This report is	required by law (42 USC 1395g; 42 CFR 413.20(b)). Fai	lure to report can resu	ult in all interim	FORM APPROVED			
payments made :	since the beginning of the cost reporting period being	deemed overpayments (4	12 USC 1395g).	OMB NO. 0938-0050			
				EXPIRES 05-31-2019			
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION SUMMARY	Provi der CCN: 15-0169					
PART I - COST	REPORT STATUS						
Provi der	1. [ X ] Electronically filed cost report		Date: 5/30/20	18 Time: 12:09 pm			
use only	2. [ ] Manually submitted cost report						
3. [ 0 ] If this is an amended report enter the number of times the provider resubmitted this cost report 4. [ F ] Medicare Utilization. Enter "F" for full or "L" for low.							
Contractor use only	5. [ 1 ]Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [ N ]Initial Report for (3) Settled with Audit 9. [ N ]Final Report for (4) Reopened (5) Amended	11. or this Provider CCN 12.					
DADT II CEDT	LELCATION						

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 OF INDIANA, INC. (15-0169) 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.

]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.

(Si gned)	
	Officer or Administrator of Provider(s)
Title	
11 11 0	
D-+-	
Date	

			Ti tle XVIII				
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	26, 242	28, 732	0	0	1.00
2.00	Subprovider - IPF	0	775	-534		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	27, 017	28, 198	0	0	200. 00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE. HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0169 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/30/2018 11:42 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 7150 CLEARVISTA DRIVE 1.00 PO Box: 1.00 2.00 City: INDIANAPOLIS State: IN Zip Code: 46256 County: MARION 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 COMMUNITY HOSPITAL OF 150169 26900 02/25/2008 Ν Р Р 3.00 1 NDIANA, INC. Subprovider - IPF COMMUNITY MENTAL HEALTH Р 4.00 15S169 26900 4 01/01/2010 N 0 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2017 12/31/2017 20.00 21.00 Type of Control (see instructions) 21.00 2 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 γ N 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 Ν Υ 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result N N 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23 00 3 Ν 23 00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" "N" fo<u>r no</u>. used in the prior cost reporting period? In column 2 for yes or In-State Out-of Medi cai d Other In-State Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days paid days el i gi bl e unpai d unpai d davs 1.00 2.00 3.00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 1, 023 1.864 12 46 20, 430 34 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2. out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

58.00   If line 56 is yes, did this facility elect cost reimb	s	N		58. 00			
defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complet	e Wkst. D-5.					
59.00 Are costs claimed on line 100 of Worksheet A? If yes	, compl	ete Wkst. D-2,	Pt. I.		N		59. 00
			NAHE 413.85	Worksheet	: A	Pass-Through	
			Y/N	Li ne #		Qual i fi cati on	
						Criterion Code	
			1. 00	2, 00		3. 00	
60.00 Are you claiming nursing and allied health education	(NAHF)	costs for	N				60.00
any programs that meet the criteria under §413.85? (see instructions)							
	Y/N	IME	Direct GME	IME		Direct GME	
	1. 00	2. 00	3. 00	4. 00		5. 00	1
61.00 Did your hospital receive FTE slots under ACA	N				0. 00	0.00	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)							
61.02 Enter the current year total unweighted primary care							61. 02
FTE count (excluding OB/GYN, general surgery FTEs,							
and primary care FTEs added under section 5503 of							
ACA). (see instructions)							
61.03 Enter the base line FTE count for primary care							61. 03
and/or general surgery residents, which is used for							
determining compliance with the 75% test. (see							
instructions)							

for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is

"N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der C	CN: 15-0169	Peri od: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Pre 5/30/2018 11:	pared:	
	Y/N	IME	Direct GME	E I ME	Direct GME		
	1. 00	2. 00	3. 00	4. 00	5. 00		
1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.0	
1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.0	
1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.0	
	Pro	gram Name	Program Coo	FTE Count	Direct GME FTE Count		
		1. 00	2. 00	3. 00	4.00		
<ul> <li>1. 10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.</li> <li>1. 20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.</li> </ul>				0.00		61. 1	
					1.00		
ACA Provisions Affecting the Health Resources and Ser 2.00 Enter the number of FTE residents that your hospital				arind for which	0.00	62.0	
your hospital received HRSA PCRE funding (see instruc		in this cost	reporting pe	Sirou ioi wiiiCii	0.00	1 02.0	
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital  O.00 during in this cost reporting period of HRSA THC program. (see instructions)  Teaching Hospitals that Claim Residents in Nonprovider Settings							
3.00 Has your facility trained residents in nonprovider se	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)						
			Unwei ghted FTEs Nonprovi de Si te	FTEs in	Ratio (col. 1/ (col. 1 + col. 2))		
			1. 00	2, 00	3.00		

used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)  Program Name Program Code Unweighted IME FTE Count Direct CME FTE Count Direct C		61.04 minus line 61.03). (see instructions)					
Care or general surgery. (See instructions)   Program Name   Program Code   Unwel ghted IME   FTE Count   Count	61. 06						61. 06
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ACA Provisions Affecting the Health Resources and Services Administration (HRSA)  62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)  62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 during in this cost reporting period of HRSA THC program. (see instructions)  Teaching Hospitals that Claim Residents in Nonprovider Settings  63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter Nonprovider Settings Unweighted FTEs in Hospital 2)  Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings—This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.  64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident 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 Program Code Program Code Unweighted Program Code Site Unweighted Program Code Name Incomposital Code Site Site Unweighted Program Code Site Unweighted Program Code Site Unweighted Program Code Site Site Unweighted Program Code Site Site Site Site Site Site Site Sit		the direct one fre diwergifted court.					
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62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)  62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 6 during in this cost reporting period of HRSA THC program. (see instructions)  Teaching Hospitals that Claim Residents in Nonprovider Settings  63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N  FTES (TES)  Nonprovider Site 1.00 2.00 3.00  Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings—This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.  Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident 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 Program Code Unweighted Unweighted Program (column 2). (see instructions)  Program Name Program Code Unweighted Unweighted Ratio (col. 3/ FTES in Nonprovider Hospital 4))		ACA Provisions Affecting the Health Resources and Se	ervices Administration	(HRSA)			
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital  O.00 during in this cost reporting period of HRSA THC program. (see instructions)  Teaching Hospitals that Claim Residents in Nonprovider Settings  Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)  Once the column 1 if line 67 is yes, or your facility trained residents in Nonprovider Settings—This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.  64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident 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)  Once the column 2 in the program Name of the program Code of the column 3 in the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)  Once the column 3 in the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)  Once the column 3 in the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)  Once the column 3 in the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)  Once the column 3 in the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)  Once the column 3 in the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)  Once the column 3 in the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	62.00				od for which	0.00	62.00
during in this cost reporting period of HRSA THC program. (see instructions)  Teaching Hospitals that Claim Residents in Nonprovider Settings  83.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter  "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)  Unweighted FTEs in Nonprovider Site  1.00 2.00 3.00  Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings.—This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.  64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident 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 Program Code Unweighted Unweighted Ratio (col. 3/FTEs in Nonprovider Hospital Site		your hospital received HRSA PCRE funding (see instru	ıcti ons)				
Teaching Hospitals that Claim Residents in Nonprovider Settings  Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)    Unweighted FTEs   FTEs in Nonprovider Site   1.00   2.00   3.00	62. 01				your hospital	0.00	62. 01
Has your facility trained residents in nonprovider settings during this cost reporting period? Enter   N   (col. 1/(col. 1 + col. 1/(col. 1				ns)			
"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)  Unweighted FTEs   Unweighted FTEs   Nonprovider Site   1.00   2.00   3.00    Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings—This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.  Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident 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 Program Code Unweighted Unweighted Ratio (col. 3/FTEs in Nonprovider Site Nonprovider Site Nonprovider Site							
Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.  64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident 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  Program Code  Unweighted FTEs   Ratio (col. 1/(col. 1 + col. 2))   (col. 1 + col. 2)      Col. 1 + col. 2)     Col. 1 + col. 2)     Col. 1 + col. 2)     Col. 1 + col. 2)     Col. 1 + col. 2)     Col. 3 + col. 3/(col. 3 + col. 4))	63. 00					N I	63.00
Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.  64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident 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 Program Code Unweighted FTEs Nonprovider Site Unweighted FTEs in Hospital 4))							
Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.  64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident 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 Program Code Unweighted Unweighted FTEs Nonprovider Site Nonprovider Site			.,		Upwai abtad	Datio (col. 1/	
Site  1.00 2.00 3.00  Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.  64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident 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  Program Code  Unweighted FTEs Nonprovider Site  Unweighted FTEs in (col. 3 + col. 4))				Unwei ghted			
Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.  64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident 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  Program Code  Unweighted FTEs Nonprovider Site  Unweighted FTEs in Hospital 4))				Unwei ghted FTEs	FTEs in	(col. 1 + col.	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.  64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident 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  Program Code  Unweighted FTEs Nonprovider Site  Unweighted FTEs in Hospital 4))				Unwei ghted FTEs Nonprovi der	FTEs in	(col. 1 + col.	
period that begins on or after July 1, 2009 and before June 30, 2010.  64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident 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  Program Code  Unweighted FTEs Nonprovider Site  Unweighted FTEs in Hospital 4))				Unwei ghted FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident 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  Program Code  Unweighted FTEs Nonprovider FTEs in Hospital Hospital 4))		Section 5504 of the ACA Base Year FTF Residents in N		Unwei ghted FTEs Nonprovi der Si te	FTES in Hospital	(col. 1 + col. 2))	
FTES FTES in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te			lonprovider Settings	Unwei ghted FTEs Nonprovi der Si te	FTES in Hospital	(col. 1 + col. 2))	
Nonprovi der Hospi tal 4)) Si te	64. 00	period that begins on or after July 1, 2009 and before Enter in column 1, if line 63 is yes, or your faciling in the base year period, the number of unweighted not resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	Jonprovider Settings ore June 30, 2010. ty trained residents on-primary care all nonprovider dd non-primary care n column 3 the ratio	Unwei ghted FTEs Nonprovi der Si te 1.00 This base year	FTES in Hospital  2.00 is your cost i	(col. 1 + col. 2))  3.00 reporting  0.000000	64.00
	64.00	period that begins on or after July 1, 2009 and before Enter in column 1, if line 63 is yes, or your faciling in the base year period, the number of unweighted not resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	Jonprovider Settings ore June 30, 2010. ty trained residents on-primary care all nonprovider dd non-primary care n column 3 the ratio	Unwei ghted FTEs Nonprovi der Si te 1.00 This base year  0.00  Unwei ghted	FTES in Hospital  2.00 is your cost i  0.00  Unweighted	(col. 1 + col. 2))  3.00 reporting  0.0000000  Ratio (col. 3/	64.00
1.00   2.00   3.00   4.00   5.00	64.00	period that begins on or after July 1, 2009 and before Enter in column 1, if line 63 is yes, or your faciling in the base year period, the number of unweighted not resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	Jonprovider Settings ore June 30, 2010. ty trained residents on-primary care all nonprovider dd non-primary care n column 3 the ratio	Unwei ghted FTEs Nonprovi der Si te 1.00 This base year  0.00  Unwei ghted FTEs Nonprovi der	FTES in Hospital  2.00 is your cost i  0.00  Unweighted FTES in	(col. 1 + col. 2))  3.00 reporting  0.000000  Ratio (col. 3/(col. 3 + col.	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0169 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/30/2018 11:42 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 0. 00 0. 00 0.000000 65.00 65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 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 2. 68 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 ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 2.00 3. 00 1.00 4.00 5.00 67.00 Enter in column 1, the program FAMILY PRACTICE 0.000000 67.00 1350 0.00 1.86 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)

yes, the GME elimination is not made on Wkst. B, Pt. I, col reimbursed. If yes complete Wkst. D-2, Pt. II.  108.00 s this a rural hospital qualifying for an exception to the	·	J	N		108. 00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					
	Physi cal	Occupati onal	Speech	Respi ratory	
	1.00	2.00	3.00	4. 00	
109.00 If this hospital qualifies as a CAH or a cost provider, are	e N	N	N	N	109. 00
therapy services provided by outside supplier? Enter "Y"					
for yes or "N" for no for each therapy.					
				1 00	

110. 00 110.00|Did this hospital participate in the Rural Community Hospital Demonstration project (§410A N 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 appl i cabl e.

140.00

140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1,

chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)

Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0169 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: To 12/31/2017 5/30/2018 11:42 am 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number
Name: COMMUNITY HEALTH NETWORK | Contractor's Name: WISCONSIN PHYSICIA 141 00 Name: Contractor's Name: WISCONSIN PHYSICIANS Contractor's Number: 08101 141 00 SERVI CES 142.00 Street: 1500 NORTH RITTER AVENUE PO Box: 142.00 143.00 City: INDIANAPOLIS 46219-3095 State: ΙN Zip Code: 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 Υ 2.00 1.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146, 00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147.00 N 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title XIX Title V 1 00 2 00 3.00 4 00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν Ν Ν N 155 00 156.00 Subprovi der - IPF 156. 00 Ν Ν Ν Ν 157.00 Subprovi der - IRF 157 00 Ν Ν Ν N 158. 00 SUBPROVI DER 158.00 159.00 SNF N Ν Ν N 159. 00 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν Ν 161.00 1.00 Mul ti campus 165.00|Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. FTE/Campus Zip Code Name County **CBSA** State | 3.00 0 1.00 2 00 4.00 5.00 166.00 If line 165 is yes, for each 0. 00 166. 00 campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.
168.00 if this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 167.00 Υ d168. 00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 9 99169 00 transition factor. (see instructions) Begi nni ng Endi ng 1.00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 01/01/2015 12/31/2015 170 00 period respectively (mm/dd/yyyy) 1. 00 2.00 171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in 0 171. 00 Ν section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0169 Peri od: Worksheet S-2 From 01/01/2017 Part II Date/Time Prepared: 12/31/2017 5/30/2018 11:42 am Date 1. 00 2.00 General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 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 column 2. (see instructions) V/I Y/N Date 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 2 00 yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transactions, including management 3.00 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1. 00 2. 00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Υ Α 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different from 5.00 those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper 1.00 2.00 Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is Ν 6.00 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 7 00 8.00 Were nursing school and/or allied health programs approved and/or renewed during the N 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9 00 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 ٧ 10.00 cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved N 11.00 Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions 12.00 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions Ν 14.00 Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, Ν 15.00 see instructions Part B Part A Y/N Date Y/N Date 1.00 3.00 PS&R Data Was the cost report prepared using  $\overline{\text{the PS\&R Report onl y?}}$ 16.00 Ν 16.00 Ν If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R Report for Υ 04/29/2014 04/29/2014 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 18.00 Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R 19.00 N Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

Heal th	Financial Systems COMMUNITY HOSPITAL	OF INDIANA, II	NC.	In Lie	u of Form CM:	S-2552-10		
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0169	Peri od: From 01/01/2017 To 12/31/2017	Worksheet S Part II	-2 repared:		
			i pti on	Y/N	Y/N	1. 12 (111		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20. 00		
20.00	Report data for Other? Describe the other adjustments:			IN	IN	20.00		
		Y/N	Date	Y/N	Date			
21. 00	Was the cost report prepared only using the provider's	1. 00 N	2. 00	3. 00 N	4. 00	21. 00		
	records? If yes, see instructions.					2 33		
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	HOSPI TALS)					
22. 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see	e instructions				22, 00		
23. 00	Have changes occurred in the Medicare depreciation expense		sals made dur	ing the cost		23. 00		
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered	ed into during	this cost re	porting period?		24. 00		
25. 00								
26. 00								
27. 00	instructions. Has the provider's capitalization policy changed during the	e cost reportir	ng period? If	yes, submit		27. 00		
	copy. Interest Expense							
28. 00	Were new loans, mortgage agreements or letters of credit er period? If yes, see instructions.		•			28. 00		
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr	ructi ons		,		29. 00		
30. 00	Has existing debt been replaced prior to its scheduled maturinstructions.	urity with new	debt? If yes	, see		30. 00		
31. 00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes	, see		31. 00		
	Purchased Services							
32. 00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		ed through co	ntractual		32. 00		
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 applies, see instructions.	olied pertainir	ng to competi	tive bidding? If		33. 00		
	Provi der-Based Physi ci ans							
34. 00	1	rrangement with	n provi der-ba	sed physi ci ans?		34. 00		
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi		nts with the	provi der-based		35. 00		
	physicians during the cost reporting period? If yes, see in	nstructions.		Y/N	Date			
				1. 00	2. 00			
24 00	Home Office Costs					24 00		
36. 00 37. 00	If line 36 is yes, has a home office cost statement been pr	repared by the	home office?			36. 00 37. 00		
38. 00						38. 00		
39. 00	the provider? If yes, enter in column 2 the fiscal year end of line 36 is yes, did the provider render services to other			,		39. 00		
40. 00	see instructions. If line 36 is yes, did the provider render services to the			40. 00				
	instructions.							
		1.	. 00	2.	00			
41. 00	Cost Report Preparer Contact Information  Enter the first name, last name and the title/position	RONALD		HELMS		41.00		
41.00	held by the cost report preparer in columns 1, 2, and 3, respectively.	NONALD		ILLIVIS		41.00		
42. 00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEAL	_TH NETWORK			42. 00		
43. 00		317-355-5501		RHELMS@ECOMMUN	ITY. COM	43. 00		
		•		,		"		

Heal th Financ	cial Systems	COMMUNITY HOSPITA	AL OF I	NDI ANA, I	INC.		In Lie	u of Form CMS	-2552-10
HOSPI TAL AND	HOSPITAL HEALTH CARE R	EIMBURSEMENT QUESTIONNAIRE	F	Provi der	CCN: 15-01			Worksheet S- Part II	
						Т	o 12/31/2017	Date/Time Pr 5/30/2018 11	epared: : 42 am
				3	3. 00				
Cost F	Report Preparer Contact	Information							
41.00 Enter	the first name, last na	ame and the title/position	REIM	BURSEMENT	MANAGER				41.00
	by the cost report prepactively.	arer in columns 1, 2, and 3,							
42.00 Enter	the employer/company na	ame of the cost report							42.00
prepai	rer.								
43.00 Enter	the telephone number a	nd email address of the cost							43.00
repor	t preparer in columns 1	and 2, respectively.							

 Heal th Financial
 Systems
 COMMUNITY HO

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

Provider CCN: 15-0169

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part I | Date/Time Prepared: |

						3 12/31/2017	5/30/2018 11:	
							I/P Days / 0/P	12 (3
							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		214	78, 110	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and				·			
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7.00	Total Adults and Peds. (exclude observation			214	78, 110	0.00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		24	8, 760	0.00	0	8. 00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12.00	NEONATAL INTENSIVE CARE UNIT	35. 00		42	15, 330	0.00	0	12. 00
13.00	NURSERY	43. 00					0	13. 00
14.00	Total (see instructions)			280	102, 200	0.00	0	14. 00
15. 00	CAH visits						0	15. 00
16.00	SUBPROVI DER - I PF	40. 00		18	6, 570		0	16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18.00	SUBPROVI DER							18. 00
19.00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20. 00
21.00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P. )							23. 00
24.00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC							25. 00
26.00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27.00	Total (sum of lines 14-26)			298				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30. 00
31.00	Employee discount days - IRF							31. 00
32.00	Labor & delivery days (see instructions)			0	0			32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33. 00
33. 01	LTCH site neutral days and discharges							33. 01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0169

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

5/30/2018 11:42 am Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 6.00 10.00 7.00 8.00 9.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 18, 144 823 55, 052 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 7.566 18, 264 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 0 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 0 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 C 0 6.00 7.00 Total Adults and Peds. (exclude observation 18, 144 823 55, 052 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 2,047 5, 572 8.00 CORONARY CARE UNIT 9.00 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 NEONATAL INTENSIVE CARE UNIT 804 11, 621 12.00 0 NURSFRY 13.00 3, 484 7.547 13.00 14.00 Total (see instructions) 20, 191 5, 111 79, 792 4.01 1, 404. 36 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 19.60 16.00 2.427 3.441 0.93 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 HOSPI CE 24 00 24 00 HOSPICE (non-distinct part) 24. 10 0 0 488 24. 10 25. 00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26, 00 FEDERALLY QUALIFIED HEALTH CENTER 0.00 0.00 26.25 0 C 0 26.25 27.00 Total (sum of lines 14-26) 4.94 1, 423. 96 27.00 28.00 Observation Bed Days 1,750 6,072 28.00 29.00 29.00 Ambul ance Trips 0 30.00 Employee discount days (see instruction) 2, 104 30.00 31.00 Employee discount days - IRF 31.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room 34 32.00 32.00 0 1, 246 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 33.01 LTCH site neutral days and discharges 33.01

 Heal th Financial
 Systems
 COMMUNITY HO

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

Provider CCN: 15-0169

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part I | Date/Time Prepared: |

					3 12/31/2017	5/30/2018 11:	
		Full Time	<u> </u>	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 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		0	,, 555		17, 042	1.00
2.00	HMO and other (see instructions)			1, 497	2, 912		2.00
3.00	HMO I PF Subprovi der				0		3. 00
4.00	HMO I RF Subprovi der				0		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 beds) (see instructions)						7. 00
8. 00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	NEONATAL INTENSIVE CARE UNIT						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0.00	0	4, 653	161	17, 042	14. 00
15. 00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF	0. 00	0	234	0	373	
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						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 Tri ps						29. 00
30.00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33. 00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			ı			33. 01

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0169

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

					To	12/31/2017	Date/Time Prep 5/30/2018 11:4	
		Wkst. A Line		Reclassificati	Adjusted	Paid Hours	Average Hourly	
		Number	Reported	on of Salaries (from Wkst.	Sal ari es (col. 2 ± col.	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	A-6) 3. 00	3) 4. 00	col . 4 5. 00	6. 00	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARI ES	222 22	00 074 740	500.054		0.0/4.040.00	0.1.00	
1. 00	Total salaries (see instructions)	200. 00	93, 274, 749	-508, 951	92, 765, 798	2, 961, 840. 00	31. 32	1.00
2. 00	Non-physician anesthetist Part		0	0	0	0.00	0. 00	2. 00
3. 00	A Non-physician anesthetist Part		0	О	О	0.00	0. 00	3. 00
4 00	B Dhygi ei an Dant A		110 001		110 001	744.00	150 /0	4 00
4. 00	Physician-Part A - Administrative		118, 801	0	118, 801	744. 00	159. 68	4. 00
4. 01	Physicians - Part A - Teaching		0	0		0.00		
5. 00	Physician and Non Physician-Part B		249, 667	0	249, 667	4, 249. 00	58. 76	5. 00
6. 00	Non-physician-Part B for		0	0	0	0.00	0. 00	6. 00
	hospital-based RHC and FQHC services							
7. 00	Interns & residents (in an	21. 00	0	0	0	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and		0	0	О	0.00	0. 00	7. 01
	residents (in an approved							
8. 00	programs) Home office and/or related		0	0	О	0.00	0. 00	8. 00
9. 00	organization personnel SNF	44. 00	0			0. 00	0. 00	9. 00
10. 00	Excluded area salaries (see	44.00	1, 927, 136	-4, 466	1, 922, 670	58, 357. 00		
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract labor: Direct Patient		1, 475, 792	0	1, 475, 792	14, 326. 00	103. 01	11. 00
12. 00	Care Contract Labor: Top Level		0	0		0. 00	0. 00	12. 00
12.00	management and other		0			0.00	0.00	12.00
	management and administrative services							
13.00	Contract Labor: Physician-Part		4, 111, 090	0	4, 111, 090	33, 522. 00	122. 64	13. 00
14. 00	A - Administrative Home office and/or related		0	0	0	0. 00	0.00	14. 00
14.00	orgainzation salaries and		0			0.00	0.00	14.00
14. 01	wage-related costs Home office salaries		27, 808, 170	0	27, 808, 170	708, 175. 00	39 27	14. 01
14. 02	Related organization salaries		0	0	0	0.00	0. 00	14. 02
15. 00	Home office: Physician Part A - Administrative		104, 391	0	104, 391	512. 00	203. 89	15. 00
16. 00	Home office and Contract		0	0	0	0. 00	0. 00	16. 00
	Physicians Part A - Teaching   WAGE-RELATED COSTS							1
17. 00	Wage-related costs (core) (see		22, 610, 788	0	22, 610, 788			17. 00
18. 00	instructions) Wage-related costs (other)		0	0	0			18. 00
	(see instructions)		440, 400		440 400			
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		462, 492 0	0	462, 492 0			19. 00 20. 00
	A		2					
21. 00	Non-physician anesthetist Part B		0					21. 00
22. 00	Physician Part A -		7, 179	0	7, 179			22. 00
22. 01	Administrative Physician Part A - Teaching		0	О	О			22. 01
23. 00	Physician Part B		41, 001	0	41, 001			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0		0			24. 00 25. 00
25 50	approved program)		7 0/1 125		7 0/1 105			25 50
25. 50	Home office wage-related (core)		7, 061, 135	0	7, 061, 135			25. 50
25. 51	Related organization		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A		0	О	О			25. 52
	- Administrative - wage-related (core)							
25. 53	Home office & Contract		0	О	О			25. 53
	Physicians Part A - Teaching - wage-related (core)							
	OVERHEAD COSTS - DIRECT SALARIE							
26. 00 27. 00	Employee Benefits Department Administrative & General	4. 00 5. 00	193, 323 5, 500, 496		193, 323 5, 474, 160	4, 693. 00 146, 538. 00		26. 00 27. 00
27.00	, Amir III Strati ve a General	3.00	3, 300, 470	-20, 330	3,474,100	140, 330.00	37.30	27.00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 01/01/2017 Part II
To 12/31/2017 Date/Time Prepared: 5/30/2018 11: 42 am

							5/30/2018 11:	<u>42 am</u>
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Paid Hours	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		10, 939, 027	0	10, 939, 027	98, 710. 00	110. 82	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00		0	0	0.00		29. 00
30.00	Operation of Plant	7. 00	2, 701, 951	-12, 993	2, 688, 958	123, 199. 00	21. 83	30.00
31.00	Laundry & Linen Service	8. 00	0	0	C	0.00	0.00	31.00
32.00	Housekeepi ng	9. 00	2, 832, 730	-35, 597	2, 797, 133	192, 163. 00	14. 56	32.00
33.00	Housekeeping under contract		417, 619	0	417, 619	9, 911. 00	42. 14	33.00
	(see instructions)							
34.00	Di etary	10. 00	2, 236, 887	-1, 629, 844	607, 043	36, 006. 00	16. 86	34.00
35.00	Di etary under contract (see		0	0	C	0.00	0.00	35.00
	instructions)							
36.00	Cafeteri a	11. 00	0	1, 623, 631	1, 623, 631	95, 327. 00	17. 03	36.00
37.00	Maintenance of Personnel	12. 00	0	0	C	0.00	0.00	37.00
38.00	Nursing Administration	13. 00	1, 711, 208	-12, 031	1, 699, 177	55, 318. 00	30. 72	38. 00
39.00	Central Services and Supply	14. 00	0	0	C	0.00	0.00	39.00
40.00	Pharmacy	15. 00	4, 329, 605	-24, 351	4, 305, 254	105, 594. 00	40. 77	40.00
41.00	Medical Records & Medical	16. 00	335, 128	-303	334, 825	8, 873. 00	37. 74	41.00
	Records Library							
42.00	Social Service	17. 00	1, 361, 593	-9, 840	1, 351, 753	40, 317. 00	33. 53	42.00
43.00	Other General Service	18. 00	0	0	C	0.00	0.00	43.00

Total overhead cost (see

instructions)

7.00

35. 38

7.00

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0169 Worksheet S-3 Peri od: From 01/01/2017 To 12/31/2017 Part III Date/Time Prepared: 5/30/2018 11:42 am Average Hourly Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col.2 ± col. (from Salaries in col . 5) Works<u>heet A-6)</u> 3) col. 4 1.00 2.00 5.00 6.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 104, 381, 728 -508, 951 103, 872, 777 3, 066, 212. 00 33. 88 1.00 instructions) 2.00 Excluded area salaries (see 1, 927, 136 1, 922, 670 58, 357. 00 32. 95 2.00 -4, 466 instructions) 3.00 Subtotal salaries (line 1 102, 454, 592 -504, 485 101, 950, 107 3, 007, 855. 00 33.89 3.00 minus line 2) 4.00 Subtotal other wages & related 33, 499, 443 33, 499, 443 756, 535. 00 44. 28 4.00 costs (see inst.) Subtotal wage-related costs 29. 11 5.00 29, 679, 102 Ω 29, 679, 102 0.00 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 165, 633, 137 -504, 485 165, 128, 652 3, 764, 390. 00 43 87

-127, 664

32, 431, 903

916, 649. 00

32, 559, 567

14.00

15.00

17 00

22.00

23.00

24.00

0 25.00

186, 534

6, 651, 835

0 16.00

0 18.00

0 19.00

0 20.00

0 21.00

135, 041

23, 121, 461

Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. In Lieu of Form CMS-2552-10 HOSPITAL WAGE RELATED COSTS Provider CCN: 15-0169 Peri od: Worksheet S-3 From 01/01/2017 Part IV 12/31/2017 Date/Time Prepared: 5/30/2018 11:42 am Amount Reported 1.00 PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 1.00 401K Employer Contributions 2, 772, 697 1.00 2 00 Tax Sheltered Annuity (TSA) Employer Contribution 2.00 0 3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0 3.00 Qualified Defined Benefit Plan Cost (see instructions) 0 4.00 4.00 PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 5.00 5.00 401K/TSA Plan Administration fees 0 6.00 Legal /Accounting/Management Fees-Pension Plan 0 6.00 7.00 Employee Managed Care Program Administration Fees 0 7.00 HEALTH AND INSURANCE COST 8.00 Health Insurance (Purchased or Self Funded) 0 8.00 8.01 Health Insurance (Self Funded without a Third Party Administrator) 0 8.01 8.02 Health Insurance (Self Funded with a Third Party Administrator) 8, 724, 635 8.02 Health Insurance (Purchased) 8.03 0 8.03 9.00 Prescription Drug Plan 3, 730, 401 9.00 Dental, Hearing and Vision Plan 79, 904 10.00 10.00 Life Insurance (If employee is owner or beneficiary) 11.00 11.00 58, 137 Accident Insurance (If employee is owner or beneficiary) 12.00 Λ 12.00 Disability Insurance (If employee is owner or beneficiary) 782, 277 13.00

Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.

Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see

Long-Term Care Insurance (If employee is owner or beneficiary)

'Workers' Compensation Insurance

Medicare Taxes - Employers Portion Only

Total Wage Related cost (Sum of lines 1 -23)

Part B - Other than Core Related Cost OTHER WAGE RELATED COSTS (SPECIFY)

State or Federal Unemployment Taxes

Non cumulative portion)

Unemployment Insurance

Tuition Reimbursement

instructions))

FICA-Employers Portion Only

Day Care Cost and Allowances

14.00

15.00

16.00

17 00

18.00

19.00

20.00

21.00

22.00

23.00

24.00

TAXES

OTHER

Health Financial Systems	COMMUNITY HOSPITAL OF INDIANA, INC.	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0169	Period: Worksheet S-3

		110111 0170172017		
		To 12/31/2017	Date/Time Pre	
		_	5/30/2018 11:	42 am_
	Cost Center Description	Contract Labor	Benefit Cost	
		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	1, 475, 792	23, 121, 461	1.00
2.00	Hospi tal	1, 475, 792	22, 658, 969	2.00
3.00	Subprovi der - IPF	0	0	3.00
4.00	Subprovi der - IRF			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			8. 00
9. 00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FOHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17. 00	Renal Dialysis	0	0	17.00
18. 00	Other	0	462, 492	18.00

th Financial Sys		COMMUNITY HOSPITAL O				eu of Form CMS-2				
PITAL UNCOMPENSAT	ED AND INDIGENT CARE DATA		Provi der CC	CN: 15-0169	Peri od:	Worksheet S-10	0			
					From 01/01/2017 To 12/31/2017	Date/Time Pre	nar			
					12, 01, 201,	5/30/2018 11:				
						1.00				
Uncompensated	and indigent care cost comp	outation				1.00				
	e ratio (Worksheet C, Part I		divided by li	ne 202 colum	n 8)	0. 214518	1			
	instructions for each line)				,					
O Net revenue f	om Medicaid					34, 255, 014	2			
Did you recei	ve DSH or supplemental payme	ents from Medicaid?				Υ	3			
O Ifline 3 is	yes, does line 2 include all	DSH and/or suppleme	ental payment	s from Medic	ai d?	Y	4			
0 If line 4 is	no, then enter DSH and/or su	upplemental payments	from Medicai	d		0	5			
	Medi cai d charges 262, 002, 439									
	(line 1 times line 6)					56, 204, 239				
	tween net revenue and costs	for Medicaid program	n (line 7 min	us sum of li	nes 2 and 5; if	21, 949, 225	8			
< zero then e		N ( : 1 : 1:	6 1 1:	`						
	of the Insurance Program (CHIF	) (see Instructions	Tor each line	e)			۱.			
· ·	rom stand-alone CHIP					0				
OO Stand-alone C		10)				0				
4										
enter zero)										
	local government indigent	care program (see in	structions fo	or each line	)					
	rom state or local indigent					0	13			
	atients covered under state					0	14			
10)		-								
	indigent care program cost					0				
	tween net revenue and costs	for state or local i	ndigent care	program (li	ne 15 minus line	0	16			
	then enter zero)					<u> </u>				
	ons and total unreimbursed	cost for Medicaid, C	HIP and state	e/Local indi	gent care progran	ns (see				
instructions  Private grant	or each line) s, donations, or endowment i	ncome restricted to	funding char	ity coro		0	17			
9	ants, appropriations or trar		J	,						
	ursed cost for Medicaid , Ch				s (sum of lines	21, 949, 225				
8, 12 and 16)		and state and rec	ar margane	oar o program	o (oum or 111100	2.1,7.7,220	' '			
				Uni nsured	Insured	Total (col. 1				
				pati ents	pati ents	+ col . 2)				
				1. 00	2. 00	3. 00				
	Care (see instructions for									
OO Charity care (see instruct	charges and uninsured discou	unts for the entire f	facility	1, 307, 7	55 2, 661, 309	3, 969, 064	20			
	nts approved for charity can	re and uninsured disc	ounts (see	280, 5	37 2, 661, 309	2, 941, 846	21			
instructions)	approved for enallty ear	5 and difficultied di se	(300	200, 0	2,001,007	2, , , , , , 0 + 0	-			
	ved from patients for amour	nts previously writte	en off as		0 149, 364	149, 364	22			
charity care										
00 Cost of chari										

imposed on patients covered by Medicaid or other indigent care program?

Total bad debt expense for the entire hospital complex (see instructions)

28.00 Non-Medicare bad debt expense (see instructions)

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

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

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

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

29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)

If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

25. 00

26.00

27.00

27. 01

28. 00 29. 00

30.00

65, 190, 881

64, 658, 997

14, 056, 679

16, 849, 161

345, 724

531, 884

38, 798, 386 31. 00

25.00

26.00

stay limit

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 15-0169 Peri od: Worksheet A From 01/01/2017 12/31/2017 Date/Time Prepared: 5/30/2018 11:42 am Cost Center Description 0ther 1 Reclassi fi cati Sal ari es Total (col. Reclassi fied + col. 2) ons (See A-6) Trial Balance (col. 3 +-col. 4) 1.00 4. 00 2.00 3.00 5.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 16, 579, 293 16, 579, 293 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 0 9, 232, 973 9, 232, 973 2.00 0 00300 OTHER CAP REL COSTS 3.00 O 3 00 235, 992 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 193, 323 429, 315 -87, 783 341, 532 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5, 500, 496 112, 999, 597 118, 500, 093 -16, 123, 397 102, 376, 696 5.00 00700 OPERATION OF PLANT 6, 667, 166 9, 329, 991 2, 701, 951 9, 369, 117 7.00 -39, 126 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 742, 266 742, 266 -80 742, 186 8.00 9.00 00900 HOUSEKEEPI NG 2, 832, 730 1, 709, 068 4, 541, 798 -7, 891 4, 533, 907 9.00 01000 DI ETARY 2, 236, 887 1, 075, 772 3, 312, 659 -2, 372, 195 940, 464 10.00 10.00 01100 CAFETERI A 2, 370, 896 2, 370, 896 11.00 11.00 Λ 01300 NURSING ADMINISTRATION 13.00 1, 711, 208 482, 262 2, 193, 470 -5, 294 2, 188, 176 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 926, 195 926, 195 -1, 511, 817 -585, 622 14.00 12, 862, 563 01500 PHARMACY 4, 329, 605 17, 192, 168 -12, 802, 760 4, 389, 408 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 335, 128 67, 893 402, 881 16,00 403, 021 -140 16.00 17.00 01700 SOCIAL SERVICE 1, 361, 593 395, 425 1, 757, 018 -258 1, 756, 760 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 0 0 19.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 21 00 0 0 0 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 0 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 29, 967, 408 15, 633, 740 45, 601, 148 -10, 987, 238 34, 613, 910 30.00 03100 INTENSIVE CARE UNIT 2,007,790 31.00 3, 958, 989 5, 966, 779 5, 289, 786 -676, 993 31 00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 6,001,934 2, 535, 568 8, 537, 502 -275, 653 8, 261, 849 35.00 04000 SUBPROVIDER - IPF 40.00 1, 456, 698 485, 191 1, 941, 889 -1, 442, 282 499, 607 40.00 <u>2, 622,</u> 381 43.00 04300 NURSERY 2, 622, 381 43 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 668, 426 32, 934, 060 37, 602, 486 -29, 167, 597 8, 434, 889 50.00 05100 RECOVERY ROOM 51.00 2,047,288 1, 114, 773 3, 162, 061 -16, 432 3, 145, 629 51.00 05200 DELIVERY ROOM & LABOR ROOM 574, 653 6, 515, 675 52 00 20.310 594 963 7, 110, 638 52 00 05400 RADI OLOGY-DI AGNOSTI C 4, 459, 806 54.00 3, 415, 781 2, 222, 386 5, 638, 167 -1, 178, 361 54.00 05500 RADI OLOGY-THERAPEUTI C 396, 766 2, 763, 182 3, 159, 948 -2, 388, 298 771, 650 55.00 55.00 57.00 05700 CT SCAN 803, 335 789, 338 1, 592, 673 -363, 550 1, 229, 123 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1, 787, 424 58.00 470, 173 1, 542, 136 2, 012, 309 -224, 885 58 00 59.00 05900 CARDIAC CATHETERIZATION 317 317 -111, 722 -111, 405 59.00 06000 LABORATORY 210, 212 9, 908, 759 10, 118, 971 10, 053, 945 60.00 -65, 026 60.00 64.00 06400 I NTRAVENOUS THERAPY 285, 185 181, 024 466, 209 -88, 985 377, 224 64.00 06500 RESPIRATORY THERAPY 2, 610, 993 65.00 1, 538, 318 4, 149, 311 -836, 300 3, 313, 011 65.00 66.00 06600 PHYSI CAL THERAPY 5, 334, 622 2, 360, 674 7, 695, 296 -2, 557, 869 5, 137, 427 66.00 67.00 06700 OCCUPATIONAL THERAPY 1, 484, 968 1, 484, 968 67.00 06800 SPEECH PATHOLOGY 318, 161 68.00 318, 161 68.00 06900 ELECTROCARDI OLOGY 35, 879 685, 274 69.00 721, 153 -10, 305 710, 848 69 00 899, 610 687, 525 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 587, 135 -222, 436 1, 364, 699 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 18, 248, 540 18, 248, 540 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 15, 632, 254 15, 632, 254 72.00 72.00 0 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 13, 308, 062 13, 308, 062 73.00 74.00 07400 RENAL DIALYSIS 606 949, 946 950, 552 950, 552 74.00 76.00 03330 ENDOSCOPY 1, 031, 848 1, 930, 139 2, 961, 987 -1, 457, 318 1, 504, 669 76.00 03954 I MAGING CENTER 76.06 1, 332, 893 1.885.194 3. 218. 087 -904, 587 2, 313, 500 76.06 03955 BREAST DIAGNOSTIC CENTER 5, 048, 895 <u>-133,</u>911 4, 914, 984 76.07 5, 048, 895 76.07 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 90.00 90. 26 04975 SPINE CENTER 204, 230 63, 732 267, 962 -479 267, 483 90. 26 91.00 09100 EMERGENCY 5.893.861 3, 492, 027 9, 385, 888 -210, 655 9, 175, 233 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 0 0 113.00 0 114.00 11400 UTILIZATION REVIEW - SNF 0 114.00 SUBTOTALS (SUM OF LINES 1 through 117) 92. 804. 311 228, 944, 497 321, 748, 808 41, 580 321, 790, 388 118, 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 191. 00 19100 RESEARCH 0 0 0 0 191.00 0 127, 890 192. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 127, 890 127, 890 0 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 194.00 07950 HOME OFFICE 0 0 194.00 0 194. 06 07956 PAVI LLI ONS 0 33, 486 33, 486 20, 987 54, 473 194. 06 194. 08 07958 OTHER NRCC 1, 791, 591 194. 08 470, 438 1, 383, 720 1, 854, 158 -62.567194. 10 07960 COMMUNITY REHAB HOSPITAL 0 194, 10 TOTAL (SUM OF LINES 118 through 199) 230, 489, 593 323, 764, 342 200. 00 200.00 93. 274. 749 323, 764, 342

Health FinancialSystemsCOMMUNITY HOSPIRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

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

Date/Time Prepared: 5/30/2018 11:42 am

			5/30/2018 11: 42	am
Cost Center Description	Adjustments	Net Expenses		
		or Allocation		
	6.00	7. 00		
GENERAL SERVICE COST CENTERS				
1.00 00100 CAP REL COSTS-BLDG & FIXT	-3, 067, 777	13, 511, 516		1.00
2.00   00200 CAP REL COSTS-MVBLE EQUIP	5, 372, 955	14, 605, 928		2.00
3.00 00300 OTHER CAP REL COSTS	0	0		3.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	3, 744, 520	4, 086, 052		4.00
5.00 00500 ADMINISTRATIVE & GENERAL	-45, 123, 954	57, 252, 742		5.00
7. 00   00700   OPERATION OF PLANT	875, 475	10, 205, 466		7. 00
8. 00   00800   LAUNDRY & LI NEN SERVI CE	0/3, 4/3	742, 186		8. 00
9. 00   00900   HOUSEKEEPI NG	0	4, 533, 907		9. 00
· · · · · · · · · · · · · · · · · · ·				
10. 00   01000   DI ETARY	-9, 248	931, 216		0.00
11. 00   01100   CAFETERI A	-67, 721	2, 303, 175		1. 00
13.00 O1300 NURSING ADMINISTRATION	3, 757, 448	5, 945, 624		3. 00
14.00 O1400 CENTRAL SERVICES & SUPPLY	1, 625, 824	1, 040, 202		4. 00
15. 00   01500   PHARMACY	-26, 250	4, 363, 158	1!	5.00
16. 00   01600   MEDI CAL RECORDS & LI BRARY	2, 428, 296	2, 831, 177	] 10	6.00
17. 00   01700   SOCIAL SERVICE	0	1, 756, 760	1	7.00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	0	11	9.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	367, 313	367, 313	2	21. 00
22.00   02200   Lar Services-Other Prgm Costs Apprvd	664, 574	664, 574	i i	22. 00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS	869, 127	35, 483, 037	31	80. 00
31. 00   03100   NTENSI VE CARE UNIT	007, 127	5, 289, 786		31. 00
35. 00   02060   NEONATAL   INTENSIVE CARE UNIT	-286, 936			35. 00
		7, 974, 913		
40. 00   04000   SUBPROVI DER -   PF	0	499, 607		0.00
43. 00   04300   NURSERY	0	2, 622, 381	4.	13.00
ANCI LLARY SERVI CE COST CENTERS				
50.00   05000   OPERATI NG ROOM	0	8, 434, 889		0.00
51.00   05100   RECOVERY ROOM	0	3, 145, 629		1. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	7, 110, 638		2. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	17, 936	4, 477, 742	5 <sub>0</sub>	4. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	771, 650	5:	5.00
57. 00   05700 CT SCAN	0	1, 229, 123	5	7. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 787, 424	5	8. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	480, 472	369, 067		9. 00
60. 00   06000   LABORATORY	-1, 300, 582	8, 753, 363		0.00
64. 00 06400 I NTRAVENOUS THERAPY	0	377, 224		4. 00
65. 00 06500 RESPI RATORY THERAPY	0	3, 313, 011		5. 00
66. 00   06600   PHYSI CAL THERAPY	-90	5, 137, 337		6. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 484, 968		7. 00
68. 00 06800 SPEECH PATHOLOGY	0	318, 161		8. 00
69. 00  06900   ELECTROCARDI OLOGY	-611, 829	99, 019		9. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	315, 417	1, 680, 116		0. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	18, 248, 540	7	1.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	15, 632, 254	7:	2.00
73.00 07300 DRUGS CHARGED TO PATIENTS	544, 533	13, 852, 595	7:	3.00
74.00 07400 RENAL DIALYSIS	0	950, 552	7-	4. 00
76. 00 03330 ENDOSCOPY	0	1, 504, 669		6. 00
76. 06   03954   I MAGI NG CENTER	0	2, 313, 500		6.06
76. 07 03955 BREAST DIAGNOSTIC CENTER	0	4, 914, 984		6. 07
OUTPATIENT SERVICE COST CENTERS	O <sub>I</sub>	4, 714, 704		0.07
	٥			0. 00
90. 00   09000   CLI NI C	0	2/7 402		
90. 26   04975   SPI NE CENTER	0	267, 483		0. 26
91. 00   09100   EMERGENCY	0	9, 175, 233		1. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			92	2. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE	0	0	<b>                                     </b>	3.00
114.00 11400 UTILIZATION REVIEW - SNF	0	0	114	4.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-29, 430, 497	292, 359, 891	11:	8.00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	n	n	190	0.00
191. 00 19100 RESEARCH	0	0		1. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		127 000		2. 00
		127, 890		
193. 00 19300 NONPALD WORKERS	O O	0		3.00
194. 00 07950 HOME OFFI CE	0	_ 0		94. 00
194. 06 07956 PAVI LLI ONS	0	54, 473		4. 06
194. 08 07958 OTHER NRCC	0	1, 791, 591		94. 08
194.10 07960 COMMUNITY REHAB HOSPITAL	0	0		94. 10
200.00   TOTAL (SUM OF LINES 118 through 199)	-29, 430, 497	294, 333, 845	200	00.00
	•		·	

COMMUNITY HOSPITAL OF INDIANA, INC.
Provider CCN: 15-0169 Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/30/2018 11:42 am

		Lnonococo			5/30/2018	11: 42 am
	Cost Center	Increases Line #	Salary	Other		
	2. 00	3.00	4.00	5. 00		
	A - Chargeable Medical Suppli					
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	18, 248, 540		1. 00
2. 00	PATI ENTS	0.00	0	0		2. 00
3. 00		0.00	o	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6. 00 7. 00		0. 00 0. 00	0	0		6. 00 7. 00
8. 00		0.00	0	0		8. 00
9. 00		0.00	Ō	Ō		9. 00
10.00		0.00	0	0		10. 00
11. 00		0.00	0	0		11.00
12. 00 13. 00	+	0. 00 0. 00	0	0		12. 00 13. 00
14. 00		0.00	0	0		14. 00
15. 00		0.00	0	0		15. 00
16. 00		0.00	0	0		16. 00
17. 00 18. 00		0. 00 0. 00	0	0		17. 00 18. 00
10.00	TOTALS — — — — —		— — <del>0</del>	18, 248, 540		18.00
	B - Implantable Device Reclas	SS	- 1	.,,		
1.00	IMPL. DEV. CHARGED TO	72. 00	0	15, 632, 254		1. 00
2. 00	PATI ENTS	0.00	o	0		2. 00
3. 00		0.00	o	0		3. 00
	TOTALS			15, 632, 254		
1 00	C - Drugs Charges to Pat	72.00	ما	12 200 0/2		1 00
1. 00 2. 00	DRUGS CHARGED TO PATIENTS	73. 00 0. 00	0	13, 308, 062 0		1. 00 2. 00
3.00		0.00	o	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0. 00 0. 00	0	0		5. 00
6. 00 7. 00		0.00	ol Ol	0		6. 00 7. 00
8. 00		0.00	o	0		8. 00
9. 00		0.00	0	0		9. 00
10.00		0. 00 0. 00	0	0		10.00
11. 00 12. 00		0.00	0	0		11. 00 12. 00
13. 00		0.00	o	0		13. 00
14.00		0.00	0	0		14. 00
15. 00		0.00	0	0		15.00
16. 00 17. 00	:	0. 00 0. 00	0	0		16. 00 17. 00
18. 00		0.00	0	0		18. 00
19. 00		0.00	0	0		19. 00
20.00		0.00	0	0		20. 00
21. 00 22. 00		0. 00 0. 00	0	0		21. 00 22. 00
22.00	TOTALS — — — — —		0	<u>0</u> 13, 308, 062		22.00
	D - Depreciation Expense		<u> </u>			
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	13, 025, 909		1. 00
2. 00 3. 00		0. 00 0. 00	0	0		2. 00 3. 00
4. 00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7. 00 8. 00		0. 00 0. 00	0	0 0		7. 00 8. 00
9. 00		0.00	0	0		9. 00
10.00		0.00	Ō	Ō		10.00
11. 00		0.00	0	0		11. 00
12.00		0. 00 0. 00	0	0		12.00
13. 00 14. 00		0.00	0	0		13. 00 14. 00
15. 00		0.00	0	0		15. 00
16.00		0.00	O	0		16. 00
17. 00		0.00	0	0		17. 00
18. 00 19. 00		0. 00 0. 00	0	0		18. 00 19. 00
20. 00		0.00	0	0		20.00
21.00		0.00	0	0		21. 00
22. 00		0.00	0	0		22. 00

Health Financial Systems RECLASSIFICATIONS COMMUNITY HOSPITAL OF INDIANA, INC. | Period: | Worksheet A-6 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: 5/30/2018 | 11: 42 am Provider CCN: 15-0169

					10 12/31/201/	5/30/2018 11:42 am
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4.00	5. 00		
23.00		0.00	0	0		23. 00
24.00		0.00	0	0		24. 00
25.00		0.00	o	0		25. 00
26.00		0.00	o	0		26. 00
27. 00		0.00	0	0		27. 00
28. 00		0.00	o	0		28. 00
20.00	TOTALS — — — —		<del>0</del>	13, 025, 909		20.00
	E - Interest Expense		9	13, 023, 707		
1. 00	CAP REL COSTS-BLDG & FIXT	1. 00	0	8, 012, 618		1.00
1.00	TOTALS		0	8, 012, 618		1.00
	F - Other Capital Rental			0,012,010		
1 00		2 00	o	4 270 704		1 00
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	- 1	4, 378, 704		1.00
2.00	OPERATION OF PLANT	7. 00	0	18, 490		2.00
3. 00	EMERGENCY	91.00	0	31, 283		3. 00
4. 00	PAVI LLI ONS	194. 06	0	38, 795		4. 00
5. 00		0.00	0	0		5. 00
6. 00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10. 00
11. 00		0.00	0	0		11. 00
12. 00		0.00	0	0		12. 00
13. 00		0.00	o	o		13. 00
14. 00		0.00	Ö	Ö		14. 00
15. 00		0.00	o	o		15. 00
16. 00		0.00	o	Ö		16.00
17. 00		0.00	0	o		17. 00
	+	· •	0	0		•
18.00		0.00	- 1			18.00
19.00		0.00	0	0		19. 00
20.00		0.00	0	0		20.00
21. 00		0.00	0	0		21. 00
22. 00		0.00	0	0		22. 00
23. 00		0.00	0	0		23. 00
24. 00		0.00	0	0		24. 00
25.00		0.00	0	0		25. 00
26.00		0.00	0	0		26. 00
27.00		0.00	0	0		27. 00
28. 00		0.00	0	0		28. 00
29.00		0.00	o	0		29. 00
	TOTALS — — — — —			4, 467, 272		
	G - STD BENEFITS		-1			
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	26, 336		1. 00
2. 00	OPERATION OF PLANT	7. 00	Ö	12, 993		2. 00
3.00	HOUSEKEEPI NG	9.00	Ö	35, 597		3. 00
4. 00	DI ETARY	10.00	o	6, 213		4.00
5. 00	NURSING ADMINISTRATION	13. 00	0	12, 031		5. 00
		· · · · · · · · · · · · · · · · · · ·	0			
6.00	PHARMACY	15.00	-	24, 351		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	303		7. 00
8. 00	SOCIAL SERVICE	17. 00	0	9, 840		8. 00
9.00	ADULTS & PEDIATRICS	30.00	0	121, 732		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	5, 420		10.00
11. 00	NEONATAL INTENSIVE CARE UNIT	35.00	0	62, 889		11.00
12.00	SUBPROVI DER - I PF	40.00	0	2, 162		12.00
13.00	OPERATING ROOM	50.00	0	56, 188		13.00
14. 00	RECOVERY ROOM	51.00	0	8, 326		14. 00
15. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	7, 135		15. 00
16. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	907		16. 00
17.00	CT SCAN	57. 00	0	738		17. 00
18. 00	LABORATORY	60.00	0	2, 851		18. 00
19. 00	RESPIRATORY THERAPY	65. 00	0	12, 280		19. 00
20.00	PHYSI CAL THERAPY	66. 00	0	31, 310		20. 00
21.00	ELECTROENCEPHALOGRAPHY	70.00	o	3, 031		21. 00
22.00	ENDOSCOPY	76.00	0	6, 086		22. 00
23. 00	I MAGI NG CENTER	76.06	0	8, 354		23. 00
24. 00	EMERGENCY	91.00	o	49, 574		24. 00
25. 00	OTHER NRCC	194. 08	Ö	2, 304		25. 00
	TOTALS	— — : <del>, ; ; ;</del> <del> </del>	<del>ŏ</del> l	508, 951		25.00
	H - Labor and Delivery		<u> </u>	333, 731		
1. 00	NURSERY	43. 00	1, 754, 501	867, 880		1.00
2. 00	DELIVERY ROOM & LABOR ROOM	52. 00	4, 359, 305	2, 156, 370		2. 00
2.00	TOTALS		6, 113, 806	3, 024, 250		2.00
	1.5.7.20		5, 115, 000	5, 027, 250		I

Health Financial Systems RECLASSIFICATIONS COMMUNITY HOSPITAL OF INDIANA, INC. In Lieu of Form CMS-2552-10 | Period: | Worksheet A-6 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: 5/30/2018 | 11: 42 am Provider CCN: 15-0169

					5/30/2018 11: 42	<u> am</u>
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	I - Cafeteria					
1.00	CAFETERI A	11. 00	1, 623, 631	747, 265		1.00
	TOTALS		1, 623, 631	747, 265		
	J - Therapy					
1.00	OCCUPATI ONAL THERAPY	67. 00	1, 057, 200	427, 768		1.00
2.00	SPEECH PATHOLOGY	68. 00	226, 510	91, 651		2.00
	TOTALS	1	1, 283, 710	519, 419		
	K - BUILDING DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8, 171, 640		1.00
	TOTALS			8, 171, 640		
	L - Capital Insurance Costs	· · · · · · · · · · · · · · · · · · ·	- 1	, , , , , , , , , , , , , , , , , , , ,		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	395, 035		1. 00
	TOTALS			395, 035		
	M - Radiology Support		- 1			
1.00	RADI OLOGY-THERAPEUTI C	55.00	86, 216	31, 202		1.00
2.00	CT SCAN	57.00	185, 809	67, 246		2. 00
3. 00	MAGNETIC RESONANCE I MAGING	58.00	51, 710	18, 714		3. 00
2.00	(MRI)		0.,,	.0, ,		2. 50
	TOTALS		323, 735	117, 162		
500 00	Grand Total: Increases		9, 344, 882	86, 178, 377		00. 00
550.00	Jordina Total Title Cuses	1 1	7, 311, 002	55, 170, 577	100	30. 00

