 0.000000 0.000000 0.000000 25.63.55.00 0.000000							
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53. 00 05300 AMESTHESI DLOGY 0 3.224, 286 0.000000 4.53, 504 55. 00 55. 00 05500 RADI LOGO-THERAPUTI C 0 0 0.000000 2.563, 25 56. 00 05. 00 0500 RADI DLOGO-THERAPUTI C 0 0 0.000000 3.274, 355 57. 00 05. 00 05000 RADI DLOGO-THERAPUTI C 0 0 0.000000 0.000000 3.271, 330 57. 00 05000 CARDI AC CATHETER TATI ON 0 21, 092, 193 0.000000 0.000000 2.764, 154 59. 00 06001 BLOOD LABORATORY 0 38, 142, 590 0.000000 0.000000 2.764, 154 60. 01 06101 DLOD DLABORATORY 0 0 0.000000 0.000000 64. 00 66. 01 06200 WHOLE BLODD & PACIK DR ESPIROM ONLY 0 0 0.000000 0.000000 64. 00 66. 00 06400 INTRAVENUS THERAPY 0 0 0.000000 0.000000 0.000000 64. 00 00 06200 WHOLE BLODD A PACKED RED BLODD CELLS 0 0.0000000 0.0000		-					•
54.00 05400 RADI LOCYDI AGNOSTI C 0 22,531,281 0.000000 0.000000 2,566,352 56.00 55.00 05500 RADI OLOCYTHERAFEUTI C 0 0.000000 0.000000 330,632 56.00 56.00 05500 CT SCAN 0.300,634,615 0.000000 0.000000 771,330 57.00 58.00 05500 MAGNETI C ESSONANCE I MAGING (MRI) 0 12,136,940 0.000000 0.000000 774,137 58.00 00.0000 CARDI AC CATHETERI ZATI ON 0 21,092,193 0.000000 0.000000 4,915,159 60.00 00.00000 LABORATORY 0 0.000000 0.000000 0 60.01 01.00 PBP CLINI CAL LAB SERVI CES-PRGI UNLY 0 0.000000 0.000000 64.00 04.00 OFGOD HYSI CAL THRAPY 0 0.000000 0.000000 64.00 05.00 BLODD STORI NG, PROCESSI NG & TRANS. 0 0.000000 0.000000 65.00 05600 RESPI HATORY THERAPY 0 1.462,279 0.000000 0.000000 2.310,459 66.00 05600 RESPI HATORY		-					•
55. 00 05500 RADIOLOGY-THERAPEUTIC 0 0 0.0000000 0.0000000 0.57.00 55. 00 05700 CT SCAN 0 30.364,615 0.000000 0.000000 3.271.330 57.00 58. 00 05600 CARDIAC CATHETERIZATION 0 121,36,940 0.000000 0.000000 2.796,134 59.00 60. 00 06000 LABORATORY 0 121,36,940 0.000000 0.000000 2.796,134 59.00 60. 01 06001 LABORATORY 0 0 0.000000 0.000000 0.000000 4.915,159 60.01 61. 00 06100 PBP CLINI CAL LAB SERVICES-PRCM ONLY 0 0 0.000000 0.000000 377,124 62.00 62.00 06300 BLODD STORI NG, PROCESSI NG & TRANS. 0 0 0.000000 0.000000 2.310,459 65.00 63.00 06600 PHYSI CAL THERAPY 0 5,064,151 0.000000 0.000000 55,456 0.000000 1.55,365 0.000000 0.000000 1.57,422 60.00 60.00 06600 PHYSI CAL THERAPY		-					
56. 00 056. 00 056. 00 056. 00 07.00		-					
57. 00 057.00 CT_SCAN 0 30. 364, 615 0.0000000 3, 271, 330 57. 00 59. 00 05500 (ARDIAC CATHETERIZATION 0 21, 992, 193 0.0000000 0.000000 2, 796, 134 59. 00 60. 00 66001 (ARDEATCRY 0 38, 142, 590 0.0000000 0.000000 0.000000 0.000000 66.00 61. 00 66001 (ARDEATCRY 0 38, 142, 590 0.000000 0.000000 0.000000 60.01 62.00 0.6200 (MHOLE BLOOD & PACKED RED BLOOD CELLS 0 1, 462, 279 0.000000 0.000000 0.000000 64.00 63.00 0.6300 (RESPI RATORY THERAPY 0 5, 064, 151 0.000000 0.000000 943, 116 65.00 RESPIRATORY THERAPY 0 81, 55, 365 0.000000 0.000000 943, 116 66.00 66.00 0.6600 PHYSI CAL THERAPY 0 1, 728, 652 0.000000 0.000000 516, 43 67.00 69.00 0.60000 0.000000 0.000000 0.000000 1, 728, 79, 822		-					
58. 00 05800 MACRETIC RESONANCE I MACH NG (MRI) 0 12, 136, 940 0.0000000 0.0000000 29, 707 58. 00 00 000000 CARDIA C CATHLETER IZATION 0 21, 09, 193 0.0000000 0.0000000 2, 796, 134 59. 00 00 0 0 0 0 0.000000 0.000000 4, 915, 155 60. 01 00 0 0 0 0 0.000000 0.000000 4, 60. 01 01 0 0.000000 0.000000 0.000000 0.000000 63. 00 01 0.06200 WHOLE BLOOD A PACKED RED BLODD CELLS 0 1, 462, 279 0.000000 0.000000 0.63. 00 0.06400 INTRAVENUIS THERAPY 0 5. 564, 151 0.000000 0.000000 5. 364 65. 00 0.06600 PESP IZAL THERAPY 0 1, 728, 652 0.000000 0.000000 5. 564, 457. 00 0.0 0.6600 PESP IZAL THERAPY 0 1, 728, 652 0.000000 0.000000 15, 749, 857. 715. 00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
59. 00 05900 CARDIAC CATHETERIZATION 0 21.092, 193 0.0000000 2.796, 134 59. 00 00. 00 06000 LABORATORY 0 38, 142, 590 0.000000 0.000000 4.915, 159 60. 00 0.00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0.000000 0.000000 0.000000 63.00 0.40. 00 06300 HHOLE BLOOD & PACKEN RED BLOOD CELLS 0 0.000000 0.000000 0.63.00 0.40. 00 06400 INTRAVENDUS THERAPY 0 5.064, 151 0.000000 0.000000 0.64.00 0.67.00 06700 OCOTATI ONAL. THERAPY 0 8, 155, 365 0.000000 0.000000 0.000000 9.311.6 66.00 0.6000 DECOTATIOLORY 0 9.43, 827 0.000000 0.000000 1.57, 820.6 69.00 0.72.00 DELECTROCARDIOLORY 0 19, 38, 827 0.000000 0.000000 12.030.250 71.00 71.00 OT100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 <td< td=""><td></td><td>-</td><td></td><td></td><td></td><td></td><td></td></td<>		-					
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61.00 06100 PEP CLI NI CAL LAB SERVI CES-PRGM ONLY 61.00 62.00 66200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 1, 462, 279 0.000000 0.000000 377, 124 62.00 63.00 06400 INTRAVENOUS THERAPY 0 0 0.000000 0.000000 0.000000 0.63.00 66.00 06500 PESPI RATORY THERAPY 0 5.064, 151 0.000000 0.000000 9.93, 116 65.00 67.00 06700 OCCUPATI ONAL THERAPY 0 1.728, 652 0.000000 0.000000 1.579, 832 67.00 68.00 DEECTROENCEPHALOGRAPHY 0 1318, 798 0.000000 0.000000 1.579, 820 67.00 71.00 VTO MERCAR DARGED TO PATI ENTS 0 38, 399, 175 0.000000 0.000000 1.650, 413 70.00 72.00 OT200 REVE CHARGED TO PATI ENTS 0 46, 227, 624 0.000000 0.000000 1.650, 417 72.00 73.00 OT300 RUSCS CHARGED TO PATI ENTS 0 420		0					
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64.00 0 <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>		0					
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69. 00 06900 ELECTROCARDIOLOGY 0 10, 318, 798 0. 000000 0. 000000 1, 579, 820 69, 00 70. 00 07000 ELECTROCREPHALOGRAPHY 0 5, 443, 826 0. 000000 0. 000000 12, 032, 225 71. 00 71. 00 07100 MPL DEV. CHARGED TO PATI ENTS 0 38, 399, 175 0. 000000 0. 000000 14, 050, 410 72. 00 73. 00 07300 RURAL DI ALYSI S 0 37, 268, 338 0. 000000 0. 000000 6, 933, 379 73. 00 74. 00 07400 RENAL DI ALYSI S 0 37, 268, 338 0. 000000 0. 000000 0. 000000 209, 733 74. 00 75. 00 07500 ASC (NON-DI STINCT PART) 0 0 0. 000000		-					
70.00 07000 ELECTROENCEPHALOGRAPHY 0 5, 443, 826 0.000000 0.000000 671, 522 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 46, 227, 624 0.000000 0.000000 12, 030, 250 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 38, 399, 175 0.000000 0.000000 6, 933, 379 73.00 74.00 07400 RENAL DIALYSIS 0 37, 268, 338 0.000000 0.000000 209, 733 74.00 07500 ASC (NON-DISTINCT PART) 0 0 0.000000 0.000000 0.000000 0 000000 0.000000 0 0 0.000000 0.000000 0 0 0 0.000000 0.000000 0 0 0.000000 0 0 0.000000 0 0 0 0.000000 0 0 0 0.000000 0 0 0 0 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		-					
71:00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 46, 227, 624 0.000000 0.000000 12, 030, 250 71.00 72:00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 38, 399, 175 0.000000 0.000000 6, 933, 379 73.00 74:00 07400 RENAL DI ALYSI S 0 37, 268, 338 0.000000 0.000000 6, 933, 379 74.00 75:00 07500 / ASC (NON-DI STINCT PART) 0 0 0.000000 <t< td=""><td></td><td>-</td><td></td><td></td><td></td><td></td><td></td></t<>		-					
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 38, 399, 175 0.000000 0.000000 14, 050, 410 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 37, 268, 338 0.000000 0.000000 6, 933, 379 73.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0.000000 0.000000 0.000000 0.000000 0 75.00 00T7500 ASC (NON-DISTINCT PART) 0 0 0.000000 0.000000 0.000000 0 88.00 000000 CLINIC 0 0 0.000000 0.000000 0 89.00 88.00 89.00 0.000000 0.000000 0 89.00 90.01 0.000000 0.000000 0 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01							
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74.00 07400 RENAL DI ALYSI S 0 402, 311 0.000000 0.000000 209, 733 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0.000000		-					
75.00 07500 ASC (NON-DI STINCT PART) 0 0 0.000000 0.000000 0 75.00 0UTPATI ENT SERVICE COST CENTERS 0 0 0.000000 0.000000 0 88.00 08800 RIRAL HEALTH CLINIC 0 0 0.000000 0.000000 0 88.00 99.00 0.000000 0.000000 0 90.00 0.000000 0.000000 0 90.01 90.01 0.000000 0.000000 0 90.01 90.01 90.01 90.01 0.000000 0 90.01 90.01 90.01 0.000000 0 90.01 90.02 90.02 KIDS PLUS CLINIC 0 0 0.000000 0 90.02 90.02 90.03 90.02 9							
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0.000000 0.0000							
88.00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0.000000 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 0.000000 0 89.00 90.00 O9000 CLINIC 0 0 0.000000 0.000000 0 90.00 90.01 00001 WOUND/OSTOMY CLINIC 0 5,886,833 0.000000 0.000000 90.01 90.02 09002 KIDS PLUS CLINIC 0 0 0.000000 0.000000 90.02 90.03 09003 ONCLOGY 0 25,121,173 0.000000 0.000000 90.02 90.04 09004 MUNCI E CLINIC 0 0 0.000000 0.000000 90.04 90.05 ANTI COAGULATI ON CLINIC 0 88.852 0.000000 0.000000 90.05 90.06 09006 PEGNANCY PLUS 0 0 0.000000 0 90.06 90.07 09007 LAB 0 0 0.000000 0.000000 90.07 91.00 91000 EMER		0	0	0.000000	0.000000	0	/ 5.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 0.000000 0 89.00 90.00 09000 CLINIC 0 0.000000 0.000000 0 90.00 90.01 09001 WOUND/OSTOMY CLINIC 0 5,886,833 0.000000 0.000000 0 90.02 90.02 VIDS PLUS CLINIC 0 0 0.000000 0.000000 0 90.02 90.03 09003 ONCOLOGY 0 25,121,173 0.000000 0.000000 0 90.03 90.04 09004 MUNCI E CLINIC 0 888,852 0.000000 0.000000 0 90.06 90.05 ANTI COAGULATI ON CLINIC 0 888,852 0.000000 0.000000 0 90.06 90.06 PREGNANCY PLUS 0 0 0.000000 0 90.06 90.07 0/P LAB 0 0 0.000000 0.000000 0 90.07 90.08 09008 O/P LAB </td <td></td> <td>0</td> <td>0</td> <td>0,00000</td> <td></td> <td>0</td> <td>88 00</td>		0	0	0,00000		0	88 00
90.00 09000 CLINIC 0 0 0.000000 0.000000 0 90.00 90.01 09001 WOUND/OSTOMY CLINIC 0 5,886,833 0.000000 0.000000 0 90.01 90.02 09002 KIDS PLUS CLINIC 0 0 0.000000 0.000000 0 90.02 90.03 09003 ONCLOGY 0 25,121,173 0.000000 0.000000 0 90.03 90.04 09004 MUNCIE CLINIC 0 0 0.000000 0.000000 0 90.04 90.05 ANTI COAGULATI ON CLINIC 0 888,852 0.000000 0.000000 0 90.06 90.06 09006 PREGNANCY PLUS 0 0 0.000000 0 90.06 90.07 0/PD LAB 0 0 0 0.000000 0 90.08 90.09 FORTVI LLE CLINIC 0 0 0.000000 0.000000 0 90.09 90.09 FORTVI LLE CLINIC <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td> <td>•</td>		-					•
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90.02 09002 KIDS PLUS CLINIC 0 0 0.00000 0.000000 0 90.02 90.03 09003 ONCOLOGY 0 25,121,173 0.000000 0.000000 104,216 90.03 90.04 09005 ANTI COAGULATI ON CLINIC 0 0 0.000000 0.000000 0 90.04 90.05 09005 ANTI COAGULATI ON CLINIC 0 888,852 0.000000 0.000000 0 90.05 90.06 09006 PREGNANCY PLUS 0 0 0.000000 0.000000 0 90.06 90.07 0/P LAB 0 0 0 0.000000 0.000000 0 90.07 90.09 FORTVI LLE CLINIC 0 0 0 0.000000 0.000000 0 90.07 90.09 PORTVI LLE CLINIC 0 0 0.000000 0.000000 0 90.08 90.09 09009 FORTVI LLE CLINIC 0 0 0.000000 0.000000 90.09 91.00 09100 EMERGENCY 0 37,369,474 0.000000		-					
90.03 09003 0NCOLOGY 0 25, 121, 173 0.000000 0.000000 104, 216 90.03 90.04 09004 MUNCL E CLINIC 0 0 0.000000 0.000000 0 90.04 90.05 09005 ANTICOAGULATION CLINIC 0 888, 852 0.000000 0.000000 0 90.05 90.06 09006 PREGNANCY PLUS 0 0 0.000000 0.000000 0 90.06 90.07 09007 0/P LAB 0 0 0.000000 0.000000 0 90.07 90.08 09008 0/P LAB 0 0 0.000000 0.000000 0 90.07 90.08 09009 FORTVILLE CLINIC 0 0 0.000000 0.000000 0 90.09 90.09 09009 FORTVILLE CLINIC 0 0 0.000000 0.000000 0 90.09 91.00 09100 EMERGENCY 0 37,369,474 0.000000 0.000000 0 92.00 92.00 DESERVATION BEDS (NON-DISTINCT PART) 0 7,431		0					
90. 04 09004 MUNCLE CLINIC 0 0 0.000000 0.000000 0 90. 04 90. 05 09005 ANTICOAGULATION CLINIC 0 888, 852 0.000000 0.000000 0 90. 05 90. 06 09006 PREGNANCY PLUS 0 0 0.000000 0.000000 0 90. 06 90. 07 09007 //P LAB 0 0 0.000000 0.000000 0 90. 07 90. 08 09008 //P LAB 0 0 0.000000 0.000000 0 90. 08 90. 09 9009 FORTVI LLE CLINIC 0 0 0.000000 0.000000 0 90. 09 91. 00 09100 EMERGENCY 0 37, 369, 474 0.000000 0.000000 0 92. 00 92. 00 OBSERVATION BEDS (NON-DISTINCT PART) 0 7, 431, 464 0.000000 0.000000 0 92. 00 92. 00 OP400 HOME PROGRAM DI ALYSIS 0 0 0.0000000 0		0	25, 121, 173				
90.05 09005 ANTI COAGULATI ON CLINIC 0 888,852 0.00000 0.000000 0 90.05 90.06 09006 PREGNANCY PLUS 0 0 0.000000 0.000000 0 90.06 90.07 09007 0/P LAB 0 0 0.000000 0.000000 0 90.07 90.08 09008 0/P LAB 0 0 0.000000 0.000000 0 90.08 90.09 PORTVILLE CLINIC 0 0 0.000000 0.000000 0 90.09 91.00 09109 EMERGENCY 0 37,369,474 0.000000 0.000000 3,526,407 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 7,431,464 0.000000 0.000000 94.00 95.00 09400 HOME PROGRAM DI ALYSIS 0 0 0.000000 95.00 95.00 96.00 09400 MABULANCE SERVICES 95.00 95.00 95.00 95.00 95.00 95.		0	0				
90.06 09006 PREGNANCY PLUS 0 0 0.00000 0.000000 0 90.06 90.06 90.07 09007 0/P LAB 0 0 0.00000 0.000000 0 90.07 90.07 90.08 09008 0/P LAB 0 0 0.000000 0.000000 0 90.08 90.09 90.09 90.07 0.000000 0.000000 0 90.08 90.09 90.00 90.00000 90.00 90.00 90.00 90.00 90.00 90.00 9		0	888, 852				
90.07 09007 0/P LAB 0 0.000000 0.000000 0.000000 0.000000 90.07 90.08 09008 0/P LAB 0 0 0.000000 0.000000 0 90.08 90.09 90009 FORTVILLE CLINIC 0 0 0.000000 0.000000 0 90.09 91.00 09100 EMERGENCY 0 37,369,474 0.000000 0.000000 3,526,407 91.00 92.00 09502 VATION BEDS (NON-DISTINCT PART) 0 7,431,464 0.000000 0.000000 0 92.00 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0.000000 0.000000 94.00 95.00 09500 AMBULANCE SERVICES - - 95.00 95.00 95.00 0.000000 0.000000 0 95.00 95.00 95.00 0.000000 0.000000 96.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 97.00 97.00 97.00 0.000		0					
90.08 09008 0/P LAB 0 0 0.00000 0.000000 0 90.08 90.08 90.09 90.09 90.09 FORTVILLE CLINIC 0 0 0.000000 0.000000 0 90.08 90.09 90.00 90.00 90.00 90.00 90.09 90.09 90.09 90.09 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 <th< td=""><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td></td></th<>		0	0				
90.09 09009 FORTVILLE CLINIC 0 0 0.00000 0.000000 0 90.09 90.09 91.00 91.00 91.00 37,369,474 0.000000 0.000000 3,526,407 91.00 92.00 0 0.000000 0.000000 0.000000 0 92.00 0 0.000000 0.000000 0 92.00 0 0.000000 0.000000 0 92.00 0 0.000000 0.000000 0 92.00 0 0.000000 0.000000 0 92.00 0 0 0.000000 0 0 92.00 0		-					
91.00 09100 EMERGENCY 0 37,369,474 0.000000 0.000000 3,526,407 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 7,431,464 0.000000 0.000000 0 92.00 01HER REI MBURSABLE COST CENTERS 0 0 0.000000 0 94.00 9400 HOME PROGRAM DI ALYSI S 94.00 95.00 0.000000 0.000000 94.00 95.00 95000 AMBULANCE SERVI CES 95.00 95.00 0.000000 0.000000 0 95.00 96.00 900000 0.000000 0 96.00 97.00 0 0.000000 0 96.00 97.00 97.00 0.000000 0.000000 0 97.00		0	0				
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OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DI ALYSI S 0 0.000000 0.000000 94.00 95.00 95.00 95.00 09500 AMBULANCE SERVICES 95.00 95.00 96.00 0.000000 0.000000 0 96.00 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0.000000 0.000000 0 97.00							
94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0.000000 0.000000 94. 00 95. 00 95. 00 95. 00 96. 00 0.9600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0.000000 0.000000 0 96. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0.000000 0.000000 0 97. 00			, , , , , , , , , , , , , , , , , , , ,				
95.00 09500 AMBULANCE SERVICES 95.00 96.00 0.000000 0.000000 95.00 96.00 96.00 96.00 0.000000 0.000000 96.00 96.00 96.00 96.00 96.00 0.000000 0.000000 0 96.00 97.00 97.00 0.000000 0.000000 0 97.00		0	0	0.00000	0.000000	0	94.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0.000000 0.000000 0 97.00	95. 00 09500 AMBULANCE SERVICES						95.00
	96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0. 000000	0. 000000	0	96.00
200.00 Total (lines 50-199) 0 434,832,074 69,898,028 200.00		0	0	0.00000	0. 000000		
	200.00 Total (lines 50-199)	0	434, 832, 074			69, 898, 028	200.00

