Health Financ	ial Systems	COMMUNITY HOSPITA	AL ANDERSON	In Lie	u of Form CMS-2552-10		
	s required by law (42 USC 1395 s since the beginning of the co				FORM APPROVED OMB NO. 0938-0050 EXPIRES 05-31-2019		
HOSPITAL AND AND SETTLEMEN	HOSPITAL HEALTH CARE COMPLEX O	COST REPORT CERTIFICATION	Provider CCN: 15-0113	Period: From 01/01/2017 To 12/31/2017			
PART I - COST	REPORT STATUS						
Provider use only							
Contractor use only	5. [1]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	Contractor No.	11.	.NPR Date: .Contractor's Vendo .[0]If line 5, co number of tim	or Code: 4 Jumn 1 is 4: Enter hes reopened = 0-9.		

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPITAL ANDERSON (15-0113) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

ws and regulations.

]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature. cryption Information

R: Date: 5/15/2018 Time: 8:33 am Officer or Administrator of Provider(s) / Officer or Administrator of Provider(s) /

Encryption Information ECR: Date: 5/15/2018 Time: 8:33 am PkVQ7whijRjj9M6bMBjqKt:las9wK0 ePu6v07ZndD7H2c35YXC6Fc2:WPwtq

1u9h1gyHNv0v2biz PI: Date: 5/15/2018 Time: 8:33 am a6irnynBby3KAFCybEKsGWz1.P3700

KPwz:0m.VCt5o0pF5WAsRyEgoJ9gwV

mTOD0.1FX.0eIHRA

45.50			Title X	VIII			jedru.
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
William I	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	25,936	49,996	0	-1,852,203	1.00
2.00	Subprovider - IPF	0	0	0		. 0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0		10		0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0			11.00
12.00	CMHC I	0		0		853	12.00
200.00	Total	0	25,936	49,996	0	-1,852,203	200.00

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

Health Financial Systems COMMUNITY HOSPITAL ANDERSON In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0113 Peri od: Worksheet S-2 From 01/01/2017 Part I 12/31/2017 Date/Time Prepared: 5/14/2018 1:52 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1515 NORTH MADISON AVE 1.00 1.00 PO Box: State: IN 2.00 City: ANDERSON Zip Code: 46011 County: MADISON 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)

/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal COMMUNITY HOSPITAL 150113 26900 01/01/1966 N n 3.00 ANDERSON Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital -Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 17. 10 Hospi tal -Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19. 00 19.00 Other To: From: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 20.00 01/01/2017 12/31/2017 21.00 Type of Control (see instructions) 2 21.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate Ν 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y' for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22 02 Is this a newly merged hospital that requires final uncompensated care payments to be N Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2, or after October 1. Did this hospital receive a geographic reclassification from urban to rural as a result Ν 22.03 Ν of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the

	i, enter iti date of admission, 2 it census days, or	3 II date	or di schar	ge. is the				
	method of identifying the days in this cost reporting	g period di	fferent fro	om the metho	od			
	used in the prior cost reporting period? In column 2	2, enter "Y	for yes o	or "N" for r	no.			
		In-State	In-State	Out-of	Out-of	Medi cai d	0ther	
		Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
		paid days	eligible	Medi cai d	Medi cai d		days	
			unpai d	paid days	eligible			
			days		unpai d			
		1. 00	2. 00	3. 00	4. 00	5. 00	6, 00	
24. 00	If this provider is an IPPS hospital, enter the	780			0	5, 541		24. 00
	in-state Medicaid paid days in column 1, in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid paid days in column 3,							
	out-of-state Medicaid eligible unpaid days in column							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							
25 00	If this provider is an IRF, enter the in-state	0	0	0	<u> </u>	n		25. 00
	Medicaid paid days in column 1, the in-state							25.00
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid days in column 3, out-of-state							
	Medicaid eligible unpaid days in column 4, Medicaid							
	HMO paid and eligible but unpaid days in column 5.			I	l	l		

N

23.00

cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with

Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column

1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the

42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

Health Financial Systems COMMUNIT	Y HOSPI	TAL ANDERSON		In L	ieu of Form CMS	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der CC		eriod: rom 01/01/201	Worksheet S-2 7 Part I	
			Ť			
		1			S Date of Geogr	
26.00 Enter your standard geographic classification (not wa			inning of the	1.00	2.00	26. 00
cost reporting period. Enter "1" for urban or "2" for 27.00 Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	ge) sta	atus at the end	of the cost		1	27. 00
enter the effective date of the geographic reclassifi 35.00 If this is a sole community hospital (SCH), enter the	cati on	in column 2.			0	35. 00
effect in the cost reporting period.				Begi nni ng:	Endi ng:	
36.00 Enter applicable beginning and ending dates of SCH st	atus '	Subscript line	36 for number	1. 00	2.00	36. 00
of periods in excess of one and enter subsequent date 37.00 If this is a Medicare dependent hospital (MDH), enter	S.	·			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" for	is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see					
instructions) 38.00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of						38. 00
enter subsequent dates.				Y/N	Y/N	
20 20 0				1. 00	2.00	20.00
39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) for yes or "N" for no. Does the facility meet the mil with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column instructions)	or (i i	i)? Enter in co equirements in	lumn 1 "Y" accordance	N	N	39. 00
40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob	er 1. I	Enter "Y" for y		N	N	40. 00
no in column 2, for discharges on or after October 1.	(see	Instructions)		,	V XVIII XIX	
Prospective Payment System (PPS)-Capital				1.	00 2.00 3.00	
45.00 Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)	t for (di sproporti onat	e share in acc	cordance	N Y N	45. 00
46.00 Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkst					N N N	46. 00
Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS c 48.00 Is the facility electing full federal capital payment					N N N N N N	47. 00 48. 00
Teaching Hospitals 56.00 Is this a hospital involved in training residents in or "N" for no.	approv	ed GME programs	? Enter "Y" 1	for yes	Y	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 "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes on h of th ", comp	r "N" for no in his cost report plete Worksheet	column 1. If ing period? [column 1 Enter "Y"	N	57.00
58.00 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	ursemei comple	nt for physicia te Wkst. D-5.			N	58. 00
59.00 Are costs claimed on line 100 of Worksheet A? If yes	, comp	lete Wkst. D-2,	Pt. I. NAHE 413.85	Worksheet A	N Pass-Through	59. 00
			Y/N	Li ne #	Qualification Criterion Code	
60 00 Are you claiming pursing and allied health education	(NAUE)	costs for	1. 00 N	2.00	3.00	60.00
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under §413.85? (see in	structions)				60. 00
	1. 00	1 ME 2. 00	Direct GME 3.00	1 ME 4.00	Direct GME 5.00	
61.00 Did your hospital receive FTE slots under ACA	N N	2.00	3.00	4.00		61. 00
section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care						61. 01
FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						01.01
61.02 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						61. 02
ACA). (see instructions) 61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 03

Health Financial Systems	COMMUNI T	Y HOSPI	TAL ANDERSON		In Lie	eu of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDEN	ITIFICATION DA	TA	Provi der C		Peri od: From 01/01/2017 To 12/31/2017		pared:
		Y/N	IME	Direct GME	IME	Direct GME	
		1. 00	2. 00	3. 00	4.00	5. 00	
61.04 Enter the number of unweighted primary surgery allopathic and/or osteopathic F current cost reporting period. (see inst 61.05 Enter the difference between the baselinand/or general surgery FTEs and the curprimary care and/or general surgery FTE 61.04 minus line 61.03). (see instruction 61.06 Enter the amount of ACA §5503 award that used for cap relief and/or FTEs that archives and the surgery for the surg	TEs in the ructions). ne primary rent year's counts (line ons) t is being						61. 04 61. 05
care or general surgery. (see instruction							
		Program Name		Program Code	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2. 00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each specialty, if any, and the number of FT for each new program. (see instructions column 1, the program name. Enter in coprogram code. Enter in column 3, the IM unweighted count. Enter in column 4, the FTE unweighted count.	E residents) Enter in lumn 2, the E FTE				0.00	0.00	61. 10
61.20 Of the FTEs in line 61.05, specify each program specialty, if any, and the numberesi dents for each expanded program. (so instructions) Enter in column 1, the presenter in column 2, the program code. En 3, the IME FTE unweighted count. Enter the direct GME FTE unweighted count.	er of FTE ee ogram name. ter in column				0.00	0.00	61. 20
						1. 00	
ACA Provisions Affecting the Health Res 62.00 Enter the number of FTE residents that your hospital received HRSA PCRE funding 62.01 Enter the number of FTE residents that	your hospital g (see instruc	trai ned cti ons)	in this cost	reporting pe			62. 00
during in this cost reporting period of	HRSA THC prog	gram. (s	<u>ee instructio</u>			0.00	02.01
Teaching Hospitals that Claim Residents 63.00 Has your facility trained residents in	nonprovi der se	ettings	during this c			N	63. 00
"Y" for yes or "N" for no in column 1.	ir yes, comple	ere fine	s 64 through	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
				1. 00	2.00	3.00	
Section 5504 of the ACA Base Year FTE R				This base yea	r is your cost i	reporting	
64.00 Enter in column 1, if line 63 is yes, o in the base year period, the number of resident FTEs attributable to rotations settings. Enter in column 2 the number resident FTEs that trained in your hosp of (column 1 divided by (column 1 + column 2)	base year period, the number of unweighted non-primary care It FTEs attributable to rotations occurring in all nonprovider Is. Enter in column 2 the number of unweighted non-primary care It FTEs that trained in your hospital. Enter in column 3 the ratio						64.00
Pro	gram Name	Pro	ogram Code	Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
	1. 00		2. 00	3. 00	4. 00	5. 00	

Health Financial Systems COMMUNITY HOSPITAL ANDERSON In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0113 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/14/2018 1:52 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. 3/ (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0. 00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ahted Unwei ghted Ratio (col. 3/ Program Code FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 Ν subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

Heal th Finance HOSPITAL AND	ial Systems COMMUNITY HOSPIT. HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	AL ANDERSON Provider CC		In Lie Period: From 01/01/2017 To 12/31/2017	w of Form CMS Worksheet S- Part I Date/Time Pr 5/14/2018 1:	2 epared:	
					1.00		
80.00 Is thi 81.00 Is thi	erm Care Hospital PPS s a long term care hospital (LTCH)? Enter "Y" for yes s a LTCH co-located within another hospital for part or r yes and "N" for no.			period? Enter	N N	80. 00 81. 00	
85.00 Is thi 86.00 Did th	Providers s a new hospital under 42 CFR Section §413.40(f)(1)(i) is facility establish a new Other subprovider (excluded O(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 00 86. 00	
87.00 Is thi	o(f)(f)(f)? Ellie i Tol yes and N Tol Ho. s hospital an extended neoplastic disease care hospital)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	classified ι	under section		N	87. 00	
11000(0) (1) (B) (VI) . EITEN 1 101 Yes of 14 101 110.			V	XI X		
				1. 00	2.00		
90.00 Does t	V and XIX Services his facility have title V and/or XIX inpatient hospital	servi ces? Er	nter "Y" for	N	Y	90. 00	
91.00 Is thi	"N" for no in the applicable column. s hospital reimbursed for title V and/or XIX through th			N	Y	91. 00	
92.00 Are ti	r in part? Enter "Y" for yes or "N" for no in the applitle XIX NF patients occupying title XVIII SNF beds (dua	al certificati			N	92. 00	
93.00 Does t	ctions) Enter "Y" for yes or "N" for no in the applicable his facility operate an ICF/IID facility for purposes of		I XIX? Enter	N	N	93. 00	
94.00 Does t							
95.00 If lin	able column. e 94 is "Y", enter the reduction percentage in the appl itle V or XIX reduce operating cost? Enter "Y" for yes			0. 00 N	0. 00 N	95. 00 96. 00	
97.00 If lin 98.00 Does t	able column. e 96 is "Y", enter the reduction percentage in the applitle V or XIX follow Medicare (title XVIII) for the int	terns and resi	dents post	0. 00 Y	0. 00 Y	97. 00 98. 00	
column 98.01 Does t	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 28.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for						
98.02 Does to bed co	XIX. itle V or XIX follow Medicare (title XVIII) for the cal sts on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or	culation of o	observati on	Y	Υ	98. 02	
98.03 Does t	tle V, and in column 2 for title XIX. itle V or XIX follow Medicare (title XVIII) for a criti rsed 101% of inpatient services cost? Enter "Y" for yes tle V, and in column 2 for title XIX.			N	N	98. 03	
98.04 Does toutpat	itle V or XIX follow Medicare (title XVIII) for a CAH r ient services cost? Enter "Y" for yes or "N" for no in			N	N	98. 04	
98.05 Does t	umn 2 for title XIX. itle V or XIX follow Medicare (title XVIII) and add bac C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co			Y	Y	98. 05	
98.06 Does t	2 for title XIX. itle V or XIX follow Medicare (title XVIII) when cost r through IV? Enter "Y" for yes or "N" for no in column 2 for title XIX.			Y	Y	98. 06	
	Provi ders					405.00	
106.00 lf thi	his hospital qualify as a CAH? s facility qualifies as a CAH, has it elected the all-i	nclusive meth	nod of payment	N N		105. 00 106. 00	
107.00 lf thi traini yes, t	tpatient services? (see instructions) s facility qualifies as a CAH, is it eligible for cost ng programs? Enter "Y" for yes or "N" for no in column he GME elimination is not made on Wkst. B, Pt. I, col.	1. (see instr	ructions) If	N		107. 00	
reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N CFR Section §412.113(c). Enter "Y" for yes or "N" for no.						108. 00	
		Physi cal	Occupati onal	Speech	Respi ratory		
therap	s hospital qualifies as a CAH or a cost provider, are y services provided by outside supplier? Enter "Y" s or "N" for no for each therapy.	1.00 N	2.00 N	3. 00 N	4. 00 N	109. 00	
	1.7			•			

110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.

1.00

N

110. 00

are claimed, enter in column 2 the home office chain number. (see instructions)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DATA	Prov	/ider CCM	N: 15-0113		iod: m 01/01/2 12/31/2	017 Part 017 Date	sheet S-2 /Time Pro /2018 1:!	epared:
1.00		2. 00				3. 00		/2010 1.3	DZ PIII
If this facility is part of a cha home office and enter the home of	<u>fice contractor name an</u>	on lines 1 nd contract			e name			е	
141.00 Name: COMMUNITY HEALTH NETWORK 142.00 Street: 1500 NORTH RITTER AVE	Contractor's Name PO Box:	: WPS		Contra	actor's	Number: (08101		141. 00 142. 00
143. 00 Ci ty: I NDI ANAPOLI S	State:	IN		Zip Co	ode:		16219		143. 00
144.00 Are provider based physicians' co	sts included in Workshe	et A?						1. 00 Y	144. 00
						1 00			
145.00 If costs for renal services are c inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N" 146.00 Has the cost allocation methodolo	'for yes or "N" for no clude Medicare utilizat for no in column 2.	in column ion for th	1. If cois cost i	olumn 1 is reporting		1.00 Y		2.00	145. 00
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/	n column 1. (See CMS Pu				lf				140.00
147.00 Was there a change in the statist	ical hasis? Enter "V" f	or ves or	'N" for	20				1. 00 N	147. 00
148.00 Was there a change in the order o 149.00 Was there a change to the simplif	f allocation? Enter "Y"	for yes o	r "N" foi	no.	for me			N N	147. 00 148. 00 149. 00
149.00 was there a change to the simpiff	rea cost irriarng method		t A	Part E		Title V	Ti ·	tle XIX	149.00
Does this facility contain a prov	ider that qualifies for		00 From	2.00	i cati or	3.00	ower of	4. 00	
or charges? Enter "Y" for yes or		ponent for	Part A			e 42 CFR §			
155.00 Hospi tal 156.00 Subprovi der - IPF		l l	N N	N N		N N		N N	155. 00 156. 00
157.00 Subprovi der - IRF			N	N		N		N	157. 00
158. 00 SUBPROVI DER 159. 00 SNF			N I	N		N		N	158. 00 159. 00
160.00 HOME HEALTH AGENCY			N	N		N		N	160.00
161. 00 CMHC 161. 10 CORF				N N		N N		N N	161. 00 161. 10
TOT. TO CORF				IN		IN			161.10
Multicampus								1. 00	
165.00 Is this hospital part of a Multic. Enter "Y" for yes or "N" for no.	ampus hospital that has	one or mo	re campus	ses in dif	fferent	t CBSAs?		N	165. 00
	Name O	Coun ⁻		State 2.00	Zip Cc 3.00			/Campus 5.00	
166.00 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)				2.00	0.00				0166.00
								1. 00	-
Health Information Technology (HI						ct			1/7 0/
167.00 Is this provider a meaningful use 168.00 If this provider is a CAH (line 1 reasonable cost incurred for the	O5 is "Y") and is a mea HIT assets (see instruc	ningful us tions)	er (line	167 is "Y	Y"), er			Υ	167. 00 0168. 00
168.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)						nardshi p			168. 0
169.00 If this provider is a meaningful transition factor. (see instruction	user (line 167 is "Y")					, enter t	he	9. 9	9169. 00
						Begi nni n		ndi ng 2. 00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	oegi nni ng date and endi	ng date fo	r the rep	oorti ng		10/01/201		30/2013	170. 00
						1. 00		2. 00	
171.00 If line 167 is "Y", does this pro section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (reported on Wkst. S-3, umn 1. If column 1 is y	Pt. I, lin	e 2, col.	6? Enter		N		(0 171.00

SPI T	Financial Systems COMMUNITY HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0113	Peri od: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Pro 5/14/2018 1:5	epared:	
				Y/N 1. 00	Date 2.00	_	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	for all NO re	esponses. Ente				
00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.00	
	reporting period? If yes, enter the date of the change in co	olumn 2. (see	instructions)) Date	V/I		
			1.00	2. 00	3. 00		
00	Has the provider terminated participation in the Medicare Pryes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		N			2. 00	
00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	fices, drug er or its the board	N			3.00	
			Y/N	Type	Date		
	Financial Data and Reports		1.00	2. 00	3. 00		
00	Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues differ	or Compiled, lable in	Y	A		4. 00	
	those on the filed financial statements? If yes, submit reco	onciliation.		Y/N	Logal Open		
				1.00	Legal Oper. 2.00		
00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is N the legal operator of the program?						
00	Are costs claimed for Allied Health Programs? If "Y" see ins Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions.		during the	N N		7. 00 8. 00	
00	Are costs claimed for Interns and Residents in an approved g program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated or	S.		N N		9.00	
00	cost reporting period? If yes, see instructions. 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. 00	
					Y/N 1. 00		
	Bad Debts						
	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.			ost reporting	Y N	12. 00 13. 00	
00	If line 12 is yes, were patient deductibles and/or co-paymen Bed Complement	nts waived? If	yes, see ins	structi ons.	N	14.00	
00	Did total beds available change from the prior cost reportin	U .	yes, see inst	tructions. Par	N t B	15. 00	
		Y/N	Date	Y/N	Date		
	PS&R Data	1. 00	2.00	3. 00	4. 00		
00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	Υ	03/30/2018	Y	03/30/2018	16.00	
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	N		N		17. 00	
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	N		N		18.00	
00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19. 00	

Heal th	Financial Systems COMMUNITY HOSP	TAL ANDERSON		In Lie	u of Form CM	S-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0113	Peri od: From 01/01/2017 To 12/31/2017	Worksheet S Part II Date/Time F 5/14/2018 1	repared:
			iption	Y/N	Y/N	
20.00	16 1: 1/ 17 :		0	1.00	3. 00 N	20.00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	Į Ņ	20. 00
	Troport data for other bookings the other day as the other	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		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCI	EPT CHILDRENS H	OSPI TALS)		1.00	
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, se				N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense	due to apprais	sals made dur	ing the cost	N	23. 00
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter-	porting period?	N	24. 00		
	If yes, see instructions	p				
25. 00	Have there been new capitalized leases entered into during	the cost repor	ting period?	If yes, see	N	25. 00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during to	ho cost ronor+:	na nori oda I	f vos soo	N	26. 00
26.00	instructions.	ne cost reporti	ng perrou? i	i yes, see	Į Ņ	26.00
27. 00	Has the provider's capitalization policy changed during the	e cost reportir	ng period? If	yes, submit	N	27. 00
	сору.	·				
00.00	Interest Expense					
28. 00	Were new loans, mortgage agreements or letters of credit eleperiod? If yes, see instructions.	nterea into aur	ring the cost	reporting	N	28. 00
29. 00	Did the provider have a funded depreciation account and/or	bond funds (De	ebt Service R	eserve Fund)	N	29. 00
	treated as a funded depreciation account? If yes, see inst					
30. 00	Has existing debt been replaced prior to its scheduled mate	urity with new	debt? If yes	, see	N	30. 00
31. 00	instructions. Has debt been recalled before scheduled maturity without is	ccuanca of now	dobt2 If you	500	N	31. 00
31.00	instructions.	SSUAIICE OI HEW	debt? IT yes	, see	IN	31.00
	Purchased Services					
32. 00	Have changes or new agreements occurred in patient care se		ed through co	ntractual	N	32. 00
22.00	arrangements with suppliers of services? If yes, see instru		.a +o oomno+i	tivo biddingO LE	N	22.00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 applino, see instructions.	pried pertainir	ig to competi	tive brading? II	N	33. 00
	Provi der-Based Physi ci ans					
34.00	Are services furnished at the provider facility under an a	rrangement with	n provi der-ba	sed physi ci ans?	Υ	34. 00
	If yes, see instructions.					
35. 00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see in		nts with the	provi der-based	N	35. 00
	phrysrcians during the cost reporting period? If yes, see if	IISTI UCTI OIIS.		Y/N	Date	
				1. 00	2. 00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?		h 55' - 5	Y		36.00
37. 00	If line 36 is yes, has a home office cost statement been p If yes, see instructions.	repared by the	nome office's	Υ		37. 00
38. 00	IT yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fice different	from that of	N		38. 00
	the provider? If yes, enter in column 2 the fiscal year en					
39. 00	If line 36 is yes, did the provider render services to other	er chain compor	nents? If yes	, N		39. 00
40.00	see instructions.	homo offico?	If you soo	N		40.00
40. 00	If line 36 is yes, did the provider render services to the instructions.	nome office?	ii yes, see	N		40. 00
		1.	00	2.	00	
44 00	Cost Report Preparer Contact Information	DEV		44.00		
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		41. 00		
	respectively.					
42. 00	Enter the employer/company name of the cost report	ERNST & YOUNG			42. 00	
10.05	preparer.	047/047510		DEV OVER 1 EV	011	40.00
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3176817519		REX. SHERA@EY. C	UM	43. 00
	1. Sps. t properties in containing it and 2, respectivery.	1		I		II

Heal th	Financial Systems COMMUNITY HOSP	TAL ANDERSON	In Lie	In Lieu of Form CMS-2552-10			
H0SPI	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0113	Peri od: From 01/01/2017	Worksheet S-2 Part II			
			To 12/31/2017	Date/Time Pre 5/14/2018 1:5	pared: 2 pm		
		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,						
	respecti vel y.						
42.00	Enter the employer/company name of the cost report				42.00		
	preparer.						
43.00	Enter the telephone number and email address of the cost				43.00		
	report preparer in columns 1 and 2, respectively.						
42. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer. Enter the telephone number and email address of the cost				42. 00		

Heal th	Financial Systems COMMUNITY HOSPITA	AL ANDERSON		Non-CMS HFS Wo	rksheet
HFS Su	upplemental Information	Provi der CCN: 15-0113	Peri od: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part IX Date/Time Pre 5/14/2018 1:5	pared:
			Title V	Title XIX	
			1. 00	2. 00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interstepdown adjustments on W/S B, Part I, column 25? Enter Y/N i and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	n column 1 for Title V	Y	Υ	1. 00
2. 00	Do Title V or XIX follow Medicare (Title XVIII) for the repor Part I (e.g. net of Physician's component)? Enter Y/N in colu in column 2 for Title XIX. (see S-2, Part I, line 98.01)		Υ	2. 00	
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calcu Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for 2 for Title XIX. (see S-2, Part I, line 98.02)		Υ	3. 00	
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3. 01	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	CRITICAL ACCESS HOSPITALS				
4. 00	Does Title V follow Medicare (Title XVIII) for Critical Acces reimbursed 101% of cost? Enter Y or N in column 1 for inpatie for outpatient. (see S-2, Part I, lines 98.03 and 98.04)		N 2	N	4. 00
5. 00	Does Title XIX follow Medicare (Title XVIII) for Critical Accreimbursed 101% of cost? Enter Y or N in column 1 for inpatie for outpatient. (see S-2, Part I, lines 98.03 and 98.04)			N	5. 00
			Title V	Title XIX	
			1. 00	2. 00	
	RCE DI SALLOWANCE				
6. 00	Do Title V or XIX follow Medicare and add back the RCE Disall column 4? Enter Y/N in column 1 for Title V and Y/N in column S-2, Part I, line 98.05)		Y	Υ	6. 00
7. 00	PASS THROUGH COST Do Title V or XIX follow Medicare when cost reimbursed (payme worksheets D, parts I through IV? Enter Y/N in column 1 for T 2 for Title XIX. (see S-2, Part I, line 98.06)	Y	Y	7. 00	
8. 00	Title V and Y/N in column 2 for Title XIX.				
9. 00	FOHC For fiscal year beginning on/after 10/01/2014, use M-series f XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 fo		N	N	9. 00

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0113

				11	0 12/31/2017	5/14/2018 1:5	
						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	122	44, 530	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	
6.00	Hospital Adults & Peds. Swing Bed NF					0	
7. 00	Total Adults and Peds. (exclude observation		122	44, 530	0. 00	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00	17	·	0. 00	0	
9.00	CORONARY CARE UNIT	32. 00	0		0. 00		
10. 00	BURN INTENSIVE CARE UNIT	33. 00			0. 00		
11. 00	SURGICAL INTENSIVE CARE UNIT	34. 00	0	0	0. 00	0	11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)					_	12.00
13. 00	NURSERY	43. 00				0	
14.00	Total (see instructions)		139	50, 735	0. 00		14.00
15. 00	CAH visits	40.00				0	15. 00
16.00	SUBPROVIDER - I PF	40. 00	0			0	16.00
17. 00	SUBPROVIDER - I RF	41. 00	0	0		0	17. 00
18.00	SUBPROVI DER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY	44. 00		_		_	19.00
20. 00 21. 00	NURSING FACILITY OTHER LONG TERM CARE	45. 00 46. 00	0	0		0	20. 00 21. 00
21.00	HOME HEALTH AGENCY	101.00	U	U		0	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00				U	23. 00
24. 00	HOSPICE	116. 00	0	0			24.00
24. 00	HOSPICE (non-distinct part)	30.00	U	U			24. 00
25. 00	CMHC - CMHC	99. 00				0	
25. 10	CMHC - CORF	99. 10					25. 10
26. 00	RURAL HEALTH CLINIC	88. 00					ł
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	
27. 00	Total (sum of lines 14-26)	07.00	139			o o	27. 00
28. 00	Observation Bed Days		107			0	1
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		Ĭ				32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges						33. 01

Health Financial Systems COMMUNIT

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3	
From 01/01/2017	Part	
To 12/31/2017	Date/Time Prepared:	5/14/2018 1:52 pm

				•		5/14/2018 1:5	2 pm
		I/P Days	s / O/P Visits	/ Trips	Full Time	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	Hospital Adults & Peds. (columns 5, 6, 7 and	9, 660	660				1. 00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2						
2 00	for the portion of LDP room available beds)	4, 320	4, 028				2. 00
2. 00 3. 00	HMO and other (see instructions) HMO IPF Subprovider	4, 320	4, 028	1			3.00
4. 00	HMO IRF Subprovider	0	0				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0				5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	U	0	·			6.00
7. 00	Total Adults and Peds. (exclude observation	9, 660	660				7.00
7.00	beds) (see instructions)	9,000	000	22, 033			7.00
8. 00	INTENSIVE CARE UNIT	1, 348	11	1, 435			8. 00
9. 00	CORONARY CARE UNIT	1, 340	0				9.00
10. 00	BURN INTENSIVE CARE UNIT	0	0				10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	0	0				11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)		0	l			12.00
13. 00	NURSERY		1, 757	2, 006			13. 00
14. 00	Total (see instructions)	11, 008	2, 428			1, 098. 99	
15. 00	CAH visits	0	0	i .	0	1,070.77	15. 00
16. 00	SUBPROVIDER - IPF	0	0		0.00	0.00	
17. 00	SUBPROVIDER - IRF	0	0	0	0.00		
18. 00	SUBPROVI DER		0	0			
19.00	SKILLED NURSING FACILITY	o	0	0	0.00	0.00	19. 00
20.00	NURSING FACILITY		0	0	0.00	0.00	20. 00
21.00	OTHER LONG TERM CARE			0	0.00	0.00	21. 00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)				0.00	0.00	23. 00
24.00	HOSPI CE	0	0	0	0.00	0.00	24. 00
24. 10	HOSPICE (non-distinct part)	0	0	207			24. 10
25.00	CMHC - CMHC	0	0	0	0.00	0.00	25. 00
25. 10	CMHC - CORF	0	0	0	0.00	0.00	25. 10
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00		
27. 00	Total (sum of lines 14-26)				0.44	1, 098. 99	27. 00
28. 00	Observation Bed Days		1, 117	2, 075			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			319			30. 00
31. 00	Employee discount days - IRF			0			31. 00
32.00	Labor & delivery days (see instructions)	0	5	111			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3	
From 01/01/2017	Part	
To 12/31/2017	Date/Time Prepared:	5/14/2018 1:52 pm

						5/14/2018 1:5	2 pm
		Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		(2, 594	1, 646	6, 981	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)			0.55			
2.00	HMO and other (see instructions)			955	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO I RF Subprovi der				U		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
0.00	beds) (see instructions)						8. 00
8.00	INTENSIVE CARE UNIT						9.00
9. 00 10. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						10.00
11. 00	1						11.00
12. 00	SURGICAL INTENSIVE CARE UNIT						12.00
12.00	OTHER SPECIAL CARE (SPECIFY)						13.00
14. 00	NURSERY Total (see instructions)	0.00	(2, 594	1, 646	6, 981	
15. 00	CAH visits	0.00	(2, 394	1, 040	0, 901	15.00
16. 00	SUBPROVIDER - IPF	0.00	(0	0	0	16.00
17. 00	SUBPROVIDER - I RF	0.00	(1	0	0	17. 00
18. 00	SUBPROVI DER	0.00	(1	0	0	18.00
19. 00	SKILLED NURSING FACILITY	0.00	,		O	O	19.00
20. 00	NURSING FACILITY	0.00					20.00
21. 00	OTHER LONG TERM CARE	0.00				0	21.00
22. 00	HOME HEALTH AGENCY	0.00				O	22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23. 00
24. 00	HOSPI CE	0.00					24.00
24. 10	HOSPICE (non-distinct part)	0.00					24. 10
25. 00	CMHC - CMHC	0.00					25. 00
25. 10	CMHC - CORF	0.00					25. 10
26. 00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance 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)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared:

24.00 Wage-related costs (RHC/FOHC) 0 0 0 25.00 Interns & residents (in an approved program) 0 0 0 25.50 Home office wage-related (core) 267,760 0 267,760 25.50						To	12/31/2017	Date/Time Prep 5/14/2018 1:5:	
PRESIDENCE 1.00 2.00 3.00 4.00 5								Average Hourly	
MART 1 - AMCE DATA			Number	керогтеа					
SALAMES SALA			1 00	2.00				4.00	
1.000 1.01a sal arise (see 200.00 65,892,254 0 65,892,254 2.285,904.69 28.83 1.00 2.0		PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
2.0 Instructions	1 00	1	202 00	/F 002 2F4		/F 002 2F4	2 205 004 (0	20.02	1 00
3.00 Non-Physician anesthetist Part	1.00		200.00	65, 892, 254	0	65, 892, 254	2, 285, 904. 69	28. 83	1.00
3.00 Shorp physic claim anesthetist Part Shorp physic claim anesthetist Part Shorp physic claim anesthetist Part Shorp physic claim - Part A - Teaching Shorp physic claim - Part A - Teaching Shorp physic claim - Part B - To hospital - To hospital - Part B	2.00			0	0	0	0. 00	0. 00	2. 00
Amin Strattve Amin Ami	3. 00			822, 673	0	822, 673	9, 528. 00	86. 34	3. 00
Amin Strattve Amin Ami	4 00	B Dhysisian Bant A		0			0.00	0.00	4 00
Physician and Non	4.00	3		0	0	U	0.00	0.00	4.00
Physician-Part B					1	-			
Nospital - based BNC and FORC Services	5.00			491	0	491	13.00	37.77	5.00
Services	6. 00			0	0	0	0. 00	0. 00	6. 00
7. 01. Contracted interns and residents (in an approved programs) 8.00 Neme orrice and/or related organization personnel (in an approved programs) 8.00 Neme orrice and/or related (in an approved programs) 8.00 Neme orrice and/or related (in an approved programs) 8.00 Neme orrice and/or related (in an approved programs) 8.00 Neme orrice and/or related (in an approved programs) 8.00 Neme orrice and/or related (in an approved programs) 8.00 Neme orrice and/or related (in an approved programs) 8.00 Neme orrice and/or related (in an approved programs) 8.00 Neme orrice and/or related (in an approved programs) 8.00 Neme orrice and/or related (in an approved programs) 8.00 Neme orrice and/or related (in an approved programs) 8.00 Neme orrice and/or related (in an approved programs) 8.00 Neme orrice and/or related (in an approved programs) 8.00 Neme orrice and contract programs (in approximation approximation approximation approximation approximation and programs) 8.00 Neme orrice and contract programs (in approximation approximati									
Contracted interins and residents (In an approved programs) Contracted interins and residents (In an approved programs) South Homo Office and/or related Color	7. 00		21. 00	0	0	0	0. 00	0. 00	7. 00
Brograms	7. 01			0	О	0	0.00	0. 00	7. 01
Nome office and/or related organization personnel 44.00 0 0 0 0 0 0 0 0 0									1
9.00 SNF 0.00 Excluded area salaries (see Instructions) OTHER WAGES & RELATED COSTS 11.00 Contract Labor: Direct Patient Carter and administrative management and other manageme	8. 00			0	О	0	0.00	0. 00	8. 00
10.00 Excluded area salaries (see 3.594, 186 0 3.594, 186 97, 030. 32 37. 04 10.00	0.00		44.00	0		0	0.00	0.00	0.00
OFFICE WAGES & RELATED COSTS 1.000		l	44.00	3, 594, 186	1	3, 594, 186			
11.00 Contract labor: Direct Patient Care Care Care Care Contract labor: Direct Patient Care Care Care Contract labor: Top level management and other management and other management and administrative services									
12.00 Contract labor: Top level management and other management and other management and administrative services 3.00 Contract labor: Physician=Part 345,100 0 345,100 3,754.00 91.93 13.00	11. 00			1, 086, 414	0	1, 086, 414	16, 470. 89	65. 96	11. 00
management and other management management and other management management and other management management and other management	12.00	1		0			0.00	0.00	12.00
Services 345, 100 0 345, 100 3,754, 00 91, 93 13, 00 14, 00 0 0 0 0 0 0 0 0 0	12.00			0	0	U	0.00	0.00	12.00
13.00 Contract Labor: Physician = Part 345, 100 0 345, 100 3,754.00 91.93 13.00 14.0									
14. 00 Home office and/or related or operation of the	13. 00			345, 100	О	345, 100	3, 754. 00	91. 93	13. 00
orgal rozation salariles and wage-rel ated costs 1,093,269	14 00			0		0	0.00	0.00	14 00
14. 01 Home office salaries 1,093,269 0 1,093,269 20,949,00 52,19 14. 01 14. 02 Rated organization salaries 0 0 0 0 0.00 0.00 14. 02 15. 00 Home office: Physician Part A 0 0 0 0 0.00 0.00 15. 00 16. 00 Home office: Physician Part A 0 0 0 0 0.00 0.00 15. 00 16. 00 Home office: Physician Part A 0 0 0 0 0.00 0.00 16. 00 17. 00 MAGE-RILATIED COSTS	14.00			U		U	0.00	0.00	14.00
14. 02 Rel ated organization salaries 0 0 0 0 0.00 0.00 14. 02 15. 00 Home office in Physician Part A 0 0 0 0 0.00 0.00 15. 00 16. 00 Home office and contract 0 0 0 0 0 0.00 0.00 16. 00 Home office and contract 0 0 0 0 0 0.00 17. 00 Physicians Part A - Teaching 0 0 0 0 0 0 18. 00 0 0 0 0 0 18. 00 0 0 0 0 0 18. 00 0 0 0 0 0 18. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 19. 00 0 0 0 19. 00 0 0 0 19. 00 0 0 19. 00 0 0 0 19. 00 0 0 0 19. 00 0 0 19. 00 0 0 0 19. 00 0 0 0 19. 00 0 0 0 19. 00 0 0 0 19. 00 0 0 0 19. 00 0 0 0 19. 00 0 0 0 19. 00 0 0 0 19. 00 0 0 0 19. 00 0 0 0 19. 00 0 0 0 19. 00 0 0 0 19. 00 0 0 0 19. 00 0 0 19. 00 0 0 0 19. 00 0 0 0 19. 00 0 0 19. 00 0 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0	14 01			1 002 240		1 002 240	20 040 00	E2 10	14 01
- Administrative home office and Contract home				1, 093, 209	ő	1, 093, 209			
16.00 Home office and Contract Physicians Part A - Teaching	15. 00			0	0	0	0. 00	0.00	15. 00
NACE-RELATED COSTS Wage-rel ated costs (core) (see instructions) 16,623,232 0 16,623,232 17.00 18.00 Wage-rel ated costs (other) (see instructions) 18.00 Wage-rel ated costs (other) (see instructions) 18.00 20.00	16. 00			0	О	0	0.00	0. 00	16. 00
17. 00 Wage-related costs (core) (see instructions) 16, 623, 232 0 16, 623, 232 17. 00 18. 00 18. 00 Wage-related costs (other) 0 0 0 0 0 18. 00 18. 00 19. 00 Excluded areas 971, 893 0 971, 893 19. 00 20. 00									
18.00 Wage-related costs (other) (see instructions) 18.00 0 0 0 0 18.00 19.00 Excluded areas 971,893 0 971,893 19.00 20.00 Non-physician anesthetist Part 222,589 0 222,589 21.00 21.00 Non-physician anesthetist Part 222,589 0 222,589 21.00 22.00 Physician Part A - Administrative 0 0 0 0 22.01 Physician Part A - Teaching 0 0 0 0 23.00 Physician Part B 0 0 0 24.00 Wage-related costs (RHC/FOHC) 0 0 0 25.00 Interns & residents (in an approved program) 25.50 25.50 Home office wage-related 267,760 0 267,760 25.51 Related organization 0 0 0 25.52 Home office Physician Part A 0 0 0 25.53 Physicians Part A - Teaching 25.53 26.00 Employee Benefits Department 4.00 3,111,933 0 3,111,933 88,541.35 35.15 26.00 Employee Benefits Department 4.00 3,111,933 0 3,111,933 88,541.35 35.15 26.00 Employee Benefits Department 4.00 3,111,933 0 3,111,933 88,541.35 35.15 26.00 Employee Benefits Department 4.00 3,111,933 0 3,111,933 88,541.35 35.15 26.00 Employee Benefits Department 4.00 3,111,933 0 3,111,933 88,541.35 35.15 26.00 Employee Benefits Department 4.00 3,111,933 0 3,111,933 88,541.35 35.15 26.00 Employee Benefits Department 4.00 3,111,933 0 3,111,933 0 3,111,933 35.15 26.00 Employee Benefits Department 4.00 3,111,933 0 3,111,933 35.15 35.	17. 00	Wage-related costs (core) (see		16, 623, 232	0	16, 623, 232			17. 00
See instructions Fact uded areas Section	18 00			0	0	0			18 00
20. 00 Non-physician anesthetist Part A Non-physician anesthetist Part B 22. 00 Physician Part A - Administrative Physician Part B 22. 01 Physician Part B 22. 01 Physician Part B 22. 02 Non-physician Part B 23. 00 Physician Part B 24. 00 Non-physician Part B 25. 00 Non-physician Part B 26. 00 Non-physician Part B 27. 00 Non-physician Part A Non-physician Part B Non-physician Part A No		(see instructions)		_	_				
21.00 Non-physician anesthetist Part				971, 893 0	0	971, 893			
B		A		· ·					
Administrative Physician Part A - Teaching 0	21. 00	Non-physician anesthetist Part B		222, 589	0	222, 589			21. 00
22. 01 Physician Part A - Teaching	22. 00			0	0	0			22. 00
23. 00 Physician Part B	22. 01	1		0	0	o			22. 01
25. 00 Interns & residents (in an approved program) 25. 00 267,760 25. 50 25. 50 267,760 267,760 267,760 25. 50 25. 51 25. 51 25. 51 25. 52 25. 52 25. 52 25. 52 25. 52 25. 53 25. 52 25. 53	23. 00	Physician Part B		0	Ō	0			23. 00
approved program Home office wage-related (core) 25.50 Related organization wage-related (core) Home office: Physician Part A 0 0 0 0 25.52 - Administrative - wage-related (core) Home office & Contract 0 0 0 0 25.53 - Physicians Part A - Teaching - wage-related (core)				0	0	0			
Core Rel ated organization 0 0 0 0 25.51	25.00			· ·	٥				
25. 51 Related organization wage-related (core) Home office: Physician Part A	25. 50			267, 760	0	267, 760			25. 50
25. 52 Home office: Physician Part A	25. 51	Related organization		0	О	О			25. 51
- Administrative - wage-related (core) Home office & Contract Physicians Part A - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES Employee Benefits Department 4.00 3,111,933 0 3,111,933 88,541.35 35.15 26.00	25 52	, ,		0	_	0			25 52
25. 53 Home office & Contract 0 0 0 0 0 25. 53 Physicians Part A - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26. 00 Employee Benefits Department 4. 00 3, 111, 933 0 3, 111, 933 88, 541. 35 35. 15 26. 00	20.02	- Administrative -		O					20. 02
Physicians Part A - Teaching -	25 53			Ω	_	n			25 53
OVERHEAD COSTS - DIRECT SALARIES 26. 00 Empl oyee Benefits Department 4. 00 3, 111, 933 0 3, 111, 933 88, 541. 35 35. 15 26. 00	20.00	Physicians Part A - Teaching -		O					
26. 00 Employee Benefits Department 4. 00 3, 111, 933 0 3, 111, 933 88, 541. 35 35. 15 26. 00			-S						
27. 00 Administrative & General 5. 00 10, 609, 968 0 10, 609, 968 376, 614. 22 28. 17 27. 00		Employee Benefits Department	4. 00						
	27. 00	Administrative & General	5. 00	10, 609, 968	0	10, 609, 968	376, 614. 22	28. 17	27. 00

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared:

							5/14/2018 1:52	
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted		Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		8, 945, 604	0	8, 945, 604	162, 890. 02	54. 92	28.00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00		29. 00
30. 00	Operation of Plant	7. 00	2, 155, 126		2, 155, 126		1	
31. 00	Laundry & Linen Service	8. 00	0	69, 302				
32. 00	Housekeepi ng	9. 00	1, 502, 556	-69, 302	1, 433, 254	87, 117. 37	16. 45	32.00
33.00	Housekeeping under contract		0	0	0	0. 00	0. 00	33.00
	(see instructions)							
34. 00	Di etary	10. 00	1, 489, 959	-825, 199	664, 760	37, 876. 49	17. 55	34. 00
35. 00	Di etary under contract (see		0	0	0	0. 00	0. 00	35.00
	instructions)							
36. 00	Cafeteri a	11. 00	0	825, 199	825, 199	47, 019. 00		36. 00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0. 00	0. 00	37. 00
38. 00	Nursing Administration	13. 00	1, 137, 795	0	1, 137, 795	24, 699. 83	46. 06	38. 00
39. 00	Central Services and Supply	14. 00	1, 035, 273	0	1, 035, 273	63, 977. 15	16. 18	39.00
40.00	Pharmacy	15. 00	1, 653, 137	0	1, 653, 137	44, 535. 18	37. 12	40.00
41.00	Medical Records & Medical	16. 00	1, 213, 422	0	1, 213, 422	46, 621. 87	26. 03	41.00
	Records Library							
42.00	Soci al Servi ce	17. 00	0	0	0	0. 00	0.00	42.00
43.00	Other General Service	18. 00	0	0	0	0. 00	0.00	43.00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION COMMUNITY HOSPITAL ANDERSON

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2017 | Part III | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 Provider CCN: 15-0113

							5/14/2018 1:5	2 pm
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		74, 014, 694	. 0	74, 014, 694	2, 439, 253. 71	30. 34	1.00
	instructions)							
2.00	Excluded area salaries (see		3, 594, 186	0	3, 594, 186	97, 030. 32	37. 04	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		70, 420, 508	0	70, 420, 508	2, 342, 223. 39	30. 07	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		2, 524, 783	0	2, 524, 783	41, 173. 89	61. 32	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		16, 890, 992	2 0	16, 890, 992	0.00	23. 99	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		89, 836, 283	0	89, 836, 283	2, 383, 397. 28	37. 69	6. 00
7.00	Total overhead cost (see		32, 854, 773	0	32, 854, 773	1, 062, 188. 20	30. 93	7. 00
	instructions)							

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0113	Peri od:	Worksheet S-3
		From 01/01/2017	

PART IV - WAGE RELATED COSTS 1.00		To 12/31/2017	Date/Time Prep 5/14/2018 1:5:	
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST				
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 401K Employer Contributions 0 1.00 2.00 3.00 401K Employer Contributions 0 2.00 3.00 400K Employer Contributions 0 2.00 3.00 400K Employer Contributions 0 2.00 3.00 400K Employer Contributions 0 2.00 3.00 400 400K Employer Contributions 0 3.00 3.00 400 400K Employer Contributions 0 3.00 3.00 400K Employer Contributions 3.103.257 4.00 400K Employer Costs (see instructions) 3.103.257 4.00 400K Employer Costs (Paid to External Organization) 5.00 401K/TSA Plan Administration Fees 0 5.00 401K/TSA Plan Administration Fees 0 5.00 401K/TSA Plan Administration Fees 0 6.00 400K Employer Costs 400K Employer Employer Costs 400K Employer Costs 400K Employer Costs 400K Employer Costs 400K Employer Employer Costs 400K Employer Employer Costs 400K Employer Em			Reported	
Part A - Core List RETIREMENT COST			1. 00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00		Part A - Core List		
2.00		RETI REMENT COST		1
3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 3.00 2.0	1.00	401K Employer Contributions	0	1.00
A. 00	2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
PLAM ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Plan Administration fees 5.00 401K/TSA Plan Administration fees 6.00 1	3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
5.00 401K/TSA Pla na Administration fees 0 5.00 6.00 Legal /Accounting/Management Fees-Pension Plan 0 6.00 T.00 Employee Managed Care Program Administration Fees 0 7.00 HEALTH AND INSURANCE COST 8.00 Health Insurance (Purchased or Self Funded) 9,753,967 8.00 8.01 Health Insurance (Self Funded without a Third Party Administrator) 0 8.01 8.03 Health Insurance (Self Funded with a Third Party Administrator) 0 8.02 8.03 Health Insurance (Purchased) 0 8.02 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) 31,577 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 169,039 13.00 13.00 Usong-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 193,511 15.00 16.00 Retirement Health Care Cost (only current year, not	4.00		3, 103, 257	4.00
		PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		l
Employee Managed Care Program Administration Fees 0 7.00	5.00	401K/TSA Plan Administration fees	0	5. 00
HEALTH AND INSURANCE COST	6.00		0	
8.00 Heal th Insurance (Purchased or Self Funded) 9,753,967 8.00 8.01 Heal th Insurance (Self Funded without a Third Party Administrator) 0 8.01 8.02 Heal th Insurance (Self Funded without a Third Party Administrator) 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) 31,577 11.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 169,093 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 14.00 15.00 Workers' Compensation Insurance 193,511 15.00 Workers' Compensation Insurance 193,511 17.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 16.00 17.00 FICA-Employers Portion Only 4,416,319 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 35,588 19.00 19.00 Unemployment Insurance 0 20.00 19.00 State or Federal Unemployment Taxes 0 20.00 10HER 200 200 200 200 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 0 21.00 21.00 23.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 27.81 24.00 24.00 27.81 24.00 27.81 24.00 27.81 24.00 27.81 24.00 27.81 24.00 27.81 24.00 27.81 24.00 27.81 24.00 27.81 24.00 27.81 24.00 27.81 27.81 24.00 2	7.00		0	7. 00
8.01 Heal th Insurance (Sel F Funded without a Third Party Administrator) 0 8.01 8.02 Heal th Insurance (Sel F Funded with a Third Party Administrator) 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) 31,577 11.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 169,039 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance (If employee is owner or beneficiary) 0 14.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 Non cumulative portion 18.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 35,588 19.00 21.00 State or Federal Unemployment Taxes 0 20.00 OTHER 20.00 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 114,455 23.00 24.00 Total Wage Related cost (Sum of lines 1 -23) 17,817,313 24.00 24.00 Total Wage Related cost (Sum of lines 1 -23)		HEALTH AND INSURANCE COST		l
Real th Insurance (Self Funded with a Third Party Administrator) 0 8.02	8.00		9, 753, 967	8. 00
8. 03 Heal th Insurance (Purchased) 0 8. 03 9. 00 Prescription Drug Plan 0 9. 00 10.	8. 01		0	8. 01
9.00 Prescription Drug Plan	8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
10.00 Dental, Hearing and Vision Plan 0 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 31,577 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 169,039 13.00 13.00 Disability Insurance (If employee is owner or beneficiary) 169,039 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 193,511 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 Non cumulative portion 16.00 Non cumulative portion 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 35,588 19.00 20.00 OTHER 20.00 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 22.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 114,455 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 17,817,713 24.00	8. 03	Health Insurance (Purchased)	0	8. 03
11.00	9.00	Prescription Drug Plan	0	9. 00
12.00	10.00	Dental, Hearing and Vision Plan	0	10.00
13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 'Workers' Compensation Insurance 18.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) 17.00 FICA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 17.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 10.00 Total Wage Related cost (Sum of Lines 1 -23) 17.00 Total Wage Related cost (Sum of Lines 1 -23)			31, 577	11. 00
14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 14.00 15.00 'Workers' Compensation Insurance 193,511 15.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 Non cumulative portion) 16.00 TAXES	12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
15.00 'Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost reported on I in structions 1 through 4 above. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost and Allowances 10.00 Title Wage Related cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Onlow 10.00 16.00 17.00 Title Wage Related Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Onlow 10.00 16.00 17.00 Title Wage Related Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Onlow 10.00 16.00 17.00 Title Wage Related Cost (Only current year (Only current year) 17.00 Title Wage Related Cost (Only current year (Only current year) 17.00 Title Wage Related Cost (Only current year (Only current year) 17.00 Title Wage Related Cost (Only current year (Only current year) 17.00 Title Wage Related Cost (Only current year (Only current year) 17.00 Title Wage Related Cost (Only current year (Only current year) 17.0	13.00	Disability Insurance (If employee is owner or beneficiary)	169, 039	13.00
Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) TAXES	14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
Non cumulative portion TAXES To A Employers Portion Only To A Medicare Taxes - Employers To A Medicare Taxes To A Medicare Taxes - To A Medicare Taxes To	15. 00		193, 511	
TAXES	16. 00		0	16. 00
17. 00 FI CA-Employers Portion Only 4, 416, 319 17. 00 18. 00 19. 00 1				1
18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 35,588 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 114,455 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 17,817,713 24.00				
19.00 Unemployment Insurance 35,588 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 114,455 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 17,817,713 24.00			4, 416, 319	1
20.00 State or Federal Unemployment Taxes 0 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 23.00 Tuition Reimbursement 1 24.00 Total Wage Related cost (Sum of Lines 1 -23)			-	1
OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 -23) 21.00 Total Wage Related cost (Sum of lines 1 -23)			35, 588	
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement Total Wage Related cost (Sum of lines 1 -23) 21.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00 29.00 29.00 20.00 2	20. 00		0	20. 00
instructions)) 22.00 Day Care Cost and Allowances 23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 -23) 26.00 Total Wage Related cost (Sum of lines 1 -23)				
22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 114, 455 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 -23) 17, 817, 713 24. 00	21. 00		0	21. 00
23.00 Tuition Reimbursement 114,455 23.00 24.00 Total Wage Related cost (Sum of lines 1 -23) 17,817,713 24.00				
24.00 Total Wage Related cost (Sum of lines 1 -23) 17,817,713 24.00				
Part B - Other than Core Related Cost	24. 00		17, 817, 713	24. 00
25.00 OTHER WAGE RELATED COSTS (SPECIFY)	25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-2552-10
Provi der CCN: 15-0113		Worksheet S-3
	From 01/01/2017	Part V
		Provider CCN: 15-0113 Period: From 01/01/2017

		To 12/31/2017	Date/Time Pre	
			5/14/2018 1:5	2 pm
	Cost Center Description	Contract Labor		
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1. 00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospi tal	0	0	2. 00
3.00	Subprovi der - I PF	0	0	3. 00
4.00	Subprovi der - I RF	0	0	4.00
5.00	Subprovi der - (0ther)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF	0	0	8. 00
9.00	Hospi tal -Based NF	0	0	9. 00
10.00	Hospi tal -Based OLTC			10.00
11.00	Hospi tal -Based HHA	0	0	11. 00
12.00	Separately Certified ASC	0	0	12.00
13.00	Hospi tal -Based Hospi ce	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14. 00
15.00	Hospital-Based Health Clinic FOHC	0	0	15. 00
16. 00	Hospi tal -Based-CMHC	0	0	16. 00
16. 10	Hospi tal -Based-CMHC 10	0	0	16. 10
17.00	Renal Dialysis	0	0	17. 00
18.00		_	0	18. 00

