Health Financial Systems COMMUNITY H				u of Form CMS-25	552-10	
This report is required by law (42 USC 1395g; 42 CFR 413.20(b)						
payments made since the beginning of the cost reporting period	being dee	emed overpayments (42	USC 1395g).	OMB NO. 0938-0		
				EXPIRES 03-31-	2022	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFIC AND SETTLEMENT SUMMARY	ATION Pro	ovider CCN: 15-0113	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prep 5/30/2022 2:53		
PART I – COST REPORT STATUS						
Provider 1. [X] Electronically prepared cost report			Date: 5/30/20	22 Time: 2:	53 pm	
use only 2. [] Manually prepared cost report						
3. [0] If this is an amended report enter the r 4. [F] Medicare Utilization. Enter "F" for full			esubmitted this co	ost report		
Contractor use only5. [1] Cost Report Status (1) As Submitted6. Date Received: 7. Contractor No.10. NPR Date: 11. Contractor's Vendor Code:4(2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended8. [N] Initial Report for this Provider CCN 9. [N] Final Report for this Provider CCN10. NPR Date: 11. Contractor's Vendor Code:4(4) Reopened (5) Amended9. [N] Final Report for this Provider CCN10. NPR Date: 11. Contractor's Vendor Code:4						
PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINI	STRATOR OF	R PROVIDER(S)				
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINE ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTL	LAW. FURT	HERMORE, IF SERVICES	IDENTIFIED IN TH	IIS REPORT WERE		
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.			· · · ·			
CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRA	TOR OF PR	OVI DER(S)				
I HEREBY CERTIFY that I have read the above certificat electronically filed or manually submitted cost report Statement of Revenue and Expenses prepared by COMMUNIT period beginning 01/01/2021 and ending 12/31/2021 and statement are true, correct, complete and prepared fro applicable instructions, except as noted. I further ce regarding the provision of health care services, and t provided in compliance with such laws and regulations.	and submi Y HOSPITAL to the bes om the book ertify that hat the se	tted cost report and ANDERSON (15-0113 st of my knowledge arks and records of the t I am familiar with	I the Balance Shee) for the cost re nd belief, this re e provider in acco the laws and regu	et and eporting eport and ordance with ulations		
SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		ELECTRONI C			
1	2	SI GN	ATURE STATEMENT			
	Y	I have read and agre statement. I certify	that I intend my	/ el ectroni c	1	

	1 101	iy iviiriaru	binding equivalent of my original signature.	
2	Signatory Printed Name	Holly Millard		2
3	Signatory Title	SVP FINANCE		3
4	Date	(Dated when report is electronica		4

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	391, 169	-313, 209	0	0	1.00
2.00	Subprovider - IPF	0	0	0		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	391, 169	-313, 209	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.

0111	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTITICATION DATA	Provic			Period: From 01/01/2		Part I	eet S-2	
						To 12/31/2	021	Date/Ti 5/30/20		
	1.00	2.00		3.00		4.	00	57 507 20	522 2.5	
	Hospital and Hospital Health Care Con									I .
00 00	Street: 1515 NORTH MADISON AVE City: ANDERSON	PO Box: State: IN	Zip Cod	o. 1601	1 Count	y: MADI SON				1.
	City. Anderson	Component Name	CCN	CBSA			Payme	nt Syst	em (P,	2
			Number	Numbe	er Type	Certified		0, or		1
		1.00	2.00	2.00	1.00	F 00	V	XVIII	-	4
	Hospital and Hospital-Based Componen	1.00 t Identification	2.00	3.00	4.00	5.00	6.00	7.00	8.00	-
00	Hospi tal	COMMUNITY HOSPITAL	150113	2690	0 1	01/01/1966	N	P	Р	3
_		ANDERSON								
)0)0	Subprovider - IPF Subprovider - IRF									4
00	Subprovider - (Other)									6
0	Swing Beds - SNF									7
0	Swing Beds - NF									8
0	Hospital-Based SNF									9
00	Hospital-Based NF Hospital-Based OLTC									10
00	Hospi tal -Based HHA									12
00	Separately Certified ASC									13
00	Hospi tal -Based Hospi ce									14
00	Hospital-Based Health Clinic - RHC									15
00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I									16
00	Renal Dialysis									18
	Other									19
						From:		To		4
00	Cost Reporting Period (mm/dd/yyyy)					1.00	21	2.0		20
	Type of Control (see instructions)					2	~ 1	12/ 51/	2021	21
	Inpatient PPS Information				1.00	2.00		3.0	00	-
00	Does this facility qualify and is it	currently receiving	pavments for	-	Y	N				22
	disproportionate share hospital adjus	stment, in accordance	with 42 CFF							
	§412.106? In column 1, enter "Y" for									
	facility subject to 42 CFR Section §4 hospital?) In column 2, enter "Y" for		amendment							
01	Did this hospital receive interim und		ents for thi	s	Y	Y				22
	cost reporting period? Enter in colur									
	the portion of the cost reporting per									
	Enter in column 2, "Y" for yes or "N" reporting period occurring on or after			cost						
02	Is this a newly merged hospital that			-e	Ν	N				22
	payments to be determined at cost rep	port settlement? (see	instructior							
	Enter in column 1, "Y" for yes or "N									
	cost reporting period prior to Octobe or "N" for no, for the portion of the									
	October 1.	c cost reporting peri								
03	Did this hospital receive a geographi				Ν	N		Y	,	22
	rural as a result of the OMB standard									
	adopted by CMS in FY2015? Enter in co for the portion of the cost reporting									
	in column 2, "Y" for yes or "N" for i									
	reporting period occurring on or after									
	Does this hospital contain at least									
	counted in accordance with 42 CFR 412 yes or "N" for no.	2. 105)? Enter in colu	IIII 3, Y IC							
04	Did this hospital receive a geographi	ic reclassification f	rom urban to		Ν	N		N	I	22
	rural as a result of the revised OMB	delineations for sta	tistical are	eas						
	adopted by CMS in FY 2021? Enter in (
	for the portion of the cost reporting in column 2, "Y" for yes or "N" for i			"						
	reporting period occurring on or after									
	Does this hospital contain at least	100 but not more than	499 beds (a							
	counted in accordance with 42 CFR 412	2.105)? Enter in col	umn 3, "Y" f	for						
	yes or "N" for no. Which method is used to determine Med	dicaid days on lines	24 and/or 25	,		3 N				23
$\cap \cap$		urcaru uays un rines	∠+ anu/01 25			J 11				23
00	below? In column 1, enter 1 if date of	of admission, 2 if ce	nsus days, c	or 3						
00		of identifying the da	ys in this o							

JUSPI TAL I	AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA I	Provider CC	N: 15-0113	Peri od:			ksheet		2552-1
						/31/2021	Date 5/30	e/Time 0/2022	2 2:5	oared: 3 pm
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d			0th Medic day	ai d	
		1.00	2.00	3.00	4.00	5.0		6.0		
in- Med out 4, col !5.00 If Med out Med	this provider is an IPPS hospital, enter the -state Medicaid paid days in column 1, in-state dicaid eligible unpaid days in column 2, t-of-state Medicaid paid days in column 3, t-of-state Medicaid eligible unpaid days in column Medicaid HMO paid and eligible but unpaid days in umn 5, and other Medicaid days in column 6. this provider is an IRF, enter the in-state dicaid paid days in column 1, the in-state dicaid eligible unpaid days in column 2, t-of-state Medicaid days in column 3, out-of-state dicaid eligible unpaid days in column 4, Medicaid D paid and eligible but unpaid days in column 5.	939	0			0 5	0		10	24. 0 25. 0
				<u> </u>	Urban,	/Rural S	Date	e of G	eogr	
26.00 Ent	ter your standard geographic classification (not wa	ade) status	at the bea	inning of t		. 00	1	2.00		26.00
7.00 Ent rep	st reporting period. Enter "1" for urban or "2" for ter your standard geographic classification (not wa porting period. Enter in column 1, "1" for urban or ter the effective date of the geographic reclassifi	r rural. age) status r "2" for ru	at the end ural. If ap	l of the cos			1			27.00
	this is a sole community hospital (SCH), enter the fect in the cost reporting period.	e number of	periods SC	CH status in	1	(0			35.00
en	ect in the cost reporting period.				Begi	nni ng:	E	indi ng	:	
6.00 Ent	ter applicable beginning and ending dates of SCH st	tatus Subs	rint line	36 for numb		. 00		2.00		36. 0
of	periods in excess of one and enter subsequent date this is a Medicare dependent hospital (MDH), enter	es.				(0			37.0
7.01 Is acc	in effect in the cost reporting period. this hospital a former MDH that is eligible for th cordance with FY 2016 OPPS final rule? Enter "Y" fo structions)									37.0
88.00 If gre	line 37 is 1, enter the beginning and ending dates eater than 1, subscript this line for the number of ter subsequent dates.									38.00
						//N . 00		Y/N 2.00		
hos 1 " acc or	es this facility qualify for the inpatient hospital spitals in accordance with 42 CFR §412.101(b)(2)(i) 'Y" for yes or "N" for no. Does the facility meet 1 cordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii "N" for no. (see instructions) this hospital subject to the HAC program reduction), (İi), or the mileage i)? Enter i	(iii)? Ent requiremen n column 2	er in colum nts in ? "Y" for ye	ime in :S	N		N		39.00
	' for no in column 1, for discharges prior to Octob in column 2, for discharges on or after October 1.	per 1. Enter	r "Y" for y			N		Ŷ		40. 0
	· · ·		<u>ructions)</u>						XIX	
		(see mst	ructions)			V 1. C			3.00	
no Pro	ospective Payment System (PPS)-Capital					1.0	0 2.	00 3	3.00	45.0
no 5.00 Pro wit	es this facility qualify and receive Capital paymer th 42 CFR Section §412.320? (see instructions)	nt for disp	roportionat			1. C	0 2.	00 3 Y	3. 00 N	45. 0 46. 0
5.00 6.00 Pro Doe wit Is pur Pt.	es this facility qualify and receive Capital payment th 42 CFR Section §412.320? (see instructions) this facility eligible for additional payment exce rsuant to 42 CFR §412.348(f)? If yes, complete Wkst III.	nt for disp eption for t. L, Pt. I	roportionat extraordina and Wkst	ary circumst :. L-1, Pt.	ances I through	e N N	00 2.	00 : Y N	8. 00 N N	46. 0
no 5.00 Doe wit 6.00 Is pur Pt. 7.00 Is 8.00 Is	es this facility qualify and receive Capital payment th 42 CFR Section §412.320? (see instructions) this facility eligible for additional payment exce suant to 42 CFR §412.348(f)? If yes, complete Wkst III. this a new hospital under 42 CFR §412.300(b) PPS of the facility electing full federal capital payment	nt for disp eption for (t. L, Pt. I capital? Ei	roportionat extraordina and Wkst nter "Y for	nry circumst :. L-1, Pt. - yes or "N"	ances I through for no.	e N N	00 2.	00 3 Y	3. 00 N	46. 0 47. 0
no 5.00 Doe wit 6.00 Is pur Pt. 7.00 Is 8.00 Is 8.00 Is Tea 6.00 Is "N" was yea	es this facility qualify and receive Capital payment th 42 CFR Section §412.320? (see instructions) this facility eligible for additional payment exce suant to 42 CFR §412.348(f)? If yes, complete Wkst III. this a new hospital under 42 CFR §412.300(b) PPS of	nt for disp eption for t. L, Pt. I capital? En t? Enter " approved GI e to column cograms in " cable CRs) I	roportionat extraordina 1 and Wkst nter "Y for Y" for yes ME programs 1 is "Y", the prior y	ry circumst . L-1, Pt. or "N" for ? Enter "Y" or if this year or penu	for no. no. for yes hospital itimate	e N N N or Y	00 2.	00 3 Y N N	8. 00 N N N	
no Pro 5.00 Doe wit 6.00 Is pur Pt. 7.00 Is 6.00 Is "N" was yea Ent 7.00 If GME is for for	es this facility qualify and receive Capital payment th 42 CFR Section §412.320? (see instructions) this facility eligible for additional payment excer- suant to 42 CFR §412.348(f)? If yes, complete Wkst III. this a new hospital under 42 CFR §412.300(b) PPS of the facility electing full federal capital payment aching Hospitals this a hospital involved in training residents in 'for no in column 1. For column 2, if the response s involved in training residents in approved GME pr ar, and are you are impacted by CR 11642 (or applic	nt for disp eption for of t. L, Pt. I capital? En t? Enter " approved Gf e to column rograms in cable CRs) f umn 2. beriod durin yes or "N th of this of (", completo	roportionat extraordina l and Wkst nter "Y for Y" for yes ME programs 1 is "Y", the prior y MA direct G ng which re ' for no in cost report e Worksheet	ry circumst . L-1, Pt. yes or "N" or "N" for ? Enter "Y" or if this rear or penu SME payment esidents in a column 1. ting period?	ances I through for no. no. for yes hospital Itimate reduction approved If column 2 Enter "	e N N N N Or Y ? N 1 Y"	00 2.	00 () Y N N N	8. 00 N N N	46. 0 47. 0 48. 0
no Pro Doe wit 6.00 Is pur Pt. 7.00 Is 8.00 Is 8.00 Is 56.00 Is "N" was yea 6.01 f GME is for "N" was 2.01 f	es this facility qualify and receive Capital payment th 42 CFR Section §412.320? (see instructions) this facility eligible for additional payment excer- suant to 42 CFR §412.348(f)? If yes, complete Wkst III. this a new hospital under 42 CFR §412.300(b) PPS of the facility electing full federal capital payment aching Hospitals this a hospital involved in training residents in 'for no in column 1. For column 2, if the response s involved in training residents in approved GME pr ar, and are you are impacted by CR 11642 (or applic ter "Y" for yes; otherwise, enter "N" for no in col line 56 is yes, is this the first cost reporting p E programs trained at this facility? Enter "Y" for "Y" did residents start training in the first mont r yes or "N" for no in column 2. If column 2 is "N	nt for disp eption for of t. L, Pt. I capital? En t? Enter " approved G e to column rograms in cable CRs) f umn 2. beriod durin r yes or "N" th of this of (", completa (, if applioursement for	roportionat extraordina 1 and Wkst nter "Y for Y" for yes ME programs 1 is "Y", the prior y MA direct G mg which re for no in cost report e Worksheet cable. or physicia	ry circumst L-1, Pt. yes or "N" or "N" for ? Enter "Y" or if this year or penu ME payment esidents in a column 1. .:ing period? E-4. If co	ances I through for no. no. for yes hospital Itimate reduction approved If column Enter " Jumn 2 is	e N N N N Or Y ? N 1 Y"		00 () Y N N N	8. 00 N N N	46. 0 47. 0 48. 0 56. 0

	Financial Systems COMMUNIT AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		TAL ANDERSON Provider C		Period:	u of Form CMS-2 Worksheet S-2	
					rom 01/01/2021 o 12/31/2021	Part I Date/Time Pre	
				NAHE 413.85	Worksheet A	5/30/2022 2:5 Pass-Through	
				Y/N	Line #	Qualification Criterion Code	
60, 00	Are you claiming nursing and allied health education		costs for	1.00 N	2.00	3.00	60.00
80. 00	any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in colu	85? (s umn 1. CR) NAHE	see If column 1				80.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
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 determining compliance with the 75% test. (see						61. 03
61. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61.04
61. 05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61.05
61.06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
(1 10	Of the FIFe in Line (1 OF appeify each new program		1.00	2.00	3.00	4.00	(1 10
	Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,				0.00		61. 10
	the direct GME FTE unweighted count.						
	ACA Provisions Affecting the Health Resources and Ser	vi ces	Administration	(HRSA)		1.00	
	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc	trai neo			iod for which	0.00	62.00
62. 01	Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	ı Teachi ıram. (s	<u>see instructio</u>	• •	your hospital	0.00	62.01
63.00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this c			N	63.00
				Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Year FTE Residents in No	nnrovi	der Settings	1.00 This base year	2.00	3.00	
	period that begins on or after July 1, 2009 and befor	<u>e</u> June	30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non 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	y trair i-primar all nor l non-pr i 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 COMPLE	X IDENTIFICATION DA	TA Provider C		eriod: rom 01/01/2021 p 12/31/2021	Worksheet S- Part I Date/Time Pr	epared:
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	5/30/2022 2: Ratio (col. 3 (col. 3 + col 4))	1
	1.00	2.00	3.00	4.00	5.00	-
55.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column			0.00	0. 00	0. 00000	0 65.00
4)). (see instructions)			Unweighted	Unweighted	Ratio (col. 1	/
			FTEs Nonprovi der Si te	FTEs in Hospital	(col . 1 + col 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current Y beginning on or after July 1, 201		n Nonprovider Setting	gsEffective fo	or cost reporti	ng periods	
56.00 Enter in column 1 the number of un FTEs attributable to rotations oc Enter in column 2 the number of un FTEs that trained in your hospita (column 1 divided by (column 1 +)	curring in all nonpr nweighted non-primar . Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00 Unweighted FTEs Nonprovider Site		Ratio (col. 3 (col. 3 + col 4))	1
_	1.00	2.00	3.00	4.00	5.00	-
b7.00 Enter in column 1, the program 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)			0.00	0. 00	0. 00000	0 67.00
				1.0	0 2.00 3.00	-
Inpatient Psychiatric Facility PP						
0.00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no.	chiatric Facility (I	PF), or does it cont	ain an IPF subp	rovider? N		70.00
71.00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Coll program in accordance with 42 CFR Column 3: If column 2 is Y, indice (see instructions) Inpatient Rehabilitation Facility	fore November 15, 20 umn 2: Did this faci 412.424 (d)(1)(iii) ate which program ye)04? Enter "Y" for y lity train residents)(D)? Enter "Y" for y	/es or "N" for n s in a new teach /es or "N" for n	io. (see ii ng io.	N O	71.00
75.00 Is this facility an Inpatient Reh	abilitation Facility	(IRF), or does it o	contain an IRF	N		75.00
subprovider? Enter "Y" for yes at 76.00 If line 75 is yes: Column 1: Did recent cost reporting period endin no. Column 2: Did this facility ti CFR 412.424 (d)(1)(iii)(D)? Enter indicate which program year began	the facility have ar ng on or before Nove rain residents in a "Y" for yes or "N"	ember 15, 2004? Enter new teaching program for no. Column 3: If	"Y" for yes or in accordance column 2 is Y,	"N" for	N O	76.00

Heal th Fi	nancial Systems COMMUNITY	HOSPI ⁻	TAL ANDERSON		In Lie	u of Form CMS-	2552-10
HOSPI TAL	AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	١	Provider CC	CN: 15-0113	Peri od:	Worksheet S-2	
					From 01/01/2021 To 12/31/2021	Part I Date/Time Pre	enared.
					10 12/01/2021	5/30/2022 2:5	
							4
	ng Term Care Hospital PPS					1.00	-
	this a long term care hospital (LTCH)? Enter "Y" fo	or ves	and "N" for r	20		N	80.00
81 00 IS	this a LTCH co-located within another hospital for p	part o	rall of the o	cost reportin	a period? Enter	N	81.00
	" for yes and "N" for no.	bai t o		ooot roportin	g porrour Entor		0.1.00
	FRA Providers					-	
	this a new hospital under 42 CFR Section §413.40(f)					N	85.00
	d this facility establish a new Other subprovider (ex	xcl ude	ed unit) under	42 CFR Secti	on		86.00
	13.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. this hospital an extended neoplastic disease care ho	nsni ta	l classified i	inder section		N	87.00
	86(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	ospi tu					07.00
					V	XI X	
					1.00	2.00	
	tle V and XIX Services			1 II)/II C	N	X	00.00
	es this facility have title V and/or XIX inpatient has s or "N" for no in the applicable column.	ospita	I services? Er	nter "Y" for	N	Y	90.00
	this hospital reimbursed for title V and/or XIX thro	ouah t	he cost report	t either in	N	N	91.00
	II or in part? Enter "Y" for yes or "N" for no in the						/
	e title XIX NF patients occupying title XVIII SNF bed			on)? (see		N	92.00
	structions) Enter "Y" for yes or "N" for no in the ap						
	es this facility operate an ICF/IID facility for purp " for yes or "N" for no in the applicable column.	poses	of title V and	d XIX? Enter	N	N	93.00
	es title V or XIX reduce capital cost? Enter "Y" for	Ves	and "N" for no	n in the	N	N	94.00
	plicable column.	y es,					71.00
	IINE 94 is "Y", enter the reduction percentage in th				0.00	0.00	95.00
	es title V or XIX reduce operating cost? Enter "Y" fo	or yes	or "N" for no	o in the	N	N	96.00
	plicable column.			_	0.00	0.00	07.00
	`line 96 is "Y", enter the reduction percentage in th es title V or XIX follow Medicare (title XVIII) for t				0.00 Y	0.00 N	97.00
	epdown adjustments on Wkst. B, Pt. I, col. 25? Enter				I	IN	70.00
	lumn 1 for title V, and in column 2 for title XIX.		j				
98.01 Doe	es title V or XIX follow Medicare (title XVIII) for t	the re	porting of cha	arges on Wkst	. Y	Y	98.01
	Pt. I? Enter "Y" for yes or "N" for no in column 1 1	for ti	tle V, and in	column 2 for			
	tle XIX. es title V or XIX follow Medicare (title XVIII) for †	the ca	loulation of (obcorvation	Y	Y	98.02
	d costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for				I	I	70.02
	r title V, and in column 2 for title XIX.	J					
	es title V or XIX follow Medicare (title XVIII) for a					N	98.03
	imbursed 101% of inpatient services cost? Enter "Y" 1	for ye	es or "N" for m	no in column	1		
	r title V, and in column 2 for title XIX. es title V or XIX follow Medicare (title XVIII) for a	а САН	raimbursad 10	1% of	N	N	98.04
	tpatient services cost? Enter "Y" for yes or "N" for					IN IN	70.04
	column 2 for title XIX.			,			
	es title V or XIX follow Medicare (title XVIII) and a					Y	98.05
	st. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no	o in c	olumn 1 for ti	tle V, and i	n		
1	lumn 2 for title XIX. es title V or XIX follow Medicare (title XVIII) when	cost	raimbursed for	r Wkst D	Y	Y	98.06
Pts	s. I through IV? Enter "Y" for yes or "N" for no in o	column	1 for title	V. and in	I	I	70.00
	lumn 2 for title XIX.						
	ral Providers					1	
	es this hospital qualify as a CAH?				N		105.00
	this facility qualifies as a CAH, has it elected the routpatient services? (see instructions)	e all-	inclusive meth	nod of paymen	t N		106.00
	lumn 1: If line 105 is Y, is this facility eligible 1	for co	st reimburseme	ent for L&R	N		107.00
tra	aining programs? Enter "Y" for yes or "N" for no in o	col umn	1. (see inst	tructions)			
Col	lumn 2: If column 1 is Y and line 70 or line 75 is Y	Y, do	you train I&Rs	s in an			
	proved medical education program in the CAH's exclude			unit(s)?			
	ter "Y" for yes or "N" for no in column 2. (see inst this a rural hospital qualifying for an exception to			441 02 500 12	N		108.00
	R Section §412.113(c). Enter "Y" for yes or "N" for r		enna ree serier	dure: 300 42			100.00
			Physi cal	Occupati ona	I Speech	Respi ratory	
			1.00	2.00	3.00	4.00	
	this hospital qualifies as a CAH or a cost provider,		N	N	N	N	109.00
	erapy services provided by outside supplier? Enter ") r yes or "N" for no for each therapy.	ř					
				I			
						1.00	
	d this hospital participate in the Rural Community Ho					N	110.00
	monstration) for the current cost reporting period? Er						
	mplete Worksheet E, Part A, lines 200 through 218, ar plicable.	nu wor	KSHEEL E-2, 11	mes 200 thro	uyii zio, as		
labi	P					1	1

Health Financial Systems COMMUNITY HOSPITAL				eu of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC		Period: From 01/01/2021 To 12/31/2021	Date/Time Pr	epared:
				5/30/2022 2:	53 pm
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to colum integration prong of the FCHIP demo in which this CAH is partic Enter all that apply: "A" for Ambulance services; "B" for addit for tele-health services.	reporting p mn 1 is Y, e cipating in	eriod? Enter nter the column 2.	1.00 N	2.00	111.00
		1.00	2.00	3.00	-
112.00 Did this hospital participate in the Pennsylvania Rural Health demonstration for any portion of the current cost reporting per Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y 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	riod? Y", enter	N			112.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N in column 1. If column 1 is yes, enter the method used (A, B, c in column 2. If column 2 is "E", enter in column 3 either "93" for short term hospital or "98" percent for long term care (inc psychiatric, rehabilitation and long term hospitals providers) the definition in CMS Pub. 15-1, chapter 22, §2208.1.	or E only) percent cludes based on	Ν			0115.00
116.00 Is this facility classified as a referral center? Enter "Y" for "N" for no.	r yes or	N			116.00
117.00 Is this facility legally-required to carry malpractice insurance "Y" for yes or "N" for no.	ce? Enter	Y			117.00
118.00 is the maipractice insurance a claims-made or occurrence policy if the policy is claim-made. Enter 2 if the policy is occurrence	, i		1		118.00
		Premi ums	2.00	I nsurance	_
118.01 List amounts of malpractice premiums and paid losses:		817, 45	57 (0	0 118. 01
			1.00	2.00	_
 118.02 Are mal practice premiums and paid losses reported in a cost cer Administrative and General? If yes, submit supporting schedule and amounts contained therein. 119.00 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Has \$3121 and applicable amendments? (see instructions) Enter in cc "N" for no. Is this a rural hospital with < 100 beds that qualifies Hold Harmless provision in ACA \$3121 and applicable amendments? 	e listing co armless prov olumn 1, "Y" ifies for th	st centers ision in ACA for yes or e Outpatient	N	N	118. 02 119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00Did this facility incur and report costs for high cost implanta	able devices	charged to	Y		121.00
patients? Enter "Y" for yes or "N" for no. 122.00Does the cost report contain healthcare related taxes as define Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is the Worksheet A line number where these taxes are included.			Ν		122.00
Transplant Center Information 125.00Does this facility operate a transplant center? Enter "Y" for y	yes and "N"	for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter					126.00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter	the certifi	cation date			127.00
in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter	the certifi	cation date			128.00
in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter 1	the certific	ation date ir	1		129. 00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, ent		i fi cati on			130.00
date in column 1 and termination date, if applicable, in column 131.00 If this is a Medicare certified intestinal transplant center, e		rti fi cati on			131.00
date in column 1 and termination date, if applicable, in column 132.00 If this is a Medicare certified islet transplant center, enter	n 2.				132.00
in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 134.00 If this is an organ procurement organization (OPO), enter the C and termination date, if applicable, in column 2.					133.00 134.00
All Providers 140.00 Are there any related organization or home office costs as defi chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes are claimed, enter in column 2 the home office chain number. (s	s, and home	office costs	Y	HB0720	140. 00

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE		SPITAL ANDERSON Provider C	CCN: 15-0113			u of Form CMS Worksheet S- Part I Date/Time Pr 5/30/2022 2:	-2 repared:
1.00		2.00			3.00		
If this facility is part of a chai home office and enter the home off 41.00Name: COMMUNITY HEALTH NETWORK		d contractor num	per.		nd address Number: 0810		141.00
42. 00 Street: 1500 NORTH RITTER AVE	PO Box:	WI 5					142.00
43.00 City: INDIANAPOLIS	State:	IN	Zip Co	ode:	4621	9	143.00
							_
44 00 Are provider based physicians!	to included in Werksher	+ 42				1.00 Y	144.00
144.00 Are provi der based physi ci ans' cos		et A?				ř	144.00
					1.00	2.00	-
45.00 If costs for renal services are cl inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodoloc	' for yes or "N" for no clude Medicare utilizati for no in column 2.	in column 1. If on for this cost	column 1 is reporting		Y		145.00
Enter "Y" for yes or "N" for no ir yes, enter the approval date (mm/c	olumn 1. (See CMS Put			lf			
						1.00	-
147.00Was there a change in the statisti	cal basis? Enter "Y" fo	or yes or "N" for	no.			N N	147.00
48.00 Was there a change in the order of	allocation? Enter "Y"	for yes or "N" f	°or no.			N	148.00
149.00 Was there a change to the simplifi	ed cost finding method?					N	149.00
		Part A 1.00	Part I 2.00		Title V 3.00	Title XIX 4.00	-
Does this facility contain a provi	der that qualifies for						-
or charges? Enter "Y" for yes or '							
55. 00 Hospi tal		N	N		N	N	155. 00
56.00 Subprovider - IPF		N	N		N	N	156.00
57.00 Subprovider - IRF 58.00 SUBPROVIDER		N	N		N	N	157.00 158.00
59. 00 SNF		N	N		Ν	N	158.00
60. OOHOME HEALTH AGENCY		N	N		N	N	160.00
161.00 CMHC			N		N	N	161.00
						1.00	_
Multicampus						1.00	-
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has	one or more camp	buses in dit	fferent	CBSAs?	N	165.00
	Name	County	State	Zip Cod		FTE/Campus	_
66.00 If line 165 is yes, for each	0	1.00	2.00	3.00	4.00	5.00	00 166. 00
campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.0	
						1.00	
Health Information Technology (HI							
67.00 is this provider a meaningful user 68.00 if this provider is a CAH (line 10 reasonable cost incurred for the H	05 is "Y") and is a mear	ningful user (lir			er the	Y	167.00 168.00
68.01 If this provider is a CAH and is r			er qualify t	for a ha	rdshi p		168. 0
exception under §413.70(a)(6)(ii)?	PEnter "Y" for yes or '	N" for no. (see	instruction	ns)			
169.00 If this provider is a meaningful u		and is not a CAH	(line 105 i	is "N"),	enter the	9.9	99169.00
transition factor. (see instruction	ons)				Begi nni ng	Endi ng	_
					1. 00	2.00	
70.00 Enter in columns 1 and 2 the EHR k period respectively (mm/dd/yyyy)	beginning date and endir	ng date for the r	reporting				170.00
					1.00	2.00	-
71.00 If line 167 is "Y", does this prov section 1876 Medicare cost plans r "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	reported on Wkst. S-3, F umn 1. If column 1 is ye	Pt. I, line 2, co	ol. 6? Enter		<u> </u>	2.00	0 171. 00

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0113	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Pre 5/30/2022 2:5	epared:
				Y/N 1.00	Date 2.00	-
	General Instruction: Enter Y for all YES responses. Enter N fo	or all NO re	sponses. Ente			
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					-
	Provider Organization and Operation					-
. 00	Has the provider changed ownership immediately prior to the be	eginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in colu	umn 2. (see				-
			Y/N 1.00	Date 2.00	V/I 3.00	
. 00	Has the provider terminated participation in the Medicare Prod	gram? If	N 1.00	2.00	5.00	2.00
00	yes, enter in column 2 the date of termination and in column 3 voluntary or "l" for involuntary. Is the provider involved in business transactions, including r contracts, with individuals or entities (e.g., chain home offi or medical supply companies) that are related to the provider	management ices, drug	N			3. 00
	officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)					
			Y/N	Туре	Date	
			1.00	2.00	3.00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certifi Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date availa column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues differen	Compiled, able in	Y	A	03/31/2021	4.00
. 00	those on the filed financial statements? If yes, submit reconc		IN IN			5.00
			•	Y/N 1.00	Legal Oper. 2.00	
. 00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column 2:	lf ves is	the provider	~ N		6.00
. 00	is the legal operator of the program?	11 yes, 13		i N		0.0
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see inst Were nursing programs and/or allied health programs approved a cost reporting period? If yes, see instructions.	e N		7.0 8.0		
. 00	Are costs claimed for Interns and Residents in an approved gra	aduate medic	al education	Ν		9.00
0. 00	program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or internet of the second sec	renewed in t	he current	N		10. 00
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & Teaching Program on Worksheet A? If yes, see instructions.	R in an App	roved	N		11.00
					Y/N	
	Bad Debts				1.00	-
2.00	Is the provider seeking reimbursement for bad debts? If yes, s If line 12 is yes, did the provider's bad debt collection poli			ost reporting	Y N	12.00 13.00
4.00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payments Bed Complement	s waived? If	yes, see ins	structions.	N	14.00
5.00	Did total beds available change from the prior cost reporting		yes, see ins t A	tructions. Par	Y t B	15.0
		Y/N	Date	Y/N	Date	
	PS&R Data	1.00	2.00	3.00	4.00	-
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	N		N		16.00
7.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	05/02/2022	Y	05/02/2022	17.0
8. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18.00
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		N		19.00

Heal th	Fi nanci al	Systems

In Lieu of Form CMS-2552-10

Health Financial Systems COMMUNITY HOSPI	ITAL ANDERSON		In Lie	u of Form CN	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	F	Period: From 01/01/2021 To 12/31/2021	Worksheet S Part II Date/Time F 5/30/2022 2	repared:
	Descri	ption	Y/N	Y/N	<u>. 55 pm</u>
)	1.00	3.00	
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		5	N	N	20.00
	Y/N	Date	Y/N	Date	
	1.00	2.00	3.00	4.00	
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
		1		1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)		1.00	
Capital Related Cost					
22.00 Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22.00
23.00 Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	als made durin	ng the cost	N	23.00
24.00 Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	this cost repo	orting period?	N	24.00
25.00 Have there been new capitalized leases entered into during instructions.	the cost repor	ting period? I	f yes, see	Ν	25.00
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	ne cost reporti	ng period? If	yes, see	Ν	26.00
27.00 Has the provider's capitalization policy changed during the copy.	e cost reportin	g period?lf y	ves, submit	Ν	27.00
Interest Expense					
28.00 Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.				N	28.00
29.00 Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr	ructions			N	29.00
30.00 Has existing debt been replaced prior to its scheduled matu instructions.	urity with new	debt? If yes,	see	N	30.00
31.00 Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes,	see	N	31.00
Purchased Services					
32.00 Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru	uctions.	Ū		N	32.00
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.	olied pertainin	g to competiti	ve bidding? If	Ν	33.00
Provi der-Based Physi ci ans					
34.00 Are services furnished at the provider facility under an ar	rrangement with	provi der-base	ed physi ci ans?	N	34.00
1f yes, see instructions.35.001f line 34 is yes, were there new agreements or amended exi		ts with the pr	ovi der-based	N	35.00
physicians during the cost reporting period? If yes, see in	nstructions.			D 1	
			Y/N 1.00	Date	
Home Office Costs			1.00	2.00	
36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been pr	cenared by the	home office?	N N		36.00 37.00
If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home off			N		38.00
the provider? If yes, enter in column 2 the fiscal year end 39.00 If line 36 is yes, did the provider render services to othe	d of the home o	ffi ce.	N		39.00
see instructions. 40.00 [If line 36 is yes, did the provider render services to the		5	N		40.00
instructions.			IN		40.00
	1.	00	2.	00	
Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	SHI RLEY		BI SHOP		41.00
respecti vel y.	COMMUNI TY HEAL	TH NETWORK			42.00
preparer.	317-355-4135		SBI SHOP@ECOMMU	NI TY. COM	43.00
report preparer in columns 1 and 2, respectively.					