APPORT	Financial Systems IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE	RVICE OTHER PASS	FAL ANDERSON Provider CO	CN: 15-0113	Peri od:	Worksheet D	2552-10
	H COSTS			SN. 10 0113	From 01/01/2016 To 12/31/2016	Part IV	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Outpatient	Outpati ent		PSA Adj.	
		Program	Program	Program		Nursing School	
		Pass-Through	Charges	Pass-Throug			
		Costs (col. 8	5	Costs (col.			
		x col. 10)		x col. 12)			
		11.00	12.00	13.00	21.00	22.00	
	ANCI LLARY SERVI CE COST CENTERS			-		-	
50.00	05000 OPERATING ROOM	0	11, 111, 164		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	393, 323	1	0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	4, 926, 441	1	0 0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	61, 974	1	0 0	0	55.00
56.00	05600 RADI OI SOTOPE	0	4, 505, 113		0 0	0	56.00
57.00	05700 CT SCAN	0	7, 738, 491		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	3, 198, 356		0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	5, 099, 876		0 0	0	59.00
60.00	06000 LABORATORY	0	3, 956, 776		0 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0 0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	126, 306		0 0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	97, 513		0 0	0	1
66.00	06600 PHYSI CAL THERAPY	0	50, 227		0 0	0	66.00
	06700 OCCUPATI ONAL THERAPY	0	27, 436		0 0	0	1
68.00	06800 SPEECH PATHOLOGY	0	4, 506		0 0	-	1
	06900 ELECTROCARDI OLOGY	0	2, 760, 170		0 0	0	1
	07000 ELECTROENCEPHALOGRAPHY	0	1, 086, 273		0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5, 528, 954		0 0	0	1
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	2,012,600		0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	5, 514, 925		0 0	0	1
	07400 RENAL DIALYSIS	0	0,011,720		0 0	-	
	07500 ASC (NON-DI STINCT PART)	0	0		0 0		1
	OUTPATIENT SERVICE COST CENTERS	-1				-	
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0		1
	09000 CLINIC	0	0		0 0		1
90.01	09001 WOUND/OSTOMY CLINIC	0	2,050,233		0 0	0	90.01
	09002 KIDS PLUS CLINIC	0	0		0 0	0	1
	09003 ONCOLOGY	0	7, 436, 188		0 0	0	
	09004 MUNCIE CLINIC	0	0		0 0	0	
90.05	09005 ANTI COAGULATI ON CLINIC	0	0		0 0	0	1
90.06	09006 PREGNANCY PLUS	0	0		0 0	0	1
	09007 0/P LAB	0	0		0 0	-	
	09008 0/P LAB	0	0		0 0		1
	09009 FORTVILLE CLINIC	0	0		0 0	-	
	09100 EMERGENCY	0	6, 949, 673		0 0		1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3, 206, 063		0 0		
,2.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	5,200,005	l	<u> </u>	0	/2.00
94 00	09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
	09500 AMBULANCE SERVICES		0				95.00
, , , , , , , , , , , , , , , , , , , ,	09600 DURABLE MEDICAL EQUIP-RENTED	0	Ω		0 0	0	1
96 00							
	09700 DURABLE MEDICAL EQUIP-RENTED	0	° ∩		0 0		97.00