	FAL UNCOMPENSATED AND INDIGENT CARE DATA Provide	er CCN: 15-0113	Peri od:	Worksheet S-1	0				
			From 01/01/2017 To 12/31/2017		naradi				
			10 12/31/201/	Date/Time Pre 5/14/2018 1:5					
				1. 00					
	Uncompensated and indigent care cost computation			T					
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided b	y line 202 colur	nn 8)	0. 241563	1.0				
2. 00	Medicaid (see instructions for each line) Net revenue from Medicaid			60, 354, 906	2.0				
3. 00	Did you receive DSH or supplemental payments from Medicaid?			Υ	3.0				
. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental pay	ments from Medio	cai d?	Υ	4.0				
. 00	If line 4 is no, then enter DSH and/or supplemental payments from Med	0							
. 00	Medi cai d charges	99, 136, 589 23, 947, 732							
7. 00 8. 00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if				1				
5. 00	<pre>< zero then enter zero)</pre>	IIII NUS SUII OI II	nes 2 and 5; 11	0	8.0				
	Children's Health Insurance Program (CHIP) (see instructions for each	line)			İ				
. 00	Net revenue from stand-alone CHIP			0	9.0				
0. 00	Stand-alone CHIP charges			0					
1.00	Stand-alone CHIP cost (line 1 times line 10)	1! 1! 0	:6 +	0	1				
2. 00	Difference between net revenue and costs for stand-alone CHIP (line 1 enter zero)	i minus iine 9;	ir < zero then	0	12.0				
	Other state or local government indigent care program (see instruction	ns for each line	e)						
3. 00	Net revenue from state or local indigent care program (Not included o			0	13.0				
4. 00	Charges for patients covered under state or local indigent care progr	am (Not included	d in lines 6 or	0	14.0				
F 00	10)				45.0				
5. 00 6. 00	State or local indigent care program cost (line 1 times line 14)	caro program (Li	no 15 minus lino	0					
10.00	13; if < zero then enter zero)	care program (11	ile 13 illi ilus i i ile						
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and	state/local indi	gent care program	ms (see					
7. 00	instructions for each line)		gent care program		17.0				
		charity care	gent care progra	10, 323 108, 831	1				
18.00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid , CHIP and state and local indig	charity care I operations		10, 323	18. 0				
8. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita	charity care I operations	ns (sum of lines	10, 323 108, 831	18. 0				
8. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid , CHIP and state and local indig	charity care I operations ent care progran Uninsured patients	ms (sum of lines	10, 323 108, 831 0 Total (col. 1 + col. 2)	18. 0				
8. 00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid , CHIP and state and local indig 8, 12 and 16)</pre>	charity care I operations ent care progran	ms (sum of lines	10, 323 108, 831 0	18. 0				
8. 00 9. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid , CHIP and state and local indig 8, 12 and 16) Uncompensated Care (see instructions for each line)	charity care I operations ent care program Uninsured patients 1.00	ns (sum of lines I Insured patients 2.00	10, 323 108, 831 0 Total (col. 1 + col. 2) 3.00	18. 0 19. 0				
8. 00 9. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid , CHIP and state and local indig 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility	charity care I operations ent care progran Uninsured patients	ns (sum of lines I Insured patients 2.00	10, 323 108, 831 0 Total (col. 1 + col. 2) 3.00	18. 0 19. 0				
8. 00 9. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid , CHIP and state and local indig 8, 12 and 16) Uncompensated Care (see instructions for each line)	Charity care I operations ent care program Uninsured patients 1.00	I Insured patients 2.00 1,770,149	10, 323 108, 831 0 Total (col. 1 + col. 2) 3.00	18. 0 19. 0				
8. 00 9. 00 20. 00	Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions)	Uninsured patients 4,844,6 ee 1,170,2	I Insured patients 2.00 1,770,149 290 1,770,149	10, 323 108, 831 0 Total (col. 1 + col. 2) 3.00 6, 614, 805 2, 940, 439	18. 0 19. 0 20. 0 21. 0				
8. 00 9. 00 20. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as	Uninsured patients 4,844,6 ee 1,170,2	I Insured patients 2.00 1,770,149	10, 323 108, 831 0 Total (col. 1 + col. 2) 3.00 6, 614, 805 2, 940, 439	18. 0 19. 0 20. 0 21. 0				
8. 00 9. 00 20. 00 21. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care	Charity care I operations ent care program Uninsured patients 1.00 4,844,6 ee 1,170,2	ns (sum of lines I Insured patients 2.00 556 1,770,149 0 0	10, 323 108, 831 0 Total (col. 1 + col. 2) 3.00 6, 614, 805 2, 940, 439	20. 0 21. 0 22. 0				
8. 00 9. 00 0. 00 11. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as	Uninsured patients 4,844,6 ee 1,170,2	ns (sum of lines I Insured patients 2.00 556 1,770,149 0 0	10, 323 108, 831 0 Total (col. 1 + col. 2) 3.00 6, 614, 805 2, 940, 439	20. 0 21. 0 22. 0				
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00	Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)	Uninsured patients 4,844,0 ee 1,170,:	ms (sum of lines I Insured patients 2.00 556 1,770,149 0 0 1,770,149	10, 323 108, 831 0 Total (col. 1 + col. 2) 3.00 6, 614, 805 2, 940, 439 0 2, 940, 439	20. 0 21. 0 23. 0				
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00	Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days	Uninsured patients 1.00 4,844,6 ee 1,170,2 beyond a length	ms (sum of lines I Insured patients 2.00 556 1,770,149 0 0 1,770,149	10, 323 108, 831 0 Total (col. 1 + col. 2) 3.00 6, 614, 805 2, 940, 439	20. 0 21. 0 23. 0				
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00	Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indi	charity care I operations ent care program Uninsured patients 1.00 4,844,6 ee 1,170,2 beyond a length	I Insured patients 2.00 290 1,770,149 0 0 0 0 1,770,149 0 of stay limit	10, 323 108, 831 0 Total (col. 1 + col. 2) 3.00 6, 614, 805 2, 940, 439 0 2, 940, 439	20. 0 21. 0 22. 0 23. 0				
8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00	Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indistay limit	Uninsured patients Uninsured patients 1.00 4,844,6 ee 1,170,2 beyond a lengthm? gent care progra	I Insured patients 2.00 290 1,770,149 0 0 0 0 1,770,149 0 o o o o o o o o o o o o o o o o o o	10, 323 108, 831 0 Total (col. 1 + col. 2) 3.00 6, 614, 805 2, 940, 439 0 2, 940, 439	20. 0 21. 0 22. 0 23. 0 24. 0				
8. 00 9. 00 00. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indi	Uninsured patients 1.00 4,844,6 ee 1,170,2 beyond a length m? gent care progra	I Insured patients 2.00 290 1,770,149 0 0 0 0 1,770,149 0 o o o o o o o o o o o o o o o o o o	10, 323 108, 831 0 Total (col. 1 + col. 2) 3.00 6, 614, 805 2, 940, 439 0 2, 940, 439	20. 0 21. 0 22. 0 23. 0 24. 0 26. 0				
8. 00 9. 00 20. 00 21. 00 22. 00 23. 00 24. 00 26. 00 27. 00	Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indistay limit Total bad debt expense for the entire hospital complex (see instructi	Uninsured patients 1.00 4,844,0 ee 1,170,2 beyond a length m? gent care progra	I Insured patients 2.00 290 1,770,149 0 0 0 0 1,770,149 0 o o o o o o o o o o o o o o o o o o	10, 323 108, 831 0 Total (col. 1 + col. 2) 3.00 6, 614, 805 2, 940, 439 0 2, 940, 439 1.00 N	20. 0 21. 0 23. 0 24. 0 25. 0 26. 0 27. 0				
8. 00 9. 00 20. 00 21. 00 22. 00 23. 00 25. 00 26. 00 27. 00 77. 01 18. 00	Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indistay limit Total bad debt expense for the entire hospital complex (see instructi Medicare allowable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see ins Non-Medicare bad debt expense (see instructions)	charity care I operations ent care program Uninsured patients 1.00 4,844,6 ee 1,170,3 beyond a length m? gent care program ons) instructions)	ns (sum of lines I Insured patients 2.00 656 1,770,149 0 0 290 1,770,149 n of stay limit am's length of	10, 323 108, 831 0 Total (col. 1 + col. 2) 3.00 6, 614, 805 2, 940, 439 0 2, 940, 439 1.00 N 0 6, 827, 941 532, 064 818, 560 6, 009, 381	20. 0 21. 0 22. 0 23. 0 24. 0 25. 0 26. 0 27. 0 28. 0				
	Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indistay limit Total bad debt expense for the entire hospital complex (see instructi Medicare allowable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see ins Non-Medicare bad debt expense (see instructions)	charity care I operations ent care program Uninsured patients 1.00 4,844,6 ee 1,170,3 beyond a length m? gent care program ons) instructions)	ns (sum of lines I Insured patients 2.00 656 1,770,149 0 0 290 1,770,149 n of stay limit am's length of	10, 323 108, 831 0 Total (col. 1 + col. 2) 3.00 6, 614, 805 2, 940, 439 0 2, 940, 439 1.00 N 0 6, 827, 941 532, 064 818, 560	20. 0 21. 0 22. 0 23. 0 25. 0 26. 0 27. 0 28. 0 29. 0				

Heal th	n Financial Systems	COMMUNITY HOSPITAL	L ANDERSON		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CO	F	Period: From 01/01/2017	Worksheet A	
				1	Го 12/31/2017	Date/Time Pre 5/14/2018 1:5	
	Cost Center Description	Sal ari es	0ther		Recl assi fi cati	Recl assi fi ed	Z piii
				+ col . 2)	ons (See A-6)	Trial Balance (col. 3 +-	
						col . 4)	
	T	1. 00	2.00	3.00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		0		6, 017, 647	6, 017, 647	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	00300 OTHER CAP REL COSTS		0	(o	0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 111, 933	13, 807, 742			16, 871, 875	4. 00
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	10, 609, 968	21, 972, 020 0	32, 581, 988	-2, 052, 903	30, 529, 085 0	5. 00 6. 00
7. 00	00700 OPERATION OF PLANT	2, 155, 126	6, 289, 634	8, 444, 760	-1, 468, 727	6, 976, 033	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	(199, 200	199, 200	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 502, 556 1, 489, 959	500, 799 1, 579, 493			1, 786, 866 1, 052, 580	9. 00 10. 00
11.00	•	1, 409, 939	1, 379, 493	3, 009, 452		1, 699, 985	11. 00
13.00	01300 NURSING ADMINISTRATION	1, 137, 795	153, 439		-203	1, 291, 031	13. 00
14.00		1, 035, 273	900, 713			1, 811, 696	14.00
15. 00 16. 00		1, 653, 137 1, 213, 422	6, 166, 116 372, 657			2, 030, 993 1, 586, 059	15. 00 16. 00
17. 00	• • • • • • • • • • • • • • • • • • •	0	0,2,00,	1,000,07		0	17. 00
19. 00		0	0	(0	0	19. 00
20. 00 21. 00		0	0			0	20. 00 21. 00
22. 00		0	0			0	22. 00
23. 00		0	0	(0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	44,000,077	0.017.000	17 157 005		44 400 400	
30. 00 31. 00	• • • • • • • • • • • • • • • • • • •	14, 089, 977 2, 588, 543	3, 367, 930 957, 831			14, 492, 630 2, 932, 072	30. 00 31. 00
32. 00		0	0	0,010,07	0 0	0	32. 00
33. 00		0	0		o o	0	33. 00
34.00	•	0	0		0	0	34.00
40. 00 41. 00	•	0	0			0	40. 00 41. 00
42. 00	l l	0	0		o o	0	42. 00
43.00		0	2, 412	2, 412	1, 179, 053	1, 181, 465	43.00
44. 00 45. 00	•	0	0			0	44. 00 45. 00
46. 00	l l	Ö	Ö		o o	0	46. 00
FO 00	ANCILLARY SERVICE COST CENTERS	4 000 405	17 220 775	22 227 100	15 722 (70	/ 502 510	F0 00
50. 00 51. 00		4, 898, 405 0	17, 338, 775 0	22, 237, 180	-15, 733, 670	6, 503, 510 0	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	Ö	0			0	52. 00
53.00		822, 673	2, 884, 731			3, 663, 808	53.00
54. 00 55. 00		2, 408, 162	1, 556, 141	3, 964, 303	-631, 255	3, 333, 048 0	54. 00 55. 00
	05600 RADI OI SOTOPE	246, 485	662, 509	908, 994	-285, 399		
57. 00	05700 CT SCAN	420, 394	587, 769	1, 008, 163	-369, 616	638, 547	57. 00
58.00		318, 485	696, 649			876, 394	58.00
59. 00 60. 00		856, 918 2, 126, 891	1, 400, 855 3, 888, 230				59. 00 60. 00
60. 01		0	0	(0	0	60. 01
61.00		200 000	0	70 (000	0	0	61.00
62. 00 63. 00	• • • • • • • • • • • • • • • • • • •	209, 292	526, 797	736, 089	-502, 446	233, 643 0	62. 00 63. 00
64. 00		o o	0			0	64. 00
65.00		959, 977	266, 346			1, 030, 790	65. 00
66.00		1, 822, 631	894, 575			2, 167, 918	66.00
67. 00 68. 00	•	343, 128 190, 146	32, 687 29, 638	1		380, 364 228, 758	67. 00 68. 00
69. 00		413, 228	206, 251			472, 570	69. 00
70 00			246, 799	735, 877	-61, 601	674, 276	70. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	489, 078	240, 177	1			70
71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	240, 749	(12, 343, 242	12, 343, 242	71.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	489, 078 0 0	240, 799 0 0	1		12, 343, 242 9, 665, 893	71. 00 72. 00 73. 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	0 0 0 0	240, 797 0 0 0 0 365, 802	(12, 343, 242 9, 665, 893 5, 481, 484	12, 343, 242 9, 665, 893 5, 481, 484 357, 317	72. 00 73. 00 74. 00
71. 00 72. 00 73. 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)	0 0	0 0 0	(12, 343, 242 9, 665, 893 5, 481, 484	12, 343, 242 9, 665, 893 5, 481, 484	72. 00 73. 00
71. 00 72. 00 73. 00 74. 00 75. 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	0 0 0 0	0 0 0	(12, 343, 242 9, 665, 893 5, 481, 484	12, 343, 242 9, 665, 893 5, 481, 484 357, 317	72. 00 73. 00 74. 00 75. 00
71. 00 72. 00 73. 00 74. 00 75. 00 88. 00 89. 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 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0 0 0 0	0 0 0	(12, 343, 242 9, 665, 893 5, 481, 484	12, 343, 242 9, 665, 893 5, 481, 484 357, 317 0	72. 00 73. 00 74. 00 75. 00 88. 00 89. 00
71. 00 72. 00 73. 00 74. 00 75. 00 88. 00 89. 00 90. 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 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 365, 802 0	365, 802	12, 343, 242 9, 665, 893 5, 481, 484 -8, 485 0 0 0	12, 343, 242 9, 665, 893 5, 481, 484 357, 317 0	72. 00 73. 00 74. 00 75. 00 88. 00 89. 00 90. 00
71. 00 72. 00 73. 00 74. 00 75. 00 88. 00 89. 00 90. 00 90. 01	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 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09001 WOUND/OSTOMY CLINIC	0 0 0 0	0 0 0	365, 802	12, 343, 242 9, 665, 893 5, 481, 484 -8, 485 0 0 0	12, 343, 242 9, 665, 893 5, 481, 484 357, 317 0 0 0 0 0, 0 1, 017, 280	72. 00 73. 00 74. 00 75. 00 88. 00 89. 00 90. 00 90. 01
71. 00 72. 00 73. 00 74. 00 75. 00 88. 00 89. 00 90. 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 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09001 WOUND/OSTOMY CLINIC	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 365, 802 0	365, 802 (0) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1	12, 343, 242 9, 665, 893 5, 481, 484 2 -8, 485 0 0 0 0 0 0 0 -398, 025	12, 343, 242 9, 665, 893 5, 481, 484 357, 317 0	72. 00 73. 00 74. 00 75. 00 88. 00 89. 00 90. 00
71. 00 72. 00 73. 00 74. 00 75. 00 88. 00 89. 00 90. 00 90. 01 90. 02	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 JASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY OUALIFIED HEALTH CENTER 09000 CLINIC 09001 WOUND/OSTOMY CLINIC 09003 ONCOLOGY 09004 MUNCIE CLINIC	0 0 0 0 0 0 0 0 0 306, 180	0 0 0 365, 802 0 0 0 0 0 1, 109, 125	365, 802 365, 802 () () () () () () () () () () () () ()	12, 343, 242 9, 665, 893 5, 481, 484 -8, 485 0 0 0 0 0 0 0 -398, 025 0 0 -1, 468, 261 -34, 926	12, 343, 242 9, 665, 893 5, 481, 484 357, 317 0 0 0 0 1, 017, 280 0 -8, 487, 836 59, 704	72. 00 73. 00 74. 00 75. 00 88. 00 89. 00 90. 01 90. 02 90. 03 90. 04

Health Financial Systems	COMMUNITY HOSPIT	AL ANDERSON		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		eri od:	Worksheet A	
				rom 01/01/2017	Doto/Time Dro	nanad.
				o 12/31/2017	Date/Time Pre 5/14/2018 1:5	
Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	Reclassi fi ed	Z piii
			+ col . 2)	ons (See A-6)	Trial Balance	
			Í	` ′	(col. 3 +-	
					col . 4)	
	1.00	2.00	3.00	4. 00	5. 00	
90. 06 09006 PREGNANCY PLUS	0	725	725	-728	-3	90. 06
90. 07 09007 0/P LAB	0	0	C	0	0	90. 07
90. 08 09008 0/P LAB	0	0	C	0	0	90. 08
90. 09 09009 FORTVI LLE CLI NI C	0	53, 649		1	600	90. 09
91. 00 09100 EMERGENCY	3, 462, 011	1, 118, 924	4, 580, 935	-638, 382	3, 942, 553	91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						04.00
94. 00 09400 HOME PROGRAM DIALYSIS	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 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0			0	96. 00 97. 00
99. 00 09900 CMHC	0	0			0	99.00
99. 10 09910 CORF	0	0			0	99. 10
100.00 10000 1&R SERVICES-NOT APPRVD PRGM		0		0		100.00
101. 00 10100 HOME HEALTH AGENCY		0		0		100.00
SPECIAL PURPOSE COST CENTERS	<u> </u>			<u> </u>	0	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	С	0	0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	o	0		Ö		106. 00
107. 00 10700 LIVER ACQUISITION	l ol	0		0		107. 00
108.00 10800 LUNG ACQUISITION	o	0	C	0		108. 00
109.00 10900 PANCREAS ACQUISITION	o	0	C	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	o	0	C	0	0	110.00
111.00 11100 I SLET ACQUI SITION	o	0	C	0	0	111. 00
113.00 11300 I NTEREST EXPENSE		0	C	0	0	113. 00
114.00 11400 UTILIZATION REVIEW-SNF	o	0	C	0	0	114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	C	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	C	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	62, 298, 068	81, 928, 955	144, 227, 023	1, 334, 304	145, 561, 327	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1	_		190. 00
190. 01 19001 WELLNESS CENTERS	883, 643	551, 858	1, 435, 501	-214, 134	1, 221, 367	
190. 02 19002 EMPLOYED ORTHO MD	0	0	440.000	0		190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)	398, 357	44, 473			421, 447	
190. 04 19004 SUMMLT CONV. (LTC) 190. 05 19005 PARKVIEW CONV. (LTC)	223, 204	18, 280			241, 484	
190.06 19006 MONTI CELLO HSE. (ASS' TD LVG.)	338, 543	24, 117			362, 660	
190.00 19000 MONTI CELLO HISE. (ASS TO EVG.)	84, 234 38, 551	7, 619 2, 592	91, 853 41, 143		91, 853 41, 143	
190. 08 19008 MADISON PLACE OF ELWOOD (LTC)	36, 331	2, 3 7 2	41, 143			190. 07
190. 09 19009 SPI NE SURGEON		0		0		190. 09
190. 10 19010 CLINICAL RESEARCH CENTER	626, 088	232, 797	858, 885	-41, 329	817, 556	
190. 11 19011 ONCOLOGI ST	0	0	000,000	0		190. 11
190. 12 19012 MEDI CAL I NTERNI ST	102, 990	79, 802	182, 792	-608	182, 184	
190. 13 19013 RHEUMATOLOGY	407, 083	525, 298			905, 430	
190. 14 19014 ROCK STEADY BOXING	92, 921	48, 508			124, 522	
191. 00 19100 RESEARCH	O	0	C	0	0	191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	o	2, 173, 211	2, 173, 211	-865, 949	1, 307, 262	192. 00
192.01 19201 MUNCIE MD OFFICES	o	138, 725	138, 725	-125, 200	13, 525	192. 01
192. 02 19202 FOUNDATI ON	203, 277	668, 526	871, 803	-8	871, 795	192. 02
192. 03 19203 SP0E	0	0	C	_		192. 03
192. 04 19204 HEALTHY HEART	195, 295	33, 116	228, 411	-6, 779	221, 632	
192.05 19205 VACANT SPACE	0	0	0	0		192. 05
192.07 19207 PARK PLACE CENTER	0	611	611			192. 07
192. 08 19208 RENTAL PROPERTY - 1924 MADI SON	0	28, 807	28, 807			
192. 09 19209 RESIDENTIAL PROPERTY - 1430 N MADI SO	0	8, 806				192. 09
200.00 TOTAL (SUM OF LINES 118 through 199)	65, 892, 254	86, 516, 101	152, 408, 355	0	152, 408, 355	200.00

Peri od: From 01/01/2017 To 12/31/2017

Date/Time Prepared: 5/14/2018 1:52 pm

				5/14/2018 1:5	2 pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				1
1.00	00100 CAP REL COSTS-BLDG & FIXT	-135, 316			1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0			2. 00
3.00	00300 OTHER CAP REL COSTS	0			3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-3, 422, 756	13, 449, 119		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-10, 365, 520	20, 163, 565		5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700 OPERATION OF PLANT	-59, 584	6, 916, 449		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0			8. 00
9. 00	00900 HOUSEKEEPI NG	Ö			9. 00
10. 00	01000 DI ETARY	0	1, 052, 580		10.00
11. 00		-956, 062			11.00
	01100 CAFETERI A	-950, 002			1
13.00	01300 NURSI NG ADMI NI STRATI ON	0 070	1, 291, 031		13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	-2, 378			14. 00
15. 00	01500 PHARMACY	0	_, -, -, -, -, -, -,		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-473	1, 585, 586		16. 00
17. 00	01700 SOCIAL SERVICE	0	0		17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0		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	02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0		22. 00
23. 00	02300 PARAMED ED PRGM-(EMS)	0	o		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	-		l .	1
30. 00	03000 ADULTS & PEDIATRICS	-4, 468	14, 488, 162		30.00
31. 00	03100 INTENSIVE CARE UNIT	-491	2, 931, 581		31.00
32. 00	03200 CORONARY CARE UNIT	0			32.00
33. 00		0	1		
	03300 BURN INTENSIVE CARE UNIT	0	0		33.00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0		34. 00
40. 00	04000 SUBPROVI DER - I PF	0	0		40. 00
41. 00	04100 SUBPROVI DER - I RF	0	0		41. 00
42. 00	04200 SUBPROVI DER	0	0		42. 00
43.00	04300 NURSERY	0	1, 181, 465		43.00
44.00	04400 SKILLED NURSING FACILITY	0	0		44.00
45.00	04500 NURSING FACILITY	0	0		45. 00
46.00	04600 OTHER LONG TERM CARE	0	0		46. 00
	ANCILLARY SERVICE COST CENTERS				1
50. 00	05000 OPERATING ROOM	0	6, 503, 510		50.00
51.00	05100 RECOVERY ROOM	0			51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0			52.00
		1	-		1
53. 00	05300 ANESTHESI OLOGY	-3, 612, 317			53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-302, 634	1		54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0			55. 00
56. 00	05600 RADI OI SOTOPE	0			56. 00
57.00	05700 CT SCAN	0	638, 547		57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	876, 394		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	1, 059, 848		59.00
60.00	06000 LABORATORY	0	3, 918, 005		60.00
60. 01	06001 BLOOD LABORATORY	0	0		60. 01
61.00		0	0		61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	233, 643		62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	200, 0.0		63.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		64. 00
65. 00	06500 RESPIRATORY THERAPY	0	1 020 700		65.00
		1/ 410	1, 030, 790		
66.00	06600 PHYSI CAL THERAPY	-16, 419			66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0			67.00
68. 00	06800 SPEECH PATHOLOGY	0	228, 758		68. 00
69. 00	06900 ELECTROCARDI OLOGY	68, 816			69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	674, 276		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12, 343, 242		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	9, 665, 893		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	228, 035			73. 00
74. 00	07400 RENAL DIALYSIS	0		l .	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0			75. 00
, 5. 50	OUTPATIENT SERVICE COST CENTERS				1 , 5. 55
88. 00	08800 RURAL HEALTH CLINIC	0	0		88. 00
			1		
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0]		89. 00
90.00	09000 CLINIC	0	0		90.00
90. 01	09001 WOUND/OSTOMY CLINIC	-832, 957	1		90. 01
90. 02	09002 KIDS PLUS CLINIC	0	-		90. 02
90. 03	09003 ONCOLOGY	-836, 710		·	90. 03
90. 04	09004 MUNCIE CLINIC	-58, 020	1, 684		90. 04
90. 05	09005 ANTI COAGULATI ON CLINI C	0	305, 966		90. 05
90.06	09006 PREGNANCY PLUS	0	-3		90.06
90. 07	09007 0/P LAB	0		·	90. 07
	•				

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0113 Period:

Peri od: Worksheet A From 01/01/2017 To 12/31/2017 Date/Time Prepared:

5/14/2018 1:52 pm Cost Center Description Adjustments Net Expenses (See A-8) For Allocation 6.00 7.00 90. 08 09008 0/P LAB 90. 08 09009 FORTVILLE CLINIC 90.09 600 90.09 91.00 09100 EMERGENCY -23, 130 3, 919, 423 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 94.00 09500 AMBULANCE SERVICES 0 95.00 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 97 00 0 99.00 09900 CMHC 0 99.00 99. 10 99 10 09910 CORF 0 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100 00 0 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 105.00 0 106. 00 10600 HEART ACQUISITION 106.00 0 107. 00 10700 LIVER ACQUISITION 0000000 0 107.00 108.00 10800 LUNG ACQUISITION 108.00 0 109.00 10900 PANCREAS ACQUISITION 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 110.00 111.00 11100 | SLET ACQUISITION 0 111. 00 113.00 11300 INTEREST EXPENSE 0 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 0 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115. 00 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM_OF_LINES_1 through 117) 118.00 -20, 332, 384 125, 228, 943 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 190. 01 19001 WELLNESS CENTERS 190. 01 0 0 0 1, 221, 367 190. 02 19002 EMPLOYED ORTHO MD 190. 02 190. 03 19003 NORTHVI EW CONV. (LTC) 421, 447 190.03 190. 04 19004 SUMMIT CONV. (LTC) 241, 484 190.04 190. 05 19005 PARKVI EW CONV. (LTC) 190. 06 19006 MONTI CELLO HSE. (ASS' TD LVG.) 190. 05 000000000000000000 362, 660 91 853 190. 06 190. 07 19007 NH PARK PLACE (LTC) 190. 07 41, 143 190. 08 19008 MADI SON PLACE OF ELWOOD (LTC) 190.08 C 190. 09 19009 SPINE SURGEON 190. 09 190. 10 19010 CLINICAL RESEARCH CENTER 190. 10 817, 556 190. 11 19011 ONCOLOGI ST 190. 11 190. 12 19012 MEDICAL INTERNIST 190. 12 182, 184 190. 13 19013 RHEUMATOLOGY 905, 430 190. 13 190. 14 19014 ROCK STEADY BOXING 124, 522 190. 14 191. 00 19100 RESEARCH 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 1, 307, 262 192.00 192. 01 19201 MUNCIE MD OFFICES 192 01 13, 525 192. 02 19202 FOUNDATI ON 871, 795 192. 02 192. 03 19203 SP0E 192. 03 192. 04 19204 HEALTHY HEART 192. 04 221, 632 192.05 19205 VACANT SPACE 192. 05 Ω 0 192. 07 19207 PARK PLACE CENTER 611 192. 07 192. 08 19208 RENTAL PROPERTY - 1924 MADI SON 0 192. 08 17, 159 192. 09 19209 RESIDENTIAL PROPERTY - 1430 N MADISO 192. 09 0 5.398 132, 075, 971 200 00 TOTAL (SUM OF LINES 118 through 199) -20, 332, 384 200.00

Worksheet Non-CMS W

			To 12/31/2017 Date/lime Pr 5/14/2018 1:	
	Cost Center Description	CMS Code	Standard Label For	
			Non-Standard Codes	
	GENERAL SERVICE COST CENTERS	1.00	2.00	
1. 00	CAP REL COSTS-BLDG & FLXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2. 00
3.00	OTHER CAP REL COSTS	00300		3. 00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5. 00 6. 00	ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	00500 00600		5. 00 6. 00
7. 00	OPERATION OF PLANT	00700		7. 00
8.00	LAUNDRY & LINEN SERVICE	00800		8. 00
9.00	HOUSEKEEPING	00900		9. 00
10. 00 11. 00	DI ETARY CAFETERI A	01000 01100		10.00
13. 00	NURSI NG ADMINI STRATI ON	01300		13. 00
14.00	CENTRAL SERVICES & SUPPLY	01400		14. 00
15. 00	PHARMACY	01500		15. 00
16. 00 17. 00	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	01600 01700		16. 00 17. 00
17. 00	NONPHYSICIAN ANESTHETISTS	01700		19.00
	NURSI NG SCHOOL	02000		20.00
21. 00	I&R SERVICES-SALARY & FRINGES APPRVD	02100		21. 00
	I &R SERVI CES-OTHER PRGM. COSTS APPRVD	02200		22. 00
23. 00	PARAMED ED PRGM-(EMS) INPATIENT ROUTINE SERVICE COST CENTERS	02300		23. 00
30. 00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31. 00
32. 00	CORONARY CARE UNIT	03200		32. 00
33. 00	BURN INTENSIVE CARE UNIT	03300 03400		33.00
40. 00	SURGICAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	04000		34. 00 40. 00
41. 00	SUBPROVI DER - I RF	04100		41. 00
42.00	SUBPROVI DER	04200		42. 00
43. 00	NURSERY	04300		43. 00
44. 00 45. 00	SKILLED NURSING FACILITY NURSING FACILITY	04400 04500		44. 00 45. 00
46. 00	OTHER LONG TERM CARE	04600		46. 00
	ANCILLARY SERVICE COST CENTERS			
50. 00 51. 00	OPERATING ROOM RECOVERY ROOM	05000 05100		50.00
52. 00	DELIVERY ROOM & LABOR ROOM	05200		52. 00
53. 00	ANESTHESI OLOGY	05300		53. 00
54.00	RADI OLOGY-DI AGNOSTI C	05400		54. 00
55. 00	RADI OLOGY-THERAPEUTI C	05500		55. 00
56. 00 57. 00	RADI 01 SOTOPE CT SCAN	05600 05700		56. 00 57. 00
	MAGNETIC RESONANCE IMAGING (MRI)	05800		58. 00
	CARDI AC CATHETERI ZATI ON	05900		59. 00
60.00	LABORATORY	06000		60.00
60. 01 61. 00	BLOOD LABORATORY PBP CLINICAL LAB SERVICES-PRGM ONLY	06001 06100		60. 01
62. 00	WHOLE BLOOD & PACKED RED BLOOD CELLS	06200		62. 00
	BLOOD STORING, PROCESSING & TRANS.	06300		63. 00
	INTRAVENOUS THERAPY	06400		64. 00
65. 00 66. 00	RESPI RATORY THERAPY PHYSI CAL THERAPY	06500 06600		65. 00 66. 00
67. 00	OCCUPATI ONAL THERAPY	06700		67. 00
	SPEECH PATHOLOGY	06800		68. 00
	ELECTROCARDI OLOGY	06900		69. 00
70. 00 71. 00	ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	07000 07100		70.00
	IMPL. DEV. CHARGED TO PATIENTS	07100		71.00
73. 00	DRUGS CHARGED TO PATIENTS	07300		73. 00
	RENAL DI ALYSI S	07400		74. 00
75. 00	ASC (NON-DISTINCT PART)	07500		75. 00
88. 00	OUTPATIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	08800		88. 00
89. 00	FEDERALLY QUALIFIED HEALTH CENTER	08900		89. 00
	CLINIC	09000		90.00
90. 01	WOUND/OSTOMY CLINIC	09001		90. 01
90. 02	KIDS PLUS CLINIC ONCOLOGY	09002 09003		90. 02
90. 04	MUNCI E CLINI C	09004		90. 04
90. 05	ANTI COAGULATION CLINIC	09005		90. 05

| Peri od: | Worksheet Non-CMS W From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0113

		To 12/31/2017 Date/Time 5/14/2018	
Cost Center Description	CMS Code	Standard Label For	1. 52 piii
· ·		Non-Standard Codes	
	1.00	2.00	
90. 06 PREGNANCY PLUS	09006	2.00	90.06
90. 07 0/P LAB	09007		90. 07
90. 08 0/P LAB	09008		90. 08
90.09 FORTVILLE CLINIC	09009		90. 09
91. 00 EMERGENCY	09100		91. 00
92. 00 OBSERVATION BEDS (NON-DISTINCT PART)	09200		92. 00
OTHER REIMBURSABLE COST CENTERS 94. 00 HOME PROGRAM DI ALYSI S	09400		94. 00
95. 00 AMBULANCE SERVICES	09500		95. 00
96. 00 DURABLE MEDI CAL EQUI P-RENTED	09600		96. 00
97. 00 DURABLE MEDICAL EQUIP-SOLD	09700		97. 00
99. 00 CMHC	09900		99. 00
99. 10 CORF	09910		99. 10
100.00 I&R SERVICES-NOT APPRVD PRGM	10000		100. 00
101. 00 HOME HEALTH AGENCY	10100		101. 00
SPECIAL PURPOSE COST CENTERS	10500		105.00
105. 00 KI DNEY ACQUI SI TI ON	10500		105. 00
106. 00 HEART ACQUISITION	10600 10700		106. 00 107. 00
107.00 LIVER ACQUISITION 108.00 LUNG ACQUISITION	10700		107.00
109. 00 PANCREAS ACQUISITION	10900		109.00
110. OO INTESTINAL ACQUISITION	11000		110.00
111. 00 I SLET ACQUI SI TI ON	11100		111. 00
113. 00 I NTEREST EXPENSE	11300		113. 00
114.00 UTILIZATION REVIEW-SNF	11400		114. 00
115.00 AMBULATORY SURGICAL CENTER (D. P.)	11500		115. 00
116. 00 HOSPI CE	11600		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)			118. 00
NONREI MBURSABLE COST CENTERS			
190. 00 GI FT, FLOWER, COFFEE SHOP & CANTEEN	19000		190. 00
190. 01 WELLNESS CENTERS	19001		190. 01 190. 02
190.02 EMPLOYED ORTHO MD 190.03 NORTHVIEW CONV. (LTC)	19002 19003		190. 02
190. 04 SUMMIT CONV. (LTC)	19003		190.03
190. 05 PARKVI EW CONV. (LTC)	19005		190. 05
190. 06 MONTI CELLO HSE. (ASS' TD LVG.)	19006		190. 06
190. 07 NH PARK PLACE (LTC)	19007		190. 07
190.08 MADISON PLACE OF ELWOOD (LTC)	19008		190. 08
190. 09 SPI NE SURGEON	19009		190. 09
190. 10 CLINICAL RESEARCH CENTER	19010		190. 10
190. 11 ONCOLOGI ST	19011		190. 11
190. 12 MEDI CAL I NTERNI ST	19012		190. 12
190. 13 RHEUMATOLOGY	19013		190. 13
190. 14 ROCK STEADY BOXING	19014		190. 14
191.00 RESEARCH 192.00 PHYSICIANS' PRIVATE OFFICES	19100		191. 00 192. 00
192. 00 PHISICIANS PRIVATE OFFICES 192. 01 MUNCIE MD OFFICES	19200 19201		192. 00
192. 01 MONGTE MID OFFICES 192. 02 FOUNDATION	19201		192. 01
192. 03 SP0E	19202		192. 02
192. 04 HEALTHY HEART	19204		192. 04
192. 05 VACANT SPACE	19205		192. 05
192. 07 PARK PLACE CENTER	19207		192. 07
192.08 RENTAL PROPERTY - 1924 MADISON	19208		192. 08
192.09 RESIDENTIAL PROPERTY - 1430 N MADISO	19209		192. 09
200.00 TOTAL (SUM OF LINES 118 through 199)			200. 00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 Period: Worksheet A-6
From 01/01/2017
To 12/31/2017 Date/Time Prepared: 5/14/2018 1:52 pm Provider CCN: 15-0113

					5/14/2018 1:	
		Increases				
	Cost Center 2.00	Li ne # 3.00	Sal ary 4. 00	0ther 5.00		
	A - DEPRECIATION	3.00	4.00	3.00		
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	С	4, 872, 104		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	C			2. 00
3. 00 4. 00		0. 00 0. 00	C			3. 00 4. 00
5. 00		0.00	(5. 00
6.00		0.00	C			6. 00
7.00		0.00	(7. 00
8. 00 9. 00		0. 00 0. 00	C			8. 00 9. 00
10.00		0.00	C			10. 00
11. 00		0.00	C			11. 00
12. 00 13. 00		0. 00 0. 00	(12. 00 13. 00
14. 00		0.00	C			14. 00
15.00		0.00	C	0		15. 00
16.00		0.00	(16. 00
17. 00 18. 00		0. 00 0. 00	C			17. 00 18. 00
19. 00		0.00	C			19. 00
20.00		0.00	C			20. 00
21. 00 22. 00		0. 00 0. 00	(21. 00 22. 00
24. 00		0.00	(24. 00
25.00		0.00	C	0		25. 00
26. 00		0.00	(26. 00
27. 00 28. 00		0. 00 0. 00	C			27. 00 28. 00
29. 00		0.00	C			29. 00
30.00		0.00	(30.00
31. 00 32. 00		0. 00 0. 00	C			31. 00 32. 00
33. 00		0.00	(33. 00
34.00		0.00	C			34. 00
35. 00		0.00	C			35. 00
36. 00 38. 00		0. 00 0. 00	(36. 00 38. 00
39. 00		0.00	C			39. 00
40.00		0.00	C			40. 00
41. 00			— — — <u>(</u>			41. 00
	B - DRUGS & SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	C	12, 343, 242		1. 00
2. 00	PATIENTS IMPL. DEV. CHARGED TO	72.00	C	9, 665, 893		2. 00
	PATI ENTS					
3. 00 4. 00	DRUGS CHARGED TO PATIENTS	73. 00 0. 00	C			3. 00 4. 00
5. 00		0.00	(5. 00
6.00		0.00	C	0		6. 00
7.00		0.00	C			7. 00
8. 00 9. 00		0. 00 0. 00	(8. 00 9. 00
10.00		0.00	C	o		10. 00
11.00		0.00	(11. 00
12. 00 13. 00		0. 00 0. 00	(12. 00 13. 00
14. 00		0.00	C			14. 00
15. 00		0.00	C			15. 00
16. 00 17. 00		0. 00 0. 00	(16. 00 17. 00
18. 00		0.00	C			18. 00
19. 00		0.00	C	0		19. 00
20.00		0.00	(20.00
21. 00 22. 00		0. 00 0. 00	(21. 00 22. 00
23.00		0.00	C	0		23. 00
24. 00		0.00	C			24. 00
25. 00 26. 00		0. 00 0. 00	(25. 00 26. 00
27. 00		0.00	C			27. 00
28. 00		0.00	C	0		28. 00
29. 00 30. 00		0. 00 0. 00	(29. 00 30. 00
50.00	I	ı 0.00	C	<u>′ı</u>		1 30.00

Cost Center						10	18 1:52 pm
1.00			Increases			· · · · · · · · · · · · · · · · · · ·	
31 00		Cost Center	Li ne #	Sal ary	0ther		
32.00		2. 00	3.00	4. 00	5. 00		
33.00 0.00 0.00 0 0.33.00 33.00 33.00 33.00 35.00 0.00 0.00 0.00 35.00 35.00 37.00 38.00 37.00 38.00 39.00 0.00 0.00 0.00 0.00 38.00 39.00 0.00 0.00 0.00 0.00 38.00 39.00 0.00 0.00 0.00 0.00 0.00 38.00 39.00 0.00 0.00 0.00 0.00 0.00 38.00 39.00 0.0				-	-		
34.00 0.00				-			
35 00				٩			
36. 00 36. 00 37. 00 38. 00 37. 00 38. 00 38. 00 38. 00 38. 00 38. 00 38. 00 38. 00 38. 00 38. 00 38. 00 38. 00 38. 00 38. 00 38. 00 38. 00 38. 00 38. 00 38. 00 39. 00				- 1			•
37.00				0			
38. 00 0				0	-		
39.00				٩			
1.00				-1			•
C - RENT	39.00						39.00
1.00		C _ DENT		U	27, 490, 619		
2.00	1 00		1 00	O	782 095		1 00
3.00 0.00 0.00 0 0 0 0 0		1		1			•
4. 00							•
6.00 0.00 0.00 0 0 0 0 0				O			
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 18. 00 19. 0	5.00		0.00	O	0		5. 00
8. 00 9. 00 9. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 11. 0	6.00		0.00	0	0		6. 00
9.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 11.00 1	7.00		0.00	O	0		7. 00
10.00	8.00		0.00	O	0		8. 00
11.00	9.00		0.00	0	0		9. 00
12.00	10.00		0.00	0	0		10.00
13.00				0	0		
14.00				0	-		
1.00				0	0		
1.00	14. 00		0.00		0		14. 00
1.00 NURSERY		0		0	1, 213, 219		
CAFETERIA RECLASS 1.00	1 00		42.00	022 (24	247 020		1 00
The color of the	1.00	NURSERY	43.00				1.00
1. 00 CAFETERI A 11. 00 853, 814 905, 121 0		E _ CAFETEDIA DECLASS		733, 030	247,027		
The color of the	1 00		11 00	853 814	905 121		1 00
Too Dietary 10.00 28,615 30,335 1.00 28,615 30,335 1.00 28,615 30,335 1.00 28,615 30,335 1.00 28,615 30,335 1.00 28,615 30,335 1.00 28,615 30,335 1.00 28,615 30,335 1.00 28,615 30,335 1.00 28,615 30,335 1.00 28,615 30,335 1.00 28,615 30,335 1.00 28,615 30,335 1.00 28,615 30,335 1.00 227,158 1.00 227,158 1.00 227,158 2.00 2.	1.00	0					1.00
1.00 DIETARY 0 10.00 28,615 30,335 0 28,615 30,335 0 28,615 30,335 0 28,615 30,335 0 28,615 30,335 0 28,615 30,335 0 28,615 30,335 0 28,615 30,335 0 28,615 30,335 0 28,615 30,335 0 28,615 30,335 0 24,7158 0 2.00 CAP REL COSTS-BLDG & FIXT 1.00 0 136,290 2.00 0 2.00 0 437,158 0 2.00 0 437,158 0 0 437,158 0 0 437,158 0 0 69,302 129,898 0 1.00 0 1		F - SPECIAL MEALS		000,01.1	7007 121		
The content of the	1.00		10.00	28, 615	30, 335		1. 00
1. 00 CAP REL COSTS-BLDG & FIXT		0 — — — — — —					
2.00 CAP REL COSTS-BLDG & FIXT 1.00 0 136, 290 3.00 CAP REL COSTS-MVBLE EQUIP 2.00 0 73, 710 3.00 0 437, 158 H - LAUNDRY 1.00 LAUNDRY & LI NEN SERVI CE 8.00 69, 302 129, 898 0 1.00 69, 302 129, 898 I - POB UTILLITIES 1.00 ADMINISTRATI VE & GENERAL 5.00 0 6, 239 2.00 LABORATORY 60.00 0 7, 529 2.00 3.00 PHYSI CAL THERAPY 66.00 0 11, 509 3.00 4.00 OCCUPATI ONAL THERAPY 67.00 0 7, 941 4.00 5.00 SEECH PATHOLOGY 68.00 0 9, 550 5.00 6.00 ELECTROCARDI OLOGY 69.00 0 15, 707 6.00 0NCOLOGY 90.03 0 89, 134 0 0.00 0NCOLOGY 90.03 0 89, 134 0.00 0NCOLOGY 90.00 0 80, 134, 609		G - INTEREST & INSURANCE		•			
3.00 CAP REL COSTS-MVBLE EQUI P 2.00 0 73,710 0 437,158 H - LAUNDRY 1.00 LAUNDRY & LI NEN SERVI CE 8.00 69,302 129,898 0 1.00	1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	227, 158		1. 00
1.00 LAUNDRY LI NEN SERVI CE 8.00 69,302 129,898 0 1.00	2.00	CAP REL COSTS-BLDG & FIXT		0	136, 290		2. 00
H - LAUNDRY LAUNDRY & LI NEN SERVI CE	3.00	CAP REL COSTS-MVBLE EQUIP	2.00				3. 00
1. 00 LAUNDRY & LI NEN SERVI CE 8. 00 69, 302 129, 898 0 1. 00 69, 302 129, 898 1. 00 69, 302 129, 898 1. 00 69, 302 129, 898 1. 00 69, 302 129, 898 1. 00 69, 302 129, 898 1. 00 69, 302 129, 898 1. 00 69, 302 129, 898 1. 00		0		0	437, 158		
O 69, 302 129, 898 I - POB UTILITIES 1.00 ADMI NI STRATI VE & GENERAL 5.00 0 6, 239 1.00 2.00 LABORATORY 60.00 0 7, 529 2.00 3.00 PHYSI CAL THERAPY 66.00 0 11, 509 3.00 4.00 OCCUPATI ONAL THERAPY 67.00 0 7, 941 4.00 5.00 SPEECH PATHOLOGY 68.00 0 9, 550 5.00 6.00 ELECTROCARDI OLOGY 69.00 0 15, 707 6.00 7.00 ONCOLOGY 90.03 0 89, 134 7.00 0 0 147, 609 147, 609 7.00							
1 - POB UTILITIES 1.00	1. 00	LAUNDRY & LINEN SERVICE	8.00				1.00
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 0 6, 239 2. 00 LABORATORY 60. 00 0 7, 529 2. 00 3. 00 PHYSI CAL THERAPY 66. 00 0 11, 509 3. 00 4. 00 OCCUPATI ONAL THERAPY 67. 00 0 7, 941 4. 00 5. 00 SPECH PATHOLOGY 68. 00 0 9, 550 5. 00 6. 00 ELECTROCARDI OLOGY 69. 00 0 15, 707 6. 00 7. 00 ONCOLOGY 90. 03 0 89, 134 90. 00 0 0 147, 609 0 147, 609		U DOD HTH LITES		69, 302	129, 898		
2. 00 LABORATORY 60. 00 0 7, 529 2. 00 3. 00 PHYSI CAL THERAPY 66. 00 0 11, 509 3. 00 4. 00 OCCUPATI ONAL THERAPY 67. 00 0 7, 941 4. 00 5. 00 SPEECH PATHOLOGY 68. 00 0 9, 550 5. 00 6. 00 ELECTROCARDI OLOGY 69. 00 0 15, 707 6. 00 7. 00 ONCOLOGY 90. 03 0 89, 134 90. 03 7. 00 0 0 0 147, 609 147, 609	1 00		5 00	O	6 220		1 00
3.00 PHYSI CAL THERAPY 66.00 0 11, 509 4.00 OCCUPATI ONAL THERAPY 67.00 0 7, 941 5.00 SPEECH PATHOLOGY 68.00 0 9, 550 6.00 ELECTROCARDI OLOGY 69.00 0 15, 707 7.00 ONCOLOGY 90.03 0 89, 134 0 0 147, 609					·		
4. 00 OCCUPATI ONAL THERAPY 67. 00 0 7, 941 4. 00 5. 00 SPEECH PATHOLOGY 68. 00 0 9, 550 5. 00 6. 00 ELECTROCARDI OLOGY 69. 00 0 15, 707 6. 00 7. 00 ONCOLOGY 90. 03 0 89, 134 7. 00 0 0 147, 609				-	·		
5. 00 SPEECH PATHOLOGY 68. 00 0 9, 550 5. 00 6. 00 ELECTROCARDI OLOGY 69. 00 0 15, 707 7. 00 ONCOLOGY 90. 03 0 89, 134 0 0 147, 609							1
6. 00 ELECTROCARDI OLOGY 69. 00 0 15, 707 6. 00 7. 00 ONCOLOGY 90. 03 0 89, 134 7. 00 0 147, 609				- 1	·		
7. 00 ONCOLOGY				- 1	·		
0 147, 609				o o			
		0		— — ŏ			
	500.00	Grand Total: Increases		1, 885, 367			500.00

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

Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/14/2018 1:52 pm

		D				5/14/2018 1:	5∠ piii
		Decreases		0.11			
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - DEPRECIATION						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	26, 879	9		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 487, 057	9		2. 00
3.00	OPERATION OF PLANT	7.00	0	1, 418, 169	0		3. 00
4. 00	HOUSEKEEPI NG	9. 00	n	9, 883	0		4. 00
5. 00	DI ETARY	10.00	0		0		5. 00
	l .	l l	0				1
6.00	NURSING ADMINISTRATION	13.00	0	203	0		6. 00
7. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	41, 145	0		7. 00
8.00	PHARMACY	15. 00	0	4, 630	0		8. 00
9.00	ADULTS & PEDIATRICS	30.00	0	254, 193	0		9. 00
10.00	INTENSIVE CARE UNIT	31.00	0	172, 057	0		10.00
11.00	NURSERY	43.00	0	2, 412	0		11. 00
12. 00	OPERATING ROOM	50.00	0		0		12. 00
13. 00	ANESTHESI OLOGY	53.00	0		0		13. 00
	l .		_		-		1
14. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	,	0		14. 00
15. 00	RADI OI SOTOPE	56. 00	0	12, 600	0		15. 00
16. 00	CT SCAN	57.00	0	265, 416	0		16. 00
17.00	MAGNETIC RESONANCE IMAGING	58.00	0	124, 137	0		17. 00
	(MRI)						
18.00	CARDÍAC CATHETERIZATION	59.00	0	110, 957	0		18. 00
19. 00	LABORATORY	60.00	0		0		19. 00
20. 00	WHOLE BLOOD & PACKED RED	62.00	0		0		20. 00
20.00		02.00	U	1, 010	U		20.00
24 00	BLOOD CELLS	/5 63	_	00 0:-	_		21 00
21. 00	RESPIRATORY THERAPY	65. 00	0	28, 947	0		21. 00
22. 00	PHYSI CAL THERAPY	66. 00	0	65, 707	0		22. 00
24.00	SPEECH PATHOLOGY	68. 00	0	166	0		24. 00
25.00	ELECTROCARDI OLOGY	69.00	0	24, 513	0		25. 00
26.00	ELECTROENCEPHALOGRAPHY	70.00	0		0		26. 00
27. 00	WOUND/OSTOMY CLINIC	90. 01	0	1	0		27. 00
28. 00	ONCOLOGY	90.03	0	1, 326, 801	0		28. 00
	l .		0	1			1
29. 00	MUNCIE CLINIC	90. 04	0	34, 916	0		29. 00
30. 00	ANTICOAGULATION CLINIC	90. 05	0	.,	0		30. 00
31. 00	PREGNANCY PLUS	90.06	0	728	0		31. 00
32.00	FORTVILLE CLINIC	90. 09	0	6, 105	0		32.00
33.00	EMERGENCY	91.00	0	123, 238	0		33.00
34.00	WELLNESS CENTERS	190. 01	0		0		34.00
35. 00	NORTHVIEW CONV. (LTC)	190. 03	0	20, 162	0		35. 00
36. 00	CLINICAL RESEARCH CENTER	190. 10	0	1, 796	0		36. 00
			0				1
38. 00	RHEUMATOLOGY	190. 13	0	2, 555	0		38. 00
39. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	716, 580	0		39. 00
40.00	HEALTHY HEART	192. 04	0	690	0		40. 00
41.00	RESIDENTIAL PROPERTY - 1430	192. 09	0	3, 408	0		41.00
	N MADISO						
				8, 978, 106			1
	B - DRUGS & SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	20, 921	0		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	0		0		2. 00
		l I	_				1
3.00	OPERATION OF PLANT	7. 00	0	,	0		3. 00
4.00	HOUSEKEEPI NG	9. 00	0	7, 406	0		4. 00
5. 00	DI ETARY	10.00	0	597	0		5. 00
6.00	CENTRAL SERVICES & SUPPLY	14. 00	0	83, 145	0		6. 00
7.00	PHARMACY	15. 00	0	5, 492, 085	0		7. 00
8.00	MEDICAL RECORDS & LIBRARY	16. 00	0	20	0		8. 00
9. 00	ADULTS & PEDIATRICS	30.00	0				9. 00
10. 00	INTENSIVE CARE UNIT	31.00	0		Ö		10. 00
			0	14, 437, 703	0		1
11.00	OPERATING ROOM	50.00	0				11.00
12. 00	ANESTHESI OLOGY	53. 00	0	36, 896	0		12. 00
13. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	180, 282	0		13. 00
14. 00	RADI OI SOTOPE	56.00	0	272, 799	0		14. 00
15.00	CT SCAN	57.00	0	104, 200	0		15. 00
16.00	MAGNETIC RESONANCE IMAGING	58. 00	0	14, 603	0		16. 00
	(MRI)						
17. 00	CARDIAC CATHETERIZATION	59. 00	0	1, 086, 968	0		17. 00
18. 00	LABORATORY	60.00	0		0		18. 00
	l .	l e	0				
19. 00	WHOLE BLOOD & PACKED RED	62. 00	0	501, 436	0		19. 00
	BLOOD CELLS						1
20. 00	RESPI RATORY THERAPY	65. 00	0		0		20. 00
21.00	PHYSI CAL THERAPY	66.00	0	20, 412	0		21. 00
22.00	OCCUPATI ONAL THERAPY	67.00	0	3, 392	0		22. 00
23. 00	SPEECH PATHOLOGY	68. 00	n	410	0		23. 00
24. 00	ELECTROCARDI OLOGY	69.00	0	1	o O		24. 00
25. 00	ELECTROENCEPHALOGRAPHY	70.00	0	21, 540	0		25. 00
			0				1
26. 00	RENAL DI ALYSI S	74.00			0		26. 00
27. 00	WOUND/OSTOMY CLINIC	90. 01	0	377, 422	0		27. 00

In Lieu of Form CMS-2552-10

500.00

RECLASSIFICATIONS

Provider CCN: 15-0113

Period:
From 01/01/2017

Period: | Worksheet A-6 From 01/01/2017 | To 12/31/2017 | Date/Time Prepared:

