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 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0169 Worksheet S Peri od: From 01/01/2020 Parts I-III AND SETTLEMENT SUMMARY 12/31/2020 Date/Time Prepared: 8/2/2021 3:48 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 8/2/2021 3:48 pm] Manually prepared cost report use only] 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
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[12] [9] If line 5, column 1 is 4: Enter
[13] NPR Date:
[14] 12. Contractor's Vendor Code:
[15] 13. NPR Date:
[16] 13. NPR Date:
[17] 14. Contractor's Vendor Code:
[18] 15. Contractor's Vendor Code:
[18] 16. NPR Date:
[19] 17. Contractor's Vendor Code:
[19] 18. Contractor's Vendor Code:
[19] 19. Contractor's Vendor Code:
[19] Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPITAL OF INDIANA, INC. (15-0169) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 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) HOLLY MI LLARD

Officer or Administrator of Provider(s)

NETWORK SVP OF FINANCE

Title

(Dated when report is electronically signed.)

Date

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	358, 708	-138, 809	0	0	1.00
2.00	Subprovider - IPF	0	5, 210	22		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3. 00
5.00	Swing Bed - SNF	0	0	0		0	5. 00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	363, 918	-138, 787	0	0	200. 00

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

In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0169 Peri od: Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 8/2/2021 3:48 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 7150 CLEARVISTA DRIVE 1.00 PO Box: 1.00 State: IN 2.00 City: INDIANAPOLIS Zi p Code: 46256 County: MARION 2.00 Component Name Payment System (P, CCN CBSA Provi der Date T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 COMMUNITY HOSPITAL OF 150169 26900 02/25/2008 Ν Р Р 3.00 1 NDIANA, INC. Subprovider - IPF COMMUNITY MENTAL HEALTH Р 4.00 4.00 15S169 26900 01/01/2010 N 0 4 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2020 12/31/2020 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ 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 Υ 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 payments to be determined at cost report settlement? (see instructions) 22.02 22.02 N Ν 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 22.03 Ν Ν Ν 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 yes or "N" for no. 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. In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days paid days unpai d 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 70 24.00 4.098 2,628 11 21, 298 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.

59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2	, Pt. I.	N N		59. 00
	NAHE 413.85	Worksheet A	Pass-Through	
	Y/N	Li ne #	Qual i fi cati on	
			Criterion Code	
	1. 00	2.00	3.00	
60.00 Are you claiming nursing and allied health education (NAHE) costs for	N			60.00
any programs that meet the criteria under 42 CFR 413.85? (see				
instructions) Enter "Y" for yes or "N" for no in column 1. If column 1				
is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment				
adjustement? Enter "Y" for yes or "N" for no in column 2.				

			OF INDIANA, IN			In Lieu of Form CMS-2552		
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ТА	Provi der CC		eriod: rom 01/01/2020 o 12/31/2020	Worksheet S-2 Part I Date/Time Pre 8/2/2021 3:48	pared:	
		Y/N	IME	Direct GME	IME	Direct GME	Pili	
		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	N			0.00	0.00	61. 00	
	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						61. 01	
61. 02	instructions) 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						61. 02	
61. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for						61. 03	
61. 04	determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or						61. 04	
	surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions). Enter the difference between the baseline primary						61. 05	
01.00	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)						01.00	
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	
	pear e or general surgery. (see mistraetrons)	Pro	Program Name Program Code Unweighted IM FTE Count			Unweighted Direct GME FTE Count		
			1. 00	2. 00	3.00	4. 00		
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE				0. 00		61. 20	
	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.							
						1.00		
62. 00	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital				od for which	0.00	62. 00	
	your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC proc	ctions) a Teachi	ng Health Cent	ter (THC) into			62. 01	
(2.00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se			ant reporting r	aniad2 Entan	N	63. 00	
	"Y" for yes or "N" for no in column 1. If yes, comple			67. (see instru	uctions)		03.00	
				Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
	Si te 1.00 2.00							
	Section 5504 of the ACA Base Year FTE Residents in No					3.00 reporting		
64. 00	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	ty train n-primar all nor d non-pr n columr	ned residents ry care nprovider rimary care n 3 the ratio	0.00	0.00	0.000000	64. 00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0169 Peri od: Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 8/2/2021 3:48 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. 3/ (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 66, 26 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 2.00 3. 00 1.00 4.00 5.00 67.00 Enter in column 1, the program FAMILY PRACTICE 0. 93 0.000000 67.00 1350 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν O N 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 Ν subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

ear un	Financial Systems COMMUNITY HOSPITAL OF INDI	ANA, INC.	In Lie	u of Form CMS	S-2552-	
OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Prov		Period: From 01/01/2020 To 12/31/2020	Worksheet S Part I Date/Time P 8/2/2021 3:	repared	
				1.00	_	
	Long Term Care Hospital PPS			1.00		
0. 00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "I	N" for no.		N	80.0	
	Is this a LTCH co-located within another hospital for part or all ("Y" for yes and "N" for no.		g period? Enter	N	81.	
F 00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA	2 Frtor "V" for you	on "N" for no	N.	85.	
	Did this facility establish a new Other subprovider (excluded unit)			N	86.	
7. 00	\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 1s this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.					
	1000(d)(1)(b)(v1): Effect 1 101 yes of 14 101 flo.		V	XI X		
			1. 00	2.00		
	Title V and XIX Services					
0. 00	Does this facility have title V and/or XIX inpatient hospital serviyes or "N" for no in the applicable column.	ices? Enter "Y" for	N	Y	90.	
1. 00	Is this hospital reimbursed for title V and/or XIX through the cosfull or in part? Enter "Y" for yes or "N" for no in the applicable		N	N	91.	
2. 00	Are title XIX NF patients occupying title XVIII SNF beds (dual cer- instructions) Enter "Y" for yes or "N" for no in the applicable col	tification)? (see		N	92	
3. 00	Does this facility operate an ICF/IID facility for purposes of titl "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' applicable column.	" for no in the	N	N	94	
5. 00	If line 94 is "Y", enter the reduction percentage in the applicable	e column.	0.00	0.00	95	
6. 00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N' applicable column.	" for no in the	N	N	96	
	If line 96 is "Y", enter the reduction percentage in the applicable		0. 00	0.00	97	
8. 00	Does title V or XIX follow Medicare (title XVIII) for the interns a stepdown adjustments on Whist. B, Pt. I, col. 25? Enter "Y" for yes		Y	N	98	
8. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting	g of charges on Wkst.	Y	Y	98	
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V,					
8 N2	title XIX. Does title V or XIX follow Medicare (title XVIII) for the calculati	ion of observation	Y	Y	98	
0. 02	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N"		'		/0	
	for title V, and in column 2 for title XIX.					
8. 03	Does title V or XIX follow Medicare (title XVIII) for a critical acreimbursed 101% of inpatient services cost? Enter "Y" for yes or "I		N	N	98	
	for title V, and in column 2 for title XIX.	N TOT TO THE COLUMN				
8. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbu		N	N	98	
	outpatient services cost? Enter "Y" for yes or "N" for no in column	n 1 for title V, and				
	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the	RCE disallowance on	Y	Y	98	
0. 00	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column of			'	70	
	column 2 for title XIX.					
8. 06	Does title V or XIX follow Medicare (title XVIII) when cost reimbu		Y	Y	98	
	Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for	title V, and in				

for outpatrent services? (see instructions)					
107.00 Column 1: If line 105 is Y, is this facility eligible for c	ost reimburseme	ent for I&R	N		107. 00
training programs? Enter "Y" for yes or "N" for no in colum	n 1. (see inst	tructions)			
Column 2: If column 1 is Y and line 70 or line 75 is Y, do					
approved medical education program in the CAH's excluded I					
Enter "Y" for yes or "N" for no in column 2. (see instruct	i ons)				
108.00 Is this a rural hospital qualifying for an exception to the	dul e? See 42	N		108.00	
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					
	Physi cal	Occupati onal	Speech	Respi ratory	
	1.00	2.00	3.00	4. 00	
109.00 If this hospital qualifies as a CAH or a cost provider, are	N	N	N	N	109. 00
therapy services provided by outside supplier? Enter "Y"					
for yes or "N" for no for each therapy.					

1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, Ν 110.00 complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as appl i cabl e.

for outpatient services? (see instructions)

integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C"

for tele-health services.

118.01 List amounts of malpractice premiums and paid losses:

	1.00	2.00	3.00	
112.00 Did this hospital participate in the Pennsylvania Rural Health Model	N			112. 00
demonstration for any portion of the current cost reporting period?				
Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter				
in column 2, the date the hospital began participating in the				
demonstration. In column 3, enter the date the hospital ceased				
participation in the demonstration, if applicable.				
Miscellaneous Cost Reporting Information				
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no	N		0	115. 00
in column 1. If column 1 is yes, enter the method used (A, B, or E only)				
in column 2. If column 2 is "E", enter in column 3 either "93" percent				
for short term hospital or "98" percent for long term care (includes				
psychiatric, rehabilitation and long term hospitals providers) based on				
the definition in CMS Pub. 15-1, chapter 22, §2208.1.				
116.00 Is this facility classified as a referral center? Enter "Y" for yes or	N			116. 00
"N" for no.	.,			
117.00 s this facility legally-required to carry malpractice insurance? Enter	Y			117. 00
"Y" for yes or "N" for no.				
118.00 Is the mal practice insurance a claims-made or occurrence policy? Enter 1	1			118. 00
if the policy is claim-made. Enter 2 if the policy is occurrence.	D '			
	Premiums	Losses	Insurance	
	1.00	0.00	2.00	
	1. 00	2. 00	3. 00	

1.00

1, 370, 521

2.00

0

2.00

1. 00

3.00

0 118. 01

	1.00	2.00	
118.02 Are mal practice premiums and paid losses reported in a cost center other than the	N		118. 02
Administrative and General? If yes, submit supporting schedule listing cost centers			
and amounts contained therein.			
119.00 DO NOT USE THIS LINE			119. 00
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA	N	N	120. 00
§3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or			
"N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient			
Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions)			
Enter in column 2, "Y" for yes or "N" for no.			
121.00 Did this facility incur and report costs for high cost implantable devices charged to	Y		121. 00
patients? Enter "Y" for yes or "N" for no.			
122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the	N		122. 00
Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2			
the Worksheet A line number where these taxes are included.			
Transplant Center Information	1		
125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below.			
126.00 of this is a Medicare certified kidney transplant center, enter the certification date			126. 00
in column 1 and termination date, if applicable, in column 2.			107.00
127.00 f this is a Medicare certified heart transplant center, enter the certification date			127. 00
in column 1 and termination date, if applicable, in column 2.			100.00
128.00 If this is a Medicare certified liver transplant center, enter the certification date			128. 00
in column 1 and termination date, if applicable, in column 2.			120.00
129.00 If this is a Medicare certified lung transplant center, enter the certification date in			129. 00
column 1 and termination date, if applicable, in column 2. 130.00 olf this is a Medicare certified pancreas transplant center, enter the certification			130. 00
date in column 1 and termination date, if applicable, in column 2.			130.00
131.00 f this is a Medicare certified intestinal transplant center, enter the certification			131. 00
date in column 1 and termination date, if applicable, in column 2.			131.00
132.00 f this is a Medicare certified islet transplant center, enter the certification date			132. 00
in column 1 and termination date, if applicable, in column 2.			132.00
133. 00Removed and reserved			133. 00
134.00 f this is an organ procurement organization (OPO), enter the OPO number in column 1			134. 00
and termination date, if applicable, in column 2.			134.00
All Providers			
140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1,	Υ	HB0720	140. 00
chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs	'	1100720	140.00
chapter to: Enter 1 for the first of the containing of the form of the containing of the contain			

are claimed, enter in column 2 the home office chain number. (see instructions)

In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0169 Peri od: Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: To 12/31/2020 8/2/2021 3:48 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number
Name: COMMUNITY HEALTH NETWORK | Contractor's Name: WISCONSIN PHYSICIA 141 00 Name: Contractor's Name: WISCONSIN PHYSICIANS Contractor's Number: 08101 141 00 SERVI CES 142.00 Street: 1500 NORTH RITTER AVENUE PO Box: 142.00 143.00 City: INDIANAPOLIS 46219-3095 State: ΙN Zip Code: 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 Υ 2.00 1.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146, 00 N Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147. 00 N 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title XIX Title V 1 00 2 00 3.00 4 00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal N Ν Ν N 155 00 156.00 Subprovi der - IPF 156. 00 Ν Ν Ν Ν 157.00 Subprovi der - IRF 157 00 Ν Ν Ν N 158. 00 SUBPROVI DER 158.00 159.00 SNF N Ν Ν N 159. 00 160.00 HOME HEALTH AGENCY Ν Ν Ν Ν 160.00 161.00 CMHC Ν Ν Ν 161.00 1.00 Mul ti campus 165.00|Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. FTE/Campus Name County Zip Code **CBSA** State | 3.00 0 1.00 2 00 4.00 5.00 166.00 If line 165 is yes, for each 0. 00 166. 00 campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.
168.00 if this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 167.00 Υ 168.00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 9 99169 00 transition factor. (see instructions) Begi nni ng Endi ng 1.00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 170. 00 period respectively (mm/dd/yyyy) 1. 00 2.00 171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in 0 171. 00 Ν section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

			Т	o 12/31/2020	Date/Time Pro 8/2/2021 3:48	
	· · · · · · · · · · · · · · · · · · ·			Y/N	Date) DIII
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N	lfor all NO re	sponses. Enter	all dates in t	the	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					
	Provi der Organi zati on and Operati on					
1.00	Has the provider changed ownership immediately prior to the			N		1. 00
	reporting period? If yes, enter the date of the change in c	column 2. (see		5 .	\	
			1. 00	Date 2.00	V/I 3. 00	
2. 00	Has the provider terminated participation in the Medicare F	Program? If	N N	2.00	3.00	2.00
	yes, enter in column 2 the date of termination and in colum					
	voluntary or "I" for involuntary.					
3.00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of		Y			3. 00
	or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other	er similar				
	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 Cert		Y	Α	03/25/2021	4. 00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" f					
	or "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	iiiabie in				
5.00	Are the cost report total expenses and total revenues diffe	erent from	N			5. 00
	those on the filed financial statements? If yes, submit rec	conciliation.				
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
6. 00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is th	ne provider is	N		6. 00
	the legal operator of the program?		•			
7.00	Are costs claimed for Allied Health Programs? If "Y" see in		7. 00			
8. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	N		8. 00		
9.00	Are costs claimed for Interns and Residents in an approved	graduate medic	al education	Υ		9. 00
	program in the current cost report? If yes, see instruction					
10. 00	Was an approved Intern and Resident GME program initiated of	or renewed in t	the current	N		10. 00
11. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I	& R in an Apr	roved	N		11. 00
	Teaching Program on Worksheet A? If yes, see instructions.	a a , ,	0.00			
					Y/N	
	Dad Dahta				1. 00	
12. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s see instruct	ions		Υ	12. 00
13. 00	If line 12 is yes, did the provider's bad debt collection p			t reporting	N	13. 00
	period? If yes, submit copy.		-			
14. 00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	yes, see inst	ructions.	N	14. 00
15 00	Bed Complement Did total beds available change from the prior cost reporti	ng neriod? If	ves see instr	ructions	N	15. 00
13.00	pro total boas available change from the prior cost reporti		t A		t B	13.00
		Y/N	Date	Y/N	Date	
	look p. p. d	1.00	2.00	3. 00	4. 00	
16. 00	PS&R Data Was the cost report prepared using the PS&R Report only?	N	1	N		16. 00
10.00	If either column 1 or 3 is yes, enter the paid-through	IN IN		IN		10.00
	date of the PS&R Report used in columns 2 and 4 (see					
47.00	instructions)	.,	07 (04 (0004	.,	07 (04 (0004	47.00
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Y	07/01/2021	Y	07/01/2021	17. 00
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report information? If yes, see instructions.					
	printofilia troff? IT yes, see flistructions.	I	I	ı	I	I

Heal th	Financial Systems COMMUNITY HOSPITAL	OF INDIANA, I	NC.	In Lie	eu of Form CM	S-2552-10		
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0169	Peri od: From 01/01/2020 To 12/31/2020	Worksheet S Part II	-2 repared:		
			i pti on	Y/N	Y/N			
20.00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20. 00		
20.00	Report data for Other? Describe the other adjustments:			IN	IN IN	20.00		
		Y/N	Date	Y/N	Date			
04.00	lui i	1.00	2. 00	3. 00	4. 00	04.00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00		
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS I	HOSPI TALS)		1. 00			
	Capital Related Cost				1			
22. 00	Have assets been relifed for Medicare purposes? If yes, see		!			22. 00		
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	sais made duri	ng the cost		23. 00		
24. 00	Were new leases and/or amendments to existing leases entere	ed into durina	this cost rea	porting period?		24. 00		
	If yes, see instructions	· ·	·	0 .				
25. 00	Have there been new capitalized leases entered into during	the cost repo	rting period?	If yes, see		25. 00		
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during the	no cost roporti	na poriod2 Li	f vos soo		26. 00		
20.00	instructions.	ie cost reporti	ing perrous ri	yes, see		20.00		
27. 00	Has the provider's capitalization policy changed during the	e cost reporti	ng period? If	yes, submit		27. 00		
	copy.							
28. 00	<pre>Interest Expense Were new Loans, mortgage agreements or Letters of credit er</pre>	ntered into duu	cina the cost	reporting		28. 00		
20.00	period? If yes, see instructions.	iterea into aai	ring the cost	reporting		20.00		
29. 00	Did the provider have a funded depreciation account and/or		ebt Service Re	eserve Fund)		29. 00		
30. 00	treated as a funded depreciation account? If yes, see instr	ructions	dob+2 lf voo			20.00		
30.00	Has existing debt been replaced prior to its scheduled maturinstructions.	urrty wrth new	debt? IT yes,	See		30. 00		
31.00	Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes,	see		31. 00		
	instructions.							
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser	rvices furnish	ed through cor	ntractual	I	32. 00		
02.00	arrangements with suppliers of services? If yes, see instru		sa tin bagii coi	Tt do tadi		02.00		
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app	olied pertaini	ng to competi	tive bidding? If		33. 00		
	no, see instructions. Provider-Based Physicians							
34. 00	Are services furnished at the provider facility under an ar	rrangement with	n provi der-bas	sed physicians?		34.00		
	If yes, see instructions.	0	·	. 3				
35. 00	If line 34 is yes, were there new agreements or amended exi		nts with the p	orovi der-based		35. 00		
	physicians during the cost reporting period? If yes, see in	ISTRUCTIONS.		Y/N	Date			
				1. 00	2.00			
	Home Office Costs				ı			
36. 00 37. 00	Were home office costs claimed on the cost report?	ropared by the	homo offico?			36. 00 37. 00		
37.00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	epared by the	nome office?			37.00		
38. 00		fice different	from that of			38. 00		
20.00	the provider? If yes, enter in column 2 the fiscal year end					20.00		
39. 00	If line 36 is yes, did the provider render services to othe see instructions.	er chain compoi	nents? If yes,	'		39. 00		
40. 00	If line 36 is yes, did the provider render services to the	home office?	If yes, see			40. 00		
	instructions.							
	1.00 2.00							
	Cost Report Preparer Contact Information	1.	UU	2.	00			
41. 00								
	held by the cost report preparer in columns 1, 2, and 3,							
42. 00	respectively. Enter the employer/company name of the cost report	COMMUNITY HEAL	TH NETWORK			42. 00		
42. UU	preparer.	OOMINION II HEAL	_ III NLIWUKK			42.00		
43. 00	Enter the telephone number and email address of the cost	317-355-4135		SBI SHOP@ECOMMU	NI TY. COM	43. 00		
	report preparer in columns 1 and 2, respectively.	I		I				

Heal th	Financial Systems	COMMUNITY HOSPITAL	OF INDIAN	A, INC.		In Lie	eu of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMEN	IT QUESTI ONNAI RE	Provi d	er CCN:	15-0169	Peri od: From 01/01/2020	Worksheet S-2 Part II	
						To 12/31/2020		pared: _pm
				3.00				
	Cost Report Preparer Contact Information	n						
41.00	Enter the first name, last name and the	title/position	DI RECTOR I	EI MBUR	SEMENT			41. 00
	held by the cost report preparer in col	umns 1, 2, and 3,						
	respecti vel y.							
42.00	Enter the employer/company name of the	cost report						42.00
	preparer.							
43.00	Enter the telephone number and email ad	dress of the cost						43.00
	report preparer in columns 1 and 2, res	pecti vel y.						

 Heal th Financial
 Systems
 COMMUNITY HO

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

Provider CCN: 15-0169

| Peri od: | Worksheet S-3 | From 01/01/2020 | Part I | To 12/31/2020 | Date/Time Prepared:

						7 12/31/2020	8/2/2021 3: 48	
							I/P Days / 0/P	J
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1.00		2. 00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		238	87, 108	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and				·			
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7.00	Total Adults and Peds. (exclude observation			238	87, 108	0.00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		24	8, 784	0.00	0	8. 00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT							11. 00
12.00	NEONATAL INTENSIVE CARE UNIT	35. 00		48	17, 568	0.00	0	12. 00
13.00	NURSERY	43. 00					0	13. 00
14.00	Total (see instructions)			310	113, 460	0.00	0	14. 00
15.00	CAH visits						0	15. 00
16.00	SUBPROVI DER - I PF	40. 00		18	6, 588		0	16. 00
17.00	SUBPROVI DER - I RF							17. 00
18.00	SUBPROVI DER							18. 00
19.00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20. 00
21.00	OTHER LONG TERM CARE							21. 00
22.00	HOME HEALTH AGENCY							22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24.00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC							25. 00
26.00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27.00	Total (sum of lines 14-26)			328				27. 00
28.00	Observation Bed Days						0	28. 00
29.00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30. 00
31.00	Employee discount days - IRF							31. 00
32.00	Labor & delivery days (see instructions)			0	0			32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33. 00
33. 01	LTCH site neutral days and discharges							33. 01

Health Financial Systems COMMUNITY HO

Provi der CCN: 15-0169

| Period: | Worksheet S-3 | From 01/01/2020 | Part I | Date/Time Prepared: | 8/2/2021 3: 48 pm | Full Time Equivalents I/P Days / O/P Visits / Trips

		17P Days	/ U/P VISITS	/ Irips	Full time i	Equi vai 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	15, 397	2, 240	54, 065			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)	11, 710	21, 543				2. 00
3.00	HMO IPF Subprovider	O	o				3. 00
4.00	HMO IRF Subprovider	o	o				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	o	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		o	0			6. 00
7.00	Total Adults and Peds. (exclude observation	15, 397	2, 240	54, 065			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	1, 723	o	6, 562			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	0	1, 444	13, 390			12.00
13.00	NURSERY		2, 808	7, 288			13. 00
14.00	Total (see instructions)	17, 120	6, 492	81, 305	4. 07	1, 505. 60	14.00
15.00	CAH visits	O	o	0			15. 00
16.00	SUBPROVIDER - IPF	2, 038	o	4, 029	3. 12	24. 95	16. 00
17.00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21. 00
22.00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			216			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				7. 19	1, 530. 55	27. 00
28. 00	Observation Bed Days		1, 244	5, 507			28. 00
29. 00	Ambul ance Trips	0					29. 00
30.00	Employee discount days (see instruction)			2, 085			30. 00
31.00	Employee discount days - IRF			0			31. 00
32.00	Labor & delivery days (see instructions)	0	70	1, 575			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01

33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0169

Peri od: Worksheet S-3 From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

8/2/2021 3:48 pm Full Time Di scharges Equi val ents Title XVIII Total All Component Nonpai d Title V Title XIX Workers Pati ents 12.00 13.00 11.00 14.00 15.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 3, 504 194 15, 959 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, 129 999 2 00 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 0 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 6.00 7.00 Total Adults and Peds. (exclude observation 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 CORONARY CARE UNIT 9.00 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 NEONATAL INTENSIVE CARE UNIT 12.00 13.00 NURSERY 13.00 14.00 Total (see instructions) 0.00 0 3,504 194 15, 959 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 0.00 188 390 16.00 0 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 HOSPI CE 24.00 24 00 HOSPICE (non-distinct part) 24. 10 24. 10 25. 00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26, 25 0 00 27.00 Total (sum of lines 14-26) 0.00 27.00 28.00 Observation Bed Days 28.00 29.00 29.00 Ambul ance Trips 30 00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 31.00 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room 32.00 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00

33.01 LTCH site neutral days and discharges

Provi der CCN: 15-0169

| Peri od: | Worksheet S-3 | From 01/01/2020 | Part II | To 12/31/2020 | Date/Time Prepared:

					T	12/31/2020	Date/Time Pre 8/2/2021 3:48	pm
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	(col.2 ± col.	Paid Hours Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	A-6) 3.00	3) 4. 00	col . 4 5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1.00	Total salaries (see	200. 00	113, 946, 024	-617, 780	113, 328, 244	3, 183, 546. 00	35. 60	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2.00
3.00	A Non-physician anesthetist Part B		0	0	0	0.00	0. 00	3.00
4.00	Physician-Part A - Administrative		492, 652	0	492, 652	1, 080. 00	456. 16	4.00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non Physician-Part B		0 226, 414	0	0 226, 414	0. 00 3, 158. 00		
6.00	Non-physician-Part B for hospital-based RHC and FQHC		0	О	О	0.00	0.00	6.00
7. 00	services Interns & residents (in an approved program)	21. 00	0	0	0	0.00	0. 00	7.00
7. 01	Contracted interns and residents (in an approved programs)		0	О	О	0.00	0.00	7.0
8. 00	Home office and/or related organization personnel		0	0	0	0.00	0. 00	8.00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 3, 143, 123	-1, 751	0 3, 141, 372	0. 00 95, 006. 00	l .	
	instructions) OTHER WAGES & RELATED COSTS							<u> </u>
11. 00	Contract labor: Direct Patient Care		947, 185		947, 185	15, 151. 00		
12. 00	Contract labor: Top level management and other management and administrative services		0	0	0	0. 00	0. 00	12.00
13. 00	Contract Labor: Physician-Part A - Administrative		2, 212, 631	0	2, 212, 631	18, 365. 00	120. 48	13.00
14. 00	Home office and/or related organization salaries and wage-related costs		0	О	0	0.00	0.00	14.00
14. 01	Home office salaries		30, 515, 585	О	30, 515, 585	693, 844. 00	43. 98	14. 0°
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0 1, 537, 764	0	-	0. 00 12, 656. 00		1
16. 00	- Administrative Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0. 00	16. 00
16. 01	Home office Physicians Part A - Teaching		0	0	0	0.00	0. 00	16. 0°
16. 02	Ŭ .		0	0	0	0.00	0.00	16. 0
17. 00	Wage-related costs (core) (see instructions)		26, 729, 404	0	26, 729, 404			17. 00
18. 00	Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		806, 837 0	0	806, 837 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	О			21.00
22. 00	Physician Part A - Administrative		11, 735	О	11, 735			22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0 34, 313	ľ	0 34, 313			22. 0° 23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an approved program)		0	0	0			24. 00 25. 00
25. 50	Home office wage-related (core)		6, 037, 437	0	6, 037, 437			25. 50
25. 51	Related organization wage-related (core)		0	0	0			25. 5
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	O			25. 52

| Period: | Worksheet S-3 | From 01/01/2020 | Part II | To 12/31/2020 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION COMMUNITY HOSPITAL OF INDIANA, INC.

Provider CCN: 15-0169

					T	o 12/31/2020	Date/Time Prep 8/2/2021 3:48	
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number		on of Salaries			Wage (col. 4 ÷	
			·	(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4	,	
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE			1				
26. 00	Employee Benefits Department	4. 00	158, 926	l .	158, 926			
27. 00	Administrative & General	5. 00	11, 673, 901			·		27. 00
28. 00	Administrative & General under		7, 968, 049	0	7, 968, 049	75, 658. 00	105. 32	28. 00
	contract (see inst.)		_	_	_			
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00		29. 00
30. 00	Operation of Plant	7. 00	2, 970, 230	-9, 410	2, 960, 820			
31. 00	Laundry & Linen Service	8. 00	0	0	0	0.00		
32. 00	Housekeepi ng	9. 00	2, 929, 719					
33. 00	Housekeeping under contract		391, 329	0	391, 329	9, 911. 00	39. 48	33. 00
	(see instructions)							
34. 00	Di etary	10. 00	2, 518, 982					34.00
35. 00	Di etary under contract (see		491, 179	0	491, 179	6, 240. 00	78. 71	35. 00
	instructions)		_					
36. 00	Cafeteri a	11. 00	0	1, 748, 848	1, 748, 848			
37. 00	Maintenance of Personnel	12. 00	0	0	0	0.00		
38. 00	Nursing Administration	13. 00	2, 104, 041					
39. 00	Central Services and Supply	14. 00	818, 111		·	34, 595. 00		
40. 00	Pharmacy	15. 00	6, 768, 246			·		40. 00
41. 00	Medical Records & Medical	16. 00	402, 251	-1, 303	400, 948	9, 986. 00	40. 15	41. 00
	Records Li brary							
42. 00	Soci al Servi ce	17. 00	1, 749, 110			·		42. 00
43. 00	Other General Service	18. 00	0	0	0	0. 00	0. 00	43. 00

Total overhead cost (see

instructions)

7.00

39. 17

7.00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provi der CCN: 15-0169 Peri od: From 01/01/2020 To 12/31/2020 8/2/2021 3:48 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . (from Salaries in col . 5) Works<u>heet A-6)</u> 3) col. 4 1.00 2.00 5.00 6.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 122, 570, 167 -617, 780 121, 952, 387 3, 272, 197. 00 37. 27 1.00 instructions) 2.00 Excluded area salaries (see 3, 143, 123 -1, 751 3, 141, 372 95, 006. 00 33.06 2.00 instructions) 3.00 Subtotal salaries (line 1 119, 427, 044 -616, 029 118, 811, 015 3, 177, 191. 00 37.39 3.00 minus line 2) 4.00 Subtotal other wages & related 35, 213, 165 35, 213, 165 740, 016. 00 47. 58 4.00 costs (see inst.) Subtotal wage-related costs 27. 59 5.00 32, 778, 576 32, 778, 576 0.00 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 187, 418, 785 -616, 029 186, 802, 756 3, 917, 207. 00 47 69

-1, 727, 849

39, 216, 225

1, 001, 190. 00

40, 944, 074

	10 12/31/2020	8/2/2021 3:48	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	2, 353, 993	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	9, 810	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	253, 239	6.00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	10, 461, 259	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	1, 561, 863	9. 00
10.00	Dental, Hearing and Vision Plan	89, 013	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	3, 452, 059	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)	1, 173, 365	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	11, 135	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	8, 084, 032	
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unempl oyment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21.00
	instructions))		
22. 00		0	
23. 00	Tuition Reimbursement	132, 519	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	27, 582, 287	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	COMMUNITY HOSPITAL OF INDIANA, INC.	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0169	Period: Worksheet S-3 From 01/01/2020 Part V
		To 12/21/2020 Pata/Time Drangrade

		0 12/31/2020	8/2/2021 3:48	
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	947, 185	27, 582, 287	1.00
2.00	Hospi tal	947, 185	26, 775, 450	2.00
3.00	Subprovi der - IPF	0	568, 244	3.00
4.00	Subprovi der - I RF			4.00
5.00	Subprovi der - (0ther)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15.00
16. 00	Hospi tal -Based-CMHC			16.00
17. 00	Renal Dialysis	0	0	17.00
18. 00	Other	0	238, 593	18. 00

	Financial Systems COMMUNITY HOSPITAL OF INDIA FAL UNCOMPENSATED AND INDIGENT CARE DATA Provi	der CCN: 15-0169	Period:	u of Form CMS-2 Worksheet S-10					
1103111	AL GNOOMI ENSATED AND THUTGENT CARE DATA	der cciv. 13-0107	From 01/01/2020	Worksheet 3-10	O				
			To 12/31/2020	Date/Time Pre 8/2/2021 3:48					
	1.00								
	Uncompensated and indigent care cost computation			0.040405					
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided	by line 202 colum	n 8)	0. 243185	1. 00				
2. 00	Medicaid (see instructions for each line) Net revenue from Medicaid			76, 747, 519	2. 00				
3. 00	Did you receive DSH or supplemental payments from Medicaid?			76, 747, 519 Y	3.00				
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental p	avments from Media	rai d2	Ϋ́	4. 00				
5. 00	If line 4 is no, then enter DSH and/or supplemental payments from M		zaru:	-28, 847, 144					
6. 00	Medi cai d charges	carcara		324, 171, 087	6.00				
7. 00	Medicaid cost (line 1 times line 6)			78, 833, 546					
8. 00	Difference between net revenue and costs for Medicaid program (line	7 minus sum of Li	nes 2 and 5: if	30, 933, 171					
	< zero then enter zero)		=,	20,122,111					
	Children's Health Insurance Program (CHIP) (see instructions for ear	ch line)							
9.00	Net revenue from stand-alone CHIP			0	9. 00				
10.00	Stand-alone CHIP charges			0	10.00				
11. 00	Stand-alone CHIP cost (line 1 times line 10)			0	11. 00				
12.00	Difference between net revenue and costs for stand-alone CHIP (line	11 minus line 9;	if < zero then	0	12.00				
	enter zero)		`						
40.00	Other state or local government indigent care program (see instruct			0	40.00				
13. 00 14. 00	Net revenue from state or local indigent care program (Not included Charges for patients covered under state or local indigent care pro			0	13. 00 14. 00				
14.00	10)	gram (Not included	i ili ililes o or	U	14.00				
15. 00	State or local indigent care program cost (line 1 times line 14)			0	15. 00				
16. 00	Difference between net revenue and costs for state or local indigen	t care program (Li	ne 15 minus line	0					
	13; if < zero then enter zero)	pg (_					
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and	d state/local indi	gent care program	ns (see					
	instructions for each line)								
17. 00	Private grants, donations, or endowment income restricted to fundin			0					
18. 00	Government grants, appropriations or transfers for support of hospi			0	18. 00				
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16)	igent care program	ns (sum of lines	30, 933, 171	19. 00				
		Uni nsured		Total (col. 1					
		patients		+ col . 2)					
	T	1.00	2. 00	3. 00					
20.00	Uncompensated Care (see instructions for each line)	00 505	100 2 445 611	22 722 412	20.00				
20. 00	Charity care charges and uninsured discounts for the entire facilit	y 20, 585, 1	198 3, 145, 214	23, 730, 412	20.00				
21. 00	(see instructions) Cost of patients approved for charity care and uninsured discounts	(see 5,006,0	3, 145, 214	8, 151, 225	21. 00				
21.00	instructions)	(366 3,000,0	3, 143, 214	0, 131, 223	21.00				
22. 00									
	charity care	,		,					
23. 00									
				1. 00					
24. 00	Does the amount on line 20 column 2, include charges for patient da	vs beyond a Length	n of stav limit	N N	24. 00				
	imposed on patients covered by Medicaid or other indigent care prog		-						
25. 00	If line 24 is yes, enter the charges for patient days beyond the in	digent care progra	am's length of	0	25. 00				

24, 447, 236

23, 987, 717

5, 994, 284

14, 125, 802

459, 519

45, 058, 973 31. 00

26.00

27. 01

28.00

29.00

30.00

298, 688 27. 00

stay limit

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

28.00 Non-Medicare bad debt expense (see instructions)

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

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

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

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

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

26.00

Health Financial Systems COMM RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	UNITY HOSPITAL (u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC	F	eriod: rom 01/01/2020	Worksheet A	
			T	o 12/31/2020	Date/Time Pre 8/2/2021 3:48	pared:
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	Pili
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +- col. 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT		0	0		19, 089, 210	1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P 3. 00 00300 OTHER CAP REL COSTS		0	0	, ,	16, 008, 457 0	2. 00 3. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	158, 926	210, 351	369, 277		280, 732	4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	11, 673, 901	145, 328, 000	157, 001, 901		135, 799, 163	5. 00
7.00 00700 OPERATION OF PLANT	2, 970, 230	7, 257, 481	10, 227, 711		9, 826, 322	7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	0	983, 957	983, 957		983, 877	8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	2, 929, 719 2, 518, 982	1, 850, 775 2, 747, 095	4, 780, 494 5, 266, 077		4, 756, 443 1, 581, 879	9. 00 10. 00
11. 00 01100 CAFETERI A	2,310,702	2, 747, 073	0, 200, 077		3, 592, 188	11.00
13. 00 01300 NURSI NG ADMINI STRATI ON	2, 104, 041	521, 887	2, 625, 928		2, 600, 926	13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	818, 111	3, 003, 995	3, 822, 106		1, 045, 640	14. 00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	6, 768, 246 402, 251	37, 230, 458 95, 833	43, 998, 704 498, 084		5, 974, 202 498, 004	15. 00 16. 00
17. 00 01700 SOCIAL SERVICE	1, 749, 110	465, 275	2, 214, 385		2, 214, 349	17. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	34, 192, 180	24, 738, 424	58, 930, 604	-11, 819, 977	47, 110, 627	30.00
31. 00 03100 NTENSI VE CARE UNI T	4, 807, 884	2, 368, 326	7, 176, 210		6, 389, 507	31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	7, 612, 232	3, 615, 967	11, 228, 199		10, 527, 516	35. 00
40. 00 04000 SUBPROVI DER - PF	1, 811, 833	482, 628	2, 294, 461		2, 274, 007	40.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	0	2, 358, 032	2, 358, 032	43. 00
50. 00 O5000 OPERATING ROOM	4, 420, 285	30, 026, 206	34, 446, 491	-20, 241, 826	14, 204, 665	50.00
51. 00 05100 RECOVERY ROOM	2, 357, 006	1, 209, 978	3, 566, 984		3, 351, 065	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	78, 431	2, 204	80, 635		5, 911, 013	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	3, 320, 966	1, 747, 759 3, 189, 050	5, 068, 725		3, 896, 437 1, 032, 799	54. 00 55. 00
57. 00 05700 CT SCAN	536, 495 943, 566	3, 189, 030 882, 780	3, 725, 545 1, 826, 346		1, 631, 938	57.00
58. 00 05800 MRI	480, 637	1, 551, 911	2, 032, 548		1, 647, 500	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	-29, 973	-29, 973		3, 087	59. 00
60. 00 06000 LABORATORY	0	11, 322, 370			11, 322, 370	60.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	664, 570 2, 995, 219	314, 376 1, 984, 168	978, 946 4, 979, 387		904, 016 4, 271, 011	64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	5, 948, 703	2, 999, 903	8, 948, 606		5, 290, 285	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	2, 041, 545	2, 041, 545	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	441, 686	441, 686	68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	32, 585 811, 719	446, 833 763, 185	479, 418 1, 574, 904		483, 824 1, 312, 448	69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	011,719	703, 103	1, 374, 704		14, 384, 461	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	O	0	0		11, 681, 234	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	, ,	14, 549, 559	73. 00
73. 01 07301 SPECIALTY PHARMACY 74. 00 07400 RENAL DIALYSIS	0	15, 387, 821 1, 159, 345	15, 387, 821 1, 159, 345		40, 673, 490 1, 159, 345	73. 01 74. 00
76. 00 03330 ENDOSCOPY	1, 174, 801	2, 401, 846	3, 576, 647		2, 026, 477	76.00
76. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 02
76. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	475 270	750 202	0	(10, 030	76. 03
76. 04 03953 WOUND CARE 76. 06 03954 I MAGI NG CENTER	275, 133 1, 579, 875	475, 260 2, 417, 748	750, 393 3, 997, 623		618, 839 2, 836, 556	76. 04 76. 06
76. 07 03955 BREAST DI AGNOSTI C CENTER	1,377,073	9, 079, 082	9, 079, 082		8, 644, 194	76.00
OUTPATIENT SERVICE COST CENTERS	-1					
90. 00 09000 CLI NI C	0	0	0	0	0	90.00
90. 01 04950 INFUSION CENTER 90. 26 04975 SPINE CENTER	107, 616 165, 633	2, 211, 906 52, 420	2, 319, 522 218, 053		154, 198	90. 01 90. 26
91. 00 09100 EMERGENCY	6, 203, 848	3, 038, 345	9, 242, 193		217, 961 8, 787, 830	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0,200,010	0,000,010	7, 212, 170	101,000	0, 707, 000	92.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 INTEREST EXPENSE		0	0	0		113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	112 614 724	222 524 075	0 426 140 700	241 205		114.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	112, 614, 734	323, 534, 975	436, 149, 709	241, 205	436, 390, 914	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	O	0	O	0	190. 00
191. 00 19100 RESEARCH	0	О	0	0		191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	102, 989	102, 989	0	102, 989	
193.00 19300 NONPALD WORKERS 194.00 07950 HOME OFFICE		0	0			193. 00 194. 00
194. 06 07956 PAVI LLI ONS	0	161, 343	161, 343	-122, 007		194. 06
194. 08 07958 OTHER NRCC	1, 331, 290	553, 846			1, 765, 938	

Health Financial Systems COMM	MUNITY HOSPITAL	OF INDIANA, IN	NC.	In Lie	eu of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der C		Peri od:	Worksheet A	
				From 01/01/2020 To 12/31/2020		nared·
					8/2/2021 3: 48	
Cost Center Description	Sal ari es	0ther	Total (col. 1	Reclassi fi cati	Recl assi fi ed	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
194. 10 07960 COMMUNITY REHAB HOSPITAL	0	0		0	0	194. 10
200.00 TOTAL (SUM OF LINES 118 through 199)	113, 946, 024	324, 353, 153	438, 299, 17	7 0	438, 299, 177	200. 00

Heal th FinancialSystemsCOMMUNITY HOSPITAL OF INDIANA, INC.RECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSESProvider CCN: 15-0169

Peri od: From 01/01/2020 To 12/31/2020

Date/Time Prepared: 8/2/2021 3:48 pm

			8/2/2021 3: 48	_pm
Cost Center Description	Adjustments	Net Expenses		
	(See A-8) 6.00	For Allocation 7.00		
GENERAL SERVICE COST CENTERS	0.00	7.00	<u> </u>	
1.00 O0100 CAP REL COSTS-BLDG & FIXT	-5, 421, 334	13, 667, 876		1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	5, 468, 245	21, 476, 702		2. 00
3.00 00300 OTHER CAP REL COSTS	0	0		3. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	3, 208, 143	3, 488, 875		4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	-81, 511, 482	54, 287, 681		5. 00
7.00 O0700 OPERATION OF PLANT	878, 061	10, 704, 383		7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	983, 877		8. 00
9. 00 00900 HOUSEKEEPI NG	0	4, 756, 443		9. 00
10. 00 01000 DI ETARY	-8, 565	1, 573, 314		10.00
11. 00 01100 CAFETERI A	-1, 910, 953	1, 681, 235		11. 00
13.00 01300 NURSING ADMINISTRATION	3, 829, 188	6, 430, 114		13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	3, 520, 764	4, 566, 404		14. 00
15. 00 01500 PHARMACY	-99, 115	5, 875, 087		15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	2, 440, 156	2, 938, 160		16.00
17. 00 01700 SOCIAL SERVICE	0	2, 214, 349		17. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	0	0	l .	19.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	589, 754	589, 754	·	21.00
22. 00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRV I NPATI ENT ROUTI NE SERVI CE COST CENTERS	874, 613	874, 613		22. 00
30. 00 03000 ADULTS & PEDIATRICS	160, 879	47, 271, 506		30.00
31. 00 03100 NTENSI VE CARE UNI T	0	6, 389, 507		31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	-348, 539	10, 178, 977	l control of the cont	35. 00
40. 00 04000 SUBPROVI DER - PF	-40, 344	2, 233, 663	l e e e e e e e e e e e e e e e e e e e	40.00
43. 00 04300 NURSERY	0	2, 358, 032		43.00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>	2,000,002		10.00
50. 00 05000 OPERATI NG ROOM	-142, 500	14, 062, 165		50.00
51. 00 05100 RECOVERY ROOM	0	3, 351, 065		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	5, 911, 013		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	42, 396	3, 938, 833		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	-37, 520	995, 279		55. 00
57. 00 05700 CT SCAN	0	1, 631, 938		57.00
58. 00 05800 MRI	0	1, 647, 500		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	225, 145	228, 232		59. 00
60. 00 06000 LABORATORY	-31	11, 322, 339		60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	904, 016		64. 00
65. 00 06500 RESPI RATORY THERAPY	0	4, 271, 011		65. 00
66. 00 06600 PHYSI CAL THERAPY	-2, 560	5, 287, 725		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	2, 041, 545		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	441, 686		68. 00
69. 00 06900 ELECTROCARDI OLOGY	54, 296	538, 120		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	51, 556	1, 364, 004		70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	14, 384, 461		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	11, 681, 234	·	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	370, 810	14, 920, 369	·	73. 00
73. 01 07301 SPECI ALTY PHARMACY	21, 217	40, 694, 707	·	73. 01
74. 00 07400 RENAL DI ALYSI S	0	1, 159, 345		74. 00
76. 00 03330 ENDOSCOPY	0	2, 026, 477		76. 00
76. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76. 01
76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76. 02
76. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	(10, 020		76. 03
76. 04 03953 WOUND CARE	0	618, 839		76. 04
76. 06 03954 I MAGING CENTER	0	2, 836, 556		76.06
76. 07 03955 BREAST DI AGNOSTI C CENTER OUTPATI ENT SERVI CE COST CENTERS	0	8, 644, 194		76. 07
90. 00 O9000 CLINIC		0		90.00
90. 00 09000 CETNIC 90. 01 04950 NFUSION CENTER		154, 198	l .	90.00
90. 26 04975 SPI NE CENTER	0	217, 961		90. 26
91. 00 09100 EMERGENCY	1, 073, 851	9, 861, 681		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1,073,031	7, 001, 001		92.00
SPECIAL PURPOSE COST CENTERS				72.00
113. 00 11300 NTEREST EXPENSE	0	0		113. 00
114. 00 11400 UTILIZATION REVIEW-SNF	0	0		114. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-66, 713, 869	369, 677, 045		118. 00
NONREI MBURSABLE COST CENTERS	22,7.3,307	22., 3, 310		1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
191. 00 19100 RESEARCH	l o	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	l ol	102, 989		192. 00
193. 00 19300 NONPALD WORKERS		0		193. 00
194. 00 07950 HOME OFFICE		0		194. 00
194. 06 07956 PAVI LLI ONS	l ol	39, 336		194. 06
194. 08 07958 OTHER NRCC		1, 765, 938	•	194. 08
194. 10 07960 COMMUNITY REHAB HOSPITAL		0		194. 10
200.00 TOTAL (SUM OF LINES 118 through 199)	-66, 713, 869	371, 585, 308		200. 00
		-		