Health Financial Systems	COMMUNI TY HOSPI T	AL ANDERSON	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCIL	LARY SERVICE OTHER PASS	Provider CCN: 15-0113	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2016 To 12/31/2016	Part IV Date/Time Prepared:
				4/14/2017 8:18 am
		Title XVIII	Hospi tal	PPS
Cost Center Description		PSA Adj. All		
	Allied Health O	ducation Cost		
	23.00	24.00		
ANCI LLARY SERVI CE COST CENTERS	20100	2.1.00		
50. 00 05000 OPERATI NG ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESI OLOGY	0	0		53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		55.00
56. 00 05600 RADI 0I SOTOPE	0	0		56.00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0	0		57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0		59.00
60. 00 06000 LABORATORY	0	0		60.00
60. 01 06001 BLOOD LABORATORY	0	Ö		60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM	ONLY			61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD		0		62.00
63.00 06300 BLOOD STORING, PROCESSING & TRA	NS. O	0		63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT		0		70.00 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	I ENTS	0		71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
74. 00 07400 RENAL DIALYSIS	0	o		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENT		0		89.00
90. 00 09000 CLINIC	0	0		90.00
90. 01 09001 WOUND/OSTOMY CLINIC	0	0		90.01
90. 02 09002 KIDS PLUS CLINIC	0	0		90.02
90. 03 09003 ONCOLOGY 90. 04 09004 MUNCI E CLINIC	0	0		90. 03 90. 04
90. 05 09005 ANTI COAGULATI ON CLINIC	0	0		90.04
90. 06 09006 PREGNANCY PLUS	0	0		90.05
90. 07 09007 0/P LAB	0	o		90.07
90. 08 09008 0/P LAB	0	ő		90.08
90. 09 09009 FORTVI LLE CLI NI C	Ő	ŏ		90.09
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	PART) 0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		94.00
95. 00 09500 AMBULANCE SERVICES				95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		97.00
200.00 Total (lines 50-199)	i Oj	0J		200.00

eal th Financial	MEDICAL, OTHER HEALTH SERVICES ANI	COMMUNI TY HOSP D VACCI NE COST	Provider C		Period: From 01/01/2016 To 12/31/2016		pared:
			Title	e XVIII	Hospi tal	PPS	_
				Charges		Costs	
Cost	Center Description	5	PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(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.)	E 00	
	SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
0. 00 05000 OPERA		0. 218280	11, 111, 164	1	0 0	2, 425, 345	50.00
51.00 05100 RECOV		0. 218280		1	0 0	2, 425, 545	51.00
	/ERY ROOM & LABOR ROOM	0. 000000			0 0	0	52.00
3. 00 05300 ANEST		0. 144388	-		0 0	56, 791	53.00
	DLOGY-DI AGNOSTI C	0. 304589			0 0	1, 500, 540	
	DLOGY-THERAPEUTIC	0. 000000		1	0 0	1, 500, 540	55.00
6. 00 05600 RADI 0		0. 079225			0 0		
57.00 05700 CT SC		0. 079225			0 0	356, 918	57.00
	TIC RESONANCE IMAGING (MRI)	0. 031841			0 0	246, 401 272, 650	
	AC CATHETERIZATION	0. 085247			0 0	484, 371	58.00
0. 00 06000 LABOR		0. 169384				670, 215	
	LABORATORY	0. 000000			0 0	070, 215	1
	CLINICAL LAB SERVICES-PRGM ONLY	0.000000			0 0	U U	60.0 ¹
	E BLOOD & PACKED RED BLOOD CELLS	0. 280578			0 0	35, 439	•
	STORING, PROCESSING & TRANS.	0. 280378			0 0	0	63.00
	VENOUS THERAPY	0. 000000				0	64.00
	RATORY THERAPY	0. 329580			0 0		
	CAL THERAPY	0. 329580			0 0	32, 138	
					0 0	20, 854	
	PATIONAL THERAPY	0. 385531	27, 436		-	10, 577	1
	CH PATHOLOGY TROCARDI OLOGY	0. 412159 0. 095726			0 0	1,857	
					-	264, 220	
	ROENCEPHALOGRAPHY	0. 246967				268, 274	
	CAL SUPPLIES CHARGED TO PATIENTS DEV. CHARGED TO PATIENTS	0. 321776			0 0	1, 779, 085	71.00
	CHARGED TO PATTENTS	0. 387461 0. 283818				779, 804	•
4.00 07400 RENAL		0. 836698			0 0 0 0	0	74.00
	NON-DI STI NCT PART) SERVI CE COST CENTERS	0. 000000	0	1	0 0	0	75.00
	HEALTH CLINIC	0. 000000				0	88.00
	ALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
					0	0	
	C D/OSTOMY CLINIC	0.000000			0 0		90.00
	PLUS CLINIC	0. 422811	2, 050, 233		0 0	866, 861	90.0 [°] 90.0
0. 02 09002 KTD3 0. 03 09003 ONCOL		0.000000			0 0	0	90.0
					0 0		
1 1	COAGULATION CLINIC	0. 000000			0 0	0	90.04
		0. 554854			0 0	0	
0. 06 09006 PREGN		0. 000000	-			-	
0.07 09007 0/P L		0. 000000			0 0	0	•
0.08 09008 0/P L		0. 000000			0 0	0	
	ILLE CLINIC	0.00000			0 0	0	90.0
1.00 09100 EMER		0. 196776			0 0	1, 367, 529	
	RVATION BEDS (NON-DISTINCT PART)	0. 423367	3, 206, 063		0 0	1, 357, 341	92.00
	BURSABLE COST CENTERS	0.000000		1			
	PROGRAM DI ALYSI S	0. 000000			0		94.0
	ANCE SERVICES	0. 000000			0	-	95.0
	BLE MEDICAL EQUIP-RENTED	0. 000000			0 0	0	
	BLE MEDICAL EQUIP-SOLD	0. 000000			0 0	0	97.0
200.00 Subto	otal (see instructions)		77, 842, 581	47, 25	9 100, 619	14, 362, 445	
	PBP Clinic Lab. Services-Program	1	1	1	0 0		201.0
					0		201.0
Onl y	Charges (line 200 +/- line 201)		77, 842, 581	47, 25	.9 100, 619	14, 362, 445	

Health Financial Systems APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	COMMUNITY HOSPI VACCINE COST	Provider CCN	: 15-0113	Period: From 01/01/2016 To 12/31/2016	u of Form CMS-2 Worksheet D Part V Date/Time Pre 4/14/2017 8:1	pared:
		Title >	(VIII	Hospi tal	PPS	
Cost Center Description	Cost Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To				
ANCI LLARY SERVI CE COST CENTERS	0.00	1100				
50. 00 05000 0PERATI NG ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C		0 0 0 0 0				50.00 51.00 52.00 53.00 54.00 55.00
56.00 05600 RADI OI SOTOPE 57.00 05700 CT SCAN 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 59.00 05900 CARDI AC CATHETERI ZATI ON 60.00 06000 LABORATORY 60.01 06001 BLOOD LABORATORY	0 0 0 7, 317 0					56.00 57.00 58.00 59.00 60.00 60.01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62. 00 06200 WHOLE BLOOD PACKED RED BLOOD CELLS 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 64. 00 06400 INTRAVENOUS THERAPY 65. 00 06500 RESPIRATORY THERAPY 66. 00 06600 PHYSICAL THERAPY 67. 00 06700 OCCUPATIONAL THERAPY		0 0 0 0 0 0				61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY 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 75. 00 07500 ASC (NON-DI STI NCT PART)	0 0 0 1, 152 0 0	0 0 0 28, 557 0 0				68.00 69.00 70.00 71.00 72.00 73.00 74.00 75.00
OUTPATIENT SERVICE COST CENTERS	-					
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC 90. 01 09001 WOUND/OSTOMY CLINIC 90. 02 09002 KIDS PLUS CLINIC 90. 03 09003 ONCOLOGY		0 0 0 0 0				88.00 89.00 90.00 90.01 90.02 90.03
90.04 09004 MUNCLE CLINIC 90.05 09005 ANTI COAGULATI ON CLINIC 90.06 09006 PREGNANCY PLUS 90.07 09007 0/P LAB 90.08 09008 0/P LAB	0 0 0	0 0 0 0				90. 04 90. 05 90. 06 90. 07 90. 08
90.09 09009 FORTVI LLE CLI NI C 91.00 09100 EMERGENCY 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0THER REI MBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DI ALYSI S		0 0 0				90.09 91.00 92.00 94.00
95.00 09500 AMBULANCE SERVICES 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 200.00 Subtotal (see instructions) 201.00 Less PBP Clinic Lab. Services-Program	0 0 0 8, 469 0	0 0 28, 557				94.00 95.00 96.00 97.00 200.00 201.00
202.00Only Charges202.00Net Charges (line 200 +/- line 201)	8, 469	28, 557				202.00

JMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0113	Period: From 01/01/2016	Worksheet D-1	
			To 12/31/2016	4/14/2017 8:18	
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS	· · · · · ·			1.
00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			23, 972 23, 972	
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	20, 772	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	(aveb bec		21, 568	4.
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	21, 300	
00	reporting period Total swing-bed SNF type inpatient days (including private ro	and dave) after December	21 of the cost	0	6.
00	reporting period (if calendar year, enter 0 on this line)	Join days) arter becember	ST OF THE COST	0	0.
00	Total swing-bed NF type inpatient days (including private roc	om days) through Decembe	r 31 of the cost	0	7.
00	reporting period Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	0	8.
00	reporting period (if calendar year, enter 0 on this line)			0 470	
00	Total inpatient days including private room days applicable t newborn days)	to the program (excluding	g swing-bed and	9, 473	9.
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days)	0	10.
. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11.
	December 31 of the cost reporting period (if calendar year, e		t		10
2. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	ix only (including priva	te room days)	0	12.
. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.
. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14.
. 00	Total nursery days (title V or XIX only)	, <u> </u>	5 /	0	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31	of the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	as through December 31 o	f the cost	0.00	10
	reporting period	5			
). 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of	the cost	0.00	20.
. 00	Total general inpatient routine service cost (see instruction			31, 373, 356	
2. 00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	per 31 of the cost repor	ting period (line	0	22.
. 00	Swing-bed cost applicable to SNF type services after December	n 31 of the cost reporti	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost report	ing period (line	0	24.
	7 x line 19)	•	0.1		
5. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	g period (line 8	0	25.
. 00	Total swing-bed cost (see instructions)			0	
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		31, 373, 356	27.
. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	28
. 00	Private room charges (excluding swing-bed charges)			0	
. 00	Semi -private room charges (excluding swing-bed charges)			0	
00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ TTHE 28)		0. 000000 0. 00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
00	Average per diem private room charge differential (line 32 mi	nus line 33) (see instru	ctions)	0.00	
00	Average per diem private room cost differential (line 34 x li			0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	
00	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	31, 373, 356	
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see	e instructions)		1, 308. 75	
 00 00 00 00 00 00 00 	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	e instructions) e 38)		1, 308. 75 12, 397, 789 0	39

COMPUT	TATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2016	Worksheet D-1	1
					To 12/31/2016		
				XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costl	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	
2. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	0 0	0	42.
8. 00	INTENSIVE CARE UNIT	4, 880, 435	1, 570	3, 108. 5	6 1, 438	4, 470, 109	43.
4.00	CORONARY CARE UNIT	0	0				
5.00	BURN INTENSIVE CARE UNIT	0	0			C	45.
b. 00		0	0	0.0	0 0	C	
7.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
	cost center bescription					1.00	-
. 00	Program inpatient ancillary service cost (Wks					18, 663, 827	/ 48.
. 00		41 through 48)(see instructio	ns)		35, 531, 725	5 49.
). 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program input	atient routine (services (from	West D sum	of Parts 1 and	1, 036, 102	50
. 00			361 11 663 (11 66	WKSt. D, Sum		1,030,102	50.
1.00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	734, 484	I 51.
2 00	and IV)	E0 and $E1$				1 770 507	En
2.00 3.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu	,	lated non-nhy	sician anesth	etist. and	1, 770, 586 33, 761, 139	
5.00	medical education costs (line 49 minus line		ratea, non phy			00,701,107	
	TARGET AMOUNT AND LIMIT COMPUTATION						
1.00						0	
. 00	5 1 5					0.00	
. 00	Difference between adjusted inpatient operati	ing cost and ta	rget amount (I	ine 56 minus	line 53)		
. 00	Bonus payment (see instructions)	5	5 .		,	0	58
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period (ending 1996, u	pdated and co	mpounded by the	0.00	59
. 00	market basket Lesser of lines 53/54 or 55 from prior year of	cost report up	dated by the m	arkat baskat		0.00	60
. 00	If line 53/54 is less than the lower of line				the amount by	0.00	
	which operating costs (line 53) are less than						
	amount (line 56), otherwise enter zero (see	instructions)				_	
2.00 3.00		opt (coo inctru	ations)				
5.00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST						1 03.
4.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64.
	instructions)(title XVIII only)						
5. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts atter Decembe	er 31 of the c	ost reporting	period (See	C	65.
5. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line (64 plus line 6	5)(title XVII	l only). For	0	66.
	CAH (see instructions)				•		
7.00	5 1	e costs through	December 31 c	f the cost re	porting period	0	67.
B. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after De	ecember 31 of	the cost repo	rtina period	c	68.
	(line 13 x line 20)						
9.00	Total title V or XIX swing-bed NF inpatient					0) 69.
0. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil					1	70.
. 00	Adjusted general inpatient routine service c	2		• •			71.
2. 00				,			72.
8. 00	Medically necessary private room cost application			ne 35)			73
. 00	Total Program general inpatient routine serv			arkahaat D. D.			74
5.00	Capital-related cost allocated to inpatient 26, line 45)	routine service	COSIS (ITOIN W	UTKSNEEL B, P	art II, corumn		75
6. 00		ne 2)					76
. 00	Program capital-related costs (line 9 x line	,					77
		,		-)			78
. 00 . 00	55 5 5				is line 70)		80
. 00	5				us IIIC /7)		80
. 00)				82
. 00	Reasonable inpatient routine service costs (see instruction					83
. 00	Program inpatient ancillary services (see in		``````````````````````````````````````				84
5.00	1 5						85
5.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS						86.
7.00	Total observation bed days (see instructions)					2,404	1 87.
B. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 308. 75	5 88.
	Observation bed cost (line 87 x line 88) (see					3, 146, 235	

