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: 15-0046 Worksheet S Peri od: From 09/01/2017 Parts I-III AND SETTLEMENT SUMMARY 08/31/2018 Date/Time Prepared: 1/30/2019 11:15 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically filed cost report Date: 1/30/2019 Time: 11:15 am use only Manually submitted cost report] 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. [1] Cost Report Status 6. Date Received: 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 (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY 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 TERRE HAUTE REGIONAL HOSPITAL (15-0046) for the cost reporting period beginning 09/01/2017 and ending 08/31/2018 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.

(Si gned) DUSTIN FOSNESS
Officer or Administrator of Provider(s)

CF0 Title

(Dated when report is electronically signed.)
Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	118, 568	145, 195	0	-2, 865, 990	1.00
2.00	Subprovider - IPF	0	10, 131	-377		94, 110	2.00
3.00	Subprovider - IRF	0	6, 694	-136		-7, 724	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	135, 393	144, 682	0	-2, 779, 604	200.00

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

Health Financial Systems TERRE HAUTE REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0046 Peri od: Worksheet S-2 From 09/01/2017 Part I Date/Time Prepared: 08/31/2018 1/30/2019 11:15 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 3901 HOSPITAL LANE 1.00 PO Box: 1.00 Ci ty: TERRE HAUTE State: IN 2.00 Zi p Code: 47802 County: VIGO 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)
/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal TERRE HAUTE REGIONAL 150046 45460 07/01/1966 Ν 0 3.00 1 HOSPI TAI Subprovi der - IPF TERRE HAUTE PSYCHIATRIC 0 4.00 15S046 45460 4 09/01/1991 Ν Ρ 4.00 UNLT 5 00 Subprovi der - IRF TERRE HAUTE REHAB UNIT 15T046 45460 09/01/2006 Ρ 0 5 00 Subprovider - (Other) 6.00 6.00 Swing Beds - SNF 7.00 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospital -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14 00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1 00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 09/01/2017 08/31/2018 20.00 21.00 Type of Control (see instructions) 21.00 1.00 2. 00 3.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for 22.00 N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care 22.02 Ν Ν payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν N 22 03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for ves or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 3 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost

	reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							
	reporting period? In column 2, enter Y for yes or							
		In-State	In-State	Out-of	Out-of	Medi cai		
		Medi cai d	Medi cai d	State	State	HMO day	rs Medicaid	
		pai d days	eligible	Medi cai d	Medi cai d		days	
			unpai d	paid days	el i gi bl e			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
24.00	If this provider is an IPPS hospital, enter the	550	230	87	101	3, 5	572 82	24.00
	in-state Medicaid paid days in column 1, in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid paid days in column 3,							
	out-of-state Medicaid eligible unpaid days in column							
	4. Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							

Health Financial Systems TERRE HAU	TE REGIONAL	HOSPI TAL		_	In Lie	u of For	m CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA I	Provi der CC	CN: 15-0046	Period: From 09/0 To 08/3		Workshe Part I Date/Ti 1/30/20	me Pre	pared:
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	ys Med	ther li cai d lays	
25.00 If this provider is an IRF, enter the in-state	1. 00 59	2.00	3.00	4. 00	5. 00	252	. 00	25. 00
Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.		44	J			Date of	Geogr	23.00
					00	2. (00	
 26.00 Enter your standard geographic classification (not woost reporting period. Enter "1" for urban or "2" fo 27.00 Enter your standard geographic classification (not wone period period. Enter in column 1, "1" for urban on enter the effective date of the geographic reclassification (15 this is a sole community hospital (SCH), enter the 	r rural. age) status r "2" for r ication in	at the end ural. If ap column 2.	d of the co pplicable,	st	1 1 0			26. 00 27. 00 35. 00
effect in the cost reporting period.	e number or	perrous s	cii status i	"	O			33.00
					ni ng:	Endi		
36.00 Enter applicable beginning and ending dates of SCH s	tatus. Subs	cript line	36 for num		00	2. (JU	36.00
of periods in excess of one and enter subsequent date 37.00 If this is a Medicare dependent hospital (MDH), ente		r of noring	de MDU etat	ue	0			37.00
is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for the	he MDH tran	usitional pa	ayment in		N			37.00
accordance with FY 2016 OPPS final rule? Enter "Y" for instructions) 38.00 If line 37 is 1, enter the beginning and ending date:	,		•					38.00
greater than 1, subscript this line for the number o	f periods i	n excess of	f one and	V	/N	Y/	N	
					00	2. (-
39.00 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) 40.00 Is this hospital subject to the HAC program reduction), (ii), or the mileage ii)? Enter	(iii)? En requirement in column :	ter in colu nts in 2 "Y" for y	mn es	N N	N N		39.00
"N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1			yes or "N"	for	V	XVIII	XIX	
					1.00		3.00	
Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment	nt for disr	roporti opa	to share in	accordanc	e N	Y	N	45.00
with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exce	eption for	extraordi na	ary circums	tances	N	N N	N	46. 00
pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	t. L, Pt. I	II and wks	t. L-1, Pt.	i through				
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS 48.00 Is the facility electing full federal capital paymen Teaching Hospitals			,		N N	N N	N N	47. 00 48. 00
56.00 Is this a hospital involved in training residents in	approved G	ME programs	s? Enter "	Y" for yes	N			56.00
or "N" for no. 57.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo					1 N			57.00
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", complet	e Workshee						
58.00 If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	bursement f complete W	or physicia /kst. D-5.		es as	N			58.00
59.00 Are costs claimed on line 100 of Worksheet A? If ye	s, complete	wkst. D-2,	, Pt. I. NAHE 413.8	85 Works	neet A	Pass-Th	rough	59.00
			Y/N	Lin	ie #	Qualifi Crite	ri on	
					00		ri on de	
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under §413.85?	, ,	I	Y/N			Cri te Cod	ri on de	60.00

Health Financial Systems TERRE HAU	TE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provi der Co	CN: 15-0046	Peri od: From 09/01/2017 To 08/31/2018	Worksheet S-2 Part I	pared:
	Y/N	I ME	Direct GME	I ME	Direct GME	15 alli
	1. 00	2. 00	3. 00	4. 00	5. 00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see	N			0.00	0. 00	61. 00
instructions) 61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. 02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61. 04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61. 05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Pro	ogram Name	Program Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1. 00	2. 00	3. 00	4. 00	
 61.10 Of the FTEs in line 61.05, specify each new program 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. 61.20 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. 20
ACA Provisions Affecting the Health Resources and Se	rvi ces	Admi ni strati or	a (HPSA)		1.00	
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc	trai ne cti ons)	d in this cost	reporting p			62.00
62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC programment of Teaching Hospitals that Claim Residents in Nonprovid	gram. (er Sett	see instructio ings	ons)		0.00	62. 01
63.00 Has your facility trained residents in nonprovider so "Y" for yes or "N" for no in column 1. If yes, comple			67. (see ins	tructions)	N	63. 00
			Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTF Residents in N	onnrovi	der Settings	1.00	2.00	3.00	
DECITOR DOOS OF THE ACA DASE TEST FIE RESIDENTS III N	OHD UVI	act actilias	THE DUANT VE	ai is voul cost	LCDOLLING	

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

0.00

0.00

0.000000 64.00

period that begins on or after July 1, 2009 and before June 30, 2010.

64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care

resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)

4	l)). (see instructions)								
						1.00	2.00	3.00	
I	npatient Psychiatric Facility F	PPS							
70. 00 I	s this facility an Inpatient Ps	ychiatric Facility (IPF), or does it conta	ain an IPF sub	orovi der?	Y			70.00
E	Enter "Y" for yes or "N" for no	· .							
71. 00 I	fline 70 is yes: Column 1: Did	I the facility have a	n approved GME teachi	ng program in	the most	N	N	0	71.00
r	recent cost report filed on or b	efore November 15, 2	004? Enter "Y" for y	es or "N" for i	no. (see				
4	12 CFR 412.424(d)(1)(iii)(c)) Co	lumn 2: Did this fac	ility train residents	in a new teacl	ni ng				
p	program in accordance with 42 CF	R 412.424 (d)(1)(iii)(D)? Enter "Y" for y	es or "N" for	no.				
C	Column 3: If column 2 is Y, indi	cate which program y	ear began during this	cost reporting	g period.				
((see instructions)								
1	npatient Rehabilitation Facilit	ry PPS							
75. 00 I	s this facility an Inpatient Re	habilitation Facilit	y (IRF), or does it c	ontain an IRF		Y			75.00
s	subprovider? Enter "Y" for yes	and "N" for no.							

resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0		iod: m 09/01/2017 08/31/2018	Workshee Part I	
	10	00/31/2016		19 11: 15
6.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching pro	arom in th	1.00	2.00 N	3. 00 0 76
recent cost reporting period ending on or before November 15, 2004? Enter "Y" fino. Column 2: Did this facility train residents in a new teaching program in ac CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If colum indicate which program year began during this cost reporting period. (see instri	or yes or cordance w n 2 is Y,	"N" for	IN	0 70
			1.00	0
Long Term Care Hospital PPS 0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80
1.00 Is this a LTCH co-located within another hospital for part or all of the cost remarks for yes and "N" for no. TEFRA Providers	eporting p	eriod? Enter	N	81
5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" 6.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CF §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		"N" for no.	N	85 86
7.00 Is this hospital an extended neoplastic disease care hospital classified under 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	secti on		N	87
11000(4)(1)(0)(v)); Eitter 1 101 yes of 14 101 110.		V	XIX	
Title V and XIX Services		1. 00	2. 00	0
Does this facility have title V and/or XIX inpatient hospital services? Enter "' yes or "N" for no in the applicable column.	Y" for	N	Y	90
I. 00 Is this hospital reimbursed for title V and/or XIX through the cost report eith full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91
2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92
B.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? "Y" for yes or "N" for no in the applicable column.		N	N	93
4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in tapplicable column. 5.00 If line 94 is "Y", enter the reduction percentage in the applicable column.	ne	N O. 00	N O. 00	94 0 95
5.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	he	N N	N. O.	96
7.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 3.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no column 1 for title V, and in column 2 for title XIX.	post o in	0. 00 Y	0. 00 Y	0 97 98
B. 01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges of C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column title XIX.		Υ	Υ	98
B. 02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observed bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in colfor title V, and in column 2 for title XIX.		Υ	Υ	98
3.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no infor title V, and in column 2 for title XIX.	I (CAH) column 1	N	N	98
3.04 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 in column 2 for title XIX.	V, and	N	N	98
B.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallow Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V column 2 for title XIX.		Υ	Y	98
B.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and column 2 for title XIX. Rural Providers		Y	Y	98
5.00 Does this hospital qualify as a CAH?		N		105
16.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of for outpatient services? (see instructions)	payment	N		106
(7.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for training programs? Enter "Y" for yes or "N" for no in column 1. (see instruction yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program	ns) If	N		107
reimbursed. If yes complete Wkst. D-2, Pt. II. OB.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule?	See 42	N		108

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C	F	eriod: rom 09/01/ o 08/31/		Worksheet S Part I Date/Time P 1/30/2019 1	repared:
	Physi cal	Occupati onal	Speec		Respi rator	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1. 00 N	2. 00 N	3. 00 N		4.00 N	109.00
					1. 00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.	'Y" for yes or	"N" for no. I	f yes,	6	N	110.00
			1.00		2. 00	
111.00 f this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this compared by the FCHIP demonstration for the compared by the FCHIP demonstration properties and the FCHIP demonstration properties and the FCHIP demonstration of th	ost reporting Dlumn 1 is Y, cticipating in	period? Enter enter the n column 2.	N			111.00
Miscellaneous Cost Reporting Information				1.00	2.00 3.0	10
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.	If column 2 nt for long te	is "E", enter erm care (inclu	in column udes	N	0	115.00
116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insurno.			"N" for	N N		116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1	if the policy	is	2		118. 00
		Premi ums	Losse	S	Insurance	
		1.00	2.00		2.00	_
118.01 List amounts of malpractice premiums and paid losses:		361, 215	2.00	0	3. 00 939, 5	87 118. 01
			1 00		2.00	
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 119.00 DO NOT USE THIS LINE			1. 00 N		2. 00	118. 02
120.00 s this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	n column 1, "Y ualifies for 1	d" for yes or the Outpatient	N		N	120.00
121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	antable device	es charged to	Y			121.00
122.00Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information			Y		5. 00	122. 00
III alispi alit Celitei Tili olillati oli	or yes and "N'	' for no. If	N			125. 00
						124 0
125.00 Does this facility operate a transplant center? Enter "Y" fo yes, enter certification date(s) (mm/dd/yyyy) below.	,					120. U
 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, enter transplant center, enter transplant center. 	nter the certi 2. ter the certif	fication date				
 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, end in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, entertable. 	nter the certi 2. ter the certif 2. ter the certif	fication date				127. 00
125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, er in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified lung transplant center, enter this is a Medicare certified lung transplant center, enter the column 129.00 If this is a Medicare certified lung transplant center, enter the column 129.00 If this is a Medicare certified lung transplant center.	nter the certi 2. cer the certif 2. cer the certif 2.	fication date fication date fication date				127. 0 128. 0
 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2 130.00 If this is a Medicare certified pancreas transplant center, 	nter the certifold. Ler the certifold Ler the certifold Ler the certifold enter the certifold enter the certifold	fication date fication date fication date cation date in				127. 00 128. 00 129. 00
 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, end in column 1 and termination date, if applicable, in column 1 127.00 If this is a Medicare certified heart transplant center, end in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified lung transplant center, ended 	nter the certiful certiful certhe certiful certi	fication date fication date fication date cation date in				127. 00 128. 00 129. 00 130. 00
 125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126. 00 If this is a Medicare certified kidney transplant center, end in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2. 130. 00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 2 and termination date, if applicable, and termination date, if applicable, a	enter the certification. The certification is a certification of the certification.	fication date fication date fication date cation date in fication certification fication date				126. 00 127. 00 128. 00 129. 00 130. 00 131. 00
 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, end in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, end in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, end column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 131.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in column 2. 	er the certification in the ce	fication date fication date fication date cation date in rtification certification fication date fication date				127. 00 128. 00 129. 00 130. 00

Health Financial Systems		REGIONAL HOSPITAL	-		In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der (CCN: 15-0046	From	d: 09/01/2017 08/31/2018	Worksheet S- Part I Date/Time Pr 1/30/2019 11	epared:
					1.00	2.22	
140.00 Are there any related organization chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column 1	I. If yes, and hom	ne office co		1. 00 Y	2.00 44H070	140.00
1. 00	nome office charm no	2.00	ictions)		3. 00		
If this facility is part of a chai			ough 143 t	he name a	and address	of the home	
141.00 Name: HOSPITAL CORP. OF AMERICA 142.00 Street: ONE PARK PLAZA	Contractor's Nam		Contra	actor's N	lumber: 1000)1	141. 00 142. 00
143. 00 Ci ty: NASHVI LLE	State:	TN	Zip Co	ode:	3720)3	143.00
						1.00	
144.00 Are provider based physicians' cos	ts included in Worksh	neet A?				Y	144.00
					1. 00	2. 00	-
145.00 If costs for renal services are clinpatient services only? Enter "Y" no, does the dialysis facility inceperiod? Enter "Y" for yes or "N" 146.00 Has the cost allocation methodologenter "Y" for yes or "N" for no in	for yes or "N" for r lude Medicare utiliza for no in column 2. y changed from the pr column 1. (See CMS F	no in column 1. If ntion for this cos reviously filed co	column 1 i t reportino st report?	3	Y N		145. 00
yes, enter the approval date (mm/c	ld/yyyy) in column 2.						
147.00Was there a change in the statisti	cal hasis? Enter "V"	for was or "N" fo	ır no			1. 00 N	147. 0
48.00Was there a change in the order of						N N	148. 0
49.00 Was there a change to the simplifi	ed cost finding metho	od? Enter "Y" for	yes or "N"			N	149. 0
		Part A	Part		Title V	Title XIX	
Does this facility contain a provi				lication			
or charges? Enter "Y" for yes or '55.00 Hospital	N for no for each co	N N	A and Part	B. (See	42 CFR 941 N	3. 13) N	155. 0
56. 00 Subprovi der - IPF		N	N		N	N	156. 0
57.00 Subprovi der - IRF		N	N		N	N	157. 0
58. 00 SUBPROVI DER		N	,		N	N.	158. 0
59. 00 SNF 60. 00 HOME HEALTH AGENCY		N N	N N		N N	N N	159. 0 160. 0
61. 00 CMHC		11	N N		N	N N	161. 0
				·		1. 00	
Mul ti campus							
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that ha	as one or more cam	ıpuses in di	fferent	CBSAs?	N	165. 0
	Name O	County 1.00	State 2.00	Zi p Code	2 CBSA 4.00	FTE/Campus	
66.00 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)	U	1.00	2.00	3.00	4.00	5.00	0 166. 00
						1. 00	-
Health Information Technology (HI) incentive in the An	merican Recovery a	and Rei nves	tment Act			4/7 -
67.00 is this provider a meaningful user 68.00 if this provider is a CAH (line 10 reasonable cost incurred for the H	5 is "Y") and is a me	eaningful user (li			er the	Y	167. 0 0168. 0
68.01 If this provider is a CAH and is r	ot a meaningful user,	does this provid	ler qualify	for a ha	rdshi p	N	168. 0
exception under §413.70(a)(6)(ii)? 169.00 If this provider is a meaningful transition factor. (see instruction	ser (line 167 is "Y")	n for no. (see and is not a CAH	l (line 105	ກາຮ <i>)</i> is "N"),	enter the	9. 9	9169. 00
transition ractor. (See mistractific				В	egi nni ng 1. 00	Endi ng 2. 00	
170.00 Enter in columns 1 and 2 the EHR b	eginning date and end	ding date for the	reporti na	10	0/01/2017	12/31/2017	170.00
period respectively (mm/dd/yyyy)	5 5 1212 22 0110	J	1 2 2 3				

Health Financial Systems TI						
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFIC	SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0046 Pe					
				om 09/01/2017 08/31/2018		renared.
	007 017 2010	1/30/2019 1				
				1. 00	2. 00	
171.00 f line 167 is "Y", does this provider have a	any days for indiv	viduals enrolled in		N		0 171. 00
section 1876 Medicare cost plans reported on						
"Y" for yes and "N" for no in column 1. If co	on					
1876 Medicare days in column 2. (see instruct						

Heal th	Financial Systems TERRE HAUTE REG	IONAL HOSPITAL		In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od:	Worksheet S-2	
				From 09/01/2017 To 08/31/2018		
				Y/N	1/30/2019 11:	15 am
				1.00	<u>Date</u> 2.00	
	General Instruction: Enter Y for all YES responses. Enter	N for all NO re	esponses. Ente			
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					+
	Provider Organization and Operation					1
1.00	Has the provider changed ownership immediately prior to th			N		1.00
	reporting period? If yes, enter the date of the change in	column 2. (see	instructions)	Date	V/I	
			1.00	2.00	3. 00	
2. 00	Has the provider terminated participation in the Medicare		N			2. 00
	yes, enter in column 2 the date of termination and in coluvoluntary or "I" for involuntary.	mn 3, V FOF				
3.00	Is the provider involved in business transactions, includi		Y			3.00
	contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provi					
	officers, medical staff, management personnel, or members	of the board				
	of directors through ownership, control, or family and oth					
	relationships? (see instructions)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports					
4. 00	Column 1: Were the financial statements prepared by a Cer Accountant? Column 2: If yes, enter "A" for Audited, "C"		N			4.00
	or "R" for Reviewed. Submit complete copy or enter date av					
F 00	column 3. (see instructions) If no, see instructions.					F 00
5. 00	Are the cost report total expenses and total revenues diff those on the filed financial statements? If yes, submit re		N			5.00
	<u>,</u>			Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	_
6. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	If yes, is t	he provider is	s N		6.00
	the legal operator of the program?					
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see i Were nursing school and/or allied health programs approved		d during the	N N		7. 00 8. 00
0.00	cost reporting period? If yes, see instructions.	and/or renewer	a dairing the	IV.		0.00
9. 00	Are costs claimed for Interns and Residents in an approved		cal education	N		9. 00
10. 00	program in the current cost report? If yes, see instructio Was an approved Intern and Resident GME program initiated		the current	N		10.00
	cost reporting period? If yes, see instructions.					
11. 00	Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.	I & R in an Ap	proved	N		11.00
	reacting trogram on worksheet A: Tr yes, see this tructions.				Y/N	
					1. 00	
12 00	Bad Debts Is the provider seeking reimbursement for bad debts? If ye	e egg inetruc	ti one		Y	12.00
	If line 12 is yes, did the provider's bad debt collection			ost reporting	N	13. 00
44.00	period? If yes, submit copy.					1
14.00	If line 12 is yes, were patient deductibles and/or co-paym Bed Complement	ents warved? I	f yes, see ins	structions.	N	14.00
15. 00	Did total beds available change from the prior cost report	ing period? If	yes, see ins	tructions.	Υ	15.00
			t A		t B	
		1. 00	2.00	Y/N 3. 00	Date 4. 00	
	PS&R Data		2.00	0.00		
16. 00	Was the cost report prepared using the PS&R Report only?	N		N		16. 00
	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see					
	instructions)					
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Y	12/17/2018	Υ	12/17/2018	17. 00
	either column 1 or 3 is yes, enter the paid-through date					
40	in columns 2 and 4. (see instructions)			<u>.</u>		10.55
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	N		N		18. 00
	but are not included on the PS&R Report used to file this					
10.00	cost report? If yes, see instructions.	N.		N.I		10.00
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19.00
	information? If yes, see instructions.					

Heal th	Financial Systems TERRE HAUTE REG	IONAL HOSPITAL		In Lie	u of Form CMS-	2552-10	
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0046	Peri od: From 09/01/2017	Worksheet S-2 Part II Date/Time Pro 1/30/2019 11	2 epared:	
		Descr	i pti on	Y/N	Y/N		
20.00	LE Line 1/ au 17 in the property and to DCOD		0	1. 00	3.00	20.00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00	
	Troport data for other besseries the other dajustments.	Y/N	Date	Y/N	Date		
		1.00	2. 00	3. 00	4. 00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPI TALS)				
	Capital Related Cost						
22. 00	Have assets been relifed for Medicare purposes? If yes, se				N	22.00	
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	e due to apprai	sais made dui	ing the cost	N	23. 00	
24. 00	Were new leases and/or amendments to existing leases enter lf yes, see instructions	ed into during	this cost re	eporting period?	Υ	24. 00	
25. 00	Have there been new capitalized leases entered into during	the cost repo	rting period	? If yes, see	N	25. 00	
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost report	ing period?	f ves see	N	26.00	
20.00	instructions.	ine cost report	ing period:	1 yes, see	IV		
27. 00	Has the provider's capitalization policy changed during the copy.	ne cost reporti	ng period? I	f yes, submit	N	27. 00	
28. 00	<pre>Interest Expense Were new loans, mortgage agreements or letters of credit e</pre>	entered into du	ring the cos	t reporting	N	28. 00	
29. 00	period? If yes, see instructions. .00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)						
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat	s, see	N	30.00			
31. 00	instructions. Has debt been recalled before scheduled maturity without i	s, see	N	31.00			
	instructions. Purchased Services					+	
32. 00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr		ed through co	ontractual	N	32. 00	
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		ng to competi	tive bidding? If		33. 00	
	Provi der-Based Physi ci ans						
34.00		rrangement wit	h provi der-ba	ased physicians?	Υ	34.00	
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	disting agreeme	nts with the	provi der-based	Υ	35.00	
	physicians during the cost reporting period? If yes, see i			<u> </u>			
				Y/N 1. 00	2. 00		
	Home Office Costs			1.00	2.00		
36.00	Were home office costs claimed on the cost report?			Υ		36.00	
	If line 36 is yes, has a home office cost statement been p	repared by the	home office	? Y		37. 00	
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of			f Y	12/31/2017	38. 00	
39. 00				s, N		39. 00	
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40. 00	
	i nstructi ons.						
		1.	00	2.	00		
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JAMES	WELLS				
42. 00	respectively. Enter the employer/company name of the cost report preparer.	HCA				42.00	
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-344-6359		JAMES. WELLS2@H OM	CAHEALTHCARE. (43.00	
		•		•			

Health Fir	nancial Systems	TERRE HAUTE REGI	ONAL HOSPITAL		In Lieu of Form CMS-2552-10				
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Provi der C		Period: From 09/01/2017 To 08/31/2018	Worksheet S-2 Part II Date/Time Pre 1/30/2019 11:	pared:		
			3.	00					
Cos	st Report Preparer Contact Information								
	ter the first name, last name and the t		REIMBURSEMENT	MANAGER			41.00		
	ld by the cost report preparer in colum spectively.	ns 1, 2, and 3,							
42. 00 Ent	ter the employer/company name of the co	st report					42.00		
	eparer.								
	ter the telephone number and email addr						43.00		
rep	port preparer in columns 1 and 2, respe	cti vel y.							

Health Financial Systems TERRE HAUTE REGIONAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CO | Peri od: | Worksheet S-3 | From 09/01/2017 | Part | To 08/31/2018 | Date/Time Prepared: Provider CCN: 15-0046

					7	o 08/31/2018	Date/Time Pre 1/30/2019 11:	
							1/P Days /	15 dill
							0/P Visits /	
							Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
	The second secon	Line Number			Avai I abl e			
		1. 00		2.00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		146	53, 290	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days)(see instructions for col. 2							
	for the portion of LDP room available beds)							
2. 00	HMO and other (see instructions)							2.00
3. 00	HMO IPF Subprovider							3. 00
4. 00	HMO I RF Subprovi der							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	
6.00	Hospital Adults & Peds. Swing Bed NF						0	
7. 00	Total Adults and Peds. (exclude observation			146	53, 290	0.00	0	7. 00
0.00	beds) (see instructions)	04.00		4.0	, 57	0.00		0.00
8.00	INTENSIVE CARE UNIT	31. 00		18	6, 570	0.00	0	
9.00	CORONARY CARE UNIT							9.00
10.00	BURN INTENSIVE CARE UNIT		ŀ					10.00 11.00
11.00	SURGICAL INTENSIVE CARE UNIT		ŀ					12.00
12. 00 13. 00	NEONATAL INTENSIVE CARE UNIT	43.00	ŀ				0	
		43.00	ŀ	174	E0 0//	0.00	-	
14.00	Total (see instructions)		ŀ	164	59, 860	0.00	0 0	
15. 00 16. 00	CAH visits SUBPROVIDER - IPF	40.00	ŀ	19	6, 935			
17. 00	SUBPROVIDER - IPF	41. 00		19			0	
18.00	SUBPROVI DER	41.00		12	4, 300	'	0	18.00
19. 00	SKILLED NURSING FACILITY		ŀ					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	
27. 00	Total (sum of lines 14-26)			195			_	27. 00
28. 00	Observation Bed Days						0	28.00
29. 00	Ambul ance Trips		İ					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				32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33.00
33. 01	LTCH site neutral days and discharges							33. 01

Provider CCN: 15-0046

Peri od: Worksheet S-3
From 09/01/2017 Part I
To 08/31/2018 Date/Time Prepared: 1/30/2019 11:15 am

		_				1/30/2019 11:	15 am
		I/P Days	/ O/P Visits	/ Tri ps	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	8, 853	968	16, 395			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	1, 837	3, 572				2.00
3.00	HMO IPF Subprovider	247	0				3. 00
4.00	HMO IRF Subprovider	85	252				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation	8, 853	968	16, 395			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	1, 593	0	3, 295			8.00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	NEONATAL INTENSIVE CARE UNIT						12.00
13.00	NURSERY		o	979			13.00
14.00	Total (see instructions)	10, 446	968	20, 669	0.00	540.05	14.00
15.00	CAH vi si ts	0	o	0			15.00
16.00	SUBPROVI DER - I PF	1, 424	2, 875	6, 598	0.00	35. 03	1
17.00	SUBPROVI DER - I RF	1, 264	103	2, 094	0.00	11. 76	17.00
18. 00	SUBPROVI DER	1,		_, -, -, .			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)	٥	0	113			24. 10
25. 00	CMHC - CMHC		Ü	113			25.00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0. 00	0.00	
27. 00	Total (sum of lines 14-26)		U	O	0.00		
28. 00	Observation Bed Days		645	1, 914	0.00	360. 64	28.00
29.00	3	0	040	1, 914			29.00
	Ambulance Trips	۷		0			
30. 00 31. 00	Employee discount days (see instruction) Employee discount days - LRF			0			30. 00 31. 00
			0.2				
32.00	Labor & delivery days (see instructions)	0	82	107			32.00
32. 01	Total ancillary labor & delivery room			56			32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0				I	33. 01

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 09/01/2017 | Part | | To 08/31/2018 | Date/Time Prepared: Provider CCN: 15-0046

				To	08/31/2018	Date/Time Pre 1/30/2019 11:	
		Full Time		Di scha	arges	1 17 007 2017 111	, o a
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
	T	11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	2, 555	253	5, 228	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)			270	1 10/		2.00
2. 00 3. 00	HMO and other (see instructions) HMO IPF Subprovider			379	1, 136		3.00
4. 00					17		4.00
4. 00 5. 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF				17		5.00
6. 00	Hospital Adults & Peds. Swing Bed SNF						6.00
7. 00	Total Adults and Peds. (exclude observation						7.00
7.00	beds) (see instructions)						7.00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	NEONATAL INTENSIVE CARE UNIT						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0.00	C	2, 555	253	5, 228	14.00
15. 00	CAH visits	3.33	_	_,,		-,	15.00
16.00	SUBPROVIDER - IPF	0.00	C	227	542	1, 203	16.00
17. 00	SUBPROVIDER - IRF	0.00	C	95	7	154	17. 00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days			0			33. 00 33. 01
33. UI	LTCH site neutral days and discharges			I O			33.01

HOSPI I	AL WAGE INDEX INFORMATION			Provider C	F	eriod: rom 09/01/2017 o 08/31/2018	Worksheet S-3 Part II Date/Time Pre 1/30/2019 11:	pared: 15 am
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	DART III WACE DATA	1.00	2. 00	3. 00	4.00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1.00	Total salaries (see instructions)	200. 00	36, 104, 758	0	36, 104, 758	1, 220, 634. 00	29. 58	1. 00
2. 00	Non-physician anesthetist Part		0	О	О	0. 00	0. 00	2. 00
3. 00	Non-physician anesthetist Part B		0	0	0	0. 00	0. 00	3. 00
4. 00	Physi ci an-Part A - Admi ni strati ve		0	0	0	0.00	0. 00	4. 00
4. 01	Physicians - Part A - Teaching		0	0	1		0. 00	4. 01
5. 00	Physician and Non Physician-Part B		0	0	0	0.00	0. 00	5. 00
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0. 00	6. 00
7. 00	Interns & residents (in an	21. 00	0	О	О	0. 00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		0	0	0	0.00	0. 00	7. 01
8. 00	programs) Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8. 00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS		3, 582, 877	23, 831	3, 606, 708	129, 385. 00	27. 88	10.00
11. 00	Contract Labor: Direct Patient Care		1, 929, 662	0	1, 929, 662	30, 435. 00	63. 40	11. 00
12. 00	Contract Labor: Top Level management and other		0	0	0	0. 00	0. 00	12. 00
13. 00	management and administrative services Contract Labor: Physician-Part		345, 233	0	345, 233	1, 924. 25	179. 41	13. 00
14. 00	A - Administrative Home office and/or related		. 0					14. 00
11.00	organization salaries and wage-related costs		S			0.00	0.00	11.00
14. 01 14. 02	Home office salaries Related organization salaries		6, 533, 042	0	6, 533, 042	176, 134. 00 0. 00	37. 09 0. 00	14. 01 14. 02
15. 00	Home office: Physician Part A		0	ő	ő		0. 00	
16. 00			0	0	0	0. 00	0. 00	16. 00
	Physicians Part A - Teaching WAGE-RELATED COSTS			_				
17. 00	Wage-related costs (core) (see instructions)		9, 355, 518	0	9, 355, 518			17. 00
18. 00	Wage-related costs (other) (see instructions)		0	0	0			18. 00
	Excluded areas Non-physician anesthetist Part		1, 038, 297 0	0	1, 038, 297 0			19. 00 20. 00
21. 00	Non-physician anesthetist Part		0	0	О			21. 00
22. 00	B Physician Part A - Administrative		0	О	О			22. 00
	Physician Part A - Teaching		0	0	0			22. 01
	Physician Part B Wage-related costs (RHC/FQHC)		0	0	0			23. 00 24. 00
25. 00	Interns & residents (in an approved program)		0	0	0			25. 00
25. 50	Home office wage-related		1, 326, 729	0	1, 326, 729			25. 50
25. 51			0	О	О			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative -		0	О	О			25. 52
25. 53	wage-related (core) Home office & Contract Physicians Part A - Teaching -		0	0	0			25. 53
	wage-related (core)							

| Peri od: | Worksheet S-3 | From 09/01/2017 | Part II | To 08/31/2018 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0046

					11	0 08/31/2018	1/30/2019 11:	
		Wkst. A Line	Amount	Recl assi fi cat	Adjusted	Pai d Hours	Average	
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
			•	Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from Wkst.	3)	col. 4	col. 5)	
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	OVERHEAD COSTS - DIRECT SALARI							
26. 00	Employee Benefits Department	4.00	113, 455	0	113, 455	4, 388. 00	25. 86	26.00
27. 00	Administrative & General	5. 00	5, 043, 251	-248, 444	4, 794, 807	139, 587. 00	34. 35	27.00
28. 00	Administrative & General under		104, 980	0	104, 980	360.00	291. 61	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00		29. 00
30.00	Operation of Plant	7. 00	677, 421	0	677, 421	24, 144. 00	28. 06	
31.00	Laundry & Linen Service	8. 00	0	0	0	0. 00	0. 00	
32.00	Housekeepi ng	9. 00	886, 265	0	886, 265			
33.00	Housekeeping under contract		0	0	0	0. 00	0. 00	33. 00
	(see instructions)							
34.00	Di etary	10. 00	172, 404				14. 07	34.00
35. 00	Dietary under contract (see		1, 006, 054	0	1, 006, 054	42, 857. 00	23. 47	35. 00
	instructions)							
36.00	Cafeteri a	11. 00	0	47, 169	47, 169			36.00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0. 00		37.00
38. 00	Nursing Administration	13. 00	489, 868	248, 444	738, 312	14, 504. 00	50. 90	38. 00
39. 00	Central Services and Supply	14. 00	0	0	0	0. 00	0. 00	
40.00	Pharmacy	15. 00	0	0	0	0. 00		40.00
41.00	Medical Records & Medical	16. 00	17, 075	0	17, 075	554. 00	30. 82	41.00
	Records Library							
42.00	Social Service	17. 00	0	0	0	0. 00		42.00
43.00	Other General Service	18. 00	0	0	0	0. 00	0. 00	43.00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION	Provider CCN: 15-0046	Period: Worksheet S-3 From 09/01/2017 Part III

						rom 09/01/2017 o 08/31/2018	Part III Date/Time Pre 1/30/2019 11:	
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet	,		ŕ	
				A-6)				
		1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		37, 215, 792	0	37, 215, 792	1, 263, 851. 00	29. 45	1.00
	instructions)							
2.00	Excluded area salaries (see		3, 582, 877	23, 831	3, 606, 708	129, 385. 00	27. 88	2.00
	instructions)							
3.00	Subtotal salaries (line 1		33, 632, 915	-23, 831	33, 609, 084	1, 134, 466. 00	29. 63	3.00
	minus line 2)							
4.00	Subtotal other wages & related		8, 807, 937	0	8, 807, 937	208, 493. 25	42. 25	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		10, 682, 247	0	10, 682, 247	0.00	31. 78	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		53, 123, 099	-23, 831	53, 099, 268	1, 342, 959. 25	39. 54	6.00
7.00	Total overhead cost (see		8, 510, 773	0	8, 510, 773	302, 298. 00	28. 15	7.00
	instructions)		,			,		
		'		!	1		'	

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lieu of For	rm CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0046	Period: Worksh From 09/01/2017 Part I	neet S-3 V
		To 08/31/2018 Date/T	

PART I V - WAGE RELATED COSTS Part A - Core List		To 08/31/2018	B Date/Time Pre 1/30/2019 11:	
PART I V - WAGE RELATED COSTS				
PART I V - WAGE RELATED COSTS Part A - Core List Part A - Core Lis			Reported	
Part A - Core List			1.00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00		Part A - Core List		
2.00		RETI REMENT COST		
3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0 3.00	1.00	401K Empl oyer Contributions	1, 246, 285	1.00
A. 00	2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Pi an Administration fees 84,441 5.00 401K/TSA Pi an Administration fees 84,441 5.00 6.00 Legal /Accounting/Management Fees-Pension Plan 0 6.00 Employee Managed Care Program Administration Fees 0 7.00 Employee Managed Care Program Administration Fees 0 7.00 Employee Managed Care Program Administration Fees 0 7.00 Employee Managed Care Program Administration Fees 0 8.00 Heal th Insurance (Purchased or Self Funded) 8.01 Heal th Insurance (Self Funded without a Third Party Administrator) 0 8.01 8.01 Heal th Insurance (Self Funded without a Third Party Administrator) 0 8.02 8.03 Heal th Insurance (Self Funded with a Third Party Administrator) 0 8.02 8.03 Heal th Insurance (Self Funded with a Third Party Administrator) 0 8.00 7.00 10.00	3.00		0	3.00
5.00	4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
Column C				
The color of the	5.00	401K/TSA Plan Administration fees	84, 441	5. 00
HEALTH AND INSURANCE COST	6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
Real th Insurance (Purchased or Self Funded) Heal th Insurance (Self Funded without a Third Party Administrator) 0 8.00 Real th Insurance (Self Funded without a Third Party Administrator) 0 8.02 Real th Insurance (Self Funded with a Third Party Administrator) 0 8.02 Real th Insurance (Purchased) 0 8.03 Real th Insurance (Purchased) 0 8.02 Real th Insurance (Purchased) 0 8.02 Real th Insurance (Purchased) 0 9.00 Real th Insurance (Purchased) 0 9.0	7.00		0	7.00
Heal th Insurance (Self Funded without a Third Party Administrator) 0 8.01				
Heal th Insurance (Self Funded with a Third Party Administrator) 0 8.02	8.00			
8.03 Heal th Insurance (Purchased) 5,559,168 8.03 9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 24,035 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 35,442 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 407,685 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 121,387 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only 2,218,039 17.00 18.00 Medicare Taxes - Employers Portion Only 516,998 18.00 Medicare Taxes - Employers Portion Only 10.00 Unemployment Insurance 0 19.00 20.00 State or Federal Unemployment Taxes 102,125 20.00 OTHER 20.00 21.00 OTHER 20.00 22.00 23.00 Tuition Reimbursement 78,210 23.00 Tuition Reimbursement 78,210 23.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 24.00 Part B - Other than Core Related Cost 24.00 Part B - Other than Core Related Cost 24.00 Part B - Other than Core Related Cost 24.00 24.00 Part B - Other than Core Related Cost 24.00 Part B - Other than Core Related Cost 24.00 Part B - Other than Core Related Cost 24.00 Part B - Other than Core Related Cost 24.00 Part B - Other than Core Related Cost 24.00 Part B - Other than Core Related Cost 24.00 Part B - Other than Core Related Cost 24.00 Part B - Other than Core Related Cost 24.00 Part B - Other than Core Related Cost 24.00 Part B - Other than Core Related Cost 24.00 Part B - Other than Core Related Cost 24.00 Part B - Other than Core Related Cost 24.00 Part B - Other than Core Related Cost 24.00 Part B - Other than Core Related Cost 24.00 Par	8. 01		0	
9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 24,035 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 35,442 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 407,685 13.00 14.00 Usor-term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 121,387 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) 2,218,039 17.00 18.00 Medicare Taxes - Employers Portion Only 2,218,039 17.00 19.00 State or Federal Unemployment Taxes 0 19.00 20.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuit to ne Reimbursement				
10.00 Dental, Hearing and Vision Plan 24,035 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 35,442 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 407,685 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 121,387 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion 10.00 17.00 FICA-Employers Portion Only 2,218,039 17.00 18.00 Medicare Taxes - Employers Portion Only 516,998 18.00 19.00 Unemployment Insurance 0 19.00 20.00 State or Federal Unemployment Taxes 102,125 0 OTHER 20.00 0 OTHER 20.00 1 OTHER 20.00 1 OTHER 20.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuit on Reimbursement 78,210 24.00 Part B - Other than Core Related Cost 24.00 24.00 Part B - Other than Core Related Cost 24.00 24.00 Part B - Other than Core Related Cost 24.00 24.00 Part B - Other than Core Related Cost 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00			5, 559, 168	
11.00				
12.00	10.00		24, 035	10.00
13.00 Disability Insurance (If employee is owner or beneficiary) Long-Term Care Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 'Workers' Compensation Insurance 121, 387 15.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumul ative portion) TAXES 17.00 FICA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 102, 125 TOTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 33.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost			35, 442	
14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 'Workers' Compensation Insurance Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance State or Federal Unemployment Taxes 17.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	12.00			
15.00 'Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 21.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost			1	
Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) TAXES				
Non cumulative portion TAXES To Axes T			121, 387	
TAXES 17.00 FI CA-Employers Portion Only 2, 218, 039 17.00 18.00 18.00 19.00	16. 00		0	16. 00
17. 00 FI CA-Employers Portion Only 2, 218, 039 17. 00 18. 00 Medicare Taxes - Employers Portion Only 516, 998 18. 00 19				
18.00 Medicare Taxes - Employers Portion Only 516, 998 18.00 19.00 Unemployment Insurance 0 19.00 20.00 State or Federal Unemployment Taxes 102, 125 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 78, 210 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 10, 393, 815 24.00 Part B - Other than Core Related Cost		·		
19.00 Unemployment Insurance 0 19.00 20.00 State or Federal Unemployment Taxes 102,125 20.00 OTHER				
20. 00 State or Federal Unemployment Taxes 102, 125 OTHER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuit ion Reimbursement 78, 210 23. 00 24. 00 Total Wage Related cost (Sum of Lines 1 -23) 10, 393, 815 24. 00 Part B - Other than Core Related Cost			1	
OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 33.00 Tuition Reimbursement Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost 21.00 Part B - Other than Core Related Cost 22.00 Part B - Other than Core Related Cost			1	
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	20. 00		102, 125	20.00
instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 78, 210 23.00 24.00 Part B - Other than Core Related Cost instructions)) 70 22.00 23.00 10, 393, 815 24.00				
22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 78, 210 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 -23) 10, 393, 815 24. 00 Part B - Other than Core Related Cost 24. 00 24. 00	21. 00		e 0	21.00
23. 00 Tui ti on Rei mbursement 78, 210 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 -23) 24. 00 Part B - Other than Core Related Cost (24. 00 24.				
24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost 24.00				
Part B - Other than Core Related Cost				
	24. 00		10, 393, 815	24.00
25.00 OTHER WAGE RELATED COSTS (SPECIFY) 0 25.00			1	
	25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

Health Financial Systems TERRE HAUT	TE REGIONAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0046	Peri od: From 09/01/2017 To 08/31/2018	Worksheet S-3 Part V Date/Time Pre 1/30/2019 11:	pared:
Cost Center Description		Contract Labor	Benefit Cost	
		1. 00	2. 00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification				

	Cost Center Description	Contract	Benefit Cost	
		Labor		
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			l
	Hospital and Hospital-Based Component Identification:			l
1.00	Total facility's contract labor and benefit cost	1, 928, 097	10, 393, 815	1.00
2.00	Hospi tal	1, 929, 662	9, 355, 518	2.00
3.00	Subprovi der - IPF	0	532, 868	3.00
4.00	Subprovi der - I RF	-1, 565	244, 115	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	Hospi tal -Based SNF			8.00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11.00	Hospi tal -Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	261, 314	18. 00