Cost Schrief Line st Splany Other Cost Schrief		Financial Systems SIFICATIONS	COMMI	JNI TY HOSPI TAL	OF INDIANA, IN		In Lieu Period:	of Form CMS-2552 Worksheet A-6	-10
Cost Center Uns y Salary Dither	RECLAS	SIFICATIONS			Provider CC	N. 15-0109	From 01/01/2020	Date/Time Prepare	ed:
2.00			Increases					8/2/2021 3: 48 pm	
A - Chargosobile Medical Supplies Suppl									
MEDICAL SUPPLIES CHANGED 10 71.00 9 14,884,461 2 0 0 0 0 0 0 0 0 0		A - Chargeable Medical Supplie	es						_
3.00 4.00 6.00 6.00 6.00 6.00 6.00 6.00 6		MEDICAL SUPPLIES CHARGED TO						1	
5.00 6.00 7.00 7.00 7.00 7.00 7.00 7.00 7									
7.00	5.00		0.00	0	0			5.	. 00
8 00					-			1	
10.00	8.00		0.00		-			8.	. 00
12.00					-				
13.00					-				
15.00	13.00		0.00	0	0			13.	. 00
17. 00					-				
18. 00					-				
20, 00	18.00		0.00	0	Ō			18.	. 00
22 00					-			1	
23.00 0.00 0.00 0 0.00 223.00 25.00 26.0					-				
25.00	23. 00		0.00	0	-			23.	. 00
26. 00					0			1	
B - Implantable Device Reclass		TOTAL C		0_	0			1	
MPL. DEV. CHARGED TO		B - Implantable Device Reclass		<u> </u>					
4.00 C - Drugs Charges to Pat C - ARDIAC CATHETERIZATION 59.00 0 2.7 RNIGS CHARGED TO PATIENTS 73.00 0 14,546 2.00 8.00 9.00 0.00 0.00 0.00 0.00 0.00 0		IMPL. DEV. CHARGED TO							
C - Drugs Charges to Pat					11. 714. 416			1	
2.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00	1 00		F0.00					1	00
4.00 0.	2.00	ELECTROCARDI OLOGY	69. 00		4, 546			2.	. 00
5. 00 0. 00 0. 00 0. 00 0. 00 6. 00 6. 00 7. 00 6. 00 7. 00 6. 00 7. 00 8. 00 9. 00 0. 00 0. 00 0. 00 0. 00 9. 00 8. 00 9. 00 9. 00 10. 00 10. 00 10. 00 11. 00 10. 00 11. 0		DRUGS CHARGED TO PATIENTS		1					
7. 00 8. 00 9. 00 10. 0	5.00		0.00		0			5.	. 00
9.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 11.00 11.00 12.00 13.00 13.00 14.00 15.00 16.00 17.00 16.00 17.00 18.00 17.00 18.00 19.00 1			0.00		-			7.	. 00
10.00					0				
12.00 13.00 14.00 15.00 15.00 16.00 17.00 18.00 19.00 19.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 10TALS 10 - Depreciation Expense CAP REL COSTS-MVBLE EQUI P 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.0	10.00		0.00	О	0			10.	. 00
14. 00 15. 00 16. 00 0. 00 0. 00 0. 00 0. 00 0. 00 17. 00 18. 00 19. 00 0. 00					-				
15. 00 16. 00 16. 00 17. 00 0. 00 0. 00 0. 00 0. 00 0. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 TOTALS D - Depreciation Expense 1. 00 2. 00 3. 00 4. 00 5. 00 0.					-				
17. 00 18. 00 19. 00 19. 00 20. 00 20. 00 21. 00 22. 00 22. 00 23. 00 24. 00 25. 00 TOTALS D - Depreciation Expense CAP REL COSTS-MVBLE EQUI P CAP REL COSTS-MVBLE EQUI P 0. 00	15. 00		0.00	0	0			15.	. 00
19. 00 20. 00 21. 00 22. 00 22. 00 22. 00 23. 00 24. 00 25. 00 TOTALS D - Depreciation Expense CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP 0. 00 0			0.00					17.	. 00
20. 00 21. 00 22. 00 22. 00 23. 00 24. 00 25. 00 TOTALS D - Depreciation Expense CAP REL COSTS-MVBLE EQUI P CAP REL COSTS-MVBLE EQUI P 0. 00 0. 0					-				
22.00	20.00		0.00	0	0			20.	. 00
24. 00 25. 00 TOTALS D - Depreciation Expense 1. 00 2. 00 3. 00 4. 00 5. 00 0. 00			0.00		-				
25. 00 TOTALS					0				
D - Depreciation Expense		TOTALS — — — — —		0	0				
2.00 0.00 0 0 2.00 3.00 0.00 0 0 3.00 4.00 0.00 0 0 4.00 5.00 0.00 0 0 5.00 6.00 0.00 0 0 6.00 7.00 0 0 0 7.00 8.00 0.00 0 0 8.00 9.00 0 0 0 9.00		D - Depreciation Expense							
3.00 0.00 0 0 3.00 4.00 0.00 0 0 4.00 5.00 0.00 0 0 5.00 6.00 0.00 0 0 6.00 7.00 0.00 0 0 7.00 8.00 0.00 0 0 8.00 9.00 0.00 0 0 9.00		CAP REL COSTS-MVBLE EQUIP							
5.00 0.00 0 0 6.00 0.00 0 0 7.00 0.00 0 0 8.00 0.00 0 0 9.00 0.00 0 0	3.00		0.00	0	0			3.	. 00
7. 00 8. 00 9. 00 0. 00 00 00 00 00 00 00 00 00 00 00 00 00	5.00		0.00	0	0			5.	. 00
8. 00 9. 00 0. 00 0 0 0 0 8. 00 9. 00				•	-				
	8.00		0.00	0	0			8.	. 00
					-				

	Financial Systems	COMMU	JNITY HOSPITAL (OF INDIANA, INC.	In Lieu of Form CMS	
RECLASS	SIFICATIONS			Provider CCN:	From 01/01/2020	
					To 12/31/2020 Date/Time Pr 8/2/2021 3:4	repared: 18 pm
	Cost Contor	Increases	Salary	Othor		
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
11. 00		0.00	0	0		11. 00
12. 00 13. 00		0. 00 0. 00	0	0		12. 00 13. 00
14. 00		0.00	Ö	0		14. 00
15. 00		0.00	O	0		15. 00
16.00		0.00	0	0		16.00
17. 00 18. 00		0. 00 0. 00	0	0		17. 00 18. 00
19. 00		0.00	Ö	Ö		19. 00
20. 00		0.00	O	0		20. 00
21. 00 22. 00		0. 00 0. 00	0	0		21. 00 22. 00
23. 00		0.00	Ö	Ö		23. 00
24. 00		0.00	o	0		24. 00
25. 00 26. 00		0. 00 0. 00	0	0		25. 00 26. 00
27. 00		0.00	0	0		27. 00
28. 00		0. 00	О	0		28. 00
29. 00		0.00	0	0		29. 00
30. 00 31. 00		0. 00 0. 00	0	0		30. 00 31. 00
32. 00		0.00		0		32. 00
	TOTALS		0	16, 844, 995		
1.00	E - Interest Expense CAP REL COSTS-BLDG & FIXT	1. 00	0	10, 607, 739		1.00
	TOTALS		0	10, 607, 739		
1. 00	F - Other Capital Rental CAP REL COSTS-MVBLE EQUIP	2. 00	0	7, 433, 684		1. 00
2.00		0.00	0	0		2. 00
3. 00 4. 00		0. 00 0. 00	0	0		3. 00 4. 00
5. 00		0.00	o	0		5. 00
6.00		0.00	O	0		6. 00
7. 00 8. 00		0. 00 0. 00	0	0		7. 00 8. 00
9. 00		0.00	o	0		9. 00
10.00		0.00	О	0		10. 00
11. 00 12. 00		0. 00 0. 00	0	0		11. 00 12. 00
13. 00		0.00	Ö	0		13. 00
14. 00		0.00	0	0		14. 00
15. 00 16. 00		0. 00 0. 00	0	0		15. 00 16. 00
17. 00		0.00	Ö	o		17. 00
18. 00		0.00	0	0		18. 00
19. 00 20. 00		0. 00 0. 00	0	0		19. 00 20. 00
21. 00		0.00	o	0		21. 00
22. 00		0.00	О	0		22. 00
23. 00 24. 00		0. 00 0. 00	0	0		23. 00 24. 00
25. 00		0.00	Ö	0		25. 00
26. 00		0.00	O	0		26. 00
27. 00 28. 00		0. 00 0. 00	0	0		27. 00 28. 00
29. 00		0.00	o	0		29. 00
30.00		0.00	0	0		30. 00
	TOTALS G - STD BENEFIT		0	7, 433, 684		
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	9, 521		1.00
	OPERATION OF PLANT	7.00	0	9, 410		2.00
	HOUSEKEEPI NG DI ETARY	9. 00 10. 00	0	26, 537 10, 502		3. 00 4. 00
5.00	NURSING ADMINISTRATION	13. 00	О	13, 668		5. 00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	4, 825		6. 00
	PHARMACY MEDICAL RECORDS & LIBRARY	15. 00 16. 00	0	23, 263 1, 303		7. 00 8. 00
9.00	SOCI AL SERVI CE	17. 00	О	6, 911		9. 00
	ADULTS & PEDIATRICS	30.00	0	215, 150		10.00
	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	31. 00 35. 00	0	29, 159 79, 929		11. 00 12. 00
	SUBPROVI DER - I PF	40. 00	Ö	1, 751		13. 00
	OPERATING ROOM	50.00	0	29, 930		14. 00
15. 00	RECOVERY ROOM	51.00	0	7, 625		15. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0169 Peri od: Worksheet A-6 From 01/01/2020 To 12/31/2020 Date/Time Prepared:

Cost Center Line # Salary Other						 8/2/2021 3:48 pm
16. 00 RADI OLOGY-THERAPEUTI C						
16. 00						
17. 00 RADIOLOGY-THERAPEUTIC 55. 00				4. 00		
18. 00 CT SCAN				0	·	
19.00 NIRAVEROUIS THERAPY 64.00 0 691 19.00 20.00 RESPI RATORY THERAPY 65.00 0 31,886 20.00 21.00 PHYSI CAL THERAPY 70.00 0 2,407 22.00 22.00 ELECTROENCEPHALOGRAPHY 70.00 0 2,407 22.00 23.00 ELODOSCOPY 76.00 0 3,860 23.00 24.00 IMAGI NG CENTER 76.06 0 6.055 24.00 25.00 EMERGENCY 91.00 0 44.251 25.00 10	17.00			0		
20.00 RESPIRATORY THERAPY				0		
21.00 PHYSICAL THERAPY				0		
22.00 ELECTROENCEPHALOGRAPHY 70.00 0 2,407 22.00 23.00 ENDOSCOPY 76.00 0 3,860 23.00 24.00 IMAGI NG CENTER 76.06 0 6.055 24.00 25.00 ENERGENCY 91.00 0 44,251 25.00 25.00 ENERGENCY 91.00 0 617,780 25.00 25.00 ENERGENCY 91.00 0 617,780 25.00 25	20.00	RESPI RATORY THERAPY	65.00	0	31, 886	
23. 00 ENDOSCOPY 76. 00 0 3, 860 23. 00 24. 00 1MaG ING CENTER 76. 06 0 0 6, 055 22. 00 25. 00 EMERGENCY 91. 00 0 44, 251 25. 00 1. 1. 0	21.00	PHYSI CAL THERAPY	66.00	0	38, 464	
MAGING CENTER	22.00	ELECTROENCEPHALOGRAPHY	70.00	0	2, 407	
25.00 EMERGENCY	23.00	ENDOSCOPY	76.00	0	3, 860	23. 00
TOTALS	24.00	I MAGING CENTER	76.06	0	6, 055	24. 00
H - Labor and Delivery	25.00	EMERGENCY	91.00	0	44, 251	25. 00
1.00 NURSERY 43.00 1,623,272 734,760 2.00 DELIVERY ROOM & LABOR ROOM 52.00 4,013,639 1,816,739 170TALS 5.00 1.00 2.00 TOTALS 5.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00		TOTALS		0	617, 780	
2.00		H - Labor and Delivery				
TOTALS	1.00		43.00	1, 623, 272	734, 760	1.00
TOTALS	2.00	DELIVERY ROOM & LABOR ROOM	52.00	4, 013, 639	1, 816, 739	2. 00
1.00 CAFETERIA 11.00 1,748,848 1,843,340 1.00 1,748,848 1,843,340 1.00 1,748,848 1,843,340 1.00 0CCUPATI ONAL THERAPY 67.00 1,403,930 637,615 1.00 SPEECH PATHOLOGY 68.00 303,739 137,947 10TALS 1,707,669 775,562 1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 8,270,222 1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 211,249 1.00 211,249 1.00 211,249 1.00 211,249 1.00 211,249 1.00 211,249 1.00 210,240 1.00 2.00 210,240 1.00 2.00 2.00 2.00 2.00 2.00 2.00 2.0		TOTALS		5, 636, 911	2, 551, 499	
TOTALS		I - Cafeteria				
1. 00	1.00	CAFETERI A	11.00	1, 748, 848	1, 843, 340	1.00
1. 00 OCCUPATI ONAL THERAPY 67. 00 1, 403, 930 637, 615 2. 00 SPECH PATHOLOGY 68. 00 303, 739 137, 947 TOTALS 7.75, 562		TOTALS		1, 748, 848	1, 843, 340	
2.00 SPEECH PATHOLOGY 68.00 303,739 137,947 170TALS 1,707,669 775,562		J - Therapy				
TOTALS	1.00	OCCUPATI ONAL THERAPY	67.00	1, 403, 930	637, 615	1. 00
K - Building Depreciation CAP REL COSTS-BLDG & FIXT 1.00 0 8,270,222 1.00 TOTALS 0 8,270,222 1.00 1.00	2.00		68. 00		137, 947	2. 00
1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 8, 270, 222 1.00		TOTALS		1, 707, 669	775, 562	
TOTALS		K - Building Depreciation				
L - Capi tal Insurance Costs 1.00	1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8, 270, 222	1.00
1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 211, 249		TOTALS		0	8, 270, 222	
TOTALS M - Radi ol ogy Support 1. 00 RADI OLOGY-THERAPEUTI C 55. 00 99, 615 36, 795 1. 00 2. 00 CT SCAN 57. 00 162, 466 60, 010 2. 00 3. 00 MRI 58. 00 69, 563 25, 694 3. 00 TOTALS 331, 644 122, 499 N - Special ty Pharmacy 1. 00 SPECIALTY PHARMACY 73. 01 1, 621, 909 23, 663, 760 TOTALS 1, 621, 909 23, 663, 760		L - Capital Insurance Costs				
M - Radi ol ogy Support 1. 00 RADI OLOGY-THERAPEUTI C 55. 00 99, 615 36, 795 2. 00 CT SCAN 57. 00 162, 466 60, 010 3. 00 MRI 58. 00 69, 563 25, 694 3. 00 TOTALS 331, 644 122, 499 1. 00 SPECIALTY PHARMACY 73. 01 1, 621, 909 23, 663, 760 TOTALS 1, 621, 909 23, 663, 760 1. 00	1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	211, 249	1.00
1. 00 RADI OLOGY-THERAPEUTI C 55. 00 99, 615 36, 795 1. 00 2. 00 CT SCAN 57. 00 162, 466 60, 010 2. 00 3. 00 MRI 58. 00 69, 563 25, 694 3. 00 TOTALS 331, 644 122, 499 1. 00 SPECIALTY PHARMACY 73. 01 1, 621, 909 23, 663, 760 TOTALS 1, 621, 909 23, 663, 760		TOTALS		0	211, 249	
2. 00 CT SCAN 57. 00 162, 466 60, 010 2. 00 3. 00 MRI 58. 00 69, 563 25, 694 3. 00 TOTALS 331, 644 122, 499 N - Special ty Pharmacy 1. 00 SPECIALTY PHARMACY 73. 01 1, 621, 909 23, 663, 760 1. 00 TOTALS 1, 621, 909 23, 663, 760		M - Radiology Support		<u> </u>	<u> </u>	
3.00 MRI 58.00 69,563 25,694 3.00 TOTALS 331,644 122,499 1.00 SPECIALTY PHARMACY 73.01 1,621,909 23,663,760 1.00 TOTALS 1,621,909 23,663,760	1.00	RADI OLOGY-THERAPEUTI C	55.00	99, 615	36, 795	1. 00
TOTALS 331, 644 122, 499 N - Special ty Pharmacy 1.00 SPECIALTY PHARMACY 73.01 1, 621, 909 23, 663, 760 TOTALS 1, 621, 909 23, 663, 760 1.00	2.00	CT SCAN	57.00	162, 466	60, 010	2.00
TOTALS 331, 644 122, 499 N - Special ty Pharmacy 1.00 SPECIALTY PHARMACY 73.01 1, 621, 909 23, 663, 760 TOTALS 1, 621, 909 23, 663, 760 1.00	3.00	MRI	58.00	69, 563	25, 694	3.00
1. 00 SPECIALTY PHARMACY		TOTALS			122, 499	
1. 00 SPECIALTY PHARMACY		N - Specialty Pharmacy				
TOTALS 1, 621, 909 23, 663, 760	1.00		73. 01	1, 621, 909	23, 663, 760	1.00
		TOTALS			23, 663, 760	
	500.00	Grand Total: Increases		11, 046, 981		500.00

Heal th	Financial Systems	COMM	MUNITY HOSPITAL	OF INDIANA,	I NC.	In Lieu of Form C	MS-2552-10
RECLASS	SIFICATIONS			Provi der		Period: Worksheet From 01/01/2020	A-6
						To 12/31/2020 Date/Time	Prepared:
		Decreases				8/2/2021 3	3: 48 pm
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref.	I	
	6. 00	7. 00	8.00	9. 00	10. 00		
	A - Chargeable Medical Suppli						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6, 51		1	1.00
2.00 3.00	OPERATION OF PLANT DIETARY	7. 00 10. 00	0	91, 20 1, 60		•	2. 00 3. 00
4. 00	CENTRAL SERVICES & SUPPLY	14. 00	o	362, 73		1	4. 00
5. 00	PHARMACY	15. 00	o	251, 24		1	5. 00
6.00	ADULTS & PEDIATRICS	30.00	О	1, 964, 43			6. 00
7.00	INTENSIVE CARE UNIT	31.00	0	430, 02		1	7. 00
8. 00	NEONATAL INTENSIVE CARE UNIT	35.00	0	512, 46		1	8. 00
9.00	SUBPROVI DER - I PF	40.00	0	2, 78		•	9.00
10. 00 11. 00	OPERATING ROOM RECOVERY ROOM	50. 00 51. 00	0	7, 264, 97 205, 11	-1	1	10. 00 11. 00
12. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	235, 99	-	1	12. 00
13. 00	RADI OLOGY-THERAPEUTI C	55. 00	o	1, 050, 38	-	1	13. 00
14.00	CT SCAN	57.00	o	52, 98	8		14. 00
15.00	MRI	58.00	0	13, 84		1	15. 00
16.00	I NTRAVENOUS THERAPY	64.00	0	69, 78		•	16.00
17. 00 18. 00	RESPIRATORY THERAPY	65.00	0	485, 69		1	17. 00 18. 00
19. 00	PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY	66. 00 70. 00	ol Ol	11, 66 16, 53		1	19.00
20. 00	ENDOSCOPY	76.00	o	1, 005, 17		1	20. 00
21. 00	WOUND CARE	76. 04	o	23, 29		1	21. 00
22. 00	IMAGING CENTER	76.06	О	79, 61			22. 00
23.00	BREAST DIAGNOSTIC CENTER	76. 07	0	14, 84		1	23. 00
24. 00	INFUSION CENTER	90. 01	0	5, 35		1	24. 00
25. 00	EMERGENCY	91.00	0	227, 47		•	25. 00
26. 00	OTHER NRCC	194.08	0	9 9 14, 385, 83	<u> </u>	<u>J</u>	26. 00
	B - Implantable Device Reclas		<u> </u>	14, 300, 03	7		
1.00	OPERATING ROOM	50.00		10, 353, 91	6		1. 00
2.00	RADI OLOGY-THERAPEUTI C	55.00		1, 183, 28			2. 00
3.00	ENDOSCOPY	76.00		177, 01			3. 00
4.00	WOUND CARE	<u>76.</u> 04			+	1	4. 00
	C - Drugs Charges to Pat		0	11, 714, 41	6		
1.00	ADMI NI STRATI VE & GENERAL	5.00	o	38	19 C		1.00
2.00	NURSING ADMINISTRATION	13. 00	ō		5 C	1	2. 00
3.00	CENTRAL SERVICES & SUPPLY	14. 00	o	1, 20	17 C		3. 00
4.00	PHARMACY	15.00	0	11, 772, 90		1	4. 00
5.00	ADULTS & PEDIATRICS	30.00	0	68, 13		1	5. 00
6. 00 7. 00	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	31. 00 35. 00	0	14, 27		1	6. 00 7. 00
8. 00	SUBPROVIDER - IPF	40.00	ol	2, 61 31		•	8. 00
9. 00	OPERATING ROOM	50.00	o	124, 13			9. 00
10.00	RECOVERY ROOM	51.00	ō	1, 76		•	10.00
11.00	RADI OLOGY-DI AGNOSTI C	54.00	O	96, 44	.4 C		11. 00
12.00	RADI OLOGY-THERAPEUTI C	55.00	0	17, 28		1	12. 00
13. 00	CT SCAN	57.00	0	139, 91		•	13. 00
14. 00 15. 00	MRI INTRAVENOUS THERAPY	58. 00 64. 00	0	74, 18 2, 28		•	14. 00 15. 00
16. 00	RESPIRATORY THERAPY	65. 00	o	2, 20 1, 45		1	16. 00
17. 00	PHYSI CAL THERAPY	66.00	o	4, 83		•	17. 00
18.00	ELECTROENCEPHALOGRAPHY	70.00	o	1, 78			18. 00
19.00	ENDOSCOPY	76.00	o	3, 03	8		19. 00
20.00	WOUND CARE	76. 04	0	1, 85		1	20. 00
21. 00	I MAGING CENTER	76. 06	0	120, 11		1	21. 00
22. 00	I NFUSION CENTER	90. 01	0	2, 077, 07		1	22. 00 23. 00
23. 00 24. 00	EMERGENCY PAVI LLI ONS	91. 00 194. 06	0	24, 96	4 0	•	24. 00
25. 00	OTHER NRCC	194. 08	o	3, 12		•	25. 00
	TOTALS		— — — ō	14, 554, 13		1	
	D - Depreciation Expense		,				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	71		1	1. 00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	9, 597, 24		•	2.00
3. 00 4. 00	OPERATION OF PLANT HOUSEKEEPING	7. 00 9. 00	0	184, 63 5, 79		•	3. 00 4. 00
5. 00	DI ETARY	10.00	ol Ol	5, 79 90, 08		1	5. 00
6. 00	NURSING ADMINISTRATION	13. 00	o	23, 44		•	6. 00
7. 00	CENTRAL SERVICES & SUPPLY	14. 00	ō	76, 59		1	7. 00
8.00	PHARMACY	15. 00	o	66, 29			8. 00
9.00	ADULTS & PEDIATRICS	30.00	0	1, 579, 96		1	9. 00
10.00	INTENSIVE CARE UNIT	31.00	0	342, 00		1	10.00
11. 00 12. 00	NEONATAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	35. 00 40. 00	0	180, 00 16, 96		•	11. 00 12. 00
12.00	DODLINOALDEN - ILI	40.00	· υ	10, 90		1	1 12.00

Provider COL 15 0 No		Financial Systems	COM	MUNITY HOSPITAL				Form CMS-2552-10
	RECLAS	SIFICATIONS			Provider (F	rom 01/01/2020	
Cost Center								
Color Colo		Cost Center		Salary	Other	Wkst. A-7 Ref.		
14.00 PAPOLICY MARKINI I		6. 00	7. 00	8. 00				
15.00 MAILOCONY - HEAMAGETIC 54.00 0 386, 232 0 15.00 17.00				· · · · · · · · · · · · · · · · · · ·				
16.00		•		- 1			•	
17.00 CT SCAM 57.00 0 223,979 0 17.00 18.00 19.00		•					•	
19.00 CARDIAC CATHETER ZATION 50.00 0 1.527 0 20.00			· · · · · · · · · · · · · · · · · · ·					1
1.00		•				_	•	•
21.00 SESPI BATORY THERAPY 66.00 0 28.166 0 22.00				- 1		_	•	1
22.00 PHYSICAL THERRY 66.00 0 288,168 0 22.00 24.00 FITCHER INCIPALIDIDATION 70.00 0 150.003 0 24.00 FITCHER INCIPALIDIDATION 70.00 0 150.003 0 24.00 FITCHER INCIPALIDIDATION 70.00 0 150.003 0 24.00 PHYSICAL THERRY 70.00 0 27.00 26.00 PHACING CARE 70.00 0 27.701 0 27.00 MAGING CANIER 70.00 0 27.701 0 29.00 IMAGING CANIER 70.00 0 23.900 0 29.00 IMPESTED ID ARMOSTIC CONTER 70.00 0 23.900 0 29.00 IMPESTED ID ARMOSTIC CONTER 70.00 0 23.900 0 29.00 IMPESTED ID ARMOSTIC CONTER 70.00 0 23.900 0 20.00 IMPESTED ID ARMOSTIC CONTER 70.00 0 23.900 0 20.00 IMPESTED IN CENTER 70.00 0 23.900 0 20.00 IMPESTED IN CENTER 70.00 0 9.200 0 20.00 IMPESTED IN CENTER 70.00 0 10.407,739 1 20.00 ADMINISTRATIVE & CENTERAL 5.00 0 10.407,739 1 20.00 ADMINISTRATIVE & CENTERAL 5.00 0 10.407,739 1 20.00 ADMINISTRATIVE & CENTERAL 5.00 0 779,602 0 2.00 20.00 IMPESTED IN CENTER 70.00 0 15.201 0 6.00 20.00 IMPESTED IN CENTER 70.00 0 15.201 0 6.00 20.00 IMPESTED IN CENTER 70.00 0 15.201 0 6.00 20.00 IMPESTED IN CENTER 70.00 0 15.201 0 6.00 20.00 IMPESTED IN CENTER 70.00 0 15.201 0 6.00 20.00 IMPESTED IN CENTER 70.00 0 15.201 0 6.00 20.00 IMPESTED IN CENTER 70.00 0 15.201 0 6.00 20.00 IMPESTED IN CENTER 70.00 0 15.201 0 6.00 20.00 IMPESTED IN CENTER 70.00 0 15.201 0 10.00 20.00 IMPESTED IN CENTER 70.00 0 15.201 0 10.00 20.00 IMPESTED IN CENTER 70.00 0 15.201 0 10.00 20.00 IMPESTED IN CENTER 70.00 0 15.201 0 10.00 20.00 IMPESTED IN CENTER 70.00 0 15.201 0 10.00 20.00 IMPESTED IN CENTER 70.00 0				- 1			1	1
23.00 ELECTROCABIOLOCY 69.00 0 1.00 0 22.00 25.00 ENGOSCOPY 70.00 0 302.542 0 24.00 25.00 ENGOSCOPY 70.00 0 302.542 0 25.00 27.00 ENGOSCOPY 70.00 0 302.542 0 25.00 28.00 BREAST DIAGNOSTIC CENTER 70.07 0 2.5.00 29.00 IMPRISON CENTER 90.01 0 22.906 0 29.00 30.01 IMPRISON CENTER 90.01 0 22.906 0 29.00 30.02 IMPRISON CENTER 90.01 0 20.1899 0 30.00 30.00 IMPRISON CENTER 90.01 0 20.1899 0 30.00 30.00 IMPRISON CENTER 90.01 0 20.1899 0 30.00 30.00 IMPRISON CENTER 90.00 0 10.607.799 11 30.00 PANILLOMS 194.06 0 10.607.799 11 30.00 ADMINISTRATIVE & GENERAL 5.00 0 10.607.799 11 30.00 ADMINISTRATIVE & GENERAL 5.00 0 77.602 0 2.00 30.00 IMPRISON A LINEN SERVICE 80.00 0 77.602 0 2.00 30.00 IMPRISON A LINEN SERVICE 80.00 0 77.602 0 2.00 30.00 IMPRISON A LINEN SERVICE 80.00 0 77.602 0 2.00 30.00 IMPRISON A LINEN SERVICE 80.00 0 125.555 0 3.00 30.00 IMPRISON OF ALIBERT 10.00 0 15.500 0 4.00 30.00 IMPRISON A LINEN SERVICE 80.00 0 6.46,300 0 4.00 30.00 IMPRISON OF ALIBERT 10.00 0 6.46,300 0 4.00 30.00 IMPRISON OF ALIBERT 10.00 0 6.46,300 0 4.00 30.00 IMPRISON OF ALIBERT 10.00 0 6.46,300 0 4.00 30.00 IMPRISON OF ALIBERT 10.00 0 6.46,300 0 4.00 30.00 IMPRISON OF ALIBERT 10.00 0 6.46,300 0 4.00 30.00 IMPRISON OF ALIBERT 10.00 0 6.46,300 0 4.00 30.00 IMPRISON OF ALIBERT 10.00 0 6.46,300 0 4.00 30.00 IMPRISON OF ALIBERT 10.00 0 6.46,300 0 4.00 30.00 IMPRISON OF ALIBERT 10.00 0 6.46,300 0 4.00 30.00 IMPRISON OF ALIBERT 10.00 0 6.46,300 0 4.00 30.00 IMPRISON OF ALIBERT 10.00 0 6.46,300 0 4.00 30.00 IMPRISON OF ALIBERT 10.00 0 6.46,300 0 6.46,300 0 6.46,300 0 6.46,300 0 6.46,300 0 6.46,300 0						_	•	•
25.00 BIODSCOPY 76.00 0 352,548 0 25.00		•		0				•
26.00 MOUND CARE		•		- 1				•
1.00 MAGING CENTER 76.0% 0 422,030 0 27.00 28.00 29.00 1 1 1 1 1 1 1 1 1						_		
28.00 BREAST DI AGNOSTIC CENTER 76.07 0 3,521 0 22.09		•				_		•
29 00 NIUSI ON CENTER 90 01 0 23,996 0 29 00 31 00 31 00 31 00 31 00 31 00 31 00 31 00 31 00 31 00 31 00 32 00 31 00 32 00 3				-				•
31.00 PAVILLIONS 194.06 0 19,226 0 31.00				Ö				
12 00 OTHER NRCC 194 08	30.00	EMERGENCY	91.00	0	201, 898	0		30.00
TOTALS		•		-			•	
E - Interest Expense	32. 00		194.08					32. 00
1,00				0	16, 844, 995			
TOTALS	1 00		5.00	٥	10 607 739	11		1 00
Colther Capit al Rental	1.00							1.00
2.00 ADMINISTRATIVE & GENERAL 5.00 0 779,602 0 2.00 4.00 LAUNDRY & LINEN SERVICE 8.00 0 8.0 0 4.00 6.00 LAUNDRY & LINEN SERVICE 8.00 0 8.0 0 4.00 6.00 DIETARY 10.00 0 3.19 0 6.00 7.00 NUSEKEEPING 7.00 0 1.556 0 7.00 8.00 CENTRAL SERVICES & SUPPLY 14.00 0 2.335,936 0 8.00 9.00 PHARMACY 15.00 0 648,390 0 9.00 10.00 MEDICAL RECORDS & LIBRARY 16.00 0 36 0 11.00 11.00 SOLAL SERVICES 30.00 0 19.031 0 12.00 12.00 ADULTS & PEDIATRICS 30.00 0 19.031 0 12.00 14.00 NEONATAL INTENSIVE CARE UNIT 31.00 0 3.96 0 14.00 16.00 OPERATING ROOM 50.00 0 871,734 0 16.00 18.00 OPERATING ROOM 50.00 0 871,734 0 16.00 18.00 MRI STRATION 15.00 0 15.644 0 19.00 18.00 OPERATING ROOM 50.00 15.644 0 70.00 18.00 OPERATING ROOM 50.00 50.00 50.00 18		F - Other Capital Rental						
3.00 DEERATI ON OF PLANT								
A. OD LAUNDRY & LINEN SERVICE							•	1
5.00 HOUSEKEEPING		•		· · · · · · · · · · · · · · · · · · ·			ł	1
6.00 DIETARY				- 1			•	1
B. 00		•		- 1			•	•
9.00 PHARMACY	7.00	NURSING ADMINISTRATION	13.00	0	1, 550	0		7. 00
10. 00 MEDICAL RECORDS & LIBRARY 16. 00 0 80 0 10. 00 11. 00 12. 00 ADULTS & PEDIATRICS 30. 00 0 19. 031 0 12. 00 13. 00 17. 10. 00 13. 00 17. 10. 00				1			1	•
11.00 SOCIAL SERVICE						_	•	1
12. 00 ADULTS & PEDIATRICS 30. 00 0 19. 031 0 12. 00				- 1		_	•	1
13. 00 INTENSIVE CARE UNIT 31. 00 0 5.952 0 14. 00 14. 00 15. 00 16. 00 0 0 0 0 0 0 0 0 0		•		- 1			•	•
15.00 SUBPROVIDER - IPF		•						
16. 00 OPERATING ROOM	14.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	5, 592	0		14. 00
17. 00 RADI OLOGY-DI AGNOSTI C				1				•
18. 00 MR				-		_		
19.00 RESPIRATORY THERAPY 66.00 0 165,644 0 20.0								•
20.00 PHYSICAL THERAPY 66.00 0 870.422 0 20.00		•		-				
21.00		1	1	-			•	1
23. 00 WOUND CARE 76. 04 0 78, 500 0 23. 00 24. 00 I MAGI NG CENTER 76. 06 0 539, 310 0 24. 00 25. 00 BREAST DI AGNOSTI C CENTER 76. 07 0 416, 520 0 25. 00 26. 00 INFUSI ON CENTER 90. 01 0 58, 891 0 26. 00 27. 00 SPI NE CENTER 90. 26 0 92 0 27. 00 28. 00 EMERGENCY 91. 00 0 27 0 28. 00 29. 00 PAVI LLI ONS 194. 06 0 103, 745 0 29. 00 29. 00 PAVI LLI ONS 194. 06 0 103, 745 0 29. 00 20. 00 OFFI AND ON	21.00			0				
24. 00 IMAGING CENTER	22. 00	1		0			•	22. 00
25. 00 BREAST DI AGNOSTI C CENTER 76. 07 0 416. 520 0 26. 00 27. 00 26. 00 1NFUSI ON CENTER 90. 01 0 58. 891 0 26. 00 27. 00 27. 00 27. 00 27. 00 27. 00 27. 00 27. 00 27. 00 27. 00 28. 00 EMERGENCY 91. 00 0 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 27. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 27. 00 27. 00 28. 00 27. 00 27. 00 28. 00 27. 00 27. 00 27. 00 27. 00 28. 00 27. 0				- 1			•	
26. 00 INFUSION CENTER 90. 01 0 58,891 0 26.00 27.00 28.00 29.00 0 27.00 28.00 29.00 27.00 28.00 29.00 27.00 28.00 29.00 27.00 28.00 29.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00				-			•	
27. 00 SPINE CENTER 90. 26 0 92 0 27 0 28. 00 28. 00 EMERGENCY 91. 00 0 27 0 28. 00 30. 00 PAVI LLI ONS 194. 06 0 103, 745 0 29. 00 TOTALS 0 194. 08 0 106, 709 0 TOTALS 0 0 PERATI VE & GENERAL 5. 00 7, 433, 684 G - STD BENEFIT 1.00 ADMI NI STRATI VE & GENERAL 7. 00 9, 521 0 0 0 1. 00 2. 00 OPERATI ON OF PLANT 7. 00 9, 410 0 0 0 2. 00 3. 00 HOUSEKEEPI NG 9. 00 26, 537 0 0 0 3. 00 4. 00 DI ETARY 10. 00 10, 502 0 0 0 4. 00 5. 00 NURSI NG ADMI NI STRATI ON 13. 00 13, 668 0 0 0 4. 00 6. 00 CENTRAL SERVI CES & SUPPLY 14. 00 4, 825 0 0 0 5. 00 7. 00 PHARMACY 15. 00 23, 263 0 0 0 7. 00 8. 00 MEDI CAL RECORDS & LI BRARY 16. 00 1, 303 0 0 0 8. 00 9. 00 SOCI AL SERVI CE 17. 00 6, 911 0 0 0 10. 00 11. 00 ADULTS & PEDI ATRICS 30. 00 29, 159 0 0 11. 00 11. 00 INTENSIVE CARE UNI T 31. 00 29, 159 0 0 12. 00 12. 00 NEONATAL I INTENSIVE CARE UNI T 35. 00 29, 930 0 0 14. 00 14. 00 OPERATI NG ROOM 50. 00 7, 625 0 0 0 15. 00 16. 00 RECOVERY ROOM 51. 00 7, 625 0 0 0 15. 00 16. 00 RADI OLOGY-DI AGNOSTI C 54. 00 13, 104 0 0 0 16. 00 16. 00 RADI OLOGY-DI AGNOSTI C 54. 00 13, 104 0 0 0 16. 00		•		0		_	•	
28. 00 EMERGENCY 91. 00 0 27 0 28. 00 29. 0				Ö			•	
30.00 OTHER NRCC		•		0				
TOTALS 0 7, 433, 684			· · · · · · · · · · · · · · · · · · ·	0			ł	t to the second
G - STD BENEFIT 1. 00 ADMINISTRATIVE & GENERAL 5. 00 9, 521 0 0 0 2. 00 OPERATION OF PLANT 7. 00 9, 410 0 0 2. 00 3. 00 HOUSEKEEPING 9. 00 26, 537 0 0 3. 00 4. 00 DI ETARY 10. 00 10, 502 0 0 0 4. 00 5. 00 NURSING ADMINISTRATION 13. 00 13, 668 0 0 0 5. 00 6. 00 CENTRAL SERVICES & SUPPLY 14. 00 4, 825 0 0 0 6. 00 7. 00 PHARMACY 15. 00 23, 263 0 0 0 7. 00 8. 00 MEDICAL RECORDS & LI BRARY 16. 00 1, 303 0 0 0 8. 00 9. 00 SOCIAL SERVICE 1 17. 00 6, 911 0 0 0 9. 00 10. 00 ADULTS & PEDIATRICS 30. 00 215, 150 0 0 0 11. 00 INTENSIVE CARE UNIT 31. 00 29, 159 0 0 11. 00 12. 00 NEONATAL INTENSIVE CARE UNIT 35. 00 79, 929 0 0 12. 00 13. 00 RECOVERY ROOM 50. 00 7, 625 0 0 16. 00 16. 00 RADI OLOGY-DI AGNOSTIC 54. 00 13, 104 0 0 16. 00	30. 00		194.08					30.00
1. 00 ADMINISTRATIVE & GENERAL 5. 00 9, 521 0 0 0 1. 00 2. 00 2. 00 OPERATION OF PLANT 7. 00 9, 410 0 0 0 3. 00 4. 00 DIETARY 10. 00 10, 502 0 0 0 0 3. 00 4. 00 DIETARY 10. 00 13. 00 13, 668 0 0 0 5. 00 6. 00 CENTRAL SERVICES & SUPPLY 14. 00 4, 825 0 0 0 0 0 5. 00 0 0 0 0 0 0 0 0 0 0 0				0	7, 433, 684	•		
2.00 OPERATION OF PLANT 7.00 9, 410 0 0 0 3.00 HOUSEKEEPING 9.00 26, 537 0 0 0 0 3.00 4.00 DIETARY 10.00 10.502 0 0 0 4.00 5.00 NURSING ADMINISTRATION 13.00 13, 668 0 0 0 5.00 6.00 CENTRAL SERVICES & SUPPLY 14.00 4, 825 0 0 0 0 5.00 8.00 MEDICAL RECORDS & LIBRARY 16.00 1, 303 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00		5. 00	9, 521	0	0		1, 00
4.00 DI ETARY								
5.00 NURSI NG ADMI NI STRATI ON 13.00 13,668 0 0 5.00 6.00 CENTRAL SERVI CES & SUPPLY 14.00 4,825 0 0 0 6.00 7.00 PHARMACY 15.00 23,263 0 0 0 7.00 8.00 MEDI CAL RECORDS & LI BRARY 16.00 1,303 0 0 0 8.00 9.00 SOCI AL SERVI CE 17.00 6,911 0 0 9.00 10.00 ADULTS & PEDI ATRI CS 30.00 215,150 0 0 10.00 11.00 INTENSI VE CARE UNI T 31.00 29,159 0 0 11.00 12.00 NEONATAL I NTENSI VE CARE UNI T 35.00 79,929 0 0 12.00 13.00 SUBPROVI DER - I PF 40.00 1,751 0 0 13.00 14.00 OPERATI NG ROOM 50.00 29,930 0 0 0 14.00 15.00 RADI OLOGY-DI AGNOSTI C 54.00<		•			0	_	•	l l
6.00 CENTRAL SERVICES & SUPPLY 14.00 4,825 0 0 0 0 7.00 PHARMACY 15.00 23,263 0 0 0 0 0 7.00 8.00 MEDICAL RECORDS & LI BRARY 16.00 1,303 0 0 0 0 9.00 SOCI AL SERVICE 17.00 6,911 0 0 0 9.00 10.00 ADULTS & PEDIATRICS 30.00 215,150 0 10.10 INTENSIVE CARE UNIT 31.00 29,159 0 11.00 INTENSIVE CARE UNIT 35.00 79,929 0 0 11.00 12.00 NEONATAL INTENSIVE CARE UNIT 35.00 79,929 0 0 12.00 SUBPROVIDER - I PF 40.00 1,751 0 0 0 13.00 14.00 OPERATING ROOM 50.00 29,930 0 0 14.00 15.00 RECOVERY ROOM 51.00 7,625 0 0 15.00 16.00 RADIOLOGY-DIAGNOSTIC 54.00 13,104 0 0 0 16.00		•			0	_	•	
7. 00 PHARMACY 15. 00 23, 263 0 0 0 7. 00 8. 00 MEDI CAL RECORDS & LI BRARY 16. 00 1, 303 0 0 0 8. 00 9. 00 SOCI AL SERVI CE 17. 00 6, 911 0 0 9. 00 10. 00 ADULTS & PEDI ATRI CS 30. 00 215, 150 0 0 10. 00 11. 00 I NTENSI VE CARE UNI T 31. 00 29, 159 0 0 11. 00 12. 00 NEONATAL I NTENSI VE CARE UNI T 35. 00 79, 929 0 0 12. 00 13. 00 SUBPROVI DER - I PF 40. 00 1, 751 0 0 13. 00 14. 00 OPERATI NG ROOM 50. 00 29, 930 0 0 14. 00 15. 00 RECOVERY ROOM 51. 00 7, 625 0 0 0 16. 00 RADI OLOGY-DI AGNOSTI C 54. 00 13, 104 0 0 0		•			0	_	•	•
8.00 MEDI CAL RECORDS & LI BRARY 16.00 1, 303 0 0 0 0 9.00 SOCI AL SERVI CE 17.00 6, 911 0 0 0 0 0 10.00 ADULTS & PEDI ATRI CS 30.00 215, 150 0 0 10.00 11.00 INTENSI VE CARE UNI T 31.00 29, 159 0 0 11.00 12.00 NEONATAL I NTENSI VE CARE UNI T 35.00 79, 929 0 0 12.00 13.00 SUBPROVI DER - I PF 40.00 1, 751 0 0 13.00 OPERATI NG ROOM 50.00 29, 930 0 0 14.00 15.00 RECOVERY ROOM 51.00 7, 625 0 0 15.00 16.00 RADI OLOGY-DI AGNOSTI C 54.00 13, 104 0 0 0 16.00					0			
9.00 SOCIAL SERVICE 17.00 6,911 0 0 0 10.00 10.00 11					0	_	•	•
11. 00 INTENSIVE CARE UNIT 31. 00 29, 159 0 0 0 11. 00 12. 00 NEONATAL INTENSIVE CARE UNIT 35. 00 79, 929 0 0 0 12. 00 13. 00 SUBPROVI DER - IPF 40. 00 1, 751 0 0 0 13. 00 14. 00 OPERATING ROOM 50. 00 29, 930 0 0 0 14. 00 15. 00 RECOVERY ROOM 51. 00 7, 625 0 0 0 15. 00 16. 00 RADI OLOGY-DI AGNOSTI C 54. 00 13, 104 0 0 0 16. 00					0		•	
12. 00 NEONATAL INTENSIVE CARE UNIT 35. 00 79, 929 0 0 12. 00 13. 00 SUBPROVI DER - I PF 40. 00 1, 751 0 0 13. 00 14. 00 OPERATI NG ROOM 50. 00 29, 930 0 0 0 14. 00 15. 00 RECOVERY ROOM 51. 00 7, 625 0 0 0 15. 00 16. 00 RADI OLOGY-DI AGNOSTI C 54. 00 13, 104 0 0 0 16. 00					0			
13. 00 SUBPROVI DER - I PF 40. 00 1, 751 0 0 13. 00 14. 00 OPERATI NG ROOM 50. 00 29, 930 0 0 0 14. 00 15. 00 RECOVERY ROOM 51. 00 7, 625 0 0 0 15. 00 16. 00 RADI OLOGY-DI AGNOSTI C 54. 00 13, 104 0 0 0 16. 00					0	_	•	
14. 00 OPERATI NG ROOM 50. 00 29, 930 0 0 14. 00 15. 00 RECOVERY ROOM 51. 00 7, 625 0 0 15. 00 16. 00 RADI OLOGY-DI AGNOSTI C 54. 00 13, 104 0 0 0 16. 00		•			0	_	•	
15. 00 RECOVERY ROOM 51. 00 7, 625 0 0 15. 00 16. 00 RADI OLOGY-DI AGNOSTI C 54. 00 13, 104 0 0 0 16. 00					0	_		
16. 00 RADI OLOGY-DI AGNOSTI C 54. 00 13, 104 0 0 16. 00					0			
				1	-		•	
	17. 00		1		0			l l

Health Financial Systems RECLASSIFICATIONS COMMUNITY HOSPITAL OF INDIANA, INC.