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lieu of Form CMS-255		
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2016	Worksheet D-1	
				To 12/31/2016	Date/Time Pre 4/14/2017 8:1	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	1, 935, 922	31, 373, 356	0.06170	5 3, 146, 235	194, 142	90.00
91.00 Nursing School cost	0	31, 373, 356	0.00000	3, 146, 235	0	91.00
92.00 Allied health cost	0	31, 373, 356	0.00000	3, 146, 235	0	92.00
93.00 All other Medical Education	0	31, 373, 356	0.00000	3, 146, 235	0	93.00

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0113	Period: From 01/01/2016 To 12/31/2016		pared:
		Title XIX	Hospi tal	4/14/2017 8:1 Cost	8 am
	Cost Center Description	-		1 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS	(c. oveluding newborn)		22.072	1 1 0
. 00 2. 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			23, 972 23, 972	
. 00	Private room days (excluding swing-bed and observation bed da	5,	rivate room days,	0	
. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	od dave)		21, 568	4.0
5. 00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	21, 500	
0.0	reporting period			0	
. 00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) atter December	31 of the cost	0	6. C
. 00	Total swing-bed NF type inpatient days (including private roo	om days) through December	31 of the cost	0	7.0
8. 00	reporting period Total swing-bed NF type inpatient days (including private roo	m davs) after December 3	1 of the cost	0	8.0
. 00	reporting period (if calendar year, enter 0 on this line)	in days) arter becenber a	of the cost	0	0.0
. 00	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	732	9. C
0.00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private r	oom davs)	0	10.0
	through December 31 of the cost reporting period (see instruc	tions)	5,		
1.00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		room days) after	0	11.0
2.00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.0
2 00	through December 31 of the cost reporting period	V only (including privat	a ream daya)	0	12.0
3.00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13.0
	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			2, 158 1, 780	
	SWING BED ADJUSTMENT				
7.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es through December 31 c	of the cost	0.00	17.0
8.00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18.0
9.00	reporting period Medicaid rate for swing-bed NF services applicable to service	as through December 31 of	the cost	0.00	19. C
9.00	reporting period	s thi dugit becember 51 of	the cost	0.00	17.0
20.00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of t	he cost	0.00	20.0
1. 00	Total general inpatient routine service cost (see instruction	is)		31, 373, 356	21.0
2.00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost report	ing period (line	0	22.0
3. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	na period (line 6	0	23.0
	x line 18)			_	
4. 00	Swing-bed cost applicable to NF type services through Decembe 7×1 (ine 19)	er 31 of the cost reporti	ng period (line	0	24.0
5.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25.0
6. 00	x line 20) Total swing-bed cost (see instructions)			0	26.0
7.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		31, 373, 356	
8. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation hed ch	arges)	0	28. C
9.00	Private room charges (excluding swing-bed charges)	and observation bed ci	lai yes)	0	
0.00	Semi-private room charges (excluding swing-bed charges)			0	1
1.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
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 mi		ctions)	0.00	
5.00 6.00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 2 x line 25)	ne 31)		0.00	
6.00 7.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	31, 373, 356	
	27 minus line 36)	,		,	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	LISTMENTS			-
8. 00	Adjusted general inpatient routine service cost per diem (see			1, 308. 75	38.0
	Program general inpatient routine service cost (line 9 x line			958,005	
	Medically necessary private room cost applicable to the Progr			0	
1.00	Total Program general inpatient routine service cost (line 39	1 ± 1 ine 40)		958, 005	1 41 (

MPUT.	Financial Systems ATION OF INPATIENT OPERATING COST	COMMUNITY HOSPIT	Provider CC	N: 15-0113	Period: From 01/01/2016	eu of Form CMS- Worksheet D-1	
					To 12/31/2016	Date/Time Pre	
			Title	e XIX	Hospi tal	4/14/2017 8: Cost	18 am
	Cost Center Description	Total Inpatient Costl	Total	Average Per	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)	2, 213, 264	2, 158	1, 025. (61 1, 780	1, 825, 586	5 42.
. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	4, 880, 435	1, 570	3, 108. !	56 0		0 43
. 00	CORONARY CARE UNIT	4, 000, 435	1, 570	3, 108. : 0. (
. 00	BURN INTENSIVE CARE UNIT	0	0	0.0			
	SURGI CAL I NTENSI VE CARE UNI T	0	0	0. (C	
. 00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost (Wks	st. D-3. col. 3.	line 200)			3, 448, 575	5 48
. 00	Total Program inpatient costs (sum of lines			ns)		6, 232, 166	
	PASS THROUGH COST ADJUSTMENTS					1	
. 00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	Wkst. D, sur	m of Parts I and	C	50
. 00) Pass through costs applicable to Program inpa	atient ancillary	services (fr	om Wkst D '	sum of Parts II	C	51
	and IV)	s and a second by					
. 00	Total Program excludable cost (sum of lines !					C	
. 00	Total Program inpatient operating cost exclud medical education costs (line 49 minus line !		ated, non-phy	sician anesti	netist, and	C	53
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
. 00	Program di scharges					0	54
. 00	Target amount per discharge					0.00	55
	Target amount (line 54 x line 55)					0	
. 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ing cost and tar	get amount (I	ne 56 minus	line 53)		
. 00 . 00	Lesser of lines 53/54 or 55 from the cost rep	ompounded by the	-				
	market basket	on thig pointed o		success and of	sinpoundou by the	0.00	
. 00	Lesser of lines 53/54 or 55 from prior year of					0.00	
. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					C	61
	amount (line 56), otherwise enter zero (see i		(TTHES 54 X	30), OI 1% OI	i the target		
. 00	Relief payment (see instructions)					C	62
. 00	Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)			0	63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Docom	bor 21 of the	cost roporti	ng pariod (Saa		64
. 00	instructions) (title XVIII only)	ts through becen		cost reporti	ng period (see		1 04
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the c	ost reporting	g period (See	C	65
~~	instructions)(title XVIII only)						
. 00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	ne costs (line 6	4 plus line 6	5)(TITIE XVII	II ONLY). FOr	C	66
. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	f the cost re	eportina period	0	67
	(line 12 x line 19)	0					
. 00	Title V or XIX swing-bed NF inpatient routine	e costs after De	cember 31 of	the cost repo	orting period	C	68
. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient (coutine costs (1	ine 67 + line	68)			69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU						
. 00	Skilled nursing facility/other nursing facili	ty/ICF/IID rout	ine service c	ost (line 37))		70
	Adjusted general inpatient routine service co		ne 70 ÷ line 2	2)			71
	Program routine service cost (line 9 x line)		(Lipo 14 v Li	no 2E)			72
. 00	Medically necessary private room cost applica Total Program general inpatient routine servi			le 33)			73
. 00	Capital -related cost allocated to inpatient	•		orksheet B, I	Part II, column		75
_	26, line 45)						
	Per diem capital related costs (line 75 ÷ lin						76
	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77
	Aggregate charges to beneficiaries for excess		ovider record	s)			79
00	Total Program routine service costs for compa	• •			nus line 79)		80
	Inpatient routine service cost per diem limi						81
	Inpatient routine service cost limitation (li						82
. 00 . 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see ins		·)				83
	Utilization review - physician compensation		is)				85
. 00	Total Program inpatient operating costs (sum	of lines 83 thr					86
	PART IV - COMPUTATION OF OBSERVATION BED PASS						
00							
. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per o		line 2)			2, 404 1, 308. 75	

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lieu of Form CMS-2552			
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2016	Worksheet D-1		
				To 12/31/2016	Date/Time Pre 4/14/2017 8:1	pared: 8 am	
		Ti tl	e XIX	Hospi tal	Cost		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST						
90.00 Capital-related cost	1, 935, 922	31, 373, 356	0.06170	6 3, 146, 235	194, 142	90.00	
91.00 Nursing School cost	0	31, 373, 356	0.00000	3, 146, 235	0	91.00	
92.00 Allied health cost	0	31, 373, 356	0.00000	3, 146, 235	0	92.00	
93.00 All other Medical Education	0	31, 373, 356	0.00000	3, 146, 235	0	93.00	

	ncial Systems COMMUNITY HOSPIT/	AL ANDERSON		In Lie	u of Form CMS-2	2552-10
INPATIENT A	NCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0113	Period: From 01/01/2016	Worksheet D-3	
				To 12/31/2016	Date/Time Pre 4/14/2017 8:1	pared:
		Title	xvi i	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges	Program Charges	Program Costs (col. 1 x col.	
					2)	
	TI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	3.00	
	O ADULTS & PEDIATRICS			16, 090, 328		30.00
				4, 591, 450		31.00
	D CORONARY CARE UNIT D BURN INTENSIVE CARE UNIT			0		32.00 33.00
	O SURGI CAL I NTENSI VE CARE UNI T			0		34.00
	0 SUBPROVIDER - IPF			0		40.00
	O SUBPROVIDER - IRF			0		41.00 42.00
	0 SUBPROVI DER 0 NURSERY			0		42.00
ANCI	LLARY SERVICE COST CENTERS		1			
	DOPERATING ROOM		0. 2182		2, 428, 252 0	50.00 51.00
	O DELIVERY ROOM & LABOR ROOM		0.0000		0	51.00
	O ANESTHESI OLOGY		0. 1443		65, 481	53.00
	0 RADI OLOGY-DI AGNOSTI C		0.3045		775, 591	54.00
	0 RADI 0L0GY-THERAPEUTI C 0 RADI 0I SOTOPE		0. 0000		0 26, 194	55.00 56.00
	O CT SCAN		0.0318		104, 162	57.00
	D MAGNETIC RESONANCE I MAGING (MRI)		0. 0852		67, 576	
	O CARDI AC CATHETERI ZATI ON O LABORATORY		0.0949		265, 568 832, 549	
	1 BLOOD LABORATORY		0. 1693		832, 549	60. 00 60. 01
	O PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	61.00
	O WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2805		105, 813	62.00
	0 BLOOD STORING, PROCESSING & TRANS. 0 INTRAVENOUS THERAPY		0.0000		0	63.00 64.00
	O RESPIRATORY THERAPY		0. 3295		761, 481	65.00
	0 PHYSI CAL THERAPY		0. 4151		412, 339	66.00
	O OCCUPATIONAL THERAPY O SPEECH PATHOLOGY		0. 3855 0. 4121		198, 796 150, 706	67.00 68.00
	0 ELECTROCARDI OLOGY		0. 0957		151, 230	
70.00 0700	0 ELECTROENCEPHALOGRAPHY		0. 2469		165, 844	70.00
	O MEDICAL SUPPLIES CHARGED TO PATIENTS		0.3217			
	O IMPL. DEV. CHARGED TO PATIENTS O DRUGS CHARGED TO PATIENTS		0. 3874 0. 2838			
	O RENAL DI ALYSI S		0. 8366			74.00
	O ASC (NON-DI STI NCT PART)		0.0000	00 00	0	75.00
	ATI ENT SERVI CE COST CENTERS		0.0000	20	0	88.00
	FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
90.00 0900			0.0000		0	90.00
	1 WOUND/OSTOMY CLINIC 2 KIDS PLUS CLINIC		0. 4228		0	90. 01 90. 02
	3 ONCOLOGY		0.0000		0	90.02
	4 MUNCIE CLINIC		0.0000		0	90. 04
	5 ANTI COAGULATI ON CLINIC		0. 5548		0	90.05
	6 PREGNANCY PLUS 7 0/P LAB		0.0000		0	90.06 90.07
	8 0/P LAB		0.0000		0	90.08
	9 FORTVILLE CLINIC		0.0000		0	90.09
	O EMERGENCY O OBSERVATION BEDS (NON-DISTINCT PART)		0. 1967 0. 4233		693, 912 0	91.00 92.00
	R REIMBURSABLE COST CENTERS		0.4233	0	0	72.00
94.00 0940	O HOME PROGRAM DI ALYSI S		0.0000	0 00	0	
	O AMBULANCE SERVI CES O DURABLE MEDI CAL EQUI P-RENTED		0. 0000		0	95.00 96.00
	O DURABLE MEDICAL EQUIP-RENTED		0.0000		0	96.00
200.00	Total (sum of lines 50-94 and 96-98)			69, 898, 028		200. 00
201.00	Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		60 000 000		201.00
202.00	Net Charges (line 200 minus line 201)		I	69, 898, 028	l	202.00

