Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. In Lieu of Form CMS-2552-10 This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 05-31-2019 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0169 Worksheet S Peri od. From 01/01/2018 Parts I-III AND SETTLEMENT SUMMARY 12/31/2018 Date/Time Prepared: То 5/29/2019 3:05 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically filed cost report Date: 5/29/2019 Time: 3:05 pm use only]Manually submitted cost report 2 []If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 3 0 Ē 4 [

 [1] Cost Report Status
 6. Date Received:

 (1) As Submitted
 7. Contractor No.

 (2) Settled without Audit
 8. [N] Initial Report for this Provider CCN

 (3) Settled with Audit
 9. [N] Final Report for this Provider CCN

 Contractor 5. use only Δ (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OF FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL. CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPITAL OF INDIANA, INC. (15-0169) for the cost reporting period beginning 01/01/2018 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. [X] 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. HOLLY MILLARD (Signed) Officer or Administrator of Provider(s) NETWORK SENIOR VICE PRESIDENT OF FIN Title (Dated when report is electronically signed.) Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	217, 404	19, 002	0	0	1.00
2.00	Subprovider - IPF	0	3, 506	20, 742		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	220, 910	39, 744	0	0	200.00

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

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0	Subprovider - IRF									5
0	Subprovider - (Other)									1 6
0	Swing Beds - SNF									
0	Swing Beds - NF									8
0	Hospital-Based SNF									
00	Hospital -Based NF									10
00 00	Hospital-Based OLTC Hospital-Based HHA									
00	Separately Certified ASC									13
00	Hospi tal -Based Hospi ce									14
00	Hospital-Based Health Clinic - RHC									15
00	Hospital-Based Health Clinic - FQHC									16
00 00	Hospital-Based (CMHC) I									17
	Renal Dialysis Other									18
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00	Type of Control (see instructions)					2				21
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	Inpatient PPS Information									
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	§412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section §									
	hospital?) In column 2, enter "Y" fo		meriamerit							
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00	Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period? In column 2, ente	er October 1. (see ins requires final uncomp port settlement? (see "for no, for the por- er 1. Enter in column e cost reporting period ic reclassification finds for delineating sta- olumn 1, "Y" for yes of g period prior to Octo no for the portion of er October 1. (see ins 100 but not more than 2. 105)? Enter in colum dicaid days on lines 2 of admission, 2 if cer of identifying the day method used in the pri r "Y" for yes or "N" i In-S Medi paid	tructions) ensated can instruction ion of the 2, "Y" for d on or aff om urban to tistical an or "N" for i ber 1. Ento the cost tructions) 499 beds (a n 3, "Y" for 4 and/or 29 sus days, of or cost or no. tate In-S caid Medi days elig unp da 00 2.	cost re yes ter o reas no er as or as or 3 cost tate caid i bl e aid ys 00	N Out-of State Medicaid paid days 3.00	3 N State M Medicaid eligible unpaid 4.00	HMO da	ays M	Other ledi cai days	22 23 d
00	Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period? In column 2, ente If this provider is an IPPS hospital in-state Medicaid paid days in colum	er October 1. (see ins requires final uncomp port settlement? (see " for no, for the por- er 1. Enter in column e cost reporting period ic reclassification finds for delineating sta- olumn 1, "Y" for yes of g period prior to Octo no for the portion of er October 1. (see ins 100 but not more than 2. 105)? Enter in colum dicaid days on lines 2 of admission, 2 if cer of identifying the day method used in the pri r "Y" for yes or "N" 1 [In-5] Medi paid 1. , enter the n 1, in-state umn 2,	tructions) ensated can instruction ion of the 2, "Y" for d on or aff om urban to tistical an or "N" for i ber 1. Ento the cost tructions) 499 beds (a n 3, "Y" for 4 and/or 29 sus days, of or cost or no. tate In-S caid Medi days elig unp da 00 2.	cost re yes ter o reas no er as or as or 3 cost tate caid i bl e aid ys 00	N Out-of State Medicaid paid days 3.00	3 N State M Medicaid eligible unpaid 4.00	HMO da	ays M	Other ledi cai days	22 23 d
00	Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octobo or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period? In column 2, ente If this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in colum	er October 1. (see ins requires final uncomp port settlement? (see " for no, for the por- er 1. Enter in column e cost reporting perio ic reclassification finds for delineating sta olumn 1, "Y" for yes of g period prior to Octo- no for the portion of er October 1. (see ins 100 but not more than 2.105)? Enter in colur dicaid days on lines 2 of admission, 2 if cer of identifying the day method used in the pri r "Y" for yes or "N" 1 In-5 Medi paid 1. , enter the n 1, in-state umn 2, olumn 3,	tructions) ensated can instruction ion of the 2, "Y" for d on or aff om urban to tistical an or "N" for i ber 1. Ento the cost tructions) 499 beds (a n 3, "Y" for 4 and/or 29 sus days, of or cost or no. tate In-S caid Medi days elig unp da 00 2.	cost re yes ter o reas no er as or as or 3 cost tate caid i bl e aid ys 00	N Out-of State Medicaid paid days 3.00	3 N State M Medicaid eligible unpaid 4.00	HMO da	ays M	Other ledi cai days	22 23 d
00	Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period? In column 2, ente If this provider is an IPPS hospital in-state Medicaid paid days in colum	er October 1. (see ins requires final uncomp port settlement? (see " for no, for the por- er 1. Enter in column e cost reporting perio dis for delineating sta olumn 1, "Y" for yes of g period prior to Octo- no for the portion of er October 1. (see ins 100 but not more than 2. 105)? Enter in colum dicaid days on lines 2 of admission, 2 if cer of identifying the day method used in the pri- r "Y" for yes or "N" for Medi paid 1. , enter the n 1, in-state umn 2, olumn 3, d days in column	tructions) ensated can instruction ion of the 2, "Y" for d on or aff om urban to tistical an or "N" for i ber 1. Ento the cost tructions) 499 beds (a n 3, "Y" for 4 and/or 29 sus days, of or cost or no. tate In-S caid Medi days elig unp da 00 2.	cost re yes ter o reas no er as or as or 3 cost tate caid i bl e aid ys 00	N Out-of State Medicaid paid days 3.00	3 N State M Medicaid eligible unpaid 4.00	HMO da	ays M	Other ledi cai days	22 23 d

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D4		Provider CC			31/2018	Part Date, 5/29,	/Time Pre /2019 3:0	epared:
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medica HMO da	ays M	Other Medi cai d days	
.00 If this provider is an IRF, enter the in-state	1.00	2.00	3.00	4.00	5.00	0	6.00	25.0
.00 If this provider is an IRF, enter the in-state 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	0					
					Rural S 00		of Geogr 2.00	-
.00 Enter your standard geographic classification (not w	vage) status	at the beg	inning of t		1		2.00	26.0
 cost reporting period. Enter "1" for urban or "2" fo Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif OI If this is a sole community hospital (SCH), enter the effect in the context period. 	wage) status or "2" for r fication in d	ural. If ap column 2.	pl i cabl e,		1			27.0
effect in the cost reporting period.				Begin	ni na:	Er	ndi ng:	
				1.	00		2.00	
.00 Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat		cript line	36 for numb	er				36.0
.00 If this is a Medicare dependent hospital (MDH), ente		r of period	s MDH statu	s	0)		37.0
is in effect in the cost reporting period. .01 Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f								37. (
instructions) .00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o								38.
enter subsequent dates.								
					<u>/N</u> 00		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 (i or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Ent requiremen	er in colum ts in	ne í	1		N	39. (
.00 Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	r "Y" for y			(Y	40. (
					V	XVI 2.0		-
Prospective Payment System (PPS)-Capital					1.00			
.00 Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions)	·	·				Y		45.0
.00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	st. L, Pt. I	II and Wkst	. L-1, Pt.	l through	N	N		46.
 .00 Is this a new hospital under 42 CFR §412.300(b) PPS .00 Is the facility electing full federal capital paymen Teaching Hospitals 			5		N	N N		47. 48.
.00 Is this a hospital involved in training residents in or "N" for no.		1 3		5	Y			56.
		" for no in	column 1. ing period?	lf column Enter "Y				57.
.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	Y", complete I, if appli	cabl e.						
 .00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. I .00 If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes, 	Y", complete I, if applie nbursement fo complete W	cable. or physicia kst. D-5.	ns' service	s as	N			
 .00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is ""N", complete Wkst. D, Parts III & IV and D-2, Pt. I .00 If line 56 is yes, did this facility elect cost reim 	Y", complete I, if applie nbursement fo complete W	cable. or physicia kst. D-5.	ns' service	5 Worksl	N N neet A e #	Qual i	-Through fication rion Code	1
 .00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. I .00 If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes, 	Y", complete I, if applie nbursement fo complete W	cable. or physicia kst. D-5.	ns' service Pt. I. NAHE 413.8	5 Works Lin	N Neet A	Quali Crite	fication	59.0

10SPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ТА	Provider CC		eriod: com 01/01/2018 com 12/31/2018	Worksheet S-2 Part I Date/Time Pre 5/29/2019 3:0	pared:
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	1
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N			0.00	0. 00	61.0
1. 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)						61.0
1. 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)						61.0
1.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.0
	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.0
1. 06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.0
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
1. 10	Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	61.1
	special ty, 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. Of the FTEs in line 61.05, specify each expanded program special ty, 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.				0.00		61. 2
						1.00	
2. 00	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct	trai nec		. ,	od for which	0.00	62.0
2. 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	a Teachi gram. (s	see instruction		your hospital	0.00	62.0
3. 00	Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, complete	ettings	during this co	67. (see instru	ictions)	N	63.0
				Unweighted FTEs Nonprovider Site	FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Year FTE Residents in No	onprovid	der Settings	1.00 This base year	2.00 is your cost r	3.00 reporting	
4. 00	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighter resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	<u>re June</u> ty trair a-primar all nor d non-pr n columr	30, 2010. med residents y care provider imary care n 3 the ratio	0.00	-		64.0

	LEX IDENTIFICATION D	ATA Provider (NC. CCN: 15-0169 Pe	eri od:	Worksheet S-2	2552-1
			Fi To	rom 01/01/2018 0 12/31/2018	Date/Time Pre	pared:
	Program Name	Program Code	Unweighted	Unweighted	5/29/2019 3:0 Ratio (col. 3/	
			FTEs	FTEs in	(col. 3 + col.	
			Nonprovi der	Hospi tal	4))	
			Si te			
	1.00	2.00	3.00	4.00	5.00	
5.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column			0.00	0. 00	0. 000000	65.0
5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
			Nonprovi der	Hospi tal	2))	
			Si te			
			1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Settin	gsEffective fo	or cost reporti	ing periods	
Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	al. Enter in column	3 the ratio of	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	1
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	FAMILY PRACTICE	1350	0.00	1. 27	7 0. 000000	67.00
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)						
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)				1.0	0 2.00 3.00	-
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)		IPF), or does it con	tain an IPF subc			70.0
<pre>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)</pre>	sychiatric Facility (). I the facility have a Defore November 15, 2 Diumn 2: Did this fac R 412.424 (d)(1)(iii cate which program y	n approved GME teachi 2004? Enter "Y" for Sility train residents)(D)? Enter "Y" for	ing program in t yes or "N" for n s in a new teach yes or "N" for n	rovider? Y he most N no. (see ing no.		
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)	ychiatric Facility (). I the facility have a vefore November 15, 2 Jumn 2: Did this fac R 412.424 (d)(1)(iii cate which program y CY PPS Phabilitation Facilit	n approved GME teach 2004? Enter "Y" for 2011 ty train resident 2012)? Enter "Y" for 2022 rear began during this	ing program in t yes or "N" for n s in a new teach yes or "N" for n s cost reporting	rovider? Y he most N no. (see ing no.	0	70.00

Heal th	Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC.	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Pre 5/29/2019 3:0	epared:
			1.00	-
	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost reportin "Y" for yes and "N" for no.	g period? Enter	N N	80. 00 81. 00
05 00	TEFRA Provi ders			
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Secti §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 classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00
		V	XI X	
	Title V and XIX Services	1.00	2.00	
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N	Y	90.00
91.00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in	N	N	91.00
92.00	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see		N	92.00
	instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter	Ν	N	93.00
	"Y" for yes or "N" for no in the applicable column.			
	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
	If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	0. 00 N	0.00 N	95.00 96.00
	IF line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in	0. 00 Y	0. 00 N	97.00 98.00
98. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for		Y	98. 01
98. 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1	Y	Y	98. 02
98. 03	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column for title V, and in column 2 for title XIX.	N 1	Ν	98. 03
98. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and	Ν	Ν	98.04
98. 05	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and i		Y	98. 05
98.06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
405 00	Rural Providers	N		105 00
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all-inclusive method of paymen for outpatient services? (see instructions)	t N		105.00 106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cos	N		107.00
108.00	reimbursed. If yes complete Wkst. D-2, Pt. II. Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Ν		108.00
	Physical Occupationa 1.00 2.00	I Speech 3.00	Respi ratory 4.00	-
109.00	If this hospital qualifies as a CAH or a cost provider, are N N N therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	109.00
			1.00	-
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§ Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 thro applicable.	lf yes,	N	110.00

Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN:		In Period: From 01/01/2 To 12/31/2	2018	u of For Workshe Part I Date/Ti	et S-2	2
		10 12/31/2	2018	5/29/20	119 3: 0)5 pm
		1.00		2.0	00	-
111.00 If this facility qualifies as a CAH, did it participate in the Frontier Commu Health Integration Project (FCHIP) demonstration for this cost reporting peri "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, ento integration prong of the FCHIP demo in which this CAH is participating in col Enter all that apply: "A" for Ambulance services; "B" for additional beds; an for tele-health services.	iod? Enter er the lumn 2.	N				111.00
			1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in co is yes, enter the method used (A, B, or E only) in column 2. If column 2 is ' 3 either "93" percent for short term hospital or "98" percent for long term of psychiatric, rehabilitation and long term hospitals providers) based on the of Pub. 15-1, chapter 22, §2208.1.	"E", enter care (incl definition	in column udes	N		0	115.00
116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for 117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for no.		"N" for	N Y			116. 00 117. 00
 118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if claim-made. Enter 2 if the policy is occurrence. 	the policy	is	1			118.00
	Premiums	Losses		Insur	ance	
	1.00	2.00		3. (00	-
118.01 List amounts of malpractice premiums and paid losses:	963, 02	25	0		(0118.01
		1.00		2. (00	-
 118.02 Are mal practice premiums and paid losses reported in a cost center other than Administrative and General? If yes, submit supporting schedule listing cost and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Lo this a SCU that much first for for the output interview. 	centers	N				118.02 119.00
120.00 s this a SCH or EACH that qualifies for the Outpatient Hold Harmless provisi §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" fo "N" for no. Is this a rural hospital with < 100 beds that qualifies for the (Hold Harmless provision in ACA §3121 and applicable amendments? (see instruc- Enter in column 2, "Y" for yes or "N" for no.	`or yes or Outpatient	N		N		120.00
121.00 Did this facility incur and report costs for high cost implantable devices cl patients? Enter "Y" for yes or "N" for no.	harged to	Y				121.00
122.00 Does the cost report contain healthcare related taxes as defined in §1903(w) Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in the Worksheet A line number where these taxes are included.						122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" for	orno.lf	N				125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certifica	ation date					126.00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter the certification date if certification date is column 2.	ition date					127.00
in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certification date if applicable in column 2.	ition date					128.00
in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the certification date if applicable, in column 2.	ion date i	n				129.00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the certified to a column 2.	icati on					130. 00
date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified intestinal transplant center, enter the certified to the column 2 and the in column 2.	i fi cati on					131.00
date in column 1 and termination date, if applicable, in column 2. 132.00 f this is a Medicare certified islet transplant center, enter the certification date, if applying 1 and termination date, if applying is a date in a column 2.	ition date					132.00
in column 1 and termination date, if applicable, in column 2. 133.00 If this is a Medicare certified other transplant center, enter the certification date is column 1 and termination date is column 2.	ition date					133. 00
in column 1 and termination date, if applicable, in column 2. 134.00 If this is an organ procurement organization (OPO), enter the OPO number in a number in column 2.	column 1					134.00
and termination date, if applicable, in column 2. All Providers						1
140.00 Are there any related organization or home office costs as defined in CMS Pul chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home offi are claimed, enter in column 2 the home office chain number. (see instruction	fice costs	Y				140.00

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	COMMUNITY HOSF		Provi der		15-0169		i: 01/01/2018	Worksheet S- Part I Date/Time Pr 5/29/2019 3:	2 epared:
1.00		2.00					3.00		
If this facility is part of a chain					143 the	name ar	nd address	of the	
home office and enter the home offi 41.00 Name: COMMUNITY HEALTH NETWORK	<u>ce contractor name</u> Contractor's Nai		NSIN PHYS		SContract	tor's N	umber: 0810)1	141.00
42.00 Street: 1500 NORTH RITTER AVENUE	PO Box:	JERVI	0L0						142.00
43. 00 Ci ty: I NDI ANAPOLI S	State:	IN			Zip Code	e:	4621	9-3095	143.00
								1.00	-
144.00 Are provider based physicians' cost	s included in Works	heet A2						1.00 Y	144.00
		1001 11.							111.00
							1.00	2.00	
145.00 If costs for renal services are cla inpatient services only? Enter "Y" no, does the dialysis facility incl period? Enter "Y" for yes or "N" f	for yes or "N" for u ude Medicare utiliza or no in column 2.	no in co ation fo	lumn 1. lf r this cos	colu t rep	mn 1 is porting		Y		145.00
46.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/dd	column 1. (See CMS I	Pub. 15-				f	N	1.00	146. 0
147.00Was there a change in the statistic	al hasis? Enter "V"	for yes	or "N" fo	r po				1.00 N	147.00
148.00 Was there a change in the order of								N	147.00
149.00 Was there a change to the simplifie						r no.		N	149.00
			Part A		Part B		Title V	Title XIX	
			1.00		2.00	- +	3.00	4.00	_
Does this facility contain a provid or charges? Enter "Y" for yes or "N									
55.00Hospi tal			Ν		Ν		N	N	155. 0
56.00 Subprovider - IPF			N		N		N	N	156.0
57.00 Subprovider - IRF 58.00 SUBPROVIDER			Ν		N		N	N	157.0 158.0
59. 00 SNF			Ν		Ν		N	N	158.0
60. 00 HOME HEALTH AGENCY			N		N		N	N	160. 0
61. 00 СМНС					Ν		Ν	N	161.00
								1.00	-
Multicampus									
65.00 Is this hospital part of a Multicam Enter "Y" for yes or "N" for no.	pus hospital that h	as one o	r more cam	puses	in diffe	erent C	BSAs?	N	165. 0
	Name		County		State Zi	ip Code	CBSA	FTE/Campus	
	0		1.00		2.00	3.00	4.00	5.00	
<pre>166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)</pre>								0.0	00166.00
								1.00	_
Health Information Technology (HIT)	incentive in the A	merican	Recovery a	and Re	einvestme	nt Act			
67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 105 reasonable cost incurred for the HI	is "Y") and is a m	eani ngfu	l user (li), ente	r the	Y	167. 0 0168. 0
 68.01 If this provider is a CAH and is no exception under §413.70(a)(6)(ii)? 69.00 If this provider is a meaningful us transition factor. (see instruction 	Enter "Y" for yes o er (line 167 is "Y")	r "N" fo	r no. (see	inst	ructions))	·	9.9	168. 0 99169. 0
	<i></i>					Be	egi nni ng	Endi ng	
		- 1	- 6- ''				1.00	2.00	170 5
70.00 Enter in columns 1 and 2 the EHR be period respectively (mm/dd/yyyy)	ginning date and end	ding dat	e for the	repor	ting	01	/01/2015	12/31/2015	170.00
							1 00	2.00	_
171.00 fline 167 is "Y", does this provi	der have any days fo	or indiv	iduals enr	olled	lin		1.00 N	2.00	0 171. 00
section 1876 Medicare cost plans re "Y" for yes and "N" for no in colum 1876 Medicare days in column 2. (se	ported on Wkst. S-3 n 1. If column 1 is	, Pt. I,	line 2, c	:ol. 6	? Enter	on			

IOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0169		Worksheet S-2 Part II Date/Time Pre 5/29/2019 3:0	epared:
				Y/N 1.00	Date 2.00	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	sponses. Ente			
	mm/dd/yyyy format.					
	COMPLETED BY ALL HOSPITALS					-
. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	boginning of	the cost	N		1.0
. 00	reporting period? If yes, enter the date of the change in c					1.00
			Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	n 3, "V" for	N			2.00
. 00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug ler or its of the board	Y			3.0
			Y/N	Туре	Date	
			1.00	2.00	3.00	
. 00 . 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe	for Compiled, Milable in	Y	A		4.00
	those on the filed financial statements? If yes, submit rec	conciliation.				_
				Y/N 1.00	Legal Oper.	
	Approved Educational Activities			1.00	2.00	
. 00	Column 1: Are costs claimed for nursing school? Column 2:	lfyes, is th	ne provider is	s N		6.0
	the legal operator of the program?	5	·			
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		during the	Y N		7.00 8.00
. 00	Are costs claimed for Interns and Residents in an approved		al education	Y		9.0
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated c cost reporting period? If yes, see instructions.		he current	Y		10. 0
1. 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	Ν		11.0
					Y/N 1.00	+
	Bad Debts				1.00	
2. 00 3. 00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	Y N	12. 0 13. 0
4. 00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	⁻ yes, see ins	structions.	Ν	14.0
5.00	Bed Complement Did total beds available change from the prior cost reporti		yes, see inst t A	tructions. Par	N t B	15.0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
6. 00	<u>PS&R Data</u> Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see	N		N		16. 0
7.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/29/2014	Y	04/29/2014	17.0
8. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18. 0
9. 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.	Ν		Ν		19. 0

Heal th	Fi nanci al	Systems

COMMUNI TY	HOSPI TAL	0F	I NDI ANA,	INC.

In Lieu of Form CMS-2552-10

ealth Financial Systems COMMUNITY HOSPITAL	L OF	INDIANA, I	NC.		In Lie	u of Form C	MS-2552-1
OSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi der	CCN: 15-0169		riod: om 01/01/2018 12/31/2018		Prepared:
		Desc	ription		Y/N	Y/N	
			0		1.00	3.00	
0.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:					Ν	Ν	20. 0
		Y/N	Date		Y/N	Date	
		1.00	2.00		3.00	4.00	
1.00 Was the cost report prepared only using the provider's		Ν			N		21.0
records? If yes, see instructions.							
						1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC Capital Related Cost	EPI (CHILDRENS	HUSPITALS)				
2.00 Have assets been relifed for Medicare purposes? If yes, se	o in	structions			-		22.0
3.00 Have changes occurred in the Medicare depreciation expense				ri ng	the cost		23. 0
reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered into during this cost reporting period?							
If yes, see instructions 5.00 Have there been new capitalized leases entered into during instructions.	g the	cost repo	orting period?	?lf	yes, see		25.0
6.00 Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	the c	ost report	ing period? I	f ye	es, see		26. 0
7.00 Has the provider's capitalization policy changed during th copy.	ne co	st reporti	ng period? If	⁻ yes	s, submit		27.0
Interest Expense 8.00 Were new Loans, mortgage agreements or letters of credit e	onter	ed into du	ring the cost	t rer	orting		28.0
period? If yes, see instructions. 9.00 Did the provider have a funded depreciation account and/or					-		29.0
treated as a funded depreciation account? If yes, see inst 0.00 Has existing debt been replaced prior to its scheduled mat	truct	ions			-		30.0
instructions. 00 Has debt been recalled before scheduled maturity without i		5	5				31.0
instructions. Purchased Services				·			
2.00 Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr			ed through co	ontra	actual		32. 0
1.00 If line 32 is yes, were the requirements of Sec. 2135.2 ap			ng to competi	tive	e bidding? If		33.0
Provi der-Based Physi ci ans							
4.00 Are services furnished at the provider facility under an a lf yes, see instructions.	arran	gement wit	h provider-ba	ased	physi ci ans?		34. C
5.00 If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i			ents with the	prov	/i der-based		35. C
					Y/N	Date	
					1.00	2.00	
Home Office Costs							
 00 Were home office costs claimed on the cost report? 00 If line 36 is yes, has a home office cost statement been p 	orepa	red by the	home office?	?			36. 0 37. 0
If yes, see instructions. 0.00 If line 36 is yes , was the fiscal year end of the home of				-			38.0
the provider? If yes, enter in column 2 the fiscal year en 0.00 If line 36 is yes, did the provider render services to oth				5,			39.0
see instructions. 0.00 If line 36 is yes, did the provider render services to the	e hom	e office?	lfyes, see				40.0
i nstructi ons.			00			20	
Cost Report Preparer Contact Information		1	. 00		2.0	JU	
1.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RON	ALD		H	ELMS		41.0
respectively. 2.00 Enter the employer/company name of the cost report	СОМ	MUNITY HEA	LTH NETWORK				42.0
preparer. 3.00 Enter the telephone number and email address of the cost		-355-5501		RI	HELMS@ECOMMUNI	TY. COM	43.0
report preparer in columns 1 and 2, respectively.							

Heal th Financial	Systems	COMMUNI TY HOSPI TAL	OF INDIANA,	INC.	In Lie	u of Form CMS-	2552-10
HOSPI TAL AND HOSP	PITAL HEALTH CARE REIMBURSEMEN	T QUESTI ONNAI RE	Provi der	CCN: 15-0169	Peri od:	Worksheet S-2	
			_		From 01/01/2018 To 12/31/2018	Part II Date/Time Pre 5/29/2019 3:0	pared: 5 pm
				3.00			
Cost Repor	t Preparer Contact Information	1					
41.00 Enter the	first name, last name and the	ti tl e/posi ti on	REI MBURSEMEN	NT MANAGER			41.00
held by th	e cost report preparer in col	umns 1, 2, and 3,					
respective	el y.						
42.00 Enter the	employer/company name of the	cost report					42.00
preparer.							
43.00 Enter the	telephone number and email ad	dress of the cost					43.00
report pre	parer in columns 1 and 2, res	pecti vel y.					

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0169	Period: From 01/01/2018	Worksheet S-3 Part I	
					To 12/31/2018	Date/Time Pre 5/29/2019 3:0	
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number 1.00	2.00	Avai I abl e 3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30, 00	214	<u>5.00</u> 78, 1 [°]		0.00	1.00
1.00	8 exclude Swing Bed, Observation Bed and	00.00	211	70, 1	0.00	Ū	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		214	78, 1 ⁻	0.00	0	•
	beds) (see instructions)		- · ·	, .		-	
8.00	INTENSIVE CARE UNIT	31.00	24	8, 70	0.00	0	8.00
9.00	CORONARY CARE UNI T						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL INTENSI VE CARE UNI T						11.00
12.00	NEONATAL INTENSIVE CARE UNIT	35.00	42	15, 33	0.00	0	
13.00	NURSERY	43.00		107 00		0	13.00
14.00	Total (see instructions)	10.00	280	102, 20	0.00	0	14.00
15.00	CAH visits		200	.02/2		0	15.00
16.00	SUBPROVIDER - IPF	40.00	18	6, 5	70	0	16.00
17.00	SUBPROVIDER - IRF	101.00		0,0	Ŭ.	, i i i i i i i i i i i i i i i i i i i	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24.10	HOSPICE (non-distinct part)	30, 00					24.10
25.00	CMHC - CMHC	00.00					25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)	07.00	298			Ū	27.00
28.00	Observation Bed Days		270			0	
29.00	Ambul ance Trips					Ŭ	29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.00	Total ancillary labor & delivery room		0		Ĭ		32.00
02.01	outpatient days (see instructions)						02.01
33.00	LTCH non-covered days						33.00
							, 55.00

)SPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	1	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part I Date/Time Pre 5/29/2019 3:0	parec
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	19, 318	1, 012	57, 06	8		1. (
00	HMO and other (see instructions)	8, 057	20, 445				2.
00	HMO IPF Subprovider	0	0				3. (
00	HMO IRF Subprovider	0	0				4.
00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.
00	Hospital Adults & Peds. Swing Bed NF	10 010	0	57.04	5		6.
00	Total Adults and Peds. (exclude observation beds) (see instructions)	19, 318	1, 012	57, 06	8		7.
00	INTENSIVE CARE UNIT	2,041	0	5, 97	2		8.
00	CORONARY CARE UNIT	2,041	0	5, 77			9.
). 00	BURN INTENSIVE CARE UNIT						10.
. 00	SURGI CAL I NTENSI VE CARE UNI T						11.
2. 00	NEONATAL INTENSIVE CARE UNIT	0	605	12, 36	2		12.
3. 00	NURSERY		3, 288	7,65	3		13.
. 00	Total (see instructions)	21, 359	4, 905	83, 05		1, 464. 80	14.
. 00	CAH visits	0	0	1	С		15.
. 00	SUBPROVIDER – IPF	2, 614	0	3, 73	3 1.58	21.85	16.
. 00	SUBPROVIDER - IRF						17
. 00	SUBPROVIDER						18
. 00	SKILLED NURSING FACILITY						19
. 00	NURSING FACILITY						20
00	OTHER LONG TERM CARE						21
00	HOME HEALTH AGENCY						22
00 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						23
. 10	HOSPICE (non-distinct part)			48	h		24
00	CMHC - CMHC			404			25
. 00	RURAL HEALTH CLINIC						26
. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0.00	0.00	26
. 00	Total (sum of lines 14-26)				5.39	1, 486. 65	27
. 00	Observation Bed Days		1, 844	6, 45	5		28
. 00	Ambulance Trips	0					29
. 00	Employee discount days (see instruction)			2, 02	2		30
. 00	Employee discount days - IRF				C		31
. 00	Labor & delivery days (see instructions)	0	47	1, 34			32
. 01	Total ancillary labor & delivery room				C		32
00	outpatient days (see instructions)						1
3.00	LTCH non-covered days LTCH site neutral days and discharges	0					33

	Financial Systems COMM TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	N: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part I Date/Time Pre 5/29/2019 3:0	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed SNF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE	0.00	0	4, 7 [,] 1, 5 [,] 4, 7 [,] 2 [,]	10 216 78 2, 886 0 0	17, 414 17, 414 370	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 14.00 15.00 12.00 20.00 21.00 22.00 23.00 24.00
24. 10 25. 00 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01 33. 00	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) TCH non-covered days LTCH site neutral days and discharges	0.00 0.00			0 0		24. 10 25. 00 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 01 33. 00 33. 01

Image: service of the servic	PITAL WA	GE INDEX INFORMATION			Provider CC	F	Period: From 01/01/2018 To 12/31/2018		pare
PART I I - BANGP DATA I. 300 J. 200 J. 300 J. 00 J. 00 <thj. 100<="" th=""> J. 00 <thj. 0<="" th=""><th></th><th></th><th></th><th></th><th>on of Salaries (from Wkst.</th><th>Salaries (col.2 ± col.</th><th>Related to Salaries in</th><th>Average Hourly Wage (col. 4 ÷</th><th></th></thj.></thj.>					on of Salaries (from Wkst.	Salaries (col.2 ± col.	Related to Salaries in	Average Hourly Wage (col. 4 ÷	
MAARIES Total service in section 3 0 Total service in section 3 200.00 100.986.509 -576.827 99.731.062 3.092.227 0 22.25 0 Description 3 0	DADT	LL - WAGE DATA	1.00	2.00				6.00	
Instructions) Instructions) Instructions) Instructions) Instructions) Non-physician-lanet A - 89,273 0 80,000 0.00 0.00 Non-physician-lanet A - 89,273 0 80,273 572,00 156,07 Physician-lanet B - 0 0.00 0.00 0.00 0.00 0.00 Instructions and Instructions 367,344 0 367,344 6,416,60 57.25 Non-physician-sets and Instructions 0.00 0 0.00 0.00 0.00 Interses and Instructions 21.00 0 0 0 0.00 0.00 Interses and Instructions 21.00 0 0 0 0.00 0.00 Instructions and resolutions 44.00 0 0 0 0.00 0.00 Instructions 0 0 0 0.00 0.00 0.00 0.00 Instructions 0 0 0 0.00 0.00 0.00 Instructions <t< td=""><td>SALAF</td><td>RES</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>	SALAF	RES							
D0 Non-physic i an anestheti st Part 0			200.00	100, 308, 509	-576, 827	99, 731, 682	3, 092, 227. 00	32.25	1
0 No. physician anesthetist Part 6 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 Non-			C	0	C	0.00	0. 00	2
Addit in strative 0		ohysician anesthetist Part		C	0	C	0.00	0.00	3
1 Physic Lams - Part A - Teaching 0 <t< td=""><td>B 0 Physi</td><td>cian-Part A -</td><td></td><td>89, 273</td><td>0</td><td>89, 273</td><td>572.00</td><td>156.07</td><td>4</td></t<>	B 0 Physi	cian-Part A -		89, 273	0	89, 273	572.00	156.07	4
0 Physic iclam and Non 367, 344 0 367, 344 6, 416, 00 57, 25 Physic iclam Part B for 0 0 0 0, 00 0, 00 Strict Cas 0 0 0 0 0 0, 00 0, 00 Strict Cas 0 0 0 0 0 0 0, 00 0, 00 1 Contracted interns and programs 0				C	0	C C	0.00	0.00	4
0 Non-physician-Part B for hespital-based RHC and GOLC services 0	0 Physi	cian and Non		-					
services 0<	0 Non-I	ohysician-Part B for		C	0	С	0.00	0. 00	e
1 Contracted interns and presidents (in an approved programs) 0 0 0 0.00 0.00 0 Home office and/or related organization personnel 0 0 0 0.00 0.00 00 Excluded areas salaries (see 0 2.154,440 -17.248 2.137,192 64,515.00 33.13 01 Contract labor: Direct Patient Care management and dahin istrative services 1,213,089 0 1,213,089 11,573.00 104.62 00 Contract labor: Direct Patient Care 0 0 0 0 0.00 0.00 01 Contract labor: Direct Patient Care 0 0 0 0 0.00 0.00 0.00 02 Contract labor: Physician-Part A - Admin istrative 4,067,837 0 4,087,837 34,315.00 119.13 0 Onegoin 210 salaries 31,026,523 0 31,026,523 711,641.00 43.60 00 Onegoin 210 salaries 0 0 0 0 0.00 0.00 01 Mee office: Addit areas and tes 0 0 0 0 0 0 0	servi 0 Inter	ces rns & residents (in an	21.00	C	0	C	0.00	0.00	7
0 bits 0	1 Conti resid	racted interns and dents (in an approved		C	0	C	0.00	0. 00	
00 Excluded area salaries (see instructions) 2, 154, 440 -17, 248 2, 137, 192 64, 515. 00 33. 13 0THER WAGES & RELATED COSTS	0 Home orgai	office and/or related		C	0	C	0.00	0. 00	8
00 Contract labor: Direct Patient Care 1, 213, 089 0 1, 213, 089 11, 573, 00 104, 82 00 Contract labor: Top level management and dim instrative services 0 0 0 0 0, 00	00 Exclu inst	ructions)	44.00	0 2, 154, 440	0 -17, 248	0 2, 137, 192			
Care 0				1 213 089	0	1 213 089	11 573 00	104 82	11.
management and administrative services 4,087,837 0 4,087,837 34,315.00 119.13 A - Administrative 0 0 0 0.00 0.00 0.00 organization salaries and wage-related costs 31,026,523 0 31,026,523 711,641.00 43.60 0 Related costs 0 0 0 0.00 0.00 Related corganization salaries 0 0 0 0.00 0.00 0.00 Related corganization salaries 0 0 0 0 0.00 0.00 0.00 Related costs 0 0 0 0 0 0.00 0.00 Wage-related costs (core) (see instructions) 1 1 0 532,111 0 532,111 0	Care					, , , , , ,			
00 Contract l abor: Physician-Part 4,087,837 0 4,087,837 34,315.00 119.13 01 Home office and/or related organization salaries and wage-related costs 0 0 0 0.00 0.00 01 Home office and/or related organization salaries 31,026,523 0 31,026,523 711,641.00 43.60 02 Related organization salaries 0 0 0 0 0.00 0.00 04 Home office: Physician Part A 0 0 0 0.00 0.00 0.00 04 Home office: and Contract 0 0 0 0 0 0.00 0.00 0 Home office: and Contract 0 0 0 0 0.00 0.00 0 Wage-related costs (core) (see Instructions) 24,705,225 0 24,705,225 0	manag	gement and administrative							
00 Home office and/or related organization salaries and wage-related costs 0 0 0.00 0.00 0.00 1 Home office salaries and wage-related coganization salaries 31,026,523 0 31,026,523 711,641.00 43.60 0 Related organization salaries 0 0 0 0.00 0.00 0 Home office short A - Teaching 0 0 0 0.00 0.00 WAGE-RELATED COSTS 0 0 0 0 0 0.00 0.00 WAGE-RELATED COSTS 0 0 0 0 0 0 0 0.00 0 Wage-rel ated costs (core) (see instructions) 24,705,225 0 24,705,225 0 0 0 0	00 Conti	ract Labor: Physician-Part		4, 087, 837	0	4, 087, 837	34, 315. 00	119. 13	13
01 Home office salaries 31,026,523 0 31,026,523 711,641.00 43.60 02 Related organization salaries 0 0 0 0.00 0.00 0.00 0 Home office: Physician Part A 0 0 0 0.00 0.00 0.00 0 Home office: Administrative 0 0 0 0.00 0.00 0 Home office: Administrative 0 0 0 0.00 0.00 0 Wage-related costs (core) (see instructions) 24,705,225 0 24,705,225 0 0 0 00 Excluded areas 532,111 0 532,111 0 0 0 00 Non-physician anesthetist Part B 0 <t< td=""><td>00 Home orgai</td><td>office and/or related nization salaries and</td><td></td><td>C</td><td>0</td><td>C</td><td>0.00</td><td>0.00</td><td>14</td></t<>	00 Home orgai	office and/or related nization salaries and		C	0	C	0.00	0.00	14
02 Related organization salaries 0 0 0 0.00 0.00 0.00 0.00 01 Home office: Physician Part A 0 0 0 0.00 0.00 0.00 02 Related organization salaries 0 0 0 0.00 0.00 0.00 02 Home office: Physician Part A - Taching 0 0 0 0.00 0.00 04 Home office: Costs Corrections 0 0 0 0.00 0.00 04 Wage-related costs (core) (see instructions) 24,705,225 0 24,705,225 0 24,705,225 05 Excluded areas 532,111 0 532,111 0 532,111 06 Non-physician anesthetist Part A 0 0 0 0 0 07 Physician Part A - Teaching 0				31, 026, 523	0	31, 026, 523	711, 641. 00	43.60	14
- Administrative 0 0 0 0 0 0.00 0.00 Home office and Contract 0 0 0 0.00 0.00 0.00 Wage-related costs (core) (see instructions) 24,705,225 0 24,705,225 0 24,705,225 00 Wage-related costs (core) (see instructions) 24,705,225 0 0 0 00 Kage-related costs (core) (see instructions) 23,711 0 0 0 01 Non-physician anesthetist Part A 0 0 0 0 0 02 Non-physician anesthetist Part A 0 0 0 0 0 03 Non-physician Part A - Teaching 0 0 0 0 0 04 Physician Part A - Teaching 0 0 0 0 0 05 Home office wage-related costs (RHC/FOHC) 0 0 0 0 0 06 Interns & residents (in an approved program) 0 0 0 0 0 0 0 06 Home office wage-related (core)	02 Rela	ted organization salaries		C	0		0.00	0. 00	14
Physicians Part A - Teaching Image: Construction of the second of the seco				Ĺ	0	Ĺ	0.00	0.00	
00 Wage-related costs (core) (see instructions) 24,705,225 0 24,705,225 0 Wage-related costs (other) (see instructions) 0 0 0 00 Excluded areas 532,111 0 532,111 01 Non-physician anesthetist Part A 0 0 0 02 Mon-physician anesthetist Part B 0 0 0 03 Non-physician Part A - Teaching 0 0 0 04 Physician Part B 63,847 0 0 0 05 Intern & residents (in an approved program) 0 0 0 0 05 Home office wage-related (core) 7,170,944 0 7,170,944 0 7,170,944 05 Home office wage-related (core) 0 0 0 0 0 05 Home office wage-related (core) 0 0 0 0 0 05 Home office wage-related (core) 0 0 0 0 0 06 0 0 0 0 0 0 0 06	00 Home Physi	office and Contract cians Part A - Teaching		C	0	C	0.00	0.00	1
00 Wage-related costs (other) (see instructions) 0 0 0 0 Excluded areas 532,111 0 532,111 00 Non-physician anesthetist Part A 0 0 0 00 Non-physician anesthetist Part A 0 0 0 01 Physician Part A - Administrative 5,692 0 5,692 01 Physician Part A - Teaching 0 0 0 02 Home office wage-related costs (RHC/FOHC) 0 0 0 03 Interns & residents (in an approved program) 0 0 0 0 04 Home office wage-related (core) 7,170,944 7,170,944 0 7,170,944 05 Home office Physician Part A 0 0 0 0 05 Home office Physician Part A 0 0 0 0 05 Home office Physician Part A 0 0 0 0 05 Home office & Contract 0 0 0 0 05 Home office & Contract 0 0 0 0	00 Wage	-related costs (core) (see		24, 705, 225	0	24, 705, 225	5		17
00Excluded areas532, 1110532, 11100Non-physician anesthetist Part00000Non-physician anesthetist Part00000Non-physician anesthetist Part00001Physician Part A -5, 69205, 69202Administrative00003Physician Part A - Teaching00004Physician Part B63, 847063, 84705Wage-related costs (RHC/FQHC)00006Interns & residents (in an approved program)00007Home office wage-related (core)7, 170, 9447, 170, 9447, 170, 94407Administrative -000008Wage-related (core)000010Home office & Contract000011Home office & Contract000012Home office & Contract000013Home office & Contract000014Home office & Contract000015Home office & Contract <t< td=""><td>00 Wage</td><td>-related costs (other)</td><td></td><td>C</td><td>0</td><td>C</td><td>)</td><td></td><td>18</td></t<>	00 Wage	-related costs (other)		C	0	C)		18
00 Non-physician anesthetist Part A 0 0 0 00 Non-physician anesthetist Part B 0 0 0 00 Physician Part A - Administrative 5,692 0 5,692 01 Physician Part A - Administrative 0 0 0 02 Physician Part A - Teaching 0 0 0 03 Physician Part A - Teaching 0 0 0 04 Physician Part A - Teaching 0 0 0 05 Physician Part B 63,847 0 63,847 06 Interns & residents (in an approved program) 0 0 0 50 Home office wage-related (core) 7,170,944 7,170,944 0 51 Related organization wage-related (core) 0 0 0 53 Home office & Contract Physicians Part A - Teaching - wage-related (core) 0 0 0 53 Home office & Contract Physicians Part A - Teaching - wage-related (core) 0 0 0 54 HOME office & CONTRACT 0 0 0 0 <t< td=""><td></td><td></td><td></td><td>522 111</td><td>0</td><td>522 111</td><td></td><td></td><td>19</td></t<>				522 111	0	522 111			19
B Admi ni strative 00 Physician Part A - Admi ni strative 0 01 Physician Part A - Teaching 00 Physician Part B 01 Physician Part B 02 0 03 Physician Part B 04 0 05 Physician Part B 063,847 0 07 0 08 approved program) 08 Home office wage-related 09 0 00 0 01 Interns & residents (in an approved program) 02 Home office wage-related 03 0 04 0 05 Related organization 06 0 07 0 08 0 09 0 00 0 00 0 01 0 02 0 03 0 04 0 053 Home office & Contract 054 </td <td></td> <td></td> <td></td> <td>552, 11</td> <td>0</td> <td>552, i l l</td> <td>þ</td> <td></td> <td>20</td>				552, 11	0	552, i l l	þ		20
Administrative01Physician Part A - Teaching0000Physician Part B63,847000Physician Part B63,847000Wage-related costs (RHC/FOHC)0000Interns & residents (in an approved program)0050Home office wage-related (core)7,170,9447,170,94451Related organization wage-related (core)0052Home office: Physician Part A - Administrative - wage-related (core)0053Home office & Contract Physicians Part A - Teaching - wage-related (core)00000000000	00 Non-j	ohysician anesthetist Part		C	О	С			2
01Physician Part A - Teaching00000Physician Part B63,847063,84700Wage-related costs (RHC/FOHC)00001Interns & residents (in an approved program)00005Home office wage-related (core)7,170,94407,170,94401Related organization wage-related (core)00002Home office: Physician Part A - Administrative - wage-related (core)00003Home office & Contract Physicians Part A - Teaching - wage-related (core)00004O000005Home office & Contract Physicians Part A - Teaching - wage-related (core)00005OVERHEAD COSTS - DIRECT SALARIES0000	5			5, 692	0	5, 692	2		22
00 Wage-related costs (RHC/FOHC) 0 0 0 01 Interns & residents (in an approved program) 0 0 0 50 Home office wage-related (core) 7,170,944 0 7,170,944 51 Related organization wage-related (core) 0 0 0 52 Home office: Physician Part A wage-related (core) 0 0 0 53 Home office & Contract Physicians Part A - Teaching - wage-related (core) 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 10 0 0 0 0 0 10 0 0 0 0 0 10 0 0 0 0 0 10 0 0 0 0 0 10 0 0 0 0 0 10 <	01 Physi	cian Part A - Teaching		(62 047	0	(42 047)		22
approved program) Home office wage-related 7,170,944 0 7,170,944 50 Home office wage-related 7,170,944 0 7,170,944 51 Related organization 0 0 0 52 Home office: Physician Part A 0 0 0 52 Home office: Core) 0 0 0 53 Home office & Contract 0 0 0 64 Home office & Contract 0 0 0 70 Physicians Part A - Teaching - 0 0 0 70 VERHEAD COSTS - DI RECT SALARIES 0 0 0	00 Wage	-related costs (RHC/FQHC)		o3, 847 C	0	o3, 847 C)		24
50 Home office wage-related (core) 7, 170, 944 0 7, 170, 944 51 Related organization wage-related (core) 0 0 0 52 Home office: Physician Part A - Administrative - wage-related (core) 0 0 0 53 Home office & Contract Physicians Part A - Teaching - wage-related (core) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				C	0	C			25
51 Related organization 0 0 0 wage-related (core) 0 0 0 0 52 Home office: Physician Part A 0 0 0 - Administrative - wage-related (core) 0 0 0 53 Home office & Contract 0 0 0 Physicians Part A - Teaching - wage-related (core) 0 0 OVERHEAD COSTS - DI RECT SALARIES 0 0 0	50 Home	office wage-related		7, 170, 944	0	7, 170, 944	Į.		25
52 Home office: Physician Part A 0 0 0 - Administrative - wage-related (core) 0 0 0 53 Home office & Contract 0 0 0 0 Physicians Part A - Teaching - wage-related (core) 0 0 0 OVERHEAD COSTS - DI RECT SALARIES 0 0 0 0	51 Rel a	ted organization		C	0	C)		25
53 Home office & Contract 0 0 0 Physicians Part A - Teaching - wage-related (core) 0 0 0 OVERHEAD COSTS - DIRECT SALARIES 0 0 0 0	52 Home - Adr	office: Physician Part A ministrative –		C	0	С			25
wage-related (core)	53 Home	office & Contract		C	0	С			25
	wage	-related (core)	S						
			<u>4.00</u>	162, 789	0	162, 789	3, 475. 00	46.85	26

Heal th	Financial Systems	COMML	JNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider C		eriod:	Worksheet S-3	
						rom 01/01/2018		
					T	o 12/31/2018		
		Wkst. A Line	Amount	Reclassi fi cati	Adjusted	Paid Hours	5/29/2019 3:0	
		Number		on of Salaries			Average Hourly Wage (col. 4 ÷	
		Number	Reported	(from Wkst.	$(col.2 \pm col.)$	Salaries in	col. 5)	
				(11011 WKSt. A-6)	3)	col. 4	COI. 5)	
		1.00	2.00	3.00	4,00	5.00	6,00	
28.00	Administrative & General under	1.00	8,870,574		8, 870, 574		91.39	28.00
20.00	contract (see inst.)		0,070,074	0	0,070,374	77,007.00	71. 57	20.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	3,040,788	-19, 655	3, 021, 133	136, 751. 00	22.09	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00		31.00
32.00	Housekeeping	9.00	2, 920, 542	-31, 881	2, 888, 661	188, 502. 00	15. 32	32.00
33.00	Housekeeping under contract		394, 740		394, 740	9, 911.00	39.83	33.00
	(see instructions)							
34.00	Dietary	10.00	2, 418, 178	-1, 782, 720	635, 458	36, 700. 00	17.31	34.00
35.00	Dietary under contract (see		0	0	0	0.00	0.00	35.00
	instructions)							
36.00	Cafeteri a	11.00	0	1, 774, 879	1, 774, 879	101, 258. 00	17.53	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,027,729	-2, 347	2, 025, 382	60, 492. 00	33.48	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	4, 643, 917	-28, 822	4, 615, 095	110, 414. 00	41.80	40.00
41.00	Medical Records & Medical	16.00	382, 171	-296	381, 875	9, 985. 00	38.24	41.00
	Records Library							
42.00	Social Service	17.00	1, 436, 425	-9, 377	1, 427, 048	41, 106. 00	34.72	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

