Health Financi	al Systems	TERRE HAUTE REGION	ΔΙ ΗΛΣΡΤΤΔΙ	Tn lie	u of Form CMS-2552-10
This report is	s required by law (42 USC 1395 since the beginning of the co	g; 42 CFR 413.20(b)). Fai	lure to report can resul	lt in all interim	
HOSPITAL AND H AND SETTLEMENT	HOSPITAL HEALTH CARE COMPLEX C T SUMMARY	OST REPORT CERTIFICATION	Provider CCN: 15-0046	Period: From 09/01/2016 To 08/31/2017	
PART I - COST	REPORT STATUS				
Provider	<ol> <li>[ X ] Electronically filed</li> </ol>	•		Date: 1/27/20	18 Time: 2:25 pm
use only	<ol> <li>] Manually submitted compared</li> <li>[ 0 ] If this is an amended</li> <li>[ F ] Medicare Utilization</li> </ol>	d report enter the number		esubmitted this co	ost report
Contractor use only	5. [ 1 ]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	7. Contractor No.	or this Provider CCN 12.		or Code: 4 plumn 1 is 4: Enter les reopened = 0-9.
PART II - CER	TIFICATION				
	TION OR FALSIFICATION OF ANY I				•

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

## CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by TERRE HAUTE REGIONAL HOSPITAL (15-0046) for the cost reporting period beginning 09/01/2016 and ending 08/31/2017 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.

(Signed)

Encryption Information

ECR: Date: 1/27/2018 Time: 2:25 pm

BMWBeLmjNJ8depm9dnkM5bjqrcLHE0
k:Uj:09SMK:iiNNwbd.VQarGoY9IcG

OmsL1ZauZr0tV41k

PI: Date: 1/27/2018 Time: 2:25 pm

PI: Date: 1/27/2018 Time: 2:25 pm b..PAluoqLmBbOeRx:KIaFj1GabGaO HM:zJ0x2Pvcppp4589zZ1sHdqUDpuo Title //oo

wh

Officer or Administrator of Provider(s)

Date

IsnW0OGK890VZVDt Title XVIII Title XIX Title V Part A Part B HIT 1.00 2.00 3.00 4.00 5.00 PART III - SETTLEMENT SUMMARY 1,274,339 1.00 69,090 -175,385 1.00 Hospital 0 17,771 -357 -189,830 2.00 2.00 Subprovider - IPF Subprovider - IRF 0 -7.946 -105 117,663 3.00 3.00 0 5.00 5.00 Swing bed - SNF 0 Swing bed - NF 6.00 6.00 0 1,202,172 200.00 200.00 Total 0 78,915 -175,847

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.

## PART II - CERTIFICATION

(4) Reopened (5) Amended

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

## CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by TERRE HAUTE REGIONAL HOSPITAL (15-0046) for the cost reporting period beginning 09/01/2016 and ending 08/31/2017 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.

Officer or Administrator of Provider(s)

Title

Date

			Title_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	69, 090	-175, 385	0	1, 274, 339	1.00
2.00	Subprovider - IPF	0	17, 771	-357		-189, 830	2.00
3.00	Subprovider - IRF	0	-7, 946	-105		117, 663	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	78, 915	-175, 847	0	1, 202, 172	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.

	In-State	In-State	Out-of	Out-of	Medicaid	Other	
	Medicaid paid days	Medicaid eligible	State Medicaid	State Medi cai d	HMO days	Medi cai d	
	paru uays	unpai d	paid days	eligible		days	
		days	para days	unpai d			
	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
24.00   If this provider is an IPPS hospital, enter the	676	255	35	188	2, 819	65	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	64	49		0	107		25. 00
Medicaid paid days in column 1, the in-state	04	49	٥	U	107		25.00
Medicaid eligible unpaid days in column 2,							
out-of-state Medicaid days in column 3, out-of-state							
Medicaid eligible unpaid days in column 4, Medicaid							
HMO paid and eligible but unpaid days in column 5.							
pino para ana origina o out unpara dayo in corumnio.	'		1	'	'		

Health Financial Systems	TERRE HAU	TE REGI	ONAL HOSPITAL		l n	Lieu of	Form C	MS-2552-			
HOSPITAL AND HOSPITAL HEALTH CARE CO	MPLEX IDENTIFICATION DA	TA	Provider CC	F	eriod: rom 09/01/20 o 08/31/20	16 Par		S-2 Prepared			
					Urban/Rural	1/2	7/2018	2:15 pm			
					1. 00	3 Date	2.00				
<ul><li>26.00 Enter your standard geographic cost reporting period. Enter '</li><li>27.00 Enter your standard geographic reporting period. Enter in col</li></ul>	'1" for urban or "2" for c classification (not wa	rural. ge) sta	atus at the end	of the cost		1		26. 0			
enter the effective date of the state of the	ne geographic reclassifi ospital (SCH), enter the	cati on	in column 2.			0		35. 0			
errect in the cost reporting i	per r ou.				Begi nni ng	: E	Endi ng:				
24 00 Enter applicable beginning applicable	5.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number										
of periods in excess of one an 37.00 If this is a Medicare dependen	nd enter subsequent date nt hospital (MDH), enter	S.	·			0		36. 0			
is in effect in the cost report 37.01 Is this hospital a former MDH accordance with FY 2016 OPPS 1	that is eligible for th				N			37. 0			
instructions) 38.00 If line 37 is 1, enter the beggreater than 1, subscript this enter subsequent dates.	, 3							38.0			
					Y/N		Y/N				
39.00 Does this facility qualify for hospitals in accordance with a or "N" for no. Does the facili	12 CFR §412.101(b)(2)(ii	)? Ente	er in column 1	"Y" for yes	1. 00 N		2. 00 N	39. 0			
40.00 CFR 412.101(b)(2)(ii)? Enter i	n column 2 "Y" for yes ne HAC program reduction scharges prior to Octob	or "N" adjust er 1. E	for no. (see i tment? Enter "Y Enter "Y" for y	nstructions) " for yes or	N		N	40. 0			
no in column 2, for discharges	s on or after October 1.	(see i	instructions)			v xv	111 X	I X			
	20) 0 111				1	. 00 2.	00 3.	00			
45.00 Does this facility qualify and	Prospective Payment System (PPS)-Capital  Does this facility qualify and receive Capital payment for disproportionate share in accordance N Y N 4 with 42 CFR Section §412.320? (see instructions)										
46.00 Is this facility eligible for	0 Is this facility eligible for additional payment exception for extraordinary circumstances N N N pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through										
47.00 Is this a new hospital under	Ols this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no. NNNN NO Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. NNN N										
56.00 Is this a hospital involved in	n training residents in	approve	ed GME programs	? Enter "Y" 1	for yes	N		56.0			
or "N" for no. 57.00 If line 56 is yes, is this the GME programs trained at this is "Y" did residents start tra for yes or "N" for no in colu "N", complete Wkst. D, Parts I	facility? Enter "Y" for aining in the first mont nn 2. If column 2 is "Y	yes or h of th ", comp	r "N" for no ir his cost report plete Worksheet	column 1. If ing period? [	column 1 Enter "Y"	N		57.0			
58.00 If line 56 is yes, did this fa defined in CMS Pub. 15-1, chap	acility elect cost reimb	ursemer	nt for physicia	ıns' services a	as	N		58. 0			
59.00 Are costs claimed on line 100	of Worksheet A? If yes	, compl	lete Wkst. D-2,			N		59. 0			
60.00 Are you claiming nursing school provider-operated criteria und					ctions)	N		60.0			
		Y/N	IME	Direct GME	IME	Di	rect GN	1E			
		1. 00	2. 00	3. 00	4.00		5. 00				
61.00 Did your hospital receive FTE section 5503? Enter "Y" for you column 1. (see instructions)		N				. 00		0.00 61.0			
61.01 Enter the average number of un FTEs from the hospital's 3 mos ending and submitted before Ma	st recent cost reports		0.00	0.00	d			61.0			
instructions) 61.02 Enter the current year total uprecision for the first count (excluding OB/GYN, gand primary care FTEs added uprecision for the first form of the first current form of the first form of the f	general surgery FTEs,		0.00	0.00				61.0			
ACA). (see instructions) 61.03 Enter the base line FTE count and/or general surgery resider determining compliance with the	for primary care nts, which is used for		0.00	0. 00	) D			61.0			
instructions) 61.04 Enter the number of unweighted surgery allopathic and/or osto	d primary care/or eopathic FTEs in the		0. 00	0.00				61.0			
current cost reporting period. 61.05 Enter the difference between and/or general surgery FTEs at primary care and/or general su	the baseline primary and the current year's		0.00	0.00				61.0			
61.04 minus line 61.03). (see											

Health Fina	ancial Systems	TERRE HAU	TE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10	
	ND HOSPITAL HEALTH CARE COMPL			Provider CC		eriod: rom 09/01/2016	Worksheet S-2		
					To		Date/Time Pre		
			Y/N	IME	Direct GME	I ME	1/27/2018 2:1 Direct GME	o piii	
			1. 00	2. 00	3. 00	4. 00	5. 00		
used	er the amount of ACA §5503 aw I for cap relief and/or FTEs e or general surgery. (see in	that are nonprimary		0.00				61.06	
		·	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
				1. 00	2. 00	3. 00	4. 00	-	
spec for col u prog unwe	the FTEs in line 61.05, speci- cialty, if any, and the numbe each new program. (see instr- mn 1, the program name, ente- gram code, enter in column 3, cighted count and enter in co- unweighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE				0. 00	0. 00	61. 10	
61. 20 Of t prog resi i nst ente 3, t	the FTEs in line 61.05, speci- pram specialty, if any, and to dents for each expanded prog- cructions) Enter in column 1, er in column 2, the program of the IME FTE unweighted count- lirect GME FTE unweighted cou	ne number of FTE ram. (see the program name, ode, enter in column and enter in column				0. 00	0. 00	61. 20	
							1. 00		
	Provisions Affecting the Hea								
	er the number of FTE resident hospital received HRSA PCRE			lin this cost	reporting peri	od for which	0.00	62.00	
62.01 Ente	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)								
63.00 Has	thing Hospitals that Claim Re your facility trained reside for yes or "N" for no in col	nts in nonprovider se	ettings	during this co		eriod? Enter	N	63. 00	
				·	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.		
					Nonprovi der Si te	Hospi tal	2))		
Sect	ion 5504 of the ACA Base Yea	r FTE Residents in No	onprovi (	der Settings	1.00 This base year	2.00 is your cost r	3.00 reporting		
64.00 Ente in t resi sett resi	od that begins on or after Jer in column 1, if line 63 is he base year period, the num dent FTEs attributable to roings. Enter in column 2 the dent FTEs that trained in yo column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	y trair n-primar all nor I non-pr n columr	ned residents by care provider imary care 1 3 the ratio	0.00	0.00	0. 000000	64.00	
101	cordiiii i di vided by (cordiiii	Program Name		ogram Code	Unwei ghted	Unwei ghted	Ratio (col. 3/		
					FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))		
		1. 00		2.00	3. 00	4. 00	5. 00		
is y trai year asso FTEs prog resi the col u unwe resi rota non- col u unwe resi your 5, t	er in column 1, if line 63 res, or your facility ned residents in the base reperiod, the program name reciated with primary care ram in which you trained dents. Enter in column 2, program code, enter in mn 3, the number of righted primary care FTE dents attributable to ritions occurring in all provider settings. Enter in mn 4, the number of righted primary care dent FTEs that trained in reconstructions of column 3 ded by (column 3 + column (see instructions)				0.00	0.00	0. 000000	05.00	

Health Financial Systems TERRE HAUTE REGIONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CC		eriod: com 09/01/2016	Worksheet S-2 Part I	
	To		Date/Time Pre	
		V	1/27/2018 2: 1 XI X	5 pm
		1. 00	2.00	
95.00 If line 94 is "Y", enter the reduction percentage in the applicable column 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no		0. 00 N	0. 00 N	95. 00 96. 00
applicable column.  97.00 If line 96 is "Y", enter the reduction percentage in the applicable column Rural Providers	l.	0. 00	0.00	97. 00
105.00 Does this hospital qualify as a critical access hospital (CAH)?  106.00 If this facility qualifies as a CAH, has it elected the all-inclusive meth	od of payment	N N		105. 00 106. 00
for outpatient services? (see instructions)  107.00  f this facility qualifies as a CAH, is it eligible for cost reimbursement training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the pr	for L&R ructions) If	N		107. 00
reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 s this a rural hospital qualifying for an exception to the CRNA fee sched	· ·	N		108. 00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Physical	Occupati onal	Speech	Respi ratory	
1.00 109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	2. 00 N	3. 00 N	4. 00 N	109. 00
for yes or "N" for no for each therapy.				
110.00 Did this hospital participate in the Rural Community Hospital Demonstratio	n project (410	A Demo)for	1. 00 N	110. 00
the current cost reporting period? Enter "Y" for yes or "N" for no.				
Minarillanana Cash Danashina Information		1.00	2.00 3.00	
Miscellaneous Cost Reporting Information  115.00 s this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in	column 1. If	column 1 N	0	115. 00
is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 3 either "93" percent for short term hospital or "98" percent for long term psychiatric, rehabilitation and long term hospitals providers) based on the Pub. 15-1, chapter 22, §2208.1.	s "E", enter i m care (includ	n column es		
116.00 s this facility classified as a referral center? Enter "Y" for yes or "N" 117.00 s this facility legally-required to carry malpractice insurance? Enter "Y"		N N" for N		116. 00 117. 00
no. 118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1 i	f the policy i	s 2		118. 00
claim-made. Enter 2 if the policy is occurrence.	Premi ums	Losses	Insurance	
	1. 00	2. 00	3. 00	-
118.01List amounts of malpractice premiums and paid losses:	337, 543			118. 01
		4.00	0.00	
118.02 Are mal practice premiums and paid losses reported in a cost center other t Administrative and General? If yes, submit supporting schedule listing co		1. 00 N	2. 00	118. 02
and amounts contained therein.  119.00 DO NOT USE THIS LINE				119. 00
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for th	for yes or e Outpatient	N	N	120. 00
Hold Harmless provision in ACA §3121 and applicable amendments? (see instr Enter in column 2, "Y" for yes or "N" for no.	ŕ			
121.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.	charged to	Υ		121. 00
122.00 Does the cost report contain state health or similar taxes? Enter "Y" for for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A		Υ	5. 00	122. 00
where these taxes are included. Transplant Center Information				
125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below.	for no. If	N		125. 00
126.00 If this is a Medicare certified kidney transplant center, enter the certifing in column 1 and termination date, if applicable, in column 2.	ication date			126. 00
127.00 If this is a Medicare certified heart transplant center, enter the certifing column 1 and termination date, if applicable, in column 2.	cation date			127. 00
128.00 If this is a Medicare certified liver transplant center, enter the certifing in column 1 and termination date, if applicable, in column 2.	cation date			128. 00
129.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2.	ation date in			129. 00
130.00  f this is a Medicare certified pancreas transplant center, enter the cert date in column 1 and termination date, if applicable, in column 2.	ification			130. 00
date in column 1 and termination date, if applicable, in column 2.  131.00  f this is a Medicare certified intestinal transplant center, enter the ce date in column 1 and termination date, if applicable, in column 2.	rti fi cati on			131. 00
132.00 If this is a Medicare certified islet transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2.	cation date			132. 00
p Got will it and tormination date, it approads 6, its condition 2.		ı	ı	ı

certification date	From 09/01/201 To 08/31/201		
		2.00	$\dashv$
umber in column 1	<b>3</b>	2.00	133. 0
			134. 0
in CMS Pub. 15-1, ad home office cost	ts	44H070	140. 0
nstructions)	3.00		
11 through 143 the		s of the	
or number. Contrac	ctor's Number: 103	301	141. 0
00	red. G Hambert 100		142. 0
Zi p Cod	le: 372	203	143. 0
		1.00	
		Y	144. C
	1. 00	2.00	
e costs for	Y	2.00	145. 0
<pre>1. If column 1 is s cost reporting ed cost report?</pre>	Y	02/22/2017	146. (
apter 40, §4020) I	f		
N" for no.		1.00 Y	147. (
"N" for no.		N	148. (
for yes or "N" fo	or no.	Y	149. (
t A Part B		Title XIX	_
00 2.00 on from the applic	3.00 cation of the Lov	4.00 wer of costs	
Part A and Part B.		13. 13)	
N N	N	N	155.
N N	N N	N N	156. ( 157. (
ı ıv	IN	IN IN	158.
N N	N	N	159. (
N N	N	N	160. (
N	N	N	161. (
		1.00	
a compuess in diff	Forest CDCAc2	N	1,5
re campuses in diff		N	165. (
y State Z 2.00	Zi p Code   CBSA 3.00   4.00	FTE/Campus 5.00	
2.00	3.00 4.00		00 166. (
	ent Act	1.00	
yory and Dai nyactma	EIII ACI	Y	167. ( 0168. (
es or "N" for no.	'), enter the		168.
		ry and Reinvestment Act sor "N" for no. (line 167 is "Y"), enter the	s or "N" for no.

Health Financial Systems					2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DATA		Peri od:	Worksheet S-2	!
			From 09/01/2016 To 08/31/2017		narod:
		10 00/31/201/	1/27/2018 2:1		
	Begi nni ng	Endi ng			
	1. 00	2.00			
170.00 Enter in columns 1 and 2 the EHR beg period respectively (mm/dd/yyyy)	01/01/2016	03/30/2016	170. 00		
			1. 00	2.00	
171.00 If line 167 is "Y", does this provid			N	C	171. 00
section 1876 Medicare cost plans rep					
"Y" for yes and "N" for no in column	1. If column 1 is yes, er	nter the number of sectio	n		
1876 Medicare days in column 2. (see	instructions)				

Heal th	Financial Systems TERRE HAUTE REG	IONAL HOSPITAL		In Lie	u of Form CMS-	2552-10	
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Peri od:	Worksheet S-2		
				From 09/01/2016 To 08/31/2017	Part II   Date/Time Pre	epared:	
				V /N	1/27/2018 2:1	5 pm	
				Y/N 1. 00	<u>Date</u> 2.00		
	General Instruction: Enter Y for all YES responses. Enter N	l for all NO re	sponses. Ente				
	mm/dd/yyyy format.						
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					-	
1.00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.00	
	reporting period? If yes, enter the date of the change in o	column 2. (see	instructions)				
			Y/N	Date	V/I		
2. 00	Has the provider terminated participation in the Medicare F	Program? If	1.00 N	2. 00	3. 00	2.00	
2.00	yes, enter in column 2 the date of termination and in colum					2.00	
	voluntary or "I" for involuntary.						
3. 00	Is the provider involved in business transactions, including		Y			3. 00	
	contracts, with individuals or entities (e.g., chain home commedical supply companies) that are related to the provide						
	officers, medical staff, management personnel, or members of						
	of directors through ownership, control, or family and other						
	relationships? (see instructions)		\/ /NI	Tymo	Doto		
			1.00	7ype 2. 00	Date 3.00		
	Financial Data and Reports		1.00	2.00	0.00		
4.00	Column 1: Were the financial statements prepared by a Cert		N			4. 00	
	Accountant? Column 2: If yes, enter "A" for Audited, "C" f						
	or "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	arrabre in					
5.00	Are the cost report total expenses and total revenues diffe			5. 00			
	those on the filed financial statements? If yes, submit reconciliation.						
				Y/N 1. 00	Legal Oper.		
	Approved Educational Activities			1.00	2. 00		
6.00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is th	ne provider is	N		6. 00	
	the legal operator of the program?						
7.00	Are costs claimed for Allied Health Programs? If "Y" see in		l dumina +ba	N		7.00	
8. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewed	i durring the	N		8. 00	
9. 00	Are costs claimed for Interns and Residents in an approved	graduate medic	al education	N		9. 00	
	program in the current cost report? If yes, see instruction						
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in t	the current	N		10. 00	
11. 00	Are GME cost directly assigned to cost centers other than I	& R in an App	roved	N		11.00	
	Teaching Program on Worksheet A? If yes, see instructions.						
					Y/N		
	Bad Debts				1. 00		
12. 00	Is the provider seeking reimbursement for bad debts? If yes	s, see instruct	i ons.		Υ	12. 00	
13.00	If line 12 is yes, did the provider's bad debt collection p	oolicy change o	luring this co	st reporting	N	13. 00	
44.00	period? If yes, submit copy.				.,	44.00	
14.00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents walved? IT	yes, see ins	tructions.	N	14. 00	
15. 00	Did total beds available change from the prior cost reporti	ng period? If	yes, see inst	ructions.	N	15. 00	
		Par	t A	Par	t B		
		Y/N	Date	Y/N	Date		
	PS&R Data	1. 00	2.00	3. 00	4. 00		
16. 00	Was the cost report prepared using the PS&R Report only?	l N		N		16. 00	
	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						
17. 00	instructions) Was the cost report prepared using the PS&R Report for	Y	01/11/2018	Υ	01/11/2018	17. 00	
17.00	totals and the provider's records for allocation? If						
	either column 1 or 3 is yes, enter the paid-through date						
40.05	in columns 2 and 4. (see instructions)					10.05	
18. 00		N		N		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.						
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00	
	Report data for corrections of other PS&R Report information? If yes, see instructions.						
	printormation: II yes, see Ilistructions.	I	I	I	ı	I	

Heal th	Financial Systems TERRE HAUTE REG	IONAL HOSPITAL		In Lie	u of Form CMS-	2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CC	CN: 15-0046	Peri od: From 09/01/2016 To 08/31/2017	Worksheet S-2 Part II Date/Time Pre 1/27/2018 2:1	pared:		
		Descri	pti on	Y/N	Y/N	J Pill		
		C		1. 00	3. 00			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00		
	The port and a trior of the research of the other and astimories.	Y/N	Date	Y/N	Date			
	lui i	1.00	2. 00	3.00	4. 00	01.00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00		
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS HO	OSPI TALS)					
	Capital Related Cost							
22. 00	Have assets been relifed for Medicare purposes? If yes, see		N N	22. 00 23. 00				
23. 00	O Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.							
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	ed into during	this cost re	porting period?	Υ	24. 00		
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see	N	25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	f yes, see	N	26. 00				
27. 00	Has the provider's capitalization policy changed during the copy.	yes, submit	N	27. 00				
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit er	reporting	N	28. 00				
29. 00	period? If yes, see instructions.  Did the provider have a funded depreciation account and/or	. 0	N	29. 00				
	treated as a funded depreciation account? If yes, see instr	,						
30. 00	Has existing debt been replaced prior to its scheduled maturinstructions.		N	30.00				
31. 00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new o	debt? IT yes	, see	N	31.00		
32. 00	Purchased Services  Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru	uctions.	•		N	32.00		
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 approx, see instructions.	olied pertainin	g to competi	tive bidding? If		33. 00		
0.4.00	Provi der-Based Physi ci ans					1 04 00		
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	Ü		. ,	Υ	34. 00		
35. 00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		ts with the	provi der-based	Υ	35. 00		
				Y/N	Date			
	lu 055' 0 1			1. 00	2. 00			
24 00	Home Office Costs			V		24 00		
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	repared by the I	home office?	Y		36. 00 37. 00		
38. 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home off			Y	12/31/2017	38. 00		
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other			, N		39. 00		
40. 00	see instructions. If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00		
	THISTI UCTIONS.							
	Cook Donort Drong Control   C	1. (	00	2.	00			
41. 00	Cost Report Preparer Contact Information  Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	JAMES		WELLS		41. 00		
42. 00	respectively. Enter the employer/company name of the cost report	HCA				42. 00		
43. 00	preparer. Enter the telephone number and email address of the cost	615-344-6359		JAMES. WELLS2@H	CAHEALTHCARE C	43. 00		
. 5. 00	report preparer in columns 1 and 2, respectively.			OM		.5. 55		

Heal th	Financial Systems T	TERRE HAUTE REG	IONAL HOSPITAL		In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi der CC			9/01/2016	Worksheet S Part II Date/Time F	_	
					10 0	0/31/201/	1/27/2018 2	
			3.	00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title		REIMBURSEMENT I	MANAGER				41. 00
	held by the cost report preparer in columns	1, 2, and 3,						
	respecti vel y.							
42.00	Enter the employer/company name of the cost	report						42. 00
	preparer.							
43.00	Enter the telephone number and email address	of the cost						43.00
	report preparer in columns 1 and 2, respective	vel y.						

					Т	o 08/31/2017	Date/Time Prep 1/27/2018 2:1	
							I/P Days / 0/P	у ріп
							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	Hospi tal Adul ts & Peds. (columns 5, 6, 7 and	30. 00		142	51, 830	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			142	51, 830	0.00	0	7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	31. 00		18	6, 570	0.00	0	8. 00
9. 00	CORONARY CARE UNIT	31.00		10	0,570	0.00	U	9. 00
10. 00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13.00	NURSERY	43. 00					0	13.00
14.00	Total (see instructions)			160	58, 400	0.00		14.00
15. 00	CAH visits						0	15.00
16. 00	SUBPROVI DER - I PF	40. 00		19			0	16. 00
17. 00	SUBPROVI DER - I RF	41. 00		12	4, 380		0	17.00
18.00	SUBPROVI DER							18.00
19. 00 20. 00	SKILLED NURSING FACILITY NURSING FACILITY							19. 00 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		404			0	26. 25
27. 00 28. 00	Total (sum of lines 14-26) Observation Bed Days			191			0	27. 00 28. 00
29. 00	Ambul ance Tri ps						U	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	C			32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33. 00

Health Financial Systems TERRE HAUTE REGIONAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CO | Peri od: | Worksheet S-3 | From 09/01/2016 | Part | To 08/31/2017 | Date/Ti me Prepared: Provider CCN: 15-0046

				Т	o 08/31/2017	Date/Time Pre 1/27/2018 2:1	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	J pili
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	Component	II ti c xviii	TI CI C XIX	Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		1, 154	16, 561			1. 00
	8 exclude Swing Bed, Observation Bed and	,	, -	-,			
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	1, 663	2, 819				2. 00
3.00	HMO IPF Subprovider	123	0				3. 00
4.00	HMO IRF Subprovider	57	107				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7. 00	Total Adults and Peds. (exclude observation	9, 342	1, 154	16, 561			7. 00
8. 00	beds) (see instructions)   INTENSIVE CARE UNIT	1, 542	0	3, 184			8. 00
9. 00	CORONARY CARE UNIT	1, 542	ď	3, 104			9.00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		0	578			13. 00
14. 00	Total (see instructions)	10, 884	1, 154	20, 323	0.00	560. 43	
15. 00	CAH visits	0	0	0			15. 00
16.00	SUBPROVIDER - IPF	1, 623	2, 848	6, 635	0.00	34. 94	16. 00
17. 00	SUBPROVI DER - I RF	1, 119	113	1, 780	0.00	11. 29	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)	0	0	121			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00 26. 25	RURAL HEALTH CLINIC	o	0	0	0.00	0.00	26. 00 26. 25
26. 25	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	١	۷	0	0.00		
28. 00	Observation Bed Days		919	2, 704	0.00	000.00	28.00
29. 00	Ambul ance Trips	o	717	2, 704			29. 00
30. 00	Employee discount days (see instruction)	٥		0			30.00
31. 00	Employee discount days (see Fristraction)			0			31. 00
32. 00	Labor & delivery days (see instructions)	o	65	85			32. 00
32. 01	Total ancillary labor & delivery room	١		0			32. 01
	outpatient days (see instructions)			· ·			
33.00	LTCH non-covered days	0					33. 00
		•	·			-	-

| Period: | Worksheet S-3 | From 09/01/2016 | Part | To 08/31/2017 | Date/Time Prepared: Provider CCN: 15-0046

				To	08/31/2017	Date/Time Prep 1/27/2018 2:1	
		Full Time Equivalents		Di sch	arges		•
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	2, 642	287	5, 254	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)			326	975		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				/		4. 00
5. 00 6. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF						5. 00 6. 00
7. 00	Total Adults and Peds. (exclude observation			•			7. 00
7.00	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	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY	0.00		0 (40	007	F 0F4	13.00
14.00	Total (see instructions)	0. 00	0	2, 642	287	5, 254	
15. 00 16. 00	CAH visits SUBPROVIDER - IPF	0. 00	0	197	102	1, 064	15. 00 16. 00
17. 00	SUBPROVIDER - I RF	0.00	0		8	1, 004	17. 00
18. 00	SUBPROVI DER	0.00	Č		Ĭ	120	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 25. 00	HOSPICE (non-distinct part) CMHC - CMHC						24. 10 25. 00
26. 00	RURAL HEALTH CLINIC						25. 00 26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
22 00	outpatient days (see instructions)						22 00
33. UU	LTCH non-covered days			1	I		33. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION TERRE HAUTE REGIONAL HOSPITAL Provider CCN: 15-0046

3.00 Non-physici an anesthetist Part   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						10	06/31/201/	Date/lime Pre 1/27/2018 2:1	
DART   1 - AMCE DATA					on of Salaries (from	Salaries (col.2 ± col.	Related to Salaries in	Wage (col. 4 ÷	
SAMPLES   1,261, 848, 00   2,900, 00   36, 622, 481   0   36, 622, 481   1,261, 848, 00   2,900   1,000   2,000   2,000   3,			1. 00	2. 00				6. 00	
1-00   10fal sail aries (see   200.00   36,622,481   0   36,622,481   1,261,848.00   29.00   1.00									4
1.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   3.00	1 00		200.00	26 622 401	1 0	26 622 401	1 261 040 00	20.02	1 00
3.0 Non-physician anesthetist Part   0	1.00		200.00	30, 022, 401		30, 022, 401	1, 201, 646. 00	29.02	1.00
4.00 Physician-Part A - Abrillian Strative	2.00	,		0	0	0	0.00	0. 00	2.00
4.00 Physician-Part A - Abrillian Strative	2 00	A		0			0.00	0.00	2 00
Admin strative 4. 01 Physicians - Part A - Teaching	3.00	B and an anesthetist Parti		U	0	U	0.00	0.00	3.00
4.01   Physicians - Part A - Teaching   0   0   0   0   0   0   0   0   0	4.00	Physician-Part A -		0	0	0	0.00	0.00	4.00
Physician Part B   Formation				_	_	_			
6. 00   Non-physician-Part B   Form   1.00				0	0	0			
hospital - based RRC and FOHC   Service   Se	5.00			0			0.00	0.00	3.00
Interns & residents (in an approved program)	6. 00	hospital-based RHC and FQHC		0	0	0	0.00	0. 00	6. 00
approved program	7. 00		21. 00	0	0	0	0.00	0.00	7.00
residents (in an approved programs)		approved program)							
Nome office and/or related organization personnel   44.00   0   0   0   0   0   0   0   0   0	7. 01	residents (in an approved		0	0	0	0.00	0.00	7. 01
9.00   SNÉ   44.00   0   0   0   0   0   0   0   0   0	8.00			0	О	0	0.00	0.00	8.00
10.00   Excluded area salaries (see   3.646, 981   0.3,646, 981   125,783.00   28,99   10.0				_	_	_			
Instructions  OTHER WAGES & RELATED COSTS			44. 00	2 646 001	_	-			
11.00   Contract labor: Direct Patient	10.00			3, 040, 901		3, 040, 901	125, 765.00	20. 99	10.00
Care   Contract labor: Top level   0   0   0   0   0   0   0   0   0									1
12.00   Contract labor: Top level management and other management and	11. 00			2, 300, 550	0	2, 300, 550	37, 619. 00	61. 15	11. 00
management and other   management and other   management and administrative   services   services	12. 00	1		0	0	0	0.00	0.00	12.00
Services   Services	.2.00			· ·			0.00	0.00	12.00
13.00   Contract labor: Physician-Part   337,004   0 337,004   1,898.00   177.56   13.0     14.00   Home office and/or related orgainzation salaries and wage-related costs   Home office salaries and wage-related costs     14.01   Home office salaries and wage-related costs   Home office wage-related costs   Home office wage-related costs   Home office wage-related costs   Home office wage-related   0   0   0   0   0   0   0   0     14.00   Robert									
A - Administrative	13 00			337 004	0	337 004	1 898 00	177 56	13 00
Orgal rozation sall ariles and wage-rel ated costs   Name of Fice sall ariles   Name of Sall sall sall sall sall sall sall sall	10.00			337, 331		007,001	1,070.00	177.00	10.00
14. 01   Home office salaries	14. 00	orgainzation salaries and		0	0	0	0.00	0. 00	14. 00
14.02   Rel ated organization salaries   0   0   0   0   0   0.00   0.00   15.00	14. 01			6, 458, 899	О	6, 458, 899	169, 530. 00	38. 10	14. 01
Administrative   Home office and Contract   Ho				0	0	0			•
16.00   Home office and Contract   9	15. 00			0	0	0	0. 00	0.00	15. 00
17. 00   Wage-related costs (core) (see instructions)   18. 00   18. 00   18. 00   18. 00   18. 00   18. 00   19. 00   18. 00   19. 00	16. 00	Home office and Contract		0	0	0	0.00	0. 00	16. 00
18.00   Wage-related costs (other)   (see instructions)   18.00   (see instructions)   19.00   Excluded areas   1,039,827   0 1,039,827   19.00   19	47.00			0 101 070	1			Т	4
18. 00   Wage-rel ated costs (other) (see instructions)   18. 00   0   0   0   0   0   0   0   0   0	17.00			9, 401, 973	0	9, 401, 973			17.00
19.00   Excluded areas   1,039,827   0   1,039,827   20.00   Non-physician anesthetist Part   20.00   Non-physician anesthetist Part   20.00	18. 00	1		0	0	0			18.00
20. 00 Non-physician anesthetist Part A	40.00			4 000 007		4 000 007			40.00
A   Non-physician anesthetist Part   B   21.00		1		1, 039, 827	0	1, 039, 827			
B	20.00	A anesthetist rait		O					20.00
Administrative   Physician Part A - Teaching   0   0   0   0   22.0	21. 00	Non-physician anesthetist Part		0	0	0			21. 00
Administrative   Physician Part A - Teaching   0   0   0   0   22.0	22 00	B   Physician Part A		0	_				22 00
22.01   Physician Part A - Teaching   0   0   0   0   22.0	ZZ. UU			U					22.00
24. 00       Wage-related costs (RHC/FQHC)       0       0       0       0       0       24. 00         25. 00       Interns & residents (in an approved program)       0       0       0       0       0       0       25. 50         25. 50       Home office wage-related       1, 298, 606       0       1, 298, 606       0       25. 51         25. 51       Related orgainzation wage-related       0       0       0       0       0       25. 52         25. 52       Home office: Physician Part A - Administrative - wage-related       0       0       0       0       0       25. 52         25. 53       Home office & Contract Physicians Part A - Teaching - wage-related       0       0       0       0       0       25. 52         26. 00       Employee Benefits Department       4. 00       89, 697       0       89, 697       2, 669. 00       33. 61       26. 00		Physician Part A - Teaching		0	0	0			22. 01
25. 00				•		0			23. 00
approved program   Home office wage-related   1,298,606   0   1,298,606   25.51   Related orgalization   0   0   0   0   25.5     25. 51   Home office: Physician Part A   0   0   0   0   0     25. 52   Home office: Physician Part A   0   0   0   0   0     25. 53   Home office & Contract   0   0   0   0     25. 54   Home office & Contract   0   0   0   0     25. 55   Physicians Part A - Teaching - wage-related   0   0   0   0     25. 56   Wage-related   0   0   0   0     26. 00   Employee Benefits Department   4. 00   89,697   0   89,697   2,669.00   33.61   26.00					1	0			
25. 51 Related orgainzation	23.00			O					25.00
wage-related   Home office: Physician Part A				1, 298, 606	0	1, 298, 606			25. 50
25. 52 Home office: Physician Part A	25. 51			0	0	0			25. 51
- Administrative - wage-related Home office & Contract Physicians Part A - Teaching - wage-related OVERHEAD COSTS - DIRECT SALARIES  26.00 Employee Benefits Department	25, 52			0	0	n			25. 52
25. 53 Home office & Contract	_3. 32			Ö		]			
Physicians Part A - Teaching -	05 55		ļ						0
wage-related         OVERHEAD COSTS - DIRECT SALARIES           26. 00 Employee Benefits Department         4. 00         89, 697         0         89, 697         2, 669. 00         33. 61         26. 00	25. 53			0	0	0			25. 53
OVERHEAD COSTS - DIRECT SALARIES           26. 00 Employee Benefits Department         4. 00         89, 697         0         89, 697         2, 669. 00         33. 61         26. 00									
		OVERHEAD COSTS - DIRECT SALARIE							4
27. 00   Aumini Strative & General   5. 00  5, 520, 991  -152, 850  5, 368, 141  137, 628. 00  39. 00  27. 00					l .		·		
	∠1.00	Auministrative & General	5. 00	5, 520, 991	- 152, 850	J 5, 368, 141	137, 628.00	y 39.00	<sub>1</sub> ∠ /. 00

| Peri od: | Worksheet S-3 | From 09/01/2016 | Part II | To 08/31/2017 | Date/Time Prepared:

							1/27/2018 2:1	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)		col. 4		
		1. 00	2.00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		131, 894	0	131, 894	519. 00	254. 13	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00		29. 00
30. 00	· ·	7. 00	768, 804	0	768, 804	28, 210. 00	27. 25	30. 00
31. 00	Laundry & Linen Service	8. 00	0	0	0	0. 00	l	
32.00	Housekeepi ng	9. 00	890, 354	0	890, 354	64, 851. 00	13. 73	32. 00
33.00	Housekeeping under contract		0	0	0	0.00	0.00	33. 00
	(see instructions)							
34.00	Di etary	10. 00	612, 938	-177, 846	435, 092	33, 564. 00	12. 96	34.00
35.00	Di etary under contract (see		279, 322	0	279, 322	7, 428. 00	37. 60	35. 00
	instructions)							
36.00	Cafeteri a	11. 00	0	177, 846	177, 846	13, 720. 00	12. 96	36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37. 00
38.00	Nursing Administration	13. 00	467, 307	152, 850	620, 157	14, 169. 00	43. 77	38. 00
39.00	Central Services and Supply	14. 00	0	0	0	0.00	0.00	39. 00
40.00	Pharmacy	15. 00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical	16. 00	46, 683	0	46, 683	1, 343. 00	34. 76	41.00
	Records Library							
42.00	Social Service	17. 00	0	0	0	0.00	0.00	42. 00
43. 00	Other General Service	18. 00	0	0	0	0.00	0.00	43. 00

							1/2//2018 2: 1:	o piii
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		37, 033, 697	0	37, 033, 697	1, 269, 795. 00	29. 17	1.00
	instructions)							
2.00	Excluded area salaries (see		3, 646, 981	0	3, 646, 981	125, 783. 00	28. 99	2.00
	instructions)							
3.00	Subtotal salaries (line 1		33, 386, 716	0	33, 386, 716	1, 144, 012. 00	29. 18	3.00
	minus line 2)							
4.00	Subtotal other wages & related		9, 096, 453	0	9, 096, 453	209, 047. 00	43. 51	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		10, 700, 579	0	10, 700, 579	0.00	32. 05	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		53, 183, 748	0	53, 183, 748	1, 353, 059. 00	39. 31	6. 00
7.00	Total overhead cost (see		8, 807, 990	0	8, 807, 990	304, 101. 00	28. 96	7. 00
	instructions)							

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lieu	of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0046	Peri od:	Worksheet S-3
		From 09/01/2016	
		T- 00/21/2017	D-+- /T! D

	To 08/31/2017	Date/Time Prep 1/27/2018 2:1	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	1, 259, 564	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	90, 725	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	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)	0	8. 02
8. 03	Health Insurance (Purchased)	5, 719, 564	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	21, 395	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	37, 414	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	457, 774	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	'Workers' Compensation Insurance	51, 765	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
17. 00	FICA-Employers Portion Only	2, 238, 971	17. 00
18. 00	Medicare Taxes - Employers Portion Only	523, 869	18. 00
19. 00	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	-92, 779	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))	0	21. 00
22. 00	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	133, 538	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	10, 441, 800	
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

	Financial Systems	TERRE HAUTE REGIONAL HOSPITAL		u of Form CMS-2	
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0046	Peri od:	Worksheet S-3	
			From 09/01/2016 To 08/31/2017		narod:
			10 06/31/2017	1/27/2018 2:1	
	Cost Center Description		Contract Labor		
	<u> </u>		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Ide	nti fi cati on:			
1.00	Total facility's contract labor and benef	it cost	2, 348, 661	10, 441, 800	1. 00
2.00	Hospi tal		2, 300, 550	9, 401, 973	2. 00
3.00	Subprovider - IPF		46, 546	507, 334	3. 00
4.00	Subprovider - IRF		1, 565	209, 289	4. 00
5.00	Subprovider - (Other)		0	0	5. 00
6.00	Swing Beds - SNF		0	0	6. 00
7.00	Swing Beds - NF		0	0	,
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 FQHC				15. 00
16. 00	Hospi tal -Based-CMHC				16. 00
17. 00	Renal Dialysis		0		
18. 00	Other		0	323, 204	18. 00

	Financial Systems TERRE HAUTE REGIONAL HOSPI TAL UNCOMPENSATED AND INDIGENT CARE DATA Provide	r CCN: 15-0046	Peri od:	worksheet S-1			
			From 09/01/2016				
			To 08/31/2017	Date/Time Pre 1/27/2018 2:1	pared: 5 pm		
				1. 00			
	Uncompensated and indigent care cost computation						
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided b	y line 202 colum	nn 8)	0. 152796	1.0		
. 00	Medicaid (see instructions for each line) Net revenue from Medicaid			17, 108, 345	2.0		
. 00	Did you receive DSH or supplemental payments from Medicaid?			N 17, 100, 343	3.0		
. 00	If line 3 is yes, does line 2 include all DSH or supplemental payment	s from Medicaid?	?		4.0		
. 00	If line 4 is no, then enter DSH or supplemental payments from Medicai	t		0			
. 00	Medi cai d charges			157, 435, 588			
. 00	Medicaid cost (line 1 times line 6)	minus sum of li	noo 2 and E. if	24, 055, 528			
. 00	Difference between net revenue and costs for Medicaid program (line 7 < zero then enter zero)	IIII Nus suii oi Ti	nes 2 and 5; 11	6, 947, 183	8.0		
	Children's Health Insurance Program (CHIP) (see instructions for each	line)					
. 00	Net revenue from stand-alone CHIP	·		0	9.0		
0. 00	Stand-alone CHIP charges			0			
1.00	Stand-alone CHIP cost (line 1 times line 10)	1! 1! 0	: 6 +	0			
2. 00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)						
	Other state or local government indigent care program (see instruction	ns for each line	<del>)</del>				
3. 00	Net revenue from state or local indigent care program (Not included o			0	13.0		
4. 00	Charges for patients covered under state or local indigent care progr	am (Not included	d in lines 6 or	0	14. 0		
5. 00	10)   State or local indigent care program cost (line 1 times line 14)			0	15. C		
6. 00		care program (Li	ne 15 minus Line				
0. 00	13; if < zero then enter zero)	sar o program (r.					
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)	state/Local indi	gent care program	ms (see			
7. 00	instructions for each line)		gent care program	ns (see	17. C		
7. 00 8. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita	charity care operations		0 0	18. 0		
	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid , CHIP and state and local indig	charity care operations		0	18. 0		
8. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita	charity care operations	ns (sum of lines	0 0	18. 0		
8. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid , CHIP and state and local indig	charity care operations ent care program Uninsured patients	ns (sum of lines	0 0 6, 947, 183 Total (col. 1 + col. 2)	18. 0		
8. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unrelmbursed cost for Medicaid , CHIP and state and local indig 8, 12 and 16)	charity care operations ent care program	ns (sum of lines	0 0 6, 947, 183 Total (col . 1	18. 0		
8. 00 9. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unrelimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line)	charity care operations ent care program  Uninsured patients 1.00	Insured patients 2.00	0 0 6, 947, 183 Total (col. 1 + col. 2) 3.00	18. C		
8. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid , CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility	charity care operations ent care program Uninsured patients	Insured patients 2.00	0 0 6, 947, 183 Total (col. 1 + col. 2) 3.00	18. C		
8. 00 9. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unrelimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line)	charity care operations ent care program  Uninsured patients 1.00	Insured patients 2.00 796,830	0 6, 947, 183 Total (col. 1 + col. 2) 3.00	18. C 19. C		
8. 00 9. 00 0. 00 1. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions)	Uninsured patients  21,355,2  23,262,9	Insured patients 2.00 796,830 650,619	0 6, 947, 183 Total (col. 1 + col. 2) 3.00 22, 151, 941 3, 913, 595	18. C 19. C		
8. 00 9. 00 0. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unrelimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as	charity care operations ent care program  Uninsured patients 1.00	Insured patients 2.00 796,830 650,619	0 6, 947, 183 Total (col. 1 + col. 2) 3. 00 22, 151, 941 3, 913, 595	18. 0 19. 0 20. 0 21. 0		
8. 00 9. 00 0. 00 1. 00 2. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unrelimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care	Uninsured patients 1.00  21,355,2 ee 3,262,9 137,8	Insured patients 2.00 276 650,619 13,020	0 6, 947, 183 Total (col. 1 + col. 2) 3.00 22, 151, 941 3, 913, 595 150, 872	20. 0 21. 0 22. 0		
8. 00 9. 00 0. 00 1. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unrelimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care	Uninsured patients  21,355,2  23,262,9	Insured patients 2.00 276 650,619 13,020	0 6, 947, 183 Total (col. 1 + col. 2) 3.00 22, 151, 941 3, 913, 595 150, 872	20. 0 21. 0 22. 0		
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00	Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)	Uninsured patients 1.00  21,355,7  ee 3,262,6  137,8  3,125,7	Insured patients 2.00 111 796,830 650,619 352 13,020 124 637,599	0 6, 947, 183 Total (col. 1 + col. 2) 3. 00 22, 151, 941 3, 913, 595 150, 872 3, 762, 723	20. 0 21. 0 23. 0		
8. 00 9. 00 0. 00 1. 00 2. 00	Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)  Does the amount in line 20 column 2 include charges for patient days	Charity care operations ent care program  Uninsured patients 1.00  21,355, 20  3,262,6 137,8 3,125,2  Deeyond a Length	Insured patients 2.00 111 796,830 650,619 352 13,020 124 637,599	0 6, 947, 183 Total (col. 1 + col. 2) 3.00 22, 151, 941 3, 913, 595 150, 872 3, 762, 723	20. 0 21. 0 23. 0		
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unrel mbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)  Does the amount in line 20 column 2 include charges for patient days imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indi	charity care operations ent care program  Uninsured patients 1.00  21,355,3  21,355,3  3,262,6  137,8  3,125,3  Deeyond a Length	Insured patients 2.00 2.00 650,619 637,599 of stay limit	0 6, 947, 183 Total (col. 1 + col. 2) 3. 00 22, 151, 941 3, 913, 595 150, 872 3, 762, 723	20. 0 21. 0 22. 0 23. 0		
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)  Does the amount in line 20 column 2 include charges for patient days imposed on patients covered by Medicaid or other indigent care progra	Uninsured patients 1.00  21,355, 20 21,355, 3,262,0 137,8 3,125,2  Deyond a Length m? gent care progra	Insured patients 2.00 2.00 650,619 637,599 of stay limit	0 0 0 6, 947, 183  Total (col. 1 + col. 2) 3.00  22, 151, 941 3, 913, 595 150, 872 3, 762, 723  1.00 Y 172, 581	20. 0 21. 0 22. 0 23. 0 24. 0		
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)  Does the amount in line 20 column 2 include charges for patient days imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indistay limit	Uninsured patients 1.00 21,355,2 21,355,2 21,355,2 22,355,2 23,262,0 23,125,2 25,20 26,00 27,355,2 27,355,2 28,00 21,355,2 29,00 21,355,2 20,00 21,355,2 21,	Insured patients 2.00 2.00 650,619 637,599 of stay limit	0 6, 947, 183 Total (col. 1 + col. 2) 3.00 22, 151, 941 3, 913, 595 150, 872 3, 762, 723 1.00 Y	20. C 21. C 22. C 23. C 24. C 25. C 26. C		
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 7. 01	Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)  Does the amount in line 20 column 2 include charges for patient days imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indistay limit Total bad debt expense for the entire hospital complex (see instructi Medicare reimbursable bad debts for the entire hospital complex (see	Uninsured patients 1.00 21,355, 20 21,355, 3,262, 137,8 3,125, 20 20eyond a length on? gent care progra	Insured patients 2.00 2.00 650,619 637,599 of stay limit	0 6, 947, 183 Total (col. 1 + col. 2) 3.00 22, 151, 941 3, 913, 595 150, 872 3, 762, 723 1.00 Y 172, 581 6, 611, 563 337, 853 519, 773	20. 0 21. 0 22. 0 23. 0 24. 0 25. 0 26. 0 27. 0 27. 0		
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 7. 01 8. 00	Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospital unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)  Does the amount in line 20 column 2 include charges for patient days imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indistay limit Total bad debt expense for the entire hospital complex (see instructi Medicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see ins Non-Medicare bad debt expense (line 26 minus line 27.01)	charity care operations ent care program  Uninsured patients 1.00  21,355,  3,262,  137,8  3,125,  Deeyond a Length m? gent care program ons) nstructions) tructions)	Insured patients 2.00 111 796,830 976 650,619 352 13,020 124 637,599 of stay limit	0 0 6, 947, 183  Total (col. 1 + col. 2) 3.00  22, 151, 941  3, 913, 595  150, 872  3, 762, 723  1.00  Y  172, 581  6, 611, 563 337, 853 519, 773 6, 091, 790	20. 0 21. 0 22. 0 23. 0 24. 0 25. 0 26. 0 27. 0 28. 0		
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 7. 01	Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)  Does the amount in line 20 column 2 include charges for patient days imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indistay limit Total bad debt expense for the entire hospital complex (see instructi Medicare reimbursable bad debts for the entire hospital complex (see	charity care operations ent care program  Uninsured patients 1.00  21,355,  3,262,  137,8  3,125,  Deeyond a Length m? gent care program ons) nstructions) tructions)	Insured patients 2.00 111 796,830 976 650,619 352 13,020 124 637,599 of stay limit	0 6, 947, 183 Total (col. 1 + col. 2) 3.00 22, 151, 941 3, 913, 595 150, 872 3, 762, 723 1.00 Y 172, 581 6, 611, 563 337, 853 519, 773	20. 0 21. 0 22. 0 23. 0 25. 0 26. 0 27. 0 28. 0 29. 0		

Heal th	n Financial Systems 1	ERRE HAUTE REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		eri od:	Worksheet A	
					rom 09/01/2016	D-+- /T: D	
				T	o 08/31/2017	Date/Time Prep 1/27/2018 2:1	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	o piii
				+ col . 2)	ons (See A-6)		
				ŕ	. ,	(col. 3 +-	
						col . 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		2, 749, 302			2, 956, 809	1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2, 687, 429			3, 389, 685	2. 00
3.00	00300 OTHER CAP REL COSTS	00 (07	0			0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	89, 697	7, 666, 938			7, 879, 837	4.00
5. 00 7. 00	00700 OPERATION OF PLANT	5, 520, 991 768, 804	11, 702, 707 2, 909, 983			16, 837, 399 3, 674, 436	5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	700, 804	528, 232			528, 232	8.00
9. 00	00900 HOUSEKEEPI NG	890, 354	407, 667			1, 282, 510	
10. 00	01000 DI ETARY	612, 938	1, 171, 453			1, 263, 829	
11. 00	01100 CAFETERI A	012,700	0			516, 596	
13. 00	01300 NURSING ADMINISTRATION	467, 307	104, 369			719, 221	13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	46, 683	997, 593			1, 041, 377	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · ·	•		· · · · ·		
30.00	03000 ADULTS & PEDIATRICS	5, 491, 147	3, 423, 193	8, 914, 340	10, 136	8, 924, 476	30. 00
31.00	03100 INTENSIVE CARE UNIT	1, 985, 050	588, 998	2, 574, 048	-6, 430	2, 567, 618	31. 00
40.00	04000 SUBPROVI DER - I PF	1, 779, 372	1, 120, 876	2, 900, 248	-2, 623	2, 897, 625	
41. 00	04100 SUBPROVI DER - I RF	734, 038	130, 259		-2, 322	861, 975	41.00
43.00	04300 NURSERY	146, 228	68, 160	214, 388	0	214, 388	43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00		3, 465, 246	4, 714, 792			8, 135, 675	
51.00	05100 RECOVERY ROOM	478, 004	99, 317		-8	577, 313	
52. 00		839, 062	407, 029	1	-7, 679	1, 238, 412	
53.00	05300 ANESTHESI OLOGY	0 0 0 0 0 0	1 052 207		-	0 725 050	53.00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	967, 554	1, 953, 387			2, 725, 059	
54. 01	03440 MAMMOGRAPHY	173, 782 131, 602	34, 334 103, 841			208, 116 234, 356	
55. 00	05500 RADI OLOGY-THERAPEUTI C	599, 157	464, 659			1, 036, 014	
56.00	05600 RADI OLOGI - MERAPEUTI C	183, 444	667, 305			850, 142	
57. 00	05700 CT SCAN	510, 039	224, 462		-90	734, 411	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	226, 237	101, 659			327, 896	
59. 00	05900 CARDI AC CATHETERI ZATI ON	534, 976	-2, 106			532, 398	
60.00	06000 LABORATORY	1, 185, 857	1, 606, 712			2, 684, 746	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	18, 203	658, 595			676, 798	
65.00	06500 RESPIRATORY THERAPY	1, 056, 996	554, 476	1, 611, 472	-179, 692	1, 431, 780	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 093, 137	202, 545	1, 295, 682	-1, 697	1, 293, 985	66. 00
69. 00	06900 ELECTROCARDI OLOGY	500, 513	292, 783			757, 783	69. 00
70.00		47, 139	11, 661			55, 714	
71. 00		380, 609	5, 920, 334			6, 249, 329	
72. 00		0	7, 131, 975			7, 306, 304	
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 443, 785	8, 947, 674			10, 377, 372	
74.00		179	672, 958			673, 137	
76.00		0 F11 F70	231, 462			231, 462	
		511, 579	597, 057			964, 353	
76. 02 76. 03		133, 388 65, 003	18, 243 661, 756			150, 269 725, 287	
76. 03		427, 625	178, 979			605, 141	
70.04	OUTPATIENT SERVICE COST CENTERS	427,023	170, 777	000,004	-1, 403	003, 141	70.04
91 00	09100 EMERGENCY	1, 983, 185	8, 672, 143	10, 655, 328	-118, 907	10, 536, 421	91. 00
		1, 703, 103	0,072,143	10, 033, 320	110, 707	10, 330, 421	92. 00
, 00	SPECIAL PURPOSE COST CENTERS						, 2. 00
113. 00	11300 INTEREST EXPENSE		0	0	O	0	113. 00
118.00	1 1	35, 488, 910	81, 385, 191	116, 874, 101	1, 585	116, 875, 686	
	NONREI MBURSABLE COST CENTERS				, , , , ,		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	23, 475	13, 818	37, 293	0	37, 293	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	O	0				192. 00
	07950 OCCUPATIONAL MEDICINE	861, 071	208, 424		-1, 585	1, 067, 910	
	1 07951 UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0		0		194. 01
	2 07952 SI TTERS	249, 025	21, 299			270, 324	
200.00	TOTAL (SUM OF LINES 118-199)	36, 622, 481	81, 628, 732	118, 251, 213	0	118, 251, 213	200. 00

| Period: | Worksheet A | From 09/01/2016 | To 08/31/2017 | Date/Time Prepared: 1/27/2018 2:15 pm