NDATLENT ANCL	al Systems COMMUNITY HOSPIT/ LLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15 0112		u of Form CMS-: Worksheet D-3	
NPATTENT ANCT	LLARY SERVICE CUST APPORTIONMENT			Period: From 01/01/2016 To 12/31/2016	Date/Time Pre	pared:
		Ti +1	e XIX	Hospi tal	4/14/2017 8:1	8 am
<u> </u>	ost Center Description		Ratio of Cos	Hospital st Inpatient	Cost Inpati ent	
0	st center bescription		To Charges		Program Costs	
			l ro onargoo	Charges	$(col \cdot 1 \times col \cdot$	
				5	2)	
			1.00	2.00	3.00	
	NT ROUTINE SERVICE COST CENTERS		1			
	DULTS & PEDIATRICS			5, 442, 799		30.0
	ITENSI VE CARE UNI T)RONARY CARE UNI T			1, 038, 937		31.0
	JRN INTENSIVE CARE UNIT			0		33.0
1 1	JRGI CAL I NTENSI VE CARE UNI T			0		34.0
	JBPROVIDER - IPF			0		40.0
1 1	JBPROVI DER – I RF			0		41.0
2.00 04200 SU	JBPROVI DER			0		42.0
3.00 04300 NU				2, 464, 209		43.0
	RY SERVICE COST CENTERS		0.0100		1 700 074	1 - 0 - 0
	PERATING ROOM		0. 2182		1, 798, 274	
	ELIVERY ROOM & LABOR ROOM		0.0000		0	
	IESTHESI OLOGY		0.0000		61, 796	
	ADI OLOGY-DI AGNOSTI C		0. 3045		138, 815	
	ADI OLOGY-THERAPEUTI C		0.0000		0	55.0
6.00 05600 RA	ADI OI SOTOPE		0. 0792	25 67, 293	5, 331	56.0
7.00 05700 CT			0. 0318		21, 614	
	AGNETIC RESONANCE IMAGING (MRI)		0.0852		16, 828	
	ARDI AC CATHETERI ZATI ON		0.0949		110, 618	
	ABORATORY		0. 1693		203, 771	1
1 1	LOOD LABORATORY 3P CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	
1 1	OLE BLOOD & PACKED RED BLOOD CELLS		0. 2805		39, 788	
1 1	LOOD STORING, PROCESSING & TRANS.		0.0000		0	1
	ITRAVENOUS THERAPY		0.0000		0	
5.00 06500 RE	SPI RATORY THERAPY		0. 3295		124, 625	65.0
	IYSI CAL THERAPY		0. 4151		42, 898	
	CCUPATIONAL THERAPY		0. 3855		24, 088	
	PEECH PATHOLOGY		0. 4121		10, 996	
	.ECTROCARDI OLOGY .ECTROENCEPHALOGRAPHY		0. 0957 0. 2469		25, 413 53, 094	
1 1	EDICAL SUPPLIES CHARGED TO PATIENTS		0. 3217		03,04	
1 1	IPL. DEV. CHARGED TO PATIENTS		0. 3874		0	
	RUGS CHARGED TO PATIENTS		0. 2838		603, 811	
	ENAL DI ALYSI S		0. 8366		0	74.0
	SC (NON-DISTINCT PART)		0.0000	00 0	0	75.0
	ENT SERVICE COST CENTERS		0.0000	22	0	
	JRAL HEALTH CLINIC EDERALLY QUALIFIED HEALTH CENTER		0.0000			
0.00 09000 FE			0.0000		0	
	DUND/OSTOMY CLINIC		0. 4228		0	
	DS PLUS CLINIC		0.0000		0	
0. 03 09003 ON			0.0000		0	
	JNCIE CLINIC		0.0000		0	
	ITI COAGULATI ON CLINIC		0. 5548		0	
	REGNANCY PLUS		0.0000		0	
0.07 09007 0/			0.0000		0	
0.08 09008 0/ 0.09 09009 F0	PLAB DRTVILLE CLINIC		0.0000		0	
1.00 09100 EM			0.0000		166, 815	
1 1	BSERVATION BEDS (NON-DISTINCT PART)		0. 4233		00,019	
	EI MBURSABLE COST CENTERS					1
4.00 09400 H0	ME PROGRAM DI ALYSI S		0.0000	00 0	0	
	IBULANCE SERVI CES					95. C
	JRABLE MEDI CAL EQUI P-RENTED		0.0000		0	
	JRABLE MEDICAL EQUIP-SOLD		0.0000		0	
00.00 To	otal (sum of lines 50-94 and 96-98)	() ()		16, 719, 225	3, 448, 575	200. 0
01.00 Le	ess PBP Clinic Laboratory Services-Program only charges	s (no 6'''				

	Financial Systems COMMUNITY HOSPITA ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0113	Peri od: From 01/01/2016 To 12/31/2016	u of Form CMS-2 Worksheet E Part A Date/Time Pre 4/14/2017 8:15	pared:
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
. 00 . 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr	ing prior to October 1 /	(500	0	1.00 1.01
. 01	instructions)	ing piror to october i t	200	0	1.0
. 02	DRG amounts other than outlier payments for discharges occurr	ing on or after October	1 (see	23, 762, 103	1. 02
. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI f	or discharges occurring	prior to October	0	1.03
	1 (see instructions)	0 0		-	
. 04	DRG for federal specific operating payment for Model 4 BPCl f October 1 (see instructions)	for discharges occurring	on or after	0	1.04
. 00	Outlier payments for discharges. (see instructions)			1, 808, 544	2.00
. 01	Outlier reconciliation amount			0	2.0
. 02 . 00	Outlier payment for discharges for Model 4 BPCI (see instruct Managed Care Simulated Payments	ions)		0	2.02
. 00	Bed days available divided by number of days in the cost repo	orting period (see instru	uctions)	132.86	
	Indirect Medical Education Adjustment	· · · ·			
. 00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	t recent cost reporting	period ending on	0.00	5.00
. 00	FTE count for allopathic and osteopathic programs which meet	the criteria for an add-	on to the cap	0.00	6.00
	for new programs in accordance with 42 CFR 413.79(e)				
. 00 . 01	MMA Section 422 reduction amount to the IME cap as specified ACA Section 5503 reduction amount to the IME cap as specified			0.00 0.00	7.00 7.0
. 01	If the cost report straddles July 1, 2011 then see instructio)(1)(10)(2)	0.00	/.0
. 00	Adjustment (increase or decrease) to the FTE count for allopa			0.00	8.0
	affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).	/9(C)(2)(IV), 64 FR 2634	10 (May 12,		
. 01	The amount of increase if the hospital was awarded FTE cap sl	ots under section 5503 d	of the ACA. If	0.00	8.0
00	the cost report straddles July 1, 2011, see instructions.			0.00	
. 02	The amount of increase if the hospital was awarded FTE cap sl under section 5506 of ACA. (see instructions)	ots from a closed teachi	ng nospi tai	0.00	8. 0
. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin	es (8, 8,01 and 8,02)	(see	0.00	9.00
0. 00	instructions)	opt yoor from your rocor	de	0.00	10.00
1.00	FTE count for allopathic and osteopathic programs in the curr FTE count for residents in dental and podiatric programs.	ent year from your recor	us	0.00	
2.00	Current year allowable FTE (see instructions)				12.0
3.00	Total allowable FTE count for the prior year.	ar and an ar after Sor	stombor 20 1007		13.0
4.00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ar ended on or arter sep	Jtember 30, 1997,	0.00	14.0
5.00	Sum of lines 12 through 14 divided by 3.				15.0
	Adjustment for residents in initial years of the program				16.0 17.0
	Adjustment for residents displaced by program or hospital clo Adjusted rolling average FTE count	isure			17.0
9.00	Current year resident to bed ratio (line 18 divided by line 4	.).		0.000000	19.0
	Prior year resident to bed ratio (see instructions)			0.000000	
	IME payment adjustment (see instructions)			0. 000000 0	1
	IME payment adjustment - Managed Care (see instructions)			0	
2 00	Indirect Medical Education Adjustment for the Add-on for Sect		410 105	0.00	
3.00	Number of additional allopathic and osteopathic IME FTE resid $(f)(1)(iv)(C)$.	ient cap slots under 42 s	Sec. 412.105	0.00	23.0
4.00	IME FTE Resident Count Over Cap (see instructions)			0.00	
5.00	If the amount on line 24 is greater than -0-, then enter the	lower of line 23 or line	e 24 (see	0.00	25.0
6.00	instructions) Resident to bed ratio (divide line 25 by line 4)			0.000000	26.0
7.00	IME payments adjustment factor. (see instructions)			0.000000	
	IME add-on adjustment amount (see instructions)	、 、		0	
8.01 9.00	IME add-on adjustment amount - Managed Care (see instructions Total IME payment (sum of lines 22 and 28)	;)		0	
9.00 9.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0	1)		0	
0 0-	Disproportionate Share Adjustment				
0.00 1.00	Percentage of SSI recipient patient days to Medicare Part A p Percentage of Medicaid patient days (see instructions)	atient days (see instruc	ctions)	5. 19 24. 37	30.0 31.0
	Sum of Lines 30 and 31			24.37	
3.00	Allowable disproportionate share percentage (see instructions)		13.60	33. C
4.00	Disproportionate share adjustment (see instructions)			807, 912	34.0

ALCUL	Financial Systems COMMUNITY HOSE ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0113	Peri od:	u of Form CMS-2 Worksheet E	
			From 01/01/2016 To 12/31/2016	Date/Time Pre	pared
		Title XVIII	Hospi tal	4/14/2017 8: 18 PPS	8 200
			Prior to 10/1		
			1.00	2.00	
	Uncompensated Care Adjustment				
	Total uncompensated care amount (see instructions)		6, 406, 145, 534		
	Factor 3 (see instructions) Hospital uncompensated care payment (Ifline 34 is zero,	enter zero on this line)	0. 000150915 966, 783	0. 000151784 907, 284	
0.02	(see instructions)		700, 703	707,204	33. (
35.03	Pro rata share of the hospital uncompensated care payment	amount (see instructions)	723, 767	228, 685	35.0
	Total uncompensated care (sum of columns 1 and 2 on line 3		952, 452		36.0
	Additional payment for high percentage of ESRD beneficiary				1 10
10.00	Total Medicare discharges on Worksheet S-3, Part I excludi 652, 682, 683, 684 and 685 (see instructions)	ng discharges for MS-DRGS	0		40. (
1.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682	. 683. 684 an 685. (see	0		41. (
	instructions)	,,	_		
11.01	Total ESRD Medicare covered and paid discharges excluding	MS-DRGs 652, 682, 683, 684	0		41. (
12 00	an 685. (see instructions)	alify for adjustment)	0.00		10
	Divide line 41 by line 40 (if less than 10%, you do not qu Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0.00		42.0
3.00	instructions)	002, 003, 004 an 005. (See	0		43.1
4.00	Ratio of average length of stay to one week (line 43 divid	ed by line 41 divided by 7	0.000000		44. (
	days)				
	Average weekly cost for dialysis treatments (see instructi		0.00		45.
	Total additional payment (line 45 times line 44 times line Subtotal (see instructions)	41.01)	27, 331, 011		46. 47.
	Hospital specific payments (to be completed by SCH and MDH	small rural bospitals	27, 331, 011		47.
0.00	only. (see instructions)		0		+0.
				Amount	
10.00				1.00	10
	Total payment for inpatient operating costs (see instructi Payment for inpatient program capital (from Wkst. L, Pt. I	-		27, 331, 011 2, 096, 449	
	Exception payment for inpatient program capital (Wkst. L,			2,070,447	
	Direct graduate medical education payment (from Wkst. E-4,			0	
	Nursing and Allied Health Managed Care payment			0	53.
	Special add-on payments for new technologies			6, 834	
	Islet isolation add-on payment			0	
	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lin			0	
	Cost of physicians' services in a teaching hospital (see i Routine service other pass through costs (from Wkst. D, Pt		rough 35)	0	
	Ancillary service other pass through costs from Wkst. D, P		lough boy.	0	
	Total (sum of amounts on lines 49 through 58)			29, 434, 294	59.
60.00	Primary payer payments			4, 694	
	Total amount payable for program beneficiaries (line 59 mi	nus line 60)		29, 429, 600	
	Deductibles billed to program beneficiaries			2, 410, 688	
	Coinsurance billed to program beneficiaries			27, 370 199, 304	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			199, 304	
	Allowable bad debts for dual eligible beneficiaries (see i	nstructions)		87, 737	
	Subtotal (line 61 plus line 65 minus lines 62 and 63)	/		27, 121, 090	
68.00	Credits received from manufacturers for replaced devices f	or applicable to MS-DRGs (se	e instructions)	0	68.
	Outlier payments reconciliation (sum of lines 93, 95 and 9	(For SCH see instructions)	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	RURAL DEMONSTRATION PROJECT			0	
70. 50	SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see i	nstructions)		0	
70. 50 70. 88				0	
70. 50 70. 88 70. 89					
70.50 70.88 70.89 70.90	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	-		0	
70.50 70.88 70.89 70.90 70.91	HSP bonus payment HVBP adjustment amount (see instructions	-		-	70.
70.50 70.88 70.89 70.90 70.91 70.92 70.93	HSP bonus payment HVBP adjustment amount (see instructions HSP bonus payment HRR adjustment amount (see instructions)	-		0	70. 70. 70.