Heal th	Financial Systems	COMM	JNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2018 To 12/31/2018		
		Worksheet A		Recl assi fi cati	,		Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY				_		
1.00	Net salaries (see		109, 206, 479	-576, 827	108, 629, 65	2 3, 192, 789. 00	34.02	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		2, 154, 440	-17, 248	2, 137, 19	2 64, 515.00	33. 13	2.00
3.00	Subtotal salaries (line 1 minus line 2)		107, 052, 039	-559, 579	106, 492, 46	3, 128, 274. 00	34.04	3.00
4.00	Subtotal other wages & related costs (see inst.)		36, 327, 449	0	36, 327, 44	9 757, 529. 00	47.96	4.00
5.00	Subtotal wage-related costs (see inst.)		31, 881, 861	0	31, 881, 86	0.00	29.94	5.00
6.00	Total (sum of lines 3 thru 5)		175, 261, 349	-559, 579	174, 701, 77	3, 885, 803. 00	44.96	6.00
7.00	Total overhead cost (see instructions)		31, 856, 570	-115, 852	31, 740, 71	8 935, 729. 00	33. 92	7.00

	I FINANCIAL SYSTEMS COMMUNITY HC TAL WAGE RELATED COSTS	DSPITAL OF INDIA). N: 15-0169	Period:	u of Form CMS-2 Worksheet S-3	
1103F11	TAL WAGE RELATED COSTS	FIOVI	uer cc	1. 15-0109	From 01/01/2018		
					To 12/31/2018	Date/Time Pre	
						5/29/2019 3:0	5 pm
						Amount	
						Reported	
						1.00	
	PART IV - WAGE RELATED COSTS						+
	Part A - Core List						-
1 00	RETIREMENT COST 401K Employer Contributions					3, 010, 227	1.00
1.00 2.00	Tax Sheltered Annuity (TSA) Employer Contribution					3, 010, 227	
						0	
3.00	Nonqualified Defined Benefit Plan Cost (see instruct						
4.00	Qualified Defined Benefit Plan Cost (see instruction PLAN ADMINISTRATIVE COSTS (Paid to External Organiza					0	4.00
F 00	401K/TSA Plan Administration fees	tion)				0	EO
5.00						-	
6.00	Legal /Accounting/Management Fees-Pension Plan					616, 145	
7.00	Employee Managed Care Program Administration Fees					0	7.00
0.00	HEALTH AND INSURANCE COST					0	
8.00	Health Insurance (Purchased or Self Funded)	۸ - ا - : - : - +)				0	
8.01	Health Insurance (Self Funded without a Third Party					0	
8.02	Health Insurance (Self Funded with a Third Party Adm	in Strator)				10, 290, 665	
8.03	Heal th Insurance (Purchased)					0	
9.00	Prescription Drug Plan					2, 944, 043	
10.00	Dental, Hearing and Vision Plan					110, 082	
11.00	Life Insurance (If employee is owner or beneficiary)					59, 783	
12.00	Accident Insurance (If employee is owner or benefici					0	
13.00	Disability Insurance (If employee is owner or benefi					863, 384	
14.00	Long-Term Care Insurance (If employee is owner or be	eneficiary)				0	
15.00	'Workers' Compensation Insurance					169, 865	
16.00	Retirement Health Care Cost (Only current year, not	the extraordinal	ry accr	ual require	ed by FASB 106.	0	16.00
	Non cumulative portion) TAXES						-
17 00						7, 120, 637	17.00
18.00						0	
19.00	Unemployment Insurance					0	
20.00	State or Federal Unemployment Taxes OTHER					0	20.00
21.00		nt Coot Donorto	l on Li	noo 1 throu	ich (about (aca	0	21.00
21.00	instructions))	ent cost Reported		nes i throu	ign 4 above. (See	0	21.00
22.00	Day Care Cost and Allowances					0	22.00
22.00						122.045	
	Total Wage Related cost (Sum of lines 1 -23)						
∠4.00	Part B - Other than Core Related Cost					25, 306, 876	24.00
	OTHER WAGE RELATED COSTS (SPECIFY)						

Heal th	Financial Systems	COMMUNI TY HOSPI T	TAL OF I	NDI ANA,	INC.		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST			Provi der	CCN: 15-0169		eri od:	Worksheet S-3	
							rom 01/01/2018		
						T	o 12/31/2018		
	Cost Center Description						Contract Labor	5/29/2019 3:0 Benefit Cost	
	cost center bescription						1.00	2.00	
	PART V - Contract Labor and Benefit Cos	+					1.00	2.00	
	Hospital and Hospital-Based Component I								
1.00	Total facility's contract labor and ben						1, 213, 089	25, 306, 876	1.00
2.00	3	erri cost							2.00
2.00	Hospi tal						1, 213, 089	24, 774, 772 374, 753	2.00
	Subprovider - IPF						0	374, 753	
4.00	Subprovider - IRF							0	4.00
5.00	Subprovider - (Other)						0	0	5.00
6.00	Swing Beds - SNF						0	0	6.00
7.00	Swing Beds - NF						0	0	7.00
8.00	Hospital-Based SNF								8.00
9.00	Hospital-Based NF								9.00
10.00	Hospital-Based OLTC								10.00
11.00	Hospital-Based HHA								11.00
12.00	Separately Certified ASC								12.00
13.00	Hospi tal -Based Hospi ce								13.00
14.00	Hospital-Based Health Clinic RHC								14.00
15.00	Hospital-Based Health Clinic FQHC								15.00
16.00	Hospital-Based-CMHC								16.00
17.00	Renal Dialysis						0	0	17.00
18.00	Other						0	157, 351	18.00

Heal th	Financial Systems COMMUNITY HOSPITAL OF I	NDI ANA, I N	C.	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	N: 15-0169	Period:	Worksheet S-1	0
				From 01/01/2018 To 12/31/2018		pared: 5 pm
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by li	ne 202 columr	ı 8)	0. 213260	1.00
	Medicaid (see instructions for each line)				L	
2.00	Net revenue from Medicaid				39, 781, 993	2.00
3.00 4.00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplement	al navments	s from Medica	ai d2	Y Y	3.00 4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr			in d :	0	5.00
6.00	Medi cai d charges		-		286, 695, 250	
7.00	Medicaid cost (line 1 times line 6)				61, 140, 629	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minu	us sum of lir	nes 2 and 5; if	21, 358, 636	8.00
	<pre>< zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions for </pre>	r oach lin	2)			-
9.00	Net revenue from stand-al one CHIP		=)		0	9.00
10.00	Stand-al one CHIP charges				0	
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 miı	nus line 9; i	f < zero then	0	12.00
	enter zero)					
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
13.00	Charges for patients covered under state or local indigent care program (Not incl					
14.00	10)		Not The udeu			14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local ind	igent care	program (lir	ne 15 minus line	0	16.00
	13; if < zero then enter zero)	<u> </u>	// / / /			
	Grants, donations and total unreimbursed cost for Medicaid, CHII instructions for each line)	P and state	e/local indig	jent care program	ns (see	
17.00	Private grants, donations, or endowment income restricted to fu	ndi ng chari	tv care		0	17.00
18.00	Government grants, appropriations or transfers for support of h				0	1
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	indigent o	care programs	s (sum of lines	21, 358, 636	19.00
			Uni nsured	Insured	Total (col. 1	
			patients 1.00	patients 2.00	+ col. 2) 3.00	
	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 (see instructions)	ility	28, 658, 9	2, 809, 447	31, 468, 358	20.00
21.00	Cost of patients approved for charity care and uninsured discou	nts (see	6, 111, 79	2, 809, 447	8, 921, 246	21.00
22. 00	instructions) Payments received from patients for amounts previously written	off oc		0 0	0	22.00
22.00	charity care			0 0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		6, 111, 79	2, 809, 447	8, 921, 246	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patien	t days bey	ond a length	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		care program	n's length of	0	25.00
	stay limit	0		0		
26.00	Total bad debt expense for the entire hospital complex (see ins				1, 959, 218	
27.00	Medicare reimbursable bad debts for the entire hospital complex				285, 931	
27.01 28.00	Medicare allowable bad debts for the entire hospital complex (s Non-Medicare bad debt expense (see instructions)	ee Instruc	tions)		439, 895 1, 519, 323	
28.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see i	nstructions		477, 975	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	0130 (300 1			9, 399, 221	
	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			30, 757, 857	
	•					-

Health Financial Systems COMM RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (Communication (NUNITY HOSPITAL (DF EXPENSES	OF INDIANA, IN Provider CO	CN: 15-0169 P	eriod:	u of Form CMS-2 Worksheet A	2552-10
			T	rom 01/01/2018 o 12/31/2018	Date/Time Pre 5/29/2019 3:09	
Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT	T T	0	0	19, 622, 377	19, 622, 377	1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP		0			10, 233, 594	2.00
3.00 00300 OTHER CAP REL COSTS		0	0	-	0	3.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL	162, 789 5, 558, 717	234, 722 121, 461, 273			308, 206 107, 819, 890	4.00 5.00
7. 00 00700 OPERATION OF PLANT	3, 040, 788	7, 384, 690			10, 309, 352	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	877, 009			876, 929	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	2, 920, 542 2, 418, 178	1, 903, 124 2, 900, 204			4, 815, 889 1, 586, 759	9.00 10.00
11. 00 01100 CAFETERI A	2, 410, 170	2, 700, 204			3, 694, 674	11.00
13.00 01300 NURSING ADMINISTRATION	2, 027, 729	521, 783			2, 544, 989	
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	0 4, 643, 917	400, 380 14, 410, 327			-620, 294 4, 931, 590	14.00 15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	382, 171	60, 101			4, 931, 390	16.00
17.00 01700 SOCIAL SERVICE	1, 436, 425	394, 059		-36	1, 830, 448	
19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	0		-	0	19.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0	0	21.00 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						22100
30. 00 03000 ADULTS & PEDIATRICS	32, 479, 369	17,025,709			37, 390, 546	
31.00 03100 INTENSIVE CARE UNIT 35.00 02060 NEONATAL INTENSIVE CARE UNIT	4, 325, 430 6, 714, 123	2, 288, 132 2, 599, 208			5, 786, 886 8, 934, 638	31.00 35.00
40. 00 04000 SUBPROVIDER - IPF	1, 623, 226	521, 776			2, 121, 792	40.00
43. 00 04300 NURSERY	0	0	0	2, 407, 581	2, 407, 581	43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	4, 870, 875	30, 551, 276	35, 422, 151	-25, 712, 121	9, 710, 030	50.00
51. 00 05100 RECOVERY ROOM	2, 381, 007	1, 208, 877			3, 229, 851	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	532, 668	19, 476			6, 546, 963	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	3, 516, 476 420, 136	2, 240, 326 2, 757, 626			4, 245, 807 797, 246	54.00 55.00
57. 00 05700 CT SCAN	825, 623	914, 253			1, 392, 380	
58. 00 05800 MRI	470, 979	862, 832			982, 514	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0 31, 877	1, 293 10, 585, 139			45 10, 604, 896	59.00 60.00
64. 00 06400 I NTRAVENOUS THERAPY	291, 332	193, 521			384, 652	
65. 00 06500 RESPI RATORY THERAPY	2, 744, 912	1, 785, 579	4, 530, 491	-723, 188	3, 807, 303	65.00
66. 00 06600 PHYSI CAL THERAPY	5, 794, 012	2, 844, 300			5, 637, 076	1
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0	0		1, 687, 272 320, 023	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	27, 517	841, 420	-		859, 085	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	945, 855	756, 758				
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		19, 073, 633 12, 842, 066	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0		14, 275, 333	
74.00 07400 RENAL DI ALYSI S	0	1, 185, 376			1, 182, 740	1
76. 00 03330 ENDOSCOPY 76. 06 03954 I MAGI NG CENTER	1, 136, 452 1, 392, 569	2, 430, 410 2, 356, 004			1, 848, 558 2, 606, 910	
76. 07 03955 BREAST DIAGNOSTIC CENTER	1, 392, 509	8, 016, 905			7, 762, 650	
OUTPATIENT SERVICE COST CENTERS	- -		-	_		
90. 00 09000 CLINIC 90. 26 04975 SPINE CENTER	0 185, 515	0 62, 836	0 248, 351	0 -721	0 247, 630	90.00 90.26
91. 00 09100 EMERGENCY	6, 476, 086	3, 531, 783			9, 453, 614	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE		0	0	0	0	113.00
114. 00 11400 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	99, 777, 295	246, 128, 487	345, 905, 782	41, 802	345, 947, 584	
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	0	0	0	0		191.00
191. 00 19100 RESEARCH		116, 952	116, 952	0	116, 952	192.00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	110, 702				
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193.00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 193. 00 19300 NONPALD WORKERS 194. 00 07950 HOME OFFI CE	0 0 0	0 0	0 0 56, 947	0 0 15, 857	0	194.00
191.00 19100 RESEARCH 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 193.00 19300 NONPAI D WORKERS 194.00 07950 HOME OFFICE 194.06 07956 PAVI LLI ONS 194.08 07958 OTHER NRCC	0 0 0 531, 214	0 0 56, 947 1, 166, 131			0 72, 804 1, 639, 686	194.00 194.06 194.08
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 193. 00 19300 NONPALD WORKERS 194. 00 07950 HOME OFFI CE 194. 06 07956 PAVI LLI ONS	000000000000000000000000000000000000000	0 0 56, 947	1, 697, 345 0	-57, 659 0	0 72, 804 1, 639, 686	194. 00 194. 06 194. 08 194. 10

ealth Financial Systems COM ECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	MUNITY HOSPITAL OF EXPENSES	OF INDIANA, INC. Provider CCN	Period:	of Form CMS-2552- Worksheet A
				Date/Time Prepared 5/29/2019 3:05 pm
Cost Center Description		Net Expenses For Allocation		
GENERAL SERVICE COST CENTERS	6.00	7.00		
.00 00100 CAP REL COSTS-BLDG & FIXT	-6, 392, 494	13, 229, 883		1.0
. 00 00200 CAP REL COSTS-MVBLE EQUIP	5, 728, 817	15, 962, 411		2.0
00 00300 OTHER CAP REL COSTS	0 5 010 0/7	0		3.0
00 00400 EMPLOYEE BENEFITS DEPARTMENT 00 00500 ADMINISTRATIVE & GENERAL	5, 219, 967 -44, 354, 021	5, 528, 173 63, 465, 869		4. C 5. C
00 00700 OPERATION OF PLANT	-44, 354, 021	10, 863, 495		7.0
00 00800 LAUNDRY & LINEN SERVICE	0	876, 929		8.0
00 00900 HOUSEKEEPI NG	0	4, 815, 889		9.0
D. 00 01000 DI ETARY	-24, 144	1, 562, 615		10.0
1. 00 01100 CAFETERI A	-2, 423, 399	1, 271, 275		11.0
3. 00 01300 NURSI NG ADMI NI STRATI ON	4, 549, 434	7,094,423		13.0
4. 00 01400 CENTRAL SERVICES & SUPPLY 5. 00 01500 PHARMACY	1, 330, 339 -47, 628	710, 045 4, 883, 962		14. 0 15. 0
6. 00 01600 MEDICAL RECORDS & LIBRARY	2, 667, 433	3, 109, 625		16.0
7. 00 01700 SOCIAL SERVICE	2,007,100	1, 830, 448		17.0
9. 00 01900 NONPHYSI CLAN ANESTHETI STS	0	0		19.0
1.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	406, 401	406, 401		21.0
2.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	621, 282	621, 282		22.0
INPATIENT ROUTINE SERVICE COST CENTERS	004.045			
D. 00 03000 ADULTS & PEDIATRICS	834, 265	38, 224, 811		30.0
1. 00 03100 INTENSIVE CARE UNIT 5. 00 02060 NEONATAL INTENSIVE CARE UNIT	-467, 403	5, 786, 886 8, 467, 235		31. 0 35. 0
0. 00 04000 SUBPROVIDER - IPF	-407, 403	2, 121, 792		40.0
3. 00 04300 NURSERY	0	2, 407, 581		43.0
ANCI LLARY SERVI CE COST CENTERS	- I - I	, , , , , , , , , , , , , , , , , , , ,		
D. 00 05000 OPERATING ROOM	-2, 500	9, 707, 530		50. C
1.00 05100 RECOVERY ROOM	0	3, 229, 851		51. C
2. 00 05200 DELIVERY ROOM & LABOR ROOM	0	6, 546, 963		52.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C 5. 00 05500 RADI OLOGY-THERAPEUTI C	125 0	4, 245, 932 797, 246		54. C 55. C
7. 00 05700 CT SCAN	0	1, 392, 380		57.0
B. 00 05800 MRI	-116, 800	865, 714		58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	127, 131	127, 176		59. C
D. 00 06000 LABORATORY	-1, 193, 952	9, 410, 944		60. C
4.00 06400 INTRAVENOUS THERAPY	0	384, 652		64.0
5. 00 06500 RESPI RATORY THERAPY	0	3, 807, 303		65. C
6. 00 06600 PHYSI CAL THERAPY	-820	5, 636, 256		66.0
7. 00 06700 0CCUPATI ONAL THERAPY B. 00 06800 SPEECH PATHOLOGY	0	1, 687, 272 320, 023		67. 0 68. 0
9. 00 06900 ELECTROCARDI OLOGY	-245, 222	613, 863		69.0
0.00 07000 ELECTROENCEPHALOGRAPHY	361, 911	1, 773, 180		70.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	19, 073, 633		71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	12, 842, 066		72.0
3. 00 07300 DRUGS CHARGED TO PATIENTS	454, 036	14, 729, 369		73.0
4. 00 07400 RENAL DIALYSIS 6. 00 03330 ENDOSCOPY	0	1, 182, 740		74.0
6. 06 03954 I MAGI NG CENTER	0	1, 848, 558 2, 606, 910		76.0
6. 07 03955 BREAST DIAGNOSTIC CENTER	0	7, 762, 650		76.0
OUTPATIENT SERVICE COST CENTERS		111021000		,,,,,
D. 00 09000 CLI NI C	0	0		90. C
D. 26 04975 SPI NE CENTER	0	247, 630		90. 2
1.00 09100 EMERGENCY	-32,879	9, 420, 735		91.0
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART				92.0
SPECIAL PURPOSE COST CENTERS 13. 00 11300 INTEREST EXPENSE	0	0		113.0
14. 00 11400 UTI LI ZATI ON REVIEW-SNF	0	0		113.0
18.00 SUBTOTALS (SUM OF LINES 1 through 117)	-32, 445, 978	313, 501, 606		114.0
NONREI MBURSABLE COST CENTERS				
90.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 0
91. 00 19100 RESEARCH	0	0		191. C
92. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	116, 952		192. C
93. 00 19300 NONPAI D WORKERS	0	0		193. 0
94. 00 07950 HOME OFFICE	0	0		194.0
	0	72, 804		194.0
94. 06 07956 PAVI LLI ONS				
94. 08 07958 OTHER NRCC 94. 10 07958 OTHER NRCC 94. 10 07960 COMMUNI TY REHAB HOSPI TAL	0	1, 639, 686		194. C 194. 1

	Financial Systems SIFICATIONS	COMML	JNI TY HOSPI TAL	OF INDIANA, INC. Provider CCN	In Lieu of Form C Period: Worksheet	
neoeno					 From 01/01/2018 To 12/31/2018 Date/Time 5/29/2019	Prepared:
	Cost Center	I ncreases Li ne #	Sal ary	Other		
	2.00 A - Chargeable Medical Supplie	3.00	4.00	5.00		
1.00 2.00	CENTRAL SERVICES & SUPPLY MEDICAL SUPPLIES CHARGED TO PATIENT	14. 00 71. 00	0 0	712, 092 19, 073, 633		1.00 2.00
3.00		0.00	0	0		3.00
4.00 5.00		0.00 0.00	0 0	0 0		4.00 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 10. 00		0.00 0.00	0	0		9.00 10.00
11. 00 12. 00		0.00 0.00	0 0	0		11.00 12.00
13.00 14.00		0.00 0.00	0 0	0		13.00 14.00
15.00		0.00	0	0		15.00
16. 00 17. 00		0.00 0.00	0 0	0 0		16.00 17.00
18. 00 19. 00		0.00 0.00	0	0 0		18.00 19.00
20.00		0.00	0	0		20.00
21. 00 22. 00		0.00 0.00	0 0	0 0		21.00 22.00
23.00 24.00		0.00 0.00	0 0	0		23.00 24.00
25. 00 26. 00		0.00 0.00	0 0	0		25. 00 26. 00
27.00		0.00	0	0		27.00
28.00	0	0.00	0	<u>0</u> 19, 785, 725		28.00
1.00	B - Implantable Device Reclass	<u>5</u> 72.00	0	12, 842, 066		1.00
2.00	PATI ENTS	0.00	0	0		2.00
3.00	0	0.00	0	<u>0</u> 12, 842, 066		3.00
1.00	C - Drugs Charges to Pat CENTRAL SERVICES & SUPPLY	14.00	0	393		1.00
2.00 3.00	DRUGS CHARGED TO PATIENTS	73.00 0.00	0	14, 275, 333 0		2.00 3.00
4.00		0.00	0	0		4.00
5.00 6.00		0. 00 0. 00	0 0	0 0		5.00 6.00
7.00 8.00		0.00 0.00	0 0	0 0		7.00 8.00
9.00 10.00		0.00 0.00	0	0		9.00 10.00
11.00		0.00	0	0		11.00
12. 00 13. 00		0. 00 0. 00	0 0	0 0		12.00 13.00
14. 00 15. 00		0.00 0.00	0 0	0 0		14.00 15.00
16.00		0.00	0	0		16.00
17. 00 18. 00		0. 00 0. 00	0 0	0 0		17.00 18.00
19. 00 20. 00		0.00 0.00	0 0	0		19.00 20.00
21.00		0.00	0	<u>0</u> 14, 275, 726		21.00
1 00	D - Depreciation Expense	2.00				1.00
1.00 2.00	CAP REL COSTS-MVBLE EQUIP	2.00 0.00	0 0	13, 877, 184 0		1.00 2.00
3.00 4.00		0.00 0.00	0 0	0 0		3.00 4.00
5.00 6.00		0.00 0.00	0 0	0 0		5.00 6.00
7.00		0.00	0	0		7.00
8.00 9.00		0. 00 0. 00	0 0	0 0		8.00 9.00
10. 00 11. 00		0. 00 0. 00	0 0	0 0		10.00 11.00
12. 00 13. 00		0.00 0.00	0 0	0 0		12.00 13.00
	. I.		3	-1		1

COMMUNITY HOSPITAL OF INDIANA, INC. In Lieu of Form CMS-2552-10 Provider CCN: 15-0169 Period: From 01/01/2018 Worksheet A-6

RECEASE	STFICATIONS			Provider CCN: 15-01	From 01/01/2018	worksneet A-6 Date/Time Prepared:
		Increases				5/29/2019 3:05 pm
	Cost Center	Line #	Salary	Other		
14.00	2.00	3.00	4.00	5.00		14.00
14.00 15.00		0.00	0	0		14.00
16.00		0.00	0	0		16.00
17.00 18.00		0.00 0.00	0	0		17.00 18.00
18.00		0.00	0	0		19.00
20.00		0.00	О	0		20.00
21.00 22.00		0.00 0.00	0	0		21.00 22.00
22.00		0.00	0	0		22.00
24.00		0.00	О	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
28.00		0.00	О	Ö		28.00
29.00		0.00	0	0		29.00
30.00	<u> </u>		0	0 13,877,184		30.00
	E - Interest Expense					
1.00	CAP REL_COSTS-BLDG & FIXT		<u>0</u>	10, 77 <u>9, 865</u> 10, 779, 865		1.00
	F - Other Capital Rental			10, 777, 003		
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4, 830, 975		1.00
2.00 3.00	OPERATION OF PLANT EMERGENCY	7.00 91.00	0	14, 139 30, 244		2.00 3.00
4.00	PAVI LLI ONS	194.06	Ő	37, 644		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	Ö	Ö		8.00
9.00		0.00	0	0		9.00
10. 00 11. 00		0.00 0.00	0	0		10.00 11.00
12.00		0.00	Ö	0		12.00
13.00		0.00	0	0		13.00
14.00 15.00		0.00 0.00	0	0		14.00 15.00
16.00		0.00	Ő	Ö		16.00
17.00		0.00	0	0		17.00
18. 00 19. 00		0.00 0.00	0	0		18.00 19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00 23.00		0.00 0.00	0	0		22.00 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
28.00		0.00	О	0		28.00
29.00			<u>0</u>	4,913,002		29.00
	G - STD BENEFITS		0	4, 713, 002		
1.00 2.00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5.00 7.00	0	15, 633 19, 655		1.00 2.00
2.00	HOUSEKEEPING	9.00	0	31, 881		3.00
4.00	DI ETARY	10.00	0	7, 841		4.00
	NURSING ADMINISTRATION PHARMACY	13.00	0	2, 347		5.00
	MEDICAL RECORDS & LIBRARY	15.00 16.00	0	28, 822 296		6. 00 7. 00
8.00	SOCI AL SERVI CE	17.00	0	9, 377		8.00
9.00	ADULTS & PEDIATRICS	30.00 31.00	0	169, 224		9.00
	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	31.00	0	17, 038 77, 126		10.00 11.00
12.00	SUBPROVI DER – I PF	40.00	0	17, 248		12.00
	OPERATING ROOM RECOVERY ROOM	50.00 51.00	0	32, 926		13.00 14.00
	RADI OLOGY-DI AGNOSTI C	51.00 54.00	0	11, 385 18, 086		14.00
16.00	CT SCAN	57.00	0	2, 785		16.00
		58.00	0	920		17.00
18. 00 19. 00	LABORATORY RESPI RATORY THERAPY	60.00 65.00	0	6, 556 22, 640		18.00 19.00
20.00	PHYSICAL THERAPY	66.00	0	39, 832		20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	1, 725		21.00

Heal th	Fi nanci al	Systems
RECLAS	SLELCATION	S

COMMUNITY HOSPITAL OF INDIANA, INC. In Lieu of Form CMS-2552-10 Provider CCN: 15-0169 Period: From 01/01/2018 Worksheet A-6

					From 01/01/2018 To 12/31/2018	Date/Time Prepared: 5/29/2019 3:05 pm
		Increases				
	Cost Center	Line #	Sal ary	Other		
	2.00	3.00	4.00	5.00		
22.00	ENDOSCOPY	76.00	0	8, 274		22.00
23.00	I MAGI NG CENTER	76.06	0	9, 378		23.00
24.00	EMERGENCY	91.00	0	25,832		24.00
	0		0	576, 827		
	H - Labor and Delivery					
1.00	NURSERY	43.00	1, 696, 926	710, 655		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	4, 225, 304	1, 769, 515		2.00
	0 — — — — — — —		5, 922, 230	2, 480, 170		
	I - Cafeteria Reclass					
1.00	CAFETERI A	11.00	1, 774, 879	1, 919, 795		1.00
	0 — — — — — —		1, 774, 879	1, 919, 795		1
	J - Therapy					
1.00	OCCUPATI ONAL THERAPY	67.00	1, 167, 985	519, 287		1.00
2.00	SPEECH PATHOLOGY	68.00	221, 530	98, 493		2.00
	0 — — — — — — —		1, 389, 515	617, 780		
	K - Depreciation by CC					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8, 474, 565		1.00
	0 — — — — — — —		o	8, 474, 565		
	L - Capital Insurance Costs	· · · · · ·	·			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	367, 947		1.00
	0		o	367, 947		
	M - Radiology Support	· · · · · · · · · · · · · · · · · · ·				
1.00	RADI OLOGY-THERAPEUTI C	55.00	98, 353	37, 782		1.00
2.00	CT SCAN	57.00	209, 853	80, 614		2.00
3.00	MRI	58.00	51, 514	19, 789		3.00
	<u> </u>		359, 720	138, 185	4	
500.00	Grand Total: Increases		9, 446, 344	91, 048, 837		500.00
		I I	.,		1	1 2001 00

Heal th	Financial Systems	COMM	UNI TY HOSPI TAL	OF INDIANA, I	NC.	ln Li€	u of Form CMS	8-2552-10
RECLAS	SIFICATIONS			Provi der	CCN: 15-0169	Period: From 01/01/2018	Worksheet A	-6
						To 12/31/2018	Date/Time P 5/29/2019 3	
		Decreases					572972019 3	
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref			
	6.00 A - Chargeable Medical Suppli	7.00	8.00	9.00	10.00			
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	118	3	0		1.00
2.00	OPERATION OF PLANT	7.00	0	64, 816		o		2.00
3.00	DIETARY	10.00	0	935		0		3.00
4.00 5.00	NURSING ADMINISTRATION PHARMACY	13.00 15.00	0	1, 133 402, 290		0		4.00 5.00
6.00	ADULTS & PEDIATRICS	30.00	0	2, 243, 582		0		6.00
7.00	INTENSIVE CARE UNIT	31.00	0	460, 422		0		7.00
8.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	207, 412		0		8.00
9. 00 10. 00	SUBPROVIDER – IPF OPERATING ROOM	40.00 50.00	0	5, 334 11, 908, 433		0		9.00 10.00
11.00	RECOVERY ROOM	51.00	0	346, 658		0		11.00
12.00	RADI OLOGY-DI AGNOSTI C	54.00	0	360, 878		0		12.00
13.00	RADI OLOGY-THERAPEUTI C	55.00	0	1, 225, 063		o		13.00
14.00 15.00	CT SCAN MRI	57.00 58.00	0	214, 213		0		14.00 15.00
16.00	LABORATORY	60.00	0	21, 098 1, 312		0		16.00
17.00	INTRAVENOUS THERAPY	64.00	0	96, 563		0		17.00
18.00	RESPI RATORY THERAPY	65.00	0	470, 989		o		18.00
19.00	PHYSI CAL THERAPY	66.00	0	85, 968	-	0		19.00
20. 00 21. 00	ELECTROENCEPHALOGRAPHY RENAL DIALYSIS	70.00 74.00	0	77, 991 2, 636		0		20.00 21.00
21.00	ENDOSCOPY	74.00	0	1, 113, 560		0		21.00
23.00	I MAGI NG CENTER	76.06	0	93, 617		0		23.00
24.00	BREAST DIAGNOSTIC CENTER	76.07	0	750		o		24.00
25.00	SPINE CENTER	90.26	0	242		0		25.00
26. 00 27. 00	EMERGENCY PAVI LLI ONS	91.00 194.06	0	377, 348 1, 527		0		26.00 27.00
28.00	OTHER NRCC	194.00	0	837		0		28.00
	0 — — — — — —		0	19, 785, 725				
4 00	B - Implantable Device Reclas			11 0/0 000				1 00
1.00 2.00	OPERATI NG ROOM RADI OLOGY-THERAPEUTI C	50.00 55.00	0	11, 962, 339 686, 597		0		1.00 2.00
3.00	ENDOSCOPY	76.00	0	193, 130		0		3.00
	0		0	12, 842, 066	j			
1 00	C - Drugs Charges to Pat	7.00	0	2 700		0		1 00
1.00 2.00	OPERATION OF PLANT DIETARY	7.00 10.00	0	2, 780 374		0		1.00 2.00
3.00	PHARMACY	15.00	0	13, 133, 944		0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	88, 935		o		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	21, 290		0		5.00
6.00 7.00	NEONATAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	35.00 40.00	0	2, 599 636		0		6.00 7.00
8.00	OPERATI NG ROOM	50.00	0	319, 894		0		8.00
9.00	RECOVERY ROOM	51.00	0	3, 358		0		9.00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	0	208, 553		o		10.00
11.00	RADI OLOGY-THERAPEUTI C	55.00	0	31, 936		0		11.00
12. 00 13. 00	CT SCAN MRI	57.00 58.00	0	178, 432 85, 810		0		12.00 13.00
14.00	INTRAVENOUS THERAPY	64.00	0	622		0		14.00
15.00	RESPI RATORY THERAPY	65.00	0	14, 225		o		15.00
16.00	PHYSI CAL THERAPY	66.00	0	3, 590		0		16.00
17. 00 18. 00	ELECTROENCEPHALOGRAPHY ENDOSCOPY	70.00 76.00	0	1, 050 4, 571		0		17.00 18.00
19.00	I MAGI NG CENTER	76.00	0	150, 844		0		19.00
20.00	EMERGENCY	91.00	0	22, 128		0		20.00
21.00	OTHER NRCC	<u> </u>	0	155		o		21.00
	0 D - Depreciation Expense		0	14, 275, 726				_
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2, 307	7	9		1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	7, 858, 205		o		2.00
3.00	OPERATION OF PLANT	7.00	0	62, 669		o		3.00
4.00 5.00	HOUSEKEEPI NG DI ETARY	9.00 10.00	0	6, 922		0		4.00
5.00 6.00	NURSING ADMINISTRATION	13.00	0 O	34, 697 853		ol		5.00 6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	61, 169		0		7.00
8.00	PHARMACY	15.00	0	54, 590)	o		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	1, 377, 944		0		9.00
10. 00 11. 00	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	31.00 35.00	0	344, 422 165, 590		0		10.00 11.00
12.00	SUBPROVIDER - IPF	40.00	0	16, 841		0		12.00
13.00	OPERATI NG ROOM	50.00	0	860, 411		o		13.00
14.00	RECOVERY ROOM	51.00	0	9, 766		0		14.00
15.00	RADI OLOGY-DI AGNOSTI C	54.00	0	442, 188	3	0		15.00

COMMUNI TY	HOSPI TAL	0F	I NDI ANA,	INC.

Provider CCN: 15-0169

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2018

1120210						From 01/01/2018 To 12/31/2018	Date/Time Prepared: 5/29/2019 3:05 pm
		Decreases					<u>- 372772017 5.03 pm</u>
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref		
16.00	6. 00 RADI OLOGY-THERAPEUTI C	7.00	8.00	<u>9.00</u> 572,375	10.00	0	16.00
17.00	CT SCAN	57.00	0	245, 318		0	17.00
18.00	MRI	58.00	0	282, 568		o	18.00
19.00	CARDIAC CATHETERIZATION	59.00	0	1, 248		0	19.00
20. 00 21. 00	LABORATORY I NTRAVENOUS THERAPY	60.00 64.00	0	3, 232 2, 856		0	20.00
21.00	RESPIRATORY THERAPY	65.00	0	120, 228		0	21.00
23.00	PHYSI CAL THERAPY	66.00	0	179, 575		0	23.00
24.00	ELECTROCARDI OLOGY	69.00	0	9, 852		0	24.00
25.00	ELECTROENCEPHALOGRAPHY	70.00	0	69, 318		0	25.00
26.00 27.00	ENDOSCOPY I MAGI NG CENTER	76.00 76.06	0	406, 883 465, 788		0	26.00 27.00
27.00	BREAST DIAGNOSTIC CENTER	76.07	0	14, 086		0	28.00
29.00	EMERGENCY	91.00	0	185, 023		0	29.00
30.00	PAVI LLI ONS	<u> </u>	0	2 <u>0, 2</u> 60	<u> </u>	o	30.00
	0		0	13, 877, 184			
1.00	E - Interest Expense ADMINISTRATIVE & GENERAL	5.00	0	10, 779, 865	1	1	1.00
1.00			— — — o	10, 779, 865		<u>-</u>	1.00
	F - Other Capital Rental	<u> </u>			1	1	
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	86, 998			1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	193, 965		0	2.00
3.00 4.00	LAUNDRY & LINEN SERVICE HOUSEKEEPING	8.00 9.00	0	80 855		0	3.00
4.00 5.00	DI ETARY	9.00 10.00	0	943		0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	2, 537		0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	1, 671, 990		o	7.00
8.00	PHARMACY	15.00	0	531, 830		0	8.00
9.00 10.00	MEDI CAL RECORDS & LI BRARY SOCI AL SERVI CE	16.00 17.00	0	80 36		0	9.00 10.00
11.00	ADULTS & PEDIATRICS	30.00	0	1, 671		0	11.00
12.00	INTENSIVE CARE UNIT	31.00	0	542		0	12.00
13.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	3, 092		o	13.00
14.00	SUBPROVIDER - IPF	40.00	0	399		0	14.00
15.00 16.00	OPERATING ROOM	50.00 51.00	0	661, 044		0	15. 00 16. 00
17.00	RECOVERY ROOM RADI OLOGY-DI AGNOSTI C	54.00	0	251 1, 471		0	17.00
18.00	RADI OLOGY-THERAPEUTI C	55.00	0	680		0	18.00
19.00	MRI	58.00	0	33, 124		o	19.00
20.00	LABORATORY	60.00	0	7, 576		0	20.00
21.00 22.00	I NTRAVENOUS THERAPY RESPI RATORY THERAPY	64.00 65.00	0	160 117, 746		0	21.00
22.00	PHYSICAL THERAPY	66.00	0	724, 808		0	22.00
24.00	ELECTROENCEPHALOGRAPHY	70.00	0	142, 985		0	24.00
25.00	ENDOSCOPY	76.00	0	160		o	25.00
26.00	I MAGI NG CENTER	76.06	0	431, 414		0	26.00
27.00 28.00	BREAST DIAGNOSTIC CENTER SPINE CENTER	76. 07 90. 26	0	239, 419 479		0	27.00 28.00
29.00	OTHER NRCC	194.08	0	56, 667		0	28.00
	0		<u>_</u>	4, 913, 002		-	
	G - STD BENEFITS					-1	
1.00	ADMINISTRATIVE & GENERAL	5.00	15, 633	0		0	1.00
2.00 3.00	OPERATION OF PLANT HOUSEKEEPING	7.00 9.00	19, 655 31, 881	0 0		0	2.00
4.00	DI ETARY	10.00	7, 841	0		0	4.00
5.00	NURSING ADMINISTRATION	13.00	2, 347	0		0	5.00
6.00	PHARMACY	15.00	28, 822	0		0	6.00
7.00	MEDI CAL RECORDS & LI BRARY	16.00	296	0		0	7.00
8.00 9.00	SOCIAL SERVICE ADULTS & PEDIATRICS	17.00 30.00	9, 377 169, 224	0		0	8. 00 9. 00
10.00	INTENSIVE CARE UNIT	31.00	17, 038	0		0	10.00
11.00	NEONATAL INTENSIVE CARE UNIT	35.00	77, 126	0		0	11.00
12.00	SUBPROVI DER – I PF	40.00	17, 248	0		o	12.00
13.00	OPERATING ROOM	50.00	32, 926	0		0	13.00
14. 00 15. 00	RECOVERY ROOM	51.00 54.00	11, 385 18, 086	0		0	14.00 15.00
16.00	RADI OLOGY-DI AGNOSTI C CT SCAN	57.00	2, 785	0		0	16.00
17.00	MRI	58.00	920	0		0	17.00
18.00	LABORATORY	60.00	6, 556	0		o	18.00
19.00	RESPIRATORY THERAPY	65.00	22, 640	0		0	19.00
20. 00 21. 00	PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY	66.00 70.00	39, 832 1, 725	0 0		0	20.00 21.00
21.00 22.00	ENDOSCOPY	76.00	8, 274	0		0	21.00
23.00	I MAGI NG CENTER	76.06	9, 378	0		0	23.00

Heal th	Financial Systems	СОММ	JNI TY HOSPI TAL O				u of Form CMS-2552-	-10
RECLAS	SIFICATIONS			Provi der (CCN: 15-0169	Peri od:	Worksheet A-6	
						From 01/01/2018 To 12/31/2018	Date/Time Prepare 5/29/2019 3:05 pm	d:
		Decreases						
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref	₽.		
	6. 00	7.00	8.00	9.00	10.00			
24.00	EMERGENCY	91.00	2 <u>5, 8</u> 32	C		<u>o</u>	24.	00
	0		576, 827	C				
	H - Labor and Delivery							
1.00	ADULTS & PEDIATRICS	30.00	5, 922, 230	2, 480, 170	D	0		. 00
2.00		0.00	0	C		0	2.	. 00
	0		5, 922, 230	2, 480, 170)			
	I - Cafeteria Reclass							
1.00	DI ETARY	10.00	<u>1, 774, 8</u> 79	<u>1, 919, 7</u> 95		0	1.	. 00
	0		1, 774, 879	1, 919, 795	5			
	J - Therapy				T			
1.00	PHYSI CAL THERAPY	66.00	1, 389, 515	617, 780	D	0		. 00
2.00		0.00	0	C)	<u>o</u>	2.	. 00
	0		1, 389, 515	617, 780)			
	K - Depreciation by CC				1			
1.00	CAP REL COSTS-MVBLE EQUIP		0	<u>8,474,5</u> 65		2	1.	. 00
	0		0	8, 474, 565	5			
	L - Capital Insurance Costs							
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	36 <u>7, 9</u> 47		12	1.	. 00
	0		0	367, 947	7			
	M - Radiology Support							
1.00	RADI OLOGY-DI AGNOSTI C	54.00	359, 720	138, 185	5	0		. 00
2.00		0.00	0	C	D	0		. 00
3.00	L	0.00	0	C	<u> </u>	이	3.	. 00
	0		359, 720	138, 185				
500.00	Grand Total: Decreases		10, 023, 171	90, 472, 010	D		500.	00

		IUNI TY HOSPI TAL					u of Form CMS-2	
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-0169		iod: m 01/01/2018 12/31/2018	Worksheet A-7 Part I Date/Time Pre 5/29/2019 3:0	pared:
				Acqui si ti on	IS			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00	Land	497,000	757, 312		0	757, 312	0	1.00
2.00	Land Improvements	2, 722, 362	0		0	0	0	2.00
3.00	Buildings and Fixtures	174, 593, 288	3, 121, 087		0	3, 121, 087	658, 831	3.00
4.00	Building Improvements	1, 751, 624	845, 503		0	845, 503	0	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	108, 146, 114	5, 301, 513		0	5, 301, 513	1, 831, 439	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	287, 710, 388	10, 025, 415		0	10, 025, 415	2, 490, 270	8.00
9.00	Reconciling Items	0	0		0	0	0	
10.00	Total (line 8 minus line 9)	287, 710, 388	10, 025, 415		0	10, 025, 415	2, 490, 270	10.00
		Endi ng Bal ance	Fully					
		5	Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00	Land	1, 254, 312	0					1.00
2.00	Land Improvements	2, 722, 362	0					2.00
3.00	Buildings and Fixtures	177, 055, 544	0					3.00
4.00	Building Improvements	2, 597, 127	o					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	111, 616, 188	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	295, 245, 533	0					8.00
9.00	Reconciling Items	0	o					9.00
10.00	Total (line 8 minus line 9)	295, 245, 533	o					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0169 Period: From 01/01/2018 From 01/01/2018 Worksheet A-7 Part II Date/Time Prepared: 5/29/2019 3:05 pm SUMMARY OF CAPITAL Provider CCN: 15-0169 Period: From 01/01/2018 From 01/01/2018 Worksheet A-7 Part II Date/Time Prepared: 5/29/2019 3:05 pm Cost Center Description Depreciation Lease Interest Insurace (see instructions) Instructions) O 10.00 CAP REL COSTS-BLOG & FIXT O O O O O 1.00 O <th co<="" th=""><th>Heal th</th><th>Financial Systems COMM</th><th>IUNI TY HOSPI TAL</th><th>OF INDIANA, I</th><th>INC.</th><th>In Lie</th><th>u of Form CMS-2</th><th>2552-10</th></th>	<th>Heal th</th> <th>Financial Systems COMM</th> <th>IUNI TY HOSPI TAL</th> <th>OF INDIANA, I</th> <th>INC.</th> <th>In Lie</th> <th>u of Form CMS-2</th> <th>2552-10</th>	Heal th	Financial Systems COMM	IUNI TY HOSPI TAL	OF INDIANA, I	INC.	In Lie	u of Form CMS-2	2552-10
To 12/31/2018 Date/Time Prepared: 5/29/2019 3:05 pm SUMMARY OF CAPITAL Depreciation Lease Interest Insurance (see instructions) Taxes (see instructions) 9.00 10.00 11.00 12.00 13.00 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 2.00 CAP REL COSTS-MUBLE EQUIP 0 0 0 0 3.00 Total (sum of lines 1-2) 0 0 0 0 0 SUMMARY OF CAPITAL 0 0 0 0 0 0 2.00 CAP REL COSTS-MUBLE EQUIP 0 0 0 0 0 3.00 Total (sum of lines 1-2) 0 0 0 0 0 0 0 0 0 0 0 0 0 1.00 CAP REL COSTS-MUBLE FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 15.00 14.00 15.00 14.00 15.00 1.00 CAP REL COSTS-MUBLE EQUIP 0 0 0 0 2.00 <td>RECONC</td> <td>ILIATION OF CAPITAL COSTS CENTERS</td> <td></td> <td>Provi der</td> <td>CCN: 15-0169</td> <td></td> <td></td> <td></td>	RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 15-0169				
SUMMARY OF CAPITAL SUMMARY OF CAPITAL Depreciation Lease Interest Insurance (see Taxes (see Instructions) 9.00 10.00 11.00 12.00 13.00 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 0 2.00 CAP REL COSTS-MUBLE EQUIP 0 0 0 0 0 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 0 0 0 3.00 SUMMARY OF CAPITAL 0 0 0 0 0 0 0 1.00 2.00 CAP REL COSTS-MUBLE EQUIP 0 0 0 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 0 3.00 Cost Center Description Other Total (1) (sum 0 0 15.00 14.00 15.00 14.00 15.00 PART 11 - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>									
SUMMARY OF CAPITAL Cost Center Description Depreciation Lease Interest Insurance (see instructions) Taxes (see instructions) 9.00 10.00 11.00 12.00 13.00 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 0 1.00 3.00 Total (sum of lines 1-2) 0 0 0 0 0 0 3.00 Cost Center Description Other Capital -Relate of costs (see instructions) Total (1) (sum of capital -Relate of costs (see instructions) 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>10 12/31/2018</td><td></td><td></td></t<>						10 12/31/2018			
Cost Center Description Depreciation Lease Interest Insurance (see instructions) Taxes (see instructions) 9.00 10.00 11.00 12.00 13.00 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 1.00 2.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 0 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 3.00 3.00 SUMMARY OF CAPITAL Cost Center Description Other Capital -Relate d Costs (see instructions) Total (1) (sum of cols. 9 through 14)		· · · · · · · · · · · · · · · · · · ·					0/29/2019 3.0	5 pili	
PART 11 - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 instructions) instructions) 1.00 CAP REL COSTS-BLDG & FIXT 0					JUNIMART OF CAL	TIAL			
PART 11 - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT 0		Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see		
PART 11 - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT 0						instructions)	instructions)		
1.00 CAP REL COSTS-BLDG & FIXT 0 <td< td=""><td></td><td></td><td>9.00</td><td>10.00</td><td>11.00</td><td>12.00</td><td>13.00</td><td></td></td<>			9.00	10.00	11.00	12.00	13.00		
2.00 CAP REL COSTS-MVBLE EQUIP 0 <td< td=""><td></td><td>PART II - RECONCILIATION OF AMOUNTS FROM WOR</td><td>KSHEET A, COLUM</td><td>N 2, LINES 1</td><td>and 2</td><td></td><td></td><td></td></td<>		PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1	and 2				
3.00 Total (sum of lines 1-2) 0 0 0 0 0 0 3.00 SUMMARY OF CAPITAL Cost Center Description 0 0 0 0 0 0 0 0 3.00 Other Capital -Relate d Costs (see instructions) Total (1) (sum of cols. 9 through 14) 0 14.00 15.00 1	1.00	CAP REL COSTS-BLDG & FIXT	0		0	0 0	0	1.00	
Cost Center Description SUMMARY OF CAPITAL Other Total (1) (sum Capital -Relate of cols. 9 d Costs (see through 14) instructions) 14.00 1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP	2.00	CAP REL COSTS-MVBLE EQUIP	0		0	0 0	0	2.00	
Cost Center Description Other Capital -Relate d Costs (see instructions) Total (1) (sum of cols. 9 through 14) 14.00 Total (1) (sum of cols. 9 through 14) PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 11.00 15.00 1.00 CAP REL COSTS-BLDG & FIXT 0 0 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 1.00	3.00	Total (sum of lines 1-2)	0		0	0 0	0	3.00	
Capital -Relate d Costs (see instructions) of cols. 9 through 14) 14.00 through 14) 15.00 PART 11 - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP 0 0 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 2.00			SUMMARY 0	F CAPITAL					
Capital -Relate d Costs (see instructions) of cols. 9 through 14) 14.00 through 14) 15.00 PART 11 - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP 0 0 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 2.00									
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT 0 0 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 2.00		Cost Center Description	Other		ım				
instructions) instructions) 14.00 15.00 PART 11 - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT 0 0 2.00 CAP REL COSTS-MVBLE EQUIP 0 0									
14.00 15.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT 0 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 2.00				through 14)					
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT 0 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 2.00					_				
1.00 CAP REL COSTS-BLDG & FI XT 0 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 2.00									
2.00 CAP REL COSTS-MVBLE EQUI P 0 0 2.00			KSHEET A, COLUM	N 2, LINES 1	and 2				
			0		0				
3.00 Total (sum of lines 1-2) 0 0 3.00			0		0				
	3.00	Total (sum of lines 1-2)	0		0			3.00	

		COMMUNI TY HOSPI TAL	OF INDIANA, IN	NC.	In Lie	u of Form CMS-2	552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2018 To 12/31/2018	Worksheet A-7 Part III Date/Time Prep 5/29/2019 3:05	pared: 5 pm
		COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	PART III - RECONCILIATION OF CAPITAL COST	1.00	2.00	3.00	4.00	5.00	
1.00 2.00 3.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	179, 359, 840 71, 670, 112 251, 029, 952	0	179, 359, 840 71, 670, 112 251, 029, 952 CAPI TAL	0. 285504	0 0 F CAPITAL	1.00 2.00 3.00
	Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COST	S CENTERS	-	-		-	
1.00 2.00 3.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	0			8, 474, 565 11, 131, 436 19, 606, 001		1.00 2.00 3.00
3.00			SI	JMMARY OF CAPI		4,030,773	3. 00
	Cost Center Description		Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COST				-		
1.00 2.00 3.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	4, 387, 371 0 4, 387, 371	0	C		13, 229, 883 15, 962, 411 29, 192, 294	1.00 2.00 3.00

Health Financial Systems

COMMUNITY HOSPITAL OF INDIANA, INC.