	TAL UNCOMPENSATED AND INDIGENT CARE DATA Pro	ovider CCN	: 15-0046	Peri od:	Worksheet S-1	0 _
				From 09/01/2017		
				To 08/31/2018	Date/Time Pre 1/30/2019 11:	
	Uncompensated and indigent care cost computation				1. 00	
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by lin	e 202 col un	n 8)	0. 147539	1.
	Medicaid (see instructions for each line)			/		
00	Net revenue from Medicaid				22, 516, 724	2
00	Did you receive DSH or supplemental payments from Medicaid?				N	3
00	If line 3 is yes, does line 2 include all DSH and/or supplemental	1 2		cai d?		4
00	If line 4 is no, then enter DSH and/or supplemental payments from	m Medicaid			140 430 070	
00 00	Medicaid charges Medicaid cost (line 1 times line 6)				169, 430, 070 24, 997, 543	
00	Difference between net revenue and costs for Medicaid program (li	ine 7 minu	s sum of Li	nes 2 and 5 if	2, 480, 819	
	< zero then enter zero)			1.00 2 and 0, 11	2, 100, 01,	
	Children's Health Insurance Program (CHIP) (see instructions for	each line)			
00	Net revenue from stand-alone CHIP				0	
00					0	
00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (li	ino 11 min	uc lino O	if a zoro thon	0	11 12
00	enter zero)		ius IIIIe 9,	II < Zero then	0	'2
	Other state or local government indigent care program (see instru	uctions fo	r each line	e)		
00	Net revenue from state or local indigent care program (Not include				0	13
00	Charges for patients covered under state or local indigent care p	program (N	ot included	lin lines 6 or	0	14
	10)				_	
00	State or local indigent care program cost (line 1 times line 14)		(1:	15! !!	0	
. 00	Difference between net revenue and costs for state or local indiging; if < zero then enter zero)	gent care	program (11	ne 15 minus iine	0	16
	Grants, donations and total unreimbursed cost for Medicaid, CHIP	and state	/local indi	gent care progra	ıms (see	
	instructions for each line)					
00					0	
	Government grants, appropriations or transfers for support of hos			(6 1!	0 2, 480, 819	
. 00	Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)	rnargent c	are program	is (suiii oi iiiles	2, 400, 619	19
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col . 2)	
	Uncompared Care (see instructions for each line)		1. 00	2. 00	3. 00	
	nuncionensaten tare isee instructions for each finel					
00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil	lity	27, 445, 2	52 300, 096	27, 745, 358	20
00	Charity care charges and uninsured discounts for the entire facil (see instructions)	lity	27, 445, 2	52 300, 096	27, 745, 358	20
	Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount		27, 445, 2 4, 049, 2			
00	Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions)	ts (see		239, 883	4, 289, 130	21
00	Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of	ts (see				21
. 00	Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care	ts (see	4, 049, 2	239, 883 0 0	4, 289, 130 0	21 22
00	Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care	ts (see		239, 883 0 0	4, 289, 130 0	21 22
00	Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22)	ts (see	4, 049, 2- 4, 049, 2-	239, 883 0 0 47 239, 883	4, 289, 130 0 4, 289, 130	21 22 23
00	Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient	ts (see ff as days beyo	4, 049, 2- 4, 049, 2-	239, 883 0 0 47 239, 883	4, 289, 130 0 4, 289, 130	21 22 23
00	Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr	ts (see ff as days beyorgram?	4, 049, 2 4, 049, 2	239, 883 0 0 47 239, 883	4, 289, 130 0 4, 289, 130 1. 00 Y	21 22 23 24
00 00 00	Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the	ts (see ff as days beyorgram?	4, 049, 2 4, 049, 2	239, 883 0 0 47 239, 883	4, 289, 130 0 4, 289, 130	21 22 23 24
00 00 00 00	Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the stay limit	ts (see ff as days beyorogram? indigent	4, 049, 2 4, 049, 2	239, 883 0 0 47 239, 883	4, 289, 130 0 4, 289, 130 1.00 Y 70, 634	21 22 23 24 25
. 00	Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the	ts (see ff as days beyorgram? indigent ructions)	4, 049, 2- 4, 049, 2- and a Length care progra	239, 883 0 0 47 239, 883	4, 289, 130 0 4, 289, 130 1. 00 Y	21 22 23 24 25 26
. 00	Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see instr	ts (see ff as days beyorogram? indigent ructions) (see instr	4,049,2. 4,049,2. Ind a Length care progra	239, 883 0 0 47 239, 883	4, 289, 130 0 4, 289, 130 1. 00 Y 70, 634 6, 764, 792	21 22 23 24 25 26 27
.00	Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided in the stay limit. Total bad debt expense for the entire hospital complex (see instructions) Medicare reimbursable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	days beyorogram? indigent ructions) (see instruct	4,049,24 4,049,24 Ind a Length care progra Tuctions) ions)	239, 883 0 0 47 239, 883 n of stay limit	4, 289, 130 0 4, 289, 130 1. 00 Y 70, 634 6, 764, 792 446, 275 686, 577 6, 078, 215	21 22 23 24 25 26 27 27 27 28
. 00	Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided in the stay limit. Total bad debt expense for the entire hospital complex (see instructions) the complex (see instructions) cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt expense	days beyorogram? indigent ructions) (see instruct	4,049,24 4,049,24 Ind a Length care progra Tuctions) ions)	239, 883 0 0 47 239, 883 n of stay limit	4, 289, 130 0 4, 289, 130 1. 00 Y 70, 634 6, 764, 792 446, 275 686, 577 6, 078, 215 1, 137, 076	21 22 23 24 25 26 27 27 28 29
. 00 . 00 . 01 . 00 . 00	Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided in the stay limit. Total bad debt expense for the entire hospital complex (see instructions) Medicare reimbursable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	days beyorogram? indigent ructions) (see instructionse (see instructions)	4,049,24 4,049,24 Ind a Length care progra Tuctions) ions)	239, 883 0 0 47 239, 883 n of stay limit	4, 289, 130 0 4, 289, 130 1. 00 Y 70, 634 6, 764, 792 446, 275 686, 577 6, 078, 215	21 22 23 24 25 26 27 27 28 29 30

Heal th	Financial Systems	TERRE HAUTE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der Co		eri od:	Worksheet A	
					rom 09/01/2017	D . I . /T' D	
					o 08/31/2018	Date/Time Pre 1/30/2019 11:	
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cat	Reclassi fi ed	15 aiii
	oost center beson per on	our ur res	Other	+ col . 2)	i ons (See	Tri al Balance	
				' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	A-6)	(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		3, 093, 031	3, 093, 031	291, 743	3, 384, 774	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2, 772, 612	2, 772, 612	754, 673	3, 527, 285	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	113, 455	7, 800, 172	7, 913, 627	103, 230	8, 016, 857	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	5, 043, 251	14, 699, 482	19, 742, 733	-454, 777	19, 287, 956	5. 00
7.00	00700 OPERATION OF PLANT	677, 421	3, 320, 143	3, 997, 564	-2, 958	3, 994, 606	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	756, 602	756, 602	0	756, 602	8. 00
9. 00	00900 HOUSEKEEPI NG	886, 265	403, 070			1, 281, 504	9. 00
10.00	01000 DI ETARY	172, 404	1, 925, 999	2, 098, 403		1, 519, 465	•
11. 00	01100 CAFETERI A	0	0	1		572, 290	
13. 00	01300 NURSI NG ADMI NI STRATI ON	489, 868	302, 873			1, 021, 599	•
16. 00	01600 MEDICAL RECORDS & LIBRARY	17, 075	1, 014, 408	1, 031, 483	-273	1, 031, 210	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	, ,		,	, , ,		
30. 00	03000 ADULTS & PEDIATRICS	5, 444, 774	3, 747, 917			9, 119, 675	
31. 00	03100 INTENSIVE CARE UNIT	1, 941, 539	604, 888			2, 492, 185	ł
40.00	04000 SUBPROVI DER - I PF	1, 851, 011	988, 368			2, 823, 673	1
41.00	04100 SUBPROVI DER - I RF	847, 975	105, 495			952, 469	
43.00	04300 NURSERY	286, 019	233, 557	519, 576	-270	519, 306	43.00
	ANCILLARY SERVICE COST CENTERS			1			
50.00	05000 OPERATING ROOM	3, 920, 392	5, 564, 486			9, 439, 625	
51.00	05100 RECOVERY ROOM	484, 139	96, 055			579, 488	
52.00	05200 DELIVERY ROOM & LABOR ROOM	778, 465	347, 195			1, 118, 172	
54.00	05400 RADI OLOGY-DI AGNOSTI C	940, 218	892, 271			1, 626, 528	
54. 01	03630 ULTRA SOUND	160, 765	28, 927			189, 692	
54. 02	03440 MAMMOGRAPHY	114, 401	89, 127			202, 757	
55.00	05500 RADI OLOGY-THERAPEUTI C	589, 454	444, 387			989, 589	
56.00	05600 RADI OI SOTOPE	160, 543	621, 665			782, 131	
57.00	05700 CT SCAN	533, 257	212, 040			743, 546	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	246, 816	106, 111			352, 927	•
59.00	05900 CARDI AC CATHETERI ZATI ON	511, 239	33, 122			544, 361	•
60.00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 234, 073	1, 807, 906			2, 942, 822	•
62.00		1	662, 576			662, 576	•
65. 00 66. 00	06500 RESPI RATORY THERAPY	916, 094	437, 287			1, 254, 984	
69.00	06600 PHYSI CAL THERAPY	880, 950	165, 048			1, 045, 875	•
70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	463, 642	375, 744			836, 117	•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	47, 673	18, 359	•		65, 065 6, 928, 949	
71. 00 72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	369, 480	6, 762, 036 6, 033, 723				1
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 493, 192	10, 979, 425			6, 321, 697 12, 466, 015	
74.00	07400 RENAL DIALYSIS	1, 473, 172	536, 827			536, 895	
76.00	03950 LI THOTRI PSY	00	231, 984			231, 984	1
	03330 ENDOSCOPY	767, 364	548, 378	•		1, 176, 465	
	03040 PRISION CLINIC	139, 992	18, 665			157, 668	
	03050 WOUND CARE	65, 555	566, 450			630, 719	
	03060 OPI C	457, 297	111, 339			567, 345	ł
70.04	OUTPATIENT SERVICE COST CENTERS	437, 277	111, 337	300, 030	-1, 271	307, 343	70.04
91 00	09100 EMERGENCY	2, 174, 741	9, 606, 844	11, 781, 585	-213, 622	11, 567, 963	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 174, 741	7, 000, 044	11, 701, 303	213, 022	11, 307, 703	92.00
72.00	SPECIAL PURPOSE COST CENTERS			L			72.00
118.00		35, 220, 867	89, 066, 594	124, 287, 461	-24, 050	124, 263, 411	118 00
110.00	NONREI MBURSABLE COST CENTERS	33, 220, 007	07,000,374	124, 207, 401	24, 030	124, 200, 411	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	49, 597	49, 597	ol ol	49 597	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES		0				192.00
	07950 OCCUPATI ONAL MEDI CI NE	639, 849	141, 536	-		779, 825	
	07951 UNOCCUPI ED SPACE/NONALLOWABLE MEALS	007,047	111, 550 N	, 51, 505) ., 500 N		194. 01
	07952 SI TTERS	244, 042	19, 435	263, 477		263, 477	
	07953 UNLI CENSED STAFF	244, 042	17, 433			•	194. 02
200.00		36, 104, 758	89, 277, 162				
200.00	Trome (som of Elikes 110 till ough 177)	1 30, 104, 730	57, 277, 102	1 120, 501, 720	., V	120, 001, 720	₁ =00.00

Provi der CCN: 15-0046

Period: Worksheet A From 09/01/2017 To 08/31/2018 Date/Time Prepared: 1/30/2019 11:15 am

				1/30/2019 11: 15	am_
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
			Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	174, 045			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-977	3, 526, 308		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	284, 763	8, 301, 620		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	7, 106, 611	26, 394, 567		5.00
7.00	00700 OPERATION OF PLANT	81, 859	4, 076, 465		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	756, 602		8.00
9.00	00900 HOUSEKEEPI NG	19, 966	1, 301, 470		9.00
10.00	01000 DI ETARY	-1, 801	1, 517, 664	1	10. 00
11.00	01100 CAFETERI A	-283, 161	289, 129	1	11. 00
13.00	01300 NURSING ADMINISTRATION	-17, 748	1, 003, 851	1	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	41, 561	1, 072, 771	1	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-1, 717, 290	7, 402, 385	3	30.00
31.00	03100 INTENSIVE CARE UNIT	-7, 691	2, 484, 494	3	31. 00
40.00	04000 SUBPROVI DER - I PF	-679, 142	2, 144, 531		40.00
41.00	04100 SUBPROVI DER - I RF	-21	952, 448		41. 00
43.00	04300 NURSERY	-142, 431	376, 875		43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-4, 516, 887	4, 922, 738	5	50.00
51.00	05100 RECOVERY ROOM	-67	579, 421	5	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	-17, 635	1, 100, 537	5	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	52, 282	1, 678, 810	5	54.00
54.01	03630 ULTRA SOUND	0	189, 692		54. 01
54.02	03440 MAMMOGRAPHY	0	202, 757		54. 02
55.00	05500 RADI OLOGY-THERAPEUTI C	-1, 377	988, 212		55. 00
56.00	05600 RADI OI SOTOPE	0	782, 131	1	56. 00
57.00	05700 CT SCAN	0	743, 546		57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	352, 927	5	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	-3, 614	540, 747		59. 00
60.00	06000 LABORATORY	-429	2, 942, 393		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	662, 576		62.00
65.00	06500 RESPI RATORY THERAPY	-95, 250			65. 00
66.00	06600 PHYSI CAL THERAPY	-42, 441	1, 003, 434		66.00
69. 00	06900 ELECTROCARDI OLOGY	-9, 639	826, 478		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	65, 065		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-284	6, 928, 665		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	6, 321, 697		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	-176	12, 465, 839		73. 00
74. 00	07400 RENAL DI ALYSI S	0	536, 895	1	74. 00
76. 00	03950 LI THOTRI PSY	0	231, 984	1	76. 00
76. 01	03330 ENDOSCOPY	-64, 123	1, 112, 342	1	76. 01
76. 02	03040 PRISION CLINIC	01,120	157, 668	1	76. 02
76. 03		-11, 596		1	76. 03
76. 04	03060 OPI C	-25, 809	541, 536	1	76. 04
70.04	OUTPATIENT SERVICE COST CENTERS	25,007	341, 330	'	70.04
91. 00		-8, 480, 218	3, 087, 745		91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0, 100, 210	0,007,710	1	92.00
72.00	SPECIAL PURPOSE COST CENTERS				72.00
118. 00		-8, 358, 720	115, 904, 691	11	18. 00
1 10.00	NONREI MBURSABLE COST CENTERS	0, 330, 720	113, 704, 071	<u> </u>	13.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	49, 597	110	90. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	49, 597		92.00
	07950 OCCUPATIONAL MEDICINE	-240, 557	539, 268		94. 00
	107951 UNOCCUPIED SPACE/NONALLOWABLE MEALS	-240, 557	0 339, 200		94. 00 94. 01
	207952 SI TTERS	-48	263, 429		94. 01
	3 07953 UNLI CENSED STAFF	-40 ^	25, 610		94. 02
200. 00		-8, 599, 325			00.00
200.00	1.01/12 (35m of Elites 110 till ough 177)	0, 077, 323	110, 702, 373	1	

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0046

					1/30/2019	11: 15 am
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2.00	3. 00	4. 00	5. 00		
1. 00	A - LEASES CAP REL COSTS-BLDG & FLXT	1.00	O	276, 091		1.00
2. 00	CAP REL COSTS-BLDG & FIXT	2. 00	0	741, 259		2.00
3. 00	CAF REL COSTS-WVBEL EQUIP	0.00	0	741, 239		3.00
4. 00		0.00	o	0		4.00
5. 00		0. 00	o	o		5. 00
6. 00		0. 00	o	Ö		6.00
7. 00		0.00	O	0		7. 00
8. 00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00		0. 00	0	0		11. 00
12.00		0. 00	0	0		12. 00
13. 00		0. 00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0 0		16.00
17. 00 18. 00		0. 00 0. 00	0	0		17. 00 18. 00
19. 00		0.00	0	0		19.00
20. 00		0.00	Ö	0		20.00
21. 00		0. 00	o	o		21.00
22. 00		0. 00	o	O		22. 00
23. 00		0. 00	o	Ö		23. 00
24.00		0.00	O	0		24.00
25.00		0.00	0	0		25. 00
26.00		0.00	0	0		26. 00
27.00		0.00	0	0		27. 00
28.00		0.00	0	0		28. 00
29. 00		0. 00	0	0		29. 00
30. 00		0. 00	0	0		30.00
31. 00		0.00	•	0		31.00
	B - PROPERTY INSURANCE		0	1, 017, 350		
1. 00	CAP REL COSTS-BLDG & FLXT	1.00	0	29, 066		1.00
1.00	O REE COSTS-BEDG & LIXI		— — —	29, 066		1.00
	C - EXECUTIVE COMP.		٩	27,000		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	104, 742		1.00
2. 00	NURSI NG ADMI NI STRATI ON	13. 00	248, 444	22, 236		2. 00
			248, 444	126, 978		
	D - CAFETERIA					
1.00	CAFETERI A	11. 00	47, 169	52 <u>5, 1</u> 21		1. 00
	0		47, 169	525, 121		
	E - MEDICAL SUPPLIES					
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	234, 195		1. 00
2 00	PATI ENTS	0.00				2.00
2. 00 3. 00		0. 00 0. 00	0	0		2. 00 3. 00
4. 00		0.00	0	0		4.00
5. 00		0.00	Ö	0		5. 00
6. 00		0.00	0	o		6. 00
7. 00		0. 00	0	O		7. 00
8. 00		0. 00	o	Ö		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11. 00
12.00		000	0_	0		12.00
	0		0	234, 195		
4 00	F - DRUG	70 6-1	_1			
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	4, 325		1.00
2.00		0.00	0	0		2.00
3. 00		0.00	0	$\frac{0}{4,325}$		3. 00
	G - IMPLANTABLE DEVICES		U	4, 325		
1. 00	IMPL. DEV. CHARGED TO	72. 00	O	428, 593		1.00
1.00	PATIENTS	72.00	٥	720, 575		1.00
2. 00		0. 00	o	О		2. 00
3. 00		0. 00	Ö	Ö		3.00
4.00		0.00	O	0		4. 00
5.00		0.00	0	0		5. 00
	0			428, 593		

Heal th	Financial Systems	Т	ERRE HAUTE REG	IONAL HOSPITAL	-	In Lieu	ı of Form CMS-	-2552-10
RECLAS	SI FI CATI ONS			Provi der (CCN: 15-0046	Peri od:	Worksheet A-	6
						From 09/01/2017 To 08/31/2018	Date/Time Pro 1/30/2019 11	epared: :15 am_
		Increases						
	Cost Center	Li ne #	Sal ary	Other				
	2. 00	3.00	4. 00	5. 00				
	H - ER BEDHOLD							
1.00	ADULTS & PEDIATRICS	30.00	74, 384	35, 265				1.00
2.00	INTENSIVE CARE UNIT	31. 00	3, 713	1, 760				2.00
			78, 097	37, 025				
	I - LOST CHARGES	<u>'</u>	<u> </u>		<u>'</u>			
1.00		0.00	0	0				1.00
			— — -					
	J - EQUIPMENT PROPERTY TAX							
1. 00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	13, 414				1.00
	0		 	13, 414				
	L - UNLICENSED STAFF		· · · · · · · · · · · · · · · · · · ·					1
1.00	UNLI CENSED STAFF	194. 03	23, 831	1, 779				1.00
2.00		0.00	0	. 0				2.00
	TOTALS — — — — —	— — 	23, 831					
500 00	Grand Total: Increases		397, 541	2, 417, 846				500.00
220.00	je. a.i.a . e tai iioi oasos	1	377,011	2, 117, 010	I			1 555. 66

RECLASSI FI CATI ONS

Provider CCN: 15-0046

Peri od: Worksheet A-6 From 09/01/2017 To 08/31/2018 Date/Time Prepared:

1/30/2019 11:15 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - LEASES EMPLOYEE BENEFITS DEPARTMENT 4.00 1, 512 10 1.00 0 2.00 ADMINISTRATIVE & GENERAL 5.00 50, 289 10 2.00 OPERATION OF PLANT 7.00 0 2.958 0 3.00 3.00 4.00 HOUSEKEEPI NG 9.00 0 7,831 0 4.00 0 0 5.00 DI ETARY 10.00 6,648 5.00 0 6.00 NURSING ADMINISTRATION 13.00 41, 822 0 6.00 0 0 MEDICAL RECORDS & LIBRARY 7.00 16.00 273 7.00 8.00 ADULTS & PEDIATRICS 30.00 0 165, 736 0 8.00 INTENSIVE CARE UNIT 0 0 9.00 31.00 58, 605 9.00 SUBPROVI DER - I PF SUBPROVI DER - I RF 40 00 0 15, 706 0 10 00 10 00 0 0 11.00 41.00 1,001 11.00 12.00 OPERATING ROOM 50.00 o 26, 249 0 12.00 13.00 RECOVERY ROOM 51.00 0 706 0 13.00 DELIVERY ROOM & LABOR ROOM 0 7, 462 0 52 00 14 00 14 00 0 15.00 RADI OLOGY-DI AGNOSTI C 54.00 0 201, 776 15.00 16.00 MAMMOGRAPHY 54.02 o 771 0 16.00 17.00 RADI OLOGY-THERAPEUTI C 55.00 0 4,548 0 17.00 0 0 56.00 RADI OLSOTOPE 18.00 77 18.00 19.00 LABORATORY 60.00 0 98, 781 0 19.00 RESPIRATORY THERAPY 20.00 65.00 40, 285 20.00 0 66 00 0 21 00 PHYSI CAL THERAPY 21 00 123 22.00 ELECTROCARDI OLOGY 69.00 0 2, 280 0 22.00 ELECTROENCEPHALOGRAPHY 70.00 967 0 23.00 23.00 MEDICAL SUPPLIES CHARGED TO 71.00 ol 0 24.00 51, 202 24.00 PATI ENTS 25 00 DRUGS CHARGED TO PATIENTS 73.00 963 0 25 00 **ENDOSCOPY** 76.01 0 0 26.00 133, 457 26.00 0 27.00 PRISION CLINIC 76.02 0 989 27.00 0 28.00 WOUND CARE 76.03 0 1,093 28.00 29.00 OPLC 76.04 0 1, 291 0 29.00 91.00 30.00 EMERGENCY 0 90, 389 0 30.00 OCCUPATIONAL MEDICINE 0 31.00 194.00 1,560 31.00 0 1, 017, 350 B - PROPERTY INSURANCE ADMINISTRATIVE & GENERAL 1.00 5. 00 29, 066 1.00 0 12 29.066 - EXECUTIVE COMP. 1.00 ADMINISTRATIVE & GENERAL 5.00 248, 444 126, 978 0 1.00 2.00 0.00 0 2.00 248. 444 126, 978 D - CAFETERIA 1.00 DI ETARY 10.00 47, 169 525, 121 1.00 0 47, 169 525, 121 E - MEDICAL SUPPLIES 1, 110 1.00 INTENSIVE CARE UNIT 31.00 0 1.00 2.00 NURSERY 43.00 o 270 0 2.00 OPERATING ROOM 50.00 0 3.00 0 16, 866 3.00 0 54.00 RADI OLOGY-DI AGNOSTI C 0 4 00 4, 147 4 00 5.00 CT SCAN 57.00 0 1, 751 0 5.00 6.00 LABORATORY 60.00 0 376 0 6.00 0 0 RESPIRATORY THERAPY 7 00 65 00 7 00 58, 112 8.00 ELECTROCARDI OLOGY 69.00 0 989 0 8.00 IMPL. DEV. CHARGED TO 0 9.00 72.00 140, 619 9.00 PATI ENTS 10.00 ENDOSCOPY 76.01 0 1, 651 0 10.00 11.00 WOUND CARE 76.03 0 193 0 11.00 <u>8, 111</u> **EMERGENCY** 0 12.00 91.00 12.00 ō 234, 195 DRUG 1.00 RADI OLOGY-DI AGNOSTI C 54.00 0 38 0 1.00 2.00 MEDICAL SUPPLIES CHARGED TO 71.00 118 0 2.00 PATI ENTS 3 00 ENDOSCOPY <u>76.</u>01 4 169 0 3 00 0 4, 325 IMPLANTABLE DEVICES 1.00 OPERATING ROOM 50.00 0 2, 138 0 1.00 DELLVERY ROOM & LABOR ROOM 0 2 00 52 00 0 2 00 26 3.00 RADI OLOGY-THERAPEUTI C 55.00 0 39.704 0 3.00 MEDICAL SUPPLIES CHARGED TO o 385, 442 0 4.00 71.00 4.00 PATI ENTS 5.00 DRUGS CHARGED TO PATIENTS 5.00 73.00 1.283 0

428, 593

Heal th	Financial Systems	-	TERRE HAUTE REGI	ONAL HOSPITA	L	In Lie	u of Form CMS-	-2552-10
RECLAS:	SI FI CATI ONS			Provi der		Period: From 09/01/2017	Worksheet A-	6
						To 08/31/2018		epared: :15 am_
		Decreases						
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref			
	6. 00	7. 00	8. 00	9. 00	10.00			
	H - ER BEDHOLD							
1.00	EMERGENCY	91.00	78, 097	37, 025	5	0		1.00
2.00		0.00	0	(o		2.00
			78, 097	37, 025	5	7		1
	I - LOST CHARGES				·	<u>'</u>		1
1.00		0.00	0	(0		1.00
						7		
	J - EQUIPMENT PROPERTY TAX					'		1
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	13, 414	1 1	3		1.00
	0 — — — — — —			13, 414	1	7		1
	L - UNLICENSED STAFF			•		'		1
1.00	DRUGS CHARGED TO PATIENTS	73.00	8, 076	605	5	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	15, 755	1, 174	1	o		2.00
	TOTALS		23, 831	1,779		7		
500.00	Grand Total: Decreases		397, 541	2, 417, 846				500.00
		'	, , , , ,		1	1		

Provi der CCN: 15-0046

				Ť	o 08/31/2018	Date/Time Pre 1/30/2019 11:	
				Acqui si ti ons		1/30/2019 11.	13 alli
		Beginning	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	1, 262, 718	0	0	0	0	1.00
2.00	Land Improvements	3, 158, 371	0	0	0	0	2.00
3.00	Buildings and Fixtures	38, 638, 215	0	0	0	0	3.00
4.00	Building Improvements	8, 056, 094	65, 121	0	65, 121	0	4.00
5.00	Fixed Equipment	27, 079, 070	22, 118	0	22, 118	115, 729	5.00
6.00	Movable Equipment	46, 356, 854	2, 602, 261	0	2, 602, 261	527, 152	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	124, 551, 322	2, 689, 500	0	2, 689, 500	642, 881	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	124, 551, 322	2, 689, 500	0	2, 689, 500	642, 881	10.00
		Endi ng	Fully				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
4 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		al				4 00
1.00	Land	1, 262, 718	0				1.00
2. 00	Land Improvements	3, 158, 371	0				2.00
3. 00	Buildings and Fixtures	38, 638, 215	0				3.00
4.00	Building Improvements	8, 121, 215	0				4.00
5. 00	Fi xed Equi pment	26, 985, 459	0				5.00
6. 00	Movable Equipment	48, 431, 963	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	126, 597, 941	0				8.00
9.00	Reconciling Items	0	0				9.00
10. 00	Total (line 8 minus line 9)	126, 597, 941	0				10.00

Heal th	Financial Systems T	ERRE HAUTE REGI	IONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Peri od:	Worksheet A-7	
					From 09/01/2017		
					To 08/31/2018	Date/Time Pre	pared:
			SI	IMMARY OF CAPI	ΤΛΙ	173072019 11.	15 alli
			30	WWWART OF CALL	IAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see	instructions)	
					instructions)		
		9. 00	10. 00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	2, 365, 943	0		0	727, 088	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2, 584, 697	179, 660	8, 25	5 0	0	2.00
3.00	Total (sum of lines 1-2)	4, 950, 640	179, 660	8, 25	5 0	727, 088	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	0ther	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	3, 093, 031				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2, 772, 612				2.00
0 00	T. I. I. (6 I 4 O)	1	I - 0/F /40				1 2 22

0 0 0

3, 093, 031 2, 772, 612 5, 865, 643

3.00

3.00 Total (sum of lines 1-2)

Health Financial	Systems	ERRE HAUTE REG	IONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION O	F CAPITAL COSTS CENTERS		Provi der C		Period: From 09/01/2017	Worksheet A-7 Part III	
						Date/Time Pre	
		COME	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	15 alli
					5 (
Cost	Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio (col. 1 -	instructions)		
				col. 2)			
		1. 00	2.00	3.00	4. 00	5. 00	
PART III -	- RECONCILIATION OF CAPITAL COSTS O		2.00	0.00	1. 00	0.00	
1.00 CAP REL CO	OSTS-BLDG & FLXT	78, 165, 979	0	78, 165, 97	9 0. 617435	0	1.00
2.00 CAP REL C	OSTS-MVBLE EQUIP	48, 431, 962	0	48, 431, 96	0. 382565	0	2.00
3.00 Total (sui	m of lines 1-2)	126, 597, 941		120/07///	1. 000000	0	3.00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPITAL	
Cost	Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at		.,		
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	- RECONCILIATION OF CAPITAL COSTS C						
	OSTS-BLDG & FLXT	0		1	2, 539, 988		1.00
	OSTS-MVBLE EQUIP	0		1	2, 583, 720		2. 00
3.00 Total (sui	m of lines 1-2)	0	·	11.11.4.5.\(\) 05.04.5.\(\)	5, 123, 708	1, 197, 010	3. 00
			St	JMMARY OF CAPI	IAL		
Cost	Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
			(see	instructions)			
			instructions)		ed Costs (see	9 through 14)	
					instructions)		
DADT III	DECONOLLIATION OF CARLTAL COSTS (11. 00	12. 00	13. 00	14. 00	15. 00	
	- RECONCILIATION OF CAPITAL COSTS C	1	20.044	712 /7	4	2 550 010	1 00
	OSTS-BLDG & FIXT OSTS-MVBLE EQUIP	8, 255		1		3, 558, 819	1. 00 2. 00
	m of lines 1-2)	8, 255		1		3, 526, 308 7, 085, 127	2. 00 3. 00
3.00 TOTAL (SU	III OI TITIES 1-2)	0, 255	29,000	121,08	ادا	1,000,12/	3.00

ADJUST	MENTS TO EXPENSES			Provi der CCN: 15-0046	Period: From 09/01/2017 To 08/31/2018	Worksheet A-8 Date/Time Pre	
				Expense Classification of		1/30/2019 11:	
			To	From Which the Amount i			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3. 00	4. 00	Ref. 5.00	
1. 00	Investment income - CAP REL		O CA	P REL COSTS-BLDG & FLXT	1.00	0	1.00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		OICA	P REL COSTS-MVBLE EQUIP	2.00	0	2.00
	COSTS-MVBLE EQUIP (chapter 2)						
3. 00	Investment income - other (chapter 2)		0		0. 00	0	3.00
4.00	Trade, quantity, and time		О		0.00	0	4.00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
	expenses (chapter 8)						
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7. 00	Telephone services (pay		O		0.00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service		О		0.00	0	8.00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0. 00	0	9.00
10.00	Provi der-based physician	A-8-2	-11, 971, 633		0.00	0	
44.00	adj ustment				0.00		44 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11.00
12.00	Related organization	A-8-1	8, 236, 167			0	12.00
13. 00	transactions (chapter 10) Laundry and Linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		O		0. 00	0	14.00
15. 00	Rental of quarters to employee and others		0		0. 00	0	15. 00
16. 00	Sale of medical and surgical		О		0.00	0	16.00
	supplies to other than patients						
17. 00	Sale of drugs to other than		О		0.00	0	17. 00
18. 00	patients Sale of medical records and		0		0.00	0	18. 00
	abstracts						
19. 00	Nursing and allied health education (tuition, fees,		0		0.00	0	19.00
	books, etc.)						
	Vending machines Income from imposition of		0		0. 00 0. 00	0	•
21.00	interest, finance or penalty		J		0.00		21.00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
22.00	overpayments and borrowings to		J		0.00		22.00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	ODE	SPIRATORY THERAPY	65. 00		23. 00
23.00	therapy costs in excess of	A-0-3	OKL	STRATORT THERALT	05.00		25.00
24.00	limitation (chapter 14)	4.0.2	ODU	VCLCAL THEDADY	44.00		24.00
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	UPH	YSI CAL THERAPY	66. 00		24.00
25 00	limitation (chapter 14)		0 * *	* Coot Conton Doloted **	* 114 00		25 00
25. 00	Utilization review - physicians' compensation		U	* Cost Center Deleted **	* 114.00		25. 00
27.00	(chapter 21)		0.04	D DEL COCTO DI DO 0 FLVT	1 00		27 00
26. 00	Depreciation - CAP REL COSTS-BLDG & FIXT		UCA	P REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	Depreciation - CAP REL		OCA	P REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0 * *	* Cost Center Deleted **	* 19.00		28. 00
29.00	Physicians' assistant	A 0 0	0		0. 00	0	
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0 **	* Cost Center Deleted **	* 67.00		30.00
00	limitation (chapter 14)			ULTO A DEDUCTO			00
30. 99	Hospice (non-distinct) (see instructions)		OAD	ULTS & PEDIATRICS	30.00		30. 99
	THE HUCHOUS)		l l		ı I	ļ	l

ADJUSTMENTS TO EXPENSES Provider CCN: 15-0046 Peri od: Worksheet A-8 From 09/01/2017 08/31/2018 Date/Time Prepared: 1/30/2019 11:15 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Description Amount Cost Center Line # Wkst. A-7 (2) Ref. 1.00 2.00 3.00 4.00 5.00 31.00 Adjustment for speech A-8-3 0 *** Cost Center Deleted *** 68.00 31.00 pathology costs in excess of limitation (chapter 14) 32.00 32.00 CAH HIT Adjustment for 0 0.00 Depreciation and Interest X-RAY COPY -825 RADI OLOGY-DI AGNOSTI C 33.00 В 54.00 33.00 33. 01 CAFETERI A -270, 756 CAFETERI A В 11.00 33.01 -12, 405 CAFETERI A 33.02 VENDI NG В 11.00 33.02 MEDICAL RECORDS 33.03 В -1, 320 MEDICAL RECORDS & LIBRARY 16.00 33.03 -1, 930 ADMINISTRATIVE & GENERAL 33.04 ED OTHER В 5.00 33.04 33 05 INCOME - COMP REHAB -99SUBPROVIDER - IRF 41 00 33 05 В -1, 081 ELECTROCARDI OLOGY 33.06 COMP REHAB В 69.00 33.06 33.07 OTHER REVENUE В -1, 168 ADMINISTRATIVE & GENERAL 5.00 33.07 -420 LABORATORY 33.08 PATHOLOGY SLIDES 60.00 33.08 В -88, 209 ADMINISTRATIVE & GENERAL 33 09 INTEREST INCOME B 5 00 ol 33 09 -88, 527 ADULTS & PEDIATRICS 33.10 HOSPI CE В 30.00 33.10 UNCLAIMED PROPERTY -3, 567 ADMINISTRATIVE & GENERAL 33.11 В 5.00 33.11 WORKER'S COMP. PAID CLAIMS 33. 12 Α -71, 202 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33.12 WORKER'S COMP INSURANCE 21, 075 EMPLOYEE BENEFITS DEPARTMENT 33.13 33.13 Α 4.00 33. 14 PATIENT TELEPHONES -9, 691 EMPLOYEE BENEFITS DEPARTMENT 4.00 33.14 Α PATIENT TELEPHONES -46, 539 ADMINISTRATIVE & GENERAL 33.15 Α 5.00 33.15 33. 16 PATIENT TV'S -35, 577 OPERATION OF PLANT 7.00 0 33, 16 Α 33.17 PATIENT TV'S Α -1, 801 DI ETARY 10.00 33.17 33. 18 PATIENT TV'S -3, 512 RADI OLOGY-DI AGNOSTI C 54.00 33.18 Α 33. 19 CONSULTING 900-317 Α -65, 753 ADMINISTRATIVE & GENERAL 5.00 33.19 ADMIN. TRAVEL 900-750 -4, 303 ADMINISTRATIVE & GENERAL 5.00 33.20 0 33, 20 Α ADMIN. MEALS 900-764 -3, 809 ADMINISTRATIVE & GENERAL 33. 21 Α 5.00 0 33.21 33.22 ADMIN. PARTIES & BANQUETS Α -800 ADMINISTRATIVE & GENERAL 5.00 33.22 900-760 33. 23 MISC. XXX870 -1.864 ADMINISTRATIVE & GENERAL 33. 23 Α 5.00 ol XXX870 -1, 946 OCCUPATIONAL MEDICINE 194.00 0 33.24 MISC. Α 33.24 33.25 MISC. XXX870 Α -660 OPERATING ROOM 50.00 33.25 NONPATIENT GIFTS 33. 26 Α -18, 334 ADMINISTRATIVE & GENERAL 5.00 33.26 NONPATIENT GIFTS 9.00 33. 27 -627 HOUSEKEEPI NG 0 Α 33.27 33. 28 NONPATIENT GIFTS Α -35 OPERATING ROOM 50.00 33.28 NONPATIENT GIFTS -3, 508 EMERGENCY 33. 29 Α 91.00 33. 29 33. 30 PATIENT GIFTS -101 ADMINISTRATIVE & GENERAL ol 5.00 33.30 Α -5, 611 ADMINISTRATIVE & GENERAL 33.31 ALCOHOL. Α 5.00 33.31 33. 32 ALCOHOL Α -63 ADULTS & PEDIATRICS 30.00 33.32 -7 INTENSIVE CARE UNIT 33.33 ALCOHOL Α 31.00 33.33 33 34 ALCOHOL -10SUBPROVIDER - IRF 41 00 33 34 Α -22 NURSERY 0 33.35 ALCOHOL Α 43.00 33.35 33. 36 ALCOHOL -10 OPERATING ROOM 50.00 33.36 Α 33.37 ALCOHOL -9 LABORATORY 60.00 33.37 Α 33.38 ALCOHOL -187 EMERGENCY 91.00 0 33.38 Α 33.39 ED ENT. NON EMPLOYEE Α -2, 715 EMERGENCY 91.00 0 33.39 COUNTRY CLUB DUES -2, 283 ADMINISTRATIVE & GENERAL 5.00 33.40 33.40 Α NONALLOWABLES 900805 -7, 106 ADMI NI STRATI VE & GENERAL 5.00 o 33.41 Α 33.41 PHYSICIAN RECRUITMENT 900827 -57, 002 ADMINISTRATIVE & GENERAL 33.42 Α 5.00 33.42 33. 43 CONTRI BUTI ONS -28, 064 ADMINISTRATIVE & GENERAL 5.00 0 33.43 Α OCC MEDCONTRIBUTION -1, 000 OCCUPATIONAL MEDICINE 33.44 Α 194.00 33.44 NONALLOWABLES 83 MED STAFF NONALLOWABLES 843 -109, 670 ADMINISTRATIVE & GENERAL 33.45 Α 5.00 0 33.45 -84, 318 ADMINISTRATIVE & GENERAL 33.46 PUBLIC RELATIONS DEPT. 920 Α 5.00 33.46 33.47 REHAB ADMPHYS RECR/CY DEPT 950 Α -9, 646 ADMINISTRATIVE & GENERAL 5.00 33.47 SALES DEPT. 965 -4, 832 ADMINISTRATIVE & GENERAL 5.00 33.48 33.48 Α LEGAL FEES -21, 777 ADMINI STRATI VE & GENERAL 33.49 Α 5.00 0 33.49 33.50 CLINICAL RESEARCH Α -1, 377 RADI OLOGY-THERAPEUTI C 55.00 33.50 33.51 CLINICAL RESEARCH Α -176 DRUGS CHARGED TO PATIENTS 73.00 33.51 CLINICAL RESEARCH -214 OPI C 33.52 76.04 33.52 Α -341 EMPLOYEE BENEFITS DEPARTMENT CLINICAL RESEARCH 33.53 Α 4.00 33.53 33.54 DEPRECIATION BUILDING Α 112 CAP REL COSTS-BLDG & FIXT 1.00 33.54 -977 CAP REL COSTS-MVBLE EQUIP 33.55 DEPRECIATION MME 2.00 33.55 Α -3, 302, 662 OPERATING ROOM 0 33.56 CRNA Α 50.00 33.56 33.57 NURSE PRACTITIONER Α -237, 611 OCCUPATIONAL MEDICINE 194.00 0 33.57 33. 58 NURSE PRACTITIONER -587 ADMINISTRATIVE & GENERAL 0 5.00 33.58

				T	o 08/31/2018	Date/Time Pre 1/30/2019 11:	pared: 15 am
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	cost center bescription	(2)	Allouit	COST Center	LITIE #	Ref.	
		1. 00	2. 00	3.00	4. 00	5. 00	
33. 59	LOBBYING DUES	A		ADMINISTRATIVE & GENERAL	5. 00	0.00	33. 59
33. 60	MOB ACCOUNTING	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 60
33. 61	MOB ACCOUNTING	Α		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 61
33. 62	USEFUL LIFE ADJUSTMENT	Α		CAP REL COSTS-BLDG & FIXT	1. 00	9	33. 62
33. 63	PHYSICIAN RECORDS STORAGE	Α	-43	OPERATION OF PLANT	7. 00	0	33. 63
33.64	ADVERTI SI NG	Α	-1, 116	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 64
33. 65	ADVERTI SI NG	Α	1, 011	ADMINISTRATIVE & GENERAL	5. 00	0	33. 65
33. 66	ADVERTI SI NG	Α	-101	MEDICAL RECORDS & LIBRARY	16. 00	0	33. 66
33. 67	ADVERTI SI NG	Α	-250	ADULTS & PEDIATRICS	30. 00	0	33. 67
33. 68	ADVERTI SI NG	Α	-48	SUBPROVI DER - I RF	41. 00	0	33. 68
33. 69	ADVERTI SI NG	Α		OPERATING ROOM	50. 00	0	33. 69
33. 70	ADVERTI SI NG	Α		ENDOSCOPY	76. 01	0	33. 70
33. 71	ADVERTI SI NG	Α	-205, 827	EMERGENCY	91. 00	0	33. 71
33. 72	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 72
	(3)		_			_	
33. 73	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 73
33. 74	(3)				0.00	0	22 74
33. /4	OTHER ADJUSTMENTS (SPECIFY) (3)		U		0. 00	Ü	33. 74
33. 75	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 75
33.73	(3)				0.00	U	33.73
50.00	TOTAL (sum of lines 1 thru 49)		-8, 599, 325				50.00
55.00	(Transfer to Worksheet A,		5, 5, 7, 625				55.00
	column 6, line 200.)						
(4) 0				0110 D 1 45 4			

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

 ⁽²⁾ Basis for adjustment (see instructions).
 A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

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

OFFICE COSTS

Line No.