	Financial Systems COMMUNITY HOSPITA ATLON OF RELIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0113	Period:	u of Form CMS-2 Worksheet F	2552-10
				From 01/01/2016	Part A	
				To 12/31/2016	Date/Time Pre 4/14/2017 8:1	
		Title	XVIII	Hospi tal	PPS	_
			FFY	′ (yyyy)	Amount	
				0	1.00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period prior to 10/1)	n column O		0	0	70.96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period ending on or af			0	0	70. 97
70. 98	Low Volume Payment-3				0	70.98
70.99	HAC adjustment amount (see instructions)				0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			26, 822, 587	
71.01	Sequestration adjustment (see instructions)	,			536, 452	71.01
72.00	Interim payments				26, 227, 854	72.00
73.00	Tentative settlement (for contractor use only)				0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72	, and 73)			58, 281	74.00
75.00	Protested amounts (nonallowable cost report items) in accorda	nce with			4, 907, 664	75.00
	CMS Pub. 15-2, chapter 1, §115.2					
~~ ~~	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1			
	Operating outlier amount from Wkst. E, Pt. A, line 2 (see ins	tructions)			0	
91.00	Capital outlier from Wkst. L, Pt. I, line 2	uctions)			0	91.00 92.00
	Operating outlier reconciliation adjustment amount (see instr Capital outlier reconciliation adjustment amount (see instruc				0	92.00
	The rate used to calculate the time value of money (see instruc-				0.00	
94.00 95.00	Time value of money for operating expenses (see instructions)	uctrons)			0.00	95.00
96.00 96.00	Time value of money for capital related expenses (see instructions)	tions)			0	96.00
			1	Prior to 10/1	On/After 10/1	
				1.00	2.00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100.00
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)			0. 000000000	0.000000000	
102.00	HVBP adjustment amount for HSP bonus payment (see instruction	s)		0	0	102.00
	HRR Adjustment for HSP Bonus Payment			0.0000		
	HRR adjustment factor (see instructions)	`		0.0000	0.0000	
04.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104. 0

ALCUL	Financial Systems ATION OF DSH PAYMENT PERCENTAGE		Provider CC		Period: From 01/01/2016 To 12/31/2016	4/14/2017 8:1	pared
				XVIII	Hospi tal	PPS	
		Original .mcrxAd Values	Values	HFS Look Up	Override Value	Revised value	
	1	1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF THE DSH PAYMENT PERCENTAGE						
. 00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	5. 19	0.00	0.0	0.00	0.00	1. (
. 00	Percentage of Medicaid patient days to total days (From line 27)	24. 37	0.00			24.37	2.
00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	29. 56	0.00			24.37	3.
. 00	Provider Type * (urban, rural,SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.
. 00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	132. 86	0.00			132.86	5.
. 00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	13.60	0.00			9.32	6.
. 00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.
00	S-2, Line 22	Yes				Yes	8.
00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9.
0. 00	S-2, Line 45	Yes				Yes	10
. 00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I,	Yes				Yes	11
. 00	line 1 geater than -O-) Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7	5. 19	0.00	0. C	00 0.00	0.00	12
. 00	- Revised from CMS) Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line	No				No	13
. 00	75, column 1 = "Y") Medicare SSI ratio (Previous from E-3, Part 111, line 2 - Revised from CMS)	0.00	0.00	0.0	0.00	0.00	14
. 00	CALCULATION OF THE PERCENTAGE OF MEDICAID DAY In-State Medicaid paid days (Worksheet S-2,	1, 071	0			1 071	115
. 00	line 24, column 1) In-State Medicaid eligible unpaid paid days	29	0			1, 071	
. 00	(Worksheet S-2, Line 24, column 2) Out-of-State Medicaid paid days (Worksheet	0	0			0	
	S-2, line 24, column 3)		0				
. 00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	25	0			25 0	
. 01 . 00	N/A Medicaid HMO days (Worksheet S-2, line 24, column 5)	5, 107	0			5, 107	
. 00	Other Medicaid days (Worksheet S-2, line 24, column 6)	21	0			21	20
. 00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	6, 253	0			6, 253	21
. 00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	25, 296	0			25, 296	
. 00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	93	0			93	
. 00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)		0			273	
. 00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)		0			0	
. 00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	25, 662	0			25, 662	26
. 00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	24. 37	0.00			24.37	27

Heal th	Financial Systems	COMMUNI TY HOSP	ITAL ANDERSON		In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF DSH PAYMENT PERCENTAGE		Provider CO	CN: 15-0113	Period: From 01/01/2016 To 12/31/2016		epared:
			Title	XVIII	Hospi tal	PPS	
		Original .r	mcrx Values	Adj usted	.mcax Values	Revi sed	
		Condi ti on	Percentage	Condi ti on	Percentage	Condi ti on	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGI	-					
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	13.60		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	Fal se	0.00		0.00	Fal se	29.00
30.00	Line 28 or 29 as applicable		13.60		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		13.60		0.00		31.00
		Original .mcrx	Adjusted .mcax	HFS Look Up	Overri de Val ue	Revi sed Val ue	
		Val ues	Val ues				
		1.00	2.00	3.00	4.00	5.00	
	DETERMINATION OF PROVIDER TYPE						
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	Fal se				Fal se	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	Fal se				Fal se	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	Fal se				Fal se	34.00
35.00	Is this a Sole Cummunity hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	Fal se				Fal se	35.00
36.00	s this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

Health Financial Systems	COMMUNI TY HOSPI TA	AL ANDERSON	In Lie	u of Form CMS-:	2552-10
CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 15-0113	Period:	Worksheet DSH	
			From 01/01/2016 To 12/31/2016	Date/Time Pre 4/14/2017 8:1	
		Title XVIII	Hospi tal	PPS	
	Revi sed				
	Percentage				
	6.00				
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAG	E				
28.00 If line 3 is greater than 20.2% - 5.88% plus	9. 32				28.00
82.5% of the difference between 20.2% and					
line 3					
29.00 If line 3 is less than 20.2% - 2.5% plus 65%	0.00				29.00
of the difference between 15% and line 3					
30.00 Line 28 or 29 as applicable	9.32				30.00
31.00 If Urban and fewer than 100 beds, Rural and	9.32				31.00
fewer than 500 beds, or an SCH the lower of					
line 30 or .1200, if RRC, MDH or otherwise					
enter line 30.					

W VO	Financial Systems DLUME CALCULATION EXHIBIT 4		COMMUNI TY HOSPI	Provi der C	CN: 15-0113	eriod: rom 01/01/2016	u of Form CMS-2 Worksheet E	
						o 12/31/2016	Date/Time Pre	pare
				Title	xVIII	Hospi tal	4/14/2017 8: 1 PPS	8 am
		line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
00	DRG amounts other than outlier	0 1.00	1.00	2.00	3.00 C	4.00	5.00 0	1
01	payments DRG amounts other than outlier payments for discharges	1. 01	0	0	С		0	1
)2	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	23, 762, 103	0		23, 762, 103	23, 762, 103	1
13	1 DRG for Federal specific operating payment for Model 4 BPCL occurring prior to	1. 03	0	0	С		0	1
)4	October 1 DRG for Federal specific operating payment for Model 4 BPCL occurring on or after	1. 04	0	0		0	0	1
0	October 1 Outlier payments for discharges (see instructions)	2.00	1, 808, 544	0	C	1, 808, 544	1, 808, 544	2
)1	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	с	0	0	2
00	Operating outlier reconciliation	2. 01	0	0	C	0	0	3
00	Managed care simulated payments	3. 00	0	0	c	0	0	4
0	Indirect Medical Education Adju Amount from Worksheet E, Part	ustment 21.00	0. 000000	0. 000000	0.000000	0. 000000		5
0	A, line 21 (see instructions) IME payment adjustment (see	22.00	0	0	C	0	0	6
1	instructions) IME payment adjustment for managed care (see instructions)	22. 01	0	0	с	0	0	e
0	Indirect Medical Education Adju IME payment adjustment factor	ustment for the 27.00	e Add-on for Se 0.000000			0. 000000		7
0	(see instructions) IME adjustment (see	28.00	0	0	C	0	0	8
1	instructions) IME payment adjustment add on for managed care (see	28.01	0	0	С	0	0	ε
0	instructions) Total IME payment (sum of lines 6 and 8)	29.00	0	0	C	0	0	9
1	Total IME payment for managed care (sum of lines 6.01 and	29.01	0	0	C	0	0	Ģ
	8.01) Disproportionate Share Adjustme							
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1360	0. 1360	0. 1360	0. 1360		10
00	Disproportionate share adjustment (see instructions)	34.00	807, 912	0	C	807, 912	807, 912	11
01	Uncompensated care payments Additional payment for high per	36.00 centage of ESF	952, 452 RD benefi ci ary	0 di scharges	952, 452	0	952, 452	11
00	Total ESRD additional payment (see instructions)	46.00	0	0	C	0	0	12
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	27, 331, 011 0	0 0	952, 452 C	26, 378, 559 0	27, 331, 011 0	13 14
00	(see instructions) Total payment for inpatient operating costs (see	49.00	27, 331, 011	0	952, 452	26, 378, 559	27, 331, 011	15
00	instructions) Payment for inpatient program capital	50.00	2, 096, 449	0	C	2, 096, 449	2, 096, 449	16
00	Special add-on payments for new technologies	54.00	6, 834	0	с	6, 834	6, 834	17
01 02	Net organ aquisition cost Credits received from manufacturers for replaced	55.00 68.00	0	0 0	c c	0	0 0	
00	devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	с	0	0	18

Heal th	Financial Systems		COMMUNI TY HOSPI	TAL ANDERSON		In Lie	eu of Form CMS-:	2552-10
LOW VO	LUME CALCULATION EXHIBIT 4			Provider C		Period: From 01/01/2016 Fo 12/31/2016		pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	952, 45	2 28, 481, 842	29, 434, 294	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1, 910, 514	0		1, 910, 514	1, 910, 514	20.00
	Model 4 BPCI Capital DRG other than outlier		0	0		0	0	
21.00	Capital DRG outlier payments	2.00	68, 056	0		68, 056	68, 056	21.00
21.01	Model 4 BPCI Capital DRG	2.01	0	0		0 0	0	21.01
	outlier payments			-				
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0. 0000	0.000	0. 0000		22.00
23.00	Indirect medical education	6.00	0	0		0 0	0	23.00
24.00	adjustment (see instructions) Allowable disproportionate share percentage (see instructions)	10. 00	0. 0617	0. 0617	0. 061	7 0. 0617		24.00
25.00	Di sproporti onate share	11.00	117, 879	0		0 117, 879	117, 879	25.00
26.00	adjustment (see instructions) Total prospective capital payments (see instructions)	12.00	2, 096, 449	0		2, 096, 449	2, 096, 449	26.00
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.00000	0. 000000		27.00
28.00	Low volume adjustment	70.96				D	0	28.00
	(transfer amount to Wkst. E, Pt. A, line)							
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