Provider CCN: 15-0169

Peri od: From 01/01/2020 To 12/31/2020 | Worksheet A-6 Date/Time Prepared: 8/2/2021 3:48 pm

						8/2/2021 3:	48 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
18.00	CT SCAN	57.00	5, 960	0	0		18. 00
19.00	INTRAVENOUS THERAPY	64.00	691	0	0		19. 00
20.00	RESPI RATORY THERAPY	65.00	31, 886	0	0		20. 00
21.00	PHYSI CAL THERAPY	66.00	38, 464	0	0		21. 00
22.00	ELECTROENCEPHALOGRAPHY	70.00	2, 407	0	0		22. 00
23.00	ENDOSCOPY	76.00	3, 860	0	0		23. 00
24.00	I MAGING CENTER	76.06	6, 055	0	0		24. 00
25.00	EMERGENCY	91.00	44, 251	0	0		25. 00
	TOTALS		617, 780				1
	H - Labor and Delivery						
1.00	ADULTS & PEDIATRICS	30.00	5, 636, 911	2, 551, 499	0		1.00
2.00		0.00	0	0	0		2. 00
	TOTALS		5, 636, 911	2, 551, 499			
	I - Cafeteria	<u>'</u>			•		
1.00	DI ETARY	10.00	1, 748, 848	1, 843, 340	0		1.00
	TOTALS		1, 748, 848	1, 843, 340			
	J - Therapy	<u>'</u>			•		
1.00	PHYSI CAL THERAPY	66.00	1, 707, 669	775, 562	. 0		1.00
2.00		0.00	0	0			2. 00
	TOTALS — — — —	— — 	1, 707, 669	775, 562		1	
	K - Building Depreciation		.,,,,	,	1	'	
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8, 270, 222	9		1.00
	TOTALS	— — - 		8, 270, 222		1	
	L - Capital Insurance Costs		<u> </u>	0,2,0,222	·I	'	
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	211, 249	12		1.00
1.00	TOTALS	— — 	— — ў	211, 249			1.00
	M - Radi ol ogy Support		<u> </u>	211,217			
1.00	RADI OLOGY-DI AGNOSTI C	54.00	331, 644	122, 499	0		1.00
2. 00	TOTAL DECOME STANDARDS	0.00	001,011	122, 177	0		2. 00
3. 00		0.00	0	0			3.00
3.00	TOTALS — — — —		331, 644	122, 499	 	7	3.00
	N - Specialty Pharmacy	L	331, 044	122, 477		<u> </u>	
1.00	PHARMACY	15.00	1, 621, 909	23, 663, 760	0		1.00
1.00	TOTALS		1, 621, 909	23, 663, 760		1	1.00
500 00	Grand Total: Decreases		11, 664, 761	112, 978, 936		1	500.00
300.00	Jordina Total. Decleases	I I	11, 004, 701	112, 110, 730	1	I	1 300. 00

7.00

8.00

9.00

HIT designated Assets

10.00 Total (line 8 minus line 9)

Reconciling Items

Subtotal (sum of lines 1-7)

7. 00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0169 Peri od: Worksheet A-7 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 8/2/2021 3:48 pm Acqui si ti ons Begi nni ng Di sposal s and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 2, 705, 851 0 1.00 0 4, 358, 832 2.00 Land Improvements 0 2.00 3.00 323, 581, 869 2, 974, 522 2, 974, 522 -216, 170 3.00 Buildings and Fixtures 0 4.00 Building Improvements 3, 219, 527 336, 490 336, 490 -1, 055, 408 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 120, 360, 146 2, 957, 485 2, 957, 485 -91, 017 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 454, 226, 225 6, 268, 497 6, 268, 497 -1, 362, 595 8.00 9.00 Reconciling Items 0 9.00 454, 226, 225 Total (line 8 minus line 9) -1, 362, 595 10.00 6, 268, 497 0 6, 268, 497 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 2, 705, 851 0 1.00 2.00 Land Improvements 4, 358, 832 0 2.00 326, 772, 561 3.00 Buildings and Fixtures 0 3.00 0 4.00 Building Improvements 4, 611, 425 4.00 5.00 Fi xed Equipment 0 5.00 Movable Equipment 6.00 123, 408, 648 0 6.00

461, 857, 317

461, 857, 317

0

0

				'	0 12/31/2020	8/2/2021 3:48	
			Sl	JMMARY OF CAPIT	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10.00	11.00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0	C	0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	C	0	0	2. 00
3.00	Total (sum of lines 1-2)	0	0	C	0	0	3. 00
SUMMARY OF CAPITAL							
	0 1 0 1 0 1 1	011	T (4) (
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
3.00	Total (sum of lines 1-2)	0	0				3. 00

Health Financial Systems COMM	JNITY HOSPITAL	OF INDIANA, II	NC.	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7	
				From 01/01/2020		
				To 12/31/2020		
	COMI	L PUTATION OF RA	TLOS	ALLOCATION OF	8/2/2021 3: 48 OTHER CAPITAL	pm
	COMI	PUTATION OF RA	1103	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 - col			
			2)			
	1.00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00 CAP REL COSTS-BLDG & FLXT	338, 448, 668	C	338, 448, 66	8 0. 732799	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	123, 408, 648	0	123, 408, 64	8 0. 267201	0	2.00
3.00 Total (sum of lines 1-2)	461, 857, 316		461, 857, 31	6 1. 000000	0	3.00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CA						
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
·		Capi tal -Relate		'		
		d Costs	through 7)			
	6. 00	7.00	8.00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS			•		
1.00 CAP REL COSTS-BLDG & FLXT	0	C		0 8, 270, 222	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0		,	0 14, 043, 018	7, 433, 684	2.00
3.00 Total (sum of lines 1-2)	0	l o	,	0 22, 313, 240	7, 433, 684	3.00
		SI	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
		,	Í	d Costs (see	through 14)	
				instructions)	Ů ,	

11.00

5, 186, 405

5, 186, 405

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

CAP REL COSTS-BLDG & FLXT

CAP REL COSTS-MVBLE EQUIP

Total (sum of lines 1-2)

12.00

211, 249

211, 249

13.00

0 0 0

instructions)

14.00

0

15.00

13, 667, 876 21, 476, 702 35, 144, 578 1.00

2.00

3. 00

1.00

2.00

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Provi der CCN: 15-0169

				Ť	Date/Time Prep 8/2/2021 3:48		
				Expense Classification on		0,2,2021 3. 10	piii
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL			CAP REL COSTS-BLDG & FIXT	1.00	0	1. 00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	o	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
	(chapter 2)						
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)	В	-4, 009	ADMINISTRATIVE & GENERAL	5. 00	0	5. 00
6.00	Rental of provider space by		0		0.00	0	6. 00
7.00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7. 00
	stations excluded) (chapter 21)						
8.00	Television and radio service		0		0.00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-756, 687			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	5, 452, 977			0	12.00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13. 00
14.00	Cafeteria-employees and guests		-1, 851, 209	CAFETERI A	11. 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 supplies to other than		0		0.00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
18. 00	patients Sale of medical records and		0		0. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0.00	0	19. 00
	education (tuition, fees, books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0	20. 00 21. 00
21.00	interest, finance or penalty		0		0.00	o o	21.00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25.00	limitation (chapter 14)		0	LITLL TATLON DEVLEW ONE	114 00		25 00
25. 00	Utilization review - physicians' compensation		0	UTILIZATION REVIEW-SNF	114. 00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	
	COSTS-MVBLE EQUIP						
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	NONPHYSICIAN ANESTHETISTS	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	1	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
00.05	limitation (chapter 14)		_			_	00.00
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32. 00
		•			•	·	

69.00

36.02

50.00

ADJUSTMENTS TO EXPENSES Provider CCN: 15-0169 Peri od: Worksheet A-8 From 01/01/2020 12/31/2020 Date/Time Prepared: 8/2/2021 3:48 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Cost Center Line # Wkst. A-7 Ref. Amount 2.00 3.00 4.00 5.00 33.00 OTHER ADJUSTMENTS (SPECIFY) 0.00 33. 00 (3) 33.01 Misc Revenue В -95, 512 EMPLOYEE BENEFITS DEPARTMENT 4.00 33.01 33. 02 Misc Revenue В -10, 277 ADMI NI STRATI VE & GENERAL 5.00 33.02 33. 03 Mi sc Revenue В -28, 250 OPERATION OF PLANT 7.00 33. 03 0 Misc Revenue -8. 565DI ETARY 10.00 33.04 33.04 B 33. 05 Misc Revenue В -99, 115 PHARMACY 15.00 0 33.05 Misc Revenue -2, 125 NEONATAL INTENSIVE CARE UNIT 35.00 33.06 33.06 В Mi sc Revenue -142, 500 OPERATING ROOM 50.00 33.07 0 33.07 В 33.08 Mi sc Revenue В -79, 524 RADI OLOGY-DI AGNOSTI C 54.00 33 08 33. 09 Misc Revenue В -31 LABORATORY 60.00 33.09 33. 10 Mi sc Revenue В -2, 260 PHYSI CAL THERAPY 66.00 33.10 Space Rental Income -19,800 OPERATION OF PLANT 7.00 0 33. 11 В 33.11 -13, 110, 559 ADMI NI STRATI VE & GENERAL 33.12 Investment Income В 5.00 33.12 HAF Tax Offset -29, 005, 196 ADMI NI STRATI VE & GENERAL 34.00 34.00 Α 5.00 -3, 337, 106 CAP REL COSTS-BLDG & FIXT 34. 01 OO NON-ALLOW INTEREST EXPENSE Α 1.00 11 34.01 -89, 088 CAP REL COSTS-BLDG & FIXT 34.02 LOC Non-Allow Interest Expense Α 1.00 11 34.02 -689, 010 CAP REL COSTS-BLDG & FIXT 34.03 12A NON-ALLOW INTEREST EXPENSE Α 1.00 11 34.03 34.04 12B Non-Allow Interest Expense Α -99,004 CAP REL COSTS-BLDG & FIXT 1.00 11 34.04 -19, 182 CAP REL COSTS-BLDG & FIXT 34.05 50M BMO NON-ALLOW INTEREST 11 34.05 Α 1.00 EXPENSE 16AB NON-ALLOW INTEREST -365, 050 CAP REL COSTS-BLDG & FIXT 11 34.06 Α 1.00 34.06 **EXPENSE** 20A NON-ALLOW INTEREST EXPENSE -822, 894 CAP REL COSTS-BLDG & FIXT 34.07 Α 1.00 11 34.07 34.08 DEBT ISSUANCE EXPENSE 27, 791 ADMI NI STRATI VE & GENERAL 34.08 5.00 0 Α -8, 861 ADMI NI STRATI VE & GENERAL 34.09 LOSS ON ASSETS Α 5.00 0 34.09 34. 10 LOSS ON ASSETS -37, 520 RADI OLOGY-THERAPEUTI C 55.00 0 34. 10 Α 34. 11 LOSS ON ASSETS Α -46, 497 ADULTS & PEDIATRICS 30.00 34. 11 -21, 456, 789 ADMI NI STRATI VE & GENERAL 5.00 35.00 Bad Debt 0 35.00 Α -226, 414 NEONATAL INTENSIVE CARE UNIT 35.01 ΔPP Α 35.00 35 01 35.02 SPONSORSHI P -1, 000 ADMI NI STRATI VE & GENERAL 5.00 35.02 35. 03 SPONSORSHI P Α -300 PHYSI CAL THERAPY 66.00 35.03 -59, 744 CAFETERI A Meals of Wheels Cost 36.00 11.00 Α 0 36,00 225, 145 CARDI AC CATHETERI ZATI ON CARDIAC CATH SHARED SERVICES 36.01 Α 59.00 36.01

54, 296 ELECTROCARDI OLOGY

-66 713 869

TOTAL (sum of lines 1 thru 49)

CARDIAC MONITORING SHARED

(Transfer to Worksheet A,

36.02

50 00

SERVI CES

[|] column 6, line 200.) | (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

⁽¹⁾ bescription - an enapter references in(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME

Provider CCN: 15-0169

Worksheet A-8-1

Peri od: From 01/01/2020 OFFICE COSTS 12/31/2020 Date/Time Prepared: 8/2/2021 3:48 pm

					0/2/2021 3.40	рш
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:		<u>, </u>			
1. 00	l control of the cont	I&R SERVICES-SALARY & FRINGE		589, 754		1. 00
2.00	l control of the cont	I&R SERVICES-OTHER PRGM COST		874, 613		2. 00
3.00	1	ADMINISTRATIVE & GENERAL	7250 CLEARVI STA	283, 410	225, 961	3. 00
3. 01	70. 00	ELECTROENCEPHALOGRAPHY	7250 CLEARVI STA	155, 812	104, 256	3. 01
3.02	73. 01	SPECIALTY PHARMACY	7250 CLEARVI STA	63, 737	42, 520	3. 02
4.00	2. 00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	5, 468, 245	0	4.00
4. 01	4. 00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	3, 303, 655	0	4. 01
4.02	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE	48, 854, 685	66, 722, 287	4. 02
4.03	7. 00	OPERATION OF PLANT	HOME OFFICE	926, 111	0	4.03
4.04	13. 00	NURSING ADMINISTRATION	HOME OFFICE	3, 829, 188	0	4.04
4.05	14.00	CENTRAL SERVICES & SUPPLY	HOME OFFICE	3, 520, 764	0	4.05
4.06	16. 00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	2, 440, 156	0	4.06
4.07	30.00	ADULTS & PEDIATRICS	HOME OFFICE	207, 376	0	4.07
4.08	54.00	RADI OLOGY-DI AGNOSTI C	HOME OFFICE	121, 920	0	4. 08
4.09	73. 00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	370, 810	0	4.09
4. 10	5. 00	ADMINISTRATIVE & GENERAL	CPN MEDICAL DIRECTOR	463, 914	o	4. 10
4. 11	91.00	EMERGENCY	CPN CALL	1, 073, 851	o	4. 11
5.00	TOTALS (sum of lines 1-4).			72, 548, 001	67, 095, 024	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

nas no	has not been posted to worksheet A, cordinas i and/or 2, the amount arrowable should be indicated in cordina part.								
				Related Organization(s) and/	or Home Office				
	Symbol (1)	Name	Percentage of	Name	Percentage of				
	Symbol (1)	Ivalie		Name					
			Ownershi p		Ownershi p				
	1. 00	2.00	3.00	4. 00	5. 00				
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

6.00	В	CHNW	100.00	0. 00	6. 00
7.00			0.00	0. 00	7. 00
8.00			0.00	0. 00	8. 00
9.00			0.00	0. 00	9. 00
10.00			0.00	0. 00	10. 00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

					To 12/31/2020	Date/Time Prep 8/2/2021 3:48	pared:
	Net	Wkst. A-7 Ref.				, 0, 2, 2021 0. 10	p
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
			ENTS REQUIRED AS A RESULT (OF TRANSACTIONS WITH RELATED (ORGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO						
1.00	589, 754						1. 00
2.00	874, 613						2. 00
3.00	57, 449						3. 00
3. 01	51, 556						3. 01
3. 02	21, 217						3. 02
4.00	5, 468, 245						4. 00
4. 01	3, 303, 655						4. 01
4. 02	-17, 867, 602						4. 02
4. 03	926, 111						4. 03
4.04	3, 829, 188						4. 04
4. 05	3, 520, 764						4. 05
4. 06	2, 440, 156						4. 06
4. 07	207, 376						4. 07
4. 08	121, 920						4. 08
4. 09	370, 810						4. 09
4. 10	463, 914						4. 10
4. 11	1, 073, 851						4. 11
5. 00	5, 452, 977						5. 00

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

Related Organization(s)						
and/or Home Office						
		4				
Type of Business						
		4				
6. 00						
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

i Ci ilibui	Chilibar Schieft under thire AVIII.								
6.00		6.00	<u> </u>						
7. 00 8. 00		7.00							
8. 00		8.00							
9.00		9.00)						
10. 00		10.00)						
10. 00 100. 00		100.00)						

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT In Lieu of Form CMS-2552-10 Provider CCN: 15-0169

						0 12/31/2020	8/2/2021 3:48	
	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	5. 00	ADMINISTRATIVE & GENERAL	706, 160	213, 507	492, 653	211, 500	1, 080	1. 00
2.00	35.00	NEONATAL INTENSIVE CARE UNIT	120, 000	120, 000	0	0	0	2. 00
3.00	40.00	SUBPROVIDER - IPF	40, 344	40, 344	0	0	0	3. 00
4.00	0.00		0	0	0	0	0	4.00
5. 00	0. 00		l o	0	0	0	0	5. 00
6. 00	0.00		0	0	0	0	0	6, 00
7. 00	0. 00		0	0	0	0	0	7. 00
8. 00	0.00		0	0	0	0	0	8. 00
9. 00	0.00		0	0	0	0	0	9. 00
10. 00	0.00	4	0	0	0	0	0	10.00
200.00			866, 504	373, 851	492, 653		1, 080	1
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er		Unadjusted RCE	Memberships &		of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
					Educati on	12		
	1. 00	2.00	8. 00	9. 00	12. 00	13.00	14. 00	
1.00	5. 00	ADMINISTRATIVE & GENERAL	109, 817	5, 491	0	0	0	1. 00
2.00		NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	2. 00
3.00	40. 00	SUBPROVIDER - IPF	0	0	0	0	0	3. 00
4.00	0. 00		0	0	0	0	0	4. 00
5.00	0. 00		0	0	0	0	0	5. 00
6.00	0. 00		0	0	0	0	0	6. 00
7.00	0. 00		0	0	0	0	0	7. 00
8.00	0. 00		0	0	0	0	0	8. 00
9.00	0. 00		0	0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	10. 00
200.00			109, 817		0	0	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
1.00	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		4 00
1.00		ADMINISTRATIVE & GENERAL	0			596, 343		1.00
2.00		NEONATAL INTENSIVE CARE UNIT	0	· ·	0	120, 000		2.00
3. 00		SUBPROVIDER - IPF	0	0	0	40, 344		3. 00
4. 00	0. 00		0	0	0	0		4. 00
5.00	0. 00		0	0	0	0		5. 00
6. 00	0. 00		0	0	0	0		6. 00
7. 00	0. 00		0	0	0	0		7. 00
8. 00	0. 00		0	0	0	0		8. 00
9. 00	0. 00		0	0	0	0		9. 00
10. 00	0. 00		0	0	0	0		10. 00
200. 00			0	109, 817	382, 836	756, 687		200. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

				10	12/31/2020	Date/lime Pre 8/2/2021 3:48	
			CAPI TAL REI	ATED COSTS		07 27 2021 0. 10	ļ i
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		col. 7)					
		0	1. 00	2. 00	4. 00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	13, 667, 876					1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	21, 476, 702 3, 488, 875		21, 476, 702 87, 345	3, 582, 221		2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	54, 287, 681	396, 429		369, 224	63, 990, 870	5. 00
7.00	00700 OPERATION OF PLANT	10, 704, 383			93, 722	12, 797, 600	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	983, 877	50, 608		0	1, 034, 564	8. 00
9.00	00900 HOUSEKEEPI NG	4, 756, 443			91, 897	4, 998, 105	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	1, 573, 314 1, 681, 235	135, 862 308, 549		24, 045 55, 358	1, 753, 602 2, 106, 840	10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	6, 430, 114	9, 142		66, 169	6, 530, 083	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	4, 566, 404	319, 356		25, 744	7, 290, 490	ł
15. 00	01500 PHARMACY	5, 875, 087	158, 178		162, 166	6, 898, 968	1
16.00	01600 MEDICAL RECORDS & LIBRARY	2, 938, 160			12, 692	2, 956, 580	1
17. 00 19. 00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	2, 214, 349	37, 411 0	36 0	55, 148 0	2, 306, 944 0	17. 00 19. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	589, 754	_	-	0	589, 754	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	874, 613	0		0	874, 613	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	47, 271, 506			897, 038		30.00
31. 00 35. 00	03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	6, 389, 507 10, 178, 977			151, 266 238, 428		1
40. 00	04000 SUBPROVI DER - I PF	2, 233, 663			57, 296		1
43. 00	04300 NURSERY	2, 358, 032	334, 873		51, 383	2, 791, 100	1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	14, 062, 165			138, 972		1
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	3, 351, 065 5, 911, 013			74, 367 129, 530	3, 776, 284 6, 984, 259	51. 00 52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 938, 833			94, 209	4, 608, 079	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	995, 279			20, 084	1, 695, 896	55. 00
57.00	05700 CT SCAN	1, 631, 938	31, 832	224, 535	34, 822	1, 923, 127	57. 00
58. 00	05800 MRI	1, 647, 500			17, 416		58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	228, 232 11, 322, 339	0 125, 220	,	0	229, 738 11, 447, 559	59. 00 60. 00
64. 00	06400 I NTRAVENOUS THERAPY	904, 016			21, 014	1, 104, 144	64. 00
65. 00	06500 RESPI RATORY THERAPY	4, 271, 011	135, 440		93, 801	4, 718, 480	65. 00
66.00	06600 PHYSI CAL THERAPY	5, 287, 725	21, 800	1, 059, 193	133, 028	6, 501, 746	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	2, 041, 545	0	,	44, 440		67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	441, 686		14, 886 0	9, 615		68. 00 69. 00
70.00	07000 ELECTROCARDI OLOGY	538, 120 1, 364, 004	74, 448		1, 031 25, 618	539, 151 1, 704, 895	•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	14, 384, 461	0		0	14, 384, 461	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	11, 681, 234		0	0	11, 681, 234	
73.00	07300 DRUGS CHARGED TO PATIENTS	14, 920, 369	0	0	0	14, 920, 369	1
73. 01 74. 00	07301 SPECI ALTY PHARMACY 07400 RENAL DI ALYSI S	40, 694, 707 1, 159, 345	0 2, 438	0	51, 340	40, 746, 047 1, 161, 783	73. 01 74. 00
76. 00	03330 ENDOSCOPY	2, 026, 477	174, 703		37, 065	2, 577, 181	76.00
76. 01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 01
76. 02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 02
76. 03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 03
76. 04 76. 06	03953 WOUND CARE 03954 I MAGI NG CENTER	618, 839 2, 836, 556		104, 761 880, 815	8, 709 49, 818	732, 309 3, 767, 189	76. 04 76. 06
76. 07	03955 BREAST DI AGNOSTI C CENTER	8, 644, 194	0		49, 818	9, 058, 541	76.00
70.07	OUTPATIENT SERVICE COST CENTERS	0,044,174		414, 547	<u> </u>	7, 030, 341	70.07
90.00	09000 CLI NI C	0	0	0	0	0	90. 00
90. 01	04950 I NFUSI ON CENTER	154, 198	0	81, 763	3, 406	239, 367	90. 01
90. 26	04975 SPI NE CENTER 09100 EMERGENCY	217, 961	0	91	5, 243		
91. 00 92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	9, 861, 681	595, 604	167, 677	194, 976	10, 819, 938 0	1
,2.00	SPECIAL PURPOSE COST CENTERS					0	, , , , , , , , , , , , , , , , , , , ,
	11300 INTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW-SNF						114. 00
118.00	9 /	369, 677, 045	13, 560, 893	21, 241, 950	3, 540, 080	369, 293, 169	j118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		82, 370	0	O	82, 370	190 00
	19100 RESEARCH		02, 370		0		191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	102, 989		0	0	102, 989	192. 00
	19300 NONPALD WORKERS	0	0	0	0		193. 00
194.00	0/07950 HOME OFFICE	0	0	0	0	0	194. 00

Health Financial Systems CC	MMUNITY HOSPITAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Peri od:	Worksheet B	
				From 01/01/2020 To 12/31/2020	Part I Date/Time Pre	pared:
					8/2/2021 3:48	
		CAPI TAL REI	_ATED COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	for Cost			BENEFITS		
	Allocation			DEPARTMENT		
	(from Wkst A					
	col. 7)	1, 00	2.00	4. 00	4A	
194, 06 07956 PAVI LLI ONS						104.06
	39, 336		120, 34		159, 685	1
194. 08 07958 0THER NRCC	1, 765, 938	24, 613	114, 40	3 42, 141	1, 947, 095	194. 08
194. 10 07960 COMMUNITY REHAB HOSPITAL	0	0		0 0	0	194. 10
200.00 Cross Foot Adjustments					0	200. 00
201.00 Negative Cost Centers		0		0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	371, 585, 308	13, 667, 876	21, 476, 70	2 3, 582, 221	371, 585, 308	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2020 | Part I | To 12/31/2020 | Date/Time Prepared: | 8/2/2021 3: 48 pm

					0 12/31/2020	8/2/2021 3:48	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE	2.22	10.00	
	GENERAL SERVICE COST CENTERS	5. 00	7. 00	8. 00	9. 00	10. 00	
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	63, 990, 870					5. 00
7.00	00700 OPERATION OF PLANT	2, 662, 362	15, 459, 962				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	215, 227	67, 879				8. 00
9.00	00900 HOUSEKEEPI NG	1, 039, 786	169, 053		6, 206, 944	0 074 044	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	364, 812 438, 299	182, 227 413, 846		74, 300 168, 739	2, 374, 941 0	
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 358, 492	12, 262		4, 999	0	
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 516, 684	428, 339		174, 648	0	1
15. 00	01500 PHARMACY	1, 435, 234	212, 158		86, 504	0	1
16.00	01600 MEDICAL RECORDS & LIBRARY	615, 075	7, 577	0	3, 089	0	16. 00
17. 00	01700 SOCIAL SERVICE	479, 927	50, 178	0	20, 459	0	
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	122, 690	0	0	0	0	
22. 00	02200 1 & R SERVI CES-OTHER PRGM COSTS APPRV NPATI ENT ROUTI NE SERVI CE COST CENTERS	181, 951		0	U	0	22. 00
30. 00	03000 ADULTS & PEDIATRICS	11, 113, 923	5, 871, 494	657, 828	2, 394, 008	1, 985, 913	30.00
31. 00	03100 NTENSI VE CARE UNI T	1, 576, 054	1, 150, 958			241, 035	1
35.00	02060 NEONATAL INTENSIVE CARE UNIT	2, 372, 412	1, 096, 158			0	
40.00	04000 SUBPROVI DER - I PF	510, 536	201, 594			147, 993	40.00
43.00	04300 NURSERY	580, 649	449, 153	33, 818	183, 135	0	43. 00
	ANCILLARY SERVICE COST CENTERS	0.50(.04	050 (00	1 (0.054	250 000		
50.00	05000 OPERATING ROOM	3, 596, 634	858, 628		350, 092	0	
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	785, 603 1, 452, 977	460, 911 1, 110, 526		187, 929 452, 799	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	958, 646	293, 179			0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	352, 807	327, 857	·	133, 678	0	1
57. 00	05700 CT SCAN	400, 080			17, 408	0	
58. 00	05800 MRI	429, 042	158, 175		64, 493	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	47, 794	0	0	0	0	
60.00	06000 LABORATORY	2, 381, 504	167, 953		68, 480	0	
64.00	06400 I NTRAVENOUS THERAPY	229, 702	236, 461	0	96, 413	0	
65. 00	06500 RESPIRATORY THERAPY	981, 614	181, 661	0	74, 069	0	
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 352, 597 448, 274	29, 239	0	11, 922	0	
68. 00	06800 SPEECH PATHOLOGY	96, 984	0	0	0	0	
69. 00	06900 ELECTROCARDI OLOGY	112, 163	Ö	Ö	o	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	354, 680	99, 854	0	40, 714	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 992, 486	0	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 430, 117	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 103, 974	0	0	0	0	
73. 01	07301 SPECIALTY PHARMACY	8, 476, 645	0	0	1 222	0	
74. 00 76. 00	07400 RENAL DI ALYSI S 03330 ENDOSCOPY	241, 693 536, 146	3, 270 234, 323		1, 333 95, 541	0	
	03950 OTHER ANCILLARY SERVICE COST CENTERS	0 330, 140		25, 803	93, 341	0	
76. 02	03951 OTHER ANCILLARY SERVICE COST CENTERS	l o	Ö	Ö	o	0	
76. 03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	
76. 04	03953 WOUND CARE	152, 347	0	0	0	0	76. 04
76. 06	03954 I MAGI NG CENTER	783, 711	0	0	0	0	
76. 07	03955 BREAST DI AGNOSTI C CENTER	1, 884, 503	0	0	0	0	76. 07
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	O	0	0	O	0	90.00
90.00	04950 I NFUSI ON CENTER	49, 797	0	0	0	0	
90. 26	04975 SPINE CENTER	46, 453	0	0	0	0	
91. 00	09100 EMERGENCY	2, 250, 937	798, 861	233, 999	325, 723	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
	11400 UTI LI ZATI ON REVI EW-SNF	(0.544.000	45.047.470	4 047 470			114. 00
118.00		63, 514, 023	15, 316, 470	1, 317, 670	6, 148, 437	2, 374, 941	1118.00
100.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	17, 136	110, 480		45, 047		190. 00
	19100 RESEARCH	17, 130	110, 480	0	45, 047		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	21, 425	0	0	0		192. 00
	19300 NONPALD WORKERS	0	Ö	Ō	Ö		193. 00
	07950 HOME OFFICE		0	0	o		194. 00
194.06	07956 PAVI LLI ONS	33, 220	0	0	О		194. 06
	07958 OTHER NRCC	405, 066	33, 012	0	13, 460		194. 08
	07960 COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194. 10
200.00			,				200.00
201.00	Negative Cost Centers	0	1 0	0	l 이	0	201. 00

Health Financial Systems	COMMUNITY HOSPITAL OF	I NDI ANA,	INC.	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 15-0169	Peri od: From 01/01/2020 To 12/31/2020	Worksheet B Part I Date/Time Prepared: 8/2/2021 3:48 pm

				!	0 12/01/2020	Date, IIIIc IIIc	pai ca.
						8/2/2021 3:48	pm
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
202.00	TOTAL (sum lines 118 through 201)	63, 990, 870	15, 459, 962	1, 317, 670	6, 206, 944	2, 374, 941	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2020 | Part I | To 12/31/2020 | Date/Time Prepared: | 8/2/2021 3: 48 pm

					8/2/2021 3:48	pm
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDICAL RECORDS &	
	11 00	12.00	SUPPLY	15.00	LI BRARY	
GENERAL SERVICE COST CENTERS	11. 00	13.00	14. 00	15. 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 & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	3, 127, 724					11. 00
13.00 O1300 NURSING ADMINISTRATION	76, 419					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	46, 397	' 이	9, 456, 558			14.00
15. 00 01500 PHARMACY	158, 297	1	279, 021	9, 070, 182		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	13, 646	1	0	0	3, 595, 967	16. 00
17. 00 01700 SOCIAL SERVICE	57, 314	1	55	0	0	17. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	C	1	0	0	0	19. 00
21. 00 02100 I &R SERVI CES-SALARY & FRINGES APPRV	C		0	0	0	21. 00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	C) 0	0	0	0	22. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 050 040	2 000 (40	E44 00/		450.041	20.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 NTENSI VE CARE UNI T	1, 058, 948		544, 906	0	452, 341 69, 900	30. 00 31. 00
31.00 03100 INTENSIVE CARE UNIT 35.00 02060 NEONATAL INTENSIVE CARE UNIT	182, 860 251, 091		105, 919 149, 924	0	266, 551	35.00
40. 00 04000 SUBPROVI DER - PF	68, 231		15, 149	0	22, 418	40. 00
43. 00 04300 NURSERY	60, 044		29, 500	0	23, 618	43. 00
ANCI LLARY SERVI CE COST CENTERS	00, 044	221, 171	27, 300	0	23,010	43.00
50. 00 05000 OPERATING ROOM	161, 026	593, 140	1, 291, 614	0	456, 292	50. 00
51. 00 05100 RECOVERY ROOM	81, 878		65, 767	0	79, 064	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	147, 380	1	72, 940	0	58, 397	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	98, 253		27, 061	0	88, 756	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	19, 105	1	35, 989	0	89, 285	55. 00
57. 00 05700 CT SCAN	38, 210		33, 605	0	171, 952	57. 00
58. 00 05800 MRI	16, 376	1	1, 812	0	74, 698	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	C	1	631	0	10, 329	59. 00
60. 00 06000 LABORATORY	C	ol	306, 950	0	288, 348	60.00
64. 00 06400 I NTRAVENOUS THERAPY	21, 834	l o	12, 024	0	7, 467	64. 00
65. 00 06500 RESPI RATORY THERAPY	103, 712	<u> </u> 0	98, 848	0	73, 161	65.00
66. 00 06600 PHYSI CAL THERAPY	35, 480	0	20, 713	0	45, 274	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	43, 668	0	5, 082	0	16, 184	67. 00
68.00 06800 SPEECH PATHOLOGY	8, 188		1, 099	0	4, 883	68. 00
69. 00 06900 ELECTROCARDI OLOGY	2, 729	1	97	0	23, 354	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	30, 022	1	26, 972	0	22, 163	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	1 -1	2, 939, 074	0	132, 667	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	C	1	2, 386, 745	0	96, 010	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	1 -1	0	9, 070, 182	260, 050	73. 00
73. 01 07301 SPECIALTY PHARMACY	49, 127	1	698, 519	0	139, 299	73. 01
74. 00 07400 RENAL DI ALYSI S	42.776		181	0	10, 964	74. 00
76. 00 03330 ENDOSCOPY	43, 668	9	62, 166	0	58, 869	76. 00
76. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS 76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS			0	0	0	76. 01
76. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS			0	0	0	76. 02 76. 03
76. 04 03953 WOUND CARE	10, 917		14, 994	0	5, 728	76. 03 76. 04
76. 06 03954 I MAGI NG CENTER	10, 717	1	32, 553	0	116, 696	76. 04
76. 07 03955 BREAST DIAGNOSTIC CENTER		1	1, 174	0	59, 442	76. 07
OUTPATIENT SERVICE COST CENTERS		,ı	1, 1, 1		07, 112	70.07
90. 00 09000 CLINIC	C	ol	0	0	0	90. 00
90. 01 04950 INFUSION CENTER	5, 459		1, 693	0	1, 064	90. 01
90. 26 04975 SPI NE CENTER	,	ol ol	750	0	939	90. 26
91. 00 09100 EMERGENCY	237, 445	874, 630	185, 576	0	369, 804	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		,				92.00
SPECIAL PURPOSE COST CENTERS		<u>'</u>				
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 127, 724	7, 982, 255	9, 449, 103	9, 070, 182	3, 595, 967	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	0	0	0	190. 00
191. 00 19100 RESEARCH	C	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	C	이	5, 564	0		192. 00
193. 00 19300 NONPALD WORKERS	C	이	0	0		193. 00
194. 00 07950 HOME OFFICE	C	이	0	0		194. 00
194. 06 07956 PAVI LLI ONS	C	이	578	0		194. 06
194. 08 07958 OTHER NRCC	C	9	1, 313	0		194. 08
194. 10 07960 COMMUNITY REHAB HOSPITAL		y O	0	0		194. 10
200.00 Cross Foot Adjustments						200. 00

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169 From 01/01/2020 From 01/01/2020 To 12/31/2020 Date/Time Prepared:

						8/2/2021 3:48	pm
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	·		ADMI NI STRATI ON	SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
		11. 00	13. 00	14.00	15.00	16.00	
201.00	Negative Cost Centers	0	0	C	0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	3, 127, 724	7, 982, 255	9, 456, 558	9, 070, 182	3, 595, 967	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

Peri od: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Ti me Prepared:

8/2/2021 3:48 pm INTERNS & RESIDENTS SOCIAL SERVICE NONPHYSI CI AN SERVI CES-SALAR SERVI CES-OTHER Subtotal Cost Center Description ANESTHETI STS Y & FRINGES PRGM COSTS **APPRV APPRV** 19.00 17.00 21.00 22.00 24.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 16 00 17.00 01700 SOCIAL SERVICE 2, 914, 877 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21 00 0 712 444 21 00 22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV 1, 056, 564 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 846, 776 318, 545 84, 040, 079 30.00 472, 407 03100 INTENSIVE CARE UNIT 12, 338, 200 31 00 224, 148 C C 31 00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 457, 382 0 0 0 17, 416, 725 35.00 04000 SUBPROVIDER - IPF 309, 123 40.00 137, 624 0 458, 434 4, 668, 354 40.00 43.00 04300 NURSERY 248, 947 0 4, 621, 135 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 21, 380 31, 706 24, 711, 879 50.00 0 05100 RECOVERY ROOM 0 51.00 0 C 5, 437, 436 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 10, 905, 760 52.00 0 0 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 6, 274, 587 54 00 55.00 05500 RADI OLOGY-THERAPEUTI C 00000000000 0 0 0 2, 667, 476 55.00 05700 CT SCAN 0 57 00 0 2, 627, 078 57 00 0 58.00 05800 MRI 0 0 2, 806, 943 58.00 05900 CARDI AC CATHETERI ZATI ON 0 0 59 00 Ω 288, 492 59 00 06000 LABORATORY 0 14, 660, 794 60.00 60.00 o 64.00 06400 I NTRAVENOUS THERAPY 0 1, 708, 045 64.00 06500 RESPIRATORY THERAPY 65.00 0 6, 231, 545 0 0 65, 00 66.00 06600 PHYSI CAL THERAPY 0 12, 453 18, 468 8, 027, 892 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 0 2, 668, 000 67.00 06800 SPEECH PATHOLOGY 0 577, 341 68.00 0 68.00 06900 FLECTROCARDI OLOGY 0 0 0 677, 494 69.00 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 00000000 0 0 2, 279, 300 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 20, 448, 688 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 16, 594, 106 72.00 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 27, 354, 575 73.00 73.01 07301 SPECIALTY PHARMACY 50, 109, 637 73.01 0 0 0 07400 RENAL DIALYSIS 0 1, 419, 224 74.00 74.00 03330 ENDOSCOPY 0 76.00 C 3, 633, 757 76.00 76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 76.01 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 76.02 0 0 0 0 76.02 03952 OTHER ANCILLARY SERVICE COST CENTERS 76.03 0 0 76.03 76.04 03953 WOUND CARE 0 0 916, 295 76.04 76.06 03954 I MAGING CENTER 0 C 0 0 4, 700, 149 76.06 03955 BREAST DIAGNOSTIC CENTER 76.07 0 11, 003, 660 76.07 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 90.00 0 04950 INFUSION CENTER 0 0 297, 380 90.01 0 90.01 04975 SPINE CENTER 0 0 271, 437 90.26 90.26 C Ol 91 00 09100 EMERGENCY 50, 943 75, 549 16, 223, 405 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114. 00 11400 UTILIZATION REVIEW-SNF 114 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 914, 877 0 712, 444 1, 056, 564 368, 606, 868 118. 00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 C 255, 033 190. 00 0 191. 00 19100 RESEARCH 0 0 0 0 0 191, 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 129, 978 192. 00 0 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 0 194.00|07950|HOME_OFFICE 0 194, 00 0 0 194. 06 07956 PAVI LLI ONS 0 0 0 193, 483 194. 06 194. 08 07958 OTHER NRCC 0 2, 399, 946 194. 08

Health Financial Systems	COMMUNITY HOSPITAL OF INDIA	NA, INC.	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi	der CCN: 15-0169	Peri od: From 01/01/2020	Worksheet B Part I

				Т	0 12/31/2020	Date/Time Pre 8/2/2021 3:48	
				INTERNS &	RESI DENTS		
	Cost Center Description	SOCIAL SERVICE	NONPHYSI CI AN	SERVI CES-SALAR	SERVI CES-OTHER	Subtotal	
			ANESTHETI STS	Y & FRINGES	PRGM COSTS		
				APPRV	APPRV		
		17. 00	19. 00	21.00	22. 00	24.00	
194. 10 07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194. 10
200.00	Cross Foot Adjustments		0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2, 914, 877	0	712, 444	1, 056, 564	371, 585, 308	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0169

					e/lime Prepared: /2021 3:48 pm
	Cost Center Description	Intern &	Total	1 , 3, 2	7 2021 01 10 011
		Residents Cost			
		& Post			
		Stepdown Adjustments			
		25. 00	26. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT				5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE				8.00
9. 00	00900 HOUSEKEEPI NG				9. 00
10.00	01000 DI ETARY				10. 00
11. 00	01100 CAFETERI A				11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON				13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY				14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY				16.00
17. 00	01700 SOCI AL SERVI CE				17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS				19. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV				21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV				22. 00
30. 00	O3000 ADULTS & PEDIATRICS	-790, 952	83, 249, 127		30.00
31. 00	03100 NTENSI VE CARE UNI T	7 70, 732	12, 338, 200		31. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	O	17, 416, 725		35. 00
40.00	04000 SUBPROVI DER - I PF	-767, 557	3, 900, 797		40. 00
43.00	04300 NURSERY	0	4, 621, 135		43. 00
E0.00	ANCI LLARY SERVI CE COST CENTERS	F2 00/	24 (50 702		F0.00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	-53, 086 0	24, 658, 793 5, 437, 436		50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	l o	10, 905, 760		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	O	6, 274, 587		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	2, 667, 476		55. 00
57. 00	05700 CT SCAN	0	2, 627, 078		57. 00
58. 00 59. 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0	2, 806, 943 288, 492		58. 00 59. 00
60. 00	06000 LABORATORY		14, 660, 794		60.00
64.00	06400 I NTRAVENOUS THERAPY	O	1, 708, 045		64.00
65. 00	06500 RESPI RATORY THERAPY	0	6, 231, 545		65. 00
66. 00	06600 PHYSI CAL THERAPY	-30, 921	7, 996, 971		66. 00
67. 00	06700 OCCUPATIONAL THERAPY	0	2, 668, 000		67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	577, 341 677, 494		68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	2, 279, 300		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	O	20, 448, 688		71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	O	16, 594, 106		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	27, 354, 575		73. 00
	07301 SPECIALTY PHARMACY	0	50, 109, 637		73. 01
76.00	07400 RENAL DI ALYSI S 03330 ENDOSCOPY	0	1, 419, 224 3, 633, 757		74. 00 76. 00
76. 00		0	0,000,707		76. 01
	03951 OTHER ANCILLARY SERVICE COST CENTERS	l o	o		76. 02
76. 03	03952 OTHER ANCILLARY SERVICE COST CENTERS	O	O		76. 03
76. 04		0	916, 295		76. 04
76.06		0	4, 700, 149		76. 06 76. 07
76.07	03955 BREAST DI AGNOSTI C CENTER OUTPATI ENT SERVI CE COST CENTERS	l ol	11, 003, 660		76.07
90. 00	09000 CLINIC	0	0		90.00
90. 01	04950 INFUSION CENTER	o	297, 380		90. 01
	04975 SPI NE CENTER	0	271, 437		90. 26
	09100 EMERGENCY	-126, 492	16, 096, 913		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS	l O			92. 00
113. 00	11300 I NTEREST EXPENSE				113. 00
	11400 UTILIZATION REVIEW-SNF				114. 00
118.00		-1, 769, 008	366, 837, 860		118. 00
100.00	NONREI MBURSABLE COST CENTERS		255 022		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	0	255, 033 0		190. 00 191. 00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES		129, 978		192. 00
	19300 NONPALD WORKERS		0		193. 00
194.00	07950 HOME OFFICE	0	0		194. 00
	07956 PAVI LLI ONS	0	193, 483		194. 06
194.08	B 07958 OTHER NRCC	0	2, 399, 946		194. 08

Health Financial Systems	COMMUNITY HOSPITAL C	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC	CN: 15-0169	Peri od:	Worksheet B
				From 01/01/2020 To 12/31/2020	Part I Date/Time Prepared:
				10 12/31/2020	8/2/2021 3:48 pm
Cost Center Description	Intern &	Total			
	Resi dents Cost				
	& Post				
	Stepdown				
	Adjustments				
	25. 00	26.00			
194.10 07960 COMMUNITY REHAB HOSPITAL	0	0			194. 10
200.00 Cross Foot Adjustments	0	0			200. 00
201.00 Negative Cost Centers	0	0			201. 00
202.00 TOTAL (sum lines 118 through 201)	-1, 769, 008	369, 816, 300			202. 00

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0169 | Period: From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: 8/2/2021 3: 48 pm

				10	12/31/2020	8/2/2021 3:48	
			CAPI TAL REI	LATED COSTS			
	0 1 0 1 0 1	D: 11	DIDO A FLVT	MANUEL FOLLIE		EMPL OVEE	
	Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs				DELAKTIMENT	
		0	1. 00	2. 00	2A	4. 00	
	GENERAL SERVI CE COST CENTERS	1		1			
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	0	6, 001	87, 345	93, 346	93, 346	4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	83, 466	396, 429		9, 417, 431	9, 623	
7.00	00700 OPERATION OF PLANT	0	1, 739, 016		1, 999, 495	2, 443	1
8.00	00800 LAUNDRY & LINEN SERVICE	0	50, 608	79	50, 687	0	8. 00
9. 00	00900 HOUSEKEEPI NG	0	126, 040		149, 765	2, 395	9. 00
10.00	01000 DI ETARY	0	135, 862	1	156, 243	627	10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	0	308, 549 9, 142	1	370, 247 33, 800	1, 443 1, 725	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	319, 356	1	2, 698, 342	671	14. 00
15. 00	01500 PHARMACY	0	158, 178	1	861, 715	4, 227	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	o	5, 649	79	5, 728	331	16. 00
17. 00	01700 SOCI AL SERVI CE	0	37, 411	1	37, 447	1, 437	17. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0		0	0	19.00
21. 00 22. 00	02100 &R SERVI CES-SALARY & FRINGES APPRV 02200 &R SERVI CES-OTHER PRGM COSTS APPRV	0	0		0	0	21. 00 22. 00
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	ı o	0	0		0	22.00
30.00	03000 ADULTS & PEDIATRICS	0	4, 377, 591	876, 207	5, 253, 798	23, 361	30. 00
31.00	03100 INTENSIVE CARE UNIT	o	858, 116	176, 983	1, 035, 099	3, 942	31. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	0	817, 259		986, 450	6, 214	1
40.00	04000 SUBPROVI DER - I PF	0	150, 302	1	163, 114	1, 493	1
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	334, 873	46, 812	381, 685	1, 339	43.00
50. 00	05000 OPERATING ROOM	0	640, 165	2, 447, 214	3, 087, 379	3, 622	50.00
51.00	05100 RECOVERY ROOM	O	343, 640	1	350, 852	1, 938	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	827, 971	1	943, 716	3, 376	
54.00	05400 RADI OLOGY -DI AGNOSTI C	0	218, 584		575, 037	2, 455	1
55. 00 57. 00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	0	244, 439 31, 832		680, 533 256, 367	523 908	
58. 00	05800 MRI	0	117, 930		397, 431	454	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		1, 506	0	59. 00
60.00	06000 LABORATORY	0	125, 220		125, 220	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	176, 297	1	179, 114	548	1
65. 00	06500 RESPI RATORY THERAPY	0	135, 440	1	353, 668	2, 445	1
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	21, 800 0		1, 080, 993 68, 807	3, 467 1, 158	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	l o	Ö		14, 886	251	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	27	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	45, 888	74, 448	240, 825	361, 161	668	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	72. 00 73. 00
73. 00	07301 SPECIALTY PHARMACY	18, 771	0		18, 771		73. 00
74. 00	07400 RENAL DIALYSIS	0	2, 438	1	2, 438	0	
76.00	03330 ENDOSCOPY	0	174, 703	338, 936	513, 639	966	76. 00
76. 01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 01
76. 02 76. 03	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 02 76. 03
76. 03 76. 04	03952 OTHER ANCILLARY SERVICE COST CENTERS 03953 WOUND CARE	0	0	104, 761	104, 761	0 227	76. 03
76. 04	03954 I MAGI NG CENTER	l o	Ö	880, 815	880, 815	1, 298	
76. 07	03955 BREAST DIAGNOSTIC CENTER	0	0	1	414, 347	0	76. 07
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	1	01 7/3	0	90.00
90. 01 90. 26	04950 INFUSION CENTER 04975 SPINE CENTER	0	0	81, 763 91	81, 763 91	89 137	1
91. 00	09100 EMERGENCY	0	595, 604		763, 281	5, 082	
					0	-,	92. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
	11400 UTI LI ZATI ON REVI EW-SNF	140 105	12 5/0 002	21 241 050	24 050 070	02.240	114. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	148, 125	13, 560, 893	21, 241, 950	34, 950, 968	92, 248	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	Ol	82, 370	0	82, 370	0	190. 00
191.00	19100 RESEARCH		0	Ö	0	0	191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	o		192. 00
	19300 NONPALD WORKERS	0	0	0	0		193. 00
	07950 HOME OFFICE 07956 PAVILLIONS		0	120, 349	120, 349	0	194. 00 194. 06
	.,	<u> </u>		120, 547	120, 547		1