				1/27/2018 2: 15	pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1. 00	00100 CAP REL COSTS-BLDG & FIXT	97, 592	3, 054, 401	I I	1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-33, 063			2.00
3.00	00300 OTHER CAP REL COSTS	0	0		3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	357, 884	8, 237, 721		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	6, 063, 686	22, 901, 085	;	5.00
7.00	00700 OPERATION OF PLANT	49, 740	3, 724, 176	,	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	528, 232		8.00
9.00	00900 HOUSEKEEPI NG	43, 798	1, 326, 308		9.00
10.00	01000 DI ETARY	0	1, 263, 829	)	10.00
11.00	01100 CAFETERI A	-314, 820	201, 776		11.00
13.00	01300 NURSING ADMINISTRATION	-2, 180	717, 041		13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	37, 379			16.00
	INPATIENT ROUTINE SERVICE COST CENTERS		,		
30.00	03000 ADULTS & PEDIATRICS	-1, 418, 847	7, 505, 629		30.00
31. 00	03100 I NTENSI VE CARE UNI T	-11, 429		1	31. 00
40. 00	04000 SUBPROVI DER - I PF	-774, 763	2, 122, 862		40. 00
41. 00	04100 SUBPROVI DER - I RF	-10, 759		1	41. 00
43. 00	04300 NURSERY	0	214, 388	1	43. 00
10.00	ANCILLARY SERVICE COST CENTERS	ı	211,000		10.00
50. 00	05000 OPERATING ROOM	-3, 769, 238	4, 366, 437	,	50. 00
51. 00	05100 RECOVERY ROOM	-278		I I	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	-23, 234	1, 215, 178	1	52. 00
53. 00	05300 ANESTHESI OLOGY	-23, 234	1, 213, 176	1	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1 041 222	_		54. 00
54. 00		-1, 041, 233	1, 683, 826		54. 00
	03630 ULTRA SOUND	0	208, 116		
54. 02	03440 MAMMOGRAPHY	0	234, 356		54. 02
55. 00	05500 RADI OLOGY-THERAPEUTI C	-1, 496	1, 034, 518		55. 00
56.00	05600 RADI OI SOTOPE	0	850, 142		56. 00
57. 00	05700 CT SCAN	0	734, 411	·	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	327, 896	1	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	532, 398		59. 00
60.00	06000 LABORATORY	-2, 513	2, 682, 233		60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	676, 798	1	62.00
65. 00	06500 RESPI RATORY THERAPY	-125, 050	1, 306, 730	1	65. 00
66. 00	06600 PHYSI CAL THERAPY	-24, 224	1, 269, 761	1	66. 00
69. 00	06900 ELECTROCARDI OLOGY	-10, 500	747, 283	i	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	55, 714		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6, 249, 329	,	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	7, 306, 304	,	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-5	10, 377, 367		73.00
74.00	07400 RENAL DIALYSIS	0	673, 137		74.00
76.00	03950 LI THOTRI PSY	0	231, 462		76.00
76. 01	03330 ENDOSCOPY	-85, 061	879, 292		76. 01
76. 02	03040 PRISION CLINIC	0	150, 269		76. 02
76. 03	03050 WOUND CARE	-11, 596	713, 691	I I	76. 03
76. 04	03060 OPI C	-74, 181	530, 960		76. 04
70.01	OUTPATIENT SERVICE COST CENTERS	, ,,	000,700		, 0. 0 .
91 00	09100 EMERGENCY	-7, 242, 406	3, 294, 015		91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	,, 242, 400	5, 2,77, 013		92.00
72.00	SPECIAL PURPOSE COST CENTERS				72.00
113 00	11300 I NTEREST EXPENSE	0	0		113. 00
118. 00		-8, 326, 797		1	118. 00
110.00	NONREI MBURSABLE COST CENTERS	-0, 320, 191	100, 540, 669	<u> </u>	110.00
100.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		27 202		100 00
		0			190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	770 543		192. 00
	07950 OCCUPATIONAL MEDICINE	-288, 368	779, 542	1	194. 00
	07951 UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0 0 10 1	1	194. 01
	207952 SI TTERS	-217	270, 107	1	194. 02
200.00	TOTAL (SUM OF LINES 118-199)	-8, 615, 382	109, 635, 831		200. 00

Heal th	Financial Systems	Т	ERRE HAUTE REGI	ONAL HOSPITAL		In Lieu	of Form CMS-	-2552-10
RECLAS	SIFICATIONS			Provi der CCN:	15-0046	Peri od: From 09/01/2016	Worksheet A-	5
						To 08/31/2017	Date/Time Pro	epared:
		Increases					1/27/2018 2:	15 pm
	Cost Center	Li ne #	Sal ary	Other				
	2. 00 A - LEASES	3. 00	4. 00	5. 00				
1.00	CAP REL COSTS-BLDG & FIXT	1.00		186, 692				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00		695, 205				2. 00
3. 00 4. 00		0. 00 0. 00	0	0				3. 00 4. 00
5. 00		0.00	0	0				5. 00
6. 00		0.00	0	0				6. 00
7. 00 8. 00		0. 00 0. 00	0	0				7. 00 8. 00
9. 00		0.00	0	O				9. 00
10.00		0.00	0	0				10.00
11. 00 12. 00		0. 00 0. 00	0	0				11. 00 12. 00
13. 00		0.00	0	O				13. 00
14.00		0.00	0	0				14. 00
15. 00 16. 00		0. 00 0. 00	0	0				15. 00 16. 00
17. 00		0.00	Ö	Ö				17. 00
18.00		0.00	0	0				18. 00
19. 00 20. 00		0. 00 0. 00	0	0				19. 00 20. 00
21. 00		0.00	Ö	Ö				21. 00
22. 00		0.00	0	0				22. 00
23. 00 24. 00		0. 00 0. 00	0	0				23. 00 24. 00
25. 00		0.00	Ö	Ö				25. 00
26.00		0.00	0	0				26.00
27. 00 28. 00		0. 00 0. 00	0	0				27. 00 28. 00
29. 00		0.00	0	0				29. 00
	TOTALS  B - PROPERTY INSURANCE		0	881, 897				-
1. 00	CAP REL COSTS-BLDG & FIXT	1.00		27, 866				1. 00
	TOTALS		0	27, 866				
1. 00	C - EXECUTIVE COMP. EMPLOYEE BENEFITS DEPARTMENT	4.00		126, 113				1.00
2.00	NURSING ADMINISTRATION	1300	15 <u>2,</u> 850	13, 790				2. 00
	TOTALS D - CAFETERIA		152, 850	139, 903				-
1.00	CAFETERI A	11.00	177, 846	338, 750				1.00
	TOTALS  E - MEDICAL SUPPLIES		177, 846	338, 750				-
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	165, 874				1.00
	PATI ENTS							
2. 00 3. 00		0. 00 0. 00	0	0				2. 00 3. 00
4. 00		0.00	Ö	Ö				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	О	0				8. 00
9. 00 10. 00		0. 00 0. 00	0	0				9. 00 10. 00
11. 00		0.00	0	0				11.00
12.00		0. 00	0	0				12. 00
13. 00 14. 00		0. 00 0. 00	0	0				13. 00 14. 00
14.00	TOTALS — — — —			165, 874				14.00
1 00	F - DRUG	72.00		/ 254				1 00
1. 00 2. 00	DRUGS CHARGED TO PATIENTS	73. 00 0. 00	0	6, 354 0				1. 00 2. 00
3.00		0.00	О	Ö				3. 00
4.00		0.00	0	0				4.00
5. 00 6. 00		0. 00 0. 00	0	0				5. 00 6. 00
7.00		0.00	0	Ō				7. 00
8. 00 9. 00		0. 00 0. 00	0	0				8. 00 9. 00
7. UU	TOTALS — — — — —		0	<u>0</u> 6, 354				9.00
4.0-	G - IMPLANTABLE DEVICES							]
1. 00	I MPL. DEV. CHARGED TO PATIENTS	72. 00	0	223, 545				1. 00
2.00		0.00	0	0				2. 00
3.00		0.00	0	0				3. 00

Heal th Financial Systems

TERRE HAUTE REGIONAL HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 15-0046
From 09/01/2016
To 08/31/2017 Date/Time Prepared:

					1/27/2018 2:	epareu: 15 nm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4.00	5. 00		
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00	L	0.00	0_	0		8. 00
	TOTALS		0	223, 545		_
	H - ER BEDHOLD					4
1.00	ADULTS & PEDIATRICS	30.00	59, 194	45, 969		1. 00
2.00	INTENSIVE CARE UNIT	<u>31.</u> 00	3, 328	<u>2, 5</u> 85		2. 00
	TOTALS		62, 522	48, 554		_
	I - LOST CHARGES					4
1. 00	OPERATING ROOM	50.00	0	1, 877		1. 00
2.00	L	0.00	0_	0		2. 00
	TOTALS		0	1, 877		_
	J - EQUIPMENT PROPERTY TAX					4
1. 00	CAP REL COSTS-MVBLE EQUIP		0_	<u>7, 0</u> 51		1. 00
	TOTALS		0	7, 051		_
	K - CARDIOLGY NURSE NAVIGATOR					4
1. 00	ADULTS & PEDIATRICS	3000	26, 832			1. 00
	TOTALS		26, 832	4, 092		
500.00	Grand Total: Increases		420, 050	1, 845, 763		500.00

Health Financial Systems RECLASSIFICATIONS

Provider CCN: 15-0046

Peri od: From 09/01/2016 To 08/31/2017 Date/Ti me Prepared: 1/27/2018 2:15 pm

					L.	1/27/2018 2:1	15 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	Other Other	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10. 00		
1 00	A - LEASES	1 00	٥	2 011	10		1 00
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00	0	2, 911	10 10		1. 00 2. 00
3. 00	OPERATION OF PLANT	7.00	0	65, 680 4, 351	0		3.00
4. 00	HOUSEKEEPI NG	9.00	0	15, 511	0		4. 00
5. 00	DI ETARY	10.00	0	3, 966			5. 00
6. 00	NURSING ADMINISTRATION	13.00	0	19, 095			6. 00
7. 00	MEDICAL RECORDS & LIBRARY	16.00	0	2, 899			7. 00
8.00	ADULTS & PEDIATRICS	30.00	0	124, 745			8. 00
9.00	INTENSIVE CARE UNIT	31.00	0	12, 271	0		9. 00
10.00	SUBPROVI DER - I PF	40.00	o	2, 162	0		10.00
11.00	SUBPROVI DER - I RF	41.00	0	2, 306	0		11. 00
12.00	OPERATING ROOM	50.00	0	19, 714	0		12. 00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	7, 067	0		13. 00
14.00	RADI OLOGY-DI AGNOSTI C	54.00	0	187, 754	0		14. 00
15.00	MAMMOGRAPHY	54.02	0	1, 087	0		15. 00
16.00	RADI OLOGY-THERAPEUTI C	55. 00	0	4, 726	0		16. 00
17. 00	RADI OI SOTOPE	56.00	0	607	0		17. 00
18. 00	LABORATORY	60.00	0	106, 156			18. 00
19. 00	RESPI RATORY THERAPY	65. 00	0	107, 168			19. 00
20. 00	PHYSI CAL THERAPY	66.00	0	1, 599			20. 00
21. 00	ELECTROCARDI OLOGY	69. 00	0	1, 852			21. 00
22. 00	ELECTROENCEPHALOGRAPHY	70.00	0	3, 086			22. 00
23. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	53, 956	0		23. 00
24.00	PATIENTS	72.00	0	1 402			24.00
24. 00 25. 00	DRUGS CHARGED TO PATIENTS	73.00	0	1, 403			24. 00
25. 00 26. 00	ENDOSCOPY PRISION CLINIC	76. 01 76. 02	0	123, 943			25. 00 26. 00
27. 00	WOUND CARE	76. 02	0	1, 362 1, 472			27. 00
28. 00	OPI C	76.03	0	1, 4/2			28. 00
29. 00	OCCUPATIONAL MEDICINE	194.00	0	1, 403			29. 00
27.00	TOTALS		— — <u> </u>				27.00
	B - PROPERTY INSURANCE		<u> </u>	001, 077			
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	27, 866	12		1.00
	TOTALS		— —  —	27, 866			
	C - EXECUTIVE COMP.						
1.00	ADMINISTRATIVE & GENERAL	5. 00	152, 850	139, 903	0		1.00
2.00		0.00	0	0	0		2. 00
	TOTALS		152, 850	139, 903			
	D - CAFETERIA						
1. 00	DI ETARY	1000	17 <u>7, 8</u> 46	33 <u>8, 7</u> 50			1. 00
	TOTALS		177, 846	338, 750			
	E - MEDI CAL SUPPLIES	11					
1.00	ADULTS & PEDIATRICS	30.00	0	1, 029			1.00
2.00	OPERATING ROOM	50.00	0	18, 188			2.00
3.00	RECOVERY ROOM	51.00	0	8			3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	228			4.00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	0	8, 008			5. 00
6.00	CARDI AC CATHETERI ZATI ON	59. 00 60. 00	0	472			6.00
7. 00 8. 00	LABORATORY  RESPIRATORY THERAPY	65.00	0	1, 667 72, 524			7. 00 8. 00
9. 00	ELECTROCARDI OLOGY	69.00	0	72, 324 2, 737			9.00
10. 00	IMPL. DEV. CHARGED TO	72.00	0	49, 216			10.00
10.00	PATIENTS	72.00	O	47, 210	O O		10.00
11. 00	ENDOSCOPY	76. 01	0	1, 398	0		11. 00
12. 00	EMERGENCY	91.00	0	7, 807			12.00
13. 00	CT SCAN	57. 00	0	90			13. 00
14. 00	DRUGS CHARGED TO PATIENTS	73. 00	0	2, 502			14. 00
	TOTALS		<sub>0</sub>	165, 874			
	F - DRUG	<u>'</u>					
1.00	ADULTS & PEDIATRICS	30.00	0	146	0		1. 00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	O	24	0		2. 00
3.00	MEDICAL SUPPLIES CHARGED TO	71.00	O	1, 092	0		3. 00
	PATI ENTS						
4.00	ENDOSCOPY	76. 01	0	4, 415	0		4. 00
5.00	EMERGENCY	91.00	0	24			5. 00
6.00	INTENSIVE CARE UNIT	31.00	0	72			6. 00
7.00	SUBPROVI DER - I PF	40.00	0	461	0		7. 00
8.00	SUBPROVI DER - I RF	41.00	0	16			8. 00
9. 00	RADI OLOGY-DI AGNOSTI C	54.00	0				9. 00
	TOTALS	ı I	0	6, 354			l

Health Financial Systems RECLASSIFICATIONS TERRE HAUTE REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0046

							1/27/2018 2: 15 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	G - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	8, 338	(		1. 00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	360	(		2. 00
3.00	RADI OLOGY-DI AGNOSTI C	54.00	0	16	(		3.00
4.00	RADI OLOGY-THERAPEUTI C	55.00	0	23, 076	(		4. 00
5.00	PHYSI CAL THERAPY	66.00	0	98	(		5. 00
6. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0	160, 594	(		6. 00
7.00	DRUGS CHARGED TO PATIENTS	73. 00	0	16, 536	(		7. 00
8.00	ENDOSCOPY	76. 01		14, 527	(		8. 00
	TOTALS		0	223, 545			
	H - ER BEDHOLD						
1.00	EMERGENCY	91.00	62, 522	48, 554	(		1. 00
2.00		0.00	0_	0	(	<u>D</u>	2. 00
	TOTALS		62, 522	48, 554			
	I - LOST CHARGES						
1. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0	1, 846	(	D 	1.00
2.00	ADULTS & PEDIATRICS	30.00	O	31	(		2. 00
	TOTALS						
	J - EQUIPMENT PROPERTY TAX						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	7, 051	13	3	1. 00
	TOTALS	T		7, 051			
	K - CARDIOLGY NURSE NAVIGATOR	824					
1.00	ELECTROCARDI OLOGY	69. 00	26, 832	4, 092	(		1. 00
	TOTALS		26, 832	4, 092			
500.00	Grand Total: Decreases		420, 050	1, 845, 763			500.00

				Ic	08/31/2017	Date/lime Prep   1/27/2018 2:1	
				Acqui si ti ons		172772010 2. 1	Din Din
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	1, 262, 718	0	0	0	0	1. 00
2.00	Land Improvements	3, 158, 371	0	0	0	0	2. 00
3.00	Buildings and Fixtures	38, 638, 215	0	0	0	0	3. 00
4.00	Building Improvements	7, 764, 969	291, 125	0	291, 125		4. 00
5.00	Fixed Equipment	27, 059, 404	19, 666	0	19, 666		5. 00
6.00	Movable Equipment	43, 431, 502	3, 790, 330	0	3, 790, 330	864, 978	1
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	121, 315, 179	4, 101, 121	0	4, 101, 121	1	1
9.00	Reconciling Items	0	0	0	0	0	7.00
10.00	Total (line 8 minus line 9)	121, 315, 179	4, 101, 121	0	4, 101, 121	864, 978	10.00
		Endi ng Bal ance	Fully				
			Depreciated				
		4.00	Assets				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	6.00	7. 00				
1. 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	1, 262, 718	0				1. 00
			U				
2. 00 3. 00	Land Improvements	3, 158, 371	0				2. 00 3. 00
4. 00	Buildings and Fixtures Building Improvements	38, 638, 215 8, 056, 094	0				4.00
4. 00 5. 00	Fixed Equipment	27, 079, 070	0				5.00
6.00		46, 356, 854	0				6.00
7. 00	Movable Equipment HIT designated Assets	40, 330, 634	0				7.00
8.00	Subtotal (sum of lines 1-7)	124, 551, 322	0				8.00
9. 00	Reconciling Items	124, 331, 322	0				9.00
10. 00	Total (line 8 minus line 9)	124, 551, 322	0				10.00
10.00	Total (Title o milius Title 7)	124, 551, 522	٥Į			l	10.00

Heal th	Financial Systems T	ERRE HAUTE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider CC		Period: From 09/01/2016 To 08/31/2017	Worksheet A-7 Part II Date/Time Pre 1/27/2018 2:1	pared:
			SU	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreci ati on	Lease	Interest	Insurance (see instructions)		
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	2, 373, 121	0		0 0	376, 181	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2, 498, 596	173, 578	15, 25	55 0	0	2. 00
3.00	Total (sum of lines 1-2)	4, 871, 717	173, 578	15, 25	55 0	376, 181	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	· ·				
1.00	CAP REL COSTS-BLDG & FLXT	0	2, 749, 302				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2, 687, 429				2. 00
0 00	T 1 1 ( C 1: 4 0)		E 407 704	1			

0 0 0

2, 749, 302 2, 687, 429 5, 436, 731

1. 00 2. 00 3. 00

3.00 Total (sum of lines 1-2)

Health Financial Systems T	ERRE HAUTE REG	IONAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 09/01/2016 To 08/31/2017		pared:
	COM	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capitalized	Gross Assets		Insurance	
		Leases	for Ratio	instructions)		
			(col . 1 - col 2)			
	1. 00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	0.00	1. 00	0.00	
1.00 CAP REL COSTS-BLDG & FLXT	78, 194, 468	0	78, 194, 46	8 0. 627809	0	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	46, 356, 854	0	46, 356, 85	4 0. 372191	0	2. 00
3.00 Total (sum of lines 1-2)	124, 551, 322		124, 551, 32			3. 00
	ALLOCA <sup>2</sup>	TION OF OTHER (	CAPI TAL	SUMMARY C	OF CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	f Depreciation	Lease	
		Capi tal -Relate				
		d Costs	through 7)	0.00	40.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	6. 00	7. 00	8. 00	9. 00	10.00	
1.00 CAP REL COSTS-BLDG & FIXT	INTERS	1		0 2, 470, 713	186, 692	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0 2, 465, 533		2.00
3.00 Total (sum of lines 1-2)	0	0		0 4, 936, 246		3. 00
		Sl	JMMARY OF CAPI		,	
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Relate		
				d Costs (see	through 14)	
	11.00	10.00	10.00	instructions)	45.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	11. 00	12.00	13. 00	14.00	15. 00	
1.00 CAP REL COSTS-BLDG & FLXT	INTERS	27, 866	369, 13	0 0	3, 054, 401	1. 00
2.00 CAP REL COSTS-BEDG & TTAT	15, 255					2.00
3.00 Total (sum of lines 1-2)	15, 255					
(		,000	2.37.0	1	, 020	

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 TERRE HAUTE REGIONAL HOSPITAL Provider CCN: 15-0046 

				Т	o 08/31/2017	Date/Time Prep 1/27/2018 2:1	
				Expense Classification on	Worksheet A	172772010 2.1	э ріп
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3. 00	4. 00	5. 00	
1. 00	Investment income - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
2.00	COSTS-MVBLE EQUIP (chapter 2)		0	NEE GOSTS MVBEE EQUIT	2.00	Ĭ	2.00
3.00	Investment income - other		0		0.00	0	3.00
4 00	(chapter 2)		•		0.00		4 00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4. 00
5. 00	Refunds and rebates of		0		0.00	0	5. 00
	expenses (chapter 8)						
6.00	Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7. 00
7.00	stations excluded) (chapter		O		0.00	Ĭ	7.00
	21)						
8.00	Television and radio service		0		0.00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0. 00	0	9. 00
10. 00	Provi der-based physician	A-8-2	-11, 009, 095		0.00	0	10.00
10.00	adjustment	N 0 2	11,007,070			Ĭ	10.00
11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
40.00	(chapter 23)	1 0 1	7 004 545				40.00
12. 00	Related organization transactions (chapter 10)	A-8-1	7, 021, 515			0	12. 00
13. 00	Laundry and Linen service		0		0.00	0	13. 00
14. 00	Cafeteria-employees and guests	;	0		0.00		14. 00
15. 00	Rental of quarters to employee		0		0.00	0	15.00
1/ 00	and others		0		0.00		1/ 00
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
	patients						
17. 00	Sale of drugs to other than		0		0.00	0	17. 00
40.00	patients						40.00
18. 00	Sale of medical records and abstracts		0		0.00	0	18. 00
19. 00	Nursing school (tuition, fees,		0		0.00	0	19. 00
	books, etc.)						
20. 00	Vendi ng machi nes		0		0.00	1	
21. 00	Income from imposition of interest, finance or penalty		0		0.00	0	21. 00
	charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	o	22. 00
	overpayments and borrowings to						
22.00	repay Medicare overpayments	4.0.2	0	DECDIDATORY THERAPY	/F 00		22.00
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of						
25. 00	limitation (chapter 14)  Utilization review -		^	  *** Cost Center Deleted ***	114. 00		25. 00
25.00	physicians' compensation		U	Cost center bereted """	114.00		25.00
	(chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	o	26. 00
27.00	COSTS-BLDG & FIXT		0	CAD DEL COSTS MUDIE FOLID	2.00		27.00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		Ü	CAP REL COSTS-MVBLE EQUIP	2.00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00	0	29. 00
30. 00	Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	67. 00		30.00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
. =	instructions)				33.30		
31. 00	Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
32. 00			0		0.00	0	32. 00
	Depreciation and Interest		0		3.00	<u> </u>	
33. 00	X-RAY COPY	В		RADI OLOGY-DI AGNOSTI C	54.00		
33. 01	CAFETERI A	В	-294, 992	CAFETERI A	11. 00	0	33. 01
				·			

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 15-0046

				To	o 08/31/2017 0 08/31/2017	Date/Time Prep	
				Expense Classification on	Worksheet A	1/27/2018 2:15	o pm
				To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
33. 02	VENDING	1. 00 B		CAFETERI A	11. 00	5.00	33. 02
33. 03	MEDI CAL RECORDS	В		MEDICAL RECORDS & LIBRARY	16. 00	Ō	33. 03
33. 04	ED OTHER	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
33. 05 33. 06	INTEREST INCOME HOSPICE	B B		ADMINISTRATIVE & GENERAL	5. 00 30. 00	0	33. 05 33. 06
33. 00	UNCLAIMED PROPERTY	В		ADULTS & PEDIATRICS ADMINISTRATIVE & GENERAL	5. 00	0	33. 07
33. 08	WORKER'S COMP. PAID CLAIMS	A	·	EMPLOYEE BENEFITS DEPARTMENT	4. 00	o	33. 08
33. 09	WORKER'S COMP INSURANCE	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 09
33. 10	PATIENT ACCOUNT INTEREST	A		ADMI NI STRATI VE & GENERAL	5.00	0	33. 10
33. 11 33. 12	PATIENT TELEPHONES PATIENT TELEPHONES	A A		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00	0	33. 11 33. 12
33. 13	PATIENT TV'S	A		OPERATION OF PLANT	7. 00	o	33. 13
33. 14	CONSULTI NG 900-317	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 14
33. 15	ADMIN. TRAVEL 900-750	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 15 33. 16
33. 16 33. 17	ADMIN. MEALS 900-764 ADMIN. PARTIES & BANQUETS	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33. 16
00. 17	900-760		,20	A SENERALE	0.00	Ĭ	00. 17
33. 18	MI SC. XXX870	A	·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 18
33. 19 33. 20	NONPATIENT GIFTS NONPATIENT GIFTS	A A		ADMINISTRATIVE & GENERAL HOUSEKEEPING	5. 00 9. 00	0	33. 19 33. 20
33. 21	NONPATIENT GIFTS	A		EMERGENCY	91. 00		33. 20
33. 22	SPOUSE TRAVEL	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 22
33. 23	ALCOHOL	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 23
33. 24 33. 25	ALCOHOL ALCOHOL	A A		ADMINISTRATIVE & GENERAL ADULTS & PEDIATRICS	5. 00 30. 00	0	33. 24 33. 25
33. 26	ALCOHOL	A		INTENSIVE CARE UNIT	31. 00	o	33. 26
33. 27	ALCOHOL	A	-19	ENDOSCOPY	76. 01	0	33. 27
33. 28	ALCOHOL	A		EMERGENCY	91. 00	0	33. 28
33. 29 33. 30	COUNTRY CLUB DUES PHYSICIAN RECRUITMENT	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33. 29 33. 30
33. 31	PHYSICIAN RECRUITMENT	A		ADMINISTRATIVE & GENERAL	5. 00	Ö	33. 31
33. 32	PHYSICIAN RECRUITMENT	A		SUBPROVIDER - IRF	41. 00	o	33. 32
33. 33	NONALLOWABLES 900805	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 33
33. 34 33. 35	CONTRIBUTIONS MED STAFF NONALLOWABLES 843971	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33. 34 33. 35
33. 36	POB DEPT. 858	A		ADMINISTRATIVE & GENERAL	5. 00	Ō	33. 36
33. 37	PUBLIC RELATIONS DEPT. 920	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 37
33. 38 33. 39	SALES DEPT. 965 LEGAL FEES	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33. 38 33. 39
33. 40	CLINICAL RESEARCH	A		RADI OLOGY-THERAPEUTI C	55. 00	o	33. 40
33. 41	CLINICAL RESEARCH	A		OPI C	76. 04	O	33. 41
33. 42	CLINICAL RESEARCH	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 42
33. 43 33. 44	DEPRECIATION BUILDING DEPRECIATION MME	A A		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1. 00 2. 00	9	33. 43 33. 44
33. 45	CRNA	A		OPERATING ROOM	50.00	ó	33. 45
33. 46	NURSE PRACTITIONER	A	·	OCCUPATIONAL MEDICINE	194. 00	o	33. 46
33. 47	NURSE PRACTITIONER	A		ADMINISTRATIVE & GENERAL	5.00	0	33. 47
33. 48 33. 49	NURSE PRACTITIONER   LOBBYING DUES	A A		ADULTS & PEDIATRICS ADMINISTRATIVE & GENERAL	30. 00 5. 00	0	33. 48 33. 49
33. 50	MOB ACCOUNTING	A	·	ADMINISTRATIVE & GENERAL	5. 00	Ö	33. 50
33. 51	MOB ACCOUNTING	Α		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 51
33. 52 33. 53	USEFUL LIFE ADJUSTMENT PHYSICIAN RECORDS STORAGE	A A		CAP REL COSTS-BLDG & FIXT OPERATION OF PLANT	1. 00 7. 00	9	33. 52 33. 53
33. 54	ADVERTISING	A		ADMINISTRATIVE & GENERAL	5. 00		33. 54
33. 55	ADVERTI SI NG	A		SUBPROVIDER - IRF	41.00	0	33. 55
33. 56	ADVERTI SI NG	A		ENDOSCOPY	76. 01	0	33. 56
33. 57 33. 58	ADVERTI SI NG ADVERTI SI NG	A A		EMERGENCY OCCUPATIONAL MEDICINE	91. 00 194. 00	0 0	33. 57 33. 58
33. 59	PATIENT TV'S	A	·	ADULTS & PEDIATRICS	30. 00	0	33. 59
33. 60	PATIENT TV'S	A	-425	INTENSIVE CARE UNIT	31. 00	0	33. 60
33. 61	PATIENT TV'S	A		DELIVERY ROOM & LABOR ROOM	52.00	0	33. 61
33. 62 33. 63	PATIENT TV'S OTHER REVENUE	A B	·	RADI OLOGY-DI AGNOSTI C ADMI NI STRATI VE & GENERAL	54. 00 5. 00	0	33. 62 33. 63
33. 64	OTHER REVENUE	В		HOUSEKEEPI NG	9. 00	0	33. 64
33. 65	PATHOLOGY SLIDES	В	-2, 513	LABORATORY	60.00	O	33. 65
33. 66	OTHER REVENUE	В	-5	DRUGS CHARGED TO PATIENTS	73.00	0	33. 66
33. 67 33. 68			0		0. 00 0. 00	0	33. 67 33. 68
33. 69			0		0. 00		
		<u>'</u>		<u>_</u>	<u>'</u>	<u>'</u>	

Heal th	Financial Systems	T	ERRE HAUTE REGI	ONAL HOSPITAL	In Lieu of Form CMS-2552-10		
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 09/01/2016 To 08/31/2017	Date/Time Pre 1/27/2018 2:1	
				Expense Classification of	Norksheet A	172772016 2. 1	5 piii
				To/From Which the Amount is			
				TOTAL COM MAN COM COMPANY	to so haj dotod		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3. 00	4. 00	5. 00	
33. 70			0		0.00	0	33. 70
33. 71			0		0.00	0	33. 71
33. 72			0		0.00	0	33. 72
33. 73			0		0.00	0	33. 73
33. 74			0		0.00	0	33. 74
33. 75			0		0.00	0	33. 75
50.00	TOTAL (sum of lines 1 thru 49)		-8, 615, 382				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

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

  B. Amount Received if cost cannot be determined.
  (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
- Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-0046 Peri od: Worksheet A-8-1 From 09/01/2016 To 08/31/2017 Date/Time Prepared: OFFICE COSTS

				To 08/31/2017	Date/Time Pre 1/27/2018 2:1	
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	о рііі
			·	Allowable Cost	Included in	
					Wks. A, column	
	1.00	2.00	2.00	4.00	5	
	1.00	2.00	3.00 TRANSACTIONS WITH RELATED OR	4. 00	5. 00	
	HOME OFFICE COSTS:	WENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLATWED	
1.00		ADMINISTRATIVE & GENERAL	HPG	94, 984	211, 467	1.00
2.00	5. 00	ADMINISTRATIVE & GENERAL	IT&S	1, 833, 839	1, 758, 415	2.00
3.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE COST	2, 129, 686	7, 016, 524	3. 00
4.00		ADMINISTRATIVE & GENERAL	HOME OFFICE DIRECT COMP.	311, 822	0	4. 00
4. 01		ADMINISTRATIVE & GENERAL	SSC	2, 556, 551	2, 556, 551	4. 01
4. 02	•	ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	SUPPLY CHAIN	1, 331, 165	1, 331, 165	4. 02
4. 03 4. 04	•	NURSING ADMINISTRATION	PARALLON WORKFORCE SOLUTIONS PARALLON WORKFORCE SOLUTIONS	52, 804 19, 280	59, 187 21, 460	4. 03 4. 04
4. 05	•	ADULTS & PEDIATRICS	PARALLON WORKFORCE SOLUTIONS	1, 000, 778	1, 113, 956	4. 05
4. 06		INTENSIVE CARE UNIT	PARALLON WORKFORCE SOLUTIONS	97, 208	108, 202	4. 06
4. 07		SUBPROVI DER - I PF	PARALLON WORKFORCE SOLUTIONS	41, 817	46, 546	4. 07
4. 08	•	SUBPROVIDER - IRF	PARALLON WORKFORCE SOLUTIONS	1, 406	1, 566	4. 08
4.09	50.00	OPERATING ROOM	PARALLON WORKFORCE SOLUTIONS	44, 769	49, 832	4. 09
4. 10	51.00	RECOVERY ROOM	PARALLON WORKFORCE SOLUTIONS	2, 457	2, 735	4. 10
4. 11		DELIVERY ROOM & LABOR ROOM	PARALLON WORKFORCE SOLUTIONS	201, 693	224, 502	4. 11
4. 12	•	PHYSI CAL THERAPY	PARALLON WORKFORCE SOLUTIONS	22, 983	25, 582	4. 12
4. 13		EMERGENCY	PARALLON WORKFORCE SOLUTIONS	643, 583	716, 366	4. 13
4. 14		SI TTERS	PARALLON WORKFORCE SOLUTIONS	1, 916	2, 133	4. 14
4. 15 4. 16	•	ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	PARALLON MARK-UP PARALLON PAYROLL	0	743, 472 34, 425	4. 15 4. 16
4. 10	•	ADMINISTRATIVE & GENERAL	CAPITAL DIVISION IT&S	34, 425 1, 230, 170	1, 253, 040	4. 10
4. 17		MEDICAL RECORDS & LIBRARY	HIM	1, 000, 020	962, 339	4. 18
4. 19		ADMINISTRATIVE & GENERAL	REVENUE INTEGRITY	138, 838	138, 838	4. 19
4. 20	•	ADMINISTRATIVE & GENERAL	CREDENTI ALI NG	70, 323	70, 323	4. 20
4. 21	40.00	SUBPROVIDER - IPF	BEHAVI ORAL HEALTH	107, 615	115, 822	4. 21
4. 22	5. 00	ADMINISTRATIVE & GENERAL	IT&S PARALLON	329, 626	329, 626	4. 22
4. 23	16. 00	MEDICAL RECORDS & LIBRARY	PREBILL DENIAL	29, 416	28, 056	4. 23
4. 24		EMPLOYEE BENEFITS DEPARTMENT	HCA HR SERVICES	534, 849	534, 849	4. 24
4. 25		ADMINISTRATIVE & GENERAL	CAD STORAGE	25, 964	25, 899	4. 25
4. 26		ADMINISTRATIVE & GENERAL	CALL CENTER	0	73, 930	4. 26
4. 27		ADMINISTRATIVE & GENERAL	PHYSICIAN RECRUITING	F24 140	89, 245	4. 27
4. 28 4. 29		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	MALPRACTICE GENERAL LIABILITY INSURANCE	524, 169 0	863, 070 10, 721	4. 28 4. 29
4. 30	•	ADMINISTRATIVE & GENERAL	PHYSICIAN SALES	0	154, 895	4. 30
4. 31		ADMINISTRATIVE & GENERAL	MARKETING ALLOCATIONS	0	137, 614	4. 31
4. 32	•	ADMINISTRATIVE & GENERAL	RI CHMOND FSC	154, 003	157, 841	4. 32
4.33		EMPLOYEE BENEFITS DEPARTMENT	RESTORATION PLAN EXP.	0	2, 292	4. 33
4.34	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INS_POOLING ADJ.	0	-482, 459	4. 34
4.35		ADMINISTRATIVE & GENERAL	INTERCOMPANY INTEREST	0	-12, 060, 824	4. 35
4. 36		ADMINISTRATIVE & GENERAL	HOME OFFICE INTEREST	569, 764	0	4. 36
4. 37	•	CAP REL COSTS-BLDG & FIXT	POB SPACE	71, 797	0	4. 37
4. 38		ADMINISTRATIVE & GENERAL	POB SPACE	32, 882	0	4. 38
4. 39	•	OPERATION OF PLANT HOUSEKEEPING	POB SPACE	61, 443	0	4. 39
4. 40 4. 41		CAP REL COSTS-BLDG & FIXT	POB SPACE PAVILLION SPACE	31, 751 72, 342	0	4. 40 4. 41
4. 41		ADMINISTRATIVE & GENERAL	PAVILLION SPACE	1, 439		4. 41
4. 43		OPERATION OF PLANT	PAVILLION SPACE	28, 642	Ö	4. 43
4. 44		HOUSEKEEPI NG	PAVILLION SPACE	12, 499	o	4. 44
4. 45	0.00			0	o	4. 45
5.00	TOTALS (sum of lines 1-4).			15, 450, 718	8, 429, 203	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.			L		

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

mao mo t	the been posted to workshoot h, cordinas i and/or 2, the amount arrowable should be mareated in cordinar i or 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 Health Financial Systems TERRE HAUTE REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-0046 Peri od: Worksheet A-8-1 From 09/01/2016 To 08/31/2017 Date/Time Prepared: OFFICE COSTS

					1/27/2018 2:1	<u>5 pm</u>
				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	
part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming						
	sement under title XVIII.	·	•		3	
6. 00	В		100.00	PARALLON	100.00	6. 00
7. 00	В		52. 73	HPG	52, 73	7. 00
8. 00	В		100, 00	HCI	100, 00	8. 00
9. 00	l B		100.00	CAPITAL DIVISIO	100.00	
10. 00	l B			WORKFORCE MGT.	100.00	

100.00 HCA

100.00 POB

100.00

100.00

10.01

10. 02

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.

10.01

10.02

В

100.00 G. Other (financial or

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS Provider CCN: 15-0046 Period: Worksheet A-8-1 From 09/01/2016 To 08/31/2017 Date/Time Prepared:

				/Time Prepared: /2018 2:15 pm
	Net	Wkst. A-7 Ref.		72016 2. 13 pili
	Adjustments	mot. A A Roll		
	(col. 4 minus			
	col. 5)*			
	6. 00	7. 00		
	A. COSTS INCUR	RED AND ADJUSTM	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMI	ED
	HOME OFFICE CO			
1.00	-116, 483			1. 00
2.00	75, 424	0		2. 00
3.00	-4, 886, 838	0		3. 00
4.00	311, 822			4. 00
4. 01	0			4. 01
4. 02	0	0		4. 02
4. 03	-6, 383			4. 03
4.04	-2, 180			4. 04
4. 05	-113, 178 -10, 994			4. 05
4. 06 4. 07	-10, 994			4. 06 4. 07
4.07	-4, 729	0		4. 07
4. 09	-5, 063			4. 09
4. 10	-278			4. 10
4. 11	-22, 809			4. 11
4. 12	-2, 599			4. 12
4. 13	-72, 783			4. 13
4.14	-217	0		4. 14
4. 15	-743, 472	o		4. 15
4. 16	0	0		4. 16
4. 17	-22, 870	0		4. 17
4. 18	37, 681	0		4. 18
4. 19	0			4. 19
4. 20	0	0		4. 20
4. 21	-8, 207	0		4. 21
4. 22 4. 23	1, 360	0		4. 22
4. 23 4. 24	1, 360			4. 23 4. 24
4. 25	65			4. 24
4. 26	-73, 930			4. 26
4. 27	-89, 245			4. 27
4. 28	-338, 901	0		4. 28
4. 29	-10, 721	0		4. 29
4.30	-154, 895			4. 30
4.31	-137, 614	0		4. 31
4.32	-3, 838	0		4. 32
4.33	-2, 292	0		4. 33
4.34	482, 459			4. 34
4. 35	12, 060, 824			4. 35
4. 36	569, 764	0		4. 36
4. 37	71, 797			4. 37
4. 38	32, 882	0		4. 38
4. 39	61, 443	0		4. 39
4.40	31, 751	0		4. 40
4. 41	72, 342			4. 41
4. 42 4. 43	1, 439 28, 642			4. 42 4. 43
4.43	12, 499			4. 43
7. 77	12,477	ı V		1 7.44

\* 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

4. 45

5.00

0

0

7, 021, 515

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

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

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

6.00	MANAGEMENT		6. 00
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4. 45 5. 00

Health Financial Systems TERRE HAUTE REGIONAL HOSPITAL			In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0046	Peri od:	Worksheet A-8-1
OFFICE COSTS			From 09/01/2016 To 08/31/2017	Date/Time Prepared:
				1/27/2018 2:15 pm
Rel ated Organization(s)				
and/or Home Office				
T 6.D :				
Type of Business				
6. 00				
7. 00 PURCHASI NG				7. 00
8. 00 I NSURANCE				8. 00
9. 00 MANAGEMENT				9. 00
10.00 STAFFING				10. 00
10.01 HOSPITAL MGT.				10. 01
10.02 PROFESSIONAL BU				10. 02
100.00				100. 00

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

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0046

					1	To 08/31/2017	Date/Time Pre 1/27/2018 2:1	epared:
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	Орш
		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		ADULTS & PEDIATRICS	1, 203, 019					1. 00
2.00		SUBPROVIDER - IPF	761, 827			,	0	2. 00
3.00		OPERATING ROOM	766, 073		·			3. 00
4.00		RADI OLOGY-DI AGNOSTI C	1, 036, 845			27.7700	0	4. 00
5.00		RADI OLOGY-THERAPEUTI C	270					5. 00
6.00		RESPI RATORY THERAPY	125, 050	•		211, 500	0	6. 00
7.00		PHYSI CAL THERAPY	72, 975	•	·		505	7. 00
8.00		ELECTROCARDI OLOGY	10, 500				0	8.00
9.00		ENDOSCOPY	103, 450				160	9.00
10.00		WOUND CARE	36, 000	•	,	211, 500	240	10.00
11. 00	76. 04		122, 073			211, 500		11. 00
12. 00 200. 00	91.00	EMERGENCY	6, 969, 712 11, 207, 794			211, 500	340 1, 898	12. 00 200. 00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	· · · · · · · · · · · · · · · · · · ·	Cost of	Provi der	Physi ci an Cost	200.00
	WKSt. A LITTE #	I denti fi er	Li mi t		Memberships &		of Malpractice	
		rucittifici		Li mi t	Continuing	Share of col.	Insurance	
				27	Educati on	12	Tribul direc	
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00	30. 00	ADULTS & PEDIATRICS	0	0	0	0		1. 00
2.00	40. 00	SUBPROVIDER - IPF	0	0	0	0	0	2.00
3.00		OPERATING ROOM	21, 323	1, 066	0	0	0	3. 00
4.00		RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	4. 00
5. 00		RADI OLOGY-THERAPEUTI C	0	0	-	0	0	5. 00
6. 00		RESPI RATORY THERAPY	0	0	0	_	0	6. 00
7.00		PHYSI CAL THERAPY	51, 350	2, 568	0	0	0	7. 00
8.00		ELECTROCARDI OLOGY	0	0	0	0	0	8. 00
9.00		ENDOSCOPY	18, 954			0	0	9.00
10.00		WOUND CARE	24, 404			0	0	10.00
11. 00	76. 04		48, 096			0	0	11. 00
12. 00 200. 00	91.00	EMERGENCY	34, 572 198, 699			_	0	12. 00 200. 00
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	U	200.00
	WKSt. A LITTE #	I denti fi er	Component	Limit	Di sal I owance	Auj us tillerit		
		rucittifici	Share of col.		Di Sai i Owance			
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00	30. 00	ADULTS & PEDIATRICS	0	0	0	1, 203, 019		1. 00
2.00	40. 00	SUBPROVIDER - IPF	0	0	0	761, 827		2.00
3.00	50.00	OPERATING ROOM	0	21, 323	3, 517	744, 750		3. 00
4.00		RADI OLOGY-DI AGNOSTI C	0	0	0	1, 036, 845		4. 00
5.00		RADI OLOGY-THERAPEUTI C	0	0	0			5. 00
6.00		RESPI RATORY THERAPY	0	0	J	125, 050		6. 00
7.00		PHYSI CAL THERAPY	0	51, 350	24, 363			7. 00
8.00		ELECTROCARDI OLOGY	0	0	0	10, 500		8. 00
9. 00		ENDOSCOPY	0					9. 00
10.00		WOUND CARE	0		·			10.00
11. 00	76. 04		0	•				11.00
12. 00	91.00	EMERGENCY	0		·	· · ·		12. 00
200.00	I I		0	198, 699	138, 305	11, 009, 095		200. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0046 Peri od: Worksheet B From 09/01/2016 Part I Date/Time Prepared: 08/31/2017 1/27/2018 2:15 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 3, 054, 401 00100 CAP REL COSTS-BLDG & FLXT 3, 054, 401 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 3, 356, 622 3, 356, 622 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 8, 237, 721 31, 615 35, 032 8, 304, 368 4.00 00500 ADMINISTRATIVE & GENERAL 1, 220, 248 24, 647, 795 5 00 22, 901, 085 249, 736 276, 726 5 00 7.00 00700 OPERATION OF PLANT 3, 724, 176 704, 583 780, 731 174, 759 5, 384, 249 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 528, 232 29, 853 33, 080 591, 165 8.00 9.00 00900 HOUSEKEEPI NG 1, 326, 308 10, 741 11, 902 202, 389 1, 551, 340 9.00 01000 DI ETARY 10.00 98, 902 1, 263, 829 48, 763 54,034 1, 465, 528 10 00 11.00 01100 CAFETERI A 201, 776 31, 101 34, 462 40, 427 307, 766 11.00 01300 NURSING ADMINISTRATION 140, 970 875, 605 13.00 717,041 8, 346 9, 248 13.00 01600 MEDICAL RECORDS & LIBRARY 1,078,756 48,064 53, 258 10, 612 1, 190, 690 16,00 16,00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 7, 505, 629 526, 601 583, 514 1, 267, 753 9, 883, 497 30.00 03100 INTENSIVE CARE UNIT 451, 984 3, 197, 078 31.00 2, 556, 189 89, 610 99, 295 31.00 04000 SUBPROVI DER - I PF 404, 474 2, 697, 882 40.00 2, 122, 862 80.901 89.645 40.00 04100 SUBPROVI DER - I RF 41.00 851, 216 96, 178 106, 572 166, 856 1, 220, 822 41 00 33, 240 04300 NURSERY 214, 388 8, 802 9, 753 43.00 266, 183 43.00 ANCILLARY SERVICE COST CENTERS 4, 366, 437 5, 602, 412 50.00 05000 OPERATING ROOM 212, 649 235, 631 787, 695 50.00 05100 RECOVERY ROOM 51.00 577.035 13, 278 14.714 108.657 713, 684 51.00 1, 215, 178 05200 DELIVERY ROOM & LABOR ROOM 67,094 190, 730 52.00 60,550 1, 533, 552 52.00 53.00 05300 ANESTHESI OLOGY 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 683, 826 110, 173 122, 080 219, 938 2, 136, 017 54.00 54.01 03630 ULTRA SOUND 208, 116 3, 423 3, 793 39, 503 254, 835 54.01 03440 MAMMOGRAPHY 54.02 234, 356 12, 604 13, 966 29, 915 290, 841 54.02 55.00 05500 RADI OLOGY-THERAPEUTI C 1,034,518 52, 077 57, 705 136, 196 1, 280, 496 55.00 56.00 05600 RADI OI SOTOPE 850, 142 6, 256 6, 932 41, 699 905, 029 56.00 05700 CT SCAN 734, 411 13, 506 14, 966 115, 938 878, 821 57.00 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 327, 896 8, 768 9, 716 51, 427 397, 807 58.00 05900 CARDI AC CATHETERI ZATI ON 21, 421 121, 607 694, 758 59 00 532.398 19, 332 59 00 60.00 06000 LABORATORY 2, 682, 233 45, 121 49, 998 269, 561 3, 046, 913 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 676, 798 2, 989 686, 623 62.00 2, 698 4, 138 62.00 06500 RESPIRATORY THERAPY 1, 306, 730 15, 311 240, 269 65.00 13, 818 1, 576, 128 65.00 06600 PHYSI CAL THERAPY 1, 759, 687 1, 269, 761 126, 910 248, 484 66.00 114, 532 66,00 69.00 06900 ELECTROCARDI OLOGY 747, 283 18, 480 20, 477 107, 674 893, 914 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 55, 714 9, 190 10, 183 10, 715 85, 802 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 6, 249, 329 71, 585 86, 517 71 00 79, 322 6, 486, 753 71 00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 7, 306, 304 C 7, 306, 304 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 10, 377, 367 22, 637 25, 083 328, 191 10, 753, 278 73.00 07400 RENAL DIALYSIS 74.00 673, 137 3, 979 4, 409 41 681, 566 74.00 03950 LI THOTRI PSY 231 462 76 00 231, 462 76 00 C 0 76.01 03330 ENDOSCOPY 879, 292 16, 229 17, 983 116, 289 1,029,793 76.01 03040 PRISION CLINIC 150, 269 63, 231 70,064 30, 321 313, 885 76.02 76.02 76.03 03050 WOUND CARE 713, 691 14, 568 16, 143 14, 776 759, 178 76.03 35, 733 76.04 03060 OPI C 530, 960 32, 248 97.205 696, 146 76.04 OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY 91.00 91.00 3, 294, 015 86, 677 96, 044 436, 592 3, 913, 328 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 108, 548, 889 2, 992, 503 3, 315, 919 108, 188, 612 118. 00 118.00 8, 046, 692 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 37, 293 5, 117 5, 336 53, 417 190. 00 5, 671 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 00 194. 00 07950 OCCUPATIONAL MEDICINE 1, 041, 922 194. 00 779, 542 31, 615 35.032 195, 733 194. 01 07951 UNOCCUPIED SPACE/NONALLOWABLE MEALS 25, 166 194. 01 25, 166 0 194. 02 07952 SI TTERS 270, 107 0 326, 714 194. 02 56, 607 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201, 00 202.00 TOTAL (sum lines 118-201) 109, 635, 831 3, 054, 401 3, 356, 622 8. 304. 368 109, 635, 831 202. 00

Provider CCN: 15-0046

						1/27/2018 2:1	5 pm
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	24, 647, 795					5. 00
7. 00	00700 OPERATION OF PLANT	1, 561, 513	ŀ				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	171, 447	1		0 007 040		8. 00
9.00	00900 HOUSEKEEPI NG	449, 912	1		2, 037, 319	0 400 000	9.00
10. 00	01000 DI ETARY	425, 025	1		49, 606	2, 103, 903	
11. 00	01100 CAFETERI A	89, 257			31, 639	0	11. 00
13.00	01300 NURSING ADMINISTRATION	253, 939			8, 491	0	13. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	345, 318	161, 394	0	48, 894	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2, 866, 362	1, 768, 292	499, 845	535, 700	820, 524	30.00
31.00	03100 INTENSIVE CARE UNIT	927, 201	300, 905		91, 159	61, 441	31.00
40. 00	04000 SUBPROVI DER - I PF	782, 426	1				
41. 00	04100 SUBPROVI DER – I RF	354, 057	1			103, 991	
43. 00	04300 NURSERY	77, 197	1		8, 954	0 0	
43.00		17, 177	27, 555	17, 231	0, 754	U	43.00
FO 00	ANCILLARY SERVICE COST CENTERS	1 (04 704	714 050	l o	217 224	0	F0 00
50.00	05000 OPERATING ROOM	1, 624, 784			216, 324	0	50.00
51. 00	05100 RECOVERY ROOM	206, 979	1	1	13, 508	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	444, 753	203, 321	0	61, 596	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	1	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	619, 477	369, 953	0	112, 077	0	54.00
54. 01	03630 ULTRA SOUND	73, 906	11, 494	0	3, 482	0	54. 01
54. 02	03440 MAMMOGRAPHY	84, 348	42, 323	0	12, 822	0	54. 02
55.00	05500 RADI OLOGY-THERAPEUTI C	371, 363	174, 870	0	52, 977	0	55. 00
56. 00	05600 RADI 0I S0T0PE	262, 472	1		6, 364	0	56. 00
57. 00	05700 CT SCAN	254, 871	45, 352		13, 739	Ö	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	115, 370	1		8, 920	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON		1			0	59.00
		201, 490	1		19, 666		
60.00	06000 LABORATORY	883, 650			45, 901	0	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	199, 131	9, 059	1	2, 744	0	62. 00
65. 00	06500 RESPI RATORY THERAPY	457, 101	46, 400		14, 057	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	510, 336			116, 511	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	259, 248	62, 055	0	18, 800	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	24, 884	30, 858	0	9, 348	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 881, 256	240, 379	0	72, 823	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 118, 938	1	o	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	3, 118, 601	76, 012	o	23, 028	0	73. 00
74. 00	07400 RENAL DIALYSIS	197, 664	1	1	4, 048	Ö	74. 00
76. 00	03950 LI THOTRI PSY	67, 127	13, 302	Ö	4, 040	0	76.00
76. 01	03330 ENDOSCOPY	298, 655	54, 496	1	16, 510	0	76. 00
				1			
76. 02	03040 PRI SI ON CLI NI C	91, 031	212, 324	1	64, 323	0	76. 02
76. 03	03050 WOUND CARE	220, 173			14, 820	0	76. 03
76. 04	03060 OPI C	201, 893	108, 285	0	32, 805	0	76. 04
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	1, 134, 924	291, 053	0	88, 175	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS	•	•				1
113 00	11300   NTEREST EXPENSE						113. 00
118. 00		24, 228, 079	6, 737, 911	862, 857	1, 999, 951	1, 266, 404	
110.00	NONREI MBURSABLE COST CENTERS	24, 220, 077	0,737,711	002,037	1, 777, 751	1, 200, 404	1110.00
100.00		15 400	17 104	1 0	F 20/	0	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	15, 492	17, 184		5, 206		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
	07950 OCCUPATIONAL MEDICINE	302, 173			32, 162		194. 00
	1 07951 UNOCCUPIED SPACE/NONALLOWABLE MEALS	7, 299		0	0	837, 499	
194. 02	2 07952 SI TTERS	94, 752	0	0	0	0	194. 02
200.00	Cross Foot Adjustments						200. 00
201.00		0	0	o	ol	0	201. 00
202.00		24, 647, 795	6, 945, 762	862, 857	2, 037, 319		202.00
_32.00	1.07.12 (33 1.1.03 110 201)		1 3,710,702	002,007	2,007,017	_, 100, 700	, 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Peri od: Worksheet B From 09/01/2016 Part I Provider CCN: 15-0046