5/14/2018 1:52 pm Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 10. 00 6.00 7.00 8.00 9.00 ONCOLOGY 28.00 90.03 230, 594 0 28.00 29.00 MUNCIE CLINIC 90.04 10 0 29.00 ANTICOAGULATION CLINIC 0 30.00 90.05 0 18, 908 30.00 EMERGENCY 91.00 0 31.00 515, 144 31.00 0 32.00 WELLNESS CENTERS 190.01 0 33, 898 32.00 NORTHVIEW CONV. (LTC) 190. 03 0 1, 221 0 33.00 33.00 CLINICAL RESEARCH CENTER 0 0 34.00 190.10 1.265 34.00 0 0 MEDICAL INTERNIST 190.12 608 35.00 35.00 36.00 ROCK STEADY BOXING 190.14 0 23 0 36.00 PHYSICIANS' PRIVATE OFFICES 0 37.00 192.00 1,760 0 37.00 38 00 FOUNDATI ON 192.02 ol 0 38 00 8 39.00 HEALTHY HEART 192.04 6, 089 0 39.00 27, 490, 619 C - RENT 1 00 0.00 1 00 0 291, 545 9 2.00 PHARMACY 15.00 0 2.00 3.00 INTENSIVE CARE UNIT 31.00 o 28 0 3.00 44, 706 0 4.00 LABORATORY 60.00 0 4.00 0 0 RESPIRATORY THERAPY 5 00 65.00 5.962 5 00 0 6.00 PHYSICAL THERAPY 66.00 0 474, 678 6.00 7.00 ELECTROCARDI OLOGY 69.00 124, 940 0 7.00 0 ELECTROENCEPHALOGRAPHY 70.00 0 8,020 8.00 8.00 9.00 FORTVILLE CLINIC 90.09 0 46, 944 0 9.00 CLINICAL RESEARCH CENTER 190.10 38, 268 0 10.00 10.00 RHEUMATOLOGY 190.13 0 24, 396 0 11.00 11.00 ROCK STEADY BOXING 16, 884 12.00 190.14 0 0 12.00 13.00 MUNCIE MD OFFICES 192.01 0 125, 200 0 13.00 RENTAL PROPERTY - 1924 192.08 0 14.00 11,648 14.00 MADI SON 1. 213. 219 D - LABOR & DELIVERY 30. 00 1.00 ADULTS & PEDIATRICS 933, 636 247, 829 0 1.00 933, 636 247, 829 - CAFETERIA RECLASS 1.00 DI ETARY 10.00 853, 814 905, 121 0 1.00 853, 814 905, 121 F - SPECIAL MEALS 1.00 CAFETERI A 11.00 2<u>8, 6</u>15 30, 335 0 1.00 30, 335 28, 615 G - INTEREST & INSURANCE 1 00 ADMINISTRATIVE & GENERAL 5 00 0 227 158 1 00 11 2.00 ADMINISTRATIVE & GENERAL 5.00 0 210,000 12 2.00 3.00 0.00 12 3.00 0 437, 158 H - LAUNDRY 1.00 HOUSEKEEPI NG 9. 00 69, 302 129, 898 0 1.00 69, 302 129, 898 - POB UTILITIES 1 00 PHYSICIANS' PRIVATE OFFICES 192.00 147, 609 0 1.00 2.00 0.00 0 0 0 2.00 3.00 0.00 0 0 3.00 0 4.00 0.00 0 0 0 4.00 5.00 0 00 0 0 0 5 00 6.00 0.00 0 0 6.00 7.00 0.00 0 7.00 147, 609

1, 885, 367

39, 579, 894

500.00 Grand Total: Decreases

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0113

| Period: | Worksheet A-6 | From 01/01/2017 | Non-CMS Worksheet | Date/Time Prepared: | 5/14/2018 1:52 pm

								5/14/2018 1:5	2 pm
	Cost Center	Li ne #	eases Sal ary	Other	Cost Center	Decre Li ne #	sases Sal ary	Other	
	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	8. 00	9. 00	
	A - DEPRECIATION								
1. 00	CAP REL COSTS-BLDG &	1. 00	0	4, 872, 104	EMPLOYEE BENEFITS	4. 00	0	26, 879	1. 00
2. 00	FIXT CAP REL COSTS-MVBLE EQUIP	2. 00	0	4, 106, 002	DEPARTMENT ADMINISTRATIVE & GENERAL	5. 00	0	1, 487, 057	2. 00
3.00	EQUIP	0.00	0	(OPERATION OF PLANT	7. 00	o	1, 418, 169	3. 00
4. 00		0.00		•	HOUSEKEEPI NG	9.00	ō	9, 883	4. 00
5.00		0. 00	k .	•	DI ETARY	10.00	0	316, 290	5. 00
6. 00		0. 00	0	C	NURSI NG	13.00	0	203	6. 00
7. 00		0. 00	0	C	ADMINISTRATION CENTRAL SERVICES & SUPPLY	14.00	0	41, 145	7. 00
8.00		0.00	0	(PHARMACY	15. 00	0	4, 630	8. 00
9.00		0.00		•	ADULTS & PEDIATRICS	30.00	0	254, 193	9. 00
10.00		0. 00		•	INTENSIVE CARE UNIT	31.00	0	172, 057	10.00
11.00		0.00		i e	NURSERY	43.00	0	2, 412	11. 00
12. 00 13. 00		0.00			OPERATING ROOM ANESTHESIOLOGY	50.00 53.00	0	1, 295, 967 6, 700	12. 00 13. 00
14. 00		0.00		•	RADI OLOGY-DI AGNOSTI C	54.00	o o	450, 973	14. 00
15. 00		0.00			RADI OI SOTOPE	56.00	0	12, 600	15. 00
16. 00		0. 00			CT SCAN	57.00	0	265, 416	16.00
17. 00		0. 00	0	C	MAGNETIC RESONANCE	58.00	0	124, 137	17. 00
18. 00		0. 00	0	C	I MAGI NG (MRI) CARDI AC CATHETERI ZATI ON	59.00	0	110, 957	18. 00
19. 00		0.00	0		LABORATORY	60.00	o	380, 678	19. 00
20. 00		0.00			WHOLE BLOOD & PACKED	62.00	0	1, 010	
					RED BLOOD CELLS				
21. 00		0.00			RESPIRATORY THERAPY	65.00	0	28, 947	21. 00
22. 00 24. 00		0.00		•	PHYSICAL THERAPY SPEECH PATHOLOGY	66.00 68.00	0	65, 707 166	22. 00 24. 00
25. 00		0.00		•	ELECTROCARDI OLOGY	69.00	o	24, 513	25. 00
26.00		0. 00	0	C	ELECTROENCEPHALOGRAPH	70.00	0	32, 041	26.00
			_	_	Υ				
27. 00 28. 00		0.00		•	WOUND/OSTOMY CLINIC ONCOLOGY	90.01	0	20, 603 1, 326, 801	27. 00 28. 00
29. 00		0.00		l .	MUNCIE CLINIC	90.03	0	34, 916	29. 00
30.00		0.00			ANTI COAGULATI ON	90.05	ō	7, 558	30.00
			_	_	CLINIC				
31. 00 32. 00		0.00			PREGNANCY PLUS FORTVILLE CLINIC	90.06 90.09	0	728 6, 105	31. 00 32. 00
33. 00		0.00		•	EMERGENCY	91.00	0	123, 238	33. 00
34. 00		0.00			WELLNESS CENTERS	190. 01	ō	180, 236	34. 00
35. 00		0. 00			NORTHVIEW CONV. (LTC)	190. 03	0	20, 162	35. 00
36. 00		0. 00	0	C	CLINICAL RESEARCH	190. 10	0	1, 796	36. 00
38. 00		0.00	0	,	CENTER RHEUMATOLOGY	190. 13	0	2, 555	38. 00
39. 00		0.00		•	PHYSI CI ANS' PRI VATE	192.00	ő	716, 580	
					OFFI CES				
40.00		0.00		•	HEALTHY HEART	192.04	0	690	
41. 00		0.00	0	(RESIDENTIAL PROPERTY - 1430 N MADISO	192. 09	0	3, 408	41. 00
	0 — — —		$$ $ _{\bar{0}}$	8, 978, 106			$$ \dagger		
	B - DRUGS & SUPPLIES								
1. 00	MEDICAL SUPPLIES	71. 00	0	12, 343, 242	EMPLOYEE BENEFITS	4. 00	0	20, 921	1. 00
2. 00	CHARGED TO PATIENTS IMPL. DEV. CHARGED TO	72. 00	0	9 665 893	DEPARTMENT ADMINISTRATIVE &	5.00	0	134, 927	2. 00
2.00	PATI ENTS	72.00		7, 003, 075	GENERAL	3.00	Ĭ	154, 727	2.00
3.00	DRUGS CHARGED TO	73. 00	0	5, 481, 484	OPERATION OF PLANT	7. 00	0	50, 558	3. 00
4 00	PATI ENTS	0.00		,	HOUSEKEEDING	9.00		7. 406	4 00
4. 00 5. 00		0.00			HOUSEKEEPI NG DI ETARY	10.00	0	7, 406 597	4. 00 5. 00
6. 00		0.00			CENTRAL SERVICES &	14.00	o	83, 145	6. 00
					SUPPLY				
7.00		0.00		•	PHARMACY	15.00	0	5, 492, 085	7. 00
8. 00		0. 00	0		MEDICAL RECORDS &	16.00	0	20	8. 00
9. 00		0.00	0	(ADULTS & PEDIATRICS	30.00	0	1, 529, 619	9. 00
10.00		0.00	0	C	INTENSIVE CARE UNIT	31.00	o	442, 217	10.00
11.00		0.00			OPERATING ROOM	50.00	0	14, 437, 703	11.00
12.00		0.00			ANESTHESI OLOGY	53.00	0	36, 896	
13. 00 14. 00		0.00			RADI OLOGY-DI AGNOSTI C RADI OI SOTOPE	54. 00 56. 00	0	180, 282 272, 799	13. 00 14. 00
15. 00		0.00			CT SCAN	57.00	o	104, 200	
	•	•	•	-	*	. '	'		

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0113

Peri od: From 01/01/2017 To 12/31/2017

In Lieu of Form CMS-2552-10
Worksheet A-6
Non-CMS Worksheet
B1/2017 Date/Time Prepared:
5/14/2018 1:52 pm

		Incre	eases			Decre	22505	5/14/2018 1:52			
	Cost Center	Li ne #	Sal ary	Other	Cost Center	Li ne #	Sal ary	Other			
	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	8. 00	9. 00			
16. 00		0.00	0	0	MAGNETIC RESONANCE	58.00	0	14, 603	16. 00		
17. 00		0. 00	0	0	IMAGING (MRI) CARDIAC	59. 00	0	1, 086, 968	17. 00		
18. 00		0.00	0	0	CATHETERI ZATI ON LABORATORY	60.00	0	1, 679, 261	18. 00		
19. 00		0.00			WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	501, 436	19. 00		
20. 00		0.00	0	0	RESPIRATORY THERAPY	65.00	o	160, 624	20. 00		
21. 00		0.00	0		PHYSI CAL THERAPY	66.00	O	20, 412	21. 00		
22. 00		0. 00			OCCUPATIONAL THERAPY	67.00	0	3, 392	22. 00		
23. 00		0.00			SPEECH PATHOLOGY	68.00	0	410	23. 00		
24. 00 25. 00		0. 00 0. 00			ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPH	69. 00 70. 00	0	13, 163 21, 540	24. 00 25. 00		
27.00		0.00			Y DENIAL DIALVELE	74.00		0.405	27, 00		
26. 00 27. 00		0.00	0		RENAL DIALYSIS WOUND/OSTOMY CLINIC	74. 00 90. 01	0	8, 485 377, 422	26. 00 27. 00		
28. 00		0.00			ONCOLOGY	90.01	-	230, 594	28. 00		
29. 00		0.00			MUNCIE CLINIC	90.04	O	10	29. 00		
30.00		0.00	0	0	ANTI COAGULATI ON	90.05	O	18, 908	30.00		
04.00		0.00			CLINIC	04.00		545 444	04 00		
31. 00 32. 00		0.00	0		EMERGENCY WELLNESS CENTERS	91. 00 190. 01	0	515, 144 33, 898	31. 00 32. 00		
33. 00		0.00			NORTHVI EW CONV. (LTC)	190.01	0	1, 221	33. 00		
34. 00		0.00			CLINICAL RESEARCH	190. 10	Ö	1, 265	34. 00		
					CENTER			·			
35. 00		0.00	0		MEDICAL INTERNIST	190. 12	0	608	35. 00		
36. 00 37. 00		0.00			ROCK STEADY BOXING PHYSICIANS' PRIVATE	190. 14 192. 00	0	23	36. 00 37. 00		
37.00		0.00	U	U	OFFICES	192.00	۷	1, 760	37.00		
38. 00		0.00	0	0	FOUNDATI ON	192. 02	0	8	38. 00		
39. 00		0.00			HEALTHY HEART	192. 04	0	6, 089	39. 00		
	0		0	27, 490, 619	0		0	27, 490, 619			
1. 00	C - RENT CAP REL COSTS-BLDG &	1.00	0	782, 095		0.00	0	0	1. 00		
00	FLXT			702,070		0.00		Ĭ	00		
2.00	CAP REL COSTS-MVBLE	2. 00	0	431, 124	PHARMACY	15. 00	0	291, 545	2. 00		
3. 00	EQUI P	0.00	0	0	INTENSIVE CARE UNIT	31.00	0	28	3. 00		
4. 00		0.00			LABORATORY	60.00	0	44, 706	4. 00		
5. 00		0.00	0		RESPI RATORY THERAPY	65.00	Ö	5, 962	5. 00		
6.00		0.00	0	0	PHYSI CAL THERAPY	66.00	0	474, 678	6.00		
7.00		0.00			ELECTROCARDI OLOGY	69.00	0	124, 940	7. 00		
8. 00		0. 00	0	0	ELECTROENCEPHALOGRAPH	70.00	0	8, 020	8. 00		
9. 00		0.00	0	0	FORTVILLE CLINIC	90. 09	o	46, 944	9. 00		
10. 00		0.00			CLINICAL RESEARCH	190. 10	Ö	38, 268	10.00		
					CENTER			·			
11. 00		0.00			RHEUMATOLOGY	190. 13		24, 396			
12. 00 13. 00		0.00			ROCK STEADY BOXING MUNCIE MD OFFICES	190. 14 192. 01		16, 884 125, 200			
14. 00		0.00			RENTAL PROPERTY -	192.01		11, 648	14. 00		
					1924 MADI SON						
	0		0	1, 213, 219	0		0	1, 213, 219			
1. 00	D - LABOR & DELIVERY NURSERY	43. 00	933, 636	247 920	ADULTS & PEDIATRICS	30.00	933, 636	247, 829	1. 00		
1.00	0	43.00	933, 636	247, 829		30.00	933, 636		1.00		
	E - CAFETERIA RECLASS			=, 32,				= : , ; 32 /			
1.00	CAFETERI A	11.00			DI ETARY	10.00		905, 121	1. 00		
	0		853, 814	905, 121	[0		853, 814	905, 121			
1. 00	F - SPECIAL MEALS DIETARY	10. 00	28, 615	20 225	CAFETERI A	11.00	28, 615	30, 335	1. 00		
1.00	0	10.00	28, 615	30, 335		11.00	28, 615	30, 335	1.00		
	G - INTEREST & INSURAN	ICE	20,010	00,000	10		20,010	20,000			
1.00	CAP REL COSTS-BLDG &	1. 00	0	227, 158	ADMINISTRATIVE &	5. 00	0	227, 158	1.00		
2.00	FIXT	1 00	_	407.000	GENERAL	- ^		240 200	2 22		
2. 00	CAP REL COSTS-BLDG &	1. 00	0	136, 290	ADMINISTRATIVE & GENERAL	5. 00	0	210, 000	2. 00		
3. 00	CAP REL COSTS-MVBLE	2. 00	0	73, 710	I control of the cont	0.00	0	О	3. 00		
	EQUI P	L _				$\perp \perp$	↓]			
	0 H LAUNDDV		0	437, 158	0		0	437, 158			
1. 00	H - LAUNDRY LAUNDRY & LINEN	8.00	69, 302	120 000	HOUSEKEEPI NG	9.00	69, 302	129, 898	1. 00		
1.00	SERVICE	0.00	07, 302	127,090	THOUSENELI TINU	7.00	07, 302	127, 070	1.00		
	0		69, 302	129, 898	0 — — — —		69, 302	129, 898			

COMMUNITY HOSPITAL ANDERSON

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0113

| Peri od: | Worksheet A-6 | From 01/01/2017 | Non-CMS Worksheet | To | 12/31/2017 | Date/Time | Prepared: | 5/14/2018 | 1:52 pm |

								3/14/2010 1.3	2 PIII
		Incre	ases		Decreases				
	Cost Center	Line #	Sal ary	Other	Cost Center	Li ne #	Sal ary	Other	
	2. 00	3. 00	4.00	5. 00	6. 00	7.00	8. 00	9. 00	
	I - POB UTILITIES								
1.00	ADMINISTRATIVE &	5. 00	0	6, 239	PHYSICIANS' PRIVATE	192.00	0	147, 609	1.00
	GENERAL				OFFICES				
2.00	LABORATORY	60.00	0	7, 529		0.00	0	0	2.00
3.00	PHYSICAL THERAPY	66. 00	0	11, 509		0.00	0	0	3.00
4.00	OCCUPATI ONAL THERAPY	67.00	0	7, 941		0.00	0	0	4.00
5.00	SPEECH PATHOLOGY	68. 00	0	9, 550		0.00	0	0	5.00
6.00	ELECTROCARDI OLOGY	69. 00	0	15, 707		0.00	0	0	6.00
7.00	ONCOLOGY	90. 03	0	89, 134		0.00	0	0	7. 00
	0 — — — —		— — — ₀	147, 609	0 — — — —		<u> </u>	147, 609	
500.00	Grand Total:		1, 885, 367	39, 579, 894	Grand Total:		1, 885, 367	39, 579, 894	500.00
	Increases				Decreases				

| Period: | Worksheet A-7 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared:

				To	12/31/2017	Date/Time Prep 5/14/2018 1:52	pared:
				Acqui si ti ons		3/14/2016 1.32	Z DIII
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances	. a. c.iaccc	2011411 011	.ota.	Retirements	
		1.00	2.00	3.00	4. 00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	T BALANCES					
1.00	Land	6, 323, 988	0	0	0	195, 750	1.00
2.00	Land Improvements	1, 967, 845	0	0	0	11, 802	2. 00
3.00	Buildings and Fixtures	67, 985, 087	1, 258, 038	4, 937, 420	6, 195, 458	1, 760, 653	3. 00
4.00	Building Improvements	0	1, 197, 015	0	1, 197, 015	0	4. 00
5.00	Fi xed Equipment	19, 773, 767	1, 339, 146	0	1, 339, 146	650, 304	5. 00
6.00	Movable Equipment	51, 767, 101	3, 562, 419	1, 297, 860	4, 860, 279	1, 362, 255	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8. 00	Subtotal (sum of lines 1-7)	147, 817, 788	7, 356, 618	6, 235, 280	13, 591, 898	3, 980, 764	
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	147, 817, 788	7, 356, 618	6, 235, 280	13, 591, 898	3, 980, 764	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	DART I ANNUALO OF OURNOSS IN OARLEN AGES	6.00	7. 00				
4 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						1 00
1.00	Land	6, 128, 238	0				1.00
2.00	Land Improvements	1, 956, 043	1, 648, 563				2.00
3.00	Buildings and Fixtures	72, 419, 892	21, 713, 879				3.00
4.00	Building Improvements	1, 197, 015	0 707 4(0				4.00
5.00	Fi xed Equipment	20, 462, 609	8, 737, 160				5. 00
6.00	Movable Equipment	55, 265, 125	27, 027, 605				6.00
7.00	HIT designated Assets	157 400 000	U 50 107 207				7. 00
8.00	Subtotal (sum of lines 1-7)	157, 428, 922	59, 127, 207				8. 00 9. 00
9.00	Reconciling Items	157 420 022	FO 127 207				
10. 00	Total (line 8 minus line 9)	157, 428, 922	59, 127, 207			l	10. 00

	51		T			6.5. 010.	
	· · · · · · · · · · · · ·	COMMUNITY HOSPI				eu of Form CMS-2	
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO	CN: 15-0113	Peri od:	Worksheet A-7	
					From 01/01/2017		
					To 12/31/2017		
						5/14/2018 1:5	2 pm
			SU	JMMARY OF CAP	PITAL		
	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 WORK	KSHEET A, COLUM	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 O	F CAPLTAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate					
		d Costs (see					
		instructions)	till odgil 11)				
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2			
1 00		SILLI A, COLUM	IN Z, LINES I d	iiu Z			1 00
1.00	CAP REL COSTS-BLDG & FIXT	0	0			ļ	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
3 00	Total (sum of lines 1_2)	1	l n	1			1 2 00

0 0 0

0 0 0

1. 00 2. 00 3. 00

1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)

Heal th	n Financial Systems	COMMUNITY HOSP	ITAL ANDERSON		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2017 To 12/31/2017		pared:
		COM	COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL				
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio (col. 1 - col	instructions)		
				2)	•		
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS	1	1			
1.00	CAP REL COSTS-BLDG & FLXT	0	0	1	0 1.000000		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0.000000		2.00
3. 00	Total (sum of lines 1-2)	0 ALLOCA:	TION OF OTHER (ADITAI	0 1. 000000		3. 00
		ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DART 111 DECONOLULATION OF OARLTH 000TO O	6.00	7. 00	8. 00	9. 00	10. 00	
4 00	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS			5 (54 400		4 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	0			0 5, 654, 199		1. 00 2. 00
2. 00 3. 00	Total (sum of lines 1-2)	0			0 4, 537, 126 0 10, 191, 325		3.00
3.00	Total (suii of Titles 1-2)	0	SI	JMMARY OF CAPI		l 0	3.00
			30	DIVINIART OF CAFT	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)		
	DART III DECONCILIATION OF CARLTAL COCTO O	11.00	12.00	13. 00	14. 00	15. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS C		127 200	ı		E 000 001	1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	91, 842		1	0 0	5, 882, 331 4, 610, 836	1. 00 2. 00
3.00	Total (sum of lines 1-2)	91, 842		1	0 0		
3.00	Total (Suil Of Titles 1-2)	71,042	210,000	"	0	10, 473, 107	J 3.00

| Period: | Worksheet A-8 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: Provi der CCN: 15-0113

Page 2017 Page 2017 Page 301 Page 30						Fo 12/31/2017	Date/Time Prep 5/14/2018 1:52	
Timestrant Income CAP REL B								E piii
100 Investment income - CAP REL 8					10/From which the amount is	to be Adjusted		
100 Investment income - CAP REL 8								
1.00 Investment Income - CAP REL 8		Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
COSTS-BLIDS & FIXT (Chapter 2) COSTS-MOBLE COUR (Chapter 2) COSTS-MOBLE COUR (Chapter 2) COSTS-MOBLE COUR (Chapter 2) COSTS-MOBLE COUR (Chapter 2) Costs (1.00		1.00	2. 00	3. 00	4. 00	5. 00	1 00
3.00 Investment Income - other (Chapter 2) 0 0.00 0 3.00 0 4.00 0 0 0 0 0 0 0 0 0		COSTS-BLDG & FLXT (chapter 2)	R	-135, 316	CAP KET CO212-REDG & FIXI	1.00	''	1.00
1.00	2. 00			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
1.00 Control	3.00	Investment income - other		0		0.00	o	3. 00
Section Sect	4. 00	Trade, quantity, and time	В	-11, 834	ADMINISTRATIVE & GENERAL	5.00	О	4. 00
6.00 Sental of provider space by suppliers (Chapter 8) A	5. 00	Refunds and rebates of		0		0.00	0	5. 00
Supplier's (chapter 8)	6. 00		1	0		0.00	0	6. 00
Stations excluded) (Chépter 1)	7 00	suppliers (chapter 8)	Δ	_117 122	ADMINISTRATIVE & GENERAL			7 00
1.00 Televi sion and radio service (Chapter 21) 0 0 0 0 0 0 0 0 0	7.00	stations excluded) (chapter		117, 122	ADMINISTRATIVE & GENERAL	3.00	J	7.00
9.00 Parking Lot (chapter 21) 0.00 0.0	8.00	Television and radio service	А	-57, 924	OPERATION OF PLANT	7. 00	0	8. 00
adjustment (chapter 23) (chapter 24) (chapte	9. 00			0		0.00	0	9. 00
11.00 Sale of scrap, waste, etc. (Chapter 23) 12.00 Related organization (A-8-1) 12.00 Related organization (A-8-1) 13.00 Laundry and linen service of the control of the c	10. 00		A-8-2	-9, 281, 467			0	10. 00
12.00 Related organization Transactions (Chapter 10) Company Compa	11. 00	Sale of scrap, waste, etc.	В	-2, 440	ADMINISTRATIVE & GENERAL	5. 00	0	11. 00
13.00 Laundry and linen service 0 0.00 0.13.00 13.00 14.00 Cafeteria-employees and guests B -850,922CAFETERIA 11.00 0.00 0.15.00 15.00 20.00 2	12. 00	Related organization	A-8-1	-2, 530, 788			0	12. 00
15. 00 Rental of quarters to employee and others 0 0 0 0 0 0 0 0 0		Laundry and linen service		0			0	
16.00 Sale of medical and surgical supplies to other than patients 0 0.00 0.				-850, 922 0	CAFETERI A		-	
patients	16. 00	and others Sale of medical and surgical		0		0. 00	0	16. 00
Datients	17 00	pati ents		0		0.00	0	17 00
abstracts 0		pati ents	_					
education (tuition, fees, books, etc.)		abstracts	В				0	
20.00 Vending machines 0 0.00	19. 00	education (tuition, fees,		0		0.00	0	19. 00
Interest, finance or penal ty charges (chapter 21)		Vending machines		0			-	
overpayments and borrowings to repay Medi care overpayments Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24. 00 Adjustment for physical A-8-3 25. 00 Utilization review - physicians' compensation (chapter 21) 26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 28. 00 Non-physician Anesthetist 29. 00 Non-physician Anesthetist 29. 00 Non-physician Anesthetist 29. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for 0 CAP REL COSTS PATHOLOGY 0 ADJULTS & PEDIATRICS 30. 00 Josephology Costs in excess of limitation (chapter 14) 30. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 30. 00 CAH HIT Adjustment for 0 0. 00 0 32. 00 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for 0 0. 00 0 0 32. 00	21.00	interest, finance or penalty		0		0.00	U	21.00
23. 00 Adj ustment for respiratory therapy costs in excess of limitation (chapter 14) 24. 00 Adj ustment for physical therapy costs in excess of limitation (chapter 14) 25. 00 Utilization review - physicians' compensation (chapter 21) 26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT	22. 00	overpayments and borrowings to		0		0.00	0	22. 00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
25.00 Utilization review - physicians' compensation (chapter 21) Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 1.00 0 26.00 COSTS-BLDG & FIXT 1.00 0 26.00 COSTS-BLDG & FIXT 1.00 0 27.00 COSTS-MVBLE EQUIP 2.00 0 27.00 COSTS-MVBLE EQUIP 2.00 0 27.00 COSTS-MVBLE EQUIP 2.00 0 27.00 28.00 Non-physician Anesthetist ONONPHYSICIAN ANESTHETISTS 19.00 28.00 29.00 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) A-8-3 OSPEECH PATHOLOGY CAP REL COSTS-MVBLE EQUIP 2.00 0 27.00 28.00 29.00 30.00 30.99 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66.00		24. 00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist ONONPHYSICIAN ANESTHETISTS ONONPHYSICIAN ANESTHETISTS 19.00 28.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAP REL COSTS-BLDG & FIXT OCAP REL COSTS-BLDG & FIXT OCAP REL COSTS-MVBLE EQUIP ONONPHYSICIAN ANESTHETISTS OCAP REL COSTS-MVBLE EQUIP OCAP REL COSTS-MVBLE	25. 00	Utilization review -		0	UTILIZATION REVIEW-SNF	114.00		25. 00
27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist 29. 00 Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAP REL COSTS-MVBLE EQUIP 2. 00 ONNONPHYSICIAN ANESTHETISTS 19. 00 OCCUPATIONAL THERAPY 67. 00 OCCUPATIONAL THERAPY 67. 00 OCCUPATIONAL THERAPY 68. 00 OCCUPATIONAL THERAPY 79. 00 OCCUPATIONAL THERAPY 70. 00 OCCUPATIONAL THERAPY	26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
28. 00 Non-physician Anesthetist	27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for		Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS			
30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 0 ADJULTS & PEDIATRICS 30.00 30.99 A-8-3 OSPEECH PATHOLOGY 68.00 31.00		Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY			
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 0 SPEECH PATHOLOGY 68.00 31.00	30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
Ii mi tation (chapter 14)	31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00

				T	o 12/31/2017	Date/Time Pre 5/14/2018 1:5	
				Expense Classification on	Worksheet A	37 147 2016 1. 5.	Z pili
				To/From Which the Amount is			
				To thom will on the two distance is	to be haj astea		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	·	1.00	2.00	3.00	4. 00	5. 00	
33.00	NONREI MBURSABLE PHYSI CI AN PTO	A	-11, 860	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 00
	SOLD						
33. 01	PHYSICIAN RECRUITMENT	A		ADMINISTRATIVE & GENERAL	5.00		33. 01
33. 02	RADI OLOGY	В	0	CT SCAN	57.00	0	33. 02
33. 03	ADVERTI SI NG	A	-87, 073	ADMINISTRATIVE & GENERAL	5.00	0	33. 03
33. 04	MUNCIE CLINIC	В	-58, 020	MUNCIE CLINIC	90.04	0	33. 04
33. 05	OUTSIDE SERVICES - SPD	В	-2, 378	CENTRAL SERVICES & SUPPLY	14.00	0	33. 05
33. 07	MI SC A&G	В	-245, 616	ADMINISTRATIVE & GENERAL	5.00	0	33. 07
33. 08	SEXUAL RESPONSE UNIT	В	-23, 130	EMERGENCY	91.00	0	33. 08
33. 09	MI SC A&P	В	-4, 468	ADULTS & PEDIATRICS	30.00	0	33. 09
33. 10	MISC EMPLOYEE BENEFITS	В	-43, 130	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 10
33. 13	MISC OPERATION OF PLANT	В	-1, 660	OPERATION OF PLANT	7.00	0	33. 13
33. 14	GUEST MEALS	A	-21, 675	CAFETERI A	11. 00	0	33. 14
33. 17	MISC OTHER OPERATING REVENUE	В	-1, 297, 468	ADMINISTRATIVE & GENERAL	5.00	0	33. 17
33. 18	ONCOLOGY SERVICES	В	-524, 440	ONCOLOGY	90. 03	0	33. 18
33. 19	ESPRESSO TO GO	В	-83, 465	CAFETERI A	11. 00	0	33. 19
33. 22	PROCARE ADMINISTRATION	В	-16, 419	PHYSI CAL THERAPY	66.00	0	33. 22
33. 28	HOSPITAL ASSESSMENT FEES (HAF)	В	-4, 923, 296	ADMINISTRATIVE & GENERAL	5.00	0	33. 28
50.00	TOTAL (sum of lines 1 thru 49)		-20, 332, 384				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

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

B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

Worksheet A-8-1

From 01/01/2017 OFFICE COSTS 12/31/2017 Date/Time Prepared: 5/14/2018 1:52 pm Li ne No. Cost Center Expense I tems 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	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE	0	3, 435, 642	1.00
2.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	67, 876	0	2.00
3.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2, 210, 610	1, 720, 692	3.00
4.00	54.00	RADI OLOGY-DI AGNOSTI C	HOME OFFICE	50, 209	0	4.00
4.01	69.00	ELECTROCARDI OLOGY	HOME OFFICE	68, 816	0	4. 01
4.02	0.00			0	0	4. 02
4.03	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	228, 035	o	4.03
5.00	TOTALS (sum of lines 1-4).			2, 625, 546	5, 156, 334	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 RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6. 00	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 organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

Heal th	Financial Syste	ems		COMMUNITY HOSPITA	AL ANDERSON	In Lie	u of Form CMS-	2552-10
STATEME	ENT OF COSTS OF	SERVICES FROM	RELATED ORGANI	ZATIONS AND HOME	Provider CCN: 15-0113	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS					From 01/01/2017	D 1 /T' D	
						To 12/31/2017	Date/Time Pro 5/14/2018 1:5	
	Net	Wkst. A-7 Ref.					07 147 2010 1. 3)Z piii
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6. 00	7. 00						
	A. COSTS INCUR	RED AND ADJUSTI	MENTS REQUIRED .	AS A RESULT OF TRA	ANSACTIONS WITH RELATED (ORGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:						
1.00	-3, 435, 642	C						1. 00
2.00	67, 876	C						2. 00
3.00	489, 918	C						3. 00
4.00	50, 209	C						4. 00
4.01	68, 816	C						4. 01
4.02	0	C						4. 02
4 03	228 035	0						4 03

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

5.00

 boon poored to not notice to	cordinate i diaret 2, the disease directed to the cordinate parti	
Related Organization(s)		
and/or Home Office		
Type of Business		
6. 00		
 B. INTERRELATIONSHIP TO RELATE	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

	Comont under the Arrive	
6. 00		6. 00
7.00		7. 00
8.00		8. 00
9. 00		9. 00
10.00		10.00
6. 00 7. 00 8. 00 9. 00 10. 00		100.00

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

-2, 530, 788

					'	12/31/201/	5/14/2018 1:5	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00	5. 00	ADMINISTRATIVE & GENERAL	4, 515, 689	4, 170, 589	345, 100	211, 500	3, 754	1. 00
2.00	31.00	INTENSIVE CARE UNIT	491	491	0	0	0	2. 00
3.00	53. 00	ANESTHESI OLOGY	3, 612, 317	3, 612, 317	0	0	0	3. 00
4.00	54. 00	RADI OLOGY-DI AGNOSTI C	352, 843	352, 843	0	0	0	4. 00
5.00	90. 01	WOUND/OSTOMY CLINIC	832, 957	832, 957	0	0	0	5. 00
6.00	90. 03	ONCOLOGY	312, 270	312, 270	0	0	0	6. 00
7.00	0.00		0	0	0	0	0	7. 00
8.00	0.00		0	0	0	0	0	8. 00
9.00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			9, 626, 567	9, 281, 467	345, 100		3, 754	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				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	381, 717	19, 086	0	0	0	
2.00		INTENSIVE CARE UNIT	0	0	0	0	0	2. 00
3.00		ANESTHESI OLOGY	0	0	0	0	0	3. 00
4.00		RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	
5. 00		WOUND/OSTOMY CLINIC	0	0	0	0	0	5. 00
6. 00		ONCOLOGY	0	0	0	0	0	
7. 00	0. 00		0	0	0	0	0	7. 00
8. 00	0. 00		0	0	0	0	0	8. 00
9.00	0. 00		0	0	0	0	0	9. 00
10. 00	0. 00		0	0	0	0	0	1
200.00			381, 717			0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identi fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1, 00	2.00	14 15. 00	16. 00	17. 00	18. 00		
1 00		ADMI NI STRATI VE & GENERAL	15.00			4, 170, 589		1. 00
1. 00 2. 00		INTENSIVE CARE UNIT				4, 170, 589		2.00
3. 00		ANESTHESIOLOGY			0			3.00
				0	0	3, 612, 317		1
4.00		RADI OLOGY - DI AGNOSTI C		0	0	352, 843		4. 00
5.00		WOUND/OSTOMY CLINIC			0	832, 957		5. 00
6.00		ONCOLOGY		0	0	312, 270		6.00
7.00	0.00				0	0		7. 00
8.00	0.00				0	0		8. 00
9.00	0.00			0	0	0		9. 00
10.00	0. 00			0	0	0 201 477		10.00
200.00	l		0	381, 717	0	9, 281, 467	l	200. 00

| Period: | Worksheet B | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0113

CAPITAL RELATED COSTS Net Expenses For Cost Allocation For Cost Benefits Department For Cost Benefits For Cost Benefits For Cost Benefits For Cost For Cost Benefits For Cost For Cost Benefits For Cost For Cost	1. 00 2. 00 4. 00 45 5. 00 25 7. 00 03 8. 00 68 9. 00
For Cost Allocation (from Wkst A col. 7)	2. 00 4. 00 45 5. 00 0 6. 00 25 7. 00 03 8. 00 68 9. 00
For Cost Allocation (from Wkst A col. 7)	2. 00 4. 00 45 5. 00 0 6. 00 25 7. 00 03 8. 00 68 9. 00
CFrom Wkst A Col. 7) 0 1.00 2.00 4.00 4A	2. 00 4. 00 45 5. 00 0 6. 00 25 7. 00 03 8. 00 68 9. 00
Col. 7)	2. 00 4. 00 45 5. 00 0 6. 00 25 7. 00 03 8. 00 68 9. 00
0 1.00 2.00 4.00 4A GENERAL SERVICE COST CENTERS	2. 00 4. 00 45 5. 00 0 6. 00 25 7. 00 03 8. 00 68 9. 00
1. 00 00100 CAP REL COSTS-BLDG & FIXT 5, 882, 331 5, 882, 331 2. 00 00200 CAP REL COSTS-MVBLE EQUIP 4, 610, 836 4, 610, 836 4, 610, 836	2. 00 4. 00 45 5. 00 0 6. 00 25 7. 00 03 8. 00 68 9. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P 4, 610, 836 4, 610, 836	2. 00 4. 00 45 5. 00 0 6. 00 25 7. 00 03 8. 00 68 9. 00
	4.00 45 5.00 0 6.00 25 7.00 03 8.00 68 9.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 13,449,119 31,759 19,092 13,499,970	0 6. 00 25 7. 00 03 8. 00 68 9. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL 20, 163, 565 472, 336 807, 130 2, 281, 514 23, 724, 5 6. 00 00600 MAI NTENANCE & REPAIRS 0 0 0 0	25 7. 00 03 8. 00 68 9. 00
6. 00 00600 MAI NTENANCE & REPAI RS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	68 9. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 199, 200 66, 801 0 14, 902 280, 9	
9. 00 00900 HOUSEKEEPI NG 1, 786, 866 133, 756 11, 246 308, 200 2, 240, 0 10. 00 01000 DI ETARY 1, 052, 580 208, 164 137, 992 142, 947 1, 541, 6	83 10.00
11. 00 01100 CAFETERI A 743, 923 39, 405 0 177, 447 960, 7	
13. 00 01300 NURSI NG ADMI NI STRATI ON 1, 291, 031 51, 375 231 244, 666 1, 587, 3	
14. 00 01400 CENTRAL SERVI CES & SUPPLY 1,809,318 98,097 7,416 222,620 2,137,4 15. 00 01500 PHARMACY 2,030,993 61,916 4,778 355,482 2,453,1	
16.00 01600 MEDICAL RECORDS & LIBRARY 1,585,586 78,501 0 260,928 1,925,0	
17. 00 01700 SOCI AL SERVI CE 0 0 0 0 0	0 17.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 19.00 0 20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 0 0	0 21.00
22. 00 02200 1 &R SERVI CES-OTHER PRGM. COSTS APPRVD 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 22.00 0 23.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	23.00
30. 00 03000 ADULTS & PEDI ATRI CS 14, 488, 162 1, 000, 159 232, 012 2, 829, 079 18, 549, 4	
31. 00 03100 I NTENSI VE CARE UNI T 2, 931, 581 132, 308 105, 135 556, 627 3, 725, 6 32. 00 03200 CORONARY CARE UNI T 0 0 0 0	51 31.00 0 32.00
33. 00 03300 BURN INTENSIVE CARE UNIT 0 0 0	0 33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0	0 34.00
40. 00 04000 SUBPROVI DER - I PF 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 0 0 0	0 40.00
42. 00 04200 SUBPROVI DER 0 0 0	0 42.00
43. 00 04300 NURSERY	
44.00 04400 SKILLED NURSING FACILITY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 44.00 0 45.00
46. 00 04600 OTHER LONG TERM CARE 0 0 0	0 46.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 6, 503, 510 427, 699 1, 287, 914 1, 053, 329 9, 272, 4	52 50.00
51. 00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 0 0	0 51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0	0 52.00
53. 00 05300 ANESTHESI OLOGY 51, 491 5, 251 7, 624 176, 903 241, 2	
54. 00 05400 RADI OLOGY-THERAPEUTI C 0 0 0 0 0	0 55.00
56. 00 05600 RADI 0I SOTOPE 623, 595 28, 632 14, 338 53, 003 719, 5	•
57. 00 05700 CT SCAN 638, 547 8, 688 3, 979 90, 399 741, 6 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 876, 394 18, 071 24, 838 68, 485 987, 7	
59. 00 05900 CARDI AC CATHETERI ZATI ON 1, 059, 848 71, 763 123, 710 184, 267 1, 439, 5	
60. 00 06000 LABORATORY 3, 918, 005 151, 132 209, 019 457, 356 4, 735, 5 60. 01 06001 BLOOD LABORATORY 0 0 0 0	
60. 01 06001 BLOOD LABORATORY 0 0 0 0 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 0 0 0 0 0 0 0	0 60.01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 233, 643 11, 294 1, 149 45, 005 291, 0	91 62.00
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 0 64. 00 06400 I NTRAVENOUS THERAPY 0 0 0 0 0 0	0 63.00
65. 00 06500 RESPI RATORY THERAPY 1, 030, 790 13, 901 32, 939 206, 429 1, 284, 0	•
66. 00 06600 PHYSI CAL THERAPY 2, 151, 499 90, 780 3, 180 391, 929 2, 637, 3	88 66. 00
67. 00 06700 0CCUPATI ONAL THERAPY 380, 364 67, 013 0 73, 785 521, 1 68. 00 06800 SPEECH PATHOLOGY 228, 758 8, 128 91 40, 888 277, 8	
69. 00 06900 ELECTROCARDI OLOGY 541, 386 29, 597 25, 117 88, 858 684, 9	
70. 00 07000 ELECTROENCEPHALOGRAPHY 674, 276 29, 597 33, 583 105, 169 842, 6	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 12, 343, 242 0 0 0 12, 343, 2 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 9, 665, 893 0 0 0 9, 665, 8	
73. 00 07300 DRUGS CHARGED TO PATIENTS 5, 709, 519 0 0 5, 709, 5	
74. 00 07400 RENAL DI ALYSI S 357, 317 3, 630 0 360, 9	
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 OUTPATIENT SERVICE COST CENTERS	0 75.00
88. 00 08800 RURAL HEALTH CLINI C 0 0 0 0	0 88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0	0 89.00
90. 00 09000 CLINIC 0 0 0 0 0 0 0 90. 01 09001 WOUND/OSTOMY CLINIC 184, 323 196, 599 4, 887 65, 839 451, 6	0 90.00 48 90.01
90. 02 09002 KI DS PLUS CLI NI C 0 30, 118 0 30, 1	18 90. 02
90. 03 09003 0NCOLOGY -9, 324, 546 330, 818 511, 851 245, 880 -8, 235, 9	97 90. 03

| Peri od: | Worksheet B | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0113

				To	12/31/2017	Date/Time Prep 5/14/2018 1:5:	
			CAPI TAL REI	LATED COSTS		37 147 2016 1. 5.	z piii
	Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col . 7)	4.00	2.22	4.00	4.0	
90. 04 0900	4 MUNCIE CLINIC	0 1, 684	1. 00 28, 728	2. 00	4.00	4A 30, 750	90. 04
1	5 ANTICOAGULATION CLINIC	305, 966	20, 720		58, 673	368, 528	90. 05
90.06 0900	PREGNANCY PLUS	-3	45, 776	727	О	46, 500	90. 06
1	17 O/P LAB	0	0	0	0	0	90. 07
	18 0/P LAB 19 FORTVILLE CLINIC	600	22, 994	0	0	0 23, 594	90. 08 90. 09
	O EMERGENCY	3, 919, 423	151, 190		744, 454	4, 934, 396	91.00
1	O OBSERVATION BEDS (NON-DISTINCT PART)		,	,		0	92. 00
	R REIMBURSABLE COST CENTERS	_					
	IO HOME PROGRAM DIALYSIS IO AMBULANCE SERVICES	0	0		0	0	94. 00 95. 00
1	O DURABLE MEDICAL EQUIP-RENTED	0	0	0	o	0	96.00
4	O DURABLE MEDICAL EQUIP-SOLD	0	0	0	o	0	97. 00
	O CMHC	0	0	0	0	0	
1	O CORF O L&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	99. 10 100. 00
	O HOME HEALTH AGENCY	0	0	-	0		100.00
SPEC	I AL PURPOSE COST CENTERS			-	- 1		
1	O KIDNEY ACQUISITION	0	0	- 1	0		105. 00
	IO HEART ACQUISITION IO LIVER ACQUISITION	0	0	0	0		106. 00 107. 00
	O LUNG ACQUISITION	0	0	0	o	-	107.00
	O PANCREAS ACQUISITION	0	0	0	o		109. 00
	O INTESTINAL ACQUISITION	0	0	0	0		110. 00
1	O ISLET ACQUISITION O INTEREST EXPENSE	0	0	0	O		111. 00 113. 00
1	O UTILIZATION REVIEW-SNF						114. 00
1	O AMBULATORY SURGICAL CENTER (D. P.)	0	0	О	О		115. 00
116. 00 1160	l .	0	0	0	0		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) EIMBURSABLE COST CENTERS	125, 228, 943	5, 150, 246	4, 393, 205	12, 727, 094	123, 506, 351	118.00
	O GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23, 284	0	0	23, 284	190. 00
190. 01 1900	WELLNESS CENTERS	1, 221, 367	23, 689		190, 014	1, 640, 162	
	12 EMPLOYED ORTHO MD	0	0	0	0 05 ((4		190. 02
	3 NORTHVIEW CONV. (LTC) 4 SUMMIT CONV. (LTC)	421, 447 241, 484	17, 704 17, 704		85, 661 47, 997	524, 812 307, 185	
	5 PARKVI EW CONV. (LTC)	362, 660	17, 704		72, 799	453, 163	
	MONTI CELLO HSE. (ASS' TD LVG.)	91, 853	17, 704	0	18, 113	127, 670	
	NH PARK PLACE (LTC)	41, 143	0	0	8, 290	49, 433	
	18 MADISON PLACE OF ELWOOD (LTC) 19 SPINE SURGEON	0	0	0	0		190. 08 190. 09
	O CLINICAL RESEARCH CENTER	817, 556	40, 003	2, 044	134, 631	994, 234	
1	1 ONCOLOGI ST	0	0	0	o		190. 11
	2 MEDI CAL I NTERNI ST	182, 184	0	- 1	22, 146	204, 330	
	3 RHEUMATOLOGY 4 ROCK STEADY BOXING	905, 430 124, 522	34, 424	2, 375 0	87, 537 19, 981	995, 342 178, 927	
191.00 1910	l .	0	01, 121	1	0		191. 00
	PHYSICIANS' PRIVATE OFFICES	1, 307, 262	358, 118		0	1, 672, 715	
	MUNCIE MD OFFICES	13, 525	110, 916		0	124, 441	
192. 02 1920	2 FOUNDATI ON 3 SPOF	871, 795 0	6, 873 0		43, 712 0	922, 380 0	192. 02
1	4 HEALTHY HEART	221, 632	Ö	785	41, 995	264, 412	
1	VACANT SPACE	0	11, 719	0	o	11, 719	
1	17 PARK PLACE CENTER 1024 MADISON	611	0	0	0		192. 07
	18 RENTAL PROPERTY - 1924 MADISON 19 RESIDENTIAL PROPERTY - 1430 N MADISO	17, 159 5, 398	28, 110 24, 133		0	45, 269 29, 531	
200. 00	Cross Foot Adjustments	3,370	21, 100	l	Ĭ		200. 00
201.00	Negative Cost Centers		0	-	0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	132, 075, 971	5, 882, 331	4, 610, 836	13, 499, 970	132, 075, 971	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared: | 5/14/2018 1:52 pm