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

Date/Time Prepared: 5/30/2018 11:42 am

						5/30/2018 11:	:42 am
	2 1 2 1	Decreases	6.1	011			
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6.00	7.00	8. 00	9. 00	10. 00		
1 00	A - Chargeable Medical Suppli ADULTS & PEDIATRICS	30.00	ol	1 710 1/0	O		1 00
1. 00 2. 00	INTENSIVE CARE UNIT	31. 00	0	1, 710, 160 306, 395	0		1. 00 2. 00
3. 00	NEONATAL INTENSIVE CARE UNIT	35. 00	o	123, 557	0		3. 00
4. 00	OPERATING ROOM	50.00	o	12, 611, 609	0		4. 00
5. 00	RADI OLOGY-DI AGNOSTI C	54. 00	o	29, 012	0		5. 00
6. 00	RADI OLOGY-THERAPEUTI C	55. 00	o	1, 240, 029	0		6. 00
7. 00	CT SCAN	l l	ol Ol		0		7. 00
8. 00	MAGNETIC RESONANCE I MAGING	57. 00 58. 00	o	213, 386 25, 386	0		8.00
8.00	(MRI)	36.00	٥	23, 300	U		0.00
9. 00	CARDI AC CATHETERI ZATI ON	59. 00	0	111, 722	0		9. 00
10. 00	LABORATORY	60.00	o	25, 972	0		10.00
11. 00	I NTRAVENOUS THERAPY	64. 00	o	86, 629	0		11. 00
12. 00	RESPIRATORY THERAPY	65. 00	o	592, 256	0		12. 00
13. 00	PHYSI CAL THERAPY	66. 00	0	219	0		13. 00
14. 00	ELECTROENCEPHALOGRAPHY	70. 00	0	93	0		14. 00
15. 00	ENDOSCOPY	76.00	o	999, 528	0		15. 00
16. 00	I MAGI NG CENTER	76. 06	0	67, 275	0		16. 00
17. 00	BREAST DIAGNOSTIC CENTER	76. 07	0	23	0		17. 00
18. 00	EMERGENCY	91.00	o	105, 289	0		18. 00
10.00	TOTALS	— — <del>/1.</del> 00	— — <del>ў</del>	18, 248, 540			10.00
	B - Implantable Device Reclas	:S	<u> </u>	10, 240, 340			1
1.00	OPERATING ROOM	50.00	0	14, 817, 786	0		1. 00
2. 00	RADI OLOGY-THERAPEUTI C	55.00	0	690, 178	0		2. 00
3. 00	ENDOSCOPY	76. 00	0	124, 290	o		3. 00
3.00	TOTALS		— — <del>ў</del>	15, 632, 254	— —  —		3.00
	C - Drugs Charges to Pat		<u> </u>	10, 002, 201			1
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	429	0		1.00
2. 00	PHARMACY	15. 00	0	12, 232, 561	0		2. 00
3. 00	SOCI AL SERVI CE	17. 00	Ö	162	0		3. 00
4. 00	ADULTS & PEDIATRICS	30.00	o	131, 682	0		4. 00
5. 00	INTENSIVE CARE UNIT	31.00	o	28, 733	0		5. 00
6. 00	NEONATAL INTENSIVE CARE UNIT	35. 00	o	8, 922	0		6. 00
7. 00	SUBPROVI DER - I PF	40. 00	o	1, 804	0		7. 00
8. 00	OPERATING ROOM	50.00	o	79, 943	0		8. 00
9. 00	RECOVERY ROOM	51.00	0	5, 555	0		9. 00
10. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	302, 866	0		10. 00
11. 00	RADI OLOGY-THERAPEUTI C	55. 00	o	37, 027	0		11. 00
12.00	CT SCAN	57. 00	o	150, 768	0		12.00
13. 00	MAGNETIC RESONANCE I MAGING	58. 00	0	124, 173	0		13. 00
13.00	(MRI)	36.00	٥	124, 173	o <sub>l</sub>		13.00
14. 00	INTRAVENOUS THERAPY	64. 00	o	292	0		14. 00
15. 00	RESPIRATORY THERAPY	65. 00	o	12, 405	0		15. 00
16. 00	PHYSI CAL THERAPY	66.00	0	3, 087	0		16. 00
17. 00	ELECTROCARDI OLOGY	69. 00	o	453	0		17. 00
18. 00	ELECTROENCEPHALOGRAPHY	70.00	0	1, 657	0		18. 00
19. 00	ENDOSCOPY	76. 00 76. 00	o	8, 157	0		19. 00
20. 00	I MAGI NG CENTER	76. 06 76. 06	o	149, 161	0		20. 00
21. 00	BREAST DIAGNOSTIC CENTER	76. 07	0	2, 840			21. 00
22. 00	EMERGENCY	91.00	0	25, 385	0		22. 00
22.00	TOTALS	<u> </u>		2 <u>5, 3</u> 65 13, 308, 062	— — <sup>Ч</sup>		22.00
	D - Depreciation Expense		U	13, 300, 002			1
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3, 975	9		1. 00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	0	3, 975 7, 520, 812	9		2. 00
3. 00	OPERATION OF PLANT	7. 00	0	7, 520, 612 57, 616	0		3. 00
4. 00	HOUSEKEEPI NG	9. 00	o	6, 922	0		4. 00
5. 00	NURSING ADMINISTRATION	13. 00	o	2, 819	0		5. 00
6. 00	CENTRAL SERVICES & SUPPLY	14. 00	o	80, 880	0		6. 00
7. 00	PHARMACY	15. 00	0		0		7. 00
8. 00	SUBPROVI DER - I PF	40.00	o	87, 816	0		8.00
	INTENSIVE CARE UNIT	31. 00	o	1, 425, 090	0		1
9. 00 10. 00	NEONATAL INTENSIVE CARE UNIT	35.00	0	341, 244 141, 781	0		9. 00 10. 00
11. 00	SUBPROVIDER - IPF	40. 00	ol Ol		0		11.00
12. 00	OPERATING ROOM	50.00	0	15, 000 826, 675	0		1
	•		0	826, 675 10, 604	0		12.00
13.00	RECOVERY ROOM	51. 00 54. 00	0	10, 604	0		13.00
14.00	RADI OLOGY THERADELITIC	54. 00 55. 00		404, 166 527, 912	0		14.00
15.00	RADI OLOGY-THERAPEUTI C CT SCAN	55. 00 57. 00	0	537, 812	0		15. 00 16. 00
16.00	l	l l	0	252, 451 109, 210	0		1
17. 00	MAGNETIC RESONANCE IMAGING	58. 00	o	108, 210	U		17. 00
18. 00	(MRI) LABORATORY	60.00	o	0 751	0		18. 00
18.00	INTRAVENOUS THERAPY	64.00	0	8, 751 1, 904	0		19.00
20. 00	RESPIRATORY THERAPY	65.00	0	201, 946	- 1		20.00
21. 00	PHYSICAL THERAPY	66.00	0	201, 946 111, 898			21.00
	PHIOTONE MENALL	00.00	니 니	111,070	u U		1 21.00

Heal th	Financial Systems	COMM	UNITY HOSPITAL	OF INDIANA, INC.		In Lieu of Form CMS	S-2552-10
RECLAS	SIFICATIONS			Provider CCN		Period: Worksheet A	-6
						From 01/01/2017 Fo 12/31/2017 Date/Time Pi	repared:
						5/30/2018 1	1: 42 am
	Cost Center	Decreases Li ne #	Sal ary	Other Wk	st. A-7 Ref.	I	
	6. 00	7.00	8.00	9. 00	10. 00		
22. 00	ELECTROCARDI OLOGY	69.00	0	9, 852	0		22. 00
23. 00	ELECTROENCEPHALOGRAPHY	70. 00	0	86, 889	0	l .	23. 00
24. 00	ENDOSCOPY	76.00	0	300, 951	0		24. 00
25. 00 26. 00	I MAGING CENTER	76.06	0	311, 690 39, 083	0		25. 00
26. 00 27. 00	BREAST DIAGNOSTIC CENTER EMERGENCY	76. 07 91. 00	0	39, 083 111, 264	0		26. 00 27. 00
28. 00	PAVI LLI ONS	194. 06	Ö	17, 808	o	l control of the cont	28. 00
20.00	TOTALS			13, 025, 909	- —  —		20.00
	E - Interest Expense	•	,				
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0_	<u>8, 012, 6</u> 18	11		1. 00
	TOTALS		0	8, 012, 618			
1 00	F - Other Capital Rental	4 00	ما	02.000	1.4		1 00
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00	0	83, 808 194, 932	14 0	l e	1. 00 2. 00
3.00	LAUNDRY & LINEN SERVICE	8. 00	o	80	0	l e e e e e e e e e e e e e e e e e e e	3. 00
4. 00	HOUSEKEEPI NG	9.00	o	969	o	l e e e e e e e e e e e e e e e e e e e	4. 00
5. 00	DI ETARY	10.00	Ö	1, 299	O	1	5. 00
6.00	NURSING ADMINISTRATION	13.00	0	2, 475	o		6. 00
7.00	CENTRAL SERVICES & SUPPLY	14. 00	0	1, 430, 508	0		7. 00
8.00	PHARMACY	15. 00	0	482, 383	0	l .	8. 00
9. 00	MEDICAL RECORDS & LIBRARY	16. 00	0	140	0	l .	9. 00
10.00	SOCIAL SERVICE	17. 00	0	96	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	7, 340	0	l .	11.00
12.00	INTENSIVE CARE UNIT	31. 00 35. 00	0	621	0	l e e e e e e e e e e e e e e e e e e e	12.00
13. 00 14. 00	NEONATAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	40.00	0	1, 393 388	0	l e	13. 00 14. 00
15. 00	OPERATING ROOM	50.00	o	831, 584	0	l e e e e e e e e e e e e e e e e e e e	15. 00
16. 00	RECOVERY ROOM	51.00	o	273	o	l I	16. 00
17. 00	RADI OLOGY-DI AGNOSTI C	54.00	Ö	1, 420	O	l I	17. 00
18.00	RADI OLOGY-THERAPEUTI C	55.00	0	670	o		18. 00
19.00	MAGNETIC RESONANCE IMAGING	58. 00	0	37, 540	0		19. 00
	(MRI)		_		_		
20.00	LABORATORY	60.00	0	30, 303	0	l .	20.00
21. 00	I NTRAVENOUS THERAPY	64.00	0	160	0		21. 00
22. 00 23. 00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65. 00 66. 00	0	29, 693 639, 536	0	l e e e e e e e e e e e e e e e e e e e	22. 00 23. 00
24. 00	ELECTROENCEPHALOGRAPHY	70.00	0	133, 797	0		24. 00
25. 00	ENDOSCOPY	76.00	Ö	24, 392	0		25. 00
26. 00	I MAGI NG CENTER	76.06	o	376, 461	o	l .	26. 00
27. 00	BREAST DIAGNOSTIC CENTER	76. 07	O	91, 965	0		27. 00
28.00	SPINE CENTER	90. 26	0	479	o		28. 00
29. 00	OTHER NRCC	194. 08	0_	<u>62, 5</u> 67	0		29. 00
	TOTALS		0	4, 467, 272			
1 00	G - STD BENEFITS	E 00	24 224	0	0		1 00
1. 00 2. 00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5. 00 7. 00	26, 336 12, 993	0	0	l l	1. 00 2. 00
3.00	HOUSEKEEPI NG	9. 00	35, 597	o	o		3. 00
4. 00	DI ETARY	10.00	6, 213	0	o		4. 00
5. 00	NURSING ADMINISTRATION	13. 00	12, 031	O	Ö	l	5. 00
6.00	PHARMACY	15. 00	24, 351	0	o		6. 00
7.00	MEDICAL RECORDS & LIBRARY	16. 00	303	0	0	l e e e e e e e e e e e e e e e e e e e	7. 00
8.00	SOCI AL SERVI CE	17. 00	9, 840	0	0	l .	8. 00
9.00	ADULTS & PEDIATRICS	30.00	121, 732	0	0	l .	9. 00
10.00	INTENSIVE CARE UNIT	31.00	5, 420	0	0	l .	10.00
11.00	NEONATAL INTENSIVE CARE UNIT	35.00	62, 889	0	0	l e	11.00
12. 00 13. 00	SUBPROVIDER - IPF OPERATING ROOM	40. 00 50. 00	2, 162 56, 188	0	0	l e e e e e e e e e e e e e e e e e e e	12. 00 13. 00
14. 00	RECOVERY ROOM	51.00	8, 326	o	0	l .	14. 00
15. 00	RADI OLOGY-DI AGNOSTI C	54.00	7, 135	0	Ö	l e e e e e e e e e e e e e e e e e e e	15. 00
16. 00	RADI OLOGY-THERAPEUTI C	55. 00	907	Ö	o	l .	16. 00
17. 00	CT SCAN	57.00	738	0	0		17. 00
18.00	LABORATORY	60.00	2, 851	0	o		18. 00
19.00	RESPI RATORY THERAPY	65.00	12, 280	0	0		19. 00
20. 00	PHYSI CAL THERAPY	66. 00	31, 310	0	0	l e	20. 00
21.00	ELECTROENCEPHALOGRAPHY	70.00	3, 031	0	0	l e	21. 00
22. 00	ENDOSCOPY	76.00	6, 086	0	0	l I	22. 00
23. 00	I MAGING CENTER EMERGENCY	76. 06 91. 00	8, 354	0	0	l e e e e e e e e e e e e e e e e e e e	23. 00
24. 00 25. 00	OTHER NRCC	91.00 194.08	49, 574 2, 304	0	0		24. 00 25. 00
20.00	TOTALS	174.08	508, 951		4		25.00
	H - Labor and Delivery		333, 701	<u>S</u>			
1.00	ADULTS & PEDIATRICS	30.00	6, 113, 806	3, 024, 250	0		1. 00
2.00		0.00	0_	0	0		2. 00
	TOTALS		6, 113, 806	3, 024, 250			

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/30/2018 11:42 am Provider CCN: 15-0169

						37 307 2010 11.	42 aiii
		Decreases			_		
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	I - Cafeteria						
1.00	DI ETARY	10.00	1, 623, 631	747, 265	0		1.00
	TOTALS		1, 623, 631	747, 265	i		
	J - Therapy						
1.00	PHYSI CAL THERAPY	66.00	1, 283, 710	519, 419	0		1.00
2.00		0.00	o	C	o		2.00
	TOTALS		1, 283, 710	519, 419			
	K - BUILDING DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8, 171, 640	9		1.00
	TOTALS		0	8, 171, 640			
	L - Capital Insurance Costs						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	395, 035	12		1.00
	TOTALS			395, 035	i		
	M - Radi ol ogy Support						
1.00	RADI OLOGY-DI AGNOSTI C	54.00	323, 735	117, 162	2 0		1.00
2.00		0.00	O	C	o		2.00
3.00		0.00	O	C	o		3.00
	TOTALS		323, 735	117, 162			
500.00	Grand Total: Decreases		9, 853, 833	85, 669, 426			500.00

| In Lieu of Form CMS-2552-10 | Period: Worksheet A-7 | From 01/01/2017 Part I | Date/Time Prepared: 5/30/2018 11: 42 am Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS COMMUNITY HOSPITAL OF INDIANA, INC. Provider CCN: 15-0169

						5/30/2018 11:4	12 am
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1. 00	2.00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	T BALANCES					
1.00	Land	2, 705, 851	0	0	0	0	1.00
2.00	Land Improvements	3, 158, 137	6, 500	0	6, 500		2.00
3.00	Buildings and Fixtures	288, 452, 547		0	25, 015, 672	0	3.00
4.00	Building Improvements	4, 615, 414	-2, 863, 790	0	-2, 863, 790	0	4.00
5.00	Fixed Equipment	3, 118, 039	-3, 118, 039	0	-3, 118, 039	0	5.00
6.00	Movable Equipment	96, 215, 374	11, 930, 740	0	11, 930, 740	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	398, 265, 362	30, 971, 083	0	30, 971, 083	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	398, 265, 362	30, 971, 083	0	30, 971, 083	0	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	2, 705, 851	0				1.00
2.00	Land Improvements	3, 164, 637	0				2.00
3.00	Buildings and Fixtures	313, 468, 219	0				3.00
4.00	Building Improvements	1, 751, 624	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	108, 146, 114	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	429, 236, 445	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	429, 236, 445	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS	PLOVIDEL CCN. 13-0109	Perrou.	WOLKSHEEL A-7
		From 01/01/2017	Part II
		To 12/31/2017	Date/Time Prepared:
			5/30/2018 11 42 am

			]	To 12/31/2017	Date/Time Pre 5/30/2018 11:	
		Sl	JMMARY OF CAPI	ΓAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see	•	
	9. 00	10. 00	11. 00	instructions) 12.00	instructions) 13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00 CAP REL COSTS-BLDG & FLXT	0	0	(	0	0	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	(	0	0	2. 00
3.00 Total (sum of lines 1-2)	0	0	(	0	0	3. 00
	SUMMARY O	F CAPITAL				
Cost Center Description	Other	Total (1) (sum				
	Capi tal -Relate	of cols. 9				
	d Costs (see	through 14)				
	instructions)					
	14. 00	15. 00				
PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00 CAP REL COSTS-BLDG & FLXT	0	0				1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
3.00  Total (sum of lines 1-2)	0	0				3. 00

Health Financial Systems	COMMUNITY HOSPITAL OF	I NDI ANA,	I NC.		In Lieu	u of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN:	15-0169	From 01/01/2017	Worksheet A-7 Part III Date/Time Prepared:

MECONCILIATION OF CAPITAL COSTS CENTERS		Frovider C	F	rom 01/01/2017 o 12/31/2017	Date/Time Prep 5/30/2018 11:4	
	COME	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	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 CE			I			
1.00 CAP REL COSTS-BLDG & FLXT	321, 090, 331	0	321, 090, 331		0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	108, 146, 114		108, 146, 114			2. 00
3.00 Total (sum of lines 1-2)	429, 236, 445	TION OF OTHER (	429, 236, 445	1.000000 SUMMARY 0		3. 00
	ALLUCA	ITON OF OTHER C	DAFITAL	JUIVIIVIAK I U	CAFITAL	
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
		d Costs	through 7)	2.22	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	6. 00	7. 00	8. 00	9. 00	10. 00	
1.00 CAP REL COSTS-BLDG & FLXT	INIERS	0		8, 171, 640	0	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	0	10, 227, 224	0	2. 00
3.00 Total (sum of lines 1-2)	0	0	0	18, 398, 864	0	3. 00
		Sl	JMMARY OF CAPIT			
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see instructions)	through 14)	
	11. 00	12.00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		12.00	10.00	11.00	10.00	
1.00 CAP REL COSTS-BLDG & FLXT	4, 944, 841	395, 035	0	0	13, 511, 516	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	0	4, 378, 704	14, 605, 928	2. 00
3.00 Total (sum of lines 1-2)	4, 944, 841	395, 035	0	4, 378, 704	28, 117, 444	3. 00

| Period: | Worksheet A-8 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES COMMUNITY HOSPITAL OF INDIANA, INC.

Provider CCN: 15-0169

					To 12/31/2017	Date/Time Prep 5/30/2018 11:4	
				Expense Classification or		3/30/2016 11.2	+2
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00	5. 00 0	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAD DEL COSTS MADLE FOLLID	2. 00	0	2. 00
2.00	COSTS-MVBLE EQUIP (chapter 2)		U	CAP REL COSTS-MVBLE EQUIP	2.00		
3.00	Investment income - other (chapter 2)		0		0.00	0	3. 00
4.00	Trade, quantity, and time	В	0	ADMINISTRATIVE & GENERAL	5. 00	О	4. 00
5.00	discounts (chapter 8) Refunds and rebates of	В	-19, 377	ADMINISTRATIVE & GENERAL	5.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
	suppliers (chapter 8)		0				
7. 00	Tel ephone servi ces (pay stations excluded) (chapter		0		0.00	0	7. 00
0.00	21)				0.00		0.00
8. 00	Television and radio service (chapter 21)		Ü		0.00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -185, 414		0.00	0	9. 00 10. 00
	adj ustment	A-0-2					
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization	A-8-1	-3, 448, 681			0	12. 00
13. 00	transactions (chapter 10) Laundry and Linen service		0		0.00	0	13. 00
14.00	Cafeteria-employees and guests		0		0. 00 0. 00	0	14. 00 15. 00
15. 00	Rental of quarters to employee and others		0				
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
47.00	pati ents				0.00		47.00
17. 00	Sale of drugs to other than patients		0		0.00	0	17. 00
18. 00	Sale of medical records and abstracts		0		0.00	0	18. 00
19. 00	Nursing and allied health		0		0.00	0	19. 00
	education (tuition, fees, books, etc.)						
20.00	Vending machines		0		0.00	0	20. 00 21. 00
21. 00	Income from imposition of interest, finance or penalty		U		0.00	U	21.00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
22.00	overpayments and borrowings to		0		0.00	S	22.00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0	UTILIZATION REVIEW - SNF	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00	•	29. 00 30. 00
30.00	therapy costs in excess of	A-0-3	0	DOGGI ATTOMAL THERAFT	67.00		30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)	1 402					
31. 00	Adjustment for speech pathology costs in excess of	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
	Depreciation and Interest		_				
33.00	Mi sc Revenue	В	-90	PHYSI CAL THERAPY	66.00	o <sub>l</sub>	33. 00

50.00

ADJUSTMENTS TO EXPENSES Provider CCN: 15-0169 Peri od: Worksheet A-8 From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/30/2018 11:42 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 33.01 Misc Revenue -146, 387 EMPLOYEE BENEFITS DEPARTMENT 33. 01 В 4.00 -478, 533 ADMI NI STRATI VE & GENERAL 33.02 Mi sc Revenue В 5.00 0 33.02 33. 03 Misc Revenue В -37, 025 OPERATION OF PLANT 7.00 0 33.03 33.04 Misc Revenue В -9, 248 DI ETARY 10.00 33.04 -26, 250 PHARMACY 33 05 Misc Revenue 15 00 ol 33 05 В -1, 562 ADULTS & PEDIATRICS 33.06 Mi sc Revenue В 30.00 0 33.06 33. 07 Misc Revenue В -2, 635 NEONATAL INTENSIVE CARE UNIT 35.00 33.07 33.08 Misc Revenue В -89. 488RADI OLOGY-DI AGNOSTI C 54.00 ol 33.08 -1, 300, 582 LABORATORY Misc Revenue 33.09 В 60.00 33.09 34.00 HAF Tax Offset Α -20, 721, 282 ADMI NI STRATI VE & GENERAL 5.00 34.00 -2, 996 OPERATION OF PLANT 34.01 Loss on Assets Α 7.00 11 34.01 -100,663 CAP REL COSTS-BLDG & FIXT LOC Non-Allow Interest Expense 34 02 34 02 1 00 11 Α 34.03 12A Non-Allow Interest Expense Α -2, 013, 083 CAP REL COSTS-BLDG & FIXT 1.00 11 34.03 12B Non-Allow Interest Expense -154, 109 CAP REL COSTS-BLDG & FIXT 1.00 11 34.04 34.04 Α -167, 854 CAP REL COSTS-BLDG & FIXT 50M BMO Non-Allow Interest 11 34.05 34.05 Α 1.00 Expense 34.06 16AB Non-Allow Interest Α -632,068 CAP REL COSTS-BLDG & FIXT 1.00 11 34.06 Expense 34.07 Allow Debt Issuance Expense Α 64, 768 ADMI NI STRATI VE & GENERAL 5.00 0 34.07 Meals of Wheels Cost -67, 721 CAFETERI A 36.00 11.00 0 36.00 Α -60, 550 ADMI NI STRATI VE & GENERAL 36 01 Sponsorshi p 5.00 ol 36 01 Α -284, 301 NEONATAL INTENSIVE CARE UNIT 36.02 Nurse Practitioner Offset Α 35.00 0 36.02 36. 03 Nurse Practitioner Offset -25, 838 ELECTROENCEPHALOGRAPHY 70.00 36.03 36.04 CARDIAC CATH SHARED SERVICES 480, 472 CARDI AC CATHETERI ZATI ON 59.00 36.04

-29, 430, 497

Α

TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A, column 6, line 200.)

50.00

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.

<sup>(2)</sup> Basis for adjustment (see instructions)

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

B. Amount Received - if cost cannot be determined.

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

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

Provider CCN: 15-0169

Worksheet A-8-1

Peri od: From 01/01/2017 OFFICE COSTS 12/31/2017 Date/Time Prepared: 5/30/2018 11:42 am

					3/30/2016 11.	42 alli
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAIMED	
	HOME OFFICE COSTS:					
1.00	•	I&R SERVICES-SALARY & FRINGE		367, 313	0	1. 00
2.00	22. 00	I&R SERVICES-OTHER PRGM COST	INTERNS & RESIDENTS	664, 574	0	2. 00
3.00	5. 00	ADMINISTRATIVE & GENERAL	7250 CLEARVI STA	231, 440	192, 934	3.00
3.01	70.00	ELECTROENCEPHALOGRAPHY	7250 CLEARVI STA	118, 623	96, 906	3. 01
4.00	2. 00	CAP REL COSTS-MVBLE EQUIP	CHNW - HOME OFFICE	5, 372, 955	0	4.00
4.01	4. 00	EMPLOYEE BENEFITS DEPARTMENT	CHNW - HOME OFFICE	3, 890, 907	0	4. 01
4.02	5. 00	ADMINISTRATIVE & GENERAL	CHNW - HOME OFFICE	47, 931, 428	71, 696, 500	4. 02
4.03	7. 00	OPERATION OF PLANT	CHNW - HOME OFFICE	915, 496	0	4. 03
4.04	13. 00	NURSING ADMINISTRATION	CHNW - HOME OFFICE	3, 757, 448	0	4. 04
4.05	14. 00	CENTRAL SERVICES & SUPPLY	CHNW - HOME OFFICE	1, 625, 824	0	4. 05
4.06	16. 00	MEDICAL RECORDS & LIBRARY	CHNW - HOME OFFICE	2, 428, 296	0	4. 06
4.07	30.00	ADULTS & PEDIATRICS	CHNW - HOME OFFICE	873, 689	0	4. 07
4.08	54. 00	RADI OLOGY-DI AGNOSTI C	CHNW - HOME OFFICE	107, 424	0	4. 08
4.09	69.00	ELECTROCARDI OLOGY	CHNW - HOME OFFICE	49, 586	661, 415	4. 09
4. 10	70.00	ELECTROENCEPHALOGRAPHY	CHNW - HOME OFFICE	319, 538	0	4. 10
4. 11	73.00	DRUGS CHARGED TO PATIENTS	CHNW - HOME OFFICE	544, 533	0	4. 11
5.00	TOTALS (sum of lines 1-4).			69, 199, 074	72, 647, 755	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	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

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

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

						10 12/31/2017	5/30/2018 11:	
	Net	Wkst. A-7 Ref.		<u> </u>				
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6. 00	7. 00						
			MENTS REQUIRED AS A RESUL	OF TRANSACTIO	NS WITH RELATED (	ORGANIZATIONS OR	CLAI MED	
	HOME OFFICE CO							
1.00	367, 313							1. 00
2.00	664, 574							2. 00
3.00	38, 506							3. 00
3. 01	21, 717							3. 01
4.00	5, 372, 955							4. 00
4.01	3, 890, 907							4. 01
4.02	-23, 765, 072							4. 02
4.03	915, 496	0						4. 03
4.04	3, 757, 448	0						4. 04
4.05	1, 625, 824	0						4. 05
4.06	2, 428, 296	0						4. 06
4.07	873, 689	0						4. 07
4.08	107, 424	0						4. 08
4.09	-611, 829	0						4. 09
4.10	319, 538	0						4. 10
4.11	544, 533	0						4. 11
5.00	-3, 448, 681							5. 00

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

 	cordinate i dilaret 27 the dimedite difference of out a be find out out in the partition	
Related Organization(s)		
and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00		6.00
7.00		7.00
8. 00		8.00
9. 00		9.00
10. 00		10.00
6. 00 7. 00 8. 00 9. 00 10. 00 100. 00	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
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0169 

						12/31/201/	5/30/2018 11:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	12 (3
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2.00	3.00	4. 00	5. 00	6. 00	7. 00	
1. 00	5. 00	AGGREGATE-ADMINISTRATIVE &	258, 066	139, 265	118, 801	211, 500	744	1. 00
		GENERAL						
2.00		AGGREGATE-ADULTS &	3, 000	3, 000	0	0	0	2. 00
		PEDI ATRI CS						
3. 00	0. 00		0	0	0	0	0	3. 00
4.00	0. 00		0	0	0	0	l ~	4. 00
5. 00	0. 00		0	0	0	0	0	5. 00
6. 00	0. 00		0	0	0	0	0	6. 00
7. 00	0. 00		0	0	0	0	0	7. 00
8. 00	0. 00		0	0	0	0	0	8. 00
9. 00	0. 00		0	0	0	0	0	9. 00
10. 00	0. 00		0	0	0	0	0	10.00
200.00			261, 066		118, 801		744	200. 00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00		AGGREGATE-ADMINISTRATIVE &	75, 652	3, 783	0	0	0	1. 00
		GENERAL	_	_	_	_	_	
2. 00		AGGREGATE-ADULTS &	0	0	0	0	0	2. 00
2 00		PEDI ATRI CS			0	0		2 00
3.00	0. 00 0. 00		0	0	0	0	0	3. 00
4.00					0	0		
5.00	0.00		0	0	_	0	0	5. 00
6.00	0. 00		0	0	0	0	0	6. 00
7.00	0.00		0	0	0	0	0	
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		0 1 0 1 (5)	75, 652		0	0	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldenti 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		AGGREGATE-ADMI NI STRATI VE &	13.00		43, 149	182, 414		1. 00
1.00		GENERAL	١	73,032	45, 147	102, 414		1.00
2.00		AGGREGATE-ADULTS &	0	0	0	3,000		2. 00
2.00		PEDI ATRI CS	Ĭ	Ĭ	Ö	0,000		2.00
3.00	0. 00		1	0	0	0		3. 00
4. 00	0. 00		1	0	0	i n		4. 00
5. 00	0.00			0	0	0		5. 00
6.00	0.00			0	0	0		6. 00
7.00	0.00				0	0		7. 00
8. 00	0.00			0	0	0		8. 00
9. 00	0.00				0	0		9. 00
9. 00 10. 00	0.00			0	0	)   0		9. 00 10. 00
200.00	0.00			_	_	Į		200. 00
200.00		I	ı	10,002	43, 149	100,414	I	200.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

| Period: | Worksheet B | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0169

					o 12/31/2017		
			CAPI TAL REI	ATED COSTS		5/30/2018 11:	42 am
	Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7)	1. 00	2.00	4. 00	4A	
	GENERAL SERVICE COST CENTERS	Ü	1.00	2.00	1. 00		
	00100 CAP REL COSTS-BLDG & FLXT	13, 511, 516	13, 511, 516				1. 00
	00200 CAP REL COSTS-MVBLE EQUIP	14, 605, 928	27 722	14, 605, 928			2.00
4	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	4, 086, 052 57, 252, 742	27, 732 408, 636			63, 824, 768	4. 00 5. 00
	00700 OPERATION OF PLANT	10, 205, 466	1, 924, 367			12, 266, 708	7. 00
	00800 LAUNDRY & LINEN SERVICE	742, 186	47, 937			790, 203	8. 00
	00900 HOUSEKEEPI NG	4, 533, 907	109, 012			4, 777, 720	9.00
	01000 DI ETARY 01100 CAFETERI A	931, 216 2, 303, 175	122, 389 324, 022			1, 094, 025 2, 732, 595	10. 00 11. 00
1	01300 NURSING ADMINISTRATION	5, 945, 624	19, 007			6, 047, 019	13. 00
	01400 CENTRAL SERVICES & SUPPLY	1, 040, 202	308, 469			2, 853, 962	14. 00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	4, 363, 158 2, 831, 177	149, 782 18, 768			5, 272, 247 2, 865, 279	15. 00 16. 00
	01700 SOCIAL SERVICE	1, 756, 760	21, 443			1, 839, 646	17. 00
4	01900 NONPHYSICIAN ANESTHETISTS	0	0	(		0	19. 00
1	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	367, 313	0	(		367, 313	21.00
	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD INPATIENT ROUTINE SERVICE COST CENTERS	664, 574	0		)  0	664, 574	22. 00
	03000 ADULTS & PEDIATRICS	35, 483, 037	4, 044, 757	657, 172	1, 077, 018	41, 261, 984	30.00
31. 00	03100 INTENSIVE CARE UNIT	5, 289, 786	891, 485			6, 540, 600	31. 00
	02060 NEONATAL INTENSIVE CARE UNIT	7, 974, 913	780, 756			9, 166, 865	35. 00
	04000  SUBPROVI DER - I PF 04300  NURSERY	499, 607 2, 622, 381	145, 929 399, 233			726, 873 3, 149, 765	40. 00 43. 00
-	ANCI LLARY SERVI CE COST CENTERS	2,022,301	377, 233	40, 320	77,023	3, 147, 703	43.00
50. 00	05000 OPERATING ROOM	8, 434, 889	615, 600			10, 896, 012	50. 00
	05100 RECOVERY ROOM	3, 145, 629	339, 675			3, 586, 795	51.00
	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	7, 110, 638 4, 477, 742	991, 952 203, 490			8, 447, 078 5, 198, 610	52. 00 54. 00
	05500 RADI OLOGY-THERAPEUTI C	771, 650	206, 504			1, 368, 108	55. 00
	05700 CT SCAN	1, 229, 123	27, 213			1, 562, 339	57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 787, 424	114, 523	1		2, 051, 542	58. 00
	05900 CARDIAC CATHETERIZATION 06000 LABORATORY	369, 067 8, 753, 363	118, 576	38, 896	_	369, 067 8, 920, 246	59. 00 60. 00
1	06400 I NTRAVENOUS THERAPY	377, 224	156, 730			548, 953	64. 00
	06500 RESPI RATORY THERAPY	3, 313, 011	128, 279			3, 789, 932	65. 00
	06600 PHYSI CAL THERAPY	5, 137, 337	0	721, 585		6, 041, 344	66.00
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	1, 484, 968 318, 161	0	22, 087 4, 732		1, 555, 034 333, 173	67. 00 68. 00
4	06900 ELECTROCARDI OLOGY	99, 019	0	9, 673		110, 320	69. 00
	07000 ELECTROENCEPHALOGRAPHY	1, 680, 116	31, 346		1	1, 971, 947	70. 00
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	18, 248, 540	0		0	18, 248, 540 15, 632, 254	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	15, 632, 254 13, 852, 595	0			13, 852, 595	
74.00	07400 RENAL DIALYSIS	950, 552	2, 376	C	28	952, 956	74. 00
	03330 ENDOSCOPY	1, 504, 669	165, 455			2, 040, 258	76. 00
	03954 IMAGING CENTER 03955 BREAST DIAGNOSTIC CENTER	2, 313, 500 4, 914, 984	0	,		3, 058, 987 5, 045, 503	76. 06 76. 07
	OUTPATIENT SERVICE COST CENTERS	4, 714, 704	U	130, 317	<u> </u>	3, 043, 303	70.07
	09000 CLI NI C	0	0	C		0	90. 00
	04975 SPI NE CENTER	267, 483	0	477		277, 229	90. 26
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	9, 175, 233	575, 329	68, 826	265, 231	10, 084, 619 0	91. 00 92. 00
	SPECIAL PURPOSE COST CENTERS						72.00
113.00	11300 I NTEREST EXPENSE						113. 00
	11400 UTI LI ZATI ON REVI EW - SNF	000 050 004	40 400 770	44 540 746	4 470 0/0	000 405 507	114.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREI MBURSABLE COST CENTERS	292, 359, 891	13, 420, 772	14, 543, 613	4, 179, 968	292, 185, 587	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	78, 285		o	78, 285	190. 00
191. 00	19100 RESEARCH	0	0	C	o	0	191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	127, 890	0	(	0	127, 890	
4	19300 NONPALD WORKERS 07950 HOME OFFICE	0	0		0		193. 00 194. 00
	07936 PAVI LLI ONS	54, 473	0			54, 473	
194. 08	07958 OTHER NRCC	1, 791, 591	12, 459	62, 315	21, 245	1, 887, 610	194. 08
	07960 COMMUNITY REHAB HOSPITAL	0	0	(	0		194. 10
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers		^				200. 00 201. 00
201.00	TOTAL (sum lines 118 through 201)	294, 333, 845	13, 511, 516	14, 605, 928	4, 201, 213	294, 333, 845	
			· · · · · · · · · · · · · · · · · · ·				

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared: | 5/30/2018 | 11: 42 am

Cost Contine Description							5/30/2018 11:	
DEBERAL SERVICE COST CRITTERS   5.00   7.00   8.00   9.00   10.00		Cost Center Description	ADMI NI STRATI VE	OPERATION OF		HOUSEKEEPI NG	DI ETARY	
CHERNAL SERVICE COST CENTERS								
1.00		SENERAL OFFICE OF SENERAL	5. 00	7. 00	8.00	9. 00	10.00	
2.00								1 00
0.000   DOUGNET SERVENT IS DEPARTMENT   6.3 824, 768   7.00   DOUGNET SERVENT IS CEREBAL   6.3 824, 768   7.00   DOUGNET SERVENT IN STREET   7.00   P. 1.00   DOUGNET SERVENT IN STREET   7.00   DOUGNET SERVENT IN STREET								
5.00   0.0000   DOSOO   ADMINISTRATIVE & CENERAL   62, 824, 768   7.00   DOTOO   DOTO   DOT								
7.00   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000		· ·	(2 024 7/0					
8.00   00800  LAURDRY & LINEN SERVICE   218, 796   67, 336   1,076, 335   1,076, 335   9,00   00900  DISTARY   302, 920   171, 1977   0   69, 620   1,638, 422   10,00   10,00   10,000								
9.00   0.0900   9.0SERCEPT NG		· · · · · · · · · · · · · · · · · · ·			1			
10.00   0.000   EFTARY								
11.00   01100  CAFTERIA   756, 617   455, 145   0   184, 317   0   11.00   13.00   13.00   01							4 (00 100	
13.00   1300   MURSI NO AMMINI STRATI ON   1, 674, 335   26, 699   0   10, 812   0   13.00								
14.00   01400   PARMACY   14.99, 811   210, 395   0   85, 202   0   15. 409   0   14. 00   16. 00   16. 00   16. 00   16. 00   16. 00   16. 00   16. 00   16. 00   16. 00   16. 00   16. 00   16. 00   17. 00   170. 0								
15.00   01500   PHARMACY   1, 499, 811   210, 305   0   85, 202   0   15.00					1			
16.00   01000   MEDICAL RECORDS & LIBRARY   793, 356   26, 362   0   10, 676   0   10   0   17.00   1700   0700								
17.00 0 1700 (MORPHYSICIAN AMESTHETISTS 0 0 0 0 0 12, 198 0 17.00 0 100 (MORPHYSICIAN AMESTHETISTS 0 0 0 0 0 0 0 19.00 121.00 121.00 121.00 187.5 SERVICES-SALARY 8 FRINCES APPRIVD 101, 704 0 0 0 0 0 0 22.00 121.00 187.5 SERVICE COST CENTERS 18.00 18.00 18.00 19.00 0 0 0 0 0 22.00 121.00 187.5 SERVICE COST CENTERS 18.00 18.00 19.00 19.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		l e e e e e e e e e e e e e e e e e e e			1			
19.00					1			
21.00   02100  IAR SERVICES-SALARY & FRINCES APPRVD   101, 704   0   0   0   0   22.00   02200  IAR SERVICES OTTER PROKU OSTS APPRVD   104, 0111   0   0   0   0   0   0   22.00   02200  IAR SERVICES OTTER PROKU OSTS APPRVD   104, 0111   0   0   0   0   0   0   0   0		l e e e e e e e e e e e e e e e e e e e	509, 372	30, 120	0	12, 198		
22.00		l e e e e e e e e e e e e e e e e e e e	0	C	0	0	0	19. 00
INPATI ENT ROUTINE SERVICE COST CENTERS   11, 424, 897   5, 681, 555   526, 846   2, 300, 820   1, 083, 725   30, 00   30, 00   30100   ADULTS & PEDIDITRIC S   11, 424, 897   1, 252, 244   43, 753   507, 112   109, 688   31, 00   31, 00   300, 00   AURTS & PEDIDITRIC S   2, 838, 177   1, 096, 706   36, 020   444, 125   228, 765   35, 00   00   400, 00   AURIS & PEDIDITRIC S   2, 838, 177   1, 096, 706   36, 020   444, 125   228, 765   35, 00   00   400, 00   AURIS & PEDIDITRIC S   2, 838, 177   1, 096, 709, 709   18, 570   38, 010   67, 738   40, 00   400, 00   AURIS & PEDIDITRIC S   43, 00   400, 00   AURIS & PEDIDITRIC S   44, 00   44, 522   270, 091   148, 566   43, 00   430, 00   4				C	0	0		
30.00   30000   ADULTS & PEDIATRICS   11,424,897   5,681,955   526,846   2,300,820   1,083,725   30.0   31.0   30300   INTENSIVE CARE UNIT   2,538,177   1,096,706   36,020   444,125   228,765   35.00   30.0   30000   INTENSIVE CARE UNIT   2,538,177   1,096,706   36,020   444,125   228,765   35.00   30.0   30000   INTENSIVE CARE UNIT   2,538,177   1,096,706   36,020   444,125   228,765   35.00   30.0   30000   INTENSIVE CARE UNIT   2,538,177   20.0   444,125   227,099   148,566   50.0   30300   INTENSIVE COST CENTERS	22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	184, 011	C	0	0	0	22. 00
31.00   03100   NATENIYE CARE UNIT   1,811,001   1,252,244   43,753   507,112   109,688   31,00   04000   NCONTATAL INTENSIYE CARE UNIT   2,538,177   1,096,706   36,020   444,125   228,765   55,00   04000   04000   NUSPERY   201,261   204,982   18,570   83,010   67,738   40,00   0300   0300   NUSPERY   872,126   560,791   34,322   227,099   148,566   43,00   0300   0300   NUSPERY   872,126   560,791   34,322   227,099   148,566   43,00   0300   0300   NUSPERY   872,126   560,791   34,322   227,099   148,566   43,00   0300   05100   PERATING ROMM   993,133   477,132   0   193,221   0   51,00   05100   RECOVERY ROOM   993,133   477,132   0   193,221   0   51,00   05100   RECOVERY ROOM   8,38,788   1,393,367   85,276   564,262   0   52,00   0500   RECOVERY ROOM   44,38,789   1,393,367   85,276   564,262   0   55,00   0500   RECOVERY ROOM   432,590   38,226   10,406   117,468   0   55,00   0500   RABIOLOGY-IARRAFUTIC   378,810   290,071   10,406   117,468   0   55,00   0500   RABIOLOGY-IARRAFUTIC   378,810   290,071   10,406   117,468   0   55,00   0500   0500   CARDIAC CATHETERI ZATION   102,1899   0   0   0   0   15,480   0   55,00   0500   0500   CARDIAC CATHETERI ZATION   102,1899   0   0   0   0   0   0   0   0   0	<u> </u>	NPATIENT ROUTINE SERVICE COST CENTERS						l
35. 00   02000 NEONATAL INTENSIVE CARE UNIT   2,538,177   1,096,706   36,020   444,125   228,765   35. 00   43. 00   04300 NURSERY   872,126   560,791   34,322   277,099   148,566   43. 00   04300 NURSERY   872,126   560,791   34,322   277,099   148,566   43. 00   04300 NURSERY   872,126   560,791   34,322   277,099   148,566   43. 00   04300 NURSERY   872,126   560,791   34,322   277,099   148,566   43. 00   04300 NURSERY   872,126   560,091   34,322   277,099   148,566   43. 00   04300 NURSERY   872,126   560,091   34,322   277,099   148,566   43. 00   04300 NURSERY   872,126	30.00	D3000 ADULTS & PEDIATRICS	11, 424, 897	5, 681, 555	526, 846	2, 300, 820	1, 083, 725	30.00
40. 00   040000 SUBPERVI DER - I PF   201, 261   204, 982   18, 570   83, 010   67, 738   40. 00   430.	31.00	03100 INTENSIVE CARE UNIT	1, 811, 001	1, 252, 244	43, 753	507, 112	109, 688	31. 00
	35.00	D2060 NEONATAL INTENSIVE CARE UNIT	2, 538, 177	1, 096, 706	36, 020	444, 125	228, 765	35. 00
ANCILLARY SERVICE COST CENTERS	40.00	04000 SUBPROVI DER - I PF	201, 261	204, 982	18, 570	83, 010	67, 738	40.00
50.00	43.00	04300 NURSERY	872, 126	560, 791	34, 322	227, 099	148, 566	43.00
51.00   05100   RECOVERY ROOM   2.938, 183   477, 132   0   193, 221   0   51.00								
52.00   05200   05200   05200   05200   05200   0550	50.00	05000 OPERATING ROOM	3, 016, 953	864, 716	37, 156	350, 178	0	50.00
54 00   05400   RADI DLOGY-DI AGNOSTIC   1,439,422   225,836   122,461   115,753   0   54.00   55.00   05500   RADI DLOGY-THERAPEUTIC   378,810   290,071   10,406   117,468   0   55.00   05500   RADI DLOGY-THERAPEUTIC   378,810   290,071   10,406   117,468   0   55.00   05900   CARDI AGNOSTIC RESONANCE I IMGI NG (IMRI )   568,043   160,867   0   65,145   0   85.00   05900   CARDI AGNOSTIC RESONANCE I IMGI NG (IMRI )   568,043   160,867   0   0   0   0   0   0   0   0   0	51.00	05100 RECOVERY ROOM	993, 133	477, 132	0	193, 221	0	51. 00
55.00   0.5500   RADIOLOGY-THERAPEUTIC   378, 810   290, 071   10, 406   117, 468   0   55.00   57.00   570   CT SCAN   432, 590   38, 226   0   15, 480   0   57.00   58.00   0.5800   MAGNETIC RESONANCE IMAGING (MRI)   568, 643   160, 867   0   65, 145   0   58.00   60.00   0.5900   CARDIA C CATHETREI ZATI ON   102, 189   0   0   0   0   0   0   0   0   0	52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 338, 878	1, 393, 367	85, 276	564, 262	0	52.00
57. 00   05700   CT SCAN	54.00	D5400 RADI OLOGY-DI AGNOSTI C	1, 439, 422	285, 836	122, 461	115, 753	0	54.00
57. 00   05700   CT SCAN						117, 468	0	55. 00
SB 00   OSBOD   MAGNETIC RESONANCE I MAGI NG (MRI)   568, 043   160, 867   0   65, 145   0   58, 00   590   0   690   0   0   0   0   0   0   0   0   0							0	57. 00
59.00   05900   CARDIAC CATHETERIZATION   102, 189   0   0   0   0   0   0   59.00		· · · · · · · · · · · · · · · · · · ·			1		0	
60.00   0.0000   LABORATORY   2, 469, 891   166, 560   0   67, 451   0   0.00						0		
64.00   06400   INTRAVENOUS THERAPY   151, 997   220, 154   0   89, 154   0   64, 00				166 560		67 451	0	
65.00   06500   RESPI RATORY THERAPY								
66.00   06600   PMSI CAL THERAPY   1,672,764   0   0   0   0   0   66.00   67.00   06700   OCCUPATI ONAL THERAPY   430,567   0   0   0   0   0   0   67.00   68.00   06800   SPECEH PATHOLOGY   92,251   0   0   0   0   0   68.00   69.00   06800   SPECEH PATHOLOGY   92,251   0   0   0   0   0   68.00   69.00   06800   SPECEH PATHOLOGY   92,251   0   0   0   0   0   68.00   69.00   06800   SPECEH PATHOLOGY   92,251   0   0   0   0   0   68.00   69.00   06800   SPECEH PATHOLOGY   92,251   0   0   0   0   0   0   69.00   71.00   07000   ELECTROCARDI OLOGY   30,546   0   0   0   0   0   0   0   71.00   07100   ELECTROCHOREPHALOGRAPHY   546,005   44,031   0   17,831   0   70.00   71.00   07100   ELECTROCHOREPHALOGRAPHY   546,005   44,031   0   17,831   0   71.00   71.00   07100   ELECTROCHOREPHALOGRAPHY   546,005   44,031   0   17,831   0   70.00   71.00   07100   ELECTROCHOREPHALOGRAPHY   546,005   44,031   0   17,831   0   70.00   71.00   07100   ELECTROCHOREPHALOGRAPHY   546,005   44,031   0   17,831   0   70.00   71.00   07100   ELECTROCHOREPHALOGRAPHY   546,005   44,031   0   17,831   0   0   0   71.00   07300   DRUGS CHARGED TO PATIENTS   3,835,590   0   0   0   0   0   0   71.00   07300   DRUGS CHARGED TO PATIENTS   3,835,590   0   0   0   0   0   0   71.00   07300   DRUGS CHARGED TO PATIENTS   3,835,590   3,337   0   1,352   0   74.00   71.00   07300   DRUGS CHARGED TO PATIENTS   3,835,590   3,337   0   1,352   0   74.00   71.00   07300   07300   07300   07500   07500   0   0   0   0   0   71.00   07300   07300   07500   07500   07500   0   0   0   0   71.00   07300   07500   07500   07500   0   0   0   0   71.00   07500   07500   07500   0   0   0   0   0   71.00   07500   07500   07500   07500   07500   0   71.00   07500   07500   07500   07500   07500   07500   0   71.00   07500   07500   07500   07500   07500   07500   0   71.00   07500   07500   07500   07500   07500   07500   0   71.00   07500   07500   07500   07500   07500   07500   07500   07500   07500   07500   07500   07500   07500   07500   075000		· · · · · · · · · · · · · · · · · · ·						
67:00   06700   06700   06700   06700   06700   068:00   069:00   07:00				100,170	م ا	, 2, , , 0		
68. 00   06800   SPEECH PATHOLOGY   92, 251   0   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   30, 546   0   0   0   0   0   0   0   70. 00   07000   ELECTROCENCEPHALOGRAPHY   546, 005   44, 031   0   17, 831   0   70. 00   71. 00   07000   DELECTROCENCEPHALOGRAPHY   546, 005   44, 031   0   17, 831   0   70. 00   71. 00   07000   ELECTROCENCEPHALOGRAPHY   546, 005   44, 031   0   17, 831   0   70. 00   71. 00   07000   ELECTROCENCEPHALOGRAPHY   546, 005   44, 031   0   17, 831   0   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   4, 328, 352   0   0   0   0   0   0   71. 00   72. 00   07200   IMPL. DE DEV. CHARGED TO PATIENTS   3, 835, 590   0   0   0   0   0   0   0   74. 00   07300   DRUGS CHARGED TO PATIENTS   3, 835, 590   0   0   0   0   0   0   0   76. 00   03330   ENDOSCOPY   564, 919   232, 410   24, 857   94, 117   0   76. 00   76. 00   03330   ENDOSCOPY   564, 919   232, 410   24, 857   94, 117   0   76. 00   76. 07   03955   BREAST DI AGNOSTI C CENTER   846, 991   0   0   0   0   0   0   0   76. 07   03955   BREAST DI AGNOSTI C CENTER   1, 397, 029   0   0   0   0   0   0   0   70. 00   09000   CLI NI C   0   0   0   0   0   0   0   0   70. 00   09000   CLI NI C   0   0   0   0   0   0   0   70. 00   09000   CLI NI C   0   0   0   0   0   0   0   70. 00   09000   CLI NI C   0   0   0   0   0   0   0   70. 00   09000   09000   09000   09000   09000   70. 00   09000   09000   09000   09000   09000   70. 00   09000   09000   09000   09000   09000   70. 00   09000   09000   09000   09000   09000   70. 00   09000   09000   09000   09000   09000   70. 00   09000   09000   09000   09000   09000   70. 00   09000   09000   09000   09000   09000   09000   70. 00   09000   09000   09000   09000   09000   09000   70. 00   09000   09000   09000   09000   09000   09000   70. 00   09000   09000   09000   09000   09000   09000   70. 00   09000   09000   09000   09000   09000   09000   09000   09000   70. 00   09000   09000   09000   09000   09000   09000   09000   09000   70. 00		l e e e e e e e e e e e e e e e e e e e				0		
69.00   06900   ELECTROCARDI OLOGY   30, 546   0   0   0   0   0   69, 00						0		
70.00   07000   ELECTROENCEPHALOGRAPHY   546,005   44,031   0   17,831   0   70.00   70.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   5,052,765   0   0   0   0   0   71.00   72.00   72.00   72.00   MPL. DEV. CHARGED TO PATIENTS   4,328,352   0   0   0   0   0   72.00   73.00   7300   DRUGS CHARGED TO PATIENTS   3,835,590   0   0   0   0   0   73.00   74.00						0		
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   5, 052, 765   0   0   0   0   0   71. 00   72. 00   72. 00   72. 00   72. 00   73. 00   07300   MPL. DEV. CHARGED TO PATIENTS   4, 328, 352   0   0   0   0   0   72. 00   73. 00   73. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   3, 835, 590   0   0   0   0   0   0   73. 00   74. 00		l e e e e e e e e e e e e e e e e e e e		14 031	΄Ι ΄΄	17 831		
72. 00   07200   MPL. DEV. CHARGED TO PATIENTS   4, 328, 352   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   3, 835, 590   0   0   0   0   73. 00   74. 00   07400   RENAL DI ALYSIS   263, 860   3, 337   0   1, 352   0   74. 00   76. 00   03330   ENDOSCOPY   564, 919   232, 410   24, 857   94, 117   0   76. 00   76. 07   03955   BREAST DI AGNOSTIC CENTER   846, 991   0   0   0   0   0   0   76. 07   03955   BREAST DI AGNOSTIC CENTER   1, 397, 029   0   0   0   0   0   0   76. 07   03955   BREAST DI AGNOSTIC CENTER   1, 397, 029   0   0   0   0   0   0   76. 07   04   05   05   05   05   76. 07   04   05   05   05   05   76. 07   05   05   05   05   05   76. 07   05   05   05   05   76. 07   05   05   05   05   76. 07   05   05   05   05   76. 07   05   05   05   05   76. 07   05   05   05   76. 08   05   05   05   05   76. 07   05   05   05   76. 07   05   05   05   76. 07   05   05   05   76. 07   05   05   05   05   76. 07   05   05   05   76. 07   05   05   05   76. 07   05   05   05   05   76. 07   05   05   76. 07   05   05   76. 07   05   05   76. 07   05   05   76		l e e e e e e e e e e e e e e e e e e e				17,631		
73.00   07300   DRUGS CHARGED TO PATIENTS   3,835,590   0   0   0   0   0   73.00   74.00   07400   RENAL DIALYSIS   263,860   3,337   0   1,352   0   74.00   76.00   03330   ENDOSCOPY   564,919   232,410   24,857   94,117   0   76.00   76.06   03954   IMAGING CENTER   846,991   0   0   0   0   0   0   76.07   03955   BREAST DIAGNOSTIC CENTER   1,397,029   0   0   0   0   0   0   76.07   070   070   070   070   070   070   070   77.00   070   070   070   070   070   070   78.00   070   070   070   070   070   070   79.00   070   070   070   070   070   070   79.00   070   070   070   070   070   070   79.00   070   070   070   070   070   070   79.00   070   070   070   070   070   070   79.00   070   070   070   070   070   070   79.00   070   070   070   070   070   070   79.00   070   070   070   070   070   070   79.00   070   070   070   070   070   070   79.00   070   070   070   070   070   070   79.00   070   070   070   070   070   070   79.00   070   070   070   070   070   070   79.00   070   070   070   070   070   070   79.00   070   070   070   070   070   070   79.00   070   070   070   070   070   070   79.00   070   070   070   070   070   070   79.00   070   070   070   070   070   070   79.00   070   070   070   070   070   79.00   070   070   070   070   070   79.00   070   070   070   070   070   79.00   070   070   070   070   070   79.00   070   070   070   070   070   79.00   070   070   070   070   070   79.00   070   070   070   070   070   79.00   070   070   070   070   070   79.00   070   070   070   070   070   79.00   070   070   070   070   070   79.00   070   070   070   070   070   79.00   070   070   070   070   070   79.00   070   070   070   070   79.00   070   070   070   070   79.00   070   070   070   070   79.00   070   070   070   070   79.00   070   070   070   070   79.00   070   070   070   070   79.00   070   070   070   070   79.00   070   070   070   070   79.00   070   070   070   79.00   070   070   070   79.00   070   070   070   79.00   070   070   070   70.00						0		
74. 00   07400   RENAL DI ALYSIS   263, 860   3, 337   0   1, 352   0   74. 00   76. 00   03330   ENDOSCOPY   564, 919   232, 410   24, 857   94, 117   0   76. 00   03951   IMAGING CENTER   846, 991   0   0   0   0   0   0   76. 06   76. 07   03955   BREAST DI AGNOSTIC CENTER   1, 397, 029   0   0   0   0   0   0   0   0   0						0		
76. 00 03330   ENDOSCOPY   564, 919   232, 410   24, 857   94, 117   0   76. 00   76. 00   76. 00   3055   BREAST DI AGNOSTIC CENTER   1, 397, 029   0   0   0   0   0   0   76. 00   76. 00   0   0   0   0   0   0   0   0   0				2 22		1 252		
76. 06   03954   IMAGI NG CENTER   846, 991   0   0   0   0   0   76. 06   76. 07   03955   BREAST DI AGNOSTIC CENTER   1,397,029   0   0   0   0   0   76. 07			1					
76. 07 03955 BREAST DI AGNOSTI C CENTER 1, 397, 029 0 0 0 0 0 76. 07 00TPATI ENT SERVI CE COST CENTERS  90. 00 09000   CLI NI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		·				94, 117		
90. 00   09000   CLI NI C   0   0   0   0   0   0   0   0   0				_	-	U		
90. 00	<u> </u>		1, 397, 029	L	)[	U	0	76.07
90. 26   04975   SPI NE CENTER   76, 761   0   0   0   0   0   0   90. 26   91. 00   09100   EMERGENCY   2, 792, 290   808, 149   136, 668   327, 270   0   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   92. 00			0		V 0	٥		00 00
91. 00			7, 7,1			U		
92. 00				000 110	0	007.070		
113. 00   11300   INTEREST EXPENSE			2, 792, 290	808, 149	136, 668	327, 270	0	
113. 00 114.00 115.535,723 1,076,335 6,202,112 1,638,482 118.00 118.00 119.00 1								92.00
114. 00 118. 00 119. 0								
118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   63, 229, 945   15, 535, 723   1, 076, 335   6, 202, 112   1, 638, 482   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   21, 676   109, 965   0   44, 532   0   190. 00   191. 00   19100   RESEARCH   0   0   0   0   0   0   191. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   35, 411   0   0   0   0   0   192. 00   193. 00   19300   NONRAID WORKERS   0   0   0   0   0   0   193. 00   194. 00   07950   HOME OFFI CE   0   0   0   0   0   0   194. 00   19								
NONREI MBURSABLE COST CENTERS   190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   21,676   109,965   0   44,532   0   190. 00   191. 00   19100   RESEARCH   0   0   0   0   0   0   191. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   35,411   0   0   0   0   0   192. 00   193. 00   193. 00   NONPAI D WORKERS   0   0   0   0   0   193. 00   194. 00   07950   HOME OFFI CE   0   0   0   0   0   0   194. 00								
190. 00			63, 229, 945	15, 535, 723	1, 076, 335	6, 202, 112	1, 638, 482	118. 00
191. 00   19100   RESEARCH								
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 35, 411 0 0 0 0 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00 194. 00 194. 00 07950 HOME OFFI CE 0 0 0 0 0 0 194. 00 194. 00 194. 06 07956 PAVI LLI ONS 15, 083 0 0 0 0 194. 06 194. 08 07958 OTHER NRCC 522, 653 17, 500 0 7, 087 0 194. 08 194. 10 07960 COMMUNI TY REHAB HOSPI TAL 00. 00 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			21, 676	109, 965	0	44, 532		
193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00 194. 00 194. 00 194. 00 07950 HOME OFFI CE 0 0 0 0 0 0 194. 00 194. 00 194. 06 07956 PAVI LLI ONS 15, 083 0 0 0 0 0 194. 06 194. 08 07958 OTHER NRCC 522, 653 17, 500 0 7, 087 0 194. 08 194. 10 07960 COMMUNI TY REHAB HOSPI TAL 200. 00 Cross Foot Adjustments Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	C	0	0		
194. 00 07950 HOME OFFICE 0 0 0 0 0 194. 00 194. 06 07956 PAVILLIONS 15, 083 0 0 0 0 194. 06 194. 08 07958 OTHER NRCC 522, 653 17, 500 0 7, 087 0 194. 08 194. 10 07960 COMMUNITY REHAB HOSPITAL 0 0 0 0 0 194. 10 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			35, 411	C	0	0		
194. 06 07956 PAVILLIONS 15, 083 0 0 0 0 194. 06 194. 08 07958 OTHER NRCC 522, 653 17, 500 0 7, 087 0 194. 08 194. 10 07960 COMMUNITY REHAB HOSPITAL 0 0 0 0 194. 10 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00			0	C	0	0		
194. 08 07958 OTHER NRCC 522, 653 17, 500 0 7, 087 0 194. 08 194. 10 07960 COMMUNITY REHAB HOSPITAL 0 0 0 0 194. 10 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00			0	C	0	0		
194. 10 07960   COMMUNITY REHAB HOSPITAL     0     0     0     0 194. 10       200. 00   Cross Foot Adjustments     201. 00   Negative Cost Centers     0     0     0     0     0     0     0			15, 083	C	0	0		
194. 10 07960   COMMUNITY REHAB HOSPITAL     0     0     0     0 194. 10       200. 00   Cross Foot Adjustments     201. 00   Negative Cost Centers     0     0     0     0     0     0     0			522, 653	17, 500	0	7, 087		
201.00   Negative Cost Centers   0   0   0   0   201.00	194. 10	07960 COMMUNITY REHAB HOSPITAL	0	C	0	0	0	194. 10
	200.00	Cross Foot Adjustments						
202.00   TOTAL (sum lines 118 through 201)   63,824,768  15,663,188  1,076,335  6,253,731  1,638,482 202.00	201.00	Negative Cost Centers	0	C	0	0		
			63, 824, 768	15, 663, 188	1, 076, 335	6, 253, 731		
	·							