In Lieu of Form CMS-2552-10

					rom 01/01/2018 o 12/31/2018	Date/Time Prep 5/29/2019 3:05	
				Expense Classification on To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
. 00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00 0	1.00
. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
	COSTS-MVBLE EQUIP (chapter 2)		0				3.00
. 00	Investment income - other (chapter 2)		0		0.00		
00	Trade, quantity, and time discounts (chapter 8)	В	0	ADMI NI STRATI VE & GENERAL	5.00	0	4.00
00	Refunds and rebates of expenses (chapter 8)	В	-26, 173	ADMI NI STRATI VE & GENERAL	5.00	0	5.00
00	Rental of provider space by		0		0.00	0	6.00
00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		0		0.00	О	7.00
00	21) Television and radio service (chapter 21)		0		0.00	0	8.00
	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -519, 470		0.00	0 0	9. 00 10. 00
1. 00	Sale of scrap, waste, etc.		0		0.00	0	11.00
	(chapter 23) Related organization transactions (chapter 10)	A-8-1	2, 344, 403			0	12.00
	Laundry and linen service Cafeteria-employees and guests	B	0 -2, 372, 374	ΟΛΕΕΤΕΡΙΛ	0.00 11.00		
	Rental of quarters to employee and others		-2, 372, 374		0.00	0	15.00
6. 00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
7.00	Sale of drugs to other than patients		0		0.00	0	17.00
3. 00	Sale of medical records and		0		0.00	0	18.00
9. 00	abstracts Nursing and allied health education (tuition, fees,		0		0.00	О	19.00
	books, etc.) Vending machines Income from imposition of interest, finance or penalty charges (chapter 21)		0 0		0. 00 0. 00	0 0	20. 00 21. 00
2. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
3. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
4. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
5. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	UTILIZATION REVIEW-SNF	114.00		25.00
6. 00	(chapter 21) Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	о	26.00
	Depreciation - CAP REL COSTS-MVBLE EQUIP			CAP REL COSTS-MVBLE EQUIP	2.00		
	Non-physician Anesthetist Physicians' assistant		0 0	NONPHYSICIAN ANESTHETISTS	19.00 0.00		28.00 29.00
	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
). 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
1.00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
2. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32.00
3. 00	Depreciation and Interest MISC REVENUE		0		0.00	о	33.00

ADJUSTMEN [®]	TS TO EXPENSES				Peri od:	Worksheet A-8	
					From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 3:0	
				Expense Classification or	n 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	
	sc Revenue	В		EMPLOYEE BENEFITS DEPARTMEN		0	
	sc Revenue	В		ADMINISTRATIVE & GENERAL	5.00		00.02
	sc Revenue	В		OPERATION OF PLANT	7.00		33.03
	sc Revenue	В		DI ETARY	10.00		00.0.
	sc Revenue	В		NURSING ADMINISTRATION	13.00	0	00.00
	sc Revenue	В		PHARMACY	15.00	0	00.00
	sc Revenue	В		ADULTS & PEDIATRICS	30.00		33.07
	sc Revenue	В		NEONATAL INTENSIVE CARE UNI			
	sc Revenue	В		OPERATING ROOM	50.00		
	sc Revenue	В		RADI OLOGY-DI AGNOSTI C	54.00		
	sc Revenue	В	-116, 800		58.00		
	sc Revenue	В		LABORATORY	60.00		
	sc Revenue	В		PHYSI CAL THERAPY	66.00		001.10
	sc Revenue	В		ELECTROENCEPHALOGRAPHY	70.00		
	sc Revenue	В		EMERGENCY	91.00		00.10
	F Tax Offset	А		ADMINISTRATIVE & GENERAL	5.00	0	000
	Non-Allow Interest Expense	А		CAP REL COSTS-BLDG & FIXT	1.00		34.01
	C Non-Allow Interest Expense	A		CAP REL COSTS-BLDG & FIXT	1.00		
	A Non-Allow Interest Expense	A		CAP REL COSTS-BLDG & FIXT	1.00		
	3 Non-Allow Interest Expense	A		CAP REL COSTS-BLDG & FIXT	1.00		
Exp	M BMO Non-Allow Interest pense	A	-123, 905	CAP REL COSTS-BLDG & FIXT	1.00	11	34.05
	AB Non-Allow Interest Dense	A	-882, 514	CAP REL COSTS-BLDG & FIXT	1.00	11	34.06
	n-Allow Debt Issuance	А	74, 866	ADMI NI STRATI VE & GENERAL	5.00	0	34.07

-1, 226 ADMI NI STRATI VE & GENERAL

-75, 500 ADMI NI STRATI VE & GENERAL -293, 970 NEONATAL I NTENSI VE CARE UNI T

127, 131 CARDI AC CATHETERI ZATI ON -294, 258 ELECTROCARDI OLOGY

-51, 025 CAFETERI A

-32, 445, 978

5.00

11.00

5.00 35.00

59.00

69.00

0 34.08

0 36.00

0 36.01

0 36.02

0 36.03

0 36.04

50.00

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. Note: See instructions for column 5 referencing to Worksheet A-7.

B. Amount Received - if cost cannot be determined.

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

А

А

А

А

А

А

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

Expense

Loss on Assets

36.00 Meals of Wheels Cost

Nurse Practitioner Offset

CARDIAC MONITORING SHARED

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

CARDIAC CATH SHARED SERVICES

TOTAL (sum of lines 1 thru 49)

Sponsorshi p

SERVI CES

34.08

36. 01

36.02

36.03

36.04

50.00

Heal th	Financial Systems	COMMUNI TY HOSPI TAI	_ OF INDIANA, INC.	In Lie	eu of Form CMS-:	2552-10
STATEME OFFICE	ENT OF COSTS OF SERVICES FROM COSTS	RELATED ORGANIZATIONS AND HO		Period: From 01/01/2018		
				To 12/31/2018	Date/Time Pre 5/29/2019 3:0	
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTM	IENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00		I&R SERVICES-SALARY & FRINGE		406, 401	0	1.00
2.00		I&R SERVICES-OTHER PRGM COST		621, 282		2.00
3.00		ADMINISTRATIVE & GENERAL	7250 CLEARVI STA	238, 275		3.00
3.01		ELECTROENCEPHALOGRAPHY	7250 CLEARVI STA	122, 126	96, 906	3.01
3.02		PHARMACY	7250 CLEARVI STA	4, 465	3, 543	3. 02
4.00		CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	5, 728, 817	0	4.00
4.01		EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	5, 357, 120		4.01
4.02		ADMINISTRATIVE & GENERAL	HOME OFFICE	53, 376, 651	75, 243, 279	4.02
4.03		OPERATION OF PLANT	HOME OFFICE	580, 400	0	4.03
4.04		NURSING ADMINISTRATION	HOME OFFICE	4, 683, 676	0	4.04
4.05		CENTRAL SERVICES & SUPPLY	HOME OFFICE	1, 330, 339	0	4.05
4.06		MEDICAL RECORDS & LIBRARY	HOME OFFICE	2, 667, 433	0	4.06
4.07		ADULTS & PEDIATRICS	HOME OFFICE	797, 906	0	4.07
4.08		RADI OLOGY-DI AGNOSTI C	HOME OFFICE	105, 223	0	4.08
4.09		ELECTROCARDI OLOGY	HOME OFFICE	49, 036	0	4.09
4.10		ELECTROENCEPHALOGRAPHY	HOME OFFICE	336, 711	0	4.10
4.11		DRUGS CHARGED TO PATIENTS	HOME OFFICE	454, 036	0	4.11
4.12		ADULTS & PEDIATRICS	HOME OFFICE	36, 404	0	4.12
4.13		ADMINISTRATIVE & GENERAL	CPN MEDICAL DIRECTOR AND CAL		1	4.13
5.00	TOTALS (sum of lines 1-4).			77, 881, 065	75, 536, 662	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

1103 1	not been posted to worksheet A, cordinars r and/or 2, the anount arrowable should be marcated rife or diar 4 or this part.							
				Related Organization(s) and/	or Home Office			
	Symbol (1)	Name	Percentage of	Name	Percentage of			
			Ownershi p		Ownershi p			
	1.00	2.00	3.00	4.00	5.00			
	B. INTERRELATIONSHIP TO 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	В	CHNW	100.00		0.00	6.00	
7.00			0.00		0.00	7.00	
8.00			0.00		0.00	8.00	
9.00			0.00		0.00	9.00	
10.00			0.00		0.00	10.00	
100.00	G. Other (financial or					100.00	
	non-financial) specify:						

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

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

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

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

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

E. Individual is director, officer, administrator, or key person of provider and related organization. F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems	COMMUNITY HOSPITAL O	FINDIANA, INC.	In Lie	u of Form CMS-2552-10
	VICES FROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0169	Peri od:	Worksheet A-8-1
OFFICE COSTS			From 01/01/2018	
			10 12/31/2018	Date/Time Prepared:
				5/29/2019 3:05 pm
Net Wkst.	. A-7 Ref.			
Adjustments				
(col. 4 minus				

	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE COS	STS:		
1.00	406, 401	0		1.00
2.00	621, 282	0		2.00
3.00	45, 341	0		3.00
3.01	25, 220	0		3. 01
3.02	922	0		3. 02
4.00	5, 728, 817	9		4.00
4.01	5, 357, 120	0		4.01
4.02	-21, 866, 628	0		4.02
4.03	580, 400	0		4.03
4.04	4, 683, 676	0		4.04
4.05	1, 330, 339	0		4.05
4.06	2, 667, 433	0		4.06
4.07	797, 906	0		4.07
4.08	105, 223	0		4.08
4.09	49, 036	0		4.09
4.10	336, 711	0		4.10
4.11	454, 036	0		4. 11
4.12	36, 404	0		4. 12
4.13	984, 764	0		4.13
5.00	2, 344, 403			5.00
* The	amounts on line	es 1-4 (and sub	scripts as appropriate) are transferred in detail to Worksheet A. column 6. lines as	

* 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

1103 110	been posted to norkaneet A,		iount anowable shoul	u be mulcated micorulini 4 of	this part.			
	Related Organization(s)							
	and/or Home Office							
	Type of Business							
	6.00							
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

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

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

i ci indui		
6.00 7.00	6.00	
7.00	7.00	
8.00 9.00 10.00 100.00	8.00	
9.00	9.00	
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 organi zati on.

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

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

Health Financial Systems

COMMUNI TY	HOSPI TAL	0F	I NDI ANA,	INC.

In Lieu of Form CMS-2552-10

	Financial Syste		MUNITY HUSPITAL	_ OF TINDIANA, T			eu or Form CMS-	
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider C	CN: 15-0169	Period:	Worksheet A-8	3-2
						From 01/01/2018	}	
						To 12/31/2018	B Date/Time Pre 5/29/2019 3:0	epared:
	What Alipa #	Cost Center/Physician	Tatal	Drafacaianal	Dravidar	DCE Amount		o pili
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		l denti fi er	Remuneration	Component	Component		ider Component	
	1.00				F 00	(00	Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	AGGREGATE-ADMI NI STRATI VE &	529, 753	138, 507	391, 246	211, 500	1, 773	1.00
		GENERAL						
2.00	35.00	AGGREGATE-NEONATAL INTENSIVE	170, 000	170, 000	0	0	0	2.00
		CARE UN						
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			699, 753	308, 507	391, 246		1, 773	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er		Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9,00	12.00	13.00	14.00	
1.00		AGGREGATE-ADMI NI STRATI VE &	180, 283	9, 014	0			1.00
		GENERAL						
2.00	35.00	AGGREGATE-NEONATAL INTENSIVE	0	0	0	0	0	2.00
		CARE UN						
3.00	0.00		l o	0	0	l o	0	3.00
4.00	0.00		l o	0	0	l o	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0		0	9.00
10.00	0.00			0	0	0	0	10.00
200.00	0.00		180, 283	9, 014	0		0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	WKSL A LINE #	I denti fi er	Component	Limit	Di sal l owance	Aujustment		
		Identifier	Share of col.	L1 III L	DISATIOWANCE			
			14					
	1.00	2.00	15. 00	16.00	17.00	18.00	-	
1.00		AGGREGATE-ADMI NI STRATI VE &	0	180, 283	210, 963			1.00
1.00	5.00	GENERAL	0	100, 203	210, 703	347,470		1.00
2.00	35.00	AGGREGATE-NEONATAL INTENSIVE	0	0	0	170,000		2.00
2.00	33.00	CARE UN	0	0	0	170,000		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00			0	0			4.00
4.00 5.00	0.00			0	0			4.00 5.00
5.00 6.00	0.00		0	0	0			6.00
	0.00			0	0			
7.00			-	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			0	180, 283	210, 963	519, 470		200. 00

	Financial Systems COMM LLOCATION - GENERAL SERVICE COSTS	UNI TY HOSPI TAL	OF INDIANA, IN Provider CC	CN: 15-0169 P	In Lie eriod: rom 01/01/2018 o 12/31/2018	u of Form CMS-: Worksheet B Part I Date/Time Pre 5/29/2019 3:0	pared:
			CAPI TAL REL	ATED COSTS		572772017 5.0	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	13, 229, 883	13, 229, 883		I		1.00
2.00 4.00 5.00 7.00 8.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	15, 962, 411 5, 528, 173 63, 465, 869 10, 863, 495 876, 929	27, 080 402, 992 1, 763, 950 46, 798	15, 962, 411 7, 976, 834 3, 231, 753 10, 572 40	13, 532, 087 753, 344 410, 593 0	67, 853, 958 13, 048, 610 923, 767	2.00 4.00 5.00 7.00 8.00
10. 00 11. 00 13. 00 14. 00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	4, 815, 889 1, 562, 615 1, 271, 275 7, 094, 423 710, 045 4, 883, 962	107, 671 115, 971 319, 953 18, 857 301, 422 146, 264	3, 912 4, 390 12, 809 1, 706 871, 713 292, 558	86, 363 241, 218 275, 264 0	5, 320, 061 1, 769, 339 1, 845, 255 7, 390, 250 1, 883, 180 5, 950, 008	11.00 13.00 14.00
16.00 17.00 19.00 21.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	3, 109, 625 1, 830, 448 0 406, 401 621, 282	18, 321 21, 381 0 0	40 18 0 0	51, 899 193, 946 0 0	3, 179, 885 2, 045, 793 0 406, 401 621, 282	16.00
31.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 02060 NEONATAL I NTENSI VE CARE UNI T	38, 224, 811 5, 786, 886 8, 467, 235	4, 082, 816 884, 031 797, 550	325, 748 92, 410 84, 370	585, 541	46, 219, 656 7, 348, 868 10, 251, 169	31.00
40. 00 43. 00	04000 SUBPROVI DEL ENTRE - I PF 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	2, 121, 792 2, 407, 581	139, 781 379, 756	8, 671 23, 978	218, 264	2, 488, 508 3, 041, 939	40.00
51. 00 52. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	9, 707, 530 3, 229, 851 6, 546, 963 4, 245, 932	602, 059 332, 212 945, 574 198, 627	756, 344 4, 091 59, 704 209, 886	322, 048 646, 642	11, 723, 444 3, 888, 202 8, 198, 883 5, 081, 012	51.00 52.00
55.00 57.00 58.00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MRI	797, 246 1, 392, 380 865, 714	201, 725 26, 679 111, 725	202, 064 128, 277 132, 288	70, 466 140, 350 70, 885	1, 271, 501 1, 687, 686 1, 180, 612	55.00 57.00 58.00
60. 00 64. 00 65. 00 66. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	127, 176 9, 410, 944 384, 652 3, 807, 303 5, 636, 256 1, 687, 272	0 115, 799 157, 663 125, 246 0 0	628 5, 436 1, 517 119, 692 433, 210 18, 207	3, 441 39, 594 369, 976 593, 189	127, 804 9, 535, 620 583, 426 4, 422, 217 6, 662, 655 1, 864, 216	60.00 64.00 65.00 66.00
68.00 69.00 70.00 71.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 I MPL. DEV. CHARGED TO PATI ENTS	320, 023 613, 863 1, 773, 180 19, 073, 633 12, 842, 066	0 0 30, 695 0 0	3, 453 4, 885 106, 781 0 0	30, 107	353, 583 622, 488 2, 038, 970 19, 073, 633 12, 842, 066	68.00 69.00 70.00 71.00 72.00
74.00 76.00 76.06	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 03330 ENDOSCOPY 03954 IMAGING CENTER 03955 BREAST DIAGNOSTIC CENTER	14, 729, 369 1, 182, 740 1, 848, 558 2, 606, 910 7, 762, 650	0 2, 391 161, 545 0 0	0 0 198, 336 416, 845 127, 503	187, 985	14, 729, 369 1, 185, 131 2, 361, 766 3, 211, 740 7, 890, 153	74.00 76.00 76.06
90.00 90.26 91.00	OUTPATI ENT SERVICE COST CENTERS 09000 CLINIC 04975 SPINE CENTER 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0 247, 630 9, 420, 735	0 0 554, 171	0 241 63, 000	25, 213	0 273, 084 10, 914, 541 0	90. 00 90. 26 91. 00
113. 00 114. 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF	212 501 (0)	12 140 705	15,022,042	12 450 001		113.00 114.00
190.00 191.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	313, 501, 606 0 0	13, 140, 705 76, 728 0	15, 933, 910 0 0 0	0	0	190. 00 191. 00
193.00 194.00	19200 PHYSI CLANS' PRI VATE OFFI CES 19300 NONPAI D WORKERS 07950 HOME OFFI CE 07956 PAVI LLI ONS	116, 952 0 0 72, 804	0 0 0 0	0 0 0 0	0 0 0 0	0	192.00 193.00 194.00 194.06
194.08	07958 OTHER NRCC 07960 COMMUNITY REHAB HOSPITAL Cross Foot Adjustments	1, 639, 686 0	12, 450 0	28, 501 0 0	72, 196 0	1, 752, 833 0 0	
201.00		315, 331, 048	13, 229, 883	15, 962, 411	13, 532, 087	315, 331, 048	

COST A	Financial Systems COM NLLOCATION - GENERAL SERVICE COSTS	MUNI TY HOSPI TAL	Provider C	CN: 15-0169 P F	Period: From 01/01/2018 To 12/31/2018	u of Form CMS- Worksheet B Part I Date/Time Pre	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	5/29/2019 3: 0 DI ETARY	5 pm
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS			1			
. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
1.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	67, 853, 958					5.00
7.00	00700 OPERATION OF PLANT	3, 577, 707	16, 626, 317				7.00
3.00	00800 LAUNDRY & LINEN SERVICE	253, 281	70, 504	1, 247, 552			8.0
9.00	00900 HOUSEKEEPI NG	1, 458, 670	162, 214	623, 776	7, 564, 721		9.0
0.00	01000 DI ETARY	485, 123	174, 719	C	80, 623	2, 509, 804	10.0
1.00	01100 CAFETERI A	505, 938	482, 032	C	222, 431	0	11.0
3.00	01300 NURSING ADMINISTRATION	2, 026, 281	28, 409	C	13, 109	0	13.0
4.00	01400 CENTRAL SERVICES & SUPPLY	516, 336	454, 113	C	209, 548	0	14.0
15.00	01500 PHARMACY	1, 631, 391	220, 358		101, 683	0	15.0
6.00	01600 MEDICAL RECORDS & LIBRARY	871, 870	27, 602	C	12, 737	0	16.0
7.00	01700 SOCIAL SERVICE	560, 922	32, 212	1		0	17.0
9.00	01900 NONPHYSICIAN ANESTHETISTS	0	C	c	0	0	19.0
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	111, 428	C	c	0 0	0	21.0
22.00		170, 345	C	c	0 0	0	22.0
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · ·					
30.00	03000 ADULTS & PEDIATRICS	12, 672, 588	6, 151, 058	232, 762	2, 838, 365	1, 650, 318	1 30. O
31.00	03100 INTENSIVE CARE UNIT	2,014,935	1, 331, 856	C	614, 576	172, 730	31.0
35.00	02060 NEONATAL INTENSIVE CARE UNIT	2, 810, 696	1, 201, 566	42, 371	554, 455	357, 490	35.0
10.00	04000 SUBPROVIDER - IPF	682, 307	210, 590			107, 953	40. C
3.00	04300 NURSERY	834, 048	572, 129			221, 313	1
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3, 214, 369	907, 045	C	418, 550	0	1 50. C
1.00	05100 RECOVERY ROOM	1,066,079	500, 501			0	51. C
2.00	05200 DELIVERY ROOM & LABOR ROOM	2, 247, 994	1, 424, 575	82, 114	657, 361	0	52.0
4.00	05400 RADI OLOGY-DI AGNOSTI C	1, 393, 127	299, 246	c	138, 085	0	54.0
5.00	05500 RADI OLOGY - THERAPEUTI C	348, 624	303, 914			0	55.0
57.00	05700 CT SCAN	462, 735	40, 193			0	57.0
58.00	05800 MRI	323, 704	168, 322			0	58.0
59.00	05900 CARDI AC CATHETERI ZATI ON	35, 042	0			0	59.0
50.00	06000 LABORATORY	2, 614, 505	174, 459	c c	80, 503	0	
4.00	06400 INTRAVENOUS THERAPY	159, 965	237, 530			0	64. C
5.00	06500 RESPI RATORY THERAPY	1, 212, 497	188, 693		87, 071	0	65. C
6. 00	06600 PHYSI CAL THERAPY	1, 826, 787	C			0	
57.00	06700 OCCUPATI ONAL THERAPY	511, 136	0		-	0	
8.00	06800 SPEECH PATHOLOGY	96, 946	0			0	
9.00	06900 ELECTROCARDI OLOGY	170, 676	0		-	0	
0.00	07000 ELECTROENCEPHALOGRAPHY	559, 051	46, 244		-	0	
1.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	5, 229, 666	0			0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	3, 521, 076	0			0	
	07300 DRUGS CHARGED TO PATIENTS	4,038,543	0			0	
	07400 RENAL DI ALYSI S	324, 943	3, 602	-	-	0	
6.00	03330 ENDOSCOPY	647, 556	243, 379			0	
		880, 605	210,077			0	
	03955 BREAST DI AGNOSTI C CENTER	2, 163, 346	C	c c	0	0	
	OUTPATIENT SERVICE COST CENTERS		-				
0.00	09000 CLI NI C	0	0	C	0 0	0	90.0
0. 26	04975 SPINE CENTER	74, 875	C	C	0 0	0	90.2
1.00		2, 992, 582	834, 899	210, 910	385, 259	0	
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.0
	SPECIAL PURPOSE COST CENTERS	· · ·					
13.00	11300 INTEREST EXPENSE						113. 0
14.00	11400 UTILIZATION REVIEW-SNF						114. (
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	67, 300, 295	16, 491, 964	1, 247, 552	7, 502, 725	2, 509, 804	118. (
	NONREIMBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	21, 038	115, 596				190. (
	19100 RESEARCH	0	0	C	0 0		191. (
92.00	19200 PHYSI CLANS' PRI VATE OFFI CES	32, 066	C	C	0	0	192. (
93.00	19300 NONPAI D WORKERS	0	C	C	0		193. (
	07950 HOME OFFICE	0	C	C	0		194.
94.06	07956 PAVI LLI ONS	19, 962	C	C	0		194. (
	07958 OTHER NRCC	480, 597	18, 757	0	8, 655		194. (
	07960 COMMUNITY REHAB HOSPITAL	0	0		0		194.
200.00			0	l	Ĭ	0	200. 0
		0	0	0	0	0	201.0
01.00		01					

	/UNITY HOSPITAL				u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod: com 01/01/2018 0 12/31/2018	Worksheet B Part I Date/Time Pre	pared:
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	5/29/2019 3: 0 MEDI CAL RECORDS & LI BRARY	5 pm
	11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						1 1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-WVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 007000 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE						1.00 2.00 4.00 5.00 7.00 8.00
9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY 11. 00 01100 CAFETERIA	3, 055, 656					9.00 10.00 11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	78, 838 0 144, 083 13, 593	4, 768, 443 0	7, 831, 620 3, 915, 789 23	11, 963, 312 5, 981, 654	10, 087, 364	13.00 14.00 15.00 16.00
17.00 01700 SOCI AL SERVICE 19.00 01900 NONPHYSICI AN ANESTHETISTS 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	54, 371 0 0	0 0 0	155 0 0	0 0 0	0 0 0	17.00 19.00 21.00
22. 00 02200 I & SERVI CES-OTHER PRGM COSTS APPRV I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	0	22.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	1, 062, 954 165, 832	358, 221	203, 424 33, 708	0 0	1, 218, 658 163, 584	31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF 43. 00 04300 NURSERY	233, 796 59, 808 67, 964	129, 194	24, 638 5, 246 12, 209	0 0 0	628, 884 55, 664 68, 064	40.00
ANCI LLARY SERVI CE COST CENTERS						1
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	193, 017 84, 275		200, 942 28, 859	0	1, 302, 910 248, 856	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	165, 832		30, 399	0	158, 218	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	114, 179		13, 632	0	285, 499	
55. 00 05500 RADI OLOGY-THERAPEUTI C	19,030		13, 773	0	217, 885	
57. 00 05700 CT_SCAN 58. 00 05800 MRI	38, 060 19, 030		1, 002 241	0	523, 012 138, 620	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	19,030	1 1	4	0	138, 620	
60. 00 06000 LABORATORY	0	0	151, 234	0	894, 116	
64.00 06400 I NTRAVENOUS THERAPY	10, 874		805	0	7, 433	
65. 00 06500 RESPI RATORY THERAPY	100, 587		21, 349	0	205, 966	1
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	38, 060 38, 060		12, 284 3, 240	0	197, 845 55, 923	
68. 00 06800 SPEECH PATHOLOGY	8, 156		615	0	16, 211	
69. 00 06900 ELECTROCARDI OLOGY	2, 719		66	0	74, 034	
70. 00 07000 ELECTROENCEPHALOGRAPHY	40, 778		10, 606	0	88, 311	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0		1, 803, 717	0	568, 591	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	1, 214, 423 0	0 5, 981, 658	322, 297 770, 808	
74. 00 07400 RENAL DI ALYSI S	0	0	177	0, 701, 000	23, 959	
76. 00 03330 ENDOSCOPY	43, 497	0	20, 454	0	166, 135	76.00
76.06 03954 I MAGI NG CENTER	0	0	11, 091	0	366, 719	
76. 07 03955 BREAST DI AGNOSTI C CENTER OUTPATI ENT SERVI CE COST CENTERS	0	0	426	0	138, 991	76.07
90. 00 09000 CLINIC	0	0	0	0	0	90.00
90. 26 04975 SPI NE CENTER	0	0	570	0	4, 232	90.26
91.00 09100 EMERGENCY	258, 263	557, 884	90, 999	0	1, 158, 390	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92.00
113. 00 11300 INTEREST EXPENSE						113.00
114.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 055, 656	9, 536, 887	7, 826, 100	11, 963, 312	10, 087, 364	114.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0	0	190.00
191. 00 19100 RESEARCH	0	0	0	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	4, 119	0	0	192.00
193.00 19300 NONPALD WORKERS	0	0	0	0		193.00
194. 00 07950 HOME_OFFICE 194. 06 07956 PAVI LLI ONS	0	0	0	0		194.00 194.06
194. 08 07958 0THER_NRCC			486 915	0		194.06
194. 10 07960 COMMUNI TY REHAB HOSPI TAL	0	o	0	0		194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0 524 007	0	11 0/2 212		201.00
202.00 TOTAL (sum lines 118 through 201)	3, 055, 656	9, 536, 887	7, 831, 620	11, 963, 312	10, 087, 364	JZUZ. 00

	Financial Systems COMM LLOCATION - GENERAL SERVICE COSTS	IUNI TY HOSPI TAL			Period: From 01/01/2018	u of Form CMS- Worksheet B Part I	
					To 12/31/2018	Date/Time Pre 5/29/2019 3:0	
				I NTERNS	& RESIDENTS		[
	Cost Center Description	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	Y & FRINGES	RSERVICES-OTHER PRGM COSTS	Subtotal	
		17.00	19.00	APPRV 21.00	APPRV 22.00	24.00	
	GENERAL SERVICE COST CENTERS	1	1				
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSING ADMINISTRATION						13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY						15.00 16.00
	01700 SOCIAL SERVICE	2, 708, 317					17.00
	01900 NONPHYSICIAN ANESTHETISTS	0	C				19.00
21.00	02100 I & R SERVI CES-SALARY & FRI NGES APPRV	0		517, 82			21.00
22.00	02200 I & R SERVICES-OTHER PRGM COSTS APPRV I NPATI ENT ROUTI NE SERVICE COST CENTERS	0			791, 627		22.00
30.00	03000 ADULTS & PEDIATRICS	1, 780, 850	C	338, 60	0 517, 632	77, 183, 000	30.00
	03100 I NTENSI VE CARE UNI T	186, 392	C C		0 0	12, 390, 702	1
	02060 NEONATAL INTENSIVE CARE UNIT	385, 766			0 0	16, 995, 863	
40.00	04000 SUBPROVIDER - IPF	116, 491	C			4, 316, 533	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	238, 818	C		0 0	5, 500, 280	43.00
50.00	05000 OPERATI NG ROOM	0	C		0 0	18, 377, 222	50.00
51.00	05100 RECOVERY ROOM	0	C	þ	0 0	6, 047, 725	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	13, 323, 597	
	05400 RADI OLOGY-DI AGNOSTI C	0			0 0	7, 324, 780	1
55.00 57.00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	0			0 0	2, 324, 744 2, 771, 235	
58.00	05800 MRI	0	C C		0 0	1, 908, 200	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	180, 399	
60.00		0	C		0 0	13, 450, 437	
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0			0 0	1, 109, 640 6, 238, 380	
66.00	06600 PHYSI CAL THERAPY	0			0 0	8, 737, 631	1
67.00	06700 OCCUPATI ONAL THERAPY	0	C		0 0	2, 472, 575	
68.00	06800 SPEECH PATHOLOGY	0	C		0 0	475, 511	
69.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0			0 0	869, 983 2, 805, 299	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0 0	26, 675, 607	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	C		0 0	17, 899, 862	
	07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	25, 520, 378	
	07400 RENAL DI ALYSI S	0			0 0	1, 539, 474	
	03330 ENDOSCOPY 03954 I MAGI NG CENTER	0				3, 595, 093 4, 470, 155	
	03955 BREAST DI AGNOSTI C CENTER	0	C		0 0	10, 192, 916	
	OUTPATIENT SERVICE COST CENTERS	1					
	09000 CLI NI C 04975 SPI NE CENTER	0			0 0	0	90.00
	09100 EMERGENCY	0			0 0 0 61,960	352, 761 17, 506, 217	90.26 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		40, 30	01, 700	17, 300, 217	92.00
	SPECIAL PURPOSE COST CENTERS	л. Т					
	11300 I NTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF SUBTOTALS (SUM OF LINES 1 through 117)	2, 708, 317	c	517, 82	9 791, 627	312, 556, 199	114.00
110.00	NONREIMBURSABLE COST CENTERS	2,700,317		1 517,82	///////////////////////////////////////	512, 000, 199	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C)	0 0	266, 703	190.00
	19100 RESEARCH	0	C		0 0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0			0 0	153, 137	
	19300 NONPALD WORKERS 07950 HOME OFFICE			Ś			193.00 194.00
	07956 PAVI LLI ONS	0			o o		194.00
194.08	07958 OTHER NRCC	0	C	þ	0 0	2, 261, 757	
	07960 COMMUNITY REHAB HOSPITAL	0	C		0 0		194. 10
200.00 201.00					0 0		200.00
201.00		2, 708, 317		517,82	9 791, 627	0 315, 331, 048	201.00
_02.00	(++++++++++++++++++++++++	2, . 30, 017		1 317,02		2.3, 331, 040	1

	Financial Systems COMM LLOCATION - GENERAL SERVICE COSTS	UNI TY HOSPI TAL	OF INDIANA, IN Provider CO		Peri od:	In Lieu of Form Workshee	
					From 01/0 To 12/3	1/2018 Date/Tir	me Prepared:
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total			5729720	19 3:05 pm
	GENERAL SERVICE COST CENTERS	25.00	26.00				
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00
5.00 7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY						15.00
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE						16.00 17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS						19.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV						21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV						22.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	-856, 232	76, 326, 768				30.00
	03100 I NTENSI VE CARE UNI T	000,202	12, 390, 702	1			31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	0	16, 995, 863	1			35.00
40.00 43.00	04000 SUBPROVIDER - IPF	-350, 734 0	3, 965, 799	1			40.00 43.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	5, 500, 280	1			43.00
50.00	05000 OPERATI NG ROOM	0	18, 377, 222				50.00
	05100 RECOVERY ROOM	0	6,047,725				51.00
	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0	13, 323, 597 7, 324, 780				52.00 54.00
	05500 RADI OLOGY-THERAPEUTI C	0	2, 324, 744	1			55.00
57.00	05700 CT SCAN	0	2, 771, 235				57.00
58.00		0	1, 908, 200	1			58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	180, 399 13, 450, 437	1			59.00 60.00
64.00	06400 I NTRAVENOUS THERAPY	0	1, 109, 640	1			64.00
65.00	06500 RESPI RATORY THERAPY	0	6, 238, 380				65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	8, 737, 631 2, 472, 575				66.00 67.00
68.00	06800 SPEECH PATHOLOGY	0	475, 511				68.00
69.00	06900 ELECTROCARDI OLOGY	0	869, 983	1			69.00
	07000 ELECTROENCEPHALOGRAPHY	0	2, 805, 299				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	26, 675, 607 17, 899, 862				71.00
	07300 DRUGS CHARGED TO PATIENTS	0	25, 520, 378				73.00
	07400 RENAL DI ALYSI S	0	1, 539, 474				74.00
		0	3, 595, 093 4, 470, 155				76.00
	03954 I MAGI NG CENTER 03955 BREAST DI AGNOSTI C CENTER	0	4, 470, 155	•			76.06 76.07
, 0, 0,	OUTPATIENT SERVICE COST CENTERS		10/172/710				
	09000 CLINIC	0	0	•			90.00
	04975 SPINE CENTER 09100 EMERGENCY	0 -102, 490	352, 761 17, 403, 727				90.26 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	-102, 490	17,403,727				92.00
	SPECIAL PURPOSE COST CENTERS	· · · · · ·		1			
	11300 I NTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF SUBTOTALS (SUM OF LINES 1 through 117)	-1, 309, 456	311, 246, 743				114.00 118.00
	NONREI MBURSABLE COST CENTERS	1,007,100	0111/2101/110	1			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	266, 703				190.00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0 153 137				191.00 192.00
	19200 PHYSICIANS PRIVATE OFFICES	0	153, 137 0	1			192.00
194.00	07950 HOME OFFICE	0	0				194.00
	07956 PAVI LLI ONS	0	93, 252				194.06
194.08	07958 OTHER NRCC 07960 COMMUNITY REHAB HOSPITAL	0	2, 261, 757				194.08 194.10
10/ 10							
194. 10 200. 00		0	0				200.00
	Cross Foot Adjustments Negative Cost Centers	0 0 -1, 309, 456	0 0 0 314, 021, 592				

	Financial Systems COMM TION OF CAPITAL RELATED COSTS	IUNI TY HOSPI TAL	OF INDIANA, IN Provider CO		In Lie Period:	u of Form CMS- Worksheet B	2552-10
				F	rom 01/01/2018 o 12/31/2018	Part II	
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Di rectl y Assi gned New Capi tal	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS		1.00	2.00	211	1.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0	27,080	7, 976, 834	8, 003, 914	8, 003, 914	2.00 4.00
4.00 5.00	00500 ADMINI STRATI VE & GENERAL	0	402, 992			445, 586	•
7.00	00700 OPERATION OF PLANT	0	1, 763, 950			242, 857	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	46, 798			0	
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	107, 671 115, 971			232, 208 51, 082	•
11.00	01100 CAFETERI A	0	319, 953			142, 675	•
13.00	01300 NURSING ADMINISTRATION	0	18, 857			162, 812	1
14.00	01400 CENTRAL SERVICES & SUPPLY	0	301, 422			0	
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	146, 264 18, 321			370, 989 30, 697	
17.00	01700 SOCIAL SERVICE	0	21, 381			114, 715	•
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0			0	
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		-	0	
22.00	02200 I & R SERVICES-OTHER PRGM COSTS APPRV	0	0	C	0	0	22.00
30.00	03000 ADULTS & PEDIATRICS	0	4, 082, 816	325, 748	4, 408, 564	2, 121, 190	30.00
	03100 I NTENSI VE CARE UNI T	0	884, 031			346, 334	
35.00	02060 NEONATAL INTENSIVE CARE UNIT	0	797, 550			533, 522	
40.00 43.00	04000 SUBPROVIDER - IPF 04300 NURSERY	0	139, 781 379, 756			129, 098	
43.00	ANCI LLARY SERVI CE COST CENTERS	0	379,730	23, 978	403,734	136, 409	43.00
50.00	05000 OPERATI NG ROOM	0	602, 059	756, 344	1, 358, 403	388, 903	50.00
51.00	05100 RECOVERY ROOM	0	332, 212			190, 484	•
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0	945, 574			382, 474	
54.00 55.00	05500 RADI OLOGY-THERAPEUTI C	0	198, 627 201, 725			252, 305 41, 679	
57.00	05700 CT SCAN	0	26, 679			83, 014	
58.00	05800 MRI	0	111, 725			41, 927	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0 115, 799	628 5, 436		0 2, 035	59.00 60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	157, 663			2, 033	1
65.00	06500 RESPI RATORY THERAPY	0	125, 246			218, 833	1
66.00	06600 PHYSI CAL THERAPY	0	0	433, 210		350, 858	1
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	18, 207 3, 453		93, 890 17, 808	•
	06900 ELECTROCARDI OLOGY	0	0				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	30, 695			75, 895	•
	07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	0	0	C	0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	
	07400 RENAL DIALYSIS	0	2, 391		2, 391	0	74.00
	03330 ENDOSCOPY	0	161, 545			90, 690	•
	03954 I MAGI NG CENTER	0	0	416, 845		111, 189	
76.07	03955 BREAST DIAGNOSTIC CENTER OUTPATIENT SERVICE COST CENTERS	0	0	127, 503	127, 503	0	76.07
90.00	09000 CLINIC	0	0	C	0	0	90.00
	04975 SPI NE CENTER	0	0	241		14, 913	•
	09100 EMERGENCY	0	554, 171	63, 000		518, 510	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS	<u> </u>			0		92.00
113.00	11300 I NTEREST EXPENSE						113.00
	11400 UTI LI ZATI ON REVI EW-SNF						114.00
118.00		0	13, 140, 705	15, 933, 910	29, 074, 615	7, 961, 212	118.00
190 00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	76, 728	0	76, 728	0	190.00
	19100 RESEARCH	0	0	C	0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	0		192.00
	19300 NONPALD WORKERS 07950 HOME OFFICE	0	0	0	0		193.00
	07950 HOME OFFICE 07956 PAVI LLI ONS	0	0		0		194.00 194.06
	07958 OTHER NRCC	0	12, 450	28, 501	40, 951		194.08
	07960 COMMUNITY REHAB HOSPITAL	0	0	C	0	0	194. 10
200.00 201.00	5		~		0	<u>^</u>	200.00
201.00	0	0	13, 229, 883	15, 962, 411	29, 192, 294		
		, °I	., .,		, _, _,		

	Financial Systems COM TION OF CAPITAL RELATED COSTS	MUNI TY HOSPI TAL	OF INDIANA, IN Provider CO	CN: 15-0169 P	eri od:	u of Form CMS-: Worksheet B	2552-10
					rom 01/01/2018 o 12/31/2018	Date/Time Pre	pared:
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	5/29/2019 3:0 DI ETARY	5 pm
		& GENERAL	PLANT	LINEN SERVICE			
	GENERAL SERVICE COST CENTERS	5.00	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	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	4,080,331	2 222 524				5.00
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	215, 145 15, 231	2, 232, 524 9, 467				7.00 8.00
9.00	00900 HOUSEKEEPING	87, 717	21, 782				9.00
10.00	01000 DI ETARY	29, 173	23, 461			229, 289	10.00
11.00	01100 CAFETERI A	30, 425	64, 726			0	
13.00	01300 NURSI NG ADMI NI STRATI ON	121, 850	3, 815			0	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	31, 050 98, 104	60, 977 29, 589	0		0	
16.00	01600 MEDICAL RECORDS & LIBRARY	52, 430	3, 706			0	
17.00	01700 SOCIAL SERVICE	33, 731	4, 325		961	0	
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
21.00	02100 I & R SERVICES-SALARY & FRINGES APPRV	6, 701	0	0	-	0	
22.00	02200 I & SERVI CES-OTHER PRGM COSTS APPRV I NPATI ENT ROUTI NE SERVI CE COST CENTERS	10, 244	0	0	0	0	22.00
30.00	03000 ADULTS & PEDIATRICS	761, 996	825, 941	13, 347	183, 501	150, 769	30,00
31.00	03100 I NTENSI VE CARE UNI T	121, 168	178, 837			15, 780	•
35.00	02060 NEONATAL INTENSIVE CARE UNIT	169, 021	161, 342		35, 845	32, 659	35.00
40.00	04000 SUBPROVIDER - IPF	41,031	28, 277			9, 862	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	50, 155	76, 823	1, 891	17, 068	20, 219	43.00
50.00	05000 OPERATING ROOM	193, 296	121, 795	0	27, 059	0	50.00
51.00	05100 RECOVERY ROOM	64, 109	67, 206			0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	135, 183	191, 287	4, 709		0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	83, 776	40, 182		8, 927	0	
55.00	05500 RADI OLOGY-THERAPEUTI C	20, 965	40, 808			0	
57.00 58.00	05700 CT SCAN 05800 MRI	27, 827 19, 466	5, 397 22, 602			0	
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 107	22,002	0		0	
60.00	06000 LABORATORY	157, 223	23, 426	0	5, 204	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	9, 620	31, 895			0	64.00
65.00	06500 RESPI RATORY THERAPY	72, 914	25, 337	0		0	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	109, 854 30, 737	0	0		0	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	5, 830	0			0	
69.00	06900 ELECTROCARDI OLOGY	10, 264	0	0		0	
70.00	07000 ELECTROENCEPHALOGRAPHY	33, 619	6, 209	0	1, 380	0	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	314, 486	0			0	
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	211, 740 242, 858	0			0	
74.00	07400 RENAL DIALYSIS	19, 540	484	-	107	0	
76.00	03330 ENDOSCOPY	38, 941	32, 680			0	
76.06	03954 I MAGI NG CENTER	52, 955	0	-	-	0	
76.07	03955 BREAST DI AGNOSTI C CENTER	130, 093	0	0	0	0	76.07
90.00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	90.00
	04975 SPI NE CENTER	4, 503	0	0	0	0	
91.00	09100 EMERGENCY	179, 959	112, 107	12, 094	24, 907	0	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
112 00	SPECIAL PURPOSE COST CENTERS	1 1					112 00
	11300 INTEREST EXPENSE 11400 UTI LI ZATI ON REVIEW-SNF						113.00
118.00		4, 047, 037	2, 214, 483	71, 536	485, 048	229, 289	
	NONREI MBURSABLE COST CENTERS			, , , , , , , , , , , , , , , , , , , ,			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 265	15, 522	0	3, 448		190.00
		0	0	0	0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	1, 928	0		0		192.00 193.00
	07950 HOME OFFICE	0	0		0		193.00
194.06	07956 PAVI LLI ONS	1, 200	0	0	0		194.06
194.08	07958 OTHER NRCC	28, 901	2, 519	0	560		194. 08
	07960 COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.10
200.00 201.00			0			0	200.00
201.00		4, 080, 331	2, 232, 524	71, 536	489, 056		
0		., 550, 501	_, _027	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	, 207	