				Fr To	com 09/01/2016 08/31/2017	Date/Time Prep	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Resi dents Cost & Post Stepdown Adjustments	5 piii
		11.00	13.00	16. 00	24. 00	25. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	F22 007					10.00
11. 00 13. 00	01100   CAFETERI A   01300   NURSI NG   ADMI NI STRATI ON	533, 097 11, 443	1, 177, 505				11. 00 13. 00
16. 00		861	1, 177, 303	1, 747, 157			16. 00
	I NPATIENT ROUTINE SERVICE COST CENTERS		-1	.,,			
30.00	03000 ADULTS & PEDIATRICS	102, 905		56, 861	17, 002, 310		30.00
31.00	03100 I NTENSI VE CARE UNI T	36, 688		22, 941	4, 894, 442		31. 00
40. 00 41. 00	04000   SUBPROVI DER -   PF   04100   SUBPROVI DER -   RF	32, 831 13, 544	85, 402 52, 466	63, 049 5, 782	4, 493, 797 2, 224, 525		40. 00 41. 00
43.00		2, 698		2, 152	415, 410		43.00
10.00	ANCILLARY SERVICE COST CENTERS	2,070	11, 110	2, 102	110, 110		10.00
50.00		63, 937	159, 408	224, 345	8, 605, 269	0	50.00
51. 00		8, 820		31, 847	1, 058, 893		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	15, 482	1	8, 739	2, 339, 211	0	52. 00
53. 00 54. 00	05300   ANESTHESI OLOGY   05400   RADI OLOGY - DI AGNOSTI C	17, 852	0 0	0 37, 763	0 3, 293, 139		53. 00 54. 00
54. 01	03630 ULTRA SOUND	3, 206		11, 587	358, 510		54. 01
54. 02		2, 428	0	5, 620	438, 382		54. 02
55. 00	•	11, 055	1	42, 604	1, 933, 365		55.00
56. 00		3, 385		32, 462	1, 230, 718		56. 00
57. 00 58. 00	05700 CT SCAN	9, 411	0	137, 624	1, 339, 818	0 0	57. 00 58. 00
59. 00	05800   MAGNETI C RESONANCE I MAGI NG (MRI)   05900   CARDI AC CATHETERI ZATI ON	4, 174 9, 871	19, 045	33, 951 67, 243	589, 664 1, 076, 987		59. 00
60. 00	06000 LABORATORY	21, 880		166, 642	4, 316, 500		60. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	336		16, 618	914, 511	0	62.00
65.00	06500 RESPI RATORY THERAPY	19, 503	1, 676	45, 292	2, 160, 157		65.00
66.00	06600 PHYSI CAL THERAPY	20, 169	26	17, 524	2, 808, 842		66. 00
69. 00 70. 00	06900   ELECTROCARDI OLOGY   07000   ELECTROENCEPHALOGRAPHY	8, 740 870		45, 004 3, 595	1, 301, 221 155, 357	0 0	69. 00 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 023	5, 745	103, 260	8, 797, 239		71. 00
72. 00		0	0	55, 222	9, 480, 464	O	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	26, 639	0	266, 936	14, 264, 494	0	73. 00
74. 00		3	0	12, 835	909, 478		74. 00
76. 00 76. 01	03950 LI THOTRI PSY 03330 ENDOSCOPY	9, 439	0	7, 321	305, 910		76. 00 76. 01
	03040 PRISION CLINIC	2, 461	33, 317 367	49, 573 1, 073	1, 491, 783 685, 464		76. 01 76. 02
76. 02		1, 199		9, 454	1, 083, 674		76. 02
76. 04	03060 OPI C	7, 890		13, 940	1, 081, 612	0	76. 04
	OUTPATIENT SERVICE COST CENTERS						
		35, 438	0	148, 298	5, 611, 216		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS					0	92. 00
113.00	0 11300   NTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	512, 181	1, 174, 605	1, 747, 157	106, 662, 362		118. 00
	NONREI MBURSABLE COST CENTERS	1					
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	433		0	91, 732		190. 00
	0 19200 PHYSICIANS' PRIVATE OFFICES 0 07950 OCCUPATIONAL MEDICINE	15, 888	0	0	0 1, 498, 307		192. 00 194. 00
	107951 UNOCCUPIED SPACE/NONALLOWABLE MEALS	13, 866		0	954, 469		194. 00
194. 02	2 07952 SI TTERS	4, 595	2, 900	Ö	428, 961	0	194. 02
200.00					0	0	200. 00
201.00		0	0	0	100 (05 05)	0	201. 00
202.00	0 TOTAL (sum lines 118-201)	533, 097	1, 177, 505	1, 747, 157	109, 635, 831	۱ 0	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS TERRE HAUTE REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0046

| Peri od: | Worksheet B | From 09/01/2016 | Part I | To 08/31/2017 | Date/Time Prepared:

CAST CONTROL   CAST CONTROL				To 08/31/2017   Date/Time Pre	
CENERAL SERVICE COST CENTERS		Cost Center Description	Total	172772010 2. 1	J piii
1.00   00100   CAP REL COSTS-BLDG & FIXT		<u>'</u>	26.00		
2.00		GENERAL SERVICE COST CENTERS			
4. 00		1 1			1
5.00   00500 ADM INISTRATIVE & GENERAL		1 1			1
1.00		1 1			1
8.00		1 1			1
9.00   00000   HOUSEKEEPIN		1 1			1
10. 00   101000   DIETARY		1 1			1
11.00   01100   CAFETERIA		1			1
13.0   01300   MURSIN CAMMINISTRATION     13.0   00   000		1			1
16. 00		1 1			
INPATIENT ROUTH NE SERVICE COST CENTERS   30,00   330,00   3010   AULTS & PEDIATRICS   17,002,310   31 0,00   3100   3100   AULTS & PEDIATRICS   31 0,00   31 0,00   310					1
30.00   03000   ADULTS & PEDIATRICS   17,002,310   31,00   031,00   03100   NITEMS IN CEARE UNIT   4,894,442   31,00   041,00   04100   SUSPROVIDER - IPF   4,493,797   40,00   041,00   04100   SUSPROVIDER - IPF   2,224,525   41,30   043,00   NUSSERY   415,410   41,00   050,00	16.00				16.00
31.00   O3100   INTERSIVE CARE UNIT	20.00		17 000 210		20.00
40.00   04000   04000   SUBPROVIDER - IPF   4, 493, 797   41.00   04300   NURSERY   415, 410   41.0		1 1	1		1
41.00   04100   SUBPROVI DER - 1 IRF   2, 224, 525   41.00   ABCULLARY SERVICE COST CONTERS   415, 410   ABCULLARY SERVICE COST CONTERS   50.00   S00.00   OFERATING ROOM   1, 088, 893   51.00   52.00   52.00   DELIVERY ROOM & LABOR ROOM   2, 339, 211   52.00   53.00   05300   ABLISTHESI OLOGY   0, 53.00   53.00   53.00   ABLISTHESI OLOGY   0, 53.00   53.00   53.00   ABLISTHESI OLOGY   0, 54.00   54.00   54.00   ABLISTHESI OLOGY   0, 54.00   54.00   54.00   ABLISTHESI OLOGY   0, 54.00   54.00   ABLISTHESI OLOGY   0, 54.00   54.00   ABLISTHESI OLOGY   0, 54.00   54.00   54.00   54.00   ABLISTHESI OLOGY   0, 54.00   54.00			1		1
43. 00   04300   NURSERY   415, 410   43. 00   ANCILARY SERVICE COST CENTERS		1 1	1		1
ANCILLARY SERVICE COST CENTERS   50.00			1		1
50.00   05000   05000   05000   05000   0510	43.00		413, 410		43.00
51.00   05.00   RECOVERY ROOM   1.058, 893   51.00   52.00   52.00   52.00   52.00   52.00   52.00   52.00   52.00   52.00   52.00   52.00   52.00   52.00   53.00	50.00		8 605 269		50.00
52.00   05.0000   05.000   05.000   05.000   05.000   05.000   05.000   05.0000   05.000   05.000   05.000   05.000   05.000   05.000   05.0000   05.000   05.000   05.000   05.000   05.000   05.000   05.0000   05.000   05.000   05.0000   05.0000   05.0000   05.0000   05.0000   05.0000   05.0000   05.0000   05.0000   05.0000   05.0000   05.0000   05.0000   05.0000   05.00000   05.00000   05.00000   05.00000   05.00000   05.00000   05.00000   05.00000   05.0			1		1
53. 00   05300   ANESTHESI OLOGY   53. 00   54. 01   36.00   ADD ILOGY PAIG AND ILOGY PAIG PAIG AND ILOGY PAIG PAIG AND ILOGY PAIG AND ILOG					1
54. 00   05400   RADIOLOGY-DIANOSTIC   3, 293, 139   54, 00   54. 01   03630   ULTRA SOUND   358, 510   54, 01   54. 02   03440   MAMMOGRAPHY   488, 382   55, 00   55. 00   05500   RADIOLOGY-THERAPEUTIC   1, 933, 365   55, 00   56. 00   05500   RADIOLOGY-THERAPEUTIC   1, 230, 718   55, 00   57. 00   05700   CT SCAN   1, 339, 818   57, 00   58. 00   05500   MACHETIC RESONANCE IMAGING (MRI)   589, 664   58, 00   59. 00   05900   CARDIOLOGY-THERAPEUTIC   1, 76, 987   59, 00   60. 00   06000   LABOORATORY   4, 316, 500   914, 511   60, 00   62. 00   06200   MACHETIC RESONANCE RED BLOOD CELLS   914, 511   62, 00   63. 00   06500   CASONATORY   4, 316, 500   914, 511   62, 00   64. 00   06600   PACKED RED BLOOD CELLS   914, 511   62, 00   65. 00   06500   CESPIRATORY THERAPY   2, 808, 842   66, 00   66. 00   06600   ELECTROCARDIOLOGY   1, 301, 221   69, 00   67. 00   07000   CLECTROCARDIOLOGY   1, 301, 221   69, 00   67. 00   07000   CLECTROCARDIOLOGY   1, 301, 221   69, 00   67. 00   07000   CLECTROCARDIOLOGY   1, 301, 221   69, 00   67. 00   07000   CLECTROCARDIOLOGY   1, 301, 221   69, 00   67. 00   07000   CLECTROCARDIOLOGY   1, 301, 221   69, 00   67. 00   07000   CLECTROCARDIOLOGY   1, 301, 221   69, 00   67. 00   07000   CLECTROCARDIOLOGY   1, 301, 221   70, 00   72. 00   07200   MPL   DEV. CHARGED TO PATIENTS   9, 480, 464   72, 20   73. 00   07300   DRUGS CHARGED TO PATIENTS   14, 264, 494   73, 300   74. 00   07300   REDAL IDIALYSIS   909, 478   76, 001   75. 00   03950   LITHOTRI PSY   305, 910   76, 001   76. 01   03330   ENDOSCODY   1, 491, 783   76, 001   76. 02   03040   PRIS ION CLINIC   685, 464   76, 03   76. 04   03060   DPIC   60, 001   76, 001   76, 001   77. 00   07100   REPAIL IDIAL SINIC   67, 001   76, 001   78. 00   07100   REFRENCY   1, 081, 612   79. 00   07100					1
54. 01 03630   LITRA SOUND 54. 02 03440   MAMMOGRAPHY 54. 02 03440   MAMMOGRAPHY 55. 00 05500   RADI OLOCY-THERAPEUTI C 55. 00 05500   RADI OLOCY-THERAPEUTI C 56. 00 05500   RADI OLOCY-THERAPEUTI C 57. 00 05700   CT SCAN 58. 00 05800   MADI OLOCY-THERAPEUTI C 58. 00 05800   MADINETI C RESONANCE I MAGI NG (MRI) 58. 00 05800   MADINETI C RESONANCE I MAGI NG (MRI) 58. 00 05800   MADINETI C RESONANCE I MAGI NG (MRI) 58. 00 05800   MADINETI C RESONANCE I MAGI NG (MRI) 58. 00 05800   MADINETI C RESONANCE I MAGI NG (MRI) 58. 00 05800   MADINETI C RESONANCE I MAGI NG (MRI) 58. 00 06000   CABURATORY 58. 00 06000   MADINETI C RESONANCE I MAGI NG (MRI) 58. 00 06000   MADINETI C RESONANCE I MAGI NG (MRI) 58. 00 06000   MADINETI C RESONANCE I MAGI NG (MRI) 58. 00 06000   MADINETI C RESONANCE I MAGI NG (MRI) 58. 00 06000   MADINETI C RESONANCE I MAGI NG (MRI) 58. 00 06500   MADINETI C RESONANCE I MAGI NG (MRI) 58. 00 06500   MADINETI C RESONANCE I MAGI NG (MRI) 58. 00 06500   MADINETI C RESONANCE I MAGI NG (MRI) 58. 00 06500   MADINETI C RESONANCE I MAGI NG (MRI) 58. 00 06500   MADINETI C RESONANCE I MAGI NG (MRI) 58. 00 06500   MADINETI C RESONANCE I MAGI NG (MRI) 58. 00 06600   MADINETI C RESONANCE I MAGI NG (MRI) 59. 00 07000   LECTROENCEPHALOGRAPHY 59. 00 07200   MEDI CAL SUPPLIES CHARGED TO PATI ENTS 59. 00 07200   MEDI CAL SUPPLIES CHARGED TO PATI ENTS 59. 00 07200   MEDI CAL SUPPLIES CHARGED TO PATI ENTS 59. 00 07200   MEDI CAL SUPPLIES CHARGED TO PATI ENTS 59. 00 07200   MEDI CAL SUPPLIES CHARGED TO PATI ENTS 59. 00 07200   MEDI CAL SUPPLIES CHARGED TO PATI ENTS 59. 00 07200   MEDI CAL SUPPLIES CHARGED TO PATI ENTS 59. 00 07200   MEDI CAL SUPPLIES CHARGED TO PATI ENTS 59. 00 07200   MEDI CAL SUPPLIES CHARGED TO PATI ENTS 59. 00 07200   MEDI CAL SUPPLIES CHARGED TO PATI ENTS 59. 00 07200   MEDI CAL SUPPLIES CHARGED TO PATI ENTS 59. 00 07200   MEDI CAL SUPPLIES CHAR		· ·	-1		1
54. 02   03440   MAMMOGRAPHY					1
55.00   05500   RADIO LOGY-THERAPEUTIC   1, 933, 365   55.00   56.00   SOSOO   RADIO STOTPE   1, 230, 718   55.00   57.00   57.00   57.00   57.00   57.00   57.00   57.00   57.00   57.00   57.00   57.00   57.00   57.00   57.00   57.00   57.00   58.00					1
56. 00   05-00   RADI OI SOTOPE   1, 230, 718   56. 00		1	1		1
57. 00   05700   CT SCAN   1, 339, 818   57. 00		1	1		1
58.00   05800   MACNETI C RESONANCE I IMAGING (MRI )   589, 664   59, 00   05900   CARDIAC CATHETERI ZATI (ON		1	1		1
59,00   05900   CARDI AC CATHETERI ZATI ON   1,076,987   60.00   06000   CABORATORY   4,316,500   60.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   914,511   62.00   06500   RESPI RATORY THERAPY   2,160,157   65.00   06500   RESPI RATORY THERAPY   2,808,842   66.00   06900   06900   ELECTROCARDI OLOGY   1,301,221   69.00   07000   ELECTROCARDI OLOGY   1,301,221   70.00   07000   ELECTROCARDI OLOGY   1,301,221   70.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   8,797,239   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   9,480,464   72.00   73.00   7300   DRUGS CHARGED TO PATI ENTS   14,264,494   73.00   7300   DRUGS CHARGED TO PATI ENTS   909,478   74.00   74.00   7500   RENAL DI ALYSI S   909,478   74.00   7500   03950   LI THOTRI PSY   305,910   76.00   03950   LI THOTRI PSY   1,491,783   76.01   76.00   03050   MURD CARE   1,081,674   76.03   03050   MURD CARE   1,083,674   76.03   03050   MURD CARE   1,083,674   76.03   03050   MURD CARE   1,083,674   76.00   76.00   03000   DRESERVATI ON BEDS (NON-DISTINCT PART)   76.01   76.02   03000   DRESERVATI ON BEDS (NON-DISTINCT PART)   76.01   76.02   03000   DRESERVATI ON BEDS (NON-DISTINCT PART)   76.01   76.02   03000   DRESERVATI ON BEDS (NON-DISTINCT PART)   76.02   03000   DRESERVATI ON BEDS (NON-DISTINCT PART)   76.03   03000   DRESERVATI ON BEDS (NON-DISTINCT PART)   76.04   03000   0		1	1		1
60.00   66000   LABORATORY   4, 316, 500   62.00   66200   WHOLE BLOOD & PACKED RED BLOOD CELLS   914, 511   62.00   662.00   665.00   66500   RESPI RATORY THERAPY   2, 160, 157   65.00   666.00   66600   PHYSI CAL THERAPY   2, 808, 842   66.00   666.00   66600   PHYSI CAL THERAPY   2, 808, 842   66.00   66.00   60600   PHYSI CAL THERAPY   2, 808, 842   66.00   60			1		1
62. 00 66200 WHOLE BLOOD & PACKED RED BLOOD CELLS 914, 511 62. 00 665. 00 06500 RESPI RATORY THERAPY 2, 160, 157 65. 00 06600 PHYSI CAL THERAPY 2, 808, 842 66. 00 06900 ELECTROCARDI OLOGY 1, 301, 221 69. 00 07000 ELECTROCARDI OLOGY 1, 301, 221 70. 00 07000 ELECTROCARDI OLOGY 1, 301, 221 70. 00 07100 WEDI CAL SUPPLIES CHARGED TO PATI ENTS 8, 797, 239 71. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 9, 480, 464 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 14, 264, 494 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 909, 478 73. 00 07300 DRUGS CHARGED TO PATI ENTS 909, 478 74. 00 07400 RENAL DI ALYSI S 909, 478 74. 00 07400 RENAL DI ALYSI S 909, 478 74. 00 07400 RENAL DI ALYSI S 909, 478 76. 01 3030 CRUS CHARGED TO PATI ENTS 9, 480, 464 76. 01 30300 PRUS CORPY 1, 491, 793 76. 01 76. 01 30300 PRUS CORPY 1, 491, 793 76. 01 76. 01 03300 ENGOSCOPY 1, 491, 793 76. 01 76. 01 03300 ENGOSCOPY 1, 491, 793 76. 01 76. 02 03040 PRI SI ON CLI NI C 685, 464 76. 03 03060 (PI C 1, 081, 612 76. 04 00 00 00 00 00 00 00 00 00 00 00 00		1 1	1		1
65. 00   06500   RESPIRATORY THERAPY   2, 160, 157   66. 00   066. 00   06600   PHYSI CAL THERAPY   2, 808, 842   66. 00   06900   ELECTROCARDI OLOGY   1, 301, 221   69. 00   07000   ELECTROENCEPHALOGRAPHY   155, 357   70. 00   07000   ELECTROENCEPHALOGRAPHY   155, 357   70. 00   07000   ELECTROENCEPHALOGRAPHY   155, 357   70. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   8, 797, 239   71. 00   07300   DRUGS CHARGED TO PATIENTS   9, 480, 464   72. 00   07300   DRUGS CHARGED TO PATIENTS   14, 264, 494   944   947   74. 00   07400   RENAL DI ALYSIS   909, 478   74. 00   07400   RENAL DI ALYSIS   909, 478   74. 00   07400   RENAL DI ALYSIS   909, 478   76. 01   07330   ENDOSCOPY   1, 491, 783   76. 01   07330   ENDOSCOPY   1, 491, 783   76. 01   075, 02   075		1 1	1		1
66. 00   66600   PHYSI CAL THERAPY   2, 808, 842   66. 00   69. 00   6900   ELECTROCARDIOLOGY   1, 301, 221   70. 00   70. 00   07000   ELECTROCARDIOLOGY   155, 357   70. 00   70. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   155, 357   70. 00   70. 00   07000   MEDI CAL SUPPLIES CHARGED TO PATIENTS   8, 797, 239   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   9, 480, 464   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   14, 264, 494   73. 00   07400   RENAL DIALYSIS   909, 478   74. 00   76. 00   03950   LITHOTRI PSY   305, 910   76. 00   03950   LITHOTRI PSY   76. 01   76. 02   03040   PRI SION CLINIC   685, 464   76. 03   03050   WINDOCOPY   1, 491, 783   76. 01   76. 02   03060   OPI C   1, 081, 612   00000   09100   EMERGENCY   09100   EMERGENCY   09100   EMERGENCY   09100   EMERGENCY   09100   EMERGENCY   09200   OBSERVATI ON BEDS (NON-DI STINCT PART)   92. 00   09200   OBSERVATI ON BEDS (NON-DI STINCT PART)   92. 00   13000   INTERST EXPENSE   113. 00   113. 00   11300   INTERST EXPENSE   113. 00   19000   GHERST EXPENSE   113. 00   19000   OHYSTI ENT SERVI CE OST CENTERS   190. 00   19000   PHYSI CI ANS' PRI VATE OFFICES   0   192. 00   19200   PHYSI CI ANS' PRI VATE OFFICES   0   194. 00   07950   OCCUPATI ONAL MEDI CI NE   1, 498, 307   194. 01   07951   UNOCCUPI ED SPACE/NONALLOWABLE MEALS   954, 469   194. 01   194. 02   07952   SI TTERS   428, 961   07952   SI TTERS   0   0   00000   000000   00000   000000		1	1		1
69. 00 6900 ELECTROCARDI OLOGY 1, 301, 221 70. 00 7000 ELECTROENCEPHALOGRAPHY 155, 357 70. 00 7000 ELECTROENCEPHALOGRAPHY 155, 357 71. 00 7000 ELECTROENCEPHALOGRAPHY 155, 357 71. 00 7000 ELECTROENCEPHALOGRAPHY 155, 357 71. 00 70. 00 FLORE CHARGED TO PATIENTS 9, 480, 464 72. 00 72. 00 FLORE CHARGED TO PATIENTS 14, 264, 494 74. 00 7400 RENAL DI ALYSIS 90, 478 73. 00 73.00 73.00 73.00 73.00 FLORE CHARGED TO PATIENTS 14, 264, 494 74. 00 7400 RENAL DI ALYSIS 90, 478 74. 00 74. 00 7400 RENAL DI ALYSIS 90, 478 74. 00 76. 01 03330 ENDOSCOPY 1, 491, 783 76. 01 03330 ENDOSCOPY 1, 491, 783 76. 01 03040 PRI SI ON CLINIC 685, 464 76. 02 76. 03 03040 PRI SI ON CLINIC 685, 464 76. 02 76. 03 03050 WOUND CARE 1, 081, 612 76. 04 000 FLORE CHARGED TO PATIENTS 1, 081, 612 76. 04 000 FLORE CHARGED TO PATIENTS 90, 480, 464 76. 03 76. 04 000 FLORE CHARGED TO PATIENTS 90, 400 FLORE CHARGED TO PATIENTS	66. 00	1 1	1		1
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   8, 797, 239   72. 00   70200   IMPL. DEV. CHARGED TO PATIENTS   9, 480, 464   72. 00   70200   IMPL. SEV. CHARGED TO PATIENTS   9, 480, 464   73. 00   73. 00   73. 00   74	69. 00	1 1	1		69. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   9, 480, 464   72. 00   73. 00   73.00   73.00   73.00   73.00   73.00   73.00   73.00   74.0	70.00	07000 ELECTROENCEPHALOGRAPHY	155, 357		70.00
73. 00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 797, 239		71. 00
74. 00 07400 RENAL DI ALYSI S 909, 478 76. 00 76. 00 03950 LI THOTRI PSY 305, 910 76. 00 76. 01 03330 ENDOSCOPY 1, 491, 783 76. 01 03030 ENDOSCOPY 1, 083, 674 76. 03 03050 ENDOSCOPY 1, 083, 674 76. 03 03050 ENDOSCOPY 1, 083, 674 76. 03 03050 ENDOSCOPY 1, 083, 674 76. 04 03060 ENDOSCOPY 1, 083, 674 76. 04 03060 ENDOSCOPY 1, 083, 674 76. 04 03050 ENDOSCOPY 1, 083, 674 76. 03 03050 ENDOSCOPY 1, 083, 674 76. 04 03050 ENDOSCOPY 1, 083, 674 1, 083, 67	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	9, 480, 464		72. 00
76. 00 03950 LITHOTRIPSY 305, 910 76. 00 76. 01 03330 ENDOSCOPY 1, 491, 783 76. 01 76. 02 03040 PRISION CLINIC 685, 464 76. 03 03050 WOUND CARE 1, 083, 674 76. 03 76. 04 03060 OPIC 1, 081, 612 76. 04 03060 OPIC	73.00	07300 DRUGS CHARGED TO PATIENTS	14, 264, 494		73. 00
76. 01	74.00	07400 RENAL DIALYSIS	909, 478		74.00
76. 02 76. 03 03040 PRISION CLINIC 76. 03 03050 WOUND CARE 1, 083, 674 76. 04 03060 OPIC 0UTPATIENT SERVICE COST CENTERS  91. 00 92. 00 92. 00 92. 00 92. 00 92. 00 92. 00 92. 00 113. 00 113. 00 113. 00 118. 00 118. 00 119. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 00 192. 00 192. 00 192. 00 194. 00 1950 OCCUPATIONAL MEDICINE 1950 OCCUPATIONAL MEDICINE 1960 OCCUPATIONAL MEDICINE 1970	76.00	03950 LI THOTRI PSY	305, 910		76. 00
76. 03 76. 04 03060 OPI C 0UTPATI ENT SERVI CE COST CENTERS  91. 00 92. 00 09100 EMERGENCY 092. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) SPECIAL PURPOSE COST CENTERS  113. 00 118. 00 118. 00 NONREI MBURSABLE COST CENTERS  190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 192. 00 194. 00 1950 OCCUPATI ONAL MEDI CI NE 194. 00 1950 OCCUPATI ONAL MEDI CI NE 194. 00 1951 TERS 196. 00 1975 OCCUPATI ONAL MEDI CI NE 1975 OCCUPATI ONAL MEDI CI	76. 01	03330 ENDOSCOPY	1, 491, 783		76. 01
76. 04   03060   OPI C   1,081,612   76. 04   OUTPATIENT SERVICE COST CENTERS   91. 00   O9200   OBSERVATION BEDS (NON-DISTINCT PART)   92. 00   SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   118. 00   SUBTOTALS (SUM OF LINES 1-117)   106,662,362   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   91,732   190. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   192. 00   194. 00   07950   OCCUPATI ONAL MEDI CINE   1,498,307   194. 01   07951   UNOCCUPI ED SPACE/NONALLOWABLE MEALS   954,469   194. 01   194. 02   07952   SI TTERS   428,961   194. 02   200. 00   Negative Cost Centers   0   Negative Cost Centers   0   201. 00   000   Negative Cost Centers   0   000	76. 02	03040 PRISION CLINIC	685, 464		76. 02
OUTPATI ENT SERVICE COST CENTERS   91. 00   92. 00   992.00   99	76. 03	03050 WOUND CARE	1, 083, 674		76. 03
91. 00 92	76. 04	03060 OPI C	1, 081, 612		76. 04
92. 00    92. 00   9200   08SERVATI ON BEDS (NON-DI STI NCT PART)   92. 00					
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   113.00   118.00   SUBTOTALS (SUM OF LINES 1-117)   106,662,362   118.00   NONREI MBURSABLE COST CENTERS   190.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   91,732   190.00   192.00   19200   194.00   07950   OCCUPATI ONAL MEDI CINE   1,498,307   194.00   194.01   07951   UNOCCUPIED SPACE/NONALLOWABLE MEALS   954,469   194.01   194.02   07952   SI TTERS   428,961   194.02   200.00   Negative Cost Centers   0   Negative Cost Centers   0   201.00			5, 611, 216		1
113.00	92.00				92. 00
118.00   SUBTOTALS (SUM OF LINES 1-117)   106,662,362   118.00   NONREI MBURSABLE COST CENTERS   190.00   19200   GIFT, FLOWER, COFFEE SHOP & CANTEEN   91,732   192.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   192.00   194.00   07950   UNOCCUPATI ONAL MEDI CI NE   1,498,307   194.01   07951   UNOCCUPI ED SPACE/NONALLOWABLE MEALS   954,469   194.01   194.02   07952   SI TTERS   428,961   194.02   200.00   Cross Foot Adjustments   0   0   0   0   0   0   0   0   0					
NONRE   MBURSABLE COST CENTERS   190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   91,732   190. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   192. 00   194. 00   07950   0CCUPATI ONAL MEDI CI NE   1,498,307   194. 01   07951   UNOCCUPI ED SPACE/NONALLOWABLE MEALS   954,469   194. 01   194. 02   07952   SI TTERS   428,961   194. 02   200. 00   Cross Foot Adjustments   0   0   0.00					1
190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   91,732   0   192. 00   19200	118. 00		106, 662, 362		<b></b> 118. 00
192. 00					1
194. 00   07950   0CCUPATI ONAL MEDI CI NE					
194. 01     07951     UNOCCUPI ED SPACE/NONALLOWABLE MEALS     954, 469       194. 02     07952     SI TTERS     428, 961       200. 00     Cross Foot Adjustments     0       201. 00     Negative Cost Centers     0			1		
194. 02     07952     SI TTERS     428, 961     194. 02       200. 00     Cross Foot Adjustments     0     200. 00       201. 00     Negative Cost Centers     0     201. 00					
200.00         Cross Foot Adjustments         0         200.00           201.00         Negative Cost Centers         0         201.00		1			
201.00   Negative Cost Centers   0   201.00		1	1		1
			1		
202.00    TOTAL (sum lines 118-201)   109, 635, 831    202.00					
	202.00	D   IUIAL (SUM LINES 118-201)	109, 635, 831		J202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0046

					То	08/31/2017	Date/Time Prep 1/27/2018 2:1	
				CAPI TAL REI	ATED COSTS		1/2//2018 2. 1	J DIII
				DI DO A FLAT	10/01 5 50/11 5		511D1 01/55	
		Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs	1.00	0.00			
	CENED	AL SERVICE COST CENTERS	0	1. 00	2.00	2A	4. 00	
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	0	31, 615		66, 647	66, 647	4. 00
5. 00 7. 00		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	2, 161, 145	249, 736 704, 583		2, 687, 607 1, 485, 314	9, 791 1, 402	5. 00 7. 00
8.00		LAUNDRY & LINEN SERVICE	0	29, 853		62, 933	0	8. 00
9. 00	1	HOUSEKEEPI NG	0	10, 741		22, 643	1, 624	9. 00
10.00	1	DI ETARY	0	48, 763		102, 797	794	10.00
11. 00 13. 00		CAFETERIA NURSING ADMINISTRATION	98	31, 101 8, 346		65, 563 17, 692	324 1, 131	11. 00 13. 00
16. 00		MEDICAL RECORDS & LIBRARY	10, 629			111, 951	85	16. 00
		ENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	5, 104 496			1, 115, 219 189, 401	10, 184 3, 627	30. 00 31. 00
40.00		SUBPROVI DER - I PF	213	80, 901		170, 759	3, 246	
41.00		SUBPROVI DER - I RF	7	96, 178		202, 757	1, 339	
43. 00		NURSERY	0	8, 802	9, 753	18, 555	267	43. 00
50. 00	O5000	LARY SERVICE COST CENTERS OPERATING ROOM	228	212, 649	235, 631	448, 508	6, 321	50. 00
51. 00		RECOVERY ROOM	13			28, 005	872	
52.00		DELIVERY ROOM & LABOR ROOM	1, 029	60, 550		128, 673	1, 530	
53.00		ANESTHESI OLOGY	0	110 173		0	1 7/5	53. 00
54. 00 54. 01		RADI OLOGY-DI AGNOSTI C ULTRA SOUND	0	110, 173 3, 423		232, 253 7, 216	1, 765 317	54. 00 54. 01
54. 02	1	MAMMOGRAPHY	0	12, 604		26, 570	240	
55. 00		RADI OLOGY-THERAPEUTI C	0	52, 077	57, 705	109, 782	1, 093	
56. 00 57. 00	1	RADI OI SOTOPE CT SCAN	0	6, 256 13, 506		13, 188	335 930	
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	0	8, 768		28, 472 18, 484	413	
59. 00		CARDI AC CATHETERI ZATI ON	0	19, 332		40, 753	976	
60.00	1	LABORATORY	0	45, 121		95, 119	2, 163	
62. 00 65. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELLS RESPIRATORY THERAPY	0	2, 698 13, 818		5, 687 29, 129	33 1, 928	
66.00	1	PHYSI CAL THERAPY	117	114, 532		241, 559	1, 994	
69. 00	06900	ELECTROCARDI OLOGY	0	18, 480	20, 477	38, 957	864	1
70.00		ELECTROENCEPHALOGRAPHY	0	9, 190		19, 373	86	70.00
71. 00 72. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	0	71, 585 0	1	150, 907 0	694 0	71. 00 72. 00
73. 00		DRUGS CHARGED TO PATIENTS	Ö	22, 637		47, 720	2, 633	
74. 00	07400	RENAL DIALYSIS	0	3, 979	4, 409	8, 388	0	74. 00
76. 00 76. 01		LI THOTRI PSY ENDOSCOPY	0	14 220		24 212	0	76. 00 76. 01
76. 01		PRISION CLINIC	0	16, 229 63, 231		34, 212 133, 295	933 243	76. 01
76. 03	1	WOUND CARE	0			30, 711	119	
76. 04	03060		0	32, 248	35, 733	67, 981	780	76. 04
91. 00		TIENT SERVICE COST CENTERS EMERGENCY	3, 282	86, 677	96, 044	186, 003	3, 503	91. 00
	1	OBSERVATION BEDS (NON-DISTINCT PART)	3, 202	00,077	70, 044	0	3, 303	92.00
	SPECI.	AL PURPOSE COST CENTERS						
	1	INTEREST EXPENSE	0.400.074	0 000 500	0.045.040	0 400 700	/ / 570	113. 00
118. 00		SUBTOTALS (SUM OF LINES 1-117) MBURSABLE COST CENTERS	2, 182, 361	2, 992, 503	3, 315, 919	8, 490, 783	64, 579	118.00
190. 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5, 117	5, 671	10, 788	43	190. 00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
		OCCUPATIONAL MEDICINE UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	31, 615		66, 647 25, 166	· ·	194. 00 194. 01
		SITTERS	10	25, 166 0		25, 166 10		194. 01
200.00	1	Cross Foot Adjustments				o		200. 00
201.00		Negative Cost Centers		0	0	O	0	201. 00
202.00	기	TOTAL (sum lines 118-201)	2, 182, 371	3, 054, 401	3, 356, 622	8, 593, 394	66, 647	1202.00

Provider CCN: 15-0046

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 09/01/2016 Part II
To 08/31/2017 Date/Time Prepared: 1/27/2018 2:15 pm

CONTROLLED   CON					'	0 00/31/201/	1/27/2018 2:1	
SEMERAL SERVICE COST CENTERS		Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		
GINERAL SERVICE COST CRITERS		·	& GENERAL	PLANT	LINEN SERVICE			
1.00   100			5. 00	7.00	8. 00	9. 00	10.00	
2,00								
4, 00   00400   DIPLOTE BENETIS DEPARTMENT   2,697,398								
5.00   00500   ADM IN STRATIVE & GENERAL   2.697, 398   1.697, 607   7.00   00700   OPERATION OF PLANT   170, 891   1.697, 607   0.800   0.8000   LANDRAY & LI NEN SERVICE   18, 763   23, 924   105, 620   82, 112   9.00   0.0000   OTERATION OF PLANT   1.00   0.1000   OTERATION   1.00   0.1000   OTERATION OF PLANT   1.00   0.1000   OTERATION   1.00		l l						
7. 00         00700   OPERATION OF PLANT         170, 891         1, 657, 607         0         23, 924         105, 620         8, 112         9, 00         9, 00         00900   IOUSEKEEPI NG         49, 238         8, 607         0         0         82, 112         9, 00         9, 00         10, 100								
8. 00 00600   LAINDRY & LI INEN SERVICE   18, 763   23, 924   105, 620   82, 112   9. 00   9. 00 00600   BUSEKEEP INFO   19, 90   10, 100   10000   BUSEKEEP INFO   10, 90   10, 100   10000   BUSEKEEP INFO   10, 90   10,			1 1					1
9,00   00900  HOUSEKEPINK   49,238   8,607   0   82,1112   9,000   11.00   01100  CAFTERIA   49,768   24,923   0   1,275   0   11,100   11.00   01100  CAFTERIA   9,768   24,923   0   1,275   0   11,100   13.00   01300  MURSI NA ADMINISTRATION   27,7791   6,689   0   342   0   13,000   16.00   01600  MUSI NA RECORDS & LIBRARY   37,7791   8,648   0   340   10,000   10.00   10000  MEDICAL RECORDS & LIBRARY   37,7791   38,5177   0   1,971   0   16,00   10000  MUSI NA FEDILARINGS   313,002   42,000   0   11,100   32,500   10000  MUSI NA FEDILARINGS   313,002   42,000   0   11,100   32,674   5,931   30,00   10000  MUSI NA FEDILARINGS   313,002   42,000   0   11,100   3,000   10000  MUSI NA FEDILARINGS   313,002   42,000   0   11,100   3,000   10000  MUSI NA FEDILARINGS   313,002   42,000   0   0   0   0   11.00   01000  SUBPROVI DER - I PF   0.516,002   71,811   11,619   3,674   5,933   30,00   11.00   01000  SUBPROVI DER - I PF   38,748   77,074   0,499   3,943   9,450   41,00   11.00   01100  SUBPROVI DER - I PF   38,748   77,074   0,499   3,943   9,450   41,00   11.00   01100  SUBPROVI DER - I RF   38,748   77,074   0,499   3,943   9,450   41,00   11.00   01100  SUBPROVI DER - I RF   38,748   77,074   0,499   3,943   9,450   41,00   11.00   01100  SUBPROVI DER - I RF   38,748   77,074   0,499   3,943   9,450   41,00   11.00   01100  SUBPROVI DER - I RF   38,748   77,074   0,499   3,943   9,450   41,00   11.00   01100  SUBPROVI DER - I RF   38,748   77,074   0,499   3,943   9,450   41,00   11.00   01100  SUBPROVI DER - I RF   38,748   77,074   0,499   3,943   9,450   41,00   11.00   01100  SUBPROVI DER - I RF   38,748   77,074   0,499   3,943   9,450   41,00   11.00   01100  SUBPROVI DER - I RF   38,748   77,074   0,499   3,943   9,450   41,00   11.00   01100  SUBPROVI DER - I RF   38,748   77,074   0,640   0,6		1 1	170, 891		1			
10.00   01000   DIETARY   46, 514   39, 078   0   1, 999   191, 182   10.00   10.00   10.00   CAFETERIA   9, 768   24, 923   0   1, 276   01.10   01.30   01300   NURSI NR ADMINISTRATION   27, 791   6, 669   0   342   0   13.00   10.00								
11.00   01100   CAFETERIA   9, 768   24, 923   0   1,275   0   11.00     10.00   NIRSI MAG ADMINISTRATION   27,791   6, 699   0   342   0   13.00     10.00   NIRSI MAG ADMINISTRATION   27,791   38,517   0   1,971   0   10.00					1			1
13. 00   01500 NURSING ADMINISTRATION   27, 791   6, 699   0   342   015, 00   10.					l .			
10. 00					1			1
INPATI ENT ROUTINE SERVICE COST CENTERS   310.00   03100   AULTS & PEDIATRICS   313.692   422,004   61,185   21,592   74,561   30.00   310.00   03100   INTENSIVE CARE UNIT   101,472   71,811   11,619   3,674   5,583   31.00   04.00   04000   SUBPROVID DET - IPF   85,628   64,832   24,212   3,317   25,484   40.00   41.00   04100   SUBPROVID ER - IPF   85,628   64,832   24,212   3,317   25,484   40.00   41.00   04100   SUBPROVID ER - IPF   85,628   64,832   24,212   3,317   25,484   40.00   41.00   04100   SUBPROVID ER - IPF   85,628   64,832   24,212   3,317   25,484   40.00   41.00					1			1
30.00   030000   ADULTS & PEDIATRICS   313,692   422,004   11,619   3,674   5,983   31.00   03100   NIFERSINE CARE UNIT   101,472   71,811   11,619   3,674   5,983   31.00   03100   SUBPROVI DER - I PF   85,628   64,832   24,212   3,317   25,484   40.00   43.00   43.00   43.00   SUBPROVI DER - I PF   87,748   64,832   24,212   3,317   25,484   40.00   43	16. 00		37, 791	38, 517	0	1, 971	0	16. 00
31 00   03100   INTENSIVE CARE UNIT   101,472   71,811   11,619   3,674   5,883   31.00								
40. 00   0-0000   SUBPROVI DER - I PF   85, 628   64, 832   24, 212   3, 317   25, 484   40 00   43. 00   0-4300   SUBPROVI DER - I PF   87, 748   77, 7074   6, 495   3, 433   9, 450   41. 00   41. 00   41. 00   41. 00   41. 00   41. 00   41. 00   41. 00   41. 00   41. 00   41. 00   41. 00   41. 00   41. 00   41. 00   43. 0					1			1
141.00   04100   SUBPROVI DER - I RF   38, 748   77, 073   2, 109   361   0, 0   43, 00		1						
ABOUT   ABOU								
ANCILLARY SERVICE COST CENTERS								1
50.00   050000   050000   050000   050000   0500000   0500000   0500000   050000   050000   050000   050000   050000   050000   0500000   0500000000	43. 00		8, 448	7, 053	2, 109	361	0	43. 00
51.00   05100   05100   RECOVERY ROOM   2.652   10.641   0   544   0   51.00   0   0   0   0   0   0   0   0   0					1			
S2. 00   05200   DELIVERY ROOM & LABOR ROOM   48, 673   48, 523   0   2, 483   0   52, 00   53. 00   055. 00   055					1			1
S3. 00   05300   AMESTHESI DLOGY   0   0   0   0   0   0   0   53. 00			1		_			
54.00   05400   RADIOLOGY-DIAGNOSTIC   67,795   88,289   0   4,517   0   54,00		1 1	1		i	2, 483		1
SA 01   03430   ULTRA SOUND			-1	ŭ	1	0		
54. 02   03440   MAMMOGRAPHY   9, 231   10, 100   0   517   0   54. 02		1 1			l .			
55.00   05500   RADIO LOGY-THERAPEUTIC		1 1			1			1
56.00   05600   RADIO I SOTOPE   28, 725   5, 013   0   256   0   56, 00   057, 00   05700   CT SCAN   27, 893   10, 823   0   554   0   57, 00   5800   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   12, 626   7, 026   0   359   0   58, 00   05900   CARDI AC CATHETERI ZATI ON   22, 051   15, 492   0   793   0   59, 00   06, 00   06000   LABORATORY   CATHETERI ZATI ON   22, 051   15, 492   0   793   0   59, 00   06, 00   06000   LABORATORY   CATHETERI ZATI ON   22, 051   15, 492   0   711   0   06, 00					1			1
57. 00   05700   CT SCAN   27, 893   10, 823   0   554   0   57, 00					1			
58. 00   05800   MAGNETIC RESONANCE IMAGING (MRI)   12, 626   7, 026   0   359   0   58. 00					1			
59,00   05900   CARDI AC CATHETERIZATION   22,051   15,492   0   793   0   59,00					1			1
60. 00   06000   LABORATORY   96, 706   36, 159   0   1,850   0   60. 00   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   21, 793   2, 162   0   1111   0   62. 00   65. 00   06500   RESPIRATORY THERAPY   50, 025   11, 073   0   567   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   55, 851   91, 782   0   4, 696   0   66. 00   67. 00   06900   ELECTROCARDI OLOGY   28, 372   14, 809   0   758   0   69. 00   67. 00   07000   ELECTROENCEPHALOGRAPHY   2, 723   7, 364   0   377   0   70. 00   67. 00   07000   MEDI CAL SUPPLIES CHARGED TO PATIENTS   205, 883   57, 366   0   2, 935   0   71. 00   67. 00   07300   DRUGS CHARGED TO PATIENTS   231, 895   0   0   0   0   0   67. 00   07300   DRUGS CHARGED TO PATIENTS   341, 260   18, 140   0   928   0   73. 00   67. 00   03950   LITHOTRIPSY   7, 346   0   0   0   0   0   67. 01   03330   ENDOSCOPY   32, 685   13, 006   0   665   0   67. 02   03340   PRIS ION CLINIC   9, 962   50, 671   0   2, 592   0   76. 02   67. 03   03050   WOUND CARE   24, 096   11, 675   0   597   0   76. 03   67. 04   03060   OPI C   0   0   0   0   0   0   67. 04   03060   OPI C   0   0   0   0   67. 05   07500   DERREGENCY   0   0   0   0   0   67. 04   03060   OPI C   0   0   0   0   0   67. 05   07500   07500   07500   07500   07500   07500   67. 07. 08   07500   07500   07500   07500   07500   67. 08   07500   07500   07500   07500   07500   67. 09   07500   07500   07500   07500   07500   07500   67. 00   07500   07500   07500   07500   07500   07500   07500   67. 00   075					l .			1
62.0 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 21,793 2,162 0 1111 0 62.00 65.00 06500 RESPIRATORY THERAPY 50.025 11.073 0 567 0 65.00 66.00 06600 PHYSI CAL THERAPY 55.025 11.073 0 567 0 65.00 66.00 06600 PHYSI CAL THERAPY 55.851 91,782 0 4,696 0 66.00 69.00 06900 ELECTROCARDI OLOGY 28,372 14,809 0 758 0 69.00 70.00 07000 ELECTROCARDI OLOGY 28,372 14,809 0 758 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 205,883 57,366 0 2,935 0 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 205,883 57,366 0 2,935 0 71.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 231,895 0 0 0 0 0 72.00 IMPL. DEV. CHARGED TO PATI ENTS 341,260 18,140 0 928 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 341,260 18,140 0 928 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 341,260 18,140 0 928 0 73.00 0 07400 RENAL DI ALYSIS 21,632 3,189 0 163 0 74.00 76.00 03950   LI THOTRI PSY 7,346 0 0 0 0 0 76.00 76.00 76.00 03950   LI THOTRI PSY 7,346 0 0 0 0 0 76.00 76.00 76.00 03950   LI THOTRI PSY 7,346 0 0 0 0 0 76.00 76.00 76.00 03950   LI THOTRI PSY 7,346 0 0 0 0 0 76.00 76.00 76.00 0300 DRUGS COPY 32,685 13,006 0 665 0 76.01 76.00 0300 DRUGS COPY 22,695 25,842 0 1,322 0 76.02 76.03 03050 WOUND CARE 24,096 11.675 0 597 0 76.03 03050 WOUND CARE 24,096 11.675 0 597 0 76.03 03050 WOUND CARE 24,096 11.675 0 597 0 76.03 03060   DITENTI SERVICE COST CENTERS 113.00 11300   NTEREST EXPENSE					1			1
65.00   06500   RESPI RATORY THERAPY   50, 025   11, 073   0   567   0   65.00   66.00   06600   PHYSI CAL THERAPY   55, 851   91, 782   0   4, 696   0   66.00   67.00   06900   ELECTROCARDI OLOGY   28, 372   14, 809   0   758   0   69.00   70.00   07000   ELECTROENCEPHALOGRAPHY   2, 723   7, 364   0   377   0   70.00   71.00   07000   ELECTROENCEPHALOGRAPHY   2, 723   7, 364   0   377   0   70.00   72.00   07000   IMPL DEV. CHARGED TO PATI ENTS   205, 883   57, 366   0   2, 935   0   71.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   231, 895   0   0   0   0   0   74.00   07400   REVAL DI ALYSI   341, 260   18, 140   0   928   0   73.00   76.00   03950   LI THOTRI PSY   7, 346   0   0   0   0   0   0   76.01   03330   ENDOSCOPY   32, 685   13, 006   0   665   0   76.00   76.01   03330   ENDOSCOPY   32, 685   13, 006   0   665   0   76.00   76.02   03040   PRIS ION CLINI C   9, 962   50, 671   0   2, 592   0   76.02   76.03   03050   WOUND CARE   24, 096   11, 675   0   597   0   76.03   76.04   00000   0000   00000   00000   00000   00000   76.04   000000   000000   000000   000000   000000					1			1
66.00   06600   PHYSI CAL THERAPY   55, 851   91, 782   0   4, 696   0   66.00   69.00   06900   ELECTROCARDIOLOGY   28, 372   11, 809   0   758   0   69.00   70.00   07000   ELECTROCARDIOLOGY   28, 372   11, 809   0   758   0   69.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   205, 883   57, 364   0   377   0   70.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   231, 895   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   311, 260   18, 140   0   928   0   73.00   74.00   07400   RENAL DIALYSI S   21, 632   3, 189   0   163   0   74.00   76.00   03950   LITHOTRI PSY   7, 46   0   0   0   0   0   0   76.01   03330   ENDOSCOPY   32, 685   13,006   0   665   0   76.01   76.02   03040   PRI SI ON CLINI C   9, 962   50, 671   0   2, 592   0   76.02   76.03   03050   WOUND CARE   24, 096   11, 675   0   5,97   0   76.02   76.04   03060   OPI C   22, 095   25, 842   0   1, 322   0   76.04   00000000000000000000000000000000000			1		1			1
69. 00			1		1			1
70. 00   07000   ELECTROENCEPHALOGRAPHY   2, 723   7, 364   0   377   0   70. 00   71. 00   7100   0   MEDI CAL SUPPLIES CHARGED TO PATIENTS   205, 883   57, 366   0   2, 935   0   71. 00   72. 00   0   0   0   0   0   0   0   0   0					1			
71. 00		l l	1		1			1
72. 00 07200   IMPL. DEV. CHARGED TO PATIENTS					1		-	1
73. 00		1		57, 366	1	2, 935		1
74. 00				10 140		020		1
76. 00		1			1			1
76. 01 03330 ENDOSCOPY 32, 685 13, 006 0 665 0 76. 01 76. 02 03040 PRI SI ON CLI NI C 9, 962 50, 671 0 2, 592 0 76. 02 76. 03 03050 WOUND CARE 24, 096 11, 675 0 597 0 76. 03 76. 04 03060 PPI C 22, 095 25, 842 0 1, 322 0 76. 04  OUTPATI ENT SERVI CE COST CENTERS  91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)  SPECIAL PURPOSE COST CENTERS  113. 00 11300 I NTEREST EXPENSE  118. 00 SUBTOTALS (SUM OF LI NES 1-117) 2, 651, 464 1, 608, 003 105, 620 80, 606 115, 078  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1, 695 4, 101 0 210 0 190. 01 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 192. 00 194. 00 07950 OCCUPATI ONAL MEDI CI NE 33, 070 25, 336 0 1, 296 0 194. 00 194. 01 07951 UNOCCUPI ED SPACE/NONALLOWABLE MEALS 799 20, 167 0 0 76, 104 194. 01 194. 02 07952 SI TTERS 10, 809 10, 370 0 0 0 0 194. 00 200. 00 Negati ve Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1		3, 189	1	1		
76. 02				12.004	1	-		1
76. 03		1 1			1			1
76. 04 03060 OPI C 0UTPATI ENT SERVICE COST CENTERS  91. 00 09100 EMERGENCY 124, 205 69, 460 0 3, 554 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00  SPECI AL PURPOSE COST CENTERS  113. 00 11300 I NTEREST EXPENSE 113. 00  SUBTOTALS (SUM OF LI NES 1-117) 2, 651, 464 1, 608, 003 105, 620 80, 606 115, 078 118. 00  NONREI MBURSABLE COST CENTERS  190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 1, 695 4, 101 0 210 0 190. 00  192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 192. 00  194. 00 07950 OCCUPATI ONAL MEDI CI NE 33, 070 25, 336 0 1, 296 0 194. 00  194. 01 07951 UNOCCUPI ED SPACE/NONALLOWABLE MEALS 799 20, 167 0 0 76, 104 194. 01  194. 02 079952 SI TTERS 10, 370 0 0 0 0 194. 00  200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					1			
OUTPATIENT SERVICE COST CENTERS   91.00   09100   EMERGENCY   124,205   69,460   0   3,554   0   91.00   92.00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   92.00   SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   118.00   SUBTOTALS (SUM OF LINES 1-117)   2,651,464   1,608,003   105,620   80,606   115,078   118.00   NONREI MBURSABLE COST CENTERS   100.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   1,695   4,101   0   210   0   190.00   192.00   192.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   0   0   0   192.00   194.00   07950   OCCUPATI ONAL MEDI CI NE   33,070   25,336   0   1,296   0   194.00   194.01   194.02   07951   UNOCCUPI ED SPACE/NONALLOWABLE MEALS   799   20,167   0   0   76,104   194.02   200.00   Cross Foot Adjustments   200.00   Negati ve Cost Centers   0   0   0   0   0   0   201.00						i i		
91. 00	70.04		22, 093	23, 642	.[ 0	1, 322	0	70.04
92. 00   9200   OBSERVATI ON BEDS (NON-DISTINCT PART)   92. 00	01 00		124 205	40.440		2 554	^	01 00
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   113.00   INTEREST EXPENSE   113.00   INTEREST EXPENSE   INTEREST   INTERE		1 1	124, 203	09, 400	1	3, 334	U	
113. 00 118. 00	92.00							92.00
118. 00   SUBTOTALS (SUM OF LINES 1-117)   2,651,464   1,608,003   105,620   80,606   115,078   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   1,695   4,101   0   210   0   190. 00   192. 00	112 0		T T		I			112 00
NONREI MBURSABLE COST CENTERS   190. 00   190000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   1,695   4,101   0   210   0   190. 00   192. 00   192.00			2 451 444	1 400 002	105 420	90 404	115 070	
190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   1,695   4,101   0   210   0   190. 00   192. 00   192.0	110.00	MONDEL MOUDS ADLE COST CENTEDS	2, 031, 404	1, 000, 003	103, 620	80, 808	113,076	1110.00
192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   0   192. 00   194. 00   194. 00   194. 01   194. 01   194. 01   194. 01   194. 02   19	100 0		1 405	4 101	1 0	210	^	100 00
194. 00   07950   OCCUPATI ONAL MEDI CI NE   33,070   25,336   0   1,296   0   194. 00   194. 01   07951   UNOCCUPI ED SPACE/NONALLOWABLE MEALS   799   20,167   0   0   0   194. 02   07952   SI TTERS   10,370   0   0   0   194. 02   200. 00   Cross Foot Adjustments   200. 00   Negati ve Cost Centers   0   0   0   0   0   201. 00   0   0   201. 00   0   0   0   0   0   0   0   0   0			1, 693	4, 101		I I		
194. 01 07951 UNOCCUPIED SPACE/NONALLOWABLE MEALS 799 20, 167 0 0 76, 104 194. 01 194. 02 07952 SI TTERS 10, 370 0 0 0 194. 02 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00			22 070	0 2E 224	1	-		
194. 02 07952 SITTERS 10, 370 0 0 194. 02 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 201. 00					1	1, 290		
200.00   Cross Foot Adjustments   200.00   201.00   Negative Cost Centers   0   0   0   0   201.00			1	20, 107				
201.00   Negative Cost Centers   0   0   0   0   201.00			10, 370	U	i o	١	U	
				^	_		0	
202.00    1017/E (30III 111163 110-201)   2,071,370  1,031,001  103,020  02,112  191,102 202.00		1 1 3		1 AE7 AO7	105 620	Ω2 112		
	202.00		2,077,370	1,037,007	103,020	02, 112	171, 102	1202.00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 09/01/2016 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0046

					o 08/31/2017		pared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown	<i>5</i> piii
		11.00	10.00	1/ 00	04.00	Adjustments	
	GENERAL SERVICE COST CENTERS	11. 00	13.00	16. 00	24. 00	25. 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	00500 ADMI NI STRATI VE & GENERAL						5. 00
7. 00 8. 00	00700 OPERATION OF PLANT 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	101, 853	1				11. 00
13. 00 16. 00	01300 NURSI NG ADMI NI STRATI ON	2, 186		100 400			13.00
10.00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	165	ıl U	190, 480	1		16. 00
30. 00	03000 ADULTS & PEDI ATRI CS	19, 667	22, 205	6, 202	2, 066, 511	0	30. 00
31. 00	03100 INTENSIVE CARE UNIT	7, 009	7, 687	2, 502	404, 385	0	31. 00
40. 00	04000 SUBPROVI DER - I PF	6, 272	1	6, 877		0	40. 00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	2, 587 515		631 235		0	41. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	513	1 542	230	36, 063	0	43.00
50.00	05000 OPERATI NG ROOM	12, 215	7, 559	24, 469	856, 016	0	50. 00
51. 00	05100 RECOVERY ROOM	1, 685		3, 473			51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	2, 958	1	953	1	0	52.00
53. 00 54. 00	05400 RADI OLOGY - O5400 RADI OLOGY - O5400 RADI OLOGY - O1400 RADI OLOGY - O1400 RADI OLOGY - O1400 RADI OLOGY	3, 411	-	4, 119	-	0	53. 00 54. 00
54. 01	03630 ULTRA SOUND	613	1	1, 264		Ö	54. 01
54. 02	03440 MAMMOGRAPHY	464	1	613		0	54. 02
55. 00	05500 RADI OLOGY-THERAPEUTI C	2, 112	1	4, 647		0	55. 00
56.00	05600 RADI OI SOTOPE	647	1	3, 541		0	56. 00
57. 00 58. 00	05700 CT SCAN   05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 798 797		15, 010 3, 703		0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 886	1	7, 334		Ö	59. 00
60.00	06000 LABORATORY	4, 180	1	18, 175		0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	64	1	1, 812		0	62. 00
65. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	3, 726	1	4, 940		0	65. 00
66. 00 69. 00	06900 ELECTROCARDI OLOGY	3, 853 1, 670	1	1, 911 4, 909		0	66. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	166	1	392		Ö	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 342	272	11, 263		0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	6, 023			72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	5, 089	0	29, 034 1, 400		0	73. 00 74. 00
76. 00	03950 LI THOTRI PSY			798			76. 00
76. 01	03330 ENDOSCOPY	1, 803	1, 580	5, 407	1	Ō	76. 01
	03040 PRISION CLINIC	470	1	117		0	76. 02
76. 03	03050 WOUND CARE	229		1, 031			
76. 04	03060 OPI C OUTPATI ENT SERVI CE COST CENTERS	1, 507	979	1, 520	122, 026	0	76. 04
91. 00	09100 EMERGENCY	6, 770	0	16, 175	409, 670	0	91. 00
92.00					,	0	92. 00
440.0	SPECIAL PURPOSE COST CENTERS	1	1		T	Г	
113.00	11300 INTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1-117)	97, 857	55, 693	190, 480	8, 311, 433		113. 00 118. 00
110.00	NONREI MBURSABLE COST CENTERS	71,007	55, 693	170, 400	0, 311, 433	0	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	83	0	C	16, 920		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	C	-		192. 00
	0/07950 OCCUPATIONAL MEDICINE 1/07951 UNOCCUPIED SPACE/NONALLOWABLE MEALS	3, 035		C			194. 00 194. 01
	207952 SITTERS	878		C	122, 236 11, 850		194. 01 194. 02
200.00					0		200. 00
201.00		0	0	C	_		201. 00
202.00	TOTAL (sum lines 118-201)	101, 853	55, 831	190, 480	8, 593, 394	0	202. 00

| Peri od: | Worksheet B | From 09/01/2016 | Part | I | To 08/31/2017 | Date/Time Prepared: Provider CCN: 15-0046