Cost Center

Expense I tems

Amount of Allowable Cost Included in Wks. A, column 5

1.00

2.00

3.00

4.00

5.00

			·	Allowable Cost		
					Wks. A, column 5	
	1.00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	F TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAIMED HOME	
4 00	OFFICE COSTS:	IADMAN OTDATINE & OFNERAL	lupo	104 000	005 750	
1.00		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	HPG I T&S	101, 330 1, 880, 602	235, 753	1.00
2. 00 3. 00		ADMINISTRATIVE & GENERAL	HOME OFFICE COST	1, 880, 602	1, 874, 416 7, 444, 765	2. 00 3. 00
4. 00		ADMINISTRATIVE & GENERAL	HOME OFFICE DIRECT COMP.	268, 082	7, 444, 703	4. 00
4. 01		ADMINISTRATIVE & GENERAL	SSC STREET SOME.	2, 815, 615	2, 778, 791	4. 01
4. 02		ADMINISTRATIVE & GENERAL	SUPPLY CHAIN	1, 479, 935	1, 472, 646	4. 02
4. 03	5. 00	ADMINISTRATIVE & GENERAL	PARALLON WORKFORCE SOLUTIONS	-2, 754	-3, 015	4. 03
4.04	13. 00	NURSING ADMINISTRATION	PARALLON WORKFORCE SOLUTIONS	186, 246	203, 994	4.04
4. 05		ADULTS & PEDIATRICS	PARALLON WORKFORCE SOLUTIONS	1, 054, 020	1, 154, 457	4. 05
4. 06		INTENSIVE CARE UNIT	PARALLON WORKFORCE SOLUTIONS	80, 635	88, 319	4. 06
4. 07		SUBPROVI DER – I RF	PARALLON WORKFORCE SOLUTIONS	-1, 429	-1, 565	4. 07
4. 08		OPERATING ROOM	PARALLON WORKFORCE SOLUTIONS	54, 023	59, 171	4. 08
4. 09		RECOVERY ROOM	PARALLON WORKFORCE SOLUTIONS	702	769	4. 09
4. 10 4. 11		DELIVERY ROOM & LABOR ROOM CARDIAC CATHETERIZATION	PARALLON WORKFORCE SOLUTIONS PARALLON WORKFORCE SOLUTIONS	185, 068 37, 926	202, 703 41, 540	4. 10 4. 11
4. 11		MEDICAL SUPPLIES CHARGED TO	PARALLON WORKFORCE SOLUTIONS	2, 983	3, 267	4. 11
4. 12		EMERGENCY	PARALLON WORKFORCE SOLUTIONS	265, 210	290, 482	4. 13
4. 14		SITTERS	PARALLON WORKFORCE SOLUTIONS	507	555	4. 14
4. 15		ADMINISTRATIVE & GENERAL	PARALLON MARK-UP	0	748, 247	4. 15
4. 16		ADMINISTRATIVE & GENERAL	PARALLON PAYROLL	18, 790	35, 665	4. 16
4. 17	5. 00	ADMINISTRATIVE & GENERAL	CAPITAL DIVISION IT&S	1, 242, 202	1, 278, 436	4. 17
4. 18	16.00	MEDICAL RECORDS & LIBRARY	HIM	1, 026, 308	986, 423	4. 18
4. 19	5. 00	ADMINISTRATIVE & GENERAL	REVENUE INTEGRITY	106, 828	98, 425	4. 19
4. 20		ADMINISTRATIVE & GENERAL	CREDENTI ALI NG	73, 848	74, 036	4. 20
4. 21		SUBPROVI DER - I PF	BEHAVI ORAL HEALTH	93, 018	111, 692	4. 21
4. 22		ADMINISTRATIVE & GENERAL	I T&S PARALLON	378, 481	378, 481	4. 22
4. 23		MEDICAL RECORDS & LIBRARY	PREBILL DENIAL	29, 484	26, 387	4. 23
4. 24 4. 25		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	OTHER FUNCTIONAL	586, 853	567, 629	4. 24 4. 25
4. 25		OPERATION OF PLANT	CAD STORAGE	229, 855 33	229, 855 33	4. 25
4. 27		ADMINISTRATIVE & GENERAL	CALL CENTER	0	71, 301	4. 27
4. 28		ADMINISTRATIVE & GENERAL	PHYSI CLAN RECRUITING	0	88, 800	4. 28
4. 29		ADMINISTRATIVE & GENERAL	MALPRACTI CE	653, 013	963, 283	4. 29
4. 30		ADMINISTRATIVE & GENERAL	GENERAL LIABILITY INSURANCE	0	13, 964	4. 30
4. 31		ADMINISTRATIVE & GENERAL	PHYSICIAN SALES	0	240, 750	4. 31
4. 32	5. 00	ADMINISTRATIVE & GENERAL	MARKETING ALLOCATIONS	0	170, 112	4. 32
4. 33	5.00	ADMINISTRATIVE & GENERAL	RICHMOND FSC	206, 052	210, 925	4. 33
4. 34		EMPLOYEE BENEFITS DEPARTMENT	1	0	5, 109	4. 34
4. 35		EMPLOYEE BENEFITS DEPARTMENT	_	0	-332, 225	4. 35
4. 36		ADMINISTRATIVE & GENERAL	I NTERCOMPANY I NTEREST	570.0(1	-14, 134, 439	4. 36
4. 37		ADMINISTRATIVE & GENERAL	HOME OFFICE INTEREST	570, 061	0	4. 37
4. 38 4. 39		CAP REL COSTS-BLDG & FIXT ADMINISTRATIVE & GENERAL	POB SPACE POB SPACE	29, 012 21, 426	0	4. 38 4. 39
4. 40		OPERATION OF PLANT	POB SPACE	44, 558	0	4. 40
4. 41		HOUSEKEEPI NG	POB SPACE	5, 760	0	4. 41
4. 42		CAP REL COSTS-BLDG & FIXT	PAVILLION SPACE	189, 433	0	
4. 43		ADMINISTRATIVE & GENERAL	PAVILLION SPACE	2, 076	0	
4.44		OPERATION OF PLANT	PAVILLION SPACE	72, 921	0	4.44
4. 45	9.00	HOUSEKEEPI NG	PAVILLION SPACE	14, 833	0	4.45
4. 46	0.00	l .		0	0	4. 46
4. 47	0.00	l .		0	0	4. 47
4. 48	0.00			0	_ 0	4. 48
5. 00	TOTALS (sum of lines 1-4).			15, 916, 104	7, 679, 937	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2, line 12.					
* The	amounts on lines 1-4 (and sul	l :	t	rsheet A colum	- (!	

^{*} The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.

Positive amounts increase cost and negative amounts decrease cost.

For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable

should be indicated in column 4 of this part.

			Related Organization(s) and/	or Home Office
Symbol (1)	Name	Percentage of	Name	Percentage of
		Ownershi p		Ownershi p
1.00	2. 00	3. 00	4. 00	5. 00
B. INTERRELATIONSHIP TO RELATE	D ORGANIZATION(S) AND/OR HO	OME OFFICE:		

Health Financial Systems		TERRE HA	TERRE HAUTE REGIONAL HOSPITAL			In Lieu of Form CMS-2552-10		
STATEMENT OF COSTS OF SERVICE OFFICE COSTS	S FROM RELATE	D ORGANI ZATI ONS	AND HOME	Provider CCN:	15-0046	Peri od: From 09/01/2017	Worksheet A-8-1	
0.1.02 000.0						To 08/31/2018	Date/Time Prepared: 1/30/2019 11:15 am	

				1/30/2019 11:	<u>: 15 alli</u>
			Related Organization(s) and/or Home Offi		
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	

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 iibui	crimbul scilicité under title AVIII.				
6. 00	В	100.00 PARALLON 100.00	6. 00		
7.00	В	55. 08 HPG 55. 08	7.00		
8.00	В	100.00 HCI 100.00	8.00		
9. 00	В	100.00 CAPITAL DIVISIO 100.00	9.00		
10.00	В	100.00 WORKFORCE MGT. 100.00	10.00		
10. 01	В	100.00 HCA 100.00	10.01		
10. 02	В	100.00 POB 100.00	10.02		
100.00	G. Other (financial or		100.00		
	non-financial) specify:				

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

	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7. 00		
			MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME	
	OFFICE COSTS:	INED AND ADSOSTIN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED GROWN ZATIONS OF CEATINED HOME	
1.00	-134, 423	0		1. 00
2. 00				2. 00
	6, 186			
3.00	-5, 532, 207			3.00
4. 00	268, 082			4.00
4. 01	36, 824			4. 01
4. 02	7, 289			4. 02
4. 03	261			4. 03
4. 04	-17, 748			4. 04
4. 05	-100, 437	0		4. 05
4.06	-7, 684	0		4.06
4.07	136	0		4.07
4.08	-5, 148	0		4.08
4. 09	-67	0		4. 09
4. 10	-17, 635	o		4. 10
4. 11	-3, 614	l ol		4. 11
4. 12	-284	l o		4. 12
4. 13	-25, 272			4. 13
4. 14	-48			4. 14
4. 15	-748, 247			4. 15
4. 16	-16, 875			4. 16
4. 17	-36, 234			4. 17
4. 18	39, 885			4. 18
4. 19	8, 403			4. 19
4. 19	-188			4. 19
4. 20	-18, 674	1		4. 20
4. 21	-10,074			4. 21
4. 22	3, 097			
				4. 23
4. 24	19, 224			4. 24
4. 25	0			4. 25
4. 26	0			4. 26
4. 27	-71, 301			4. 27
4. 28	-88, 800			4. 28
4. 29	-310, 270	1		4. 29
4.30	-13, 964			4. 30
4. 31	-240, 750			4. 31
4.32	-170, 112			4.32
4. 33	-4, 873			4. 33
4.34	-5, 109	o		4.34
4. 35	332, 225			4.35
4. 36	14, 134, 439	o		4. 36
4. 37	570, 061			4. 37
4. 38	29, 012			4. 38
4. 39	21, 426	1		4. 39
4. 40	44, 558			4. 40
4. 41	5, 760			4. 41
4. 42	189, 433	1		4. 42
4. 43	2, 076	1		4. 43
4. 44	72, 921			4. 44
4. 45	14, 833			4. 45
4. 46	14, 655	1		4. 46
4. 40				4. 40
4. 47				4. 47
5. 00	8, 236, 167	1		5. 00
3. 00	0, 230, 107		and in detail to Manhart A column (Lines	5.00

 $^{^{\}star}$ 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.

should be that cated the column 4 of this part.					
	Related Organization(s)				
	and/or Home Office				
	and/or nome office				
	Type of Business				
	Type of business				
	6, 00				
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:			
		TED ORGANIZATION(S) AND/OR HOME OFFICE:			

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

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that

Health Financial Systems		TERRE HAUTE REGION	In Lieu of Form CMS-2552-10		
		RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0046	Peri od:	Worksheet A-8-1
OFFICE	COSTS			From 09/01/2017 To 08/31/2018	Date/Time Prepared:
				10 00/31/2016	1/30/2019 11:15 am
	Related Organization(s) and/or Home Office				
	Type of Business				
	6. 00				
the cos	ts applicable to services, fa	acilities, and supplies furnished	by organizations relate	ed to you by comm	on 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

reimbur	sement under title XVIII.		
6.00	MANAGEMENT	6.0	00
7. 00	PURCHASI NG	7.0	00
8. 00	I NSURANCE	8.0	00
9. 00	MANAGEMENT	9.0	00
10.00	STAFFING	10.0	00
10. 01	HOSPITAL MGT.	10.0	01
10. 02	PROFESSIONAL BU	10.0	ე2
100.00		100.0	00
		·	

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

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

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

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

					'	00/31/2010	1/30/2019 11:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3. 00	4.00	5. 00	6. 00	7. 00	
1. 00	30.00	ADULTS & PEDIATRICS	1, 528, 013	1, 528, 013	0	211, 500	0	1. 00
2.00	40. 00	SUBPROVIDER - IPF	660, 468	660, 468	0	181, 300	0	2. 00
3.00		NURSERY	161, 500		46, 700	169, 700	234	3.00
4.00	50. 00	OPERATING ROOM	1, 208, 321	1, 206, 251		246, 400	15	4.00
5.00	54. 00	RADI OLOGY-DI AGNOSTI C	-56, 619			271, 900	0	5. 00
6.00	65. 00	RESPIRATORY THERAPY	95, 250			211, 500	0	6. 00
7. 00	66. 00	PHYSICAL THERAPY	86, 775	21, 375	65, 400	211, 500	436	7. 00
8.00	69. 00	ELECTROCARDI OLOGY	32, 962	-3, 001	35, 963	211, 500	240	8. 00
9. 00	76. 01	ENDOSCOPY	93, 100	45, 100	48, 000	246, 400	240	9. 00
10.00	76. 03	WOUND CARE	36,000	0	36, 000	211, 500	240	10.00
11.00	76. 04		56, 100			211, 500	300	11. 00
12.00	91, 00	EMERGENCY	8, 265, 079		55, 000	211, 500	220	12.00
200.00			12, 166, 949		· ·	,	1, 925	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit		Memberships &		of Mal practice	
				Limit	Continuing	Share of col.	Insurance	
					Education	12		
	1.00	2.00	8. 00	9.00	12.00	13. 00	14.00	
1. 00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1. 00
2.00	40. 00	SUBPROVIDER - IPF	0	0	0	0	0	2.00
3.00	43. 00	NURSERY	19, 091	955	0	0	0	3.00
4.00	50. 00	OPERATING ROOM	1, 777	89	0	0	0	4.00
5.00	54. 00	RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	5.00
6.00	65. 00	RESPI RATORY THERAPY	0	0	0	0	0	6. 00
7.00	66. 00	PHYSICAL THERAPY	44, 334	2, 217	0	0	0	7. 00
8.00	69. 00	ELECTROCARDI OLOGY	24, 404	1, 220	0	0	0	8. 00
9.00	76. 01	ENDOSCOPY	28, 431	1, 422	0	0	0	9. 00
10.00	76. 03	WOUND CARE	24, 404	1, 220	0	0	0	10.00
11. 00	76. 04	OPI C	30, 505	1, 525	0	0	0	11. 00
12.00	91. 00	EMERGENCY	22, 370	1, 119	0	0	0	12.00
200.00			195, 316	9, 767	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADULTS & PEDIATRICS	0		_	1, 528, 013		1.00
2.00		SUBPROVI DER - I PF	0		_	660, 468		2.00
3.00		NURSERY	0			142, 409		3.00
4.00		OPERATING ROOM	0	.,		1, 206, 544		4.00
5.00		RADI OLOGY-DI AGNOSTI C	0	-	-	-56, 619		5.00
6. 00		RESPI RATORY THERAPY	0	-	J	95, 250		6.00
7. 00		PHYSI CAL THERAPY	0					7. 00
8. 00		ELECTROCARDI OLOGY	0		· ·	8, 558	•	8. 00
9. 00		ENDOSCOPY	0	,		64, 669		9. 00
10.00		WOUND CARE	0			11, 596		10.00
11. 00	76. 04		0	,	· ·	25, 595		11. 00
12.00	91. 00	EMERGENCY	0		· ·	· ·	•	12.00
200.00			0	195, 316	149, 917	11, 971, 633		200.00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 09/01/2017 Part I Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0046

				To	rom 09/01/2017 o 08/31/2018	Part I Date/Time Pre	
			CAPI TAL REI	LATED COSTS		1/30/2019 11:	15 am
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	cost conto. Boson per on	for Cost	5250 a		BENEFI TS		
		Allocation (from Wkst A			DEPARTMENT		
		col. 7)					
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4. 00	4A	
1. 00	00100 CAP REL COSTS-BLDG & FIXT	3, 558, 819	3, 558, 819				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	3, 526, 308	,,,,,,	3, 526, 308			2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	8, 301, 620	16, 333		8, 334, 137		4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	26, 394, 567 4, 076, 465	325, 692 928, 467		1, 110, 286 156, 864	28, 153, 262 6, 081, 780	5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	756, 602	38, 192		130, 004	832, 637	8.00
9. 00	00900 HOUSEKEEPI NG	1, 301, 470	27, 095		205, 224	1, 560, 637	9. 00
10.00	01000 DI ETARY 01100 CAFETERI A	1, 517, 664	56, 860		28, 999	1, 659, 864	1
11. 00 13. 00	01300 NURSI NG ADMI NI STRATI ON	289, 129 1, 003, 851	34, 323 11, 487		10, 922 170, 964	368, 383 1, 197, 684	13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 072, 771	8, 278		3, 954	1, 093, 206	16.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	7 402 205	FF2 20F	T 47 250	1 274 257	0.77/ 20/	1 20 00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	7, 402, 385 2, 484, 494	552, 295 113, 450		1, 274, 356 450, 443	9, 776, 286 3, 160, 801	30.00 31.00
40. 00	04000 SUBPROVI DER - I PF	2, 144, 531	98, 149		428, 620	2, 768, 553	1
41. 00	04100 SUBPROVI DER - I RF	952, 448	92, 857		196, 357	1, 333, 671	41.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	376, 875	21, 263	21, 069	66, 231	485, 438	43.00
50. 00	05000 OPERATING ROOM	4, 922, 738	273, 259	270, 763	907, 806	6, 374, 566	50.00
51. 00	05100 RECOVERY ROOM	579, 421	14, 734		112, 107	720, 861	51.00
52. 00 54. 00	05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C	1, 100, 537 1, 678, 810	44, 080 154, 000		180, 261	1, 368, 555 2, 203, 315	
54. 00	03630 ULTRA SOUND	1, 678, 610	154, 098 13, 971		217, 717 37, 227	254, 733	
54. 02	03440 MAMMOGRAPHY	202, 757	31, 458		26, 491	291, 876	
55. 00	05500 RADI OLOGY-THERAPEUTI C	988, 212	40, 675		136, 494	1, 205, 685	1
56. 00 57. 00	05600	782, 131 743, 546	9, 739 17, 357		37, 175 123, 481	838, 695 901, 582	56.00 57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	352, 927	17, 291		57, 153	444, 505	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	540, 747	21, 328		118, 383	701, 591	59.00
60. 00 62. 00	O6000 LABORATORY O6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 942, 393 662, 576	65, 622 2, 911		285, 762 0	3, 358, 800 668, 372	60.00 62.00
65. 00	06500 RESPIRATORY THERAPY	1, 159, 734	17, 552		212, 131	1, 406, 809	1
66. 00	06600 PHYSI CAL THERAPY	1, 003, 434	67, 789	67, 170	203, 993	1, 342, 386	66.00
69. 00 70. 00	06900 ELECTROCARDI OLOGY	826, 478	40, 378		107, 361	1, 014, 226	
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	65, 065 6, 928, 665	4, 958 60, 023		11, 039 85, 557	85, 974 7, 133, 719	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	6, 321, 697	0		0	6, 321, 697	1
73.00	07300 DRUGS CHARGED TO PATIENTS	12, 465, 839	41, 364		343, 893	12, 892, 082	73.00
74. 00 76. 00	07400 RENAL DI ALYSI S 03950 LI THOTRI PSY	536, 895 231, 984	9, 208 0		16 0	555, 243 231, 984	1
76. 01	03330 ENDOSCOPY	1, 112, 342	14, 734	_	177, 691	1, 319, 366	
	03040 PRISION CLINIC	157, 668				272, 157	
76. 03 76. 04	03050 WOUND CARE 03060 OPI C	619, 123 541, 536	23, 812 41, 206		15, 180 105, 892	681, 709 729, 463	
70.04	OUTPATIENT SERVICE COST CENTERS	341, 330	41, 200	40, 829	103, 692]	727, 403	70.04
	09100 EMERGENCY	3, 087, 745	130, 779	129, 584	485, 499		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS					0	92.00
118.00		115, 904, 691	3, 524, 291	3, 492, 096	8, 123, 946	115, 625, 760	118. 00
100.00	NONREI MBURSABLE COST CENTERS	40 507	F 2/F	F 247		(0.070	100.00
	1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1920 PHYSICIANS' PRIVATE OFFICES	49, 597 0	5, 265 0	1	0	60, 079 0	190.00
	07950 OCCUPATI ONAL MEDI CI NE	539, 268	29, 263	_	148, 163	745, 689	194. 00
	07951 UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	0		194. 01
	207952 SI TTERS 307953 UNLI CENSED STAFF	263, 429 25, 610	0	0	56, 510 5, 518	319, 939 31, 128	
200.00	1 1	25,010			5, 510	0 0	200.00
201.00	Negative Cost Centers		0	_	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	116, 782, 595	3, 558, 819	3, 526, 308	8, 334, 137	116, 782, 595	J202. 00

Provider CCN: 15-0046

			To	08/31/2018	Date/Time Pre 1/30/2019 11:	
Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	15 alli
oust content besoft per on	E & GENERAL	PLANT	LINEN SERVICE	HOUSEREELTHO	DI LIMIN	
	5. 00	7. 00	8.00	9. 00	10.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	28, 153, 262					5.00
7.00 00700 OPERATION OF PLANT	1, 931, 890	8, 013, 670				7.00
8.00 00800 LAUNDRY & LINEN SERVICE	264, 489	133, 747	1, 230, 873			8.00
9. 00 00900 HOUSEKEEPI NG	495, 739	94, 887	0	2, 151, 263		9.00
10. 00 01000 DI ETARY	527, 259	199, 123	0	55, 024	2, 441, 270	10.00
11. 00 01100 CAFETERI A	117, 018	120, 197	0	33, 214	0	11.00
13.00 01300 NURSING ADMINISTRATION	380, 447	40, 228	0	11, 116	0	13.00
16.00 01600 MEDICAL RECORDS & LIBRARY	347, 259	28, 991	0	8, 011	0	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	3, 105, 457	1, 934, 124		534, 463	1, 024, 877	30.00
31.00 03100 INTENSIVE CARE UNIT	1, 004, 035	397, 301		109, 787	79, 679	31.00
40. 00 04000 SUBPROVI DER - 1 PF	879, 436	343, 717		94, 980		40. 00
41. 00 04100 SUBPROVI DER - I RF	423, 643	325, 183		89, 859	156, 073	41. 00
43. 00 04300 NURSERY	154, 200	74, 463	41, 042	20, 577	0	43. 00
ANCILLARY SERVICE COST CENTERS			_		_	
50. 00 05000 OPERATI NG ROOM	2, 024, 894	956, 948		264, 437	0	50.00
51. 00 05100 RECOVERY ROOM	228, 983	51, 597		14, 258	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	434, 724	154, 366		42, 657	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	699, 887	539, 648		149, 122	0	54.00
54. 01 03630 ULTRA SOUND	80, 916	48, 926		13, 520	0	54. 01
54. 02 03440 MAMMOGRAPHY	92, 715	110, 164		30, 442	0	54.02
55. 00 05500 RADI OLOGY-THERAPEUTI C	382, 988	142, 445		39, 362	0	55.00
56. 00 05600 RADI 01 SOTOPE	266, 413	34, 105		9, 424	0	56. 00
57. 00 05700 CT SCAN	286, 389	60, 782		16, 796	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	141, 198	60, 554		16, 733	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	222, 862	74, 691		20, 640	0	59.00
60. 00 06000 LABORATORY	1, 066, 930	229, 807		63, 503	0	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	212, 310	10, 196	1	2, 817	0	62.00
65. 00 06500 RESPIRATORY THERAPY	446, 876	61, 466		16, 985	0	65.00
66. 00 06600 PHYSI CAL THERAPY	426, 412	237, 397		65, 601	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	322, 171	141, 402		39, 074	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	27, 310	17, 362		4, 798	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 266, 040	210, 198	1	58, 085	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	2, 008, 100	144 055	-	40.020	0	72.00
· · · · · · · · · · · · · · · · · · ·	4, 095, 173	144, 855		40, 028 8, 911	0	73. 00 74. 00
74. 00 07400 RENAL DI ALYSI S 76. 00 03950 LI THOTRI PSY	176, 374 73, 690	32, 248 0		0, 911	0	76.00
76. 00 03330 ENDOSCOPY	419, 099	51, 597		14, 258	0	76.00
76. 02 03040 PRI SI ON CLI NI C	86, 451	144, 366		39, 893	0	76. 01
76. 03 03050 WOUND CARE	216, 546	83, 389		23, 043	0	76. 02
76. 04 03060 OPI C	231, 715	144, 301		39, 875	0	76. 04
OUTPATIENT SERVICE COST CENTERS	251, 715	144, 301		37, 073	0	70.04
91. 00 09100 EMERGENCY	1, 217, 753	457, 985	0	126, 557	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,217,700	107, 700		120, 007	Ŭ	92.00
SPECIAL PURPOSE COST CENTERS						72.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	27, 785, 791	7, 892, 756	1, 230, 873	2, 117, 850	1, 615, 078	118.00
NONREI MBURSABLE COST CENTERS		.,,	1, 200, 0.0	=,,	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19, 084	18, 437	0	5, 095	0	190. 00
192. 00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194. 00 07950 OCCUPATIONAL MEDICINE	236, 870	102, 477	0	28, 318		194.00
194. 01 07951 UNOCCUPIED SPACE/NONALLOWABLE MEALS	o	. 0	o	0	826, 192	194. 01
194. 02 07952 SI TTERS	101, 629	0	ol	0		194. 02
194. 03 07953 UNLI CENSED STAFF	9, 888	0	o	0		194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	o	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	28, 153, 262	8, 013, 670	1, 230, 873	2, 151, 263	2, 441, 270	202. 00
	·					

Period: Worksheet B
From 09/01/2017 Part I Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0046

					o 08/31/2018		pared: 15 am
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O N	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	ie am
		11. 00	13. 00	16. 00	24.00	25. 00	
4 00	GENERAL SERVICE COST CENTERS		1	<u> </u>	T		
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7.00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8. 00 9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A	638, 812					11. 00
13.00	01300 NURSING ADMINISTRATION	16, 010					13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	370	0	1, 477, 837	1		16. 00
30.00	03000 ADULTS & PEDIATRICS	119, 326	644, 797	42, 764	17, 869, 405	0	30. 00
31.00	03100 INTENSIVE CARE UNIT	42, 181	224, 107			0	31.00
40.00	04000 SUBPROVI DER - I PF	40, 137					40.00
41.00	04100 SUBPROVI DER - I RF	18, 387					41.00
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	6, 202	34, 204	3, 861	819, 987	0	43. 00
50.00	05000 OPERATING ROOM	85, 010	254, 764	206, 251	10, 166, 870	0	50.00
51.00	05100 RECOVERY ROOM	10, 498		27, 372			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	16, 880				0	52. 00 54. 00
54. 00 54. 01	03630 ULTRA SOUND	20, 388 3, 486	1	28, 181 9, 853		0	54.00
54. 02	03440 MAMMOGRAPHY	2, 481	Ö	3, 792		_	54. 02
55.00	05500 RADI OLOGY-THERAPEUTI C	12, 782	0			0	55. 00
56.00	05600 RADI OI SOTOPE	3, 481	0	,			56.00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	11, 563 5, 352	1			0 0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	11, 086	l i	49, 146		ő	59.00
60.00	06000 LABORATORY	26, 760				0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	10.045		,		0	62.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	19, 865 19, 103	1	34, 504 13, 368		0	65. 00 66. 00
69. 00	06900 ELECTROCARDI OLOGY	10, 054	1			ő	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 034	0	2, 627		0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 012					71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	32, 203	0	50, 333 222, 859			72. 00 73. 00
74. 00	07400 RENAL DIALYSIS	1	0			ő	74.00
76.00	03950 LI THOTRI PSY	0	О	6, 225	311, 899	0	76. 00
76. 01	03330 ENDOSCOPY	16, 640					76. 01
76. 02	03040 PRISION CLINIC 03050 WOUND CARE	3, 036 1, 421	0				76. 02 76. 03
	03060 OPI C	9, 916					76.03
	OUTPATIENT SERVICE COST CENTERS	, -		,	, , , , , , , , , , , , , , , , , , , ,		
	09100 EMERGENCY	45, 464	0	124, 563	5, 805, 929		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS					0	92.00
118.00		619, 129	1, 643, 335	1, 477, 837	114, 255, 937	0	118. 00
	NONREI MBURSABLE COST CENTERS		, , , , , , , , , , , , , , , , , , , ,	,			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1		1		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OCCUPATIONAL MEDICINE	0 13, 874	0				192. 00 194. 00
	07951 UNOCCUPI ED SPACE/NONALLOWABLE MEALS	13, 8/4					194. 00
194. 02	07952 SI TTERS	5, 292		d	429, 010	0	194. 02
	07953 UNLI CENSED STAFF	517	0	C	41, 533		194. 03
200. 00 201. 00		_	0	,	0		200. 00 201. 00
202.00		638, 812	1, 645, 485	1, 477, 837	116, 782, 595		201.00
	, , ,	•	,		•	•	•

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

| Peri od: | Worksheet B | From 09/01/2017 | Part I | To 08/31/2018 | Date/Time Prepared:

			10 08/31/2018 Date/Time Pre	
	Cost Center Description	Total	1,700,7201,711.	1
	·	26. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FLXT			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL			5.00
7. 00	00700 OPERATION OF PLANT			7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE			8.00
9. 00	00900 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10.00
11. 00	01100 CAFETERI A			11.00
13. 00	01300 NURSING ADMINISTRATION			13.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY			16. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	17.0/0.405		00.00
30.00	03000 ADULTS & PEDI ATRI CS	17, 869, 405		30.00
	03100 I NTENSI VE CARE UNI T	5, 175, 430		31.00
	04000 SUBPROVI DER - I PF	4, 924, 028		40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF	2, 519, 565		41.00
43.00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	819, 987		43.00
50. 00	05000 OPERATING ROOM	10, 166, 870		50.00
51.00	05100 RECOVERY ROOM	1, 106, 360		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 122, 695		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 640, 541		54.00
54. 00	03630 ULTRA SOUND	411, 434		54.00
54. 01	03440 MAMMOGRAPHY	531, 470		54.02
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 814, 294		55.00
56. 00	05600 RADI OI SOTOPE	1, 175, 760		56.00
57. 00	05700 CT SCAN	1, 384, 086		57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	692, 526		58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 104, 553		59.00
60.00	06000 LABORATORY	4, 886, 981		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	905, 535		62.00
65.00	06500 RESPI RATORY THERAPY	1, 986, 505		65.00
66.00	06600 PHYSI CAL THERAPY	2, 104, 304		66.00
69.00	06900 ELECTROCARDI OLOGY	1, 578, 836		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	139, 105		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 771, 423		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	8, 380, 130		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	17, 427, 200		73.00
	07400 RENAL DIALYSIS	780, 924		74. 00
	03950 LI THOTRI PSY	311, 899		76. 00
76. 01	03330 ENDOSCOPY	1, 961, 999		76. 01
	03040 PRI SI ON CLI NI C	547, 040		76. 02
76. 03	03050 WOUND CARE	1, 010, 725		76. 03
76. 04	03060 OPI C	1, 198, 398		76. 04
04 00	OUTPATIENT SERVICE COST CENTERS	5 005 000		04.00
91.00	09100 EMERGENCY	5, 805, 929		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
440.00	SPECIAL PURPOSE COST CENTERS	444 055 007		110 00
118.00		114, 255, 937		118. 00
100.00	NONREI MBURSABLE COST CENTERS	100 (05		100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	102, 695		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	1 127 229		192.00
	07950 OCCUPATI ONAL MEDI CI NE	1, 127, 228		194.00
	07951 UNOCCUPIED SPACE/NONALLOWABLE MEALS	826, 192		194. 01
	07952 SI TTERS 07953 UNLI CENSED STAFF	429, 010		194. 02
		41, 533 0		194. 03 200. 00
200. 00 201. 00		0		200.00
201.00		116, 782, 595		202.00
202.00	TOTAL (Sum Times 110 till dagit 201)	110, 102, 393		1202.00

| Peri od: | Worksheet B | From 09/01/2017 | Part II | To 08/31/2018 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0046

				To	08/31/2018	Date/Time Pre 1/30/2019 11:	pared:
			CAPITAL REI	LATED COSTS		1/30/2019 11.	15 alli
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New Capital				BENEFI TS DEPARTMENT	
		Related Costs				DEFARTMENT	
		0	1.00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0	14 222	14 104	22 517	22 E17	2.00 4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	2, 339, 840	16, 333 325, 692		32, 517 2, 988, 249	32, 517 4, 330	5.00
7. 00	00700 OPERATION OF PLANT	2, 337, 040	928, 467		1, 848, 451	612	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	38, 192		76, 035	0	8. 00
9. 00	00900 HOUSEKEEPI NG	0	27, 095		53, 943	800	9. 00
10.00	01000 DI ETARY	0	56, 860	1	113, 201	113	1
11.00	01100 CAFETERI A	1, 098	34, 323	1	68, 332	43	11.00
13. 00 16. 00	O1300 NURSI NG ADMI NI STRATI ON O1600 MEDI CAL RECORDS & LI BRARY	10, 377	11, 487 8, 278		23, 967 26, 858	667 15	13. 00 16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	10, 377	0,270	0, 203	20, 030	13	10.00
30.00	03000 ADULTS & PEDIATRICS	6, 218	552, 295	547, 250	1, 105, 763	4, 987	30. 00
31.00	03100 INTENSIVE CARE UNIT	476			226, 340	1, 757	1
40.00	04000 SUBPROVI DER – I PF	0			195, 402	1, 671	40.00
41. 00 43. 00	O4100 SUBPROVI DER - I RF O4300 NURSERY	-8 0	1	1	184, 858	766 258	1
43.00	ANCI LLARY SERVICE COST CENTERS	0	21, 263	21, 069	42, 332	200	43.00
50. 00	05000 OPERATI NG ROOM	319	273, 259	270, 763	544, 341	3, 540	50.00
51.00	05100 RECOVERY ROOM	4	14, 734		29, 337	437	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 092	44, 080		88, 849	703	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	154, 098		306, 788	849	
54. 01 54. 02	03630 ULTRA SOUND 03440 MAMMOGRAPHY	0	13, 971 31, 458		27, 814 62, 628	145 103	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	40, 675		80, 979	532	
56. 00	05600 RADI OI SOTOPE	0	9, 739		19, 389	145	1
57.00	05700 CT SCAN	0	17, 357	17, 198	34, 555	482	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	17, 291		34, 425	223	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	224	21, 328		42, 685	462	1
60. 00 62. 00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	65, 622 2, 911		130, 645 5, 796	1, 114 0	60.00 62.00
65. 00	06500 RESPIRATORY THERAPY	0	17, 552		34, 944	827	65.00
66. 00	06600 PHYSI CAL THERAPY	0	67, 789	1	134, 959	795	
69. 00	06900 ELECTROCARDI OLOGY	0	40, 378	40, 009	80, 387	419	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	4, 958	1	9, 870	43	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	18	1	1	119, 515	334	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0 41, 364		0 82, 350	0 1, 341	72.00 73.00
74. 00	07400 RENAL DIALYSIS	0	9, 208	1	18, 332	0	74.00
76.00	03950 LI THOTRI PSY	0	0	1	0	0	76.00
76. 01	03330 ENDOSCOPY	0	14, 734	1	29, 333	693	1
76. 02	03040 PRI SI ON CLI NI C	0	41, 224		82, 072	126	
	03050 WOUND CARE	0	23, 812 41, 206		47, 406	59	
76. 04	03060 OPI C OUTPATI ENT SERVI CE COST CENTERS	0	41, 200	40, 829	82, 035	413	76. 04
91. 00	09100 EMERGENCY	1, 565	130, 779	129, 584	261, 928	1, 893	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0	,	92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	2, 361, 223	3, 524, 291	3, 492, 096	9, 377, 610	31, 697	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		5, 265	5, 217	10, 482	0	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	J 3, 265	3, 217 N	10, 482 N		190.00
	07950 OCCUPATI ONAL MEDI CI NE		29, 263	28, 995	58, 258		194. 00
	07951 UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	0		194. 01
	07952 SI TTERS	3	0	0	3		194. 02
	07953 UNLI CENSED STAFF	0	0	0	0	22	194. 03
200. 00 201. 00		1	_		0	0	200. 00 201. 00
201.00		2, 361, 226	3, 558, 819	3, 526, 308	9, 446, 353		201.00
00	1 1 1 1 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2	_, 55., 220	_,,,,	1, 525, 550	.,,	32,317	,

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0046

Period: Worksheet B From 09/01/2017 Part II To 08/31/2018 Date/Time Prepared:

1/30/2019 11:15 am Cost Center Description ADMINISTRATIV OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY E & GENERAL PLANT LINEN SERVICE 9. 00 5.00 7.00 10.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 2, 992, 579 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 205, 351 2, 054, 414 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 28, 114 34, 288 138, 437 8.00 00900 HOUSEKEEPI NG 52 695 24, 326 131, 764 9 00 9 00 0 10.00 01000 DI ETARY 56,045 51,048 0 3, 370 223, 777 10.00 2, 034 01100 CAFETERI A 12, 438 0 0 11.00 30, 814 11.00 13.00 01300 NURSING ADMINISTRATION 40, 440 10, 313 0 681 0 13.00 01600 MEDICAL RECORDS & LIBRARY 36, 912 16.00 7.432 491 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 495, 838 30.00 03000 ADULTS & PEDIATRICS 330, 096 77.302 32, 735 93, 945 30.00 03100 INTENSIVE CARE UNIT 106, 724 101, 853 6,724 7, 304 31.00 15, 536 31.00 40.00 04000 SUBPROVI DER - I PF 5, 818 32, 490 93, 480 88, 117 31, 110 40.00 41.00 04100 SUBPROVI DER - I RF 45, 031 83, 365 9,873 5,504 14, 306 41.00 04300 NURSERY 43.00 16, 391 19,090 4,616 1, 260 0 43.00 ANCILLARY SERVICE COST CENTERS 50 00 215, 237 245, 327 50.00 05000 OPERATING ROOM 0 16, 197 0 05100 RECOVERY ROOM 24, 340 13, 228 0 873 51.00 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 46, 209 39, 574 2,613 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 74.395 54.00 138, 346 9, 134 0 54.00 54.01 03630 ULTRA SOUND 8,601 12, 543 828 0 54.01 54.02 03440 MAMMOGRAPHY 9,855 28, 242 0 1,865 0 54.02 05500 RADI OLOGY-THERAPEUTI C 0 40.710 2, 411 55.00 36, 518 0 55.00 οĺ 56.00 05600 RADI OI SOTOPE 28.319 8, 743 577 0 56.00 05700 CT SCAN 30, 442 15, 582 0 1,029 0 57.00 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 15,009 15, 524 1,025 0 58.00 05900 CARDI AC CATHETERI ZATI ON 23, 689 0 59.00 19, 148 1, 264 0 59.00 0 60.00 06000 LABORATORY 113, 410 58, 914 3,890 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 22, 568 2, 614 173 0 62.00 06500 RESPIRATORY THERAPY 0 47, 501 15, 758 1,040 0 65.00 65.00 0 06600 PHYSI CAL THERAPY 45.326 66,00 60,860 4.018 0 66.00 69.00 06900 ELECTROCARDI OLOGY 34, 245 36, 250 2, 393 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 2,903 4, 451 294 0 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 240.870 53, 887 0 71.00 3.558 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72.00 213, 452 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 435, 312 37, 136 0 73.00 2, 452 0 73.00 07400 RENAL DIALYSIS 18, 748 8, 267 0 74.00 546 0 74.00 76 00 03950 LI THOTRI PSY 7 833 0 Ω 76 00 0 03330 ENDOSCOPY 0 76.01 44, 548 13, 228 873 0 76.01 03040 PRISION CLINIC 9, 189 37, 010 0 2, 443 0 76.02 76.02 76.03 03050 WOUND CARE 23, 018 21, 378 0 1, 411 0 76.03 36, 994 03060 OPLC 0 76.04 76.04 24,630 2.442 0 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 129, 442 117, 411 0 7, 752 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 953, 518 2, 023, 417 138, 437 129, 718 148, 045 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190 00 0 2 029 4.726 312 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 192.00 194.00 07950 OCCUPATIONAL MEDICINE 0 0 194.00 25, 178 26, 271 1.734 194. 01 07951 UNOCCUPI ED SPACE/NONALLOWABLE MEALS 0 75, 732 194. 01 C 0 0 194.02 194, 02 07952 SI TTERS 10 803 C 0 0 194. 03 07953 UNLICENSED STAFF 1,051 0 0 0 194.03 C 200. 00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 201, 00 202.00 TOTAL (sum lines 118 through 201) 2, 992, 579 2, 054, 414 138 437 131, 764 223, 777 202. 00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 09/01/2017 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0046

					To	com 09/01/2017 o 08/31/2018	Part II Date/Time Pre 1/30/2019 11:	
		Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O N	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown	13 aiii
							Adjustments	
	CENED	AL CEDIUCE COST CENTERS	11. 00	13. 00	16. 00	24. 00	25. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT				I		1.00
2. 00	1	CAP REL COSTS-MVBLE EQUIP						2.00
4. 00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00		ADMINISTRATIVE & GENERAL						5.00
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00		HOUSEKEEPI NG						9. 00
10.00	1	DI ETARY						10.00
11.00	1	CAFETERI A	113, 661	70 01/				11.00
13. 00 16. 00	1	NURSING ADMINISTRATION MEDICAL RECORDS & LIBRARY	2, 848 66		71, 774			13. 00 16. 00
10.00		I ENT ROUTINE SERVICE COST CENTERS		<u> </u>	71,771			10.00
30.00		ADULTS & PEDIATRICS	21, 238		2, 084	2, 194, 912	0	30.00
31.00	1	INTENSIVE CARE UNIT	7, 505		946	485, 437	0	31.00
40. 00 41. 00		SUBPROVI DER – I PF SUBPROVI DER – I RF	7, 141 3, 271	5, 596 3, 818	2, 412 261	463, 237 351, 053	0	40. 00 41. 00
43. 00	1	NURSERY	1, 103		188	86, 878	0	43.00
		LARY SERVICE COST CENTERS						
50.00	1	OPERATING ROOM	15, 125		10, 053	1, 062, 038	0	50.00
51. 00 52. 00	1	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	1, 868 3, 003		1, 334 443	73, 949 186, 018	0	51.00 52.00
54. 00		RADI OLOGY-DI AGNOSTI C	3, 627	0	1, 374	534, 513	0	54.00
54. 01	1	ULTRA SOUND	620	o	480	51, 031	0	54. 01
54. 02	1	MAMMOGRAPHY	441	0	185	103, 319	0	54. 02
55. 00 56. 00		RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	2, 274 619	0	1, 513 1, 152	164, 937 58, 944	0	55. 00 56. 00
57. 00	1	CT SCAN	2, 057	Ö	5, 214	89, 361	0	57.00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	952		1, 179	68, 337	0	58. 00
59.00		CARDI AC CATHETERI ZATI ON	1, 972		2, 395	92, 792	0	59.00
60. 00 62. 00	1	LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELLS	4, 761 0	0	6, 881 577	319, 615 31, 728	0	60.00 62.00
65. 00	1	RESPIRATORY THERAPY	3, 534	Ö	1, 682	105, 286	0	65.00
66.00		PHYSI CAL THERAPY	3, 399		652	250, 011	0	66. 00
69.00	1	ELECTROCARDI OLOGY	1, 789		1, 836	158, 002	0	69.00
70. 00 71. 00	1	ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	184 1, 425	0 44	128 4, 603	17, 873 424, 236	0	70.00 71.00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	0	2, 453	215, 905	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5, 730		10, 607	574, 928	0	73. 00
74.00		RENAL DI ALYSI S	0	0	397	46, 290	0	74.00
76. 00 76. 01	1	LI THOTRI PSY ENDOSCOPY	2, 960	0 3, 289	303 3, 532	8, 136 98, 456	0	76. 00 76. 01
76. 02		PRISION CLINIC	540		55	131, 435	0	76.01
76. 03	03050	WOUND CARE	253	o	225	93, 750	0	
76. 04	03060		1, 764	1, 518	559	150, 355	0	76. 04
91. 00		TIENT SERVICE COST CENTERS EMERGENCY	8, 089	0	6, 071	532, 586	0	91.00
	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0,007		0,071	332, 300		92. 00
118.00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	110, 158	78, 813	71, 774	9, 225, 348	0	118. 00
	NONRE	IMBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1	0	17, 549		190. 00 192. 00
		PHYSICIANS' PRIVATE OFFICES OCCUPATIONAL MEDICINE	2, 469	0	0	0 114, 488		192.00 194.00
	1	UNOCCUPIED SPACE/NONALLOWABLE MEALS	2, 707	Ö	0	75, 732		194. 01
		SITTERS	942	103	0	12, 071		194. 02
194. 03 200. 00		UNLICENSED STAFF Cross Foot Adjustments	92	0	0	1, 165 0		194. 03 200. 00
200.00		Negative Cost Centers	0	0	n	ol Ol		200.00
202.00		TOTAL (sum lines 118 through 201)	113, 661	1	71, 774	9, 446, 353		202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS TERRE HAUTE REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0046