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	COMMUNI TY HOSPI TAL	OF INDIANA, IN Provider CC	CN: 15-0169 Pe	eriod: .om 01/01/2018	u of Form CMS-2 Worksheet B Part II	2552-10
			Тс		Date/Time Pre 5/29/2019 3:0	pared: 5 pm
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
1.00 GENERAL SERVICE COST CENTERS						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUI P 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMI NI STRATI VE & GENERAL 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 11.00 01100 CAFETERI A 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY	584, 968 15, 093 0	324, 981 162, 489	1, 441, 198			2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	27, 583 2, 602		720, 610	1, 692, 271 846, 138	954, 761	15.00 16.00
17. 00 01700 SOCIAL SERVICE	10, 409		28	040, 130	954, 701 0	17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0		0	0	0	19.00
21. 00 02100 I &R SERVICES-SALARY & FRINGES APPI			0	0	0	21.00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPI INPATIENT ROUTINE SERVICE COST CENTERS	RV 0	0	0	0	0	22.00
30. 00 03000 ADULTS & PEDI ATRI CS	203, 491	78, 244	37, 434	0	115, 307	30.00
31.00 03100 INTENSIVE CARE UNIT	31, 746		6, 203	0	15, 478	•
35. 00 02060 NEONATAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF	44, 757 11, 450		4, 534 965	0	59, 504 5, 267	35.00 40.00
43. 00 04300 NURSERY	13, 011		2, 247	0	6, 440	
ANCI LLARY SERVICE COST CENTERS				-1		
50. 00 05000 OPERATING ROOM	36, 951		36, 977	0	123, 595	•
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	16, 133 31, 746		5, 311 5, 594	0	23, 546 14, 970	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	21, 858		2, 508	Ő	27, 013	•
55. 00 05500 RADI OLOGY-THERAPEUTI C	3, 643	1 1	2, 535	0	20, 616	1
57. 00 05700 CT SCAN 58. 00 05800 MRI	7,286	1 1	184	0	49, 486	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	3, 643	1	44 1	0	13, 116 1, 660	
60. 00 06000 LABORATORY	0	0	27, 830	0	84, 600	•
64. 00 06400 I NTRAVENOUS THERAPY	2,082		148	0	703	•
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	19, 256 7, 286		3, 929 2, 260	0	19, 488 18, 720	•
67. 00 06700 OCCUPATI ONAL THERAPY	7,286		596	0	5, 291	•
68.00 06800 SPEECH PATHOLOGY	1, 561		113	0	1, 534	•
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	520 7, 807		12	0	7,005	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEI		1	1, 952 331, 919	0	8, 356 53, 799	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	223, 478	0		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	846, 133	72, 932	•
74. 00 07400 RENAL DIALYSIS 76. 00 03330 ENDOSCOPY	8, 327	0	33 3, 764	0	2, 267 15, 719	
76. 06 03954 I MAGI NG CENTER	0,027	Ő	2, 041	Ō	34, 698	
76. 07 03955 BREAST DI AGNOSTI C CENTER	0	0	78	0	13, 151	76.07
0UTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC	0		0	0	0	90.00
90. 26 04975 SPI NE CENTER	0	0	105	0	400	
91.00 09100 EMERGENCY	49, 441	19, 011	16, 746	0	109, 605	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAI SPECIAL PURPOSE COST CENTERS	RT					92.00
113. 00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
118.00 SUBTOTALS (SUM OF LINES 1 through	117) 584,968	324, 981	1, 440, 183	1, 692, 271	954, 761	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTER	EN O	0	0	0	0	190.00
191. 00 19100 RESEARCH	0	0	0	0		190.00
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	758	О	0	192.00
193.00 19300 NONPALD WORKERS	0	0	0	0		193.00
194. 00 07950 HOME OFFICE 194. 06 07956 PAVI LLI ONS		0	0 89	0		194. 00 194. 06
194. 08 07958 OTHER NRCC	0	0	168	0		194.08
194. 10 07960 COMMUNI TY REHAB HOSPI TAL	0	0	0	о	0	194. 10
200.00Cross Foot Adjustments201.00Negative Cost Centers	_		0	_	0	200. 00 201. 00
201.00 Negative cost centers 202.00 TOTAL (sum lines 118 through 201)	584, 968	324, 981	0 1, 441, 198	0 1, 692, 271	954, 761	
			.,,		,	

LOCA	Financial Systems COM TION OF CAPITAL RELATED COSTS	IMUNI TY HOSPI TAL		CN: 15-0169	Period: From 01/01/2018	u of Form CMS- Worksheet B Part II	
					To 12/31/2018	Date/Time Pre	epared:
				I NTERNS	& RESIDENTS	5/29/2019 3:0	
	Cost Center Description	SOCI AL SERVI CE	NONPHYSI CI AN	SEDVICES_SAL	ARISERVI CES-OTHER	Subtotal	
	cost center bescription	SUCIAL SERVICE	ANESTHETI STS	Y & FRI NGES		Subtotal	
		17.00	19.00	APPRV 21.00	APPRV 22.00	24.00	
	GENERAL SERVICE COST CENTERS	17.00	19.00	21.00	22.00	24.00	
00	00100 CAP REL COSTS-BLDG & FIXT						1.00
00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
00	00500 ADMI NI STRATI VE & GENERAL						5.00
00	00700 OPERATION OF PLANT						7.00
00	00800 LAUNDRY & LINEN SERVICE						8.00
00 . 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
	01100 CAFETERIA						11.0
	01300 NURSI NG ADMI NI STRATI ON						13.0
	01400 CENTRAL SERVICES & SUPPLY						14.0
							15.0
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	185, 568					16.0
	01900 NONPHYSICIAN ANESTHETISTS	00,000	0				19.0
. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0		6, 70	01		21.0
2.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0			10, 244		22.0
0. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	122,020		1		0 021 904	30.0
	03100 I NTENSI VE CARE UNI T	122, 020				9, 021, 804 1, 756, 697	
	02060 NEONATAL INTENSIVE CARE UNIT	26, 432				1, 969, 176	
	04000 SUBPROVI DER – I PF	7, 982				393, 806	
8.00	04300 NURSERY	16, 363				749, 363	43.0
0. 00	ANCI LLARY SERVI CE COST CENTERS	0		1		2, 301, 187	50.0
	05100 RECOVERY ROOM	0				718, 023	1
	05200 DELIVERY ROOM & LABOR ROOM	0				1, 825, 946	
	05400 RADI OLOGY-DI AGNOSTI C	0				845, 082	
	05500 RADI OLOGY-THERAPEUTI C	0				543, 662	
	05700 CT SCAN 05800 MRI					329, 349 349, 832	
	05900 CARDI AC CATHETERI ZATI ON	0				4, 396	
	06000 LABORATORY	0				421, 553	60.0
	06400 I NTRAVENOUS THERAPY	0				234, 133	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0				610, 324 922, 188	
	06700 OCCUPATI ONAL THERAPY					156, 007	
	06800 SPEECH PATHOLOGY	0				30, 299	
	06900 ELECTROCARDI OLOGY	0				24, 898	
	07000 ELECTROENCEPHALOGRAPHY	0				272, 694	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0				700, 204 465, 713	
	07300 DRUGS CHARGED TO PATIENTS					1, 161, 923	
	07400 RENAL DIALYSIS	0				24, 822	
	03330 ENDOSCOPY	0				557, 263	
	03954 I MAGI NG CENTER	0				617, 728	
o. 07	03955 BREAST DI AGNOSTI C CENTER OUTPATI ENT SERVI CE COST CENTERS	0				270, 825	76.0
0. 00	09000 CLINIC	0				0	90.0
). 26	04975 SPINE CENTER	0				20, 162	90.2
	09100 EMERGENCY	0				1, 659, 551	
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92.0
3 00	11300 INTEREST EXPENSE						113. 0
	11400 UTI LI ZATI ON REVI EW-SNF						114.0
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	185, 568	0		0 0	28, 958, 610	118. 0
	NONREI MBURSABLE COST CENTERS			1			1.00 0
	19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0				96, 963	
	19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES						191. 0 192. 0
	19300 NONPAID WORKERS	0					193.0
4.00	07950 HOME OFFICE	0				0	194. C
	07956 PAVI LLI ONS	0					194.0
	07958 OTHER NRCC	0				115, 801	194. 0 194. 1
0. 00	07960 COMMUNITY REHAB HOSPITAL Cross Foot Adjustments		C	6,70	01 10, 244	0 16, 945	
			-		0 10, 244		
1.00	Negative Cost Centers	0	0	/	0 01	0	201.0

LOCATI O	ancial Systems COMN N OF CAPITAL RELATED COSTS	NUNITY HOSPITAL O	Provider CCN:	Period:	ieu of Form CMS- Worksheet B	
				From 01/01/201 To 12/31/201	18 Date/Time Pre	epared:
	Cost Center Description	Intern &	Total		5/29/2019 3:0)5 pm
	cost center bescription	Residents Cost	Total			
		& Post				
		Stepdown				
		Adjustments 25.00	26.00			
GEN	ERAL SERVICE COST CENTERS	23.00	20.00			
	00 CAP REL COSTS-BLDG & FIXT					1.00
	00 CAP REL COSTS-MVBLE EQUIP					2.00
1	00 EMPLOYEE BENEFITS DEPARTMENT					4.00
	OO ADMINISTRATIVE & GENERAL OO OPERATION OF PLANT					5.0
	00 LAUNDRY & LINEN SERVICE					8.00
	00 HOUSEKEEPI NG					9.00
. 00 010	00 DI ETARY					10.0
	00 CAFETERIA					11.0
	00 NURSI NG ADMI NI STRATI ON					13.0
	00 CENTRAL SERVICES & SUPPLY					14.0
	00 PHARMACY 00 MEDI CAL RECORDS & LI BRARY					16.00
	00 SOCIAL SERVICE					17.00
	00 NONPHYSICIAN ANESTHETISTS					19.00
. 00 021	00 I&R SERVICES-SALARY & FRINGES APPRV					21.00
	00 I &R SERVICES-OTHER PRGM COSTS APPRV					22.00
	ATIENT ROUTINE SERVICE COST CENTERS		0.001.001			
	00 ADULTS & PEDIATRICS 00 INTENSIVE CARE UNIT	0	9,021,804			30.00
	60 NEONATAL INTENSIVE CARE UNIT	0	1, 756, 697 1, 969, 176			31.00
	00 SUBPROVIDER - IPF	0	393, 806			40.00
	00 NURSERY	0	749, 363			43.00
	I LLARY SERVICE COST CENTERS					
	00 OPERATING ROOM	0	2, 301, 187			50.00
	00 RECOVERY ROOM	0	718, 023			51.00
	00 DELIVERY ROOM & LABOR ROOM 00 RADIOLOGY-DIAGNOSTIC	0	1, 825, 946 845, 082			52.00
	00 RADI OLOGY-THERAPEUTI C	0	543, 662			55.00
1	00 CT SCAN	0	329, 349			57.00
	00 MRI	0	349, 832			58.00
	00 CARDI AC CATHETERI ZATI ON	0	4, 396			59.00
		0	421, 553			60.00
	00 I NTRAVENOUS THERAPY 00 RESPI RATORY THERAPY	0	234, 133 610, 324			64.00 65.00
	00 PHYSI CAL THERAPY	0	922, 188			66.00
	00 OCCUPATI ONAL THERAPY	0	156, 007			67.00
	00 SPEECH PATHOLOGY	0	30, 299			68.00
	00 ELECTROCARDI OLOGY	0	24, 898			69.00
	00 ELECTROENCEPHALOGRAPHY	0	272, 694			70.00
	00 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	700, 204			71.00
	00 IMPL. DEV. CHARGED TO PATIENTS 00 DRUGS CHARGED TO PATIENTS	0	465, 713 1, 161, 923			72.00
	00 RENAL DIALYSIS	0	24, 822			74.00
	30 ENDOSCOPY	0	557, 263			76.00
. 06 039	54 I MAGI NG CENTER	0	617, 728			76.0
	55 BREAST DI AGNOSTI C CENTER	0	270, 825			76.07
	PATIENT SERVICE COST CENTERS					
		0	0 20, 162			90.00
	75 SPINE CENTER 00 EMERGENCY	0	1, 659, 551			90.26
	00 OBSERVATION BEDS (NON-DISTINCT PART	0	1,037,331			92.00
	CIAL PURPOSE COST CENTERS	1 -1				
	00 INTEREST EXPENSE					113.00
	00 UTILIZATION REVIEW-SNF					114.00
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	28, 958, 610			118.00
	REIMBURSABLE COST CENTERS OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	96, 963			190. 00
	00 RESEARCH	0	90, 903			190.00
	00 PHYSICIANS' PRIVATE OFFICES	0	2, 686			192.00
	00 NONPAI D WORKERS	0	0			193.00
	50 HOME OFFICE	0	0			194.00
	56 PAVI LLI ONS	0	1, 289			194.06
	58 OTHER NRCC	0	115, 801			194.08
	60 COMMUNITY REHAB HOSPITAL	0				194.10
0.00	Cross Foot Adjustments Negative Cost Centers	0	16, 945			200.00
1.00		0				

Heal th Financial	Systems	
COST ALLOCATION	- STATI STI CAL	BASI S

COMMUNITY HOSPITAL OF INDIANA, INC. Provider CCN: 15-0169

In Lieu of Form CMS-2552-10 Period: Worksheet B-1 From 01/01/2018

					rom 01/01/2018 o 12/31/2018	Date/Time Pre 5/29/2019 3:0	
	Cost Center Description	BLDG & FIXT	LATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS	(01 77)	1 1				1 1 00
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	691, 776	31, 736, 808				1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 416		99, 568, 893			4.00
	00500 ADMI NI STRATI VE & GENERAL	21, 072		5, 543, 084		247, 477, 090	
7.00	00700 OPERATION OF PLANT	92, 235	21, 019	3, 021, 133	0	13, 048, 610	7.00
	00800 LAUNDRY & LINEN SERVICE	2, 447	1 1	0	-	923, 767	
	00900 HOUSEKEEPI NG 01000 DI ETARY	5, 630 6, 064		2, 888, 661 635, 458		5, 320, 061 1, 769, 339	
	01100 CAFETERI A	16, 730		1, 774, 879		1, 845, 255	
	01300 NURSI NG ADMI NI STRATI ON	986		2, 025, 382		7, 390, 250	
	01400 CENTRAL SERVICES & SUPPLY	15, 761	1, 733, 159	0		1, 883, 180	14.00
	01500 PHARMACY	7,648		4, 615, 095		5, 950, 008	
	01600 MEDICAL RECORDS & LIBRARY	958	1	381, 875		3, 179, 885 2, 045, 793	
	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	1, 118 0	1	1, 427, 048 0		2,045,793	1
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	-	0	-	406, 401	
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		621, 282	
	INPATIENT ROUTINE SERVICE COST CENTERS	1			1		
	03000 ADULTS & PEDIATRICS	213, 486		26, 387, 915		46, 219, 656	
	03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	46, 225 41, 703		4, 308, 392 6, 636, 997		7, 348, 868 10, 251, 169	
	04000 SUBPROVIDER - IPF	7, 309		1, 605, 978		2, 488, 508	
	04300 NURSERY	19,857		1, 696, 926		3, 041, 939	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	31, 481		4, 837, 949		11, 723, 444	
	05100 RECOVERY ROOM	17, 371		2, 369, 622		3, 888, 202	
	05200 DELIVERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C	49, 443 10, 386		4, 757, 972 3, 138, 670		8, 198, 883 5, 081, 012	
	05500 RADI OLOGY-THERAPEUTI C	10, 548		518, 489		1, 271, 501	
	05700 CT SCAN	1, 395		1, 032, 691		1, 687, 686	
	05800 MRI	5, 842		521, 573		1, 180, 612	
	05900 CARDI AC CATHETERI ZATI ON	0		0	-	127, 804	
	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	6, 055 8, 244		25, 321 291, 332		9, 535, 620 583, 426	
	06500 RESPI RATORY THERAPY	6, 549		2, 722, 272		4, 422, 217	
	06600 PHYSI CAL THERAPY	0		4, 364, 665		6, 662, 655	
	06700 OCCUPATI ONAL THERAPY	0	36, 200	1, 167, 985		1, 864, 216	
	06800 SPEECH PATHOLOGY	0	6, 866	221, 530		353, 583	
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	1, 605	9, 712 212, 304	27, 517 944, 130		622, 488 2, 038, 970	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,005	212, 304	944, 130 0		19, 073, 633	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	12, 842, 066	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	14, 729, 369	73.00
	07400 RENAL DI ALYSI S	125		0	0	1, 185, 131	
	03330 ENDOSCOPY 03954 I MAGI NG CENTER	8, 447		1, 128, 178		2, 361, 766	
	03955 BREAST DI AGNOSTI C CENTER	0		1, 383, 191 0		3, 211, 740 7, 890, 153	
	OUTPATIENT SERVICE COST CENTERS					., ., ., .,]
90.00	09000 CLI NI C	0		0		0	
	04975 SPI NE CENTER	0	479	185, 515		273, 084	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	28, 977	125, 257	6, 450, 254	. 0	10, 914, 541	
72.00	SPECIAL PURPOSE COST CENTERS						92.00
13.00	11300 I NTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF						114.00
118.00		687, 113	31, 680, 141	99, 037, 679	-67, 853, 958	245, 457, 773	118.00
	NONREIMBURSABLE COST CENTERS	4.010		~		74 700	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	4,012	1	0			190.00 191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0		116, 952	
192.00	19300 NONPAID WORKERS	0	0	0	o o		193.00
			0	0	0		194.00
193.00 194.00	07950 HOME OFFICE	0					
193.00 194.00 194.06	07956 PAVI LLI ONS	0	0	0	0		
193.00 194.00 194.06 194.08	07956 PAVI LLI ONS 07958 OTHER NRCC	0 0 651	0 56, 667	0 531, 214	0	1, 752, 833	194.08
193.00 194.00 194.06 194.08	07956 PAVILLIONS 07958 OTHER NRCC 07960 COMMUNITY REHAB HOSPITAL	0 0 651 0	0 56, 667 0	0 531, 214 0		1, 752, 833	194.06 194.08 194.10 200.00

Health Fir	nancial Systems COMM	UNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2018	Worksheet B-1	
					To 12/31/2018		
		CAPITAL REI	LATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	DEPARTMENT	Reconci I i ati on	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
				(GROSS SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	13, 229, 883	15, 962, 411	13, 532, 08	7	67, 853, 958	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	19. 124519	0. 502962	0. 13590	7	0. 274183	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			8, 003, 914	1	4, 080, 331	204.00
205.00	Unit cost multiplier (Wkst. B, Part			0. 080380	5	0. 016488	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

COST A	LLOCATION - STATISTICAL BASIS		OF INDIANA, IN Provider C	CN: 15-0169 Pe	eri od:	u of Form CMS-2 Worksheet B-1	
				Fr Tc	com 01/01/2018 0 12/31/2018		
	Cost Center Description	OPERATI ON OF	LAUNDRY &	HOUSEKEEPING	DI ETARY	5/29/2019 3: 0 CAFETERI A	
		PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(TOTAL PATI ENT DAYS)	(MEALS SERVED)	
		7.00	LAUNDRY)	0.00		11 00	
	GENERAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00	11.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
4.00 5.00	00500 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	577, 053					7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	2,447	71, 194 35, 597				8.00
	01000 DI ETARY	5, 630 6, 064	35, 597	568, 976 6, 064	86, 789		9.00
	01100 CAFETERI A	16, 730	0	16, 730	0	1, 124	•
	01300 NURSI NG ADMI NI STRATI ON	986	0	986	0	29	
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	15, 761 7, 648		15, 761 7, 648	0	0 53	
	01600 MEDICAL RECORDS & LIBRARY	958	0	958	0	5	16.00
	01700 SOCIAL SERVICE	1, 118	0	1, 118	0	20	•
	01900 NONPHYSICIAN ANESTHETISTS 02100 I&R SERVICES-SALARY & FRINGES APPRV	0		0	0	0	19.00
	02200 I &R SERVICES-SALART & TRINGES AFFRV	0	0	-	0	0	21.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1	1				
	03000 ADULTS & PEDIATRICS	213, 486	13, 283		57,068	391	30.00
	03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	46, 225 41, 703	, o	46, 225 41, 703	5, 973 12, 362	61 86	31.00 35.00
	04000 SUBPROVIDER - IPF	7, 309		7, 309	3, 733	22	40.00
43.00	04300 NURSERY	19, 857	1, 882	19, 857	7, 653	25	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	31, 481	0	31, 481	0	71	50.00
	05100 RECOVERY ROOM	17, 371	0		0	31	51.00
	05200 DELIVERY ROOM & LABOR ROOM	49, 443	4, 686		0	61	52.00
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	10, 386	0	10, 386	0	42 7	•
	05700 CT SCAN	10, 548		10, 548 1, 395	0	14	55.00 57.00
58.00	05800 MRI	5, 842	0	5, 842	0	7	58.00
	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60.00 64.00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	6, 055 8, 244	0	6, 055 8, 244	0	0	60.00 64.00
65.00	06500 RESPI RATORY THERAPY	6, 549	0		0	37	65.00
	06600 PHYSI CAL THERAPY	0	0	0	0	14	66.00
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	0	14	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	0		0	0	3	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 605	0	1, 605	0	15	70.00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0		71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS			0	0	0	•
	07400 RENAL DI ALYSI S	125	0	125	Ő	0	
	03330 ENDOSCOPY	8, 447	0	8, 447	0	16	
	03954 I MAGI NG CENTER 03955 BREAST DI AGNOSTI C CENTER	0		0	0	0	
70.07	OUTPATIENT SERVICE COST CENTERS		0	0	0	0	/0.0/
	09000 CLI NI C	0	0	0	0	0	
	04975 SPI NE CENTER 09100 EMERGENCY	0 28, 977	12 026	0 28, 977	0	0 95	•
	09200 OBSERVATION BEDS (NON-DISTINCT PART	20,911	12, 036	20, 977	0	90	91.00
	SPECIAL PURPOSE COST CENTERS		1	· · · · ·			
	11300 I NTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF SUBTOTALS (SUM OF LINES 1 through 117)	572, 390	71, 194	564, 313	86, 789	1 124	114.00 118.00
	NONREI MBURSABLE COST CENTERS	072,070	,,,,,,	001,010		1, 121	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 012	0	4, 012	0		190.00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		191.00 192.00
	19300 NONPALD WORKERS	0	0	0	0		192.00
194.00	07950 HOME OFFICE	0	0	0	0	0	194.00
	07956 PAVI LLI ONS	0	0	0	0		194.06
	07958 OTHER NRCC 07960 COMMUNITY REHAB HOSPITAL	651		651 0	0		194.08 194.10
200.00			l		0	0	200.00
201.00	Negative Cost Centers						201.00
	Cost to be allocated (per Wkst. B,	16, 626, 317	1, 247, 552	7, 564, 721	2, 509, 804	3, 055, 656	202.00
202.00	Part I)						

Heal th	Financial Systems COMM	IUNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-:	2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2018		
					To 12/31/2018	Date/Time Pre 5/29/2019 3:0	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE FEET)	(TOTAL PATI	(MEALS SERVED)	
		(SQUARE FEET)	(POUNDS OF		ENT DAYS)		
			LAUNDRY)				
		7.00	8.00	9.00	10.00	11.00	
204.00	Cost to be allocated (per Wkst. B,	2, 232, 524	71, 536	489, 05	6 229, 289	584, 968	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	3. 868837	1. 004804	0. 85953	7 2. 641913	520. 434164	205.00
	11)						
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

	ncial Systems COMM ATION - STATISTICAL BASIS	UNI TY HOSPI TAL	OF INDIANA, IN Provider CO		In Lie Period:	u of Form CMS-: Worksheet B-1	
CUST ALLUCA	ATTON - STATISTICAL BASIS		Provider CC		From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 3:0	pared:
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY (COSTED	MEDI CAL RECORDS &	SOCIAL SERVICE	
		(DI RECT NRSI NG	SUPPLY (COSTED	REQUIS.)	LI BRARY (GROSS CHAR	(TOTAL PATI ENT DAYS)	
		HRS) 13.00	REQUIS.) 14.00	15.00	GES) 16. 00	17.00	
	RAL SERVICE COST CENTERS			1 101 00	10100		
	O CAP REL COSTS-BLDG & FIXT O CAP REL COSTS-MVBLE EQUIP						1.00 2.00
	O EMPLOYEE BENEFITS DEPARTMENT						4.00
	O ADMINISTRATIVE & GENERAL O OPERATION OF PLANT						5.00 7.00
	O LAUNDRY & LINEN SERVICE						8.00
	0 HOUSEKEEPI NG 0 DI ETARY						9.00 10.00
	O CAFETERIA O NURSING ADMINISTRATION	1 () (11.00
	O CENTRAL SERVICES & SUPPLY	1, 624 812	82, 816, 871				13.00 14.00
	O PHARMACY O MEDI CAL RECORDS & LI BRARY	0	41, 408, 437				15.00
	0 SOCIAL SERVICE	0	241 1, 636			86, 789	16.00 17.00
	O NONPHYSI CI AN ANESTHETI STS	0	0		-	0	19.00
	0 I &R SERVICES-SALARY & FRINGES APPRV 0 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0 0			0	21.00 22.00
I NPA	TIENT ROUTINE SERVICE COST CENTERS		0 454 400			57.0(0	1
	O ADULTS & PEDIATRICS O INTENSIVE CARE UNIT	391 61	2, 151, 128 356, 450		0 176, 310, 491 23, 666, 719	57, 068 5, 973	
35.00 02060	NEONATAL INTENSIVE CARE UNIT	86	260, 538		90, 984, 335	12, 362	35.00
	0 SUBPROVI DER – I PF 0 NURSERY	22 25	55, 472 129, 103		0 8, 053, 217 0 9, 847, 218	3, 733 7, 653	
ANCI L	LLARY SERVICE COST CENTERS	· · ·		· · · · · · · · · · · · · · · · · · ·			
	O OPERATING ROOM O RECOVERY ROOM	71	2, 124, 887 305, 174		0 188, 573, 743 0 36, 003, 536	0	50.00 51.00
52.00 05200	O DELIVERY ROOM & LABOR ROOM	61	321, 462		22, 890, 363	0	52.00
	0 RADI OLOGY-DI AGNOSTI C 0 RADI OLOGY-THERAPEUTI C	0	144, 150 145, 647		0 41, 304, 857 0 31, 522, 658	0	54.00 55.00
57.00 05700	O CT SCAN	0	10, 598		75, 667, 221	0	57.00
58.00 05800 59.00 05900	0 MRI 0 CARDI AC CATHETERI ZATI ON	0	2, 549 45		20, 055, 048 2, 538, 853	0	58.00 59.00
60.00 06000	0 LABORATORY	0	1, 599, 248		129, 357, 058	0	60.00
	O I NTRAVENOUS THERAPY O RESPI RATORY THERAPY	0	8, 510 225, 762		0 1, 075, 444 0 29, 798, 389	0	64.00 65.00
	O PHYSI CAL THERAPY	0	129, 896		28, 623, 451	0	66.00
	0 OCCUPATI ONAL THERAPY 0 SPEECH PATHOLOGY	0	34, 267 6, 499		0 8, 090, 743 0 2, 345, 397	0	67.00 68.00
	0 ELECTROCARDI OLOGY	0	698		10, 710, 977	0	69.00
	O ELECTROENCEPHALOGRAPHY	0	112, 151		0 12, 776, 486 0 82, 261, 468	0	
	O MEDICAL SUPPLIES CHARGED TO PATIENT O IMPL. DEV. CHARGED TO PATIENTS	0	19, 073, 636 12, 842, 066		46, 628, 663	0	71.00 72.00
	O DRUGS CHARGED TO PATIENTS	0	0	,		0	
	0 RENAL DI ALYSI S 0 ENDOSCOPY	0	1, 868 216, 289		0 3, 466, 226 24, 035, 729	0	74.00 76.00
	4 I MAGI NG CENTER	0	117, 278		0010001110	0	76.06
	5 BREAST DI AGNOSTI C CENTER ATI ENT SERVI CE COST CENTERS	0	4, 506	1	20, 108, 703	0	76.07
		0	0		0 (12, 22)	0	90.00
	5 SPI NE CENTER 0 EMERGENCY	0 95	6, 029 962, 285		0 612, 326 0 167, 591, 198	0	90.26 91.00
	O OBSERVATION BEDS (NON-DISTINCT PART						92.00
	I AL PURPOSE COST CENTERS						113.00
114.00 11400	UTILIZATION REVIEW-SNF						114.00
118.00 NONRE	SUBTOTALS (SUM OF LINES 1 through 117) EIMBURSABLE COST CENTERS	1, 624	82, 758, 505	28, 793, 270	0 1, 459, 473, 247	86, 789	118.00
190.001900	O GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 00
191.001910	0 RESEARCH 0 PHYSI CI ANS' PRI VATE OFFI CES	0	0 43, 552			0	191.00 192.00
193.00 19300	O NONPAID WORKERS	0	0		0 0	0	193.00
	0 HOME OFFICE 6 PAVILLIONS	0	0 5, 138				194. 00 194. 06
194.0807958	8 OTHER NRCC	0	9, 676			0	194. 08
194. 10 07960 200. 00	O COMMUNITY REHAB HOSPITAL Cross Foot Adjustments	0	0		0 0	0	194. 10 200. 00
200.00	Negative Cost Centers						200.00
202.00	Cost to be allocated (per Wkst. B, Part I)	9, 536, 887	7, 831, 620	11, 963, 312	2 10, 087, 364	2, 708, 317	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	5, 872. 467365	0. 094566	0. 415490	0. 006912	31. 205763	203.00

Health Fi	nancial Systems COM	MUNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-:	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
					From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 3:0	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUIS.)	LI BRARY	(TOTAL PATI	
		(DI RECT NRSI NG	(COSTED		(GROSS CHAR	ENT DAYS)	
		HRS)	REQUIS.)		GES)		
		13.00	14.00	15.00	16.00	17.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	324, 981	1, 441, 198	1, 692, 27	1 954, 761	185, 568	204.00
205.00	Unit cost multiplier (Wkst. B, Part	200. 111453	0. 017402	0. 05877	3 0. 000654	2. 138151	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

	Financial Systems COMM LLOCATION - STATISTICAL BASIS	IUNI TY HOSPI TAL	OF INDIANA, IN Provider C		In Lieu Period:	of Form CMS-2552-10 Worksheet B-1
					rom 01/01/2018 o 12/31/2018	Date/Time Prepared:
			INTERNS &	RESI DENTS		5/29/2019 3:05 pm
	Cost Center Description	NONPHYSI CI AN	SERVI CES-SALAR			
	cost center bescription	ANESTHETI STS	Y & FRI NGES	PRGM COSTS	κ.	
		(ASSI GNED TI ME)	APPRV (ASSI GNED	APPRV (ASSI GNED		
			TIME)	TIME)	_	
	GENERAL SERVICE COST CENTERS	19.00	21.00	22.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT					2.00 4.00
5.00	00500 ADMI NI STRATI VE & GENERAL					5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE					7.00 8.00
9.00	00900 HOUSEKEEPI NG					9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A					10.00
	01300 NURSING ADMINISTRATION					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY					14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY					15.00 16.00
17.00	01700 SOCIAL SERVICE					17.00
	01900 NONPHYSICIAN ANESTHETISTS 02100 I&R SERVICES-SALARY & FRINGES APPRV	C	53, 904			19.00 21.00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV		33, 704	53, 904	L	22.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS		25 247	25.24	2	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT		0 35,247 0 0	35, 247		30.00 31.00
	02060 NEONATAL INTENSIVE CARE UNIT	0	0 0	(35.00
40.00 43.00	04000 SUBPROVI DER – I PF 04300 NURSERY					40.00 43.00
	ANCI LLARY SERVI CE COST CENTERS		-	· · · · · · · · · · · · · · · · · · ·		
	05000 OPERATING ROOM 05100 RECOVERY ROOM					50.00 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM					52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0 0	0		54.00
55.00 57.00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN					55.00 57.00
58.00	05800 MRI	0		()	58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY					59.00 60.00
64.00	06400 I NTRAVENOUS THERAPY	0				64.00
65.00	06500 RESPIRATORY THERAPY	0				65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY					66.00 67.00
68.00	06800 SPEECH PATHOLOGY	C	0 0			68.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY					69.00 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		, c)	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS					72.00 73.00
	07400 RENAL DI ALYSI S					74.00
	03330 ENDOSCOPY 03954 I MAGI NG CENTER	0				76.00 76.06
	03955 BREAST DI AGNOSTI C CENTER					76.07
00.00	OUTPATIENT SERVICE COST CENTERS					
	09000 CLINIC 04975 SPINE CENTER					90.00 90.26
91.00	09100 EMERGENCY	0	4, 219	4, 219	2	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS					92.00
113.00	11300 I NTEREST EXPENSE					113.00
	11400 UTI LI ZATI ON REVI EW-SNF		F2 004	F2 00		114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	(53,904	53, 904	+	118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	(0			190.00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES		0 0			191.00 192.00
193.00	19300 NONPAI D WORKERS				þ	193.00
	07950 HOME OFFICE			(194.00
	07956 PAVI LLI ONS 07958 OTHER NRCC					194. 06 194. 08
194.10	07960 COMMUNITY REHAB HOSPITAL	(C	0 0	0)	194.10
200.00 201.00						200. 00 201. 00
		I	1	1	1	120.00

Health Fina	ncial Systems COMM	IUNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provider CO		Period:	Worksheet B-1	
					From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 3:0	
			INTERNS &	RESI DENTS			
	Cost Center Description	NONPHYSI CI AN ANESTHETI STS	SERVICES-SALAR Y&FRINGES	SERVICES-OTHE PRGM COSTS	R		
		(ASSI GNED	APPRV	APPRV			
		TI ME)	(ASSI GNED	(ASSI GNED			
			TIME)	TIME)			
		19.00	21.00	22.00			
202.00	Cost to be allocated (per Wkst. B, Part I)	0	517, 829	791, 62	7		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	9. 606504	14. 68586	7		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	6, 701	10, 24	4		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0. 000000	0. 124314	0. 19004	2		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Financial Systems	CON	MUNITY HUSPITAL	OF INDIANA, II	IC.	In Lie	U OT FORM CMS-	2552-10
COMPUTATION OF RATIO OF COST	S TO CHARGES		Provider C		Period: From 01/01/2018 To 12/31/2018		epared:
			Ti tl c	XVIII	Hospi tal	PPS	
			nue		Costs	113	
Cost Center Desc	ription	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		26)					
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERV	/ICE COST CENTERS						
30.00 03000 ADULTS & PEDIATR	I CS	76, 326, 768		76, 326, 76	8 0	76, 326, 768	30.00
31.00 03100 INTENSIVE CARE U	NI T	12, 390, 702		12, 390, 70	2 0	12, 390, 702	31.00
35.00 02060 NEONATAL INTENSI	VE CARE UNIT	16, 995, 863		16, 995, 86	3 0	16, 995, 863	35.00
40. 00 04000 SUBPROVIDER - IP	· · · · · · · · · ·	3, 965, 799		3, 965, 79			
43.00 04300 NURSERY		5, 500, 280		5, 500, 28			
ANCI LLARY SERVICE COST	CENTERS	0,000,200		0,000,20	<u> </u>	0,000,200	101.00
50. 00 05000 OPERATING ROOM	<u>SELITERS</u>	18, 377, 222		18, 377, 22	2 0	18, 377, 222	50.00
51.00 05100 RECOVERY ROOM		6,047,725		6, 047, 72			
52.00 05200 DELIVERY ROOM &	LABOR ROOM	13, 323, 597		13, 323, 59			
54. 00 05400 RADI OLOGY-DI AGNO		7, 324, 780		7, 324, 78			
55. 00 05500 RADI OLOGY - THERAP		2, 324, 744		2, 324, 74			
57. 00 05700 CT SCAN	Lonie	2, 324, 744		2, 324, 74			
58. 00 05800 MRI		1, 908, 200		1, 908, 20			
59. 00 05900 CARDI AC CATHETER		1, 908, 200		1, 908, 20			
60. 00 06000 LABORATORY	I ZATI UN	13, 450, 437		13, 450, 43			
64. 00 06400 INTRAVENOUS THER							
		1, 109, 640		1, 109, 64			
65.00 06500 RESPI RATORY THER		6, 238, 380				-,,	
66. 00 06600 PHYSI CAL THERAPY		8, 737, 631	0	-,,		-,	
67.00 06700 OCCUPATIONAL THE		2, 472, 575	C	_,,			
68.00 06800 SPEECH PATHOLOGY		475, 511	C	475, 51			
69.00 06900 ELECTROCARDI OLOG		869, 983		869, 98			
70.00 07000 ELECTROENCEPHALO		2, 805, 299		2, 805, 29		_, _, _, _, _, _,	
71.00 07100 MEDICAL SUPPLIES		26, 675, 607		26, 675, 60			
72.00 07200 I MPL. DEV. CHARG		17, 899, 862		17, 899, 86	2 0	17, 899, 862	72.00
73.00 07300 DRUGS CHARGED TO	PATIENTS	25, 520, 378		25, 520, 37	8 0	25, 520, 378	73.00
74.00 07400 RENAL DIALYSIS		1, 539, 474		1, 539, 47	4 0	1, 539, 474	74.00
76.00 03330 ENDOSCOPY		3, 595, 093		3, 595, 09	3 0	3, 595, 093	76.00
76.06 03954 I MAGI NG CENTER		4, 470, 155		4, 470, 15	5 0	4, 470, 155	76.06
76.07 03955 BREAST DI AGNOSTI	C CENTER	10, 192, 916		10, 192, 91	6 0	10, 192, 916	76.07
OUTPATIENT SERVICE COS	ST CENTERS						
90.00 09000 CLINIC		0			0 0	0	90.00
90. 26 04975 SPI NE CENTER		352, 761		352, 76	1 0	352, 761	90.26
91.00 09100 EMERGENCY		17, 403, 727		17, 403, 72	7 0	17, 403, 727	91.00
92.00 09200 OBSERVATION BEDS	(NON-DISTINCT PART	7, 756, 070		7, 756, 07		7, 756, 070	
SPECIAL PURPOSE COST (
113.00 11300 INTEREST EXPENSE							113.00
114.00 11400 UTI LI ZATI ON REVI	EW-SNF						114.00
200.00 Subtotal (see in	structions)	319, 002, 813	C	319, 002, 81	3 0	319, 002, 813	
201.00 Less Observation		7, 756, 070		7, 756, 07	0	7, 756, 070	201.00
202.00 Total (see instr		311, 246, 743					
	<i>*</i>				1		

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CC	CN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/29/2019 3:C	eparec)5 pm
		Title	XVIII	Hospi tal	PPS	-
		Charges				
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						1
D. 00 03000 ADULTS & PEDIATRICS	165, 830, 748		165, 830, 74			30.
1. 00 03100 I NTENSI VE CARE UNI T	23, 666, 719		23, 666, 71			31.
5.00 02060 NEONATAL INTENSIVE CARE UNIT	90, 984, 335		90, 984, 33			35.
D. 00 04000 SUBPROVIDER - IPF	8, 053, 217		8, 053, 21			40.
3. 00 04300 NURSERY	9, 847, 218		9, 847, 21	18		43.
ANCI LLARY SERVI CE COST CENTERS	1 1					
D. 00 05000 OPERATI NG ROOM	124, 545, 112	64, 028, 631	188, 573, 74		0.00000	
1.00 05100 RECOVERY ROOM	20, 751, 392	15, 252, 144	36, 003, 53		0.00000	
2.00 05200 DELIVERY ROOM & LABOR ROOM	22, 890, 363	0	22, 890, 36		0.00000	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	11, 334, 580	29, 970, 277	41, 304, 85		0. 000000	
5. 00 05500 RADI OLOGY-THERAPEUTI C	13, 806, 724	17, 715, 934	31, 522, 65		0. 000000	55.
7.00 05700 CT SCAN	24, 054, 429	51, 612, 792	75, 667, 22	0. 036624	0.00000	57.
8. 00 05800 MRI	4, 560, 411	15, 494, 637	20, 055, 04	18 0. 095148	0.00000	58.
9. 00 05900 CARDI AC CATHETERI ZATI ON	2, 538, 853	0	2, 538, 85	0. 071055	0.00000	59.
D. 00 06000 LABORATORY	79, 951, 073	49, 405, 985	129, 357, 05		0.00000	
4. 00 06400 I NTRAVENOUS THERAPY	940, 072	135, 372	1, 075, 44		0.00000	
5. 00 06500 RESPI RATORY THERAPY	27, 101, 391	2, 696, 998	29, 798, 38	0. 209353	0.00000	65.
6. 00 06600 PHYSI CAL THERAPY	5, 873, 213	22, 750, 238	28, 623, 45	0. 305261	0.00000	66.
7.00 06700 OCCUPATIONAL THERAPY	5, 121, 206	2, 969, 537	8, 090, 74	0. 305605	0.00000	67.
B. 00 06800 SPEECH PATHOLOGY	1, 542, 336	803, 061	2, 345, 39	0. 202742	0.00000	68.
9. 00 06900 ELECTROCARDI OLOGY	9, 037, 225	1, 673, 752	10, 710, 97	0. 081223	0.00000	69.
0.00 07000 ELECTROENCEPHALOGRAPHY	989, 174	11, 787, 312	12, 776, 48	0. 219567	0.00000	70.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	58, 183, 514	24,077,954	82, 261, 46	0. 324278	0.00000	71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	39, 072, 783	7, 555, 880	46, 628, 66	0. 383881	0.00000	72.
3.00 07300 DRUGS CHARGED TO PATIENTS	81, 103, 033	30, 414, 257	111, 517, 29	0. 228847	0.00000	73.
4. 00 07400 RENAL DIALYSIS	3, 466, 226	0	3, 466, 22	0. 444135	0.00000	74.
6. 00 03330 ENDOSCOPY	4, 708, 315	19, 327, 414	24, 035, 72	0. 149573	0.00000	76.
6. 06 03954 I MAGI NG CENTER	362, 351	52, 693, 089	53, 055, 44	0. 084254	0.00000	76.
6. 07 03955 BREAST DI AGNOSTI C CENTER	19, 977	20, 088, 726	20, 108, 70		0.000000	
OUTPATIENT SERVICE COST CENTERS						
D. 00 09000 CLINIC	0	0		0 0.000000	0.00000	90.
D. 26 04975 SPI NE CENTER	0	612, 326	612, 32	0. 576100	0.00000	90.
1.00 09100 EMERGENCY	36, 580, 611	131,010,587	167, 591, 19		0. 000000	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 607, 178	8, 872, 565	10, 479, 74		0. 000000	
SPECIAL PURPOSE COST CENTERS						1
13. 00 11300 I NTEREST EXPENSE						113.
14. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.
00.00 Subtotal (see instructions)	878, 523, 779	580, 949, 468	1, 459, 473, 24	17		200.
01.00 Less Observation Beds	,,	, , , , , , , , , , , , , , , , , ,	,,			201.
02.00 Total (see instructions)	878, 523, 779	500 010 160	1, 459, 473, 24	17		202

In Lieu of Form CMS-2552-10 Worksheet C

Heal th	Financial Systems COM	MUNITY HOSPITAL OF	INDIANA, INC.	In Lieu	u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0169	Peri od:	Worksheet C	
				From 01/01/2018	Part I	
				To 12/31/2018	Date/Time Pre	epared:
					5/29/2019 3:0	05 pm
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 I NTENSI VE CARE UNI T					31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT					35.00
40.00	04000 SUBPROVIDER - IPF					40.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS	· · · · · ·				
50.00	05000 OPERATING ROOM	0. 097454				50.00
51.00	05100 RECOVERY ROOM	0. 167976				51.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 582061				52.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 177335				54.00
	05500 RADI OLOGY-THERAPEUTI C	0. 073748				55.00
	05700 CT SCAN	0.036624				57.00
	05800 MRI	0. 095148				58.00
	05900 CARDI AC CATHETERI ZATI ON					
		0.071055				59.00
		0. 103979				60.00
	06400 I NTRAVENOUS THERAPY	1.031797				64.00
	06500 RESPI RATORY THERAPY	0. 209353				65.00
	06600 PHYSI CAL THERAPY	0. 305261				66.00
	06700 OCCUPATI ONAL THERAPY	0. 305605				67.00
	06800 SPEECH PATHOLOGY	0. 202742				68.00
	06900 ELECTROCARDI OLOGY	0. 081223				69.00
	07000 ELECTROENCEPHALOGRAPHY	0. 219567				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 324278				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 383881				72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 228847				73.00
	07400 RENAL DIALYSIS	0. 444135				74.00
76.00	03330 ENDOSCOPY	0. 149573				76.00
76.06	03954 I MAGI NG CENTER	0. 084254				76.06
76.07	03955 BREAST DI AGNOSTI C CENTER	0. 506891				76.07
	OUTPATIENT SERVICE COST CENTERS	· · ·				1
	09000 CLI NI C	0.000000				90.00
90, 26	04975 SPINE CENTER	0. 576100				90.26
	09100 EMERGENCY	0. 103846				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 740101				92.00
	SPECIAL PURPOSE COST CENTERS					
113 00	11300 I NTEREST EXPENSE					113.00
	11400 UTI LI ZATI ON REVIEW-SNF					114.00
200.00						200.00
200.00						200.00
201.00						201.00
202.00		i l				202.00