Company Seption Sept		Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	5/14/2018 1:5 HOUSEKEEPI NG	
OUR OUR PRICE			& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
1.00 0.0000 CAP FILL DOSS F-BULD & F F MIX		GENERAL SERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	
0.00 0.000 DEPLOYEE BERNET IS DEPAIRMENT 23,724,546 0 0.000 0.000 DEPLOYEE BERNET IS 0.000 0.000 DEPLOYEE REPAIRS 1,600,556 0.000 DEPLOYEE REPAIRS 1,6	1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
5.00 DOSDO MAYIN STRINT IVE & CEMERAL 23, 724, 945 0 0 0 0 0 0 0 0 0								1
0.000 0.0000 UM IN ILEMANCE & REPAILS 0 0 0, 99. 30. 181 0.000 0.000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000000			22 724 545					•
1,00			23, 724, 545	0				•
8.00 00800 JAURDRY & LINEN SERVICE			1, 680, 556	0	9, 939, 181			•
10.00 01000 DETARY		l l		0				•
11.00 0 1100 QAFETERIA 105,500 0 81,905 0 17.00 11.00				0				•
13.00 01300 MURSING ASIAN MISTRATION				0	1		1	1
14.00 01400 CENTRAL SERVICES & SUPPLY				0	1		l .	ł
15.00 01500 PHARMACY 1991 0 128,680 0 18,941 15.00 17.00 01700 05.01 18,741 15.00 17.00				0	1			•
16.00 01-000 MEDICAL RECORDS & LIBRARY 391,723 0 163,147 0 5,544 16,00 17,00 170			1	Ö	1			•
19.00 01900 NOMPHYSIC (AM AMESTHETISTS 0 0 0 0 0 0 0 0 20.00	16.00		1	0	1			1
20.00		1	0	0	0	0	l	•
21 00 02100 IAS SERVICES-SALARY & FEN NEES APPRIVD 0 0 0 0 0 0 22 00 0220 02200 PARAMED ED PROM-LERS 0 0 0 0 0 0 0 0 0			0	0	0	0		•
22.00 02200 ARS SERVICES-OTHER PROM. COSTS APPRVD 0 0 0 0 0 22.00		1	0	0		0		•
23.00 02500 PARAMEDE DE PREMI - (EUIS) 0 0 0 0 0 22,00				0		0	-	
INPATE INT ROUTE NOT SERVICE COST CENTERS 3,774,692 0 2,078,621 170,844 1,446,883 30.00 30.00 30.00 0.00 0.00 0.01 170,844 1,446,883 30.00 30.00 30.00 0.00 0.00 0.00 0.00 32.00			Ö	O	o o	0		23. 00
33.00 03100 INTERNI WE CARE UNIT 758, 136 0 274, 975 31, 392 197, 722 31.00 202.00		INPATIENT ROUTINE SERVICE COST CENTERS						
32.00 03200 CORDINARY CARE UNIT			1	0	1 ' '			1
33 00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 33.00 40.00 34.00 0340.00 CHICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 34.00 40.00 10 04000 SUBFORVI DER - I.PF 0 0 0 0 0 0 0 0 41.00 42.00 10 04000 SUBFORVI DER - I.PF 0 0 0 0 0 0 0 0 0 44.00 42.00 10 04000 SUBFORVI DER - I.PF 0 0 0 0 0 0 0 0 0 0 44.00 42.00 10 04000 SUBFORVI DER - I.PF 0 0 0 0 0 0 0 0 0 0 0 44.00 42.00 14.0			1	0	1	31, 392	1	
34. 00 03400 SURGICAL INTERSIVE CARE UNIT 0 0 0 0 0 0 0 0 0		1		0		0	•	
A0. 00 0.0000 SUBPROVI DER - I PF				Ö	ol ö	0		1
42.00 04200 04200 0400 0 0 0 0 0 42.00 43.00 04400 04400 SKI LLED NURSING FACILITY 0 0 0 0 0 0 0 0 0 44.00 04400 NURSING FACILITY 0 0 0 0 0 0 0 0 0 45.00 04600 NURSING FACILITY 0 0 0 0 0 0 0 0 0 46.00 04600 NURSING FACILITY 0 0 0 0 0 0 0 0 0 46.00 04600 NURSING FACILITY 0 0 0 0 0 0 0 0 0			o	0	0	0	0	
43.00 04300 NURSERY 288,935 0 75,033 0 21,713 43.00 44.00 04500 04500 OSKILLEN DIVESTING FACILITY 0 0 0 0 0 0 0 0 0 44.00 46.00 04500 OTHER LONG TERM CARE 0 0 0 0 0 0 0 0 0 45.00 NOCTUBE TO SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 0 NOCTUBE TO SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0		•
44. 00 04400 SKILLED NURSING FACILITY			0	0	0	0		
45.00 04500 OHREN LORD TERM CARE		l l	1	0	/5, 033	0	l	1
ACCORDING OCCUPATION CREME O O O O O O O O O O O O O O O O O O			-1	0		0	l	•
50.00 05000 05000 05000 05000 0		l l	-	0	o o	0		•
51.00 05100 RECOVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		ANCILLARY SERVICE COST CENTERS						
S2.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0				0	888, 884	137, 018		ł
53.00 05300 AINSTHESI OLOGY		1	0	0	0	0		
54.00 05400 RADI OLOGY-DI AGNOSTI C 874, 154 0 0 0 0 0 0 0 0 0			49 096	0	10 914	0		•
55.00 05500 RADIO LOGY-THERAPEUTIC				Ö	1			1
57. 00 05700 CT SCAN 150, 912 0 18, 056 18, 510 0 57. 00	55.00		1	0	1	0		55. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 201,006 0 37,557 5,922 4,620 58. 00				0				
59, 00 05900 CARDI AC CATHETERI ZATION 292, 943 0 149, 144 1, 622 23, 098 59, 00			1	0	1		l e	•
60. 00 06000 LABORATORY 963, 634 0 314, 097 859 39, 267 60. 00				0	1			
60.01 06001 BLOOD LABDRATORY 0 0 0 0 0 0 0 60.01			1	0	1			1
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 59, 234 0 23, 473 0 6, 930 62. 00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 64.00 06400 INTRAVENOUS THERAPY 261, 294 0 28, 890 0 22, 636 65. 00 65.00 06500 RESPIRATORY THERAPY 536, 685 0 188, 667 191 7, 853 66. 00 66.00 06600 PHYSI CAL THERAPY 536, 685 0 188, 667 191 7, 853 66. 00 67.00 06700 OCUPATIONAL THERAPY 56, 543 0 16, 893 0 6, 006 67. 00 68.00 06800 SPEECH PATHOLOGY 56, 543 0 16, 893 0 6, 006 67. 00 69.00 06900 ELECTROCARDIOLOGY 139, 383 0 61, 511 3, 101 0 69. 00 71.00 07000 ELECTROENCEPHALOGRAPHY 171, 467 0 611, 511 4, 294 33, 262 70. 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 511, 739 0 0 0 0 0 0 72.00 07300 PURGS CHARGED TO PATIENTS 1, 161, 836 0 0 0 0 0 0 74.00 07400 RENAL DIALYSIS 73, 449 0 7, 543 0 0 74. 00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 89.00 08900 REDRALLLY CLINIC 0 0 0 0 0 0 90.01 09000 KIDS CLINIC 91, 906 90. 00 0 0 0 90.02 09000 KIDS PLUS CLINIC 91, 906 0 0 0 0 90.03 09000 KIDS PLUS CLINIC 6, 129 0 62, 595 0 0 0 90.04 09004 MINCIE CLINIC 6, 257 0 59, 706 0 0 0 90.05 09005 ANTI COAGULATION CLINIC 74, 992 0 0 0 0 0 90.06 09006 ANTI COAGULATION CLINIC 74, 992 0 0 0 0 0 90.07 09007 O7P LAB			1	O	0	0		
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 65.00 06500 RESPI RATORY THERAPY 261,294 0 28,890 0 22,636 65.00 06600 PHYSI CAL THERAPY 536,685 0 188,667 191 7,853 66.00 67.00 06700 OCCUPATI ONAL THERAPY 106,052 0 139,273 0 6,006 68.00 69.00 06800 SPEECH PATHOLOGY 56,543 0 16,893 0 6,006 68.00 69.00 06900 ELECTROCARDI OLOGY 139,383 0 61,511 3,101 0 69.00 70.00 07000 ELECTROCARDI OLOGY 139,383 0 61,511 4,294 33,262 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1,966,922 0 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1,161,836 0 0 0 0 0 0 74.00 07400 RENAL DI ALYSI S 73,449 0 7,543 0 0 74.00 75.00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 0 89.00 08900 REDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 0 0 0 90.01 09001 MUND/OSTOMY CLI NI C 91,906 0 408,590 1,527 60,980 90.01 90.02 09002 KI DS PLUIS CLI NI C 91,906 0 408,590 1,527 60,980 90.01 90.03 09003 ANTI COAGULATION CLI NI C 6,257 0 59,706 0 0 0 0 90.04 09004 MUNCIE CLI NI C 6,257 0 59,706 0 0 0 0 90.05 09005 ANTI COAGULATION CLI NI C 74,992 0 0 0 0 0 0 90.06 09007 OPO07 O		1 1						1
64.00 06400 NTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 0			1	0	1			
65. 00 06500 RESPIRATORY THERAPY 261, 294 0 28, 890 0 22, 636 65. 00 66. 00 06600 PHYSI CAL THERAPY 536, 685 0 188, 667 191 7, 853 66. 00 67. 00 06700 OCCUPATIONAL THERAPY 106, 052 0 139, 273 0 6, 006 67. 00 68. 00 06800 SPEECH PATHOLOGY 56, 543 0 16, 893 0 6, 006 68. 00 69. 00 06900 ELECTROCARDI OLOGY 139, 383 0 61, 511 3, 101 0 69. 00 70. 00 07000 ELECTROCARDI OLOGY 139, 383 0 61, 511 4, 294 33, 262 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 2, 511, 739 0 0 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 1, 966, 922 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 1, 161, 836 0 0 0 0 0 0 74. 00 07400 RENAL DIALYSIS 73, 449 0 7, 543 0 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 90. 01 09001 WOUND/OSTOMY CLINIC 91, 906 0 408, 590 1, 527 60, 980 90. 01 90. 02 09002 KIDS PLUS CLINIC 6, 129 0 62, 595 0 0 0 90. 03 09003 NOCOLOGY 0 0 687, 538 10, 591 0 90. 02 90. 04 09004 MUNCIE CLINIC 6, 257 0 59, 706 0 0 0 90. 05 09005 ANTI COAGULATION CLINIC 74, 992 0 0 0 90. 06 09006 PREGNANCY PLUS 9, 462 0 95, 136 0 0 90. 05 90. 07 09007 OPD 07 PLAB			0	0	0	0	l	
66. 00 06600 PHYSI CAL THERAPY 536, 685 0 188, 667 191 7, 853 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 106, 052 0 139, 273 0 6, 006 67. 00 68. 00 06900 ELECTROCARDI OLOGY 56, 543 0 16, 893 0 6, 006 68. 00 06900 ELECTROCARDI OLOGY 139, 383 0 61, 511 3, 101 0 69. 00 07		1 1	261 294	0	28 890	0		1
68.00 06800 SPEECH PATHOLOGY 56,543 0 16,893 0 6,006 68.00 69.00 06900 ELECTROCARDI OLOGY 139,383 0 61,511 3,101 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 171,467 0 61,511 4,294 33,262 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 2,511,739 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1,966,922 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 1,161,836 0 0 0 0 74.00 07400 RENAL DI ALYSIS 73,449 0 7,543 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 90.00 099000 CLINIC 0 0 0 0 0 90.01 09001 WOUND/OSTOMY CLINIC 91,906 0 408,590 1,527 60,980 90.02 09002 KIDS PLUS CLINIC 6,129 0 62,595 0 0 0 90.04 09004 MUNCIE CLINIC 6,257 0 59,706 0 0 90.03 90.04 09004 MUNCIE CLINIC 74,992 0 0 0 0 0 90.05 09005 ANTICOAGULATION CLINIC 74,992 0 0 0 0 90.06 09007 07P LAB 0 0 0 0 0 0 90.07 09007 07P LAB 0 0 0 0 0 0 90.07 09007 07P LAB 0 0 0 0 0 90.07 09007 07P LAB 0 0 0 0 0 90.07 09007 07P LAB 0 0 0 0 90.00 0007 07P LAB 0 0 0 0 0 90.00 0007 07P LAB 0 0 0 0 90.00 0007 07P LAB 0 0 0 0 0 90.00 0007 07P LAB 0 0 0 0 0 90.00 0007 07P LAB 0 0 0 0 0 90.00 0007 07P LAB 0 0 0 0 90.00 0007 07P LAB 0 0 0 0 0 90.00 0007 07P LAB 0 0 0 0 90.00 0007 07P LAB 0 0 0 0 0 90.00 0007 07P LAB 0 0 0 0 0 90.00 0007 07P LAB 0 0 0 0 0 90.00 0007 07P LAB 0 0 0 0 0 90.00 0007 07P LAB 0 0 0 0 0 90.				0	1		1	1
69. 00 06900 ELECTROCARDIOLOGY 139, 383 0 61, 511 3, 101 0 69. 00 700 00 07000 ELECTROENCEPHALOGRAPHY 171, 467 0 61, 511 4, 294 33, 262 70. 00 71. 00 07000 ELECTROENCEPHALOGRAPHY 171, 467 0 61, 511 4, 294 33, 262 70. 00 71. 00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 2, 511, 739 0 0 0 0 0 0 71. 00 72. 00 1MPL. DEV. CHARGED TO PATIENTS 1, 966, 922 0 0 0 0 0 0 72. 00 73. 00 74. 00 07400 RENAL DIALYSIS 1, 161, 836 0 0 0 0 0 74. 00 74. 00 74. 00 07400 RENAL DIALYSIS 73, 449 0 7, 543 0 0 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 75. 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	67. 00	1 1	1	0	139, 273	0	1	67. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 171, 467 0 61, 511 4, 294 33, 262 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 2, 511, 739 0 0 0 0 71. 00 72. 00 O7200 IMPL. DEV. CHARGED TO PATI ENTS 1, 966, 922 0 0 0 0 72. 00 73. 00 O7300 DRUGS CHARGED TO PATI ENTS 1, 161, 836 0 0 0 0 0 0 73. 00 74. 00 O7400 RENAL DI ALYSI S 73, 449 0 7, 543 0 0 0 0 74. 00 75. 00 O7500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 0 75. 00 88. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 0 0 0 0 89. 00 90. 01 09001 WOUND/OSTOMY CLI NI C 91, 906 0 408, 590 1, 527 60, 980 90. 01 90. 02 09002 NI DS PLUS CLI NI C 6, 129 0 62, 595 0 0		1 1		0				1
71. 00				0	1		l	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 1,966,922 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 1,161,836 0 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSIS 73,449 0 7,543 0 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 00 0 0				0	01,511	4, 294		1
73. 00 07300 DRUGS CHARGED TO PATIENTS 1, 161, 836 0 0 0 0 0 73. 00 74. 00 07400 RENAL DIALYSIS 73, 449 0 7, 543 0 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 90. 00 09000 CLINIC 0 0 0 0 0 0 90. 01 09001 WOUND/OSTOMY CLINIC 91, 906 0 408, 590 1, 527 60, 980 90. 01 90. 02 09002 KIDS PLUS CLINIC 91, 906 0 62, 595 0 0 90. 02 90. 03 09003 ONCOLOGY 0 0 687, 538 10, 591 0 90. 03 90. 04 09004 MUNCIE CLINIC 6, 257 0 59, 706 0 0 90. 04 90. 05 09005 ANTICOAGULATION CLINIC 74, 992 0 0 95, 136 0 0 90. 06 90. 07 09007 0/P LAB 0 0 0 0 0 0 90. 07 09007 0/P LAB 0 0 0 0 0 90. 07 09007 0/P LAB 0 0 0 0 0 0 0 0 0				0		0		•
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0			1	0	o o	Ö	1	
SECTION SURVINCE COST CENTERS SECTION	74.00	07400 RENAL DIALYSIS	73, 449	0	7, 543	0	0	74. 00
88. 00	75. 00		0	0	0	0	0	75. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89. 00 90. 00 09000 CLINIC 0 0 0 0 0 90. 00 90. 01 09001 WOUND/OSTOMY CLINIC 91, 906 0 408, 590 1, 527 60, 980 90. 01 90. 02 09002 KI DS PLUS CLINIC 6, 129 0 62, 595 0 0 90. 02 90. 03 09003 ONCOLOGY 0 0 687, 538 10, 591 0 90. 03 90. 04 MUNCIE CLINIC 6, 257 0 59, 706 0 0 90. 04 90. 05 09005 ANTI COAGULATI ON CLINIC 74, 992 0 0 0 0 0 90. 05 90. 06 09006 PREGNANCY PLUS 9, 462 0 95, 136 0 0 0 90. 05 90. 07 0907 0/P LAB 0 0 0 0 0	00.00							00.00
90. 00 09000 CLINIC 0 0 0 0 0 0 90. 00 90. 00 90. 01 90. 01 90. 01 90. 01 90. 02 90. 02 90. 03 90. 03 90. 04 90. 04 90. 04 90. 05 90. 05 90. 05 90. 05 90. 06 90. 06 90. 06 90. 06 90. 06 90. 07		1 1		0		0	l	1
90. 01 09001 WOUND/OSTOMY CLINIC 91, 906 0 408, 590 1, 527 60, 980 90. 01 90. 02 09002 KI DS PLUS CLINIC 6, 129 0 62, 595 0 0 90. 02 90. 03 09003 ONCOLOGY 0 0 687, 538 10, 591 0 90. 03 90. 04 09004 MUNCIE CLINIC 6, 257 0 59, 706 0 0 90. 04 90. 05 09005 ANTI COAGULATI ON CLINIC 74, 992 0 0 0 90. 05 90. 06 09006 PREGNANCY PLUS 9, 462 0 95, 136 0 0 90. 06 90. 07 09007 O/P LAB 0 0 0 0 0 90. 07				0	0	0		
90. 03 09003 0NCOLOGY 0 0 687, 538 10, 591 0 90. 03 90. 04 90. 04 90. 05 90. 05 90. 06 90. 06 90. 06 90. 07 09007 0/P LAB 0 0 0 0 0 90. 07 09007 0/P LAB 0 0 0 0 0 0 0 0 0			91, 906	0	408, 590	1, 527		•
90. 04 09004 MUNCI E CLINI C 6, 257 0 59, 706 0 0 90. 04 90. 05 90. 06 90. 06 90. 06 90. 07 09007 0/P LAB 0 0 0 0 0 90. 07 09007 0/P LAB 0 0 0 0 0 0 0 0 0		1 1	6, 129	0			l e	•
90. 05 09005 ANTI COAGULATI ON CLI NI C 74, 992 0 0 0 0 90. 05 90. 06 09006 PREGNANCY PLUS 9, 462 0 95, 136 0 0 90. 06 90. 07 09007 0/P LAB 0 0 0 0 0 0 0 0 0			0	0				
90. 06 09006 PREGNANCY PLUS 9, 462 0 95, 136 0 0 90. 06 90. 07 09007 0/P LAB 0 0 0 0 0 0 0 0 0		1 1		0	59, /06	0		1
90. 07 09007 0/P LAB 0 0 0 0 90. 07		1 1	1	0	95. 136	0		1
90. 08 09008 0/P LAB 0 0 0 0 0 90. 08		09007 0/P LAB	1	0) , , , , , , , ,	Ö	l e	1
	90. 08	09008 0/P LAB	o	0) 0	0	0	90. 08

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0113

Peri od: Worksheet B From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared:

5/14/2018 1:52 pm Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL **REPAIRS PLANT** LINEN SERVICE 5.00 6.00 7.00 9.00 8.00 90. 09 09009 FORTVILLE CLINIC 4, 801 47. 789 90. 09 0 09100 EMERGENCY 91.00 1,004,105 C 314, 217 42, 517 251, 773 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94 00 94 00 0 0 00000 09500 AMBULANCE SERVICES 0 95.00 0 0 0 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 97.00 99. 00 109900 CMHC 0 99 00 0 0 0 99. 10 09910 CORF 0 0 99. 10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 Ω 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 0 105. 00 0 106.00 10600 HEART ACQUISITION 0 0 0 0 0 106.00 0 οĺ 107. 00 10700 LIVER ACQUISITION 0 0 107.00 0 108.00 10800 LUNG ACQUISITION 0 0 0 108.00 109. 00 10900 PANCREAS ACQUISITION 0 109.00 0 0 0 0 110.00 110.00 11000 INTESTINAL ACQUISITION 0 0 111.00 11100 I SLET ACQUISITION 0 r 0 0 0 1111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115, 00 0 0 0 0 116. 00 11600 HOSPI CE C 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 21, 980, 705 0 8, 417, 693 476, 282 2, 978, 771 118. 00 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 4.738 48.390 0 190. 01 19001 WELLNESS CENTERS 333, 758 0 49, 233 16, 631 190. 01 190. 02 19002 EMPLOYED ORTHO MD 0 190.02 0 0 0 0 190. 03 19003 NORTHVI EW CONV. (LTC) 106, 795 0 36, 794 0 190.03 190. 04 19004 SUMMIT CONV. (LTC) 62, 509 0 36, 794 0 190, 04 190. 05 19005 PARKVI EW CONV. (LTC) 92, 215 0 36, 794 0 190.05 190. 06 19006 MONTI CELLO HSE. (ASS' TD LVG.) 25, 980 0 0 0 0 0 0 0 0 0 0 190.06 0 36, 794 190. 07 19007 NH PARK PLACE (LTC) 10 059 0 O 0 190.07 190. 08 19008 MADISON PLACE OF ELWOOD (LTC) 0 190. 08 0 0 0 190. 09 19009 SPINE SURGEON 0 0 0 190. 09 190. 10 19010 CLINICAL RESEARCH CENTER 202.318 0 83.138 0 190, 10 190. 11 19011 ONCOLOGI ST 0 190. 11 0 0 190. 12 19012 MEDICAL INTERNIST 41, 579 0 0 0 190. 12 190. 13 19013 RHEUMATOLOGY 0 190. 13 202, 543 190. 14 19014 ROCK STEADY BOXING 36, 410 0 0 190, 14 71, 542 191. 00 19100 RESEARCH C C 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 340, 382 744, 274 0 10, 163 192. 00 0 192. 01 19201 MUNCIE MD OFFICES 25, 323 0 230, 517 0 192. 01 192. 02 19202 FOUNDATION 0 192. 02 Ω 14, 284 187, 696 192. 03 19203 SP0E 0 C 0 0 192. 03 192. 04 19204 HEALTHY HEART 53, 805 614 0 192.04 192. 05 19205 VACANT SPACE 0 24, 356 0 0 192. 05 2, 385 192. 07 19207 PARK PLACE CENTER 0 192 07 Ω 124 C192. 08 19208 RENTAL PROPERTY - 1924 MADI SON 9, 212 0 58, 422 0 0 192. 08 192. 09 19209 RESIDENTIAL PROPERTY - 1430 N MADISO 0 192.09 6,009 50, 156 200.00 Cross Foot Adjustments 200.00 201 00 Negative Cost Centers Ω 0 201 00 202.00 TOTAL (sum lines 118 through 201) 23, 724, 545 9, 939, 181 476, 896 3, 005, 565 202. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet B	
From 01/01/2017	Part	
To 12/31/2017	Date/Time Prepared:	5/14/2018 1:52 pm

						5/14/2018 1:5:	2 pm
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	,
				ADMI NI STRATI ON	SERVI CES & SUPPLY		
		10.00	11. 00	13. 00	14. 00	15. 00	
	GENERAL SERVICE COST CENTERS						
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	01000 DI ETARY	2, 368, 409					10. 00
11. 00	01100 CAFETERI A	0	1, 238, 179				11.00
13.00	01300 NURSING ADMINISTRATION	0	19, 524	2, 054, 156			13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	50, 570	1	2, 862, 032		14. 00
15. 00	01500 PHARMACY	0	35, 202	1	8, 511	3, 143, 701	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	36, 852	0	251	0	16.00
17. 00 19. 00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	17. 00 19. 00
20. 00	02000 NURSING SCHOOL		0		0	0	20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD		0		0	0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	o	0	Ö	0	Ö	22. 00
23. 00	02300 PARAMED ED PRGM-(EMS)	O	0	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	2, 028, 390	368, 427	1, 285, 532	137, 753	0	30.00
31. 00	03100 INTENSIVE CARE UNIT	332, 400	68, 092	237, 586	41, 815	0	31. 00
32. 00	03200 CORONARY CARE UNIT	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 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0	0	0	0	34. 00 40. 00
41. 00	04100 SUBPROVIDER - TPF		0	0	0	0	41. 00
42. 00	04200 SUBPROVI DER		0		0	0	42. 00
43. 00	04300 NURSERY		23, 057	80, 451	0	Ö	43. 00
44. 00	04400 SKILLED NURSING FACILITY	o	0	0	0	Ö	44. 00
45.00	04500 NURSING FACILITY	0	0	O	0	0	45.00
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	269	129, 138		451, 943	0	50.00
51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	269 0	129, 138 0	450, 587 0	451, 943 0	0	51.00
51. 00 52. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	1	0		0	0	51. 00 52. 00
51. 00 52. 00 53. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	1	0 0 7, 531	0 0 0	0 0 159	0 0 18, 801	51. 00 52. 00 53. 00
51. 00 52. 00 53. 00 54. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC	1	0	0 0 0	0	0 0 18, 801 1, 424	51. 00 52. 00 53. 00 54. 00
51. 00 52. 00 53. 00 54. 00 55. 00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	1	0 0 7, 531 56, 857 0	0 0 0 0	0 0 159 3, 120 0	0 0 18, 801	51. 00 52. 00 53. 00 54. 00 55. 00
51. 00 52. 00 53. 00 54. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC	1	0 0 7, 531	0 0 0	0 0 159	0 0 18, 801 1, 424 0	51. 00 52. 00 53. 00 54. 00
51. 00 52. 00 53. 00 54. 00 55. 00 56. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	1	0 0 7, 531 56, 857 0 4, 953	0 0	0 0 159 3, 120 0 530	0 0 18, 801 1, 424 0 61	51. 00 52. 00 53. 00 54. 00 55. 00 56. 00
51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON	0 0 0 0 0 0	0 7, 531 56, 857 0 4, 953 10, 277 8, 037 20, 191	0 0 0	0 0 159 3, 120 0 530 8, 277 299 6, 634	0 0 18, 801 1, 424 0 61 0 47	51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00
51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC 05500 RADIOLOGY-THERAPEUTIC 05600 RADIOISOTOPE 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY	0 0 0 0 0 0 0	0 7, 531 56, 857 0 4, 953 10, 277 8, 037 20, 191 69, 296		0 0 159 3, 120 0 530 8, 277 299 6, 634 5, 771	0 0 18, 801 1, 424 0 61 0 47 0	51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00
51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 01	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC 05500 RADIOLOGY-THERAPEUTIC 05600 RADIOLOGY-THERAPEUTIC 05600 CT SCAN 05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY	0 0 0 0 0 0	0 7, 531 56, 857 0 4, 953 10, 277 8, 037 20, 191		0 0 159 3, 120 0 530 8, 277 299 6, 634	0 0 18, 801 1, 424 0 61 0 47 0	51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01
51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 01 61. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY	0 0 0 0 0 0 0	0 7, 531 56, 857 0 4, 953 10, 277 8, 037 20, 191 69, 296		0 0 159 3, 120 0 530 8, 277 299 6, 634 5, 771	0 0 18, 801 1, 424 0 61 0 47 0 0	51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01 61. 00
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51. 00 52. 00 53. 00 54. 00 55. 00 57. 00 58. 00 59. 00 60. 01 61. 00 62. 00 63. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0 0 0 0 0 0 0	0 7, 531 56, 857 0 4, 953 10, 277 8, 037 20, 191 69, 296		0 0 159 3, 120 0 530 8, 277 299 6, 634 5, 771	0 0 18, 801 1, 424 0 61 0 47 0 0	51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 60. 00 60. 01 61. 00 62. 00 63. 00
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Peri od: Worksheet B From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared:

			10	12/31/2017	5/14/2018 1:52 pm	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
, , , , , , , , , , , , , , , , , , ,			ADMI NI STRATI ON	SERVICES &		
				SUPPLY		
	10.00	11. 00	13. 00	14. 00	15. 00	
90. 08 09008 0/P LAB	0	0	0	0	0 90.	. 08
90. 09 09009 FORTVILLE CLINIC	0	0	0	0	0 90.	. 09
91. 00 09100 EMERGENCY	7, 350	92, 357	0	49, 054	0 91.	. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.	. 00
OTHER REIMBURSABLE COST CENTERS	<u> </u>			'		
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0 94.	. 00
95. 00 09500 AMBULANCE SERVICES	o	0	l o	o	0 95.	. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	o	0	O	o		. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	o	0	0	o		. 00
99. 00 09900 CMHC	0	0	0	0	0 99.	
99. 10 09910 CORF	0	0	ا	0	0 99.	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0	0 100.	
101. 00 10100 HOME HEALTH AGENCY		0		0	0 101.	
SPECIAL PURPOSE COST CENTERS	<u> </u>		<u> </u>	۷۱	0 101.	. 00
105. 00 10500 KIDNEY ACQUISITION	0	0	0	0	0 105.	00
106. 00 10600 HEART ACQUI SI TI ON	o	0		0	0 106.	
107. 00 10700 LI VER ACQUI SI TI ON		0		0	0 107.	
108. 00 10800 LUNG ACQUISITION	o o	0		0	0 108.	
109. 00 10900 PANCREAS ACQUISITION		0		0	0 109.	
110. 00 11000 I NTESTI NAL ACQUI SI TI ON		0		0	0 110.	
111. 00 11100 SLET ACQUISITION		0		0	0 111.	
113. 00 11300 NTEREST EXPENSE		O		ď	113.	
114. 00 11400 UTI LI ZATI ON REVI EW-SNF					114.	
115. OO 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0	0 115.	
116. 00 11600 HOSPI CE	0	0		0	0 116.	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 368, 409	1, 161, 481	2, 054, 156	2, 860, 914	3, 143, 676 118.	
NONREI MBURSABLE COST CENTERS	2, 300, 409	1, 101, 401	2,034,130	2, 000, 914	3, 143, 070 116.	. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	O	O	0 190.	$\cap \cap$
190. 01 19001 WELLNESS CENTERS		20, 518		73	0 190.	
190. 02 19002 EMPLOYED ORTHO MD		20, 310		75	0 190.	
190. 03 19003 NORTHVI EW CONV. (LTC)		8, 591		150	0 190.	
190. 04 19004 SUMMIT CONV. (LTC)	0	4, 626		130	0 190.	
190. 05 19005 PARKVI EW CONV. (LTC)	0	7, 365		0	0 190.	
190. 06 19006 MONTI CELLO HSE. (ASS' TD LVG.)	0	1, 843		0	0 190.	
190. 07 19007 NH PARK PLACE (LTC)		828		0	0 190.	
190. 08 19008 MADISON PLACE OF ELWOOD (LTC)	0	020		0	0 190.	
190. 09 19009 SPI NE SURGEON		0		0	0 190.	
190. 10 19010 CLI NI CAL RESEARCH CENTER	0	19, 475		162	2 190.	
190. 11 19011 ONCOLOGIST	0	17, 475		102	0 190.	
190. 12 19012 MEDI CAL I NTERNI ST	0	3, 136		58	0 190.	
190. 13 19013 RHEUMATOLOGY	0	1, 319		20	0 190.	
190. 13 19013 RHEUWATOLOGT 190. 14 19014 ROCK STEADY BOXING	0	2, 856		0	0 190.	
191. 00 19100 RESEARCH	0	2, 630		2	0 190.	
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		59	0 191.	
192. 01 19201 MUNCI E MD OFFICES	0	0		0	0 192.	
192. 02 19202 FOUNDATION	0	2, 899		1	0 192.	
192. 03 19203 SP0E	0	2, 099		1		
192.04 19204 HEALTHY HEART		3, 242		606	0 192. 23 192.	
		ى, 242 م		000	0 192.	
192. 05 19205 VACANT SPACE 192. 07 19207 PARK PLACE CENTER		0		O O	0 192.	
192.08 19207 PARK PLACE CENTER 192.08 19208 RENTAL PROPERTY - 1924 MADISON		0		U -	0 192.	
192.09 19208 RENTAL PROPERTY - 1924 WADISON 192.09 19209 RESIDENTIAL PROPERTY - 1430 N MADISO		0		/	0 192.	
200.00 Cross Foot Adjustments	١	Ü	١	Ч	200.	
201.00 Regative Cost Centers		^			0 201.	
	i Ul	U	1 0	UI	UJ2U1.	. 00
202.00 TOTAL (sum lines 118 through 201)	2, 368, 409	1, 238, 179	2, 054, 156	2, 862, 032	3, 143, 701 202.	$\cap \cap$

In Lieu of Form CMS-2552-10

Period:	Worksheet B	
From 01/01/2017	Part	
To 12/31/2017	Date/Time Prepared:	5/14/2018 1:52 pm

11. 00 0 10100 (ASETERIA) 11. 00 0 10400 (ASETERIA) 11. 00 0 10400 (ASETERIA SERVICES & SUPPLY) 11. 00 0 10400 (PARRIACY) 11. 00 10400						0 12/31/2017	5/14/2018 1:5	
COST Center Description								
BENNISM. SHAVICE CIDST CHRISES LIBERATY 16.00 17.00 19.00 20.00 21.00		Cost Center Description	MEDICAL	SOCIAL SERVICE	NUNDHASTULTVN	MIIDSI NG SCHOOL		
LIBRARY 16.00 17.00 19.00 20.00 21.00		cost center bescription		SOCIAL SERVICE		NUKST NG SCHOOL		
GRINSON STRIVET CISTS CHITTEES								
0.00 0.00 QAP REL COSTS-BLDG & FIXT			16. 00	17. 00	19. 00	20.00	21. 00	
2.00 0.0200 CAP REL COSTS-MUSE EQUIP			T	T	Т	T	Γ	
0.000 DAMPOLE BENEFITS DEPARTMENT		l I						1.00
0.000 0.00		l I						2. 00 4. 00
0.000 0.00		l I						5. 00
0.000 0.0700 0.0FRATION OF PLANT		i i						6. 00
9.90 00900 HOUSERCEP IN 6 01100 CAFTER IA 11.00 01100 DETARY 11.00 DETARY 1		i i						7. 00
10.00 01000 DIEJARY	8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
11. 0.0 01.00 CAFETERIA		l l						9. 00
13.0 0 01300 NURSI NC ADMINISTRATION		l l						10.00
14. 00 01400 CENTRAL SERVICES & SUPPLY		l l						11.00
15.00 01500 PHARMACY		l l						13. 00 14. 00
10 00 01 00 MEDICAL RECORDS & LIBRARY 2,522,532 0 0 0 0 0 0 0 0 0		l l						15. 00
17.00 01700 SOCIAL SERVICE 0 0 0 0 0 0 0 0 0		l l	2, 522, 532					16. 00
20.00 020000 NURSI NS SCHOOL 0 0 0 0 0 0 0 0 0		l l		1				17. 00
22.00 02.00 RA SERVICES-SALARY & FRINCES APPRVD 0 0 0 23.00 02.300 RAS SERVICES-OTHER PREAM COSTS APPRVD 0 0 0 23.00 02.300 RAS SERVICES-OTHER PREAM COSTS APPRVD 0 0 0 0 23.00 02.300 RAS SERVICES-OTHER PREAM COSTS APPRVD 0 0 0 0 0 0 0 0 0	19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	C			19. 00
22.00 02200 IAR SERVICES-OTHER PROM. COSTS APPRVD 0 0 0 0 0 0 0 0 0			0	0		0		20. 00
123.00 023.00 PARAULD ED PROM_CEMS 0 0 0 0 0 0 0 0 0		i	0	0			0	21. 00
INPATI ENT ROUTINE SERVICE COST CENTERS		l I		1				22. 00
30.00 03000 ADULTS & PEDI ATRIC S 058, 453 0 0 0 0 0 0 0 0 0	23.00	• • •	0	0				23. 00
31.00	30 00		658 453	0		0	0	30. 00
32.00 03200 CORDINARY CARE UNIT		1				_		31. 00
334.00 03400 SURPROVIDER - I PF 0							1	32. 00
40.00 04000 SUBPROVIDER - IPF	33.00	03300 BURN INTENSIVE CARE UNIT	0	0	C	0	0	33. 00
41.00 04100 SUBPROVI DER		l I	0	0	C	0	0	34. 00
42.00 04200 SUBPROVI DER 43.00 04300 NURSERY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		l I	0	0	0	0	1	40.00
43.00 04300 NURSERY		l I	0	0		0	1	41.00
44.00 04400 SKILLED NURSING FACILITY 0 0 0 0 0 0 0 0 0		l I	0	0		0	· -	42. 00 43. 00
45.00 04500 NURSING FACILITY		i i	0	1		0		44. 00
ANCILLARY SERVICE COST CENTERS		l I	0	1	i c	0		45. 00
50. 00 5000	46.00	l I	0	0	C	0	0	46. 00
51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 52.00 05200						,		
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 0 5 5 5 5		l l						50.00
53.00		l l	_	1		0		51.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 19,754 0 0 0 0 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 0				1	1	0	_	52. 00 53. 00
55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 0		l l		1		0		54. 00
57. 00 05700 CT SCAN 0 05800 0ASON MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		l l	0	0	l c	0		55. 00
58. 00	56.00	05600 RADI OI SOTOPE	0	0	C	0	0	56. 00
59. 00 05900 CARDIAC CATHETERIZATION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	57.00	05700 CT SCAN	0	0	C	0	0	57. 00
60. 00 06000 LABORATORY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	C	0		58. 00
60.01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0			0	0	0	0	_	59. 00
61. 00		i i	0	0		0	0	60. 00 60. 01
62. 00		l I	0	0		0	l 0	61. 00
63. 00			0	0	l c	0	o	62. 00
65. 00		l I	0	0	C	0		63.00
66. 00	64.00	06400 I NTRAVENOUS THERAPY	0	0	C	0	0	64. 00
67. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		l l	0	0	C	0	0	65. 00
68. 00		l I	0	0	0	0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		l I	0	0		0	0	67.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 7 7 7 7 7		l I				0		68. 00 69. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 0 0 0		l I	0	0	, n	0	1	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 0 0		l I	0	0	0	O		71. 00
74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 75. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 0 0 0 0	72.00		0	0		0	O	72. 00
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0		l I	0	0	0	0	0	73. 00
OUTPATIENT SERVICE COST CENTERS		l l	0	0	0	0		74.00
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0	75. 00		0	0		0	0	75. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 90. 00 09000 CLINIC 0 0 0 0 0 0 0 90. 01 09001 WOUND/OSTOMY CLINIC 595, 241 0 0 0 0 0 0	go 🗥			_		^		88. 00
90. 00 09000 CLI NI C				1		0		89.00
90. 01 09001 WOUND/OSTOMY CLINIC 595, 241 0 0 0 0		l l	0		0	n	ا	90.00
		l l	595, 241	0		Ö	0	90. 01
אט. טב נטאטטבוגועט בינואול בינ		09002 KIDS PLUS CLINIC	0	0	C	0	0	90. 02
			0	0	C	0	0	90. 03
		i	0	0	0	0	_	90. 04
90. 05 09005 ANTI COAGULATI ON CLI NI C 0 0 0 0 0 9	90.05	U9UU5 ANTI CUAGULATI UN CLINI C	1 0	1 0	l C	0	<u> </u> 0	90. 05

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared: | 5/14/2018 1:52 pm

			'		5/14/2018 1:5	2 pm
					INTERNS &	
					RESI DENTS	
Cost Center Description	MEDI CAL	SOCIAL SERVICE	NONPHYSICI AN	NURSING SCHOOL	SERVI CES-SALAR	
	RECORDS &		ANESTHETI STS		Y & FRINGES	
	LI BRARY					
	16. 00	17. 00	19. 00	20.00	21. 00	
90. 06 09006 PREGNANCY PLUS	C	0	0	0	0	90. 06
90. 07 09007 0/P LAB	C	0	0	0	0	90. 07
90. 08 09008 0/P LAB	C	0	0	0	0	90. 08
90. 09 09009 FORTVILLE CLINIC	C	o	0	0	0	90. 09
91. 00 09100 EMERGENCY	713, 324	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS	<u>'</u>			<u>'</u>	•	
94. 00 09400 HOME PROGRAM DI ALYSI S	C	0	0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES		ol	0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		ol	0	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	C		0	0	0	97. 00
99. 00 09900 CMHC	i c		0	0	0	99. 00
99. 10 09910 CORF			0	0	0	99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM			0	0	0	100.00
101. 00 10100 HOME HEALTH AGENCY		1	0	0	1	101. 00
SPECIAL PURPOSE COST CENTERS		,				101.00
105.00 10500 KIDNEY ACQUISITION	C	0	0	0	0	105. 00
106. 00 10600 HEART ACQUISITION					l e	106. 00
107. 00 10700 LIVER ACQUISITION			0	0		100.00
107.00 10700 EIVER ACQUISITION			0	0	l e	107.00
109. 00 10900 PANCREAS ACQUISITION			0	0	l	
			0	0	l	109. 00
110.00 11000 I NTESTI NAL ACQUI SI TI ON			0	0	l	110.00
111. 00 11100 I SLET ACQUI SI TI ON	C	١	U	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	U	0	0	115. 00
116. 00 11600 HOSPI CE	2 4// 5/4			0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 466, 564	0	0	0	0	118. 00
NONREI MBURSABLE COST CENTERS	1 007	, ,				100 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 097		0		•	190. 00
190. 01 19001 WELLNESS CENTERS	C	1	0	0	•	190. 01
190. 02 19002 EMPLOYED ORTHO MD		0	0	0	l	190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)		0	0	0	l	190. 03
190. 04 19004 SUMMI T CONV. (LTC)		0	0	0	•	190. 04
190. 05 19005 PARKVI EW CONV. (LTC)		0	0	0	l	190. 05
190. 06 19006 MONTI CELLO HSE. (ASS' TD LVG.)	C	0	0	0	l	190. 06
190. 07 19007 NH PARK PLACE (LTC)		0	0	0	1	190. 07
190. 08 19008 MADISON PLACE OF ELWOOD (LTC)	C	0	0	0	1	190. 08
190. 09 19009 SPI NE SURGEON	C	0	0	0	1	190. 09
190. 10 19010 CLINI CAL RESEARCH CENTER	C	0	0	0	1	190. 10
190. 11 19011 ONCOLOGI ST	C	0	0	0	l	190. 11
190. 12 19012 MEDI CAL I NTERNI ST	C	0	0	0		190. 12
190. 13 19013 RHEUMATOLOGY	C	0	0	0	l	190. 13
190. 14 19014 ROCK STEADY BOXING	C	0	0	0	l e	190. 14
191. 00 19100 RESEARCH	C	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	54, 871	0	0	0		192. 00
192.01 19201 MUNCIE MD OFFICES	C	0	0	0	0	192. 01
192. 02 19202 FOUNDATI ON	C	0	0	0	0	192. 02
192. 03 19203 SP0E	C	0	0	0	0	192. 03
192. 04 19204 HEALTHY HEART	C	0	0	0	l e	192. 04
192. 05 19205 VACANT SPACE	C	0	0	0		192. 05
192.07 19207 PARK PLACE CENTER	C	0	0	0		192. 07
192.08 19208 RENTAL PROPERTY - 1924 MADISON	C	0	0	0	0	192. 08
192.09 19209 RESIDENTIAL PROPERTY - 1430 N MADISO	C	0	0	0	0	192. 09
200.00 Cross Foot Adjustments			0	0		200. 00
201.00 Negative Cost Centers	C	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	2, 522, 532	0	0	0	0	202. 00

NAME PROPERTY PR		ILLOCATION - GENERAL SERVICE COSTS	COMMUNITY HOST	Provider Co	F	Period: From 01/01/2017 To 12/31/2017		pared:
BERRIAD SERVICE COST CERTIESS		Cost Center Description	RESI DENTS SERVI CES-OTHER		Subtotal	Residents Cost & Post Stepdown		
1.00			22. 00	23. 00	24. 00		26. 00	
2.00 00.000 CAP FILL COSTS-MOBILE EQUIP	1 00							1 00
0.00 0.000	2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 PARAMED ED PRGM-(EMS)	0	0				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
32.00 03200 CORONARY CARE UNIT 0 0 0 0 0 0 32.00	30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	1	0				30. 00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0		03200 CORONARY CARE UNIT	0	0) -,,			32. 00
40.00 04000 SUBPROVI DER - IPF			0	0		0	_	
11 00 04100 SUBPROVI DER N			0	0			_	1
43. 00 04300 NURSERY			0	Ö		o o	_	
44. 00 04400 SALLED NURSING FACILITY	42.00	04200 SUBPROVI DER	0	0) (0	0	42.00
45. 00 04500 NURSI NG FACILITY		1	0	0	1, 909, 079			
A6, 00 04600 O1 O1 O2 O3 O3 O4 O4 O4 O5			0	0		-		
ANCIL LARY SERVICE COST CENTERS S0.00 Composition			0	0				
51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 0 0		ANCILLARY SERVICE COST CENTERS		-				
S2.00 05300 05300 0510VERY ROOM & LABOR ROOM 0 0 0 0 327,770 0 327,770 53.00			1	0	1			
S3. 00 05300 AMESTHESI OLOGY 0 0 327, 770 0 327, 770 53. 00		+ I	0	0				
54.00 05400 RADI OLOGY-DI AGNOSTIC 0 0 6,092,185 0 6,092,185 54.00			0	0	327. 770		_	
56. 00 05600 RADI OI SOTOPE 0 0 951, 925 0 951, 925 56. 00	54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0				54. 00
57. 00 05700 CT SCAN 0 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0 0 1, 245, 276 0 1, 245, 276 58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0 0 1, 245, 276 0 1, 245, 276 58. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 1, 933, 220 0 1, 933, 220 0 1, 933, 220 0 1, 933, 220 0 1, 933, 220 0 1, 933, 220 0 1, 933, 220 0 1, 933, 220 0 1, 933, 220 0 0 0 0 0 0 0 0 0			0	0	(0		
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 1, 245, 276 0 1, 245, 276 58. 00 59. 00 05900 CARDIAC CATHETERIZATION 0 0 1, 933, 220 0 60. 01 06000 LABORATORY 0 0 0 6, 128, 436 0 60. 01 06001 BLOOD LABORATORY 0 0 0 0 61. 00 06001 BLOOD LABORATORY 0 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 385, 920 0 385, 920 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 65. 00 06500 RESPIRATORY THERAPY 0 0 0 1, 626, 045 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 1, 626, 045 65. 00 67. 00 06600 PHYSI CAL THERAPY 0 0 0 0 779, 200 68. 00 06800 SPECH PATHOLOGY 0 0 0 0 0 69. 00 06900 ELECTROCARDIOLOGY 0 0 0 0 69. 00 06900 ELECTROCENCEPHALOGRAPHY 0 0 0 0 0 71. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 1, 126, 680 0 1, 126, 680 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 16, 644, 757 0 16, 644, 757 71, 00 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 12, 564, 530 0 12, 564, 530 72, 00 71. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 75. 00 09000 CLINIC 0 0 0 0 0 75. 00 09000 CLINIC 0 0 0 0 0 75. 00 09000 CLINIC 0 0 0 0 75. 00 09000 CLINIC 0 0 0 0 0 75. 00 09000 CLINIC 0 0 0 0 75. 00 09000 CLINIC 0 0 0 0 75. 00 09000 CLINIC 0 0 0 75. 00 09000 CLINIC 0			0	0				
59.00 05900 CARDI AC CATHETERIZATION 0 0 1,933,220 0 1,933,220 59.00		1 1	0	0				1
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0	59. 00		0	0				
61. 00			0	0	1			
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 385,920 0 385,920 62. 00 63. 00 64. 00 6400 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 0 63. 00 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 1, 626, 045 0. 1, 626, 045 65. 00 06500 RESPIRATORY THERAPY 0 0 0 1, 626, 045 65. 00 06700 0 000 0 0 0 0 0 0			U	0	,	ט ט		1
64. 00			0	0	385, 920	0	_	1
65. 00 06500 RESPIRATORY THERAPY 0 0 1, 626, 045 0 1, 626, 045 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 3, 415, 565 0 3, 415, 565 66. 00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 779, 200 0 779, 200 67. 00 68. 00 06900 SPEECH PATHOLOGY 0 0 362, 010 0 362, 010 0 362, 010 0 362, 010 0 0 902, 245 0 902, 245 0 0 902, 245 0 902		1	0	0) (0		1
66. 00			0	0	1 626 045	0		1
67. 00			0	0				
69. 00 06900 ELECTROCARDI OLOGY 0 0 902, 245 0 902, 245 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 1, 126, 680 0 1, 126, 680 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 16, 044, 757 0 16, 044, 757 71. 00 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 75. 0			0	0				1
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 1, 126, 680 0 1, 126, 680 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 16, 044, 757 0 16, 044, 757 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 12, 564, 530 0 12, 564, 530 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 9, 993, 973 0 9, 993, 973 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 442, 408 0 442, 408 74. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 0 0 0 0			0	0				1
71. 00			0	0				1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 9, 993, 973 0 9, 993, 973 73. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 90. 00 09000 CLINIC 0 0 0 0 0 90. 01 09001 WOUND/OSTOMY CLINIC 0 0 0 1, 630, 179 90. 01 90. 02 09002 KIDS PLUS CLINIC 0 0 98, 842 0 98, 842 90. 02		1 1	Ö	0				
74. 00			0	0				
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0			0	0				
S8. 00 OB800 RURAL HEALTH CLINIC O O O O O O S80.00		1 1	0	0	1			
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89. 00 90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0		OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC 0 0 0 0 0 90. 00 90. 01 09001 WOUND/OSTOMY CLINIC 0 0 1,630,179 0 1,630,179 90. 01 90. 02 09002 KIDS PLUS CLINIC 0 0 98,842 0 98,842 90. 02			0	0	1			
90. 01 09001 WOUND/OSTOMY CLINIC 0 1,630,179 0 1,630,179 90. 01 90. 02 09002 KLDS PLUS CLINIC 0 0 98,842 0 98,842 90. 02			0	0		0	_	
90. 02 09002 KI DS PLUS CLI NI C 0 98, 842 0 98, 842 90. 02				0	1, 630, 179		_	
90. 03 09003 0NCOLOGY 0	90. 02	09002 KIDS PLUS CLINIC	0	0	98, 842	0	98, 842	90. 02
	90. 03	09003 ONCOLOGY	0	0	-7, 495, 395	5 0	-7, 495, 395	90. 03

| Peri od: | Worksheet B | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0113

				To 12/31/2017	Date/Time Pre 5/14/2018 1:5	
Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM. COSTS	PARAMED ED PRGM-(EMS)	Subtotal	Intern & Residents Cost & Post	Total	Σ βιιι
				Stepdown Adjustments		
	22.00	23. 00	24.00	25. 00	26.00	
90. 04 09004 MUNCI E CLI NI C	0	0	1			•
90. 05 09005 ANTI COAGULATI ON CLINIC	0	0	450, 04		450, 047	90. 05
90. 06 09006 PREGNANCY PLUS	0	0	151, 09		151, 098	1
90. 07 09007 0/P LAB 90. 08 09008 0/P LAB	0	0	•	0 0	0	90. 07 90. 08
90. 09 09009 FORTVILLE CLINIC		0	76, 18	ٽ -	76, 184	90.09
91. 00 09100 EMERGENCY	O	0	7, 409, 09			
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92. 00
OTHER REIMBURSABLE COST CENTERS			ı			04.00
94. 00 09400 HOME PROGRAM DIALYSIS 95. 00 09500 AMBULANCE SERVICES	0	0	1	0 0	l	94. 00 95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0	1	0 0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	o	0		0 0	0	97. 00
99. 00 09900 CMHC	0	0		0	0	99. 00
99. 10 09910 CORF	0	0	1	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY	0	0	1	0 0 0		100. 00 101. 00
SPECIAL PURPOSE COST CENTERS	J U	0		0	0	101.00
105. 00 10500 KIDNEY ACQUISITION	0	0		0 0	0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	O	0)	0	0	106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0	•	107. 00
108.00 10800 LUNG ACQUISITION 109.00 10900 PANCREAS ACQUISITION	0	0		0 0 0	l	108. 00 109. 00
110.00 11000 PANCREAS ACQUISITION		0		0 0		1109.00
111. 00 11100 SLET ACQUI SI TI ON	O	0		0 0	l	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	1	0	l	115. 00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	1	0 6 0		116.00
NONREI MBURSABLE COST CENTERS	<u> </u>		120,017,00	0	120, 017, 000	1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	77, 50	9 0	77, 509	190. 00
190. 01 19001 WELLNESS CENTERS	0	0	_, _, _,		_,,	
190. 02 19002 EMPLOYED ORTHO MD	0	0	1	0	l	190. 02
190. 03 19003 NORTHVIEW CONV. (LTC) 190. 04 19004 SUMMIT CONV. (LTC)		0	677, 14 411, 11		677, 142 411, 114	1
190. 05 19005 PARKVI EW CONV. (LTC)		0	589, 53		589, 537	1
190. 06 19006 MONTI CELLO HSE. (ASS' TD LVG.)	0	0	192, 28		192, 287	1
190. 07 19007 NH PARK PLACE (LTC)	0	0	60, 32		60, 320	1
190.08 19008 MADISON PLACE OF ELWOOD (LTC)	0	0		0	l .	190. 08
190. 09 19009 SPI NE SURGEON 190. 10 19010 CLI NI CAL RESEARCH CENTER		0	1, 299, 32	9 0	l .	190. 09 190. 10
190. 11 19011 ONCOLOGI ST		0	1,277,32	o o		190. 11
190. 12 19012 MEDI CAL I NTERNI ST	0	0	249, 10	3 0	l	
190. 13 19013 RHEUMATOLOGY	0	0			., , == .	
190. 14 19014 ROCK_STEADY_BOXING 191. 00 19100 RESEARCH	0	0	289, 73		289, 737	
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		0	2, 822, 46	0	2, 822, 464	191.00
192. 01 19201 MUNCI E MD OFFICES		0	380, 28		380, 281	1
192. 02 19202 FOUNDATI ON	O	0	1, 127, 26		1, 127, 260	192. 02
192. 03 19203 SPOE	0	0	1	0		192. 03
192. 04 19204 HEALTHY HEART	0	0	322, 70		322, 702	•
192. 05 19205 VACANT SPACE 192. 07 19207 PARK PLACE CENTER		0	38, 46 73			192. 05 192. 07
192. 08 19208 RENTAL PROPERTY - 1924 MADI SON		0	112, 91		l	1
192.09 19209 RESIDENTIAL PROPERTY - 1430 N MADISO	0	0	85, 69		1	
200.00 Cross Foot Adjustments	0	0	1	0		200. 00
201.00 Negative Cost Centers	0	0	1	0 1 0		201. 00
202.00 TOTAL (sum lines 118 through 201)	ı V	U	132, 075, 97	1	132, 075, 971	202.00

Health Financial Systems
COST ALLOCATION STATISTICS In Lieu of Form CMS-2552-10
Worksheet Non-CMS W COMMUNITY HOSPITAL ANDERSON Provider CCN: 15-0113

Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/14/2018 1:52 pm

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVI CE COST CENTERS	1.00	2.00	
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	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & 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	CAFETERI A	11	MAN HOURS	11.00
13.00	NURSI NG ADMINI STRATI ON	13	DI RECT NURS. HRS.	13.00
14.00	CENTRAL SERVI CES & 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	SOCI AL SERVI CE	17	TIME SPENT	17.00
19.00	NONPHYSI CI AN ANESTHETI STS	19	ASSIGNED TIME	19.00
20.00	NURSI NG SCHOOL	20	ASSIGNED TIME	20.00
21. 00	I &R SERVI CES-SALARY & FRI NGES APPRVD	21	ASSIGNED TIME	21.00
22. 00	I &R SERVI CES-OTHER PRGM. COSTS APPRVD	22	ASSIGNED TIME	22. 00
23. 00	PARAMED ED PRGM-(EMS)	23	ASSIGNED TIME	23. 00

| Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0113

				To	12/31/2017	Date/Time Prep 5/14/2018 1:5	
			CAPI TAL REI	LATED COSTS		37 147 2010 1. 3.	2 piii
	Cost Center Description	Di rectly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	cost center bescription	Assigned New	DEDO & TIXI	WVDEE EQUIT	Subtotal	BENEFI TS	
		Capital Related Costs				DEPARTMENT	
		0	1.00	2.00	2A	4. 00	
1 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT						1 00
1. 00 2. 00	00200 CAP REL COSTS-BLDG & FIXT						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	31, 759		50, 851	50, 851	4. 00
5. 00 6. 00	OO5OO ADMINISTRATIVE & GENERAL OO6OO MAINTENANCE & REPAIRS	0	472, 336 0	1	1, 279, 466 0	8, 594 0	5. 00 6. 00
7. 00	00700 OPERATION OF PLANT	0	595, 859	_	878, 748		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	66, 801		66, 801	56	8. 00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	133, 756	1	145, 002		9.00
10. 00 11. 00	01100 CAFETERI A	0	208, 164 39, 405		346, 156 39, 405		10. 00 11. 00
13.00	01300 NURSING ADMINISTRATION	0	51, 375	231	51, 606	922	13. 00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	98, 097 41, 014	1	105, 513		14. 00 15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	61, 916 78, 501	1	66, 694 78, 501	983	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	_	0	0	17. 00
19. 00 20. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	0	0	0	0	19. 00 20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0	0	Ö	0	0	21. 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) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	0	23. 00
30. 00	03000 ADULTS & PEDIATRICS	0	1, 000, 159	232, 012	1, 232, 171	10, 654	30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	132, 308		237, 443		31. 00
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	Ö	0	0	34. 00
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40. 00
41. 00 42. 00	04100 SUBPROVI DER	0	0	0	0	0	41. 00 42. 00
43. 00	04300 NURSERY	0	36, 103	1, 558	37, 661	756	43. 00
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	0	0	45. 00 46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	0		9	0	0	40.00
50.00	05000 OPERATING ROOM	0	427, 699		1, 715, 613		50. 00
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	0	5, 251	_	12, 875	_	53. 00
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	372, 308		747, 532	1, 951	54.00
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	28, 632	0 14, 338	0 42, 970	0 200	55. 00 56. 00
57.00	05700 CT SCAN	0	8, 688	3, 979	12, 667	341	57. 00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	18, 071		42, 909	258	
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	71, 763 151, 132	1	195, 473 360, 151		59. 00 60. 00
60. 01	06001 BLOOD LABORATORY	0	0	1	0	0	60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	11, 294	1 140	0 12, 443	170	61. 00 62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	11, 294		12, 443	170	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	0	13, 901 90, 780		46, 840 93, 960	778 1, 476	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	67, 013		67, 013		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	8, 128		8, 219		68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	29, 597 29, 597		54, 714 63, 180	335 396	69. 00 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	27, 377		03, 100	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0 3, 630	0	0 3, 630	0	73. 00 74. 00
	07500 ASC (NON-DISTINCT PART)	0	3, 030	1	3, 030		75. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88. 00 89. 00
90.00	09000 CLINIC	0	0		0	0	90.00
90. 01	09001 WOUND/OSTOMY CLINIC	0	196, 599	1	201, 486		90. 01
90. 02 90. 03	09002 KIDS PLUS CLINIC 09003 ONCOLOGY	0	30, 118 330, 818	1	30, 118 842, 669		90. 02 90. 03
	09004 MUNCI E CLINIC	0	28, 728		29, 066		90. 04

| Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0113

			To	12/31/2017	Date/Time Pre 5/14/2018 1:5	
		CAPI TAL REI	LATED COSTS		37 147 2010 1.3	2 0111
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New Capital				BENEFITS DEPARTMENT	
	Related Costs				DELAKTIMENT	
	0	1.00	2.00	2A	4. 00	
90. 05 09005 ANTI COAGULATION CLINIC	0	ľ	-,	3, 889	221	90. 05
90. 06 09006 PREGNANCY PLUS	0	45, 776		46, 503	0	90.06
90. 07 09007 0/P LAB 90. 08 09008 0/P LAB	0	0	0	0	0	90. 07 90. 08
90. 09 09009 FORTVILLE CLINIC	0	22, 994		22, 994	0	90.08
91. 00 09100 EMERGENCY	0	151, 190		270, 519	2, 804	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0	·	92. 00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DIALYSIS	0	ľ		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 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	0	0	0	96. 00 97. 00
99. 00 09900 CMHC	0	1 0	0	0	0	99.00
99. 10 09910 CORF	0	Ö	Ö	Ö	Ö	99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	O	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS				al		405 00
105. 00 10500 KIDNEY ACQUISITION 106. 00 10600 HEART ACQUISITION	0	0		0		105. 00 106. 00
107. 00 10700 LIVER ACQUISITION	0		0	0		107. 00
108. 00 10800 LUNG ACQUISITION	0	ĺ	Ö	Ö		107. 00
109.00 10900 PANCREAS ACQUISITION	0	O	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
111. 00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
113. 00 11300 INTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.)	0	,	0	0	0	114. 00 115. 00
116. 00 11600 HOSPI CE	0		0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	5, 150, 246		9, 543, 451	47, 940	
NONREI MBURSABLE COST CENTERS				,		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23, 284		23, 284		190. 00
190. 01 19001 WELLNESS CENTERS	0	23, 689		228, 781		190. 01
190. 02 19002 EMPLOYED ORTHO MD 190. 03 19003 NORTHVI EW CONV. (LTC)	0	17 704	_	17 704		190. 02
190. 03 19003 NORTHVIEW CONV. (LTC)	0	17, 704 17, 704	1	17, 704 17, 704		190. 03 190. 04
190. 05 19005 PARKVI EW CONV. (LTC)	0	17, 704		17, 704		190. 05
190. 06 19006 MONTI CELLO HSE. (ASS' TD LVG.)	0	17, 704		17, 704		190. 06
190. 07 19007 NH PARK PLACE (LTC)	0	0	0	0	31	190. 07
190.08 19008 MADISON PLACE OF ELWOOD (LTC)	0	0	0	0		190. 08
190. 09 19009 SPI NE SURGEON	0	40.000	0	42.047		190. 09
190. 10 19010 CLI NI CAL RESEARCH CENTER 190. 11 19011 ONCOLOGI ST	0	40, 003	2, 044	42, 047		190. 10 190. 11
190. 12 19012 MEDI CAL I NTERNI ST	0	0	0	0		190. 11
190. 13 19013 RHEUMATOLOGY	0	Ö	2, 375	2, 375		190. 13
190. 14 19014 ROCK STEADY BOXING	0	34, 424		34, 424	75	190. 14
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	358, 118		365, 453		192. 00
192. 01 19201 MUNCIE MD OFFICES	0	110, 916	I	110, 916		192. 01
192. 02 19202 FOUNDATI ON 192. 03 19203 SP0E	0	6, 873 0		6, 873 0		192. 02 192. 03
192. 04 19204 HEALTHY HEART		0	785	785		192. 03
192. 05 19205 VACANT SPACE	0	11, 719		11, 719		192. 05
192.07 19207 PARK PLACE CENTER	0	0	0	0	0	192. 07
192. 08 19208 RENTAL PROPERTY - 1924 MADI SON	0	28, 110		28, 110		192. 08
192. 09 19209 RESIDENTIAL PROPERTY - 1430 N MADISO	0	24, 133	0	24, 133		192. 09
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		0		0		200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	0			10, 493, 167		
	1	1 5,002,001	1 ., 510, 550	.5, 175, 107	55, 551	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0113