Peri od: Worksheet B From 09/01/2017 Part II To 08/31/2018 Date/Time Prepared:

			1/30/2019 1	
	Cost Center Description	Total		
		26. 00		
G	ENERAL SERVICE COST CENTERS			
	0100 CAP REL COSTS-BLDG & FLXT			1.00
	0200 CAP REL COSTS-MVBLE EQUIP			2.00
4.00 0	0400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00 0	0500 ADMINISTRATIVE & GENERAL			5. 00
7.00 0	0700 OPERATION OF PLANT			7. 00
	0800 LAUNDRY & LINEN SERVICE			8. 00
9.00 0	0900 HOUSEKEEPI NG			9. 00
10.00 0	1000 DI ETARY			10.00
11.00 0	1100 CAFETERI A			11.00
	1300 NURSI NG ADMI NI STRATI ON			13.00
16. 00 0	1600 MEDICAL RECORDS & LIBRARY			16. 00
	NPATIENT ROUTINE SERVICE COST CENTERS			
	3000 ADULTS & PEDIATRICS	2, 194, 912		30.00
	3100 INTENSIVE CARE UNIT	485, 437		31.00
	4000 SUBPROVI DER - I PF	463, 237		40. 00
	4100 SUBPROVI DER – I RF	351, 053		41.00
	4300 NURSERY	86, 878		43. 00
	NCILLARY SERVICE COST CENTERS			
	5000 OPERATING ROOM	1, 062, 038		50.00
	5100 RECOVERY ROOM	73, 949		51.00
	5200 DELIVERY ROOM & LABOR ROOM	186, 018		52. 00
	5400 RADI OLOGY-DI AGNOSTI C	534, 513		54.00
	3630 ULTRA SOUND	51, 031		54. 01
1	3440 MAMMOGRAPHY	103, 319		54. 02
	5500 RADI OLOGY-THERAPEUTI C	164, 937		55. 00
	5600 RADI OI SOTOPE	58, 944		56. 00
	5700 CT SCAN	89, 361		57.00
	5800 MAGNETIC RESONANCE IMAGING (MRI)	68, 337		58. 00
	5900 CARDI AC CATHETERI ZATI ON	92, 792		59. 00
	6000 LABORATORY	319, 615		60.00
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	31, 728		62. 00
65. 00 0	6500 RESPI RATORY THERAPY	105, 286		65. 00
66. 00 0	6600 PHYSI CAL THERAPY	250, 011		66. 00
	6900 ELECTROCARDI OLOGY	158, 002		69. 00
	7000 ELECTROENCEPHALOGRAPHY	17, 873		70. 00
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	424, 236		71.00
	7200 IMPL. DEV. CHARGED TO PATIENTS	215, 905		72. 00
	7300 DRUGS CHARGED TO PATIENTS	574, 928		73. 00
	7400 RENAL DI ALYSI S	46, 290		74.00
76. 00 0	3950 LI THOTRI PSY	8, 136		76. 00
76. 01 0	3330 ENDOSCOPY	98, 456		76. 01
	3040 PRISION CLINIC	131, 435		76. 02
	3050 WOUND CARE	93, 750		76. 03
76. 04 0	3060 OPI C	150, 355		76. 04
0	UTPATIENT SERVICE COST CENTERS			
	9100 EMERGENCY	532, 586		91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)			92. 00
S	PECIAL PURPOSE COST CENTERS			
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	9, 225, 348		118. 00
	ONREIMBURSABLE COST CENTERS			
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	17, 549		190. 00
	9200 PHYSICIANS' PRIVATE OFFICES	0		192. 00
194. 00 0	7950 OCCUPATIONAL MEDICINE	114, 488		194. 00
194. 01 0	7951 UNOCCUPIED SPACE/NONALLOWABLE MEALS	75, 732		194. 01
	7952 SI TTERS	12, 071		194. 02
194. 03 0	7953 UNLICENSED STAFF	1, 165		194. 03
200. 00	Cross Foot Adjustments	0		200.00
201.00	Negative Cost Centers	0		201.00
202. 00	TOTAL (sum lines 118 through 201)	9, 446, 353		202.00
	• '			•

	n Financial Systems T ALLOCATION - STATISTICAL BASIS		Provi der C	F	eriod: rom 09/01/2017	worksheet B-1	l
		CARLTAL REL	ATED COCTO		o 08/31/2018	Date/Time Pre 1/30/2019 11:	epared: 15 am
	Cost Center Description	CAPITAL REL BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET 2)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
		1. 00	2. 00	4. 00	5A	5. 00	
	GENERAL SERVICE COST CENTERS				1		
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 16. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	382, 607 1, 756 35, 015 99, 819 4, 106 2, 913 6, 113 3, 690 1, 235 890	2, 913 6, 113	35, 991, 303 4, 794, 807 677, 421 0 886, 265 125, 235 47, 169 738, 312	-28, 153, 262 0 0 0 0 0 0 0	88, 629, 333 6, 081, 780 832, 637 1, 560, 637 1, 659, 864 368, 383 1, 197, 684 1, 093, 206	7. 00 8. 00 9. 00 10. 00 11. 00 13. 00
30.00	03000 ADULTS & PEDIATRICS	59, 377	59, 377				
31. 00 40. 00 41. 00 43. 00	03100 INTENSI VE CARE UNIT 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04300 NURSERY	12, 197 10, 552 9, 983 2, 286	12, 197 10, 552 9, 983 2, 286	1, 851, 011 847, 975	0		40. 00 41. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	29, 378	29, 378	3, 920, 392	0	6, 374, 566	50.00
76. 00 76. 01 76. 02 76. 03	07400 RENAL DI ALYSI S 03950 LI THOTRI PSY 03330 ENDOSCOPY	29, 378 1, 584 4, 739 16, 567 1, 502 3, 382 4, 373 1, 047 1, 866 1, 859 2, 293 7, 055 313 1, 887 7, 288 4, 341 533 6, 453 0 4, 447 990 0 1, 584 4, 432 2, 560 4, 430	1, 047 1, 866 1, 859 2, 293 7, 055 313 1, 887 7, 288 4, 341 533 6, 453 0 4, 447 990 0 1, 584 4, 432 2, 560	484, 139 778, 465 940, 218 160, 765 114, 401 589, 454 160, 543 533, 257 246, 816 511, 239 1, 234, 073 0 916, 094 880, 950 463, 642 47, 673 369, 480 0 1, 485, 116 68 0 767, 364 139, 992 65, 555		231, 984 1, 319, 366 272, 157 681, 709	51. 00 52. 00 54. 01 54. 02 55. 00 57. 00 58. 00 69. 00 62. 00 65. 00 66. 00 67. 00 71. 00 72. 00 73. 00 74. 00 76. 01 76. 01 76. 02 76. 03
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	14, 060	14, 060	2, 096, 644	0	3, 833, 607	91. 00 92. 00
118. 00	NONREI MBURSABLE COST CENTERS	378, 895	378, 895	35, 083, 581	-28, 153, 262	87, 472, 498	118. 00
192. 00 194. 00 194. 02 194. 02	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 OCCUPATIONAL MEDICINE 107951 UNOCCUPIED SPACE/NONALLOWABLE MEALS 207952 SITTERS 307953 UNLICENSED STAFF	566 0 3, 146 0 0	566 0 3, 146 0 0	0	0 0 0 0	0 745, 689 0 319, 939	194. 01
201. 00 202. 00	Negative Cost Centers	3, 558, 819	3, 526, 308	8, 334, 137		28, 153, 262	201.00
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	9. 301500	9. 216528	0. 231560 32, 517		0. 317652 2, 992, 579	1
205. 00	Part II) Unit cost multiplier (Wkst. B, Part II)			0. 000903		0. 033765	205. 00
206.00							206. 00

Health Financial Systems TE	ERRE HAUTE REGI	ONAL HOSPITAL		In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
				From 09/01/2017 To 08/31/2018	Date/Time Pre 1/30/2019 11:	
	CAPITAL REL	ATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET 2)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
	1. 00	2. 00	4.00	5A	5. 00	
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

CUSTA	LLOCATION - STATISTICAL BASIS		Provi der CO				
			Trovider ex		eriod: rom 09/01/2017 o 08/31/2018	Worksheet B-1 Date/Time Pre 1/30/2019 11:	pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL	HOUSEKEEPING (SQUARE FEET 2)	DI ETARY (MEALS SERVED)	CAFETERI A (GROSS SALARI ES)	15 dill
		7. 00	PATI ENT DAYS) 8. 00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS	7.00	0.00	9.00	10.00	11.00	
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY	246, 017 4, 106 2, 913 6, 113 3, 690 1, 235 890	29, 361 0 0 0 0	238, 998 6, 113 3, 690 1, 235 890		29, 460, 406 738, 312 17, 075	13.00
30. 00	O3000 ADULTS & PEDIATRICS	59, 377	16, 395	59, 377	59, 888	5, 503, 403	30.00
31. 00 40. 00 41. 00 43. 00	033000 ABUELTS & FEDTAINES 03100 INTENSIVE CARE UNIT 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	12, 197 10, 552 9, 983 2, 286	3, 295 6, 598 2, 094	12, 197 10, 552 9, 983 2, 286	4, 656 20, 712		31. 00 40. 00
	05000 OPERATING ROOM	29, 378	0	29, 378	0	3, 920, 392	50.00
52. 00 54. 00 54. 01 54. 02 55. 00 56. 00	05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND 03440 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE 05700 CT SCAN	1, 584 4, 739 16, 567 1, 502 3, 382 4, 373 1, 047	0 0 0 0 0	1, 584 4, 739 16, 567 1, 502 3, 382 4, 373 1, 047 1, 866	0 0 0 0 0	484, 139 778, 465 940, 218 160, 765 114, 401 589, 454 160, 543	52. 00 54. 00 54. 01 54. 02 55. 00
58. 00 59. 00 60. 00 62. 00 65. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPIRATORY THERAPY	1, 859 2, 293 7, 055 313 1, 887	0 0 0 0	1, 859 2, 293 7, 055 313 1, 887	0 0 0 0	246, 816 511, 239 1, 234, 073 0 916, 094	58. 00 59. 00 60. 00 62. 00 65. 00
69. 00 70. 00 71. 00 72. 00 73. 00	06600 PHYSICAL THERAPY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	7, 288 4, 341 533 6, 453 0 4, 447	0 0 0 0	7, 288 4, 341 533 6, 453 0 4, 447	0 0 0 0 0	880, 950 463, 642 47, 673 369, 480 0 1, 485, 116	69. 00 70. 00 71. 00 72. 00 73. 00
76. 00 76. 01 76. 02 76. 03	07400 RENAL DI ALYSI S 03950 LI THOTRI PSY 03330 ENDOSCOPY 03040 PRI SI ON CLI NI C 03050 WOUND CARE 03060 OPI C	990 0 1, 584 4, 432 2, 560 4, 430	0 0 0	990 0 1, 584 4, 432 2, 560 4, 430		65, 555	76. 00 76. 01 76. 02 76. 03
	OUTPATIENT SERVICE COST CENTERS	11.00			ما		
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS	14, 060	0	14, 060	0	2, 096, 644	91.00 92.00
118. 00	NONREI MBURSABLE COST CENTERS	242, 305			94, 376		
192. 00 194. 00 194. 01 194. 02 194. 03 200. 00	, ,	566 0 3, 146 0 0	0 0 0	566 0 3, 146 0 0 0	0 0 0 48, 278 0 0	0 639, 849 0 244, 042	194. 01 194. 02 194. 03 200. 00
201. 00 202. 00	Cost to be allocated (per Wkst. B,	8, 013, 670	1, 230, 873	2, 151, 263	2, 441, 270	638, 812	201. 00 202. 00
203. 00 204. 00	Cost to be allocated (per Wkst. B,	32. 573643 2, 054, 414		9. 001176 131, 764		0. 021684 113, 661	
205. 00	Part II) Unit cost multiplier (Wkst. B, Part II)	8. 350699	4. 714996	0. 551318	1. 568670	0. 003858	205. 00
206. 00							206. 00
207. 00	1 "						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS TERRE HAUTE REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0046 NURSI NG MEDI CAL ADMI NI STRATI O RECORDS & Cost Center Description

	ADMI NI STRATI O	RECORDS & LI BRARY		
	(DI RECT NURS.	(GROSS		
	SALARI ES)	CHARGES)		
GENERAL SERVICE COST CENTERS	13. 00	16. 00		
1.00 O0100 CAP REL COSTS-BLDG & FLXT				1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 00 00500 ADMINISTRATIVE & GENERAL				5.00
7. 00 00700 OPERATION OF PLANT				7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG				8. 00 9. 00
10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERI A				11.00
13.00 01300 NURSING ADMINISTRATION	12, 563, 787			13.00
16.00 01600 MEDICAL RECORDS & LIBRARY	O	774, 409, 765		16.00
INPATIENT ROUTINE SERVICE COST CENTERS		00 440 047		
30. 00 03000 ADULTS & PEDI ATRI CS	4, 923, 183	22, 412, 817		30.00
31. 00 03100 INTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF	1, 711, 129 890, 868	10, 170, 730 25, 931, 452		31. 00 40. 00
41. 00 04100 SUBPROVI DER - 1 FF	607, 789	2, 810, 229		41.00
43. 00 04300 NURSERY	261, 162	2, 023, 695		43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	1, 945, 210	108, 098, 050		50.00
51. 00 05100 RECOVERY ROOM	403, 080	14, 346, 017		51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	736, 262	4, 761, 754 14, 769, 853		52.00 54.00
54. 01 03630 ULTRA SOUND		5, 164, 080		54. 01
54. 02 03440 MAMMOGRAPHY	Ö	1, 987, 527		54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	o	16, 264, 193		55.00
56. 00 05600 RADI OI SOTOPE	0	12, 391, 103		56.00
57. 00 05700 CT SCAN	0	56, 065, 827		57.00
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 59. 00 05900 CARDIAC CATHETERIZATION	0 187, 347	12, 674, 794 25, 757, 934		58. 00 59. 00
60. 00 06000 LABORATORY	0	73, 994, 218		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	l ol	6, 205, 675		62.00
65. 00 06500 RESPIRATORY THERAPY	o	18, 083, 936		65.00
66. 00 06600 PHYSI CAL THERAPY	286	7, 006, 479		66.00
69. 00 06900 ELECTROCARDI OLOGY	108, 692	19, 745, 264		69.00
70.00 O7000 ELECTROENCEPHALOGRAPHY 71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7 044	1, 376, 633		70.00
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	7, 046	49, 499, 941 26, 380, 181		71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		116, 663, 884		73.00
74.00 07400 RENAL DIALYSIS	o	4, 269, 713		74.00
76. 00 03950 LI THOTRI PSY	0	3, 262, 674		76.00
76. 01 03330 ENDOSCOPY	523, 597	37, 978, 885		76. 01
76. 02 03040 PRISION CLINIC	0	596, 060		76.02
76. 03 03050 WOUND CARE 76. 04 03060 OPI C	241, 719	2, 419, 924 6, 011, 486	<u> </u>	76. 03 76. 04
OUTPATIENT SERVICE COST CENTERS	241,717	0,011,400		70.04
91. 00 09100 EMERGENCY	0	65, 284, 757		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
SPECIAL PURPOSE COST CENTERS	10 547 070	774 400 775		110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	12, 547, 370	774, 409, 765		118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	o o	0		192.00
194.00 07950 OCCUPATIONAL MEDICINE	0	0		194. 00
194. 01 07951 UNOCCUPI ED SPACE/NONALLOWABLE MEALS	0	0		194. 01
194. 02 07952 SI TTERS	16, 417	0		194. 02
194. 03 07953 UNLI CENSED STAFF 200. 00 Cross Foot Adjustments	O O	0		194. 03 200. 00
201.00 Negative Cost Centers				200.00
202.00 Cost to be allocated (per Wkst. B,	1, 645, 485	1, 477, 837		202.00
Part I)	, 1 12, 120	, , , , , , , , , , , , , , , , , , , ,		
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 130970	0. 001908		203. 00
204.00 Cost to be allocated (per Wkst. B,	78, 916	71, 774		204. 00
Part II)	0.004304	0.000000		20E 00
205.00 Unit cost multiplier (Wkst. B, Part	0. 006281	0. 000093		205.00
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)	ı l		1	1

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

				ř	o 08/31/2018	Date/Time Pre 1/30/2019 11:	pared: 15 am
			Title	XVIII	Hospi tal	PPS	TO UIII
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
	03000 ADULTS & PEDI ATRI CS	17, 869, 405		17, 869, 405	ol ol	17, 869, 405	30.00
	03100 NTENSI VE CARE UNI T	5, 175, 430		5, 175, 430		5, 175, 430	•
	04000 SUBPROVI DER – I PF	4, 924, 028		4, 924, 028		4, 924, 028	
	04100 SUBPROVI DER – I RF	2, 519, 565		2, 519, 565		2, 519, 565	41.00
	04300 NURSERY	819, 987		819, 987		847, 596	•
.0.00	ANCILLARY SERVICE COST CENTERS	0.77707		0177707	27,007	0177070	10.00
50.00	05000 OPERATING ROOM	10, 166, 870		10, 166, 870	293	10, 167, 163	50.00
51.00	05100 RECOVERY ROOM	1, 106, 360		1, 106, 360		1, 106, 360	•
	05200 DELIVERY ROOM & LABOR ROOM	2, 122, 695		2, 122, 695		2, 122, 695	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 640, 541		3, 640, 541		3, 640, 541	1
	03630 ULTRA SOUND	411, 434		411, 434		411, 434	1
54.02	03440 MAMMOGRAPHY	531, 470		531, 470	o	531, 470	54.02
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 814, 294		1, 814, 294	o	1, 814, 294	55.00
56.00	05600 RADI 0I SOTOPE	1, 175, 760		1, 175, 760	o	1, 175, 760	56.00
	05700 CT SCAN	1, 384, 086		1, 384, 086	o	1, 384, 086	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	692, 526		692, 526	o	692, 526	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 104, 553		1, 104, 553	0	1, 104, 553	59.00
60.00	06000 LABORATORY	4, 886, 981		4, 886, 981	0	4, 886, 981	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	905, 535		905, 535	0	905, 535	62.00
	06500 RESPI RATORY THERAPY	1, 986, 505	0	1, 986, 505	0	1, 986, 505	65.00
66.00	06600 PHYSI CAL THERAPY	2, 104, 304	0	2, 104, 304	21, 066	2, 125, 370	
69.00	06900 ELECTROCARDI OLOGY	1, 578, 836		1, 578, 836	11, 559	1, 590, 395	69.00
	07000 ELECTROENCEPHALOGRAPHY	139, 105		139, 105	0	139, 105	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 771, 423		9, 771, 423		9, 771, 423	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	8, 380, 130		8, 380, 130		8, 380, 130	
	07300 DRUGS CHARGED TO PATIENTS	17, 427, 200		17, 427, 200		17, 427, 200	
	07400 RENAL DIALYSIS	780, 924		780, 924		780, 924	1
	03950 LI THOTRI PSY	311, 899		311, 899		311, 899	•
	03330 ENDOSCOPY	1, 961, 999		1, 961, 999		1, 981, 568	
	03040 PRISION CLINIC	547, 040		547, 040		547, 040	
	03050 WOUND CARE	1, 010, 725		1, 010, 725		1, 022, 321	
76. 04	03060 OPI C	1, 198, 398		1, 198, 398	25, 595	1, 223, 993	76. 04
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	5, 805, 929		5, 805, 929		5, 838, 559	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 868, 045	_	1, 868, 045		1, 868, 045	
200.00		116, 123, 982	0	,,		116, 273, 899	
201.00		1, 868, 045	_	1, 868, 045		1, 868, 045	
202. 00	Total (see instructions)	114, 255, 937	0	114, 255, 937	149, 917	114, 405, 854	202.00

				o 08/31/2018	Date/Time Pre	pared:
		Ti +l c	xVIII	Hospi tal	1/30/2019 11: PPS	<u>15 am</u>
		Charges	AVIII	HOSPI tai	FFJ	
Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
	6. 00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
30. 00 03000 ADULTS & PEDIATRICS	20, 487, 222		20, 487, 222			30.00
31. 00 03100 I NTENSI VE CARE UNI T	10, 170, 730		10, 170, 730		ļ	31.00
40. 00 04000 SUBPROVI DER - PF	25, 931, 452		25, 931, 452	I		40.00
41. 00 04100 SUBPROVI DER - I RF	2, 810, 229		2, 810, 229			41.00
43. 00 04300 NURSERY	2, 023, 695		2, 023, 695			43. 00
ANCILLARY SERVICE COST CENTERS	2,020,070		2,020,070			10.00
50. 00 05000 OPERATING ROOM	53, 564, 008	54, 534, 042	108, 098, 050	0. 094052	0.000000	50.00
51.00 05100 RECOVERY ROOM	5, 640, 970	8, 705, 047			0.000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	4, 466, 522	295, 232	4, 761, 754	0. 445780	0.000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 605, 323	10, 164, 530	14, 769, 853	0. 246485	0.000000	54.00
54. 01 03630 ULTRA SOUND	1, 320, 056	3, 844, 024			0.000000	54. 01
54. 02 03440 MAMMOGRAPHY	3, 390	1, 984, 137			0.000000	54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	884, 598	15, 379, 595			0.000000	55.00
56. 00 05600 RADI 0I SOTOPE	1, 099, 026	11, 292, 077			0.000000	56.00
57. 00 05700 CT SCAN	18, 327, 303	37, 738, 524			0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 781, 637	8, 893, 157	12, 674, 794	0. 054638	0.000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	13, 008, 804	12, 749, 130	25, 757, 934	0. 042882	0.000000	59.00
60. 00 06000 LABORATORY	33, 076, 895	40, 917, 323	73, 994, 218	0. 066045	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	4, 939, 004	1, 266, 671	6, 205, 675	0. 145920	0.000000	62.00
65. 00 06500 RESPIRATORY THERAPY	16, 944, 931	1, 139, 005	18, 083, 936	0. 109849	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	6, 740, 674	265, 805	7, 006, 479	0. 300337	0.000000	66.00
69. 00 06900 ELECTROCARDI OLOGY	10, 960, 713	8, 784, 551	19, 745, 264	0. 079960	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	550, 549	826, 084	1, 376, 633	0. 101047	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	29, 142, 049	20, 357, 892	49, 499, 941	0. 197403	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	13, 956, 821	12, 423, 360	26, 380, 181	0. 317668	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	65, 450, 818	51, 213, 066	116, 663, 884	0. 149380	0.000000	73.00
74. 00 07400 RENAL DI ALYSI S	4, 178, 788	90, 925	4, 269, 713	0. 182898	0.000000	74.00
76. 00 03950 LI THOTRI PSY	60, 830	3, 201, 844	3, 262, 674	0. 095596	0.000000	76.00
76. 01 03330 ENDOSCOPY	3, 540, 340	34, 438, 545	37, 978, 885	0. 051660	0.000000	76. 01
76. 02 03040 PRISION CLINIC	3, 291	592, 769	596, 060	0. 917760	0.000000	76. 02
76. 03 03050 WOUND CARE	43, 823	2, 376, 101	2, 419, 924	0. 417668	0.000000	76. 03
76. 04 03060 OPI C	28, 272	5, 983, 214	6, 011, 486	0. 199351	0.000000	76. 04
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	19, 975, 229	45, 309, 528			0.000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	410, 068	1, 515, 527			0. 000000	
200.00 Subtotal (see instructions)	378, 128, 060	396, 281, 705	774, 409, 765			200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	378, 128, 060	396, 281, 705	774, 409, 765			202. 00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lieu of Form CMS-2552-1		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0046	From 09/01/2017	Worksheet C Part I Date/Time Prepared: 1/30/2019 11:15 am	

					1/30/2019 11:15 am
			Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
<u>l</u>	NPATIENT ROUTINE SERVICE COST CENTERS				
30.00	D3000 ADULTS & PEDIATRICS				30.00
31.00	D3100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVI DER - I PF				40.00
41.00	04100 SUBPROVI DER - I RF				41.00
43.00	04300 NURSERY				43.00
I	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 094055			50.00
51.00	05100 RECOVERY ROOM	0. 077120			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 445780			52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 246485			54.00
54. 01	03630 ULTRA SOUND	0. 079672			54. 01
54. 02	D3440 MAMMOGRAPHY	0. 267403			54. 02
	05500 RADI OLOGY-THERAPEUTI C	0. 111551			55. 00
	05600 RADI OI SOTOPE	0. 094887			56.00
	05700 CT SCAN	0. 024687			57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 054638			58.00
	05900 CARDI AC CATHETERI ZATI ON	0. 042882			59. 00
	06000 LABORATORY	0. 066045			60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 145920			62.00
	06500 RESPIRATORY THERAPY	0. 109849			65.00
	06600 PHYSI CAL THERAPY	0. 303344			66.00
	06900 ELECTROCARDI OLOGY	0. 080546			69.00
	07000 ELECTROENCEPHALOGRAPHY	0. 101047			70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 197403			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 317668			72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 149380			73.00
	07400 RENAL DIALYSIS	0. 182898			74.00
	03950 LI THOTRI PSY	0. 095596			76.00
	D3330 ENDOSCOPY	0. 052176			76.01
	03040 PRI SI ON CLI NI C	0. 917760			76.02
	03050 WOUND CARE	0. 422460			76.02
	03060 OPI C	0. 203609			76.03
	DUTPATIENT SERVICE COST CENTERS	0. 203009			78.04
	D9100 EMERGENCY	0. 089432			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 970113			92.00
200.00	Subtotal (see instructions)	0. 7/0113			200.00
200.00	Less Observation Beds				201.00
201.00	Total (see instructions)				201.00
202.00	Tiotai (See Tiisti ucti olis)	1			J202.00

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

			Ţ	o 08/31/2018	Date/Time Pre 1/30/2019 11:	pared: 15 am
		Ti tl	e XIX	Hospi tal	Cost	10 4
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
, , , , , , , , , , , , , , , , , , ,	(from Wkst.	Adj .		Di sal I owance		
	B, Part I,					
	col . 26)					
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	17, 869, 405		17, 869, 405	0	17, 869, 405	30.00
31.00 03100 INTENSIVE CARE UNIT	5, 175, 430		5, 175, 430	0	5, 175, 430	31.00
40. 00 04000 SUBPROVI DER - 1 PF	4, 924, 028		4, 924, 028	0	4, 924, 028	40. 00
41. 00 04100 SUBPROVI DER - I RF	2, 519, 565		2, 519, 565	0	2, 519, 565	41.00
43. 00 04300 NURSERY	819, 987		819, 987	27, 609	847, 596	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	10, 166, 870		10, 166, 870	293	10, 167, 163	50.00
51.00 05100 RECOVERY ROOM	1, 106, 360		1, 106, 360	0	1, 106, 360	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 122, 695		2, 122, 695	0	2, 122, 695	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 640, 541		3, 640, 541	0	3, 640, 541	54.00
54.01 03630 ULTRA SOUND	411, 434		411, 434	0	411, 434	54. 01
54. 02 03440 MAMMOGRAPHY	531, 470		531, 470	0	531, 470	54.02
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 814, 294		1, 814, 294	0	1, 814, 294	55.00
56. 00 05600 RADI 01 SOTOPE	1, 175, 760		1, 175, 760	0	1, 175, 760	56.00
57. 00 05700 CT SCAN	1, 384, 086		1, 384, 086	0	1, 384, 086	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	692, 526		692, 526	0	692, 526	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 104, 553		1, 104, 553	0	1, 104, 553	59. 00
60. 00 06000 LABORATORY	4, 886, 981		4, 886, 981	0	4, 886, 981	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	905, 535		905, 535	0	905, 535	62.00
65. 00 06500 RESPIRATORY THERAPY	1, 986, 505	0	1, 986, 505	0	1, 986, 505	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 104, 304	0	2, 104, 304	21, 066	2, 125, 370	66.00
69. 00 06900 ELECTROCARDI OLOGY	1, 578, 836		1, 578, 836	11, 559	1, 590, 395	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	139, 105		139, 105	0	139, 105	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 771, 423		9, 771, 423	0	9, 771, 423	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	8, 380, 130		8, 380, 130	0	8, 380, 130	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	17, 427, 200		17, 427, 200	0	17, 427, 200	73.00
74. 00 07400 RENAL DI ALYSI S	780, 924		780, 924	0	780, 924	74.00
76. 00 03950 LI THOTRI PSY	311, 899		311, 899	0	311, 899	76.00
76. 01 03330 ENDOSCOPY	1, 961, 999		1, 961, 999	19, 569	1, 981, 568	76. 01
76. 02 03040 PRI SI ON CLI NI C	547, 040		547, 040	0	547, 040	76. 02
76. 03 03050 WOUND CARE	1, 010, 725		1, 010, 725	11, 596	1, 022, 321	76. 03
76. 04 03060 OPI C	1, 198, 398		1, 198, 398	25, 595	1, 223, 993	76. 04
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	5, 805, 929		5, 805, 929	32, 630	5, 838, 559	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 868, 045		1, 868, 045		1, 868, 045	
200.00 Subtotal (see instructions)	116, 123, 982	ł .		149, 917	116, 273, 899	
201.00 Less Observation Beds	1, 868, 045		1, 868, 045		1, 868, 045	
202.00 Total (see instructions)	114, 255, 937	0	114, 255, 937	149, 917	114, 405, 854	202. 00

				From 09/01/2017 To 08/31/2018	Part I Date/Time Pre 1/30/2019 11:	
		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
	6. 00	7.00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	20, 487, 222		20, 487, 222			30.00
31.00 03100 INTENSIVE CARE UNIT	10, 170, 730		10, 170, 730			31.00
40. 00 04000 SUBPROVI DER - 1 PF	25, 931, 452		25, 931, 452	2		40.00
41. 00 04100 SUBPROVI DER - I RF	2, 810, 229		2, 810, 229			41.00
43. 00 04300 NURSERY	2, 023, 695		2, 023, 695	5		43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	53, 564, 008	54, 534, 042			0.000000	
51.00 05100 RECOVERY ROOM	5, 640, 970	8, 705, 047			0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	4, 466, 522	295, 232			0.000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 605, 323	10, 164, 530			0.000000	54.00
54. 01 03630 ULTRA SOUND	1, 320, 056	3, 844, 024	5, 164, 080		0.000000	54. 01
54. 02 03440 MAMMOGRAPHY	3, 390	1, 984, 137	1, 987, 527	0. 267403	0.000000	54.02
55. 00 05500 RADI OLOGY-THERAPEUTI C	884, 598	15, 379, 595	16, 264, 193	0. 111551	0.000000	55.00
56. 00 05600 RADI 01 SOTOPE	1, 099, 026	11, 292, 077	12, 391, 103	0. 094887	0.000000	56.00
57. 00 05700 CT SCAN	18, 327, 303	37, 738, 524	56, 065, 827	0. 024687	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 781, 637	8, 893, 157	12, 674, 794	0. 054638	0.000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	13, 008, 804	12, 749, 130	25, 757, 934	0. 042882	0.000000	59.00
60. 00 06000 LABORATORY	33, 076, 895	40, 917, 323	73, 994, 218	0. 066045	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	4, 939, 004	1, 266, 671	6, 205, 675	0. 145920	0.000000	62.00
65. 00 06500 RESPIRATORY THERAPY	16, 944, 931	1, 139, 005	18, 083, 936	0. 109849	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	6, 740, 674	265, 805	7, 006, 479	0. 300337	0.000000	66.00
69. 00 06900 ELECTROCARDI OLOGY	10, 960, 713	8, 784, 551	19, 745, 264	0. 079960	0.000000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	550, 549	826, 084	1, 376, 633	0. 101047	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	29, 142, 049	20, 357, 892	49, 499, 941	0. 197403	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	13, 956, 821	12, 423, 360	26, 380, 181	0. 317668	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	65, 450, 818	51, 213, 066	116, 663, 884	0. 149380	0.000000	73.00
74.00 07400 RENAL DIALYSIS	4, 178, 788	90, 925	4, 269, 713	0. 182898	0.000000	74.00
76. 00 03950 LI THOTRI PSY	60, 830	3, 201, 844	3, 262, 674	0. 095596	0.000000	76.00
76. 01 03330 ENDOSCOPY	3, 540, 340	34, 438, 545	37, 978, 885	0. 051660	0.000000	76. 01
76. 02 03040 PRISION CLINIC	3, 291	592, 769	596, 060	0. 917760	0.000000	76. 02
76. 03 03050 WOUND CARE	43, 823	2, 376, 101	2, 419, 924	0. 417668	0.000000	76. 03
76. 04 03060 0PI C	28, 272	5, 983, 214	6, 011, 486	0. 199351	0.000000	76. 04
OUTPATIENT SERVICE COST CENTERS				'		1
91. 00 09100 EMERGENCY	19, 975, 229	45, 309, 528	65, 284, 757	0. 088932	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	410, 068	1, 515, 527	1, 925, 595	0. 970113	0.000000	92.00
200.00 Subtotal (see instructions)	378, 128, 060	396, 281, 705		5		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	378, 128, 060	396, 281, 705	774, 409, 765	5		202. 00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lieu of Form CMS-2552-1		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0046	From 09/01/2017 F To 08/31/2018 [Worksheet C Part I Date/Time Prepared: 1/30/2019 11:15 am	

			10 00,01,2010	1/30/2019 11:15 am
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
· ·	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
40. 00 04000 SUBPROVI DER - I PF				40.00
41. 00 04100 SUBPROVI DER - I RF				41.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			50.00
51. 00 05100 RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
54. 01 03630 ULTRA SOUND	0. 000000			54. 01
54. 02 03440 MAMMOGRAPHY	0. 000000			54.02
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.00
56. 00 05600 RADI OI SOTOPE	0. 000000			56.00
57. 00 05700 CT SCAN	0. 000000			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00 06000 LABORATORY	0. 000000			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
74. 00 07400 RENAL DIALYSIS	0. 000000			74.00
76. 00 03950 LI THOTRI PSY	0. 000000			76.00
76. 01 03330 ENDOSCOPY	0. 000000			76. 01
76. 02 03040 PRISION CLINIC	0. 000000			76. 02
76. 03 03050 WOUND CARE	0. 000000			76. 03
76. 04 03060 OPI C	0. 000000			76.04
OUTPATIENT SERVICE COST CENTERS	· ·			
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				

Health Financial Systems TERRE HAUTE REGIONAL HOSPITAL In Lieu of Form CMS-2552-						2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provi der C		Period: From 09/01/2017 To 08/31/2018	Worksheet D Part I Date/Time Pre 1/30/2019 11:	pared: 15 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.404.040			10.000	110.00	
30. 00 ADULTS & PEDIATRICS	2, 194, 912		_, ., ., , .			
31. 00 INTENSIVE CARE UNIT	485, 437		485, 43			
40. 00 SUBPROVI DER - I PF	463, 237		463, 23		70. 21	40.00
41. 00 SUBPROVI DER - I RF	351, 053		351, 05		167. 65	
43. 00 NURSERY	86, 878		86, 87		88. 74	
200.00 Total (lines 30 through 199)	3, 581, 517		3, 581, 51	7 31, 275		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
	6. 00	col. 6) 7.00	-			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS	8, 853	1, 061, 298				30.00
31. 00 INTENSIVE CARE UNIT	1, 593					31.00
40. 00 SUBPROVI DER - I PF	1, 343		•			40.00
41. 00 SUBPROVI DER - I RF	1, 264		•			41.00
43. 00 NURSERY	1, 204	211, 910	1			43.00
200.00 Total (lines 30 through 199)	13, 134	_	I .			200.00

Hoal	th Financial Systems T	ERRE HAUTE REGI	IATIDONAL NAMAL		In Lie	u of Form CMS-2	0552 10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provi der C		Period: From 09/01/2017 To 08/31/2018	Worksheet D Part II Date/Time Pre 1/30/2019 11:	pared:
				XVIII	Hospi tal	PPS	
	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
-	ANCILLARY SERVICE COST CENTERS						
50. C		1, 062, 038	108, 098, 050	0. 00982	5 23, 690, 168	232, 756	50.00
51. C		73, 949		1		13, 745	
52. C		186, 018		1	·		
54. C		534, 513				83, 667	54.00
54. C	_ I	51, 031		1	·	6, 060	
54. C		103, 319				46	54.02
55. C		164, 937		1	·		55.00
56. C		58, 944		1			56.00
57. C		89, 361		1			57.00
58. C		68, 337					58. 00
59. C		92, 792					
60. C		319, 615					60.00
62. C		31, 728					
65. C		105, 286					65. 00
66. C		250, 011					66. 00
69. C		158, 002					
70. C		17, 873			·		
71. C		424, 236		1			71.00
72. C		215, 905					
73. C		574, 928		1			
74. C		46, 290					
76. C		8, 136				0	

98, 456

131, 435

93, 750

150, 355

532, 586

229, 454 5, 873, 285

2, 419, 924

6, 011, 486

65, 284, 757

1, 925, 595 712, 986, 437

596, 060

37, 978, 885

0.002592

0. 220506

0.038741

0. 025011

0.008158

0. 119160

2, 094, 405

8, 532, 498 201, 372 148, 793, 580

26, 477

16, 303

0

5, 429

1,026

408

23, 995 92. 00 1, 104, 706 200. 00

69, 608 91. 00

76.01

76.02

76.03

76.04

76.02 03040 PRISION CLINIC

03050 WOUND CARE

OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
200.00 Total (lines 50 through 199)

76. 01 03330 ENDOSCOPY

03060 OPI C

91. 00 09100 EMERGENCY

76.03

76. 04

Health Financial Systems	TERRE HAUTE REG	IONAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS			Period: From 09/01/2017 To 08/31/2018	Worksheet D Part III Date/Time Pre 1/30/2019 11:	epared:
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng School Post-Stepdown Adj ustments	Nursi ng School	Allied Healt Post-Stepdow Adjustments	n Allied Health Cost	All Other Medical Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00	0 0 0 0	_		0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0	31. 00 40. 00 41. 00
200.00 Total (lines 30 through 199)	0	C		0 0	0	200.00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patien Days	t Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5.00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY 200. 00 Total (Lines 30 through 199)	0 0	C	3, 29 6, 59 0 2, 09	0.00 0.00 0.00 0.00 9 0.00	1, 593 1, 424 1, 264 0	31. 00 40. 00 41. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	-	31, 27	<u> </u>	10, 104	200.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF 41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY	0 0 0 0					30. 00 31. 00 40. 00 41. 00 43. 00
200.00 Total (lines 30 through 199)	0					200.

