	UNITY HOSPITAL ANDERSON	In Lie	u of Form CMS	5-2552-10
This report is required by law (42 USC 1395g; 42 CFR 41	3.20(b)). Failure to report ca	an result in all interim	FORM APPROVI	ED
payments made since the beginning of the cost reporting	period being deemed overpayme	ents (42 USC 1395g).	OMB NO. 0938	8-0050
10 TO	201 10007 100000 1000000 1000000		EXPIRES 05-	31-2019
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CONTROL SETTLEMENT SUMMARY	ERTIFICATION Provider CCN: 15	From 01/01/2018		repared:
PART I - COST REPORT STATUS				, p
Provider 1. [ X ] Electronically filed cost report use only 2. [   Manually submitted cost report		Date: 5/28/20	19 Time:	4:13 pm

O ] If this is an amended report enter the number of times the provider resubmitted this cost report F ] Medicare Utilization. Enter "F" for full or "L" for low.

PART II - CERTIFICATION

Contractor

use only

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 WE'RE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

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

6. Date Received:

7. Contractor No.

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPITAL ANDERSON ( 15-0113 ) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Encryption Information

ECR: Date: 5/28/2019 Time: 4:13 pm omWvDKqEdNbMSe62dJbEt1tpg85Qt0 CHtFp0gkJB185V0GNvgGV6zJWFUUPv napo1Jcrbg08KQMm

5. [ 1 ]Cost Report Status

(3) Settled with Audit

(4) Reopened (5) Amended

(2) Settled without Audit

PI: Date: 5/28/2019 Time: 4:13 pm XJlRynbzvHkc2pWSgjyRljz1q0ba10 dDFulODXpB15yS.qlXb1w7zlQEgFVS RF: i02YZNL097iNG

(Signed)

Officer or Administrator of Provider(s)

10.NPR Date:

8. [ N ] Initial Report for this Provider CCN | 12. [ 0 ] If line 5, column 1 is 4: Enter 9. [ N ] Final Report for this Provider CCN | number of times reopened = 0-9.

11. Contractor's Vendor Code:

number of times reopened = 0-9.

Title

			Title X	VIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	7,153	74,130	0	-4,704,496	1.0
2.00	Subprovider - IPF	0	0	0		0	2.0
3.00	Subprovider - IRF	0	0	0		0	3.0
4.00	SUBPROVIDER I						4.0
5.00	Swing bed - SNF	0	0	0		0	5.0
6.00	Swing bed - NF	0				0	6.0
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.0
3.00	NURSING FACILITY	0				0	8.0
00.6	HOME HEALTH AGENCY I	0	0	0		0	9.0
LO.00	RURAL HEALTH CLINIC I	0		0		0	10.0
1.00	FEDERALLY QUALIFIED HEALTH CENTER I	o		0		0	11.0
12.00	CMHC I	0		0		0	12.0
200.00	Total	0	7,153	74,130	0	-4,704,496	200.0

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

Health Financial Systems COMMUNITY HOSPITAL ANDERSON In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0113 Peri od: Worksheet S-2 From 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 5/28/2019 4:13 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1515 NORTH MADISON AVE 1.00 PO Box: 1.00 State: IN Zip Code: 46011 County: MADISON 2.00 City: ANDERSON 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)

/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal COMMUNITY HOSPITAL 150113 26900 01/01/1966 3.00 ANDERSON Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovi der - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 Hospital-Based (CMHC) I 17.00 17.00 17. 10 Hospi tal -Based (CORF) I 17. 10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 20.00 01/01/2018 12/31/2018 21.00 Type of Control (see instructions) 2 21.00 1. 00 2. 00 3.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for 22. 00 N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22. 01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.

Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care Ν Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to N Ν Υ 22 03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	-
24.00 If this provider is an IPPS hospital, enter the 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.	839			0	5, 791	9	24. 00

	Financial Systems COMMUNIT AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	Y HOSPITAL TA I	Provider CC	N: 15-0113	Peri od:	III LI			CMS-2 t S-2	
					From 01/0 To 12/3	31/2018	B Par B Dat 5/2	t I e/Tim 28/201	e Prep 9 4:13	pared
		In-State Medicaid paid days	In-State Medi cai d eligible unpai d days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medic HMO c	days	Medi da	ys	
00	If this provider is an IRF, enter the in-state	1.00	2. 00	3.00	4. 00	5. (	00	6.	00	25.
	Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	U	U					0	25.
					Urban/I		S Date	2.00		
5. 00	Enter your standard geographic classification (not wa	age) status	at the beg	jinning of t		00	1	2.00	,	26.
. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	age) status "2" for r	ural. If ap		t		1			27.
. 00	If this is a sole community hospital (SCH), enter the	e number of	periods SC	H status in			0			35.
	effect in the cost reporting period.				Begi n	ni ng:		Endi n	g:	
00	Enter applicable beginning and ending dates of SCH s	tatue Cub-	orint line	26 for min-	1.	00		2.00	)	36
. 00	of periods in excess of one and enter subsequent date		cript rine	30 TOT TIUIID	er					30
. 00	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	the numbe	r of period	ls MDH statu	s		0			37
01	Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)									37
00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.									38
					Y,			Y/N 2. 00		
00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)	), (ii), or the mileage	(iii)? Ent	er in colum nts in	me f	V		N	,	39
. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	oer 1. Ente	r "Y" for y			N		Υ		40
						1.0		. 00	XI X 3. 00	
	Prospective Payment System (PPS)-Capital								0.00	
	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce	eption for	extraordi na	nry circumst	ances	N N		Y N	N N	45 46
	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.	ı. L, Pt. I	ıı and Wkst	L-1, Pt.	ı tnrough					
00	Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals					N N		N N	N N	47 48
00	Is this a hospital involved in training residents in	approved G	ME programs	? Enter "Y	" for yes	Y				56
00	or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first month	yes or "N	" for no in	column 1.	lf column					57
00	for yes or "N" for no in column 2. If column 2 is "\ "N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb	/", complete , if appli	e Worksheet cable.	E-4. If co	lumn 2 is	, N				58
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complete W	kst. D-5.							
00	Are costs claimed on line 100 of Worksheet A? If yes	s, complete	wkst. D-2,	Pt. I. NAHE 413.8 Y/N	35 Worksl Lin	neet A e #	Pas Qua	ss-Thr Lifica terion	ation	59
. 00							CIT	.61101	Code	
. 00				1. 00	2.	00		3. 00		

Used the Firenesial Contains	V HOCDI I	FAL ANDEDCON		1 1:-	£ F CMC (	DEE2 40
Health Financial Systems COMMUNIT HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATE		FAL ANDERSON Provider C		Period: From 01/01/2018 To 12/31/2018		pared:
	Y/N	I ME	Direct GME	I ME	Direct GME	<u> Б.</u>
	1. 00	2. 00	3. 00	4.00	5. 00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see	N			0.00	0.00	61. 00
instructions)  61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. 02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions). 61.05 Enter the difference between the baseline primary						61. 04 61. 05
and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61. 06
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						01.00
	Pro	gram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2. 00	3.00	4.00	
<ul> <li>61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.</li> <li>61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.</li> </ul>				0. 00		61. 20
					1.00	
ACA Provisions Affecting the Health Resources and Ser						
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc	tions)					62. 00
62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	ıram. (s	<u>ee instructio</u>		your hospital	0.00	62. 01
63.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ttings	during this c			N	63. 00
		_	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3. 00	

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting

0.00

0. 00

0. 000000 64. 00

section 5504 of the ACA Base Year FIE Residents in Nonprovider Settings-period that begins on or after July 1, 2009 and before June 30, 2010.

64.00 Enter in column 1, if line 63 is yes, or your facility trained residents
in the base year period, the number of unweighted non-primary care
resident FTEs attributable to rotations occurring in all nonprovider
settings. Enter in column 2 the number of unweighted non-primary care
resident FTEs that trained in your hospital. Enter in column 3 the ratio
of (column 1 divided by (column 1 + column 2)). (see instructions)

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0113 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/28/2019 4:13 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0. 00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 Ν subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

Health Financial Systems COMMUNITY HOSPIT HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	N: 15-0113	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Pre 5/28/2019 4:	epared:
				1. 00	
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes	and "N" for r	10.		N	80.00
81.00 Is this a LTCH co-located within another hospital for part of "Y" for yes and "N" for no.  TEFRA Providers			ng period? Enter	N	81. 00
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 86.00 Did this facility establish a new Other subprovider (excluder §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 00 86. 00
87.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	l classified ι	ınder section	1	N	87. 00
1000(d) (1) (b) (v1): Enter 1 101 yes 01 N 101 110.			V	XIX	
Title V and XIX Services			1. 00	2. 00	
90.00 Does this facility have title V and/or XIX inpatient hospita	l services? Er	iter "Y" for	N	Y	90. 00
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the second s			N	Y	91. 00
full or in part? Enter "Y" for yes or "N" for no in the appl 92.00 Are title XIX NF patients occupying title XVIII SNF beds (du	al certificati			N	92. 00
instructions) Enter "Y" for yes or "N" for no in the applical 93.00 Does this facility operate an ICF/IID facility for purposes of the control of the contro		I XIX? Enter	N	N	93. 00
"Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for no	in the	N	N	94. 00
applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the app			0. 00	0. 00	95. 00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.	or "N" for no	in the	N	N	96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the app 98.00 Does title V or XIX follow Medicare (title XVIII) for the in stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for	terns and resi	dents post	0. 00 Y	0. 00 Y	97. 00 98. 00
column 1 for title V, and in column 2 for title XIX.  98.01 Does title V or XIX follow Medicare (title XVIII) for the report of the column 1 for title XIX.  C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title XIX.				Y	98. 01
title XIX.  98.02 Does title V or XIX follow Medicare (title XVIII) for the calbed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of for title V, and in column 2 for title XIX.			Y	Y	98. 02
98.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for yer for title V, and in column 2 for title XIX.				N	98. 03
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.			N	N	98. 04
98.05 Does title V or XIX follow Medicare (title XVIII) and add baw Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.				Y	98. 05
98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.	reimbursed for 1 for title \	Wkst. D, /, and in	Y	Y	98. 06
Rural Providers  105.00 Does this hospital qualify as a CAH?			N		 105. 00
106.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	inclusive meth	nod of paymer			106. 00
107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col.	1. (see instr	ructions) If	N		107. 00
reimbursed. If yes complete Wkst. D-2, Pt. II.  108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sched	lul e? See 42	2 N		108. 00
prix section 3712. 115(c). Litter 1 101 yes of N 101 110.	Physi cal	Occupation	<del></del>	Respi ratory	
100 00 f this bootital gualifies CAU	1.00	2.00	3.00	4.00	100.00
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109. 00

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

1.00

N

110. 00

· · · · · · · · · · · · · · · · · · ·	ANDERSON Provider CCN: 15-0113	Peri od:	III LIC	u of Form CMS Worksheet S-	
ISSTERNE AND HOSTEFINE HEALTH GARL GOWN LEA TOURITH TOATTON DATA	11001 doi: 10-0113	From 01/0	1/2018 1/2018	Part I	epared
		1.0	0	2.00	_
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to colum integration prong of the FCHIP demo in which this CAH is partic Enter all that apply: "A" for Ambulance services; "B" for addit for tele-health services.	reporting period? Ente nn 1 is Y, enter the cipating in column 2.	N		2.00	111. (
			1. 00	0 2.00 3.00	)
Miscellaneous Cost Reporting Information  15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N is yes, enter the method used (A, B, or E only) in column 2. If 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers) Pub. 15-1, chapter 22, §2208.1.	column 2 is "E", ente for long term care (inc based on the definition	r in column Iudes		0	115. (
16.00 s this facility classified as a referral center? Enter "Y" for 17.00 s this facility legally-required to carry malpractice insurance no.		r "N" for	N Y		116. (
18.00 is the mal practice insurance a claims-made or occurrence policy claim-made. Enter 2 if the policy is occurrence.	/? Enter 1 if the polic	y is	1		118. (
jordanii iliaasi. Erresi E 11 tilo porrey 10 eeeari erree.	Premi ums	Loss	es	Insurance	
	1.00	2.0		3. 00	
18.01 List amounts of malpractice premiums and paid losses:	690,	036 3	25, 442		0 118. (
		1.0	0	2. 00	
18. 02 Are malpractice premiums and paid losses reported in a cost cer Administrative and General? If yes, submit supporting schedule and amounts contained therein. 19. 00 DO NOT USE THIS LINE		N			118.
20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in co "N" for no. Is this a rural hospital with < 100 beds that quali Hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no.	olumn 1, "Y" for yes or fies for the Outpatien			N	120.
21.00 Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no.	able devices charged to	Y			121.
22.00 Does the cost report contain healthcare related taxes as define Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is the Worksheet A line number where these taxes are included.					122.
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for y	ves and "N" for no If	N			125.
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, enter					126.
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.	the certification date				127.
28.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.	the certification date				128.
29.00 If this is a Medicare certified lung transplant center, enter t column 1 and termination date, if applicable, in column 2.		in			129.
30.00  f this is a Medicare certified pancreas transplant center, ent date in column 1 and termination date, if applicable, in column 2.00  first	1 2.				130.
31.00  f this is a Medicare certified intestinal transplant center, edate in column 1 and termination date, if applicable, in column 32.00  f this is a Medicare certified islet transplant center, enter	1 2.				131.
in column 1 and termination date, if applicable, in column 2 33.00  f this is a Medicare certified other transplant center, enter					133.
in column 1 and termination date, if applicable, in column 2.  34.00 If this is an organ procurement organization (OPO), enter the Canada termination date, if applicable, in column 2.					134.
All Providers					
40.00 Are there any related organization or home office costs as defi chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes		Υ Υ		HB0040	140. (

Health Financial Systems COMMUNITY HOSPITAL ANDERSON In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0113 Peri od: Worksheet S-2 From 01/01/2018 Part I То 12/31/2018 Date/Time Prepared: 5/28/2019 4:13 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141.00 Name: COMMUNITY HEALTH NETWORK Contractor's Name: WPS Contractor's Number: 08101 141 00 142.00 Street: 1500 NORTH RITTER AVE PO Box: 142.00 143.00 City: INDIANAPOLIS State: Zip Code: 143. 00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? γ 144. 00 1. 00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν 148. 00 N 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν N 155.00 N 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 Ν Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160. 00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 161. 10 CORF Ν Ν Ν 161. 10 1.00 Mul ti campus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Ν 165.00 Enter "Y" for yes or "N" for no. FTE/Campus Zip Code CBSA Name County State 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in

column 5 (see instructions)							
						1. 00	
Health Information Technology (HIT) incenti	ve in the A	American Recovery and	Rei nvest	tment Act			
167.00 Is this provider a meaningful user under §1	886(n)? En	iter "Y" for yes or "N	" for no	).		Υ	167. 00
168.00 If this provider is a CAH (line 105 is "Y")	and is a m	neaningful user (line	167 is "	'Y"), enter	the		0168. 00
reasonable cost incurred for the HIT assets	(see instr	ructions)					
168.01 If this provider is a CAH and is not a mean					shi p		168. 01
exception under §413.70(a)(6)(ii)? Enter "Y							
169.00 If this provider is a meaningful user (line	: 167 is "Y"	) and is not a CAH (I	ine 105	is "N"), ∈	nter the	9. 9	9169. 00
transition factor. (see instructions)							
				Be	gi nni ng	Endi ng	
					1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning	date and en	nding date for the rep	orting	10/	′01/2012	09/30/2013	170. 00
period respectively (mm/dd/yyyy)							
					1. 00	2. 00	
171.00 If line 167 is "Y", does this provider have					N	(	0 171. 00
section 1876 Medicare cost plans reported o							
"Y" for yes and "N" for no in column 1. If		yes, enter the numbe	r of sec	cti on			
1876 Medicare days in column 2. (see instru	ctions)						1

	Financial Systems COMMUNITY HOSP	ITAL ANDERSON		in Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider Co		Peri od: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II	epared:
				Y/N	Date	DIII
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.  COMPLETED BY ALL MOSPITALS  Description Operation and Operation	l for all NO re	esponses. Ente	r all dates in t	the	
1. 00	Provider Organization and Operation 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 c	column 2. (see	instructions)			
			Y/N	Date	V/I	
2. 00	Has the provider terminated participation in the Medicare F	Program2 If	1. 00 N	2. 00	3. 00	2.00
3. 00	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.  Is the provider involved in business transactions, including the provider involved in business transactions.	mn 3, "V" for	N N			3. 00
3.00	contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the providual officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3.00
	Teratronsii ps: (see riisti detrons)		Y/N	Type	Date	
			1.00	2.00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert	tified Dublic	ΙΥ	A		4. 00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	for Compiled, ailable in	·	A		
5. 00	Are the cost report total expenses and total revenues differenthese on the filed financial statements? If yes, submit reconstructions are total expenses and total revenues differenthese differ		N			5. 00
	Those on the fired findhold Statements. If yes, sasimit rec	soner i a tron.		Y/N	Legal Oper.	
				1. 00	2. 00	
6. 00	Approved Educational Activities  Column 1: Are costs claimed for nursing school? Column 2: the Legal operator of the program?	If yes, is th	ne provider is	N		6. 00
7.00	Are costs claimed for Allied Health Programs? If "Y" see in	nstructions.		N		7. 00
8.00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		Ü	N		8. 00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	Y		9. 00
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in t		Y		10.00
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	Y/N	11. 00
					1.00	
	Bad Debts					
12. 00 13. 00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.	•		st reporting	Y N	12. 00 13. 00
14. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see ins	structi ons.	N	14. 00
15. 00	Did total beds available change from the prior cost reporti		yes, see inst t A		Y T B	15. 00
		Y/N	Date	Y/N	Date	
		1.00	2. 00	3. 00	4.00	
16. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Y	05/15/2019	Y	05/15/2019	16. 00
17. 00	date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	N		N		17. 00
18. 00	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00
19. 00	cost report? If yes, see instructions.  If line 16 or 17 is yes, were adjustments made to PS&R  Report data for corrections of other PS&R Report  information? If yes, see instructions.	N		N		19. 00

10SPI T	Financial Systems COMMUNITY HOSPI TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CC	N: 15-0113	Peri od: From 01/01/2018	Worksheet S		
				To 12/31/2018	Part II Date/Time P 5/28/2019 4		
		Descri	ption	Y/N	Y/N	. 15 piii	
		0		1. 00	3. 00		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 0	
		Y/N	Date	Y/N	Date		
1. 00	Was the cost report prepared only using the provider's	1. 00 N	2. 00	3. 00 N	4. 00	21. 0	
	records? If yes, see instructions.						
	COMPLETED BY COST DELABORDED AND TEEDA HOSDITALS ONLY (EVOE	DT OUL DRENG H	CDI TALC)		1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEI Capital Related Cost	PI CHILDRENS HO	DSPLIALS)				
2. 00	Have assets been relifed for Medicare purposes? If yes, see	instructions			N	22. 0	
3. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		als made dur	ring the cost	N	23. 0	
4. 00	Were new leases and/or amendments to existing leases entered of the second of the seco	d into during f	this cost re	eporting period?	N	24.0	
5. 00	Have there been new capitalized leases entered into during instructions.	the cost report	ting period?	? If yes, see	N	25. 0	
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	e cost reportin	ng period? I	f yes, see	N	26. 0	
7. 00	Has the provider's capitalization policy changed during the	cost reportino	g period? If	yes, submit	N	27. 0	
	copy. Interest Expense				N.	28. 0	
8. 00	period? If yes, see instructions.						
9. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instru	uctions		,	N	29. (	
0. 00	Has existing debt been replaced prior to its scheduled matuinstructions.	rity with new o	debt? If yes	s, see	N	30.0	
1. 00	Has debt been recalled before scheduled maturity without is:	suance of new o	debt? If yes	s, see	N	31.0	
2. 00	Purchased Services Have changes or new agreements occurred in patient care ser		d through co	ontractual	N	32.0	
3. 00	arrangements with suppliers of services? If yes, see instru- If line 32 is yes, were the requirements of Sec. 2135.2 app- no, see instructions.		g to competi	tive bidding? If	N	33. 0	
	Provi der-Based Physi ci ans						
4. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with	provi der-ba	ased physicians?	Y	34.0	
5. 00	If line 34 is yes, were there new agreements or amended eximply physicians during the cost reporting period? If yes, see in:		ts with the	provi der-based	N	35. 0	
				Y/N	Date		
	Home Office Costs			1. 00	2. 00		
6. 00	Were home office costs claimed on the cost report?			Y		36.0	
7. 00	If line 36 is yes, has a home office cost statement been prolef yes, see instructions.	epared by the h	nome office?	? Y		37. C	
8. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			= N		38. 0	
9. 00	If line 36 is yes, did the provider render services to othe see instructions.			s, N		39. 0	
0. 00	If line 36 is yes, did the provider render services to the instructions.	home office? I	If yes, see	N		40. 0	
		1. (	00	2.	00		
	Cost Report Preparer Contact Information			2.			
1. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	REX		SHERA		41. (	
2 00		ERNST & YOUNG L	_LP			42.0	
2. 00	preparer.						

Heal th	Financial Systems COMMUNI	TY HOSPI	TAL ANDERSON	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNA	II RE	Provider CCN: 15-0113	eriod: -om 01/01/2018 o 12/31/2018		epared:
					37 207 2017 4.	J pili
			3.00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/posit		MANAGING DIRECTOR			41. 00
	held by the cost report preparer in columns 1, 2, a	nd 3,				
	respecti vel y.					
42. 00	Enter the employer/company name of the cost report					42. 00
	preparer.					
43.00	Enter the telephone number and email address of the	cost				43. 00
	report preparer in columns 1 and 2, respectively.					

Health Financial Systems COMMUNIT | Peri od: | Worksheet S-3 | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0113

S/28/2019 4:13 pm
Component    Worksheet A   No. of Beds   Bed Days   Available   Title V
Component   Worksheet A   No. of Beds   Bed Days   Available   Title V
Line Number   Available
1.00 2.00 3.00 4.00 5.00  1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and 0 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and 30.00 117 44,189 0.00 0 1.0
Hospice days)(see instructions for col. 2
for the portion of LDP room available beds)
2.00 HMO and other (see instructions)
3.00 HMO IPF Subprovider 3.0
4.00 HMO IRF Subprovider 4.0
5.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00
6.00 Hospital Adults & Peds. Swing Bed NF 0 6.0
7.00   Total Adults and Peds. (exclude observation   117 44,189 0.00 0 7.0
beds) (see instructions)
8.00   INTENSIVE CARE UNIT   31.00   17   6,205   0.00   0   8.0
9. 00 CORONARY CARE UNIT 32. 00 0 0. 00 0 9. 0
10.00 BURN INTENSIVE CARE UNIT 33.00 0 0 0.00 0 10.00
11. 00 SURGICAL INTENSIVE CARE UNIT 34. 00 0 0. 00 0. 00 11. 0
12. 00 OTHER SPECIAL CARE (SPECIFY)
13. 00 NURSERY 43. 00 0 13. 0
14. 00 Total (see instructions)
15. 00   CAH visits   0   15. 00
16. 00   SUBPROVI DER - I PF   40. 00   0   0   16. 0
17. 00   SUBPROVI DER -   RF   41. 00   0   0   17. 0
18. 00   SUBPROVI DER   42. 00   0   0   18. 0
19. 00   SKILLED NURSING FACILITY   44. 00   0   0   19. 0
20. 00   NURSI NG FACILITY   45. 00   0   0   20. 0
21. 00 OTHER LONG TERM CARE 46. 00 0 0 21. 0
22. 00 HOME HEALTH AGENCY 101. 00 0 22. 0
23. 00   AMBULATORY SURGICAL CENTER (D. P. )
25. 00 CMHC - CMHC 99. 00 0 25. 10 CMHC - CORF 99. 10 0 25. 1
26. 00 RURAL HEALTH CLINIC 88. 00 0 26. 0
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 0 26. 2
27. 00 Total (sum of lines 14-26)
28. 00   Observation Bed Days   0   0   0   0   0   0   0   0   0
29. 00   Ambul ance Tri ps   29. 0
30.00 Employee discount days (see instruction)
31. 00 Employee discount days (see Histractron)  31. 00 Employee discount days - IRF
32.00 Labor & delivery days (see instructions)
32. 01 Total ancillary labor & delivery room 32.0
outpatient days (see instructions)
33. 00 LTCH non-covered days
33.01 LTCH site neutral days and discharges

				'	0 12/31/2010	5/28/2019 4:1	
		I/P Days	o/P Visits	/ Trips	Full Time	Equi val ents	, p
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				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	8, 745	593	24, 479			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)	5, 977	4, 431				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				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	8, 745	593	24, 479			7. 00
0.00	beds) (see instructions)	4 000	, ,	4 0/0			0.00
8.00	INTENSIVE CARE UNIT	1, 302	66	1, 368			8. 00
9.00	CORONARY CARE UNIT	0	0	0			9.00
10.00	BURN INTENSIVE CARE UNIT	0	0	0			10.00
11.00	SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)		4 704	4 000			12.00
13.00	NURSERY	10.047	1, 731	1, 809		1 100 10	13.00
14.00	Total (see instructions)	10, 047	2, 390	27, 656		1, 123. 18	14.00
15. 00	CAH visits	0	0	0		0.00	15.00
16.00	SUBPROVIDER - I PF	0	0	0			16.00
17. 00	SUBPROVIDER - I RF	0	0	0			
18.00	SUBPROVI DER	0	0	0			
19. 00 20. 00	SKILLED NURSING FACILITY NURSING FACILITY	٩	0	0	0.00	l e e e e e e e e e e e e e e e e e e e	
21. 00	OTHER LONG TERM CARE		U	0			
21.00	HOME HEALTH AGENCY	0	0	0	0.00		
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	٩	U	U	0.00		23. 00
24. 00	HOSPICE	٥	0	0	0.00		
24. 00	HOSPICE (non-distinct part)	٥	U	268		0.00	24. 00
25. 00	CMHC - CMHC	٥	0	200	0.00	0.00	
25. 10	CMHC - CORF	0	0	0	0.00		25. 00
26. 00	RURAL HEALTH CLINIC	0	0	0	0.00		
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00		26. 25
27. 00	Total (sum of lines 14-26)	١	O	0	0.00		27. 00
28. 00	Observation Bed Days		435	3, 888		1, 123. 10	28.00
29. 00	Ambulance Trips	0	433	3, 000			29.00
30. 00	Employee discount days (see instruction)	١		407			30.00
31. 00	Employee discount days - IRF			0			31.00
32. 00	Labor & delivery days (see instructions)	0	9	138			32.00
32. 00	Total ancillary labor & delivery room	١	7	130			32. 00
JZ. UI	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days	n					33. 00
	LTCH site neutral days and discharges	o					33. 01
55.51	1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 =	١		ı	I .	ı	, 50.01

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared:

					J 12/31/2016	5/28/2019 4:1	
		Full Time		Di sch	arges		
		Equi val ents			3		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	·	Workers				Pati ents	
		11. 00	12.00	13.00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	2, 504	1, 815	7, 653	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, 341	0		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
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		_				13. 00
14.00	Total (see instructions)	0. 00	0	2, 504	1, 815	7, 653	
15. 00	CAH visits						15. 00
16. 00	SUBPROVIDER - I PF	0.00	0		0	0	16.00
17. 00	SUBPROVIDER - IRF	0.00	0	1	0	0	17. 00
18.00	SUBPROVI DER	0.00	0	)	0	0	18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY	0.00					20.00
21. 00	OTHER LONG TERM CARE	0.00				0	21.00
22. 00	HOME HEALTH AGENCY	0.00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	0.00					23. 00
24. 00	HOSPI CE	0. 00					24. 00
24. 10	HOSPICE (non-distinct part)	0.00					24. 10
25. 00	CMHC - CMHC	0.00					25. 00
25. 10	CMHC - CORF	0.00					25. 10
26. 00	RURAL HEALTH CLINIC	0.00					26. 00
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER	0. 00 0. 00					26. 25 27. 00
	Total (sum of lines 14-26)	0.00					•
28. 00 29. 00	Observation Bed Days						28. 00 29. 00
30. 00	Ambulance Trips Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see Histruction)						31.00
31.00	Labor & delivery days (see instructions)						31.00
32. 00	Total ancillary labor & delivery room						32.00
32.01	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days			0			33. 00
	LTCH site neutral days and discharges			0			33. 01
00.01	1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 =	1		1 ~	ı		, 50.01

| Period: | Worksheet S-3 | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0113

A Non-physici an anesthetist Part B 219, 489 0 219, 489 21.00  22.00 Physici an Part A - Administrative 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						To	12/31/2018	Date/Time Pre	
Number   Reported   On of Salaries   Salaries   Salaries   Card 2 + card   Salaries   Salaries   Card 2 + card   Salaries   Sa			Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d Hours		3 pm
MATTIL - MARF PATA					on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
PART   1 - BMCF DATA						`		col . 5)	
SAMANES   SAMA			1 00	2 00				6.00	
### ACAMES**   Total Salaries (See   200.00 70,917.019   0 70,917.019   2,336,208.20   30.38   1.00		PART II - WAGE DATA	1.00	2.00	3.00	4.00	3.00	0.00	
2.00   Non-physic cian mestherit st Part		SALARI ES							
Non-physic claim anestheritist Part   Sept.	1.00		200. 00	70, 917, 019	0	70, 917, 019	2, 336, 208. 20	30. 36	1. 00
3. 00 Non-physician anesthetist Part 4. 00 Physician Part A - Identify Part 4. 01 Physician Part A - Identify Part 4. 01 Physician Part A - Identify Part 4. 01 Physician Part A - Identify Part 5. 00 Physician Part A - Identify Part 6. 02 Non-part Part A - Identify Part 6. 03 Non-part 6. 03 Non-part 6. 04 Non-part 6. 05 Non-part 6. 05 Non-part 6. 06 Non-part 6. 07 Non-part 6. 07 Non-part 6. 08 Non-part 6. 08 Non-part 6. 08 Non-part 6. 08 Non-part 6. 09 Non-part 6. 00	2 00			(		0	0.00	0.00	2.00
4 00 Physician-Part A - Administrative approximation of the physician-Part B   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00	A			)		0.00	0.00	2.00
Administrative   Action   Administrative   Action   Actio	3.00	Non-physician anesthetist Part		804, 277	0	804, 277	9, 205. 98	87. 36	3. 00
Administrative   Action   Administrative   Action   Actio	4 00	B Dhysisian Dont A					0.00	0.00	4 00
4.01   Physicians - Part A - Teaching   0   0   0   0.00   0.00   0.00   5.00	4.00			(	٥	U	0.00	0.00	4.00
Physician-Part B   Form   Color   Co	4. 01			(	0	0	0.00	0.00	4. 01
Non-physician-Part B for   0   0   0   0   0   0   0   0   0	5.00			(	0	0	0.00	0.00	5. 00
hospital -based RRC and FDRC	6 00			ſ		0	0.00	0.00	6.00
Services	0.00				)		0.00	0.00	0.00
2.00   2.00		servi ces							
7.01 Contracted interns and residents (in an approved programs) 8.00 Home office and/or related	7. 00	`	21. 00	(	0	0	0. 00	0.00	7. 00
Residents (in an approved programs)   Residents (in approved program	7 01			(	0	0	0.00	0.00	7 01
Nome office and/or related organization personnel   44.00   0   0   0   0   0   0   0   0   0	,, , ,				]		0.00		,,,,,
Organization personnel   Section   Adv.   O   O   O   O   O   O   O   O   O				_					
9.00   SNF   44.00   0   0   0   0   0   0   0   0   0	8.00			(	) O	0	0.00	0.00	8.00
Instructions  OTHER WACES & RELATED COSTS   11.00   Contract labor: Direct Patient   1.724, 321   0   1.724, 321   18,567.30   92.87   11.00   Cortract labor: Direct Patient   1.724, 321   0   0   0   0   0   0   0   0   0	9. 00		44. 00	(	0	0	0.00	0.00	9. 00
OTHER WACES & RELATED COSTS	10.00			2, 856, 286	0	2, 856, 286	66, 507. 91	42. 95	10. 00
11.00   Contract labor: Direct Patient									
Care   Contract labor: Top level   0   0   0   0   0   0   0   0   0	11. 00			1, 724, 321	0	1, 724, 321	18, 567, 30	92.87	11. 00
management and other management and other management and administrative services		Care		.,,		.,,	·		
management and administrative   Services   13.00   Contract I abor: Physician-Part   136,000   0   136,000   1,733.11   78.47   13.00	12. 00			(	0	0	0.00	0.00	12. 00
Services									
A - Administrative   A - Adm									
14. 00   Home office and/or related or organization sal aries and wage-related costs   1,549,784   0   1,549,784   42,751.00   36,25   14. 01     14. 01   Home office sal aries   1,549,784   0   1,549,784   42,751.00   36,25   14. 01     14. 02   Related organization salaries   0   0   0   0   0   0.00   0.00     15. 00	13.00			136, 000	0	136, 000	1, 733. 11	78. 47	13. 00
Organization sallaries and wage-related costs   1,549,784   0   1,549,784   42,751.00   36,25   14,01   14,02   Related organization salaries   0   0   0   0   0,00   0,00   14,02   15,00   16,00	14 00					0	0.00	0.00	14 00
Wage-related costs   1,549,784	14.00			(	)	U	0.00	0.00	14.00
14. 02   Rel ated organization salaries   0   0   0   0   0.00   0.00   14. 02     15. 00   Home offfice Physician Part A		wage-related costs							
15. 00				1, 549, 784	0	1, 549, 784			
- Admin istrative Home office and Contract Home office wage-related (core) Home office Repair (a) Physician Part A - Admin istrative wage-related (core) Home office Repair (core) Hom				(		0		•	
Physicians Part A - Teaching	13.00				)		0.00	0.00	13.00
WAGE-RELATED COSTS   17.00   Wage-related costs (core) (see instructions)   18.354,430   0   18,354,430   17.00   18.00   Wage-related costs (other) (see instructions)   19.00   20	16. 00			(	0	О	0.00	0.00	16. 00
17.00   Wage-related costs (core) (see instructions)   18,354,430   0   18,354,430   18.00   18.00   Wage-related costs (other)   0   0   0   0   0   18.00   18.00   Wage-related costs (other)   0   0   0   0   0   0   0   0   0									
18.00   Wage-related costs (other)   (see instructions)   18.00   (see instructions)   19.00   (see i	17. 00			18, 354, 430	0	18, 354, 430		1	17. 00
19.00   Excl uded areas   19.00   20						., ,			
19. 00   Excluded areas   1779, 487   0   1779, 487   20. 00   2	18. 00			(	0	0			18. 00
20. 00   Non-physician anesthetist Part   219, 489   211, 00   219, 489   211, 00   219, 489   221, 00   2	19 00	,		779 487	, 0	779 487			19 00
B   Physician Part A -				(	o o	0			20. 00
B   Physician Part A -		A		040 400		040 400			
Administrative   Administrative   Physician Part A - Teaching   0   0   0   0   22.01	21.00	Non-pnysician anesthetist Part  B		219, 489	ή ο	219, 489			21.00
22. 01   Physician Part A - Teaching   0   0   0   0   22. 01	22. 00	- Physician Part A -		C	0	o			22. 00
23.00   Physician Part B   0   0   0   0   24.00     24.00   25.00   Interns & residents (in an approved program)   Home office wage-related (core)     25.51   Related organization   0   0   0   0     25.52   Home office Physician Part A   0   0   0     25.53   Home office & Contract   0   0   0   0     25.53   Physicians Part A - Teaching - wage-related (core)   0   0   0   0     26.00   Employee Benefits Department   4.00   2,809,351   0   2,809,351   83,840.50   33.51   26.00	00.01			_	_	_			00.05
24. 00   Wage-related costs (RHC/FQHC)   0   0   0   0   24. 00   25. 00   Interns & residents (in an approved program)   25. 00   0   0   0   25. 50   Home office wage-related (core)   25. 51   25. 51   Related organization   0   0   0   0   25. 52   Home office: Physician Part A   0   0   0   25. 52   Home office: Physician Part A   0   0   0   25. 53   Physicians Part A - Teaching - wage-related (core)   26. 00   Employee Benefits Department   4. 00   2, 809, 351   0   2, 809, 351   83, 840. 50   33. 51   26. 00				(	0	0			
25. 00   Interns & residents (in an approved program)   25. 00   25. 50   25. 50   25. 50   25. 51   25. 51   25. 52   2				(		0			
25. 50   Home office wage-related (core)   25. 50   (core)   25. 51   Related organization   25. 51   wage-related (core)   25. 52   Home office: Physician Part A   0   0   0   0   25. 52   - Administrative - wage-related (core)   Home office & Contract   0   0   0   0   25. 53   Physicians Part A - Teaching - wage-related (core)   0   0   0   0   0   0   0   0   0		` ` '		C	o	0			25. 00
Core   Rel ated organization   O O O O O O O O O O O O O O O O O O	25 50			251 000		251 000			25 50
25. 51 Related organization wage-related (core) Home office: Physician Part A	25. 50			351, 808	3	351, 808			25.50
wage-related (core)	25. 51			C	0	o			25. 51
- Administrative - wage-related (core) Home office & Contract Physicians Part A - Teaching - wage-related (core)  OVERHEAD COSTS - DIRECT SALARIES  Employee Benefits Department	0.5	wage-related (core)							
25. 53     wage-related (core)       Home office & Contract     0     0     0       Physicians Part A - Teaching - wage-related (core)       OVERHEAD COSTS - DIRECT SALARIES       26. 00     Employee Benefits Department     4. 00     2, 809, 351     0     2, 809, 351     83, 840. 50     33. 51     26. 00	25. 52			(	) 0	이			25. 52
25. 53 Home office & Contract 0 0 0 0 25. 53  Physicians Part A - Teaching - wage-related (core)  OVERHEAD COSTS - DIRECT SALARIES  Employee Benefits Department 4. 00 2, 809, 351 0 2, 809, 351 83, 840. 50 33. 51 26. 00									
wage-related (core)         OVERHEAD COSTS - DIRECT SALARIES           26.00 Employee Benefits Department         4.00         2,809,351         0         2,809,351         83,840.50         33.51         26.00	25. 53	Home office & Contract		(	0	О			25. 53
OVERHEAD COSTS - DIRECT SALARIES           26.00 Employee Benefits Department         4.00         2,809,351         0         2,809,351         83,840.50         33.51         26.00									
26.00 Employee Benefits Department 4.00 2,809,351 0 2,809,351 83,840.50 33.51 26.00		wage-related (core)  OVERHEAD COSTS - DIRECT SALARIE	ES .						
27. 00   Administrative & General       5. 00   11, 534, 924   0   11, 534, 924   379, 356. 96   30. 41   27. 00	26. 00	Employee Benefits Department	4. 00						
	27. 00	Administrative & General	5. 00	11, 534, 924	1 0	11, 534, 924	379, 356. 96	30. 41	27. 00

							5/28/2019 4: 1	
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted		Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		8, 493, 043	0	8, 493, 043	152, 722. 70	55. 61	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00		29. 00
30. 00	Operation of Plant	7. 00	2, 386, 506		2, 386, 506			
31. 00	Laundry & Linen Service	8. 00	0	73, 093		,		
32. 00	Housekeepi ng	9. 00	1, 584, 735	-73, 093	1, 511, 642			
33. 00	Housekeeping under contract		0	0	0	0.00	0. 00	33. 00
	(see instructions)							
34. 00	Di etary	10. 00	1, 560, 896	-826, 297	734, 599	39, 846. 51		34.00
35. 00	Di etary under contract (see		0	0	0	0.00	0. 00	35. 00
	instructions)							
36. 00	Cafeteri a	11. 00		826, 297	826, 297			36. 00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0.00		37. 00
38. 00	Nursing Administration	13. 00	1, 292, 410	0	1, 292, 410	25, 323. 78	51. 04	38. 00
39. 00	Central Services and Supply	14. 00	1, 043, 851	0	1, 043, 851	62, 053. 79	16. 82	39. 00
40.00	Pharmacy	15. 00	2, 026, 966	0	2, 026, 966	49, 146. 75	41. 24	40. 00
41.00	Medical Records & Medical	16. 00	1, 266, 515	0	1, 266, 515	47, 150. 61	26. 86	41. 00
	Records Library							
42.00	Soci al Servi ce	17. 00	0	0	0	0.00	0.00	42.00
43. 00	Other General Service	18. 00	0	0	0	0.00	0.00	43. 00

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

Worksheet S-3 Part III Date/Time Prepared: Provi der CCN: 15-0113 Peri od: From 01/01/2018 To 12/31/2018 5/28/2019 4:13 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1. 00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 78, 605, 785 78, 605, 785 2, 479, 724. 92 31. 70 1.00 instructions) 2.00 Excluded area salaries (see 2, 856, 286 ol 2, 856, 286 66, 507. 91 42. 95 2.00 instructions) 3.00 Subtotal salaries (line 1 75, 749, 499 0 75, 749, 499 2, 413, 217. 01 31.39 3.00

3, 410, 105

18, 706, 238

97, 865, 842

33, 999, 197

0

0

63, 051. 41

2, 476, 268. 42

1, 060, 075. 80

0.00

54.08

24.69

39 52

32.07

4.00

5.00

6.00

7.00

3, 410, 105

18, 706, 238

97, 865, 842

33, 999, 197

minus line 2)

(see inst.)

instructions)

costs (see inst.)

Subtotal other wages & related

Subtotal wage-related costs

Total overhead cost (see

Total (sum of lines 3 thru 5)

4.00

5.00

6.00

7.00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0113		Worksheet S-3
		From 01/01/2018	
		To 12/21/2010	Data/Timo Dronarod

	To 12/3	1/2018	Date/Time Prep 5/28/2019 4:1:	
			Amount	
			Reported	
			1.00	
	PART IV - WAGE RELATED COSTS			
	Part A - Core List			
	RETI REMENT COST			
1.00	401K Employer Contributions		0	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		3, 465, 107	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees		0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan		0	6. 00
7.00	Employee Managed Care Program Administration Fees		0	7. 00
	HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)		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)		10, 285, 758	8. 02
8.03	Health Insurance (Purchased)		0	8. 03
9.00	Prescription Drug Plan		0	9. 00
10.00	Dental, Hearing and Vision Plan		0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)		33, 712	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)		176, 679	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15. 00	'Workers' Compensation Insurance		167, 910	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			
	FICA-Employers Portion Only		5, 064, 490	
18. 00	Medicare Taxes - Employers Portion Only		0	18. 00
19. 00	Unemployment Insurance		75, 868	
20. 00	State or Federal Unemployment Taxes		0	20. 00
	OTHER			
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above.	. (see	0	21. 00
	instructions))			
22. 00	Day Care Cost and Allowances		0	22. 00
23. 00			83, 881	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)		19, 353, 405	24. 00
	Part B - Other than Core Related Cost			
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25. 00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lieu of Form CMS-255	2-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0113	Peri od: Worksheet S-3 From 01/01/2018 Part V	
		To 12/31/2018 Date/Time Prenar	-ed·

		То	12/31/2018	Date/Time Pre	
	Cost Center Description		ontract Labor	5/28/2019 4:1 Benefit Cost	3 pm
	cost center bescription	C			
	DADT V Contract Labor and Danafi + Cont	_	1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
1 00	Hospital and Hospital-Based Component Identification:		O	0	1. 00
1. 00 2. 00	Total facility's contract labor and benefit cost		0	0	2. 00
3.00	Hospi tal		0	0	
4. 00	Subprovi der - IPF		0	0	3.00
	Subprovi der - I RF		0	0	4. 00
5.00	Subprovi der - (0ther)		O O	0	5. 00
6.00	Swing Beds - SNF		U	0	6. 00
7.00	Swing Beds - NF		U	0	7. 00
8.00	Hospi tal -Based SNF		U	0	8. 00
9.00	Hospital -Based NF		٩	0	9. 00
	Hospi tal -Based OLTC			0	10.00
	Hospi tal -Based HHA		0	0	
	Separately Certified ASC		0	0	
	Hospi tal -Based Hospi ce		0	0	13. 00
	Hospital-Based Health Clinic RHC		0	0	14. 00
	Hospital-Based Health Clinic FQHC		0	0	15. 00
	Hospi tal -Based-CMHC		0	0	16. 00
	Hospi tal -Based-CMHC 10		0	0	16. 10
	Renal Dialysis		0	0	17. 00
18. 00	Other		0	0	18. 00

Heal th	Financial Systems COMMUNITY HOSPITAL	ANDERSON		In Lie	u of Form CMS-2	2552-10	
		Provider CCN: 15-011		i od:	Worksheet S-1		
			Fro   To	m 01/01/2018 12/31/2018	Date/Time Pre	nared:	
			10	12/31/2010	5/28/2019 4: 1		
					1. 00		
	Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by line 202 co	lumn 8)		0. 248662	1. 00	
2 00	Medicaid (see instructions for each line)				71 (15 202	2 00	
2. 00 3. 00	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?				71, 615, 203 Y	2. 00 3. 00	
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplement	al payments from Me	edi cai d?		Ϋ́	4. 00	
5. 00	If line 4 is no, then enter DSH and/or supplemental payments fr		ar our ur		. 0	5. 00	
6.00	Medi cai d charges	103, 469, 917	6. 00				
7.00	Medicaid cost (line 1 times line 6)						
8. 00	Difference between net revenue and costs for Medicaid program (	line 7 minus sum of	lines	2 and 5; if	0	8. 00	
	<pre>&lt; zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions fo</pre>	reach line)					
9. 00	Net revenue from stand-alone CHIP	cacii i i iic)			0	9. 00	
10. 00	Stand-alone CHIP charges					10.00	
11. 00	Stand-alone CHIP cost (line 1 times line 10)				0	11. 00	
12. 00	Difference between net revenue and costs for stand-alone CHIP (	line 11 minus line	9; if <	zero then	0	12. 00	
	enter zero)	austions for each I	i no)				
13. 00	Other state or local government indigent care program (see inst Net revenue from state or local indigent care program (Not incl				0	13. 00	
14. 00	Charges for patients covered under state or local indigent care			lines 6 or	0		
	10)	1 1 3 1 ( 11 1 1 1					
15. 00	State or local indigent care program cost (line 1 times line 14					15. 00	
16. 00	Difference between net revenue and costs for state or local ind	igent care program	(line 1	5 minus line	0	16. 00	
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state/Local i	ndi gent	care program	ns (see		
	instructions for each line)	and State/Tocal T	nai gent	care program	13 (300		
17. 00	Private grants, donations, or endowment income restricted to fu	9			105, 166		
18.00	Government grants, appropriations or transfers for support of h		/-	6   !	23, 147		
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	rnargent care prog	Ji allis (S	um of fines	Ü	19. 00	
		Uni nsu	red	Insured	Total (col. 1		
		pati er		pati ents	+ col . 2)		
	Uncompensated Care (see instructions for each line)	1.00	)	2. 00	3. 00		
20. 00	Charity care charges and uninsured discounts for the entire fac	ility 4 71	19, 444	1, 298, 850	6, 018, 294	20 00	
20.00	(see instructions)		. , , , , ,	., 2,0,000	0,0.0,27.	20.00	
21. 00	Cost of patients approved for charity care and uninsured discou	nts (see   1,17	73, 546	1, 298, 850	2, 472, 396	21. 00	
	instructions)	66		00.454	00.404		
22. 00	Payments received from patients for amounts previously written	off as	9, 235	80, 456	89, 691	22.00	
23. 00	charity care Cost of charity care (line 21 minus line 22)	1 16	54, 311	1, 218, 394	2, 382, 705	23 00	
20.00	poor or onarry our o (rrito 2) military rrito 22)		, , , , , , ,	1,210,071	2,002,700	20.00	
					1.00		
24. 00	Does the amount on line 20 column 2, include charges for patien		ngth of	stay limit	N	24. 00	
25. 00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond th		ogram's	length of	0	25. 00	
	stay limit	J	J	<i>3</i>			
26. 00	Total bad debt expense for the entire hospital complex (see ins	,			7, 549, 807		
27. 00	Medicare reimbursable bad debts for the entire hospital complex	,			599, 836		
27. 01	Medicare allowable bad debts for the entire hospital complex (s	ee instructions)			922, 825		
28. 00 29. 00	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see instructi	ons)		6, 626, 982 1, 970, 868		
	Cost of uncompensated care (line 23 column 3 plus line 29)	(300 TH311 dCt1	5115)		4, 353, 573		
	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			4, 353, 573	•	

	Financial Systems	COMMUNITY HOSPIT				eu of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der CO		Period: From 01/01/2018	Worksheet A	
					o 12/31/2018	Date/Time Pre	pared:
	Cook Cooker Bookinties	C-1:	0+1	T-+-1 (1 1	D1: £:+:	5/28/2019 4:1	3 pm
	Cost Center Description	Sal ari es	Other	+ col . 2)	Reclassifications (See A-6)	Reclassified Trial Balance	
				+ (01. 2)	ons (see A-o)	(col . 3 +-	
						col . 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS			1			
1.00	00100 CAP REL COSTS-BLDG & FIXT		0	(	6, 175, 465		1.00
2. 00 3. 00	00300 OTHER CAP REL COSTS		0	(	4, 818, 175	4, 818, 175 0	2. 00 3. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 809, 351	14, 846, 580	17, 655, 931	-55, 114		4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	11, 534, 924	22, 916, 681				5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	0	(	0	0	6. 00
7.00	00700 OPERATION OF PLANT	2, 386, 506	7, 161, 729	9, 548, 235			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0 400 00	200, 413		8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 584, 735 1, 560, 896	518, 359 1, 694, 735				9. 00 10. 00
11. 00	01100 CAFETERI A	1, 300, 840	1,074,733	3, 255, 05	1, 723, 444		
12. 00	01200 MAINTENANCE OF PERSONNEL		0		0	0	12.00
13.00	01300 NURSING ADMINISTRATION	1, 292, 410	175, 660	1, 468, 070	-203	1, 467, 867	
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 043, 851	995, 651				
15. 00	01500 PHARMACY	2, 026, 966	7, 860, 151			2, 358, 896	1
16.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	1, 266, 515	384, 229	1, 650, 744	-80	1, 650, 664 0	1
17. 00 19. 00	01900 NONPHYSICIAN ANESTHETISTS		0			0	17. 00 19. 00
20. 00	02000 NURSI NG SCHOOL		0		o o	Ö	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	O	0		0	0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	0	0	(	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(EMS)	0	0	(	0	0	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	45 050 545	0.7/4.005	40.040.046	0.005.750	45 704 057	00.00
30. 00 31. 00	03000   ADULTS & PEDIATRICS   03100   NTENSIVE CARE UNIT	15, 258, 515 3, 083, 959	3, 761, 295 1, 000, 002				30. 00 31. 00
32.00	03200 CORONARY CARE UNIT	3,003,939	1,000,002	4, 003, 90	-031,000	3, 432, 075	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT		0		o o	Ö	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	(	0	0	34. 00
40.00	04000 SUBPROVI DER - I PF	0	0	(	0	0	40. 00
41.00	04100 SUBPROVI DER - I RF	0	0	(	0	0	41.00
42. 00	04200 SUBPROVI DER	0	1 510	(	0	0	42. 00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY		1, 510	1, 510	1, 425, 636	1, 427, 146 0	43. 00 44. 00
45. 00	04500 NURSING FACILITY		0			0	45. 00
46. 00	04600 OTHER LONG TERM CARE	O	0	d	0	0	46. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	5, 189, 361	15, 419, 696	20, 609, 057	-13, 868, 933		1
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0	(	0	0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	804, 277	2, 467, 651	3, 271, 928	-48, 302		1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 779, 227	1, 652, 576				1
54. 01	1 1	296, 036	59, 008				1
	05402 WOMEN' S CENTER	355, 534	106, 885	462, 419	-64, 738	397, 681	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	(	0	0	55. 00
56.00	05600 RADI OI SOTOPE	255, 254	854, 453			783, 616	
57. 00 58. 00	05700 CT SCAN   05800 MAGNETIC RESONANCE IMAGING (MRI)	485, 675 341, 165	597, 480 576, 420				1
59. 00	05900 CARDI AC CATHETERI ZATI ON	889, 684	1, 253, 940				
60. 00	06000 LABORATORY	2, 206, 286	3, 945, 527				
60. 01	06001 BLOOD LABORATORY	0	0	(	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	(	0	0	61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	201, 193	567, 319	768, 512	-541, 035		
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(	0	0	63.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	1, 249, 679	266, 903	1, 516, 582	-165, 727	0 1, 350, 855	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	2, 178, 686	924, 844		· ·	2, 497, 023	
67. 00	06700 OCCUPATI ONAL THERAPY	359, 597	33, 306				
68. 00	06800 SPEECH PATHOLOGY	243, 270	42, 179	285, 449	8, 664	294, 113	68. 00
69. 00	06900 ELECTROCARDI OLOGY	424, 887	217, 341				
70. 00	07000 ELECTROENCEPHALOGRAPHY	526, 016	233, 687				
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	,,		
72. 00 73. 00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		7, 710, 228 7, 162, 806		
74.00	07400 RENAL DIALYSIS	0	366, 153	366, 153		352, 392	1
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	330, 130	0	0	75. 00
	OUTPATIENT SERVICE COST CENTERS						]
88. 00	08800 RURAL HEALTH CLINIC	0	0	(	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	
90.00	09000 CLINIC	350 007	1 042 201	1 400 000	0	1 174 705	90.00
90. 01 90. 02	09001   WOUND/OSTOMY CLINIC   09002   KIDS PLUS CLINIC	358, 907	1, 063, 384 0	1, 422, 291	-247, 496 0	1, 174, 795 0	
70.02	1	1 9	0	1	·. <sub>.</sub>	. 0	1 .3. 02