Heal th	Fi nar	ici a	I Syst	ems			
COMPLIT		0E	DATIO		COSTS	ΤO	(

Title XIX Hospital PPS Cost Center Description Total Cost (Pron Wkst. B) 26) Therapy Limit Adj. Total Costs Disal Lowance Total Costs Disal Cost Disal Cost Disal Lowance Total Costs Disal Cost Disal Lowance Total Cost Disal Lowance Total Cos	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 15-0169	Period: Worksheet C From 01/01/2018 Part I To 12/31/2018 Date/Time Pr 5/29/2019 3:		pared: 5 pm
Cost Center Description Total Cost (From Wisch 20) Total Cost (From Wisch 20) REE (From Wisch 20) Total Costs (From Wisch 20) REE (From Wisch 20) Total Costs (From Wisch 20) <thtpstal (from="" wisch<br="">20) Total Costs (From Wisch 20</thtpstal>			Titl	e XIX	Hospi tal	PPS	
Inpart level (from Wkst. B, Part I, col. Ádj. Di sal I owance 0.0 03000 ADULTS & PEDI ATRI CE COST CENTERS 1.00 2.00 3.00 4.00 5.00 0.0 03000 INTENS VE CARE UNIT 12, 390, 702 12, 390, 702 0 12, 390, 702 0 12, 390, 702 30.00 0.0 04000 SUBEROVI DER - 1 FF 4, 316, 533 0 4, 316, 533 0 4, 316, 533 0 4, 316, 533 0 4, 316, 533 4, 30, 0 30.00 0.0 04000 SUBEROVI DER - 1 FF 4, 316, 533 4, 316, 533 0 4, 316, 533 0 4, 316, 533 0 4, 316, 533 4, 30, 0 0.0 0500 OPERATI INE ROOM 18, 377, 222 18, 377, 222 0 18, 377, 222 50, 00 5, 500, 280 43, 30 0.0 0500 OPERATI INE NEADER DEUIT 2, 324, 744 2, 324, 744 2, 324, 744 55, 500, 280 55, 500, 280 55, 500, 280 55, 500, 280 55, 500, 280 55, 500, 280 55, 500, 280 55, 500, 280 55, 500, 280 55, 500, 280 55, 500, 280							
Part I, col. 20 3.00 4.00 5.00 30.00 (3000 ADULTS & PEDIATRICS 77, 183,000 77, 183,000 0 73,000 0 73,000 0 73,000 0 73,000 0 73,000 0 73,01,000 0 73,21,722 0 18,377,222 0 18,377,222 0 18,377,222 0 18,377,222 0 13,323,597 13,323,597 0 73,24,780 73,24,780 73,24,780 73,24,780 73,24,780 73,24,780 73,24,780 73,24,780 <td< td=""><td>Cost Center Description</td><td></td><td></td><td>Total Costs</td><td></td><td>Total Costs</td><td></td></td<>	Cost Center Description			Total Costs		Total Costs	
26) -			Adj.		Di sal I owance		
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 30.00 03000 APULTS & PEDIATRICS 77, 183.000 77, 183.000 0 77, 183.000 30.00 12, 390, 702 10, 300 10, 995, 863 35, 000 16, 995, 863 35, 000 16, 995, 863 10, 005 16, 997, 803 10, 005 16, 977, 725 0 6, 047, 725 0 6, 047, 725 0 6, 047, 725 0 6, 047, 725 0 6, 047, 725 0 7, 333, 597 52, 00 55, 00, 280 13, 323, 597 13, 323, 597 13, 323, 597 52, 00 56, 00 56, 00 56, 00 56, 00 7, 12, 355 2, 771, 235 62, 771, 235 6, 407, 725 0 6, 40, 725 6, 44, 725 6, 40, 40 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
INPATIENT ROUTINE SERVICE COST CENTERS Image of the service of the serv							
30.00 02000 ADULTS & PEDIATRICS 77, 183,000 77, 183,000 0 77, 183,000 0 77, 183,000 12, 390, 702 12, 390, 702 31, 300 31.00 02060 INFENSI VE CARE UNIT 16, 995, 863 16, 995, 863 0 16, 995, 863 0 14, 316, 533 40, 00 04.00 04000 SUBPROVIDER - 1PF 4, 316, 533 4, 316, 533 0 4, 316, 533 0 4, 316, 533 0 4, 316, 533 0 0 43, 00 50.00 05000 OPERATING ROOM 18, 377, 222 18, 377, 222 0 18, 377, 225 50, 00 51, 00 55, 00, 280 13, 323, 597 51, 00 51, 00 51, 00 05000 RADI OLGOY-THERAPEUTIC 2, 324, 744 35, 500 0 50, 00 50, 00 50, 00 50, 00 <td< td=""><td></td><td>1.00</td><td>2.00</td><td>3.00</td><td>4.00</td><td>5.00</td><td></td></td<>		1.00	2.00	3.00	4.00	5.00	
31.00 IS3100 INTENSIVE CARE UNIT 12, 390, 702 12, 390, 702 0 12, 390, 702 31.00 35.00 02600 NEOMTAL INTENSIVE CARE UNIT 16, 995, 863 16, 995, 863 35.00 0 43.00 43.00 43.00 43.00 04.000 SUBPROVIDER - 1PF 4, 316, 533 4, 316, 533 0 4, 316, 533 0 4, 316, 533 0 4, 316, 533 0 4, 316, 533 0 0 50.00 50.00 200 055.00 200 18, 377, 222 0 18, 377, 225 50.00 6, 047, 725 13, 323, 597 0 13, 323, 597 13, 323, 597 13, 323, 597 13, 323, 597 13, 323, 597 13, 323, 597 13, 323, 597 50.00 50.00 50.00 60.00 7, 324, 780 7, 7, 324, 780 7, 7, 324, 780 2, 771, 235 7, 271, 235 7, 271, 235 7, 271, 235 7, 271, 235 7, 271, 235 7, 271, 235 7, 271, 235 7, 271, 235 7, 271, 235 7, 271, 235 7, 271, 235 7, 271, 235 7, 271, 235 7, 271, 235 7, 271, 235 7, 271, 235 7, 271, 235 7, 271, 235 7, 200 7, 304, 374 7,		77 400 000		77 400 00		77 400 000	
35. 00 02060 NEONATAL INTERSIVE CARE UNIT 16, 995, 863 0 16, 995, 863 0 16, 995, 863 0 16, 995, 863 0 16, 995, 863 0 16, 995, 863 0 13, 00 43. 00 04300 NUBSERY 5, 500, 280 5, 500, 280 0 5, 500, 280 43, 00 50. 00 05000 DFRATING ROM 18, 377, 222 16, 047, 725 6, 647, 725 0 6, 447, 725 51, 00 51, 00 51, 00 51, 00 13, 323, 597 13, 323, 597 13, 323, 597 52, 00 51, 00 55, 00, 280 17, 324, 780 0 0, 330 0 0							•
40. 00 04000 SUBPROVIDER - IPF 4,316,533 4,316,533 0 4,316,533 0 4,316,533 0 4,316,533 0 4,300 30. 00 4000 SUBPROVIDER - IPF 5,500,280 5,500,280 0 5,500,280 43.00 ANCILLARY SERVICE COST CENTERS						12, 390, 702	31.00
43.00 0A300 NURSERY 5,500,280 5,500,280 43.00 50.00 05000 OPERATING ROOM 18,377,222 18,377,222 0 18,377,222 50.00 50.00 05000 OPERATING ROOM 6,047,725 6,047,725 0 6,047,725 0 6,047,725 0 6,047,725 0 7,324,780 7,324,780 7,324,780 7,324,780 7,324,740 2,324,744 0 2,324,744 0 2,324,744 0 2,324,744 0 2,324,744 0 2,324,744 0 2,324,744 0 2,324,744 0 2,324,744 0 2,324,744 0 2,324,744 0 2,324,744 0 0,390 180,399 180,399 180,399 180,399 180,399 180,399 190,8200 0 180,399 190,640 0 1,096,400 1,096,400 1,096,400 1,096,400 1,096,400 1,096,400 1,096,400 1,096,400 1,096,400 1,096,200 18,377,631 6,03 6,03600 180,399							
ANCI LLARY SERVICE COST CENTERS ANCI LLARY SERVICE COST CENTERS 00 05000 OPERATING ROM 10.00 05100 RECOVERY ROM 51.00 05200 DELIVERY ROM & LABOR ROM 13.323,597 13.323,597 52.00 05200 RADIOLOGY-DIAGNOSTIC 7.324,780 7.324,780 7.324,780 05500 RADIOLOGY-THERAPEUTIC 2.324,744 2.324,744 2.324,744 0500 CT SCAN 2.771,235 0500 CARDIALCGY-THERAPEUTIC 2.324,744 0500 CT SCAN 2.771,235 000 CARDIALCGY-THERAPEUTIC 2.324,744 010 S800 CRI 1.908,200 010 S800 CRI 1.908,200 010 S800 CARDIAL CATHETERIZATION 180.399 180.399 180.399 00 S600 CARDIALCARTHERAPY 1.908,200 1.908,640 1.109,640 010 CARDIAL CATHETERIZATION 18.377,631 010 CARDIAL THERAPY 4.72,575 02 ATZ,575 02 ATZ,575 030 CARDIAL CATHETERIZATION 4.75,511 040 CARDIALDIALTHERAPY 2.865,299							
50.00 05000 0FERATING ROOM 18, 377, 222 18, 377, 222 0 18, 377, 222 50.00 51.00 05100 05100 6, 047, 725 6, 047, 725 0 6, 047, 725 0 7, 324, 780 0 7, 324, 780 0 7, 324, 780 0 7, 324, 780 0 7, 324, 780 0 7, 324, 780 0 7, 324, 780 0 7, 324, 780 0 7, 324, 780 0 7, 324, 780 0 7, 324, 780 0 7, 324, 780 0 7, 324, 780 0 7, 324, 780 0 7, 324, 780 0 7, 324, 780 0 7, 324, 780 55.00 0 560.00 560.00 560.00 58.00 0 57.00 0 57.00 1, 908, 200 1, 908, 200 1, 908, 200 180, 399 180, 399 180, 399 180, 399 180, 399 180, 399 180, 399 180, 399 180, 399 180, 399 180, 390 180, 399 180, 390 180, 390 180, 390 180, 390 180, 390 180, 370, 60.00 0 0		5, 500, 280		5, 500, 28	0 0	5, 500, 280	43.00
51:00 05100 RECOVERY ROOM 6,047,725 0,047,725 0,047,725 51:00 52:00 05200 DELIVERY ROOM & LABOR ROOM 13,333,597 13,333,597 13,333,597 51:00 54:00 05400 RADIOLOGY-THERAPEUTIC 2,324,744 2,324,744 0,2,324,744 0,2,324,744 0,2,324,744 0,2,324,744 0,2,324,744 0,2,324,744 0,2,324,744 0,2,324,744 0,2,324,744 0,2,324,744 0,2,324,744 0,2,324,744 0,2,324,744 0,2,324,744 0,2,324,744 0,2,324,744 0,2,324,744 50:00 0,000 0,000 CLSON CTS CAN 2,771,235 0,2,717,235 0,2,717,235 0,2,717,235 0,2,717,235 0,2,717,235 0,2,717,235 0,000 0,000 180,399 0,000 0,000 10,008,000 0,000 10,008,000 0,000 10,008,000 0,000 0,000 13,450,437 0,00 180,399 180,399 180,309 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000 0,000							
52:00 05200 DELIVERY ROOM & LABOR ROOM 13, 323, 597 13, 323, 597 13, 323, 597 52, 00 54:00 05400 RADIOLOGY-DIAGNOSTIC 7, 324, 780 7, 324, 780 0 1, 308, 60, 0 6, 30, 800 6, 30 0 6, 00 0 100, 640 0 10, 640 0 10, 640 0 0 0 0 0 0							
54:00 05:00 05:00 7, 324, 780 7, 324, 780 7, 324, 780 54:00 55:00 05:00 05:00 RDI OLOGY-THERAPEUTI C 2, 324, 744 2, 324, 744 0 2, 324, 744 0 2, 324, 744 0 2, 324, 744 0 2, 324, 744 0 2, 324, 744 0 2, 324, 744 0 2, 324, 744 0 2, 324, 744 0 2, 324, 744 0 2, 324, 744 0 2, 324, 744 0 2, 324, 744 0 2, 324, 744 0 2, 324, 744 0 2, 324, 744 0 2, 324, 744 0 2, 324, 744 0 2, 324, 740 55:00 0 2, 771, 235 0 2, 771, 235 0 2, 771, 235 0 2, 771, 235 0 2, 771, 235 0 1, 09, 640 0 1, 09, 640 0 1, 09, 640 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
55.00 0500 RADI 0LOGY - THERAPEUTI C 2, 324, 744 2, 324, 744 2, 324, 744 55.00 57.00 05700 CT SCAN 2, 771, 235 0 2, 771, 235 0 2, 771, 235 57.00 58.00 05800 MRI 1, 908, 200 1, 908, 200 0 1, 908, 200 0 1, 908, 200 0 1, 908, 200 0 1, 908, 200 0 1, 908, 200 0 1, 908, 200 0 1, 908, 200 0 1, 908, 200 0 1, 908, 200 0 1, 908, 200 0 1, 908, 200 0 1, 908, 200 0 1, 908, 200 0 1, 908, 200 0 1, 908, 200 0 1, 908, 200 0 1, 908, 200 0 1, 908, 200 0							
57.00 05700 CT SCAN 2,771,235 2,771,235 0 2,771,235 57.00 58.00 05800 MRI 1,908,200 1,908,200 0 1,908,200 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 180,399 180,399 0 180,399 0 180,399 0 180,399 0 180,399 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0 1,109,640 0 1,109,640 0 1,109,640 0 0 2,472,575 0 2,472,575 0 2,472,575 0 2,472,575 0 2,472,575 0 2,472,575 0 2,472,575 0 2,472,575 0 2,805,299 0 2,805,299 0 2,805,299 0 2,805,299 0 2,805,299 0 2,805,299 0 2,805,299 0 2,520,378 0 2,520,378 0 2,520,378 0 2,520,378 0 2,520,378 0 2,520,378 0 2,520,378 0 0 0 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
58.00 05800 MRI 1,908,200 1,80,399 0 1,80,399 0 1,80,399 0 1,80,399 0 1,80,399 0 1,80,399 0 1,908,200 1,80,399 0 1,80,399 0 1,80,399 0 1,80,399 0 1,80,399 0 1,80,399 0 1,80,399 0 1,908,200 1,80,399 0 1,908,200 1,908,200 1,80,399 0 1,80,399 0 1,80,399 0 1,80,399 0 1,80,399 0 1,80,399 0 1,80,313 0 1,10,90,410 0 1,108,1039							
59:00 05900 CARDI AC CATHETERI ZATI ON 180, 399 180, 399 0 180, 399 59:00 60:00 06000 LABORATORY 13, 450, 437 0 13, 450, 437 0 13, 450, 437 0 13, 450, 437 0 13, 450, 437 0 0 13, 450, 437 0 0 13, 450, 437 0 0 13, 450, 437 0 0 13, 450, 437 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
60.00 06000 LABORATORY 13, 450, 437 13, 450, 437 0 13, 450, 437 60.00 64.00 06400 INTRAVENOUS THERAPY 1, 109, 640 1, 109, 640 0 1, 109, 640 64.00 65.00 06500 RESPI RATORY THERAPY 6, 238, 380 0 62, 328, 380 0 62, 328, 380 0 62, 328, 380 0 62, 328, 380 0 62, 328, 380 0 62, 328, 380 0 62, 00 06000 CUPATIONAL THERAPY 8, 737, 631 0 8, 737, 631 0 8, 737, 631 0 8, 737, 631 0 8, 737, 631 0 8, 737, 631 0 800 900 06000 SPEECH PATHOLOGY 475, 511 0 475, 511 0 475, 511 0 475, 511 0 475, 511 0 475, 511 0 475, 511 0 475, 511 0 475, 511 0 476, 507 70, 607 26, 675, 607 0 26, 675, 607 0 26, 675, 607 0 26, 675, 607 0 26, 57, 607 10, 102, 916 10, 102, 916 10, 102, 916 10, 102, 916 0 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
64.00 06400 INTRAVENOUS THERAPY 1, 109, 640 1, 109, 640 0 1, 109, 640 64.00 65.00 06500 RESPI RATORY THERAPY 6, 238, 380 0 6, 238							
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66.00 06600 PHYSI CAL THERAPY 8, 737, 631 0 8, 737, 631 0 8, 737, 631 0 8, 737, 631 0 8, 737, 631 0 8, 737, 631 0 8, 737, 631 0 8, 737, 631 0 8, 737, 631 0 2, 472, 575 0 2, 65, 299 0 2, 805, 299 0 2, 805, 299 0 2, 805, 299 0 2, 805, 299 0 2, 65, 297 70, 00 0 0 0 0 0 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
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90. 00 09000 CLINIC 0 0 0 0 90. 00 90. 26 04975 SPINE CENTER 352, 761 352, 761 0 352, 761 90. 26 91. 00 09100 EMERGENCY 17, 506, 217 17, 506, 217 0 17, 506, 217 91. 00 92. 00 09200 DBSERVATI ON BEDS (NON-DI STINCT PART 7, 756, 070 7, 756, 070 92. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 114. 00 11400 UI LI ZATI ON REVIEW-SNF 114. 00 320, 312, 269 0 320, 312, 269 0 320, 312, 269 200. 00 201. 00 Less Observation Beds 7, 756, 070 7, 756, 070 7, 756, 070 7, 756, 070 201. 00		10, 192, 916		10, 192, 91	6 0	10, 192, 916	76.07
90. 26 04975 SPI NE CENTER 352, 761 352, 761 91. 00 91. 00 91. 00 91. 00 91. 00 92. 00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART 7, 506, 217 17, 506, 217 0 17, 506, 217 91. 00 92. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 114.00 114 LI ZATI ON REVIEW-SNF 114. 00 200, 00 Subtotal (see instructions) 320, 312, 269 0 320, 312, 269 0 320, 312, 269 200. 00 200, 00							
91. 00 09100 EMERGENCY 17, 506, 217 0 17, 506, 217 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 7, 756, 070 7, 756, 070 92. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11400 UTI LI ZATI ON REVIEW-SNF 113. 00 114.00 114.00 114.01 114.02 114.02 120, 312, 269 0 320, 312, 269 0 320, 312, 269 0 320, 312, 269 0 320, 312, 269 200. 00 201. 00 Less Observation Beds 7, 756, 070 7, 756, 070 7, 756, 070 201. 00		-					•
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 7,756,070 7,756,070 92.00 SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 11400 UTI LI ZATION REVIEW-SNF 114.00 114.00 114.00 320,312,269 0 320,312,269 0 320,312,269 0 320,312,269 0 320,312,269 0 320,312,269 200.00 201.00 14.00 7,756,070 7,756,070 201.00 7,756,070 201.00 7,756,070 201.00 7,756,070 7,756,070 201.00 7,756,070 7,756,070 201.00 7,756,070 201.00 7,756,070 7,756,070 201.00		352, 761		352, 76	1 0	352, 761	90.26
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVIEW-SNF 114.00 200.00 Subtotal (see instructions) 320,312,269 0 320,312,269 0 201.00 Less Observation Beds 7,756,070 7,756,070 7,756,070 201.00						17, 506, 217	91.00
113.00 INTEREST EXPENSE 113.00 114.00 UTI LI ZATI ON REVIEW-SNF 114.00 200.00 Subtotal (see instructions) 320, 312, 269 0 320, 312, 269 0 201.00 Less Observation Beds 7, 756, 070 7, 756, 070 7, 756, 070 7, 756, 070		7, 756, 070		7, 756, 07	0	7, 756, 070	92.00
114.00 UTI LI ZATI ON REVIEW-SNF 114.00 200.00 Subtotal (see instructions) 320, 312, 269 0 320, 312, 269 0 201.00 Less Observation Beds 7, 756, 070 7, 756, 070 7, 756, 070 7, 756, 070							
200.00 Subtotal (see instructions) 320, 312, 269 0 320,							•
201.00 Less Observation Beds 7, 756, 070 7, 756, 070 7, 756, 070 201.00							
			0			320, 312, 269	200. 00
202. 00 Total (see instructions) 312, 556, 199 0 312, 556, 199 0 312, 556, 199							
	202.00 Total (see instructions)	312, 556, 199	0	312, 556, 19	9 0	312, 556, 199	202.00

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CC	CN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/29/2019 3:0	parec
		Titl	e XIX	Hospi tal	PPS	<u> </u>
		Charges	-			
Cost Center Description	Inpati ent	Outpatient	Total (col.	6 Cost or Other	TEFRA	1
·			+ col. 7)	Ratio	Inpati ent	
			· · · · · ·		Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	· ·		•			
0. 00 03000 ADULTS & PEDIATRICS	165, 830, 748		165, 830, 74	18		30.
1.00 03100 INTENSIVE CARE UNIT	23, 666, 719		23, 666, 71	19		31.
5.00 02060 NEONATAL INTENSIVE CARE UNIT	90, 984, 335		90, 984, 33	35		35.
0. 00 04000 SUBPROVIDER - IPF	8, 053, 217		8, 053, 21	17		40.
3. 00 04300 NURSERY	9, 847, 218		9, 847, 21	8		43.
ANCI LLARY SERVI CE COST CENTERS	· · ·					1
0.00 05000 OPERATING ROOM	124, 545, 112	64, 028, 631	188, 573, 74	13 0. 097454	0.00000	50.
1.00 05100 RECOVERY ROOM	20, 751, 392	15, 252, 144	36, 003, 53	0. 167976	0.00000	51.
2.00 05200 DELIVERY ROOM & LABOR ROOM	22, 890, 363	0	22, 890, 36	0. 582061	0.00000	52.
4. 00 05400 RADI OLOGY-DI AGNOSTI C	11, 334, 580	29, 970, 277	41, 304, 85	0. 177335	0.00000	54.
5. 00 05500 RADI OLOGY-THERAPEUTI C	13, 806, 724	17, 715, 934	31, 522, 65	0. 073748	0.00000	55.
7.00 05700 CT SCAN	24, 054, 429	51, 612, 792	75, 667, 22	0. 036624	0.00000	57.
8. 00 05800 MRI	4, 560, 411	15, 494, 637	20, 055, 04	18 0. 095148	0.00000	58.
9. 00 05900 CARDI AC CATHETERI ZATI ON	2, 538, 853	0	2, 538, 85	0. 071055	0.00000	59.
0. 00 06000 LABORATORY	79, 951, 073	49, 405, 985	129, 357, 05	0. 103979	0.00000	60.
4.00 06400 INTRAVENOUS THERAPY	940, 072	135, 372	1, 075, 44	1. 031797	0.00000	64.
5. 00 06500 RESPI RATORY THERAPY	27, 101, 391	2, 696, 998	29, 798, 38	0. 209353	0.00000	65.
6. 00 06600 PHYSI CAL THERAPY	5, 873, 213	22, 750, 238	28, 623, 45	0. 305261	0.00000	66.
7.00 06700 OCCUPATI ONAL THERAPY	5, 121, 206	2, 969, 537	8, 090, 74	13 0. 305605	0.00000	67.
8.00 06800 SPEECH PATHOLOGY	1, 542, 336	803, 061	2, 345, 39	0. 202742	0.00000	68.
9. 00 06900 ELECTROCARDI OLOGY	9, 037, 225	1, 673, 752	10, 710, 97	0. 081223	0.00000	69.
0. 00 07000 ELECTROENCEPHALOGRAPHY	989, 174	11, 787, 312	12, 776, 48	36 0. 219567	0.00000	70.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	58, 183, 514	24, 077, 954	82, 261, 46	0. 324278	0.00000	71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	39, 072, 783	7, 555, 880	46, 628, 66	0. 383881	0.00000	72.
3.00 07300 DRUGS CHARGED TO PATIENTS	81, 103, 033	30, 414, 257	111, 517, 29	0. 228847	0.00000	73.
4.00 07400 RENAL DIALYSIS	3, 466, 226	0	3, 466, 22	0. 444135	0.00000	74.
6. 00 03330 ENDOSCOPY	4, 708, 315	19, 327, 414	24, 035, 72	0. 149573	0.00000	76.
6.06 03954 I MAGI NG CENTER	362, 351	52, 693, 089	53, 055, 44	0. 084254	0.000000	76.
6. 07 03955 BREAST DIAGNOSTIC CENTER	19, 977	20, 088, 726	20, 108, 70	0. 506891	0.00000	76.
OUTPATIENT SERVICE COST CENTERS						
0. 00 09000 CLINIC	0	0		0 0.000000	0. 000000	
0. 26 04975 SPI NE CENTER	0	612, 326			0.00000	
1.00 09100 EMERGENCY	36, 580, 611	131, 010, 587	167, 591, 19		0.00000	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 607, 178	8, 872, 565	10, 479, 74	0. 740101	0.00000	92.
SPECIAL PURPOSE COST CENTERS	1		[- r		4
13.00 11300 INTEREST EXPENSE						113.
14.00 11400 UTILIZATION REVIEW-SNF						114.
00.00 Subtotal (see instructions)	878, 523, 779	580, 949, 468	1, 459, 473, 24	17		200.
01.00 Less Observation Beds						201.
02.00 Total (see instructions)	878, 523, 779	580, 949, 468	1, 459, 473, 24	17		202

	WINDINI IT HOSTITAL OF			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/29/2019 3:05 pm
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient	ПССАТА		113
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 I NTENSI VE CARE UNI T				31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT				35.00
40. 00 04000 SUBPROVIDER - IPF				40.00
43. 00 04300 NURSERY				43.00
ANCI LLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 097454			50.00
51.00 05100 RECOVERY ROOM	0. 167976			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 582061			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 177335			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 073748			55.00
57. 00 05700 CT SCAN	0. 036624			57.00
58. 00 05800 MRI	0. 095148			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 071055			59.00
60. 00 06000 LABORATORY	0. 103979			60.00
64. 00 06400 I NTRAVENOUS THERAPY	1. 031797			64.00
65. 00 06500 RESPI RATORY THERAPY	0. 209353			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 305261			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 305605			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 202742			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 081223			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 219567			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 324278			71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 383881			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 228847			73.00
74.00 07400 RENAL DIALYSIS	0. 444135			74.00
76. 00 03330 ENDOSCOPY	0. 149573			76.00
76. 06 03954 I MAGI NG CENTER	0. 084254			76.06
76. 07 03955 BREAST DI AGNOSTI C CENTER	0. 506891			76.07
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC	0. 000000			90.00
90. 26 04975 SPI NE CENTER	0. 576100			90.26
91.00 09100 EMERGENCY	0. 104458			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 740101			92.00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				114.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00
	i I			12021 00

	COMMUNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-1
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGI REDUCTIONS FOR MEDICAID ONLY	E RATIOS NET OF	Provider CO	CN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part II Date/Time Pre 5/29/2019 3:0	pared: 5 pm
		Titl	e XIX	Hospi tal	PPS	o piii
Cost Center Description	Total Cost	Capital Cost			Operating Cost	
'	(Wkst. B, Part				Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	18, 377, 222	2, 301, 187	16, 076, 03	35 0	0	50.00
51.00 05100 RECOVERY ROOM	6, 047, 725	718, 023	5, 329, 70		0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	13, 323, 597	1, 825, 946		51 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	7, 324, 780	845, 082	6, 479, 69	98 0	0	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	2, 324, 744	543, 662	1, 781, 08	32 0	0	55.00
57.00 05700 CT SCAN	2, 771, 235	329, 349	2, 441, 88	36 0	0	57.00
58. 00 05800 MRI	1, 908, 200	349, 832	1, 558, 30	68 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	180, 399	4, 396	176, 00	03 0	0	59.00
60. 00 06000 LABORATORY	13, 450, 437	421, 553	13, 028, 88	34 0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	1, 109, 640	234, 133	875, 50	0 07	0	64.00
65. 00 06500 RESPI RATORY THERAPY	6, 238, 380	610, 324	5, 628, 0	56 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	8, 737, 631	922, 188	7, 815, 44	43 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	2, 472, 575	156,007			0	67.00
68.00 06800 SPEECH PATHOLOGY	475, 511	30, 299			0	68.00
69. 00 06900 ELECTROCARDI OLOGY	869, 983	24, 898			0	•
70.00 07000 ELECTROENCEPHALOGRAPHY	2,805,299	272, 694			0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		700, 204			0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	17, 899, 862	465, 713			0	•
73. 00 07300 DRUGS CHARGED TO PATIENTS	25, 520, 378	1, 161, 923			0	
74. 00 07400 RENAL DI ALYSI S	1, 539, 474	24, 822			0	•
76. 00 03330 ENDOSCOPY	3, 595, 093	557, 263			0	76.00
76. 06 03954 I MAGI NG CENTER	4, 470, 155	617, 728			0	76.00
76. 07 03955 BREAST DI AGNOSTI C CENTER	10, 192, 916	270, 825			0	
OUTPATIENT SERVICE COST CENTERS			.,, .	· ·] -]		
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 26 04975 SPINE CENTER	352, 761	20, 162			0	
91. 00 09100 EMERGENCY	17, 506, 217	1, 659, 551			0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		916, 767			0	•
SPECIAL PURPOSE COST CENTERS				-		1
113.00 11300 I NTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVIEW-SNF						114.00
200.00 Subtotal (sum of lines 50 thru 199)	203, 925, 891	15, 984, 531	187, 941, 30	50 0		200.00
201.00 Less Observation Beds	7, 756, 070	916, 767				201.00
202.00 Total (line 200 minus line 201)	196, 169, 821	15,067,764				202.00

		MUNITY HOSPITAL				u of Form CMS	-2552-1(
	FION OF OUTPATIENT SERVICE COST TO CHARGE R. DNS FOR MEDICAID ONLY	ATIOS NET OF	Provider C	CN: 15-0169	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part II Date/Time Pr 5/29/2019 3:	epared: 05 pm
				e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and	(Worksheet C,	Cost to Char	ge		
		Operating Cost			6		
		Reduction	8)	/ col. 7)			
		6.00	7.00	8.00			
	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	18, 377, 222	188, 573, 743				50.00
	5100 RECOVERY ROOM	6, 047, 725	36, 003, 536				51.00
	5200 DELIVERY ROOM & LABOR ROOM	13, 323, 597	22, 890, 363				52.00
	5400 RADI OLOGY-DI AGNOSTI C	7, 324, 780	41, 304, 857				54.00
55.00 0	5500 RADI OLOGY-THERAPEUTI C	2, 324, 744	31, 522, 658	0.0737	48		55.00
57.00 0	5700 CT SCAN	2, 771, 235	75, 667, 221	0. 0366	24		57.00
	5800 MRI	1, 908, 200	20, 055, 048	0. 0951	48		58.00
59.00 0	5900 CARDI AC CATHETERI ZATI ON	180, 399	2, 538, 853	0.0710	55		59.00
60.00 00	6000 LABORATORY	13, 450, 437	129, 357, 058	0. 1039	79		60.00
64.00 00	6400 INTRAVENOUS THERAPY	1, 109, 640	1, 075, 444	1.0317	97		64.00
65.00 0	6500 RESPI RATORY THERAPY	6, 238, 380	29, 798, 389	0. 2093	53		65.00
66.00 00	6600 PHYSI CAL THERAPY	8, 737, 631	28, 623, 451	0.3052	61		66.00
67.00 0	6700 OCCUPATI ONAL THERAPY	2, 472, 575	8,090,743		05		67.00
68.00 0	6800 SPEECH PATHOLOGY	475, 511	2, 345, 397	0. 2027	42		68.00
69.00 00	6900 ELECTROCARDI OLOGY	869, 983	10, 710, 977	0. 0812	23		69.00
70.00 0	7000 ELECTROENCEPHALOGRAPHY	2, 805, 299	12, 776, 486	0. 2195	67		70.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	26, 675, 607	82, 261, 468				71.00
	7200 IMPL. DEV. CHARGED TO PATIENTS	17, 899, 862	46, 628, 663				72.00
	7300 DRUGS CHARGED TO PATIENTS	25, 520, 378					73.00
	7400 RENAL DIALYSIS	1, 539, 474	3, 466, 226				74.00
	3330 ENDOSCOPY	3, 595, 093	24, 035, 729				76.00
	3954 I MAGI NG CENTER	4, 470, 155					76.06
	3955 BREAST DI AGNOSTI C CENTER	10, 192, 916	20, 108, 703				76.07
	UTPATIENT SERVICE COST CENTERS	1071727710	207 1007 700	010000	· ·		
	9000 CLINIC	0	0	0.0000	20		90.00
	4975 SPINE CENTER	352, 761	612, 326				90.26
	9100 EMERGENCY	17, 506, 217	167, 591, 198				91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART	7, 756, 070	10, 479, 743				92.00
	PECIAL PURPOSE COST CENTERS	7,700,070	10, 177, 740	0.7401			- /2.00
	1300 INTEREST EXPENSE						113.00
	1400 UTI LI ZATI ON REVI EW-SNF						114.00
200.00	Subtotal (sum of lines 50 thru 199)	203 925 891	1, 161, 091, 010				200.00
201.00	Less Observation Beds	7, 756, 070					200.00
	Total (line 200 minus line 201)		1, 161, 091, 010				201.00

Health Financial Systems	COMMUNI TY HOSPI TAL	OF INDIANA, IN	NC.	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE (CAPI TAL COSTS	Provider C		Period: From 01/01/2018 To 12/31/2018		pared: 5 pm
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTER	S					
30. 00 ADULTS & PEDIATRICS	9, 021, 804	0	9, 021, 80	4 63, 523	142.02	30.00
31.00 INTENSIVE CARE UNIT	1, 756, 697		1, 756, 69	7 5, 973	294.11	31.00
35.00 NEONATAL INTENSIVE CARE UNIT	1, 969, 176		1, 969, 17	6 12, 362	159.29	35.00
40.00 SUBPROVIDER - IPF	393, 806	0	393, 80	6 3, 733	105.49	40.00
43.00 NURSERY	749, 363		749, 36	3 7,653	97.92	43.00
200.00 Total (lines 30 through 199)	13, 890, 846		13, 890, 84	6 93, 244		200.00
Cost Center Description	I npati ent	Inpati ent			•	
	Program days	Program				
	0 3	Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTER	S					
30. 00 ADULTS & PEDIATRICS	19, 318	2, 743, 542				30.00
31.00 INTENSIVE CARE UNIT	2,041	600, 279				31.00
35.00 NEONATAL INTENSIVE CARE UNIT	0	0				35.00
40.00 SUBPROVIDER - IPF	2,614	275, 751				40.00
43.00 NURSERY	0		1			43.00
200.00 Total (lines 30 through 199)	23, 973	3, 619, 572				200.00

Health Financial Systems COMM	UNI TY HOSPI TAL	OF INDIANA, II	VC.	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Peri od:	Worksheet D	
				From 01/01/2018 To 12/31/2018		norod.
				To 12/31/2018	Date/Time Pre 5/29/2019 3:0	pareu: 5 nm
		Title	XVIII	Hospi tal	PPS	<u>o p</u>
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0.001.107	100 570 740		a		
50. 00 05000 OPERATING ROOM	2, 301, 187					
51.00 05100 RECOVERY ROOM	718, 023					
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 825, 946					•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	845, 082					
55. 00 05500 RADI OLOGY-THERAPEUTI C	543, 662					
57. 00 05700 CT SCAN	329, 349		0.00435		42, 654	
58. 00 05800 MRI	349, 832					•
59. 00 05900 CARDI AC CATHETERI ZATI ON	4, 396					
	421, 553					
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	234, 133 610, 324					
66. 00 06600 PHYSI CAL THERAPY	922, 188		0. 02048			
67. 00 06700 OCCUPATI ONAL THERAPY	156,007					
68. 00 06800 SPEECH PATHOLOGY	30, 299					
69. 00 06900 ELECTROCARDI OLOGY	24, 898					
70. 00 07000 ELECTROENCEPHALOGRAPHY	24, 696					•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	700, 204					
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	465, 713					
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 161, 923					
74. 00 07400 RENAL DI ALYSI S	24, 822					•
76. 00 03330 ENDOSCOPY	557, 263					
76. 06 03954 I MAGI NG CENTER	617, 728					
76. 07 03955 BREAST DI AGNOSTI C CENTER	270, 825					•
OUTPATIENT SERVICE COST CENTERS	2,0,020	20,100,700	0.01040	0	0	1 . 0. 07
90. 00 09000 CLINIC	0	0	0.00000	0 0	0	90.00
90. 26 04975 SPI NE CENTER	20, 162	-			-	
91. 00 09100 EMERGENCY	1, 659, 551				-	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	916, 767					92.00
200.00 Total (lines 50 through 199)		1, 161, 091, 010		194, 538, 932		•

Health Financial Systems COM	IMUNI TY HOSPI TAL	OF INDIANA, IN	NC.	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	ASS THROUGH COS		-	Period: From 01/01/2018 Fo 12/31/2018	Date/Time Pre 5/29/2019 3:0	pared: 5 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School		Allied Health	All Other	
	Post-Stepdown		Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	· ·			·		
30. 00 03000 ADULTS & PEDIATRICS	0	0	(0 0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0		0	0	31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0	0		0	0	
40. 00 04000 SUBPROVI DER - I PF	0	0			0	
43. 00 04300 NURSERY	0	0			0	1
	0	0			-	200.00
200.00 Total (lines 30 through 199)	U Curi a a Da d	Total Costs				200.00
Cost Center Description	Swing-Bed			Per Diem (col.	Inpatient	
	Adj ustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)	(0.0	7.00	0.00	
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	-		(0.50)		10.010	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	63, 523			
31.00 03100 INTENSIVE CARE UNIT		0	5, 973			
35.00 02060 NEONATAL INTENSIVE CARE UNIT		0	12, 362			
40. 00 04000 SUBPROVIDER - IPF	0	0	3, 73	0.00	2, 614	40.00
43. 00 04300 NURSERY		0	7,65	0.00	0	43.00
200.00 Total (lines 30 through 199)		0	93, 24	1	23, 973	200.00
Cost Center Description	I npati ent			·		
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0					35.00
40. 00 04000 SUBPROVI DER - I PF	0					40.00
						1 40.00
						13 00
43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0					43.00 200.00

Health Financial Systems COMM	IUNI TY HOSPI TAL	OF INDIANA, II	NC.	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	5 Provider C	CN: 15-0169	Period: From 01/01/2018 To 12/31/2018		pared: 5 pm
		Title	e XVIII	Hospi tal	PPS	•
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
		Post-Stepdown	Ŭ	Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	C)	0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0)	0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C		0 0	0	55.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MRI	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0			0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0			0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0 0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0				0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0				0	73.00
74. 00 07400 RENAL DIALYSIS	0				0	74.00
76. 00 03330 ENDOSCOPY	0				0	76.00
76. 06 03954 I MAGI NG CENTER	0	0		0 0	0	76.06
76. 07 03955 BREAST DI AGNOSTI C CENTER	0			0 0	0	76.07
OUTPATIENT SERVICE COST CENTERS	0		1	0 0	0	70.07
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 26 04975 SPINE CENTER	0				0	90.00
90. 28 04975 SPINE CENTER 91. 00 09100 EMERGENCY	0				0	90.28
	0	U	1	0	0	91.00
	0				e e	92.00 200.00
200.00 Total (lines 50 through 199)	1 0		1	0 0	0	1200.00

	MUNI TY HOSPI TAL		NC.	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	CN: 15-0169	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2018 To 12/31/2018		norod.
				10 12/31/2018	Date/Time Pre 5/29/2019 3:0	
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)	, , , , , , , , , , , , , , , , , , ,	,	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0 0		0 188, 573, 743		
51.00 05100 RECOVERY ROOM	0	0 0		0 36, 003, 536		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0 0		0 22, 890, 363	0. 000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	0 41, 304, 857	0.00000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 31, 522, 658	0. 000000	55.00
57.00 05700 CT SCAN	0	0		0 75, 667, 221	0.000000	57.00
58. 00 05800 MRI	0	0		0 20, 055, 048	0. 000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 2, 538, 853	0. 000000	59.00
60. 00 06000 LABORATORY	0	0		0 129, 357, 058	0. 000000	60.00
64.00 06400 INTRAVENOUS THERAPY	0	c c		0 1,075,444	0. 000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 29, 798, 389	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	c c		0 28, 623, 451	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	c c		0 8, 090, 743	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	o c		0 2, 345, 397	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0			0 10, 710, 977	0. 000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0			0 12, 776, 486		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	o c		0 82, 261, 468	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	o c		0 46, 628, 663		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	o c		0 111, 517, 290	0. 000000	73.00
74.00 07400 RENAL DIALYSIS	0	o c		0 3, 466, 226		74.00
76.00 03330 ENDOSCOPY	0	o c		0 24, 035, 729	0. 000000	76.00
76. 06 03954 I MAGI NG CENTER	0	o c		0 53, 055, 440	0. 000000	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	o c		0 20, 108, 703	0. 000000	76.07
OUTPATIENT SERVICE COST CENTERS	•			- i · ·		1
90. 00 09000 CLINIC	0	0		0 0	0.00000	90.00
90. 26 04975 SPI NE CENTER	0	0 0		0 612, 326	0. 000000	90.26
91.00 09100 EMERGENCY	0	0 0		0 167, 591, 198	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0 0		0 10, 479, 743		92.00
200.00 Total (lines 50 through 199)	0	C		0 1, 161, 091, 010		200.00

APPORTIONMENT OF INPARIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-0169 Period: From 01/01/2018 Worksheet 0 From 01/01/2018 Impact Introduct Costs Title XVIII Hospital Form 01/01/2018 Program Pass-Through Costs (col. 9 Dutpatient Program Pass-Through Costs (col. 9 Hospital Program Pass-Through Costs (col. 9 Dutpatient Program Pass-Through Costs (col. 9 Dutpatient Pass-Through Costs (col. 9 Dutpatient Pass-Thr	Health Financial Systems COM	MUNITY HOSPITAL ()FINDIANA, IN	IC.	In Li	eu of Form CMS-	2552-10
Cost Center Description Outpatient Ratio of Cost to Charges (col. 6 + col. 7) Inpatient Program Charges Inpatient Program Pass-Through Costs (col. 9 Outpatient Program Charges Program Pass-Through Costs (col. 9 Outpatient Program Pass-Through Costs (col. 9 50.00 05000 PECVTERY 0000 0.000000 45, 194, 925 0 12, 587, 813 0 0.00 50.00 05000 PECVTERY ROOM 0.000000 5, 871, 168 0 5, 48, 220 0 5, 43, 220 0 5, 23, 25, 591 0 5, 00 5, 00, 5, 20, 12, 32, 228, 591 0 5, 00, 5, 23, 22, 00 5, 43, 220 0 5, 43, 220 0 5, 43, 220 0 5, 43, 220 0 5, 43, 220 0 5, 43, 220 0 5, 43, 220 0 5, 43, 220 0 5, 43, 220 0 5, 43, 220 0 5, 43, 220 0 5, 43, 220 0 5, 43, 220 0 5, 43, 220 0 5, 43, 220 0 5, 43, 220 0 5, 43, 220 0 5, 43, 220 0 6, 40, 0 6, 00 0 6, 5, 00 0 0,		RVICE OTHER PASS	Provider C	CN: 15-0169	From 01/01/2018	B Part IV	pared:
Cost Center Description Outpatient Ratio of Cost to Charges (col. 6 + col. 7) Inpatient Program (Charges) Inpatient Program (Charges) Unpatient Program (Charges) Outpatient Program (Charges)						5/29/2019 3:0	
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		0. 000000	15, 913, 268		0 16, 661, 634	t 0	
200.00 Total (lines 50 through 199) 194, 538, 932 0 112, 938, 003 0 200.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	484, 644		0 3, 682, 973		
	200.00 Total (lines 50 through 199)		194, 538, 932		0 112, 938, 003	3 0	200.00

Health Financial Systems COMM	UNI TY HOSPI TAL	OF INDIANA, IN	NC.	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0169	Peri od:	Worksheet D	
				From 01/01/2018 To 12/31/2018	Part V Date/Time Pre	pared.
					5/29/2019 3:0	
	1	Title	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	Servi ces (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins (see inst.)	. Ded. & Coins. (see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	0. 097454	12, 587, 813		0 0	1, 226, 733	50.00
51. 00 05100 RECOVERY ROOM	0. 167976			0 0		
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 582061	2,200,071	1	0 0		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 177335	-		0 0	-	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 073748			0 0	577,059	
57. 00 05700 CT SCAN	0. 036624			0 0		
58. 00 05800 MRI	0. 095148			0 0	348, 598	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 071055			0 0	0	
60. 00 06000 LABORATORY	0. 103979)	0 0	914, 610	60.00
64.00 06400 INTRAVENOUS THERAPY	1.031797	0	1	0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 209353	271, 209		0 0	56, 778	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 305261	97, 812		0 0	29, 858	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 305605	51, 564		0 0	15, 758	67.00
68.00 06800 SPEECH PATHOLOGY	0. 202742			0 0	3, 066	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 081223	300, 426	,	0 0	24, 402	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 219567	2, 399, 994		0 0	526, 959	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 324278			0 0	.,	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 383881			0 0	.,	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 228847			0 121, 895	1, 897, 561	
74.00 07400 RENAL DIALYSIS	0. 444135			0 0	0	
76.00 03330 ENDOSCOPY	0. 149573			0 0		
76.06 03954 I MAGI NG CENTER	0. 084254			0 0		
76. 07 03955 BREAST DI AGNOSTI C CENTER	0. 506891	1, 916, 745		0 0	971, 581	76.07
OUTPATIENT SERVICE COST CENTERS			1	-		
90. 00 09000 CLINIC	0.00000			0 0		
90. 26 04975 SPI NE CENTER	0. 576100			0 0	2, 085	
91.00 09100 EMERGENCY	0. 103846			0 0		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Subtotal (see instructions)	0. 740101			0 0 0 121, 895	2, 725, 772	
200.00Subtotal (see instructions)201.00Less PBP Clinic Lab. Services-Program		112, 938, 003		0 121, 895		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0		201.00
202.00 Net Charges (line 200 - line 201)		112, 938, 003		0 121, 895	17, 636, 038	202.00

Health Financial Systems COMM	IUNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-0169	Period: From 01/01/2018	Worksheet D Part V	
				To 12/31/2018	Date/Time Pro 5/29/2019 3:0	epared:
		Title	XVIII	Hospi tal	PPS	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins. (see inst.)	Ded. & Coins. (see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	0100	7100	1			
50. 00 05000 OPERATI NG ROOM	0	0				50.00
51.00 05100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
57.00 05700 CT SCAN	0	0				57.00
58. 00 05800 MRI	0	0				58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60.00 06000 LABORATORY	0	0				60.00
64.00 06400 INTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	0	0				66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	27, 895				73.00
74.00 07400 RENAL DIALYSIS	0	0				74.00
76.00 03330 ENDOSCOPY	0	0				76.00
76.06 03954 I MAGI NG CENTER	0	0				76.06
76.07 03955 BREAST DI AGNOSTI C CENTER	0	0				76.07
OUTPATIENT SERVICE COST CENTERS			1			_
90. 00 09000 CLI NI C	0	0				90.00
90. 26 04975 SPI NE CENTER	0	0				90.26
91.00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	0	0				92.00
200.00Subtotal (see instructions)201.00Less PBP Clinic Lab. Services-Program	0	27, 895				200. 00 201. 00
Only Charges	0					201.00
202.00 Net Charges (line 200 - line 201)	0	27, 895				202.00
	۲ VI	2.,070	1			1-02.00