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0046	Period: Worksheet D
THROUGH COSTS		From 09/01/2017 Part IV

			7	Го 08/31/2018	Date/Time Pre 1/30/2019 11:	
-		Ti tl e	e XVIII	Hospi tal	PPS	TO UIII
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0)	0	0	50.00
51. 00 05100 RECOVERY ROOM	0	0)	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0)	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	0	0	54.00
54. 01 03630 ULTRA SOUND	0	0)	0	0	54. 01
54. 02 03440 MAMMOGRAPHY	0	0)	0	0	54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0)	0	0	55.00
56. 00 05600 RADI OI SOTOPE	0	0)	0	0	56.00
57. 00 05700 CT SCAN	0	0		0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0)	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0)	0	0	59.00
60. 00 06000 LABORATORY	0	0		0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0			0	0	73.00
74. 00 07400 RENAL DI ALYSI S	0			0	0	74.00
76. 00 03950 LI THOTRI PSY	0			0	0	76.00
76. 01 03330 ENDOSCOPY	0			0	0	76. 01
76. 02 03040 PRI SI ON CLI NI C	0			0	0	76. 02
76. 03 03050 WOUND CARE	0	0	1	0	0	76. 03
76. 04 03060 OPI C	0	0) (0	0	76. 04
OUTPATIENT SERVICE COST CENTERS					_	01.00
91. 00 09100 EMERGENCY	0	0	1		_	, 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			1		0	1 /2.00
200.00 Total (lines 50 through 199)	0	0) (0	0	200. 00

Heal th Finan	cial Systems		TERRE	HAUTE R	REGI ONA	L HOSPITA	L	In Lieu	of Form CMS-2552-10
APPORTI ONMEN THROUGH COST	T OF INPATIENT/ S	OUTPATIENT AND	ICI LLARY SERVI C	E OTHER F	PASS	Provi der	CCN: 15-0046	From 09/01/2017	Worksheet D Part IV Date/Time Prepared:

			7	o 08/31/2018	Date/Time Pre 1/30/2019 11:	
		Ti tl e	xVIII	Hospi tal	PPS	10 4
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)			
ANOLI LADV CEDVILOE COCT CENTERS	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS 50.00 OFERATING ROOM	1 0	J		108, 098, 050	0. 000000	50.00
	0	1				
51. 00 05100 RECOVERY ROOM	0	0		14, 346, 017	0.000000	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0			4, 761, 754		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			14, 769, 853		
54. 01 03630 ULTRA SOUND	0			5, 164, 080		
54. 02 03440 MAMMOGRAPHY 55. 00 05500 RADI OLOGY-THERAPEUTI C	0			1, 987, 527 16, 264, 193	0. 000000 0. 000000	
56. 00 05600 RADI 0LOGY - THERAPEUTIC	0			10, 264, 193		
57. 00 05700 CT SCAN				56, 065, 827	0.000000	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0			12, 674, 794		
59. 00 05900 CARDIAC CATHETERIZATION				25, 757, 934		
60. 00 06000 LABORATORY	0			73, 994, 218		
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS				6, 205, 675		
65. 00 06500 RESPIRATORY THERAPY						
66. 00 06600 PHYSI CAL THERAPY				7, 006, 479		
69. 00 06900 ELECTROCARDI OLOGY	0			19, 745, 264		
70. 00 07000 ELECTROCARD OLOGT				1, 376, 633		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				49, 499, 941	0.000000	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS				26, 380, 181	0.000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS				116, 663, 884		
74. 00 07400 RENAL DI ALYSI S	0			4, 269, 713		
76. 00 03950 LI THOTRI PSY	0			3, 262, 674	0. 000000	
76. 01 03330 ENDOSCOPY	0			37, 978, 885		
76. 02 03040 PRI SI ON CLI NI C	0			596, 060		
76. 03 03050 WOUND CARE	0					
76. 04 03060 OPI C	0			6, 011, 486		
OUTPATIENT SERVICE COST CENTERS		<u> </u>		0,011,100	0.000000	70.01
91. 00 09100 EMERGENCY	0	0	(65, 284, 757	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				
200.00 Total (lines 50 through 199)	0) o	(200. 00

llool +h	Financial Systems	ERRE HAUTE REGIO	ONAL LIOCOLTAL		lo li o	eu of Form CMS-2	DEED 10
APPORT	Financial Systems T TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI SH COSTS		Provi der CC	Provi der CCN: 15-0046 Peri od: From 09/01/2017 To 08/31/2018		Worksheet D Part IV Date/Time Pre 1/30/2019 11:	pared:
				XVIII	Hospi tal	PPS	
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. x col. 10)		Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9. 00	10. 00	11. 00	12. 00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	23, 690, 168		0 16, 373, 870	0	
51. 00	05100 RECOVERY ROOM	0. 000000	2, 666, 370		0 2, 485, 243	1	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	8, 608		0 0	1	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	2, 311, 943		0 2, 493, 929		
54. 01	03630 ULTRA SOUND	0. 000000	613, 248		0 935, 391	•	54. 01
54. 02	03440 MAMMOGRAPHY	0. 000000	881		0 160, 552	•	54.02
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	417, 092		0 8, 546, 498		55.00
56.00	05600 RADI OI SOTOPE	0. 000000	586, 384		0 5, 285, 160	•	56.00
57.00	05700 CT SCAN	0. 000000	9, 090, 967		0 11, 266, 585	•	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	1, 928, 138		0 2, 478, 057	•	
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	6, 239, 513		0 6, 714, 804		59.00
60.00	06000 LABORATORY	0. 000000	16, 306, 807		9, 065, 653	1	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	2, 564, 961		0 589, 067	0	62.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	9, 426, 224		0 213, 022	. 0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 873, 642		0 39, 931	0	66.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	6, 184, 266		0 3, 390, 457	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	349, 173		0 260, 046		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	14, 000, 839		0 7, 539, 329	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	6, 611, 240		0 5, 059, 057	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	30, 181, 065		0 19, 461, 715	0	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	2, 870, 996		0 90, 925	0	74.00
76.00	03950 LI THOTRI PSY	0. 000000	0		0 879, 263		
76. 01	03330 ENDOSCOPY	0. 000000	2, 094, 405		0 14, 006, 015	0	76. 01
76. 02	03040 PRISION CLINIC	0. 000000	0		0 0	1	
76. 03	03050 WOUND CARE	0. 000000	26, 477		0 1, 119, 610	•	76. 03
76. 04	03060 OPI C	0. 000000	16, 303		0 2, 671, 577	0	76. 04

0.000000

0. 000000

8, 532, 498 201, 372 148, 793, 580

8, 448, 159 278, 593 129, 852, 508

0 0 0

0 91.00 0 92.00 0 200.00

OUTPATIENT SERVICE COST CENTERS
91. 00 O9100 EMERGENCY

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
200.00 Total (lines 50 through 199)

Health Financial Systems	TERRE HAUTE REGION	TERRE HAUTE REGIONAL HOSPITAL			
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-0046	Peri od: From 09/01/2017	Worksheet D Part V	

08/31/2018 Date/Time Prepared: 1/30/2019 11:15 am Title XVIII Hospi tal PPS Charges Costs PPS Services Cost Center Description Cost to PPS Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, Subject To Subject To inst.) Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 16, 373, 870 0.094052 1, 539, 995 50.00 05100 RECOVERY ROOM 0 0 0 0.077120 191, 662 51.00 2, 485, 243 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.445780 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 246485 2, 493, 929 0 0 614, 716 54.00 03630 ULTRA SOUND 0.079672 935, 391 0 0 74, 524 54.01 54.01 03440 MAMMOGRAPHY 0 0 42, 932 54.02 0. 267403 160, 552 54 02 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0.111551 8, 546, 498 953, 370 55.00 56.00 05600 RADI OI SOTOPE 0. 094887 5, 285, 160 0 0 0 501, 493 56.00 0 57.00 05700 CT SCAN 0.024687 278, 138 57.00 11, 266, 585 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.054638 0 58.00 2, 478, 057 135, 396 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.042882 6, 714, 804 287, 944 59.00 06000 LABORATORY 0 60.00 0.066045 9,065,653 0 0 598, 741 60.00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 85, 957 62 00 0 145920 589 067 62 00 0 65.00 06500 RESPIRATORY THERAPY 0.109849 213, 022 23, 400 65.00 66.00 06600 PHYSI CAL THERAPY 0.300337 39, 931 0 0 11, 993 66.00 06900 ELECTROCARDI OLOGY 0 0 69.00 0.079960 3, 390, 457 271, 101 69.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70 00 0 101047 260, 046 70 00 26, 277 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0.197403 7, 539, 329 1, 488, 286 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 317668 5, 059, 057 0 1, 607, 101 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.149380 19, 461, 715 73.176 2, 907, 191 73.00 07400 RENAL DIALYSIS 0.182898 90, 925 0 74 00 0 16, 630 74 00 76.00 03950 LI THOTRI PSY 0.095596 879, 263 0 84,054 76.00 03330 ENDOSCOPY 0.051660 14, 006, 015 0 0 723, 551 76.01 76.01 03040 PRISION CLINIC 0. 917760 0 76.02 76.02 0 ō 467, 625 03050 WOUND CARE 1, 119, 610 76.03 0.417668 0 76.03 76.04 03060 OPI C 0.199351 2, 671, 577 0 532, 582 76.04 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 8, 448, 159 0 91 00 0.088932 0 751, 312 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 970113 278, 593 0 270, 267 92.00 0 14, 486, 238 200. 00 200.00 Subtotal (see instructions) 129, 852, 508 73, 176 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 0 Only Charges 202.00 Net Charges (line 200 - line 201) 129, 852, 508 0 14, 486, 238 202. 00 73, 176

Health Financial Systems	TERRE HAUTE REGION.	In Lieu	u of Form CMS-2552-10	
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-0046	Peri od: From 09/01/2017 To 08/31/2018	Worksheet D Part V Date/Time Prepared: 1/30/2019 11:15 am
		Ti +1 o V/// / /	Hospi tal	DDC

				10 08/31/2018	1/30/2019 11:	
		Title	XVIII	Hospi tal	PPS	10 4
	Cos			· · · · · · · · · · · · · · · · · · ·		
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						1
50. 00 05000 OPERATING 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
54.01 03630 ULTRA SOUND	0	0				54. 01
54. 02 03440 MAMMOGRAPHY	0	0				54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
56. 00 05600 RADI OI SOTOPE	0	0				56.00
57.00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60. 00 06000 LABORATORY	0	0				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	10, 931	1			73.00
74. 00 07400 RENAL DI ALYSI S	0	0				74.00
76. 00 03950 LI THOTRI PSY	0	0				76.00
76. 01 03330 ENDOSCOPY	0	0				76. 01
76. 02 03040 PRI SI ON CLI NI C	0	0				76. 02
76. 03 03050 WOUND CARE	0	0				76. 03
76. 04 03060 OPI C	0	0				76. 04
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	0	•			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	10, 931				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges		40.001				000 00
202.00 Net Charges (line 200 - line 201)	0	10, 931	l			202. 00

Health Financial Systems TERRE HAUTE REGIONAL HOSPITAL In Lieu of Form CMS-2552-10						
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0046	Peri od:	Worksheet D	
		Component	CCN: 15-S046	From 09/01/2017 To 08/31/2018		pared: 15 am
		Title	: XVIII	Subprovi der -	PPS	
				I PF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col . 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1 2/2 222	100 000 050			1	
50.00 05000 OPERATING ROOM	1, 062, 038				19	
51. 00 05100 RECOVERY ROOM	73, 949				0	
52. 00 05200 DELI VERY ROOM & LABOR ROOM	186, 018				0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	534, 513		l .		564	
54. 01 03630 ULTRA SOUND	51, 031				13	
54. 02 03440 MAMMOGRAPHY	103, 319				0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	164, 937				0	55.00
56. 00 05600 RADI OI SOTOPE	58, 944				•	
57. 00 05700 CT SCAN	89, 361	56, 065, 827			79	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	68, 337				0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	92, 792				80	
60. 00 06000 LABORATORY	319, 615				1, 904	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	31, 728				0	
65. 00 06500 RESPI RATORY THERAPY	105, 286	1			561	1
66. 00 06600 PHYSI CAL THERAPY	250, 011				537	66.00
69. 00 06900 ELECTROCARDI OLOGY	158, 002				567	
70.00 07000 ELECTROENCEPHALOGRAPHY	17, 873				40	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS	424, 236				123	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	215, 905					
73. 00 07300 DRUGS CHARGED TO PATIENTS	574, 928				3, 151	
74. 00 07400 RENAL DI ALYSI S	46, 290			· ·	118	1
76. 00 03950 LI THOTRI PSY	8, 136				0	76.00
76. 01 03330 ENDOSCOPY	98, 456				0	76. 01
76. 02 03040 PRI SI ON CLI NI C	131, 435				0	
76. 03 03050 WOUND CARE	93, 750				16	1
76. 04 03060 OPI C	150, 355	6, 011, 486	0. 02501	1, 667	42	76. 04
OUTPATIENT SERVICE COST CENTERS	F22 F24	/F 204 757	0.00045	0 400 (00	2 407	01 00
91. 00 09100 EMERGENCY	532, 586			· ·		1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 E 442 921	, , , , , , , , , , , , , , , , , , , ,	l .	· ·	11 200	92.00 200.00
200.00 Total (lines 50 through 199)	5, 643, 831	712, 986, 437	I	1, 825, 420	11, 380	₁ 200.00

Health Financial Systems T	ERRE HAUTE REG	IONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provi der C	Provider CCN: 15-0046		Worksheet D	
THROUGH COSTS		Component	CCN: 15-S046	From 09/01/2017 To 08/31/2018		norod.
		Component	CCN. 13-3040	10 00/31/2010	1/30/2019 11:	pareu. 15 am
		Title	XVIII	Subprovi der -	PPS	
				. I PF		
Cost Center Description	Non Physician		Nursi ng	Allied Health	Allied Health	
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
	1.00	Adjustments	2.00	3A	2.00	
ANCI LLARY SERVI CE COST CENTERS	1. 00	2A	2.00	3A	3. 00	
50. 00 05000 OPERATING ROOM	0	0		0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0			0 0	0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0	Ö	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54. 01 03630 ULTRA SOUND	0	0		0 0	Ö	54. 01
54. 02 03440 MAMMOGRAPHY	0	l o		0 0	Ö	54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSI S	0	0		0	0	73. 00 74. 00
76. 00 07400 RENAL DI ALYSI S 76. 00 03950 LI THOTRI PSY	0	0		0		
76. 00 03930 ET THOTRIPST 76. 01 03330 ENDOSCOPY	0			0 0	0	
76. 02 03040 PRI SI ON CLI NI C	0			0 0	0	76.01
76. 03 03050 WOUND CARE	0			0 0	0	
76. 04 03060 0PIC	0			0 0	Ö	
OUTPATIENT SERVICE COST CENTERS				<u> </u>		70.0.
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00

Health Financial Systems TI APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	ERRE HAUTE REGI		CN: 15-0046	Peri od:	u of Form CMS-2 Worksheet D	<u> 2552-10</u>
THROUGH COSTS		Component	CCN: 15-S046	From 09/01/2017 To 08/31/2018		pared: 15 am
		Title	XVIII	Subprovi der -	PPS	
Cost Center Description	All Other	Total Cost	Total	I PF Total Charges	Patio of Cost	
cost center bescription	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Education	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
	Cost	4)	col s. 2, 3,		col . 7)	
	0031	''	and 4)	001. 0)	001. 7)	
	4. 00	5. 00	6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 108, 098, 050	0.000000	50.00
51. 00 05100 RECOVERY ROOM	0	0		0 14, 346, 017	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 4, 761, 754	0.000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 14, 769, 853	0.000000	54.00
54. 01 03630 ULTRA SOUND	0	0		0 5, 164, 080	0.000000	54.01
54. 02 03440 MAMMOGRAPHY	0	0		0 1, 987, 527	0. 000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 16, 264, 193	0. 000000	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0 12, 391, 103	0. 000000	
57. 00 05700 CT SCAN	0	0		0 56, 065, 827	0. 000000	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 12, 674, 794	0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 25, 757, 934	0. 000000	
60. 00 06000 LABORATORY	0	0		0 73, 994, 218	0. 000000	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 6, 205, 675	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 18, 083, 936	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 7, 006, 479	0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 19, 745, 264	0. 000000	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 1, 376, 633	0. 000000	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 49, 499, 941	0. 000000	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 26, 380, 181	0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 116, 663, 884	0.000000	
74. 00 07400 RENAL DI ALYSI S	0	0		0 4, 269, 713	0.000000	
76. 00 03950 LI THOTRI PSY	0	0		0 3, 262, 674	0.000000	
76. 01 03330 ENDOSCOPY	0	0		0 37, 978, 885	0.000000	
76. 02 03040 PRI SI ON CLI NI C	0	0		0 596, 060	0.000000	
76. 03 03050 WOUND CARE	0		1	0 2, 419, 924	0.000000	
76. 04 03060 OPI C	0	0		0 6, 011, 486	0. 000000	76. 04
91. 00 OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	0	0		0 65, 284, 757	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	l e	l .	0 1, 925, 595	0.000000	
200.00 Total (lines 50 through 199)	0	l e		0 712, 986, 437		200.00
200.00 Total (Titles 50 till ough 179)	1	ı	I	0 112, 700, 431		₁ 200.00

Health Financial Systems T	ERRE HAUTE REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der C	CN: 15-0046	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-S046	From 09/01/2017 To 08/31/2018	Part IV Date/Time Pre 1/30/2019 11:	epared: 15 am
		Title	: XVIII	Subprovi der -	PPS	
				I PF		
Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col . 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	1, 916		0	0	
51.00 05100 RECOVERY ROOM	0. 000000	0		0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	15, 572		0 0	0	
54.01 03630 ULTRA SOUND	0. 000000	1, 282		0	0	54. 01
54. 02 03440 MAMMOGRAPHY	0. 000000	0		0	0	54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
56. 00 05600 RADI 0I SOTOPE	0. 000000	4, 610		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	49, 771		0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	22, 323		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	440, 755		0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	96, 431		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	15, 038		0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	70, 901		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	3, 108		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	14, 319		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	5, 738		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	639, 307		0 5, 968	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	10, 866		0 0	0	74.00
76. 00 03950 LI THOTRI PSY	0. 000000	0		0 0	0	76.00
76. 01 03330 ENDOSCOPY	0. 000000	0		0 0	0	76. 01
76. 02 03040 PRISION CLINIC	0. 000000	0		0 0	0	76. 02
76. 03 03050 WOUND CARE	0. 000000	425		0 0	0	76.03
76. 04 03060 OPI C	0. 000000	1, 667		0 0	0	76.04
OUTPATIENT SERVICE COST CENTERS			•			
91. 00 09100 EMERGENCY	0. 000000	428, 639		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	2, 752		0 0	0	92.00
200.00 Total (lines 50 through 199)	1 1	1, 825, 420		0 5, 968		200.00

	nancial Systems T NMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider Component		Period: From 09/01/2017 To 08/31/2018	Worksheet D Part V Date/Time Pre 1/30/2019 11:	epared: 15 am
			Title	XVIII	Subprovi der - I PF	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col.	PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1. 00	2.00	3. 00	4. 00	5. 00	
	CILLARY SERVICE COST CENTERS		_				
51. 00 05 52. 00 05	000 OPERATING ROOM 100 RECOVERY ROOM 200 DELIVERY ROOM & LABOR ROOM 400 RADIOLOGY-DIAGNOSTIC	0. 094052 0. 077120 0. 445780 0. 246485	0		0 0 0 0 0	0 0 0	51. 00 52. 00
	630 ULTRA SOUND	0. 079672				0	
	440 MAMMOGRAPHY	0. 267403				0	
	500 RADI OLOGY-THERAPEUTI C	0. 111551	l o		ol ol	0	
	600 RADI OI SOTOPE	0. 094887	0		o o	0	56.00
57. 00 05	700 CT SCAN	0. 024687	0		o o	0	57.00
	800 MAGNETIC RESONANCE IMAGING (MRI)	0. 054638			0 0	0	00.00
	900 CARDI AC CATHETERI ZATI ON	0. 042882	0		0 0	0	
	000 LABORATORY	0. 066045	0		0	0	
	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 145920			0	0	02.00
	500 RESPI RATORY THERAPY	0. 109849	0		0 0	0	
	600 PHYSI CAL THERAPY	0. 300337	0		0 0	0	
	900 ELECTROCARDI OLOGY 000 ELECTROENCEPHALOGRAPHY	0. 079960 0. 101047			0 0	0	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 101047				0	
72.00 07	200 IMPL. DEV. CHARGED TO PATIENTS	0. 177403	l e			0	1
	300 DRUGS CHARGED TO PATIENTS	0. 149380			0 7, 588	891	
	400 RENAL DI ALYSI S	0. 182898			0 7,000	0	
	950 LI THOTRI PSY	0. 095596			o o	0	1
	330 ENDOSCOPY	0. 051660			o o	0	
	040 PRISION CLINIC	0. 917760	0		o o	0	
76. 03 03	050 WOUND CARE	0. 417668	0		o o	0	76. 03
76. 04 03	060 OPI C	0. 199351	0		o o	0	76. 04
	TPATIENT SERVICE COST CENTERS						
	100 EMERGENCY	0. 088932			0 0	0	
	200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 970113			0 0	0	1
200.00	Subtotal (see instructions)		5, 968	1	0 7, 588	891	200.00
201. 00	Less PBP Clinic Lab. Services-Program Only Charges			'	0 0		201.00
	join y orial gos	1	1		1		1

	Financial Systems ONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	TERRE HAUTE REG	Provider C	CN: 15_0046	Period:	of Form CMS Worksheet D	-2552-10
ALLOKIT	ONNENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST		CCN: 15-S046	From 09/01/2017	Part V Date/Time Pr 1/30/2019 11	epared:
			Title	: XVIII	Subprovi der -	1/30/2019 11 PPS	: 15 am
		Cos	sts		I PF		
	Cost Center Description	Cost	Cost				
	oost conter bescription	Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	1			50.00
	D5100 RECOVERY ROOM	0	0	1			51.00
	D5200 DELIVERY ROOM & LABOR ROOM	0	0	1			52.00
	D5400 RADI OLOGY-DI AGNOSTI C	0	0	1			54.00
	03630 ULTRA SOUND	0	0	1			54. 01
	03440 MAMMOGRAPHY	0	0	•			54.02
	D5500 RADI OLOGY-THERAPEUTI C	0	0	1			55.00
	D5600 RADI OI SOTOPE	0	0	•			56.00
	D5700 CT SCAN	0	0	1			57.00
	D5800 MAGNETIC RESONANCE IMAGING (MRI)		0	1			58.00
4	D5900 CARDI AC CATHETERI ZATI ON D6000 LABORATORY	0		1			59. 00 60. 00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS						62.00
	06500 RESPIRATORY THERAPY		0	1			65.00
	06600 PHYSI CAL THERAPY		0				66.00
	06900 ELECTROCARDI OLOGY		0	1			69.00
	07000 ELECTROENCEPHALOGRAPHY		0				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0				72.00
	07300 DRUGS CHARGED TO PATIENTS	0	1, 133				73.00
	07400 RENAL DIALYSIS	0	0				74.00
76.00	03950 LI THOTRI PSY	0	0				76.00
76. 01	03330 ENDOSCOPY	0	0				76. 01
76. 02	03040 PRISION CLINIC	0	0				76. 02
76. 03 C	03050 WOUND CARE	0	0				76. 03
76. 04	03060 OPI C	0	0				76.04
C	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	0	0	1			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200. 00	Subtotal (see instructions)	0	1, 133				200.00
201. 00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						1
202.00	Net Charges (line 200 - line 201)	1 0	1, 133	1			202.00

Health Financial Systems	ERRE HAUTE REGI	ONAL HOSDITAL		In Lio	u of Form CMS-2	DEE2 10
Health Financial Systems T APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C	CN: 15-0046	Peri od:	Worksheet D	2552-10
ALTONIO CONTROL OF THE ALTONIO CENTROL CANTER	12 00010		CCN: 15-T046	From 09/01/2017 To 08/31/2018	Part II	pared:
		Title	Title XVIII		PPS	<u></u>
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	IRF t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS			1			
50. 00 05000 OPERATING ROOM	1, 062, 038					
51. 00 05100 RECOVERY ROOM	73, 949					
52. 00 05200 DELIVERY ROOM & LABOR ROOM	186, 018				1	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	534, 513				1, 825	
54. 01 03630 ULTRA SOUND	51, 031	5, 164, 080				1
54. 02 03440 MAMMOGRAPHY	103, 319				_	
55. 00 05500 RADI OLOGY-THERAPEUTI C	164, 937	16, 264, 193				55. 00
56. 00 05600 RADI 01 SOTOPE	58, 944	12, 391, 103				
57. 00 05700 CT SCAN	89, 361	56, 065, 827			86	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	68, 337	12, 674, 794			170	
59. 00 05900 CARDI AC CATHETERI ZATI ON	92, 792				0	
60. 00 06000 LABORATORY	319, 615				1, 471	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	31, 728		l .			
65. 00 06500 RESPIRATORY THERAPY	105, 286					
66. 00 06600 PHYSI CAL THERAPY	250, 011	7, 006, 479				
69. 00 06900 ELECTROCARDI OLOGY	158, 002					69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	17, 873					70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	424, 236 215, 905	49, 499, 941 26, 380, 181				71.00 72.00
73.00 07300 DRUGS CHARGED TO PATTENTS	574, 928				0 5, 237	73.00
74. 00 07400 RENAL DI ALYSI S	46, 290			· · · · · · · · · · · · · · · · · · ·	1, 001	74.00
76. 00 03950 LI THOTRI PSY	8, 136	3, 262, 674			1,001	1
76. 00 03930 ET THOTRIPST 76. 01 03330 ENDOSCOPY	98, 456					
76. 02 03040 PRI SI ON CLI NI C	131, 435					1
76. 03 03050 WOUND CARE	93, 750					1
76. 04 03060 OPI C	150, 355		1			76.03
OUTPATIENT SERVICE COST CENTERS	150, 355	0,011,460	0.02301	1 0		1 70.04
91. 00 09100 EMERGENCY	532, 586	65, 284, 757	0. 00815	8 6, 959	57	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 925, 595			0	
200.00 Total (lines 50 through 199)	5, 643, 831			4, 304, 977	_	

Health Financial Systems T	ERRE HAUTE REG	IONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS			Peri od:	Worksheet D	
THROUGH COSTS			CON 15 TO 47	From 09/01/2017		
		Component	CCN: 15-T046	To 08/31/2018	Date/Time Pre 1/30/2019 11:	pared: 15 am
		Title	XVIII	Subprovi der -	PPS	TO UIII
				I RF		
Cost Center Description	Non Physician		Nursi ng	Allied Health	Allied Health	
	Anestheti st	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
	1.00	Adjustments				
ANCILLARY SERVICE COST CENTERS	1. 00	2A	2. 00	3A	3. 00	
50. 00 05000 OPERATING ROOM	0	0		0 0	0	50.00
51. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM	0			0 0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C				0 0	0	54.00
54. 01 03630 ULTRA SOUND	0	0		0 0	0	54.00
54. 02 03440 MAMMOGRAPHY	0			0 0	0	54.02
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0	l o		0 0	Ö	56.00
57. 00 05700 CT SCAN	0	Ö		0 0	Ō	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
74. 00 07400 RENAL DI ALYSI S 76. 00 03950 LI THOTRI PSY	0	0		0	0	74. 00 76. 00
76. 00 03950 ETHOTRIPSY 76. 01 03330 ENDOSCOPY	0	0		0	0	76.00
76. 01 03330 ENDOSCOPT 76. 02 03040 PRI SI ON CLI NI C	0			0 0	0	76.01
76. 03 03050 WOUND CARE	0			0 0		76.02
76. 04 03060 001 C	0			0 0	0	
OUTPATIENT SERVICE COST CENTERS				<u> </u>		70.01
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1		0	0	
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00
	•			•		•

Weelth Firessial Control	EDDE HAUTE DECL	ONAL HOCDITAL		1 1:-	£ [CMC :	2552 40
Health Financial Systems T APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE	ERRE HAUTE REGI		CN: 15-0046	IN LIE Period:	u of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS	WICE OTHER TAS			From 09/01/2017 To 08/31/2018	Part IV	pared: 15 am
		Title	· XVIII	Subprovi der - I RF	PPS	
Cost Center Description	All Other	Total Cost	Total			
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)			
ANCILLARY CERVICE COCT CENTERS	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM	0	0	ı	100 000 050	0.000000	50.00
50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM	0		1	0 108, 098, 050 0 14, 346, 017	0. 000000 0. 000000	
52. 00 05100 RECOVERY ROOM LABOR ROOM	0	0	1	0 14, 346, 017	0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0 14, 769, 853	0.00000	1
54. 01 03630 ULTRA SOUND	0	0	1	5, 164, 080	l	1
54. 02 03440 MAMMOGRAPHY	0	0	1	0 1, 987, 527	0.000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 16, 264, 193	l	1
56. 00 05600 RADI OI SOTOPE	0	0		12, 391, 103	0. 000000	
57. 00 05700 CT SCAN	0	0	1	56, 065, 827	0. 000000	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	Ö	1	0 12, 674, 794	0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	l .	0 25, 757, 934	0.000000	1
60. 00 06000 LABORATORY	0	0		73, 994, 218	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 6, 205, 675	0.000000	62.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0 18, 083, 936	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		7, 006, 479	0.000000	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 19, 745, 264	0.000000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		1, 376, 633	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 49, 499, 941	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	l .	0 26, 380, 181	0.000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 116, 663, 884	0. 000000	
74. 00 07400 RENAL DI ALYSI S	0	0		0 4, 269, 713	0. 000000	
76. 00 03950 LI THOTRI PSY	0	0	1	0 3, 262, 674	0.000000	1
76. 01 03330 ENDOSCOPY	0	0		0 37, 978, 885		
76. 02 03040 PRI SI ON CLI NI C	0	0	1	596, 060		
76. 03 03050 WOUND CARE	0	0	1	0 2, 419, 924	0.000000	
76. 04 03060 OPI C	0	0		0 6, 011, 486	0.000000	76. 04
OUTPATIENT SERVICE COST CENTERS				N 4E 204 7E7	0.000000	01 00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		1	0 65, 284, 757 0 1, 925, 595	l	
200.00 Total (lines 50 through 199)	0			0 1, 925, 595 0 712, 986, 437		200.00
200.00 Total (Titles 50 till ough 199)	ı o	٠ ٠	'I	U ₁ /12, 700, 43/	I	200.00

51. 00 05100 RECOVERY ROOM 0.000000 18, 294 0 0 0 0 0 0 0 0 0			TERRE HAUTE REGIO	NAL HOSPITAL		In Lie	u of Form CMS-	<u> 2552-10</u>
Component CCN: 15-T046 To			RVICE OTHER PASS	Provi der C	CN: 15-0046			
Title XVIII Subprovider - PPS IRF Cost Center Description	THROUG	GH COSTS		Component	CCN: 15-T046		Part IV Date/Time Pre 1/30/2019 11:	epared: 15 am
Cost Center Description				Title	: XVIII	Subprovi der -	PPS	
Ratio of Cost to Charges								
To Charges Col. 6 + Col. 7) Costs (col. 8 Costs (col. 8 Col. 7) Costs (col. 9 Costs (col.		Cost Center Description						
Costs (col. 8 Costs (col. 8 Costs (col. 8 X col. 10) X col. 10) X col. 12)								
COL. 7)				Charges				
SOLITION STATE SERVICE COST CENTERS SOLITION						8		
ANCI LLARY SERVI CE COST CENTERS					x col. 10)		x col. 12)	
50.00			9. 00	10. 00	11. 00	12. 00	13.00	
51. 00 05100 RECOVERY ROOM 0.000000 18, 294 0 0 0 52. 00 05200 DELI YERY ROOM & LABOR ROOM 0.000000 0 0 0 0 54. 00 36400 RADI LOGY-DI AGNOSTI C 0.000000 50, 421 0 0 0 0 54. 01 03630 ULTRA SOUND 0.000000 7,075 0		ANCILLARY SERVICE COST CENTERS						
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 0 <td>50.00</td> <td>05000 OPERATING ROOM</td> <td>0. 000000</td> <td>96, 739</td> <td></td> <td>0 0</td> <td>0</td> <td>50.00</td>	50.00	05000 OPERATING ROOM	0. 000000	96, 739		0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 50,421 0 0 0 54. 01 03630 ULTRA SOUND 0.000000 7,075 0 0 0 54. 02 03440 MAMMOGRAPHY 0.000000 0 0 0 0 55. 00 05500 RADI OLOGY-THERAPEUTI C 0.000000 3,700 0 0 0 56. 00 05600 RADI OLOGY-THERAPEUTI C 0.000000 14,640 0	51.00	05100 RECOVERY ROOM	0. 000000	18, 294		0 0	0	51.00
54. 01 03630 ULTRA SOUND	52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54. 02 03440 MAMMOGRAPHY 0.000000 0<	54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	50, 421		0 0	0	54.00
54. 02 03440 MAMMOGRAPHY 0.000000 0<	54.01	03630 ULTRA SOUND	0. 000000	7, 075		0 0	0	54. 01
56. 00 05600 RADI OI SOTOPE 0.000000 14, 640 0 0 0 0 0 0 0 0 0	54.02	03440 MAMMOGRAPHY	0. 000000	0		0 0	0	54.02
56. 00 05600 RADI OI SOTOPE 0.000000 14,640 0 0 0 57. 00 05700 CT SCAN 0.000000 54,237 0 0 0 58. 00 05900 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 31,487 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 0 0 60. 00 06000 LABORATORY 0.000000 340,534 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 42,649 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0.000000 42,649 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0.000000 2,158,963 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0.000000 36,156 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 6,215 0 0 0 71. 00 07100 MEDI CAL SUPPLIES C	55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	3, 700		0 0	0	55.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 31,487 0 0 0 59. 00 05900 CARDIAC CATHETERIZATION 0.000000 0 0 0 0 60. 00 06000 LABORATORY 0.000000 340,534 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 42,649 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0.000000 42,649 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0.000000 2,158,963 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0.000000 36,156 0 0 0 0 0 70. 00 07000 ELECTROENCEPHAL GRAPHY 0.000000 6,215 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	56.00		0. 000000	14, 640		0 0	0	56.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 31, 487 0 0 0 59. 00 05900 CARDIAC CATHETERIZATION 0.000000 0 0 0 0 60. 00 06000 LABORATORY 0.000000 340, 534 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 42, 649 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0.000000 42, 649 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0.000000 2, 158, 963 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0.000000 36, 156 0 0 0 70. 00 07000 ELECTROENCEPHAL OGRAPHY 0.000000 6, 215 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 219, 035 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS <td>57.00</td> <td>05700 CT SCAN</td> <td>0. 000000</td> <td>54, 237</td> <td></td> <td>0 0</td> <td>l o</td> <td>57.00</td>	57.00	05700 CT SCAN	0. 000000	54, 237		0 0	l o	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0<	58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			0 0	0	58.00
60. 00 06000 LABORATORY	59.00			·	•	0 0	0	59.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 000000 42, 649 0 0 0 0 65. 00 06500 RESPIRATORY THERAPY 0. 000000 62, 842 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	60.00			340, 534		0 0	0	60.00
65. 00 06500 RESPIRATORY THERAPY 0. 000000 62, 842 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				·		0 0	l o	
66. 00 06600 PHYSI CAL THERAPY 0. 000000 2, 158, 963 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						0 0	0	
69. 00 06900 ELECTROCARDI OLOGY 0. 000000 36, 156 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		l l				0 0	l o	
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 6, 215 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 000000 219, 035 0 0 0 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0. 000000 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 1, 062, 670 0 2, 226 0 74. 00 07400 RENAL DI ALYSIS 0. 000000 92, 361 0 0 0 76. 01 03330 ENDOSCOPY 0. 000000 0 0 0 0 76. 02 03040 PRISION CLINIC 0. 000000 0 0 0 0 76. 04 03060 OPI C 0. 000000 0 0 0 0 0 00UTPATIENT SERVICE COST CENTERS 0. 000000 0 0 0 0 0 0 0						0 0	l o	
71. 00		1 1				0	0	
72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 0.000000 0 0		l l				٦	0	
73. 00						٦	0	
74. 00				•	l .	0		
76. 00 03950 LI THOTRI PSY 0. 000000 0 0 0 0 0 0 0							ĺ	
76. 01 03330 ENDOSCOPY 0. 000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1	1			٦	ĺ	
76. 02 03040 PRISION CLINIC 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				ŭ			0	
76. 03 03050 WOUND CARE 0.000000 0 0 401 0 0 0 0 0 0 0 0 0				0				
76. 04 03060 OPI C 0. 000000 0 0 0 0 0 0 0 0				0		٦		
OUTPATIENT SERVICE COST CENTERS								
	70.04		0.000000	0		0 0		1 70.04
	01 00		0.000000	6 050		0 0	0	91.00
		1 1	1 1	0, 939 0				
			0.000000	4 304 077				200.00

	ERRE HAUTE REG				u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 15-0046	Peri od: From 09/01/2017	Worksheet D Part V	
		Component	CCN: 15-T046	To 08/31/2018		pared: 15 am
		Ti tl e	× XVIII	Subprovi der - I RF	PPS	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see		Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins			
	9		(see inst.)			
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	0.004050	1	1			
50. 00 05000 OPERATING ROOM	0. 094052			0 0	0	
51. 00 05100 RECOVERY ROOM	0. 077120			0 0	0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 445780			0 0	0	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 246485		1	0 0	0	
54. 01 03630 ULTRA SOUND	0. 079672			0 0	0	
54. 02 03440 MAMMOGRAPHY	0. 267403			0 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 111551	0	1	0 0	0	1
56. 00 05600 RADI 01 SOTOPE	0. 094887	0		0 0	0	56.00
57. 00 05700 CT SCAN	0. 024687	0	1	0 0	0	57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 054638			9	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 042882			0 0	0	59.00
60. 00 06000 LABORATORY	0. 066045					60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 65.00 06500 RESPI RATORY THERAPY	0. 145920 0. 109849		1		0	62. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 300337				0	
69. 00 06900 ELECTROCARDI OLOGY	0. 300337	1				
70. 00 07000 ELECTROCARDI OLOGT	0. 101047					
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 101047		1		0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 197403		1	0 0	0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 149380		1	0 2,741	333	
74. 00 07400 RENAL DI ALYSI S	0. 147380		1	0 2,741	0	1
76. 00 03950 LI THOTRI PSY	0. 102070		1	0 0	0	
76. 01 03330 ENDOSCOPY	0. 051660			0 0	0	
76. 02 03040 PRI SI ON CLI NI C	0. 917760			0 0	0	1
76. 03 03050 WOUND CARE	0. 417668			0 0	167	
76. 04 03060 0PI C	0. 199351	1 0	1	0 0	0	
OUTPATIENT SERVICE COST CENTERS	0. 177331		1	0 0		70.04
91. 00 09100 EMERGENCY	0. 088932	0		0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 970113		1	0 0	Ö	
200.00 Subtotal (see instructions)	0.7.5110	2, 627		0 2, 741		200.00
201.00 Less PBP Clinic Lab. Services-Program		2,027		0 0	1	201.00
Only Charges			1		l	
202.00 Net Charges (line 200 - line 201)		2, 627		0 2, 741	500	202. 00

Heal th Financ	cial Systems T OF MEDICAL, OTHER HEALTH SERVICES AND	ERRE HAUTE REGI	Provider C	CN. 1E 0046	Peri od:	u of Form CMS Worksheet D	-2552-10
APPORTI UNIVIEN	I OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	UN: 15-0046	From 09/01/2017	Part V	
			Component	CCN: 15-T046	To 08/31/2018	Date/Time Pr 1/30/2019 11	
			Title	XVIII	Subprovi der - I RF	PPS	
		Cos	sts				
1	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Servi ces Not				
		Subject To	Subj ect To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
1110111	ADV OFFICE OFFICE	6. 00	7. 00				
	ARY SERVICE COST CENTERS		^				
1 1	OPERATING ROOM	0	-				50.00
	RECOVERY ROOM	0					51.00
	DELIVERY ROOM & LABOR ROOM	0	0				52.00
	RADI OLOGY-DI AGNOSTI C	_					54.00
	ULTRA SOUND MAMMOGRAPHY	0	0				54. 01
		0					54. 02
	RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	0		•			55. 00 56. 00
	CT SCAN	0	0				57.00
	MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
	CARDIAC CATHETERIZATION	0	0				59.00
	LABORATORY	0	0				60.00
	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
	RESPIRATORY THERAPY	0					65.00
	PHYSI CAL THERAPY	0	0	1			66.00
	ELECTROCARDI OLOGY	0		1			69.00
1 1	ELECTROENCEPHALOGRAPHY	0		1			70.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	_	1			71.00
	IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00 07300 1	DRUGS CHARGED TO PATIENTS	0	409				73.00
74. 00 07400 1	RENAL DIALYSIS	0	0				74.00
76. 00 03950	LI THOTRI PSY	0	0				76.00
76. 01 03330	ENDOSCOPY	0	0				76. 01
76. 02 03040	PRISION CLINIC	0	0				76. 02
76. 03 03050	WOUND CARE	0	0				76. 03
76. 04 03060	OPI C	0	0				76. 04
	TENT SERVICE COST CENTERS						
1 1	EMERGENCY	0	_				91.00
	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
	Subtotal (see instructions)	0					200.00
	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)	0	409	1			202.00

Health Financial Systems	TERRE HAUTE REG	IONAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER		STS Provi der C		Period: From 09/01/2017 To 08/31/2018	Worksheet D Part III Date/Time Pre 1/30/2019 11:	
			e XIX	Hospi tal	Cost	
Cost Center Description	Nursi ng School Post-Stepdown Adj ustments	Nursi ng School	Allied Healt Post-Stepdow Adjustments	h Allied Health Cost	All Other Medical Education Cost	
	1A	1. 00	2A	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	Ι ΙΛ	1.00		2.00	3.00	
30. 00	000000000000000000000000000000000000000	000000000000000000000000000000000000000		0 0 0 0 0 0 0 0 0 0	0 0 0 0	31. 00 40. 00 41. 00 43. 00
200.00 Total (lines 30 through 199) Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	t Per Diem	Inpatient	200.00
cost center bescription	Adjustment Amount (see	(sum of cols. 1 through 3, minus col. 4)	Days	(col. 5 ÷ col. 6)	Program Days	
	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	0 0	0	3, 29 6, 59 2, 09	0.00 0.00 0.00 0.00	0 2, 875 103	31. 00 40. 00 41. 00
200.00 Total (lines 30 through 199)		0	31, 27	5	3, 946	200.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY	000000000000000000000000000000000000000					30.00 31.00 40.00 41.00 43.00
200.00 Total (lines 30 through 199)	0					200. 00

Health Financial Systems	TERRE HAUTE REGION	AL HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0046	From 09/01/2017	Worksheet D Part IV Date/Time Prepared

Non Physician Non Physicia					To 08/31/2018	Date/Time Pre 1/30/2019 11:	
Anesthetist Cost Post-Stepdown Adjustments Cost Cost			Ti tl	e XIX	Hospi tal		
ANCILLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
Adjustments		Anesthetist			Post-Stepdown		
ANCILLARY SERVICE COST CENTERS		Cost			Adjustments		
ANCILLARY SERVICE COST CENTERS							
50, 00 05000 0FRATING ROOM 0 0 0 0 0 0 0 0 0		1. 00	2A	2.00	3A	3. 00	
51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 0 0							
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 52. 00		0	0		0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 54. 00 54. 01 03630 ULTRA SOUND 0 0 0 0 0 0 54. 00 54. 02 03630 ULTRA SOUND 0 0 0 0 0 0 54. 01 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 55. 00 57. 00 05700 CT SCAN 0 0 0 0 0 0 0 55. 00 58. 00 05700 CT SCAN 0 0 0 0 0 0 0 55. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 58. 00 60. 00 06000 LABORATORY 0 0 0 0 0 0 0 59. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0		0	0	
54. 01 03630 ULTRA SOUND 0 0 0 0 0 54. 01 54. 02 03440 MAMMGRAPHY 0 0 0 0 0 0 0 55. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 55. 00 56. 00 05600 RADI OLSOTOPE 0 0 0 0 0 0 0 55. 00 57. 00 05700 CT SCAN 0 0 0 0 0 0 0 0 56. 00 57. 00 05700 CT SCAN 0 0 0 0 0 0 0 0 56. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 59. 00 60. 00 05800 MAGNETI C RESONANCE IMAGING (MRI) 0 0 0 0 0 0 0 0 59. 00 60. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 0 59. 00 60. 00 06000 LABORATORY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0		0	l ~	
54. 02 03440 MAMMOGRAPHY 0 0 0 0 0 0 0 0 54. 02		0)	0	ľ	
55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 55.00 56.00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 55.00 57.00 05700 CT SCAN 0 0 0 0 0 57.00 0 0 0 0 0 57.00 0		0)	0	0	
56.00 05600 RADI OI SOTOPE 0 0 0 0 0 0 0 0 56.00		0)	0	0	
57.00 05700 CT SCAN 0 0 0 0 0 0 0 57.00		0)	0	0	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 0 0 0 59. 00 59. 00 05900 CARDIAC CATHETERIZATION 0 0 0 0 0 59. 00 60. 00 06000 LABORATORY 0 <td></td> <td>0</td> <td></td> <td>)</td> <td>0</td> <td>0</td> <td></td>		0)	0	0	
59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 59.00 60.00 06000 LABORATORY 0 <td></td> <td>0</td> <td></td> <td>)</td> <td>0</td> <td>0</td> <td></td>		0)	0	0	
60. 00		0)	0	0	
62. 00		0			0	0	
65. 00		0			0	1	1
66. 00	· · · · · · · · · · · · · · · · · · ·	0			0	1	1
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0			0	1	
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 70. 00 71. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 74. 00 76. 00 0 0 0 0 76. 00 76. 00 0 0 0 0 0 76. 00 76. 01 03330 ENDOSCOPY 0 0 0 0 0 0 0 0 0 76. 01 76. 02 03040 PRI SI ON CLI NI C 0 0 0 0 0 0 0 0 0 76. 02 76. 03 03050 WOUND CARE 0 0 0 0 0 0 0 0 0 76. 03 76. 04 03060 OPI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					0	1	
71. 00		0			0	1	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 0 74. 00 76. 00 03950 LI THOTRI PSY 0 0 0 0 0 0 0 0 76. 00 76. 01 03330 ENDOSCOPY 0 0 0 0 0 0 0 0 76. 01 76. 02 03040 PRI SI ON CLI NI C 0 0 0 0 0 0 0 0 0 76. 02 76. 03 03050 WOUND CARE 0 0 0 0 0 0 0 0 0 0 76. 03 76. 04 03060 OPI C 0						1	
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 74. 00 76. 00 03950 LI THOTRI PSY 0 0 0 0 0 0 76. 00 76. 01 03330 ENDOSCOPY 0 0 0 0 0 0 76. 01 76. 02 03040 PRI SI ON CLI NI C 0 0 0 0 0 0 76. 02 76. 03 03050 WOUND CARE 0 0 0 0 0 0 76. 03 76. 04 03060 OPI C 0 0 0 0 0 0 76. 04 0UTPATIENT SERVI CE COST CENTERS 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 92. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 92. 00						1 0	1
74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 74. 00 76. 00 03950 LI THOTRI PSY 0 0 0 0 0 0 0 76. 00 76. 01 03330 ENDOSCOPY 0 0 0 0 0 0 0 76. 01 76. 02 03040 PRI SI ON CLI NI C 0 0 0 0 0 0 76. 02 76. 03 03050 WOUND CARE 0 0 0 0 0 0 0 76. 03 76. 04 03060 OPI C 0 0 0 0 0 0 0 76. 03 76. 04 00TPATI ENT SERVI CE COST CENTERS 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 92. 00					0	l o	1
76. 00 03950 LI THOTRI PSY 0 0 0 0 0 0 76. 00 76. 00 76. 01 03330 ENDOSCOPY 0 0 0 0 0 0 0 76. 01 76. 02 03040 PRI SI ON CLI NI C 0 0 0 0 0 0 0 76. 02 76. 03 03050 WOUND CARE 0 0 0 0 0 0 0 76. 03 76. 04 03060 OPI C 0 0 0 0 0 0 0 0 0 0 76. 03 76. 04 00TPATI ENT SERVI CE COST CENTERS 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 92. 00		0			0	l o	
76. 01 03330 ENDOSCOPY 0 0 0 0 0 0 76. 01 76. 02 03040 PRISION CLINIC 0 0 0 0 0 0 76. 02 76. 03 03050 WOUND CARE 0 0 0 0 0 0 0 76. 03 76. 04 03060 OPI C 0 0 0 0 0 0 0 76. 04 04 04 04 04 04 04 04 04 04 04 04 04		0			0 0	ا م	1
76. 02		0			0	0	
76. 03		0			0	0	1
76. 04 03060 OPI C 0 0 0 0 0 0 76. 04 OUTPATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 0 0 0 0 0 91. 00 92. 00 92. 00 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 92. 00		0			0 0	0	1
OUTPATI ENT SERVI CE COST CENTERS 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 92.00		0			0	0	
91. 00 09100 EMERGENCY 0 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92. 00					<u> </u>		70.0.
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00		0	0		0 0	0	91.00
200.00 Total (lines 50 through 199) 0 0 0 0 200.00		0			O	0	1
	200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0046	Peri od: Worksheet D
THROUGH COSTS		From 09/01/2017 Part IV