Heal th	Financial Systems COMMUNITY HOS	SPITAL ANDERSON	In Lie	In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0113	Period:	Worksheet S-2			
			From 01/01/2021 To 12/31/2021		pared: 3 pm		
		3.00					
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	NETWORK DI RECTOR OF			41.00		
	held by the cost report preparer in columns 1, 2, and 3,	REIMBURSEMENT					
	respecti vel y.						
42.00	Enter the employer/company name of the cost report				42.00		
	preparer.						
43.00	Enter the telephone number and email address of the cost				43.00		
	report preparer in columns 1 and 2, respectively.						

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	COMMUNITY HOSPI	Provider CC	N. 15_0113	Peri od:	u of Form CMS-2 Worksheet S-3	
1105111	AL AND HOST THE HEALTH CARE COMPLEX STATISTIC			5N. 13-0113	From 01/01/2021	Part I	
					To 12/31/2021	Date/Time Pre 5/30/2022 2:5	
						I/P Days / 0/P	
						<u>Visits / Trips</u>	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number 1.00	2.00	Avai I abl e 3. 00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30, 00	2.00	39, 05		0	1.00
	8 exclude Swing Bed, Observation Bed and	00100	107	0,1,0,		, i i i i i i i i i i i i i i i i i i i	
	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 I PF Subprovi der						3.00
4.00	HMO I RF Subprovider						4.00
5.00 6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF					0	5.00
6.00 7.00	Total Adults and Peds. (exclude observation		107	39, 0	0.00	0	
7.00	beds) (see instructions)		107	37,00	0.00	0	7.00
8.00	INTENSI VE CARE UNI T	31.00	17	6, 20	0. 00	0	8.00
9.00	CORONARY CARE UNIT			-,			9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		124	45, 20	60 0.00	0	14.00
15.00	CAH visits					0	15.00
16.00 17.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVI DER – I RF SUBPROVI DER						17.00
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	104			0	26.25
27.00	Total (sum of lines 14-26)		124			0	27.00
28.00 29.00	Observation Bed Days Ambulance Trips					0	28.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days (see first detroit)						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room		Ű		-		32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	CN: 15-0113		eriod: com 01/01/2021 o 12/31/2021	Worksheet S-3 Part I Date/Time Pre 5/30/2022 2:5	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients		Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00		9.00	10.00	
1.00 2.00 3.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider	6, 068 8, 159 0	568 4, 763 0	20, 68	84			1.00 2.00 3.00
4.00 5.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF	0 0	0 0		0			4.00 5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation	6, 068	0 568	20, 68	0 84			6.00 7.00
8.00	beds) (see instructions) INTENSIVE CARE UNIT	1, 167	231	4, 22	28			8.00
9.00 10.00 11.00 12.00 13.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY		1, 316	1, 38	80			9.00 10.00 11.00 12.00 13.00
$\begin{array}{c} 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00 \end{array}$	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	7, 235 0	2, 115 0	1, 30 26, 30	01	0. 25	918.56	14.00 15.00 16.00 17.00 18.00 20.00 21.00 22.00 23.00 24.00
24. 10 25. 00 26. 00	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC				0			24.10 25.00 26.00
26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0 0	0 312 10		0 61 60 0 91 0	0. 00 0. 25	0. 00 918. 56	26. 25
33. 00 33. 01	LTCH non-covered days LTCH si te neutral days and discharges	0 0						33. 00 33. 01

HOSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0113	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part I Date/Time Pre 5/30/2022 2:5	pared:
		Full Time		Di s	charges		
	Component	Equi val ents Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
	1	11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT		0	1, 4		5, 700	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)	0. 00	0	1, 4	57 181	5, 700	12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00
24. 00 24. 10 25. 00 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0. 00 0. 00					24. 0 24. 1 25. 0 26. 0 26. 2 27. 0 28. 0 29. 0 30. 0 31. 0 32. 0
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges				0 0		33. C 33. C

ipi t	AL WAGE INDEX INFORMATION			Provider CC	F	Period: From 01/01/2021 To 12/31/2021		par
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							1
0	Total salaries (see	200. 00	67, 652, 538	-430, 115	67, 222, 423	3 1, 910, 601. 00	35. 18	1
0	instructions) Non-physician anesthetist Part		C	0	C	0.00	0.00	
0	A		C	0		0.00	0.00	
0	Non-physician anesthetist Part		C	0	C	0.00	0. 00	
0	B Physician-Part A -		123, 232	0	123, 232	832.00	148. 12	
0	Admi ni strati ve		120,202		.20,202			
1	Physicians - Part A - Teaching		0	0				
0	Physician and Non Physician-Part B		290, 349	0	290, 349	3, 809. 00	76. 23	- E
0	Non-physician-Part B for		C	0	C	0.00	0.00	6
	hospital-based RHC and FQHC services							
0	Interns & residents (in an	21.00	C	0	C	0.00	0.00	5
	approved program)							
11	Contracted interns and residents (in an approved		C	0	C	0.00	0.00	7
	programs)							
0	Home office and/or related		C	0	C	0.00	0.00	8
0	organization personnel SNF	44.00	C	0	(0.00	0.00	
00	Excluded area salaries (see	11.00	515, 414	-386	515, 028			
	instructions)							
00	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		1, 835, 135	0	1, 835, 135	5 15, 273. 00) 120. 16	11
	Care							
00	Contract labor: Top level		C	0	C	0.00	0.00	12
	management and other management and administrative							
	services							
00	Contract Labor: Physician-Part A - Administrative		1, 434, 878	0	1, 434, 878	3 19, 238. 00	74.59	1
00	Home office and/or related		C	0	C	0.00	0.00	14
	organization salaries and							
01	wage-related costs Home office salaries		12, 204, 885	0	12, 204, 885	280, 764. 00	43. 47	1
02	Related organization salaries		C	0	C	0.00	0.00	14
00	Home office: Physician Part A - Administrative		C	0	C	0.00	0.00	1!
00	Home office and Contract		C	0	C	0.00	0. 00	1
	Physicians Part A - Teaching							
01	Home office Physicians Part A - Teaching		C	0 0	C	0.00	0.00	16
02	Home office contract		C	0	C	0.00	0.00	16
	Physicians Part A - Teaching							
00	WAGE-RELATED COSTS Wage-related costs (core) (see		10, 044, 725	0	10, 044, 725	5		1
	instructions)							
00	Wage-related costs (other) (see instructions)							18
00	Excluded areas		77, 163	0	77, 163	3		19
00	Non-physician anesthetist Part		C	0	C			20
00	A Non-physician anesthetist Part		C	0	C			2
00	B			0				2
00	Physician Part A -		6, 453	0	6, 453	3		22
01	Administrative Physician Part A - Teaching		C	0	C)		22
00	Physician Part B		29, 541	0	29, 541			23
00	Wage-related costs (RHC/FQHC)		C	0				24
00	Interns & residents (in an approved program)		Ĺ					25
50	Home office wage-related		3, 230, 031	0	3, 230, 031			25
F 1	(core) Related organization		~		(2!
51	wage-related (core)		Ĺ	, 0				2
52	Home office: Physician Part A		C	0	(C	D		25
	- Administrative - wage-related (core)							

Heal th	Financial Systems	(COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part II Date/Time Pre 5/30/2022 2:5	pared:
		Wkst. A Line		Recl assi fi cati			Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.		col. 5)	
				A-6)	3)	col. 4		
	1	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							
26.00	Employee Benefits Department	4.00	169, 181	0	169, 18			
27.00	Administrative & General	5.00	8, 342, 374	-25, 797				27.00
28.00	Administrative & General under		3, 098, 254	0	3, 098, 25	4 24, 977.00	124.04	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0		0.00		29.00
30.00	Operation of Plant	7.00	2,847,065	-6, 836	2, 840, 22			30.00
31.00	Laundry & Linen Service	8.00	0	0		0 0.00		31.00
32.00	Housekeepi ng	9.00	2, 109, 084	-9, 641	2, 099, 44	3 101, 527. 00	20. 68	32.00
33.00	Housekeeping under contract (see instructions)		0	0		0 0.00	0.00	33.00
34.00	Dietary	10.00	1, 601, 784	-1, 031, 485	570, 29	9 27, 368. 00	20. 84	34.00
35.00	Dietary under contract (see instructions)		0	0		0 0.00	0.00	35.00
36.00	Cafeteria	11.00	38, 525	1, 015, 355	1, 053, 88	0 50, 212. 00	20. 99	36.00
37.00	Maintenance of Personnel	12.00	0	0		0.00	0.00	37.00
38.00	Nursing Administration	13.00	1, 349, 141	-755	1, 348, 38	6 42, 800. 00	31.50	38.00
39.00	Central Services and Supply	14.00	803, 970	-3, 719	800, 25	1 34, 582.00	23.14	39.00
40.00	Pharmacy	15.00	2, 429, 161	-27, 496	2, 401, 66	5 52, 593.00	45.67	40.00
41.00	Medical Records & Medical	16.00	0	0		0 0.00		41.00
	Records Library							
42.00	Soci al Servi ce	17.00	0	0		0.00	0.00	42.00
43.00	Other General Service	18.00	0	0		0.00	0.00	43.00

Health Financial Systems		COMMUNITY HOSP	ITAL ANDERSON		In Lie	eu of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2021 To 12/31/2021		pared:
	Worksheet A		Recl assi fi cati			Average Hourly	
	Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
			(from	(col.2 ± col.		col. 5)	
			Worksheet A-6)	,	col. 4		
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE	INDEX_SUMMARY						
1.00 Net salaries (see		70, 460, 443	-430, 115	70, 030, 32	8 1, 931, 769. 00	36.25	1.00
instructions)							
2.00 Excluded area salaries (s	ee	515, 414	-386	515, 02	8 14, 379. 00	35. 82	2.00
3.00 Subtotal salaries (line 1		69, 945, 029	-429, 729	69, 515, 30	0 1, 917, 390. 00	36.26	3.00
minus line 2)		07, 743, 027	-427,727	07, 515, 50	1, 717, 370.00	50.20	5.00
4.00 Subtotal other wages & re	lated	15, 474, 898	0	15, 474, 89	8 315, 275. 00	49.08	4.00
costs (see inst.)							
5.00 Subtotal wage-related cos (see inst.)	its	13, 281, 209	0	13, 281, 20	9 0.00	19. 11	5.00
6.00 Total (sum of lines 3 thr	u 5)	98, 701, 136	-429, 729	98, 271, 40	7 2, 232, 665. 00	44.02	6.00
7.00 Total overhead cost (see		22, 788, 539	-90, 374	22, 698, 16	5 656, 607. 00	34.57	7.00
instructions)							

th Financial Systems PITAL WAGE RELATED COSTS		Y HOSPITAL ANDERSON Provider CCN: 15-01		u of Form CMS-2 Worksheet S-3	
			From 01/01/2021		
			To 12/31/2021		
				5/30/2022 2:5	3 pr
				Amount	
				Reported	
	70			1.00	
PART IV - WAGE RELATED COS	15				-
Part A - Core List					-
RETIREMENT COST				0.000.001	
0 401K Employer Contribution				2, 889, 294	
0 Tax Sheltered Annuity (TSA	Employer Contribution			0	2
	it Plan Cost (see instructi			0	
	Plan Cost (see instructions			0	4
	(Paid to External Organizat	i on)			
0 401K/TSA Plan Administrati				0	
0 Legal /Accounting/Managemer				0	6
0 Employee Managed Care Prog	ram Administration Fees			0	7
HEALTH AND INSURANCE COST					
0 Health Insurance (Purchase				0	
	nded without a Third Party A			0	
	nded with a Third Party Admi	ni strator)		1, 364, 950	
3 Health Insurance (Purchase	ed)			0	-
0 Prescription Drug Plan				426, 101	9
00 Dental, Hearing and Visior				14, 714	10
	e is owner or beneficiary)			7, 989	11
00 Accident Insurance (If emp	loyee is owner or beneficia	iry)		0	12
DO Disability Insurance (If e	employee is owner or benefic	ci ary)		473, 303	13
DO Long-Term Care Insurance	If employee is owner or ber	nefi ci ary)		0	
00 'Workers' Compensation Ins				33, 628	15
00 Retirement Health Care Cos	st (Only current year, not t	he extraordinary accrual rec	quired by FASB 106.	0	16
Non cumulative portion)					
TAXES					
00 FICA-Employers Portion Onl				4, 884, 383	
00 Medicare Taxes - Employers	Portion Only			0	18
00 Unemployment Insurance				0	19
00 State or Federal Unemployr	nent Taxes			0	20
OTHER					
00 Executive Deferred Compens instructions))	ation (Other Than Retiremer	nt Cost Reported on lines 1 t	through 4 above. (see	0	21
00 Day Care Cost and Allowand	res.			0	22
00 Tuition Reimbursement				63, 519	
00 Total Wage Related cost (S	Sum of lines 1 -23)			10, 157, 881	
Part B - Other than Core R				10, 137, 001	24
00 OTHER WAGE RELATED COSTS					25

Heal th	Financial Systems	COMMUNI TY HOSPI TAL	ANDERSON	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0113	Peri od:	Worksheet S-3	
				From 01/01/2021	Part V	
				To 12/31/2021	Date/Time Pre 5/30/2022 2:53	
	Cost Center Description			Contract Labor	Benefit Cost	
	Cost center beschiption			1.00	2.00	
	PART V - Contract Labor and Benefit Cost			1100	2100	
	Hospital and Hospital-Based Component Ident	i fi cati on:				
1.00	Total facility's contract labor and benefit	t cost		1, 835, 135	10, 157, 881	1.00
2.00	Hospi tal			1, 835, 135	10, 157, 881	2.00
3.00	Subprovider - IPF					3.00
4.00	Subprovider - IRF					4.00
5.00	Subprovider - (Other)			0	0	5.00
6.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	7.00
8.00	Hospital-Based SNF					8.00
9.00	Hospital-Based NF					9.00
10.00	Hospital-Based OLTC					10.00
11.00	Hospital-Based HHA					11.00
12.00	Separately Certified ASC					12.00
13.00	Hospital-Based Hospice					13.00
14.00	Hospital-Based Health Clinic RHC					14.00
15.00	Hospital-Based Health Clinic FQHC					15.00
16.00	Hospital-Based-CMHC					16.00
	Renal Dialysis			0	0	17.00
18.00	Other			0	0	18.00

Heal th	Financial Systems COMMUNITY HOSPITAL	ANDERSON		In Lie	eu of Form CMS-	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	N: 15-0113	Peri od:	Worksheet S-7	
				From 01/01/2021 To 12/31/2021		
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by lin	e 202 columr	1 8)	0. 253500	1.00
	Medicaid (see instructions for each line)	3		,		
2.00	Net revenue from Medicaid				39, 470, 742	
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemen			ii d?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments f	rom Medicaid			-7, 738, 923	
6.00	Medicaid charges				150, 403, 263	
7.00 8.00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program	(line 7 minu	c cum of lir	upe 2 and E. if	38, 127, 227 6, 395, 408	
8.00	<pre>< zero then enter zero)</pre>	(The / minu	IS SUIT OF ITT	ies z and s; TT	0, 395, 408	8.00
	Children's Health Insurance Program (CHIP) (see instructions for	or each line			I	
9.00	Net revenue from stand-al one CHIP		/		0	9,00
10.00	Stand-alone CHIP charges					10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP	(line 11 min	us line 9; i	f < zero then	(c	12.00
	enter zero)					
	Other state or local government indigent care program (see ins				-	
13.00	Net revenue from state or local indigent care program (Not inc				0	
14.00	Charges for patients covered under state or local indigent car 10)	e program (N	lot inciuded	In lines 6 or	C	14.00
15.00	State or local indigent care program cost (line 1 times line 1	4)			0	15.00
16.00	Difference between net revenue and costs for state or local in		program (Lir	e 15 minus line		
10.00	13; if < zero then enter zero)	argent care				10.00
	Grants, donations and total unreimbursed cost for Medicaid, CH	IP and state	/local indig	ent care progra	ms (see	
	instructions for each line)				1	
17.00	Private grants, donations, or endowment income restricted to f				46, 606	
18.00	Government grants, appropriations or transfers for support of			(<u> </u>	0	
19.00	Total unreimbursed cost for Medicaid , CHIP and state and loca 8, 12 and 16)	i indigent c	are programs	s (sum of lines	6, 395, 408	3 19.00
			Uni nsured	Insured	Total (col. 1	
		-	patients	patients	+ col . 2)	
			1.00	2.00	3.00	
20.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fa	cility	4, 538, 28	899, 696	5, 437, 982	2 20.00
20.00	(see instructions)	CITICY	4, 550, 20	50 877, 070	5,457,702	20.00
21.00	Cost of patients approved for charity care and uninsured disco	unts (see	1, 150, 45	6 899, 696	2, 050, 152	2 21.00
	instructions)		.,,		_,,	
22.00	Payments received from patients for amounts previously written	off as		0 0	0	22.00
	chari ty care					
23.00	Cost of charity care (line 21 minus line 22)		1, 150, 4	66 899, 696	2, 050, 152	2 23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patie	nt davis have	nd a longth	of ctoy limit	1.00 N	24.00
24.00	imposed on patients covered by Medicaid or other indigent care		inu a rengtn	or stay frint	IN IN	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond t		care program	's length of	0	25.00
	stay limit	0		0		
26.00	Total bad debt expense for the entire hospital complex (see in				7, 183, 316	
27.00	Medicare reimbursable bad debts for the entire hospital comple				141, 650	
	Medicare allowable bad debts for the entire hospital complex (see instruct	ions)		217, 923	
28.00	Non-Medicare bad debt expense (see instructions)				6, 965, 393	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	pense (see i	nstructions)		1, 842, 000	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)			3, 892, 152	
31.00	Total uniennouised and uncompensated care cost (Time 19 plus I	THE 30)			10, 287, 560	1 31.00

ULAS.	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C		eriod: rom 01/01/2021	Worksheet A	2552-10
				T		Date/Time Pre 5/30/2022 2:5	pared: 3 pm
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			0	2 1/0 40/	2 1/0 40/	1.00
	00200 CAP REL COSTS-BLUG & FIXT		0	0	3, 168, 406 6, 934, 067	3, 168, 406 6, 934, 067	2.00
00	00300 OTHER CAP REL COSTS		0	0	0	0	3.00
	00400 EMPLOYEE BENEFI TS DEPARTMENT	169, 181	46, 331		-804	214, 708	
	00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS	8, 342, 374 0	101, 973, 152 0	110, 315, 526 0	-957, 690 0	109, 357, 836 0	5.00 6.00
	00700 OPERATION OF PLANT	2, 847, 065	6, 346, 799	9, 193, 864	-1, 669, 638	7, 524, 226	7.00
	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
00 . 00	00900 HOUSEKEEPI NG 01000 DI ETARY	2, 109, 084 1, 601, 784	1, 029, 315 1, 735, 980		-3, 151 -2, 217, 710	3, 135, 248 1, 120, 054	9.00 10.00
	01100 CAFETERI A	38, 525	66, 696		1, 968, 456	2, 073, 677	11.00
	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	1, 349, 141 803, 970	433, 533 958, 938		-571- 467, 239-	1, 782, 103 1, 295, 669	
	01500 PHARMACY	2, 429, 161	10, 726, 192		-9, 875, 978	3, 279, 375	
. 00	01600 MEDICAL RECORDS & LIBRARY	0	-17, 736		0	-17, 736	
	01700 SOCI AL SERVI CE	0	0	0	0	0	17.00
	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG PROGRAM	0	0	0	0	0	19.00 20.00
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
. 00	02300 PARAMED ED PRGM-(EMS) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	0	23.00
. 00	03000 ADULTS & PEDIATRICS	16, 163, 121	8, 078, 312	24, 241, 433	-3, 217, 779	21, 023, 654	30.00
. 00	03100 I NTENSI VE CARE UNI T	3, 510, 784	2, 276, 387	5, 787, 171	-422, 109	5, 365, 062	31.00
. 00		0	0	0	975, 119	975, 119	43.00
. 00	ANCI LLARY SERVI CE COST CENTERS	5, 904, 262	15, 598, 022	21, 502, 284	-11, 069, 849	10, 432, 435	50.00
	05100 RECOVERY ROOM	0	0	0	0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	1, 756, 266	1, 756, 266	
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 1, 650, 826	911, 360 1, 495, 045		-45, 115 -589, 621	866, 245 2, 556, 250	
	05401 ULTRASOUND	526, 410	165, 282	691, 692	18, 421	710, 113	
	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
	05600 RADI OI SOTOPE 05700 CT SCAN	308, 104 665, 109	449, 080 643, 483		-254, 126 -118, 244	503, 058 1, 190, 348	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	611, 587	1, 006, 753		-434, 643	1, 190, 348	
	05900 CARDI AC CATHETERI ZATI ON	736, 136	1, 431, 326		-980, 653	1, 186, 809	
		2, 491, 060	5, 398, 581	7, 889, 641	-264, 604	7, 625, 037	60.00
	06001 BLOOD LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0 180, 486	0 526, 548	-	0 -2, 968	0 704, 066	
. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	
	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	2, 249, 696 3, 047, 025	866, 720 1, 825, 053		-73, 703 -1, 483, 877	3, 042, 713 3, 388, 201	65.00 66.00
	06700 OCCUPATI ONAL THERAPY	0	0	0	463, 733	463, 733	
	06800 SPEECH PATHOLOGY	0	0	0	209, 395	209, 395	68.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	975, 041 597, 815	593, 265 376, 962	1, 568, 306 974, 777	-186, 262 -75, 243	1, 382, 044 899, 534	69.00 70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4, 940, 443	4, 940, 443	71.00
. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7, 046, 903	7, 046, 903	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	706	706	9, 854, 160	9, 854, 866	73.00
	07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	U	353, 447	353, 447	-1, 479	351, 968	74.00
	09000 CLINIC	0	0	0	0	0	90.00
	09001 WOUND/OSTOMY CLINIC	611,069	1, 338, 208		-204, 263	1, 745, 014	90.01
	09002 CTR ADVANCED HEART CARE 09003 RADI ATI ON ONCOLOGY	220, 060 1, 703, 483	68, 066 4, 149, 877	288, 126 5, 853, 360	-1, 025 -1, 373, 396	287, 101 4, 479, 964	90.02 90.03
	09004 MUNCI E CLINIC	0	95, 267	95, 267	-13, 811	81, 456	90.04
	09005 ANTI COAGULATI ON CLINIC	323, 594	136, 610	460, 204	0	460, 204	90.05
	09006 PREGNANCY PLUS 09007 0/P LAB	0	0	0	0	0	90.06 90.07
	09008 0/P LAB	0	0	0	0	0	90.07
. 09	09009 FORTVILLE CLINIC	0	47, 602	47, 602	-46, 690	912	90.09
	09010 1030 S SCATTERFIELD (MEDCHECK)	0	0	0	0	0	90.10
	09011 DI ABETI C PLUS CLI NI C 09012 OTHER ONCOLOGY SERVI CES	332, 242	89, 227 0	421, 469	-2, 142	419, 327 0	90. 11 90. 12
. 00	09100 EMERGENCY	4, 638, 929	1, 982, 641	6, 621, 570	-170, 251	6, 451, 319	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						

Health Financial Systems	COMMUNITY HOSPIT	TAL ANDERSON		In Lie	eu of Form CMS-:	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES Provider CCN: 15-0113			Period: Worksheet A		
				From 01/01/2021	Data (Time Drag	
				To 12/31/2021	Date/Time Pre 5/30/2022 2:5	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
SPECIAL PURPOSE COST CENTERS	(7.407.404	170 000 000	040 040 45	4 440 705	0.44 450 000	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	67, 137, 124	173, 203, 030	240, 340, 15	4 1, 110, 735	241, 450, 889	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0			0	190.00
190. 01 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	416, 697	562, 471	979, 16	-342, 112		
190. 02 19002 EMPLOYED ORTHO MD	410, 097	502, 471	777,10	0 -342,112		190.01
190. 03 19003 NORTHVI EW CONV. (LTC)	0	0				190.02
190. 04 19004 SUMMI T CONV. (LTC)	0	0				190.03
190. 05 19005 PARKVI EW CONV. (LTC)	0	0		0 0		190.05
190. 06 19006 MONTI CELLO HSE.	0	75, 619	75, 61	-46,099		
190. 07 19007 NH PARK PLACE (LTC)	0	0		0 0		190.07
190. 08 19008 MADI SON PLACE OF ELWOOD (LTC)	0	0		0 0	0	190. 08
190. 09 19009 SPI NE SURGEON	0	0		0 0	0	190.09
190. 10 19010 CLINI CAL RESEARCH CENTER	0	66	6	6 -181	-115	190. 10
190. 11 19011 ONCOLOGI ST	0	0		0 0	0	190. 11
190. 12 19012 MEDI CAL I NTERNI ST	13, 149	4, 220	17, 36	9 0	17, 369	
190. 13 19013 RHEUMATOLOGY	0	0		0 0		190. 13
190. 14 19014 ROCK STEADY BOXING	85, 568	70, 161	155, 72	9 -22, 472	133, 257	
190. 15 19015 OTHER ONCOLOGY SERVICES	0	0		0 0		190. 15
191. 00 19100 RESEARCH	0	0		0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	2, 151, 612				
192. 01 19201 MUNCI E MD OFFICES	0	156, 409	156, 40	9 -129,000		
192. 02 19202 FOUNDATI ON	0	0		0 0		192.02
192. 03 19203 SPOE	0	0		0 0		192.03
192. 04 19204 HEALTHY HEART	0	0		0 0		192.04
192. 05 19205 VACANT SPACE	0	11	1	0 0		192. 05 192. 07
192. 07 19207 PARK PLACE CENTER 192. 08 19208 RENTAL PROPERTY	0	9, 178				192.07
192.09/19208/RENTAL PROPERTY 192.09/19209/RESIDENTIAL PROPERTY (1430 N MADISON		9, 178 6, 270	6, 27			192.08
192. 10 19209 RESIDENTIAL PROPERTY (1430 N MADISON 192. 10 19210 HOSPITAL RENTAL (1927 N MADISON AVE)	0	0,270	0,27	0 -3,718		192.09
200.00 TOTAL (SUM OF LINES 118 through 199)	67, 652, 538	176, 239, 047	243, 891, 58		-	
	07,002,000	110,207,047	275,071,50	SI 0	275,071,505	1200.00

ULH3	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	I LAI LINJLJ	Provider CCN: 15-01	13 Period: From 01/01/2021 To 12/31/2021	Worksheet A Date/Time Prepare
				10 12/31/2021	5/30/2022 2:53 pr
	Cost Center Description	Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00		
	GENERAL SERVICE COST CENTERS				
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	1 150 952	3, 168, 406 8, 084, 920		1
	00300 OTHER CAP REL COSTS	1, 150, 853	8,084,920		3
	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 913, 078	-		4
	00500 ADMINISTRATIVE & GENERAL	-61, 482, 907	47, 874, 929		5
	00600 MAINTENANCE & REPAIRS	0	0		6
	00700 OPERATION OF PLANT	0	7, 524, 226		7
	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	0 3, 135, 248		8
	01000 DI ETARY	0	1, 120, 054		10
. 00	01100 CAFETERI A	-853, 638	1, 220, 039		11
	01200 MAINTENANCE OF PERSONNEL	0	0		12
	01300 NURSI NG ADMI NI STRATI ON	1, 750, 330			13
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	952, 388 0	2, 248, 057 3, 279, 375		14
	01600 MEDICAL RECORDS & LIBRARY	1, 013, 575			16
	01700 SOCIAL SERVICE	0	0		17
	01900 NONPHYSICIAN ANESTHETISTS	0	0		19
	02000 NURSING PROGRAM	0	0		20
	02100 I & R SERVI CES-SALARY & FRI NGES APPRVD 02200 I & R SERVI CES-OTHER PRGM. COSTS APPRVD	26, 146 35, 381	26, 146 35, 381		21
	02300 PARAMED ED PRGM-(EMS)	0	0		23
	INPATIENT ROUTINE SERVICE COST CENTERS				
	03000 ADULTS & PEDI ATRI CS	215, 002			30
	03100 I NTENSI VE CARE UNI T	0			31
	04300 NURSERY ANCI LLARY SERVICE COST CENTERS	0	975, 119		43
	05000 OPERATI NG ROOM	-131, 858	10, 300, 577		50
	05100 RECOVERY ROOM	0	0		51
	05200 DELIVERY ROOM & LABOR ROOM	0	1, 756, 266		52
	05300 ANESTHESI OLOGY	-866, 245	1		53
	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	74,970	2, 631, 220 710, 113		54
	05500 RADI OLOGY-THERAPEUTI C	0	0		55
	05600 RADI OI SOTOPE	0	503, 058		56
	05700 CT SCAN	0	1, 190, 348		57
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 183, 697		58
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0 -6, 472	1, 186, 809 7, 618, 565		59 60
	06001 BLOOD LABORATORY	0,472	0		60
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	704, 066		62
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63
	06400 I NTRAVENOUS THERAPY	0	0		64
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	-166, 999	2, 875, 714 3, 388, 201		65
	06700 OCCUPATI ONAL THERAPY	0	463, 733		67
. 00	06800 SPEECH PATHOLOGY	0	209, 395		68
	06900 ELECTROCARDI OLOGY	0	1, 382, 044		69
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	899, 534		70
	07200 IMPL. DEV. CHARGED TO PATIENTS	0 0	4, 940, 443 7, 046, 903		71
	07300 DRUGS CHARGED TO PATIENTS	0	9, 854, 866		73
	07400 RENAL DIALYSIS	0	351, 968		74
	OUTPATIENT SERVICE COST CENTERS	-			
	09000 CLINIC 09001 WOUND/OSTOMY CLINIC	0	0 1, 745, 014		90 90
	09002 CTR ADVANCED HEART CARE	-124, 348			90
	09003 RADI ATI ON ONCOLOGY	-521, 080	3, 958, 884		90
	09004 MUNCIE CLINIC	-81, 456	0		90
	09005 ANTI COAGULATI ON CLINI C	0	460, 204		90
	09006 PREGNANCY PLUS 09007 0/P LAB	0			90 90
	09008 0/P LAB	0	o		90
	09009 FORTVILLE CLINIC	-912	0		90
	09010 1030 S SCATTERFIELD (MEDCHECK)	0	0		90
	09011 DI ABETI C PLUS CLI NI C	-3, 885	415, 442		90
	09012 OTHER ONCOLOGY SERVICES 09100 EMERGENCY	0 874, 516	0 7, 325, 835		90 91
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0/4, 310	1, 323, 033		91
	OTHER REIMBURSABLE COST CENTERS		<u> </u>		72
00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		98
	SPECIAL PURPOSE COST CENTERS				

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lieu	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provider CCN:	15-0113	Peri od:	Worksheet A
				From 01/01/2021 To 12/31/2021	Date/Time Prepared: 5/30/2022 2:53 pm
Cost Center Description		Net Expenses			
		or Allocation			
NONREI MBURSABLE COST CENTERS	6.00	7.00			
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190.00
190. 01 19001 WELLNESS CENTERS	0	637, 056			190.01
190. 02 19002 EMPLOYED ORTHO MD	0	007,000			190.02
190. 03 19003 NORTHVI EW CONV. (LTC)	0	o			190.03
190. 04 19004 SUMMIT CONV. (LTC)	0	0			190. 04
190. 05 19005 PARKVI EW CONV. (LTC)	0	o			190.05
190. 06 19006 MONTI CELLO HSE.	0	29, 520			190.06
190.07 19007 NH PARK PLACE (LTC)	0	o			190. 07
190.08 19008 MADISON PLACE OF ELWOOD (LTC)	0	o			190. 08
190. 09 19009 SPI NE SURGEON	0	0			190. 09
190. 10 19010 CLINICAL RESEARCH CENTER	0	-115			190. 10
190. 11 19011 ONCOLOGI ST	0	0			190. 11
190. 12 19012 MEDI CAL I NTERNI ST	0	17, 369			190. 12
190. 13 19013 RHEUMATOLOGY	0	0			190. 13
190. 14 19014 ROCK STEADY BOXING	0	133, 257			190. 14
190. 15 19015 OTHER ONCOLOGY SERVICES	0	0			190. 15
191. 00 19100 RESEARCH	0	0			191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	1, 585, 430			192.00
192.01 19201 MUNCIE MD OFFICES	0	27, 409			192.01
192. 02 19202 FOUNDATI ON	0	0			192.02
192. 03 19203 SPOE	0	0			192. 03
192. 04 19204 HEALTHY HEART	0	0			192.04
192. 05 19205 VACANT SPACE	0	0			192.05
192. 07 19207 PARK PLACE CENTER	0	11			192.07
192. 08 19208 RENTAL PROPERTY	0	8, 207			192.08 192.09
192. 09 19209 RESIDENTIAL PROPERTY (1430 N MADISON 192. 10 19210 HOSPITAL RENTAL (1927 N MADISON AVE)	0	2, 552			192. 10
200.00 TOTAL (SUM OF LINES 118 through 199)	-55, 233, 561	0 188, 658, 024			200. 00