				To 08/31/2017   Date/Time Pre	
	Cost Center Description		Total	172772010 2.1	J Dill
			26. 00		
	GENERAL SERVICE COST CENTERS				
	00100 CAP REL COSTS-BLDG & FI				1. 00
	00200 CAP REL COSTS-MVBLE EQU				2. 00
	00400 EMPLOYEE BENEFITS DEPAR				4. 00
	00500 ADMINISTRATIVE & GENERA	L			5. 00
	00700 OPERATION OF PLANT				7.00
	00800 LAUNDRY & LINEN SERVICE				8.00
	00900 HOUSEKEEPI NG				9.00
	01000  DI ETARY  01100  CAFETERI A				10.00
	01300 NURSING ADMINISTRATION				11. 00
	01600 MEDICAL RECORDS & LIBRA	DV			16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COS				10.00
30.00	03000 ADULTS & PEDIATRICS	O CENTERO	2, 066, 511		30.00
	03100 INTENSIVE CARE UNIT		404, 385		31. 00
	04000 SUBPROVI DER - I PF		394, 677		40.00
	04100 SUBPROVI DER - I RF		345, 512		41. 00
	04300 NURSERY		38, 085		43.00
	ANCILLARY SERVICE COST CENTER	RS	•		
50.00	05000 OPERATING ROOM		856, 016		50.00
51.00	05100 RECOVERY ROOM		69, 743		51.00
52.00	05200 DELIVERY ROOM & LABOR R	OOM	237, 196		52. 00
53.00	05300 ANESTHESI OLOGY		0		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C		402, 149		54. 00
	03630 ULTRA SOUND		20, 381		54. 01
	03440 MAMMOGRAPHY		47, 735		54. 02
	05500 RADI OLOGY-THERAPEUTI C		202, 144		55. 00
	05600 RADI OI SOTOPE		51, 705		56. 00
	05700 CT SCAN		85, 480		57. 00
	05800 MAGNETIC RESONANCE I MAG	` '	43, 408		58. 00
	05900 CARDI AC CATHETERI ZATI ON		90, 188		59.00
	06000 LABORATORY	D DLOOD CELLC	254, 352		60.00
	06200 WHOLE BLOOD & PACKED RE	D BLOOD CELLS	31, 662		62.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		101, 467		65. 00 66. 00
	06900 ELECTROCARDI OLOGY		401, 647 90, 977		69.00
	07000 ELECTROENCEPHALOGRAPHY		30, 481		70.00
	07100 MEDICAL SUPPLIES CHARGE	D TO PATIENTS	430, 662		71.00
	07200 I MPL. DEV. CHARGED TO P		237, 918		72.00
	07300 DRUGS CHARGED TO PATIEN		444, 804		73. 00
	07400 RENAL DIALYSIS		34, 773		74. 00
	03950 LI THOTRI PSY		8, 144		76. 00
	03330 ENDOSCOPY		90, 291		76. 01
76. 02	03040 PRISION CLINIC		197, 367		76. 02
76. 03	03050 WOUND CARE		69, 877		76. 03
76. 04	03060 OPI C		122, 026		76. 04
	OUTPATIENT SERVICE COST CENTE	ERS			
	09100 EMERGENCY		409, 670		91. 00
	09200 OBSERVATION BEDS (NON-D	ISTINCT PART)			92. 00
	SPECIAL PURPOSE COST CENTERS				
	11300 INTEREST EXPENSE				113. 00
118. 00		1-117)	8, 311, 433		118. 00
400.05	NONREI MBURSABLE COST CENTERS	OD A CANTEST!	A		100 00
	19000 GIFT, FLOWER, COFFEE SH		16, 920		190. 00
	19200 PHYSI CLANS' PRI VATE OFF	I CE2	120 055		192. 00
	07950 OCCUPATI ONAL MEDI CI NE	OWADLE MEALS	130, 955		194. 00
	07951 UNOCCUPIED SPACE/NONALL	OMARTE MEATS	122, 236		194. 01
	07952 SITTERS		11, 850 0		194. 02
200. 00 201. 00			0		200. 00 201. 00
201.00		1)	8, 593, 394		201.00
202.00	/	17	0, 575, 574		1202.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0046 Peri od: Worksheet B-1 From 09/01/2016 08/31/2017 Date/Time Prepared: 1/27/2018 2:15 pm CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE (SQUARE FEET) (SQUARE FEET BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT 2) (GROSS SALARI ES) 1.00 2.00 5A 5. 00 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 362 293 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 359, 308 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 3,750 3, 750 36, 532, 784 4.00 00500 ADMINISTRATIVE & GENERAL 84. 988. 036 5 00 29 622 29, 622 5 368 141 -24, 647, 795 5 00 7.00 00700 OPERATION OF PLANT 83, 573 83, 573 768, 804 0 5, 384, 249 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 3,541 3, 541 591, 165 8.00 0 00900 HOUSEKEEPI NG 1, 274 1, 274 890, 354 1, 551, 340 9.00 9.00 01000 DI ETARY 10.00 5, 784 5.784 435, 092 1, 465, 528 10 00 11.00 01100 CAFETERI A 3,689 3,689 177, 846 0 307, 766 11.00 01300 NURSING ADMINISTRATION 0 13.00 990 990 620, 157 875, 605 13.00 01600 MEDICAL RECORDS & LIBRARY 5.701 5, 701 46, 683 1, 190, 690 16,00 0 16,00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 62, 462 62, 462 5, 577, 173 0 9, 883, 497 30.00 1, 988, 378 03100 INTENSIVE CARE UNIT 0 3, 197, 078 31.00 10,629 10,629 31.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 9, 596 1, 779, 372 0 40.00 9.596 2, 697, 882 40.00 41.00 11, 408 11, 408 734.038 0 1, 220, 822 41 00 04300 NURSERY 1,044 1,044 43.00 146, 228 266, 183 43.00 ANCILLARY SERVICE COST CENTERS 5, 602, 412 50.00 05000 OPERATING ROOM 25, 223 25, 223 3, 465, 246 0 50.00 05100 RECOVERY ROOM 0 51.00 1,575 1, 575 478.004 713, 684 51.00 05200 DELIVERY ROOM & LABOR ROOM 7, 182 7, 182 839, 062 0 52.00 1, 533, 552 52.00 05300 ANESTHESI OLOGY 53.00 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 13.068 13,068 967.554 2, 136, 017 54.00 54.01 03630 ULTRA SOUND 406 406 173, 782 254, 835 54.01 03440 MAMMOGRAPHY 54.02 1.495 1, 495 131, 602 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 290, 841 54.02 6, 177 6, 177 55.00 05500 RADI OLOGY-THERAPEUTI C 599, 157 1, 280, 496 55.00 56.00 05600 RADI OI SOTOPE 742 742 183, 444 905, 029 56.00 878, 821 05700 CT SCAN 510, 039 57.00 1.602 1,602 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 1,040 1,040 226, 237 397, 807 58.00 05900 CARDI AC CATHETERI ZATI ON 534.976 694, 758 59 00 2.293 2.293 59 00 60.00 06000 LABORATORY 5, 352 5, 352 1, 185, 857 3, 046, 913 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 320 320 18, 203 686, 623 62.00 06500 RESPIRATORY THERAPY 1, 056, 996 65.00 1.639 1.639 1, 576, 128 65.00 06600 PHYSI CAL THERAPY 13, 585 1, 759, 687 13, 585 1, 093, 137 66.00 66,00 69.00 06900 ELECTROCARDI OLOGY 2, 192 2, 192 473, 681 893, 914 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 1,090 1,090 47, 139 85, 802 70.00 8, 491 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 8, 491 380, 609 71 00 6, 486, 753 71 00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 0 7, 306, 304 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2,685 2, 685 1, 443, 785 10, 753, 278 73.00 07400 RENAL DIALYSIS 74.00 472 472 179 681, 566 74.00 03950 LI THOTRI PSY 76 00 0 231, 462 76 00 0 76.01 03330 ENDOSCOPY 1,925 1, 925 511, 579 1,029,793 76.01 03040 PRISION CLINIC 7, 500 0 313, 885 76.02 7.500 133.388 76.02 ol 76.03 03050 WOUND CARE 1.728 1,728 65,003 759, 178 76.03 76.04 03060 OPI C 3,825 3,825 427, 625 696, 146 76.04 OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY 91.00 91.00 10, 281 10, 281 1, 920, 663 0 3, 913, 328 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 354, 951 354, 951 35, 399, 213 -24, 647, 795 83, 540, 817 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 53, 417 190. 00 607 607 23, 475 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192. 00 194. 00 07950 OCCUPATIONAL MEDICINE 3, 750 3, 750 0 1, 041, 922 194. 00 861,071 194. 01 07951 UNOCCUPIED SPACE/NONALLOWABLE MEALS 25, 166 194. 01 0 2.985 194. 02 07952 SI TTERS 249, 025 326, 714 194. 02 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 24, 647, 795 202. 00 202.00 Cost to be allocated (per Wkst. B, 3, 054, 401 3, 356, 622 8.304.368 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 8. 430748 9. 341907 0.227313 0. 290015 203. 00 204.00 Cost to be allocated (per Wkst. B, 2, 697, 398 204. 00 66, 647 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.001824 0. 031739 205. 00 H)

	LLOCATION - STATISTICAL BASIS	TERRE HAUTE REG	Provider CO	°N: 15-0046   F	Peri od:	Worksheet B-1	
C031 F	REDUCATION - STATISTICAL BASIS		Trovider co	F	rom 09/01/2016		
				Т	To 08/31/2017	Date/Time Pre 1/27/2018 2:1	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	J pill
		PLANT	LINEN SERVICE		(MEALS SERVED)	(GROSS	
		(SQUARE FEET)	(TOTAL PATIENT	2)		SALARI ES)	
			DAYS)				
	I	7.00	8.00	9. 00	10.00	11. 00	_
1 00	GENERAL SERVICE COST CENTERS	1			1		1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP					1	1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					1	4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL					1	5. 00
7. 00	00700 OPERATION OF PLANT	245, 348	3			ı	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	3, 541				1	8.00
9.00	00900 HOUSEKEEPI NG	1, 274	0	237, 548	3	1	9. 00
10. 00	01000 DI ETARY	5, 784		5, 784		ı	10.00
11. 00	01100 CAFETERI A	3, 689		3, 689		28, 892, 547	1
13.00	01300 NURSING ADMINISTRATION	990		990		620, 157	1
16.00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	5, 701	0	5, 701	I <u> </u> 0	46, 683	16. 00
30. 00	03000 ADULTS & PEDIATRICS	62, 462	16, 767	62, 462	51, 429	5, 577, 173	30.00
31. 00	03100   NTENSI VE CARE UNI T	10, 629				1, 988, 378	
40. 00	04000 SUBPROVI DER – I PF	9, 596					1
41. 00	04100 SUBPROVI DER - I RF	11, 408				734, 038	
43.00	04300 NURSERY	1, 044	578	1, 044	1 0	146, 228	43.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	25, 223		25, 223		3, 465, 246	1
51.00	05100 RECOVERY ROOM	1, 575		1, 575		478, 004	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	7, 182	1	.,		839, 062	
53.00	05300 ANESTHESI OLOGY	12.00	1			0	
54. 00 54. 01	05400   RADI OLOGY-DI AGNOSTI C   03630   ULTRA SOUND	13, 068				967, 554 173, 782	1
54. 01	03440 MAMMOGRAPHY	1, 495		1, 495		131, 602	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	6, 177		6, 177		599, 157	
56. 00	05600 RADI OI SOTOPE	742		742		183, 444	
57. 00	05700 CT SCAN	1, 602		1, 602		510, 039	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 040	o	1, 040	o	226, 237	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 293		2, 293		534, 976	59.00
60.00	06000 LABORATORY	5, 352				1, 185, 857	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	320				18, 203	
65.00	06500 RESPI RATORY THERAPY	1, 639		,		1, 056, 996	
66. 00 69. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	13, 585 2, 192		13, 585		1, 093, 137	1
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 090		2, 192 1, 090		473, 681 47, 139	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 491		8, 491		380, 609	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0, 171				0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 685	0	2, 685	o o	1, 443, 785	
74.00	07400 RENAL DIALYSIS	472	0	472	0	179	74.00
76. 00	03950 LI THOTRI PSY	C	1		·	0	
	03330 ENDOSCOPY	1, 925		, , ,		511, 579	1
	03040 PRI SI ON CLI NI C	7, 500		·		133, 388	
	03050 WOUND CARE	1, 728		, , ,			76. 03
76. 04	03060 OPI C OUTPATIENT SERVI CE COST CENTERS	3, 825	0	3, 825	5 0	427, 625	76. 04
01 00	09100 EMERGENCY	10, 281	0	10, 281	ıl ol	1, 920, 663	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	10, 201		10, 201	٥	1, 920, 003	92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
113.00	11300 I NTEREST EXPENSE						113. 00
118.00		238, 006	28, 944	233, 191	79, 376	27, 758, 976	
	NONREI MBURSABLE COST CENTERS						1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	607	0	607	· O		190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	C	1	C	-		192. 00
	07950 OCCUPATI ONAL MEDI CI NE	3, 750		3, 750		861, 071	
	07951 UNOCCUPIED SPACE/NONALLOWABLE MEALS	2, 985	0		52, 493		194. 01
200.00	07952 SITTERS   Cross Foot Adjustments		) 	١	η ·	249, 025	200.00
200.00	1 1					1	200.00
202.00	1 1 3	6, 945, 762	862, 857	2, 037, 319	2, 103, 903	533, 097	
202.00	Part I)	3, ,43, 702	332, 337	2,007,017	2, 100, 700	555, 677	
203.00		28. 309837	29. 811256	8. 576452	15. 954493	0. 018451	203. 00
204.00		1, 657, 607	1			101, 853	1
	Part II)		]				
	N III-: 44   4:  : /W 4 D D4	6. 756146	3. 649116	0. 345665	1. 449787	0.003525	1205.00
205.00	1 1	0. 750140	1 0.0.,		1		
205. 00	Unit cost multiplier (wkst. B, Part	0. 730140	9. 9.7.119				

Health Financial Systems TERRE HAUTE REGIONAL HOSPITAL In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0046 Peri od: Worksheet B-1 From 09/01/2016 08/31/2017 Date/Time Prepared: 1/27/2018 2:15 pm Cost Center Description NURSI NG MEDI CAL ADMI NI STRATI ON RECORDS & LI BRARY (DI RECT NURS. (GROSS CHARGES) SALARI ES) 13.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 12, 424, 192 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY 698, 069, 350 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30 00 4 941 419 22, 717, 250 30 00 31.00 03100 INTENSIVE CARE UNIT 1, 710, 467 9, 165, 538 31.00 04000 SUBPROVIDER - IPF 40.00 901, 100 25, 189, 381 40.00 04100 SUBPROVI DER - I RF 2, 310, 130 553.590 41 00 41 00 04300 NURSERY 43.00 120, 706 859, 640 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 1, 681, 958 89, 630, 321 50.00 05100 RECOVERY ROOM 12, 723, 357 51 00 416, 430 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 757, 246 3, 491, 242 52.00 05300 ANESTHESI OLOGY 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 15, 087, 275 54.00 03630 ULTRA SOUND 4, 629, 232 54 01 54.01 0 54.02 03440 MAMMOGRAPHY 2, 245, 316 54.02 05500 RADI OLOGY-THERAPEUTI C 0 17, 021, 301 55.00 55.00 0 05600 RADI OI SOTOPE 12, 969, 304 56.00 56, 00 05700 CT SCAN 54, 983, 436 57.00 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 13, 564, 098 58.00 05900 CARDI AC CATHETERI ZATI ON 59 00 200, 953 26, 864, 974 59.00 66, 576, 871 60.00 06000 LABORATORY 60.00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 6, 639, 188 62 00 17, 679 06500 RESPIRATORY THERAPY 18, 094, 921 65.00 65.00 06600 PHYSI CAL THERAPY 7, 001, 120 66.00 270 66.00 06900 ELECTROCARDI OLOGY 17, 980, 132 69.00 69.00 142,022 07000 ELECTROENCEPHALOGRAPHY 70.00 1, 436, 203 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 60,616 41, 254, 590 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 22, 062, 481 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 106, 690, 818 73.00 74.00 07400 RENAL DIALYSIS 0 5, 127, 940 74.00 76.00 03950 LI THOTRI PSY 2, 924, 730 76.00 03330 ENDOSCOPY 19, 805, 246 76.01 351, 541 76.01 76.02 03040 PRISION CLINIC 3,874 428, 705 76.02 76.03 03050 WOUND CARE 315, 811 3, 777, 071 76.03 03060 OPI C 217, 911 76.04 76.04 5, 569, 446 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 59, 248, 093 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 12, 393, 593 698, 069, 350 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192.00 194. 00 07950 OCCUPATIONAL MEDICINE 0 194.00 0 194. 01 07951 UNOCCUPI ED SPACE/NONALLOWABLE MEALS 0 194.01 194. 02 07952 SI TTERS 30, 599 194 02 Ω 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, 202.00 1, 177, 505 1, 747, 157 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 203 00 0.094775 0.002503 204.00 Cost to be allocated (per Wkst. B, 55, 831 190, 480 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.004494 0.000273 205.00 II)

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0046		Worksheet C
		From 09/01/2016	

To 08/31/2017 Dat	te/Time Prepa 27/2018 2:15	ared:
Title XVIII Hospital	PPS	Pili
Costs		
	tal Costs	
(from Wkst. B, Adj. Disallowance		
Part I, col.		
26)		
1.00 2.00 3.00 4.00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		
30. 00 03000 ADULTS & PEDI ATRI CS 17, 002, 310 17, 002, 310 0	17, 002, 310	30.00
31. 00   03100   I NTENSI VE CARE UNI T 4, 894, 442 4, 894, 442 0	4, 894, 442	31.00
40. 00   04000   SUBPROVI DER - I PF   4, 493, 797   4, 493, 797   0	4, 493, 797	40.00
41. 00   04100   SUBPROVI DER -   RF   2, 224, 525   2, 224, 525   0	2, 224, 525	41.00
43. 00   04300   NURSERY   415, 410   415, 410   0	415, 410	43.00
ANCI LLARY SERVI CE COST CENTERS		
50. 00	8, 608, 786	50.00
51. 00   05100   RECOVERY ROOM   1, 058, 893   1, 058, 893   0	1, 058, 893	51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM   2, 339, 211   2, 339, 211   0	2, 339, 211	52.00
53. 00   05300   ANESTHESI OLOGY   0   0   0	0	53.00
54. 00   05400   RADI 0LOGY - DI AGNOSTI C   3, 293, 139   3, 293, 139   0	3, 293, 139	54.00
54. 01   03630   ULTRA SOUND   358, 510   358, 510   0	358, 510	54. 01
54. 02   03440   MAMMOGRAPHY   438, 382   438, 382   0	438, 382	54.02
55. 00   05500   RADI OLOGY-THERAPEUTI C   1, 933, 365   1, 933, 365   0	1, 933, 365	55.00
56. 00   05600   RADI 0I SOTOPE   1, 230, 718   1, 230, 718   0	1, 230, 718	56.00
57. 00   05700   CT SCAN   1, 339, 818   1, 339, 818   0		57.00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)   589,664   589,664   0		58.00
59. 00   05900   CARDI AC CATHETERI ZATI ON   1, 076, 987   1, 076, 987   0	1, 076, 987	59.00
60. 00   06000   LABORATORY   4, 316, 500   4, 316, 500   0	4, 316, 500	60.00
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   914, 511   914, 511   0	914, 511	62.00
65. 00   06500   RESPI RATORY THERAPY   2, 160, 157   0   2, 160, 157   0	2, 160, 157	65.00
66. 00   06600   PHYSI CAL THERAPY   2, 808, 842   0   2, 808, 842   24, 363	2, 833, 205	66.00
69. 00   06900   ELECTROCARDI OLOGY   1, 301, 221   1, 301, 221   0	1, 301, 221	69. 00
70. 00   07000   ELECTROENCEPHALOGRAPHY   155, 357   155, 357   0	155, 357	70.00
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   8, 797, 239   8, 797, 239   0		71. 00
72. 00   07200   I MPL. DEV. CHARGED TO PATI ENTS   9, 480, 464   9, 480, 464   0		72.00
		73.00
74. 00   07400   RENAL DI ALYSI S   909, 478   909, 478   0		74.00
76. 00   03950   LI THOTRI PSY   305, 910   305, 910   0		76.00
76. 01   03330   ENDOSCOPY   1, 491, 783   1, 491, 783   13, 046		76. 01
76. 02   03040   PRI SI ON CLI NI C   685, 464   685, 464   0		76. 02
76. 03   03050   WOUND CARE   1, 083, 674   1, 083, 674   11, 596		76. 03
76. 04 03060 OPI C 1, 081, 612 1, 081, 612 40, 355	1, 121, 967	76. 04
OUTPATIENT SERVICE COST CENTERS		
91. 00   09100   EMERGENCY   5, 611, 216   5, 611, 216   45, 428		91. 00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   2, 386, 415   2, 386, 415	2, 386, 415	92. 00
SPECIAL PURPOSE COST CENTERS		
113. 00 11300 INTEREST EXPENSE		13. 00
	109, 187, 082 2	
201.00 Less Observation Beds 2, 386, 415 2, 386, 415	2, 386, 415 2	
202.00   Total (see instructions)   106,662,362  0  106,662,362  138,305  10	106, 800, 667 2	202.00

From 09/01/2016 Part I Date/Time Prepared: 08/31/2017 1/27/2018 2:15 pm Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 19, 905, 207 19, 905, 207 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 9, 165, 538 9, 165, 538 31.00 25, 189, 381 04000 SUBPROVIDER - IPF 40.00 25, 189, 381 40.00 41.00 04100 SUBPROVI DER - I RF 2, 310, 130 2, 310, 130 41.00 04300 NURSERY 43.00 859,640 859, 640 43.00 ANCILLARY SERVICE COST CENTERS 42, 931, 700 50 00 05000 OPERATING ROOM 46, 698, 621 89, 630, 321 0.096008 0.000000 50.00 05100 RECOVERY ROOM 8,007,211 4, 716, 146 12, 723, 357 0.083224 0.000000 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 105, 830 3, 491, 242 52.00 3, 385, 412 0.670023 0.000000 52 00 53.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 502, 365 10, 584, 910 15, 087, 275 0. 218273 0.000000 54.00 03630 ULTRA SOUND 3, 512, 077 4, 629, 232 0.000000 54.01 1, 117, 155 0.077445 54.01 54.02 03440 MAMMOGRAPHY 1,027 2, 244, 289 2, 245, 316 0.195243 0.000000 54.02 55.00 05500 RADI OLOGY-THERAPEUTI C 597, 574 16, 423, 727 17, 021, 301 0. 113585 0.000000 55.00 56.00 05600 RADI OI SOTOPE 1, 240, 376 11, 728, 928 12, 969, 304 0.094895 0.000000 56.00 05700 CT SCAN 16, 686, 412 38, 297, 024 54, 983, 436 0.024368 57 00 0.000000 57 00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 3, 012, 517 10, 551, 581 13, 564, 098 0.043472 0.000000 58.00 05900 CARDIAC CATHETERIZATION 0.040089 0.000000 59.00 14, 234, 013 12, 630, 961 26, 864, 974 59.00 06000 LABORATORY 36, 193, 276 66, 576, 871 0.000000 60.00 30, 383, 595 0.064835 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1, 528, 730 0. 137744 62.00 5, 110, 458 6, 639, 188 0.000000 62.00 65.00 06500 RESPIRATORY THERAPY 16, 765, 647 1, 329, 274 18, 094, 921 0.119379 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 5, 471, 629 1, 529, 491 7, 001, 120 0.401199 0.000000 66.00 8, 169, 204 17, 980, 132 69 00 06900 ELECTROCARDI OLOGY 9, 810, 928 0.072370 0 000000 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 660,860 775, 343 1, 436, 203 0.108172 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 24, 692, 610 16, 561, 980 41, 254, 590 0. 213243 0.000000 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 11, 652, 273 10, 410, 208 22, 062, 481 0.429710 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 44, 614, 831 73.00 62, 075, 987 106, 690, 818 0.133699 0.000000 73.00 74.00 07400 RENAL DIALYSIS 4, 946, 228 181, 712 5, 127, 940 0.177357 0.000000 74.00 03950 LI THOTRI PSY 76.00 27,650 2, 897, 080 2, 924, 730 0.104594 0.000000 76.00 76 01 03330 ENDOSCOPY 3, 497, 664 16, 307, 582 19 805 246 0.075323 0.000000 76 01 03040 PRISION CLINIC 76.02 428, 705 428, 705 1.598918 0.000000 76.02 76.03 03050 WOUND CARE 42, 982 3, 734, 089 3, 777, 071 0. 286909 0.000000 76.03 76.04 03060 OPI C 61,023 5, 508, 423 5, 569, 446 0.194205 0.000000 76.04 OUTPATIENT SERVICE COST CENTERS 91.00 42, 804, 535 09100 EMERGENCY 16, 443, 558 59, 248, 093 0.094707 0.000000 91.00 2, 144, 226 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2, 812, 043 0.848641 0.000000 92.00 92.00 667, 817 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 342, 165, 502 355, 903, 848 698, 069, 350 200.00 201.00 Less Observation Beds 201.00

342, 165, 502

355, 903, 848

698, 069, 350

202. 00

202.00

Total (see instructions)

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0046	From 09/01/2016	Worksheet C Part I Date/Time Prepared:

			10 08/31/201/	Date/II me Prepared:   1/27/2018 2:15 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient	THE AVIII		113
cost center bescription	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
30. 00 03000 ADULTS & PEDIATRICS				30.00
31. 00   03100   NTENSI VE CARE UNI T				31. 00
40. 00   04000   SUBPROVI DER - I PF				
				40.00
41. 00   04100   SUBPROVI DER - I RF				41.00
43. 00   04300   NURSERY				43. 00
ANCI LLARY SERVI CE COST CENTERS				
50. 00   05000   OPERATI NG ROOM	0. 096048			50.00
51. 00   05100   RECOVERY ROOM	0. 083224			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 670023			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 218273			54.00
54. 01   03630   ULTRA SOUND	0. 077445			54. 01
54. 02   03440   MAMMOGRAPHY	0. 195243			54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 113585			55.00
56. 00   05600   RADI 0I SOTOPE	0. 094895			56.00
57. 00  05700 CT SCAN	0. 024368			57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 043472			58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	0. 040089			59. 00
60. 00   06000 LABORATORY	0. 064835			60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 137744			62.00
65. 00 06500 RESPIRATORY THERAPY	0. 119379			65. 00
66. 00   06600   PHYSI CAL THERAPY	0. 404679			66. 00
69. 00   06900   ELECTROCARDI OLOGY	0. 072370			69. 00
70. 00   07000   ELECTROENCEPHALOGRAPHY	0. 072370			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 108172			70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 429710			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 133699			73.00
74. 00   07400   RENAL DI ALYSI S	0. 177357			74.00
76. 00   03950   LI THOTRI PSY	0. 104594			76. 00
76. 01   03330   ENDOSCOPY	0. 075981			76. 01
76. 02 03040 PRISION CLINIC	1. 598918			76. 02
76. 03   03050   WOUND CARE	0. 289979			76. 03
76. 04 03060 OPI C	0. 201450			76. 04
OUTPATIENT SERVICE COST CENTERS				
91. 00   09100   EMERGENCY	0. 095474			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 848641			92. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300   NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202.00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1			1

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0046	Peri od: Worksheet C

COMPO	ATTOM OF NATIO OF COSTS TO CHANGES		Provider Co		From 09/01/2016 To 08/31/2017	Part I Date/Time Pre 1/27/2018 2:1	pared: 5 pm
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1			_		
30.00	03000 ADULTS & PEDI ATRI CS	17, 002, 310		17, 002, 31		17, 002, 310	
31. 00	03100 I NTENSI VE CARE UNI T	4, 894, 442		4, 894, 44		4, 894, 442	
40. 00	04000 SUBPROVI DER - I PF	4, 493, 797		4, 493, 79		4, 493, 797	
41. 00	04100 SUBPROVI DER - I RF	2, 224, 525		2, 224, 52		2, 224, 525	
43. 00	04300 NURSERY	415, 410		415, 41	0 0	415, 410	43. 00
	ANCILLARY SERVICE COST CENTERS	0 (05 0(0			0 547	0 (00 70)	
50.00	05000 OPERATI NG ROOM	8, 605, 269		8, 605, 26		8, 608, 786	
51.00	05100 RECOVERY ROOM	1, 058, 893		1, 058, 89		1, 058, 893	
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 339, 211		2, 339, 21		2, 339, 211	52.00
53.00	05300 ANESTHESI OLOGY	0			0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 293, 139		3, 293, 13		3, 293, 139	1
54. 01	03630 ULTRA SOUND	358, 510		358, 51		358, 510	
54. 02	03440 MAMMOGRAPHY	438, 382		438, 38		438, 382	
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 933, 365		1, 933, 36		1, 933, 365	
56.00	05600 RADI OI SOTOPE	1, 230, 718		1, 230, 71		1, 230, 718	
57. 00	05700 CT SCAN	1, 339, 818		1, 339, 81		1, 339, 818	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	589, 664		589, 66		589, 664	
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 076, 987		1, 076, 98		1, 076, 987	
60.00	06000 LABORATORY	4, 316, 500		4, 316, 50		4, 316, 500	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	914, 511		914, 51		914, 511	62.00
65. 00	06500 RESPI RATORY THERAPY	2, 160, 157	0	,		2, 160, 157	
66.00	06600 PHYSI CAL THERAPY	2, 808, 842	0	2, 808, 84		2, 833, 205	
69. 00	06900 ELECTROCARDI OLOGY	1, 301, 221		1, 301, 22		1, 301, 221	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	155, 357		155, 35		155, 357	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 797, 239		8, 797, 23		8, 797, 239	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	9, 480, 464		9, 480, 46		9, 480, 464	
73.00	07300 DRUGS CHARGED TO PATIENTS	14, 264, 494		14, 264, 49		14, 264, 494	
74.00	07400 RENAL DI ALYSI S	909, 478		909, 47		909, 478	
76.00	03950 LI THOTRI PSY	305, 910		305, 91		305, 910	
76. 01	03330 ENDOSCOPY	1, 491, 783		1, 491, 78		1, 504, 829	
76. 02 76. 03	03040 PRISION CLINIC 03050 WOUND CARE	685, 464		685, 46		685, 464	
76. 03		1, 083, 674		1, 083, 67		1, 095, 270	
76. 04	03060 OPI C	1, 081, 612		1, 081, 61	2 40, 355	1, 121, 967	76. 04
91. 00	OUTPATIENT SERVICE COST CENTERS O9100 EMERGENCY	5, 611, 216		5, 611, 21	6 45, 428	5, 656, 644	91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						
92.00	SPECIAL PURPOSE COST CENTERS	2, 386, 415		2, 386, 41	<u>၂</u>	2, 386, 415	92.00
112 00	11300 INTEREST EXPENSE						113. 00
200.00		109, 048, 777	0	109, 048, 77	7 138, 305	109, 187, 082	
200.00	,	2, 386, 415	U	2, 386, 41		2, 386, 415	
201.00		106, 662, 362	0				
202.00	Total (300 matruotions)	100,002,302	0	100, 002, 30.	2 130, 303	100, 000, 007	1202.00

From 09/01/2016 Part I Date/Time Prepared: 08/31/2017 1/27/2018 2:15 pm Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 19, 905, 207 19, 905, 207 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 9, 165, 538 9, 165, 538 31.00 25, 189, 381 04000 SUBPROVIDER - IPF 40.00 25, 189, 381 40.00 41.00 04100 SUBPROVI DER - I RF 2, 310, 130 2, 310, 130 41.00 04300 NURSERY 43.00 859,640 859, 640 43.00 ANCILLARY SERVICE COST CENTERS 42, 931, 700 50 00 05000 OPERATING ROOM 46, 698, 621 89, 630, 321 0.096008 0.000000 50.00 05100 RECOVERY ROOM 8, 007, 211 4, 716, 146 12, 723, 357 0.083224 0.000000 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 105, 830 3, 491, 242 52 00 3, 385, 412 0.670023 0.000000 52 00 53.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 502, 365 10, 584, 910 15, 087, 275 0. 218273 0.000000 54.00 03630 ULTRA SOUND 3, 512, 077 4, 629, 232 0.000000 54.01 1, 117, 155 0.077445 54.01 54.02 03440 MAMMOGRAPHY 1,027 2, 244, 289 2, 245, 316 0.195243 0.000000 54.02 55.00 05500 RADI OLOGY-THERAPEUTI C 597, 574 16, 423, 727 17, 021, 301 0. 113585 0.000000 55.00 56.00 05600 RADI OI SOTOPE 1, 240, 376 11, 728, 928 12, 969, 304 0.094895 0.000000 56.00 05700 CT SCAN 16, 686, 412 38, 297, 024 54, 983, 436 0.024368 57 00 0.000000 57 00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 3, 012, 517 10, 551, 581 13, 564, 098 0.043472 0.000000 58.00 05900 CARDIAC CATHETERIZATION 0.040089 0.000000 59.00 14, 234, 013 12, 630, 961 26, 864, 974 59.00 06000 LABORATORY 36, 193, 276 66, 576, 871 0.000000 60.00 30, 383, 595 0.064835 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1, 528, 730 0. 137744 62.00 5, 110, 458 6, 639, 188 0.000000 62.00 65.00 06500 RESPIRATORY THERAPY 16, 765, 647 1, 329, 274 18, 094, 921 0.119379 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 5, 471, 629 1, 529, 491 7, 001, 120 0.401199 0.000000 66.00 8, 169, 204 17, 980, 132 69 00 06900 ELECTROCARDI OLOGY 9, 810, 928 0.072370 0 000000 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 660,860 775, 343 1, 436, 203 0.108172 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 24, 692, 610 16, 561, 980 41, 254, 590 0. 213243 0.000000 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 11, 652, 273 10, 410, 208 22, 062, 481 0.429710 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 44, 614, 831 73.00 62, 075, 987 106, 690, 818 0.133699 0.000000 73.00 74.00 07400 RENAL DIALYSIS 4, 946, 228 181, 712 5, 127, 940 0.177357 0.000000 74.00 76.00 03950 LI THOTRI PSY 27,650 2, 897, 080 2, 924, 730 0.104594 0.000000 76.00 76 01 03330 ENDOSCOPY 3, 497, 664 16, 307, 582 19 805 246 0.075323 0.000000 76 01 03040 PRISION CLINIC 76.02 428, 705 428, 705 1.598918 0.000000 76.02 76.03 03050 WOUND CARE 42, 982 3, 734, 089 3, 777, 071 0. 286909 0.000000 76.03 76.04 03060 OPI C 61,023 5, 508, 423 5, 569, 446 0.194205 0.000000 76.04 OUTPATIENT SERVICE COST CENTERS 91.00 42, 804, 535 09100 EMERGENCY 16, 443, 558 59, 248, 093 0.094707 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2, 812, 043 0.848641 0.000000 92.00 92.00 667, 817 2, 144, 226 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 342, 165, 502 355, 903, 848 698, 069, 350 200.00 201.00 Less Observation Beds 201.00

342, 165, 502

355, 903, 848

698, 069, 350

202. 00

202.00

Total (see instructions)

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0046	Peri od: From 09/01/2016   Worksheet C Part I To 08/31/2017   Date/Time Prepared: 1/27/2018 2:15 pm

			10 00/31/201/	1/27/2018 2:15 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31. 00   03100   NTENSI VE CARE UNI T				31.00
40. 00   04000   SUBPROVI DER - I PF				40.00
41. 00   04100   SUBPROVI DER -   I RF				41. 00
43. 00   04300   NURSERY				43. 00
ANCI LLARY SERVI CE COST CENTERS				43.00
50. 00 05000 OPERATING ROOM	0. 000000			50.00
51. 00   05100   RECOVERY   ROOM	0. 000000			51.00
	1			52.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM	0.000000			
53. 00 05300 ANESTHESI OLOGY	0. 000000			53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0. 000000			54. 00
54. 01   03630   ULTRA SOUND	0. 000000			54. 01
54. 02   03440   MAMMOGRAPHY	0. 000000			54. 02
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
56. 00   05600   RADI 0I SOTOPE	0. 000000			56. 00
57.00  05700 CT SCAN	0. 000000			57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00   06000   LABORATORY	0. 000000			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
74. 00 07400 RENAL DIALYSIS	0. 000000			74. 00
76. 00 03950 LI THOTRI PSY	0. 000000			76. 00
76. 01 03330 ENDOSCOPY	0. 000000			76. 01
76. 02 03040 PRI SI ON CLI NI C	0. 000000			76. 02
76. 03   03050   WOUND CARE	0. 000000			76. 02
76. 04   03060   OPI C	0. 000000			76. 03
OUTPATIENT SERVICE COST CENTERS	0.000000			70.04
91. 00 09100 EMERGENCY	0.000000			01.00
	0. 000000 0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92. 00
SPECIAL PURPOSE COST CENTERS				112 22
113. 00 11300 I NTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	TERRE HAUTE REGI	ONAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAP	ITAL COSTS	Provider Co	<u> </u>	Period: From 09/01/2016 To 08/31/2017	Date/Time Pre 1/27/2018 2:1	pared: 5 pm
		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 & PEDIATRICS	2, 066, 511	0	2, 066, 51	1 19, 265	107. 27	30.00
31. 00 INTENSIVE CARE UNIT	404, 385		404, 38	3, 184	127. 01	31.00
40. 00 SUBPROVI DER - I PF	394, 677	0	394, 67	6, 635	59. 48	40.00
41. 00 SUBPROVI DER - I RF	345, 512	0	345, 51:	1, 780	194. 11	41.00
43. 00 NURSERY	38, 085		38, 08	5 578	65. 89	43.00
200.00 Total (lines 30-199)	3, 249, 170		3, 249, 170	31, 442		200.00
Cost Center Description	I npati ent	Inpatient				
'	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	9, 342	1, 002, 116				30.00
31. 00 INTENSIVE CARE UNIT	1, 542	195, 849				31.00
40. 00 SUBPROVI DER - I PF	1, 623					40.00
41. 00 SUBPROVI DER - I RF	1, 119					41.00
43. 00 NURSERY	0	l	1			43. 00
200.00 Total (lines 30-199)	13, 626	1	1			200.00

Uool +b	Financial Systems	ERRE HAUTE REG	IATIDOOL IAMAI		la lie	eu of Form CMS-2	DEE2 10
	Financial Systems T FIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C		Period: From 09/01/2016 To 08/31/2017	Worksheet D Part II	pared:
			Ti tl e	XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.		. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCI LLARY SERVI CE COST CENTERS		T	T			
50.00		856, 016					
	05100 RECOVERY ROOM	69, 743		1			
		237, 196				0	
53.00	05300 ANESTHESI OLOGY	0	1	0.00000		0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	402, 149					
54. 01	03630 ULTRA SOUND	20, 381			· ·		
54. 02		47, 735					54. 02
55.00	05500 RADI OLOGY-THERAPEUTI C	202, 144			•		
56. 00		51, 705					
57. 00		85, 480					
58. 00		43, 408					58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	90, 188					•
60.00	06000 LABORATORY	254, 352					
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	31, 662					
65. 00	06500 RESPI RATORY THERAPY	101, 467					
66. 00	06600 PHYSI CAL THERAPY	401, 647		1			
69. 00		90, 977		1			69. 00
	07000 ELECTROENCEPHALOGRAPHY	30, 481		1	•		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	430, 662	41, 254, 590	0. 01043	9 13, 095, 381	136, 703	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	237, 918	22, 062, 481	0. 01078	4 6, 292, 830	67, 862	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	444, 804	106, 690, 818	0. 00416	9 29, 338, 540		
	07400 RENAL DIALYSIS	34, 773		1			
	03950 LI THOTRI PSY	8, 144		1	•		76. 00
76. 01	03330 ENDOSCOPY	90, 291		1			
	03040 PRISION CLINIC	197, 367				_	
7/ 00	DOOF O WOUND CARE	/ 0 077	2 777 071	0 01050	0 24 725	/ / 12	7/ 00

69, 877 122, 026

409, 670

290, 052

5, 352, 315

3, 777, 071 5, 569, 446

59, 248, 093 2, 812, 043

640, 639, 454

0.018500

0. 021910

0.006914

0. 103146

34, 735

16, 086

7, 151, 093

141, 838, 149

389, 370

643 76. 03 352 76. 04

49, 443 91. 00

40, 162 92. 00 1, 028, 024 200. 00

76. 03 03050 WOUND CARE 03060 OPI C

OUTPATIENT SERVICE COST CENTERS
91. 00 09100 EMERGENCY

92. 00 | 09200 | 085ERVATION BEDS (NON-DISTINCT PART) 200. 00 | Total (lines 50-199)

Health Financial Systems T	ERRE HAUTE REG	I ONAL	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS P	rovi der Co	CN: 15-0046	Period: From 09/01/2016 To 08/31/2017	Date/Time Pre 1/27/2018 2:1	
				XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School		Cost	All Other Medical Education Cos		Total Costs (sum of cols. 1 through 3,	
	1.00		2.00	3.00	4. 00	minus col. 4) 5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	1	2.00	3.00	4.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS		1				0	30.00
31. 00   03100   NTENSI VE CARE UNI T	0	()	0			0	31.00
40. 00   04000 SUBPROVI DER -   PF	0		0			0	40.00
41. 00   04100   SUBPROVI DER -   RF	0	ál –	0			0	
43. 00   04300   NURSERY	0	ál –	0			0	
200. 00 Total (Lines 30-199)	0	ál	0		0	_	200. 00
Cost Center Description	Total Patient	Per D	Diem (col.	Inpati ent	Inpatient	- C	200.00
	Days	1	col . 6)	Program Days			
			Í		Pass-Through		
					Cost (col. 7 x		
					col. 8)		
	6. 00		7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00   03000   ADULTS & PEDI ATRI CS	19, 265		0. 00				30.00
31.00 03100 INTENSIVE CARE UNIT	3, 184		0. 00				31. 00
40. 00   04000   SUBPROVI DER - 1 PF	6, 635		0. 00				40. 00
41. 00   04100   SUBPROVI DER - I RF	1, 780		0. 00				41. 00
43. 00   04300   NURSERY	578	1	0. 00		0		43. 00
200.00   Total (lines 30-199)	31, 442	2		13, 62	26 0		200. 00

Health Financial Systems	TERRE HAUTE REGION	AL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0046	Peri od:	Worksheet D
THROUGH COSTS			From 09/01/2016	Part IV   Date/Time Prepared:

THROUGI	n C0313				o 08/31/2017	Date/Time Pre 1/27/2018 2:1	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician Nu	ursing School	Allied Health	All Other	Total Cost	
		Anestheti st	,		Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	0	0	0	50.00
	05100 RECOVERY ROOM	0	0	0	0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
	03630 ULTRA SOUND	0	0	0	0	0	54. 01
	03440 MAMMOGRAPHY	0	0	0	0	0	54. 02
	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
	05600 RADI 0I S0T0PE	0	0	0	0	0	56. 00
57. 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	0	0	0	59. 00
60. 00	06000 LABORATORY	0	0	C	0	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	C	0	0	62. 00
65. 00	06500 RESPI RATORY THERAPY	0	0	C	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	C	0	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	C	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	C	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73. 00
74. 00	07400 RENAL DIALYSIS	0	0	C	0	0	74. 00
76. 00	03950 LI THOTRI PSY	0	0	C	0	0	76. 00
76. 01	03330 ENDOSCOPY	0	0	C	o	0	76. 01
76. 02	03040 PRISION CLINIC	0	0	C	o	0	76. 02
76. 03	03050 WOUND CARE	0	0	C	o	0	76. 03
76. 04	03060 OPI C	0	0	C	o	0	76. 04
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	0	0	C	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	O	C	o	0	92. 00
200. 00	Total (lines 50-199)	0	0	0	o	0	200. 00

	5	EDDE HAUTE DEG	ONAL HOODITAL			6 F 046	2550 40	
APPORT	Financial Systems T IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	ERRE HAUTE REGI VICE OTHER PASS	S Provider C		Period: From 09/01/2016 To 08/31/2017	Date/Time Pre 1/27/2018 2:1	pared:	
	Title XVIII Hospital PPS							
	Cost Center Description	Total	Total Charges			I npati ent		
		Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program		
		Cost (sum of	Part I, col.			Charges		
		col. 2, 3 and	8)	7)	(col . 6 ÷ col .			
		4)	7.00		7)	40.00		
	ANOLLI ADV. CEDVI OF COCT. CENTEDO	6. 00	7. 00	8. 00	9. 00	10. 00		
	ANCILLARY SERVICE COST CENTERS		00 (00 004	0.00000	0 000000	00 407 440	F0 00	
	05000 OPERATING ROOM	0		1		20, 137, 449	1	
	05100 RECOVERY ROOM	0	12, 723, 357			2, 250, 997	51.00	
	05200 DELIVERY ROOM & LABOR ROOM	0	3, 491, 242	1		0	52.00	
53.00	05300 ANESTHESI OLOGY	0	45 007 075			0	53.00	
	05400 RADI OLOGY-DI AGNOSTI C	0	15, 087, 275			2, 303, 523	54.00	
	03630 ULTRA SOUND	0	4, 629, 232	1		528, 654	1	
	03440   MAMMOGRAPHY   05500   RADI OLOGY-THERAPEUTI C	0	2, 245, 316			1, 021 451, 878	54. 02 55. 00	
55. 00 56. 00	05600 RADI OLOGY - THERAPEUTT C	0	17, 021, 301	l .			56.00	
	05700 CT SCAN		12, 969, 304 54, 983, 436	1		846, 864 8, 360, 116		
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0				1, 371, 326	1	
	05900 CARDIAC CATHETERIZATION	0	13, 564, 098 26, 864, 974			8, 475, 217	59.00	
60. 00	06000 LABORATORY		66, 576, 871			15, 257, 656		
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		6, 639, 188	l .		2, 799, 383		
	06500 RESPIRATORY THERAPY		18, 094, 921			9, 600, 581	65.00	
	06600 PHYSI CAL THERAPY		7, 001, 120			1, 634, 748		
	06900 ELECTROCARDI OLOGY	0	17, 980, 132	1		5, 828, 225		
	07000 ELECTROENCEPHALOGRAPHY	0	1, 436, 203	1		323, 753		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41, 254, 590	1		13, 095, 381	71.00	
	07200 IMPL. DEV. CHARGED TO PATIENTS		22, 062, 481	1		6, 292, 830		
	07300 DRUGS CHARGED TO PATIENTS	0	106, 690, 818			29, 338, 540		
	07400 RENAL DIALYSIS	0	5, 127, 940	1		3, 419, 398	1	
76.00	03950 LI THOTRI PSY	0	2, 924, 730	1		27, 650	•	
	03330 ENDOSCOPY	0	19, 805, 246	1		1, 901, 675		
	03040 PRI SI ON CLI NI C	0	428, 705			1, 701, 073	76. 02	
76. 02	03050 WOUND CARE	0	3, 777, 071			34, 735	76. 02	
	03060 OPI C	0	5, 569, 446	1		16, 086		
	OUTDATI FUT CERVI OF COCT OFNITERS	·	2, 22,, 110		2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2	. 5, 666	1	