Health Financial Systems COMM	IUNITY HOSPITAL	OF INDIANA, I	NC.	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		Period: From 01/01/2020 To 12/31/2020	Worksheet B Part II Date/Time Pre 8/2/2021 3:48	pared:
		CAPI TAL RE	LATED COSTS		10/2/2021 3.40	Pill
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1.00	2.00	2A	4. 00	
194. 08 07958 OTHER NRCC	0	24, 613	114, 40	139, 016	1, 098	194. 08
194.10 07960 COMMUNITY REHAB HOSPITAL	0	(0	0	194. 10
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		(0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	148, 125	13, 667, 876	21, 476, 70	35, 292, 703	93, 346	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0169

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2020 Part II
To 12/31/2020 Date/Time Prepared: 8/2/2021 3: 48 pm

				,	0 12/31/2020	8/2/2021 3:48	
	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5.00	7. 00	8.00	9. 00	10.00	
	NERAL SERVICE COST CENTERS OTOO CAP REL COSTS-BLDG & FIXT			I			1.00
	200 CAP REL COSTS-BEDG & TTXT						2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	D500 ADMINISTRATIVE & GENERAL	9, 427, 054					5. 00
	0700 OPERATION OF PLANT	392, 221	2, 394, 159				7.00
	0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING	31, 707 153, 182	10, 512 26, 180		331, 522		8. 00 9. 00
	000 DI ETARY	53, 744	28, 220		3, 968	242, 802	1
	100 CAFETERI A	64, 570	64, 089		9, 013	0	1
	300 NURSING ADMINISTRATION	200, 134	1, 899		1	0	1
	400 CENTRAL SERVICES & SUPPLY	223, 439	66, 333		.,	0	
	500 PHARMACY 600 MEDI CAL RECORDS & LI BRARY	211, 440 90, 613	32, 855 1, 173	1		0	
	700 SOCIAL SERVICE	70, 703	7, 771	0		0	
	900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	
	2100 I&R SERVICES-SALARY & FRINGES APPRV	18, 075	0	0	0	0	1
	2200 I &R SERVI CES-OTHER PRGM COSTS APPRV	26, 805	0	0	0	0	22. 00
	IPATIENT ROUTINE SERVICE COST CENTERS SOOO ADULTS & PEDIATRICS	1, 637, 189	909, 271	46, 382	127, 866	203, 030	30.00
	100 INTENSIVE CARE UNIT	232, 185	178, 240		· · ·	24, 642	1
	2060 NEONATAL INTENSIVE CARE UNIT	349, 505	169, 753		· · · · · · · · · · · · · · · · · · ·	0	1
	OOO SUBPROVI DER - I PF	75, 212	31, 219		4, 390	15, 130	
	3300 NURSERY	85, 542	69, 557	2, 384	9, 781	0	43. 00
	ICILLARY SERVICE COST CENTERS OOO OPERATING ROOM	529, 858	132, 969	4, 431	18, 699	0	50.00
	5100 RECOVERY ROOM	115, 736	71, 378		· · ·	0	
	5200 DELIVERY ROOM & LABOR ROOM	214, 054	171, 978			0	
	7400 RADI OLOGY-DI AGNOSTI C	141, 228	45, 402			0	1
	5500 RADI OLOGY-THERAPEUTI C	51, 976	50, 773		7, 140	0	
	5700 CT SCAN 5800 MRI	58, 940 63, 207	6, 612 24, 495		930 3, 445	0	
	5900 CARDI AC CATHETERI ZATI ON	7, 041	24, 473	Ö	0, 443	0	
	0000 LABORATORY	350, 845	26, 009	0	3, 658	0	60.00
	400 INTRAVENOUS THERAPY	33, 840	36, 619		5, 150	0	1
	5500 RESPI RATORY THERAPY	144, 612	28, 132		-,	0	1
	600 PHYSICAL THERAPY 6700 OCCUPATIONAL THERAPY	199, 266 66, 040	4, 528 0	0	637	0	
	8800 SPEECH PATHOLOGY	14, 288	Ö	Ö	_	0	
	900 ELECTROCARDI OLOGY	16, 524	0	0	o	0	
	OOO ELECTROENCEPHALOGRAPHY	52, 252	15, 464	0	2, 175	0	
	1100 MEDICAL SUPPLIES CHARGED TO PATIENT	440, 855	0	0	0	0	
	/200 IMPL. DEV. CHARGED TO PATIENTS /300 DRUGS CHARGED TO PATIENTS	358, 006 457, 279	0	0	0	0	
	301 SPECIALTY PHARMACY	1, 248, 785	Ö	Ö	l o	0	
	400 RENAL DIALYSIS	35, 606	506	0	71	0	
	ENDOSCOPY	78, 985	36, 288		5, 103	0	
	3950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	
	3951 OTHER ANCILLARY SERVICE COST CENTERS 3952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	
	3953 WOUND CARE	22, 444	Ö	Ö	l o	0	
76. 06 03	3954 I MAGI NG CENTER	115, 457	0	0	o	0	1
76. 07 03	B955 BREAST DIAGNOSTIC CENTER	277, 626	0	0	0	0	76. 07
	ITPATIENT SERVICE COST CENTERS	O	0	0	O	0	90.00
	1950 INFUSION CENTER	7, 336	0	0		0	
	1975 SPI NE CENTER	6, 844	Ö	Ö	o	0	
	2100 EMERGENCY	331, 609	123, 713	16, 499	17, 397	0	91. 00
	2200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	PECIAL PURPOSE COST CENTERS						112 00
	300 INTEREST EXPENSE 400 UTI LI ZATI ON REVIEW-SNF						113. 00 114. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	9, 356, 805	2, 371, 938	92, 906	328, 397	242, 802	
	NREI MBURSABLE COST CENTERS	,	, , , , ,			,	
	2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 524	17, 109	0	2, 406		190. 00
	2100 RESEARCH	0	0	0	0		191.00
	2200 PHYSICIANS' PRIVATE OFFICES 2300 NONPAID WORKERS	3, 156	0	0			192. 00 193. 00
	7950 HOME OFFICE		n	0			194. 00
194. 06 07	7956 PAVI LLI ONS	4, 894	0	Ō	o	0	194. 06
	958 OTHER NRCC	59, 675	5, 112	0	719		194. 08
	7960 COMMUNITY REHAB HOSPITAL	0	0	0	이	0	194. 10
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers	0	0	_	٥	Λ	200. 00 201. 00
	1 -9	١			, <u> </u>		1 50

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0169 | Period: From 01/01/2020 | Part II | To 12/31/2020 | Date/Time Prepared: 8/2/2021 3: 48 pm

						8/2/2021 3:48	piii
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
202.00	TOTAL (sum lines 118 through 201)	9, 427, 054	2, 394, 159	92, 906	331, 522	242, 802	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0169

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2020 Part II
To 12/31/2020 Date/Time Prepared: 8/2/2021 3: 48 pm

) 12/31/2020	8/2/2021 3:48	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVI CES & SUPPLY		RECORDS & LI BRARY	
	11. 00	13.00	14. 00	15. 00	16. 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 O0400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT						5. 00 7. 00
8.00 00700 OPERATION OF PLANT						8.00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	509, 362				•	11.00
13.00 01300 NURSING ADMINISTRATION	12, 445	250, 270				13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	7, 556	1	3, 005, 669			14. 00
15. 00 01500 PHARMACY	25, 779		88, 684	1, 229, 320		15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	2, 222		0	0	100, 232	16.00
17. 00 01700 SOCIAL SERVICE 19. 00 01900 NONPHYSICIAN ANESTHETISTS	9, 334 0	1	17 0	0	0	17. 00 19. 00
21. 00 02100 1&R SERVI CES-SALARY & FRINGES APPRV			0	0	0	21.00
22. 00 02200 &R SERVI CES-OTHER PRGM COSTS APPRV	Ö		0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS		<u> </u>	31			22.00
30. 00 03000 ADULTS & PEDI ATRI CS	172, 455	122, 297	173, 193	0	12, 523	30.00
31.00 03100 INTENSIVE CARE UNIT	29, 779	21, 119	33, 665	0	1, 935	31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	40, 891	28, 999	47, 652	0	7, 379	35. 00
40. 00 04000 SUBPROVI DER - PF	11, 112	,	4, 815	0		40. 00
43. 00 04300 NURSERY	9, 778	6, 934	9, 376	0	654	43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM	26, 224	18, 597	410, 526	0	13, 310	50.00
51. 00 05100 RECOVERY ROOM	13, 334		20, 904	0		51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	24, 001	17, 021	23, 183	0		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	16, 001	0	8, 601	0	2, 457	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	3, 111	0	11, 439	0	2, 472	55. 00
57. 00 05700 CT SCAN	6, 223	0	10, 681	0	4, 760	57. 00
58. 00 05800 MRI	2, 667	0	576	0	2, 068	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	200	0	286	59. 00
60. 00 06000 LABORATORY	0	0	97, 561	0	7, 983	•
64. 00 06400 I NTRAVENOUS THERAPY	3, 556	1	3, 822	0	207	64.00
65. 00 06500 RESPI RATORY THERAPY	16, 890		31, 418	0	2, 025	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	5, 778 7, 112	0	6, 583 1, 615	0	1, 253 448	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	1, 333	-	349	0	135	68.00
69. 00 06900 ELECTROCARDI OLOGY	444	1	31	0	647	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	4, 889		8, 573	0	614	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	О	934, 153	0	3, 673	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	o	758, 603	0	2, 658	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	-	0	1, 229, 320		73. 00
73. 01 07301 SPECI ALTY PHARMACY	8, 000	1	222, 017	0	3, 856	73. 01
74. 00 07400 RENAL DIALYSIS	7 112		58	0		74.00
76. 00 03330 ENDOSCOPY 76. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS	7, 112	0	19, 759	0	1, 630	76. 00 76. 01
76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 01
76. 03 03952 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	76. 02
76. 04 03953 WOUND CARE	1, 778	Ö	4, 766	0	159	76. 04
76.06 03954 I MAGING CENTER	0		10, 347	0	3, 231	76. 06
76. 07 03955 BREAST DIAGNOSTIC CENTER	0	0	373	0	1, 646	76. 07
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0		0	0	0	90.00
90. 01 04950 I NFUSI ON CENTER	889	0	538	0	29	90. 01
90. 26 04975 SPI NE CENTER	0	07 422	238	0	26	90. 26
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	38, 669	27, 423	58, 983	0	10, 238	•
SPECIAL PURPOSE COST CENTERS						92. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	509, 362	250, 270	3, 003, 299	1, 229, 320	100, 232	
NONREI MBURSABLE COST CENTERS	·					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	이	1, 769	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 HOME OFFI CE	0		0	0		194.00
194. 06 07956 PAVI LLI ONS 194. 08 07958 OTHER NRCC	0		184 417	0		194. 06 194. 08
194. 08 07958 OTHER NRCC 194. 10 07960 COMMUNITY REHAB HOSPITAL			417	0		194. 08
200.00 Cross Foot Adjustments			٥	U		200.00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1	ı			1	

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0169
From 01/01/2020
To 12/31/2020
Date/Time Prepared:

						8/2/2021 3:48	pm
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON	SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
		11. 00	13.00	14.00	15. 00	16.00	
201.00	Negative Cost Centers	0	0	0	0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	509, 362	250, 270	3, 005, 669	1, 229, 320	100, 232	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2020 Part II
To 12/31/2020 Date/Time Prepared: 8/2/2021 3: 48 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0169

					72/31/2020	8/2/2021 3: 48	
				INTERNS &	RESI DENTS		
	Cost Contor Dosorintion	SOCIAL SERVICE	NONDHASTCTVN	SEDVICES SALAD	SEDVI CES OTHER	Subtotal	
	Cost Center Description	SOCIAL SERVICE	ANESTHETI STS	SERVICES-SALAR Y & FRINGES	PRGM COSTS	Subtotal	
			ANESTHETTSTS	APPRV	APPRV		
		17. 00	19. 00	21.00	22. 00	24. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
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 NURSI NG ADMI NI STRATI ON						13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY						14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16. 00
17. 00	01700 SOCI AL SERVI CE	127, 802					17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	C				19. 00
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRV	0		18, 075			21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0			26, 805		22. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	00.074				2.7/2.00/	
30.00	03000 ADULTS & PEDIATRICS	80, 971				8, 762, 336	1
31. 00 35. 00	03100 NTENSI VE CARE UNIT 02060 NEONATAL INTENSI VE CARE UNIT	9, 828 20, 054	ł			1, 600, 336 1, 684, 119	
40. 00	04000 SUBPROVIDER - I PF	6, 034				321, 701	40.00
43. 00	04300 NURSERY	10, 915				587, 945	1
	ANCILLARY SERVICE COST CENTERS			•	,		1
50.00	05000 OPERATING ROOM	0	ŀ			4, 245, 615	1
51.00	05100 RECOVERY ROOM	0				586, 369	1
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0				1, 429, 026 803, 282	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0				808, 874	1
57. 00	05700 CT SCAN	0				345, 421	1
58. 00	05800 MRI	0				494, 343	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0				9, 033	1
60.00	06000 LABORATORY	0				611, 276	1
64.00	06400 I NTRAVENOUS THERAPY	0				262, 856	1
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0				583, 146 1, 302, 505	1
67. 00	06700 OCCUPATI ONAL THERAPY	0				145, 180	1
68. 00	06800 SPEECH PATHOLOGY	0				31, 242	1
69. 00	06900 ELECTROCARDI OLOGY	0				17, 673	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0				445, 796	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				1, 378, 681	1
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0				1, 119, 267 1, 693, 798	
	07301 SPECIALTY PHARMACY	0				1, 502, 767	
74. 00	07400 RENAL DIALYSIS	0	ŀ			38, 983	
76. 00	03330 ENDOSCOPY	0				665, 306	
76. 01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0				0	
	03951 OTHER ANCILLARY SERVICE COST CENTERS	0				0	1
76. 03 76. 04	03952 OTHER ANCILLARY SERVICE COST CENTERS 03953 WOUND CARE	0				124 125	
76. 04 76. 06	03954 I MAGI NG CENTER	0				134, 135 1, 011, 148	
76. 07	03955 BREAST DIAGNOSTIC CENTER	0				693, 992	1
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0				0	
	04950 I NFUSI ON CENTER	0				90, 644	1
90. 26	04975 SPI NE CENTER 09100 EMERGENCY	0				7, 336 1, 392, 894	
	09200 OBSERVATION BEDS (NON-DISTINCT PART					1, 392, 694	91.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
113.00	11300 INTEREST EXPENSE						113. 00
	11400 UTI LI ZATI ON REVI EW-SNF						114. 00
118.00	, j	127, 802	C	0	0	34, 807, 025	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN					104, 409	190 00
	19100 RESEARCH	0					191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0					192. 00
193.00	19300 NONPALD WORKERS	0		1			193. 00
	07950 HOME OFFICE	0					194. 00
	07956 PAVILLIONS	0		1		125, 427	
194.08	B 07958 OTHER NRCC	0	l	1		206, 037	1194. U8

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0169 | Period: From 01/01/2020 | Part II | To 12/31/2020 | Date/Time Prepared:

				'	0 12/31/2020	Date/ IT life IT e	
						8/2/2021 3:48	pm
				INTERNS &	RESI DENTS		
	Cost Center Description	SOCIAL SERVICE	NONPHYSI CI AN	SERVI CES-SALAR	SERVI CES-OTHER	Subtotal	
			ANESTHETI STS	Y & FRINGES	PRGM COSTS		
				APPRV	APPRV		
		17. 00	19. 00	21.00	22. 00	24. 00	
194. 10 07960	COMMUNITY REHAB HOSPITAL	0				0	194. 10
200.00	Cross Foot Adjustments		0	18, 075	26, 805	44, 880	200. 00
201.00	Negative Cost Centers	0	0	0	0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	127, 802	0	18, 075	26, 805	35, 292, 703	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2020 Part II
To 12/31/2020 Date/Time Prepared: 8/2/2021 3: 48 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0169

					10 12/31/2020	8/2/2021 3:48 pm
	Cost Center Description	Intern &	Total	<u>'</u>		
		Residents Cost				
		& Post				
		Stepdown				
		Adjustments	0/ 00			
	CENEDAL CEDVICE COST CENTEDS	25. 00	26. 00			
1.00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 00	00500 ADMINISTRATIVE & GENERAL					5. 00
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 NURSI NG ADMI NI STRATI ON					13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00	01500 PHARMACY					15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY					16.00
17. 00	01700 SOCIAL SERVICE					17. 00
19. 00 21. 00	01900 NONPHYSICIAN ANESTHETISTS					19. 00 21. 00
21.00	O2100 I &R SERVICES-SALARY & FRINGES APPRV O2200 I &R SERVICES-OTHER PRGM COSTS APPRV					22. 00
22.00	I NPATIENT ROUTINE SERVICE COST CENTERS					22.00
30. 00	03000 ADULTS & PEDIATRICS	O	8, 762, 336			30.00
31. 00	03100 NTENSI VE CARE UNI T		1, 600, 336			31.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	0	1, 684, 119			35. 00
40.00	04000 SUBPROVI DER - I PF	0	321, 701			40.00
43.00	04300 NURSERY	O	587, 945			43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATI NG ROOM	0	4, 245, 615			50.00
51. 00	05100 RECOVERY ROOM	0	586, 369			51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 429, 026			52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	803, 282			54. 00
55. 00	O5500 RADI OLOGY-THERAPEUTI C	0	808, 874			55.00
57. 00	05700 CT SCAN 05800 MRI	0	345, 421			57. 00
58. 00 59. 00	05900 CARDI AC CATHETERI ZATI ON		494, 343 9, 033			58. 00 59. 00
60.00	06000 LABORATORY		611, 276			60.00
64. 00	06400 I NTRAVENOUS THERAPY		262, 856			64. 00
65. 00	06500 RESPIRATORY THERAPY		583, 146			65. 00
66. 00	06600 PHYSI CAL THERAPY	o	1, 302, 505			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	O	145, 180			67. 00
68.00	06800 SPEECH PATHOLOGY	0	31, 242			68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	17, 673			69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	445, 796			70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 378, 681			71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATI ENTS	0	1, 119, 267			72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	1, 693, 798			73.00
	07301 SPECIALTY PHARMACY	0	1, 502, 767			73. 01
74. 00 76. 00	07400 RENAL DI ALYSI S 03330 ENDOSCOPY		38, 983 665, 306			74. 00 76. 00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS		005, 300			76. 01
	03951 OTHER ANCILLARY SERVICE COST CENTERS		0			76. 02
	03952 OTHER ANCILLARY SERVICE COST CENTERS	o	0			76. 03
		0	134, 135			76. 04
76.06	03954 I MAGI NG CENTER	0	1, 011, 148			76. 06
76. 07	03955 BREAST DIAGNOSTIC CENTER	0	693, 992			76. 07
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLINIC	0	0			90.00
	04950 I NFUSI ON CENTER	0	90, 644			90. 01
	04975 SPI NE CENTER	0	7, 336			90. 26
	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART		1, 392, 894			91. 00 92. 00
92.00	SPECIAL PURPOSE COST CENTERS	J O				92.00
113 00	11300 INTEREST EXPENSE					113. 00
	11400 UTILIZATION REVIEW-SNF					114. 00
118.00	1	o	34, 807, 025			118. 00
	NONREI MBURSABLE COST CENTERS		, . = 0			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	104, 409			190. 00
	19100 RESEARCH	0	0			191. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	4, 925			192. 00
	19300 NONPALD WORKERS	0	0			193. 00
	07950 HOME OFFI CE	0	0			194. 00
	07956 PAVI LLI ONS	0	125, 427			194. 06
194. 08	07958 OTHER NRCC	<u> </u> 0	206, 037			194. 08

Health Financial Systems	COMMUNITY HOSPITAL OF	INDIANA, IN	C.	In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC	N: 15-0169	Peri od:	Worksheet B	
				From 01/01/2020 To 12/31/2020	Part II Date/Time Prep	arod:
				10 12/31/2020	8/2/2021 3:48	
Cost Center Description	Intern &	Total				
	Resi dents Cost					
	& Post					
	Stepdown					
	Adjustments					
	25. 00	26.00				
194.10 07960 COMMUNITY REHAB HOSPITAL	0	0				194. 10
200.00 Cross Foot Adjustments	0	44, 880				200. 00
201.00 Negative Cost Centers	0	0				201.00
202.00 TOTAL (sum lines 118 through 201)	0	35, 292, 703				202. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Provi der CCN: 15-0169

				-	Го 12/31/2020	Date/Time Pre 8/2/2021 3:48	
		CAPITAL REI	LATED COSTS			7 07 27 2021 0. 10	ļ
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	 EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	555 Conto. 5555 Fer 6.1	(SQUARE FEET)		BENEFITS		& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS SALARI ES)			
		1.00	2.00	4. 00	5A	5. 00	
4 00	GENERAL SERVI CE COST CENTERS	500.004	I	T	1		1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	583, 084	21, 771, 818				1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	256			3		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	16, 912					5. 00
7.00	00700 OPERATION OF PLANT	74, 188		1		12, 797, 600	7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	2, 159 5, 377		2, 903, 182	-	1, 034, 564 4, 998, 105	8. 00 9. 00
10.00	01000 DI ETARY	5, 796		759, 632		1, 753, 602	
11. 00	01100 CAFETERI A	13, 163				2, 106, 840	
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	390 13, 624				6, 530, 083 7, 290, 490	13. 00 14. 00
15. 00	01500 PHARMACY	6,748				6, 898, 968	
16. 00	01600 MEDICAL RECORDS & LIBRARY	241	80			2, 956, 580	
17. 00	01700 SOCIAL SERVICE	1, 596		1		2, 306, 944	
19. 00 21. 00	01900 NONPHYSICIAN ANESTHETISTS 02100 I&R SERVICES-SALARY & FRINGES APPRV	0 0			0 0	0 589, 754	19. 00 21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0		•	o o	1	1
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	186, 752 36, 608					30.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	34, 865					1
40.00	04000 SUBPROVI DER - I PF	6, 412					1
43. 00	04300 NURSERY	14, 286	47, 455	1, 623, 272	2 0	2, 791, 100	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	27, 310	2, 480, 842	4, 390, 35!	5 0	17, 288, 516	50.00
51. 00	05100 RECOVERY ROOM	14, 660		2, 349, 38			
52.00	05200 DELIVERY ROOM & LABOR ROOM	35, 322				6, 984, 259	52. 00
54.00	05400 RADI OLOGY THERAPELITIC	9, 325		2, 976, 218		4, 608, 079	1
55. 00 57. 00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	10, 428 1, 358				1, 695, 896 1, 923, 127	1
58. 00	05800 MRI	5, 031	283, 342			2, 062, 347	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	.,	(0	229, 738	
60. 00 64. 00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	5, 342 7, 521	0 2, 856	663, 87	0	11, 447, 559 1, 104, 144	
65. 00	06500 RESPI RATORY THERAPY	5, 778				4, 718, 480	
66. 00	06600 PHYSI CAL THERAPY	930				6, 501, 746	
67.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	69, 752			2, 154, 792	
68. 00 69. 00	06900 ELECTROCARDI OLOGY	0	1	303, 73 ⁹ 32, 58!		466, 187 539, 151	
70. 00	07000 ELECTROENCEPHALOGRAPHY	3, 176	244, 134			1, 704, 895	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0	14, 384, 461	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0			11, 681, 234 14, 920, 369	
73. 01	07301 SPECIALTY PHARMACY	0	o o	1, 621, 90	e o	40, 746, 047	73. 01
74. 00	07400 RENAL DIALYSIS	104			0	1, 161, 783	1
76. 00 76. 01	03330 ENDOSCOPY 03950 OTHER ANCILLARY SERVICE COST CENTERS	7, 453	343, 593	1, 170, 94	0	2, 577, 181 0	76. 00 76. 01
76. 01	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0			0	
76. 03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	76. 03
76. 04	03953 WOUND CARE	0		275, 133		732, 309	
76. 06 76. 07	03954 I MAGING CENTER 03955 BREAST DI AGNOSTIC CENTER	0		1, 573, 820		3, 767, 189 9, 058, 541	
70.07	OUTPATIENT SERVICE COST CENTERS		720,041		51 0	7,000,041	70.07
90.00	09000 CLI NI C	0	0	(0	90.00
90. 01 90. 26	04950 I NFUSION CENTER 04975 SPI NE CENTER	0	82, 887	107, 616 165, 633		239, 367	
90. 20	09100 EMERGENCY	25, 409	92 169, 981	6, 159, 59		223, 295 10, 819, 938	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART			2, 121, 211		12, 211, 122	92. 00
	SPECIAL PURPOSE COST CENTERS	I	ı	Г	T	Г	
	11300 INTEREST EXPENSE 11400 UTI LI ZATI ON REVI EW-SNF						113. 00 114. 00
114.00		578, 520	21, 533, 840	111, 838, 028	-63, 990, 870	305, 302, 299	
	NONREI MBURSABLE COST CENTERS		1				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 514	1		0		190.00
	19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	1		0	0 102, 989	191. 00 192. 00
	19300 NONPALD WORKERS	0	1				193. 00
	07950 HOME OFFICE	0	0	(0	0	194. 00

				'	0 12/31/2020	8/2/2021 3:48	
		CAPI TAL REI	_ATED_COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		(SQUARE FEET)	(DOLLAR VALUE)			& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS			
		1. 00	2.00	SALARI ES) 4. 00	5A	5. 00	
194, 06 0795	6 PAVI LLI ONS	0	122, 003		0	159, 685	194. 06
	8 OTHER NRCC	1, 050			0	1, 947, 095	1
194. 10 0796	O COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194. 10
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	13, 667, 876	21, 476, 702	3, 582, 221		63, 990, 870	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	23. 440664	0. 986445	0. 031654		0. 208036	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)			93, 346		9, 427, 054	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000825		0. 030648	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Provider CCN: 15-0169

			T	o 12/31/2020	Date/Time Pre 8/2/2021 3:48	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	Į į
	PLANT (SQUARE FEET)	(POUNDS OF LAUNDRY)	(SQUARE FEET)	(MEALS SERVED)	(MEALS SERVED)	
	7. 00	8. 00	9. 00	10.00	11. 00	
GENERAL SERVICE COST CENTERS 1.00 O0100 CAP REL COSTS-BLDG & FLXT						1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 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	491, 728					7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	2, 159	254, 745				8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	5, 377 5, 796	0	484, 192 5, 796			9. 00 10. 00
11. 00 01100 CAFETERI A	13, 163	0	13, 163		1, 146	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	390	0	390	0	28	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	13, 624	0	13, 624		17	14. 00
15. 00 01500 PHARMACY	6, 748	0	6, 748	0	58	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	241 1, 596	0	241 1, 596	0	5 21	16. 00 17. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	1, 340	0	1, 390	0	0	19. 00
21. 00 02100 I &R SERVI CES-SALARY & FRINGES APPRV	o o	0	Ö	0	0	21. 00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1					
30. 00 03000 ADULTS & PEDIATRICS	186, 752	127, 178			388 67	30.00
31. 00 03100 INTENSI VE CARE UNIT 35. 00 02060 NEONATAL INTENSI VE CARE UNIT	36, 608 34, 865	13, 263 9, 186			92	31. 00 35. 00
40. 00 04000 SUBPROVI DER - 1 PF	6, 412	1, 866			25	40. 00
43. 00 04300 NURSERY	14, 286	6, 538			22	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	27, 310	12, 151	27, 310		59	50.00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	14, 660 35, 322	0 16, 164	14, 660 35, 322	0	30 54	51. 00 52. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	9, 325	15, 674	9, 325	0	36	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	10, 428	2, 486		0	7	55. 00
57.00 05700 CT SCAN	1, 358	0	1, 358	0	14	57. 00
58. 00 05800 MRI	5, 031	0	5, 031	0	6	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00 06000 LABORATORY 64. 00 06400 INTRAVENOUS THERAPY	5, 342 7, 521	0	5, 342 7, 521	0	0 8	60. 00 64. 00
65. 00 06500 RESPI RATORY THERAPY	5, 778	0	5, 778	0	38	65. 00
66. 00 06600 PHYSI CAL THERAPY	930	0	930	0	13	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	16	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	3	68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	3, 176	0	3, 176	0	1 11	69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 170	0	3, 170	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
73. 01 07301 SPECIALTY PHARMACY	0	0	0	0	18	73. 01
74. 00 07400 RENAL DIALYSIS 76. 00 03330 ENDOSCOPY	104	0 E 000	104	0	0	74.00
76. 00 03330 ENDOSCOPY 76. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS	7, 453	5, 000	7, 453	0	16 0	76. 00 76. 01
76. 02 03951 OTHER ANCI LLARY SERVICE COST CENTERS	l o	0	0	0	Ö	76. 02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 03
76. 04 03953 WOUND CARE	0	0	0	0	4	76. 04
76. 06 03954 I MAGING CENTER	0	0	0	0	0	76. 06
76. 07 03955 BREAST DI AGNOSTI C CENTER OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	76. 07
90. 00 09000 CLINIC	ol	0	0	0	0	90. 00
90. 01 04950 I NFUSI ON CENTER	0	0	Ō	0	2	90. 01
90. 26 04975 SPI NE CENTER	0	0	0	0	0	90. 26
91. 00 09100 EMERGENCY	25, 409	45, 239	25, 409	0	87	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92. 00
113.00 11300 INTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	487, 164	254, 745	479, 628	64, 656	1, 146	118. 00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 514	0	3, 514	0		190. 00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		191. 00 192. 00
193. 00 19300 NONPALD WORKERS		0	l 0	0		192. 00
194.00 07950 HOME OFFICE		0	0	Ö		194. 00
194. 06 07956 PAVI LLI ONS	0	0	0	0		194. 06
194. 08 07958 OTHER NRCC	1, 050	0	1, 050	0		194. 08
194. 10 07960 COMMUNITY REHAB HOSPITAL	0	0	1 0	0	0	194. 10

Health Financial Systems	COMMUNITY HOSPITAL OF INDIANA,	I NC.	In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi de	r CCN: 15-0169	Peri od:	Worksheet B-1

					rom 01/01/2020		
				1	o 12/31/2020		
						8/2/2021 3: 48	pm
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(MEALS SERVED)	
		(SQUARE FEET)	(POUNDS OF				
			LAUNDRY)				
		7. 00	8. 00	9. 00	10.00	11. 00	
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	15, 459, 962	1, 317, 670	6, 206, 944	2, 374, 941	3, 127, 724	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	31. 440068	5. 172506	12. 819179	36. 731951	2, 729. 253054	203. 00
204.00	Cost to be allocated (per Wkst. B,	2, 394, 159	92, 906	331, 522	242, 802	509, 362	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	4. 868869	0. 364702	0. 684691	3. 755290	444. 469459	205. 00
	[11]						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						
	•	,		•	•		-

Provider Cut 10-9199			MUNITY HOSPITAL				u of Form CMS-	
Control Cont	COST	ALLOCATION - STATISTICAL BASIS		Provider CC	F			pared:
DATE STREET STR		Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
INTERNAL SERVICE COST CENTERS 13.00 14.00 15.00 17.0		·				RECORDS &		
PHISD PRODUCTS 13.00 14.00 15.00 16.00 17.00 1			(DIRECT NRSING		REQUIS.)		(IIME SPENI)	
DEBRING SERVICE COST CENTERS 1.00			HRS)	REQUIS.)		GES)		
1.00 00000 MILTURE SERVICE		CENEDAL SEDVICE COST CENTERS	13.00	14. 00	15. 00	16. 00	17. 00	
4.00 DOGOOD LINE OFFICE INFELLIS DEPARTMENT	1. 00							1.00
5.00 DOCOD_NAMIN IN STRATION S. GINIPAL 5.70 DOCOD_OPERATION OF PLAN T. S. GINIPAL T. S. GINIPA								1
0.000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000000								
9.00 00000 MUSEREEPI NG								
10.00 01000 DETARY		1						
11.00								1
14.00 01400 CRITIALS SERVICES & SURPLY 0		1						1
15.00 01500 NIAMBACY 0			1	44 000 407				•
16.00 01-000 NEDICAL RECORDS & LIBRARY 0 0 0 1, 508, 469, 729 1.6.00 1.700 01-700			0		14 653 392			
19.00 0.990 NOMPHYSICIAN AMESTHEITISTS 0 0 0 0 0 0 0 22.00 22.			0	0	0			
21.00 02100 188 SERVICES-SALARY & FIN NOES APPRY 0 0 0 0 0 0 0 21.00			0	269	0	0		1
22.00		1	0	0	0			1
30.00			1	o		· ·	_	
31.00 03100 NTENSI VE CARE UNIT 67 518, 391 0 29, 320, 631 6, 562 31, 00 0300 03000 NORMATAL INTENSI VE CARE UNIT 92 733, 760 0 111, 808, 356 13, 300 35, 00 04000 SUBPROVIDER - I.PF 25 74, 141 0 9, 403, 664 4, 029 40, 00 40, 00 04000 SUBPROVIDER - I.PF 25 74, 141 0 9, 403, 664 4, 029 40, 00 40, 00 04000 SUBPROVIDER - I.PF 25 74, 141 0 9, 403, 664 4, 029 40, 00 50, 00 50, 00 50, 00 05000 DERATI NER ROUM 59 6, 321, 431 0 9, 906, 848 7, 288 43, 00 51, 00 50, 00 05000 DERATI NER ROUM 59 6, 321, 431 0 191, 491, 447 0 50, 00 50, 00 50, 00 05000 DERATI NER ROUM 59 6, 321, 431 0 191, 491, 447 0 50, 00								
15.00			1 1					1
40.00 04000 UNSERY 197 25								1
MACL LARY SERVICE COST CENTERS		04000 SUBPROVI DER - I PF		74, 141		9, 403, 664	4, 029	40.00
50.00	43. 00		22	144, 378	0	9, 906, 848	7, 288	43.00
52.00 05200 DELIVERY ROME ALBOR ROM 54 356, 985 0. 44, 495, 294 0. 52.00	50. 00		59	6, 321, 431	0	191, 491, 447	0	50.00
54. 00 05400 RADIOLOGY-DI AGNOSTIC 0 132, 443 0 37, 229, 733 0 54. 00 55. 00 05500 CARDIALOGY-PHERAPEUTIC 0 0164, 470 0 72, 127, 637 0 57. 00 57. 00 05700 CT SCAN 0 164, 470 0 72, 127, 637 0 57. 00 58. 00 5			1				_	
55.00 05500 RADIOLOGY-THERAPEUTIC 0 176, 136 0 37, 451, 555 0 55.00 57.00 57.00 05700 CT SCAN 0 164, 470 0 72, 127, 637 0 57.00 58.00 05800 MRI 0 8, 866 0 31, 333, 210 0 58.00 05800 MRI 0 0 8, 866 0 31, 333, 210 0 58.00 059.00 05900 CARDI AC CATHETERI ZATI ON 0 1, 502, 279 0 120, 951, 460 0 60.00 60.00 106000 INTRAVENOUS THERAPY 0 1, 502, 279 0 120, 951, 460 0 60.00 66.00 06600 INTRAVENOUS THERAPY 0 483, 783 0 30, 688, 543 0 65.00 65.00 65.00 PKSY IRATORY THERAPY 0 483, 783 0 30, 688, 543 0 65.00 66.00 66.00 06600 PKSY IRATORY THERAPY 0 101, 374 0 18, 990, 859 0 66.00 66.00 06600 PKSY IRATORY THERAPY 0 24, 874 0 6, 788, 773 0 67.00 67.00 06700 05200 DKSY IRATORY THERAPY 0 24, 874 0 6, 788, 773 0 67.00 69.00 06900 DKSECH PATHOLOGY 0 474 0 9, 796, 094 0 69.00 06900 ELECTROCARDI OLOGY 0 474 0 9, 796, 094 0 69.00 06900 ELECTROCARDI OLOGY 0 474 0 9, 796, 094 0 69.00 07.00 07000 ELECTROCARDI OLOGY 0 122, 009 0 9, 296, 517 0 70.00 07			1				_	1
57.00 05700 CT SCAN			0		-	0., ==.,	_	
59.00 0.5900 CARDI AC CATHETERIZATION 0 3.087 0 4.332, 485 0 59.00	57. 00	05700 CT SCAN	0	164, 470	0	72, 127, 637	0	57. 00
60.00 06000 LABORATORY 0 1.502, 279 0 120, 951, 460 0 60.00		1	0		-	l ' '	_	
65. 00 0.6500 RESPIRATORY THERAPY 0 483, 783 0 30, 688, 543 0 65. 00			1			.,	_	•
66.00 06600 PHYSI CAL THERAPY 0 101, 374 0 18, 990, 859 0 66.00 07			0	58, 848		3, 132, 146	0	•
67.00 06700 06700 06700 06700 06700 06700 068.00 06800 06800 06800 06800 06800 06800 069			0		-		_	•
68. 00 06900 DEECH PATHOLOGY 0 5.381 0 2.048, 154 0 68. 00			0		-		_	•
70. 00 07000 LELECTROENCEPHALOGRAPHY 0 132,009 0 9,296,517 0 70. 00	68. 00	06800 SPEECH PATHOLOGY	0	5, 381	0	2, 048, 154	0	68. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 14, 384, 460 0 55, 648, 722 0 71, 00 72, 00 72, 00 72, 00 72, 00 73, 00 74,			0		-		_	
12. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 11, 681, 234 0 40, 272, 549 0 72. 00			1 -1					
73.01 07301 SPECIALTY PHARMACY 0 3,418,698 0 58,430,692 0 73.01 74.00 07400 RENAL DI ALYSIS 0 887 0 4,598,982 0 74.00 76.00 03330 ENDOSCOPY 0 304,255 0 24,693,541 0 76.00 76.00 76.01 03950 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 76.01 76.02 03951 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 76.03 76.03 03952 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 0	72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		0			
74. 00 07400 RENAL DIALYSIS 0 887 0 4,598,982 0 74. 00 76. 00 0330 RENAL DIALYSIS 0 3304,255 0 24,693,541 0 76. 00 0 0 0 0 0 0 0 0 0			0		14, 653, 392		0	
76. 00 03330 ENDOSCOPY 0 304, 255 0 24, 693, 541 0 76. 00 76. 01 03590 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 76. 02 76. 02 3951 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 02 76. 03 03952 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 03 76. 04 03953 WOUND CARE 0 73, 385 0 2, 402, 705 0 76. 03 76. 06 03954 MAGIN CENTER 0 159, 323 0 48, 949, 872 0 76. 07 76. 06 03954 MAGIN CENTER 0 5, 745 0 24, 933, 705 0 76. 07 76. 07 76. 07 76. 08 76. 09 76.			0		0		0	
76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 76. 02 76. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 76. 03 76. 04 03953 WOUND CARE 0 0 73, 385 0 2, 402, 705 0 76. 04 76. 06 03954 IMAGING CENTER 0 159, 323 0 48, 949, 872 0 76. 06 76. 07 03955 BREAST DIAGNOSTIC CENTER 0 159, 323 0 48, 949, 872 0 76. 06 76. 07 03955 BREAST DIAGNOSTIC CENTER 0 5, 745 0 24, 933, 705 0 76. 07 00 09000 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	76. 00	03330 ENDOSCOPY	0	•	0		0	76. 00
76. 03 03952 OTHER ANCI LLARY SERVICE COST CENTERS			0	0	0	0	_	
76. 04 03953 WOUND CARE 0 73, 385 0 2, 402, 705 0 76. 04 76. 06 03954 IMAGI NG CENTER 0 159, 323 0 48, 949, 872 0 76. 06 76. 06 76. 07 76. 06 76. 07 76. 06 76. 07 76. 06 76. 07 76. 06 76. 07 76. 06 76. 07 76. 06 76. 07 76. 06 76. 07 76. 06 76. 07			0	0	0	0	0	1
76. 07 03955 BREAST DI AGNOSTIC CENTER 0 5,745 0 24,933,705 0 76. 07	76. 04	03953 WOUND CARE	0	73, 385	0	2, 402, 705	0	
90. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 0			0				_	
90. 00 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 026 90. 04975 SPI NE CENTER 90. 04975 SPI NE CENTER 90. 09100 EMERGENCY 91. 00 92.	76.07		<u> </u>	5, 745	0	24, 933, 705	0	76.07
90. 26		09000 CLI NI C	0	0	0	0	0	90.00
91. 00			0		0			
92. 00 9200 09200 0BSERVATI ON BEDS (NON-DISTINCT PART		l	1 -1					
113.00				700, 217		1007 1177 07 1		
114. 00	112 0		1	T				1112 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 794 46, 245, 919 14, 653, 392 1, 508, 469, 729 85, 334 118. 00								
190.00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 191.00 19100 RESEARCH 0 0 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 27, 233 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 0 193.00 194.00 07950 HOME OFFI CE 0 0 0 0 0 194.00 194.06 07956 PAVI LLI ONS 0 2, 831 0 0 0 194.06			794	46, 245, 919	14, 653, 392	1, 508, 469, 729	85, 334	
191. 00	400.04			ام				
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 27, 233 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 HOME OFFI CE 0 0 0 0 0 194.00 194.00 194.06 07956 PAVI LLI ONS 0 0 2, 831 0 0 0 194.06			0	0				
193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 194. 00 19750 HOME OFFI CE 0 0 0 0 0 194. 00 194. 00 194. 00 194. 00 0 0 194. 00 0 194.				27, 233		· ·		
194. 06 07956 PAVI LLI ONS 0 2, 831 0 0 0 194. 06	193.00	19300 NONPALD WORKERS	0	0	0	0	0	193. 00
			0	0 2 021		· ·		
						· ·		

Health Financial Systems	COMMUNITY HOSPITAL OF INDIANA, INC.	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0169	Peri od: Worksheet B-1
		From 01/01/2020

				To	12/31/2020		
						8/2/2021 3:48	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
		(DIRECT NRSING	(COSTED		(GROSS CHAR		
		HRS)	REQUIS.)		GES)		
		13.00	14.00	15. 00	16. 00	17. 00	
194. 10	07960 COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194. 10
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	7, 982, 255	9, 456, 558	9, 070, 182	3, 595, 967	2, 914, 877	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	10, 053. 217884	0. 204323	0. 618982	0.002384	34. 158448	203. 00
204.00	Cost to be allocated (per Wkst. B,	250, 270	3, 005, 669	1, 229, 320	100, 232	127, 802	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	315. 201511	0. 064942	0. 083893	0.000066	1. 497668	205. 00
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						1
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0169 Peri od: Worksheet B-1 From 01/01/2020 12/31/2020 Date/Time Prepared: 8/2/2021 3:48 pm INTERNS & RESIDENTS Cost Center Description NONPHYSI CI AN SERVI CES-SALAR SERVI CES-OTHER Y & FRINGES ANESTHETI STS PRGM COSTS (ASSI GNED **APPRV APPRV** (ASSI GNED TIME) (ASSI GNED TIME) TIME) 19.00 21. 00 22. 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 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10 00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 71, 912 21 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV 71, 912 22.00 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDLATRICS 0 32, 153 30.00 32, 153 31.00 03100 INTENSIVE CARE UNIT 31.00 02060 NEONATAL INTENSIVE CARE UNIT 35.00 0 C 35.00 04000 SUBPROVIDER - IPF 40.00 31, 202 31, 202 40.00 04300 NURSERY 43.00 43.00 C ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 2, 158 2, 158 50.00 51.00 05100 RECOVERY ROOM 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 C 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 0 55.00 57 00 05700 CT SCAN 0 57 00 C 0 58.00 05800 MRI C 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 0 59.00 06000 LABORATORY 0 60.00 0 60.00 06400 INTRAVENOUS THERAPY 0 0 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0 65.00 66.00 06600 PHYSI CAL THERAPY 1, 257 1, 257 66.00 06700 OCCUPATIONAL THERAPY 67 00 C 0 67 00 06800 SPEECH PATHOLOGY 68.00 C 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71 00 Ω 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73. 01 07301 SPECIALTY PHARMACY 73.01 07400 RENAL DIALYSIS 0 74 00 Ω 74 00 76.00 03330 ENDOSCOPY 0 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 76.01 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 76. 02 0 76.02 03952 OTHER ANCILLARY SERVICE COST CENTERS 0 76.03 0 76.03 76.04 03953 WOUND CARE 0 76.04 03954 I MAGING CENTER 0 0 76 06 76 06 03955 BREAST DIAGNOSTIC CENTER 0 0 76.07 76.07 0 OUTPATIENT SERVICE COST CENTERS

0

0

0

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0

90.00

90.01

90. 26

09000 CLI NI C

04950 INFUSION CENTER

04975 SPINE CENTER

90.00

90.01

90.26

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

					8/2/2021 3: 48	pm
	·		INTERNS &	RESI DENTS		
	Cost Center Description		SERVI CES-SALAR			
		ANESTHETI STS	Y & FRINGES	PRGM COSTS		
		(ASSI GNED	APPRV	APPRV		
		TIME)	(ASSI GNED	(ASSI GNED		
			TIME)	TIME)		
	Ta construction	19. 00	21.00	22. 00		
	07956 PAVI LLI ONS	C	0	0	l l	194. 06
1	07958 OTHER NRCC	C	0	0	l l	194. 08
1	07960 COMMUNITY REHAB HOSPITAL	C	0	0	l l	194. 10
200.00	Cross Foot Adjustments				l l	200. 00
201.00	Negative Cost Centers				l l	201. 00
202. 00	Cost to be allocated (per Wkst. B,	C	712, 444	1, 056, 564	[202. 00
	Part I)					
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	l .		l l	203. 00
204.00	Cost to be allocated (per Wkst. B,	C	18, 075	26, 805		204. 00
	Part II)					
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 251349	0. 372747		205. 00
	[11]					
206. 00	NAHE adjustment amount to be allocated					206. 00
	(per Wkst. B-2)					
207. 00	NAHE unit cost multiplier (Wkst. D,				[207. 00
	Parts III and IV)		1			