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

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

5/30/2018 11:42 am Cost Center Description CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL RECORDS & SERVICES & ADMI NI STRATI ON SUPPLY LI BRARY 11. 00 13.00 15.00 14.00 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 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 4, 128, 674 11.00 01300 NURSING ADMINISTRATION 7, 863, 339 13.00 104, 474 13.00 4, 252, 951 01400 CENTRAL SERVICES & SUPPLY 14.00 14 00 16, 592 15.00 01500 PHARMACY 197, 341 7, 241, 588 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 15, 478 31 3, 711, 182 16.00 01700 SOCIAL SERVICE 17.00 73, 519 0 0 17.00 113 0 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 C 0 0 0 19.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 22.00 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 404, 603 3, 711, 823 254, 251 0 426, 962 30.00 03100 INTENSIVE CARE UNIT 220, 557 582, 848 0 31.00 39, 845 58, 578 31.00 o 02060 NEONATAL INTENSIVE CARE UNIT 818, 033 35.00 35.00 309, 554 47.870 227, 149 04000 SUBPROVIDER - IPF 77, 388 0 40.00 204, 508 6, 337 19, 783 40.00 04300 NURSERY 43.00 100,605 265, 861 14,063 0 26,640 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 266, 990 705, 553 517 0 493 435 50 00 05100 RECOVERY ROOM 59,082 0 51.00 104, 474 96, 995 51.00 05200 DELIVERY ROOM & LABOR ROOM 247, 643 654, 426 34, 942 0 62, 530 52.00 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 158, 646 0 50, 294 0 109, 256 54.00 05500 RADI OLOGY-THERAPEUTI C 27,086 55.00 C 10, 639 74, 387 55.00 57.00 05700 CT SCAN 54, 172 C 379 190, 376 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 27,086 0 1,013 0 65, 547 58.00 05900 CARDIAC CATHETERIZATION 59 00 Ω 6, 053 59 00 06000 LABORATORY 60.00 7,739 152, 690 324, 229 60.00 06400 INTRAVENOUS THERAPY 15, 478 0 3, 319 64.00 421 64.00 65.00 06500 RESPIRATORY THERAPY 143, 169 5, 948 0 71, 741 65.00 06600 PHYSI CAL THERAPY 16, 470 73, 481 66.00 50.302 66 00 06700 OCCUPATIONAL THERAPY 67.00 50, 302 2,075 20, 458 67.00 06800 SPEECH PATHOLOGY 0 6, 799 68.00 11,608 445 68.00 0 69.00 06900 ELECTROCARDI OLOGY 3,869 0 454 25, 054 69.00 07000 ELECTROENCEPHALOGRAPHY 18, 029 70 00 50, 302 Ω 35, 457 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 726, 399 0 226, 378 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 1, 653, 736 120, 319 72.00 07300 DRUGS CHARGED TO PATIENTS 272, 560 73.00 0 0 7, 241, 588 73.00 07400 RENAL DIALYSIS 74.00 0 0 801 0 7.432 74 00 76.00 03330 ENDOSCOPY 58,041 0 8, 352 0 58, 970 76.00 76.06 03954 I MAGING CENTER 13, 692 0 142, 192 76.06 0 03955 BREAST DIAGNOSTIC CENTER 0 76.07 0 339 0 34, 057 76.07 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 2, 103 04975 SPINE CENTER 569 0 90. 26 90.26 09100 EMERGENCY 91.00 348, 248 920, 287 109, 376 428, 942 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW - SNF 114 00 SUBTOTALS (SUM OF LINES 1 through 117) 7, 863, 339 4, 245, 764 7, 241, 588 4, 128, 674 3, 711, 182 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 191. 00 19100 RESEARCH 0 C 0 0 0 191. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 6, 148 0 0 192.00 0 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 0 194.00 07950 HOME OFFICE 01194.00 C Ω 0 194. 06 07956 PAVI LLI ONS 0 425 0 194.06 194. 08 07958 OTHER NRCC 0 0 0 194. 08 0 614 0 0 194. 1007960 COMMUNITY REHAB HOSPITAL C 0 194, 10 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 4, 128, 674 7, 863, 339 4, 252, 951 7, 241, 588 3, 711, 182 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

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

Un Lieu of Form CMS-2552-10
Worksheet B
01/2017 Part I
031/2017 Date/Time Prepared: 5/30/2018 11: 42 am

			INTERNS &	RESI DENTS	373072018 11.	42 4111
Cost Center Description	SOCIAL SERVICE	NONPHYSI CLAN	SERVI CES-SALAR	SERVI CES-OTHER	Subtotal	
3331 3311131 23331 1 pt. 311		ANESTHETI STS	Y & FRINGES	PRGM COSTS		
CENEDAL CEDALCE COCT CENTEDS	17. 00	19. 00	21.00	22. 00	24. 00	
GENERAL SERVICE COST CENTERS  1. 00 00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00   00500   ADMI NI STRATI VE & GENERAL						5. 00
7.00   00700   OPERATION OF PLANT 8.00   00800   LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00   01100   CAFETERI A						11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00   01400   CENTRAL SERVI CES & SUPPLY 15. 00   01500   PHARMACY						14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY						16. 00
17. 00   01700   SOCI AL   SERVI CE	2, 464, 968					17. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0				19. 00
21. 00   02100   1 &R SERVI CES-SALARY & FRINGES APPRVD	0		469, 017	I I		21.00
22. 00   02200   I &R SERVI CES-OTHER PRGM COSTS APPRVD   I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0			848, 585		22. 00
30. 00 03000 ADULTS & PEDIATRICS	1, 630, 381	0	360, 858	652, 895	70, 721, 600	30.00
31. 00   03100   NTENSI VE CARE UNI T	165, 016		· · · · · · · · · · · · · · · · · · ·	·	11, 331, 242	31. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	344, 159	l .	0	O	15, 257, 423	
40. 00   04000   SUBPROVI DER - I PF	101, 906	l	1	l '	1, 969, 247	40. 00
43. 00 04300 NURSERY	223, 506	0	0	0	5, 623, 344	43. 00
ANCILLARY SERVICE COST CENTERS  50. 00 OPERATING ROOM	0	0	0	ol	16, 631, 510	50.00
51. 00   05100   RECOVERY   ROOM				-	5, 510, 832	1
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	O	13, 828, 402	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	7, 480, 278	1
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	0	0	· · · · · · · · · · · · · · · · · · ·	2, 276, 975	1
57. 00   05700   CT SCAN 58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	2, 293, 562 2, 939, 243	57. 00 58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	0	0		2, 939, 243 477, 309	59.00
60. 00   06000   LABORATORY	0	Ö	ő	o	12, 108, 806	1
64.00 06400 INTRAVENOUS THERAPY	0	0	0	O	1, 029, 476	64. 00
65. 00 06500 RESPIRATORY THERAPY	0	0	0	0	5, 313, 329	1
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   OCCUPATI ONAL THERAPY	0		0	· ·	7, 854, 361	1
68. 00   06800   SPEECH PATHOLOGY	0	0	0		2, 058, 436 444, 276	1
69. 00   06900   ELECTROCARDI OLOGY	0	Ö	ő	o	170, 243	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	O	2, 683, 602	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	25, 254, 082	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	21, 734, 661	
73. 00   07300   DRUGS CHARGED TO PATIENTS 74. 00   07400   RENAL DIALYSIS	0	0	0	0	25, 202, 333 1, 229, 738	
76. 00 03330 ENDOSCOPY		٥	Ö	l ol	3, 081, 924	1
76. 06   03954   I MAGI NG CENTER	0			· ·	4, 061, 862	
76. 07 03955 BREAST DIAGNOSTIC CENTER	0	0	0	0	6, 476, 928	76. 07
OUTPATIENT SERVICE COST CENTERS				٥		
90. 00   09000   CLI NI C 90. 26   04975   SPI NE CENTER	0	0	0	0	0 356, 662	90. 00 90. 26
91. 00   09100   EMERGENCY	0			30, 243	16, 002, 807	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			10, 710	00, 210	10, 002, 007	92. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW - SNF 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2 4/4 0/0		440.017	040 505	201 404 402	114.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	2, 464, 968	0	469, 017	848, 585	291, 404, 493	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	O	254, 458	190. 00
191. 00 19100 RESEARCH	0	0	0	o		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	169, 449	
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 HOME OFFI CE 194. 06 07956 PAVI LLI ONS	0	0	0	0	0 69 981	194. 00 194. 06
194. 08 07958 OTHER NRCC		١	0		2, 435, 464	
194. 10 07960 COMMUNITY REHAB HOSPITAL	0	0	Ö			194. 10
200.00 Cross Foot Adjustments		0	0	0		200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00   TOTAL (sum lines 118 through 201)	2, 464, 968	0	469, 017	848, 585	294, 333, 845	J202. 00

Provi der CCN: 15-0169

Purpose   Purp				To 12/31/2017 Date/Ti	me Prepared: 18 11:42 am
Residence   Service Cost Centers   Security   Service	Cost Center Description		Total	, , , , , , , , , , , , , , , , , , , ,	
Stepdom   Adjustments   Adju					
A DISTRICT   STATE					
CHRIMAL SIMPLE COST CENTERS   1.00   0.000   0.000   HEL COSTS SHOWED EIGHT   1.00   0.000   0.000   HEL COSTS SHOWED EIGHT   1.00   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.00000000		'			
1.00   1000   CAP REL COSIS-MUNEL FORM P		25. 00	26. 00		
2.00					1 00
4.00   0.000   DIPLOYCE BEREFTS DEPARTWENT   5.00   0.0000   DIPLOYER SCHEMAL   5.0000   DIPLOYER SCHEMAL   5.00000   D	· ·		+		•
0.000   0.00	1 1				•
8.00		i i			•
0.000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000					•
10.00   10.000   DETARY					•
11.00   11.00   CAFETERIA     11.00   13.00		1			<b>I</b>
13.00   1300   NURSING ADMINISTRATION     15.00   15					
15.00					13. 00
16. 00   1000   MEDICAL, RECORDS & LIBRARY   17. 00   17					
17. 00   01700   O1700   O187 SERVICES-SALARY & FIRINGES APPRIVD					
19. 00   1900   NOMINYSTICIAN AMESTHETISTS     19. 00   22. 10					•
21.00					
INPATI ENT ROUTINE SERVICE COST CENTERS   30.00   331.00   03100   AULTS & PEDIATRICS   1.013,753   69,707,847   30.00   331.00   20100   AULTS & PEDIATRICS   2.01   31.00   15,257,423   35.00   40.00   40000   KORMATA I INTERSIVE CARE UNIT   0.15,257,423   35.00   40.00   40000   KORMATA I INTERSIVE CARE UNIT   0.5,266,891   1,712,356   40.00   40.00   40000   MISSERY   43.00					
30 00   30000   ADULTS & PEDIATRICS   -1,013,753   69,707,847   30,00   31,00   3100   11   11   11   11   11   11					22. 00
31.00   03100   INTERSIVE CARE UNIT   0   11, 331, 242   35.00   04000 NOMATAL INTERSIVE CARE UNIT   0   15, 257, 4223   35.00   04000 NOMATAL INTERSIVE CARE UNIT   0   15, 257, 4223   35.00   04000 NUMSTERY   0   04000 NUMSTERY   0   04000 NUMSTERY   040.00   04000 NUMSTERY   0   05, 023, 344   040.00   04000 NUMSTERY   0   05, 023, 344   040.00   04000 NUMSTERY   040.00   05000 NUMSTERY   040.00   05000 PERATI ING ROOM   0   16, 631, 510   05100 RECOVERY ROOM   0   18, 262, 402   052.00   05200 DELIVERY ROOM & LABOR ROOM   0   18, 262, 402   052.00   05200 RADI OLOGY-IDARDISTIC   0   7, 480, 278   055.00   05500 RADI OLOGY-IDARDISTIC   0   2, 275, 755   055.00   05500 RADI OLOGY-IDARDISTIC   0   2, 275, 952   057.00   05700 CT SCAN   05700 RADI OLOGY-IDARDISTIC   0   2, 273, 562   057.00   05000 RADI PARTICIPATIVE   0   2, 273, 562   057.00   05000 RADI RADI CARTIFERI ZATI ON   0   477, 309   059.00   05000 RADI RADI CARTIFERI ZATI ON   0   477, 309   059.00   05000 RADI RADI CARTIFERI ZATI ON   0   477, 309   059.00   05000 RESIDERATION   156.00		1 012 752	(0.707.047		20.00
15. 00   02060   NEONATAL INTENSIVE CARE UNIT   0   15, 257, 423   35, 00   43.00   04300   SUBPROVIDES   F   171, 2356   40.00   04300   NURSERY   6   05, 623, 344   43.00   04300   NURSERY   6   05, 623, 344   50.00   05000   OFFARTING ROOM   0   5, 563, 344   50.00   05000   OFFARTING ROOM   0   5, 503, 352   55, 00   05, 00   05000   OFFARTING ROOM   0   5, 503, 832   55, 00   05200   OFFARTING ROOM   0   5, 503, 832   55, 00   05200   OFFARTING ROOM   0   13, 828, 402   55, 00   05500   OFFARTING ROOM   0   13, 828, 402   55, 00   05500   OFFARTING ROOM   0   2, 276, 975   55, 00   05500   RADIOLOGY-THERAPEUTIC   0   2, 276, 975   55, 00   05500   RADIOLOGY-THERAPEUTIC   0   2, 276, 975   55, 00   05500   OFFARTING ROOM   0   477, 309   59, 00   05000   CARDIAC CATHETERI ZATIO   0   2, 939, 243   58, 00   05000   CARDIAC CATHETERI ZATIO   0   12, 108, 806   60, 00   06000   LABORATORY   0   1, 209, 476   64, 00   06400   UNROWANDUS THERAPY   0   1, 209, 476   64, 00   06400   UNROWANDUS THERAPY   0   1, 209, 476   64, 00   06600   UNSIGAL THERAPY   0   5, 313, 329   65, 00   05000   OFFECH PATHOLOGY   0   444, 276   66, 00   06600   CLECTROCKEDIOLOGY   0   444, 276   66, 00   06600   CLECTRO		1			
A0. 00   040000 SUBPERVIDER - IPF   -256, 891   1,712, 356   40. 00   A0.	1	1			
ANCIL LARY SERVICE COST CENTERS   50.00	· · · · · · · · · · · · · · · · · · ·	-256, 891	1		40. 00
50.00   0500		0	5, 623, 344		43. 00
51.00   05100   RECOVERY ROOM & LABOR ROOM   0   5, 510, 832   51.00			14 421 E10		E0 00
S2.00   OS200   DELLYERY ROOM & LABOR ROOM   0   13, 828, 402   52.00		1			•
55. 00   05.00   ADDI OLOGY-THERAPEUTIC   0   2, 276, 975   55. 00   57. 00   05.70   CT SCAN   0   0   2, 293, 562   57. 00   58. 00   05.800   MAGNETIC RESONANCE IMAGING (MRI)   0   2, 293, 243   58. 00   05. 00   05.00   CARDI AC CATHETERI ZATI ON   0   477, 309   59. 00   05.	l l				•
57.00   05700   05700   CT SCAN	1 1	0	7, 480, 278		•
SB. 00   OSBOO   MAGNETI C RESONANCE I MACI NG (MRI )   0   2, 939, 243		1	1		•
59.00   05900   CARDIA C CATHETERI ZATION   0   477, 309   0   0   0   0   0   0   0   0   0		1			•
60.00   06000   LABIORATORY   0   12, 108, 806   6.0   064.00   06400   NTRAVENOUS THERAPY   0   1, 029, 476   6.6   0.0   06500   RESPIRATORY THERAPY   0   5, 313, 329   65, 00   066.00   06600   PHYSI CAL THERAPY   0   7, 854, 361   6.6   00   06600   PHYSI CAL THERAPY   0   7, 854, 361   6.6   00   0600   06000   CHEOTRO TONAL THERAPY   0   2, 058, 436   6.7   00   069.00   06900   CHEOTRO CARDIOLOGY   0   444, 276   6.8   00   069.00   LECTROCARDIOLOGY   0   170, 243   6.9   00   09000   LECTROCARDIOLOGY   0   170, 243   6.9   00   09000   LECTROCARDIOLOGY   0   170, 243   6.9   00   07100   CHEOTRO CARDIOLOGY   0   170, 243   6.9   00   07100   CHEOTRO CARDIOLOGY   0   25, 254, 082   71, 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   25, 254, 082   71, 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   25, 254, 082   71, 00   07300   DRUGS CHARGED TO PATIENTS   0   21, 734, 661   72, 00   73, 00   07300   DRUGS CHARGED TO PATIENTS   0   25, 252, 032, 333   73, 00   07300   DRUGS CHARGED TO PATIENTS   0   25, 202, 333   73, 00   07300   DRUGS CHARGED TO PATIENTS   0   25, 202, 333   73, 00   07300   DRUGS CHARGED TO PATIENTS   0   25, 202, 333   74, 00   03300   ENDOSCOPY   0   3, 081, 924   76, 00   03300   ENDOSCOPY   0   3, 081, 924   76, 00   03300   ENDOSCOPY   0   3, 081, 924   76, 00   00   00   00   00   00   00   00		1			•
65. 00   06500   RESPI RATORY THERAPY   0   5, 313, 329   65. 00   66. 00   66.00   66		1			•
66. 00   06600   PHYSICAL THERAPY   0   7, 854, 361   66, 00   0670   06COV   0CCUPATI ONAL THERAPY   0   2, 058, 436   67. 00   068. 00   06800   SPEECH PATHOLOGY   0   444, 276   68. 00   069. 00   06900   ELECTROCARDI OLOGY   0   170, 243   69. 00   070. 00   07000   ELECTROCHECPHALOGRAPHY   0   2, 683, 602   70. 00   070. 00   07000   ELECTROCHECPHALOGRAPHY   0   2, 683, 602   71. 00   071. 00   07100   MDIL CAL SUPPLIES CHARGED TO PATIENTS   0   25, 254, 082   71. 00   072. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   21, 734, 661   72. 00   073. 00   07300   DRUGS CHARGED TO PATIENTS   0   25, 202, 333   73. 00   074. 00   07400   RENAL DILAYSIS   0   1, 229, 738   74. 00   076. 00   03330   ENDOSCOPY   0   3, 081, 924   76. 00   076. 00   03955   BREAST DI AGNOSTIC CENTER   0   4, 061, 862   76. 06   076. 07   03955   BREAST DI AGNOSTIC CENTER   0   6, 476, 928   0017PATIENT SERVICE COST CENTER   0   356, 662   90. 026   090. 26   04975   SPINE CENTER   0   356, 662   90. 026   090. 20   09970   CLINIC   0   0   0   090. 20   09970   CLINIC   0   0   0   090. 20   09975   SPINATION BEDS (NON-DISTINCT PART)   0   090. 00   09000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   290, 086, 891   0113. 00   11300   INTEREST EXPENSE   113. 00   114. 00   11400   UTILIZATION REVIEW - SNF   114. 00   1191. 00   19100   RESEARCH   0   0   0   191. 00   19100   PHYSICIANS   PRIVATE OFFICES   0   169, 449   192. 00   191. 00   19100   PHYSICIANS   PRIVATE OFFICES   0   0   0   191. 00   19100   PHYSICIANS   PRIVATE OFFICES   0   0   0   191. 00   19300   NONPAID   WORKERS   0   0   0   191. 00   19300   NONPAID   WORKERS   0   0   0   191. 00   19750   HOME OFFICE   0   0   0   191. 00   194. 00   07956   PHER RINGC   0   0   0   194. 00   07956   DHER RINGC   0   0   0   194. 10   07950   00000   0000   00000   0000   00000   00000   00000   000		1			•
67. 00   06700   05CUIPATI IONAL THERAPY   0   2, 058, 436   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   444, 276   68. 00   070. 0		1			•
68. 00   06800   SPEECH PATHOLOGY   0   444, 276   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   71. 00   70. 00   07000   ELECTROCENCEPHALOGRAPHY   0   2, 683, 602   70. 00   71. 00   07000   ELECTROCENCEPHALOGRAPHY   0   2, 683, 602   71. 00   72. 00   07000   ELECTROCENCEPHALOGRAPHY   0   2, 683, 602   71. 00   72. 00   07000   ELECTROCENCEPHALOGRAPHY   0   2, 5254, 062   71. 00   72. 00   07000   ELECTROCENCEPHALOGRAPHY   0   2, 5254, 062   71. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   21, 734, 661   72. 00   74. 00   07400   RENAL DIALYSIS   0   1, 229, 738   73. 00   76. 00   03330   ENDOSCOPY   0   3, 081, 924   76. 00   76. 00   03330   ENDOSCOPY   0   3, 081, 924   76. 00   76. 07   03955   BREAST DIAGNOSTIC CENTER   0   4, 061, 862   76. 07   76. 07   03955   BREAST DIAGNOSTIC CENTER   0   6, 476, 928   76. 07   76. 07   03955   BREAST DIAGNOSTIC CENTER   0   356, 662   90. 00   79. 00   09000   CLINIC   0   0   0   0   79. 20   09000   08ERVANTION BEDS (NON-DISTINCT PART)   0   79. 00   09000   08ERVANTION BEDS (NON-DISTINCT PART)   0   79. 00   09000   09000   09000   09000   09000   09000   79. 00   09000   09000   09000   09000   09000   09000   79. 00   09000   09000   09000   09000   09000   09000   79. 00   09000   09000   09000   09000   09000   09000   79. 00   09000   09000   09000   09000   09000   09000   79. 00   09000   09000   09000   09000   09000   09000   79. 00   09000   09000   09000   09000   09000   09000   79. 00   09000   09000   09000   09000   09000   09000   79. 00   09000   09000   09000   09000   09000   09000   09000   79. 00   090		1			<b>I</b>
69.00   06900   LECTROCARDIOLOGY   0   170, 243   69.00   70.0		1			•
77. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   25, 254, 082   72. 00   772. 00   772. 00   772. 00   772. 00   772. 00   772. 00   773. 00   07300   MURCS CHARGED TO PATIENTS   0   25, 202, 333   773. 00   774. 00		0			69. 00
72. 00   07200   MPL. DEV. CHARGED TO PATIENTS   0   21, 734, 661   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   25, 202, 333   73. 00   74. 00   07400   RENAL DI ALYSIS   0   1, 229, 738   74. 00   76. 06   03330   ENDOSCOPY   0   3, 081, 924   76. 00   76. 06   03955   BREAST DI AGNOSTIC CENTER   0   4, 061, 862   76. 07   76. 0		1			
73. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 75. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 7		1			•
74. 00 07400 RENAL DIALYSIS 0 1,229,738 76. 00 76. 00 0330 ENDOSCOPY 0 3,081,924 76. 00 76. 07 76. 06 03954 I MAGING CENTER 0 4,061,862 76. 00 76. 07 00790 10 09000 CLINIC 0 0 0 0 90. 00 90. 26 04975 SPINE CENTER 0 356,662 90. 26 91. 00 09000 RERGENCY -46,958 15,955,849 91. 00 92. 00 09000 SERVATI ON BEDS (NON-DISTINCT PART) 92. 00 92. 00 09000 INTERST EXPENSE 113. 00 113. 00 11300 I NTERST EXPENSE 114. 00 114. 00 11400 UTILIZATION REVIEW - SNF 114. 00 118. 00 1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 290,086,891 118. 00 191. 00 19000 RESEARCH 0 0 0 0 0 191. 00 19000 RESEARCH 0 0 0 0 0 191. 00 19000 RESEARCH 0 0 0 0 0 0 191. 00 19000 RESEARCH 0 0 0 0 0 0 191. 00 19000 RESEARCH 0 0 0 0 0 0 191. 00 19000 RESEARCH 0 0 0 0 0 0 0 191. 00 19000 RESEARCH 0 0 0 0 0 0 0 191. 00 19000 RESEARCH 0 0 0 0 0 0 0 0 0 191. 00 19000 RESEARCH 0 0 0 0 0 0 0 0 0 0 0 194. 00 07950 HOME OFFICE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					•
76. 00 03330 ENDOSCOPY 0 3,081,924 76. 00 76. 06 03954 HMGI NG CENTER 0 4,061,862 76. 07  76.					
76. 07 03955 BREAST DI AGNOSTIC CENTER 0 6, 476, 928 00 04975 SPI NE CENTER 0 90. 00 9		0			
90. 00   09000   CLI NI C   0   0   0   0   0   0   0   0   0	1 1				
90. 00 90. 26   04975   SPI NE CENTER		O O	6, 476, 928		/6. 0/
90. 26 91. 00 91. 00 92		0	0		90.00
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0       92. 00		1	- 1		
SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   114. 00   11400   UTI LI ZATI ON REVIEW - SNF   114. 00   118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   -1, 317, 602   290, 086, 891   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   19100   RESEARCH   0   0   0   191. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   169, 449   192. 00   193. 00   19300   NONPAI D WORKERS   0   0   0   194. 00   194. 00   07950   HOME OFFI CE   0   0   0   194. 00   194. 06   07956   PAVI LI ONS   0   69, 981   194. 06   194. 08   07958   OTHER NRCC   0   2, 435, 464   194. 08   194. 08   195. 00   194. 00		-46, 958	15, 955, 849		
113. 00		0			92. 00
114. 00					113 00
118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   -1, 317, 602   290, 086, 891   118. 00   190. 00   1900   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   254, 458   191. 00   19100   RESEARCH   0   0   0   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   169, 449   192. 00   193. 00   19300   NONPAI D WORKERS   0   0   0   193. 00   194. 00   0   194. 00   1					
190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   254, 458   190. 00   191. 00   19100   RESEARCH   0   0   0   191. 00   192. 00   192. 00   192. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   194.	118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-1, 317, 602	290, 086, 891		118. 00
191. 00   19100   RESEARCH					
192. 00		0	254, 458		
193. 00     19300     NONPAI D WORKERS     0     0       194. 00     07950     HOME OFFI CE     0     0       194. 06     07956     PAVI LLI ONS     0     69, 981       194. 08     07958     OTHER NRCC     0     2, 435, 464       194. 10     07960     COMMUNI TY REHAB HOSPI TAL     0     0       200. 00     Cross Foot Adjustments     0     0     200. 00       201. 00     Negati ve Cost Centers     0     0     201. 00			169 449		
194. 00     07950     HOME OFFICE     0     0       194. 06     07956     PAVI LLI ONS     0     69, 981       194. 08     07958     OTHER NRCC     0     2, 435, 464       194. 10     07960     COMMUNI TY REHAB HOSPI TAL     0     0     194. 10       200. 00     Cross Foot Adjustments     0     0     200. 00       201. 00     Negati ve Cost Centers     0     0     201. 00			0		
194. 08     07958     OTHER NRCC     0     2, 435, 464     194. 08       194. 10     07960     COMMUNITY REHAB HOSPITAL     0     0     194. 10       200. 00     Cross Foot Adjustments     0     0     200. 00       201. 00     Negative Cost Centers     0     0     0	194.00 07950 HOME OFFICE	0	o		194. 00
194. 10 07960     COMMUNITY REHAB HOSPITAL     0     0     194. 10       200. 00 201. 00     Cross Foot Adjustments     0     0     200. 00       201. 00     Negative Cost Centers     0     0     201. 00		0			
200.00       Cross Foot Adjustments       0       0       200.00         201.00       Negative Cost Centers       0       0       0		0	2, 435, 464		•
201.00   Negative Cost Centers   0   0   201.00			O O		<b>I</b>
			ol		
		-1, 317, 602	293, 016, 243		

Provider CCN: 15-0169

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | 5/30/2018 | 11: 42 am

					12/31/2017	5/30/2018 11:	
			CAPI TAL REI	LATED COSTS			
		B	DI DO A FLYT	10/01 5 50/11 0		ENDL OVEE	
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capital Related Costs				DEPARTMENT	
		0	1. 00	2. 00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	Ŭ	1.00	2.00	Z/(	1. 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	0	27, 732	87, 429	115, 161	115, 161	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	0	408, 636	5, 914, 956	6, 323, 592	6, 810	5. 00
7.00	00700 OPERATION OF PLANT	0	1, 924, 367	14, 842	1, 939, 209	3, 345	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	47, 937		48, 017	0	
9.00	00900 HOUSEKEEPI NG	0	109, 012		116, 871	3, 480	1
10. 00	01000 DI ETARY	0	122, 389		135, 260	755	1
11. 00	01100 CAFETERI A	0	324, 022		355, 735	2, 020	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	19, 007		24, 281	2, 114	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	308, 469		1, 813, 760	0	
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	149, 782		713, 704	5, 356	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	0	18, 768 21, 443		18, 907 21, 539	417 1, 682	1
	01900 NONPHYSICIAN ANESTHETISTS	0	21, 443	70	21, 539	1, 002	1
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	Ö	0	0	0	1
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0	Ö		o	0	
	INPATIENT ROUTINE SERVICE COST CENTERS				- 1		
30.00	03000 ADULTS & PEDI ATRI CS	0	4, 044, 757	657, 172	4, 701, 929	29, 521	30. 00
31.00	03100 INTENSIVE CARE UNIT	0	891, 485	179, 904	1, 071, 389	4, 918	31. 00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	0	780, 756		922, 420	7, 388	
40. 00	04000 SUBPROVI DER - I PF	0	145, 929		161, 255	1, 809	1
43. 00	04300 NURSERY	0	399, 233	48, 526	447, 759	2, 183	43. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS		/15 /00	1 (2( 20)	2 251 007	F 720	F0 00
50. 00 51. 00	O5000   OPERATI NG ROOM   O5100   RECOVERY ROOM	0	615, 600		2, 251, 806	5, 738	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	339, 675 991, 952		348, 632 1, 112, 522	2, 536 6, 138	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	203, 490		580, 865	3, 838	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	206, 504		574, 580	600	1
57. 00	05700 CT SCAN	0	27, 213		288, 359	1, 230	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	114, 523		240, 433	649	1
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	О	0	59. 00
60.00	06000 LABORATORY	0	118, 576	38, 896	157, 472	258	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	156, 730	2, 056	158, 786	355	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	128, 279		358, 984	3, 233	1
66. 00	06600 PHYSI CAL THERAPY	0	0	721, 585	721, 585	5, 000	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	22, 087	22, 087	1, 315	1
68. 00	06800 SPEECH PATHOLOGY	0	0	4, 732	4, 732	282	1
69. 00	06900 ELECTROCARDI OLOGY	0	21 244	9, 673	9, 673	45	1
70. 00 71. 00	07000   ELECTROENCEPHALOGRAPHY   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	31, 346	219, 796	251, 142	1, 115 0	1
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	1
	07300 DRUGS CHARGED TO PATIENTS	0	0	_	ol	0	1
	07400 RENAL DIALYSIS	0	2, 376		2, 376	1	74. 00
76.00	03330 ENDOSCOPY	0	165, 455		489, 037	1, 276	1
76.06	03954 I MAGI NG CENTER	0	0	685, 375	685, 375	1, 648	76. 06
76. 07	03955 BREAST DIAGNOSTIC CENTER	0	0	130, 519	130, 519	0	76. 07
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0	0	0	
	04975 SPI NE CENTER	0	0	477	477	254	1
	O9100   EMERGENCY   O9200   OBSERVATION   BEDS (NON-DISTINCT PART)	0	575, 329	68, 826	644, 155 0	7, 270	91. 00 92. 00
92.00	SPECIAL PURPOSE COST CENTERS				U		92.00
113 00	11300   INTEREST EXPENSE						113. 00
	11400 UTI LI ZATI ON REVI EW - SNF						114. 00
118.00	1 1	0	13, 420, 772	14, 543, 613	27, 964, 385	114, 579	1
	NONREI MBURSABLE COST CENTERS			,			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	78, 285	0	78, 285	0	190. 00
191.00	19100 RESEARCH	0	0	0	0	0	191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
	19300 NONPALD WORKERS	0	0	0	o		193. 00
	07950 HOME OFFI CE	0	0	0	0		194. 00
	07956 PAVI LLI ONS	0	0	0	0		194. 06
	07958 OTHER NRCC	0	12, 459	62, 315	74, 774		194. 08
	07960 COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194. 10
200. 00 201. 00			^		0	0	200. 00 201. 00
201.00	1 1 0	0	13, 511, 516	14, 605, 928	28, 117, 444	115, 161	
202.00	1.01/12 (Sam Triles Tio till bagil 201)	١	13, 511, 510	1 1, 000, 720	20, 117, 744	113, 101	1-02.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2017 Part II
To 12/31/2017 Date/Time Prepared: 5/30/2018 11: 42 am

					12/31/201/	5/30/2018 11:	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	5.00	7.00	0.00	9.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	6, 330, 402	2 270 425				5. 00 7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	336, 881 21, 701	2, 279, 435 9, 799	1			8.00
9. 00	00900 HOUSEKEEPI NG	131, 211	22, 284	l	273, 846		9. 00
10. 00	01000 DI ETARY	30, 045	25, 019	1	3, 049	194, 128	1
11. 00	01100 CAFETERI A	75, 045	66, 236	1	8, 071	0	
13. 00	01300 NURSING ADMINISTRATION	166, 069	3, 885	1	473	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	78, 378	63, 057	1	7, 684	0	14. 00
15. 00	01500 PHARMACY	144, 792	30, 618	1	3, 731	0	15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	78, 689 50, 522	3, 836 4, 383	1	467 534	0	16. 00 17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	4, 303	0	0	0	19.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	10, 088	0	Ō	Ö	0	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	18, 251	0	0	0	0	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1, 133, 108	826, 827	1		128, 400	30.00
31. 00 35. 00	03100   NTENSI VE CARE UNIT 02060   NEONATAL   NTENSI VE CARE UNIT	179, 624 251, 750	182, 237 159, 602	1	22, 206 19, 448	12, 996 27, 104	
40. 00	04000 SUBPROVI DER – I PF	19, 962	29, 831		3, 635	8, 026	40.00
43. 00	04300 NURSERY	86, 502	81, 611			17, 602	
	ANCILLARY SERVICE COST CENTERS			, , , , , , , , , , , , , , , , , , , ,	,		
50.00	05000 OPERATING ROOM	299, 237	125, 841	1		0	1
51.00	05100 RECOVERY ROOM	98, 504	69, 436		8, 461	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	231, 982 142, 769	202, 774	1		0	52.00
54. 00 55. 00	05500 RADI OLOGY - DI AGNOSTI C	37, 572	41, 597 42, 213	l	5, 069 5, 144	0	54. 00 55. 00
57. 00	05700 CT SCAN	42, 907	5, 563	1	678	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	56, 341	23, 411	0	2, 853	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	10, 136	0	0	O	0	59. 00
60.00	06000 LABORATORY	244, 977	24, 239	1	2, 954	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	15, 076	32, 039	1	3, 904	0	64. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	104, 083	26, 223 0		3, 195	0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	165, 913 42, 706	0	0	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	9, 150	Ö	Ö	o	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	3, 030	0	0	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	54, 156	6, 408	0	781	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	501, 160	0		0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	429, 309	0	0	0	0	72. 00 73. 00
74. 00	07400 RENAL DIALYSIS	380, 434 26, 171	486	0	59	0	74.00
76. 00	03330 ENDOSCOPY	56, 032	33, 822	1	4, 121	0	76.00
76.06	03954 I MAGI NG CENTER	84, 009	0		0	0	76. 06
76. 07	03955 BREAST DIAGNOSTIC CENTER	138, 565	0	0	0	0	76. 07
00.00	OUTPATIENT SERVICE COST CENTERS		0	J	ما		00.00
90. 00 90. 26	09000   CLI NI C   04975   SPI NE CENTER	7, 614	0	0	0	0	90. 00
91. 00	09100 EMERGENCY	276, 954	117, 608	10, 097	14, 331	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		,		,	_	92. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW - SNF	( 271 405	2 2/0 005	70 517	271 50/	104 100	114.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	6, 271, 405	2, 260, 885	79, 517	271, 586	194, 128	1118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 150	16, 003	0	1, 950	0	190. 00
	19100 RESEARCH	0	0	ő	0		191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	3, 512	0	0	0	0	192. 00
	19300 NONPALD WORKERS	0	0	0	0		193. 00
	07950 HOME OFFICE	0	0	0	0		194. 00
	07956 PAVI LLI ONS 07958 OTHER NRCC	1, 496 51, 839	0 2, 547	0	0 310		194. 06 194. 08
	07958 OTHER NRCC	31, 639 n	∠, 34 <i>1</i>	0	310		194. 08
200.00					Ĭ	O	200.00
201.00	1 1	0	0	0	o		201. 00
202.00		6, 330, 402	2, 279, 435	79, 517	273, 846	194, 128	202. 00

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Cost Center Description		NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	5/30/2018 11: MEDI CAL RECORDS & LI BRARY	
CENEDAL CEDVICE COCT CENTEDS	11. 00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS	507, 107 12, 832 0 24, 238 1, 901 9, 030 0	209, 654 0 0 0	1, 962, 879 7, 658 14 52 0 0	930, 097 0 0 0 0 0	104, 231 0 0 0 0	1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 21. 00 22. 00
30. 00 03000 ADULTS & PEDI ATRI CS	172, 522	98, 965	117, 346	0	11, 981	
31. 00   03100   INTENSIVE CARE UNIT 35. 00   02060   NEONATAL   INTENSIVE CARE UNIT 40. 00   04000   SUBPROVI DER -   IPF 43. 00   04300   NURSERY   ANCI LLARY SERVI CE COST CENTERS	27, 090 38, 021 9, 505 12, 357	21, 811 5, 453	18, 390 22, 094 2, 925 6, 491	0 0 0 0	1, 644 6, 374 555 748	31. 00 35. 00 40. 00 43. 00
50. 00 05000 OPERATING ROOM	32, 793	18, 812	239	o	13, 937	50.00
	32, 793 12, 832 30, 417 19, 486 3, 327 6, 654 3, 327 0 951 1, 901 17, 585 6, 178 6, 178 0 0 0 7, 129 0 0 42, 774	0 17, 448 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	239 27, 268 16, 127 23, 213 4, 910 175 467 0 70, 472 194 2, 745 7, 601 958 205 209 8, 321 796, 789 763, 256 0 370 3, 855 6, 319 156	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	13, 937 2, 722 1, 755 3, 066 2, 087 5, 342 1, 839 170 9, 098 93 2, 013 2, 062 574 191 703 995 6, 352 3, 376 7, 648 209 1, 655 3, 990 956	51. 00 52. 00 54. 00 55. 00 57. 00 58. 00 59. 00 60. 00 64. 00 65. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 76. 00 76. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE 114.00 11400 UTILIZATION REVIEW - SNF 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	507, 107	209, 654	1, 959, 562	930, 097	104, 231	113. 00 114. 00 118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH 192.00 19200 PHYSICIANS' PRIVATE OFFICES 193.00 19300 NONPAID WORKERS 194.00 07950 HOME OFFICE 194.06 07956 PAVILLIONS 194.08 07958 OTHER NRCC 194.10 07960 COMMUNITY REHAB HOSPITAL Cross Foot Adjustments Negative Cost Centers TOTAL (sum lines 118 through 201)	0 0 0 0 0 0 0 0 507, 107	0 0 0 0 0 0 0	0 0 2, 838 0 0 196 283 0 0 1, 962, 879	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	190. 00 191. 00 192. 00 193. 00 194. 00 194. 06 194. 08 194. 10 200. 00 201. 00 202. 00

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

Un Lieu of Form CMS-2552-10
Worksheet B
01/2017 Part II
01/2017 Date/Time Prepared:
5/30/2018 11: 42 am

			I NTERNS &	RESI DENTS	3/30/2016 11.	42 4111
Cost Center Description	SOCIAL SERVICE		SERVI CES-SALAR		Subtotal	
	17. 00	ANESTHETI STS 19. 00	Y & FRINGES 21.00	PRGM COSTS 22.00	24.00	
GENERAL SERVICE COST CENTERS	17.00	17.00	21.00	22.00	24.00	
1. 00						1. 00 2. 00
4. 00   00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5. 00
7.00   00700   OPERATION OF PLANT 8.00   00800   LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00   01000   DI ETARY						10. 00
11. 00 01100 CAFETERI A						11.00
13. 00   O1300   NURSI NG ADMINI STRATI ON 14. 00   O1400   CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00 01500 PHARMACY						15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY						16. 00
17. 00   01700   SOCIAL SERVICE 19. 00   01900   NONPHYSICIAN ANESTHETISTS	87, 742 0	0				17. 00 19. 00
21. 00   02100   &R SERVI CES-SALARY & FRI NGES APPRVD	0		10, 088			21. 00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0			18, 251		22. 00
I NPATIENT ROUTINE SERVICE COST CENTERS	F0 024				7 410 205	20.00
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   NTENSIVE CARE UNIT	58, 034 5, 874				7, 418, 305 1, 545, 140	30. 00 31. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	12, 251				1, 490, 924	35. 00
40. 00   04000   SUBPROVI DER - I PF	3, 627				247, 955	40. 00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS	7, 956				682, 778	43. 00
50. 00   O5000   OPERATING ROOM	0				2, 766, 482	50. 00
51.00   05100   RECOVERY ROOM	0				570, 391	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0				1, 650, 172	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 55. 00   05500   RADI OLOGY-THERAPEUTI C	0				828, 950 671, 202	54. 00 55. 00
57. 00   05700 CT SCAN	0				350, 908	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0				329, 320	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON 60. 00   06000   LABORATORY	0				10, 306 510, 421	59. 00 60. 00
64. 00   06400   INTRAVENOUS THERAPY					212, 348	64. 00
65. 00 06500 RESPIRATORY THERAPY	0				518, 061	65. 00
66. 00   06600   PHYSI CAL THERAPY	0				908, 339	66.00
67. 00   06700   OCCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	0				73, 818 15, 986	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	Ö				14, 135	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0				329, 096	70. 00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00   07200   IMPL. DEV. CHARGED TO PATIENTS	0				1, 304, 301 1, 195, 941	
73. 00 07300 DRUGS CHARGED TO PATTENTS	0				1, 193, 941	73.00
74. 00   07400   RENAL DI ALYSI S	0				29, 672	74. 00
76. 00   03330   ENDOSCOPY	0				598, 763	
76. 06   03954   IMAGING CENTER  76. 07   03955   BREAST DI AGNOSTIC CENTER	0				781, 341 270, 196	76. 06 76. 07
OUTPATIENT SERVICE COST CENTERS					270, 170	70.07
90. 00 09000 CLI NI C	0				0	90.00
90. 26   04975   SPI NE CENTER 91. 00   09100   EMERGENCY	0				8, 666 1, 200, 244	90. 26 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				1, 200, 244	92.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300   INTEREST EXPENSE 114. 00 11400   UTI LI ZATI ON REVI EW - SNF						113. 00 114. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	87, 742	o	0	0	27, 852, 340	
NONREI MBURSABLE COST CENTERS				-,	=:, ===, =:=	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				98, 388	
191. 00 19100  RESEARCH 192. 00 19200  PHYSI CLANS' PRI VATE OFFI CES	0					191. 00 192. 00
193. 00 19300 NONPALD WORKERS	0					193. 00
194.00 07950 HOME OFFICE	0				0	194. 00
194. 06 07956 PAVI LLI ONS 194. 08 07958 OTHER NRCC	0				1, 692 130, 335	194. 06
194. 08 07958 OTHER NRCC 194. 10 07960 COMMUNITY REHAB HOSPITAL	0					194. 08
200.00 Cross Foot Adjustments		0	10, 088	18, 251	28, 339	
201.00 Negative Cost Centers	0	0		0		201. 00
202.00   TOTAL (sum lines 118 through 201)	87,742	0	10, 088	18, 251	28, 117, 444	J202. 00

| 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: 15-0169

Cost Center Passari pit on   Passari p				10 12/31/2017 Date/II	me Prepared: 18 11:42 am
PARESTAL SERVICE COST CENTERS   1.00   1.0	Cost Center Description		Total		
Column   C					
EMBRIAL SCHOTE COST CENTERS  1.00 GOTOLOGY NELL COSTS-LINES # 1.10 CO.  2.00 GOTOLOGY NELL COSTS-LINES # 1.10 CO.  3.00 GOTOLOGY NELL COSTS-LINES # 5.0 CO.  3.00 GOTOLOGY NELL COSTS-LINES # 5.0 CO.  3.00 GOTOLOGY NELL COSTS-LINES # 5.0 CO.  3.00 GOTOLOGY NELL COSTS PARTITION # 5.0 CO.  3.00 GOTOLOGY CAFTERS A STORY # 1.0 CO.  3.00 GOTOLOGY CAFTERS A STORY # 1.0 CO.  3.00 GOTOLOGY CAFTERS A STORY # 1.0 CO.  3.00 GOTOLOGY COSTS # 1.0 CO.  3.00 GOTOLOGY PARTITION # 1.0 CO					
1.00   00100 CAP REL COSTS-BLID & FIXT		25. 00	26. 00		
2.00		1			1 00
0.000   DOMO   DATE OF THE SERVETTS DEPARTWEST   0.000   0.000   DOMO   DEPART   0.000   0.000   DEPART   0.0000   DEPART   0.000   DEPART					•
D. 00   DOSON ARM INSTRATION A CENTRAL					•
0.000   0.000   0.000   0.000   0.000   0.000     0.000   0.000   0.000   0.000     0.000   0.000   0.000   0.000     0.000   0.000   0.000   0.000     0.000   0.000   0.000   0.000     0.000   0.000   0.000   0.000     0.000   0.000   0.000   0.000     0.000   0.000   0.000   0.000     0.000   0.000   0.000   0.000     0.000   0.000   0.000   0.000     0.000   0.000   0.000   0.000     0.000   0.000   0.000   0.000     0.000   0.000   0.000   0.000     0.000   0.000     0.000   0.000   0.000     0.000   0.0000     0.000   0.0000	· ·				5. 00
0.000   0.0000   0.0000   0.000000   0.00000000					•
10.00   10.00   10.00   10.00   10.00   10.00   10.00   11.00   13.00   3.00					•
11.00   01.00   CAFETERIA     11.00   13.00					
13.00   1300   MINESTRY CAPEN ADMINISTRATION   1.1.00   14.0					•
15.00     1500   PHARMACY					•
16. 00   10-00   MEDICAL RECORDS & LIBRARY     10. 00   17-0					
17.00   10700   SOCIAL SERVICE					
19.00					•
21.00					•
INPATI ENT ROUTINE SERVICE COST CENTERS   30.00   330.00   330.00   301.00   AUDITS & PEDIA INTICS   0   7, 418, 305   30.00   310.00   331.00					
30.00					22. 00
31.00   03100   INTENSIVE CARE UNIT   0   1,545,140   33.00   035.00   0200   NEONEMATAL INTENSIVE CARE UNIT   0   1,449,924   35.50   040.00   04000   NEONEMATAL INTENSIVE CARE UNIT   0   247,955   40.00   04000   NURSERY   0   682,778   43.00   430.00   430.00   15.00   15.00   051.00   PERATING ROOM   0   570.391   51.00   51.00   051.00   PERATING ROOM   0   570.391   51.00   51.00   051.00   RECOVERY ROOM & LABOR ROOM   0   570.391   51.00   55.00   55.00   65.			7 440 005		
15.00   02060   NEONATAL INTENSIVE CARE UNIT   0   1,490,924   35.00   43.00   43.00   04200   SUBPROVIDES   F   19   0   247,955   43.00   43.00   43.00   04200   NURSERY   6   682,778   5   64.00   682,778   5   6   68.00   682,778   5   6   68.00   682,778   5   6   6   6   6   6   6   6   6   6					
40, 00   040000   SUBPROVIDER - I PF   0   247, 955   40, 00		1			
ANCIL LARY SERVICE COST CENTERS   50.00		1			
50.00   05000   0FECRATING ROOM   0   2, 766, 482   55.00   55.00   55.00   05200		0	682, 778		43. 00
51.00   OSTOIQ RECOVERY ROOM   SABOR ROOM   0   570, 391   51.00   52.00   520, 00   520, 00   61.00			2.7// 402		F0 00
S2.00   05200   05200   DELLYERY ROOM & LABOR ROOM   0   1,650.172   52.00   55.00   55.00   05500   RADI OLOGY-THERAPEUTIC   0   671.202   55.00   55.00   05500   RADI OLOGY-THERAPEUTIC   0   671.202   55.00   55.00   05500   CRODI OLOGY-THERAPEUTIC   0   671.202   55.00   55.00   05500   CRODI OLOGY-THERAPEUTIC   0   0   329.320   58.000   58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)   0   329.320   58.000   59.00   05900   CARDI ACC ALTHETERI ZATI ON   0   10.306   59.00   05900   CARDI ACC ALTHETERI ZATI ON   0   510.421   60.00   60.00   66.00   10.000   INTERVANOUS THERAPY   0   510.421   60.00   65.00   65.00   0.5000   PRYSI CAL THERAPY   0   518.061   65.00   66.00   66.00   66.00   66.00   66.00   07.000   PRYSI CAL THERAPY   0   518.061   65.00   66.00   66.00   PRYSI CAL THERAPY   0   73.818   67.00		1			
54.00   05400   RADI OLOGY-DI ACMOSTIC   0   828, 950   55.00   55.00   6		1			
1.00	· ·	0			54.00
S8. 00   OSBOO   MAGNETI C RESONANCE I MACI NG (MRI )   0   3.29, 320   58, 00   59. 00   59. 00   59. 00   6		1			•
59.00   05900   CARDI AC CATHETRI ZATION   0   10, 306   0   60.00   60.00   ABORDATORY   0   0   510, 421   60.00   60.00   ABORDATORY   0   510, 421   60.00   60.00   ABORDATORY   0   510, 421   66.00   66.00   66.00   66.00   66.00   66.00   66.00   66.00   66.00   66.00   66.00   66.00   66.00   66.00   66.00   67.00		1			•
60.00   06000   LABORATORY   0   510, 421   06.00   064.00   06400   NTRAVENOUS THERAPY   0   212, 348   064.00   06500   RESPIRATORY THERAPY   0   518, 061   05.00   06500   RESPIRATORY THERAPY   0   908, 339   066.00   06600   0700   07000   0CCUPATI ONAL THERAPY   0   73, 818   07.00   07		1			•
65. 00   06500		1			
66. 00   06600   PHYSICAL THERAPY   0   908, 339   66, 00   6700   0CCUPATI ONAL THERAPY   0   73, 818   67, 00   68. 00   06900   0CCUPATI ONAL THERAPY   0   73, 818   68. 00   06900   0CCUPATI ONAL THERAPY   0   14, 135   69, 00   06900   0CCUPATI ONAL THERAPY   0   329, 096   70, 00   07000   ELECTROCARDI OLOGY   0   14, 135   69, 00   07, 00   07, 000   0.00   07000   ELECTROCARDI OLOGY   0   14, 135   69, 00   07, 00   07, 00   0   0   0   0   0   0   0   0   0	64.00 06400 I NTRAVENOUS THERAPY	0	212, 348		64.00
67. 00 66700 DCCUPATI ONAL THERAPY 0 73, 818 68. 00 68. 00 06800 SPEECH PATHOLOGY 0 15, 986 68. 00 69. 00 06900 ELECTROCARDI OLDGY 0 15, 986 68. 00 70. 00 07000 ELECTROCARDI OLDGY 0 14, 135 69. 00 70. 00 07000 ELECTROCARDI OLDGY 0 329, 096 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 1, 304, 301 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 1, 318, 179 72. 00 73. 00 07300 DRIUGS CHARGED TO PATI ENTS 0 1, 318, 179 73. 00 74. 00 07300 DRIUGS CHARGED TO PATI ENTS 0 1, 318, 179 73. 00 74. 00 07300 DRIUGS CHARGED TO PATI ENTS 0 1, 318, 179 73. 00 74. 00 07300 DRIUGS CHARGED TO PATI ENTS 0 1, 318, 179 73. 00 74. 00 07400 RENNAL DI ALYSI S 0 29, 672 74. 00 76. 00 03330 ENDOSCOPY 0 598, 763 76. 00 76. 00 03354 I MAGIN KIC ENTER 0 76. 00 76. 00 03554 I MAGIN KIC ENTER 0 76. 00 76. 00 03555 BREAST DI AGNOSTIC CENTER 0 270, 196 76. 00 79. 00 09000 CLI NI C 0 76. 00 79. 00 09000 CLI NI C 0 0 76. 00 79. 00 09000 CLI NI C 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 90. 00 79. 00 09000 OLI NI C 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 90. 00 79. 00 09000 CLI NI C 0 0 0 0 90. 00 79. 00 09000 CLI NI					•
68. 00   06800   SPEECH PATHOLOGY   0   15, 986   68. 00   69. 00   69000   ELECTROCARDI OLOGY   0   14, 135   69. 00   70. 00   70000   ELECTROCENDE OLOGY   0   14, 135   70. 00   70000   ELECTROCENCEPHALOGRAPHY   0   329, 096   70. 00   71. 00   70700   MPL. DEV. CHARGED TO PATIENTS   0   1, 304, 301   71. 00   72. 00   70700   MPL. DEV. CHARGED TO PATIENTS   0   1, 195, 941   72. 00   72. 00   70700   MPL. DEV. CHARGED TO PATIENTS   0   1, 318, 179   73. 00   74. 00   07400   RENAL DIALYSIS   0   29, 672   74. 00   76. 00   03330   ENDOSCOPY   0   598, 763   76. 00   76. 00   03330   ENDOSCOPY   0   598, 763   76. 00   76. 00   03330   ENDOSCOPY   0   598, 763   76. 00   76.		1			
69.00   06900   ELECTROCARDI OLOGY   0   14, 135   70.00   70.					•
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   1, 304, 301   72. 00   772. 00   772. 00   772. 00   772. 00   772. 00   772. 00   772. 00   772. 00   773. 00   773. 00   774. 00   77		o			•
72. 00   07200   MPL. DEV. CHARGED TO PATIENTS   0   1, 195, 941   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   1, 318, 179   73. 00   74. 00   07400   RENAL DI ALYSIS   0   29, 672   74. 00   76. 00   03303   ENDOSCOPY   0   598, 763   76. 00   76. 06   03954   MAGI NG CENTER   0   781, 341   76. 06   76. 07   03955   BREAST DI AGNOSTIC CENTER   0   270, 196   76. 07   0000   CLI NI C   0   0   0   0   0   0   0   0   0	70. 00 07000 ELECTROENCEPHALOGRAPHY	0	329, 096		70. 00
73. 00 07300 BRUGS CHARGED TO PATIENTS 0 1,318,179 74. 00 07400 RENAL DIALYSIS 0 29,672 76. 00 03954 IMAGING CENTER 0 76. 00 76. 06 03954 IMAGING CENTER 0 76. 00 76. 07 03955 BREAST DIAGNOSTIC CENTER 0 76. 00 00 090. 26 04975 SPINE CENTER 0 8,666 90. 26 04975 SPINE CENTER 0 8,666 90. 26 04975 SPINE CENTER 0 8,666 91. 00 09100 EMERGENCY 0 1,200,244 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 9200 OBSERVATION BEDS (NON-DISTINCT PART) 0 9200 OMBER JABURSABLE COST CENTERS 113. 00 114. 00 11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW - SNF SUBTOTALS (SUM OF LINES 1 through 117) 0 27,852,340 190. 00 19100 ERESCARCH 0 9,888 190. 00 191. 00 19100 RESEARCH 0 9,888 190. 00 191. 00 19100 RESEARCH 0 0 0 19100 PRESEARCH 0 0 0 19100 PRESEARCH 0 0 192. 00 19300 NONPAID WORKERS 0 0 0 19300 NONPAID WORKERS 0 192. 00 194. 00 07950 HOME OFFICE 0 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 0 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 0 0 0 194. 00 194. 00 07950 HOME OFFICE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1			
74. 00   07400   RENAL DI ALYSI S   0   29, 672   74. 00   76. 00   0330   ENDOSCOPY   0   598, 763   76. 00   76. 00   03954   IMAGI NG CENTER   0   776. 06   76. 07   03955   BREAST DI AGNOSTI C CENTER   0   270, 196   76. 07   00000   00000   00000   00000   00000   00000   00000   00000   000000		1			
76. 00 03330 ENDOSCOPY 0 598, 763 76. 00 76. 06 03954 IMAGI NG CENTER 0 781, 341 76. 00 76. 07 03955 BREAST DI AGNOSTIC CENTER 0 270, 196 0UTPATI ENT SERVICE COST CENTERS  90. 00 09000 CLI NI C 0 8, 666 90. 26 91. 00 09100 EMERGENCY 0 1, 200, 244 91. 00 92. 00 09200 [OBSERVATI ON BEDS (NON-DISTINCT PART) 0 92. 00 92. 00 09200 [OBSERVATI ON BEDS (NON-DISTINCT PART) 0 92. 00 92. 01 13300 INTEREST EXPENSE 113. 00 114. 00 11300 INTEREST EXPENSE 114. 00 114. 00 11400 UTI LI ZATI ON REVI EW - SNF 114. 00 118. 00 NONREI MBURSABLE COST CENTERS  190. 00 19000 [GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 19000 [GIFT, FLOWER, COST, C		1			
76. 07   03955   BREAST DI AGNOSTIC CENTER   0   270, 196   0   0   0   0   0   0   0   0   0		1			
OUTPATIENT SERVICE COST CENTERS   90. 00   990.00   CLINIC   90. 26   94975   SPI NE CENTER   90. 26   94975   SPI NE CENTER   90. 26   94975   SPI NE CENTER   90. 26   90. 26   91. 00   91. 00   91. 00   91. 00   92. 00   992.00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   92. 00   92. 00   SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   114. 00   11400   UTILIZATION REVIEW - SNF   114. 00   11400   UTILIZATION REVIEW - SNF   114. 00   NONREI MBURSABLE COST CENTERS   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   98, 388   190. 00   191. 00   19100   RESEARCH   0   0   0   0   191. 00   192.00   192.00   192.00   194.00   197.00   19		1			
90. 00 90. 26		0	270, 196		76. 07
90. 26			0		90.00
91. 00	· ·	1	-1		
SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   114. 00   114. 0	91. 00 09100 EMERGENCY	0			
113. 00		0			92. 00
114. 00		T	T		112 00
118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   0   27, 852, 340   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   191. 00   19100   RESEARCH   0   0   0   191. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFICES   0   6, 350   192. 00   193. 00   19300   NONPAI D WORKERS   0   0   0   194. 00   194. 00   07950   HOME OFFICE   0   0   0   194. 00   194. 00   194. 00   195. 00   194. 00   194. 00   194. 00   194. 00   194. 00   194. 00   194. 00   194. 00   194. 00   194. 00   194. 10   194. 00   194. 10   194. 00   194. 10   194. 00   194. 1					
190. 00       19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN       0       98, 388       190. 00         191. 00       19100 RESEARCH       0       0       191. 00         192. 00       19200 PHYSI CI ANS' PRI VATE OFFI CES       0       6, 350       192. 00         193. 00       19300 NONPAI D WORKERS       0       0       193. 00         194. 00       07950 HOME OFFI CE       0       0       194. 00         194. 06       07956 PAVI LLI ONS       0       1, 692       194. 06         194. 08       07958 OTHER NRCC       0       130, 335       194. 08         194. 10       07960 COMMUNI TY REHAB HOSPI TAL       0       0       194. 10         200. 00       Cross Foot Adjustments       0       28, 339       200. 00         201. 00       Negati ve Cost Centers       0       0       201. 00		O	27, 852, 340		
191. 00       19100       RESEARCH       0       0       191. 00         192. 00       19200       PHYSI CI ANS' PRI VATE OFFI CES       0       6, 350       192. 00         193. 00       19300       NONPAI D WORKERS       0       0       193. 00         194. 00       07950       HOME OFFI CE       0       0       194. 00         194. 06       07956       PAVI LLI ONS       0       1, 692       194. 06         194. 08       07958       OTHER NRCC       0       130, 335       194. 08         194. 10       07960       COMMUNI TY REHAB HOSPI TAL       0       0       194. 10         200. 00       Cross Foot Adjustments       0       28, 339       200. 00         201. 00       Negati ve Cost Centers       0       0       0					
192. 00     19200     PHYSI CI ANS' PRI VATE OFFI CES     0     6, 350       193. 00     19300     NONPAI D WORKERS     0     0       194. 00     07950     HOME OFFI CE     0     0     194. 00       194. 06     07956     PAVI LLI ONS     0     1, 692     194. 06       194. 08     07958     OTHER NRCC     0     130, 335     194. 08       194. 10     07960     COMMUNI TY REHAB HOSPI TAL     0     0     194. 10       200. 00     Cross Foot Adjustments     0     28, 339     200. 00       201. 00     Negati ve Cost Centers     0     0     201. 00		-			
193. 00     19300     NONPAI D WORKERS     0     0     193. 00       194. 00     07950     HOME OFFI CE     0     0     194. 00       194. 06     07956     PAVI LLI ONS     0     1, 692     194. 06       194. 08     07958     OTHER NRCC     0     130, 335     194. 08       194. 10     07960     COMMUNI TY REHAB HOSPI TAL     0     0     194. 10       200. 00     Cross Foot Adjustments     0     28, 339     200. 00       201. 00     Negati ve Cost Centers     0     0     201. 00			٩		
194. 00     07950     HOME OFFICE     0     0     194. 00       194. 06     07956     PAVI LLI ONS     0     1, 692     194. 06       194. 08     07958     OTHER NRCC     0     130, 335     194. 08       194. 10     07960     COMMUNI TY REHAB HOSPI TAL     0     0     194. 10       200. 00     Cross Foot Adjustments     0     28, 339     200. 00       201. 00     Negati ve Cost Centers     0     0     0					
194. 06     07956     PAVI LLI ONS     0     1, 692     194. 06       194. 08     07958     OTHER NRCC     0     130, 335     194. 08       194. 10     07960     COMMUNI TY REHAB HOSPI TAL     0     0     194. 10       200. 00     Cross Foot Adjustments     0     28, 339     200. 00       201. 00     Negati ve Cost Centers     0     0     0		o	ŏ		
194. 10     07960     COMMUNITY REHAB HOSPITAL     0     0     194. 10       200. 00     Cross Foot Adjustments     0     28, 339     200. 00       201. 00     Negative Cost Centers     0     0     0	194. 06 07956 PAVI LLI ONS	0			
200. 00       Cross Foot Adjustments       0       28, 339       200. 00         201. 00       Negative Cost Centers       0       0       0		0	130, 335		•
201. 00   Negative Cost Centers   0   0   201. 00		0	20 220		
			20, 339 N		
			28, 117, 444		