THROUGH COSTS				o 08/31/2018	Date/Time Pre 1/30/2019 11:	
		Ti tl	e XIX	Hospi tal	Cost	15 4111
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col . 7)	
		·	and 4)			
	4. 00	5. 00	6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	1					
50.00 05000 OPERATING ROOM	0	0	(, ,	0. 000000	
51.00 05100 RECOVERY ROOM	0	0	(,	0.000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	(4, 761, 754	0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(, ,	0.000000	
54. 01 03630 ULTRA SOUND	0	0	(5, 164, 080	0.000000	
54. 02 03440 MAMMOGRAPHY	0	0	(1, 987, 527	0.000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	(10, =0 .,	0.000000	
56. 00 05600 RADI 01 SOTOPE	0	0	(12/0/1/100	0.000000	
57. 00 05700 CT SCAN	0	0	(,,	0.000000	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	(1=, 4: .,	0.000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	(0.000000	
60. 00 06000 LABORATORY	0	0	(73, 994, 218	0.000000	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(6, 205, 675	0.000000	
65. 00 06500 RESPI RATORY THERAPY	0	0	(18, 083, 936	0.000000	
66. 00 06600 PHYSI CAL THERAPY	0	0	(7, 006, 479	0.000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0	(19, 745, 264	0.000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(1, 376, 633	0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(49, 499, 941	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	26, 380, 181	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	116, 663, 884	0.000000	73.00
74. 00 07400 RENAL DI ALYSI S	0	0	C	4, 269, 713	0.000000	74. 00
76. 00 03950 LI THOTRI PSY	0	0	C	3, 262, 674	0.000000	76. 00
76. 01 03330 ENDOSCOPY	0	0	C	37, 978, 885	0.000000	76. 01
76.02 03040 PRISION CLINIC	0	0	C	596, 060	0.000000	76. 02
76. 03 03050 WOUND CARE	0	0	C	2, 419, 924	0.000000	76. 03
76. 04 03060 OPI C	0	0	C	6, 011, 486	0.000000	76. 04
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	0	C		0.000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	1	., .==,	0.000000	
200.00 Total (lines 50 through 199)	0	0	C	712, 986, 437		200. 00

Health Financial Systems	TERRE HAUTE REGIO	NAL HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE OTHER PASS	Provi der CCN: 15-0046	From 09/01/2017	Worksheet D Part IV Date/Time Prepared: 1/30/2019 11:15 am
		Title XIX	Hospi tal	Cost

THROUGH COSTS				o 08/31/2018	Date/Time Pre 1/30/2019 11:	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col. 8		Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS			ı			
50. 00 05000 OPERATI NG ROOM	0. 000000	6, 495, 797			0	
51. 00 05100 RECOVERY ROOM	0. 000000	709, 121	•	0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	2, 809, 631		0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	581, 455		0	0	54.00
54.01 03630 ULTRA SOUND	0. 000000	279, 637	[C	0	0	54. 01
54. 02 03440 MAMMOGRAPHY	0. 000000	0	C	0	0	54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	103, 401	(0	0	55.00
56. 00 05600 RADI 0I SOTOPE	0. 000000	155, 103		0	0	
57. 00 05700 CT SCAN	0. 000000	2, 093, 224		0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	489, 432		0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	1, 383, 339	[C	0	0	59.00
60. 00 06000 LABORATORY	0. 000000	4, 428, 796	[C	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	672, 121	(0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	2, 759, 715	(0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	317, 624	(0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	1, 239, 973	(0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	77, 194	(0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	2, 663, 045		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	1, 545, 352	(0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	9, 258, 192	(0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	413, 501	(0	0	74.00
76. 00 03950 LI THOTRI PSY	0. 000000	0	(0	0	76.00
76. 01 03330 ENDOSCOPY	0. 000000	371, 080	l c	0	0	76. 01
76. 02 03040 PRISION CLINIC	0. 000000	1, 616	l c	0	0	76. 02
76. 03 03050 WOUND CARE	0. 000000	7, 300	l c	0	0	76. 03
76. 04 03060 OPI C	0. 000000	293	l c	0	0	76. 04
OUTPATIENT SERVICE COST CENTERS			•			1
91. 00 09100 EMERGENCY	0. 000000	2, 316, 474	C	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	84, 518	0	0	0	92.00
200.00 Total (lines 50 through 199)		41, 256, 934	C	0	0	200.00
	•		•			•

Health Financial Systems	TERRE HAUTE REGION	IAL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDI CAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-0046	Peri od: From 09/01/2017	Worksheet D

To 08/31/2018 Date/Time Prepared: 1/30/2019 11:15 am Title XIX Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 11, 148, 970 50.00 0.094052 05100 RECOVERY ROOM 0 1, 773, 321 51.00 0.077120 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.445780 0 52.00 138, 003 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 246485 0 2, 478, 284 0 54.00 54.01 03630 ULTRA SOUND 0.079672 0 989, 872 54.01 03440 MAMMOGRAPHY 54.02 0. 267403 0 0 183, 338 0 54.02 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0.111551 0 1, 247, 199 0 55.00 56.00 05600 RADI OI SOTOPE 0.094887 1, 064, 407 56.00 0 57.00 05700 CT SCAN 0.024687 7, 894, 920 0 57.00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.054638 0 1, 329, 755 58.00 58.00 0 59.00 05900 CARDI AC CATHETERI ZATI ON 0.042882 1, 176, 251 0 59.00 06000 LABORATORY 9, 691, 501 60.00 60.00 0.066045 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.145920 0 140, 886 62 00 0 62 00 06500 RESPIRATORY THERAPY 394, 506 65.00 0.109849 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.300337 0 35, 012 0 66.00 06900 ELECTROCARDI OLOGY 0.079960 1, 338, 285 69.00 0 69.00 0. 101047 07000 ELECTROENCEPHALOGRAPHY 0 0 70 00 242, 585 70 00 0 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0.197403 3, 116, 487 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 317668 2, 225, 286 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.149380 0 0 8, 013, 936 0 73.00 07400 RENAL DIALYSIS 0 74 00 0. 182898 0 74 00 0 03950 LI THOTRI PSY 0 76.00 0.095596 0 486, 636 0 76.00 03330 ENDOSCOPY 0.051660 0 0 4, 072, 768 0 76.01 76.01 03040 PRISION CLINIC 0. 917760 0 0 712 76.02 76.02 0 309, 627 03050 WOUND CARE 0. 417668 0 0 Ω 76.03 76.03 76.04 03060 OPI C 0.199351 0 0 658, 101 0 76.04 OUTPATIENT SERVICE COST CENTERS 91.00 0.088932 91.00 09100 EMERGENCY 0 0 15, 090, 962 Ω 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0. 970113 0 533, 393 0 92.00 200.00 0 200.00 Subtotal (see instructions) 75, 775, 003 0 201.00 Less PBP Clinic Lab. Services-Program 201.00 0 Only Charges 0 0 202.00 202.00 Net Charges (line 200 - line 201) 75, 775, 003

Health Financial Systems	TERRE HAUTE REGION	In Lieu	u of Form CMS-2552-10	
APPORTIONMENT OF MEDICAL	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0046	From 09/01/2017	Worksheet D Part V Date/Time Prepared:

			Т	o 08/31/2018	Date/Time Prepared: 1/30/2019 11:15 am
		Ti tl	e XIX	Hospi tal	Cost
	Cos	sts			
Cost Center Description	Cost	Cost			
· ·	Rei mbursed	Rei mbursed			
	Servi ces	Services Not			
	Subject To	Subject To			
	Ded. & Coins.	Ded. & Coins.			
	(see inst.)	(see inst.)			
	6. 00	7. 00			
ANCILLARY SERVICE COST CENTERS	_				
50.00 05000 OPERATING ROOM	0		1		50.00
51.00 05100 RECOVERY ROOM	0	,	1		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		1		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	,			54.00
54. 01 03630 ULTRA SOUND	0	78, 865			54.0
54. 02 03440 MAMMOGRAPHY	0	49, 025			54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	0				55.00
56. 00 05600 RADI 0I SOTOPE	0				56.00
57. 00 05700 CT SCAN	0	194, 902			57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	,			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	,			59.00
60. 00 06000 LABORATORY	0	640, 075			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	,			62.00
65. 00 06500 RESPI RATORY THERAPY	0	43, 336			65.00
66. 00 06600 PHYSI CAL THERAPY	0	10, 515			66.00
69. 00 06900 ELECTROCARDI OLOGY	0	,			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	24, 512			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	615, 204			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	., ,	1		73.00
74. 00 07400 RENAL DI ALYSI S	0	0			74.00
76. 00 03950 LI THOTRI PSY	0	10,020			76.00
76. 01 03330 ENDOSCOPY	0	210, 399			76.01
76. 02 03040 PRISION CLINIC	0				76. 02
76. 03 03050 WOUND CARE	0	, ,			76. 03
76. 04 03060 OPI C	0	131, 193			76.04
OUTPATIENT SERVICE COST CENTERS					
91. 00 09100 EMERGENCY	0	, ,			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				92.00
200.00 Subtotal (see instructions)	0	8, 286, 571			200. 00
201.00 Less PBP Clinic Lab. Services-Program	0				201.00
Only Charges	_	0 00/			
202.00 Net Charges (line 200 - line 201)	0	8, 286, 571			202.00

Health Financial Systems TERRE HAUTE REGIONAL HOSPITAL In Lieu of Form CMS-2552-1 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0046 Period: Worksheet D THROUGH COSTS From 09/01/2017 Part IV							
THROUGH COSTS From 09/01/2017 Part IV	lealth Financial Systems	TERRE HAUTE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider Co	CN: 15-0046			
	THROUGH COSTS			0011 45 0044			
Component CCN: 15-S046 To 08/31/2018 Date/Time Prepared:			Component	CCN: 15-S046	10 08/31/2018	1/30/2010 11:	pared:
Title XIX Subprovider - Cost			Ti +I	e XIX	Subprovi der -		13 4111
I FF			""	C AIA		0031	
Cost Center Description Non Physician Nursing Nursing Allied Health Allied Health	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
Anesthetist School School Post-Stepdown		Anesthetist	School	School	Post-Stepdown		
Cost Post-Stepdown Adjustments		Cost	Post-Stepdown		Adjustments		
Adjustments Adjustments			Adjustments				
1.00 2A 2.00 3A 3.00		1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS							
		-				_	50.00
		0	0		0	0	51.00
		0	0		0	0	52.00
		0	0		0	0	54.00
		0	0		0	0	54. 01
		0	0		0	0	54. 02
		0	0		0 0	0	55.00
		0	0		0 0	_	56.00
		0	0		0	_	57.00
		0	0		0	_	58. 00
		0	0		0		59. 00
		0	0		0	_	60.00
		0	0		0	_	62.00
		0	0		0		65. 00
	ł ł	0	0		0 0	_	66.00
		0	0		0 0	_	69. 00
		0	0		0 0		70.00
	ł ł	0	0		0 0	_	71.00
		0	0		0		72.00
		0	0		0	_	73.00
		0	0		0	_	74.00
		0	0		0		76.00
		0	0		0	_	76. 01
		0	0		0	_	76. 02
		-					76. 03
		0	0		0 0	0	76. 04
OUTPATIENT SERVICE COST CENTERS			0			0	04 00
			0			_	
		1	_			_	
200.00 Total (lines 50 through 199) 0 0 0 0 0 200.00	200.00 Total (Tries 50 through 199)	ı	0	I	U _I U	0	J∠UU. UU

Health Financial Systems T APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	ERRE HAUTE REG		CN: 15 0044	In Lie	u of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS	RVICE UTHER PAS		CCN: 15-0046 CCN: 15-S046	From 09/01/2017 To 08/31/2018	Part IV	pared: 15 am
		Ti tl	e XIX	Subprovi der -	Cost	
Cost Center Description	All Other	Total Cost	Total	I PF	Ratio of Cost	
Cost Center Description	Medical	(sum of cols.	Outpatient	(from Wkst.	to Charges	
	Education	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
	Cost	4)	col s. 2, 3,		col. 7)	
	COST	4)	and 4)	COI. 6)	COI. 7)	
	4. 00	5. 00	6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS		0.00	0.00	7.00	0.00	
50. 00 05000 OPERATING ROOM	0	0		0 108, 098, 050	0.000000	50.00
51. 00 05100 RECOVERY ROOM	0	0		0 14, 346, 017	0. 000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 4, 761, 754	0.000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 14, 769, 853	0.000000	54.00
54. 01 03630 ULTRA SOUND	0	0		0 5, 164, 080	0.000000	54.01
54. 02 03440 MAMMOGRAPHY	0	0		0 1, 987, 527	0.000000	54.02
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 16, 264, 193	0.000000	55.00
56. 00 05600 RADI 0I SOTOPE	0	0		0 12, 391, 103	0.000000	56.00
57. 00 05700 CT SCAN	0	0		0 56, 065, 827	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 12, 674, 794	0.000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 25, 757, 934	0.000000	59.00
60. 00 06000 LABORATORY	0	0		0 73, 994, 218	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 6, 205, 675	0.000000	62.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 18, 083, 936	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 7, 006, 479	0.000000	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 19, 745, 264	0.000000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 1, 376, 633	0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 49, 499, 941	0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 26, 380, 181	0.000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 116, 663, 884	0.000000	
74. 00 07400 RENAL DI ALYSI S	0	0		0 4, 269, 713		
76. 00 03950 LI THOTRI PSY	0	0		0 3, 262, 674	0.000000	
76. 01 03330 ENDOSCOPY	0	0		0 37, 978, 885	0.000000	
76. 02 03040 PRI SI ON CLI NI C	0	0		0 596, 060		
76. 03 03050 WOUND CARE	0			0 2, 419, 924	0. 000000	
76. 04 03060 OPI C	0	0		0 6, 011, 486	0. 000000	76. 04
OUTPATIENT SERVICE COST CENTERS	1 -	1 -	1	0 45 004 353	0.000000	01.00
91. 00 09100 EMERGENCY	0		l .	0 65, 284, 757		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 1, 925, 595		
200.00 Total (lines 50 through 199)	0	0	1	0 712, 986, 437	I	200. 00

Health Financial Systems T	ERRE HAUTE REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI		Provi der Co	CN: 15-0046	Peri od:	Worksheet D	
THROUGH COSTS			CCN: 15-S046	From 09/01/2017 To 08/31/2018		pared: 15 am
		Ti tl	e XIX	Subprovi der -	Cost	
				I PF		
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	533		0	-	
51.00 05100 RECOVERY ROOM	0. 000000	0		0	-	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	35, 192		0	0	54.00
54. 01 03630 ULTRA SOUND	0. 000000	13, 683		0	0	
54. 02 03440 MAMMOGRAPHY	0. 000000	0		0	0	54.02
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	
56. 00 05600 RADI 0I SOTOPE	0. 000000	4, 147		0	0	56.00
57. 00 05700 CT SCAN	0. 000000	108, 107		0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	14, 303		0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	59.00
60. 00 06000 LABORATORY	0. 000000	967, 247		0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	3, 594		0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	113, 957		0	0	
66. 00 06600 PHYSI CAL THERAPY	0. 000000	14, 579		0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	64, 299		0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	3, 356		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	15, 105		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 003, 920		0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0	0	74.00
76. 00 03950 LI THOTRI PSY	0. 000000	0		0	0	76.00
76. 01 03330 ENDOSCOPY	0. 000000	5, 400		0 0	0	76. 01
76. 02 03040 PRISION CLINIC	0. 000000	0		0 0	0	76. 02
76. 03 03050 WOUND CARE	0. 000000	0		0 0	0	76. 03
76. 04 03060 OPI C	0. 000000	0		0 0	0	76. 04
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0. 000000	1, 093, 971		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	5, 136		0		
200.00 Total (lines 50 through 199)		3, 466, 529		0 0	0	200. 00

Health Financial Systems TERRE HAUTE REGIONAL HOSPITAL In Lieu of Form CMS-2552-1 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS THROUGH COSTS Provider CCN: 15-0046 Component CCN: 15-T046 To 08/31/2018 Date/Time Prepared: 1/30/2019 11: 15 am
TI + I - VIV
Title XIX Subprovider - Cost
Cost Center Description Non Physician Anesthetist School Post-Stepdown Adjustments Nursing School Post-Stepdown Adjustments Nursing School Post-Stepdown Adjustments
1.00 2A 2.00 3A 3.00
ANCILLARY SERVICE COST CENTERS
50. 00 05000 0PERATING ROOM 0 0 0 50. 0
51.00 05100 RECOVERY ROOM
52. 00 05200 DELI VERY ROOM & LABOR ROOM
54. 00 03400 RADI OLOGI - DI AGNOSTI C 0 0 0 54. 0 0 54. 0 0 54. 0 0 0 0 0 54. 0 0 0 0 0 0 0 54. 0 0 0 0 0 0 0 0 0 0
54. 02 03440 MAMMOGRAPHY
55. 00 05500 RADI OLOGY-THERAPEUTI C
56. 00 05600 RADI 0I SOTOPE 0 0 0 56. 0
57. 00 05700 CT SCAN 0 0 0 57. 0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 58.0
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 59. 0
60. 00 06000 LABORATORY 0 0 0 0 60. 0
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 62.0
65. 00 06500 RESPI RATORY THERAPY 0 0 0 65. 0
66. 00 06600 PHYSI CAL THERAPY 0 0 0 66. 0
69. 00 06900 ELECTROCARDI OLOGY
70. 00 07000 ELECTROENCEPHALOGRAPHY
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 72.00 0 72.00 0 0 0 0 72.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73. 0
74. 00 07400 RENAL DI ALYSI S 0 0 0 0 74. 0
76. 00 03950 Li THOTRI PSY
76. 01 03330 ENDOSCOPY
76. 02 03040 PRI SI ON CLI NI C 0 0 0 76. 0
76. 03 03050 WOUND CARE 0 0 0 0 76. 0
76. 04 03060 OPI C 0 0 0 76. 0
OUTPATIENT SERVICE COST CENTERS
91. 00 09100 EMERGENCY 0 0 0 0 91. 0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.0
200.00 Total (lines 50 through 199) 0 0 0 0 0 200.0

		Component		From 09/01/2017	Worksheet D Part IV	
			CCN: 15-1046	To 08/31/2018	Date/Time Pre 1/30/2019 11:	pared: 15 am
		Ti tl	e XIX	Subprovi der -	Cost	15 4111
				I RF		
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Education	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col . 8)	col. 7)	
 -	4. 00	5. 00	and 4) 6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
50. 00 05000 OPERATING ROOM	ol	0		0 108, 098, 050	0. 000000	50.00
51. 00 05100 RECOVERY ROOM	ő	0		0 14, 346, 017	0. 000000	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	ol	0		0 4, 761, 754	0. 000000	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	ol	0		0 14, 769, 853	0. 000000	
54. 01 03630 ULTRA SOUND	ol	0		5, 164, 080	0. 000000	
54. 02 03440 MAMMOGRAPHY	o	0		0 1, 987, 527	0.000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	o	0		0 16, 264, 193	0.000000	55.00
56. 00 05600 RADI OI SOTOPE	o	0		0 12, 391, 103	0.000000	56.00
57. 00 05700 CT SCAN	0	0		0 56, 065, 827	0.000000	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 12, 674, 794	0.000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 25, 757, 934	0.000000	
60. 00 06000 LABORATORY	0	0		0 73, 994, 218	0. 000000	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 6, 205, 675	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 18, 083, 936	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 7, 006, 479	0.000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 19, 745, 264	0. 000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 1, 376, 633	0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 49, 499, 941 0 26, 380, 181	0. 000000 0. 000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 116, 663, 884	0.000000	
74. 00 07400 RENAL DIALYSIS	0	0		0 4, 269, 713	0. 000000	
76. 00 03950 LI THOTRI PSY	0	0		0 3, 262, 674	0. 000000	
76. 01 03330 ENDOSCOPY	0	0		0 37, 978, 885	0. 000000	
76. 02 03040 PRI SI ON CLI NI C	ol	0		0 596, 060	0. 000000	
76. 03 03050 WOUND CARE	o	0		0 2, 419, 924	0. 000000	
76. 04 03060 OPI C	ol	0		0 6, 011, 486	0. 000000	76. 04
OUTPATIENT SERVICE COST CENTERS	-1	-				
91. 00 09100 EMERGENCY	0	0		0 65, 284, 757	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	0		0 1, 925, 595	0.000000	92.00
200.00 Total (lines 50 through 199)	O	0		0 712, 986, 437		200. 00

Health Financial Systems T	ERRE HAUTE REGIO	NAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVI CE OTHER PASS	Provi der Co		Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T046	From 09/01/2017 To 08/31/2018		epared: 15 am
		Ti tl	e XIX	Subprovi der -	Cost	
				I RF		
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS				_1	_	
50. 00 05000 OPERATI NG ROOM	0. 000000	231, 782		0 0	_	
51. 00 05100 RECOVERY ROOM	0. 000000	7, 427		0 0		51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	14, 032		0 0	0	54.00
54. 01 03630 ULTRA SOUND	0. 000000	1, 347		0 0	0	54. 01
54. 02 03440 MAMMOGRAPHY	0. 000000	0		0	0	54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	24, 954		0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0	0	56. 00
57. 00 05700 CT SCAN	0. 000000	37, 677		0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	59. 00
60. 00 06000 LABORATORY	0. 000000	96, 549		0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	38, 631		0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	44, 922		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	301, 231		0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	11, 196		0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	71, 174		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	47, 198		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	309, 409		0	0	73.00
74. 00 07400 RENAL DI ALYSI S	0. 000000	59, 763		0	0	74.00
76. 00 03950 LI THOTRI PSY	0. 000000	0		0	0	76. 00
76. 01 03330 ENDOSCOPY	0. 000000	0		0	0	76. 01
76. 02 03040 PRISION CLINIC	0. 000000	0		0	0	76. 02
76. 03 03050 WOUND CARE	0. 000000	0		0	0	76. 03
76. 04 03060 OPI C	0. 000000	0		0 0	0	76. 04
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0. 000000	31, 761		0 0	l .	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0	l .	
200.00 Total (lines 50 through 199)		1, 329, 053		0 0	0	200. 00

Heal th	Financial Systems TERRE HAUTE REGION	AL HOSPITAL	In Lie	u of Form CMS-:	2552-10	
COMPUT	ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0046	Peri od:	Worksheet D-1		
			From 09/01/2017 To 08/31/2018	Date/Time Pre	pared:	
		T		1/30/2019 11:	15 am	
	Cost Contor Description	Title XVIII	Hospi tal	PPS		
	Cost Center Description			1. 00		
	PART I - ALL PROVIDER COMPONENTS			1.00		
	I NPATI ENT DAYS					
1.00	Inpatient days (including private room days and swing-bed day			18, 309	1.00	
2.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed days)		sivete seem deve	18, 309		
3. 00	do not complete this line.	iys). II you have only p	Tivate room days,	0	3. 00	
4. 00	Semi-private room days (excluding swing-bed and observation b	ed days)		16, 395	4.00	
5.00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	5.00	
	reporting period					
6. 00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6. 00	
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roc	m days) through Decembe	r 31 of the cost	0	7.00	
7.00	reporting period	m days) through become	31 01 116 6031	O	7.00	
8.00	Total swing-bed NF type inpatient days (including private roo	m days) after December	31 of the cost	0	8. 00	
	reporting period (if calendar year, enter 0 on this line)					
9. 00	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	8, 853	9. 00	
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private	room days)	0	10.00	
10.00	through December 31 of the cost reporting period (see instruc	days)	Ü	10.00		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11.00	
	December 31 of the cost reporting period (if calendar year, e			_		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI	0	12.00			
13. 00	through December 31 of the cost reporting period .00 Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days)					
10.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)					
14.00	4.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)					
15.00	Total nursery days (title V or XIX only)			0		
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.00	
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31	of the cost	0.00	17. 00	
	reporting period	ies till sagi. Bessinger et		0.00		
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00	
10.00	reporting period	- th	6 +1+	0.00	10.00	
19. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 o	r the cost	0. 00	19. 00	
20. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0. 00	20.00	
	reporting period					
21. 00	Total general inpatient routine service cost (see instruction			17, 869, 405		
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost repor	ting period (line	0	22.00	
23. 00	$5 ext{ x line 17}$ Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	na neriod (line A	0	23.00	
20.00	x line 18)	or or the cost reporting	ig perrou (irric o	· ·	20.00	
24.00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost report	ng period (line	0	24.00	
05.00	7 x line 19)	04 . 6 . 11		0	05.00	
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	g period (line 8	0	25. 00	
26. 00	Total swing-bed cost (see instructions)			0	26. 00	
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		17, 869, 405		
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed c	narges)	0	1	
29. 00	Pri vate room charges (excluding swing-bed charges)			0	1	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	30. 00 31. 00	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	1	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00		

8, 640, 439 41. 00

Heal th	Financial Systems TERRE HAUTE REGIONAL HOSPITAL In Lieu	u of Form CMS-2	2552-10				
COMPUT	ATION OF INPATIENT OPERATING COST Provider CCN: 15-0046 Period: From 09/01/2017	Worksheet D-1					
	To 08/31/2018	Date/Time Pre	pared:				
	Title XVIII Hospital	1/30/2019 11: PPS	15 am_				
	Cost Center Description Total Total Average Per Program Days	Program Cost					
	Inpatient Inpatient Diem (col. 1	(col. 3 x					
	Cost Days ÷ col . 2) 1.00 2.00 3.00 4.00	col . 4) 5.00					
42. 00	NURSERY (title V & XIX only) 0 0 0.00 0		42.00				
43. 00	Intensive Care Type Inpatient Hospital Units	2 502 100	43. 00				
44. 00	INTENSIVE CARE UNIT 5, 175, 430 3, 295 1, 570. 69 1, 593 CORONARY CARE UNIT	2, 502, 109	44.00				
45.00	BURN INTENSIVE CARE UNIT		45.00				
46.00	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT		46. 00 47. 00				
47.00	Cost Center Description		47.00				
		1. 00					
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	18, 324, 338 29, 466, 886					
47.00	PASS THROUGH COST ADJUSTMENTS	27, 400, 000	49.00				
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	1, 295, 995	50.00				
51. 00		1, 104, 706	51.00				
01.00	and IV)						
52.00	Total Program excludable cost (sum of lines 50 and 51)	2, 400, 701	52.00				
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	27, 066, 185	53. 00				
	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00 55. 00	Program discharges Target amount per discharge	0 0. 00					
56. 00	Target amount (line 54 x line 55)	0.00	56.00				
57. 00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00				
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the	0.00	58. 00 59. 00				
37.00	market basket						
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0. 00 0	60. 00 61. 00				
61.00	61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						
62. 00 63. 00	0	62. 00 63. 00					
03.00	0	03.00					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See	0	64.00				
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	0	65. 00				
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66. 00				
67. 00		0	67. 00				
(0.00	(line 12 x line 19)	0	(0.00				
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	U	68. 00				
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69. 00				
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70. 00				
71. 00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00				
72. 00 73. 00	Program routine service cost (line 9 x line 71) Medically processary private room cost applicable to Program (line 14 x line 35)		72. 00 73. 00				
74.00	Medically necessary private room cost applicable to Program (line 14 x line 35) Total Program general inpatient routine service costs (line 72 + line 73)		73.00 74.00				
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column		75. 00				
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ line 2)		76. 00				
77. 00	Program capital related costs (line 9 x line 76)		77. 00				
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00				
79. 00 80. 00	Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		79. 00 80. 00				
81. 00	Inpatient routine service cost per diem limitation		81.00				
82. 00 83. 00	Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions)		82. 00 83. 00				
84. 00	Program inpatient ancillary services (see instructions)		84. 00				
85.00	Utilization review - physician compensation (see instructions)		85.00				
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		86. 00				
87. 00	Total observation bed days (see instructions)	1, 914					
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) Observation bed cost (line 87 x line 88) (see instructions)	975. 99 1, 868, 045					
U7. UU		1, 000, 045	07.00				

Health Financial Systems	TERRE HAUTE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 09/01/2017 To 08/31/2018	Date/Time Pre 1/30/2019 11:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	2, 194, 912	17, 869, 405	0. 12283	1 1, 868, 045	229, 454	90.00
91.00 Nursing School cost	0	17, 869, 405	0.00000	0 1, 868, 045	0	91.00
92.00 Allied health cost	0	17, 869, 405	0.00000	0 1, 868, 045	0	92.00
93.00 All other Medical Education	0	17, 869, 405	0.00000	0 1, 868, 045	0	93.00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0046	Peri od: From 09/01/2017		
	Component CCN: 15-S046			pared: 15 am
	Title XVIII	Subprovi der -	PPS	
		I PF		
Cost Center Description				

		I PF		
	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)		6, 598	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6, 598	2. 00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only pr	ivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed days)		6, 598	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through Decembe	r 31 of the cost	0, 370	5.00
	reporting period			
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December	21 of the cost	0	7. 00
7.00	reporting period	31 Of the Cost	Ü	7.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 3	1 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)			
9. 00	Total inpatient days including private room days applicable to the Program (excluding	swing-bed and	1, 424	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private re	nom days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)	Join days)	· ·	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private re	oom days) after	0	11. 00
10.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	10.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private through December 31 of the cost reporting period	e room days)	0	12.00
13.00		e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line			
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed	days)	0	14.00
15.00	J 3 1		0	15.00
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT		0	16. 00
17. 00		f the cost	0.00	17. 00
	reporting period			
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of	the cost	0.00	19. 00
17.00	reporting period	the cost	0.00	17.00
20.00	1	ne cost	0.00	20.00
04.00	reporting period			
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost report	ing ported (line	4, 924, 028 0	21. 00 22. 00
22.00	5 x line 17)	ing period (iine	Ü	22.00
23.00		g 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 reporting 7×1 line 19)	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting	period (line 8	0	25. 00
	x line 20)			
26.00			0	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		4, 924, 028	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed ch	arges)	0	28. 00
	Private room charges (excluding swing-bed charges)	3,	0	1
30.00	Semi-private room charges (excluding swing-bed charges)		0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	•
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)		0. 00 0. 00	ı
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instruc	tions)	0.00	1
35. 00	Average per diem private room cost differential (line 34 x line 31)	- /	0. 00	1
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost di	fferential (line	4, 924, 028	37.00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)		746. 29	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)		1, 062, 717	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)		1 0/2 717	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1, 062, 717	41.00

Heal th	Financial Systems TI	ERRE HAUTE REGIO	ONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
СОМРИТ	ATION OF INPATIENT OPERATING COST			CCN: 15-0046 CCN: 15-S046	Period: From 09/01/2017 To 08/31/2018		pared:
			Title	e XVIII	Subprovi der -	1/30/2019 11: PPS	<u>15 am</u>
	Cost Center Description	Total I npati ent	Total I npati ent	Average Per Diem (col.		Program Cost (col. 3 x	
		1.00	2. 00	÷ col. 2)	4.00	col . 4) 5.00	
42.00	NURSERY (title V & XIX only)	0	(0. (00 0	0	42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	O	(0. (0 00	0	43.00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT			9		0	44. 00 45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT						46. 00 47. 00
	Cost Center Description						
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)	-		1. 00 200, 693	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructi			1, 263, 410	49. 00
50. 00	Pass through costs applicable to Program inp	atient routine	servi ces (fro	om Wkst. D, su	ım of Parts I and	99, 979	50.00
51. 00	Pass through costs applicable to Program inp and IV)	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	11, 380	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu medical education costs (line 49 minus line	ding capital re	lated, non-ph	nysician anest	hetist, and	111, 359 1, 152, 051	1
F4 00	TARGET AMOUNT AND LIMIT COMPUTATION					0	1 54 00
	Program discharges Target amount per discharge					0 0. 00	
56.00	Target amount (line 54 x line 55)					0	56.00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (line 56 minus	s line 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	endi ng 1996,	updated and o	compounded by the		
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line which operating costs (line 53) are less tha	s 55, 59 or 60 n expected cost	enter the Les	ser of 50% of	the amount by	0.00	
62.00	, , ,	•				0	
63.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	mber 31 of th	e cost report	ing period (See	0	64.00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	er 31 of the	cost reportir	ng period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	•	·	, ,	3,	0	66.00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31	of the cost r	reporting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)			•	porting period	0	
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70.00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	tine service	cost (line 37	')		70.00
71.00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 x l	ine 35)			72. 00 73. 00
74.00	Total Program general inpatient routine serv	ice costs (line	72 + line 73	3)			74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from	worksheet B,	Part II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77.00	Program capital-related costs (line 9 x line						77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	rovi der recor	ds)			78. 00 79. 00
80.00	Total Program routine service costs for comp			•	nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi		`				81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (•				82. 00 83. 00
84. 00	1		٥,				84.00
85.00	Utilization review - physician compensation	(see instructio					85.00
86. 00	3 1 3 1		rough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			0. 00	88. 00
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				0	89. 00

Health Financial Systems T	ERRE HAUTE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (From 09/01/2017 To 08/31/2018	Date/Time Pre	narad.
		Component	JUN. 13-3040	10 00/31/2010	1/30/2019 11:	
		Title	XVIII	Subprovi der -	PPS	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	463, 237	4, 924, 028	0. 09407	7 0	0	90.00
91.00 Nursing School cost	0	4, 924, 028	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	4, 924, 028	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 924, 028	0. 00000	0 0	0	93.00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0046	Peri od: From 09/01/2017	Worksheet D-1
	Component CCN: 15-T046		
	Title XVIII	Subprovi der -	PPS
		I RF	
Cost Contor Doscription			

		IRF		
	Cost Center Description		1.00	
	PART I - ALL PROVIDER COMPONENTS		1.00	
	I NPATI ENT DAYS			1
1.00	Inpatient days (including private room days and swing-bed day		2, 094	1
2.00	Inpatient days (including private room days, excluding swing-		2, 094	
3. 00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ys). It you have only private room d	ays, 0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation b	ed days)	2, 094	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro		cost 0	5. 00
4 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om dovo) often December 21 of the co	o+ 0	4 00
6. 00	reporting period (if calendar year, enter 0 on this line)	on days) after becember 31 of the co	st 0	6.00
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December 31 of the c	ost 0	7.00
0.00	reporting period			0.00
8. 00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December 31 of the cos	t 0	8. 00
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding swing-bed a	nd 1, 264	9. 00
	newborn days)		_	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		ter 0	11.00
	December 31 of the cost reporting period (if calendar year, e			
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including private room days)	0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	X only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed days)	0	
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)		0 0	1
10.00	SWING BED ADJUSTMENT			10.00
17. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 of the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	os after December 21 of the cost	0.00	18. 00
16.00	reporting period	es alter becember 31 of the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of the cost	0.00	19. 00
20.00	reporting period	a after December 21 of the cost	0.00	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after beceinber 31 of the cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instruction		2, 519, 565	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost reporting period (line 0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting period (Li	ne 6 0	23. 00
20.00	x line 18)	or ar the book roper tring perrou (ii]	20.00
24. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporting period (I	i ne 0	24.00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting period (lin	e 8 0	25. 00
25.00	x line 20)	or the cost reporting period (in		25.00
	Total swing-bed cost (see instructions)		0	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)	2, 519, 565	27.00
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed charges)	0	28. 00
	Pri vate room charges (excluding swing-bed charges)	, , , , , , , , , , , , , , , , , , ,	0	
30.00	Semi-private room charges (excluding swing-bed charges)		0	
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ line 28)	0. 000000 0. 00	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	
34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instructions)	0.00	1
35. 00	Average per diem private room cost differential (line 34 x li	ne 31)	0.00	1
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost differential (0 Lina 2 510 565	
37.00	27 minus Line 36)	and private room cost differential (line 2, 519, 565	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		·]
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ		4 000 00	1 20 22
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line		1, 203. 23 1, 520, 883	1
40. 00	Medically necessary private room cost applicable to the Progr	,	1, 520, 665	
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)	1, 520, 883	41.00

		ERRE HAUTE REGI				u of Form CMS-2	
COMPUT	TATION OF INPATIENT OPERATING COST				Period: From 09/01/2017 To 08/31/2018	Worksheet D-1 Date/Time Pre	
			•	e XVIII		1/30/2019 11: PPS	
					Subprovi der - I RF		
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1. 00	2.00	3.00	4. 00 0 0	5. 00	42.00
42.00	Intensive Care Type Inpatient Hospital Units		(η 0.0	0 0	0	42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	(0.0	0 0	0	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	NEONATAL INTENSIVE CARE UNIT Cost Center Description			1			47.00
48. 00	Program inpatient ancillary service cost (Wk	st D 2 col 2	2 Lino 200)			1. 00 941, 923	48. 00
	Total Program inpatient costs (sum of lines			ons)		2, 462, 806	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routino	sorvi cos (fro	m Wkst D sur	n of Parts I and		
30.00		attent routine	services (110	III WKSt. D, Sui	II OI PAILS I AIIC	211, 910	30.00
51. 00	Pass through costs applicable to Program inp and IV)		ry services (f	rom Wkst. D, s	sum of Parts II	90, 938	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non-ph	vsician anesth	netist and	302, 848 2, 159, 958	1
33.00	medical education costs (line 49 minus line		rated, non pr	ysi ci aii aiicsti	ictist, and	2, 137, 730	33.00
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55.00	Target amount per discharge					0. 00	55.00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	arget amount (line 56 minus	line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)					0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	endi ng 1996,	updated and co	ompounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	•
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less than					0	61.00
	amount (line 56), otherwise enter zero (see		(tillo tal got	_	
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ıcti ons)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos			a agat rangeti	ng nonind (Coo	0	64.00
65. 00	instructions)(title XVIII only)					0	
	instructions) (title XVIII only)				, , ,		
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)		•			0	
	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	-					67.00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	ıtine service	cost (line 37))		70. 00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applic		n (line 14 x l	ine 35)			73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		•	Part II column		74. 00 75. 00
73.00	26, line 45)	routine service	COSTS (Troil	worksneet b, i	art II, cordiiii		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	. *					76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu	s line 77)					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 79)		79. 00 80. 00
81.00	Inpatient routine service cost per diem limi	tati on		(81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82. 00 83. 00
84. 00	Program inpatient ancillary services (see in		,				84.00
85. 00 86. 00	Utilization review - physician compensation						85. 00 86. 00
00.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ıı ouyı1 85)				86.00
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•				0	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (se					0.00	1

Health Financial Systems T	ERRE HAUTE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (From 09/01/2017 To 08/31/2018	Date/Time Pre 1/30/2019 11:	
		Title	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	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	351, 053	2, 519, 565	0. 13933	11 0	0	90.00
91.00 Nursing School cost	0	2, 519, 565	0.00000	0 0	0	91.00
92.00 Allied health cost	0	2, 519, 565	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 519, 565	0.00000	00	0	93.00

Heal th	Financial Systems TERRE HAUTE REGION	AL HOSPITAL	In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0046	Peri od:	Worksheet D-1	
			From 09/01/2017 To 08/31/2018	Date/Time Pre	pared:
		Ti +I o VI V		1/30/2019 11:	15 am
	Cost Center Description	Title XIX	Hospi tal	Cost	
	·			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed day	rs. excluding newborn)		18. 309	1.00
2.00	Inpatient days (including private room days, excluding swing-	bed and newborn days)		18, 309	2.00
3. 00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	rivate room days,	0	3.00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ed days)		16, 395	4.00
5. 00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	5. 00
/ 00	reporting period		21 -6	0	, 00
6. 00	Total swing-bed SNF type inpatient days (including private roreporting period (if calendar year, enter 0 on this line)	om days) arter becember	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00
0.00	reporting period	m daya) aftar Dagambar 1)1 of the cost	0	0.00
8. 00	Total swing-bed NF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	ill days) after beceiliber s	or the cost	U	8. 00
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	g swing-bed and	968	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including privator	coom days)	0	10.00
10.00	through December 31 of the cost reporting period (see instruc		doili days)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.00
12.00	through December 31 of the cost reporting period	A only (Therauling privat	ic room days)	Ü	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
14. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14.00
15. 00	Total nursery days (title V or XIX only)	(979	
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 (of the cost	0.00	17. 00
17.00	reporting period	es through becomber or c	The cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19. 00
	reporting period	G			
20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of 1	the cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instruction	s)		17, 869, 405	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ing period (line		22. 00
22 00	5 x line 17)	21 of the cost reporting	na pariod (line 4	0	23. 00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	ig period (Title o	0	23.00
24.00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24.00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	neriod (line 8	0	25. 00
25.00	x line 20)	31 of the cost reporting	perrou (Trie 8	O	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 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		17, 869, 405	27. 00
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		- ·	0	29. 00
30.00	Semi -private room charges (excluding swing-bed charges)	1: 20)		0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27	÷ IINe 28)		0. 000000 0. 00	31. 00 32. 00
32.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)				32.00
34. 00		nus line 33)(see instrud	ctions)		34.00

Heal th	Financial Systems TERRE HAUTE REGIONAL HOSPITAL In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST Provider CCN: 15-0046 Period: From 09/01/2017	Worksheet D-1	
	To 08/31/2018	Date/Time Pre 1/30/2019 11:	pared: 15 am
	Title XIX Hospital	Cost	
	Cost Center Description Total Total Average Per Program Days Inpatient Inpatient Diem (col. 1	Program Cost (col. 3 x	
	Cost Days ÷ col . 2) 1.00 2.00 3.00 4.00	col . 4) 5. 00	
42. 00	NURSERY (title V & XIX only) 819, 987 979 837. 58 0		42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT 5,175,430 3,295 1,570.69 0	0	43. 00
44.00	CORONARY CARE UNIT		44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT		45. 00 46. 00
	NEONATAL INTENSIVE CARE UNIT		47. 00
	Cost Center Description	1. 00	
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	5, 930, 745	
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions) PASS THROUGH COST ADJUSTMENTS	6, 875, 503	49. 00
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines 50 and 51)	0	52. 00
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and	Ö	53.00
	medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION		
	Program di scharges	0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)	0. 00 0	55. 00 56. 00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the	0.00	58. 00 59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0. 00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by	0.00	61.00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		
62.00	Relief payment (see instructions)	0	62. 00 63. 00
63. 00	Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST	U	03.00
64. 00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64. 00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65. 00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period	0	67. 00
49.00	(line 12 x line 19)		68. 00
	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	0	69. 00
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71. 00 72. 00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) Program routine service cost (line 9 x line 71)		71. 00 72. 00
73.00			73.00
74. 00 75. 00	Total Program general inpatient routine service costs (line 72 + line 73) Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column		74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ line 2)		76. 00
77. 00	Program capital-related costs (line 9 x line 76)		77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records)		78. 00 79. 00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80. 00
81. 00 82. 00	Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81)		81. 00 82. 00
83.00	Reasonable inpatient routine service costs (see instructions)		83. 00
84. 00 85. 00	Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions)		84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		86. 00
87. 00	Total observation bed days (see instructions)	1, 914	
88. 00 89. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) Observation bed cost (line 87 x line 88) (see instructions)	975. 99 1, 868, 045	
		,, - 10	