Health Financial Systems	COMMUNITY HOSPIT	AL ANDERSON		In Lie	u of Form CMS-:	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co	CN: 15-0113	Peri od:	Worksheet A	
				From 01/01/2018		
			'	Γο 12/31/2018		
					5/28/2019 4:1	3 pm
Cost Center Description	Sal ari es	Other		Recl assi fi cati	Recl assi fi ed	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
	1.00	2.00	3.00	4. 00	5. 00	
90. 03   09003   0NC0L0GY	1, 700, 895	3, 804, 989			3, 835, 790	90. 03
90. 04   09004   MUNCI E CLINI C	1,700,070	83, 392				1
l l	207 202					1
90. 05   09005   ANTI COAGULATI ON CLINI C	297, 203	80, 176				1
90. 06   09006   PREGNANCY PLUS	0	686	68	-686	0	1
90. 07  09007   0/P LAB	0	0	1	0	0	
90. 08  09008 0/P LAB	0	0		0	0	90. 08
90. 09  09009  FORTVI LLE CLI NI C	0	55, 542	55, 54	2 -54, 867	675	90.09
90. 10   09010   1030 S SCATTERFIELD (MEDCHECK)	0	0		0	0	90. 10
90. 11 09011 DIABETIC PLUS CLINIC	405, 315	58, 446	463, 76	1 -1, 549	462, 212	90. 11
91. 00 09100 EMERGENCY	3, 663, 958	1, 135, 979	1	1	'	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,000,700	1, 100, 777	1, , , , , , ,		1, ,	92. 00
OTHER REIMBURSABLE COST CENTERS						/2.00
				0		1 04 00
94. 00   09400   HOME   PROGRAM DI ALYSI S	0	0		٥	0	
95. 00 09500 AMBULANCE SERVICES	0	0	1	0	0	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	0	97.00
99. 00 09900 CMHC	0	0		0	0	99. 00
99. 10   09910   CORF	0	0		0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	o	0		0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0	0	101.00
SPECIAL PURPOSE COST CENTERS	-1			-		1
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0	0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	o	0		0		106. 00
107. 00 10700 LI VER ACQUI SI TI ON		0		0		107. 00
108. 00 10800 LUNG ACQUISITION		0				108.00
109. 00 10900 PANCREAS ACQUISITION		0				109.00
		0				
110. 00 11000   INTESTINAL ACQUISITION		0				110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0	1	0		111. 00
113. 00 11300 I NTEREST EXPENSE		0	1	) 0		113. 00
114.00 11400 UTILIZATION REVIEW-SNF	0	0	1	0		114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	1	0		115. 00
116. 00 11600 HOSPI CE	0	0	1	0	0	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	68, 060, 733	97, 184, 544	165, 245, 27	7 1, 182, 187	166, 427, 464	1118. 00
NONREI MBURSABLE COST CENTERS			T	1		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
190. 01 19001 WELLNESS CENTERS	332, 257	310, 103	642, 36	59, 202	583, 158	190. 01
190.02 19002 EMPLOYED ORTHO MD	0	0		0		190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)	341, 636	50, 181	391, 81	7 -22, 198	369, 619	190. 03
190.04 19004 SUMMIT CONV. (LTC)	201, 190	14, 677	215, 86	7 0	215, 867	190. 04
190. 05 19005 PARKVIEW CONV. (LTC)	260, 104	18, 290	278, 39	4 0	278, 394	190. 05
190. 06 19006 MONTI CELLO HSE.	o	213, 009	213, 00	-3, 085	209, 924	190.06
190. 07 19007 NH PARK PLACE (LTC)	27, 679	1, 853				190. 07
190. 08 19008 MADI SON PLACE OF ELWOOD (LTC)	0	0		0		190. 08
190. 09 19009 SPI NE SURGEON	ا	0		n 0		190. 09
190. 10 19010 CLINI CAL RESEARCH CENTER	594, 797	225, 091	819, 88	3 -39, 977	779, 911	
190. 11 19011 ONCOLOGI ST	374, 777	223, 091	017,00	-37, 7//		190. 10
	07 077	21 000	110.00	7 400		
190. 12 19012 MEDI CAL I NTERNI ST	87, 977	31, 890			119, 374	
190. 13 19013 RHEUMATOLOGY	419, 922	518, 848	1		912, 006	
190. 14 19014 ROCK STEADY BOXING	87, 887	47, 968	135, 85	-19, 482	116, 373	
191. 00 19100 RESEARCH	0	0		0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	2, 336, 268				
192.01 19201 MUNCIE MD OFFICES	0	141, 978	141, 97	-123, 200	18, 778	192. 01
192. 02 19202 FOUNDATI ON	233, 887	666, 684	900, 57	1 0	900, 571	192. 02
192. 03 19203 SP0E	o	0		0	0	192. 03
192. 04 19204 HEALTHY HEART	268, 950	54, 294	323, 24	-5, 878	317, 366	192. 04
192. 05 19205 VACANT SPACE	l	0		0		192. 05
192.07 19207 PARK PLACE CENTER		7	1	7 0		192. 07
192. 08 19208 RENTAL PROPERTY	ا	28, 966	28, 96	-11, 649		192. 08
192. 09 19209 RESIDENTIAL PROPERTY (1430 N MADISON		11, 028				192. 09
192. 10 19210 HOSPI TAL RENTAL (1927 N MADI SON AVE)		7, 176				192. 10
200.00 TOTAL (SUM OF LINES 118 through 199)	70, 917, 019	101, 862, 855				
255.55     10 THE (55m of EINES 116 through 177)	, 5, 717, 517	101, 302, 033	1,2,7,7,07	.,	1,2,777,074	1-00.00

Peri od: From 01/01/2018 To 12/31/2018

Date/Time Prepared: 5/28/2019 4:13 pm

				5/28/2019 4: 1	3 pm
	Cost Center Description	Adjustments	Net Expenses		
			For Allocation		
	OFNEDAL CEDIU OF COCT OFNITEDO	6. 00	7. 00		
1 00	GENERAL SERVICE COST CENTERS	201 205	E 004 100	,	1 00
1.00	00100 CAP REL COSTS-BLDG & FIXT	-291, 285	5, 884, 180		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS	0	4, 818, 175 0		2.00
3.00		2 04/ 751	-		3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-3, 046, 751	14, 554, 066	•	4.00
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	-11, 491, 476 0	21, 170, 685 0		5.00
		-	_		6.00
7.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	-36, 877	7, 803, 106		7. 00 8. 00
8.00	00900 HOUSEKEEPING	0	200, 413		
9. 00 10. 00		0	1, 885, 937		9.00
	01000 DI ETARY	1 015 0/1	1, 205, 785		10.00
11.00	01100 CAFETERI A	-1, 015, 861	707, 583		11.00
12.00	01200 MAI NTENANCE OF PERSONNEL	0/ 470	1 554 227		12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	86, 470			13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	683, 059	2, 418, 533		14.00
15.00	1	0	2, 358, 896		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-846 0	1, 649, 818		16.00
17. 00 19. 00	01700 SOCIAL SERVICE	1	0		17. 00
	01900 NONPHYSI CLAN ANESTHETI STS	0	0		19.00
20. 00 21. 00	02000 NURSING SCHOOL	1	12 500		20.00
	1	12, 598		1	21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	20, 189	20, 189 0	1	22. 00
23. 00	02300 PARAMED ED PRGM-(EMS) INPATIENT ROUTINE SERVICE COST CENTERS		0	<u> </u>	23. 00
30. 00		02 124	15, 806, 193	J	20.00
30.00	03100 I NTENSI VE CARE UNI T	82, 136			30.00
	03200 CORONARY CARE UNIT	0	3, 432, 075		31.00
32. 00 33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		32. 00 33. 00
34. 00	1 1	0	0		
	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0		34.00
40. 00 41. 00		0	0		40.00
41.00	04100  SUBPROVI DER - I RF 04200  SUBPROVI DER	0	0		41. 00 42. 00
	l l	1	U 1 427 146		1
43. 00 44. 00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	0	1, 427, 146 0		43.00
45. 00	04500 NURSING FACILITY	0			44. 00 45. 00
46. 00	04600 OTHER LONG TERM CARE	0		1	46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	0	0		40.00
50. 00	05000 OPERATI NG ROOM	0	6, 740, 124		50.00
51.00	05100 RECOVERY ROOM	0	0, 740, 124		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53. 00	05300 ANESTHESI OLOGY	-3, 172, 305	51, 321		53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-278, 936	2, 693, 231		54.00
54. 01	05401 ULTRASOUND	270, 730	321, 465		54. 01
54. 02	05402 WOMEN' S CENTER	0	397, 681	l control of the cont	54. 02
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		55. 00
56. 00	05600 RADI OI SOTOPE	0	783, 616		56.00
57. 00	05700 CT SCAN	0	769, 360	1	57.00
58. 00		0	831, 497	1	58.00
59. 00		0	1, 070, 807	.1	59.00
60.00	1 1	0	4, 069, 826		60.00
60. 01	06001 BLOOD LABORATORY	0	0 1,007,020	l .	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	227, 477		62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	227, 177		63.00
64. 00		0	0		64.00
65. 00	06500 RESPI RATORY THERAPY	0	1, 350, 855		65.00
66. 00	06600 PHYSI CAL THERAPY	-19, 525	2, 477, 498		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	17, 323	397, 618		67.00
68. 00	06800 SPEECH PATHOLOGY	0	294, 113		68.00
69. 00	06900 ELECTROCARDI OLOGY	61, 154	550, 633		69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0.7.01	698, 744		70.00
71.00			12, 181, 192	l e e e e e e e e e e e e e e e e e e e	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		7, 710, 228		72.00
73. 00			7, 162, 806		73.00
74. 00	1	0	352, 392		74.00
75. 00	1 1	0	332, 342		75.00
, 5. 00	OUTPATIENT SERVICE COST CENTERS	. 0		1	1 , 3. 50
88. 00	08800 RURAL HEALTH CLINIC	0	0		88. 00
89. 00		1 0	0		89.00
90.00	09000 CLINIC	1			90.00
	1	-774, 637	400, 158		90.00
90 N1	10.00 1 100 10 10 10 10 10 10 10 10 10 10 1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1 700, 100		90.02
90. 01 90. 02	09002 KLDS PLUS CLINIC	l 0	Λ	,,	
90. 02	09002 KLDS PLUS CLINIC 09003 0NCOLOGY	-851 995	0 2 983 795		
	1 1	-851, 995 -63, 900		1	90. 03

Health FinancialSystemsCOMMUNITY FRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 15-0113

Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared:

			5/28/2019 4:	
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6. 00	7. 00		
90. 05 09005 ANTI COAGULATI ON CLINIC	0	343, 486		90. 05
90. 06   09006   PREGNANCY PLUS	0	0		90. 06
90. 07  09007 0/P LAB	0	0		90. 07
90. 08   09008   0/P LAB	0	0		90. 08
90. 09   09009   FORTVILLE CLINIC	0	675		90. 09
90. 10 09010 1030 S SCATTERFIELD (MEDCHECK)	0	0		90. 10
90. 11 09011 DI ABETI C PLUS CLINIC	0	462, 212		90. 11
91. 00 09100 EMERGENCY	-23, 147	4, 088, 697		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94. 00
95. 00 09500 AMBULANCE SERVICES	0	0		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97. 00
99. 00 09900 CMHC	0	0		99. 00
99. 10   09910   CORF	0	0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0	l .	101. 00
SPECIAL PURPOSE COST CENTERS				
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		105. 00
106. 00 10600 HEART ACQUISITION	0	0		106. 00
107. 00 10700 LIVER ACQUISITION	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0		108.00
109. 00 10900 PANCREAS ACQUISITION	0	0		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		110.00
111.00 11100   SLET ACQUISITION	0	0		111. 00
113. 00 11300   NTEREST EXPENSE	0	0		113.00
114.00 11400 UTILIZATION REVIEW-SNF	0	0		114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		115. 00
116. 00 11600 HOSPI CE	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-20, 121, 935	146, 305, 529		118. 00
NONREI MBURSABLE COST CENTERS			<u> </u>	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
190. 01 19001 WELLNESS CENTERS	0	583, 158		190. 01
190. 02 19002 EMPLOYED ORTHO MD	0	0		190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)	0	369, 619		190. 03
190. 04 19004 SUMMIT CONV. (LTC)	0	215, 867		190. 04
190. 05 19005 PARKVIEW CONV. (LTC)	0	278, 394		190. 05
190. 06 19006 MONTI CELLO HSE.	0	209, 924		190. 06
190. 07 19007 NH PARK PLACE (LTC)	0	29, 532		190. 07
190.08 19008 MADISON PLACE OF ELWOOD (LTC)	0	0		190. 08
190. 09 19009 SPI NE SURGEON	0	0		190. 09
190. 10 19010 CLINICAL RESEARCH CENTER	0	779, 911		190. 10
190. 11 19011 ONCOLOGI ST	0	0		190. 11
190. 12 19012 MEDI CAL I NTERNI ST	0	119, 374		190. 12
190. 13 19013 RHEUMATOLOGY	l 0	912, 006	·	190. 13
190. 14 19014 ROCK STEADY BOXING	0	116, 373	·	190. 14
191. 00 19100 RESEARCH	0	l ·		191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	1	l .	192. 00
192. 01 19201 MUNCI E MD OFFICES	n	18, 778		192. 01
192. 02 19202 FOUNDATION	n	900, 571		192. 02
192. 03 19203 SP0E	n	0		192. 03
192. 04 19204 HEALTHY HEART	n	317, 366		192. 04
192. 05 19205 VACANT SPACE	l o	017,000		192. 05
192. 07 19207 PARK PLACE CENTER	l 0	7		192. 07
192. 08 19208 RENTAL PROPERTY		17, 317		192. 08
192. 09 19209 RESIDENTIAL PROPERTY (1430 N MADISON		7, 310		192. 09
192. 10 19210 HOSPI TAL RENTAL (1927 N MADI SON AVE)	l 0	245		192. 10
200.00 TOTAL (SUM OF LINES 118 through 199)	-20, 121, 935	l .		200. 00
	,,	1	I	,

| Peri od: | Worksheet A-6 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: 5/28/2019 4:13 pm

					5/28/2019 4: 13	pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4. 00	5. 00		
	A - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5, 019, 173		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4, 139, 284		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6. 00 7. 00		0. 00 0. 00	0	0	· · · · · · · · · · · · · · · · · · ·	6. 00 7. 00
8. 00	•	0.00	0	0		8. 00
9. 00		0.00	0	0		9. 00
10. 00		0.00	0	o	· · · · · · · · · · · · · · · · · · ·	10. 00
11. 00		0.00	o	Ö		11. 00
12. 00		0.00	Ö	Ö		12.00
13. 00		0.00	O	O		13.00
14.00		0.00	0	0		14.00
15.00		0.00	О	0	1	15. 00
16.00		0.00	0	0	1	16.00
17. 00		0.00	0	0	1	17. 00
18.00		0.00	0	0	1	18.00
19. 00		0.00	0	0		19. 00
20. 00		0.00	0	0		20. 00
21. 00		0.00	0	0		21. 00
22. 00		0.00	0	0		22. 00
23. 00		0.00	0	0		23. 00
24. 00		0.00	0	0		24. 00
26. 00 27. 00	•	0. 00 0. 00	0	0		26. 00 27. 00
28. 00		0.00	0	0		28. 00
29. 00		0.00	0	o		29. 00
30. 00		0.00	o	Ö		30. 00
31. 00		0.00	Ö	o		31. 00
32. 00		0.00	o	Ö	· · · · · · · · · · · · · · · · · · ·	32. 00
33. 00		0.00	0	O		33. 00
34.00		0.00	O	0		34. 00
35.00		0.00	o	0	3	35. 00
36.00		0.00	O	0	3	36. 00
38.00		0.00	0	0	3	38. 00
39. 00		0.00	0	0	3	39. 00
40.00		0.00	0	0		10.00
42.00		0.00	0	0		12. 00
43.00		0.00	0	0		13. 00
44. 00		0.00	0	0		14.00
45. 00		0.00	0	0		15.00
46. 00		0.00	0	0 9, 158, 457	4	16. 00
	B - DRUGS & SUPPLIES		<u> </u>	7, 130, 437		
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	12, 181, 192		1.00
	PATI ENTS		٦			
2.00	IMPL. DEV. CHARGED TO	72. 00	O	7, 710, 228		2.00
	PATI ENTS					
3.00	DRUGS CHARGED TO PATIENTS	73. 00	0	7, 162, 806		3. 00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8. 00 9. 00		0. 00 0. 00	0	0		8. 00 9. 00
10. 00		0.00	0	0		10.00
11. 00		0.00	o	Ö		11. 00
12. 00		0.00	o	Ö		12.00
13. 00		0.00	0	O		13.00
14.00		0.00	O	0	· · · · · · · · · · · · · · · · · · ·	14.00
15. 00		0.00	O	0		15. 00
17. 00		0.00	О	0		17. 00
18.00		0.00	0	0		18. 00
19. 00		0.00	0	0		19. 00
20.00		0.00	0	0		20. 00
21. 00		0.00	0	0		21. 00
22. 00		0.00	0	0		22. 00
23. 00		0.00	0	0		23. 00
24. 00		0.00	0	0		24. 00
25. 00		0.00	0	0		25. 00
26. 00 27. 00		0. 00 0. 00	0	0		26. 00 27. 00
27.00	1	0.00	Ч	o <sub>l</sub>	2	

In Lieu of Form CMS-2552-10

Health Financial Systems RECLASSI FI CATI ONS Provi der CCN: 15-0113 Peri od: Worksheet A-6 From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/28/2019 4:13 pm Increases Cost Center Li ne # Sal ary 0ther 2. 00 5.00 3.00 4.00 28. 00 0.00 0 28. 00 0 0 29. 00 0.00 0 29. 00

30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
33.00		0.00	0	0	33.00
35.00		0.00	0	0	35. 00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37. 00
38. 00		0.00	o	0	38. 00
41.00		0.00	o	0	41.00
42.00		0.00	O	0	42. 00
43.00		0.00	0	0	43.00
45.00		0.00	o	0	45. 00
				27, 054, 226	
	C - RENT	<u> </u>	-1		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	842, 315	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	o	605, 454	2. 00
3.00		0.00	o	0	3. 00
4. 00		0.00	Ö	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
9. 00		0.00		0	9. 00
10. 00		0.00		0	10.00
11. 00		0.00	0	0	11.00
12. 00		0.00	O O	0	12.00
			U	0	
13.00		0.00	0	0	13.00
14. 00		0.00	0	0	14. 00
	U LABOR O BELLVERY		0	1, 447, 769	_
4 00	D - LABOR & DELIVERY		4 444 644	222 222	4
1.00	NURSERY	43.00	<u>1, 146, 914</u>	280, 232	1. 00
	0		1, 146, 914	280, 232	4
	E - CAFETERIA RECLASS				
1. 00	CAFETERI A	1100	<u>856, 7</u> 24	<u>930, 1</u> 83	1. 00
	0		856, 724	930, 183	_
	F - SPECIAL MEALS	,			
1.00	DI ETARY	10.00	30, 427	3 <u>3, 0</u> 36	1. 00
	0		30, 427	33, 036	_
	G - INTEREST & INSURANCE	,			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	177, 414	1. 00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	136, 563	2. 00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	73, 437	3. 00
	0 — — — —			387, 414	
	H - LAUNDRY				
1.00	LAUNDRY & LINEN SERVICE	8.00	73, 093	127, 320	1. 00
	0 — — — — —		73, 093	127, 320	
	I - POB UTILITIES	· · · · · · · · · · · · · · · · · · ·			
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6, 328	1. 00
2.00	LABORATORY	60.00	0	3, 357	2. 00

2, 107, 158

39, 748

96, 525 39, 515, 162 7.00

500.00

<u>90.</u>03

7.00

ONCOLOGY

500.00 Grand Total: Increases

Peri od: From 01/01/2018 To 12/31/2018

Date/Time Prepared: 5/28/2019 4:13 pm

		Decreases				5/28/2019 4:	13 pili
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10.00		
	A - DEPRECIATION						
	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	'			1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0				2. 00
3. 00	OPERATION OF PLANT	7. 00	0				3. 00
	HOUSEKEEPI NG	9.00	0	8, 80			4. 00
	DI ETARY	10.00	0	'			5. 00
6. 00 7. 00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13. 00 14. 00	0	20 82, 60			6. 00 7. 00
	PHARMACY	15. 00	0	4, 98	1		8. 00
9. 00	ADULTS & PEDIATRICS	30.00	0	301, 48			9. 00
	INTENSIVE CARE UNIT	31.00	0				10.00
	NURSERY	43. 00	0	'	1		11. 00
	OPERATING ROOM	50.00	0				12.00
13.00	ANESTHESI OLOGY	53.00	0	6, 70	0 0		13. 00
14.00	RADI OLOGY-DI AGNOSTI C	54.00	0	356, 96	9 0		14. 00
	ULTRASOUND	54. 01	0	19, 56			15. 00
	WOMEN'S CENTER	54. 02	0	5, 97			16. 00
	RADI OI SOTOPE	56.00	0	42, 84			17. 00
	CT SCAN	57.00	0				18.00
19. 00	MAGNETIC RESONANCE IMAGING	58. 00	0	75, 20	7 0		19. 00
20. 00	(MRI) CARDIAC CATHETERIZATION	59.00	0	182, 47	5 0		20. 00
21. 00	LABORATORY	60.00	0	247, 77			21. 00
	WHOLE BLOOD & PACKED RED	62.00	0	'			22. 00
22.00	BLOOD CELLS	02.00	O	', ', '			22.00
23. 00	RESPIRATORY THERAPY	65.00	0	38, 15	4 0		23. 00
24.00	PHYSI CAL THERAPY	66.00	0	75, 34	1 0		24. 00
26.00	SPEECH PATHOLOGY	68. 00	0	8	6 0		26. 00
27.00	ELECTROCARDI OLOGY	69. 00	0	29, 57	0 0		27. 00
28. 00	ELECTROENCEPHALOGRAPHY	70.00	0	27, 40	5 0		28. 00
	WOUND/OSTOMY CLINIC	90. 01	0				29. 00
	ONCOLOGY	90. 03	0	, ,	1		30.00
	MUNCIE CLINIC	90. 04	0	35, 18	1		31. 00
	ANTI COAGULATION CLINIC	90.05	0				32. 00
	PREGNANCY PLUS	90.06	0	68			33. 00
	FORTVILLE CLINIC	90.09	0	'			34. 00
	DIABETIC PLUS CLINIC	90. 11	0	28			35. 00
	EMERGENCY	91. 00 190. 03	0	124, 55			36. 00 38. 00
	NORTHVIEW CONV. (LTC) MONTICELLO HSE.	190.03	0	20, 16 3, 08	1		39. 00
	CLINICAL RESEARCH CENTER	190.00	0				40. 00
	RHEUMATOLOGY	190. 13	0	2, 36			42. 00
	PHYSICIANS' PRIVATE OFFICES	192.00	0				43. 00
	HEALTHY HEART	192.04	0	47	1		44. 00
	RESIDENTIAL PROPERTY (1430 N	192. 09	0	3, 71			45. 00
	MADI SON						
46.00	HOSPITAL RENTAL (1927 N	192. 10	0	6, 93	1 0		46. 00
	<u>MADI SON_AVE)</u>			L	<u> </u>		
	0		0	9, 158, 45	7		-
1 00	B - DRUGS & SUPPLIES EMPLOYEE BENEFITS DEPARTMENT	4.00	0	20 05	6 0		1 00
1. 00 2. 00	ADMINISTRATIVE & GENERAL	5. 00	0	· ·			1. 00 2. 00
	OPERATION OF PLANT	7.00	0	46, 16			3. 00
	HOUSEKEEPI NG	9.00	0	7, 93			4. 00
	DI ETARY	10.00	0	'			5. 00
6. 00	CENTRAL SERVICES & SUPPLY	14.00	0				6. 00
7. 00	PHARMACY	15. 00	0		1		7. 00
	MEDICAL RECORDS & LIBRARY	16. 00	0	8			8. 00
9. 00	ADULTS & PEDIATRICS	30.00	0				9. 00
	INTENSIVE CARE UNIT	31.00	0	462, 37			10. 00
	OPERATI NG ROOM	50.00	0	12, 466, 11			11. 00
	ANESTHESI OLOGY	53.00	0	41, 60			12.00
	RADI OLOGY-DI AGNOSTI C	54.00	0	, , , , ,	1		13.00
	ULTRASOUND	54. 01	0				14.00
	WOMEN' S CENTER RADI OI SOTOPE	54. 02 56. 00	0	'			15. 00 17. 00
	IRADI OI SOTOPE ICT SCAN	57.00	0	283, 24 116, 95			18.00
	MAGNETIC RESONANCE IMAGING	58.00	0				19. 00
17.00	(MRI)	35.00	0	10,00	.]		' 55
20. 00	CARDIAC CATHETERIZATION	59. 00	0	890, 34	2 0		20. 00
	LABORATORY	60.00	0		1		21. 00
	WHOLE BLOOD & PACKED RED	62.00	0				22. 00
	BLOOD CELLS						
23. 00	RESPIRATORY THERAPY	65.00	0	121, 86	9 0		23. 00
-							

Peri od: From 01/01/2018 To 12/31/2018

Date/Time Prepared: 5/28/2019 4:13 pm

						5/28/2019 4:	13 piii
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
24. 00	PHYSI CAL THERAPY	66.00	0	15, 860			24. 00
25. 00	OCCUPATIONAL THERAPY	67.00	0	3, 649	0		25. 00
26.00	SPEECH PATHOLOGY	68.00	0	1, 310	0		26. 00
27.00	ELECTROCARDI OLOGY	69.00	o	13, 572	o		27. 00
28. 00	ELECTROENCEPHALOGRAPHY	70.00	ol	27, 493			28. 00
29. 00	RENAL DIALYSIS	74. 00	o	13, 761	o		29. 00
30. 00	WOUND/OSTOMY CLINIC	90. 01	o	226, 893			30.00
31. 00	ONCOLOGY	90.01	o	142, 242	l		31. 00
	II.		-				
33. 00	ANTI COAGULATI ON CLINI C	90.05	0	27, 475			33. 00
35. 00	DIABETIC PLUS CLINIC	90. 11	0	1, 263			35. 00
36. 00	EMERGENCY	91.00	0	563, 536			36. 00
37. 00	WELLNESS CENTERS	190. 01	0	59, 202	0		37. 00
38.00	NORTHVIEW CONV. (LTC)	190. 03	0	2, 036	0		38. 00
41.00	MEDICAL INTERNIST	190. 12	0	493	0		41.00
42.00	ROCK STEADY BOXING	190. 14	ol	198	ol		42. 00
43.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1, 238			43. 00
45. 00	HEALTHY HEART	192.04	o	5, 399			45. 00
45.00	0		<u> </u>	<u>27, 054, 226</u>			45.00
			U	27, 034, 220			-
4 00	C - RENT	44.00		107.1/0	4.0		4
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	137, 160			1. 00
2.00	PHARMACY	15. 00	0	328, 543			2. 00
3.00	LABORATORY	60.00	0	51, 161	0		3. 00
4.00	RESPIRATORY THERAPY	65.00	0	5, 704	0		4. 00
5.00	PHYSI CAL THERAPY	66.00	o	527, 429	O		5. 00
6.00	ELECTROCARDI OLOGY	69.00	o	126, 152	l		6. 00
7. 00	ELECTROENCEPHALOGRAPHY	70.00	0	6, 061	o		7. 00
9. 00	FORTVILLE CLINIC	90.09	Ö	48, 762			9. 00
10. 00	CLINICAL RESEARCH CENTER	190. 10	0	38, 268			10.00
			U				1
11. 00	RHEUMATOLOGY	190. 13	0	24, 396			11.00
12. 00	ROCK STEADY BOXING	190. 14	0	19, 284	l		12. 00
13. 00	MUNCIE MD OFFICES	192. 01	0	123, 200			13. 00
14. 00	RENTAL PROPERTY	192.08	0	1 <u>1, 6</u> 49			14. 00
	0		0	1, 447, 769			
	D - LABOR & DELIVERY						4
1.00	ADULTS & PEDIATRICS	30.00	1, 146, 914	280, 232	0		1. 00
			1, 146, 914	280, 232			1
	E - CAFETERIA RECLASS		,				1
1.00	DI ETARY	10.00	856, 724	930, 183	0		1.00
1.00	<u> </u>	10.00	856, 724	930, 183			1.00
	F - SPECIAL MEALS		030, 724	730, 103			4
1 00		11 00	20 427	22.027			1 00
1. 00	CAFETERI A	11.00	30, 427	33, 036			1. 00
	0		30, 427	33, 036			_
	G - INTEREST & INSURANCE						4
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	177, 414			1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	210, 000			2. 00
3.00		0.00	0	0	12		3. 00
	0 — — — — — —		o	387, 414			
	H - LAUNDRY						1
1.00	HOUSEKEEPI NG	9.00	73, 093	127, 320	0		1.00
1.00	n	— — <del>/.</del> 00	73, 093	127, 320			1.00
	I - POB UTILITIES		73,073	127, 320			-
1 00		100.00	٥	0/ 525			1 00
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	96, 525	l		1.00
2.00		0.00	이	0	0		2. 00
3.00		0.00	0	0	0		3. 00
4.00		0.00	0	0	0		4. 00
5.00		0.00	0	0	0		5. 00
6.00		0.00	ol	0	0		6. 00
7.00		0.00	o	0	o		7. 00
	<u> </u>		<u> </u>	96, 525			1
500 00	Grand Total: Decreases		2, 107, 158				500.00
		1	, ,	. , ,	'		

| Period: | Worksheet A-7 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared:

				To	12/31/2018	Date/Time Prep 5/28/2019 4:1:	pared:
				Acqui si ti ons		3/20/2019 4. 1.	3 piii
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances	r ur chases	Donation	Total	Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	T BALANCES				0.00	
1.00	Land	6, 128, 238	30, 000	0	30, 000	0	1.00
2.00	Land Improvements	1, 956, 043	33, 191	0	33, 191	0	2. 00
3.00	Buildings and Fixtures	72, 419, 891	804, 633	1, 731, 624	2, 536, 257	-208, 555	3. 00
4.00	Building Improvements	1, 197, 015	93, 139	0	93, 139	-93, 139	4. 00
5.00	Fi xed Equi pment	20, 462, 609	601, 180	0	601, 180	-240, 408	5. 00
6.00	Movable Equipment	55, 265, 125	1, 770, 795	498, 985	2, 269, 780	-1, 116, 381	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	157, 428, 921	3, 332, 938	2, 230, 609	5, 563, 547	-1, 658, 483	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	157, 428, 921	3, 332, 938	2, 230, 609	5, 563, 547	-1, 658, 483	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	6, 158, 238	0				1. 00
2.00	Land Improvements	1, 989, 234	1, 667, 669				2. 00
3.00	Buildings and Fixtures	75, 164, 703	23, 274, 919				3. 00
4.00	Building Improvements	1, 383, 293	0				4. 00
5.00	Fixed Equipment	21, 304, 197	10, 629, 291				5. 00
6.00	Movable Equipment	58, 651, 286	28, 648, 789				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	164, 650, 951	64, 220, 668				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	164, 650, 951	64, 220, 668				10.00

Heal th	Financial Systems	COMMUNITY HOSPI	TAL ANDERSON		In Lieu of Form CMS-2552-10		
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-0113	Peri od:	Worksheet A-7	
					From 01/01/2018 To 12/31/2018	Part II   Date/Time Pre	pared:
						5/28/2019 4:1	
	SUMMARY OF CAPITAL						
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	•	
					instructions)		
		9. 00	10. 00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0	)	0 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	)	0 0	0	2. 00
3.00	Total (sum of lines 1-2)	0	0	)	0 0	0	3. 00
		SUMMARY 0	F CAPITAL				
	0 1 0 1 0 1 1	011	T     (4) (				
	Cost Center Description		Total (1) (sum	1			
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)	45.00				
		14. 00	15. 00	L			
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	ind 2			
1. 00	CAP REL COSTS-BLDG & FIXT	0	0	1			1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	1			2. 00
3. 00	Total (sum of lines 1-2)	0	0	1			3. 00

Health Financial Systems	COMMUNITY HOSP	ITAL ANDERSON		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2018 To 12/31/2018	Date/Time Pre	
	COM	PUTATION OF RA	TIOS	ALLOCATION OF	5/28/2019 4: 1: OTHER CAPITAL	3 piii
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio	instructions)		
			2)	•		
	1. 00	2.00	3, 00	4, 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS				1	0.00	
1.00 CAP REL COSTS-BLDG & FLXT	104, 915, 461	0	104, 915, 46	1 0. 650300	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	56, 418, 523	8 0	56, 418, 52	0. 349700	0	2.00
3.00 Total (sum of lines 1-2)	161, 333, 984		161, 333, 98			3. 00
	ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
· ·		Capi tal -Relate				
		d Costs	through 7)			
	6. 00	7. 00	8. 00	9. 00	10. 00	
PART III - RECONCILIATION OF CAPITAL COSTS			1			
1.00 CAP REL COSTS-BLDG & FLXT	C		)	0 5, 019, 173		1. 00
2.00 CAP REL COSTS-MVBLE EQUIP			2	0 4, 139, 284		2.00
3.00 Total (sum of lines 1-2)	C		IMMADY OF CARL	0 9, 158, 457	1, 447, 769	3. 00
		50	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
				d Costs (see	through 14)	
				instructions)		
	11.00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS		404 =	.1	-	5 004 :	
1.00 CAP REL COSTS-BLDG & FIXT	-113, 871			0	5, 884, 180	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	112.071	,	•	0	.,	2.00
3.00  Total (sum of lines 1-2)	-113, 871	210, 000	יו	0 0	10, 702, 355	3. 00

From 01/01/2018 12/31/2018 Date/Time Prepared: 5/28/2019 4:13 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL -291, 285 CAP REL COSTS-BLDG & FLXT 1. 00 В 1.00 11 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) Trade, quantity, and time 4 00 В -13, 961 ADMINISTRATIVE & GENERAL 4 00 5 00 discounts (chapter 8) 5.00 Refunds and rebates of 0 0.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay -114, 906 ADMINI STRATI VE & GENERAL 7.00 5.00 7.00 Α stations excluded) (chapter 21) 8.00 Tel evi si on and radio servi ce -36, 727 OPERATION OF PLANT 7.00 8.00 Α (chapter 21) Parking lot (chapter 21) 9.00 9.00 0.00 Provider-based physician -8, 609, 142 A-8-2 10.00 10.00 adj ustment -921 ADMINI STRATI VE & GENERAL 11.00 Sale of scrap, waste, etc. В 5.00 11.00 (chapter 23) Related organization 12.00 A-8-1 -1, 589, 069 12.00 transactions (chapter 10) 13 00 Laundry and linen service 0 00 13 00 14.00 Cafeteria-employees and guests В -915, 640 CAFETERI A 11.00 14.00 Rental of quarters to employee 15.00 15.00 0.00 and others 16.00 Sale of medical and surgical 0 0.00 16.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents -846 MEDICAL RECORDS & LIBRARY 18.00 Sale of medical records and В 16.00 18.00 abstracts Nursing and allied health 19 00 19 00 0 00 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 20.00 Income from imposition of 21.00 0.00 21.00 interest, finance or penalty charges (chapter 21) 22.00 22.00 Interest expense on Medicare 0.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 23.00 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 24 00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review OUTILIZATION REVIEW-SNF 114.00 25.00 physicians' compensation (chapter 21) Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 26.00 1.00 26.00 COSTS-BLDG & FLXT Depreciation - CAP REL 27.00 OCAP REL COSTS-MVBLE EQUIP 2.00 27.00 COSTS-MVBLE EQUIP 28.00 ONONPHYSICIAN ANESTHETISTS 19.00 28.00 Non-physician Anesthetist Physicians' assistant 29 00 29.00 0.00 30.00 Adjustment for occupational A-8-3 O OCCUPATIONAL THERAPY 67.00 30.00 therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see 30.99 OADULTS & PEDIATRICS 30.00 30.99 instructions) 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00 pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 0.00 32.00 Depreciation and Interest

From 01/01/2018 | To 12/31/2018 | Date/Time Prepared:

				T	o 12/31/2018	Date/Time Pre 5/28/2019 4:1	
				Expense Classification on	Worksheet A	372072017 4. 1	5 piii
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center	Line #	Wkst. A-7 Ref.	
33. 00	NONREI MBURSABLE PHYSI CI AN PTO	1. 00 A	2.00	3.00 EMPLOYEE BENEFITS DEPARTMENT	4. 00	5. 00 0	33. 00
33. 00	SOLD		O	LINI LOTEE BENEFIT TO BETAKTMENT	4.00		33.00
33. 01	PHYSICIAN RECRUITMENT		0		0.00	l e	
33. 02	RADI OLOGY, DI AGNOSTI C		0		0.00	ł	00.02
33. 03 33. 04	ADVERTISING MUNCIE CLINIC	A B		ADMINISTRATIVE & GENERAL MUNCIE CLINIC	5. 00 90. 04	l e	33. 03 33. 04
33. 04	OUTSIDE SERVICES - SPD	В	·	CENTRAL SERVICES & SUPPLY	14. 00	l e	
33. 06	OTHER ADJUSTMENTS (SPECIFY)		0	SERVI SES & SOLLET	0.00	Ö	33. 06
	(3)						
33. 07	MI SC A&G	В		ADMI NI STRATI VE & GENERAL	5. 00	l	
33. 08 33. 09	SEXUAL RESPONSE UNIT	B B		EMERGENCY	91.00	l e	33. 08 33. 09
33. 09	MISC ARP	B B		ADULTS & PEDIATRICS EMPLOYEE BENEFITS DEPARTMENT	30. 00 4. 00	l	
33. 11	OTHER ADJUSTMENTS (SPECIFY)		00, 102	EMI ESTEE BENEFIT IS BELYKVIMENT	0. 00	l e	1
	(3)						
33. 12	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 12
33. 13	(3) MISC OPERATION OF PLANTS	В	-150	  OPERATION OF PLANT	7. 00	0	33. 13
33. 14	GUEST MEALS	A		CAFETERI A	11. 00		33. 14
33. 15	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	l e	ı
	(3)						
33. 16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	33. 16
33. 17	MISC OTHER OPERATING REVENUE	В	-1, 365, 604	ADMINISTRATIVE & GENERAL	5. 00	0	33. 17
33. 18	ONCOLOGY SERVICES	В		ONCOLOGY	90. 03	l e	ı
33. 19	ESPRESSO TO GO	В	-82, 061	CAFETERI A	11.00	ł	33. 19
33. 20	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 20
33. 21	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 21
33. 21	(3)		0		0.00	0	33.21
33. 22	PROCARE ADMINISTRATION	В	-19, 525	PHYSICAL THERAPY	66. 00	0	33. 22
33. 23	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 23
33. 24	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 24
33. 24	(3)		Ü		0.00	0	33. 24
33. 25	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 25
	(3)						
33. 26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	33. 26
33. 27	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 27
	(3)						
33. 28	HOSPITAL ASSESSMENT FEES (HAF)	В	-6, 158, 566	ADMINISTRATIVE & GENERAL	5. 00	0	
33. 29	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 29
33. 30	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 30
55	(3)		0		3.00		
33. 31	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 31
22 22	(3)		^		0.00	_	22 22
33. 32	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	33. 32
50.00	TOTAL (sum of lines 1 thru 49)		-20, 121, 935				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						1

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.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-0113

Worksheet A-8-1

From 01/01/2018 | Date/Time Prepared:

				10 12/31/2010	5/28/2019 4: 1	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	1	EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE	0	3, 080, 184	1.00
2.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	64, 726	0	2.00
3.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2, 153, 135	1, 720, 692	3.00
4.00	54.00	RADI OLOGY-DI AGNOSTI C	HOME OFFICE	48, 498	0	4.00
4.01	69. 00	ELECTROCARDI OLOGY	HOME OFFICE	61, 154	0	4. 01
4.02	13. 00	NURSING ADMINISTRATION	HOME OFFICE	86, 470	0	4. 02
4.03	14. 00	CENTRAL SERVICES & SUPPLY	HOME OFFICE	685, 307	0	4. 03
4.04	30.00	ADULTS & PEDIATRICS	HOME OFFICE	79, 730	0	4.04
4.05	0.00			0	0	4.05
4.06	21. 00	I&R SERVICES-SALARY & FRINGE	I&R SERVICES-SALARY & FRINGE	12, 598	0	4.06
4.07	22. 00	I&R SERVICES-OTHER PRGM. COS	I&R SERVICES-OTHER PRGM. COS	20, 189	0	4. 07
5.00	TOTALS (sum of lines 1-4).			3, 211, 807	4, 800, 876	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

has not been posted to worksheet h, cordinate a drawn of 2, the amount arrowable should be marked to cordinate of this part.							
				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of	Name	Percentage of		
			Ownershi p		Ownershi p		
	1. 00	2. 00	3.00	4. 00	5. 00		
	B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:				

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

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

6.00	A	IN PROHEALTH	100.00	0.00	6. 00
7.00	В		O. 00 CHN	0.00	7. 00
8.00	С	CHE	O. OO CHE-CANCER CARE	100.00	8. 00
9.00			0.00	0.00	9. 00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider. B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related
- 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				COMMUNITY HOSPITAL ANDERSON					In Lieu of Form CMS-2552-10		
STATEME	NT OF COSTS OF	SERVICES FR	OM RELATED	ORGANIZATION:	S AND HOME	Provi der	CCN:	15-0113	Peri od:	Worksheet A-	8-1
OFFICE	COSTS								From 01/01/2018		
									To 12/31/2018		
	N - ±	WI+ A 7 D-	٤						L.	5/28/2019 4:	13 pm
		Wkst. A-7 Re	эт.								
	Adjustments										
	(col. 4 minus										
	col. 5)*										
	6. 00	7. 00									
	A. COSTS INCUR	RED AND ADJU	STMENTS RE	EQUIRED AS A R	ESULT OF TRA	ANSACTI ONS	WI TH	RELATED (	ORGANI ZATI ONS OR	CLAIMED	
	HOME OFFICE CO:	STS:									
1.00	-3, 080, 184		0								1.00
2.00	64, 726		O								2.00
3.00	432, 443		O								3.00
4.00	48, 498		0								4. 00
4.01	61, 154		0								4. 01
4.02	86, 470		0								4. 02
4.03	685, 307		0								4. 03
4.04	79, 730		0								4. 04
4.05	0		O								4. 05
4.06	12, 598		O								4. 06
4.07	20, 189		0								4. 07

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

5.00

Related Organization(s) and/or Home Office					
and/or nome 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		6.00
7.00		7.00
	CANCER CARE	8.00
9.00		9.00
10.00		10.00
10. 00 100. 00		100.00

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

5.00

-1, 589, 069

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0113 

						To 12/31/2018	B   Date/Time Pro   5/28/2019 4:1	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
					·		Hours	
	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00		EMPLOYEE BENEFITS DEPARTMENT	811					
2.00	5. 00	ADMINISTRATIVE & GENERAL	4, 149, 633	4, 013, 63	3 136, 000	211, 500	1, 733	2.00
3.00	53. 00	ANESTHESI OLOGY	3, 172, 305	3, 172, 30	5 0	0	0	3.00
4.00	54. 00	RADI OLOGY-DI AGNOSTI C	327, 434	327, 43	4 0	0	0	4.00
5.00	90. 01	WOUND/OSTOMY CLINIC	774, 637	774, 63	7 0	0	0	5. 00
6.00	90. 03	ONCOLOGY	320, 322	320, 32	2 0	0	0	6. 00
7.00	0. 00		0	)	0	0	0	7. 00
8.00	0. 00		0	)	0	0	0	8. 00
9.00	0. 00		0	)	0	0	0	9. 00
10.00	0. 00		0	)	0	0	0	10.00
200.00			8, 745, 142	8, 609, 142	2 136, 000		1, 733	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		l denti fi er	Limit		E Memberships &	Component	of Malpractice	:
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
4.00	1.00	2.00	8.00	9. 00	12.00	13.00	14.00	1 00
1.00		EMPLOYEE BENEFITS DEPARTMENT	077, 047		0			
2.00	5. 00 ADMI NI STRATI VE & GENERAL		176, 216			0		
3.00		ANESTHESI OLOGY				0	0	
4.00	54. 00 RADI OLOGY - DI AGNOSTI C		0			0	0	4. 00 5. 00
5.00	90. 01 WOUND/OSTOMY CLINIC					0	0	
6. 00 7. 00	90. 03 ONCOLOGY 0. 00					0	0	6. 00 7. 00
7. 00 8. 00	0.00				0	0	0	
9. 00	0.00					0		9.00
10. 00	0.00							
200.00	0.00		176, 216	8, 81	1 0		-	200.00
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE		Adjustment	0	200.00
	WKSt. A LITIC #	I denti fi er	Component	Limit	Di sal I owance	Adj d3 tillerit		
		ruenti ir ei	Share of col.		Di Sai i olianee			
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	0	(	0 0	811		1.00
2.00	5. 00 ADMINISTRATIVE & GENERAL		0	176, 21	6 0	4, 013, 633		2. 00
3.00	53. 00 ANESTHESI OLOGY		0	)	0	3, 172, 305		3. 00
4.00	54. 00 RADI OLOGY-DI AGNOSTI C		0	)	0	327, 434		4. 00
5.00	90. 01	WOUND/OSTOMY CLINIC	0	)	0	774, 637		5. 00
6.00	90. 03	ONCOLOGY	0	)	0	320, 322		6. 00
7.00	0. 00		0	)	0	0		7.00
8.00	0. 00		0	)	0	0		8. 00
9.00	0.00		0	)	0 0	0		9. 00
10.00	0.00		0	)	0 0	0		10.00
200.00			0	176, 21	6 0	8, 609, 142		200.00

Health Financial Systems COMMUNITY HOSPITAL ANDERSON In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0113 Peri od: Worksheet B From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/28/2019 4:13 pm CAPITAL RELATED COSTS Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal Cost Center Description for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 5, 884, 180 5, 884, 180 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4, 818, 175 4, 818, 175 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 14, 554, 066 31, 881 11, 162 14, 597, 109 4.00 00500 ADMINISTRATIVE & GENERAL 2, 472, 211 5 00 21, 170, 685 714, 055 24, 850, 265 493, 314 5 00 6.00 6.00 00600 MAINTENANCE & REPAIRS 7.00 00700 OPERATION OF PLANT 7, 803, 106 598, 143 300, 385 511, 486 9, 213, 120 7.00 00800 LAUNDRY & LINEN SERVICE 200, 413 67, 057 283, 136 8.00 8.00 15, 666 00900 HOUSEKEEPI NG 1, 885, 937 9 00 139, 947 10. 275 323.981 2, 360, 140 9 00 10.00 01000 DI ETARY 1, 205, 785 208, 962 141, 701 157, 442 1, 713, 890 10.00 01100 CAFETERI A 707, 583 11.00 39, 556 177, 095 924, 234 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00  $\cap$ 276, 994 51, 572 13.00 01300 NURSING ADMINISTRATION 1, 554, 337 237 1, 883, 140 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 2, 418, 533 98, 473 5, 567 223, 722 2, 746, 295 14.00 01500 PHARMACY 15.00 2, 358, 896 62, 154 5, 306 434, 427 2, 860, 783 15.00 01600 MEDICAL RECORDS & LIBRARY 271, 445 1, 649, 818 78, 801 2,000,064 16,00 0 16,00 17 00 01700 SOCIAL SERVICE 0 0 17 00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 0 0 20.00 02000 NURSING SCHOOL 0 Ω 0 0 20.00 0 02100 | &R SERVICES-SALARY & FRINGES APPRVD 21.00 12, 598 0 0 12, 598 0 21.00 O 22.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 20, 189 0 20, 189 22.00 02300 PARAMED ED PRGM-(EMS) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 15, 806, 193 20, 075, 130 30.00 1.007.324 237, 157 3, 024, 456 31.00 03100 INTENSIVE CARE UNIT 3, 432, 075 134, 036 160, 751 660, 966 4, 387, 828 31.00 03200 CORONARY CARE UNIT 32.00 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 33.00 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 C 0 0 0 34.00 04000 SUBPROVIDER - IPF 0 40.00 40.00 0 41.00 04100 SUBPROVIDER - IRF 0 C 0 0 0 41.00 04200 SUBPROVI DER 42 00  $\cap$ Λ 42 00 43.00 04300 NURSERY 1, 427, 146 36, 242 583 245, 811 1, 709, 782 43.00 04400 SKILLED NURSING FACILITY 44.00 44.00 0 0 04500 NURSING FACILITY 45.00 45.00 0 04600 OTHER LONG TERM CARE 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 6, 740, 124 429, 338 1, 466, 223 1, 112, 205 9, 747, 890 50.00 05100 RECOVERY ROOM 51 00 51 00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 n 52.00 53.00 05300 ANESTHESI OLOGY 51, 321 5, 272 7, 815 172, 376 236, 784 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 693, 231 373, 735 235, 699 381, 331 3, 683, 996 54.00 05401 ULTRASOUND 321, 465 56 533 441, 446 54 01 54 01 63.448 54.02 05402 WOMEN'S CENTER 397, 681 12, 482 76, 199 486, 362 54.02 05500 RADI OLOGY-THERAPEUTI C 55.00 55.00 875, 637 56, 00 05600 RADI 0I SOTOPE 783, 616 28, 741 8.573 54, 707 56, 00 05700 CT SCAN 882, 512 57 00 769, 360 8, 721 339 104, 092 57 00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 831, 497 18, 140 17, 126 73, 120 939, 883 58.00 05900 CARDIAC CATHETERIZATION 59.00 1,070,807 72,677 200, 731 190, 681 1, 534, 896 59.00 06000 LABORATORY 4, 910, 005 60.00 4, 069, 826 215, 608 472, 860 60.00 151, 711 06001 BLOOD LABORATORY 60.01 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 227, 477 11, 338 2, 272 43, 120 284, 207 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 63 00 64.00 06400 INTRAVENOUS THERAPY 64.00 0 1, 350, 855 06500 RESPIRATORY THERAPY 9, 574 1, 672, 767 65.00 44, 502 267, 836 65.00 2, 999, 334 06600 PHYSI CAL THERAPY 2, 477, 498 66.00 52, 037 2,854 466, 945 66,00 06700 OCCUPATIONAL THERAPY 397, 618 47, 793 77, 070 522, 481 67.00 C 67.00 06800 SPEECH PATHOLOGY 294, 113 39, 556 52, 139 385, 808 68.00 68.00 06900 ELECTROCARDI OLOGY 29, 710 69 00 550, 633 34, 490 91,063 705, 896 69 00 07000 ELECTROENCEPHALOGRAPHY 698, 744 39, 168 29,016 112, 738 879, 666 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 12, 181, 192 C 0 12, 181, 192 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 7, 710, 228 7, 710, 228 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 7, 162, 806 0 0 7, 162, 806 73.00 07400 RENAL DIALYSIS 74.00 352, 392 3, 644 0 0 356, 036 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 0 0