	Financial Systems SIFICATIONS	C	OMMUNI TY HOSPI	TAL ANDERSON Provider CCN	N: 15-0113	Period: From 01/01	Wo	f Form CMS- orksheet A-6	
							/2021 Da	te/Time Pre 30/2022 2:5	epared: 53 pm
	Cost Center	Increases Line #	Salary	Other					
	2.00	3.00	4.00	5.00					
1 00	A - Chargeable Medical Supplie MEDICAL SUPPLIES CHARGED TO	s71.00	0	4 040 442					1 00
1.00	PATIENTS	71.00	0	4, 940, 443					1.00
2.00		0.00 0.00	0	0					2.00
3.00 4.00		0.00	0 0	0					3.00 4.00
5.00		0.00	0	0					5.00
6.00 7.00		0.00 0.00	0	0					6.00 7.00
8.00		0.00	0	0					8.00
9. 00 10. 00		0.00 0.00	0 0	0					9.00 10.00
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	0	0					14.00
15. 00 16. 00		0.00 0.00	0	0					15.00 16.00
17.00		0.00	0	0					17.00
18. 00 19. 00		0.00 0.00	0 0	0					18.00 19.00
20.00		0.00	0	0					20.00
21. 00 22. 00		0.00 0.00	0	0					21.00 22.00
23.00		0.00	0	0					23.00
24. 00 25. 00		0.00 0.00	0	0					24.00 25.00
26.00		0.00	0	0					26.00
27.00 28.00		0.00 0.00	0 0	0					27.00 28.00
20.00	TOTALS			4, 940, 443					20.00
1.00	B - Implantable Device Reclass	72.00		7,046,903					1.00
2.00	PATIENTS	72.00		7,040,703					2.00
3.00	+	+		7,046,903					3.00
	C - Drugs Charges to Pat			7,040,903					
1.00 2.00	CENTRAL SERVICES & SUPPLY DRUGS CHARGED TO PATIENTS	14.00 73.00	0 0	2, 834 9, 854, 160					1.00 2.00
3.00		0.00	0	0					3.00
4.00 5.00		0.00 0.00	0 0	0					4.00 5.00
6.00		0.00	0	0					6.00
7.00 8.00		0.00 0.00	0 0	0					7.00 8.00
9.00		0.00	0	0					9.00
10. 00 11. 00		0.00 0.00	0	0					10.00 11.00
12.00		0.00	0	0					12.00
13.00 14.00		0.00 0.00	0 0	0					13.00 14.00
15.00		0.00	0	0					15.00
16. 00 17. 00		0.00 0.00	0 0	0					16.00 17.00
18.00		0.00	0	0					18.00
19. 00 20. 00		0.00 0.00	0 0	0					19.00 20.00
21.00		0.00	0	0					21.00
22.00	TOTALS	0.00	0	<u> </u>					22.00
	D - Depreciation Expense	I							
1.00 2.00	CAP REL COSTS-MVBLE EQUIP	2.00 0.00	0 0	7, 622, 559 0					1.00 2.00
3.00		0.00	0	0					3.00
4.00 5.00		0.00 0.00	0	0					4.00 5.00
6.00		0.00	0	0					6.00
7.00 8.00		0.00 0.00	0	0					7.00 8.00
9.00		0.00	0	0					9.00
10. 00 11. 00		0.00 0.00	0 0	0					10. 00 11. 00
		0.00	0	0					12.00

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	S

COMMUNITY HOSPITAL ANDERSON Provider CCN: 15-0113 Period:

In Lieu of Form CMS-2552-10 Worksheet A-6

RECLAS	SIFICATIONS			Provider (CCN: 15-0113	Period: From 01/01/2021	Worksheet A	A-6
						To 12/31/2021	Date/Time 5/30/2022	Prepared:
		Increases			_	- I	57 507 2022	2.33 pm
	Cost Center 2.00	Li ne # 3.00	Salary 4.00	0ther 5.00	-			
13.00		0.00	0	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
16.00		0.00	0	0				17.00
17.00		0.00	0	0				17.00
18.00 19.00		0.00	0	0				19.00
20.00		0.00	0	0				20.00
21.00		0.00	0	0				21.00
22.00		0.00	0	0				22.00
23.00		0.00	0	0				23.00
24.00		0.00	0	0				24.00
25.00		0.00	0	0				25.00
26.00		0.00	0	0				26.00
27.00		0.00	0	0				27.00
28.00		0.00	0	0				28.00
29. 00 30. 00		0.00 0.00	0	0 0				29.00 30.00
30.00		0.00	0	0				30.00
32.00		0.00	o	0				32.00
33.00		0.00	0	0				33.00
34.00		0.00	0	0)			34.00
35.00		0.00	0	0				35.00
	TOTALS		0	7, 622, 559				
	F - Other Capital Rental				1			
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2, 350, 053				1.00
2.00		0.00	0	0				2.00
3.00 4.00		0.00 0.00	0 0	0				3.00
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
10.00		0.00	0	0				10.00
11.00		0.00	0	0				11.00
12.00		0.00	0	0				12.00
13.00		0.00	0	0				13.00
14.00		0.00	0	0				14.00
15. 00 16. 00		0.00 0.00	0	0				15.00 16.00
17.00		0.00		0				17.00
17.00	TOTALS		<u>0</u>	2, 350, 053				17.00
	G - Therapy Reclass	· · · · · · · · · · · · · · · · · · ·		, ,				
1.00	OCCUPATI ONAL THERAPY	67.00	358, 631	0				1.00
2.00	SPEECH PATHOLOGY	68.00	161, 937	0				2.00
3.00	OCCUPATIONAL THERAPY	67.00	0	105, 102				3.00
4.00	SPEECH PATHOLOGY		0	47,458				4.00
	TOTALS H - Labor and Delivery		520, 568	152, 560	1			
1.00	NURSERY	43.00	702, 138	272, 981				1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1, 264, 606	491, 660				2.00
	TOTALS		1, 966, 744	764, 641				
	I - Cafeteria				1			
1.00	CAFETERI A	<u> </u>	<u>1, 015, 3</u> 55	95 <u>3, 1</u> 01				1.00
	TOTALS		1, 015, 355	953, 101				
1.00	J - STD BENEFIT RECLASS ADMINISTRATIVE & GENERAL	5.00	0	25, 797				1.00
2.00	OPERATION OF PLANT	7.00	0	6, 836				2.00
2.00 3.00	HOUSEKEEPI NG	9.00	0	9, 641				3.00
4.00	DI ETARY	10.00	0	16, 130				4.00
5.00	NURSING ADMINISTRATION	13.00	Ö	755				5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	3, 719				6.00
7.00	PHARMACY	15.00	О	27, 496				7.00
8.00	ADULTS & PEDIATRICS	30.00	0	96, 123				8.00
9.00	INTENSIVE CARE UNIT	31.00	0	26, 243				9.00
10.00	OPERATING ROOM	50.00	0	44, 286				10.00
11.00	RADI OLOGY-DI AGNOSTI C	54.00	0	8, 082				11.00
12.00	MAGNETIC RESONANCE IMAGING	58.00	0	58				12.00
13.00	(MRI) CARDIAC CATHETERIZATION	59.00	0	5, 891				13.00
13.00 14.00	LABORATORY	60.00	0	5, 891 8, 740				13.00
14.00 15.00	RESPIRATORY THERAPY	65.00	0	43, 253				14.00
16.00	PHYSI CAL THERAPY	66.00	0	37, 161				16.00
	•		-					

Health Financial Systems		COMMUNI TY HOSPI TAL ANDERSON				In Lieu of Form CMS-2552-10		
RECLAS	SIFICATIONS			Provider (CCN: 15-0113	Peri od:	Worksheet A-	6
						From 01/01/2021 To 12/31/2021	Date/Time Pr 5/30/2022 2:	
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2. 00	3.00	4.00	5.00				
17.00	ELECTROCARDI OLOGY	69.00	0	3, 922				17.00
18.00	ELECTROENCEPHALOGRAPHY	70.00	0	2, 703				18.00
19.00	WOUND/OSTOMY CLINIC	90.01	0	12, 508				19.00
20.00	RADIATION ONCOLOGY	90.03	0	20, 016				20.00
21.00	EMERGENCY	91.00	0	30, 369				21.00
22.00	WELLNESS CENTERS	190.01	0	386				22.00
	TOTALS		0	430, 115				
	K - Building Depreciation							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3, 038, 545				1.00
	TOTALS		0	3, 038, 545				
	L - Capital Insurance Costs							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	12 <u>9, 8</u> 61				1.00
	TOTALS		0	129, 861				
	M - Radiology Support Staff							
1.00	ULTRASOUND	54.01	16, 840	6, 581				1.00
2.00	RADI OI SOTOPE	56.00	17, 191	6, 718				2.00
3.00	CT SCAN	57.00	84, 920	33, 189				3.00
4.00	MAGNETIC RESONANCE IMAGING	58.00	24, 467	9, 562				4.00
	(MRI)							
	TOTALS		143, 418	56, 050				
500.00	Grand Total: Increases		3, 646, 085	37, 341, 825				500.00

Heal th	Fi nanci al	Systems	
RECLAS	SIFICATION	S	

COMMUNITY HOSPITAL ANDERSON Provider CCN: 15-0113

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2021 To 12/31/2021 Date/Time Prepared:

02T		
021	Date/Time	Prepared:
	E/20/2022	2.52 nm

						2022 2:53 pm
		Decreases				
	Cost Center 6.00	Li ne # 7.00	Salary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00	
	A - Chargeable Medical Suppli		8.00	9.00	10.00	
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	16, 416		1.00
2.00	OPERATION OF PLANT	7.00	0	964		2.00
3.00	HOUSEKEEPI NG	9.00	0	27	0	3.00
4.00 5.00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13.00 14.00	0	341 243, 344	0	4.00 5.00
6.00	PHARMACY	15.00	0	243, 344 28, 153		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	275, 075	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	271, 567	0	8.00
9.00	OPERATING ROOM	50.00	0	2, 896, 658		9.00
10. 00 11. 00	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	53.00 54.00	0	3, 377 35, 449	0	10.00
12.00	ULTRASOUND	54.00	0	2, 350		12.00
13.00	RADI OI SOTOPE	56.00	0	111	0	13.00
14.00	CT SCAN	57.00	0	136, 122		14.00
15.00	MAGNETIC RESONANCE IMAGING	58.00	0	7, 753	0	15.00
16.00	(MRI) CARDIAC CATHETERIZATION	59.00	0	546, 704	0	16.00
17.00	LABORATORY	60.00	0	1, 264	0	17.00
18.00	RESPI RATORY THERAPY	65.00	0	11, 468	0	18.00
19.00	PHYSICAL THERAPY	66.00	0	102	0	19.00
20.00	ELECTROCARDI OLOGY	69.00	0	42, 639		20.00
21. 00 22. 00	ELECTROENCEPHALOGRAPHY RENAL DI ALYSI S	70.00 74.00	0	2, 744 1, 479	0	21.00 22.00
22.00	WOUND/OSTOMY CLINIC	90.01	0	153, 931	0	23.00
24.00	CTR ADVANCED HEART CARE	90.02	0	148	-	24.00
25.00	RADIATION ONCOLOGY	90. 03	0	136, 119		25.00
26.00	EMERGENCY	91.00	0	103, 835		26.00
27.00 28.00	WELLNESS CENTERS PHYSICIANS' PRIVATE OFFICES	190. 01 192. 00	0	22, 087 216	0	27.00 28.00
20.00	TOTALS	192.00	— — — d	4, 940, 443		28.00
	B - Implantable Device Reclas	SS	-			
1.00	OPERATING ROOM	50.00		6, 788, 294		1.00
2.00	CARDIAC CATHETERIZATION	59.00		229, 002		2.00
3.00	WOUND/OSTOMY CLINIC	90.01		<u> </u>		3.00
	C - Drugs Charges to Pat	<u> </u>		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	<u> </u>	
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	194		1.00
2.00	PHARMACY	15.00	0	9, 446, 612		2.00
3.00 4.00	ADULTS & PEDIATRICS	30.00 31.00	0	4, 291 1, 200	0	3.00
4.00 5.00	OPERATING ROOM	50.00	0	2, 943	-	5.00
6.00	ANESTHESI OLOGY	53.00	0	41, 738		6.00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	0	34, 494		7.00
8.00	RADI OI SOTOPE	56.00	0	188, 825		8.00
9.00 10.00	CT SCAN MAGNETIC RESONANCE IMAGING	57.00 58.00	0	99, 297 27, 726	0	9.00 10.00
10.00	(MRI)	30.00	0	27,720	0	10.00
11.00	CARDÍ AC CATHETERI ZATI ON	59.00	0	2, 749		11.00
12.00	LABORATORY	60.00	0	80		12.00
13.00	RESPIRATORY THERAPY	65.00	0	65		13.00
14.00 15.00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66.00 69.00	0	89 788		14.00 15.00
16.00	ELECTROENCEPHALOGRAPHY	70.00	0	812		16.00
17.00	WOUND/OSTOMY CLINIC	90.01	0	1, 695		17.00
18.00	CTR ADVANCED HEART CARE	90.02	0	512		18.00
19.00	RADIATION ONCOLOGY	90.03 90.11	0	688	0	19.00
20. 00 21. 00	DIABETIC PLUS CLINIC EMERGENCY	90.11	0	37 2, 142	0	20.00 21.00
22.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	17		22.00
	TOTALS			9, 856, 994		
	D - Depreciation Expense					
1.00 2.00	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4.00 5.00	0	804 809, 386	9	1.00
2.00 3.00	OPERATION OF PLANT	7.00	0	809, 386 1, 668, 674		3.00
4.00	HOUSEKEEPING	9.00	0	3, 124	0	4.00
5.00	DI ETARY	10.00	0	246, 694	0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	230		6.00
7.00 8.00	CENTRAL SERVICES & SUPPLY PHARMACY	14.00 15.00	0	72, 462 5, 394	0	7.00 8.00
9.00	ADULTS & PEDIATRICS	30.00	0	207, 028		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	149, 228	0	10.00
11.00	OPERATING ROOM	50.00	0	1,079,092		11.00
12.00	RADI OLOGY-DI AGNOSTI C	54.00	0	320, 210	0	12.00

Health Financial Systems

COMMUNITY HOSPITAL ANDERSON

In Lieu of Form CMS-2552-10

	FINANCIAI SYSTEMS		COMMUNITY HOSE					
RECLAS	SIFICATIONS			Provider (CCN: 15-0113	Peri od:	Worksheet A-6	5
						From 01/01/2021 To 12/31/2021	Date/Time Pre 5/30/2022 2:5	
		Decreases						
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref	,		
	6. 00	7.00	8.00	9.00	10.00			
13.00	ULTRASOUND	54.01	0	2, 650		0		13.00
14.00	RADI OI SOTOPE	56.00	0	89, 099		0		14.00
15.00	CT SCAN	57.00	0	934		0		15.00
16. 00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	106, 193		0		16.00
17.00	CARDIAC CATHETERIZATION	59.00	0	202, 198		0		17.00
18.00	LABORATORY	60.00	0	209, 869		0		18.00
19. 00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	2, 968		0		19.00
20.00	RESPI RATORY THERAPY	65.00	0	62, 170		0		20.00
21.00	PHYSI CAL THERAPY	66.00	0	96, 662		0		21.00
22.00	ELECTROCARDI OLOGY	69.00	0	142, 835		0		22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	62, 860		0		23.00
24.00	WOUND/OSTOMY CLINIC	90.01	0	19, 030		0		24.00
25.00	CTR ADVANCED HEART CARE	90.02	0	365		0		25.00
26.00	RADIATION ONCOLOGY	90.03	0	1, 236, 589		0		26.00
27.00	MUNCIE CLINIC	90.04	0	13, 811		0		27.00
28.00	FORTVILLE CLINIC	90.09	0	2, 086		0		28.00
29.00	DIABETIC PLUS CLINIC	90.11	0	2, 105		0		29.00
30.00	EMERGENCY	91.00	0	64, 160		0		30.00
31.00	WELLNESS CENTERS	190.01	0	128, 226		0		31.00
32.00	MONTICELLO HSE.	190.06	0	46, 099		0		32.00
33.00	CLINICAL RESEARCH CENTER	190. 10	0	181		0		33.00
34.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	565, 425		0		34.00

30.00		91.00	0	120, 224	0	50.00	
31.00	WELLNESS CENTERS	190.01	0	128, 226	0	31.00	
32.00	MONTI CELLO HSE.	190.06	0	46, 099	0	32.00	
33.00	CLINICAL RESEARCH CENTER	190.10	0	181	0	33.00	
34.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	565, 425	0	34.00	
35.00	RESIDENTIAL PROPERTY (1430 N	192.09	0	3, 718	0	35.00)
	MADI SON						
	TOTALS		0	7, 622, 559			
	F - Other Capital Rental						
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	1, 833	10	1.00)
2.00	DI ETARY	10.00	0	2, 560	0	2.00)
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	154, 267	0	3.00)
4.00	PHARMACY	15.00	0	395, 819	o	4.00)
5.00	INTENSIVE CARE UNIT	31.00	0	114	0	5.00)
6.00	OPERATING ROOM	50.00	0	302, 862	o	6.00)
7.00	MAGNETIC RESONANCE I MAGI NG	58.00	0	327,000	0	7.00	
	(MRI)	00100	Ű	027,000	0		
8.00	LABORATORY	60.00	0	53, 391	0	8.00)
9.00	PHYSICAL THERAPY	66.00	0	713, 896	0	9.00	
10.00	ELECTROENCEPHALOGRAPHY	70.00	0	8, 827	0	10.00	
11.00	FORTVILLE CLINIC	90.09	0	44, 604	0	11.00	
12.00	EMERGENCY	90.09	0	44, 004	0	12.00	
			0		0		
13.00	WELLNESS CENTERS	190.01	0	191, 799	0	13.00	
14.00	ROCK STEADY BOXING	190.14	0	22, 472	0	14.00	
15.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	524	0	15.00	
16.00	MUNCIE MD OFFICES	192.01	0	129, 000	0	16.00	
17.00	RENTAL PROPERTY	192.08	0	971	0	17.00)
	TOTALS		0	2, 350, 053			
	G - Therapy Reclass						
1.00	PHYSI CAL THERAPY	66.00	520, 568	0	0	1.00	
2.00		0.00	0	0	0	2.00)
3.00	PHYSI CAL THERAPY	66.00	0	152, 560	0	3.00)
4.00		0.00	0	0	0	4.00)
	TOTALS		520, 568	152, 560]		
	H - Labor and Delivery						
1.00	ADULTS & PEDIATRICS	30.00	1, 966, 744	764, 641	0	1.00)
2.00		0.00	0	0	o	2.00)
	TOTALS		1, 966, 744	764, 641			
	I - Cafeteria				I		
1.00	DI ETARY	10.00	1, 015, 355	953, 101	0	1.00)
	TOTALS		1,015,355	953, 101]		
	J - STD BENEFIT RECLASS		.,,		1		
1.00	ADMI NI STRATI VE & GENERAL	5.00	25, 797	0	0	1.00)
2.00	OPERATION OF PLANT	7.00	6, 836	0	0	2.00	
3.00	HOUSEKEEPING	9.00	9, 641	0	o	3.00	
4.00	DI ETARY	10.00	16, 130	0	0	4.00	
5.00	NURSING ADMINISTRATION	13.00	755	0	0	5.00	
6.00				0	-		
	CENTRAL SERVICES & SUPPLY	14.00	3, 719	0	0	6.00	
7.00	PHARMACY	15.00	27, 496	0	0	7.00	
8.00	ADULTS & PEDIATRICS	30.00	96, 123	0	0	8.00	
9.00	INTENSIVE CARE UNIT	31.00	26, 243	0	0	9.00	
10.00	OPERATING ROOM	50.00	44, 286	0	0	10.00	
11.00	RADI OLOGY-DI AGNOSTI C	54.00	8, 082	0	0	11.00	
12.00	MAGNETIC RESONANCE IMAGING	58.00	58	0	0	12.00)
	(MRI)						

Heal th	Financial Systems		COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS	-2552-10
RECLASS	SEFECATIONS			Provider C	CCN: 15-0113	Peri od:	Worksheet A-	-6
						From 01/01/2021 To 12/31/2021	Date/Time Pr 5/30/2022 2:	
		Decreases						
	Cost Center	Line #	Salary		Wkst. A-7 Ref	,		
	6. 00	7.00	8.00	9.00	10.00			
13.00	CARDIAC CATHETERIZATION	59.00	5, 891	0		0		13.00
14.00	LABORATORY	60.00	8, 740	0		0		14.00
15.00	RESPI RATORY THERAPY	65.00	43, 253	0		0		15.00
16.00	PHYSICAL THERAPY	66.00	37, 161	0		0		16.00
17.00	ELECTROCARDI OLOGY	69.00	3, 922	0		0		17.00
18.00	ELECTROENCEPHALOGRAPHY	70.00	2, 703	0		0		18.00
19.00	WOUND/OSTOMY CLINIC	90.01	12, 508	0		0		19.00
20.00	RADIATION ONCOLOGY	90.03	20, 016	0		0		20.00
21.00	EMERGENCY	91.00	30, 369	0		0		21.00
22.00	WELLNESS CENTERS	190.01	386	0		0		22.00
	TOTALS		430, 115	0		7		
	K - Building Depreciation	· ·	· · ·					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3, 038, 545		9		1.00
	TOTALS			3, 038, 545		7		
	L - Capital Insurance Costs							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	129, 861	1	2		1.00
	TOTALS		0	129, 861				
	M - Radiology Support Staff							
1.00	RADI OLOGY-DI AGNOSTI C	54.00	143, 418	56, 050		0		1.00
2.00		0.00	0	0		0		2.00
3.00		0.00	0	0		0		3.00
4.00		0.00	0	0		0		4.00
	TOTALS		143, 418	56, 050				
500.00	Grand Total: Decreases		4, 076, 200	36, 911, 710				500.00

		COMMUNI TY HOSPI					u of Form CMS-2	
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0113		riod: om 01/01/2021	Worksheet A-7	
					To	12/31/2021	Date/Time Pre	pared:
							5/30/2022 2:5	3 pm
				Acqui si ti on	S			
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	6, 208, 238	0		0	0	-71, 915	
2.00	Land Improvements	1, 989, 234	1, 502, 692		0	1, 502, 692	1, 484, 381	
3.00	Buildings and Fixtures	78, 460, 300	0		0	0	274, 274	
4.00	Building Improvements	1, 311, 533	0		0	0	-1, 451, 792	
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	78, 070, 536	0		0	0	-1, 260, 138	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	166, 039, 841	1, 502, 692		0	1, 502, 692	-1, 025, 190	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	166, 039, 841	1, 502, 692		0	1, 502, 692	-1, 025, 190	10.00
		Endi ng Bal ance	Fully					
			Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	6, 280, 153	0					1.00
2.00	Land Improvements	2,007,545	0					2.00
3.00	Buildings and Fixtures	78, 186, 026	0					3.00
4.00	Building Improvements	2, 763, 325	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	79, 330, 674	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	168, 567, 723	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	168, 567, 723	0					10.00

Heal th	Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0113	Peri od:	Worksheet A-7	
					From 01/01/2021 To 12/31/2021		norod.
					10 12/31/2021	Date/Time Pre 5/30/2022 2:53	
			SL	JMMARY OF CAF	TAL	0,00,2022 210	
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Contor Description	Othor	Tatal (1) (aum				
	Cost Center Description	Other Capital-Relate	Total (1) (sum of cols. 9				
		d Costs (see					
		instructions)	thi ough 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORI			nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	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
	· ·						-

Heal th	n Financial Systems	COMMUNI TY HOSP	ITAL ANDERSON		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part III Date/Time Prep 5/30/2022 2:53	
		COMI	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		-			-	
1.00	CAP REL COSTS-BLDG & FIXT	89, 237, 049		89, 237, 049		0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	79, 330, 674		79, 330, 674		0	2.00
3.00	Total (sum of lines 1-2)	168, 567, 723		168, 567, 723			3.00
		ALLOCA	TION OF OTHER (CAPITAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	Other Capi tal -Rel ate		Depreciation	Lease	
			d Costs	through 7)			
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS			0 000 545		
1.00	CAP REL COSTS-BLDG & FIXT	0	0		3, 038, 545		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	(5, 734, 867	2, 350, 053	2.00
3.00	Total (sum of lines 1-2)	0	0	(8, 773, 412	2, 350, 053	3.00
			SL	JMMARY OF CAPI	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capital -Relate	of cols. 9	
					d Costs (see	through 14)	
					instructions)	-	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS	1	1	1		
1.00	CAP REL COSTS-BLDG & FIXT	0	129, 861	(0 0	3, 168, 406	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	(0 0	8, 084, 920	2.00
3.00	Total (sum of lines 1-2)	0	129, 861	(0 0	11, 253, 326	3.00

Health Financial Systems	COMMUNI TY HOSPI TAL ANDERSON	In Lieu	of Form CMS-2552-10
ADJUSTMENTS TO EXPENSES	Provider CCN: 15-0113	Period:	Worksheet A-8

	WENTS TO EXPENSES			Provider CCN. 15-0115	From 01/01/2021 To 12/31/2021	Date/Time Pre	
			Т	Expense Classification o o/From Which the Amount is		5/30/2022 2:53	<u>3 pm</u>
			Amount	Cost Costor			
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
. 00	Investment income - CAP REL		0 C	AP REL COSTS-BLDG & FIXT	1.00		1. C
. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		oc	AP REL COSTS-MVBLE EQUIP	2.00	0	2.0
. 00	Investment income - other (chapter 2)		0		0.00	0	3. (
00	Trade, quantity, and time discounts (chapter 8)		OA	DMI NI STRATI VE & GENERAL	5.00	0	4. (
00	Refunds and rebates of expenses (chapter 8)	В	OA	DMI NI STRATI VE & GENERAL	5.00	0	5.
00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.
00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7.
. 00	21) Television and radio service (chapter 21)		0		0.00	0	8.
. 00 0. 00	Parking lot (chapter 21) Provider-based physician	A-8-2	0 -1, 095, 664		0.00	0 0	9. (10. (
1.00	adjustment Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.
2. 00	Related organization transactions (chapter 10)	A-8-1	-1, 158, 629			0	12.
3. 00	Laundry and linen service		0		0.00		
1.00 5.00	Cafeteria-employees and guests Rental of quarters to employee		-846, 641 C 0	AFETERI A	11.00 0.00	0 0	14. 15.
. 00	and others Sale of medical and surgical supplies to other than		0		0.00	0	16.
7.00	patients Sale of drugs to other than		0		0.00	0	17.
8. 00	patients Sale of medical records and	В	ОМ	EDI CAL RECORDS & LI BRARY	16.00	0	18.
. 00	abstracts Nursing and allied health education (tuition, fees,		0		0.00	0	19.
). 00	books, etc.) Vending machines		0		0.00	0	20.
. 00	Income from imposition of interest, finance or penalty		0		0.00		
2. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to	,	0		0.00	0	22.
3. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	OR	ESPI RATORY THERAPY	65.00		23.
. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	OP	HYSI CAL THERAPY	66.00		24.
. 00	limitation (chapter 14) Utilization review - physicians' compensation		0 *	** Cost Center Deleted ***	114.00		25.
. 00	(chapter 21) Depreciation - CAP REL		oc	AP REL COSTS-BLDG & FIXT	1.00	0	26.
. 00	COSTS-BLDG & FIXT Depreciation - CAP REL		oc	AP REL COSTS-MVBLE EQUIP	2.00	0	27.
. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist	А	ON	ONPHYSICIAN ANESTHETISTS	19.00		28.
. 00 . 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0 00	CCUPATI ONAL THERAPY	0.00 67.00		29. 30.
. 99	limitation (chapter 14) Hospice (non-distinct) (see		OA	DULTS & PEDIATRICS	30.00		30.
. 00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	os	PEECH PATHOLOGY	68.00		31.
. 00	Limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32.
	Depreciation and Interest Misc Rev Sales	В		DMI NI STRATI VE & GENERAL	5.00		33.

Health Financial Systems		COMMUNI TY HOSPI	TAL ANDERSON	In Lie	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8	
				From 01/01/2021		
				To 12/31/2021	Date/Time Prep 5/30/2022 2:53	
			Expense Classification or			
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4,00	5.00	
33.01 Investment Income	B		ADMI NI STRATI VE & GENERAL	5.00		33.01
33.02 Space Rental Income	В		ADMI NI STRATI VE & GENERAL	5.00	0	33.02
33.03 Space Rental Income	B		RADIATION ONCOLOGY	90.03		33.03
33.04 Space Rental Income	В		MUNCIE CLINIC	90.04		33.04
33.05 Misc Revenue	В		EMPLOYEE BENEFITS DEPARTMEN			33.05
33.06 Misc Revenue	В		ADMI NI STRATI VE & GENERAL	5.00		33.06
33.07 Misc Revenue	В		CAFETERI A	11.00		33.07
33.08 Misc Revenue	В		MEDICAL RECORDS & LIBRARY	16.00		33.08
33.09 Misc Revenue	В		OPERATING ROOM	50.00		33.09
33.10 Misc Revenue	В		LABORATORY	60.00	0	33.10
34.00 HAF Tax Offset	A		ADMI NI STRATI VE & GENERAL	5.00		34.00
34.01 Loss on Assets	A		OPERATING ROOM	50.00	0	34.01
34.02 Sponsorshi p	A	-526, 789	ADMI NI STRATI VE & GENERAL	5.00	0	34.02
34.03 Sponsorshi p	A	-997 (CTR ADVANCED HEART CARE	90.02	0	34.03
34.04 Sponsorshi p	A	-3, 885 [DIABETIC PLUS CLINIC	90.11	0	34.04
34. 05 APP	A	-166, 999	RESPI RATORY THERAPY	65.00	0	34.05
34.06 APP	A	-123, 3510	CTR ADVANCED HEART CARE	90.02	0	34.06
34.07 Hospitalist Loss	A	-30, 607, 199	ADMI NI STRATI VE & GENERAL	5.00	0	34.07
34.08 Hospitalist Loss	A	-42, 180	ANESTHESI OLOGY	53.00	0	34.08
34. 09 CRNA	A	-824, 065	ANESTHESI OLOGY	53.00	0	34.09
34.12 EPIC Amortization	A	97, 9680	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.12
34.13 EPIC Amortization	A	1, 134, 351	ADMINISTRATIVE & GENERAL	5.00	0	34.13
35.00 Bad Debt	A	-7, 910, 635	ADMINISTRATIVE & GENERAL	5.00	0	35.00
35.01 OFFSET COSTS TO ELIMINATE HFS	6 A	-21, 341	MUNCIE CLINIC	90.04	0	35. 01
ERROR						
36.00 OFFSET COSTS TO ELIMINATE HFS	A A	-912 F	FORTVILLE CLINIC	90.09	0	36.00
ERROR						
36.01 Non Allow Marketing	A		ADMI NI STRATI VE & GENERAL	5.00	0	00.01
50.00 TOTAL (sum of lines 1 thru 4	2	-55, 233, 561				50.00
(Transfer to Worksheet A,						
column 6, line 200.)					L	

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	COMMUNI TY HOSI	PITAL ANDERSON	In Lie	eu of Form CMS-	2552-10
STATEME	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-0113	Period:	Worksheet A-8	8-1
OFFICE	COSTS			From 01/01/2021 To 12/31/2021	Date/Time Pre 5/30/2022 2:5	
	Line 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 ADJUST HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED C	RGANIZATIONS OR	CLAI MED	
1.00	21.00	I&R SERVICES-SALARY & FRINGE	RESI DENTS	26, 146	0	1.00
2.00	22.00	I&R SERVICES-OTHER PRGM. COS	RESI DENTS	35, 381	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	1, 052, 885	0	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	2, 913, 288	0	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	19, 976, 424	30, 134, 721	3. 02
3.03	13.00	NURSING ADMINISTRATION	HOME OFFICE	1, 750, 330	0	3.03
3.04	14.00	CENTRAL SERVICES & SUPPLY	HOME OFFICE	952, 388	0	3.04
3.05	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	1, 016, 357	0	3.05
3.06	30.00	ADULTS & PEDIATRICS	HOME OFFICE	215, 002	0	3.06
3.07	54.00	RADI OLOGY-DI AGNOSTI C	HOME OFFICE	74, 970	0	3.07
4.00	5.00	ADMINISTRATIVE & GENERAL	CPN MEDICAL DIRECTOR	88, 405	0	4.00
4.01	91.00	EMERGENCY	CPN CALL	874, 516	0	4.01
5.00	TOTALS (sum of lines 1-4).			28, 976, 092	30, 134, 721	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	ot been posted to worksheet A,	columns I and/or 2, the amou	nt allowable sn	ould be indicated in column 4	or this part.	-		
				Related Organization(s) and/	or Home Office			
				3				
					-	·		
	Symbol (1)	Name	Percentage of	Name	Percentage of			
			Ownershi p		Ownershi p	1		
	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	A	IN PROHEALTH	100.00	0.0	0 6.00
7.00	В	CHNW	100.00	0.0	0 7.00
8.00			0.00	0.0	0 8.00
9.00			0.00	0.0	0 9.00
10.00			0.00	0.0	0 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 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	COMMUNI TY HOSPI TA	L ANDERSON	In Lieu	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FRO	OM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0113	Period: From 01/01/2021	Worksheet A-8-1
			To 12/31/2021	Date/Time Prepared:

					5	5/30/2022 2:53	pm
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6.00	7.00					
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED C	RGANIZATIONS OR CL	AIMED	
	HOME OFFICE CO	STS:					
1.00	26, 146	0					1.00
2.00	35, 381	0					2.00
3.00	1, 052, 885	9					3.00
3.01	2, 913, 288	0					3.01
3.02	-10, 158, 297	0					3. 02
3.03	1, 750, 330	0					3.03
3.04	952, 388	0					3.04
3.05	1,016,357	0					3.05
3.06	215,002	0					3.06
3.07	74, 970						3.07
4.00	88, 405						4.00
4.01	874, 516						4.01
5.00	-1, 158, 629						5.00
		1					

* 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.