Health Financial Systems	ERRE HAUTE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 09/01/2017 To 08/31/2018	Date/Time Pre 1/30/2019 11:	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	2, 194, 912	17, 869, 405	0. 12283	1 1, 868, 045	229, 454	90.00
91.00 Nursing School cost	0	17, 869, 405	0.00000	0 1, 868, 045	0	91.00
92.00 Allied health cost	0	17, 869, 405	0.00000	0 1, 868, 045	0	92.00
93.00 All other Medical Education	0	17, 869, 405	0. 00000	0 1, 868, 045	0	93.00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0046	Peri od: From 09/01/2017	Worksheet D-1	
	Component CCN: 15-S046			pared: 15 am
	Title XIX	Subprovi der -	Cost	
		I PF		
Cost Center Description				
			1. 00	

		I PF		
	Cost Center Description		1. 00	
PART	I - ALL PROVIDER COMPONENTS		1.00	
	TIENT DAYS			1
00 I npa	atient days (including private room days and swing-bed days, excluding newborn)		6, 598	1.
	atient days (including private room days, excluding swing-bed and newborn days)		6, 598	2.
	vate room days (excluding swing-bed and observation bed days). If you have only priva	ate room days,	0	3.
	not complete this line.		, 500	١.
	-private room days (excluding swing-bed and observation bed days)	21 -6	6, 598	4.
	al swing-bed SNF type inpatient days (including private room days) through December : orting period	31 OF the Cost	0	5.
	nting period al swing-bed SNF type inpatient days (including private room days) after December 31	of the cost	0	6.
	orting period (if calendar year, enter 0 on this line)	or the cost	G	0.
	al swing-bed NF type inpatient days (including private room days) through December 3	1 of the cost	0	7.
	orting period			
	al swing-bed NF type inpatient days (including private room days) after December 31 o	of the cost	0	8.
	orting period (if calendar year, enter 0 on this line)		0.075	
	al inpatient days including private room days applicable to the Program (excluding so	wing-bed and	2, 875	9.
1	oorn days) ng-bed SNF type inpatient days applicable to title XVIII only (including private room	m dave)	0	10.
	ough December 31 of the cost reporting period (see instructions)	ii days)	0	10.
	ng-bed SNF type inpatient days applicable to title XVIII only (including private room	m days) after	0	11.
	ember 31 of the cost reporting period (if calendar year, enter 0 on this line)	3 ,		
	$_{ m ng}$ -bed NF type inpatient days applicable to titles V or XIX only (including private $_{ m ng}$	room days)	0	12.
	ough December 31 of the cost reporting period		_	
	ng-bed NF type inpatient days applicable to titles V or XIX only (including private in Parameter 31 of the continuous applicable to titles V or XIX only (including private in Parameter 31 of the continuous applicable to titles V or XIX only (including private in Parameter 31 of the continuous applicable to titles V or XIX only (including private in Parameter 31 of the continuous applicable to titles V or XIX only (including private in Parameter 31 of the continuous applicable to titles V or XIX only (including private in Parameter 31 of the continuous applicable to titles V or XIX only (including private in Parameter 31 of the continuous applicable to titles V or XIX only (including private in Parameter 31 of the continuous applicable to titles V or XIX only (including private in Parameter 31 of the continuous applicable to titles V or XIX only (including private in Parameter 31 of the continuous applicable to titles V or XIX only (including private in Parameter 31 of the continuous applicable to titles V or XIX only (including private in Parameter 31 of the continuous applicable to the continuous app	room days)	0	13.
arte . 00 Medi	er December 31 of the cost reporting period (if calendar year, enter 0 on this line) cally necessary private room days applicable to the Program (excluding swing-bed da	(c)	0	14.
	il nursery days (title V or XIX only)	ys)	979	
	sery days (title V or XIX only)		0	1
	G BED ADJUSTMENT	,	-	
. 00 Medi	care rate for swing-bed SNF services applicable to services through December 31 of	the cost	0.00	17.
	orting period			
	care rate for swing-bed SNF services applicable to services after December 31 of the	e cost	0. 00	18.
	orting period		0.00	10
	caid rate for swing-bed NF services applicable to services through December 31 of the Orting period	ie cost	0. 00	19.
	caid rate for swing-bed NF services applicable to services after December 31 of the	cost	0. 00	20.
	orting period			
. 00 Tota	al general inpatient routine service cost (see instructions)		4, 924, 028	21.
	ng-bed cost applicable to SNF type services through December 31 of the cost reporting	g period (line	0	22.
	line 17)			
	ng-bed cost applicable to SNF type services after December 31 of the cost reporting	period (line 6	0	23.
	ne 18) ng-bed cost applicable to NF type services through December 31 of the cost reporting	poriod (line	0	24.
	line 19)	perrou (Title	U	24.
	ng-bed cost applicable to NF type services after December 31 of the cost reporting p	eriod (line 8	0	25.
	ne 20)	sirod (iiiie o	G	20.
	al swing-bed cost (see instructions)		0	26.
. 00 Gene	eral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4, 924, 028	27.
	ATE ROOM DIFFERENTIAL ADJUSTMENT			
1	eral inpatient routine service charges (excluding swing-bed and observation bed charges)	ges)	0	
	vate room charges (excluding swing-bed charges)		0	1
	-private room charges (excluding swing-bed charges)		0 000000	
	eral inpatient routine service cost/charge ratio (line 27 ÷ line 28) rage private room per diem charge (line 29 ÷ line 3)		0. 000000 0. 00	1
4	rage semi-private room per diem charge (line 30 ÷ line 4)		0. 00	1
	rage per diem private room charge differential (line 32 minus line 33)(see instruction	ons)	0. 00	1
	rage per diem private room cost differential (line 34 x line 31)	<i>'</i>	0. 00	
4	vate room cost differential adjustment (line 3 x line 35)		0	36
	eral inpatient routine service cost net of swing-bed cost and private room cost diffe	erential (line	4, 924, 028	37.
	ninus line 36)			
	11 - HOSPITAL AND SUBPROVIDERS ONLY			1
	RAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		74/ 00	1
1 -	usted general inpatient routine service cost per diem (see instructions) gram general inpatient routine service cost (line 9 x line 38)		746. 29	1
9	cally necessary private room cost applicable to the Program (line 14 x line 35)		2, 145, 584 0	1
1	I Program general inpatient routine service cost (line 39 + line 40)		2, 145, 584	
	.5	'	_, ,	

		ERRE HAUTE REGI			In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST				Period: From 09/01/2017	Worksheet D-1	
					To 08/31/2018	1/30/2019 11:	
			litl	e XIX	Subprovi der - IPF	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	MUDGEDY (4: 41 a. V. o. VI.V. and c.)	1. 00	2. 00	3. 00	4.00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	С	0.0	0 0	0	42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	C	0.0	0 0	0	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT						46. 00 47. 00
47.00	Cost Center Description						47.00
48. 00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3	3. line 200)			1. 00 355, 939	48. 00
	Total Program inpatient costs (sum of lines			ons)		2, 501, 523	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sur	m of Parts I and	0	50.00
51. 00		ationt ancillar	ry sarvicas (f	From Wkst D	cum of Darts II	0	51.00
	and IV)		y services (i	TOII WKSt. D, .	sum of farts fr		
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		elated, non-ph	vsician anestl	netist and	0	
	medical education costs (line 49 minus line						
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00 56. 00						0. 00 0	1
57. 00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (line 56 minus	line 53)	0	1
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	norting period	ending 1996	undated and co	omnounded by the	0.00	
	market basket			•	Simpounded by the		
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0. 00 0	1
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see	n expected cost					
	Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	uctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 of th	e cost report	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	per 31 of the	cost reportin	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XVI	I only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	December 31 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	ıtine service	cost (line 37))		70.00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine 70 ÷ line	: 2)			71.00 72.00
73.00	Medically necessary private room cost applic	abĺe to Program					73. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient 26, line 45)	•		,	Part II, column		74.00 75.00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces	s costs (from p			>		79. 00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost iimitatio	n (iine 78 mii	nus iine 79)		80. 00 81. 00
82.00	Inpatient routine service cost limitation (I	ine 9 x line 81					82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		15)				83. 00 84. 00
85. 00 86. 00	Utilization review - physician compensation	(see instructio					85. 00 86. 00
	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST	n Jugir 63)				
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	- line 2)			0 0. 00	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (se					0	

Health Financial Systems T	ERRE HAUTE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO	Provider CCN: 15-0046		Worksheet D-1	
		Component (CCN: 15-S046	From 09/01/2017 To 08/31/2018		pared: 15 am_
		Ti tl	e XIX	Subprovi der -	Cost	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	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	463, 237	4, 924, 028	0. 09407	7 0	0	90.00
91.00 Nursing School cost	0	4, 924, 028	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	4, 924, 028	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 924, 028	0. 00000	00	0	93. 00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0046	Peri od: From 09/01/2017	Worksheet D-1	
	Component CCN: 15-T046			pared: 15 am
	Title XIX	Subprovi der -	Cost	
		l RF		
Cost Center Description				

	IR	-		
	Cost Center Description	-	1. 00	
	PART I - ALL PROVIDER COMPONENTS		1.00	
	I NPATI ENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2, 094	1.00
2. 00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2, 094	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room do not complete this line.	m days,	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation bed days)		2, 094	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of t	he cost	0	5. 00
	reporting period			
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the	cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)		0	7. 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the reporting period	e cost	U	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the	cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)			
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-be	d and	103	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)		0	10.00
10.00	through December 31 of the cost reporting period (see instructions)		0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)			
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days applicable to titles V or XIX	ys)	0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days	ivs)	0	13. 00
10.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	93)	G	10.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15. 00	Total nursery days (title V or XIX only)		979	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT		0	16. 00
17. 00		t	0.00	17. 00
17.00	report in a peri od		0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		0.00	18. 00
40.00	reporting period			40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost		0. 00	20.00
	reporting period			
21. 00	Total general inpatient routine service cost (see instructions)		2, 519, 565	•
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period 5×1 ine 17)	d (line	0	22. 00
23. 00		(line 6	0	23. 00
20.00	x line 18)	(· ·	20.00
24.00		(line	0	24.00
25 00	7 x line 19)	11: 0	0	25 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period ($ x $ line 20)	Tine 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)		0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2, 519, 565	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		_	
	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)		0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0. 000000	31.00
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	•
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	•
35. 00 36. 00	Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differentia	d (line	-	37.00
	27 minus line 36)			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
00.05	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		4 000	00.05
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38)		1, 203. 23 123, 933	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		123, 933	40.00
	Total Program general inpatient routine service cost (line 39 + line 40)		123, 933	
		,		

		ERRE HAUTE REGI			In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST				Period: From 09/01/2017	Worksheet D-1	
			•		To 08/31/2018	1/30/2019 11:	
			liti	e XIX	Subprovi der - I RF	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	MUDGEDY (4: 41 - V 0 VIV1.)	1.00	2. 00	3. 00	4.00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	(0.0	0 0	0	42.00
43.00		0	(0.0	0 0	0	
44. 00 45. 00							44. 00 45. 00
	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT						46. 00 47. 00
47.00	Cost Center Description						47.00
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	R Line 200)			1. 00 226, 987	48. 00
	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ons)		350, 920	1
50.00	Pass through costs applicable to Program inp	atient routine	servi ces (fro	m Wkst. D, sur	m of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D, s	sum of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines					0	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		elated, non-ph	ysician anestl	netist, and	0	53.00
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55.00	Target amount per discharge					0. 00	55. 00
56. 00 57. 00	,	ing cost and ta	ırget amount (line 56 minus	line 53)	0	56. 00 57. 00
	Bonus payment (see instructions)					0	
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	ending 1996,	updated and co	ompounded by the		
60. 00 61. 00	, ,				the amount by	0. 00 0	1
01100	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see	n expected cost				J	011.00
	Relief payment (see instructions)					0	
	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST					0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	ember 31 of th	e cost reporti	ing period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the	cost reporting	g period (See	0	65.00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XVI	ll only). For	0	66.00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after [ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil	ity/ICF/IID rou	ıtine service	cost (line 37))		70. 00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71.00 72.00
73.00	Medically necessary private room cost applic	abĺe to Program					73. 00
74. 00 75. 00	Capital-related cost allocated to inpatient			•	Part II, column		74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00			rovi der recor	ds)			79.00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		cost limitatio	n (line 78 min	nus line 79)		80. 00 81. 00
82.00	Inpatient routine service cost limitation (ine 9 x line 81					82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		ns)				83. 00 84. 00
85.00	Utilization review - physician compensation	(see instruction					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)				86.00
87. 00	Total observation bed days (see instructions)	Line 2)			0 00	
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se					0.00	88. 00 89. 00

Health Financial Systems T	ERRE HAUTE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 09/01/2017		
		Component (CCN: 15-T046	To 08/31/2018	Date/Time Pre 1/30/2019 11:	
		Ti +1	e XIX	Subprovi der -	Cost	13 alli
		11 (1	e vi v		COST	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	351, 053	2, 519, 565	0. 13933	31 0	0	90.00
91.00 Nursing School cost	0	2, 519, 565	0.00000	00	0	91.00
92.00 Allied health cost	0	2, 519, 565	0. 00000	00	0	92.00
93.00 All other Medical Education	0	2, 519, 565	0. 00000	0 0	0	93.00

	INCI LLARY SERVICE COST APPORTIONMENT	REGIONAL HOSPITAL Provider C	CN: 15-0046	Peri od:	u of Form CMS-2 Worksheet D-3	
				From 09/01/2017 To 08/31/2018	Date/Time Pre 1/30/2019 11:	
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2) 3.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	O ADULTS & PEDIATRICS			9, 619, 386		30.00
	O INTENSIVE CARE UNIT			4, 822, 956		31.00
	O SUBPROVI DER - I PF			0		40.00
	O SUBPROVI DER – I RF			0		41.00
43.00 0430						43.00
	LLARY SERVICE COST CENTERS		•			
50.00 0500	O OPERATING ROOM		0. 0940	55 23, 690, 168	2, 228, 179	50.00
51.00 0510	O RECOVERY ROOM		0. 0771	20 2, 666, 370	205, 630	51.00
52.00 0520	ODELIVERY ROOM & LABOR ROOM		0. 4457	80 8, 608	3, 837	52.00
54.00 0540	O RADI OLOGY-DI AGNOSTI C		0. 2464	85 2, 311, 943	569, 859	54.00
54. 01 0363	O ULTRA SOUND		0. 0796	72 613, 248	48, 859	54.01
54. 02 0344	O MAMMOGRAPHY		0. 2674	03 881	236	54.02
	O RADI OLOGY-THERAPEUTI C		0. 1115	· ·	46, 527	
	0 RADI 0I SOTOPE		0. 0948	· ·	55, 640	
	O CT SCAN		0. 0246		224, 429	
	O MAGNETIC RESONANCE IMAGING (MRI)		0. 0546		105, 350	
1	O CARDI AC CATHETERI ZATI ON		0. 0428		267, 563	
	O LABORATORY		0.0660		1, 076, 983	
	O WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 1459		374, 279	
	O RESPI RATORY THERAPY		0. 1098		1, 035, 461	65.00
	O PHYSI CAL THERAPY		0. 3033		568, 358	
	O ELECTROCARDI OLOGY		0.0805			
	O ELECTROENCEPHALOGRAPHY O MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1010 0. 1974		35, 283 2, 763, 808	
	O IMPL. DEV. CHARGED TO PATTENTS		0. 1974			
	O DRUGS CHARGED TO PATIENTS		0. 1493			
	O RENAL DIALYSIS		0. 1493		525, 099	
	O LI THOTRI PSY		0. 1828		0 323,044	76.00
	O ENDOSCOPY		0.0733			
	O PRISION CLINIC		0. 9177		0	76.02
	O WOUND CARE		0. 4224		11, 185	
	O OPI C		0. 2036		3, 319	76.04
	ATIENT SERVICE COST CENTERS		1.2000		2,017	1
	O EMERGENCY		0. 0894	32 8, 532, 498	763, 078	91.00
	O OBSERVATION BEDS (NON-DISTINCT PART)		0. 9701		195, 354	
200.00	Total (sum of lines 50 through 94 and 96 through	98)		148, 793, 580	18, 324, 338	200.00
201. 00	Less PBP Clinic Laboratory Services-Program only	charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)	- · · · · ·		148, 793, 580		202.00

Cost Center Description	Ratio of Co To Charge:	•	Date/Time Pre 1/30/2019 11: PPS	pareo 15 ar
Cost Center Description	Ratio of Co	IPF st Inpatient	PPS	
		st Inpatient	Inpatient	
	To Charges	s Program		
			Program Costs	
		Charges	(col. 1 x	
	1.00	2.22	col . 2)	_
	1.00	2. 00	3. 00	-
INPATIENT ROUTINE SERVICE COST CENTERS				1 20
.00 03000 ADULTS & PEDIATRICS .00 03100 NTENSIVE CARE UNIT		0	I	30.
.00 03100 INTENSIVE CARE UNIT .00 04000 SUBPROVIDER - IPF		5, 577, 050	I	31. 40.
. 00 04100 SUBPROVI DER		3, 377, 030	I	41.
. 00 04300 NURSERY		0	I	43.
ANCI LLARY SERVI CE COST CENTERS				1 73.
. 00 05000 OPERATI NG ROOM	0. 0940	055 1, 916	180	50.
. 00 05100 RECOVERY ROOM	0. 077	·	0	1
.00 05200 DELIVERY ROOM & LABOR ROOM	0. 445		0	52.
. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 2464	185 15, 572	3, 838	54.
. 01 03630 ULTRA SOUND	0.0796	572 1, 282	102	54.
. 02 03440 MAMMOGRAPHY	0. 2674	103 0	0	54.
. 00 05500 RADI OLOGY-THERAPEUTI C	0. 1115		0	
. 00 05600 RADI 0I SOTOPE	0. 0948	· ·	437	
.00 05700 CT SCAN	0. 0246		1, 229	
.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.0546		0	
. 00 05900 CARDI AC CATHETERI ZATI ON	0.0428		957	
. 00 06000 LABORATORY	0.0660		29, 110	
.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS .00 06500 RESPI RATORY THERAPY	0. 1459 0. 1098		0 10, 593	
. 00 06600 PHYSI CAL THERAPY	0. 1090	·	4, 562	
. 00 06900 ELECTROCARDI OLOGY	0. 080!	·	5, 711	1
. 00 07000 ELECTROENCEPHALOGRAPHY	0. 1010		314	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 1974	·	2, 827	
. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 3176		1, 823	
. 00 07300 DRUGS CHARGED TO PATIENTS	0. 1493		95, 500	
. 00 07400 RENAL DI ALYSI S	0. 1828		1, 987	74.
. 00 03950 LI THOTRI PSY	0. 0955	596 0	0	76.
. 01 03330 ENDOSCOPY	0. 052	176 0	0	76.
. 02 03040 PRISION CLINIC	0. 917		0	76.
. 03 03050 WOUND CARE	0. 4224		180	
. 04 03060 OPI C	0. 2036	509 1, 667	339	76.
OUTPATIENT SERVICE COST CENTERS				4
OO O9100 EMERGENCY	0. 0894	·	38, 334	
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 970	·	2, 670	
7.00 Total (sum of lines 50 through 94 and 96 through 98)	(1)	1, 825, 420	200, 693	
1.00 Less PBP Clinic Laboratory Services-Program only charges (line 2.00 Net charges (line 200 minus line 201)	01)	0 1, 825, 420	I	201. 202.

ATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0046	Period: From 09/01/2017	Worksheet D-3	3
	Component	CCN: 15-T046	To 08/31/2018	Date/Time Pre	
	Ti tl e	: XVIII	Subprovi der - I RF	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
		1 00	0.00	col . 2)	_
INDATIENT DOUTING CEDAL OF COCT CENTERS		1.00	2. 00	3. 00	\vdash
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 00 03000 ADULTS & PEDI ATRI CS		T	0	<u> </u>	3
00 03100 INTENSIVE CARE UNIT			0	l	3
00 04000 SUBPROVI DER - I PF			0		4
00 04100 SUBPROVI DER			1, 684, 077		4
00 04300 NURSERY			1,004,077		4
ANCI LLARY SERVI CE COST CENTERS					1 '
00 05000 OPERATING ROOM		0. 0940	55 96, 739	9, 099	5
00 05100 RECOVERY ROOM		0. 0771	· ·		
00 05200 DELIVERY ROOM & LABOR ROOM		0. 44578	80 0	0	5
00 05400 RADI OLOGY-DI AGNOSTI C		0. 24648	85 50, 421	12, 428	5
01 03630 ULTRA SOUND		0. 0796	72 7, 075	564	5
02 03440 MAMMOGRAPHY		0. 26740		ľ	
00 05500 RADI OLOGY-THERAPEUTI C		0. 1115!			
00 05600 RADI 0I SOTOPE		0. 0948	· ·		
00 05700 CT SCAN		0. 02468		1, 339	
00 05800 MAGNETIC RESONANCE MAGING (MRI)		0. 05463		1, 720	
00 05900 CARDI AC CATHETERI ZATI ON		0. 0428		0	
00 06000 LABORATORY		0.06604			
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 00 06500 RESPIRATORY THERAPY		0. 14592 0. 10984	· ·		
00 06600 PHYSI CAL THERAPY		0. 30334			
00 06900 ELECTROCARDI OLOGY		0. 08054			
00 07000 ELECTROENCEPHALOGRAPHY		0. 1010	· ·		
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 19740	· ·	l	
00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 3176			
00 07300 DRUGS CHARGED TO PATIENTS		0. 1493	1, 062, 670	158, 742	7
00 07400 RENAL DIALYSIS		0. 1828	98 92, 361	16, 893	7
00 03950 LI THOTRI PSY		0. 09559	96 0	0	7
01 03330 ENDOSCOPY		0. 0521	76 0	0	7
02 03040 PRISION CLINIC		0. 9177		0	
03 03050 WOUND CARE		0. 4224			1 '
04 03060 OPI C		0. 20360	09 0	0	7
OUTPATIENT SERVICE COST CENTERS		0.0001	22 (252	/ ^ ^	4
00 09100 EMERGENCY		0.0894	· ·	l e	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	arough 00)	0. 9701		041 022	
Total (sum of lines 50 through 94 and 96 th .00 Less PBP Clinic Laboratory Services-Program			4, 304, 977	941, 923	20
.00 Less PBP Clinic Laboratory Services-Program	ii oniy charges (rine 61)	I	0	I	ĮΖŪ

Health Figureial Systems	AL HOCDITAL		المانما	u of Form CMC	2552 10
Health Financial Systems TERRE HAUTE REGIONAL INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	°N: 15_0046	Peri od:	u of Form CMS-2 Worksheet D-3	
THE ATTENT AND LEAR SERVICE COST ATTORTONNENT	i i ovi dei c	CN. 13-0040	From 09/01/2017	Worksheet D-3	
			To 08/31/2018	Date/Time Pre 1/30/2019 11:	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x	
		1.00	0.00	col . 2)	
INDATIENT DOUTINE CEDVICE COCT CENTEDO		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			2 004 100		20.00
30. 00 03000 ADULTS & PEDI ATRI CS			2, 984, 198		30.00
31. 00 03100 INTENSI VE CARE UNI T			1, 361, 302		31.00
40. 00 04000 SUBPROVI DER - PF 41. 00 04100 SUBPROVI DER - RF			0		40. 00 41. 00
			1 272 000		
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS			1, 373, 909		43. 00
50. 00 05000 OPERATING ROOM		0. 0940	52 6, 495, 797	610, 943	50.00
51. 00 05100 RECOVERY ROOM		0. 0771		54, 687	1
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 44578		1, 252, 477	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 24648		143, 320	
54. 01 03630 ULTRA SOUND		0. 2404	· ·	22, 279	1
54. 02 03440 MAMMOGRAPHY		0. 0740		22, 2/9	1
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 2074		11, 534	1
56. 00 05600 RADI 0I SOTOPE		0. 09488	· ·	14, 717	1
57. 00 05700 CT SCAN		0. 02468		51, 675	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 0546		26, 742	1
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 0428		59, 320	1
60. 00 06000 LABORATORY		0. 06604		292, 500	1
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 1459:		98, 076	
65. 00 06500 RESPIRATORY THERAPY		0. 1098		303, 152	1
66. 00 06600 PHYSI CAL THERAPY		0. 3003		95, 394	
69. 00 06900 ELECTROCARDI OLOGY		0. 07996		99, 148	1
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 1010		7, 800	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 19740	03 2, 663, 045	525, 693	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 3176		490, 909	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1493	9, 258, 192	1, 382, 989	73.00
74. 00 07400 RENAL DIALYSIS		0. 1828		75, 629	74.00
76. 00 03950 LI THOTRI PSY		0. 0955		0	76.00
76. 01 03330 ENDOSCOPY		0. 0516	60 371, 080	19, 170	76. 01
76. 02 03040 PRI SI ON CLI NI C		0. 9177	· ·	1, 483	1
76. 03 03050 WOUND CARE		0. 4176	68 7, 300	3, 049	76. 03
76. 04 03060 OPI C		0. 1993!		58	1
OUTPATIENT SERVICE COST CENTERS]
91. 00 09100 EMERGENCY		0. 08893	32 2, 316, 474	206, 009	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 9701 ⁻	13 84, 518	81, 992	92.00
200 00 Total (sum of lines 50 through 94 and 96 through 98)		1	41 256 934	5 930 745	200 00

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

206, 009 91. 00 81, 992 92. 00 5, 930, 745 200. 00

201. 00 202. 00

41, 256, 934

41, 256, 934

200.00

201. 00 202. 00

IPATI ENT A	NCILLARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 15-0046	Peri od:	Worksheet D-3	3
		Component (CCN: 15-S046	From 09/01/2017 To 08/31/2018	Date/Time Pre	
		Ti tl	e XIX	Subprovi der -	Cost	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
			1 00		col . 2)	-
LAIDA	THENT POUTLING CERVICE COCT CENTERS		1. 00	2. 00	3. 00	-
	TIENT ROUTINE SERVICE COST CENTERS			0		1 20
	O ADULTS & PEDIATRICS O INTENSIVE CARE UNIT			0	l	30.
	O SUBPROVI DER – I PF			9, 682, 394		40.
4	O SUBPROVI DER – T PF			9, 002, 394		41.
	O NURSERY			0	l .	43.
	LLARY SERVICE COST CENTERS					43.
	O OPERATING ROOM		0. 0940	52 533	50	50.
	O RECOVERY ROOM		0. 0771		l	
	D DELIVERY ROOM & LABOR ROOM		0. 4457		0	
	O RADI OLOGY-DI AGNOSTI C		0. 2464		· -	1
	O ULTRA SOUND		0. 0796			
	O MAMMOGRAPHY		0. 2674	·	l '	
	RADI OLOGY-THERAPEUTI C		0. 1115		0	55
	O RADI OI SOTOPE		0. 0948		393	
	O CT SCAN		0. 0246		2, 669	57
. 00 05800	O MAGNETIC RESONANCE IMAGING (MRI)		0. 0546	38 14, 303	781	58
. 00 05900	O CARDI AC CATHETERI ZATI ON		0. 0428	82 0	0	59
. 00 06000	O LABORATORY		0. 0660	45 967, 247	63, 882	60
. 00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 1459	20 3, 594	524	62
	RESPI RATORY THERAPY		0. 1098	49 113, 957	12, 518	65
. 00 06600	O PHYSI CAL THERAPY		0. 3003	37 14, 579	4, 379	66
	0 ELECTROCARDI OLOGY		0. 0799	·	•	
	0 ELECTROENCEPHALOGRAPHY		0. 1010		l	
	O MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1974	·		
	O IMPL. DEV. CHARGED TO PATIENTS		0. 3176		1	
	D DRUGS CHARGED TO PATIENTS		0. 1493		l	
	O RENAL DI ALYSI S		0. 1828		0	
	O LI THOTRI PSY		0. 0955		1	
	0 ENDOSCOPY		0. 0516		l	1 .
	O PRISION CLINIC		0. 9177			
	0 WOUND CARE		0. 4176			
	O OPIC		0. 1993	51 0	0	76
	ATLENT SERVICE COST CENTERS March March		0.0000	22 1 002 074	07 200	91
	U EMERGENCY O OBSERVATION BEDS (NON-DISTINCT PART)		0.0889	· · · · · ·	97, 289	
1	UDBSERVATION BEDS (NON-DISTINCT PART) Total (sum of lines 50 through 94 and 96 through 9	0)	0. 9701	·		
0. 00 1. 00	Less PBP Clinic Laboratory Services-Program only c			3, 466, 529 0	l	200
71.00	Less for Citilic Laboratory services-Program only C	naryes (Trie 61)		1	I	201

NPATIENT ANCI	LLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0046	Peri od:	Worksheet D-3	3
		Component	CCN: 15-T046	From 09/01/2017 To 08/31/2018	Date/Time Pre 1/30/2019 11:	pared:
		Ti tl	e XIX	Subprovi der - I RF	Cost	
Co	st Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
			1.00	0.00	col . 2)	
LNDATLEN	T DOUTING CERVICE COCT CENTERS		1.00	2. 00	3. 00	-
	T ROUTINE SERVICE COST CENTERS ULTS & PEDIATRICS		I	0		30.0
	TENSIVE CARE UNIT			0		31.0
	BPROVI DER - I PF			0		40.0
	BPROVIDER - IRF			315, 815		41.0
43. 00 04300 NU				010,010		43.0
	Y SERVICE COST CENTERS					1
	ERATING ROOM		0. 0940	52 231, 782	21, 800	50.0
	COVERY ROOM		0. 0771	20 7, 427	573	51.0
52. 00 05200 DE	LIVERY ROOM & LABOR ROOM		0. 4457	80 0	0	52.0
	DI OLOGY-DI AGNOSTI C		0. 2464		3, 459	54.0
	TRA SOUND		0. 0796		107	
	MMOGRAPHY		0. 2674		0	
	DI OLOGY-THERAPEUTI C		0. 1115		2, 784	
	DI OI SOTOPE		0. 0948		0	1
57. 00 05700 CT			0. 0246		930	
	GNETIC RESONANCE IMAGING (MRI) RDIAC CATHETERIZATION		0. 0546 0. 0428		0	
60. 00 06000 LA			0.0428		6, 377	
1 1	OLE BLOOD & PACKED RED BLOOD CELLS		0.0000		5, 637	1
	SPI RATORY THERAPY		0. 1098		4, 935	
	YSI CAL THERAPY		0. 3003		90, 471	
	ECTROCARDI OLOGY		0. 0799		895	1
	ECTROENCEPHALOGRAPHY		0. 1010		0	
1.00 07100 ME	DICAL SUPPLIES CHARGED TO PATIENTS		0. 1974	03 71, 174	14, 050	71. C
72.00 07200 I M	PL. DEV. CHARGED TO PATIENTS		0. 3176	68 47, 198	14, 993	72.0
	UGS CHARGED TO PATIENTS		0. 1493	80 309, 409	46, 220	73.0
	NAL DIALYSIS		0. 1828		10, 931	
1 1	THOTRI PSY		0. 0955		0	1
6. 01 03330 EN			0. 0516		0	
	ISION CLINIC		0. 9177		0	
76. 03 03050 WO			0. 4176		0	
76. 04 03060 OP			0. 1993	51 0	0	76.0
91.00 09100 EM	NT SERVICE COST CENTERS		0. 0889	22 21 7/1	2, 825	91.0
	ERGENCY SERVATION BEDS (NON-DISTINCT PART)		0.0889		2, 825	1
	tal (sum of lines 50 through 94 and 96 through	98)	0.9/01	1, 329, 053	226, 987	
	ss PBP Clinic Laboratory Services-Program only			1, 329, 033	220, 707	200. 0
-000 LC	t charges (line 200 minus line 201)	charges (Title 01)	1	1, 329, 053		202. 0

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0046	Period: From 09/01/2017 To 08/31/2018	Date/Time Prepared:
	T		1/30/2019 11:15 am

			10 08/31/2018	Date/IIMe Pre 1/30/2019 11:	
		Title XVIII	Hospi tal	PPS	
	DADT A LANDATIENT HOSDITAL SERVICES LINDED LDDS			1. 00	
1. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0	1.00
1. 01	DRG amounts other than outlier payments for discharges occurrinstructions)	ing prior to October 1	(see	1, 791, 657	1.01
1. 02	DRG amounts other than outlier payments for discharges occurrinstructions)	ing on or after October	1 (see	19, 918, 771	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI f 1 (see instructions)	prior to October	0	1. 03	
1. 04	DRG for federal specific operating payment for Model 4 BPCI f October 1 (see instructions)	for discharges occurring	on or after	0	1.04
2.00	Outlier payments for discharges. (see instructions)			594, 046 0	1
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instruct	i one)		0	1
3. 00	Managed Care Simulated Payments	1 0115)		3, 374, 087	3.00
4. 00	Bed days available divided by number of days in the cost repo	orting period (see instru	uctions)	158. 29	1
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the mos	t recent cost reporting	period ending on	0. 00	5.00
	or before 12/31/1996. (see instructions)				
6. 00	FTE count for allopathic and osteopathic programs that meet t new programs in accordance with 42 CFR 413.79(e)		·	0.00	
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified ACA \S 5503 reduction amount to the IME cap as specified under			0. 00 0. 00	1
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413.			0. 00	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap 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 lines (8, 8,01 and 8,02) (see				9. 00
	instructions) FTE count for allopathic and osteopathic programs in the curr	rent year from your reco	rds		10.00
	FTE count for residents in dental and podiatric programs.				11.00
	Current year allowable FTE (see instructions)				12.00
13. 00 14. 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that ye	or anded on ar after Son	tombor 20 1007	0. 00 0. 00	
14.00	otherwise enter zero.	ear ended on or arter sep	Telliber 30, 1997,	0.00	14.00
15. 00	Sum of lines 12 through 14 divided by 3.			0.00	15. 00
	Adjustment for residents in initial years of the program				16.00
	Adjustment for residents displaced by program or hospital clo	sure			17.00
18.00	Adjusted rolling average FTE count			0.00	18. 00
19.00	Current year resident to bed ratio (line 18 divided by line 4	·).		0.000000	19. 00
	Prior year resident to bed ratio (see instructions)			0.000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
	IME payment adjustment (see instructions)			0	
22.01	IME payment adjustment - Managed Care (see instructions)	2 -£ +b - MMA		0	22.01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 42 Number of additional allopathic and osteopathic IME FTE resid		CFR 412. 105	0.00	23. 00
24.00	(f)(1)(iv)(C).			0.00	24 00
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the	lower of line 23 or line	e 24 (see	0. 00 0. 00	1
24 00	<pre>instructions) Resident to bed ratio (divide line 25 by line 4)</pre>			0. 000000	26. 00
26.00	IME payments adjustment factor. (see instructions)			0.000000	
	IME add-on adjustment amount (see instructions)			0.000000	1
	TME add-on adjustment amount (see Firstructions) IME add-on adjustment amount - Managed Care (see instructions	.)		0	1
	Total IME payment (sum of lines 22 and 28)	5)		0	
	Total IME payment - Managed Care (sum of lines 22.01 and 28.0	1)		0	
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A p	nationt days (soo instru	ctions)	5. 39	30.00
	Percentage of Medicaid patient days (see instructions)	acroni days (see institut	ati ons)	22. 25	1
	Sum of lines 30 and 31			27. 64	1
	Allowable disproportionate share percentage (see instructions			12. 02	1
	Disproportionate share adjustment (see instructions)			652, 398	
5 55	1-1 1 1. 0.1010 0.1010 0.00 0.001 (000 111011 0011 0		l	302, 370	, 000

CALCIII	I Financial Systems TERRE HAUTE I _ATION OF REIMBURSEMENT SETTLEMENT	REGIONAL HOSPI	TAL er CCN: 15-0046	Period:	eu of Form CMS-2 Worksheet E	2552-10
CALCUL	ATTON OF RETWIDORSEMENT SETTLEMENT	Provide	21 CCN. 15-0046	From 09/01/2017 To 08/31/2018	Part A	
		Т	itle XVIII	Hospi tal	PPS	15 aiii
					On/After 10/1	
				1. 00	2. 00	
35. 00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)			5 977 483 147	6, 766, 695, 164] 35. 00
35. 01	Factor 3 (see instructions)			0. 000121143		
35. 02	,	o, enter zero d	on this line) (
05 00	instructions)			FO F40	500 070	05.00
	Pro rata share of the hospital uncompensated care payme Total uncompensated care (sum of columns 1 and 2 on lin		e instructions)	59, 518 642, 596		35. 03 36. 00
00.00	Additional payment for high percentage of ESRD beneficia		(lines 40 thro]
40. 00	Total Medicare discharges on Worksheet S-3, Part I excl	udi ng di scharç	ges for MS-DRGs	C		40.00
	652, 682, 683, 684 and 685 (see instructions)			Before 1/1	On/After 1/1	
				1.00	1. 01	
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652,	682, 683, 684	an 685. (see	C		41.00
41 01	instructions)	MC DDO: 13	-2 (02 (22 (44 0.
41. 01	Total ESRD Medicare covered and paid discharges excludi an 685. (see instructions)	ng MS-DRGS 6	02, 682, 683, 68	34 C	0	41.0
42. 00	1	qualify for a	ndjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 6	552, 682, 683,	684 an 685. (se	ee C		43.00
44.00	instructions)		44 - 41 - 11 - 11 - 11 - 11 - 11	7 0 000000		144.00
44. 00	Ratio of average length of stay to one week (line 43 didays)	vided by Tine	41 divided by	0.000000		44.00
45. 00		ıcti ons)		0.00	0.00	45.00
46. 00	1 3 1	ine 41.01)		0		46.00
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and	MDU cmall ru	al bosnitals	23, 599, 468		47.00
40.00	only. (see instructions)	MDH, SIIIAH FUI	ai ilospi tai s			40.00
				<u> </u>	Amount	
40.00	Total navment for innetient energing costs (cost instru	unti ana)			1.00	40.00
49. 00 50. 00	Total payment for inpatient operating costs (see instru Payment for inpatient program capital (from Wkst. L, Pt		as applicable	2)	23, 599, 468 1, 916, 319	•
51.00	Exception payment for inpatient program capital (Wkst.				0	1
52.00		E-4, line 49 se	e instructions).	0	
53. 00 54. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies				0 6, 110	
54. 00	Islet isolation add-on payment				0,110	1
55. 00	' 3	line 69)			0	
56. 00	Cost of physicians' services in a teaching hospital (se				0	
57. 00 58. 00	Routine service other pass through costs (from Wkst. D, Ancillary service other pass through costs from Wkst. D			through 35).	0	
59. 00), I t. I V, COI.	11 111le 200)		25, 521, 897	
60.00	Primary payer payments				5, 735	60.00
61.00	1 3 1 3	minus line 60))		25, 516, 162	
62. 00 63. 00					2, 278, 912 59, 969	
64. 00	Allowable bad debts (see instructions)				170, 432	
65. 00					110, 781	
66.00	Allowable bad debts for dual eligible beneficiaries (se	e instructions	s)		66, 790	
67. 00 68. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced device	s for applicat	No to MS DDCs	(soo instructions	23, 288, 062	1
59. 00 59. 00						1
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			,	0	1
70. 50	, , ,		adjustment (se	e instructions)	0	
70. 87 70. 88	Demonstration payment adjustment amount before sequestres SCH or MDH volume decrease adjustment (contractor use o				0	
70. 89	1	J,	s)			70.8
70. 90	HSP bonus payment HVBP adjustment amount (see instruction	ons)	•		0	70. 9
70 01	, ,	ons)			0	
70. 91	Bundled Model 1 discount amount (see instructions)				0	
70. 92	,				_77 676	1 7N 0
70. 92 70. 93	,				-27, 636 -180, 247	1

CALCULATION OF REIMBURSEMENT SETTLEMENT		CN: 15-0046		Worksheet E Part A Date/Time Prep 1/30/2019 11:	
	ппе	XVIII	Hospi tal (yyyy)	PPS Amount	
		111	0	1. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter in	col umn 0		0		70. 96
the corresponding federal year for the period prior to 10/1) 170.97 Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or after the corresponding federal year for the period ending on or after the period prior to 10/1)			0	0	
70.99 HAC adjustment amount (see instructions) 71.00 Amount due provider (line 67 minus lines 68 plus/minus lines 69 71.01 Sequestration adjustment (see instructions) 71.02 Demonstration payment adjustment amount after sequestration	9 & 70)			0 23, 080, 179 461, 604	
72.00 Interim payments 73.00 Tentative settlement (for contractor use only) 74.00 Balance due provider/program (line 71 minus lines 71.01, 71.02, 73)	72, and			22, 500, 007 0 118, 568	72. 00 73. 00
75.00 Protested amounts (nonallowable cost report items) in accordance CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)	ce with			646, 606	75. 00
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of plus 2.04 (see instructions)	f 2.03			0	90.00
91.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00 Operating outlier reconciliation adjustment amount (see instruct				0	92.00
93.00 Capital outlier reconciliation adjustment amount (see instruction 94.00 The rate used to calculate the time value of money (see instruction)				0 0. 00	93. 00 94. 00
95.00 Time value of money for operating expenses (see instructions)	211 0113)			0.00	95.00
96.00 Time value of money for capital related expenses (see instructi	ons)			o	
			Prior to 10/1		
LICD Darria Darriant America			1.00	2. 00	
HSP Bonus Payment Amount 100.00 HSP bonus amount (see instructions)			0	0	100. 00
HVBP Adjustment for HSP Bonus Payment			0	0	100.00
TO LOUINVER AND USUMENT LACTOR (See This tructions)			0. 0000000000	0. 0000000000	101. 00
101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions))		0.0000000000	0. 0000000000 0	101. 00 102. 00
)		1		
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions))		0. 0000	0. 0000	102. 00 103. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions)			0	0. 0000	102. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstra	ation) Adju		0. 0000	0.0000	102. 00 103. 00 104. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration period of the current 5-year demonstration period of the current period of the current 5-year demonstration period of the current	ation) Adju		0. 0000	0.0000	102. 00 103. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration period of the current 5-year demonstration period century Cures Act? Enter "Y" for yes or "N" for no.	ation) Adju		0. 0000	0.0000	102. 00 103. 00 104. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§41	ation) Adju		0. 0000	0. 0000	102. 00 103. 00 104. 00 200. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration period of the current 5-year demonstration period century Cures Act? Enter "Y" for yes or "N" for no.	ation) Adju		0. 0000	0.0000	102. 00 103. 00 104. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§41	ation) Adju od under	the 21st	0.0000	0.0000	102. 00 103. 00 104. 00 200. 00 201. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§41	ation) Adju od under	the 21st	0.0000	0.0000 0.tration	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Periodentry Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 202.00 Medicare discharges (see instructions) 203.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fperiod) 204.00 Medicare target amount	ation) Adju od under	the 21st	0.0000	0.0000 0.tration	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Periodental Periodental Project (§410A Demonstration Periodental Project (§410A Demonstration Periodental Project (§410A Demonstration Periodental Project (§410A Demonstration Periodental Project (§410A Dem	ation) Adju od under	the 21st	0.0000	0. 0000 0 tration	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Periodental Control	ation) Adju od under	the 21st	0.0000	0. 0000 0 tration	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstra	ation) Adju od under 49) First year	the 21st	0.0000	0.0000 0.tration	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00
102. 00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103. 00 HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration (§410A	ation) Adju od under 49) First year	the 21st	0.0000	0.0000 0	102. 00 103. 00 104. 00 200. 00 201. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration period) 1 s this the first year of the current 5-year demonstration period (century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 202.00 Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fine) 203.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fine) 204.00 Medicare target amount 205.00 Case-mix adjusted target amount (line 203 times line 204) 206.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 207.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I	ation) Adju od under 49) First year	the 21st	0.0000	0.0000 0	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00
102. 00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103. 00 HRR adjustment factor (see instructions) 104. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration (N/A in 19 Demonstration Project (§410A Demonstration (N/A in 19 Demonstration Project (§410A Demonstration Project (§410A Demonstration (§410A	ation) Adju od under 49) First year	the 21st	0.0000	0.0000 0	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Periodentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 202.00 Medicare discharges (see instructions) 203.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fine 10d) 204.00 Medicare target amount 205.00 Case-mix adjusted target amount (line 203 times line 204) 206.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 207.00 Program reimbursement under the §410A Demonstration (see instructions) 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I 209.00 Adjustment to Medicare IPPS payments (see instructions)	ation) Adju od under 49) First year	the 21st	0.0000	0.0000 0	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration (N/A in 19 Demonstration Project (§410A Demonstration (N/A in 19 Demonstration Project (§410A Demonstration (N/A in 19 Demonstration Project (§410A Demonstration (See Instructions) Program reimbursement under the §410A Demonstration (See Instructions) Adjustment to Medicare IPPS payments (See Instructions) Comparision of PPS versus Cost Reimbursement	49) First year uctions)	the 21st	0.0000	0.0000 0 tration	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 211. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration (N/A in 1910A) Demonstration (See instructions) Adjustment to Medicare Part A Inpatient Reimbursement 107.00 Program reimbursement under the §410A Demonstration (See instructions) Demonstration (See instructions) Reserved for future use 111.00 Total adjustment to Medicare IPPS payments (See instructions) Comparision of PPS versus Cost Reimbursement 112.00 Total adjustment to Medicare Part A IPPS payments (from line 202 Total adjustment to Medicare Part A IPPS payments (from Line 202 Total Adjustment to Medicare Part A IPPS payments (from Line 202 Total Adjustment to Medicare Part A IPPS payments (from Line 202 Total Adjustment to Medicare Part A IPPS payments (from Line 203 Total Adjustment to Medicare Part A IPPS payments (from Line 203 Total Adjustment to Medicare Part A IPPS payments (from Line 204 Demonstration (from Line 204 Demonstration (from Line 205 Demonstration (from Lin	49) First year uctions)	the 21st	0.0000	0.0000 0.tration	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration period) 1 s this the first year of the current 5-year demonstration period Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 202.00 Medicare discharges (see instructions) 203.00 Case-mix adjustment factor (see instructions) 204.00 Medicare target amount 205.00 Case-mix adjusted target amount (line 203 times line 204) 206.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 207.00 Program reimbursement under the §410A Demonstration (see instructions) 208.00 Medicare Part A inpatient Reimbursement 209.00 Medicare Part A inpatient Reimbursement 209.01 Reserved for future use 210.00 Reserved for future use 211.00 Comparision of PPS versus Cost Reimbursement	49) First year uctions) line 59)	of the curre	0.0000	0.0000 0.tration	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 211. 00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0046	Period: From 09/01/2017 To 08/31/2018	Worksheet E Part B Date/Time Prepared: 1/30/2019 11:15 am