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09000 CLI NI C

89 00

90.00

08900 FEDERALLY QUALIFIED HEALTH CENTER

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0113

			Т	o 12/31/2018	Date/Time Pre 5/28/2019 4:1	
		CAPI TAL REI	LATED COSTS		3/20/2019 4. 1	5 piii
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
cost center bescription	for Cost	DEDG & TIXI	WVDLL LQ011	BENEFI TS	Subtotal	
	Allocation			DEPARTMENT		
	(from Wkst A col. 7)					
	0	1. 00	2. 00	4. 00	4A	
90. 01   09001   WOUND/OSTOMY CLINIC	400, 158	197, 353	5, 010	76, 922	679, 443	90. 01
90. 02   09002   KI DS   PLUS   CLI NI C 90. 03   09003   0NCOLOGY	2, 983, 795	332, 707	750, 198	364, 543	0 4, 431, 243	90. 02 90. 03
90. 04   09004   MUNCI E CLINI C	-15, 693	0	, 55, 176	0	-15, 693	90. 04
90. 05 09005 ANTI COAGULATI ON CLINI C	343, 486	0	2, 657	63, 698	409, 841	90. 05
90. 06   09006   PREGNANCY PLUS 90. 07   09007   0/P   LAB	0	0		0	0	90. 06 90. 07
90. 08 09008 0/P LAB	o o	Ö	Č	Ö	0	90. 08
90. 09 09009 FORTVILLE CLINIC	675	0	C	0	675	90.09
90. 10   09010   1030   S   SCATTERFIELD (MEDCHECK) 90. 11   09011   DIABETIC PLUS CLINIC	0 462, 212	0	334	0 86, 869	0 549, 415	90. 10 90. 11
91. 00 09100 EMERGENCY	4, 088, 697	151, 769	•		5, 151, 799	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92. 00
94.00 OTHER REIMBURSABLE COST CENTERS  94.00 O9400 HOME PROGRAM DI ALYSI S	0	0	1		0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	C	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	C	0	0	96. 00
97. 00   09700   DURABLE MEDI CAL EQUI P-SOLD 99. 00   09900   CMHC	0	0	C	0	0	97. 00 99. 00
99. 10   09910 CORF	0	0		0	0	99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	C	0		100. 00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	<u> </u>	0	0	101. 00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	С	0	0	105. 00
106. 00 10600 HEART ACQUISITION	0	0	C	0		106. 00
107. 00 10700 LIVER ACQUISITION 108. 00 10800 LUNG ACQUISITION	0	0		0		107. 00 108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0		0		109. 00
110. 00 11000 INTESTINAL ACQUISITION	0	0	C	0		110. 00
111. 00 11100 ISLET ACQUISITION 113. 00 11300 INTEREST EXPENSE	0	0	C	0	0	111. 00 113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	C	0		115. 00
116.00 11600 HOSPICE 118.00  SUBTOTALS (SUM OF LINES 1 through 117)	0 146, 305, 529	0 5, 050, 446	4, 805, 700	0 13, 984, 938		116. 00 118. 00
NONREI MBURSABLE COST CENTERS	140, 303, 327	3,030,440	4, 003, 700	13, 704, 730	144, 047, 147	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23, 373			23, 373	
190. 01 19001 WELLNESS CENTERS 190. 02 19002 EMPLOYED ORTHO MD	583, 158	23, 780	C	71, 211	678, 149	190. 01 190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)	369, 619	17, 772	Č	73, 221	460, 612	
190. 04 19004 SUMMIT CONV. (LTC)	215, 867	17, 772		43, 120	276, 759	
190. 05 19005 PARKVIEW CONV. (LTC) 190. 06 19006 MONTICELLO HSE.	278, 394 209, 924	17, 772 85, 604		55, 747	351, 913 295, 528	
190. 07 19007 NH PARK PLACE (LTC)	29, 532	03,004		5, 932	35, 464	
190. 08 19008 MADI SON PLACE OF ELWOOD (LTC)	0	0	C	0		190. 08
190. 09 19009  SPI NE SURGEON 190. 10 19010  CLI NI CAL RESEARCH CENTER	779, 911	40, 157	1, 993	0 127, 479	949, 540	190. 09 190. 10
190. 11 19011 ONCOLOGI ST	0	0	1, , , ,	0		190. 11
190. 12 19012 MEDI CAL I NTERNI ST	119, 374	0	0	18, 856	138, 230	
190. 13 19013 RHEUMATOLOGY 190. 14 19014 ROCK STEADY BOXING	912, 006 116, 373	34, 556	2, 404	89, 999 18, 836	1, 004, 409 169, 765	
191. 00 19100 RESEARCH	0	0	Č	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1, 476, 658	359, 491	7, 519	0	1, 843, 668	
192. 01 19201 MUNCLE MD OFFICES 192. 02 19202 FOUNDATION	18, 778 900, 571	111, 341 6, 899		0 50, 128	130, 119 957, 598	
192. 03 19203 SPOE	0	0, 377		0 30, 120		192. 02
192.04 19204 HEALTHY HEART	317, 366	0	559	57, 642	375, 567	192. 04
192. 05 19205 VACANT SPACE 192. 07 19207 PARK PLACE CENTER	0 7	11, 764		0	11, 764 7	192. 05 192. 07
192.08 19208 RENTAL PROPERTY	17, 317	28, 218		o	45, 535	192. 08
192.09 19209 RESIDENTIAL PROPERTY (1430 N MADISON	7, 310	24, 226	c	o	31, 536	192. 09
192.10 19210 HOSPITAL RENTAL (1927 N MADISON AVE) 200.00 Cross Foot Adjustments	245	31, 009	C	0	31, 254	192. 10 200. 00
201.00 Negative Cost Centers		О	c	o		200.00
202.00   TOTAL (sum lines 118 through 201)	152, 657, 939	5, 884, 180	4, 818, 175	14, 597, 109	152, 657, 939	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared: | 5/28/2019 4:13 pm

	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	5/28/2019 4: 1 HOUSEKEEPI NG	
	oust deliter bescription	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	GENERAL SERVICE COST CENTERS	5.00	6. 00	7. 00	8. 00	9. 00	
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	24, 850, 265	_				5. 00
6.00	00600 MAI NTENANCE & REPAIRS 00700 OPERATION OF PLANT	1 701 122	C	11 004 252			6.00
7. 00 8. 00	00800 LAUNDRY & LINEN SERVICE	1, 791, 132 55, 045		11, 004, 252 154, 996			7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	458, 837	Č	323, 475		3, 149, 876	9. 00
10.00	01000 DI ETARY	333, 199	C	482, 996		56, 293	10. 00
11. 00	01100 CAFETERI A	179, 681	C	91, 430	0	0	11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	C	0	0	0	12.00
13. 00 14. 00	01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	366, 103 533, 910		119, 203 227, 611	688	12, 425 20, 539	13. 00 14. 00
15. 00	01500 PHARMACY	556, 168	C	143, 662		11, 664	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	388, 834	Ċ	182, 142	Ö	4, 311	16. 00
17. 00	01700 SOCIAL SERVICE	0	C	0	0	0	17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	C	0	0	0	19. 00
20.00	02000 NURSING SCHOOL	0	C	0	0	0	20.00
21. 00 22. 00	02100   &R SERVICES-SALARY & FRINGES APPRVD 02200   &R SERVICES-OTHER PRGM. COSTS APPRVD	2, 449 3, 925			0	0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(EMS)	3, 723			0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	-1					
30. 00	03000 ADULTS & PEDIATRICS	3, 902, 825	C	_, _,,		890, 039	30. 00
31.00	03100 INTENSIVE CARE UNIT	853, 042	C	1 007,012	•	164, 822	31.00
32. 00	03200 CORONARY CARE UNIT	0	C	0	0	0	32.00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT				0	0	33. 00 34. 00
40. 00	04000 SUBPROVIDER - I PF				0	0	40.00
41. 00	04100 SUBPROVI DER – I RF	0	C	o o	0	0	41.00
42.00	04200 SUBPROVI DER	0	C	0	0	0	42. 00
43.00	04300 NURSERY	332, 400	C	83, 769	0	9, 129	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	C	0	0	0	44.00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0			0	0	45. 00 46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		,,			70.00
50.00	05000 OPERATI NG ROOM	1, 895, 097	C	992, 376	113, 124	338, 012	50.00
51.00	05100 RECOVERY ROOM	0	C	0	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	C	0	0	0	52.00
53. 00 54. 00	05300   ANESTHESI OLOGY   05400   RADI OLOGY-DI AGNOSTI C	46, 033		12, 185 863, 855		0 39, 050	53. 00 54. 00
54. 00	05401 ULTRASOUND	716, 209 85, 822		003, 633	20, 509	39,000	54. 00
54. 02	05402 WOMEN' S CENTER	94, 554	Č		6, 207	Ö	54. 02
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C	0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	170, 233	C	66, 433		8, 621	
57. 00	05700 CT SCAN	171, 570	C	20, 158		0	57. 00
58. 00 59. 00	05800   MAGNETI C RESONANCE I MAGING (MRI)   05900   CARDI AC CATHETERI ZATI ON	182, 724 298, 401	C	41, 929 167, 987		6, 593 4, 311	1
60.00	06000 LABORATORY	954, 559		350, 667	2, 455	21, 047	ı
60. 01	06001 BLOOD LABORATORY	0	Ċ	0	Ö	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	55, 253	C	26, 206	0	4, 311	62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63. 00 64. 00
65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	325, 204		22, 129	0	11, 157	65.00
66. 00	06600 PHYSI CAL THERAPY	583, 104	Č	120, 279		5, 071	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	101, 576	C	110, 468		3, 804	67. 00
68. 00	06800 SPEECH PATHOLOGY	75, 005	C	91, 430	0	2, 282	68. 00
69. 00	06900 ELECTROCARDI OLOGY	137, 234	C	68, 673		3, 804	69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY	171, 017	C	90, 534	3, 789		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 368, 158 1, 498, 953			0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 392, 528	C		0	0	73.00
74. 00	07400 RENAL DI ALYSI S	69, 217	C	8, 422	Ō	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	C	0	0	0	75. 00
	OUTPATIENT SERVICE COST CENTERS		_	_	_		
88. 00	08800 RURAL HEALTH CLINIC	0	C	0	0	0	88. 00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0			0	0	89. 00 90. 00
90. 01	09001 WOUND/OSTOMY CLINIC	132, 091	C	456, 162	5, 118	_	90. 01
90. 02	09002 KIDS PLUS CLINIC	0	C	0	0	0	90. 02
90. 03	09003 ONCOLOGY	861, 482	C	769, 021	5, 173	0	90. 03
90. 04	09004 MUNCIE CLINIC	0	C	0	0	0	90.04
90. 05	09005 ANTICOAGULATION CLINIC	79, 678	<u> </u>	)  0	1 0	0	90. 05

					5/28/2019 4: 1	3 pm
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
· ·	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		1
	5.00	6. 00	7. 00	8. 00	9. 00	
90. 06   09006   PREGNANCY PLUS	0		0			90. 06
90. 07   09007   0/P LAB	0	1	0	0		90. 07
90. 08 09008 0/P LAB		0	0	0		90. 08
	121	0	0	0	0	•
90. 09   09009   FORTVILLE CLINIC	131	0	0	0	0	90. 09
90. 10   09010   1030 S SCATTERFIELD (MEDCHECK)	0	0	0	0	0	90. 10
90. 11   09011   DIABETIC PLUS CLINIC	106, 812	0	0	1, 506	. 0	90. 11
91. 00   09100   EMERGENCY	1, 001, 566	0	350, 801	70, 459	117, 658	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						1
94. 00 09400 HOME PROGRAM DI ALYSIS	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	o o	0	0	-	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0	0	0		1
	0	U	0	0	0	96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	0	0	0	97. 00
99. 00  09900 CMHC	0	0	0	0	0	99. 00
99. 10   09910   CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	l o	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS		<u>'</u>		1		l
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0	0	105. 00
106. 00 10600 HEART ACQUISITION	0	Ö	0	0	•	106. 00
107. 00 10700 LIVER ACQUISITION		0	0	0	•	107. 00
	0	0	0	0	•	1
108. 00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0	•	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P. )	0	0	0	0	ا ا	115. 00
116. 00 11600 HOSPI CE	0	٥	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	23, 331, 761	l o	9, 077, 153	493, 023		
	23, 331, 701	<u> </u>	9,077,133	473, 023	1, 700, 103	116.00
NONREI MBURSABLE COST CENTERS	1		F.4. 00F			100 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 544		54, 025	0		190. 00
190. 01 19001 WELLNESS CENTERS	131, 840	0	54, 965	0	23, 075	1
190.02 19002 EMPLOYED ORTHO MD	0	0	0	0	0	190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)	89, 548	0	41, 078	0	0	190. 03
190. 04 19004 SUMMIT CONV. (LTC)	53, 805	O	41, 078	0	0	190. 04
190. 05 19005 PARKVI EW CONV. (LTC)	68, 416		41, 078	0	0	190. 05
190. 06 19006 MONTI CELLO HSE.	57, 454	0	197, 866	0		190. 06
190. 07 19007 NH PARK PLACE (LTC)	6, 895	1	177,000	0	•	190. 07
	0, 093	0	0	0		•
190. 08 19008 MADI SON PLACE OF ELWOOD (LTC)	0	0	0	0		190. 08
190. 09 19009 SPI NE SURGEON	0	0	0	0		190. 09
190. 10 19010 CLINICAL RESEARCH CENTER	184, 601	0	92, 818	0	•	190. 10
190. 11 19011  ONCOLOGI ST	0	0	0	0	0	190. 11
190. 12 19012 MEDICAL INTERNIST	26, 873	0	0	0	0	190. 12
190. 13 19013 RHEUMATOLOGY	195, 268	0	0	0	0	190. 13
190. 14 19014 ROCK STEADY BOXING	33, 004	l o	79, 872	0	0	190. 14
191. 00 19100 RESEARCH	0	0	0	0	•	191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	358, 429	0	830, 930	0		1
		1			1	1
192. 01 19201 MUNCI E MD OFFI CES	25, 297		257, 356			192. 01
192. 02 19202 FOUNDATI ON	186, 168		15, 948			192. 02
192. 03 19203 SP0E	0	"	0	0		192. 03
192. 04 19204 HEALTHY HEART	73, 014	0	0	154	0	192. 04
192. 05 19205 VACANT SPACE	2, 287	0	27, 191	0	0	192. 05
192.07 19207 PARK PLACE CENTER	1	0	0	0		192. 07
192. 08 19208 RENTAL PROPERTY	8, 853	ا م	65, 224	l n		192. 08
192. 09 19209 RESIDENTIAL PROPERTY (1430 N MADISON	6, 131		55, 996			192. 09
· ·						192. 10
192. 10 19210 HOSPI TAL RENTAL (1927 N MADI SON AVE)	6, 076	ا	71, 674			
200.00 Cross Foot Adjustments	_	_	_	_		200.00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00   TOTAL (sum lines 118 through 201)	24, 850, 265	0	11, 004, 252	493, 177	3, 149, 876	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared: | 5/28/2019 4:13 pm

	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	5/28/2019 4: 1 CENTRAL	
	·				ADMI NI STRATI ON	SERVI CES & SUPPLY	
		10.00	11. 00	12.00	13.00	14. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00	00200 CAP REL COSTS-BEDG & TTXT						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT			•			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAI NTENANCE & REPAI RS						6. 00
7. 00 8. 00	00700 OPERATION OF PLANT						7.00
9. 00	O0800			•			8. 00 9. 00
10. 00	01000 DI ETARY	2, 592, 190					10.00
11.00	01100 CAFETERI A	0	1, 195, 345				11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	0	0			12.00
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	0	18, 772 45, 999		2, 399, 643	3, 575, 042	13. 00 14. 00
15. 00	01500 PHARMACY	0	36, 431	1	0	10, 066	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	o	34, 952	1	Ö	338	1
17. 00	01700 SOCIAL SERVICE	O	0	0	o	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20. 00 21. 00	02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0 27	0	0	0	20.00
21.00	02200 I &R SERVI CES-SALARY & FRINGES APPRVD	0	27		0	0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(EMS)	o	0	_	Ö	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	2, 249, 851	346, 515	l .	1 1	198, 355	•
31. 00 32. 00	03100 I NTENSI VE CARE UNI T	333, 861	75, 255	0	315, 892	59, 353	1
32.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0		0	0	32. 00 33. 00
34. 00	03400 SURGI CAL INTENSI VE CARE UNI T	o	0	Ö	Ö	0	34. 00
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40.00
41. 00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41. 00
42. 00	04200 SUBPROVI DER	0	0.4.454	0	0	0	42.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	24, 451 0		102, 635	0	43. 00 44. 00
45. 00	04500 NURSING FACILITY		0		o	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	Ö	0	0	46. 00
	ANCILLARY SERVICE COST CENTERS			1			
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	355 0	125, 446 0	ı	,	594, 652 0	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	o	6, 824	Ö	Ö	267	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	O	38, 418	0	o	2, 561	54. 00
54. 01	05401 ULTRASOUND	0	5, 260	l .	0	433	1
54. 02 55. 00	05402 WOMEN' S CENTER   05500 RADI OLOGY-THERAPEUTI C	0	7, 625		0	537 0	54. 02 55. 00
56. 00	05600 RADI OLOGI - THERAFEUTI C	0	4, 675		0	862	56. 00
57. 00	05700 CT SCAN	O	10, 880	l .	0	13, 235	ı
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	8, 356	l .	-	565	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	18, 225			0	
60. 00 60. 01	06000   LABORATORY   06001   BLOOD   LABORATORY	0	64, 498	0	0	8, 143 0	60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		O			J	61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	O	4, 509	0	0	31	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	31, 530 48, 086	1		1, 475 1, 075	1
67. 00	06700 OCCUPATI ONAL THERAPY		6, 304	1	o	67	67. 00
68. 00	06800 SPEECH PATHOLOGY	O	4, 764	1	O	26	1
69. 00	06900 ELECTROCARDI OLOGY	0	11, 456		0	1, 371	1
	07000 ELECTROENCEPHALOGRAPHY	0	11, 857	0	0	531	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1, 575, 942 997, 696	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	977, 070	73.00
	07400 RENAL DIALYSIS	O	0	Ō	0	498	1
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
00.00	OUTPATIENT SERVICE COST CENTERS			J ~			00.00
88. 00 89. 00	08800   RURAL HEALTH CLINIC   08900   FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0	88. 00 89. 00
90.00	09000 CLINIC		0	n n		0	90.00
90. 01	09001 WOUND/OSTOMY CLINIC		7, 746	Ö	ol ol	19, 911	90. 01
90. 02	09002 KIDS PLUS CLINIC	0	0	0	o	0	90. 02
90. 03 90. 04	09003 ONCOLOGY 09004 MUNCIE CLINIC	0	40, 843	1		13, 101	1
<del>7</del> 0. 04	O 7004 MONGIE GETNIC	<u> </u>	0	'I U	'I U	0	90. 04

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2018	Part
To 12/31/2018	Date/Time Prepared:
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			Ι'	0 12/31/2010	5/28/2019 4:1	
Cost Center Description	DIETARY	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	
	10.00	11 00	12.00	12.00	SUPPLY	
90. 05   09005   ANTI COAGULATI ON CLINI C	10.00	11. 00 6, 061	12.00	13.00	14. 00 145	90. 05
90. 05   09005 ANTICOAGULATION CLINIC 90. 06   09006   PREGNANCY PLUS		0,001	0	0	145	90.05
90. 07   09007   0/P LAB		0	0	0	0	90.08
90. 08   09008   0/P   LAB		0		0	0	1
		0	0	0	0	90. 08 90. 09
1 I		0	0	0	0	1
90. 10   09010   1030 S SCATTERFIELD (MEDCHECK) 90. 11   09011   DIABETIC PLUS CLINIC		7 024	0	0	_	90. 10
91. 00   09100   EMERGENCY	0 122	7, 834	0	0	72 404	90. 11 91. 00
	8, 123	92, 446	U	U	72, 406	91.00
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
94. 00 09400 HOME PROGRAM DI ALYSI S	O	0	0	0	0	94. 00
95. 00   09500   AMBULANCE   SERVI CES		0	0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0	0	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0		0	0	97. 00
99. 00 09900 CMHC		0	0	0	0	99.00
99. 10 09910 CORF		0	0	0	0	99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	o	0	0	0	_	100.00
101. 00 10100 HOME HEALTH AGENCY	0	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>					
105. 00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106. 00 10600 HEART ACQUISITION	o	0	0	0	0	106. 00
107.00 10700 LIVER ACQUISITION	o	0	0	0	0	107. 00
108.00 10800 LUNG ACQUISITION	o	0	0	0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 592, 190	1, 146, 045	0	2, 399, 643	3, 573, 706	118. 00
NONREI MBURSABLE COST CENTERS			_	_	_	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
190. 01 19001 WELLNESS CENTERS	0	7, 985	0	0		190. 01
190. 02 19002 EMPLOYED ORTHO MD	0	4 041	0	0		190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)	0	4, 841	0	0		190. 03
190. 04 19004 SUMMIT CONV. (LTC)		3, 410		0		190. 04 190. 05
190. 05 19005 PARKVI EW CONV. (LTC) 190. 06 19006 MONTI CELLO HSE.		4, 326	0	0		190. 05
190. 07 19007 NH PARK PLACE (LTC)		369		0		190. 00
190. 08 19008 MADISON PLACE OF ELWOOD (LTC)		0	0	0		190. 07
190. 09 19009 SPI NE SURGEON		0	0	0		190. 09
190. 10 19010 CLINI CAL RESEARCH CENTER	0	15, 429	0	0		190. 10
190. 11 19011 ONCOLOGI ST	0	0	0	0		190. 11
190. 12 19012 MEDI CAL I NTERNI ST	o	2, 529	Ö	0		190. 12
190. 13 19013 RHEUMATOLOGY	0	1, 237		0		190. 13
190. 14 19014 ROCK STEADY BOXING	o	2, 459		0		190. 14
191. 00 19100 RESEARCH	o	0	0	0	0	191. 00
192. 00 19200 PHYSICIANS' PRIVATE OFFICES	o	0	0	0		192. 00
192.01 19201 MUNCIE MD OFFICES	0	0	0	0	0	192. 01
192. 02 19202 FOUNDATI ON	0	2, 686	0	0	2	192. 02
192. 03 19203 SP0E	0	0	0	0	0	192. 03
192. 04 19204 HEALTHY HEART	0	4, 029	0	0		192. 04
192. 05 19205 VACANT SPACE	0	0	0	0		192. 05
192.07 19207 PARK PLACE CENTER	0	0	0	0		192. 07
192. 08 19208 RENTAL PROPERTY	0	0		0		192. 08
192.09 19209 RESIDENTIAL PROPERTY (1430 N MADISON	0	0	·	0		192. 09
192. 10 19210 HOSPI TAL RENTAL (1927 N MADI SON AVE)	0	0	0	0	0	192. 10
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0 500 400	1 105 0:5	0	-		201. 00
202.00   TOTAL (sum lines 118 through 201)	2, 592, 190	1, 195, 345	0	2, 399, 643	3, 575, 042	J202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part I
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				'	0 12/31/2010	5/28/2019 4:1	
	Cost Center Description	PHARMACY		SOCIAL SERVICE		NURSING SCHOOL	
			RECORDS &		ANESTHETI STS		
		15. 00	16. 00	17. 00	19. 00	20.00	
	GENERAL SERVICE COST CENTERS	15.00	10.00	17.00	17.00	20.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	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						10.00
11. 00 12. 00	01100   CAFETERI A   01200   MAI NTENANCE OF PERSONNEL						11. 00 12. 00
13. 00	01300 NURSING ADMINISTRATION						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY	3, 618, 774					15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	2, 610, 641				16. 00
17. 00	01700 SOCIAL SERVICE	0	0	) c	)		17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	(	0		19. 00
20. 00	02000 NURSI NG SCHOOL	0	0		)	0	
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0		)		21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	0	0		1		22. 00 23. 00
23. 00	02300 PARAMED ED PRGM-(EMS) INPATIENT ROUTINE SERVICE COST CENTERS	U U	0	1	<u>/</u>		23.00
30. 00	03000 ADULTS & PEDIATRICS	7	760, 767		) 0	0	30.00
31. 00	03100 I NTENSI VE CARE UNI T	36	9, 912	l .		Ö	1
32. 00	03200 CORONARY CARE UNIT	0	0		o o	Ö	
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	d	0	0	1
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	(	0	0	34.00
40.00	04000 SUBPROVI DER - I PF	0	0	) c	0	0	40. 00
41. 00	04100 SUBPROVI DER - I RF	0	0	(	0	0	41. 00
42.00	04200 SUBPROVI DER	0	0	C	0	0	
43. 00	04300 NURSERY	0	2, 478	C	0	0	
44. 00	04400 SKILLED NURSING FACILITY	0	0		0	0	1
45. 00	04500 NURSING FACILITY	0	0		0	0	1
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0	(	)  0		46. 00
50. 00	05000 OPERATI NG ROOM	O	503, 047		0	0	50.00
51. 00	05100 RECOVERY ROOM	o	0	d		Ō	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	· C	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	19, 626	0	(	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	831	66, 908	C	0	0	54. 00
54. 01	05401 ULTRASOUND	0	0	(	0	0	1
54. 02	05402 WOMEN' S CENTER	0	0		0	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	
56. 00	05600	46	0		0	0	
57. 00 58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	9	12, 390			0	1
59. 00	05900 CARDIAC CATHETERIZATION	10	12, 390 N			0	
60. 00	06000 LABORATORY		167, 269			0	1
60. 01	06001 BLOOD LABORATORY		0		o o	Ö	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(	0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	) c	0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0	(	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	0	(	0	0	1
66. 00	06600 PHYSI CAL THERAPY	94	0		0	0	
67. 00	06700 OCCUPATI ONAL THERAPY	3	0		0	0	
68.00	06800  SPEECH PATHOLOGY 06900  ELECTROCARDI OLOGY	10	0			0	1
69. 00 70. 00	07000 ELECTROCARDI OLOGY	10	11, 151	1		0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12	11, 131			0	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0		0	Ö	
73. 00	07300 DRUGS CHARGED TO PATIENTS	3, 596, 932	0	d	Ö	Ō	1
74.00	07400 RENAL DIALYSIS	0	0	· C	0	0	1
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	(	0	0	75. 00
	OUTPATIENT SERVICE COST CENTERS						1
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0	1
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	
90.00	09000 CLINIC	0	0	(	0	0	1
90. 01 90. 02	09001 WOUND/OSTOMY CLINIC 09002 KIDS PLUS CLINIC	200	505, 525			0 0	
7U. UZ		343	0			0	1
90 0s	109003L0NCOL0GY						
90. 03 90. 04	O9003   ONCOLOGY   O9004   MUNCI E CLI NI C	0	0		0	0	1

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0113

Peri od: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

5/28/2019 4:13 pm Cost Center Description **PHARMACY** MEDI CAL SOCIAL SERVICE NONPHYSICIAN NURSING SCHOOL ANESTHETI STS RECORDS & LI BRARY 15.00 17.00 19. 00 20.00 16.00 90. 05 09005 ANTI COAGULATION CLINIC 90 05 0 0 0 0 0 09006 PREGNANCY PLUS 0 90.06 0 0 0 90.06 09007 0/P LAB 0 90.07 90.07 0 90.08 09008 0/P LAB 0 0 90.08 0 09009 FORTVILLE CLINIC 0 0 90.09 0 C 0 90.09 09010 1030 S SCATTERFIELD (MEDCHECK) 0 o 90.10 90.10 0 90.11 09011 DIABETIC PLUS CLINIC 0 90. 11 230 0 91.00 09100 EMERGENCY 472,071 0 0 91 00 371 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 0 94.00 94.00 0 0 0 0 0 0 0 09500 AMBULANCE SERVICES 95.00 95.00 C 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 09900 CMHC 0 99.00 99.00 0 0 09910 CORF 0 99. 10 99. 10 C 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 0 0 105. 00 106. 00 10600 HEART ACQUISITION 0 0 0 106.00 0000 0 0 0 107. 00 10700 LIVER ACQUISITION 0 0 0 107.00 108.00 10800 LUNG ACQUISITION 0 0 108, 00 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 0 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 0 0 111.00 111.00 11100 I SLET ACQUISITION 0 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 ol 0 115.00 0 116. 00 11600 HOSPI CE 0 0 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 3, 618, 766 2, 511, 518 0 118.00 NONREI MBURSABLE COST CENTERS 190, 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 0 0 0 7 0 0 0 0 0 0 0 10 0 190, 00 0 0 190.01 190. 01 19001 WELLNESS CENTERS C 190. 02 19002 EMPLOYED ORTHO MD 0 0 0 190. 02 190. 03 19003 NORTHVI EW CONV. (LTC) 0 0 190. 03 0 190. 04 19004 SUMMIT CONV. (LTC) 0 0 0 190, 04 190. 05 19005 PARKVI EW CONV. (LTC) 0 0 0 190, 05 190. 06 19006 MONTI CELLO HSE. 0 190.06 190. 07 19007 NH PARK PLACE (LTC) 0 0 0 190. 07 190. 08 19008 MADISON PLACE OF ELWOOD (LTC) 0 0 190 08 Ω 190. 09 19009 SPI NE SURGEON 0 190. 09 190. 10 19010 CLINICAL RESEARCH CENTER 0 0 190. 10 190. 11 19011 ONCOLOGI ST 0 0 190. 11 0 0 190. 12 19012 MEDICAL INTERNIST 0 190. 12 Ω 190. 13 19013 RHEUMATOLOGY 0 0 0 190. 13 190. 14 19014 ROCK STEADY BOXING 0 190. 14 191. 00 19100 RESEARCH 0 0 191.00 C 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 192.00 99, 123 192. 01 19201 MUNCIE MD OFFICES 0 192. 01 192. 02 19202 FOUNDATION 0 0 192. 02 0 0 192. 03 19203 SP0E 0 192, 03 0 192. 04 19204 HEALTHY HEART 0 0 192. 04 192. 05 19205 VACANT SPACE 0 0 192. 05 0 192. 07 19207 PARK PLACE CENTER 0 0 192. 07 0 192. 08 19208 RENTAL PROPERTY 0 192. 08 192. 09 19209 RESIDENTIAL PROPERTY (1430 N MADISON 0 0 0 192. 09 192. 10 19210 HOSPITAL RENTAL (1927 N MADISON AVE) 0 0 192. 10 200.00 0 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 0 201.00 202.00 TOTAL (sum lines 118 through 201) 3, 618, 774 2, 610, 641 0 202. 00

Health Financial Systems

COMMUNITY HOSPITAL ANDERSON

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0113

Period:
From 01/01/2018
To 12/31/2018

Part I
Date/Time Prepared:
5/28/2019 4: 13 pm

				'	0 12/31/2018	5/28/2019 4:1	
		INTERNS &	RESI DENTS				
	Cost Center Description	SEDVI CES SALAD	SERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	
	Cost Center Description	Y & FRINGES	PRGM. COSTS	PRGM-(EMS)	Subtotal	Residents Cost	
				1110111 (2.110)		& Post	
						Stepdown	
		21.00	22.00	22.00	24.00	Adjustments	
	GENERAL SERVICE COST CENTERS	21. 00	22. 00	23. 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 ADMINISTRATIVE & GENERAL						5.00
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00 12. 00	01100   CAFETERI A   01200   MAI NTENANCE OF PERSONNEL						11. 00 12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY						16.00
17. 00 19. 00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS						17. 00 19. 00
20. 00	02000 NURSING SCHOOL						20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	15, 074					21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD		24, 114				22. 00
23. 00	02300 PARAMED ED PRGM-(EMS)			0			23. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	15, 074	24, 114	0	32, 455, 763	-39, 188	30.00
31. 00	03100 I NTENSI VE CARE UNI T	0	0				31.00
32.00	03200 CORONARY CARE UNIT	0	0	0			32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	C	0	33. 00
34.00	03400 SURGI CAL INTENSI VE CARE UNIT	0	0	0	C	0	34. 00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0	0	0	_	0	40. 00 41. 00
42. 00	04200 SUBPROVI DER	0	0	Ö	_		42. 00
43.00	04300 NURSERY	0	0	0	2, 264, 644	0	43. 00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	_	1	44.00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0			1	45. 00 46. 00
46.00	ANCI LLARY SERVICE COST CENTERS	0	U	0		<u>,                                    </u>	46.00
50.00	05000 OPERATI NG ROOM	0	0	0	14, 836, 571	0	50.00
51. 00	05100 RECOVERY ROOM	0	0				51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	_	1	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0	0   0		1	53. 00 54. 00
54. 01	05401 ULTRASOUND	0	0	Ö		l .	54. 01
54. 02	05402 WOMEN' S CENTER	0	0	0			54. 02
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0			0	55.00
56.00	05600	0	0	0			56.00
57. 00 58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	1, 098, 364 1, 192, 456		57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	Ö	Ö	2, 026, 275	1	59. 00
60.00	06000 LABORATORY	0	0	0	6, 476, 188	0	60. 00
60. 01	06001 BLOOD LABORATORY	0	0	0	C	0	60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	_	_	_	374, 517	) '  0	61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	374, 317	1	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0	Ö	Ö	C	o o	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	0	0	, ,		65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	0	3, 758, 314	1	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	744, 703 559, 315		67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0			1	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	O	Ö			70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0			71. 00
72.00	07200 DRUCS CHARGED TO PATIENTS	0	0	0		1	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS		0	0   0		1	73. 00 74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0			1	75. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0			1	1
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0			l .	
70.00	10,000 OEI III O	1	0	<u> </u>	1	,, 0	70.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0113

						То	12/31/2018	Date/Time Prep 5/28/2019 4:1:	
			INTERNS &	RESI DENTS				3/20/2019 4. 1.	э рііі
		Cost Center Description	SERVI CES-SALAR	SERVI CES_OTHER	PARAMED ED		Subtotal	Intern &	
		oost denter beserver on	Y & FRINGES	PRGM. COSTS	PRGM-(EMS)			Residents Cost	
								& Post Stepdown	
								Adj ustments	
90. 01	00001	WOUND/OSTOMY CLINIC	21.00	22. 00	23. 00	0	24. 00 1, 842, 457	25. 00 0	90. 01
		KIDS PLUS CLINIC	0	0		0	1, 842, 437	0	90. 01
		ONCOLOGY	0	0		0	6, 121, 206	0	90. 03
		MUNCIE CLINIC ANTICOAGULATION CLINIC	0	0		0	-15, 693 495, 725	0	90. 04 90. 05
90. 06	09006	PREGNANCY PLUS	Ö	0		Ö	0	0	90. 06
		O/P LAB O/P LAB	0	0		0	0	0	90. 07 90. 08
		FORTVILLE CLINIC	0	0		0	806	0	90. 09
		1030 S SCATTERFIELD (MEDCHECK)	0	0		0	0	0	90. 10
		DIABETIC PLUS CLINIC EMERGENCY	0	0		0	665, 861 7, 337, 700	0	90. 11 91. 00
92. 00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						0	92. 00
		REIMBURSABLE COST CENTERS HOME PROGRAM DIALYSIS	0	0	<u> </u>	0	0	0	94. 00
		AMBULANCE SERVICES	0	0		0	0	0	95. 00
		DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	0	96.00
	09700 09900	DURABLE MEDICAL EQUIP-SOLD	0	0		0	0	0	97. 00 99. 00
99. 10	09910	CORF	0	0		0	0	0	99. 10
		I&R SERVICES-NOT APPRVD PRGM HOME HEALTH AGENCY	0	0		0	0		100. 00 101. 00
		AL PURPOSE COST CENTERS				<u> </u>	<u> </u>	O	101.00
		KIDNEY ACQUISITION	0	_		0	0		105.00
		HEART ACQUISITION LIVER ACQUISITION	0	0		0	0		106. 00 107. 00
108.00	10800	LUNG ACQUISITION	0	0		0	0		108. 00
		PANCREAS ACQUISITION INTESTINAL ACQUISITION	0	0		0	0		109. 00 110. 00
		ISLET ACQUISITION	0	0		0	0		111. 00
		INTEREST EXPENSE							113.00
		UTILIZATION REVIEW-SNF AMBULATORY SURGICAL CENTER (D.P.)	0	0		0	0		114. 00 115. 00
116. 00		HOSPI CE				0	0		116. 00
118. 00	NONRE	SUBTOTALS (SUM OF LINES 1 through 117)   MBURSABLE COST CENTERS	15, 074	24, 114		0	139, 887, 914	-39, 188	118. 00
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	81, 942	0	190. 00
		WELLNESS CENTERS EMPLOYED ORTHO MD	0	0		0	896, 027		190. 01 190. 02
		NORTHVI EW CONV. (LTC)	0	0		0	596, 362		190. 02
		SUMMIT CONV. (LTC)	0	0		0	375, 052	-	190. 04
		PARKVIEW CONV. (LTC) MONTICELLO HSE.	0	0		0	465, 733 550, 848		190. 05 190. 06
190. 07	19007	NH PARK PLACE (LTC)	0	0		0	42, 728	0	190. 07
		MADISON PLACE OF ELWOOD (LTC) SPINE SURGEON	0	0		0	0		190. 08 190. 09
		CLINICAL RESEARCH CENTER	0	0		o	1, 242, 395		190. 09
		ONCOLOGI ST	0	0		0	0		190. 11
		MEDICAL INTERNIST RHEUMATOLOGY	0	0		0	167, 714 1, 200, 914		190. 12 190. 13
190. 14	19014	ROCK STEADY BOXING	0	0		0	285, 131	0	190. 14
		RESEARCH PHYSI CI ANS' PRI VATE OFFI CES	0	0		0	0 4, 472, 958		191. 00 192. 00
		MUNCIE MD OFFICES	0	0		0	412, 772		192. 01
		FOUNDATI ON	0	0		0	1, 162, 402		192. 02
192. 03 192. 04		SPOE HEALTHY HEART	0	0		0	0 453, 518		192. 03 192. 04
192.05	19205	VACANT SPACE	o o	0		0	41, 242	0	192. 05
		PARK PLACE CENTER RENTAL PROPERTY	0	0		0	8 119, 612		192. 07 192. 08
192. 09	19209	RESIDENTIAL PROPERTY (1430 N MADISON	0	0		0	93, 663	0	192. 09
	19210	HOSPITAL RENTAL (1927 N MADISON AVE)	0	0		0	109, 004		192. 10
200. 00 201. 00		Cross Foot Adjustments Negative Cost Centers	0	0		0	0	0	200. 00 201. 00
202. 00		TOTAL (sum lines 118 through 201)	15, 074	24, 114		0	152, 657, 939	-39, 188	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part I | To | 12/31/2018 | Date/Time Prepared: | 5/28/2019 4:13 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0113

			5/28/2019 4: 1	3 pm
	Cost Center Description	Total		
		26. 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			5. 00
6.00	00600 MAINTENANCE & REPAIRS			6. 00
7.00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9. 00	00900 HOUSEKEEPI NG			9. 00
10. 00	01000 DI ETARY			10.00
11. 00	01100 CAFETERI A			11.00
12. 00	01200 MAINTENANCE OF PERSONNEL			12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY			14. 00
15. 00	01500 PHARMACY			15. 00
16. 00				16. 00
	01600 MEDICAL RECORDS & LIBRARY			1
17.00	01700 SOCIAL SERVICE			17. 00
19.00	01900 NONPHYSI CLAN ANESTHETI STS			19.00
20.00	02000 NURSI NG SCHOOL			20.00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD			21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD			22. 00
23. 00	02300 PARAMED ED PRGM-(EMS)			23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDI ATRI CS	32, 416, 575		30.00
31. 00	03100 I NTENSI VE CARE UNI T	6, 542, 241		31. 00
32. 00	03200 CORONARY CARE UNIT	0		32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0		33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0		34. 00
40.00	04000 SUBPROVI DER - I PF	0		40.00
41.00	04100 SUBPROVI DER - I RF	0		41.00
42.00	04200 SUBPROVI DER	0		42.00
43.00	04300 NURSERY	2, 264, 644		43.00
44.00	04400 SKILLED NURSING FACILITY	o		44. 00
45.00	04500 NURSING FACILITY	o		45. 00
46.00	04600 OTHER LONG TERM CARE	o		46. 00
	ANCILLARY SERVICE COST CENTERS			
50.00		14, 836, 571		50.00
51. 00	05100 RECOVERY ROOM	O		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		52. 00
53. 00	05300 ANESTHESI OLOGY	321, 719		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 432, 337		54.00
54. 01	05401 ULTRASOUND	532, 961		54. 01
54. 02	05402 WOMEN' S CENTER	595, 285		54. 02
55. 00	05500 RADI OLOGY-THERAPEUTI C	0		55. 00
56. 00	05600 RADI OI SOTOPE	1, 129, 116		56. 00
57. 00	05700 CT SCAN	1, 098, 364		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 192, 456		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 026, 275		59. 00
60. 00	06000 LABORATORY	6, 476, 188		60.00
60. 01	06001 BLOOD LABORATORY	0,470,100		60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	374, 517		62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	374, 317		63. 00
64. 00	06400 I NTRAVENOUS THERAPY			64. 00
65. 00	06500 RESPIRATORY THERAPY	2, 064, 262		65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 758, 314		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	744, 703		67. 00
68.00	06800 SPEECH PATHOLOGY	1		68.00
		559, 315		1
69. 00 70. 00	06900 ELECTROCARDI OLOGY	932, 695 1, 183, 518		69. 00 70. 00
	07000 ELECTROENCEPHALOGRAPHY	1 1		1
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	16, 125, 292		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	10, 206, 877		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	12, 152, 266		73. 00
74.00	07400 RENAL DIALYSIS	434, 173		74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0		75. 00
00	OUTPATIENT SERVICE COST CENTERS			00.5-
88. 00		0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		89. 00
90.00	09000 CLI NI C	0		90.00
90. 01	09001 WOUND/OSTOMY CLINIC	1, 842, 457		90. 01
90. 02	09002 KIDS PLUS CLINIC	0		90. 02
90. 03	09003 ONCOLOGY	6, 121, 206		90. 03
90. 04	09004 MUNCIE CLINIC	-15, 693		90. 04
90. 05	09005 ANTI COAGULATION CLINIC	495, 725		90. 05
90.06	09006 PREGNANCY PLUS	0		90.06

Health Financial Systems COMMUNITY HOSPITAL ANDERSON In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0113 Period: Worksheet B

From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/28/2019 4:13 pm Cost Center Description Total 26. 00 90. 07 09007 0/P LAB 0 90. 07 90. 08 09008 0/P LAB 0 90.08 90. 09 09009 FORTVILLE CLINIC 806 90.09 09010 1030 S SCATTERFIELD (MEDCHECK) 90. 10 90.10 0 09011 DIABETIC PLUS CLINIC 90 11 665, 861 90 11 91.00 09100 EMERGENCY 7, 337, 700 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 94.00 0 0 95.00 09500 AMBULANCE SERVICES 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 99.00 09900 CMHC 99.00 99. 10 09910 CORF 99. 10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 105.00 106.00 10600 HEART ACQUISITION 0 0 0 106. 00 107. 00 10700 LIVER ACQUISITION 107.00 108.00 10800 LUNG ACQUISITION 108.00 109. 00 10900 PANCREAS ACQUISITION 109. 00 0 110.00 11000 INTESTINAL ACQUISITION 110.00 111.00 11100 | SLET ACQUISITION 0 111. 00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115. 00 116. 00 11600 HOSPI CE 0 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 139, 848, 726 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 81 942 190.00 190. 01 19001 WELLNESS CENTERS 896, 027 190.01 190. 02 19002 EMPLOYED ORTHO MD 190.02 190. 03 19003 NORTHVI EW CONV. (LTC) 596, 362 190. 03 190. 04 19004 SUMMIT CONV. (LTC) 375, 052 190. 04 190. 05 19005 PARKVI EW CONV. (LTC) 465, 733 190.05 190. 06 19006 MONTI CELLO HSE. 550, 848 190.06 190. 07 19007 NH PARK PLACE (LTC) 190. 07 42,728 190. 08 19008 MADI SON PLACE OF ELWOOD (LTC) 0 190.08 190. 09 19009 SPI NE SURGEON 0 190.09 190. 10 19010 CLINI CAL RESEARCH CENTER 1, 242, 395 190. 10 190. 11 19011 ONCOLOGI ST 190. 11 190. 12 19012 MEDICAL INTERNIST 167, 714 190. 12 190. 13 19013 RHEUMATOLOGY 1, 200, 914 190. 13 190. 14 19014 ROCK STEADY BOXING 285, 131 190. 14 191. 00 19100 RESEARCH 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 4, 472, 958 192. 00 192. 01 19201 MUNCIE MD OFFICES 412, 772 192.01 192. 02 19202 FOUNDATION 192. 02 1, 162, 402 192. 03 19203 SP0E 192. 03 192. 04 19204 HEALTHY HEART 453, 518 192. 04 192. 05 19205 VACANT SPACE 192. 05 41, 242 192. 07 192. 07 19207 PARK PLACE CENTER 192. 08 19208 RENTAL PROPERTY 119, 612 192. 08 192.09 19209 RESIDENTIAL PROPERTY (1430 N MADISON 93,663 192. 09 192. 10 19210 HOSPITAL RENTAL (1927 N MADISON AVE) 192. 10 109,004 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 201.00 202.00 TOTAL (sum lines 118 through 201) 152, 618, 751 202.00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2018 | Part II |
| To | 12/31/2018 | Date/Time Prepared: | 5/28/2019 4:13 pm | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0113

					12/31/2018	5/28/2019 4:1	
			CAPI TAL REI	LATED COSTS		10,20,20.7	, p
			DI DO 4 ELVE	1000 5 5000 5		5454 0V55	
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New Capital				BENEFITS DEPARTMENT	
		Related Costs				DEFARTMENT	
		0	1.00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P		21 001	11 1/0	42.042	42.042	2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	0	31, 881 493, 314	· ·	43, 043 1, 207, 369	43, 043 7, 290	4. 00 5. 00
6. 00	00600 MAI NTENANCE & REPAI RS	0	473, 314	714,033	1, 207, 307	7, 270	6. 00
7. 00	00700 OPERATION OF PLANT	o o	598, 143	300, 385	898, 528	1, 508	1
8.00	00800 LAUNDRY & LINEN SERVICE	0	67, 057		67, 057	46	8. 00
9.00	00900 HOUSEKEEPI NG	0	139, 947	10, 275	150, 222	955	9. 00
10. 00	01000 DI ETARY	0	208, 962	·	350, 663	464	10.00
11.00	01100 CAFETERIA	0	39, 556	0	39, 556	522	11.00
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	0	E1 E70	237	51, 809	0	12.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	51, 572 98, 473		104, 040	817 660	13. 00 14. 00
15. 00	01500 PHARMACY	0	62, 154		67, 460	1, 281	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	78, 801		78, 801	800	1
17.00	01700 SOCIAL SERVICE	0	0	0	o	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21. 00 22. 00	02100   1 & R SERVI CES-SALARY & FRINGES APPRVD   02200   1 & R SERVI CES-OTHER PRGM. COSTS APPRVD	0	0		0	0	21.00
23. 00	02300 PARAMED ED PRGM-(EMS)	0	0	1	0	0	
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0	,	<u> </u>	0	23.00
30.00	03000 ADULTS & PEDIATRICS	0	1, 007, 324	237, 157	1, 244, 481	8, 919	30.00
31.00	03100 INTENSIVE CARE UNIT	0	134, 036	160, 751	294, 787	1, 949	31. 00
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0		0	0	34. 00 40. 00
41. 00	04100 SUBPROVIDER - I RF	0	0		0	0	41. 00
42. 00	04200 SUBPROVI DER	0	Ö		ő	0	42. 00
43. 00	04300 NURSERY	0	36, 242	583	36, 825	725	1
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
45. 00	04500 NURSING FACILITY	0	0	0	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	429, 338	1, 466, 223	1, 895, 561	3, 280	50.00
51. 00	05100 RECOVERY ROOM	0	427, 330	1	0	0, 200	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	o	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	5, 272		13, 087	508	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	373, 735		609, 434	1, 124	
54. 01	05401 ULTRASOUND	0	0	56, 533	56, 533	187	54. 01
54. 02 55. 00	05402 WOMEN' S CENTER   05500 RADI OLOGY-THERAPEUTI C	0	0	12, 482	12, 482 0	225 0	1
56. 00	05600 RADI OI SOTOPE	0	28, 741	٦	37, 314	161	
57. 00	05700 CT SCAN	0	8, 721		9, 060	307	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	18, 140	17, 126	35, 266	216	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	72, 677		273, 408	562	
60.00	06000 LABORATORY	0	151, 711	1	367, 319	1, 394	
60. 01 61. 00	O6001   BLOOD LABORATORY   O6100   PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0	0	60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	11, 338	2, 272	13, 610	127	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	1	0	0	1
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	o	0	1
65. 00	06500 RESPI RATORY THERAPY	0	9, 574	44, 502	54, 076	790	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	52, 037		54, 891	1, 377	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	47, 793		47, 793	227	67.00
68. 00	06800 SPEECH PATHOLOGY	0	39, 556		39, 556	154	68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	29, 710 39, 168	·	64, 200 68, 184	269 332	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	27,010	00, 104	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	Ö	Ö	ol ol	ő	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	o	0	1
74. 00	07400 RENAL DIALYSIS	0	3, 644		3, 644	0	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC	0	0		ما	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	n		ol Ol	0	
90. 00	09000 CLI NI C	0	0	o	o	0	1
90. 01	09001 WOUND/OSTOMY CLINIC	0	197, 353	5, 010	202, 363	227	90. 01
		_	_		_		

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Ti Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0113

					10	12/31/2018	Date/IIme Pre    5/28/2019 4:13	
				CAPI TAL REI	LATED COSTS			,
		Cook Cooks December	D:+1	DIDC & FLVT	MVDLE FOLLID	Culatatal	EMDL OVEE	
		Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs					
90. 02	00000	KIDS PLUS CLINIC	0	1.00	2.00	2A 0	4. 00	90. 02
90. 02	1	ONCOLOGY	0	332, 707		1, 082, 905	1, 075	
90. 04		MUNCIE CLINIC	0	0	0	0	0	90. 04
90. 05		ANTICOAGULATION CLINIC	0	0	2, 657	2, 657	188	90. 05
90.06		PREGNANCY PLUS	0	0		0	0	90.06
90. 07 90. 08		O/P LAB O/P LAB	0	1 0		0	0	90. 07 90. 08
90. 09		FORTVILLE CLINIC	Ö	Ö	Ö	Ö	0	90. 09
90. 10		1030 S SCATTERFIELD (MEDCHECK)	0	0	0	0	0	90. 10
90. 11		DI ABETI C PLUS CLI NI C	0	0		334	256	90. 11
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	U	151, 769 	126, 059	277, 828 0	2, 316	91. 00 92. 00
72.00		REIMBURSABLE COST CENTERS				<u> </u>		72.00
94. 00		HOME PROGRAM DIALYSIS	0	0		0	0	94. 00
95. 00	1	AMBULANCE SERVI CES	0	0	0	0	0	95. 00
96. 00 97. 00		DURABLE MEDICAL EQUIP-RENTED DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	96. 00 97. 00
99. 00	09900		o	0	Ö	o	0	99. 00
99. 10	09910		0	0	O	O	0	99. 10
		I &R SERVICES-NOT APPRVD PRGM	0	0	- 1	0		100.00
101.00		HOME HEALTH AGENCY AL PURPOSE COST CENTERS	0	0	0	0	0	101. 00
105.00		KIDNEY ACQUISITION	0	0	O	O	0	105. 00
106.00	10600	HEART ACQUISITION	0	0	O	O	0	106. 00
		LIVER ACQUISITION	0	0	0	0		107. 00
		LUNG ACQUISITION PANCREAS ACQUISITION	0	0	0	0		108. 00 109. 00
		INTESTINAL ACQUISITION	0			o		110.00
		ISLET ACQUISITION	0	0	0	0		111. 00
	1	I NTEREST EXPENSE						113. 00
	1	UTILIZATION REVIEW-SNF AMBULATORY SURGICAL CENTER (D.P.)	0	,		0		114. 00 115. 00
		HOSPICE	0	0		0		116. 00
118.00	1	SUBTOTALS (SUM OF LINES 1 through 117)	0	5, 050, 446	4, 805, 700	9, 856, 146	41, 238	
400.00		I MBURSABLE COST CENTERS	ا	00.070		00.070		400.00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN WELLNESS CENTERS	0	23, 373 23, 780		23, 373 23, 780		190. 00 190. 01
		EMPLOYED ORTHO MD	0	23, 780	1	23, 780		190. 01
	1	NORTHVIEW CONV. (LTC)	0	17, 772	0	17, 772		190. 03
		SUMMIT CONV. (LTC)	0	17, 772	1	17, 772		190. 04
	1	PARKVIEW CONV. (LTC) MONTICELLO HSE.	0	17, 772 85, 604		17, 772 85, 604		190. 05 190. 06
		NH PARK PLACE (LTC)	0	03,004	l	05, 004		190. 00
190. 08	19008	MADISON PLACE OF ELWOOD (LTC)	0	0		O		190. 08
	1	SPI NE SURGEON	0		0	0		190. 09
		CLINICAL RESEARCH CENTER ONCOLOGIST	0	40, 157	1, 993	42, 150		190. 10 190. 11
	1	MEDICAL INTERNIST	0	0		o		190. 11
190. 13	19013	RHEUMATOLOGY	0	0	2, 404	2, 404		190. 13
		ROCK STEADY BOXING	0	34, 556	0	34, 556		190. 14
		RESEARCH PHYSI CI ANS' PRI VATE OFFI CES	0	0 359, 491	0 7, 519	247 010		191. 00 192. 00
	1	MUNCIE MD OFFICES	0	111, 341	1	367, 010 111, 341		192. 00
		FOUNDATION	0	6, 899		6, 899		192. 02
192. 03			0	0	_ 0	0		192. 03
		HEALTHY HEART VACANT SPACE	0	0 11, 764	559	559 11, 764		192. 04 192. 05
		PARK PLACE CENTER		11, 704	0	11, 764 0		192. 05 192. 07
		RENTAL PROPERTY	0	28, 218	o	28, 218	0	192. 08
		RESIDENTIAL PROPERTY (1430 N MADISON	0	24, 226	0	24, 226		192. 09
192. 10 200. 00		HOSPITAL RENTAL (1927 N MADISON AVE)	이	31, 009	0	31, 009	0	192. 10 200. 00
200.00	1	Cross Foot Adjustments Negative Cost Centers		<u> </u>	n	0	0	200. 00 201. 00
202.00	1	TOTAL (sum lines 118 through 201)	o	5, 884, 180	4, 818, 175	10, 702, 355	43, 043	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0113