	Rel ated Organi zati on(s)		
	and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	
-			

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

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

6.00	6.00
7.00	7.00
8.00	8.00
9.00	9.00
10.00	10.00
6.00 7.00 8.00 9.00 10.00 100.00	100.00

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

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

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

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

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

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

Heal th	Financial Syste	ems	COMMUNI TY HOSE	PITAL ANDERSON		In Lie	eu of Form CMS-	2552-10
	ER BASED PHYSIC				CN: 15-0113	Peri od:	Worksheet A-8	
						From 01/01/2021 To 12/31/2021	Date/Time Pre 5/30/2022 2:5	
	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	AGGREGATE-ADMI NI STRATI VE &	1, 180, 264	1, 057, 032	123, 23	2 211, 500	832	1.00
		GENERAL						
2.00	0.00	1	0	0	(
3.00	0.00		0	0	(-	
4.00	0.00		0	0	(°	0	
5.00	0.00		0	0	(-	0	
6.00	0.00		0	0	(-	0	
7.00	0.00		0	0	(°	0	
8.00	0.00		0	0	(-	0	
9.00	0.00		0	0	(-	0	
10.00	0.00		0	0	(°	0	
200.00			1, 180, 264	1, 057, 032	123, 23		832	200.00
	Wkst. A Line #		Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
	1.00	2.00	0.00	9.00	Education	12 13.00	14.00	
1.00	1.00	2.00 AGGREGATE-ADMI NI STRATI VE &	8.00 84,600	9.00	12.00		14.00 0	1.00
1.00	5.00	GENERAL	84, 000	4, 230	(0	0	1.00
2.00	0.00		0	0	(0	0	2.00
3.00	0.00		0	0	(-	-	
4.00	0.00		0	0	(-	°,	
5.00	0.00			0	(0	
6.00	0.00		0	0	(-	0	
7.00	0.00		0	Ő	(°	0	
8.00	0.00		0	0	(0	
9.00	0.00		0	0	(°	0	
10.00	0.00		0	0	(°		
200.00	0.00		84, 600	4, 230	(0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		200.00
		I denti fi er	Component	Limit	Di sal I owance	nuj us tinont		
			Share of col.	21.001	bi our ronanoo			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	AGGREGATE-ADMI NI STRATI VE &	0	84, 600	38, 63	2 1, 095, 664		1.00
		GENERAL						
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	0.00		0	0	(-		7.00
8.00	0.00		0	0	(-		8.00
9.00	0.00		0	0	(0 0		9.00
10.00	0.00		0	0	(-		10.00
200.00			0	84, 600	38, 632	1, 095, 664		200.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	COMMUNI TY HOSPI	Provi der CC	F	reriod: from 01/01/2021 o 12/31/2021	u of Form CMS-: Worksheet B Part I Date/Time Pre	
			CAPI TAL REL			5/30/2022 2:5	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	3, 168, 406	3, 168, 406	[F	1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT	8, 084, 920	3, 100, 400	8, 084, 920			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 127, 786	19, 401	0,001,720	3, 147, 187		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	47, 874, 929	173, 592	1, 405, 689	390, 347	49, 844, 557	5.00
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0 7, 524, 226	0 374, 792	0 658, 742	0 133, 309	0 8, 691, 069	6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 524, 220	374,792	058,742	0	0, 091, 009	8.00
9.00	00900 HOUSEKEEPI NG	3, 135, 248	19, 357	3, 148	98, 539	3, 256, 292	9.00
10.00	01000 DI ETARY	1, 120, 054	25, 058	35, 594		1, 207, 474	
11. 00 12. 00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	1, 220, 039	48, 275 0	48, 582	49, 465	1, 366, 361 0	11.00
12.00	01300 NURSI NG ADMI NI STRATI ON	3, 532, 433	20, 217	232	0	3, 616, 170	1
14.00	01400 CENTRAL SERVICES & SUPPLY	2, 248, 057	48, 022	214, 717		2, 548, 357	14.00
15.00	01500 PHARMACY	3, 279, 375	21, 932	403, 844	112, 725	3, 817, 876	
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	995, 839	23, 767		0	1, 019, 606 0	16.00 17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0		0	0	19.00
20.00	02000 NURSI NG PROGRAM	0	0	C	0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	26, 146	0	C	0	26, 146	
22.00 23.00	02200 I & SERVICES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM-(EMS)	35, 381 0	0		-	35, 381 0	22.00 23.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0		0	0	23.00
30.00	03000 ADULTS & PEDIATRICS	21, 238, 656	256, 486	178, 866	661, 785	22, 335, 793	30.00
31.00	03100 I NTENSI VE CARE UNI T	5, 365, 062	84, 110	149, 123		5, 761, 845	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	975, 119	62, 019	10, 619	32, 956	1, 080, 713	43.00
50.00	05000 OPERATING ROOM	10, 300, 577	208, 901	1, 377, 436	275, 044	12, 161, 958	50.00
51.00	05100 RECOVERY ROOM	0	0	C	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 756, 266	52, 122	19, 125	59, 356	1, 886, 869	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	2, 631, 220	0 73, 162	262, 605	70, 372	0 3, 037, 359	53.00 54.00
54.01	05401 ULTRASOUND	710, 113	7, 328	2, 911		745, 850	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	C	0	0	55.00
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	503, 058 1, 190, 348	9, 511 37, 132	89, 780 1, 217		617, 617 1, 263, 900	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 183, 697	5, 923	436, 853		1, 656, 324	
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 186, 809	41, 251	177, 600		1, 439, 935	59.00
		7, 618, 565	49, 193	263, 314	116, 510		
60. 01 62. 00	06001 BLOOD LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0 704, 066	0 5, 404	2, 991	8, 471	0 720, 932	60.01 62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0, 101	C	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	C	0	0	64.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	2,875,714	1, 190			3, 040, 346	
67.00	06700 OCCUPATI ONAL THERAPY	3, 388, 201 463, 733	36, 638 6, 828	811, 468 3, 639		4, 353, 145 491, 033	
68.00	06800 SPEECH PATHOLOGY	209, 395	3, 082	1, 643		221, 721	68.00
69.00	06900 ELECTROCARDI OLOGY	1, 382, 044	110, 073	143, 926		1, 681, 623	
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	899, 534 4, 940, 443	21, 850 0	72, 235	27, 932	1, 021, 551 4, 940, 443	70.00
72.00	07200 I MPL. DEV. CHARGED TO PATTENTS	7, 046, 903	0		0	7, 046, 903	
73.00	07300 DRUGS CHARGED TO PATIENTS	9, 854, 866	3, 164	C	0	9, 858, 030	
74.00	07400 RENAL DI ALYSI S	351, 968	0	C	0	351, 968	74.00
90.00	OUTPATIENT SERVICE COST CENTERS	0	0	C	0	0	90.00
90.00 90.01	09001 WOUND/OSTOMY CLINIC	1, 745, 014	34, 411	5, 764	-	1, 813, 283	
90. 02	09002 CTR ADVANCED HEART CARE	162, 753	13, 396	368		186, 846	
90.03		3, 958, 884	73, 985	676, 390	79, 015	4, 788, 274	90.03
90. 04 90. 05	09004 MUNCIE CLINIC 09005 ANTICOAGULATION CLINIC	0 460, 204	0		15, 188	0 475, 392	90.04 90.05
90.06	09006 PREGNANCY PLUS	0	0	C	0	473, 372	90.06
90.07	09007 0/P LAB	0	0	c	0	0	90.07
90. 08 90. 09	09008 0/P LAB 09009 FORTVILLE CLINIC	0	0		0	0	90.08
90.09 90.10	09009 FORTVILLE CLINIC 09010 1030 S SCATTERFIELD (MEDCHECK)	0	0			0	90.09 90.10
90. 11	09011 DIABETIC PLUS CLINIC	415, 442	8, 233	2, 121	15, 594	441, 390	90.11
90.12	09012 OTHER ONCOLOGY SERVICES	0	0		0	0	90.12
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 325, 835	79, 149	50, 023	216, 307	7, 671, 314 0	
72.00	107200 0DSERVATION DEDS (NUN-DISTINCT PART)	I		I	I	0	J 72.00

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	1	Period: From 01/01/2021 Fo 12/31/2021	Worksheet B Part I Date/Time Pre 5/30/2022 2:5	pared: 3 pm
		CAPITAL REL				
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
OTHER REIMBURSABLE COST CENTERS		-		-1 -1		
98.00 09850 OTHER REI MBURSABLE COST CENTERS	0	0	(0 0	0	98.00
SPECIAL PURPOSE COST CENTERS	404 047 000	0.050.054	7 570 44		404 540 000	1110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	186, 217, 328	2, 058, 954	7, 570, 44	5 3, 123, 014	184, 569, 228	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		ol ol	0	190.00
190. 01 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	637,056	23, 078			1, 002, 144	
190. 02 19002 EMPLOYED ORTHO MD	037,030	23, 078	322,470	19, 540		190.01
190. 03 19003 NORTHVI EW CONV. (LTC)	0	0				190.02
190. 04 19004 SUMMI T CONV. (LTC)	0	0				190.04
190. 05 19005 PARKVI EW CONV. (LTC)	0	0				190.05
190. 06 19006 MONTI CELLO HSE.	29, 520	76, 377			105, 897	1
190. 07 19007 NH PARK PLACE (LTC)	0	0	(0		190.07
190.08 19008 MADISON PLACE OF ELWOOD (LTC)	o	0	(0 0		190.08
190. 09 19009 SPI NE SURGEON	0	0	(0		190.09
190. 10 19010 CLINI CAL RESEARCH CENTER	-115	10, 093	182	2 0	10, 160	190. 10
190. 11 19011 ONCOLOGI ST	0	0	(0 0	0	190. 11
190. 12 19012 MEDI CAL I NTERNI ST	17, 369	0	(617	17, 986	190. 12
190. 13 19013 RHEUMATOLOGY	0	0	(0 0	0	190. 13
190. 14 19014 ROCK STEADY BOXING	133, 257	32, 936	22, 64	4, 016	192, 853	190. 14
190. 15 19015 OTHER ONCOLOGY SERVICES	0	0	(0 0	0	190. 15
191. 00 19100 RESEARCH	0	0	(0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 585, 430	907, 948			2, 531, 593	
192.01 19201 MUNCLE MD OFFICES	27, 409	36, 410	129, 980	6 0	193, 805	
192. 02 19202 FOUNDATI ON	0	0	(0 0		192.02
192. 03 19203 SPOE	0	0	(0 0		192. 03
192.04 19204 HEALTHY HEART	0	0	(0 0		192. 04
192.05 19205 VACANT SPACE	0	0	(192.05
192.07 19207 PARK PLACE CENTER	11	0	(192.07
192. 08 19208 RENTAL PROPERTY	8, 207	4, 575				192.08
192. 09 19209 RESIDENTIAL PROPERTY (1430 N MADI SON	2, 552	7, 910	(-		192.09
192. 10 19210 HOSPI TAL RENTAL (1927 N MADI SON AVE)	0	10, 125	(ן ע		192.10
200.00 Cross Foot Adjustments		_				200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	188, 658, 024	0 3, 168, 406	8, 084, 920	3, 147, 187	0 188, 658, 024	201.00
	100,000,024	0, 100, 400	0,001,720	3, 11, 10,	100, 000, 024	1-02.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	COMMUNI TY HOSPI T	AL ANDERSON	CN: 15-0113 P	In Lie eriod:	u of Form CMS-2 Worksheet B	2552-10
00017				F	rom 01/01/2021 o 12/31/2021	Part I	pared:
	Cost Center Description	ADMI NI STRATI VE N	MAINTENANCE &	OPERATION OF	LAUNDRY &	Date/Time Prep 5/30/2022 2:53 HOUSEKEEPING	3 pm
		& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	GENERAL SERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINI STRATI VE & GENERAL	49, 844, 557					4.00 5.00
6.00	00600 MAI NTENANCE & REPAI RS	47,044,337	0				6.00
7.00	00700 OPERATION OF PLANT	3, 120, 754	0	11, 811, 823			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0		8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 169, 256 433, 575	0	87, 917 113, 813		4, 513, 465 0	
11.00	01100 CAFETERI A	433, 575	0	219, 262		77, 018	
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0		0	12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 298, 480	0	91, 826		11, 758	
14.00	01400 CENTRAL SERVICES & SUPPLY	915,054	0	218, 112		159, 914	
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	1, 370, 908 366, 116	0	99, 615 107, 950		20, 577 25, 868	
17.00	01700 SOCI AL SERVICE	0	0	0		20,000	
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
20.00	02000 NURSI NG PROGRAM	0	0	0	0	0	
21.00 22.00	02100 I & SERVI CES-SALARY & FRI NGES APPRVD 02200 I & SERVI CES-OTHER PRGM. COSTS APPRVD	9, 388 12, 704	0		0	0	21.00
23.00	02300 PARAMED ED PRGM-(EMS)	0	0	0		0	
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
30.00	03000 ADULTS & PEDIATRICS	8,020,222	0			1, 353, 983	
31.00 43.00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	2, 068, 940 388, 058	0	382, 019 281, 686		206, 360 92, 891	
45.00	ANCI LLARY SERVICE COST CENTERS	500,050	0	201,000	0	72,071	43.00
50.00	05000 OPERATI NG ROOM	4, 367, 067	0	948, 812	0	974, 772	50.00
51.00	05100 RECOVERY ROOM	0	0	0	-	0	
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	677, 529	0	236, 736		0	52.00 53.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	1,090,643	0	332, 298	-	174, 024	1
54.01	05401 ULTRASOUND	267, 817	0	33, 282		0	1
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	-	0	55.00
56.00	05600 RADI OI SOTOPE	221, 771	0	43, 197		7, 643	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	453, 836 594, 746	0	168, 650 26, 901		0 6, 467	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	517,046	0	187, 360		92, 891	
60.00	06000 LABORATORY	2, 889, 694	0	223, 429	0	105, 826	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	258, 869	0	24, 544	0	2, 940 0	
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	1
65.00	06500 RESPI RATORY THERAPY	1, 091, 715	0	5, 403	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	1, 563, 110	0	166, 408		27, 632	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	176, 318 79, 615	0	31, 011 13, 997		29, 396 7, 643	
	06900 ELECTROCARDI OLOGY	603, 830	0	499, 942		452, 699	
70.00	07000 ELECTROENCEPHALOGRAPHY	366, 814	0	99, 241		63, 495	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	1, 773, 995	0	0	0	0	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	2, 530, 374 3, 539, 782	0	0 14, 370	0	0	72.00
74.00	07400 RENAL DIALYSIS	126, 383	0	14, 370		0	
	OUTPATIENT SERVICE COST CENTERS			-			
90.00	09000 CLINIC	0	0	-	-	0	
90. 01 90. 02	09001 WOUND/OSTOMY CLINIC 09002 CTR ADVANCED HEART CARE	651, 106 67, 092	0	156, 291 60, 844		89, 952 0	1
90. 02 90. 03	09003 RADIATION ONCOLOGY	1, 719, 354	0	336, 035		0	
90.04	09004 MUNCIE CLINIC	0	0	000,000	0	0	90.04
90.05	09005 ANTI COAGULATI ON CLINIC	170, 702	0	0	0	0	90.05
90.06	09006 PREGNANCY PLUS	0	0	0	0	0	90.06
90. 07 90. 08	09007 0/P LAB 09008 0/P LAB	0	0		0	0	90.07 90.08
90.08 90.09	09009 FORTVILLE CLINIC	0	0	0	0	0	90.08
90.10	09010 1030 S SCATTERFIELD (MEDCHECK)	0	0	0	0	0	90.10
	09011 DI ABETI C PLUS CLI NI C	158, 493	0	37, 391		0	90.11
90.11	09012 OTHER ONCOLOGY SERVICES	0	0	0	0	0 484, 446	90.12
90. 12		2 7E/ EOF			. ()		91.00
90. 12 91. 00	09100 EMERGENCY	2, 754, 585	0	359, 487	Ŭ	101, 110	92 00
90. 12 91. 00		2, 754, 585	0	359, 487			92.00
90. 12 91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09850 OTHER REIMBURSABLE COST CENTERS	2, 754, 585	0			0	
90. 12 91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09850 OTHER REIMBURSABLE COST CENTERS SPECIAL PURPOSE COST CENTERS		0	0	0	0	98.00

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F	eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part I	pared:
Cost Center Description	ADMI NI STRATI VE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	5.00	6.00	7.00	8.00	9.00	
NONREI MBURSABLE COST CENTERS	5.00	0.00	7.00	0.00	7.00	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190. 01 19001 WELLNESS CENTERS	359, 846	0	104, 817	-		190.01
190.02 19002 EMPLOYED ORTHO MD	0	0	0	0		190.02
190. 03 19003 NORTHVI EW CONV. (LTC)	0	0		0		190.03
190. 04 19004 SUMMI T CONV. (LTC)	0	0		0		190.04
190. 05 19005 PARKVI EW CONV. (LTC)	0	0		0		190.05
190. 06 19006 MONTI CELLO HSE.	38, 025	0	346, 899	0		190.06
190. 07 19007 NH PARK PLACE (LTC)	0	0	l c	0	0	190.07
190.08 19008 MADISON PLACE OF ELWOOD (LTC)	0	0	l c	0	0	190.08
190. 09 19009 SPI NE SURGEON	0	0	c c	0	0	190.09
190. 10 19010 CLI NI CAL RESEARCH CENTER	3, 648	0	45, 841	0	0	190. 10
190. 11 19011 ONCOLOGI ST	0	0	l c	0	0	190. 11
190. 12 19012 MEDI CAL I NTERNI ST	6, 458	0	(c	0	0	190. 12
190. 13 19013 RHEUMATOLOGY	0	0	(c	0	0	190. 13
190.14 19014 ROCK STEADY BOXING	69, 249	0	149, 595	0	0	190. 14
190. 15 19015 OTHER ONCOLOGY SERVICES	0	0	c	0	0	190. 15
191. 00 19100 RESEARCH	0	0	c	0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	909, 034	0	4, 123, 838	0	0	192.00
192.01 19201 MUNCIE MD OFFICES	69, 591	0	165, 373	0	0	192.01
192. 02 19202 FOUNDATI ON	0	0	C	0	0	192.02
192. 03 19203 SPOE	0	0	C	0		192.03
192.04 19204 HEALTHY HEART	0	0	C	0		192.04
192. 05 19205 VACANT SPACE	0	0	C	0		192.05
192.07 19207 PARK PLACE CENTER	4	0	C	0		192.07
192.08 19208 RENTAL PROPERTY	4, 941	0	20, 779			192.08
192.09 19209 RESIDENTIAL PROPERTY (1430 N MADISON	3, 757	0	35, 926			192.09
192.10 19210 HOSPI TAL RENTAL (1927 N MADI SON AVE)	3, 636	0	45, 985	0	0	192.10
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	C	0		201.00
202.00 TOTAL (sum lines 118 through 201)	49, 844, 557	0	11, 811, 823	0	4, 513, 465	202.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	COMMUNITY HOSPI	TAL ANDERSON Provider CO		eriod:	u of Form CMS-: Worksheet B	2552-10
					rom 01/01/2021 o 12/31/2021	Part I Date/Time Pre	pared:
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI ON	5/30/2022 2:5 CENTRAL SERVI CES & SUPPLY	<u>3 pm</u>
		10.00	11.00	12.00	13.00	14.00	
1 00	GENERAL SERVICE COST CENTERS				1		1 00
1.00 2.00 4.00 5.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						1.00 2.00 4.00 5.00
6.00 7.00 8.00 9.00	00600 MAI NTENANCE & REPAI RS 00700 OPERATION OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	1 754 040					6.00 7.00 8.00 9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	1, 754, 862	2, 153, 268				10.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	2, 100, 200	0			12.00
13.00	01300 NURSING ADMINISTRATION	О	66, 596	0	5, 084, 830		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	53, 911	0		3, 895, 348	
	01500 PHARMACY	0	79, 281	0	-	1, 947, 811	
16.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	0	0	-	2	16.00
17.00 19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0		0	0	
20.00	02000 NURSI NG PROGRAM	0	0		0	0	20.00
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300 PARAMED ED PRGM-(EMS)	0	0	0	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS			-			
30.00	03000 ADULTS & PEDIATRICS	1, 514, 419	593, 020			91,099	
31.00 43.00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	206, 135 0	133, 192 25, 370	0		25, 522 5, 480	
43.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>	23, 370		131,003	5,400	43.00
50.00	05000 OPERATING ROOM	731	253, 699	0	1, 280, 237	196, 222	50.00
51.00	05100 RECOVERY ROOM	0	0	0		0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	47, 569	0	-	9, 870	
53.00	05300 ANESTHESI OLOGY	0	0 57,000	0		0	53.00
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	0	57, 082 15, 856		-	11, 607 531	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	15, 850		-	0	
56.00	05600 RADI OI SOTOPE	0	9, 514	0	-	789	
57.00	05700 CT SCAN	0	25, 370	0	0	1, 493	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	25, 370	0		2, 386	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	25, 370 130, 021			15, 156 264, 135	
60. 00 60. 01	06001 BLOOD LABORATORY	0	130, 021		0	204, 135	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	6, 342	0	-	44, 695	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	
		0	72, 938	0	0	15, 780	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	120, 507 6, 342		0	3, 245 124	
	06800 SPEECH PATHOLOGY	0	3, 171	0	-	56	1
69.00	06900 ELECTROCARDI OLOGY	0	44, 397	0	0	15, 865	
	07000 ELECTROENCEPHALOGRAPHY	0	25, 370	0	0	4, 303	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	474, 910	
	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0	0		0	677, 398 42	
	07400 RENAL DIALYSIS	0	0	0		273	
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0		0	
	09001 WOUND/OSTOMY CLINIC	0	22, 199	0	-	7,679	
90. 02 90. 03	09002 CTR ADVANCED HEART CARE 09003 RADI ATI ON ONCOLOGY	0	9, 514 63, 425	0	0	1, 022 15, 295	
90.04	09004 MUNCIE CLINIC	o	03, 423		0	13, 273	
90.05	09005 ANTI COAGULATI ON CLINIC	Ő	12, 685	0	0	2, 943	
90.06	09006 PREGNANCY PLUS	0	0	0	0	0	90.06
90.07	09007 0/P LAB	0	0	0	0	0	90.07
90. 08 90. 09	09008 0/P LAB 09009 FORTVI LLE CLI NI C	0	0		0	0	90.08 90.09
	09009 FORTVILLE CLINIC 09010 1030 S SCATTERFIELD (MEDCHECK)		0		0	0	90.09
90.11	09011 DI ABETI C PLUS CLI NI C	o	15, 856	0	0	227	90.11
90. 12	09012 OTHER ONCOLOGY SERVICES	O	0	0	0	0	90. 12
91.00	09100 EMERGENCY	33, 577	190, 274	0	0	55, 444	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
98.00	OTHER REIMBURSABLE COST CENTERS 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
20.00	SPECIAL PURPOSE COST CENTERS		0	. 0	<u> </u>	0	, 5. 00
118.00		1, 754, 862	2, 134, 241	0	5, 084, 830	3, 891, 404	118.00
	· · · · · · · · · · · · · · · · · · ·						

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		Inlie	eu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C	CN: 15-0113	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I
Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE PERSONNEL	OF NURSI NG ADMI NI STRATI ON	CENTRAL
	10.00	11.00	12.00	13.00	14.00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	
190.01 19001 WELLNESS CENTERS	0	15, 856	,	0 0	707 190. 01
190.02 19002 EMPLOYED ORTHO MD	0	0		0 0	0 190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)	0	0)	0 0	0 190. 03
190.04 19004 SUMMIT CONV. (LTC)	0	0		0 0	0 190. 04
190. 05 19005 PARKVI EW CONV. (LTC)	0	0		0 0	0 190. 05
190. 06 19006 MONTI CELLO HSE.	0	0		0 0	0 190. 06
190.07 19007 NH PARK PLACE (LTC)	0	0		0 0	0 190. 07
190.08 19008 MADISON PLACE OF ELWOOD (LTC)	0	0		0 0	0 190. 08
190. 09 19009 SPI NE SURGEON	0	0		0 0	0 190. 09
190. 10 19010 CLINI CAL RESEARCH CENTER	0	0		0 0	0 190. 10
190. 11 19011 ONCOLOGI ST	0	0)	0 0	0 190. 11
190. 12 19012 MEDI CAL I NTERNI ST	0	0		0 0	179 190. 12
190. 13 19013 RHEUMATOLOGY	0	0)	0 0	0 190. 13
190.14 19014 ROCK STEADY BOXING	0	3, 171		0 0	152 190. 14
190. 15 19015 OTHER ONCOLOGY SERVICES	0	0)	0 0	0 190. 15
191. 00 19100 RESEARCH	0	0)	0 0	0 191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0)	0 0	2, 906 192. 00
192.01 19201 MUNCLE MD OFFICES	0	0)	0 0	0 192. 01
192. 02 19202 FOUNDATI ON	0	0)	0 0	0 192. 02
192. 03 19203 SPOE	0	0)	0 0	0 192. 03
192. 04 19204 HEALTHY HEART	0	0)	0 0	0 192.04
192. 05 19205 VACANT SPACE	0	0)	0 0	0 192.05
192.07 19207 PARK PLACE CENTER	0	0)	0 0	0 192. 07
192. 08 19208 RENTAL PROPERTY	0	0)	0 0	0 192.08
192.09 19209 RESIDENTIAL PROPERTY (1430 N MADISON	0	0		0 0	0 192.09
192. 10 19210 HOSPI TAL RENTAL (1927 N MADI SON AVE)	0	0		0 0	0 192. 10
200.00 Cross Foot Adjustments					200.00
201.00 Negative Cost Centers	0	0		0 0	0 201.00
202.00 TOTAL (sum lines 118 through 201)	1, 754, 862	2, 153, 268		0 5, 084, 830	

COST A	Financial Systems	COMMUNITY HOSPI	Provi der CO		Period:	u of Form CMS-: Worksheet B	2002 10
					From 01/01/2021 To 12/31/2021	Part I Date/Time Pre	pared:
	Cost Center Description	PHARMACY	RECORDS &	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	5/30/2022 2:5 NURSI NG PROGRAM	3 pm
		15.00	LI BRARY 16. 00	17.00	19.00	20.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00 8.00							7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8.00 9.00
10.00	01000 DI ETARY						10.00
11.00							11.00
12.00 13.00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION						12.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY	7, 336, 068					15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	3, 668, 030	5, 187, 572				16.00
17.00 19.00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0				17.00
20.00	02000 NURSI NG PROGRAM	0	0	(0	•
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	(21.00
22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM-(EMS)	0	0				22.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0		<u>ا</u>		23.00
30.00	03000 ADULTS & PEDIATRICS	0	4, 255, 672	(0 0	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0	C		0	•
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	57, 689	(0 0	0	43.00
50.00	05000 OPERATING ROOM	0	230, 756	(ol ol	0	50.00
51.00	05100 RECOVERY ROOM	0	0	(0	0	•
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0			0	53.00 54.00
54.00 54.01	05400 RADIOLOGI-DIAGNOSTIC	0	0			0	•
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	(0	0	•
56.00	05600 RADI OI SOTOPE	0	0	(0	0	56.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	13, 313 44, 376			0	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	44, 370	(0	59.00
60.00	06000 LABORATORY	0	328, 384	(0 0	0	60.00
60. 01 62. 00	06001 BLOOD LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	105 255			0	60.01 62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	195, 255 0			0	•
	06400 I NTRAVENOUS THERAPY	0	0	(0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0	(0	0	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0			0	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	0	0	(0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	(0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0	70.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 668, 038	0	(0	0	•
74.00	07400 RENAL DI ALYSI S	0	0		0 0	0	74.00
00.00			0	· · · · ·			00.00
90. 00 90. 01	09000 CLINIC 09001 WOUND/OSTOMY CLINIC	0	0 62, 127			0	90.00 90.01
90.02	09002 CTR ADVANCED HEART CARE	0	0			0	90.02
90.03		0	0			0	90.03
90. 04 90. 05	09004 MUNCLE CLINIC 09005 ANTICOAGULATION CLINIC	0	0			0	90.04 90.05
90.05 90.06	09005 ANTICOAGULATION CLINIC	0	0	(0	90.05
90.07	09007 0/P LAB	0	0	0	o o	0	90.07
90.08	09008 0/P LAB	0	0	(0	0	90.08
90. 09 90. 10	09009 FORTVILLE CLINIC 09010 1030 S SCATTERFIELD (MEDCHECK)	0	0			0	90.09
90. 10 90. 11	09010 IOSO S SCATTERFIELD (MEDCHECK)	0	0			0	90.10
90. 12	09012 OTHER ONCOLOGY SERVICES	0	0	(0	90.12
91.00	09100 EMERGENCY	0	0	(0 0	0	
92.00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	(0	0	98.00
	SPECIAL PURPOSE COST CENTERS		5, 187, 572				1
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	7, 336, 068			0 0		118.00

Health Financial Systems	COMMUNI TY HOSPI				u of Form CMS-2552-1
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F	eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part I Date/Time Prepared: 5/30/2022 2:53 pm
Cost Center Description	PHARMACY	RECORDS & LI BRARY	SOCIAL SERVICE	ANESTHET I STS	NURSI NG PROGRAM
	15.00	16.00	17.00	19.00	20.00
NONREI MBURSABLE COST CENTERS				1	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEE	N O	0	0	0	0 190. 0
190.01 19001 WELLNESS CENTERS	0	0	0	0	0 190. 0
190.02 19002 EMPLOYED ORTHO MD	0	0	0	0	0 190. 0
190.03 19003 NORTHVI EW CONV. (LTC)	0	0	0	0	0 190. 0
190.04 19004 SUMMIT CONV. (LTC)	0	0	0	0	0 190. 0
190. 05 19005 PARKVI EW CONV. (LTC)	0	0	0	0	0 190. 0
190. 06 19006 MONTI CELLO HSE.	0	0	0	0	0 190. 0
190.07 19007 NH PARK PLACE (LTC)	0	0	0	0	0 190. 0
190.08 19008 MADISON PLACE OF ELWOOD (LTC)	0	0	0	0	0 190. 0
190. 09 19009 SPI NE SURGEON	0	0	0	0	0 190. 0
190. 10 19010 CLINICAL RESEARCH CENTER	0	0	0	0	0 190. 1
190. 11 19011 ONCOLOGI ST	0	0	0	0	0 190. 1
190. 12 19012 MEDI CAL I NTERNI ST	0	0	0	0	0 190. 1
190. 13 19013 RHEUMATOLOGY	0	0	0	0	0 190. 1
190. 14 19014 ROCK STEADY BOXING	0	0	0	0	0 190. 1
190. 15 19015 OTHER ONCOLOGY SERVICES	0	0	0	0	0 190. 1
191. 00 19100 RESEARCH	0	0	0	0	0 191. 0
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0 192. 0
192.01 19201 MUNCIE MD OFFICES	0	0	0	0	0 192. 0
192. 02 19202 FOUNDATI ON	0	0	0	0	0 192. 0
192. 03 19203 SPOE	0	0	0	0	0 192. 0
192.04 19204 HEALTHY HEART	0	0	0	0	0 192. 0
192.05 19205 VACANT SPACE	0	0	0	0	0 192. 0
192.07 19207 PARK PLACE CENTER	0	0	0	0	0 192. 0
192.08 19208 RENTAL PROPERTY	0	0	0	0	0 192. 0
192.09 19209 RESIDENTIAL PROPERTY (1430 N MADIS		0	0	0	0 192. 0
192. 10 19210 HOSPI TAL RENTAL (1927 N MADI SON AV	E) 0	0	0	0	0 192. 1
200.00 Cross Foot Adjustments				0	0 200. 0
201.00 Negative Cost Centers	0	0	0	0	0 201. 0
202.00 TOTAL (sum lines 118 through 201)	7, 336, 068	5, 187, 572	0	0	0 202. 0