Provider CCN: 15-0169

Peri od:

COMPUTATION OF RATIO OF COSTS TO CHARGES

From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 8/2/2021 3:48 pm Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30 00 03000 ADULTS & PEDIATRICS 83. 249. 127 83, 249, 127 83, 249, 127 03100 INTENSIVE CARE UNIT 12, 338, 200 12, 338, 200 0 12, 338, 200 31.00 31.00 02060 NEONATAL INTENSIVE CARE UNIT o 35.00 17, 416, 725 17, 416, 725 17, 416, 725 35.00 04000 SUBPROVI DER - I PF 3, 900, 797 40.00 3, 900, 797 0 3, 900, 797 40.00 04300 NURSERY 43.00 4, 621, 135 4, 621, 135 4, 621, 135 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 24, 658, 793 24, 658, 793 24, 658, 793 50.00 05100 RECOVERY ROOM 0 5, 437, 436 5, 437, 436 5, 437, 436 51 00 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 10, 905, 760 10, 905, 760 10, 905, 760 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 6, 274, 587 6, 274, 587 0 0 0 6, 274, 587 54.00 2, 667, 476 55.00 05500 RADI OLOGY-THERAPEUTI C 2, 667, 476 2, 667, 476 55.00 05700 CT SCAN 2, 627, 078 2, 627, 078 2, 627, 078 57.00 57.00 58.00 05800 MRI 2, 806, 943 2, 806, 943 2, 806, 943 58.00 05900 CARDIAC CATHETERIZATION 59.00 288, 492 288, 492 0 0 0 0 0 288, 492 59.00 06000 LABORATORY 14, 660, 794 14, 660, 794 14, 660, 794 60 00 60 00 64.00 06400 I NTRAVENOUS THERAPY 1, 708, 045 1, 708, 045 1, 708, 045 64.00 06500 RESPIRATORY THERAPY 6, 231, 545 6, 231, 545 6, 231, 545 65.00 65.00 06600 PHYSI CAL THERAPY 7, 996, 971 66.00 7, 996, 971 7, 996, 971 66.00 06700 OCCUPATIONAL THERAPY 2, 668, 000 67 00 2, 668, 000 0 2, 668, 000 67 00 0 68.00 06800 SPEECH PATHOLOGY 577, 341 577, 341 577, 341 68.00 69.00 06900 ELECTROCARDI OLOGY 677, 494 677, 494 0 0 0 677, 494 69.00 2, 279, 300 70 00 07000 ELECTROENCEPHALOGRAPHY 2 279 300 2, 279, 300 70 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 20, 448, 688 20, 448, 688 20, 448, 688 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 16, 594, 106 16, 594, 106 16, 594, 106 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 27, 354, 575 27, 354, 575 0 27, 354, 575 73.00 50, 109, 637 50, 109, 637 07301 SPECIALTY PHARMACY 50, 109, 637 73 01 73 01 07400 RENAL DIALYSIS 74.00 1, 419, 224 1, 419, 224 1, 419, 224 74.00 03330 ENDOSCOPY 3, 633, 757 3, 633, 757 3, 633, 757 76.00 0 76.00 76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 C 0 76.01 76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 0 76 02 0 0 76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 76.03 916, 295 916, 295 03953 WOUND CARE 0 916, 295 76.04 76.04 0 76.06 03954 I MAGING CENTER 4, 700, 149 4, 700, 149 4, 700, 149 76.06 03955 BREAST DIAGNOSTIC CENTER 11,003,660 76.07 11,003,660 11, 003, 660 76.07 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0 O 0 90 00 04950 INFUSION CENTER 297, 380 297, 380 297, 380 0 90.01 90.01 04975 SPINE CENTER 0 90.26 271, 437 271, 437 271, 437 90.26 16, 096, 913 91.00 09100 EMERGENCY 16, 096, 913 16, 096, 913 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 7, 695, 757 7, 695, 757 7, 695, 757 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 200.00 374, 533, 617 0 374, 533, 617 0 374, 533, 617 200. 00 Subtotal (see instructions) 7, 695, 757 201. 00 201.00 Less Observation Beds 7, 695, 757 7, 695, 757 202.00 366, 837, 860 366, 837, 860 366, 837, 860 202. 00 Total (see instructions)

201.00

202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0169 Peri od: Worksheet C From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 8/2/2021 3:48 pm Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 180, 394, 113 180, 394, 113 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 29, 320, 631 29, 320, 631 31.00 02060 NEONATAL INTENSIVE CARE UNIT 35.00 111, 808, 358 111, 808, 358 35.00 40.00 04000 SUBPROVIDER - IPF 9, 403, 664 9, 403, 664 40.00 04300 NURSERY 9, 906, 848 43.00 9, 906, 848 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 119, 336, 921 72, 154, 526 191 491 447 0 128772 0.000000 50.00 05100 RECOVERY ROOM 15, 557, 009 17.607.567 33, 164, 576 0.163953 0.000000 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 24, 495, 294 52 00 24, 495, 294 0.445219 0.000000 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 11, 228, 950 26,000,783 37, 229, 733 0.168537 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 13, 892, 447 23, 559, 108 37, 451, 555 0.071225 0.000000 55.00 25, 382, 373 46, 745, 264 05700 CT SCAN 0.000000 57.00 72, 127, 637 0.036423 57.00 58.00 05800 MRI 5, 539, 201 25, 794, 009 31, 333, 210 0.089584 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 4, 319, 038 13, 447 4, 332, 485 0.066588 0.000000 59.00 60.00 06000 LABORATORY 80, 078, 929 40, 872, 531 120, 951, 460 0.121212 0.000000 60.00 06400 INTRAVENOUS THERAPY 0.545327 64.00 1, 466, 616 1, 665, 530 3, 132, 146 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 29, 038, 164 1,650,379 30, 688, 543 0. 203058 0.000000 65.00 06600 PHYSI CAL THERAPY 18, 990, 859 0. 421096 0.000000 66.00 4, 521, 623 14, 469, 236 66.00 06700 OCCUPATIONAL THERAPY 2, 414, 249 6, 788, 773 0.393002 0.000000 67.00 4.374.524 67.00 06800 SPEECH PATHOLOGY 68.00 1, 492, 873 555, 281 2, 048, 154 0.281884 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 8, 356, 933 1, 439, 161 9, 796, 094 0.069160 0.000000 69.00 9, 296, 517 70.00 07000 ELECTROENCEPHALOGRAPHY 783, 674 8, 512, 843 0. 245178 0.000000 70.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 36 107 835 19 540 887 55 648 722 0 000000 71 00 0.367460 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 27, 301, 845 12, 970, 704 40, 272, 549 0.412045 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 77, 352, 280 31, 729, 192 109, 081, 472 0.250772 0.000000 73.00 73.00 73.01 07301 SPECIALTY PHARMACY 58, 430, 692 58, 430, 692 0.857591 0.000000 73.01 07400 RENAL DIALYSIS 4, 598, 982 4, 598, 982 74.00 0.308595 0.000000 74.00 76.00 03330 ENDOSCOPY 6, 410, 816 18, 282, 725 24, 693, 541 0.147154 0.000000 76.00 76. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 C 0.000000 0.000000 76.01 76 02 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0.000000 0.000000 76 02 Ω 03952 OTHER ANCILLARY SERVICE COST CENTERS 76.03 0.000000 0.000000 76.03 03953 WOUND CARE 917, 440 1, 485, 265 2, 402, 705 0.381360 0.000000 76.04 76.04 76.06 03954 I MAGING CENTER 491, 304 48, 458, 568 48, 949, 872 0.096020 0.000000 76.06 03955 BREAST DIAGNOSTIC CENTER 26, 783 24, 906, 922 24, 933, 705 76.07 0.441317 0.000000 76.07 OUTPATIENT SERVICE COST CENTERS 90.00 0.000000 0.000000 09000 CLI NI C 0 90.00 90.01 04950 INFUSION CENTER 0 446, 475 446, 475 0.666062 0.000000 90.01 90 26 04975 SPINE CENTER 393, 777 393.777 0.689317 0.000000 90 26 0 91.00 09100 EMERGENCY 37, 683, 934 117, 435, 140 155, 119, 074 0.103771 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 2, 137, 685 7, 208, 381 9, 346, 066 0.823422 0.000000 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 200.00 Subtotal (see instructions) 885, 777, 645 622, 692, 084 1, 508, 469, 729 200.00

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Less Observation Beds

Total (see instructions)

Peri od: Worksheet C
From 01/01/2020 Part I
To 12/31/2020 Date/Time Prepared: 8/2/2021 3:48 pm

INPATIENT ROUTINE SERVICE COST CENTERS 30.00 030000 ADULTS & PEDIATRICS 31.00 03100 0110 INTENSI VE CARE UNIT 33.00 03100 03100 INTENSI VE CARE UNIT 33.00 03100 03100 INTENSI VE CARE UNIT 33.00 03100 03100 INTENSI VE CARE UNIT 34.00 04000 SUBPROVIDER - IPF 44.00 04300				Title XVIII	Hospi tal	PPS
NATI ENT ROUTI NE SERVICE COST CENTERS 11.00		Cost Center Description	PPS Inpatient			
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72. 00	70.00	07000 ELECTROENCEPHALOGRAPHY	0. 245178			70.00
73. 00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 367460			71.00
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SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 114.00 11400 UTI LI ZATI ON REVIEW-SNF 114.00 114	91.00	09100 EMERGENCY	0. 103771			91. 00
113. 00 11300 INTEREST EXPENSE	92.00		0. 823422			92. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						
						113. 00
200.00 Subtotal (see instructions)	114. 00	11400 UTILIZATION REVIEW-SNF				114. 00
	200.00					200. 00
	201.00					201. 00
202.00 Total (see instructions) 202.00	202.00	Total (see instructions)				202. 00

7, 695, 757 201. 00

368, 606, 868 202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0169 Peri od: Worksheet C From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 8/2/2021 3:48 pm Title XIX Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30 00 03000 ADULTS & PEDIATRICS 84, 040, 079 84.040.079 84, 040, 079 03100 INTENSIVE CARE UNIT 12, 338, 200 12, 338, 200 0 12, 338, 200 31.00 31.00 02060 NEONATAL INTENSIVE CARE UNIT o 35.00 17, 416, 725 17, 416, 725 17, 416, 725 35.00 04000 SUBPROVI DER - I PF 0 40.00 4,668,354 4, 668, 354 4, 668, 354 40.00 04300 NURSERY 43.00 4, 621, 135 4, 621, 135 4, 621, 135 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 24, 711, 879 24, 711, 879 24, 711, 879 50.00 05100 RECOVERY ROOM 0 5, 437, 436 51 00 5, 437, 436 5, 437, 436 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 10, 905, 760 10, 905, 760 10, 905, 760 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 6, 274, 587 6, 274, 587 0 0 0 6, 274, 587 54.00 2, 667, 476 55.00 05500 RADI OLOGY-THERAPEUTI C 2, 667, 476 2, 667, 476 55.00 05700 CT SCAN 2, 627, 078 2, 627, 078 2, 627, 078 57.00 57.00 58.00 05800 MRI 2, 806, 943 2, 806, 943 2, 806, 943 58.00 05900 CARDIAC CATHETERIZATION 59.00 288, 492 288, 492 0 0 0 0 0 288, 492 59.00 06000 LABORATORY 14, 660, 794 14, 660, 794 14, 660, 794 60 00 60 00 64.00 06400 I NTRAVENOUS THERAPY 1, 708, 045 1, 708, 045 1, 708, 045 64.00 06500 RESPIRATORY THERAPY 6, 231, 545 6, 231, 545 6, 231, 545 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 8,027,892 8, 027, 892 8, 027, 892 66.00 06700 OCCUPATIONAL THERAPY 67 00 2, 668, 000 0 2, 668, 000 2, 668, 000 67 00 0 68.00 06800 SPEECH PATHOLOGY 577, 341 577, 341 577, 341 68.00 69.00 06900 ELECTROCARDI OLOGY 677, 494 677, 494 0 0 0 677, 494 69.00 2, 279, 300 70 00 07000 ELECTROENCEPHALOGRAPHY 2 279 300 2, 279, 300 70 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 20, 448, 688 20, 448, 688 20, 448, 688 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 16, 594, 106 16, 594, 106 16, 594, 106 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 27, 354, 575 27, 354, 575 0 27, 354, 575 73.00 50, 109, 637 50, 109, 637 07301 SPECIALTY PHARMACY 50, 109, 637 73 01 73 01 07400 RENAL DIALYSIS 74.00 1, 419, 224 1, 419, 224 1, 419, 224 74.00 03330 ENDOSCOPY 3, 633, 757 3, 633, 757 3, 633, 757 76.00 0 76.00 76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 C 0 76.01 76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 0 76 02 0 0 76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 76.03 916, 295 916, 295 03953 WOUND CARE 0 916, 295 76.04 76.04 0 76.06 03954 I MAGING CENTER 4, 700, 149 4, 700, 149 4, 700, 149 76.06 03955 BREAST DIAGNOSTIC CENTER 11,003,660 76.07 11,003,660 11, 003, 660 76.07 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0 O 0 90 00 04950 INFUSION CENTER 297, 380 297, 380 297, 380 0 90.01 90.01 04975 SPINE CENTER 0 90.26 271, 437 271, 437 271, 437 90.26 91.00 09100 EMERGENCY 16, 223, 405 16, 223, 405 16, 223, 405 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 7, 695, 757 7, 695, 757 7, 695, 757 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 200.00 376, 302, 625 0 376, 302, 625 0 376, 302, 625 200. 00 Subtotal (see instructions)

7, 695, 757

368, 606, 868

7, 695, 757

368, 606, 868

201.00

202.00

Less Observation Beds

Total (see instructions)

Provider CCN: 15-0169

Peri od:

COMPUTATION OF RATIO OF COSTS TO CHARGES

From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 8/2/2021 3:48 pm Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 180, 394, 113 180, 394, 113 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 29, 320, 631 29, 320, 631 31.00 02060 NEONATAL INTENSIVE CARE UNIT 35.00 111, 808, 358 111, 808, 358 35.00 40.00 04000 SUBPROVIDER - IPF 9, 403, 664 9, 403, 664 40.00 04300 NURSERY 9, 906, 848 43.00 9, 906, 848 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 119, 336, 921 72, 154, 526 191 491 447 0 129050 0.000000 50.00 05100 RECOVERY ROOM 15, 557, 009 17.607.567 33, 164, 576 0.163953 0.000000 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 24, 495, 294 52 00 24, 495, 294 0.445219 0.000000 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 11, 228, 950 26,000,783 37, 229, 733 0.168537 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 13, 892, 447 23, 559, 108 37, 451, 555 0.071225 0.000000 55.00 25, 382, 373 46, 745, 264 05700 CT SCAN 0.000000 57.00 72, 127, 637 0.036423 57.00 58.00 05800 MRI 5, 539, 201 25, 794, 009 31, 333, 210 0.089584 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 4, 319, 038 13, 447 4, 332, 485 0.066588 0.000000 59.00 60.00 06000 LABORATORY 80, 078, 929 40, 872, 531 120, 951, 460 0.121212 0.000000 60.00 06400 INTRAVENOUS THERAPY 0.545327 64.00 1, 466, 616 1, 665, 530 3, 132, 146 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 29, 038, 164 1,650,379 30, 688, 543 0. 203058 0.000000 65.00 06600 PHYSI CAL THERAPY 18, 990, 859 0.000000 66.00 4, 521, 623 14, 469, 236 0. 422724 66.00 06700 OCCUPATIONAL THERAPY 2, 414, 249 6, 788, 773 0.393002 0.000000 67.00 4.374.524 67.00 06800 SPEECH PATHOLOGY 68.00 1, 492, 873 555, 281 2, 048, 154 0.281884 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 8, 356, 933 1, 439, 161 9, 796, 094 0.069160 0.000000 69.00 9, 296, 517 70.00 07000 ELECTROENCEPHALOGRAPHY 783, 674 8, 512, 843 0. 245178 0.000000 70.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 36 107 835 19 540 887 55 648 722 0 000000 71 00 0.367460 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 27, 301, 845 12, 970, 704 40, 272, 549 0.412045 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 77, 352, 280 31, 729, 192 109, 081, 472 0.250772 0.000000 73.00 73.00 73.01 07301 SPECIALTY PHARMACY 58, 430, 692 58, 430, 692 0.857591 0.000000 73.01 07400 RENAL DIALYSIS 4, 598, 982 4, 598, 982 74.00 0.308595 0.000000 74.00 76.00 03330 ENDOSCOPY 6, 410, 816 18, 282, 725 24, 693, 541 0.147154 0.000000 76.00 76. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 C 0.000000 0.000000 76.01 76 02 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0.000000 0 000000 76 02 Ω 03952 OTHER ANCILLARY SERVICE COST CENTERS 76.03 0.000000 0.000000 76.03 03953 WOUND CARE 917, 440 1, 485, 265 2, 402, 705 0.381360 0.000000 76.04 76.04 76.06 03954 I MAGING CENTER 491, 304 48, 458, 568 48, 949, 872 0.096020 0.000000 76.06 03955 BREAST DIAGNOSTIC CENTER 26, 783 24, 906, 922 24, 933, 705 76.07 0.441317 0.000000 76.07 OUTPATIENT SERVICE COST CENTERS 90.00 0.000000 0.000000 09000 CLI NI C 0 90.00 90.01 04950 INFUSION CENTER 0 446, 475 446, 475 0.666062 0.000000 90.01 90 26 04975 SPINE CENTER 393, 777 393.777 0.689317 0.000000 90 26 0 91.00 09100 EMERGENCY 37, 683, 934 117, 435, 140 155, 119, 074 0.104587 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 2, 137, 685 7, 208, 381 9, 346, 066 0.823422 0.000000 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 200.00 Subtotal (see instructions) 885, 777, 645 622, 692, 084 1, 508, 469, 729 200.00 Less Observation Beds 201.00 201.00 202.00 Total (see instructions) 885, 777, 645 622, 692, 084 1, 508, 469, 729 202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2020 | Part | | Date/Time Prepared: | 8/2/2021 3: 48 pm |

					8/2/2021 3:48 pm
			Title XIX	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
	·	Ratio			
		11.00			
I NPA	ATIENT ROUTINE SERVICE COST CENTERS				
30. 00 030	00 ADULTS & PEDIATRICS				30.00
1	OO INTENSIVE CARE UNIT				31.00
	60 NEONATAL INTENSIVE CARE UNIT				35. 00
	00 SUBPROVI DER - I PF				40.00
	00 NURSERY				43.00
	I LLARY SERVI CE COST CENTERS				10. 00
	OO OPERATI NG ROOM	0. 129050			50.00
	OO RECOVERY ROOM	0. 163953			51.00
	OO DELIVERY ROOM & LABOR ROOM	0. 445219			52.00
	OO RADI OLOGY-DI AGNOSTI C	0. 168537			54.00
	OO RADI OLOGY-THERAPEUTI C	0. 071225			55. 00
	00 CT SCAN	0. 036423			57. 00
	OO MRI	0. 089584			58.00
1	OO CARDI AC CATHETERI ZATI ON	0. 066588			59. 00
	00 LABORATORY	0. 121212			60. 00
	00 INTRAVENOUS THERAPY	0. 545327			64. 00
	00 RESPI RATORY THERAPY	0. 203058			65. 00
	00 PHYSI CAL THERAPY	0. 422724			66. 00
	00 OCCUPATI ONAL THERAPY	0. 393002			67. 00
	00 SPEECH PATHOLOGY	0. 281884			68. 00
	00 ELECTROCARDI OLOGY	0. 069160			69. 00
70. 00 070	00 ELECTROENCEPHALOGRAPHY	0. 245178			70.00
71. 00 071	OO MEDICAL SUPPLIES CHARGED TO PATIENT	0. 367460			71. 00
72. 00 072	OO IMPL. DEV. CHARGED TO PATIENTS	0. 412045			72. 00
73. 00 073	OO DRUGS CHARGED TO PATIENTS	0. 250772			73. 00
73. 01 073	01 SPECIALTY PHARMACY	0. 857591			73. 01
74.00 074	OO RENAL DIALYSIS	0. 308595			74.00
76. 00 033	30 ENDOSCOPY	0. 147154			76.00
76. 01 039	50 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000			76. 01
	51 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000			76. 02
	52 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000			76. 03
	53 WOUND CARE	0. 381360			76. 04
	54 I MAGI NG CENTER	0. 096020			76. 06
	55 BREAST DI AGNOSTI C CENTER	0. 441317			76. 07
	PATIENT SERVICE COST CENTERS	0. 111017			70.07
	OO CLINIC	0. 000000			90.00
	50 I NFUSION CENTER	0. 666062			90. 01
	75 SPINE CENTER	0. 689317			90. 26
	OO EMERGENCY	0. 009317			91.00
1	OO OBSERVATION BEDS (NON-DISTINCT PART	0. 104587			92.00
	CIAL PURPOSE COST CENTERS	U. 023422			92.00
	OO INTEREST EXPENSE				113. 00
	•				•
	00 UTI LI ZATI ON REVI EW-SNF				114.00
200.00	Subtotal (see instructions)				200. 00
201.00	Less Observation Beds				201. 00
202. 00	Total (see instructions)	1			202. 00

						8/2/2021 3:48	pm
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost		Operating Cost	Capi tal	Operating Cost	
		(Wkst. B, Part			Reduction	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col . 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	24, 711, 879	4, 245, 615		0	0	
	05100 RECOVERY ROOM	5, 437, 436	586, 369		0		51. 00
	05200 DELIVERY ROOM & LABOR ROOM	10, 905, 760	1, 429, 026		0		
	05400 RADI OLOGY-DI AGNOSTI C	6, 274, 587	803, 282		0	0	
	05500 RADI OLOGY-THERAPEUTI C	2, 667, 476	808, 874		0	0	
	05700 CT SCAN	2, 627, 078	345, 421		0	0	57. 00
58. 00	05800 MRI	2, 806, 943	494, 343		0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	288, 492	9, 033		0	0	59. 00
60.00	06000 LABORATORY	14, 660, 794	611, 276		0	0	60.00
	06400 I NTRAVENOUS THERAPY	1, 708, 045	262, 856		0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	6, 231, 545	583, 146		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	8, 027, 892	1, 302, 505		0	0	66. 00
	06700 OCCUPATIONAL THERAPY	2, 668, 000	145, 180		0	0	67. 00
	06800 SPEECH PATHOLOGY	577, 341	31, 242		0	0	68. 00
	06900 ELECTROCARDI OLOGY	677, 494	17, 673		0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	2, 279, 300	445, 796		0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	20, 448, 688	1, 378, 681		0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	16, 594, 106	1, 119, 267		0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	27, 354, 575	1, 693, 798		0	0	73. 00
	07301 SPECIALTY PHARMACY	50, 109, 637	1, 502, 767		0	0	73. 01
	07400 RENAL DI ALYSI S	1, 419, 224	38, 983		0	0	
	03330 ENDOSCOPY	3, 633, 757	665, 306		0	0	76. 00
	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 01
	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 02
	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 03
	03953 WOUND CARE	916, 295	134, 135		0	0	76. 04
	03954 I MAGI NG CENTER	4, 700, 149	1, 011, 148		0	0	76. 06
	03955 BREAST DIAGNOSTIC CENTER	11, 003, 660	693, 992	10, 309, 668	0	0	76. 07
	OUTPATIENT SERVICE COST CENTERS					_	
	09000 CLI NI C	0	0		0		
	04950 INFUSION CENTER	297, 380	90, 644		0	1	
	04975 SPI NE CENTER	271, 437	7, 336		0	0	
	09100 EMERGENCY	16, 223, 405	1, 392, 894		0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	7, 695, 757	810, 009	6, 885, 748	0	0	92. 00
	SPECIAL PURPOSE COST CENTERS			T		T	
	11300 INTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW-SNF	050 010 1	00 //0 ===	000 553 553	=	_	114.00
200.00		253, 218, 132	22, 660, 597		0	•	200. 00
201.00	l	7, 695, 757	810, 009		0		201. 00
202. 00	Total (line 200 minus line 201)	245, 522, 375	21, 850, 588	223, 671, 787	0	J 0	202. 00

Heal th Financial Systems COMMUNITY HOSPIT CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF Period: Worksheet C From 01/01/2020 Part II To 12/31/2020 Date/Time Prepared: 8/2/2021 3:48 pm Provi der CCN: 15-0169 REDUCTIONS FOR MEDICALD ONLY

						8/2/2021 3:48 pm
			Ti tl	e XIX	Hospi tal	PPS
	Cost Center Description	Cost Net of	Total Charges	Outpatient		
	0001 0011101 20001 pt on	Capital and	(Worksheet C,	Cost to Chara	10	
		Operating Cost			D	
		Reducti on	8)	/ col. 7)		
		6. 00	7. 00	8. 00		
	ANCILLARY SERVICE COST CENTERS	•			<u> </u>	
50.00	05000 OPERATING ROOM	24, 711, 879	191, 491, 447	0. 12905	:0	50.00
				1		
51. 00	05100 RECOVERY ROOM	5, 437, 436		1		51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	10, 905, 760	24, 495, 294	0. 44521	9	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 274, 587	37, 229, 733	0. 16853	37	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	2, 667, 476	37, 451, 555	0. 07122	25	55.00
57. 00	05700 CT SCAN	2, 627, 078				57. 00
58. 00	05800 MRI	2, 806, 943	l '			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	288, 492				59. 00
60.00	06000 LABORATORY	14, 660, 794	120, 951, 460	0. 12121	2	60.00
64.00	06400 I NTRAVENOUS THERAPY	1, 708, 045	3, 132, 146	0. 54532	7	64.00
65. 00	06500 RESPI RATORY THERAPY	6, 231, 545	l '	1		65. 00
	1		l '	1		
66. 00	06600 PHYSI CAL THERAPY	8, 027, 892	1			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	2, 668, 000	6, 788, 773			67. 00
68.00	06800 SPEECH PATHOLOGY	577, 341	2, 048, 154	0. 28188	34	68. 00
69.00	06900 ELECTROCARDI OLOGY	677, 494	9, 796, 094	0. 06916	0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	2, 279, 300	1			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT					71.00
		20, 448, 688				
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	16, 594, 106	1			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	27, 354, 575	109, 081, 472	0. 25077	'2	73.00
73. 01	07301 SPECIALTY PHARMACY	50, 109, 637	58, 430, 692	0. 85759	71	73. 01
74.00	07400 RENAL DI ALYSI S	1, 419, 224	l		5	74.00
76.00	03330 ENDOSCOPY	3, 633, 757		1		76.00
		3,033,737	1	1		
76. 01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	C			76. 01
76. 02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	C	0.00000	00	76. 02
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	C	0.00000	00	76. 03
76. 04	03953 WOUND CARE	916, 295	2, 402, 705	0. 38136	0	76. 04
	03954 I MAGI NG CENTER	4, 700, 149				76. 06
76. 07	03955 BREAST DI AGNOSTI C CENTER	11, 003, 660	24, 933, 705	0. 44131	/	76. 07
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C	0			00	90.00
90. 01	04950 INFUSION CENTER	297, 380	446, 475	0. 66606	2	90. 01
90. 26	04975 SPINE CENTER	271, 437				90. 26
91. 00	09100 EMERGENCY	16, 223, 405	l	1		91.00
	1 1		l '			
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	7, 695, 757	9, 346, 066	0. 82342	[2]	92. 00
	SPECIAL PURPOSE COST CENTERS			1		
	11300 I NTEREST EXPENSE			1		113. 00
114.00	11400 UTILIZATION REVIEW-SNF			1		114. 00
200.00	Subtotal (sum of lines 50 thru 199)	253, 218, 132	1, 167, 636, 115			200. 00
201.00		7, 695, 757		1		201. 00
	1		1, 167, 636, 115			202. 00
202.00	Total (line 200 minus line 201)	245, 522, 375	1, 107, 030, 115	1	I I	J202. 00

Health Financial Systems COMM	UNITY HOSPITAL	OF INDIANA, IN	NC.	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 01/01/2020 To 12/31/2020	8/2/2021 3:48	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	8, 762, 336		-,			
31.00 INTENSIVE CARE UNIT	1, 600, 336		1, 600, 33	6, 562	243. 88	31.00
35.00 NEONATAL INTENSIVE CARE UNIT	1, 684, 119		1, 684, 11	9 13, 390	125. 77	35. 00
40. 00 SUBPROVI DER - I PF	321, 701	0	321, 70	1 4, 029	79. 85	40. 00
43. 00 NURSERY	587, 945		587, 94	5 7, 288	80. 67	43.00
200.00 Total (lines 30 through 199)	12, 956, 437		12, 956, 43	7 90, 841		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	15, 397	2, 264, 745				30.00
31.00 INTENSIVE CARE UNIT	1, 723	420, 205				31.00
35.00 NEONATAL INTENSIVE CARE UNIT	0	0				35. 00
40. 00 SUBPROVI DER - I PF	2, 038	162, 734				40.00
43. 00 NURSERY	0	l	1			43. 00
200.00 Total (lines 30 through 199)	19, 158	2, 847, 684				200. 00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-0169 Peri od: Worksheet D From 01/01/2020 Part II Date/Time Prepared: 12/31/2020 8/2/2021 3:48 pm Title XVIII Hospi tal Capital Costs Cost Center Description Capi tal Total Charges Ratio of Cost Inpati ent to Charges (from Wkst. C. (column 3 x Related Cost Program (from Wkst. B. column 4) Part I. col. (col. 1 ÷ col Charges 2) Part II, col. 8) 26) 2.00 3.00 4.00 5.00 1.00 ANCILLARY SERVICE COST CENTERS 4, 245, 615 50.00 05000 OPERATING ROOM 191, 491, 447 0.022171 35, 061, 252 777. 343 50.00 51.00 05100 RECOVERY ROOM 586, 369 33, 164, 576 0.017681 3, 841, 944 67, 929 51.00 05200 DELIVERY ROOM & LABOR ROOM 1, 429, 026 24, 495, 294 0.058339 52.00 52.00 05400 RADI OLOGY-DI AGNOSTI C 803, 282 37, 229, 733 0.021576 2, 841, 842 54.00 61.316 54.00 05500 RADI OLOGY-THERAPEUTI C 5, 911, 449 55.00 808.874 37, 451, 555 0.021598 127, 675 55.00 57.00 05700 CT SCAN 345, 421 72, 127, 637 0.004789 8, 754, 808 41, 927 57.00 58.00 05800 MRI 494, 343 31, 333, 210 0.015777 1, 688, 673 26, 642 58.00 3, 882 59.00 05900 CARDIAC CATHETERIZATION 0.002085 1, 862, 009 9 033 4 332 485 59 00 23, 187, 288 06000 LABORATORY 120, 951, 460 60.00 611, 276 0.005054 117, 189 60.00 64.00 06400 I NTRAVENOUS THERAPY 262, 856 3, 132, 146 0.083922 374, 455 31, 425 64.00 06500 RESPIRATORY THERAPY 65.00 583, 146 30, 688, 543 0.019002 5, 445, 653 103, 478 65.00 06600 PHYSI CAL THERAPY 118, 278 18, 990, 859 0.068586 1, 724, 519 66 00 1 302 505 66 00 67.00 06700 OCCUPATIONAL THERAPY 145, 180 6, 788, 773 0.021385 1, 415, 133 30, 263 67.00 06800 SPEECH PATHOLOGY 2, 048, 154 68.00 31, 242 0.015254 420, 667 6, 417 68.00 9, 796, 094 06900 ELECTROCARDI OLOGY 0.001804 5. 244 69.00 69 00 17 673 2, 906, 905 206, 987 70.00 07000 ELECTROENCEPHALOGRAPHY 445, 796 9, 296, 517 0.047953 9, 926 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 378, 681 55, 648, 722 0.024775 7, 161, 730 177, 432 71.00 11, 317, 948 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 119, 267 40, 272, 549 0.027792 314, 548 72.00 07300 DRUGS CHARGED TO PATIENTS 19, 005, 618 73 00 1, 693, 798 109, 081, 472 0.015528 295, 119 73 00 07301 SPECIALTY PHARMACY 73.01 1, 502, 767 58, 430, 692 0.025719 0 73.01 07400 RENAL DIALYSIS 38, 983 4, 598, 982 0.008476 1, 855, 217 15, 725 74.00 74.00 76.00 03330 ENDOSCOPY 665, 306 24, 693, 541 0.026943 2, 520, 790 67, 918 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 76.01 76.01 0 0 0 76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 0.000000 0 0 76.02 03952 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 76.03 0 76.03 03953 WOUND CARE 349, 744 76.04 134, 135 2, 402, 705 0.055827 19.525 76.04 41, 960 03954 I MAGING CENTER 48, 949, 872 76.06 1, 011, 148 0.020657 867 76.06 03955 BREAST DIAGNOSTIC CENTER 693, 992 24, 933, 705 0.027833 1, 384 76.07 76.07 39 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.000000 90.00 0 04950 INFUSION CENTER 90, 644 446, 475 90 01 0.203021 0 0 90 01 04975 SPINE CENTER 7, 336 393, 777 0.018630 90.26 91.00 09100 EMERGENCY 1, 392, 894 155, 119, 074 0.008980 12, 376, 254 111, 139 91.00 810, 009 106, 836 92. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 9, 346, 066 1, 232, 709 0.086668 22, 660, 597 1, 167, 636, 115 200.00 Total (lines 50 through 199) 151, 506, 938 2, 638, 082 200. 00

Heal th Financial	Systems	COMMUNI T	Y HOSPITAL OF	I NDI ANA,	INC.	In Lie	u of Form CMS-2552-10

Health Financial Systems	COMMUNITY HOSPITAL	OF INDIANA, IN	NC.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	R PASS THROUGH COS		F	eriod: rom 01/01/2020 o 12/31/2020	8/2/2021 3:48	pared: pm
			XVIII	Hospi tal	PPS	
Cost Center Description		Nursing School			All Other	
	Post-Stepdown		Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	0	0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35. 00
40. 00 04000 SUBPROVI DER - I PF	0	0	0	0	0	40. 00
43. 00 04300 NURSERY		0	0	0	0	43. 00
200.00 Total (lines 30 through 199)		0	l 0	0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
'	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,		,	o ,	
	instructions)	minus col. 4)				
	4.00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDIATRICS	0	0	59, 572	0.00	15, 397	30.00
31.00 03100 INTENSIVE CARE UNIT		0	6, 562	0.00	1, 723	31. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT		0	13, 390	0.00	0	35. 00
40. 00 04000 SUBPROVI DER - I PF		0	4, 029	0.00	2, 038	40. 00
43. 00 04300 NURSERY		0	7, 288	0.00	0	43.00
200.00 Total (lines 30 through 199)		0			19, 158	200.00
Cost Center Description	Inpatient					
'	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30. 00
31.00 03100 INTENSIVE CARE UNIT	0					31. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0					35. 00
40. 00 04000 SUBPROVI DER - 1 PF						40. 00
43. 00 04300 NURSERY						43. 00
200.00 Total (lines 30 through 199)						200. 00
1 (1	I				, , , , , ,

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

						8/2/2021 3:48	pm
			Titl∈	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
		Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0)	0 0	0	50. 00
51.00	05100 RECOVERY ROOM	0	0		0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	l o		0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0			0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	l 0		0	0	55. 00
57. 00	05700 CT SCAN	0			0	0	57. 00
58. 00	05800 MRI	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	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	Ö		0	0	64. 00
65. 00	06500 RESPIRATORY THERAPY	0	Ö		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	Ĭ			0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		l o			0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0			o o	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0			0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0				0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				0	71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS					0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS					0	73. 00
73. 00	07301 SPECIALTY PHARMACY					0	73. 00
74. 00	07400 RENAL DIALYSIS					0	74.00
76. 00	03330 ENDOSCOPY	0				0	76.00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS				0	0	76. 00 76. 01
76. 01	03951 OTHER ANCILLARY SERVICE COST CENTERS				0	0	76. 01
76. 02 76. 03		0			0	0	
76. 03	03952 OTHER ANCILLARY SERVICE COST CENTERS 03953 WOUND CARE	0			0		76. 03 76. 04
		0			0	0	
76. 06	03954 I MAGI NG CENTER	0	0	,	0	0	76. 06
76. 07	03955 BREAST DI AGNOSTI C CENTER	0)	0 0	0	76. 07
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	1	0		90.00
90. 01	04950 I NFUSI ON CENTER	0			0	0	90. 01
90. 26	04975 SPI NE CENTER	0	0		0	0	90. 26
91. 00	09100 EMERGENCY	0	0	ין	0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			J	0	92. 00
200.00	Total (lines 50 through 199)	0	0)	0 (C	0	200. 00

Health Financial Systems

COMMUNITY HOSPITAL OF INDIANA, INC.

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-0169
Period: From 01/01/2020 To 12/31/2020
To 12/31/2020
Part IV Date/Time Prepared: 8/2/2021 3: 48 pm

Title XVIII Hospital PPS

Cost Center Description

All Other Medical Systems
Medical Sum of cols. Sum of cols. Service (sum of cost (sum of co

Cost Center Description				Title	XVIII	Hospi tal	PPS	
Medical Education Cost S. 3, and A) Cost (sum of cols. 2, 3, and 4) Cost (sum of cols. 2, 4, 45, 244 Cost (sum of cols. 2, 4,		Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
ACILLARY SERVICE COST CENTERS			Medi cal	(sum of cols.	Outpati ent			
ANCILLARY SERVICE COST CENTERS			Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 + col.	
ANCILLARY SERVICE COST CENTERS				4)	col s. 2, 3,	8)	7)	
ANCILLARY SERVICE COST CENTERS					and 4)		(see	
ANCILLARY SERVICE COST CENTERS 0					,		instructions)	
50.00 050000 05000 050000 050000 050000 050000 050000 0500000 050000 0500000 0500000 0500000 0500000 05000000 050000000 0500000000			4.00	5. 00	6. 00	7. 00	8. 00	
51-00 05100 RECOVERY ROOM 0 0 0 33, 164, 576 0, 000000 51, 00		ANCILLARY SERVICE COST CENTERS						
52.00 05200 05200 0521 VERY ROOM & LABOR ROOM 0 0 0 0 0 24, 495, 294 0 0 0 0 0 0 0 0 0	50.00	05000 OPERATING ROOM	0	0	0	191, 491, 447	0.000000	50. 00
54.00 05400 RADI OLOGY-DI CARONSTI C	51.00	05100 RECOVERY ROOM	0	0	0	33, 164, 576	0.000000	51. 00
55.00 05500 RADI OLOGY-THERAPEUTI C	52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	24, 495, 294	0.000000	52. 00
57.00 05700 CT SCAN 0 0 0 0 0 72, 127, 637 0.000000 57.00	54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	37, 229, 733	0.000000	54.00
57.00 05700 CT SCAN 0 0 0 0 0 72, 127, 637 0.000000 57.00	55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	37, 451, 555	0.000000	55. 00
59, 00 05,900 CARDI AC CATHETERI ZATI ON 0 0 0 4, 332, 485 0, 000000 59, 00 60,000 66,000	57.00	05700 CT SCAN	0	0	0		0.000000	57. 00
59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 4, 332, 485 0, 000000 59.00	58. 00		0	0	0		0.000000	58. 00
60. 00 06000 LABORATORY 0 0 0 120, 951, 460 0 0 0 0 0 0 0 0 0	59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0			59.00
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 3, 132, 146 0.000000 64. 00 65. 00 0.000000 65. 00 0.000000 66. 00 0.000000 65. 00 0.000000 66. 00 0.000000 66. 00 0.000000 66. 00 0.000000 66. 00 0.000000 66. 00 0.000000 66. 00 0.000000 66. 00 0.000000 66. 00 0.000000 66. 00 0.000000 66. 00 0.000000 66. 00 0.000000 66. 00 0.000000 66. 00 0.000000 66. 00 0.000000 66. 00 0.000000 67. 00 0.0000000 67. 00 0.000000 67. 00 0.000000 67. 00 0.000000 67. 00 0.000000 67. 00 0.000000 67. 00 0.000000 67. 00 0.000000 67. 00 0.000000 67. 00 0.000000 67. 00 0.000000 67. 00 0.000000 67. 00 0.000000 67. 00 0.000000 67. 00 0.000000 67. 00 0.000000 67. 00 0.0000000 67. 00 0.0000000 67. 00 0.0000000 67. 00 0.00000000 67. 00 0.00000000 67. 00 0.00			0	0	0			
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 30, 688, 543 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 18, 990, 859 0.000000 66. 00 67. 00 06700 DCUPATIONAL THERAPY 0 0 0 0 18, 990, 859 0.000000 67. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0				
66. 00 06600 PHYSICAL THERAPY 0 0 0 0 18, 990, 859 0.000000 66. 00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0.6, 788, 773 0.000000 67. 00 68. 00 06800 SPECEH PATHOLOGY 0 0 0 0.2, 048, 154 0.000000 68. 00 06900 ELECTROCARDI OLOGY 0 0 0 0, 796, 094 0.000000 69. 00 0.000000 ELECTROCARDI OLOGY 0 0 0 9, 296, 517 0.000000 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 9, 296, 517 0.000000 71. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 55, 648, 722 0.000000 71. 00 07000 DRUGS CHARGED TO PATI ENTS 0 0 0 40, 272, 549 0.000000 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 40, 272, 549 0.000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 109, 081, 472 0.000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 58, 430, 692 0.000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 58, 430, 692 0.000000 73. 00 07400 RENAL DI ALYSI S 0 0 0 4, 598, 982 0.000000 74. 00 07400 RENAL DI ALYSI S 0 0 0 4, 598, 982 0.000000 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 4, 598, 982 0.000000 76. 00 07500 DTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 24, 693, 541 0.000000 76. 00 03950 DTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0.000000 76. 00 0.000000 76. 00 03951 DTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0.000000 76. 00 076. 00 03953 DTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0.000000 76. 00 0 0.000000 76. 00 0 0 0.000000 76. 00 0 0 0 0.000000 76. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		I I	0	0				
67. 00 06700 OCCUPATI ONAL THERAPY O O O 0 6, 788, 773 O. 000000 67. 00 68. 00 06800 SPEECH PATHOLOGY O O O O O O O 70. 00 06900 ELECTROCARDI OLOGY O O O O O O 70. 00 07000 ELECTROCARDI OLOGY O O O O O 71. 00 07000 ELECTROENCEPHALOGRAPHY O O O O O 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT O O O O 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS O O O O 73. 00 07300 DRUGS CHARGED TO PATI ENTS O O O O 74. 00 07300 DRUGS CHARGED TO PATI ENTS O O O O 75. 00 07300 DRUGS CHARGED TO PATI ENTS O O O O 76. 00 07300 SPECI ALTY PHARMACY O O O O 76. 00 03300 ENDOSCOPY O O O O 76. 01 03950 OTHER ANCI LLARY SERVI CE COST CENTERS O O O O 76. 02 03951 OTHER ANCI LLARY SERVI CE COST CENTERS O O O O 76. 04 03953 WOUND CARE O O O O O 76. 06 03954 IMAGI NG CENTER O O O O 76. 07 03955 BREAST DI AGNOSTI C CENTER O O O O 76. 07 03950 INFUSI ON CENTER O O O O 76. 08 03951 INFUSI ON CENTER O O O 76. 07 09000 OLI NI C O 76. 08 07000 O O 76. 09 07000 O 76. 09 07000			0	0	·			
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 2, 048, 154 0.000000 68. 00 69. 00 00 06900 ELECTROCARDI OLOGY 0 0 0 0 9, 796, 094 0.000000 69. 00 70. 00 70. 00 70. 00 70. 00 70. 00 0 70. 00 0 0 9, 296, 517 0.000000 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 55, 648, 722 0.000000 71. 00 72. 00 72.00 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 40, 272, 549 0.000000 73. 00 73. 00 73.00 DRUGS CHARGED TO PATIENTS 0 0 0 109, 081, 472 0.000000 73. 00 73. 01 073.01 SPECI ALTY PHARMACY 0 0 0 58, 430, 692 0.000000 73. 01 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 45, 598, 982 0.000000 74. 00 76. 01 03950 DRUGS CHARGED TO PATIENTS 0 0 0 0 45, 598, 982 0.000000 76. 01 76. 01 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 24, 693, 541 0.000000 76. 01 76. 02 03951 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 0.000000 76. 02 76. 03 03952 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0.000000 76. 03 76. 04 03953 WOUND CARE 0 0 0 0 0 0.000000 76. 03 76. 04 03953 BREAST DI AGNOSTIC CENTER 0 0 0 0 24, 933, 705 0.000000 76. 07 0000000 76. 07 0000000000			0	١				
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 9, 796, 094 0.000000 69. 00 70. 00 07000 ELECTROCEPHAL LOGRAPHY 0 0 0 0 9, 296, 517 0.000000 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 55, 648, 722 0.000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 40, 272, 549 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 109, 081, 472 0.000000 73. 00 73. 01 07301 SPECI ALTY PHARMACY 0 0 0 109, 081, 472 0.000000 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 4, 598, 982 0.000000 74. 00 76. 00 03330 ENDOSCOPY 0 0 0 24, 693, 541 0.000000 76. 00 76. 01 03950 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 24, 693, 541 0.000000 76. 00 76. 03 03952 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0.000000 76. 03 76. 04 03953 WOUND CARE 0 0 0 0 2, 402, 705 0.000000 76. 03 76. 06 03954 I MAGI NG CENTER 0 0 0 0 48, 949, 872 0.000000 76. 04 76. 07 03955 BREAST DI AGNOSTI C CENTERS 0 0 0 0 48, 949, 872 0.000000 76. 07 76. 07 03955 BREAST DI AGNOSTI C CENTERS 0 0 0 0 0 0 0 0 0.000000 76. 07 76. 07 03955 SPI NE CENTER 0 0 0 0 0 446, 475 0.000000 76. 07 76. 07 03955 SPI NE CENTER 0 0 0 0 0 0 0 0.000000 76. 07 76. 07 03950 I NEUSI ON CENTER 0 0 0 0 0 0 0.000000 76. 07 76. 07 03955 SPI NE CENTER 0 0 0 0 0 0 0.000000 76. 07 76. 07 03955 SPI NE CENTER 0 0 0 0 0 0 0.000000 76. 07 76. 07 03955 SPI NE CENTER 0 0 0 0 0 0 0.000000 76. 07 76. 07 03955 SPI NE CENTER 0 0 0 0 0 0 0 0.000000 76. 07 76. 07 03955 SPI NE CENTER 0 0 0 0 0 0 0 0 0.000000 90. 07 76. 07 90. 00 09000 BEERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 9, 346, 066 0.000000 92. 00		I I	0	١				
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 9, 296, 517 0.000000 70.00 70.00 71.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 55, 648, 722 0.000000 71.00 72.00 72.00 MPL DEV. CHARGED TO PATIENTS 0 0 0 40, 272, 549 0.000000 72.00 73.00 73.00 73.00 DRUGS CHARGED TO PATIENTS 0 0 0 109, 081, 472 0.000000 73.00 73.01 73.01 73.01 73.01 73.01 73.01 74.00				١	0			
71. 00		I I		١	0			
72.00			0	0				
73. 00			0	0	·			
73. 01 07301 SPECIALTY PHARMACY 0 0 0 58, 430, 692 0.000000 73. 01 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 4, 598, 982 0.000000 74. 00 76. 00 03330 ENDOSCOPY 0 0 0 0 0 0.000000 76. 00 76. 01 03950 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0.000000 76. 01 76. 02 03951 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0.000000 76. 01 76. 02 03952 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0.000000 76. 03 76. 04 03953 WOUND CARE 0 0 0 0.000000 76. 04 76. 06 03954 I MAGI NG CENTER 0 0 0 0.000000 76. 04 76. 06 03955 BREAST DI AGNOSTI C CENTER 0 0 0 0.000000 76. 07			0	0				
74. 00			0	0				
76. 00 03330 ENDOSCOPY 0 0 0 24, 693, 541 0.000000 76. 00 76. 01 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0.000000 76. 01 76. 02 03951 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0.000000 76. 02 76. 03 03952 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0.000000 76. 02 76. 04 03953 WOUND CARE 0 0 0 0 0.000000 76. 03 76. 04 03953 WOUND CARE 0 0 0 0 0.000000 76. 04 76. 06 03954 I MAGI NG CENTER 0 0 0 0 48, 949, 872 0.000000 76. 04 76. 07 03955 BREAST DI AGNOSTI C CENTER 0 0 0 0 24, 933, 705 0.000000 76. 06 76. 07 04950 I NFUSI ON CENTER 0 0 0 0 0 0 0.000000 76. 07 000000 CLI NI C 0 0 0 0 0 0.000000 90. 01 90. 01 04950 I NFUSI ON CENTER 0 0 0 0 446, 475 0.000000 90. 01 90. 26 04975 SPI NE CENTER 0 0 0 0 393, 777 0.000000 90. 26 91. 00 09100 EMERGENCY 0 0 0 155, 119, 074 0.000000 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 9, 346, 066 0.000000 92. 00			0	0	·			
76. 01 03950 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0.000000 76. 01 76. 02 03951 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0.000000 76. 02 76. 03 03952 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0.000000 76. 03 76. 04 03953 WOUND CARE 0 0 0 0 2, 402, 705 0.000000 76. 04 76. 06 03954 I MAGI NG CENTER 0 0 0 0 248, 949, 872 0.000000 76. 06 76. 07 OUTPATI ENT SERVI CE COST CENTERS 0 0 0 0 0 24, 933, 705 0.000000 76. 07 00 OUTPATI ENT SERVI CE COST CENTERS 0 0 0 0 0 0 0.000000 90. 01 90. 01 04950 I NFUSI ON CENTER 0 0 0 0 446, 475 0.000000 90. 01 90. 26 04975 SPI NE CENTER 0 0 0 0 393, 777 0.000000 90. 26 91. 00 09100 EMERGENCY 0 0 0 155, 119, 074 0.000000 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 9, 346, 066 0.000000 92. 00			0		· -			
76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0.000000 76. 02 76. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0.000000 76. 03 76. 04 03953 WOUND CARE 0 0 0 0 2, 402, 705 0.000000 76. 04 76. 06 03954 I MAGI NG CENTER 0 0 0 0 48, 949, 872 0.000000 76. 06 76. 07 03955 BREAST DI AGNOSTIC CENTER 0 0 0 24, 933, 705 0.000000 76. 07 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0 0 0 0.000000 90. 00 90. 01 04950 I NFUSI ON CENTER 0 0 0 0 446, 475 0.000000 90. 01 90. 26 04975 SPI NE CENTER 0 0 0 393, 777 0.000000 90. 26 91. 00 09100 EMERGENCY 0 0 0 155, 119, 074 0.000000 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 9, 346, 066 0.000000 92. 00			0			24, 073, 341		
76. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0.000000 76. 03 76. 04 03953 WOUND CARE 0 0 0 0 2, 402, 705 0.000000 76. 04 76. 06 03954 I MAGI NG CENTER 0 0 0 0 48, 949, 872 0.000000 76. 06 76. 07 03955 BREAST DI AGNOSTIC CENTER 0 0 0 0 24, 933, 705 0.000000 76. 07 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0			0		
76. 04 03953 WOUND CARE 0 0 0 2, 402, 705 0.000000 76. 04 76. 06 03954 I MAGI NG CENTER 0 0 0 0 48, 949, 872 0.000000 76. 06 76. 07 03955 BREAST DI AGNOSTIC CENTER 0 0 0 24, 933, 705 0.000000 76. 07 0000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0			0		
76. 06						2 402 705		
76. 07 03955 BREAST DIAGNOSTIC CENTER 0 0 0 24,933,705 0.000000 76. 07 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0 0 0 0 0.000000 90. 00 90. 00 90. 01 04950 INFUSION CENTER 0 0 0 446,475 0.000000 90. 01 90. 26 04975 SPINE CENTER 0 0 0 3933,777 0.000000 90. 26 91. 00 09100 EMERGENCY 0 0 0 155,119,074 0.000000 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 9,346,066 0.000000 92. 00								
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0 0 0.000000 90.00 90. 01 04950 INFUSION CENTER 0 0 0 446,475 0.000000 90.01 90. 26 04975 SPINE CENTER 0 0 0 393,777 0.000000 90.26 91. 00 09100 EMERGENCY 0 0 155,119,074 0.000000 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 9,346,066 0.000000 92.00			0	0				
90. 00 09000 CLI NI C 0 0 0 0 0.000000 90. 00 90	70.07					24, 933, 703	0.000000	76.07
90. 01 04950 INFUSION CENTER 0 0 0 446, 475 0.000000 90. 01 90. 26 04975 SPINE CENTER 0 0 0 393, 777 0.000000 90. 26 91. 00 09100 EMERGENCY 0 0 0 155, 119, 074 0.000000 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 9, 346, 066 0.000000 92. 00 092	00 00						0.00000	00 00
90. 26 04975 SPI NE CENTER 0 0 0 393, 777 0. 000000 90. 26 91. 00 09100 EMERGENCY 0 0 0 155, 119, 074 0. 000000 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 9, 346, 066 0. 000000 92. 00 0920								
91. 00 09100 EMERGENCY						•		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 9, 346, 066 0. 000000 92. 00		I I	0			•		
			0					
200.00			0					
	200.00	liotai (Tines 50 through 199)	1	l 0	l 0	1, 167, 636, 115		₁ 200. 00