Period: Worksheet B From 01/01/2017 Part II To 12/31/2017 Date/Time Prepared:

5/14/2018 1:52 pm Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL **REPAIRS PLANT** LINEN SERVICE 9.00 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 1, 288, 060 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 91, 241 971, 735 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 3.103 0 13.573 83.533 8.00 203, 638 00900 HOUSEKEEPI NG 9.00 24.748 0 27, 178 5.549 9 00 10.00 01000 DI ETARY 17,033 42, 297 5, 446 10.00 11.00 01100 CAFETERI A 10,615 8,007 0 11.00 01300 NURSING ADMINISTRATION 17.537 C 10, 439 1.189 13 00 13 00 0 14.00 01400 CENTRAL SERVICES & SUPPLY 23, 615 19, 932 418 2, 222 14.00 15.00 01500 PHARMACY 27, 103 12, 581 0 1, 283 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 21, 268 15. 951 376 16,00 01700 SOCIAL SERVICE 17.00 0 C C0 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 0 19.00 02000 NURSING SCHOOL 0 0 20 00 0 0 20.00 0 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 0 0 0 21.00 0 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 22 00 0 C 0 0 0 22 00 02300 PARAMED ED PRGM-(EMS) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 98, 029 204.934 29, 927 30.00 203, 223 30.00 31.00 03100 INTENSIVE CARE UNIT 41, 161 26, 884 5, 499 13, 396 31.00 32.00 03200 CORONARY CARE UNIT 0 0 32.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 0 33.00 0 03400 SURGICAL INTENSIVE CARE UNIT 34 00 0 0 0 0 Λ 34 00 40.00 04000 SUBPROVIDER - IPF 0 C 0 0 0 40.00 04100 SUBPROVI DER - I RF 0 41.00 0 0 0 41.00 0 04200 SUBPROVI DER 0 0 42.00 0 0 42.00 04300 NURSERY 43.00 15, 687 C 7, 336 1, 471 43.00 44.00 04400 SKILLED NURSING FACILITY C 0 0 44.00 04500 NURSING FACILITY 45.00 0 C 0 0 0 45.00 46 00 04600 OTHER LONG TERM CARE O 0 46 00 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 86, 904 24, 000 42, 036 50.00 102, 442 51.00 05100 RECOVERY ROOM 0 51.00 C 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 \cap 0 Λ 52.00 53.00 05300 ANESTHESI OLOGY 2,666 0 1,067 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 47, 460 75, 650 2, 163 3, 725 54.00 55 00 05500 RADI OLOGY-THERAPEUTI C Ω 0 55 00 56.00 05600 RADI OI SOTOPE 7,950 C 5,818 259 1, 315 56.00 05700 CT SCAN 8, 193 1, 765 3, 242 57.00 57.00 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 10, 913 0 3, 672 1,037 313 58.00 05900 CARDIAC CATHETERIZATION 15 905 59 00 Ω 59 00 14 581 284 1.565 60.00 06000 LABORATORY 52, 318 0 30, 709 150 2,661 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 2, 295 Ω 470 62 00 3.216 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 63.00 06400 INTRAVENOUS THERAPY 64.00 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 14.186 0 2.825 65.00 1,534 66 00 06600 PHYSI CAL THERAPY 29 138 C 18, 446 33 532 66 00 06700 OCCUPATIONAL THERAPY 5,758 67.00 67.00 13, 616 0 407 68.00 06800 SPEECH PATHOLOGY 3,070 1, 652 0 407 68.00 06900 ELECTROCARDI OLOGY 6,014 69.00 7.567 543 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 9, 309 C 6,014 752 2, 254 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 136, 368 C 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 106, 789 0 72.00 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 63, 079 0 0 0 73.00 74.00 07400 RENAL DIALYSIS 3, 988 C 738 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 75.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 0 90.00 09000 CLI NI C 0 0 90.00 C 0 09001 WOUND/OSTOMY CLINIC 4,990 39, 947 90.01 C 267 4, 132 90.01 90.02 09002 KIDS PLUS CLINIC 333 C 6, 120 0 90.02 09003 ONCOLOGY 90.03 0 67, 219 1.855 0 90.03 90.04 09004 MUNCIE CLINIC 340 0 5.837 90.04 0 09005 ANTICOAGULATION CLINIC C 90.05 90.05 4.071 \cap 0 0 90.06 09006 PREGNANCY PLUS 0 9, 301 0 0 90.06 514 09007 0/P LAB 90.07 0 0 0 90.07 90. 08 09008 0/P LAB 0 0 90.08 0

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | T

			10	3 12/31/2017	5/14/2018 1:5	
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	_ p
,	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5.00	6. 00	7. 00	8. 00	9. 00	
90. 09 09009 FORTVILLE CLINIC	261	0	4, 672	0	0	90. 09
91. 00 09100 EMERGENCY	54, 515	0	30, 720	7, 447	17, 059	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				•		92.00
OTHER REIMBURSABLE COST CENTERS	'					
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95. 00 09500 AMBULANCE SERVI CES	o	0	0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	ol	0	0	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	ol	0	0	0	0	97. 00
99. 00 09900 CMHC	ol	0	0	0	0	99. 00
99. 10 09910 CORF	ol	0	0	0	0	99. 10
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	ol	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	o	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS	<u>ا</u>					101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	ol	0	0	0	0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	l o	0	ő	0		106.00
107. 00 10700 LI VER ACQUI SI TI ON	l o	0	o o	0		107. 00
108. 00 10800 LUNG ACQUISITION		0	٥	0		108. 00
109. 00 10900 PANCREAS ACQUISITION		0	0	0	Ö	
110. 00 11000 I NTESTI NAL ACQUI SI TI ON		0	0	0	0	
111. 00 11100 SLET ACQUISITION		0		0	-	111.00
113. 00 11300 NTEREST EXPENSE	l	0		O		113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115. OO 11500 AMBULATORY SURGICAL CENTER (D. P.)	٥	0	0	0	_	115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 193, 384	0	822, 983	83, 425		
NONREI MBURSABLE COST CENTERS	1, 173, 304	0	022, 703	03, 423	201, 022	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	257	0	4, 731	0	0	190. 00
190. 01 19001 WELLNESS CENTERS	18, 121	0	.,	0		190. 00
190. 02 19002 EMPLOYED ORTHO MD	16, 121	0	· ·	0		1
190. 03 19003 NORTHVI EW CONV. (LTC)	5. 798	0		0		1
190. 04 19004 SUMMIT CONV. (LTC)	3, 394	0		0	-	
190. 05 19005 PARKVI EW CONV. (LTC)	5, 007	0	3, 597	0	0	
190. 06 19006 MONTI CELLO HSE. (ASS' TD LVG.)	1, 410	0	3, 597	0	· · · · · · · · · · · · · · · · · · ·	190.05
190. 07 19007 NH PARK PLACE (LTC)	546	0	3, 547	0		
190. 08 19008 MADISON PLACE OF ELWOOD (LTC)	0	0	0	0		190. 07
190. 09 19009 SPI NE SURGEON	0	0	0	0	0	
190. 10 19010 CLINICAL RESEARCH CENTER		0	l "	0	-	190. 09
190. 10 19010 CLINICAL RESEARCH CENTER	10, 984	0	8, 128	0	0	
190. 11 19011 0NC0L0GFST 190. 12 19012 MEDI CAL INTERNI ST	2 257	0	0	0	0	
	2, 257	0	0	0	_	
190. 13 19013 RHEUMATOLOGY	10, 997	0		0		
190. 14 19014 ROCK STEADY BOXING	1, 977	0	6, 995	0	0	
191. 00 19100 RESEARCH	10 100	0	70.7//	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	18, 480	0	72, 766	0		
192. 01 19201 MUNCI E MD OFFI CES	1, 375	0	22, 537	0		192. 01
192. 02 19202 FOUNDATI ON	10, 190	0	1, 397	0		192. 02
192. 03 19203 SP0E	0	0	0	0		192. 03
192. 04 19204 HEALTHY HEART	2, 921	0	0	108		
192. 05 19205 VACANT SPACE	129	0	2, 381	0		192. 05
192. 07 19207 PARK PLACE CENTER	7	0	0	0		192. 07
192. 08 19208 RENTAL PROPERTY - 1924 MADI SON	500	0	5, 712	0		
192. 09 19209 RESIDENTIAL PROPERTY - 1430 N MADISO	326	0	4, 904	0	0	192. 09
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 288, 060	0	971, 735	83, 533	203, 638	202. 00

	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	5/14/2018 1: 5 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-BLDG & TTXT						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	00700 OPERATION OF PLANT						7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8. 00 9. 00
10.00	01000 DI ETARY	411, 470					10.00
11. 00	01100 CAFETERI A	0	58, 695	5			11. 00
13.00	01300 NURSING ADMINISTRATION	o	926	82, 619			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	2, 397		154, 936		14. 00
15. 00	01500 PHARMACY	0	1, 669	1	461	111, 130	15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	1, 747	0	14	0	16. 00 17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS		0	ol ol	ő	0	19. 00
20. 00	02000 NURSI NG SCHOOL	Ö	O	o	Ō	0	20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	o	0	0	o	0	21. 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	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	352, 397	17, 465	51, 704	7, 457	0	30.00
31. 00	03100 NTENSIVE CARE UNIT	57, 749	3, 228		2, 264	0	31. 00
32. 00	03200 CORONARY CARE UNIT	0	0, 220	0	0	0	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	o	0	0	0	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34. 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	41.00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	١	1, 093	3, 236	0	0	42. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	1, 073	0	o	0	44. 00
45. 00	04500 NURSING FACILITY	Ö	O	o	Ō	0	45. 00
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
	ANCILLARY SERVICE COST CENTERS	[
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	47 O	6, 122 0		24, 465	0	50. 00 51. 00
51.00	05200 DELIVERY ROOM & LABOR ROOM		0		0	0	51.00
53. 00	05300 ANESTHESI OLOGY		357	, ol	9	665	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	O	2, 695		169	50	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	o	0	0	o	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	235		29	2	56. 00
57. 00	05700 CT SCAN	0	487	1	448	0	57. 00
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	381 957	1	16 359	2	58. 00 59. 00
60. 00	06000 LABORATORY	0	3, 285		312	0	60.00
60. 01	06001 BLOOD LABORATORY	o	0, 200		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	242	0	5	0	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	0	1, 337		51	0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY		2, 079		42	5	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	Ö	318		0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	222	0	1	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	583		54	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	619	0	22	2	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		64, 411	0	71.00
72. 00 73. 00	07300 DRUGS CHARGED TO PATIENTS		0		50, 437	110, 384	72. 00 73. 00
74. 00	07400 RENAL DIALYSIS	o	0	ol ol	25	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	O	O	o	0	0	75. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90. 00 90. 01	09000 CLINIC 09001 WOUND/OSTOMY CLINIC		338		702	0 7	90. 00 90. 01
90. 01	09001 WOUND/03TOWN CLINIC		330 0		,02 N	0	90.01
90. 03	09003 0NC0L0GY		1, 596	S ől	460	11	90. 03
90. 04	09004 MUNCIE CLINIC	o	0	o o	2	0	90. 04
90. 05	09005 ANTICOAGULATION CLINIC	0	304	0	6	0	90. 05
90.06	09006 PREGNANCY PLUS	0	0		0	0	90.06
90. 07	09007 0/P LAB	0	0	U	·	0	90. 07

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | T

			10	12/31/201/	5/14/2018 1:5	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI ON	SERVICES &		
				SUPPLY		
	10.00	11. 00	13. 00	14. 00	15. 00	
90. 08 09008 0/P LAB	0	0	0	0	0	90. 08
90. 09 09009 FORTVI LLE CLI NI C	0	0	0	0	0	90. 09
91. 00 09100 EMERGENCY	1, 277	4, 378	0	2, 655	0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS				ما		04.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	-	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
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 09700 DURABLE MEDICAL EQUIP-SOLD 99. 00 09900 CMHC		0	0	0	0	97. 00 99. 00
99. 10 09900 CMRC		0	0	0	0	99. 00
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY		0	0	0		101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	0	<u> </u>	9	0	1101.00
105. 00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106. 00 10600 HEART ACQUISITION	o	0		o		106. 00
107. 00 10700 LI VER ACQUI SI TI ON	o	0	0	o		107. 00
108. 00 10800 LUNG ACQUISITION	o	0	l o	o		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0	O	O	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	o	0	0	o	0	110.00
111.00 11100 ISLET ACQUISITION	o	0	0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION 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	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	411, 470	55, 060	82, 619	154, 876	111, 129	118. 00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
190. 01 19001 WELLNESS CENTERS	0	973	0	4		190. 01
190. 02 19002 EMPLOYED ORTHO MD	0	0	0	0		190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)	0	407	0	8		190. 03
190. 04 19004 SUMMIT CONV. (LTC) 190. 05 19005 PARKVIEW CONV. (LTC)	0	219 349	0	0	0	190. 04 190. 05
190. 05 19005 PARKVIEW CONV. (LTC) 190. 06 19006 MONTI CELLO HSE. (ASS' TD LVG.)		349 87	0	0	•	190. 05
190. 00 19000 MONTI CELLO TISE. (A33 TO EVG.)		39	0	0	0	190. 00
190. 08 19008 MADISON PLACE OF ELWOOD (LTC)	0	0		0	•	190. 07
190. 09 19009 SPI NE SURGEON		0	0	0	0	190. 09
190. 10 19010 CLINI CAL RESEARCH CENTER	o	923	0	9	0	190. 10
190. 11 19011 ONCOLOGI ST	o	0	l o	o	0	190. 11
190. 12 19012 MEDI CAL I NTERNI ST	O	149	O	3	0	190. 12
190. 13 19013 RHEUMATOLOGY	О	63	0	o	0	190. 13
190. 14 19014 ROCK STEADY BOXING	0	135	0	O	0	190. 14
191. 00 19100 RESEARCH	o	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	3	0	192. 00
192.01 19201 MUNCIE MD OFFICES	0	0	0	0	0	192. 01
192. 02 19202 FOUNDATI ON	0	137	0	0		192. 02
192. 03 19203 SP0E	0	0	0	0		192. 03
192. 04 19204 HEALTHY HEART	0	154	0	33		192. 04
192. 05 19205 VACANT SPACE	0	0	0	0		192. 05
192. 07 19207 PARK PLACE CENTER	0	0	0	0		1.72.07
192. 08 19208 RENTAL PROPERTY - 1924 MADI SON	0	0	0	0		192. 08
192. 09 19209 RESIDENTIAL PROPERTY - 1430 N MADISO		0	0	이	0	11,2.0,
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		^			^	200.00
	411 470	E0 405	92 (10	154 024		201. 00
202.00 TOTAL (sum lines 118 through 201)	411, 470	58, 695	82, 619	154, 936	111, 130	J∠U∠. UU

| Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0113

				Т	o 12/31/2017	Date/Time Pre 5/14/2018 1:5	
						INTERNS &	·
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	NURSI NG SCHOOL	RESI DENTS SERVI CES-SALAR	
		RECORDS &		ANESTHETI STS		Y & FRINGES	
		16. 00	17. 00	19. 00	20.00	21. 00	
	GENERAL SERVICE COST CENTERS		1				
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6. 00 7. 00	OO6OO MAINTENANCE & REPAIRS OO7OO OPERATION OF PLANT						6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON						11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	118, 840	0				16. 00 17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	Ö	c			19. 00
20. 00	02000 NURSI NG SCHOOL	0	0		0		20. 00
21. 00 22. 00	O2100 I &R SERVI CES-SALARY & FRI NGES APPRVD O2200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	0	0			0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(EMS)		0				23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		_			ı	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	31, 021	0				30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	0	Ö				32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0				33. 00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0				34. 00 40. 00
41. 00	04100 SUBPROVI DER – TPF		0				41.00
42. 00	04200 SUBPROVI DER	0	0				42. 00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	0				43. 00 44. 00
45. 00	04500 NURSING FACILITY	0	Ö	•			45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0				46. 00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	22, 604	0				50. 00
51. 00	05100 RECOVERY ROOM	0	0				51. 00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	931	0				53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
56. 00 57. 00	05600	0	0				56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0				58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	0				60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0				63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	0	Ö				65. 00
66.00	06600 PHYSI CAL THERAPY	0	0				66. 00
67. 00 68. 00	O6700 OCCUPATI ONAL THERAPY O6800 SPEECH PATHOLOGY		0				67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	Ö				69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS		0				71. 00 72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	Ō				73. 00
74. 00 75. 00	07400 RENAL DIALYSIS	0	0				74. 00 75. 00
75.00	O7500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS		0				75.00
88. 00	08800 RURAL HEALTH CLINIC	0	0				88. 00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0				89. 00 90. 00
90. 00	09001 WOUND/OSTOMY CLINIC	28, 043	0				90. 00
90. 02	09002 KIDS PLUS CLINIC	0	0				90. 02
90. 03 90. 04	O9003 ONCOLOGY O9004 MUNCI E CLINIC	0	0				90. 03 90. 04
	09005 ANTI COAGULATI ON CLINIC		o o			<u> </u>	90. 05

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | T Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0113

			'	0 12/31/2017	5/14/2018 1:5	
					INTERNS &	Z piii
					RESI DENTS	
Cost Center Description	MEDI CAL	SOCIAL SERVICE	NONPHYSICIAN	NURSING SCHOOL		
555 C 5511 C 5555	RECORDS &	0001712 021111 02	ANESTHETI STS		Y & FRINGES	
	LI BRARY		7.11.20111211010		I W THINGES	
	16. 00	17. 00	19. 00	20.00	21.00	
90. 06 09006 PREGNANCY PLUS	10.00	17.00		20.00	21.00	90. 06
90. 07 09007 0/P LAB	0	0	1			90. 07
90. 08 09008 0/P LAB	0	0				90.08
90. 09 09009 FORTVI LLE CLI NI C	0					90.09
91. 00 09100 EMERGENCY	33, 604					91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	33,004	0				92.00
OTHER REIMBURSABLE COST CENTERS						92.00
	0		I		Γ	04.00
94. 00 09400 HOME PROGRAM DIALYSIS	0	0				94.00
95. 00 09500 AMBULANCE SERVI CES 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0				95. 00
	0	0				96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0				97. 00
99. 00 09900 CMHC	0	0				99. 00
99. 10 09910 CORF	0	0				99. 10
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0				100. 00
101.00 10100 HOME HEALTH AGENCY	0	0				101. 00
SPECIAL PURPOSE COST CENTERS						1
105.00 10500 KIDNEY ACQUISITION	0					105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0				106. 00
107. 00 10700 LIVER ACQUISITION	0	0				107. 00
108.00 10800 LUNG ACQUISITION	0	0				108. 00
109.00 10900 PANCREAS ACQUISITION	0	0				109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0				110. 00
111.00 11100 ISLET ACQUISITION	0	0				111.00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0				115. 00
116. 00 11600 HOSPI CE	0	0				116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	116, 203	0	C	0	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	52	0				190. 00
190. 01 19001 WELLNESS CENTERS	0	0				190. 01
190.02 19002 EMPLOYED ORTHO MD	0	0				190. 02
190.03 19003 NORTHVIEW CONV. (LTC)	0	0				190. 03
190.04 19004 SUMMIT CONV. (LTC)	0	0				190. 04
190.05 19005 PARKVIEW CONV. (LTC)	0	0				190. 05
190.06 19006 MONTI CELLO HSE. (ASS' TD LVG.)	0	0				190. 06
190.07 19007 NH PARK PLACE (LTC)	0	0				190. 07
190.08 19008 MADISON PLACE OF ELWOOD (LTC)	0	0				190. 08
190. 09 19009 SPI NE SURGEON	0	0				190. 09
190. 10 19010 CLINICAL RESEARCH CENTER	0	0				190. 10
190. 11 19011 ONCOLOGI ST	0	l o				190. 11
190. 12 19012 MEDI CAL I NTERNI ST	0	0				190. 12
190. 13 19013 RHEUMATOLOGY	0	0				190. 13
190. 14 19014 ROCK STEADY BOXING	0	0				190. 14
191. 00 19100 RESEARCH	0	0				191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	2, 585	Ö				192. 00
192. 01 19201 MUNCI E MD OFFICES	0	Ö	•			192. 01
192. 02 19202 FOUNDATION	n o	Ö	•			192. 02
192. 03 19203 SP0E	n	ĺ				192. 03
192.04 19204 HEALTHY HEART	l 0					192. 03
192. 05 19205 VACANT SPACE	0		1			192. 05
192.07 19207 PARK PLACE CENTER	0	0	•			192. 03
192. 07 19207 PARK PLACE CENTER 192. 08 19208 RENTAL PROPERTY - 1924 MADISON	0					192. 07
192.09 19209 RESIDENTIAL PROPERTY - 1430 N MADI SO						192. 06
200.00 Cross Foot Adjustments		١	C	0	_	200. 00
201.00 Negative Cost Centers	^	О	•			200.00
202.00 TOTAL (sum lines 118 through 201)	118, 840					201.00
202. 00 TOTAL (Suill TITIES TTO LTITUUGH 201)	110,840	ı	1	ارا	ı	1202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0113		Peri od:	Worksheet B	
					From 01/01/2017 Fo 12/31/2017	Part II Date/Time Pre	pared:
						5/14/2018 1:5	2 pm
		I NTERNS & RESI DENTS					
	Cost Center Description	SERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	Total	
	р	PRGM. COSTS	PRGM-(EMS)		Residents Cost		
					& Post		
					Stepdown Adjustments		
		22. 00	23. 00	24. 00	25. 00	26.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 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 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	01500 PHARMACY						15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY						16. 00
	01700 SOCIAL SERVICE						17.00
19. 00 20. 00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL						19. 00 20. 00
21. 00							21.00
22. 00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0					22. 00
23. 00	02300 PARAMED ED PRGM-(EMS)		0)			23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			2 220 00		2 220 002	20.00
31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT			2, 238, 982 399, 27			1
32. 00	03200 CORONARY CARE UNIT				o o		
33. 00	03300 BURN INTENSIVE CARE UNIT				0	0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT				0	0	34. 00
40.00	04000 SUBPROVIDER - I PF				0	0	
41.00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER					0	41. 00 42. 00
43. 00	04300 NURSERY			67, 240		67, 240	
	04400 SKILLED NURSING FACILITY			1	0	0	1
45. 00	04500 NURSING FACILITY			•	0	l .	
46. 00	04600 OTHER LONG TERM CARE				0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM			2, 046, 324	1 0	2, 046, 324	50.00
	05100 RECOVERY ROOM			1 ' '	0	l	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM				0		52. 00
53. 00				18, 30!		18, 305	
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C			882, 320	0		1
	05600 RADI OLOGY-THERAPEUTI C			58, 778	٥ ا		56.00
57. 00				27, 143		l	
58. 00				59, 50°	0	l '	
59. 00	05900 CARDI AC CATHETERI ZATI ON			229, 818		,	
60. 00	06000 LABORATORY 06001 BLOOD LABORATORY			451, 309	0 0	451, 309 0	1
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			,	0	0	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			18, 84°	0	18, 841	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.				0	0	63. 00
64.00				(7.55	0	1	
65. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY			67, 552			1
66. 00 67. 00	06700 OCCUPATIONAL THERAPY			145, 71° 87, 390		· ·	
	06800 SPEECH PATHOLOGY			13, 72!			68. 00
69. 00				69, 810			69. 00
	07000 ELECTROENCEPHALOGRAPHY			82, 548			70. 00
71. 00				200, 779			
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS			157, 226 173, 463		157, 226 173, 463	
74.00	07400 RENAL DIALYSIS			8, 38			
	07500 ASC (NON-DISTINCT PART)	<u> </u>			0		1
	OUTPATIENT SERVICE COST CENTERS				1		
	08800 RURAL HEALTH CLINIC				0	1	
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC				0	0	
90. 01	09001 WOUND/OSTOMY CLINIC			280, 160			1
90. 02	09002 KIDS PLUS CLINIC]		36, 57°	0	36, 571	90. 02
90. 03	09003 0NCOLOGY	1		914, 730	5 0	914, 736	90. 03

| Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0113

			Т	o 12/31/2017	Date/Time Prep 5/14/2018 1:5	
Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM. COSTS	PARAMED ED PRGM-(EMS)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	2 piii
	22. 00	23. 00	24.00	25. 00	26. 00	
90. 04 09004 MUNCI E CLINIC 90. 05 09005 ANTI COAGULATI ON CLINIC 90. 06 09006 PREGNANCY PLUS 90. 07 09007 0/P LAB 90. 09 09009 FORTVI LLE CLINIC 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0THER REIMBURSABLE COST CENTERS			35, 245 8, 491 56, 318 0 27, 927 424, 978	0 0 0	35, 245 8, 491 56, 318 0 27, 927 424, 978	90. 04 90. 05 90. 06 90. 07 90. 08 90. 09 91. 00 92. 00
94. 00			0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0	94. 00 95. 00 96. 00 97. 00 99. 00 99. 10 100. 00 101. 00
105. 00 10500 KIDNEY ACQUISITION 106. 00 10600 HEART ACQUISITION 107. 00 10700 LIVER ACQUISITION 108. 00 10800 LUNG ACQUISITION 109. 00 10900 PANCREAS ACQUISITION 110. 00 11000 INTESTINAL ACQUISITION 111. 00 11100 ISLET ACQUISITION 113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTILIZATION REVIEW-SNF 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPICE			000000000000000000000000000000000000000	0 0 0 0 0 0	0 0 0 0 0	105. 00 106. 00 107. 00 108. 00 109. 00 110. 00 111. 00 113. 00 114. 00 115. 00 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	9, 288, 855	0	9, 288, 855	118. 00
NONREL MBURSABLE COST CENTERS 190. 00			28, 324 254, 535 0 27, 837 25, 095 26, 931 22, 866 616 0 62, 598 0 2, 492 13, 765 43, 606 0 459, 976 134, 828 18, 762 0 4, 160 14, 229 7 34, 322 29, 363	0 0 0 0 0 0 0 0 0 0 0 0	27, 837 25, 095 26, 931 22, 866 616 0 0 62, 598 0 2, 492 13, 7655 43, 606 459, 976 134, 828 18, 762 0 4, 160 14, 229	190. 01 190. 02 190. 03 190. 04 190. 05 190. 06 190. 07 190. 08 190. 09 190. 10 190. 11 190. 12 190. 13 190. 14 191. 00 192. 00 192. 01 192. 02 192. 03 192. 04 192. 05 192. 07 192. 08
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	0 0 0	0 0 0	0	0 0 0		200. 00 201. 00 202. 00

COMMUNITY HOSPITAL ANDERSON In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0113 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/14/2018 1:52 pm CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE Cost Center Description (SQUARE FEET) (DOLLAR VALUE) BENEFITS & GENERAL DEPARTMENT (ACCUM. COST) (GROSS SALARI ES) 1.00 2.00 5. 00 4.00 5A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 304 680 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4, 052, 027 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1,645 16,778 62, 780, 321 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 709, 310 10, 609, 968 -23, 724, 545 116, 587, 423 24, 465 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 30, 863 248, 604 2, 155, 126 8, 258, 625 7.00 00800 LAUNDRY & LINEN SERVICE 3, 460 0 280, 903 8.00 8.00 69.302 0 00900 HOUSEKEEPI NG 9, 883 9 00 6.928 1, 433, 254 2, 240, 068 9 00 10.00 01000 DI ETARY 10, 782 121, 268 664, 760 1, 541, 683 10.00 01100 CAFETERI A 2,041 825, 199 11.00 0 960, 775 11.00 01300 NURSING ADMINISTRATION 1, 137, 795 1, 587, 303 13.00 2,661 203 13.00 5, 081 14.00 01400 CENTRAL SERVICES & SUPPLY 6, 517 1, 035, 273 2, 137, 451 14 00 15.00 01500 PHARMACY 3, 207 4, 199 1, 653, 137 0 2, 453, 169 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 4,066 1, 213, 422 1, 925, 015 16.00 0 01700 SOCIAL SERVICE 17.00 0 0 0 17.00 19 00 01900 NONPHYSICIAN ANESTHETISTS 0 C 0 0 19 00 02000 NURSING SCHOOL 0 0 0 20.00 20.00 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 0 0 0 21.00 0 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 0 0 22.00 22.00 C 0 02300 PARAMED ED PRGM-(EMS) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 51, 804 203, 893 13, 156, 341 18, 549, 412 30.00 31.00 03100 INTENSIVE CARE UNIT 6, 853 92, 393 2, 588, 543 0 3, 725, 651 31.00 32.00 03200 CORONARY CARE UNIT C 0 32.00 03300 BURN INTENSIVE CARE UNIT 33.00 0 0 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 C 0 34.00 0 40.00 04000 SUBPROVIDER - IPF 0 C 0 0 40.00 04100 SUBPROVIDER - IRF 0 0 41.00 0 41.00 0 04200 SUBPROVI DER 42.00 0 O 0 42.00 04300 NURSERY 1, 419, 890 43 00 1,870 1, 369 933, 636 43 00 0 44.00 04400 SKILLED NURSING FACILITY 0 0 44.00 04500 NURSING FACILITY 0 45.00 0 0 0 45.00 04600 OTHER LONG TERM CARE 46.00 46.00 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 22, 153 1, 131, 826 4, 898, 405 0 9, 272, 452 50.00 51.00 05100 RECOVERY ROOM 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 0 C 0 52 00 0 241, 269 05300 ANESTHESI OLOGY 0 53.00 272 6, 700 822, 673 53.00 2, 408, 162 54.00 05400 RADI OLOGY-DI AGNOSTI C 19, 284 329, 749 0 4, 295, 785 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 05600 RADI OI SOTOPE 1, 483 719, 568 56 00 12 600 246, 485 56 00 57.00 05700 CT SCAN 450 3, 497 420, 394 741, 613 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 21, 828 318, 485 987, 788 58.00 936 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 3,717 108, 717 856, 918 1, 439, 588 59.00 06000 LABORATORY 4, 735, 512 60.00 7.828 183, 687 2, 126, 891 60 00 60.01 06001 BLOOD LABORATORY 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1, 010 291, 091 585 209, 292 62.00 62.00 06300 BLOOD STORING, PROCESSING & TRANS 63.00 0 C0 63.00 0 64.00 06400 I NTRAVENOUS THERAPY 64.00 06500 RESPIRATORY THERAPY 28, 947 0 65.00 720 959, 977 1, 284, 059 65 00 0 06600 PHYSI CAL THERAPY 4 702 1, 822, 631 2, 637, 388 66.00 2, 795 66 00 0 67.00 06700 OCCUPATIONAL THERAPY 3, 471 343, 128 521, 162 67.00 06800 SPEECH PATHOLOGY 0 68.00 421 80 190, 146 277, 865 68.00 0 06900 ELECTROCARDI OLOGY 22, 073 413, 228 684, 958 69.00 1.533 69.00 07000 ELECTROENCEPHALOGRAPHY 842, 625 70.00 1.533 29, 513 489.078 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 12, 343, 242 71.00 71.00 C 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 0 0 9, 665, 893 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 5, 709, 519 73.00 0 0 73.00 0 74.00 07400 RENAL DIALYSIS 188 C 0 360, 947 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 75.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 90.00 09000 CLI NI C 0 0 90.00

4, 295

449, 817

306, 180

1, 143, 440

10.183

17, 135

1,560

0

8, 235, 997

451, 648

30, 118

0 90.03

90.01

90 02

90.01

90 02

90.03

09001 WOUND/OSTOMY CLINIC

09002 KIDS PLUS CLINIC

09003 ONCOLOGY

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0113

					1	o 12/31/2017	Date/Time Pre 5/14/2018 1:5	
			CAPI TAL REI	ATED COSTS			07 1 17 20 10 1. 0.	E piii
		Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		dost deliter bescription		(DOLLAR VALUE)	BENEFITS	incconci i i ati on	& GENERAL	
					DEPARTMENT		(ACCUM. COST)	
					(GROSS SALARI ES)			
			1.00	2. 00	4.00	5A	5. 00	
90. 04		MUNCIE CLINIC	1, 488	297				1
90. 05 90. 06	1 1	ANTICOAGULATION CLINIC PREGNANCY PLUS	2, 371	3, 418 639			368, 528 46, 500	1
90. 07		O/P LAB	0	0			0	1
90. 08		O/P LAB	0	0	0	0	0	
90. 09 91. 00		FORTVILLE CLINIC EMERGENCY	1, 191 7, 831	0 104, 867	3, 462, 011	0	23, 594 4, 934, 396	1
		OBSERVATION BEDS (NON-DISTINCT PART)	7,031	104, 007	3, 402, 011		4, 754, 570	92.00
		REIMBURSABLE COST CENTERS						
	1 1	HOME PROGRAM DI ALYSIS AMBULANCE SERVICES	0	0				1
		DURABLE MEDICAL EQUIP-RENTED	0	0	0		0	1
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	
	09900		0	0	0	0	0	
	10000	I&R SERVICES-NOT APPRVD PRGM	0	0		0	0	99. 10 100. 00
	1 1	HOME HEALTH AGENCY	0	Ö				101. 00
405.00		AL PURPOSE COST CENTERS						105.00
		KIDNEY ACQUISITION HEART ACQUISITION	0	0			_	105. 00 106. 00
107.00	10700	LIVER ACQUISITION	Ö	0	Ö		0	107. 00
		LUNG ACQUISITION	0	0	0	0		108.00
		PANCREAS ACQUISITION INTESTINAL ACQUISITION	0	0	0	0		109. 00 110. 00
		ISLET ACQUISITION		0		0		111.00
		INTEREST EXPENSE						113. 00
	1 1	UTILIZATION REVIEW-SNF						114.00
		AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	0	0		0		115. 00 116. 00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	266, 761	3, 860, 772	59, 186, 135	-15, 488, 548		1
100.00		MBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	1 204	0	0	0	22 204	100 00
		WELLNESS CENTERS	1, 206 1, 227	180, 236				
	1 1	EMPLOYED ORTHO MD	0	0	0	0		190. 02
	1 1	NORTHVI EW CONV. (LTC)	917	0	398, 357		524, 812	1
		SUMMIT CONV. (LTC) PARKVIEW CONV. (LTC)	917 917	0	223, 204 338, 543		307, 185 453, 163	1
		MONTI CELLO HSE. (ASS' TD LVG.)	917	0	84, 234		127, 670	1
		NH PARK PLACE (LTC)	0	0	38, 551		49, 433	1
		MADISON PLACE OF ELWOOD (LTC) SPINE SURGEON	0	0	0	0		190. 08 190. 09
		CLINICAL RESEARCH CENTER	2, 072	1, 796	626, 088	0	994, 234	
		ONCOLOGI ST	0	0	0	0		190. 11
		MEDICAL INTERNIST RHEUMATOLOGY	0	0 2, 087	,			
		ROCK STEADY BOXING	1, 783	1				
		RESEARCH	0	0	Ĭ			191. 00
		PHYSICIANS' PRIVATE OFFICES MUNCIE MD OFFICES	18, 549 5, 745		0	0	1, 672, 715 124, 441	
		FOUNDATION	356		203, 277	_	922, 380	
192. 03	19203	SP0E	0	l	0	0	0	192. 03
	1 1	HEALTHY HEART	0	690			264, 412	1
		VACANT SPACE PARK PLACE CENTER	607	0	0	0		192. 05 192. 07
		RENTAL PROPERTY - 1924 MADISON	1, 456	0	Ö	Ö		
		RESIDENTIAL PROPERTY - 1430 N MADISO	1, 250		0	0		192. 09
200. 00 201. 00	1 1	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
202.00		Cost to be allocated (per Wkst. B, Part I)	5, 882, 331	4, 610, 836	13, 499, 970		23, 724, 545	
203. 00 204. 00	1 1	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	19. 306587	1. 137909	0. 215035 50, 851		0. 203491 1, 288, 060	1
205. 00		Part II) Unit cost multiplier (Wkst. B, Part			0. 000810		0. 011048	205. 00
206. 00		II) NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0113

Peri od: Worksheet B-1 From 01/01/2017 To 12/31/2017 Date/Ti me Prepared:

5/14/2018 1:52 pm Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY **REPALRS** PLANT LINEN SERVICE (HOURS OF (MEALS SERVED) (SQUARE FEET) (SQUARE FEET) (POUNDS OF SERVICE) LAUNDRY) 7.00 6.00 9.00 10.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 FMPLOYEE BENEFLTS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 0 7.00 247, 707 7.00 00800|LAUNDRY & LINEN SERVICE 8.00 3, 460 702, 805 8.00 6, 928 9.00 00900 HOUSEKEEPI NG 0000000 46,685 6.506 9.00 01000 DI ETARY 10, 782 174 123, 408 10.00 10.00 01100 CAFETERIA 2.041 11 00 \cap Λ 11.00 01300 NURSING ADMINISTRATION 13.00 2, 661 38 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 5, 081 3, 515 71 0 14.00 01500 PHARMACY 3, 207 15.00 0 41 15.00 0 01600 MEDICAL RECORDS & LIBRARY 16,00 4,066 0 12 0 16.00 17.00 01700 SOCIAL SERVICE 0 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 C 0 0 0 19.00 02000 NURSING SCHOOL 20.00 0 0 20 00 C 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 C 0 0 21.00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 0 0 0 0 22.00 22.00 0 02300 PARAMED ED PRGM-(EMS) 23.00 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 51,804 251, 773 3, 132 105, 691 30.00 0 31.00 03100 INTENSIVE CARE UNIT 6,853 46, 263 428 17, 320 31.00 32 00 03200 CORONARY CARE UNIT 0 0 0 0 0 32 00 03300 BURN INTENSIVE CARE UNIT 33.00 C 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 34.00 0 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 0 40.00 0 0 0 0 40.00 0 41 00 0 41 00 C 0 04200 SUBPROVI DER 42.00 0 0 0 42.00 04300 NURSERY 0 0 47 43.00 43.00 1.870 0 44.00 04400 SKILLED NURSING FACILITY 0 0 0 44.00 0 0 04500 NURSING FACILITY 45 00 C 0 45 00 04600 OTHER LONG TERM CARE 0 0 46.00 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 22, 153 201, 925 1, 343 14 50.00 0 05100 RECOVERY ROOM 51.00 C 0 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 52.00 0 53 00 05300 ANESTHESI OLOGY 0 272 C 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 18, 202 54.00 119 54.00 19, 284 0 55 00 05500 RADI OLOGY-THERAPEUTI C 0 0 55 00 56.00 05600 RADI OI SOTOPE 0 0 0 1, 483 2, 180 42 0 56.00 57.00 05700 CT SCAN 450 27, 279 0 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 936 8,727 10 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 3, 717 2, 390 50 0 59.00 60.00 06000 LABORATORY 0 7,828 1, 266 85 60.00 0 06001 BLOOD LABORATORY 0 60.01 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 585 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 00000000000 0 0 O 63.00 06400 INTRAVENOUS THERAPY 64.00 0 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 720 0 49 0 65.00 66, 00 06600 PHYSI CAL THERAPY 4, 702 281 17 0 66.00 06700 OCCUPATIONAL THERAPY 13 67.00 3.471 67.00 C0 06800 SPEECH PATHOLOGY 68.00 421 \cap 13 0 68.00 69.00 06900 ELECTROCARDI OLOGY 1,533 4,570 0 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 1,533 6, 328 72 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 C 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 C 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 07400 RENAL DIALYSIS 0 0 74.00 188 0 0 74.00 0 75 00 07500 ASC (NON-DISTINCT PART) O 0 0 75 00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 o 09000 CLI NI C 90 00 90 00 0 0 0 90.01 09001 WOUND/OSTOMY CLINIC 10, 183 2, 250 132 0 90.01 09002 KIDS PLUS CLINIC 90.02 1, 560 90.02 0 90.03 09003 ONCOLOGY 17, 135 15, 608 0 0 90.03 09004 MUNCIE CLINIC 0 90.04 90 04 1, 488 C 0 90.05 09005 ANTI COAGULATION CLINIC 0 0 0 90.05 90.06 09006 PREGNANCY PLUS 2, 371 0 0 90.06

| Peri od: | Worksheet B-1 | To | 12/31/2017 | T Provider CCN: 15-0113

				To	com 01/01/2017 D 12/31/2017	Date/Time Pre 5/14/2018 1:5	
	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (MEALS SERVED)	_ p
		6. 00	7. 00	8. 00	9. 00	10.00	
	007 0/P LAB	0	1	1	0		
1	008 0/P LAB	0	_	1	0	0	90.08
1	009 FORTVILLE CLINIC OO EMERGENCY	0	1, 191 7, 831		545	0 383	90. 09 91. 00
	OO OBSERVATION BEDS (NON-DISTINCT PART)		7,631	02, 030	545	303	92.00
	ER REIMBURSABLE COST CENTERS						, , , , , , ,
94. 00 094	00 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
1	OOO AMBULANCE SERVICES	0	0	0	0	_	
	000 DURABLE MEDICAL EQUIP-RENTED 000 DURABLE MEDICAL EQUIP-SOLD	0	0		0	0	96. 00 97. 00
1	OO CMHC		0		0	0	99.00
99. 10 099	•	0	Ö	ő	0	ő	99. 10
100.00 100	000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100. 00
	OO HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	CIAL PURPOSE COST CENTERS		0	ا			105.00
1	600 KIDNEY ACQUISITION 600 HEART ACQUISITION	0		- I	0		105. 00 106. 00
	OO LIVER ACQUISITION	0	Ö	1	0		107. 00
	BOO LUNG ACQUISITION	0	0	0	0		108. 00
	PANCREAS ACQUISITION	0	0	0	0		109. 00
1	000 INTESTINAL ACQUISITION	0	0	0	0		110.00
1	00 SLET ACQUI SI TI ON	0	0		0	0	111.00
	OO INTEREST EXPENSE						113. 00 114. 00
1	OO AMBULATORY SURGICAL CENTER (D. P.)	0	o	О	0	0	115. 00
	000 HOSPI CE	0	0	0	0	0	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	209, 788	701, 900	6, 448	123, 408	118. 00
	REI MBURSABLE COST CENTERS	1	1 00/	1 0		1	100.00
1	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 001 WELLNESS CENTERS	0	1, 206 1, 227	0	0 36		190. 00 190. 01
1	002 EMPLOYED ORTHO MD	0	1, 227	1	0		190. 01
1	03 NORTHVI EW CONV. (LTC)	0	917	o	0		190. 03
190. 04 190	004 SUMMIT CONV. (LTC)	0	917	0	0	0	190. 04
1	005 PARKVI EW CONV. (LTC)	0	917	· ·	0		190. 05
1	006 MONTICELLO HSE. (ASS'TD LVG.) 007 NH PARK PLACE (LTC)	0	917	0	0	l .	190. 06 190. 07
	008 MADISON PLACE OF ELWOOD (LTC)	0	0		0		190. 07
1	009 SPI NE SURGEON	0	Ö	Ö	0		190. 09
190. 10 190	010 CLINICAL RESEARCH CENTER	0	2, 072	0	0	0	190. 10
1	011 ONCOLOGI ST	0	0	0	0	l .	190. 11
	012 MEDICAL INTERNIST 013 RHEUMATOLOGY	0	0		0		190. 12 190. 13
	114 ROCK STEADY BOXING	0	1, 783		0	0	
	00 RESEARCH	0	0	O	0	0	191. 00
	200 PHYSICIANS' PRIVATE OFFICES	0	10/01/		22		192. 00
	MUNCIE MD OFFICES	0			0		192. 01
192. 02 192	102 FOUNDATION	0			0		192. 02 192. 03
1	104 HEALTHY HEART				0		192. 03
	205 VACANT SPACE	0			0		192. 05
192. 07 192	PARK PLACE CENTER	0	0	0	0		192. 07
	08 RENTAL PROPERTY - 1924 MADISON	0	1, 456		0		192. 08
192. 09 192 200. 00	209 RESIDENTIAL PROPERTY - 1430 N MADISO Cross Foot Adjustments	0	1, 250	0	0	0	192. 09 200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	0	9, 939, 181	476, 896	3, 005, 565	2, 368, 409	
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000			461. 968183		
204. 00	Cost to be allocated (per Wkst. B,	0	971, 735	83, 533	203, 638	411, 470	204.00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part	0. 000000	3. 922921	0. 118857	31. 300031	3. 334225	205. 00
255.55		3. 000000	3. /22/21	3.110007	2000001	3.001220	
206. 00	NAHE adjustment amount to be allocated						206. 00
207 00	(per Wkst. B-2)						207 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
(1	1	I .			•	

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0113 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/14/2018 1:52 pm Cost Center Description CAFETERI A NURSI NG CENTRAL **PHARMACY** MEDI CAL SERVICES & RECORDS & (MAN HOURS) ADMI NI STRATI ON (COSTED **SUPPLY** REQUIS.) LI BRARY (DIRECT NURS (COSTED (TIME SPENT) HRS.) REQUIS.) 11.00 13.00 14.00 15.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 1,566,441 11.00 13.00 01300 NURSING ADMINISTRATION 24, 700 744, 796 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 63, 977 29, 691, 737 14.00 01500 PHARMACY 44 535 88 297 5, 518, 494 15 00 15 00 C 16.00 01600 MEDICAL RECORDS & LIBRARY 46,622 2,605 57, 465 16.00 01700 SOCIAL SERVICE 17.00 0 0 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 19 00 0 C 0 0 19 00 0 20.00 02000 NURSING SCHOOL 0 C 0 0 0 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 0 0 0 21.00 21.00 0 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 22.00 0 0 0 22.00 0 02300 PARAMED ED PRGM-(EMS) 23 00 23.00 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 429, 090 0 15, 000 30.00 466, 108 466, 108 31.00 03100 INTENSIVE CARE UNIT 86, 144 86. 144 433, 799 0 31.00 0 03200 CORONARY CARE UNIT 32 00 32 00 0 C 0 0 03300 BURN INTENSIVE CARE UNIT 33.00 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34.00 0 0 34.00 04000 SUBPROVIDER - IPF 40.00 0 0 0 0 40.00 04100 SUBPROVIDER - IRF 0 0 41.00 C 0 41.00 0 42.00 04200 SUBPROVI DER 0 0 42.00 0 04300 NURSERY 43.00 29, 170 29, 170 0 0 43.00 0 44.00 04400 SKILLED NURSING FACILITY 0 44.00 C 0 0 04500 NURSING FACILITY 0 45.00 0 r 0 0 45 00 04600 OTHER LONG TERM CARE 46.00 46.00 0 ANCILLARY SERVICE COST CENTERS 10, 930 05000 OPERATING ROOM 50.00 163, 374 163, 374 4, 688, 598 0 50.00 05100 RECOVERY ROOM 51.00 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 0 0 52.00 05300 ANESTHESI OLOGY 9,528 33,003 53.00 1,653 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 71, 931 2, 500 450 54.00 32, 366 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 56.00 05600 RADI OI SOTOPE 6, 266 5, 494 107 56.00 0 13, 001 05700 CT SCAN 57.00 0 85, 873 0 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 10, 168 3, 101 82 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 25, 544 68, 818 59.00 06000 LABORATORY 59, 868 0 60.00 60.00 87.667 0 0 0 06001 BLOOD LABORATORY 60.01 C 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 6, 453 945 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 63.00 0 64.00 06400 I NTRAVENOUS THERAPY 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 35, 691 9,715 32 0 65.00 06600 PHYSI CAL THERAPY 66.00 55, 496 7,973 257 0 66.00 67 00 06700 OCCUPATIONAL THERAPY 8.475 0 Ω 67 00 80 06800 SPEECH PATHOLOGY 68.00 5, 928 178 0 0 68.00 06900 ELECTROCARDI OLOGY 15, 558 10, 276 5 69.00 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 16, 524 0 4, 199 97 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS Ω 12, 343, 242 0 71 00 71 00 0 0 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 9, 665, 893 0 0 72.00 5, 481, 484 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 73.00 0 74.00 07400 RENAL DIALYSIS 0 0 4,869 0 74.00 07500 ASC (NON-DISTINCT PART) 0 0 0 75.00 0 0 75.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 C 0 89.00 0 0 90.00 09000 CLI NI C 0 C 0 0 90.00 09001 WOUND/OSTOMY CLINIC 9,011 13, 560 90.01 134, 506 349 90.01 90.02 09002 KIDS PLUS CLINIC 0 0 90.02 \cap 90.03 90 03 109003 ONCOLOGY 42.589 0 88, 230 533 0 90.04 09004 MUNCIE CLINIC 0 343 0 90.04 90.05 09005 ANTI COAGULATION CLINIC 8.109 1, 218 0 0 90.05

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0113

			To	12/31/2017	Date/Time Pre 5/14/2018 1:5	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	2 piii
	(MAN HOURS)	ADMI NI STRATI ON	SERVI CES & SUPPLY	(COSTED REQUIS.)	RECORDS & LI BRARY	
		(DIRECT NURS.	(COSTED	REGULO.	(TIME SPENT)	
	11.00	HRS.) 13. 00	REQUI S.) 14. 00	15. 00	16. 00	
90. 06 09006 PREGNANCY PLUS	11.00 C	0		0	0	90. 06
90. 07 09007 0/P LAB	C	0	0	0	0	90. 07
90. 08 09008 0/P LAB 90. 09 09009 FORTVI LLE CLI NI C		0	0	ol Ol	0	90. 08 90. 09
91. 00 09100 EMERGENCY	116, 842	Ō	508, 903	ō	16, 250	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	PART)					92. 00
94. 00 OTHER REIMBURSABLE COST CENTERS 94. 00 O9400 HOME PROGRAM DIALYSIS	C	0	0	ol	0	94. 00
95. 00 09500 AMBULANCE SERVICES	C	0	0	o	0	95. 00
96. 00 O9600 DURABLE MEDICAL EQUIP-RENTED 97. 00 O9700 DURABLE MEDICAL EQUIP-SOLD	C	0	0	0	0	96. 00 97. 00
99. 00 09900 CMHC		0	0	o	0	99.00
99. 10 09910 CORF	C	0	0	o	0	99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY		0	0	0 0		100. 00 101. 00
SPECIAL PURPOSE COST CENTERS			0			101.00
105. 00 10500 KIDNEY ACQUISITION	C	,		0		105. 00
106.00 10600 HEART ACQUISITION 107.00 10700 LIVER ACQUISITION		0	0	0		106. 00 107. 00
108. 00 10800 LUNG ACQUISITION		o o	0	o		107. 00
109.00 10900 PANCREAS ACQUISITION	C	0	0	o		109. 00
110.00 11000 INTESTINAL ACQUISITION 111.00 11100 ISLET ACQUISITION		0	0	0		110. 00 111. 00
113. 00 11300 INTEREST EXPENSE		0	J	ď		113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. F 116. 00 11600 HOSPICE	P.)	0	0	0		115. 00 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 throu	ıgh 117) 1, 469, 411	744, 796	_	5, 518, 449	56, 190	1
NONREI MBURSABLE COST CENTERS			_			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CAI 190.01 19001 WELLNESS CENTERS	ITEEN C 25, 958		0 761	O O		190. 00 190. 01
190. 02 19002 EMPLOYED ORTHO MD	23, 730	ő	0	Ö		190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)	10, 869	0	1, 558	0		190. 03
190.04 19004 SUMMIT CONV. (LTC) 190.05 19005 PARKVIEW CONV. (LTC)	5, 852 9, 317	0	0	0		190. 04 190. 05
190. 06 19006 MONTI CELLO HSE. (ASS' TD LVG.)	2, 331	Ö	0	Ö		190. 06
190. 07 19007 NH PARK PLACE (LTC)	1, 047	0	0	0		190. 07
190.08 19008 MADI SON PLACE OF ELWOOD (LTC) 190.09 19009 SPI NE SURGEON		0	0	0		190. 08 190. 09
190. 10 19010 CLINI CAL RESEARCH CENTER	24, 638	Ö	1, 677	4		190. 10
190. 11 19011 ONCOLOGI ST	C	0	0	0		190. 11
190. 12 19012 MEDI CAL I NTERNI ST 190. 13 19013 RHEUMATOLOGY	3, 967 1, 669	0	600 0	0		190. 12 190. 13
190. 14 19014 ROCK STEADY BOXING	3, 613			Ö		190. 14
191. 00 19100 RESEARCH	C			o		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 192.01 19201 MUNCIE MD OFFICES	C	0	617 0	0		192. 00 192. 01
192. 02 19202 FOUNDATION	3, 668	Ö	11	Ö		192. 02
192. 03 19203 SP0E	0	0	0	0		192. 03
192.04 19204 HEALTHY HEART 192.05 19205 VACANT SPACE	4, 101	0	6, 284 0	41 0		192. 04 192. 05
192.07 19207 PARK PLACE CENTER	C	ő	0	Ö	0	192. 07
192. 08 19208 RENTAL PROPERTY - 1924 MADI SON	14 D L CO	0	74	0		192. 08 192. 09
192.09 19209 RESIDENTIAL PROPERTY - 1430 N M 200.00 Cross Foot Adjustments	MADI SU	0	U	U U	U	200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. Part I)	B, 1, 238, 179	2, 054, 156	2, 862, 032	3, 143, 701	2, 522, 532	202. 00
203.00 Unit cost multiplier (Wkst. B,	Part I) 0.790441	2. 758012	0. 096392	0. 569666	43. 896842	203. 00
204.00 Cost to be allocated (per Wkst.				111, 130	118, 840	1
Part II) Unit cost multiplier (Wkst. B,	Part 0. 037470	0. 110928	0. 005218	0. 020138	2. 068041	205 00
		0. 110920	0.003210	0.020130	2.000041	200.00
206.00 NAHE adjustment amount to be al	Iocated					206. 00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wks	. D,					207. 00
Parts III and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: Worksheet B-1 From 01/01/2017 To 12/31/2017 Date/Time Prepared: Provider CCN: 15-0113