Peri od: Worksheet B From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared:

5/28/2019 4:13 pm Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL **REPAIRS PLANT** LINEN SERVICE 9.00 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 1, 214, 659 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 87, 552 987, 588 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 2, 691 0 13, 910 83.704 8.00 00900 HOUSEKEEPI NG 29, 031 203, 896 9.00 22, 428 0 1, 260 9 00 3, 644 10.00 01000 DI ETARY 16, 287 43, 347 986 10.00 11.00 01100 CAFETERI A 8,783 8, 205 0 Ω 11.00 01200 MAINTENANCE OF PERSONNEL C 12 00 12 00 Ω 0 0 13.00 01300 NURSING ADMINISTRATION 17, 895 10,698 0 804 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 26,098 20, 427 117 1, 330 14.00 01500 PHARMACY 15.00 27, 186 12.893 755 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 19,007 16, 347 279 16.00 17.00 01700 SOCIAL SERVICE C 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 19 00 0 0 0 19.00 0 02000 NURSING SCHOOL 20.00 0 0 20.00 0 0 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 21.00 120 0 0 0 21.00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 22.00 192 0 22.00 23.00 02300 PARAMED ED PRGM-(EMS) 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 190, 729 0 208.958 35, 674 57, 614 30.00 31.00 03100 INTENSIVE CARE UNIT 41, 698 0 27, 804 5,504 10,669 31.00 03200 CORONARY CARE UNIT 32.00 32.00 0 03300 BURN INTENSIVE CARE UNIT 33.00 0 0 0 0 Λ 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 C 0 0 0 34.00 04000 SUBPROVI DER - I PF 0 40.00 0 0 0 40.00 0 04100 SUBPROVIDER - IRF 0 0 0 41.00 0 41.00 04200 SUBPROVI DER 42.00 0 C  $\cap$ Λ 42.00 43.00 04300 NURSERY 16, 248 7,518 0 591 43.00 04400 SKILLED NURSING FACILITY 0 44.00 0 0 0 44.00 0 45 00 04500 NURSING FACILITY 0 Ω 0 0 45 00 0 04600 OTHER LONG TERM CARE 46.00 0 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 92.634 0 89,062 19, 200 21, 880 50.00 05100 RECOVERY ROOM C 51.00 Λ 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 0 0 0 52.00 05300 ANESTHESI OLOGY 53.00 2, 250 0 1,094 0 53.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 35 009 Ω 77, 528 3 481 2 528 54 00 05401 ULTRASOUND 54.01 4, 195 C C 0 54.01 05402 WOMEN'S CENTER 1,053 54.02 4,622 0 54.02 55.00 05500 RADI OLOGY-THERAPEUTI C 0 C 0 55.00 05600 RADI 0I SOTOPE 5, 962 8 321 Ω 558 56 00 443 56.00 57.00 05700 CT SCAN 8, 387 1,809 0 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 8, 932 3.763 0 427 58.00 05900 CARDIAC CATHETERIZATION 14, 586 279 59.00 15.076 417 59.00 06000 LABORATORY 60.00 46,660 Ω 31, 471 0 1, 362 60.00 60.01 06001 BLOOD LABORATORY C C 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 2,701 0 279 62.00 2, 352 0 63 00 06300 BLOOD STORING, PROCESSING & TRANS C 0 0 63.00 06400 I NTRAVENOUS THERAPY 0 64.00 0 64.00 65.00 06500 RESPIRATORY THERAPY 15, 896 1, 986 0 722 65.00 06600 PHYSI CAL THERAPY 10. 795 66,00 28.503 0 216 328 66,00 06700 OCCUPATI ONAL THERAPY 67.00 4.965 9, 914 0 246 67.00 06800 SPEECH PATHOLOGY 8, 205 0 148 68.00 3,666 68.00 06900 ELECTROCARDI OLOGY 69.00 6,708 722 69.00 6. 163 246 70.00 07000 ELECTROENCEPHALOGRAPHY 8.359 8, 125 643 968 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 115, 758 C 0 0 71.00 C 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73, 270 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 68, 068 73.00 0 0 0 0 73.00 74.00 07400 RENAL DIALYSIS 3, 383 0 756 0 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 0 0 0 75.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 C 0 0 0 89.00 09000 CLI NI C 90.00 0 0 C 90.00 90.01 09001 WOUND/OSTOMY CLINIC 6.457 0 40, 939 869 2, 347 90.01 09002 KIDS PLUS CLINIC 90.02 90 02 C 0 90.03 09003 ONCOLOGY 0 69,017 878 0 90.03 42, 110 09004 MUNCIE CLINIC 90.04 0 0 90.04 09005 ANTI COAGULATION CLINIC 3.895 0 0 90.05 90.05 0

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Ti

			10	0 12/31/2018	5/28/2019 4:1	
Cost Center Description	ADMI NI STRATI VE N	IAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	J piii
oost conten beser per on	& GENERAL	REPAI RS	PLANT	LINEN SERVICE	HOOSEKEELTING	
	5. 00	6.00	7. 00	8. 00	9. 00	
90. 06 09006 PREGNANCY PLUS	0	0	0	0	0	90. 06
90. 07 09007 0/P LAB	o	ol	0	0	0	90. 07
90. 08 09008 0/P LAB	0	0	0	0	0	90. 08
90. 09   09009   FORTVI LLE CLI NI C	6	0	0	0	٥	90.09
90. 10 09010 1030 S SCATTERFIELD (MEDCHECK)		0	0	0	o o	90. 10
90. 11   09011   DI ABETI C PLUS CLINI C	5, 221	0	0	256	_	90. 11
91. 00 09100 EMERGENCY	48, 958	0	31, 483	11, 959		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	40, 730	ď	31, 403	11, 757	7,010	92.00
OTHER REIMBURSABLE COST CENTERS						92.00
		O	0		0	04.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	-	0	0	_	94.00
95. 00 09500 AMBULANCE SERVI CES	0	0	0	0	0	95. 00
96. 00   09600   DURABLE MEDI CAL EQUI P-RENTED	0	0	0	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	O	0	0	0	97. 00
99. 00  09900 CMHC	0	0	0	0	0	99. 00
99. 10  09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106.00 10600 HEART ACQUISITION	0	0	0	0	0	106. 00
107.00 10700 LIVER ACQUISITION	0	o	0	0	0	107. 00
108.00 10800 LUNG ACQUISITION	o	o	0	0	0	108. 00
109. 00 10900 PANCREAS ACQUISITION	o	o	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	o	o	0	0	l .	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111. 00
113. 00 11300   NTEREST EXPENSE	1	]	_	_		113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P. )		0	0	0	1	115. 00
116. 00 11600 HOSPI CE		ő	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 140, 434	o	814, 638	83, 678		•
NONREI MBURSABLE COST CENTERS	1, 140, 434	<u> </u>	014, 030	03, 070	113, 020	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	222	ol	4, 848	0	0	190. 00
190. 01 19001 WELLNESS CENTERS	6, 444	0	4, 933	0		190. 00
190. 02 19002 EMPLOYED ORTHO MD	0,444	0	4, 733	0		190. 01
	4 277	o o	2 (07	0		•
190. 03 19003 NORTHVI EW CONV. (LTC)	4, 377	U	3, 687	0		190. 03
190. 04 19004 SUMMIT CONV. (LTC)	2, 630	0	3, 687	0		190. 04
190. 05 19005 PARKVI EW CONV. (LTC)	3, 344	0	3, 687	0		190. 05
190. 06 19006 MONTI CELLO HSE.	2, 808	0	17, 758	0		190. 06
190.07 19007 NH PARK PLACE (LTC)	337	0	0	0		190. 07
190.08 19008 MADISON PLACE OF ELWOOD (LTC)	0	0	0	0		190. 08
190. 09 19009 SPI NE SURGEON	0	0	0	0		190. 09
190. 10 19010 CLI NI CAL RESEARCH CENTER	9, 023	0	8, 330	0	0	190. 10
190. 11 19011 ONCOLOGI ST	0	0	0	0	0	190. 11
190. 12 19012 MEDI CAL I NTERNI ST	1, 314	0	0	0	0	190. 12
190. 13 19013 RHEUMATOLOGY	9, 545	0	0	0	0	190. 13
190. 14 19014 ROCK STEADY BOXING	1, 613	0	7, 168	0	0	190. 14
191. 00 19100 RESEARCH	o	o	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	17, 520	ol	74, 573	0	86, 782	192. 00
192. 01 19201 MUNCIE MD OFFICES	1, 237	o	23, 097	0	0	192. 01
192. 02 19202 FOUNDATI ON	9, 100	0	1, 431	0		192. 02
192. 03 19203 SP0E	0	o	.,	0		192. 03
192. 04 19204 HEALTHY HEART	3, 569	o	0	26		192. 04
192. 05 19205 VACANT SPACE	112	Ö	2, 440	0		192. 05
192. 07 19207 PARK PLACE CENTER	0	Ö	2, 440	0		192. 07
192. 08 19208 RENTAL PROPERTY	433	0	5, 854	0		192. 07
192.09 19208 RENTAL PROPERTY 192.09 19209 RESIDENTIAL PROPERTY (1430 N MADISON	300	0	5, 854 5, 025	0		192. 08
	297	ol ol		0		192. 09
192. 10 19210 HOSPI TAL RENTAL (1927 N MADI SON AVE)	297	٩	6, 432	0		
200.00 Cross Foot Adjustments		٦		^	_	200. 00
201.00 Negative Cost Centers	0	0	007.500	00 70:		201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 214, 659	이	987, 588	83, 704	203, 896	J2U2. UU

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Ti

				'	0 12/31/2018	Date/lime Pre 5/28/2019 4:1	
Cost Center Descrip	otion	DI ETARY	CAFETERI A	MAINTENANCE OF		CENTRAL	J J I
				PERSONNEL	ADMI NI STRATI ON	SERVICES &	
		10.00	11.00	12. 00	13.00	SUPPLY 14.00	
GENERAL SERVICE COST CENT	TERS				10.00		
1.00 00100 CAP REL COSTS-BLDG							1. 00
2. 00 00200 CAP REL COSTS-MVBLE							2. 00
4.00 00400 EMPLOYEE BENEFITS D							4. 00
5. 00   00500   ADMINISTRATIVE & GE							5. 00
6.00   00600   MAI NTENANCE & REPAI 7.00   00700   OPERATION OF PLANT	KS						6. 00 7. 00
8.00   00800   LAUNDRY & LINEN SER	VI CE			•			8. 00
9. 00   00900   HOUSEKEEPI NG	WIGE						9. 00
10. 00 01000 DI ETARY		415, 391					10. 00
11. 00   01100   CAFETERI A		0	57, 066				11. 00
12.00 01200 MAINTENANCE OF PERS	ONNEL	O	0	c			12.00
13.00 01300 NURSING ADMINISTRAT		0	896	1	82, 919		13.00
14. 00   01400   CENTRAL SERVICES &	SUPPLY	0	2, 196	1	´	154, 868	14.00
15. 00   01500   PHARMACY	LDDADV	0	1, 739	1	´I	436	15. 00
16. 00   01600   MEDI CAL RECORDS & L 17. 00   01700   SOCI AL SERVI CE	I BRARY	0	1, 669			15 0	16. 00 17. 00
19. 00 01900 NONPHYSICIAN ANESTH	IFTI STS		0			0	17.00
20. 00   02000   NURSI NG SCHOOL	1211010		0		ol ol	0	20. 00
21. 00   02100   L&R SERVICES-SALARY	& FRINGES APPRVD	o	1		o	0	21. 00
22. 00   02200   1 &R SERVI CES-OTHER	PRGM. COSTS APPRVD	O	0	c	o	0	22. 00
23. 00 02300 PARAMED ED PRGM-(EM		0	0	C	0	0	23. 00
INPATIENT ROUTINE SERVICE							
30. 00   03000   ADULTS & PEDI ATRI CS		360, 532	16, 544	l .		8, 592	30.00
31. 00   03100   INTENSIVE CARE UNIT 32. 00   03200   CORONARY CARE UNIT		53, 500	3, 593	C	10, 916	2, 571 0	31.00
32. 00   03200   CORONARY CARE UNIT 33. 00   03300   BURN INTENSIVE CARE	LINIT		0			0	32. 00 33. 00
34. 00 03400 SURGI CAL INTENSI VE			0			0	34. 00
40. 00   04000   SUBPROVI DER - I PF	OF INCE OF IT		0		ol ol	0	40. 00
41. 00   04100   SUBPROVI DER - I RF		O	0	d	o	0	41. 00
42. 00   04200   SUBPROVI DER		O	0	ol c	o	0	42.00
43. 00   04300 NURSERY		0	1, 167	C	3, 547	0	43.00
44.00   04400   SKILLED NURSING FAC	CLLITY	0	0	C	0	0	44. 00
45. 00   04500   NURSI NG FACILITY	. F	0	0	C	1	0	45. 00
46. 00 04600 OTHER LONG TERM CAR ANCI LLARY SERVICE COST CE		0	0	<u> </u> C	)  0	0	46. 00
50. 00 05000 OPERATI NG ROOM	INTERS	57	5, 989	· C	18, 196	25, 758	50. 00
51. 00   05100   RECOVERY ROOM		o	0,707	1		0	51. 00
52.00 05200 DELIVERY ROOM & LAB	OR ROOM	O	0	d	o	0	52.00
53. 00 05300 ANESTHESI OLOGY		O	326	c	o	12	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI	C	0	1, 834	C	0	111	54.00
54. 01   05401   ULTRASOUND		0	251	0	0	19	54. 01
54. 02   05402   WOMEN' S CENTER	1.0	0	364		0	23	54. 02
55. 00   05500   RADI OLOGY-THERAPEUT   56. 00   05600   RADI OI SOTOPE	TC .	0	223			0 37	55. 00 56. 00
57. 00 05700 CT SCAN			519			573	57. 00
58. 00 05800 MAGNETI C RESONANCE	IMAGING (MRI)		399		ol ol	24	
59. 00 05900 CARDI AC CATHETERI ZA		O	870		o	0	59. 00
60. 00   06000   LABORATORY		O	3, 079	c	o	353	60.00
60. 01 06001 BLOOD LABORATORY		0	0	) c	0	0	60. 01
61. 00 06100 PBP CLINICAL LAB SE			0.4.5				61.00
62. 00   06200   WHOLE BLOOD & PACKE		0	215			1	62.00
63. 00   06300   BLOOD STORING, PROC 64. 00   06400   I NTRAVENOUS THERAPY		0	0			0	63. 00 64. 00
65. 00   06500   RESPI RATORY   THERAPY			1, 505			64	65. 00
66. 00   06600   PHYSI CAL THERAPY			2, 296			47	66. 00
67. 00 06700 OCCUPATIONAL THERAP	Υ	o	301		ol ol	3	67. 00
68.00 06800 SPEECH PATHOLOGY		0	227	1	o	1	68. 00
69. 00 06900 ELECTROCARDI OLOGY		O	547	C	o	59	69. 00
70. 00 07000 ELECTROENCEPHALOGRA		0	566	c	0	23	70. 00
71. 00 07100 MEDICAL SUPPLIES CH		0	0	C	0	68, 276	71. 00
72. 00   07200   IMPL. DEV. CHARGED		0	0		0	43, 216	72.00
73. 00   07300   DRUGS CHARGED TO PA 74. 00   07400   RENAL DI ALYSI S	MILENIS	0	0			0 22	73.00
74.00 07400 RENAL DIALYSIS 75.00 07500 ASC (NON-DISTINCT P	ADT)		0			0	74. 00 75. 00
OUTPATIENT SERVICE COST O		ı U	0	ı	, 0	0	73.00
88. 00 08800 RURAL HEALTH CLINIC		ol	0	l c	ol	0	88. 00
89.00 08900 FEDERALLY QUALIFIED		o	0	d	ol ol	0	89. 00
90. 00  09000   CLI NI C		0	0	C	o  o	0	90. 00
90. 01 09001 WOUND/OSTOMY CLINIC		0	370	C	0	862	90. 01
90. 02   09002 KIDS PLUS CLINIC		0	0	<u> </u>		0	90. 02
90. 03   09003   0NCOLOGY			1, 950	1	<u>]</u>	567	90. 03
90. 04  09004 MUNCIE CLINIC		0	0	<u> </u> C	기 이	0	90. 04

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0113

Peri od: Worksheet B From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared:

5/28/2019 4:13 pm Cost Center Description DI ETARY CAFETERI A MAINTENANCE OF NURSI NG CENTRAL PERSONNEL ADMI NI STRATI ON SERVICES & SUPPLY 10.00 11.00 12.00 13.00 14.00 90. 05 09005 ANTI COAGULATION CLINIC 289 90 05 0 0 09006 PREGNANCY PLUS 0 0 90.06 0 0 0 90.06 09007 0/P LAB 0 90.07 90.07 0 90.08 09008 0/P LAB 0 0 90.08 0 09009 FORTVILLE CLINIC 0 0 90.09 0 C 0 90.09 09010 1030 S SCATTERFIELD (MEDCHECK) 0 0 o 90.10 90.10 09011 DIABETIC PLUS CLINIC 90.11 0 374 0 0 90. 11 91.00 09100 EMERGENCY 0 91 00 1.302 4, 413 0 3.136 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 0 94.00 0 0 94.00 0 0 0 0 0 0 09500 AMBULANCE SERVICES 95.00 95.00 C 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 09900 CMHC 0 99.00 99.00 0 0 09910 CORF 0 99. 10 99. 10 C 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 0 0 105. 00 106. 00 10600 HEART ACQUISITION 0 0 0 106.00 0000 0 0 0 107. 00 10700 LIVER ACQUISITION 0 0 0 107.00 108.00 10800 LUNG ACQUISITION 0 0 0 108, 00 109.00 10900 PANCREAS ACQUISITION 0 0 0 109.00 0 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 0 111.00 11100 I SLET ACQUISITION C 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 115.00 0 116. 00 11600 HOSPI CE 0 116.00 0 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 415, 391 54, 712 0 82, 919 154, 810 118. 00 NONREI MBURSABLE COST CENTERS 0 190, 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN 00000000000000000000000000 0 0 190, 00 190. 01 19001 WELLNESS CENTERS 0 1 190. 01 381 0 190. 02 19002 EMPLOYED ORTHO MD 0 190. 02 190. 03 19003 NORTHVI EW CONV. (LTC) 0 231 12 190. 03 190. 04 19004 SUMMIT CONV. (LTC) 0 0 190, 04 163 0 190. 05 19005 PARKVI EW CONV. (LTC) 207 0 190, 05 190. 06 19006 MONTI CELLO HSE. 0 190.06 190. 07 19007 NH PARK PLACE (LTC) 18 0 0 190. 07 190. 08 19008 MADISON PLACE OF ELWOOD (LTC) 0 0 190 08 C 190. 09 19009 SPI NE SURGEON 0 190. 09 190. 10 19010 CLINICAL RESEARCH CENTER 737 0 0 190. 10 190. 11 19011 ONCOLOGI ST 0 0 190. 11 0 190. 12 19012 MEDICAL INTERNIST 4 190 12 121 190. 13 19013 RHEUMATOLOGY 59 0 0 190. 13 190. 14 19014 ROCK STEADY BOXING 117 1 190. 14 191. 00 19100 RESEARCH 0 0 191.00 C 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 7 192.00 C 192. 01 19201 MUNCIE MD OFFICES 0 192. 01 192. 02 19202 FOUNDATION 0 128 0 192. 02 0 192. 03 19203 SP0E 0 192, 03 C 192. 04 19204 HEALTHY HEART 192 33 192. 04 192. 05 19205 VACANT SPACE C 0 0 192. 05 192. 07 19207 PARK PLACE CENTER 0 0 192. 07 0 ő 192. 08 19208 RENTAL PROPERTY Ω 0 192. 08 192. 09 19209 RESIDENTIAL PROPERTY (1430 N MADISON 0 0 0 0 192. 09 192. 10 19210 HOSPITAL RENTAL (1927 N MADISON AVE) 0 0 192. 10 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 0 0 201.00 202.00 TOTAL (sum lines 118 through 201) 415.391 57, 066 82, 919 154, 868 202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0113

Peri od: Worksheet B From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared:

5/28/2019 4:13 pm Cost Center Description **PHARMACY** MEDI CAL SOCIAL SERVICE NONPHYSICIAN NURSING SCHOOL RECORDS & **ANESTHETI STS** LI BRARY 15. 00 17.00 19. 00 20.00 16,00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 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 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 111, 750 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 116, 918 16.00 17.00 01700 SOCIAL SERVICE 0 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 0 19.00 0 02000 NURSING SCHOOL Ω 20 00 C 20.00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD C 21.00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 0 0 22.00 22.00 02300 PARAMED ED PRGM-(EMS) 0 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 34, 072 0 30.00 03100 INTENSIVE CARE UNIT 0 31.00 444 31.00 0 32 00 03200 CORONARY CARE UNIT C 32 00 000000000 03300 BURN INTENSIVE CARE UNIT 0 33.00 C 33.00 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 0 40.00 0 40.00 0 41.00 C 41.00 42.00 04200 SUBPROVI DER C 42.00 04300 NURSERY 0 43.00 111 43.00 0 44 00 04400 SKILLED NURSING FACILITY 44 00 C 04500 NURSING FACILITY 45.00 C 45.00 04600 OTHER LONG TERM CARE 0 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0 O 50 00 22 529 0 0 51.00 05100 RECOVERY ROOM 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 52.00 53.00 05300 ANESTHESI OLOGY 606 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 2.996 54 00 26 54 00 54.01 05401 ULTRASOUND 0 54.01 54.02 05402 WOMEN'S CENTER 0 0 1 0 0 54.02 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 0 0 56.00 05600 RADI OI SOTOPE C 56.00 57.00 05700 CT SCAN 00000 C 0 57.00 58 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 555 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 59.00 C 0 60.00 06000 LABORATORY 7.491 60.00 06001 BLOOD LABORATORY 60.01 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 000030000 C 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 0 65.00 0 66.00 06600 PHYSI CAL THERAPY Ω 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY C 0 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 499 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 С 71.00 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 0 07300 DRUGS CHARGED TO PATIENTS 111, 078 73.00 C 73.00 74.00 07400 RENAL DIALYSIS C 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 0 0 75.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00  $\mathcal{C}$ 0 0 90.00 09000 CLI NI C 90.00 09001 WOUND/OSTOMY CLINIC 0 90 01 90 01 22, 640 0 90.02 09002 KIDS PLUS CLINIC 0 C 90.02 09003 ONCOLOGY 0 90.03 90.03 90. 04 09004 MUNCIE CLINIC 0 0 90.04

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | 5/28/2019 4:13 pm

					5/28/2019 4: 1	3 pm
Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	NURSING SCHOOL	
	15. 00	16. 00	17. 00	19. 00	20. 00	
90. 05   09005   ANTI COAGULATI ON CLI NI C	13.00	10.00		17.00	20.00	90. 05
90. 06   09006   PREGNANCY PLUS	o	0	_			90.06
90. 07   09007   0/P LAB	0	0			!	90.00
	0	0				•
90. 08   09008   0/P LAB	0	0			!	90. 08
90. 09   09009   FORTVILLE CLINIC	0	0	0		!	90. 09
90. 10   09010   1030 S SCATTERFIELD (MEDCHECK)	0	0	0		!	90. 10
90. 11   09011   DI ABETI C PLUS CLINI C	7	0	0			90. 11
91. 00   09100   EMERGENCY	11	21, 142	. 0			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						l
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0			94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0			95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0			96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	o	0	0			97. 00
99. 00 09900 CMHC	o	0	0			99. 00
99. 10 09910 CORF	l ol	0	0			99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	o	0	0			100.00
101.00 10100 HOME HEALTH AGENCY	o	0	Ö		!	101. 00
SPECIAL PURPOSE COST CENTERS	٥					
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0			105. 00
106. 00 10600 HEART ACQUISITION	o	0	l .		!	106.00
107. 00 10700 LI VER ACQUI SI TI ON		0				107. 00
108. 00 10800 LUNG ACQUISITION		0			!	107.00
109. 00 10900 PANCREAS ACQUISITION	0	0			!	109.00
110. 00 11000   NTESTI NAL ACQUI SI TI ON	0	0			!	•
	U	0			!	110.00
111. 00 11100   SLET ACQUISITION	U	0	1			111.00
113. 00 11300 I NTEREST EXPENSE					!	113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF					!	114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0			115. 00
116. 00 11600 HOSPI CE	0	0	0			116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	111, 750	112, 479	0	0	0	118. 00
NONREI MBURSABLE COST CENTERS				1		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
190. 01 19001 WELLNESS CENTERS	0	0	0			190. 01
190. 02 19002 EMPLOYED ORTHO MD	0	0	0		!	190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)	0	0	0		!	190. 03
190. 04 19004 SUMMIT CONV. (LTC)	0	0	0			190. 04
190. 05 19005 PARKVI EW CONV. (LTC)	0	0	0			190. 05
190. 06 19006 MONTI CELLO HSE.	0	0	0			190. 06
190.07 19007 NH PARK PLACE (LTC)	0	0	0			190. 07
190.08 19008 MADISON PLACE OF ELWOOD (LTC)	0	0	0			190. 08
190. 09 19009 SPI NE SURGEON	0	0	0			190. 09
190. 10 19010 CLINICAL RESEARCH CENTER	0	0	0			190. 10
190. 11 19011 ONCOLOGI ST	0	0	0			190. 11
190. 12 19012 MEDI CAL I NTERNI ST	0	0	0		!	190. 12
190. 13 19013 RHEUMATOLOGY	0	0	0		!	190. 13
190. 14 19014 ROCK STEADY BOXING	o	0	0			190. 14
191. 00 19100 RESEARCH	o	0	0			191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	o	4, 439	l .			192. 00
192. 01 19201 MUNCIE MD OFFICES	o	0	1		!	192. 01
192. 02 19202 FOUNDATION	0	0			!	192. 02
192. 03 19203 SP0E	o	0	_		!	192. 03
192. 04 19204 HEALTHY HEART	o o	0			!	192. 04
192. 05 19205 VACANT SPACE	o	0	_			192. 05
192. 05 19205 VACANT SPACE 192. 07 19207 PARK PLACE CENTER		0				192. 03
		0	]			192. 07
192. 08 19208 RENTAL PROPERTY		0	]			
192. 09 19209 RESIDENTIAL PROPERTY (1430 N MADISON	0	0				192. 09
192. 10 19210 HOSPITAL RENTAL (1927 N MADISON AVE)	0	0	0			192. 10
200.00 Cross Foot Adjustments		=		0		200.00
201.00 Negative Cost Centers	0	0	0			201. 00
202.00 TOTAL (sum lines 118 through 201)	111, 750	116, 918	0	0	0	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Ti Provider CCN: 15-0113

					To 12/31/2018	Date/lime Pre   5/28/2019 4:1	
		INTERNS &	RESI DENTS			0,20,201, 1.1	о ріп
	Cost Center Description	SERVI CES-SALAR Y & FRI NGES	SERVI CES-OTHER PRGM. COSTS	PARAMED ED PRGM-(EMS)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		21.00	22. 00	23. 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 EQUI P						2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00	00600 MAINTENANCE & REPAIRS						6.00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
12. 00 13. 00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION						12. 00 13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16. 00
17. 00	01700 SOCIAL SERVICE						17. 00
19. 00 20. 00	01900 NONPHYSI CLAN ANESTHETI STS						19.00
21. 00	02000   NURSING SCHOOL   02100   I&R SERVICES-SALARY & FRINGES APPRVD	121					20. 00 21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	121	192				22. 00
23.00	02300 PARAMED ED PRGM-(EMS)				0		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS				2, 216, 375	1	30.00
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T				453, 436		31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT					o o	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT				C	0	34. 00
40.00	04000 SUBPROVI DER - I PF				C	0	40. 00
41. 00	04100 SUBPROVI DER - I RF				C	0	41.00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY				66, 732	0	42. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY				00,702	1	44. 00
45. 00	04500 NURSING FACILITY				C	1	45. 00
46. 00	04600 OTHER LONG TERM CARE				C	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM				2, 194, 146	0	50. 00
51. 00	05100 RECOVERY ROOM				2, 171, 110	1	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM				C	0	52. 00
53. 00	05300 ANESTHESI OLOGY				17, 883	1	53. 00
54. 00 54. 01	05400   RADI OLOGY-DI AGNOSTI C   05401   ULTRASOUND				734, 071 61, 185	1	54. 00 54. 01
	05402 WOMEN' S CENTER				18, 769	1	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C				0	1	55. 00
56. 00	05600 RADI OI SOTOPE				53, 020	0	56. 00
57. 00	05700 CT SCAN				20, 655		57. 00
58. 00 59. 00	05800   MAGNETIC RESONANCE I MAGING (MRI)   05900   CARDIAC CATHETERIZATION				49, 582 305, 198		58. 00 59. 00
60.00	06000 LABORATORY				459, 129	1	60.00
60. 01	06001 BLOOD LABORATORY				, c		60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS				19, 285		62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY					1	63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY				75, 039	1	65. 00
66.00	06600 PHYSI CAL THERAPY				98, 456		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY				63, 449		67. 00
68. 00	06800 SPEECH PATHOLOGY				51, 957		68. 00
69. 00 70. 00	06900  ELECTROCARDI OLOGY   07000  ELECTROENCEPHALOGRAPHY				78, 914 87, 699	1	69. 00 70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				184, 034	1	70.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS				116, 486	1	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS				179, 146	l .	73. 00
74.00	07400 RENAL DI ALYSI S				7, 805	l .	74.00
/5.00	O7500   ASC (NON-DISTINCT PART)   OUTPATIENT SERVICE COST CENTERS				C	0	75. 00
88. 00	08800 RURAL HEALTH CLINIC				С	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER				C		89. 00
90.00	09000  CLI NI C	<u> </u>	l	l	0	0	90. 00

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To 12/31/2018 | Date/Time Prepared: | Part | I | Part | Part | I | Part | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0113

			To	12/31/2018	Date/Time Pre 5/28/2019 4:1	
	INTERNS &	RESI DENTS			372072017 4. 1	5 piii
	050,4,050,04,40	050,4,050,07,150	2424452 52			
Cost Center Description	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM. COSTS	PARAMED ED PRGM-(EMS)	Subtotal	Intern & Residents Cost	
	I & IKINGLS	FRGW. COSTS	FRGINI-(LINIS)		& Post	
					Stepdown	
					Adjustments	
OO OI OOOOI WOUND /OSTOMY CLINIC	21.00	22.00	23. 00	24. 00 277, 080	25.00	00.01
90.01   09001   WOUND/OSTOMY CLINIC 90.02   09002   KIDS PLUS CLINIC				277,080	0	90. 01 90. 02
90. 03   09003   0NCOLOGY				1, 198, 513	o o	90. 03
90. 04   09004   MUNCI E CLINI C				0	Ō	90. 04
90. 05 09005 ANTI COAGULATI ON CLINIC				7, 035	0	90. 05
90. 06   09006   PREGNANCY PLUS				0	0	90. 06
90. 07   09007   0/P LAB				0	0	90. 07
90. 08   09008   0/P   LAB 90. 09   09009   FORTVI LLE   CLI NI C				6		90. 08 90. 09
90. 10   09010   1030   S   SCATTERFIELD (MEDCHECK)				0	ő	90. 10
90. 11 09011 DIABETIC PLUS CLINIC				6, 451	0	90. 11
91. 00   09100   EMERGENCY				410, 164	0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS  94. 00 09400 HOME PROGRAM DI ALYSI S	Ī			0	0	94. 00
95. 00 09500 AMBULANCE SERVI CES				0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED				0	Ō	96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD				0	0	97. 00
99. 00 09900 CMHC				0	0	99. 00
99. 10   09910   CORF				0	0	99. 10
100.00 10000 1&R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY				0		100. 00 101. 00
SPECIAL PURPOSE COST CENTERS						1101.00
105. 00 10500 KI DNEY ACQUI SI TI ON				0		105. 00
106. 00 10600 HEART ACQUI SI TI ON				0	l	106. 00
107. 00 10700 LIVER ACQUISITION 108. 00 10800 LUNG ACQUISITION				0	l .	107. 00 108. 00
109. 00 10900 PANCREAS ACQUISITION				0	l	109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON				0	l	110. 00
111.00 11100 ISLET ACQUISITION				0	0	111. 00
113. 00 11300   I NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				0	_	114. 00 115. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPICE				0	l e	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	9, 511, 700	l	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				28, 443	l e	190. 00
190. 01 19001 WELLNESS CENTERS 190. 02 19002  EMPLOYED ORTHO MD				37, 243		190. 01 190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)				26, 295	<b>l</b>	190. 02
190. 04 19004 SUMMIT CONV. (LTC)				24, 379	<b>l</b>	190. 04
190.05 19005 PARKVI EW CONV. (LTC)				25, 174		190. 05
190. 06 19006 MONTI CELLO HSE.				106, 170		190. 06
190. 07 19007 NH PARK PLACE (LTC)				372		190. 07
190. 08 19008 MADISON PLACE OF ELWOOD (LTC) 190. 09 19009 SPINE SURGEON				0		190. 08 190. 09
190. 10 19010 CLINI CAL RESEARCH CENTER				60, 616	l	190. 10
190. 11 19011 ONCOLOGI ST				0		190. 11
190. 12 19012 MEDI CAL I NTERNI ST				1, 495	l	190. 12
190. 13 19013 RHEUMATOLOGY				12, 273	l	190. 13
190. 14 19014 ROCK STEADY BOXING 191. 00 19100 RESEARCH				43, 511		190. 14 191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES				550, 331	l	191.00
192. 01 19201 MUNCIE MD OFFICES				135, 675	l	192. 01
192. 02 19202 FOUNDATI ON				17, 706	0	192. 02
192. 03 19203 SP0E				0		192. 03
192. 04 19204 HEALTHY HEART				4, 549		192. 04
192. 05 19205 VACANT SPACE 192. 07 19207 PARK PLACE CENTER				14, 316		192. 05 192. 07
192. 08 19208 RENTAL PROPERTY				34, 505		192. 07
192.09 19209 RESIDENTIAL PROPERTY (1430 N MADISON				29, 551		192. 09
192.10 19210 HOSPITAL RENTAL (1927 N MADISON AVE)				37, 738		192. 10
200.00 Cross Foot Adjustments	121	192		313		200.00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	0 121		0	0 10, 702, 355		201. 00 202. 00
202.00   TOTAL (Sum TITIES TTO THEOUGH 201)	121	1 172	١	10, 702, 333	1	1202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0113

		5/28/2019 4: 13	3 pm
Cost Center Description	Total		
	26. 00		
GENERAL SERVICE COST CENTERS			
1.00 O0100 CAP REL COSTS-BLDG & FLXT			1. 00
2.00 O0200 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
6.00   00600   MAI NTENANCE & REPAI RS			6. 00
7. 00   00700   OPERATION OF PLANT			7. 00
8.00   00800   LAUNDRY & LINEN SERVICE			8. 00
9. 00   00900   HOUSEKEEPI NG			9. 00
10. 00   01000   DI ETARY			10.00
11. 00   01100   CAFETERI A			11. 00
12. 00   01200   MAI NTENANCE OF PERSONNEL			12. 00
13. 00   01300   NURSI NG ADMINISTRATION			13. 00
14. 00   01400   CENTRAL SERVI CES & SUPPLY			14. 00
15. 00  01500  PHARMACY			15. 00
16. 00   01600   MEDI CAL RECORDS & LI BRARY			16. 00
17. 00   01700   SOCIAL SERVICE			17. 00
19. 00   01900   NONPHYSI CLAN ANESTHETI STS			19. 00
20. 00   02000   NURSI NG SCHOOL			20. 00
21.00   02100   1 &R SERVI CES-SALARY & FRI NGES APPRVD			21. 00
22. 00   02200   I &R SERVI CES-OTHER PRGM. COSTS APPRVD			22. 00
23. 00   02300   PARAMED ED PRGM-(EMS)			23. 00
INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00   03000   ADULTS & PEDI ATRI CS	2, 216, 375		30.00
31.00 03100 INTENSIVE CARE UNIT	453, 436		31. 00
32. 00 03200 CORONARY CARE UNIT	0		32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0		33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0		34. 00
40. 00   04000   SUBPROVI DER - 1 PF	0		40. 00
41. 00   04100   SUBPROVI DER - I RF	0		41. 00
42. 00   04200   SUBPROVI DER	0		42. 00
43. 00   04300   NURSERY	66, 732		43. 00
44.00 O4400 SKILLED NURSING FACILITY	0		44. 00
45.00 O4500 NURSING FACILITY	0		45. 00
46.00 O4600 OTHER LONG TERM CARE	0		46. 00
ANCI LLARY SERVI CE COST CENTERS			
50. 00   05000   OPERATI NG ROOM	2, 194, 146		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	17, 883		53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	734, 071		54. 00
54. 01   05401   ULTRASOUND	61, 185		54. 01
54. 02   05402   WOMEN' S CENTER	18, 769		54. 02
55. 00   05500   RADI OLOGY-THERAPEUTI C	0		55. 00
56. 00   05600   RADI OI SOTOPE	53, 020		56. 00
57. 00  05700   CT   SCAN	20, 655		57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	49, 582		58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	305, 198		59. 00
60. 00   06000   LABORATORY	459, 129		60.00
60. 01   06001   BL00D   LABORATORY	0		60. 01
61. 00  06100   PBP CLINICAL LAB SERVICES-PRGM ONLY			61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	19, 285		62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0		63.00
64. 00 06400 I NTRAVENOUS THERAPY	0		64. 00
65. 00 06500 RESPI RATORY THERAPY	75, 039		65.00
66. 00 06600 PHYSI CAL THERAPY	98, 456		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	63, 449		67. 00
68. 00 06800 SPEECH PATHOLOGY	51, 957		68. 00
69. 00 06900 ELECTROCARDI OLOGY	78, 914		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	87, 699		70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	184, 034		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	116, 486		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	179, 146		73. 00
74. 00   07400   RENAL DI ALYSI S	7, 805		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0		75. 00
OUTPATIENT SERVICE COST CENTERS			
88.00 08800 RURAL HEALTH CLINIC	0		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		89. 00
90. 00 09000 CLI NI C	0		90. 00
90. 01 09001 WOUND/OSTOMY CLINIC	277, 080		90. 01
90. 02 09002 KIDS PLUS CLINIC	0		90. 02
90. 03   09003   0NCOLOGY	1, 198, 513		90. 03
90. 04   09004   MUNCIE CLINIC	0		90. 04
90. 05 09005 ANTI COAGULATI ON CLINIC	7, 035		90. 05
90. 06   09006   PREGNANCY PLUS	0		90.06

Heal th Financial Systems COMMUNITY HOSPITAL ANDERSON In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0113 Period: Worksheet B

From 01/01/2018 Part II Date/Time Prepared: 12/31/2018 5/28/2019 4:13 pm Cost Center Description Total 26. 00 90. 07 09007 0/P LAB 0 90. 07 90. 08 09008 0/P LAB 0 90.08 90. 09 09009 FORTVILLE CLINIC 6 90.09 09010 1030 S SCATTERFIELD (MEDCHECK) 0 90. 10 90.10 09011 DIABETIC PLUS CLINIC 90 11 6, 451 90 11 91.00 09100 EMERGENCY 410, 164 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 94.00 0 95.00 09500 AMBULANCE SERVICES 0 0 0 0 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 09900 CMHC 99.00 99.00 99. 10 09910 CORF 99. 10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 101 00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 105.00 106.00 10600 HEART ACQUISITION 0 0 0 0 106. 00 107. 00 10700 LIVER ACQUISITION 107. 00 108.00 10800 LUNG ACQUISITION 108.00 109. 00 10900 PANCREAS ACQUISITION 109.00 110.00 11000 INTESTINAL ACQUISITION 110.00 111.00 11100 | SLET ACQUISITION 0 111. 00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115. 00 116. 00 11600 HOSPI CE 0 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 9, 511, 700 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 28 443 190. 01 19001 WELLNESS CENTERS 37, 243 190.01 190. 02 19002 EMPLOYED ORTHO MD 190.02 190. 03 19003 NORTHVI EW CONV. (LTC) 26, 295 190. 03 190. 04 19004 SUMMIT CONV. (LTC) 190. 04 24, 379 190. 05 19005 PARKVI EW CONV. (LTC) 25, 174 190.05 190. 06 19006 MONTI CELLO HSE. 106, 170 190.06 190. 07 19007 NH PARK PLACE (LTC) 190. 07 372 190. 08 19008 MADI SON PLACE OF ELWOOD (LTC) 0 190.08 190. 09 19009 SPI NE SURGEON 0 190.09 190. 10 19010 CLINI CAL RESEARCH CENTER 60.616 190. 10 190. 11 19011 ONCOLOGI ST 190. 11 190. 12 19012 MEDICAL INTERNIST 1, 495 190. 12 190. 13 19013 RHEUMATOLOGY 190. 13 12, 273 190. 14 19014 ROCK STEADY BOXING 190. 14 43, 511 191. 00 19100 RESEARCH 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 550, 331 192. 00 192. 01 19201 MUNCIE MD OFFICES 135, 675 192.01 192. 02 19202 FOUNDATION 192. 02 17, 706 192. 03 19203 SP0E 192. 03 192. 04 19204 HEALTHY HEART 4, 549 192. 04 192. 05 19205 VACANT SPACE 192. 05 14.316 192. 07 192. 07 19207 PARK PLACE CENTER 192. 08 19208 RENTAL PROPERTY 34, 505 192. 08 192.09 19209 RESIDENTIAL PROPERTY (1430 N MADISON 29, 551 192. 09 192. 10 19210 HOSPITAL RENTAL (1927 N MADISON AVE) 192. 10 37 738 200.00 Cross Foot Adjustments 313 200.00 201.00 Negative Cost Centers 201. 00 202.00 TOTAL (sum lines 118 through 201) 10, 702, 355 202.00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0113 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/28/2019 4:13 pm CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE Cost Center Description (SQUARE FEET) (DOLLAR VALUE) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5. 00 4.00 5A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 303 612 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4, 130, 847 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1,645 9,570 68, 107, 668 4.00 00500 ADMINISTRATIVE & GENERAL 127, 823, 367 5 00 25, 454 612, 193 11, 534, 924 -24, 850, 265 5 00 6.00 6.00 00600 MAINTENANCE & REPAIRS 7.00 00700 OPERATION OF PLANT 30, 863 257.534 2, 386, 506 9, 213, 120 7.00 00800 LAUNDRY & LINEN SERVICE 3,460 73,093 0 283, 136 8.00 8.00 0 00900 HOUSEKEEPI NG 9 00 7.221 8.809 1, 511, 642 2, 360, 140 9 00 10.00 01000 DI ETARY 10, 782 121, 487 734, 599 0 1, 713, 890 10.00 01100 CAFETERI A 2,041 11.00 826, 297 0 0 0 0 0 924, 234 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 2 661 203 1, 292, 410 1, 883, 140 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 5,081 4,773 1, 043, 851 2, 746, 295 14.00 01500 PHARMACY 15.00 3, 207 4, 549 2, 026, 966 2, 860, 783 15.00 01600 MEDICAL RECORDS & LIBRARY 4, 066 2,000,064 16,00 C 1, 266, 515 16,00 17 00 01700 SOCIAL SERVICE C C 0 17 00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 19.00 19.00 0 20.00 02000 NURSING SCHOOL 0 C 0 0 20.00 0 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 21.00 0 0 12, 598 0 21.00 O 22.00 02200 & SERVICES-OTHER PRGM. COSTS APPRVD 0 r 0 20, 189 22.00 02300 PARAMED ED PRGM-(EMS) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 20, 075, 130 30.00 51.976 203.326 14, 111, 601 0 31.00 03100 INTENSIVE CARE UNIT 6,916 137, 819 3, 083, 959 0 4, 387, 828 31.00 03200 CORONARY CARE UNIT 32.00 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 C 0 0 34.00 04000 SUBPROVIDER - IPF 0 40.00 40.00 0 0 41.00 04100 SUBPROVIDER - IRF 0 Ω 0 0 41.00 04200 SUBPROVI DER 0 42 00 Ω Ω Λ 42 00 0 43.00 04300 NURSERY 1,870 500 1, 146, 914 1, 709, 782 43.00 04400 SKILLED NURSING FACILITY 0 44.00 0 0 0 44.00 04500 NURSING FACILITY 45.00 0 45.00 0 0 04600 OTHER LONG TERM CARE 46.00  $\cap$ 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 22, 153 1, 257, 062 5, 189, 361 9, 747, 890 50.00 o 05100 RECOVERY ROOM 51 00 51 00 C 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0  $\cap$ 0 n 52.00 53.00 05300 ANESTHESI OLOGY 272 6, 700 804, 277 0 236, 784 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 19, 284 202, 076 1, 779, 227 0 3, 683, 996 54.00 05401 ULTRASOUND 54 01 296, 036 441, 446 54 01 48 468 54.02 05402 WOMEN'S CENTER 0 10, 701 355, 534 486, 362 54.02 05500 RADI OLOGY-THERAPEUTI C 55.00 0 0 0 0 0 0 55.00 7, 350 56, 00 05600 RADI 0I SOTOPE 1,483 255, 254 875, 637 56, 00 485, 675 882, 512 57 00 05700 CT SCAN 450 291 57 00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 936 14, 683 341, 165 939, 883 58.00 05900 CARDIAC CATHETERIZATION 59.00 3.750 172,096 889, 684 1, 534, 896 59.00 06000 LABORATORY 184, 851 4, 910, 005 60.00 7.828 2, 206, 286 60.00 06001 BLOOD LABORATORY 60.01 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 585 1,948 201, 193 284, 207 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63 00 0 C 0 63 00 0 64.00 06400 INTRAVENOUS THERAPY 64.00 0 06500 RESPIRATORY THERAPY 1, 249, 679 1, 672, 767 65.00 494 38, 154 0 65.00 2, 999, 334 06600 PHYSI CAL THERAPY 2, 178, 686 66.00 2.685 2, 447 66,00 06700 OCCUPATIONAL THERAPY 359, 597 67.00 2.466 522, 481 67 00 06800 SPEECH PATHOLOGY 2,041 243, 270 385, 808 68.00 68.00 0 0 0 06900 ELECTROCARDI OLOGY 69 00 1,533 29, 570 424, 887 705, 896 69 00 07000 ELECTROENCEPHALOGRAPHY 879, 666 70.00 2,021 24,877 526, 016 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 C 12, 181, 192 71 00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 7, 710, 228 72.00 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 0 7, 162, 806 73.00 07400 RENAL DIALYSIS 0 74.00 188 0 0 356, 036 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 75.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89 00 Ol 89.00