Health Financial Systems COMM	MUNITY HOSPITAL (OF INDIANA, IN	NC.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provi der Co		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2020	Part IV	
				To 12/31/2020		pared:
		Ti +Lo	xVIII	Hospi tal	8/2/2021 3: 48 PPS	pm
Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
cost center bescription	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.	chai ges	Costs (col. 8		Costs (col. 9	
	,			·	,	
	7)	10. 00	x col . 10) 11.00	12. 00	x col. 12) 13.00	
ANCI LLARY SERVI CE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
50. 00 O5000 OPERATING ROOM	0. 000000	35, 061, 252		0 15, 088, 157	0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000		•		0	51.00
		3, 841, 944		-,	_	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	2, 841, 842		0 3, 691, 953	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	5, 911, 449		0 11, 179, 284	0	55. 00
57. 00 05700 CT SCAN	0. 000000	8, 754, 808	•	0 7, 875, 249		57. 00
58. 00 05800 MRI	0. 000000	1, 688, 673		0 12, 198, 633	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	1, 862, 009		0	0	59. 00
60. 00 06000 LABORATORY	0. 000000	23, 187, 288		0 6, 726, 515	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	374, 455		0 497, 309	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	5, 445, 653		0 238, 713	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 724, 519		76, 829	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 415, 133		0 16, 793	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	420, 667		5, 091	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	2, 906, 905		0 262, 426	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	206, 987		0 1, 564, 284	0	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	7, 161, 730		0 4, 261, 914	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	11, 317, 948		0 3, 492, 195	o o	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	19, 005, 618		0 12, 364, 652	0	73. 00
73. 01 07301 SPECI ALTY PHARMACY	0. 000000	17, 003, 010	•	0 12, 304, 032	0	73. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000	1, 855, 217		0 0	0	74. 00
76. 00 03330 ENDOSCOPY	0. 000000	2, 520, 790		0 4, 976, 263	0	76.00
	0. 000000				ĭ	
	1 1	0		0 0	0	76. 01
76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		-	0	76. 02
76. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0	0	76. 03
76. 04 03953 WOUND CARE	0. 000000	349, 744	•	0 413, 753	0	76. 04
76. 06 03954 I MAGI NG CENTER	0. 000000	41, 960		0 12, 701, 121	0	76. 06
76. 07 03955 BREAST DIAGNOSTIC CENTER	0. 000000	1, 384		0 2, 724, 246	0	76. 07
OUTPATIENT SERVICE COST CENTERS	, ,					
90. 00 09000 CLI NI C	0. 000000	0	1	0	0	90. 00
90. 01 04950 I NFUSI ON CENTER	0. 000000	0		0 278, 166		90. 01
90. 26 04975 SPI NE CENTER	0. 000000	0		0	0	90. 26
91. 00 09100 EMERGENCY	0. 000000	12, 376, 254		0 13, 482, 398	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	1, 232, 709		0 3, 972, 704	0	92. 00
200.00 Total (lines 50 through 199)		151, 506, 938		0 120, 337, 170	0	200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0169 Peri od: Worksheet D From 01/01/2020 Part V Date/Time Prepared: 12/31/2020 8/2/2021 3:48 pm Title XVIII Hospi tal Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 128772 15, 088, 157 17, 781 1, 942, 932 50.00 51.00 05100 RECOVERY ROOM 0. 163953 0 51.00 2, 248, 522 C 368, 652 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 0 445219 52 00 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.168537 3, 691, 953 0 622, 231 54.00 05500 RADI OLOGY-THERAPEUTI C 0.071225 11, 179, 284 796, 245 55.00 57.00 05700 CT SCAN 0.036423 7.875.249 0 0 286, 840 57 00 05800 MRI 0 58.00 0.089584 12, 198, 633 1, 092, 802 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.066588 0 59.00 06000 LABORATORY 60.00 0. 121212 6, 726, 515 0 0 815, 334 60.00 497, 309 0 06400 INTRAVENOUS THERAPY 271, 196 64 00 0 545327 64 00 0 65.00 06500 RESPIRATORY THERAPY 0. 203058 238, 713 48, 473 65.00 06600 PHYSI CAL THERAPY 0. 421096 0 32, 352 66.00 76, 829 66.00 0 06700 OCCUPATIONAL THERAPY 0.393002 16, 793 0 67.00 6.600 67.00 06800 SPEECH PATHOLOGY 0 5, 091 1, 435 68.00 0 281884 68 00 69.00 06900 ELECTROCARDI OLOGY 0.069160 262, 426 0 0 18, 149 69.00 07000 ELECTROENCEPHALOGRAPHY 0. 245178 0 70.00 1, 564, 284 383, 528 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.367460 4, 261, 914 0 0 1, 566, 083 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 0.412045 3, 492, 195 0 1, 438, 941 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 250772 12, 364, 652 0 52, 560 3, 100, 709 73.00 07301 SPECIALTY PHARMACY 0 73.01 0.857591 0 0 73.01 07400 RENAL DIALYSIS 74.00 0.308595 0 0 74.00 0 03330 ENDOSCOPY 4, 976, 263 76.00 0.147154 5.927 732, 277 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 0 76.01 76.01 0 0 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 76. 02 0.000000 0 76.02 οl 03952 OTHER ANCILLARY SERVICE COST CENTERS 0 76.03 0.000000 76.03 0 0 0 76.04 03953 WOUND CARE 0.381360 413, 753 157, 789 76.04 03954 I MAGING CENTER 0.096020 12, 701, 121 1, 219, 562 76.06 76.06 0. 441317 2, 724, 246 76. 07 03955 BREAST DIAGNOSTIC CENTER 0 1, 202, 256 76.07 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 0 0 90.00 0 o 90. 01 04950 INFUSION CENTER 0.666062 278, 166 185, 276 90.01 04975 SPINE CENTER 0.689317 0 90.26 90. 26 0 91.00 09100 EMERGENCY 0. 103771 13, 482, 398 0 0 1, 399, 082 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.823422 3, 972, 704 3, 271, 212 92.00 200.00 Subtotal (see instructions) 23, 708 52, 560 200.00 120, 337, 170 20, 959, 956 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 120, 337, 170 23, 708 52, 560 20, 959, 956 202. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0169 Peri od: Worksheet D From 01/01/2020 Part V Date/Time Prepared: 12/31/2020 8/2/2021 3:48 pm Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 290 0 50.00 51.00 05100 RECOVERY ROOM 0 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 52 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 55.00 57.00 05700 CT SCAN 00000000000000000 0 57.00 05800 MRI 0 58.00 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 06000 LABORATORY 0 60.00 60.00 06400 I NTRAVENOUS THERAPY 0 64 00 64 00 65.00 06500 RESPIRATORY THERAPY 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72 00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 13, 181 73.00 07301 SPECIALTY PHARMACY 73.01 73.01 0 07400 RENAL DIALYSIS 74.00 0 74.00 03330 ENDOSCOPY 76.00 872 0 76.00 76. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 76.01 0 0 0 03951 OTHER ANCILLARY SERVICE COST CENTERS 76. 02 0 76.02 03952 OTHER ANCILLARY SERVICE COST CENTERS 76.03 0 76.03 76. 04 03953 WOUND CARE 0 76.04 76.06 03954 I MAGING CENTER 0 76.06 03955 BREAST DIAGNOSTIC CENTER 76. 07 76.07 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 04950 INFUSION CENTER 0 90. 01 0 90.01 04975 SPINE CENTER 90. 26 0 90.26 0 91. 00 | 09100 | EMERGENCY 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 200.00 Subtotal (see instructions) 200.00 3.162 13, 181

3, 162

13, 181

201. 00

202.00

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

	MUNITY HOSPITAL				eu of Form CMS-:	2552-
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C		Peri od: From 01/01/2020	Worksheet D Part II	
		Component		To 12/31/2020	Date/Time Pre	pared
		· ·			8/2/2021 3:48	g'pm_
		Titl€	e XVIII	Subprovi der -	PPS	
Cost Center Description	Capi tal	Total Charges	Doti o of Coo	I PF t I npati ent	Capital Costs	
Cost Center Description		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,				column 4)	
	Part II, col.	8)	2)	. Charges	COT dillit 4)	
	26)					
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS			•	<u> </u>	•	
50. 00 05000 OPERATING ROOM	4, 245, 615	191, 491, 447	0. 02217	1, 645	36	50.0
1.00 05100 RECOVERY ROOM	586, 369	33, 164, 576	0. 01768	1 0	0	51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	1, 429, 026	24, 495, 294	0. 05833	9 0	0	52. (
4. 00 05400 RADI OLOGY-DI AGNOSTI C	803, 282	37, 229, 733			686	54. (
5. 00 05500 RADI OLOGY-THERAPEUTI C	808, 874		0. 02159		0	55.
7.00 05700 CT SCAN	345, 421			117, 428	562	57.
8. 00 05800 MRI	494, 343				126	
9. 00 05900 CARDI AC CATHETERI ZATI ON	9, 033				138	
0. 00 06000 LABORATORY	611, 276		1			1
4. 00 06400 I NTRAVENOUS THERAPY	262, 856					
5. 00 06500 RESPI RATORY THERAPY	583, 146				364	
6. 00 06600 PHYSI CAL THERAPY	1, 302, 505					
7. 00 06700 OCCUPATI ONAL THERAPY	145, 180			· ·	l .	
8. 00 06800 SPEECH PATHOLOGY	31, 242				67	
9. 00 06900 ELECTROCARDI OLOGY	17, 673				70	
0. 00 07000 ELECTROENCEPHALOGRAPHY	445, 796			· ·	265	
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 378, 681				594	1
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3.00 07300 DRUGS CHARGED TO PATIENTS	1, 119, 267				0	1
3.00 07300 DRUGS CHARGED TO PATIENTS 3.01 07301 SPECIALTY PHARMACY	1, 693, 798 1, 502, 767		1		6, 202 0	1
4. 00 07400 RENAL DI ALYSI S	38, 983		1		0	1
6. 00 03330 ENDOSCOPY	665, 306		1		0	
6. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS	005, 300		0.00000		0	1
6. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS			1		0	
6. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS			0.00000		0	1
6. 04 03953 WOUND CARE	134, 135	2, 402, 705			0	
6. 06 03954 I MAGI NG CENTER	1, 011, 148				0	1
6. 07 03955 BREAST DIAGNOSTIC CENTER	693, 992				1	1
OUTPATIENT SERVICE COST CENTERS	0,0,772	2.,,,,,,,,,	3. 32700	-, 0		1
0. 00 09000 CLI NI C	0) C	0.00000	0	0	90.
0. 01 04950 NFUSION CENTER	90, 644	1	1	-1	1	1
0. 26 04975 SPI NE CENTER	7, 336	1	1		Ō	1
01. 00 09100 EMERGENCY	1, 392, 894		1		3, 077	91.
22 OO O9200 OBSERVATION BEDS (NON-DISTINCT PART						92

1, 392, 894 155, 119, 074 0 9, 346, 066 21, 850, 588 1, 167, 636, 115

0. 008980 0. 000000

1, 976, 462

77 91.00 0 92.00

22, 131 200. 00

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

Health Financial Systems	COMMUNITY HOSPITAL OF	INDIANA, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE OTHER PASS	Provider CCN: 15-0169 Component CCN: 15-S169	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 8/2/2021 3:48 pm
				-

						0/2/2021 3.40	PIII
			Ti tl e	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	·	Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	C) (0	0	50.00
51.00	05100 RECOVERY ROOM	0	C) (0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C) (0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C) (0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C) (0	0	55.00
57. 00	05700 CT SCAN	0	l c) (0	0	57. 00
58. 00	05800 MRI	0	l c) (0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	l c) (0	0	59. 00
60.00	06000 LABORATORY	0	l c) (0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	C		o	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	C		o	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	C		o	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0			0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0			0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0) (0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0			0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0			0	0	73. 00
73. 01	07301 SPECIALTY PHARMACY	0			0	0	73. 01
74.00	07400 RENAL DIALYSIS	0			0	0	74. 00
	03330 ENDOSCOPY	0			0	0	76. 00
	03950 OTHER ANCILLARY SERVICE COST CENTERS	0			0	0	76, 01
	03951 OTHER ANCILLARY SERVICE COST CENTERS	0			0	0	76. 02
	03952 OTHER ANCILLARY SERVICE COST CENTERS	0			0	0	76. 03
	03953 WOUND CARE	0			0	0	76. 04
	03954 I MAGI NG CENTER	0			0	0	76. 06
	03955 BREAST DIAGNOSTIC CENTER	0	l c		0	0	76. 07
	OUTPATIENT SERVICE COST CENTERS	-	-				
90. 00	09000 CLI NI C	0	C) (0	0	90.00
	04950 INFUSION CENTER	0			ol o	0	90. 01
90. 26	04975 SPI NE CENTER	0	l .		ol o	0	90. 26
	09100 EMERGENCY	0	l d		ol o	0	ı
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	ı
200.00		0	l c		o o	_	200.00
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1	1	'			

	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI H COSTS	RVICE OTHER PASS	Component	CCN: 15-S169	Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 8/2/2021 3:48	pared:
			Titl∈	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see instructions)	
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
50. 00	05000 OPERATING ROOM	0	0	I	0 191, 491, 447	0. 000000	50.00
51.00	05100 RECOVERY ROOM	0	Ö	l .	0 33, 164, 576	l .	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	Ö	1	0 24, 495, 294		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	Ö		0 37, 229, 733		
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	Ö	1	0 37, 451, 555		
57. 00	05700 CT SCAN	0	Ö	1	0 72, 127, 637	0. 000000	
58. 00	05800 MRI	0	Ö	1	0 31, 333, 210	l	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	O	,	0 4, 332, 485		
60.00	06000 LABORATORY	0	O	,	0 120, 951, 460		60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0)	0 3, 132, 146	0.000000	64.00
65. 00	06500 RESPIRATORY THERAPY	0	0)	0 30, 688, 543	0. 000000	65.00
66. 00	06600 PHYSI CAL THERAPY	0	0		0 18, 990, 859	0. 000000	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	1	0 6, 788, 773		
68. 00	06800 SPEECH PATHOLOGY	0	0	1	0 2, 048, 154		
69. 00	06900 ELECTROCARDI OLOGY	0	0	1	0 9, 796, 094		
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	1	0 9, 296, 517	0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	0 55, 648, 722	1	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1	0 40, 272, 549	l	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 109, 081, 472	l	1
73. 01	07301 SPECIALTY PHARMACY	0	0	1	0 58, 430, 692	l	1
74.00	07400 RENAL DI ALYSI S	0	0		0 4, 598, 982	l e	1
76. 00 76. 01	03330 ENDOSCOPY 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	1	0 24, 693, 541 0 0	0.000000	1
76. 01	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	1	0 0	0. 000000 0. 000000	
	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	1	0 0	0.00000	
	03953 WOUND CARE	0	0		0 2, 402, 705	l	
76. 04	03954 I MAGI NG CENTER	0	Ö		0 48, 949, 872	0. 000000	
	03955 BREAST DIAGNOSTIC CENTER	0	Ö	l .	0 24, 933, 705	l	
. 5. 57	OUTPATIENT SERVICE COST CENTERS	<u> </u>		1	21,700,700	2. 223000	1
90. 00	09000 CLINI C	0	C		0 0	0.000000	90.00
90. 01	04950 INFUSION CENTER	0	O	l .	0 446, 475	l	
90. 26	04975 SPINE CENTER	0	O	l .	0 393, 777	0.000000	
	09100 EMERGENCY	0	O		0 155, 119, 074	l e	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	O		0 9, 346, 066	l e	
200.00	Total (lines 50 through 199)	0	O	d	0 1, 167, 636, 115	I	200.00

Heal th	Financial Systems COMI	MUNITY HOSPITAL O	F INDIANA. IN	IC.	In Lie	u of Form CMS-:	2552-10
	ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI		Provi der CO		Peri od:	Worksheet D	
THROUGH	1 COSTS		Component (CCN: 15-S169	From 01/01/2020 To 12/31/2020	Part IV Date/Time Pre 8/2/2021 3:48	
			Title	XVIII	Subprovi der – I PF	PPS	
	Cost Center Description	Outpatient Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Pass-Through	Outpatient Program Charges	Outpatient Program Pass-Through	
		(col. 6 ÷ col. 7)		Costs (col. x col. 10)	8	Costs (col. 9 x col. 12)	
		9.00	10.00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0. 000000	1, 645		0 0	0	50.00
	05100 RECOVERY ROOM	0. 000000	0		0 0	0	
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	31, 787		0 0	0	
	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	
	05700 CT SCAN	0. 000000	117, 428		0 0	0	57. 00
	05800 MRI	0. 000000	7, 959		0 0	0	
	05900 CARDI AC CATHETERI ZATI ON	0.000000	66, 264		9	0	59.00
	06000 LABORATORY	0.000000	806, 718		- 1	0	60.00
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0. 000000 0. 000000	15, 605 19, 132		0 0	0	64. 00 65. 00
	06600 PHYSI CAL THERAPY	0. 000000	53, 539			0	
	06700 OCCUPATIONAL THERAPY	0. 000000	41, 375			0	
	06800 SPEECH PATHOLOGY	0. 000000	4, 417			0	
	06900 ELECTROCARDI OLOGY	0. 000000	39, 032		0 276	0	
	07000 ELECTROENCEPHALOGRAPHY	0. 000000	5, 532			0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	23, 989			0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	20, 707		ol ol	0	
	07300 DRUGS CHARGED TO PATIENTS	0. 000000	399, 380		0 43	0	73. 00
	07301 SPECIALTY PHARMACY	0. 000000	0		ol ol	0	
74.00	07400 RENAL DIALYSIS	0. 000000	0		o o	0	74.00
76. 00	03330 ENDOSCOPY	0. 000000	0		o o	0	76. 00
76. 01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76. 01
76. 02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76. 02
	03952 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76. 03
76. 04	03953 WOUND CARE	0. 000000	0		0 0	0	76. 04
76. 06	03954 I MAGING CENTER	0. 000000	0		0 0	0	76. 06
	03955 BREAST DIAGNOSTIC CENTER	0. 000000	0		0 0	0	76. 07
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0. 000000	0		0 0	0	
	04950 I NFUSI ON CENTER	0. 000000	0		0 0	0	
	04975 SPI NE CENTER	0. 000000	0		0 0	0	
	09100 EMERGENCY	0. 000000	342, 660			0	91.00
	ACCORDING TO AN DEDC (MON DICTINGT DART	0.000000				^	00 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART Total (lines 50 through 199)	0. 000000	0 1, 976, 462		0 0 366	0	92. 00 200. 00

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

Health Financial Systems COMM	MUNITY HOSPITAL	OF INDIANA, IN	VC.	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2020		
		Component	CCN: 15-S169	To 12/31/2020	Date/Time Pre 8/2/2021 3:48	parea:
		Ti +L c	e XVIII	Subprovi der -	PPS	рш
		11116	; AVIII	I PF	PFS	
			Charges	IFI	Costs	
Cost Center Description	Cost to Charge	DDS Doimburged		Cost	PPS Services	
cost center bescription	Ratio From	Services (see		Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	(See Hist.)	
	Part I, col. 9		Subject To	Subject To		
	rait i, coi. 9		Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 O5000 OPERATI NG ROOM	0. 128772	0	ı	0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0. 128772		1	0 0		
	1			0 0	1	
	0. 445219		1		0	52.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 168537	0		0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 071225	0		0	0	55. 00
57. 00 05700 CT SCAN	0. 036423	0		0	0	57. 00
58. 00 05800 MRI	0. 089584	0	1	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 066588	0	1	0	0	59. 00
60. 00 06000 LAB0RATORY	0. 121212	47	1	0	6	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 545327	0)	0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 203058	0	1	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 421096	0	1	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 393002	0)	0 0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 281884	0)	0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 069160	276		0 0	19	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 245178	0	1	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 367460	0	1	0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 412045	0)	0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 250772	43		0 2, 224	11	73. 00
73. 01 07301 SPECIALTY PHARMACY	0. 857591	0	1	0 0	0	1
74. 00 07400 RENAL DI ALYSI S	0. 308595	l o	l .	0 0	0	74. 00
76. 00 03330 ENDOSCOPY	0. 147154	l o	1	0 0	o o	76.00
76. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0	1	0 0	0	76. 01
76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76. 02
76. 03 03952 OTHER ANCI LLARY SERVICE COST CENTERS	0. 000000	ĺ		o o	Ö	76. 03
76. 04 03953 WOUND CARE	0. 381360	٥	l .	0 0	0	76. 04
76. 06 03954 I MAGI NG CENTER	0. 096020	٥	1	0 0	0	76.04
76. 07 03955 BREAST DIAGNOSTIC CENTER	0. 441317		l .	0 0	0	
OUTPATIENT SERVICE COST CENTERS	0. 441317		1	0 0		70.07
90. 00 09000 CLI NI C	0. 000000	0	.I	0 0	0	90.00
90. 01 04950 I NFUSI ON CENTER	0. 666062		l .	0 0	0	90.00
90. 01 04950 TNF051 ON CENTER 90. 26 04975 SPI NE CENTER	0. 689317			0 0	0	
91. 00 09100 EMERGENCY	1		1	0 0	0	
· · · · · · · · · · · · · · · · · · ·	0. 103771		1		· ·	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Subtotal (see instructions)	0. 823422	0	1	0 0	0	1
		366	1	0 2, 224	36	200.00
201.00 Less PBP Clinic Lab. Services-Program				0		201. 00
Only Charges		3//		0 2 224	27	202 00
202.00 Net Charges (line 200 - line 201)	1	366	1	0 2, 224	36	202. 00

Health Financial Systems	COMMUNITY HOSPITAL OF	INDIANA, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0169 Component CCN: 15-S169	From 01/01/2020	
•		Ti +1 o V/////	Subprovi dor	DDC

		Title	× XVIII	Subprovi der -	PPS	, рш
	Cos	ts				
Cost Center Description	Cost	Cost	1			
	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 OPERATI NG ROOM	0	0				50.00
51.00 05100 RECOVERY ROOM	0	0)			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0)			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
57.00 05700 CT SCAN	0	0				57. 00
58. 00 05800 MRI	0	0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60. 00 06000 LABORATORY	0	0				60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	1			64. 00
65. 00 06500 RESPI RATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	1			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	1			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	1			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0				71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	558				73. 00
73. 01 07301 SPECIALTY PHARMACY	0	0	1			73. 01
74. 00 07400 RENAL DI ALYSI S	0	0				74.00
76. 00 03330 ENDOSCOPY	0	0				76. 00
76. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	1			76. 01
76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0				76. 02
76. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0				76. 03
76. 04 03953 WOUND CARE	0	0				76. 04
76. 06 03954 IMAGING CENTER 76. 07 03955 BREAST DIAGNOSTIC CENTER	0 0	0	1			76. 06 76. 07
OUTPATIENT SERVICE COST CENTERS	l d	0	1			76.07
90. 00 09000 CLINIC	0	0	ı.			90. 00
90. 01 04950 NFUSION CENTER		0	1			90.00
90. 26 04975 SPI NE CENTER		0				90. 26
91. 00 09100 EMERGENCY		0	1			90. 20
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0	1			91.00
200.00 Subtotal (see instructions)		558				200.00
201.00 Less PBP Clinic Lab. Services-Program		330				201.00
Only Charges						231.00
202.00 Net Charges (line 200 - line 201)	0	558				202. 00
	1 91	000	1			

Health Financial Systems COMM	UNITY HOSPITAL	OF INDIANA, IN	NC.	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 8/2/2021 3:48	
			e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capi tal Rel ated Cost	Days	Per Diem (col. 3 / col. 4)	
	Part II, col. 26)		(col . 1 - col 2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		•	1		
30. 00 ADULTS & PEDIATRICS	8, 762, 336	0	8, 762, 33	6 59, 572	147. 09	30.00
31.00 INTENSIVE CARE UNIT	1, 600, 336		1, 600, 33	6, 562	243. 88	31.00
35.00 NEONATAL INTENSIVE CARE UNIT	1, 684, 119		1, 684, 11	9 13, 390	125. 77	35. 00
40. 00 SUBPROVI DER - I PF	321, 701	0	321, 70	1 4, 029	79. 85	40.00
43. 00 NURSERY	587, 945		587, 94	5 7, 288	80. 67	43.00
200.00 Total (lines 30 through 199)	12, 956, 437		12, 956, 43	7 90, 841		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program Capital Cost				
		(col. 5 x col.				
		6)	4			
LABORT FUT DOUTLAG OFFICE OF CONT. OFFITEDO	6. 00	7. 00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.040	000 400				00.00
30. 00 ADULTS & PEDIATRICS	2, 240	329, 482				30.00
31. 00 INTENSIVE CARE UNIT	1 114	101 (10	2			31.00
35. 00 NEONATAL INTENSIVE CARE UNIT	1, 444	181, 612				35.00
40. 00 SUBPROVI DER - I PF 43. 00 NURSERY	2 200	224 521	,			40. 00 43. 00
200.00 Total (lines 30 through 199)	2, 808 6, 492		•			200.00
200. 00 Total (Titles 30 till ough 199)	0, 492	737, 615	יו			J200. 00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-0169 Peri od: Worksheet D From 01/01/2020 Part II Date/Time Prepared: 12/31/2020 8/2/2021 3:48 pm Title XIX Hospi tal PPS Capital Costs Cost Center Description Capi tal Total Charges Ratio of Cost Inpati ent (from Wkst. C, to Charges (column 3 x Related Cost Program (from Wkst. B. column 4) Part I. col. (col. 1 ÷ col Charges 2) Part II, col. 8) 26) 2.00 3.00 4.00 5.00 1.00 ANCILLARY SERVICE COST CENTERS 4, 245, 615 2, 714, 513 50.00 05000 OPERATING ROOM 191, 491, 447 0.022171 50.00 60, 183 51.00 05100 RECOVERY ROOM 586, 369 33, 164, 576 0.017681 405, 494 7, 170 51.00 05200 DELIVERY ROOM & LABOR ROOM 1, 429, 026 24, 495, 294 0.058339 552, 016 52.00 32, 204 52.00 05400 RADI OLOGY-DI AGNOSTI C 803, 282 37, 229, 733 0.021576 530, 674 11, 450 54.00 54.00 05500 RADI OLOGY-THERAPEUTI C 16, 830 55.00 808.874 37, 451, 555 0.021598 779, 244 55.00 57.00 05700 CT SCAN 345, 421 72, 127, 637 0.004789 1,000,665 4, 792 57.00 58.00 05800 MRI 494, 343 31, 333, 210 0.015777 225, 323 3, 555 58.00 59.00 05900 CARDIAC CATHETERIZATION 9.033 0.002085 4 332 485 41 898 87 59 00 06000 LABORATORY 120, 951, 460 60.00 611, 276 0.005054 3, 506, 320 17, 721 60.00 64.00 06400 I NTRAVENOUS THERAPY 262, 856 3, 132, 146 0.083922 68, 554 5, 753 64.00 06500 RESPIRATORY THERAPY 65.00 583, 146 30, 688, 543 0.019002 1, 843, 876 35, 037 65.00 06600 PHYSI CAL THERAPY 18, 990, 859 0.068586 66 00 1 302 505 121, 257 8.317 66 00 67.00 06700 OCCUPATIONAL THERAPY 145, 180 6, 788, 773 0.021385 170, 175 3, 639 67.00 06800 SPEECH PATHOLOGY 2, 048, 154 0.015254 68.00 31, 242 89, 041 1, 358 68.00 9, 796, 094 06900 ELECTROCARDI OLOGY 0.001804 296, 953 69 00 17,673 536 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 445, 796 9, 296, 517 0.047953 64, 562 3,096 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 378, 681 55, 648, 722 0.024775 1, 614, 721 40,005 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 119, 267 40, 272, 549 0.027792 72.00 0 07300 DRUGS CHARGED TO PATIENTS 2, 992, 487 73 00 1, 693, 798 109, 081, 472 0.015528 73 00 46.467 07301 SPECIALTY PHARMACY 73.01 1, 502, 767 58, 430, 692 0.025719 0 73.01 07400 RENAL DIALYSIS 38, 983 4, 598, 982 0.008476 227, 358 1, 927 74.00 74.00 76.00 03330 ENDOSCOPY 665, 306 24, 693, 541 0.026943 201, 930 5, 441 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 76.01 0 0 Ω 76.01 76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0.000000 0 0 76.02 03952 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 76.03 0 76.03 03953 WOUND CARE 76.04 134, 135 2, 402, 705 0.055827 33, 594 1,875 76.04 03954 I MAGING CENTER 48, 949, 872 0.020657 76.06 1, 011, 148 0 0 76.06 03955 BREAST DIAGNOSTIC CENTER 693, 992 24, 933, 705 0.027833 0 76.07 76.07 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.000000 90.00 0 0 04950 INFUSION CENTER 90, 644 446, 475 0 203021 90 01 0 0 90 01 04975 SPINE CENTER 7, 336 393, 777 0.018630 90. 26 91.00 09100 EMERGENCY 1, 392, 894 155, 119, 074 0.008980 1, 512, 007 13, 578 91.00 810, 009 20, 537 92. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 9, 346, 066 236, 965 0.086668 22, 660, 597 1, 167, 636, 115 200.00 Total (lines 50 through 199) 19, 229, 627 341, 558 200. 00

Health Financial Systems	COMMUNITY HOSPITAL	OF INDIANA, IN	NC.	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	R PASS THROUGH COS		F	Period: From 01/01/2020 To 12/31/2020	8/2/2021 3:48	pared:
			e XIX	Hospi tal	PPS	
Cost Center Description		Nursing School			All Other	
	Post-Stepdown		Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00 03000 ADULTS & PEDIATRICS	0	0	C	0	0	
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	0	C	0	0	35. 00
40. 00 04000 SUBPROVI DER - 1 PF	0	0	C	0	0	40. 00
43. 00 04300 NURSERY	0	0	C	0	0	43.00
200.00 Total (lines 30 through 199)	0	0	C	0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
·	Adj ustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4. 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	0	59, 572	0.00	2, 240	30.00
31.00 03100 INTENSIVE CARE UNIT		0	6, 562	0.00	0	31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT		0	13, 390	0.00	1, 444	35. 00
40. 00 04000 SUBPROVI DER - 1 PF		0	4, 029	0.00	0	40.00
43. 00 04300 NURSERY		0	7, 288	0.00	2, 808	43.00
200.00 Total (lines 30 through 199)		0	90, 841		6, 492	200. 00
Cost Center Description	I npati ent					
·	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT						31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT						35. 00
40. 00 04000 SUBPROVI DER - 1 PF						40.00
43. 00 04300 NURSERY	1 0					43. 00
200.00 Total (lines 30 through 199)						200. 00
(-	'	I				

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

						8/2/2021 3: 48	pm
				e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
		Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0	0	50.00
51.00	05100 RECOVERY ROOM	0	0)	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	Ö	1	0	0	55.00
57.00	05700 CT SCAN	0	l o)	0 0	0	57.00
58. 00	05800 MRI	0	d)	0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	l o)	0 0	0	59. 00
60.00	06000 LABORATORY	0	o)	0 0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	Ó)	0 0	ol	64.00
65. 00	06500 RESPIRATORY THERAPY	0	Ó	,	0 0	o	65.00
66. 00	06600 PHYSI CAL THERAPY	0	O	,	0 0	o	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	Ö	,	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	Ö	,	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	Ö	,	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	Ö	,	0	Ö	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	Ö		0	o o	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	Ö		0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	Ô		0	0	73. 00
73. 01	07301 SPECIALTY PHARMACY	0	Ö			0	73. 01
	07400 RENAL DIALYSIS	0	Ö			l o	74. 00
76. 00	03330 ENDOSCOPY	0	Ö		0	0	76.00
76. 01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	Ö		0	0	76. 01
76. 02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	Ö		0	0	76. 02
76. 02	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	Ö		0	0	76. 03
	03953 WOUND CARE	0	Ö			0	76. 04
76. 06	03954 I MAGI NG CENTER	0	Ö		0 0	0	76. 06
	03955 BREAST DIAGNOSTIC CENTER	0			0 0	0	76. 07
70.07	OUTPATIENT SERVICE COST CENTERS			1	0	0	70.07
90. 00	09000 CLINIC	0	0	I	0 0	0	90. 00
90. 00	04950 I NFUSI ON CENTER	0			0 0	0	90. 00
90. 26	04975 SPINE CENTER	0				0	90. 26
91. 00	09100 EMERGENCY						91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
200.00	1 1		O		0 0		200. 00
200.00	/ I Total (ITHES 50 thi bugh 177)	ı	٠ -	1	0	١	200.00

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0169 Peri od: Worksheet D From 01/01/2020 To 12/31/2020 THROUGH COSTS Part IV Date/Time Prepared: 8/2/2021 3:48 pm Title XIX Hospi tal Ratio of Cost Cost Center Description All Other Total Cost Total Total Charges to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col 4) 8) col s. 2, 3, 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 191, 491, 447 0.00000050.00 000000000000000000000000000000 05100 RECOVERY ROOM 0 0 33, 164, 576 0.000000 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 24, 495, 294 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 37, 229, 733 54 00 0.000000 54 00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 37, 451, 555 0.000000 55.00 57. 00 05700 CT SCAN 72, 127, 637 0.000000 57.00 31, 333, 210 58.00 05800 MRI 0 0 0.000000 58 00 05900 CARDIAC CATHETERIZATION 0 0 59.00 4, 332, 485 0.000000 59.00 60.00 06000 LABORATORY 120, 951, 460 0.000000 60.00 64.00 06400 I NTRAVENOUS THERAPY 0 3, 132, 146 0.000000 64.00 06500 RESPIRATORY THERAPY 0 30 688 543 0.000000 65 00 65 00 66.00 06600 PHYSI CAL THERAPY 0 18, 990, 859 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 6, 788, 773 0.000000 67.00 67.00 06800 SPEECH PATHOLOGY 0 2, 048, 154 0.000000 68.00 68.00 9, 796, 094 06900 ELECTROCARDI OLOGY 0 69 00 0.000000 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 9, 296, 517 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 55, 648, 722 0.000000 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 40, 272, 549 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 109, 081, 472 73.00 0.000000 73.00 73. 01 07301 SPECIALTY PHARMACY 58, 430, 692 0.000000 73.01 07400 RENAL DIALYSIS 4, 598, 982 0.000000 74.00 74.00 03330 ENDOSCOPY 76.00 0 24, 693, 541 0.000000 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0.000000 76.01 76 01 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0.000000 76.02 76.02 03952 OTHER ANCILLARY SERVICE COST CENTERS 76. 03 0 0 0.000000 76.03 03953 WOUND CARE 0 0 2, 402, 705 0.000000 76.04 76.04 03954 I MAGING CENTER 0 76.06 0 48, 949, 872 0.000000 76.06 03955 BREAST DIAGNOSTIC CENTER 24, 933, 705 0.000000 76.07 0 76.07 OUTPATIENT SERVICE COST CENTERS

0

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446, 475

393, 777

155, 119, 074

1, 167, 636, 115

9, 346, 066

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90. 26

91.00

92.00

200.00

90 00

90. 01

200.00

09000 CLINIC

90. 26 04975 SPINE CENTER

91. 00 09100 EMERGENCY

04950 INFUSION CENTER

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

Heal th Financial Systems COMMUNITY HOSPITAL OF APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS | Peri od: | Worksheet D | From 01/01/2020 | Part IV | To 12/31/2020 | Date/Time Prepared: Provi der CCN: 15-0169 THROUGH COSTS

					10 12/31/2020	8/2/2021 3:48	
			Titl	e XIX	Hospi tal	PPS	<u> </u>
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	'	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.	_	Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11. 00	12.00	13.00	
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	2, 714, 513		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	405, 494		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	552, 016		0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	530, 674		0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	779, 244		0	0	55.00
57.00	05700 CT SCAN	0. 000000	1, 000, 665		0	0	57. 00
58.00	05800 MRI	0. 000000	225, 323		0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	41, 898		0 0	0	59. 00
60.00	06000 LABORATORY	0. 000000	3, 506, 320		0 0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	68, 554		0 0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 000000	1, 843, 876		0 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	121, 257		0 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	170, 175		0 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 000000	89, 041		0 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	296, 953		0 0	0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	64, 562		0 0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	1, 614, 721		0 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	2, 992, 487		0 0	0	73. 00
73. 01	07301 SPECIALTY PHARMACY	0. 000000	0		0	0	73. 01
74. 00	07400 RENAL DIALYSIS	0. 000000	227, 358		0 0	0	74. 00
76. 00	03330 ENDOSCOPY	0. 000000	201, 930		0 0	0	76. 00
76. 01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76. 01
76. 02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76. 02
76. 03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76. 03
76. 04	03953 WOUND CARE	0. 000000	33, 594		0 0	0	76. 04
76. 06	03954 I MAGI NG CENTER	0. 000000	00,071	i	0 0	0	76.06
76. 07	03955 BREAST DIAGNOSTIC CENTER	0. 000000	0		0 0	0	76. 07
70.07	OUTPATIENT SERVICE COST CENTERS	0.000000			<u> </u>		7 0. 07
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90.00
90. 01	04950 INFUSION CENTER	0. 000000	0	•	0 0	0	90. 01
90. 26	04975 SPI NE CENTER	0. 000000	0		0 0	0	90. 26
91. 00	09100 EMERGENCY	0. 000000	1, 512, 007		0 0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	236, 965		0 0	0	92.00
200.00		3. 333300	19, 229, 627		0 0		200.00
	1.222 (1	.,,,, 02,	1	-1		1-30.00

						8/2/2021 3:48	piii
			Ti tl	e XIX	Hospi tal	PPS	
				Charges		Costs	
	Cook Cooker Dooreitstier	C+ +- Ch	DDC D-!		C+		
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
		lart I, cor. /					
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0. 129050	0	1, 402, 919	0	0	50.00
						_	
51. 00	05100 RECOVERY ROOM	0. 163953	0	,		0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 445219	0	(0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 168537	0	923, 311	ıl ol	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 071225	l o	424, 927		0	55. 00
						_	l
57. 00	05700 CT SCAN	0. 036423	0	_,,		0	57. 00
58. 00	05800 MRI	0. 089584	0	169, 706	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 066588	0	(0	0	59. 00
60.00	06000 LABORATORY	0. 121212	l n	1, 852, 557	را ما	0	60.00
	1					_	
64. 00	06400 I NTRAVENOUS THERAPY	0. 545327	0	25, 437		0	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 203058	0	65, 747	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 422724	0	116, 208	3 ol	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 393002	l o	47, 298		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 281884		34, 519		0	68. 00
			0			_	•
69. 00	06900 ELECTROCARDI OLOGY	0. 069160	0	41, 599		0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 245178	0	153, 845	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 367460	0	335, 458	3 O	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 412045	l o	(ો ત	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 250772	1	569, 554	i o	0	73. 00
							1
73. 01	07301 SPECIALTY PHARMACY	0. 857591	0	(1	0	73. 01
74.00	07400 RENAL DIALYSIS	0. 308595	0	(-	0	74. 00
76.00	03330 ENDOSCOPY	0. 147154	0	240, 573	3 O	0	76. 00
76. 01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0	(ol ol	0	76. 01
76. 02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000		7	ا ا	0	76. 02
					,	_	
76. 03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000) U	0	76. 03
76. 04	03953 WOUND CARE	0. 381360	0	29, 451	0	0	76. 04
76.06	03954 I MAGI NG CENTER	0. 096020	0	440, 717	rl ol	0	76. 06
76. 07	03955 BREAST DIAGNOSTIC CENTER	0. 441317	l 0	159, 380	ol	0	76. 07
, 0, 0,	OUTPATIENT SERVICE COST CENTERS	01 111017		1077000	,		7 0. 07
00 00		0.000000	1	,	v ol	0	00.00
	09000 CLI NI C	0. 000000	•			0	90. 00
90. 01	04950 INFUSION CENTER	0. 666062	0	192	2 0	0	90. 01
90. 26	04975 SPI NE CENTER	0. 689317	0	(ol ol	0	90. 26
91. 00	09100 EMERGENCY	0. 104587	0	-	-	0	91. 00
				7,037,000		_	•
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 823422	1	(0	0	92. 00
200.00			0	17, 223, 131	0	0	200. 00
201.00	Less PBP Clinic Lab. Services-Program			(ol ol		201. 00
	Only Charges						
202.00		1	0	17, 223, 131	0	n	202. 00
202.00	, 200 (200 201)	I	1	1, 223, 10	٦ ٧		