59, 248, 093 2, 812, 043 640, 639, 454

0

0.000000

0.000000

0.000000

0.000000

7, 151, 093 91. 00

389, 370 92. 00 141, 838, 149 200. 00

OUTPATIENT SERVICE COST CENTERS
91. 00 09100 EMERGENCY

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50-199)

200.00

Health Financial Systems	TERRE HAUTE REGI	ONAL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0046	Peri od: From 09/01/2016 To 08/31/2017	Worksheet D Part IV Date/Time Prepared:

				10 08/31/201/	1/27/2018 2:15 pm
		Title	xVIII	Hospi tal	PPS
Cost Center Description	I npati ent	Outpati ent	Outpati ent		
	Program	Program	Program		
	Pass-Through	Charges	Pass-Through	۱	
	Costs (col. 8		Costs (col.	9	
	x col. 10)		x col. 12)		
	11. 00	12. 00	13. 00		
ANCILLARY SERVICE COST CENTERS			T		
50. 00   05000   OPERATI NG ROOM	0	14, 041, 263		0	50. 00
51. 00   05100   RECOVERY ROOM	0	2, 234, 736		0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	52. 00
53. 00   05300   ANESTHESI OLOGY	0	0		0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	2, 534, 765	1	0	54. 00
54. 01   03630   ULTRA SOUND	0	883, 934	l .	0	54. 01
54. 02   03440   MAMMOGRAPHY	0	172, 768	l .	0	54. 02
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	9, 013, 054		0	55. 00
56. 00   05600   RADI 0I SOTOPE	0	5, 113, 209		0	56. 00
57. 00  05700   CT   SCAN	0	11, 003, 315	l .	0	57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	3, 070, 594		0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	7, 217, 442		0	59.00
60. 00  06000  LABORATORY	0	7, 606, 158		0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	619, 659		0	62. 00
65. 00 06500 RESPIRATORY THERAPY	0	233, 251		0	65. 00
66. 00   06600 PHYSI CAL THERAPY	0	26, 141		0	66. 00
69. 00  06900 ELECTROCARDI OLOGY	0	2, 664, 817		0	69. 00
70. 00  07000  ELECTROENCEPHALOGRAPHY	0	194, 851		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5, 904, 259		0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	3, 794, 901		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	15, 850, 329		0	73. 00
74. 00   07400   RENAL DI ALYSI S	0	116, 185		0	74. 00
76. 00   03950   LI THOTRI PSY	0	718, 894		0	76. 00
76. 01   03330   ENDOSCOPY	0	7, 205, 081		0	76. 01
76. 02 03040 PRISION CLINIC	0	0		0	76. 02
76. 03   03050   WOUND CARE	0	1, 497, 966		0	76. 03
76. 04   03060   OPI C	0	2, 354, 187		0	76. 04
OUTPATIENT SERVICE COST CENTERS					
91. 00 09100 EMERGENCY	0	7, 953, 753		0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	404, 537	l .	0	92. 00
200.00 Total (lines 50-199)	0	112, 430, 049	1	0	200. 00

Health Financial Systems	TERRE HAUTE REGION	AL HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0046	Peri od:	Worksheet D

APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Period: From 09/01/2016 To 08/31/2017	Date/Time Pre 1/27/2018 2:1	pared: 5 pm
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.			
				(see inst.)	(see inst.)		
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			1			
	05000 OPERATING ROOM	0. 096008			0	1, 348, 074	1
	05100 RECOVERY ROOM	0. 083224	2, 234, 736		0	185, 984	
	05200 DELIVERY ROOM & LABOR ROOM	0. 670023	0		0	0	
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 218273	2, 534, 765		0	553, 271	54.00
54.01	03630 ULTRA SOUND	0. 077445	883, 934		0	68, 456	54. 01
54.02	03440 MAMMOGRAPHY	0. 195243	172, 768		0	33, 732	54. 02
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 113585	9, 013, 054		0	1, 023, 748	55.00
56.00	05600 RADI OI SOTOPE	0. 094895	5, 113, 209		o o	485, 218	56.00
57.00	05700 CT SCAN	0. 024368			0 0	268, 129	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 043472	3, 070, 594		o o	133, 485	
	05900 CARDI AC CATHETERI ZATI ON	0. 040089			o o	289, 340	59.00
60.00	06000 LABORATORY	0. 064835			4 0	493, 145	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 137744			o	85, 354	1
65. 00	06500 RESPI RATORY THERAPY	0. 119379			0	27, 845	
	06600 PHYSI CAL THERAPY	0. 401199			o o	10, 488	
	06900 ELECTROCARDI OLOGY	0. 072370			0	192, 853	
	07000 ELECTROENCEPHALOGRAPHY	0. 108172		l .	0	21, 077	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 213243			0	1, 259, 042	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 429710		l .	o o	1, 630, 707	1
	07300 DRUGS CHARGED TO PATIENTS	0. 133699			0 118, 618	2, 119, 173	
	07400 RENAL DIALYSIS	0. 177357	116, 185		0 110, 010	20, 606	1
	03950 LI THOTRI PSY	0. 177597			0 0	75, 192	
	03330 ENDOSCOPY	0. 075323			0 0	542, 708	1
	03040 PRISION CLINIC	1. 598918			0 0	0	1
	03050 WOUND CARE	0. 286909			0 0	429, 780	
	03060 0PI C	0. 194205	2, 354, 187			457, 195	
70.04	OUTPATIENT SERVICE COST CENTERS	0. 194203	2, 334, 167		0	457, 195	70.04
91. 00	09100 EMERGENCY	0. 094707	7, 953, 753		0 0	753, 276	01 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 848641			0 0	343, 307	
200.00		0. 040041	1	1			
200.00		-	112, 430, 049	1	0 0	12,001,185	201. 00
201.00	Only Charges						201.00
202. 00		1	112, 430, 049	66	4 118, 618	12, 851, 185	202 00
202.00		1	1 12, 430, 049	1 00	7 110,010	12,001,100	1202.00

Health Financial Systems	TERRE HAUTE REGION	AL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-0046	Peri od: From 09/01/2016 To 08/31/2017	Worksheet D Part V Date/Time Prepared: 1/27/2018 2:15 pm

				To 08/31/2017		
		Ti tl e	e XVIII	Hospi tal	PPS	то ріп
	Cos					
Cost Center Description	Cost	Cost	1			
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7. 00				
ANCI LLARY SERVI CE COST CENTERS	_	_	.1			
50. 00   05000   OPERATI NG ROOM	0	0				50.00
51. 00   05100   RECOVERY   ROOM	0					51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM	0	· ·				52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	1			53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	C				54.00
54. 01   03630   ULTRA SOUND	0	C				54. 01
54. 02   03440   MAMMOGRAPHY	0	C				54. 02
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	C				55. 00
56. 00   05600   RADI OI SOTOPE	0	C				56.00
57. 00 05700 CT SCAN	0	1				57. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1				58. 00 59. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON   060. 00   06000   LABORATORY	43					60.00
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS	0	ł	1			62.00
65. 00 06500 RESPIRATORY THERAPY	0	1				65.00
66. 00   06600 PHYSI CAL THERAPY	0	1				66.00
69. 00   06900   ELECTROCARDI OLOGY	0					69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0					70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	· ·	1			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	15, 859				73. 00
74. 00 07400 RENAL DI ALYSI S	0	.0,007	1			74. 00
76. 00 03950 LI THOTRI PSY	0	l d				76. 00
76. 01 03330 ENDOSCOPY	0	Ì				76. 01
76. 02 03040 PRISION CLINIC	0	ď				76. 02
76. 03   03050   WOUND CARE	0	d				76. 03
76. 04   03060   OPI C	0		ol			76. 04
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	C				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C				92. 00
200.00 Subtotal (see instructions)	43	15, 859				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00   Net Charges (line 200 +/- line 201)	43	15, 859	9			202. 00

Health Financial Systems  TERRE HAUTE REGIONAL HOSPITAL  APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS  Provider CCN: 15-0046 From C  Component CCN: 15-S046	: 09/01/2016 08/31/2017 rovi der -	worksheet D Part II Date/Time Pre	
From C	09/01/2016 08/31/2017 	Part II Date/Time Pre	
Component CCN: 15-S046   To C	ovider -		
	I PF	PPS	
Cost Center Description Capital Total Charges Ratio of Cost In	pati ent	Capital Costs	
Related Cost (from Wkst. C, to Charges P	rogram	(column 3 x	
(from Wkst. B,   Part I, col.  (col. 1 ÷ col.   C	harges	column 4)	
Part II, col.   8)   2)			
26)			
	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS			
50. 00 05000 OPERATI NG ROOM 856, 016 89, 630, 321 0. 009551	1, 386	13	50.00
51. 00   05100   RECOVERY ROOM   69, 743   12, 723, 357   0. 005481	0	0	51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM   237, 196   3, 491, 242   0. 067940	0	0	52. 00
53. 00   05300   ANESTHESI OLOGY   0   0. 000000	0	0	53.00
54. 00   05400   RADI 0LOGY-DI AGNOSTI C 402, 149 15, 087, 275 0. 026655	16, 127	430	54.00
54. 01   03630   ULTRA SOUND   20, 381   4, 629, 232   0. 004403	4, 073	18	54. 01
54. 02 03440 MAMMOGRAPHY 47, 735 2, 245, 316 0. 021260	0	0	54. 02
55. 00   05500   RADI OLOGY-THERAPEUTI C 202, 144 17, 021, 301 0. 011876	0	0	55. 00
56. 00   05600   RADI OI SOTOPE   51, 705   12, 969, 304   0. 003987	0	0	56. 00
57. 00   05700   CT SCAN   85, 480   54, 983, 436   0. 001555	109, 325	170	57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI) 43,408 13,564,098 0.003200	. 0	0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON 90, 188 26, 864, 974 0. 003357	0	0	59.00
60. 00   06000   LABORATORY   254, 352   66, 576, 871   0. 003820	597, 889	2, 284	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 31,662 6,639,188 0.004769	0	0	ı
65. 00   06500   RESPI RATORY THERAPY 101, 467   18, 094, 921   0. 005607	51, 165	287	65. 00
66. 00   06600   PHYSI CAL THERAPY 401, 647 7, 001, 120 0. 057369	14, 410	827	66. 00
69. 00   06900   ELECTROCARDI OLOGY 90, 977 17, 980, 132 0. 005060	36, 933	187	69. 00
70. 00   07000   ELECTROENCEPHALOGRAPHY 30, 481 1, 436, 203 0. 021223	9, 092		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 430,662 41,254,590 0.010439	8, 668	90	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 237, 918 22, 062, 481 0.010784	0	0	72. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   444, 804   106, 690, 818   0.004169	732, 586	3, 054	1
74. 00   07400   RENAL DI ALYSI S   34, 773   5, 127, 940   0.006781	86, 928	589	1
76. 00   03950   LI THOTRI PSY   8, 144   2, 924, 730   0.002785	0.,0	0	
76. 01   03330   ENDOSCOPY   90, 291   19, 805, 246   0. 004559	0	0	1
76. 02 03040 PRI SI ON CLI NI C 197, 367 428, 705 0. 460380	0	l ő	76. 02
76. 03   03050  WOUND CARE   69, 877   3, 777, 071   0. 018500	0	l ő	
76. 04   03060  OPI C   122, 026   5, 569, 446   0. 021910	0	0	
OUTPATIENT SERVICE COST CENTERS			70.04
91. 00   09100   EMERGENCY   409, 670   59, 248, 093   0. 006914	420, 583	2, 908	91.00
92. 00   09200  0BSERVATI ON BEDS (NON-DISTINCT PART)   0   2,812,043   0.000000	1, 354	2, 700	92.00
200. 00 Total (lines 50-199) 5, 062, 263 640, 639, 454	2, 090, 519		

Heal th	Financial Systems T	ERRE HAUTE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS		Component	CCN: 15-S046	Peri od: From 09/01/2016 To 08/31/2017	Worksheet D Part IV Date/Time Pre 1/27/2018 2:1	pared:
			Titl∈	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Non Physician Anesthetist Cost	Ů		h All Other Medical Education Cost	4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			,			
50.00	05000 OPERATING ROOM	0	0	1	0 0	0	
51.00	05100 RECOVERY ROOM	0	0	1	0 0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0 0	0	
53.00	05300 ANESTHESI OLOGY	0	0	1	0 0	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
54. 01	03630 ULTRA SOUND 03440 MAMMOGRAPHY	0	U		0 0	0	
54. 02		0	0		0 0	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	-	
56. 00 57. 00	05600  RADI OI SOTOPE   05700  CT SCAN	0	0		0 0	0	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
60.00	06000 LABORATORY	0	0		0 0	0	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	Ö	
65. 00	06500 RESPIRATORY THERAPY	Ö	Ö		0 0	ő	1
66. 00	06600 PHYSI CAL THERAPY	o	Ö		0 0	0	
69. 00	06900 ELECTROCARDI OLOGY	o	Ö	,	0 0	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	o	O	,	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	)	0 0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	)	0 0	0	74. 00
76.00	03950 LI THOTRI PSY	0	0		0 0	0	76. 00
76. 01	03330 ENDOSCOPY	0	0	1	0 0	0	
	03040 PRISION CLINIC	0	0		0	0	
76. 03	03050 WOUND CARE	0	0	1	0 0	0	
76. 04	03060 OPI C	0	0	1	0 0	0	76. 04
91. 00	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	0	C	1	0 0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	1	0 0	0	
200.00	,	0	0	1	0 0	-	200.00
200.00		١		TI .	0	ı	1200.00

Health Financial Systems T	ERRE HAUTE REG	IONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER			CN: 15-0046	Peri od:	Worksheet D	2002 10
THROUGH COSTS				From 09/01/2016 To 08/31/2017	Part IV Date/Time Pre	
		Ti +l c	: XVIII	Subprovi der -	1/27/2018 2: 1 PPS	5 piii
		11 (1)	, XVIII	IPF	113	
Cost Center Description	Total	Total Charges	Ratio of Cos		Inpatient	
·	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
	col . 2, 3 and	8)	7)	(col. 6 ÷ col.	_	
	4)			7)		
	6. 00	7. 00	8. 00	9. 00	10. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM	0				1, 386	1
51.00   05100   RECOVERY ROOM	0	, , , , , ,			0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0				0	52. 00
53. 00 05300 ANESTHESI OLOGY	0				0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0				16, 127	54. 00
54. 01   03630   ULTRA SOUND	0	.,,			4, 073	
54. 02   03440   MAMMOGRAPHY	0	_, _ , _ , _ , _ ,	•		0	54. 02
55. 00   05500   RADI OLOGY-THERAPEUTI C	0				0	55. 00
56. 00   05600   RADI 0I SOTOPE	0	, ,			0	56. 00
57. 00   05700   CT   SCAN	0		•		109, 325	57. 00
58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI)	0				0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0				0	59.00
60. 00   06000   LABORATORY	0		0.00000		597, 889	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	-,,			0	62.00
65. 00 06500 RESPI RATORY THERAPY	0		l .		51, 165	65. 00
66. 00   06600   PHYSI CAL THERAPY	0				14, 410	
69. 00 06900 ELECTROCARDI OLOGY	0	,,			36, 933	69.00
70. 00   07000   ELECTROENCEPHALOGRAPHY 71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS	0	.,,			9, 092	
		,,			8, 668 0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS		,,,			732, 586	
73.00 07300 DRUGS CHARGED TO PATTENTS  74.00 07400 RENAL DIALYSIS					86, 928	74.00
74. 00   07400   RENAL DI ALYSI S 76. 00   03950   LI THOTRI PSY					80, 928	
76. 01   03330   ENDOSCOPY					0	76.00
76. 02   03040   PRI SI ON CLI NI C					0	76.01
76. 03   03050   WOUND CARE					0	76. 02
76. 04   03060   OPI C					0	
OUTPATIENT SERVICE COST CENTERS		3, 307, 440	0.00000	<u>0. 000000</u>	U	70.04
91. 00 09100 EMERGENCY	0	59, 248, 093	0.00000	0. 000000	420, 583	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					1, 354	1
200. 00 Total (lines 50-199)	0			3. 333000	2, 090, 519	
255.55	1	1 010,007,404	ı	1	2,070,017	1-50. 50

Hoal th	Financial Systems T	ERRE HAUTE REGI	ONAL HOSDITAL		In Lie	u of Form CMS-	2552 10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS		Provider Co	CN: 15-0046 CCN: 15-S046	Peri od: From 09/01/2016 To 08/31/2017	Worksheet D Part IV Date/Time Pro	epared:
			Title	· XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10) 11.00	Outpatient Program Charges	Outpatient Program Pass-Throug Costs (col. x col. 12)	h		
50. 00	ANCI LLARY SERVI CE COST CENTERS    O5000   OPERATI NG ROOM	O	0		0		50.00
51.00	05100 RECOVERY ROOM	o	0		0		51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52. 00
53. 00	05300 ANESTHESI OLOGY	0	0		0		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
54. 01	03630 ULTRA SOUND	0	0		0		54. 01
	03440 MAMMOGRAPHY	0	0		0		54. 02
	05500 RADI OLOGY-THERAPEUTI C	0	0		0		55. 00
56. 00 57. 00	05600	0	3, 500		0		56. 00 57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	3, 500	1	0		58.00
59. 00	05900 CARDIAC CATHETERIZATION	0	0	i .	0		59.00
60.00	06000 LABORATORY	0	744		0		60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0		0		62. 00
65. 00	06500 RESPIRATORY THERAPY		0		0		65. 00
66. 00	06600 PHYSI CAL THERAPY	o	0		0		66. 00
69. 00	06900 ELECTROCARDI OLOGY	o	0		0		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	o	0		0		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	138		0		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0		0		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	5, 415		0		73. 00
74.00	07400 RENAL DIALYSIS	0	0		0		74.00
	03950 LI THOTRI PSY	0	0		0		76. 00
	03330 ENDOSCOPY	0	0		0		76. 01
	03040 PRISION CLINIC	0	0		0		76. 02
76. 03	03050 WOUND CARE	0	0		0		76. 03
76. 04	03060 OPI C	0	0		0		76. 04

0 0 0

1, 840

0 11, 637

0 0 0

91.00 92. 00 200. 00

Heal th	n Financial Systems	TERRE HAUTE REGI	LONAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provi der C		Period: From 09/01/2016 To 08/31/2017	Worksheet D Part V	pared:
			Title	· XVIII	Subprovi der  - I PF	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	· ·	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9	ĺ	Subject To	Subject To		
				Ded. & Coins	. Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	•					
50.00	05000 OPERATING ROOM	0. 096008	0		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0. 083224	l o		o o	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 670023	l o		0 0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0. 000000	0		0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 218273			0	o o	54. 00
54. 01	03630 ULTRA SOUND	0. 077445			0	Ō	54. 01
54. 02	03440 MAMMOGRAPHY	0. 195243	0		0	o o	54. 02
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 113585	0		0	o o	55. 00
56. 00	05600 RADI OI SOTOPE	0. 094895	0		o o	o o	56. 00
57. 00	05700 CT SCAN	0. 024368	3, 500		o o	85	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 043472	0	l .	o o	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 040089	0		0	o o	59. 00
60. 00	06000 LABORATORY	0. 064835	744		0	48	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 137744	0		0	0	62. 00
65. 00	06500 RESPIRATORY THERAPY	0. 119379	0		0	o o	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 401199			0	o o	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 072370			o o	o o	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 108172			0 0	o o	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 213243			0	29	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 429710			0 0	0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 133699			0 5, 517		73. 00
74. 00	07400 RENAL DIALYSIS	0. 177357	0, 110		0 0,017	0	74. 00
76. 00	03950 LI THOTRI PSY	0. 104594	l		0 0	o o	76. 00
76. 01	03330 ENDOSCOPY	0. 075323	l			o o	76. 01
76. 02	03040 PRI SI ON CLI NI C	1. 598918			0 0	l o	76. 02
76. 02		0. 286909			0 0		76. 02
	03050 MOOND OAKE	0. 200707				1 0	76.03

0. 194205

0. 094707

0.848641

1,840

11, 637

11, 637

0

0 0 0

0

5, 517

5, 517

0 76.04

174

0 92.00

1, 060 200. 00

1, 060 202. 00

91.00

201. 00

76.04

91.00

200.00

201.00

202.00

03060 OPI C

OUTPATIENT SERVICE COST CENTERS
09100 EMERGENCY

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges

Net Charges (line 200 +/- line 201)

APPORTI	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Component	CN: 15-0046 CCN: 15-S046	Peri od: From 09/01/2016 To 08/31/2017	Worksheet D Part V Date/Time Pre 1/27/2018 2:1	pared: 5 pm
			Title	xVIII	Subprovider - IPF	PPS	
			sts			1	
	Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
	NCILLARY SERVICE COST CENTERS	6. 00	7. 00				
	D5000 OPERATING ROOM		0				50. 00
	05100 RECOVERY ROOM		Ö				51.00
	05200 DELIVERY ROOM & LABOR ROOM		Ö				52.00
	05300 ANESTHESI OLOGY	0	O				53. 0
54.00	D5400 RADI OLOGY-DI AGNOSTI C	0	0				54.0
54. 01	03630 ULTRA SOUND	0	0				54.0
	03440 MAMMOGRAPHY	0	0				54. 02
	D5500 RADI OLOGY-THERAPEUTI C	0	0				55.00
	D5600 RADI OI SOTOPE	0	0				56. 00
	D5700 CT SCAN	0	0				57.00
	D5800 MAGNETIC RESONANCE IMAGING (MRI) D5900 CARDIAC CATHETERIZATION		0	•			58. 00 59. 00
	06000 LABORATORY						60.0
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0				62.0
	06500 RESPIRATORY THERAPY						65. 0
	06600 PHYSI CAL THERAPY		Ö				66.0
	06900 ELECTROCARDI OLOGY	0	0				69. 0
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0				70.0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.0
	07300 DRUGS CHARGED TO PATIENTS	0	738				73. 0
	07400 RENAL DIALYSIS	0	0				74.00
	03950 LI THOTRI PSY	0	0				76.00
	03330 ENDOSCOPY	0	0				76.0
	03040 PRISION CLINIC		0	1			76. 0: 76. 0:
4	03050 WOUND CARE 03060 OPLC		0	1			76.0
_	DUTPATIENT SERVICE COST CENTERS		<u> </u>	1			1 70.04
_	09100 EMERGENCY	1 0	0				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		1			92.00
200.00	Subtotal (see instructions)	1	738				200.00

0 0 0

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges
Net Charges (line 200 +/- line 201)

738

201. 00

202. 00

201.00

202.00

Health Financial Systems	TERRE HAUTE REG	IONAL HOSPITAL		In lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provi der CCN: 15-0046		Worksheet D	
				From 09/01/2016	Part II	
		Component	CCN: 15-T046	To 08/31/2017 Subprovi der -	Date/Time Pre 1/27/2018 2:1	
		Title	Title XVIII		PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	IRF t Inpatient	Capital Costs	
000 00 00 00 00 0 0 0 0 0 0 0 0 0 0 0		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.		9	column 4)	
	Part II, col.	8)	2)	J	ĺ	
	26)	ŕ	,			
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM	856, 016				936	50. 00
51.00   05100   RECOVERY ROOM	69, 743			, ,	105	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	237, 196	3, 491, 242			0	52. 00
53. 00   05300   ANESTHESI OLOGY	0		0.00000		0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	402, 149	15, 087, 275			1, 241	
54. 01   03630   ULTRA SOUND	20, 381				22	
54. 02   03440   MAMMOGRAPHY	47, 735		l .		0	
55. 00   05500   RADI OLOGY-THERAPEUTI C	202, 144				54	
56. 00   05600   RADI 0I SOTOPE	51, 705				l e	
57. 00  05700 CT SCAN	85, 480				88	
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	43, 408				73	1
59. 00   05900   CARDI AC CATHETERI ZATI ON	90, 188				0	59. 00
60. 00   06000   LABORATORY	254, 352	1			l	1
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	31, 662				138	1
65. 00 06500 RESPIRATORY THERAPY	101, 467					65. 00
66. 00 06600 PHYSI CAL THERAPY	401, 647				l	1
69. 00  06900 ELECTROCARDI OLOGY	90, 977		l .		190	
70. 00 07000 ELECTROENCEPHALOGRAPHY	30, 481	1, 436, 203			66	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	430, 662					1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	237, 918				97	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	444, 804				3, 863	1
74.00 07400 RENAL DIALYSIS	34, 773				1, 094	
76. 00 03950 LI THOTRI PSY	8, 144				0	
76. 01 03330 ENDOSCOPY	90, 291				0	
76. 02 03040 PRISION CLINIC	197, 367				0	76. 02
76. 03   03050   WOUND CARE	69, 877				0	
76. 04 03060 OPI C	122, 026	5, 569, 446	0. 02191	0 0	0	76. 04
OUTPATIENT SERVICE COST CENTERS	1					
91. 00   09100   EMERGENCY	409, 670				l e	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	_, -, ,	l .		0	92.00
200.00   Total (lines 50-199)	5, 062, 263	640, 639, 454	I	3, 902, 328	114, 119	J200. 00

Health Financial Contains	TEDDE HAUTE DECL	ONAL HOCDITAL		1 - 11 -	6 F CMC	2552 40
Health Financial Systems TERRE HAUTE REGIONAL HOSPITAL  APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0046			CN: 15-0046	In Lieu of Form CMS-2552- Period: Worksheet D		2552-10
THROUGH COSTS			CCN: 15-T046	From 09/01/2016 To 08/31/2017	Part IV	
		Ti tl e	× XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Non Physician	Nursing School	Allied Heal	h All Other	Total Cost	
	Anesthetist Cost			Medical Education Cost	(sum of col 1 through col. 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	1	0 0		
51.00   05100   RECOVERY ROOM	0	0	)	0	1	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0	0	1
53. 00 05300 ANESTHESI OLOGY	0	0	1	0 0	0	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0		0 0	0	
54. 01   03630   ULTRA SOUND 54. 02   03440   MAMMOGRAPHY	0	0		0 0	0	1
55. 00   05500 RADI OLOGY-THERAPEUTI C		0		0 0	0	
56. 00   05600   RADI 0I SOTOPE		0		0 0		
57. 00 05700 CT SCAN		0				
58. 00   05800   MAGNETIC RESONANCE   MAGING (MRI)		0			Ö	
59. 00 05900 CARDI AC CATHETERI ZATI ON	o	0			ő	
60. 00   06000 LABORATORY	o	0	)	0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	o	0	1	0 0	0	62. 00
65. 00 06500 RESPIRATORY THERAPY	o	0	)	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66. 00
69. 00  06900   ELECTROCARDI OLOGY	0	0	)	0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	0 0	0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1	0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
74. 00   07400   RENAL DI ALYSI S 76. 00   03950   LI THOTRI PSY	0	0		0 0	0	
76. 00   03930 ELTHOTRIPST 76. 01   03330 ENDOSCOPY		0				
76. 02   03040   PRI SI ON CLI NI C		0				
76. 03   03050   WOUND CARE		0			1	
76. 04   03060   OPI C	o	0	1	o o		
OUTPATIENT SERVICE COST CENTERS	,			-,	<u> </u>	1
91. 00 09100 EMERGENCY	0	0		0 0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	0	1	0 0	1	
200.00   Total (lines 50-199)	0	0		0 0	0	200. 00

Health Financial Systems	TERRE HAUTE REG	IONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS			Provi der CCN: 15-0046		Worksheet D		
THROUGH COSTS					Part IV		
		Component	CCN: 15-T046	To 08/31/2017	Date/Time Pre 1/27/2018 2:1		
		Ti tl e	: XVIII	Subprovi der -	PPS	5 piii	
				I RF			
Cost Center Description	Total	Total Charges	Ratio of Cos	t Outpatient	Inpati ent		
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program		
	Cost (sum of	Part I, col.			Charges		
	col . 2, 3 and	8)	7)	(col. 6 ÷ col.			
	4)	7.00		7)	10.00		
ANOLLI ADV. CEDVI OF COCT OFFITEDO	6. 00	7. 00	8. 00	9. 00	10. 00		
ANCILLARY SERVICE COST CENTERS	1	00 (20 221	0.00000	0.00000	07.0/0	FO 00	
50. 00 05000 OPERATI NG ROOM	0	1			97, 969		
51. 00 05100 RECOVERY ROOM	0				19, 232		
52. 00   05200 DELIVERY ROOM & LABOR ROOM	0				0		
53. 00 05300 ANESTHESI OLOGY	0		0.0000		0		
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0				46, 540		
54. 01   03630   ULTRA SOUND 54. 02   03440   MAMMOGRAPHY	0	1,,			4, 970	1	
55. 00   05500 RADI OLOGY-THERAPEUTI C	0				0 4, 569	54. 02 55. 00	
56. 00   05600   RADI 01 01 SOTOPE					9, 410		
57. 00   05700   CT   SCAN					56, 323		
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)			l .		22, 957		
59. 00   05900   CARDI AC CATHETERI ZATI ON			•		22, 737	59.00	
60. 00   06000   LABORATORY		,,			300, 478	1	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS					28, 973		
65. 00   06500   RESPI RATORY THERAPY		-,,			82. 728		
66. 00 06600 PHYSI CAL THERAPY	0		l .		1, 761, 915		
69. 00 06900 ELECTROCARDI OLOGY	0		l .		37, 474	1	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		l .		3, 108	1	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0				326, 129		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0. 000000	8, 967	72. 00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	106, 690, 818	0.00000	0. 000000	926, 544	73. 00	
74. 00   07400   RENAL DI ALYSI S	0	5, 127, 940	0. 00000	0. 000000	161, 294	74. 00	
76. 00   03950   LI THOTRI PSY	0	2, 924, 730	0.00000	0. 000000	0	76. 00	
76. 01   03330   ENDOSCOPY	0	19, 805, 246	0.00000	0. 000000	0	76. 01	
76. 02   03040   PRISION CLINIC	0	428, 705	0.00000	0. 000000	0	76. 02	
76. 03   03050   WOUND CARE	0	3, 777, 071	0.00000	0. 000000	0	76. 03	
76. 04 03060 OPI C	0	5, 569, 446	0.00000	0. 000000	0	76. 04	
OUTPATIENT SERVICE COST CENTERS							
91. 00   09100   EMERGENCY	0				2, 748		
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0. 000000	0		
200.00   Total (lines 50-199)	0	640, 639, 454	l		3, 902, 328	200. 00	

alth Financial Systems PORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	TERRE HAUTE REGI RVI CE OTHER PASS		CN: 15-0046	Peri od:	u of Form CMS- Worksheet D	2332-
IROUGH COSTS		Component	CCN: 15-T046	From 09/01/2016 To 08/31/2017	Part IV Date/Time Pre 1/27/2018 2:	epared:
		Title	e XVIII	Subprovi der - I RF	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through Costs (col. 8	Charges	Pass-Throug Costs (col.			
	x col. 10)		x col. 12)	9		
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS		12100	10.00			
0. 00 O5000 OPERATI NG ROOM	0	C		0		50.0
. 00 05100 RECOVERY ROOM	0	C		0		51.
.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0		52.
i. 00   05300   ANESTHESI OLOGY	0	C	)	0		53.
. 00   05400   RADI OLOGY-DI AGNOSTI C	0	C	1	0		54.
. 01   03630   ULTRA SOUND	0	C	1	0		54.
. 02 03440 MAMMOGRAPHY	0	C	1	0		54.
5. 00   05500   RADI OLOGY-THERAPEUTI C 5. 00   05600   RADI OI SOTOPE	0	C		0		55.
. 00   05600  RADI OF SOTOPE 2. 00   05700  CT   SCAN	0	C		0		56. 57.
8. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)			1	0		58.
0. 00 05900 CARDI AC CATHETERI ZATI ON		C	1	0		59.
0. 00   06000   LABORATORY	O	C		Ö		60.
. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0		62.
. 00 06500 RESPIRATORY THERAPY	0	C		0		65.
. 00  06600 PHYSI CAL THERAPY	0	C		0		66.
0. 00 06900 ELECTROCARDI OLOGY	0	C		0		69.
0.00 07000 ELECTROENCEPHALOGRAPHY	0	C	)	0		70.
. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0		71.
2.00   07200   IMPL. DEV. CHARGED TO PATIENTS 3.00   07300 DRUGS CHARGED TO PATIENTS	0	1, 268	1	0		72. 73.
. 00 07300 BROGS CHARGED TO FATTENTS	0	1, 200	•	0		74.
0. 00 03950 LI THOTRI PSY		C		0		76.
. 01 03330 ENDOSCOPY	O	C		Ö		76.
0. 02 03040 PRISION CLINIC	0	C		0		76.
. 03   03050   WOUND CARE	0	C		0		76.
03060 OPI C	0	C	)	0		76.
OUTPATIENT SERVICE COST CENTERS						
. 00   09100   EMERGENCY	0	C	1	0		91.
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C	)	0		92.

Health Financial Systems	TERRE HAUTE REG	IONAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES	AND VACCINE COST	Provider Component	F	Period: From 09/01/2016 To 08/31/2017	Worksheet D Part V	pared:
		Title	× XVIII	Subprovi der - I RF	PPS	<u>o p</u>
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000 OPERATING ROOM	0. 096008			-		
51.00   05100   RECOVERY ROOM	0. 083224		(	0	0	51.00
52.00  05200 DELIVERY ROOM & LABOR ROOM	0. 670023		(	0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0. 000000		(	0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 218273		(	0	0	54.00
54. 01   03630   ULTRA SOUND	0. 077445		(	0	0	54. 01
54. 02   03440   MAMMOGRAPHY	0. 195243		(	0	0	54. 02
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 113585		(	0	0	55. 00
56. 00   05600   RADI 0I SOTOPE	0. 094895		(	0	0	56. 00
57. 00  05700 CT SCAN	0. 024368	0	(	0	0	57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0. 043472		(	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 040089		(	0	0	59. 00
60. 00  06000  LABORATORY	0. 064835		(	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL			(	0	0	62. 00
65. 00 06500 RESPI RATORY THERAPY	0. 119379		(	0	0	65. 00
66. 00  06600 PHYSI CAL THERAPY	0. 401199		(	0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 072370		(	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 108172		(	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	S 0. 213243	0	(	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 429710		(	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 133699		(	1, 624	170	73. 00
74.00   07400   RENAL DIALYSIS	0. 177357		(	0	0	74. 00
76. 00   03950   LI THOTRI PSY	0. 104594		(	0	0	76. 00
76. 01   03330   ENDOSCOPY	0. 075323		(	0	0	76. 01
76. 02   03040   PRI SI ON CLI NI C	1. 598918		(	0	0	76. 02
76. 03   03050   WOUND CARE	0. 286909		(	0	0	
76 04 02060 ODLC	0 104205	1 0	1 (	n n	Ι	76 04

0. 194205

0. 094707

0.848641

1, 268

1, 268

0 0

0 0 0

0

1, 624

1, 624

0 76.04

0

0 92.00

170 200. 00 201. 00

170 202. 00

91.00

76.04

200.00

201.00

202.00

03060 OPI C

OUTPATIENT SERVICE COST CENTERS
91. 00 O9100 EMERGENCY

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges
Net Charges (line 200 +/- line 201)

	inancial Systems T DNMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 15-0046	Peri od: From 09/01/2016	Worksheet D Part V	
			Component	CCN: 15-T046	To 08/31/2017		
			Ti tl e	e XVIII	Subprovi der - I RF	PPS	
		Co	sts		110		
	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.)				
Δ.	MOLLIADY CEDVICE COCT CENTEDS	6. 00	7. 00				
	NCILLARY SERVICE COST CENTERS 5000 OPERATING ROOM		0	J			50.00
4	5100 RECOVERY ROOM						51.00
	5200 DELIVERY ROOM & LABOR ROOM		1				52.00
4	5300 ANESTHESI OLOGY						53.00
1	5400 RADI OLOGY-DI AGNOSTI C						54.00
4	3630 ULTRA SOUND						54. 01
	3440 MAMMOGRAPHY			,			54. 02
4	5500 RADI OLOGY-THERAPEUTI C			)			55. 00
56. 00 0	5600 RADI OI SOTOPE	C	0	)			56.00
	5700 CT SCAN	C	0	)			57.00
58. 00 0	5800 MAGNETIC RESONANCE IMAGING (MRI)	C	0				58.00
59. 00 0	5900 CARDI AC CATHETERI ZATI ON	C	0				59. 00
60.00	6000 LABORATORY	C	0				60.00
62. 00 0	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	C	0	)			62.00
	6500 RESPI RATORY THERAPY	C	٦ -				65.00
- 1	6600 PHYSI CAL THERAPY	C	1				66.00
	6900 ELECTROCARDI OLOGY	C	٦ -				69.00
4	7000 ELECTROENCEPHALOGRAPHY	C	1	1			70.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0				71.00
	7200 IMPL. DEV. CHARGED TO PATIENTS	C	0	1			72. 00
	7300 DRUGS CHARGED TO PATIENTS	0	217				73.00
4	7400 RENAL DIALYSIS	C	0	1			74.00
4	3950 LI THOTRI PSY		0				76.00
	3330 ENDOSCOPY		0				76. 01
	3040 PRISION CLINIC 3050 WOUND CARE	C		1			76. 02 76. 03
	3060 OPI C	C					76. 03
	UTPATIENT SERVICE COST CENTERS		ή <u></u>	1			1 /0. 04
	9100 EMERGENCY		0	1			91. 00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)		•	1			92.00
200.00	Subtotal (see instructions)						200.00

0 0 0

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges
Net Charges (line 200 +/- line 201)

217

200. 00

202. 00

201.00 202.00

Health Financial Systems T	ERRE HAUTE REG	I ONAL	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS F		CN: 15-0046	Peri od: From 09/01/2016 To 08/31/2017	Date/Time Pre 1/27/2018 2:1	
				e XIX	Hospi tal	Cost	
Cost Center Description	Nursing School	Alli	Cost	All Other Medical Education Cos	Swing-Bed Adjustment St Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00		2.00	3, 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		'				2.00	
30. 00   03000   ADULTS & PEDI ATRI CS 31. 00   03100   NTENSI VE CARE UNI T	0		0		0 0	0	
40. 00   04000  SUBPROVI DER -   PF		í	0				40.00
41. 00   04100   SUBPROVI DER -   I RF			0				41. 00
43. 00   04300   NURSERY	0	ol .	0		0	0	
200.00 Total (lines 30-199)	O		0		0	0	200.00
Cost Center Description	Total Patient Days		Diem (col. col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 >		
	6. 00		7. 00	8. 00	9. 00		
I NPATI ENT ROUTI NE SERVI CE COST CENTERS   30.00   03000   ADULTS & PEDI ATRI CS   31.00   03100   I NTENSI VE CARE UNI T   40.00   04000   SUBPROVI DER - I PF   41.00   04100   SUBPROVI DER - I RF   43.00   04300   NURSERY   00.4000   04300   NURSERY   00.4000   04300   04	19, 265 3, 184 6, 635 1, 780 578	 	0. 00 0. 00 0. 00 0. 00 0. 00	2, 8,	0 0 48 0 13 0		30. 00 31. 00 40. 00 41. 00 43. 00
200.00   Total (lines 30-199)	31, 442	2		4, 1	15  C	1	200. 00

Health Financial Systems	TERRE HAUTE REGION	IAL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0046	Peri od:	Worksheet D
THROUGH COSTS			From 09/01/2016	

I HROUGI	1 (0313				o 08/31/2017	Date/Time Pre	
			Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description	Non Physician N	lursing School	Allied Health	All Other	Total Cost	
	•	Anesthetist	ŭ		Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	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
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54. 00
54. 01	03630 ULTRA SOUND	0	0	0	0	0	54. 01
54. 02	03440 MAMMOGRAPHY	0	0	0	0	0	54. 02
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00	05600 RADI 0I S0T0PE	0	0	0	0	0	56.00
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00	06000 LABORATORY	0	0	0	0	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65. 00	06500 RESPI RATORY THERAPY	0	0	0	0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	O	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	O	0	73. 00
74. 00	07400 RENAL DIALYSIS	0	0	0	o	0	74. 00
76. 00	03950 LI THOTRI PSY	0	0	0	o	0	76. 00
76. 01	03330 ENDOSCOPY	0	0	0	o	0	76. 01
76. 02	03040 PRISION CLINIC	O	0	0	o	0	76. 02
76. 03	03050 WOUND CARE	o	0	0	o	0	76. 03
76. 04	03060 OPI C	o	0	0	o	0	76. 04
Ī	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	0	0	0	0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	o	0	o	0	92. 00
200.00	Total (lines 50-199)	0	o	0	o	0	200. 00

Health Financial Systems  TERRE HAUTE REGIONAL HOSPITAL  APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS  THROUGH COSTS  TERRE HAUTE REGIONAL HOSPITAL  Provider CCN: 15-0046 From To					u of Form CMS-2 Worksheet D Part IV Date/Time Pre 1/27/2018 2:1	pared:
Title XIX Hospital Cos						
Cost Center Description	Total	Total Charges			I npati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6. 00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS		_				
50.00   05000   OPERATING ROOM	( C	., .,,,			6, 890, 772	
51.00   05100   RECOVERY ROOM	C	, , , , , ,	1		739, 074	
52.00   05200   DELIVERY ROOM & LABOR ROOM	C	3, 491, 242			1, 688, 692	
53. 00   05300   ANESTHESI OLOGY	C	) C	7 0,0000		0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	C				618, 992	54.00
54.01  03630 ULTRA SOUND		4, 629, 232	0.00000	0. 000000	185, 245	54. 01
54. 02   03440   MAMMOGRAPHY	C	2, 245, 316	0.00000	0. 000000	0	54. 02
55. 00   05500   RADI OLOGY-THERAPEUTI C	C	17, 021, 301	0.00000	0. 000000	98, 383	55. 00
56. 00   05600   RADI 0I SOTOPE	C	12, 969, 304	0.00000	0. 000000	104, 969	56. 00
57. 00  05700   CT   SCAN	C	54, 983, 436	0.00000	0. 000000	2, 292, 716	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	C	13, 564, 098	0.00000	0. 000000	380, 394	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	C	26, 864, 974	0.00000	0. 000000	1, 196, 283	59. 00
60. 00   06000   LABORATORY		66, 576, 871	0.00000	0. 000000	3, 889, 044	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		6, 639, 188	0. 00000	0. 000000	726, 887	62. 00
65. 00 06500 RESPIRATORY THERAPY		18, 094, 921	0.00000	0. 000000	2, 878, 705	65. 00
66. 00 06600 PHYSI CAL THERAPY	C	7, 001, 120	0.00000	0. 000000	208, 075	66. 00
69. 00 06900 ELECTROCARDI OLOGY		17, 980, 132	0.00000	0. 000000	1, 148, 930	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		1, 436, 203	0.00000	0. 000000	73, 889	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		41, 254, 590	0. 00000	0. 000000	2, 818, 018	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		22, 062, 481	0.00000	0. 000000	1, 504, 225	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		106, 690, 818	0. 00000	0. 000000	9, 570, 255	73. 00
74. 00   07400   RENAL DI ALYSI S		5, 127, 940	0. 00000	0. 000000	319, 774	74.00
76. 00   03950   LI THOTRI PSY	C		1		0	76. 00
76. 01 03330 ENDOSCOPY	C				392, 223	76. 01
76. 02 03040 PRISION CLINIC	C	428, 705	0. 00000	0. 000000	0	76. 02
76. 03 03050 WOUND CARE	C	3, 777, 071	0.00000	0. 000000	3, 106	76. 03
76. 04 03060 OPI C		5, 569, 446	0.00000	0. 000000	28, 835	76. 04

59, 248, 093 2, 812, 043 640, 639, 454

0

0.000000

0.000000

0.000000

0.000000

2, 274, 371 91. 00

104, 557 92. 00 40, 136, 414 200. 00

OUTPATIENT SERVICE COST CENTERS
91. 00 09100 EMERGENCY

92. 00 | 09200 | 085ERVATION BEDS (NON-DISTINCT PART) 200. 00 | Total (lines 50-199)

Health Financial Systems	TERRE HAUTE REGIO	NAL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0046	Peri od: From 09/01/2016 To 08/31/2017	Worksheet D Part IV Date/Time Prepared:

Title XIX   Hospital   Cost
Program Pass=Through Costs (col. 8 x col. 10)   x col. 12)   x col.
Pass-Through Costs (col. 8   x col. 10)
ANCI LLARY SERVI CE COST CENTERS
X COL. 10)   X COL. 12)
11.00   12.00   13.00
ANCILLARY SERVICE COST CENTERS
50. 00         05000         OPERATI NG ROOM         0         0         0         50. 00           51. 00         05100         RECOVERY ROOM         0         0         0         51. 00           52. 00         05200         DELI VERY ROOM & LABOR ROOM         0         0         0         52. 00           53. 00         05300         ANESTHESI OLOGY         0         0         0         53. 00           54. 00         05400         RADI OLOGY-DI AGNOSTI C         0         0         0         54. 00           54. 01         03630         JLTRA SOUND         0         0         0         54. 01           54. 02         03440         MAMMOGRAPHY         0         0         0         54. 02           55. 00         05500         RADI OLOGY-THERAPEUTI C         0         0         0         55. 00           57. 00         05600         RADI OLOGY-THERAPEUTI C         0         0         0         55. 00           56. 00         05600         RADI OLOGY-THERAPEUTI C         0         0         0         55. 00           57. 00         05700         CT SCAN         0         0         0         56. 00           58. 00
51. 00         05100         RECOVERY ROOM         0         0         51. 00           52. 00         05200         DELI VERY ROOM & LABOR ROOM         0         0         0         52. 00           53. 00         05300         ANESTHESI OLOGY         0         0         0         0         53. 00           54. 00         05400         RADI OLOGY-DI AGNOSTI C         0         0         0         54. 00           54. 01         03630         ULTRA SOUND         0         0         0         54. 01           54. 02         03440         MAMMOGRAPHY         0         0         0         54. 02           55. 00         05500         RADI OLOGY-THERAPEUTI C         0         0         0         55. 00           56. 00         05600         RADI OLOGY-THERAPEUTI C         0         0         0         55. 00           57. 00         05700         CT SCAN         0         0         0         55. 00           58. 00         05800         MAGNETIC RESONANCE I MAGI NG (MRI)         0         0         0         57. 00           59. 00         05900         CARDI AC CATHETERI ZATI ON         0         0         0         59. 00
52. 00         05200         DELI VERY ROOM & LABOR ROOM         0         0         52. 00           53. 00         05300         ANESTHESI OLOGY         0         0         0         53. 00           54. 00         05400         RADI OLOGY-DI AGNOSTI C         0         0         0         54. 00           54. 01         03630         ULTRA SOUND         0         0         0         54. 01           54. 02         03440         MAMMOGRAPHY         0         0         0         54. 01           55. 00         05500         RADI OLOGY-THERAPEUTI C         0         0         0         55. 00           56. 00         05600         RADI OLOGY-THERAPEUTI C         0         0         0         55. 00           57. 00         05500         RADI OLOGY-THERAPEUTI C         0         0         0         55. 00           56. 00         05600         RADI OLOGY-THERAPEUTI C         0         0         0         55. 00           57. 00         05700         CT SCAN         0         0         0         55. 00           58. 00         05800         MAGNETIC RESONANCE I MAGI NG (MRI )         0         0         0         58. 00           59. 00
53. 00       05300       ANESTHESI OLOGY       0       0       53. 00         54. 00       05400       RADI OLOGY-DI AGNOSTI C       0       0       0       54. 00         54. 01       03330       ULTRA SOUND       0       0       0       54. 01         54. 02       03440       MAMMOGRAPHY       0       0       0       54. 02         55. 00       05500       RADI OLOGY-THERAPEUTI C       0       0       0       55. 02         56. 00       05600       RADI OLOGY-THERAPEUTI C       0       0       0       0       55. 02         57. 00       05700       RADI OLOGY-THERAPEUTI C       0       0       0       0       55. 00         57. 00       05500       RADI OLOGY-THERAPEUTI C       0       0       0       0       55. 00         57. 00       05700       CT SCAN       0       0       0       0       55. 00         58. 00       05800       MAGNETI C RESONANCE I MAGI NG (MRI )       0       0       0       58. 00         59. 00       05900       CARDI AC CATHETERI ZATI ON       0       0       0       59. 00         60. 00       06200       MHOLE BLOOD & PACKED RED BLOOD CELLS
54. 00       05400       RADI OLOGY - DI AGNOSTI C       0       0       54. 00         54. 01       03630       ULTRA SOUND       0       0       54. 01         54. 02       03440       MAMMOGRAPHY       0       0       0       54. 02         55. 00       05500       RADI OLOGY-THERAPEUTI C       0       0       0       55. 00         56. 00       05600       RADI OI SOTOPE       0       0       0       0       55. 00         57. 00       05700       CT SCAN       0       0       0       0       57. 00         58. 00       05800       MAGNETI C RESONANCE I MAGI NG (MRI)       0       0       0       0       58. 00         59. 00       05900       CARDI AC CATHETERI ZATI ON       0       0       0       59. 00         60. 00       06200       MHOLE BLOOD & PACKED RED BLOOD CELLS       0       0       0       60. 00         65. 00       06500       RESPI RATORY THERAPY       0       0       0       0       65. 00         69. 00       06900       ELECTROCARDI OLOGY       0       0       0       0       0
54. 01       03630       ULTRA SOUND       0       0       54. 01         54. 02       03440       MAMMOGRAPHY       0       0       0       54. 02         55. 00       05500       RADI OLOGY-THERAPEUTI C       0       0       0       0       55. 00         56. 00       05600       RADI OLOGY-THERAPEUTI C       0       0       0       0       55. 00         57. 00       05700       CT SCAN       0       0       0       0       57. 00         58. 00       05800       MAGNETI C RESONANCE I MAGI NG (MRI)       0       0       0       58. 00         59. 00       05900       CARDI AC CATHETERI ZATI ON       0       0       0       59. 00         60. 00       06000       LABORATORY       0       0       0       60. 00         62. 00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0       0       0       65. 00         65. 00       06500       RESPI RATORY THERAPY       0       0       0       65. 00         66. 00       06900       ELECTROCARDI OLOGY       0       0       0       69. 00
54. 02       03440       MAMMOGRAPHY       0       0       0       54. 02         55. 00       05500       RADI OLOGY-THERAPEUTI C       0       0       0       55. 00         56. 00       05600       RADI OI SOTOPE       0       0       0       0       56. 00         57. 00       05700       CT SCAN       0       0       0       57. 00         58. 00       05800       MAGNETI C RESONANCE I MAGI NG (MRI)       0       0       0       58. 00         59. 00       05900       CARDI AC CATHETERI ZATI ON       0       0       0       59. 00         60. 00       06000       LABORATORY       0       0       0       60. 00         62. 00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0       0       0       62. 00         65. 00       06500       RESPI RATORY THERAPY       0       0       0       65. 00         66. 00       06900       ELECTROCARDI OLOGY       0       0       0       69. 00
55. 00       05500   05600   05600   05600   05600   05600   05600   05600   05600   05700   05700   05700   05700   05700   05700   05700   05700   05700   05700   05800   0
56. 00       05600       RADI OI SOTOPE       0       0       0       56. 00         57. 00       05700       CT SCAN       0       0       0       57. 00         58. 00       05800       MAGNETI C RESONANCE I MAGI NG (MRI)       0       0       0       0       58. 00         59. 00       05900       CARDI AC CATHETERI ZATI ON       0       0       0       59. 00         60. 00       06000       LABORATORY       0       0       0       60. 00         62. 00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0       0       0       65. 00         65. 00       06500       RESPI RATORY THERAPY       0       0       0       65. 00         66. 00       06600       PHYSI CAL THERAPY       0       0       0       66. 00         69. 00       06900       ELECTROCARDI OLOGY       0       0       0       69. 00
57. 00       05700       CT SCAN       0       0       0       57. 00         58. 00       05800       MAGNETI C RESONANCE I MAGI NG (MRI)       0       0       0       0       58. 00         59. 00       05900       CARDI AC CATHETERI ZATI ON       0       0       0       59. 00         60. 00       06000       LABORATORY       0       0       0       60. 00         62. 00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0       0       0       60. 00         65. 00       06500       RESPI RATORY THERAPY       0       0       0       65. 00         66. 00       06600       PHYSI CAL THERAPY       0       0       0       66. 00         69. 00       06900       ELECTROCARDI OLOGY       0       0       0       69. 00
58. 00     05800     MAGNETI C RESONANCE I MAGI NG (MRI)     0     0     0     58. 00       59. 00     05900     CARDI AC CATHETERI ZATI ON     0     0     0     59. 00       60. 00     06000     LABORATORY     0     0     0     60. 00       62. 00     06200     WHOLE BLOOD & PACKED RED BLOOD CELLS     0     0     0     62. 00       65. 00     06500     RESPI RATORY THERAPY     0     0     0     65. 00       66. 00     06900     PHYSI CAL THERAPY     0     0     0     66. 00       69. 00     06900     ELECTROCARDI OLOGY     0     0     0     69. 00
59. 00       05900       CARDI AC CATHETERI ZATI ON       0       0       0       59. 00         60. 00       06000       LABORATORY       0       0       0       60. 00         62. 00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0       0       0       62. 00         65. 00       06500       RESPI RATORY THERAPY       0       0       0       65. 00         66. 00       06600       PHYSI CAL THERAPY       0       0       0       66. 00         69. 00       06900       ELECTROCARDI OLOGY       0       0       0       69. 00
60. 00   06000   LABORATORY   0 0 0 0   60. 00   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0 0 0 0   65. 00   06500   RESPI RATORY THERAPY   0 0 0   66. 00   06600   PHYSI CAL THERAPY   0 0 0   69. 00   06900   ELECTROCARDI OLOGY   0 0   69. 00   06900   0 0   60. 00   06000   0 0   60. 00   06000   0 0   60. 00   06000   0 0   60. 00   06000   0 0   60. 00   0600
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0   62. 00   65. 00   65. 00   665. 00   666. 00   666. 00   666. 00   669. 00
65. 00   06500   RESPIRATORY THERAPY   0 0 0 0   65. 00   66. 00   66. 00   69. 00   06900   ELECTROCARDI OLOGY   0 0 0   69. 00   0 0   69. 00   69. 00   0 0   0 0   0 0   0   0   0   0
66. 00   06600   PHYSI CAL THERAPY   0 0 0   06900   ELECTROCARDI OLOGY   0 0   0 0   69. 00
69. 00 06900 ELECTROCARDI OLOGY 0 0 69. 00
70 00 07000 ELECTROENCERIAL OCRARIUV
70. 00  07000  ELECTROENCEPHALOGRAPHT   0  0  0  0    70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00
74. 00   07400   RENAL DI ALYSI S   0 0 0   74. 00
76. 00   03950   LI THOTRI PSY   0   0   76. 00
76. 01 03330 ENDOSCOPY 0 0 76. 01
76. 02 03040 PRISION CLINIC 0 0 0 76. 02
76. 03 03050 WOUND CARE 0 0 0 76. 03
76. 04 03060 OPI C 0 0 0 76. 04
OUTPATIENT SERVICE COST CENTERS
91. 00 09100 EMERGENCY 0 0 0 91. 00
92.00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0 0 0 0 92.00
200.00   Total (lines 50-199)   0   0   200.00