0

0

0

0 90.00

09000 CLI NI C

90.00

Cost Center Description					Т	o 12/31/2018	Date/Time Pre 5/28/2019 4:1	
SOURCE FEED   CONTACT   SELECTION   SELECTION   CONTACT   SELECTION   CONTACT   SELECTION   CONTACT   SELECTION   CONTACT   SELECTION			CAPI TAL REI	LATED COSTS			072072017 1.11	O PIII
SUMMER FEET  COULDAY VALUE)   BENEFITS   CACCUMA COST		Cost Center Description	BIDG & FIXT	MVRLE FOLLE	FMPLOYEE	Reconciliation	ADMI NI STRATI VE	
90.01   99001   MANINJOSTINY CLINI C		cost denter bescription				Reconciliation		
SALARIES    1,000   2,000   4,000   5A   5,000   6,0							(ACCUM. COST)	
1,00   2,00   4,00   5A   5,00   0,00								
90 02   90002   RIDS PLUS CLINIC   0   0   0   0   0   90   02   02   03   90003   RIDS RUDS (RECEDISTY   17, 167   443, 180   1, 700, 898   0   4, 431, 243   90. 03   03   03   03   03   03   03   03			1.00	2.00		5A	5. 00	
99.03   DOCKO   DOCKO			10, 183		·	0		•
90.04   OPRICAL MINICE CLINIC   0   0   0   0   0   0   0   0   0		•	17 167	_	_	0	_	1
90.06   00006   PRECHANCY PULS   0   0   0   0   0   0   0   0   0			0	0	0			1
90.07   90.0	1	l .	0	2, 278	297, 203	0		•
90.08   90000   97   AB   90.09   9000   97   AB   90.09   9000   97   9000   97   9000   97   9000   97   9000   97   9000   90	1	•	0	0	0	0		•
90.10   90.11   90.011   10.030 S SCATTERFIFLD (DETOCHOCK)			0	Ö	Ö	0		•
90.11   000-010	1	ł	0	0	0	0		•
91.00	1	1	0	286	405 315	0	_	1
DITHER RELIMBURSABLE COST CENTERS  9. 00   904 OND   904 OND   905 OND   90	1	ł	7, 831					
94.00   09400   MOMBULANCE SERVEYORS   0   0   0   0   0   0   0   95.00   95.00   09500   09500   DIRABLE WEDLCAL EQUIP-RENTED   0   0   0   0   0   0   0   0   0   95.00   09500   DIRABLE WEDLCAL EQUIP-RENTED   0   0   0   0   0   0   0   0   0   97.00   09700   DIRABLE WEDLCAL EQUIP-SIDD   0   0   0   0   0   0   0   0   0								92. 00
95.00   09500   DORABLE MEDICAL EQUIP-RENTED   0   0   0   0   0   95.00   97.00   09500   OMEQ   OMEQ   0   0   0   0   0   0   0   0   97.00   09500   OMEQ   OMEQ   0   0   0   0   0   0   0   0   97.00   09500   OMEQ   OMEQ   0   0   0   0   0   0   0   0   97.10   09710   OMEQ   OMEQ   0   0   0   0   0   0   0   0   97.10   09710   OMEQ   OMEQ   0   0   0   0   0   0   0   0   97.10   09710   OMEQ			Ι ο	1 0	1 0	1	0	94 00
97.00   09700   COMPAGE MEDICAL EQUIP-SOLD   0   0   0   0   0   0   99.00   99.00   09900   09900   09900   09900   09900   099.00   09900   099.00   09900   099.00   09900   099.00			0	Ö	1			1
99, 00   9990   CORPET   CORPE	1	•	0	0	0	0		1
99, 10, 0910 CORF 101. 001 CORD ( ) 0 S SERVICES-NOT APPRVD PRGM	-		0	0	0	0	_	1
101. DOI   1010   101			0	0			_	•
SPECIAL PURPOSE COST CENTRES		l .	0				l .	1
195. 00   10500   KIDNEY ACQUISITION			0	0	0	0	0	101. 00
107. 00 10700 LIVER ACQUISITION 0 0 0 0 0 107. 00 109. 00 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 0 109. 00 109. 00 109. 00 109. 00 109. 00 111. 00 11100 LIVEST HALA CQUISITION 0 0 0 0 0 0 0 111. 00 11100 LIVEST HALA CQUISITION 0 0 0 0 0 0 111. 00 111. 00 11100 LIVEST HALA CQUISITION 0 0 0 0 0 0 111. 00 11100 LIVERST EXPENSE 1 113. 00 1300 LIVERST EXPENSE 1 113. 00 1300 LIVERST EXPENSE 1 113. 00 1300 LIVERST EXPENSE 1 114. 00 111. ZATION REVIEW-SNF 1 114. 00 111. ZATION REVIEW-SNF 1 114. 00 111. ZATION REVIEW-SNF 1 114. 00 116. 00 114.00 LIVERST EXPENSE 1 115. 00 1500 AMBULATORY SUGGICAL CENTER (D.P.) 0 0 0 0 0 0 0 115. 00 1500 AMBULATORY SUGGICAL CENTER (D.P.) 0 0 0 0 0 0 0 115. 00 1500 AMBULATORY SUGGICAL CENTER (D.P.) 1 0 0 0 0 0 0 0 0 115. 00 1500 G 116. 00 116.			0	0	0	0	0	105. 00
108. 00   08000 LUNG ACQUISITION	106. 00 1060	OO HEART ACQUISITION	0	0	0	0		l
100.00   10000   PARCREAS ACQUISITION   0   0   0   0   0   1010.00   1010		•	0	0	0	0		•
110.00   11000   INTESTI NAL ACQUISITION   0   0   0   0   0   0   111.00   110.00   110.00   SLET ACQUISITION   0   0   0   0   0   111.00   110.00   110.00   SLET ACQUISITION   113.00   0   0   0   0   0   111.00   110.00   11	1			0	0			•
113.00   11300   NTEREST EXPENSE	110. 00 1100	OO INTESTINAL ACQUISITION	0	0	0	0		•
114. 00   11400   011L1ZATI ON REVIEW-SNF   0   0   0   0   0   0   0   0   0	1	•	0	0	0	0	0	•
115. 00   11500   AMBILIATORY SURGICAL CENTER (D. P.)								•
118.0   SUBTOTALS (SUM OF LINES 1 through 117)   260,593   4, 120,152   65, 251,382   -24,834,572   120,012,577   118.0   0   190000   19000   190000   190000   190000   190000   1900000   1900000   19000	115. 00 1150	OO AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0		115. 00
NONEE IMBURSABLE COST CENTERS   1, 206	1	l .	260 593	0 4 120 152	0 65 251 382	_24_834_572		1
190. 01   19001   WELLNESS CENTERS   1, 227   0   332, 257   0   678, 149   190. 01   190. 02   19002   19002   19002   19002   19002   19003   19005   1900			200, 373	4, 120, 132	05, 251, 302	-24, 034, 372	120, 012, 377	1110.00
190. 02   190.02   190.02   190.02   190.03   190.05			1	l .		_		
190.03   190.03   190.04   190.04   190.04   190.04   190.06   1			1, 227	0	332, 257	0		1
190. 05   19005   19005   19006   19006   19006   19006   19006   19006   19006   19006   19006   19006   19006   19006   19007   19007   19007   19007   19007   19008   19		•	917	Ö	341, 636	0		1
190.06   19006   MONTI CELLO HSE.			1					
190. 07   19007   NH PARK PLACE (LTC)			1	l .				
190. 09   19009   SPI NE SURGEON   0   0   0   0   0   190. 09   190. 10   19010   CLI NI CAL RESEARCH CENTER   2, 072   1, 709   594, 797   0   949, 540   190. 10   190. 11   190. 11   19011   0NCOLOGIST   0   0   0   0   0   0   0   0   0			1	l	· · · · · ·			
190. 10   19010   19010   CLINI CAL RESEARCH CENTER   2,072   1,709   594,797   0   949,540   190. 10   190. 11   19011   0NCOLOGI ST   0   0   0   0   0   0   0   190. 11   190. 12   19012   MEDI CAL I NTERNI ST   0   0   0   87,977   0   138,230   190. 13   190. 13   190. 13   190. 13   190. 13   190. 13   190. 13   190. 13   190. 14   190. 14   190. 14   190. 14   190. 14   190. 14   190. 14   190. 14   190. 14   190. 14   190. 15   190.			0	0	0	0		
190. 11 19011   0NCOLOGI ST	1	l .	2 072	1 700	504 707	0	l .	1
190. 13 19013 RHEUMATOLOGY 190. 14 19014 ROCK STEADY BOXING 1, 783 190. 14 19014 ROCK STEADY BOXING 1, 783 190. 14 19014 ROCK STEADY BOXING 1, 783 190. 1900 RESEARCH 191. 00 19100 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 18, 549 192. 01 19201 MUNCI E MD OFFI CES 18, 549 192. 02 19202 FOUNDATION 192. 03 19203 SPOE 192. 04 19204 HEALTHY HEART 192. 05 19205 VACANT SPACE 192. 07 19207 RESIDENTI AL PROPERTY 192. 08 19208 RENTAL PROPERTY 192. 08 19208 RENTAL PROPERTY 192. 09 19209 RESIDENTI AL PROPERTY (1430 N MADI SON 1, 250 0) 192. 00 10 0 10 0 10 0 11, 004, 409 190. 13 169. 169, 765 190. 14 169. 169, 765 190. 14 169. 169, 765 190. 14 169. 169, 765 190. 14 169. 169, 765 190. 14 169. 169, 765 190. 14 169. 169, 765 190. 14 169. 169, 765 190. 14 191. 10 192. 01 192.			2,072	1, 709	394, 797	0		
190. 14 19014 ROCK STEADY BOXING			0	0				1
191. 00		•	1 702					
192.00     19200     PHYSICIANS' PRIVATE OFFICES     18,549     6,446     0     0     1,843,668     192.00       192.01     19201     MUNCIE MD OFFICES     5,745     0     0     0     130,119     192.01       192.02     19202     FOUNDATION     356     0     233,887     0     957,598     192.02       192.03     19203     SPOE     0     0     0     0     0     957,598     192.02       192.04     19204     HEALTHY HEART     0     479     268,950     0     375,567     192.03       192.05     19205     VACANT SPACE     607     0     0     0     11,764     192.05       192.07     19207     PARK PLACE CENTER     0     0     0     0     7192.07       192.08     19208     RENTAL PROPERTY     1,456     0     0     0     45,535     192.08       192.09     19210     HOSPITAL RENTAL (1927 N MADISON AVE)     1,600     0     0     0     31,536     192.09       200.00     Negative Cost Centers     200.00     0     0     0     31,254     192.10       203.00     Unit cost multiplier (Wkst. B, Part I)     19.380591     1.166389     0.214324     0.194411 </td <td></td> <td>•</td> <td>1, 763</td> <td></td> <td>07,007</td> <td></td> <td></td> <td>•</td>		•	1, 763		07,007			•
192.02 19202 FOUNDATION 356 0 233,887 0 957,598 192.02 192.03 19203 SPOE 0 0 0 0 0 0 0 192.03 192.04 192.04 HEALTHY HEART 0 479 268,950 0 375,567 192.04 192.05 192.07 192.07 192.07 192.07 192.07 192.07 192.08 192.08 192.08 RENTAL PROPERTY 0 0 0 0 0 11,764 192.05 192.09 192.09 192.09 192.09 RESI DENTI AL PROPERTY (1430 N MADI SON 1, 250 0 0 0 31,536 192.09 192.10 192.10 192.10 192.10 HOSPI TAL RENTAL (1927 N MADI SON AVE) 1,600 0 0 31,254 192.10 200.00 Cross Foot Adjustments Negative Cost Centers 201.00 Regative Cost Centers 203.00 Unit cost multiplier (Wkst. B, Part I) 19.380591 1.166389 0.214324 0.194411 203.00 204.00 Cost to be allocated (per Wkst. B, Cost	192. 00 1920	OO PHYSICIANS' PRIVATE OFFICES			0	0	1, 843, 668	192. 00
192.03 19203 SPOE 0 0 0 0 0 0 192.03 19204 HEALTHY HEART 0 479 268,950 0 375,567 192.04 192.05 192.05 VACANT SPACE 607 0 0 0 11,764 192.05 192.07 19207 PARK PLACE CENTER 0 0 0 0 0 7 192.05 192.08 19208 RENTAL PROPERTY 1,456 0 0 0 0 45,535 192.08 192.09 19209 RESI DENTI AL PROPERTY (1430 N MADI SON 1,250 0 0 0 31,536 192.09 192.10 19210 HOSPI TAL RENTAL (1927 N MADI SON AVE) 1,600 0 0 31,254 192.10 200.00 Cross Foot Adjustments Negative Cost Centers 201.00 Negative Cost Centers 202.00 Unit cost multiplier (Wkst. B, Part I) 19.380591 1.166389 0.214324 0.194411 203.00 204.00 Cost to be allocated (per Wkst. B, Cost Cost to be allocated (per Wkst. B, Cost Cost Cost Cost Cost Cost Cost Cost	1	•	1		222 007	0		1
192.04 19204 HEALTHY HEART 0 479 268,950 0 375,567 192.04 192.05 19205 VACANT SPACE 607 0 0 0 11,764 192.05 192.07 19207 PARK PLACE CENTER 0 0 0 0 0 7 192.07 192.08 192.08 RENTAL PROPERTY 1,456 0 0 0 0 45,535 192.08 192.09 192.09 RESIDENTIAL PROPERTY (1430 N MADISON 1,250 0 0 0 31,536 192.09 192.10 19210 HOSPITAL RENTAL (1927 N MADISON AVE) 1,600 0 0 31,254 192.10 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, Part I) 19.380591 1.166389 0.214324 0.194411 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 19.380591 1.166389 0.214324 0.194411 203.00 204.00			0					1
192.07 19207 PARK PLACE CENTER 192.08 19208 RENTAL PROPERTY 1,456 0 0 0 0 45,535 192.08 192.09 19209 RESIDENTIAL PROPERTY (1430 N MADISON 1,250 0 0 0 31,536 192.09 192.10 19210 HOSPITAL RENTAL (1927 N MADISON AVE) 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, Cost to be allocated (per	192. 04 1920	04 HEALTHY HEART	0		268, 950	0	375, 567	192. 04
192.08 19208 RENTAL PROPERTY			607	0	0	0		
192.09 19209 RESIDENTIAL PROPERTY (1430 N MADISON 1, 250 0 0 0 31,536 192.09 192.10 19210 HOSPITAL RENTAL (1927 N MADISON AVE) 1,600 0 0 0 31,254 192.10 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 19.380591 1.166389 0.214324 0.194411 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 19.380591 1.166389 0.214324 1.214,659 204.00	1	ł	1, 456	n	l o	0	l .	1
200.00       Cross Foot Adjustments       200.00         201.00       Negative Cost Centers       201.00         202.00       Cost to be allocated (per Wkst. B, Part I)       5,884,180       4,818,175       14,597,109       24,850,265       202.00         203.00       Unit cost multiplier (Wkst. B, Part I)       19.380591       1.166389       0.214324       0.194411       203.00         204.00       Cost to be allocated (per Wkst. B,       43,043       1,214,659       204.00	192. 09 1920	9 RESIDENTIAL PROPERTY (1430 N MADISON			O	0	l	1
201.00   Negative Cost Centers   201.00   Cost to be allocated (per Wkst. B, Part I)   19.380591   1.166389   0.214324   0.194411   203.00   204.00   Cost to be allocated (per Wkst. B, Part I)   19.380591   1.166389   0.214324   0.194411   203.00   1,214,659   204.00   204.00   205			1, 600	0	0	0	31, 254	
202.00     Cost to be allocated (per Wkst. B, Part I)     5,884,180     4,818,175     14,597,109     24,850,265     202.00       203.00     Unit cost multiplier (Wkst. B, Part I)     19.380591     1.166389     0.214324     0.194411     203.00       204.00     Cost to be allocated (per Wkst. B,     43,043     1,214,659     204.00	1							
203.00 Unit cost multiplier (Wkst. B, Part I) 19.380591 1.166389 0.214324 0.194411 203.00 204.00 Cost to be allocated (per Wkst. B, 43,043 1,214,659 204.00		Cost to be allocated (per Wkst. B,	5, 884, 180	4, 818, 175	14, 597, 109		24, 850, 265	1
204.00   Cost to be allocated (per Wkst. B,   43,043   1,214,659 204.00	203 00	1	10 200501	1 166290	0.214224		0 104411	203 00
			17. 300091	1. 100389			1	1
		Part II)						

Heal th Finar	ncial Systems	COMMUNITY HOSP	ITAL ANDERSON		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS				Period: From 01/01/2018	Worksheet B-1	
					To 12/31/2018	Date/Time Pre 5/28/2019 4:1	
		CAPITAL REI	LATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1. 00	2.00	4. 00	5A	5. 00	
205. 00	Unit cost multiplier (Wkst. B, Part			0. 00063	2	0. 009503	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

				To	12/31/2018	Date/Time Pre 5/28/2019 4:1	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		REPAIRS (SQUARE FEET)	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(HOURS OF SERVICE)	(MEALS SERVED)	
		/ 00	7.00	LAUNDRY)	0.00	10.00	
	GENERAL SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 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
6. 00	00600 MAINTENANCE & REPAIRS	0					6. 00
7.00	00700 OPERATION OF PLANT	0	245, 650				7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	3, 460 7, 221	1	12, 422		8. 00 9. 00
10. 00	01000 DI ETARY	0	10, 782	1	222		10.00
11. 00	01100 CAFETERI A	0	2, 041		0	-	11. 00
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	0	0 2, 661	0	0 49	0 0	12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY		5, 081	- 1	81	0	14. 00
15. 00	01500 PHARMACY	0	3, 207		46	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	4, 066		17	0	16.00
17. 00 19. 00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	17. 00 19. 00
20. 00	02000 NURSI NG SCHOOL	0	Ö	Ö	0	0	20.00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0	0	0	0	0	21. 00
22. 00 23. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0 0	22. 00 23. 00
23.00	02300 PARAMED ED PRGM-(EMS) INPATIENT ROUTINE SERVICE COST CENTERS			<u> </u>	0	0	23.00
30.00	03000 ADULTS & PEDIATRICS	0	51, 976	1	3, 510		30. 00
31.00	03100   NTENSI VE CARE UNI T 03200   CORONARY CARE UNI T	0	6, 916		650		31.00
32. 00 33. 00	03300 BURN INTENSIVE CARE UNIT		0	0	0	0	32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	Ö	Ö	0	0	34. 00
40. 00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40. 00
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	0	0	0	0	0 0	41. 00 42. 00
43. 00	04300 NURSERY		1, 870	Ö	36	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	O	0	0	44. 00
45. 00	04500 NURSING FACILITY	0	0		0	0 0	45. 00
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0		ıı U	0	0	46. 00
50.00	05000 OPERATING ROOM	0	22, 153		1, 333		50. 00
51. 00 52. 00	O5100   RECOVERY ROOM   O5200   DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY		272	_	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	19, 284	30, 645	154	0	54. 00
54. 01 54. 02	05401   ULTRASOUND   05402   WOMEN' S CENTER	0	0	0 274	0	0 0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C			9, 274	0	0	54. 02 55. 00
56.00	05600 RADI 0I SOTOPE	0	1, 483	3, 898	34	0	56. 00
57.00	05700 CT SCAN	0	450		0	0	57. 00
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	936 3, 750		26 17	0	58. 00 59. 00
60.00	06000 LABORATORY	0	7, 828		83		60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	585		17	0	61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0		0		63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	_	0	0	64. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	494		44 20	0 0	65. 00 66. 00
67. 00	06700 OCCUPATIONAL THERAPY		2, 685 2, 466	1	15		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	2, 041	1	9		68. 00
69.00	06900 ELECTROCARDI OLOGY	0	1, 533		15		69.00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 021		59 0	0 0	70. 00 71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	Ö	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
74. 00 75. 00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0	188 0		0	0 0	74. 00 75. 00
75.00	OUTPATIENT SERVICE COST CENTERS						73.00
88. 00		0	0		0	_	88. 00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0		0	0	0 0	89. 00 90. 00
90. 01	09001 WOUND/OSTOMY CLINIC	0	10, 183	7, 648	143		90. 01
	09002 KIDS PLUS CLINIC	0	0	0	0		90. 02
90. 03	09003  0NCOLOGY	1 0	17, 167	7, 730	0	0	90. 03

			To	rom 01/01/2018 5 12/31/2018	Date/Time Pre 5/28/2019 4:1	
Cost Center Description	MAINTENANCE &		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5 PIII
	REPAIRS (SQUARE FEET)	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(HOURS OF SERVICE)	(MEALS SERVED)	
	(SQUARE TEET)	(SQUARE TEET)	LAUNDRY)	SERVICE)		
00.04.00004.0004.000	6.00	7. 00	8.00	9. 00	10.00	00.04
90. 04   09004   MUNCIE CLINIC 90. 05   09005   ANTICOAGULATION CLINIC		C	0	0		90. 04 90. 05
90. 06   09006   PREGNANCY PLUS	0	C	o	0	0	90. 06
90. 07   09007   0/P LAB	0	C	0	0	0	90. 07
90. 08   09008   0/P   LAB 90. 09   09009   FORTVI LLE   CLI NI C			0	0	0	90. 08 90. 09
90. 10 09010 1030 S SCATTERFIELD (MEDCHECK)	0	C	o	0	0	90. 10
90. 11   09011   DI ABETI C PLUS CLI NI C	0	7 021	2, 251	0	1	90. 11
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION   BEDS (NON-DISTINCT PART)		7, 831	105, 281	464	458	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS						72.00
94. 00   09400   HOME PROGRAM DI ALYSI S	0	C		0	-	94.00
95. 00   09500   AMBULANCE SERVICES 96. 00   09600   DURABLE MEDICAL EQUIP-RENTED		C	0	0	0	95. 00 96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	C	o	0	0	97. 00
99. 00   09900   CMHC	0	C	0	0	0	99.00
99. 10   09910   CORF 100. 00   10000   I &R SERVI CES-NOT APPRVD   PRGM	0			0	0	99. 10 100. 00
101. 00 10100 HOME HEALTH AGENCY	0	C		0		101. 00
SPECIAL PURPOSE COST CENTERS						105 00
105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON	0	C		0		105. 00 106. 00
107. 00 10700 LI VER ACQUI SI TI ON		Č	o o	0	_	107. 00
108.00 10800 LUNG ACQUISITION	0	C	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION 110.00 11000 INTESTINAL ACQUISITION	0		0	0		109. 00 110. 00
111. 00 11100 I SLET ACQUI SI TI ON				0		111.00
113. 00 11300   I NTEREST EXPENSE				_		113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPICE			0	0		115. 00 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)		202, 631	1	7, 044		1
NONREI MBURSABLE COST CENTERS	Τ .	I	1			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.01 19001 WELLNESS CENTERS	0	1, 206 1, 227		0 91	-	190. 00 190. 01
190. 02 19002 EMPLOYED ORTHO MD		1, 22,		0		190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)	0	917	•	0		190. 03
190. 04 19004 SUMMIT CONV. (LTC) 190. 05 19005 PARKVIEW CONV. (LTC)	0	917 917	•	0		190. 04 190. 05
190. 06 19006 MONTI CELLO HSE.		4, 417		0		190. 05
190. 07 19007 NH PARK PLACE (LTC)	0	c	0	0		190. 07
190. 08 19008 MADI SON PLACE OF ELWOOD (LTC)	0	C	0	0		190. 08
190. 09 19009 SPI NE SURGEON 190. 10 19010 CLI NI CAL RESEARCH CENTER		2, 072	0	0		190. 09 190. 10
190. 11 19011 ONCOLOGI ST	0	_, _, _		0		190. 11
190. 12 19012 MEDI CAL I NTERNI ST	0	C		0		190. 12
190. 13 19013 RHEUMATOLOGY 190. 14 19014 ROCK STEADY BOXING		1, 783	1	0		190. 13 190. 14
191. 00 19100 RESEARCH		1, 705	o o	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	18, 549		5, 287		192. 00
192. 01 19201 MUNCI E MD OFFICES	0	5, 745		0		192. 01 192. 02
192. 02   19202   FOUNDATI ON 192. 03   19203   SPOE		356	1	0		192. 02
192. 04 19204 HEALTHY HEART	0	C		0		192. 04
192. 05 19205 VACANT SPACE	0	607		0		192. 05
192. 07   19207   PARK PLACE CENTER 192. 08   19208   RENTAL   PROPERTY		1, 456	1	0		192. 07 192. 08
192. 08 19208 RENTAL PROPERTY (1430 N MADISON		1, 450		0		192. 08
192. 10 19210 HOSPITAL RENTAL (1927 N MADISON AVE)		1, 600		0		192. 10
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B,	0	11, 004, 252	493, 177	3, 149, 876	2, 592, 190	201. 00 202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	l .		253. 572372		•
204.00   Cost to be allocated (per Wkst. B, Part II)		987, 588	83, 704	203, 896	415, 391	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	4. 020305	0. 113588	16. 414104	2. 842282	205. 00
206.00 NAHE adjustment amount to be allocated						206 00
(per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)	1	l	1		I	<u> </u>

CAST TABLE   Provide COL 115-0133   Provide		Financial Systems LLOCATION – STATISTICAL BASIS	COMMUNITY HOSPI		*CN: 15_0113 Dc	In Lie	u of Form CMS-2 Worksheet B-1	2552-10
CAPE LIST A	CUST	LLLUCATION - STATISTICAL BASIS		Provider C	Fr	om 01/01/2018	Date/Time Pre	pared: 3 pm
CEREBIAL SERVICE COST CENTERS   11.00   12.00   13.00   14.00   15.00   15.00   14.00   15.00   15.00   14.00   15.0		Cost Center Description		PERSONNEL (NUMBER	ADMI NI STRATI ON	SERVI CES & SUPPLY	(COSTED	
DEBISHER SERVICE OOST CENTERS     1.00   1.00     1.00					HRS. )	REQUIS.)		
1.00		CENEDAL SEDVICE COST CENTEDS	11. 00	12. 00	13. 00	14. 00	15. 00	
4.00	1.00							1. 00
31.00 03100   INTENSIVE CARE UNIT   00 0 0 0 0 0 0 32.00 33.00 33.00   O3200 COROMANY CARE UNIT   00 0 0 0 0 0 0 33.00 33.00   O3200 SURGICAL INTENSIVE CARE UNIT   00 0 0 0 0 0 0 0 33.00 40.00 340.00 340.00   O4000 SURGICAL INTENSIVE CARE UNIT   00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00	00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAIRS 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD 02200 PARAMED ED PRGM- (EMS)	0 25, 324 62, 054 49, 147 47, 151 0 0 0 37			77, 788 2, 610 0 0 0 0 0	0 0 0 0 0	2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00
32.00   03200C CORDARY CARE UNIT   0 0 0 0 0 0 0 32.00		03000 ADULTS & PEDIATRICS	1	(	1			
33.00			1 1	(	1	458, 683 0		
40. 00   04000   SUBPROVI DER - I PF   0	33.00	03300 BURN INTENSIVE CARE UNIT	o	C		ő		33. 00
41.00   04100   SUBPROVI DER - 1 RF   0 0 0 0 0 0 0 0 42.00   42.00   04200   SUBPROVI DER   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	(		0	0	
43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSING FACILITY 0 0 0 0 0 0 0 0 44. 00 45. 00 04500 NURSING FACILITY 0 0 0 0 0 0 0 0 44. 00 46. 00 04500 OTHER LONG TERM CARE 0 0 0 0 0 0 0 0 0 0 46. 00 46. 00 04500 OTHER LONG TERM CARE 0 0 0 0 0 0 0 0 0 0 46. 00 46. 00 46. 00 04500 OTHER LONG TERM CARE 0 0 0 0 0 0 0 0 0 0 46. 0			0	(		0	0	
44 .00   04400   SALLED NURSING FACILITY		1 1	0	(	0	o	-	
45.00		1 1	1 1	(	1	0	-	
ANCILLARY SERVICE COST CENTERS	45.00	04500 NURSING FACILITY	0	Ć	o o	- 1	-	45. 00
50.00   0500	46. 00		0	(	0	0	0	46. 00
S2.00   0520		05000 OPERATING ROOM	169, 231	(	169, 231	4, 595, 494	0	50.00
53.00   05300   ABSTHESI OLOGY   9, 206   0   2, 064   39, 083   33. 00			0	(		0		
54.01   05401   ULTRASQUND			9, 206	(		2, 064		
54.02   05402   00500   RADI OLOGY-THERAPEUTI C			l I	(	0			
55. 00   05500   RADI OLOCY-THERAPEUTI C				_				1
57.00   05700   CT SCAN   14,678   0   0   102,277   18   57.00   58.00   05800   MAGNETIC RESONANCE I MAGI NG (MRI )   11,272   0   0   4,365   32   58.00   05900   CARDI AC CATHETERI ZATI ON   24,586   0   0   0   0   0   0   0   0   0	55.00	05500 RADI OLOGY-THERAPEUTI C	0	-	1	i	0	55. 00
58. 00		1 1	1 1	(				
60. 00   06000   LABORATORY   87, 010   0   0   62, 933   0   60. 00   60. 01   60. 01   60. 01   60. 01   60. 01   60. 01   60. 01   60. 01   60. 01   60. 01   60. 01   60. 01   60. 01   60. 01   60. 01   60. 01   60. 01   60. 01   60. 01   60. 00   60. 01   60. 00   60.				(		ı		
60. 01   06001   BLOOD LABORATORY   0   0   0   0   0   0   0   60. 01   61. 00   06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY   61. 00   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   6,083   0   0   0   0   0   0   63. 00   06300   BLOOD STORI NG, PROCESSI NG & TRANS.   0   0   0   0   0   0   64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   65. 00   06500   RESPI RATORY THERAPY   42,535   0   0   11,396   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   44,535   0   0   11,396   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   64,870   0   0   8,304   188   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   8,504   0   0   516   6   67. 00   68. 00   06800   SPEECH PATHOLOGY   6,427   0   0   199   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   15,454   0   0   10,592   20   69. 00   70. 00   07000   ELECTROCARDI OLOGY   15,454   0   0   10,592   20   69. 00   71. 00   07000   ELECTROCARDI OLOGY   15,454   0   0   10,592   20   69. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   12,178,902   0   71. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   7,710,228   0   74. 00   74. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   75. 00   07500   ASC (NON-DI STI NCT PART)   0   0   0   0   0   0   88. 00   08900   RURAL DI ALYSI S   0   0   0   0   0   0   89. 00   08900   FEDERALLY QUALI FIED HEALTH CENTER   0   0   0   0   0   90. 01   09000   CLI NI C   0   0   0   0   90. 01   09000   UNUND/OSTOMY CLI NI C   0   0   0   0   90. 01   09000   UNUND/OSTOMY CLI NI C   0   0   0   0   90. 01   09000   UNUND/OSTOMY CLI NI C   0   0   0   90. 01   09000   UNUND/OSTOMY CLI NI C		1 1	1	(		0		
61. 00   06100   PBP CLINICAL LAB SERVICES-PRGM ONLY		1 1	1 1	(		62, 933		
63. 00		1 1		_		0.40		
64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   64. 00   65. 00   06500   RESPI RATORY THERAPY   42, 535   0   0   11, 396   0   65. 00   66. 00   66. 00   66. 00   66. 00   66. 00   66. 00   66. 00   67.		1 1	1 1	(		240		
66. 00   06600   PHYSI CAL THERAPY   64, 870   0   0   8, 304   188   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   8, 504   0   0   516   6   67. 00   68. 00   06800   SPECH PATHOLOGY   6, 427   0   0   199   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   15, 454   0   0   10, 592   20   69. 00   70. 00   07000   ELECTROCARDI OLOGY   15, 995   0   0   4, 106   23   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   12, 178, 902   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   7, 710, 228   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   7, 162, 805   73. 00   74. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   0   0   75. 00   00   00   00   00   00   00   00	64.00	06400 I NTRAVENOUS THERAPY	O	Ć		ō		64. 00
67. 00   06700   0CCUPATI ONAL THERAPY   8, 504   0   0   516   6   67. 00   68. 00   06800   SPEECH PATHOLOGY   6, 427   0   0   199   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   15, 454   0   0   10, 592   20   69. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   15, 995   0   0   4, 106   23   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   12, 178, 902   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   7, 710, 228   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   7, 162, 805   73. 00   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   0   0   0   0   75. 00   07500   ASC (NON-DI STI NCT PART)   0   0   0   0   0   0   0   0   0			1	(				
69. 00   06900   ELECTROCARDI OLOGY   15, 454   0   0   10, 592   20   69. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   15, 995   0   0   4, 106   23   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   12, 178, 902   0   71. 00   72. 00   07200   MPL. DEV. CHARGED TO PATI ENTS   0   0   0   7, 710, 228   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   7, 162, 805   73. 00   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   0   0   0   0   0		1	1	(				
70. 00   07000   ELECTROENCEPHALOGRAPHY   15, 995   0   0   4, 106   23   70. 00   100   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   12, 178, 902   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   7, 710, 228   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   7, 162, 805   73. 00   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   0   0   0   0   0			1	(	o		-	
71. 00			1	(				
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   7, 162, 805   73. 00   74. 00   07400   RENAL DI ALYSIS   0   0   0   3, 848   0   74. 00   75. 00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   0    OUTPATIENT SERVICE COST CENTERS  88. 00   08900   RURAL HEALTH CLINIC   0   0   0   0   0   89. 00    89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   89. 00    90. 01   09001   WOUND/OSTOMY CLINIC   10, 449   0   0   153, 870   398   90. 01	71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(	0	12, 178, 902	0	71. 00
74. 00			0	(			-	
SB. 00   OBSOO   RURAL   HEALTH   CLINI C   O   O   O   O   O   SB. 00	74.00	07400 RENAL DIALYSIS		(		-		74. 00
88. 00	75. 00		0	(	0	0	0	75. 00
90. 00   09000   CLINIC   0   0   0   0   0   0   90. 00   90. 01   09001   WOUND/OSTOMY CLINIC   10, 449   0   0   153, 870   398   90. 01		08800 RURAL HEALTH CLINIC	0	(		0	0	
90. 01   09001   WOUND/OSTOMY CLINIC   10, 449   0   0   153, 870   398   90. 01			0	(		o		
			10, 449	(		153, 870		
	90. 02	09002 KIDS PLUS CLINIC	0	(		o	0	90. 02

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Peri od: Wo From 01/01/2018 Provider CCN: 15-0113

				o 12/31/2018		
Cost Center Description	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	5/28/2019 4: 1 PHARMACY	3 pm
	(MAN HOURS)	PERSONNEL (NUMBER	ADMI NI STRATI ON	SERVI CES & SUPPLY	(COSTED REQUIS.)	
		HOUSED)	(DI RECT NURS.	(COSTED	KLQUI 3. )	
	11. 00	12.00	HRS. )	REQUIS.) 14.00	15 00	
90. 03   09003   0NCOLOGY	55, 099	12. 00	13.00		15. 00 683	90. 03
90. 04   09004   MUNCIE CLINIC	0	C	) c	0	0	90. 04
90. 05   09005   ANTI COAGULATI ON CLINI C 90. 06   09006   PREGNANCY PLUS	8, 176			1, 122	0	90. 05 90. 06
90. 07   09007   0/P LAB	0			0	0	90.00
90. 08 09008 0/P LAB	0	C	C	0	0	90. 08
90.09   09009   FORTVILLE CLINIC 90.10   09010   1030 S SCATTERFIELD (MEDCHECK)	0			0	0	90. 09 90. 10
90. 11   09011   DI ABETI C PLUS CLINI C	10, 569			495	458	90. 10
91. 00 09100 EMERGENCY	124, 713	C	) c	559, 555	738	91.00
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS			<u> </u>			92. 00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	С	C	0	0	94. 00
95. 00 09500 AMBULANCE SERVI CES	0	C	C	0	0	95.00
96. 00   09600   DURABLE MEDI CAL EQUI P-RENTED 97. 00   09700   DURABLE MEDI CAL EQUI P-SOLD	0			0	0	96. 00 97. 00
99. 00   09900   CMHC	0	Č		0	0	99. 00
99. 10   09910   CORF	0	C	C	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY	0			0		100. 00 101. 00
SPECIAL PURPOSE COST CENTERS						
105.00   10500   KIDNEY ACQUISITION 106.00   10600   HEART ACQUISITION	0	C		-		105. 00 106. 00
107. 00 10700 LI VER ACQUI SI TI ON				0		107. 00
108.00 10800 LUNG ACQUISITION	0	C	C	0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	C		0		109.00
110. 00 11000 1NTESTINAL ACQUISITION 111. 00 11100 1SLET ACQUISITION				0		110. 00 111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	_			0	114. 00 115. 00
116. 00 11600 HOSPI CE	0			0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 546, 059	c	771, 203	27, 617, 681	7, 206, 284	118. 00
NONREI MBURSABLE COST CENTERS  190. 00   1900   GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		ol c	O	0	190. 00
190. 01 19001 WELLNESS CENTERS	10, 772	Č		99		190. 01
190. 02 19002 EMPLOYED ORTHO MD	0	C		0		190. 02
190. 03   19003   NORTHVI EW CONV. (LTC) 190. 04   19004   SUMMI T CONV. (LTC)	6, 531 4, 600			2, 189 0		190. 03 190. 04
190. 05 19005 PARKVI EW CONV. (LTC)	5, 836	C	C	0		190. 05
190. 06 19006 MONTI CELLO HSE.	0	C		0		190.06
190.07 19007 NH PARK PLACE (LTC) 190.08 19008 MADISON PLACE OF ELWOOD (LTC)	498			0		190. 07 190. 08
190. 09 19009 SPI NE SURGEON	0	C	o c	0	0	190. 09
190. 10 19010 CLINI CAL RESEARCH CENTER 190. 11 19011 ONCOLOGI ST	20, 814	ľ	1	-		190. 10 190. 11
190. 11 19011 ONCOLOGIST 190. 12 19012 MEDI CAL I NTERNI ST	3, 412	1				190. 11
190. 13 19013 RHEUMATOLOGY	1, 669	ł	) c	0		190. 13
190. 14 19014 ROCK STEADY BOXING 191. 00 19100 RESEARCH	3, 317			239		190. 14 191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			1, 331		191.00
192.01 19201 MUNCIE MD OFFICES	0	c	) c	0		192. 01
192. 02 19202 FOUNDATI ON 192. 03 19203 SP0E	3, 624			19		192. 02 192. 03
192. 04 19204 HEALTHY HEART	5, 435			5, 820		192. 04
192.05 19205 VACANT SPACE	0	C	) c	0		192. 05
192. 07   19207   PARK PLACE CENTER 192. 08   19208   RENTAL PROPERTY	0			0		192. 07 192. 08
192. 09 19209 RESIDENTIAL PROPERTY (1430 N MADISON	0	Č		0		192. 09
192. 10 19210 HOSPI TAL RENTAL (1927 N MADI SON AVE)	0	C	) c	0	0	192. 10
200.00   Cross Foot Adjustments 201.00   Negative Cost Centers						200. 00 201. 00
202.00 Cost to be allocated (per Wkst. B,	1, 195, 345	c	2, 399, 643	3, 575, 042	3, 618, 774	
Part I)	0.744040		0 444550	0.400000	0 5004/0	000 00
203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B,	0. 741268 57, 066	ł	3. 111558 82, 919		0. 502168 111, 750	
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 035388	0. 000000	0. 107519	0. 005605	0. 015507	205. 00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)			1			

Health Financial Systems	COMMUNITY HOSP	ITAL ANDERSON		In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1		
				From 01/01/2018 To 12/31/2018	Date/Time Pre 5/28/2019 4:1		
Cost Center Description	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY		
	(MAN HOURS)	PERSONNEL	ADMI NI STRATI O	N SERVICES &	(COSTED		
		(NUMBER		SUPPLY	REQUIS.)		
		HOUSED)	(DIRECT NURS.	(COSTED			
			HRS. )	REQUIS.)			
	11.00	12.00	13. 00	14.00	15. 00		
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00	
Parts III and IV)							

						0 12/31/2018	Date/lime Pre 5/28/2019 4:1	
							I NTERNS & RESI DENTS	
		Cost Center Description		SOCIAL SERVICE		NURSING SCHOOL	SERVI CES-SALAR	
			RECORDS & LI BRARY	(TIME SPENT)	ANESTHETI STS (ASSI GNED	(ASSI GNED	Y & FRINGES (ASSIGNED	
			(TIME SPENT)		TI ME)	TI ME)	TI ME)	
	CENED	AL SERVICE COST CENTERS	16. 00	17. 00	19. 00	20. 00	21.00	
1.00		CAP REL COSTS-BLDG & FLXT						1. 00
2.00		CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 00	1	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00		MAINTENANCE & REPAIRS						6. 00
7. 00		OPERATION OF PLANT						7. 00
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE  HOUSEKEEPING						8. 00 9. 00
10.00	1	DI ETARY						10.00
11. 00	1	CAFETERI A						11. 00
12. 00 13. 00	1	MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION						12. 00 13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY						14. 00
15. 00	1	PHARMACY						15. 00
16. 00 17. 00	1	MEDICAL RECORDS & LIBRARY   SOCIAL SERVICE	52, 675	452	,			16. 00 17. 00
19. 00	1	NONPHYSICIAN ANESTHETISTS	0	452	1			19. 00
20. 00	02000	NURSI NG SCHOOL	0	C		0		20. 00
21. 00 22. 00		I&R SERVICES-SALARY & FRINGES APPRVD   I&R SERVICES-OTHER PRGM. COSTS APPRVD	0		1		37	21. 00 22. 00
23. 00	1	PARAMED ED PRGM-(EMS)	0		1			23. 00
	I NPAT	IENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	1	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	15, 350 200				37	30. 00 31. 00
32. 00	1	CORONARY CARE UNIT	0		1		0	32.00
33.00		BURN INTENSIVE CARE UNIT	0	C	1	0	0	33. 00
34. 00 40. 00		SURGICAL INTENSIVE CARE UNIT  SUBPROVIDER - IPF	0			0	0	34. 00 40. 00
41. 00	1	SUBPROVIDER - I RF	0				0	41. 00
42. 00		SUBPROVI DER	0	C		0	0	42. 00
43. 00 44. 00	1	NURSERY  SKILLED NURSING FACILITY	50		1	0	0	43. 00 44. 00
45. 00	1	NURSING FACILITY	0		1		0	45. 00
46. 00		OTHER LONG TERM CARE	0	C	) (	0	0	46. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	10, 150	(		0	0	50. 00
51. 00		RECOVERY ROOM	0	C			ő	51. 00
52.00	1	DELIVERY ROOM & LABOR ROOM	0	C		0	0	52. 00
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	1, 350			0	0	53. 00 54. 00
54. 01		ULTRASOUND	0	Č		o o	ő	54. 01
54. 02	1	WOMEN' S CENTER	0	C			0	
55. 00 56. 00	1	RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	0			0	0	55. 00 56. 00
57. 00		CT SCAN	0	C		o o	o o	57. 00
58. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	250	C		0	0	58. 00
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	3, 375			0	0	59. 00 60. 00
60. 01		BLOOD LABORATORY	0,070	C		o o	ő	60. 01
61.00		PBP CLINICAL LAB SERVICES-PRGM ONLY		_				61.00
62. 00 63. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS   BLOOD STORING, PROCESSING & TRANS.	0	(	) (		0	62. 00 63. 00
64. 00		INTRAVENOUS THERAPY	Ö	C		o o	ő	64. 00
65.00		RESPIRATORY THERAPY	0	C		0	0	65. 00
66. 00 67. 00		PHYSICAL THERAPY OCCUPATIONAL THERAPY	0		) (		0	66. 00 67. 00
68. 00		SPEECH PATHOLOGY	0	C		o o	0	68. 00
69.00	1	ELECTROCARDI OLOGY	0	C		0	0	69. 00
70. 00 71. 00	1	ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	225	(	(	) )	0	70. 00 71. 00
72. 00	07200	IMPL. DEV. CHARGED TO PATIENTS	0			o o	ő	72. 00
73.00		DRUGS CHARGED TO PATIENTS	0	( )		0	0	73.00
74. 00 75. 00	1	RENAL DIALYSIS ASC (NON-DISTINCT PART)	0		1	-	0	74. 00 75. 00
	OUTPA	TIENT SERVICE COST CENTERS						
	08800	RURAL HEALTH CLINIC	0	C	1	-	0	
89. 00 90. 00		FEDERALLY QUALIFIED HEALTH CENTER   CLINIC	0		1	0	0	89. 00 90. 00
90. 01		WOUND/OSTOMY CLINIC	10, 200		1		ő	

						o 12/31/2018	Date/Time Prep 5/28/2019 4:1	
							INTERNS &	
		Cost Center Description	MEDI CAL	SOCIAL SERVICE	NONPHYSICI AN	NURSING SCHOOL	RESI DENTS SERVI CES-SALAR	
			RECORDS &	/TIME CDENT)	ANESTHETI STS	(ACCL CNED	Y & FRINGES	
			LIBRARY (TIME SPENT)	(TIME SPENT)	(ASSI GNED TI ME)	(ASSIGNED TIME)	(ASSIGNED TIME)	
00.00	00000	MIDE DIVIC CLIMIC	16.00	17. 00	19.00	20.00	21. 00	00.00
90. 02 90. 03	1	KIDS PLUS CLINIC ONCOLOGY	0	0		0	0	90. 02 90. 03
90. 04	09004	MUNCIE CLINIC	0	O	C	0	0	90. 04
90. 05 90. 06	1	ANTICOAGULATION CLINIC PREGNANCY PLUS	0	0	C	0	0	90. 05 90. 06
90. 07	1	O/P LAB	Ö	ő	Č	Ö	Ö	90. 07
90. 08 90. 09	4	O/P LAB FORTVILLE CLINIC	0	0	C	0	0	90. 08 90. 09
90. 09	1	1030 S SCATTERFIELD (MEDCHECK)	0			0	0	90. 09
90. 11		DIABETIC PLUS CLINIC	0	0	C	0	0	90. 11
91. 00 92. 00	1	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	9, 525	0	C	0	0	91. 00 92. 00
	OTHER	REIMBURSABLE COST CENTERS						
94. 00 95. 00	1	HOME PROGRAM DIALYSIS AMBULANCE SERVICES	0	0			0	
96. 00	09600	DURABLE MEDICAL EQUIP-RENTED	o o	ő	Č	Ö	ő	96.00
97. 00		DURABLE MEDICAL EQUIP-SOLD	0	0	C	0	0	97.00
99. 00 99. 10	09900 09910	l .	0			0	0	99. 00 99. 10
	1	I &R SERVICES-NOT APPRVD PRGM	0	0	C	0		100.00
101.00		HOME HEALTH AGENCY AL PURPOSE COST CENTERS	0	0	C	0	0	101. 00
	10500	KIDNEY ACQUISITION	0	0	C	0		105. 00
		HEART ACQUISITION LIVER ACQUISITION	0	0	C	0		106. 00 107. 00
	1	LUNG ACQUISITION	o o	ő	Č	Ö		107.00
	1	PANCREAS ACQUISITION	0	0	C	0		109.00
	1	INTESTINAL ACQUISITION ISLET ACQUISITION	0			0		110. 00 111. 00
113.00	11300	INTEREST EXPENSE						113. 00
	1	UTILIZATION REVIEW-SNF AMBULATORY SURGICAL CENTER (D.P.)	0	0		0		114. 00 115. 00
116.00	11600	HOSPI CE	Ö	Ö		0		116. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)  IMBURSABLE COST CENTERS	50, 675	452	C	0	37	118. 00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	С	0	0	190. 00
		WELLNESS CENTERS EMPLOYED ORTHO MD	0	0	C	0		190. 01 190. 02
	1	NORTHVIEW CONV. (LTC)	0			0		190. 02
		SUMMIT CONV. (LTC)	0	0	C	0		190. 04
	1	PARKVIEW CONV. (LTC) MONTICELLO HSE.	0			0		190. 05 190. 06
190. 07	19007	NH PARK PLACE (LTC)	0	0	C	0	0	190. 07
		MADISON PLACE OF ELWOOD (LTC) SPINE SURGEON	0	0	C	0		190. 08 190. 09
190. 10	19010	CLINICAL RESEARCH CENTER	Ö	Ö	Č	Ö	0	190. 10
		ONCOLOGIST MEDICAL INTERNIST	0	0	C	0		190. 11 190. 12
		RHEUMATOLOGY	0	0	C	0		190. 12
		ROCK STEADY BOXING	0	0	C	0		190. 14
		RESEARCH PHYSI CI ANS' PRI VATE OFFI CES	2,000			0		191. 00 192. 00
192. 01	19201	MUNCIE MD OFFICES	0	0	C	0	0	192. 01
192. 02 192. 03		FOUNDATION SPOF	0	0		0		192. 02 192. 03
192. 04	19204	HEALTHY HEART	Ö	Ö	Č	0	0	192. 04
		VACANT SPACE PARK PLACE CENTER	0	0	C	0		192. 05 192. 07
		RENTAL PROPERTY	0	0		0		192. 07
192. 09	19209	RESIDENTIAL PROPERTY (1430 N MADISON	0	0	C	0	0	192. 09
192. 10 200. 00		HOSPITAL RENTAL (1927 N MADISON AVE) Cross Foot Adjustments	0	o		0	0	192. 10 200. 00
201.00		Negative Cost Centers						201. 00
202.00	)	Cost to be allocated (per Wkst. B, Part I)	2, 610, 641	0	C	0	15, 074	202. 00
203.00		Unit cost multiplier (Wkst. B, Part I)	49. 561291	0. 000000	0. 000000	0. 000000	407. 405405	
204.00	)	Cost to be allocated (per Wkst. B, Part II)	116, 918	0	C	0	121	204. 00
205.00		Unit cost multiplier (Wkst. B, Part	2. 219611	0. 000000	0. 000000	0. 000000	3. 270270	205. 00
		11)			l			<u> </u>

Health Financial Systems		COMMUNITY HOSPITAL ANDERSON			In Lieu of Form CMS-2552-10		
COST ALLOC	ATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2018 Fo 12/31/2018	Date/Time Pre 5/28/2019 4:1	
						INTERNS &	
			000141 05511105			RESI DENTS	
	Cost Center Description		SOCIAL SERVICE				
		RECORDS &		ANESTHETI STS		Y & FRINGES	
		LI BRARY	(TIME SPENT)	(ASSI GNED	(ASSI GNED	(ASSI GNED	
		(TIME SPENT)		TIME)	TIME)	TIME)	
		16.00	17. 00	19. 00	20.00	21.00	
206.00	NAHE adjustment amount to be allocated				0		206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,				0.000000		207. 00
	Parts III and IV)						

COMMUNITY HOSPITAL ANDERSON

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: Worksheet B-1 From 01/01/2018 To 12/31/2018 Date/Time Prepared: Provider CCN: 15-0113

					10	5/28/2019 4: 1	
			I NTERNS & RESI DENTS				
		Cost Center Description	SERVI CES-OTHER	PARAMED ED			
		·	PRGM. COSTS	PRGM-(EMS)			
			(ASSIGNED TIME)	(ASSI GNED TIME)			
			22.00	23. 00			
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT			I		1.00
2.00		CAP REL COSTS-BLDG & TTXT					2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00		ADMINISTRATIVE & GENERAL					5. 00
6. 00 7. 00		MAINTENANCE & REPAIRS  OPERATION OF PLANT					6. 00 7. 00
8. 00		LAUNDRY & LINEN SERVICE					8. 00
9.00	1	HOUSEKEEPI NG					9. 00
10.00	1	DIETARY					10.00
11. 00 12. 00	1	CAFETERIA   MAINTENANCE OF PERSONNEL					11. 00 12. 00
13. 00	1	NURSI NG ADMI NI STRATI ON					13. 00
14.00	1	CENTRAL SERVICES & SUPPLY					14. 00
15. 00 16. 00	1	PHARMACY   MEDICAL RECORDS & LIBRARY					15. 00 16. 00
17. 00	1	SOCIAL SERVICE					17. 00
19. 00	1	NONPHYSICIAN ANESTHETISTS					19. 00
20. 00 21. 00	1	NURSING SCHOOL  I&R SERVICES-SALARY & FRINGES APPRVD					20. 00 21. 00
22. 00		I &R SERVICES-SALARY & TRINGES AFFROD	37				22. 00
23. 00		PARAMED ED PRGM-(EMS)		0			23. 00
20.00		I ENT ROUTI NE SERVI CE COST CENTERS	37	0	ı		1 20 00
30. 00 31. 00		ADULTS & PEDIATRICS   INTENSIVE CARE UNIT	0	0	•		30. 00 31. 00
32. 00		CORONARY CARE UNIT	0	0	1		32. 00
33. 00		BURN INTENSIVE CARE UNIT	0	0	•		33. 00
34. 00 40. 00		SURGICAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	0	0	•		34. 00 40. 00
41. 00	1	SUBPROVI DER - I RF	o	0	•		41. 00
42.00		SUBPROVI DER	0	0			42. 00
43. 00 44. 00		NURSERY  SKILLED NURSING FACILITY	0	0	1		43. 00 44. 00
45. 00		NURSING FACILITY	0	0			45. 00
46. 00		OTHER LONG TERM CARE	0	0			46. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	0	0			50. 00
51. 00	1	RECOVERY ROOM	0	O	1		51. 00
52.00	1	DELIVERY ROOM & LABOR ROOM	0	0	1		52.00
53. 00 54. 00	1	ANESTHESI OLOGY   RADI OLOGY-DI AGNOSTI C	0	0			53. 00 54. 00
54. 01		ULTRASOUND	O	0			54. 01
54. 02	1	WOMEN'S CENTER	0	0			54. 02
55. 00 56. 00	1	RADI OLOGY-THERAPEUTI C   RADI OI SOTOPE	0	0	•		55. 00 56. 00
57. 00	1	CT SCAN	o	0	1		57. 00
58.00	1	MAGNETIC RESONANCE I MAGING (MRI)	0	0	•		58. 00
59. 00 60. 00	1	CARDI AC CATHETERI ZATI ON LABORATORY	0	0	•		59. 00 60. 00
60. 01	1	BLOOD LABORATORY	l o	0			60. 01
61. 00		PBP CLINICAL LAB SERVICES-PRGM ONLY	_	_			61.00
62. 00 63. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS   BLOOD STORING, PROCESSING & TRANS.	0	0			62. 00 63. 00
64. 00		I NTRAVENOUS THERAPY	l o	0	•		64. 00
65. 00	1	RESPI RATORY THERAPY	o	0			65. 00
66. 00 67. 00		PHYSI CAL THERAPY   OCCUPATI ONAL THERAPY	0	0			66. 00 67. 00
68. 00		SPEECH PATHOLOGY	0	0			68. 00
69. 00	1	ELECTROCARDI OLOGY	0	0	1		69. 00
70. 00 71. 00	1	ELECTROENCEPHALOGRAPHY	0	0			70. 00 71. 00
71.00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS   IMPL. DEV. CHARGED TO PATIENTS		0	•		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		O			73. 00
74.00	1	RENAL DIALYSIS	0	0	1		74. 00
75. 00		ASC (NON-DISTINCT PART) TIENT SERVICE COST CENTERS	] 0	O	1		75. 00
88. 00	08800	RURAL HEALTH CLINIC	0	C			88. 00
89. 00 90. 00		FEDERALLY QUALIFIED HEALTH CENTER	0	0	1		89. 00
90.00		WOUND/OSTOMY CLINIC		0	1		90. 00 90. 01
		•	1				<u> </u>

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Peri od: From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/28/2019 4:13 pm Provider CCN: 15-0113