Cost (f st. B, P col .)))))))))))))))))))	Component Title Title Total Charges from Wkst. C, Part I, col. 8) 2.00 188,573,743 36,003,534 22,890,365 41,304,855 31,522,654 75,667,222 20,055,044 2,538,855 129,357,055 1,075,444	CCN: 15-S169 XVIII Ratio of Costor to Charges (col. 1 ÷ col 2) 3.00 0.01220 0.01994 0.07976 0.02046 0.01724 0.0435 0.01744 0.00173 0.0025	. Program Charges 3 0 3 0 9 0 0 33, 606 7 0 3 87, 949 4 8, 489 1 0	Date/Time Preg 5/29/2019 3: 02 PPS Capi tal Costs (col umn 3 x col umn 4) 5: 00 0 0 0 688 0 383 148 0 2, 695	5 pm 50. 00 51. 00 52. 00 54. 00 55. 00 57. 00 57. 00 58. 00 59. 00
Cost (f st. B, P col .)))))))))))))))))))	Ti tl 1 Ti tl 1 Total Charges from Wkst. C, Part I, col. 8) 2.00 188, 573, 743 36, 003, 534 22, 890, 363 41, 304, 857 31, 522, 654 75, 667, 227 20, 055, 044 2, 538, 855 129, 357, 055 1, 075, 444	CCN: 15-S169 XVIII Ratio of Cos- to Charges (col. 1 ÷ col 2) 3.00 0.01220 0.01994 0.07976 0.02046 0.01724 0.00435 0.01744 0.00435 0.01744 0.00173 0.00325	To 12/31/2018 Subprovi der - IPF Inpati ent Program Charges 4.00 4.00 3 0 9 0 0 33,606 7 0 0 33,606 7 0 87,949 4 8,489 1 0	Date/Time Pret 5/29/2019 3:02 PPS Capi tal Costs (col umn 3 x col umn 4) 5:00 0 0 688 0 383 148 0 2,695	5 pm 50. 00 51. 00 52. 00 54. 00 55. 00 57. 00 57. 00 58. 00 59. 00
Cost (f st. B, P col .)))))))))))))))))))	Ti tl 1 Ti tl 1 Total Charges from Wkst. C, Part I, col. 8) 2.00 188, 573, 743 36, 003, 534 22, 890, 363 41, 304, 857 31, 522, 654 75, 667, 227 20, 055, 044 2, 538, 855 129, 357, 055 1, 075, 444	 XVIII Ratio of Costo Charges (col. 1 + col 2) 3.00 0.01220 0.01994 0.07976 0.02046 0.01724 0.00435 0.01744 0.00173 0.00325 	Subprovi der - IPF Inpatient Program Charges 4.00 4.00 3 0 9 0 0 33,606 7 0 3 87,949 4 8,489 1 0	5/29/2019 3: 05 PPS Capi tal Costs (col umn 3 x col umn 4) 5: 00 0 0 0 688 0 383 148 0 2, 695	5 pm 50. 00 51. 00 52. 00 54. 00 55. 00 57. 00 57. 00 58. 00 59. 00
Cost (f st. B, P col .)))))))))))))))))))	otal Charges from Wkst. C, Part I, col. 8) 2.00 188,573,744 36,003,534 22,890,365 41,304,85 31,522,654 75,667,22 20,055,044 2,538,855 129,357,055 1,075,444	Rati o of Cost to Charges (col. 1 ÷ col 2) 3.00 0.01220 0.01994 0.07976 0.02046 0.01724 0.00435 0.01744 0.00173 0.00325	I PF I npati ent Program Charges 4.00 3 0 9 0 0 33,606 7 0 3 87,949 4 8,489 1 0	PPS Capital Costs (column 3 x column 4) 5.00 0 0 0 688 0 383 148 0 2,695	50.00 51.00 52.00 55.00 55.00 57.00 57.00 58.00 59.00
Cost (f st. B, P col .)))))))))))))))))))	from Wkst. C, Part I, col. 8) 2.00 188,573,74: 36,003,53(22,890,363 41,304,85 31,522,65(75,667,22 20,055,067,22 20,055,05(129,357,05(1,075,444)	to Charges (col. 1 ÷ col 2) 3.00 0.01220 0.01994 0.07976 0.02046 0.01724 0.00435 0.01744 0.00173 0.00325	I npati ent Program Charges 4.00 4.00 3 0 9 0 0 33,606 7 0 3 87,949 4 8,489 1 0	(col umn 3 x col umn 4) 5.00 0 0 0 688 0 383 148 0 2,695	51.00 52.00 54.00 55.00 57.00 58.00 59.00
Cost (f st. B, P col .)))))))))))))))))))	from Wkst. C, Part I, col. 8) 2.00 188,573,74: 36,003,53(22,890,363 41,304,85 31,522,65(75,667,22 20,055,067,22 20,055,05(129,357,05(1,075,444)	to Charges (col. 1 ÷ col 2) 3.00 0.01220 0.01994 0.07976 0.02046 0.01724 0.00435 0.01744 0.00173 0.00325	. Program Charges 3 0 3 0 9 0 0 33, 606 7 0 3 87, 949 4 8, 489 1 0	(col umn 3 x col umn 4) 5.00 0 0 0 688 0 383 148 0 2,695	51.00 52.00 54.00 55.00 57.00 58.00 59.00
st. B, P, col.), 187 18, 023 25, 946 45, 082 43, 662 29, 349 49, 832 4, 396 21, 553 34, 133	Part I, col. 8) 2.00 188,573,743 36,003,534 22,890,363 41,304,85 31,522,654 75,667,22 20,055,044 2,538,855 129,357,055 1,075,444	(col . 1 + col 2) 3.00 0.01220 0.01994 0.07976 0.02046 0.01724 0.00435 0.01744 0.00173 0.00325	. Charges 4.00 3 0 9 0 0 33,606 7 0 3 87,949 4 8,489 1 0	col umn 4) 5.00 0 0 688 0 383 148 0 2,695	51.00 52.00 54.00 55.00 57.00 58.00 59.00
col . 0 0 0 0 0 0 0 1, 187 18, 023 25, 946 45, 082 13, 662 29, 349 49, 832 4, 396 21, 553 34, 133 0 0 0 0 0 0 0 0 0 0 0 0 0	8) 2.00 188,573,743 36,003,533 22,890,363 41,304,855 31,522,655 75,667,227 20,055,044 2,538,855 129,357,055 1,075,444	2) 3.00 0.01220 0.01994 0.07976 0.02046 0.01724 0.00435 0.01744 0.00173 0.00125	4.00 3 0 3 0 9 0 33,606 0 7 0 3 87,949 4 8,489 1 0	5.00 0 0 688 0 383 148 0 2,695	51.00 52.00 54.00 55.00 57.00 58.00 59.00
0) 11, 187 18, 023 25, 946 45, 082 13, 662 29, 349 19, 832 4, 396 21, 553 34, 133	2.00 188,573,743 36,003,534 22,890,363 41,304,855 31,522,654 75,667,222 20,055,044 2,538,855 129,357,055 1,075,444	3.00 0.01220 0.01994 0.07976 0.02046 0.01724 0.00435 0.01744 0.00173 0.00173	3 0 3 0 9 0 0 33, 606 7 0 3 87, 949 4 8, 489 1 0	0 0 688 0 383 148 0 2, 695	51.00 52.00 54.00 55.00 57.00 58.00 59.00
01, 187 18, 023 25, 946 45, 082 43, 662 29, 349 49, 832 4, 396 21, 553 34, 133	188, 573, 743 36, 003, 534 22, 890, 363 41, 304, 85 31, 522, 654 75, 667, 22 20, 055, 044 2, 538, 855 129, 357, 058 1, 075, 444	0. 01220 0. 01994 0. 07976 0. 02046 0. 01724 0. 00435 0. 01744 0. 00173 0. 00325	3 0 3 0 9 0 0 33, 606 7 0 3 87, 949 4 8, 489 1 0	0 0 688 0 383 148 0 2, 695	51.00 52.00 54.00 55.00 57.00 58.00 59.00
01, 187 18, 023 25, 946 45, 082 43, 662 29, 349 49, 832 4, 396 21, 553 34, 133	188, 573, 743 36, 003, 534 22, 890, 363 41, 304, 85 31, 522, 654 75, 667, 22 20, 055, 044 2, 538, 855 129, 357, 058 1, 075, 444	0. 01220 0. 01994 0. 07976 0. 02046 0. 01724 0. 00435 0. 01744 0. 00173 0. 00325	3 0 3 0 9 0 0 33, 606 7 0 3 87, 949 4 8, 489 1 0	0 0 688 0 383 148 0 2, 695	51.00 52.00 54.00 55.00 57.00 58.00 59.00
18, 023 25, 946 45, 082 43, 662 29, 349 49, 832 4, 396 21, 553 34, 133	36, 003, 536 22, 890, 363 41, 304, 85 31, 522, 656 75, 667, 22 20, 055, 044 2, 538, 853 129, 357, 056 1, 075, 444	0. 01994 0. 07976 0. 02046 0. 01724 0. 00435 0. 01744 0. 00173 0. 00325	3 0 9 0 7 0 3 87, 949 4 8, 489 1 0	0 0 688 0 383 148 0 2, 695	51.00 52.00 54.00 55.00 57.00 58.00 59.00
18, 023 25, 946 45, 082 43, 662 29, 349 49, 832 4, 396 21, 553 34, 133	36, 003, 536 22, 890, 363 41, 304, 85 31, 522, 656 75, 667, 22 20, 055, 044 2, 538, 853 129, 357, 056 1, 075, 444	0. 01994 0. 07976 0. 02046 0. 01724 0. 00435 0. 01744 0. 00173 0. 00325	3 0 9 0 7 0 3 87, 949 4 8, 489 1 0	0 0 688 0 383 148 0 2, 695	51.00 52.00 54.00 55.00 57.00 58.00 59.00
25, 946 45, 082 43, 662 29, 349 49, 832 4, 396 21, 553 34, 133	22, 890, 363 41, 304, 85 31, 522, 658 75, 667, 22 20, 055, 048 2, 538, 853 129, 357, 058 1, 075, 444	0. 07976 0. 02046 0. 01724 0. 00435 0. 01744 0. 00173 0. 00325	9 0 0 33,606 7 0 3 87,949 4 8,489 1 0	0 688 0 383 148 0 2, 695	52.00 54.00 55.00 57.00 58.00 59.00
45, 082 43, 662 29, 349 49, 832 4, 396 21, 553 34, 133	41, 304, 85 31, 522, 658 75, 667, 22 20, 055, 048 2, 538, 85 129, 357, 058 1, 075, 444	0. 02046 0. 01724 0. 00435 0. 01744 0. 00173 0. 00325	0 33, 606 7 0 3 87, 949 4 8, 489 1 0	688 0 383 148 0 2, 695	54.00 55.00 57.00 58.00 59.00
43, 662 29, 349 49, 832 4, 396 21, 553 34, 133	31, 522, 658 75, 667, 22 20, 055, 048 2, 538, 853 129, 357, 058 1, 075, 444	0. 01724 0. 00435 0. 01744 0. 00173 0. 00325	7 0 3 87,949 4 8,489 1 0	0 383 148 0 2, 695	55.00 57.00 58.00 59.00
29, 349 49, 832 4, 396 21, 553 34, 133	75, 667, 22 20, 055, 048 2, 538, 85 129, 357, 058 1, 075, 444	0. 00435 0. 01744 0. 00173 0. 00325	3 87, 949 4 8, 489 1 0	383 148 0 2, 695	57.00 58.00 59.00
49, 832 4, 396 21, 553 34, 133	20, 055, 048 2, 538, 853 129, 357, 058 1, 075, 444	0. 01744 0. 00173 0. 00325	4 8, 489 1 0	148 0 2, 695	58.00 59.00
4, 396 21, 553 34, 133	2, 538, 853 129, 357, 058 1, 075, 444	0. 00173 0. 00325	1 0	0 2, 695	59.00
21, 553 34, 133	129, 357, 058 1, 075, 444	0. 00325		2, 695	
34, 133	1, 075, 444		9 826, 848		
			10 / 04	1 1 0 0 0	60.00 64.00
0 224					
10, 324 22, 188	29, 798, 389				65.00 66.00
22, 188 56, 007	28, 623, 45 8, 090, 743				67.0
30, 299					68.0
24, 898	2, 345, 39 10, 710, 97				69.0
24, 090 72, 694	12, 776, 480				70.00
0, 204	82, 261, 468				70.00
55, 713	46, 628, 663				72.00
51, 923	111, 517, 290				73.00
24, 822	3, 466, 220				74.00
57, 263	24, 035, 729			-	76.0
17,728	53, 055, 440			-	76.0
70, 825	20, 108, 703				76.0
0,023	20, 100, 70.	0.01340	0 0	0	70.0
	(0,0000	0	0	90.00
0				-	90.20
0			-	-	91.00
20, 162					92.00
20, 162 59, 551	167, 591, 198			<u>۱</u>	
	-	20, 162 612, 326	20, 162 612, 326 0. 03292	20, 162 612, 326 0. 032927 0 559, 551 167, 591, 198 0. 009902 244, 191	20, 162 612, 326 0. 032927 0 0

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-0109 Component CCN: 15-5169 Worksheet D From 01/12/2018 To 12/31/2019 Worksheet D Part I V Subprovider - 1	Health Financial Systems COMM	UNITY HOSPITAL	OF INDIANA, IN	VC.	In Lie	eu of Form CMS-2	2552-10
Component CCN: 15-S169 To 12/31/2018 Date/Time Prepared: 5/29/2019 Stobprovider - 197 Cost Center Description Non Physician Nursing School Nursing Schop Nursing School Nursing School Nursing Schop Nursing Sc	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der C	CN: 15-0169			
Cost Center Description Non Physician Nursing School Nursing School Nursing School Allied Health Allied Health Cost Adjustments Allied Health Allied Health Allied Health Cost Stepdown Adjustments ANCILLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 50.00 050000 PERATING ROOM 0	THROUGH COSTS		Component	CON. 15 61/0			norod.
Cost Center Description Non Physician Adjustments Nursing School Post-Stepdown Adjustments Allied Health Post-Stepdown Adjustments Allied Health Post-Stepdown Adjustments ANCILLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00 50.00 05000 (PEERATING ROM 0			component	CCN: 15-5109	10 12/31/2018		
Cost Center Description Non Physician Nursing School Nursing School Nursing School All I ed Health Post-Stepdown Adjustments All I ed Health Post-Stepdown Adjustments ANCILLARY SERVICE COST CENTERS 0 0 0 3A 50.00 05000 (PERATING ROM 0 <td></td> <td></td> <td>Title</td> <td>XVIII</td> <td>Subprovider -</td> <td></td> <td><u> </u></td>			Title	XVIII	Subprovider -		<u> </u>
Anesthetist Post-Stepdown Adjustments Post-Stepdown Adjustments ANCILLARY SERVICE COST CENTERS 0 2.00 3A 3.00 ANCILLARY SERVICE COST CENTERS 0							
Cost Adj ustments Adj ustments Adj ustments 1.00 2A 2.00 3A 3.00 50.00 05000 PERATI NG ROOM 0 <t< td=""><td>Cost Center Description</td><td></td><td></td><td></td><td></td><td>Allied Health</td><td></td></t<>	Cost Center Description					Allied Health	
Image: Notification of the service cost centres 1.00 2A 2.00 3A 3.00 50.00 05000 OPERATING ROOM 0 0 0 0 50.00 50.00 05000 OPERATING ROOM 0 0 0 0 0 50.00 51.00 05000 PELVERY ROOM & LABOR ROOM 0 0 0 0 51.00 52.00 05000 RECOVERY ROOM & LABOR ROOM 0 0 0 51.00 55.00 05500 ROI-LOGY-THERAPEUTIC 0 0 0 0 55.00 57.00 05700 CT SCAN 0 0 0 0 55.00 58.00 05800 MRI 0 0 0 0 59.00 60.00 0 0 0 0 0 0 0 59.00 60.00 0 0 0 0 0 0 0 0 0 60.00 0 <							
ANCILLARY SERVICE COST CENTERS 50.00 05000 0PERATING ROOM 0 <						0.00	
50.00 05000 DERATING ROOM 0		1.00	2A	2.00	3A	3.00	
51.00 05100 RECOVERY ROOM 0				1	0		F0 00
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 52.00 54.00 05400 RADI OLOGY-TI AGNOSTI C 0 0 0 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 55.00 55.00 05500 CASON LOGY-THERAPEUTI C 0 0 0 0 57.00 57.00 05700 CT SCAN 0 0 0 0 57.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 59.00 60.00 06000 LABORATORY 0 0 0 0 64.00 64.00 064001 INTRAVENOUS THERAPY 0 0 0 0 65.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 67.00 67.00 06400 DECONTERDATIONAL THERAPY 0 0 0 66.00 69.00		0	0		0 0	-	
54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 55.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 55.00 57.00 CT SCAN 0 0 0 0 0 57.00 58.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 58.00 60.00 06400 INTRAVENDUS THERAPY 0 0 0 0 64.00 65.00 66.00 67.00 66.00 67.00 66.00 67.00 66.00 67.00 66.00 67.00 66.00 67.00 66.00 67.00 66.00 67.00 67.00 67.00<		0	0		0 0	-	
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APPORTI ONMENT OF INPARIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-016 Component CON: 15-5169 Morksheet D From 01/01/2018 To 12/31/2018 Worksheet D Part I V Data/Time Prepared: 50/2079 12/31/2018		UNITY HOSPITAL				u of Form CMS-:	2552-10
Interest in Source Component CCN: 15-S169 To 12/3/12/018 Date:TI me Prepared: 5/29/2019 3:05 pm Cost Center Description All Other Education Cost Total Cost Total Cost Supprovider - IPF PPS MCILLARY SERVICE COST CENTERS 4:00 5:00 6:00 7:00 8:00 6:00 5:00 6:00 7:00 8:00 5:00 0:000000 5:00 5:00 0:000000 5:00 0:000000 5:00 5:00 0:000000 5:00 5:00 0:000000 5:00 5:00 0:000000 5:00 5:00 5:00 0:000000 5:00 5:00 5:00 0:000000 5:00 5:00 5:00 5:00 5:00 5:00 5:00 0:010000000 5:00<		RVICE OTHER PASS	S Provider C			Worksheet D	
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58.00 05800 MRI 0 0 20,055,048 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI 0N 0 0 2,538,853 0.000000 60.000 60.00 LABORATORY 0 0 129,357,058 0.000000 60.000 60.000 60.000 11,075,444 0.000000 64.00 65.00 06400 INTRAVENOUS THERAPY 0 0 0 29,788,389 0.000000 65.00 66.00 06600 RESPI RATORY THERAPY 0 0 0 28,623,451 0.000000 67.00 67.00 06700 0CUPATI ONAL THERAPY 0 0 0 8,090,743 0.000000 68.00 69.00 06800 SPEECH PATHOLOGY 0 0 0 10,710,977 0.000000 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 22,261,468 0.000000 71.00 72.00 07200 INPL. DEV. CHARGED TO PATI ENTS 0 0 11,1517,290 0.000000 72.00 73.00 07300		0	C				
59.00 05900 CARDI AC CATHETERI ZATI 0N 0 0 2, 538, 853 0.000000 59.00 60.00 06000 LABORATORY 0 0 129, 357, 058 0.000000 60.00 64.00 06400 INTRAVENOUS THERAPY 0 0 1,075, 444 0.00000 64.00 65.00 06500 RESPI RATORY THERAPY 0 0 29, 798, 389 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 28, 623, 451 0.000000 66.00 67.00 0C000 CUPATI ONAL THERAPY 0 0 0 28, 623, 451 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 2, 345, 397 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 10, 710, 977 0.000000 69.00 71.00 OTOO ELECTROCARDI PATI ENT 0 0 12, 776, 486 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 111, 517, 290 0.0000000 73.0		0	C				
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64.00 06400 INTRAVENOUS THERAPY 0 0 1,075,444 0.00000 64.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 29,798,389 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 28,623,451 0.000000 66.00 67.00 0CCUPATI ONAL THERAPY 0 0 0 8,090,743 0.000000 66.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 2,345,397 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 10,710,977 0.000000 69.00 70.00 07000 ELECTROCARDI OLOGY 0 0 12,776,486 0.000000 70.00 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 46,628,663 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 46,628,663 0.000000 73.00 73.00 07300 RUGS CHARGED TO PATI ENTS 0 0 </td <td></td> <td>0</td> <td>C</td> <td></td> <td></td> <td></td> <td>•</td>		0	C				•
65.00 06500 RESPI RATORY THERAPY 0 0 29,798,389 0.00000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 28,623,451 0.000000 66.00 67.00 06700 0CUPATI ONAL THERAPY 0 0 0 8,090,743 0.000000 67.00 68.00 06800 SPECH PATHOLOGY 0 0 2,345,397 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 12,776,486 0.000000 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 12,776,486 0.000000 71.00 72.00 IMUS CHARGED TO PATI ENTS 0 0 0 11,517,29 0.000000 73.00 74.00 O7400 RENAL DI ALYSI S 0 0 0 3,466,226 0.000000 74.00 76.00 03330 ENDSCOPY 0 0 0 24,035,729 0.000000 76.07 76.01 03954 I MAGI NG CENTER 0 0		0	C				
66.00 06600 PHYSI CAL THERAPY 0 0 28, 623, 451 0.000000 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 8, 090, 743 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 2, 345, 397 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 10, 710, 977 0.000000 68.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 12, 776, 486 0.000000 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 46, 628, 663 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 3, 466, 226 0.000000 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 24, 035, 729 0.000000 76.00 76.00 03330 ENDSCOPY 0 0 0 23, 055, 440 0.000000 76.07 76.07 03355 BREAST DI AGNOSTI C CENTER		0	C				
67.00 06700 0CCUPATI ONAL THERAPY 0 0 8,090,743 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 2,345,397 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 10,710,977 0.000000 69.00 70.00 07000 ELECTROCARDI OLOGY 0 0 0 12,776,486 0.000000 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 82,261,468 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 111,517,290 0.000000 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 3,466,226 0.000000 74.00 74.00 07400 RENAL DI ALYSI S 0 0 0 24,035,729 0.000000 76.06 76.00 03305 ENDSCOPY 0 0 0 20,108,703 0.000000 76.07 76.07 03955 BREAST DI AGNOSTI C CENTER		0	C				
68.00 06800 SPEECH PATHOLOGY 0 0 2,345,397 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 10,710,977 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 12,776,486 0.000000 70.00 71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 82,261,468 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 46,628,663 0.000000 72.00 73.00 07300 RENAL DIALYSIS 0 0 0 111,517,290 0.000000 73.00 74.00 03330 ENDOSCOPY 0 0 0 24,035,729 0.000000 74.00 76.00 03330 ENDOSCOPY 0 0 0 24,035,729 0.000000 76.07 76.07 03954 IMAGING CENTER 0 0 0 20,108,703 0.000000 76.07 70.00 09000 CLINIC 0 0 0		0	C				
69.00 06900 ELECTROCARDIOLOGY 0 0 10,710,977 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 12,776,486 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 82,261,468 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 46,628,663 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 111,517,290 0.000000 74.00 74.00 07400 RENAL DIALYSIS 0 0 0 3,466,226 0.000000 74.00 76.00 0330 ENDOSCOPY 0 0 0 24,035,729 0.000000 76.00 76.01 03955 BREAST DIAGNOSTIC CENTER 0 0 0 20,108,703 0.000000 76.07 70.02 09000 CLINIC 0 0 0 0.000000 76.07 76.07 03955 BREAST DIAGNOSTIC CENTER 0 <td></td> <td>0</td> <td>C</td> <td></td> <td></td> <td></td> <td>•</td>		0	C				•
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 12, 776, 486 0. 000000 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 082, 261, 468 0. 000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 46, 628, 663 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 111, 517, 290 0. 000000 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 3, 466, 226 0. 000000 74. 00 76. 00 03330 ENDOSCOPY 0 0 0 0 24, 035, 729 0. 000000 76. 00 76. 06 03954 IMAGING CENTER 0 0 0 20, 108, 703 0. 000000 76. 07 70. 00 OPG00 CLINI C 0 0 0 0 0. 000000 76. 07 70. 20 09000 CLINI C 0 0 0		0	C				
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 82, 261, 468 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 46, 628, 663 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 111, 517, 290 0.000000 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 3, 466, 226 0.000000 74.00 76.00 03330 ENDOSCOPY 0 0 0 24, 035, 729 0.000000 76.00 76.01 03955 BREAST DI AGNOSTI C CENTER 0 0 0 20, 108, 703 0.000000 76.06 76.07 03955 BREAST DI AGNOSTI C CENTER 0 0 0 20, 108, 703 0.000000 76.07 70.00 09000 CLI NI C 0 0 0 0 0.00000 90.00 90.26 04975 SPI NE CENTER 0 0 0 0.00000		0	C				
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 46, 628, 663 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 111, 517, 290 0.000000 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 3, 466, 226 0.000000 74.00 76.00 03330 ENDOSCOPY 0 0 0 0 24, 035, 729 0.000000 76.00 76.06 03954 IMAGING CENTER 0 0 0 53, 055, 440 0.000000 76.06 76.07 03955 BREAST DI AGNOSTI C CENTER 0 0 0 20, 108, 703 0.000000 76.06 76.07 09000 CLINIC 0 0 0 0.000000 76.07 90.00 09000 CLINIC 0 0 0 0.000000 90.00 90.26 04975 SPI NE CENTER 0 0 0 0.000000 90.26		0	C				
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 111, 517, 290 0.000000 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 3, 466, 226 0.000000 74.00 76.00 03330 ENDOSCOPY 0 0 0 24, 035, 729 0.000000 76.00 76.06 03954 I MAGI NG CENTER 0 0 0 53, 055, 440 0.000000 76.06 76.07 03955 BREAST DI AGNOSTI C CENTER 0 0 0 20, 108, 703 0.000000 76.06 70.00 09000 CLI NI C 0 0 0 0.000000 90.00 90.00 09000 CLI NI C 0 0 0 0.000000 90.26 91.00 09100 EMERGENCY 0 0 0 0 0.000000 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 10, 479, 743 0.000000 92.00		0	C				
74.00 07400 RENAL DIALYSIS 0 0 3,466,226 0.000000 74.00 76.00 03330 ENDOSCOPY 0 0 0 24,035,729 0.000000 76.00 76.06 03954 IMAGING CENTER 0 0 0 53,055,440 0.000000 76.06 76.07 03955 BREAST DIAGNOSTIC CENTER 0 0 0 20,108,703 0.000000 76.06 76.07 03955 BREAST DIAGNOSTIC CENTER 0 0 0 0.000000 76.06 70.00 09000 CLINIC 0 0 0 0.000000 90.00 90.00 09000 CLINIC 0 0 0 0.000000 90.26 91.00 09100 EMERGENCY 0 0 0 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 10,479,743 0.000000 92.00		0	C				•
76.00 03330 ENDOSCOPY 0 0 24,035,729 0.000000 76.00 76.06 03954 IMAGING CENTER 0 0 0 53,055,440 0.000000 76.06 76.07 03955 BREAST DIAGNOSTIC CENTER 0 0 0 20,108,703 0.000000 76.06 70.00 00475 BREAST DIAGNOSTIC CENTER 0 0 0 0.000000 76.07 90.00 09000 CLINIC 0 0 0 0.000000 90.00 90.100 GM4975 SPI NE CENTER 0 0 0 0.000000 90.26 91.00 09100 EMERGENCY 0 0 0 0.000000 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 10,479,743 0.000000 92.00		0	C				
76.06 03954 IMAGI NG CENTER 0 0 53,055,440 0.000000 76.06 76.07 03955 BREAST DI AGNOSTI C CENTER 0 0 0 20,108,703 0.000000 76.06 70.07 09000 CLI NI C 0 0 0 0.000000 90.00 90.00 09000 CLI NI C 0 0 0 0.000000 90.00 90.26 04975 SPI NE CENTER 0 0 0 0.000000 90.26 91.00 09100 EMERGENCY 0 0 0 167, 591, 198 0.000000 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 10, 479, 743 0.000000 92.00		0	0				
76. 07 03955 BREAST DI AGNOSTI C CENTER 0 0 20, 108, 703 0.000000 76. 07 90. 00 00000 CLI NI C 0 0 0 0.000000 90.00 90.00 90.00 0 0.000000 90.00 </td <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td></td>		0	0				
OUTPATI ENT_SERVICE_COST_CENTERS 90. 00 09000 CLINIC 0 0 0.00 90.00 90. 26 04975 SPI NE_CENTER 0 0 0 0.00000 90.26 91. 00 09100 EMERGENCY 0 0 0 167, 591, 198 0.000000 91.00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 10, 479, 743 0.000000 92.00		0	0				•
90. 00 09000 CLINIC 0 0 0.00 90. 00 90. 26 04975 SPINE CENTER 0 0 0 0.00000 90. 26 91. 00 09100 EMERGENCY 0 0 0 167, 591, 198 0.000000 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 10, 479, 743 0.000000 92. 00		0	0		0 20, 108, 703	0.000000	76.07
90. 26 04975 SPINE CENTER 0 0 612, 326 0.00000 90. 26 91. 00 09100 EMERGENCY 0 0 0 167, 591, 198 0.000000 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 10, 479, 743 0.000000 92. 00		-		1		0.000000	00.00
91. 00 09100 EMERGENCY 0 0 167, 591, 198 0. 000000 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 10, 479, 743 0. 000000 92. 00		0	0				
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 10, 479, 743 0. 000000 92. 00		0	0				
		0	0				
200.00 10tal (Lines 50 through 199) 0 0 0 1, 161, 091, 010 [200.00		0					
	200.00 10tal (11nes 50 through 199)	0		1	U 1, 161, 091, 010	1	200.00

Health Financial Systems COM	NUNITY HOSPITAL C	FINDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C	CN: 15-0169	Peri od:	Worksheet D	
THROUGH COSTS		Composit	20N 15 01/0	From 01/01/2018 To 12/31/2018	Part IV	
		Component (CCN: 15-S169	To 12/31/2018	Date/Time Pre 5/29/2019 3:0	
		Title	XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)	10.00	x col. 10)	10.00	x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0.000000	0	1	0 0	0	
	0. 000000	-		0 0	-	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	33, 606		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
57. 00 05700 CT SCAN	0. 000000	87, 949		0 0	0	57.00
	0. 000000	8, 489		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
	0. 000000	826, 848		0 0	0	60.00 64.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0. 000000 0. 000000	18, 684		0 0	0	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0.000000	25, 891 78, 395			0	65.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	78, 395 74, 941			Ű	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	6, 527			0	67.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	6, 527 17, 686		0 0	0	69.00
70. 00 07000 ELECTROCARDIOLOGY	0. 000000	4, 598			0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	4, 398 106, 027		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	600		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	591,469		0 0	0	73.00
74. 00 07400 RENAL DIALYSIS	0. 000000	0 J F I, 407		0 0	0	74.00
76. 00 03330 ENDOSCOPY	0. 000000	0			0	76.00
76. 06 03954 I MAGI NG CENTER	0. 000000	0		0 0	0	76.06
76. 07 03955 BREAST DI AGNOSTI C CENTER	0. 000000	0		0 0	0	76.07
OUTPATIENT SERVICE COST CENTERS	0.000000	0		0 0	0	/0.0/
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
90. 26 04975 SPINE CENTER	0. 000000	0		0 0	0	90.26
91. 00 09100 EMERGENCY	0. 000000	244, 191		0 2,645	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0, 000000	21,097		0 0	0	92.00
200.00 Total (lines 50 through 199)	0.000000	2, 146, 998		0 2,645	-	200.00
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Health Financ	cial Systems COM	UNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-	2552-10
APPORTI ONMEN	IT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0169	Peri od:	Worksheet D	
					From 01/01/2018	Part V	
			Component	CCN: 15-S169	To 12/31/2018	Date/Time Pre 5/29/2019 3:0	pared:
			Title	XVIII	Subprovi der -	PPS	
			in the		IPF	115	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	. ,	
		Part I, col. 9	,	Subject To	Subject To		
				Ded. & Coi ns	. Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	0. 097454	0		0 0	0	50.00
	RECOVERY ROOM	0. 167976	0		0 0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0. 582061	0		0 0	0	52.00
	RADI OLOGY-DI AGNOSTI C	0. 177335	0		0 0	0	54.00
	RADI OLOGY-THERAPEUTI C	0. 073748	0		0 0	0	55.00
	CT SCAN	0. 036624	0		0 0	0	57.00
58.00 05800		0. 095148	0		0 0	0	58.00
59.00 05900	CARDI AC CATHETERI ZATI ON	0. 071055	0		0 0	0	59.00
60.00 06000	LABORATORY	0. 103979	0		0 0	0	60.00
64.00 06400	INTRAVENOUS THERAPY	1. 031797	0		0 0	0	64.00
65.00 06500	RESPI RATORY THERAPY	0. 209353	0		0 0	0	65.00
66.00 06600	PHYSI CAL THERAPY	0. 305261	0		0 0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0. 305605	0		0 0	0	67.00
	SPEECH PATHOLOGY	0. 202742	0		0 0	0	68.00
69.00 06900	ELECTROCARDI OLOGY	0. 081223	0		0 0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0. 219567	0		0 0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 324278	0		0 0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0. 383881	0		0 0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0. 228847	0		0 6, 685	0	73.00
74.00 07400	RENAL DIALYSIS	0. 444135	0		0 0	0	74.00
76.00 03330	ENDOSCOPY	0. 149573	0		0 0	0	76.00
	I MAGI NG CENTER	0. 084254	0		0 0	0	76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	0. 506891	0		0 0	0	76.07
	TIENT SERVICE COST CENTERS						
	CLINIC	0. 000000			0 0	0	90.00
90.26 04975	SPINE CENTER	0. 576100	0		0 0	0	
	EMERGENCY	0. 103846	2, 645		0 0	275	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0. 740101	0		0 0	0	92.00
200.00	Subtotal (see instructions)		2, 645		0 6, 685	275	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		2, 645	l	0 6, 685	275	202.00

	MUNITY HOSPITAL				u of Form CMS-255	52-1
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-0169	Period: From 01/01/2018	Worksheet D Part V	
		Component	CCN: 15-S169	To 12/31/2018	Date/Time Prepar 5/29/2019 3:05 p	red: pm
		Title	XVIII	Subprovider - IPF	PPS	
	Cos	sts		<u> </u>		
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						-
0.00 05000 OPERATING ROOM	0	-				50.0
1.00 05100 RECOVERY ROOM	0	-				51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	-				52.0
4.00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.0
7. 00 05700 CT SCAN	0	-				57.0
8.00 05800 MRI	0	0				58.0
9.00 05900 CARDIAC CATHETERIZATION	0	0				59.0
0. 00 06000 LABORATORY	0	0				50.0
4.00 06400 INTRAVENOUS THERAPY	0	0				64.0
5. 00 06500 RESPI RATORY THERAPY	0	0				55.0
66. 00 06600 PHYSI CAL THERAPY	0	0				66. 0
57.00 06700 OCCUPATI ONAL THERAPY	0	0				57.0
8.00 06800 SPEECH PATHOLOGY	0	0				58. C
9.00 06900 ELECTROCARDI OLOGY	0	0				59. C
0.00 07000 ELECTROENCEPHALOGRAPHY	0	0				70. C
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 530				73.0
4. 00 07400 RENAL DIALYSIS	0	0				74. (
6.00 03330 ENDOSCOPY	0	0				76. 0
6.06 03954 I MAGI NG CENTER	0					76. C
6. 07 03955 BREAST DI AGNOSTI C CENTER	0	0			7	76. C
OUTPATIENT SERVICE COST CENTERS	-	-	1			
0. 00 09000 CLINIC	0	-				90.0
0. 26 04975 SPI NE CENTER	0	-				90.2
1.00 09100 EMERGENCY	0	-				91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	-				92.0
00.00 Subtotal (see instructions)	0	1, 530)O. C
201.00 Less PBP Clinic Lab. Services-Program	0				20	01.0
Only Charges		4				
202.00 Net Charges (line 200 - line 201)	0	1, 530			20	02.0

Health Financial Systems	COMMUNI TY HOSPI TAL	OF INDIANA, I	NC.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAP	PLTAL COSTS	Provi der C		Period: From 01/01/2018	Worksheet D Part I	
				To 12/31/2018		nared
				10 12/01/2010	5/29/2019 3:0	5 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS		-	-	1	-	
30. 00 ADULTS & PEDIATRICS	9, 021, 804		9, 021, 80			•
31.00 INTENSIVE CARE UNIT	1, 756, 697		1, 756, 69	7 5, 973		31.00
35.00 NEONATAL INTENSIVE CARE UNIT	1, 969, 176		1, 969, 17	6 12, 362	159.29	35.00
40. 00 SUBPROVIDER - IPF	393, 806	0	393, 80	6 3, 733	105.49	40.00
43. 00 NURSERY	749, 363		749, 36	3 7,653	97.92	43.00
200.00 Total (lines 30 through 199)	13, 890, 846		13, 890, 84	6 93, 244		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	-			
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 012	143, 724				30.00
31.00 INTENSIVE CARE UNIT	0	0				31.00
35.00 NEONATAL INTENSIVE CARE UNIT	605	96, 370				35.00
40. 00 SUBPROVIDER - IPF	0	0				40.00
43.00 NURSERY	3, 288					43.00
200.00 Total (lines 30 through 199)	4, 905	562, 055				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-0169 Period: From 01/01/2018 Worksheet D From 01/01/2018 Worksheet D From 01/01/2018 	Health Financial Systems COM	MUNI TY HOSPI TAL	OF INDIANA, II	VC.	In Lie	u of Form CMS-:	2552-10
Image: construction To 12/31/2018 Date/Time Prepared: 5/29/2019 3:06 pm Cost Center Description Capital Related Cost (from Wkst. B, Part II. col. 26) Title XIX Hospital Capital Capital PPS 05000 (PECATING ROM 52:00) Capital 26) Capital (1:00) Capital 20) Inpatient (Capital 20) Capital (Capital 20) Capital (Capital 20) Capital (Capital 20) Capital (Capital 20) Capital (Capital 20) Capital 20) Capital 20) <td>APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA</td> <td>AL COSTS</td> <td>Provider C</td> <td>CN: 15-0169</td> <td></td> <td></td> <td></td>	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0169			
Cost Center Description Capital Related cost (From Wkst. 6, Part I, col. 26) Total Charges (col. 1 + col. 2) Inpatient Program (col. 1 + col. 2) Cost Center Cost (col. 1 + col. 2) Cost Charges (col. 1 + col. 2) Cost Cost (col. 1 + col. 2) Inpatient (col. ma) x (col. ma) x 50:00 05000 (PERATING ROOM 2.301, 187 188, 573, 743 0.012203 1, 403, 694 17, 129 50.00 51:00 05000 RECOVERY ROOM 718, 023 36, 003, 536 0.012903 1, 403, 694 17, 129 50.00 52:00 05200 DELIVERY ROOM 18, 829, 946 22, 890, 363 0.017976 391, 897 31, 261 52, 00 54:00 05500 RADI OLGOV-THERAPEUTIC 543, 662 31, 522, 658 0.017247 336, 058 5, 766 55, 00 59:00 05500 OR RADI OLGOV-THERAPEUTIC 543, 662 31, 522, 658 0.017247 336, 058 5, 766 55, 00 59:00 05600 MRI 49, 832 20, 055, 048 0.017247 336, 058 5, 766 5, 766 5, 766 5, 766 5, 766 5, 766 5, 766 5, 766 5, 766 5, 766 5, 766 <							narod
Cost Center Description Capital Related Cost (from Wkst. B, Part II, col. 26) Inpatient Col. 1 + col. 8) Inpatient Col. 1 + col. 2) Inpatient Col. 1 + col. 2) Program Charges Col. 1 + col. 2) Col. 1 + col. Col. 1 + col. 2) 50.00 OPERATING ROOM 2, 301, 187 (1, 000) 188, 573, 743 (2, 000) 0.012203 (2, 000) 1, 403, 694 (2, 280) 17, 129 (2, 000) 50.00 50.00 OPERATING ROOM 2, 301, 187 (1, 800) 188, 573, 743 (2, 000) 0.012203 (2, 000) 1, 403, 694 (2, 280) 17, 129 (2, 000) 50.00 50.00 OEXOUERY ROOM (0500) DELIVERY ROOM (2, 000) 1, 825, 946 (2, 280) 0.017203 (2, 000) 1, 403, 694 (2, 288) 17, 129 (2, 000) 50.00 51.00 DSOOD RADULOCY-DI AGNOSTIC 845, 082 (2, 31, 522, 658 (0, 017247) 33, 605 (2, 127, 127) 0.004353 (4, 26, 966 (1, 857) 1857 (7, 00 (5700) 58.00 DSBOO RADU LOCY-THERAPEUTI C 543, 662 (2, 538, 853) 0.001731 (0, 00730) 0 0 99 (0, 004353) 426, 696 (1, 857) 1, 857 (0, 005700 59.00 GARATORY 421, 553 (1, 258, 853) 0.001731 (0, 0, 0770) 0 0 99 (0, 00000) 0 0 0 0 <td></td> <td></td> <td></td> <td></td> <td>10 12/31/2010</td> <td></td> <td></td>					10 12/31/2010		
ANCILLARY SERVICE COST CENTERS Column 3 x (column 4) Column 3 x (column 4) 50.00 D5000 (DFERATINE ROOM 05000 (DFERATINE ROOM 05400 (RADI LOGY-DI AGNOSTI C 05400 (DFERATINE ROOM 05700 (DT SCAN 05700 (DT SCAN 05900 (CARDI AC CATHETERI ZATION 05900 (CARDI AC CATHETERI ZATION 05900 (CARDI AC CATHETERI ZATION 05900 (CARDI AC CATHETERI ZATION 05900 (DFERATINE ROOM 05900 (DFERAT			Ti tl	e XIX	Hospi tal		
ANCI LLARY SERVICE COST CENTERS Col um 4 26) 1.00 2.00 3.00 4.00 5.00 50.00 05000 [RECOVERY ROM 2.301.187 188,573.743 0.012203 1,403,694 17,129 50.00 52.000 [RECOVERY ROM 718,023 36,003,553 0.017943 211,950 4,22 51.00 52.000 [RECOVERY ROM 1.825,946 22,803,363 0.079769 391,897 31,261 52.00 54.00 [S500 RAD LLOGY-DI AGNOSTI C 845,062 31,522,658 0.017247 336,058 5,796 55.00 55.00 [S500 RAD LLOGY-THERAPEUTI C 543,662 31,522,658 0.017247 336,058 5,796 55.00 50.00 [ABO CLORY THERAPEUTI C 845,082 20,055,048 0.01744 49,670 866 58.00 59.00 [ABO CLORY THERAPEUTI C 843,082 20,055,048 0.01744 49,670 866 58.00 64.00 [ABO CLORY THERAPY 234,133 1,075,444 0.217708 15,392 3,3151 64.00 65.00 06500 [RESPI RATORY THERAPY 1	Cost Center Description						
Part II, col. 8) 2)							
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Incol 2.00 3.00 4.00 5.00 50.00 05000 OPERATING ROM 2, 301, 187 188, 573, 743 0.012203 1, 403, 694 17, 129 50.00 50.00 05100 RECOVERY ROM 718, 023 36, 003, 536 0.019943 211, 950 4, 227 51.00 52.00 05200 DELI VERY ROM & LABOR ROM 1, 825, 946 22, 890, 363 0.019943 211, 950 4, 227 51.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 845, 082 41, 304, 857 0.020460 222, 541 4, 553 54.00 55.00 05500 RADI OLOGY-DI AGNOSTI C 543, 662 31, 522, 658 0.017247 366, 696 1, 857 57.00 58.00 05800 RAI A CATHETERIZATI ON 4, 396 2, 558 0.017444 49, 670 866 58.00 69.00 05900 CARDI AC CATHETERIZATI ON 4, 396 2, 578, 853 0.001734 0 59.00 59.00 60.00 06000 INTRAVENUS THERAPY 234, 133 1.075, 444 0.217708 15			8)	2)			
ANCL LLARY SERVICE COST CENTERS 2 3 3 0 0 2 0 1 1 2 5 0 0 5 0 0 5 0 0 5 0 0 5 0 0 6 0 7 1 2 1 1 2 5 0 0 0 0 0 0 0 0 0 0 0 0 0 1 1 2 5 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
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51.00 RECOVERY ROOM 718.023 36.003,536 0.019943 211.950 4,227 51.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 1,825,946 22,890,363 0.079769 391,897 31,261 55.00 55.00 05500 RADI OLOGY-DI AGNOSTI C 845,082 41,304,857 0.020460 222,541 4,555 55.00 57.00 05700 CT SCAN 329,349 75,667,221 0.004353 426,696 1,857 57.00 58.00 05800 MRI 349,832 20,055,048 0.017444 49,670 866 58.00 59.00 05900 GARDI AC CATHETERI ZATI ON 4,396 2,538,853 0.001731 0 0 59.00 64.00 IARRAVENOUS THERAPY 4234,133 1,075,444 0.217708 15.392 3.351 64.00 65.00 06500 RESPI RATORY THERAPY 922,188 28,623,451 0.032218 79,118 2,549 66.00 66.00 06600 PHYSI CAL THERAPY 92,345,397 0.012918 35,145 454 68.00 67.00 06700 00000		0 004 407	400 570 740	0.0100	1 400 404	47.400	50.00
52.00 05200 DELI VERY ROOM & LABOR ROOM 1, 825, 946 22, 890, 363 0.079769 391, 897 31, 261 52.00 54.00 05400 RADI OLOGY - THERAPEUTI C 543, 662 31, 522, 658 0.017247 336, 058 5, 796 55.00 57.00 05700 CT SCAN 329, 349 75, 667, 221 0.004353 426, 696 1, 857 57.00 58.00 05900 CARDI AC CATHETERI ZATI 0N 4, 396 2, 538, 853 0.001731 0 0590 60.00 06400 INTRAVENOUS THERAPY 234, 133 1, 075, 444 0.217708 15, 392 3, 351 64.00 64.00 06500 RESPI RATORY 421, 553 129, 357, 058 0.002482 1, 034, 622 21, 191 65.00 65.00 06500 RESPI RATORY THERAPY 922, 188 28, 623, 451 0.032218 79, 118 2, 549 66.00 66.00 06600 PHYSI CAL THERAPY 922, 188 28, 623, 451 0.032218 79, 118 2, 549 66.00 67.00 06700 0CCUPATI ONAL THERAPY 922, 188 90, 021343 3							
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64.00 06400 INTRAVENOUS THERAPY 234,133 1,075,444 0.217708 15,392 3,351 64.00 65.00 06500 RESPIRATORY THERAPY 610,324 29,798,389 0.020482 1,034,622 21,191 65.00 66.00 06600 PHYSI CAL THERAPY 922,188 28,623,451 0.032218 79,118 2,549 66.00 67.00 0CCUPATI ONAL THERAPY 156,007 8,090,743 0.019282 115,763 2,232 67.00 68.00 06800 SPEECH PATHOLOGY 30,299 2,345,397 0.012918 35,145 454 68.00 69.00 06900 ELECTROCARDI OLOGY 272,694 12,776,486 0.021343 32,173 687 70.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATI ENT 700,204 82,261,468 0.008512 812,504 6,916 71.00 72.00 07100 REMACED TO PATI ENTS 46,5713 46,628,663 0.00998 0 72.00 73.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 76.00 73.00							
65.00 06500 RESPI RATORY THERAPY 610, 324 29, 798, 389 0.020482 1, 034, 622 21, 191 65.00 66.00 06600 PHYSI CAL THERAPY 922, 188 28, 623, 451 0.032218 79, 118 2, 549 66.00 67.00 0CUPATI ONAL THERAPY 156, 007 8, 090, 743 0.012928 115, 763 2, 232 67.00 68.00 06800 SPEECH PATHOLOGY 30, 299 2, 345, 397 0.012918 35, 145 454 68.00 69.00 06900 ELECTROCARDI OLOGY 24, 898 10, 710, 977 0.002325 167, 592 390 69.00 70.00 07000 ELECTROCARDI OLOGY 272, 694 12, 776, 486 0.021343 32, 173 687 70.00 71.00 07100 MEDI CAL SUPPLI LES CHARGED TO PATI ENT 700, 204 82, 261, 468 0.008512 812, 504 6, 916 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 1, 161, 923 111, 517, 290 0.10419 2, 096, 639 21, 845 73.00 74.00 07400 REAL DI ALYSI S 24, 822 3, 466, 226							
66.00 06600 PHYSI CAL THERAPY 922, 188 28, 623, 451 0.032218 79, 118 2, 549 66.00 67.00 06700 OCCUPATI ONAL THERAPY 156, 007 8, 090, 743 0.019282 115, 763 2, 232 67.00 68.00 06800 SPEECH PATHOLOCY 30, 299 2, 345, 397 0.012918 35, 145 454 68.00 69.00 ELECTROCARDI OLOGY 24, 898 10, 710, 977 0.002325 167, 592 390 69.00 70.00 ELECTROCARDI OLOGY 24, 898 10, 710, 977 0.002325 167, 592 390 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 700, 204 82, 261, 468 0.008512 812, 504 6, 916 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 465, 713 46, 628, 663 0.009988 0 0 72.00 74.00 07400 REAL DI ALYSI S 24, 822 3, 466, 226 0.007161 28, 120 201 74.00 76.00 0330 ENDSCOPY 557, 263 24, 035, 729 0.023185 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
67.00 06700 0CCUPATI ONAL THERAPY 156,007 8,090,743 0.019282 115,763 2,232 67.00 68.00 06800 SPEECH PATHOLOGY 30,299 2,345,397 0.012918 35,145 454 68.00 69.00 06900 ELECTROCARDI OLOGY 24,898 10,710,977 0.002325 167,592 390 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 272,694 12,776,486 0.021343 32,173 687 70.00 71.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 700,204 82,261,468 0.009812 812,504 6,916 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 465,713 46,628,663 0.009988 0 72.00 74.00 07400 RENAL DI ALYSI S 1,161,923 111,517,290 0.010419 2,096,639 21,845 73.00 74.00 07400 RENAL DI ALYSI S 24,822 3,466,226 0.007161 28,120 201 74.00 76.00 03305 ENDOSCOPY 557,263 24,035,729 0.023185 42,061 975							
68.00 06800 SPEECH PATHOLOGY 30, 299 2, 345, 397 0. 012918 35, 145 454 68.00 69.00 06900 ELECTROCARDI OLOGY 24, 898 10, 710, 977 0. 002325 167, 592 390 69.00 70.00 D7000 ELECTROENCEPHALOGRAPHY 272, 694 12, 776, 486 0. 021343 32, 173 687 70.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 700, 204 82, 261, 468 0. 008512 812, 504 6, 916 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 465, 713 46, 628, 663 0.009988 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 1, 161, 923 111, 517, 290 0.010419 2, 096, 639 21, 845 73.00 74.00 07400 RENAL DI ALYSI S 24, 822 3, 466, 226 0.007161 28, 120 201 74.00 76.00 03330 ENDOSCOPY 557, 263 24, 035, 729 0.023185 42, 061 975 76.00 76.07 03955 BREAST DI AGNOSTI C CENTER 617, 728 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
69.00 06900 ELECTROCARDIOLOGY 24,898 10,710,977 0.002325 167,592 390 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 272,694 12,776,486 0.021343 32,173 687 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 700,204 82,261,468 0.008512 812,504 6,916 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 465,713 46,628,663 0.009988 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,161,923 111,517,290 0.010419 2,096,639 21,845 73.00 74.00 07400 RENAL DI ALYSI S 24,822 3,466,226 0.007161 28,120 201 74.00 76.00 03330 ENDOSCOPY 557,263 24,035,729 0.023185 42,061 975 76.00 76.01 03954 IMAGI NG CENTER 617,728 53,055,440 0.011643 0 0 76.07 70.02 09000 CLI NI C 0 0.00000 0 0 90.06							
70.00 07000 ELECTROENCEPHALOGRAPHY 272, 694 12, 776, 486 0.021343 32, 173 687 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 700, 204 82, 261, 468 0.008512 812, 504 6, 916 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 465, 713 46, 628, 663 0.009988 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 161, 923 111, 517, 290 0.010419 2, 096, 639 21, 845 73.00 74.00 O7400 RENAL DI ALYSI S 24, 822 3, 466, 226 0.007161 28, 120 201 74.00 76.00 03330 ENDOSCOPY 557, 263 24, 035, 729 0.0213185 42, 061 975 76.00 76.00 03355 BREAST DI AGNOSTI C CENTER 617, 728 53, 055, 440 0.011643 0 0 76.07 70.017PATIENT SERVICE COST CENTER 270, 825 20, 108, 703 0.013468 0 0 76.07 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 700, 204 82, 261, 468 0.008512 812, 504 6, 916 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 465, 713 46, 628, 663 0.009988 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 161, 923 111, 517, 290 0.010419 2, 096, 639 21, 845 73.00 74.00 07400 RENAL DI ALYSI S 24, 822 3, 466, 226 0.007161 28, 120 201 74.00 76.00 03330 ENDOSCOPY 557, 263 24, 035, 729 0.023185 42, 061 975 76.00 76.06 03954 I MAGI NG CENTER 617, 728 53, 055, 440 0.011643 0 0 76.06 70.00 09000 CLI NI C 270, 825 20, 108, 703 0.013468 0 0 90.00 90.00 09000 CLI NI C 0 0 0.000000 0 0 90.00 90.00 91.00 09100 EMERGENCY 1, 659, 551 167, 591, 198 0.009902 732, 75							
72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 465,713 46,628,663 0.009988 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 1,161,923 111,517,290 0.010419 2,096,639 21,845 73.00 74.00 07400 RENAL DI ALYSI S 24,822 3,466,226 0.007161 28,120 201 74.00 76.00 03330 ENDOSCOPY 557,263 24,035,729 0.023185 42,061 975 76.00 76.06 03955 BREAST DI AGNOSTI C CENTER 617,728 53,055,440 0.011643 0 0 76.06 76.07 09000 CLI NI C 270,825 20,108,703 0.013468 0 0 76.07 90.00 09000 CLI NI C 0 0.000000 0 0 90.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
73.00 07300 DRUGS CHARGED TO PATIENTS 1, 161, 923 111, 517, 290 0.010419 2, 096, 639 21, 845 73.00 74.00 07400 RENAL DI ALYSI S 24, 822 3, 466, 226 0.007161 28, 120 201 74.00 76.00 03300 ENDOSCOPY 557, 263 24, 035, 729 0.023185 42, 061 975 76.00 76.06 03954 I MAGI NG CENTER 617, 728 53, 055, 440 0.011643 0 0 76.06 76.07 03955 BREAST DI AGNOSTI C CENTER 270, 825 20, 108, 703 0.013468 0 0 76.07 00000 CLI NI C 0 0 0.000000 0 0 90.00 90.00 09000 CLI NI C 0 0 0.032927 0 0 90.26 91.00 09100 EMERGENCY 1, 659, 551 167, 591, 198 0.009902 732, 756 7, 256 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 916, 762 10, 479, 743 0.087479 44, 022 3, 851 92.00 <							
74.00 07400 RENAL DI ALYSI S 24,822 3,466,226 0.007161 28,120 201 74.00 76.00 03300 ENDOSCOPY 557,263 24,035,729 0.023185 42,061 975 76.00 76.06 03954 IMAGI NG CENTER 617,728 53,055,440 0.011643 0 0 76.06 76.07 03955 BREAST DI AGNOSTI C CENTER 270,825 20,108,703 0.013468 0 0 76.07 00TPATI ENT SERVI CE COST CENTER 20,162 612,326 0.032927 0 0 90.00 90.00 09100 EMERGENCY 1,659,551 167,591,198 0.009902 732,756 7,256 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 916,762 10,479,743 0.087479 44,022 3,851 92.00						-	
76.00 03330 ENDOSCOPY 557, 263 24, 035, 729 0.023185 42, 061 975 76.00 76.06 03954 IMAGING CENTER 617, 728 53, 055, 440 0.011643 0 0 76.06 76.07 03955 BREAST DI AGNOSTI C CENTER 270, 825 20, 108, 703 0.013468 0 0 76.07 0UTPATI ENT SERVICE COST CENTER 0 0 0.000000 0 0 90.00 90.00 09000 CLINIC 0 0.00000 0 90.00							
76.06 03954 I MAGI NG CENTER 617,728 53,055,440 0.011643 0 0 76.06 76.07 03955 BREAST DI AGNOSTI C CENTER 270,825 20,108,703 0.011643 0 0 76.06 70.07 0 00000 CLI NI C 0 0 0.00000 0 0 90.00 90.00 090000 CLI NI C 0 0 0.032927 0 0 90.26 04975 SPI NE CENTER 20,162 612,326 0.032927 0 0 90.26 91.00 09100 EMERGENCY 1,659,551 167,591,198 0.009902 732,756 7,256 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 916,762 10,479,743 0.087479 44,022 3,851 92.00							
76. 07 03955 BREAST DI AGNOSTI C CENTER 270, 825 20, 108, 703 0.013468 0 0 76. 07 OUTPATI ENT SERVICE COST CENTERS 0 0 0.00000 0 0.00000 0 0 90. 00 90. 00 90. 00 0 0.000000 0 0 90. 00 90. 26 91. 00 90. 26 91. 00 92. 00 095200 0BSERVATI 0N BEDS (NON-DI STI NCT PART 916, 762 10, 479, 743 0. 087479 44, 022 3, 851 92. 00							
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0.00000 0.000000 0 00000 90.00 90.00 90.00 90.00 0.000000 0 00000 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.26 91.00 90.26 91.00 91						-	
90. 00 09000 CLI NI C 0 0.00 0.00000 0 0 90. 00 90. 26 04975 SPI NE CENTER 20, 162 612, 326 0. 032927 0 0 90. 26 91. 00 09100 EMERGENCY 1, 659, 551 167, 591, 198 0. 009902 732, 756 7, 256 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 916, 762 10, 479, 743 0. 087479 44, 022 3, 851 92. 00		270,023	20,100,703	0.01340	0	0	/0.0/
90. 2604975SPI NE CENTER20, 162612, 3260. 0329270090. 2691. 0009100EMERGENCY1, 659, 551167, 591, 1980. 009902732, 7567, 25691. 0092. 00092000BSERVATI ON BEDS (NON-DI STINCT PART916, 76210, 479, 7430. 08747944, 0223, 85192. 00		0		0,0000	0	0	90 00
91. 00 09100 EMERGENCY 1, 659, 551 167, 591, 198 0. 009902 732, 756 7, 256 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 916, 762 10, 479, 743 0. 087479 44, 022 3, 851 92. 00		-	-			-	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 916, 762 10, 479, 743 0. 087479 44, 022 3, 851 92. 00						-	
	200.00 Total (lines 50 through 199)				9, 907, 271		