Provider CCN: 15-0169

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

| Period: | Worksheet B-1 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared:

					o 12/31/2017		
		CAPITAL REL	L _ATED COSTS			5/30/2018 11:	42 am
	Cook Cooker Doorsinking	DIDC 0 FLVT	MVDLE FOLLID	EMDL OVEE	D	ADMINI CTDATIVE	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS	Reconciliation	ADMINISTRATIVE & GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS SALARI ES)			
		1.00	2.00	4. 00	5A	5. 00	
	RAL SERVICE COST CENTERS						
	O CAP REL COSTS-BLDG & FIXT O CAP REL COSTS-MVBLE EQUIP	676, 739	14, 665, 087				1. 00 2. 00
	O EMPLOYEE BENEFITS DEPARTMENT	1, 389	87, 783	92, 572, 475			4.00
5.00 00500	O ADMINISTRATIVE & GENERAL	20, 467	5, 938, 915			230, 509, 077	5. 00
	O OPERATION OF PLANT	96, 384	14, 902	2, 688, 958			
	O LAUNDRY & LINEN SERVICE O HOUSEKEEPING	2, 401 5, 460	80 7, 891	2, 797, 133	-	790, 203 4, 777, 720	8. 00 9. 00
	O DI ETARY	6, 130		607, 043			
1	O CAFETERI A	16, 229	31, 841	1, 623, 631		2,,02,0,0	
	O NURSING ADMINISTRATION	952	5, 295			-, ,	
	O CENTRAL SERVICES & SUPPLY O PHARMACY	15, 450 7, 502	1, 511, 388 566, 206	4, 305, 25 <sup>4</sup>	-	2, 853, 962 5, 272, 247	14. 00 15. 00
•	O MEDICAL RECORDS & LIBRARY	940	140	334, 825			
	O SOCIAL SERVICE	1, 074	96	1, 351, 753	0	1,,	1
	O NONPHYSICIAN ANESTHETISTS O I&R SERVICES-SALARY & FRINGES APPRVD	0	0	(	0	0 367, 313	19. 00 21. 00
•	O I & R SERVI CES-OTHER PRGM COSTS APPRVD	0	0			1	22. 00
I NPA	TIENT ROUTINE SERVICE COST CENTERS						
	O ADULTS & PEDIATRICS	202, 586					30.00
	O INTENSIVE CARE UNIT O NEONATAL INTENSIVE CARE UNIT	44, 651 39, 105	180, 633 142, 238			-, ,	1
	O SUBPROVI DER - I PF	7, 309	15, 388				40. 00
	0 NURSERY	19, 996	48, 723	1, 754, 501	0	3, 149, 765	43. 00
	LLARY SERVICE COST CENTERS	20.022	1 (42 022	4 (12 22)		10 00/ 012	FO 00
	O OPERATING ROOM O RECOVERY ROOM	30, 833 17, 013	1, 642, 833 8, 993				1
	O DELIVERY ROOM & LABOR ROOM	49, 683				1	
	O RADI OLOGY-DI AGNOSTI C	10, 192	378, 903				1
	O RADI OLOGY-THERAPEUTI C O CT SCAN	10, 343	369, 567	482, 075		1, 222, 122	1
	O MAGNETIC RESONANCE IMAGING (MRI)	1, 363 5, 736	262, 204 126, 420	988, 40 <i>6</i> 521, 883			1
	O CARDI AC CATHETERI ZATI ON	0	0	(		369, 067	59. 00
1	O LABORATORY	5, 939	39, 054	207, 361		-,,	
1	O INTRAVENOUS THERAPY O RESPIRATORY THERAPY	7, 850 6, 425	2, 064 231, 639	285, 185 2, 598, 713		0.07,700	
	O PHYSI CAL THERAPY	0, 423	724, 508				
	O OCCUPATIONAL THERAPY	0	22, 176	1, 057, 200	0	1, 555, 034	67. 00
•	O SPEECH PATHOLOGY	0	4, 751	226, 510		333, 173	
	0  ELECTROCARDI OLOGY 0  ELECTROENCEPHALOGRAPHY	0 1, 570	9, 712 220, 686	35, 879 896, 579		110, 320 1, 971, 947	69. 00 70. 00
	O MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(			
	O I MPL. DEV. CHARGED TO PATIENTS	0	0	(	0		1
	O DRUGS CHARGED TO PATIENTS O RENAL DIALYSIS	0 119	0	606	-	13, 852, 595 952, 956	
	O ENDOSCOPY	8, 287	324, 893			2, 040, 258	
76. 06 03954	4 I MAGING CENTER	0	688, 151	1, 324, 539		3, 058, 987	76. 06
	5 BREAST DIAGNOSTIC CENTER	0	131, 048	(	0	5, 045, 503	76. 07
	ATIENT SERVICE COST CENTERS OCLINIC	0	0	(	) 0	0	90.00
	5 SPI NE CENTER	0	479	204, 230			
	O EMERGENCY	28, 816	69, 105	5, 844, 287	0	10, 084, 619	
	O OBSERVATION BEDS (NON-DISTINCT PART) IAL PURPOSE COST CENTERS						92.00
	O INTEREST EXPENSE						113. 00
	UTILIZATION REVIEW - SNF						114. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	672, 194	14, 602, 520	92, 104, 341	-63, 824, 768	228, 360, 819	118. 00
	EIMBURSABLE COST CENTERS OGIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 921	0	(		78, 285	190 00
191. 00 19100		0	0		Ó	•	191. 00
192. 00 19200	O PHYSICIANS' PRIVATE OFFICES	0	0	(	0	127, 890	192. 00
	O NONPALD WORKERS	0	0	(	0	•	193. 00
	O HOME OFFICE 6 PAVILLIONS	0	) n	(	) 0	54, 473	194. 00 194. 06
	8 OTHER NRCC	624	62, 567	468, 134	ı  o	1, 887, 610	
	O COMMUNITY REHAB HOSPITAL	0	0	(	0	0	194. 10
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
201. 00	The section of the se	I	ı	ı	ı	1	1-01.00

Health Financial Systems	COMMUNITY HOSPITAL OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CC	<u>F</u>	Period: From 01/01/2017 Fo 12/31/2017	Worksheet B-1 Date/Time Prep	pared:
				5/30/2018 11: 4	12 am
	CAPITAL RELATED COSTS				

				'	0 12/01/201/	5/30/2018 11:	
		CAPITAL REL	ATED COSTS	·			
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP		Reconciliation	ADMI NI STRATI VE	
		(SQUARE FEET)	(DOLLAR VALUE)			& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS			
				SALARI ES)			
		1. 00	2. 00	4. 00	5A	5. 00	
202. 00	Cost to be allocated (per Wkst. B,	13, 511, 516	14, 605, 928	4, 201, 213		63, 824, 768	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	19. 965623	0. 995966	0. 045383		0. 276886	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)			115, 161		6, 330, 402	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 001244		0. 027463	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

			T	o 12/31/2017	Date/Time Prep 5/30/2018 11:4	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(TOTAL PATIENT DAYS)	(MEALS SERVED)	
		LAUNDRY)		,		
GENERAL SERVICE COST CENTERS	7. 00	8. 00	9. 00	10.00	11. 00	
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00   00200   CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00   00500   ADMINISTRATIVE & GENERAL 7.00   00700   OPERATION OF PLANT	558, 499					5. 00 7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	2, 401	260, 539				8. 00
9. 00   00900   HOUSEKEEPI NG	5, 460	l	550, 638			9. 00
10. 00 01000 DI ETARY	6, 130	ł .	6, 130			10. 00
11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG   ADMI NI STRATI ON	16, 229 952	0	16, 229 952	0	1, 067	11.00
13. 00   01300   NURSI NG ADMINI STRATI ON 14. 00   01400   CENTRAL SERVI CES & SUPPLY	15, 450	0	15, 450	0	27 0	13. 00 14. 00
15. 00 01500 PHARMACY	7, 502	Ö	7, 502	o	51	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	940	0	940	0	4	16. 00
17. 00   01700   SOCI AL SERVI CE 19. 00   01900   NONPHYSI CI AN ANESTHETI STS	1, 074 0	0	1, 074	0	19 0	17. 00
19. 00   01900   NONPHYSICIAN ANESTHETISTS 21. 00   02100   I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	19. 00 21. 00
22. 00   02200   &R SERVI CES-OTHER PRGM COSTS APPRVD	Ö	Ö	Ö	o	Ö	22. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	202, 586	127, 529 10, 591			363	30.00
31.00   03100   INTENSIVE CARE UNIT 35.00   02060   NEONATAL INTENSIVE CARE UNIT	44, 651 39, 105		44, 651 39, 105		57 80	31. 00 35. 00
40. 00   04000   SUBPROVI DER -   PF	7, 309	1			20	40. 00
43. 00 04300 NURSERY	19, 996	1			26	43. 00
ANCILLARY SERVICE COST CENTERS	20.000	0.004	20.000			F0 00
50. 00   05000   OPERATING ROOM 51. 00   05100   RECOVERY ROOM	30, 833 17, 013		30, 833 17, 013		69 27	50. 00 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	49, 683	ł			64	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	10, 192	29, 643	10, 192	0	41	54. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C	10, 343	1		0	7	55. 00
57.00   05700   CT SCAN 58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	1, 363 5, 736	0	1, 363 5, 736	0	14  7	57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0,730	0	5, 730	0	0	59. 00
60. 00   06000   LABORATORY	5, 939	0	5, 939	0	2	60.00
64. 00 06400 I NTRAVENOUS THERAPY	7, 850	0	7, 850	0	4	64. 00
65. 00 06500 RESPI RATORY THERAPY	6, 425	0	6, 425	0	37	65. 00
66. 00   06600  PHYSI CAL THERAPY 67. 00   06700  OCCUPATI ONAL THERAPY	0	0	0	0	13 13	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	o o	Ö	Ö	o	3	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	1	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 570	0	1, 570	0	13	70.00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00   07200   IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
74. 00 07400 RENAL DIALYSIS	119		119		0	74. 00
76. 00   03330   ENDOSCOPY	8, 287				15	76. 00
76. 06   03954   IMAGING CENTER 76. 07   03955   BREAST DIAGNOSTIC CENTER	0	0	0	0	0	76. 06 76. 07
OUTPATIENT SERVICE COST CENTERS	0	0	0	<u> </u>	0	76.07
90. 00 09000 CLI NI C	0	0	0	0	0	90. 00
90. 26   04975   SPI NE CENTER	0		0	0	0	90. 26
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	28, 816	33, 082	28, 816	0	90	91. 00 92. 00
SPECIAL PURPOSE COST CENTERS						92.00
113. 00 11300   NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW - SNF						114. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	553, 954	260, 539	546, 093	83, 233	1, 067	118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 921	0	3, 921	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 HOME OFFICE 194. 06 07956 PAVILLIONS	0	0	0	0		194. 00 194. 06
194.08 07958 OTHER NRCC	624		624			194. 08
194. 10 07960 COMMUNITY REHAB HOSPITAL	0	0	0	0		194. 10
200.00 Cross Foot Adjustments						200.00
201.00   Negative Cost Centers 202.00   Cost to be allocated (per Wkst. B,	15, 663, 188	1, 076, 335	6, 253, 731	1, 638, 482	4, 128, 674	201. 00
Part I)	15,005,188	1,070,335	0, 200, 731	1, 030, 402	4, 120, 0/4	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	28. 045150	4. 131186	11. 357246	19. 685485	3, 869. 422680	203. 00

Health Fir	nancial Systems COMM	MUNITY HOSPITAL	OF INDIANA, IN	IC.	In Lie	eu of Form CMS-2	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der Co		Period: From 01/01/2017	Worksheet B-1	
					Γο 12/31/2017	Date/Time Pre 5/30/2018 11:	pared: 42 am_
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE FEET)	(TOTAL PATIENT	(MEALS SERVED)	
		(SQUARE FEET)	(POUNDS OF		DAYS)		
			LAUNDRY)				
		7. 00	8. 00	9. 00	10.00	11. 00	
204. 00	Cost to be allocated (per Wkst. B, Part II)	2, 279, 435	79, 517	273, 84	194, 128	507, 107	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	4. 081359	0. 305202	0. 49732	2. 332344	475. 264292	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS COMMUNITY HOSPITAL OF INDIANA, INC. In Lieu of Form CMS-2552-10 Provider CCN: 15-0169 Worksheet B-1 Peri od: From 01/01/2017 To 12/31/2017 

	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED REQUIS.)	RECORDS & LI BRARY	(TOTAL PATIENT	
		(DIRECT NURS.	(COSTED	KEQUI 3. )	(GROSS	DAYS)	
		`HRS.)	REQUIS.)		CHARGES)	ŕ	
12.5		13. 00	14. 00	15. 00	16. 00	17. 00	
	ENERAL SERVICE COST CENTERS					ı	1 00
	0100 CAP REL COSTS-BLDG & FIXT 0200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
1	0400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	0500 ADMINISTRATIVE & GENERAL						5. 00
	0700 OPERATION OF PLANT						7. 00
	0800 LAUNDRY & LINEN SERVICE						8. 00
1	0900 HOUSEKEEPI NG						9. 00
10.00 01	1000 DI ETARY						10. 00
	1100 CAFETERI A						11. 00
	1300 NURSING ADMINISTRATION	769					13. 00
1	1400 CENTRAL SERVI CES & SUPPLY	0	44, 955, 128				14. 00
	1500 PHARMACY	0	175, 388	_	1 252 271 775		15.00
	1600 MEDICAL RECORDS & LIBRARY 1700 SOCIAL SERVICE	0	327 1, 195	0	1, 352, 271, 775	83, 233	16. 00 17. 00
	1900 NONPHYSICIAN ANESTHETISTS	0	1, 143		0	03, 233	19.00
	2100 I &R SERVICES-SALARY & FRINGES APPRVD		0	o o	0		21. 00
	2200 I &R SERVICES-OTHER PRGM COSTS APPRVD		0	o	0	Ö	22. 00
_	NPATIENT ROUTINE SERVICE COST CENTERS	-1		- "			
30.00 03	3000 ADULTS & PEDIATRICS	363	2, 687, 528	0	155, 598, 274	55, 052	30. 00
	3100 INTENSIVE CARE UNIT	57	421, 173	0	21, 347, 624		31. 00
	2060 NEONATAL INTENSIVE CARE UNIT	80	506, 005		82, 780, 126		•
	4000 SUBPROVI DER - I PF	20	66, 983		7, 209, 375		•
	4300 NURSERY	26	148, 654	0	9, 708, 410	7, 547	43. 00
	NCILLARY SERVICE COST CENTERS	4.0	E 44.2		170 (22 072	1 0	FO 00
	5000 OPERATING ROOM 5100 RECOVERY ROOM	69	5, 463 624, 515		179, 622, 972 35, 348, 051		50. 00 51. 00
1	5200 DELIVERY ROOM & LABOR ROOM	64	369, 352		22, 787, 921		52.00
1	5400 RADI OLOGY-DI AGNOSTI C	0	531, 631	Ö	39, 816, 484		54. 00
	5500 RADI OLOGY-THERAPEUTI C		112, 459		27, 109, 094		55. 00
	5700 CT SCAN	O	4, 006		69, 379, 077		57. 00
58. 00 05	5800 MAGNETIC RESONANCE IMAGING (MRI)	o	10, 706	0	23, 887, 438	0	58. 00
59.00 05	5900 CARDI AC CATHETERI ZATI ON	o	0	0	2, 206, 059	0	59. 00
	6000 LABORATORY	0	1, 613, 996		118, 159, 395		60. 00
1	6400 I NTRAVENOUS THERAPY	0	4, 450		1, 209, 694		64. 00
1	6500 RESPI RATORY THERAPY	0	62, 871	0	26, 144, 674		65. 00
1	6600 PHYSI CAL THERAPY	0	174, 093		26, 778, 761		66.00
	6700 OCCUPATIONAL THERAPY 6800 SPEECH PATHOLOGY	0	21, 935 4, 700		7, 455, 444		67. 00 68. 00
	6900 ELECTROCARDI OLOGY	0	4, 700		2, 477, 919 9, 130, 621		69. 00
	7000 ELECTROENCEPHALOGRAPHY	0	190, 577	0	12, 921, 823		70.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS		18, 248, 537	-	82, 499, 342		71.00
	7200 I MPL. DEV. CHARGED TO PATIENTS	o	17, 480, 616		43, 848, 199		72. 00
	7300 DRUGS CHARGED TO PATIENTS	o	0		99, 329, 272		73. 00
74. 00 07	7400 RENAL DIALYSIS	0	8, 463	0	2, 708, 309	0	74. 00
	3330 ENDOSCOPY	0	88, 287		21, 490, 481	0	76. 00
	3954 I MAGI NG CENTER	0	144, 726		51, 819, 154		
	3955 BREAST DIAGNOSTIC CENTER	0	3, 581	0	12, 411, 554	0	76. 07
	JTPATIENT SERVICE COST CENTERS 9000 CLINIC	O	0	0	0	0	90. 00
	4975 SPI NE CENTER	0	6, 011	0	766, 280		90. 26
	9100 EMERGENCY	90	1, 156, 141		156, 319, 948		91. 00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	, ,	.,,		100/01///10		92. 00
	PECIAL PURPOSE COST CENTERS			! !			
113. 00 11	1300 INTEREST EXPENSE						113. 00
	1400 UTILIZATION REVIEW - SNF						114. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	769	44, 879, 163	13, 400, 035	1, 352, 271, 775	83, 233	118. 00
	ONREI MBURSABLE COST CENTERS		ام			1	
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	9100 RESEARCH 9200 PHYSICIANS'PRIVATE OFFICES	0	0 64, 990	0	0		191. 00 192. 00
	9300 NONPALD WORKERS	0	04, 990	0	0		193. 00
	7950 HOME OFFICE		0	0	0		194. 00
	7956 PAVI LLI ONS		4, 489	l o	0		194. 06
	7958 OTHER NRCC	0	6, 486		0		194. 08
	7960 COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194. 10
200. 00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	7, 863, 339	4, 252, 951	7, 241, 588	3, 711, 182	2, 464, 968	202. 00
203. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	10, 225. 408322	0. 094604	0. 540416	0. 002744	29. 615273	203 00
203.00	onit cost multiplier (WKSL D, Pail I)	10, 220. 400322	0. 094004	0. 540410	0.002744	27.0102/3	<sub>1</sub> 200.00

Heal th Fi	nancial Systems COMM	MUNITY HOSPITAL	OF INDIANA, IN	IC.	In Lie	eu of Form CMS-2	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					From 01/01/2017 To 12/31/2017		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUI S. )		(TOTAL PATIENT	
		(DI RECT NURS.	(COSTED		(GROSS	DAYS)	
		HRS. )	REQUIS.)		CHARGES)		
		13.00	14.00	15. 00	16. 00	17. 00	
204.00	Cost to be allocated (per Wkst. B, Part II)	209, 654	1, 962, 879	930, 09	104, 231	87, 742	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	272. 631990	0. 043663	0. 06941	0. 000077	1. 054173	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

In Lieu of Form CMS-2552-10
Worksheet B-1

Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/30/2018 11:42 am

2.00						5/30/2018 11:4	42 am_
ARSTHETISTS   176   17				INTERNS &	RESI DENTS		
ARSTHETISTS   176   17		Coot Conton Decemintion	MONDHIVELCLAN	CEDVI CEC CALAD	CEDVI CEC OTHER		
CASSIGNED   CASS		Cost Center Description					
TIMES   TIME							
19.00   21.00   22.00   22.00			,				
BIRKERAL SERVICE COST CENTERS							
1.00   1.00		GENERAL SERVICE COST CENTERS					
2.00	1.00						1.00
0.000   0.00	2.00						2. 00
1.00   00700   OPENATION OF PLANT	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
8.00   00900   LAUNDRY & LINEN SERVICE   9.00   10.00   01000   DETARY   10.00   11.	5.00	00500 ADMINISTRATIVE & GENERAL					5. 00
9.00 09900 HOUSEKEEPING 10.00 110.00 01000 DI ETARY 10.00 111.00 01100 DI ETARY 11.00 D	7.00	00700 OPERATION OF PLANT					7. 00
10.00   01000   DIETARY	8.00	00800 LAUNDRY & LINEN SERVICE					8. 00
11. 00   01000   CAFETERIA     11. 00   13. 00	9.00	00900 HOUSEKEEPI NG					9. 00
13.00   01300   NURSING AMMINISTRATION   14.00   114.00   01500   CENTRAL SERVICE CS & SUPPLY   14.00   116.00   01500   PHARMACY   15.00   15.00   15.00   16.00   16.00   EDICAL RECORDS & LIBRARY   16.00   17.00	10.00	01000 DI ETARY					10.00
14.00   01400   CENTRAL SERVICES & SUPPLY	11. 00	01100 CAFETERI A					11. 00
15.00   01500   PHARMACY							13. 00
16.00   01600   MEDICAL RECORDS & LIBRARY							14. 00
17. 00   01700   SOLIAL SERVICE     17. 00   1900   1000   000   00000000000000		1					15. 00
19. 00   01900   NOMPYSI CLIAN ANESTHETISTS   0   21. 00   2200   18F SERVI CES-SALARY & FRI NICES APPRVD   477   22. 00   2200   18F SERVI CES-SALARY & FRI NICES APPRVD   477   22. 00   2200   18F SERVI CES-SALARY & FRI NICES   20   367   367   30. 00							
21.00   02100   IAR SERVICES-SALARY & FRINCES APPRVD   477   22.00   220.00   220.00   RA SERVICES-OTHER PROM COSTS APPRVD   30.00   330.00   RESPICATION COSTS APPRVD   30.00   330.00   ASSESSED APPRVD   31.00   330.00   ASSESSED APPRVD   31.00   330.00		1 1					
22. 00			0				
INPATI ENT ROUTINE SERVICE COST CENTERS   30.00   33		1 1		477			
30.00   03000   ADULTS & PEDIATRIC S   0   367   367   367   30.00   31.00	22. 00				4//		22.00
331.00   03100   INTENSI VE CARE UNIT   0   0   0   0   31.00   35.00   02000   NEOMATA INTENSI VE CARE UNIT   0   0   0   0   0   40.00   04000   NUBSERY   F   F   0   0   0   0   40.00   04000   NUBSERY   F   F   0   0   0   0   40.00   A3000   NUSSERY   F   F   0   0   0   0   40.00   A3000   NUSSERY   F   F   0   0   0   0   40.00   A3000   NUSSERY   F   F   0   0   0   0   40.00   A3000   NUSSERY   F   F   0   0   0   0   40.00   ARCILLARY SERVICE COST CENTERS    50.00   GS000   OPERATI IN ROOM   0   0   0   0   51.00   05100   RECOVERY ROOM   0   0   0   0   52.00   05200   DELL VERY ROOM   LABOR ROOM   0   0   0   0   53.00   05500   DELL VERY ROOM   LABOR ROOM   0   0   0   0   54.00   05400   RADIOLICEY-IN EARDEUTI C   0   0   0   0   55.00   05500   RADIOLOCY-INERAPEUTI C   0   0   0   0   57.00   05700   CT SCAN   0   0   0   0   58.00   05800   MAGNETI C RESONANCE I IMGI NG (MRI )   0   0   0   59.00   05800   MAGNETI C RESONANCE I IMGI NG (MRI )   0   0   0   59.00   05800   MAGNETI C RESONANCE I IMGI NG (MRI )   0   0   0   60.00   06000   LABORATORY   0   0   0   0   60.00   06000   LABORATORY   0   0   0   60.00   06000   PH'SI CAL THERAPY   0   0   0   0   60.00   06000   PH'SI CAL THERAPY   0   0   0   60.00   06000   DELECTROCARDIOLOCY   0   0   60.00   0700   O   0700   O   60.00   0700   O   0   60.00   0700   O	00.00			0.7	0.7		00.00
35. 00   02000   NEDRONTO IDER - I I PF   0   0   0   0   0   0   0   0   0			_	367			
40.00   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000		1	0	0			
43.00   04300  NURSERY   0   0   0   0   0   0   0		1	0	0			
ANCILLARY SERVICE COST CENTERS							
50.00   05000   05000   05000   05000   051.00   050.00	43.00				U		43.00
51.00   05100   RECOVERY ROOM   0   0   0   0   0   51.00	50 00		1	1			50 00
52.00   05.200   DELIVERY ROOM & LABOR ROOM   0   0   0   52.00				1			
54.00   05500   RADI OLOCY-DI ACMOSTIC   0   0   0   55.00   05500   RADI OLOCY-DI ACMOSTIC   0   0   0   0   0   0   0   0   0							
55. 00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0   0   0   0   0   0				0	_		
57.00   05700   CT SCAN   0   0   0   0   0   57.00		1 1					
58. 00   05800   MAGNETIC RESONANCE IMAGING (MRI)   0   0   0   559. 00   59. 00   05900   CARDIAC CATHETRIZATION   0   0   0   0   60. 00   06000   LABORATORY   0   0   0   0   64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   65. 00   06500   RESPIRATORY THERAPY   0   0   0   0   66. 00   06500   RESPIRATORY THERAPY   0   0   0   0   66. 00   06500   RESPIRATORY THERAPY   0   0   0   0   67. 00   06700   OCCUPATI ONAL THERAPY   0   0   0   0   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   69. 00   06800   SPEECH PATHOLOGY   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   69. 00   07000   ELECTROCARDI OLOGY   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   74. 00   07400   RENAL DI ALYSIS   0   0   0   76. 00   03330   ENDOSCOPY   0   0   0   76. 00   03954   IMAGING CENTER   0   0   0   76. 00   03955   BREAST DI AGNOSTIC CENTER   0   0   0   76. 07   03955   BREAST DI AGNOSTIC CENTER   0   0   0   79. 00   09000   CLINIC   0   0   0   70. 00   09000   08ERGENCY   0   0   0   71. 00   09100   DRESERVATI ON BEDS (NON-DISTINCT PART)   92. 00   70. 00   09000   GIFT, FLOWER, SIMPLISING   0   0   0   70. 00   09000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   70. 00   09100   OBSERVATION BEDS (NON-DISTINCT PART)   0   70. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   70. 110. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   70. 110. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   70. 110. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   70. 110. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   70. 110. 00   19100   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   70. 110. 00   19100   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   70. 110. 00   19100   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   70. 110. 00							
59, 00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   0   0   0   0   0   0		1	0	0	_		
60. 00   06000   LABORATORY   0   0   0   0   0   0   0   0   0			0	0			
64. 00 06400 I NTRAVENOUS THERAPY 0 0 0 0 65. 00 65. 00 65. 00 6500 RESPI RATORY THERAPY 0 0 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 67. 00 67. 00 67. 00 67. 00 66. 00 0 68. 00 0 68. 00 0 68. 00 0 68. 00 0 68. 00 0 68. 00 0 68. 00 0 68. 00 0 68. 00 0 69. 00 0 0 0 0 0 0 0 68. 00 0 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0			
65. 00   06500   RESPI RATORY THERAPY   0   0   0   0   65. 00   66. 00   06600   06700   06CUPATI ONAL THERAPY   0   0   0   0   0   67. 00   06700   06CUPATI ONAL THERAPY   0   0   0   0   0   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   69. 00   07000   ELECTROCARDI OLOGY   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   76. 00   03935   IMAGI NG CENTER   0   0   0   0   76. 00   03955   IMAGI NG CENTER   0   0   0   76. 07   03955   BREAST DI AGNOSTIC CENTER   0   0   0   79. 00   09000   CLINIC   79. 00   09000   CLINIC   0   0   0   79. 20   09000   OSSERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   79. 13. 00   11400   UTI LI ZATI ON REVI EW - SNF   114. 00   118. 00   SUBTOTALS (SUM OF LI NES ) THOUGH 117)   0   477   477   118. 00   119. 00   19000   GESEARCH   0   0   0   0   191. 00   19000   RESEARCH   0   0   0   0   192. 00   192. 00   PLYSI CI ANS' PRI VATE OFFICES   0   0   191. 00   192. 00   PLYSI CI ANS' PRI VATE OFFICES   0   0   192. 00   193. 00   192. 00   194. 00   192. 00   195. 00   192. 00   195. 00   192. 00   195. 00   192. 00   195. 00   192. 00   195. 00   192. 00   195. 00   192. 00   195. 00   192. 00   195. 00   192. 00   195. 00   192. 00   195. 00   192. 00   195. 00   192. 00			0	0			
66. 00			0	0			
67. 00   06700   0CCUPATIONAL THERAPY   0   0   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   68. 00   06900   SPEECH PATHOLOGY   0   0   0   0   0   0   0   0   0			0	Ö			
68. 00   06800   SPEECH PATHOLOGY   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   73. 00   07300   DRIGS CHARGED TO PATI ENTS   0   0   0   74. 00   07400   RENAL DI ALYSI S   0   0   0   76. 00   07400   RENAL DI ALYSI S   0   0   0   76. 00   03330   ENDOSCOPY   0   0   0   76. 00   03955   BREAST DI AGNOSTI C CENTER   0   0   0   76. 07   03955   BREAST DI AGNOSTI C CENTER   0   0   0   76. 07   04775   SPI NE CENTER   0   0   0   79. 00   09000   CLI NI C   0   0   79. 20   04975   SPI NE CENTER   0   0   0   79. 20   09490   BMERGENCY   0   17   17   79. 20   09200   DBSERVATI ON BEDS (NON-DI STI NCT PART)   79. 20   09200   DBSERVATI ON BEDS (NON-DI STI NCT PART)   79. 20   09100   INTEREST EXPENSE   114. 00   114. 00   11400   UTI LI ZATI ON REVIEW - SNF   113. 00   SUBTOTALS (SUM OF LI NES 1 through 117)   0   477   477   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GI FT. FLOWER, COFFEE SHOP & CANTEEN   0   0   0   191. 00   19100   RESEARCH   0   0   0   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   0   192. 00   19200   19200   0   0   192. 00   1920		1	0	0	0		67.00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 70. 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 70. 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 70. 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 72. 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 72. 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 73. 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 74. 00 76. 00 0 76. 00 0 76. 00 0 76. 00 0 76. 00 0 76. 00 0 76. 00 0 76. 00 0 76. 00 0 76. 00 0 76. 00 0 0 76. 00 0 0 76. 00 0 0 76. 00 0 0 0 76. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	68.00	1 1	0	0	0		68. 00
71. 00	69.00	06900 ELECTROCARDI OLOGY	0	0	0		69. 00
72. 00	70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 7300 DRUGS CHARGED TO PATIENTS 0 0 0 0 74. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 74. 00 76. 06 03330 ENDOSCOPY 0 0 0 0 0 0 76. 06 03954 I MAGI NG CENTER 0 0 0 0 0 0 76. 06 76. 07 03955 BREAST DI AGNOSTI C CENTER 0 0 0 0 0 0 76. 06 76. 07 00179ATIENT SERVI CE COST CENTERS 0 0 0 0 0 0 90. 00 90	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71. 00
74. 00	72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
76. 00			0	0	0		73. 00
76. 06	74.00	07400 RENAL DIALYSIS	0	0	0		74. 00
76. 07 03955 BREAST DI AGNOSTI C CENTER 0 0 0 0 76. 07  OUTPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 0 0 0 0 90. 00  90. 26 04975 SPI NE CENTER 0 0 0 0 90. 26  91. 00 09100 EMERGENCY 0 17 17 91. 00  92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00  SPECIAL PURPOSE COST CENTERS  113. 00 11300 I NTEREST EXPENSE 113. 00  114. 00 11400 UTI LI ZATI ON REVI EW - SNF 114. 00  NONREI MBURSABLE COST CENTERS  190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 19100 RESEARCH 0 0 0 0 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 192. 00  191. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 192. 00			0	0	0		76. 00
OUTPATIENT SERVICE COST CENTERS   O			0	0	0		76. 06
90. 00   09000   CLINIC   0   0   0   0   0   90. 00   90. 26   04975   SPINE CENTER   0   0   0   0   0   0   90. 26   91. 00   09100   EMERGENCY   0   17   17   17   91. 00   92. 00   SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   114. 00   11400   UTI LI ZATI ON REVIEW - SNF   114. 00   SUBTOTALS (SUM OF LINES 1 through 117)   0   477   477   477   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   191. 00   19100   RESEARCH   0   0   0   0   191. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   0   0   192. 00   192.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   0   192. 00   192.00   19	76. 07		0	0	0		76. 07
90. 26							
91. 00				1			
92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   92. 00   SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   114. 00   11400   UTI LI ZATI ON REVI EW - SNF   114. 00   SUBTOTALS (SUM OF LINES 1 through 117)   0   477   477   118. 00   NONREI MBURSABLE COST CENTERS   119. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   19100   RESEARCH   0   0   0   0   19100   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   0   0   192. 00   192. 00   19200			_	1			
SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   113. 00   11400   UTI LI ZATI ON REVIEW - SNF   114. 00   11400   SUBTOTALS (SUM OF LINES 1 through 117)   0   477   477   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   19100   RESEARCH   0   0   0   0   19100   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   0   0   192. 00   19200			0	17	17		
113. 00 11300   INTEREST EXPENSE 114. 00 11400   UTI LI ZATI ON REVI EW - SNF 118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   O	92. 00						92.00
114. 00	440.00			I			440.00
118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   0   477   477   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   191. 00   191. 00   192. 00							
NONREI MBURSABLE COST CENTERS           190. 00         19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         190. 00           191. 00         19100 RESEARCH         0         0         0         191. 00           192. 00         19200 PHYSI CI ANS' PRI VATE OFFI CES         0         0         0         192. 00				477	477		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 191. 00 191. 00 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 192. 00	118.00			4//	4//		118.00
191. 00   19100   RESEARCH 0 0 0 0 192. 00   1	100 00						100 00
192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 192. 00			0	0			
192. 00 19200 PHTSI CLANS PRIVATE OFFICES   0  0  0  1192. 00			0	0			
193. 00 19300 NONPALD WORKERS 0 0 0 193. 00			0		0		193. 00
							193.00
							194. 00
							194. 08
							194. 10
							200.00
							201.00
			0	469, 017	848, 585		202.00
Part 1)	00			.57,517	3.5,500		
		· · · · · · · · · · · · · · · · · · ·	•	•		'	·

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169 | Period: From 01/01/2017 | To 12/31/2017 | Date/Time Prepared:

				''	0 12/31/201/	5/30/2018 11:	
			INTERNS &	RESI DENTS			
	Cost Center Description	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME)	SERVI CES-SALAR Y & FRI NGES (ASSI GNED TI ME)	SERVI CES-OTHER PRGM COSTS (ASSI GNED TI ME)			
		19. 00	21. 00	22. 00			
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	983. 264151	1, 779. 004193			203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	0	10, 088	18, 251			204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	21. 148847	38. 262055			205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0169 Peri od: Worksheet C From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/30/2018 11:42 am Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 69.707.847 69.707.847 69, 707, 847 03100 INTENSIVE CARE UNIT 11, 331, 242 11, 331, 242 0 11, 331, 242 31.00 31.00 02060 NEONATAL INTENSIVE CARE UNIT o 35.00 15, 257, 423 15, 257, 423 15, 257, 423 35.00 04000 SUBPROVI DER - I PF 40.00 1, 712, 356 1, 712, 356 0 1, 712, 356 40.00 04300 NURSERY 43.00 5, 623, 344 5, 623, 344 5, 623, 344 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 16, 631, 510 16, 631, 510 16, 631, 510 50.00 0 05100 RECOVERY ROOM 5, 510, 832 5, 510, 832 51 00 5, 510, 832 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 13, 828, 402 13, 828, 402 13, 828, 402 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 7, 480, 278 7, 480, 278 0 0 0 7, 480, 278 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 2, 276, 975 2, 276, 975 2, 276, 975 55.00 2, 293, 562 05700 CT SCAN 2, 293, 562 57.00 2, 293, 562 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 2, 939, 243 2, 939, 243 2, 939, 243 58.00 05900 CARDIAC CATHETERIZATION 59.00 477, 309 477, 309 0 0 0 0 0 477, 309 59.00 06000 LABORATORY 12, 108, 806 12, 108, 806 60 00 12 108 806 60 00 64.00 06400 I NTRAVENOUS THERAPY 1, 029, 476 1, 029, 476 1, 029, 476 64.00 65.00 06500 RESPIRATORY THERAPY 5, 313, 329 5, 313, 329 5, 313, 329 65.00 66.00 06600 PHYSI CAL THERAPY 7, 854, 361 7, 854, 361 7, 854, 361 66.00 06700 OCCUPATIONAL THERAPY 2, 058, 436 2, 058, 436 0 2, 058, 436 67 00 67 00 0 68.00 06800 SPEECH PATHOLOGY 444, 276 444, 276 444, 276 68.00 69.00 06900 ELECTROCARDI OLOGY 170, 243 170, 243 0 0 0 0 0 0 170, 243 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 2 683 602 2 683 602 2 683 602 70 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 25, 254, 082 25, 254, 082 25, 254, 082 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 21, 734, 661 21, 734, 661 21, 734, 661 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 25, 202, 333 25, 202, 333 25, 202, 333 73.00 07400 RENAL DIALYSIS 74 00 1 229 738 1, 229, 738 1, 229, 738 74 00 76.00 03330 ENDOSCOPY 3, 081, 924 3, 081, 924 3, 081, 924 76.00 03954 I MAGING CENTER 4, 061, 862 4, 061, 862 0 4, 061, 862 76.06 76.06 76.07 03955 BREAST DIAGNOSTIC CENTER 6, 476, 928 6, 476, 928 0 6, 476, 928 76.07 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 0 04975 SPINE CENTER 0 90.26 356, 662 356, 662 356, 662 90.26 91.00 09100 EMERGENCY 15, 955, 849 15, 955, 849 ol 15, 955, 849 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 6, 924, 691 6, 924, 691 92.00 6, 924, 691 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVI EW - SNF 114.00 297, 011, 582 200. 00 200.00 Subtotal (see instructions) 297, 011, 582 0 297, 011, 582 0 201.00 Less Observation Beds 6, 924, 691 6, 924, 691 6, 924, 691 201. 00 202.00 Total (see instructions) 290, 086, 891 290, 086, 891 290, 086, 891 202. 00

202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0169 Peri od: Worksheet C From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/30/2018 11:42 am Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 146, 027, 168 146, 027, 168 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 21, 347, 624 21, 347, 624 31.00 02060 NEONATAL INTENSIVE CARE UNIT 82, 780, 126 82, 780, 126 35.00 35.00 04000 SUBPROVIDER - IPF 40.00 7, 209, 375 7, 209, 375 40.00 04300 NURSERY 9, 708, 410 43.00 9, 708, 410 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 124, 614, 375 55 008 597 179, 622, 972 0.092591 0.000000 50.00 05100 RECOVERY ROOM 20, 106, 870 15, 241, 181 35, 348, 051 0.155902 0.000000 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.606830 0.000000 52 00 22, 787, 921 22, 787, 921 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 10, 959, 566 28, 856, 918 39, 816, 484 0.187869 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 12, 042, 912 15, 066, 182 27, 109, 094 0.083993 0.000000 55.00 05700 CT SCAN 48, 197, 426 69, 379, 077 21, 181, 651 0.033058 0.000000 57.00 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 5, 044, 790 18, 842, 648 23, 887, 438 0.123046 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 2, 206, 059 2, 206, 059 0. 216363 0.000000 59.00 60.00 06000 LABORATORY 72, 246, 799 45, 912, 596 118, 159, 395 0.102479 0.000000 60.00 |06400| I NTRAVENOUS THERAPY 1.066.795 142, 899 1, 209, 694 0.851022 0.000000 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 23, 998, 890 2, 145, 784 26, 144, 674 0. 203228 0.000000 65.00 06600 PHYSI CAL THERAPY 5, 719, 926 21, 058, 835 26, 778, 761 0. 293306 0.000000 66.00 66.00 06700 OCCUPATIONAL THERAPY 4, 808, 659 2, 646, 785 7, 455, 444 0. 276098 0.000000 67.00 67.00 06800 SPEECH PATHOLOGY 2, 477, 919 0. 179294 68.00 1, 624, 975 852, 944 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 7, 710, 266 1, 420, 355 9, 130, 621 0.018645 0.000000 69.00 12, 921, 823 70.00 07000 ELECTROENCEPHALOGRAPHY 861, 812 12, 060, 011 0.207680 0.000000 70.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 60 368 874 22, 130, 468 82, 499, 342 0.306113 0.000000 71 00 07200 I MPL. DEV. CHARGED TO PATIENTS 43, 848, 199 72.00 37, 425, 261 6, 422, 938 0.495680 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 70, 880, 258 28, 449, 014 99, 329, 272 0. 253725 0.000000 73.00 74.00 07400 RENAL DIALYSIS 2, 708, 309 2, 708, 309 0.454061 0.000000 74.00 03330 ENDOSCOPY 17, 103, 559 21, 490, 481 0.143409 76.00 4, 386, 922 0.000000 76.00 76.06 03954 I MAGING CENTER 315, 140 51, 504, 014 51, 819, 154 0.078385 0.000000 76.06 03955 BREAST DIAGNOSTIC CENTER 76.07 24, 251 12, 387, 303 12, 411, 554 0. 521847 0.000000 76.07 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0.000000 0.000000 90.00 90. 26 04975 SPINE CENTER 0 766, 280 766, 280 0.465446 0.000000 90. 26 91.00 09100 EMERGENCY 32, 863, 173 123, 456, 775 156, 319, 948 0.102072 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 7, 919, 589 9, 571, 106 0.723500 0.000000 92.00 92 00 1, 651, 517 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW - SNF 114.00 537, 593, 101 1, 352, 271, 775 200.00 814, 678, 674 200. 00 Subtotal (see instructions) 201.00 Less Observation Beds 201. 00

814, 678, 674

537, 593, 101 1, 352, 271, 775

202.00

Total (see instructions)

Cost Center Description				10 12/31/2017	5/30/2018 11: 42 am
INPATIENT ROUTINE SERVICE COST CENTERS   11.00			Title XVIII	Hospi tal	
INPATIENT ROUTINE SERVICE COST CENTERS   30.00   030000 AUIDETS & PEDIATRI CS   31.00   31.0	Cost Center Description	PPS Inpatient		<u> </u>	
INPATIENT ROUTINE SERVICE COST CENTERS   30.00   31.		Ratio			
30. 00   030000   ADULTS & PEDI ATRI CS   31. 00   31. 00   310.		11.00			
31.00   O3100   INTENSIVE CARE UNIT	INPATIENT ROUTINE SERVICE COST CENT	ERS			
35. 00   20200   NEONATAL INTENSIVE CARE UNIT	30. 00 03000 ADULTS & PEDIATRICS				30.00
A0, 00   0.0000   SUBPROVIDER - I PF   40, 00	31.00 03100 INTENSIVE CARE UNIT				31. 00
A3. 00   OA300 NURSERY	35.00 02060 NEONATAL INTENSIVE CARE UNIT				35. 00
ANCILLARY SERVICE COST CENTERS   50.00	40. 00   04000   SUBPROVI DER - I PF				40. 00
50.00   050000   050000   050000   050000   050000   050000   050000   05000	43. 00   04300 NURSERY				43.00
S1 00   05100   RECOVERY ROOM   0.155902   0.5200   DELIVERY ROOM & LABOR ROOM   0.606830   52.00   0.5200   DELIVERY ROOM & LABOR ROOM   0.606830   52.00   0.5200   DELIVERY ROOM & LABOR ROOM   0.606830   55.00   0.5500   RADI OLOGY-DI AGNOSTI C   0.083993   55.00   0.5500   RADI OLOGY-DI AGNOSTI C   0.083993   55.00   0.5500   RADI OLOGY-THERAPEUTI C   0.083993   55.00   0.5800   MAGNETI C RESONANCE I MAGI NG (MRI )   0.123046   58.00   0.5900   CARDIA C CATHETERI ZATI ON   0.123046   58.00   0.5900   CARDIA C CATHETERI ZATI ON   0.102479   60.00   0.6000   LABORATORY   0.102479   60.00   0.6000   LABORATORY   0.102479   60.00   0.6000   CARDIA C ATTORY THERAPY   0.851022   66.00   0.6000   RESPI RATORY THERAPY   0.293306   66.00   0.6000   RESPI RATORY THERAPY   0.293306   66.00   0.6000   RESPI RATORY THERAPY   0.293306   66.00   0.6000   CELECTROCARDI OLOGY   0.179294   68.00   0.6000   SPEECH PATHOLOGY   0.179294   68.00   0.6000   CELECTROCARDI OLOGY   0.179294   68.00   0.6000   CELECTROCARDI OLOGY   0.179294   68.00   0.6000   CELECTROCARDI OLOGY   0.18645   67.00   0.7000   0.7000   CELECTROCARDI OLOGY   0.18645   67.00   0.7100   CELECTROCARDI OLOGY   0.18645   67.00   0.7100   CELECTROCARDI OLOGY   0.18645   70.00   0.7000   CELECTROCARDI OLOGY   0.18645   70.00   0.7000   CELECTROCARDI OLOGY   0.184409   70.00   0.7000   0.7000   CELECTROCARDI OLOGY   0.184409   70.00   0.7000   0.	ANCILLARY SERVICE COST CENTERS				
S2.00   05200   0521   VERY ROOM & LABOR ROOM   0.606830   52.00   05400   RADI OLOGY-DI AGNOSTIC   0.187869   54.00   05500   RADI OLOGY-DI AGNOSTIC   0.083993   55.00   05500   RADI OLOGY-THERAPEUTIC   0.083993   55.00   05500   RADI OLOGY-THERAPEUTIC   0.083993   57.00   05700   CT SCAN   0.033058   57.00   05900   CARDI AC CATHETERI ZATI ON   0.216363   59.00   05000   CARDI AC CATHETERI ZATI ON   0.216363   59.00   06000   LABORATORY   0.102479   60.00   06000   LABORATORY   0.102479   60.00   06000   CABORATORY   0.102479   60.00   06000   CABORATORY   0.203228   65.00   06500   RESPI RATORY THERAPY   0.203228   65.00   06500   RESPI RATORY THERAPY   0.203228   65.00   06000   PHYSI CAL THERAPY   0.293306   66.00   06000   PHYSI CAL THERAPY   0.276098   66.00   06000   PHYSI CAL THERAPY   0.276098   67.00   06000   CUCUPATI ONAL THERAPY   0.276098   67.00   06000   ELECTROCARDI OLOGY   0.179294   68.00   06000   ELECTROCARDI OLOGY   0.179294   68.00   07000   0ELECTROCARDI OLOGY   0.18645   69.00   07000   0ELECTROCARDI OLOGY   0.18645   69.00   07000   07000   ELECTROCARDI OLOGY   0.18645   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.253725   73.00   07300   DRUGS	50. 00 05000 OPERATING ROOM	0. 092591			50.00
54.00   05400   RADI OLOGY-DI AGNOSTI C   0. 187869   55.00   05500   RADI OLOGY-THERAPEUTI C   0. 083993   55.00   05700   CT SCAN   0. 033058   57.00   05700   CT SCAN   0. 034058   57.00   05700   CT SCAN   0. 0216363   59.00   05900   CARDIAC CATHETERI ZATI ON   0. 216363   59.00   06000   LABORATORY   0. 102479   0. 00500   06500   RESPI RATORY THERAPY   0. 203228   065.00   06500   RESPI RATORY THERAPY   0. 203228   065.00   06500   RESPI RATORY THERAPY   0. 203228   065.00   06500   RESPI RATORY THERAPY   0. 293306   06.00   06600   PHYSI CAL THERAPY   0. 293306   06.00   06600   06600   PHYSI CAL THERAPY   0. 276098   067.00   06900   ELECTROCARDI OLOGY   0. 179294   0. 06900   ELECTROCARDI OLOGY   0. 179294   0. 06900   ELECTROCARDI OLOGY   0. 018645   0. 07000   06900   ELECTROCARDI OLOGY   0. 018645   0. 07000   07000   ELECTROCARDI OLOGY   0. 018645   0. 07000   07000   ELECTROCARDI OLOGY   0. 018645   0. 07000   07000   ELECTROCARDI OLOGY   0. 07000   07000   ELECTROCARDI OLOGY   0. 07000   07000   ELECTROCARDI OLOGY   0. 07000   07000	51.00   05100   RECOVERY ROOM	0. 155902			51. 00
55. 00     05500 RADI OLOGY-THERAPEUTI C     0.083993     55. 00       57. 00     05700 CT S CAN     0.033058     57. 00       58. 00     05800 MAGNETI C RESONANCE IMAGING (MRI)     0.123046     58. 00       59. 00     05900 CARDIAC CATHETERIZATION     0.216363     59. 00       64. 00     06000 LABORATORY     0.102479     60. 00       65. 00     06000 LABORATORY     0.851022     64. 00       65. 00     06000 LABORATORY     0.293228     65. 00       66. 00     06600 PHYSI CAL THERAPY     0.293228     65. 00       67. 00     06700 OCCUPATI ONAL THERAPY     0.293306     66. 00       68. 00     06800 SPEECH PATHOLOGY     0.179294     68. 00       69. 00     06900 ELECTROCARDI OLOGY     0.179294     68. 00       70. 00     07000 ELECTROCARDI OLOGY     0.18645     69. 00       70. 00     07000 ELECTROCARDI OLOGY     0.18645     69. 00       70. 00     07000 MPLI CAL SUPPLIES CHARGED TO PATI ENTS     0.306113     71. 00       72. 00     07200 IMPL DEV. CHARGED TO PATI ENTS     0.253725     72. 00       73. 00     07300 DRUGS CHARGED TO PATI ENTS     0.253725     73. 00       76. 07     093954 IMAGI NG CENTER     0.76385     76. 00       76. 07     093954 IMAGI NG CENTER	52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 606830			52. 00
57.00   05700   CT SCAN   0.033058   57.00	54. 00   05400 RADI OLOGY-DI AGNOSTI C	0. 187869			54. 00
SB 00   05800   MAGNETI C RESONANCE I MAGING (MRI )   0. 123046   59. 00   05900   CARDI AC CATHETERI ZATI ON   0. 216363   59. 00   06000   LABORATORY   0. 102479   66. 00   06000   LABORATORY   0. 851022   64. 00   06400   INTRAVENOUS THERAPY   0. 203228   65. 00   06500   RESPIRATORY THERAPY   0. 203228   65. 00   06600   PHYSI CAL THERAPY   0. 293306   67. 00   06600   PHYSI CAL THERAPY   0. 293306   67. 00   06600   PHYSI CAL THERAPY   0. 293306   67. 00   06600   PHYSI CAL THERAPY   0. 276098   67. 00   06600   PHYSI CAL THERAPY   0. 276098   67. 00   06600   EECTROCARDI OLOGY   0. 179294   68. 00   06800   SELECTROCARDI OLOGY   0. 018645   69. 00   07000   ELECTROCARDI OLOGY   0. 018645   69. 00   07100   ELECTROCARDI OLOGY   0. 018645   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 306113   71. 00   07300   RUBLO ELECTROCARDI CALLOR ELECTROCARDI OLOGY   0. 018645   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 495680   72. 00   07300   RUBLO ELACTROCARDI CALLOR ELACTROCARDI CALL	55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 083993			55. 00
SB 00   05800   MAGNETI C RESONANCE I MAGING (MRI )   0. 123046   59. 00   05900   CARDI AC CATHETERI ZATI ON   0. 216363   59. 00   06000   LABORATORY   0. 102479   66. 00   06000   LABORATORY   0. 851022   64. 00   06400   INTRAVENOUS THERAPY   0. 203228   65. 00   06500   RESPIRATORY THERAPY   0. 203228   65. 00   06600   PHYSI CAL THERAPY   0. 293306   67. 00   06600   PHYSI CAL THERAPY   0. 293306   67. 00   06600   PHYSI CAL THERAPY   0. 293306   67. 00   06600   PHYSI CAL THERAPY   0. 276098   67. 00   06600   PHYSI CAL THERAPY   0. 276098   67. 00   06600   EECTROCARDI OLOGY   0. 179294   68. 00   06800   SELECTROCARDI OLOGY   0. 018645   69. 00   07000   ELECTROCARDI OLOGY   0. 018645   69. 00   07100   ELECTROCARDI OLOGY   0. 018645   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 306113   71. 00   07300   RUBLO ELECTROCARDI CALLOR ELECTROCARDI OLOGY   0. 018645   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 495680   72. 00   07300   RUBLO ELACTROCARDI CALLOR ELACTROCARDI CALL	57. 00 05700 CT SCAN	0. 033058			57. 00
59.00   05900   CARDIAC CATHETERIZATION   0.216363   59.00					58. 00
64. 00   06400   NTRAVENOUS THERAPY   0. 851022   64. 00   06500   RESPI RATORY THERAPY   0. 203228   65. 00   06500   RESPI RATORY THERAPY   0. 203228   65. 00   06600   PHYSI CAL THERAPY   0. 276098   66. 00   06600   PHYSI CAL THERAPY   0. 276098   67. 00   06700   0CCUPATI ONAL THERAPY   0. 276098   67. 00   06900   DELECTROCARDI OLOGY   0. 1779294   68. 00   06900   ELECTROCARDI OLOGY   0. 179294   0. 207680   70. 00   07000   ELECTROENCEPHALOGRAPHY   0. 207680   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATIENTS   0. 306113   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 495680   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 495680   72. 00   07300   DRUGS CHARGED TO PATIENTS   0. 253725   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 253725   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 454061   74. 00   74					59.00
65. 00   06500   RESPI RATORY THERAPY   0. 203228   65. 00   66. 00   06600   PHYSI CAL THERAPY   0. 293306   66. 00   67. 00   06700   0CUPATI ONAL THERAPY   0. 276098   67. 00   67. 00   06700   0CUPATI ONAL THERAPY   0. 179294   68. 00   68. 00   06800   SPEECH PATHOLOGY   0. 179294   68. 00   06900   ELECTROCARDI OLOGY   0. 018645   69. 00   07. 00	60. 00 06000 LABORATORY	0. 102479			60.00
66. 00   06600   PHYSI CAL THERAPY   0. 293306   66. 00   06700   0CCUPATI ONAL THERAPY   0. 276098   67. 00   06700   0CCUPATI ONAL THERAPY   0. 276098   67. 00   06900   06900   ELECTROCARDI OLOGY   0. 018645   69. 00   06900   ELECTROCARDI OLOGY   0. 018645   69. 00   07000   ELECTROCARDI OLOGY   0. 0207680   70. 00   07000   ELECTROCEPHALOGRAPHY   0. 207680   71. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 306113   71. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 495680   72. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 253725   73. 00   07400   RENAL DI ALYSI S   0. 454061   74. 00   07400   RENAL DI ALYSI S   0. 454061   76. 00   03305   ENDOSCOPY   0. 143409   76. 00   03955   BREAST DI AGNOSTI C CENTER   0. 078385   76. 00   03955   BREAST DI AGNOSTI C CENTER   0. 521847   76. 07   00900   CLI NI C   0. 000000   090. 00   09000   CLI NI C   0. 000000   090. 00   09000	64. 00 06400 I NTRAVENOUS THERAPY	0. 851022			64. 00
66. 00   06600   PHYSI CAL THERAPY   0. 293306   66. 00   06700   0CCUPATI ONAL THERAPY   0. 276098   67. 00   06700   0CCUPATI ONAL THERAPY   0. 276098   67. 00   06900   06900   ELECTROCARDI OLOGY   0. 018645   69. 00   06900   ELECTROCARDI OLOGY   0. 018645   69. 00   07000   ELECTROCARDI OLOGY   0. 0207680   70. 00   07000   ELECTROCEPHALOGRAPHY   0. 207680   71. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 306113   71. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 495680   72. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 253725   73. 00   07400   RENAL DI ALYSI S   0. 454061   74. 00   07400   RENAL DI ALYSI S   0. 454061   76. 00   03305   ENDOSCOPY   0. 143409   76. 00   03955   BREAST DI AGNOSTI C CENTER   0. 078385   76. 00   03955   BREAST DI AGNOSTI C CENTER   0. 521847   76. 07   00900   CLI NI C   0. 000000   090. 00   09000   CLI NI C   0. 000000   090. 00   09000	65. 00 06500 RESPIRATORY THERAPY	0. 203228			65. 00
68. 00	l l	1			66. 00
69. 00 06900   ELECTROCARDI OLOGY	67. 00 06700 OCCUPATI ONAL THERAPY	0. 276098			67. 00
69. 00 06900   ELECTROCARDI OLOGY	68. 00 06800 SPEECH PATHOLOGY	0. 179294			68. 00
71. 00	69. 00 06900 ELECTROCARDI OLOGY	0. 018645			69. 00
72. 00	70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 207680			70. 00
73. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PA	ATI ENTS 0. 306113			71. 00
74. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 495680			72. 00
76. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 253725			73. 00
76. 06 03954 IMAGING CENTER 0. 078385 76. 07 03955 BREAST DI AGNOSTI C CENTER 0. 521847 76. 07 00000 CLI NI C 0. 000000 CLI NI C 0. 465446 90. 26 04975 SPI NE CENTER 0. 465446 90. 26 09100 EMERGENCY 0. 102072 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 723500 992. 00 09200 COST CENTERS 113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW - SNF 200. 00 Less Observati on Beds 201. 00 201. 00 Less Observation Beds 201. 00 201.	74. 00 07400 RENAL DIALYSIS	0. 454061			74. 00
76. 07 03955 BREAST DI AGNOSTI C CENTER 0. 521847  90. 00 90. 00 90. 00 90. 26 04975 SPI NE CENTER 0. 465446 91. 00 992. 00 99	76. 00 03330 ENDOSCOPY	0. 143409			76. 00
OUTPATIENT SERVICE COST CENTERS   O   000000   O   00000   O   00000   O   00000   O   00000   O   00000   O   00000   O   000000   O   0000000   O   0000000   O   0000000   O   00000000	76.06 03954 I MAGI NG CENTER	0. 078385			76. 06
OUTPATIENT SERVICE COST CENTERS   O   000000   O   00000   O   00000   O   00000   O   00000   O   00000   O   00000   O   000000   O   0000000   O   0000000   O   0000000   O   00000000	76. 07 03955 BREAST DIAGNOSTIC CENTER	0. 521847			76. 07
90. 26	OUTPATIENT SERVICE COST CENTERS				
91. 00	90. 00 09000 CLINIC	0. 000000			90.00
92. 00	90. 26  04975   SPI NE CENTER	0. 465446			90. 26
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   114.00   11400   UTILIZATION REVIEW - SNF   114.00   200.00   Subtotal (see instructions)   200.00   201.00   Less Observation Beds   201.00	91. 00  09100 EMERGENCY	0. 102072			91.00
113.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT	F PART) 0. 723500			92. 00
114.00 11400 UTILIZATION REVIEW - SNF 200.00 Subtotal (see instructions) 201.00 Less Observation Beds 114.00 201.0	SPECIAL PURPOSE COST CENTERS				
200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 200.00	113. 00 11300 I NTEREST EXPENSE				113. 00
201.00 Less Observation Beds 201.00	114.00 11400 UTILIZATION REVIEW - SNF				114. 00
	200.00 Subtotal (see instructions)				200. 00
202.00 Total (see instructions) 202.00	201.00 Less Observation Beds				201. 00
	202.00 Total (see instructions)				202. 00