				5/28/2019 4:	
	Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM. COSTS (ASSI GNED TI ME) 22. 00	PARAMED ED PRGM-(EMS) (ASSI GNED TI ME) 23.00		
90. 02	09002 KIDS PLUS CLINIC	22.00	23.00		90. 02
90. 02	09003 0NC0L0GY		0		90. 03
	1	-			1
90. 04	09004 MUNCI E CLI NI C	0	0		90. 04
90. 05	09005 ANTI COAGULATI ON CLI NI C	0	0		90. 05
90. 06	09006 PREGNANCY PLUS	0	0		90. 06
90. 07	09007 0/P LAB	0	0		90. 07
90. 08	09008 0/P LAB	0	0		90. 08
90. 09	09009 FORTVILLE CLINIC	0	0		90. 09
90. 10	09010 1030 S SCATTERFIELD (MEDCHECK)	0	0		90. 10
90. 11	09011 DIABETIC PLUS CLINIC	o	0		90. 11
91. 00	09100 EMERGENCY	o	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	OTHER REIMBURSABLE COST CENTERS		,		
94.00	09400 HOME PROGRAM DIALYSIS	0	0		94.00
	09500 AMBULANCE SERVI CES	o	o		95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	o	0		96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	أم	0		97. 00
	09900 CMHC		o o		99. 00
	09910 CORF		o		99. 10
	10000 I&R SERVICES-NOT APPRVD PRGM		ol		100.00
	10100 HOME HEALTH AGENCY		0		101. 00
101.00	SPECIAL PURPOSE COST CENTERS	l ol	<u> </u>		101.00
105.00	10500 KIDNEY ACQUISITION	l ol	0		105. 00
	10600 HEART ACQUISITION		0		
		0	-1		106.00
	10700 LI VER ACQUI SI TI ON	0	0		107. 00
	10800 LUNG ACQUISITION	0	0		108.00
	10900 PANCREAS ACQUISITION	0	0		109. 00
	11000   I NTESTI NAL ACQUI SI TI ON	0	0		110.00
	11100 I SLET ACQUI SI TI ON	0	0		111. 00
	11300 I NTEREST EXPENSE				113. 00
	11400 UTI LI ZATI ON REVI EW-SNF				114. 00
	11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		115. 00
116.00	11600  HOSPI CE		0		116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	37	0		118. 00
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
	19001 WELLNESS CENTERS	0	0		190. 01
190. 02	19002 EMPLOYED ORTHO MD	0	0		190. 02
190. 03	19003 NORTHVI EW CONV. (LTC)	0	0		190. 03
190. 04	19004 SUMMIT CONV. (LTC)	0	0		190. 04
190. 05	19005 PARKVIEW CONV. (LTC)	0	0		190. 05
190.06	19006 MONTI CELLO HSE.	0	0		190. 06
190. 07	19007 NH PARK PLACE (LTC)	0	0		190. 07
190. 08	19008 MADISON PLACE OF ELWOOD (LTC)	0	0		190. 08
190. 09	19009 SPI NE SURGEON	o	0		190. 09
190. 10	19010 CLINICAL RESEARCH CENTER	o	o		190. 10
190. 11	19011 ONCOLOGI ST	o	o		190. 11
190. 12	19012 MEDI CAL I NTERNI ST	o	o		190. 12
	19013 RHEUMATOLOGY	l ol	o		190. 13
190. 14	19014 ROCK STEADY BOXING	l ol	o		190. 14
	19100 RESEARCH	o	0		191. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	ا م	o		192. 00
	19201 MUNCIE MD OFFICES		o		192. 01
	19202 FOUNDATION		0		192. 02
	19203 SP0E		0		192. 02
	19204 HEALTHY HEART		0		192. 03
	19205 VACANT SPACE		0		192. 04
	19205 VACANT SPACE 19207 PARK PLACE CENTER		0		192. 05
					192. 07
	19208 RENTAL PROPERTY		0		
	19209 RESIDENTIAL PROPERTY (1430 N MADISON	0	0		192. 09
	19210 HOSPITAL RENTAL (1927 N MADISON AVE)	0	0		192. 10
200.00	, ,				200.00
201.00					201. 00
202.00		24, 114	0		202. 00
0	Part I)				
203.00		651. 729730	0. 000000		203. 00
204.00	,,	192	0		204. 00
	Part II)				1
205.00		5. 189189	0. 000000		205. 00
		1			1

Heal th Fina	ncial Systems	COMMUNITY HOSPITAL ANDERSON			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS			Provi der Co	Provider CCN: 15-0113		Worksheet B-1		
					To 12/31/2018	Date/Time Pre 5/28/2019 4:1		
	Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM. COSTS	PARAMED ED PRGM-(EMS)					
		(ASSI GNED TI ME) 22, 00	(ASSI GNED TI ME) 23, 00					
206. 00	NAHE adjustment amount to be allocated		23.00				206, 00	
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,		0. 000000				207. 00	
	Parts III and IV)			I				

						12/31/2010	5/28/2019 4:1	
				Title	XVIII	Hospi tal	PPS	
		Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
			Part I, col.					
			26) 1. 00	2. 00	3. 00	4. 00	5. 00	
	I NPAT	IENT ROUTINE SERVICE COST CENTERS						
30. 00	1	ADULTS & PEDIATRICS	32, 416, 575		32, 416, 575	0	32, 416, 575	1
31.00		INTENSIVE CARE UNIT	6, 542, 241		6, 542, 241	0	6, 542, 241	31.00
32. 00 33. 00		CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0		0	0	0	32. 00 33. 00
34. 00		SURGICAL INTENSIVE CARE UNIT	0		o o	0	0	34. 00
40.00		SUBPROVIDER - IPF	0		0	0	0	40.00
41. 00	1	SUBPROVI DER - I RF	0		0	0	0	41. 00
42.00		SUBPROVI DER	0		0	0	0	
43. 00 44. 00	1	NURSERY SKILLED NURSING FACILITY	2, 264, 644		2, 264, 644 0	0	2, 264, 644 0	1
45. 00		NURSING FACILITY	0		0	0	0	ı
46. 00		OTHER LONG TERM CARE	0		0	0	0	46. 00
		LARY SERVICE COST CENTERS				_		
50. 00 51. 00		OPERATING ROOM RECOVERY ROOM	14, 836, 571		14, 836, 571 0	0	14, 836, 571 0	50. 00 51. 00
51.00		DELIVERY ROOM & LABOR ROOM	0		0	0	0	
53. 00		ANESTHESI OLOGY	321, 719		321, 719	0	321, 719	
54.00		RADI OLOGY-DI AGNOSTI C	5, 432, 337		5, 432, 337	0	5, 432, 337	
54. 01		ULTRASOUND	532, 961		532, 961	0	532, 961	•
54. 02 55. 00		WOMEN' S CENTER RADI OLOGY-THERAPEUTI C	595, 285 0		595, 285 0	0	595, 285 0	54. 02 55. 00
56. 00		RADI OLOGI - THERAPEUTT C	1, 129, 116		1, 129, 116	0	1, 129, 116	1
57. 00		CT SCAN	1, 098, 364		1, 098, 364	0	1, 098, 364	•
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	1, 192, 456		1, 192, 456	0	1, 192, 456	•
59.00	1	CARDI AC CATHETERI ZATI ON	2, 026, 275		2, 026, 275	0	2, 026, 275	1
60. 00 60. 01	1	LABORATORY BLOOD LABORATORY	6, 476, 188		6, 476, 188	0	6, 476, 188 0	1
61. 00	1	PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61. 00
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS	374, 517		374, 517	0	374, 517	•
63. 00		BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63. 00
64. 00		I NTRAVENOUS THERAPY	0		0	0	0	
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	2, 064, 262 3, 758, 314	0	2, 064, 262 3, 758, 314	0	2, 064, 262 3, 758, 314	1
67. 00		OCCUPATIONAL THERAPY	744, 703		744, 703	0	744, 703	
68. 00		SPEECH PATHOLOGY	559, 315	0	559, 315	0	559, 315	
69. 00		ELECTROCARDI OLOGY	932, 695		932, 695	0	932, 695	1
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 183, 518 16, 125, 292		1, 183, 518 16, 125, 292	0	1, 183, 518 16, 125, 292	
71.00		IMPL. DEV. CHARGED TO PATIENTS	10, 123, 242		10, 123, 242	0	10, 125, 242	
73. 00		DRUGS CHARGED TO PATIENTS	12, 152, 266		12, 152, 266	0	12, 152, 266	•
74. 00		RENAL DIALYSIS	434, 173		434, 173	0	434, 173	1
75. 00		ASC (NON-DISTINCT PART)	0		0	0	0	75. 00
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	0		0	0	0	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	•
90.00		CLINIC	0		0	0	0	90. 00
90. 01		WOUND/OSTOMY CLINIC	1, 842, 457		1, 842, 457	0	1, 842, 457	1
90. 02 90. 03		KIDS PLUS CLINIC ONCOLOGY	0 6, 121, 206		0 6, 121, 206	0	0 6, 121, 206	
90. 03		MUNCIE CLINIC	0, 121, 200		0, 121, 200	0	0, 121, 200	90.03
90. 05		ANTICOAGULATION CLINIC	495, 725		495, 725	0	495, 725	
90. 06		PREGNANCY PLUS	0		0	0	0	•
90. 07		O/P LAB	0		0	0	0	90. 07 90. 08
90. 08 90. 09		O/P LAB FORTVILLE CLINIC	806		806	0	0 806	ı
90. 10		1030 S SCATTERFIELD (MEDCHECK)	0		0	0	0	90. 10
90. 11		DIABETIC PLUS CLINIC	665, 861		665, 861	0	665, 861	90. 11
91.00		EMERGENCY	7, 337, 700		7, 337, 700	0	7, 337, 700	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS	4, 443, 051		4, 443, 051		4, 443, 051	92. 00
94. 00		HOME PROGRAM DI ALYSIS	0		0	0	0	94. 00
95. 00		AMBULANCE SERVICES	0		0	0	0	95. 00
96. 00		DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96. 00
97. 00 99. 00	09700 09900	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97. 00 99. 00
	09900		0		0		0	•
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0		o o		0	100. 00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101. 00

Health Financial Systems	COMMUNITY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co	CN: 15-0113	Period: From 01/01/2018		
				To 12/31/2018	Date/Time Pre 5/28/2019 4:1	
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0			0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0			0		106. 00
107. 00 10700 LIVER ACQUISITION	0			0		107. 00
108.00 10800 LUNG ACQUISITION	0			0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	0			0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0			0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0			0	0	111.00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0			0	0	115. 00
116. 00 11600 HOSPI CE	0			0	0	116. 00
200.00 Subtotal (see instructions)	144, 307, 470	0	144, 307, 4	70 0	144, 307, 470	200.00
201.00 Less Observation Beds	4, 443, 051		4, 443, 0	51	4, 443, 051	201.00
202.00 Total (see instructions)	139, 864, 419	0	139, 864, 4	19 0	139, 864, 419	202. 00

				12/31/2010	5/28/2019 4:1	
			XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	53, 060, 690		53, 060, 690			30.00
31. 00 03100 INTENSIVE CARE UNIT	12, 875, 190		12, 875, 190			31.00
32. 00   03200   CORONARY CARE UNIT 33. 00   03300   BURN INTENSIVE CARE UNIT	0					32. 00 33. 00
34. 00   03400 SURGI CAL INTENSIVE CARE UNIT	0					34.00
40. 00   04000   SUBPROVI DER -   PF	o					40. 00
41. 00   04100   SUBPROVI DER -   I RF	0			)		41.00
42. 00   04200   SUBPROVI DER	O					42. 00
43. 00   04300   NURSERY	5, 134, 373		5, 134, 373	3		43. 00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0					44. 00
45.00   04500   NURSING FACILITY 46.00   04600   OTHER LONG TERM CARE	0 0		(			45. 00 46. 00
ANCI LLARY SERVI CE COST CENTERS	l ol			,		46.00
50. 00 05000 OPERATI NG ROOM	21, 268, 473	48, 389, 381	69, 657, 854	0. 212992	0. 000000	50.00
51.00   05100   RECOVERY ROOM	0	0		l	0.000000	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	O	0	(	0. 000000	0. 000000	52.00
53. 00 05300 ANESTHESI OLOGY	1, 823, 113	1, 729, 180			0. 000000	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 760, 965	13, 318, 311	17, 079, 276		0. 000000	54.00
54. 01   05401   ULTRASOUND	586, 589	2, 971, 770			0.000000	54. 01
54. 02   05402   WOMEN' S CENTER 55. 00   05500   RADI OLOGY-THERAPEUTI C	2, 888	3, 051, 016	3, 053, 904		0. 000000 0. 000000	54. 02 55. 00
56. 00   05600   RADI 01 SOTOPE	1, 102, 244	13, 814, 309	`		0. 000000	56.00
57. 00   05700   CT   SCAN	9, 094, 371	30, 549, 474			0. 000000	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 038, 894	10, 334, 902			0.000000	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	6, 146, 014	14, 979, 037			0.000000	59. 00
60. 00   06000   LABORATORY	12, 195, 960	33, 958, 573	1		0. 000000	60.00
60. 01   06001   BLOOD   LABORATORY	0	0	(		0. 000000	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	000 041	740.044	1 750 10	0. 000000 0. 213997	0. 000000 0. 000000	61.00
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS 63. 00   06300   BLOOD STORING, PROCESSING & TRANS.	990, 041 0	760, 066 0	1, 750, 107		0. 000000	62. 00 63. 00
64. 00   06400   NTRAVENOUS THERAPY	0	0		0. 000000	0. 000000	64.00
65. 00 06500 RESPIRATORY THERAPY	3, 494, 583	1, 274, 976	4, 769, 559		0. 000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 288, 803	9, 420, 885			0. 000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	738, 323	928, 352			0.000000	67. 00
68. 00   06800   SPEECH PATHOLOGY	502, 983	404, 979			0. 000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	4, 028, 050	9, 171, 260			0.000000	69.00
70.00   07000   ELECTROENCEPHALOGRAPHY 71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 225, 353 22, 583, 628	3, 434, 500 25, 179, 516			0. 000000 0. 000000	70. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	17, 718, 084	10, 091, 805			0. 000000	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	22, 097, 259	27, 997, 195			0. 000000	73. 00
74.00   07400   RENAL DI ALYSI S	520, 401	0	520, 401	0. 834305	0. 000000	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	(	0. 000000	0. 000000	75. 00
OUTPATIENT SERVICE COST CENTERS						00.00
88. 00   08800   RURAL HEALTH CLINIC 89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0	0	(			88. 00 89. 00
90. 00   09000   CLI NI C		0			0. 000000	90.00
90. 01 09001 WOUND/OSTOMY CLINIC	o	8, 565, 090			0. 000000	90. 01
90. 02 09002 KIDS PLUS CLINIC	0	0	(	0. 000000	0. 000000	90. 02
90. 03 09003 ONCOLOGY	671, 296	32, 443, 092	33, 114, 388		0.000000	90. 03
90. 04   09004   MUNCI E CLI NI C	0	0	()	0.000000	0. 000000	90. 04
90. 05   09005   ANTI COAGULATI ON CLI NI C 90. 06   09006   PREGNANCY PLUS	0	903, 811	903, 811		0.000000	90.05
90. 06   09006   PREGNANCY PLUS 90. 07   09007   0/P LAB	0	0	(	0. 000000 0. 000000	0. 000000 0. 000000	90. 06 90. 07
90. 08   09008   0/P LAB	0	0		0.000000	0. 000000	90.07
90. 09   09009 FORTVI LLE CLI NI C	o	0		0. 000000	0. 000000	90. 09
90.10 09010 1030 S SCATTERFIELD (MEDCHECK)	o	0	(	0. 000000	0. 000000	90. 10
90. 11 09011 DIABETIC PLUS CLINIC	0	2, 895			0.000000	90. 11
91. 00   09100   EMERGENCY	11, 028, 028	32, 960, 751	43, 988, 779		0. 000000	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	9, 855, 683	9, 855, 683	0. 450811	0. 000000	92.00
94. 00 OP400 HOME PROGRAM DI ALYSI S	l ol	0		0. 000000	0. 000000	94. 00
95. 00   09500   AMBULANCE   SERVI CES	0	0		1	0. 000000	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	o	0		l	0. 000000	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	o	0		l	0. 000000	97. 00
99. 00 09900 CMHC	0	0	(	)		99. 00
99. 10   09910   CORF	0	0	)			99. 10
100.00 10000 1&R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY	0 0	0				100. 00 101. 00
SPECIAL PURPOSE COST CENTERS	ı U	0	1	1		1101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	(			105. 00
<u> </u>						

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0113		Worksheet C Part I Date/Time Prepared: 5/28/2019 4:13 pm

					3/20/2019 4. 1	is pili
		Ti tl e	XVIII	Hospi tal	PPS	
	Charges					
Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6. 00	7. 00	8. 00	9. 00	10.00	
106. 00 10600 HEART ACQUI SI TI ON	0	0	)	O		106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	)	O		107. 00
108.00 10800 LUNG ACQUISITION	0	0	) (	O		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	)	O		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	) (	O		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	)	O		111. 00
113.00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	o	0	) (	O		115. 00
116. 00 11600 HOSPI CE	o	0	) (	O		116. 00
200.00 Subtotal (see instructions)	215, 976, 596	346, 490, 809	562, 467, 40!	5		200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	215, 976, 596	346, 490, 809	562, 467, 40!	5		202. 00

				10 12/31/2010	5/28/2019 4: 13	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
30. 00	03000 ADULTS & PEDIATRICS					30.00
31. 00	03100   NTENSI VE CARE UNIT					31.00
32. 00	03200 CORONARY CARE UNIT					32.00
33. 00	03300 BURN INTENSIVE CARE UNIT					33. 00
34. 00	03400 SURGI CAL INTENSI VE CARE UNI T					34. 00
40. 00	04000 SUBPROVI DER – I PF					40.00
41. 00	04100 SUBPROVI DER – I RF					41. 00
42. 00	04200 SUBPROVI DER					42. 00
43. 00	04300 NURSERY					43. 00
44. 00	04400 SKILLED NURSING FACILITY					44. 00
45. 00	04500 NURSING FACILITY					45. 00
46. 00	04600 OTHER LONG TERM CARE					46. 00
10.00	ANCI LLARY SERVI CE COST CENTERS					10.00
50.00	05000 OPERATI NG ROOM	0. 212992				50.00
51. 00	05100 RECOVERY ROOM	0. 000000				51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52. 00
53. 00	05300 ANESTHESI OLOGY	0. 090567				53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 318066				54.00
54. 01	05401 ULTRASOUND	0. 149777				54. 01
54. 02	05402 WOMEN' S CENTER	0. 194926				54. 02
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000				55. 00
56. 00	05600 RADI OI SOTOPE	0. 075696				56.00
57. 00	05700 CT SCAN	0. 027706				57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 096369				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 095918				59.00
60.00	06000 LABORATORY	0. 140315				60.00
60. 01	06001 BLOOD LABORATORY	0. 000000				60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000				61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 213997				62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000				64.00
65. 00	06500 RESPI RATORY THERAPY	0. 432799				65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 350927				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 446820				67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 616011				68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 070662				69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 253982				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 337610				71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 367023				72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 242587				73.00
74. 00	07400 RENAL DIALYSIS	0. 834305				74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000				75. 00
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC					88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER					89. 00
90.00	09000 CLI NI C	0. 000000				90.00
90. 01	09001 WOUND/OSTOMY CLINIC	0. 215112				90. 01
90. 02	09002 KIDS PLUS CLINIC	0. 000000				90. 02
90. 03	09003 ONCOLOGY	0. 184850				90. 03
90. 04	09004 MUNCI E CLINIC	0. 000000				90. 04
90. 05	09005 ANTI COAGULATI ON CLINIC	0. 548483				90. 05
90.06	09006 PREGNANCY PLUS	0. 000000				90.06
90. 07	09007 0/P LAB	0. 000000				90. 07
90. 08	09008 0/P LAB	0. 000000				90. 08
90. 09	09009 FORTVILLE CLINIC	0. 000000				90. 09
90. 10	09010 1030 S SCATTERFIELD (MEDCHECK)	0. 000000				90. 10
90. 11	09011 DI ABETI C PLUS CLI NI C	230. 003800				90. 11
91.00	09100 EMERGENCY	0. 166808				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 450811				92.00
	OTHER REIMBURSABLE COST CENTERS					1
94. 00	09400 HOME PROGRAM DIALYSIS	0. 000000				94. 00
95. 00	09500 AMBULANCE SERVICES	0. 000000				95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000				96.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000				97. 00
	09900 CMHC	3. 333333				99.00
	09910 CORF					99. 10
	10000 I &R SERVICES-NOT APPRVD PRGM					100.00
	10100 HOME HEALTH AGENCY				•	101.00
101.00	SPECIAL PURPOSE COST CENTERS					
105 00	10500 KIDNEY ACQUISITION					105. 00
	10600 HEART ACQUISITION				•	106. 00
	10700 LIVER ACQUISITION					107. 00
	1 1	1				

Health Financial Systems	COMMUNITY HOSPIT	TAL ANDERSON	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0113	Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/28/2019 4:1	epared:	
		Title XVIII	Hospi tal	PPS		
Cost Center Description	PPS Inpatient Ratio 11.00					
108.00 10800 LUNG ACQUISITION					108. 00	
109.00 10900 PANCREAS ACQUISITION					109.00	
110. 00 11000 INTESTINAL ACQUISITION					110.00	
111.00 11100 I SLET ACQUI SITION					111. 00	
113.00 11300 INTEREST EXPENSE					113. 00	
114.00 11400 UTILIZATION REVIEW-SNF					114. 00	
44E OO 44EOO AMBUU ATODY CUBOLOAL OFNITED (D.D.)					1445 00	

115. 00 116. 00

200. 00 201. 00 202. 00

115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)
116.00 11600 HOSPICE
200.00 Subtotal (see instructions)
201.00 Less Observation Beds

202.00

Subtotal (see instructions)
Less Observation Beds
Total (see instructions)

						0 12/31/2010	5/28/2019 4:1	3 pm
				Ti tl	e XIX	Hospi tal	Cost	
		Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
			26)					
			1.00	2. 00	3. 00	4. 00	5. 00	
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	32, 416, 575	I	32, 416, 575	0	32, 416, 575	30.00
31. 00	1	INTENSIVE CARE UNIT	6, 542, 241		6, 542, 241	0	6, 542, 241	31.00
32. 00		CORONARY CARE UNIT	0, 342, 241		0, 342, 241	0	0, 342, 241	32.00
33. 00		BURN INTENSIVE CARE UNIT	0		0	0	0	33. 00
34.00		SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
40.00	04000	SUBPROVI DER - I PF	0		0	0	0	40. 00
41. 00	1	SUBPROVI DER - I RF	0		0	0	0	41. 00
42. 00		SUBPROVI DER	0		0	0	0	
43. 00 44. 00	1	NURSERY	2, 264, 644		2, 264, 644	0	2, 264, 644	
45. 00		SKILLED NURSING FACILITY NURSING FACILITY	0		0	0	0	
46. 00		OTHER LONG TERM CARE	0		0	0	0	46. 00
10.00		LARY SERVICE COST CENTERS						10.00
50.00		OPERATING ROOM	14, 836, 571		14, 836, 571	0	14, 836, 571	50. 00
51.00		RECOVERY ROOM	0		0	0	0	51.00
52.00		DELIVERY ROOM & LABOR ROOM	0		0	0	0	
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	321, 719 5, 432, 337		321, 719 5, 432, 337	0	321, 719 5, 432, 337	1
54. 00		ULTRASOUND	532, 961		532, 961	0	532, 961	
54. 02		WOMEN' S CENTER	595, 285		595, 285	0	595, 285	•
55. 00		RADI OLOGY-THERAPEUTI C	0		0	0	0	55. 00
56.00		RADI OI SOTOPE	1, 129, 116		1, 129, 116	0	1, 129, 116	56. 00
57. 00		CT SCAN	1, 098, 364		1, 098, 364	0	1, 098, 364	
58. 00		MAGNETIC RESONANCE I MAGING (MRI)	1, 192, 456		1, 192, 456	0	1, 192, 456	•
59.00		CARDI AC CATHETERI ZATI ON	2, 026, 275		2, 026, 275	0	2, 026, 275	•
60. 00 60. 01	1	LABORATORY BLOOD LABORATORY	6, 476, 188		6, 476, 188	0	6, 476, 188 0	1
61. 00	1	PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61. 00
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS	374, 517		374, 517	0	374, 517	•
63.00		BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63. 00
64.00		I NTRAVENOUS THERAPY	0		0	0	0	64. 00
65. 00		RESPI RATORY THERAPY	2, 064, 262	l e		0	2, 064, 262	1
66.00		PHYSI CAL THERAPY	3, 758, 314	l e	3, 758, 314	0	3, 758, 314	
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	744, 703 559, 315	l e		0	744, 703 559, 315	
69. 00		ELECTROCARDI OLOGY	932, 695	l e	932, 695	0	932, 695	
70. 00		ELECTROENCEPHALOGRAPHY	1, 183, 518	l e	1, 183, 518	0	1, 183, 518	1
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 125, 292		16, 125, 292	0	16, 125, 292	71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	10, 206, 877		10, 206, 877	0	10, 206, 877	1
73.00		DRUGS CHARGED TO PATIENTS	12, 152, 266	l	12, 152, 266		12, 152, 266	1
74. 00 75. 00		RENAL DIALYSIS ASC (NON-DISTINCT PART)	434, 173 0		434, 173 0	0	434, 173 0	1
75.00		TIENT SERVICE COST CENTERS	0		0	<u> </u>	0	75.00
88. 00		RURAL HEALTH CLINIC	0		0	0	0	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89. 00
90.00		CLI NI C	0		0	0	0	90.00
90. 01		WOUND/OSTOMY CLINIC	1, 842, 457		1, 842, 457	0	1, 842, 457	1
90. 02 90. 03		KIDS PLUS CLINIC ONCOLOGY	6, 121, 206		6, 121, 206	0	0 6, 121, 206	
90. 04		MUNCI E CLINIC	0, 121, 200		0, 121, 200	0	0, 121, 200	90.03
90. 05		ANTICOAGULATION CLINIC	495, 725		495, 725	0	495, 725	
90.06	09006	PREGNANCY PLUS	0		0	0	0	90. 06
90. 07		O/P LAB	0		0	0	0	90. 07
90. 08		O/P LAB	0		0	0	0	•
90. 09 90. 10		FORTVILLE CLINIC   1030 S SCATTERFIELD (MEDCHECK)	806		806	0	806 0	90. 09 90. 10
90. 10	1	DIABETIC PLUS CLINIC	665, 861		665, 861	0	665, 861	90. 10
91. 00		EMERGENCY	7, 337, 700		7, 337, 700	0	7, 337, 700	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	4, 443, 051		4, 443, 051		4, 443, 051	
		REIMBURSABLE COST CENTERS						
94.00		HOME PROGRAM DI ALYSI S	0		0	0	0	•
95.00		AMBULANCE SERVICES	0		0	0	0	95.00
96. 00 97. 00		DURABLE MEDICAL EQUIP-RENTED DURABLE MEDICAL EQUIP-SOLD					0	96. 00 97. 00
	09900		0				0	•
	09910		0		Ö		0	•
		I&R SERVICES-NOT APPRVD PRGM	0		0			100. 00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101. 00

Health Financial Systems	COMMUNITY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-0113	Peri od: From 01/01/2018 To 12/31/2018		
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2. 00	3.00	4. 00	5. 00	
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KIDNEY ACQUISITION	0			0	0	105. 00
106.00 10600 HEART ACQUISITION	0			0	0	106. 00
107.00 10700 LIVER ACQUISITION	0			0	0	107. 00
108.00 10800 LUNG ACQUISITION	0			0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	0			0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0			0	0	110. 00
111.00 11100 I SLET ACQUI SI TI ON	0			0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0			0	0	115. 00
116. 00 11600 HOSPI CE	0			0	0	116. 00
200.00 Subtotal (see instructions)	144, 307, 470	0	144, 307, 4	70 0	144, 307, 470	200.00
201.00 Less Observation Beds	4, 443, 051		4, 443, 0	51	4, 443, 051	201. 00
202.00 Total (see instructions)	139, 864, 419	0	139, 864, 4	19 0	139, 864, 419	202. 00

				12/31/2010	5/28/2019 4:1	
			e XIX	Hospi tal	Cost	
Cost Center Description	I npati ent	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
	6. 00	7. 00	8. 00	9. 00	10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			2.22	1.00		
30. 00 03000 ADULTS & PEDIATRICS	53, 060, 690		53, 060, 690			30. 00
31.00 03100 INTENSIVE CARE UNIT	12, 875, 190		12, 875, 190			31.00
32. 00   03200   CORONARY CARE UNIT	0		(			32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	0		(			33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT	0					34.00
40. 00   04000   SUBPROVI DER -   PF 41. 00   04100   SUBPROVI DER -   RF	0					40. 00 41. 00
42. 00   04200   SUBPROVI DER						42.00
43. 00 04300 NURSERY	5, 134, 373		5, 134, 373	S I		43. 00
44.00 04400 SKILLED NURSING FACILITY	0					44. 00
45.00 04500 NURSING FACILITY	o					45. 00
46.00 O4600 OTHER LONG TERM CARE	0		(	)		46. 00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	21, 268, 473	48, 389, 381			0.000000	50.00
51. 00   05100   RECOVERY ROOM 52. 00   05200   DELIVERY ROOM & LABOR ROOM	0	0		0. 000000 0. 000000	0. 000000 0. 000000	51. 00 52. 00
53. 00   05200   DELI VERT   ROOM & LABOR ROOM   53. 00   05300   ANESTHESI OLOGY	1, 823, 113	1, 729, 180	3, 552, 293		0. 000000	53.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	3, 760, 965	13, 318, 311			0. 000000	54.00
54. 01   05401   ULTRASOUND	586, 589	2, 971, 770			0. 000000	54. 01
54. 02   05402   WOMEN' S CENTER	2, 888	3, 051, 016			0.000000	54. 02
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	0	(	0.00000	0.000000	55. 00
56. 00   05600   RADI 0I SOTOPE	1, 102, 244	13, 814, 309			0. 000000	56. 00
57. 00   05700   CT   SCAN	9, 094, 371	30, 549, 474			0. 000000	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 038, 894	10, 334, 902			0.000000	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON 60. 00   06000   LABORATORY	6, 146, 014 12, 195, 960	14, 979, 037 33, 958, 573			0. 000000 0. 000000	59. 00 60. 00
60. 01   06000   EABORATORY	12, 193, 900	33, <del>7</del> 30, 373	40, 154, 555		0. 000000	60.00
61. 00 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY	0	0		0. 000000	0. 000000	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	990, 041	760, 066	1, 750, 107		0. 000000	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	1		0.000000	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	(	0. 000000	0.000000	64. 00
65. 00 06500 RESPI RATORY THERAPY	3, 494, 583	1, 274, 976			0. 000000	65. 00
66. 00   06600   PHYSI CAL THERAPY	1, 288, 803	9, 420, 885			0. 000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	738, 323	928, 352			0.000000	67.00
68. 00   06800  SPEECH PATHOLOGY 69. 00   06900  ELECTROCARDI OLOGY	502, 983 4, 028, 050	404, 979 9, 171, 260	1		0. 000000 0. 000000	68. 00 69. 00
70. 00 07000 ELECTROCARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 225, 353	3, 434, 500			0. 000000	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	22, 583, 628	25, 179, 516			0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	17, 718, 084	10, 091, 805			0. 000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	22, 097, 259	27, 997, 195	50, 094, 454	0. 242587	0. 000000	73. 00
74.00 07400 RENAL DIALYSIS	520, 401	0	520, 401		0.000000	74. 00
75. 00   07500   ASC (NON-DISTINCT PART)	0	0	(	0. 000000	0. 000000	75. 00
OUTPATIENT SERVICE COST CENTERS			ı ,	0.000000	0. 000000	1 00 00
88. 00   08800   RURAL HEALTH CLINIC 89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0 0	0	1		0. 000000	
90. 00   09000   CLI NI C		0			0. 000000	90.00
90. 01 09001 WOUND/OSTOMY CLINIC	o	8, 565, 090	1		0. 000000	90. 01
90. 02 09002 KIDS PLUS CLINIC	0	0	(	0. 000000	0.000000	90. 02
90. 03   09003   0NCOLOGY	671, 296	32, 443, 092	33, 114, 388	0. 184850	0.000000	90. 03
90. 04   09004   MUNCIE CLINIC	0	0	(	0. 000000	0. 000000	90. 04
90. 05   09005   ANTI COAGULATI ON CLI NI C	0	903, 811	903, 811		0. 000000	90. 05
90. 06   09006   PREGNANCY PLUS	0	0		0.000000	0.000000	90.06
90. 07   09007   0/P LAB 90. 08   09008   0/P LAB	0	0		0. 000000 0. 000000	0. 000000 0. 000000	90. 07 90. 08
90. 09   09009   FORTVI LLE CLI NI C		0			0. 000000	90.08
90. 10 09010 1030 S SCATTERFIELD (MEDCHECK)		0		0. 000000	0. 000000	90. 10
90. 11 09011 DI ABETI C PLUS CLINI C	o	2, 895	2, 895		0. 000000	90. 11
91. 00 09100 EMERGENCY	11, 028, 028	32, 960, 751	43, 988, 779	0. 166808	0.000000	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0	9, 855, 683	9, 855, 683	0. 450811	0.000000	92. 00
OTHER REIMBURSABLE COST CENTERS	,		1			
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0			0.000000	94.00
95. 00   09500   AMBULANCE SERVI CES 96. 00   09600   DURABLE MEDI CAL EQUI P-RENTED	0	0			0. 000000 0. 000000	95.00
97. 00   09700   DURABLE MEDI CAL EQUI P-RENTED		0		l	0. 000000	96. 00 97. 00
99. 00   09900 CMHC		0		0.000000	0.000000	99.00
99. 10 09910 CORF		0		ol l		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	o	0				100.00
101.00 10100 HOME HEALTH AGENCY	0	0				101. 00
SPECIAL PURPOSE COST CENTERS			1			405 55
105. 00 10500 KIDNEY ACQUISITION	0	0	(	ן		105. 00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0113	From 01/01/2018	Worksheet C Part I Date/Time Prepared: 5/28/2019 4:13 nm

					5/28/2019 4:1	13 pm
		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Rati o	
	6.00	7. 00	8. 00	9. 00	10.00	
106.00 10600 HEART ACQUISITION	0	0	C			106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	C			107. 00
108.00 10800 LUNG ACQUISITION	0	0	C			108.00
109.00 10900 PANCREAS ACQUISITION	0	0	C			109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	C			110.00
111.00 11100 ISLET ACQUISITION	0	0	C			111.00
113. 00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	C			115.00
116. 00 11600 HOSPI CE	0	0	C			116.00
200.00 Subtotal (see instructions)	215, 976, 596	346, 490, 809	562, 467, 405	5		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	215, 976, 596	346, 490, 809	562, 467, 405	5		202.00

5/28/2019 4:13 pm Title XIX Hospi tal Cost Cost Center Description PPS Inpatient Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 32.00 03200 CORONARY CARE UNIT 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 40.00 40.00 41.00 41 00 04200 SUBPROVI DER 42.00 42.00 43 00 04300 NURSERY 43.00 04400 SKILLED NURSING FACILITY 44.00 44 00 45.00 04500 NURSING FACILITY 45.00 46.00 04600 OTHER LONG TERM CARE 46.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 50.00 0.000000 51.00 05100 RECOVERY ROOM 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 0.000000 05300 ANESTHESI OLOGY 0.000000 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 54 00 05401 ULTRASOUND 0.000000 54.01 54.01 54.02 05402 WOMEN'S CENTER 0.000000 54.02 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 55.00 56.00 05600 RADI OI SOTOPE 0.000000 56.00 57.00 05700 CT SCAN 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0.000000 58.00 05900 CARDI AC CATHETERI ZATI ON 59 00 0.000000 59 00 60.00 06000 LABORATORY 0.000000 60.00 06001 BLOOD LABORATORY 60.01 0.000000 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 62.00 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63.00 06400 INTRAVENOUS THERAPY 64.00 0.000000 64.00 06500 RESPIRATORY THERAPY 65 00 0.000000 65 00 06600 PHYSI CAL THERAPY 66.00 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 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 07300 DRUGS CHARGED TO PATIENTS 73.00 0.000000 73.00 74.00 07400 RENAL DIALYSIS 0.000000 74.00 07500 ASC (NON-DISTINCT PART)
OUTPATIENT SERVICE COST CENTERS 75.00 0.000000 75.00 88.00 08800 RURAL HEALTH CLINIC 0.000000 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89.00 90.00 09000 CLI NI C 0.000000 90.00 09001 WOUND/OSTOMY CLINIC 90.01 0.000000 90.01 90.02 09002 KIDS PLUS CLINIC 0.000000 90.02 09003 ONCOLOGY 0.000000 90.03 90.03 90.04 09004 MUNCIE CLINIC 0.000000 90.04 09005 ANTI COAGULATION CLINIC 90.05 0.000000 90.05 90.06 09006 PREGNANCY PLUS 0.000000 90.06 90. 07 09007 0/P LAB 0.000000 90.07 09008 0/P LAB 0.000000 90.08 90.08 09009 FORTVILLE CLINIC 90.09 0.000000 90.09 90.10 09010 1030 S SCATTERFIELD (MEDCHECK) 0.000000 90.10 09011 DIABETIC PLUS CLINIC 90. 11 0.000000 90.11 09100 EMERGENCY 91.00 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0.000000 94.00 09500 AMBULANCE SERVICES 95.00 0.000000 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 96.00 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 0.000000 97.00 99. 00 09900 CMHC 99.00 99. 10 09910 CORF 99. 10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 100.00 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 105.00 106. 00 10600 HEART ACQUISITION 106.00 107. 00 10700 LIVER ACQUISITION 107. 00

Health Financial Systems	COMMUNITY HOSPI	TAL ANDERSON	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0113	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/28/2019 4:13 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient Ratio 11.00			
108. 00   10800   LUNG ACQUISITION   109. 00   10900   PANCREAS ACQUISITION   110. 00   11000   INTESTINAL ACQUISITION   113. 00   11300   ISLET ACQUISITION   114. 00   11400   UTILIZATION REVIEW-SNF   115. 00   11500   AMBULATORY SURGICAL CENTER (D. P.)   116. 00   11600   HOSPICE   Subtotal (see instructions)   Less Observation Beds   Total (see instructions)				108. 00 109. 00 110. 00 111. 00 1113. 00 114. 00 115. 00 200. 00 201. 00 202. 00

Health Financial Systems	COMMUNITY HOSP	ITAL ANDERSON		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part I Date/Time Pre 5/28/2019 4:1	pared:
			XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col 2)		3 / col . 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 SURGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 42.00 SUBPROVIDER 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30 through 199)  Cost Center Description	2, 216, 375 453, 436 0 0 0 0 0 0 66, 732 0 0 2, 736, 543 Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col.	2, 216, 33 453, 43 66, 73 2, 736, 54	1, 368 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 36. 89 0. 00	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS  30.00 ADULTS & PEDIATRICS INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 SURGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 42.00 SUBPROVIDER 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30 through 199)	8, 745 1, 302 0 0 0 0 0 0 0 0 0 0 0 0 0 0	431, 561 0 0 0 0 0 0 0 0				30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 00 200. 00

Health Financial Systems	COMMUNITY HOSP	ITAL ANDERSON		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co		Period: From 01/01/2018 To 12/31/2018		pared:
		Ti tl e	XVIII	Hospi tal	PPS	о ріп
Cost Center Description	Capi tal	Total Charges			Capital Costs	
cost center bescription	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	0.00				
	1.00	2.00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS	T					
50. 00 05000 OPERATING ROOM	2, 194, 146	69, 657, 854			252, 843	
51.00   05100   RECOVERY ROOM	0	0	0. 00000		0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	0. 00000		0	52. 00
53. 00   05300   ANESTHESI OLOGY	17, 883	3, 552, 293	0. 00503	4 310, 175	1, 561	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	734, 071	17, 079, 276	0. 04298	0 1, 905, 309	81, 890	54. 00
54. 01   05401   ULTRASOUND	61, 185	3, 558, 359	0. 01719	5 94, 553	1, 626	54. 01
54. 02   05402   WOMEN' S CENTER	18, 769	3, 053, 904	0.00614	6 0	0	54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.00000	0 0	0	55. 00
56. 00 05600 RADI OI SOTOPE	53, 020	14, 916, 553			1, 833	56.00
57. 00   05700 CT SCAN	20, 655				2, 059	1
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	49, 582				2, 902	58.00
59. 00   05900   CARDI AC CATHETERI ZATI ON	305, 198				29, 308	
60. 00   06000   LABORATORY	459, 129				49, 401	1
	437, 127				0	60.00
	0	0	0. 00000	U U	U	1
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	40.005	4 750 407	0.04404	000 (44	4 000	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	19, 285				4, 392	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	•			0	63. 00
64.00   06400   I NTRAVENOUS THERAPY	0	-	0. 00000		0	64. 00
65. 00   06500   RESPI RATORY THERAPY	75, 039				24, 112	
66. 00  06600 PHYSI CAL THERAPY	98, 456	10, 709, 688	0. 00919			66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	63, 449	1, 666, 675	0. 03806	9 288, 233	10, 973	67. 00
68. 00   06800   SPEECH PATHOLOGY	51, 957	907, 962	0. 05722	4 230, 465	13, 188	68. 00
69. 00 06900 ELECTROCARDI OLOGY	78, 914	13, 199, 310	0. 00597	9 1, 598, 073	9, 555	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	87, 699	4, 659, 853	0. 01882	0 439, 606	8, 273	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	184, 034	47, 763, 144	0.00385	3 7, 956, 617	30, 657	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	116, 486	27, 809, 889	0.00418	9 6, 556, 842	27, 467	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	179, 146					
74.00 07400 RENAL DIALYSIS	7, 805		0. 01499		0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0		1			75. 00
OUTPATIENT SERVICE COST CENTERS				-		
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.00000	0 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000		0	
90. 00   09000   CLI NI C	0		0. 00000		Ō	90.00
90. 01 09001 WOUND/OSTOMY CLINIC	277, 080				ő	90. 01
90. 02 09002 KIDS PLUS CLINIC	277,000	0,000,070	0. 00000		0	90. 02
90. 03   09003   0NCOLOGY	1, 198, 513	33, 114, 388				
90. 04   09004   MUNCI E CLINI C	1, 170, 513	33, 114, 300	0.00000		12, 900	90.03
	7 025	002 011				
90. 05 09005 ANTI COAGULATI ON CLINI C	7, 035		0.00778		0	90.05
90. 06   09006   PREGNANCY PLUS	0				0	
90. 07   09007   0/P LAB	0	1			_	
90. 08  09008  0/P LAB	0	0			0	
90. 09   09009   FORTVILLE CLINIC	6	0	0.00000	0	0	90. 09
90. 10   09010   1030 S SCATTERFIELD (MEDCHECK)	0	0	0.00000	0	0	90. 10
90. 11   09011   DIABETIC PLUS CLINIC	6, 451	2, 895	2. 22832	5 0	0	90. 11
91. 00 09100 EMERGENCY	410, 164	43, 988, 779	0.00932	4, 751, 340	44, 301	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	303, 780	9, 855, 683	0. 03082	3 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0.00000	0 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	1					95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0. 00000	0 0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	1 0	0. 00000		0	97. 00
200.00 Total (lines 50 through 199)	7, 078, 937	491, 397, 152		53, 856, 931		
,			'			

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

Health Financial Systems	COMMUNITY HOSP	TIAL ANDERSON		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER I	PASS THROUGH COS	TS Provider C	F	Period: From 01/01/2018 To 12/31/2018		pared:
		Ti tl e	e XVIII	Hospi tal	PPS	5 piii
Cost Center Description	Nursing School	Nursing School			All Other	
oost conten beschiption	Post-Stepdown		Post-Stepdown		Medi cal	
	Adjustments		Adjustments	0031	Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	IA	1.00	ZA	2.00	3.00	
			\	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1 0	20.00
30. 00   03000   ADULTS & PEDI ATRI CS	C	1				
31. 00 03100 INTENSIVE CARE UNIT	C	1				
32. 00   03200   CORONARY CARE UNIT	C	) (	) (	0	0	
33.00   03300   BURN INTENSIVE CARE UNIT	C	) (	) (	0	0	33. 00
34.00   03400   SURGI CAL INTENSIVE CARE UNIT			) (	0	0	34.00
40. 00   04000   SUBPROVI DER - 1 PF				0	0	40.00
41. 00   04100   SUBPROVI DER - I RF				0	0	41.00
42. 00   04200   SUBPROVI DER				0	Ō	1
43. 00 04300 NURSERY					0	1
					0	44. 00
45. 00   04500   NURSI NG FACI LI TY			)	0	_	45. 00
200.00   Total (lines 30 through 199)	C		) (	0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4.00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	C		28, 367	0.00	8, 745	30.00
31.00 03100 INTENSIVE CARE UNIT			1		1, 302	
32. 00 03200 CORONARY CARE UNIT			1			
33. 00 03300 BURN INTENSIVE CARE UNIT				0.00	0	1
			Ί	0.00		1
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT		,	Ί '	0.00		
40. 00   04000   SUBPROVI DER - I PF	C	1		0.00	0	1
41. 00   04100   SUBPROVI DER - I RF	C				0	
42. 00   04200   SUBPROVI DER			) (	0.00	0	
43. 00   04300   NURSERY			1, 809	0.00	0	43.00
44.00   04400   SKILLED NURSING FACILITY				0.00	0	44.00
45.00 04500 NURSING FACILITY				0.00	0	45. 00
200.00 Total (lines 30 through 199)			31, 544	ı	10 047	200. 00
Cost Center Description	Inpatient		, 31,731	·I	10/01/	200.00
oost conten beschiption	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)	-				
INDATIENT DOUTINE CEDVICE COCT CENTERS	9. 00					
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		\				20.00
30. 00   03000   ADULTS & PEDI ATRI CS	C	1				30.00
31.00 03100 NTENSIVE CARE UNIT	C					31. 00
32. 00  03200   CORONARY CARE UNIT	(					32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	C	)				33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT						34.00
40. 00   04000   SUBPROVI DER - I PF		ol				40.00
41. 00   04100   SUBPROVI DER -   RF						41. 00
42. 00   04200   SUBPROVI DER		1				42. 00
43. 00   04300   NURSERY		1				43. 00
	1	1				
44. 00 04400 SKILLED NURSING FACILITY	C					44. 00
45. 00 04500 NURSING FACILITY	C					45. 00
200.00   Total (lines 30 through 199)	C	기				200. 00

Peri od: Worksheet D
From 01/01/2018
To 12/31/2018 Date/Time Prepared: 5/28/2019 4:13 pm THROUGH COSTS

						5/28/2019 4: 1.	3 pm
				XVIII	Hospi tal	PPS	
	Cost Center Description		Nursing School	Nursing School	Allied Health	Allied Health	
		Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1, 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0	0	50. 00
51.00	05100 RECOVERY ROOM						51.00
	1						
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	0	(	0	0	54. 00
54. 01	05401 ULTRASOUND	0	0	(	0	0	54. 01
54.02	05402 WOMEN' S CENTER	0	0	(	0	0	54. 02
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	1	0	o	55. 00
56. 00	05600 RADI OI SOTOPE	0	0		0		56. 00
57. 00	05700 CT SCAN		Ö				57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		ĺ				58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60. 00	06000 LABORATORY	0	0	1	_		60. 00
60. 01	06001 BLOOD LABORATORY	0	0	(	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	1	0	o	63. 00
64.00	06400 I NTRAVENOUS THERAPY		0	ď	0	1	64.00
65. 00	06500 RESPIRATORY THERAPY		l o	1	_	_	65. 00
66. 00	06600 PHYSI CAL THERAPY		٥				66. 00
	l l						
67. 00	06700 OCCUPATI ONAL THERAPY		0			_	67. 00
68. 00	06800 SPEECH PATHOLOGY		0			1	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0			1	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	(	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	1	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	1	0	o	74.00
75. 00	07500 ASC (NON-DISTINCT PART)						75. 00
73.00	OUTPATIENT SERVICE COST CENTERS				, 0		75.00
00 00			0		0		00 00
88. 00	08800 RURAL HEALTH CLINIC						88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0				•	89. 00
90. 00	09000 CLI NI C	0	1	1			90. 00
90. 01	09001 WOUND/OSTOMY CLINIC	0	0	[	0	0	90. 01
90. 02	09002 KIDS PLUS CLINIC	0	0	(	0	0	90. 02
90. 03	09003 ONCOLOGY	0	0	(	0	0	90. 03
90.04	09004 MUNCIE CLINIC	0	l 0	1 0	0	ol	90. 04
90. 05	09005 ANTI COAGULATI ON CLINIC	1	0		0	o	90. 05
90. 06	09006 PREGNANCY PLUS		Ö			1	90. 06
90. 07	09007 0/P LAB		1			1	90. 07
	1						
90. 08	09008 0/P LAB		0			_	90. 08
90.09	09009 FORTVILLE CLINIC		0			_	90. 09
90. 10	09010 1030 S SCATTERFIELD (MEDCHECK)	0	0		_	1	90. 10
90. 11	09011 DI ABETI C PLUS CLINI C	0	0				90. 11
91.00	09100 EMERGENCY	0	0	C	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		(	)	0	92.00
	OTHER REIMBURSABLE COST CENTERS				•		
94.00	09400 HOME PROGRAM DI ALYSI S	0	0	(	0	0	94. 00
95. 00	09500 AMBULANCE SERVICES		l				95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	o	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-RENTED		1				97. 00
200.00	Total (lines 50 through 199)	1	1	I	0	1	200. 00

| Peri od: | Worksheet D | From 01/01/2018 | Part IV | To | 12/31/2018 | Date/Time | Prepared: | THROUGH COSTS

					10 12/31/2018	5/28/2019 4:1	
			Ti tl e	e XVIII	Hospi tal	PPS	<u> </u>
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
			ĺ	and 4)		,	
		4. 00	5. 00	6.00	7. 00	8. 00	
-	ANCILLARY SERVICE COST CENTERS	*			<u>'</u>		
50.00	05000 OPERATI NG ROOM	0	C	)	69, 657, 854	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	C		0	0.000000	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C		0	0.000000	52. 00
53.00	05300 ANESTHESI OLOGY	0	C		3, 552, 293	0.000000	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C		17, 079, 276	0.000000	54.00
54. 01	05401 ULTRASOUND	0	C		3, 558, 359	0.000000	54. 01
54. 02	05402 WOMEN' S CENTER	0	C		3, 053, 904	0.000000	54. 02
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C		0	0.000000	55. 00
56.00	05600 RADI OI SOTOPE	0	C		14, 916, 553	0.000000	56. 00
57.00	05700 CT SCAN	0	C		39, 643, 845		57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	Ċ		12, 373, 796		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	Ċ		21, 125, 051	0.000000	59. 00
60.00	06000 LABORATORY	0	Ċ		46, 154, 533		60.00
60. 01	06001 BLOOD LABORATORY	0	d		0		60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	c		1, 750, 107	0. 000000	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	Č		) .,,,,,,,	0. 000000	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	Č			0. 000000	64. 00
65. 00	06500 RESPI RATORY THERAPY			1	4, 769, 559		65. 00
66. 00	06600 PHYSI CAL THERAPY			1	10, 709, 688		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY			1	1, 666, 675		67. 00
68. 00	06800 SPEECH PATHOLOGY	0		1	907, 962		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		•	13, 199, 310		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0		1	4, 659, 853		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		1	47, 763, 144		71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		1	27, 809, 889		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0		1	50, 094, 454		73. 00
74. 00	07400 RENAL DIALYSIS	0			520, 401		
75. 00	07500 ASC (NON-DISTINCT PART)	0	_		0 320, 401		75. 00
73.00	OUTPATIENT SERVICE COST CENTERS			'I	5  0	0.000000	75.00
88. 00	08800 RURAL HEALTH CLINIC	0	C	1	0	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER			1			89. 00
90. 00	09000 CLINIC			1		0.000000	90.00
90. 01	09001 WOUND/OSTOMY CLINIC			1	8, 565, 090		90.00
90. 01	09002 KIDS PLUS CLINIC			1	0, 303, 070	0.000000	90. 01
90. 02	09003 ONCOLOGY			1	33, 114, 388		90. 02
90. 04	09004 MUNCIE CLINIC			1	0 33, 114, 300	0.000000	90.03
90. 05	09005 ANTI COAGULATI ON CLINIC			1	903, 811	0.000000	90.05
90.06	09006 PREGNANCY PLUS			1	0 703, 011		90.06
90.00	09007 0/P LAB			1		0.000000	90.00
90. 07	09008 0/P LAB				0	0.000000	90.07
90.08	09009 FORTVILLE CLINIC					0.00000	
90. 09	09010 1030 S SCATTERFIELD (MEDCHECK)			l			•
90. 10			C	1			•
	O9011   DI ABETI C PLUS CLINI C   O9100   EMERGENCY	0		1	2, 895		
91.00		_	_	•	43, 988, 779		•
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C	'	9, 855, 683	0.000000	92. 00
04.00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	0		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1 0	0.000000	04.00
94.00	· ·		C	ή '	0	0.000000	94.00
95. 00	09500 AMBULANCE SERVICES		,			0.00000	95. 00
96. 00 97. 00	09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD	0	C		0	0. 000000 0. 000000	96. 00 97. 00
200.00			C C	1	0 491, 397, 152		97. 00 200. 00
200. U	p Total (Titles 50 till bugli 199)	1	١ ٠	'I	ع <sub>ار</sub> 471, 377, 132	I	<sub>1</sub> 200.00

| Peri od: | Worksheet D | From 01/01/2018 | Part IV | To 12/31/2018 | Date/Time Prepared: THROUGH COSTS