Health Financial Systems	TERRE HAUTE REGION	In Lieu	u of Form CMS-2552-10	
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0046	From 09/01/2016	Worksheet D Part V

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	) VACCINE COST			From 09/01/2016 To 08/31/2017	Date/Time Pre 1/27/2018 2:1	pared: 5 pm
		Ti tl	e XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Servi ces Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		,		_		
50. 00   05000 OPERATING ROOM	0. 096008	0	l .	0 10, 420, 829	0	50.00
51.00   05100   RECOVERY ROOM	0. 083224	0	)	0 1, 690, 307	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 670023	0	)	0 61, 504	0	52.00
53. 00   05300   ANESTHESI OLOGY	0. 000000	0	)	0 0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 218273	0		0 2, 939, 897	0	54. 00
54. 01   03630   ULTRA SOUND	0. 077445	0		0 810, 836	0	54. 01
54. 02   03440   MAMMOGRAPHY	0. 195243	0		0 166, 561	0	54. 02
55. 00   05500 RADI OLOGY-THERAPEUTI C	0. 113585	0		0 1, 798, 015	0	55. 00
56. 00   05600 RADI OI SOTOPE	0. 094895	0		0 1, 662, 730	0	56. 00
57. 00  05700 CT SCAN	0. 024368			0 8, 757, 052	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 043472	0		0 1, 670, 802	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 040089	0		0 1, 070, 330	0	59. 00
60. 00   06000   LABORATORY	0. 064835	0		0 9, 302, 567	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 137744			0 207, 394	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 119379	l o		0 453, 535		65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 401199	l o		0 288, 801	l o	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 072370	l o		0 1, 443, 895	l o	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 108172	l o		0 305, 533		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 213243			0 2, 703, 289		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 429710			0 2, 150, 896		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 133699			0 7, 231, 513		73. 00
74.00 07400 RENAL DIALYSIS	0. 177357			0 4, 931		74. 00
76. 00   03950   LI THOTRI PSY	0. 104594			0 438, 299		76. 00
76. 01   03330   ENDOSCOPY	0. 075323			0 1, 277, 771	0	76. 01
76. 02 03040 PRI SI ON CLI NI C	1. 598918			0 0	0	76. 02
76. 03   03050   WOUND CARE	0. 286909		1	0 648, 586	1	76. 03
76. 04   03060   OPI C	0. 194205			0 675, 462		
OUTPATIENT SERVICE COST CENTERS	0. 171200		1	070, 102		70.01
91. 00 09100 EMERGENCY	0. 094707	С	)	0 14, 082, 491	0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 848641		1	0 728, 558		
200.00 Subtotal (see instructions)	0.010011		1	0 72, 992, 384		200. 00
201.00 Less PBP Clinic Lab. Services-Program			1	0 72, 772, 304		201. 00
Only Charges						201.00
202.00 Net Charges (line 200 +/- line 201)				0 72, 992, 384	0	202. 00
1 1 1 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1		1	, , , , , , , , , , , , , , , , , , , ,	,	

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL			In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE COST	Provider CCN: 15-0046	Peri od: From 09/01/2016	

To 08/31/2017 Date/Time Prepared: 1/27/2018 2:15 pm Title XIX Hospi tal Cost 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 1, 000, 483 50.00 51.00 05100 RECOVERY ROOM 0000000000000000000000000000 140, 674 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 41, 209 52 00 05300 ANESTHESI OLOGY 53.00 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 641, 700 54.00 54. 01 03630 ULTRA SOUND 62, 795 54.01 03440 MAMMOGRAPHY 54.02 32, 520 54.02 55.00 05500 RADI OLOGY-THERAPEUTI C 204, 228 55.00 05600 RADI OI SOTOPE 56.00 157, 785 56.00 05700 CT SCAN 57 00 213, 392 57 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 72, 633 58.00 59.00 05900 CARDIAC CATHETERIZATION 42, 908 59.00 06000 LABORATORY 603, 132 60.00 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 28, 567 62.00 62.00 65.00 06500 RESPIRATORY THERAPY 54, 143 65.00 66.00 06600 PHYSI CAL THERAPY 115, 867 66.00 69.00 06900 ELECTROCARDI OLOGY 104, 495 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 33,050 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 576, 457 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 924, 262 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 966, 846 73.00 74.00 07400 RENAL DIALYSIS 875 74 00 76.00 03950 LI THOTRI PSY 45, 843 76.00 03330 ENDOSCOPY 76. 01 96, 246 76.01 76.02 03040 PRISION CLINIC 76.02 03050 WOUND CARE 76.03 186, 085 76.03 76.04 03060 OPI C 131, 178 76.04 OUTPATIENT SERVICE COST CENTERS 0 91.00 09100 EMERGENCY 1, 333, 710 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 618, 284 92.00 0 200.00 Subtotal (see instructions) 8, 429, 367 200. 00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges Net Charges (line 200 +/- line 201) 0 202.00 8, 429, 367 202.00

Heal th	Financial Systems 1	ERRE HAUTE REGI	ONAL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS		S Provider Component	CCN: 15-S046	Peri od: From 09/01/2016 To 08/31/2017	Worksheet D Part IV	pared:
			Titl	e XIX	Subprovi der - I PF	Cost	
	Cost Center Description	Non Physician Anesthetist Cost	ŭ		Medical Education Cost	4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 0	1	
51. 00	05100 RECOVERY ROOM	0	0		0 0	1	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
53. 00	05300 ANESTHESI OLOGY	0	0		0 0	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
54. 01	03630 ULTRA SOUND 03440 MAMMOGRAPHY	0			0 0	0	
54. 02		0			0 0	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0			0 0	1	
56. 00 57. 00	05600	0			0 0	0	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	
59.00	05900 CARDIAC CATHETERIZATION	0			0 0	0	
60.00	06000 LABORATORY	0			0 0	0	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0 0	0	
65. 00	06500 RESPIRATORY THERAPY	0	Ö		0 0	Ö	1
66. 00	06600 PHYSI CAL THERAPY	0	Ö		0 0	0	
69. 00	06900 ELECTROCARDI OLOGY	0	Ö		0 0	Ō	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	O		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0 0	0	74.00
76.00	03950 LI THOTRI PSY	0	0		0 0	0	76. 00
76. 01	03330 ENDOSCOPY	0	0		0	0	
76. 02	03040 PRISION CLINIC	0	0		0	0	76. 02
76. 03	03050 WOUND CARE	0	0		0	0	
76. 04	03060 OPI C	0	0		0 0	0	76. 04
01 00	OUTPATIENT SERVICE COST CENTERS				0 0	_	01 00
91.00	09100 EMERGENCY	0			0 0		
92. 00 200. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) Total (lines 50-199)	0	0		0 0	l	92. 00 200. 00
200.00	Total (Titles 30-199)	١	1	1	U <sub>I</sub> U	ı	1200.00

Health Financial Systems T	ERRE HAUTE REG	IONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER				Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-S046	From 09/01/2016 To 08/31/2017	Part IV Date/Time Pre 1/27/2018 2:1	
		Ti tl	e XIX	Subprovi der -	Cost	о рііі
Coot Conton Decemintion	Total	Total Charges	Doti o of Coo	IPF t Outpatient	I nnoti ont	
Cost Center Description	Total Outpatient	(from Wkst. C,	to Charges	Ratio of Cost	Inpatient Program	
	Cost (sum of	Part I, col.			Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.	charges	
	4)	0)	')	7)		
	6.00	7. 00	8.00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	89, 630, 321	0.00000	0. 000000	17, 509	50.00
51.00 05100 RECOVERY ROOM	0	12, 723, 357	0. 00000	0. 000000	4, 585	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0. 000000	0	52.00
53. 00   05300   ANESTHESI OLOGY	0			0. 000000	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	15, 087, 275	0.00000	0. 000000	38, 070	54.00
54. 01 03630 ULTRA SOUND	0	4, 629, 232	0. 00000	0. 000000	5, 873	54. 01
54. 02 03440 MAMMOGRAPHY	0			0. 000000	0	54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	17, 021, 301	0. 00000	0. 000000	1, 485	55. 00
56. 00   05600   RADI OI SOTOPE	0	12, 969, 304	0. 00000	0. 000000	0	56. 00
57. 00  05700 CT SCAN	0	54, 983, 436	0. 00000	0. 000000	157, 244	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	13, 564, 098	0. 00000	0. 000000	11, 824	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	26, 864, 974	0.00000	0. 000000	0	59. 00
60. 00   06000   LABORATORY	0	66, 576, 871	0. 00000	0. 000000	1, 261, 877	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	6, 639, 188	0.00000	0. 000000	1, 525	62.00
65. 00 06500 RESPIRATORY THERAPY	0	18, 094, 921	0.00000	0. 000000	72, 056	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	7, 001, 120	0.00000	0. 000000	3, 455	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	17, 980, 132			43, 107	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	1, 436, 203			6, 215	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41, 254, 590	0. 00000		14, 134	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0. 00000		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0				1, 080, 895	
74.00   07400   RENAL DIALYSIS	0	-,,			0	
76. 00   03950   LI THOTRI PSY	0	, , , , , , , , , , , , , , , , , , , ,			0	
76. 01 03330 ENDOSCOPY	0				0	
76. 02   03040   PRI SI ON CLI NI C	0				0	76. 02
76. 03   03050   WOUND CARE	0				0	
76. 04 03060 OPI C	0	5, 569, 446	0.00000	0.000000	0	76. 04
OUTPATIENT SERVICE COST CENTERS						
91. 00   09100   EMERGENCY	0				950, 973	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0. 000000	13, 856	
200.00   Total (lines 50-199)	0	640, 639, 454	l		3, 684, 683	J200. 00

ADDODT	Financial Systems T TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	ERRE HAUTE REGI		^N: 15 0044	Peri od:	u of Form CMS- Worksheet D	2332 10
	TONMENT OF INPATTENT/OUTPATTENT ANCILLARY SER H COSTS	WICE UIHER PASS	Provider Co	UN: 15-0046	From 09/01/2016		
	555.5		Component	CCN: 15-S046	To 08/31/2017	Date/Time Pro 1/27/2018 2:	epared:
			Ti tl	e XIX	Subprovi der -	Cost	15 piii
					IPF		
	Cost Center Description	I npati ent	Outpati ent	Outpati ent			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Throug			
		Costs (col. 8		Costs (col.	9		
		x col . 10)	10.00	x col . 12)			
	ANOLILARY CERVICE COCT CENTERS	11. 00	12. 00	13. 00			
FO 00	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0		0		50.00
51.00	05100 RECOVERY ROOM	0	0		0		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52. 00
53.00	05300 ANESTHESI OLOGY	0	0		0		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54. 00
54. 01	03630 ULTRA SOUND	0	0		0		54. 01
54. 02		0	0		0		54. 02
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0		55. 00
56.00	05600 RADI OI SOTOPE	0	0		0		56. 00
57. 00	05700 CT SCAN	0	0		0		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0		59. 00
60.00	06000 LABORATORY	0	0		0		60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0		62. 00
65. 00	06500 RESPI RATORY THERAPY	0	0		0		65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0		66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0		69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0		0		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0		73. 00
	07400 RENAL DI ALYSI S	0	0		0		74. 00
76. 00	03950 LI THOTRI PSY	0	0		0		76. 00
76. 01	03330 ENDOSCOPY	0	0		0		76. 01
76. 02	03040 PRISION CLINIC	0	0		0		76. 02
76. 03	03050 WOUND CARE	0	0		0		76. 03
76.04	03060 OPI C	I ol	0		0		76. 04

0 0

0 0 0

91. 00 92. 00 200. 00

Heal th	Financial Systems T	ERRE HAUTE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER		Provider Component	CCN: 15-T046	Peri od: From 09/01/2016 To 08/31/2017	Worksheet D Part IV Date/Time Pre 1/27/2018 2:1	pared:
			Ti tl	e XIX	Subprovi der - I RF	Cost	
	Cost Center Description	Non Physician N Anesthetist Cost	Ü		Medical Education Cost	4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			1			
	05000 OPERATING ROOM	0	0	l .	0 0	0	
	05100 RECOVERY ROOM	0	0		0 0	0	
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY		0		0 0	0	
	05300 RADI OLOGY-DI AGNOSTI C		0		0 0	0	
	03630 ULTRA SOUND		0		0 0	0	
	03440 MAMMOGRAPHY		0		0 0	0	1
	05500 RADI OLOGY-THERAPEUTI C		0		0 0	0	1
	05600 RADI OI SOTOPE	0	0		0 0	0	1
	05700 CT SCAN	o	0		0 0	0	1
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	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	0	0		0 0	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	62. 00
	06500 RESPI RATORY THERAPY	0	0		0 0	0	
	06600 PHYSI CAL THERAPY	0	0		0 0	0	
	06900 ELECTROCARDI OLOGY	0	0		0 0	0	
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS		0		0 0	0	
	03950 LI THOTRI PSY		0		0 0	0	
	03330 ENDOSCOPY		0		0 0	0	
	03040 PRI SI ON CLI NI C		0		0 0	0	
	03050 WOUND CARE	0	0		0 0	0	
	03060 OPI C	o o	0			0	
	OUTPATIENT SERVICE COST CENTERS	<u> </u>					1
	09100 EMERGENCY	0	0		0 0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
200.00	Total (lines 50-199)	0	0		0 0	0	200. 00

Health Financial Systems	TERRE HAUTE REG	IONAL HOSPITAL		Inlie	u of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER			CN: 15-0046	Peri od:	Worksheet D	2552 10
THROUGH COSTS	WI OL OTHER TAO			From 09/01/2016	Part IV	
		'		To 08/31/2017	Date/Time Pre 1/27/2018 2:1	
		Ti tl	e XIX	Subprovi der - I RF	Cost	
Cost Center Description	Total	Total Charges	Ratio of Cost		Inpati ent	
'	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.	Ü	
	4)			7)		
	6. 00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM	0				0	50.00
51. 00   05100   RECOVERY ROOM	0			0. 000000	0	51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	3, 491, 242	0.00000	0. 000000	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	0.00000	0. 000000	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	15, 087, 275	0.00000	0. 000000	858	54.00
54. 01   03630   ULTRA SOUND	0	4, 629, 232	0.00000	0. 000000	0	54. 01
54. 02 03440 MAMMOGRAPHY	0	2, 245, 316	0.00000	0. 000000	0	54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	17, 021, 301	0.00000	0. 000000	0	55.00
56. 00   05600   RADI 0I SOTOPE	0	12, 969, 304	0.00000	0. 000000	0	56.00
57. 00 05700 CT SCAN	0			0. 000000	3, 570	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	13, 564, 098	0. 00000	0. 000000	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0. 000000	0	1
60. 00 06000 LABORATORY	0	66, 576, 871	0.00000	0. 000000	10, 065	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0				0	1
65. 00 06500 RESPIRATORY THERAPY	0				12, 960	65.00
66. 00 06600 PHYSI CAL THERAPY	0		•		119, 774	
69. 00 06900 ELECTROCARDI OLOGY	0				0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0				0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0				657	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		•		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0				53, 918	
74. 00   07400   RENAL DI ALYSI S	0		•		0	1
76. 00 03950 LI THOTRI PSY	0	-,,			Ö	
76. 01 03330 ENDOSCOPY	0				0	
76. 02 03040 PRI SI ON CLI NI C	0				Ö	
76. 03   03050   WOUND CARE	0	1			Ö	
76. 04   03060   0PI C	0				o o	
OUTPATIENT SERVICE COST CENTERS		3, 307, 440	0.0000	0. 000000		1 ,0.04
91. 00 09100 EMERGENCY	0	59, 248, 093	0.00000	0. 000000	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				Ö	
200. 00 Total (lines 50-199)	0			3. 333000	201, 802	
	1	3.0,007,101	1	1	20.,002	1-00.00

ealth Financial Systems PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEITHROUGH COSTS	TERRE HAUTE REGI RVI CE OTHER PASS	Provi der C	CN: 15-0046 CCN: 15-T046	Period: From 09/01/2016 To 08/31/2017	w of Form CMS Worksheet D Part IV Date/Time Pr 1/27/2018 2:	epared:
		Ti tl	e XIX	Subprovi der - I RF	Cost	•
Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10) 11.00	Outpatient Program Charges	Outpatient Program Pass-Throug Costs (col. x col. 12) 13.00	jh 9		
ANCILLARY SERVICE COST CENTERS			10.00			
10.00   05000   0PERATING ROOM   05100   RECOVERY ROOM   05200   DELIVERY ROOM   & LABOR ROOM   05300   ANESTHESI OLOGY   05400   RADI OLOGY-DI AGNOSTI C   03630   ULTRA SOUND   03630   ULTRA SOUND   03440   MAMMOGRAPHY   05500   RADI OLOGY-THERAPEUTI C   05600   RADI OLOGY-THERAPEUTI C   05600   RADI OLOGY-THERAPEUTI C   05600   RADI OLOGY-THERAPEUTI C   05700   CT SCAN   05800   MAGNETI C RESONANCE   MAGING (MRI )   05900   CARDI AC CATHETERI ZATI ON   06900   LABORATORY   06000   LABORATORY   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   05500   RESPIRATORY THERAPY   06500   RESPIRATORY THERAPY   06600   PHYSI CAL THERAPY   06900   07000   ELECTROENCEPHALOGRAPHY   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   07200   IMPL. DEV. CHARGED TO PATI ENTS   07300   DRUGS CHARGED TO PATI ENTS   07400   RENAL DI ALYSI S   03330   ENDOSCOPY   03040   PRI SI ON CLI NI C   0604   03060   PI C   0606   03060   PI C   0606				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		50. 00 51. 00 52. 00 53. 00 54. 00 54. 00 55. 00 57. 00 58. 00 59. 00 60. 00 65. 00 66. 00 66. 00 70. 00 71. 00 73. 00 74. 00 76. 00 76. 00 76. 00
OUTPATIENT SERVICE COST CENTERS						
01.00	0 0	( ( (		0 0 0		91. 00 92. 00 200. 00

	Financial Systems	TERRE HAUTE REGION			u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 15-0046	Peri od: From 09/01/2016	Worksheet D-1	
				To 08/31/2017		
			Title XVIII	Hospi tal	1/27/2018 2: 1 PPS	5 pm
	Cost Center Description		THE AVIII	nospi tai	113	
	<u>'</u>				1. 00	
	PART I - ALL PROVIDER COMPONENTS					
. 00	INPATIENT DAYS Inpatient days (including private room day	e and swing had day	s eveluding newbern)		19, 265	1.0
. 00	Inpatient days (including private room day				19, 265	
. 00	Private room days (excluding swing-bed and			rivate room days,	0	3.0
	do not complete this line.			-		١.,
. 00	Semi-private room days (excluding swing-be Total swing-bed SNF type inpatient days (i			or 21 of the cost	16, 561 0	
. 00	reporting period	ncruding private to	on days) through becembe	si si di the cost	U	3.0
. 00	Total swing-bed SNF type inpatient days (i	ncluding private ro	om days) after December	31 of the cost	0	6.0
	reporting period (if calendar year, enter				_	
. 00	Total swing-bed NF type inpatient days (ir reporting period	icluding private roo	m days) through December	31 of the cost	0	7.0
. 00	Total swing-bed NF type inpatient days (ir	ncluding private roo	m davs) after December 3	31 of the cost	0	8.0
	reporting period (if calendar year, enter	0 on this line)	•			
. 00	Total inpatient days including private room	om days applicable t	o the Program (excluding	g swing-bed and	9, 342	9.0
0. 00	newborn days) Swing-bed SNF type inpatient days applicab	alo to titlo VVIII o	nly (including privato r	coom days)	0	10.0
0. 00	through December 31 of the cost reporting			dolli days)	U	10.0
1. 00	Swing-bed SNF type inpatient days applicab			room days) after	0	11.0
	December 31 of the cost reporting period (					
2. 00	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			0	12.0	
3. 00	Swing-bed NF type inpatient days applicabl		X only (including privat	e room days)	0	13.0
	after December 31 of the cost reporting pe	eriod (if calendar y	ear, enter O on this lir	ne)		
4. 00	Medically necessary private room days appl	icable to the Progra	am (excluding swing-bed	days)	0	
5. 00 6. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)				0	
0. 00	SWING BED ADJUSTMENT					10.0
7. 00	Medicare rate for swing-bed SNF services a	pplicable to servic	es through December 31 o	of the cost	0.00	17. C
0 00	reporting period		CL D L 24 C		0.00	100
8. 00	Medicare rate for swing-bed SNF services a reporting period	ipplicable to servic	es after December 31 of	the cost	0.00	18. C
9. 00	Medicaid rate for swing-bed NF services ap	plicable to service	s through December 31 of	the cost	0.00	19.0
	reporting period .	•	J			
0. 00	Medicaid rate for swing-bed NF services ap	plicable to service	s after December 31 of 1	the cost	0. 00	20.0
1. 00	reporting period Total general inpatient routine service co	st (see instruction	5)		17, 002, 310	21.0
2. 00	Swing-bed cost applicable to SNF type serv			ing period (line	0	
	5 x line 17)	· ·	·			
3. 00	Swing-bed cost applicable to SNF type serv	ices after December	31 of the cost reportir	ng period (line 6	0	23.0
4. 00	x line 18) Swing-bed cost applicable to NF type servi	ces through Decembe	r 31 of the cost reporti	ng period (line	0	24.0
1. 00	7 x line 19)	ces through becombe	i or or the cost reporti	ng perrou (rine	· ·	21.0
5. 00	Swing-bed cost applicable to NF type servi	ces after December	31 of the cost reporting	period (line 8	0	25. 0
4 00	x line 20)				0	24 0
6. 00 7. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net	of swing-bed cost	(line 21 minus line 26)		0 17, 002, 310	
. 50	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	2. 3g bod 603t	( 21 m.nd3 11110 20)		, 552, 510	1 -/
3. 00	General inpatient routine service charges		d and observation bed ch	narges)	0	1
9. 00	Private room charges (excluding swing-bed				0	1
0.00	Semi - pri vate room charges (excluding swing	, ,	. Line 20)		0	
1. 00 2. 00	General inpatient routine service cost/cha Average private room per diem charge (line	9	- IIIIC 20 <i>)</i>		0. 000000 0. 00	1
3 00	Average semi-private room per diem charge				0.00	

	PART I - ALL PROVIDER COMPONENTS		
	I NPATI ENT DAYS		
1.00		19, 265	1. 00
2.00		19, 265	2. 00
3.00		0	3. 00
	do not complete this line.		
4.00		16, 561	4. 00
5.00		0	5. 00
	reporting period		,
6. 00		0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)		7 00
7. 00		0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	o	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	۷	0.00
9. 00		9, 342	9.00
7. 00	newborn days)	7, 342	7.00
10. 0		0	10.00
	through December 31 of the cost reporting period (see instructions)	-	
11. 0		ol	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.0		0	12. 00
	through December 31 of the cost reporting period		
13.0		0	13. 00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14. C	0   Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. C		0	15. 00
16. C		0	16. 00
	SWING BED ADJUSTMENT		
17. C		0. 00	17. 00
	reporting period		
18. 0		0. 00	18. 00
40.4	reporting period	0.00	40.00
19. 0	-	0.00	19. 00
20. 0	reporting period 0 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
20. 0	reporting period	0.00	20.00
21. 0		17, 002, 310	21. 00
22. 0	· · · · · · · · · · · · · · · · · · ·	17, 002, 310	22.00
22. 0	15 x line 17)	Ĭ	22.00
23. 0	, ,	0	23. 00
	x line 18)	-	
24. 0	0   Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	o	24. 00
	7 x line 19)		
25.0	0   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
26. 0	0 Total swing-bed cost (see instructions)	0	26. 00
27.0		17, 002, 310	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 0		0	28. 00
29. 0		0	29. 00
30. C		0	30. 00
31. 0		0. 000000	1
32.0		0.00	1
33.0		0.00	1
34.0		0.00	34.00
35.0		0.00	ł
36.0		0	36.00
37. C		17, 002, 310	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20 (	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  O Adjusted general inpatient routine service cost per diem (see instructions)	882. 55	38. 00
38. C			
39. 0		8, 244, 782	1

	Financial Systems	TERRE HAUTE REGI		CN: 15 0044		workshoot D 1	
CUMPU I	ATION OF INPATIENT OPERATING COST		Provi der Co	1	Period: From 09/01/2016		
				-	To 08/31/2017	Date/Time Prep 1/27/2018 2:1	
				XVIII	Hospi tal	PPS	<u>о р</u>
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	inpatrent bays	col. 2)	÷	(col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0 0	0	42. 00
43. 00	Intensive Care Type Inpatient Hospital Unit INTENSIVE CARE UNIT	4, 894, 442	3, 184	1, 537. 20	0 1, 542	2, 370, 362	43.00
44. 00	CORONARY CARE UNIT	4,074,442	3, 104	1, 337. 20	1, 542	2, 370, 302	44.00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT						46. 00
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
	cost center bescription					1.00	
	Program inpatient ancillary service cost (V					18, 238, 968	48. 00
49. 00	Total Program inpatient costs (sum of lines	s 41 through 48)(	see instructio	ns)		28, 854, 112	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program in	nationt routing	sarvicas (from	Wket D sum	of Parts I and	1, 197, 965	50.00
30. 00	III)	ipatrent routine .	services (ITOIII	WK3t. D, Sum	or rarts r and	1, 177, 703	30.00
51. 00	Pass through costs applicable to Program in	npatient ancillar	y services (fr	om Wkst. D, s	um of Parts II	1, 028, 024	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				2, 225, 989	52. 00
53.00	Total Program excludable cost (sum of fines		lated, non-phy	sician anesth	etist, and	26, 628, 123	1
	medical education costs (line 49 minus line						
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION						F4 00
	Program discharges Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0.00	1
	Difference between adjusted inpatient opera	ating cost and ta	rget amount (I	ine 56 minus l	ine 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost i	concerting ported	anding 1004 u	undated and cou	mnounded by the	0.00	
39.00	market basket	eporting period	enarng 1990, u	puateu anu con	iipourided by the	0.00	39.00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	1
61. 00	If line 53/54 is less than the lower of line the second of					0	61.00
	which operating costs (line 53) are less the amount (line 56), otherwise enter zero (see		s (Tines 54 x	60), OF 1% OF	the target		
62. 00	Relief payment (see instructions)					0	62.00
63. 00	Allowable Inpatient cost plus incentive pay	yment (see instru	ctions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine co	osts through Dece	mher 31 of the	cost reporti	ng period (See	0	64. 00
01.00	instructions)(title XVIII only)	osts till odgir boool		cost reportir	ig period (see	١	01.00
65. 00	Medicare swing-bed SNF inpatient routine co	osts 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 rout</pre>	tine costs (line d	64 nlus line 6	5)(title XVII	lonly) For	o	66. 00
00.00	CAH (see instructions)		or prus rriie e	0)(11110 /1111	om y). To		00.00
67. 00	Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 o	f the cost rep	porting period	0	67. 00
68 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routi	ne costs after Do	ecember 31 of	the cost reno	rting period	o	68. 00
00.00	(line 13 x line 20)	ne costs arter b	ceember 51 01	the cost repor	tring perrod	١	00.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER Skilled nursing facility/other nursing faci						70.00
71.00	Adjusted general inpatient routine service	-					71.00
72. 00	Program routine service cost (line 9 x line	e 71)		•			72. 00
73.00	Medically necessary private room cost appli						73.00
74. 00 75. 00	Total Program general inpatient routine ser Capital-related cost allocated to inpatient				art II column		74. 00 75. 00
, 5. 00	26, line 45)	L TOURTHO SELVICE	COSES (TION W	OF KOHOUL D, FO	are ir, corumit		, 3. 00
76. 00	Per diem capital-related costs (line 75 $\div$ l	,					76. 00
77. 00	Program capital -related costs (line 9 x lin	•					77. 00 78. 00
78. 00 79. 00	Inpatient routine service cost (line 74 mir Aggregate charges to beneficiaries for exce		rovi der record	s)			79.00
	Total Program routine service costs for cor				us line 79)		80.00
81.00	Inpatient routine service cost per diem lin						81.00
82. 00	Inpatient routine service cost limitation ( Reasonable inpatient routine service costs	•					82. 00 83. 00
	Program inpatient ancillary services (see i	•	-,				84. 00
83. 00 84. 00			ns)				85. 00
83. 00 84. 00 85. 00	Utilization review - physician compensation						
83. 00 84. 00 85. 00	Total Program inpatient operating costs (su	um of lines 83 th					86. 00
83. 00 84. 00 85. 00 86. 00	Total Program inpatient operating costs (SUPART IV - COMPUTATION OF OBSERVATION BED PA	um of lines 83 th				2 704	
83. 00 84. 00 85. 00	Total Program inpatient operating costs (su	um of lines 83 th ASS THROUGH COST ns)	rough 85)			2, 704 882. 55 2, 386, 415	87. 00 88. 00

Health Financial Systems	TERRE HAUTE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 09/01/2016 Fo 08/31/2017	Doto/Time Dres	aanad.
				To 08/31/2017	Date/Time Prep 1/27/2018 2:1	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	2, 066, 511	17, 002, 310	0. 12154	3 2, 386, 415	290, 052	90.00
91.00 Nursing School cost	0	17, 002, 310	0.00000	2, 386, 415	0	91.00
92.00 Allied health cost	0	17, 002, 310	0.00000	2, 386, 415	0	92.00
93.00 All other Medical Education	0	17, 002, 310	0.00000	2, 386, 415	0	93.00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0046	Peri od: From 09/01/2016	Worksheet D-1
	Component CCN: 15-S046	To 08/31/2017	Date/Time Prepared: 1/27/2018 2:15 pm
	Title XVIII	Subprovi der -	PPS

		II the XVIII	I PF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		6, 635	1.00
2.00	Inpatient days (including private room days, excluding swing-			6, 635	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)	•	6, 635	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after December 3	31 or the cost	0	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	swing-bed and	1, 623	9. 00
	newborn days)		5		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		nom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, en	nter 0 on this line)	om days) arter	G	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		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
13.00	after December 31 of the cost reporting period (if calendar ve			U	13.00
14.00	Medically necessary private room days applicable to the Progra		, i	0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
	reporting period	, and the second			
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	<i>z</i> )		4, 493, 797	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
	5 x line 17)			_	
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	period (line 6	0	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
	7 x line 19)	·			
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 493, 797	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	d and abasement an had aba	, mass)	0	20.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	a and observation bed cha	ir ges)	0	28. 00 29. 00
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	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	nus line 33)(see instruct	ions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x lin	, ,	/	0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost dif	Terential (line	4, 493, 797	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		677. 29	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program			1, 099, 242 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39	,		1, 099, 242	
	j - j - j - j - j - j - j - j - j - j -	- · · · <b>/</b>	1	– . – .	

		ERRE HAUTE REGIO				eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CC Component C	F	Period: From 09/01/2016 Fo 08/31/2017		
			·	XVIII	Subprovi der -	1/27/2018 2: 1 PPS	5 pm
	Cook Contan December	T-+-1			I PF		
	Cost Center Description	Total Inpatient CostIr	Total npatient Days	Average Per Diem (col. 1 - col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units		-1			0	42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0	0.00	0	0	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1. 00 217, 506	48. 00
49. 00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS			ns)		1, 316, 748	
50.00	Pass through costs applicable to Program inpu	atient routine se	ervices (from	Wkst. D, sum	of Parts I and	96, 536	50. 00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillary	services (fro	om Wkst. D, su	um of Parts II	11, 050	51. 00
52.00	Total Program excludable cost (sum of lines					107, 586	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION		ated, non-pnys	sician anestne	etist, and	1, 209, 162	53. 00
54.00	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	1
57. 00	Difference between adjusted inpatient operat	ing cost and targ	get amount (Li	ine 56 minus I	ine 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	norting period er	ndina 1996 ili	ndated and con	nnounded by the	0.00	
	market basket				ipounded by the		
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines				the amount by	0.00	1
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see	n expected costs					
62.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ant (see instruct	tions)			0 0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	·					
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions) (title XVIII only)	•		·			64. 00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after December	131 of the co	ost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routil CAH (see instructions)	ne costs (line 64	1 plus line 6	5)(title XVIII	only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through [	December 31 o	f the cost rep	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after Dec	cember 31 of	the cost repor	ting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						70. 00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne 70 ÷ line :	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applications	•	(line 14 x liı	ne 35)			73. 00
74. 00 75. 00	Total Program general inpatient routine servicapital-related cost allocated to inpatient	•		orkehoot P. Dr	art II column		74. 00 75. 00
	26, line 45)		LOSTS (TIOII W	JI KSHEEL B, F	irt II, Cordiiii		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li    Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus	s line 77)					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa	· ·			ıs line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limit	tati on		(	,		81. 00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (	· · · · · · · · · · · · · · · · · · ·	)				82. 00 83. 00
84.00	Program inpatient ancillary services (see in	structions)					84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	<i>,</i>				
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		ine 2)			0.00	87. 00 88. 00
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00

Health Financial Systems T	ERRE HAUTE REGI	ONAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (		From 09/01/2016 To 08/31/2017	Date/Time Pre 1/27/2018 2:1	
		Title	XVIII	Subprovi der - I PF	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	394, 677	4, 493, 797	0. 08782	7 0	0	90. 00
91.00 Nursing School cost	0	4, 493, 797	0. 00000	0 0	0	91. 00
92.00 Allied health cost	0	4, 493, 797	0.00000	0	0	92. 00
93.00 All other Medical Education	0	4, 493, 797	0. 00000	0 0	0	93. 00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0046	Peri od: From 09/01/2016	Worksheet D-1
	Component CCN: 15-T046		
	Title XVIII	Subprovi der -	PPS

		II the Aviii	I RF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		1, 780	1.00
2.00	Inpatient days (including private room days, excluding swing-			1, 780	
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)		1, 780	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after becember 3	or the cost	0	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	swing-bed and	1, 119	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		oom davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)			
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX	( 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
13.00	after December 31 of the cost reporting period (if calendar ye			Ö	13.00
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	lays)	0	14. 00
15. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15.00
16. 00	SWING BED ADJUSTMENT			U	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
40.00	reporting period				40.00
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	G			
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of th	ne cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	s)		2, 224, 525	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
22.00	5 x line 17)	21 of the cost reporting	, nominal (line (	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	perrod (Trie 6	U	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	ng period (line	0	24. 00
05.00	7 x line 19)				05.00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	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)		2, 224, 525	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation had abs	rgos)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed cha	ii ges)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
33. 00 34. 00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruct	ions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x lin	, ,	/	0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost dif	Terential (line	2, 224, 525	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 249. 73	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		1, 398, 448 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39	•		1, 398, 448	
	j - j - j - j - j - j - j - j - j - j -		ı		

		<u> </u>	ERRE HAUTE REGIO			In Li	eu of Form CMS-	2552-10
Total   Total   Average Per   Program Bays   Program Bays   Call 3 x pp.	COMPUT	FATION OF INPATIENT OPERATING COST				From 09/01/2016	1	
Cost Centur Description  Total Program Buyes  Program Puyes  4.00  4.00  Puyes  Program Puyes  4.00  Puyes  Program Puyes  Program Puyes  Puyes  Puyes  Puyes  Pu				·			1/27/2018 2:1	
				Title	XVIII		PPS	
1.00   2.00   3.00   4.00   5.00   4.20   5.00   4.20   5.00   4.20   5.00   4.20   5.00   4.20   5.00   4.20   5.00   4.20   5.00   4.20   5.00   4.20   5.00   4.20   5.00   4.20   5.00   4.20   5.00   4.20   5.00   4.20   5.00   4.20   5.00   4.20   5.00   4.20   5.00   6.00   4.20   5.00   6.00   4.20   5.00   6.00   4.20   5.00   6.00   4.20   5.00   6.00   4.20   5.00   6.00		Cost Center Description			Diem (col. 1		(col. 3 x col.	
Intensive Care Type I reput int Hospital Units  40. 00   NIENS LORGE UNIT   0   0   0   0   0   0   0   0   0					3.00		5. 00	
	42. 00		0	0	0.	00 0	) 0	42.00
45.00   SURPLINTENSIVE CARE UNIT   46.00   SURCIAL INTENSIVE CARE UNIT   46.00   SURCIAL INTENSIVE CARE UNIT   46.00   SURCIAL INTENSIVE CARE UNIT   46.00   47.00   OTHER SPECIAL CARE (SPECIFY)   47.00   Total Program inpatient ancillary service cost (#kst. D-3, col. 3, line 200)   1.00. 887   48.00   Pagram inpatient costs (sum of lines 41 through 48) (see instructions)   2.3993 335   49.00   Pags through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II and 17)   114, 119   51.00   Pags through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II and 17)   114, 119   51.00   Pags through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II and 17)   114, 119   51.00   Pags through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II and 17)   114, 119   51.00   Pags through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II and 17)   114, 119   51.00   Pags through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II and 17)   114, 119   51.00   114, 119		INTENSIVE CARE UNIT	0	0	0.	00 0	0	
3.00   Program program explicable cost (sum of lines 54 and 51)   1.00								1
Cost Center Description								1
1.00		OTHER SPECIAL CARE (SPECIFY)						1
49.00   Program Inpati ent ancillary service cost (West. D-3, col. 3, Tine 200)   1,000,887   49.00   Total Program Inpati ent costs (com of Tines 4,1 through 48)(see Instructions)   2,399,355   49.00   Pass Through costs applicable to Program Inpati ent routine services (from West. D, sum of Parts I and 197)   114,119   51.00   114,119   114		Cost Center Description					1 00	
PASS_THROUGH_COST_ADJUSTMENTS	48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)				48. 00
50.00   Pass through costs applicable to Program inpatient routine services (From West. D., sum of Parts. I and 17).	49. 00		41 through 48)(s	ee instructio	ns)		2, 399, 335	49. 00
51.00   Pass through costs applicable to Program inpatient ancillarly services (From Wikst. D., sum of Parts II   114, 119   51, 00   20, 20   70   70   70   70   70   70   70	50. 00		atient routine s	ervices (from	Wkst. D, su	m of Parts I and	217, 209	50.00
and IV)  1. 20. 00 Total Program excludable cost (sum of lines 50 and 51)  1. 20. 00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and program inpatient operating cost excluding capital related, non-physician anesthetist, and program inpatient operating cost excluding capital related, non-physician anesthetist, and program of costs. (line 49 minus line 52)  1. 20. 00 Program discharges  1. 20. 00 Program discharges  2. 20. 08. 00 Program discharges  3. 20. 00 Program discharges  4. 20. 00 Program discharges  4. 20. 00 Program discharges  5. 20. 00 Program discharges  6. 20. 00 Program discharges  7. 20. 00 Program discharges  8. 20. 00 Progr	E4 00	1 *						
10   Total Program excludable cost (sum of lines 50 and 51)   331,328   52.00   3.00   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and nedical education costs (line 49 minus line 52)   54.00   76	51.00		atient ancillary	services (fr	om WKST. D,	sum of Parts II	114, 119	51.00
medical education costs (line 49 innus line 52)	52. 00	Total Program excludable cost (sum of lines					331, 328	52. 00
TARGET MOUNT AND LINIT COMPUTATION   54.00   55.00   1   54.00   7   1   54.00   7   1   54.00   7   1   54.00   1   55.00   1   1   54.00   1   54.00   55.00   1   1   54.00   1   54.00   55.00   1   1   55.00   1   55.00   1   55.00   1   55.00   55.00   1   55.00   55.00   1	53. 00			ated, non-phy	sician anest	hetist, and	2, 068, 007	53. 00
55.00   Target amount per discharge   0.00   55.00   0.00   55.00   0.00   10   10   10   54.00   10   10   54.00   10   10   54.00   10   10   54.00   10   10   54.00   10   10   54.00   10   10   54.00   10   10   54.00   10   10   54.00   10   10   10   55.00   10   10   10   10   10   10   10			32)					1
56.00   Target amount (line 54 x line 55)   0   56.00   0   56.00   0   56.00   0   50.0							l .	
57.00   Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)   0   57.00							1	
Section   Lesser of lines \$3/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket   0.00   59.00		,	ing cost and tar	get amount (I	ine 56 minus	line 53)	-	
market basket  0.00   0			nanting paried a	nding 100/	ndoted and a	ampaundad by tha		
1.00   If line 53/54 is less than the lower of lines 55. \$0 or 60 enter the lesser of 50% of the amount by 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)   0 c2.00	59.00		porting period e	enarng 1996, u	puateu anu c	ompounded by the	0.00	59.00
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)  0							1	1
amount (line 56), otherwise enter zero (see instructions)   0   62.00	61.00						0	61.00
Allowable   Inpatient cost plus incentive payment (see instructions)   O   63.00		amount (line 56), otherwise enter zero (see		(111100 01111		· · · · · · · · · · · · · · · · · · ·		
PROGRAM INPATIENT ROUTINE SWING BED COST		1 7	ent (see instruc	tions)				
instructions) (title XVIII only)  66.00 (and care swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 (Alf (See instructions)  67.00 (Title V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only). For (line 12 x line 19)  68.00 (Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 (Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 (Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 (Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 (Alien 13 x line 20)  69.00 (Alien 14 x line 20)  69.00 (Alien 15 x line 20)  69.00 (Alien 25 x line 20)  69.0	03.00	PROGRAM INPATIENT ROUTINE SWING BED COST						03.00
66.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (See Instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 37) 70.00 Program routine service cost (line 9 x line 71) 71.00 Program routine service cost (line 9 x line 71) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 Program routine service cost (line 75 + line 2) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Program capital -related costs (line 75 + line 2) 77.00 Program capital -related costs (line 76 minus line 77) 78.00 Inpatient routine service cost (line 76 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost (see instructions) 81.00 Reasonab	64. 00		ts through Decem	ber 31 of the	cost report	ing period (See	0	64. 00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Program capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 77.00 Total Program routine service cost film 1imitation (line 78 minus line 79) 78.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 78.00 Program inpatient ancillary services (see instructions) 78.00 Program inpatient ancillary service (see instructions) 78.00 Utilization review - physician compensation (see instructions) 78.00 Utilization review - physician compensation (see instructions) 78.00 Valueted general inpatient routine cost per diem (line 27 + line 2) 79.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 79.00 Repair inpatient cost in bed days (see instructions)	65. 00	, ,	ts after Decembe	er 31 of the c	ost reportin	g period (See	0	65. 00
CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (1ine 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (1ine 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 69.00  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/Other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Modically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 75 + line 2) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Inpatient routine service cost for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 83.00 Reasonable inpatient routine service cost (see instructions) 84.00 Program inpatient ancillary services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Total Program inpatient routine service cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	44 00		no costs (lino 4	4 plus lips 4	E) (+; +  o V//	II only) For		44 00
(line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  70.01 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  70.02 Total title Norsing facility/other nursing f	00.00		ne costs (Title c	4 prus rine d	5)(title xvi	rr omy). ro		00.00
68.00   Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)   68.00	67. 00		e costs through	December 31 d	f the cost r	eporting period	0	67. 00
Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)   0   69.00	68. 00		e costs after De	cember 31 of	the cost rep	orting period	0	68. 00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  10 Inpatient routine service cost (line 74 minus line 77)  78.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  81.00 Reasonable inpatient routine service costs (see instructions)  82.00 Utilization review - physician compensation (see instructions)  83.00 Willization review - physician compensation (see instructions)  84.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  85.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  87.00 Racsonable inpatient routine cost per diem (line 27 + line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	(0.00			: /7   !:	(0)			(0.00
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 75 * line 2) 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost service costs (see instructions) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  10 Oscillated Cost (line 37 in line 2) 10 Oscillate (line 27 in line 2) 10 Oscillate (line 37) 11 Oscillate (line 37) 12 Oscillate (line 37) 13 Oscillate (line 37) 14 Oscillate (line 37) 15 Oscillate (line 37) 16 Oscillate (line 37) 17 Oscillate (line 37) 17 Oscillate (line 37) 18 Oscillate (line 37)	69.00						0	1 69.00
72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost limitation 81.00 Reasonable inpatient routine service cost (see instructions) 82.00 Reasonable inpatient routine service cost (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Program inpatient operating costs (sum of lines 83 through 85)  87.00 Total Program inpatient operating costs (sum of lines 83 through 85)  87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		Skilled nursing facility/other nursing facil	ity/ICF/IID rout	ine service c	ost (line 37	)		
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 78 ± line 76) 78.00 Inpatient routine service cost (line 74 ± line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 ± line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Occupant in patient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		,		ne /0 ÷ line	2)			
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost limitation (line 9 x line 81)  83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Occupance of the following service costs (from Worksheet B, Part II, column 75.00  76.00 70.00 North III, column 75.00  76.00 70.00 North III, column 75.00  77.00 70.00 North III, column 75.00  78.00 70		,	,	(line 14 x li	ne 35)			
26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  80.00 Inpatient routine service cost per diem limitation  81.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Inpatient routine service costs (see instructions)  83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  76.00 Program inpatient routine service costs (from provider records)  87.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)			•			Dort II column		
77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	75.00	·	routine service	COSTS (II OIII W	OIRSHEEL B,	Part II, Corumn		75.00
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost per diem limitation 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 October 78 minus line 79  89.00 Adjusted general inpatient operating costs (sum of lines 83 through 85)  98.00 October 79.00  80.00 October 79.00  81.00 October 79.00  82.00 October 79.00  82.00 October 79.00  83.00 October 79.00  84.00 October 79.00  85.00 October 79.00  86.00 October 79.00  87.00 October 79.00  87.00 October 79.00  87.00 October 79.00  88.00		,	,					
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 October 1 in the cost limitation (line 78 minus line 79) 88.00 October 2 minus line 79 89.00 October 3 minu		,	,					
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 86.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2)								
82.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Beasonable inpatient routine service cost limitation (line 9 x line 81)  88.00 Beasonable inpatient routine service cost (see instructions)  88.00 Beasonable inpatient routine service costs (see instructions)  89.00 Beasonable inpatient routine service costs (see instructions)  80.00 Beasonable inpatient routine service costs (see instructions)  80.00 Beasonable inpatient routine service costs (see instructions)  80.00 Beasonable inpatient routine services (see instructions)  80.00 Beasonable inpatient routine services (see instructions)  81.00 Beasonable inpatient routine services (see instructions)  82.00 Beasonable inpatient routine services (see instructions)  83.00 Beasonable inpatient routine services (see instructions)  84.00 Beasonable inpatient routine services (see instructions)  85.00 Beasonable				st limitation	(line 78 mi	nus line 79)		
84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  89.00 Review of the second seco		· ·						1
85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Responsible to the following section (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Responsible to the following section (see instructions)  89.00 Responsible to the following section (see instruction				5)				1
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				ıs)				
87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  0.00 88.00		Total Program inpatient operating costs (sum	of lines 83 thr					1
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 0.00 88.00	97 00							97 00
		,	•	line 2)				
	89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89.00

Health Financial Systems T	ERRE HAUTE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (		From 09/01/2016 To 08/31/2017		
		Title	XVIII	Subprovi der -	PPS	
C+ C+ D	0+	D-1.41 C4		I RF	0	
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	345, 512	2, 224, 525	0. 15531	9 0	0	90.00
91.00 Nursing School cost	0	2, 224, 525	0. 00000	0	0	91.00
92.00 Allied health cost	0	2, 224, 525	0.00000	0	0	92.00
93.00 All other Medical Education	0	2, 224, 525	0. 00000	o o	0	93. 00

	Financial Systems TERRE HAUTE ATION OF INPATIENT OPERATING COST	REGIONAL HOSPITAL  Provider CCN: 15-0046	Peri od:	u of Form CMS-2 Worksheet D-1	
JOINIPUT	ATTON OF INPATIENT OPERATING COST	Provider CCN. 15-0046	From 09/01/2016 To 08/31/2017		pared:
		Title XIX	Hospi tal	Cost	э рііі
	Cost Center Description		•		
	DADT I ALL DDOVIDED COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				1
. 00	Inpatient days (including private room days and swing-b	ed days, excluding newborn)		19, 265	1.00
2. 00	Inpatient days (including private room days, excluding			19, 265	
3. 00	Private room days (excluding swing-bed and observation	bed days). If you have only pr	rivate room days,	0	3.00
	do not complete this line.				1
. 00	Semi-private room days (excluding swing-bed and observa			16, 561	
. 00	Total swing-bed SNF type inpatient days (including priv	ate room days) through Decembe	er 31 of the cost	0	5. 00
00	reporting period	dava) Darambara	21 -6	0	/ 00
. 00	Total swing-bed SNF type inpatient days (including privreporting period (if calendar year, enter 0 on this lin		31 of the cost	0	6.00
. 00	Total swing-bed NF type inpatient days (including priva		1 of the cost	0	7. 00
. 00	reporting period	te room days) till odgir becember	01 01 1110 0031		/. 00
. 00	Total swing-bed NF type inpatient days (including priva	te room days) after December 3	31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this lin				ĺ
00	Total inpatient days including private room days applic	able to the Program (excluding	g swing-bed and	1, 154	9. 00
	newborn days)				1
0. 00	Swing-bed SNF type inpatient days applicable to title X		room days)	0	10.00
4 00	through December 31 of the cost reporting period (see i				14.00
1. 00	Swing-bed SNF type inpatient days applicable to title X December 31 of the cost reporting period (if calendar y		room days) arter	0	11. 00
2. 00	Swing-bed NF type inpatient days applicable to titles V		te room days)	0	12.00
2.00	through December 31 of the cost reporting period	or xix only (Ther daring priva	te room days)	0	12.00
3. 00	Swing-bed NF type inpatient days applicable to titles V	or XIX only (including priva	te room days)	0	13.00
	after December 31 of the cost reporting period (if cale				ĺ
4. 00	Medically necessary private room days applicable to the	Program (excluding swing-bed	days)	0	
5. 00	Total nursery days (title V or XIX only)			578	
6. 00	Nursery days (title V or XIX only)			0	16.00
7 00	SWING BED ADJUSTMENT		-6 +b+	0.00	17.00
7. 00	Medicare rate for swing-bed SNF services applicable to reporting period	services through December 31 (	or the cost	0. 00	17.00
8. 00	Medicare rate for swing-bed SNF services applicable to	services after December 31 of	the cost	0.00	18.00
0. 00	reporting period	Services arter becomber 51 or	the cost	0.00	10.00
9. 00	Medicaid rate for swing-bed NF services applicable to s	ervices through December 31 o	f the cost	0.00	19.00
	reporting period	<u> </u>			l
0. 00	Medicaid rate for swing-bed NF services applicable to s	ervices after December 31 of	the cost	0.00	20.00
	reporting period				
1.00	Total general inpatient routine service cost (see instr			17, 002, 310	
2. 00	Swing-bed cost applicable to SNF type services through $5 \times 1$ ine 17)	December 31 of the cost repor	ting period (line	0	22. 00
3. 00	Swing-bed cost applicable to SNF type services after De	cember 31 of the cost reportion	na neriod (line 6	0	23. 00
0. 00	x line 18)	cember 31 of the cost reportin	ig period (inic o	0	25.00
4. 00	Swing-bed cost applicable to NF type services through D	ecember 31 of the cost reporti	ng period (line	0	24.00
	7 x line 19)		3   1		
5. 00	Swing-bed cost applicable to NF type services after Dec	ember 31 of the cost reporting	g period (line 8	0	25. 00
	x line 20)				1
6. 00	Total swing-bed cost (see instructions)			0	26.00
7. 00	General inpatient routine service cost net of swing-bed	cost (line 21 minus line 26)		17, 002, 310	27. 00
0.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ing had and absented to the	20000)	2	20.00
3.00	General inpatient routine service charges (excluding sw	nng-bed and observation bed cl	iai ges)	0	
9. 00 0. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	30.00
	John Drivate Loom Charaes (CACLUALIN SWING-DEG CHALAES)			ı U	1 30.00