					, ,	0 12/31/2017	5/14/2018 1:5	
						INTERNS &	RESI DENTS	
	Cost Center Description	SOCIAL S	SERVI CE		NURSING SCHOOL	SERVI CES-SALAR		
		(TIME S	SPENT)	ANESTHETI STS (ASSI GNED	(ASSI GNED	Y & FRINGES (ASSIGNED	PRGM. COSTS (ASSIGNED	
			·	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 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							15. 00 16. 00
17. 00	01700 SOCIAL SERVICE		452					17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS		0	0				19. 00
20.00	02000 NURSI NG SCHOOL		0		0			20.00
21. 00 22. 00	02100 1&R SERVI CES-SALARY & FRINGES APPRVD 02200 1&R SERVI CES-OTHER PRGM. COSTS APPRVD		0			0	0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(EMS)		0					23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		451	0	•			30.00
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T		0	0	0		0 0	31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT		0	0	Ö	_	Ö	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT		0	0	0	_	0	34. 00
40.00	04000 SUBPROVI DER - I PF		0	0	0		_	40.00
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER		0	0		_	0 0	41. 00 42. 00
43. 00	04300 NURSERY		Ö	0	Ö		0	43. 00
44.00	04400 SKILLED NURSING FACILITY		0	0	0		0	44.00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE		0	0			0 0	45. 00 46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS				0	0	0	40.00
50.00	05000 OPERATING ROOM		0	0	0			50. 00
51.00	05100 RECOVERY ROOM		0	0			-	51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY		0	0	0	_	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		o	0	Ö	_	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C		0	0	0	0	0	55. 00
56. 00 57. 00	05600		0	0	0	0	0 0	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0	0			_	•
59. 00	05900 CARDI AC CATHETERI ZATI ON		0	0	0	0	0	59. 00
60.00	06000 LABORATORY		0	0	0	0	0	60.00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		U	U	0	0	0	60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	0	0	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		0	0	0	0	0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY		0	0	0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		0	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY		0	0	0	0	0	68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY		0	0	0	0	0 0	69. 00 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	Ö	0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74. 00 75. 00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)		0	0	0		0	74. 00 75. 00
. 5. 55	OUTPATIENT SERVICE COST CENTERS		<u> </u>					1
88. 00	08800 RURAL HEALTH CLINIC		0	0				88. 00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC		0	0	0	0	0 0	89. 00 90. 00
90. 00	09001 WOUND/OSTOMY CLINIC		o	0		0	0	90.00
90. 02	09002 KIDS PLUS CLINIC		О	0	0	0	0	90. 02
90. 03	O9003 ONCOLOGY O9004 MUNCI E CLI NI C		0	0	0		0	90. 03 90. 04
70.04	TO YOU A MICHIGAL OF THE C	1	니 기		1	1 0	<u> </u>	1 70.04

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0113

Peri od: Worksheet B-1 From 01/01/2017 To 12/31/2017 Date/Ti me Prepared:

5/14/2018 1:52 pm INTERNS & RESIDENTS SOCIAL SERVICE NONPHYSICIAN NURSING SCHOOL SERVICES-SALAR SERVICES-OTHER Cost Center Description Y & FRINGES **ANESTHETISTS** PRGM. COSTS (ASSI GNED (ASSI GNED (TIME SPENT) (ASSLGNED (ASSI GNED TIME) TIME) TIME) TIME) 17.00 19.00 20.00 21.00 22.00 09005 ANTI COAGULATION CLINIC 90. 05 0 0 09006 PREGNANCY PLUS 0 90.06 90.06 0 09007 0/P LAB 0 90.07 90.07 0 0 90.08 09008 0/P LAB 0 0 0 0 90.08 0 90.09 09009 FORTVILLE CLINIC 0 0 0 90.09 09100 EMERGENCY 0 0 ol 91 00 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 0 0 0 94 00 0 0 94 00 0 09500 AMBULANCE SERVICES 0 0 95.00 C 0 95.00 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 0 99 00 09900 CMHC 0 99 00 Ω 0 99. 10 | 09910 | CORF 0 0 0 99.10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 0 100.00 C 101.00 10100 HOME HEALTH AGENCY 0 101.00 0 0 0 0 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 0 0 0 105, 00 0 106.00 106.00 10600 HEART ACQUISITION 0 0 0 0 107. 00 10700 LIVER ACQUISITION 0 0 0 107.00 0 0 108.00 10800 LUNG ACQUISITION 0 0 108.00 Ω 0 109. 00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 0 111.00 11100 | SLET ACQUISITION 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 Ω 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 452 0 0 0 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.01 19001 WELLNESS CENTERS 0 0 0 0 0 190. 00 0 0 0 0 190 01 C 0 190. 02 19002 EMPLOYED ORTHO MD 0 0 190. 02 190. 03 19003 NORTHVI EW CONV. (LTC) 0 0 190. 03 00000000000000000000 0 190.04 19004 SUMMIT CONV. (LTC) 0 190. 04 0 0 190. 05 19005 PARKVI EW CONV. (LTC) 190. 06 19006 MONTI CELLO HSE. (ASS' TD LVG.) 0 190. 05 0 0 0 0 190.06 190. 07 19007 NH PARK PLACE (LTC) 0 0 190. 07 n 190 ns 190. 08 19008 MADI SON PLACE OF ELWOOD (LTC) 0 0 190. 09 19009 SPI NE SURGEON 0 0 0 190. 09 190. 10 19010 CLINICAL RESEARCH CENTER 0 190. 10 190. 11 19011 ONCOLOGI ST 0 0 0 190. 11 190. 12 19012 MEDICAL INTERNIST 0 0 190, 12 0 190. 13 19013 RHEUMATOLOGY 0 190. 13 190. 14 19014 ROCK STEADY BOXING 0 190. 14 0 191. 00 19100 RESEARCH O 0 191.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192. 00 0 192.01 19201 MUNCIE MD OFFICES 0 192. 01 192. 02 19202 FOUNDATI ON 0 192. 02 192. 03 19203 SP0E O 0 192 03 192. 04 19204 HEALTHY HEART 0 0 192.04 192.05 19205 VACANT SPACE 0 192.05 0 0 192. 07 19207 PARK PLACE CENTER 0 0 192. 07 192. 08 19208 RENTAL PROPERTY - 1924 MADI SON 0 192. 08 0 192. 09 19209 RESIDENTIAL PROPERTY - 1430 N MADISO 0 192. 09 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, 202.00 0 0 0 202.00 Part I) Unit cost multiplier (Wkst. B, Part I) 0.000000 0.000000 203.00 203.00 0.000000 0.000000 0.000000 Cost to be allocated (per Wkst. B, 204.00 0 204.00 Part II) 0. 000000 205. 00 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.000000 0.000000 0.000000 II) 206.00 NAHE adjustment amount to be allocated 206. 00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 0.000000 207.00 207.00 Parts III and IV)

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPITAL ANDERSON

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0113 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/14/2018 1:52 pm Cost Center Description PARAMED ED PRGM-(EMS) (ASSI GNED TIME) 23.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 FMPLOYEE BENEFLTS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16,00 17. 00 01700 SOCIAL SERVICE 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02000 NURSING SCHOOL 20.00 20 00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21.00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 22.00 22.00 23.00 02300 PARAMED ED PRGM-(EMS) 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 03100 INTENSIVE CARE UNIT 31.00 0000000000 31.00 32 00 03200 CORONARY CARE UNIT 32 00 03300 BURN INTENSIVE CARE UNIT 33.00 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 40.00 40.00 41 00 41 00 04200 SUBPROVI DER 42.00 42.00 04300 NURSERY 43.00 43.00 44.00 04400 SKILLED NURSING FACILITY 44.00 45.00 45.00 04500 NURSING FACILITY 46.00 04600 OTHER LONG TERM CARE 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 000000000000 05100 RECOVERY ROOM 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 53 00 05300 ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 55.00 56.00 05600 RADI OI SOTOPE 56.00 57.00 05700 CT SCAN 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 58.00 05900 CARDIAC CATHETERIZATION 59.00 59.00 60.00 06000 LABORATORY 60.00 06001 BLOOD LABORATORY 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 00000000000 63.00 06400 I NTRAVENOUS THERAPY 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 07400 RENAL DIALYSIS 74.00 74.00 75 00 07500 ASC (NON-DISTINCT PART) 75 00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 000000 89.00 09000 CLI NI C 90 00 90 00 90.01 09001 WOUND/OSTOMY CLINIC 90.01 09002 KIDS PLUS CLINIC 90.02 90.02 90.03 09003 ONCOLOGY 90.03 09004 MUNCIE CLINIC 90 04 90.04 90.05 09005 ANTI COAGULATION CLINIC 90.05

90.06

90. 06 09006 PREGNANCY PLUS

Health Financial Systems COMMUNITY HOSPITAL ANDERSON In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0113 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/14/2018 1:52 pm Cost Center Description PARAMED ED PRGM-(EMS) (ASSI GNED TIME) 23.00 90. 07 09007 0/P LAB 0 90.07 90. 08 09008 0/P LAB 0 90.08 0 90.09 09009 FORTVILLE CLINIC 90.09 91.00 09100 EMERGENCY 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 95. 00 09500 AMBULANCE SERVICES 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 99. 00 09900 CMHC 99.00 99. 10 09910 CORF 99. 10 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 105.00 106. 00 10600 HEART ACQUISITION 0 0 0 0 106.00 107. 00 10700 LIVER ACQUISITION 107. 00 108.00 10800 LUNG ACQUISITION 108.00 109.00 10900 PANCREAS ACQUISITION 109.00 110.00 11000 INTESTINAL ACQUISITION 110.00 111.00 11100 I SLET ACQUISITION 0 111 00 113. 00 11300 | INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115 00 0 116. 00 11600 HOSPI CE 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 190. 01 19001 WELLNESS CENTERS 000000000000000000000000 190.01 190. 02 19002 EMPLOYED ORTHO MD 190.02 190. 03 19003 NORTHVI EW CONV. (LTC) 190.03 190.04 19004 SUMMIT CONV. (LTC) 190 04 190. 05 19005 PARKVI EW CONV. (LTC) 190. 06 19006 MONTI CELLO HSE. (ASS' TD LVG.) 190.05 190. 06 190. 07 19007 NH PARK PLACE (LTC) 190. 07 190. 08 19008 MADI SON PLACE OF ELWOOD (LTC) 190. 08 190. 09 19009 SPINE SURGEON 190. 09 190. 10 19010 CLINICAL RESEARCH CENTER 190. 10 190. 11 19011 ONCOLOGI ST 190. 11 190. 12 19012 MEDICAL INTERNIST 190. 12 190. 13 19013 RHEUMATOLOGY 190. 13 190. 14 19014 ROCK STEADY BOXING 190. 14 191. 00 19100 RESEARCH 191. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 192.00 192. 01 19201 MUNCIE MD OFFICES 192. 01 192. 02 19202 FOUNDATI ON 192. 02 192. 03 19203 SP0E 192 03 192.04 19204 HEALTHY HEART 192. 04 192. 05 192. 05 19205 VACANT SPACE 192. 07 19207 PARK PLACE CENTER 192. 07 192. 08 19208 RENTAL PROPERTY - 1924 MADI SON 192. 08 192. 09 19209 RESIDENTIAL PROPERTY - 1430 N MADISO 0 192. 09 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 0 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 203.00 Cost to be allocated (per Wkst. B, 204. 00 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 205.00 II)206.00 NAHE adjustment amount to be allocated 0 206.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 0.000000 207.00 Parts III and IV)

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: | 5/14/2018 1:52 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0113

							5/14/2018 1:5	2 pm
				Title	XVIII	Hospi tal	PPS	1
		Ct Ct Dt	T-+-1 C+	Th	T-+-1 C+-	Costs	T-+-1 C+-	
		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	
	INPAT	IENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
30.00		ADULTS & PEDIATRICS	30, 499, 007		30, 499, 007	0	30, 499, 007	30. 00
31.00		INTENSIVE CARE UNIT	5, 667, 769		5, 667, 769	0	5, 667, 769	31. 00
32.00		CORONARY CARE UNIT	0		0	0	0	1
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33. 00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34. 00
40.00		SUBPROVIDER - IPF	0		0	0	0	
41. 00		SUBPROVI DER - I RF	0		0	0	0	
42. 00		SUBPROVI DER	0		0	0	0	42. 00
43.00		NURSERY	1, 909, 079		1, 909, 079	0	1, 909, 079	
44. 00		SKILLED NURSING FACILITY	0		0	0	0	
45. 00		NURSING FACILITY	0		0	0	0	
46. 00		OTHER LONG TERM CARE LARY SERVICE COST CENTERS	0		0	U	0	46. 00
50. 00		OPERATING ROOM	14, 317, 367		14, 317, 367	O	14, 317, 367	50.00
51. 00		RECOVERY ROOM	14, 317, 307		14, 317, 307	0	0	1
52. 00		DELIVERY ROOM & LABOR ROOM	0		0	0	Ö	
53. 00		ANESTHESI OLOGY	327, 770		327, 770	0	327, 770	
54.00		RADI OLOGY-DI AGNOSTI C	6, 092, 185	l e	6, 092, 185	0	6, 092, 185	
55.00	05500	RADI OLOGY-THERAPEUTI C	0		0	0	0	55. 00
56.00	05600	RADI OI SOTOPE	951, 925		951, 925	0	951, 925	56. 00
57.00	05700	CT SCAN	947, 645		947, 645	0	947, 645	57. 00
58.00		MAGNETIC RESONANCE IMAGING (MRI)	1, 245, 276	l	1, 245, 276	0	1, 245, 276	
59. 00		CARDI AC CATHETERI ZATI ON	1, 933, 220	l e	1, 933, 220	0	1, 933, 220	1
60.00		LABORATORY	6, 128, 436		6, 128, 436	0	6, 128, 436	
60. 01		BLOOD LABORATORY	0		0	0	0	
61.00		PBP CLINICAL LAB SERVICES-PRGM ONLY	205 020		205 020	0	205 020	61.00
62. 00 63. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS BLOOD STORING, PROCESSING & TRANS.	385, 920		385, 920	0	385, 920 0	1
64. 00		INTRAVENOUS THERAPY	0		0	0	0	
65. 00		RESPIRATORY THERAPY	1, 626, 045	0	1, 626, 045	0	1, 626, 045	1
66. 00		PHYSI CAL THERAPY	3, 415, 565	ł		0	3, 415, 565	
67. 00		OCCUPATI ONAL THERAPY	779, 200	ł		O	779, 200	
68. 00		SPEECH PATHOLOGY	362, 010		362, 010	0	362, 010	
69.00	06900	ELECTROCARDI OLOGY	902, 245		902, 245	0	902, 245	69. 00
70.00	07000	ELECTROENCEPHALOGRAPHY	1, 126, 680		1, 126, 680	0	1, 126, 680	70. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 044, 757		16, 044, 757	0	16, 044, 757	71. 00
72. 00	07200	IMPL. DEV. CHARGED TO PATIENTS	12, 564, 530		12, 564, 530	0	12, 564, 530	
73. 00	07300	DRUGS CHARGED TO PATIENTS	9, 993, 973	l e	9, 993, 973	0	9, 993, 973	
74.00		RENAL DIALYSIS	442, 408	l	442, 408	0	442, 408	
75. 00		ASC (NON-DISTINCT PART) TIENT SERVICE COST CENTERS	0		0	0	0	75. 00
88. 00		RURAL HEALTH CLINIC	1		0	0	0	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0		Ö	· ·	0	
90.00	1	CLINIC	0		Ö	0		90.00
90. 01	1	WOUND/OSTOMY CLINIC	1, 630, 179		1, 630, 179		1, 630, 179	1
90. 02	09002	KIDS PLUS CLINIC	98, 842	l	98, 842	0	98, 842	1
90. 03		ONCOLOGY	0		0	0	0	90. 03
90. 04	1	MUNCIE CLINIC	96, 746		96, 746	0	96, 746	
90. 05		ANTI COAGULATION CLINIC	450, 047		450, 047	0	450, 047	
90.06		PREGNANCY PLUS	151, 098		151, 098	0	151, 098	
90. 07		O/P LAB	0		0	0	0	90. 07
90. 08	1	O/P LAB	7/ 10/		7, 104	0	7/ 104	
90. 09 91. 00		FORTVILLE CLINIC EMERGENCY	76, 184 7, 409, 093		76, 184 7, 409, 093	0	76, 184 7, 409, 093	
92.00	1	OBSERVATION BEDS (NON-DISTINCT PART)	2, 561, 131		2, 561, 131	U	2, 561, 131	
72.00		REIMBURSABLE COST CENTERS	2, 301, 131		2, 301, 131		2, 301, 131	72.00
94. 00		HOME PROGRAM DIALYSIS	0		0	0	0	94. 00
95.00		AMBULANCE SERVICES	0		0	0	0	
96.00		DURABLE MEDICAL EQUIP-RENTED	0		0	o	0	1
97. 00		DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	
99. 00	09900		0		0		0	
	09910		0		0		0	
	1	I &R SERVI CES-NOT APPRVD PRGM	0		0			100.00
101.00		HOME HEALTH AGENCY	0		0		0	101. 00
105.00		AL PURPOSE COST CENTERS					^	105 00
		KIDNEY ACQUISITION HEART ACQUISITION			0			105. 00 106. 00
		LIVER ACQUISITION	0					107. 00
		LUNG ACQUISITION	0		Ö			108. 00
				•			•	·

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	u of Form CMS-2552-10	
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0113		Worksheet C Part I Date/Time Prepared: 5/14/2018 1:52 pm

		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		C)	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0		C		0	110.00
111.00 11100 ISLET ACQUISITION	0		C		0	111. 00
113. 00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	o		[c		0	115. 00
116. 00 11600 HOSPI CE	o		[c		0	116. 00
200.00 Subtotal (see instructions)	130, 136, 332	0	130, 136, 332	0	130, 136, 332	200.00
201.00 Less Observation Beds	2, 561, 131		2, 561, 131		2, 561, 131	201.00
202.00 Total (see instructions)	127, 575, 201	0	127, 575, 201	0	127, 575, 201	202. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet C
From 01/01/2017	Part
To 12/31/2017	Date/Time Prepared:
5/14/2018 1:52 pm	Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0113

			T: +1 -		0 12/31/201/	5/14/2018 1:5	
			Charges	e XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpati ent Rati o	
	INDATIENT POUTINE CEDVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	45, 365, 445		45, 365, 445			30.00
31. 00	03100 I NTENSI VE CARE UNI T	12, 211, 116		12, 211, 116			31. 00
32.00	03200 CORONARY CARE UNIT	0		C			32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0		C			33. 00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0					34. 00 40. 00
41. 00	04100 SUBPROVIDER - TPF	0					41.00
42. 00	04200 SUBPROVI DER	o		d			42. 00
43.00	04300 NURSERY	4, 618, 368		4, 618, 368			43. 00
44. 00	04400 SKILLED NURSING FACILITY	0		C			44. 00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0					45. 00 46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>					40.00
50.00	05000 OPERATI NG ROOM	20, 437, 995	46, 743, 022	67, 181, 017		0. 000000	50. 00
51.00	05100 RECOVERY ROOM	0	0	C	0.000000	0. 000000	51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0 1, 752, 686	1, 728, 647) ' 3, 481, 333	0. 000000 0. 094151	0. 000000 0. 000000	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 596, 719	18, 834, 833			0. 000000	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0 23, 131, 332	0. 000000	0. 000000	55. 00
56. 00	05600 RADI OI SOTOPE	1, 149, 580	12, 376, 651			0.000000	56. 00
57. 00	05700 CT SCAN	7, 724, 881	27, 391, 904			0.000000	57. 00
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	1, 773, 238 7, 116, 773	9, 461, 569 14, 407, 470			0. 000000 0. 000000	58. 00 59. 00
60. 00	06000 LABORATORY	11, 963, 130	32, 124, 539			0. 000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0)		0. 000000	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0) c	0. 000000	0. 000000	61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 046, 274	647, 120	1, 693, 394		0.000000	62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0		0. 000000 0. 000000	0. 000000 0. 000000	63. 00 64. 00
65. 00	06500 RESPI RATORY THERAPY	3, 705, 123	1, 827, 111	5, 532, 234		0. 000000	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 404, 473	7, 660, 200			0. 000000	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	759, 469	834, 459			0. 000000	67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	469, 697	427, 513	1		0. 000000 0. 000000	68. 00 69. 00
70.00	07000 ELECTROCARDI OLOGI	3, 612, 852 1, 133, 409	8, 076, 943 3, 557, 124			0. 000000	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21, 731, 408	23, 408, 482			0. 000000	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	20, 007, 691	12, 000, 315			0. 000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	21, 084, 068	22, 392, 724			0.000000	73.00
74. 00 75. 00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	573, 648 0	0	1		0. 000000 0. 000000	74. 00 75. 00
73.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		ή	0.00000	0.000000	73.00
88. 00	08800 RURAL HEALTH CLINIC	0	C) C			88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0.00000	89. 00
90.00	09000 CLINIC 09001 WOUND/OSTOMY CLINIC	0	7, 924, 449	1		0. 000000 0. 000000	
90. 01	09002 KIDS PLUS CLINIC	0	7, 724, 447) 7, 724, 447	0. 000000	0. 000000	90.01
90. 03	09003 ONCOLOGY	486, 157	29, 791, 954	30, 278, 111		0. 000000	90. 03
90. 04	09004 MUNCI E CLINI C	0	0	0	0. 000000	0. 000000	90. 04
90. 05 90. 06	09005 ANTI COAGULATI ON CLINI C 09006 PREGNANCY PLUS	0	840, 348	840, 348	0. 535548 0. 000000	0. 000000 0. 000000	90. 05 90. 06
90.00	09007 0/P LAB	0	0		0.000000	0. 000000	90.00
90. 08	09008 0/P LAB	0	0		0. 000000	0. 000000	90. 08
90. 09	09009 FORTVILLE CLINIC	0	0) c	0. 000000	0.000000	90. 09
91.00	09100 EMERGENCY	9, 338, 222	31, 335, 426			0.000000	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	10, 269, 540	10, 269, 540	0. 249391	0. 000000	92.00
94.00	09400 HOME PROGRAM DI ALYSI S	0	O) C	0.000000	0. 000000	94. 00
95. 00	09500 AMBULANCE SERVICES	0	0) c	0. 000000	0.000000	95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0			0.000000	96.00
97. 00 99. 00	09700 DURABLE MEDICAL EQUIP-SOLD 09900 CMHC		0		0. 000000	0. 000000	97. 00 99. 00
	09910 CORF	o	0				99. 10
	10000 I&R SERVICES-NOT APPRVD PRGM	O	0) c			100. 00
101.00	10100 HOME HEALTH AGENCY	0	0) C			101. 00
105 00	SPECIAL PURPOSE COST CENTERS 10500 KIDNEY ACQUISITION	O	C) C			105. 00
	10600 HEART ACQUISITION	0	0				106.00
107.00	10700 LIVER ACQUISITION	0	0	C			107. 00
	10800 LUNG ACQUISITION	0	0	C			108.00
109.00	10900 PANCREAS ACQUISITION	0	C) C	1		109. 00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	NITY HOSPITAL ANDERSON In Lieu		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0113	Peri od: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/14/2018 1:52 pm	

		Title	xVIII	Hospi tal	PPS	
	Charges					
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6.00	7. 00	8. 00	9. 00	10.00	
110.00 11000 INTESTINAL ACQUISITION	0	0	C			110.00
111.00 11100 ISLET ACQUISITION	0	0	C			111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	O	0	ol c)		115. 00
116. 00 11600 HOSPI CE	O	0	ol c)		116. 00
200.00 Subtotal (see instructions)	204, 062, 422	324, 062, 343	528, 124, 765			200. 00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	204, 062, 422	324, 062, 343	528, 124, 765			202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared: | 5/14/2018 1:52 pm | PPS | Title XVIII

		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS				3	30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
32. 00 03200 CORONARY CARE UNIT					32.00
33. 00 03300 BURN INTENSIVE CARE UNIT					33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT					34.00
40. 00 04000 SUBPROVI DER - I PF				1	40.00
41. 00 04100 SUBPROVI DER - I RF					41. 00
42. 00 04200 SUBPROVI DER					42. 00
43. 00 04300 NURSERY				1	43. 00
· · · · · · · · · · · · · · · · · · ·				1	
				1	44. 00
45. 00 04500 NURSI NG FACILITY					45. 00
46.00 O4600 OTHER LONG TERM CARE					46. 00
ANCI LLARY SERVI CE COST CENTERS	1				
50.00 05000 OPERATING ROOM	0. 213116			1	50. 00
51. 00 05100 RECOVERY ROOM	0. 000000				51. 00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0. 000000				52. 00
53. 00 05300 ANESTHESI OLOGY	0. 094151			į	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 259999			Ę	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			Ę	55. 00
56. 00 05600 RADI 01 SOTOPE	0. 070376			Ę	56.00
57. 00 05700 CT SCAN	0. 026986			Ĺ	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 110841			1	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 089816			1	59. 00
60. 00 06000 LABORATORY	0. 139006				60.00
60. 01 06001 BLOOD LABORATORY	0. 000000				60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			1	61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 227897			1	62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			1	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000				64. 00
	1				
65. 00 06500 RESPIRATORY THERAPY	0. 293922			1	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 376800				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 488855				67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 403484			1	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 077182			1	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 240203			7	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 355445			7	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 392543			1.7	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 229869				73.00
74.00 07400 RENAL DIALYSIS	0. 771219			-	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000			-	75. 00
OUTPATIENT SERVICE COST CENTERS	<u>'</u>				
88. 00 08800 RURAL HEALTH CLINIC					88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER				1	89. 00
90. 00 09000 CLI NI C	0. 000000			1	90.00
90. 01 09001 WOUND/OSTOMY CLINIC	0. 205715			1	90. 01
90. 02 09002 KI DS PLUS CLI NI C	0. 000000				90. 02
90. 03 09003 0NCOLOGY	0. 000000			1	90. 03
90. 04 09004 MUNCI E CLI NI C	0. 000000			1	90. 03
90. 05 09005 ANTI COAGULATI ON CLINIC	0. 535548				90. 05
	0. 000000				90.06
90. 07 09007 0/P LAB	0. 000000				90. 07
90. 08 09008 0/P LAB	0. 000000				90. 08
90. 09 09009 FORTVI LLE CLI NI C	0. 000000				90. 09
91. 00 09100 EMERGENCY	0. 182160				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 249391				92. 00
OTHER REIMBURSABLE COST CENTERS					
94.00 09400 HOME PROGRAM DIALYSIS	0. 000000				94. 00
95. 00 09500 AMBULANCE SERVICES	0. 000000			(95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			(96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			(97. 00
99. 00 09900 CMHC				1	99. 00
99. 10 09910 CORF					99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM				1	00.00
101. 00 10100 HOME HEALTH AGENCY					01. 00
SPECIAL PURPOSE COST CENTERS	<u>'</u>				00
105. 00 10500 KIDNEY ACQUISITION				11	05. 00
106. 00 10600 HEART ACQUISITION					06. 00
					06.00
107. 00 10700 LING ACQUISITION					
108. 00 10800 LUNG ACQUI SI TI ON					08. 00
109. 00 10900 PANCREAS ACQUI SI TI ON					09. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON				1	10.00
111.00 11100 ISLET ACQUISITION				11	11. 00

Health Financial Systems	COMMUNITY HOSPIT	AL ANDERSON	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0113	Peri od: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/14/2018 1:5		
		Title XVIII	Hospi tal	PPS		
Cost Center Description	PPS Inpatient Ratio 11.00					
113.00 11300 INTEREST EXPENSE 114.00 11400 UTILIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116.00 11600 Experiment of the control					113. 00 114. 00 115. 00 116. 00 200. 00 201. 00 202. 00	

	TATION OF DATIO OF COSTS TO CHARCES	COMMUNITY HOSPI	Provider C	°N: 15 ∩112	Peri od:	Worksheet C	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C		Ferrod: From 01/01/2017 To 12/31/2017	Part I Date/Time Pre	pared:
			Ti tl	e XIX	Hospi tal	5/14/2018 1:5 Cost	2 pm
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		26) 1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	30, 499, 007 5, 667, 769		30, 499, 00 5, 667, 76		30, 499, 007 5, 667, 769	30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	3,007,707		3,007,70	0 0	0,007,707	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0			0	0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0			0 0	0	34. 00
40.00	04000 SUBPROVI DER	0			0	0	40. 00 41. 00
41. 00 42. 00	04200 SUBPROVI DER	0			0 0		41.00
43. 00	04300 NURSERY	1, 909, 079		1, 909, 07	9 0	1, 909, 079	1
44. 00	04400 SKILLED NURSING FACILITY	0			0 0	0	44. 00
45. 00	04500 NURSING FACILITY	0			0	0	45. 00
46. 00	O4600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0			0 0	0	46. 00
50.00	05000 OPERATING ROOM	14, 317, 367		14, 317, 36	7 0	14, 317, 367	50.00
51. 00	05100 RECOVERY ROOM	0			0 0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0			0	0	52.00
53.00	05300 ANESTHESI OLOGY	327, 770		327, 77		327, 770	
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	6, 092, 185		6, 092, 18	0 0	6, 092, 185 0	54. 00 55. 00
56. 00	05600 RADI OI SOTOPE	951, 925		951, 92	-	951, 925	1
57. 00	05700 CT SCAN	947, 645		947, 64		947, 645	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 245, 276		1, 245, 27		1, 245, 276	
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 933, 220		1, 933, 22		1, 933, 220	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	6, 128, 436 0		6, 128, 43	0	6, 128, 436 0	60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0 0	0	61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	385, 920		385, 92	0	385, 920	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0			0	0	63. 00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY	1 (2) 045		1 (2(04	0 5 0	1 424 045	64.00
66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 626, 045 3, 415, 565		1, 626, 04 3, 415, 56		1, 626, 045 3, 415, 565	
67. 00	06700 OCCUPATI ONAL THERAPY	779, 200		779, 20		779, 200	
68. 00	06800 SPEECH PATHOLOGY	362, 010		362, 01	0 0	362, 010	
69. 00	06900 ELECTROCARDI OLOGY	902, 245		902, 24		902, 245	1
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 126, 680 16, 044, 757		1, 126, 68 16, 044, 75		1, 126, 680 16, 044, 757	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	12, 564, 530		12, 564, 53		12, 564, 530	
73. 00	07300 DRUGS CHARGED TO PATIENTS	9, 993, 973		9, 993, 97		9, 993, 973	
74. 00	07400 RENAL DIALYSIS	442, 408		442, 40		442, 408	
75. 00	O7500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0			0 0	0	75. 00
88. 00	08800 RURAL HEALTH CLINIC	0			0 (0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	Ō	89. 00
90. 00	09000 CLI NI C	0			0 0	0	90. 00
90. 01	09001 WOUND/OSTOMY CLINIC	1, 630, 179		1, 630, 17		1, 630, 179	90. 01
90. 02 90. 03	09002 KIDS PLUS CLINIC 09003 ONCOLOGY	98, 842		98, 84	0 0	98, 842 0	90. 02 90. 03
90. 03	09004 MUNCIE CLINIC	96, 746		96, 74	-	96, 746	1
90. 05	09005 ANTI COAGULATI ON CLINIC	450, 047		450, 04		450, 047	90. 05
90. 06	09006 PREGNANCY PLUS	151, 098		151, 09	8 0	151, 098	
90. 07 90. 08	09007	0			0	0	90. 07 90. 08
90.08	09009 FORTVILLE CLINIC	76, 184		76, 18	4 0	76, 184	
91. 00	09100 EMERGENCY	7, 409, 093		7, 409, 09		7, 409, 093	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 561, 131		2, 561, 13	1	2, 561, 131	92. 00
04.00	OTHER REIMBURSABLE COST CENTERS			1			04.00
94. 00 95. 00	09400 HOME PROGRAM DI ALYSIS 09500 AMBULANCE SERVICES	0			0 0	0	94. 00 95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0			0 0	0	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	•		0	0	97. 00
99. 00	09900 CMHC	0			O	0	99. 00
	09910 CORF	0			טן	0	99. 10
	10000 &R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	0			0	•	100. 00 101. 00
101.00	SPECIAL PURPOSE COST CENTERS			,	9	<u> </u>	1.01.00
	10500 KIDNEY ACQUISITION	0			O .	l	105. 00
	10600 HEART ACQUISITION	0			0	l	106.00
	10700 LIVER ACQUISITION 10800 LUNG ACQUISITION	0			0		107. 00 108. 00
100.00	1.0000 2010 10001 01 11 011	ı	<u> </u>	1	~ <u> </u>	1 0	1,00.00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0113	From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/14/2018 1:52 pm

		Ti tl	e XIX	Hospi tal	Cost	
				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		0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0		0		0	110. 00
111.00 11100 ISLET ACQUISITION	0		C		0	111. 00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0		C		0	115.00
116. 00 11600 HOSPI CE	0		C		0	116.00
200.00 Subtotal (see instructions)	130, 136, 332	0	130, 136, 332	0	130, 136, 332	200.00
201.00 Less Observation Beds	2, 561, 131		2, 561, 131		2, 561, 131	201.00
202.00 Total (see instructions)	127, 575, 201	О (127, 575, 201	0	127, 575, 201	202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0113

				Titl	e XIX	Hospi tal	5/14/2018 1:5 Cost	2 pm
				Charges			TEED.	
		Cost Center Description	Inpatient	Outpati ent	lotal (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient	
					ŕ		Rati o	
	ΙΝΡΔΤ	IENT ROUTINE SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
30. 00		ADULTS & PEDIATRICS	45, 365, 445		45, 365, 445			30.00
31. 00		INTENSIVE CARE UNIT	12, 211, 116		12, 211, 116			31.00
32. 00		CORONARY CARE UNIT	0		C			32. 00
33.00		BURN INTENSIVE CARE UNIT	0		C			33.00
34. 00 40. 00		SURGICAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	0					34. 00 40. 00
41. 00		SUBPROVI DER - I RF	o		Č			41. 00
42. 00		SUBPROVI DER	0		C			42. 00
43. 00 44. 00		NURSERY SKILLED NURSING FACILITY	4, 618, 368		4, 618, 368			43. 00 44. 00
45. 00		NURSING FACILITY	o					45. 00
46. 00	04600	OTHER LONG TERM CARE	0		C			46. 00
F0 00		LARY SERVICE COST CENTERS	00 407 005	47.740.000	T 404 045	0.04044/	0.00000	
50. 00 51. 00		OPERATING ROOM RECOVERY ROOM	20, 437, 995	46, 743, 022 0			0. 000000 0. 000000	
52. 00		DELIVERY ROOM & LABOR ROOM	ő	0		0. 000000	0. 000000	
53.00	05300	ANESTHESI OLOGY	1, 752, 686	1, 728, 647		0. 094151	0. 000000	53. 00
54.00		RADI OLOGY - DI AGNOSTI C	4, 596, 719	18, 834, 833			0.000000	
55. 00 56. 00		RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	1, 149, 580	0 12, 376, 651			0. 000000 0. 000000	
57. 00		CT SCAN	7, 724, 881	27, 391, 904			0. 000000	
58. 00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1, 773, 238	9, 461, 569			0. 000000	
59.00		CARDI AC CATHETERI ZATI ON	7, 116, 773	14, 407, 470			0.000000	
60. 00 60. 01		LABORATORY BLOOD LABORATORY	11, 963, 130	32, 124, 539 0			0. 000000 0. 000000	
61. 00		PBP CLINICAL LAB SERVICES-PRGM ONLY	o	0		0. 000000	0. 000000	
62. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 046, 274	647, 120	1, 693, 394		0. 000000	1
63.00		BLOOD STORING, PROCESSING & TRANS.	0	0	C	0.000000	0.000000	
64. 00 65. 00		I NTRAVENOUS THERAPY RESPI RATORY THERAPY	3, 705, 123	0 1, 827, 111	5, 532, 234	0. 000000 0. 293922	0. 000000 0. 000000	
66. 00		PHYSI CAL THERAPY	1, 404, 473	7, 660, 200			0. 000000	
67. 00		OCCUPATI ONAL THERAPY	759, 469	834, 459			0. 000000	
68. 00		SPEECH PATHOLOGY	469, 697	427, 513			0.000000	
69. 00 70. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	3, 612, 852 1, 133, 409	8, 076, 943 3, 557, 124			0. 000000 0. 000000	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	21, 731, 408	23, 408, 482			0. 000000	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20, 007, 691	12, 000, 315		0. 392543	0. 000000	72. 00
73.00		DRUGS CHARGED TO PATIENTS	21, 084, 068	22, 392, 724			0.000000	
74. 00 75. 00		RENAL DIALYSIS ASC (NON-DISTINCT PART)	573, 648 0	0			0. 000000 0. 000000	
70.00		TIENT SERVICE COST CENTERS	<u> </u>			0.00000	0.00000	70.00
88. 00		RURAL HEALTH CLINIC	0	0	i e		0. 000000	
89. 00 90. 00		FEDERALLY QUALIFIED HEALTH CENTER	0	0	•	0. 000000 0. 000000	0. 000000 0. 000000	
90. 00		WOUND/OSTOMY CLINIC	o	7, 924, 449	l	0 005745	0.00000	
90. 02		KIDS PLUS CLINIC	O	0	C	0. 000000	0. 000000	1
90. 03		ONCOLOGY	486, 157	29, 791, 954	30, 278, 111		0.000000	
90. 04 90. 05		MUNCIE CLINIC ANTICOAGULATION CLINIC	0	840, 348	840, 348	0. 000000 0. 535548	0. 000000 0. 000000	
90. 06		PREGNANCY PLUS	ő	040, 340	040, 340	0. 000000	0. 000000	
90. 07	1	O/P LAB	o	0	C	0. 000000	0. 000000	1
90. 08		O/P LAB	0	0	C	0.000000	0.000000	
90. 09 91. 00		FORTVILLE CLINIC EMERGENCY	9, 338, 222	31, 335, 426	40, 673, 648	0. 000000 0. 182160	0. 000000 0. 000000	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	0	10, 269, 540			0. 000000	1
		REIMBURSABLE COST CENTERS						
94. 00 95. 00		HOME PROGRAM DIALYSIS AMBULANCE SERVICES	0	0		0. 000000 0. 000000	0. 000000 0. 000000	
96. 00	1	DURABLE MEDICAL EQUIP-RENTED	o	0		0.000000	0. 000000	
97. 00		DURABLE MEDICAL EQUIP-SOLD	o	0	C	0. 000000	0. 000000	
99. 00	09900	•	0	0	C			99. 00
	09910	CURF I&R SERVICES-NOT APPRVD PRGM	0	0				99. 10 100. 00
		HOME HEALTH AGENCY	o	0	•			101.00
	SPECI	AL PURPOSE COST CENTERS	· -1					
		KIDNEY ACQUISITION	0	0	i e			105.00
		HEART ACQUISITION LIVER ACQUISITION		0				106. 00 107. 00
		LUNG ACQUISITION	o	0				108. 00
109.00	10900	PANCREAS ACQUISITION	0	0	c)		109. 00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0113	Peri od: From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared: 5/14/2018 1:52 pm

10.00
11.00
13.00
14.00
15.00
16.00
200.00
201.00
202.00
1 1 2 2

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared: 5/14/2018 1:52 pm | Hospital | Cost

				5/14/2018 1:52 pm
Cost Conton Decement on	DDC Innotiont	Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30. 00
31. 00 03100 INTENSIVE CARE UNIT				31.00
32. 00 03200 CORONARY CARE UNIT				32.00
33. 00 03300 BURN INTENSIVE CARE UNIT				33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - IPF				34. 00 40. 00
41. 00 04100 SUBPROVI DER - 1 FF				41. 00
42. 00 04200 SUBPROVI DER				42.00
43. 00 04300 NURSERY				43.00
44.00 04400 SKILLED NURSING FACILITY				44. 00
45.00 04500 NURSING FACILITY				45. 00
46.00 O4600 OTHER LONG TERM CARE				46. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			50.00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 000000 0. 000000			51. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
56. 00 05600 RADI 0I SOTOPE	0. 000000			56.00
57. 00 05700 CT SCAN	0. 000000			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00 06000 LABORATORY	0. 000000			60.00
60.01 06001 BLOOD LABORATORY 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000 0. 000000			60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63. 00
64. 00 06400 NTRAVENOUS THERAPY	0. 000000			64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72. 00 07200 MPL. DEV. CHARGED TO PATIENTS	0. 000000 0. 000000			71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
74. 00 07400 RENAL DIALYSIS	0. 000000			74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0. 000000			88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89.00
90. 00 09000 CLI NI C	0. 000000			90.00
90. 01 09001 WOUND/OSTOMY CLINIC 90. 02 09002 KIDS PLUS CLINIC	0. 000000 0. 000000			90. 01
90. 03 09003 0NCOLOGY	0. 000000			90. 02
90. 04 09004 MUNCI E CLINI C	0. 000000			90.03
90. 05 09005 ANTI COAGULATI ON CLINI C	0. 000000			90. 05
90. 06 09006 PREGNANCY PLUS	0. 000000			90. 06
90. 07 09007 0/P LAB	0. 000000			90. 07
90. 08 09008 0/P LAB	0. 000000			90. 08
90. 09 09009 FORTVILLE CLINIC	0. 000000			90. 09
91. 00 09100 EMERGENCY	0.000000			91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0. 000000			92. 00
94. 00 09400 HOME PROGRAM DIALYSIS	0. 000000			94. 00
95. 00 09500 AMBULANCE SERVI CES	0. 000000			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			97. 00
99. 00 09900 CMHC				99. 00
99. 10 09910 CORF				99. 10
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM				100.00
101. 00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				105.00
105. 00 10500 KIDNEY ACQUISITION 106. 00 10600 HEART ACQUISITION				105. 00 106. 00
106. 00 10600 HEART ACQUISITION 107. 00 10700 LIVER ACQUISITION				106.00
108.00 10800 LIVER ACQUISITION				108. 00
109. 00 10900 PANCREAS ACQUISITION				109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON				110. 00
111.00 11100 I SLET ACQUISITION	<u> </u>			111. 00

Health Financial Systems	COMMUNITY HOSPIT	AL ANDERSON	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0113	Peri od: From 01/01/2017	Worksheet C Part I
			To 12/31/2017	Date/Time Prepared: 5/14/2018 1:52 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
113. 00 11300 NTEREST EXPENSE				113. 00
114.00 11400 UTILIZATION REVIEW-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		CN: 15-0113	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D Part I Date/Time Pre 5/14/2018 1:5	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capi tal Rel ated Cos (col. 1 - co 2)		Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT 32. 00 CORONARY CARE UNIT 33. 00 BURN INTENSIVE CARE UNIT 34. 00 SUBGICAL INTENSIVE CARE UNIT 40. 00 SUBPROVIDER - IPF 41. 00 SUBPROVIDER - IRF 42. 00 SUBPROVIDER - IRF 42. 00 SUBPROVIDER 43. 00 NURSERY 44. 00 SKILLED NURSING FACILITY 45. 00 NURSING FACILITY 200. 00 Total (lines 30 through 199) Cost Center Description	2, 238, 982 399, 277 0 0 0 0 67, 240 0 2, 705, 499 Inpatient Program days		2, 238, 94 399, 2	77 1, 435 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	90. 61 278. 24 0. 00 0. 00 0. 00 0. 00 0. 00 33. 52 0. 00 0. 00	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00
INPATIENT ROUTINE SERVICE COST CENTERS	6.00	7.00				
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT 32. 00 CORONARY CARE UNIT 33. 00 BURN INTENSIVE CARE UNIT 34. 00 SURGICAL INTENSIVE CARE UNIT 40. 00 SUBPROVIDER - IPF 41. 00 SUBPROVIDER - IRF 42. 00 SUBPROVIDER 43. 00 NURSERY 44. 00 SKILLED NURSING FACILITY 45. 00 NURSING FACILITY 200. 00 Total (lines 30 through 199)	9, 660 1, 348 0 0 0 0 0 0 0 0 0	375, 068				30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 00 200. 00

Heal th	Financial Systems	COMMUNITY HOSP	TAL ANDERSON		In Lie	eu of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0113	Peri od:	Worksheet D	
					From 01/01/2017	Part II	
					To 12/31/2017	Date/Time Pre	pared:
-						5/14/2018 1:5	2 pm
				XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 + col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)	·				
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	•	•	•			
50.00	05000 OPERATI NG ROOM	2, 046, 324	67, 181, 017	0. 03046	9, 257, 916	281, 996	50.00
51.00	05100 RECOVERY ROOM	0	0	0.00000			1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000		0	1
53. 00	05300 ANESTHESI OLOGY	18, 305	١	1		1	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	882, 326	23, 431, 552	l .			•
		002, 320	23, 431, 332				
55.00	O5500 RADI OLOGY-THERAPEUTI C	50 770	40 50/ 004	0.00000		0	
56. 00	05600 RADI OI SOTOPE	58, 778					•
57. 00	05700 CT SCAN	27, 143					
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	59, 501	11, 234, 807				
59. 00	05900 CARDI AC CATHETERI ZATI ON	229, 818	21, 524, 243	0. 01067	77 3, 093, 585	33, 030	59. 00
60.00	06000 LABORATORY	451, 309	44, 087, 669	0. 01023	5, 589, 839	57, 223	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0.00000	00	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	18, 841	1, 693, 394	0. 01112	459, 366	5, 111	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	10,041	1,075,574	0. 00000		0, 111	1
64. 00	06400 I NTRAVENOUS THERAPY			0.00000		0	1
		(7.552	U F F22 224	1		1	
65. 00	06500 RESPI RATORY THERAPY	67, 552	5, 532, 234	1			1
66. 00	06600 PHYSI CAL THERAPY	145, 711	9, 064, 673	l .			1
67. 00	06700 OCCUPATI ONAL THERAPY	87, 390					
68. 00	06800 SPEECH PATHOLOGY	13, 725	897, 210	0. 01529	257, 525	3, 939	68. 00
69. 00	06900 ELECTROCARDI OLOGY	69, 810	11, 689, 795	0.00597	1, 922, 261	11, 480	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	82, 548	4, 690, 533	0. 01759	99 413, 913	7, 284	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	200, 779	45, 139, 890	0. 00444	9, 732, 202	43, 289	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	157, 226	32, 008, 006	0. 00491	9, 926, 784	48, 760	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	173, 463		1			1
74. 00	07400 RENAL DI ALYSI S	8, 381	573, 648	1			1
75. 00	07500 ASC (NON-DISTINCT PART)	0,001	l	1		-	
73.00	OUTPATIENT SERVICE COST CENTERS			0.00000	0		75.00
88. 00	08800 RURAL HEALTH CLINIC	1 0	0	0.00000	00 0	0	88. 00
		_	ľ			-	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000			
90.00	09000 CLI NI C	0	0	0. 00000		-	
90. 01	09001 WOUND/OSTOMY CLINIC	280, 160	7, 924, 449			0	
90. 02	09002 KIDS PLUS CLINIC	36, 571	0	0.00000		0	90. 02
90. 03	09003 ONCOLOGY	0	0	0.00000	0 0	0	90. 03
90.04	09004 MUNCIE CLINIC	35, 245	0	0.00000	0 0	0	90. 04
90. 05	09005 ANTI COAGULATI ON CLINI C	8, 491	840, 348	0. 01010	0	0	90. 05
90.06	09006 PREGNANCY PLUS	56, 318	l	0. 00000		0	1
90. 07	09007 0/P LAB	0	0	0.00000		0	90. 07
90. 08	09008 0/P LAB	0	0	0. 00000		0	1
	09009 FORTVILLE CLINIC	27, 927		0.00000			
	09100 EMERGENCY	424, 978				_	91.00
				l .			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	188, 018	10, 269, 540	0. 01830	0 8	0	92.00
	OTHER REIMBURSABLE COST CENTERS			1	. =1		4
94. 00	09400 HOME PROGRAM DIALYSIS	0	0	0. 00000	00	0	
95. 00	09500 AMBULANCE SERVI CES					1	95. 00
96. 00	1 1	0	0	0. 00000		0	
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.00000		0	
200.00	Total (lines 50 through 199)	5, 856, 638	435, 651, 725		62, 810, 199	729, 356	200.00
	•						

Health Financial Systems	COMMUNITY HOSP	ITAL ANDERSON		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS	TS Provider C		Peri od:	Worksheet D	
				From 01/01/2017 Fo 12/31/2017	Part III Date/Time Pre	narod:
				10 12/31/2017	5/14/2018 1:5	2 pm
		Ti tl e	e XVIII	Hospi tal	PPS	
Cost Center Description		Nursing School		Allied Health	All Other	
	Post-Stepdown		Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	_	_	.1			
30. 00 03000 ADULTS & PEDI ATRI CS	C		1			
31. 00 03100 I NTENSI VE CARE UNIT	C		1	0		1
32. 00 03200 CORONARY CARE UNIT	C	1			1	
33. 00 03300 BURN INTENSIVE CARE UNIT	C	Ί		0	1	
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT	C	1		0	0	
40. 00 04000 SUBPROVI DER - I PF	C	Ί "			0	
41. 00 04100 SUBPROVI DER - I RF	C				0	
42. 00 04200 SUBPROVI DER					0	
43. 00 04300 NURSERY	C	1			0	
44. 00 04400 SKI LLED NURSI NG FACI LI TY	C	Ί			<u>'</u>	44. 00
45. 00 04500 NURSI NG FACI LI TY	C					45. 00
200.00 Total (lines 30 through 199)		,	Total Dotiont	Don Diam (and		200. 00
Cost Center Description	Swing-Bed Adjustment	Total Costs (sum of cols.	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient	
	Amount (see	1 through 3,	Days	5 ÷ COI. 6)	Program Days	
	instructions)	mi nus col . 4)				
	4. 00	5. 00	6.00	7. 00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1. 00	0.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	C		24, 710	0.00	9, 660	30.00
31. 00 03100 I NTENSI VE CARE UNI T						
32. 00 03200 CORONARY CARE UNIT				0.00		
33.00 03300 BURN INTENSIVE CARE UNIT				0.00	•	
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0		0.00		1
40. 00 04000 SUBPROVI DER - I PF) 0		0.00	0	40.00
41. 00 04100 SUBPROVI DER - RF		0		0.00	0	41.00
42. 00 04200 SUBPROVI DER	C	0		0.00	0	42. 00
43. 00 04300 NURSERY		0	2,00	0.00	0	43.00
44.00 04400 SKILLED NURSING FACILITY		0		0.00	0	44.00
45.00 04500 NURSING FACILITY		0		0.00	0	45. 00
200.00 Total (lines 30 through 199)		0	28, 15 ⁻	1	11, 008	200. 00
Cost Center Description	I npati ent	PSA Adj. All				
	Program	Other Medical				
	Pass-Through		:			
	Cost (col. 7 x					
	col . 8)	40.00	_			
INDATI ENT. DOUTINE CEDIM OF COCT OFNITEDS	9. 00	13. 00				
INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS		\	J			20.00
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 NTENSIVE CARE UNIT	C	l control of the cont	1			30. 00 31. 00
		l l	1			31.00
32.00 03200 CORONARY CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT	C	l l	1			33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T		1				34.00
40. 00 04000 SUBPROVI DER - 1 PF		-				40.00
41. 00 04100 SUBPROVI DER - 1 PF		-	1			41.00
42. 00 04200 SUBPROVI DER - 1 RF		 	1			41.00
43. 00 04300 NURSERY		 				42.00
44.00 04400 SKILLED NURSING FACILITY		 	ή			44.00
45. 00 04500 NURSING FACILITY		1				45.00
200.00 Total (lines 30 through 199)		1				200.00
255. 55 ₁ 10tal (11105 55 thi bagii 177)		1	1			1-30. 00

Peri od: Worksheet D From 01/01/2017 Part IV To 12/31/2017 Date/Time Prepared: 5/14/2018 1:52 pm THROUGH COSTS