	Financial Systems	COMMUNI TY HOSP				u of Form CMS-2	2552-10
COST	ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F	eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part I Date/Time Pre	narodi
			DECUDENTO		0 12/31/2021	5/30/2022 2:5	
		INTERNS &	RESI DENTS				
	Cost Center Description	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM.COSTS	PARAMED ED PRGM-(EMS)	Subtotal	Intern & Residents Cost	
		T & TRINGES	111000. 00010	TROM (Em3)		& Post	
						Stepdown Adjustments	
		21.00	22.00	23.00	24.00	25.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.00							4.00
5.00 6.00	00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS						5.00 6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8.00 9.00
10.00							10.00
11.00 12.00							11. 00 12. 00
12.00							12.00
14.00							14.00
15.00 16.00							15.00 16.00
17.00	01700 SOCIAL SERVICE						17.00
19.00 20.00							19.00 20.00
20.00		35, 534					20.00
22.00			48, 085				22.00
23.00	02300 PARAMED ED PRGM-(EMS) I NPATI ENT ROUTI NE SERVI CE COST CENTERS			0			23.00
30.00	03000 ADULTS & PEDI ATRI CS	35, 534		0			30.00
31.00 43.00		0					31.00 43.00
43.00	ANCI LLARY SERVICE COST CENTERS		0		2,003,770	0	43.00
50.00		0				0	50.00
51.00 52.00		0		0		0	51.00 52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	0	0		4, 703, 013 1, 063, 336	0	54.00 54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55.00
56.00 57.00		0	0	0	900, 531 1, 926, 562	0	56.00 57.00
58.00		0	0	0	2, 356, 570	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0			2, 277, 758		59.00
60. 00 60. 01		0	0	0	, ,	0	60. 00 60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	1, 253, 577	0	62.00
63.00 64.00		0	0	0	0	0	63.00 64.00
65.00		0	0	0	4, 226, 182	0	65.00
66.00		0	0	0	6, 234, 047	0	66.00
67.00 68.00		0	0	0	734, 224 326, 203	0	67.00 68.00
69.00		0	0	0	3, 298, 356		69.00
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		1, 580, 774 7, 189, 348		70.00 71.00
72.00		0	0	0	10, 254, 675	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	1		73.00
74.00	07400 RENAL_DIALYSIS OUTPATIENT SERVICE COST CENTERS	0	0	0	478, 624	0	74.00
90.00	09000 CLI NI C	0		0	-	0	90.00
90.01	09001 WOUND/OSTOMY CLINIC 09002 CTR ADVANCED HEART CARE	0	0	0	2, 802, 637 325, 318	0	90. 01 90. 02
	09003 RADI ATI ON ONCOLOGY	0	0	0	6, 922, 383	0	90.02
90.04		0	0	0	0	0	90.04
90. 05 90. 06		0	0		661, 722 0	0	90. 05 90. 06
90.07	09007 0/P LAB	0	0	0	0	0	90. 07
90. 08 90. 09		0	0		0	0	90. 08 90. 09
	09010 1030 S SCATTERFIELD (MEDCHECK)	0	0	0	0	0	90. 09 90. 10
90.11	09011 DI ABETI C PLUS CLI NI C 09012 OTHER ONCOLOGY SERVI CES	0	0	0	653, 357	0	90. 11 90. 12
90. 12 91. 00		0	0	0	0 11, 549, 127	0	90. 12 91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON			In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0113		i od: m 01/01/2021 12/31/2021	Worksheet B Part I Date/Time Pre 5/30/2022 2:5	pared: 3 pm
Cost Center Description	I NTERNS & SERVI CES-SALAR Y & FRI NGES	SERVI CES-OTHER PRGM. COSTS	PRGM-(EMS)			Intern & Residents Cost & Post Stepdown Adjustments	
	21.00	22.00	23.00		24.00	25.00	
OTHER REIMBURSABLE COST CENTERS							00.00
98. 00 09850 OTHER REI MBURSABLE COST CENTERS	0	0		0	0	0	98.00
SPECIAL PURPOSE COST CENTERS	05 504	40.005		0	477 000 745	00 (10	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	35, 534	48, 085		0	177, 993, 745	-83, 619	118.00
		0					100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0		190.00
190. 01 19001 WELLNESS CENTERS	0	0		0	1, 528, 640		190.01
190. 02 19002 EMPLOYED ORTHO MD	0	0		0	0		190.02
190. 03 19003 NORTHVI EW CONV. (LTC)	0	0		0	0		190.03
190. 04 19004 SUMMIT CONV. (LTC)	0	0		0	0		190.04
190. 05 19005 PARKVI EW CONV. (LTC)	0	0		0	100 001		190.05
190. 06 19006 MONTI CELLO HSE.	0	0		0	490, 821		190.06
190. 07 19007 NH PARK PLACE (LTC)	0	0		0	0		190.07
190.08 19008 MADI SON PLACE OF ELWOOD (LTC)	0	0		0	0		190.08
190. 09 19009 SPI NE_SURGEON	0	0		0	50 (10		190.09
190. 10 19010 CLINICAL RESEARCH CENTER	0	0		0	59, 649		190.10
190. 11 19011 ONCOLOGI ST	0	0		0	0		190.11
190. 12 19012 MEDI CAL I NTERNI ST	0	0		0	24, 623		190.12
190. 13 19013 RHEUMATOLOGY	0	0		0	0		190.13
190. 14 19014 ROCK STEADY BOXING	0	0		0	415, 020		190.14
190. 15 19015 OTHER ONCOLOGY SERVICES	0	0		0	0		190. 15 191. 00
	0	0		-			
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	7, 567, 371		192.00
192. 01 19201 MUNCI E MD OFFICES	0	0		0	428, 769		192.01
192. 02 19202 FOUNDATI ON	0	0		0	0		192.02
192. 03 19203 SPOE	0	0		0	0		192.03
192. 04 19204 HEALTHY HEART	0	0		0	0		192.04
192. 05 19205 VACANT SPACE	0	0		0	1		192.05
192. 07 19207 PARK PLACE CENTER	0	0		0	15		192.07
192. 08 19208 RENTAL PROPERTY	0	0		0	39, 480		192.08
192. 09 19209 RESIDENTIAL PROPERTY (1430 N MADI SON	0	0		0	50, 145		192.09
192. 10 19210 HOSPI TAL RENTAL (1927 N MADI SON AVE)	0	0		0	59, 746		192.10
200.00Cross Foot Adjustments201.00Negative Cost Centers	0	0		0	0		200. 00 201. 00
201.00 Negative cost centers 202.00 TOTAL (sum lines 118 through 201)	35, 534	49.005		0	0 188, 658, 024	-83, 619	
202.00 IUTAL (Sum TIMES TIO UN OUGH 201)	30, 534	48, 085		U	100, 000, 024	-03, 019	202.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	COMMUNITY HOSPIT	Provider CCN: 15-0113	Peri od:	u of Form CMS-2552 Worksheet B
				From 01/01/2021 To 12/31/2021	Part I Date/Time Prepare
	Cost Center Description	Total			5/30/2022 2:53 pm
		26.00			
00	GENERAL SERVICE COST CENTERS				1.
00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP				2.
00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.
00	00500 ADMI NI STRATI VE & GENERAL				5.
00	00600 MAINTENANCE & REPAIRS				6.
00	00700 OPERATION OF PLANT				7.
00	00800 LAUNDRY & LINEN SERVICE				8.
00	00900 HOUSEKEEPI NG				9.
	01000 DI ETARY				10.
. 00	01100 CAFETERI A				11.
00	01200 MAINTENANCE OF PERSONNEL				12.
00	01300 NURSING ADMINISTRATION				13.
00	01400 CENTRAL SERVICES & SUPPLY				14.
00	01500 PHARMACY				15.
00	01600 MEDICAL RECORDS & LIBRARY				16.
	01700 SOCIAL SERVICE				17.
	01900 NONPHYSI CLAN ANESTHETI STS				19.
	02000 NURSI NG PROGRAM				20.
	02100 I &R SERVICES-SALARY & FRINGES APPRVD				21.
	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD				22.
	02300 PARAMED ED PRGM-(EMS)				23.
	INPATIENT ROUTINE SERVICE COST CENTERS	i			23.
00	03000 ADULTS & PEDIATRICS	42, 326, 110			30.
	03100 I NTENSI VE CARE UNI T	9, 459, 762			31.
	04300 NURSERY	2,063,770			43.
. 00	ANCI LLARY SERVI CE COST CENTERS	2,003,770			43.
. 00	05000 OPERATI NG ROOM	20, 414, 254			50.
	05100 RECOVERY ROOM				51.
	05200 DELIVERY ROOM & LABOR ROOM	2, 858, 573			52.
	05300 ANESTHESI OLOGY	0			53.
	05400 RADI OLOGY-DI AGNOSTI C	4, 703, 013			54.
	05401 ULTRASOUND	1,063,336			54.
	05500 RADI OLOGY-THERAPEUTI C	0			55.
	05600 RADI OI SOTOPE	900, 531			56.
. 00	05700 CT SCAN	1, 926, 562			57.
. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 356, 570			58.
. 00	05900 CARDI AC CATHETERI ZATI ON	2, 277, 758			59.
. 00	06000 LABORATORY	11, 989, 071			60.
. 01	06001 BLOOD LABORATORY	0			60.
. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 253, 577			62.
. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0			63.
00	06400 INTRAVENOUS THERAPY	0			64.
. 00	06500 RESPI RATORY THERAPY	4, 226, 182			65.
	06600 PHYSI CAL THERAPY	6, 234, 047			66.
	06700 OCCUPATI ONAL THERAPY	734, 224			67.
	06800 SPEECH PATHOLOGY	326, 203			68.
	06900 ELECTROCARDI OLOGY	3, 298, 356			69.
	07000 ELECTROENCEPHALOGRAPHY	1, 580, 774			70.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 189, 348			71.
	07200 I MPL. DEV. CHARGED TO PATIENTS	10, 254, 675			72
	07300 DRUGS CHARGED TO PATIENTS	17, 080, 262			73.
	07400 RENAL DI ALYSI S	478, 624			74
00	OUTPATIENT SERVICE COST CENTERS	170,024			/ .
00	09000 CLINIC	0			90.
	09001 WOUND/OSTOMY CLINIC	2, 802, 637			90.
	09002 CTR ADVANCED HEART CARE	325, 318			90.
	09003 RADI ATI ON ONCOLOGY	6, 922, 383			90.
	09004 MUNCIE CLINIC	0, 722, 303			90
	09005 ANTI COAGULATI ON CLINIC	661, 722			90.
	09006 PREGNANCY PLUS	001,722			90.
	09007 0/P LAB	0			90.
	09008 0/P LAB	0			90.
	09009 FORTVILLE CLINIC	0			
		-			90.
	09010 1030 S SCATTERFIELD (MEDCHECK)	(52.257			90.
	09011 DI ABETI C PLUS CLI NI C	653, 357			90.
	09012 OTHER ONCOLOGY SERVICES	0			90.
	09100 EMERGENCY	11, 549, 127			91.
00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.
_	OTHER REIMBURSABLE COST CENTERS				
00	09850 OTHER REIMBURSABLE COST CENTERS	0			98.
	SPECIAL PURPOSE COST CENTERS				
	SUBTOTALS (SUM OF LINES 1 through 117)	177, 910, 126			118.
3. 00	NONREIMBURSABLE COST CENTERS				

Health Financial Systems	COMMUNITY HOSPITA	AL ANDERSON	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0113	Peri od: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Prepared: 5/30/2022 2:53 pm
Cost Center Description	Total			
	26.00			
190.01 19001 WELLNESS CENTERS	1, 528, 640			190. 01
190.02 19002 EMPLOYED ORTHO MD	0			190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)	0			190. 03
190.04 19004 SUMMIT CONV. (LTC)	0			190. 04
190. 05 19005 PARKVI EW CONV. (LTC)	0			190. 05
190. 06 19006 MONTI CELLO HSE.	490, 821			190.06
190.07 19007 NH PARK PLACE (LTC)	0			190. 07
190.08 19008 MADISON PLACE OF ELWOOD (LTC)	0			190. 08
190. 09 19009 SPI NE SURGEON	0			190. 09
190. 10 19010 CLINICAL RESEARCH CENTER	59, 649			190. 10
190. 11 19011 ONCOLOGI ST	0			190. 11
190. 12 19012 MEDI CAL I NTERNI ST	24, 623			190. 12
190. 13 19013 RHEUMATOLOGY	0			190. 13
190.14 19014 ROCK STEADY BOXING	415, 020			190. 14
190. 15 19015 OTHER ONCOLOGY SERVICES	0			190. 15
191. 00 19100 RESEARCH	0			191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	7, 567, 371			192.00
192.01 19201 MUNCIE MD OFFICES	428, 769			192.01
192. 02 19202 FOUNDATI ON	0			192.02
192. 03 19203 SPOE	0			192.03
192.04 19204 HEALTHY HEART	0			192.04
192. 05 19205 VACANT SPACE	0			192.05
192.07 19207 PARK PLACE CENTER	15			192.07
192. 08 19208 RENTAL PROPERTY	39, 480			192.08
192.09 19209 RESIDENTIAL PROPERTY (1430 N MADISON	50, 145			192.09
192. 10 19210 HOSPITAL RENTAL (1927 N MADISON AVE)	59, 746			192.10
200.00 Cross Foot Adjustments	0			200.00
201.00 Negative Cost Centers	0			201.00
202.00 TOTAL (sum lines 118 through 201)	188, 574, 405			202.00

LOCA	Financial Systems TION OF CAPITAL RELATED COSTS		Provider CC		riod: om 01/01/2021 12/31/2021	Worksheet B Part II Date/Time Pre	
			CAPI TAL REL	ATED COSTS		5/30/2022 2:5	
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
00 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
00	00400 EMPLOYEE BENEFI TS DEPARTMENT	0	19, 401	0	19, 401	19, 401	4.00
00	00500 ADMI NI STRATI VE & GENERAL	0	173, 592	1, 405, 689	1, 579, 281	2, 403	
00 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0	0 374, 792	0 658, 742	0 1, 033, 534	0 821	6.00
00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
00	00900 HOUSEKEEPI NG	0	19, 357	3, 148	22, 505	607	9.00
	01000 DI ETARY 01100 CAFETERI A	0	25, 058 48, 275	35, 594 48, 582	60, 652 96, 857	165 305	
	01200 MAINTENANCE OF PERSONNEL	0	40, 273	48, 582	90, 837	0	1
	01300 NURSI NG ADMI NI STRATI ON	0	20, 217	232	20, 449	390	
	01400 CENTRAL SERVICES & SUPPLY	0	48, 022	214, 717	262, 739	231	14.00
	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	0	21, 932 23, 767	403, 844 0	425, 776 23, 767	694 0	15.0 16.0
	01700 SOCIAL SERVICE	0	23,707	0	23, 707	0	17.0
	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.0
	02000 NURSI NG PROGRAM	0	0	0	0	0	20.0
	02100 I & R SERVICES-SALARY & FRINGES APPRVD 02200 I & SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	21.0
	02300 PARAMED ED PRGM-(EMS)	0	0	0	0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	0	256, 486	178, 866 149, 123	435, 352	4,095	
	03100 I NTENSI VE CARE UNI T 04300 NURSERY	0	84, 110 62, 019	149, 123	233, 233 72, 638	1, 007 203	31.0 43.0
	ANCI LLARY SERVI CE COST CENTERS		027017	10,017	, 2, 000	200	
	05000 OPERATING ROOM	0	208, 901	1, 377, 436	1, 586, 337	1, 694	
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0 52, 122	0 19, 125	0 71, 247	0 365	51.0 52.0
	05300 ANESTHESI OLOGY	0	52, 122	19, 125	/1, 24/		1
. 00	05400 RADI OLOGY-DI AGNOSTI C	0	73, 162	262, 605	335, 767	433	54.0
	05401 ULTRASOUND	0	7, 328	2, 911	10, 239	157	54.0
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0 9, 511	0 89, 780	0 99, 291	0 94	55.0 56.0
	05700 CT SCAN	0	37, 132	1, 217	38, 349	217	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	5, 923	436, 853	442, 776	184	
	05900 CARDI AC CATHETERI ZATI ON	0	41, 251	177,600	218, 851	211	59.0
	06000 LABORATORY 06001 BLOOD LABORATORY	0	49, 193 0	263, 314 0	312, 507 0	717 0	60.0 60.0
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	5, 404	2, 991	8, 395	52	62.0
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.0
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0 1, 190	0 59, 880	0 61, 070	0 638	64.0 65.0
	06600 PHYSI CAL THERAPY	0	36, 638	811, 468	848, 106	719	
	06700 OCCUPATI ONAL THERAPY	0	6, 828	3, 639	10, 467	104	
	06800 SPEECH PATHOLOGY	0	3, 082	1, 643	4, 725	47	68.0
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	110, 073 21, 850	143, 926 72, 235	253, 999 94, 085	281 172	69.0 70.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21,030	, 2, 233	0	0	71.0
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.0
	07300 DRUGS CHARGED TO PATIENTS	0	3, 164	0	3, 164	0	
. 00	07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	0	0	0	<u> </u>	0	74.0
. 00	09000 CLINIC	0	0	0	0	0	90.0
	09001 WOUND/OSTOMY CLINIC	0	34, 411	5, 764	40, 175	173	
	09002 CTR ADVANCED HEART CARE 09003 RADI ATI ON ONCOLOGY	0	13, 396 73, 985	368 676, 390	13, 764 750, 375	64 487	90.0 90.0
	09004 MUNCIE CLINIC	0	/3, 705	070, 340	/30, 3/3	487	90.0
	09005 ANTI COAGULATI ON CLINIC	0	0	0	0	94	90.0
. 06	09006 PREGNANCY PLUS	0	0	0	О	0	90.0
	09007 0/P LAB 09008 0/P LAB	0	0	0	0	0	
	09008 07P LAB 09009 FORTVILLE CLINIC	0	0	0	0	0	90.0 90.0
	09010 1030 S SCATTERFIELD (MEDCHECK)	0	0	0	0	0	
). 11	09011 DIABETIC PLUS CLINIC	0	8, 233	2, 121	10, 354	96	
10	09012 OTHER ONCOLOGY SERVICES	0	0	0	0	0	90.1
	09100 EMERGENCY		79, 149	50, 023	129, 172	1, 332	91.0

Health Financial Systems	COMMUNI TY HOSP	TAL ANDERSON		In Lie	u of Form CMS-25	52-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0113	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepa 5/30/2022 2:53	
		CAPI TAL REL	ATED COSTS			
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	
OTHER REI MBURSABLE COST CENTERS						
98. 00 09850 OTHER REI MBURSABLE COST CENTERS SPECI AL PURPOSE COST CENTERS	0	0		0 0	0 9	98.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	2, 058, 954	7, 570, 44	9, 629, 399	19, 252 11	18 00
NONREI MBURSABLE COST CENTERS	0	2,030,934	7, 570, 44	-J 7, 027, 377	17, 232 11	10.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0 19	90.00
190. 01 19001 WELLNESS CENTERS	0	23, 078	322, 47	345, 548	120 19	
190.02 19002 EMPLOYED ORTHO MD	0	0		0 0	0 19	90. 02
190.03 19003 NORTHVI EW CONV. (LTC)	0	0		0 0	0 19	90. 03
190.04 19004 SUMMIT CONV. (LTC)	0	0		0 0	0 19	90.04
190. 05 19005 PARKVI EW CONV. (LTC)	0	0		0 0		90.05
190.06 19006 MONTI CELLO HSE.	0	76, 377		0 76, 377		90.06
190.07 19007 NH PARK PLACE (LTC)	0	0		0 0		90.07
190.08 19008 MADISON PLACE OF ELWOOD (LTC)	0	0		0 0		90. 08
190. 09 19009 SPI NE SURGEON	0	0		0 0		90.09
190. 10 19010 CLINI CAL RESEARCH CENTER	0	10, 093	18			90.10
190. 11 19011 ONCOLOGI ST	0	0		0 0		90.11
190. 12 19012 MEDI CAL I NTERNI ST	0	0		0 0		90.12
190. 13 19013 RHEUMATOLOGY	0	0	22.44			90.13
190. 14 19014 ROCK STEADY BOXING	0	32, 936	22, 64	14 55, 580		90.14
190. 15 19015 OTHER ONCOLOGY SERVI CES 191. 00 19100 RESEARCH	0	0		0 0		90.15 91.00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	907, 948	38, 21	5 946, 163		91.00 92.00
192. 01 19201 MUNCIE MD OFFICES	0	36, 410	129, 98			92.00 92.01
192. 0219202 FOUNDATI ON		50, 410	127, 70	0 100, 370		92.01 92.02
192. 03 19203 SPOE	0	0		0 0		92.02 92.03
192. 04 19204 HEALTHY HEART	0	0		0 0		92.00 92.04
192. 05 19205 VACANT SPACE	0	0		0 0		92.05
192. 07 19207 PARK PLACE CENTER	0	0		0 0		92.07
192. 08 19208 RENTAL PROPERTY	0	4, 575	97			92.08
192.09 19209 RESIDENTIAL PROPERTY (1430 N MADISON	0	7, 910		0 7,910		92.09
192. 10 19210 HOSPITAL RENTAL (1927 N MADISON AVE)	0	10, 125		0 10, 125		92.10
200.00 Cross Foot Adjustments				0		00.00
201.00 Negative Cost Centers		0		0 0	0 20	01.00
202.00 TOTAL (sum lines 118 through 201)	0	3, 168, 406	8, 084, 92	20 11, 253, 326	19, 401 20	02.00

ALLUCA	Financial Systems TION OF CAPITAL RELATED COSTS	COMMUNI TY HOSPI		F	eriod: rom 01/01/2021 o 12/31/2021	u of Form CMS-: Worksheet B Part II Date/Time Pre	epared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	MAI NTENANCE & REPAI RS	OPERATI ON OF PLANT	LAUNDRY & LINEN SERVICE	5/30/2022 2:5 HOUSEKEEPI NG	3 pm
	L	5.00	6.00	7.00	8.00	9.00	
1 00	GENERAL SERVICE COST CENTERS			1			1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	1, 581, 684					5.00
6.00	00600 MAI NTENANCE & REPAI RS	0	C				6.00
7.00	00700 OPERATION OF PLANT	99, 026	C	1, 133, 381			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	C	0	0		8.00
9.00	00900 HOUSEKEEPI NG	37, 102	C	8, 436		68, 650	1
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	13, 758 15, 568		10, 921 21, 039	0	0 1, 171	
12.00	01200 MAINTENANCE OF PERSONNEL	15, 506		21,039		1, 171	
13.00	01300 NURSI NG ADMI NI STRATI ON	41, 203	C	8, 811	0	179	
14.00	01400 CENTRAL SERVICES & SUPPLY	29, 036	C	20, 929	-	2, 432	
15.00	01500 PHARMACY	43, 501	C	9, 558		313	1
16.00	01600 MEDICAL RECORDS & LIBRARY	11, 617	C	10, 358	0	393	16.00
17.00	01700 SOCIAL SERVICE	0	C	0	-	0	
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	C	0	0	0	
20.00	02000 NURSI NG PROGRAM	0	C	0	0	0	
21.00 22.00	02100 I & R SERVI CES-SALARY & FRI NGES APPRVD 02200 I & R SERVI CES-OTHER PRGM. COSTS APPRVD	298 403			-	0	
22.00	02300 PARAMED ED PRGM-(EMS)	403	C		-	0	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		<u>, </u>			20.00
30.00	03000 ADULTS & PEDIATRICS	254, 539	C	111, 780	0	20, 595	30.00
31.00	03100 I NTENSI VE CARE UNI T	65, 650	C			3, 139	31.00
43.00	04300 NURSERY	12, 314	C	27, 029	0	1, 413	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	400 570		01.011		11.00/	1 50 00
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	138, 573	C		0	14, 826 0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	21, 499		22, 716	-	0	
53.00	05300 ANESTHESI OLOGY	21,477	C	0		0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	34, 608	C	31, 885	-	2,647	1
54.01	05401 ULTRASOUND	8, 498	C	3, 193	0	0	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C	0 0	0	0	55.00
56.00	05600 RADI OI SOTOPE	7,037	C	4, 145		116	
57.00	05700 CT SCAN	14, 401	C	16, 182		0	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	18,872	C	2, 581	0	98	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	16, 407 91, 694		17, 978 21, 439		1, 413 1, 610	
60.00	06001 BLOOD LABORATORY	91,094	C	0		1, 010	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	8, 214	C	2, 355	-	45	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C	0		0	
64.00	06400 I NTRAVENOUS THERAPY	0	C	0 0	-	0	
	06500 RESPI RATORY THERAPY	34, 642	C	518		0	
66.00	06600 PHYSI CAL THERAPY	49,600	C	15, 967		420	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	5, 595 2, 526		2, 976 1, 343		447 116	
69.00	06900 ELECTROCARDI OLOGY	19, 160		47,971		6, 886	
70.00	07000 ELECTROENCEPHALOGRAPHY	11, 640	C	9, 522		966	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	56, 291	C	0	0	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	80, 292	C	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	112, 322	C	1, 379		0	
74.00	07400 RENAL DIALYSIS	4,010	C	0 0	0	0	74.00
90.00	OUTPATIENT SERVICE COST CENTERS	0	C.		0	0	90.00
90.00 90.01	09001 WOUND/OSTOMY CLINIC	20, 661		14,997	-	1, 368	
90. 01 90. 02	09002 CTR ADVANCED HEART CARE	2, 129	C C	5, 838		1, 308	
90.03	09003 RADIATION ONCOLOGY	54, 558	C	32, 244		0	
90.04	09004 MUNCIE CLINIC	0	C	0	0	0	
90.05	09005 ANTI COAGULATI ON CLINIC	5, 417	C	0	0	0	
90.06	09006 PREGNANCY PLUS	0	C	0	0	0	
90.07	09007 0/P LAB	0	C	0	0	0	
90.08		0	C	0	0	0	
90. 09 90. 10	09009 FORTVILLE CLINIC 09010 1030 S SCATTERFIELD (MEDCHECK)	0			0	0	
90. 10 90. 11	09011 DIABETIC PLUS CLINIC	5, 029	C C	3, 588	-	0	
90.11	09012 OTHER ONCOLOGY SERVICES	0,027	C C	0,000	0	0	
91.00	09100 EMERGENCY	87, 407	C	34, 494	-	7, 368	
71.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.00							1
92.00	OTHER REIMBURSABLE COST CENTERS			1	1		1
92.00		0	C	0	0	0	98.00

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		Inlie	eu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II	epared:
Cost Center Description	ADMI NI STRATI VE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	5.00	6. 00	7.00	8. 00	9.00	
NONREI MBURSABLE COST CENTERS	0100	0100	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0.00	7100	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
190. 01 19001 WELLNESS CENTERS	11, 418	0	10, 05	7 0	689	190.01
190.02 19002 EMPLOYED ORTHO MD	0	0		0 0	0	190.02
190. 03 19003 NORTHVI EW CONV. (LTC)	0	0		0 0	0	190.03
190.04 19004 SUMMIT CONV. (LTC)	0	0		0 0	0	190.04
190. 05 19005 PARKVI EW CONV. (LTC)	0	0		0 0	0	190.05
190. 06 19006 MONTI CELLO HSE.	1, 207	0	33, 28	6 0	0	190.06
190.07 19007 NH PARK PLACE (LTC)	0	0		0 0	0	190.07
190.08 19008 MADISON PLACE OF ELWOOD (LTC)	0	0		0 0	0	190.08
190. 09 19009 SPI NE SURGEON	0	0		0 0	0	190.09
190. 10 19010 CLINI CAL RESEARCH CENTER	116	0	4, 39	9 0	0	190. 10
190. 11 19011 ONCOLOGI ST	0	0		0 0	0	190. 11
190. 12 19012 MEDI CAL I NTERNI ST	205	0		0 0	0	190. 12
190. 13 19013 RHEUMATOLOGY	0	0		0 0	0	190. 13
190.14 19014 ROCK STEADY BOXING	2, 197	0	14, 35	4 0	0	190. 14
190. 15 19015 OTHER ONCOLOGY SERVICES	0	0		0 0	0	190. 15
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	28, 845	0	395, 69	5 0		192.00
192.01 19201 MUNCLE MD OFFICES	2, 208	0	15, 86	8 0		192.01
192. 02 19202 FOUNDATI ON	0	0		0 0		192. 02
192. 03 19203 SPOE	0	0		0 0		192.03
192.04 19204 HEALTHY HEART	0	0		0 0		192.04
192. 05 19205 VACANT SPACE	0	0		0 0		192.05
192.07 19207 PARK PLACE CENTER	0	0		0 0		192.07
192.08 19208 RENTAL PROPERTY	157	0	1, 99			192.08
192.09 19209 RESIDENTIAL PROPERTY (1430 N MADISON	119	0	3, 44			192.09
192.10 19210 HOSPITAL RENTAL (1927 N MADISON AVE)	115	0	4, 41	2 0	0	192.10
200.00 Cross Foot Adjustments		_		-	_	200.00
201.00 Negative Cost Centers	0	0	4 400 00	0		201.00
202.00 TOTAL (sum lines 118 through 201)	1, 581, 684	0	1, 133, 38	1 0	68,650	202.00

Heal th	Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC		eriod: rom 01/01/2021	Worksheet B Part II	
					o 12/31/2021	Date/Time Pre 5/30/2022 2:5	pared:
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF		CENTRAL	
				PERSONNEL	ADMI NI STRATI ON	SERVICES & SUPPLY	
	<u></u>	10.00	11.00	12.00	13.00	14.00	
1.00	GENERAL SERVICE COST CENTERS 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 6.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						5.00 6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	85, 496					9.00 10.00
11.00	01100 CAFETERI A	0	134, 940				11.00
12.00 13.00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	0	0 4, 173				12.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	4, 173 3, 378			318, 745	
15.00	01500 PHARMACY	0	4, 968	C		159, 379	15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	0			0	
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0			0	
20.00	02000 NURSI NG PROGRAM	0	0	C	0	0	
21.00 22.00	02100 I & R SERVICES-SALARY & FRINGES APPRVD 02200 I & R SERVICES-OTHER PRGM. COSTS APPRVD	0	0		0	0	
22.00	02300 PARAMED ED PRGM-(EMS)	0	0			0	•
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	-					1
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	73, 781 10, 043	37, 163 8, 347			7, 455 2, 088	•
43.00	04300 NURSERY	10, 043	1, 590			2,088	•
	ANCI LLARY SERVI CE COST CENTERS						
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	36	15, 899			16, 057 0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	2, 981			808	
53.00	05300 ANESTHESI OLOGY	0	0	C		0	
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	0	3, 577 994			950	
54. 01 55. 00	05500 RADI OLOGY-THERAPEUTI C	0	994 0			43 0	1
56.00	05600 RADI OI SOTOPE	0	596	C		65	56.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 590 1, 590		0	122 195	1
58.00 59.00	05900 CARDI AC CATHETERI ZATI ON	0	1, 590		0	1, 240	
60.00	06000 LABORATORY	0	8, 148	C	-	21, 614	
60. 01 62. 00	06001 BLOOD LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0 397		0	0 3, 657	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0			3,037	1
	06400 I NTRAVENOUS THERAPY	0	0	C	0	0	•
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	4, 571 7, 552		0	1, 291 266	1
67.00	06700 OCCUPATI ONAL THERAPY	0	397		0	10	1
68.00	06800 SPEECH PATHOLOGY	0	199	C	0	5	•
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	2, 782 1, 590		0	1, 298 352	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	38, 862	•
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	55, 431	•
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0			3 22	•
	OUTPATIENT SERVICE COST CENTERS	-			-		1
90. 00 90. 01		0	0			0	
90. 01 90. 02	09001 WOUND/OSTOMY CLINIC 09002 CTR ADVANCED HEART CARE	0	1, 391 596			628 84	1
90.03	09003 RADI ATI ON ONCOLOGY	0	3, 975	C	0	1, 252	1
90.04		0	0 795	0	0	0	
90. 05 90. 06	09005 ANTI COAGULATI ON CLINIC 09006 PREGNANCY PLUS	0	795 0		0	241 0	
90.07	09007 0/P LAB	0	0	C	o o	0	90.07
90. 08 90. 09	09008 0/P LAB 09009 FORTVILLE CLINIC	0	0		0	0	
90. 09 90. 10	09009 FORTVILLE CLINIC 09010 1030 S SCATTERFIELD (MEDCHECK)	0	0		0	0	
90. 11	09011 DIABETIC PLUS CLINIC	0	994	C	0	19	•
90. 12 91. 00	09012 OTHER ONCOLOGY SERVICES 09100 EMERGENCY	0	0 11, 924		0	0	
91.00 92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 636	11, 924			4, 537	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS	. I			. I		
98.00	09850 OTHER REIMBURSABLE COST CENTERS SPECIAL PURPOSE COST CENTERS	0	0	C	0	0	98.00
118.00		85, 496	133, 747	C	75, 205	318, 422	118.00
		•					

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/30/2022 2:5	pared:
Cost Center Description	DI ETARY		MAINTENANCE O PERSONNEL	ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	
	10.00	11.00	12.00	13.00	14.00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
190.01 19001 WELLNESS CENTERS	0	994	Ļ	0 0	58	190. 01
190.02 19002 EMPLOYED ORTHO MD	0	0		0 0	0	190. 02
190.03 19003 NORTHVIEW CONV. (LTC)	0	0		0 0	0	190. 03
190.04 19004 SUMMIT CONV. (LTC)	0	0		0 0	0	190. 04
190.05 19005 PARKVI EW CONV. (LTC)	0	0		0 0	0	190.05
190. 06 19006 MONTI CELLO HSE.	0	0		0 0	0	190.06
190.07 19007 NH PARK PLACE (LTC)	0	0		0 0	0	190. 07
190.08 19008 MADISON PLACE OF ELWOOD (LTC)	0	0		0 0	0	190. 08
190. 09 19009 SPI NE SURGEON	0	0		0 0	0	190.09
190. 10 19010 CLI NI CAL RESEARCH CENTER	0	0		o o	0	190. 10
190. 11 19011 ONCOLOGI ST	0	0		o o	0	190. 11
190. 12 19012 MEDI CAL I NTERNI ST	0	0		o o	15	190. 12
190. 13 19013 RHEUMATOLOGY	0	0		o o	0	190. 13
190. 14 19014 ROCK STEADY BOXING	0	199		0 0	12	190. 14
190. 15 19015 OTHER ONCOLOGY SERVICES	0	0		0 0		190, 15
191. 00 19100 RESEARCH	0	0		0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
192. 01 19201 MUNCLE MD OFFICES	0	0		0 0		192.01
192. 02 19202 FOUNDATI ON	0	0		0 0	0	192.02
192. 03 19203 SPOE	0	0		0 0		192.03
192. 04 19204 HEALTHY HEART	0	0		0 0	0	192.04
192. 05 19205 VACANT SPACE	0	0		0 0		192.05
192. 07 19207 PARK PLACE CENTER	0	0		0 0		192.07
192. 08 19208 RENTAL PROPERTY	0	0		0 0	0	192.08
192.09 19209 RESIDENTIAL PROPERTY (1430 N MADISON	0	0		0 0		192.09
192. 10 19210 HOSPI TAL RENTAL (1927 N MADI SON AVE)	0	0		0 0		192.10
200.00 Cross Foot Adjustments		J. J			0	200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum Lines 118 through 201)	85, 496	134, 940		0 75, 205	318, 745	