			10 00/01/2010	1/30/2019 11:	
		Title XVIII	Hospi tal	PPS	
	DART R. MEDICAL AND OTHER HEALTH OFFINANCE			1. 00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			10 021	1.00
1. 00 2. 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions)			10, 931 14, 486, 238	
3. 00	OPPS payments			14, 625, 261	
4. 00	Outlier payment (see instructions)				4.00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructions))		0. 000	5.00
6.00	Line 2 times line 5			0	6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0. 00	
8. 00	Transitional corridor payment (see instructions)			0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col	. 13, line 200		0	
10.00	Organ acquisitions			10.021	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			10, 931	11.00
	Reasonable charges				-
12. 00	Ancillary service charges			73, 176	12.00
13. 00)		0	1
14.00	Total reasonable charges (sum of lines 12 and 13)			73, 176	14. 00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment			0	
16. 00	Amounts that would have been realized from patients liable for payme	ent for services o	on a chargebasis	0	16. 00
17 00	had such payment been made in accordance with 42 CFR §413.13(e)			0.000000	17.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000 73, 176	
	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only if I	ine 18 evceeds li	ne 11) (see	62, 245	
17.00	instructions)	THE TO EXCEEUS IT	116 11) (366	02, 243	17.00
20. 00	Excess of reasonable cost over customary charges (complete only if I	ine 11 exceeds li	ne 18) (see	0	20.00
	instructions)		, `		
21.00	Lesser of cost or charges (see instructions)			10, 931	21.00
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see instruction	is)		0	
24. 00	,			14, 693, 380	24.00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)			0	25.00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (f	for CAH see instr	ructions)	2, 762, 313	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the			11, 941, 998	1
27.00	instructions)		20] (000	,,,,,	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50))		0	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29)			11, 941, 998	1
	Primary payer payments			3, 456	
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			11, 938, 542	32.00
33 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
	Allowable bad debts (see instructions)			500, 240	
	Adjusted reimbursable bad debts (see instructions)			325, 156	
	Allowable bad debts for dual eligible beneficiaries (see instruction	ıs)		396, 514	36.00
	Subtotal (see instructions)			12, 263, 698	
	MSP-LCC reconciliation amount from PS&R			59	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
39. 97 39. 98		dess (see Instru	stions)	0	
39. 90	Partial or full credits received from manufacturers for replaced dev RECOVERY OF ACCELERATED DEPRECIATION	rices (see ilistiud	LLI ULIS)	0	1
	Subtotal (see instructions)			12, 263, 639	
40. 01				245, 273	
	Demonstration payment adjustment amount after sequestration			0	
	0 Interim payments				41.00
	Tentative settlement (for contractors use only)			0	42.00
43.00	Balance due provider/program (see instructions)			145, 195	1
44.00	,	th CMS Pub. 15-2,	chapter 1,	0	44.00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				-
90 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0.00	1
	Total (sum of lines 91 and 93)			0	94.00
			,		

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046	Period: From 09/01/2017	Worksheet E
	Component CCN: 15-S046		Date/Time Prepared:
			1/30/2019 11:15 am
	Title XVIII	Subprovi der -	PPS
		LDE	

		Title XVIII	Subprovi der - I PF	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			1, 133	1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruc OPPS payments	tions)		891 1, 202	2. 00 3. 00
4. 00	Outlier payment (see instructions)			1, 202	4. 00
4. 01	Outlier reconciliation amount (see instructions)		0	4. 01	
5.00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0. 000	5.00
6. 00	Line 2 times line 5			0	6. 00
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	7. 00 8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV col 13 line 200		0	9. 00
10.00	Organ acqui si ti ons	,		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			1, 133	11. 00
	Reasonable charges				
12.00	Ancillary service charges			7, 588	12.00
	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)			7, 588	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for	navment for services on	a charge hasis	0	15. 00
16. 00	Amounts that would have been realized from patients liable fo		9	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(
17. 00				0. 000000	
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete on	ly if line 18 evceeds li	no 11) (soo	7, 588 6, 455	18. 00 19. 00
19.00	instructions)	Ty IT ITTIE TO exceeds IT	116 11) (366	0, 433	17.00
20.00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds li	ne 18) (see	0	20.00
04.00	instructions)			4 400	04 00
21. 00 22. 00	,			1, 133	21. 00 22. 00
23. 00	1	ructions)		0	23. 00
24.00				1, 202	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instruction	•	unti ana)	0	25. 00 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, 335	27. 00
27.00	instructions)	pr do 1110 od 01 111100 21	20] (000	2, 000	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, I			0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
30. 00 31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			2, 335 0	30. 00 31. 00
	Subtotal (line 30 minus line 31)			2, 335	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	34. 00 35. 00
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	36. 00
37.00	Subtotal (see instructions)	,		2, 335	37.00
	MSP-LCC reconciliation amount from PS&R			0	38. 00
39.00	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	5)		0	39. 50
39. 98	Partial or full credits received from manufacturers for repla	ced devices (see instruc	ctions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		,	0	39. 99
40.00	Subtotal (see instructions)			2, 335	40.00
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			47 0	40. 01 40. 02
41.00	Interim payments			2, 665	40. 02
42. 00					42.00
43.00	Balance due provider/program (see instructions)			-377	43.00
44. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90. 00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93. 00 94. 00
, 00	1.2.2. (2.3. 0. 1.1.00). and /0/		ı	٥١	, , 00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046	Peri od:	Worksheet E
	Component CCN: 15-T046	From 09/01/2017 To 08/31/2018	Date/Time Prepared:
			1/30/2019 11:15 am
	Title XVIII	Subprovi der -	PPS
		LDE	

		Title XVIII	Subprovi der - I RF	PPS	
			7100	1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1. 00	Medical and other services (see instructions)			409	1.00
2.00	Medical and other services reimbursed under OPPS (see instruc	tions)		500	2.00
3. 00 4. 00	OPPS payments Outlier payment (see instructions)			556 0	3. 00 4. 00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0. 000	5.00
6. 00	Line 2 times line 5			0	6.00
7.00	Sum of 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	8. 00 9. 00
10. 00	Organ acquisitions	1 7, 601. 13, 11116 200		0	10.00
	Total cost (sum of lines 1 and 10) (see instructions)			409	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
10.00	Reasonable charges			2 741	10.00
12.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 60)		2, 741 0	
14. 00		THE 07)		2, 741	•
	Customary charges			=,	
15. 00	Aggregate amount actually collected from patients liable for			0	15. 00
16. 00	Amounts that would have been realized from patients liable fo	. 3	on a chargebasis	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)			2, 741	1
19. 00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds l	ine 11) (see	2, 332	•
	instructions)	•			
20. 00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds l	ine 18) (see	0	20. 00
21 00	instructions) Lesser of cost or charges (see instructions)			409	21.00
21.00	,			0	22.00
23. 00	,	ructions)		Ö	•
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			556	24.00
05.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instruction Deductibles and Coinsurance amounts relating to amount on lin	•	ructions)	0 20	25. 00 26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	•		945	•
	instructions)		, (1	
28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
30. 00 31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			945	30. 00 31. 00
	Subtotal (line 30 minus line 31)			945	1
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
	Allowable bad debts (see instructions)			0	34.00
35. 00 36. 00	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ructions)		0	35. 00 36. 00
37. 00		r de tr ons)		945	
38. 00	MSP-LCC reconciliation amount from PS&R			0	38. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)			39. 50
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repla	ced devices (see instru	ctions)	0	39. 97 39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	ced devices (see mstra	(10113)	0	1
40.00				945	1
40. 01	Sequestration adjustment (see instructions)			19	•
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
41. 00 42. 00	Interim payments Tentative settlement (for contractors use only)			1, 062 0	41. 00 42. 00
43. 00				-136	•
44. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	1
	§115. 2		•		
00.05	TO BE COMPLETED BY CONTRACTOR				00.00
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90. 00 91. 00
	The rate used to calculate the Time Value of Money				91.00
	Time Value of Money (see instructions)			0.00	1
94.00	Total (sum of lines 91 and 93)			0	94.00

Peri od: Worksheet E-1
From 09/01/2017 Part I
To 08/31/2018 Date/Time Prepared: 1/30/2019 11:15 am Provider CCN: 15-0046

					1/30/2019 11:	15 am
			XVIII	Hospi tal	PPS	
		Inpati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		22, 500, 007		11, 873, 171	1.00
2.00	Interim payments payable on individual bills, either		()	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVI DER		C		0	3. 01
3. 02			(0	3. 02
3. 03			(0	3. 03
3.04			(0	3.04
3. 05			()	0	3.05
	Provider to Program					
3. 50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 51			C		0	3. 51
3. 52			C		0	3. 52
3. 53			C		0	3. 53
3. 54			(0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C)	0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		22, 500, 007		11, 873, 171	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
г оо	TO BE COMPLETED BY CONTRACTOR	Γ	Γ			- no
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			1	0	5. 01
5. 02	TENTATIVE TO PROVIDER					5.01
5. 02						5.02
5.05	Provider to Program			/	0	3.03
5. 50	TENTATI VE TO PROGRAM)	0	5. 50
5. 51	TENTATI VE TO TROOKAW					5.51
5. 52						5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	5. 99
0. 77	5. 50-5. 98)					0. , ,
6. 00	Determined net settlement amount (balance due) based on					6.00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		118, 568	3	145, 195	6. 01
6. 02	SETTLEMENT TO PROGRAM		1		0	6. 02
7. 00	Total Medicare program liability (see instructions)		22, 618, 575	5	12, 018, 366	
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
)	1. 00	2.00	
8. 00	Name of Contractor					8. 00

Health Financial Systems	TERRE HAUTE REGIO	NAL HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR	SERVICES RENDERED	Provider CCN: 15-0046	Peri od: From 09/01/2017	Worksheet E-1 Part I
		Component CCN: 15-S046	To 08/31/2018	Date/Time Prepared: 1/30/2019 11:15 am
		Title XVIII	Subprovi der -	PPS

		Title	xVIII	Subprovi der -	1/30/2019 11: PPS	15 2
				I PF		
		Inpatien	nt Part A	Par	⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4. 00	
00	Total interim payments paid to provider		972, 668	3	2, 665	1.
00	Interim payments payable on individual bills, either			D	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)					
	Program to Provider					
01	ADJUSTMENTS TO PROVIDER				0	3
02)	0	3
23				D	0	3
04				O	0	3
05			(O	0	3
	Provi der to Program	Ι	1	_		
50	ADJUSTMENTS TO PROGRAM		l .		0	3
51 52			1		0	3
52 53						3
54						3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	3
	3. 50-3. 98)					
00	Total interim payments (sum of lines 1, 2, and 3.99)		972, 668	3	2, 665	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
00	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
01	TENTATI VE TO PROVI DER		1	O	0	5
02					0	5
03	Durani dan da Duranan				0	5
50	Provider to Program TENTATIVE TO PROGRAM		1 /		0	5
50 51	TENTATI VE TO TROOKAW		1			5
52						5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	5
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on					6
	the cost report. (1)		10.10			١.
01 02	SETTLEMENT TO PROVIDER		10, 13		0	6
	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		982, 79		377 2, 288	
	Total medicale program frability (see firstructions)		702, 79	Contractor	NPR Date	'
00				Number	(Mo/Day/Yr)	

Health Financial Systems	TERRE HAUTE RE	GIONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR	SERVI CES RENDERED	Provider Component		Peri od: From 09/01/2017 To 08/31/2018		pared:
		Title	: XVIII	Subprovi der – I RF	PPS	
		I npati en	it Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1 00	2 00	3 00	4 00	

				I RF		
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		2, 054, 415		1, 062	1.00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		0	3. 02
3.03			0		0	3.03
3.04			0		0	3. 04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3.53			0		0	3.53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 054, 415		1, 062	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
E 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after	I				E 00
5. 00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02	TENTATIVE TO PROVIDER		0			5. 02
5. 03			0			5. 03
5. 05	Provider to Program					3.00
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			o o		0	5. 51
5. 52			o o		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		6, 694		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		136	6. 02
7. 00	Total Medicare program liability (see instructions)		2, 061, 109		926	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8.00	Name of Contractor				1	8.00

Heal th	Health Financial Systems TERRE HAUTE REGIONAL HOSPITAL In Lieu			u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0046	Peri od:	Worksheet E-1	
			From 09/01/2017 To 08/31/2018		narod
			10 06/31/2016	Date/Time Pre 1/30/2019 11:	
		Title XVIII	Hospi tal	PPS	
	·				
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				1
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.		e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	3-12			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	3-12			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 o	certified 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 instruction	ns)		32.00
			·		-

Heal th	Financial Systems TERRE HAUTE REGIO	NAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0046	Peri od: From 09/01/2017	Worksheet E-3 Part II	
		Component CCN: 15-S046	To 08/31/2018	Date/Time Pre 1/30/2019 11:	
		Title XVIII	Subprovi der - I PF	PPS	
				1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and me	dical education payments)	1, 188, 999	1.00
2.00 Net IPF PPS Outlier Payments				0	2.00
3.00	Net IPF PPS ECT Payments			0	3.00
4. 00	Unweighted intern and resident FTE count in the most recent	cost report filed on or I	oefore November	0. 00	4. 00

	1. 00	
PART II - MEDICARE PART A SERVICES - IPF PPS		
00 Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1, 188, 999	
00 Net IPF PPS Outlier Payments	0	
00 Net IPF PPS ECT Payments	0)
Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	
Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	
0 New Teaching program adjustment. (see instructions)	0.00)
O Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	
O Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	
0 Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00)
ON Average Daily Census (see instructions)	18. 076712	
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	1
00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1, 188, 999	1
00 Nursing and Allied Health Managed Care payment (see instruction)	0	1
00 Organ acquisition (DO NOT USE THIS LINE)		1
00 Cost of physicians' services in a teaching hospital (see instructions)	0) 1
00 Subtotal (see instructions)	1, 188, 999	1
00 Primary payer payments	6, 546	1
00 Subtotal (line 16 less line 17).	1, 182, 453	1
00 Deductibles	182, 332	1 1
00 Subtotal (line 18 minus line 19)	1, 000, 121	2
00 Coi nsurance	7, 603	2
00 Subtotal (line 20 minus line 21)	992, 518	2
00 Allowable bad debts (exclude bad debts for professional services) (see instructions)	15, 905	2
00 Adjusted reimbursable bad debts (see instructions)	10, 338	2
00 Allowable bad debts for dual eligible beneficiaries (see instructions)	0) 2
00 Subtotal (sum of lines 22 and 24)	1, 002, 856) 2
00 Direct graduate medical education payments (from Wkst. E-4, line 49)	0) 2
00 Other pass through costs (see instructions)	0) 2
00 Outlier payments reconciliation	0) 2
00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0) 3
50 Pioneer ACO demonstration payment adjustment (see instructions)	0) 3
99 Demonstration payment adjustment amount before sequestration	0) 3
00 Total amount payable to the provider (see instructions)	1, 002, 856) 3
01 Sequestration adjustment (see instructions)	20, 057	3
02 Demonstration payment adjustment amount after sequestration	0) 3
00 Interim payments	972, 668	3 3
00 Tentative settlement (for contractor use only)	0) 3
00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	10, 131	3
OO Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	3
TO BE COMPLETED BY CONTRACTOR		
00 Original outlier amount from Worksheet E-3, Part II, line 2) 5
00 Outlier reconciliation adjustment amount (see instructions)) 5
.00 The rate used to calculate the Time Value of Money	0.00	
.00 Time Value of Money (see instructions)	0) 5

Heal th	Financial Systems TERRE HAUTE REGION	NAL HOSPITAL	In Lie	u of Form CMS-:	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046	Peri od:	Worksheet E-3	
		Component CCN: 15-T046	From 09/01/2017 To 08/31/2018	Date/Time Pre	pared:
		T: +1 o V/// 1 1	Cubaravi dan	1/30/2019 11:	15 am_
		Title XVIII	Subprovi der -	PPS	
				•	
				1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			1, 754, 306	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0343	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			106, 486	3.00
4.00	Outlier Payments			266, 787	4. 00
5. 00	Unweighted intern and resident FTE count in the most recent to November 15, 2004 (see instructions)	cost reporting period e	nding on or prior	0.00	5. 00

		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	1, 754, 306	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0343	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	106, 486	3.00
4.00	Outlier Payments	266, 787	4. 00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior	0.00	5.00
	to November 15, 2004 (see instructions)		
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0. 00	5. 01
6. 00	New Teaching program adjustment. (see instructions)	0. 00	6. 00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0. 00	7. 00
	teaching program" (see instructions)		
8. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0. 00	8. 00
	teaching program" (see instructions)		
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	
10.00	Average Daily Census (see instructions)	5. 736986	
11.00	Teaching Adjustment Factor (see instructions)	0. 000000	
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	2, 127, 579	
14. 00 15. 00	Nursing and Allied Health Managed Care payments (see instruction)	0	14. 00 15. 00
16. 00	Organ acquisition (DO NOT USE THIS LINE)		16.00
17. 00	Cost of physicians' services in a teaching hospital (see instructions)	2, 127, 579	
18. 00			18.00
19.00	Primary payer payments Subtotal (line 17 less line 18).		
	Deductibles	2, 127, 579 14, 692	
21. 00	Subtotal (line 19 minus line 20)	2, 112, 887	
22. 00	Coi nsurance		22.00
23. 00	Subtotal (line 21 minus line 22)	2, 103, 172	
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	2, 103, 172	1
	Adjusted reimbursable bad debts (see instructions)	0	
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	
27. 00	Subtotal (sum of lines 23 and 25)	2, 103, 172	
	Direct graduate medical education payments (from Wkst. E-4, line 49)		28.00
29. 00	Other pass through costs (see instructions)	0	
30.00	Outlier payments reconciliation	0	
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	o l	
31. 99	Demonstration payment adjustment amount before sequestration	ő	
32. 00	Total amount payable to the provider (see instructions)	2, 103, 172	
32. 01	Sequestration adjustment (see instructions)	42, 063	
	Demonstration payment adjustment amount after sequestration	0	
33. 00	Interim payments	2, 054, 415	
34. 00	Tentative settlement (for contractor use only)	0	•
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	6, 694	35.00
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	
	§115. 2		
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	266, 787	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
	Time Value of Money (see instructions)		53.00
	·	'	

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lieu of Form CMS-2552-		2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0046	Peri od:	Worksheet E-3	
		From 09/01/2017	Part VII	
		To 08/31/2018	Date/Time Pre	
			1/30/2019 11:	15 am_
	Title XIX	Hospi tal	Cost	
		I npati ent	Outpati ent	
		1. 00	2. 00	
PART VII - CALCULATION OF REIMBURSEMENT -	ALL OTHER HEALTH SERVICES FOR TITLES V OR	XIX SERVICES		

		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE	ES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		6, 875, 503		1.00
2.00	Medical and other services			8, 286, 571	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		6, 875, 503	8, 286, 571	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		6, 875, 503	8, 286, 571	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES		.,,		
	Reasonable Charges				
8.00	Routi ne servi ce charges		0		8.00
9. 00	Ancillary service charges		41, 256, 934	75, 775, 003	9.00
10.00	Organ acquisition charges, net of revenue		0	7077707000	10.00
11. 00	Incentive from target amount computation		0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		41, 256, 934	75, 775, 003	
12.00	CUSTOMARY CHARGES		41, 230, 734	73, 773, 003	12.00
13. 00	Amount actually collected from patients liable for payment for se	rvices on a charge	0	0	13.00
13.00	basis	Wices on a charge		O	13.00
14. 00	Amounts that would have been realized from patients liable for pa	wment for services on	0	0	14.00
14.00	a charge basis had such payment been made in accordance with 42 C			O	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	11. 3415. 15(e)	0. 000000	0.000000	15.00
16. 00	Total customary charges (see instructions)		41, 256, 934	75, 775, 003	16.00
17. 00	Excess of customary charges over reasonable cost (complete only i	flino 16 ovecode	34, 381, 431	67, 488, 432	17.00
17.00	line 4) (see instructions)	I Title to exceeds	34, 301, 431	07, 400, 432	17.00
18. 00	Excess of reasonable cost over customary charges (complete only i	Fline 4 evenede line	0	0	18. 00
10.00	16) (see instructions)	i iiile 4 exceeus iiile	U	U	16.00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instruct	i one)	0	0	20.00
		i ons)	4 075 503		
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)	-1 -+1	6, 875, 503	8, 286, 571	21.00
22 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be com	preted for PPS provide			22 00
22. 00	Other than outlier payments		0	0	22. 00 23. 00
23. 00	Outlier payments		0	Ü	
24. 00	Program capital payments		0		24.00
25. 00	Capital exception payments (see instructions)		0	0	25.00
26. 00	Routine and Ancillary service other pass through costs		0	0	26.00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		6, 875, 503	8, 286, 571	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		6, 875, 503	8, 286, 571	
32.00	Deducti bl es		0	0	32.00
33. 00	Coi nsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	6, 875, 503	8, 286, 571	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		6, 875, 503	8, 286, 571	38. 00
39.00	Direct graduate medical education payments (from Wkst. E-4)		O		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		6, 875, 503	8, 286, 571	40.00
41. 00	Interim payments		10, 673, 045	7, 355, 019	41.00
42. 00	Balance due provider/program (line 40 minus line 41)		-3, 797, 542	931, 552	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2.	0	0	43.00
	chapter 1, §115.2			Ü	
	1 · · · · · · · · · · · · · · · · · · ·		'		•

Health Financial Systems TERRE HAUTE REGIONAL HOSPITAL In				u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0046 F		Worksheet E-3 Part VII	
		Component CCN: 15-S046	To 08/31/2018	Date/Time Pre 1/30/2019 11:	pared: 15 am
•		Title XIX	Subprovi der -	Cost	
			I PF		
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEAL	TH SERVICES FOR TITLES V OR >	(IX SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		2, 501, 523		1.00
2.00	Medical and other services			0	2.00

1.00 Inpatient 2.00 Medical ar 3.00 Organ acqu 4.00 Subtotal	CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX N OF NET COST OF COVERED SERVICES hospital/SNF/NF services	1.00 (SERVI CES	2. 00	
1.00 Inpatient 2.00 Medical ar 3.00 Organ acqu 4.00 Subtotal	N OF NET COST OF COVERED SERVICES	(SERVI CES		
1.00 Inpatient 2.00 Medical ar 3.00 Organ acqu 4.00 Subtotal				
2.00 Medical ar 3.00 Organ acqu 4.00 Subtotal	hospi tal /SNE/NE servi ces			
3.00 Organ acqu 4.00 Subtotal		2, 501, 523		1.00
4.00 Subtotal	nd other services		0	2.00
	uisition (certified transplant centers only)	0		3.00
1	(sum of lines 1, 2 and 3)	2, 501, 523	0	4.00
	primary payer payments	0		5.00
6.00 Outpatient	primary payer payments		0	
	(line 4 less sum of lines 5 and 6)	2, 501, 523	0	
	N OF LESSER OF COST OR CHARGES	2,001,020		7.00
Reasonabl e				i
	ervice charges	n		8.00
•	service charges	3, 466, 529	0	
			O ₁	10.00
	uisition charges, net of revenue	0	ļ	1
	from target amount computation	0 4// 500		11.00
	sonable charges (sum of lines 8 through 11)	3, 466, 529	0	12.00
CUSTOMARY				1.0.00
	cually collected from patients liable for payment for services on a charge	0	0	13. 00
basi s		_	_ !	
	nat would have been realized from patients liable for payment for services on	0	0	14. 00
	pasis had such payment been made in accordance with 42 CFR §413.13(e)			
	ine 13 to line 14 (not to exceed 1.000000)	0. 000000	0. 000000	
The state of the s	omary charges (see instructions)	3, 466, 529	0	
	customary charges over reasonable cost (complete only if line 16 exceeds	965, 006	0	17. 00
	see instructions)		ļ	
	reasonable cost over customary charges (complete only if line 4 exceeds line	0	0	18. 00
	nstructions)		ļ	
19.00 Interns ar	nd Residents (see instructions)	0	0	19.00
20.00 Cost of ph	nysicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00 Cost of co	overed services (enter the lesser of line 4 or line 16)	2, 501, 523	0	21.00
PROSPECTI V	E PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS provide	ers.		
22.00 Other than	n outlier payments	0	0	22. 00
23.00 Outlier pa	ayments	0	0	23.00
24.00 Program ca	apital payments	0	ļ	24.00
25. 00 Capi tal ex	cception payments (see instructions)	o	ļ	25.00
	nd Ancillary service other pass through costs	0	0	
	(sum of lines 22 through 26)	0	0	
	charges (title V or XIX PPS covered services only)	0	0	
,	or XIX (sum of lines 21 and 27)	2, 501, 523	0	
	N OF REIMBURSEMENT SETTLEMENT	2,001,020		27.00
	reasonable cost (from line 18)	0	0	30.00
N Company of the Comp	(sum of lines 19 and 20, plus 29 minus lines 5 and 6)	2, 501, 523	0	
		· · · · · · · · · · · · · · · · · · ·	0	
32.00 Deductible		0		
33. 00 Coi nsurano		0	0	
N I	bad debts (see instructions)	0	0	
35.00 Utilizatio		0		35.00
	(sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	2, 501, 523	0	
	ISTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	
4	(line 36 ± line 37)	2, 501, 523	0	
	aduate medical education payments (from Wkst. E-4)	0	ļ	39.00
40.00 Total amou	unt payable to the provider (sum of lines 38 and 39)	2, 501, 523	0	1 .0.00
41.00 Interim pa	ayments	2, 407, 413	0	41.00
42.00 Balance du	ue provider/program (line 40 minus line 41)	94, 110	0	42.00
43.00 Protested	amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	0	0	43.00
chapter 1,	, ,		ļ	

Heal th	Financial Systems TERRE HAUTE REGIONA	AL HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0046	Peri od:	Worksheet E-3	
			From 09/01/2017		
		Component CCN: 15-T046	To 08/31/2018	Date/Time Pre 1/30/2019 11:	pared:
		Ti tle XIX	Subprovi der -	1/30/2019 11: Cost	is alli
		II the XIX	I RF	COST	
			I npati ent	Outpati ent	
			1, 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR X		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	CVI DED TOK TITLED V OK X	IN SERVICES		
1.00	Inpatient hospital/SNF/NF services		350, 920		1.00
2. 00	Medical and other services		000,720	0	2.00
3. 00	Organ acquisition (certified transplant centers only)		0	١	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		350, 920	0	4.00
5. 00	Inpatient primary payer payments		0	١	5.00
6. 00	Outpatient primary payer payments			0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		350, 920	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			-	
	Reasonabl e Charges				
8. 00	Routine service charges		0		8.00
9. 00	Ancillary service charges		1, 329, 053	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
	Incentive from target amount computation		o		11.00
	Total reasonable charges (sum of lines 8 through 11)		1, 329, 053	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basis	3			
14.00	4.00 Amounts that would have been realized from patients liable for payment for services on			0	14.00
	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15.00
16.00	Total customary charges (see instructions)		1, 329, 053	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only	v if line 16 exceeds	978, 133	0	17.00

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

Provi der CCN: 15-0046

Peri od: From 09/01/2017 To 08/31/2018 Worksheet G Date/Time Prepared: 1/30/2019 11: 15 am

oni y)					1/30/2019 11:	15 am
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	16, 897	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	
3.00	Notes receivable	0	0	0	0	
4. 00 5. 00	Accounts receivable	36, 188, 541	0	0	0	
6. 00	Other receivable Allowances for uncollectible notes and accounts receivable	15, 675 -13, 113, 584	0	0	0	
7. 00	Inventory	7, 026, 956	-	0	0	
8.00	Prepai d expenses	1, 071, 521	Ö	Ö	0	
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	-7, 010		0	0	
11. 00	Total current assets (sum of lines 1-10)	31, 198, 996	0	0	0	11.00
12 00	FI XED ASSETS	1 2/2 710	l ol	O	0	12 00
12. 00 13. 00	Land Land improvements	1, 262, 718 3, 158, 371	0	0	0	
14. 00	Accumulated depreciation	-3, 054, 391		0	0	
15. 00	Bui I di ngs	38, 638, 215		Ö	0	
16.00	Accumulated depreciation	-26, 768, 240		0	0	
17.00	Leasehold improvements	8, 121, 216	0	0	0	17.00
18.00	Accumulated depreciation	-6, 242, 960		0	0	
19. 00	Fi xed equipment	26, 985, 459		0	0	
20.00	Accumulated depreciation	-20, 575, 747		0	0	
21. 00 22. 00	Automobiles and trucks	0	0	0	0	
23. 00	Accumulated depreciation Major movable equipment	43, 685, 632	· ·	0	0	
24. 00	Accumulated depreciation	-34, 399, 898		0	0	
25. 00	Mi nor equipment depreciable	4, 746, 330		0	0	
26. 00	Accumulated depreciation	-3, 624, 977		0	0	
27.00	HIT designated Assets	0	0	0	0	27.00
28. 00	Accumulated depreciation	0	0	0	0	
29. 00	Mi nor equi pment-nondepreci abl e	5, 042, 581	0	0	0	
30. 00	Total fixed assets (sum of lines 12-29)	36, 974, 309	0	0	0	30.00
31. 00	OTHER ASSETS Investments	3, 063, 197	O	0	0	31.00
32. 00	Deposits on Leases	0,000,177	0	0	0	
33.00	Due from owners/officers	Ö	O	0	0	
34.00	Other assets	2, 386, 484	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5, 449, 681	0	0	0	
36. 00	Total assets (sum of lines 11, 30, and 35)	73, 622, 986	0	0	0	36.00
27 00	CURRENT LIABILITIES	E 040 420		O	0] 37. 00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	5, 042, 639 2, 655, 653		0	0	
39. 00	Payrol I taxes payable	3, 209, 369		0	0	
40.00	Notes and Loans payable (short term)	174, 064	0	ő	0	
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	207	0	0	0	
44.00	Other current liabilities	0	-	0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	11, 081, 932	0	0	0	45.00
46. 00	LONG TERM LIABILITIES Mortgage payable		0	0	0	46. 00
47. 00	Notes payable	277, 811	T .	0	0	
48. 00	Unsecured Loans	-227, 733, 846		Ö	0	
49.00	Other long term liabilities	61, 916	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-227, 394, 119	0	0	0	
51.00	Total liabilities (sum of lines 45 and 50)	-216, 312, 187	0	0	0	51.00
F0 00	CAPI TAL ACCOUNTS	000 005 470				
52.00	General fund balance	289, 935, 173	o			52.00
53. 00 54. 00	Specific purpose fund Donor created - endowment fund balance - restricted		o o	0		53.00 54.00
55. 00	Donor created - endowment fund balance - restricted			n		55.00
56. 00	Governing body created - endowment fund balance			Ö		56.00
57. 00	Plant fund balance - invested in plant				0	
58.00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion					
59.00	Total fund balances (sum of lines 52 thru 58)	289, 935, 173		0	0	1
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	73, 622, 986	0	O	0	60.00
	<i>≤′/</i>	I	ı	ı		I

Period: Worksheet G-1 From 09/01/2017 Do 08/31/2018 Date/Time Prepared: Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 15-0046

					To 08/31/2018	Date/Time Pre 1/30/2019 11:	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	0.00	2.00	4.00	F 00	
1. 00	Fund balances at beginning of period	1. 00	2. 00 275, 280, 739	3. 00	4.00	5. 00	1. 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)		17, 667, 895				2.00
3. 00	Total (sum of line 1 and line 2)		292, 948, 634		0		3.00
4. 00	Additions (credit adjustments) (specify)	О	2,2,,,0,001		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	T-1-1	0			0	0	9.00
10.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		0 292, 948, 634		C		10.00
11. 00 12. 00	FEDERAL TAX LIABILITY ENTRY	3, 013, 409	292, 948, 034		0	0	11. 00 12. 00
13. 00	ROUNDI NG	52			0	0	13.00
14. 00	NOONDI NO	0			0	0	14.00
15. 00		o			Ö	0	15. 00
16.00		0			0	0	16.00
17.00		0			0	0	17.00
18. 00	Total deductions (sum of lines 12-17)		3, 013, 461		C		18. 00
19. 00	Fund balance at end of period per balance		289, 935, 173		C		19. 00
	sheet (line 11 minus line 18)	Endowment	DLont	Fund			
		Fund	Frant	Turiu			
		T dild					
		6. 00	7. 00	8. 00			
1. 00	Fund balances at beginning of period	0			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	U	0		0		3. 00 4. 00
5. 00	Additions (credit adjustments) (specify)		0				5. 00
6. 00			0				6.00
7. 00			0				7. 00
8.00			0				8. 00
9.00			0				9. 00
10.00	Total additions (sum of line 4-9)	0			0		10.00
11. 00	Subtotal (line 3 plus line 10)	0			0		11. 00
12.00	FEDERAL TAX LIABILITY ENTRY		0				12.00
13.00	ROUNDI NG		0				13.00
14. 00 15. 00			0				14. 00 15. 00
16. 00			0				16.00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 12-17)	o	0		0		18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19. 00

| Peri od: | Worksheet G-2 | From 09/01/2017 | Parts | & II | To 08/31/2018 | Date/Time Prepared: Health Financial Systems TERM STATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0046

			To	08/31/2018	Date/Time Prep 1/30/2019 11:	
	Cost Center Description		npati ent	Outpati ent	Total	15 alli
	oddt denten besentptron	-	1.00	2.00	3. 00	
	PART I - PATIENT REVENUES				0.00	
	General Inpatient Routine Services					
1.00	Hospi tal		22, 510, 917		22, 510, 917	1.00
2.00	SUBPROVI DER - I PF		25, 931, 452		25, 931, 452	2.00
3.00	SUBPROVI DER - I RF		2, 810, 229		2, 810, 229	3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF		0		0	5.00
6.00	Swing bed - NF		0		0	6.00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9. 00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		51, 252, 598		51, 252, 598	10.00
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT		10, 170, 730		10, 170, 730	
12. 00	CORONARY CARE UNIT					12.00
13. 00	BURN INTENSIVE CARE UNIT					13.00
14. 00	SURGI CAL INTENSIVE CARE UNIT					14.00
15. 00	NEONATAL INTENSIVE CARE UNIT					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of	lines	10, 170, 730		10, 170, 730	16. 00
17 00	11-15)		(1 400 000		/1 /22 220	17.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)		61, 423, 328	240 454 450	61, 423, 328	17.00
18. 00 19. 00	Ancillary services Outpatient services	4	296, 319, 435 20, 385, 297	349, 456, 650	645, 776, 085 67, 210, 352	18. 00 19. 00
20.00	RURAL HEALTH CLINIC			46, 825, 055 0		20. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	20.00
21.00	HOME HEALTH AGENCY		U	٩	٥	22.00
23. 00	AMBULANCE SERVICES					23. 00
24.00	CMHC					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00
26. 00	HOSPI CE					26.00
27. 00	OCCUPATI ONAL MEDI CI NE		0	421, 555	421, 555	
27. 01	ROUNDI NG		100	121, 000	100	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst	378, 128, 160	396, 703, 260	774, 831, 420	
20.00	G-3, line 1)	in i	0,0,120,100	0,0,,00,200	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	20.00
	PART II - OPERATING EXPENSES	· '		,		
29.00	Operating expenses (per Wkst. A, column 3, line 200)			125, 381, 920		29.00
30.00	ROUNDI NG		23			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)			23		36.00
37.00	GAIN/LOSS ON DISPOSAL		1, 415			37.00
38. 00	INTEREST INCOME		88, 209			38.00
39. 00	UNCLAI MED PROPERTY		3, 567			39.00
40.00			0			40.00
41.00			0			41.00
42.00	Total deductions (sum of lines 37-41)			93, 191		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		125, 288, 752		43.00
	to Wkst. G-3, line 4)				l	

Health Financial Systems TERRE HAUTE REGIONAL HOSPITAL In Lieu of Form CMS-2552-10					
	OF REVENUES AND EXPENSES	Provi der CCN: 15-0046	Peri od:	Worksheet G-3	
			From 09/01/2017 To 08/31/2018	Date/Time Pre 1/30/2019 11:	
				1. 00	
1. 00 Tota	ıl patient revenues (from Wkst. G-2, Part I, column 3, li	ne 28)		774, 831, 420	1.00
	s contractual allowances and discounts on patients' accou			632, 170, 813	
4	patient revenues (line 1 minus line 2)	1113		142, 660, 607	3.00
	s total operating expenses (from Wkst. G-2, Part II, line	43)		125, 288, 752	4.00
	income from service to patients (line 3 minus line 4)	10)		17, 371, 855	
	R I NCOME			1770717000	0.00
6. 00 Cont	ributions, donations, bequests, etc			0	6.00
	ome from investments			0	7. 00
8. 00 Reve	enues from telephone and other miscellaneous communicatio	n services		0	8. 00
9.00 Reve	enue from television and radio service			0	9. 00
10.00 Purc	chase di scounts			0	10.00
11. 00 Reba	ites and refunds of expenses			0	11.00
12.00 Park	ing lot receipts			0	12.00
13. 00 Reve	enue from Laundry and Linen service			0	13.00
14.00 Reve	enue from meals sold to employees and guests			0	14.00
15.00 Reve	enue from rental of living quarters			0	15.00
16.00 Reve	enue from sale of medical and surgical supplies to other	than patients		0	16.00
17. 00 Reve	enue from sale of drugs to other than patients			0	17. 00
	enue from sale of medical records and abstracts				18. 00
	ion (fees, sale of textbooks, uniforms, etc.)			0	19. 00
	enue from gifts, flowers, coffee shops, and canteen			0	
	al of vending machines			0	
22. 00 Rent	al of hospital space			0	22. 00
23. 00 Gove	ernmental appropriations			0	23. 00
24. 00 MI SC	CELLANEOUS INCOME			296, 040	24.00
	other income (sum of lines 6-24)			296, 040	
	ıl (line 5 plus line 25)			17, 667, 895	26. 00
1	R EXPENSES (SPECIFY)			0	
28 00 Tota	18 00 Total other eveness (sum of line 27 and subscripts)				

28.00

17, 667, 895 29. 00

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

Heal th	Financial Systems TERRE HAUTE REGION	NAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0046	Period: From 09/01/2017 To 08/31/2018	Worksheet L Parts I-III	pared:
		Title XVIII	Hospi tal	PPS	TO UIII
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			1, 760, 482	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1.01
2.00	Capital DRG outlier payments			54, 433	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2.01
3.00	Total inpatient days divided by number of days in the cost re	eporting period (see ins	tructions)	54. 24	
4.00	Number of interns & residents (see instructions)			0.00	
5. 00 6. 00	Indirect medical education percentage (see instructions)	o sum of lines 1 and 1 0	1 columns 1 and	0.00	6.00
6.00	Indirect medical education adjustment (multiply line 5 by the 1.01) (see instructions)	e sum of fines fand f.o	i, corumns i and	U	6.00
7. 00	Percentage of SSI recipient patient days to Medicare Part A	nationt days (Workshoot	F nart Alina	5. 39	7. 00
7.00	30) (see instructions)	patrent days (worksheet	L, part A rine	5. 57	7.00
8. 00	Percentage of Medicaid patient days to total days (see instru	uctions)		22. 25	8.00
9. 00	Sum of lines 7 and 8	4011 0113)		27. 64	
10.00	Allowable disproportionate share percentage (see instructions	5)		5. 76	
11. 00	Disproportionate share adjustment (see instructions)			101, 404	
	Total prospective capital payments (see instructions)			1, 916, 319	
				.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1. 00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	
3. 00	Total inpatient program capital cost (line 1 plus line 2)			0	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 circumstan	ces (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	
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	
6.00	Percentage adjustment for extraordinary circumstances (see in		1! ()	0.00	
7.00	Adjustment to capital minimum payment level for extraordinary	y circumstances (fine 2	x iine 6)	0	
8.00	Capital minimum payment level (line 5 plus line 7)	:		0	
9. 00 10. 00	Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level to		loco lino O)	0	9. 00 10. 00
11. 00	Carryover of accumulated capital minimum payment level over			0	11.00
11.00	Worksheet L, Part III, line 14)	capital payment (110m pr	ror year	0	11.00
12.00	Net comparison of capital minimum payment level to capital payment	ayments (line 10 plus li	ne 11)	0	12.00
13. 00	Current year exception payment (if line 12 is positive, enter			0	13.00
14. 00	Carryover of accumulated capital minimum payment level over			0	
	(if line 12 is negative, enter the amount on this line)		3 1		
15.00		structions)		0	15.00
	Current year operating and capital costs (see instructions)			0	
17. 00	Current year exception offset amount (see instructions)			0	17. 00