Provider CCN: 15-0169

Peri od:

COMPUTATION OF RATIO OF COSTS TO CHARGES

From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/30/2018 11:42 am Title XIX Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30 00 03000 ADULTS & PEDIATRICS 69.707.847 69.707.847 69, 707, 847 03100 INTENSIVE CARE UNIT 11, 331, 242 11, 331, 242 0 11, 331, 242 31.00 31.00 02060 NEONATAL INTENSIVE CARE UNIT o 35.00 15, 257, 423 15, 257, 423 15, 257, 423 35.00 04000 SUBPROVI DER - I PF 40.00 1, 712, 356 1, 712, 356 0 1, 712, 356 40.00 04300 NURSERY 43.00 5, 623, 344 5, 623, 344 5, 623, 344 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 16, 631, 510 16, 631, 510 16, 631, 510 50.00 0 05100 RECOVERY ROOM 5, 510, 832 5, 510, 832 51 00 5, 510, 832 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 13, 828, 402 13, 828, 402 13, 828, 402 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 7, 480, 278 7, 480, 278 0 0 0 7, 480, 278 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 2, 276, 975 2, 276, 975 2, 276, 975 55.00 2, 293, 562 05700 CT SCAN 2, 293, 562 57.00 2, 293, 562 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 2, 939, 243 2, 939, 243 2, 939, 243 58.00 05900 CARDIAC CATHETERIZATION 59.00 477, 309 477, 309 0 0 0 0 0 477, 309 59.00 06000 LABORATORY 12, 108, 806 12, 108, 806 60 00 12 108 806 60 00 64.00 06400 I NTRAVENOUS THERAPY 1, 029, 476 1, 029, 476 1, 029, 476 64.00 65.00 06500 RESPIRATORY THERAPY 5, 313, 329 5, 313, 329 5, 313, 329 65.00 66.00 06600 PHYSI CAL THERAPY 7, 854, 361 7, 854, 361 7, 854, 361 66.00 06700 OCCUPATIONAL THERAPY 2, 058, 436 2, 058, 436 0 2, 058, 436 67 00 67 00 0 68.00 06800 SPEECH PATHOLOGY 444, 276 444, 276 444, 276 68.00 69.00 06900 ELECTROCARDI OLOGY 170, 243 170, 243 0 0 0 0 0 0 170, 243 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 2 683 602 2 683 602 2 683 602 70 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 25, 254, 082 25, 254, 082 25, 254, 082 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 21, 734, 661 21, 734, 661 21, 734, 661 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 25, 202, 333 25, 202, 333 25, 202, 333 73.00 07400 RENAL DIALYSIS 74 00 1 229 738 1, 229, 738 1, 229, 738 74 00 76.00 03330 ENDOSCOPY 3, 081, 924 3, 081, 924 3, 081, 924 76.00 03954 I MAGING CENTER 4, 061, 862 4, 061, 862 0 4, 061, 862 76.06 76.06 76.07 03955 BREAST DIAGNOSTIC CENTER 6, 476, 928 6, 476, 928 0 6, 476, 928 76.07 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 0 04975 SPINE CENTER 0 90.26 356, 662 356, 662 356, 662 90.26 91.00 09100 EMERGENCY 15, 955, 849 15, 955, 849 ol 15, 955, 849 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 6, 924, 691 6, 924, 691 92.00 6, 924, 691 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVI EW - SNF 114.00 297, 011, 582 200. 00 200.00 Subtotal (see instructions) 297, 011, 582 0 297, 011, 582 0 201.00 Less Observation Beds 6, 924, 691 6, 924, 691 6, 924, 691 201. 00 202.00 Total (see instructions) 290, 086, 891 290, 086, 891 290, 086, 891 202. 00

202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0169 Peri od: Worksheet C From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/30/2018 11:42 am Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 146, 027, 168 146, 027, 168 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 21, 347, 624 21, 347, 624 31.00 02060 NEONATAL INTENSIVE CARE UNIT 82, 780, 126 82, 780, 126 35.00 35.00 04000 SUBPROVIDER - IPF 40.00 7, 209, 375 7, 209, 375 40.00 04300 NURSERY 9, 708, 410 43.00 9, 708, 410 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 124, 614, 375 55 008 597 179, 622, 972 0.092591 0.000000 50.00 05100 RECOVERY ROOM 20, 106, 870 15, 241, 181 35, 348, 051 0.155902 0.000000 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.606830 0.000000 52 00 22, 787, 921 22, 787, 921 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 10, 959, 566 28, 856, 918 39, 816, 484 0.187869 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 12, 042, 912 15, 066, 182 27, 109, 094 0.083993 0.000000 55.00 05700 CT SCAN 48, 197, 426 69, 379, 077 21, 181, 651 0.033058 0.000000 57.00 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 5, 044, 790 18, 842, 648 23, 887, 438 0.123046 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 2, 206, 059 2, 206, 059 0. 216363 0.000000 59.00 60.00 06000 LABORATORY 72, 246, 799 45, 912, 596 118, 159, 395 0.102479 0.000000 60.00 |06400| I NTRAVENOUS THERAPY 1.066.795 142, 899 1, 209, 694 0.851022 0.000000 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 23, 998, 890 2, 145, 784 26, 144, 674 0. 203228 0.000000 65.00 06600 PHYSI CAL THERAPY 5, 719, 926 21, 058, 835 26, 778, 761 0. 293306 0.000000 66.00 66.00 06700 OCCUPATIONAL THERAPY 4, 808, 659 2, 646, 785 7, 455, 444 0. 276098 0.000000 67.00 67.00 06800 SPEECH PATHOLOGY 2, 477, 919 0. 179294 68.00 1, 624, 975 852, 944 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 7, 710, 266 1, 420, 355 9, 130, 621 0.018645 0.000000 69.00 12, 921, 823 70.00 07000 ELECTROENCEPHALOGRAPHY 861, 812 12, 060, 011 0.207680 0.000000 70.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 60 368 874 22, 130, 468 82, 499, 342 0.306113 0.000000 71 00 07200 I MPL. DEV. CHARGED TO PATIENTS 43, 848, 199 72.00 37, 425, 261 6, 422, 938 0.495680 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 70, 880, 258 28, 449, 014 99, 329, 272 0. 253725 0.000000 73.00 74.00 07400 RENAL DIALYSIS 2, 708, 309 2, 708, 309 0.454061 0.000000 74.00 03330 ENDOSCOPY 17, 103, 559 21, 490, 481 0.143409 76.00 4, 386, 922 0.000000 76.00 76.06 03954 I MAGING CENTER 315, 140 51, 504, 014 51, 819, 154 0.078385 0.000000 76.06 03955 BREAST DIAGNOSTIC CENTER 76.07 24, 251 12, 387, 303 12, 411, 554 0. 521847 0.000000 76.07 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0.000000 0.000000 90.00 90. 26 04975 SPINE CENTER 0 766, 280 766, 280 0.465446 0.000000 90. 26 91.00 09100 EMERGENCY 32, 863, 173 123, 456, 775 156, 319, 948 0.102072 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 7, 919, 589 9, 571, 106 0.723500 0.000000 92.00 92 00 1, 651, 517 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW - SNF 114.00 537, 593, 101 1, 352, 271, 775 200.00 814, 678, 674 200. 00 Subtotal (see instructions) 201.00 Less Observation Beds 201. 00

814, 678, 674

537, 593, 101 1, 352, 271, 775

202.00

Total (see instructions)

Title XIX   Hospital	/30/2018 11: 42 am
NPATIENT ROUTINE SERVICE COST CENTERS	PPS
11.00	
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00	
31. 00	
35. 00	30.00
40. 00	31.00
43. 00	35. 00
ANCI LLARY SERVI CE COST CENTERS  50. 00	40.00
50. 00	43. 00
51. 00	
52. 00	50.00
54. 00	51.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	52.00
57. 00 05700 CT SCAN 0. 033058 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0. 123046 59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 216363	54.00
58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI)	55. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON   0. 216363	57. 00
	58.00
60. 00   06000   LABORATORY 0. 102479	59. 00
	60.00
64. 00   06400   NTRAVENOUS THERAPY 0. 851022	64.00
65. 00 06500 RESPI RATORY THERAPY 0. 203228	65. 00
66. 00 06600 PHYSI CAL THERAPY 0. 293306	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 0. 276098	67.00
68. 00 06800 SPEECH PATHOLOGY 0. 179294	68. 00
69. 00   06900   ELECTROCARDI OLOGY 0. 018645	69. 00
70. 00   07000   ELECTROENCEPHALOGRAPHY 0. 207680	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 306113	71.00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS 0. 495680	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 253725	73. 00
74. 00 07400 RENAL DIALYSIS 0. 454061	74.00
76. 00   03330   ENDOSCOPY 0. 143409	76.00
76. 06   03954   I MAGI NG CENTER 0. 078385	76. 06
76. 07   03955   BREAST DI AGNOSTI C CENTER 0. 521847	76. 07
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLI NI C 0. 000000	90.00
90. 26   04975   SPI NE CENTER 0. 465446	90. 26
91. 00 09100 EMERGENCY 0. 102072	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 723500	92. 00
SPECIAL PURPOSE COST CENTERS	
113.00   11300   NTEREST EXPENSE	113. 00
114.00 11400 UTI LI ZATI ON REVI EW - SNF	114. 00
200.00 Subtotal (see instructions)	200. 00
201.00 Less Observation Beds	201. 00
202.00 Total (see instructions)	202. 00

Heal th Financial Systems COMMUNITY HOSPIT CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | In Lieu of Form CMS-2552-10 | Peri od: | Worksheet C | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | To 12/3 Provider CCN: 15-0169

				'	0 12/31/2017	5/30/2018 11:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
	·	(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reducti on	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col . 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	16, 631, 510	2, 766, 482	13, 865, 028	0	0	50. 00
51. 00	05100 RECOVERY ROOM	5, 510, 832	570, 391	4, 940, 441	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	13, 828, 402	1, 650, 172	12, 178, 230	0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 480, 278	828, 950	6, 651, 328	0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	2, 276, 975	671, 202	1, 605, 773	0	0	55. 00
57. 00	05700 CT SCAN	2, 293, 562	350, 908	1, 942, 654	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 939, 243	329, 320	2, 609, 923	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	477, 309	10, 306	467, 003	0	0	59. 00
	06000 LABORATORY	12, 108, 806	510, 421	11, 598, 385	0	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	1, 029, 476				0	64.00
65. 00	06500 RESPIRATORY THERAPY	5, 313, 329	518, 061	4, 795, 268	0	ol	65. 00
66. 00	06600 PHYSI CAL THERAPY	7, 854, 361	908, 339			o	66. 00
	06700 OCCUPATI ONAL THERAPY	2, 058, 436				o	67. 00
68. 00	06800 SPEECH PATHOLOGY	444, 276				o	68. 00
	06900 ELECTROCARDI OLOGY	170, 243				o	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	2, 683, 602	329, 096	2, 354, 506	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	25, 254, 082	1, 304, 301			o	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	21, 734, 661	1, 195, 941			0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	25, 202, 333	1, 318, 179	23, 884, 154	0	o	73. 00
	07400 RENAL DIALYSIS	1, 229, 738				0	74.00
76, 00	03330 ENDOSCOPY	3, 081, 924	598, 763	2, 483, 161	0	o	76. 00
76. 06	03954 I MAGING CENTER	4, 061, 862				o	76. 06
	03955 BREAST DIAGNOSTIC CENTER	6, 476, 928				o	76. 07
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	C	(	0	0	90. 00
90. 26	04975 SPI NE CENTER	356, 662	8, 666	347, 996	0	0	90. 26
91. 00	09100 EMERGENCY	15, 955, 849	1, 200, 244	14, 755, 605	0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 924, 691	736, 926	6, 187, 765	0	0	92.00
	SPECIAL PURPOSE COST CENTERS				*		
113.00	11300 INTEREST EXPENSE						113. 00
114.00	11400 UTILIZATION REVIEW - SNF						114. 00
200.00	Subtotal (sum of lines 50 thru 199)	193, 379, 370	17, 204, 164	176, 175, 206	0	0	200. 00
201.00	Less Observation Beds	6, 924, 691	736, 926	6, 187, 765	0	0	201. 00
202.00	Total (line 200 minus line 201)	186, 454, 679	16, 467, 238	169, 987, 441	0	0	202. 00

Heal th Financial Systems COMMUNITY HOSPIT CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | In Lieu of Form CMS-2552-10 | Period: Worksheet C | From 01/01/2017 Part II | Date/Time Prepared: 5/30/2018 11: 42 am Provi der CCN: 15-0169

Cost Center Description							5/30/2018 11	42 am
Capital and   Operating Cost   Part 1, column   Acol. (7)				Ti tl	e XIX	Hospi tal	PPS	
ANCILLARY SERVICE COST CENTERS	Cost Co	enter Description	Cost Net of					
Reduction   8   / col. 7								
ANCILLARY SERVICE COST CENTERS			Operating Cost	Part I, column	Ratio (col.	6		
ANCIL LARY SERVICE COST CENTERS   50.00								
50.00   0500			6.00	7. 00	8. 00			
51.00   05100   RECOVERY ROOM   5.510, 832   35, 348, 051   0.155902   51.00   05200   DELIVERY ROOM & LABOR ROOM   13, 828, 402   22, 787, 921   0.606830   52.00   05400   RADIOLOGY-DI AGNOSTIC   7, 480, 278   39, 816, 484   0.187869   54.00   05400   RADIOLOGY-DI AGNOSTIC   2, 276, 975   27, 109, 094   0.083993   55.00   57.00   05700   CT SCAN   2, 293, 656   69, 379, 077   0.33058   57.00   05700   CT SCAN   2, 293, 656   69, 379, 077   0.33058   57.00   05900   CARDIA C CATHETERI ZATI ON   477, 309   2, 206, 059   0.216363   59.00   05900   CARDIA C CATHETERI ZATI ON   477, 309   2, 206, 059   0.216363   59.00   05900   CARDIA C ATHETERI ZATI ON   477, 309   2, 206, 059   0.216363   59.00   05900   CARDIA C ATHETERI ZATI ON   477, 309   2, 206, 059   0.216363   59.00   05900   CARDIA C ATHETERI ZATI ON   477, 309   2, 206, 059   0.216363   0.00	ANCILLARY SE	RVICE COST CENTERS						
52.00   0520	50. 00 05000 OPERATI	NG ROOM	16, 631, 510	179, 622, 972	0. 09259	91		50. 00
54.00   05400   RADI OLOGY - DI AGNOSTI C   7, 480, 278   39, 816, 484   0, 187869   55.00   05500   RADI OLOGY - THERAPEUTI C   2, 276, 975   27, 109, 094   0, 083993   55.00   05700   CT SCAN   2, 293, 562   69, 379, 077   0, 033058   57.00   05700   CT SCAN   2, 293, 562   69, 379, 077   0, 033058   57.00   05900   ARDIA CATHETERI ZATI ON   477, 309   2, 206, 059   0, 216363   59.00   05900   CARDIA CATHETERI ZATI ON   477, 309   2, 206, 059   0, 102479   60.00	51. 00   05100 RECOVE	RY ROOM	5, 510, 832	35, 348, 051	0. 15590	)2		51. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C   2, 276, 975   27, 109, 094   0, 083993   55. 00   05700   CT SCAN   2, 293, 562   69, 379, 077   0, 033058   57. 00   58. 00   05800   MAGNETI C RESONANCE   IMAGI NG (MRI )   2, 939, 243   23, 887, 438   0, 123046   58. 00   05900   CARDI AC CATHETERI ZATI ON   477, 309   2, 206, 059   0, 216363   59. 00   06000   LABORATORY   12, 108, 806   118, 159, 395   0, 102479   60. 00   60. 00   60.00   ABORATORY   12, 108, 806   118, 159, 395   0, 102479   60. 00   60	52. 00 05200 DELI VEI	RY ROOM & LABOR ROOM	13, 828, 402	22, 787, 921	0. 60683	30		52. 00
57. 00 05700   CT SCAN   2, 293, 562   69, 379, 077   0.033058   57. 00   58. 00 05800   MAGNETIC RESONANCE IMAGING (MRI)   2, 939, 243   23, 887, 438   0.123046   58. 00   60. 00 05900   CARDIAC CATHETERIZATION   477, 309   2, 206, 059   0. 216363   59. 00   60. 00 06000   LABORATORY   12, 108, 806   118, 159, 395   0. 102479   66. 00   64. 00 06400   INTRAVENDUS THERAPY   1, 029, 476   1, 209, 694   0. 851022   64. 00   65. 00 06500   RESPIRATORY THERAPY   5, 313, 329   26, 144, 674   0. 203228   65. 00   66. 00 06600   PHYSI CAL THERAPY   7, 854, 361   26, 778, 761   0. 293306   66. 00   67. 00 06700   OCCUPATIONAL THERAPY   2, 058, 436   7, 455, 444   0. 276098   67. 00   68. 00 06800   SPECL PATHOLOGY   444, 276   2, 477, 919   0. 179294   68. 00   69. 00 06900   ELECTROCARDIOLOGY   170, 243   9, 130, 621   0. 018645   69. 00   71. 00 07000   ELECTROCARDIOLOGY   170, 243   9, 130, 621   0. 018645   69. 00   71. 00 07000   ELECTROCROEPHALOGRAPHY   2, 683, 602   12, 291, 823   0. 207680   72. 00   71. 00 07000   MEDICAL SUPPLIES CHARGED TO PATIENTS   25, 254, 082   82, 499, 342   0. 306113   71. 00   71. 00 0700   MEDICAL SUPPLIES CHARGED TO PATIENTS   21, 734, 661   43, 848, 199   0. 495680   72. 00   73. 00 07300   DRUGS CHARGED TO PATIENTS   25, 202, 333   99, 329, 272   0. 253725   73. 00   74. 00 07400   RENAL DIALYSIS   1, 229, 738   2, 708, 309   0. 454061   74. 00   76. 00 0330   ENDOSCOPY   3, 081, 292, 272   0. 253725   73. 00   76. 00 03954   IMAGING CENTER   4, 061, 862   51, 819, 154   0. 078385   76. 06   76. 07 03955   BREAST DIAGNOSTIC CENTERS   4, 061, 862   51, 819, 154   0. 073385   76. 07   0000   00000   CLINIC   0   0   0. 000000   0. 000000   00 0600   00000   00000   000000   000000   000000	54. 00 05400 RADI OL0	DGY-DI AGNOSTI C	7, 480, 278	39, 816, 484	0. 18786	59		54. 00
\$8. 00   05800   MACNETI C RESONANCE I MAGI NG (MRI )   2, 939, 243   23, 887, 438   0. 123046   59, 00   05900   CARDI AC CATHETERI ZATI ON   477, 309   2, 206, 059   0. 216363   59, 00   06000   LABORATORY   12, 108, 806   118, 159, 395   0. 102479   60, 00   06400   INTRAVENOUS THERAPY   1, 029, 476   1, 209, 694   0. 851022   64, 00   65, 00   06500   RESPI RATORY THERAPY   5, 313, 329   26, 144, 674   0. 203228   65, 00   06600   PHYSI CAL THERAPY   7, 854, 361   26, 778, 761   0. 293306   66, 00   06600   PHYSI CAL THERAPY   7, 854, 361   26, 778, 761   0. 293306   66, 00   06600   PHYSI CAL THERAPY   2, 058, 436   7, 455, 444   0. 276098   67, 00   06700   OCCUPATI ONAL THERAPY   2, 058, 436   7, 455, 444   0. 276098   67, 00   06900   ELECTROCARDI OLOGY   444, 276   2, 477, 919   0. 179294   68, 00   06800   SPECH PATHOLOGY   444, 276   2, 477, 919   0. 179294   68, 00   06900   ELECTROCARDI OLOGY   170, 243   9, 130, 621   0. 018645   69, 00   07000   ELECTROCARDI OLOGY   2, 683, 602   12, 921, 823   0. 207680   70, 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   25, 254, 082   82, 499, 342   0. 306113   71, 00   73.00   07300   DRUGS CHARGED TO PATI ENTS   25, 254, 082   82, 499, 342   0. 306113   71, 00   07300   DRUGS CHARGED TO PATI ENTS   25, 202, 333   99, 329, 272   0. 253725   73, 00   07300   DRUGS CHARGED TO PATI ENTS   25, 202, 333   99, 329, 272   0. 253725   73, 00   07300   DRUGS CHARGED TO PATI ENTS   25, 202, 333   99, 329, 272   0. 253725   73, 00   07300   DRUGS CHARGED TO PATI ENTS   25, 202, 333   99, 329, 272   0. 253725   73, 00   07300   DRUGS CHARGED TO PATI ENTS   25, 202, 333   99, 329, 272   0. 253725   73, 00   07300   DRUGS CHARGED TO PATI ENTS   25, 202, 333   99, 329, 272   0. 253725   73, 00   07300   DRUGS CHARGED TO PATI ENTS   25, 202, 333   99, 329, 272   0. 253725   73, 00   07300   DRUGS CHARGED TO PATI ENTS   25, 202, 333   99, 329, 272   0. 253725   73, 00   07400   RENAL DI ALYSI S   74, 00   74, 00   74, 00   74, 00   74, 00   74, 00   74, 00   74, 00   7	55. 00 05500 RADI OLO	OGY-THERAPEUTI C	2, 276, 975	27, 109, 094	0. 08399	93		55. 00
59. 00   05900   CARDIAC CATHETERI ZATION   477, 309   2, 206, 059   0. 216363   59. 00   60. 00   06000   LABORATORY   12, 108, 806   118, 159, 395   0. 102479   60. 00   60	57. 00 05700 CT SCAI	V	2, 293, 562	69, 379, 077	0. 03305	58		57. 00
60. 00   06000   LABORATORY   12, 108, 806   118, 159, 395   0. 102479   60. 00   06400   NTRAVENOUS THERAPY   1, 029, 476   1, 209, 694   0. 851022   64. 00   06600   RESPIRATORY THERAPY   5, 313, 329   26, 144, 674   0. 203228   65. 00   06600   PHYSI CAL THERAPY   7, 854, 361   26, 778, 761   0. 293306   66. 00   06700   0CCUPATI ONAL THERAPY   2, 058, 436   7, 455, 444   0. 276098   67. 00   06700   0CCUPATI ONAL THERAPY   2, 058, 436   7, 455, 444   0. 276098   67. 00   06900   ELECTROCARDI OLOGY   170, 243   9, 130, 621   0. 018645   69. 00   06900   ELECTROCENCEPHALLOGRAPHY   2, 683, 602   12, 921, 823   0. 207680   70. 00   07000   ELECTROENCEPHALLOGRAPHY   2, 683, 602   12, 921, 823   0. 207680   70. 00   71000   MEDICAL SUPPLIES CHARGED TO PATI ENTS   25, 254, 082   82, 499, 342   0. 306113   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   21, 734, 661   43, 848, 199   0. 495680   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   25, 202, 333   99, 329, 272   0. 253725   73. 00   74. 00   7400   RENAL DI ALYSI S   1, 229, 738   2, 708, 309   0. 454061   74. 00   76. 00   03330   ENDOSCOPY   3, 081, 924   21, 490, 481   0. 143409   76. 00   76. 00   03955   BREAST DI JAGNOSTI C CENTER   4, 061, 862   51, 819, 154   0. 078385   76. 06   09000   CLI NI C   0   0   0. 000000   0. 000000   0. 0000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000	58. 00   05800   MAGNETI	C RESONANCE IMAGING (MRI)	2, 939, 243	23, 887, 438	0. 12304	16		58. 00
64. 00	59. 00 05900 CARDI A	C CATHETERI ZATI ON	477, 309	2, 206, 059	0. 21636	53		59. 00
65. 00	60. 00 06000 LABORA	TORY	12, 108, 806	118, 159, 395	0. 10247	79		60.00
66. 00   06600   PHYSI CAL THERAPY   7, 854, 361   26, 778, 761   0. 293306   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   2, 058, 436   7, 455, 444   0. 276098   67. 00   68. 00   06800   SPEECH PATHOLOGY   444, 276   2, 477, 919   0. 179294   68. 00   06900   ELECTROCARDI OLOGY   170, 243   9, 130, 621   0. 018645   69. 00   07000   ELECTROCARDI OLOGY   170, 243   9, 130, 621   0. 018645   69. 00   07000   ELECTROCARDI OLOGY   170, 243   9, 130, 621   0. 018645   69. 00   07000   ELECTROCARDI OLOGY   170, 243   9, 130, 621   0. 018645   69. 00   07200   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   25, 254, 082   82, 499, 342   0. 306113   71. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   21, 734, 661   43, 848, 199   0. 495680   72. 00   07300   DRUGS CHARGED TO PATI ENTS   25, 202, 333   99, 329, 272   0. 253725   73. 00   07400   RENAL DI ALYSI S   1, 229, 738   2, 708, 309   0. 454061   74. 00   07400   RENAL DI ALYSI S   1, 229, 738   2, 708, 309   0. 454061   74. 00   03954   IMAGI NG CENTER   4, 061, 862   51, 819, 154   0. 078385   76. 06   03955   BREAST DI AGNOSTI C CENTER   4, 061, 862   51, 819, 154   0. 078385   76. 07   0017971   ENT SERVI CE COST CENTERS   12, 411, 554   0. 521847   76. 07   0017971   ENT SERVI CE COST CENTERS   15, 955, 849   156, 319, 948   0. 102072   91. 00   90. 00   09200   DSERVATI ON BEDS (NON-DI STI NCT PART)   6, 924, 691   9, 571, 106   0. 723500   92. 00   00000   0. 723500	64. 00 06400 I NTRAVI	ENOUS THERAPY	1, 029, 476	1, 209, 694	0. 85102	22		64. 00
66. 00   06600   PHYSI CAL THERAPY   7, 854, 361   26, 778, 761   0. 293306   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   2, 058, 436   7, 455, 444   0. 276098   67. 00   68. 00   06800   SPECEH PATHOLOGY   444, 276   2, 477, 919   0. 179294   68. 00   06900   ELECTROCARDI OLOGY   170, 243   9, 130, 621   0. 018645   69. 00   07000   ELECTROCARDI OLOGY   170, 243   9, 130, 621   0. 018645   69. 00   07000   ELECTROCARDI OLOGY   2, 683, 602   12, 921, 823   0. 207680   70. 00   07000   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   25, 254, 082   82, 499, 342   0. 306113   71. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   21, 734, 661   43, 848, 199   0. 495680   72. 00   07300   DRUGS CHARGED TO PATI ENTS   25, 202, 333   99, 329, 272   0. 253725   73. 00   07400   RENAL DI ALYSI S   1, 229, 738   2, 708, 309   0. 454061   74. 00   03954   IMAGI NG CENTER   4, 061, 862   51, 819, 154   0. 078385   76. 06   03955   BREAST DI AGNOSTI C CENTER   4, 061, 862   51, 819, 154   0. 078385   76. 07   0017971 ENT SERVI CE COST CENTERS   0 0 00000   090000   CLI NI C   0 0 00000   090000   00000000	65. 00 06500 RESPIRA	ATORY THERAPY	5, 313, 329	26, 144, 674	0. 20322	28		65. 00
68.00 06800 SPEECH PATHOLOGY 444, 276 2, 477, 919 0. 179294 68.00 6900 ELECTROCARDI OLOGY 170, 243 9, 130, 621 0. 018645 69.00 70.00 7000 ELECTROENCEPHALOGRAPHY 2, 683, 602 12, 921, 823 0. 207680 70.00 71.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 25, 254, 082 82, 499, 342 0. 306113 71.00 712.00 7120 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 21, 734, 661 43, 848, 199 0. 495680 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 25, 202, 333 99, 329, 272 0. 253725 73.00 74.00 07400 RENAL DI ALYSI S 1, 229, 738 2, 708, 309 0. 454061 74.00 76.00 03330 ENDOSCOPY 3, 081, 924 21, 490, 481 0. 143409 76.00 76.00 03954 IMAGI NG CENTER 4, 061, 862 51, 819, 154 0. 078385 76.06 76.07 03955 BREAST DI AGNOSTI C CENTER 6, 476, 928 12, 411, 554 0. 521847 76.07 0UTPATI ENT SERVI CE COST CENTERS 356, 662 766, 280 0. 465446 90. 26 04975 SPI NE CENTER 356, 662 766, 280 0. 465446 90. 26 091.00 0BSERVATI ON BEDS (NON-DI STI NCT PART) 6, 924, 691 9, 571, 106 0. 723500 992.00 DSERVATI ON BEDS (NON-DI STI NCT PART) 6, 924, 691 9, 571, 106 0. 723500 992.00 Subtotal (sum of lines 50 thru 199) 193, 379, 370 1, 085, 199, 072 00.00 0.00 0.00 0.00 0.00 0.00 0.00	66. 00 06600 PHYSI CA	AL THERAPY	7, 854, 361	26, 778, 761	0. 29330	06		66. 00
69. 00 06900 ELECTROCARDI OLOGY 170, 243 9, 130, 621 0. 018645 69. 00 70. 00 07000 ELECTROCREPHALOGRAPHY 2, 683, 602 12, 921, 823 0. 207680 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 25, 254, 082 82, 499, 342 0. 306113 71. 00 7200 IMPL. DEV. CHARGED TO PATI ENTS 21, 734, 661 43, 848, 199 0. 495680 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 25, 202, 333 99, 329, 272 0. 253725 73. 00 74. 00 07400 RENAL DI ALYSI S 1, 229, 738 2, 708, 309 0. 454061 74. 00 76. 00 03330 ENDOSCOPY 3, 081, 924 21, 490, 481 0. 143409 76. 00 76. 00 03954 IMAGI NG CENTER 4, 061, 862 51, 819, 154 0. 078385 76. 00 03955 BREAST DI AGNOSTI C CENTER 6, 476, 928 12, 411, 554 0. 521847 76. 07 00 09000 CLI NI C 0 0 09000 EMERGENCY 15, 955, 849 156, 319, 948 0. 102072 91. 00 99200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 6, 924, 691 9, 571, 106 0. 723500 92. 00 SPECIAL PURPOSE COST CENTERS 113. 00 111400 UTI LI ZATI ON REVIEW - SNF 200. 00 Coll NI C 0 0 0 00 00 00 00 00 00 00 00 00 00 0	67. 00 06700 OCCUPA	TI ONAL THERAPY	2, 058, 436	7, 455, 444	0. 27609	98		67. 00
70. 00   07000   ELECTROENCEPHALOGRAPHY   2, 683, 602   12, 921, 823   0. 207680   70. 00   71. 00   7100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   25, 254, 082   82, 499, 342   0. 306113   71. 00   72. 00   70. 00   1MPL. DEV. CHARGED TO PATIENTS   21, 734, 661   43, 848, 199   0. 495680   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   25, 202, 333   99, 329, 272   0. 253725   73. 00   74. 00   07400   RENAL DIALYSIS   1, 229, 738   2, 708, 309   0. 454061   74. 00   76. 00   03330   ENDOSCOPY   3, 081, 924   21, 490, 481   0. 143409   76. 00   76. 00   03954   IMAGI NG CENTER   4, 061, 862   51, 819, 154   0. 078385   76. 06   76. 07   000000000000000000000000000000000	68. 00 06800 SPEECH	PATHOLOGY	444, 276	2, 477, 919	0. 17929	94		68. 00
71. 00	69. 00 06900 ELECTRO	OCARDI OLOGY	170, 243	9, 130, 621	0. 01864	15		69. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 21, 734, 661 43, 848, 199 0. 495680 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 25, 202, 333 99, 329, 272 0. 253725 73. 00 74. 00 07400 RENAL DIALYSIS 1, 229, 738 2, 708, 309 0. 454061 74. 00 76. 00 03330 ENDOSCOPY 3, 081, 924 21, 490, 481 0. 143409 76. 06 0 03954 IMAGING CENTER 4, 061, 862 51, 819, 154 0. 078385 76. 06 76. 07 03955 BREAST DIAGNOSTIC CENTER 6, 476, 928 12, 411, 554 0. 521847 76. 07 00TPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0 0 0. 000000 90. 26 04975 SPINE CENTER 356, 662 766, 280 0. 465446 90. 26 91. 00 09100 EMERGENCY 15, 955, 849 156, 319, 948 0. 102072 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 6, 924, 691 9, 571, 106 0. 723500 92. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTILIZATION REVIEW - SNF 200. 00 Subbtotal (sum of lines 50 thru 199) 193, 379, 370 1, 085, 199, 072 200. 00 201. 00 Less Observation Beds 6, 924, 691 0 0 201. 00	70. 00 07000 ELECTRO	DENCEPHALOGRAPHY	2, 683, 602	12, 921, 823	0. 20768	30		70. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 21, 734, 661 43, 848, 199 0. 495680 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 25, 202, 333 99, 329, 272 0. 253725 73. 00 74. 00 07400 RENAL DIALYSIS 1, 229, 738 2, 708, 309 0. 454061 74. 00 76. 00 03330 ENDOSCOPY 3, 081, 924 21, 490, 481 0. 143409 76. 00 76. 00 03954 IMAGING CENTER 4, 061, 862 51, 819, 154 0. 078385 76. 06 76. 07 03955 BREAST DIAGNOSTIC CENTER 6, 476, 928 12, 411, 554 0. 521847 76. 07 00TPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0 0 0.000000 90. 26 04975 SPINE CENTER 356, 662 766, 280 0. 465446 90. 26 91. 00 09100 EMERGENCY 15, 955, 849 156, 319, 948 0. 102072 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 6, 924, 691 9, 571, 106 0. 723500 92. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTILIZATION REVIEW - SNF 200. 00 Subtotal (sum of lines 50 thru 199) 193, 379, 370 1, 085, 199, 072 201. 00 201. 00 Less Observation Beds 6, 924, 691 0 0 201. 00	71. 00 07100 MEDI CAI	SUPPLIES CHARGED TO PATIENTS	25, 254, 082	82, 499, 342	0. 3061	13		71. 00
74. 00 07400 RENAL DI ALYSI S 1, 229, 738 2, 708, 309 0. 454061 74. 00 76. 00 03330 ENDOSCOPY 3, 081, 924 21, 490, 481 0. 143409 76. 00 76. 06 03954 I MAGI NG CENTER 4, 061, 862 51, 819, 154 0. 078385 76. 06 76. 07 03955 BREAST DI AGNOSTI C CENTER 6, 476, 928 12, 411, 554 0. 521847 76. 07  OUTPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 0 0 0. 000000 90. 26 04975 SPI NE CENTER 356, 662 766, 280 0. 465446 90. 26 91. 00 09100 EMERGENCY 15, 955, 849 156, 319, 948 0. 102072 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 6, 924, 691 9, 571, 106 0. 723500 92. 00  113. 00 11300 INTEREST EXPENSE 113. 00 114. 00 11400 UTI LI ZATI ON REVI EW - SNF 200. 00 Subtotal (sum of lines 50 thru 199) 193, 379, 370 1, 085, 199, 072 200. 00 201. 00 Less Observati on Beds 6, 924, 691 0 0 201. 00	72.00 07200 I MPL. I	DEV. CHARGED TO PATIENTS	21, 734, 661	43, 848, 199	0. 49568	30		72. 00
76. 00 03330 ENDOSCOPY 3, 081, 924 21, 490, 481 0. 143409 76. 00 76. 06 03954 IMAGING CENTER 4, 061, 862 51, 819, 154 0. 078385 76. 06 76. 07 03955 BREAST DI AGNOSTIC CENTER 6, 476, 928 12, 411, 554 0. 521847 76. 07  OUTPATIENT SERVICE COST CENTERS  90. 00 09000 CLI NI C 0 0 0. 000000 90. 26 04975 SPI NE CENTER 356, 662 766, 280 0. 465446 90. 26 91. 00 09100 EMERGENCY 15, 955, 849 156, 319, 948 0. 102072 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 6, 924, 691 9, 571, 106 0. 723500 92. 00  SPECI AL PURPOSE COST CENTERS  113. 00 11300 INTEREST EXPENSE 113. 00 114. 00 11400 UTI LI ZATI ON REVI EW - SNF 200. 00 Subtotal (sum of lines 50 thru 199) 193, 379, 370 1, 085, 199, 072 200. 00 201. 00 Less Observati on Beds 6, 924, 691 0 201. 00	73. 00 07300 DRUGS (	CHARGED TO PATIENTS	25, 202, 333	99, 329, 272	0. 25372	25		73. 00
76. 06	74.00 07400 RENAL I	DI ALYSI S	1, 229, 738	2, 708, 309	0. 45406	51		74. 00
76. 06	76. 00 03330 ENDOSC	OPY	3, 081, 924	21, 490, 481	0. 14340	)9		76. 00
OUTPATIENT SERVICE COST CENTERS   O		G CENTER				35		76. 06
OUTPATIENT SERVICE COST CENTERS   O	76. 07 03955 BREAST	DI AGNOSTI C CENTER	6, 476, 928	12, 411, 554	0. 52184	17		76. 07
90. 00				, , , , , , , , , , , , , , , , , , , ,				
90. 26			0	0	0, 00000	00		90.00
91. 00	90. 26 04975 SPINE (	CENTER	356, 662	766, 280	0. 46544	16		90. 26
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   6, 924, 691   9, 571, 106   0. 723500   92. 00								
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   114.00   11400   UTI LI ZATI ON REVIEW - SNF   114.00   200.00   Subtotal (sum of lines 50 thru 199)   193, 379, 370   1, 085, 199, 072   200.00   201.00   Less Observation Beds   6, 924, 691   0   201.00								
113. 00 114. 00 114. 00 114. 00 114. 00 200. 00 201. 00 115. 00 116. 00 117. 00 118. 00 119. 00 119		,				<u> </u>		
114.00 11400 UTILIZATION REVIEW - SNF 200.00 Subtotal (sum of lines 50 thru 199) 193, 379, 370 1, 085, 199, 072 201.00 Less Observation Beds 1,085, 199, 072 201.00								113. 00
200.00 Subtotal (sum of lines 50 thru 199) 193,379,370 1,085,199,072 201.00 Less Observation Beds 200.00 201.00				•				
201.00 Less Observation Beds 6,924,691 0 201.00			193, 379, 370	1, 085, 199, 072	İ			
	1 1			0				
	1 1			1, 085, 199, 072				202. 00

Health Financial Systems COMM	UNITY HOSPITAL	OF INDIANA, IN	NC.	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2017	Worksheet D Part I	
				To 12/31/2017		
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	7, 418, 305	0	7, 418, 30	5 61, 124	121. 36	30. 00
31.00 INTENSIVE CARE UNIT	1, 545, 140		1, 545, 14	0 5, 572	277. 30	31.00
35.00 NEONATAL INTENSIVE CARE UNIT	1, 490, 924		1, 490, 92	4 11, 621	128. 30	35. 00
40. 00   SUBPROVI DER - I PF	247, 955	0	247, 95	5 3, 441	72.06	40.00
43. 00 NURSERY	682, 778		682, 77	7, 547	90. 47	43.00
200.00 Total (lines 30 through 199)	11, 385, 102		11, 385, 10	2 89, 305		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	18, 144	2, 201, 956				30. 00
31.00 INTENSIVE CARE UNIT	2, 047	567, 633				31.00
35.00 NEONATAL INTENSIVE CARE UNIT	0	0				35. 00
40. 00 SUBPROVI DER - I PF	2, 427	174, 890				40. 00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	22, 618	2, 944, 479				200. 00

Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. In Lieu of Form CMS-2552-10 APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-0169 Peri od: Worksheet D From 01/01/2017 Part II 12/31/2017 Date/Time Prepared: 5/30/2018 11:42 am Title XVIII Hospi tal PPS Capital Costs Cost Center Description Capi tal Total Charges Ratio of Cost Inpati ent to Charges (from Wkst. C. (column 3 x Related Cost Program (from Wkst. B. column 4) Part I. col. (col. 1 + col Charges 2) Part II, col. 8) 26) 2.00 3.00 4.00 5.00 1.00 ANCILLARY SERVICE COST CENTERS 2, 766, 482 50.00 05000 OPERATING ROOM 0.015402 43, 639, 651 672, 138 50.00 179, 622, 972 51. 00 | 05100 | RECOVERY ROOM 570, 391 35, 348, 051 0.016136 5, 279, 668 85, 193 51.00 05200 DELIVERY ROOM & LABOR ROOM 1, 650, 172 22, 787, 921 0.072414 52.00 52.00 05400 RADI OLOGY-DI AGNOSTI C 828, 950 39, 816, 484 0.020819 4, 326, 276 90, 069 54.00 54.00 05500 RADI OLOGY-THERAPEUTI C 27, 109, 094 4, 771, 794 55.00 671, 202 0.024759 118, 145 55.00 57.00 05700 CT SCAN 350, 908 69, 379, 077 0.005058 8, 482, 777 42, 906 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 329, 320 23, 887, 438 0.013786 1, 803, 803 24, 867 58.00 2, 206, 059 5, 786 05900 CARDIAC CATHETERIZATION 10, 306 0.004672 1, 238, 506 59 00 59 00 06000 LABORATORY 60.00 510, 421 118, 159, 395 0.004320 25, 464, 938 110,009 60.00 64.00 06400 I NTRAVENOUS THERAPY 212, 348 1, 209, 694 0.175539 388, 212 68, 146 64.00 06500 RESPIRATORY THERAPY 65.00 518, 061 26, 144, 674 0.019815 6, 283, 703 124, 512 65.00 06600 PHYSI CAL THERAPY 26, 778, 761 0.033920 66 00 908 339 2, 426, 693 82.313 66 00 67.00 06700 OCCUPATIONAL THERAPY 73,818 7, 455, 444 0.009901 1, 729, 335 17, 122 67.00 06800 SPEECH PATHOLOGY 15, 986 2, 477, 919 0.006451 68.00 618, 183 3, 988 68.00 3, 411, 803 06900 ELECTROCARDI OLOGY 9, 130, 621 5. 281 69 00 14 135 0.001548 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 329, 096 12, 921, 823 0.025468 297, 559 7, 578 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 304, 301 82, 499, 342 0.015810 16, 378, 482 258, 944 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 195, 941 43, 848, 199 0.027275 14, 726, 532 401, 666 72.00 07300 DRUGS CHARGED TO PATIENTS 99, 329, 272 73 00 1, 318, 179 0.013271 20, 931, 783 277, 786 73 00 74.00 07400 RENAL DIALYSIS 29,672 2, 708, 309 0.010956 1, 537, 221 16,842 74.00 76.00 03330 ENDOSCOPY 598, 763 21, 490, 481 0.027862 235, 420 6, 559 76.00 76.06 03954 I MAGING CENTER 781, 341 51, 819, 154 0.015078 5, 709 86 76.06 03955 BREAST DIAGNOSTIC CENTER 270, 196 12, 411, 554 0.021770 1, 302 76.07 28 76.07 OUTPATIENT SERVICE COST CENTERS 90.00 0.000000 90.00 09000 CLI NI C 0 04975 SPINE CENTER 8, 666 766, 280 0.011309 90. 26 90. 26 0 1, 200, 244 91.00 91. 00 09100 EMERGENCY 156, 319, 948 0.007678 14, 327, 738 110, 008

736, 926

17, 204, 164 1, 085, 199, 072

9, 571, 106

0.076995

178, 307, 088

0 92.00

2, 529, 972 200. 00

92.00

200.00

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

Health Financial Systems	COMMUNITY HOSPITAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTH	ER PASS THROUGH COS		F	eriod: rom 01/01/2017 o 12/31/2017	Worksheet D Part III Date/Time Pre 5/30/2018 11:	pared: 42 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School			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						
30. 00 03000 ADULTS & PEDIATRICS	0	0	0	0	0	
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35. 00
40. 00   04000   SUBPROVI DER - I PF	0	0	0	0	0	40. 00
43. 00   04300 NURSERY	0	0	0	0	0	43.00
200.00 Total (lines 30 through 199)	0	0	0	0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adj ustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4.00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00   03000   ADULTS & PEDIATRICS	0	0	61, 124	0.00	18, 144	30. 00
31.00 03100 INTENSIVE CARE UNIT		0	5, 572	0.00	2, 047	31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT		0	11, 621	0.00	0	35. 00
40. 00   04000   SUBPROVI DER -   I PF	0	0	3, 441	0.00	2, 427	40.00
43. 00   04300 NURSERY		0	7, 547	0.00	0	43.00
200.00 Total (lines 30 through 199)		0	89, 305		22, 618	200. 00
Cost Center Description	Inpatient					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30. 00
31.00 03100 INTENSIVE CARE UNIT	0					31. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0					35. 00
40. 00   04000   SUBPROVI DER - 1 PF	0					40. 00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200. 00
	1	•				

Health Financial Systems COMMUNITY HOSPITAL OF APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0169 THROUGH COSTS

						5/30/2018 11:	42 am
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	I Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	)	0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	)	0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	)	0 0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	O	0	)	0 0	0	55.00
57.00	05700 CT SCAN	O	0	)	0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	O	0	)	0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	o	0	)	0 0	0	59. 00
60.00	06000 LABORATORY	o	0	)	0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	o	0	)	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	o	0	)	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	o	0	)	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	o	0	1	0 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	o	0	1	0 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	o	0	)	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	o	0	1	0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0	1	0 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	)	0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	O	0	1	0 0	0	73.00
74.00	07400 RENAL DIALYSIS	O	0	1	0 0	0	74.00
76.00	03330 ENDOSCOPY	o	0	)	0 0	0	76. 00
76.06	03954 I MAGI NG CENTER	o	0	1	0 0	0	76. 06
76. 07	03955 BREAST DIAGNOSTIC CENTER	O	0	1	0 0	0	76. 07
	OUTPATIENT SERVICE COST CENTERS				·		
90.00	09000 CLI NI C	0	0		0 0	0	90.00
90. 26	04975 SPI NE CENTER	O	0	1	0 0	0	90. 26
91.00	09100 EMERGENCY	0	0	1	0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00	Total (lines 50 through 199)	o	0		0 0	0	200. 00
	· · · · · · · · · · · · · · · · · · ·	. '		•	•		•

Heal th Financial Systems COMMUNITY HOSPITAL OF APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS | Period: | Worksheet D | From 01/01/2017 | Part IV | To | 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0169 THROUGH COSTS

				Т	o 12/31/2017	Date/Time Prep 5/30/2018 11:4	
			Title	xVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	through col.	Cost (sum of		(col. 5 ÷ col.	
			4)	col. 2, 3 and	8)	7)	
		4.00	5. 00	4) 6. 00	7. 00	8. 00	
F	ANCILLARY SERVICE COST CENTERS			2. 2.2		9. 9.	
50.00	05000 OPERATING ROOM	0	0	C	179, 622, 972	0.000000	50.00
51.00	D5100 RECOVERY ROOM	0	0	C	35, 348, 051	0.000000	51.00
52.00	D5200 DELIVERY ROOM & LABOR ROOM	0	0	C	22, 787, 921	0.000000	52.00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	0	0	C	39, 816, 484	0.000000	54.00
	D5500 RADI OLOGY-THERAPEUTI C	0	0	C	27, 109, 094		55. 00
	D5700 CT SCAN	0	0	C	69, 379, 077	0.000000	57. 00
	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	C	23, 887, 438		58. 00
1	D5900 CARDI AC CATHETERI ZATI ON	0	0	C	_,,	0.000000	59. 00
	06000 LABORATORY	0	0	C	-, -, -, -, -, -, -, -, -, -, -, -, -, -	0.000000	60. 00
	06400 INTRAVENOUS THERAPY	0	0	C	.,,	0. 000000	64. 00
	06500 RESPI RATORY THERAPY	0	0	C		0. 000000	65.00
1	D6600 PHYSI CAL THERAPY	0	0	C	26, 778, 761	0. 000000	
1	06700 OCCUPATI ONAL THERAPY	0	0	C	7, 455, 444		67. 00
1	D6800 SPEECH PATHOLOGY	0	0	C	2, 477, 919		68. 00
	D6900 ELECTROCARDI OLOGY	0	0	C	9, 130, 621	0. 000000	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0	C	,,		
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	,,		
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	10/010/1/		72. 00
	D7300 DRUGS CHARGED TO PATIENTS	0	0	C	99, 329, 272	0. 000000	73. 00
	07400 RENAL DIALYSIS	0	0	C	2, 708, 309	0. 000000	74. 00
	D3330 ENDOSCOPY	0	0	C		0. 000000	76. 00
1	D3954 I MAGI NG CENTER	0	0	C			76. 06
	D3955 BREAST DIAGNOSTIC CENTER DUTPATIENT SERVICE COST CENTERS	0	0	<u> </u>	12, 411, 554	0. 000000	76. 07
	09000 CLINIC		0		0	0. 000000	90. 00
	04975 SPINE CENTER		0				
	09100 EMERGENCY		0				
	D9200 OBSERVATION BEDS (NON-DISTINCT PART)		0				
200.00	Total (lines 50 through 199)		0	1	.,,		200. 00
200.00	Total (Tries 30 through 199)	١	O	1	1,000,177,072		1200.00

Health Financial Systems	COMMUNITY HOSPITAL OF	INDIANA, INC.	In Lieu of Form CMS-2552-10
ADDODEL OUMENT OF LANDATI FAIT (OUTDAT! FAIT		001	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0169 Peri od: Worksheet D From 01/01/2017 To 12/31/2017 THROUGH COSTS Part IV Date/Time Prepared: 5/30/2018 11:42 am Title XVIII Hospi tal PPS Cost Center Description Outpati ent Inpatient Inpati ent Outpati ent Outpati ent Program Ratio of Cost Program Program Program to Charges Pass-Through Pass-Through Charges Charges (col. 6 ÷ col Costs (col. 8 Costs (col. x col . 12) 13.00 x col. 10) 7) 9.00 10.00 11.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 43, 639, 651 11, 386, 569 50.00 0 0 51.00 05100 RECOVERY ROOM 0.000000 5, 279, 668 2, 256, 417 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 52.00 0 05400 RADI OLOGY-DI AGNOSTI C 0.000000 4, 326, 276 0 5, 555, 485 54.00 0 54.00 4, 771, 794 0 6, 719, 892 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 0 57.00 05700 CT SCAN 0.000000 8, 482, 777 0 10, 141, 136 0 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 1, 803, 803 0 4, 512, 943 0 58.00 0 05900 CARDIAC CATHETERIZATION 0.000000 1, 238, 506 59.00 59 00 0 0 06000 LABORATORY 60.00 0.000000 25, 464, 938 8, 400, 877 0 60.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 388, 212 0 64.00 06500 RESPIRATORY THERAPY 65.00 0.000000 6, 283, 703 0 215, 165 0 65.00 06600 PHYSI CAL THERAPY 0 0.000000 2, 426, 693 50, 460 66 00 0 66.00 0 67.00 06700 OCCUPATIONAL THERAPY 0.000000 1, 729, 335 41, 387 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 0.000000 618, 183 16,863 0 68.00 06900 ELECTROCARDI OLOGY 3, 411, 803 0 69.00 69 00 0.000000 263 290 0 07000 ELECTROENCEPHALOGRAPHY 70.00 0.000000 297, 559 2, 943, 404 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 16, 378, 482 4, 583, 730 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.000000 14, 726, 532 2, 019, 637 0 72.00 07300 DRUGS CHARGED TO PATIENTS 20, 931, 783 0 73 00 0.000000 7, 754, 324 73 00 Ω 0 74.00 07400 RENAL DIALYSIS 0.000000 1, 537, 221 0 74.00 76.00 03330 ENDOSCOPY 0.000000 235, 420 4, 888, 790 0 76.00 0 76.06 03954 I MAGING CENTER 0.000000 5, 709 13, 217, 853 0 76.06 03955 BREAST DIAGNOSTIC CENTER 0.000000 0 76.07 76.07 1, 302 874, 132 0 OUTPATIENT SERVICE COST CENTERS 90.00 0.000000 0 0 90.00 09000 CLI NI C 0 04975 SPINE CENTER 0.000000 90. 26 90. 26 0 0 91. 00 09100 EMERGENCY 14, 327, 738 16, 393, 562 0.000000 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 3, 124, 676 0 92.00 Total (lines 50 through 199) 178, 307, 088 0 200. 00 200.00 105, 360, 592

Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0169 Peri od: Worksheet D From 01/01/2017 Part V Date/Time Prepared: 12/31/2017 5/30/2018 11:42 am Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.092591 11, 386, 569 1, 054, 294 50.00 51.00 05100 RECOVERY ROOM 0. 155902 2, 256, 417 0 0 351, 780 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 0.606830 52 00 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.187869 5, 555, 485 1,043,703 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.083993 6, 719, 892 564, 424 55.00 57.00 05700 CT SCAN 0.033058 10.141.136 0 0 335. 246 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0.123046 4, 512, 943 555, 300 58.00 59.00 05900 CARDIAC CATHETERIZATION 0. 216363 0 59.00 0 60.00 06000 LABORATORY 0.102479 8, 400, 877 0 860, 913 60.00 0 06400 I NTRAVENOUS THERAPY 64 00 0.851022 64 00 0 65.00 06500 RESPIRATORY THERAPY 0. 203228 215, 165 43, 728 65.00 06600 PHYSI CAL THERAPY 0. 293306 50, 460 0 0 14, 800 66.00 66.00 0 06700 OCCUPATIONAL THERAPY 0. 276098 41, 387 0 11, 427 67.00 67.00 0 3, 023 68.00 06800 SPEECH PATHOLOGY 0.179294 16, 863 68 00 69.00 06900 ELECTROCARDI OLOGY 0.018645 263, 290 0 0 4, 909 69.00 07000 ELECTROENCEPHALOGRAPHY 0. 207680 2, 943, 404 0 611, 286 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 306113 4, 583, 730 0 0 1, 403, 139 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 0.495680 2, 019, 637 0 1,001,094 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 253725 7, 754, 324 168, 395 1, 967, 466 73.00 07400 RENAL DIALYSIS 0 74.00 0.454061 0 0 74.00 03330 ENDOSCOPY 0 76.00 0.143409 4, 888, 790 0 701, 096 76.00 0 03954 I MAGING CENTER 0 76.06 0.078385 13, 217, 853 1, 036, 081 76.06 03955 BREAST DIAGNOSTIC CENTER 0.521847 874, 132 0 456, 163 76.07 76.07 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 90.00 0 0 0 04975 SPINE CENTER 90. 26 0.465446 0 Λ 90. 26 91.00 09100 EMERGENCY 0.102072 16, 393, 562 0 0 1, 673, 324 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.723500 3, 124, 676 2, 260, 703 92.00 0 0 200.00 Subtotal (see instructions) 168, 395 200. 00 105, 360, 592 15, 953, 899 201.00 Less PBP Clinic Lab. Services-Program 201.00

105, 360, 592

0

168, 395

15, 953, 899 202. 00

Only Charges

Net Charges (line 200 - line 201)

202.00

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0169 Peri od: Worksheet D From 01/01/2017 Part V 12/31/2017 Date/Time Prepared: 5/30/2018 11:42 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 00000000000000000000000 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 57.00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 58.00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 06000 LABORATORY 0 60.00 60.00 06400 I NTRAVENOUS 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 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 Ω 73.00 07300 DRUGS CHARGED TO PATIENTS 42, 726 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 03330 ENDOSCOPY 76.00 0 76.00 03954 I MAGING CENTER 76.06 0 76.06 76. 07 03955 BREAST DIAGNOSTIC CENTER 0 76.07 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 0 0 0 0 0 04975 SPINE CENTER 90. 26 0 90. 26 91.00 09100 EMERGENCY 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 200.00 Subtotal (see instructions) 200. 00 42, 726 Less PBP Clinic Lab. Services-Program 201.00 201. 00

42, 726

202.00

Only Charges

Net Charges (line 200 - line 201)

202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS  Provider CCN: 15-0169 Component CCN: 15-S169  To 12/31/2017  To 12/31/2017  To 12/31/2017  Provider CCN: 15-0169 Part II Date/Time Prepared: 5/30/2018 11: 42 am PPS  Cost Center Description  Capital Related Cost (from Wkst. B, Part II, col. Part I, col. Part II Date/Time Prepared: 5/30/2018 11: 42 am PPS  Capital Costs (col umn 3 x col umn 4)							
Component CCN: 15-S169  Title XVIII  Cost Center Description  Capital Related Cost (from Wkst. B, Part II, col. 26)  Part II, col. 26)  Component CCN: 15-S169  To 12/31/2017  To 12/31/2017  Subprovider - IPF  Cost Center Description  Capital Charges (from Wkst. C, Part I, col. 20)  Part II Date/Time Prepared: 5/30/2018 11: 42 am  PPS  Cost Center Description  Capital Charges (col. 1 ÷ col. Charges (col. 1 ÷ col. 20)  Charges (col. 1 + col. 20)							2552-10
Component CCN: 15-S169 To 12/31/2017 Date/Time Prepared: 5/30/2018 11: 42 am  Title XVIII Subprovider - IPF  Cost Center Description  Capital Related Cost (from Wkst. C, (from Wkst. C, Part I, col. 26)  Part II, col. 26)  Component CCN: 15-S169 To 12/31/2017 Date/Time Prepared: 5/30/2018 11: 42 am  PPS  Inpatient Capital Costs (column 3 x column 4)  Capital Costs (column 4)	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der Ci	UN: 15-0169			
Cost Center Description  Capital Related Cost (from Wkst. B, Part II, col. 26)  Title XVIII Subprovider - IPF Cost Center Description  Capital Capital Charges (from Wkst. C, Part I, col. 28)  Subprovider - IPF Capital Costs (column 3 x (column 4)  Capital Costs (column 3 x Charges		Component			Date/Time Prepared:		
Cost Center Description  Capital Related Cost (from Wkst. C, to Charges (column 3 x (from Wkst. B, Part I, col. 26)  Capital Total Charges (from Wkst. C, to Charges (column 3 x (column 4) 2)			Title	Title XVIII			
Related Cost (from Wkst. C, to Charges Program (column 3 x (from Wkst. B, Part I, col. 8) 2) Charges column 4)							
(from Wkst. B, Part I, col. (col. 1 ÷ col. Charges column 4) Part II, col. 8) 2) 26)	Cost Center Description						
Part II, col. 8) 2)							
26)					. Charges	column 4)	
			8)	2)			
		26) 1. 00	2.00	2.00	4.00	F 00	
1. 00 2. 00 3. 00 4. 00 5. 00 ANCI LLARY SERVI CE COST CENTERS	ANCILLADY SEDVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00   05000   0PERATI NG ROOM   2, 766, 482   179, 622, 972   0. 015402   0   50. 00		2 766 492	170 622 072	0.01540	12	0	50 00
51. 00   05100   RECOVERY ROOM   570, 391   35, 348, 051   0. 016136   0   0   51. 00							
51. 00   05100   RECOVERT ROOM		· ·				-	
52. 00   05200   BEET VERT ROOM & EABOR ROOM   1, 030, 172   22, 787, 721   0. 072414   0   0   0   0   0   0   0   0   0						_	
55. 00   05500   RADI OLOGY-THERAPEUTI C   671, 202   27, 109, 094   0. 024759   0   0   55. 00		· ·					
57. 00   05700   CT SCAN   350, 908   69, 379, 077   0.005058   73, 983   374   57. 00							
58. 00   05800   MAGNETI C RESONANCE I MAGING (MRI)   329, 320   23, 887, 438   0. 013786   22, 015   303   58. 00							
59. 00   05900   CARDI AC CATHETERI ZATI ON   10, 306   2, 206, 059   0, 004672   0   0   59. 00							
60. 00   06000   LABORATORY   510, 421   118, 159, 395   0. 004320   731, 550   3, 160   60. 00		· ·				_	
64. 00   06400   I NTRAVENOUS THERAPY   212, 348   1, 209, 694   0. 175539   6, 312   1, 108   64. 00							
65. 00   06500  RESPI RATORY THERAPY   518. 061   26. 144, 674   0. 019815   17. 046   338   65. 00							
66. 00   06600   PHYSI CAL THERAPY   908, 339   26, 778, 761   0.033920   75, 214   2, 551   66. 00				l .			
67. 00   06700   0CCUPATI ONAL THERAPY   73, 818   7, 455, 444   0.009901   57, 126   566   67. 00							
68. 00   06800   SPEECH PATHOLOGY   15, 986   2, 477, 919   0. 006451   11, 368   73   68. 00							
69. 00   06900   ELECTROCARDI OLOGY   14, 135   9, 130, 621   0. 001548   19, 877   31   69. 00		· ·					69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 329, 096 12, 921, 823 0. 025468 12, 889 328 70. 00	70. 00 07000 ELECTROENCEPHALOGRAPHY	329, 096	12, 921, 823	0. 02546	12, 889	328	70. 00
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   1, 304, 301   82, 499, 342   0. 015810   52, 288   827   71. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 304, 301	82, 499, 342	0. 01581	0 52, 288	827	71. 00
72. 00   07200   I MPL. DEV. CHARGED TO PATIENTS   1, 195, 941   43, 848, 199   0. 027275   0   0   72. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 195, 941	43, 848, 199	0. 02727	'5 0	0	72. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   1,318,179   99,329,272   0.013271   483,705   6,419   73.00	73.00 07300 DRUGS CHARGED TO PATIENTS	1, 318, 179	99, 329, 272	0. 01327	1 483, 705	6, 419	73. 00
74. 00   07400   RENAL DI ALYSIS   29, 672   2, 708, 309   0. 010956   6, 116   67   74. 00		29, 672	2, 708, 309	0. 01095	6, 116	67	74. 00
76. 00   03330   ENDOSCOPY   598, 763   21, 490, 481   0. 027862   0   0   76. 00	76. 00   03330   ENDOSCOPY	598, 763	21, 490, 481			0	76. 00
76. 06   03954   I MAGI NG CENTER   781, 341   51, 819, 154   0. 015078   0   0   76. 06	76. 06   03954   I MAGI NG CENTER	781, 341	51, 819, 154			0	76. 06
76. 07 03955 BREAST DI AGNOSTI C CENTER 270, 196 12, 411, 554 0. 021770 0 0 76. 07		270, 196	12, 411, 554	0. 02177	0 0	0	76. 07
OUTPATIENT SERVICE COST CENTERS							
90. 00   09000   CLI NI C   0   0   0.000000   0   0   90. 00		-				-	
90. 26   04975   SPI NE CENTER   8, 666   766, 280   0. 011309   0   0   90. 26		· ·				-	
91. 00   09100   EMERGENCY   1, 200, 244   156, 319, 948   0. 007678   293, 889   2, 256   91. 00							
92.00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0 9,571,106 0.000000 0 0 92.00		-				_	
200.00   Total (lines 50 through 199)   16, 467, 238   1, 085, 199, 072   1, 901, 637   19, 198   200.00	200.00   Total (lines 50 through 199)	16, 467, 238	1, 085, 199, 072	l	1, 901, 637	19, 198	200. 00

Health Financial Systems	COMMUNITY HOSPITAL OF	INDIANA, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0169	Peri od: From 01/01/2017	Worksheet D
THROUGH COSTS		Component CCN: 15-S169		Date/Time Prepared: 5/30/2018 11:42 am
		Title XVIII	Subprovi der -	PPS

			Title	xVIII	Subprovi der -	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	oust conten bescription		Post-Stepdown	litar strig seriour	Post-Stepdown	711 T Ca T Car til	
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	•		•	·		
50.00	05000 OPERATING ROOM	0	0	C	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	C	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	C	0	0	55. 00
	05700  CT SCAN	0	0	C	0	0	57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	C	0	0	58. 00
	05900   CARDI AC   CATHETERI ZATI ON	0	0	C	0	0	59. 00
	06000 LABORATORY	0	0	C	0	0	60.00
	06400 I NTRAVENOUS THERAPY	0	0	C	0	0	64. 00
	06500 RESPI RATORY THERAPY	0	0	C	0	0	65. 00
	06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	0	0	C	0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0	C	0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0	C	0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0	C	0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
	07400 RENAL DI ALYSI S	0	0		0	0	74.00
	03330 ENDOSCOPY	0	0		0	0	76. 00
	03954 I MAGI NG CENTER	0	0		0	0	76.06
76.07	03955 BREAST DI AGNOSTI C CENTER	0	0		0	0	76. 07
00.00	OUTPATIENT SERVICE COST CENTERS  09000 CLINIC					0	00 00
	04975 SPI NE CENTER					0	90. 00 90. 26
	09100 EMERGENCY					0	90. 26
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				i i	0	91.00
200.00			О		o	0	200.00
200.00	1 Total (Tries 50 till bugh 177)	1	1 0	1	1 4	U	1200.00

Heal th Financial Systems	Health Financial Systems COMM	IIINI TV UOSDI TAI	OE INDIANA II	NC.	In lic	u of Form CMS 1	2552 10
Through COSTS							2332-10
Title XVIII   Subprovider   PPS		VIOL OTHER TAO			From 01/01/2017	Part IV Date/Time Pre	pared:
Cost Center Description			Ti +Lo	VVI I I	Subprovi dor		42 am
All Other   Medical Education Cost   Sum of Col 1   Sum of Col 2   Sum of Col 2			11116	XVIII		113	
Education Cost   Through col.   Cost (sum of col. 2, 3 and   Part I, col.   (col. 5 * col. 7)	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
ANCILLARY SERVICE COST CENTERS		Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,	to Charges	
ANCILLARY SERVICE COST CENTERS		Education Cost	through col.				
ANOLLLARY SERVICE COST CENTERS			4)		id 8)	7)	
ANCILLARY SERVICE COST CENTERS					7.00	0.00	
SOLO   05000   05000   05000   0   0   0   0	ANCILLADY CEDVICE COCT CENTEDS	4.00	5.00	6.00	7.00	8.00	
51. 00         05100         RECOVERY ROOM         0         0         35, 348, 051         0.000000         51. 00           52. 00         05200         DELI VERY ROOM & LABOR ROOM         0         0         0         22, 787, 921         0.000000         52. 00           54. 00         05400         RADI OLOGY-THE AGNOSTI C         0         0         0         27, 109, 094         0.000000         55. 00           55. 00         05500         RADI OLOGY-THERAPEUTI C         0         0         0         27, 109, 094         0.000000         55. 00           57. 00         05700         CT SCAN         0         0         0         69, 379, 077         0.000000         55. 00           59. 00         05700         CATRIA C CATHETERI ZATION         0         0         22, 206, 059         0.000000         59. 00           64. 00         06400         LABORATORY         0         0         0         118, 159, 395         0.000000         69. 00           65. 00         06500         RESPI RATORY THERAPY         0         0         0         1, 209, 694         0.000000         65. 00           65. 00         06500         PESPI RATORY THERAPY         0         0         0         26					0 170 622 072	0.00000	50 00
52. 00         05200 DELIVERY ROOM & LABOR ROOM         0         0         22, 787, 921         0.000000         52. 00           54. 00         05400 RADIO LOGY-THERAPEUTIC         0         0         0         39, 816, 484         0.000000         54. 00           57. 00         05500 RADIO LOGY-THERAPEUTIC         0         0         0         77, 109, 094         0.000000         55. 00           57. 00         05700 CT SCAN         0         0         0         69, 379, 077         0.000000         57. 00           58. 00         05800 MAGNETIC RESONANCE IMAGING (MRI)         0         0         0         2, 206, 059         0.000000         58. 00           60. 00         05900 CARDI AC CATHETERI ZATI ON         0         0         0         2, 206, 059         0.000000         59. 00           60. 00         06400 LABORATORY         0         0         0         118, 159, 395         0.000000         64. 00           64. 00         06400 INTRAVENOUS THERAPY         0         0         0         1, 209, 694         0.00000         64. 00           66. 00         06500 RESPI RATORY THERAPY         0         0         0         26, 174, 674         0.000000         66. 00           66. 00         0		_	_	1			
54. 00         0 5400 RADI OLOGY-DI AGNOSTIC         0         0         39,816,484         0.000000         54.00           55. 00         0 5500 RADI OLOGY-THERAPEUTIC         0         0         0.71,09,094         0.000000         55.00           57. 00         0 5700 CT SCAN         0         0         69,379,077         0.000000         57.00           58. 00         0 5800 MAGNETIC RESONANCE I MAGI NG (MRI)         0         0         0         23,887,438         0.000000         58.00           59. 00         0 5900 CARDI AC CATHETERI ZATI ON         0         0         0         118,159,395         0.000000         60.00		_	_				
55. 00         05500 RADI OLOGY-THERAPEUTI C         0         0         0         27, 109, 094         0.000000         55. 00           57. 00         05700 CT SCAN         0         0         0         69, 379, 077         0.000000         55. 00           58. 00         05800 MAGNETI C RESONANCE I MAGI NG (MRI)         0         0         0         23, 887, 438         0.000000         58. 00           59. 00         05900 CARDI AC CATHETERI ZATI ON         0         0         0         2, 206, 059         0.000000         59. 00           60. 00         0600 LABORATORY         0         0         0         118, 159, 395         0.000000         69. 00           64. 00         06400 INTRAVENOUS THERAPY         0         0         0         1, 209, 694         0.000000         64. 00           65. 00         06500 RESPI RATORY THERAPY         0         0         0         26, 174, 674         0.000000         65. 00           66. 00         06600 PHYSI CAL THERAPY         0         0         0         26, 778, 761         0.000000         65. 00           68. 00         06900 ELECTROSADI OLOGY         0         0         0         7, 455, 444         0.000000         67. 00           69. 00		0					1
57. 00         05700         CT SCAN         0         0         69, 379, 077         0.000000         57. 00           58. 00         05800         MAGNETI C RESONANCE I MAGI NG (MRI)         0         0         0.23, 887, 438         0.000000         58. 00           59. 00         05900         CARDI AC CATHETERI ZATI ON         0         0         0.20, 606, 6059         0.000000         59. 00           60. 00         06000         LABORATORY         0         0         0         118, 159, 395         0.000000         60. 00           64. 00         06400         INTRAVENOUS THERAPY         0         0         0         1, 209, 694         0.000000         64. 00           65. 00         06600         PHYSI CAL THERAPY         0         0         0         26, 174, 674         0.000000         66. 00           66. 00         06600         PHYSI CAL THERAPY         0         0         0         7, 455, 444         0.000000         66. 00           67. 00         06700         OCCUPATI ONAL THERAPY         0         0         0         7, 455, 444         0.000000         67. 00           68. 00         06900         ELECTROCARDI OLOGY         0         0         0         7, 479, 919		0					
58.00         05800         MAGNETIC RESONANCE IMAGING (MRI)         0         0         23,887,438         0.000000         58.00           59.00         05900         CARDIAC CATHETERIZATION         0         0         0         2,206,059         0.000000         59.00           60.00         06000         LABORATORY         0         0         0         118,159,395         0.000000         60.00           64.00         06400         INTRAVENOUS THERAPY         0         0         0         1,209,694         0.000000         64.00           65.00         06500         RESPI RATORY THERAPY         0         0         0         26,144,674         0.000000         65.00           66.00         06600         PHYSI CAL THERAPY         0         0         0         26,778,761         0.000000         66.00           67.00         06700         OCCUPATI ONAL THERAPY         0         0         0         7,455,444         0.000000         66.00           68.00         O6800         SPECH PATHOLOGY         0         0         0         2,477,919         0.000000         68.00           69.00         O6900         LECTROCARDI OLOGY         0         0         0         12,921,823 <td></td> <td>0</td> <td>Ö</td> <td></td> <td></td> <td></td> <td></td>		0	Ö				
59.00         05900         CARDI AC CATHETERI ZATI ON         0         0         2, 206, 059         0.000000         59.00           60.00         06000         LABORATORY         0         0         0         118, 159, 395         0.000000         60.00           64.00         06400         INTRAVENOUS THERAPY         0         0         0         1, 209, 694         0.000000         64.00           65.00         06500         RESPI RATORY THERAPY         0         0         0         26, 144, 674         0.000000         65.00           66.00         06600         PHYSI CAL THERAPY         0         0         0         26, 778, 761         0.000000         66.00           67.00         06700         OCCUPATI ONAL THERAPY         0         0         0         7, 455, 444         0.000000         66.00           68.00         06800         SPEECH PATHOLOGY         0         0         0         2, 477, 919         0.000000         68.00           69.00         06900         ELECTROCARDI OLOGY         0         0         0         9, 130, 621         0.000000         70.00           70.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0         12, 49		0	O	,			
64. 00   06400   INTRAVENOUS THERAPY   0   0   0   1, 209, 694   0.000000   64. 00   65. 00   665. 00   RESPI RATORY THERAPY   0   0   0   0   26, 144, 674   0.000000   65. 00   66. 00   66. 00   6600   PHYSI CAL THERAPY   0   0   0   0   26, 778, 761   0.000000   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   7, 455, 444   0.000000   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   2, 477, 919   0.000000   68. 00   69. 00   0   0.000000   69. 00   0.0000000   69. 00   0.0000000   69. 00   0.000000   69. 00   0.0000000   69. 00	59. 00   05900 CARDI AC CATHETERI ZATI ON	0	o	,			59. 00
65. 00   06500   RESPIRATORY THERAPY   0   0   0   26, 144, 674   0.000000   65. 00   66. 00   66. 00   66. 00   66. 00   66. 00   66. 00   0   0   0   26, 778, 761   0.000000   66. 00   67. 00   67. 00   0.000000   67. 00   0.000000   67. 00   0.000000   67. 00   0.000000   68. 00   0.000000   68. 00   0.000000   69. 00   0.000000   69. 00   0.000000   69. 00   0.000000   69. 00   0.000000   69. 00   0.000000   69. 00   0.000000   69. 00   0.000000   69. 00   0.000000   69. 00   0.000000   69. 00   0.000000000000000000000000000000	60. 00   06000   LABORATORY	0	0	1	0 118, 159, 395	0.000000	60.00
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 26, 778, 761 0.000000 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 7, 455, 444 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0, 2, 477, 919 0.000000 68. 00 69. 00 0 0 0, 2, 477, 919 0.000000 68. 00 0 0 0 0, 2, 477, 919 0.000000 68. 00 0 0 0 0 0 0 0, 2, 477, 919 0.000000 68. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	64. 00 06400 I NTRAVENOUS THERAPY	0	0	)	0 1, 209, 694	0. 000000	64. 00
67. 00		0	0	)	0 26, 144, 674		
68. 00		0	0	1			
69. 00		0	ĭ	1			
70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   12, 921, 823   0.000000   70. 00   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0   0   0   82, 499, 342   0.000000   71. 00   72. 00   07200   MPL. DEV. CHARGED TO PATI ENTS   0   0   0   43, 848, 199   0.000000   72. 00   73. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   99, 329, 272   0.000000   73. 00   74. 00   07400   RENAL DI ALYSI S   0   0   0   2, 708, 309   0.000000   74. 00   76. 00   0.3330   ENDOSCOPY   0   0   0   21, 490, 481   0.000000   76. 00   76. 00   0.0000000   76. 00   0.000000   76. 00   0.000000   76. 00   0.000000   76. 00   0		0	_				
71. 00		0	ĭ				
72. 00         07200 IMPL. DEV. CHARGED TO PATIENTS         0         0         43, 848, 199 (0.000000)         0.000000         72. 00           73. 00         07300 DRUGS CHARGED TO PATIENTS         0         0         0         99, 329, 272 (0.000000)         0.000000 (73. 00)           74. 00         07400 RENAL DIALYSIS         0         0         0         2, 708, 309 (0.00000)         0.000000 (74. 00)           76. 00         03330 ENDOSCOPY         0         0         0         21, 490, 481 (0.00000)         0.000000 (76. 00)           76. 07         03955 BREAST DIAGNOSTIC CENTER         0         0         0         51, 819, 154 (0.00000)         0.000000 (76. 00)           90. 00         09000 CLI NI C         0         0         0         0         0.000000 (76. 00)           90. 26         04975 SPI NE CENTER         0         0         0         0         0.000000 (0.00000)         90. 26           91. 00         09100 EMERGENCY         0         0         0         0         0.000000 (0.00000)         91. 00           92. 00         09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)         0         0         0         0         0         0.000000 (92. 00)		0	ĭ	1			
73. 00         07300         DRUGS CHARGED TO PATIENTS         0         0         99, 329, 272         0.000000         73. 00           74. 00         07400         RENAL DI ALYSI S         0         0         0         2, 708, 309         0.000000         74. 00           76. 00         03330         ENDOSCOPY         0         0         0         21, 490, 481         0.000000         76. 00           76. 06         03954         I MAGI NG CENTER         0         0         0         51, 819, 154         0.000000         76. 06           76. 07         03955         BREAST DI AGNOSTI C CENTER         0         0         12, 411, 554         0.000000         76. 07           90. 00         O9000         CLI NI C         0         0         0         0         0.000000         76. 07           90. 26         04975         SPI NE CENTER         0         0         0         0         0.000000         90. 26           91. 00         09100         EMERGENCY         0         0         0         156, 319, 948         0.000000         91. 00           92. 00         09200         OBSERVATI ON BEDS (NON-DI STI NCT PART)         0         0         9, 571, 106         0.000000		0	_				
74. 00       07400 RENAL DI ALYSI S       0       0       2, 708, 309       0.000000       74. 00         76. 00       03330 ENDOSCOPY       0       0       0       21, 490, 481       0.000000       76. 00         76. 06       03954 I MAGI NG CENTER       0       0       0       51, 819, 154       0.000000       76. 06         76. 07       03955 BREAST DI AGNOSTI C CENTER       0       0       12, 411, 554       0.000000       76. 07         90. 00       09000 CLI NI C       0       0       0       0       0.000000       90. 00         90. 26       04975 SPI NE CENTER       0       0       0       766, 280       0.000000       90. 26         91. 00       09100 EMERGENCY       0       0       0       156, 319, 948       0.000000       91. 00         92. 00       09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)       0       0       9, 571, 106       0.000000       92. 00		0					
76. 00		0					
76. 06 03954   IMAGING CENTER 0 0 0 51, 819, 154 0.000000 76. 06 76. 07 03955   BREAST DI AGNOSTI C CENTER 0 0 0 12, 411, 554 0.000000 76. 07 00 0 12, 411, 554 0.000000 76. 07 00 0 0 0 0.000000 0 0 0 0 0 0 0 0 0		0					
76. 07 03955 BREAST DI AGNOSTI C CENTER 0 0 0 12, 411, 554 0.000000 76. 07 0 0 12, 411, 554 0.000000 76. 07 0 0 12, 411, 554 0.000000 76. 07 0 0 0 0 0 0.000000 90. 00 90. 26 04975 SPI NE CENTER 0 0 0 0 0 766, 280 0.000000 90. 26 91. 00 09100 EMERGENCY 0 0 0 156, 319, 948 0.000000 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 9, 571, 106 0.000000 92. 00		0	0				
OUTPATIENT SERVICE COST CENTERS							
90. 00   09000   CLINI C   0   0   0   0   0   0   0   0   0		<u> </u>		1	0 12, 111, 001	0.000000	70.07
91. 00   09100   EMERGENCY   0   0   156, 319, 948   0.000000   91. 00   92. 00   09200   09SERVATI ON BEDS (NON-DI STI NCT PART)   0   0   0   9, 571, 106   0.000000   92. 00		0	O		0 0	0.000000	90.00
91. 00   09100   EMERGENCY   0   0   156, 319, 948   0.000000   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   0   0   0   9, 571, 106   0.000000   92. 00				1			
92. 00   09200  OBSERVATI ON BEDS (NON-DI STI NCT PART)   0   0   9,571,106   0.000000   92.00	91. 00 09100 EMERGENCY	0	O				
200.00   Total (lines 50 through 199)   0   0   1,085,199,072   200.00	92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
	200.00   Total (lines 50 through 199)	0	0	)	0 1, 085, 199, 072		200. 00

Health Financial Systems COMM	IUNITY HOSPITAL C	F INDIANA, IN	NC.	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der Co	CN: 15-0169	Peri od:	Worksheet D	
THROUGH COSTS			00N 4E 6440	From 01/01/2017	Part IV	
		Component	CCN: 15-S169	To 12/31/2017	Date/Time Pre 5/30/2018 11:	
		Title	: XVIII	Subprovi der -	PPS	72 UIII
				IPF		
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	0. 000000	0		0 0	0	50.00
51.00   05100   RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	38, 259		0	0	54.00
55. 00   05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55. 00
57.00 05700 CT SCAN	0. 000000	73, 983		0 0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	22, 015		0 0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59. 00
60. 00 06000 LABORATORY	0. 000000	731, 550		0 0	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	6, 312		0 0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	17, 046		0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	75, 214		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	57, 126		0 0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	11, 368		0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	19, 877		0 0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	12, 889		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	52, 288		0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	483, 705		0 0	0	73. 00
74.00 07400 RENAL DIALYSIS	0. 000000	6, 116		0 0	0	74.00
76. 00 03330 ENDOSCOPY	0. 000000	0		0 0	0	76. 00
76. 06 03954 I MAGI NG CENTER	0. 000000	0		0 0	0	76. 06
76. 07 03955 BREAST DIAGNOSTIC CENTER	0. 000000	0		0 0	0	76. 07
OUTPATIENT SERVICE COST CENTERS	· · · · · ·		•	_		
90. 00 09000 CLI NI C	0.000000	0		0 0	0	90. 00
90. 26   04975   SPI NE CENTER	0. 000000	0		0 0	0	90. 26
91. 00 09100 EMERGENCY	0. 000000	293, 889		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	1
200.00 Total (lines 50 through 199)		1, 901, 637		0 0	0	200. 00
			•			-

Health Financial Systems	COMMUNITY HOSPITAL OF	INDIANA, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0169	Peri od: From 01/01/2017	Worksheet D

| From 101/01/2017 | From 01/01/2017 | From 01/01/2017 | From 01/01/2017 | From 01/01/2017 | Part V | Date/Time Prepared: 5/30/2018 11: 42 am | Title XVIII | Subprovider - PPS

						07 007 2010 11.	12 4111
			Title	XVIII	Subprovi der  - I PF	PPS	
				Charges	IFI	Costs	
	Cost Center Description	Cost to Charge P	PS Reimbursed		Cost	PPS Services	
	cost content boson per on		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	( , , , , , , , , , , , , , , , , , , ,	
		Part I, col. 9	,	Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	CILLARY SERVICE COST CENTERS				_		
	OOO OPERATING ROOM	0. 092591	0		0	0	
	100 RECOVERY ROOM	0. 155902	0		0	0	51. 00
	200 DELIVERY ROOM & LABOR ROOM	0. 606830	0		0	0	52. 00
•	400 RADI OLOGY-DI AGNOSTI C	0. 187869	0		0	0	54. 00
	500 RADI OLOGY-THERAPEUTI C	0. 083993	0		0	0	55. 00
	700 CT SCAN	0. 033058	0		0	0	57. 00
	BOO MAGNETIC RESONANCE IMAGING (MRI)	0. 123046	0		0	0	58. 00
	900 CARDI AC CATHETERI ZATI ON	0. 216363	0		0	0	59. 00
	DOO LABORATORY	0. 102479	0		0	0	60.00
	400 I NTRAVENOUS THERAPY	0. 851022	0		0	0	64. 00
	500 RESPI RATORY THERAPY	0. 203228	0		0	0	65. 00
	600 PHYSI CAL THERAPY	0. 293306	0		0	0	66.00
	700 OCCUPATI ONAL THERAPY	0. 276098	0		0	0	67. 00
	BOO SPEECH PATHOLOGY	0. 179294	0		0	0	68. 00
	900 ELECTROCARDI OLOGY	0. 018645	0		0	0	69. 00
	DOO ELECTROENCEPHALOGRAPHY	0. 207680	0		0	0	70.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 306113	0		0	0	71.00
	200 IMPL. DEV. CHARGED TO PATIENTS	0. 495680	0		0	0	72.00
	BOO DRUGS CHARGED TO PATIENTS	0. 253725	0		0 3, 618		73.00
	400 RENAL DI ALYSI S	0. 454061	0		0	0	74.00
	330 ENDOSCOPY	0. 143409	0		0	0	76. 00
	954 I MAGI NG CENTER	0. 078385	0		0	-	76.06
	955 BREAST DIAGNOSTIC CENTER	0. 521847	0		0 0	0	76. 07
	FPATIENT SERVICE COST CENTERS DOO CLINIC	0. 000000	0		ol o	0	90.00
	975 SPI NE CENTER	0. 465446	0		0 0	0	90.00
	100 EMERGENCY	0. 465446	0		0	0	90. 26
	200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 723500	0		0	0	
200. 00	Subtotal (see instructions)	0. 723300	0		0 3, 618	_	200.00
200.00	Less PBP Clinic Lab. Services-Program		U		0 3,010	1	200.00
201.00	Only Charges				٥		201.00
202. 00	Net Charges (line 200 - line 201)		0		0 3, 618	0	202. 00
202.00	1.10 2.10 201)	1	U	l	5,010	,	1-02.00

Health Financial Systems COMM	MUNITY HOSPITAL OF	INDIANA, IN	VC.	In	Lieu of Form CMS	-2552-10
APPORTI ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co		Peri od: From 01/01/20		
		Component	CCN: 15-S169	To 12/31/20	D17 Date/Time Pr 5/30/2018 1	
		Title	XVIII	Subprovi der	- PPS	
				I PF		
	Costs					

			Title	XVIII	Subprovi der - LPF	PPS	
		Cos	sts		'''		
	Cost Center Description	Cost	Cost				
	3031 3011131 20301 Pt 1 311	Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0				50.00
51.00	05100 RECOVERY ROOM	0	0				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
57.00	05700 CT SCAN	0	0				57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60.00	06000 LABORATORY	0	0				60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0				64.00
65. 00	06500 RESPI RATORY THERAPY	0	0				65. 00
66.00	06600 PHYSI CAL THERAPY	0	0				66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0				68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0				69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	918				73. 00
	07400 RENAL DIALYSIS	0	0				74.00
76. 00	03330 ENDOSCOPY	0	0				76. 00
76. 06	03954 I MAGI NG CENTER	0	0				76. 06
76. 07	03955 BREAST DIAGNOSTIC CENTER	0	0				76. 07
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0				90.00
	04975 SPI NE CENTER	0	0				90. 26
91.00	09100 EMERGENCY	0	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00		0	918				200.00
201.00		0					201.00
	Only Charges						
202.00		0	918				202. 00

Health Financial Systems	COMMUNITY HOSPITAL	OF INDIANA, IN	NC.	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPI	TAL COSTS	Provider Co	F	Period: From 01/01/2017 To 12/31/2017		
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col .			
	26)		2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		Г	T	T		
30.00 ADULTS & PEDIATRICS	7, 418, 305		7, 418, 305			
31.00 INTENSIVE CARE UNIT	1, 545, 140	l e	1, 545, 140			
35.00 NEONATAL INTENSIVE CARE UNIT	1, 490, 924	l e	1, 490, 924		128. 30	
40. 00 SUBPROVI DER - I PF	247, 955	l e	247, 955		72. 06	
43. 00 NURSERY	682, 778		682, 778	7, 547	90. 47	43. 00
200.00 Total (lines 30 through 199)	11, 385, 102		11, 385, 102	89, 305		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	823	99, 879	1			30.00
31.00 INTENSIVE CARE UNIT	0	0	)			31.00
35.00 NEONATAL INTENSIVE CARE UNIT	804	103, 153				35. 00
40. 00 SUBPROVI DER - I PF	0	0	)			40. 00
43. 00 NURSERY	3, 484	315, 197				43.00
200.00 Total (lines 30 through 199)	5, 111					200.00
		•	•			

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-0169 Peri od: Worksheet D From 01/01/2017 Part II 12/31/2017 Date/Time Prepared: 5/30/2018 11:42 am Title XIX Hospi tal PPS Capital Costs Cost Center Description Capi tal Total Charges Ratio of Cost Inpati ent to Charges (from Wkst. C, (column 3 x Related Cost Program (from Wkst. B. column 4) Part I. col. (col. 1 + col Charges 2) Part II, col. 8) 26) 2.00 3.00 4.00 5.00 1.00 ANCILLARY SERVICE COST CENTERS 2, 766, 482 50.00 05000 OPERATING ROOM 0.015402 952, 794 14, 675 50.00 179, 622, 972 51. 00 | 05100 | RECOVERY ROOM 570, 391 35, 348, 051 0.016136 138, 665 2, 237 51.00 05200 DELIVERY ROOM & LABOR ROOM 1, 650, 172 22, 787, 921 0.072414 317, 283 22, 976 52.00 52.00 05400 RADI OLOGY-DI AGNOSTI C 828, 950 39, 816, 484 0.020819 187, 456 3, 903 54.00 54.00 05500 RADI OLOGY-THERAPEUTI C 27, 109, 094 2,009 55.00 671, 202 0.024759 81, 127 55.00 57.00 05700 CT SCAN 350, 908 69, 379, 077 0.005058 290, 757 1, 471 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 329, 320 23, 887, 438 0.013786 35, 401 488 58.00 2, 206, 059 05900 CARDIAC CATHETERIZATION 10, 306 0.004672 89. 706 419 59 00 59 00 1, 279, 884 06000 LABORATORY 118, 159, 395 60.00 510, 421 0.004320 5, 529 60.00 64.00 06400 I NTRAVENOUS THERAPY 212, 348 1, 209, 694 0.175539 6, 915 1, 214 64.00 06500 RESPIRATORY THERAPY 65.00 518, 061 26, 144, 674 0.019815 550, 072 10, 900 65.00 06600 PHYSI CAL THERAPY 26, 778, 761 0.033920 70, 139 2 379 66 00 908 339 66 00 67.00 06700 OCCUPATIONAL THERAPY 73,818 7, 455, 444 0.009901 131, 982 1, 307 67.00 06800 SPEECH PATHOLOGY 15, 986 2, 477, 919 0.006451 68.00 60, 616 391 68.00 06900 ELECTROCARDI OLOGY 9, 130, 621 0.001548 69 00 14 135 123 180 191 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 329, 096 12, 921, 823 0.025468 18, 490 471 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 304, 301 82, 499, 342 0.015810 671, 855 10, 622 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 1, 195, 941 43, 848, 199 0.027275 72.00 0 07300 DRUGS CHARGED TO PATIENTS 99, 329, 272 1, 499, 487 73 00 1, 318, 179 0.013271 19, 900 73 00 74.00 07400 RENAL DIALYSIS 29,672 2, 708, 309 0.010956 6, 297 69 74.00 76.00 03330 ENDOSCOPY 598, 763 21, 490, 481 0.027862 43, 890 1, 223 76.00 76.06 03954 I MAGING CENTER 781, 341 51, 819, 154 0.015078 0 0 76.06 03955 BREAST DIAGNOSTIC CENTER 270, 196 12, 411, 554 0.021770 76.07 0 0 76.07 OUTPATIENT SERVICE COST CENTERS 90.00 0.000000 90.00 09000 CLI NI C 0 90. 26 04975 SPI NE CENTER 8, 666 766, 280 0.011309 90. 26 0 0 91. 00 |09100 EMERGENCY 1, 200, 244 91.00 156, 319, 948 0.007678 472, 911 3.631 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 736, 926 9, 571, 106 0.076995 38, 254 2, 945 92.00 200.00 Total (lines 50 through 199) 17, 204, 164 1, 085, 199, 072 7, 067, 161 108, 950 200. 00

Health Financial Systems	COMMUNITY HOSPITAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	R PASS THROUGH COS		F	eriod: rom 01/01/2017 o 12/31/2017	Worksheet D Part III Date/Time Pre 5/30/2018 11:	pared: 42 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School			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						
30. 00 03000 ADULTS & PEDIATRICS	0	0	0	0	0	30. 00
31.00   03100   INTENSIVE CARE UNIT	0	0	0	0	0	31. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35. 00
40. 00   04000   SUBPROVI DER - 1 PF	0	0	0	0	0	40.00
43. 00   04300   NURSERY	0	0	0	0	0	43.00
200.00 Total (lines 30 through 199)	0	0	0	0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
·	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,			•	
	instructions)	minus col. 4)				
	4.00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	·					
30. 00   03000   ADULTS & PEDI ATRI CS	0	0	61, 124	0.00	823	30. 00
31.00 03100 INTENSIVE CARE UNIT		0	5, 572	0.00	0	31. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT		0	11, 621	0.00	804	35. 00
40. 00   04000   SUBPROVI DER - 1 PF	0	0	3, 441	0.00	0	40. 00
43. 00   04300   NURSERY		0	7, 547	0.00	3, 484	43. 00
200.00 Total (lines 30 through 199)		0			5, 111	200. 00
Cost Center Description	I npati ent					
·	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0					35. 00
40. 00   04000   SUBPROVI DER - 1 PF	0					40.00
43. 00   04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200. 00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	,	1				

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 01/01/2017 | Part IV | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | To 12/3 Health Financial Systems COMMUNITY HOSPITAL OF APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0169 THROUGH COSTS

					10 12/01/201/	5/30/2018 11:4	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
			Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0		0	0	50. 00
51.00	05100 RECOVERY ROOM	0	0		0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
54.00	05400  RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55. 00
57.00	05700 CT SCAN	0	0		0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
60.00	06000 LABORATORY	0	0		0	0	60. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
74. 00	07400 RENAL DI ALYSI S	0	0		0	0	74. 00
76. 00	03330 ENDOSCOPY	0	0		0	0	76. 00
76. 06	03954 I MAGI NG CENTER	0	0		0	0	76. 06
76. 07	03955 BREAST DI AGNOSTI C CENTER	0	0		0 0	0	76. 07
	OUTPATIENT SERVICE COST CENTERS			ı		_	
90.00	09000 CLI NI C	0	0		0	· ·	90. 00
	04975 SPI NE CENTER	0	0		0	0	90. 26
91. 00	09100 EMERGENCY	0	0		0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	_		0	0	92. 00
200.00	Total (lines 50 through 199)	0	0	1	0 0	J 01	200. 00

Heal th Financial Systems COMMUNITY HOSPITAL OF APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0169 THROUGH COSTS

THROUGH GOOTS			Τ	o 12/31/2017	Date/Time Pre 5/30/2018 11:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of col 1		(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col. 2, 3 and	8)	7)	
			4)			
ANOLILIA DIVI OFRIVI OF COOT OFFITERS	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS		0		170 (22 072	0.000000	
50. 00   05000   OPERATING ROOM	0	0				
51. 00 05100 RECOVERY ROOM	0	0			0.000000	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0			0.000000	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0				
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	0				
57. 00 05700 CT SCAN	0	0				1
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		23, 887, 438		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		2,200,007		l .
60. 00   06000   LABORATORY	0	0		,,		60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		., 20,,0,,		64. 00
65. 00 06500 RESPIRATORY THERAPY	0	0		, ,		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		26, 778, 761	0.000000	1
67. 00 06700 OCCUPATIONAL THERAPY	0	0		7, 455, 444		l
68. 00 06800 SPEECH PATHOLOGY	0	0		2, 477, 919		
69. 00 06900 ELECTROCARDI OLOGY	0	0		9, 130, 621	0.000000	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		,,		l .
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		43, 848, 199		
73. 00   07300   DRUGS CHARGED TO PATIENTS 74. 00   07400   RENAL DIALYSIS	0	0		99, 329, 272		ł
	0	0		2, 708, 309		
76. 00 03330 ENDOSCOPY	0	0				
76. 06   03954   I MAGI NG CENTER 76. 07   03955   BREAST DI AGNOSTIC CENTER	0	0		, ,		
	<u> </u>	0	(	12, 411, 554	0. 000000	76. 07
OUTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC		0		0	0. 000000	90.00
	0	0	1	1		1
90. 26   04975   SPI NE CENTER 91. 00   09100   EMERGENCY		0	0			
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)		0	0			1
		0		.,,		1
200.00   Total (lines 50 through 199)	١	0	1	1, 085, 199, 072	I	200. 00

| Peri od: | Worksheet D | From 01/01/2017 | Part IV | To 12/31/2017 | Date/Time Prepared: Heal th Financial Systems COMMUNITY HOSPITAL OF APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0169 THROUGH COSTS

				o 12/31/2017	Date/lime Prep   5/30/2018 11:4	
		Ti tl	e XIX	Hospi tal	PPS	12 (1111
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCI LLARY SERVI CE COST CENTERS						
50.00   05000   OPERATING ROOM	0. 000000	952, 794		_	0	50. 00
51.00   05100   RECOVERY ROOM	0. 000000	138, 665		0	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	317, 283		0	0	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	187, 456		0	0	54. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 000000	81, 127		0	0	55. 00
57.00  05700   CT   SCAN	0. 000000	290, 757	(	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	35, 401	(	0	0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0. 000000	89, 706		0	0	59. 00
60. 00   06000   LABORATORY	0. 000000	1, 279, 884		0	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	6, 915		0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	550, 072		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	70, 139		0	0	66. 00
67. 00   06700   OCCUPATI ONAL THERAPY	0. 000000	131, 982		0	0	67. 00
68. 00   06800   SPEECH PATHOLOGY	0. 000000	60, 616	(	0	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY	0. 000000	123, 180	(	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	18, 490	(	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	671, 855	(	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	(	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 499, 487	(	0	0	73. 00
74. 00   07400   RENAL DI ALYSI S	0. 000000	6, 297		0	0	74. 00
76. 00   03330   ENDOSCOPY	0. 000000	43, 890	C	0	0	76. 00
76. 06   03954   I MAGI NG CENTER	0. 000000	0	C	0	0	76. 06
76. 07 03955 BREAST DIAGNOSTIC CENTER	0. 000000	0	C	0	0	76. 07
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0	(	0	0	90. 00
90. 26   04975   SPI NE CENTER	0. 000000	0	C	0	0	90. 26
91. 00   09100   EMERGENCY	0. 000000	472, 911	(	0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	38, 254	(	0	0	92.00
200.00 Total (lines 50 through 199)		7, 067, 161	C	0	0	200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0169 Peri od: Worksheet D From 01/01/2017 Part V Date/Time Prepared: 12/31/2017 5/30/2018 11:42 am Title XIX Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.092591 357, 442 0 50.00 51.00 05100 RECOVERY ROOM 0. 155902 0 37, 611 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 52 00 0.606830 0 O 52 00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 0.187869 0 487, 958 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.083993 109, 451 0 55.00 57.00 05700 CT SCAN 0.033058 0 834, 212 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0.123046 160, 618 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0. 216363 0 59.00 06000 LABORATORY 60.00 0.102479 0 887, 024 0 60.00 06400 I NTRAVENOUS THERAPY 0.851022 0 64 00 0 64 00 C 65.00 06500 RESPIRATORY THERAPY 0. 203228 0 44, 387 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 293306 0 82, 772 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0. 276098 40, 852 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 32, 785 0.179294 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.018645 0 20, 437 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0. 207680 60, 493 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 306113 0 144, 185 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.495680 0 72.00 72 00 C0 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 253725 324, 373 0 73.00 07400 RENAL DIALYSIS 0 74.00 74.00 0.454061 С 0 03330 ENDOSCOPY 76.00 0.143409 0 104.688 0 76.00 03954 I MAGING CENTER Ω 76.06 0.078385 260, 850 Ω 76.06 03955 BREAST DIAGNOSTIC CENTER 76.07 0.521847 0 42, 502 0 76.07 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 0.000000 0 0 04975 SPINE CENTER 90. 26 0.465446 0 0 0 90. 26 91.00 09100 EMERGENCY 0.102072 3, 492, 750 0 0 0 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.723500 0 288, 489 0 92.00 200.00 Subtotal (see instructions) Λ 7, 813, 879 200. 00 0 Less PBP Clinic Lab. Services-Program 201.00 0 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 7, 813, 879 0 0 202.00

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0169 Peri od: Worksheet D From 01/01/2017 Part V 12/31/2017 Date/Time Prepared: 5/30/2018 11:42 am Title XIX Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 33, 096 0 50.00 51.00 05100 RECOVERY ROOM 5,864 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 91,672 0 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 9, 193 55.00 57.00 05700 CT SCAN 27.577 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 19, 763 58.00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 06000 LABORATORY 0 60.00 90, 901 60.00 06400 I NTRAVENOUS THERAPY 0 64 00 64 00 0 65.00 06500 RESPIRATORY THERAPY 9,021 0 65.00 66.00 06600 PHYSI CAL THERAPY 24, 278 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 11, 279 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 5,878 68.00 69.00 06900 ELECTROCARDI OLOGY 381 0 69.00 07000 ELECTROENCEPHALOGRAPHY 12, 563 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 44, 137 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 82, 302 0 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 03330 ENDOSCOPY 0 76.00 15.013 76.00 03954 I MAGING CENTER 76.06 20, 447 0 76.06 76. 07 03955 BREAST DIAGNOSTIC CENTER 22, 180 0 76.07 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 0 0 04975 SPINE CENTER 90. 26 0 0 90. 26 91. 00 09100 EMERGENCY 356, 512 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 208, 722 92.00 200.00 Subtotal (see instructions) 1,090,779 0 200. 00 Less PBP Clinic Lab. Services-Program 201.00 201. 00 Only Charges

1,090,779

0

202.00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	COMMUNITY HOSPITAL OF	INDIANA, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169	Period: From 01/01/2017	Worksheet D-1
				Date/Time Prepared: 5/30/2018 11:42 am
		Title XVIII	Hospi tal	PPS

10.00 fortal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost operating period (if called partial period of the cost operating period (if called partial period of the cost operating period (if called period period of the cost operating period (if called period of the cost operating period (if called period of the cost operating period (if called period of the cost operating period of the cost operating period (if called period of the cost operating period of t					5/30/2018 11:	42 am
PART 1 - ALL PROVIDER COMPOBENTS			Title XVIII	Hospi tal	PPS	
PART   - ALL PROVIDER COMPONENTS		Cost Center Description				
Impatient days (including private room days, and swing-bed days, excluding newborn)					1. 00	
1,00   Inpatient days (Including private room days and sking-bed days, excluding newborn)   6,1,124   1,00   1,00   Inpatient days (Including private room days, excluding sking-bed and newborn days)   6,1,124   2,0   1,00						
10. politherit days (including private room days, excluding saling-bed and newborn days) 10. private room days (excluding saling-bed and observation bed days) 10. private room days (excluding saling-bed and observation bed days) 10. private room days (excluding saling-bed and observation bed days) 10. private room days (excluding saling-bed and observation bed days) 10. private room days (excluding saling-bed saling private room days) through December 31 of the cost reporting period (if callendar year, enter 0 on this line) 10. private room days after becember 31 of the cost reporting period (if callendar year, enter 0 on this line) 10. private room days) through December 31 of the cost reporting period (if callendar year, enter 0 on this line) 10. private room days) through December 31 of the cost reporting period (if callendar year, enter 0 on this line) 10. private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 10. private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 10. private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 10. private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 10. private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 10. private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 10. private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 10. private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 10. private room days) after December 31 of the cost reporting December 31 of	4 00				(4.404	4 00
1.00   2.0					· ·	•
1.00 ont complete this I line.  Semi-private room days (excluding swing-bed and observation bed days)  Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this I ine)  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 I ine)  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 I ine)  Total sing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this I ine)  Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this I ine)  Maing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this I ine)  December 31 of the cost reporting period (if calendar year, enter 0 on this I ine)  Through December 31 of the cost reporting period (if calendar year, enter 0 on this I ine)  Through December 31 of the cost reporting period (if calendar year, enter 0 on this I ine)  Through December 31 of the cost reporting period (if calendar year, enter 0 on this I ine)  Through December 31 of the cost reporting period (if calendar year, enter 0 on this I ine)  Through December 31 of the cost reporting period (if calendar year, enter 0 on this I ine)  Through December 31 of the cost reporting period (if calendar year, enter 0 on this I ine)  Through December 31 of the cost reporting period (if calendar year, enter 0 on this I ine)  Through December 31 of the cost reporting period (if calendar year, enter 0 on this I ine)  Through December 31 of the cost reporting period (if calendar year, enter 0 on this I ine)  Through December 31 of the cost reporting period (ine)  Through Decemb				ivato room dave		•
55, 622 4.0  6.00 Fortal swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (including private room days) through December 31 of the cost reporting period (including private room days) through December 31 of the cost reporting period (including private room days) through December 31 of the cost reporting period (including private room days) through December 31 of the cost reporting period (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) after December 31 of the cost reporting period (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) after December 31 of the cost reporting period (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) after December 31 of the cost reporting period (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 period (including private room days) after December 31 of the cost reporting period (including period (including private room days) after December 31 of the cost reporting period (including period (including private room days) after December 31 of the cost reporting period (including period (including private room days) after December 31 of the cost reporting period (including period (including private room days) after December 31 of the cost reporting period (including period	3.00		ys). If you have only pr	i vate i ooni days,	J	3.00
10   10   10   10   10   10   10   10	4.00	· ·	ed days)		55, 052	4. 00
reporting period.  Total swing-bed SN type inpatient days (including private room days) after December 31 of the cost reporting period.  Total swing-bed Mf type inpatient days (including private room days) through December 31 of the cost reporting period.  Total swing-bed Mf type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endary were, renter 0 on this sline)  Total inpatient days including private room days after December 31 of the cost reporting period (if cal endary were, renter 0 on this sline)  Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  Through December 31 of the cost reporting period (see instructions)  Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  Through December 31 of the cost reporting period (see instructions)  Swing-bed NF type inpatient days applicable to title XVIII only (including private room days)  Through December 31 of the cost reporting period (see instructions)  Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  Through December 31 of the cost reporting period (see instructions)  Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  Total nursery days (title V or XIX only)  Total nursery days (title V or XIX only)  Swing-bed NF type inpatient days applicable to services through December 31 of the cost on the Indian Private room days applicable to services after December 31 of the cost on the Swing-bed SNF services applicable to services after December 31 of the cost on the Swing-bed SNF services applicable to services after December 31 of the cost reporting period (see instructions)  Swing-bed cost applicable to	5. 00			r 31 of the cost	00,002	5.00
10					- 1	
Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days applicable to the Program (excluding swing-bed and Total inpatient days including private room days applicable to the Program (excluding swing-bed and Total inpatient days including private room days applicable to the Program (excluding swing-bed and Total inpatient days applicable to title XVII only (including private room days) after December 31 of the cost reporting period (see instructions)  11.00 Swing-bed SMF type inpatient days applicable to title XVII 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 NF type inpatient days applicable to title XVII only (including private room days)  13.00 Swing-bed NF 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)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  13.00 Swing-bed DAUDSTNEWN  14.00 Mursery days (title V or XIX only)  15.00 Total inpatient days applicable to services after December 31 of the cost reporting period (including private room days)  16.00 Mursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services 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 after December 31 of the cost reporting period (including private room days)  18.00 Medicare rate for swing-bed SNF services after December 31 of the cost reporting period (including private room days applicable to SNF type services after December 31 of the cost repor	6.00		om days) after December :	31 of the cost	0	6.00
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newborn days	0.00		+b- D (		10 144	0.00
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16.00   Nursery days (title V or XIX only)			am (excluding swing-bed	days)	-	
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x line 18) 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 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRI VATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Pri vate room charges (excluding swing-bed charges) Semi-private room cost differential (line 27 ÷ line 28) Semi-private room cost differential (line 30 ÷ line 4) Semi-private room cost differential (line 30 ÷ line 31) Semi-private room cost differential (line 30 ÷ line 31) Semi-private room cost differential (line 30 ÷ line 31) Semi-private room cost differential (line 69, 707, 847) Semi-private room cost differential (line 30 ÷ line 31) Semi-private room cost differential (line 69, 7	23 00	· · · · · · · · · · · · · · · · · · ·	31 of the cost reporting	n neriod (line 6	0	23 00
Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 x line 20)  Total swing-bed cost (see instructions)  Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Ceneral inpatient routine service cost/charge ratio (line 27 + line 28)  Average private room per diem charge (line 29 + line 3)  Average per diem private room charge differential (line 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 3 x line 35)  Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 35)  PRATT II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost applicable to the Program (line 14 x line 35)  O 40dically necessary private room cost applicable to the Program (line 14 x line 35)  O 40dically necessary private room cost applicable to the Program (line 14 x line 35)  O 40dically necessary private room cost applicable to the Program (line 14 x line 35)	23.00		or the cost reporting	g perrou (Triic o	ا	25.00
7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 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 General inpatient routine service charges (excluding swing-bed and observation bed charges) General inpatient routine service charges (excluding swing-bed and observation bed charges) OPrivate room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) OPrivate room charges (excluding swing-bed charges) OPRIVATE ROOM DIFFERENTIAL ADJUSTMENT  OPRIVATE ROOM DIF	24. 00	/	31 of the cost reporti	na period (line	0	24.00
x line 20) Total swing-bed cost (see instructions) Q26.00 Reneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  Q8.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Q9.00 Private room charges (excluding swing-bed charges) Q8.00 Semi-private room charges (excluding swing-bed charges) Q9.00 Q9.0				5   1		
Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) General inpatient routine service charges (excluding swing-bed and observation bed charges) General inpatient routine service charges (excluding swing-bed and observation bed charges) General inpatient routine service charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 30 ÷ line 4) Ceneral inpatient routine service cost/charge ratio (line 30 ÷ line 4) Ceneral inpatient routine service cost (line 30 ÷ line 4) Ceneral inpatient routine service cost (line 32 minus line 33) (see instructions) Ceneral inpatient routine service cost differential (line 34 x line 31) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 69, 707, 847) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 69, 707, 847) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine se	25.00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  RRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Pri vate room charges (excluding swing-bed charges)  Semi-pri vate room charges (excluding swing-bed charges)  Semi-pri vate room charges (excluding swing-bed charges)  Semi-pri vate room charges (excluding swing-bed charges)  Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28)  Average pri vate room per diem charge (line 29 ÷ line 3)  Average semi-pri vate room per diem charge (line 30 ÷ line 4)  Average per diem pri vate room cost differential (line 32 minus line 33) (see instructions)  Average per diem pri vate room cost differential (line 34 x line 31)  Average per diem pri vate room cost differential (line 3 x line 35)  Pri vate room cost differential adjustment (line 3 x line 35)  Ceneral inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 49, 707, 847)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  O 40.00						
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)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 69, 707, 847)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00 29.0	26. 00					
General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  Average private room per diem charge (line 29 ÷ line 3)  Average semi-private room per diem charge (line 30 ÷ line 4)  Average per diem private room charge differential (line 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 69, 707, 847)  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  Occurrence of the charges (excluding swing-bed and observation bed charges)  Occurrence of the charges (excluding swing-bed charges)  Occurrence of the charges (line 27 ÷ line 28)  Occurrence of the charges (line 27 ÷ line 28)  Occurrence of the charges (line 27 ÷ line 28)  Occurrence of the charges (line 27 ÷ line 28)  Occurrence of the charges (line 27 ÷ line 28)  Occurrence of the charges (line 27 ÷ line 28)  Occurrence of the charges (line 27 ÷ line 28)  Occurrence of the charges (line 27 ÷ line 28)  Occurrence of the charges (line 27 ÷ line 28)  Occurrence of the charges (line 27 ÷ line 28)  Occurrence of the charges (line 27 ÷ line 28)  Occurrence of the charges (line 27 ÷ line 28)  Occurrence of the charges (line 27 ÷ line 28)  Occurrence of the charges (line 27 ÷ line 28)  Occurrence of the charges (line 27 ÷ line 28)  Occurrence of the charges (line 27 ÷ line 28)  Occurrence of the charges (line 27 ÷ line 28)  Occurrence of the charges (lin	27. 00		(line 21 minus line 26)		69, 707, 847	27. 00
Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  Average private room per diem charge (line 29 ÷ line 3)  Average semi-private room per diem charge (line 30 ÷ line 4)  Average per diem private room charge differential (line 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 69, 707, 847)  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 29. 0  30. 0  0 30. 0  0 0. 000000  31. 0  0 . 0000000  32. 0  0 . 0000000  32. 0  0 . 0000000  32. 0  0 . 0000000  32. 0  0 . 0000000  32. 0  0 . 0000000  33. 0  0 . 0000000  34. 00  36. 00  Average per diem private room cost differential (line 34 x line 35)  0 36. 00  37. 00  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 69, 707, 847)  38. 00  Adjusted general inpatient routine service cost (line 9 x line 38)  40. 00  Medically necessary private room cost applicable to the Program (line 14 x line 35)	20.00		d and abase (ation had ab	25222)		1 20 00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 69, 707, 847) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 30.00 Onumber 20.000000 31.00 Onumber 20.000000 32.00 Onumber 20.000000 33.00 Onumber 20.000000 33.00 Onumber 20.000000 33.00 Onumber 20.000000 33.00 Onumber 20.0000000 33.000 Onumber 20.000000 33.000 Onumber 20.000000 33.000 Onumber 20.000000 33.000 Onumber 20.0000000 33.000 Onumber 20.00000000 33.000 Onumber 20.000000000 33.000000000000000000000000			a and observation bed cha	arges)		
31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00 Average private room per diem charge (line 29 ÷ line 3)  33. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  34. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 69, 707, 847)  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)  0. 00 000 33. 00  0. 00 32. 00  0. 00 34. 00  0. 00 35. 00  0. 00 35. 00  0. 00 35. 00  0. 00 35. 00  0. 00 35. 00  0. 00 34. 00  0. 00 35. 00  0. 00 36. 00  37. 00 69, 707, 847  38. 00 9, 707, 847  39. 00 9, 707, 847  39. 00 9, 707, 847  39. 00 9, 707, 847  39. 00 9, 707, 847  39. 00 9, 707, 847  39. 00 9, 707, 847  39. 00 9, 707, 847  39. 00 9, 707, 847  39. 00 9, 707, 847  39. 00 9, 707, 847  39. 00 9, 707, 847  39. 00 9, 707, 847  39. 00 9, 707,					-	
Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 69, 707, 847)  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)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 32.00			: line 28)			
Average semi-private room per diem charge (line 30 ÷ line 4)  Average per diem private room charge differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Brivate room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 69, 707, 847)  Average per diem private room cost differential (line 34 x line 31)  Brivate room cost differential (line 69, 707, 847)  Average per diem private room cost differential (line 69, 707)  Brivate room cost differential (line 69, 707, 847)  Average per diem private room cost differential (line 69, 707)  Brivate room cost differential (line 69, 707, 847)  Broven Brivate room cost differential (line 69, 707, 847)  Broven Brivate room cost differential (line 69, 707, 847)  Broven Brivate room cost differential (line 69, 707, 847)  Broven Brivate room cost differential (line 69, 707, 847)  Broven Brivate room cost differential (line 69, 707, 847)  Broven Brivate room cost differential (line 69, 707, 847)  Broven Brivate room cost differential (line 69, 707, 847)  Broven Brivate room cost differential (line 69, 707, 847)  Broven Brivate room cost differential (line 69, 707, 847)  Broven Brivate room cost differential (line 69, 707, 847)  Broven Brivate room cost differential (line 69, 707, 847)  Broven Brivate room cost differential (line 69, 707, 847)  Broven Brivate room cost differential (line 69, 707, 847)  Broven Brivate room cost differential (line 69, 707, 847)  Broven Brivate room cost differential (line 69, 707, 847)  Broven Broven Brivate room cost differential (line 69, 707, 847)  Broven Brivate room cost differential (line 34 x line 31)  Broven Brivate room cost differential (line 34 x line 31)  Broven Brove	32. 00	,				l
Average per diem private room charge differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Brivate room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 69, 707, 847)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost (line 9 x line 38)	33. 00	, , , , , , , , , , , , , , , , , , , ,				
Average per diem private room cost differential (line 34 x line 31)  35.00 Private room cost differential adjustment (line 3 x line 35)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 69, 707, 847)  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)  0 0 35.00 O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	34.00		nus line 33)(see instruc	tions)		1
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 69, 707, 847 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)  0 36.00 Adjusted general inpatient routine service cost per diem (see instructions) 20,691,962 30.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	35.00			•		1
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)  1,140.43 38.03 39.00 Program general inpatient routine service cost (line 9 x line 38)  20,691,962 39.03 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	36.00				0	36.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,140.43 38.00 Program general inpatient routine service cost (line 9 x line 38)  20,691,962 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37. 00				69, 707, 847	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,140.43 38.00 Program general inpatient routine service cost (line 9 x line 38)  20,691,962 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						ļ
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,140.43 38.03 39.00 Program general inpatient routine service cost (line 9 x line 38)  20,691,962 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						ļ
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) 20,691,962 39.00 40.00				-		
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	38. 00	, , , , , , , , , , , , , , , , , , , ,	*			
		, , ,	•			
1. 00   10 tal   110gram general   11patrent 100tine Service Cost (11ne S9 + 11ne 40)   20,091,902  41. C		, , , , , , , , , , , , , , , , , , , ,	*		-	1
	<del>+</del> 1.00	Trotal Trogram general impatrent routine service cost (IIIIe 39	11116 40)	l	20,071,702	1 41.00