ALLOCA	Financial Systems TION OF CAPITAL RELATED COSTS	COMMUNITY HOSPI	Provi der CCI		Period: From 01/01/2021	u of Form CMS- Worksheet B Part II	
					o 12/31/2021	Date/Time Pre 5/30/2022 2:5	
	Cost Center Description	PHARMACY	MEDI CAL S RECORDS & LI BRARY	OCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	NURSI NG PROGRAM	
	<u></u>	15.00	16.00	17.00	19.00	20.00	
1.00	GENERAL SERVICE COST CENTERS 00100 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 ADMI NI STRATI VE & GENERAL						5.00
5.00	00600 MAINTENANCE & REPAIRS						6.00
7.00 3.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00
9.00 9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
12.00	01200 MAINTENANCE OF PERSONNEL						12.00
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13.00
	01500 PHARMACY	644, 189					15.00
	01600 MEDICAL RECORDS & LIBRARY	322, 093	368, 228				16.00
17.00	01700 SOCIAL SERVICE	0	0	C			17.00
	01900 NONPHYSICIAN ANESTHETISTS	0	0	C	0		19.00
	02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	C		C	20.00
	02200 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	C			21.00
	02300 PARAMED ED PRGM-(EMS)	o	o	C			23.00
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · ·	- 1				
	03000 ADULTS & PEDI ATRI CS	0	302, 078	C			30.00
	03100 I NTENSI VE CARE UNI T	0	0	C			31.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	4, 095	C			43.00
50.00	05000 OPERATING ROOM	0	16, 380	C			50.00
	05100 RECOVERY ROOM	0	0	C			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C			52.00
	05300 ANESTHESI OLOGY	0	0	C			53.00
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	0	0	C			54.00 54.01
	05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
	05600 RADI OI SOTOPE	0	0	C			56.00
57.00	05700 CT SCAN	0	945	C			57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	3, 150	C			58.00
59.00 50.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0 23, 310				59.00 60.00
	06001 BLOOD LABORATORY	0	23, 310				60.01
52.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	13, 860	C			62.00
53.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C			63.00
	06400 I NTRAVENOUS THERAPY	0	0	C			64.00
55.00 56.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0				65.00 66.00
57.00	06700 OCCUPATIONAL THERAPY	0	0				67.00
	06800 SPEECH PATHOLOGY	0	0	C			68.00
	06900 ELECTROCARDI OLOGY	0	0	C			69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0	C			70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				71.00
	07300 DRUGS CHARGED TO PATIENTS	322, 096	0				73.00
	07400 RENAL DIALYSIS	0	0	C			74.00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	0	0	C			90.00
	09001 WOUND/OSTOMY CLINIC	0	4, 410	C			90.01
	09002 CTR ADVANCED HEART CARE 09003 RADI ATI ON ONCOLOGY		0				90.02
	09004 MUNCIE CLINIC	0	0	0			90.04
	09005 ANTI COAGULATI ON CLINIC	Ő	o	C			90.05
	09006 PREGNANCY PLUS	0	О	C			90.06
	09007 0/P LAB	0	0	C			90.07
90.08 90.09	09008 0/P LAB 09009 FORTVI LLE CLI NI C	0	0	0			90.08
	09009 FORTVILLE CLINIC 09010 1030 S SCATTERFIELD (MEDCHECK)	0	0	ſ			90.09
	09011 DI ABETI C PLUS CLI NI C	o	o	C			90.11
90. 12	09012 OTHER ONCOLOGY SERVICES	O	0	C			90.12
	09100 EMERGENCY	0	0	C			91.00
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92.00
28 00	OTHER REIMBURSABLE COST CENTERS 09850 OTHER REIMBURSABLE COST CENTERS	0	0	C			98.00
5.00	SPECIAL PURPOSE COST CENTERS		0	L. L	n		1 /0.00
				C			-

Health Financial Systems	COMMUNI TY HOSPI				u of Form CMS	5-2552-10
ALLOCATION OF CAPITAL RELATED COSTS			CN: 15-0113	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pr 5/30/2022 2:	repared: 53 pm
Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY		CE NONPHYSI CI AN ANESTHETI STS	NURSI NG PROGRAM	
	15.00	16.00	17.00	19.00	20.00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	(0		190.00
190.01 19001 WELLNESS CENTERS	0	(0		190. 01
190.02 19002 EMPLOYED ORTHO MD	0	(0		190. 02
190.03 19003 NORTHVI EW CONV. (LTC)	0	(D	0		190. 03
190.04 19004 SUMMIT CONV. (LTC)	0	(D	0		190. 04
190. 05 19005 PARKVI EW CONV. (LTC)	0	(D	0		190. 05
190. 06 19006 MONTI CELLO HSE.	0	(D	0		190.06
190.07 19007 NH PARK PLACE (LTC)	0	(D	0		190. 07
190.08 19008 MADISON PLACE OF ELWOOD (LTC)	0	(D	0		190. 08
190. 09 19009 SPI NE SURGEON	0	(D	0		190. 09
190. 10 19010 CLI NI CAL RESEARCH CENTER	0	(D	0		190. 10
190. 11 19011 ONCOLOGI ST	0	(D	0		190. 11
190. 12 19012 MEDI CAL I NTERNI ST	0	(D	0		190. 12
190. 13 19013 RHEUMATOLOGY	0	(D	0		190. 13
190.14 19014 ROCK STEADY BOXING	0	(D	0		190. 14
190. 15 19015 OTHER ONCOLOGY SERVICES	0	(D	0		190. 15
191. 00 19100 RESEARCH	0	(D	0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	(0		192.00
192.01 19201 MUNCLE MD OFFICES	0	(0		192.01
192. 02 19202 FOUNDATI ON	0	(0		192.02
192. 03 19203 SPOE	0	(0		192.03
192.04 19204 HEALTHY HEART	0	(0		192.04
192. 05 19205 VACANT SPACE	0	(0		192.05
192.07 19207 PARK PLACE CENTER	0	(D	0		192.07
192. 08 19208 RENTAL PROPERTY	0	(0		192.08
192.09 19209 RESIDENTIAL PROPERTY (1430 N MADISON	0	(0		192.09
192.10 19210 HOSPI TAL RENTAL (1927 N MADI SON AVE)	0	(0		192.10
200.00 Cross Foot Adjustments				0		0 200. 00
201.00 Negative Cost Centers	0	(0 0		0 201.00
202.00 TOTAL (sum lines 118 through 201)	644, 189	368, 228	3	0 0		0 202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	COMMUNI TY HOSPI	Provi der CC		eriod: rom 01/01/2021	u of Form CMS-2 Worksheet B Part II	
					0 12/31/2021	Date/Time Pre 5/30/2022 2:5	
		INTERNS &	RESI DENTS				
	Cost Center Description	SERVI CES-SALAR Y & FRI NGES	SERVI CES-OTHER PRGM. COSTS	PARAMED ED PRGM-(EMS)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		21.00	22.00	23.00	24.00	25.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 20.00 21.00	00200CAP REL COSTS-MVBLE EQUI P00400EMPLOYEE BENEFITS DEPARTMENT00500ADMI NI STRATI VE & GENERAL00600MAI NTENANCE & REPAI RS00700OPERATI ON OF PLANT00800LAUNDRY & LI NEN SERVI CE00900HOUSEKEEPI NG01000DI ETARY01100CAFETERI A01200MAI NTENANCE OF PERSONNEL01300NURSI NG ADMI NI STRATI ON01400CENTRAL SERVI CES & SUPPLY01500PHARMACY01600MEDI CAL RECORDS & LI BRARY01700SOCI AL SERVI CE01900NOMPHYSI CI AN ANESTHETI STS02000NURSI NG PROGRAM02100I & RERVI CES-SALARY & FRI NGES APPRVD	298					2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 19.00 20.00 21.00
22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD		403	0			22.00
23.00	02300 PARAMED ED PRGM-(EMS) I NPATI ENT ROUTI NE SERVI CE COST CENTERS			0			23.00
30.00	03000 ADULTS & PEDIATRICS				1, 291, 163	0	30.00
31.00	03100 I NTENSI VE CARE UNI T				370, 157	0	31.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS				121, 681	0	43.00
50.00	05000 OPERATI NG ROOM				1, 899, 778	0	50.00
51.00	05100 RECOVERY ROOM				0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM				119, 616	0	52.00
53.00	05300 ANESTHESI OLOGY				0	0	53.00
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND				409, 867 23, 124	0	54.00 54.01
55.00	05500 RADI OLOGY-THERAPEUTI C				0	0	55.00
56.00	05600 RADI OI SOTOPE				111, 344	0	56.00
57.00	05700 CT SCAN				71, 806	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)				469, 446	0	58.00
	05900 CARDI AC CATHETERI ZATI ON				257, 690	0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY				481, 039		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS				36, 975	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.				0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY				0	0	64.00
65.00	06500 RESPI RATORY THERAPY				102, 730	0	65.00
66.00 67.00	06600 PHYSI CAL THERAPY				922, 630	0	66.00 67.00
68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY				19, 996 8, 961	0	68.00
69.00	06900 ELECTROCARDI OLOGY				332, 377	0	69.00
	07000 ELECTROENCEPHALOGRAPHY				118, 327	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				95, 153	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS				135, 723	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS				438, 964	0	73.00
74.00	07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS				4, 032	0	74.00
90.00	09000 CLINIC				0	0	90.00
90.01	09001 WOUND/OSTOMY CLINIC				83, 803	0	90.01
	09002 CTR ADVANCED HEART CARE				22, 475	0	90.02
	09003 RADI ATI ON ONCOLOGY				842, 891	0	90.03
90. 04 90. 05	09004 MUNCIE CLINIC 09005 ANTICOAGULATION CLINIC				6, 547	0	90.04 90.05
90.05	09006 PREGNANCY PLUS				0, 347	0	90.05
90.07	09007 0/P LAB				0	0	90.07
	09008 0/P LAB				0	0	90.08
90.09	09009 FORTVILLE CLINIC				0	0	90.09
	09010 1030 S SCATTERFIELD (MEDCHECK)				0	0	90.10
90.11 90.12	09011 DIABETIC PLUS CLINIC 09012 OTHER ONCOLOGY SERVICES				20, 080	0	90. 11 90. 12
91.00	09100 EMERGENCY				277, 870		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1			1	0	

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2552	2-10
ALLOCATION OF CAPITAL RELATED COSTS	,	Provider CC	CN: 15-0113	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepard 5/30/2022 2:53 pr	red:
	INTERNS &	RESI DENTS				
Cost Center Description	SERVI CES-SALAR				Intern &	
	Y & FRINGES	PRGM. COSTS	PRGM-(EMS)		Residents Cost & Post	
					Stepdown	
					Adjustments	
	21.00	22.00	23.00	24.00	25.00	
OTHER REIMBURSABLE COST CENTERS						
98.00 09850 OTHER REIMBURSABLE COST CENTERS				0	0 98	8.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0		0 9, 096, 245	0 118	3.00
NONREI MBURSABLE COST CENTERS				-		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				0	0 190	
190.01 19001 WELLNESS CENTERS				368, 884	0 190	
190.02 19002 EMPLOYED ORTHO MD				0	0 190	
190. 03 19003 NORTHVI EW CONV. (LTC)				0	0 190	
190.04 19004 SUMMI T CONV. (LTC)				0	0 190	
190. 05 19005 PARKVI EW CONV. (LTC)				0	0 190	
190. 06 19006 MONTI CELLO HSE.				110, 870	0 190	
190. 07 19007 NH PARK PLACE (LTC) 190. 08 19008 MADI SON PLACE OF ELWOOD (LTC)				0	0 190	
190. 08 19008 MADISON PLACE OF ELWOOD (ETC) 190. 09 19009 SPINE SURGEON				0	0 190 0 190	
190. 10 19009 SPINE SURGEON 190. 10 19010 CLINICAL RESEARCH CENTER				14, 790	0 190	
190. 11 19011 ONCOLOGI ST				14, 790	0 190	
190. 12 19012 MEDI CAL I NTERNI ST				224	0 190	
190. 13 19013 RHEUMATOLOGY				0	0 190	
190. 14 19014 ROCK STEADY BOXING				72, 367	0 190	
190. 15 19015 OTHER ONCOLOGY SERVICES				0	0 190	
191. 00 19100 RESEARCH				0	0 191	
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES				1, 370, 941	0 192	2.00
192.01 19201 MUNCLE MD OFFICES				184, 472	0 192	2. 01
192. 02 19202 FOUNDATI ON				0	0 192	2. 02
192. 03 19203 SP0E				0	0 192	
192.04 19204 HEALTHY HEART				0	0 192	2.04
192.05 19205 VACANT SPACE				0	0 192	
192.07 19207 PARK PLACE CENTER				0	0 192	
192. 08 19208 RENTAL PROPERTY				7, 704	0 192	
192. 09 19209 RESIDENTIAL PROPERTY (1430 N MADI SON				11, 476	0 192	
192. 10 19210 HOSPI TAL RENTAL (1927 N MADI SON AVE)		100		14, 652	0 192	
200.00 Cross Foot Adjustments	298	403		0 701	0 200	
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0 298	0 403		0 0 0 11, 253, 326	0 201 0 202	
202.00 TOTAL (Sum TIMES TTO UN OUGH 201)	290	403	l	0 11, 200, 520	0 202	<u>-</u> . 00

Heal th	Financial Systems	COMMUNI TY HOSPI TA	AL ANDERSON	In Lieu	of Form CMS-2552-10
	TION OF CAPITAL RELATED COSTS		Provider CCN: 15-0113	To 12/31/2021	Worksheet B Part II Date/Time Prepared: 5/30/2022 2:53 pm
	Cost Center Description	Total	· ·		
		26.00			
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL				5.00
6.00	00600 MAINTENANCE & REPAIRS				6.00
7.00	00700 OPERATION OF PLANT				7.00
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPI NG				9.00
10.00	01000 DI ETARY				10.00
11.00	01100 CAFETERIA				11.00
	01200 MAINTENANCE OF PERSONNEL				12.00
					13.00
	01400 CENTRAL SERVICES & SUPPLY				14.00
	01500 PHARMACY				15.00
	01600 MEDI CAL RECORDS & LI BRARY				16.00
	01700 SOCIAL SERVICE				17.00
	01900 NONPHYSI CI AN ANESTHETI STS				19.00
	02000 NURSING PROGRAM				20.00
					21.00
22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD				22.00
23.00	02300 PARAMED ED PRGM-(EMS)				23.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 201 1(2			20,00
30.00		1, 291, 163			30.00
31.00 43.00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	370, 157 121, 681			31.00 43.00
43.00	ANCI LLARY SERVICE COST CENTERS	121,081			43.00
50.00		1, 899, 778			50.00
50.00	05100 RECOVERY ROOM	1, 899, 778			50.00
	05200 DELIVERY ROOM & LABOR ROOM	119, 616			52.00
JZ. UU	UUUUUUUUUUUUUUUUUUUUUUUUUUUUUUUUUUUUUU	117,010			52.00

30.00	03000 ADULTS & PEDIATRICS	1, 291, 163	30.00
31.00	03100 INTENSIVE CARE UNIT	370, 157	31.00
43.00	04300 NURSERY	121, 681	43.00
	ANCILLARY SERVICE COST CENTERS		
50.00	05000 OPERATING ROOM	1, 899, 778	50.00
51.00	05100 RECOVERY ROOM	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	119, 616	52.00
53.00	05300 ANESTHESI OLOGY	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	409, 867	54.00
54.01	05401 ULTRASOUND	23, 124	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	55.00
56.00	05600 RADI OI SOTOPE	111, 344	56.00
57.00	05700 CT SCAN	71, 806	57.00
58,00	05800 MAGNETIC RESONANCE IMAGING (MRI)	469, 446	58,00
59.00	05900 CARDI AC CATHETERI ZATI ON	257, 690	59.00
60.00	06000 LABORATORY	481,039	60.00
60, 01	06001 BLOOD LABORATORY	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	36, 975	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	64.00
65.00	06500 RESPI RATORY THERAPY	102, 730	65.00
66.00	06600 PHYSI CAL THERAPY	922, 630	66.00
67.00	06700 OCCUPATI ONAL THERAPY	19, 996	67.00
68.00	06800 SPEECH PATHOLOGY	8, 961	68.00
69.00	06900 ELECTROCARDI OLOGY	332, 377	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		70.00
		118, 327	70.00
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	95, 153	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	135, 723	72.00
	07300 DRUGS CHARGED TO PATIENTS	438, 964	
74.00	07400 RENAL DI ALYSI S	4,032	74.00
90, 00	OUTPATIENT SERVICE COST CENTERS	0	90.00
		-	
90.01	09001 WOUND/OSTOMY CLINIC	83, 803	90.01
90.02	09002 CTR ADVANCED HEART CARE	22, 475	90.02
90.03	09003 RADI ATI ON ONCOLOGY	842, 891	90.03
90.04	09004 MUNCIE CLINIC	0	90.04
90.05	09005 ANTI COAGULATI ON CLINIC	6, 547	90.05
90.06	09006 PREGNANCY PLUS	0	90.06
90.07	09007 0/P LAB	0	90.07
90.08	09008 0/P LAB	0	90.08
90.09	09009 FORTVILLE CLINIC	0	90.09
90.10	09010 1030 S SCATTERFIELD (MEDCHECK)	0	90.10
90.11	09011 DIABETIC PLUS CLINIC	20, 080	90. 11
	09012 OTHER ONCOLOGY SERVICES	0	90. 12
91.00	09100 EMERGENCY	277, 870	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
	OTHER REIMBURSABLE COST CENTERS		
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	98.00
	SPECIAL PURPOSE COST CENTERS		
118.00		9, 096, 245	118.00
	NONREIMBURSABLE COST CENTERS		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00

Health Financial Systems	COMMUNITY HOSPITA	AL ANDERSON	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0113	Peri od:	Worksheet B
			From 01/01/2021 To 12/31/2021	Part II Date/Time Prepared:
				5/30/2022 2:53 pm
Cost Center Description	Total			
	26.00			
190. 01 19001 WELLNESS CENTERS	368, 884			190. 01
190.02 19002 EMPLOYED ORTHO MD	0			190. 02
190.03 19003 NORTHVI EW CONV. (LTC)	0			190. 03
190. 04 19004 SUMMI T CONV. (LTC)	0			190. 04
190. 05 19005 PARKVI EW CONV. (LTC)	0			190. 05
190. 06 19006 MONTI CELLO HSE.	110, 870			190.06
190.07 19007 NH PARK PLACE (LTC)	0			190. 07
190.08 19008 MADISON PLACE OF ELWOOD (LTC)	0			190. 08
190. 09 19009 SPI NE SURGEON	0			190. 09
190. 10 19010 CLINI CAL RESEARCH CENTER	14, 790			190. 10
190. 11 19011 0NC0L0GI ST	0			190. 11
190. 12 19012 MEDI CAL I NTERNI ST	224			190. 12
190. 13 19013 RHEUMATOLOGY	0			190. 13
190.14 19014 ROCK STEADY BOXING	72, 367			190. 14
190. 15 19015 OTHER ONCOLOGY SERVICES	0			190. 15
191. 00 19100 RESEARCH	0			191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 370, 941			192.00
192.01 19201 MUNCLE MD OFFICES	184, 472			192.01
192. 02 19202 FOUNDATI ON	0			192.02
192. 03 19203 SP0E	0			192.03
192.04 19204 HEALTHY HEART	0			192.04
192. 05 19205 VACANT SPACE	0			192.05
192.07 19207 PARK PLACE CENTER	0			192.07
192.08 19208 RENTAL PROPERTY	7,704			192.08
192.09 19209 RESIDENTIAL PROPERTY (1430 N MADISON	11, 476			192.09
192. 10 19210 HOSPITAL RENTAL (1927 N MADISON AVE)	14, 652			192.10
200.00 Cross Foot Adjustments	701			200.00
201.00 Negative Cost Centers	0			201.00
202.00 TOTAL (sum lines 118 through 201)	11, 253, 326			202.00
				-

	Financial Systems LLOCATION - STATISTICAL BASIS	COMMUNI TY HOSP	ITAL ANDERSON Provider C		eri od:	eu of Form CMS-2 Worksheet B-1	
					rom 01/01/2021 o 12/31/2021		
		CAPI TAL RE	LATED COSTS			5/30/2022 2:5	3 pm
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	500, 709		I	1		1.00
2.00	00200 CAP REL COSTS-BLDG & FIXT	500,709	8, 023, 623				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	3,066		67, 053, 242			4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	27, 433	1, 395, 036	8, 316, 577	-49, 844, 557	138, 813, 467	5.00
6.00	00600 MAINTENANCE & REPAIRS	C	0	0	0		
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	59, 229	653, 747	2, 840, 229	0	8, 691, 069 0	1
9.00	00900 HOUSEKEEPI NG	3, 059	3, 124	2, 099, 443		-	
10.00	01000 DI ETARY	3, 960				.,,	
11.00		7,629		1, 053, 880	0		
12.00 13.00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	3, 195	0 230	1, 348, 386		0 3, 616, 170	
14.00	01400 CENTRAL SERVICES & SUPPLY	7, 589				2, 548, 357	
	01500 PHARMACY	3, 466					
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	3, 756	0	-	-		
	01900 NONPHYSICIAN ANESTHETISTS					0	
	02000 NURSI NG PROGRAM	C C	0	0	0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	C	0	0	0	26, 146	
22.00 23.00	02200 I & R SERVICES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM-(EMS)						
23.00	INPATIENT ROUTINE SERVICE COST CENTERS		<u>/</u>	<u>/</u>		0	23.00
30.00	03000 ADULTS & PEDIATRICS	40, 533	177, 510	14, 100, 254	0	22, 335, 793	30.00
31.00	03100 I NTENSI VE CARE UNI T	13, 292					
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	9, 801	10, 538	702, 138	0	1, 080, 713	43.00
50.00	05000 OPERATI NG ROOM	33, 013	1, 366, 992	5, 859, 976	0	12, 161, 958	50.00
51.00	05100 RECOVERY ROOM	C	0	0	-		
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	8, 237	18, 980	1, 264, 606			
53.00	05400 RADI OLOGY-DI AGNOSTI C	11, 562	260, 614	1, 499, 326		0 3, 037, 359	
54.01	05401 ULTRASOUND	1, 158					
55.00	05500 RADI OLOGY-THERAPEUTI C	C	0	0		-	
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	1, 503 5, 868					
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	936				1, 656, 324	1
59.00	05900 CARDI AC CATHETERI ZATI ON	6, 519				1, 439, 935	
60.00		7,774	261, 318	2, 482, 320		-, ,	
60. 01 62. 00	06001 BLOOD LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	854	2,968	180, 486		-	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	C	0	0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	C	0	0	0	-	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	188				3, 040, 346 4, 353, 145	
67.00	06700 OCCUPATI ONAL THERAPY	1,079				491,033	
68.00	06800 SPEECH PATHOLOGY	487				221, 721	
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	17,395				1, 681, 623 1, 021, 551	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 453	71, 687 0	595, 112		4, 940, 443	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	C	0	0	0	7, 046, 903	
	07300 DRUGS CHARGED TO PATIENTS	500	0	0	0	9, 858, 030	
74.00	07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	C	0 0		0	351, 968	74.00
90.00	09000 CLINIC	C	0	0	0	0	90.00
	09001 WOUND/OSTOMY CLINIC	5, 438				1, 813, 283	
90.02	09002 CTR ADVANCED HEART CARE	2, 117				186, 846	1
90. 03 90. 04	09003 RADIATION ONCOLOGY 09004 MUNCIE CLINIC	11, 692	671, 262	1, 683, 467		4, 788, 274 0	90. 03 90. 04
90.05	09005 ANTI COAGULATI ON CLINIC	C	0	323, 594	0	475, 392	
90.06	09006 PREGNANCY PLUS	C	0	0	0	0	90.06
90.07	09007 0/P LAB	C	0	0	0	0	90.07
90. 08 90. 09	09008 0/P LAB 09009 FORTVILLE CLINIC					0	90.08 90.09
90.10	09010 1030 S SCATTERFIELD (MEDCHECK)	C	o o	0	0	0	90.10
90.11	09011 DI ABETI C PLUS CLI NI C	1, 301	2, 105	332, 242	0	441, 390	
90. 12 91. 00	09012 OTHER ONCOLOGY SERVICES 09100 EMERGENCY	12, 508	0 49,644	0 0 4, 608, 560		0 7, 671, 314	90.12 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	12, 500	47,044	4,000,000		7,071,314	91.00
			,		•		•

ST ALLOCATION – STATISTICAL BASIS		Provider CC		Peri od:	Worksheet B-1	
				From 01/01/2021		
				To 12/31/2021	Date/Time Pre 5/30/2022 2:5	
	CAPI TAL RELA	TED COSTS				ĺ
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconci I i ati on		
	(SQUARE FEET) (DOLLAR VALUE)	BENEFITS		& GENERAL	
			DEPARTMENT		(ACCUM. COST)	
			(GROSS SALARI ES)			
	1.00	2.00	4. 00	5A	5.00	+
OTHER REIMBURSABLE COST CENTERS	1.00	2.00	1.00	ON	0.00	-
00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98
SPECIAL PURPOSE COST CENTERS						
3.00 SUBTOTALS (SUM OF LINES 1 through 117)	325, 380	7, 513, 049	66, 538, 21	4 -49, 844, 557	134, 724, 671]118
NONREI MBURSABLE COST CENTERS				_		
D. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		19
D. 01 19001 WELLNESS CENTERS	3, 647	320, 025	416, 31		1, 002, 144	
D. 02 19002 EMPLOYED ORTHO MD	0	0		0 0		190
D. 03 19003 NORTHVI EW CONV. (LTC)	0	0		0 0	-	19
D. 04 19004 SUMMIT CONV. (LTC)	0	0		0 0		19
D. 05 19005 PARKVI EW CONV. (LTC) D. 06 19006 MONTI CELLO HSE.	0	0		0 0	0 105, 897	19
D. 07 19000 MONTICELLO HSE.	12, 070 0	0		0 0		190
D. 08 19008 MADI SON PLACE OF ELWOOD (LTC)	0	0		0 0		190
D. 09 19009 SPI NE SURGEON	0	0		0 0		19
D. 1019010 CLINICAL RESEARCH CENTER	1, 595	181		0 0	10, 160	
D. 11 19011 ONCOLOGI ST	0	0		0 0		119
D. 12 19012 MEDI CAL I NTERNI ST	0	0	13, 14	9 0	17, 986	
D. 13 19013 RHEUMATOLOGY	0	0		0 0	0	19
D. 14 19014 ROCK STEADY BOXING	5, 205	22, 472	85, 56	0 8	192, 853	19
D. 15 19015 OTHER ONCOLOGY SERVICES	0	0		0 0	0	19
1. 00 19100 RESEARCH	0	0		0 0		19
2. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	143, 485	37, 925		0 0	2, 531, 593	
2.01 19201 MUNCIE MD OFFICES	5, 754	129, 000		0 0	193, 805	
2. 02 19202 FOUNDATI ON	0	0		0 0		19
2. 03 19203 SPOE	0	0		0 0		19
2. 04 19204 HEALTHY HEART	0	0		0 0		19
2. 05 19205 VACANT SPACE 2. 07 19207 PARK PLACE CENTER	0	0		0 0		19 19
2. 08 19208 RENTAL PROPERTY	723	0 971		0 0	13, 760	
2.09/19209 RESIDENTIAL PROPERTY (1430 N MADI SON	1, 250	7/1		0 0	10, 462	
2. 10 19210 HOSPITAL RENTAL (1927 N MADISON AVE)	1,600	0		0 0	10, 125	
D. 00 Cross Foot Adjustments	1,000	Ű		ů ů	10, 120	20
1.00 Negative Cost Centers						20
2.00 Cost to be allocated (per Wkst. B, Part I)	3, 168, 406	8, 084, 920	3, 147, 18	37	49, 844, 557	20
3.00 Unit cost multiplier (Wkst. B, Part I)	6. 327839	1.007640	0. 04693	6	0. 359076	20
4.00 Cost to be allocated (per Wkst. B, Part II)			19, 40		1, 581, 684	
5.00 Unit cost multiplier (Wkst. B, Part			0. 00028	9	0. 011394	20
5.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						20
7.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						20

CUSTA	LLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	2552-10
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/30/2022 2:5	
	Cost Center Description	MAI NTENANCE & REPAI RS (SQUARE FEET)	PLANT	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (MEALS SERVED)	
		6.00	7.00	8. 00	9.00	10.00	
1 00	GENERAL SERVICE COST CENTERS	1	1	-			1
1.00 2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY	0 0 0 0 0 0	410, 981 0 3, 059 3, 960	()) 7,677) 0	55, 191	1.00 2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
11.00		0	7, 629		131	0	11.00
12.00 13.00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	0	0 3, 195		0 0 0 20	0	12.00 13.00
	01400 CENTRAL SERVICES & SUPPLY	0	7, 589		272	0	14.00
15.00	01500 PHARMACY	0	3, 466	(35	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	3, 756		44	0	16.00
	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0			0	17.00 19.00
	02000 NURSI NG PROGRAM	0	0			0	20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	(0 0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	0		0 0	0	22.00
23.00	02300 PARAMED ED PRGM-(EMS) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	(0 0	0	23.00
30.00	03000 ADULTS & PEDIATRICS	0	40, 533		2, 303	47, 629	30.00
31.00	03100 I NTENSI VE CARE UNI T	0			351	6, 483	
43.00	04300 NURSERY	0	9, 801	(158	0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	33, 013		1, 658	23	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	8, 237		0 0	0	52.00
53.00 54.00	05300 ANESTHESI OLOGY	0	11 543		0 0 0 296	0	53.00 54.00
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND		11, 562 1, 158		296	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
56.00	05600 RADI OI SOTOPE	0	1, 503		13	0	56.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	5, 868 936		0 0 0 11	0	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	6, 519		158	0	59.00
60.00	06000 LABORATORY	0	7, 774		180	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	(0	0	60.01
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	854		5	0	62.00 63.00
	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	188		0 0	0	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	5, 790 1, 079		0 47 0 50	0	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	0	487		13	0	68.00
	06900 ELECTROCARDI OLOGY	0	17, 395	(770	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	3, 453	(108	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS				0 0	0	71.00
	07300 DRUGS CHARGED TO PATIENTS	0	500			0	73.00
	07400 RENAL DIALYSIS	0	0	(0 0	0	74.00
00.00						0	00.00
	09000 CLINIC 09001 WOUND/OSTOMY CLINIC	0	0 5, 438		0 0 0 153	0	90.00 90.01
	09002 CTR ADVANCED HEART CARE	0	2, 117		0	0	90.02
	09003 RADI ATI ON ONCOLOGY	0	11, 692	(0 0	0	90.03
		0	0			0	90.04
90.05 90.06	09005 ANTI COAGULATI ON CLINIC 09006 PREGNANCY PLUS		0 0			0	90.05 90.06
90.07	09007 0/P LAB	0	0		o o	0	90.07
	09008 0/P LAB	0	0	(0	0	90.08
	09009 FORTVILLE CLINIC 09010 1030 S SCATTERFIELD (MEDCHECK)				0 0	0	90.09 90.10
	09011 DIABETIC PLUS CLINIC	0	1, 301			0	90.10
	09012 OTHER ONCOLOGY SERVICES	0	0			0	90.12
	09100 EMERGENCY	0	12, 508	(824	1, 056	
	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS						92.00

Health Fina	ncial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	eu of Form CMS-2	2552-10
	TI ON - STATI STI CAL BASI S		Provider C		Period:	Worksheet B-1	
					From 01/01/2021		
					To 12/31/2021		
	Cast Castan Description					5/30/2022 2:5	3 pm
	Cost Center Description	MAI NTENANCE & REPAI RS	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPI NG (HOURS OF		
		(SQUARE FEET)		(POUNDS OF	SERVICE)	(MEALS SERVED)	
		(SQUARE FEET)	(SQUARE FEET)	LAUNDRY)	SERVICE)		
		6.00	7.00	8.00	9.00	10.00	
SPEC	AL PURPOSE COST CENTERS	0.00	7.00	0.00	9.00	10.00	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	235, 652	1	0 7,600	55, 191	118.00
NONRI	EIMBURSABLE COST CENTERS					•	1
190.001900	OGIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0)	0 0	0	190.00
190.01 1900	1 WELLNESS CENTERS	0	3, 647		0 77	0	190. 01
190.02 1900	2 EMPLOYED ORTHO MD	0	0)	0 0	0	190. 02
190.03 1900	3 NORTHVIEW CONV. (LTC)	0	0		0 0	0	190.03
190.04 1900	4 SUMMIT CONV. (LTC)	0	0		0 0	0	190. 04
	5 PARKVIEW CONV. (LTC)	0	0		0 0	0	190. 05
	6 MONTI CELLO HSE.	0	12,070		0 0		190.06
	7 NH PARK PLACE (LTC)	0	0		0 0	0	190. 07
	B MADISON PLACE OF ELWOOD (LTC)	0	0		0 0		190.08
	9 SPI NE SURGEON	0	0		0 0		190.09
	CLINICAL RESEARCH CENTER	0	1, 595		0 0		190.10
	1 ONCOLOGI ST	0	., ., .		0 0		190. 11
	2 MEDI CAL I NTERNI ST	0	0		0 0		190.12
	3 RHEUMATOLOGY	0	0		0 0		190.13
	4 ROCK STEADY BOXING	0	5, 205		0 0		190.14
	5 OTHER ONCOLOGY SERVICES	0	0, 200		0 0		190.15
191.001910		0	0		0 0		191.00
	D PHYSI CI ANS' PRI VATE OFFI CES	0	143, 485		0 0		192.00
	1 MUNCIE MD OFFICES	0	5, 754		0 0		192.00
	2 FOUNDATI ON	0	0,701		0 0		192.02
192.03 1920		0	0		0 0		192.02
	4 HEALTHY HEART	0	0		0 0		192.03
	5 VACANT SPACE	0	0		0 0		192.05
	7 PARK PLACE CENTER	0	0		0 0		192.03
	B RENTAL PROPERTY	0	723		0 0		192.08
	9 RESIDENTIAL PROPERTY (1430 N MADISON	0	1, 250		0 0		192.00
	D HOSPI TAL RENTAL (1927 N MADI SON AVE)	0	1, 200				192.10
200.00	Cross Foot Adjustments	0	1,000		0	0	200.00
200.00	Negative Cost Centers						200.00
201.00	Cost to be allocated (per Wkst. B,	0	11, 811, 823		0 4, 513, 465	1, 754, 862	
202.00	Part I)	0	11, 011, 023	1	4, 515, 405	1, 754, 602	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	28. 740557	0.00000	0 587. 920412	31. 796162	203 00
203.00	Cost to be allocated (per Wkst. B,	0.000000	1, 133, 381		0 68, 650		203.00
204.00	Part II)	0	1, 133, 381		00,000	00, 490	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	2. 757745	0. 00000	0 8. 942295	1. 549093	205. 00
204 00	II)						204 00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

IST ALI	Financial Systems LOCATION - STATISTICAL BASIS	COMMUNI TY HOSP			Peri od:	u of Form CMS-2 Worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre	
	Cost Center Description	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	5/30/2022 2:5 PHARMACY	3 pm
	Cost center bescription	(MAN HOURS)	PERSONNEL	ADMI NI STRATI O		(COSTED	
			(NUMBER		SUPPLY	REQUIS.)	
			HOUSED)	(DI RECT NURS			
		11.00	12.00	HRS.) 13.00	REQUIS.) 14.00	15.00	
G	ENERAL SERVICE COST CENTERS			1	1		
	00100 CAP REL COSTS-BLDG & FIXT						1.(
	0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT						2.0
	0500 ADMI NI STRATI VE & GENERAL						5. (
	00600 MAINTENANCE & REPAIRS						6.0
	00700 OPERATION OF PLANT						7.
	00800 LAUNDRY & LINEN SERVICE						8.
	10900 HOUSEKEEPI NG 11000 DI ETARY						9. (10. (
	1100 CAFETERI A	679					11.
. 00 0	1200 MAINTENANCE OF PERSONNEL	0	C				12.
	1300 NURSI NG ADMI NI STRATI ON	21	C	659, 03			13.
	1400 CENTRAL SERVICES & SUPPLY	17			0 40, 522, 747		14.
	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	25			0 20, 262, 741 0 20	19, 825, 570 9, 912, 785	
	1700 SOCIAL SERVICE	0			0 0	0	17.
	1900 NONPHYSICIAN ANESTHETISTS	0	C		0 0	0	19.
	2000 NURSI NG PROGRAM	0	C		0 0	0	20.
	2100 I & R SERVI CES-SALARY & FRI NGES APPRVD	0	0		0 0	0	21.
	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM-(EMS)	0			0 0	0	22. 23.
	NPATIENT ROUTINE SERVICE COST CENTERS	0		/	0 0	0	
	3000 ADULTS & PEDIATRICS	187	C	388, 42	8 947, 693	0	30.
	03100 I NTENSI VE CARE UNI T	42	C				31.
	14300 NURSERY	8	C	17,09	57,008	0	43.
	NCI LLARY SERVI CE COST CENTERS	80	C	165, 92	2, 041, 275	0	50.
	05100 RECOVERY ROOM	0			0 2, 041, 2, 3	0	51.
	05200 DELIVERY ROOM & LABOR ROOM	15	C		0 102, 676	0	52.
	5300 ANESTHESI OLOGY	0	C		0 0	0	53.
	05400 RADI OLOGY-DI AGNOSTI C	18	0		0 120, 744	0	54.
)5401 ULTRASOUND)5500 RADI OLOGY-THERAPEUTI C	5			0 5,521 0 0	0	54. 55.
	05600 RADI OLOGI - MERALEO II C	3			0 8, 204	0	56.
	05700 CT SCAN	8	C		0 15, 529	0	57.
	5800 MAGNETIC RESONANCE IMAGING (MRI)	8	C		0 24, 825	0	58.
	05900 CARDI AC CATHETERI ZATI ON	8	0		0 157, 665	0	59.
	06000 LABORATORY 06001 BLOOD LABORATORY	41			0 2, 747, 770 0 0	0	60. 60.
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2			0 464, 953		
	6300 BLOOD STORING, PROCESSING & TRANS.	0			0 0	0	63.
00 0	06400 I NTRAVENOUS THERAPY	0	(C		0 0	0	64.
	06500 RESPI RATORY THERAPY	23	C		0 164, 158	0	65
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	38			0 33, 762	0	66.
	6800 SPEECH PATHOLOGY	2			0 1, 290 0 582		67. 68.
	6900 ELECTROCARDI OLOGY	14			0 165, 041	0	69.
00 0	7000 ELECTROENCEPHALOGRAPHY	8	(C		0 44, 762	0	70.
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 4, 940, 444		71.
	7200 IMPL. DEV. CHARGED TO PATIENTS	0			0 7, 046, 903		72.
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0			0 432 0 2,835		73.
	UTPATIENT SERVICE COST CENTERS	0		1	2,033	0	1 '4.
00 0	99000 CLINIC	0	C		0 0	0	90.
	99001 WOUND/OSTOMY CLINIC	7	C		0 79, 880	0	90.
	09002 CTR ADVANCED HEART CARE	3			0 10, 630	0	90.
	09003 RADIATION ONCOLOGY 09004 MUNCIE CLINIC	20			0 159, 115	0	90.
	09005 ANTI COAGULATI ON CLINIC	4		ó	0 30, 619	0	90.
	09006 PREGNANCY PLUS	0			0 0	0	90
07 0	99007 0/P LAB	0	c		0 0	0	90.
	9008 O/P LAB	0	C		0 0	0	90.
	9009 FORTVILLE CLINIC	0			0 0	0	90.
	19010 1030 S SCATTERFIELD (MEDCHECK) 19011 DIABETIC PLUS CLINIC	U E			0 0 2,360		90. 90.
	090112 OTHER ONCOLOGY SERVICES	5			0 ∠, 360 0 ∩		90.
	9100 EMERGENCY	60			0 576, 779	-	90.
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.
	THER REIMBURSABLE COST CENTERS						
	9850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0		98.