6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)		7.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	ď	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	1, 154	9. 00
	newborn days)	,	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 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	0	11. 00
10.00	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 XLX only (including private room days)	o	10.00
12. 00	through December 31 of the cost reporting period	۷	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days)	0	13. 00
10.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	ĭ	10.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	578	15.00
16. 00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
10.00	reporting period	0.00	18. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0. 00	18.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
17.00	report in g peri od	0.00	17.00
20.00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	17, 002, 310	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22.00
00.00	5 x line 17)		00.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
24.00	7 x line 19)	o	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
	x line 20)		
26. 00	Total swing-bed cost (see instructions)	0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	17, 002, 310	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)	0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33. 00
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	17, 002, 310	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	000 55	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)	882. 55 1, 018, 463	38. 00 39. 00
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	1, 018, 463	40. 00
	Total Program general inpatient routine service cost (line 39 + line 40)	1, 018, 463	
		., 5.5, .50	

	Financial Systems ATION OF INPATIENT OPERATING COST	TERRE HAUTE REGI	ONAL HOSPITAL  Provider Co	CN: 15-0046	Period:	u of Form CMS- Worksheet D-	
CONFUI	ATTON OF THE ATTENT OF ENATING COST		Trovider CC	JIN. 13-0040	From 09/01/2016		
					To 08/31/2017	Date/Time Pro 1/27/2018 2:	
				e XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total	Average Per		Program Cost (col. 3 x col.	
		Impatrent cost	impatrent bays	col. 2)	-	4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	415, 410	578	718. 7	70 0	(	42.00
43. 00	Intensive Care Type Inpatient Hospital Unit INTENSIVE CARE UNIT	4, 894, 442	3, 184	1, 537. 2	20 0	(	43.00
44. 00	CORONARY CARE UNIT	4,074,442	3, 104	1, 557. 2	0	`	44. 00
45.00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	4						46. 00
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
	cost center bescription					1. 00	
48. 00	Program inpatient ancillary service cost (W	Vkst. D-3, col. 3	, line 200)			5, 939, 75	7 48.00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(	see instructio	ns)		6, 958, 220	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program in	nationt routing	sorvicos (from	Wkst D sum	of Parts L and	,	50.00
30.00		ipatrent routine	services (IIIIII	WKSt. D, Suii	I OI FAILS I AIIU	(	30.00
51. 00	Pass through costs applicable to Program in	npatient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	(	51.00
F0 00	and IV)	FO   F4)				_	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost excl		lated non-nby	sician anos+h	netist and		52. 00 53. 00
33.00	medical education costs (line 49 minus line		rateu, non-priy	31 Clair allesti	ieti st, and	`	33.00
	TARGET AMOUNT AND LIMIT COMPUTATION	,					
	Program discharges						54.00
56.00	Target amount per discharge Target amount (line 54 x line 55)						55. 00 56. 00
57. 00	,	nting cost and ta	rget amount (I	ine 56 minus	line 53)		57.00
58. 00	Bonus payment (see instructions)	· ·			•		58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost r	reporting period	endi ng 1996, u	pdated and co	ompounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report. up	dated by the m	arket basket		0.00	60.00
61.00	If line 53/54 is less than the lower of lin				the amount by		61.00
	which operating costs (line 53) are less th		s (lines 54 x	60), or 1% of	the target		
62 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	e instructions)				(	62.00
	Allowable Inpatient cost plus incentive pay	ment (see instru	ctions)				63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	sts through Dece	mber 31 of the	cost reporti	ng period (See	(	64. 00
65. 00	Medicare swing-bed SNF inpatient routine co	sts after Decemb	er 31 of the c	ost reportino	period (See	(	65. 00
	instructions) (title XVIII only)				, ,		
66. 00	Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus line 6	5)(title XVII	I only). For	(	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 o	f the cost re	eporting period	(	67. 00
07.00	(line 12 x line 19)	no ocoro im ougn	200020.		por tring por roa		7
68. 00	Title V or XIX swing-bed NF inpatient routi	ne costs after D	ecember 31 of	the cost repo	orting period	(	68. 00
69 00	(line 13 x line 20)  Total title V or XIX swing-bed NF inpatient	routine costs (	line 67 ± line	68)		,	69.00
07.00	PART III - SKILLED NURSING FACILITY, OTHER						27.00
70. 00	Skilled nursing facility/other nursing faci						70.00
71.00	Adjusted general inpatient routine service		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost appli		(line 14 x li	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine ser			110 00)			74. 00
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from W	orksheet B, F	Part II, column		75. 00
74 00	26, line 45)	ino 2)					74 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ l Program capital-related costs (line 9 x lin	. *					76. 00 77. 00
78. 00	, ,						78. 00
79.00	Aggregate charges to beneficiaries for exce				1: 70)		79. 00
80. 00 81. 00	Total Program routine service costs for com Inpatient routine service cost per diem lim	•	ust iimitation	(iine 78 mir	ius iine 79)		80. 00 81. 00
82. 00	Inpatient routine service cost per diem in Inpatient routine service cost limitation (		)				82. 00
83. 00	Reasonable inpatient routine service costs	•	•				83. 00
84. 00	Program inpatient ancillary services (see i		,				84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (su						85. 00 86. 00
JU. UU	PART IV - COMPUTATION OF OBSERVATION BED PA		rough 65)				1 55.00
07.00	Total observation bed days (see instruction					2, 70	87. 00
87. 00	,				l.		
88. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (s	•	line 2)				88.00

Health Financial Systems	TERRE HAUTE REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 09/01/2016 To 08/31/2017	Date/Time Pre 1/27/2018 2:1	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THRO	DUGH COST					
90.00 Capi tal -related cost	2, 066, 511	17, 002, 310	0. 12154	2, 386, 415	290, 052	90.00
91.00 Nursing School cost	O	17, 002, 310	0.00000	2, 386, 415	0	91.00
92.00 Allied health cost	o	17, 002, 310	0.00000	2, 386, 415	0	92.00
93.00 All other Medical Education	0	17, 002, 310	0. 00000	2, 386, 415	0	93.00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0046	Peri od: From 09/01/2016	Worksheet D-1
	Component CCN: 15-S046		Date/Time Prepared: 1/27/2018 2:15 pm
	Title XIX	Subprovi der -	Cost

		Title XIX	Subprovi der - I PF	Cost	
	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		6, 635		
2.00	Inpatient days (including private room days, excluding swing-l Private room days (excluding swing-bed and observation bed day		6, 635	2.00	
3. 00	do not complete this line.	ys). IT you have only pr	ivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		6, 635	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om davs) after December	31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becomber	01 01 1110 0031	o .	0.00
7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	ii days) arter becember s	T OF THE COST	O	0.00
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	2, 848	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or	alv (including private r	oom days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruc-	tions)	,	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	The daing privat	c room days)	O	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar you Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	( taringg		578	
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
	reporting period	oo tiii ougii boooiiiboi oi o		0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
	reporting period	-			
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	he cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	s)		4, 493, 797	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 173	er 31 of the cost report	ing 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 reportin	a period (line 6	0	23. 00
	x line 18)	·			
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
0, 00	x line 20)				
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 4, 493, 797	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(11110 21 1111100 11110 20)		17 1707 777	27.00
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)		28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 mi)		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)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	fferential (line	4, 493, 797	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 Program general inpatient routine service cost (line 9 x line			677. 29 1, 928, 922	
40. 00	Medically necessary private room cost applicable to the Program			1, 920, 922	40.00
	Total Program general inpatient routine service cost (line 39	•		1, 928, 922	

OMPUI	Financial Systems T ATION OF INPATIENT OPERATING COST		NAL HOSPITAL Provider C	CN: 15-0046	Peri od:		u of Form CMS- Worksheet D-1	
			Component	CCN: 15-S046	From 09/0 To 08/3	01/2016 01/2017	Date/Time Pre	
			Ti tl	e XIX	Subprovi	der -	1/27/2018 2:1 Cost	5 pm
	Control Description	Tabal			. I PF	· .		
	Cost Center Description	Total Inpatient Cost	Total npatient Days	Average Pe Diem (col. 1 col. 2)			Program Cost (col. 3 x col. 4)	
	Tuupoepy () I I I I I I I I I I I I I I I I I I	1.00	2.00	3. 00	4.0		5. 00	
2. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.	00	0	0	42.0
3. 00	INTENSIVE CARE UNIT	0	0	0.	00	0	0	43. (
4. 00	CORONARY CARE UNIT							44. (
5. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT							45. 46.
	OTHER SPECIAL CARE (SPECIFY)							47.
	Cost Center Description					-	1 00	-
3. 00	Program inpatient ancillary service cost (Wks	st. D-3. col. 3.	line 200)				1. 00 360, 499	48.
9. 00	Total Program inpatient costs (sum of lines			ns)			2, 289, 421	
2 00	PASS THROUGH COST ADJUSTMENTS		(6	WI+ D	E Dt-	1		
0. 00	Pass through costs applicable to Program inpa	atient routine s	ervices (Trom	WKST. D, SU	m or Parts	i and	0	50.
1. 00	Pass through costs applicable to Program inpa	atient ancillary	services (fr	om Wkst. D,	sum of Par	ts II	0	51.
00	and IV) Total Program excludable cost (sum of lines!	O and E1)					0	52.
2. 00 3. 00	Total Program inpatient operating cost excluded the cost of the state of the cost of the c		ated, non-phy	sician anest	hetist, an	d	0	1
	medical education costs (line 49 minus line !							]
4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						0	54.
5. 00	Target amount per discharge						0. 00	
	Target amount (line 54 x line 55)						0	
7. 00 3. 00	Difference between adjusted inpatient operations payment (see instructions)	ng cost and tar	get amount (I	ine 56 minus	line 53)		0	1
9. 00	Lesser of lines 53/54 or 55 from the cost rep	ortina period e	ndi na 1996. u	pdated and c	ompounded	bv the	0. 00	
	market basket	· ·	-		•			
0. 00 1. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines					t by	0.00	1
1.00	which operating costs (line 53) are less than						0	01.
2 00	amount (line 56), otherwise enter zero (see i	nstructions)					0	
2. 00 3. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paymo	ent (see instruc	tions)				0	
	PROGRAM INPATIENT ROUTINE SWING BED COST							
4. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Decem	ber 31 of the	cost report	ing period	(See	0	64.
5. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the c	ost reportin	g period (	See	0	65.
, 00	instructions) (title XVIII only)	no ocoto (lino (	4 plug lipo (	E) (+: +1 a V//	(برامه ال	For	0	
6. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ie costs (Title o	4 prus rine o	5)(title xvi	ii oiiiy).	F01	Ü	66.
7. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	f the cost r	eporting p	eri od	0	67.
8. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after De	cember 31 of	the cost ren	ortina per	iod	0	68.
	(line 13 x line 20)			·				
9. 00	Total title V or XIX swing-bed NF inpatient I PART III - SKILLED NURSING FACILITY, OTHER NU	•					0	69.
0. 00	Skilled nursing facility/other nursing facili				)			70.
1. 00	Adjusted general inpatient routine service co		ne 70 ÷ line	2)				71.
2. 00 3. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)	,	(line 14 x li	ne 35)				72.
4. 00	Total Program general inpatient routine servi		•	00)				74.
5. 00	Capital -related cost allocated to inpatient	routine service	costs (from W	orksheet B,	Part II, c	ol umn		75.
6. 00	26, line 45)  Per diem capital-related costs (line 75 ÷ line	ne 2)						76.
7. 00	Program capital-related costs (line 9 x line							77.
3. 00 9. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		ovider record	e)				78. 79.
). 00	Total Program routine service costs for compa				nus line 7	9)		80.
1.00	Inpatient routine service cost per diem limi	tati on						81.
2. 00 3. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (							82.
4. 00	Program inpatient ancillary services (see ins					ŀ		84.
5. 00	Utilization review - physician compensation	(see instruction						85.
6. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ough 85)					86.
	Total observation bed days (see instructions)						0	87.
7. 00								

Health Financial Systems T	ERRE HAUTE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (		From 09/01/2016 To 08/31/2017		
		Titl	e XIX	Subprovi der - I PF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	394, 677	4, 493, 797	0. 08782	7 0	0	90.00
91.00 Nursing School cost	0	4, 493, 797	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	4, 493, 797	0.00000	0	0	92.00
93.00 All other Medical Education	0	4, 493, 797	0.00000	0 0	0	93. 00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0046	Peri od: From 09/01/2016	Worksheet D-1
	Component CCN: 15-T046		Date/Time Prepared: 1/27/2018 2:15 pm
	Title XIX	Subprovi der -	Cost

		II tie xix	I RF	Cost	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		1, 780	1. 00
2.00	Inpatient days (including private room days, excluding swing-b			1, 780	
3. 00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pri	vate room days,	0	3. 00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		1, 780	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period				,
6.00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after December 3	11 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	n davs) through December	31 of the cost	0	7. 00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 31	of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing_hed and	113	9. 00
7. 00	newborn days)	the frogram (exerualing	Swifing bed and	113	7. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		om days) after	0	11. 00
11. 00	December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)	oolii days) arter	U	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)		room days)	0	12. 00
40.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ve			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra		,	0	14. 00
15. 00	Total nursery days (title V or XIX only)	, 3	,	578	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	os through Docombor 21 of	the cost	0.00	17. 00
17.00	reporting period	es through becember 31 or	the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0.00	18. 00
10.00	reporting period	through December 21 of	the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through becember 31 01	the cost	0.00	19. 00
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	e cost	0.00	20. 00
04 00	reporting period	`		0.004.505	04.00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ng period (line	2, 224, 525 0	21. 00 22. 00
22.00	5 x line 17)	si Si di the cost reporti	ing period (Title	O	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
24.00	X line 18)	a 21 of the cost respontin	a ported (Line	0	24. 00
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	31 of the cost reportin	ig perrou (Trile	U	24.00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
04 00	x line 20)				04 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		0 2, 224, 525	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Trice 21 iii rius Trice 20)		2, 224, 323	27.00
	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	irges)		28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 -	line 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	1111e 20)		0.00000	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 mir	, ,	i ons)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	2, 224, 525	
37.00	27 minus line 36)			2, 22 1, 020	000
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	IOTHENTO			
38 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			1 2/0 72	38. 00
38. 00 39. 00	Program general inpatient routine service cost per drem (see			1, 249. 73 141, 219	
40. 00	Medically necessary private room cost applicable to the Progra	•		0	
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		141, 219	41. 00

		ERRE HAUTE REGIO			In Li	eu of Form CMS-	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST			CN: 15-0046 CCN: 15-T046	Period: From 09/01/2016 To 08/31/2017		
			·	e XIX	Subprovi der -	1/27/2018 2:1 Cost	
			11 (1		IRF		
	Cost Center Description	Total Inpatient Cost	Total npatient 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) Intensive Care Type Inpatient Hospital Units	0	0	0.	00 (	0	42. 00
43.00	INTENSIVE CARE UNIT	0	C	0.	00 (	0	43. 00
44.00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3,	line 200)			57, 876	48. 00
49. 00	Total Program inpatient costs (sum of lines	11 through 48)(s	see instructio	ons)		199, 095	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program input	atient routine s	services (from	n Wkst. D. su	m of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inpand IV)	atient ancillary	services (fr	om Wkst. D,	sum of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclu		ated, non-phy	sician anest	hetist, and	0	53.00
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	02)					1
	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	1
57. 00	Difference between adjusted inpatient operation	ng cost and tar	get amount (I	ine 56 minus	line 53)	Ö	
58. 00			" 4007			0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period 6	enaing 1996, L	ipaatea ana c	ompounaea by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	1
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less than					0	61.00
	amount (line 56), otherwise enter zero (see		, (Tries or x	00), 01 1% 0	Tile target		
62. 00 63. 00	Relief payment (see instructions)	ont (coo instru	ations)			0 0	
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST						] 63.00
64. 00		ts through Decem	ber 31 of the	cost report	ing period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decembe	er 31 of the c	ost reportin	g period (See	0	65. 00
	instructions)(title XVIII only)			•			
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line 6	o4 plus line 6	55)(title XVI	II only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 c	of the cost r	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after De	cember 31 of	the cost ren	orting period	0	68. 00
00.00	(line 13 x line 20)	costs arter be	Cember 31 01	the cost rep	or tring period		00.00
69. 00	Total title V or XIX swing-bed NF inpatient   PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70. 00	Skilled nursing facility/other nursing facility				)		70. 00
71.00	Adjusted general inpatient routine service of		ne 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)	•	(line 14 x li	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv	ce costs (line	72 + line 73)	ŕ			74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from W	lorksheet B,	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	,					76. 00
77. 00 78. 00	,	•					77. 00 78. 00
79. 00	,	,	ovi der record	ls)			79. 00
80.00	Total Program routine service costs for compa	arison to the co			nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		ı				81. 00 82. 00
83. 00	1 '						83. 00
84.00			ne)				84.00
85. 00 86. 00	1 3						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST					
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			0.00	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (see		- /				89. 00

Health Financial Systems T	ERRE HAUTE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (		From 09/01/2016 To 08/31/2017		
		Ti tl	e XIX	Subprovi der -	Cost	
	0 1	D 11 0 1		IRF		
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	345, 512	2, 224, 525	0. 15531	9 0	0	90.00
91.00 Nursing School cost	0	2, 224, 525	0. 00000	0	ol	91.00
92.00 Allied health cost	0	2, 224, 525	0.00000	0	0	92.00
93.00 All other Medical Education	0	2, 224, 525	0. 00000	o o	0	93. 00

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0046	Peri od: From 09/01/2016 To 08/31/2017	Worksheet D-3 Date/Time Pre 1/27/2018 2:1	pare
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
		1. 00	2. 00	3. 00	₩
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			0 (00 000		٠
00 03000 ADULTS & PEDI ATRI CS			9, 600, 823		30.
00   03100   INTENSI VE CARE UNI T			4, 641, 915		31.
00   04000   SUBPROVI DER - I PF			0		40.
00   04100   SUBPROVI DER - I RF			0		41.
00   04300   NURSERY   ANCI LLARY SERVI CE COST CENTERS					43.
00 05000 OPERATING ROOM		0. 09604	48 20, 137, 449	1, 934, 162	50.
00   05100   RECOVERY ROOM		0. 08322		187, 337	1
00 05200 DELIVERY ROOM & LABOR ROOM		0. 67002		0	1
00 05300 ANESTHESI OLOGY		0.00000		0	
00 05400 RADI OLOGY-DI AGNOSTI C		0. 2182		502, 797	
01   03630   ULTRA SOUND		0. 0774		40, 942	
02   03440   MAMMOGRAPHY		0. 1952		199	
00 05500 RADI OLOGY-THERAPEUTI C		0. 11358		51, 327	
00   05600   RADI 0I SOTOPE		0. 09489		80, 363	
00 05700 CT SCAN		0. 02436		203, 719	
00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.04347	72 1, 371, 326	59, 614	58
00 05900 CARDI AC CATHETERI ZATI ON		0. 04008	8, 475, 217	339, 763	59
00 06000 LABORATORY		0. 06483	35 15, 257, 656	989, 230	60
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 1377	44 2, 799, 383	385, 598	62
00 06500 RESPI RATORY THERAPY		0. 1193	79 9, 600, 581	1, 146, 108	65
00   06600   PHYSI CAL THERAPY		0. 4046		661, 548	
00   06900   ELECTROCARDI OLOGY		0. 0723	70 5, 828, 225	421, 789	69
00   07000   ELECTROENCEPHALOGRAPHY		0. 1081		35, 021	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2132		2, 792, 498	
00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 4297		2, 704, 092	
00 07300 DRUGS CHARGED TO PATIENTS		0. 13369		3, 922, 533	
00 07400 RENAL DI ALYSI S		0. 1773		606, 454	
00   03950   LI THOTRI PSY		0. 10459		2, 892	
01   03330   ENDOSCOPY		0. 07598		144, 491	
02   03040   PRI SI ON CLI NI C		1. 5989		10.073	
03   03050   WOUND CARE		0. 28997		10, 072	
04   03060   OPI C   OUTPATI ENT SERVI CE COST CENTERS		0. 2014!	50 16, 086	3, 241	76
OUTPATIENT SERVICE COST CENTERS  OU 09100 EMERGENCY		0. 0954	7, 151, 093	682, 743	91
00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)		0. 0934		330, 435	
0.00 Total (sum of lines 50 through 94 and 96 through 98)		0.04004	141, 838, 149	18, 238, 968	
1.00 Less PBP Clinic Laboratory Services-Program only charges	(Line 61)		141, 636, 149	10, 230, 700	201
2.00 Net charges (line 200 minus line 201)	(1110 01)		141, 838, 149		202

NPALLENT A	NCILLARY SERVICE COST APPORTIONMENT	Provi der C		eriod: rom 09/01/2016	Worksheet D-3	
		Component	CCN: 15-S046		Date/Time Pre 1/27/2018 2:1	
		Titl∈	XVIII :	Subprovider - IPF	PPS	
	Cost Center Description		Ratio of Cost	I npati ent	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col. 2)	
			1.00	2. 00	3. 00	
I NPA	FIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	ADULTS & PEDIATRICS			0		30.
	INTENSIVE CARE UNIT			0		31.
0.00 0400	SUBPROVI DER - I PF			6, 124, 507		40.
1.00 0410	SUBPROVI DER - I RF			0		41
3.00 0430	NURSERY					43
	LLARY SERVICE COST CENTERS					4
	OPERATING ROOM		0. 096048	1, 386	133	
	RECOVERY ROOM		0. 083224	0	0	
	DELIVERY ROOM & LABOR ROOM		0. 670023	0	0	
	ANESTHESI OLOGY		0.000000	0	0	
	RADI OLOGY-DI AGNOSTI C		0. 218273	16, 127	3, 520	
	ULTRA SOUND		0.077445	4, 073	315	
	MAMMOGRAPHY		0. 195243	0	0	
	RADI OLOGY-THERAPEUTI C		0. 113585	0	0	
	D RADIOISOTOPE CT SCAN		0. 094895 0. 024368	109, 325	0 2, 664	
	MAGNETIC RESONANCE IMAGING (MRI)		0. 024306	109, 323	2, 664	1
	CARDI AC CATHETERI ZATI ON		0.040089	0	0	
	LABORATORY		0. 064835	597, 889	38, 764	
	WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 137744	0,7,007	00, 701	
	RESPIRATORY THERAPY		0. 119379	51, 165	6, 108	
	PHYSI CAL THERAPY		0. 404679	14, 410	5, 831	
9.00 0690	ELECTROCARDI OLOGY		0. 072370	36, 933	2, 673	69
0.00 0700	D ELECTROENCEPHALOGRAPHY		0. 108172	9, 092	983	70
1.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 213243	8, 668	1, 848	71
	IMPL. DEV. CHARGED TO PATIENTS		0. 429710	0	0	
	DRUGS CHARGED TO PATIENTS		0. 133699	732, 586	97, 946	
	RENAL DIALYSIS		0. 177357	86, 928	15, 417	
	LI THOTRI PSY		0. 104594	0	0	
	ENDOSCOPY		0. 075981	0	0	1
	PRISION CLINIC		1. 598918	0	0	
	WOUND CARE		0. 289979	0	0	
	OPIC		0. 201450	0	0	76
	ATIENT SERVICE COST CENTERS DEMERGENCY		0.005474	420 502	40 155	91
- 1	DOBSERVATION BEDS (NON-DISTINCT PART)		0. 095474 0. 848641	420, 583 1 254	40, 155 1, 149	
2.00  0920i 200.00	Total (sum of lines 50 through 94 and 96 through 98)		0. 848041	1, 354 2, 090, 519	1, 149 217, 506	
201.00	Less PBP Clinic Laboratory Services-Program only charges	(Line 61)		2, 090, 519		200
202.00	Net charges (line 200 minus line 201)	(11116 01)		2, 090, 519		201

IPATI ENT	ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0046	Period: From 09/01/2016	Worksheet D-3	3
		Component	CCN: 15-T046	To 08/31/2017		
		Ti tl e	: XVIII	Subprovi der - I RF	PPS	о р
	Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2)	-
LNDA	ATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
	DO ADULTS & PEDIATRICS			0		30
	DO INTENSIVE CARE UNIT			0		31
	OO SUBPROVIDER - IPF			0		40
	OO SUBPROVI DER - I RF			1, 447, 475		41
	DO NURSERY			.,,		43
	LLARY SERVICE COST CENTERS		•	<b>'</b>	•	
	OO OPERATING ROOM		0. 0960	48 97, 969	9, 410	50
	DO RECOVERY ROOM		0. 0832	24 19, 232	1, 601	51
	DO DELIVERY ROOM & LABOR ROOM		0. 6700	23 0	0	52
	DO ANESTHESI OLOGY		0.0000	00	0	53
	DO RADI OLOGY-DI AGNOSTI C		0. 2182			
	30 ULTRA SOUND		0. 0774			
	40 MAMMOGRAPHY		0. 1952		·	
	DO RADI OLOGY-THERAPEUTI C		0. 1135			
	DO RADI OI SOTOPE		0. 0948	·		
	OO CT SCAN		0. 0243 0. 0434		1, 372 998	
	DO MAGNETIC RESONANCE IMAGING (MRI) DO CARDIAC CATHETERIZATION		0.0434			
	OO LABORATORY		0.0400			
	00 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 1377			
4	00 RESPI RATORY THERAPY		0. 1193			
	DO PHYSI CAL THERAPY		0. 4046	·		
	DO ELECTROCARDI OLOGY		0. 0723			
	DO ELECTROENCEPHALOGRAPHY		0. 1081	72 3, 108	336	70
. 00 0710	DO MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2132	43 326, 129	69, 545	71
. 00 0720	DO IMPL. DEV. CHARGED TO PATIENTS		0. 4297		3, 853	72
	DO DRUGS CHARGED TO PATIENTS		0. 1336	99 926, 544	123, 878	73
	DO RENAL DI ALYSI S		0. 1773	57 161, 294	28, 607	
- 1	50 LI THOTRI PSY		0. 1045			
	BO ENDOSCOPY		0. 0759			
	40 PRISION CLINIC		1. 5989			
	50 WOUND CARE		0. 2899			
	00 OPI C		0. 2014	50 0	0	76
	PATIENT SERVICE COST CENTERS DO EMERGENCY		0. 0954	7.4	262	
	DO OBSERVATION BEDS (NON-DISTINCT PART)		0. 0954	·	262	
0. 00   0920 0. 00	Total (sum of lines 50 through 94 and 96 through	98)	0. 0480	3, 902, 328		
1.00	Less PBP Clinic Laboratory Services-Program only			3, 702, 320 A	1,000,007	201
1.00	Net charges (line 200 minus line 201)	charges (Title 01)		3, 902, 328		202

	n Financial Systems TERRE HAUTE REGI				u of Form CMS-2	
I NPAT	IENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0046	Peri od: From 09/01/2016	Worksheet D-3	
				To 08/31/2017	Date/Time Pre 1/27/2018 2:1	
		Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	0.00	2)	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00	03000 ADULTS & PEDIATRICS			2, 777, 362		30.00
31. 00				1, 358, 386		31.00
40. 00	04000 SUBPROVI DER - I PF			1, 330, 300		40.00
41. 00	04100 SUBPROVI DER - I RF			0		41. 00
43. 00	04300 NURSERY			503, 729		43. 00
101.00	ANCILLARY SERVICE COST CENTERS			000,727		10.00
50.00	05000 OPERATI NG ROOM		0. 0960	08 6, 890, 772	661, 569	50.00
51.00	05100 RECOVERY ROOM		0. 0832	739, 074	61, 509	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 6700	23 1, 688, 692	1, 131, 462	52.00
53.00	05300 ANESTHESI OLOGY		0.0000	00	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 2182	73 618, 992	135, 109	54. 00
54. 01	03630 ULTRA SOUND		0. 0774		14, 346	
54. 02	03440 MAMMOGRAPHY		0. 1952		0	
55. 00	05500 RADI OLOGY-THERAPEUTI C		0. 1135			
56. 00	05600 RADI OI SOTOPE		0. 0948			
57. 00	05700 CT SCAN		0. 0243		l	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0434			
59. 00 60. 00	05900   CARDI AC CATHETERI ZATI ON   06000   LABORATORY		0. 0400 0. 0648			1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 0648			
65. 00	06500 RESPIRATORY THERAPY		0. 1377		1	
66. 00	06600 PHYSI CAL THERAPY		0. 1173		1	
69. 00	06900 ELECTROCARDI OLOGY		0. 0723			
70. 00	07000 ELECTROENCEPHALOGRAPHY		0. 1081			
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2132			
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 4297			1
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 1336			
74. 00	07400 RENAL DI ALYSI S		0. 1773		56, 714	
76. 00	03950 LI THOTRI PSY		0. 1045	94 0	0	
76. 01	03330 ENDOSCOPY		0. 0753	23 392, 223	29, 543	76. 01
76. 02	03040 PRI SI ON CLI NI C		1. 5989		0	1
76. 03	03050 WOUND CARE		0. 2869			76. 03
76. 04	03060 OPI C		0. 1942	28, 835	5, 600	76. 04

0.094707

0.848641

2, 274, 371

40, 136, 414

40, 136, 414

104, 557

215, 399

88, 731 92. 00

5, 939, 757 200. 00

91.00

201. 00 202. 00

OUTPATIENT SERVICE COST CENTERS
91. 00 09100 EMERGENCY

200.00

201. 00 202. 00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

NPATIENT AN	CILLARY SERVICE COST APPORTIONMENT	rovi der C	CN: 15-0046	Peri od:	/01 /001 :	Worksheet D-3	
	C	omponent	CCN: 15-S046		/01/2016 /31/2017	Date/Time Prep 1/27/2018 2:1	
		Ti tl	e XIX		vi der - PF	Cost	
	Cost Center Description		Ratio of Cos To Charges	st Inpa	atient ogram	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2	2. 00	3. 00	
	ENT ROUTINE SERVICE COST CENTERS						4
	ADULTS & PEDI ATRI CS				0		30.
	INTENSIVE CARE UNIT			1.0	0		31.
	SUBPROVI DER - I PF			10	), 797, 274		40.
	SUBPROVIDER - IRF NURSERY				0		41.
	LARY SERVICE COST CENTERS				<u> </u>		43.
	OPERATING ROOM		0.0960	08	17, 509	1, 681	50.
1.00 05100	RECOVERY ROOM		0. 0832	24	4, 585	382	51.
2.00 05200	DELIVERY ROOM & LABOR ROOM		0. 6700	23	o	0	52.
	ANESTHESI OLOGY		0.0000	00	o	0	53.
	RADI OLOGY-DI AGNOSTI C		0. 2182	73	38, 070	8, 310	54
	ULTRA SOUND		0.0774	45	5, 873	455	
	MAMMOGRAPHY		0. 1952		0	0	
1 1	RADI OLOGY-THERAPEUTI C		0. 1135		1, 485	1	
1 1	RADI OI SOTOPE		0. 0948		0	0	
	CT SCAN		0. 0243	1	157, 244	3, 832	
	MAGNETIC RESONANCE I MAGING (MRI)		0.0434	1	11, 824	514	
1 1	CARDI AC CATHETERI ZATI ON		0.0400		2/1 077	01 014	
1 1	LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 0648 0. 1377		, 261, 877 1, 525	81, 814 210	
1 1	RESPIRATORY THERAPY		0. 1377		72, 056	8, 602	
	PHYSI CAL THERAPY		0. 4011		3, 455	1, 386	
	ELECTROCARDI OLOGY		0. 0723		43, 107	3, 120	
	ELECTROENCEPHALOGRAPHY		0. 1081		6, 215	672	
1 1	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2132		14, 134		
	IMPL. DEV. CHARGED TO PATIENTS		0. 4297		0	0	
	DRUGS CHARGED TO PATIENTS		0. 1336	99 1	, 080, 895	144, 515	73
4.00 07400	RENAL DIALYSIS		0. 1773	57	o	0	74
	LI THOTRI PSY		0. 1045	94	0	0	
	ENDOSCOPY		0. 0753		0	0	1 , ~
	PRISION CLINIC		1. 5989		0	0	1
	WOUND CARE		0. 2869		0	0	
6. 04 03060			0. 1942	05	0	0	76
	FIENT SERVICE COST CENTERS		0.0047	0.7	050 070	00.044	1 01
	EMERGENCY  ORSEDVATION REDS (NON DISTINCT DART)		0.0947		950, 973	90, 064	
	OBSERVATION BEDS (NON-DISTINCT PART) Total (sum of lines 50 through 94 and 96 through 98)		0. 8486		13, 856		
	Less PBP Clinic Laboratory Services-Program only charges (	ling 61)		3	3, 684, 683 0	360, 499	200
	Net charges (line 200 minus line 201)	11116 01)			0 3, 684, 683		201

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0046	Peri od: From 09/01/201	Worksheet D-3	3
	Component	CCN: 15-T046	To 08/31/201		
	Ti tl	e XIX	Subprovi der - I RF	Cost	
Cost Center Description		Ratio of Cos	· -	Inpatient	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3. 00	1
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
. 00 03000 ADULTS & PEDI ATRI CS				ol	30
. 00   03100   NTENSI VE CARE UNIT				o	31
. 00   04000   SUBPROVI DER - I PF				o	40
. 00   04100   SUBPROVI DER - I RF			103, 94	3	41
. 00 04300 NURSERY				o	43
ANCILLARY SERVICE COST CENTERS					
. 00 05000 OPERATING ROOM		0. 0960	08	0 0	50
. 00 05100 RECOVERY ROOM		0. 0832	24	0 0	51
.00   05200   DELIVERY ROOM & LABOR ROOM		0. 6700	23	0 0	) 52
. 00   05300   ANESTHESI OLOGY		0.0000		0	
. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 2182		l l	
. 01   03630   ULTRA SOUND		0. 0774		0	
. 02   03440   MAMMOGRAPHY		0. 1952		0	
. 00   05500   RADI OLOGY-THERAPEUTI C		0. 1135		0	
. 00   05600   RADI 01 SOTOPE		0. 0948		0 0	
. 00 05700 CT SCAN		0.0243		0 87	
. 00   05800   MAGNETI C RESONANCE I MAGING (MRI) . 00   05900   CARDIAC CATHETERIZATION		0.0434		0 0	
. 00   06900   CARDIAC CATHETERIZATION		0.0400		-	
. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 1377		0 0	
. 00 06500 RESPIRATORY THERAPY		0. 1193		-1	
. 00 06600 PHYSI CAL THERAPY		0. 4011			
. 00 06900 ELECTROCARDI OLOGY		0. 0723		0 0	
. 00 07000 ELECTROENCEPHALOGRAPHY		0. 1081		0 0	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2132	43 65	7 140	71
.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4297	10	0 0	72
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1336	99 53, 91	8 7, 209	73
. 00 07400 RENAL DIALYSIS		0. 1773		0 0	
. 00   03950   LI THOTRI PSY		0. 1045		0 0	
. 01   03330   ENDOSCOPY		0. 0753		0	
. 02   03040   PRI SI ON CLI NI C		1. 5989		0	
. 03   03050   WOUND CARE		0. 2869		0 0	
0.04 03060 OPI C		0. 1942	05	0 0	76
OUTPATIENT SERVICE COST CENTERS		0.0047	0.7		4
. 00 09100 EMERGENCY		0. 0947		0 0	
.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.00 Total (sum of lines 50 through 94 an	d 06 through 00)	0.8486	201, 80	-1	
1.00 Less PBP Clinic Laboratory Services-		1	201, 80	5/,8/6	201
2.00 Net charges (line 200 minus line 201			201, 80	ূ	201

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lieu of Form CMS-2552-		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0046	Peri od: From 09/01/2016 To 08/31/2017	Worksheet E Part A Date/Time Prepared: 1/27/2018 2:15 pm	

		Title XVIII	Hospi tal	1/27/2018 2: 1 PPS	5 pm
		TI LI E XVIII	nospi tai	FF3	
				1. 00	
1. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring instructions)	prior to October 1 (s	see	1, 689, 484	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring instructions)	on or after October 1	(see	19, 699, 343	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	discharges occurring p	orior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	discharges occurring o	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			660, 239 0	2. 00 2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see instruction	s)		0	2. 02
3.00	Managed Care Simulated Payments			0	3. 00
4. 00	Bed days available divided by number of days in the cost reporti Indirect Medical Education Adjustment			152. 26	4. 00
5. 00	FTE count for allopathic and osteopathic programs for the most r or before 12/31/1996. (see instructions)			0. 00	5. 00
6. 00	FTE count for allopathic and osteopathic programs which meet the for new programs in accordance with 42 CFR 413.79(e)		·	0. 00	6. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified und ACA Section 5503 reduction amount to the IME cap as specified un			0. 00 0. 00	7. 00 7. 01
8.00	If the cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopathi affiliated programs in accordance with 42 CFR 413.75(b), 413.79(1998), and 67 FR 50069 (August 1, 2002).			0.00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots the cost report straddles July 1, 2011, see instructions.	under section 5503 of	the ACA. If	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots under section 5506 of ACA. (see instructions)	from a closed teaching	ng hospi tal	0.00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)			0. 00	9. 00
	FTE count for allopathic and osteopathic programs in the current FTE count for residents in dental and podiatric programs.	year from your record	ls		11. 00
12.00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.			0.00	12. 00 13. 00
14. 00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ended on or after Sept	ember 30, 1997,	0.00	
15. 00	Sum of lines 12 through 14 divided by 3.			0. 00	15. 00
16. 00	Adjustment for residents in initial years of the program			0.00	
17. 00	Adjustment for residents displaced by program or hospital closur	е			17. 00
18. 00	Adjusted rolling average FTE count			0.00	
20. 00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	
	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0. 000000 0. 000000	
22. 00	IME payment adjustment (see instructions)			0.000000	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			0	22. 01
22.0.	Indirect Medical Education Adjustment for the Add-on for Section	422 of the MMA			22.0.
23. 00	Number of additional allopathic and osteopathic IME FTE resident $(f)(1)(iv)(C)$ .		ec. 412.105	0. 00	23. 00
24.00	IME FTE Resident Count Over Cap (see instructions)			0. 00	24. 00
25. 00	If the amount on line 24 is greater than -O-, then enter the low instructions)	er of line 23 or line	24 (see	0. 00	
	Resident to bed ratio (divide line 25 by line 4)			0. 000000	
	IME payments adjustment factor (see instructions)			0. 000000	
	IME add-on adjustment amount (see instructions)			0	28. 00
	IME add-on adjustment amount - Managed Care (see instructions)			0	
29. 00 29. 01	Total IME payment ( sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29. 00 29. 01
30 00	<u>Disproportionate Share Adjustment</u> Percentage of SSI recipient patient days to Medicare Part A pati	ent days (see instruct	ione)	5. 51	30. 00
	Percentage of SSI recipient patient days to medicare Part A patiencentage of Medicaid patient days (see instructions)	ent days (see Instruct	.1 0115)	5. 51 19. 79	
	Sum of Lines 30 and 31			25. 30	
	Allowable disproportionate share percentage (see instructions)			10. 09	
	Disproportionate share adjustment (see instructions)			539, 533	
			ı		•

CVI CIII	Financial Systems TERRE HAUTE REG ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046	In Lie	eu of Form CMS-2 Worksheet E	2552-1
CALCUL	ATTON OF REIMBURSEMENT SETTLEMENT	Provider Con. 15-0046	From 09/01/2016 To 08/31/2017	Part A	
		Title XVIII	Hospi tal	PPS	о рііі
				On/After 10/1	
			1. 00	2. 00	
35. 00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		6 406 145 534	5, 977, 483, 147	35. 0
35. 01	Factor 3 (see instructions)		0. 000114159		
35. 02	Hospital uncompensated care payment (If line 34 is zero, en	enter zero on this line) (se	e 731, 318	724, 129	35. C
DE 02	instructions)	amount (and i notruptions)	E0 044	/// /11	25.0
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment a Total uncompensated care (sum of columns 1 and 2 on line 3).		59, 944 724, 555		35. C
30.00	Additional payment for high percentage of ESRD beneficiary				00.0
40. 00	Total Medicare discharges on Worksheet S-3, Part I excludi		0		40.0
	652, 682, 683, 684 and 685 (see instructions)		Poforo 1/1	On/After 1/1	
			Before 1/1 1.00	0n/After 1/1 1.01	
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682	e, 683, 684 an 685. (see	0		41. C
	instructions)				
41. 01	Total ESRD Medicare covered and paid discharges excluding lan 685. (see instructions)	MS-DRGs 652, 682, 683, 684	0	0	41.0
42. 00	Divide line 41 by line 40 (if less than 10%, you do not que	ualify for adiustment)	0.00		42.0
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,				43.0
	instructions)				l
44. 00	Ratio of average length of stay to one week (line 43 divided days)	led by line 41 divided by 7	0. 000000		44.0
15. 00	Average weekly cost for dialysis treatments (see instruction	ons)	0.00	0.00	45. 0
16.00		•	0		46. (
17.00	Subtotal (see instructions)		23, 313, 154		47. (
48. 00	Hospital specific payments (to be completed by SCH and MDH only. (see instructions)	i, small rural hospitals	0		48.0
	John y. (See Thisti de trons)			Amount	
	Tarana arang ar			1. 00	
49. 00 50. 00	Total payment for inpatient operating costs (see instruction Payment for inpatient program capital (from Wkst. L, Pt. I			23, 313, 154 1, 870, 724	•
51. 00	Exception payment for inpatient program capital (Wkst. L, Ft. 1			1, 870, 724	1
52. 00	Direct graduate medical education payment (from Wkst. E-4,			0	1
3.00	Nursing and Allied Health Managed Care payment			0	1
4. 00 4. 01	Special add-on payments for new technologies Islet isolation add-on payment			0	
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	ne 69)		0	
56. 00	Cost of physicians' services in a teaching hospital (see i			0	1
7. 00	Routine service other pass through costs (from Wkst. D, Pt		hrough 35).	0	
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, P Total (sum of amounts on lines 49 through 58)	Pt. IV, col. 11 line 200)		0	
50.00	Primary payer payments			25, 183, 878 712	
51. 00	Total amount payable for program beneficiaries (line 59 min	nus line 60)		25, 183, 166	1
52. 00	Deductibles billed to program beneficiaries			2, 265, 312	
3. 00	. 9			85, 624	
64. 00 65. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			230, 903 150, 087	
6. 00	Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		42, 705	1
7. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	·		22, 982, 317	67.
8. 00	Credits received from manufacturers for replaced devices for	• •		0	1
	Outlier payments reconciliation (sum of lines 93, 95 and 90 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	6).(For SCH see instruction	is)	0 0	1
	RURAL DEMONSTRATION PROJECT			0	1
70. 00	SCH or MDH volume decrease adjustment			0	1
70. 00 70. 50		nstructions)		0	1
70. 00 70. 50 70. 88 70. 89	Pioneer ACO demonstration payment adjustment amount (see i			1 0	70.
70. 00 70. 50 70. 88 70. 89 70. 90	HSP bonus payment HVBP adjustment amount (see instructions	5)		1	1
70. 00 70. 50 70. 88 70. 89 70. 90 70. 91	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	5)		0	70.
69. 00 70. 00 70. 50 70. 88 70. 89 70. 91 70. 91 70. 93	HSP bonus payment HVBP adjustment amount (see instructions	5)		1	70. 70.
70. 00 70. 50 70. 88 70. 89 70. 90 70. 91 70. 92 70. 93 70. 94	HSP bonus payment HVBP adjustment amount (see instructions HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	5)		0 0 15, 036 -178, 034	70. 70. 70.

	Financial Systems TERRE HAUTE REGION				u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046		Peri od: From 09/01/2016	Worksheet E Part A	
				To 08/31/2017	Date/Time Pre	pared:
					1/27/2018 2:1	5 pm
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
70.04		1		0	1. 00	70, 96
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	n corumn o		0	0	70.96
70 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0	0	70. 97
, 0. , ,	the corresponding federal year for the period ending on or af			Ĭ	Ü	10.77
70. 98	Low Volume Payment-3	,			0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			22, 819, 319	71. 00
71. 01	Sequestration adjustment (see instructions)				456, 386	1
	Interim payments				22, 293, 843	1
73. 00	Tentative settlement (for contractor use only)				0	
	74.00 Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)				69, 090	1
75. 00	Protested amounts (nonallowable cost report items) in accordan	nce with			318, 761	75. 00
	CMS Pub. 15-2, chapter 1, §115.2  TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)					
90 00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see ins	tructions)			0	90.00
91. 00	Capital outlier from Wkst. L, Pt. I, line 2	ti de ti ons)			0	
92. 00	Operating outlier reconciliation adjustment amount (see instru	uctions)			0	92.00
93. 00	Capital outlier reconciliation adjustment amount (see instruc				0	93. 00
94.00	The rate used to calculate the time value of money (see instru				0.00	94.00
95.00	Time value of money for operating expenses (see instructions)	ŕ			0	95. 00
96. 00	Time value of money for capital related expenses (see instruc	tions)			0	96. 00
				Prior to 10/1		
				1. 00	2. 00	
400.00	HSP Bonus Payment Amount			1 0		
100.00	HSP bonus amount (see instructions)			0	0	100. 00
101 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			0.0000000000	0. 0000000000	101 00
	HVBP adjustment ractor (see Instructions)  HVBP adjustment amount for HSP bonus payment (see instructions)	c)		0.000000000		101.00
102.00	HRR Adjustment for HSP Bonus Payment	3)		u u	0	1102.00
103.00	HRR adjustment factor (see instructions)			0.0000	0.0000	103. 00
	HRR adjustment amount for HSP bonus payment (see instructions	)		0.0000		104. 00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10			
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0046	From 09/01/2016	Worksheet E Part B Date/Time Prepared: 1/27/2018 2:15 pm		
	Title XVIII	Hospi tal	PPS		

			To 08/31/2017	Date/Time Pre 1/27/2018 2:1	
		Title XVIII	Hospi tal	PPS	<u> </u>
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			15, 902	1.00
2.00	Medical and other services reimbursed under OPPS (see instruc	tions)		12, 851, 185	2. 00
3.00	PPS payments			12, 652, 044	1
4.00	Outlier payment (see instructions)			38, 216	
5.00	Enter the hospital specific payment to cost ratio (see instructions 2 times 2 times 2	ctions)		0.000	
6. 00 7. 00	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6			0 0.00	
8. 00	Transitional corridor payment (see instructions)			0.00	1
9. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV. col. 13. line 200		Ö	1
10.00	Organ acquisitions	,		0	ı
11.00	Total cost (sum of lines 1 and 10) (see instructions)			15, 902	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
40.00	Reasonable charges			440,000	40.00
12.00	Ancillary service charges	ino (0)		119, 282	1
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii Total reasonable charges (sum of lines 12 and 13)	THE 69)		0 119, 282	1
14.00	Customary charges			117, 202	14.00
15. 00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15. 00
16.00	Amounts that would have been realized from patients liable for			0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(	e)		I	
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
	Total customary charges (see instructions)	l : 6 li == 10	11) (	119, 282	1
19. 00	Excess of customary charges over reasonable cost (complete onlinstructions)	Ty IT Time 18 exceeds II	ne II) (See	103, 380	19. 00
20. 00	Excess of reasonable cost over customary charges (complete on	lvifline 11 exceeds li	ne 18) (see	0	20. 00
	instructions)	. ,	, (===	1	
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	e instructions)		15, 902	21. 00
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)  COMPUTATION OF REIMBURSEMENT SETTLEMENT			12, 690, 260	24. 00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	r CAH, see instructions)		2, 429, 018	1
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)		and 23] (see	10, 277, 144	1
	instructions)			I	
	Direct graduate medical education payments (from Wkst. E-4, li	ine 50)		0	
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29) Primary payer payments			10, 277, 144 6, 052	
	Subtotal (line 30 minus line 31)			10, 271, 092	ı
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)		, = ,	
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
	Allowable bad debts (see instructions)			260, 984	1
	Adjusted reimbursable bad debts (see instructions)			169, 640	1
	Allowable bad debts for dual eligible beneficiaries (see instructions)	ructions)		145, 082 10, 440, 732	1
	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			10, 440, 732	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			-137	1
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		Ö	1
39. 98	Partial or full credits received from manufacturers for replace		tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
	Subtotal (see instructions)			10, 440, 869	1
40. 01	Sequestration adjustment (see instructions)			208, 817	
	Interim payments			10, 407, 437	1
42. 00 43. 00	,			0 -175, 385	1
44. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2	chapter 1.	-175, 365	1
00	§115. 2			ı	00
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	1
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)				94.00
74.00	Total (Said Of Filles / Lana /s)			U	1 /4.00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046	Peri od:	Worksheet E
	Component CCN: 15-S046	From 09/01/2016 To 08/31/2017	Part B   Date/Time Prepared:   1/27/2018 2:15 pm
	Title XVIII	Subprovi der -	PPS

		Title XVIII	Subprovi der - I PF	PPS	
			171		
				1. 00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			720	1 00
1. 00 2. 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruc	tions)		738 1, 060	1. 00 2. 00
3.00	PPS payments	11 0113)		1, 480	3. 00
4. 00	Outlier payment (see instructions)			0	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0. 000	5. 00
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of line 3 plus line 4 divided by line 6 Transitional corridor payment (see instructions)			0.00	
8. 00 9. 00	Ancillary service other pass through costs from Wkst. D, Pt.	V col 13 line 200		0	8. 00 9. 00
10.00	Organ acquisitions	V, COI: 13, 11116 200		0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			738	
	COMPUTATION OF LESSER OF COST OR CHARGES				
40.00	Reasonabl e charges				40.00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	no 60)		5, 517	12. 00 13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)	ne 07)		5, 517	
00	Customary charges			0,017	00
15.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for		on a chargebasis	0	16. 00
17 00	had such payment been made in accordance with 42 CFR §413.13(	e)		0. 000000	17 00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			5, 517	
19. 00	Excess of customary charges over reasonable cost (complete on	y if line 18 exceeds li	ne 11) (see	4, 779	
	instructions)		, ,	•	
20. 00	Excess of reasonable cost over customary charges (complete on	y if line 11 exceeds li	ne 18) (see	0	20. 00
21 00	instructions)	i notruoti ono)		720	21. 00
21. 00 22. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH ser Interns and residents (see instructions)	e mstructions)		738	
23. 00					23. 00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	,		1, 480	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)	- (4)		0	
26. 00 27. 00	Deductibles and Coinsurance relating to amount on line 24 (for Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)]		1	106 2, 112	
27.00	instructions)	or us the sum of fines 22	and 25] (see	2, 112	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ne 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			2, 112	
31. 00 32. 00	Primary payer payments Subtotal (line 30 minus line 31)			0 2, 112	31. 00 32. 00
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE)	CFS)		2, 112	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34.00	Allowable bad debts (see instructions)			0	
35. 00	Adjusted reimbursable bad debts (see instructions)			0	35. 00
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see instable Subtotal (see instructions)	ructions)		0 2, 112	36. 00 37. 00
38.00	MSP-LCC reconciliation amount from PS&R			2, 112	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	39. 50
39. 98	Partial or full credits received from manufacturers for repla	ced devices (see instruc	ctions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			2, 112 42	
41. 00				2, 427	
42.00				0	
43.00	3.00 Balance due provider/program (see instructions)			-357	
44. 00	Protested amounts (nonallowable cost report items) in accordance	nce with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)		I	0	90. 00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	91. 00
92.00	The rate used to calculate the Time Value of Money			0. 00	92. 00
93.00	Time Value of Money (see instructions)			0	93.00
94. 00	Total (sum of lines 91 and 93)		I	0	94. 00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10			
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0046	Peri od: From 09/01/2016	Worksheet E		
	Component CCN: 15-T046				
	Title XVIII	Subprovi der -	PPS		