HOSPI 1	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CC		Period: From 01/01/2016 To 12/31/2016	Date/Time Prep 4/14/2017 8:18	pared:
				XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0		0	0	1. 01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	23, 762, 103		23, 762, 103	23, 762, 103	1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2.00	1, 808, 544		0 1, 808, 544	1, 808, 544	2.00
2. 01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2. 01
3.00	Operating outlier reconciliation	2.01	0		0 0	-	3.00
4.00	Managed care simulated payments	3.00	0		0 0	0	4.00
5.00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0.00000	0.00000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0		0 0	0	6.00
6. 01	IME payment adjustment for managed care (see instructions)	22.01	0		0 0	-	6. 01
	Indirect Medical Education Adjustment for the						
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000		0.00000		7.00
B. 00	IME adjustment (see instructions)	28.00	0		0 0	-	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0		0 0	0	8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9.00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment	29.01	0		0 0	0	9. 01
10.00	Al I owable disproportionate share percentage	33.00	0. 1360	0. 136	0. 1360		10.00
	(see instructions)						
11.00	Disproportionate share adjustment (see instructions)	34.00	807, 912		0 807, 912		
11.01	Uncompensated care payments	36.00	952, 452	723, 76	07 0	723, 767	11.01
12. 00	Additional payment for high percentage of ESF Total ESRD additional payment (see instructions)	46.00	of scharges 0		0 0	0	12.00
13 00	Subtotal (see instructions)	47.00	27, 331, 011	723, 76	26, 607, 244	27, 331, 011	13 00
	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48.00	0		0 0		14.00
15.00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	27, 331, 011	723, 76	26, 607, 244	27, 331, 011	15.00
16.00	Payment for inpatient program capital	50.00	2, 096, 449		0 2, 096, 449	2, 096, 449	16.00
17.00	Special add-on payments for new technologies	54.00	6, 834		0 6, 834		
17.01	Net organ acquisition cost	55.00	0		0 0	0	17.01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	17. 02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	18.00
	SUBTOTAL			723, 76	28, 710, 527	29, 434, 294	

Health Financial Systems	COMMUNI TY HOSP	ITAL ANDERSON			In Lie	u of Form CMS-	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCUL	ATION EXHIBIT 5	Provider C	CN: 15-0113		d: 01/01/2016 12/31/2016		pared:
		Title	XVIII	Ho	spi tal	PPS	
	Wkst. L, line	(Amt. from					
	0	Wkst. L) 1.00	2.00		3.00	4,00	
20.00 Capital DRG other than outlier	1.00	1, 910, 514		0	1, 910, 514		20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1.01	0		0	1, 710, 011	0	•
21.00 Capital DRG outlier payments	2.00	68, 056		0	68, 056	-	
21.01 Model 4 BPCI Capital DRG outlier payments	2.01	0		0	0	0	•
22.00 Indirect medical education percentage (see	5.00	0,0000	0.00	20	0.0000	-	22.00
instructions)							
23.00 Indirect medical education adjustment (see instructions)	6.00	0		0	0	0	23.00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0. 0617	0.06	17	0. 0617		24.00
25.00 Disproportionate share adjustment (see instructions)	11.00	117, 879		0	117, 879	117, 879	25.00
26.00 Total prospective capital payments (see instructions)	12.00	2, 096, 449		0	2, 096, 449	2, 096, 449	26.00
	Wkst. E, Pt.	(Amt. from					
	A, line	Wkst. E, Pt.					
		A)	0.00			4.00	
27.00	0	1.00	2.00		3.00	4.00	27.00
27.00 28.00 Low volume adjustment prior to October 1	70.04	0		0		0	27.00
	70.96 70.97	0		0	0	0	
29.00 Low volume adjustment on or after October 1 30.00 HVBP payment adjustment (see instructions)	70.97	106, 085		0	106, 085	-	
	70.93	100,085		0	106, 085	106, 085 0	•
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0		0	0	0	30.01
31.00 HRR adjustment (see instructions)	70, 94	-404, 588		0	-404, 588	-404, 588	31 00
31.01 HRR adjustment for HSP bonus payment (see	70.91	1 404, 300		0	404, 300 0		1
instructions)	70.71			U	0	0	01.01
						(Amt. to Wkst.	
						E, Pt. A)	
	0	1.00	2.00		3.00	4.00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0	0	0	02.00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N					100.00

	Financial Systems COMMUNITY HOSPITAL ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0113	Period: From 01/01/2016 To 12/31/2016	Date/Time Pre	pare
		Title XVIII	Hospi tal	4/14/2017 8:1 PPS	8 am
			- Hospi tui		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
00	Medical and other services (see instructions)			37, 026] 1.
00	Medical and other services reimbursed under OPPS (see instruct	tions)		14, 362, 445	
00	PPS payments			13, 518, 299	
00	Outlier payment (see instructions)			89, 176	
)0)0	Enter the hospital specific payment to cost ratio (see instruc Line 2 times line 5	ctions)		0.000	
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		0	
00	Organ acqui si ti ons			0	10
00	Total cost (sum of lines 1 and 10) (see instructions)			37, 026	11
	COMPUTATION OF LESSER OF COST OR CHARGES				-
~~	Reasonable charges			147.070	1 1 2
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li	ne 60)		147, 878	
00	Total reasonable charges (sum of lines 12 and 13)	ne 07)		147, 878	
00	Customary charges			111/0/0	
. 00	Aggregate amount actually collected from patients liable for p	payment for services on	a charge basis	0	15
00	Amounts that would have been realized from patients liable for		n a chargebasis	0	16
	had such payment been made in accordance with 42 CFR §413.13(e	e)			
00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete onl	viflipo 19 ovcoods li	no 11) (coo	147, 878 110, 852	
. 00	instructions)	y IT THE TO EXCEEds IT	ne II) (see	110, 052	'3
00	Excess of reasonable cost over customary charges (complete onl	vifline 11 exceeds li	ne 18) (see	0	20
	instructions)	5			
00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	e instructions)		37, 026	
	Interns and residents (see instructions)			0	
. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	
00	Total prospective payment (sum of lines 3, 4, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			13, 607, 475	24
00	Deductibles and coinsurance (for CAH, see instructions)			0	2!
00	Deductibles and Coinsurance relating to amount on line 24 (for	· CAH, see instructions)		2, 822, 419	
00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	olus the sum of lines 22	and 23] (see	10, 822, 082	27
	instructions)				
00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	
00 00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 10, 822, 082	1 - 1
00	Primary payer payments			3, 984	
	Subtotal (line 30 minus line 31)			10, 818, 098	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	ES)			
	Composite rate ESRD (from Wkst. I-5, line 11)				33
	Allowable bad debts (see instructions)			531, 102	
	Adjusted reimbursable bad debts (see instructions)			345, 216	
00 00	Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions)	"uctions)		393, 096	
00	MSP-LCC reconciliation amount from PS&R			11, 163, 314 150	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	
98	Partial or full credits received from manufacturers for replac		tions)	0	
99	RECOVERY OF ACCELERATED DEPRECIATION			0	39
00	Subtotal (see instructions)			11, 163, 164	
01	Sequestration adjustment (see instructions)			223, 263	
	Interim payments Tentative settlement (for contractors use only)			10, 974, 273	
00 00	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			-34, 372	42
00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2	chapter 1		44
	§115. 2			ĺ	'
	TO BE COMPLETED BY CONTRACTOR				1
	Original outlier amount (see instructions)				90
00	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	
υU	Total (sum of lines 91 and 93)			0 Overri des	94
				overrides	
				1.00	

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0113	Period: From 01/01/2016 To 12/31/2016		
			XVIII	Hospi tal	PPS	
		Inpati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		26, 227, 8	54	10, 865, 273	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.00
3.00	amount based on subsequent revision of the interim rate					3.00
	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	07/08/2016		0 07/08/2016	109, 000	3. 01
3.02				0	0	3.02
3.03				0	0	3. 03
3.04				0	0	3.04
3.05				0	0	3.05
3.50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3.50
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.52				0	0	3. 52
3.53				0	0	3.53
3.54				0	0	3.54
3.99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	109, 000	3.99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		26, 227, 8	54	10, 974, 273	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER			0	0	5.01
5.02				0	0	5.02
5.03	Provider to Program			0	0	5.03
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.50				0	0	5.5
5.52				0	0	5.52
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5.99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)		50.0	0.1		
6.01	SETTLEMENT TO PROVIDER		58, 2		0	6.01
6.02	SETTLEMENT TO PROGRAM		26 204 1	0	34, 372	6.02 7.00
7.00	Total Medicare program liability (see instructions)		26, 286, 1	Contractor	10, 939, 901 NPR Date	7.00
				Number	(Mo/Day/Yr)	
		C)	1.00	2.00	
8.00	Name of Contractor					8.00

Health Financi	al Systems	COMMUNI TY HOSPI TAI	ANDERSON	In Lie	u of Form CMS-2	2552-10
CALCULATION 0	F REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0113	Peri od:	Worksheet E-1	
				From 01/01/2016 To 12/31/2016	Part II Date/Time Pre	aarad
				10 12/31/2010	4/14/2017 8:1	
			Title XVIII	Hospi tal	PPS	
					1.00	
TO BE (COMPLETED BY CONTRACTOR FOR NONSTANE	DARD COST REPORTS				
	INFORMATION TECHNOLOGY DATA COLLECT					
	nospital discharges as defined in A/			14	7, 047	1.00
	re days from Wkst. S-3, Pt. I, col.		-12		10, 911	2.00
	re HMO days from Wkst. S-3, Pt. I, o				3, 789	3.00
	npatient days from S-3, Pt. I col.		-12		23, 138	4.00
	nospital charges from Wkst C, Pt. I,				487, 793, 243	5.00
	nospital charity care charges from N				5, 401, 049	
7.00 CAH on line 1	y - The reasonable cost incurred fo 58	or the purchase of ce	ertified HIT technology	Wkst. S-2, Pt. I	0	7.00
8.00 Cal cul	ation of the HIT incentive payment	(see instructions)			0	8.00
9.00 Seques	tration adjustment amount (see inst	ructions)			0	9.00
10.00 Cal cul	ation of the HIT incentive payment a	after sequestration ((see instructions)		0	10.00
I NPATI E	INT HOSPITAL SERVICES UNDER THE IPPS	S & CAH				
	/interim HIT payment adjustment (se	ee instructions)			0	30.00
	Adjustment (specify)				0	31.00
32.00 Bal anc	e due provider (line 8 (or line 10)	minus line 30 and li	ne 31) (see instruction	s)	0	32.00
					Overri des	
					1.00	
	CTOR OVERRIDES					
108.00 0verri	de of HIT payment				0	108.00

ALCUI	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part VII Date/Time Pre	
			10 12/31/2010	4/14/2017 8:1	
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpatient	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR X	1.00	2.00	-
	COMPUTATION OF NET COST OF COVERED SERVICES	TOES FOR THEES V OR X	TX SERVICES		1
. 00	Inpatient hospital/SNF/NF services		6, 232, 166		1 1.
. 00	Medical and other services			0	2.
. 00	Organ acquisition (certified transplant centers only)		0		3.
. 00	Subtotal (sum of lines 1, 2 and 3)		6, 232, 166	0	4.
. 00	Inpatient primary payer payments		0		5
. 00	Outpatient primary payer payments			0	
. 00	Subtotal (line 4 less sum of lines 5 and 6)		6, 232, 166	0	7.
	COMPUTATION OF LESSER OF COST OR CHARGES				4
00	Reasonable Charges		0.045.044		
. 00 . 00	Routine service charges Ancillary service charges		8, 945, 944 16, 719, 225	0	8.
D. 00	Organ acquisition charges, net of revenue		10, 719, 225	0	10
1.00	Incentive from target amount computation		0		11
2.00	Total reasonable charges (sum of lines 8 through 11)		25, 665, 169	0	
	CUSTOMARY CHARGES		20/000/10/		1
3. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13
	basi s	0			
4.00	Amounts that would have been realized from patients liable for	payment for services of	n 0	0	14
	a charge basis had such payment been made in accordance with 4	2 CFR §413.13(e)			
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.00000	
5.00	Total customary charges (see instructions)		25, 665, 169	0	
7.00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	19, 433, 003	0	17
3. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete onl	vifling 4 avgods lin		0	18
5.00	16) (see instructions)	y IT ITTLE 4 exceeds ITTL	e 0	0	10
9.00	Interns and Residents (see instructions)		0	0	19
0.00	Cost of physicians' services in a teaching hospital (see instr	uctions)	0	0	
1.00	Cost of covered services (enter the lesser of line 4 or line 1	-	6, 232, 166	0	21
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provid	ders.		
2.00	Other than outlier payments		0	0	
3.00	Outlier payments		0	0	
4.00	Program capital payments		0		24
5.00	Capital exception payments (see instructions)		0	0	25
b. 00	Routine and Ancillary service other pass through costs		0	0	
7.00 3.00	Subtotal (sum of lines 22 through 26) Customary charges (title V or XIX PPS covered services only)		0	0	
7.00 7.00	Titles V or XIX (sum of lines 21 and 27)		6, 232, 166	0	
7.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		0, 232, 100	0	27
0. 00	Excess of reasonable cost (from Line 18)		0	0	30
1.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		6, 232, 166	0	
2.00	Deducti bl es		0	0	32
8.00	Coinsurance		0	0	33
. 00	Allowable bad debts (see instructions)		0	0	
5.00	Utilization review		0		35
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	6, 232, 166	0	
7.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
3.00	Subtotal (line 36 ± line 37)		6, 232, 166	0	
9.00	Direct graduate medical education payments (from Wkst. E-4)			^	39
). 00	Total amount payable to the provider (sum of lines 38 and 39)		6, 232, 166	0	
1.00	Interim payments Balance due provider/program (line 40 minus line 41)		7, 932, 423 -1, 700, 257	0	
2.00	Protested amounts (nonallowable cost report items) in accordar	ce with CMS Pub 15 2	-1, 700, 257	0	
. 00	chapter 1, §115.2	CE WITH CWS MUD 13-2,	0	0	43
	OVERRI DES				1
	Override Ancillary service charges (line 9)		0	0	109