Health Financial Systems	COMMUNI TY HOSPI TAL	OF INDIANA, II	NC.	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTH	ER PASS THROUGH COS		F	Period: From 01/01/2018 Fo 12/31/2018		
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown		Post-Stepdown	Cost	Medi cal	
	Adjustments		Adj ustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	C) (0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	C		0 0	0	31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	0		0	0	35.00
40. 00 04000 SUBPROVIDER - IPF	0	0		0	0	
43. 00 04300 NURSERY	0	0		0	0	1
200.00 Total (lines 30 through 199)	0				-	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	200.00
cost center beschiption	Adjustment	(sum of cols.	Days	$5 \div col.$ (col.	Program Days	
	Amount (see	1 through 3,	Duys	5 . COL 0)	riogram bays	
		minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	0.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	63, 523	3 0.00	1, 012	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0		5, 973			
35. 00 02060 NEONATAL INTENSIVE CARE UNIT		0	12, 362			
40. 00 04000 SUBPROVIDER - IPF	0		3, 733			1
43. 00 04300 NURSERY	0		7,653			40.00
			93, 244			
200.00 Total (lines 30 through 199)	l anati ant	0	93, 242	ł	4, 905	200.00
Cost Center Description	Inpatient Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
INPATIENT ROUTINE SERVICE COST CENTERS	9.00					
	0					30.00
30. 00 03000 ADULTS & PEDI ATRI CS	e e e e e e e e e e e e e e e e e e e					
31.00 03100 INTENSIVE CARE UNIT	0					31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0					35.00
40. 00 04000 SUBPROVIDER - IPF	0					40.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems COMM	IUNI TY HOSPI TAL	OF INDIANA, II	NC.	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	5 Provider C	CN: 15-0169	Period: From 01/01/2018 To 12/31/2018		pared: 5 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician			Allied Health	Allied Health	
		Post-Stepdown	J	Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS		-	•			
50. 00 05000 OPERATI NG ROOM	0	C)	0 0	0	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
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
57. 00 05700 CT SCAN	0	0		0 0	0	57.00
58. 00 05800 MRI	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0			0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0			0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0				0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0				0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0				0	73.00
74. 00 07400 RENAL DI ALYSI S	0				0	74.00
76. 00 03330 ENDOSCOPY	0				0	76.00
76. 06 03350 ENDOSCOFT 76. 06 03954 I MAGI NG CENTER	0			0 0	0	76.00
76. 07 03955 BREAST DI AGNOSTI C CENTER	0	0		0 0	0	76.07
OUTPATIENT SERVICE COST CENTERS	0		1	0 0	0	70.07
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 26 04975 SPINE CENTER	0				0	90.26
91. 00 09100 EMERGENCY	0				0	90.20
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0		91.00
200.00 Total (lines 50 through 199)	0			0 0	, v	200.00
	1 0		1	0	1 0	I∠00. 00

Health Financial Systems COM	MUNITY HOSPITAL	OF INDIANA, I	VC.	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	CN: 15-0169	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2018		
				To 12/31/2018	Date/Time Pre 5/29/2019 3:0	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)	,	, í	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	C		0 188, 573, 743		
51.00 05100 RECOVERY ROOM	0	C		0 36, 003, 536		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 22, 890, 363	0. 000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 41, 304, 857	0. 000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 31, 522, 658	0. 000000	55.00
57.00 05700 CT SCAN	0	0		0 75, 667, 221	0.000000	57.00
58. 00 05800 MRI	0	0		0 20, 055, 048	0.000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 2, 538, 853	0. 000000	59.00
60. 00 06000 LABORATORY	0	0		0 129, 357, 058	0. 000000	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 1,075,444	0. 000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 29, 798, 389	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 28, 623, 451	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 8, 090, 743	0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 2, 345, 397	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0 10, 710, 977	0.00000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	C		0 12, 776, 486	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0 82, 261, 468	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 46, 628, 663	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 111, 517, 290	0. 000000	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 3, 466, 226		74.00
76.00 03330 ENDOSCOPY	0	C		0 24, 035, 729	0. 000000	76.00
76.06 03954 I MAGI NG CENTER	0	0		0 53, 055, 440	0. 000000	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0		0 20, 108, 703	0. 000000	76.07
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0	0		0 0	0.000000	90.00
90. 26 04975 SPI NE CENTER	0	0		0 612, 326	0. 000000	90.26
91.00 09100 EMERGENCY	0	0		0 167, 591, 198	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 10, 479, 743		92.00
200.00 Total (lines 50 through 199)	0	C		0 1, 161, 091, 010		200.00

Health Financial Systems COM	MUNITY HOSPITAL O	FINDIANA, IN	VC.	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider CO		Period: From 01/01/2018 To 12/31/2018		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS			1		1	
50.00 05000 OPERATI NG ROOM	0. 000000	1, 403, 694		0 0		
51.00 05100 RECOVERY ROOM	0. 000000	211, 950		0 0		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	391, 897		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	222, 541		0 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	336, 058		0 0	0	
57.00 05700 CT SCAN	0. 000000	426, 696		0 0	0	57.00
58. 00 05800 MRI	0. 000000	49, 670		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	1, 628, 858		0 0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	15, 392		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	1,034,622		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	79, 118		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	115, 763		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	35, 145		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	167, 592		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	32, 173		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	812, 504		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	2,096,639		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	28, 120		0 0	0	74.00
76.00 03330 ENDOSCOPY	0. 000000	42,061		0 0	0	76.00
76.06 03954 I MAGI NG CENTER	0. 000000	0		0 0	0	76.06
76. 07 03955 BREAST DI AGNOSTI C CENTER	0. 000000	0		0 0	0	76.07
OUTPATIENT SERVICE COST CENTERS	· ·					
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
90. 26 04975 SPI NE CENTER	0.000000	0		0 0	0	90.26
91. 00 09100 EMERGENCY	0.000000	732, 756		0 0	0	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	44, 022		0 0		1
200.00 Total (lines 50 through 199)		9, 907, 271		0 0	0	200.00
	1					

Health Financial Systems	COMMUNI TY HOSPI TAL	OF INDIANA, II	NC.	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICE	S AND VACCINE COST	Provider C		Period:	Worksheet D	
				From 01/01/2018 To 12/31/2018		nared
				10 12/31/2010	5/29/2019 3:0	
			e XIX	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Services (see		Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coi ns.			
	1.00	2.00	(see inst.)	(see inst.)	F 00	
ANCI LLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	0. 097454		673, 33	6 0	0	50.00
51. 00 05100 RECOVERY ROOM	0. 097454		149,83			
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 582061			0 0	0	
54.00 05400 RADI OLOGY - DI AGNOSTI C	0. 177335		612, 21		0	•
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 073748		252, 29		0	•
	0. 073748				0	
	0. 036624		1, 125, 59		0	
58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON			167, 14	9 0	0	
	0. 071055 0. 103979		1 224 72	0 0	-	
60. 00 06000 LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY	1. 031797		1, 224, 73		0	
	0. 209353		9,45		0	000
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0. 209353		52, 41		0	
	0. 305261		181, 89		-	
	0. 305605		70, 74		0	
	0. 202742		31, 65		0	
			27,85		-	
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 219567		83, 81		0	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI EI			207, 19		0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 383881 0. 228847			0 0	0	
			377, 17		0	
74. 00 07400 RENAL DIALYSIS 76. 00 03330 ENDOSCOPY	0. 444135			0 0	0	
	0. 149573 0. 084254		101, 34		0	
	0. 084254		394, 11 97, 68		-	
76. 07 03955 BREAST DI AGNOSTI C CENTER	0. 506891		97,08	0 0	0	/0.0/
90. 00 09000 CLINIC	0. 000000		1	0 0	0	90.00
90. 26 04975 SPI NE CENTER	0. 576100					
90. 20 04975 SPINE CENTER 91. 00 09100 EMERGENCY	0. 576100		4,074,47	0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PAI			114, 17		0	
200.00 Subtotal (see instructions)	0.740101		10, 029, 15		-	200.00
201.00 Less PBP Clinic Lab. Services-Prog	mam				0	200.00
Only Charges	Ji cilli			0		201.00
202.00 Net Charges (line 200 - line 201)		c	10, 029, 15	1 0	n	202.00
202.00 met ondriges (1116 200 - 1116 201)	I	1 0	1 10,027,13	'I 0	0	1202.00

PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		OF INDIANA, II Provider C		Period: From 01/01/2018 To 12/31/2018	u of Form CMS Worksheet D Part V Date/Time Pr 5/29/2019 3:	repared
		Titl	e XIX	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)	_			
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	-					
D. 00 05000 OPERATI NG ROOM	65, 619	C				50. (
1.00 05100 RECOVERY ROOM	25, 169	0				51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	108, 567	C				54.
5. 00 05500 RADI OLOGY-THERAPEUTI C	18, 606	0				55.
7.00 05700 CT SCAN	41, 224	C				57.
3. 00 05800 MRI	15, 904	C				58.
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	C				59.
D. 00 06000 LABORATORY	127, 347	C				60.
4. 00 06400 I NTRAVENOUS THERAPY	9, 758	C				64.
5. 00 06500 RESPI RATORY THERAPY	10, 973	C				65.
5. 00 06600 PHYSI CAL THERAPY	55, 526	C				66.
7.00 06700 OCCUPATI ONAL THERAPY	21, 620	C				67.
3. 00 06800 SPEECH PATHOLOGY	6, 417	C				68.
9. 00 06900 ELECTROCARDI OLOGY	2, 263	0				69.
D. 00 07000 ELECTROENCEPHALOGRAPHY	18, 402	0				70.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	67, 187	0				71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.
3.00 07300 DRUGS CHARGED TO PATIENTS	86, 315	0				73.
4. 00 07400 RENAL DIALYSIS	0	0				74.
5. 00 03330 ENDOSCOPY	15, 158	0				76.
6. 06 03954 I MAGI NG CENTER	33, 206	0				76.
5. 07 03955 BREAST DI AGNOSTI C CENTER	49, 513	0				76.
OUTPATIENT SERVICE COST CENTERS						
D. 00 09000 CLINIC	0	C				90.
D. 26 04975 SPINE CENTER	0	C				90.
1.00 09100 EMERGENCY	425, 612	C				91.
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	84, 502	C				92.
00.00 Subtotal (see instructions)	1, 288, 888	C				200.
D1.00 Less PBP Clinic Lab. Services-Program	0					201.
Only Charges						
D2.00 Net Charges (line 200 - line 201)	1, 288, 888	C				202.

Health Financial Systems

		D 11	0.011	45 04(0	7
COMMUNITY HOSPITAL O	F	I NDI ANA,	INC.		

In Lieu of Form CMS-2552-10

	ATION OF INDATIENT OPEDATING COST				2002-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0169	Period: From 01/01/2018	Worksheet D-1	
			To 12/31/2018	Date/Time Pre	pared:
				5/29/2019 3:0	5 pm
		Title XVIII	Hospi tal	PPS	
	Cost Center Description			1 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		63, 523	1.00
2.00	Inpatient days (including private room days, excluding swing-be			63, 523	2.00
3.00	Private room days (excluding swing-bed and observation bed days		ivate room davs.	00,020	3.00
0.00	do not complete this line.		r varo r oom aajo,	Ũ	0.00
4.00	Semi-private room days (excluding swing-bed and observation bed	d days)		57, 068	4.00
5.00	Total swing-bed SNF type inpatient days (including private room	n days) through Decembe	er 31 of the cost	0	5.00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private room	n days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)				
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7.00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8.00
0 00	reporting period (if calendar year, enter 0 on this line)	the Dreaman (avaluding	owing had and	10 210	9.00
9.00	Total inpatient days including private room days applicable to newborn days)	the program (excluding	swing-bed and	19, 318	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII onl	v (including private r	nom davs)	0	10.00
10.00	through December 31 of the cost reporting period (see instructi		oom days)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII onl		noom days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, ent		com dayo) ar cor	Ũ	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00
	through December 31 of the cost reporting period		- ·		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.00
	after December 31 of the cost reporting period (if calendar yea	ar, enter O on this lin	ie)		
14.00	Medically necessary private room days applicable to the Program	n (excluding swing-bed	days)	0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
47.00	SWING BED ADJUSTMENT		6.11	0.00	47.00
17.00	Medicare rate for swing-bed SNF services applicable to services	s through December 31 o	or the cost	0.00	17.00
18.00	reporting period Medicare rate for swing-bed SNF services applicable to services	after December 21 of	the cost	0.00	10 00
16.00	reporting period	salter becember 31 01	the cost	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19.00
17.00	reporting period	through becember 31 of		0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20.00
	reporting period				
21.00	Total general inpatient routine service cost (see instructions))		76, 326, 768	21.00
22.00	Swing-bed cost applicable to SNF type services through December	- 31 of the cost report	ing period (line	0	22.00
	5 x line 17)				
23.00	Swing-bed cost applicable to SNF type services after December 3	31 of the cost reportin	ng period (line 6	0	23.00
	x line 18)				
24.00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24.00
25.00	7 x line 19) Swing had anot appliable to NE type conviges often December 21	1 of the cost concrting	noried (line 0	0	25 00
25.00	Swing-bed cost applicable to NF type services after December 31 x line 20)	I OI THE COST LEPOITING	perioù (rine o	0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		76, 326, 768	
27.00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT			10/020/700	2// 00
28.00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)		5 /	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minu		tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x line	e 31)		0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)		CC 11 1 (11	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost ar	nd private room cost di	tterential (line	76, 326, 768	37.00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	STMENTS			ł
38.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS Adjusted general inpatient routine service cost per diem (see i			1, 201. 56	38 00
38.00 39.00	Program general inpatient routine service cost (line 9 x line 3			23, 211, 736	
40.00	Medically necessary private room cost applicable to the Program	-		23, 211, 730	1
	Total Program general inpatient routine service cost (line 39 +			23, 211, 736	•
				, , , , 00	

	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0169	Period: From 01/01/2018	Worksheet D-	1
					To 12/31/2018		
			Title	XVIII	Hospi tal	PPS	os pi
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	+
00	NURSERY (title V & XIX only)	0	0	0. (0 0	() 42
~ ~	Intensive Care Type Inpatient Hospital Units			0.074			
00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	12, 390, 702	5, 973	2,074.4	15 2, 041	4, 233, 952	
00 00	BURN INTENSIVE CARE UNIT						44
	SURGICAL INTENSIVE CARE UNIT						46
00	NEONATAL INTENSIVE CARE UNIT	16, 995, 863	12, 362	1, 374.8	35 0	0	47
	Cost Center Description						_
00	Program inpatient ancillary service cost (Wks	et D 2 col 2	Lino 200)			1.00 33,776,822	2 48
00	Total Program inpatient costs (sum of lines			ns)		61, 222, 510	
00	PASS THROUGH COST ADJUSTMENTS			1137		01, 222, 310	1 1
00	Pass through costs applicable to Program inpa	atient routine s	services (from	Wkst. D, sun	of Parts I and	3, 343, 821	1 50
00	Pass through costs applicable to Program inpa and IV)	atient ancillary	y services (Tr	OM WKST. D, S	sum of Parts II	2, 148, 323	3 51
00	Total Program excludable cost (sum of lines !	50 and 51)				5, 492, 144	4 52
00	Total Program inpatient operating cost exclud		lated, non-phy	sician anesth	netist, and	55, 730, 366	
	medical education costs (line 49 minus line !	52)					
00	TARGET AMOUNT AND LIMIT COMPUTATION						
00 00	Program discharges Target amount per discharge					0.00) 54) 55
00	Target amount (line 54 x line 55)						5 56
00	Difference between adjusted inpatient operati	ing cost and tai	rget amount (I	ine 56 minus	line 53)		57
00	Bonus payment (see instructions)					0	
00	Lesser of lines 53/54 or 55 from the cost rep	porting period e	ending 1996, u	pdated and co	ompounded by the	0.00	59
00	market basket Lesser of lines 53/54 or 55 from prior year of	cost report up	dated by the m	arket hasket		0.00	0 60
00	If line 53/54 is less than the lower of lines				the amount by		0 61
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	the target		
~~	amount (line 56), otherwise enter zero (see i	instructions)					
00 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ont (coo instru	ctions)) 62) 63
00	PROGRAM INPATIENT ROUTINE SWING BED COST						
00	Medicare swing-bed SNF inpatient routine cos	ts through Decer	mber 31 of the	cost reporti	ng period (See	(64
	instructions)(title XVIII only)						
00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	er 31 of the c	ost reporting	period (See	(0 65
00	Total Medicare swing-bed SNF inpatient routin	ne costs (line d	64 plus line 6	5)(title XVII	l only). For	(0 66
	CAH (see instructions)			-, (
00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	f the cost re	eporting period	0) 67
00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	o costs after D	acombor 21 of	the east range	sting pariod		1 40
00	(line 13 x line 20)	e costs arter be	ecember 31 01	the cost rept	n tring period) 68
. 00	Total title V or XIX swing-bed NF inpatient	routine costs (I	line 67 + line	68)		0	69 0
	PART III - SKILLED NURSING FACILITY, OTHER NU						
. 00	Skilled nursing facility/other nursing facili						70
00 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine /U ÷ line	∠)			71
00	Medically necessary private room cost application	· ·	(line 14 x li	ne 35)			73
00	Total Program general inpatient routine servi			,			74
. 00	Capital-related cost allocated to inpatient	routine service	costs (from W	orksheet B, F	Part II, column		75
00	26, line 45)	20 2)					76
00	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line	,					77
	Inpatient routine service cost (line 74 minus						78
00	Aggregate charges to beneficiaries for excess	,	rovider record	s)			79
00	Total Program routine service costs for compa		ost limitation	(line 78 mir	nus line 79)		80
00	Inpatient routine service cost per diem limi		N N				81
00 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (82
00	Program inpatient ancillary services (see ins		-,				84
00	Utilization review - physician compensation		ns)				85
00	Total Program inpatient operating costs (sum	of lines 83 th					86
	PART IV - COMPUTATION OF OBSERVATION BED PASS					/ 155	5 87
00	Total obconvotion had dove (and instructions)						
. 00 . 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per o		line 2)			6, 455 1, 201. 56	

Health Financial Systems COMM	IUNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	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	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	9, 021, 804	76, 326, 768	0. 11820	7, 756, 070	916, 767	90.00
91.00 Nursing School cost	0	76, 326, 768	0.00000	7, 756, 070	0	91.00
92.00 Allied health cost	0	76, 326, 768	0.00000	7, 756, 070	0	92.00
93.00 All other Medical Education	0	76, 326, 768	0.00000	7, 756, 070	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Pre 5/29/2019 3:0	pare
		Title XVIII	Subprovider -	PPS	<u>o pii</u>
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	s excluding newborn)		3, 733	1 1.
00	Inpatient days (including private room days and swing bed days Inpatient days (including private room days, excluding swing-b			3, 733	
00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pr	ivate room days,	0	3
00 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo reporting period		r 31 of the cost	3, 733 0	
00	Total swing-bed SNF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private room reporting period	5.		0	
00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	5		0	
00	Total inpatient days including private room days applicable to newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or		-	2, 614	
00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or	tions) nly (including private r		0	
00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period		e room days)	0	12
00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye	5 . 51	5,	0	13
	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT			0	
00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost	0.00	17
	Medicare rate for swing-bed SNF services applicable to service reporting period			0.00	
	Medicaid rate for swing-bed NF services applicable to services reporting period	Ū.		0.00	
	Medicaid rate for swing-bed NF services applicable to services reporting period Total general inpatient routine service cost (see instructions		ne cost	0. 00 3, 965, 799	
	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)		ing period (line	3, 703, 777 0	
00	Swing-bed cost applicable to SNF type services after December x line 18)			0	
	Swing-bed cost applicable to NF type services through December 7 x line 19)			0	
00	Swing-bed cost applicable to NF type services after December 3 x line 20) Total swing-bed cost (see instructions)	si or the cost reporting	perioa (line 8	0	
	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		3, 965, 799	
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 -	- line 28)		0 0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.000000	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	
	Average per diem private room cost differential (line 34 x lir	ne 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 3, 965, 799	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 042 24	20
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 062. 36 2, 777, 009	
	Medically necessary private room cost applicable to the Progra			2, 777, 009	
00					

			-		From 01/01/2018		
			Component	CCN: 15-S169	To 12/31/2018	Date/Time Pre	
			Title	e XVIII	Subprovider -	5/29/2019 3:0 PPS	Jo pi
	Cost Center Description	Total Inpatient Cost	Total	Average Per	IPF Program Days	Program Cost (col. 3 x col.	
		-		col . 2)		4)	
00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00 00 0	5.00	0 42
	Intensive Care Type Inpatient Hospital Units	-		1	T.		
	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	(0.	00 0	C	0 43 44
	BURN INTENSIVE CARE UNIT						45
	SURGI CAL I NTENSI VE CARE UNI T						46
00	NEONATAL INTENSIVE CARE UNIT Cost Center Description	0	(0.	00 0		3 47
	·					1.00	
	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines 4			anc)		382, 205 3, 159, 214	
	PASS THROUGH COST ADJUSTMENTS			51137			<u>+</u> + '
. 00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, su	m of Parts I and	275, 751	1 50
. 00	<pre>III) Pass through costs applicable to Program inpa</pre>	atient ancillar	v services (fi	om Wkst D	sum of Parts II	22, 196	51
	and IV)		,				
	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclud		lated non nh	sician anact	hatist and	297, 947	
	medical education costs (line 49 minus line 5		i a teu, non-pny		netist, diù	2, 861, 267	03
	TARGET AMOUNT AND LIMIT COMPUTATION					1 .	1 -
	Program discharges Target amount per discharge					0.00	D 54 D 55
. 00	Target amount (line 54 x line 55)					C) 5 <i>6</i>
	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and ta	rget amount (I	ine 56 minus	line 53)	-	0 57 0 58
	Lesser of lines 53/54 or 55 from the cost rep	porting period	ending 1996, u	updated and c	ompounded by the	-	
	market basket						
	Lesser of lines 53/54 or 55 from prior year of lines 53/54 is less than the lower of lines					0.00	
	which operating costs (line 53) are less than						1
00	amount (line 56), otherwise enter zero (see i	nstructions)					0 62
	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)) 62) 63
	PROGRAM INPATIENT ROUTINE SWING BED COST					1	
	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts through Dece	mber 31 of the	e cost report	ing period (See	C	0 64
	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the d	cost reportin	g period (See	C	0 65
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	no costs (lino	64 plus lipo 4	5) (titlo VVI	LL oply) For		0 66
. 00	CAH (see instructions)	le costs (Trile	o4 prus rine o	55)(title xi	TT Only). TO		
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 d	of the cost r	eporting period	C) 67
. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost rep	orting period	C	3 68
	(line 13 x line 20)				517		
	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					C	5 69
	Skilled nursing facility/other nursing facili)		70
	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71
	Program routine service cost (line 9 x line 7 Medically necessary private room cost applica	,	(line 14 x li	ne 35)			72
. 00	Total Program general inpatient routine servi	ce costs (line	72 + line 73))			74
. 00	Capital-related cost allocated to inpatient r	routine service	costs (from W	Vorksheet B,	Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
	Program capital -related costs (line 9 x line						77
	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovider record	ds)			78
00	Total Program routine service costs for compa	arison to the c			nus line 79)		80
	Inpatient routine service cost per diem limit		`				81
	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s						82
	Program inpatient ancillary services (see ins		- /				84
	Utilization review - physician compensation						85
	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		i uugri 85)			1	86
. 00	Total observation bed days (see instructions))					3 87
	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see		line 2)			0.00	2 88 2 89

Health Financial Systems COMM	IUNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2018	Worksheet D-1	
		Component (CCN: 15-S169	To 12/31/2018		bared: 5 pm
		Title	XVIII	Subprovider - IPF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST	•				
90.00 Capital-related cost	393, 806	3, 965, 799	0. 09930	01 0	0	90.00
91.00 Nursing School cost	0	3, 965, 799	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	3, 965, 799	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 965, 799	0. 00000	0 0	0	93.00

Health Financial Systems

COMMUNI TY	HOSPI TAL	0F	I NDI	ANA,	INC.		
			-		0.011	45	0411

In Lieu of Form CMS-2552-10

alth Financial Systems COMMUNITY HOSPITAL	OF INDIANA, INC.	In Lie	u of Form CMS-2	2552-1
MPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018		pared:
· · · · · · · · · · · · · · · · · · ·	Title XIX	Hospi tal	5/29/2019 3: 0 PPS	s pili
Cost Center Description				
			1.00	
PART I – ALL PROVIDER COMPONENTS				-
00 Inpatient days (including private room days and swing-bed of	days excluding newborn)		63, 523	1.0
00 Inpatient days (including private room days, excluding swir			63, 523	
00 Private room days (excluding swing-bed and observation bed		rivate room days,	0	
do not complete this line.		-		
00 Semi-private room days (excluding swing-bed and observation			57, 068	
00 Total swing-bed SNF type inpatient days (including private	room days) through Decemb	er 31 of the cost	0	5.0
reporting period 00 Total swing-bed SNF type inpatient days (including private	room days) after December	31 of the cost	0	6.0
reporting period (if calendar year, enter 0 on this line)	room days) arter becember	ST OF the cost	0	0.0
00 Total swing-bed NF type inpatient days (including private r	room days) through Decembe	r 31 of the cost	0	7.0
reporting period				
00 Total swing-bed NF type inpatient days (including private r	room days) after December	31 of the cost	0	8.0
reporting period (if calendar year, enter 0 on this line)		a and a solar state	1 010	
00 Total inpatient days including private room days applicable newborn days)	e to the program (excluding	j swing-bed and	1, 012	9.0
0. 00 Swing-bed SNF type inpatient days applicable to title XVIII	l only (including private	room davs)	0	10.0
through December 31 of the cost reporting period (see instr			-	
.00 Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11.0
December 31 of the cost reporting period (if calendar year,		+	0	10.0
2.00 Swing-bed NF type inpatient days applicable to titles V or through December 31 of the cost reporting period	XIX only (Including priva	te room days)	0	12.0
8.00 Swing-bed NF type inpatient days applicable to titles V or	XIX only (including priva	te room davs)	0	13.0
after December 31 of the cost reporting period (if calendar	r year, enter 0 on this li	ne)	-	
.00 Medically necessary private room days applicable to the Pro	ogram (excluding swing-bed	days)	0	
5.00 Total nursery days (title V or XIX only)			7,653	
b. OO Nursery days (title V or XIX only) SWING BED ADJUSTMENT			3, 288	16.0
7.00 Medicare rate for swing-bed SNF services applicable to serv	vices through December 31	of the cost	0.00	17.0
reporting period				
8.00 Medicare rate for swing-bed SNF services applicable to serv	vices after December 31 of	the cost	0.00	18.0
reporting period 0.00 Medicaid rate for swing-bed NF services applicable to servi	i and through December 21 a	f the east	0.00	10.0
 Medicaid rate for swing-bed NF services applicable to servi reporting period 	rces through becember 31 0	the cost	0.00	19.0
0.00 Medicaid rate for swing-bed NF services applicable to servi	ices after December 31 of	the cost	0.00	20.0
reporting period				
.00 Total general inpatient routine service cost (see instructi		the second set (1) as	77, 183, 000	
2.00 Swing-bed cost applicable to SNF type services through Dece 5 x line 17)	ember 31 of the cost repor	ting period (line	0	22.0
8.00 Swing-bed cost applicable to SNF type services after Decemb	ber 31 of the cost reportio	ng period (line 6	0	23.0
x line 18)				
4.00 Swing-bed cost applicable to NF type services through Decem	mber 31 of the cost report	ng period (line	0	24.0
7 x line 19) 5.00 Swing-bed cost applicable to NF type services after Decembe	or 21 of the cost reporting	a pariod (line 9	0	25.0
x line 20)	er si or the cost reporting	j per lou (Trile o	0	25.0
0.00 Total swing-bed cost (see instructions)			0	26.0
00 General inpatient routine service cost net of swing-bed cost	st (line 21 minus line 26)		77, 183, 000	27.0
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
8.00 General inpatient routine service charges (excluding swing-	-bed and observation bed cl	harges)	0	
 0.00 Private room charges (excluding swing-bed charges) 0.00 Semi-private room charges (excluding swing-bed charges) 			0	
.00 General inpatient routine service cost/charge ratio (line 2	27 ÷ line 28)		0.000000	
2.00 Average private room per diem charge (line 29 ÷ line 3)			0.00	
3.00 Average semi-private room per diem charge (line 30 ÷ line 4	4)		0.00	33.0
A 00 Average per diem private room charge differential (line 32		ctions)	0.00	
5.00 Average per diem private room cost differential (line 34 x			0.00	
b.00 Private room cost differential adjustment (line 3 x line 35 %.00 General inpatient routine service cost net of swing-bed cost		ifferential (line	0 77, 183, 000	
27 minus line 36)	st and private room cost d	rielential (IIIIe	11, 163, 000	37.0
PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST A	ADJUSTMENTS			1
8.00 Adjusted general inpatient routine service cost per diem (s			1, 215. 04	
0.00 Program general inpatient routine service cost (line 9 x li	ine 38)		1, 229, 620	
	ogram (line 14 v line 25)	i	~	1 10 0
.00 Medically necessary private room cost applicable to the Pro .00 Total Program general inpatient routine service cost (line	3 ,		0 1, 229, 620	

	ATION OF INPATIENT OPERATING COST		Provider C	IN: 15-0169	Period: From 01/01/2018		
					To 12/31/2018	Date/Time Pre 5/29/2019 3:0	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	-
00	NURSERY (title V & XIX only)	5, 500, 280	7, 653	718. 7	1 3, 288	2, 363, 118	42
	Intensive Care Type Inpatient Hospital Unit						
00	INTENSIVE CARE UNIT	12, 390, 702	5, 973	2,074.4	15 0	0	
00 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44
00	SURGI CAL INTENSIVE CARE UNIT						40
00	NEONATAL INTENSIVE CARE UNIT	16, 995, 863	12, 362	1, 374.8	605	831, 784	
	Cost Center Description						
						1.00	
00	Program inpatient ancillary service cost (W			>		1, 845, 478	
00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	5 41 through 48)(s	ee instructio	ns)		6, 270, 000	49
00	Pass through costs applicable to Program in	natient routine s	ervices (from	Wkst D sum	of Parts L and	562, 055	50
00				WK31. D, 30		302,033	
00	Pass through costs applicable to Program in	patient ancillary	services (fr	om Wkst. D, s	um of Parts II	142, 895	51
	and IV)						
00	Total Program excludable cost (sum of lines	,				704, 950	
00	Total Program inpatient operating cost excl medical education costs (line 49 minus line		ated, non-phy	sician anestr	erist, and	5, 565, 050	53
	TARGET AMOUNT AND LIMIT COMPUTATION					I	
00	Program di scharges					0	54
00	Target amount per discharge					0.00	55
00	Target amount (line 54 x line 55)					0	
00	Difference between adjusted inpatient opera	iting cost and tar	get amount (I	ine 56 minus	line 53)	0	
00	Bonus payment (see instructions)					0	
00	Lesser of lines 53/54 or 55 from the cost r market basket	reporting period e	ending 1996, u	pdated and co	mpounded by the	0.00	59
00	Lesser of lines 53/54 or 55 from prior year	cost report. upd	lated by the m	arket basket		0.00	60
00	If line 53/54 is less than the lower of lin				the amount by	0	
	which operating costs (line 53) are less th	an expected costs	(lines 54 x	60), or 1% of	the target		
	amount (line 56), otherwise enter zero (see	e instructions)					
00	Relief payment (see instructions)					0	
00	Allowable Inpatient cost plus incentive pay PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see Instruc	tions)			0	63
00	Medicare swing-bed SNF inpatient routine co	sts through Decem	her 31 of the	cost reporti	na period (See	0	64
	instructions)(title XVIII only)					-	
00	Medicare swing-bed SNF inpatient routine co	sts after Decembe	er 31 of the c	ost reporting	period (See	0	65
	instructions)(title XVIII only)					_	
00	Total Medicare swing-bed SNF inpatient rout	ine costs (line 6	4 plus line 6	5)(title XVII	I only). ⊦or	0	66
00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 o	f the cost re	porting period	0	67
00	(line 12 x line 19)	ne costs thi ough	becchiber 51 0		por tring period		
00	Title V or XIX swing-bed NF inpatient routi	ne costs after De	cember 31 of	the cost repo	orting period	0	68
	(line 13 x line 20)						
00	Total title V or XIX swing-bed NF inpatient			,		0	69
00	PART III - SKILLED NURSING FACILITY, OTHER Skilled nursing facility/other nursing faci					1	70
00	Adjusted general inpatient routine service	2		• •			71
00	Program routine service cost (line 9 x line			-,			72
00	Medically necessary private room cost appli	,	(line 14 x li	ne 35)			73
00	Total Program general inpatient routine ser	vice costs (line	72 + line 73)				74
00	Capital-related cost allocated to inpatient	routine service	costs (from W	orksheet B, F	Part II, column		75
00	26, line 45) Por diam capital related costs (line 75 : l	ino 2)					-,
00 00	Per diem capital-related costs (line 75 ÷ l Program capital-related costs (line 9 x lin						76
00	Inpatient routine service cost (line 74 min						78
00	Aggregate charges to beneficiaries for exce		ovider record	s)			79
00	Total Program routine service costs for com	• •		•	us line 79)		80
00	Inpatient routine service cost per diem lim						81
00	Inpatient routine service cost limitation (·					82
00	Reasonable inpatient routine service costs	•	.)				83
00	Program inpatient ancillary services (see i)				84
00 00	Utilization review - physician compensation Total Program inpatient operating costs (su						85
00	PART IV - COMPUTATION OF OBSERVATION BED PA		ough 65)			I	
00	Total observation bed days (see instruction					6, 455	87
			1				
00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 215. 04	88

Health Financial Systems COM	MUNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2018	Worksheet D-1	
				To 12/31/2018		
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	9, 021, 804	77, 183, 000	0. 116888	7, 843, 083	916, 762	90.00
91.00 Nursing School cost	0	77, 183, 000	0.00000	7, 843, 083	0	91.00
92.00 Allied health cost	0	77, 183, 000	0.00000	7, 843, 083	0	92.00
93.00 All other Medical Education	0	77, 183, 000	0.00000			93.00

Health Financial Systems INPATIENT ANCILLARY SERVICE COST APPORTIONME	COMMUNITY HOSPITAL OF INDIANA, I	NC. CN: 15-0169	In Lie Period:	u of Form CMS- Worksheet D-3	
INPATIENT ANCILLARY SERVICE CUST APPORTIUNWE		CN: 12-0109	From 01/01/2018	worksneet D-3)
			To 12/31/2018	Date/Time Pre 5/29/2019 3:0	epared:
	Ti †le	e XVIII	Hospi tal	PPS	is pili
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
		J	Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	i	1			
30. 00 03000 ADULTS & PEDI ATRI CS			38, 397, 826		30.00
31.00 03100 INTENSIVE CARE UNIT			7, 860, 443		31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT			0		35.00
40. 00 04000 SUBPROVIDER - IPF			0		40.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS		0.007.4	- 45 404 005	4 404 404	-
50. 00 05000 OPERATING ROOM		0.0974			
51.00 O5100 RECOVERY ROOM		0. 1679			
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.5820			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1773			
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.0737			
57. 00 05700 CT SCAN		0. 0366		358, 868	
58. 00 05800 MRI		0.0951			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0710		99, 960	
60. 00 06000 LABORATORY		0. 1039			
64.00 06400 I NTRAVENOUS THERAPY		1.0317		297, 749	
65. 00 06500 RESPI RATORY THERAPY		0. 2093			
66. 00 06600 PHYSI CAL THERAPY		0.3052			
67.00 06700 OCCUPATI ONAL THERAPY		0.3056			
68.00 06800 SPEECH PATHOLOGY		0. 2027			
69. 00 06900 ELECTROCARDI OLOGY		0. 0812			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 2195			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATI	ENT	0. 3242		5, 161, 590	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 3838			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2288		5, 753, 205	
74.00 07400 RENAL DI ALYSI S		0. 4441		798, 402	
76. 00 03330 ENDOSCOPY		0. 1495			
76. 06 03954 I MAGI NG CENTER		0. 0842			
76. 07 03955 BREAST DI AGNOSTI C CENTER		0. 5068	91 0	0	76.07
OUTPATIENT SERVICE COST CENTERS		0.0000			00.07
90. 00 09000 CLINIC		0.0000		-	
90. 26 04975 SPI NE CENTER		0. 57610			
91.00 09100 EMERGENCY		0. 1038			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT P		0. 74010		358, 686	
200.00 Total (sum of lines 50 through 9			194, 538, 932	33, 776, 822	
	ces-Program only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line	201)		194, 538, 932		202.00

INDATIENT AN	cial Systems COMMUNITY HOSPI ICILLARY SERVICE COST APPORTIONMENT	TAL OF INDIANA, I	CN: 15-0169	Peri od:	u of Form CMS Worksheet D-3	
INPATTENT AN	ICILLARY SERVICE CUST APPORTIONMENT	Provider C	CN: 15-0169	From 01/01/2018	worksneet D-3)
		Component	CCN: 15-S169	To 12/31/2018	Date/Time Pre 5/29/2019 3:0	
		Title	e XVIII	Subprovider - IPF	PPS	•
	Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2)	
	ENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	ADULTS & PEDIATRICS		1	0		30.00
	INTENSIVE CARE UNIT			0		31.00
	NEONATAL INTENSIVE CARE UNIT			0		35.00
	SUBPROVIDER - IPF			5, 664, 871		40.00
	NURSERY					43.00
	ARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM		0. 0974	54 0	0	50.00
51.00 05100	RECOVERY ROOM		0. 1679	76 0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM		0. 5820	61 0	0	52.00
	RADI OLOGY-DI AGNOSTI C		0. 1773		5, 960	
	RADI OLOGY-THERAPEUTI C		0.0737		0	
	CT SCAN		0. 0366		3, 221	
58.00 05800			0.0951		808	
	CARDI AC CATHETERI ZATI ON		0.0710		0	
			0.1039		85, 975	
	I NTRAVENOUS THERAPY RESPI RATORY THERAPY		1. 0317 0. 2093		19, 278 5, 420	
	PHYSI CAL THERAPY		0. 2093		23, 931	
	OCCUPATIONAL THERAPY		0.3052		22, 902	
	SPEECH PATHOLOGY		0. 2027		1, 323	
	ELECTROCARDI OLOGY		0.0812		1, 437	
	ELECTROENCEPHALOGRAPHY		0. 2195			70.00
	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3242		34, 382	
	IMPL. DEV. CHARGED TO PATIENTS		0. 3838	81 600	230	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS		0. 2288	47 591, 469	135, 356	73.00
	RENAL DI ALYSI S		0. 4441	35 0	0	
76.00 03330	ENDOSCOPY		0. 1495	73 0	0	76.00
	I MAGI NG CENTER		0. 0842		0	
	BREAST DI AGNOSTI C CENTER		0. 5068	91 0	0	76.07
	TI ENT SERVICE COST CENTERS		0.0000	20		
	CLINIC SPINE CENTER		0.0000		0	
			0.5761		0	
	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART		0. 1038 0. 7401		25, 358	
200.00	Total (sum of lines 50 through 94 and 96 through 9	987	0.7401	2, 146, 998	15, 614 382, 205	
	Less PBP Clinic Laboratory Services-Program only c			2, 140, 998	302, 205	200.00
201.00	Net charges (line 200 minus line 201)	nuiges (inie 01)	1	2, 146, 998		201.00

Health Financial Systems COMMUNITY HOSPITAL OF	INDIANA, IN	IC.	In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CO	CN: 15-0169	Peri od:	Worksheet D-3	3
			From 01/01/2018		
			To 12/31/2018	Date/Time Pre 5/29/2019 3:0	epared:
	Ti †1	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
		i i o onargoo	Charges	$(col. 1 \times col.$	
			51121 955	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		•		•	
30. 00 03000 ADULTS & PEDI ATRI CS			3, 681, 825		30.00
31. 00 03100 I NTENSI VE CARE UNI T			660, 760		31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT			6, 524, 711		35.00
40. 00 04000 SUBPROVIDER - IPF			65, 208		40.00
43. 00 04300 NURSERY			419, 312		43.00
ANCI LLARY SERVI CE COST CENTERS					1
50. 00 05000 OPERATING ROOM		0.0974	54 1, 403, 694	136, 796	50.00
51.00 05100 RECOVERY ROOM		0. 1679			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 5820	51 391, 897	228, 108	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1773			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.0737	48 336, 058	24, 784	55.00
57. 00 05700 CT SCAN		0. 0366			
58. 00 05800 MRI		0.0951			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0710			1
60. 00 06000 LABORATORY		0. 1039		169, 367	60,00
64. 00 06400 I NTRAVENOUS THERAPY		1.0317			
65. 00 06500 RESPI RATORY THERAPY		0. 2093			
66. 00 06600 PHYSI CAL THERAPY		0. 3052			
67.00 06700 OCCUPATI ONAL THERAPY		0.3056			
68.00 06800 SPEECH PATHOLOGY		0. 2027			
69. 00 06900 ELECTROCARDI OLOGY		0.0812			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 2195			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3242			
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 3838			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2288		479, 810	
74.00 07400 RENAL DI ALYSI S		0. 4441			
76. 00 03330 ENDOSCOPY		0. 1495		6, 291	
76. 06 03954 I MAGI NG CENTER		0.0842			
76. 07 03955 BREAST DI AGNOSTI C CENTER		0. 5068			
OUTPATIENT SERVICE COST CENTERS		010000		<u> </u>	
90. 00 09000 CLINIC		0.0000	0 00	C	90.00
90. 26 04975 SPI NE CENTER		0. 5761			
91. 00 09100 EMERGENCY		0. 1044		, s	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 7401			
200.00 Total (sum of lines 50 through 94 and 96 through 98)			9, 907, 271		
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)	(9, 907, 271		202.00
		1	.,,	I	