	Financial Systems COMM ATION OF INPATIENT OPERATING COST	UNITY HOSPITAL				u of Form CMS-1	
COMPUT	ATTON OF INPATTENT OPERATING COST		Provider C	CN: 15-0169	Peri od: From 01/01/2017	Worksheet D-1	
					To 12/31/2017	Date/Time Pre 5/30/2018 11:	
			Ti tl e	e XVIII	Hospi tal	PPS	72 diii
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatrent cost	Inpatient Days	col. 2)	÷	(col. 3 x col. 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	00 0	0	42. 00
43. 00	INTENSIVE CARE UNIT	11, 331, 242	5, 572	2, 033. 6	2, 047	4, 162, 779	43.00
44. 00	CORONARY CARE UNIT						44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	15, 257, 423	11, 621	1, 312. 9	02	0	46. 00 47. 00
	Cost Center Description		, -	1			
48. 00	Program inpatient ancillary service cost (Wk:	et D 2 col 3	Lino 200)			1. 00 32, 309, 731	48. 00
49. 00	Total Program inpatient costs (sum of lines			ons)		57, 164, 472	1
	PASS THROUGH COST ADJUSTMENTS						1
50. 00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sum	of Parts I and	2, 769, 589	50.00
51. 00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	2, 529, 972	51.00
F0 00	and IV)	50   54)				F 000 F/4	F0 00
52. 00 53. 00	Total Program excludable cost (sum of lines! Total Program inpatient operating cost exclud	,	lated non-phy	sician anesth	etist and	5, 299, 561 51, 864, 911	1
00.00	medical education costs (line 49 minus line !					0170017711	]
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION					0	E4 00
54. 00 55. 00	Program discharges Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)		0	56. 00			
57. 00							57. 00 58. 00
58. 00 59. 00							58. 00 59. 00
	market basket						
60. 00 61. 00							60. 00 61. 00
011.00	which operating costs (line 53) are less than	n expected cost				0	011.00
62. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				0	62. 00
63.00	Allowable Inpatient cost plus incentive payme	ent (see instru	ıcti ons)			0	1
	PROGRAM INPATIENT ROUTINE SWING BED COST					_	
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions) (title XVIII only)	ts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64. 00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	no costs (lino	64 plus lipo 6	SS) (+i +l o VVIII	Lonly) For	0	66. 00
00.00	CAH (see instructions)	ie costs (Title	04 prus rine c	os)(title xvii	1 Only). To		00.00
67. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 c	of the cost re	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after [	ecember 31 of	the cost repo	rting period	0	68. 00
	(line 13 x line 20)				0 1	_	
69. 00	Total title V or XIX swing-bed NF inpatient I PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70. 00	Skilled nursing facility/other nursing facili						70. 00
71. 00	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)		ı (line 14 x li	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine servi	9	•	,			74. 00
75. 00	Capital -related cost allocated to inpatient	routine service	costs (from W	lorksheet B, F	art II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital related costs (line 9 x line						77. 00
78.00	Inpatient routine service cost (line 74 minus		unavil dare ::	10)			78.00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				us line 79)		79. 00 80. 00
81.00	Inpatient routine service cost per diem limi	tati on			,		81. 00
82. 00 83. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s						82. 00 83. 00

83.00

84.00

85. 00

86.00

6, 072 87. 00 1, 140. 43 88. 00 6, 924, 691 89. 00

Reasonable inpatient routine service costs (see instructions)

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)

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

Program inpatient ancillary services (see instructions)

89.00 Observation bed cost (line 87 x line 88) (see instructions)

83.00

84.00

85.00 86.00

Health Financial Systems COMI	MUNITY HOSPITAL	OF INDIANA, IN	IC.	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 5/30/2018 11:4	oared: 42 am
		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	7, 418, 305	69, 707, 847	0. 106420	6, 924, 691	736, 926	90.00
91.00 Nursing School cost	0	69, 707, 847	0.00000	6, 924, 691	0	91.00
92.00 Allied health cost	0	69, 707, 847	0.00000	6, 924, 691	0	92.00
93.00 All other Medical Education	0	69, 707, 847	0.00000	6, 924, 691	0	93. 00

Health Financial Systems	COMMUNITY HOSPITAL OF INDIANA, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-016	Period: From 01/01/2017	Worksheet D-1
	Component CCN: 15-S1	59 To 12/31/2017	Date/Time Prepared: 5/30/2018 11:42 am
	Ti tle XVIII	Subprovider -	PPS

		II the Aviii	I PF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			3, 441	1.00
2.00	Inpatient days (including private room days, excluding swing-			3, 441	2.00
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 days)		3, 441	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5.00
	reporting period Total swing-bed SNF type inpatient days (including private roo	om dava) ofter December 3	01 of the cost	0	4 00
6. 00	reporting period (if calendar year, enter 0 on this line)	om days) after becember 3	si di the cost	U	6. 00
7.00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	n days) after December 31	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	2, 427	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruc-		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, en	nter 0 on this line)			
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	( only (including private	e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	( only (including private	room days)	0	13. 00
.0.00	after December 31 of the cost reporting period (if calendar ye			· ·	
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	days)	0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT			U	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
10.00	reporting period	<del></del>		0.00	10.00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of t	the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period			0.00	
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of tr	ne cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	6)		1, 712, 356	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost reporti	ng period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	neriod (line 6	0	23. 00
23.00	x line 18)	31 of the cost reporting	g perrou (Trile o	O	23.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportir	ng period (line	0	24.00
25 00	7 x line 19)	of the cost respecting	pariod (line 0	0	25 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	of the cost reporting	perrod (Trie 8	U	25. 00
26. 00	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		1, 712, 356	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation hed cha	arnes)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed ene	11 903)	0	
30. 00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruct	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x li	ne 31)		0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	and private ream east -!:4	forential (lin-	1 712 254	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	anu private room cost dif	recential (line	1, 712, 356	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see			497.63	
40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program			1, 207, 748 0	40. 00
	Total Program general inpatient routine service cost (line 39	,		1, 207, 748	
			·	,	

MPUTAT	FION OF INPATIENT OPERATING COST		Provider CCN: 15-0		riod: om 01/01/2017	Worksheet D-1	
			Component CCN: 15-5	S169 To	12/31/2017	Date/Time Pre 5/30/2018 11:	
			Title XVIII	S	Subprovi der - I PF	PPS	
	Cost Center Description	Total Inpatient CostIn	Total Averagonatient Days Diem (col.	ol . 1 ÷	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2. 00 3.	00	4. 00	5. 00	
	URSERY (title V & XIX only) ntensive Care Type Inpatient Hospital Units	0	0	0. 00	0	0	42
	NTENSIVE CARE UNIT	0	0	0.00	0	0	4:
	ORONARY CARE UNIT						44
	URN INTENSIVE CARE UNIT URGICAL INTENSIVE CARE UNIT						4!
	EONATAL INTENSIVE CARE UNIT	0	o	0. 00	0	0	4
00	Cost Center Description	<u> </u>	<u> </u>	0.00			
	· · · · · · · · · · · · · · · · · · ·					1. 00	
	rogram inpatient ancillary service cost (Wks otal Program inpatient costs (sum of lines 4					310, 576 1, 518, 324	
	ASS THROUGH COST ADJUSTMENTS	ri tili ougii 40) (se	e mstructrons)			1, 510, 324	4
	ass through costs applicable to Program inpa	atient routine se	ervices (from Wkst.	D, sum o	f Parts I and	174, 890	50
	)	+! on+ or-!!!-	complete (form W	D -:	of Dort- U	10 100	_
	ass through costs applicable to Program inpa nd IV)	itient ancillary	services (Trom WKST	. D, SUM	or Parts II	19, 198	5
	otal Program excludable cost (sum of lines 5	50 and 51)				194, 088	5:
	otal Program inpatient operating cost exclud		ited, non-physician	anesthet	ist, and	1, 324, 236	5
	edical education costs (line 49 minus line 5 ARGET AMOUNT AND LIMIT COMPUTATION	02)					1
	Program discharges					0	5
	arget amount per discharge					0.00	
	arget amount (line 54 x line 55) Difference between adjusted inpatient operati	ng cost and taxa	net amount (line E4)	minue I:	ne 53)	0	1
	onus payment (see instructions)	ng cost and targ	jet alliourit (Trile 56 i	IIII IIUS III	ne 53)	0	
	esser of lines 53/54 or 55 from the cost rep	orting period er	nding 1996, updated	and comp	ounded by the	0.00	
- 1	arket basket						١,
	esser of lines 53/54 or 55 from prior year of fline 53/54 is less than the lower of lines				e amount by	0. 00 0	
wl	hich operating costs (line 53) are less than	expected costs				Ŭ	~
	mount (line 56), otherwise enter zero (see i	nstructions)					١.
	elief payment (see instructions) Jlowable Inpatient cost plus incentive payme	ent (see instruct	ions)			0	
	ROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mistruct	.1 0113)			0	1 0
	ledicare swing-bed SNF inpatient routine cost	s through Decemb	er 31 of the cost r	eporti ng	period (See	0	6
	nstructions)(title XVIII only) Hedicare swing-bed SNF inpatient routine cost	s after December	31 of the cost ren	ortina n	eriod (See	n	6
i i	nstructions)(title XVIII only)		•				
	otal Medicare swing-bed SNF inpatient routin	ne costs (line 64	plus line 65)(title	e XVIII	only). For	0	6
	AH (see instructions) ïtle V or XIX swing-bed NF inpatient routine	costs through [	Accombar 31 of the co	nst rann	rting period	0	6
	line 12 x line 19)	costs through t	recember 31 of the co	ost repo	rting perrou		1 "
00 T	itle V or XIX swing-bed NF inpatient routine	e costs after Dec	cember 31 of the cos	t report	ing period	0	6
1 -	line 13 x line 20) otal title V or XIX swing-bed NF inpatient m	coutino costs (li	no 67   lino 69)			_	6
	ART III - SKILLED NURSING FACILITY, OTHER NU					0	1 0
00 SI	killed nursing facility/other nursing facili	ty/ICF/IID routi	ne service cost (li	ne 37)			70
	djusted general inpatient routine service co		ne 70 ÷ line 2)				7
	rogram routine service cost (line 9 x line 7 ledically necessary private room cost applica	,	line 14 x line 35)				7:
1	otal Program general inpatient routine servi		,				7.
	apital-related cost allocated to inpatient r	routine service o	costs (from Workshee	t B, Par	t II, column		7!
- 1	6, line 45) er diem capital-related costs (line 75 ÷ lir	ne 2)					7
	Program capital related costs (line 9 x line						7
	npatient routine service cost (line 74 minus		and described to the control of the				7
	ggregate charges to beneficiaries for excess otal Program routine service costs for compa			78 minus	line 791		8
	npatient routine service costs for compa		st rimitation (Tille	, o mi nus	11116 77)		8
00 11	npatient routine service cost limitation (li	ne 9 x line 81)					8:
1	leasonable inpatient routine service costs (s						8
	rogram inpatient ancillary services (see ins Hilization review - physician compensation (		3)				8
1	otal Program inpatient operating costs (sum						8
PA	ART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST					
.00 To	otal observation bed days (see instructions) djusted general inpatient routine cost per d		ine 2)			0 0. 00	
00 A							

Health Financial Systems COMM	MUNITY HOSPITAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
		Component (		From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 11:	pared:
		Title	XVIII	Subprovi der -	PPS	42 alli
				. I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from		
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	247, 955	1, 712, 356	0. 14480	3 0	0	90. 00
91.00 Nursing School cost	0	1, 712, 356	0.00000	0 0	0	91. 00
92.00 Allied health cost	0	1, 712, 356	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	1, 712, 356	0.00000	0 0	0	93. 00

Health Financial Systems	COMMUNITY HOSPITAL OF	INDIANA, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D-1  Date/Time Prepared: 5/30/2018 11:42 am
		Title XIX	Hospi tal	PPS

100 Total iswing-bed SNF type inpatient days (including private room days) after December 31 of the cost operating period (if calendar year, enter 0 on this line) or total swing-bed NF type inpatient days (including private room days) after December 31 of the cost operating period (if calendar year, enter 0 on this line) or total swing-bed NF type inpatient days (including private room days) through December 31 of the cost operating period (if calendar year, enter 0 on this line) or total swing-bed (if calendar year, enter 0 on this line) or total inpatient days including private room days after December 31 of the cost or evoluting period (if calendar year, enter 0 on this line) or total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) or total 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) or through December 31 of the cost reporting period (if calendar year, enter 0 on this line) or through December 31 of the cost reporting period (if calendar year, enter 0 on this line) or through December 31 of the cost reporting period (if calendar year, enter 0 on this line) or through December 31 of the cost reporting period (if calendar year, enter 0 on this line) or through December 31 of the cost reporting period (if calendar year, enter 0 on this line) or through December 31 of the cost reporting period (if calendar year, enter 0 on this line) or the cost reporting period (if calendar year, enter 0 on this line) or through December 31 of the cost reporting period (if calendar year, enter 0 on this line) or the cost reporting period (if calendar year, enter 0 on this line) or the cost reporting period (if calendar year, enter 0 on this line) or the cost reporting period (if calendar year, enter 0 on this line) or the cost reporting period (if calendar year, enter 0 on this line) or the cost reporting period (if calendar year, enter 0 on this lin					5/30/2018 11:	42 am
PART 1 - ALL PROVIDER COMPONENTS			Title XIX	Hospi tal	PPS	
PART   - ALL PROVIDER COMPORENTS   Inpatient days (including private room days and swing-bed days, excluding newborn)   61,124   1.0   1		Cost Center Description				
Inpatient days (including private room days, and saing-bed days, excluding newborn)   1.10					1. 00	
1.00 Inpatient days (Including private room days, excluding swing-bed days, excluding newborn) 2.00 Inpatient days (Including private room days, excluding swing-bed and newborn days) 3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, 5.00 Inpatient days (Including private room days) 5.00 Semilar brivate room days (excluding swing-bed and observation bed days). 5.00 Total swing-bed SWF type inpatient days (Including private room days) through December 31 of the cost reporting period (Including private room days) through December 31 of the cost reporting period (Including private room days) through December 31 of the cost reporting period (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) after December 31 of the cost reporting period (Including private room days) after December 31 of the cost reporting period (Including private room days) after December 31 of the cost supporting period (Including private room days) after December 31 of the cost supporting period (Including private room days) after December 31 of the cost supporting period (Including private room days) after December 31 of the cost supporting period (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) after December 31 of the cost reporting period (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) after December 31 of the cost reporting period (Including private room days) after December 31 of the cost reporting period (Including period (Inclu						1
1.20   Impatient days (including private room days, excluding saing-bed and newborn days)   1.7 you have room days, coulding saing-bed and observation bed days).   1.7 you have nowll y private room days, coulding saing-bed and observation bed days).   1.7 you have nowll y private room days, coulding saing-bed saing saing	4 00				/4 404	4 00
7 rivate room days (excluding swing-bed and observation bed days). If you have only private room days. do not complete this I line. Illine. Story of not complete this I line. Illine. Story of not complete this I line. Story of not complete the story of					· ·	
do not complete this line.  Semi-private room days (excluding swing-bed and observation bed days)  Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  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)  Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  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)  Total impatient days including private room days applicable to the Program (excluding swing-bed and lotal swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and through December 31 of the cost reporting period (see instructions)  Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions)  Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  Total nursery days (title V or XIX only)  14.00  Medicard processors of the cost reporting period (if calendar year, enter 0 on this line)  Ned care rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Ned care rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Ned care rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (in exporting period (in exporting period (in expo				ivata room dave		
Semi_private room days (excluding swing-bed and observation bed days)   55,652   4.0	3.00		ys). If you have only pr	i vate i ooni days,	Ü	3.00
total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calandar year, enter 0 on this line)  Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calandar year, enter 0 on this line)  Total sing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calandar year, enter 0 on this line)  Total sing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calandar year, enter 0 on this line)  Total sing-bed NF type inpatient days applicable to the Program (excluding swing-bed and newborn days)  Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days)  Swing-bed SNF type inpatient days applicable to the SNF type inpatient days applicable to SNF type inpatient days applicable to the SNF type inpatient days applicable to SNF type i	4.00	· ·	ed days)		55, 052	4. 00
ceporting period  O Total swing-bed SNR type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total swing-bed SNR type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total swing-bed SNR type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  Total inpatient days spil cable to this line)  Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  Total inpatient days applicable to this line)  Through December 31 of the cost reporting period (see instructions)  Wing-bed SNR type inpatient days applicable to little XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions)  Wing-bed SNR type inpatient days applicable to little XVIII only (including private room days)  Through December 31 of the cost reporting period (see instructions)  Wing-bed NR type inpatient days applicable to little XVIII only (including private room days)  Through December 31 of the cost reporting period (see instructions)  Wing-bed NR type inpatient days applicable to little XVIII only (including private room days)  Through December 31 of the cost reporting period (see instructions)  Wing-bed NR type inpatient days applicable to little XVIII only (including private room days)  Through December 31 of the cost reporting period (see instructions)  Wing-bed Cost applicable to SNR services applicable to services through December 31 of the cost period (see instructions)  Wing-bed Doublines SNR type services applicable to services after December 31 of the cost period (see instructions)  Wing-bed Cost applicable to SNR type services after December 31 of the cost reporting p				r 31 of the cost	0	5. 00
10						
Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (If calendar year, enter 0 on this line) 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) Total inpatient days including private room days applicable to the Program (excluding swing-bed and Total inpatient days including private room days) Total inpatient days including private room days applicable to the Program (excluding private room days) Through December 31 of the cost reporting period (see instructions)  11.00 Swing-bed SNF type inpatient days applicable to title XVII only (including private room days) after becember 31 of the cost reporting period (If calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to title avoid (If calendar year, enter 0 on this line)  13.00 Swing-bed NF type inpatient days applicable to title avoid (If calendar year, enter 0 on this line)  14.00 Swing-bed NF type inpatient days applicable to title avoid (If calendar year)  15.00 Total nursery days (Itile V or XIX only)  16.00 Swing-bed NF type inpatient days applicable to the Program (excluding private room days)  16.00 Swing-bed DAUDISTIMEN  17.00 Hedicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Swing-bed DAUDISTIMEN  18.00 Swing-bed Cost applicable to SNF services applicable to services after December 31 of the cost  18.00 Swing-bed cost applicable to SNF services after December 31 of the cost  18.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period  18.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period  18.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (Iine 6 of Sx iine 17)  28.00 Swing-bed cost applicable to SNF type services after December 31 of the cost report	6.00		om days) after December :	31 of the cost	0	6.00
reporting period Total siwing-bed Ni type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and period days) Total inpatient days including private room days applicable to the Program (excluding swing-bed and period days) Total patient days including private room days) Total patient days including private room days) Total patient days applicable to title XVIII only (including private room days) Total patient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (including private room days) Through December 31 of the cost reporting period (including private room days) Through December 31 of the cost reporting period (including private room days) Through December 31 of the cost reporting period (including private room days) Through December 31 of the cost reporting period (including private room days) Through December 31 of the cost reporting period (including private room days) Through December 31 of the cost reporting period (including private room days) Total through December 31 of the cost reporting period (including private room days) Total through December 31 of the cost reporting period (including private room days) Total through December 31 of the cost reporting period (including private room days) Total through December 31 of the cost reporting period (including private room days) Total through December 31 of the cost reporting period (including private room days) Total through December 31 of the cost reporting period (including private room days) Total through December 31 of the cost reporting period (including private room days applicable to services after December 31 of the cost reporting period (including private room days applicable to SNF type services after December 31 of the cost reporting period (including private room days applicable to SNF type services after			<i>,</i>			
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)  Total inpatient days including private room days applicable to the Program (excluding swing-bed and sex) and the program of the cost reporting period (see instructions)  Ning-bed SNF type Inpatient days applicable to title XVIII only (including private room days) after shrough December 31 of the cost reporting period (see instructions)  Ning-bed SNF type inpatient days applicable to title XVIII only (including private room days) after shrough December 31 of the cost reporting period (see instructions)  None of the type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions)  None of the type inpatient days applicable to title XVIII only (including private room days)  None of None o	7.00		m days) through December	31 of the cost	0	7. 00
reporting period (if calendar year, enter 0 on this line)  10 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) after becember 31 of the cost reporting period (see instructions)  11 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)  12 00 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  13 00 Simp-bed NF type inpatient days applicable to titles V or XX only (including private room days) after becember 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 XX only (including private room days)  15 00 Total nursery days (title V or XIX only)  16 00 Nursery days (title V or XIX only)  17 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  17 00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost  18 00 Medical rate for swing-bed NF services applicable to services after December 31 of the cost  18 00 Medical rate for swing-bed NF services applicable to services after December 31 of the cost  18 00 Medical rate for swing-bed NF services applicable to services after December 31 of the cost  18 00 Medical rate for swing-bed NF services applicable to services after December 31 of the cost  18 00 Medical rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 S NF structure)  19 00 Medical rate for swing-bed NF services applicable to SNF type servic					_	
10.00   Note   Program	8. 00		m days) after December 3	1 of the cost	0	8. 00
newborn days   newb	0.00		+b- D (		022	0.00
Swing-bed SWF type Inpatient days applicable to title XVIII only (Including private room days)   0   10.0	9.00		the Program (excluding	swing-bed and	823	9.00
through December 31 of the cost reporting period (see instructions)  11.00 Swing-bed SNF type inpatient days applicable to titlet 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 NF 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 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  15.00 Introduction of the cost reporting period (if calendar year, enter 0 on this line)  16.00 Medically necessary private room days applicable to titles V or XIX only (including private room days)  17.01 Medicare roate for swing-bed SNF services applicable to services through December 31 of the cost  18.00 Now Introduction of the cost of the cost reporting period (if calendar year, enter 0 on this line)  18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (id rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (id rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (id rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 on NF year)  18.00 Medicard rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 on NF year)  18.00 Medicard rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 on NF year)  18.00 Medicard rate for swing-bed NF services after December 31 of the cost reporting period (line 6 on NF year)  18.00 Swing-bed cost applicable to NF type services after De	10 00	,	alv (including private r	nom days)	0	10 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) 25.00 x line 20) 26.00 Total swing-bed cost (see instructions) 26.00 Total swing-bed cost (see instructions) 27.00 PRIVATE ROOM DIFFERNTIAL ADJUSTMENT 28.00 Private room charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 29.00 Semi-private room charges (excluding swing-bed charges) 29.00 Average per diem private room per diem charge (line 29 ± line 3) 29.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 29.00 Average per diem private room cost differential (line 3 x line 31) 29.00 Average per diem private room cost differential (line 3 x line 35) 29.00 Average per diem private room cost differential (line 3 x line 35) 29.00 Average per diem private room cost differential (line 3 x line 35) 29.00 Average per diem private room cost differential (line 3 x line 35) 29.00 Average per diem private room cost differential (line 3 x line 35) 29.00 Average per diem private room cost differential (line 3 x line 35) 29.00 Average per diem private room cost differential (line 3 x line 35) 29.00 Average per diem private room cost differential (line 3 x line 35) 29.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost diff	23.00		or the cost reporting	g perrou (Triic o	O	25.00
7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 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 General inpatient routine service charges (excluding swing-bed and observation bed charges) General inpatient routine service charges (excluding swing-bed and observation bed charges) O Private room charges (excluding swing-bed charges) O Semi-private room charges (excluding swing-bed charges) O Semi-private room charges (excluding swing-bed charges) O Semi-private room per diem charge (line 27 ÷ line 28) O Average private room per diem charge (line 30 ÷ line 4) O Average per diem private room cost differential (line 32 minus line 33)(see instructions) O Average per diem private room cost differential (line 34 x line 31) O Private room cost differential adjustment (line 3 x line 35) O Average per diem private room cost differential (line 3 x line 35) O General inpatient routine service cost net of swing-bed cost and private room cost differential (line 69, 707, 847) O SO O O O O O O O O O O O O O O O O O	24. 00	/	31 of the cost reporti	na period (line	0	24.00
x line 20) Total swing-bed cost (see instructions) Qeneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges) Qeneral inpatient routine service charges (excluding swing-bed and observation bed charges) Qeneral inpatient routine service charges (excluding swing-bed and observation bed charges) Qeneral inpatient routine service charges) Qeneral inpatient routine service cost/charge ratio (line 27 + line 28) Qeneral inpatient routine service cost/charge ratio (line 27 + line 28) Qeneral inpatient routine service cost/charge ratio (line 27 + line 28) Qeneral inpatient routine service cost/charge ratio (line 27 + line 28) Qeneral inpatient routine service cost (line 30 + line 4) Qeneral inpatient routine service cost differential (line 32 minus line 33) (see instructions) Qeneral inpatient routine service cost differential (line 34 x line 31) Qeneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) Qeneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 32 minus line 36) Qeneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 49, 707, 847) Qeneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 49, 707, 847) Qeneral inpatient routine service cost per diem (see instructions) Qeneral inpatient routine service cost per diem (see instructions) Qeneral inpatient routine service cost per diem (see instructions) Qeneral inpatient routine service cost per diem (see instructions) Qeneral inpatient routine service cost per diem (see instructions) Qeneral inpatient routine service cost per diem (see instructions) Qeneral inpatient routine service cost per diem (see instructions) Qeneral inpatient routine service cost per diem (see instructions) Qeneral inpatient routine servic				5   1		
Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  General inpatient routine service charges (excluding swing-bed and observation bed charges)  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Comparison of the comparison of the charge (line 27 + line 28)  Average private room per diem charge (line 29 + line 3)  Average semi-private room per diem charge (line 30 + line 4)  Average per diem private room cost differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 34 x line 31)  Comparison of the compar	25.00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
Caneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   69, 707, 847   PRIVATE ROOM DIFFERENTIAL ADJUSTMENT						
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)  31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00 Average private room per diem charge (line 29 ÷ line 3)  33. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  34. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 69, 707, 847)  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)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28. 0  28. 0 29. 0  29. 0  29. 0  20. 00  20. 00  20. 00  20. 00  30. 0  30. 00  30.	26. 00					
General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28)  Average private room per diem charge (line 29 ÷ line 3)  Average semi-private room per diem charge (line 30 ÷ line 4)  Average per diem private room charge differential (line 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 69,707,847)  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  O 28.0  29.0  30.0  29.0  30.0	27. 00		(line 21 minus line 26)		69, 707, 847	27.00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 69, 707, 847) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	20 00		d and observetion had the	argos)	^	20 00
30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 69, 707, 847) 37. 00 PRT II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0.0000000 31. 0 0 0.000000 32. 0 0 0.000000 32. 0 0.000 33. 0 0.000 33. 0 0.000000 31. 0 0.000000 32. 0 0.000000 32. 0 0.000 32. 0 0.000 33. 0 0.000000 31. 0 0.000000 31. 0 0.000000 31. 0 0.000000 32. 0 0.000000 0.000000 0.000000 0.000000 0.000000			a and observation bed ch	ai yes)		
31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00 Average private room per diem charge (line 29 ÷ line 3)  33. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  34. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 ÷ line 36)  PART II - HOSPI TAL AND SUBPROVI DERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  38. 00 Program general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0. 00 00 00 00 00 00 00 00 00 00 00 00 0						
32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 69, 707, 847)  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)  7.10 Program general inpatient routine service cost (line 9 x line 38)  88.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  9.00 Value (line 32 minus line 33)  9.00 Value (line 30 minus line			: line 28)			
33. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  34. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 69, 707, 847)  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)  0 0 33. 0  0 0 34. 0  35. 00  36. 00  37. 00  38. 00  39. 00  40. 00		,	. 11116 20)			
Average per diem private room charge differential (line 32 minus line 33) (see instructions)  34. 00 Average per diem private room cost differential (line 34 x line 31)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Average per diem private room cost differential (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 69, 707, 847)  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)  1, 140. 43 38. 00 Average per diem private room cost differential (line 69, 707, 847)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 35. 00 36. 00 37. 00 38. 00 39. 00 Average per diem private room cost differential (line 32 minus line 33)  0 0 35. 00 36. 00 37. 00 38. 00 39. 00 Average per diem private room cost differential (line 32 minus line 33)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 69, 707, 847)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 36.00  37.00 Jac. 00  38.00 Jac. 00  38.00 Jac. 00  39.00 Program general inpatient routine service cost per diem (see instructions)  1, 140.43  38.00 Jac. 00  39.00 Jac. 00	34. 00		nus line 33)(see instruc	tions)		1
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 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)  36.00 Adjusted General (line 49, 707, 847)  37.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	35. 00			•		1
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)  1,140.43 38.0  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 40.0	36.00				0	36. 00
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,140.43 38.0  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	37. 00		and private room cost di	fferential (line	69, 707, 847	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,140.43 38.00 938,574 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)  1,140.43 38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  1,140.43 38.00 938,574 39.00 40.00						1
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) 938,574 39.0 40.0				-		
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	38. 00		*			
		, , ,	•			
41.00   Total Trogram general impatrent routine service cost (Time 37 + Time 40)		, , , , , , , , , , , , , , , , , , , ,	*			
	<del>-1</del> 1.00	Trotal Trogram general impatrent routine service cost (IIIIe 39	11116 40)	l	730, 374	1 41.00

Hool th	Financial Systems COMM	UNITY HOSDITAL OF	E INDIANA IA	NC.	la lio	u of Form CMS	2552 10
	Financial Systems COMM ATION OF INPATIENT OPERATING COST	IUNITY HOSPITAL OI	Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Pre 5/30/2018 11:	pared:
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost In	Total patient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	5, 623, 344	7, 547	745. 1	3, 484	2, 595, 963	42. 00
	Intensive Care Type Inpatient Hospital Units			,			
43.00	INTENSIVE CARE UNIT	11, 331, 242	5, 572	2, 033. 6	0 0	0	
44. 00	CORONARY CARE UNIT						44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT	15 257 422	11 (21	1 212 (	004	1 055 500	46.00
47.00	NEONATAL INTENSIVE CARE UNIT   Cost Center Description	15, 257, 423	11, 621	1, 312. 9	92 804	1, 055, 588	47. 00
	cost center bescription					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1, 371, 858	48. 00
49. 00	Total Program inpatient costs (sum of lines			ons)		5, 961, 983	
	PASS THROUGH COST ADJUSTMENTS			- /			
50.00	Pass through costs applicable to Program inp	atient routine se	ervices (from	n Wkst. D, sun	of Parts I and	518, 229	50. 00
51. 00	Pass through costs applicable to Program inpand IV)	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	108, 950	51. 00
52.00	Total Program excludable cost (sum of lines					627, 179	
53. 00	Total Program inpatient operating cost exclu		ited, non-phy	/sician anesth	netist, and	5, 334, 804	53. 00
	medical education costs (line 49 minus line	52)					
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION  . 00 Program discharges						
54. 00 55. 00	Target amount per discharge	0 0. 00					
56. 00	Target amount (line 54 x line 55)		0.00	1			
57. 00	Difference between adjusted inpatient operat	ing cost and tard	net amount (L	ine 56 minus	line 53)	Ö	
58. 00	Bonus payment (see instructions)	ing cost and targ	jot amount (i	THE OF III HGS	11110 00)	ő	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period er	nding 1996, ι	ipdated and co	ompounded by the	0.00	
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, upda	ated by the m	narket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line				the amount by	0	61. 00
	which operating costs (line 53) are less that	n expected costs	(lines 54 x	60), or 1% of	the target		
	amount (line 56), otherwise enter zero (see	instructions)					
62.00	Relief payment (see instructions)					0	1
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instruct	ions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	to through Docomb	or 21 of the	oct reporti	na port od (Soo	0	64. 00
04.00	instructions)(title XVIII only)	ts through becenic	bei 31 Oi the	cost reporti	ng perrou (see	0	04.00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after December	31 of the c	cost reportino	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	l plus line 6	55)(title XVII	I only). For	0	66. 00
	CAH (see instructions)	, , , , , , , , , , , , , , , , , , , ,			3,	-	
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through D	ecember 31 c	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after Dec	cember 31 of	the cost repo	orting period	0	68. 00
69. 00							69. 00
70. 00	Skilled nursing facility/other nursing facil						70. 00
71. 00	Adjusted general inpatient routine service c						71.00
72. 00	Program routine service cost (line 9 x line	, ,		•			72. 00
73.00	Medically necessary private room cost application	able to Program (	[line 14 x li	ne 35)			73. 00
74.00	Total Program general inpatient routine serv						74. 00
75. 00	Capital-related cost allocated to inpatient	routine service c	costs (from W	lorksheet B, F	Part II, column		75. 00
7/ 05	26, line 45)	0)					7, 00
76. 00	Program capital related costs (line 75 ÷ li	•					76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
. 5. 55	1 1					l .	

	Intensive Care Type Inpatient Hospital Units		
43.00	INTENSIVE CARE UNIT 11, 331, 242 5, 572 2, 033. 60 0	0	43.00
44.00	CORONARY CARE UNIT		44.00
45.00	BURN INTENSIVE CARE UNIT		45.00
46.00			46.00
47.00	NEONATAL INTENSIVE CARE UNIT 15, 257, 423 11, 621 1, 312. 92 804	1, 055, 588	47.00
	Cost Center Description		
		1. 00	
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1, 371, 858	48. 00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5, 961, 983	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	518, 229	50.00
51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II	108, 950	51. 00
	and IV)		
52. 00	Total Program excludable cost (sum of lines 50 and 51)	627, 179	52.00
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and	5, 334, 804	53. 00
	medical education costs (line 49 minus line 52)		
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges	0	54. 00
54. 00 55. 00	Target amount per discharge	0. 00	55. 00
56. 00	Target amount (line 54 x line 55)	0.00	56. 00
57. 00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57. 00
58. 00	Bonus payment (see instructions)	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the	0.00	59. 00
37.00	market basket	0.00	37.00
60. 00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61. 00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by	0	61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target	_	
	amount (line 56), otherwise enter zero (see instructions)		
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See	0	64.00
	instructions)(title XVIII only)		
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	0	65.00
	instructions)(title XVIII only)		
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For	0	66. 00
	CAH (see instructions)		
67. 00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period	0	67. 00
(0.00	(line 12 x line 19)	0	(0.00
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69. 00
09.00	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	U	09.00
70. 00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70. 00
71. 00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72. 00	Program routine service cost (line 9 x line 71)		72. 00
73. 00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73. 00
74. 00	Total Program general inpatient routine service costs (line 72 + line 73)		74. 00
75. 00	Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column		75. 00
	26, line 45)		
76.00			76.00
77. 00			77. 00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81. 00	Inpatient routine service cost per diem limitation		81. 00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84. 00	Program inpatient ancillary services (see instructions)		84.00
85. 00	Utilization review - physician compensation (see instructions)		85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85)		86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87. 00	Total observation bed days (see instructions)	6, 072	87. 00
88. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1, 140. 43	88. 00
89. 00	Observation bed cost (line 87 x line 88) (see instructions)	6, 924, 691	89. 00

Health Financial Systems COM	MUNITY HOSPITAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Period: From 01/01/2017	Worksheet D-1	
				To 12/31/2017	Date/Time Prep 5/30/2018 11:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	7, 418, 305	69, 707, 847	0. 106420	6, 924, 691	736, 926	90.00
91.00 Nursing School cost	0	69, 707, 847	0. 000000	6, 924, 691	0	91.00
92.00 Allied health cost	0	69, 707, 847	0. 000000	6, 924, 691	0	92.00
93.00 All other Medical Education	0	69, 707, 847	0. 000000	6, 924, 691	0	93. 00

Health Financial Systems	COMMUNITY HOSPITAL OF IN	NDI ANA, INC.		In Lieu of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTION	IMENT Pr	rovider CCN: 15-	0169 Period	Worksheet D-3

Heal th Finan	cial Systems	COMMUNITY HOSPITAL OF	INDIANA, IN	NC.	In Li€	eu of Form CMS-2	2552-10
INPATIENT AN	NCILLARY SERVICE COST APPORTIONMENT		Provi der Co	CN: 15-0169	Peri od:	Worksheet D-3	
					From 01/01/2017		
					To 12/31/2017	Date/Time Pre	
			Ti +Lo	· XVIII	Hospi tal	5/30/2018 11:	42 am_
	Cost Center Description		II ti e	Ratio of Cos		PPS Inpatient	
	cost center bescription				Program	Program Costs	
				To Charges	9	(col. 1 x col.	
					Charges	2)	
				1.00	2. 00	3. 00	
I NPAT	IENT ROUTINE SERVICE COST CENTERS			1.00	2.00	3.00	
	ADULTS & PEDIATRICS				34, 736, 165		30. 00
	INTENSIVE CARE UNIT				7, 668, 004		31.00
1	NEONATAL INTENSIVE CARE UNIT				7,000,001		35. 00
4	SUBPROVIDER - I PF						40.00
	NURSERY						43. 00
	LARY SERVICE COST CENTERS			l			43.00
	OPERATING ROOM			0. 0925	91 43, 639, 651	4, 040, 639	50.00
1	RECOVERY ROOM			0. 1559			51. 00
	DELIVERY ROOM & LABOR ROOM			0. 6068		023, 111	52.00
	RADI OLOGY-DI AGNOSTI C			0. 1878		812, 773	
	RADI OLOGY-THERAPEUTI C			0. 0839			55. 00
	CT SCAN			0. 0330		280, 424	57. 00
	MAGNETIC RESONANCE IMAGING (MRI)			0. 1230			58. 00
1	CARDI AC CATHETERI ZATI ON			0. 2163		1	59. 00
	LABORATORY			0. 1024		1	60.00
	INTRAVENOUS THERAPY			0. 8510		330, 377	64. 00
	RESPIRATORY THERAPY			0. 2032			
	PHYSI CAL THERAPY			0. 2933			66.00
	OCCUPATIONAL THERAPY			0. 2760		l	
	SPEECH PATHOLOGY			0. 1792			68. 00
1	ELECTROCARDI OLOGY			0. 0186			
4	ELECTROCARDIOLOGY			0. 2076			70.00
	MEDICAL SUPPLIES CHARGED TO PATIEN	ITC		0. 3061			
	IMPL. DEV. CHARGED TO PATIENTS	115		0. 4956			
	DRUGS CHARGED TO PATIENTS			0. 2537			73.00
	RENAL DIALYSIS			0. 4540		697, 992	
4	ENDOSCOPY			0. 14340			76.00
4	I MAGING CENTER			0. 0783		l	76.06
	BREAST DIAGNOSTIC CENTER			0. 5218		679	76.00
	TIENT SERVICE COST CENTERS			0.5210	47  1,302	0/9	70.07
	CLINI C			0.0000	00	0	90. 00
	SPINE CENTER			0. 4654			
1	EMERGENCY			0. 4034			90. 26
1	OBSERVATION BEDS (NON-DISTINCT PAR	OT)		0. 1020		1, 462, 461	
200. 00	Total (sum of lines 50 through 94			0.7233	178, 307, 088	ľ	
200.00	Less PBP Clinic Laboratory Service		(line 61)		170, 307, 000	32, 307, 731	200.00
201.00	Net charges (line 200 minus line 2		(TITIE OI)	1	178, 307, 088		201.00
202.00	Iner charges (Time 200 minus Time 2	.01)		I	170, 307, 000	l	1202.00

NPAT	Financial Systems COMMUNITY HOSPITAL OF ENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0169	Peri od:	eu of Form CMS- Worksheet D-3	
	ENT PROTEERING SERVICE GOOT PROTECTION SERVICE			From 01/01/2017		
			CCN: 15-S169	To 12/31/2017	Date/Time Pre 5/30/2018 11:	
		Titl∈	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description		Ratio of Cos	•	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2. 00	2) 3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
0. 00	03000 ADULTS & PEDIATRICS			0		30.
1. 00	03100   NTENSI VE CARE UNI T			0		31.
5. 00	02060 NEONATAL INTENSIVE CARE UNIT			0		35.
0. 00	04000 SUBPROVI DER - I PF			5, 103, 201		40.
3. 00	04300 NURSERY					43.
	ANCILLARY SERVICE COST CENTERS			<u> </u>		
0. 00	05000 OPERATING ROOM		0. 0925	91 0	0	50.
1. 00	05100 RECOVERY ROOM		0. 1559	02 0	0	51.
2. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 6068		1	
1. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1878		7, 188	
5. 00	05500 RADI OLOGY-THERAPEUTI C		0. 0839			
7. 00	05700 CT SCAN		0. 0330			
3. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 1230			
9. 00	05900 CARDI AC CATHETERI ZATI ON		0. 2163			
0.00	06000 LABORATORY		0. 1024			
4. 00	06400 I NTRAVENOUS THERAPY		0. 8510			1
5.00	06500 RESPIRATORY THERAPY		0. 2032			
5. 00 7. 00	O6600  PHYSI CAL THERAPY   O6700  OCCUPATI ONAL THERAPY		0. 2933 0. 2760			1
7. 00 3. 00	06800 SPEECH PATHOLOGY		0. 2760			
9. 00	06900 ELECTROCARDI OLOGY		0. 1792			
). 00	07000 ELECTROEARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY		0. 0186			
1. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3061			1
2. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4956			1
3. 00	07300 DRUGS CHARGED TO PATIENTS		0. 2537			
1. 00	07400 RENAL DIALYSIS		0. 4540			
5. 00	03330 ENDOSCOPY		0. 1434			
5. 06	03954 I MAGI NG CENTER		0.0783	85 0	0	76.
5. 07	03955 BREAST DIAGNOSTIC CENTER		0. 5218	47 0	0	76.
	OUTPATIENT SERVICE COST CENTERS					
0. 00	09000 CLI NI C		0.0000			
). 26	04975 SPI NE CENTER		0. 4654		·	1
1. 00	09100 EMERGENCY		0. 1020			
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 7235		0	
0.00				1, 901, 637	310, 576	
01.00		(line 61)		0		201.
02.00	Net charges (line 200 minus line 201)			1, 901, 637		202

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

Heal th Finar	ncial Systems COMMUNITY	HOSPITAL OF INDIANA, IN	NC.	In Lie	u of Form CMS-2	2552-10
INPATIENT A	NCILLARY SERVICE COST APPORTIONMENT	Provi der Co		Peri od:	Worksheet D-3	
				From 01/01/2017		
				To 12/31/2017	Date/Time Prep 5/30/2018 11:4	
		Ti tl	e XIX	Hospi tal	PPS	42 aiii
	Cost Center Description	11.61	Ratio of Cos		Inpatient	
	Sect Conton Boson Ptron		To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
I NPAT	IENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS			2, 507, 597		30.00
	INTENSIVE CARE UNIT			532, 280		31.00
	NEONATAL INTENSIVE CARE UNIT			5, 999, 745		35.00
40.00 04000	SUBPROVI DER - I PF			0		40.00
	NURSERY			267, 985		43.00
ANCI L	LARY SERVICE COST CENTERS					
4	OPERATING ROOM		0. 09259		88, 220	50.00
51.00 05100	RECOVERY ROOM		0. 15590		21, 618	51.00
	DELIVERY ROOM & LABOR ROOM		0. 60683		192, 537	52.00
	RADI OLOGY-DI AGNOSTI C		0. 18786		35, 217	54.00
	RADI OLOGY-THERAPEUTI C		0. 08399		6, 814	55. 00
	CT SCAN		0. 03305		9, 612	57. 00
	MAGNETIC RESONANCE IMAGING (MRI)		0. 12304		4, 356	
	CARDI AC CATHETERI ZATI ON		0. 21636		19, 409	59. 00
	LABORATORY		0. 10247		131, 161	60.00
64.00 06400	I NTRAVENOUS THERAPY		0. 85102		5, 885	64.00
	RESPI RATORY THERAPY		0. 20322		111, 790	65.00
66. 00 06600	PHYSI CAL THERAPY		0. 29330	70, 139	20, 572	66.00
67.00 06700	OCCUPATI ONAL THERAPY		0. 27609	131, 982	36, 440	67.00
68. 00 06800	SPEECH PATHOLOGY		0. 17929	60, 616	10, 868	68. 00
69. 00 06900	ELECTROCARDI OLOGY		0. 01864	5 123, 180	2, 297	69.00
	ELECTROENCEPHALOGRAPHY		0. 20768	18, 490	3, 840	70.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 30611	3 671, 855	205, 664	71.00
	IMPL. DEV. CHARGED TO PATIENTS		0. 49568		0	72.00
	DRUGS CHARGED TO PATIENTS		0. 25372	1, 499, 487	380, 457	73.00
74.00 07400	RENAL DIALYSIS		0. 45406	6, 297	2, 859	74.00
76. 00 03330	ENDOSCOPY		0. 14340	9 43, 890	6, 294	76.00
76. 06 03954	I MAGI NG CENTER		0. 07838	35 0	0	76.06
76. 07 03955	BREAST DIAGNOSTIC CENTER		0. 52184	7 0	0	76. 07
	TIENT SERVICE COST CENTERS					
	CLI NI C		0.00000		0	90.00
	SPINE CENTER		0. 46544		0	90. 26
	EMERGENCY		0. 10207		48, 271	91. 00
	OBSERVATION BEDS (NON-DISTINCT PART)		0. 72350	00 38, 254	27, 677	92. 00
200. 00	Total (sum of lines 50 through 94 and 96 thro			7, 067, 161	1, 371, 858	200. 00
201. 00	Less PBP Clinic Laboratory Services-Program	only charges (line 61)		0		201. 00
202. 00	Net charges (line 200 minus line 201)			7, 067, 161		202. 00

Health Financial Systems	COMMUNITY HOSPITAL OF	I NDI ANA,	I NC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der	CCN: 15-0169	Peri od: From 01/01/2017	Worksheet E Part A
				To 12/31/2017	Date/Time Prepared:

			10 12/31/2017	5/30/2018 11:	
		Title XVIII	Hospi tal	PPS	
	DADT A LABORT WAS DITH. OF DAY OF A LABOR.			1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			0	1 00
1.00	DRG Amounts Other than Outlier Payments			0 30, 923, 563	1.00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)				1. 01
1. 02	DRG amounts other than outlier payments for discharges occurri	ng on or after October	1 (500	10, 404, 522	1. 02
1.02	instructions)	ring on or arter october	(366	10, 404, 322	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring	orior to October	0	1. 03
	1 (see instructions)	god codag		_	
1.04	DRG for federal specific operating payment for Model 4 BPCI for	or discharges occurring	on or after	0	1. 04
	October 1 (see instructions)	-			
2.00	Outlier payments for discharges. (see instructions)			1, 309, 276	2. 00
2.01	Outlier reconciliation amount			0	2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructi	ons)		0	2. 02
3.00	Managed Care Simulated Payments			14, 443, 660	3. 00
4.00	Bed days available divided by number of days in the cost report	rting period (see instru	ctions)	262. 03	4. 00
	Indirect Medical Education Adjustment			0.00	
5.00	FTE count for allopathic and osteopathic programs for the most	t recent cost reporting	period ending on	0. 00	5. 00
4 00	or before 12/31/1996. (see instructions)	the criteria for an add	on to the con	0.00	4 00
6. 00	FTE count for allopathic and osteopathic programs which meet if for new programs in accordance with 42 CFR 413.79(e)	the criteria for all add-	on to the cap	0. 00	6. 00
7. 00	MMA Section 422 reduction amount to the IME cap as specified u	inder 42 CFR \$412 105(f)	(1) (i v) (B) (1)	0. 00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under			0.00	7. 01
,, , , ,	cost report straddles July 1, 2011 then see instructions.	12 311 31121 100 (1) (1) (1	,,(5,(2, 11 1110	0.00	,, , , ,
8.00	Adjustment (increase or decrease) to the FTE count for allopa	thic and osteopathic pro	grams for	3. 75	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.7	79(c)(2)(iv), 64 FR 2634	Ö (May 12,		
	1998), and 67 FR 50069 (August 1, 2002).				
8. 01	The amount of increase if the hospital was awarded FTE cap slo	ots under § 5503 of the A	ACA. If the cost	0.00	8. 01
	report straddles July 1, 2011, see instructions.				
8. 02	The amount of increase if the hospital was awarded FTE cap slo	ots from a closed teachi	ng hospital	0. 00	8. 02
	under § 5506 of ACA. (see instructions)	(0.001 10.00) (		0.75	
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line	es (8, 8,01 and 8,02) (	see	3. 75	9. 00
10. 00	instructions) FTE count for allopathic and osteopathic programs in the curre	ant year from your recor	16	2 60	10. 00
	FTE count for residents in dental and podiatric programs.	ent year from your record	43	2. 26	
12. 00	Current year allowable FTE (see instructions)			4. 94	
	Total allowable FTE count for the prior year.			4. 38	
14. 00	Total allowable FTE count for the penultimate year if that year	ar ended on or after Sep	tember 30. 1997.	2. 59	
	otherwise enter zero.				
15.00	Sum of lines 12 through 14 divided by 3.			3. 97	15. 00
16.00	Adjustment for residents in initial years of the program			0.00	16. 00
17.00	Adjustment for residents displaced by program or hospital clos	sure		0.00	17. 00
18.00	Adjusted rolling average FTE count			3. 97	18. 00
19.00	Current year resident to bed ratio (line 18 divided by line 4)	).		0. 015151	
	Prior year resident to bed ratio (see instructions)			0. 016226	
	Enter the lesser of lines 19 or 20 (see instructions)			0. 015151	
22. 00	IME payment adjustment (see instructions)			340, 833	
22. 01	IME payment adjustment - Managed Care (see instructions)			119, 117	22. 01
22.00	Indirect Medical Education Adjustment for the Add-on for § 422		ED 412 10E	0.00	22.00
23.00	Number of additional allopathic and osteopathic IME FTE reside	ent cap slots under 42 C	FR 412. 105	0.00	23. 00
24. 00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			-1. 07	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the I	lower of line 23 or line	24 (500		25. 00
23.00	instructions)	Tower of Time 25 of Time	24 (366	0.00	23.00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
	IME payments adjustment factor. (see instructions)			0. 000000	
	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)			340, 833	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0	1)		119, 117	29. 01
	Disproportionate Share Adjustment				
	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	tions)	3. 57	
31. 00	Percentage of Medicaid patient days (see instructions)			28. 16	
	Sum of lines 30 and 31			31. 73	
	Allowable disproportionate share percentage (see instructions)	)		15.39	
34.00	Disproportionate share adjustment (see instructions)		l	1, 590, 098	34.00