						5/14/2018 1:5	2 pm
			Title	xVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	,	Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2/1	2.00	071	0.00	
50.00	05000 OPERATING ROOM	1	0		0	0	50.00
51. 00	05100 RECOVERY ROOM	0	0				51.00
		0		1	-	1	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	ı c	0	-	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	(0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	(0	0	55. 00
56. 00	05600 RADI 0I SOTOPE	0	0	(0	0	56. 00
57.00	05700 CT SCAN	0	0	(0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	·	0	0	59. 00
60.00	06000 LABORATORY	0	0		0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	d	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	1	_				61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1	0		0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.				-	1	63. 00
64. 00	06400 I NTRAVENOUS THERAPY					0	64.00
	1	0				-	
65. 00	06500 RESPI RATORY THERAPY	0		1	-	1	65.00
66.00	06600 PHYSI CAL THERAPY	0	0			1	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		,	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	(0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	(1	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	(,	1	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	(0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0	0	75. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0	88.00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89. 00
90.00	09000 CLINIC	0	0				90.00
90. 01	09001 WOUND/OSTOMY CLINIC	0	0		-	1	90. 01
90. 02	09002 KIDS PLUS CLINIC				-	Ö	90. 02
90. 03	09003 ONCOLOGY				,	•	90. 03
90. 04	09004 MUNCI E CLINI C				-	1	90.03
90. 04	09005 ANTI COAGULATION CLINIC					0	90.05
		0		1	,	1	
90.06	09006 PREGNANCY PLUS	0	0		0	0	90.06
90. 07	09007 0/P LAB	0	0		0	0	90. 07
90. 08	09008 0/P LAB	0	0	(,	0	90. 08
90. 09	09009 FORTVILLE CLINIC	0	0	(0	90. 09
91. 00	09100 EMERGENCY	0	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 DIALYSIS	0	0	(0	0	94. 00
95.00	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	(0	0	96. 00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	· C	0	0	97. 00
200.00		0	0	ıl c	0	0	200. 00
	1 , , , , , , , , , , , , , , , , , , ,	-	'	'	1	1	

In Lieu of Form CMS-2552-10

| Period: | Worksheet D |
| From 01/01/2017 | Part IV |
| To 12/31/2017 | Date/Time Prepared: | 5/14/2018 1:52 pm | Provider CCN: 15-0113 THROUGH COSTS

				'	0 12/01/201/	5/14/2018 1:5	2 pm
			Ti tl e	e XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	'	Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col. 2, 3 and	8)	7)	
			,	4)	·	,	
		4.00	5. 00	6.00	7. 00	8. 00	
<u> </u>	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	(0	67, 181, 017	0.000000	50. 00
51.00	05100 RECOVERY ROOM	0	(0	0	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	(0	0	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	0	(0	3, 481, 333	0.000000	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	(0	23, 431, 552	0.000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	(o	0	0.000000	55. 00
56.00	05600 RADI OI SOTOPE	0	(ol c	13, 526, 231	0.000000	56. 00
57.00	05700 CT SCAN	0	(ol c	35, 116, 785	0.000000	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		ol c	11, 234, 807	0.000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0		ol c	21, 524, 243	0.000000	59. 00
60.00	06000 LABORATORY	0		ol o		0. 000000	60.00
60. 01	06001 BLOOD LABORATORY	0	(ol o	0	0. 000000	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	(1, 693, 394	0. 000000	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0		1	0	0. 000000	
64. 00	06400 I NTRAVENOUS THERAPY	0			-	0. 000000	64. 00
65. 00	06500 RESPI RATORY THERAPY	l o			_	0. 000000	65. 00
66. 00	06600 PHYSI CAL THERAPY	0		1		0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	0		1		0. 000000	
68. 00	06800 SPEECH PATHOLOGY	0			1	0. 000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0				0. 000000	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0		1	,	0. 000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		~I		0. 000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	i o		1		0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	(1		0. 000000	
74. 00	07400 RENAL DIALYSIS	0		1		0. 000000	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0				0. 000000	75.00
70.00	OUTPATIENT SERVICE COST CENTERS			71	· · · · · ·	0.000000	70.00
88. 00	08800 RURAL HEALTH CLINIC	0	(0	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0. 000000	89. 00
90.00	09000 CLI NI C	0	Ċ		0	0. 000000	90.00
90. 01	09001 WOUND/OSTOMY CLINIC	0	(l	
90. 02	09002 KIDS PLUS CLINIC	0		1		0. 000000	90. 02
90. 03	09003 ONCOLOGY	0	Ċ	1		0.000000	90. 03
90. 04	09004 MUNCI E CLINI C	0	(0. 000000	
90. 05	09005 ANTI COAGULATI ON CLINIC	0			840, 348	0. 000000	90. 05
90. 06	09006 PREGNANCY PLUS	0				0. 000000	90. 06
90. 07	09007 0/P LAB	0		1	0	0. 000000	90. 07
90. 08	09008 0/P LAB	o o			0	0. 000000	90. 08
90. 09	09009 FORTVILLE CLINIC	0		1	_	0. 000000	90.09
91. 00	09100 EMERGENCY			1		0.000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		1		0. 000000	92. 00
12.00	OTHER REIMBURSABLE COST CENTERS			1	10, 207, 340	0.000000	72.00
94. 00	09400 HOME PROGRAM DI ALYSI S	0	(0	0.000000	94. 00
95. 00	09500 AMBULANCE SERVICES			1		3.000000	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	(0	0. 000000	
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0		1		0. 000000	
200.00	1	0		1	_	l e	200.00
200.00	, 1.5ta. (111105 00 till ough 177)	1		1	100, 727, 000	ı	_50.00

| Peri od: | Worksheet D | From 01/01/2017 | Part IV | To 12/31/2017 | Date/Time Prepared: THROUGH COSTS

51. 00 05100 RECOVERY ROOM 0.000000 0 0 0 0 51. 00 52. 0 0 0 0 0 0 0 53.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 55.00 0 0 0 0 0 0 0 0 0 55. 0 55.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <t< th=""><th>ed: m</th></t<>	ed: m
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Rati o of Cost to Charges (col . 6 + col . 7) Program Program Program Program Program Charges Pass-Through Costs (col . 8 x col . 10)	
Costs (col 8 x col 10) x col 12) x	
Costs (col 8 x col 10) x col 12) x	
77 x col. 10 12 00 13 00 15 00 1	
NOTE	
ANCI LLARY SERVICE COST CENTERS	
50. 00 05000 OPERATI NG ROOM 0.000000 9, 257, 916 0 13, 659, 551 0 50. 51. 00 05200 DELIVERY ROOM 0.000000 0 0 0 55. 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 0 55. 53. 00 05300 ANESTHESI OLOGY 0.000000 379, 479 0 455, 719 0 53. 54. 00 05400 RADI OLOGY-THERAPEUTI C 0.000000 2, 526, 689 0 5, 395, 922 0 54. 55. 00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 0 0 55. 56. 00 05500 RADI OLOGY-THERAPEUTI C 0.000000 584, 573 0 4, 976, 257 0 56. 57. 00 05700 CT SCAN 0.000000 3, 839, 486 0 8, 980, 914 0 57. 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 352, 803	
51. 00 05100 RECOVERY ROOM 0.000000 0 0 0 0 51. 00 52. 52. 0 0 0 0 0 0 0 0 0 0 0 0 0 53.00 0 0 0 0 0 0 0 0 0 54.00 0 0 0 0 55.00 0 <t< td=""><td>0.00</td></t<>	0.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 0 0 0 52. 53. 00 05300 ANESTHESI OLOGY 0.000000 379, 479 0 455, 719 0 53. 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 2, 526, 689 0 5, 395, 922 0 54. 55. 00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 0 55. 56. 00 05600 RADI OLOGY-THERAPEUTI C 0.000000 584, 573 0 4,976, 257 0 56. 57. 00 05700 CT SCAN 0.000000 3,839, 486 0 8,980, 914 0 57. 56. 0.00000 682, 803 0 2,970, 390 0 58. 59.00 0.5900 CARDI AC CATHETERI ZATI ON 0.000000 3,093, 585 0 5,374, 204 0 59. 60.00 0.60001 LABORATORY 0.000000 0 0 4,221, 720 0 60. 60. 60.	1. 00
53. 00 05300 ANESTHESI OLOGY 0.000000 379, 479 0 455, 719 0 53. 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 2,526,689 0 5,395,922 0 54. 55. 00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 55. 56. 00 05600 RADI OLOGY-THERAPEUTI C 0.000000 584,573 0 4,976,257 0 56. 57. 00 05700 CT SCAN 0.000000 3,839,486 0 8,980,914 0 57. 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 852,803 0 2,970,390 0 58. 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 3,093,585 0 5,374,204 0 59. 60. 01 06001 LABORATORY 0.000000 5,589,839 0 4,221,720 0 60. 61. 00 06100 PBP CLI IN CAL LAB SERVI CES-PRGM ONLY 0.00000	2. 00
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64. 00 06400 INTRAVENOUS THERAPY 0. 000000 0 0 0 0 64. 65. 00 06500 RESPI RATORY THERAPY 0. 000000 2, 146, 062 0 309, 532 0 65. 66. 00 06600 PHYSI CAL THERAPY 0. 000000 778, 701 0 40, 162 0 66. 67. 00 06700 0CCUPATI ONAL THERAPY 0. 000000 404, 846 0 23, 826 0 67. 68. 00 06800 SPEECH PATHOLOGY 0. 000000 257, 525 0 4, 476 0 68. 69. 00 06900 ELECTROCARDI OLOGY 0. 000000 1, 922, 261 0 3, 070, 961 0 69. 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 413, 913 0 903, 066 0 70. 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 9, 732, 202 0 6, 935, 113 0 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 000000 9, 926, 784 0 4, 389, 563 0 72.	2. 00
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68. 00 06800 SPEECH PATHOLOGY 0. 000000 257, 525 0 4, 476 0 68. 69. 00 06900 ELECTROCARDI OLOGY 0. 000000 1, 922, 261 0 3, 070, 961 0 69. 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 413, 913 0 903, 066 0 70. 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 000000 9, 732, 202 0 6, 935, 113 0 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 000000 9, 926, 784 0 4, 389, 563 0 72.	7. 00
69. 00 06900 ELECTROCARDI OLOGY 0.000000 1,922,261 0 3,070,961 0 69.	8. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 413, 913 0 903, 066 0 70. 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 000000 9, 732, 202 0 6, 935, 113 0 71. 072. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 000000 9, 926, 784 0 4, 389, 563 0 72. 072	9. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 9,732,202 0 6,935,113 0 71.	0.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 000000 9, 926, 784 0 4, 389, 563 0 72.	
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 6. 510. 981 0 8. 102. 797 0 73.	3. 00
	4. 00
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OUTPATIENT SERVICE COST CENTERS	3. 00
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91. 00 09100 EMERGENCY 0. 000000 4, 133, 188 0 7, 304, 364 0 91.	1. 00
	2. 00
OTHER REI MBURSABLE COST CENTERS	
	4. 00
	5. 00
	6. 00
	7. 00
200.00 Total (lines 50 through 199) 63,013,341 0 95,721,205 0 200.). 00

Heal th Financial Systems COMMUNITY HOSPITAL ANDERSON In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0113 Period: From 01/01/2017 Part IV

THROUGH COSTS Provider CCN: 15-0113 Period: Part IV

To 12/31/2017 Date/Time Prepared:

5/14/2018 1:52 pm Title XVIII Hospi tal PPS PSA Adj. Non PSA Adj. All Cost Center Description Physi ci an Other Medical Education Cost Anestheti st Cost 24.00 21.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 000000000000 05100 RECOVERY ROOM 51 00 51.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 05300 ANESTHESI OLOGY 0 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 56.00 56.00 05600 RADI OI SOTOPE 0 57.00 05700 CT SCAN 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 0 59.00 60.00 06000 LABORATORY 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 000000000000000 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 63.00 06400 INTRAVENOUS THERAPY 0 64 00 64 00 65.00 06500 RESPIRATORY THERAPY 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 06800 SPEECH PATHOLOGY 0 68 00 68 00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 07400 RENAL DIALYSIS 74.00 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 75.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 000000000000 0 89.00 90.00 09000 CLI NI C 0 90 00 09001 WOUND/OSTOMY CLINIC 90.01 0 90.01 09002 KIDS PLUS CLINIC 90.02 90.02 0 90.03 09003 ONCOLOGY 90.03 09004 MUNCIE CLINIC 90.04 0 90.04 90.05 09005 ANTI COAGULATION CLINIC 0 90.05 90.06 09006 PREGNANCY PLUS 0 90.06 09007 0/P LAB 90.07 0 90.07 09008 0/P LAB 0 90.08 90.08 90.09 09009 FORTVILLE CLINIC 0 90.09 91.00 09100 EMERGENCY 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS 0 0 92.00 92.00 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 09500 AMBULANCE SERVICES 95.00 95.00 0 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 200. 00 200.00 Total (lines 50 through 199)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0113 Peri od: Worksheet D From 01/01/2017 Part V Date/Time Prepared: 12/31/2017 5/14/2018 1:52 pm Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Subject To Part I, col. Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 5. 00 2.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 213116 13, 659, 551 2, 911, 069 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52 00 0.000000 52 00 0 0 0 53.00 05300 ANESTHESI OLOGY 0.094151 455, 719 42, 906 53.00 1, 402, 934 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 259999 5, 395, 922 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 55 00 0 55 00 05600 RADI OI SOTOPE 0 56.00 0.070376 4, 976, 257 350, 209 56.00 57.00 05700 CT SCAN 0.026986 8, 980, 914 0 242, 359 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.110841 2, 970, 390 0 0 329, 241 58.00 05900 CARDIAC CATHETERIZATION 0.089816 482, 690 59 00 59 00 5.374.204 0 60.00 06000 LABORATORY 0.139006 4, 221, 720 28, 785 586, 844 60.00 06001 BLOOD LABORATORY 0.000000 0 60.01 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0 0 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62 00 0.227897 141.309 32, 204 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 63.00 0 06400 INTRAVENOUS THERAPY 0.000000 64.00 64.00 06500 RESPIRATORY THERAPY 0. 293922 309, 532 0 90, 978 65.00 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 0.376800 40, 162 15, 133 66.00 67.00 06700 OCCUPATIONAL THERAPY 0. 488855 23, 826 11,647 67.00 06800 SPEECH PATHOLOGY 0 68.00 0.403484 4, 476 0 1,806 68.00 06900 ELECTROCARDI OLOGY 3, 070, 961 69.00 0.077182 0 237, 023 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0.240203 903, 066 216, 919 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.355445 6, 935, 113 0 0 2, 465, 051 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.392543 4, 389, 563 0 1, 723, 092 72.00 07300 DRUGS CHARGED TO PATIENTS 0.229869 8, 102, 797 0 73.00 114, 244 1,862,582 73.00 0 74.00 07400 RENAL DIALYSIS 0.771219 Ω 74.00 07500 ASC (NON-DISTINCT PART) 0.000000 75.00 0 75.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0. 000000 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 89.00 90.00 09000 CLI NI C 0.000000 0 O 90.00 09001 WOUND/OSTOMY CLINIC 0 90.01 0. 205715 2, 509, 552 0 516, 252 90.01 09002 KIDS PLUS CLINIC 0 90.02 0.000000 Λ 90.02 90.03 09003 ONCOLOGY 0.000000 12, 043, 637 0 0 0 90.03 09004 MUNCIE CLINIC 0.000000 0 90.04 90.04 0 90.05 09005 ANTICOAGULATION CLINIC 0.535548 0 90.05 Λ 0 90.06 09006 PREGNANCY PLUS 0.000000 C 0 0 90.06 90.07 09007 0/P LAB 0.000000 0 90.07 o 90.08 09008 0/P LAB 0 90.08 0.000000 0 09009 FORTVILLE CLINIC 0 90.09 0.000000 0 Ω 90.09 91.00 09100 EMERGENCY 0.182160 7, 304, 364 0 160 1, 330, 563 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0. 249391 3, 908, 170 0 40 974, 662 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 94.00 09500 AMBULANCE SERVICES 0.000000 0 95.00 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 96.00 0 0

0.000000

95, 721, 205

95, 721, 205

0

114, 444

114, 444

28, 785

28, 785

97 00

200.00

201. 00

0

15, 826, 164 202. 00

15, 826, 164

97 00

200.00

201.00

202.00

09700 DURABLE MEDICAL EQUIP-SOLD

Only Charges

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Health Financial Systems COMMUNITY HOSPI APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST COMMUNITY HOSPITAL ANDERSON

Provider CCN: 15-0113

							5/14/2018 1:5	2 pm
					XVIII	Hospi tal	PPS	
			Cos	sts				
		Cost Center Description	Cost	Cost				
			Reimbursed	Rei mbursed				
			Servi ces	Services Not				
			Subject To	Subject To				
			Ded. & Coins.	Ded. & Coins.				
			(see inst.)	(see inst.)				
			6. 00	7. 00				
		LARY SERVICE COST CENTERS						4
50.00		OPERATI NG ROOM	0	0	1			50. 00
51. 00	1	RECOVERY ROOM	0	0				51. 00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0)			52. 00
53.00		ANESTHESI OLOGY	0	0)			53. 00
54.00	1	RADI OLOGY-DI AGNOSTI C	0	0)			54. 00
55.00	05500	RADI OLOGY-THERAPEUTI C	0	0				55. 00
56.00	05600	RADI OI SOTOPE	0	0				56. 00
57.00	05700	CT SCAN	0	0				57. 00
58. 00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0				58. 00
59.00	05900	CARDIAC CATHETERIZATION	0	0				59. 00
60.00	06000	LABORATORY	4, 001	0)			60.00
60. 01	06001	BLOOD LABORATORY	0	0)			60. 01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61. 00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0)			62. 00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0)			63.00
64.00		I NTRAVENOUS THERAPY	0	0)			64.00
65.00	06500	RESPI RATORY THERAPY	0	0)			65.00
66.00		PHYSI CAL THERAPY	0	0				66. 00
67.00	1	OCCUPATIONAL THERAPY	0	0)			67. 00
68. 00		SPEECH PATHOLOGY	0	0)			68. 00
69. 00	1	ELECTROCARDI OLOGY	0	0)			69.00
70.00		ELECTROENCEPHALOGRAPHY	0	0)			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00	1	IMPL. DEV. CHARGED TO PATIENTS	0	0)			72.00
73.00		DRUGS CHARGED TO PATIENTS	0	26, 261				73.00
74.00		RENAL DIALYSIS	0	0	1			74. 00
75.00	1	ASC (NON-DISTINCT PART)	0	0	1			75. 00
		TIENT SERVICE COST CENTERS	,	<u>'</u>				
88. 00		RURAL HEALTH CLINIC	0	0)			88. 00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0)			89. 00
90.00	1	CLINIC	0	0)			90.00
90. 01	1	WOUND/OSTOMY CLINIC	0	0)			90. 01
90. 02		KIDS PLUS CLINIC	0	l o	1			90. 02
90. 03		ONCOLOGY	0	0	1			90. 03
90. 04		MUNCIE CLINIC	0	0)			90. 04
90. 05		ANTI COAGULATION CLINIC	0	Ö	1			90. 05
90. 06	1	PREGNANCY PLUS	0	0	1			90.06
90. 07		O/P LAB	0	0)			90. 07
90. 08		O/P LAB	0	0)			90. 08
90. 09		FORTVILLE CLINIC	0	0)			90. 09
91. 00		EMERGENCY	0	29	1			91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	0	10				92.00
		REIMBURSABLE COST CENTERS	-					1
94.00		HOME PROGRAM DI ALYSI S	n	0				94. 00
95. 00	1	AMBULANCE SERVICES	n	Ĭ				95. 00
96. 00		DURABLE MEDICAL EQUIP-RENTED	1 0	0	,			96. 00
97. 00		DURABLE MEDICAL EQUIP-SOLD	1 0	ĺ				97. 00
200.00		Subtotal (see instructions)	4, 001	26, 300				200. 00
201.00	1	Less PBP Clinic Lab. Services-Program	,, sor	25, 300	1			201. 00
		Only Charges						
202.00		Net Charges (line 200 - line 201)	4, 001	26, 300)			202. 00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0113	Peri od: From 01/01/2017	Worksheet D-1	
			Date/Time Pre 5/14/2018 1:5	
	Title XVIII	Hospi tal	PPS	
Cook Cook on Document on				

Dept All			Title XVIII	Hospi tal	PPS	Ζ μιι
PART 1 - ALL PROVIDER COMPONENTS		Cost Center Description				
INPACTION DAYS		DADT I ALL DDOVIDED COMPONENTS			1.00	
Inpattient days (Including private room days and swing-bed days, excluding newborn) 24,710 1,00 2,00 1,00 2,00 1,00 2,00 1,00 2,0						
Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SW type inpatient days (including private room days) through Docember 31 of the cost reporting period (if call ender year, enter 0 on this line) 7.00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if call ender year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if call ender year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost of total swing-bed NF type inpatient days including private room days) after December 31 of the cost reporting period (including private room days) 10.00 Swing-bed SW type inpatient days applicable to title xVIII only (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) 11.00 Swing-bed SW type inpatient days applicable to title xVIII only (including private room days) 12.00 Exember 31 of the cost reporting period (including private room days) 13.00 Swing-bed NF type inpatient days applicable to interest year XIX only (including private room days) 14.00 Medically precises are private room days applicable to title xV or XIX only (including private room days) 15.00 Total provide private room days applicable to title xV or XIX only (including private room days) 16.00 Total provide private room days applicable to title xV or XIX only (including private room days) 17.00 Medical room to the cost reporting period (including view or XIX only) 18.00 Total provide room days applicable to title xV or XIX only (includin	1.00		s, excluding newborn)		24, 710	1.00
do not complete this line. 4.0 Semi-private room days (excluding swing-bed and observation bed days) 5.00 Intail swing-bed SW type inpatient days (including private room days) after December 31 of the cost proporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed MF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Swing-bed SW type inpatient days applicable to this swing-bed swing-bed and newborn days) 8.00 Swing-bed SW type inpatient days applicable to the cost increase in the swing-bed s	2.00				24, 710	
Semi_private room days (excluding swing-fed and observation bed days) 1 of the cost reporting period 0 0 0 0 0 0 0 0 0	3.00		/s). If you have only pri	vate room days,	0	3. 00
Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost of the cost reporting period (if calendar year, enter 0 on this line) or reporting period (if calendar year, enter	4 00		od days)		22 625	4 00
reporting period (if calendar year, enter 0 on this line) 7. 00 lotal saing-bed SNF type inpatient days (including private room days) after December 31 of the cost of proporting period (if calendar year, enter 0 on this line) 8. 00 reporting period (if calendar year, enter 0 on this line) 8. 00 reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 12. 00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15. 00 Total nursery days (title V or XIX only) 16. 00 Increment days applicable to titles V or XIX only (including private room days) 17. 00 Well cally in encessary private room days applicable to services after December 31 of the cost reporting period (including private room days) 18. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line S x I including private room days applicable to SNF type services after December 31 of the cost reporting period (line S x I				31 of the cost		
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed Nr type inpatient days (including private room days) after December 31 of the cost 8.00 Total inpatient days including private room days after December 31 of the cost 9.00 Total inpatient days including private room days after December 31 of the cost 10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) 11.00 Swing-bed SNF type inpatient days applicable to 11 to XVIII only (including private room days) after 11.00 Swing-bed SNF type inpatient days applicable to XVIII only (including private room days) after 11.00 Swing-bed SNF type inpatient days applicable to XVIII only (including private room days) after 12.00 Swing-bed SNF type inpatient days applicable to XVIII only (including private room days) after 13.00 Swing-bed SNF type inpatient days applicable to XVIII only (including private room days) 14.00 Swing-bed SNF type inpatient days applicable to XVIII only (including private room days) 15.00 Total nursery private room days applicable to XVIII only (including private room days) 16.00 Swing-bed Nr type Inpatient days applicable to Itles V or XV X only (including private room days) 17.00 Total nursery days (tiltle V or XVIX only (including private room days) 18.00 Swing-bed SNF services applicable to SNF type services applicable to Services through December 31 of the cost reporting period (including private room days) 18.00 Swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Swing-bed cost applicable to SNF type services applicable to services after December 31 of the cost reporting period (line S X I including private room days) 18.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line S X I including swing-bed cost applicable	0.00		adyer till edgi. December	0. 0. 1 0001	١	0.00
Total swing-bed NF type inpatient days (including private room days) through Becember 31 of the cost properting period (if calendar year, enter 0 on this line) 7.00 Interesting period (if calendar year, enter 0 on this line) 7.00 Interesting period (if calendar year, enter 0 on this line) 7.00 Interesting period (if calendar year, enter 0 on this line) 7.00 Interesting period (if calendar year, enter 0 on this line) 7.00 Interesting period (if calendar year, enter 0 on this line) 7.00 Interesting period (if calendar year, enter 0 on this line) 7.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Intrough becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Intrough becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Intrough becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Intrough becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Intrough becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.01 Intrough becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.01 Intrough becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.01 Intrough becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.01 Intrough becember 31 of the cost reporting period (if calendar period	6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00
reporting period 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed Swit type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed Swit type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed Ski type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 12.00 through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 0 13.00 step December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 13.00 step December 31 of the cost (if it it december 31 of the cost (if it	7.00			21 -6		7 00
10.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost of reporting period (if calendar year, enter 0 on this line) 10.00 10	7.00		days) through becember	31 of the cost	U	7.00
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24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20) 25. 00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room per diem charge (line 27 + line 28) 30. 00 Average per diem private room per diem charge (line 29 + line 3) 31. 00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 32. 00 Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 11, 234. 28 38. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23. 00	l	31 of the cost reporting	period (line 6	0	23. 00
7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20) 26.00 Total swing-bed cost (see instructions) 0 26.00 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 30,499,007 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00 29.00 Private room charges (excluding swing-bed charges) 0 29.00 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.000000 31.00 Average private room per diem charge (line 29 + line 3) 0.00 31.00 32.00 Average semi-private room per diem charge (line 30 + line 4) 0.00 32.00 33.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 0.00 34.00 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 36.00 Private room cost differential adjustment (line 3 x line 35) 0 36.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 30,499,007) 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 11,234.28 38.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		x line 18)		, , ,		
25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26. 00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 30. 00 Average private room per diem charge (line 29 + line 3) 30. 00 Average semi-private room per diem charge (line 30 + line 4) 30. 00 Average per diem private room charged differential (line 32 minus line 33) (see instructions) 30. 00 Average per diem private room cost differential (line 34 x line 31) 30. 00 Average per diem private room cost differential (line 34 x line 31) 30. 00 Private room cost differential adjustment (line 3 x line 35) 30. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 30, 499, 007) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 30, 499, 007) 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 11, 234. 28 38. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00	24. 00		31 of the cost reporti	ng period (line	0	24. 00
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37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 20, 499,007) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 234.28 Ag 9.00 11, 923, 145 Ag 9.00 40.00		, , ,	01)			
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,234.28 38.00 Program general inpatient routine service cost (line 9 x line 38) 11,923,145 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , ,	and private room cost di	fferential (line	-	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 234.28 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,234.28 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,234.28 38.00 11,923,145 39.00 40.00			ICTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 11,923,145 39.00 40.00	38 UU				1 23/1 20	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 11,923,145 41.00		, ,	•			
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		11, 923, 145	41. 00

	Financial Systems	COMMUNITY HOSPIT		0110 -		u of Form CMS-2	
COMPUL	ATION OF INPATIENT OPERATING COST		Provider CCN: 15	F	eriod: rom 01/01/2017	Worksheet D-1	
				T	o 12/31/2017	Date/Time Prep 5/14/2018 1:52	
			Title XVII		Hospi tal	PPS	
	Cost Center Description	Total	Total Avenue Ave	rage Per (col 1 ÷	Program Days	Program Cost (col. 3 x col.	
		·	C	ol . 2)		4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	0.00	4. 00 0	5. 00	42. 00
	Intensive Care Type Inpatient Hospital Units		<u> </u>	0.00	0	0	42.00
	INTENSIVE CARE UNIT	5, 667, 769	1, 435	3, 949. 66		5, 324, 142	
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0. 00 0. 00	0	0	
	SURGI CAL INTENSI VE CARE UNIT	o	Ö	0.00	0	0	
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	cost center bescription					1. 00	
	Program inpatient ancillary service cost (WH					15, 143, 838	
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(s	see instructions)			32, 391, 125	49. 00
50. 00	Pass through costs applicable to Program in	oatient routine s	services (from Wkst	. D, sum o	of Parts I and	1, 250, 361	50.00
51. 00	III) Pass through costs applicable to Program in	nationt ancillary	, sarvicas (from Wk	et Deur	m of Darte II	729, 356	51.00
31.00	and IV)	battent ancitrary	Services (ITOII WK	.st. D, sui	ii or raits ii	727, 330	31.00
	Total Program excludable cost (sum of lines					1, 979, 717	1
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ated, non-physicia	in anestne	tist, and	30, 411, 408	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	,					1
	Program discharges Target amount per discharge					0 0. 00	1
	Target amount (line 54 x line 55)					0.00	1
	Difference between adjusted inpatient operations	ting cost and tar	get amount (line 5	66 minus li	ine 53)	0	
	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	eportina period e	ending 1996, update	ed and com	oounded by the	0 0. 00	
	market basket						
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				ne amount by	0. 00 0	60.00
01.00	which operating costs (line 53) are less that	an expected costs					01.00
62. 00	amount (line 56), otherwise enter zero (see	instructions)				0	62. 00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive payr	ment (see instruc	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	sts through Decem	nber 31 of the cost	reporting	g period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	sts after Decembe	er 31 of the cost r	eporting p	period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line 6	Anlus line 65)(ti	tle XVIII	only) For	o	66. 00
00.00	CAH (see instructions)	THE COSTS (TITLE O	74 prus rrne 00) (tr	tic XVIII	om y). To		00.00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	ne costs through	December 31 of the	cost rep	orting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing	ne costs after De	ecember 31 of the c	ost repor	ting period	0	68. 00
	(line 13 x line 20)			·			,,,,,,,
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	· · · · · · · · · · · · · · · · · · ·				U	69. 00
	Skilled nursing facility/other nursing facil	ity/ICF/IID rout	ine service cost (line 37)			70. 00
	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne 70 ÷ line 2)				71. 00
	Medically necessary private room cost applic		(line 14 x line 35	5)			73. 00
74.00	Total Program general inpatient routine serv			+ D D	-+ III		74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from worksh	вет в, Ра	rt II, column		75. 00
	Per diem capital-related costs (line 75 ÷ li						76. 00
	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00
	Aggregate charges to beneficiaries for excess		ovi der records)				79.00
	Total Program routine service costs for complete the cost part in the cost		st limitation (lin	ne 78 minus	s line 79)		80.00
	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81. 00 82. 00
83. 00	Reasonable inpatient routine service costs	(see instructions					83. 00
84. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)				84. 00 85. 00
	our reaction review - physician compensation						86.00
85. 00	Total Program inpatient operating costs (sur	ii or rrites 63 tili	ough 63)] 00.00
85. 00 86. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS	SS THROUGH COST	ougn 65)			2.075	
85. 00 86. 00 87. 00		SS THROUGH COST S)				2, 075 1, 234. 28	87. 00

Health Financial Systems	COMMUNITY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Prep 5/14/2018 1:53	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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	2, 238, 982	30, 499, 007	0. 07341	2 2, 561, 131	188, 018	90.00
91.00 Nursing School cost	0	30, 499, 007	0.00000	2, 561, 131	0	91.00
92.00 Allied health cost	o	30, 499, 007	0.00000	2, 561, 131	0	92.00
93.00 All other Medical Education	0	30, 499, 007	0.00000	2, 561, 131	0	93.00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0113	Peri od: From 01/01/2017	Worksheet D-1	
		To 12/31/2017	Date/Time Pre 5/14/2018 1:5	
	Title XIX	Hospi tal	Cost	
Cost Center Description				

		Title XIX	Hospi tal	Cost	<u> </u>
	Cost Center Description			1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			24, 710	•
2.00	Inpatient days (including private room days, excluding swing-b			24, 710	
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	(s). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed davs)		22, 635	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private room	om days) after December 3	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
7.00	reporting period	. aayo, t oag. boosbo.	0. 0. 1 0001	· ·	,,,,,
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 3°	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)				0.00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	660	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days)	0	10.00
	through December 31 of the cost reporting period (see instruct	i ons)	,		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Comy (Therdaing private	e room days)	O	12.00
13.00	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 ye	ear, enter 0 on this line	e) .	_	
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed o	days)	2 004	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			2, 006 1, 757	ı
10.00	SWING BED ADJUSTMENT			1, 707	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
40.00	reporting period	CI D I 01 C		0.00	40.00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0.00	18. 00
19. 00	Medicald rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	-)		30, 499, 007	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		na period (line	0	22. 00
	5 x line 17)		3 1		
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reportion	ng period (line	0	24. 00
24.00	7 x line 19)	31 of the cost reportin	ig perrou (Trile	O	24.00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
0/ 00	x line 20)				0, 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		0 30, 499, 007	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Trile 21 illitius Trile 20)		30, 499, 007	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
	Private room charges (excluding swing-bed charges)			0	ł
30.00	Semi-private room charges (excluding swing-bed charges)	line 20)		0. 000000	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 ± Average private room per diem charge (line 29 ± line 3)	- II ne 28)		0.00000	ı
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	ı
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	1
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	ł
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35)	and private room east di	Eforontial (lima	0 30, 499, 007	36. 00 37. 00
37.00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost dr	recential (TIME)	30, 477, 007	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU		,		
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 234. 28	1
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		814, 625 0	ı
	Total Program general inpatient routine service cost (line 39	•		814, 625	1
	, J. J	/	ı	2, 220	

	Financial Systems TATION OF INPATIENT OPERATING COST	COMMUNITY HOSPI	TAL ANDERSON Provider CO	°N- 15_0112	In Lie	worksheet D-1	
COMPU	ATTON OF INPATTENT OPERATING COST		Provider Co		From 01/01/2017		
					To 12/31/2017	Date/Time Pre 5/14/2018 1:5	
	Coot Contan Decement on	Total	_	e XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Davs	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
		·		col . 2)		4)	
42.00	NURSERY (title V & XIX only)	1. 00 1, 909, 079	2. 00	3. 00 951. 6	4. 00 8 1, 757	5. 00 1, 672, 102	12 00
42.00	Intensive Care Type Inpatient Hospital Units		2,000	751.0	1,737	1,072,102	42.00
43. 00	INTENSIVE CARE UNIT	5, 667, 769	1, 435				43. 00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0 0	0				
46. 00	1	0	0	0.0		l e	1
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (W	kst. D-3, col. 3	, line 200)			1, 582, 350	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(see instructio	ns)		4, 112, 523	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program in	nationt routine	sarvicas (from	Wket D sum	of Parts I and	0	50.00
30.00		patrent routine	services (IIOIII	WKSt. D, Suii	or raits rain	ľ	30.00
51. 00	Pass through costs applicable to Program in	patient ancillar	y services (fr	om Wkst. D, s	um of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53. 00	Total Program inpatient operating cost excl	uding capital re	lated, non-phy	sician anesth	etist, and	Ö	
	medical education costs (line 49 minus line	52)					
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					l	55. 00
56.00	, ,	ting cost and to	mast smount ()	ino E/ minuo	line E2)	0	
57. 00 58. 00	Difference between adjusted inpatient opera Bonus payment (see instructions)	tring cost and ta	rget amount (i	The 50 III hus	11 ne 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost r	eporting period	endi ng 1996, u	pdated and co	mpounded by the		59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report up	datad by the m	arkat backat		0.00	60.00
61. 00					the amount by	0.00	1
	which operating costs (line 53) are less th	an expected cost					
62 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.00
	Allowable Inpatient cost plus incentive pay	ment (see instru	ctions)			Ö	
(4.00	PROGRAM I NPATIENT ROUTINE SWING BED COST	- t - thursus - D					(4.00
64. 00	Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	sts through Dece	mber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine co	sts after Decemb	er 31 of the c	ost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 nlus line 6	5)(title XVII	Lonly) For	0	66. 00
00.00	CAH (see instructions)	The costs (The	04 prus rriie 0	5)(title XVII	i only). Tol		00.00
67. 00	Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 o	f the cost re	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routi	ne costs after D	ecember 31 of	the cost repo	rtina period	0	68. 00
	(line 13 x line 20)			·			
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER I					0	69.00
70. 00	Skilled nursing facility/other nursing faci						70.00
71. 00	Adjusted general inpatient routine service		ine 70 ÷ line	2) `			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost appli		(line 14 v li	ne 35)			72. 00 73. 00
74.00	Total Program general inpatient routine ser			ne 33)			74.00
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from W	orksheet B, P	art II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ l	ine 2)					76. 00
77. 00	Program capital -related costs (line 9 x lin						77. 00
78. 00	, '						78. 00
79.00	Aggregate charges to beneficiaries for exce Total Program routine service costs for com				us line 79)		79.00
81. 00	Inpatient routine service cost per diem lim			(70 mm			81.00
82.00	Inpatient routine service cost limitation (* .				82.00
83. 00 84. 00	Reasonable inpatient routine service costs Program inpatient ancillary services (see i	•	5)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ns)				85. 00
86. 00			rough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASTOTAL Observation bed days (see instruction					2, 075	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 234. 28	88. 00
	Observation bed cost (line 87 x line 88) (s					2, 561, 131	

Health Financial Systems	COMMUNITY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2017 Fo 12/31/2017	Date/Time Prep 5/14/2018 1:52	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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	2, 238, 982	30, 499, 007	0. 073412	2, 561, 131	188, 018	90.00
91.00 Nursing School cost	0	30, 499, 007	0.000000	2, 561, 131	0	91.00
92.00 Allied health cost	0	30, 499, 007	0.000000	2, 561, 131	0	92.00
93.00 All other Medical Education	0	30, 499, 007	0. 000000	2, 561, 131	0	93. 00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lieu of Form CMS-2552-10		
INDATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0113	Pari ad:	Worksheet D_3	

Heal th	Financial Systems COMMUNITY HOSPITAL	ANDERSON		In Lie	eu of Form CMS-2	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
				rom 01/01/2017 o 12/31/2017	Date/Time Pre	nared·
			'	0 12/01/201/	5/14/2018 1:5	
		Titl∈	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cost		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2. 00	2) 3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00	03000 ADULTS & PEDIATRICS			19, 856, 018		30. 00
31.00	03100 INTENSIVE CARE UNIT			4, 488, 468		31.00
32.00	03200 CORONARY CARE UNIT			0		32. 00
33.00	03300 BURN INTENSIVE CARE UNIT			0		33. 00
34. 00	03400 SURGI CAL INTENSIVE CARE UNIT			0		34. 00
40. 00	04000 SUBPROVI DER - I PF			0		40.00
41. 00 42. 00	O4100 SUBPROVI DER			0		41. 00 42. 00
43. 00	04300 NURSERY		•			43.00
10.00	ANCI LLARY SERVI CE COST CENTERS					10.00
50.00	05000 OPERATI NG ROOM		0. 213116	9, 257, 916	1, 973, 010	50.00
51.00	05100 RECOVERY ROOM		0.000000		0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 000000		_	52. 00
53. 00	05300 ANESTHESI OLOGY		0. 094151			1
54.00	05400 RADI OLOGY - DI AGNOSTI C		0. 259999			54.00
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE		0. 000000 0. 07037 <i>6</i>		_	55. 00 56. 00
57. 00	05700 CT SCAN		0. 026986			1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 110841			1
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 089816			
60.00	06000 LABORATORY		0. 139006	5, 589, 839	777, 021	60.00
60. 01	06001 BLOOD LABORATORY		0.000000	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0. 000000	0	0	61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 227897	· ·		1
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY		0.000000			63.00
65. 00	06500 RESPI RATORY THERAPY		0. 000000 0. 293922		_	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY		0. 376800		293, 415	1
67. 00	06700 OCCUPATI ONAL THERAPY		0. 488855			67. 00
68.00	06800 SPEECH PATHOLOGY		0. 403484	257, 525	103, 907	68. 00
69. 00	06900 ELECTROCARDI OLOGY		0. 077182	1, 922, 261		1
70. 00	07000 ELECTROENCEPHALOGRAPHY		0. 240203			1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 355445			1
72. 00 73. 00	O7200 IMPL. DEV. CHARGED TO PATIENTS O7300 DRUGS CHARGED TO PATIENTS		0. 392543 0. 229869			1
74. 00	07400 RENAL DIALYSIS		0. 771219			74.00
75. 00	07500 ASC (NON-DISTINCT PART)		0. 000000			75. 00
	OUTPATIENT SERVICE COST CENTERS		•		•	
88. 00	08800 RURAL HEALTH CLINIC		0.000000)	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.000000		0	89. 00
	09000 CLINIC		0.000000			1
90. 01 90. 02	09001 WOUND/OSTOMY CLINIC 09002 KIDS PLUS CLINIC		0. 205715 0. 000000	0		90. 01 90. 02
90. 02	09003 0NC0L0GY		0.000000			90.02
	09004 MUNCI E CLI NI C		0. 000000			90.04
90. 05	09005 ANTI COAGULATI ON CLINI C		0. 535548			90. 05
90.06	09006 PREGNANCY PLUS		0.000000		0	90. 06
90. 07	09007		0.000000		0	90. 07
90. 08	09008		0. 000000		_	90. 08
90. 09	09009 FORTVI LLE CLI NI C		0.000000		_	90.09
91. 00 92. 00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 182160			91. 00 92. 00
92.00	OTHER REIMBURSABLE COST CENTERS		0. 249391	0	0	92.00
94. 00	09400 HOME PROGRAM DI ALYSI S		0.000000	0	0	94.00
95. 00	09500 AMBULANCE SERVI CES					95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED		0.000000			96. 00
97. 00	09700 DURABLE MEDI CAL EQUI P-SOLD		0. 000000		0	
200.00		(1: (4)		63, 013, 341	15, 143, 838	1
201. 00 202. 00		(11ne 61)		62 012 241		201. 00 202. 00
202. UC	n inet charges (fille 200 illinus fille 201)		I	63, 013, 341	I	J2U2. UU

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-2552-10
INDATIENT ANGLE ADV CEDULOE COCT ADDODTI ONMENT	D 1 1 00N 4E 0440	D : 1	W 1 1 1 D 0

Hear th	Financial Systems COMMUNITY HOSPIT	AL ANDERSON		In Lie	u of Form CMS-2	2552-10
I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	F	eriod: rom 01/01/2017 o 12/31/2017	Worksheet D-3 Date/Time Pre 5/14/2018 1:5	
		Ti tl	le XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cost	Inpati ent	Inpati ent	
	<u>'</u>		To Charges	Program	Program Costs	
					(col. 1 x col.	
				3.1	2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS		1	3, 501, 969		30. 00
31. 00	03100 NTENSI VE CARE UNI T			951, 467		31. 00
32. 00	03200 CORONARY CARE UNIT			701, 107		32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT			0		33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT			0		34.00
				0		•
40.00	04000 SUBPROVI DER - I PF			0		40.00
41.00	04100 SUBPROVI DER - I RF			0		41.00
42. 00	04200 SUBPROVI DER			0		42. 00
43. 00	04300 NURSERY			1, 352, 029		43. 00
	ANCI LLARY SERVI CE COST CENTERS					
50.00	05000 OPERATI NG ROOM		0. 213116	3, 055, 990	651, 280	50.00
51.00	05100 RECOVERY ROOM		0.000000	0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0.000000	0	0	52.00
53.00	05300 ANESTHESI OLOGY		0. 094151	253, 355	23, 854	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 259999	282, 156	73, 360	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C		0.000000		0	55. 00
56. 00	05600 RADI OI SOTOPE		0. 070376		4, 192	56. 00
57. 00	05700 CT SCAN		0. 026986		13, 317	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 110841	108, 839	12, 064	58. 00
			•			
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 089816		38, 966	59. 00
60.00	06000 LABORATORY		0. 139006		129, 696	60.00
60. 01	06001 BLOOD LABORATORY		0.000000		0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.000000		0	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 227897	97, 118	22, 133	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		0.000000	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY		0.000000	0	0	64.00
65.00	06500 RESPI RATORY THERAPY		0. 293922	257, 873	75, 795	65.00
66.00	06600 PHYSI CAL THERAPY		0. 376800	51, 812	19, 523	66. 00
67.00	06700 OCCUPATI ONAL THERAPY		0. 488855		15, 891	67. 00
68. 00	06800 SPEECH PATHOLOGY		0. 403484		8, 963	68. 00
69. 00	06900 ELECTROCARDI OLOGY		0. 077182		15, 275	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY		0. 240203		12, 141	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 355445		0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 392543		Ö	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 229869		366, 509	73. 00
74.00			1			74.00
	07400 RENAL DIALYSIS		0. 771219		0	
75. 00	07500 ASC (NON-DISTINCT PART)		0.000000	0	0	75. 00
00.00	OUTPATIENT SERVICE COST CENTERS		0.00000			00.00
88. 00	08800 RURAL HEALTH CLINIC		0.000000		0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.000000		0	89. 00
90.00	09000 CLI NI C		0.000000			90. 00
90. 01	09001 WOUND/OSTOMY CLINIC		0. 205715		0	90. 01
90. 02	09002 KIDS PLUS CLINIC		0.000000		0	90. 02
90. 03	09003 ONCOLOGY		0.000000	1, 405	0	90. 03
90.04	09004 MUNCI E CLINI C		0.000000	0	0	90. 04
90. 05	09005 ANTI COAGULATI ON CLINI C		0. 535548	0	0	90. 05
90. 06	09006 PREGNANCY PLUS		0. 000000		0	90.06
90. 07	09007 0/P LAB		0. 000000	n	0	90. 07
90. 08	09008 0/P LAB		0. 000000	٥	0	90. 08
90. 09	09009 FORTVI LLE CLI NI C		0.000000		0	90.09
91. 00	09100 EMERGENCY		0. 182160		99, 391	91. 00
			1	343, 624		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 249391	0	0	92. 00
04.05	OTHER REIMBURSABLE COST CENTERS		0.000555		=	04.55
94. 00	09400 HOME PROGRAM DI ALYSI S		0.000000	0	0	94.00
95. 00	09500 AMBULANCE SERVICES					95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED		0.000000		0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD		0.000000		0	97. 00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			8, 471, 677	1, 582, 350	200. 00
201.00	Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0		201. 00
202.00	Net charges (line 200 minus line 201)			8, 471, 677		202. 00
			•	,		•

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0113	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/14/2018 1:52 pm

		Title XVIII	Hospi tal	5/14/2018 1:5	2 pm
		Title XVIII	nospi tai	FF3	
				1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			0	1 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring instructions)	prior to October 1 (s	see	0	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see				1. 02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI for	discharges occurring p	orior to October	0	1. 03
1.04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	discharges occurring o	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions)			1, 475, 755 0	2. 00 2. 01
2.01	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instruction	ns)		0	2. 01
3.00	Managed Care Simulated Payments	/		8, 947, 236	3. 00
4. 00	Bed days available divided by number of days in the cost reporti Indirect Medical Education Adjustment	•		132. 75	4. 00
5. 00	FTE count for allopathic and osteopathic programs for the most r or before 12/31/1996. (see instructions)	recent cost reporting p	period ending on	0. 00	5. 00
6. 00	FTE count for allopathic and osteopathic programs which meet the for new programs in accordance with 42 CFR 413.79(e)	e criteria for an add-o	on to the cap	0.00	6. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified und ACA § 5503 reduction amount to the IME cap as specified under 42			0. 00 0. 00	7. 00 7. 01
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopathi affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c and osteopathic prog	grams for	0.00	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost				8. 01
8. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital				8. 02
9. 00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see				9. 00
10. 00	<pre>instructions) FTE count for allopathic and osteopathic programs in the current</pre>	vear from vour record	ls	0. 00	10. 00
11. 00	FTE count for residents in dental and podiatric programs.	,		0. 44	11. 00
12.00	Current year allowable FTE (see instructions)			0. 44	12.00
13. 00 14. 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year	anded on an after Cont	ombor 20 1007	0. 07 0. 40	13. 00 14. 00
14.00	otherwise enter zero.	ended on or arter sept	.elliber 30, 1997,	0.40	14.00
15. 00	Sum of lines 12 through 14 divided by 3.			0. 30	15. 00
16. 00	Adjustment for residents in initial years of the program			0.00	
17. 00	Adjustment for residents displaced by program or hospital closur	e			17. 00
18. 00	Adjusted rolling average FTE count			0.30	
19. 00 20. 00	Current year resident to bed ratio (line 18 divided by line 4). Prior year resident to bed ratio (see instructions)			0. 002260 0. 002183	
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 002183	
22. 00	IME payment adjustment (see instructions)			26, 618	
22. 01	IME payment adjustment - Managed Care (see instructions)			10, 674	
22.01	Indirect Medical Education Adjustment for the Add-on for § 422 o	f the MMA		10, 07 1	22.01
23. 00	Number of additional allopathic and osteopathic IME FTE resident $(f)(1)(i\vee)(C)$.		R 412. 105	0. 00	23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)			0. 00	24. 00
25. 00	If the amount on line 24 is greater than -O-, then enter the low instructions)	er of line 23 or line	24 (see	0. 00	25. 00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26. 00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27. 00
28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29.00	Total IME payment (sum of lines 22 and 28)			26, 618	
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			10, 674	29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A pati	ent days (see instruct	i ons)	5. 37	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)		- /		31. 00
32. 00	Sum of lines 30 and 31			29. 75	
33. 00	Allowable disproportionate share percentage (see instructions)				33. 00
	Disproportionate share adjustment (see instructions)			767, 521	
			'	- 1	•

CALCUI	Financial Systems COMMUNITY HOSPI			u of Form CMS-2	2552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0113	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Pre		
		Title XVIII	Hospi tal	5/14/2018 1: 52 PPS	2 pm	
		11 11 0 70111	Prior to 10/1			
			1. 00	2. 00		
25 00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		E 077 402 147	4 744 40E 144	35. OC	
35. 00 35. 01	Factor 3 (see instructions)		0. 000151784	6, 766, 695, 164 0. 000179762		
35. 02	Hospital uncompensated care payment (If line 34 is zero, ent	ter zero on this line) (se		1, 216, 397	35. 02	
	instructions)					
	Pro rata share of the hospital uncompensated care payment am	,	678, 599	306, 599		
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35. Additional payment for high percentage of ESRD beneficiary d		985, 198		36.00	
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding		0		40.00	
	652, 682, 683, 684 and 685 (see instructions)					
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683, 684 an 685. (see	0		41.00	
41. 01	instructions) Total ESRD Medicare covered and paid discharges excluding MS	S_DRGs 652 682 683 684	4 0		41. 01	
	an 685. (see instructions)	5 555 552, 562, 565, 565			'''	
42. 00	Divide line 41 by line 40 (if less than 10%, you do not qual		0.00		42.00	
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6	582, 683, 684 an 685. (see	9 0		43.00	
44. 00	instructions) Ratio of average length of stay to one week (line 43 divided	h by line 41 divided by 7	0. 000000		44.00	
00	days)	a sy iiiis ii ai vi asa sy i	0.00000			
45. 00	Average weekly cost for dialysis treatments (see instruction		0.00		45. 00	
46. 00	Total additional payment (line 45 times line 44 times line 4	11. 01)	0		46.00	
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	25, 566, 759		47. 00 48. 00	
40.00	only. (see instructions)	Smarr rarar nospi tars			70.00	
				Amount		
49. 00	Total payment for inpatient operating costs (see instruction	ne)		1. 00 25, 577, 433	49.00	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I a)	1, 974, 163		
51.00	Exception payment for inpatient program capital (Wkst. L, Pt			0	51.00	
52. 00				10, 854		
53. 00 54. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			0		
54. 00	Islet isolation add-on payment			0	l	
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	55. 00	
56. 00	Cost of physicians' services in a teaching hospital (see int			0	56. 00	
57. 00	Routine service other pass through costs (from Wkst. D. Pt.		through 35).	0	57. 00 58. 00	
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)	TV, Cor. IT Time 200)		0 27, 562, 450		
60. 00	Primary payer payments			9, 408		
61. 00	Total amount payable for program beneficiaries (line 59 minu	us line 60)		27, 553, 042		
62. 00	Deductibles billed to program beneficiaries			2, 414, 328 30, 268		
63. 00 64. 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)				63. 00 64. 00	
	Adjusted reimbursable bad debts (see instructions)			132, 166		
66. 00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		83, 282		
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			25, 240, 612	1	
68. 00				0		
69. 00 70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	, (LOL SUR SEE LIISTLUCTIO	13)	0		
70. 50	Rural Community Hospital Demonstration Project (§410A Demons	stration) adjustment (see	instructions)	0	70. 50	
70. 87	Demonstration payment adjustment amount before sequestration	•	•	0		
	SCH or MDH volume decrease adjustment (contractor use only)	atruationa)		0	70. 88	
70. 88	, , , , , , , , , , , , , , , , , , , ,			0	70. 89 70. 90	
70. 88 70. 89	, , , , , , , , , , , , , , , , , , , ,					
70. 88 70. 89 70. 90		1				
70. 88 70. 89 70. 90				0	ı	
70. 88 70. 89 70. 90 70. 91	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)				70. 92 70. 93	

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON		In Lie	u of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CC	CN: 15-0113	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Pre 5/14/2018 1:5	
	Title	XVIII	Hospi tal	PPS	
		FFY	(уууу)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fisca the corresponding federal year for the			0	0	70. 96
70.97 Low volume adjustment for federal fisca the corresponding federal year for the	l year (yyyy) (Enter in column 0		0	0	70. 97
70 00 Low Valuma Daymont 2				0	70 00

	FFY (yyyy)	Amount	
	0	1. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70. 96
70. 97 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70. 97
70.98 Low Volume Payment-3		0	70. 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)		24, 973, 693	71.00
71.01 Sequestration adjustment (see instructions)		499, 474	71. 01
71.02 Demonstration payment adjustment amount after sequestration		0	71. 02
72.00 Interim payments		24, 448, 283	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, 71.02, 72, and 73)		25, 936	
75.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		507, 086	75. 00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1	
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	
91.00 Capital outlier from Wkst. L, Pt. I, line 2		0	
92.00 Operating outlier reconciliation adjustment amount (see instructions)		0	
93.00 Capital outlier reconciliation adjustment amount (see instructions)		0	93. 00
94.00 The rate used to calculate the time value of money (see instructions) 95.00 Time value of money for operating expenses (see instructions)		0.00	94. 00 95. 00
96.00 Time value of money for capital related expenses (see instructions)		0	96.00
96. 00 Trille Varue of money for capital related expenses (see first uctions)	Prior to 10/1	On/After 10/1	90.00
	1.00	2.00	
HSP Bonus Payment Amount	1.00	2.00	
100.00 HSP bonus amount (see instructions)	0		100. 00
HVBP Adjustment for HSP Bonus Payment			100.00
101.00 HVBP adjustment factor (see instructions)	0.000000000	0.000000000	101 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0.000000000		102. 00
HRR Adjustment for HSP Bonus Payment			1.02.00
103.00 HRR adjustment factor (see instructions)	0.0000	0.0000	103. 00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	0		104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus	stment		1
200.00 Is this the first year of the current 5-year demonstration period under the	ne 21st		200. 00
Century Cures Act? Enter "Y" for yes or "N" for no.			
Cost Reimbursement			
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201. 00
202. 00 Medicare discharges (see instructions)			202. 00
203. 00 Case-mix adjustment factor (see instructions)			203. 00
Computation of Demonstration Target Amount Limitation (N/A in first year of period)	of the current 5-year demons:	tration	
204.00 Medicare target amount			204. 00
205.00 Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement			206. 00
207.00 Program reimbursement under the \$410A Demonstration (see instructions)		T	207. 00
208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)		1	208. 00
209.00 Adjustment to Medicare IPPS payments (see instructions)		1	209. 00
210.00 Reserved for future use			210. 00
211.00 Total adjustment to Medicare IPPS payments (see instructions)			211. 00
Comparisi on of PPS versus Cost Reimbursement			211.00
212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)			212. 00
213.00 Low-volume adjustment (see instructions)		1	213. 00
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimb	oursement)	1	218. 00
(line 212 minus line 213) (see instructions)			
· · · · · · · · · · · · · · · · · · ·	1	•	•

CALCUL	ATION OF DSH PAYMENT PERCENTAGE		Provider CC		Peri od:	Worksheet DSH	
					From 01/01/2017 To 12/31/2017	Date/Time Pre	pared:
			Title	XVIII	Hospi tal	5/14/2018 1: 5: PPS	2 pm
		Original .mcrxA	djusted .mcax		Overri de Val ue		
		Val ues 1.00	Val ues	3. 00	4. 00	5. 00	
	CALCULATION OF THE DSH PAYMENT PERCENTAGE	1.00	2. 00	3.00	4.00	5.00	
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line	5. 37	0. 00	0.00	0.00	0.00	1. 00
2. 00	30 - Revised from CMS) Percentage of Medicaid patient days to total	24. 38	0. 00			24. 38	2. 00
3. 00	days (From line 27) Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	29. 75	0. 00			24. 38	3. 00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4. 00
5. 00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	132. 75	0. 00			132. 75	5. 00
6. 00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	13. 76	0. 00			9. 33	6. 00
7. 00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7. 00
8.00	S-2, Li ne 22	Yes				Yes	8. 00
9. 00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)? S-2, Line 45	Yes Yes				No Yes	9. 00 10. 00
11. 00	Is the provider reimbursed under the fully	Yes				Yes	11. 00
	prospective method? (Worksheet L, Part I, line 1 geater than -0-)						
12. 00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	5. 37	0. 00	0.00	0.00	0. 00	12. 00
13. 00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13. 00
14. 00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0. 00	0. 00	0. 00	0.00	0. 00	14. 00
15 00	CALCULATION OF THE PERCENTAGE OF MEDICALD DAY					700	15 00
15. 00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	780	0			780	15. 00
16. 00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	131	O			131	16. 00
17. 00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	4	0			4	17. 00
18. 00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18. 00
18. 01 19. 00	N/A Medicaid HMO days (Worksheet S-2, line 24,	0 5, 541	0 0			0 5, 541	
20. 00	column 5) Other Medicaid days (Worksheet S-2, line 24,	5	0			5	20. 00
21. 00	column 6) Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	6, 461	0			6, 461	21. 00
22. 00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	26, 076	0			26, 076	22. 00
23. 00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	111	0			111	23. 00
24. 00	Plus total employee discount days (Worksheet	319	0			319	24. 00
25. 00	S-3, Part I, Column 8, Line 30) Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5	0	0			0	25. 00
26. 00	and 6) Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line	26, 506	0			26, 506	26. 00
27. 00	25) Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	24. 38	0. 00			24. 38	27. 00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-2552-10
CALCULATION OF DSH PAYMENT PERCENTAGE	Provi der CCN: 15-0113	Peri od:	Worksheet DSH

From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/14/2018 1:52 pm Title XVIII Hospi tal PPS Original .mcrx Values Adjusted . 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 PERCENTAGE If line 3 is greater than 20.2% - 5.88% plus 28.00 True 13. 76 0.00 True 28.00 82.5% of the difference between 20.2% and line 3 29.00 29.00 If line 3 is less than 20.2% - 2.5% plus 65% Fal se 0.00 0.00 Fal se of the difference between 15% and line 3 30.00 Line 28 or 29 as applicable 13.76 0.00 30.00 If Urban and fewer than 100 beds, Rural and 13. 76 0.00 31.00 31.00 fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30. Original .mcrxAdjusted .mcax HFS Look Up Overri de Value Revi sed Value Val ues Val ues 3.00 4. 00 5. 00 2.00 1.00 DETERMINATION OF PROVIDER TYPE 32.00 Does the hospital qualify under the Pickle Fal se Fal se 32.00 ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y") Is This a Rural Referral Center? (Worksheet 33 00 Fal se Fal se 33.00 S-2, Part I, line 116, column 1 = "Y") 34.00 Is this a Medicare Dependant Hospital? Fal se Fal se 34.00 (Worksheet S-2, Part I, Line 37 greater than -0-) 35.00 Is this a Sole Cummunity hospital? Fal se Fal se 35.00 (Worksheet S-2, Part I, Line 35 greater than -0-) 36.00 Is this an Urban or Rural hospital? Urban 36.00 Urban (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)

Health Financial Systems	COMMUNITY HOSPIT	AL ANDERSON	In Lie	u of Form CMS-2	2552-10
CALCULATION OF DSH PAYMENT PERCENTAGE		Provi der CCN: 15-0113	From 01/01/2017	Worksheet DSH Date/Time Pre 5/14/2018 1:5	pared:
		Title XVIII	Hospi tal	PPS	

			Title XVIII	Hospi tal	PPS	
		Revi sed				
		Percentage				
		6. 00				
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE					
28.00	If line 3 is greater than 20.2% - 5.88% plus	9. 33				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. 33				30.00
31.00	If Urban and fewer than 100 beds, Rural and	9. 33				31.00
	fewer than 500 beds, or an SCH the lower of					
	line 30 or .1200, if RRC, MDH or otherwise					
	enter line 30.					