					0 12/31/2018	5/28/2019 4:13	
			Titl∈	xVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
	ANOLILIA DIVI OF DUTI OF ADOT ACRITEDO	9. 00	10. 00	11. 00	12. 00	13. 00	
F0 00	ANCILLARY SERVICE COST CENTERS	0.000000	0.007.007		40.000.440		F0 00
50.00	05000 OPERATING ROOM	0.000000	8, 027, 027	1	13, 099, 412		50.00
51.00	05100 RECOVERY ROOM	0.000000	0	l .	0	1	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0.000000	210 175	1		_	52.00
53. 00 54. 00	05400 RADI OLOGY - O5400 RADI OLOGY	0. 000000 0. 000000	310, 175	1			53. 00 54. 00
54. 00	05401 ULTRASOUND	0. 000000	1, 905, 309	i	3, 834, 680 567, 899		54. 00
54. 01	05402 WOMEN' S CENTER	0. 000000	94, 553 0	i			54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	1	,		55. 00
56. 00	05600 RADI OLOGI - MERAPEUTI C	0. 000000	515, 660	1	4, 800, 460		56. 00
57. 00	05700 CT SCAN	0. 000000	3, 952, 911		8, 934, 415		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	724, 194	1			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	2, 028, 667		4, 646, 473		59. 00
60. 00	06000 LABORATORY	0. 000000	4, 965, 897		3, 666, 301	Ö	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	1, 700, 077		0,000,001		60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	`		o o	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	398, 611		128, 826	o	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0,0,011	1	0 120, 020	o o	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0	1	o o	Ö	64. 00
65. 00	06500 RESPIRATORY THERAPY	0. 000000	1, 532, 601	1	590, 134	Ö	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	562, 179	1	28, 766	Ö	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	288, 233		20, 848		67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	230, 465	1	2, 442		68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	1, 598, 073	1	2, 798, 211	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	439, 606		769, 326	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	7, 956, 617		6, 497, 924	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	6, 556, 842	(	2, 825, 925	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	6, 661, 546	,	9, 677, 690	0	73. 00
74. 00	07400 RENAL DI ALYSI S	0. 000000	0	l .			74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0	) (	0	0	75. 00
	OUTPATIENT SERVICE COST CENTERS	T T		1	T		
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0	1			88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0	_	89. 00
90.00	09000 CLINIC	0.000000	0		0	0	90.00
90. 01 90. 02	09001 WOUND/OSTOMY CLINIC	0.000000	0		2, 811, 914	0	90. 01 90. 02
90. 02	09002 KIDS PLUS CLINIC 09003 0NCOLOGY	0. 000000 0. 000000	356, 425		11, 613, 722		90. 02
90. 03	09003 ONCOLOGY	0. 000000	350, 425	1	0 11, 613, 722		90.03
90. 05	09005 ANTI COAGULATI ON CLI NI C	0. 000000	0		324, 414		90.04
90.06	09006 PREGNANCY PLUS	0. 000000	0		0 324, 414		90.06
90. 07	09007 0/P LAB	0. 000000	0	1		Ö	90. 07
90. 08	09008 0/P LAB	0. 000000	0	1		0	90. 08
90. 09	09009 FORTVILLE CLINIC	0. 000000	0	1	o o	"	90.09
90. 10	09010 1030 S SCATTERFIELD (MEDCHECK)	0. 000000	0	1	o o		90. 10
90. 11	09011 DI ABETI C PLUS CLINIC	0. 000000	0			Ö	90. 11
91. 00	09100 EMERGENCY	0. 000000	4, 751, 340	1			91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			3, 181, 318		92.00
	OTHER REIMBURSABLE COST CENTERS	<u>'</u>		•			
94.00		0. 000000	0	(	0	0	94. 00
95.00							95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0	0	96. 00
97. 00		0. 000000	0	l .	0	0	97. 00
200.00	Total (lines 50 through 199)	1	53, 856, 931		91, 432, 348	0	200. 00

From 01/01/2018 Part V Date/Time Prepared: 12/31/2018 5/28/2019 4:13 pm Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Subject To Part I, col. 9 Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 5. 00 2.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 212992 13, 099, 412 2, 790, 070 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52 00 0.000000 52 00 0 0 0 53.00 05300 ANESTHESI OLOGY 0.090567 431, 730 39, 100 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 318066 3, 834, 680 0 1, 219, 681 54.00 54.01 05401 ULTRASOUND 0.149777 567.899 0 0 85.058 54 01 05402 WOMEN'S CENTER 0 54.02 0.194926 189, 300 36, 899 54.02 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 55.00 56.00 05600 RADI OI SOTOPE 0.075696 4, 800, 460 0 0 363, 376 56.00 247, 537 05700 CT SCAN 8, 934, 415 O 57 00 0.027706 57 00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.096369 3, 302, 087 0 318, 219 58.00 05900 CARDIAC CATHETERIZATION 0.095918 4, 646, 473 25, 097 0 59.00 445, 680 59.00 0 06000 LABORATORY 0.140315 60.00 3, 666, 301 0 514, 437 60.00 0 06001 BLOOD LABORATORY 60.01 0.000000 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0 0 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 0.213997 128, 826 27, 568 62.00 0 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 63.00 63.00 0 06400 INTRAVENOUS THERAPY 0 64.00 0.000000 0 64.00 0 65.00 06500 RESPIRATORY THERAPY 0. 432799 590, 134 255, 409 65.00 66.00 06600 PHYSI CAL THERAPY 0 0.350927 28, 766 0 10,095 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0.446820 20, 848 9.315 67.00 06800 SPEECH PATHOLOGY 0 68.00 0.616011 2, 442 1, 504 68 00 06900 ELECTROCARDI OLOGY 0.070662 2, 798, 211 0 0 197, 727 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70 00 0. 253982 769, 326 195, 395 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 6, 497, 924 0 71.00 0.337610 2, 193, 764 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.367023 2, 825, 925 0 1, 037, 179 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 242587 9,677,690 2, 347, 682 73.00 72.429 73.00 74.00 07400 RENAL DIALYSIS 0.834305 0 O 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 0.000000 Λ 75.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 O 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0.000000 89.00 0 90.00 09000 CLI NI C 0.000000 0 90.00 604, 876 90.01 09001 WOUND/OSTOMY CLINIC 0. 215112 2, 811, 914 0 0 90.01 0 09002 KIDS PLUS CLINIC 0.000000 0 90.02 90.02 09003 ONCOLOGY 0. 184850 0 2, 146, 797 90.03 90.03 11, 613, 722 0 90.04 09004 MUNCIE CLINIC 0.000000 0 0 90.04 90.05 09005 ANTICOAGULATION CLINIC 0.548483 324, 414 0 0 0 177, 936 90.05 09006 PREGNANCY PLUS 0.000000 0 90.06 90.06 C 0 09007 0/P LAB 0 90.07 0.000000 C 0 90.07 90.08 09008 0/P LAB 0.000000 0 90.08 09009 FORTVILLE CLINIC 90.09 0.000000 0 0 90.09 0 90.10 09010 1030 S SCATTERFIELD (MEDCHECK) 0.000000 0 90 10 0 0 90.11 09011 DIABETIC PLUS CLINIC 230.003800 Λ 90.11 09100 EMERGENCY 0.166808 6, 688, 131 0 0 1, 115, 634 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.450811 3, 181, 318 0 1, 434, 173 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 94.00 09500 AMBULANCE SERVICES 0.000000 0 95.00 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 0 0 96.00 97 00 09700 DURABLE MEDICAL EQUIP-SOLD 97 00 0.000000 0 0 200.00 Subtotal (see instructions) 91, 432, 348 25, 097 72, 429 17, 815, 111 200.00 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 17, 815, 111 202. 00 91, 432, 348 25, 097 72, 429

Health Financial Systems COMMUNITY HOSP
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST COMMUNITY HOSPITAL ANDERSON Provi der CCN: 15-0113

						5/28/2019 4: 1	3 pm
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)					
		6.00	7.00	-			
	ANCILLARY SERVICE COST CENTERS						
50. 00   51. 00   52. 00   53. 00   54. 00   54. 02   55. 00   56. 00   57. 00   58. 00   60. 01   61. 00   62. 00   63. 00   64. 00   65. 00   66. 00   66. 00   67. 00   68. 00   69. 00   70. 00   71. 00   72. 00   73. 00   74. 00   75. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND 05402 WOMEN'S CENTER 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 06000 LABORATORY 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS. 1NTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROENCEPHALOGRAPHY 077100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				50. 00 51. 00 52. 00 53. 00 54. 01 54. 02 55. 00 56. 00 57. 00 58. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 67. 00 68. 00 67. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00
-	OUTPATIENT SERVICE COST CENTERS			ı			00 00
89. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 90. 09 90. 10 90. 11 91. 00 92. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09001 CLINIC 09001 WOUND/OSTOMY CLINIC 09002 KIDS PLUS CLINIC 09003 ONCOLOGY 09004 MUNCIE CLINIC 09005 ANTICOAGULATION CLINIC 09006 PREGNANCY PLUS 09007 O/P LAB 09008 O/P LAB 09009 FORTVILLE CLINIC 09010 1030 S SCATTERFIELD (MEDCHECK) 09010 DIABETIC PLUS CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0THER REIMBURSABLE COST CENTERS	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0				88. 00 89. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 90. 09 90. 10 90. 11 91. 00 92. 00
95. 00 96. 00	09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD Subtotal (see instructions) Less PBP Clinic Lab. Services-Program	0 0 0 0 2, 407	0 0 0 17, 570				94. 00 95. 00 96. 00 97. 00 200. 00 201. 00
202.00	Only Charges Net Charges (line 200 - line 201)	2, 407	17, 570				202. 00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0113	Peri od: From 01/01/2018	Worksheet D-1	
			Date/Time Pre 5/28/2019 4:1	
	Title XVIII	Hospi tal	PPS	-
Cost Center Description	_		1 00	

		Title XVIII	Hospi tal	5/28/2019 4: 1. PPS	<u>5 piii                                 </u>
	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)		28, 367	1.00
2.00	Inpatient days (including private room days, excluding swing-b			28, 367	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	/s). If you have only pri	ivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	od days)		24, 479	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roc		r 31 of the cost	24, 479	ı
0.00	reporting period	adyer till edgi. December		١	0.00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)		24 6 11		7 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) through becember	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	,		-	
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	8, 745	9. 00
10.00	newborn days)	alv. (i polydina privoto r	aam daya)		10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		Dolli days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) 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 XI)	( only (including private	e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	( only (including private	o room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ye			٥	13.00
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	
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 o	f the cost	0.00	17. 00
17.00	reporting period	es through becember 31 of	i the cost	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
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	he cost	0. 00	20. 00
20.00	reporting period			0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions			32, 416, 575	1
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost reporti	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reporting	a ported (line 6	0	23. 00
23.00	x line 18)	31 of the cost reporting	g period (iiile o	٥	23.00
24.00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)				
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) 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)		32, 416, 575	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	ł
	Private room charges (excluding swing-bed charges)			0	ł
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)	111le 20)		0.00000	ı
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	ı
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	ł
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35)	and private room cost di	fferential (line	0 32 416 575	
37.00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost dr	rierential (IINe	32, 416, 575	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 142. 76	1
39. 00	Program general inpatient routine service cost (line 9 x line	•		9, 993, 436	
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	•		0 9, 993, 436	
71.00	Trotal Trogram gonoral Impatront routine service cost (ITHE 37	11110 40)		7, 775, 450	1 71.00

	Financial Systems ATION OF INPATIENT OPERATING COST	COMMUNITY HOSPIT	AL ANDERSON Provider CCN: 15	0112 0-	In Lie	eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 15	Fr	om 01/01/2018	Worksheet D-1	
				То	12/31/2018	Date/Time Prep 5/28/2019 4:1:	
			Title XVIII		Hospi tal	PPS	
	Cost Center Description	Total	Total Aver npatient Days Diem		Program Days	Program Cost (col. 3 x col.	
			cc	ol . 2)		4)	
42 00	NURSERY (title V & XIX only)	1.00	2.00	0.00	4.00	5. 00	42. 00
12. 00	Intensive Care Type Inpatient Hospital Units		٥	0.00			12.00
43.00	INTENSIVE CARE UNIT	6, 542, 241	1, 368	4, 782. 34	1, 302	6, 226, 607	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0. 00 0. 00	0	0	44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
	•					1. 00	
48. 00	Program inpatient ancillary service cost (W					12, 476, 101	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(S	ee instructions)			28, 696, 144	49. 00
50. 00	Pass through costs applicable to Program in	oatient routine s	ervices (from Wkst.	. D, sum o	f Parts I and	1, 114, 808	50. 00
51. 00		natient ancillary	services (from Wkg	st D sum	of Parts II	638, 231	51.00
01.00	and IV)	acreme uner raily	301 V1 003 (11 0iii 1110	ot. D, Sam	or rants in	000, 201	01.00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated non physicis:	n anocthot	ist and	1, 753, 039 26, 943, 105	•
55.00	medical education costs (line 49 minus line		ateu, non-physiciai	ii allestilet	ist, and	20, 743, 103	33.00
E 4 .00	TARGET AMOUNT AND LIMIT COMPUTATION	·					F 4 00
54. 00 55. 00	Program discharges Target amount per discharge					0.00	•
56. 00	Target amount (line 54 x line 55)					0	56. 00
57. 00 58. 00	Difference between adjusted inpatient operations payment (see instructions)	ting cost and tar	get amount (line 50	6 minus li	ne 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	eporting period e	nding 1996, updated	d and comp	ounded by the	0.00	1
40.00	market basket	and report und	atad by the market	backet		0.00	(0.00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				e amount by	0.00	60. 00 61. 00
	which operating costs (line 53) are less that		(lines 54 x 60), (	or 1% of t	he target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	Instructions)				0	62. 00
	Allowable Inpatient cost plus incentive payr	ment (see instruc	tions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	sts through Decem	her 31 of the cost	renortina	neriod (See	0	64. 00
	instructions)(title XVIII only)	Ü					
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	sts after Decembe	r 31 of the cost re	eporting p	eriod (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 65)(ti	tle XVIII	only). For	0	66. 00
<i>(</i> 7, 00	CAH (see instructions)	a acata through	Dagambar 21 of the		nting ported	0	(7.00
67. 00	(line 12 x line 19)	· ·		·	0.		67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin	ne costs after De	cember 31 of the co	ost report	ing period	0	68. 00
69. 00	(line 13 x line 20)  Total title V or XIX swing-bed NF inpatient	routine costs (I	ine 67 + line 68)			0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER N						
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	-	•	line 37)			70. 00 71. 00
72. 00	Program routine service cost (line 9 x line	71)	·				72. 00
73. 00 74. 00	Medically necessary private room cost applications and program general inpatient routine services.	•	,	)			73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient			eet B, Par	t II, column		75. 00
74 00	26, line 45)	no 2)					7/ 00
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 minu						78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for comp	, ,	,	e 78 minus	line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi	tati on	·		,		81. 00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs						82. 00 83. 00
84. 00	Program inpatient ancillary services (see in	•					84. 00
	Utilization review - physician compensation						85.00
80. UU	Total Program inpatient operating costs (sur PART IV - COMPUTATION OF OBSERVATION BED PAS		ougn 85)				86. 00
87. 00	Total observation bed days (see instructions	5)				3, 888	1
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se		line 2)			1, 142. 76 4, 443, 051	
57.00	10000. Vali on Dod Cool (11110 07 X 11110 00) (50	matructions)				1 7, 773, 031	1 57.00

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	2, 216, 375	32, 416, 575	0. 06837	2 4, 443, 051	303, 780	90.00
91.00 Nursing School cost	0	32, 416, 575	0.00000	4, 443, 051	0	91.00
92.00 Allied health cost	0	32, 416, 575	0.00000	4, 443, 051	0	92.00
93.00 All other Medical Education	0	32, 416, 575	0.00000	4, 443, 051	0	93.00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0113	Peri od: From 01/01/2018	Worksheet D-1	
			Date/Time Pre 5/28/2019 4:1	
	Title XIX	Hospi tal	Cost	
Cost Center Description				
			1. 00	

		Title XIX	Hospi tal	Cost	s piii
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	,		28, 367	1. 00
2.00	Inpatient days (including private room days, excluding swing-b			28, 367	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)		24, 479	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 roo	om days) after December :	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	days) through Docombor	21 of the cost	0	7. 00
7.00	reporting period	r days) till odgir becellber	31 Of the Cost	٥	7.00
8. 00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	<b>3</b> ,			
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	593	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	nom dave)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruct		Joili days)	٥	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period  Swing-bed NF type inpatient days applicable to titles V or XI)	(only (including private	e room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ye			١	13.00
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)			1, 809	
16. 00	Nursery days (title V or XIX only)			1, 731	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	as through December 31 of	f the cost	0.00	17. 00
17.00	reporting period	es till odgir beceilber 31 o	the cost	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
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0. 00	20. 00
20.00	reporting period			0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions			32, 416, 575	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost reporti	ng period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reporting	a ported (line 6	0	23. 00
23.00	x line 18)	31 of the cost reporting	g perrou (Trile o	٥	23.00
24.00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)				
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (	Tine 21 minus line 26)		32, 416, 575	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	
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 20)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	- ITTIE 28)		0. 000000	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	1
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	and anticota re "	Fforontial (III	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	rrerential (line	32, 416, 575	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 142. 76	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		677, 657	
40.00	Medically necessary private room cost applicable to the Program	•		0 677 657	40.00
4 I. UU	Total Program general inpatient routine service cost (line 39	+ IIIIE 4U)		677, 657	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	COMMUNITY HOSPIT	AL ANDERSON Provider CCN: 15-0113	In Lie	eu of Form CMS-2 Worksheet D-1	
COMITOT	ATTON OF THE ATTENT OF ERATTING COST		Trovider CCN. 13-0113	From 01/01/2018		
				To 12/31/2018	Date/Time Prep 5/28/2019 4:1:	
	Cost Center Description	Total	Title XIX  Total Average Pe	Hospital Program Days	Cost Program Cost	
	cost center bescription		npatient DaysDiem (col.		(col. 3 x col.	
		1.00	2.00 col. 2)	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	2, 264, 644	1, 809 1, 251		2, 167, 004	42. 00
40.00	Intensive Care Type Inpatient Hospital Units		4 2/0	24	245 (24	40.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	6, 542, 241	1, 368 4, 782 0 0	. 34 . 00 0	315, 634	1
45.00	BURN INTENSIVE CARE UNIT	0	0 0	. 00	0	45. 00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	0 0	. 00	0	46. 00 47. 00
47.00	Cost Center Description					47.00
10.00			11 000)		1.00	10.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines				2, 620, 645 5, 780, 940	
. ,	PASS THROUGH COST ADJUSTMENTS	<u> </u>	·		6,766,716	.,,,,,
50. 00	Pass through costs applicable to Program inp	atient routine se	ervices (from Wkst. D, s	um of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillary	services (from Wkst. D,	sum of Parts II	0	51.00
F2 00	and IV)	FO F1)				F2 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated, non-physician anes	thetist, and	0	
	medical education costs (line 49 minus line	9 1				
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges				0	54.00
55. 00	Target amount per discharge				0.00	
56.00	Target amount (line 54 x line 55)			- 1: 52)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and targ	get amount (Tine 56 minu	s line 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	nding 1996, updated and	compounded by the	0. 00	
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report und	ated by the market baske	t	0.00	60.00
61. 00	If line 53/54 is less than the lower of line				0.00	61.00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		(lines 54 x 60), or 1%	of the target		
62. 00	Relief payment (see instructions)	Tristructions)			0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)		0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	sts through Decemb	per 31 of the cost repor	ting period (See	0	64. 00
<i>(</i> = 00	instructions)(title XVIII only)					/= 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	its after December	r 31 of the cost reporti	ng period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	4 plus line 65)(title XV	III only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routir	ne costs through [	December 31 of the cost	renorting period	0	67. 00
	(line 12 x line 19)	3		1 31		07.00
68. 00	Title V or XIX swing-bed NF inpatient routin	ne costs after Dec	cember 31 of the cost re	porting period	0	68. 00
69. 00	(line 13 x line 20)  Total title V or XIX swing-bed NF inpatient	routine costs (li	ne 67 + line 68)		0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER N			7)		70.00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	,	•	7)		70. 00 71. 00
72. 00	Program routine service cost (line 9 x line	71)	•			72. 00
73. 00 74. 00	Medically necessary private room cost application of the cost application of t		,			73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient			Part II, column		75. 00
74 00	26, line 45)	no 2)				74 00
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 minu					78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp	, ,	,	inus line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi	tati on				81. 00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (		)			82. 00 83. 00
84. 00	Program inpatient ancillary services (see in		,			84. 00
	Utilization review - physician compensation					85.00
86. UU	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		ougn 85)			86.00
87. 00	Total observation bed days (see instructions	5)			3, 888	
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se		ine 2)		1, 142. 76 4, 443, 051	1
57.00	(36)	.5 . 11511 4611 6113)			1, 443, 031	1 57.00

Health Financial Systems	COMMUNITY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018	Date/Time Pre 5/28/2019 4:1	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	2, 216, 375	32, 416, 575	0. 06837	2 4, 443, 051	303, 780	90.00
91.00 Nursing School cost	0	32, 416, 575	0.00000	4, 443, 051	0	91.00
92.00 Allied health cost	o	32, 416, 575	0.00000	4, 443, 051	0	92. 00
93.00 All other Medical Education	0	32, 416, 575	0.00000	0 4, 443, 051	0	93. 00

Health Financial Systems	COMMUNITY HOSPITA	L ANDERSON	V		In Lieu	of Form CMS-2552-10
LNDATI ENT ANGLE LABY OFFICE OF COOT APPORTS ON THE		I	0.011 45 0440	n		

nearth Financial Systems Community Hospital				u or Form CM3-2	2332-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-01	13 P	eri od:	Worksheet D-3	
			rom 01/01/2018	D 1 (T' D	
		1	o 12/31/2018	Date/Time Pre	
				5/28/2019 4: 13	3 pm
	Title XVIII		Hospi tal	PPS	
Cost Center Description	Ratio o	f Cost	Inpatient	Inpati ent	
	To Cha	irges	Program	Program Costs	
		Ü	Charges	(col. 1 x col.	
			3	2)	
	1. C	) <u> </u>	2. 00	3. 00	
INDATIENT DOUTINE CEDVICE COST CENTEDS	1.0	<del>,,,,</del>	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			10 (10 000		00.00
30. 00   03000   ADULTS & PEDI ATRI CS			19, 643, 992		30. 00
31. 00   03100   I NTENSI VE CARE UNI T			4, 448, 029		31. 00
32. 00  03200  CORONARY CARE UNIT			0		32.00
33.00 03300 BURN INTENSIVE CARE UNIT	İ		0		33.00
34. 00   03400   SURGI CAL   INTENSI VE CARE UNI T			0		34. 00
			0		
40. 00   04000   SUBPROVI DER -   PF			0		40.00
41. 00   04100   SUBPROVI DER - I RF			0		41. 00
42. 00   04200   SUBPROVI DER			0		42.00
43. 00   04300   NURSERY					43.00
ANCILLARY SERVICE COST CENTERS	•				
50. 00 05000 OPERATING ROOM	0	212992	8, 027, 027	1, 709, 693	50. 00
51. 00   05100   RECOVERY ROOM		000000		0	51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM		000000		0	52. 00
53. 00   05300   ANESTHESI OLOGY	0.	090567	310, 175	28, 092	53.00
54. OO 05400 RADI OLOGY-DI AGNOSTI C	0.	318066	1, 905, 309	606, 014	54.00
54. 01   05401   ULTRASOUND		149777	94, 553	14, 162	54. 01
54. 02   05402   WOMEN' S CENTER		194926		0	54. 02
				0	
		000000			55.00
56. 00   05600   RADI 01 SOTOPE		075696		39, 033	56. 00
57. 00  05700 CT SCAN	0.	027706	3, 952, 911	109, 519	57.00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0.	096369	724, 194	69, 790	58.00
59. 00   05900 CARDI AC CATHETERI ZATI ON	l l	095918		194, 586	59.00
60. 00   06000   LABORATORY	l l	140315		696, 790	60. 00
	l l				
60. 01   06001   BLOOD LABORATORY	l l	000000		0	60. 01
61.00  06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.	000000	0	0	61. 00
62.00  06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.	213997	398, 611	85, 302	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0.	000000	0	0	63.00
64. 00   06400   I NTRAVENOUS THERAPY		000000		0	64.00
65. 00   06500   RESPI RATORY   THERAPY					65. 00
		432799		663, 308	
66. 00 O6600 PHYSI CAL THERAPY		350927	562, 179	197, 284	66. 00
67. 00  06700 0CCUPATI ONAL THERAPY	0.	446820	288, 233	128, 788	67. 00
68. 00   06800   SPEECH PATHOLOGY	0.	616011	230, 465	141, 969	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0.	070662	1, 598, 073	112, 923	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		253982		111, 652	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		337610		2, 686, 233	71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		367023		2, 406, 512	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		242587			73. 00
74. 00  07400  RENAL DI ALYSI S	0.	834305	0	0	74.00
75. 00  07500 ASC (NON-DISTINCT PART)	0.	000000	0	0	75.00
OUTPATIENT SERVICE COST CENTERS	•				
88. 00 08800 RURAL HEALTH CLINIC	1 0	000000		0	88. 00
				0	89. 00
		000000			
90. 00   09000   CLI NI C		000000		0	90.00
90. 01   09001   WOUND/OSTOMY CLINIC		215112		0	90. 01
90. 02   09002   KIDS PLUS CLINIC	0.	000000	0	0	90. 02
90. 03   09003   0NC0L0GY	l 0.	184850	356, 425	65, 885	90. 03
90. 04   09004 MUNCI E CLI NI C	l l	000000		0	90.04
90. 05   09005   ANTI COAGULATION CLINIC		548483		0	90. 05
				0	
90. 06   09006   PREGNANCY PLUS		000000	0		90.06
90. 07   09007   0/P LAB		000000	0	0	90. 07
90. 08   09008   0/P LAB	0.	000000	0	0	90. 08
90. 09   09009   FORTVI LLE CLI NI C	0.	000000	0	0	90.09
90. 10 09010 1030 S SCATTERFIELD (MEDCHECK)		000000	n	0	90. 10
90. 11   09011   DI ABETI C PLUS CLI NI C		003800		0	90. 11
91. 00   09100   EMERGENCY		166808	4, 751, 340	792, 562	91.00
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	] 0.	450811	0	0	92. 00
OTHER REIMBURSABLE COST CENTERS					
94. 00 09400 HOME PROGRAM DIALYSIS	0.	000000	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	[				95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		000000	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		000000		0	97. 00
	0.				
Total (sum of lines 50 through 94 and 96 through 98)			53, 856, 931	12, 476, 101	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)			53, 856, 931		202. 00
	•				

Health Financial Systems	COMMUNITY HOSPITAL ANDERS	SON	In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi de		Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Pre 5/28/2019 4:1	pared:
		Title XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		<u> </u>			
30. 00 03000 ADULTS & PEDI ATRI CS			5, 632, 697		30.00
31.00 03100 INTENSIVE CARE UNIT		İ	1, 495, 825		31. 00
32. 00 03200 CORONARY CARE UNIT			0		32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT			0		33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T		į	0		34.00
40. 00   04000   SUBPROVI DER -   PF		ı	0		40.00
41. 00   04100   SUBPROVI DER -   I RF			0		41.00
42. 00   04200   SUBPROVI DER			0		42.00
			2 0/0 7/2		1
43. 00   04300  NURSERY			2, 069, 763		43. 00
ANCI LLARY SERVI CE COST CENTERS		0.04000	0 5 057 4/0	4 077 405	F0 00
50. 00   05000   OPERATI NG ROOM		0. 21299		1, 077, 135	1
51. 00   05100   RECOVERY ROOM		0.00000		0	51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM		0.00000		0	52. 00
53. 00 05300 ANESTHESI OLOGY		0. 09056		58, 267	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 31806		104, 708	1
54. 01  05401  ULTRASOUND		0. 14977	7 0	0	54. 01
54. 02   05402   WOMEN' S CENTER		0. 19492	6 0	0	54. 02
55. 00   05500   RADI OLOGY-THERAPEUTI C		0.00000	0 0	0	55. 00
56. 00   05600   RADI 0I SOTOPE		0. 07569	6 95, 475	7, 227	56. 00
57.00 05700 CT SCAN		0. 02770	6 770, 387	21, 344	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 09636	9 242, 135	23, 334	58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON		0. 09591		96, 223	1
60. 00   06000   LABORATORY		0. 14031		193, 885	1
60. 01   06001   BLOOD   LABORATORY		0.00000		0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0. 00000		0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 21399		36, 549	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 21349		0 30, 549	63.00
·		1			
64. 00   06400   I NTRAVENOUS THERAPY		0.00000		120.017	64. 00
65. 00 06500 RESPIRATORY THERAPY		0. 43279		139, 916	65. 00
66. 00   06600   PHYSI CAL THERAPY		0. 35092		23, 761	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 44682		20, 948	
68. 00   06800   SPEECH PATHOLOGY		0. 61601		17, 980	
69. 00 06900 ELECTROCARDI OLOGY		0. 07066		21, 730	
70. 00  07000  ELECTROENCEPHALOGRAPHY		0. 25398		25, 288	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 33761		0	71. 00
72.00 O7200 MPL. DEV. CHARGED TO PATIENTS		0. 36702		0	72. 00
73.00  07300 DRUGS CHARGED TO PATIENTS		0. 24258	7 2, 438, 652	591, 585	73. 00
74. 00   07400   RENAL DI ALYSI S		0. 83430	5 0	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)		0.00000	0	0	75. 00
OUTPATIENT SERVICE COST CENTERS					
88.00   08800   RURAL HEALTH CLINIC		0.00000	0		
89.00  08900  FEDERALLY QUALIFIED HEALTH CENTER		0.00000	0	0	89. 00
90. 00  09000  CLI NI C		0.00000	0	0	90. 00
90.01  09001 WOUND/OSTOMY CLINIC		0. 21511	2 0	0	90. 01
90. 02  09002 KIDS PLUS CLINIC		0.00000	0 0	0	90. 02
90. 03   09003   0NCOLOGY		0. 18485	0 32, 003	5, 916	90. 03
90. 04   09004 MUNCIE CLINIC		0.00000	0	0	90. 04
90. 05   09005 ANTI COAGULATION CLINIC		0. 54848	3 0	0	90. 05
90. 06 09006 PREGNANCY PLUS		0.00000		0	90.06
90. 07   09007   0/P LAB		0.00000		0	90. 07
90. 08 09008 0/P LAB		0.00000		0	90. 08
90. 09   09009 FORTVILLE CLINIC		0.00000		0	90. 09
90. 10 09010 1030 S SCATTERFIELD (MEDCHECK)		0. 00000		0	
90. 11   09011   DI ABETI C PLUS CLINI C		230. 00380		0	90. 11
91. 00   09100   EMERGENCY		0. 16680		154, 849	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 45081		0	92.00
OTHER REIMBURSABLE COST CENTERS		0.43001	ij o	0	72.00
94. 00 09400 HOME PROGRAM DI ALYSI S		0.00000	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES		0.00000	ا ا		95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0. 00000		0	
				0	1
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	d 04 through 00\	0.00000			97.00
Total (sum of lines 50 through 94 and	<b>o</b> ,	41)	13, 966, 587	2, 620, 645	1
201.00 Less PBP Clinic Laboratory Services-	9 9 1	01)	12 044 507		201. 00
202.00   Net charges (line 200 minus line 201)	)	I	13, 966, 587		202. 00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	eu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0113	From 01/01/2018	Worksheet E Part A Date/Time Prepared: 5/28/2019 4:13 pm

DART A - IMPATIBIT HISSPITUS SERVICES UNDER IPPS   1.00			Title XVIII	Hospi tal	5/28/2019 4: 1 PPS	3 pm
PART A - INPATIENT HOSPITAL SERVICES WIDER IPPS					1.00	
1.00   DRC Amounts other than outlier payments for discharges occurring prior to October 1 (see   16,032,149   1.01		PART A - INPATIENT HOSPITAL SERVICES UNDER LPPS			1.00	
Instructions	1.00				0	1. 00
1.02   DRC anounts of their than outliter payment for discharges occurring on an after October 1 (see instructions)   DRC for Federal specific operating payment for Model 4 BPCI for discharges occurring on or after   0   1.04	1. 01		prior to October 1 (s	see	16, 032, 149	1. 01
1.03   RRC for federal specific operating payment for Model 4 BRCI for discharges occurring prior to October 1 (see instructions)   1.03	1.02	DRG amounts other than outlier payments for discharges occurring	on or after October 1	1 (see	5, 344, 049	1. 02
1.04   DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after	1.03	DRG for federal specific operating payment for Model 4 BPCI for d	ischarges occurring p	orior to October	0	1. 03
2.00         Outlier payments for discharges. (see instructions)         76,384 2.00         2.01           2.01         Outlier peopment for discharges for Model 4 BPCI (see instructions)         0.20         2.01           3.00         Maraged Cares Similated Payments         11,773,142         3.00           4.00         Bed days available of deep by number of days in the cost reporting period (see instructions)         126,68           5.00         To proceed the control of a post of the country o	1.04	DRG for federal specific operating payment for Model 4 BPCI for d	ischarges occurring o	on or after	0	1. 04
2.02   Outlier payment for discharges for Model 4 BPCI (see instructions)		Outlier payments for discharges. (see instructions)				
Managet Care Simulated Payments   11,773,142   3.00			)		- 1	
Bed days available divided by number of days in the cost reporting period (see instructions)   126.68   4.00			,		- 1	
FIE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions) FIE count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)  NMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) if the cost report straddles July 1, 2011 then see instructions  National Special		Bed days available divided by number of days in the cost reporting	g period (see instruc	ctions)		
FTE count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)   7.00   MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(v)(B)(2) if the 0.00   7.00   7.01	5.00	FTE count for allopathic and osteopathic programs for the most re-	cent cost reporting p	period ending on	0.00	5. 00
7.00         MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(v)(8)(2) if the cost report straddles July 1, 2011 then see instructions.         0.00         Ajustment (increase or decrease) to the FIE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12. 1998), and 67 FR 50069 (August 1, 2002).         0.00         8.00           8.00         Ajustment (increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.         0.00         8.01           8.02         The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions).         0.00         8.02           9.00         Sum of lines § plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see         0.00         9.00           11.00         FTE count for all lopathic and osteopathic programs in the current year from your records         0.00         1.07         11.00           12.00         Current year allowable FTE (see instructions)         0.17 11.00         0.01         0.00         1.01         11.00         12.00         0.01         0.00         0.01         1.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00 <t< td=""><td>6.00</td><td>FTE count for allopathic and osteopathic programs that meet the co</td><td>riteria for an add-or</td><td>n to the cap for</td><td>0.00</td><td>6. 00</td></t<>	6.00	FTE count for allopathic and osteopathic programs that meet the co	riteria for an add-or	n to the cap for	0.00	6. 00
7.01   ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(i)(i)(B)(2) if the cost report straddle sJuly 1, 2011 then see instructions.	7 00	1 9	r 42 CFR §412 105(f)	(1) (i v) (B) (1)	0.00	7 00
8.00   Adjustment (increase or decrease) to the FTE count for al lopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 04 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		ACA § 5503 reduction amount to the IME cap as specified under 42 (				
8. 01   The amount of Increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report stradies July 1, 2011, see instructions.   20. 00   8. 01	8. 00	Adjustment (increase or decrease) to the FTE count for allopathic affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)			0. 00	8. 00
8. 02   The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 550.6 of ACA. (see instructions)	8. 01	The amount of increase if the hospital was awarded FTE cap slots	under § 5503 of the /	ACA. If the cost	0.00	8. 01
9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see	8. 02	The amount of increase if the hospital was awarded FTE cap slots	from a closed teachir	ng hospital	0.00	8. 02
10.00   FTE count for allopathic and osteopathic programs in the current year from your records   0.00   10.00   11.00   FTE count for residents in dental and podiatric programs.   0.17   11.00   12.00   Current year allowable FTE (see instructions)   0.17   12.00   13.00   Total allowable FTE count for the prior year.   0.44   13.00   10.01   10	9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8	8, 8,01 and 8,02) (s	see	0. 00	9. 00
11.00   FTE count for residents in dental and podiatric programs.   0.17   11.00   12.00   12.00   10.00   1	10. 00		year from your record	ds	0. 00	10. 00
13.00   Total all owable FTE count for the prior year.   0.44   13.00   14.00   Total all owable FTE count for the penul timate year if that year ended on or after September 30, 1997,   0.07   14.00   otherwise enter zero.   15.00   Sum of lines 12 through 14 divided by 3.   0.23   15.00   16.00   Adjustment for residents in initial years of the program   0.00   16.00   17.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   Adjustment for residents displaced by program or hospital closure   0.00   18		, , , , ,	,			
14.00       Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, otherwise enter zero.       0.07       14.00         15.00       Sum of Lines 12 through 14 divided by 3.       0.23       15.00         16.00       Adjustment for residents in initial years of the program       0.00       16.00         17.00       Adjustment for residents displaced by program or hospital closure       0.00       17.00         18.00       Adjustment for residents displaced by program or hospital closure       0.00       17.00         18.00       Adjustment for residents displaced by program or hospital closure       0.00       17.00         19.00       Current year resident to bed ratio (see instructions)       0.001816       19.00         10.00       Prior year resident to bed ratio (see instructions)       0.001816       21.00         21.00       Enter the lesser of lines 19 or 20 (see instructions)       0.001816       21.00         22.01       IME payment adjustment (see instructions)       21.00       22.00         10.01       IME payment adjustment - Managed Care (see instructions)       0.00       22.01         10.02       Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA       0.00       22.00         23.00       IME FTE Resident Count Over Cap (see instructions)       0.00	12. 00	Current year allowable FTE (see instructions)			0. 17	12. 00
otherwise enter zero.         0 Sum of lines 12 through 14 divided by 3.         0.23 15.00           16.00 Adjustment for residents in initial years of the program         0.00 16.00           17.00 Adjustment for residents displaced by program or hospital closure         0.00 17.00           18.00 Adjustment for residents displaced by program or hospital closure         0.00 17.00           18.00 Adjustment for residents displaced by program or hospital closure         0.00 17.00           19.00 Current year resident to bed ratio (line 18 divided by line 4).         0.001816           20.01 Prior year resident to bed ratio (see instructions)         0.00260           21.00 Enter the lesser of lines 19 or 20 (see instructions)         0.001816           22.00 IME payment adjustment (see instructions)         21,205           22.01 IME payment adjustment - Managed Care (see instructions)         11,679           23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105         0.00           (f)(1)(iy)(c).         0.00           24.00 IME FTE Resident Count Over Cap (see instructions)         0.00           25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)         0.00           26.00 Resident to bed ratio (divide line 25 by line 4)         0.000000           27.00 IME payments adjustment factor. (see instructions)         0.00 <tr< td=""><td></td><td></td><td></td><td></td><td></td><td></td></tr<>						
15.00   Sum of lines 12 through 14 divided by 3.   0.23   15.00   16.00   Adjustment for residents in initial years of the program   0.00   16.00   17.00   18.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   Adjusted rolling average FTE count   0.23   18.00   19.00   0.00   19.00   0.001816   19.00   18.0	14. 00		nded on or after Sept	tember 30, 1997,	0. 07	14. 00
16.00       Adjustment for residents in initial years of the program       0.00       16.00         17.00       Adjustment for residents displaced by program or hospital closure       0.00       17.00         18.00       Adjustment for residents displaced by program or hospital closure       0.00       17.00         18.00       Adjustment for residents displaced by program or hospital closure       0.00       17.00         19.00       Current year resident to bed ratio (line 18 divided by line 4).       0.001816       19.00         20.00       Prior year resident to bed ratio (see instructions)       0.002260       20.00         21.00       Inter the lesser of lines 19 or 20 (see instructions)       0.001816       21.00         22.00       IME payment adjustment (see instructions)       21,205       22.00         22.01       IME payment adjustment - Managed Care (see instructions)       11,679       22.01         1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA       11,679       22.01         24.00       IME FTE Resident Count Over Cap (see instructions)       0.00       23.00         25.00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see       0.00       25.00         26.00       Resident to bed ratio (divide line 25 by line 4)       0.000000       26.00	15 00				0.23	15 00
17.00						
18.00       Adjusted rolling average FTE count       0.23       18.00         19.00       Current year resident to bed ratio (see instructions)       0.001816       19.00         20.00       Prior year resident to bed ratio (see instructions)       0.002260       20.00         21.00       Enter the lesser of lines 19 or 20 (see instructions)       0.001816       21.00         22.01       IME payment adjustment (see instructions)       21,205       22.00         11ME payment adjustment - Managed Care (see instructions)       11,679       22.01         1ndirect Medical Education Adjustment for the Add-on for § 422 of the MMA       22.01         23.00       Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105       0.00       23.00         (f)(1)(iv)(C).       0.00       24.00         25.00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)       0.00       25.00         26.00       Resident to bed ratio (divide line 25 by line 4)       0.000000       27.00       28.00         27.00       IME payments adjustment amount (see instructions)       0.000000       27.00         28.01       IME add-on adjustment amount - Managed Care (see instructions)       0.28.00         29.01       Total IME payment (sum of lines 22 and 28)						
20.00   Prior year resident to bed ratio (see instructions)   0.002260   20.00   21.00   Enter the lesser of lines 19 or 20 (see instructions)   0.001816   21.00   22.00   22.00   IME payment adjustment (see instructions)   21,205   22.00   22.01   IME payment adjustment - Managed Care (see instructions)   11,679   22.01   Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA   23.00   Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105   0.00   23.00   (f)(1)(iv)(C)   .   .   .   .   .   .   .   .   .		, , , , ,			0. 23	18. 00
21.00   Enter the lesser of lines 19 or 20 (see instructions)   0.001816   21.00	19.00	Current year resident to bed ratio (line 18 divided by line 4).			0. 001816	19. 00
22.00   IME payment adjustment (see instructions)   21, 205   11, 679   11, 679   11, 679   11, 679   11, 679   11, 679   11, 679   12.00   11, 679   11, 679   11, 679   12.00   11, 679   11, 679   12.00   11, 679   12.00   11, 679   12.00   11, 679   12.00   11, 679   12.00	20.00	Prior year resident to bed ratio (see instructions)			0.002260	20. 00
IME payment adjustment - Managed Care (see instructions)   11,679   11,679   11,679   11,679   11,679   11,679   12,000   10,000   11,679   12,000   10,000   11,679   12,000   10,000   12,000   10,00		· · · · · · · · · · · · · · · · · · ·				
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 (f) (1) (iv) (C).  24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 instructions)  26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME payments adjustment amount (see instructions) 0.000000 27.00 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 Total IME payment (sum of lines 22 and 28) 21,205 29.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 11,679 29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 4.11 30.00 31.00 Sum of lines 30 and 31 28.33 32.00 Allowable disproportionate share percentage (see instructions) 12.59 33.00						
Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105   0.00   23.00   (f)(1)(iv)(C).	22. 01				11, 679	22. 01
24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  25.00 IME payments adjustment factor. (see instructions) 26.00 IME payments adjustment factor. (see instructions) 27.00 IME payments adjustment amount (see instructions) 28.01 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 31.00 Allowable disproportionate share percentage (see instructions) 32.00 IME add-on adjustment amount - Managed Care (sum of lines 22.01 and 28.01) 33.00 Allowable disproportionate share percentage (see instructions) 34.11 30.00	23. 00	Number of additional allopathic and osteopathic IME FTE resident		FR 412. 105	0.00	23. 00
25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  0.00 25.00 instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  0.000000 26.00  27.00 IME payments adjustment factor. (see instructions)  1ME add-on adjustment amount (see instructions)  28.00 IME add-on adjustment amount (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  24.12 31.00  32.00 Sum of lines 30 and 31  28.33 32.00  33.00 Allowable disproportionate share percentage (see instructions)  12.59 33.00	24.00				0.00	24.00
Instructions   Resident to bed ratio (divide line 25 by line 4)   0.000000   26.00   27.00   IME payments adjustment factor. (see instructions)   0.000000   27.00   28.00   IME add-on adjustment amount (see instructions)   0.28.01   28.00   IME add-on adjustment amount - Managed Care (see instructions)   0.28.01   29.00   Total IME payment (sum of lines 22 and 28)   21,205   29.00   29.01   29		. ,	r of line 23 or line	24 (500		
26. 00       Resident to bed ratio (divide line 25 by line 4)       0.000000       26. 00         27. 00       IME payments adjustment factor. (see instructions)       0.000000       27. 00         28. 00       IME add-on adjustment amount (see instructions)       0       28. 00         28. 01       IME add-on adjustment amount - Managed Care (see instructions)       0       28. 01         29. 00       Total IME payment (sum of lines 22 and 28)       21, 205       29. 00         29. 01       Total IME payment - Managed Care (sum of lines 22.01 and 28.01)       11, 679       29. 01         Disproportionate Share Adjustment       29. 01         30. 00       Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)       4. 11       30. 00         31. 00       Percentage of Medicaid patient days (see instructions)       24. 22       31. 00         32. 00       Sum of lines 30 and 31       28. 33       32. 00         33. 00       Allowable disproportionate share percentage (see instructions)       12. 59       33. 00	23.00		of fille 23 of fille	24 (366	0.00	23.00
28. 00 IME add-on adjustment amount (see instructions) 0 28. 00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0 28. 01 29. 00 Total IME payment (sum of lines 22 and 28) 21, 205 29. 00 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 11, 679 29. 01  Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 4. 11 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 24. 22 31. 00 32. 00 Sum of lines 30 and 31 28. 33 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 12. 59 33. 00	26.00				0.000000	26. 00
28. 01 IME add-on adjustment amount - Managed Care (see instructions)  29. 00 Total IME payment (sum of lines 22 and 28)  29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  32. 00 Sum of lines 30 and 31  33. 00 Allowable disproportionate share percentage (see instructions)  32. 00 Sum of lines 30 and 31  33. 00 Allowable disproportionate share percentage (see instructions)  32. 01 Sum of lines 30 and 31  33. 00 Allowable disproportionate share percentage (see instructions)	27. 00	IME payments adjustment factor. (see instructions)			0.000000	27. 00
29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  32. 00 Sum of lines 30 and 31  33. 00 Allowable disproportionate share percentage (see instructions)  21, 205	28.00	IME add-on adjustment amount (see instructions)			0	28. 00
29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  32. 00 Sum of lines 30 and 31  33. 00 Allowable disproportionate share percentage (see instructions)  11, 679 29. 01  4. 11 30. 00  24. 22 31. 00  32. 00 32. 00 Allowable disproportionate share percentage (see instructions)  12. 59 33. 00	28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  33.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)					21, 205	
31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of Lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  24.22 31.00  28.33 32.00  12.59 33.00	29. 01				11, 679	29. 01
32. 00       Sum of lines 30 and 31       28. 33       32. 00         33. 00       Allowable disproportionate share percentage (see instructions)       12. 59       33. 00	30.00	Percentage of SSI recipient patient days to Medicare Part A patien	nt days (see instruct	tions)	4. 11	30. 00
33.00 Allowable disproportionate share percentage (see instructions) 12.59 33.00		, , , , , , , , , , , , , , , , , , , ,				
34. UU     UI sproporti onate share adjustment (see i instructions) 672, 816   34. 00						
	34.00	puisproportionate snare adjustment (see instructions)		ļ	6/2, 816	34.00

	Financial Systems COMMUNITY HOSPI			u of Form CMS-2	2552-10			
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0113	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Pre 5/28/2019 4:13				
		Title XVIII	Hospi tal	PPS	5 piii			
				On/After 10/1				
	Uncompensated Care Adjustment		1. 00	2. 00				
35. 00	Total uncompensated care amount (see instructions)		6, 766, 695, 164	8, 272, 872, 447	35.00			
35. 01	Factor 3 (see instructions)		0. 000179762	0. 000192671	35. 01			
35. 02		1, 593, 939	35. 02					
35 03	instructions) Pro rata share of the hospital uncompensated care payment a	mount (see instructions)	909, 798	401, 760	35. 03			
	Total uncompensated care (sum of columns 1 and 2 on line 35.		1, 311, 558		36.00			
	Additional payment for high percentage of ESRD beneficiary of							
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding	g discharges for MS-DRGs	0		40.00			
41. 00	652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683 684 an 685 (see	0		41.00			
+1.00	instructions)	005, 004 an 005. (3cc			71.00			
41. 01	Total ESRD Medicare covered and paid discharges excluding M	S-DRGs 652, 682, 683, 68	4 0		41. 01			
42 00	an 685. (see instructions)	lify for adjustment)	0.00		42.00			
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not qual Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0.00		42.00			
10. 00	instructions)	502, 500, 501 dil 500. (50)			10.00			
44. 00	Ratio of average length of stay to one week (line 43 divided	d by line 41 divided by 7	0. 000000		44.00			
45. 00	days)   Average weekly cost for dialysis treatments (see instruction	ne)	0.00		45. 00			
46. 00			0.00		46.00			
47. 00	Subtotal (see instructions)		24, 128, 161		47. 00			
48. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48. 00			
	only. (see instructions)			Amarın+				
				Amount 1.00				
49. 00	Total payment for inpatient operating costs (see instruction	ns)		24, 139, 840	49. 00			
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I		)	1, 909, 373	l l			
51.00	Exception payment for inpatient program capital (Wkst. L, P			7 405	51.00			
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E-4, Nursing and Allied Health Managed Care payment	Title 49 See Thstructions)		7,485	52. 00 53. 00			
54. 00	Special add-on payments for new technologies			Ö	ı			
54. 01	Islet isolation add-on payment			0				
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	*		0	55.00			
56. 00 57. 00	Cost of physicians' services in a teaching hospital (see in Routine service other pass through costs (from Wkst. D, Pt.		through 35)	0	56. 00 57. 00			
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.		tin ough oo).	Ö				
59. 00	Total (sum of amounts on lines 49 through 58)			26, 056, 698				
60.00		11 (0)		0				
61. 00 62. 00	Total amount payable for program beneficiaries (line 59 minum Deductibles billed to program beneficiaries	us iine 60)		26, 056, 698 2, 325, 544				
63. 00	Coinsurance billed to program beneficiaries			87, 429				
64. 00	Allowable bad debts (see instructions)			230, 649	64.00			
	Adjusted reimbursable bad debts (see instructions)			149, 922				
66.00	3	structions)		48, 873				
67. 00 68. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	r applicable to MS-DRGs (	see instructions)	23, 793, 647 0				
69. 00	1			0	1			
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0				
70. 50	Rural Community Hospital Demonstration Project (§410A Demonstration Projec	•	ınstructions)	0	70.50			
	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)			0	70. 87			
	, ,				70.89			
70. 88	, , , , , , , , , , , , , , , , , , , ,	-		0				
70. 88 70. 89 70. 90		0	70. 9°					
70. 87 70. 88 70. 89 70. 90 70. 91	HSP bonus payment HRR adjustment amount (see instructions)							
70. 88 70. 89 70. 90 70. 91 70. 92	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0 76 <i>4</i> 75				
70. 88 70. 89 70. 90 70. 91	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)			0 76, 475 -282, 089	70. 93			

Health Financial Systems	COMMUNITY HOSPITAL AM	NDERSON		In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pr	ovider CC	N: 15-0113	Peri od: From 01/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1. 00	
70.96 Low volume adjustment for federal fis		olumn O		0	0	70. 96
70.97 Low volume adjustment for federal fis				0	0	70. 97

70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0	0	0	70. 96
	the corresponding federal year for the period prior to 10/1)			
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0	0	0	70. 97
	the corresponding federal year for the period ending on or after 10/1)			
70. 98	Low Volume Payment-3		0	70. 98
70. 99	HAC adjustment amount (see instructions)		65, 348	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		23, 522, 685	
71. 01	Sequestration adjustment (see instructions)		470, 454	
71. 02	Demonstration payment adjustment amount after sequestration		0	
72. 00	Interim payments		23, 045, 078	
73. 00	Tentative settlement (for contractor use only)		0	73. 00
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and		7, 153	
7 1. 00	73)		7, 100	7 1. 00
75. 00	Protested amounts (nonallowable cost report items) in accordance with		359, 135	75. 00
70.00	CMS Pub. 15-2, chapter 1, §115.2		007,100	70.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03		0	90. 00
	plus 2.04 (see instructions)		_	
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91. 00
92. 00	Operating outlier reconciliation adjustment amount (see instructions)		0	92. 00
93. 00	Capital outlier reconciliation adjustment amount (see instructions)		0	93. 00
94. 00	The rate used to calculate the time value of money (see instructions)		0.00	
95. 00	Time value of money for operating expenses (see instructions)		0.00	95. 00
96. 00	Time value of money for capital related expenses (see instructions)		0	
90.00	Trille varue of money for capital related expenses (see fristructions)	Prior to 10/1		90.00
		1. 00	2.00	
	HSP Bonus Payment Amount	1.00	2.00	
100.00	HSP bonus amount (see instructions)	0	0	100. 00
100.00	HVBP Adjustment for HSP Bonus Payment		U	100.00
101 00		0.000000000	0.000000000	101 00
	HVBP adjustment factor (see instructions)	0. 0000000000	0. 0000000000	
	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions)	0. 0000000000		101. 00 102. 00
102.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment	0	0	102. 00
102.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)	0.0000	0. 0000	102. 00 103. 00
102.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)	0	0. 0000	102. 00
102.00 103.00 104.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment	0.0000	0.0000	102. 00 103. 00 104. 00
102.00 103.00 104.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st	0.0000	0.0000	102. 00 103. 00
102.00 103.00 104.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.	0.0000	0.0000	102. 00 103. 00 104. 00
102.00 103.00 104.00 200.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) RRural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	0.0000	0.0000	102. 00 103. 00 104. 00 200. 00
102. 00 103. 00 104. 00 200. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)	0.0000	0.0000	102. 00 103. 00 104. 00 200. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions)	0.0000	0.0000	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	0.0000	0.0000	102. 00 103. 00 104. 00 200. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the computation)	0.0000	0.0000	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the operiod)	0.0000	0.0000 0.ration	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the coperiod) Medicare target amount	0.0000	0. 0000 0. ooon	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the coperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	0.0000	0. 0000 0. ooon	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Dis this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the operiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	0.0000	0. 0000 0. ooon	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the coperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	0.0000	0.0000 0	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the operiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions)	0.0000	0.0000 0.rration	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the operiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)	0.0000	0.0000 0.ration	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the operiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Derogram reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions)	0.0000	0.0000 0.ration	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the coperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Drogram reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	0.0000	0.0000 0.ration	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the coperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	0.0000	0.0000 0.ration	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the operiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	0.0000	0.0000 0.rration	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the operiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare Part A IPPS payments (from line 211)	0.0000	0.0000 0.ration	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the operiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Drogram reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 211) Low-volume adjustment (see instructions)	current 5-year demonst	0.0000 0.rration	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the operiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare Part A IPPS payments (from line 211)	current 5-year demonst	0.0000 0.rration	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00