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0169 Period: From 01/01/2020 To 12/31/2020 Part V Date/Time Prepared: 8/2/2021 3: 48 pm

Cost Center Description Cost Cost Reimbursed Reimbursed Reimbursed

			Title	VIV	Hospi tal	PPS	, p
		0		: AI A	поѕрітаі	PP3	
			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				
AN	ICILLARY SERVICE COST CENTERS						
50.00 05	5000 OPERATING ROOM	181, 047	0				50. 00
51.00 05	5100 RECOVERY ROOM	49, 601	l ol				51.00
	5200 DELIVERY ROOM & LABOR ROOM	0	l ol				52. 00
	5400 RADI OLOGY-DI AGNOSTI C	155, 612	0				54.00
	5500 RADI OLOGY-THERAPEUTI C	30, 265	1				55. 00
	5700 CT SCAN	73, 848	1				57. 00
	5800 MRI	15, 203					58.00
	5900 CARDI AC CATHETERI ZATI ON	15, 203	1				59. 00
		_					1
	5000 LABORATORY	224, 552					60.00
1	5400 I NTRAVENOUS THERAPY	13, 871	0				64. 00
	5500 RESPI RATORY THERAPY	13, 350	1				65. 00
	6600 PHYSI CAL THERAPY	49, 124	1 1				66. 00
	5700 OCCUPATIONAL THERAPY	18, 588	1 1				67. 00
	SPEECH PATHOLOGY	9, 730					68. 00
	5900 ELECTROCARDI OLOGY	2, 877					69. 00
	7000 ELECTROENCEPHALOGRAPHY	37, 719	0				70. 00
71.00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	123, 267	0				71. 00
72. 00 07	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73. 00 07	7300 DRUGS CHARGED TO PATIENTS	142, 828	0				73. 00
73. 01 07	7301 SPECIALTY PHARMACY	0	0				73. 01
74. 00 07	7400 RENAL DIALYSIS	0	0				74. 00
	3330 ENDOSCOPY	35, 401	o				76. 00
76. 01 03	3950 OTHER ANCILLARY SERVICE COST CENTERS	0	l ol				76. 01
76. 02 03	3951 OTHER ANCILLARY SERVICE COST CENTERS	0	l ol				76. 02
	3952 OTHER ANCILLARY SERVICE COST CENTERS	0	0				76. 03
	3953 WOUND CARE	11, 231	0				76. 04
	3954 I MAGI NG CENTER	42, 318					76. 06
	B955 BREAST DIAGNOSTIC CENTER	70, 337					76. 07
	JTPATIENT SERVICE COST CENTERS	70,337	<u> </u>				70.07
	2000 CLINIC	0	0				90. 00
	4950 NFUSION CENTER						1
		128					90. 01
	1975 SPI NE CENTER	000 001	0				90. 26
	9100 EMERGENCY	822, 021	0				91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92. 00
200. 00	Subtotal (see instructions)	2, 122, 918	0				200. 00
201. 00	Less PBP Clinic Lab. Services-Program	0					201. 00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)	2, 122, 918	0				202. 00

Health Financial Systems	COMMUNITY HOSPITAL OF	INDIANA, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0169	Peri od: From 01/01/2020	Worksheet D-1
			To 12/31/2020	Date/Time Prepared: 8/2/2021 3:48 pm
		Title XVIII	Hosni tal	PPS

PART 1 - ALL PROVIDER COMPONENTS 1.00 PART 1	-		Title XVIII	Hospi tal	8/2/2021 3: 48 PPS	pm
IRBATILE ILMS IRBATILE ILM		Cost Center Description	TI LI E XVIII	nospi tai	113	
INPARTENT MAYS		·			1. 00	
Impatient days (including private room days and swing-bed days, excluding newborn)						
Impatient days (including private room days, excluding swing-bed and newborn days) 59,772 2,00	1 00		excluding newborn)		59 572	1 00
Private room days (excluding swing-bed and observation bed days). If you have only private room days, do do not complete this line. 4.00 Somi-private room days (excluding swing-bed and observation bed days). 5.10 Total swing-bed SW type inpatient days (including private room days) through Becember 31 of the cost reporting period (if callendary year, enter 0 on this line). 7.00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if callendary year, enter 0 on this line). 8.00 Into the swing-bed Ni type inpatient days (including private room days) after December 31 of the cost reporting period (if callendary year, enter 0 on this line). 9.00 Total lineatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions). 10.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days). 11.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days). 12.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days). 13.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days). 14.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days). 15.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days). 16.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days). 17.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days). 18.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days). 18.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days). 18.00 Swing-bed XW type inpatient days applicable to title XVIII only (including private room days). 18.00 Swing-bed XW type inpatient days applicable to title XVIII only					· ·	
5.00 Total swin,p-ted Str type inpatient days (including private room days) after December 31 of the cost reporting period of type inpatient days (including private room days) after December 31 of the cost reporting period of type inpatient days (including private room days) after December 31 of the cost reporting period of the cost period by the cost reporting period of the cost reporting period of the cost period by the cost reporting period of the cost period by the cost reporting period of the cost period by the cost reporting period of the cost reporting period of the cost period by the cost reporting period of the cost reporting period of the cost period by the cost reporting period of the cost re				vate room days,		
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x line 20) 26. 00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 29. 00 Private room charges (excluding swing-bed and observation bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32. 00 Average private room per diem charge (line 29 + line 3) 33. 00 Average semi-private room per diem charge (line 30 + line 4) 30. 00 Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Beneral inpatient routine service cost per diem private room cost differential (line 3 x line 35) Trivate room cost differential adjustment (line 3 x line 35) Ceneral inpatient routine service cost per diem (see instructions) Average per diem private room cost differential (see instructions) Average per diem private room cost differential (see instructions) Average per diem private room cost differential (see instructions) Average per diem private room cost differential (see instructions) Average per diem private room cost differential (see instructions) Average per diem private room cost differential (see instructions) Average per diem private room cost differential (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost (line 9 x line 38) Adjusted general inpatient routine service cost (line 9 x line 38) Adjusted general inpatient routine service cost (line 9 x line 38) Adjusted general inpatient routine service cost (line 9 x line 38) Adjusted general inpatient routine service cost (line 14 x line 35)	05.00					05.00
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28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 32.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 32.00 Average per diem private room cost differential (line 34 x line 31) 33.00 Average per diem private room cost differential (line 34 x line 31) 34.00 Private room cost differential adjustment (line 3 x line 35) 35.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 83, 249, 127) 36.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 30.01 Oscillatory of the charges of the c	27. 00		(line 21 minus line 26)		83, 249, 127	27. 00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 83, 249, 127) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 29.00 29.00 29.00 30.00 0.000000 31.00 0.000000 32.0	20.00		d and abasement an had abo	, race)	0	20.00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 83, 249, 127) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			and observation bed cha	arges)		
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37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 27.00			10 01 <i>)</i>			
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,397.45 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 21,516,538 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , ,	and private room cost di	ferential (line		
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,397.45 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 21,516,538 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,397.45 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,397.45 38.00 21,516,538 39.00 40.00			ICTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 21,516,538 39.00 40.00	38 00				1 397 45	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 21,516,538 41.00		Medically necessary private room cost applicable to the Progra	am (line 14 x line 35)		0	
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		21, 516, 538	41.00

COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C		Period: From 01/01/2020	Worksheet D-1	
					Γο 12/31/2020	Date/Time Pre 8/2/2021 3:48	pared:
			Title	e XVIII	Hospi tal	PPS	рш
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	npatient Days	Diem (col. 1 - col. 2)	÷	(col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	0	C	0.00	0	0	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	12, 338, 200	6, 562	1, 880. 25	1, 723	3, 239, 671	43.00
44. 00	CORONARY CARE UNIT	12, 000, 200	0, 002	1, 000. 20	1,720	0,207,071	44. 00
45.00	BURN INTENSIVE CARE UNIT						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	17, 416, 725	13, 390	1, 300. 73	3 0	0	46. 00 47. 00
47.00	Cost Center Description	17, 410, 723	13, 370	1, 300. 7	5,	O O	47.00
10.00						1. 00	10.00
48. 00 49. 00	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines 4			nns)		27, 854, 254 52, 610, 463	
17. 00	PASS THROUGH COST ADJUSTMENTS					02, 010, 100	17.00
50.00	Pass through costs applicable to Program inpa	atient routine	services (from	m Wkst. D, sum	of Parts I and	2, 684, 950	50.00
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (fr	om Wkst. D, su	um of Parts II	2, 638, 082	51. 00
52. 00							52. 00
53.00	OU Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program di scharges	0	54. 00				
55. 00							55. 00
56. 00 57. 00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (1	ine 56 minus l	ine 53)	0	56. 00 57. 00
58. 00	00 Bonus payment (see instructions)						
59. 00	OD Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59. 00
60.00							
61. 00	If line 53/54 is less than the lower of lines					0	61. 00
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		s (lines 54 x	60), or 1% of	the target		
62.00	Relief payment (see instructions)	ŕ				0	62. 00
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the	e cost reportir	na period (See	0	64. 00
01.00	instructions)(title XVIII only)	Ü					0 11 00
65. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts after Decemb	er 31 of the d	cost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	55)(title XVIII	only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 d	of the cost rep	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	costs after D	acombor 21 of	the cost reper	sting ported	0	49.00
08.00	(line 13 x line 20)	e costs after D	ecember 31 or	the cost repor	triig perrou		68. 00
69. 00	Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70. 00	Skilled nursing facility/other nursing facili						70.00
71.00	Adjusted general inpatient routine service co		ne 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line 7 Medically necessary private room cost applications)		(line 14 x li	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine servi						74. 00
75. 00	Capital -related cost allocated to inpatient r	routine service	costs (from V	Vorksheet B, Pa	art II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lir	ne 2)					76. 00
77. 00	Program capital related costs (line 9 x line						77. 00
78.00	Inpatient routine service cost (line 74 minus		and don	do)			78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa			•	us line 79)		79. 00 80. 00
01.00					,	•	01.00

1.72 1.72	40.00	Intensive care Type Impatrent hospital units	0.000.474	40.00
SURBLINTENSIVE CARE UNIT			3, 239, 6/1	
3.00 Cost Center Description 17,416,725 13,390 1,300,73 0 0,47,00				
A. 200 NEWARTAL INTERSIVE CARE BUIT 17,416,725 13,300 1,300.73 0 0 47,00				
2.00 Program Inpatient costs (sour of lines 41 through 48) (see instructions) 1.00	46. 00	SURGICAL INTENSIVE CARE UNIT		46. 00
1.00	47. 00		0	47. 00
48.00 Program Inpatient ancillary service cost (West D-3, col. 3, 11ne 200) 27,854,254 48.00 Pass THROUGH COST ADJUSTNETS 52,61,643 49.00 Pass THROUGH COST ADJUSTNETS 52,61,643 49.00 Pass THROUGH COST ADJUSTNETS 55,000 Pass through costs applicable to Program Inpatient routine services (from Wkst. D. sum of Parts I and 2,684,950 50.00 Pass through costs applicable to Program Inpatient ancillary services (from Wkst. D. sum of Parts II and 19.00 2,684,950 50.00 Pass through costs applicable to Program Inpatient ancillary services (from Wkst. D. sum of Parts II and 19.00 2,684,950 50.00 2,684,950 2,684		Cost Center Description		
10.00 Pass through costs applicable to Program inputient routine services (from Wkst. D., sum of Parts I and D. 2, 684, 950 50.00			1. 00	
PASS_THROUGH_COST_ADJUSTNEWTS	48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	27, 854, 254	48. 00
PASS_THROUGH_COST_ADJUSTNEWTS	49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	52, 610, 463	49.00
50.00 Pass through costs applicable to Program Inpatient routine services (from West. D., sum of Parts II and III 11.00		PASS THROUGH COST ADJUSTMENTS		
1110 Sass through costs applicable to Program Inpatient ancillary services (from Wkst. D., sum of Parts II 2,638,082 51.00 and IV) 52.00 Total Program excludable cost (sum of Fines 50 and 51) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 47,287,431 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 47,287,431 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 47,287,431 53.00 Total Program discharges 0.54,00 0.00 55.00 Total Related mount per discharges 0.54,00 0.00 55.00 Total Exclusive and program discharges 0.54,00 0.00 55.00 Total Exclusive and program discharges 0.54,00 0.00 55.00 0.00 0.00 55.00 0.0	50.00		2, 684, 950	50.00
1.00 Pass through costs applicable to Program Inpatient ancillary services (from Wkst. D., sum or Parts II 2,638,082 51.00 2.00 Total Program excludable cost (sum of lines 50 and 51) 5.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and modical education costs. (line 49 minus line 52) 7.50 7.			, ,	
and IV) 52.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and ended aducation costs (tine 40 minus line 52) 54.00 Program inpatient operating cost excluding capital related, non-physician anesthetist, and ended aducation costs (tine 40 minus line 52) 55.00 Target amount (line 54 x line 55) 56.00 Target amount per discharge 0.05 4.00 57.00 Target amount per discharge 0.05 5.00 58.00 Target amount (line 54 x line 55) 58.00 Target amount (line 54 x line 55) 59.00 Loses payent (see instructions) 59.00 Loses payent (see instructions) 60.00 Lesser of lines 53/54 or 55 from prior year cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report prior year cost from year cost report prior year cost report year cost year year year year year year year year	51.00		2, 638, 082	51.00
Transfer Program Inspiration operating cost exclude So and 51) So 23, 032 \$2, 00 So Transfer Program in paper and pro			, ,	
Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	52 00		5 323 032	52 00
medical education costs (line 40 minus line 52)* FARCET AMOUNT AMO LIMIT COMPUTATION		S ,		
TARGET AMOUNT AND LIMIT COMPUTATION 55.00 167.00	00.00		17, 207, 101	00.00
54.00 Program discharges 0.0 54.00 55.00 Target amount free discharge 0.0 55.00 56.00 Target amount free discharge 0.0 55.00 56.00 Target amount free discharge 0.0 55.00 56.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 58.00 57.00 58.00 59				
1.5	54 00		0	54 00
1.0 1.0				
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57.00 58.00 Besser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the morket basket 0.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 lesser of lines 53/54 or 55 from prior year costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0.00 lesser of lines 53/54 or 60 lesser provided lesser pro				
88.00 Bonus payment (see Instructions) 9.00 Bonus payment (see Instruc		, , ,		
59.00 Lesser of Lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 59.00				
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Health Financial Systems COMM	MUNITY HOSPITAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2020 Fo 12/31/2020	Date/Time Prep 8/2/2021 3:48	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	8, 762, 336	83, 249, 127	0. 105254	7, 695, 757	810, 009	90.00
91.00 Nursing School cost	0	83, 249, 127	0. 000000	7, 695, 757	0	91.00
92.00 Allied health cost	0	83, 249, 127	0. 000000	7, 695, 757	0	92.00
93.00 All other Medical Education	0	83, 249, 127	0. 000000	7, 695, 757	0	93. 00

Health Financial Systems	COMMUNITY HOSPITAL OF INDIANA, INC.	In Lieu of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0	0169 Period: Worksheet D-1 From 01/01/2020
	Component CCN: 15-	S169 To 12/31/2020 Date/Time Prepared: 8/2/2021 3: 48 pm
	Title XVIII	Subprovi der - PPS

Cost: Center Description 1.00			II the Aviii	I PF	FF3	
INPATITION MAYS INPATITION		Cost Center Description				
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Cost Center Description am inpatient ancillary service cost (Wk Program inpatient costs (sum of lines THROUGH COST ADJUSTMENTS through costs applicable to Program inp through costs (sum of lines Program excludable cost (sum of lines Program inpatient operating cost exclu all education costs (line 49 minus line AMOUNT AND LIMIT COMPUTATION am discharges t amount per discharge t amount (line 54 x line 55) rence between adjusted inpatient operat payment (see instructions) r of lines 53/54 or 55 from the cost re t basket r of lines 53/54 or 55 from prior year ne 53/54 is less than the lower of line	est. D-3, col. 3, 41 through 48)(set atient routine set atient ancillary 50 and 51) adding capital relations cost and target eporting period er cost report, updates.	line 200) se instructions) ervices (from Wks: services (from Wi sted, non-physicia	t. D, sum c kst. D, sun an anesthet	of Parts I and n of Parts II ist, and	1. 00 313, 781 2, 286, 932 162, 734 22, 131 184, 865 2, 102, 067	48. 00 49. 00 50. 00 51. 00 52. 00 53. 00 54. 00 55. 00					
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Program inpatient operating cost exclual education costs (line 49 minus line AMOUNT AND LIMIT COMPUTATION am discharges tamount per discharge tamount (line 54 x line 55) rence between adjusted inpatient operat payment (see instructions) rof lines 53/54 or 55 from the cost retabasket of lines 53/54 or 55 from prior year ne 53/54 is less than the lower of line	ding capital related by the second se	get amount (line!			2, 102, 067 0 0. 00 0	53. 00 54. 00 55. 00					
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am discharges t amount per discharge t amount (line 54 x line 55) rence between adjusted inpatient operat payment (see instructions) r of lines 53/54 or 55 from the cost re t basket r of lines 53/54 or 55 from prior year ne 53/54 is less than the lower of line	eporting period er cost report, upda	,	56 minus li	>	0. 00 0	55.00					
t amount per discharge t amount (line 54 x line 55) rence between adjusted inpatient operat payment (see instructions) r of lines 53/54 or 55 from the cost re t basket r of lines 53/54 or 55 from prior year ne 53/54 is less than the lower of line	eporting period er cost report, upda	,	56 minus li		0. 00 0	55.00					
t amount (line 54 x line 55) rence between adjusted inpatient operat payment (see instructions) r of lines 53/54 or 55 from the cost re t basket r of lines 53/54 or 55 from prior year ne 53/54 is less than the lower of line	eporting period er cost report, upda	,	56 minus li	>	0						
payment (see instructions) r of lines 53/54 or 55 from the cost re t basket r of lines 53/54 or 55 from prior year ne 53/54 is less than the lower of line	eporting period er cost report, upda	,	56 minus li		ام	56.00					
r of lines 53/54 or 55 from the cost re t basket r of lines 53/54 or 55 from prior year ne 53/54 is less than the lower of line	cost report, upda	nding 1996, update		Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							
t basket r of lines 53/54 or 55 from prior year ne 53/54 is less than the lower of line	cost report, upda	nding 1996, update	00 Bonus payment (see instructions) 00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the								
r of lines 53/54 or 55 from prior year ne 53/54 is less than the lower of line			ea ana comp	ounded by the	0.00	59.00					
	s 55 59 or 60 er	ited by the marke	t basket		0.00	60.00					
operating costs (line 53) are less tha					0	61.00					
t (line 56), otherwise enter zero (see		(lines 54 x 60),	or 1% of t	the target							
f payment (see instructions)	Tristi ucti oris)				0	62.00					
able Inpatient cost plus incentive paym	nent (see instruct	i ons)			0						
PROGRAM INPATIENT ROUTINE SWING BED COST 1.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See											
are swing-bed SNF inpatient routine cos uctions)(title XVIII only)	its through Decemb	per 31 of the cos	t reportino	period (See	0	64.00					
are swing-bed SNF inpatient routine cos	sts after December	31 of the cost i	reporting p	eriod (See	0	65.00					
uctions)(title XVIII only)					_						
Medicare swing-bed SNF inpatient routi see instructions)	ne costs (line 64	l plus line 65)(ti	tle XVIII	only). For	0	66.00					
V or XIX swing-bed NF inpatient routin	ne costs through D	ecember 31 of the	e cost repo	orting period	0	67.00					
12 x line 19)											
V or XIX swing-bed NF inpatient routin	ne costs after Dec	cember 31 of the d	cost report	ing period	0	68.00					
13 x line 20) title V or XIX swing-bed NF inpatient	routine costs (Li	ne 67 + line 68)			o	69.00					
II - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY,	AND ICF/IID ONLY			Ů						
ed nursing facility/other nursing facil			(line 37)			70.00					
ted general inpatient routine service c am routine service cost (line 9 x line	, ,	ie /u ÷ IINe 2)				71. 00 72. 00					
ally necessary private room cost applic	,	[line 14 x line 3!	5)			73.00					
3		•	•			74.00					
•	routine service o	costs (from Works	neet B, Par	t II, column		75. 00					
	ne 2)					76.00					
·						77.00					
ent routine service cost (line 74 minu	ıs line 77)					78. 00					
noto obonggo to bongf! -!! f	s costs (from pro			lino 70)		79.00					
-	Contract to the		70 '			80.00					
Program routine service costs for comp		st limitation (lin	ne 78 minus	s i i ne 79)	l l	1 81 nr					
-	tati on	st limitation (lin	ne 78 minus	5 TTNe 79)		81. 00 82. 00					
Program routine service costs for comp lent routine service cost per diem limi	tation ine 9 x line 81)	·	ne 78 minus	5 11 ne 79)							
Program routine service costs for complent routine service cost per diem limitent routine service cost limitation (Inable inpatient routine service costs (am inpatient ancillary services (see in	tation ine 9 x line 81) [see instructions) structions)		ne 78 minus	5 TTNE 79)		82. 00 83. 00 84. 00					
Program routine service costs for complent routine service cost per diem limitent routine service cost limitation (Inable inpatient routine service costs (am inpatient ancillary services (see in zation review - physician compensation	tation ine 9 x line 81) see instructions) structions) (see instructions	· ·	ne 78 minus	s i i ne 79)		82. 00 83. 00 84. 00 85. 00					
Program routine service costs for compient routine service cost per diem limitent routine service cost limitation (Inable inpatient routine service costs (amm inpatient ancillary services (see in zation review - physician compensation Program inpatient operating costs (sum	tation ine 9 x line 81) see instructions) structions) (see instructions of lines 83 thro	· ·	ne 78 minus	5 TTHE 79)		82. 00 83. 00 84. 00					
Program routine service costs for complent routine service cost per diem limitent routine service cost limitation (Inable inpatient routine service costs (am inpatient ancillary services (see in zation review - physician compensation	tation ine 9 x line 81) [see instructions) istructions) (see instructions n of lines 83 thro S THROUGH COST	· ·	ne 78 minus	5 TTHE 79)	0	82. 00 83. 00 84. 00 85. 00 86. 00					
i	Program general inpatient routine serval-related cost allocated to inpatient ne 45) em capital-related costs (line 75 ÷ lime capital-related costs (line 9 x line ent routine service cost (line 74 minu	Program general inpatient routine service costs (line 7al-related cost allocated to inpatient routine service on 45) em capital-related costs (line 75 ÷ line 2) em capital-related costs (line 9 x line 76) ent routine service cost (line 74 minus line 77) gate charges to beneficiaries for excess costs (from programs)	Program general inpatient routine service costs (line 72 + line 73) al-related cost allocated to inpatient routine service costs (from Worksline 45) em capital-related costs (line 75 ÷ line 2) am capital-related costs (line 9 x line 76)	Program general inpatient routine service costs (line 72 + line 73) al-related cost allocated to inpatient routine service costs (from Worksheet B, Par ne 45) em capital-related costs (line 75 ÷ line 2) am capital-related costs (line 9 x line 76) ent routine service cost (line 74 minus line 77) gate charges to beneficiaries for excess costs (from provider records)	Program general inpatient routine service costs (line 72 + line 73) al-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column ne 45) em capital-related costs (line 75 ÷ line 2) am capital-related costs (line 9 x line 76) ent routine service cost (line 74 minus line 77)	Program general inpatient routine service costs (line 72 + line 73) al-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column ne 45) em capital-related costs (line 75 ÷ line 2) em capital-related costs (line 9 x line 76) ent routine service cost (line 74 minus line 77) gate charges to beneficiaries for excess costs (from provider records) Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					

Health Financial Systems	COMM	IUNI TY HOSPI TAL	OF INDIANA, IN	IC.	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATI	NG COST		Provi der CO		Peri od:	Worksheet D-1	
			Component (From 01/01/2020 To 12/31/2020		
			Title	XVIII	Subprovi der – I PF	PPS	
Cost Center Descript	i on	Cost	Routine Cost	column 1 ÷	Total	Observati on	
			(from line 21)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
		1. 00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION	N BED PASS THROUGH (COST					
90.00 Capital -related cost		321, 701	3, 900, 797	0. 08247	1 0	0	90.00
91.00 Nursing School cost		0	3, 900, 797	0. 00000	0	0	91.00
92.00 Allied health cost		0	3, 900, 797	0. 00000	o o	0	92. 00
93.00 All other Medical Educati	on	0	3, 900, 797	0. 00000	o o	0	93. 00

Health Financial Systems	COMMUNITY HOSPITAL OF	INDIANA, INC.	In Li€	eu of Form CMS-2	552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-016	Period: From 01/01/2020	Worksheet D-1	
				Date/Time Prep 8/2/2021 3:48	
		Title XIX	Hospi tal	PPS	

Cest Centrer Description DAIL ALL PROVIDER COMPONENTS			Title XIX	Hospi tal	8/2/2021 3: 48 PPS	pm
PART 1 - ALL PROVIDER COMPONENTS		Cost Center Description				
Impatriant days (including private room days and swing-bed days, excluding neaborn) 59,572 1.0 Inpatriant days (including private room days, excluding swing-bed and meaborn days) 59,572 3.0 Inpatriant days (including private room days, excluding swing-bed and meaborn days) 59,572 3.0 3		PART I - ALL PROVIDER COMPONENTS			1. 00	
2.00 Injectient days (Including private room days, excluding swing-bed and newborn days) 3.00 Private room days, excluding swing-bed and observation bed days) 4.00 Derivate room days, excluding swing-bed and observation bed days) 5.4.086 5.00 Injective room days (sectual page swing-bed and observation bed days) 6.00 Injective room days (sectual page swing-bed and observation bed days) 6.00 Injective room days (sectual page swing-bed and observation bed days) 6.00 Injective room days (sectual page swing-bed swin						
and private room days (excluding swing-bed and observation bed days). If you have only private room days, do do not complete this line. 54,066 55,00 56m; perivate room days (excluding saing-bed and observation bed days) 55,00 56m; perivate room days (excluding sping-bed and observation bed days) 55,00 56m; perivate room days (excluding sping-bed and observation bed days) 55,00 56m; perivate room days (excluding sping-bed and observation bed days) 56m; perivate room days (excluding sping-bed and observation bed days) 57,00						•
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x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 Frivate room charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ± line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average per diem private room charge (line 29 + line 3) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 36.00 Frivate room cost differential adjustment (line 3 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	22.00		,	ing portou (inio	, and the second	22.00
24.00 24.00 25.00 25.00 25.00 25.00 25.00 25.00 26.00 26.00 26.00 27.00 28.00 28.00 29.00 29.00 29.00 20.00	23. 00		31 of the cost reporting	g period (line 6	0	23. 00
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 30 + line 4) 31.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 32.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 84,040,079) 37.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 40.00	24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
x line 20) 26.00 Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Pri vate room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) Ceneral inpatient routine service cost/charges) Semi-private room charges (excluding swing-bed charges) Ceneral inpatient routine service cost/charge ratio (line 27 + line 28) Average private room per diem charge (line 29 + line 3) Average per diem private room charge differential (line 30 + line 4) Average per diem private room charge differential (line 30 + line 4) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 84, 040, 079) Average per diem private room cost differential (line 30 x line 31) Conough 33.00 Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 84, 040, 079) Average per diem private room cost differential (line 3 x line 35) Oracle 10 de	25 00		21 of the cost reporting	neriod (line 8	0	25 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 84, 040, 079 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) 9. 00 9. 00 30. 00 Semi-private room charges (excluding swing-bed charges) 9. 00 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 9. 00 32. 00 Average private room per diem charge (line 29 + line 3) 9. 00 34. 00 Average semi-private room charge differential (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33) (see instructions) 9. 00 35. 00 Average per diem private room cost differential (line 34 x line 31) 9. 00 36. 00 77. 00 PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) 9. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 9. 00 40. 00	25.00	9 11 31	or the cost reporting	perrou (rriie o	Ü	25.00
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29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31. 00 Average private room per diem charge (line 29 ÷ line 3) 32. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 33. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 84,040,079) 37. 00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost (line 9 x line 38) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 39. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0. 00	28. 00		d and observation bed ch	arges)	0	28. 00
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37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37. 00 84, 040, 079 84, 040, 079 87. 00 84, 040, 079 87. 00 87. 00 87. 00 87. 00 87. 00 88. 040, 079 88. 040, 079 88. 05 1, 410. 73 88. 00 39. 00 40. 00			10 01)		0.00	ł
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PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 7 40.00 Adjusted general inpatient routine service cost (line 9 x line 38) 8 5 4 5 6 7 7 8 7 8 7 8 7 8 7 8 7 8 7 8 7 8 7 8		27 minus line 36)		(
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,410.73 38.00 Program general inpatient routine service cost (line 9 x line 38) 3,160,035 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			ICTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 3, 160, 035 39.00 40.00	20.00				1 410 70	20.00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						1
						1
			•			1

Heal th	Financial Systems COMM	UNITY HOSPITAL (OF INDIANA, IN	NC.	In Lie	eu of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST		Provider Co	CN: 15-0169	Peri od: From 01/01/2020 To 12/31/2020		
			T	VIV		8/2/2021 3:48	pm
	Cost Center Description	Total	Total	e XIX Average Per	Hospital Program Days	PPS Program Cost	
	cost center bescription	Inpatient Cost				(col. 3 x col.	
				col . 2)		4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only)	4, 621, 135	7, 288	634.0	2, 808	1, 780, 469	42. 00
40.00	Intensive Care Type Inpatient Hospital Units	40,000,000	, 5,0	1 000 (\r_\		40.00
43.00	INTENSIVE CARE UNIT	12, 338, 200	6, 562	1, 880. 2	25 0	0	43. 00 44. 00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						45.00
46. 00	SURGICAL INTENSIVE CARE UNIT						46.00
47. 00	1	17, 416, 725	13, 390	1, 300. 7	1, 444	1, 878, 254	1
	Cost Center Description	,,		., .,	.,	.,,	
						1. 00	
48. 00	Program inpatient ancillary service cost (Wks					3, 693, 051	1
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(s	ee instructio	ons)		10, 511, 809	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	ationt routing c	onvisos (from	Wkst D sum	of Dorte L and	737, 615	50.00
30.00		atrent routine s	services (IIOII	I WKSt. D, Sull	I UI PAILS I AIIU	/37,013	30.00
51. 00							51.00
52.00	Total Program excludable cost (sum of lines!	1, 079, 173	52.00				
53.00	Total Program inpatient operating cost exclude	9, 432, 636	53.00				
	medical education costs (line 49 minus line !	52)					
E 4 .00	TARGET AMOUNT AND LIMIT COMPUTATION						F 4 00
54.00	Program discharges					0.00	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)	0.00	1				
57. 00	Difference between adjusted inpatient operati	0	57. 00				
58. 00	Bonus payment (see instructions)	Ö	58.00				
59. 00	Lesser of lines 53/54 or 55 from the cost rep	oorting period e	ending 1996, u	pdated and co	mpounded by the	0.00	
	market basket	0 1	9	•			
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 lines					0	61. 00
	which operating costs (line 53) are less than		(lines 54 x	60), or 1% of	the target		
62. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)			Ö	
00.00	PROGRAM INPATIENT ROUTINE SWING BED COST	(000 11101140					00.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost reporti	ng period (See	0	64. 00
	instructions)(title XVIII only)					_	
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the c	ost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	Anlus line 6	5)(title XVII	Lonly) For	0	66. 00
00.00	CAH (see instructions)	ie costs (Title o	14 prus rine c	o) (title XVII	i only). To		00.00
67.00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 c	of the cost re	porting period	0	67. 00
	(line 12 x line 19)	· ·					
68. 00	Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost repo	rting period	0	68. 00
(0.00	(line 13 x line 20)		! /7 !!	(0)			(0.00
69. 00	Total title V or XIX swing-bed NF inpatient I PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70. 00	Skilled nursing facility/other nursing facility						70.00
71.00	Adjusted general inpatient routine service of	•		• • • • • • • • • • • • • • • • • • • •			71.00
72. 00	Program routine service cost (line 9 x line			•			72. 00
73.00	Medically necessary private room cost applica	able to Program	(line 14 x li	ne 35)			73. 00
74. 00	Total Program general inpatient routine servi	•					74. 00
75. 00	Capital -related cost allocated to inpatient	routine service	costs (from W	lorksheet B, F	art II, column		75. 00
74 00	26, line 45)	20. 2)					74 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line						76. 00 77. 00
, , . 00	1	,				l .	, , ,

42. 00	NURSERY (title V & XIX only)	4, 621, 135	7, 288	634. 07	2, 808	1, 780, 469	42. 00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	12, 338, 200	6, 562	1, 880. 25	0	0	43. 00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT					l	46. 00
	NEONATAL INTENSIVE CARE UNIT	17, 416, 725	13, 390	1, 300. 73	1, 444	1, 878, 254	1
	Cost Center Description	,,		.,,	- 1,	.,	
						1. 00	
48. 00	Program inpatient ancillary service cost (Wks	st D-3 col 3 li	ne 200)			3, 693, 051	48. 00
49. 00						10, 511, 809	•
	PASS THROUGH COST ADJUSTMENTS					,,	
50. 00	Pass through costs applicable to Program inpa	atient routine serv	ices (from Wk	st D sum of Pa	rts L and	737, 615	50.00
00.00		trent reatine serv	rees (rrom me	or. D, Sam of Fa	rts r and	707,010	00.00
51.00	Pass through costs applicable to Program inpa	ntient ancillary se	rvices (from)	Wkst D sum of	Parts II	341, 558	51.00
	and IV)		(2 , 2	
52.00		0 and 51)				1, 079, 173	52.00
53. 00	,		d non-physic	ian anesthetist	and	9, 432, 636	1
00.00	medical education costs (line 49 minus line 5		a, pyo. o	i air airostriotrot,	aa	7, 102, 000	00.00
	TARGET AMOUNT AND LIMIT COMPUTATION	_,					İ
54 00	Program di scharges					0	54.00
	Target amount per discharge					0.00	•
56. 00						0	1
57. 00	,	ng cost and target	amount (Line	56 minus line 5	(3)	o l	57.00
58. 00	, , ,	ing cost and target	amount (11116	oo iiii rida i riric o		ő	1
59. 00	, ,	orting period endi	na 1996 unda	ted and compound	led by the	0.00	1
07.00	market basket	or tring period endi-	ng 1770, apaa	tea ana compouna	ca by the	0.00	07.00
60.00		cost report, update	d by the mark	et basket		0.00	60.00
	If line 53/54 is less than the lower of lines				ount by	0.00	61.00
011.00	which operating costs (line 53) are less than					١	000
	amount (line 56), otherwise enter zero (see i	,		, 0. 1.0 0. 1.10 1	a. got		
62.00	1	,				ol	62.00
63.00		ent (see instruction	ns)			o	ı
	PROGRAM INPATIENT ROUTINE SWING BED COST	(==================================				_	
64.00	Medicare swing-bed SNF inpatient routine cost	s through December	31 of the co	st reportina per	i od (See	0	64.00
	instructions)(title XVIII only)						
65.00	Medicare swing-bed SNF inpatient routine cost	d (See	ol	65.00			
	instructions) (title XVIII only)						
66.00							66.00
	CAH (see instructions)						
67.00		costs through Dec	ember 31 of t	he cost reportin	g peri od	o	67.00
	(line 12 x line 19)	G		·	·		
68.00	Title V or XIX swing-bed NF inpatient routine	costs after Decemb	ber 31 of the	cost reporting	peri od	o	68.00
	(line 13 x line 20)						
69.00	Total title V or XIX swing-bed NF inpatient r	routine costs (line	67 + line 68)		0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NU	RSING FACILITY, AND	O ICF/IID ONL	Y			
70.00	Skilled nursing facility/other nursing facili	ty/ICF/IID routine	servi ce cost	(line 37)			70.00
71.00	Adjusted general inpatient routine service co	st per diem (line	70 ÷ line 2)				71.00
72.00	Program routine service cost (line 9 x line 7	' 1)					72.00
73.00	Medically necessary private room cost applica	able to Program (li	ne 14 x line :	35)			73.00
74.00	Total Program general inpatient routine servi	ce costs (line 72	+ line 73)				74.00
75.00	Capital-related cost allocated to inpatient r	outine service cos	ts (from Work	sheet B, Part II	, column		75. 00
	26, line 45)						
76.00	Per diem capital-related costs (line 75 ÷ lin	ne 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
			der records)				79. 00
79. 00	Inggi egate charges to belief charles for excess				20)	l	80.00
	Total Program routine service costs for compa	rison to the cost	limitation (l	ine 78 minus lin	le /9)	ì	
	Total Program routine service costs for compa		limitation (I	ine 78 minus lin	le 79)		81.00
80.00	Total Program routine service costs for compa Inpatient routine service cost per diem limit	ati on	limitation (I	ine 78 minus lin	le 79)		1
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li	ation ne 9 x line 81)	limitation (I	ine 78 minus lin	le 79)		81.00
80. 00 81. 00 82. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s	ation ne 9 x line 81) see instructions)	limitation (I	ine 78 minus lin	le 79)		81. 00 82. 00
80. 00 81. 00 82. 00 83. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s Program inpatient ancillary services (see ins	ation ne 9 x line 81) see instructions) structions)	limitation (I	ine 78 minus lin	le 79)		81. 00 82. 00 83. 00
80. 00 81. 00 82. 00 83. 00 84. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s Program inpatient ancillary services (see ins Utilization review - physician compensation (ation ne 9 x line 81) see instructions) tructions) (see instructions)	·	ine 78 minus lin	le 79)		81. 00 82. 00 83. 00 84. 00
80. 00 81. 00 82. 00 83. 00 84. 00 85. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s Program inpatient ancillary services (see ins Utilization review - physician compensation (ation ne 9 x line 81) see instructions) structions) (see instructions) of lines 83 throug	·	ine 78 minus lin	le 19)		81. 00 82. 00 83. 00 84. 00 85. 00
80. 00 81. 00 82. 00 83. 00 84. 00 85. 00	Total Program routine service costs for comparing the cost per diem limit in patient routine service cost per diem limit inpatient routine service cost limitation (li Reasonable inpatient routine service costs (see insulting the cost of the cost	ation ne 9 x line 81) see instructions) structions) see instructions) of lines 83 throug	·	ine 78 minus lin	(e 79)	5, 507	81. 00 82. 00 83. 00 84. 00 85. 00
80. 00 81. 00 82. 00 83. 00 84. 00 85. 00 86. 00	Total Program routine service costs for comparing the cost per diem limit Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (serogram inpatient ancillary services (see instruction review - physician compensation (Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)	ne 9 x line 81) see instructions) structions) structions) of lines 83 through	h 85)	ine 78 minus lin	(E /9)	5, 507 1, 410. 73	81. 00 82. 00 83. 00 84. 00 85. 00 86. 00
80. 00 81. 00 82. 00 83. 00 84. 00 85. 00 86. 00	Total Program routine service costs for compaination routine service cost per diem limit Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (see Insultive Inpatient ancillary services (see insultization review - physician compensation (Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions) Adjusted general inpatient routine cost per comparation of the cost per cos	ne 9 x line 81) see instructions) structions) (see instructions) of lines 83 through THROUGH COST	h 85)	ine 78 minus lin	(e 79)		81. 00 82. 00 83. 00 84. 00 85. 00 86. 00 87. 00 88. 00

Health Financial Systems COMM	MUNITY HOSPITAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2020 Fo 12/31/2020	Date/Time Prep 8/2/2021 3:48	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	8, 762, 336	84, 040, 079	0. 104264	7, 768, 890	810, 016	90.00
91.00 Nursing School cost	0	84, 040, 079	0.000000	7, 768, 890	0	91.00
92.00 Allied health cost	0	84, 040, 079	0.000000	7, 768, 890	0	92.00
93.00 All other Medical Education	0	84, 040, 079	0.000000	7, 768, 890	0	93. 00

Health Financial Systems COMMUNITY HOSPITAL OF	INDIANA, IN	IC.	In Li∈	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provid		CN: 15-0169	Peri od:	Worksheet D-3	
			From 01/01/2020 To 12/31/2020	Doto/Timo Dro	parad.
			To 12/31/2020	Date/Time Pre 8/2/2021 3:48	
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
LARGE FUT DOUTLAND OFFICE COOT OFFITEDO		1. 00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			20.0(0.407		
30. 00 03000 ADULTS & PEDI ATRI CS			33, 862, 107		30.00
31. 00 03100 INTENSI VE CARE UNIT			7, 477, 707		31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT			0		35. 00
40. 00 04000 SUBPROVI DER - PF			0		40.00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM		0. 1287	72 35, 061, 252	4, 514, 908	50.00
51. 00 05100 RECOVERY ROOM		0. 1287		629, 898	1
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 1039		027, 070	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1685		478, 956	
55. 00 05500 RADI OLOGY - THERAPEUTI C		0. 0712		421, 043	
57. 00 05700 CT SCAN		0. 0364		318, 876	
58. 00 05800 MRI		0. 0895			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 0665			
60. 00 06000 LABORATORY		0. 1212		2, 810, 578	
64. 00 06400 I NTRAVENOUS THERAPY		0. 5453			
65. 00 06500 RESPIRATORY THERAPY		0. 2030		1, 105, 783	
66. 00 06600 PHYSI CAL THERAPY		0. 4210		726, 188	1
67. 00 06700 OCCUPATI ONAL THERAPY		0. 3930		556, 150	
68. 00 06800 SPEECH PATHOLOGY		0. 2818		118, 579	1
69. 00 06900 ELECTROCARDI OLOGY		0. 0691			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 2451		50, 749	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3674			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4120		4, 663, 504	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2507		4, 766, 077	1
73. 01 07301 SPECIALTY PHARMACY		0. 8575		0	
74. 00 07400 RENAL DI ALYSI S		0. 3085		572, 511	1
76. 00 03330 ENDOSCOPY		0. 1471		370, 944	
76. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS		0.0000		0	1
76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS		0.0000		0	1
76. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS		0.0000		Ō	
76. 04 03953 WOUND CARE		0. 3813		133, 378	
76. 06 03954 I MAGI NG CENTER		0. 0960		4, 029	1
76. 07 03955 BREAST DIAGNOSTIC CENTER		0. 4413		611	
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0.0000	00 00	0	90.00
90. 01 04950 INFUSION CENTER		0. 6660	62 0	0	90. 01
90. 26 04975 SPI NE CENTER		0. 6893	17 0	0	90. 26
91. 00 09100 EMERGENCY		0. 1037	71 12, 376, 254	1, 284, 296	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART		0. 8234	22 1, 232, 709	1, 015, 040	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			151, 506, 938	27, 854, 254	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)			151, 506, 938		202. 00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der (Peri od: From 01/01/2020	Worksheet D-3	
	Component		To 12/31/2020	Date/Time Pre 8/2/2021 3:48	
	Ti tl	e XVIII	Subprovider - IPF	PPS	•
Cost Center Description		Ratio of Cost	I npati ent	Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS			0		30.0
31.00 03100 INTENSIVE CARE UNIT			0		31.0
35.00 02060 NEONATAL INTENSIVE CARE UNIT			0		35.0
40. 00 04000 SUBPROVI DER - 1 PF			4, 769, 276		40.0
43. 00 04300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 12877		212	50. 0
51.00 05100 RECOVERY ROOM		0. 16395		0	51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 44521		0	52.0
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 16853		5, 357	54.0
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 07122		0	55.0
57. 00 05700 CT SCAN		0. 03642		4, 277	57.0
58. 00 05800 MRI		0.08958		713	58. 0
59. 00 05900 CARDI AC CATHETERI ZATI ON 50. 00 06000 LABORATORY		0. 06658 0. 12121		4, 412 97, 784	59. 0 60. 0
64. 00 06400 NTRAVENOUS THERAPY		0. 12121		97, 784 8, 510	64.0
55. 00 06500 RESPI RATORY THERAPY		0. 20305		3, 885	65. 0
66. 00 06600 PHYSI CAL THERAPY		0. 20303		22, 545	66.0
57. 00 06700 OCCUPATI ONAL THERAPY		0. 39300		16, 260	67. 0
58. 00 06800 SPEECH PATHOLOGY		0. 28188		1, 245	68. 0
59. 00 06900 ELECTROCARDI OLOGY		0. 06916		2, 699	69. 0
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 24517		1, 356	70. 0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 36746		8, 815	71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 41204	5 0	0	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 25077	2 399, 380	100, 153	73.0
73. 01 07301 SPECIALTY PHARMACY		0. 85759	1 0	0	73. 0
74.00 07400 RENAL DIALYSIS		0. 30859	5 0	0	74.0
76. 00 03330 ENDOSCOPY		0. 14715		0	76. 0
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS		0. 00000		0	76. 0
76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS		0.00000		0	76. 0
76. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS		0.00000		0	76.0
76. 04 03953 WOUND CARE		0. 38136		0	76.0
76. 06 03954 IMAGING CENTER		0.09602		0	76.0
76. 07 03955 BREAST_DIAGNOSTIC_CENTER OUTPATIENT_SERVICE_COST_CENTERS		0. 44131	7 0	0	76. 0
90. 00 09000 CLINIC		0. 00000	0 0	0	90.0
90. 00 09000 CET MTC 90. 01 04950 INFUSION CENTER		0.66606		0	90.0
PO. 26 04975 SPI NE CENTER		0. 68931		0	90. 2
91. 00 09100 FMFRGENCY		0. 10377			

0. 103771

0.823422

1, 976, 462

91.00

201. 00

202. 00

35, 558

0 92.00

313, 781 200. 00

91. 00 09100 EMERGENCY

200.00

201.00

202.00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

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

Health Financial Systems	COMMUNITY HOSPITAL OF	I NDI ANA,	I NC.	In Lie	u of Form CMS-2552-10