DART B - MEDICAL AND OTHER HEALTH SERVICES   277   1.00			Title XVIII	Subprovi der - I RF	PPS	
APATE B - NEDICAL AND OTHER HEALTH SERVICES   1.00   1.0		IN				
Medical and other services (see instructions)		PART R - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
PPS payments	1.00				217	1. 00
0.000   0.0000   0.000   0.00000   0.0000   0.000000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.00000000		· ·	ti ons)			
Enter the hospit tal specific payment to cost ratio (see instructions)   0.000   5.00						
Line 2 times line 5		, , ,	ctions)			
Transit fioral corridor payment (see instructions)   0			,			
Ancillary service other pass through costs from Wist. D. Pt. IV, col. 13, line 200   9, 90   10, 100   00   00   00   00   10, 100   00						
10.00   Organ acquisitions   0   10.00   10.			IV col 12 line 200			
11.00   Total cost (sum of lines 1 and 10) (see instructions)   217   11.00			1V, COI. 13, TITIE 200		_	
Reasonable charges   1, 624   12. 00   Ancil Tarry service charges   1, 624   12. 00   Ancil Tarry service charges   1, 624   12. 00   13. 00   1					217	
12.00   Ancil lary service charges   1,624   12.00   13.00   Total reasonable charges (from Wist. D-4, Pt. III, col. 4, line 69)   0,3.00   13.00   13.00   10   10   13.00						
13.00   organ acquisition charges (from Wikst. D-4, Pt. IIII, col. 4, line 69)	12 00				1 624	12 00
Customary charges			ne 69)			
15.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   16.00   Amounts that would have been realized from patients liable for payment for services on a chargebasis   0   16.00   10.00	14. 00	g ;	·		1, 624	14. 00
16.00   Amount's that would have been realized from patients   iable   for payment   for services on a chargebasis   had such payment been made in accordance with 142 CFR \$413.13(e)   0.000000   17.00   18.00   1	15 00	3 9	coment for condess on	a abarga basi s	0	15 00
had such payment been made in accordance with 42 CPR \$413.13(e)						
18.00   Total customery charges (see instructions)   1.62   18.00   1.60   1.400   19.00   1.50   1.400   19.00   1.50   1.50   1.400   19.00   1.50   1.50   1.400   19.00   1.50   1				a chargeren		
19.00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see   1,407   9.00   1.87   1.00						
Instructions			vifline 18 evceeds li	ne 11) (see		
Instructions	17.00		Ty IT TITLE TO EXCECUS IT	110 11) (300	1, 407	17.00
21. 00   Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)   0.20	20. 00		y if line 11 exceeds li	ne 18) (see	0	20. 00
22.00   Interns and residents (see instructions)   0.23.00   0.23.00   0.24.00   0.25.00   0.24.00   0.25.00   0.2	21 00		e instructions)		217	21 00
24. 00   Computation of Peti MBURSEMINT SETTLEMENT						
COMPUTATION OF REIMBURSEMENT SETTLEMENT   25.00   25.00   26			ructions)			
25.00   Deductibles and coinsurance (for CAH, see instructions)   0   25.00   Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)   0   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)   0   28.00   29.00   29.00   ESRD direct medical education payments (from Wkst. E-4, line 50)   0   29.0	24. 00				257	24. 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)   10 rect graduate medical education payments (from Wkst. E-4, line 50)   28. 00   29. 00   25RD direct medical education costs (from Wkst. E-4, line 36)   0 29. 00   29. 00	25. 00				0	25. 00
Instructions		,				
28. 00   0   0   0   0   0   0   0   0   0	27.00		olus the sum of lines 22	and 23] (see	4/4	27.00
30.00   Subtotal (sum of lines 27 through 29)   474   30.00   71 mary payer payments   0.31.00   71 mary payer payments   0.31.00   72 mary payer payments   0.31.00   73 minus line 31)   474   74   74   74   74   74   74	28. 00		ne 50)		0	28. 00
31.00   Subtotal (line 30 minus line 31)   477   32.00   31.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   33.00   33.00   33.00   33.00   34.					_	
32.00   Subtotal (ine 30 minus line 31)   A74   32.00     ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00     Composite rate ESRD (from Wkst. 1-5, line 11)   0   34.00     34.00   Allowable bad debts (see instructions)   0   34.00     35.00   Adjusted reimbursable bad debts (see instructions)   0   36.00     37.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   36.00     37.00   Subtotal (see instructions)   474   37.00     38.00   MSP-LCC reconciliation amount from PS&R   0   38.00     39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00     39.50   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.50     39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99     40.00   Subtotal (see instructions)   474   40.00     40.01   Sequestration adjustment (see instructions)   474   40.00     40.01   Interim payments   570   41.00     40.02   Tentative settlement (for contractors use only)   6   42.00     40.00   Balance due provider/program (see instructions)   10   42.00     40.00   Tentative settlement (for contractors use only)   7   6   6     40.00   Tentative settlement (for contractors use only)   7   6   6     40.00   Tentative settlement (see instructions)   0   90.00     40.00   Ottier reconciliation adjustment amount (see instructions)   0   90.00     40.00   The rate used to calculate the Time Value of Money (see instructions)   0   93.00     40.00   Time Value of Money (see instructions)   0   93.00     40.00   Time Value of Money (see instructions)   0   93.00     40.00   Time Value of Money (see instructions)   0   93.00     40.00   Time Value of Money (see instructions)   0   93.00     40.00   Time Value of Money (see instructions)   0   93.00     40.00   Time Value of Money (see instructions)   0   93.00     40.00   Time Value of Money (see instructions)   0   93.00     40.00   Time Value of Money (see instructions)   0   93.00     40.00   Time Value of Money (see instructions)		,				
33.00   Composite rate ESRD (from Wkst. I - 5, line 11)   0   34.00   All owable bad debts (see instructions)   0   34.00   34.00   All owable bad debts (see instructions)   0   35.00   35.00   Adjusted reimbursable bad debts (see instructions)   0   36.00   All owable bad debts for dual eligible beneficiaries (see instructions)   0   36.00   37.00   Subtotal (see instructions)   0   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   MSP-LCC reconciliation amount from PS&R   0   39.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   0   39.50   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   40.00   Subtotal (see instructions)   474   40.00   40.01   Sequestration adjustment (see instructions)   474   40.00   40.01   41.00   Interim payments   570   41.00   42.00   Tentative settlement (for contractors use only)   41.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,					_	
34.00   Allowable bad debts (see instructions)   0   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   0   35.00   35.00   Adjusted reimbursable bad debts (see instructions)   0   36.00   37.00   38.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   474   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   0   39.50   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   474   40.00   40.00   Subtotal (see instructions)   474   40.00   40.01   Sequestration adjustment (see instructions)   9   40.01   41.00   Interim payments   570   41.00   42.00   43.00   Bal ance due provider/program (see instructions)   -105   43.00   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   44.00   15.20   1			CES)			
35.00   Adjusted reimbursable bad debts (see instructions)   0   35.00     36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   36.00     37.00   Subtotal (see instructions)   474   37.00     38.00   MSP-LCC reconciliation amount from PS&R   0   38.00     39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00     39.50   Pioneer ACO demonstration payment adjustment (see instructions)   0   39.50     39.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.98     39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.98     39.90   Subtotal (see instructions)   474   40.00     40.01   Sequestration adjustment (see instructions)   9   40.01     41.00   Interim payments   570   41.00     42.00   Tentative settlement (for contractors use only)   0   42.00     43.00   Balance due provider/program (see instructions)   -105   43.00     44.00   Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   44.00     43.15.2   To BE COMPLETED BY CONTRACTOR   90.00     91.00   Outlier reconciliation adjustment amount (see instructions)   0   90.00     92.00   The rate used to calculate the Time Value of Money (see instructions)   0   93.00     93.00   Time Value of Money (see instructions)   0   93.00     93.00   Time Value of Money (see instructions)   0   93.00     93.00   Time Value of Money (see instructions)   0   93.00     93.00   Time Value of Money (see instructions)   0   93.00     93.00   Time Value of Money (see instructions)   0   93.00     93.00   Time Value of Money (see instructions)   0   93.00     93.00   Time Value of Money (see instructions)   0   93.00     93.00   Time Value of Money (see instructions)   0   93.00     93.00   Time Value of Money (see instructions)   0   93.00     93.00   Time Value of Money (see instructions)   0   93.00     93.00   Time Value of Money (see instructions)   0   93.00     93.00   Time Value of Money (see instructions)   0   93.00     9						
36.00		1				
38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.00 Pioneer ACO demonstration payment adjustment (see instructions) 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 474 40.00 Sequestration adjustment (see instructions) 40.01 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, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 90.00 The rate used to calculate the Time Value of Money 91.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions)			ructions)			
39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00						
99. 50 Pi oneer ACO demonstrati on payment adjustment (see instructions)  39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions)  39. 98 RECOVERY OF ACCELERATED DEPRECIATION  40. 00 Subtotal (see instructions)  47. 40. 00  40. 01 Sequestration adjustment (see instructions)  41. 00 Interim payments  570 41. 00  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, 0 44. 00  90. 00 Original outlier amount (see instructions)  90. 00 Outlier reconciliation adjustment amount (see instructions)  91. 00 Outlier reconciliation adjustment amount (see instructions)  92. 00 The rate used to calculate the Time Value of Money  10 Time Value of Money (see instructions)  10 39. 50  39. 98  39. 98  39. 98  39. 99  474  40. 00  39. 99  475  40. 00  474  40. 00  475  40. 00  476  40. 00  477  40. 00  478  40. 00  42. 00  42. 00  43. 00  44. 00  44. 00  479  40. 00  41. 00  42. 00  43. 00  44. 00  44. 00  44. 00  479  470  470  470  470  470  470  4						
39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99			s)			
40.00       Subtotal (see instructions)       474       40.00         40.01       Sequestration adjustment (see instructions)       9       40.01         41.00       Interim payments       570       41.00         42.00       Tentative settlement (for contractors use only)       0       42.00         43.00       Balance due provider/program (see instructions)       -105       43.00         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2       0       44.00         90.00       Original outlier amount (see instructions)       0       90.00         91.00       Outlier reconciliation adjustment amount (see instructions)       0       91.00         92.00       The rate used to calculate the Time Value of Money       0.00       92.00         93.00       Time Value of Money (see instructions)       0       93.00			ced devices (see instruc	tions)		
40.01   Sequestration adjustment (see instructions)   9   40.01   41.00   Interim payments   570   41.00   42.00   Tentative settlement (for contractors use only)   0   42.00   43.00   Balance due provider/program (see instructions)   -105   43.00   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   44.00   15.2   15.2   10   15.2   15.2   10   15.2   15.2   10   15.2   15.2   10   15.2						
41.00   Interim payments   570   41.00   42.00   42.00   43.00   Balance due provider/program (see instructions)   -105   43.00   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   44.00   0   0   0   0   0   0   0   0   0						
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, 0 44.00  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Time Value of Money (see instructions)  93.00 Time Value of Money (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  95.00 Outlier reconciliation adjustment amount (see instructions)  97.00 Outlier reconciliation adjustment amount (see instructions)  98.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)						
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,		,				
\$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00						
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) 90.00 91.00 92.00 93.00	44.00					44.00
91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 91.00  92.00  93.00		TO BE COMPLETED BY CONTRACTOR		,		
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00						
93.00 Time Value of Money (see instructions) 0 93.00		1				
94.00   Total (sum of lines 91 and 93)   0   94.00	93. 00	Time Value of Money (see instructions)			0	93. 00
	94. 00	00  Total (sum of lines 91 and 93)			0	94. 00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider Ci		Period: From 09/01/2016 To 08/31/2017	Worksheet E-I Part I Date/Time Pre 1/27/2018 2:1	pared:
		Title	e XVIII	Hospi tal	PPS	
		I npati en	nt 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		22, 293, 84	3	10, 380, 437	
2.00	Interim payments payable on individual bills, either			0	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					]
3. 01	ADJUSTMENTS TO PROVIDER		1	0 03/06/2017	27, 000	
3.02			1	0	0	
3. 03			l	0	0	
3.04				0	0	
3. 05	Provider to Program			0	0	3. 05
3. 50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51	ADJUSTIMENTS TO TROUBLAND		1	0	0	
3. 52			1	0	0	
3.53				0	0	
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	27, 000	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		22, 293, 84	3	10, 407, 437	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR		1			1
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	T		_		
5. 01	TENTATI VE TO PROVI DER		1	0	0	
5. 02 5. 03				0	0	
5.03	Provider to Program			U	0	3.03
5. 50	TENTATI VE TO PROGRAM			0	0	5.50
5. 51			1	0	0	
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
/ 01	the cost report. (1) SETTLEMENT TO PROVIDER		40.00		0	/ 01
6. 01 6. 02	SETTLEMENT TO PROGRAM	1	69, 09		175, 385	
7. 00	Total Medicare program liability (see instructions)		22, 362, 93	3	10, 232, 052	
7.00	Total mode out o program readerity (See Thistractions)		22, 302, 73	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
			0	1. 00	2, 00	

8.00 Name of Contractor

		Title	XVIII	Subprovi der - I PF	PPS	
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1, 092, 645 (	5	2, 427	1. 00 2. 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider					3. 00
3.01	ADJUSTMENTS TO PROVIDER		(		0	3. 01
3.02			(		0	3. 02
3.03			(		0	3. 03
3. 04			(		0	3. 04
3. 05			(		0	3. 05
0.50	Provi der to Program			J		0 50
3. 50 3. 51	ADJUSTMENTS TO PROGRAM		(		0	3. 50 3. 51
3. 51				-		3. 51
3. 52						3. 53
3. 54						3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		ì	1	l ő	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		1, 092, 645	5	2, 427	4. 00
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider			.1	_	
5. 01	TENTATI VE TO PROVI DER		(		0	5. 01
5. 02 5. 03			(		0 0	5. 02 5. 03
5.05	Provider to Program			<u>/ </u>	U	5. 03
5. 50	TENTATI VE TO PROGRAM		(		0	5. 50
5. 51					l ol	5. 51
5. 52			(		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		(	)	0	5. 99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		17, 77 <sup>-</sup>		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		,		357	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 110, 416	5	2, 070	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		(		1. 00	2. 00	
8. 00	Name of Contractor				I I	8. 00

		Title	· XVIII	Subprovider -	PPS	<u>, p</u>
		Inpatien	t Part A		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		1, 953, 66		570	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	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)					
0.04	Program to Provider		ı	٥		0.01
3. 01 3. 02	ADJUSTMENTS TO PROVIDER			0	0 0	3. 01 3. 02
3. 02				0		3. 02
3. 03				0		3. 03
3. 05				o	l ol	3. 05
	Provider to Program		•	- 1		
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				0	0	3. 51
3. 52				0	0	3. 52
3. 53 3. 54			l .	0	0 0	3. 53 3. 54
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		3. 54 3. 99
J. 77	3. 50-3. 98)					3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 953, 66	4	570	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
Г 00	TO BE COMPLETED BY CONTRACTOR		1			г оо
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5. 03				0	0	5. 03
F F0	Provider to Program		1	ما		г го
5. 50 5. 51	TENTATI VE TO PROGRAM			0	0 0	5. 50 5. 51
5. 52				0		5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			o	l ol	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		7.04	0	0	6. 01
6. 02 7. 00	SETTLEMENT TO PROGRAM   Total Medicare program liability (see instructions)		7, 94 1, 045, 71		105 465	6. 02 7. 00
7.00	Total medicale program frability (see instructions)		1, 945, 71	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

Health Financial Systems TERRE HAUTE REGIONAL HOSPITAL In Lieu of F					2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0046	Peri od:	Worksheet E-1	
			From 09/01/2016 To 08/31/2017		aanad.
			To 08/31/2017	Date/Time Pre 1/27/2018 2:1	
		Title XVIII	Hospi tal	PPS	<u> </u>
				1. 00	
	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	2 14	5, 254	1.00
2.00	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			10, 884	2.00
3.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			1, 663	3.00
4.00	4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			698, 069, 350	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20		22, 151, 941	6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I	0	7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)			0	8. 00
9.00	Sequestration adjustment amount (see instructions)			0	9. 00
10.00	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)			0	30.00
31.00 Other Adjustment (specify)			0	31.00	
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00		
			·		

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046	Peri od: From 09/01/2016	Worksheet E-3
	Component CCN: 15-S046		
	Title XVIII	Subprovi der - I PF	PPS

	IPF		
		1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1, 296, 893	1.00
2.00	Net IPF PPS Outlier Payments	100	2.00
3.00	Net IPF PPS ECT Payments	0	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
	15, 2004. (see instructions)		
4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42	0.00	4. 01
5. 00	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)  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
6.00	teaching program" (see instuctions)	0.00	6.00
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
7.00	teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8. 00
9.00	Average Daily Census (see instructions)	18. 178082	9. 00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1, 296, 993	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	15. 00
16. 00	Subtotal (see instructions)	1, 296, 993	16. 00
17. 00	Primary payer payments	8, 329	17. 00
18. 00	Subtotal (line 16 less line 17).	1, 288, 664	18. 00
19. 00	Deducti bl es	145, 068	19. 00
20. 00	Subtotal (line 18 minus line 19)	1, 143, 596	
21. 00	Coi nsurance	28, 644	21. 00
22. 00	Subtotal (line 20 minus line 21)	1, 114, 952	
23. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	27, 886	23. 00
24. 00	Adjusted reimbursable bad debts (see instructions)	18, 126	24. 00
25. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	2, 998	
26. 00	Subtotal (sum of lines 22 and 24)	1, 133, 078	
27. 00 28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27. 00 28. 00
28. 00 29. 00	Other pass through costs (see instructions) Outlier payments reconciliation		29. 00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		30.00
30. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30. 50
30. 99	Recovery of Accel erated Depreciation		30. 99
31. 00	Total amount payable to the provider (see instructions)	1, 133, 078	
31. 01	Sequestration adjustment (see instructions)	22, 662	31. 01
32. 00	Interim payments	1, 092, 645	
33. 00	Tentative settlement (for contractor use only)	0	33.00
34. 00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	17, 771	34. 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		
	Original outlier amount from Worksheet E-3, Part II, line 2		50.00
	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52. 00	The rate used to calculate the Time Value of Money	0.00	
53. 00	Time Value of Money (see instructions)	0	53. 00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046		Worksheet E-3
	0 1 000 45 7047	From 09/01/2016	
	Component CCN: 15-T046	10 08/31/201/	
			1/27/2018 2:15 pm
	Title XVIII	Subprovi der -	PPS
		LDE	

New Tederal PPS Payment (see instructions)   1.00   1.031,722   1.00   Net Federal PPS Payment (see instructions)   1.031,722   1.00   Nedicare SSI ratio (IRF PPS enly) (see instructions)   0.0406   2.00   1.001		IRF				
PART III - MEDICARE PART A SERVICES - LIRE PPS						
1.00						
Medicare SSI ratio (IRF PPS only) (see instructions)   0.0406   2.00   0.00						
Inpati ent Rehabilitation LIP Payments (see Instructions)						
4.00   Outlier Payments   290,973   4.00   5.00   Use instructions   5.00   Use instructions   5.00   Movember 15, 2004 (see instructions)   5.01   Cap increases for the Unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 (CFR \$472.434(0)(1)(1)(1)(5)(7) or (2) (see instructions)   6.00   6.00   7.00	2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0406	2.00		
Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 20d (see instructions)	3.00	Inpatient Rehabilitation LIP Payments (see instructions)	80, 770	3.00		
to November 15, 2004 (see Instructions) 5.01 cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR \$412.424(d)(i)(ii)(ii)(ii)(i)(i)(i)(i)(ii)(i)(iii)(ii)(ii)(iii)(iii)(ii)(ii)(ii)(ii)(ii)(ii)(ii)(ii)(ii)(iii)(ii)(ii)(	4.00	Outlier Payments	290, 973	4.00		
5.01   Cap Increases for the unweighted intern and resident FTE count for residents that were displaced by 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	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior	0.00	5.00		
program or hospital closure, that would not be counted without a temporary cap adjustment under 42   CFR 9411-424(d) (i) (ii) (i) (i) (i) (i) (i) (i) (i) (		to November 15, 2004 (see instructions)				
CFR \$412.424(d)(1)(III)(F)(1) or (2) (see instructions)	5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	5. 01		
New Teaching program adjustment. (see instructions)   0.00   6.00   7.00   0.00   7.00   0.00   7.00   0.00   7.00   0.00   7.00   0.00   7.00   0.00   7.00   0.						
2.00   Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)   0.00						
teaching program" (see Instructions)   0.00   8.00		, , ,				
Section   Corrent 'year's unweighted IRR FTE count for residents within the new program growth period of a "new teaching program" (see instructions)   0.00   0.00	7. 00		0. 00	7. 00		
teaching program" (see instructions)   0,00   9,00   0.0						
9.00       Intern and resident count for IRF PPS medical education adjustment (see instructions)       4.876712       10.00         10.00       Average Daily Census (see instructions)       4.876712       10.00         11.00       Teaching Adjustment Factor (see instructions)       0.000000       11.00         12.00       Teaching Adjustment (see instructions)       2.003, 465       13.00         14.00       Nursing and Allied Heal th Managed Care payments (see instructions)       0       14.00         15.00       Cost of physicians' services in a teaching hospital (see instructions)       0       15.00         16.00       Cost of physicians' services in a teaching hospital (see instructions)       2.003, 465       17.00         18.00       Primary payer payments       10.800       18.00         19.00       Subtotal (see instructions)       1.0800       18.00         19.00       Deductibles       5.264       20.00         20.00       Deductibles       5.264       20.00         21.00       Subtotal (line 17 less line 18).       1,987,401       21.00         21.00       Subtotal (line 19 minus line 20)       1,987,401       21.00         22.00       Coinsurance       1,987,401       22.00         23.00       Subtotal (line 21 minus line 22)	8.00		0.00	8. 00		
10. 00   Average Daily Census (see instructions)   1. 00   Teaching Adjustment Factor (see instructions)   0. 000000   11. 00   12. 00   12. 00   13. 00   10. 10. 00   12. 00   13. 00   10. 10. 00   13. 00   10. 10. 00   13. 00   10. 10. 00   13. 00   10. 10. 00   13. 00   10. 10. 00   13. 00   10. 10. 00   10. 00   13. 00   10. 10. 00   13. 00   14. 00   15.						
11.00   Teaching Adjustment Factor (see instructions)   0.000000   11.00   12.00   13.00   14.00   1						
12.00   Teaching Adjustment (see instructions)   12.00   Total PPS Payment (see instructions)   2.003, 465   13.00   14.00   15.00   0rgan acquisition (DD NOT USE THIS LINE)   15.00   15.0						
13.00   Total PPS Payment (see instructions)   2,003,465   13.00   14.00   15.00   14.00   15.00   1		, , , , , , , , , , , , , , , , , , , ,				
14. 00   Nursing and Ållied Health Managed Care payments (see instruction)   15. 00   15. 0						
15. 00						
16.00   Cost of physicians' services in a teaching hospital (see instructions)   2,003,465   17.00   17.00   Subtotal (see instructions)   2,003,465   17.00   18.00   19.00			0			
17. 00       Subtotal (see instructions)       2,003,465       17. 00         18. 00       Primary payer payments       10,800       18. 00         19. 00       Subtotal (line 17 less line 18).       1,992,665       19. 00         20. 00       Deductibles       5,264       20. 00         21. 00       Subtotal (line 19 minus line 20)       1,974, 22. 00         22. 00       Coinsurance       1,974, 22. 00         23. 00       Subtotal (line 21 minus line 22)       1,985, 427, 23.00         24. 00       All owable bad debts (exclude bad debts for professional services) (see instructions)       0       25. 00         25. 00       All owable bad debts for dual eligible beneficiaries (see instructions)       0       25. 00         26. 00       All owable bad debts for dual eligible beneficiaries (see instructions)       0       25. 00         28. 00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0       1,985, 427       27.00         29. 00       Other pass through costs (see instructions)       0       28. 00         30. 00       Ottlier payments reconciliation       0       30. 00         31. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0       31. 00         31. 99       Recovery of Accelerated De			_			
18.00   Primary payer payments   10,800   18.00   19.00   Subtotal (line 17 less line 18).   1,992,665   19.00   19.00   Subtotal (line 19 minus line 20)   1,987,401   21.00   22.00   Coinsurance   1,987,401   21.00   22.00   23.00   Subtotal (line 21 minus line 22)   1,985,427   23.00   24.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   0 24.00   24.00   24.00   25.00   Adjusted reimbursable bad debts (see instructions)   0 26.00   25.00   26.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0 26.00   27.00   Subtotal (sum of lines 23 and 25)   1,985,427   27.00   28.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0 29.00   0 0 Utilier payments reconciliation   0 30.00   0 0 Utilier payments reconciliation   0 31.00   31.50   21.00   22.00   23.00			- 1			
19.00   Subtotal (line 17 less line 18).   1,992,665   19.00		·				
20. 00       Deductibles       5, 264       20. 00         21. 00       Subtotal (line 19 minus line 20)       1, 974 02       20. 00         22. 00       Coinsurance       1, 974 22. 00         23. 00       Subtotal (line 21 minus line 22)       1, 985, 427 23. 00         24. 00       Allowable bad debts (exclude bad debts for professional services) (see instructions)       0 25. 00         25. 00       Adjusted reimbursable bad debts (see instructions)       0 25. 00         26. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       1, 985, 427 27. 00         27. 00       Subtotal (sum of lines 23 and 25)       1, 985, 427 27. 00         28. 00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0 28. 00         29. 00       Other pass through costs (see instructions)       0 29. 00         30. 00       Outlier payments reconciliation       0 30. 00         31. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0 31. 50         31. 99       Recovery of Accelerated Depreciation       39, 709         32. 01       Sequestration adjustment (see instructions)       1, 985, 427         32. 01       Sequestration adjustment (see instructions)       1, 985, 427         33. 00       Interim payments       1, 985, 427 </td <td></td> <td></td> <td></td> <td></td>						
21.00   Subtotal (line 19 minus line 20)   1,987,401   21.00   22.00   Coinsurance   1,974   22.00   22.00   23.00   Subtotal (line 21 minus line 22)   1,985,427   23.00   24.00   25.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   0   24.00   25.00   Adjusted reimbursable bad debts (see instructions)   0   25.00   26.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   25.00   26.00   27.00   Subtotal (sum of lines 23 and 25)   1,985,427   27.00   28.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0   28.00   29.00   0   0   0   0   0   0   0   0   0						
22.00   Coinsurance   1,974   22.00   23.00   Subtotal (line 21 minus line 22)   23.00   24.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   0   24.00   25.00   Adjusted reimbursable bad debts (see instructions)   0   26.00   26.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   26.00   27.00   Subtotal (sum of lines 23 and 25)   1,985,427   27.00   28.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0   28.00   29.00   0   0   0   0   0   0   0   0   0						
23.00   Subtotal (line 21 minus line 22)   1,985,427   23.00   24.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   0 24.00   25.00   26.00   Allowable bad debts (see instructions)   0 25.00   26.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0 26.00   27.00   Subtotal (sum of lines 23 and 25)   1,985,427   27.00   28.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0 28.00   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		, ,				
24. 00       Allowable bad debts (exclude bad debts for professional services) (see instructions)       0       24. 00         25. 00       Adjusted reimbursable bad debts (see instructions)       0       25. 00         26. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       0       26. 00         27. 00       Subtotal (sum of lines 23 and 25)       1, 985, 427       27. 00         28. 00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0       28. 00         29. 00       Other pass through costs (see instructions)       0       29. 00         30. 00       Outlier payments reconciliation       0       30. 00         31. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       31. 50         31. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0       31. 50         31. 99       Recovery of Accelerated Depreciation       0       31. 90         32. 01       Sequestration adjustment (see instructions)       1, 985, 427       32. 00         32. 01       Sequestration adjustment (see instructions)       1, 985, 427       32. 00         35. 00       Interim payments       1, 953, 664       33. 00         36. 00       Protested amounts (nonal lowable cost report items) in accordance with CMS Pub.						
25.00						
26.00 Allowable bad debts for dual eligible beneficiaries (see instructions)  27.00 Subtotal (sum of lines 23 and 25)  28.00 Direct graduate medical education payments (from Wkst. E-4, line 49)  29.00 Other pass through costs (see instructions)  30.00 Outlier payments reconciliation  30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  31.50 Pioneer ACO demonstration payment adjustment (see instructions)  31.99 Recovery of Accelerated Depreciation  Total amount payable to the provider (see instructions)  32.01 Sequestration adjustment (see instructions)  33.00 Sequestration adjustment (see instructions)  34.00 Tentative settlement (for contractor use only)  35.00 Balance due provider/program (line 32 minus lines 32.01, 33, and 34)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4  Outlier reconciliation adjustment amount (see instructions)  0 26.00 27.00  1, 985, 427 27.00  28.00  1, 985, 427 27.00  28.00  28.00  29.00  30.00  30.00  31.00  31.00  31.00  31.00  31.00  31.00  31.00  31.00  31.99  32.01  31.99  32.01  33.90  39,709  32.01  39,709  32.01  39,709  30.00  30.0						
27.00   Subtotal (sum of lines 23 and 25)   1,985,427   27.00     28.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0 28.00     29.00   Other pass through costs (see instructions)   0 29.00     30.00   Outlier payments reconciliation   0 30.00     31.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0 31.00     31.50   Pioneer ACO demonstration payment adjustment (see instructions)   0 31.99     32.00   Recovery of Accelerated Depreciation   0 31.99     32.01   Saguestration adjustment (see instructions)   1,985,427   32.00     32.01   Saguestration adjustment (see instructions)   39,709   32.01     33.00   Interim payments   1,953,664   33.00     34.00   Tentative settlement (for contractor use only)   0 34.00     35.00   Balance due provider/program (line 32 minus lines 32.01, 33, and 34)   -7,946   35.00     36.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0 36.00     50.00   Original outlier amount from Wkst. E-3, Pt. III, line 4   290,973   50.00     50.00   Outlier reconciliation adjustment amount (see instructions)   0 51.00		*				
28.00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0       28.00         29.00       Other pass through costs (see instructions)       0       29.00         30.00       Outlier payments reconciliation       0       30.00         31.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       31.00         31.50       Pioneer ACO demonstration payment adjustment (see instructions)       0       31.00         31.99       Recovery of Accelerated Depreciation       0       31.99         32.00       Total amount payable to the provider (see instructions)       1,985,427       32.00         32.01       Sequestration adjustment (see instructions)       39,709       32.01         33.00       Interim payments       1,953,664       33.00         34.00       Tentative settlement (for contractor use only)       0       34.00         35.00       Balance due provider/program (line 32 minus lines 32.01, 33, and 34)       -7,946       35.00         36.00       Tentested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0       0       36.00         50.00       Original outlier amount from Wkst. E-3, Pt. III, line 4       290,973       50.00         51.00       Outlier reconciliation adjustment amount (see instructions) <t< td=""><td></td><td></td><td></td><td></td></t<>						
29.00       Other pass through costs (see instructions)       0       29.00         30.00       Outlier payments reconciliation       0       30.00         31.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       31.00         31.50       Pioneer ACO demonstration payment adjustment (see instructions)       0       31.50         31.99       Recovery of Accelerated Depreciation       0       31.50         32.00       Total amount payable to the provider (see instructions)       1,985,427       32.00         32.01       Sequestration adjustment (see instructions)       39,709       32.01         33.00       Interim payments       1,953,664       33.00         34.00       Tentative settlement (for contractor use only)       0       34.00         35.00       Balance due provider/program (line 32 minus lines 32.01, 33, and 34)       -7,946       35.00         36.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2       0       36.00         50.00       Original outlier amount from Wkst. E-3, Pt. III, line 4       290,973       50.00         51.00       Outlier reconciliation adjustment amount (see instructions)       0       51.00		·				
30.00 Outlier payments reconciliation						
31.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   31.00						
31.50   Pi oneer ACO demonstration payment adjustment (see instructions)   0   31.50   31.99   Recovery of Accelerated Depreciation   0   31.99   32.00   Total amount payable to the provider (see instructions)   1,985,427   32.00   32.01   Sequestration adjustment (see instructions)   39,709   32.01   33.00   Interim payments   1,953,664   33.00   34.00   35.00   Balance due provider/program (line 32 minus lines 32.01, 33, and 34)   -7,946   35.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,						
31.99   Recovery of Accelerated Depreciation   0   31.99   32.00   Total amount payable to the provider (see instructions)   1,985,427   32.00   32.01   Sequestration adjustment (see instructions)   39,709   32.01   33.00   Interim payments   1,953,664   33.00   34.00   35.00   Balance due provider/program (line 32 minus lines 32.01, 33, and 34)   -7,946   35.00   36.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,						
32.00   Total amount payable to the provider (see instructions)   1,985,427   32.00   32.01   33.00   Interim payments   1,953,664   33.00   34.00   Tentative settlement (for contractor use only)   0   34.00   35.00   Balance due provider/program (line 32 minus lines 32.01, 33, and 34)   -7,946   35.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   36.00   Silbs 2   10   BE COMPLETED BY CONTRACTOR   290,973   50.00   51.00   Outlier reconciliation adjustment amount (see instructions)   0   51.00			- 1			
32.01 Sequestration adjustment (see instructions) 39,709 32.01 31.00 Interim payments 1,953,664 33.00 34.00 Tentative settlement (for contractor use only) 35.00 Balance due provider/program (line 32 minus lines 32.01, 33, and 34) 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515.2 TO BE COMPLETED BY CONTRACTOR  Original outlier amount from Wkst. E-3, Pt. III, line 4 0 Utilier reconciliation adjustment amount (see instructions) 0 51.00						
33.00 Interim payments  1, 953, 664 33.00  Tentative settlement (for contractor use only)  35.00 Balance due provider/program (line 32 minus lines 32.01, 33, and 34)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4  Outlier reconciliation adjustment amount (see instructions)  1, 953, 664 33.00  34.00  35.00  77, 946 35.00  36.00  70 Be COMPLETED BY CONTRACTOR  Original outlier amount from Wkst. E-3, Pt. III, line 4  Outlier reconciliation adjustment amount (see instructions)						
34.00 Tentative settlement (for contractor use only) 35.00 Balance due provider/program (line 32 minus lines 32.01, 33, and 34) 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 36.00 Original outlier amount from Wkst. E-3, Pt. III, line 4  Outlier reconciliation adjustment amount (see instructions)  34.00 35.00 36.00 37.00 38.00 39.00 30.00						
35.00 Balance due provider/program (line 32 minus lines 32.01, 33, and 34)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00  10 Be COMPLETED BY CONTRACTOR  10 De COMPLETED BY CONTRACTOR  10 Outlier reconciliation adjustment amount (see instructions)  11 Outlier reconciliation adjustment amount (see instructions)						
36.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 \[ \frac{\frac{\text{9115.2}}{10 \text{ BE COMPLETED BY CONTRACTOR}}}{\text{70 BE COMPLETED BY CONTRACTOR}}  50.00 Outlier reconciliation adjustment amount (see instructions)  50.00 Outlier reconciliation adjustment amount (see instructions)						
\$115. 2 TO BE COMPLETED BY CONTRACTOR  50. 00 Original outlier amount from Wkst. E-3, Pt. III, line 4  50. 00 Outlier reconciliation adjustment amount (see instructions)  50. 00 51. 00						
TO BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4  50.00 Outlier reconciliation adjustment amount (see instructions)  50.00 51.00	36. 00					
50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4  290,973 50.00 Outlier reconciliation adjustment amount (see instructions)  50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4  50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4  50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4		·				
51.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00	F0 05		600 0==	F0 00		
- by OD The rate used to calculate the Lime Value of Money		, , , , , , , , , , , , , , , , , , ,	- 1			
		The rate used to calculate the Time Value of Money	0.00			
53.00   Time Value of Money (see instructions)   0   53.00	os. 00	Time value of money (see instructions)	θĮ	o3. UU		

Health Financial Systems	TERRE HAUTE REGIO	DNAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMEN	IT	Provider CCN: 15-0046	Peri od: From 09/01/2016 To 08/31/2017		pared:
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1. 00	2. 00	
PART VII - CALCULATION OF REIMBU	URSEMENT - ALL OTHER HEALTH S	ERVICES FOR TITLES V OR X	IX SERVICES		
COMPUTATION OF NET COST OF COVE	RED SERVICES				ĺ
1.00 Inpatient hospital/SNF/NF servi	ces		6, 958, 220		1.00
2.00 Medical and other services				8, 429, 367	2.00
3.00 Organ acquisition (certified tr	ansplant centers only)		o		3.00
4.00 Subtotal (sum of lines 1, 2 and	3)		6, 958, 220	8, 429, 367	4.00

		1 00	2 00	
		1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES			ı
1.00	Inpatient hospital/SNF/NF services	6, 958, 220		1.00
2.00	Medical and other services		8, 429, 367	2. 00
3.00	Organ acquisition (certified transplant centers only)	o		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	6, 958, 220	8, 429, 367	4.00
5. 00	Inpatient primary payer payments	0, 700, 220	0, 127,007	5. 00
6. 00	Outpatient primary payer payments	٩	0	6.00
		4 050 220	0 420 247	
7. 00	Subtotal (line 4 less sum of lines 5 and 6)	6, 958, 220	8, 429, 367	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES			1
	Reasonabl e Charges			
8. 00	Routine service charges	0		8. 00
9. 00	Ancillary service charges	40, 136, 414	72, 992, 384	9. 00
10.00	Organ acquisition charges, net of revenue	0		10.00
11. 00	Incentive from target amount computation	o		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)	40, 136, 414	72, 992, 384	12.00
	CUSTOMARY CHARGES			
13. 00	Amount actually collected from patients liable for payment for services on a charge	0	0	13. 00
10.00	basis		Ü	10.00
14. 00	Amounts that would have been realized from patients liable for payment for services on	0	0	14. 00
14.00	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	٩	U	14.00
15 00		0.000000	0.000000	15 00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	
16. 00	Total customary charges (see instructions)	40, 136, 414	72, 992, 384	
17. 00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds	33, 178, 194	64, 563, 017	17. 00
	line 4) (see instructions)			1
18. 00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line	0	0	18. 00
	16) (see instructions)			ł
19. 00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	o	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)	6, 958, 220	8, 429, 367	21.00
200	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS provider		0/ 12//00/	
22. 00	Other than outlier payments	0	0	22. 00
23. 00	Outlier payments	0	0	23. 00
		0	U	
	Program capital payments	U		24. 00
	Capital exception payments (see instructions)	0	_	25. 00
26. 00	Routine and Ancillary service other pass through costs	0	0	
27. 00	Subtotal (sum of lines 22 through 26)	0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)	0	0	28. 00
29.00	Titles V or XIX (sum of lines 21 and 27)	6, 958, 220	8, 429, 367	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	<u> </u>		1
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	6, 958, 220	8, 429, 367	
32. 00	Deducti bl es	0, 750, 220	0, 427, 307	1
33. 00		0	0	
		U	0	
34. 00	Allowable bad debts (see instructions)	0	0	34.00
	Utilization review	0		35. 00
36. 00		6, 958, 220	8, 429, 367	
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37. 00
38. 00	Subtotal (line 36 ± line 37)	6, 958, 220	8, 429, 367	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)	ol		39. 00
	Total amount payable to the provider (sum of lines 38 and 39)	6, 958, 220	8, 429, 367	
41. 00	Interim payments	8, 786, 480	5, 326, 768	ł
	Balance due provider/program (line 40 minus line 41)		3, 102, 599	
42. 00		-1, 828, 260		
43. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2	1		1

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0046	Peri od: From 09/01/2016	Worksheet E-3 Part VII
	Component CCN: 15-S046		
	Title XIX	Subprovi der -	Cost
		I PF	

		litle XIX	Subprovi der -	Cost	
			I PF I npati ent	Outpati ent	
			1, 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
	COMPUTATION OF NET COST OF COVERED SERVICES	S TOR TITLES V OR ALL	COLINALOES		
1.00	Inpatient hospital/SNF/NF services		2, 289, 421		1.00
2. 00	Medical and other services		2,207,121	0	2. 00
3. 00	Organ acquisition (certified transplant centers only)		0	Ü	3. 00
4. 00	Subtotal (sum of lines 1, 2 and 3)		2, 289, 421	0	4. 00
5. 00	Inpatient primary payer payments		0	Ü	5. 00
6. 00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		2, 289, 421	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		0		8. 00
9. 00	Ancillary service charges		3, 684, 683	0	9. 00
10. 00	Organ acquisition charges, net of revenue		0	_	10.00
11. 00	Incentive from target amount computation		o		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		3, 684, 683	0	12. 00
	CUSTOMARY CHARGES				
13. 00	Amount actually collected from patients liable for payment for ser	vices on a charge	0	0	13. 00
	basis	9			
14.00	Amounts that would have been realized from patients liable for pays	ment for services on	0	0	14. 00
	a charge basis had such payment been made in accordance with 42 CFI	R §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		3, 684, 683	0	16. 00
17.00	Excess of customary charges over reasonable cost (complete only if	line 16 exceeds	1, 395, 262	0	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only if	line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instruction	ons)	0	0	20. 00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		2, 289, 421	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be compl	leted for PPS provide			
22. 00	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24.00	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0	0	25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0 000 404	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		2, 289, 421	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT  Excess of reasonable cost (from line 18)			0	30.00
30.00			0 2, 289, 421	0	30.00
31. 00 32. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		2, 289, 421	0	31.00
33. 00	Coinsurance		0	0	33. 00
34. 00	Allowable bad debts (see instructions)		0	0	34.00
35. 00	Utilization review		0	U	35.00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		2, 289, 421	0	36.00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		2, 207, 421	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		2 200 421	0	38.00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		2, 289, 421	U	39.00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		2, 289, 421	0	40.00
41. 00	Interim payments		2, 479, 251	0	40.00
42. 00	Balance due provider/program (line 40 minus line 41)		-189, 830	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance wi	ith CMS Pub 15-2	-107, 030	0	43. 00
10.00	chapter 1, §115.2	OMO 1 GD 10 Z,		O	10.00
	1h		1		1

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0046	Peri od: From 09/01/2016	Worksheet E-3 Part VII
	Component CCN: 15-T046	To 08/31/2017	Date/Time Prepared: 1/27/2018 2:15 pm
	Title XIX	Subprovi der -	Cost

		II tie xix	I RF	COST	
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVIC	ES FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		199, 095		1.00
2. 00	Medical and other services		177,070	0	1
3. 00	Organ acquisition (certified transplant centers only)		0	Ü	3. 00
4. 00	Subtotal (sum of lines 1, 2 and 3)		199, 095	0	4. 00
5. 00	Inpatient primary payer payments		0	ŭ	5. 00
6. 00	Outpatient primary payer payments		Ĭ	0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		199, 095	0	
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		1777070		7.00
	Reasonable Charges				1
8. 00	Routine service charges		0		8.00
9. 00	Ancillary service charges		201, 802	0	1
10.00	Organ acquisition charges, net of revenue		0	_	10.00
11. 00	Incentive from target amount computation		o		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		201, 802	0	•
	CUSTOMARY CHARGES		, , , , ,		
13.00	Amount actually collected from patients liable for payment for se	rvices on a charge	0	0	13.00
	basis	3.			
14.00	Amounts that would have been realized from patients liable for pa	yment for services on	0	0	14. 00
	a charge basis had such payment been made in accordance with 42 C	FR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		201, 802	0	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only i	fline 16 exceeds	2, 707	0	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only i	fline 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	
20. 00	Cost of physicians' services in a teaching hospital (see instruct	i ons)	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		199, 095	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be com	pleted for PPS provide			
	Other than outlier payments		0	0	
23. 00	Outlier payments		0	0	23. 00
	Program capital payments		0		24.00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	1
29. 00	Titles V or XIX (sum of lines 21 and 27)		199, 095	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	1 20 00
30.00	Excess of reasonable cost (from line 18)		100,005	0	
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		199, 095	0	31.00
32. 00	Deducti bl es		0	0	
33. 00	Coinsurance		0	0	33.00
	Allowable bad debts (see instructions)		0	Ü	34.00
35. 00 36. 00	Utilization review	`	100 005	0	35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	)	199, 095	0	
	Subtotal (line 36 ± line 37)		199, 095	0	38.00
	1		199, 093	U	39.00
40. 00	Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39)		199, 095	0	40.00
41. 00	Interim payments		81, 432	0	41. 00
41.00	Balance due provider/program (line 40 minus line 41)		117, 663	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2	117, 663	0	42.00
73.00	chapter 1, §115.2	OWS 1 GD 13-2,	١	U	75.00
			1		1

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

Provider CCN: 15-0046

Peri od: Worksheet G From 09/01/2016 To 08/31/2017 Date/Time Prepared:

onl y)				10 08/31/201/	1/27/2018 2:1	
		General Fund	Speci fi c	Endowment Fund		, p
		1. 00	Purpose Fund 2.00	3.00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	12, 571	1	1 1	0	
2.00	Temporary investments	0	1	0	0	
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	0 114 170	1	0	0	
5. 00	Other receivable	29, 416, 470 7, 986			0	
6. 00	Allowances for uncollectible notes and accounts receivable	-9, 947, 330	•	ol ol	0	
7.00	Inventory	6, 140, 266	•	o	0	
8.00	Prepai d expenses	769, 930	)	o	0	
9.00	Other current assets	0		0	0	
10.00	Due from other funds	-9, 355		0	0	
11. 00	Total current assets (sum of lines 1-10)	26, 390, 538	3] (	0	0	11. 00
12. 00	FIXED ASSETS Land	1, 262, 718	2	ol	0	12. 00
13. 00	Land improvements	3, 158, 371	1	ol ol	0	
14. 00	Accumulated depreciation	-3, 038, 794	1	o o	0	
15.00	Bui I di ngs	38, 638, 215	5	o	0	15. 00
16. 00	Accumulated depreciation	-25, 807, 069	1	0	0	
17. 00	Leasehold improvements	8, 056, 095	1	0	0	
18.00	Accumulated depreciation	-5, 851, 048	1	0	0	
19. 00 20. 00	Fixed equipment Accumulated depreciation	27, 079, 070	1		0	
21. 00	Automobiles and trucks	-19, 695, 434			0	
22. 00	Accumulated depreciation	0			0	
23. 00	Major movable equipment	41, 671, 474	•	ol ol	0	
24.00	Accumul ated depreciation	-31, 439, 116	1	o	0	24. 00
25. 00	Mi nor equi pment depreci abl e	4, 685, 379		0	0	25. 00
26. 00	Accumul ated depreciation	-3, 121, 955	1	0	0	
27. 00	HIT designated Assets	0		0	0	
28. 00 29. 00	Accumulated depreciation	U 4 E10 441			0	
30.00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	4, 519, 661 40, 117, 567			0	
30.00	OTHER ASSETS	40, 117, 307	`	9  9	0	30.00
31.00	Investments	3, 063, 197	' (	0	0	31. 00
32.00	Deposits on Leases	0	) (	o	0	32. 00
33. 00	Due from owners/officers	0	)	0	0	
34. 00	Other assets	2, 386, 484	•	0	0	
35. 00	Total other assets (sum of lines 31-34)	5, 449, 681		0	0	1
36. 00	Total assets (sum of lines 11, 30, and 35)  CURRENT LIABILITIES	71, 957, 786	9	0	0	36. 00
37. 00	Accounts payable	4, 463, 024		ol ol	0	37. 00
38. 00	Salaries, wages, and fees payable	3, 856, 055		ol ol	0	
39. 00	Payrol I taxes payable	1, 772, 246	•	o o	0	
40.00	Notes and Loans payable (short term)	165, 123		o	0	40.00
41.00	Deferred income	0	) (	0	0	
42. 00	Accel erated payments	0	)		_	42. 00
43. 00	Due to other funds	396	1	0	0	
44. 00 45. 00		0 10, 256, 844	1		0	
45.00	LONG TERM LIABILITIES	10, 230, 644		<u> </u>	U	45.00
46. 00	Mortgage payable	0	) (	0	0	46. 00
47.00	Notes payable	445, 743	3	o	0	
48. 00	Unsecured Loans	-214, 085, 355	5	0	0	48. 00
49. 00	Other long term liabilities	59, 815	1	0	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	-213, 579, 797		0	0	
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	-203, 322, 953	<u> </u>	0	0	51. 00
52. 00	General fund balance	275, 280, 739				52.00
53. 00	Specific purpose fund	270,200,707				53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted		1	0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	275, 280, 739	,		0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	71, 957, 786			0	
55. 66	[59]	. 1, 757, 700	`			55.00
		•	•	, '		•

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0046

0

0

0

Peri od: Worksheet G-1 From 09/01/2016

15.00

16.00

17.00

18.00

19.00

08/31/2017 Date/Time Prepared: 1/27/2018 2:15 pm General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 268, 942, 469 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 9, 255, 954 2.00 3.00 Total (sum of line 1 and line 2) 278, 198, 423 0 3.00 4.00 ROUNDI NG 0 0 4.00 5.00 0 5.00 0 0 0 0 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 0 9. 00 10.00 Total additions (sum of line 4-9) 33 10.00 Subtotal (line 3 plus line 10) 278, 198, 456 11.00 11.00 0 12.00 FEDERAL TAX LIABILITY 2, 917, 717 0 12.00 13.00 13.00 14.00 0 0 0 0 14.00 0 15.00 15.00 0 16.00 0 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 2, 917, 717 18.00 18.00 Fund balance at end of period per balance 275, 280, 739 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 ROUNDI NG 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 11.00 Subtotal (line 3 plus line 10) 0 0 11.00 12.00 FEDERAL TAX LIABILITY 12.00 13.00 13.00 14.00 0 14.00

0

15. 00 16. 00

17.00

18.00

19.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

Health Financial Systems TER STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0046

			То	08/31/2017	Date/Time Pre 1/27/2018 2:1	
	Cost Center Description	Inpatient		Outpati ent	Total	J pili
	oust deficer beserver on	1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES	1.00		2.00	0.00	
	General Inpatient Routine Services					
1.00	Hospi tal	18, 078, 1	43		18, 078, 143	1. 00
2.00	SUBPROVI DER - I PF	25, 189, 3			25, 189, 381	2. 00
3.00	SUBPROVI DER - I RF	2, 310, 1			2, 310, 130	3. 00
4.00	SUBPROVI DER	,			, ,	4. 00
5.00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	6. 00
7.00	SKILLED NURSING FACILITY					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)	45, 577, 6	54		45, 577, 654	
	Intensive Care Type Inpatient Hospital Services				, , , , , , , , , , , , , , , , , , , ,	
11. 00	INTENSIVE CARE UNIT	9, 165, 5	38		9, 165, 538	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	OTHER SPECIAL CARE (SPECIFY)					15. 00
16.00	Total intensive care type inpatient hospital services (sum of lines	9, 165, 5	38		9, 165, 538	16. 00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)	54, 743, 1	92		54, 743, 192	17. 00
18.00	Ancillary services	268, 449, 4	27	316, 146, 151	584, 595, 578	18. 00
19.00	Outpati ent servi ces	16, 443, 5	58	42, 804, 535	59, 248, 093	19. 00
20.00	RURAL HEALTH CLINIC		0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	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			0	0	0	27. 00
27. 01			0	0	0	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	339, 636, 1	77	358, 950, 686	698, 586, 863	28. 00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			118, 251, 213		29. 00
30.00	ADD (SPECIFY)		0			30.00
31. 00	ROUNDI NG		15			31. 00
32. 00			0			32.00
33. 00			0			33. 00
34. 00			0			34.00
35. 00			0			35. 00
36. 00	Total additions (sum of lines 30-35)			15		36. 00
37. 00	DEDUCT (SPECIFY)		0			37. 00
38. 00	GAIN/LOSS ON DISPOSALS	7, 7				38. 00
39. 00	INTEREST INCOME	14, 8				39. 00
40.00	UNCLAIMED PROPERTY	4, 5				40.00
41.00	HI TECH	1, 9	83			41.00
42. 00	Total deductions (sum of lines 37-41)			29, 222		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transf	er		118, 222, 006		43. 00
	to Wkst. G-3, line 4)	1	- 1			

Health Financial Systems TERRE HAUTE REGIONAL HOSPITAL In Lieu of Form CMS-2552-1					
STATE	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0046	Peri od:	Worksheet G-3	
			From 09/01/2016 To 08/31/2017	Date/Time Pre 1/27/2018 2:1	
				1.00	
1. 00	Total nations revenues (from What C.2 Port I column 2 lin	20.		1. 00 698, 586, 863	1. 00
2.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir Less contractual allowances and discounts on patients' accour			571, 489, 502	2.00
3.00	Net patient revenues (line 1 minus line 2)	11.5		127, 097, 361	3. 00
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line	42)		118, 222, 006	4. 00
5.00	Net income from service to patients (line 3 minus line 4)	43)		8, 875, 355	5. 00
3.00	OTHER I NCOME			0, 073, 333	3.00
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other t	than patients		0	16. 00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22. 00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER I NCOME			380, 599	24.00
25. 00	Total other income (sum of lines 6-24)			380, 599	25. 00
	Total (line 5 plus line 25)			9, 255, 954	26. 00
27. 00	OTHER EXPENSES (SPECIFY)			0	
20 00	2.00 Total other expenses (sum of line 27 and subscripts)				20 00

28.00

9, 255, 954 29. 00

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

Heal th	Financial Systems TERRE HAUTE REGION	NAL HOSPITAL	In Lie	u of Form CMS-2	2552-10	
	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0046	Peri od: From 09/01/2016 To 08/31/2017	Worksheet L Parts I-III Date/Time Pre 1/27/2018 2:1	pared:	
		Title XVIII	Hospi tal	PPS		
	DART I FILLY PROCEEDING METHOD			1. 00		
	PART I - FULLY PROSPECTIVE METHOD  CAPITAL FEDERAL AMOUNT					
1.00	Capital DRG other than outlier			1, 719, 942	1.00	
1. 01	Model 4 BPCI Capital DRG other than outlier			1, 719, 942	1	
2. 00	Capital DRG outlier payments			60, 485		
2. 01	Model 4 BPCI Capital DRG outlier payments			0	1	
3.00	Total inpatient days divided by number of days in the cost re	eporting period (see inst	ructions)	54. 33		
4.00	Number of interns & residents (see instructions)		,	0.00	4. 00	
5.00	Indirect medical education percentage (see instructions)			0.00	5. 00	
6.00	Indirect medical education adjustment (multiply line 5 by the	e sum of lines 1 and 1.01	, columns 1 and	0	6. 00	
	1.01) (see instructions)					
7. 00	Percentage of SSI recipient patient days to Medicare Part A p	oatient days (Worksheet E	., part A line	5. 51	7. 00	
8. 00	30) (see instructions) Percentage of Medicaid patient days to total days (see instru	ictions)		19. 79	8. 00	
9. 00	Sum of lines 7 and 8	de (1 0113)		25. 30		
10.00	Allowable disproportionate share percentage (see instructions	5)		5. 25		
11. 00	Disproportionate share adjustment (see instructions)	-,		90, 297		
12.00					12. 00	
				1. 00		
	PART II - PAYMENT UNDER REASONABLE COST			1.00		
1.00	Program inpatient routine capital cost (see instructions)			0	1.00	
2.00	Program inpatient ancillary capital cost (see instructions)			0	2. 00	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0		
4.00	Capital cost payment factor (see instructions)			0		
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00	
				1. 00		
	PART III - COMPUTATION OF EXCEPTION PAYMENTS					
1.00	Program inpatient capital costs (see instructions)			0		
2.00	Program inpatient capital costs for extraordinary circumstance	ces (see instructions)		0		
3.00	Net program inpatient capital costs (line 1 minus line 2)			0 0. 00		
4. 00 5. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)			0.00		
6.00	Percentage adjustment for extraordinary circumstances (see in		0.00			
7. 00	Adjustment to capital minimum payment level for extraordinary	(line 6)	0.00			
8. 00	Capital minimum payment level (line 5 plus line 7)	, erredmistances (Trice 2 )	11110 0)	0		
9. 00	Current year capital payments (from Part I, line 12, as appli	cabl e)		0		
10.00	Current year comparison of capital minimum payment level to c		less line 9)	0	10.00	
11. 00	Carryover of accumulated capital minimum payment level over of Worksheet L, Part III, line 14)	capital payment (from pri	or year	0	11. 00	
12. 00	Net comparison of capital minimum payment level to capital pa	avments (line 10 plus lir	ne 11)	0	12. 00	
13. 00	Current year exception payment (if line 12 is positive, enter		0			
14. 00						
	00   Carryover of accumulated capital minimum payment level over capital payment for the following period   0   14.00   (if line 12 is negative, enter the amount on this line)					
15. 00	00 Current year allowable operating and capital payment (see instructions)					
16. 00				0		
17. 00	Current year exception offset amount (see instructions)   0   17.00					