Heal th	Financial Systems COMMUNITY HOSPITAL O	FINDIANA, INC.	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0169	Period: From 01/01/2018	Worksheet E Part A	
			To 12/31/2018	Date/Time Pre 5/29/2019 3:0	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr	ring prior to October 1 (see	0 32, 981, 412	
1.02	instructions) DRG amounts other than outlier payments for discharges occurr instructions)	ring on or after October	1 (see	10, 912, 271	1. 02
1.03	DRG for federal specific operating payment for Model 4 BPCI 1 1 (see instructions)	for discharges occurring	prior to October	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI 1 October 1 (see instructions)	for discharges occurring	on or after	0	1. 04
2.00	Outlier payments for discharges. (see instructions)			1, 399, 379	2.00
2.01 2.02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instruct	tions)		0	2.01 2.02
3.00	Managed Care Simulated Payments			15, 598, 570	3.00
4.00	Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment	orting period (see instru	ctions)	261.00	4.00
5.00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	st recent cost reporting	period ending on	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet 1 new programs in accordance with 42 CFR 413.79(e)	the criteria for an add-o	n to the cap for	0.00	6. 00
7.00	MMA Section 422 reduction amount to the IME cap as specified			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under cost report straddles July 1, 2011 then see instructions.	~ 42 CFR §412.105(†)(1)(1	v)(B)(2) If the	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413.			3. 25	8.00
8.01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap sl	ots under § 5503 of the	ACA. If the cost	0.00	8. 01
8.02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap sl	ots from a closed teachi	ng hospital	0.00	8. 02
9.00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lir instructions)	nes (8, 8,01 and 8,02) (see	3. 25	9.00
10.00	FTE count for allopathic and osteopathic programs in the curr	rent year from your recor	ds	2.85	10.00
	FTE count for residents in dental and podiatric programs.				11.00
12. 00 13. 00	Current year allowable FTE (see instructions)				12.00 13.00
13.00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that ye	ear ended on or after Sep	tember 30 1997		13.00
	otherwise enter zero.				
15.00	Sum of lines 12 through 14 divided by 3.				15.00
	Adjustment for residents in initial years of the program				16.00
	Adjustment for residents displaced by program or hospital clo Adjusted rolling average FTE count	JSule			17.00 18.00
	Current year resident to bed ratio (line 18 divided by line 4	4).		0. 018774	
20.00	Prior year resident to bed ratio (see instructions)			0. 018853	20.00
	Enter the lesser of lines 19 or 20 (see instructions)			0.018774	
	IME payment adjustment (see instructions)			448, 023	
	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 42 Number of additional allopathic and osteopathic IME FTE resid		EP 412 105	159, 215	23.00
	(f)(1)(iv)(C).	dent cap siots under 42 c	TR 412. 105		
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter the instructions?	lower of line 23 or line	24 (see	-0. 40 0. 00	24.00 25.00
26.00	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	
	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions	5)		0	28.01
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0)1)		448, 023 159, 215	
27.01	Disproportionate Share Adjustment			137, 213	27.01
30.00	Percentage of SSI recipient patient days to Medicare Part A p	patient days (see instruc	tions)	3.88	30.00
	Percentage of Medicaid patient days (see instructions)			29.39	
	Sum of lines 30 and 31	-)			32.00
	Allowable disproportionate share percentage (see instructions Disproportionate share adjustment (see instructions)	<i>)</i>		16.66 1,828,172	33.00 34.00
			I	, -=-, ·/ -	

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0169	Period: From 01/01/2018		
			To 12/31/2018	Date/Time Pre 5/29/2019 3:0	
		Title XVIII	Hospi tal	PPS	<u>o p</u>
			Prior to 10/1		
	Uncompanyated Caro Adjuctment		1.00	2.00	
5.00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		6 766 695 164	8, 272, 872, 447	35.
5. 01	Factor 3 (see instructions)		0. 000438215	0. 000343050	
	Hospital uncompensated care payment (If line 34 is zero, enter	r zero on this line) (se		2, 838, 006	
	instructions)				
5. 03	Pro rata share of the hospital uncompensated care payment among	unt (see instructions)	2, 217, 857	715, 334	35.
6. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.0		2, 933, 191		36.
~~~	Additional payment for high percentage of ESRD beneficiary dis				1 10
. 00	Total Medicare discharges on Worksheet S-3, Part I excluding 652, 682, 683, 684 and 685 (see instructions)	discharges for MS-DRGS	0		40.
. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 66	83 684 an 685 (see	0		41
. 00	instructions)		0		- 1.
I. 01	Total ESRD Medicare covered and paid discharges excluding MS-	DRGs 652, 682, 683, 684	0		41.
	an 685. (see instructions)				
2.00	Divide line 41 by line 40 (if less than 10%, you do not quali		0.00		42.
3. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68	2, 683, 684 an 685. (see	0		43
1.00	instructions) Ratio of average length of stay to one week (line 43 divided	by Lipo 41 divided by 7	0. 000000		44
1.00	days)	by The 41 divided by /	0.00000		44
5.00	Average weekly cost for dialysis treatments (see instructions)	)	0.00		45
6. 00	Total additional payment (line 45 times line 44 times line 41		0		46
. 00	Subtotal (see instructions)		50, 502, 448		47
8. 00	Hospital specific payments (to be completed by SCH and MDH, si	mall rural hospitals	0		48
	only. (see instructions)			A +	
				Amount 1.00	
. 00	Total payment for inpatient operating costs (see instructions	)		50, 661, 663	49
). 00	Payment for inpatient program capital (from Wkst. L, Pt. I and	-		4, 027, 525	
. 00	Exception payment for inpatient program capital (Wkst. L, Pt.	<pre>III, see instructions)</pre>		0	51
. 00	Direct graduate medical education payment (from Wkst. E-4, li	ne 49 see instructions).		127, 949	
. 00	Nursing and Allied Health Managed Care payment			0	
. 00	Special add-on payments for new technologies			14, 979 0	
. 01	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	0)		0	
. 00	Cost of physicians' services in a teaching hospital (see intra			0	56
. 00	Routine service other pass through costs (from Wkst. D, Pt. I	-	hrough 35).	0	
3. 00	Ancillary service other pass through costs from Wkst. D, Pt.			0	58
. 00	Total (sum of amounts on lines 49 through 58)			54, 832, 116	59
. 00	Primary payer payments			16, 601	60
. 00	Total amount payable for program beneficiaries (line 59 minus	line 60)		54, 815, 515	
. 00	Deductibles billed to program beneficiaries			4, 278, 760	
. 00	Coinsurance billed to program beneficiaries			92, 107	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			149, 416 97, 120	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		97, 120 93, 062	
7.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			50, 541, 768	
3.00	Credits received from manufacturers for replaced devices for a	applicable to MS-DRGs (se	ee instructions)	00,011,700	
. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 50	Rural Community Hospital Demonstration Project (§410A Demonst	ration) adjustment (see	instructions)	0	
0.87	Demonstration payment adjustment amount before sequestration			0	
. 88	SCH or MDH volume decrease adjustment (contractor use only)	ructions)		0	
	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70
	HSP bonus payment HVBP adjustment amount (see instructions)			0	
. 90	HSP honus navment HRP adjustment amount (see instructions)			0	1 '0
). 90 ). 91	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	70
). 91 ). 92	Bundled Model 1 discount amount (see instructions)			0 -391, 243	
). 90 ). 91 ). 92 ). 93				0 -391, 243 -414, 529	70

CULATION OF REIMBURSEMENT SETTLEMENT	Provider CO	CN: 15-0169	Period: From 01/01/2018	
			To 12/31/2018	Date/Time Pre 5/29/2019 3:0
	Title	XVIII	Hospi tal	PPS
		FFY	(уууу)	Amount
			0	1.00
96 Low volume adjustment for federal fiscal year (yyyy) (Enter in	column O		0	0
the corresponding federal year for the period prior to 10/1)				
97 Low volume adjustment for federal fiscal year (yyyy) (Enter in			0	0
the corresponding federal year for the period ending on or after	er 10/1)			
98 Low Volume Payment-3				0
99 HAC adjustment amount (see instructions)				535, 413
00 Amount due provider (line 67 minus lines 68 plus/minus lines 69	0 & 70)			49, 200, 583
01 Sequestration adjustment (see instructions)				984, 012
02 Demonstration payment adjustment amount after sequestration				0
00 Interim payments				47, 999, 167
00 Tentative settlement (for contractor use only)	70 1			0
00 Balance due provider/program (line 71 minus lines 71.01, 71.02,	72, and			217, 404
73)				400 444
00 Protested amounts (nonallowable cost report items) in accordance CMS Pub. 15-2, chapter 1, §115.2	e with			489, 444
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	5 0 0 2			0
plus 2.04 (see instructions)	2.03			0
00 Capital outlier from Wkst. L. Pt. I, line 2				0
00 Operating outlier reconciliation adjustment amount (see instruc	tions)			0
00 Capital outlier reconciliation adjustment amount (see instructi				0
00 The rate used to calculate the time value of money (see instruct	,			0.00
00 Time value of money for operating expenses (see instructions)	(1 0110)			0,00
00 Time value of money for capital related expenses (see instructi	ons)			0
			Prior to 10/1	
			1.00	2.00
HSP Bonus Payment Amount				
0.00 HSP bonus amount (see instructions)			0	0
HVBP Adjustment for HSP Bonus Payment				
.00 HVBP adjustment factor (see instructions)			0.000000000	0.000000000
2.00 HVBP adjustment amount for HSP bonus payment (see instructions)			0	0
			0	•
HRR Adjustment for HSP Bonus Payment				
8.00 HRR adjustment factor (see instructions)			0. 0000	0. 0000
8.00 HRR adjustment factor (see instructions) 9.00 HRR adjustment amount for HSP bonus payment (see instructions)				
<ul> <li>B. 00 HRR adjustment factor (see instructions)</li> <li>B. 00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>Rural Community Hospital Demonstration Project (§410A Demonstration</li> </ul>	tion) Adju		0. 0000	0. 0000
<ul> <li>00 HRR adjustment factor (see instructions)</li> <li>00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>Rural Community Hospital Demonstration Project (§410A Demonstration peri</li> <li>00 Is this the first year of the current 5-year demonstration peri</li> </ul>	tion) Adju		0. 0000	0. 0000
<ul> <li>00 HRR adjustment factor (see instructions)</li> <li>00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>Rural Community Hospital Demonstration Project (§410A Demonstration 200 Is this the first year of the current 5-year demonstration pericentury Cures Act? Enter "Y" for yes or "N" for no.</li> </ul>	tion) Adju		0. 0000	0. 0000
<ul> <li>00 HRR adjustment factor (see instructions)</li> <li>00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration 00 Is this the first year of the current 5-year demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> </ul>	tion) Adju od under t		0. 0000	0. 0000
<ul> <li>00 HRR adjustment factor (see instructions)</li> <li>00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Is this the first year of the current 5-year demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line</li> </ul>	tion) Adju od under t		0. 0000	0. 0000
<ul> <li>00 HRR adjustment factor (see instructions)</li> <li>00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line</li> <li>00 Medicare discharges (see instructions)</li> </ul>	tion) Adju od under t		0. 0000	0. 0000
<ul> <li>00 HRR adjustment factor (see instructions)</li> <li>00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line</li> <li>00 Medicare discharges (see instructions)</li> <li>00 Case-mix adjustment factor (see instructions)</li> </ul>	tion) Adju od under t 49)	he 21st	0.0000	0.0000
<ul> <li>00 HRR adjustment factor (see instructions)</li> <li>00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line</li> <li>00 Medicare discharges (see instructions)</li> <li>00 Case-mix adjustment factor (see instructions)</li> <li>Computation of Demonstration Target Amount Limitation (N/A in f</li> </ul>	tion) Adju od under t 49)	he 21st	0.0000	0.0000
<ul> <li>00 HRR adjustment factor (see instructions)</li> <li>00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line</li> <li>00 Medicare discharges (see instructions)</li> <li>00 Case-mix adjustment factor (see instructions)</li> <li>Computation of Demonstration Target Amount Limitation (N/A in f period)</li> </ul>	tion) Adju od under t 49)	he 21st	0.0000	0.0000
<ul> <li>3. 00 HRR adjustment factor (see instructions)</li> <li>4. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration period)</li> <li>0. 00 Is this the first year of the current 5-year demonstration period</li> <li>0. 00 Is this the first year of the current 5-year demonstration period</li> <li>0. 00 Is this the first year of the current 5-year demonstration period</li> <li>0. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line</li> <li>0. 00 Medicare discharges (see instructions)</li> <li>00 Case-mix adjustment factor (see instructions)</li> <li>00 Computation of Demonstration Target Amount Limitation (N/A in figeriod)</li> <li>00 Medicare target amount</li> </ul>	tion) Adju od under t 49)	he 21st	0.0000	0.0000 0
<ul> <li>00 HRR adjustment factor (see instructions)</li> <li>00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line</li> <li>00 Medicare discharges (see instructions)</li> <li>00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in f period)</li> <li>00 Medicare target amount</li> <li>00 Case-mix adjusted target amount (line 203 times line 204)</li> </ul>	tion) Adju od under t 49)	he 21st	0.0000	0.0000
<ul> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>5.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line</li> <li>6.00 Medicare discharges (see instructions)</li> <li>8.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in f period)</li> <li>6.00 Medicare inpatient service costs (line 203 times line 204)</li> <li>6.00 Medicare inpatient routine cost cap (line 202 times line 205)</li> </ul>	tion) Adju od under t 49)	he 21st	0.0000	0.0000 0
<ul> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>4.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line</li> <li>7.00 Medicare discharges (see instructions)</li> <li>8.00 Case-mix adjustment factor (see instructions)</li> <li>8.00 Medicare target amount (line 203 times line 204)</li> <li>9.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement</li> </ul>	tion) Adju od under t 49) ïrst year	he 21st	0.0000	0.0000 0
<ul> <li>00 HRR adjustment factor (see instructions)</li> <li>00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line</li> <li>00 Medicare discharges (see instructions)</li> <li>00 Case-mix adjustment factor (see instructions)</li> <li>00 Medicare target amount</li> <li>00 Medicare inpatient cost cap (line 203 times line 204)</li> <li>00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>00 Program reimbursement under the §410A Demonstration (see instruction)</li> </ul>	tion) Adju od under t 49) irst year uctions)	he 21st	0.0000	0.0000 0
<ul> <li>8.00 HRR adjustment factor (see instructions)</li> <li>8.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line</li> <li>00 Medicare discharges (see instructions)</li> <li>00 Case-mix adjustment factor (see instructions)</li> <li>00 Medicare target amount</li> <li>00 Medicare inpatient routine cost cap (line 203 times line 204)</li> <li>00 Medicare inpatient routine cost cap (line 202 times line 205)</li> <li>Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I</li> </ul>	tion) Adju od under t 49) irst year uctions)	he 21st	0.0000	0.0000 0
<ul> <li>00 HRR adjustment factor (see instructions)</li> <li>00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line</li> <li>00 Medicare discharges (see instructions)</li> <li>00 Case-mix adjustment factor (see instructions)</li> <li>00 Medicare target amount</li> <li>00 Medicare inpatient cost cap (line 203 times line 204)</li> <li>00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>00 Program reimbursement under the §410A Demonstration (see instruction)</li> </ul>	tion) Adju od under t 49) irst year uctions)	he 21st	0.0000	0.0000 0
<ul> <li>8.00 HRR adjustment factor (see instructions)</li> <li>8.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>9.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line</li> <li>9.00 Medicare discharges (see instructions)</li> <li>9.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in f period)</li> <li>9.00 Medicare inpatient routine cost cap (line 203 times line 204)</li> <li>9.00 Medicare inpatient outline cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>9.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I</li> <li>9.00 Adjustment to Medicare IPPS payments (see instructions)</li> </ul>	tion) Adju od under t 49) irst year uctions)	he 21st	0.0000	0.0000 0
<ul> <li>8.00 HRR adjustment factor (see instructions)</li> <li>8.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>9.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line</li> <li>9.00 Medicare discharges (see instructions)</li> <li>9.00 Case-mix adjustment factor (see instructions)</li> <li>9.00 Case-mix adjustment factor (see instructions)</li> <li>9.00 Medicare target amount</li> <li>9.00 Medicare inpatient routine cost cap (line 203 times line 204)</li> <li>9.00 Medicare part A Inpatient Reimbursement</li> <li>9.00 Program reimbursement under the §410A Demonstration (see instructions)</li> <li>9.00 Medicare Part A Inpatient service costs (from Wkst. E, Pt. A, I</li> <li>9.00 Reserved for future use</li> <li>9.00 Total adjustment to Medicare IPPS payments (see instructions)</li> </ul>	tion) Adju od under t 49) irst year uctions)	he 21st	0.0000	0.0000 0
<ul> <li>00 HRR adjustment factor (see instructions)</li> <li>00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line</li> <li>00 Medicare discharges (see instructions)</li> <li>00 Case-mix adjustment factor (see instructions)</li> <li>00 Medicare target amount</li> <li>00 Medicare inpatient routine cost cap (line 203 times line 204)</li> <li>00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>00 Program reimbursement under the §410A Demonstration (see instructions)</li> <li>00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I 0.00 Medicare IPPS payments (see instructions)</li> <li>00 Cose-wix for future use</li> <li>00 Total adjustment to Medicare IPPS payments (see instructions)</li> </ul>	tion) Adju od under t 49) irst year ictions) ine 59)	he 21st	0.0000	0.0000 0
<ul> <li>8.00 HRR adjustment factor (see instructions)</li> <li>8.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>9.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line</li> <li>9.00 Medicare discharges (see instructions)</li> <li>9.00 Case-mix adjustment factor (see instructions)</li> <li>9.00 Case-mix adjustment factor (see instructions)</li> <li>9.00 Medicare target amount</li> <li>9.00 Medicare inpatient routine cost cap (line 203 times line 204)</li> <li>9.00 Medicare part A Inpatient Reimbursement</li> <li>9.00 Program reimbursement under the §410A Demonstration (see instructions)</li> <li>9.00 Medicare Part A Inpatient service costs (from Wkst. E, Pt. A, I</li> <li>9.00 Reserved for future use</li> <li>9.00 Total adjustment to Medicare IPPS payments (see instructions)</li> </ul>	tion) Adju od under t 49) irst year ictions) ine 59)	he 21st	0.0000	0.0000 0
<ul> <li>00 HRR adjustment factor (see instructions)</li> <li>00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line</li> <li>00 Medicare discharges (see instructions)</li> <li>00 Case-mix adjustment factor (see instructions)</li> <li>00 Medicare target amount</li> <li>00 Medicare target amount</li> <li>00 Medicare inpatient routine cost cap (line 202 times line 204)</li> <li>00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I</li> <li>00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I</li> <li>00 Medicare for future use</li> <li>00 Total adjustment to Medicare IPPS payments (see instructions)</li> <li>00 Total adjustment to Medicare Part A IPPS payments (from line 21</li> </ul>	tion) Adju od under t 49) irst year actions) ine 59)	he 21st	0.0000	0.0000 0

	Financial Systems COMMUNITY HOSPITAL O ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0169	Period: From 01/01/2018	u of Form CMS-2 Worksheet E Part B	2002-
			To 12/31/2018	Date/Time Pre	
		Title XVIII	Hospi tal	5/29/2019 3:0 PPS	5 pm
			••••	1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)	ati ana)		27, 895	
2.00 3.00	Medical and other services reimbursed under OPPS (see instruction OPPS payments)	ctions)		17, 636, 038 15, 320, 553	
4.00	Outlier payment (see instructions)			32, 565	
4.01	Outlier reconciliation amount (see instructions)			0	4.0
5.00 5.00	Enter the hospital specific payment to cost ratio (see instru Line 2 times line 5	uctions)		0.000	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
3.00	Transitional corridor payment (see instructions)			0	
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	IV, COL. 13, LINE 200		0	9. (
11.00	Total cost (sum of lines 1 and 10) (see instructions)			27, 895	
	COMPUTATION OF LESSER OF COST OR CHARGES				
12.00	Reasonable charges Ancillary service charges			121, 895	1 12. (
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	line 69)		0	
4.00	Total reasonable charges (sum of lines 12 and 13)			121, 895	14. (
15.00	Customary charges Aggregate amount actually collected from patients liable for	payment for services on	a charge basi s	0	15.0
16.00	Amounts that would have been realized from patients liable for			0	16. (
17 00	had such payment been made in accordance with 42 CFR §413.13	(e)		0.000000	47.0
	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 121, 895	
19.00	Excess of customary charges over reasonable cost (complete or	nly if line 18 exceeds li	ne 11) (see	94,000	
	instructions)				
20.00	Excess of reasonable cost over customary charges (complete or instructions)	nly if line 11 exceeds li	ne 18) (see	0	20.
21.00	Lesser of cost or charges (see instructions)			27, 895	21.
	Interns and residents (see instructions)	tt!		0	
	Cost of physicians' services in a teaching hospital (see inst Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	tructions)		0 15, 353, 118	23.0
211 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			10,000,110	
25.00 26.00	Deductibles and coinsurance amounts (for CAH, see instruction	-	suctions)	0 2, 957, 446	
26.00 27.00	Deductibles and Coinsurance amounts relating to amount on lin Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	-		2, 957, 446 12, 423, 567	
	instructions)				
	Direct graduate medical education payments (from Wkst. E-4, I			35, 111	
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)	)		0 12, 458, 678	
31.00	Primary payer payments			3, 188	
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI			12, 455, 490	32. (
3. 00	Composite rate ESRD (from Wkst. I-5, line 11)	I GES)		0	33.
	Allowable bad debts (see instructions)			284, 976	
35.00	Adjusted reimbursable bad debts (see instructions)	+)		185, 234	
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (see instructions)	tructions)		264, 422 12, 640, 724	
38.00	MSP-LCC reconciliation amount from PS&R			97	38.
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	<b>`</b>		0	
	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration			0	39. 39.
39. 98	Partial or full credits received from manufacturers for repla		ctions)	0	
39.99	RECOVERY OF ACCELERATED DEPRECIATION	•		0	39.
0.00	Subtotal (see instructions) Sequestration adjustment (see instructions)			12, 640, 627 252, 813	
	Demonstration payment adjustment amount after sequestration			232, 015	
1.00	Interim payments			12, 368, 812	
12.00 13.00	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			0 19, 002	42. 43.
43.00 44.00	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-2.	chapter 1,	19,002	
	§115. 2				
90.00	TO BE COMPLETED BY CONTRACTOR			0	90.
90.00 91.00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	92.
	Time Value of Money (see instructions)			0	93.

CALCUL	Financial Systems COMMUNITY HOSPITAL OF ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0169	Period: From 01/01/2018	w of Form CMS-2 Worksheet E Part B	2002 10
		Component CCN: 15-S169	To 12/31/2018		
		Title XVIII	Subprovider - IPF	PPS	
				1.00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			1 530	1 1 00
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruc	ctions)		1, 530 275	1
3.00	OPPS payments	,		1, 041	
4.00	Outlier payment (see instructions)			21, 524	
4.01 5.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instru	uctions)		0.000	4.01 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	
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	IV col 13 line 200		0	
10.00	Organ acqui si ti ons	1V, col. 13, 111c 200		0	
11.00	Total cost (sum of lines 1 and 10) (see instructions)			1, 530	11. OC
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				-
12.00	Ancillary service charges			6, 685	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			6, 685	14.00
15.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for	or payment for services o		0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13( Ratio of line 15 to line 16 (not to exceed 1.000000)	(e)		0.000000	17.00
18.00	Total customary charges (see instructions)			6, 685	
19.00	Excess of customary charges over reasonable cost (complete or	nly if line 18 exceeds li	ne 11) (see	5, 155	
20.00	instructions)	ly if line 11 exceeds li	no 19) (coo	0	20.00
20.00	Excess of reasonable cost over customary charges (complete or instructions)	ITY IT ITTLE IT EXCEEDS IT	ne io) (see	0	20.00
21.00	Lesser of cost or charges (see instructions)			1, 530	
22.00 23.00	Interns and residents (see instructions)	tructions)		0	
23.00	Cost of physicians' services in a teaching hospital (see inst Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	li ucti ons)		22, 565	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
25.00 26.00	Deductibles and coinsurance amounts (for CAH, see instruction Deductibles and Coinsurance amounts relating to amount on lir		suctions)	0	25.00 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			24, 095	
	instructions)		- (		
28.00 29.00	Direct graduate medical education payments (from Wkst. E-4, I ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29)			24,095	
31.00	Primary payer payments			0	31.00
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)		24, 095	32.00
33.00	Composite rate ESRD (from Wkst. 1-5, line 11)	613)		0	33.00
34.00	Allowable bad debts (see instructions)			0	34.00
35.00 36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		0	
37.00	Subtotal (see instructions)	li uctions)		24,095	
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00 39.50
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	15)		0	
39. 98	Partial or full credits received from manufacturers for repla	aced devices (see instruc	tions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			24, 095 482	1
40. 02	Demonstration payment adjustment amount after sequestration			0	1
41.00	Interim payments			2, 871	
42.00 43.00	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			0 20, 742	
44.00	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-2,	chapter 1,	20,742	44.00
	\$115.2				-
90.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
90.00 91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money				92.00
93.00	Time Value of Money (see instructions)			0	•

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO		Period: From 01/01/2018 To 12/31/2018	Date/Time Prep 5/29/2019 3:05	pare
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt B	
			Amount		Amount	
		1.00	2.00	3.00	4,00	
00	Total interim payments paid to provider	1.00	47, 999, 16		12, 368, 812	1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.
	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)					
01	Program to Provider ADJUSTMENTS TO PROVIDER			0	0	3
)2	ADJUSTMENTS TO PROVIDER			0	0	3
)2 )3				0	0	3
)3 )4				0	0	3
)5 )5				0	0	3
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	3
52				0	0	3
53				0	0	3
54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3
~~	3. 50-3. 98)		47 000 4/	-	10.0/0.010	
00	Total interim payments (sum of lines 1, 2, and 3.99)		47, 999, 16	o /	12, 368, 812	4
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
)1	TENTATI VE TO PROVIDER			0	0	5
)2				0	0	5
)3	Provider to Program			0	0	5
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	Ő	5
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on					6
	the cost report. (1)					
)1	SETTLEMENT TO PROVIDER		217, 40		19, 002	6
)2	SETTLEMENT TO PROGRAM			0	0	6
00	Total Medicare program liability (see instructions)		48, 216, 57		12, 387, 814	7
				Contractor	NPR Date	
			)	<u>Number</u> 1.00	(Mo/Day/Yr) 2.00	
	Name of Contractor	(	)	1.00	2.00	8

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider Co	CN: 15-0169 CCN: 15-S169	Period: From 01/01/2018 To 12/31/2018	Date/Time Prep	parec
		Title	XVIII	Subprovider -	5/29/2019 3:05 PPS	5 pm
		Inpatien	t Part A	I PF Pai	rt B	
	-	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2, 260, 1	10 0	2, 871 0	1. 2.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER		1	0	0	3.
02 03 04 05						3. 3. 3. 3.
05	Provider to Program			0	0	5.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
50 51 52 53 54 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0 0 0 0	3. 3. 3. 3. 3. 3.
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		2, 260, 1	10	2, 871	4
0	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5
D1	TENTATI VE TO PROVI DER			0	0	5
)2 )3				0	0	5 5
-	Provider to Program			<u> </u>		
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	SETTLEMENT TO PROVIDER		3, 5	06	20, 742	6
02	SETTLEMENT TO PROGRAM			0	0	6
00	Total Medicare program liability (see instructions)		2, 263, 6	16	23, 613	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
			)	1.00	2.00	_

Heal th	Financial Systems COMMUNITY HOSPITAL OF	INDIANA, INC.	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0169	Peri od:	Worksheet E-1	
			From 01/01/2018		
			To 12/31/2018	Date/Time Pre	
		Title XVIII	Hospi tal	5/29/2019 3:0 PPS	5 pili
				ГГЭ	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			1.00	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				1
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instructior	is)		32.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0169	Period: From 01/01/2018	Worksheet E-3 Part II	
		Component CCN: 15-S169	To 12/31/2018	Date/Time Pre 5/29/2019 3:0	
		Title XVIII	Subprovider - IPF	PPS	
				1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS				
. 00	Net Federal IPF PPS Payments (excluding outlier, ECT, and med	ical education payments)		2, 527, 777	1.0
. 00	Net IPF PPS Outlier Payments			21, 524	2.0
. 00	Net IPF PPS ECT Payments			0	3.0
. 00	Unweighted intern and resident FTE count in the most recent c	ost report filed on or b	efore November	0.00	4. (
. 01	15, 2004. (see instructions)	t for recidents that wer	a displaced by	0.00	1
. 01	Cap increases for the unweighted intern and resident FTE coun program or hospital closure, that would not be counted withou			0.00	4.0
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)		merri unuer 42		
. 00	New Teaching program adjustment. (see instructions)			0.00	5.0
. 00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	eriod of a "new	0.00	6. (
	teaching program" (see instuctions)				
. 00	Current year's unweighted I&R FTE count for residents within	the new program growth p	eriod of a "new	0.00	7.(
	teaching program" (see instuctions)				
. 00	Intern and resident count for IPF PPS medical education adjus	tment (see instructions)		0.00	
. 00	Average Daily Census (see instructions)			10. 227397	
0.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to	the power of .5150 -1}.		0.000000	
1.00	Teaching Adjustment (line 1 multiplied by line 10).			0	11.
2.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	``````````````````````````````````````		2, 549, 301	
3.00	Nursing and Allied Health Managed Care payment (see instructi	on)		0	13.
4.00 5.00	Organ acquisition (DO NOT USE THIS LINE) Cost of physicians' services in a teaching hospital (see inst	ructions)		0	14. 15.
6.00	Subtotal (see instructions)	ructrons)		2, 549, 301	
7.00	Primary payer payments			2, 349, 301	17.
8.00	Subtotal (line 16 less line 17).			2, 549, 301	
9.00	Deducti bl es			199, 516	
0.00	Subtotal (line 18 minus line 19)			2, 349, 785	
1.00	Coinsurance			43, 550	
2.00	Subtotal (line 20 minus line 21)			2, 306, 235	
3.00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		5, 503	23.
4.00	Adjusted reimbursable bad debts (see instructions)			3, 577	24.
5.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		5, 168	25.
5.00	Subtotal (sum of lines 22 and 24)			2, 309, 812	26.
7.00	Direct graduate medical education payments (from Wkst. E-4, I	ine 49)		0	27.
3.00	Other pass through costs (see instructions)			0	28.
9.00	Outlier payments reconciliation			0	29.
0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	- )		0	30.
D. 50	Pioneer ACO demonstration payment adjustment (see instruction	5)		0	30. 30.
0.99	Demonstration payment adjustment amount before sequestration Total amount payable to the provider (see instructions)			0 2, 309, 812	
1.00	Sequestration adjustment (see instructions)			46, 196	
1. 02	Demonstration payment adjustment amount after sequestration			40, 190	
2.00				2, 260, 110	
3.00	Tentative settlement (for contractor use only)			0	33.
4.00	Balance due provider/program (line 31 minus lines 31.01, 31.0	2, 32 and 33)		3, 506	
5. 00	Protested amounts (nonallowable cost report items) in accorda §115.2		chapter 1,	0	35.
	TO BE COMPLETED BY CONTRACTOR				1
0. 00	Original outlier amount from Worksheet E-3, Part II, line 2			21, 524	50.
1. 00	Outlier reconciliation adjustment amount (see instructions)			0	51.
2.00	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0	53.

DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CO		Peri od:	Worksheet E-4	
IEDI CAI	EDUCATION COSTS			From 01/01/2018 To 12/31/2018	Date/Time Pre	
		Title	XVIII	Hospi tal	5/29/2019 3:0 PPS	5 pm
					1.00	
. 00	COMPUTATION OF TOTAL DIRECT GME AMOUNT Unweighted resident FTE count for allopathic and osteopathic	programs for	cost reporti	na periods	0.00	1 1.0
	ending on or before December 31, 1996.	p g				
. 00	Unweighted FTE resident cap add-on for new programs per 42 CF		1) (see instr	uctions)	0.00	
. 00 . 01	Amount of reduction to Direct GME cap under section 422 of MM Direct GME cap reduction amount under ACA §5503 in accordance		8412 70 (m)	(500	0.00 0.00	
. 01	instructions for cost reporting periods straddling 7/1/2011)	WITH 42 CIK	9413.79 (11).	(366	0.00	3.
. 00	Adjustment (plus or minus) to the FTE cap for allopathic and		programs due	to a Medicare	3.25	4.
01	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)			un un est a de	0.00	
. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst straddling 7/1/2011)	ructions for	cost reporti	ng periods	0.00	4.
. 02	ACA Section 5506 number of additional direct GME FTE cap slot	s (see inst	ructions for	cost reporting	0.00	4.
	periods straddling 7/1/2011)					
. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl 4.02 plus applicable subscripts	us or minus	line 4 plus l	ines 4.01 and	3.25	5.
. 00	Unweighted resident FTE count for allopathic and osteopathic	programs for	the current	vear from vour	2.85	6.
	records (see instructions)	1 5				
. 00	Enter the lesser of line 5 or line 6			0.11	2.85	7.
			Primary Care 1.00	0ther 2.00	<u> </u>	
. 00	Weighted FTE count for physicians in an allopathic and osteop	athi c	1.2		2.85	8.
	program for the current year.			_		
. 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		1.2	1.58	2.85	9.
	6.	unt on the				
0. 00	Weighted dental and podiatric resident FTE count for the curr	ent year		2.54		10.
	Unweighted dental and podiatric resident FTE count for the cu	rrent year		2.54		10.
1.00 2.00	Total weighted FTE count Total weighted resident FTE count for the prior cost reportin	a voor (coo	1.2			11.
2.00	instructions)	y year (see	1.4	5. 12		12.
3.00	Total weighted resident FTE count for the penultimate cost re	porti ng	1.0	4 2.61		13.
4 00	year (see instructions)	h., 2)	1.0	1 2 20		14
4.00 5.00	Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs	by 3).	1.2 0.0			14. 15.
	Unweighted adjustment for residents in initial years of new p	rograms	0.0			15.
6. 00	Adjustment for residents displaced by program or hospital clo		0. C	0.00		16.
6. 01	Unweighted adjustment for residents displaced by program or h	ospi tal	0.0	0.00		16.
7.00	closure Adjusted rolling average FTE count		1.2	4 3.28		17.
	Per resident amount		93, 984. 3			18.
9.00	Approved amount for resident costs		116, 54		424, 810	
				-	1 00	
0.00	Additional unweighted allopathic and osteopathic direct GME F	TE resident	cap slots rec	eived under 42	1.00	20.
0.00	Sec. 413. 79(c) (4)		Sap 51013 100		0.00	20.
	Direct GME FTE unweighted resident count over cap (see instru				0.00	
	Allowable additional direct GME FTE Resident Count (see instr	,			0.00	
3.00 4.00	Enter the locality adjustment national average per resident a Multiply line 22 time line 23	mount (see i	nstructions)		0.00 0	
	Total direct GME amount (sum of lines 19 and 24)				424, 810	
			Inpatient Par	t Managed care		
			A 1.00	2.00	2.00	
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	3.00	
6. 00	Inpatient Days (see instructions)		23, 97	3 8, 057		26.
7.00	Total Inpatient Days (see instructions)		80, 48			27.
	Ratio of inpatient days to total inpatient days		0. 29787	0. 100112		28.
	Program direct GME amount		126, 54			29.
	Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount			6, 009	163, 060	30.
	NEL FIVUIAIII UITEUL GME AIIIUUITL		1	1	103,000	1 31.

Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. IN I	_ieu of Form CMS-2	2552-10
DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT Provider CCN: 15-0169 Period:	Worksheet E-4	
MEDICAL EDUCATION COSTS From 01/01/20 To 12/31/20		arad
10 12/31/20	5/29/2019 3:05	
Title XVIII Hospital	PPS	<u> </u>
	1.00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAM	EDICAL	
EDUCATI ON COSTS)		
32.00 Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74	0	32.00
and 94)		
33.00 Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	3, 466, 226	
34.00 Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00 Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00 Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
Part A Reasonable Cost	(4.004.704	07 00
37.00 Reasonable cost (see instructions)	64, 381, 724	37.00
38.00 Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	0	38.00
39.00 Cost of physicians' services in a teaching hospital (see instructions)	0	39.00 40.00
40.00 Primary payer payments (see instructions) 41.00 Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	16, 601	
Part B Reasonable Cost	64, 365, 123	41.00
42. 00 Reasonable cost (see instructions)	17, 665, 738	12 00
43.00 Primary payer payments (see instructions)	3, 188	42.00
44.00 Total Part B reasonable cost (line 42 minus line 43)	17, 662, 550	43.00
45.00 Total reasonable cost (sum of lines 41 and 44)	82, 027, 673	
46.00 Ratio of Part A reasonable cost to tal reasonable cost (line 41 ÷ line 45)	0. 784676	
47.00 Ratio of Part B reasonable cost to total reasonable cost (line 44 + line 45)	0. 215324	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B	01210021	
48.00 Total program GME payment (line 31)	163, 060	48.00
49.00 Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	127, 949	49.00
50.00 Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	35, 111	

	SHEET (If you are nonproprietary and do not maintain	Provider C		Period: From 01/01/2018	Worksheet G	
na-typ nly)	be accounting records, complete the General Fund column			To 12/31/2018	Date/Time Pre 5/29/2019 3:0	pare
		General Fund	Specific Purpose Fund	Endowment Fund		
CI		1.00	2.00	3.00	4.00	
	JRRENT ASSETS ash on hand in banks	9, 020		0 0	0	1 1
	emporary investments	0		0 0	0	
	otes receivable	0		0 0	0	3
00 A	ccounts receivable	1, 725, 816, 418		0 0	0	4
	ther receivable	-217, 170, 947		0 0	0	
	llowances for uncollectible notes and accounts receivable	878, 062		0 0	0	6
	nventory repaid expenses	5, 786, 797 15, 050		0 0	0	8
	ther current assets	13,030		0 0	0	
	ue from other funds	0		0 0	0	10
00 T	otal current assets (sum of lines 1-10)	1, 515, 334, 400		0 0	0	11
	I XED ASSETS	1	1	-		
	and	2, 705, 851		0 0	0	
	and improvements	3, 747, 533		0 0	0	
	ccumulated depreciation uildings	320, 765, 033		0 0	0	14
	ccumul ated depreciation	J J20, 700, 033		0 0	0	16
	easehold improvements	2, 597, 127		0 0	0	17
	ccumulated depreciation	0		0 0	0	18
. 00   F	ixed equipment	111, 222, 719		0 0	0	19
	ccumulated depreciation	0		0 0	0	20
	utomobiles and trucks	77, 200		0 0	0	21
	ccumulated depreciation	0		0 0	0	22
	ajor movable equipment ccumulated depreciation	-224, 838, 346		0 0	0	23
	i nor equipment depreciable	-224, 030, 340		0 0	0	25
	ccumul ated depreciation	0		0 0	0	26
	IT designated Assets	0		0 0	0	27
	ccumulated depreciation	0		0 0	0	28
	inor equipment-nondepreciable	316, 270		0 0	0	29
	otal fixed assets (sum of lines 12-29) THER ASSETS	216, 593, 387		0 0	0	30
	nvestments	0		0 0	0	31
	eposits on leases	0		0 0	0	32
	ue from owners/officers	0		0 0	0	33
00 0	ther assets	-573, 517, 965		0 0	0	34
	otal other assets (sum of lines 31-34)	-573, 517, 965		0 0	0	
	otal assets (sum of lines 11, 30, and 35)	1, 158, 409, 822		0 0	0	36
	JRRENT LIABILITIES ccounts payable	1, 664, 540		0 0	0	37
	alaries, wages, and fees payable	1,004,040		0 0	0	38
	ayroll taxes payable	0		0 0	0	
	otes and loans payable (short term)	0		0 0	0	
	eferred income	0		0 0	0	41
	ccelerated payments	0				42
	ue to other funds	0		0 0	0	
	ther current liabilities	2, 099, 858 3, 764, 398		0 0 0 0	0	
	otal current liabilities (sum of lines 37 thru 44) DNG TERM LIABILITIES	3, 704, 390		0 0	0	40
	ortgage payable	0		0 0	0	46
	otes payable	0		0 0	0	
	nsecured Loans	0		0 0	0	
	ther long term liabilities	0		0 0	0	
	otal long term liabilities (sum of lines 46 thru 49)	0		0 0	0	
	otal liabilities (sum of lines 45 and 50)	3, 764, 398		0 0	0	51
	APITAL ACCOUNTS eneral fund balance	1, 154, 645, 424				52
	pecific purpose fund	1, 134, 043, 424		0		53
	onor created - endowment fund balance - restricted			0		54
	onor created - endowment fund balance - unrestricted			0		55
	overning body created - endowment fund balance			0		56
	lant fund balance - invested in plant				0	
	lant fund balance - reserve for plant improvement,				0	58
	eplacement, and expansion	1 154 445 404			_	EC
	otal fund balances (sum of lines 52 thru 58) otal liabilities and fund balances (sum of lines 51 and	1, 154, 645, 424 1, 158, 409, 822		0 0 0 0	0	59

		UNITY HOSPITAL (	DF_INDIANA, IN	IC.		In Lie	u of Form CMS	-25	52-10
STATEME	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0169		eriod: com 01/01/2018 0 12/31/2018	Worksheet G- Date/Time Pr 5/29/2019 3:	ера	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fun		pin
1.00	Fund balances at beginning of period	1.00	2.00 1,030,678,250	3.00		4.00	5.00		1.00
	Net income (loss) (from Wkst. G-3, line 29)		123, 967, 172			0			2.00
	Total (sum of line 1 and line 2)		1, 154, 645, 422			0			3.00
4.00	ROUNDING	2			0			0	4.00
5.00		0			0			0	5.00
6.00		0			0			0	6.00
7.00		0			0			0	7.00
8.00		0			0			0	8.00
9.00		0	2		0	0		0	9.00
	Total additions (sum of line 4–9) Subtotal (line 3 plus line 10)		2 1, 154, 645, 424			0			10.00 11.00
	Deductions (debit adjustments) (specify)	0	1, 154, 645, 424		0	0			12.00
13.00	beddetrons (debrt adjustments) (specify)	0			0				12.00
14.00		0			0				14.00
15.00		0			0				15.00
16.00		0			0			0	16.00
17.00		0			0			0	17.00
	Total deductions (sum of lines 12-17)		0			0			18.00
	Fund balance at end of period per balance		1, 154, 645, 424			0			19.00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund				_	
1.00	Fund balances at beginning of period	6.00	7.00	8.00	0			_	1.00
	Net income (loss) (from Wkst. G-3, line 29)	0							
					U				2 00
$\prec$ ()()		0			-				2.00
	Total (sum of line 1 and line 2)	О	0		0				3.00
		0	0 0		-				
4.00	Total (sum of line 1 and line 2)	0	-		-				3.00 4.00
4.00 5.00	Total (sum of line 1 and line 2)	0	0		-				3.00 4.00 5.00
4.00 5.00 6.00 7.00 8.00	Total (sum of line 1 and line 2)	o	0 0 0 0		-				3.00 4.00 5.00 6.00 7.00 8.00
4.00 5.00 6.00 7.00 8.00 9.00	Total (sum of line 1 and line 2) ROUNDING		0 0 0		0				3.00 4.00 5.00 6.00 7.00 8.00 9.00
4.00 5.00 6.00 7.00 8.00 9.00 10.00	Total (sum of line 1 and line 2) ROUNDING Total additions (sum of line 4-9)	o	0 0 0 0		0				3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Total (sum of line 1 and line 2) ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		0 0 0 0		0				3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Total (sum of line 1 and line 2) ROUNDING Total additions (sum of line 4-9)	o	0 0 0 0 0		0				3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Total (sum of line 1 and line 2) ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	o	0 0 0 0 0 0 0		0				3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Total (sum of line 1 and line 2) ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	o	0 0 0 0 0		0				$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Total (sum of line 1 and line 2) ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	o	0 0 0 0 0 0 0 0 0		0				3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	Total (sum of line 1 and line 2) ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	o			0				$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ \end{array}$
$\begin{array}{c} 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	Total (sum of line 1 and line 2) ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	o			0				$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
$\begin{array}{c} 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Total (sum of line 1 and line 2) ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0			0				$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$

	Financial Systems COMMUNITY HOSPITAL OF	Provider CC		Period:	eu of Form CMS-: Worksheet G-2	
STATEN	ENT OF FATTENT REVENUES AND OPERATING EXPENSES	Provider CC	1. 15-0109	From 01/01/2018 To 12/31/2018	Parts I & II Date/Time Pre	pared:
	Cost Center Description		Inpati ent	Outpati ent	5/29/2019 3:0 Total	
	Cost Conter Description	-	1.00	2.00	3.00	
	PART I - PATIENT REVENUES	I				
	General Inpatient Routine Services					1
1.00	Hospi tal		162, 916, 7	88	162, 916, 788	1.00
2.00	SUBPROVIDER - IPF		8, 052, 9	81	8, 052, 981	2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE		170 0/0 7	( a)	470 0/0 7/0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)		170, 969, 7	69	170, 969, 769	10.00
44 00	Intensive Care Type Inpatient Hospital Services		04.754.0	0.0	04.754.000	1 4 4 . 00
11.00	I NTENSI VE CARE UNI T		24, 756, 8	80	24, 756, 880	
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00 15.00	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT		94, 060, 1	02	94, 060, 102	14.00 15.00
15.00	Total intensive care type inpatient hospital services (sum of	Lines	94, 060, 1 118, 816, 9		118, 816, 982	
10.00	11-15)	THES	110, 010, 9	02	110, 010, 902	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)		289, 786, 7	51	289, 786, 751	17.00
18.00	Ancillary services		580, 484, 5		1, 213, 839, 638	
19.00	Outpatient services		000, 101, 0	0 000,000,100		•
20.00	RURAL HEALTH CLINIC			0 0		
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0		
22.00	HOME HEALTH AGENCY				-	22.00
23.00	AMBULANCE SERVI CES					23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE					26.00
27.00	OTHER (SPECIFY)			0 0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	870, 271, 2	89 633, 355, 100	1, 503, 626, 389	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES				1	
29.00	Operating expenses (per Wkst. A, column 3, line 200)			347, 777, 026		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				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00 38.00	DEDUCT (SPECI FY)			0		37.00
				0		38.00
39.00 40.00				0		39.00
40.00				0		40.00
41.00	Total doductions (sum of lines 27 41)					41.00
42.00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42	)(transfor		347, 777, 026	()	42.00
40.00	to Wkst. G-3, line 4)			347,777,020	1	1 43.00

Heal th	Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC.	In Lieu of Form CMS-2	552-10
STATEM	ENT OF REVENUES AND EXPENSES Provider CCN: 15-0169 Perio		
		01/01/2018 12/31/2018 Date/Time Prep 5/29/2019 3:05	
		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1, 503, 626, 389	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1, 036, 595, 941	2.00
3.00	Net patient revenues (line 1 minus line 2)	467, 030, 448	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	347, 777, 026	4.00
5.00	Net income from service to patients (line 3 minus line 4)	119, 253, 422	5.00
	OTHER I NCOME		
6.00	Contributions, donations, bequests, etc	186, 376	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase di scounts	26, 173	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	-	13.00
14.00	Revenue from meals sold to employees and guests	2, 372, 374	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC REVENUE	2, 128, 827	24.00
25.00	Total other income (sum of lines 6-24)	4, 713, 750	25.00
26.00	Total (line 5 plus line 25)		26.00
27.00	OTHER EXPENSES (SPECIFY)		27.00
28.00	Total other expenses (sum of line 27 and subscripts)		28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	123, 967, 172	29.00

Heal th	Financial Systems	COMMUNITY HOSPITAL OF	INDIANA, INC.	In Lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT		Provi der CCN: 15-0169	Period: From 01/01/2018 To 12/31/2018		
			Title XVIII	Hospi tal	PPS	
					1.00	
	PART I - FULLY PROSPECTIVE METHOD					
	CAPITAL FEDERAL AMOUNT					
1.00	Capital DRG other than outlier				3, 574, 520	1.00
1.01	Model 4 BPCI Capital DRG other than	outlier			0	1.01
2.00	Capital DRG outlier payments				180, 984	2.00
2.01	Model 4 BPCI Capital DRG outlier pay	yments			0	2. 01
3.00 Total inpatient days divided by number of days in the cost reporting period (see instructions)				215.81	3.00	
4.00	Number of interns & residents (see i	nstructions)			4.90	4. OC
5.00	Indirect medical education percentage	ge (see instructions)			0.64	5. OC
1 00					00 077	1 00

	linear is a set and the set of the linear set of
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)
4.00	Number of interns & residents (see instructions)

Ζ.	00	capital DRG outlier payments	180, 984	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 reporting period (see instructions)	215.81	3.00
4.	00	Number of interns & residents (see instructions)	4.90	4.00
5.	00	Indirect medical education percentage (see instructions)	0.64	5.00
6.	00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and	22, 877	6.00
		1.01) (see instructions)		
7.	00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line	3. 88	7.00
		30) (see instructions)		
8.	00	Percentage of Medicaid patient days to total days (see instructions)		8.00
9.	00	Sum of Lines 7 and 8	33.27	9.00
10	. 00	Allowable disproportionate share percentage (see instructions)	6. 97	10.00
11	. 00	Disproportionate share adjustment (see instructions)	249, 144	11.00
12	. 00	Total prospective capital payments (see instructions)	4, 027, 525	12.00

1 00

		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13 00	Current year exception navment (if line 12 is positive enter the amount on this line)	0	13 00

13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period	0	14.00
	(if line 12 is negative, enter the amount on this line)		
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00