Health Financial Systems	COMMUNI TY HOSP	ITAL ANDERSON		In Lie	u of Form CMS-2552	2-10
COST ALLOCATION - STATISTICAL BASIS		Provider (CCN: 15-0113	Peri od:	Worksheet B-1	
				From 01/01/2021 To 12/31/2021	Date/Time Prepare 5/30/2022 2:53 pm	
Cost Center Description	CAFETERI A	MAINTENANCE OI		CENTRAL	PHARMACY	
	(MAN HOURS)	PERSONNEL	ADMI NI STRATI ((COSTED	
		(NUMBER		SUPPLY	REQUIS.)	
		HOUSED)	(DI RECT NURS			
	11.00	12.00	HRS.)	REQUIS.)	15.00	
	11.00	12.00	13.00	14.00	15.00	
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	673	1	0 659, 03	40, 481, 714	19, 825, 570 118.	00
NONREI MBURSABLE COST CENTERS	073	1	0 009,00	40, 461, 714	19, 025, 570 110.	. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0 0	0 190.	00
190. 01 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5		0	0 7,359	0 190.	
190. 02 19002 EMPLOYED ORTHO MD	0		0	0 7,334	0 190.	
190. 03 19003 NORTHVI EW CONV. (LTC)	0			0 0	0 190.	
190. 04 19004 SUMMIT CONV. (LTC)	0			0 0	0 190.	
190. 05 19005 PARKVI EW CONV. (LTC)	0			0 0	0 190.	
190. 06 19006 MONTI CELLO HSE.	0			0 0	0 190.	
190. 07 19007 NH PARK PLACE (LTC)	0			0 0	0 190.	
190. 08 19008 MADISON PLACE OF ELWOOD (LTC)	0			0 0	0 190.	
190. 09 19009 SPINE SURGEON	0			0 0	0 190.	
190. 10 19010 CLINI CAL RESEARCH CENTER	0			0 0	0 190.	
190. 11 19011 ONCOLOGI ST	0			0 0	0 190.	
190. 12 19012 MEDI CAL I NTERNI ST	0			0 1,858	0 190.	
190. 13 19013 RHEUMATOLOGY				0 1,000	0 190.	
190. 14 19014 ROCK STEADY BOXING	1			0 1, 581	0 190.	
190. 15 19015 OTHER ONCOLOGY SERVICES				0 1, 561	0 190.	
190. 15 19015 OTHER ONCOLOGY SERVICES	0			0 0	0 190.	
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			0 30, 235	0 191.	
192. 01 19200 PHISICIANS PRIVATE OFFICES			0	0 30, 233	0 192.	
192. 02 19202 FOUNDATI ON				0 0	0192.	
192. 03 19203 SPOE	0			0 0	0 192.	
192. 04 19204 HEALTHY HEART	0			0 0	0 192.	
192. 05 19205 VACANT SPACE	0			0 0	0 192.	
192. 07 19207 PARK PLACE CENTER	0			0 0	0 192.	
192. 08 19208 RENTAL PROPERTY					0 192.	
192. 09 19209 RESIDENTIAL PROPERTY (1430 N MADI SON					0 192.	
192. 10 19210 HOSPI TAL RENTAL (1927 N MADI SON AVE)	0				0 192.	
200.00 Cross Foot Adjustments				0	200.	
201.00 Negative Cost Centers					200	
202.00 Cost to be allocated (per Wkst. B,	2, 153, 268		5, 084, 83	3, 895, 348		
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	3, 171. 234168				0. 370031 203.	
204.00 Cost to be allocated (per Wkst. B, Part II)	134, 940	(0 75, 20	318, 745	644, 189 204.	. 00
205.00 Unit cost multiplier (Wkst. B, Part	198. 733432	0. 00000	0 0. 1141	5 0.007866	0. 032493 205.	. 00
206.00 NAHE adjustment amount to be allocated					206.	. 00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D,					207.	. 00
Parts III and IV)						

	Financial Systems ALLOCATION - STATISTICAL BASIS	COMMUNI TY HOSP			CN: 15-0113	Per	In Lie	u of Form CMS-: Worksheet B-1	
							om 01/01/2021 12/31/2021	Date/Time Pre	pared:
								5/30/2022 2:5 INTERNS &	3 pm
	Cost Center Description	MEDI CAL RECORDS & LI BRARY (TI ME SPENT) 16.00	(TI ME	SERVI CE SPENT) 7.00	NONPHYSI CI AI ANESTHETI ST (ASSI GNED TI ME) 19.00		NURSI NG PROGRAM (ASSI GNED TI ME) 20. 00	RESI DENTS SERVI CES-SALAR Y & FRI NGES (ASSI GNED TI ME) 21.00	
	GENERAL SERVICE COST CENTERS	10.00	. ·	7.00	17.00		20.00	21.00	
$\begin{array}{c} 1.00\\ 2.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ 19.00\\ 20.00\\ 21.00\\ 22.00\\ 22.00\\ \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM 02100 I &R SERVICES-SALARY & FRINGES APPRVD 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	29, 225 C C C C C C C C C C				0	0	2, 466	22.00
23.00	02300 PARAMED ED PRGM-(EMS) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	C		0					23.00
30.00 31.00 43.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY	23, 975 C 325		0 0 0		0 0 0	0 0 0	2, 466 0 0	30. 00 31. 00 43. 00
	ANCILLARY SERVICE COST CENTERS				1			-	
$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 55.\ 00\\ 54.\ 01\\ 55.\ 00\\ 57.\ 00\\ 59.\ 00\\ 60.\ 01\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 00\\ 71.\ 00\\ 71.\ 00\\ 71.\ 00\\ 73.\ 00\\ 74.\ 00\\ 90.\ 01\\ 90.\ 01\\ \end{array}$	05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 0UTPATI ENT SERVICE COST CENTERS 09000 CLI NI C	1, 300 C C C C C C C C C C C C C							62.00 63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 72.00 73.00 74.00 90.00
91.00	09001 WOUND/OSTOMY CLINIC 09002 CTR ADVANCED HEART CARE 09003 RADIATION ONCOLOGY 09004 MUNCIE CLINIC 09005 ANTICOAGULATION CLINIC 09006 PREGNANCY PLUS 09007 0/P LAB 09008 0/P LAB 09009 FORTVILLE CLINIC 09010 1030 S SCATTERFIELD (MEDCHECK) 09011 DIABETIC PLUS CLINIC 09012 OTHER ONCOLOGY SERVICES 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	350 C C C C C C C C C C C C C C C C C C C				0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 90. 09 90. 10 90. 11 90. 12 91. 00 92. 00

	cial Systems ION - STATISTICAL BASIS	COMMUNI TY HOSP	Provider C	CN: 15-0113 P	eri od:	Worksheet B-1	2552-
001 /12200/11				F	rom 01/01/2021		
				T	o 12/31/2021		parec
						5/30/2022 2:5 INTERNS &	53 pm
						RESIDENTS	
	Cost Center Description	MEDI CAL	SOCI AL SERVI CE	NONPHYSI CI AN	NURSI NG	SERVI CES-SALAR	2
		RECORDS &		ANESTHETI STS	PROGRAM	Y & FRINGES	
		LI BRARY	(TIME SPENT)	(ASSI GNED	(ASSI GNED	(ASSI GNED	
		(TIME SPENT)		TIME)	TIME)	TIME)	
		16.00	17.00	19.00	20.00	21.00	
OTHER	REIMBURSABLE COST CENTERS						
	OTHER REIMBURSABLE COST CENTERS	0	0	C	0	0	98.0
SPECI A	AL PURPOSE COST CENTERS			_			
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	29, 225	0	C	0	2, 466	118.
	MBURSABLE COST CENTERS		1				
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		C			190. (
	WELLNESS CENTERS	0	-	C			190.
	EMPLOYED ORTHO MD	0	0	C	0		190.
	NORTHVIEW CONV. (LTC)	0	0 0	C	0	0	190.
90.04 19004	SUMMIT CONV. (LTC)	0	0	C	0	0	190.
	PARKVIEW CONV. (LTC)	0	0	C	0	0	190.
90.06 19006	MONTI CELLO HSE.	0	0	C	0	0	190.
90. 07 19007	NH PARK PLACE (LTC)	0	0	C	0	0	190.
90. 08 19008	MADISON PLACE OF ELWOOD (LTC)	0	0	C	0	0	190.
90.09 19009	SPINE SURGEON	0	0	c	0	0	190.
	CLINICAL RESEARCH CENTER	0	0 0	c	0	0	190.
90. 11 19011	ONCOLOGI ST	0	0	c	0	0	190.
90. 12 19012	MEDI CAL I NTERNI ST	0	0	c	0	0	190.
1 1	RHEUMATOLOGY	0	0	C	0	0	190.
90.1419014	ROCK STEADY BOXING	0	0	C	0	0	190.
	OTHER ONCOLOGY SERVICES	0	0	C	0		190.
91.0019100		0	0	C	0		191.
	PHYSICIANS' PRIVATE OFFICES	0	0	C	0	0	192.
	MUNCIE MD OFFICES	0	0	C			192.
92.02 19202		0	0	C			192.
92.0319203		0	0	0	-		192.
	HEALTHY HEART	0	0	C	0		192
	VACANT SPACE	0	0				192.
	PARK PLACE CENTER	0	0	0	-		192.
	RENTAL PROPERTY	0	0		-		192.
	RESIDENTIAL PROPERTY (1430 N MADISON	0	0		-		192.
	HOSPITAL RENTAL (1927 N MADI SON AVE)				0		192.
	Cross Foot Adjustments		0		0	0	200.
	Negative Cost Centers						200.
		E 107 E70	0	C	0	35, 534	
	Cost to be allocated (per Wkst. B, Part I)	5, 187, 572	0		0	30, 534	202.
03.00	Unit cost multiplier (Wkst. B, Part I)	177. 504602	0. 000000	0.00000	0.000000	14. 409570	203.
04.00	Cost to be allocated (per Wkst. B,	368, 228	0	C	0	298	204.
05.00	Part II) Unit cost multiplier (Wkst. B, Part	12. 599760	0. 000000	0. 000000	0. 000000	0. 120843	205.
	II) NAHE adjustment amount to be allocated				0		206.
	(per Wkst. B-2)						
07.00	NAHE unit cost multiplier (Wkst. D,	1	1	1	0.000000		207

	Financial Systems ALLOCATION - STATISTICAL BASIS	COMMUNI TY HOSPI	Provider CC	CN: 15-0113	Peri od:	u of Form CMS-2 Worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre	
		INTERNS &				5/30/2022 2:5	3 pm
		RESI DENTS					
	Cost Center Description	SERVICES-OTHER PRGM. COSTS	PARAMED ED PRGM-(EMS)				
		(ASSIGNED	(ASSI GNED				
		TIME)	TIME)				
	GENERAL SERVICE COST CENTERS	22.00	23.00				
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERIA						11.00
12.00 13.00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON						12.00 13.00
14.00							14.00
15.00	01500 PHARMACY						15.00
16.00							16.00
17.00	01700 SOCIAL SERVICE						17.00
20.00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM						19.00
21.00							20.00
22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	2, 466					22.00
23.00	02300 PARAMED ED PRGM-(EMS)		0				23.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2.474	0				
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	2,466	0				30.00
43.00	04300 NURSERY	0	0				43.00
	ANCI LLARY SERVI CE COST CENTERS	1					
50.00 51.00	05000 OPERATING ROOM	0	0				50.00
51.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0				51.00 52.00
53.00		0	0				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
54.01	05401 ULTRASOUND	0	0				54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
56.00 57.00	05600 RADI 0I SOTOPE 05700 CT SCAN	0	0				56.00 57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (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
60.01	06001 BLOOD LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				60.01 62.00
63.00		0	0				63.00
	06400 I NTRAVENOUS THERAPY	0	0				64.00
65.00		0	o				65.00
66.00		0	0				66.00
67.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0				67.00 68.00
	06900 ELECTROCARDI OLOGY	0	0				69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	o				71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DI ALYSI S	0	0				73.00
74.00	OUTPATIENT SERVICE COST CENTERS		0				, 4. 00
90.00	09000 CLI NI C	0	0				90.00
	09001 WOUND/OSTOMY CLINIC	0	0				90.01
	09002 CTR ADVANCED HEART CARE	0	0				90.02
	09003 RADIATION ONCOLOGY 09004 MUNCIE CLINIC	0	0				90.03 90.04
90.04	09005 ANTI COAGULATI ON CLINIC	0	o				90.04
90.06	09006 PREGNANCY PLUS	0	0				90.06
90.07	09007 0/P LAB	0	0				90.07
		0	0				90.08
90.09	09009 FORTVILLE CLINIC 09010 1030 S SCATTERFIELD (MEDCHECK)	0	0				90.09
		0	0				90.10
	09011 DIABETIC PLUS CLINIC						1 70. 11
90. 11	09011 DI ABETI C PLUS CLI NI C 09012 OTHER ONCOLOGY SERVI CES	0	0				90.12
90. 11 90. 12 91. 00		0	0 0 0				

	2	COMMUNITY HOSPI		In Lieu of Form CMS-2552-1
COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 15-0113	Period: Worksheet B-1 From 01/01/2021
				To 12/31/2021 Date/Time Prepared:
				5/30/2022 2:53 pm
		INTERNS &		
	Cast Castas Deserintian	RESI DENTS SERVI CES-OTHER	PARAMED ED	
	Cost Center Description	PRGM. COSTS	PARAMED ED PRGM-(EMS)	
		(ASSI GNED	(ASSI GNED	
		TI ME)	TI ME)	
		22.00	23.00	
OTHER	REIMBURSABLE COST CENTERS	22.00	20.00	
	OTHER REIMBURSABLE COST CENTERS	0	0	98.0
	AL PURPOSE COST CENTERS	. <u> </u>		
	SUBTOTALS (SUM OF LINES 1 through 117)	2,466	0	118.0
	MBURSABLE COST CENTERS		1	
190.0019000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190. 0
190.01 19001	WELLNESS CENTERS	0	0	190. 0
190. 02 19002	EMPLOYED ORTHO MD	0	0	190. 0
190.03 19003	NORTHVIEW CONV. (LTC)	0	0	190. 0
190.04 19004	SUMMIT CONV. (LTC)	0	0	190. 0
190.05 19005	PARKVIEW CONV. (LTC)	0	0	190. 0
190.06 19006	MONTI CELLO HSE.	0	0	190. 0
190.07 19007	NH PARK PLACE (LTC)	0	0	190. 0
190.08 19008	MADISON PLACE OF ELWOOD (LTC)	0	0	190. 0
190.0919009	SPINE SURGEON	0	0	190. 0
190.1019010	CLINICAL RESEARCH CENTER	0	0	190. 1
190. 11 19011		0	O	190. 1
	MEDICAL INTERNIST	0	O	190. 1
	RHEUMATOLOGY	0	0	190. 1
	ROCK STEADY BOXING	0	0	190. 1
	OTHER ONCOLOGY SERVICES	0	0	190. 1
191.0019100		0	0	191. C
	PHYSI CLANS' PRI VATE OFFI CES	0	0	192. 0
	MUNCIE MD OFFICES	0	0	192. 0
192.02 19202		0	0	192. 0
192.0319203		0	0	192. 0
	HEALTHY HEART	0	0	192. 0
	VACANT SPACE	0	0	192. 0
	PARK PLACE CENTER	0	0	192. 0
	RENTAL PROPERTY	0	0	192. 0
	RESIDENTIAL PROPERTY (1430 N MADI SON	0	•	192. 0
	HOSPITAL RENTAL (1927 N MADISON AVE)	0	0	192. 1
	Cross Foot Adjustments			200. 0
	Negative Cost Centers	40.005		201.0
	Cost to be allocated (per Wkst. B, Part I)	48, 085	0	202. 0
	Unit cost multiplier (Wkst. B, Part I)	19. 499189	0. 000000	203. 0
	Cost to be allocated (per Wkst. B, Part II)	403	0	204. 0
205.00	Unit cost multiplier (Wkst. B, Part	0. 163423	0. 000000	205. 0
	NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206. 0
207.00	NAHE unit cost multiplier (Wkst. D,		0. 000000	207. 0

	Financial Systems ATION OF RATIO OF COSTS TO CHARGES	COMMUNI TY HOSPI	Provi der C	CN: 15-0113	Peri od:	u of Form CMS-2 Worksheet C	
					From 01/01/2021 To 12/31/2021	Part I Date/Time Pre 5/30/2022 2:5	pared: 3 pm
			Title	XVIII	Hospi tal	PPS	-
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col. 26)					
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		2100	0.00		0100	
30.00	03000 ADULTS & PEDIATRICS	42, 326, 110		42, 326, 11	0 0	42, 326, 110	30.00
31.00	03100 INTENSIVE CARE UNIT	9, 459, 762		9, 459, 76		9, 459, 762	
43.00	04300 NURSERY	2,063,770		2, 063, 77	0 0	2, 063, 770	43.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	20, 414, 254		20, 414, 25		20, 414, 254	
51.00 52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 858, 573		2, 858, 57	0 0 3 0	0 2, 858, 573	51.00 52.00
53.00	05300 ANESTHESI OLOGY	2,000,073			0 0	2,050,573	
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 703, 013		4, 703, 01	-	4, 703, 013	•
54.00	05401 ULTRASOUND	1, 063, 336		1, 063, 33	°	1, 063, 336	
55.00	05500 RADI OLOGY-THERAPEUTI C	0			0 0	0	55.00
56.00	05600 RADI OI SOTOPE	900, 531		900, 53	1 0	900, 531	•
57.00	05700 CT SCAN	1, 926, 562		1, 926, 56	2 0	1, 926, 562	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 356, 570		2, 356, 57		2, 356, 570	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 277, 758		2, 277, 75	8 0	2, 277, 758	59.00
60.00	06000 LABORATORY	11, 989, 071		11, 989, 07		11, 989, 071	60.00
60. 01	06001 BLOOD LABORATORY	0			0 0	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 253, 577		1, 253, 57		1, 253, 577	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0			0 0	0	63.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 4, 226, 182	0	4 224 10	0 0 2 0	0	64.00 65.00
66. 00	06600 PHYSI CAL THERAPY	6, 234, 047	0	4, 226, 18 6, 234, 04		4, 226, 182 6, 234, 047	•
67.00	06700 OCCUPATI ONAL THERAPY	734, 224	0	734, 22		734, 224	
68.00	06800 SPEECH PATHOLOGY	326, 203	•	326, 20		326, 203	
69.00	06900 ELECTROCARDI OLOGY	3, 298, 356		3, 298, 35		3, 298, 356	•
	07000 ELECTROENCEPHALOGRAPHY	1, 580, 774		1, 580, 77		1, 580, 774	•
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 189, 348		7, 189, 34	8 0	7, 189, 348	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	10, 254, 675		10, 254, 67	5 0	10, 254, 675	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	17, 080, 262		17, 080, 26		17, 080, 262	
74.00	07400 RENAL DI ALYSI S	478, 624		478, 62	4 0	478, 624	74.00
~~ ~~	OUTPATIENT SERVICE COST CENTERS		[[
90. 00 90. 01	09000 CLINIC 09001 WOUND/OSTOMY CLINIC	0 2, 802, 637		2, 802, 63	0 0 7 0	0 2, 802, 637	90.00 90.01
90.01	09002 CTR ADVANCED HEART CARE	325, 318		2, 802, 83		325, 318	•
90. 02 90. 03	09003 RADIATION ONCOLOGY	6, 922, 383		6, 922, 38		6, 922, 383	•
90.04	09004 MUNCI E CLINIC	0, 722, 000		0, 722, 00	0 0	0, 722, 000	90.04
90.05	09005 ANTI COAGULATI ON CLINIC	661, 722		661, 72	2 0	661, 722	
90.06	09006 PREGNANCY PLUS	0			0 0	0	
90.07	09007 0/P LAB	0			0 0	0	90.07
90.08	09008 0/P LAB	0			0 0	0	90.08
90.09	09009 FORTVILLE CLINIC	0			0 0	0	
90. 10	09010 1030 S SCATTERFIELD (MEDCHECK)	0			0 0	0	
90.11	09011 DI ABETI C PLUS CLI NI C	653, 357		653, 35	7 0	653, 357	90.11
90.12	09012 OTHER ONCOLOGY SERVICES	0		44 540	0	0	
91.00	09100 EMERGENCY	11, 549, 127		11, 549, 12		11, 549, 127	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 835, 315		3, 835, 31	5	3, 835, 315	92.00
98.00	OTHER REIMBURSABLE COST CENTERS 09850 OTHER REIMBURSABLE COST CENTERS	0			0 0	0	98.00
200.00		181, 745, 441	0			181, 745, 441	
			0				•
201.00	Less Observation Beds	3, 835, 315		3, 835, 31	5	3, 835, 315	201.00

Heal th Financ	cial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	eu of Form CMS-:	2552-10
COMPUTATI ON (OF RATIO OF COSTS TO CHARGES		Provider CO		Period:	Worksheet C	
					From 01/01/2021 To 12/31/2021	Part I Date/Time Pre 5/30/2022 2:5	pared:
			Title	XVIII	Hospi tal	PPS	<u>s pili</u>
			Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	•	•		+ col. 7)	Rati o	Inpati ent	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
	ENT ROUTINE SERVICE COST CENTERS				-	1	
	ADULTS & PEDIATRICS	62, 287, 273		62, 287, 27			30.00
	INTENSIVE CARE UNIT	18, 485, 103		18, 485, 10			31.00
	NURSERY	2, 172, 258		2, 172, 25	8		43.00
ANCILL	ARY SERVICE COST CENTERS	04 740 074	00 040 740	400 (57.00		0.000000	1 50 00
	OPERATING ROOM	36, 743, 376	92, 913, 718				
	RECOVERY ROOM	2 012 412	0		0.00000		•
52.00 05200 53.00 05300	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	3, 912, 412	0		2 0. 730642 0. 000000		
	RADI OLOGY – DI AGNOSTI C	3, 225, 792	11, 147, 760				
	ULTRASOUND	1, 896, 655	7, 158, 213	9, 054, 86			
	RADI OLOGY - THERAPEUTI C	1, 070, 000	7, 150, 213		0. 000000	0.000000	
	RADI OLOGI - MERALEO MO	602, 791	8, 688, 556			0.000000	
	CT SCAN	10, 354, 487	35, 548, 758				
	MAGNETIC RESONANCE IMAGING (MRI)	2, 157, 136	14, 801, 397			0.000000	
	CARDI AC CATHETERI ZATI ON	7, 764, 833	16, 950, 026			0.000000	•
	LABORATORY	15, 077, 143	45, 126, 430			0.000000	
	BLOOD LABORATORY	0	0	,,	0.00000	0.000000	
	WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 351, 367	678, 468	2, 029, 83		0. 000000	
	BLOOD STORING, PROCESSING & TRANS.	0	0		0. 000000	0.000000	
	INTRAVENOUS THERAPY	0	0	(0. 000000		
	RESPI RATORY THERAPY	11, 054, 198	2, 323, 493	13, 377, 69			
66.00 06600	PHYSI CAL THERAPY	1, 096, 909	8, 645, 423	9, 742, 33	0. 639893	0. 000000	66.00
67.00 06700	OCCUPATIONAL THERAPY	822, 150	971, 037	1, 793, 18	0. 409452	0.000000	67.00
68.00 06800	SPEECH PATHOLOGY	509, 453	301, 517	810, 97	0. 402238	0.000000	68.00
	ELECTROCARDI OLOGY	4, 295, 133	10, 458, 169			0. 000000	
	ELECTROENCEPHALOGRAPHY	810, 476	3, 985, 322				
	MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 309, 308	12, 345, 399			0. 000000	
	IMPL. DEV. CHARGED TO PATIENTS	7, 156, 560	14, 599, 593			0.000000	
	DRUGS CHARGED TO PATIENTS	32, 967, 767	32, 388, 265				
	RENAL DIALYSIS	813, 372	0	813, 37	2 0. 588444	0.000000	74.00
	I ENT SERVICE COST CENTERS					0.00000	
		0	0		0.00000		
	WOUND/OSTOMY CLINIC	340, 078	6, 747, 641	7, 087, 71		0.000000	
	CTR ADVANCED HEART CARE RADIATION ONCOLOGY	6, 470 1, 233, 702	448, 539	455, 00 48, 607, 90		0.000000	
	MUNCIE CLINIC	1, 233, 702	47, 374, 204		6 0. 142413 0. 000000		•
	ANTICOAGULATION CLINIC	1,853	787, 579			0.000000	
	PREGNANCY PLUS	1, 000	/6/, 5/9		0. 000000	0.000000	
	0/P LAB	0	0		0. 000000		
90.08 09008		0	0		0. 000000		
	FORTVILLE CLINIC	0	0		0. 000000		
	1030 S SCATTERFIELD (MEDCHECK)	0	0		0. 000000	0.000000	
	DIABETIC PLUS CLINIC	7,835	229, 752	237, 58		0. 000000	
	OTHER ONCOLOGY SERVICES	0	0		0. 000000	0.000000	•
	EMERGENCY	21, 951, 098	69, 323, 418	91, 274, 51			
	OBSERVATION BEDS (NON-DISTINCT PART)	953, 671	2, 512, 641	3, 466, 31		0.000000	
	REI MBURSABLE COST CENTERS						1
	OTHER REIMBURSABLE COST CENTERS	0	0		0. 000000	0. 000000	98.00
	Subtotal (see instructions)	255, 360, 659	446, 455, 318	701, 815, 97			200. 00
	Less Observation Beds						201.00
202.00	Total (see instructions)	255, 360, 659	446, 455, 318	701, 815, 97	7		202.00

	ncial Systems OF RATIO OF COSTS TO CHARGES	COMMUNITY HOSPIT	Provider CCN: 15-0113	Peri od:	u of Form CMS-2 Worksheet C	2002-
JMPUTATION	UF RAILO UF CUSIS TO CHARGES			From 01/01/2021 To 12/31/2021	Part I Date/Time Prep	
				llaonital	5/30/2022 2:53	3 pm
	Cost Center Description	PPS Inpatient	Title XVIII	Hospital	PPS	
	bost center bescription	Ratio				
		11.00				
I NPAT	IENT ROUTINE SERVICE COST CENTERS					
	ADULTS & PEDIATRICS					30.0
	INTENSIVE CARE UNIT					31. C
	NURSERY					43. C
	LARY SERVICE COST CENTERS	0.4574.40				
	OPERATING ROOM	0. 157448				50.0
	RECOVERY ROOM	0. 000000				51.0
	DELIVERY ROOM & LABOR ROOM	0. 730642				52.0
) ANESTHESI OLOGY) RADI OLOGY-DI AGNOSTI C	0. 000000 0. 327199				53.0 54.0
	ULTRASOUND	0. 117433				54.0
	RADI OLOGY-THERAPEUTI C	0. 000000				54.0
	RADI OL SOTOPE	0. 096921				56.0
	CT SCAN	0. 041970				57.0
	MAGNETIC RESONANCE IMAGING (MRI)	0. 138961				58.0
	CARDI AC CATHETERI ZATI ON	0. 092161				59.0
	LABORATORY	0. 199142				60. (
	BLOOD LABORATORY	0. 000000				60.
	WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 617576				62.
3.00 06300	BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.
1.00 06400	INTRAVENOUS THERAPY	0. 000000				64.
	RESPI RATORY THERAPY	0. 315913				65.
	PHYSI CAL THERAPY	0. 639893				66. (
	OCCUPATIONAL THERAPY	0. 409452				67.
	SPEECH PATHOLOGY	0. 402238				68.
	ELECTROCARDI OLOGY	0. 223567				69.
		0. 329616				70.
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 407220				71.
	IMPL. DEV. CHARGED TO PATIENTS	0. 471346				72.
	DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	0. 261342 0. 588444				73. 74.
	TIENT SERVICE COST CENTERS	0. 300444				/4.
		0. 000000				90.
	WOUND/OSTOMY CLINIC	0. 395422				90.
	CTR ADVANCED HEART CARE	0. 714970				90.
0.03 09003	RADIATION ONCOLOGY	0. 142413				90.
0. 04 09004	MUNCIE CLINIC	0. 000000				90.
0, 05 09005	ANTICOAGULATION CLINIC	0. 838225				90.
09006	PREGNANCY PLUS	0. 000000				90.
	0/P LAB	0. 000000				90. (
	O/P LAB	0. 000000				90.
	FORTVILLE CLINIC	0. 000000				90.
	1030 S SCATTERFIELD (MEDCHECK)	0. 000000				90.
	DIABETIC PLUS CLINIC	2. 749969				90.
	OTHER ONCOLOGY SERVICES	0.000000				90.
	EMERGENCY	0. 126532				91. 02
	OBSERVATION BEDS (NON-DISTINCT PART)	1. 106454				92.
	REIMBURSABLE COST CENTERS	0, 000000				00
3.00 09850 00.00	OTHER REIMBURSABLE COST CENTERS Subtotal (see instructions)	0.000000				98. (200. (
01.00	Less Observation Beds					200.0
						_∠UI. (