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0113

Title XVIII	2
Iine	
1.00	
DRG amounts other than outlier 1.01	- 1 00
1.01 DRG amounts other than outlier 1.01 0 0 0 0 0 0 0 0 0	0 1.00
1.02 DRG amounts other than outlier 1.02 22,311,667 0 22,311,667 22,311, 22,311, 22,311, 23,311, 24,311,	0 1.01
Operating payment for Model 4 BPCI occurring prior to October 1 1.04	567 1. 02
1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 Outlier payments for discharges (see instructions) Outlier payments for discharges (see instructions) Outlier payments for discharges (see instructions) Outlier payments for discharges for Model 4 BPCI Operating outlier Operating o	0 1.03
2.00 Outlier payments for discharges (see instructions) Outlier payments for discharges (see instructions) Outlier payments for discharges for Model 4 BPCl	0 1.04
2. 01 Outlier payments for discharges for Model 4 BPCI Outlier payments for discharges for Model 4 BPCI Outlier payments Outlier payment adjustment (see payment adjustment (see payment adjustment for payment adjustment for payment adjustment for payment payme	755 2.00
reconciliation	0 2.01
Dayments Indirect Medical Education Adjustment S. 00 Amount from Worksheet E, Part A, I ine 21 (see instructions) A, I ine 21 (see instructions) IME payment adjustment (see 22.00 26,618 0 0 26,618 26, instructions) O. 002183 O.	0 3.00
5.00 Amount from Worksheet E, Part A, Line 21 (see instructions) 6.00 IME payment adjustment (see 22.00 26,618 0 0 0 26,618 26, instructions) 6.01 IME payment adjustment for 22.01 10,674 0 10,674 0 10,674 IME payment adjustment for 22.01 10,674 0 10,674 0 10,674 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor 27.00 0.000000 0.000000 0.000000 0.000000 (see instructions) 8.00 IME adjustment (see 28.00 0 0 0 0 0 0 instructions) 8.01 IME payment adjustment add on 28.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	236 4.00
A, line 21 (see instructions) 6.00 IME payment adjustment (see 22.00 26,618 0 0 26,618 26, instructions) 6.01 IME payment adjustment for 22.01 10,674 0 10,674 0 10, managed care (see instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor 27.00 0.000000 0.000000 0.000000 (see instructions) 8.00 IME adjustment (see 28.00 0 0 0 0 0 instructions) 8.01 IME payment adjustment add on 28.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5.00
6.00 IME payment adjustment (see 22.00 26,618 0 0 26,618 26, instructions) 6.01 IME payment adjustment for 22.01 10,674 0 10,674 0 10,674 0 10, 674 10, 674	5.00
managed care (see instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA	6. 00
7.00 IME payment adjustment factor (see instructions) 27.00 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	6. 01
(see instructions) 8.00 IME adjustment (see	7.00
instructions) 8.01 IME payment add ustment add on for managed care (see instructions) 0 0 0 0 0 0	7.00
for managed care (see instructions)	0 8.00
9.00 Total IME payment (sum of 29.00 26.618 0 0 26.618 26.	0 8.01
lines 6 and 8)	518 9.00
9.01 Total IME payment for managed 29.01 10,674 0 10,674 0 10, 674 0 10, 674 8.01)	574 9. 01
Di sproporti onate Share Adjustment	10.00
10. 00 Allowable disproportionate 33. 00 0. 1376	10.00
	521 11.00
	198 11. 01
Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment	0 12.00
(see instructions) 13.00 Subtotal (see instructions) 47.00 25,566,759 0 678,599 24,888,160 25,566,	759 13.00
14.00 Hospital specific payments 48.00 0 0 0 0 (completed by SCH and MDH, small rural hospitals only.) (see instructions)	0 14.00
15.00 Total payment for inpatient 49.00 25,577,433 0 689,273 24,888,160 25,577, operating costs (see	133 15.00
capital (from Wkst. L, Pt. I,	163 16. 00
if applicable) 17.00 Special add-on payments for 54.00 0 0 0	0 17.00
new technologies 17.01 Net organ aquisition cost 17.02 Credits received from 68.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	17. 01 0 17. 02

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lieu of Form CMS-2552-10
LOW VOLUME CALCULATION EXHIBIT 4	Provider CCN: 15-0113	Period: Worksheet E From 01/01/2017 Part A Exhibit 4

						o 12/31/2017	Date/Time Pre 5/14/2018 1:5	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		On/After 10/01	through 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	0	0	0	18. 00
19.00	SUBTOTAL			0	689, 273	26, 862, 323	27, 551, 596	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, 818, 294	0	0	1, 818, 294	1, 818, 294	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	0	0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	40, 771	0	0	40, 771	40, 771	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	0	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0013	0. 0013	0. 0013	0. 0013		22. 00
	Indirect medical education adjustment (see instructions)	6. 00	2, 364	0		2, 364	2, 364	
	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0620	0. 0620	0. 0620	0. 0620		24. 00
25. 00	Di sproporti onate share adjustment (see instructions)	11. 00	112, 734	0	0	112, 734	112, 734	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	1, 974, 163	0	0	1, 974, 163	1, 974, 163	26. 00
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2. 00	3. 00	4. 00	5. 00	
	Low volume adjustment factor				0. 000000	0. 000000		27. 00
28. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0		0	28.00
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	O	29. 00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

Heal th Financial Systems

COMMUNITY HOSPITAL ANDERSON

In Lieu of Form CMS-2552-10

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-0113

Period:
From 01/01/2017
To 12/31/2017

Part A Exhibit 5
Date/Time Prepared:
5/14/2018 1:52 pm

Wkst. E, Pt.
Amt. from Period to A, line Wkst. E, Pt. 10/01

A)

West. E, Pt. 10/01

After 10/01

And 3)

						5/14/2018 1:52	2 pm
				XVIII	Hospi tal	PPS	
		Wkst. E, Pt.	Amt. from	Period to	Period on	Total (cols. 2	
		A, line	Wkst. E, Pt.	10/01	after 10/01	and 3)	
		0	A) 1.00	2.00	3. 00	4. 00	
1. 00	DRG amounts other than outlier payments	1.00	11.00	2.00	0.00	11 00	1. 00
1. 01	DRG amounts other than outlier payments for	1. 01	C	0		0	1. 01
	discharges occurring prior to October 1						
1.02	DRG amounts other than outlier payments for	1. 02	22, 311, 667	'	22, 311, 667	22, 311, 667	1. 02
	discharges occurring on or after October 1						
1. 03	DRG for Federal specific operating payment	1. 03	0	0		0	1. 03
	for Model 4 BPCI occurring prior to October						
1. 04	DRG for Federal specific operating payment	1. 04		,	0	o	1. 04
1.01	for Model 4 BPCI occurring on or after	1.01		1		Ĭ	1.01
	October 1						
2.00	Outlier payments for discharges (see	2.00	1, 475, 755	0	1, 475, 755	1, 475, 755	2. 00
	instructions)						
2.01	Outlier payments for discharges for Model 4	2. 02	C	0	0	0	2. 01
2 00	BPCI	2.01			_		2 00
3. 00 4. 00	Operating outlier reconciliation	2. 01 3. 00	0 047 224	0		0 047 224	3. 00 4. 00
4.00	Managed care simulated payments Indirect Medical Education Adjustment	3.00	8, 947, 236	0	8, 947, 236	8, 947, 236	4.00
5.00	Amount from Worksheet E, Part A, Line 21	21. 00	0. 002183	0. 002183	0. 002183		5. 00
0.00	(see instructions)	21.00	0.002.00	0.002.00	0.002.00		0.00
6.00	IME payment adjustment (see instructions)	22.00	26, 618	0	26, 618	26, 618	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	10, 674	0	10, 674	10, 674	6. 01
	instructions)						
	Indirect Medical Education Adjustment for the						
7. 00	IME payment adjustment factor (see	27. 00	0. 000000	0. 000000	0. 000000		7. 00
8. 00	instructions) IME adjustment (see instructions)	28. 00		0	0	o	8. 00
8. 01	IME payment adjustment add on for managed	28. 00					8. 01
0.01	care (see instructions)	20.01				Ŭ.	0.01
9.00	Total IME payment (sum of lines 6 and 8)	29. 00	26, 618	0	26, 618	26, 618	9. 00
9.01	Total IME payment for managed care (sum of	29. 01	10, 674	0	10, 674	10, 674	9. 01
	lines 6.01 and 8.01)						
40.00	Disproportionate Share Adjustment				0.407/		40.00
10. 00	Allowable disproportionate share percentage	33.00	0. 1376	0. 1376	0. 1376		10. 00
11. 00	(see instructions) Disproportionate share adjustment (see	34.00	767, 521	0	767, 521	767, 521	11. 00
11.00	instructions)	34.00	707, 521		707, 521	707, 521	11.00
11. 01	Uncompensated care payments	36.00	985, 198	678, 599	306, 599	985, 198	11. 01
	Additional payment for high percentage of ESF	D beneficiary		•	· ·		
12.00	Total ESRD additional payment (see	46. 00	C	0	0	0	12.00
	instructions)						
13. 00	Subtotal (see instructions)	47. 00	25, 566, 759	678, 599			13. 00
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48. 00	(0	0	0	14. 00
	instructions)						
15. 00	Total payment for inpatient operating costs	49.00	25, 577, 433	678, 599	24, 898, 834	25, 577, 433	15 00
13.00	(see instructions)	47.00	25, 577, 450	0,0,3,,	24, 070, 034	25, 577, 455	13.00
16.00	Payment for inpatient program capital (from	50.00	1, 974, 163	0	1, 974, 163	1, 974, 163	16. 00
	Wkst. L, Pt. I, if applicable)						
17. 00	Special add-on payments for new technologies	54.00	C	0	0	0	17. 00
17. 01	Net organ acquisition cost						17. 01
17. 02	Credits received from manufacturers for	68. 00	C	0	0	0	17. 02
10.00	replaced devices for applicable MS-DRGs	02.00		,	_	_	10.00
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	1	ή	0	0	18. 00
19 00	SUBTOTAL			678, 599	26, 872, 997	27, 551, 596	19 00
	1		1	3,3,0,,	20,0.2,777	2.,00.,070	

Health Financial Systems	COMMUNITY HOSPI	TAL ANDERSON		In Lie	eu of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5	Provider CO		Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Exhibi Date/Time Pre 5/14/2018 1:53	pared:
		Title	: XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)		·		
	0	1.00	2.00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1.00	1, 818, 294		0 1, 818, 294		

			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from				
			Wkst. L)				
		0	1. 00	2.00	3. 00	4. 00	
20. 00	Capital DRG other than outlier	1.00	1, 818, 294	0	1, 818, 294	1, 818, 294	
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	0	0	
21. 00	Capital DRG outlier payments	2.00	40, 771	0	40, 771	40, 771	
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	0	0	1
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0013	0. 0013	0. 0013		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	2, 364	0	2, 364	2, 364	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0620	0. 0620	0. 0620		24. 00
25. 00		11. 00	112, 734	0	112, 734	112, 734	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	1, 974, 163	0	1, 974, 163	1, 974, 163	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
		0	A) 1. 00	2.00	3. 00	4. 00	
27. 00		U	1.00	2.00	3.00	4.00	27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	_			0	
29. 00	Low volume adjustment on or after October 1	70. 98 70. 97	0	0		0	1
30.00	HVBP payment adjustment (see instructions)	70. 97	23, 366	1	23, 366	1	
30. 00	HVBP payment adjustment for HSP bonus	70. 9 3 70. 90	23, 300		23, 300	23, 300	
30. 01	payment (see instructions)	70. 90	0	0	١	l	30.01
31. 00		70. 94	-290, 285	0	-290, 285	-290, 285	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	0	0	0	1
						(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	32. 00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0113	From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/14/2018 1:52 pm

22.00 Interns and residents (see instructions) 0 22.00 23.00				10 12,01,201,	5/14/2018 1:5	2 pm
MART B - MEDICAL AND OTHER MEALTH SERVICES 1.00 Model and other services (see instructions) 1.00 3.00 1.00 Medical and other services (see instructions) 1.50 3.00 1.00 1.00 Medical and other services relaburated under OPPS (see instructions) 1.50 3.00 1.00 1.50 1.00			Title XVIII	Hospi tal	PPS	
MART B - MEDICAL AND OTHER MEALTH SERVICES 1.00 Model and other services (see instructions) 1.00 3.00 1.00 Medical and other services (see instructions) 1.50 3.00 1.00 1.00 Medical and other services relaburated under OPPS (see instructions) 1.50 3.00 1.00 1.50 1.00						
Medical and other services reinstructions 30,301 1.00 1.					1. 00	
Medical and other services in hoursed under OPPS (see Instructions) 15, 262, 164 2.0					22.221	
1985 payments						
Duti Fr payment (see instructions)			tions)			
0.00		1 . 3				
Enter the hospital specific payment to cost ratio (see instructions) 0.000 5.00						
Line 2 times line 5						
2.00 Sum of lines 3, 4, and 4,01, divided by line 6 0.00 7, or 2, or 2			ctions)			
Transitional corridor payment (see instructions) 0.80 0.00		1				
Ancillary service other pass through costs from West. D, Pt. IV, col. 13, line 200 9, 00						
10.00 Organ acquisitions 3.0, 301		, , , , , , , , , , , , , , , , , , , ,	11/! 12 !: 200			
1.00 Total cost (sum of lines 1 and 10) (see instructions) 11.00			IV, COI. 13, 11 ne 200		-	
COMPUTATION OF LESSER OF COST OR CHÂRGES Reasonable charges Reasonable charges (sum of lines 12 and 13) Reasonable charges (sum of lines 14 and 14					1	
Reasonable charges	11.00				30, 301	111.00
12.00 Ancil lary service charges 143, 229 12.00 10.1						1
13.00 Organ acquisition charges (from Wist. D-4. Pt. III. col. 4, line 69) 0 13.00 0 13.00 0 14.00 15.00 0 1	12 00				1/2 220	12 00
14.00 Total reasonable charges (sum of lines 12 and 13) 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 16.00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis 0 16.00 Aggregate amount actually collected from patients 0 16.00 Aggregate 0 16.00 Aggre			no 60)			
Customery_charges			THE 04)			
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00	14.00				143, 229	14.00
16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis 0 16.00 Nature Natu	15 00		navment for services on	a charge hasis	0	15 00
had such payment been made in accordance with 42 CFR \$413.13(e)						
17.00 Ratio of i ine 15 to line 16 (not to exceed 1.000000) 17.00 17.0	10.00			ii a chargebasis	ĺ	10.00
18.00 Total customary charges (see instructions) 143,229 18.00 19.00	17 00		-)		0.00000	17 00
19. 00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 112,928 19. 00		,				
Instructions			v if line 18 exceeds li	ne 11) (see		
20. 00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20. 00 1.	17.00		Ty IT TITLE TO EXCEEDS IT	110 11) (300	112, 720	17.00
Instructions	20 00		vifline 11 exceeds li	ne 18) (see	0	20 00
21.00 Lesser of cost or charges (see instructions) 0, 30, 301 21.00	20.00		ye exceeds	(000	ĺ	20.00
22 00 Interns and residents (see instructions) 0 22 00 23 00 23 00 25 00 70 total physical can's services in a teaching hospital (see instructions) 15,953,700 24.00 70 total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 15,953,700 24.00 25.0	21. 00				30, 301	21.00
23. 00 Cost of physicians' services in a teaching hospital (see instructions) 15, 953, 700 24. 00 24. 00 25. 00 26.						1
Total prospective payment (sum of lines 3. 4, 4.01, 8 and 9)		,	ructions)			23. 00
COMPUTATION OF REIMBURSEMENT SETTLEMENT Composition						
25.00 Deductibles and coin surance (for CAH, see instructions) 0 25.00						1
26.00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 3,077,475 26.00 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 12,906,526 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 36) 5,313 28.00 30.00 Subtotal (sum of lines 27 through 29) 12,911,839 30.00 31.00 Primary payer payments 6,222 31.00 ALOWABLE BAD DEBTS (EXCLUSE BAD DEBTS FOR PROFESSIONAL SERVICES) 12,905,617 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 615,228 34.00 Allowable bad debts (see instructions) 615,228 34.00 35.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 465,313 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 465,313 36.00 38.00 MSP-LCC reconciliation amount from PS&R 13,305,515 37.00 39.90 Pioneer ACO demonstration payment adjustment (see instructions) 39,96 39.91 Pioneer ACO demonstration payment adjustment amount befo	25.00				0	25. 00
Instructions	26.00	,	r CAH, see instructions)		3, 077, 475	26.00
Instructions	27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	olus the sum of lines 22	and 23] (see	12, 906, 526	27. 00
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29.00 30.00 Subtotal (sum of lines 27 through 29) 12,911,839 30.00 30.00 Subtotal (sum of lines 27 through 29) 12,911,839 30.00 31.00 Primary payer payments 6,222 31.00 21,905,617 32.00 All Jowable Labor DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33.00 34.00 All lowable bad debts (see instructions) 399,898 35.00 36.00 All lowable bad debts (see instructions) 399,898 35.00 36.00 All lowable bad debts for dual eligible beneficiaries (see instructions) 465,313 36.00 37.00		instructions)				
30.00 Subtotal (sum of lines 27 through 29) 12, 911, 839 30.00 31.00 Primary payer payments 12, 905, 617 32.00	28.00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		5, 313	28. 00
31.00 Primary payer payments 6, 222 31.00 22.00 Subtotal (line 30 minus line 31) 12, 905, 617 32.00 Composite rate ESRD (from Wkst. I - 5, line 11) 0 33.00 33.00 33.00 34.00 All lowable bad debts (see instructions) 399, 898 35.00 36.00 All lowable bad debts (see instructions) 465, 313 36.00 37.00 38.00	29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
32.00 Subtotal (ine 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I - 5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 615, 228 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 465, 313 36.00 37.00 Subtotal (see instructions) 67.00 6	30.00	Subtotal (sum of lines 27 through 29)			12, 911, 839	30.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I -5, line II) 0 33.00 34.00 Allowable bad debts (see instructions) 615, 228 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 399, 898 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 465, 313 36.00 37.00 Subtotal (see instructions) 13, 305, 515 37.00 38.00 MSP-LCC reconciliation amount from PS&R -1 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.95 Pioneer ACO demonstration payment adjustment (see instructions) 39.97 Pioneer ACO demonstration payment adjustment for sequestration 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 Allowable bad debts for dual eligible beneficiaries (see instructions) 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 Allowable (see instructions) 39.99	31.00	Primary payer payments			6, 222	31.00
33.00 Composite rate ESRD (from Wkst. I-5, line 11)	32.00	Subtotal (line 30 minus line 31)			12, 905, 617	32.00
34.00 Allowable bad debts (see instructions) 35.00 Adjusted reimbursable bad debts (see instructions) 35.00 Adjusted reimbursable bad debts (see instructions) 37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.97 Demonstration payment adjustment amount before sequestration 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 Sequestration adjustment (see instructions) 39.90 Demonstration payment adjustment amount after sequestration 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.02 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Bal ance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 50 Demonstration payment amount (see instructions) 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions)		ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE)	CES)			
35.00 Adjusted reimbursable bad debts (see instructions) 399, 898 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 465, 313 36.00 37.00 Subtotal (see instructions) 13, 305, 515 37.00 38.00 MSP-LCC reconciliation amount from PS&R -1 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 90.00 39.90	33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
36.00		· · · · · · · · · · · · · · · · · · ·				
37. 00 Subtotal (see instructions) 13, 305, 515 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R -1 38. 00 39. 00 39. 00 39. 50 39. 50 39. 50 39. 50 39. 50 39. 97 39. 98 39. 99 39. 99 39. 99 39. 99 39. 99 39. 99 39. 99 39. 90 3	35.00	Adjusted reimbursable bad debts (see instructions)			399, 898	
38.00 MSP-LCC reconciliation amount from PS&R -1 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39.97 Demonstration payment adjustment amount before sequestration 0 39.50 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.96 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.96 40.01 Subtotal (see instructions) 13,305,516 40.00 40.02 Demonstration adjustment (see instructions) 266,110 40.00 40.01 Interim payments 12,989,410 41.00 41.00 Interim payments 12,989,410 41.00 43.00 Balance due provider/program (see instructions) 49,996 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515.2 0 44.00 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 90.00	36.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		465, 313	
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.77 Demonstration payment adjustment amount before sequestration 39.88 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.02 Interim payments 42.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Bal ance due provider/program (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{5}{115}.2\$ \$\frac{1}{10} \text{ BC COMPLETED BY CONTRACTOR}\$ 90.00 Ottlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 96.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 98.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions)	37. 00	Subtotal (see instructions)			13, 305, 515	37.00
39. 50 39. 97 39. 98 39. 98 39. 97 39. 98 39. 97 Acceleration payment adjustment amount before sequestration 39. 97 39. 98 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 39. 99 40. 00 Subtotal (see instructions) 39. 90 40. 00 Demonstration adjustment (see instructions) 39. 90 40. 01 Demonstration adjustment (see instructions) 39. 90 40. 02 Interim payments 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{115.2}{10.0000}\$ To BE COMPLETED BY CONTRACTOR 90. 00 Q1. 00 Q2. 00 Q1. 00 Q2. 00 Q3. 00 Q1. 00 Q1. 00 Q1. 00 Q2. 00 Q3. 00 Q1. 00 Q1. 00 Q1. 00 Q2. 00 Q3. 00 Q1. 00 Q1. 00 Q1. 00 Q1. 00 Q2. 00 Q3. 00 Q1. 0		MSP-LCC reconciliation amount from PS&R				
39. 97 Demonstration payment adjustment amount before sequestration 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515. 2 TO BE COMPLETED BY CONTRACTOR 90. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 93. 00 Time Value of Money (see instructions) 94. 00 Outlier reconciliation adjustment amount (see instructions) 95. 00 Outlier reconciliation adjustment amount (see instructions) 96. 00 Outlier reconciliation adjustment amount (see instructions) 97. 00 Outlier reconciliation adjustment amount (see instructions) 98. 00 Outlier reconciliation adjustment amount (see instructions) 99. 00 Time Value of Money (see instructions) 99. 00 Outlier reconciliation adjustment amount (see instructions)					0	
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2			s)			39. 50
39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 5 Sequestration adjustment (see instructions) 40. 01 Demonstration payment adjustment amount after sequestration 40. 02 Demonstration payment adjustment amount after sequestration 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, spi15. 2 TO BE COMPLETED BY CONTRACTOR 90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 93. 00 O 93. 00	39. 97					39. 97
40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, s115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 92.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 940.00 Contractors use only of value of Money 95.00 Time Value of Money (see instructions) 97.00 Time Value of Money (see instructions) 98.00 Time Value of Money (see instructions) 99.00 Time Value of Money (see instructions) 90.00 Time Value of Money (see instructions) 90.00 Time Value of Money (see instructions) 90.00 Time Value of Money (see instructions)	39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	0	39. 98
40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{\text{515.2}}{\text{10 BE COMPLETED BY CONTRACTOR}} 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 92.60 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 92.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Time Value of Money (see instructions) 95.00 Time Value of Money (see instructions) 97.00 Time Value of Money (see instructions) 98.00 Time Value of Money (see instructions) 99.00 Time Value of Money (see instructions) 90.00 Time Value of Money (see instructions)	39. 99				0	39. 99
40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{\text{515.2}}{\text{10 BE COMPLETED BY CONTRACTOR}} 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 9 O O O O O O O O O O O O O O O O O O O	40.00				13, 305, 516	40.00
41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)	40. 01	Sequestration adjustment (see instructions)			266, 110	40. 01
42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions)	40. 02	D2 Demonstration payment adjustment amount after sequestration			0	40. 02
43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions)	41. 00				12, 989, 410	41.00
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions)	42.00					
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 Utlier reconciliation adjustment amount (see instructions) 0 P1.00 1 The rate used to calculate the Time Value of Money 1 Time Value of Money (see instructions) 0 P3.00 0 P3.00				49, 996		
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 98.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions)	44. 00	, , , , , , , , , , , , , , , , , , , ,	nce with CMS Pub. 15-2,	chapter 1,	0	44. 00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Original outlier amount (see instructions) 94.00 Original outlier amount (see instructions) 97.00 Original outlier amount (see instructions)					L	
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 92.00 93.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 93.00						
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00		, ,				l
93.00 Time Value of Money (see instructions) 0 93.00		,				
94.00 lotal (sum of lines 91 and 93) 0 94.00		,				
	94. 00	lotal (sum of lines 91 and 93)			0	94. 00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0113	Peri od:	Worksheet E	
		From 01/01/2017	Part B	
		To 12/31/2017	Date/Time Pre	pared:
			5/14/2018 1:5	2 pm
	Title XVIII	Hospi tal	PPS	
			Overri des	
			1. 00	
WORKSHEET OVERRIDE VALUES				
112.00 Override of Ancillary service charges (line	12)		0	112. 00

Health Financial Systems COMMU ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0113

					5/14/2018 1:5	2 pm
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		24, 448, 283		12, 989, 410	1. 00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,		0		0	2. 00
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3. 00
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02	NBOOTHIENTO TO THOUSEN		o o		0	3. 02
3. 03			0		o	3. 03
3.04			0		o	3. 04
3. 05			0		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3. 54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		24, 448, 283		12, 989, 410	4. 00
	appropri ate)					
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5. 03			0		0	5. 03
	Provi der to Program					
5. 50	TENTATIVE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52 5. 99			0		0	5. 52 5. 99
5. 99	5. 50-5. 98)		0		U	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		25, 936		49, 996	6. 01
6. 02	SETTLEMENT TO PROGRAM		25, 750		47, 770	6. 02
7. 00	Total Medicare program liability (see instructions)		24, 474, 219		13, 039, 406	7. 00
			21, 17 1, 217	Contractor Number	NPR Date (Mo/Day/Yr)	7. 30
		()	1. 00	2. 00	
8. 00	Name of Contractor			1.00	2.00	8. 00
0.00	2. 22 2000	l			1	0.00

Heal th	Financial Systems CO	MMUNITY HOSPITAL	L ANDERSON	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0113	Peri od:	Worksheet E-1	
				From 01/01/2017	Part II	
				To 12/31/2017	Date/Time Pre 5/14/2018 1:5	
-			Title XVIII	Hospi tal	PPS	2 piii
					1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD (COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION A	AND CALCULATION				
1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14						1.00
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12						2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. (3. 00
4.00	4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12					4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col.					5. 00
6.00	Total hospital charity care charges from Wkst.					6. 00
7. 00	CAH only - The reasonable cost incurred for the	e purchase of ce	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see	instructions)				8. 00
9.00						9.00
10.00						10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					1
30.00	Initial/interim HIT payment adjustment (see in	structions)				30.00
31.00	Other Adjustment (specify)					31.00
32.00	Balance due provider (line 8 (or line 10) minus	s line 30 and li	ne 31) (see instruction	s)		32.00
					Overri des	
					1 00	

108. 00

CONTRACTOR OVERRIDES

108.00 Override of HIT payment

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0113		Worksheet E-3 Part VII Date/Time Prepared: 5/14/2018 1:52 pm

			0 12/31/2017	5/14/2018 1:5	
		Title XIX	Hospi tal	Cost	
	<u> </u>		Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		4, 112, 523		1. 00
2.00	Medical and other services			0	
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		4, 112, 523	0	4. 00
5.00	Inpatient primary payer payments		82, 792		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		4, 029, 731	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8. 00	Routine service charges		5, 805, 464		8. 00
9.00	Ancillary service charges		8, 471, 677	0	
10. 00	Organ acquisition charges, net of revenue		0		10. 00
11. 00	Incentive from target amount computation		0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		14, 277, 141	0	12. 00
	CUSTOMARY CHARGES				
13. 00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	13. 00
	basis				
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
15 00	a charge basis had such payment been made in accordance with	42 CFR 9413. 13(e)	0. 000000	0.000000	15 00
15. 00 16. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)			0. 000000	
	Total customary charges (see instructions)	v if line 1/ evenede	14, 277, 141	0	
17. 00	Excess of customary charges over reasonable cost (complete onl	y IT Time 16 exceeds	10, 164, 618	0	17. 00
18. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete onl	vifling 4 avends line		0	18. 00
18.00	16) (see instructions)	y II IIIle 4 exceeds IIIle	J J	Ü	10.00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
	Cost of physicians' services in a teaching hospital (see instr	cuctions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		4, 112, 523	0	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				21.00
22. 00	Other than outlier payments	Compreted for 115 provide	0	0	22. 00
	Outlier payments		o	0	23. 00
	Program capital payments		0	_	24. 00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		o	0	•
27. 00	Subtotal (sum of lines 22 through 26)		o	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		o	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		4, 112, 523	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30. 00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	4, 029, 731	0	31. 00
32.00	Deducti bl es		7, 257	0	32.00
33.00	Coi nsurance		10, 345	0	33. 00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	4, 012, 129	0	36. 00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		4, 012, 129	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		4, 012, 129	0	40.00
41.00	Interim payments		5, 864, 332	0	41. 00
42.00	Balance due provider/program (line 40 minus line 41)		-1, 852, 203	0	42. 00
43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2				
	OVERRI DES				
109.00	Override Ancillary service charges (line 9)		0	0	109. 00

	Financial Systems COMMUNITY HOSPITA		ON 15 0112		u of Form CMS-2	
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT L EDUCATION COSTS	Provi der Co	UN: 15-0113	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E-4 Date/Time Prep	pared:
		Title	xVIII	Hospi tal	5/14/2018 1: 52 PPS	2 pm
				ļ	1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
1.00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	0. 00	1. 00			
2. 00 3. 00	Unweighted FTE resident cap add-on for new programs per 42 CF Amount of reduction to Direct GME cap under section 422 of MM		1) (see instr	ructi ons)	0. 00 0. 00	
3. 01	Direct GME cap reduction amount under ACA §5503 in accordance		§413.79 (m).	(see	0.00	
4. 00	instructions for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	to a Medicare	0. 00	4. 00
4. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst		cost reporti	ng periods	0. 00	4. 01
4. 02	straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	s (see inst	ructions for	cost reporting	0.00	4. 02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl 4.02 plus applicable subscripts	us or minus	line 4 plus l	ines 4.01 and	0. 00	5. 00
6. 00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	the current	year from your	0. 00	6. 00
7. 00	Enter the lesser of line 5 or line 6		1 = .		0.00	7. 00
			Primary Care	e 0ther 2.00	<u>Total</u> 3. 00	
8. 00	Weighted FTE count for physicians in an allopathic and osteop program for the current year.	athi c	0. (0.00	8. 00
9. 00	If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo		0.0	0.00	0. 00	9. 00
10. 00 10. 01 11. 00	6. Weighted dental and podiatric resident FTE count for the curr Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count		0.0	0. 44 0. 00 00 0. 44		10. 00 10. 01 11. 00
12. 00	Total weighted TE count FTE count for the prior cost reportin instructions)	g year (see	0. (12.00
13. 00	Total weighted resident FTE count for the penultimate cost re year (see instructions)		0. (0. 40		13. 00
14. 00 15. 00	Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs	by 3).	0.0			14. 00 15. 00
15. 01	Unweighted adjustment for residents in initial years of new p		0.0	0.00		15. 01
16. 00 16. 01	Adjustment for residents displaced by program or hospital clo Unweighted adjustment for residents displaced by program or h closure		0. (16. 00 16. 01
17. 00	Adjusted rolling average FTE count		0.0			17. 00
	Per resident amount Approved amount for resident costs		88, 539.	78 88, 539. 78 0 26, 562	26, 562	18. 00 19. 00
					1. 00	
20. 00	Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)	TE resident	cap slots red	cei ved under 42		20. 00
21. 00	Direct GME FTE unweighted resident count over cap (see instru				0.00	
22. 00 23. 00	Allowable additional direct GME FTE Resident Count (see instr Enter the locally adjustment national average per resident am		structions)		0. 00 0. 00	
	Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)	`	ŕ		0 26, 562	24. 00
25.00	Total direct GML amount (Sum of Times 17 and 24)		Inpatient Pa	rt Managed care	20, 302	25.00
			1. 00	2. 00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD					
26. 00 27. 00	Inpatient Days (see instructions) Total Inpatient Days (see instructions)		11, 00 24, 18			26. 00 27. 00
28. 00	Ratio of inpatient days to total inpatient days		0. 45523	0. 178653		28. 00
29. 00 30. 00	Program direct GME amount Reduction for direct GME payments for Medicare Advantage		12, 0	92 4, 745 670		29. 00 30. 00
	Net Program direct GME amount			370	16, 167	

Heal th	Financial Systems COMMUNITY HOSPITA	AL ANDERSON	In Lie	u of Form CMS-2	2552-10
DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-0113	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS		From 01/01/2017 To 12/31/2017	Date/Time Prep 5/14/2018 1:5	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL EDUCATION COSTS)	`		CAL	
32. 00	Renal dialysis direct medical education costs (from Wkst. B,	Pt. I, sum of col. 20 ar	nd 23, lines 74	0	32. 00
	and 94)				
33. 00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.		74 and 94)	573, 648	
34. 00	Ratio of direct medical education costs to total charges (lin	ne 32 ÷ line 33)		0. 000000	
	Medicare outpatient ESRD charges (see instructions)	0.4 1' 05)		0	
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII Part A Reasonable Cost	UNLY			<u> </u>
37. 00				32, 391, 125	37. 00
38. 00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			32, 391, 123	ı
	00 Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40. 00				-	40. 00
	Total Part A reasonable cost (sum of lines 37 through 39 minu	ıs line 40)		32, 381, 717	1
	Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)			15, 856, 465	42.00
43.00	Primary payer payments (see instructions)			6, 222	43. 00
44.00	Total Part B reasonable cost (line 42 minus line 43)			15, 850, 243	44. 00
45.00	Total reasonable cost (sum of lines 41 and 44)			48, 231, 960	45. 00
46.00	Ratio of Part A reasonable cost to total reasonable cost (lin	ne 41 ÷ line 45)		0. 671375	46. 00
47.00	Ratio of Part B reasonable cost to total reasonable cost (lin			0. 328625	47. 00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA	RT B			
	Total program GME payment (line 31)			16, 167	
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)			10, 854	1
50. 00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instructions)		5, 313	50. 00

Health Financial Systems

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

Provider CCN: 15-0113 P

Period: Worksheet G From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/14/2018 1:52 pm

37		General Fund	Speci fi c	Endowment Fund	5/14/2018 1:5 Plant Fund	2 pm
		General Tuna	Purpose Fund	Lildowillett Turid	Frant Tunu	
	louppeur 1005T0	1.00	2. 00	3. 00	4. 00	
1. 00	CURRENT ASSETS	21 000 277	Г	O	0	1.00
2.00	Cash on hand in banks Temporary investments	31, 098, 377			0	
3.00	Notes receivable		Ö		0	
4.00	Accounts receivable	69, 728, 419	C	0	0	
5.00	Other recei vabl e	0	C	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-48, 128, 230		0	0	6. 00
7.00	Inventory	2, 919, 936		0	0	
8. 00 9. 00	Prepaid expenses Other current assets	800, 580		0	0	8. 00 9. 00
10. 00	Due from other funds	1, 091, 295		0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	57, 510, 377		0	0	11. 00
	FIXED ASSETS					
12. 00	Land	6, 128, 238			0	
13.00	Land improvements	1, 956, 043			0	13.00
14. 00 15. 00	Accumulated depreciation Buildings	-1, 785, 135 73, 418, 503		_	0	14. 00 15. 00
16. 00	Accumulated depreciation	-35, 175, 477		0	0	16.00
17. 00	Leasehold improvements	1, 197, 015		o	0	17. 00
18. 00	Accumul ated depreciation	-69, 258		0	0	18. 00
19. 00	Fi xed equipment	20, 462, 609	C	0	0	19. 00
20.00	Accumulated depreciation	-13, 707, 287	C	_	0	20.00
21. 00	Automobiles and trucks	913, 916		_	0	21.00
22. 00 23. 00	Accumulated depreciation Major movable equipment	-734, 542 16, 164, 660			0	22. 00
24. 00	Accumulated depreciation	-11, 022, 444		0	0	24.00
25. 00	Mi nor equi pment depreci abl e	38, 186, 548		Ö	0	25. 00
26. 00	Accumulated depreciation	-26, 320, 341		Ö	0	26. 00
27. 00	HIT designated Assets	0	C	0	0	27. 00
28. 00	Accumulated depreciation	0	C	-	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	C		0	29. 00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	69, 613, 048	C	0	0	30.00
31. 00	Investments	163, 390, 967		ol	0	31. 00
32. 00	Deposits on Leases	0	C	0	0	32. 00
33.00	Due from owners/officers	0	C	0	0	33. 00
34. 00	Other assets	0	C	0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	163, 390, 967		_	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	290, 514, 392	C	0	0	36.00
37. 00	Accounts payable	3, 074, 550		ol	0	37. 00
38. 00	Salaries, wages, and fees payable	8, 480, 477			0	
39. 00	Payroll taxes payable	431, 917	[c	0	0	39. 00
40. 00	Notes and Loans payable (short term)	1, 613, 304	0	0	0	40. 00
41. 00	Deferred income	0	C	0	0	41.00
42. 00 43. 00	Accel erated payments	107.000	1		0	42. 00 43. 00
44. 00	Due to other funds Other current liabilities	487, 088 3, 328, 164		0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	17, 415, 500				
	LONG TERM LIABILITIES	, ,				
46.00	Mortgage payable	0	C	0	0	46. 00
47. 00	Notes payable	0	C		0	1
48. 00	Unsecured Loans	0	C	_	0	1
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	3, 628, 951 3, 628, 951			0	
51. 00	Total liabilities (sum of lines 45 and 50)	21, 044, 451			0	
31.00	CAPITAL ACCOUNTS	21,044,431		<u> </u>		31.00
52.00	General fund balance	269, 469, 941				52. 00
53.00	Specific purpose fund		0			53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00 57. 00	Governing body created - endowment fund balance			0	0	56.00
57. 00 58. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	
55. 00	replacement, and expansion				O	55. 50
59. 00	Total fund balances (sum of lines 52 thru 58)	269, 469, 941	C	o	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	290, 514, 392	C	0	0	60. 00
	[59]	I	I	ı l		I

Provi der CCN: 15-0113

					То	12/31/2017	Date/Time Prep 5/14/2018 1:52	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	
		1.00	2. 00	3.00		4. 00	5. 00	
1.00	Fund balances at beginning of period		225, 774, 672			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		43, 716, 551					2. 00
3.00	Total (sum of line 1 and line 2)		269, 491, 223			0		3. 00
4.00	Additions (credit adjustments) (specify)	0			0		0	4. 00
5.00		0			0		0	5. 00
6.00		0			0		0	6. 00
7.00		0			0		0	7. 00
8.00		0			0		0	8. 00
9.00	Total additions (sum of line 4-9)	١	0		U	0	ا ا	9. 00 10. 00
10.00	Subtotal (line 3 plus line 10)		269, 491, 223			0		10.00
11. 00 12. 00	Deductions (debit adjustments) (specify)		209, 491, 223		0	U	o	12. 00
13. 00	beductions (debit adjustillents) (specify)				0		0	13. 00
14. 00					0		0	14. 00
15. 00					0		0	15. 00
16. 00					0		Ö	16. 00
17. 00					0		l ől	17. 00
18. 00	Total deductions (sum of lines 12-17)		0		Ŭ	0	Ĭ	18. 00
19. 00	Fund balance at end of period per balance		269, 491, 223			0		19. 00
	sheet (line 11 minus line 18)		, , , ,					
		Endowment Fund	PI ant	Fund				
			7.00	0.00				
4 00		6.00	7. 00	8. 00				4.00
1.00	Fund balances at beginning of period	0			0			1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)				0			2. 00 3. 00
4. 00	Additions (credit adjustments) (specify)	١	0		U			4. 00
5.00	Additions (credit adjustillents) (specify)		0					5. 00
6.00			0					6. 00
7. 00			0					7. 00
8. 00			0					8. 00
9. 00			0					9. 00
10. 00	Total additions (sum of line 4-9)	0	, i		0			10. 00
11. 00	Subtotal (line 3 plus line 10)	0			0			11. 00
12.00	Deductions (debit adjustments) (specify)		0					12.00
13.00			o					13.00
14.00			o					14.00
15. 00			0				ļ	15.00
16.00			0					16.00
17. 00			O					17.00
18. 00	Total deductions (sum of lines 12-17)	0			0			18. 00
19. 00	Fund balance at end of period per balance	0			0			19. 00
	sheet (line 11 minus line 18)						l	

Health Financial Systems CC STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0113

				0 12/31/201/	Date/IIme Prep 5/14/2018 1:5:	
	Cost Center Description		I npati ent	Outpati ent	Total	
			1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>				
	General Inpatient Routine Services					
1.00	Hospi tal		46, 223, 260)	46, 223, 260	1. 00
2.00	SUBPROVI DER - I PF		C		0	2. 00
3.00	SUBPROVI DER - I RF		C)	0	3. 00
4.00	SUBPROVI DER		C	y .	0	4. 00
5.00	Swing bed - SNF		C)	0	5. 00
6. 00	Swing bed - NF		Ö)	0	6. 00
7. 00	SKILLED NURSING FACILITY		C)	0	7. 00
8. 00	NURSING FACILITY		C)	0	8. 00
9. 00	OTHER LONG TERM CARE		Ö)	0	9. 00
10.00	Total general inpatient care services (sum of lines 1-9)		46, 223, 260)	46, 223, 260	
	Intensive Care Type Inpatient Hospital Services	L	,,		, ===, ===	
11. 00	INTENSIVE CARE UNIT		12, 455, 100		12, 455, 100	11. 00
12.00	CORONARY CARE UNIT		0		0	12. 00
13.00	BURN INTENSIVE CARE UNIT		C)	0	13. 00
14.00	SURGI CAL INTENSIVE CARE UNIT		C)	0	14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of	ines	12, 455, 100)	12, 455, 100	
	11-15)		,,		,,	
17.00	Total inpatient routine care services (sum of lines 10 and 16)		58, 678, 360)	58, 678, 360	17. 00
18.00	Ancillary services		133, 337, 272	251, 386, 610	384, 723, 882	18. 00
19.00	Outpatient services		9, 927, 667	71, 953, 125	81, 880, 792	19. 00
20.00	RURAL HEALTH CLINIC				0	20. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		C	0	0	21. 00
22.00	HOME HEALTH AGENCY			0	0	22. 00
23.00	AMBULANCE SERVICES		Ö	0	0	23. 00
24.00	CMHC			0	0	24. 00
24. 10	CORF		C	0	0	24. 10
25.00	AMBULATORY SURGICAL CENTER (D. P.)		Ö	0	0	25. 00
26.00	HOSPI CE		Ö	0	0	26. 00
27.00	NURSERY, NRCC AND OTHER		4, 697, 736	12, 140, 657	16, 838, 393	27. 00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	206, 641, 035	335, 480, 392	542, 121, 427	28. 00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			152, 408, 355		29. 00
30.00	ADD (SPECIFY)		C			30.00
31.00			C			31.00
32.00			C			32.00
33.00			C			33.00
34.00			C			34.00
35.00			C			35. 00
36.00	Total additions (sum of lines 30-35)			0		36. 00
37.00	DEDUCT (SPECIFY)		C			37.00
38. 00			C			38. 00
39. 00			C			39. 00
40.00			C			40.00
41. 00			C			41. 00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		152, 408, 355		43. 00
	to Wkst. G-3, line 4)					

	Financial Systems	COMMUNITY HOSPITAL ANDERSON		u of Form CMS-2	
STATE	IENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0113	Peri od:	Worksheet G-3	
			From 01/01/2017 To 12/31/2017	Date/Time Pre	narad.
			To 12/31/2017	5/14/2018 1:5	
				1 37 147 2010 1. 3.	Z piii
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part	L column 3 line 28)		542, 121, 427	1. 00
2.00	Less contractual allowances and discounts or			367, 802, 599	1
3.00	Net patient revenues (line 1 minus line 2)			174, 318, 828	1
4.00	Less total operating expenses (from Wkst. G-	-2. Part II. line 43)		152, 408, 355	•
5. 00	Net income from service to patients (line 3			21, 910, 473	
0.00	OTHER I NCOME	minus initial in		2.177.107.170	0.00
6.00	Contributions, donations, bequests, etc			0	6.00
7. 00	Income from investments			135, 316	1
8.00	Revenues from telephone and other miscellane	eous communication services		122, 017	1
9.00	Revenue from television and radio service			57, 924	1
10. 00	Purchase di scounts			11, 834	1
11. 00	Rebates and refunds of expenses			0	1
12. 00	Parking lot receipts			0	12.00
13. 00	Revenue from Laundry and Linen service			0	13. 00
14. 00	Revenue from meals sold to employees and que	ests		850, 922	
15. 00	Revenue from rental of living quarters			0	1
16. 00	Revenue from sale of medical and surgical su	upplies to other than patients		0	1
17. 00	g .			0	
18. 00	Revenue from sale of medical records and abs			0	
	Tuition (fees, sale of textbooks, uniforms,			0	•
20. 00	Revenue from gifts, flowers, coffee shops, a	· · · · · · · · · · · · · · · · · · ·		0	
21. 00	Rental of vending machines	and carreson		0	•
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
24. 00	SALE OF SCRAP			_	24. 00
24. 01	GENERAL NON-OPERATING REVENUE			20, 855, 840	1
	GENERAL OTHER OPERATING REVENUE			6, 597, 726	1
	Total other income (sum of lines 6 24)			20 624 010	1

6, 597, 726 24. 02 28, 634, 019 25. 00 50, 544, 492 26. 00 6, 827, 941 27. 00 6, 827, 941 28. 00 43, 716, 551 29. 00

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 PROVISION FOR BAD DEBTS

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0113	Peri od:	u of Form CMS-2 Worksheet L	
			From 01/01/2017 To 12/31/2017	Parts I-III Date/Time Pre	pared:
				5/14/2018 1:5	2 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			1, 818, 294	1.00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			40, 771	2. 00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	
3.00	Total inpatient days divided by number of days in the cos	t reporting period (see ins	tructi ons)	67. 12	
4.00	Number of interns & residents (see instructions)			0. 30	
5.00	Indirect medical education percentage (see instructions)			0. 13	
6. 00	Indirect medical education adjustment (multiply line 5 by 1.01) (see instructions)			2, 364	
7. 00	Percentage of SSI recipient patient days to Medicare Part 30) (see instructions)	, , , , , , , , , , , , , , , , , , , ,	E, part A line	5. 37	7.00
8.00	Percentage of Medicaid patient days to total days (see in:	structions)		24. 38	
9. 00	Sum of lines 7 and 8			29. 75	
10.00	Allowable disproportionate share percentage (see instruct	i ons)			10.00
11.00	Disproportionate share adjustment (see instructions)			112, 734	1
12. 00	Total prospective capital payments (see instructions)			1, 974, 163	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	
2.00	Program inpatient ancillary capital cost (see instructions	s)		0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4.00	Capital cost payment factor (see instructions)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	1.00
2.00	Program inpatient capital costs for extraordinary circums	tances (see instructions)		0	2. 00
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	3.00
4.00	Applicable exception percentage (see instructions)			0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 00
6.00	Percentage adjustment for extraordinary circumstances (see			0. 00	
7. 00	Adjustment to capital minimum payment level for extraordi	nary circumstances (line 2 :	x line 6)	0	
8. 00	Capital minimum payment level (line 5 plus line 7)			0	
9.00	Current year capital payments (from Part I, line 12, as a			0	9.00
10.00	Current year comparison of capital minimum payment level			0	10.00
11. 00	Carryover of accumulated capital minimum payment level over the part III line 14)	er capitai payment (from pr	ror year	0	11. 00

Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)

Current year exception payment (if line 12 is positive, enter the amount on this line)

Carryover of accumulated capital minimum payment level over capital payment for the following period

0 12.00

0 13.00

0 14.00

0 15.00

0 16.00

0 17.00

Worksheet L, Part III, line 14)

(if line 12 is negative, enter the amount on this line)

17.00 Current year exception offset amount (see instructions)

15.00 Current year allowable operating and capital payment (see instructions)

16.00 Current year operating and capital costs (see instructions)

13.00

14.00