Health Financial Systems COMMUNITY HOSPITAL OF INDIANA		In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT Provide		Peri od:	Worksheet E	
		From 01/01/2017 To 12/31/2017	Part A   Date/Time Pre	nared:
		10 12/31/201/	5/30/2018 11:	42 am
T	Title XVIII	Hospi tal	PPS	
		Prior to 10/1		
		1. 00	2. 00	
Uncompensated Care Adjustment  35.00 Total uncompensated care amount (see instructions)		E 077 402 144	6, 766, 695, 164	35. 00
35. 01   Factor 3 (see instructions)		0. 000471897	0. 000438215	35. 00
35.02   Hospital uncompensated care payment (If line 34 is zero, enter zero o	on this line) (see		2, 965, 267	35. 01
instructions)		2,020,700	2,700,207	00.02
35.03 Pro rata share of the hospital uncompensated care payment amount (see	e instructions)	2, 109, 770	747, 410	35. 03
36.00 Total uncompensated care (sum of columns 1 and 2 on line 35.03)		2, 857, 180		36.00
Additional payment for high percentage of ESRD beneficiary discharges				
40.00 Total Medicare discharges on Worksheet S-3, Part I excluding discharg	jes for MS-DRGs	0		40. 00
652, 682, 683, 684 and 685 (see instructions)	(05 (			41 00
41.00 Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 instructions)	an 685. (See	0		41. 00
41.01 Total ESRD Medicare covered and paid discharges excluding MS-DRGs 65	52 682 683 684	0		41. 01
an 685. (see instructions)	12, 002, 003, 004			41.01
42.00 Divide line 41 by line 40 (if less than 10%, you do not qualify for a	adjustment)	0.00		42.00
43.00 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683,		0		43.00
instructions)				
44.00 Ratio of average length of stay to one week (line 43 divided by line	41 divided by 7	0. 000000		44.00
days)				
45.00 Average weekly cost for dialysis treatments (see instructions)		0.00		45. 00
46.00 Total additional payment (line 45 times line 44 times line 41.01) 47.00 Subtotal (see instructions)		47, 425, 472		46. 00 47. 00
48.00 Hospital specific payments (to be completed by SCH and MDH, small rur	ral hosnitals	47, 425, 472		47.00
only. (see instructions)	ai ilospi tais			40.00
om y. (300 matruotrons)			Amount	
			1. 00	
49.00 Total payment for inpatient operating costs (see instructions)			47, 544, 589	49. 00
50.00 Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II			3, 743, 464	50.00
51.00 Exception payment for inpatient program capital (Wkst. L, Pt. III, se			0	51. 00
52.00 Direct graduate medical education payment (from Wkst. E-4, line 49 se	e instructions).		110, 415	52. 00
53.00 Nursing and Allied Health Managed Care payment			0	53.00
54.00   Special add-on payments for new technologies   54.01   Islet isolation add-on payment			0	54. 00 54. 01
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 intructions)	1		0	56. 00
57. 00   Routine service other pass through costs (from Wkst. D, Pt. III, colu		rough 35).	0	57. 00
58.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col.		3 / .	0	58. 00
59.00 Total (sum of amounts on lines 49 through 58)	,		51, 398, 468	59.00
60.00 Primary payer payments			3, 671	60.00
61.00 Total amount payable for program beneficiaries (line 59 minus line 60	))		51, 394, 797	61. 00
62.00 Deductibles billed to program beneficiaries			4, 225, 872	62.00
63.00   Coinsurance billed to program beneficiaries			142, 100	63.00

223, 003 64. 00

0

0

0 70.50

0 70. 91

-296, 439

-271, 814

66.00

67.00

68.00

69.00

70.00

70.87

70.88

70.89

70.90

70.92

70. 93

70. 94

0 70.95

144, 952

116, 445

47, 171, 777

64.00 Allowable bad debts (see instructions)

70.94 | HRR adjustment amount (see instructions)

70.95 Recovery of accelerated depreciation

66.00

67.00

68.00

70.00

70.50

70.87

70. 89 70. 90

70. 91

70. 93

MCRI F32 - 14. 2. 164. 1

65.00 Adjusted reimbursable bad debts (see instructions)

OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)

Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (line 61 plus line 65 minus lines 62 and 63)

Pioneer ACO demonstration payment adjustment amount (see instructions)

Demonstration payment adjustment amount before sequestration

SCH or MDH volume decrease adjustment (contractor use only)

HSP bonus payment HVBP adjustment amount (see instructions)

HSP bonus payment HRR adjustment amount (see instructions)

Bundled Model 1 discount amount (see instructions)

HVBP payment adjustment amount (see instructions)

Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)

Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)

Outlier payments reconciliation (sum of lines 93, 95 and 96) (For SCH see instructions)

Health Financial Systems	COMMUNITY HOSPITAL OF INDIANA	ι, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF DELMBURGEMENT CETTLEMENT	D: -!	CCN 1F 01/0	D - :-! I	Wasaliahaa + E

CALCULATION OF DELMDUDGEMENT CETTLEMENT				u of Form CMS-2	
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0169	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Pre	nare
			10 12/31/2017	5/30/2018 11:	42 a
	Titl∈	e XVIII	Hospi tal	PPS	
		FFY	(уууу)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0	0	70.
the corresponding federal year for the period prior to 10/1)					
0.97 Low volume adjustment for federal fiscal year (yyyy) (Enter i			0	0	70.
the corresponding federal year for the period ending on or af	fter 10/1)				
0.98 Low Volume Payment-3				0	70.
0.99 HAC adjustment amount (see instructions)				506, 303	
1.00 Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			46, 097, 221	
1.01 Sequestration adjustment (see instructions)				921, 944	
1.02 Demonstration payment adjustment amount after sequestration				0	1
2.00 Interim payments				45, 149, 035	
3.00 Tentative settlement (for contractor use only)	22 and			0	
4.00 Balance due provider/program (line 71 minus lines 71.01, 71.0 73)	J2, 72, and			26, 242	/4.
'5.00 Protested amounts (nonallowable cost report items) in accorda	anco with			397, 184	75.
CMS Pub. 15-2, chapter 1, §115.2	ance with			377, 104	/ 3.
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
0.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see ins	structions)			0	90.
1.00 Capital outlier from Wkst. L, Pt. I, line 2				0	
2.00 Operating outlier reconciliation adjustment amount (see instr	ructions)			0	
3.00 Capital outlier reconciliation adjustment amount (see instruc	,			0	
4.00 The rate used to calculate the time value of money (see instr	,			0.00	
5.00 Time value of money for operating expenses (see instructions)	)			0	95
6.00 Time value of money for capital related expenses (see instruc	ctions)			0	96.
			Prior to 10/1	On/After 10/1	
			1. 00	2. 00	
HSP Bonus Payment Amount					
00.00 HSP bonus amount (see instructions)			0	0	100.
HVBP Adjustment for HSP Bonus Payment					
			0. 0000000000	0.000000000	
02.00 HVBP adjustment amount for HSP bonus payment (see instruction	าร)		0.0000000000		
02.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment	าร)		0	0	102
O2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment O3.00 HRR adjustment factor (see instructions)			0.0000000000	0. 0000	102 103
02.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instructions	5)	ictment.	0	0. 0000	102
O2.00  HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment O3.00  HRR adjustment factor (see instructions) O4.00  HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst	s) tration) Adju		0	0.0000	102 103 104
02.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 00.00 Is this the first year of the current 5-year demonstration pe	s) tration) Adju		0	0.0000	102 103 104
02.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 00.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.	s) tration) Adju		0	0.0000	102. 103. 104.
D2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment D3.00 HRR adjustment factor (see instructions) D4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Dem	s) tration) Adju eriod under t		0	0.0000	103 104 200
D2.00  HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment  D3.00  HRR adjustment factor (see instructions)  D4.00  HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst D0.00  Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  D1.00  Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir	s) tration) Adju eriod under t		0	0.0000	102 103 104 200 201
D2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment D3.00 HRR adjustment factor (see instructions) D4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst D5.00.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement D1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir D2.00 Medicare discharges (see instructions)	s) tration) Adju eriod under t		0	0.0000	102 103 104 200 201 202
D2.00  HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment  D3.00  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  D1.00  Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir D2.00  Medicare discharges (see instructions)  Ocase-mix adjustment factor (see instructions)	s) tration) Adju eriod under t ne 49)	the 21st	0.0000	0.0000	102 103 104 200 201 202
D2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment D3.00 HRR adjustment factor (see instructions) D4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst D5.00.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement D1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir D2.00 Medicare discharges (see instructions)	s) tration) Adju eriod under t ne 49)	the 21st	0.0000	0.0000	102 103 104 200 201 202
D2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment  O3.00 HRR adjustment factor (see instructions)  O4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A D	s) tration) Adju eriod under t ne 49)	the 21st	0.0000	0.0000	102. 103. 104. 200. 201. 202. 203.
D2. 00  HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment  O3. 00  HRR adjustment factor (see instructions)  O4. 00  HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration Project (§	s) tration) Adju eriod under t ne 49)	the 21st	0.0000	0.0000	102 103 104 200 201 202 203
D2. 00  HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment  O3. 00  HRR adjustment factor (see instructions)  O4. 00  HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration Project (§	s) tration) Adju eriod under t ne 49) n first year	the 21st	0.0000	0.0000 0	102. 103. 104. 200. 201. 202. 203. 204. 205.
D2. 00  HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment  O3. 00  HRR adjustment factor (see instructions)  O4. 00  HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration Project (§	s) tration) Adju eriod under t ne 49) n first year	the 21st	0.0000	0.0000 0	102. 103. 104. 200. 201. 202. 203. 204. 205.
D2. 00  HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment  D3. 00  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  D1. 00  Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir D2. 00  Medicare discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in period)  D4. 00  Medicare target amount  D5. 00  Case-mix adjusted target amount (line 203 times line 204)  Medicare inpatient routine cost cap (line 202 times line 205)  Adjustment to Medicare Part A Inpatient Reimbursement	s) tration) Adju eriod under t ne 49) n first year	the 21st	0.0000	0.0000 0	102. 103. 104. 200. 201. 202. 203. 204. 205. 206.
D2.00  HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment  O3.00  HRR adjustment factor (see instructions)  O4.00  HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410	s) tration) Adju eriod under t me 49) n first year ) tructions)	the 21st	0.0000	0.0000 0	102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208.
O2. 00  HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment O3. 00 HRR adjustment factor (see instructions) O4. 00  HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410	s) tration) Adju eriod under t me 49) n first year ) tructions)	the 21st	0.0000	0.0000 0	102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209.
O2. 00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment O3. 00 HRR adjustment factor (see instructions) O4. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst O0. 00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement O1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir O2. 00 Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) O4. 00 Medicare target amount O5. 00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) O6. 00 Medicare target amount O7. 00 Medicare inpatient routine cost cap (line 202 times line 204) Adjustment to Medicare Part A Inpatient Reimbursement O7. 00 Program reimbursement under the \$410A Demonstrations) O8. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, O9. 00 Adjustment to Medicare IPPS payments (see instructions)	s) tration) Adju eriod under t  ne 49)  n first year  tructions) line 59)	the 21st	0.0000	0.0000 0 ration	102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210.
D2. 00  HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment  O3. 00  HRR adjustment factor (see instructions)  O4. 00  HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration (N/A in period)  O4. 00  Medicare inpatient routine cost cap (line 202 times line 204)  O5. 00  Medicare inpatient routine cost cap (line 202 times line 205)  Adjustment to Medicare Part A Inpatient Reimbursement  O7. 00  Program reimbursement under the §410A Demonstration (see instructions)  Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 209. 00  Adjustment to Medicare IPPS payments (see instructions)  Total adjustment to Medicare IPPS payments (see instructions)	s) tration) Adju eriod under t  ne 49)  n first year  tructions) line 59)	the 21st	0.0000	0.0000 0 ration	102 103 104 200 201 202 203 204 205 206 207 208 209 210
O2. 00  HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment  O3. 00 HRR adjustment factor (see instructions)  O4. 00  HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration Demonstration Project (§410A Demonstration Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Demonstration Project (§410A Demonstration (N/A In Demonstration Project (§410A Demonstration (See Instructions) Program reimbursement under the §410A Demonstration (See Instructions) Medicare Part A Inpatient Reimbursement (See Instructions) Project Projec	tructions)	the 21st	0.0000	0.0000 0	102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 211.
02. 00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 03. 00 HRR adjustment factor (see instructions) 04. 00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration (N/A in Demonstration Project (§410A Demonstration (See Instructions) Program reimbursement under the §410A Demonstration (see Instructions) Reserved for future use 11. 00 Reserved for future use 11. 00 Total adjustment to Medicare IPPS payments (see Instructions) Comparision of PPS versus Cost Reimbursement	tructions)	the 21st	0.0000	0.0000 0	102.
<ul> <li>03.00 HRR adjustment factor (see instructions)</li> <li>04.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 1s this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir 02.00 Medicare discharges (see instructions)</li> <li>03.00 Case-mix adjustment factor (see instructions)</li> <li>04.00 Medicare target amount (line 203 times line 204)</li> <li>05.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>06.00 Medicare inpatient routine cost cap (line 202 times line 205)</li> <li>Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>07.00 Program reimbursement under the §410A Demonstration (see inst</li> <li>08.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A,</li> <li>09.00 Adjustment to Medicare IPPS payments (see instructions)</li> <li>10.00 Reserved for future use</li> <li>11.00 Total adjustment to Medicare IPPS payments (see instructions)</li> <li>12.00 Total adjustment to Medicare Part A IPPS payments (from line</li> <li>13.00 Low-volume adjustment (see instructions)</li> </ul>	s) tration) Adju- eriod under to the 49) first year tructions) line 59)	of the curren	0.0000	0.0000 0 ration	200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 211.
02. 00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 03. 00 HRR adjustment factor (see instructions) 04. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Demonstration Project (§410A Demonstration (N/A in period) 04. 00 Medicare target amount (line 203 times line 204) 05. 00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 07. 00 Program reimbursement under the §410A Demonstration (see inst Notation Project (§410A Demonstration Project (§410A De	s) tration) Adju- eriod under to the 49) first year tructions) line 59)	of the curren	0.0000	0.0000 0 ration	200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 211.

Health Financial Systems	COMMUNITY HOSPITAL OF IN	IDI ANA, INC.		In Lieu	ı of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pr	rovider CCN:	15-0169	From 01/01/2017	Worksheet E Part B Date/Time Prepared:

PART B - VEDICAL AND OTHER HEALTH SERVICES   1.00				10 12/31/2017	Date/Time Pre 5/30/2018 11:	
DART B			Title XVIII	Hospi tal		72 am
DART B						
Medical and other services (see instructions)		T			1. 00	
Medical and other services in incursed under OPPS (see Instructions)   11,953,899   10,000   11,005,000   3.00   000	1 00				42.72/	1 00
0.000   0.00		· · · · · · · · · · · · · · · · · · ·	tions)			
0.01   critical payment (see instructions)		· · · · · · · · · · · · · · · · · · ·	ti ons)			
Outlier reconciliation amount (see instructions)		1 1				
Enter the hospital specific payment to cost ratio (see instructions)						
Line 2 times line 5		· · · · · · · · · · · · · · · · · · ·	ctions)			
Transitional corridor payment (see instructions)						1
	7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
0.00   organ acquisitions   0.10,00   0.00		Transitional corridor payment (see instructions)				8. 00
1.00   Total cost (sum of lines 1 and 10) (see instructions)   1.00   CoMPUTATION OF LESSER OF COST 0R CHARGES   1.00   Amount of larges   1.00   1			IV, col. 13, line 200		-	9. 00
COMPUTATION OF LISSER OF LOST OR CHARGES   Reasonable charges   Reasonable charges   Reasonable charges   Reasonable charges   Reasonable charges   Reasonable charges (sum of lines 12 and 13)   Reasonable charges (sum of lines 15 to line 16 (not to exceed 1.000000)   Reasonable charges (see instructions)   Reasonable charges (see instructions)   Reasonable charges (see lines 125,669   Reasonable charges (see instructions)   Reasonable charges (sum of lines 14 (see instructions)   Reasonable charges						
Reasonable charges   12.00   Ancil Tary service charges   12.00   13.00	11. 00				42, 726	] 11. 00
12.00   Ancil lary service charges   168, 395   12.00   Total reasonable charges (from Wist. D-4, Pt. III, col. 4, line 69)   168, 395   12.00   Total reasonable charges (sum of lines 12 and 13)   168, 395   14.00   Total reasonable charges (sum of lines 12 and 13)   168, 395   14.00   168, 395   14.00   168, 395   14.00   168, 395   14.00   168, 395   14.00   168, 395   14.00   168, 395   14.00   168, 395   14.00   168, 395   14.00   168, 395   14.00   168, 395   14.00   168, 395   14.00   168, 395   14.00   168, 395   14.00   168, 395   14.00   168, 395   14.00   168, 395   14.00   168, 395   14.00   168, 395   14.00   168, 395   168, 39						1
13.00   Organ acquisition charges (from West. D-4, Pt. III. col. 4, line 69)   0   13.00	12 00				140 205	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 chargebasis   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   Liable for payment for services on a chargebasis   0   16.00   Aggregate amount actually collected   Aggregate   A			ine 60)			
Customery_charges			1116 07)			
15.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   15.00	14.00				100, 373	14.00
16.00   Amounts that would have been realized from patients liable for payment for services on a chargebasis   0   16.00	15. 00		payment for services on	a charge basis	0	15. 00
had such payment been made in accordance with 42 CFR \$413.13(e)						16. 00
18. 00   Total customary charges (see instructions)   16.8, 395   18. 00   17. 00				Ü		
19. 00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see   125, 669   9. 00   125, 669   125, 669   125, 669   125, 669   125, 669   125, 669   125, 669	17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)				
Instructions					'	
20. 00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20. 00	19. 00		ly if line 18 exceeds li	ne 11) (see	125, 669	19. 00
Instructions	20.00	1	l ! & l! == 11	10) (		20.00
21.00   Lesser of cost or charges (see Instructions)   0.2.00   22.00   22.00   Cost of physicians' services in a teaching hospital (see instructions)   0.2.00   22	20. 00		ry if line il exceeds il	ne 18) (See	0	20.00
22 .00   Interns and residents (see instructions)   0 22 .00   23 .00   23 .00   25 .00   25 .00   25 .00   25 .00   25 .00   25 .00   25 .00   25 .00   25 .00   25 .00   25 .00   25 .00   25 .00   25 .00   26 .00   27 .00   2	21 00	1			42 726	21 00
23. 00   Cost of physicians' services in a teaching hospital (see instructions)   14, 107, 323   24. 00   Total prospective payment (sum of lines 3, 4, 4, 01, 8 and 9)   14, 107, 323   24. 00   COMPUTATION OF REINBURSEMENT SETTLEMENT   Deductibles and coinsurance (for CAH, see instructions)   2, 795, 515   26. 00   Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)   2, 795, 515   26. 00   Direct graduate medical education payments (from Whst. E-4, line 50)   30, 092   27. 00   ESPE direct medical education costs (from Whst. E-4, line 36)   29. 00   ESPE direct medical education costs (from Whst. E-4, line 36)   29. 00   ESPE direct medical education costs (from Whst. E-4, line 36)   29. 00   ESPE direct medical education costs (from Whst. E-4, line 36)   11, 384, 626   30. 00   30. 00   30. 00   20.					'	
24. 00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   14, 107, 323   24. 00   COMPUTATION OF REIMBURSEMINT SETTLEMENT		· · · · · · · · · · · · · · · · · · ·	ructions)			23. 00
COMPUTATION OF REIMBURSEMENT SETTLEMENT   Computation	24. 00		,		14, 107, 323	24.00
26.00         Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)         2.795, 515 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)         11,354,534         27.00           28.00         Direct graduate medical education payments (from Wkst. E-4, line 36)         30,092         28.00           29.00         ESRD direct medical education costs (from Wkst. E-4, line 36)         11,384,626         30.00           30.00         Subtotal (line 30 minus line 31)         11,379,303         32.00           31.00         Subtotal (line 30 minus line 31)         11,379,303         32.00           32.00         Composite rate ESRD (from Wkst. I-5, line 11)         30,065         34.00           34.00         Allowable bad debts (see instructions)         30,665         34.00           35.00         Allowable bad debts for dual eligible beneficiaries (see instructions)         270,336         36.00           36.00         Milowable bad debts for dual eligible beneficiaries (see instructions)         270,336         37.00           38.00         MSP-LCC reconciliation amount from PS&         -78         38.00           MPS-LCC reconciliation amount from PS&R         -78         -78         39.00           99.99         RECOVERY OF ACCELERATED DEPRE		COMPUTATION OF REIMBURSEMENT SETTLEMENT				
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)						25. 00
Instructions   Direct graduate medical education payments (from Wkst. E-4, line 50)   30,092   28,00   29,00   ESRD direct medical education costs (from Wkst. E-4, line 36)   0   29,00   30,00   30,00   Subtotal (sum of lines 27 through 29)   11,384,626   30,00   30,00   30,00   30,00   30,00   30,00   30,00   30,0						
28.00	27.00	- · · · · · · · · · · · · · · · · · · ·	plus the sum of lines 22	and 23] (see	11, 354, 534	27.00
29.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   29.00   Subtotal (sum of lines 27 through 29)   11, 384, 626   30.00   31.00   Primary payer payments   5, 323   31.00   All Lowable (line 30 minus line 31)   11, 379, 303   32.00   All Lowable (line 30 minus line 31)   32.00   Composite rate ESRD (from Wkst. I-5, line 11)   0   33.00   30.00   All lowable bad debts (see instructions)   307, 665   34.00   35.00   All lowable bad debts (see instructions)   199, 982   35.00   36.00   All lowable bad debts for dual eligible beneficiaries (see instructions)   270, 336   36.00   All lowable bad debts for dual eligible beneficiaries (see instructions)   270, 336   36.00   All lowable bad debts for dual eligible beneficiaries (see instructions)   270, 336   36.00   All lowable bad debts for dual eligible beneficiaries (see instructions)   270, 336   36.00   39.00	28 00		ine 50)		30 002	28 00
30.00   Subtotal (sum of lines 27 through 29)   11, 384, 626   30.00   Primary payer payments   5, 323   31.00   Subtotal (line 30 minus line 31)   11, 379, 303   32.00   Subtotal (line 30 minus line 31)   11, 379, 303   32.00   Subtotal (line 30 minus line 31)   11, 379, 303   32.00   Subtotal (see instructions)   30.00   Composite rate ESRD (from Wkst. I-5, line 11)   33.00   34.00   Allowable bad debts (see instructions)   307, 665   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   307, 665   34.00   37.00   Subtotal (see instructions)   270, 336   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   270, 336   36.00   37.00   Subtotal (see instructions)   270, 336   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   11, 579, 285   37.00   38.00   MSP-LCC reconciliation amount from PS&R   -78   38.00   MSP-LCC reconciliation amount from PS&R   -78   38.00   39.90   Pioneer ACO demonstration payment adjustment (see instructions)   0 39.90   39.90   Pioneer ACO demonstration payment adjustment (see instructions)   0 39.90   39.90   RECOVERY OF ACCELERATED DEPRECIATION   0 39.90   Allowable see instructions)   0 39.90   Allowable constration payment adjustment amount after sequestration   0 39.90   Allowable constration payment adjustment amount after sequestration   0 39.90   Allowable constration payment adjustment amount after sequestration   0 40.00   Allowable cost report items)   0 40.00   Allowable cost report items)   0 40.00   Allowable cost report items)   0 40.00   Allowable cost report items   0 40.00   Allowable cost report ite			THE 30)			
31.00   Primary payer payments   5, 323   31.00   Subtotal (line 30 minus line 31)   11, 379, 303   32.00						
32.00   Subtotal (line 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)   307,665   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   270,336   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   270,336   36.00   37.00   Subtotal (see instructions)   270,336   36.00   38.00   MSP-LCC reconciliation amount from PS&R   78   38.00   MSP-LCC reconciliation amount from PS&R   78   38.00   MSP-LCD reconciliation amount from PS&R   78   38.00   MSP-LCD reconciliation payment adjustment (see instructions)   39.95   Pioneer ACO demonstration payment adjustment (see instructions)   39.95   Partial or full credits received from manufacturers for replaced devices (see instructions)   39.96   39.99   RECOVERY OF ACCELERATED DEPRECIATION   39.99   RECOVERY OF ACCELERATED DEPRECIATION   39.99   Recovery of Accelerated (see instructions)   31,579,363   40.01   40.00   Subtotal (see instructions)   231,587   40.01   40.00   Demonstration payment adjustment amount after sequestration   40.02   Demonstration payment adjustment amount after sequestration   40.02   42.00   Tentative settlement (for contractors use only)   42.00   Real acce due provider/program (see instructions)   42.00   43.00   8a lance due provider/program (see instructions)   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,		,				1
33.00   Composite rate ESRD (from Wkst. I-5, line 11)   0   33.00   33.00   All owable bad debts (see instructions)   307,665   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   199,982   35.00   36.00   All owable bad debts for dual eligible beneficiaries (see instructions)   270,336   36.00   270,336   270,366   270	32.00				11, 379, 303	32.00
34.00		ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)			
35.00   Adjusted reimbursable bad debts (see instructions)   199,982   35.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   270,336   36.00   37.00   Subtotal (see instructions)   11,579,285   37.00   38.00   MSP-LCC reconciliation amount from PS&R   -78   38.00   39.50		1 .				
36.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       270,336       36.00         37.00       Subtotal (see instructions)       11,579,285       37.00         38.00       MSP-LCC reconciliation amount from PS&R       -78       38.00         39.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       39.00         39.50       Pioneer ACO demonstration payment adjustment (see instructions)       39.90         39.97       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39.97         39.99       RECOVERY OF ACCELERATED DEPRECIATION       0       39.99         40.01       Sequestration adjustment (see instructions)       11,579,363       40.00         40.02       Linterim payments       231,587       40.01         42.00       Education adjustment (for contractors use only)       0       41.00         43.00       Balance due provider/program (see instructions)       28,732       43.00         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515.2       44.00         90.00       Designal outlier amount (see instructions)       0       90.00         91.00       The rate used to calculate the Time Value of Money       0.00       90.00		· · · · · · · · · · · · · · · · · · ·				1
37. 00   Subtotal (see instructions)   11,577,285   37. 00   38. 00   MSP-LCC reconciliation amount from PS&R   -78   38. 00   39. 00   39. 00   39. 50   39. 50   39. 97   91 oneer ACO demonstration payment adjustment (see instructions)   0   39. 97   39. 98   39. 99   82. 00   39. 99   82. 00   39. 99   82. 00   39. 99   82. 00   39. 99   82. 00   39. 99   82. 00   39. 99   82. 00   39. 99   82. 00   39. 99   82. 00   39. 99   82. 00   39. 99   82. 00   39. 99   82. 00   39. 99   82. 00   39. 99   82. 00   39. 99   82. 00   39. 99   82. 00   39. 99   82. 00   39. 99   39.						
38. 00       MSP-LCC reconciliation amount from PS&R       -78       38. 00         39. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       39. 00         39. 50       Pioneer ACO demonstration payment adjustment (see instructions)       39. 90         39. 97       Demonstration payment adjustment amount before sequestration       0       39. 95         39. 98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39. 98         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 98         40. 01       Subtotal (see instructions)       11, 579, 363       40. 00         40. 01       Demonstration adjustment (see instructions)       231, 581       40. 01         40. 02       Demonstration payment adjustment amount after sequestration       0       40. 01         41. 00       Interim payments       11, 319, 044       41. 00         42. 00       Tentative settlement (for contractors use only)       0       42. 00         43. 00       Balance due provider/program (see instructions)       28, 732       43. 00         44. 00       Sil15. 2       0       45. 00         TO BE COMPLETED BY CONTRACTOR       0       90. 00         91. 00       Outlier reconciliation adjustment amount (see instruction			ructions)			
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 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 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{\f						
Pi oneer ACO demonstration payment adjustment (see instructions)  39. 50 39. 97 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION  40. 00 Subtotal (see instructions)  50. 231, 587 40. 01 Demonstration payment adjustment amount after sequestration  60. 20 Demonstration adjustment (see instructions)  61. 579, 363 62. 00 Demonstration payment adjustment amount after sequestration  62. 00 Demonstration payment adjustment amount after sequestration  63. 9. 96 Contractors use only) Contractors use only)  63. 00 Demonstration payments  64. 00 Demonstration payments  65. 11, 319, 044 Demonstration payments  76. 11, 319, 044 Demonstration payment adjustment amount after sequestration  77. 12, 13, 13, 14, 10, 10, 10, 10, 10, 10, 10, 10, 10, 10						
39. 97 39. 98 39. 99 Recovery of Accelerated Deprectations			s)			
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 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)  0 39. 98 instructions)  0 11, 579, 363 40. 00  231, 587 40. 01  11, 319, 044 41. 00  1			2,		0	
39. 99 RECOVERY OF ACCELERATED DEPRECIATION  40. 00 Subtotal (see instructions)  5 Sequestration adjustment (see instructions)  11, 579, 363  40. 00  11, 579, 363  40. 00  231, 587  40. 01  11, 319, 044  11, 319,			ced devices (see instruc	tions)		
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, 8115.2 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		· ·		,	0	39. 99
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, 8115.2 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	Subtotal (see instructions)			11, 579, 363	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) 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) 99.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions)	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) 0 42.00 93.00 Time Value of Money (see instructions) 0 93.00		Demonstration payment adjustment amount after sequestration				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,						
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) 0 93.00						
\$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 P1.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 Time Value of Money (see instructions) 0 P3.00						
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)  0 93.00  93.00	44.00		nce with CMS Pub. 15-2,	cnapter 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) 0 90.00 91.00 92.00 93.00						1
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  0.00 92.00  93.00	90 00				n	90 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 0 93.00		,				
93.00 Time Value of Money (see instructions) 0 93.00						
						1

Health Financial Systems	COMMUNITY HOSPITAL OF	INDIANA, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169	Peri od: From 01/01/2017	Worksheet E Part B
		Component CCN: 15-S169	To 12/31/2017	Date/Time Prepared: 5/30/2018 11:42 am
		Title XVIII	Subprovi der -	PPS

		Title XVIII	Subprovi der - I PF	PPS	
			111	1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			918	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)	ti ons)		0	2.00
3. 00 4. 00	OPPS payments Outlier payment (see instructions)			595 0	3. 00 4. 00
4. 01	Outlier reconciliation amount (see instructions)			Ö	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0. 000	5. 00
6.00	Line 2 times line 5			0	6.00
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	7. 00 8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV. col. 13. line 200		0	9. 00
10.00	Organ acqui si ti ons	,		0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			918	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES  Reasonable charges				
12. 00	Ancillary service charges			3, 618	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, II	ine 69)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			3, 618	14. 00
15 00	Customary charges	normant for convices on	o charge basis	0	15 00
15. 00 16. 00	Aggregate amount actually collected from patients liable for partients that would have been realized from patients liable for			0	15. 00 16. 00
.0.00	had such payment been made in accordance with 42 CFR §413.13(		n a ona gozao. o		10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
18. 00 19. 00	Total customary charges (see instructions)	ly if lime 10 evenede lie	no 11) (coo	3, 618	
19.00	Excess of customary charges over reasonable cost (complete onlinstructions)	Ty IT TITLE TO exceeds IT	ile II) (See	2, 700	19.00
20.00	Excess of reasonable cost over customary charges (complete only	ly if line 11 exceeds li	ne 18) (see	0	20. 00
	instructions)				
21. 00 22. 00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			918 0	21. 00 22. 00
23. 00	Cost of physicians' services in a teaching hospital (see insti	ructions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			595	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00 26. 00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for	r CAU soo instructions)		0 0	25. 00 26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)]		and 231 (see	_	27. 00
	instructions)			.,	
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ine 50)		0	28. 00
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 1, 513	29. 00 30. 00
31. 00	Primary payer payments			1, 513	31.00
32.00	Subtotal (line 30 minus line 31)			1, 513	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE)	CES)			
33.00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0	33. 00 34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			0	35.00
36. 00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		0	36. 00
37. 00	Subtotal (see instructions)				37. 00
	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	5)		0	39. 00 39. 50
39. 97	Demonstration payment adjustment amount before sequestration	,		0	39. 97
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40. 00 40. 01	Subtotal (see instructions)   Sequestration adjustment (see instructions)			1, 513	
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
41. 00	Interim payments	2, 017 0			
42.00	,				42.00
43. 00 44. 00	Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance	nce with CMS Pub 15_2	chapter 1	-534 0	43. 00 44. 00
77.00	§115. 2	nee with own rub. 15-2, t	onaptor I,		77.00
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 00	91. 00 92. 00
93. 00	Time Value of Money (see instructions)			0.00	
94. 00	Total (sum of lines 91 and 93)			0	94. 00

From 01/01/2017 Part I 12/31/2017 Date/Time Prepared: 5/30/2018 11:42 am Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 45, 149, 035 11, 319, 044 1. 00 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 0 3.01 3.02 0 0 3.02 3.03 0 3.03 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 0 3.51 0 0 3.52 3.52 3.53 0 3.53 0 0 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 Ω 3.99 3.50-3.98) 45, 149, 035 11, 319, 044 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 5.01 TENTATIVE TO PROVIDER 0 0 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 26, 242 28, 732 6.01 SETTLEMENT TO PROGRAM 6 02 0 6.02 7.00 Total Medicare program liability (see instructions) 45, 175, 277 11, 347, 776 7.00 Contractor NPR Date (Mo/Day/Yr) Number

Provider CCN: 15-0169

0

1 00

2 00

8.00

Peri od:

8.00 Name of Contractor

Health Financial Systems COMMUNITY
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0169 Component CCN: 15-S169 Title XVIII

		Title	XVIII	Subprovi der - I PF	PPS	
		Inpatien	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		2, 119, 528		2, 017	1. 00
2.00	Interim payments payable on individual bills, either		C	)	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
2 00	write "NONE" or enter a zero					2 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3. 00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		C	)	0	3. 01
3.02			C		0	3. 02
3.03			C		0	3. 03
3. 04			C		0	3. 04
3. 05	Durani dana da Duranyana		C		0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 50	ADJUSTNIENTS TO PROGRAM		0			3. 50
3. 52			O		l ől	3. 52
3. 53			O		o o	3. 53
3.54			C	)	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C	)	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 119, 528	l e	2, 017	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5. 02			C		0	5. 02
5. 03			C		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		C	(	0	5. 50
5. 50	TENTATIVE TO PROGRAW		0			5. 51
5. 52			0			5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		O		Ö	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		775		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		2 120 202		534	6. 02
7. 00	Total Medicare program liability (see instructions)		2, 120, 303	Contractor	1,483 NPR Date	7. 00
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	'			•		

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT  Provider CCN: 15-0169 Provider CCN: 12-0169 Provider CCN: 12-0169 Provider CCN: 16-0169 Provider CCN: 16-0169 Provider CCN: 16-0169 Provider CN: 12-0169 Provider CCN: 16-0169 Provider CCN: 16-0	Heal th	Financial Systems COMMUNITY HOSPITAL 0	F INDIANA, INC.	In Lie	u of Form CMS-	2552-10
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS  HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION  1.00 Total hospital discharges as defined in AARA \$4102 from Wkst. S-3, Pt. I col. 15 line 14  2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12  3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2  4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12  5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200  6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20  7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168  8.00 Calculation of the HIT incentive payment (see instructions)  9.00 Sequestration adjustment amount (see instructions)	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0169	From 01/01/2017	Part II Date/Time Pre	pared:
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS  HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION  1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14  2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12  3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2  4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12  5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200  6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20  7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168  8.00 Calculation of the HIT incentive payment (see instructions)  8.00 Sequestration adjustment amount (see instructions)  9.00			Title XVIII	Hospi tal	PPS	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS  HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION  1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14  2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12  3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2  4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12  5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200  6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20  7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168  8.00 Calculation of the HIT incentive payment (see instructions)  8.00 Sequestration adjustment amount (see instructions)  9.00						
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION  1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14  2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12  3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2  4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12  5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200  6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20  7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168  8.00 Calculation of the HIT incentive payment (see instructions)  8.00 Sequestration adjustment amount (see instructions)					1. 00	
Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14  2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12  3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2  4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12  5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200  6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20  7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168  8.00 Calculation of the HIT incentive payment (see instructions)  8.00 Sequestration adjustment amount (see instructions)  9.00		TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 8.00 Sequestration adjustment amount (see instructions) 9.00		HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	N .			
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 8.00 Sequestration adjustment amount (see instructions) 9.00	1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	e 14		1.00
4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 9.00	2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	3-12			2. 00
5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 9.00	3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 9.00	4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12			4.00
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 9.00	5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
line 168  8.00 Calculation of the HIT incentive payment (see instructions)  9.00 Sequestration adjustment amount (see instructions)  9.00	6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6. 00
8.00 Calculation of the HIT incentive payment (see instructions)  9.00 Sequestration adjustment amount (see instructions)  8.00  9.00	7.00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	Wkst. S-2, Pt. I		7. 00
9.00 Sequestration adjustment amount (see instructions) 9.00		line 168				
	8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
	9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)	10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00

inpatient Hospital Services Under the ipps & CAH

30.00 Initial/interim HIT payment adjustment (see instructions)

31.00 Other Adjustment (specify)

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

30. 00 31. 00

32.00

Health Financial Systems	COMMUNITY HOSPITAL OF I	INDIANA, IN	NC.	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	F	Provider CO		Peri od:	Worksheet E-3	
				From 01/01/2017	Part II	
		Component (	CCN: 15-S169	To 12/31/2017	Date/Time Pre	pared:
		•			5/30/2018 11:	42 am_
		Title	XVIII	Subprovi der -	PPS	
				IPF		

	. IPF		
	DADT II. MEDICADE DADT A CEDITICE. LDE DOC	1.00	
1. 00	PART II - MEDICARE PART A SERVICES - IPF PPS  Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2, 355, 945	1. 00
2.00	Net IPE PPS Outlier Payments	6, 129	2.00
3.00	Net IPF PPS ECT Payments	0, 127	3.00
4. 00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November	0.00	4. 00
1. 00	15. 2004. (see instructions)	0.00	1.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	4. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		
5.00	New Teaching program adjustment. (see instructions)	0.00	5. 00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0.00	6. 00
	teaching program" (see instuctions)		
7. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0.00	7. 00
0.00	teaching program" (see instuctions)	0.00	0 00
8. 00 9. 00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0. 00 9. 427397	8. 00 9. 00
10.00	Average Daily Census (see instructions)	0.000000	10.00
11. 00		0.000000	11.00
12. 00		2, 362, 074	12.00
13. 00		2, 302, 074	13. 00
14. 00			14. 00
15. 00		0	15. 00
16. 00		2, 362, 074	
17. 00		0	17. 00
18. 00		2, 362, 074	
19. 00		177, 576	
20.00		2, 184, 498	
21.00		21, 714	21.00
22.00	Subtotal (line 20 minus line 21)	2, 162, 784	22. 00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	1, 216	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	790	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26. 00	Subtotal (sum of lines 22 and 24)	2, 163, 574	26. 00
27. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27. 00
28. 00		0	28. 00
29. 00	1 · · · · · · · · · · · · · · · · · · ·	0	29. 00
30.00		0	30.00
30. 50		0	30. 50
30. 99	1	0	30. 99
31.00		2, 163, 574	
31. 01		43, 271	
31. 02		0	31. 02
32.00		2, 119, 528	
33. 00 34. 00	·	0 775	33. 00 34. 00
35.00		//5	35.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50. 00		6, 129	50. 00
51. 00		0, 127	51.00
	The rate used to calculate the Time Value of Money	0.00	52.00
	Time Value of Money (see instructions)	0.00	53.00
	· · · · · · · · · · · · · · · · · · ·	,	

	Financial Systems COMMUNITY HOSPITAL OF GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der Co	CN: 15-0169	Peri od:	Worksheet E-4	
DI CA	L EDUCATION COSTS			From 01/01/2017 To 12/31/2017	Date/Time Prep 5/30/2018 11:4	
		Title	xVIII	Hospi tal	PPS	42 alli
					1. 00	
00	COMPUTATION OF TOTAL DIRECT GME AMOUNT Unweighted resident FTE count for allopathic and osteopathic	programs for	cost reporti	ng pori ode	0.00	1. 0
	ending on or before December 31, 1996.	. 0	·			
00 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	ructions)	0. 00 0. 00	2. 00 3. 00
01	Direct GME cap reduction amount under ACA §5503 in accordance		§413.79 (m).	(see	0. 00	3. 0
00	instructions for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	to a Medicare	3. 75	4. 00
01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst		cost reporti	ng peri ods	0. 00	4. 0
02	straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap slot	s (see inst	ructions for	cost reporting	0. 00	4. 0
	periods straddling 7/1/2011)					
00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl 4.02 plus applicable subscripts	us or minus	iine 4 pius i	Thes 4.01 and	3. 75	5.00
00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	the current	year from your	2. 68	6. 00
00	Enter the lesser of line 5 or line 6		1		2. 68	7. 0
			Primary Care	0ther 2.00	<u>Total</u> 3. 00	
00	Weighted FTE count for physicians in an allopathic and osteop	athi c	1. 4		2. 68	8. 0
00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw	i se	1. 4	1. 26	2. 68	9. 0
	multiply line 8 times the result of line 5 divided by the amo 6.	unt on line				
. 00	Weighted dental and podiatric resident FTE count for the curr			1. 86		10. 0
01	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count	rrent year	1.4	1. 86 12 3. 12		10. 0 11. 0
. 00	Total weighted resident FTE count for the prior cost reporting	g year (see	1.5			12. 0
00	<pre>instructions) Total weighted resident FTE count for the penultimate cost re year (see instructions)</pre>	porting	1. 6	1. 48		13. 0
. 00	Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	1. 5	55 2.48		14. 0
. 00 . 01	Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new p	rograme	0. 0 0. 0			15. 0 15. 0
. 00	Adjustment for residents displaced by program or hospital clo		0.0			16. 0
. 01	Unweighted adjustment for residents displaced by program or holosure	ospi tal	0.0	0.00		16. 0
. 00	Adjusted rolling average FTE count		1.5			17. 00
. 00	Per resident amount Approved amount for resident costs		92, 126. 1 142, 79	,	371, 268	18. 00 19. 00
. 00	The restaure costs		112,7	220, 170		17.0
. 00	Additional unweighted allopathic and osteopathic direct GME F	TE resident	cap slots red	cei ved under 42	1. 00	20. 00
. 00	Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instru	ctions)			0.00	21. 0
. 00	Allowable additional direct GME FTE Resident Count (see instr				0. 00	
. 00	Enter the locally adjustment national average per resident am	ount (see in	structions)		0.00	
	Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)				0 371, 268	24. 0 25. 0
			Inpatient Par	t Managed care		
			1. 00	2. 00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD					_
. 00	Inpatient Days (see instructions) Total Inpatient Days (see instructions)		22, 61 76, 93			26. 0 27. 0
. 00	Ratio of inpatient days to total inpatient days		0. 29400			28. 0
			1			29. 0
. 00	Program direct GME amount Reduction for direct GME payments for Medicare Advantage		109, 15	5, 159		30.00

Hoal th	Financial Systems COMMUNITY HOSPITAL OF	E INDIANA INC	In Lio	u of Form CMS-2	2552 10
	Financial Systems COMMUNITY HOSPITAL OF GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-0169	Peri od:	Worksheet E-4	
	MEDICAL EDUCATION COSTS   From 01/01/2017   To 12/31/2017   E				
-		Title XVIII	Hospi tal	5/30/2018 11: PPS	
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL EDUCATION COSTS)	E XVIII ONLY (NURSING SC	HOOL AND PARAMEDI	CAL	
32. 00	Renal dialysis direct medical education costs (from Wkst. B, and 94)	Pt. I, sum of col. 20 an	nd 23, lines 74	0	32. 00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I, col. 8, sum of lines	74 and 94)	2, 708, 309	33. 00
34.00	Ratio of direct medical education costs to total charges (lin	e 32 ÷ line 33)		0.000000	34.00
35. 00	Medicare outpatient ESRD charges (see instructions)			0	35. 00
36.00	36.00 Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY			
	Part A Reasonable Cost				
37. 00				58, 682, 796	
38. 00				0	
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
	Primary payer payments (see instructions)			3, 671	
41. 00	Total Part A reasonable cost (sum of lines 37 through 39 minu	is line 40)		58, 679, 125	41. 00
	Part B Reasonable Cost			45 007 540	
	Reasonable cost (see instructions)			15, 997, 543	
43. 00	1 3 1 3 1 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1			5, 323	
44. 00				15, 992, 220	1
	Total reasonable cost (sum of lines 41 and 44)	44 11 45)		74, 671, 345	
	Ratio of Part A reasonable cost to total reasonable cost (lin			0. 785832	
47.00	Ratio of Part B reasonable cost to total reasonable cost (lin ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA			0. 214168	47. 00
40 00	Total program GME payment (line 31)	KI D		140, 507	10 00
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(coo instructions)		140, 507	
	Part B Medicare GME payment (line 47 x 48) (title XVIII only)			30, 092	
50.00	Trail b Medicale GME payment (Time 47 x 40) (LILLE XVIII OHLY)	(See Thisti uctions)	I	30, 092	1 30.00

Health Financial Systems COMMUNITY HOSPITE
BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column onl y)

Provider CCN: 15-0169

oni y)					5/30/2018 11:	
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS		2.00	0.00	1. 00	
1.00	Cash on hand in banks	7, 700	1	0	0	1
2.00	Temporary investments	0		-		
3.00	Notes receivable	1 2/1 2// 2/2		0	0	
4. 00 5. 00	Accounts recei vabl e Other recei vabl e	1, 261, 346, 242 4, 725		0		
6. 00	Allowances for uncollectible notes and accounts receivable	-215, 377, 133	1	0	0	
7. 00	Inventory	4, 843, 116		Ö	Ö	
8.00	Prepai d expenses	0	) (	0	0	8. 00
9.00	Other current assets	572, 562	2 0	0	0	
10. 00	Due from other funds	0	0	_	0	1
11. 00	Total current assets (sum of lines 1-10)	1, 051, 397, 212	2	0	0	11. 00
12. 00	FI XED ASSETS Land	2, 705, 851	ıl	0	0	12. 00
13. 00	Land improvements	3, 164, 637			1	
14. 00	Accumulated depreciation	0, 101, 007		_		
15. 00	Bui I di ngs	313, 468, 219		-	Ö	
16.00	Accumulated depreciation	0	) (	0	0	16. 00
17. 00	Leasehold improvements	1, 751, 624	1 0	0	0	
18. 00	Accumulated depreciation	0		0	0	
19. 00	Fixed equipment	107, 802, 694	1	0	0	
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	27, 150			0 1 0	
22. 00	Accumulated depreciation	27, 150		_		
23. 00	Major movable equipment			_	Ö	
24. 00	Accumulated depreciation	-213, 102, 407	1	o o	Ö	
25.00	Mi nor equi pment depreci abl e	0		0	0	25. 00
26. 00	Accumulated depreciation	0	0	0	0	
27. 00	HIT designated Assets	0		0	0	
28. 00	Accumulated depreciation	0		1	0	
29. 00	Minor equipment-nondepreciable	316, 270	1	_	0	
30. 00	Total fixed assets (sum of lines 12-29)  OTHER ASSETS	216, 134, 038	3  (	) 0		30.00
31. 00	Investments			0	0	31.00
32.00	Deposits on Leases	0		0	l	
33.00	Due from owners/officers	0		0	0	33. 00
34.00	Other assets	-232, 499, 409		0	0	
35. 00	Total other assets (sum of lines 31-34)	-232, 499, 409	1	1	0	1
36. 00	Total assets (sum of lines 11, 30, and 35)	1, 035, 031, 841		0	0	36. 00
37. 00	CURRENT LIABILITIES  Accounts payable	1, 459, 200		0	0	37. 00
38. 00	Salaries, wages, and fees payable	1, 437, 200		-		
39. 00	Payroll taxes payable			_	Ö	
40.00	Notes and Loans payable (short term)	0		0	0	
41.00	Deferred income	0	) (	0	0	41. 00
42. 00	Accel erated payments	0				42. 00
43.00	Due to other funds	0 (00 705		0	0	
44.00	Other current liabilities	3, 639, 725	1	1	ľ	
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	5, 098, 925	5	0	0	45. 00
46. 00	Mortgage payable			0	0	46. 00
47. 00	Notes payable	0		0		
48.00	Unsecured Loans	0	) (	0	0	48. 00
49. 00	Other long term liabilities	0	0	-	ı	1
50.00	Total long term liabilities (sum of lines 46 thru 49)	0				
51. 00	Total liabilities (sum of lines 45 and 50)	5, 098, 925	5	0	0	51.00
52. 00	CAPITAL ACCOUNTS  General fund balance	1, 029, 932, 916	:			52. 00
53. 00	Specific purpose fund	1,027,732,710	1 (	)		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	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
E0 00	replacement, and expansion	1 020 022 014			_	50.00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	1, 029, 932, 916 1, 035, 031, 841	1	0	0	
00.00	[59]	1, 000, 001, 041	΄			00.00
	· •	•	•	1	•	•

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0169

					0 12/31/2017	5/30/2018 11:	
		Genera	I Fund	Special Pu	urpose Fund	Endowment Fund	42 dili
		1.00	2.00	3.00	4. 00	5. 00	
1. 00	Fund balances at beginning of period		912, 430, 045		(		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		117, 502, 871				2. 00
3.00	Total (sum of line 1 and line 2)		1, 029, 932, 916		(		3. 00
4.00	Additions (credit adjustments) (specify)	0		C	)	0	4. 00
5.00		0		C	)	0	5. 00
6.00		0		C	1	0	6. 00
7. 00		0		C		0	7. 00
8. 00		0		C	1	0	8. 00
9. 00		0	_	C	)	0	9. 00
10.00	Total additions (sum of line 4-9)		0		(	)	10.00
11.00	Subtotal (line 3 plus line 10)		1, 029, 932, 916		(	)	11.00
12.00	Deductions (debit adjustments) (specify)	0		C	1	0	12.00
13. 00 14. 00		0		C		0	13. 00 14. 00
15. 00		0					15. 00
16. 00		0					16.00
17. 00		0				0	17. 00
18. 00	Total deductions (sum of lines 12-17)		0		ĺ		18. 00
19. 00	Fund balance at end of period per balance		1, 029, 932, 916				19. 00
	sheet (line 11 minus line 18)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
		Endowment Fund	PI ant	Fund			
1.00	TE	6.00	7. 00	8. 00			4.00
1.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0		C	)		1.00
2. 00 3. 00	Total (sum of line 1 and line 2)	0		(			2. 00 3. 00
4. 00	Additions (credit adjustments) (specify)	0			,		4. 00
5. 00	Additions (credit adjustments) (specify)		0				5. 00
6. 00			0				6.00
7. 00			0				7. 00
8. 00			Ö				8. 00
9. 00			0				9. 00
10.00	Total additions (sum of line 4-9)	0		l			10.00
11. 00	Subtotal (line 3 plus line 10)	0		C			11. 00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13. 00
14.00			0				14. 00
15.00			0				15. 00
16.00			0				16. 00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 12-17)	0	1	C			18. 00
19. 00	Fund balance at end of period per balance	0		C	)		19. 00
	sheet (line 11 minus line 18)						

 Heal th Financial Systems
 COMMUNITY

 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

In Lieu of Form CMS-2552-10 

		'	0 12/31/201/	5/30/2018 11:	
	Cost Center Description	Inpatient	Outpati ent	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	151, 013, 740	)	151, 013, 740	1. 00
2.00	SUBPROVI DER - I PF	7, 228, 185	5	7, 228, 185	2.00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF			0	5. 00
6.00	Swing bed - NF			0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	158, 241, 925	5	158, 241, 925	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	22, 464, 406	b	22, 464, 406	11. 00
12.00	CORONARY CARE UNIT				12. 00
13.00	BURN INTENSIVE CARE UNIT				13. 00
14.00	SURGI CAL INTENSIVE CARE UNIT				14.00
15. 00	NEONATAL INTENSIVE CARE UNIT	86, 124, 693	3	86, 124, 693	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	108, 589, 099		108, 589, 099	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	266, 831, 024	ļ	266, 831, 024	17. 00
18.00	Ancillary services	510, 972, 083		964, 494, 278	18. 00
19.00	Outpati ent servi ces	33, 501, 332		164, 260, 057	19. 00
20.00	RURAL HEALTH CLINIC			0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22. 00	HOME HEALTH AGENCY				22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26. 00	HOSPI CE				26. 00
27. 00	OTHER (SPECIFY)		0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wks	st. 811, 304, 439	584, 280, 920	1, 395, 585, 359	28. 00
	G-3, line 1)			, , ,	
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		323, 764, 342		29. 00
30.00	ADD (SPECIFY)				30.00
31.00					31.00
32.00					32.00
33.00					33. 00
34.00					34.00
35.00					35. 00
36.00	Total additions (sum of lines 30-35)		0		36. 00
37.00	DEDUCT (SPECIFY)				37. 00
38. 00					38. 00
39. 00					39. 00
40. 00					40. 00
41. 00					41. 00
42. 00	Total deductions (sum of lines 37-41)		o		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tran	nsfer	323, 764, 342		43. 00
	to Wkst. G-3, line 4)				

Health Financial Systems	COMMUNITY HOSPITAL OF IN	NDIANA, INC.	In Lie	u of Form CMS-2552-10
STATEMENT OF DEVENUES AND EVDENSES	Di	rovidor CCN: 15 0160	Pari ad:	Workshoot C 2

Heal th	Financial Systems	COMMUNITY HOSPITAL OF INDIANA, INC.		In Lie	In Lieu of Form CMS-2552-10		
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-0169		Peri od:	Worksheet G-3				
				From 01/01/2017	Doto/Time Dro	aanad.	
				To 12/31/2017	Date/Time Pre 5/30/2018 11:		
					0,00,2010 111	12 (	
					1. 00		
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)				1, 395, 585, 359	1. 00	
2.00	Less contractual allowances and discounts on patients' accounts			956, 872, 176	2.00		
3.00	Net patient revenues (line 1 minus line 2)			438, 713, 183	3. 00		
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			323, 764, 342	4. 00		
5.00	Net income from service to patients	(line 3 minus line 4)			114, 948, 841	5. 00	
	OTHER INCOME						
6.00	Contributions, donations, bequests,	etc			0	6. 00	
7.00	Income from investments				0	7. 00	
8.00	Revenues from telephone and other mi	scellaneous communication	servi ces		0	8. 00	
9.00	Revenue from television and radio se	rvi ce			0	9. 00	
10.00	Purchase di scounts				0	10.00	
11. 00	Rebates and refunds of expenses				0	11. 00	
12.00	Parking Lot receipts				0	12.00	
13.00	Revenue from Laundry and Linen servi	ce			0	13.00	
14.00	Revenue from meals sold to employees	and guests			0	14.00	
15. 00	Revenue from rental of living quarte	rs			0	15.00	
16.00	Revenue from sale of medical and sur	gical supplies to other t	han patients		0	16.00	
17.00	Revenue from sale of drugs to other	than patients			26, 250	17. 00	
18. 00	Revenue from sale of medical records	and abstracts			0	18.00	
19.00	Tuition (fees, sale of textbooks, un	iforms, etc.)			0	19.00	
20.00	Revenue from gifts, flowers, coffee	shops, and canteen			0	20.00	
21. 00	Rental of vending machines				0	21. 00	
22. 00	Rental of hospital space				0	22. 00	
23.00	Governmental appropriations				0	23.00	
24.00	OTHER MISC REVENUE				2, 527, 780	24.00	
25.00	Total other income (sum of lines 6-2	4)			2, 554, 030	25.00	
26.00	Total (line 5 plus line 25)				117, 502, 871	26.00	
27.00	OTHER EXPENSES (SPECIFY)				0	27. 00	
28.00	Total other expenses (sum of line 27	and subscripts)			0	28. 00	
29. 00	Net income (or loss) for the period	(line 26 minus line 28)			117, 502, 871	29. 00	

	Financial Systems COMMUNITY HOSPITAL OF	<u> </u>		u of Form CMS-2	2552-10
CALCULATION OF CAPITAL PAYMENT		Provi der CCN: 15-0169	Peri od: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Prepared: 5/30/2018 11:42 am	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
1 00	CAPITAL FEDERAL AMOUNT Capital DRG other than outlier			2 251 000	1 00
1. 00 1. 01	Model 4 BPCI Capital DRG other than outlier			3, 351, 909 0	1. 00 1. 01
2. 00	Capital DRG outlier payments			150, 888	2. 00
2.00				150, 888	2. 00
3.00				207. 11	3. 00
4. 00				3. 97	4. 00
5. 00	Indirect medical education percentage (see instructions)			0.54	5. 00
6. 00				18, 100	6. 00
	1.01) (see instructions)		,		
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line			3. 57	7.00
	30) (see instructions)				
8.00	Percentage of Medicaid patient days to total days (see instructions)			28. 16	8.00
9.00	Sum of lines 7 and 8			31. 73	9. 00
	Allowable disproportionate share percentage (see instructions)			6. 64	
	.00 Disproportionate share adjustment (see instructions)			222, 567	
12.00 Total prospective capital payments (see instructions)			3, 743, 464	12. 00	
				4.00	
	DADT II DAVMENT UNDER REACONARIE COCT			1. 00	
PART II - PAYMENT UNDER REASONABLE COST					

	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)		1. 00
2.00	Program inpatient ancillary capital cost (see instructions)		2. 00
3.00	Total inpatient program capital cost (line 1 plus line 2)		3. 00
4.00	Capital cost payment factor (see instructions)		4. 00
5.00	Total inpatient program capital cost (line 3 x line 4)		5. 00
		1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1. 00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2. 00
3.00	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 instructions)	0.00	6. 00
7.00			7. 00
8.00			8. 00
9.00	Current year capital payments (from Part I, line 12, as applicable)		9. 00
10. 00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11. 00	Carryover of accumulated capital minimum payment level over capital payment (from prior year	0	11. 00
	Worksheet L, Part III, line 14)		ı
	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13. 00
14. 00	Carryover of accumulated capital minimum payment level over capital payment for the following period	0	14. 00
	(if line 12 is negative, enter the amount on this line)		
	Current year allowable operating and capital payment (see instructions)	0	10.00
	Current year operating and capital costs (see instructions)	0	10.00
17. 00	Current year exception offset amount (see instructions)	0	17. 00