In Lieu of Form CMS-2552-10

Period: Worksheet E
From 01/01/2018 Part A Exhibit 4
To 12/31/2018 Date/Time Prepared: 5/28/2019 4:13 pm Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0113

-					1'	12/31/2018	5/28/2019 4: 1	
		W/C F Dowt A	Amounto (from	Title Pre/Post	XVIII Period Prior	Hospi tal Peri od	PPS Total (Col 2	
		line	Amounts (from E, Part A)	Entitlement		On/After 10/01	through 4)	
		0	1.00	2.00	3. 00	4. 00	5. 00	
1. 00	DRG amounts other than outlier payments	1. 00	0	0	0	0	0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 01	16, 032, 149	0	16, 032, 149		16, 032, 149	1. 01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	5, 344, 049	0		5, 344, 049	5, 344, 049	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	О	0	0		0	1. 03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2. 00	746, 384	0	0	746, 384	746, 384	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
3. 00	Operating outlier reconciliation	2. 01	0	O	0	0	0	3. 00
4. 00	Managed care simulated payments	3. 00	11, 773, 142	0	0	11, 773, 142	11, 773, 142	4. 00
F 00	Indirect Medical Education Adju	ustment 21.00	0. 001816	0. 001816	0.001017	0.001017		5. 00
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.001816	0.001816	0. 001816	0. 001816		5. 00
6. 00	IME payment adjustment (see instructions)	22. 00	21, 205	0	15, 904	5, 301	21, 205	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	11, 679	0	11, 679	0	11, 679	6. 01
	instructions) Indirect Medical Education Adju	ustmont for the	Add on for So	ction 122 of th	bo MMA			
7. 00	IME payment adjustment factor	27.00	0. 000000	0.000000	0.00000	0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see	28. 00	0	0	0	0	0	8. 00
8. 01	instructions) IME payment adjustment add on for managed care (see	28. 01	0	0	0	0	0	8. 01
9. 00	instructions) Total IME payment (sum of	29. 00	21, 205	0	15, 904	5, 301	21, 205	9. 00
9. 01	lines 6 and 8) Total IME payment for managed	29. 01	11, 679	0	11, 679		11, 679	9. 01
	care (sum of lines 6.01 and 8.01)							
10.00	Di sproporti onate Share Adjustmo		0.1050	0.1050	0 1250	0 1250		10.00
10.00	Allowable disproportionate share percentage (see	33. 00	0. 1259	0. 1259	0. 1259	0. 1259		10. 00
11. 00	<pre>instructions) Disproportionate share adjustment (see instructions)</pre>	34. 00	672, 816	0	504, 612	168, 204	672, 816	11. 00
11. 01	Uncompensated care payments  Additional payment for high per	36.00 rcentage of ESI	1, 311, 558 RD beneficiary	0 di scharges	909, 798	401, 760	1, 311, 558	11. 01
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	0	12. 00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments	47. 00 48. 00	24, 128, 161 0	0	17, 462, 463 0	6, 665, 698 0	24, 128, 161 0	13. 00 14. 00
15.00	(completed by SCH and MDH, small rural hospitals only.) (see instructions)	40.00	24 120 040	0	17 474 140	/ //F /00	24 120 040	15.00
15. 00	Total payment for inpatient operating costs (see instructions)	49.00	24, 139, 840	0	17, 474, 142	6, 665, 698	24, 139, 840	15.00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1, 909, 373	0	0	1, 909, 373	1, 909, 373	16. 00
17. 00	Special add-on payments for new technologies	54. 00	0	0	0	0	0	17. 00
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	O	O	0	0	0	17. 01 17. 02
	Tuevices for applicable MS-DRGS	I	ı	ı			l	

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lieu of Form CMS-2552-10
LOW VOLUME CALCULATION EXHIBIT 4	Provider CCN: 15-0113	Peri od: Worksheet E From 01/01/2018 Part A Exhi bi t 4 To 12/31/2018 Date/Ti me Prepared:

						0 12/31/2018	Date/Time Pre 5/28/2019 4:1	pared:
				Title	XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement		On/After 10/01	through 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	O	0	0	18. 00
19.00	SUBTOTAL			0	17, 474, 142	8, 575, 071	26, 049, 213	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	1, 776, 953	0	0	1, 776, 953	1, 776, 953	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	0	0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	25, 803	0	0	25, 803	25, 803	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	0	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0009	0. 0009	0.0009	0. 0009		22. 00
	Indirect medical education adjustment (see instructions)	6. 00	1, 599	0		1, 599	1, 599	
	Allowable disproportionate share percentage (see instructions)	10.00	0. 0591	0. 0591	0. 0591	0. 0591		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	105, 018	0	0	105, 018	105, 018	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	1, 909, 373	0	0	1, 909, 373	1, 909, 373	26. 00
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
	Low volume adjustment factor				0. 000000	0. 000000		27. 00
28. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0		0	28. 00
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29. 00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet E | From 01/01/2018 | Part A Exhibit 5 | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 
 Heal th Financial
 Systems
 COMMUNITY HOSPITAL
 ANDERSON

 HOSPITAL
 ACQUIRED
 CONDITION (HAC)
 REDUCTION CALCULATION EXHIBIT 5
 Provider Conditions
 Provider CCN: 15-0113

					10 12/31/2018	5/28/2019 4:13	
			Title	XVIII	Hospi tal	PPS	
	·	Wkst. E, Pt.	Amt. from	Period to		Total (cols. 2	
		A, line	Wkst. E, Pt.	10/01	after 10/01	and 3)	
			A)		0.00	4.00	
1 00	DDC	0	1.00	2. 00	3. 00	4. 00	1 00
1.00	DRG amounts other than outlier payments	1.00	1/ 000 1/0	17 000 14		17 000 140	1.00
1. 01	DRG amounts other than outlier payments for	1. 01	16, 032, 149	16, 032, 14	9	16, 032, 149	1. 01
1. 02	discharges occurring prior to October 1 DRG amounts other than outlier payments for	1. 02	5, 344, 049		5, 344, 049	5, 344, 049	1. 02
1.02	di scharges occurring on or after October 1	1.02	3, 344, 049		3, 344, 049	3, 344, 049	1. 02
1. 03	DRG for Federal specific operating payment	1. 03	0		0	o	1. 03
1.05	for Model 4 BPCI occurring prior to October	1.05		,			1.00
	1						
1.04	DRG for Federal specific operating payment	1. 04	0		0	0	1. 04
	for Model 4 BPCI occurring on or after						
	October 1						
2.00	Outlier payments for discharges (see	2. 00	746, 384	559, 78	186, 596	746, 384	2.00
	instructions)						
2. 01	Outlier payments for discharges for Model 4	2. 02	0	'	0	0	2. 01
2 00	BPCI	2 01					2 00
3. 00 4. 00	Operating outlier reconciliation	2.01	U 11 772 142	0 000 05	J 042 205	11 772 142	3. 00 4. 00
4.00	Managed care simulated payments Indirect Medical Education Adjustment	3. 00	11, 773, 142	8, 829, 85	7 2, 943, 285	11, 773, 142	4.00
5.00	Amount from Worksheet E, Part A, Line 21	21.00	0. 001816	0. 00181	0. 001816		5. 00
3.00	(see instructions)	21.00	0.001010	0.00101	0.001010		3.00
6.00	IME payment adjustment (see instructions)	22. 00	21, 205	15, 90	4 5, 301	21, 205	6. 00
6. 01	IME payment adjustment for managed care (see		11, 679		•		6. 01
	instructions)		,	,		,	
	Indirect Medical Education Adjustment for the	Add-on for Se	ction 422 of t	he MMA	<u>'</u>		
7.00	IME payment adjustment factor (see	27. 00	0. 000000	0. 00000	0. 000000		7.00
	instructions)						
8.00	IME adjustment (see instructions)	28. 00	0		0		8. 00
8. 01	IME payment adjustment add on for managed	28. 01	0	'	0	0	8. 01
0.00	care (see instructions)	20.00	21 205	15.00	f 201	24 205	0.00
9.00	Total IME payment (sum of lines 6 and 8)	29.00	21, 205		•		9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	11, 679	8, 75	9 2, 920	11, 679	9. 01
	Disproportionate Share Adjustment						
10. 00	Allowable disproportionate share percentage	33.00	0. 1259	0. 125	9 0. 1259		10. 00
.0.00	(see instructions)	00.00	0.1207	020	, 0.1207		
11.00	Di sproporti onate share adjustment (see	34.00	672, 816	504, 61	168, 204	672, 816	11. 00
	instructions)			·		·	
11. 01	Uncompensated care payments	36.00	1, 311, 558	909, 79	8 401, 760	1, 311, 558	11. 01
	Additional payment for high percentage of ESR						
12. 00	Total ESRD additional payment (see	46. 00	0	(	0	0	12. 00
40.00	instructions)	47.00	04 400 4/4	40 000 05	1 / 105 010	04 400 444	10.00
13.00	Subtotal (see instructions)	47.00	24, 128, 161	18, 022, 25	6, 105, 910		13.00
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48. 00	0	'	0	0	14. 00
	instructions)						
15. 00	Total payment for inpatient operating costs	49. 00	24, 139, 840	18, 031, 01	6, 108, 830	24, 139, 840	15 00
13.00	(see instructions)	47.00	24, 137, 040	10, 031, 01	0, 100, 030	24, 137, 040	13.00
16. 00	Payment for inpatient program capital (from	50. 00	1, 909, 373	1, 432, 03	477, 343	1, 909, 373	16. 00
	Wkst. L, Pt. I, if applicable)		, ,	,,		, , .	
17.00	Special add-on payments for new technologies	54.00	0		0 0	0	17.00
17. 01	Net organ acquisition cost						17. 01
17. 02	Credits received from manufacturers for	68. 00	0		0 0	0	17. 02
	replaced devices for applicable MS-DRGs						
18. 00	Capital outlier reconciliation adjustment	93. 00	0		0	0	18. 00
10.00	amount (see instructions)			10 4/2 2:	, 50, 430	2/ 2/2 2/3	10.00
19.00	SUBTOTAL		l	19, 463, 04	0 6, 586, 173	26, 049, 213	19.00

Health Financial Systems	COMMUNITY HOSPIT	AL ANDERSON	In Lie	u of Form CMS-2552-10
HOSPITAL ACQUIRED CONDITION (HAC)	) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0113		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/28/2019 4:13 pm
		Title XVIII	Hospi tal	PPS
	Wkst I line	(Amt from		

				To 12/31/2018	Date/Time Pre 5/28/2019 4:1	
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1. 00	2. 00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1.00	1, 776, 953	1, 332, 71	5 444, 238	1, 776, 953	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0		0	0	20. 01
21.00 Capital DRG outlier payments	2.00	25, 803	19, 35	2 6, 451	25, 803	21. 00
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0		0	0	21. 01
22.00 Indirect medical education percentage (see instructions)	5. 00	0.0009	0.000	9 0.0009		22. 00
23.00 Indirect medical education adjustment (see instructions)	6. 00	1, 599	1, 19	9 400	1, 599	23. 00
24.00 Allowable disproportionate share percentage (see instructions)	10. 00	0. 0591	0. 059	0. 0591		24. 00
25.00 Disproportionate share adjustment (see instructions)	11.00	105, 018	78, 76	26, 254	105, 018	25. 00
26.00 Total prospective capital payments (see instructions)	12. 00	1, 909, 373	1, 432, 03	0 477, 343	1, 909, 373	26. 00
That detrois)	Wkst. E, Pt.	(Amt. from				
	A, line	Wkst. E, Pt.				
	.,	A)				
	0	1. 00	2. 00	3. 00	4. 00	
27. 00						27. 00
28.00 Low volume adjustment prior to October 1	70. 96	0		0	0	28. 00
29.00 Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00 HVBP payment adjustment (see instructions)	70. 93	76, 475	57, 35	6 19, 119	76, 475	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0	0	30. 01
31.00 HRR adjustment (see instructions)	70. 94	-282, 089	-211, 56	7 -70, 522	-282, 089	31. 00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0	0	1
					(Amt. to Wkst. E, Pt. A)	
	0	1.00	2.00	3. 00	4.00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0 65, 348	65, 348	32. 00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100. 00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0113		Worksheet E Part B Date/Time Prepared: 5/28/2019 4:13 pm

			12, 01, 2010	5/28/2019 4:1	
		Title XVIII	Hospi tal	PPS	
				1. 00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			10.077	1 00
1. 00 2. 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruct	tions)		19, 977 17, 815, 111	1
3. 00	OPPS payments	ti ons)		15, 737, 155	
4. 00	Outlier payment (see instructions)			32, 970	1
4. 01	Outlier reconciliation amount (see instructions)			0	1
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	5. 00
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV, col. 13, line 200		0	
10.00	Organ acquisitions			0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			19, 977	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES  Reasonable charges				-
12. 00	Ancillary service charges			97 526	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ine 69)		0	1
14. 00	Total reasonable charges (sum of lines 12 and 13)	67)		97, 526	1
	Customary charges				1
15.00	Aggregate amount actually collected from patients liable for p	payment for services on a	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	e)			
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18.00	Total customary charges (see instructions)		44) (	97, 526	1
19. 00	Excess of customary charges over reasonable cost (complete onlinstructions)	Ty If Tine 18 exceeds III	ne 11) (see	77, 549	19. 00
20. 00	Excess of reasonable cost over customary charges (complete onl	Ly if line 11 eyceeds lin	ne 18) (see	0	20. 00
20.00	instructions)	Ty IT Title IT exceeds IT	16 10) (366	ĺ	20.00
21.00	Lesser of cost or charges (see instructions)			19, 977	21.00
22.00	Interns and residents (see instructions)			0	1
23.00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			15, 770, 125	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				4
	Deductibles and coinsurance amounts (for CAH, see instructions			5, 019	•
26. 00	Deductibles and Coinsurance amounts relating to amount on line			2, 991, 071	•
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	plus the sum of lines 22	and 23] (see	12, 794, 012	27. 00
28. 00	instructions) Direct graduate medical education payments (from Wkst. E-4, li	ine 50)		4, 652	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	1116 30)		0	1
30.00	Subtotal (sum of lines 27 through 29)			12, 798, 664	1
31.00	Primary payer payments			1, 682	1
32.00	Subtotal (line 30 minus line 31)			12, 796, 982	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	CES)			
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	1
34.00	Allowable bad debts (see instructions)			692, 176	•
35. 00	Adjusted reimbursable bad debts (see instructions)			449, 914	
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions)	ructions)		519, 839 13, 246, 896	1
	MSP-LCC reconciliation amount from PS&R			7	38.00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			Ó	•
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)			39. 50
39. 97	Demonstration payment adjustment amount before seguestration	-,		0	1
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	0	1
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	•	<b>,</b>	0	39. 99
40.00	Subtotal (see instructions)			13, 246, 889	40. 00
40. 01	Sequestration adjustment (see instructions)			264, 938	1
40. 02	Demonstration payment adjustment amount after sequestration				40. 02
41.00	Interim payments			12, 907, 821 0	1
42. 00	, , , , , , , , , , , , , , , , , , , ,				
43.00	Balance due provider/program (see instructions)	acc with CMC Dut 15 0	chantar 1	74, 130	1
44. 00	Protested amounts (nonallowable cost report items) in accordar	nce writh CMS Pub. 15-2, (	unapter I,	0	44. 00
	§115.2 TO BE COMPLETED BY CONTRACTOR				1
	TO DE COM LETED DI CONTINUOTOR			0	90.00
90.00	Original outlier amount (see instructions)				
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)		1		1
91.00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0	1
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91. 00 92. 00

Health Financial Systems COMMU ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0113

			'	0 12/31/2010	5/28/2019 4:13	
		Title	Title XVIII		PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2, 00	3. 00	4.00	
1. 00	Total interim payments paid to provider		23, 045, 078		12, 907, 821	1. 00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		23, 313, 376		0	2. 00
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		C	)	0	3. 01
3.02			(	)	0	3. 02
3.03			(	)	0	3. 03
3.04			(		0	3. 04
3. 05			(	)	0	3. 05
	Provi der to Program		_		_	
3.50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 51			(		0	3. 51
3. 52					0	3. 52
3. 53 3. 54						3. 53 3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines					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		23, 045, 078	3	12, 907, 821	4. 00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		Г			
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVI DER			)	0	5. 01
5. 02	TENTATI VE TO TROVIDER				0	5. 02
5. 03					Ö	5. 03
	Provider to Program			•		
5.50	TENTATI VE TO PROGRAM		C	)	0	5. 50
5. 51			(	)	0	5. 51
5.52			(	)	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C	)	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		7, 153	3	74, 130	6. 01
6.02	SETTLEMENT TO PROGRAM		C		0	6. 02
7. 00	Total Medicare program liability (see instructions)		23, 052, 231		12, 981, 951	7. 00
				Contractor	NPR Date	
		(	)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		<b>-</b>	1.00	2.00	8. 00
0.00		l		1	'	0.00

Health Financial Systems COMMUNITY HOSPITAL ANDERSON In Lieu of					u of Form CMS-	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0113 Period: Wol					I
				From 01/01/2018 To 12/31/2018	Part II   Date/Time Pre	anared:
				10 12/31/2010	5/28/2019 4: 1	
			Title XVIII	Hospi tal	PPS	
					1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST					4
1 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND		t Lool 15 line	14		1.00
1. 00 2. 00	Total hospital discharges as defined in AARA §4102 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of		t. i coi. is iine	14		2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. I					3. 00
4. 00	Total inpatient days from S-3, Pt. I col. 8 sum of					4. 00
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8					5. 00
6.00	Total hospital charity care charges from Wkst. S-1					6. 00
7.00	CAH only - The reasonable cost incurred for the pu	ırchase of certifie	d HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168					
8.00	Calculation of the HIT incentive payment (see inst					8. 00
9.00	Sequestration adjustment amount (see instructions)					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					4
	30.00  Initial/interim HIT payment adjustment (see instructions)					30.00
31. 00	1 3/	no 20 and line 21)	(occ i notructi on	٥)		31.00
32.00	Balance due provider (line 8 (or line 10) minus li	ne 30 and Tine 31)	(see instruction	S)		32. 00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0113		Worksheet E-3 Part VII Date/Time Prepared: 5/28/2019 4:13 pm

PART VIII - CALCILLATION OF RELIBURGEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				10 12/31/2018	5/28/2019 4:1	
PART VII - CALCULATION OF RELIBURISEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V.OR XIX SERVICES			Title XIX	Hospi tal		
DART VII - CALCULATION OF REI DBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES						
PART VII - CACCULATION OF RELIMBURSCHENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES						
COMPUTATION OF NET COST OF COVERED SERVICES   1.00   1.0		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XI			
Inpatient hospital/SNF/NF services						
Medical and other services   0   2.00	1.00			5, 780, 940		1.00
1.00   Organ acquisition (certified transplant centers only)   0   3.00   3.00   1.0					0	
Subtotal (sum of lines 1, 2 and 3)   5,780,940   0,400   0,000   0,0000   0,0000   0,0000   0,0000   0,000				0		
Inpatient primary payer payments				5. 780. 940	0	
0.00   Outpatient primary payer payments   0.6 0.00						
Subtotal (line 4 less sum of lines 5 and 6)				,	0	
COMPUTATION OF LESSER OF COST OR CHARGES   9,198,285   8.00				5, 567, 028		
Reasonable Charges   8.00   Routine service charges   9,198, 285   8.00   Routine service charges   9,198, 285   8.00   Routine service charges   13,966,587   0,9.00   10.00   Incentive from target amount computation   10.00   Incentive from target amount computation   10.00   Incentive from target amount computation   11.00   Incentive from target amount computation   11.00   Incentive from target amount computation   11.00   Incentive from target amount computation   123,164,872   0.12.00   Incentive from target amount computation   12.00   Incentive from target amount computation   123,164,872   0.12.00   Incentive from the part of the payment for services on a charge   0   0   13.00   Incentive from patients I liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)   0.000000   0.000000   0.000000   15.00   Ratio of line 13 to line 14 (not to exceed 1.000000)   0.0000000   0.0000000   0.00000000						
Routine service charges   9,198,285   8.00						İ
9,00   Ancillary service charges   13,966,887   0 9,00	8.00			9, 198, 285		8.00
10.00   Organ acquisition charges, net of revenue   0   10.0	9.00				0	9.00
12.00   Total reasonable charges (sum of lines 8 through 11)   23, 164, 872   12.00	10.00	Organ acquisition charges, net of revenue		0		10.00
CUSTOMARY CHARGES	11.00	Incentive from target amount computation		0		11. 00
13.00   Amount actually collected from patients	12.00	Total reasonable charges (sum of lines 8 through 11)		23, 164, 872	0	12. 00
basis   14.00   Anounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)   15.00   Ratio of line 13 to line 14 (not to exceed 1.000000)   15.00   16.00   17.00		CUSTOMARY CHARGES				1
14.00   Amounts that would have been realized from patients Liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413. 13(e)   0.000000   0.000000   15.00   15.00   16.00	13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
a charge basis had such payment been made in accordance with 42 CFR \$413.13(e)  16. 00 Tatio of line 13 to line 14 (not to exceed 1.000000)  17. 00 Total customary charges (see instructions)  18. 00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 17, 383, 932 0 17. 00  18. 00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)  19. 00 Interns and Residents (see instructions)  19. 00 Interns and Residents (see instructions)  19. 00 Interns and Residents (see instructions)  10. 00 Cost of physicians' services in a teaching hospital (see instructions)  10. 00 Cost of payments  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of payments  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 01 Cost of covered services (enter the lesser of line 4 or line 16)  10. 01 Cost of covered services (enter the lesser of line 4 or line 16)  10. 01 Cost of covered services (enter the lesser of line 4 or line 16)  10. 02 Cost of covered services (enter the lesser of line 4 or line 16)  10. 02 Cost of covered services (enter the lesser of line 4 or line 16)  10. 01 Cost of covered services (enter the lesser of line 4 or line 16)  10. 02 Cost of covered services (enter the lesser of line 4 or line 16)  10. 01 Cost of covered services (enter the lesser of line 4 or line 16)  10. 01 Cost of covered services (enter the lesser of line 16)  10. 01 Cost of covered services (enter the lesser of line 16)  10. 01 Cost of covered services (enter the lesser of		basis				
15.00	14.00			0	0	14. 00
16. 00   Total customary charges (see instructions)   23, 164, 872   0   16. 00   Excess of customary charges over reasonable cost (complete only if line 16 exceeds   17, 383, 932   0   17. 00   11   17. 00   11   17. 00   12   17. 00   17. 00   18. 00			12 CFR §413.13(e)			
17.00   Excess of customary charges over reasonable cost (complete only if line 16 exceeds   17, 383, 932   0   17.00		·				
Ine 4) (see instructions)   Excess of reasonable cost over customary charges (complete only if line 4 exceeds line   0   0   18.00   16) (see instructions)   0   0   19.00   10   10   10   10   10   10   10						
18.00   Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)   0   18.00   16) (see instructions)   0   0   19.00   17.00	17. 00		y if line 16 exceeds	17, 383, 932	0	17. 00
16) (see instructions)	40.00					40.00
19.00   Interns and Residents (see instructions)	18. 00		y if line 4 exceeds line	0	0	18.00
20. 00   Cost of physicians' services in a teaching hospital (see instructions)   Cost of covered services (enter the lesser of line 4 or line 16)   5, 780, 940   Description	40.00				0	40.00
21.00				٩	-	
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				٩	-	
22. 00   Other than outlier payments   0   0   22. 00	21.00				0	21.00
23. 00       Outlier payments       0       0       23. 00         24. 00       Program capital payments       0       24. 00         25. 00       Capital exception payments (see instructions)       0       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       0       28. 00         29. 00       Titles V or XIX (sum of lines 21 and 27)       5, 780, 940       0       29. 00         20. 00       Excess of reasonable cost (from line 18)       0       30. 00       31. 00         31. 00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       5, 567, 028       0       31. 00         32. 00       Deductibles       6, 463       0       32. 00         33. 00       Coinsurance       25, 520       0       33. 00         34. 00       Allowable bad debts (see instructions)       0       35. 00         35. 00       Uitilization review       0       35. 00         36. 00       Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)       5, 535, 045	22 00		compreted for PPS provid		0	22.00
24.00       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       0.26.00         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       0.28.00         29.00       Titles V or XIX (sum of lines 21 and 27)       5,780,940       0         COMPUTATION OF REIMBURSEMENT SETTLEMENT         30.00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       5,567,028       0       31.00         32.00       Deductibles       6,463       0.32.00       0       32.00         33.00       Coinsurance       25,520       0.33.00       0       34.00       Allowable bad debts (see instructions)       0       0.34.00       35.00         34.00       Allowable bad debts (see instructions)       0       0.35.00       35.00       36.00       37.00       0       37.00       0       37.00       0       37.00       0       37.00       0       0       37.00       0       0       37.00       0       0       37.00       0				-		
25. 00 Capital exception payments (see instructions) 26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT  30. 00 Excess of reasonable cost (from line 18) 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 Deductibles 33. 00 Coinsurance 34. 00 Allowable bad debts (see instructions) 35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Interim payments 40. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 40. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 40. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 40. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 40. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 40. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 40. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 40. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 40. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 40. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 40. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 40. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 40. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 40. 00 Protested amounts (nonallowable cost report items) in ac				-	Ü	
26. 00 Routine and Ancillary service other pass through costs  27. 00 Subtotal (sum of lines 22 through 26)  28. 00 Customary charges (title V or XIX PPS covered services only)  29. 00 Titles V or XIX (sum of lines 21 and 27)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  30. 00 Excess of reasonable cost (from line 18)  30. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  32. 00 Deductibles  33. 00 Coinsurance  34. 00 Allowable bad debts (see instructions)  36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  38. 00 Subtotal (line 36 ± line 37)  39. 00 Direct graduate medical education payments (from Wkst. E-4)  40. 00 Total amount payable to the provider (sum of lines 38 and 39)  41. 00 Inter im payments  42. 00 Bal ance due provider/program (line 40 minus line 41)  43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 26. 00 27. 00  0 27. 00  0 27. 00  0 27. 00  0 28. 00  0 5, 780, 940  0 0 30. 00  0 30. 00  0 30. 00  0 30. 00  0 30. 00  0 31. 00  0 30. 00  0 31. 00  0 32. 00  30				-		
27. 00   Subtotal (sum of lines 22 through 26)				1	0	
28. 00 Customary charges (title V or XIX PPS covered services only)  7				Ĭ		
29.00 Titles V or XIX (sum of lines 21 and 27)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  30.00 Excess of reasonable cost (from line 18)  Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  Deductibles  30.00 Coinsurance  30.00 Allowable bad debts (see instructions)  40.00 Allowable bad debts (see instructions)  Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  Subtotal (line 36 ± line 37)  Direct graduate medical education payments (from Wkst. E-4)  Total amount payable to the provider (sum of lines 38 and 39)  Total amount payable to the provider (sum of lines 38 and 39)  Total amount payable to the provider (sum of lines 38 and 39)  Total anount payable to the provider (sum of lines 38 and 39)  Tot				0	-	
30.00   Excess of reasonable cost (from line 18)   0   30.00				5. 780. 940		
30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 32.00 Coi nsurance 33.00 Allowable bad debts (see instructions) 35.00 Utilization review 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 30.00 5, 567, 028 0 31.00 5, 567, 028 0 31.00 32.00 32.00 32.00 34.00 35.00 35.00 0 0 34.00 35.00 0 0 35.00 0 0 35.00 0 0 37.00 36.00 37.00 38.00 39.00 0 0 37.00 39.00 0 0 37.00 0 0 37.00 0 0 37.00 0 0 37.00 0 0 37.00 0 0 37.00 0 0 37.00 0 0 37.00 0 0 37.00 0 0 37.00 0 0 37.00 0 0 37.00 0 0 37.00 0 0 37.00 0 0 37.00 0 0 37.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	27.00			0,,00,,10		27.00
31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  32.00 Deductibles  32.00 Deductibles  32.00 Coinsurance  32.50 O Allowable bad debts (see instructions)  35.00 Utilization review  36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  38.00 Subtotal (line 36 ± line 37)  39.00 Direct graduate medical education payments (from Wkst. E-4)  40.00 Total amount payable to the provider (sum of lines 38 and 39)  41.00 Balance due provider/program (line 40 minus line 41)  42.00 Balance due provider (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 31.00  5, 567, 028  6, 463  0 32.00  35.00  35.00  35.00  35.00  35.00  35.00  35.05  0 36.00  37.00  37.00  37.00  38.00  37.00  38.00  39.00  40.00  41.00 Interim payments	30.00			0	0	30.00
32.00   Deductibles   6,463   0   32.00   33.00   Coinsurance   25,520   0   33.00   34.00   Allowable bad debts (see instructions)   0   0   34.00   35.00   Utilization review   0   0   35.00   35.00   Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   5,535,045   0   36.00   37.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   0   37.00   38.00   Subtotal (line 36 ± line 37)   5,535,045   0   38.00   Direct graduate medical education payments (from Wkst. E-4)   0   Total amount payable to the provider (sum of lines 38 and 39)   5,535,045   0   39.00   Other impayments   10,239,541   0   41.00   Interim payments   10,239,541   0   41.00   42.00   Balance due provider/program (line 40 minus line 41)   -4,704,496   0   42.00   43.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,   0   0   43.00		, ,		5, 567, 028	0	31.00
33.00   Coinsurance   25,520   0   33.00   34.00   Allowable bad debts (see instructions)   0   34.00   35.00   Utilization review   0   35.00   35.00   Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   5,535,045   0   36.00   37.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   0   37.00   38.00   Subtotal (line 36 ± line 37)   5,535,045   0   38.00   39.00   Direct graduate medical education payments (from Wkst. E-4)   0   Total amount payable to the provider (sum of lines 38 and 39)   5,535,045   0   40.00   41.00   Interim payments   10,239,541   0   41.00   42.00   Balance due provider/program (line 40 minus line 41)   -4,704,496   0   42.00   43.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,   0   0   43.00					0	
35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 35.00 5,535,045 0 36.00 5,535,045 0 38.00 39.00 0 39.00 0 39.00 0 40.00 0 41.00 0 42.00					0	
35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 35.00 5,535,045 0 36.00 5,535,045 0 38.00 39.00 0 39.00 0 39.00 0 40.00 0 41.00 0 42.00	34.00	Allowable bad debts (see instructions)		0	0	34.00
37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  38.00 Subtotal (line 36 ± line 37)  39.00 Direct graduate medical education payments (from Wkst. E-4)  40.00 Total amount payable to the provider (sum of lines 38 and 39)  41.00 Interim payments  42.00 Balance due provider/program (line 40 minus line 41)  43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 37.00  5,535,045  0 38.00  5,535,045  0 40.00  41.00  42.00  43.00				0		35. 00
38.00   Subtotal (line 36 ± line 37)   5,535,045   0   38.00   39.00   Direct graduate medical education payments (from Wkst. E-4)   0   39.00   40.00   Total amount payable to the provider (sum of lines 38 and 39)   5,535,045   0   40.00   41.00   Interim payments   10,239,541   0   41.00   42.00   Balance due provider/program (line 40 minus line 41)   -4,704,496   0   42.00   43.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,   0   43.00	36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	5, 535, 045	0	36.00
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 5,535,045 0 40.00 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 39.00 40.00 41.00 42.00 43.00	37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
40.00       Total amount payable to the provider (sum of lines 38 and 39)       5,535,045       0 40.00         41.00       Interim payments       10,239,541       0 41.00         42.00       Balance due provider/program (line 40 minus line 41)       -4,704,496       0 42.00         43.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,       0 43.00	38.00	Subtotal (line 36 ± line 37)		5, 535, 045	0	38. 00
41.00 Interim payments 10, 239, 541 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00	39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 42.00 43.00	40.00	Total amount payable to the provider (sum of lines 38 and 39)		5, 535, 045	0	40. 00
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00	41.00	Interim payments			0	41. 00
	42.00			-4, 704, 496	0	42. 00
chapter 1, §115.2	43.00		nce with CMS Pub 15-2,	0	0	43. 00
		chapter 1, §115.2				l

	Financial Systems COMMUNITY HOSPITA GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	AL ANDERSON Provider C	CN: 15 O112	In Lie Period:	u of Form CMS-2 Worksheet E-4	
	L EDUCATION COSTS	Provider C	CN. 15-0115	From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
		Title	e XVIII	Hospi tal	5/28/2019 4: 1: PPS	3 pm
			, ,,,,,,	noop. tu.		
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				1. 00	
1. 00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs for	cost reporti	ng periods	0. 00	1. 00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CF Amount of reduction to Direct GME cap under section 422 of MM.		(1) (see insti	ructions)	0. 00 0. 00	
3. 00 3. 01	Direct GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011)		R §413.79 (m).	(see	0.00	
4. 00	Adjustment (plus or minus) to the FTE cap for allopathic and (GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	to a Medicare	0.00	4. 00
4. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst straddling 7/1/2011)		cost reporti	ng periods	0. 00	4. 01
4. 02	ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	s (see inst	ructions for	cost reporting	0.00	4. 02
5. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl 4.02 plus applicable subscripts	us or minus	line 4 plus l	ines 4.01 and	0. 00	5. 00
6. 00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	the current	year from your	0. 00	6. 00
7. 00	Enter the lesser of line 5 or line 6		Dri mary Car	0 Othor	0. 00 Total	7. 00
			Primary Card	0ther 2.00	3. 00	
8. 00	Weighted FTE count for physicians in an allopathic and osteop program for the current year.	athi c	0. (	0.00	0. 00	8. 00
9. 00	If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6.		0. (	0.00	0. 00	9. 00
10.00	Weighted dental and podiatric resident FTE count for the curr			0. 17		10.00
10. 01 11. 00	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count	rrent year	0.4	0. 00 0. 17		10. 01 11. 00
12. 00	Total weighted resident FTE count for the prior cost reporting instructions)	g year (see	0. (	0. 44		12. 00
13. 00	Total weighted resident FTE count for the penultimate cost re year (see instructions)	porting	0. (	0. 07		13. 00
14. 00 15. 00	Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs	by 3).	0. (			14. 00 15. 00
15. 00	Unweighted adjustment for residents in initial years of new p	rograms	0.			15. 00
16. 00	Adjustment for residents displaced by program or hospital clo	sure	0. (			16. 00
16. 01	Unweighted adjustment for residents displaced by program or holosure	ospi tal	0. (	0.00		16. 01
17. 00 18. 00	Adjusted rolling average FTE count Per resident amount		0.0			17. 00 18. 00
	Approved amount for resident costs		90, 325.	67 90, 325. 67 0 20, 775	20, 775	
					1. 00	
20. 00	Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)	TE resident	cap slots red	cei ved under 42		20. 00
21. 00	Direct GME FTE unweighted resident count over cap (see instru				0.00	
22. 00 23. 00	Allowable additional direct GME FTE Resident Count (see instr	,	nstructions)		0. 00 0. 00	
24. 00					0.00	1
25. 00	Total direct GME amount (sum of lines 19 and 24)		Inpatient Pa	rt Managed care	20, 775	25. 00
			· A	J J		
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2. 00	3. 00	
26. 00	Inpatient Days (see instructions)		10, 0			26. 00
27. 00	Total Inpatient Days (see instructions)		25, 9			27. 00
28. 00 29. 00	Ratio of inpatient days to total inpatient days Program direct GME amount		0. 3866			28. 00 29. 00
30.00	Reduction for direct GME payments for Medicare Advantage			675		30.00
31. 00	Net Program direct GME amount				12, 137	31.00

	Financial Systems COMMUNITY HOSPITA	AL ANDERSON	In Lie	u of Form CMS-2	2552-10
DI REC	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-0113	Peri od:	Worksheet E-4	
MEDI CA	From 01/01/2018				
		Title XVIII	Hospi tal	PPS	
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL EDUCATION COSTS)	•		CAL	
32.00	,	Pt. I, sum of col. 20 an	d 23, lines 74	0	32. 00
	and 94)				
33. 00			74 and 94)	520, 401	
34. 00	Ratio of direct medical education costs to total charges (lin	e 32 ÷ line 33)		0. 000000	ł
	Medicare outpatient ESRD charges (see instructions)	0.4		0	
36. 00	Medicare outpatient ESRD direct medical education costs (line			0	36. 00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	UNLY			
37. 00	Part A Reasonable Cost Reasonable cost (see instructions)			28, 696, 144	37. 00
38.00	,			20, 090, 144	38.00
	Cost of physicians' services in a teaching hospital (see inst			0	
	Primary payer payments (see instructions)	ructions)		0	ı
	Total Part A reasonable cost (sum of lines 37 through 39 minu	s line 40)		28, 696, 144	
41.00	Part B Reasonable Cost	3 11110 40)		20, 070, 144	41.00
42. 00				17, 835, 088	42 00
43. 00	,			1, 682	1
	Total Part B reasonable cost (line 42 minus line 43)			17, 833, 406	
	Total reasonable cost (sum of lines 41 and 44)			46, 529, 550	1
46.00	Ratio of Part A reasonable cost to total reasonable cost (lin	e 41 ÷ line 45)		0. 616729	
47.00	Ratio of Part B reasonable cost to total reasonable cost (lin	e 44 ÷ line 45)		0. 383271	47. 00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA	RT B			
48. 00	Total program GME payment (line 31)			12, 137	48. 00
49. 00	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		7, 485	49. 00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instructions)		4, 652	50. 00

Health Financial Systems

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

Provider CCN: 15-0113 Period From (

Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/28/2019 4:13 pm

OH y)					5/28/2019 4:1	3 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Pl ant Fund	
		1. 00	2.00	3. 00	4. 00	
4 00	CURRENT ASSETS	0/ 004 5/0	J		1	4 00
1.00	Cash on hand in banks	36, 001, 568		_	_	
2. 00 3. 00	Temporary i nvestments Notes receivable		0	_		2. 00 3. 00
4.00	Accounts receivable	76, 590, 141	1	_	0	
5.00	Other recei vable	70, 370, 141		0	o o	5.00
6. 00	Allowances for uncollectible notes and accounts receivable	-52, 061, 870	o o	Ö	ő	6.00
7.00	Inventory	3, 159, 324		0	0	
8.00	Prepai d expenses	277, 486	0	0	0	8. 00
9.00	Other current assets	0	0	0	0	9. 00
10.00	Due from other funds	9, 340, 489	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	73, 307, 138	0	0	0	11. 00
40.00	FI XED ASSETS	4 450 000		_		40.00
12.00	Land	6, 158, 238		_	_	12.00
13. 00 14. 00	Land improvements Accumulated depreciation	1, 989, 234 -1, 812, 151	1	_		13. 00 14. 00
15. 00	Buildings	75, 697, 942	1	_		15.00
16. 00	Accumulated depreciation	-38, 630, 362	1	0	ő	16.00
17. 00	Leasehold improvements	1, 197, 015	1	Ö	ő	17. 00
18. 00	Accumul ated depreciation	-149, 059		0	0	18. 00
19.00	Fi xed equipment	20, 823, 381	0	0	0	19. 00
20.00	Accumulated depreciation	-14, 718, 927	0	0	0	20. 00
21. 00	Automobiles and trucks	968, 366	1	0	0	21. 00
22. 00	Accumulated depreciation	-813, 833	1	0	0	22. 00
23. 00	Maj or movable equipment	15, 601, 434	1	0	0	23. 00
24. 00	Accumulated depreciation	-11, 573, 132		_	0	24. 00
25. 00	Mi nor equipment depreciable	39, 848, 724		_	0	25. 00
26. 00	Accumulated depreciation HIT designated Assets	-28, 716, 311	0	0	0	26. 00 27. 00
27. 00 28. 00	Accumulated depreciation			0	0	28.00
29. 00	Mi nor equi pment-nondepreci abl e			_		29.00
30.00	Total fixed assets (sum of lines 12-29)	65, 870, 559		_		30.00
00.00	OTHER ASSETS	1 00,0,0,00				00.00
31.00	Investments	170, 574, 876	0	0	0	31. 00
32.00	Deposits on Leases	0	0	0	0	32. 00
33. 00	Due from owners/officers	0	0	0	0	33. 00
34. 00	Other assets	0	0		0	34. 00
35. 00	Total other assets (sum of lines 31-34)	170, 574, 876		_	_	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	309, 752, 573	0	0	0	36. 00
37. 00	CURRENT LIABILITIES Accounts payable	-3, 930, 840	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	-10, 742, 961	1			38.00
39. 00	Payroll taxes payable	-285, 570	1	0	ő	
40. 00	Notes and Loans payable (short term)	-1, 613, 304	1	0	ő	
41. 00	Deferred income	0	ō	0	ō	41. 00
42.00	Accel erated payments	0				42. 00
43.00	Due to other funds	-238, 362	2 0	0	0	43. 00
44.00	Other current liabilities	-2, 654, 776	0	0	0	44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	-19, 465, 813	0	0	0	45. 00
	LONG TERM LIABILITIES	_	_		T -	
46. 00	Mortgage payable	0	0	_	_	
47. 00 48. 00	Notes payable		0	_	_	
49. 00	Unsecured Loans Other Long term Liabilities	-2, 015, 647		_		49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-2, 015, 647		_		50.00
51.00	Total liabilities (sum of lines 45 and 50)	-21, 481, 460				51.00
011.00	CAPI TAL ACCOUNTS	21, 101, 100	<u>,                                      </u>			0 00
52.00	General fund balance	-288, 271, 113	1			52. 00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54. 00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,		1		0	58. 00
E0 00	replacement, and expansion	200 271 112		_	_	E0 00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	-288, 271, 113 -309, 752, 573			0	
50.00	[59]	307, 132, 313	.]			55.50
	1 * /	1	1	ļ	1	1

Provider CCN: 15-0113

					То	12/31/2018	Date/Time Prep 5/28/2019 4:13	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	, p
				·				
		1.00					5.00	
1 00	Trund halanan at hankankan as anni ad	1.00	2.00	3. 00		4. 00	5. 00	1 00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		269, 469, 939 18, 801, 174			0		1. 00 2. 00
3.00	Total (sum of line 1 and line 2)	+	288, 271, 113			0		3. 00
4. 00	Additions (credit adjustments) (specify)	0	200, 271, 113		0	U	0	4. 00
5.00	Additions (credit adjustments) (specify)				0		0	5. 00
6.00		0			0		0	6. 00
7. 00		0			0		ő	7. 00
8. 00		o			0		o	8. 00
9.00		O			0		0	9. 00
10.00	Total additions (sum of line 4-9)		0			0		10.00
11.00	Subtotal (line 3 plus line 10)		288, 271, 113			0		11.00
12.00	Deductions (debit adjustments) (specify)	0			0		0	12.00
13. 00		0			0		0	13.00
14. 00		0			0		0	14. 00
15. 00		0			0		0	15. 00
16.00		0			0		0	16. 00
17. 00	T-t-1 d-dti (6 li 12 17)	0	0		U	0	0	17. 00 18. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance		288, 271, 113			0		18.00
19.00	sheet (line 11 minus line 18)		200, 2/1, 113			U		19.00
	janeer (Title II milles IIIIe 10)	Endowment Fund	PI ant	Fund				
		6. 00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2. 00
3.00	Total (sum of line 1 and line 2)	0			0			3. 00
4. 00 5. 00	Additions (credit adjustments) (specify)		0					4. 00 5. 00
6.00			0					6. 00
7. 00			0					7. 00
8.00			0					8. 00
9. 00			0					9. 00
10. 00	Total additions (sum of line 4-9)	0	Ŭ.		0			10. 00
11. 00	Subtotal (line 3 plus line 10)	O			0			11. 00
12.00	Deductions (debit adjustments) (specify)		0					12.00
13.00			0					13.00
14.00			0					14.00
15. 00			0					15.00
16. 00			0					16. 00
17. 00			0					17. 00
18.00	Total deductions (sum of lines 12-17)	0			0			18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	O			U			19. 00
	Janeer (Title II IIII IIII III III)	1		I	ļ		ı	

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

			То	12/31/2018	Date/Time Prep 5/28/2019 4:13		
	Cost Center Description	I npati e	nt	Outpati ent	Total	<b>У</b> РШ	
	555 551151 55551 Pt 611	1, 00		2. 00	3. 00		
	PART I - PATIENT REVENUES	1.00		2.00	0.00		
	General Inpatient Routine Services						
1.00	Hospi tal	54, 100	979		54, 100, 979	1. 00	
2.00	SUBPROVIDER - I PF	0.,.55	0		0 17 1007 77 7	2. 00	
3.00	SUBPROVI DER - I RF		0		0	3. 00	
4. 00	SUBPROVI DER		0		0	4. 00	
5. 00	Swing bed - SNF		0		0	5. 00	
6. 00	Swing bed - NF		0		0	6. 00	
7. 00	SKILLED NURSING FACILITY		0		0	7. 00	
8.00	NURSING FACILITY		0		0	8. 00	
9. 00	OTHER LONG TERM CARE		Ō		0	9. 00	
10.00	Total general inpatient care services (sum of lines 1-9)	54, 100	. 979		54, 100, 979		
	Intensive Care Type Inpatient Hospital Services	,					
11. 00	INTENSIVE CARE UNIT	13, 189	, 403		13, 189, 403	11. 00	
12.00	CORONARY CARE UNIT		0		0	12.00	
13.00	BURN INTENSIVE CARE UNIT		0		0	13.00	
14.00	SURGI CAL INTENSIVE CARE UNIT		0		0	14.00	
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00	
16.00	Total intensive care type inpatient hospital services (sum of li	nes 13, 189	, 403		13, 189, 403	16.00	
	11-15)						
17.00	Total inpatient routine care services (sum of lines 10 and 16)	67, 290	, 382		67, 290, 382	17.00	
18.00	Ancillary services	135, 217	, 165	268, 622, 506	403, 839, 671	18.00	
19.00	Outpatient services	11, 860	, 980	76, 187, 836	88, 048, 816	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			0	0	22.00	
23.00	AMBULANCE SERVICES		0	0	0	23.00	
24.00	CMHC			0	0	24.00	
24. 10	CORF		0	0	0	24. 10	
25.00	AMBULATORY SURGICAL CENTER (D. P. )		0	0	0	25.00	
26.00	HOSPI CE		0	0	0	26.00	
27. 00	NURSERY, NRCC AND OTHER	5, 202	, 935	11, 580, 604	16, 783, 539	27.00	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	) Wkst. 219,571	, 462	356, 390, 946	575, 962, 408	28. 00	
	G-3, line 1)						
	PART II - OPERATING EXPENSES						
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			172, 779, 874		29. 00	
30. 00	ADD (SPECIFY)		0			30. 00	
31. 00			0			31. 00	
32. 00			0			32. 00	
33. 00			0			33. 00	
34.00			0			34.00	
35. 00	T		0			35. 00	
36. 00	Total additions (sum of lines 30-35)			0		36. 00	
37. 00	DEDUCT (SPECIFY)		0			37. 00	
38. 00			0			38. 00	
39.00			0			39. 00	
40.00			0			40.00	
41. 00 42. 00	Total deductions (sum of lines 27 41)		U			41. 00	
42.00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)	transfor		172, 779, 874		42. 00 43. 00	
43.00	to Wkst. G-3, line 4)	(rigilalei		112, 117, 014		43.00	
	10 mkst. 0-0, 11110 4)	I		ı			

	Financial Systems	COMMUNITY HOSPITAL ANDERSON		u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES		ri od:	Worksheet G-3	
		Fr To	om 01/01/2018 12/31/2018		
				5/28/2019 4: 1:	3 pm
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part	L column 3 line 28)		575, 962, 408	1. 00
2.00	Less contractual allowances and discounts on			383, 892, 218	
3.00	Net patient revenues (line 1 minus line 2)		192, 070, 190		
4. 00	Less total operating expenses (from Wkst. G-	2. Part II. line 43)		172, 779, 874	
5. 00	Net income from service to patients (line 3			19, 290, 316	
	OTHER I NCOME		'	, , , , , ,	
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			291, 285	7. 00
8.00	Revenues from telephone and other miscellane	ous communication services		119, 390	8. 00
9.00	Revenue from television and radio service			36, 727	9. 00
10.00	Purchase di scounts			13, 961	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 gue	sts		915, 640	14.00
	Revenue from rental of living quarters			0	15. 00
	Revenue from sale of medical and surgical su			0	16.00
	Revenue from sale of drugs to other than pat			0	17.00
	Revenue from sale of medical records and abs			846	
	Tuition (fees, sale of textbooks, uniforms,			0	19.00
	Revenue from gifts, flowers, coffee shops, a	nd canteen		0	20. 00
	Rental of vending machines			0	21.00
	Rental of hospital space			0	22. 00
	Governmental appropriations			0	23. 00
	SALE OF SCRAP, WASTE, ETC			921	24.00
	GENERAL NON-OPERATING REVENUE			-12, 765, 600	
	GENERAL OTHER OPERATING REVENUE			18, 447, 495	
	Total other income (sum of lines 6-24)			7, 060, 665	
26 00	Total (line 5 plus line 25)			26 350 081	26 00

26, 350, 981 26. 00 7, 549, 807 27. 00 7, 549, 807 28. 00 18, 801, 174 29. 00

24.02 GENERAL OTHER OPERATING REVENUE
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 PROVISION FOR BAD DEBTS
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

Heal th	Financial Systems COMMUNITY HOSPIT.	AL ANDERSON	In Lie	u of Form CMS-2	2552-10
CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0113	Peri od: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III	pared:
	PPS				
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier	1, 776, 953	1.00		
1. 01	Model 4 BPCI Capital DRG other than outlier			0,770,700	1
2.00	Capital DRG outlier payments			25, 803	2. 00
2.01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost re	eporting period (see inst	ructions)	72. 31	3. 00
4.00	Number of interns & residents (see instructions)			0. 23	
5. 00	Indirect medical education percentage (see instructions)			0. 09	
6. 00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)			1, 599	
7. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)			4. 11	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)			24. 22	
9. 00	Sum of lines 7 and 8			28. 33	
10.00	Allowable disproportionate share percentage (see instructions	5)		5. 91	
11.00	·   ·   ·   ·   ·   ·   ·   ·   ·   ·			105, 018 1, 909, 373	
12.00	Total prospective capital payments (see instructions)			1, 909, 373	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1. 00
2.00	Program inpatient ancillary capital cost (see instructions)			0	
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	
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	1 00
1. 00 2. 00	Program inpatient capital costs (see instructions)	nos (soo instructions)		0	
3.00	Program inpatient capital costs for extraordinary circumstances (see instructions)  Net program inpatient capital costs (line 1 minus line 2)		0		
4. 00	Applicable exception percentage (see instructions)		0.00		
5. 00	Capital cost for comparison to payments (line 3 x line 4)		0		
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6. 00	
7.00	Adjustment to capital minimum payment level for extraordinary	y circumstances (line 2 >	(line 6)	0	7. 00
8.00	Capital minimum payment level (line 5 plus line 7)			0	
9. 00	Current year capital payments (from Part I, line 12, as appli			0	
10.00	Current year comparison of capital minimum payment level to			0	
11. 00	Carryover of accumulated capital minimum payment level over of Worksheet L. Part III, line 14)	capitai payment (from pri	or year	0	11. 00
12. 00		avments (line 10 nlus lin	ne 11)	0	12. 00
13. 00			0		
14. 00			0		
	(if line 12 is negative, enter the amount on this line)		3 1		
15. 00	Current year allowable operating and capital payment (see instructions)			0	
	Current year operating and capital costs (see instructions)			0	
17.00	00   Current year exception offset amount (see instructions)				17. 00