	Financial Systems COMMUNITY HOSPI E SHEET (If you are nonproprietary and do not maintain who accounting records, complete the Constal Fund column	Provi der C		Period: From 01/01/2016	eu of Form CMS-2 Worksheet G	
na-t il y)	ype accounting records, complete the General Fund column			To 12/31/2016		pare 8 am
		General Fund	Specific Purpose Fund		Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	35, 360, 818		0 0	0	1 1
00	Temporary investments	0		0 0	0	2
00	Notes receivable	0		0 0	0	3
00	Accounts receivable	67, 071, 069		0 0	0	
00	Other receivable	0		0 0	0	
00	Allowances for uncollectible notes and accounts receivable	-46, 753, 546		0 0	0	
00	Inventory	2, 618, 435		0 0	0	
00 00	Prepaid expenses Other current assets	271, 261 117, 620, 893		0 0	0	8
. 00	Due from other funds	4, 187, 258		0 0	0	10
	Total current assets (sum of lines 1-10)	180, 376, 188		0 0		
. 00	FIXED ASSETS	100, 370, 100		<u> </u>		1
. 00	Land	6, 323, 988		0 0	0	1 12
. 00	Land improvements	1, 967, 845		0 0	0	13
. 00	Accumulated depreciation	-1, 770, 084	6	0 0	0	14
. 00	Bui I di ngs	71, 405, 968		0 0	0	15
	Accumul ated depreciation	-33, 528, 931		0 0	0	16
	Leasehold improvements	0		0 0	0	17
	Accumulated depreciation	0		0 0	0	18
	Fixed equipment	19, 773, 767		0 0	0	19
	Accumulated depreciation	-13, 163, 303		0 0	0	20
	Automobiles and trucks	783, 916		0 0	0	21
	Accumulated depreciation Major movable equipment	-648, 149 14, 731, 503		0 0	0	22
	Accumulated depreciation	-10, 472, 360		0 0	0	23
	Minor equipment depreciable	36, 251, 681		0 0	0	25
	Accumulated depreciation	-24, 227, 014		0 0	0	26
	HIT designated Assets	0		0 0	0	27
	Accumulated depreciation	0		0 0	0	
	Mi nor equipment-nondepreciable	0		0 0		
	Total fixed assets (sum of lines 12-29)	67, 428, 827		0 0	0	
	OTHER ASSETS					1
. 00	Investments	0		0 0	0	31
	Deposits on Leases	0		0 0	0	32
. 00	Due from owners/officers	0		0 0	0	33
	Other assets	0		0 0	0	34
	Total other assets (sum of lines 31-34)	0		0 0	0	35
. 00	Total assets (sum of lines 11, 30, and 35)	247, 805, 015		0 0	0	36
00	CURRENT LI ABI LI TI ES	4 200 000			0	1 27
	Accounts payable Salaries, wages, and fees payable	4, 399, 080 8, 007, 842		0 0 0 0		37
	Payroll taxes payable	488, 584		0 0	0	
	Notes and Loans payable (short term)	1, 613, 304			0	
	Deferred income	1, 013, 304		0 0	0	
	Accel erated payments	0			Ű	42
	Due to other funds	746, 489		0 0	0	
	Other current liabilities	1, 532, 787		0 0		
. 00	Total current liabilities (sum of lines 37 thru 44)	16, 788, 086	1	0 0	0	45
	LONG TERM LIABILITIES					
	Mortgage payable	0		0 0	0	46
	Notes payable	0		0 0	0	47
	Unsecured Loans	0		0 0	0	
	Other long term liabilities	5, 242, 255		0 0	0	
	Total long term liabilities (sum of lines 46 thru 49)	5, 242, 255		0 0	0	
. 00	Total liabilities (sum of lines 45 and 50)	22, 030, 341	L	0 0	0	51
	CAPITAL ACCOUNTS	005 774 (74				1
	General fund balance	225, 774, 674				52
. 00	Specific purpose fund			0	1	53
. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0	l -	54
. 00				0	1	56
. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	
. 00	Plant fund balance - reserve for plant improvement,		1			
	replacement, and expansion		1		l U	"
. 00						
. 00	Total fund balances (sum of lines 52 thru 58)	225, 774, 674		0 0	0	59

Heal th	Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet G-1	bared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)		189, 880, 943 35, 893, 731 225, 774, 674 0 225, 774, 674			0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00 \end{array}$
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 0 Endowment Fund	0 225, 774, 674 Pl ant	Fund		0 0 0 0	13.00 14.00 15.00 16.00 17.00 18.00 19.00
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0 0 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	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)	0 0 0 0	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

	Financial Systems COMMUNITY HOSPIT/				u of Form CMS-2	2552-10
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	N: 15-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet G-2 Parts I & II Date/Time Pre 4/14/2017 8:18	pared: 8 am
	Cost Center Description	_	Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES General Inpatient Routine Services					
1.00	Hospi tal		38, 576, 60	lor	38, 576, 609	1.00
2.00	SUBPROVIDER - IPF		30, 370, 0	0	00, 370, 007	2.00
3.00	SUBPROVIDER - IRF			0	0	3.00
4.00	SUBPROVI DER			0	0	4.00
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	6.00
7.00	SKILLED NURSING FACILITY			0	0	7.00
8.00	NURSING FACILITY			0	0	8.00
9.00 10.00	OTHER LONG TERM CARE Total general inpatient care services (sum of lines 1-9)		38, 576, 60	0	0 38, 576, 609	9.00 10.00
10.00	Intensive Care Type Inpatient Hospital Services	I	30, 370, 0	59	38, 378, 809	10.00
11.00	I NTENSI VE CARE UNI T		9, 960, 2	99	9, 960, 299	11.00
12.00	CORONARY CARE UNIT			0	0	12.00
13.00	BURN INTENSIVE CARE UNIT			0	0	13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T			0	0	14.00
15.00 16.00	OTHER SPECIAL CARE (SPECIFY) Total intensive care type inpatient hospital services (sum of		9, 960, 29	0	9, 960, 299	15. 00 16. 00
10.00	11-15)	TTHES	9, 900, 21	77	9, 900, 299	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 16	b)	48, 536, 90		48, 536, 908	17.00
18.00	Ancillary services		146, 717, 5		366, 080, 325	18.00
19.00	Outpatient services		8, 939, 10		70, 205, 599	19.00
20.00	RURAL HEALTH CLINIC			0 0	0	20.00
21.00 22.00	FEDERALLY QUALIFIED HEALTH CENTER HOME HEALTH AGENCY			0 0	0	21.00 22.00
22.00	AMBULANCE SERVICES			0 0	0	22.00
24.00	CMHC			0	0	24.00
24.10	CORF			0 0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D. P.)			0 0	0	25.00
26.00	HOSPI CE			0 0	0	26.00
27.00	NURSERY NRCC AND OTHER		5, 381, 9		14, 511, 076	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 G-3, line 1)	3 to Wkst.	209, 575, 5	24 289, 758, 384	499, 333, 908	28.00
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			143, 327, 027		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00 36.00	Total additions (sum of lines 30-35)			0		35.00 36.00
37.00	DEDUCT (SPECIFY)			0		37.00
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 4	2)(transfer		143, 327, 027		43.00
	to Wkst. G-3, line 4)	I		1		

Heal th	Financial Systems	COMMUNI TY HOSPI TA	L ANDERSON	In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-0113	Peri od:	Worksheet G-3	
				From 01/01/2016 To 12/31/2016	Date/Time Pre	nared
				10 12/31/2010	4/14/2017 8: 1	
					1.00	
1.00	Total patient revenues (from Wkst. G-2, Pa				499, 333, 908	1.00
2.00	Less contractual allowances and discounts	•	ts		331, 769, 802	2.00
3.00	Net patient revenues (line 1 minus line 2)				167, 564, 106	3.00
4.00	Less total operating expenses (from Wkst.		43)		143, 327, 027	4.00
5.00	Net income from service to patients (line	3 minus line 4)			24, 237, 079	5.00
(00	OTHER I NCOME					(00
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				134, 326 92, 820	7.00 8.00
8.00						
9.00	Revenue from television and radio service				67, 876	9.00
10.00	Purchase di scounts				12, 330	
11.00	Rebates and refunds of expenses				0	11. 00 12. 00
12.00 13.00	Parking lot receipts				0	12.00
13.00	Revenue from laundry and linen service	waata			712, 792	
14.00	Revenue from meals sold to employees and g Revenue from rental of living quarters	Juests			/12, /92	
	Revenue from sale of medical and surgical	supplies to other t	han nationts		0	16.00
	Revenue from sale of drugs to other than p		nan patrents		0	17.00
17.00	Revenue from sale of medical records and a				1, 312	
	Tuition (fees, sale of textbooks, uniforms				1, 312	
20.00	Revenue from gifts, flowers, coffee shops,				0	20.00
20.00	Rental of vending machines	and canteen			0	20.00
21.00	Rental of hospital space				0	21.00
23.00	Governmental appropriations				0	22.00
23.00	GENERAL NON-OPERATING REVENUE				14, 079, 940	
24.00	Total other income (sum of lines 6-24)				15, 101, 396	
26.00	Total (line 5 plus line 25)				39, 338, 475	
27.00	PROVISION FOR BAD DEBTS				3, 444, 744	
	Total other expenses (sum of line 27 and s	subscrints)			3, 444, 744	
	Net income (or loss) for the period (line	1 /			35, 893, 731	
27.00	Incernation (or ross) for the period (fille	zo minus rine zo)			55, 075, 751	27.00

Health Financial Systems	COMMUNI TY HO	COMMUNITY HOSPITAL ANDERSON		In Lieu of Form CMS-2552-10		
CALCULATION OF CAPITAL PAYME	NT	Provider CCN: 15-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prep 4/14/2017 8:18	bared: 3 am	
		Title XVIII	Hospi tal	PPS		
				1.00		
PART I - FULLY PROSPEC	TIVE METHOD					
CAPITAL FEDERAL AMOUNT						
1.00 Capital DRG other than outlier				1, 910, 514	1.00	
1.01 Model 4 BPCI Capital DRG other than outlier					1.01	
2.00 Capital DRG outlier payments					2.00	

0

0

0 15.00

0 17.00

16.00 0

0.00

5.00

6.00

64.22

0.00

0.00

2.01

3.00

4.00

5.00

2.00 Capital DRG outlier payments

2.01 Model 4 BPCI Capital DRG outlier payments 3.00 Total inpatient days divided by number of days in the cost reporting period (see instructions)

4.00 Number of interns & residents (see instructions)

5.00 Indirect medical education percentage (see instructions)

6.00 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 0 6.00 1.01) (see instructions) Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 7.00 5.19 7.00 30) (see instructions) 8.00 Percentage of Medicaid patient days to total days (see instructions) 24.37 8.00 9.00 Sum of lines 7 and 8 29.56 9.00 6.17 10.00 Allowable disproportionate share percentage (see instructions) 10.00 11.00 Disproportionate share adjustment (see instructions) 117, 879 11.00 12.00 Total prospective capital payments (see instructions) 2,096,449 12.00

		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	00 Net program inpatient capital costs (line 1 minus line 2)		3.00
4.00	4.00 Applicable exception percentage (see instructions)		4.00

5.00 Capital cost for comparison to payments (line 3 x line 4)

6.00 Percentage adjustment for extraordinary circumstances (see instructions)

7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 0 7.00 Capital minimum payment level (line 5 plus line 7) 8.00 0 8.00 Current year capital payments (from Part I, line 12, as applicable) 9.00 0 9.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 10.00 0 10.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year 0 11.00 11.00 Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) 0 12.00 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 13.00 0 14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period 0 14.00

(if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions) 16.00 Current year operating and capital costs (see instructions)

17.00 Current year exception offset amount (see instructions)