Health Financial Systems COMMUNITY HOSPITAL OF	INDIANA, II	NC.	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0169	Peri od:	Worksheet D-3	
			From 01/01/2020		
			To 12/31/2020	Date/Time Pre	
		VI V		8/2/2021 3: 48	pm
	litl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x col .	
				2)	
LNDATIENT DOUTINE CERVI OF COCT OFNITERS		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			6, 797, 079		30. 00
31. 00 03100 I NTENSI VE CARE UNI T			1, 526, 845		31. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT			13, 096, 192		35. 00
40. 00 04000 SUBPROVI DER - 1 PF			482, 915		40. 00
43. 00 04300 NURSERY			556, 253		43. 00
ANCI LLARY SERVI CE COST CENTERS		T	T		
50.00 05000 OPERATING ROOM		0. 12905		350, 308	50. 00
51. 00 05100 RECOVERY ROOM		0. 16395	· ·	66, 482	51. 00
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0. 44521		245, 768	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 16853		89, 438	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 07122	5 779, 244	55, 502	55.00
57. 00 05700 CT SCAN		0. 03642	3 1, 000, 665	36, 447	57.00
58. 00 05800 MRI		0. 08958	4 225, 323	20, 185	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 06658	8 41, 898	2, 790	59.00
60. 00 06000 LABORATORY		0. 12121	2 3, 506, 320	425, 008	60.00
64. 00 06400 I NTRAVENOUS THERAPY		0. 54532		37, 384	64.00
65. 00 06500 RESPIRATORY THERAPY		0. 20305		374, 414	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 42272		51, 258	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 39300		66, 879	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 28188		25, 099	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 06916		20, 537	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 24517		15, 829	70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		1			70.00
		0. 36746		593, 345	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS		0. 41204 0. 25077		750 433	
		1		750, 432	73. 00
73. 01 O7301 SPECIALTY PHARMACY		0. 85759		0	73. 01
74. 00 07400 RENAL DI ALYSI S		0. 30859		70, 162	74.00
76. 00 03330 ENDOSCOPY		0. 14715		29, 715	76. 00
76. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS		0.00000		0	76. 01
76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS		0.00000		0	76. 02
76. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS		0.00000		0	76. 03
76. 04 03953 WOUND CARE		0. 38136	· ·	12, 811	76. 04
76. 06 03954 I MAGI NG CENTER		0. 09602		0	76. 06
76. 07 03955 BREAST DIAGNOSTIC CENTER		0. 44131	7 0	0	76. 07
OUTPATIENT SERVICE COST CENTERS			_		
90. 00 09000 CLI NI C		0.00000	0	0	90. 00
90. 01 04950 I NFUSI ON CENTER		0. 66606		0	90. 01
90. 26 04975 SPI NE CENTER		0. 68931		0	90. 26
91. 00 09100 EMERGENCY		0. 10458	7 1, 512, 007	158, 136	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 82342	2 236, 965	195, 122	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			19, 229, 627	3, 693, 051	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)	·		19, 229, 627		202. 00
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Health Financial Systems	COMMUNITY HOSPITAL OF INDIANA	, INC.	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi de	er CCN: 15-0169		Worksheet E Part A Date/Time Prepared:

			10 12/31/2020	8/2/2021 3:48	
		Title XVIII	Hospi tal	PPS	
	DADT A LABOUT HOODITH OFFINIAFO HINDER LIDER			1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			0	1 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring instructions)	ng prior to October 1 (see	26, 664, 815	1. 00 1. 01
1. 02					
1.03	B DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October				1. 03
1.04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for	or discharges occurring	on or after	0	1. 04
2.00	October 1 (see instructions) Outlier payments for discharges. (see instructions)			_	2. 00
2. 01	Outlier reconciliation amount			0	2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruct			015 141	2. 02
2.03	Outlier payments for discharges occurring prior to October 1			815, 141	2. 03
2.04	Outlier payments for discharges occurring on or after October	(see instructions)		175, 733	
3. 00 4. 00	Managed Care Simulated Payments	sting pariod (see instru	ctions)	23, 926, 561	
	Bed days available divided by number of days in the cost repoll ndirect Medical Education Adjustment			294. 36	
5. 00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)			0.00	5. 00
6. 00	FTE count for allopathic and osteopathic programs that meet the new programs in accordance with 42 CFR 413.79(e)			0. 00	6. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified ACA \S 5503 reduction amount to the IME cap as specified under			0. 00 0. 00	7. 00 7. 01
	cost report straddles July 1, 2011 then see instructions.		_	4. 09	
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,				8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slo	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 slo	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
10.00	instructions) FTE count for allopathic and osteopathic programs in the current.	ent year from your recor	ds	4. 36	
11.00	FTE count for residents in dental and podiatric programs.			2. 83	
12.00	Current year allowable FTE (see instructions)			6. 92	1
13.00	Total allowable FTE count for the prior year.	or anded on an after Con	+amban 20 1007	6. 14 5. 39	
14. 00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ar ended on or arter sep	telliber 30, 1997,	5. 39	14. 00
15. 00	Sum of lines 12 through 14 divided by 3.			6 15	15. 00
16. 00	Adjustment for residents in initial years of the program				16.00
17. 00	Adjustment for residents displaced by program or hospital clos	sure			17. 00
18.00	Adjusted rolling average FTE count			6. 15	18. 00
19.00	Current year resident to bed ratio (line 18 divided by line 4)).		0. 020893	19.00
20.00	Prior year resident to bed ratio (see instructions)			0. 021325	20.00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 020893 408, 286	
22. 00					
22. 01	IME payment adjustment - Managed Care (see instructions)	of the MMA		271, 662	22.01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 42: Number of additional allopathic and osteopathic IME FTE residents		FR 412. 105	0.00	23. 00
24. 00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			0. 27	24. 00
25. 00	If the amount on line 24 is greater than -O-, then enter the	ower of line 23 or line	24 (see		25. 00
26. 00	instructions) Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)			0. 000000	
28. 00	IME add-on adjustment amount (see instructions)			0.000000	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)		0	28. 01
29. 00	Total IME payment (sum of lines 22 and 28)	,		408, 286	
29. 01	,			271, 662	1
30. 00	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	tions)	3. 66	30.00
31. 00	Percentage of Medicaid patient days (see instructions)		-: -::0)	33. 08	
32. 00	Sum of lines 30 and 31			36. 74	
33. 00				19. 53	
34.00	Disproportionate share adjustment (see instructions)			1, 755, 731	34.00

Heal th	Financial Systems COMMUNITY HOSPITAL OF	INDIANA, INC.	In Lie	eu of Form CMS-2	2552-10
		Provider CCN: 15-0169	Peri od:	Worksheet E	
			From 01/01/2020 To 12/31/2020		
		Title XVIII	Hospi tal	PPS	_p
			Prior to 10/1	On/After 10/1	
			1. 00	2. 00	
	Uncompensated Care Adjustment				
35. 00	Total uncompensated care amount (see instructions)			8, 290, 014, 521	
35. 01	Factor 3 (see instructions)		0. 000049391	0. 000145077	1
35. 02	Hospital uncompensated care payment (If line 34 is zero, enter instructions)	zero on this line) (see	412, 446	1, 202, 694	35. 02
35. 03	Pro rata share of the hospital uncompensated care payment amour	nt (see instructions)	308, 771	303, 145	35. 03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03))	611, 916		36. 00
	Additional payment for high percentage of ESRD beneficiary disc	charges (lines 40 throug	h 46)		
40. 00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684	4 and 685. (see	0		40. 00
41. 00	instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683	3. 684 an 685. (see	0		41.00
	instructions)	•			
41. 01	Total ESRD Medicare covered and paid discharges excluding MS-DF an 685. (see instructions)	RGs 652, 682, 683, 684	0		41. 01
42. 00	Divide line 41 by line 40 (if less than 10%, you do not qualify	y for adjustment)	0.00		42. 00
43.00					43.00
	instructions)				
44. 00	Ratio of average length of stay to one week (line 43 divided by days)	y line 41 divided by 7	0. 000000		44. 00
45. 00	Average weekly cost for dialysis treatments (see instructions)		0.00		45. 00
46.00	Total additional payment (line 45 times line 44 times line 41.0	01)	0		46. 00
47.00	Subtotal (see instructions)		39, 726, 478		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, small	all rural hospitals	0		48. 00
	only. (see instructions)				
				Amount	
49. 00	Total navment for innetient energing costs (occ. instructions)			1. 00 39. 998. 140	49. 00
50. 00	Total payment for inpatient operating costs (see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I and	Dt II as applicable)		39, 998, 140	
51. 00	Exception payment for inpatient program capital (Wkst. L, Pt. I and			3, 170, 420	1
	Direct graduate medical education payment (from Wkst. E-4, line			161, 862	
53. 00	Nursing and Allied Health Managed Care payment	e 47 See Mistractions).		0	1
54. 00	Special add-on payments for new technologies			108, 511	1
54. 01	Islet isolation add-on payment			0	1
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69))		o o	
56. 00				0	
57. 00	Routine service other pass through costs (from Wkst. D, Pt. III		rough 35).	0	57.00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV		<i>,</i>	0	1
59.00	Total (sum of amounts on lines 49 through 58)	,		43, 444, 933	1
60.00	Pri mary payer payments			19, 221	1
61.00	Total amount payable for program beneficiaries (line 59 minus I	ine 60)		43, 425, 712	61.00
62.00	Deductibles billed to program beneficiaries			3, 404, 984	62. 00
63. 00	Coinsurance billed to program beneficiaries			137, 357	
44 00	Allowable had debte (see instructions)			144 027	44 00

Health Financial Systems COMMUNITY HOSPITAL OF	INDIANA, II	NC.	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		CN: 15-0169 F	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Pre 8/2/2021 3:48	pared:
	Ti tl e	e XVIII	Hospi tal	PPS	рш
			(уууу)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column O		0	0	70. 96
the corresponding federal year for the period prior to 10/1)					
70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column 0		0	0	70. 97
the corresponding federal year for the period ending on or aft					
70.98 Low Volume Payment-3	,			0	70. 98
70.99 HAC adjustment amount (see instructions)				420, 297	70. 99
71.00 Amount due provider (line 67 minus lines 68 plus/minus lines 6	59 & 70)			39, 023, 869	71.00
71.01 Sequestration adjustment (see instructions)	ŕ			257, 558	71. 01
71.02 Demonstration payment adjustment amount after sequestration				0	71. 02
71.03 Sequestration adjustment-PARHM pass-throughs					71. 03
72.00 Interim payments				38, 407, 603	72.00
72.01 Interim payments-PARHM					72. 01
73.00 Tentative settlement (for contractor use only)				0	73.00
73.01 Tentative settlement-PARHM (for contractor use only)					73. 01
74.00 Balance due provider/program (line 71 minus lines 71.01, 71.02	2, 72, and			358, 708	74.00
73)					
74.01 Balance due provider/program-PARHM (see instructions)					74. 01
75.00 Protested amounts (nonallowable cost report items) in accordan	nce with			1, 024, 988	75.00
CMS Pub. 15-2, chapter 1, §115.2					
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	of 2.03			0	90.00
plus 2.04 (see instructions)					
91.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00 Operating outlier reconciliation adjustment amount (see instru				0	92.00
93.00 Capital outlier reconciliation adjustment amount (see instruct				0	93. 00
94.00 The rate used to calculate the time value of money (see instru	ucti ons)			0.00	94. 00
95.00 Time value of money for operating expenses (see instructions)				0	95.00
96.00 Time value of money for capital related expenses (see instruct	(Tons)		Dr. or to 10/1	0 /After 10/1	96. 00
			Prior to 10/1 1.00	2.00	
HSP Bonus Payment Amount			1.00	2.00	
100.00 HSP bonus amount (see instructions)			0	0	100. 00
HVBP Adjustment for HSP Bonus Payment			-1		
101.00 HVBP adjustment factor (see instructions)			0.000000000	0.000000000	101.00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions	s)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					1
103.00 HRR adjustment factor (see instructions)			0.0000	0.0000	103. 00
104.00 HRR adjustment amount for HSP bonus payment (see instructions))		0	0	104. 00
Rural Community Hospital Demonstration Project (§410A Demonstr	ration) Adju	ıstment			
200.00 Is this the first year of the current 5-year demonstration per	iod under t	the 21st			200. 00
Century Cures Act? Enter "Y" for yes or "N" for no.					
Cost Reimbursement	40)				004 00
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	e 49)				201. 00
202.00 Medicare discharges (see instructions)					202. 00
203. 00 Case-mix adjustment factor (see instructions)	first was	of the oursent	E veen demand	ration	203. 00
Computation of Demonstration Target Amount Limitation (N/A in period)	iiist year	or the current	5-year demonst	ration	
204. 00 Medicare target amount					204. 00
205.00 Case-mix adjusted target amount (line 203 times line 204)					205. 00
206. 00 Medicare inpatient routine cost cap (line 202 times line 205)					206. 00
Adjustment to Medicare Part A Inpatient Reimbursement					200.00
207.00 Program reimbursement under the §410A Demonstration (see instr	ructions)				207. 00
208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A,					208.00
209.00 Adjustment to Medicare IPPS payments (see instructions)	,				209. 00
210. 00 Reserved for future use					210. 00
211.00 Total adjustment to Medicare IPPS payments (see instructions)					211. 00
Comparision of PPS versus Cost Reimbursement			, '		1
212.00 Total adjustment to Medicare Part A IPPS payments (from line 2	211)				212. 00
213.00 Low-volume adjustment (see instructions)	•				213. 00
218.00 Net Medicare Part A IPPS adjustment (difference between PPS ar	nd cost reim	mbursement)			218. 00
(line 212 minus line 213) (see instructions)					

Health Financial Systems	COMMUNITY HOSPITAL OF	INDIANA, INC	C.	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCI		From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 8/2/2021 3:48 pm
		T: +1 -	VA /I I I	11: 4-1	DDC

	Ti †I	e XVIII	Hospi tal	8/2/2021 3: 48 PPS	pm
		<u> </u>	noop: ta:		
	DART D. MEDICAL AND OTHER HEALTH CERVICES			1.00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			16, 343	1.00
2. 00	Medical and other services reimbursed under OPPS (see instructions)			20, 959, 956	2.00
3. 00	OPPS payments			15, 936, 290	3.00
4.00	Outlier payment (see instructions)			273, 730	4. 00
4. 01	Outlier reconciliation amount (see instructions)			0	
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0. 000	1
6.00	Line 2 times line 5			0	
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	ı
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13	line 200			9.00
10. 00	Organ acquisitions	, TTHE 200			ı
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			16, 343	ı
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
12.00	Ancillary service charges			76, 268	
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	
14. 00	Total reasonable charges (sum of lines 12 and 13) Customary charges			76, 268	14.00
15. 00	Aggregate amount actually collected from patients liable for payment for	services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for payment f			0	
	had such payment been made in accordance with 42 CFR §413.13(e)		3	- 1	
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17. 00
18. 00	Total customary charges (see instructions)			76, 268	
19. 00	Excess of customary charges over reasonable cost (complete only if line	18 exceeds li	ne 11) (see	59, 925	19. 00
20. 00	<pre>instructions) Excess of reasonable cost over customary charges (complete only if line</pre>	11 overode Li	no 10) (coo	0	20.00
20.00	instructions)	II exceeds III	116 10) (366		20.00
21. 00	Lesser of cost or charges (see instructions)			16, 343	21.00
22.00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instructions)			0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			16, 210, 020	24.00
05.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			4 740	05 00
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24 (for C	AU coo inctr	uctions)	4, 742 2, 892, 567	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the su			13, 329, 054	
27.00	instructions)	01 111103 22	una 20] (300	10,027,001	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)			61, 866	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
	Subtotal (sum of lines 27 through 29)			13, 390, 920	
31. 00	Primary payer payments			1, 656	
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			13, 389, 264	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
	Allowable bad debts (see instructions)			307, 320	1
35.00	Adjusted reimbursable bad debts (see instructions)			199, 758	35.00
36. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)			282, 136	36. 00
37. 00				13, 589, 022	
	MSP-LCC reconciliation amount from PS&R				38.00
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00 39. 50
39. 97	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration			0	l
39. 98	Partial or full credits received from manufacturers for replaced devices	(see instruc	tions)		1
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	(555 11.51.45		0	1
	Subtotal (see instructions)			13, 588, 818	40.00
40. 01	Sequestration adjustment (see instructions)			89, 686	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03	, ,				40. 03
	Interim payments			13, 637, 941	1
	Interim payments-PARHM				41.01
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42. 00 42. 01
43. 00	Balance due provider/program (see instructions)			-138, 809	
43. 01	Balance due provider/program-PARHM (see instructions)			150, 507	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CM	S Pub. 15-2,	chapter 1,	0	l .
	§115. 2		·]
0-	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)			0 00	
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92. 00 93. 00
	Total (sum of lines 91 and 93)				94.00
				,	

Health Financial Systems	COMMUNITY HOSPITAL OF INDIANA, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0169	Peri od:	Worksheet E
		From 01/01/2020	Part B
	Component CCN: 15-S169	To 12/31/2020	Date/Time Prepared:
	·		8/2/2021 3:48 pm
	Title XVIII	Subprovi der -	PPS

		Title XVIII	Subprovider - IPF	PPS	
			111	1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			558	1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruction opps payments	tions)		36 270	2. 00 3. 00
4. 00	Outlier payment (see instructions)			270	4. 00
4. 01	Outlier reconciliation amount (see instructions)			Ö	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		l o	9. 00
10.00	Organ acqui si ti ons			0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			558	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12. 00	Ancillary service charges			2, 224	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			2, 224	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 for			Ö	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)	J		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete on	lv if line 18 evceeds li	no 11) (soo	2, 224 1, 666	
19.00	instructions)	Ty IT Title To exceeds IT	116 11) (366	1, 000	17.00
20. 00	Excess of reasonable cost over customary charges (complete on instructions)	ly if line 11 exceeds li	ne 18) (see	0	20. 00
21. 00	Lesser of cost or charges (see instructions)			558	21. 00
22. 00	Interns and residents (see instructions)			0	
23. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			270	24. 00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions	s)		0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line			16	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	plus the sum of lines 22	! and 23] (see	812	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, I)	ine 50)		o	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	ŕ		0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			812	
31. 00 32. 00	Primary payer payments Subtotal (line 30 minus line 31)			0 812	31. 00 32. 00
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)		012	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	•		0	
34. 00	Allowable bad debts (see instructions)			0	
35. 00 36. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	35. 00 36. 00
37. 00	Subtotal (see instructions)	ractions)		812	
38. 00	MSP-LCC reconciliation amount from PS&R				38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instruction: Demonstration payment adjustment amount before sequestration	S)		o	39. 50 39. 97
39. 98	Partial or full credits received from manufacturers for replacements	ced devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	•	,	0	39. 99
40. 00	Subtotal (see instructions)			812	
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			5 O	40. 01 40. 02
40. 02	Sequestration adjustment-PARHM pass-throughs			ا	40. 02
41.00	Interim payments			785	
41. 01	Interim payments-PARHM			_	41. 01
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42. 00 42. 01
43. 00	Balance due provider/program (see instructions)			22	43. 00
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordar §115.2	nce with CMS Pub. 15-2,	chapter 1,	0	44. 00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			1	90.00
91. 00 92. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 00	91. 00 92. 00
93. 00	Time Value of Money (see instructions)			0.00	93.00
	Total (sum of lines 91 and 93)			o	

0

138, 809

13, 499, 132

NPR Date (Mo/Day/Yr)

2 00

6.01

6.02

7.00

8.00

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0169 Peri od: Worksheet E-1 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 8/2/2021 3:48 pm Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 38, 312, 103 13, 533, 641 1. 00 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 08/05/2020 95, 500 08/05/2020 104, 300 3.01 3.02 3.02 3.03 0 3.03 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 0 3.51 0 3.51 0 0 3.52 3.52 0 3.53 3.53 0 3.54 \cap Λ 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 95, 500 104, 300 3.99 3.50-3.98) 38, 407, 603 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 13, 637, 941 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 5. 99 0 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00

358, 708

Contractor

Number

1 00

38, 766, 311

0

the cost report. (1) SETTLEMENT TO PROVIDER

SETTLEMENT TO PROGRAM

8.00 Name of Contractor

Total Medicare program liability (see instructions)

6.01

6 02

7.00

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

Inpatient Part A			Title	XVIII	Subprovi der - I PF	PPS	
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00 1.00			Inpatien	t Part A	Par	rt B	
1,896,037 785 1,00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interim payments payable on individual bills, either subtitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.			1. 00	2.00	3. 00	4. 00	
Submitted for to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 Ust separately each retroactive lump sum adjustment amount based on subsequent revision of the Interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 1.00 0 0 0 0 0 0 0 0 0				1, 896, 037	7	785	
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero.	2.00			()	0	2.00
write "NONE" or enter a zero 1.00 1.15 separately gach retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 3.02 3.03 3.04 3.05 8.00 3.04 3.05 8.00 3.04 3.05 8.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	2 00						2 00
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	3.00						3.00
payment. If none, write "NONE" or enter a zero. (1)							
Program to Provider ADJUSTMENTS TO PROVIDER							
3.02 3.03 3.04 0 0 0 3.03 3.02 3.05 3.							
3.04 3.05 3.04 3.06 0 0 3.04 3.05 3.04 3.05 0 0 0 3.04 3.05 3	3.01	ADJUSTMENTS TO PROVIDER		C)	0	3. 01
3. 04 0 0 0 3. 04 3. 05							
3.05							
Provider to Program							
3. 50 ADJUSTMENTS TO PROGRAM 0 0 3. 50	3.05	District date to District		()	0	3. 05
3.51 3.52 3.53 0 0 0 3.51 3.52 3.53 0 0 0 3.53 3.53 3.54 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 1,896,037 785 4.00 10 10 10 10 10 10 10	3 50						3 50
3.52		ADJUSTIMENTS TO TROUKAIM					
3.53 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.55 3.59 3.50-3.98 3.50							
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.09 3.59-3.98) 1,896,037 785 4.00 10tal interim payments (sum of lines 1, 2, and 3.99) 1,896,037 785 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR							
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) 1,896,037 785 4.00	3.54					0	3. 54
1,896,037 785 4.00 1,896,037 785 4.00	3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C		0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR							
appropriate TO BE COMPLETED BY CONTRACTOR	4. 00			1, 896, 037	'	785	4. 00
TO BE COMPLETED BY CONTRACTOR							
5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Aiso show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	5. 00						5. 00
Write "NONE" or enter a zero. (1) Program to Provider S. 01 TENTATIVE TO PROVIDER O O O S. 02 S. 03 O O S. 02 S. 03 O O S. 05 O O O O O O O O O	0.00						0.00
TENTATI VE TO PROVI DER							
Solition							
Description		TENTATI VE TO PROVI DER					
Provider to Program						- 1	
TENTATI VE TO PROGRAM	5.03	Dravi dan ta Draggam)	0	5. 03
5.51 0	5 50					0	5 50
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.52 0		TENTATI VE TO TROCKAWI					
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00 minus sum							
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 5,210 22 6.01 6.02 SETTLEMENT TO PROGRAM 0 0 6.02 7.00 Total Medicare program liability (see instructions) 1,901,247 807 7.00 Contractor Number (Mo/Day/Yr) 0 1.00 2.00		Subtotal (sum of lines 5.01-5.49 minus sum of lines		d		0	
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00		5. 50-5. 98)					
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6.00						6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	. 01			F 0.4.6			
7.00 Total Medicare program liability (see instructions) 1,901,247 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				5, 210		1	
Contractor Number NPR Date (Mo/Day/Yr) 0 1.00 2.00				1 001 245	,	1 - 1	
Number (Mo/Day/Yr) 0 1.00 2.00	7.00	Total medicale program frability (See Histructions)		1, 901, 247			7.00
0 1.00 2.00							
8.00 Name of Contractor 8.00			()			
	8.00	Name of Contractor					8. 00

llool +b	Financial Customs COMMUNITY HOCDITAL OF	LNDLANA LNC	مالعا	u of Form CMC	2552 10
	Financial Systems COMMUNITY HOSPITAL OF			u of Form CMS-:	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0169	Peri od: From 01/01/2020	Worksheet E-1	
			To 12/31/2020		nared:
			10 12/31/2020	8/2/2021 3:48	
		Title XVIII	Hospi tal	PPS	_p
				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.	S-3, Pt. I col. 15 line	14		1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7.00
	line 168	33			
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	,			ĺ
30.00	Initial/interim HIT payment adjustment (see instructions)				30. 00
	Other Adjustment (specify)				31.00
22 00	Palance due provider (line 8 (or line 10) minus line 20 and L	ino 21) (soo instruction	c)		22 00

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

30. 00 31. 00 32. 00

Health Financial Systems	COMMUNITY HOSPITAL OF INDIANA, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0169	Peri od:	Worksheet E-3
	Component CCN: 15-S169	From 01/01/2020	
	Component Con. 15-3109	10 12/31/2020	8/2/2021 3: 48 pm
	Title XVIII	Subprovi der -	PPS
		IPF	

		<u>1</u> -		
			4 00	
	DADT II. MEDICADE DADT A SERVICES IDE DOS		1. 00	
1.00	PART II - MEDICARE PART A SERVICES - IPF PPS Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		2, 064, 569	1. 00
2.00	Net IPE PPS Outlier Payments		20, 674	2. 00
3.00	Net IPF PPS ECT Payments		20, 074	3. 00
4. 00	Unweighted intern and resident FTE count in the most recent cost report filed on or before Nov	/emher	0.00	4. 00
1. 00	15. 2004. (see instructions)	CIIIDCI	0.00	1. 00
4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced	ed by	0. 00	4. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment under	r 42		
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)			
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of	a "new	0.00	6. 00
	teaching program" (see instuctions)			
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of	a "new	0. 00	7. 00
0.00	teaching program" (see instuctions)		0.00	0.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8. 00 9. 00
9.00	Average Daily Census (see instructions)		11. 008197	
10. 00 11. 00	3 3 3		0. 000000 0	10. 00 11. 00
12. 00 13. 00			2, 085, 243 0	12. 00 13. 00
14. 00			U	14. 00
15. 00			0	15. 00
16. 00			2, 085, 243	
17. 00			2, 065, 245	17. 00
18. 00			2, 085, 243	
19. 00			149, 160	
20. 00			1, 936, 083	
21. 00	· · · · · · · · · · · · · · · · · · ·		25, 696	
22. 00			1, 910, 387	
23. 00			5, 372	23. 00
24. 00	, , , , , , , , , , , , , , , , , , , ,		3, 492	
25. 00			0, 472	25. 00
26. 00	,		1, 913, 879	26. 00
27. 00			1, 713, 377	27. 00
28. 00			0	28. 00
29. 00			0	29. 00
30. 00			0	30. 00
30. 50			0	30. 50
30. 99	Demonstration payment adjustment amount before sequestration		0	30. 99
31. 00			1, 913, 879	31. 00
31. 01			12, 632	
31. 02			0	31. 02
32.00	, , ,		1, 896, 037	32.00
33.00			0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		5, 210	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1	ı, İ	0	35.00
	§115. 2			
	TO BE COMPLETED BY CONTRACTOR			
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		20, 674	
51.00	· · · · · · · · · · · · · · · · · · ·		0	51.00
52.00	1		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

IRECT	Financial Systems COMMUNITY HOSPITAL OF GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CO		Peri od:	u of Form CMS-2 Worksheet E-4	
	EDUCATION COSTS	Trovider ed		From 01/01/2020		
				To 12/31/2020	Date/Time Prep 8/2/2021 3:48	
		Title	XVIII	Hospi tal	PPS	
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT Unweighted resident FTE count for allopathic and osteopathic	programs for	cost roporti	ng pori ods	0.00	1 1.
	ending on or before December 31, 1996.	. 0	•		0.00	'.
	Unweighted FTE resident cap add-on for new programs per 42 CFI		1) (see instr	uctions)	0.00	
00 01	Amount of reduction to Direct GME cap under section 422 of MM. Direct GME cap reduction amount under ACA §5503 in accordance		8413 79 (m)	(see	0. 00 0. 00	1
•	instructions for cost reporting periods straddling 7/1/2011)				0.00	
00	Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	to a Medicare	4. 10	4.
01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst	•	cost reporti	ng periods	0.00	4
	straddling 7/1/2011)					١.
02	ACA Section 5506 number of additional direct GME FTE cap slot: periods straddling 7/1/2011)	s (see inst	ructions for	cost reporting	0.00	4
	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl	us or minus	line 4 plus l	ines 4.01 and	4. 10	5
00	4.02 plus applicable subscripts Unweighted resident FTE count for allopathic and osteopathic	programs for	the current	wear from your	4. 36	6
	records (see instructions)	programs ron	the current	year rrom your	4. 30	"
00	Enter the lesser of line 5 or line 6		D : 0	1 011	4. 10	7
			Primary Care 1.00	0ther 2.00	<u>Total</u> 3. 00	
00	Weighted FTE count for physicians in an allopathic and osteop	athi c	0.9		4. 36	8
00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw	ri sa	0.8	3. 23	4. 10	9
	multiply line 8 times the result of line 5 divided by the amount		0.0	3.23	4. 10	′
00	6.	ont year		2 02		10
	Weighted dental and podiatric resident FTE count for the currounweighted dental and podiatric resident FTE count for the cu			2. 83 2. 83		10
00	Total weighted FTE count	, i	0.8	6. 06		11
00	Total weighted resident FTE count for the prior cost reporting instructions)	g year (see	1.4	4. 65		12
00	Total weighted resident FTE count for the penultimate cost re	porting	1. 2	4. 12		13
00	year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided	by 2)	1. 2	4. 94		14
	Adjustment for residents in initial years of new programs	Dy 3).	0.0			15
01	Unweighted adjustment for residents in initial years of new p		0.0	I I		15
1	Adjustment for residents displaced by program or hospital clos		0.0	I I		16
01	Unweighted adjustment for residents displaced by program or holosure	ospi tal	0.0	0.00		16
00	Adjusted rolling average FTE count		1. 2	4. 94		17
- 1	Per resident amount		96, 394. 2			18
00	Approved amount for resident costs		116, 63	476, 188	592, 825	19
					1. 00	
00	Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)	TE resident	cap slots rec	ei ved under 42	0. 00	20
00	Direct GME FTE unweighted resident count over cap (see instru	ctions)			0. 26	21
	Allowable additional direct GME FTE Resident Count (see instru				0.00	22
	Enter the locality adjustment national average per resident a	mount (see i	nstructions)		0. 00	
- 1	Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)				0 592, 825	
00	Total direct dwc amount (sum of fines 17 and 24)		Inpatient Par	t Managed Care	Total	23
			1. 00	2.00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	3.00	
00	Inpatient Days (see instructions) (Title XIX - see S-2 Part II	X, line	19, 15	11, 710		26
00	3.02, column 2) Total Inpatient Days (see instructions)		79, 62	79, 621		27
.00	Ratio of inpatient days to total inpatient days		0. 24061			28
	Program direct GME amount		142, 64		229, 831	
1						
. 01	Percent reduction for MA DGME Reduction for direct GME payments for Medicare Advantage			7. 00 6, 103	6, 103	29 30

Heal th	Financial Systems COMMUNITY HOSPITAL OF	LNDLANA LNC	Inlie	u of Form CMS-2	2552_10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der CCN: 15-0169	Peri od:	Worksheet E-4	
	AL EDUCATION COSTS		From 01/01/2020 To 12/31/2020	Date/Time Pre 8/2/2021 3:48	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLI EDUCATION COSTS)	`		CAL	
32. 00	Renal dialysis direct medical education costs (from Wkst. B, and 94)	Pt. I, sum of col. 20 an	d 23, lines 74	0	32. 00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I, col. 8, sum of lines	74 and 94)	4, 598, 982	33. 00
34.00	Ratio of direct medical education costs to total charges (line	e 32 ÷ line 33)		0.000000	34.00
	Medicare outpatient ESRD charges (see instructions)			0	35. 00
36.00	Medicare outpatient ESRD direct medical education costs (line			0	36. 00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY			
	Part A Reasonable Cost				
37. 00				54, 897, 395	
38. 00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
40.00	1 2 1 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	11 40)		19, 221	
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minu	s line 40)		54, 878, 174	41.00
42.00	Part B Reasonable Cost Reasonable cost (see instructions)		T	20, 976, 893	42.00
	Primary payer payments (see instructions)				43.00
44. 00				20, 975, 237	
45. 00	Total reasonable cost (sum of lines 41 and 44)			75, 853, 411	
46. 00	,	e 41 ÷ line 45)		0. 723477	
	Ratio of Part B reasonable cost to total reasonable cost (line			0. 276523	
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA				1
48.00	Total program GME payment (line 31)			223, 728	48. 00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		161, 862	49. 00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instructions)		61, 866	50.00

Health Financial Systems

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

Provider CCN: 15-0169 P

Peri od: Worksheet G
From 01/01/2020
To 12/31/2020 Date/Ti me Prepared: 8/2/2021 3: 48 pm

		General Fund		Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS			2.22		
1.00	Cash on hand in banks	8, 700		0	_	1. 00
2.00	Temporary investments	0	0	0		2.00
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	307, 262, 169	0	0	0	3. 00 4. 00
5.00	Other receivable	-225, 936, 710		0	0	5.00
6. 00	Allowances for uncollectible notes and accounts receivable	593, 366		0	0	6.00
7. 00	Inventory	7, 543, 956		0	0	7. 00
8.00	Prepai d expenses	0	0	0	0	8. 00
9.00	Other current assets	4, 767, 654	0	0	0	9. 00
10. 00	Due from other funds	0	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	94, 239, 135	0	0	0	11. 00
12. 00	FI XED ASSETS Land	2, 705, 851	T 0	0	0	12. 00
13. 00	Land improvements	4, 358, 832		0	1	13.00
14. 00	Accumulated depreciation	0	o o	0		14. 00
15. 00	Bui I di ngs	326, 772, 560	0	0	0	15. 00
16.00	Accumulated depreciation	0	0	0	0	16. 00
17. 00	Leasehold improvements	4, 611, 425	0	0	0	17. 00
18. 00	Accumul ated depreciation	0	0	0	0	18. 00
19. 00	Fixed equipment	122, 988, 387	0	0	0	19.00
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	102 001	0	0	0	20.00
21.00	Accumulated depreciation	103, 991		0	0	22.00
23. 00	Major movable equipment			0	0	23. 00
24. 00	Accumulated depreciation	-255, 913, 251	Ö	0	l o	24. 00
25. 00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26.00	Accumulated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Minor equipment-nondepreciable	316, 270	1	0	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	205, 944, 065	0	0	0	30. 00
31. 00	Investments		0	0	0	31.00
32. 00	Deposits on Leases		o o	0		32. 00
33. 00	Due from owners/officers	0	0	0	0	33. 00
34.00	Other assets	1, 133, 415, 406	0	0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	1, 133, 415, 406	1	0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	1, 433, 598, 606	0	0	0	36. 00
27.00	CURRENT LIABILITIES	2 000 //5	1	0		07.00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	2, 000, 665	0	0	1	37. 00 38. 00
39. 00	Payroll taxes payable			0	0	39.00
40. 00	Notes and Loans payable (short term)	0	Ö	0	l o	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43. 00
44. 00	Other current liabilities	16, 678, 432	1	0	0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44)	18, 679, 097	'] 0	0	0	45. 00
46. 00	LONG TERM LIABILITIES Mortgage payable	1 0	0	0	0	46. 00
47. 00	Notes payable			_	1	47. 00
48. 00	Unsecured Loans	0	ō			48. 00
49.00	Other long term liabilities	20, 558, 318	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	20, 558, 318	0	0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	39, 237, 415	0	0	0	51.00
	CAPI TAL ACCOUNTS	1	1		I	
52.00	General fund balance	1, 394, 361, 191	0			52.00
53.00	Specific purpose fund Donor created - endowment fund balance - restricted		0	0		53. 00 54. 00
54. 00 55. 00	Donor created - endowment fund balance - restricted		1	0		55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant		1		0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansi on					
59. 00	Total fund balances (sum of lines 52 thru 58)	1, 394, 361, 191		0	0	59.00
60. 00	Total liabilities and fund balances (sum of lines 51 and	1, 433, 598, 606	0	0	0	60.00
	[59]	I	I	l	I	I

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0169

					10 12/31/2020	8/2/2021 3:48	
		Genera	l Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period		1, 265, 676, 286		(1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		128, 684, 905				2. 00
3.00	Total (sum of line 1 and line 2)		1, 394, 361, 191		(3. 00
4.00	Additions (credit adjustments) (specify)	0			0	0	4. 00
5.00		0			0	0	5. 00
6.00		0			0	0	6. 00
7.00		0			0	0	7. 00
8.00		0			0	0	8. 00
9.00		0			0	0	9. 00
10.00	Total additions (sum of line 4-9)		0				10. 00
11. 00	Subtotal (line 3 plus line 10)		1, 394, 361, 191				11. 00
12. 00	Deductions (debit adjustments) (specify)	0			0	0	12. 00
13. 00		0			0	0	13. 00
14. 00		0			0	0	14. 00
15.00		0			0	0	15. 00
16.00		0			0	0	16.00
17. 00	T	0			0	0	17. 00
18.00	Total deductions (sum of lines 12-17)		0				18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		1, 394, 361, 191		()	19. 00
	Sheet (Time II minus II ne 18)	Endowment Fund	PI ant	Fund			
		Endowner Tund	Traire	l			
		6. 00	7. 00	8.00			
1.00	Fund balances at beginning of period	0			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2. 00
3.00	Total (sum of line 1 and line 2)	0			0		3. 00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			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	Deductions (debit adjustments) (specify)		0				12. 00
13.00			0				13. 00
14.00			0				14. 00
15. 00			0				15. 00
16.00			0				16. 00
17. 00			0				17. 00
18. 00	,	0			0		18. 00
19. 00	Fund balance at end of period per balance	0			0		19. 00
	sheet (line 11 minus line 18)			l			l

Heal th Financial Systems COMMUNI
STATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0169

| In Lieu of Form CMS-2552-10 | Period: | Worksheet G-2 | From 01/01/2020 | Parts | & | I | | To 12/31/2020 | Date/Time Prepared: | 8/2/2021 3: 48 pm

					8/2/2021 3:48	pm
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		168, 706, 375		168, 706, 375	1.00
2.00	SUBPROVI DER - I PF		9, 403, 664		9, 403, 664	2.00
3.00	SUBPROVI DER - I RF					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)		178, 110, 039		178, 110, 039	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT		29, 445, 481		29, 445, 481	11.00
12.00	CORONARY CARE UNIT					12.00
13. 00	BURN INTENSIVE CARE UNIT					13.00
14. 00	SURGI CAL INTENSIVE CARE UNIT					14. 00
15. 00	NEONATAL INTENSIVE CARE UNIT		117, 924, 265		117, 924, 265	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of	lines	147, 369, 746		147, 369, 746	16. 00
10.00	11-15)	111103	117,007,710		117,007,710	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		325, 479, 785		325, 479, 785	17. 00
18. 00	Ancillary services		556, 450, 424		1, 166, 878, 373	18. 00
19. 00	Outpatient services		030, 430, 424		0	19. 00
20. 00	RURAL HEALTH CLINIC	•	0	_	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00
22. 00	HOME HEALTH AGENCY		0	U	U	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	PRO FEES		0	486, 312	486, 312	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst	881, 930, 209		1, 492, 844, 470	28. 00
20.00	G-3, line 1)	IO WKSI.	001, 930, 209	010, 914, 201	1, 492, 044, 470	26.00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)	T		438, 299, 177		29. 00
30. 00	ADD (SPECIFY)		0			30.00
31. 00	ADD (SECTIF)		0			31. 00
32. 00			0			32. 00
33. 00			0			33. 00
			0			34. 00
34. 00			0			
35. 00	Total additions (sum of lines 20 25)		Ü	0		35. 00
36.00	Total additions (sum of lines 30-35)		0	U		36.00
37. 00	DEDUCT (SPECIFY)		0			37. 00
38. 00			J			38. 00
39. 00			0			39. 00
40.00			0			40.00
41. 00	T + 1 + 1 + 1		0	_		41.00
42. 00	Total deductions (sum of lines 37-41)	\(\(\)		420 200 477		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		438, 299, 177		43. 00
	to Wkst. G-3, line 4)					

Health Financial Systems	COMMUNITY HOSPITAL OF INDIANA, INC.	In Lie	u of Form CMS-2552-10
STATEMENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0169	Peri od: From 01/01/2020 To 12/31/2020	Worksheet G-3 Date/Time Prepared: 8/2/2021 3:48 pm

STATEN	ILIVI OF REVENUES AND EXPENSES	FIOVIDEI CCN. 15-0109	From 01/01/2020	WOLKSHEET G-3	
			To 12/31/2020	Date/Time Pre	oared:
			12, 01, 2020	8/2/2021 3:48	
	· · · · · · · · · · · · · · · · · · ·				
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		1, 492, 844, 470	1. 00
2.00	Less contractual allowances and discounts on patients' account	ts		1, 026, 434, 371	2.00
3.00	Net patient revenues (line 1 minus line 2)			466, 410, 099	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 4	43)		438, 299, 177	4.00
5.00	Net income from service to patients (line 3 minus line 4)			28, 110, 922	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			265, 399	6.00
7.00	Income from investments			13, 110, 559	7. 00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			4, 009	10.00
11. 00	Rebates and refunds of expenses			0	11.00
12.00	Parking Lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			1, 851, 209	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other th	nan patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18. 00	Revenue from sale of medical records and abstracts			0	18.00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			59, 105, 051	22.00
23.00	Governmental appropriations			0	23.00
24.00	OTHER (SPECIFY)			0	24.00
24. 50	COVI D-19 PHE Funding			26, 237, 756	24. 50
25.00	Total other income (sum of lines 6-24)			100, 573, 983	25.00
26.00	Total (line 5 plus line 25)			128, 684, 905	26.00
27.00	OTHER EXPENSES (SPECIFY)			0	27. 00
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)			128, 684, 905	29. 00

Heal th	Financial Systems	COMMUNITY HOSPITAL OF	F INDIANA, INC.	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT		Provider CCN: 15-0169	Peri od: From 01/01/2020 To 12/31/2020		
			Title XVIII	Hospi tal	PPS	
	DART I SULLY DROOPS OT LYS METHOD				1. 00	
	PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT					
1. 00	Capital DRG other than outlier				2, 808, 200	1. 00
1.00	Model 4 BPCI Capital DRG other tha	an outlier			2, 808, 200	1. 00
2.00	Capital DRG outlier payments	an outriei			128, 400	2. 00
2. 01	Model 4 BPCI Capital DRG outlier	payments			120, 400	2. 01
3.00			eporting period (see inst	ructions)	212. 23	3. 00
4.00	Total inpatient days divided by number of days in the cost reporting period (see instructions) Number of interns & residents (see instructions)			,	6. 15	4. 00
5.00	Indirect medical education percentage (see instructions)			0. 82	5. 00	
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and			23, 027	6. 00	
7. 00	1.01) (see instructions) Percentage of SSI recipient patien	at days to Madicara Dart A r	antiont days (Warkshoot F	nort Alino	2.44	7. 00
7.00	30) (see instructions)	it days to medicale Part A p	datrent days (worksheet i	, part A Title	3. 66	7.00
8.00	Percentage of Medicaid patient day	ys to total days (see instru	ıcti ons)		33. 08	8. 00
9.00	Sum of lines 7 and 8				36. 74	9. 00
10. 00	Allowable disproportionate share p		s)		7. 72	10.00
11. 00	Disproportionate share adjustment				216, 793	
12. 00	Total prospective capital payments	s (see instructions)			3, 176, 420	12. 00
					1. 00	
	PART II - PAYMENT UNDER REASONABLE	COST				
1.00	Program inpatient routine capital				0	1. 00
2.00	Program inpatient ancillary capita				0	2. 00
3.00	Total inpatient program capital co				0	3. 00
4.00	Capital cost payment factor (see i				0	4. 00
5. 00	Total inpatient program capital co	ost (line 3 x line 4)			0	5. 00
					1. 00	
	PART III - COMPUTATION OF EXCEPTION	N PAYMENTS			1.00	
1.00	Program inpatient capital costs (s				0	1. 00
2.00	Program inpatient capital costs for	or extraordinary circumstand	ces (see instructions)		0	2. 00
3.00	Net program inpatient capital cost				0	3. 00
4 00	Applicable exception percentage (coo inctructions)			0.00	4 00

	. 00	Capital DRG other than outlier	2, 808, 200	1.00
1	. 01	Model 4 BPCI Capital DRG other than outlier	0	1. 01
2	2. 00	Capital DRG outlier payments	128, 400	2. 00
2	2. 01	Model 4 BPCI Capital DRG outlier payments	0	2. 01
3	3. 00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	212. 23	3. 00
4	. 00	Number of interns & residents (see instructions)	6. 15	4.00
5	. 00	Indirect medical education percentage (see instructions)	0. 82	5. 00
6	. 00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and	23, 027	6. 00
		1.01) (see instructions)		
7	. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	3. 66	7. 00
۶	3. 00	Percentage of Medicaid patient days to total days (see instructions)	33. 08	8. 00
	0.00	Sum of lines 7 and 8	36.74	9. 00
	0. 00	Allowable disproportionate share percentage (see instructions)	7. 72	
	1. 00	Disproportionate share adjustment (see instructions)	216, 793	
		Total prospective capital payments (see instructions)	3, 176, 420	
	2.00	Total prospective capital payments (see Histructions)	3, 170, 420	12.00
			1. 00	
		PART II - PAYMENT UNDER REASONABLE COST		
	. 00	Program inpatient routine capital cost (see instructions)	0	1. 00
	2. 00	Program inpatient ancillary capital cost (see instructions)	0	2. 00
	3. 00	Total inpatient program capital cost (line 1 plus line 2)	0	3. 00
	. 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	
1	. 00	Program inpatient capital costs (see instructions)	0	1. 00
	. 00	Program inpatient capital costs (see instructions)	0	2.00
	3. 00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
	. 00	Applicable exception percentage (see instructions)	0.00	4.00
	5. 00	Capital cost for comparison to payments (line 3 x line 4)	0.00	5.00
			0.00	6.00
	o. 00 '. 00	Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0.00	7.00
			0	
	3. 00	Capital minimum payment level (line 5 plus line 7)	0	8. 00
	0.00	Current year capital payments (from Part I, line 12, as applicable)	_	9.00
	0.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
	1. 00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11. 00
		Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12. 00
1		Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13. 00
	4. 00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14. 00
1		[C	0	15. 00
	5. 00	Current year allowable operating and capital payment (see instructions)	U	
1		Current year allowable operating and capital payment (see instructions)	0	16. 00