COMPLIT	Financial Systems ATION OF RATIO OF COSTS TO CHARGES		TAL ANDERSON Provider CO	CN: 15-0113	Peri od:	u of Form CMS-2 Worksheet C	2002 10
					From 01/01/2021 To 12/31/2021	Part I Date/Time Pre 5/30/2022 2:5	pared: 3 pm
			Titl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	42, 409, 729		42, 409, 72		42, 409, 729	1
31.00	03100 INTENSIVE CARE UNIT	9, 459, 762		9, 459, 76		9, 459, 762	
43.00	04300 NURSERY	2,063,770		2, 063, 77	0 0	2, 063, 770	43.00
	ANCI LLARY SERVI CE COST CENTERS	1					
50.00	05000 OPERATI NG ROOM	20, 414, 254		20, 414, 25			50.00
51.00	05100 RECOVERY ROOM	0			0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 858, 573		2, 858, 57		2, 858, 573	
53.00	05300 ANESTHESI OLOGY	0			0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 703, 013		4, 703, 01		4, 703, 013	
54.01	05401 ULTRASOUND	1, 063, 336		1, 063, 33		1, 063, 336	
55.00	05500 RADI OLOGY-THERAPEUTI C	0		000 50	0 0	0	55.00
56.00	05600 RADI OI SOTOPE	900, 531		900, 53		900, 531	56.00
57.00	05700 CT SCAN	1, 926, 562		1, 926, 56		1, 926, 562	1
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 356, 570		2, 356, 57		2, 356, 570	
59.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	2, 277, 758		2, 277, 75		2, 277, 758	
60.00	06000 LABORATORY	11, 989, 071		11, 989, 07	0 0 0	11, 989, 071	60.00
60.01		1 252 577		1 252 57	-	1 252 577	60.01
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	1, 253, 577		1, 253, 57	0 0	1, 253, 577 0	62.00 63.00
64.00	06400 I NTRAVENOUS THERAPY	0			0 0	0	64.00
65.00	06500 RESPIRATORY THERAPY	4, 226, 182	0	4, 226, 18	0	4, 226, 182	
66.00	06600 PHYSI CAL THERAPY	6, 234, 047	0	6, 234, 04		6, 234, 047	
67.00	06700 OCCUPATI ONAL THERAPY	734, 224	0	734, 22		734, 224	
68.00	06800 SPEECH PATHOLOGY	326, 203	0	326, 20		326, 203	
69.00	06900 ELECTROCARDI OLOGY	3, 298, 356	0	3, 298, 35		3, 298, 356	
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 580, 774		1, 580, 77		1, 580, 774	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 189, 348		7, 189, 34		7, 189, 348	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	10, 254, 675		10, 254, 67		10, 254, 675	
73.00	07300 DRUGS CHARGED TO PATIENTS	17, 080, 262		17, 080, 26		17, 080, 262	
74.00	07400 RENAL DIALYSIS	478, 624		478, 62		478, 624	
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0			0 0	0	90.00
90.01	09001 WOUND/OSTOMY CLINIC	2, 802, 637		2, 802, 63	37 0	2, 802, 637	90.01
90.02	09002 CTR ADVANCED HEART CARE	325, 318		325, 31	8 0	325, 318	90.02
90.03	09003 RADIATION ONCOLOGY	6, 922, 383		6, 922, 38	33 0	6, 922, 383	90.03
90.04	09004 MUNCIE CLINIC	0			0 0	0	90.04
90.05	09005 ANTI COAGULATI ON CLINIC	661, 722		661, 72	22 0	661, 722	90.05
90.06	09006 PREGNANCY PLUS	0			0 0	0	90.06
90.07	09007 0/P LAB	0			0 0	0	90.07
90.08	09008 0/P LAB	0			0 0	0	
90.09	09009 FORTVILLE CLINIC	0			0 0	0	90.09
90. 10	09010 1030 S SCATTERFIELD (MEDCHECK)	0			0 0	0	90.10
90. 11	09011 DIABETIC PLUS CLINIC	653, 357		653, 35	57 0	653, 357	90.11
90. 12	09012 OTHER ONCOLOGY SERVICES	0			0 0	0	90.12
91.00	09100 EMERGENCY	11, 549, 127		11, 549, 12		11, 549, 127	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 835, 315		3, 835, 31	5	3, 835, 315	92.00
	OTHER REIMBURSABLE COST CENTERS				-		
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0			0 0		
200.00		181, 829, 060	0			181, 829, 060	
201.00 202.00		3, 835, 315	-	3, 835, 31		3, 835, 315	
	Total (see instructions)	177, 993, 745	0	177, 993, 74	5 0	177, 993, 745	1202 00

Heal th	Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	eu of Form CMS-:	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C		Period:	Worksheet C	
					From 01/01/2021 To 12/31/2021	Part I Date/Time Pre 5/30/2022 2:5	pared:
			Titl	e XIX	Hospi tal	PPS	5 pili
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient	
				,		Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · ·			-		
30.00	03000 ADULTS & PEDIATRICS	62, 287, 273		62, 287, 27			30.00
31.00	03100 I NTENSI VE CARE UNI T	18, 485, 103		18, 485, 10			31.00
43.00	04300 NURSERY	2, 172, 258		2, 172, 25	8		43.00
	ANCI LLARY SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
50.00	05000 OPERATI NG ROOM	36, 743, 376	92, 913, 718				
51.00	05100 RECOVERY ROOM	0	0		0 0.00000		
52.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	3, 912, 412	0				52.00
53.00		0	0		0 0.00000		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 225, 792	11, 147, 760				54.00
54.01	05401 ULTRASOUND	1, 896, 655	7, 158, 213				54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0 100 701	0 (00 55)		0 0.00000	0.000000	
56.00	05600 RADI OI SOTOPE	602, 791	8, 688, 556			0.000000	
57.00	05700 CT SCAN	10, 354, 487	35, 548, 758				
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 157, 136	14, 801, 397			0.000000	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	7, 764, 833	16, 950, 026			0.000000	59.00
60.00		15, 077, 143	45, 126, 430	60, 203, 57		0.000000	60.00
60.01	06001 BLOOD LABORATORY	1 251 277	0	2 020 02	0 0.00000	0.000000	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 351, 367	678, 468			0.000000	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0			0.000000	63.00
64.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	11 054 100	2 222 402		0.000000		
65.00	06600 PHYSI CAL THERAPY	11,054,198	2, 323, 493				
66.00 67.00	06700 OCCUPATIONAL THERAPY	1,096,909	8, 645, 423 971, 037				67.00
67.00 68.00	06800 SPEECH PATHOLOGY	822, 150					68.00
69.00	06900 ELECTROCARDI OLOGY	509, 453 4, 295, 133	301, 517 10, 458, 169			0. 000000	69.00
70.00	07000 ELECTROCARDI OLOGI	4, 295, 135 810, 476	3, 985, 322			0. 000000	70.00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 309, 308	12, 345, 399			0. 000000	
72.00	07200 I MPL. DEV. CHARGED TO PATTENTS	7, 156, 560	14, 599, 593			0.000000	
72.00	07300 DRUGS CHARGED TO PATIENTS	32, 967, 767	32, 388, 265				
73.00	07400 RENAL DIALYSIS	813, 372	32, 366, 203 0			0.000000	
74.00	OUTPATIENT SERVICE COST CENTERS	013, 372	0	013, 37	2 0. 500444	0.000000	74.00
90.00	09000 CLINIC	0	0		0 0. 000000	0. 000000	90.00
90.01	09001 WOUND/OSTOMY CLINIC	340, 078	6, 747, 641			0. 000000	90.01
90.02	09002 CTR ADVANCED HEART CARE	6, 470	448, 539				90.02
90.02	09003 RADI ATI ON ONCOLOGY	1, 233, 702	47, 374, 204			0.000000	90.02
90.03	09004 MUNCI E CLINIC	1, 200, 702	47, 374, 204		0.000000		
90.05	09005 ANTI COAGULATI ON CLINIC	1,853	787, 579			0. 000000	
90.06	09006 PREGNANCY PLUS	1,000	, , , , , , , , , , , , , , , , , , , ,		0.000000	0. 000000	
90.07	09007 0/P LAB	0	0		0.000000		
	09008 0/P LAB	0	0		0 0. 000000		
	09009 FORTVILLE CLINIC	0	0		0.000000		
90.10	09010 1030 S SCATTERFIELD (MEDCHECK)	0	0		0.000000	0. 000000	90.10
90.11	09011 DI ABETI C PLUS CLINI C	7,835	229, 752			0.000000	90.11
90.12	09012 OTHER ONCOLOGY SERVICES	,,000	227, , <u>3</u> 2	207,00	0.000000	0. 000000	90.12
91.00	09100 EMERGENCY	21, 951, 098	69, 323, 418	91, 274, 51			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	953, 671	2, 512, 641			0. 000000	
,2, 50	OTHER REIMBURSABLE COST CENTERS	,,.	2, 5.2, 611	6, 100, 01			1.2.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0. 000000	0.000000	98.00
200.00		255, 360, 659	446, 455, 318				200.00
201.00							201.00
202.00		255, 360, 659	446, 455, 318	701, 815, 97	7		202.00
					1	•	•

	ncial Systems OF RATIO OF COSTS TO CHARGES	COMMUNITY HOSPIT	Provi der CCN: 15-0113	Peri od:	u of Form CMS-25 Worksheet C	<u>JJZ-1</u>
MPUTATION	UF RATIO UF CUSIS TO CHARGES		PLOVIDEL CON. 15-0115	From 01/01/2021 To 12/31/2021	Part I Date/Time Prepa	ared:
				llaonital	5/30/2022 2:53	pm
	Cost Center Description	PPS Inpatient	Title XIX	Hospital	PPS	
	cost center bescription	Ratio				
		11.00				
I NPAT	IENT ROUTINE SERVICE COST CENTERS					
	ADULTS & PEDIATRICS					30.0
	INTENSIVE CARE UNIT					31.0
	NURSERY					43.0
	LARY SERVICE COST CENTERS	0.4574.40				
	OPERATING ROOM	0. 157448				50.0
	RECOVERY ROOM	0. 000000				51.0
	DELIVERY ROOM & LABOR ROOM	0. 730642				52.0
) ANESTHESI OLOGY) RADI OLOGY-DI AGNOSTI C	0. 000000 0. 327199				53. C 54. C
	ULTRASOUND	0. 117433				54. C
	RADI OLOGY-THERAPEUTI C	0. 000000				55.0
	RADI OLOGI - THERALE OT C	0. 096921				56.0
	CT SCAN	0. 041970				57.0
	MAGNETIC RESONANCE IMAGING (MRI)	0. 138961				58.0
	CARDI AC CATHETERI ZATI ON	0. 092161				59.0
	LABORATORY	0. 199142				60.0
	BLOOD LABORATORY	0. 000000				60. (
	WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 617576				62. (
3.00 06300	BLOOD STORING, PROCESSING & TRANS.	0. 000000				63. (
1.00 06400	INTRAVENOUS THERAPY	0. 000000				64. (
	RESPI RATORY THERAPY	0. 315913				65.0
	PHYSI CAL THERAPY	0. 639893				66. (
	OCCUPATIONAL THERAPY	0. 409452				67.(
	SPEECH PATHOLOGY	0. 402238				68. (
	ELECTROCARDI OLOGY	0. 223567				69. (
		0. 329616				70.0
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 407220				71.0
) I MPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0. 471346 0. 261342				72. (73. (
	RENAL DIALYSIS	0. 588444				74. (
	TIENT SERVICE COST CENTERS	0. 300444				74.0
		0. 000000				90. (
	WOUND/OSTOMY CLINIC	0. 395422				90.0
	CTR ADVANCED HEART CARE	0. 714970				90.0
	RADIATION ONCOLOGY	0. 142413				90.
0. 04 09004	MUNCIE CLINIC	0. 000000				90. (
0. 05 09005	ANTICOAGULATION CLINIC	0. 838225				90. (
0. 06 09006	PREGNANCY PLUS	0. 000000				90. (
	0/P LAB	0. 000000				90. (
	3 O/P LAB	0. 000000				90. (
	FORTVILLE CLINIC	0. 000000				90. (
	1030 S SCATTERFIELD (MEDCHECK)	0. 000000				90.
	DIABETIC PLUS CLINIC	2. 749969				90.
	OTHER ONCOLOGY SERVICES	0.000000				90.
	EMERGENCY	0. 126532				91. (
	OBSERVATION BEDS (NON-DISTINCT PART)	1. 106454				92. (
	R REIMBURSABLE COST CENTERS	0, 000000				00 0
3.00 09850 00.00	OTHER REIMBURSABLE COST CENTERS Subtotal (see instructions)	0.000000				98. 0 200. 0
01.00	Less Observation Beds					200. (201. (

	Financial Systems ATION OF OUTPATIENT SERVICE COST TO CHARGE RA	COMMUNITY HOSPI		CN: 15-0113	Peri od:	u of Form CMS- Worksheet C	2002-1
	TONS FOR MEDICALD ONLY	ATTOS NET OF	FIOVIDEI	CN. 13-0113	From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	
			Ti t	le XIX	Hospi tal	5/30/2022 2:5 PPS	3 pm
	Cost Center Description	Total Cost		Operating Co		Operating Cost	
		(Wkst. B, Part				Reduction	
		I, col. 26)		Cost (col. 1		Amount	
				col. 2)			
	ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50.00	05000 OPERATING ROOM	20, 414, 254	1, 899, 778	3 18, 514, 4	76 0	0	50.00
51.00	05100 RECOVERY ROOM	20, 414, 234	1, 0, 7, 770		0 0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 858, 573	119, 616			0	52.00
53.00	05300 ANESTHESI OLOGY	2,030,373	119,010	2,730,7	0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 703, 013	409, 867	4, 293, 1		0	54.00
54.00	05401 ULTRASOUND	1, 063, 336	23, 124			0	54.0
55.00	05500 RADI OLOGY-THERAPEUTI C	1,003,330	23, 124		0 0	0	55.00
56.00	05600 RADI OLOGI - MERAPEOTI C	900, 531	111, 344	-		0	56.00
57.00	05700 CT SCAN	1, 926, 562	71, 806			0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 356, 570	469, 446			0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 358, 370	257, 690				59.0
						0	
60.00		11, 989, 071	481, 039			0	60.00
60.01	06001 BLOOD LABORATORY	1 252 577)	1	0 0	0	60.0
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 253, 577	36, 975			0	62.0
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	(0 0	0	63.0
64.00	06400 I NTRAVENOUS THERAPY	0	(0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	4, 226, 182	102, 730			0	65.0
66.00	06600 PHYSI CAL THERAPY	6, 234, 047	922, 630			0	66.00
67.00	06700 OCCUPATIONAL THERAPY	734, 224	19, 996			0	67.00
68.00	06800 SPEECH PATHOLOGY	326, 203	8, 96			0	68.00
69.00	06900 ELECTROCARDI OLOGY	3, 298, 356	332, 37			0	69.0
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 580, 774	118, 327			0	70.0
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	7, 189, 348	95, 153			0	71.0
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	10, 254, 675	135, 723			0	72.0
73.00	07300 DRUGS CHARGED TO PATIENTS	17, 080, 262	438, 964			0	73.0
74.00	07400 RENAL DI ALYSI S	478, 624	4, 032	2 474, 5	92 0	0	74.00
90.00	OUTPATIENT SERVICE COST CENTERS	0	(0 0	0	90.00
90.00 90.01	09001 WOUND/OSTOMY CLINIC	2, 802, 637	83, 803			0	90.0
90.02	09002 CTR ADVANCED HEART CARE	325, 318	22, 475			0	90.0
90.02	09003 RADIATION ONCOLOGY	6, 922, 383	842, 891			0	90.0
90.03	09004 MUNCI E CLINIC	0, 722, 303	042,07		0 0	0	90.0
90.04	09005 ANTI COAGULATI ON CLINIC	661, 722	6, 547	-		0	90.0
90.06	09006 PREGNANCY PLUS	001,722	0, 041		0 0	0	90.0
90.07	09007 0/P LAB	0	(-	0 0	0	90.0
90.08	09008 0/P LAB	0	(0 0	0	90.0
90.08	09009 FORTVILLE CLINIC	0	(-	0 0	0	90.0
90.09	09010 1030 S SCATTERFIELD (MEDCHECK)	0	(0 0	0	90.10
90.10	09011 DI ABETI C PLUS CLINIC	653, 357	20, 080			0	90.1
90.11	09012 OTHER ONCOLOGY SERVICES	000,007	20, 080		0 0	0	90.1
90.12	09100 EMERGENCY	11, 549, 127	277, 870	1	-	0	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 835, 315	116, 996			0	
72.00	OTHER REIMBURSABLE COST CENTERS	3,035,315	110, 990	5,710,5	0	0	72.0
98.00		0	(0 0	0	98.0
200.00		127, 895, 799	7, 430, 240	120, 465, 5			200. 0
201.00	Less Observation Beds	3, 835, 315	116, 996	5 3, 718, 3	19 0	0	201.0

	Financial Systems ATION OF OUTPATIENT SERVICE COST TO CHARGE R IONS FOR MEDICAID ONLY	ATIOS NET OF		CN: 15-0113	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part II Date/Time Pre 5/30/2022 2:5	epared: 3 pm
				e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges				
		Capital and	(Worksheet C,				
		Operating Cost			6		
		Reduction	8)	/ col. 7)			
		6.00	7.00	8.00			
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	20, 414, 254	129, 657, 094				50.00
	05100 RECOVERY ROOM	0	0	0. 0000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 858, 573	3, 912, 412	0. 7306	42		52.00
	05300 ANESTHESI OLOGY	0	C	0.0000	00		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 703, 013	14, 373, 552	0. 3271	99		54.00
54.01	05401 ULTRASOUND	1, 063, 336	9, 054, 868	0. 1174	33		54.0
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0.0000	00		55.00
56.00	05600 RADI OI SOTOPE	900, 531	9, 291, 347	0. 0969	21		56.00
	05700 CT SCAN	1, 926, 562	45, 903, 245				57.0
	05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 356, 570	16, 958, 533				58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 277, 758	24, 714, 859				59.00
	06000 LABORATORY	11, 989, 071	60, 203, 573				60.0
	06001 BLOOD LABORATORY	0	00, 200, 0,0	0.0000			60.0
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 253, 577	2, 029, 835				62.0
	06300 BLOOD STORING, PROCESSING & TRANS.	1, 203, 577	2,029,033	0.0000			63.0
		Ŭ	U				
	06400 I NTRAVENOUS THERAPY	0	0	0.0000			64.0
65.00	06500 RESPI RATORY THERAPY	4, 226, 182	13, 377, 691				65.0
	06600 PHYSI CAL THERAPY	6, 234, 047	9, 742, 332				66.0
67.00	06700 OCCUPATI ONAL THERAPY	734, 224	1, 793, 187				67.0
	06800 SPEECH PATHOLOGY	326, 203	810, 970				68.0
	06900 ELECTROCARDI OLOGY	3, 298, 356	14, 753, 302				69.0
	07000 ELECTROENCEPHALOGRAPHY	1, 580, 774	4, 795, 798				70.0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 189, 348	17, 654, 707				71.0
	07200 IMPL. DEV. CHARGED TO PATIENTS	10, 254, 675	21, 756, 153	0. 4713	46		72.0
73.00	07300 DRUGS CHARGED TO PATIENTS	17, 080, 262	65, 356, 032	0. 2613	42		73.0
74.00	07400 RENAL DIALYSIS	478, 624	813, 372	0. 5884	44		74.0
	OUTPATIENT SERVICE COST CENTERS				·		1
90.00	09000 CLI NI C	0	C	0. 0000	00		90.0
90. 01	09001 WOUND/OSTOMY CLINIC	2, 802, 637	7, 087, 719				90.0
	09002 CTR ADVANCED HEART CARE	325, 318	455,009				90.0
	09003 RADIATION ONCOLOGY	6, 922, 383	48, 607, 906				90.0
	09004 MUNCI E CLINIC	0,722,000	10,007,700	0.0000			90.0
	09005 ANTI COAGULATI ON CLINIC	661, 722	789, 432				90.0
	09006 PREGNANCY PLUS	001,722	/0/, 432				90.0
	09007 0/P LAB	0	0				90.0
		0	0				90.0
	09008 0/P LAB	0	0	0.0000			
	09009 FORTVILLE CLINIC	0	0	0.0000			90.0
	09010 1030 S SCATTERFIELD (MEDCHECK)	0	0	0.0000			90.10
	09011 DIABETIC PLUS CLINIC	653, 357	237, 587				90.1
	09012 OTHER ONCOLOGY SERVICES	0	0	0.0000			90.1
	09100 EMERGENCY	11, 549, 127	91, 274, 516				91.0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 835, 315	3, 466, 312	1. 1064	54		92.00
	OTHER REIMBURSABLE COST CENTERS						
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0. 0000	00		98.0
200.00	Subtotal (sum of lines 50 thru 199)	127, 895, 799	618, 871, 343				200. 0
201.00	Less Observation Beds	3, 835, 315	C				201.0
	Total (line 200 minus line 201)	124,060,484	618, 871, 343	1	1		202.0

Health Financial Systems	COMMUNI TY HOSP	ITAL ANDERSON		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period:	Worksheet D	
				From 01/01/2021	Part I	
				To 12/31/2021	Date/Time Pre 5/30/2022 2:5	pared: 3 nm
		Title	e XVIII	Hospi tal	PPS	<u>5 piii</u>
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 & PEDIATRICS	1, 291, 163	0	1, 291, 16	3 22, 745	56.77	30.00
31.00 INTENSIVE CARE UNIT	370, 157		370, 15	7 4, 228	87.55	31.00
43.00 NURSERY	121, 681		121, 68	1 1, 389	87.60	43.00
200.00 Total (lines 30 through 199)	1, 783, 001		1, 783, 00	1 28, 362		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	-			
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS		r				
30. 00 ADULTS & PEDIATRICS	6, 068		1			30.00
31.00 INTENSIVE CARE UNIT	1, 167	102, 171				31.00
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	7, 235	446, 651				200. 00

	Financial Systems	COMMUNITY HOSP		CN 15 0110		u of Form CMS-	2332-10
APPOR	FIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL CUSTS	Provider C	CN: 15-0113	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 5/30/2022 2:5	pared:
			Title	e XVIII	Hospi tal	PPS	s pili
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	· ·	$(col \cdot 1 \div col$		column 4)	
		Part II, col.	8)	2)	J		
		26)		, í			
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	1, 899, 778	129, 657, 094	0. 0146	52 11, 070, 937	162, 211	50.00
51.00	05100 RECOVERY ROOM	0	0	0.0000	0 00	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	119, 616	3, 912, 412	0. 0305	73 17, 431	533	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0.0000	0 00	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	409, 867	14, 373, 552	0. 0285	1, 027, 388	29, 296	54.00
54.01	05401 ULTRASOUND	23, 124	9, 054, 868	0.0025	54 495, 726	1, 266	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0.0000	0 00	0	55.00
56.00	05600 RADI OI SOTOPE	111, 344	9, 291, 347	0.01198	34 177, 282	2, 125	56.00
57.00	05700 CT SCAN	71, 806	45, 903, 245	0.00150			
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	469, 446	16, 958, 533	0. 02768			58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	257,690					
60.00	06000 LABORATORY	481,039				34, 777	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0.0000		0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	36, 975	2, 029, 835			5, 931	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	2,02,,000	0.0000		0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	1		0	64.00
65.00	06500 RESPI RATORY THERAPY	102, 730	-			23, 297	
66.00	06600 PHYSI CAL THERAPY	922, 630					
67.00	06700 OCCUPATIONAL THERAPY	19, 996				2, 998	
68.00	06800 SPEECH PATHOLOGY	8, 961	810, 970				
69.00	06900 ELECTROCARDI OLOGY	332, 377	14, 753, 302				
70.00	07000 ELECTROENCEPHALOGRAPHY	118, 327				7, 230	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	95, 153					
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	135, 723					•
73.00	07300 DRUGS CHARGED TO PATIENTS	438, 964					73.00
74.00	07400 RENAL DI ALYSI S	4,032					•
74.00	OUTPATIENT SERVICE COST CENTERS	4,032	013, 372	0.0049	222,030	1, 104	74.00
90.00	09000 CLINIC	0	0	0.0000	0 00	0	90.00
90.00	09001 WOUND/OSTOMY CLINIC	83, 803					90.00
90.01	09002 CTR ADVANCED HEART CARE	22, 475				1, 522	90.01
90.02	09003 RADI ATI ON ONCOLOGY	842, 891	48, 607, 906			6, 186	
90.03	09004 MUNCIE CLINIC	042, 091	46, 007, 900	0.0000		0, 180	90.03
90.04	09005 ANTI COAGULATI ON CLINIC	6, 547	789, 432				90.04
90.05	09006 PREGNANCY PLUS	0, 347	109,432				90.05
		0	°				•
90.07	09007 0/P LAB	0	0			0	90.07
90.08	09008 0/P LAB	0	0	0.0000			90.08
90.09	09009 FORTVILLE CLINIC	0	0			-	90.09
90.10	09010 1030 S SCATTERFIELD (MEDCHECK)	0	0			0	90.10
90.11	09011 DI ABETI C PLUS CLI NI C	20, 080	237, 587			0	90.11
90.12	09012 OTHER ONCOLOGY SERVICES	0	0	0.0000		0	90.12
91.00	09100 EMERGENCY	277, 870					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	116, 996	3, 466, 312	0.03375	52 333, 492	11, 256	92.00
~ ~ ~	OTHER REIMBURSABLE COST CENTERS	-	-	0.0777	-	-	
98.00		0					98.00
200.00) Total (lines 50 through 199)	7, 430, 240	618, 871, 343	1	48, 484, 262	499, 141	1200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-0113 Period: From 01/01/2021 To 12/31/2021 Warksheet D Date/Time Prepared: 5/30/2022 2:53 pm Cost Center Description Nursing Program Adjustments Nursing Program Adjustments Nursing Program Adjustments Provider CCN: 15-0113 Period: From 01/01/2021 Cost Center Description PPS INPATIENT ROUTINE SERVICE COST CENTERS Nursing Program	Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-	2552-10
Cost Center Description Nursing Program ost-Stepdown Adjustments Nursing Program Adjustments Nursing Program Adjustments Nursing Program Adjustments Allied Health St-Stepdown Adjustments Allied Health Cost Allied Health Education Cost 0.00 03000 ADULTS & PEDIATRICS 1A 1.00 2A 2.00 3.00 0.00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 0 0 30.00 200.00 Total (lines 30 through 199) 0 0 0 0 0 0 20.00 10through 3, instructions) 10tal Costs 1 through 3, instructions) Total Costs 1 through 3, instructions) Total Costs 1 through 3, instructions) Total Costs 1 through 3, instructions) 5 + col. 6) Program Days 20.00 0 03000 ADULTS & PEDIATRICS 0 0 ADULTS & PEDIATRICS 0 0 2.745 0.00 6.068 30.00 0.00 03000 ADULTS & PEDIATRICS 0 0 2.745 0.00 4.00 4.00 4.00 4.00 4.00 4.00 4.228 0.00 1.167 31.00 0.0	APPORTIONMENT OF INPATIENT ROUTINE SERVICI	E OTHER PASS THROUGH COST			From 01/01/2021	Part III Date/Time Pre	
Program Adjustments Program Adjustments Program Adjustments Post-Stepdown Adjustments Cost Adjustments Medical Education Cost 30.00 0 03000 ADULTS & PEDIATRICS 0<			Title	XVIII	Hospi tal	PPS	
Post-STepdown Adj ustments Adj ustments Educati on Cost 1A 1.00 2A 2.00 3.00 0.00 03000 ADULTS & PEDIATRICS 0 <	Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
INPATI ENT ROUTINE SERVICE COST CENTERS 0		Program	Program	Post-Stepdowr	n Cost	Medi cal	
INPATI ENT ROUTINE SERVICE COST CENTERS 0		Post-Stepdown	U U	Adjustments		Education Cost	
INPATI ENT_ROUTI NE_SERVICE_COST_CENTERS 0		Adjustments					
30.00 03000 ADULTS & PEDIATRICS 0<			1.00	2A	2.00	3.00	
31.00 03100 INTENSIVE CARE UNIT 0	INPATIENT ROUTINE SERVICE COST CENT	ERS					
43.00 04300 NURSERY 0	30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
200.00 Total (lines 30 through 199) 0	31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
Cost Center Description Swing-Bed Adjustment Amount (see instructions) Total Costs (sum of cols. 1 through 3, minus col. 4) Total Patient Days Per Diem (col. 5 + col. 6) Inpatient Program Days 30.00 03000 ADULTS & PEDI ATRI CS 03000 0 0.00 6.00 7.00 8.00 31.00 03000 ADULTS & PEDI ATRI CS 04300 0 0 22,745 0.00 6,068 30.00 200.00 Total (lines 30 through 199) 0 0 2,745 0.00 6,068 30.00 200.00 Total (lines 30 through 199) 0 28,362 7,235 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 30.00 30.00 30.00 03000 ADULTS & PEDI ATRI CS 0 0 30.00 30.00 30.00 30.00 03000 ADULTS & PEDI ATRI CS 0 0 30.00 30.00 30.00 31.00 03000 ADULTS & PEDI ATRI CS 0 0 0 30.00 30.00 31.00 03000 ADULTS & PEDI ATRI CS 0 0 0 31.00 31.00 31.00 04300 NURSERY 0 0 0	43.00 04300 NURSERY	0	0		o o	0	43.00
Cost Center Description Swing-Bed Adjustment Amount (see instructions) Total Costs (sum of cols. 1 through 3, minus col. 4) Total Patient Days Per Diem (col. 5 + col. 6) Inpatient Program Days 30.00 03000 ADULTS & PEDI ATRI CS 03000 0 0.00 6.00 7.00 8.00 31.00 03000 ADULTS & PEDI ATRI CS 04300 0 0 22,745 0.00 6,068 30.00 200.00 Total (lines 30 through 199) 0 0 2,745 0.00 6,068 30.00 200.00 Total (lines 30 through 199) 0 28,362 7,235 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 30.00 30.00 30.00 03000 ADULTS & PEDI ATRI CS 0 0 30.00 30.00 30.00 30.00 03000 ADULTS & PEDI ATRI CS 0 0 30.00 30.00 30.00 31.00 03000 ADULTS & PEDI ATRI CS 0 0 0 30.00 30.00 31.00 03000 ADULTS & PEDI ATRI CS 0 0 0 31.00 31.00 31.00 04300 NURSERY 0 0 0	200.00 Total (lines 30 through 199)	0	0		o o	0	200.00
Adjustment Amount (see instructions) Days 5 ÷ col. 6) Program Days 1 through 3, instructions) 1 through 3, instructions) 0		Swi na-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
Amount (see instructions) 1 through 3, minus col. 4) 0 <t< td=""><td></td><td></td><td>(sum of cols.</td><td></td><td></td><td></td><td></td></t<>			(sum of cols.				
INPATI ENT ROUTINE SERVICE COST CENTERS 0 0 0.00 7.00 8.00 30.00 03000 ADULTS & PEDIATRICS 0 0 22,745 0.00 6,068 30.00 31.00 03000 ADULTS & PEDIATRICS 0 0 22,745 0.00 6,068 30.00 43.00 04300 NURSERY 0 1,389 0.00 0 43.00 200.00 Total (lines 30 through 199) 0 28,362 7,235 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 9.00 30.00 30.00 100 03000 ADULTS & PEDIATRICS 0 30.00 30.00 30.00 30.00 30.00 30.00 43.00 <t< td=""><td></td><td></td><td>through 3,</td><td></td><td>· · · ·</td><td>5 5</td><td></td></t<>			through 3,		· · · ·	5 5	
4.00 5.00 6.00 7.00 8.00 30.00 03000 ADULTS & PEDIATRICS 0 0.22,745 0.00 6,068 30.00 31.00 03100 INTENSI VE CARE UNI T 0 4,228 0.00 1,167 31.00 43.00 04300 NURSERY 0 0 28,362 7,235 200.00 Cost Center Description Inpatient Program Pass-Through Cost Center Description Inpatient Program Pass-Through Cost Center S 0 30.00 30.00 30.00 03000 ADULTS & PEDIATRICS 0 30.00 30.00 30.00 30.00 03000 Inpatient Program Pass-Through 30.00 30.00 30.00 30.00 03000 ADULTS & PEDIATRICS 0 30.00 31.00		instructions)					
30. 00 03000 ADULTS & PEDIATRICS 0 0 22,745 0.00 6,068 30. 00 31. 00 03100 INTENSI VE CARE UNIT 0 4,228 0.00 1,167 31. 00 43. 00 04300 NURSERY 0 1,389 0.00 0 43. 00 200. 00 Total (Lines 30 through 199) 0 28,362 7,235 200. 00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 0 30. 00 30. 00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 0 30. 00 31. 00 03000 ADULTS & PEDIATRICS 0 31. 00 31. 00 31. 00 03100 INTENSIVE CARE UNIT 0 31. 00 31. 00 31. 00 31. 00 03100 INTENSIVE CARE UNIT 0 0 31. 00 31. 00 31. 00 04300 NURSERY 0 0 43. 00 43. 00 43. 00				6.00	7.00	8.00	
31.00 03100 INTENSIVE CARE UNIT 0 4,228 0.00 1,167 31.00 43.00 04300 NURSERY 0 1,389 0.00 0 43.00 200.00 Total (lines 30 through 199) 0 28,362 7,235 200.00 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 31.00 31.00 31.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 43.00 04300 NURSERY 0 - 43.00	INPATIENT ROUTINE SERVICE COST CENT	ERS		•	-		
43.00 04300 NURSERY 0 1,389 0.00 0 43.00 200.00 Total (lines 30 through 199) 0 28,362 7,235 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	30. 00 03000 ADULTS & PEDI ATRI CS	0	0	22, 74	5 0.00	6, 068	30.00
200.00 Total (lines 30 through 199) 0 28,362 7,235 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	31.00 03100 INTENSIVE CARE UNIT		0	4, 22	8 0.00	1, 167	31.00
200.00 Total (lines 30 through 199) 0 28, 362 7, 235 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	43.00 04300 NURSERY		0	1, 38	9 0.00	0	43.00
Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 30.00 03000 ADULTS & PEDIATRICS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 43.00 0 0000 ADULTS & PEDIATRICS 0000 ADULTS & PEDIATRICS 00000 ADUL			0				
INPATIENT ROUTINE SERVICE COST CENTERS O 30.00 03000 ADULTS & PEDIATRICS 0 31.00 03100 INTENSIVE CARE UNIT 0 43.00 04300 NURSERY 0		Inpatient		, · · ·			
INPATI ENT ROUTI NE SERVI CE COST CENTERS 0 30.00 03000 ADULTS & PEDI ATRI CS 0 30.00 31.00 1NTENSI VE CARE UNI T 0 31.00 43.00 43.00 0 0 43.00 0 43.00 0 43.00 0 0 0 43.00 0 43.00 0 43.00 0 43.00 0 43.00 0 43.00 0 43.00 0 43.00 0 43.00 0 43.00 0 43.00 0 43.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
Cost (col. 7 x col. 8) Cost (col. 7 x col. 8) Cost (col. 7 x 9.00 Cost (col. 7 x x x 9.00 Cost (col. 7 x x x x 9.00<							
COI.8) 9.00 INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDIATRICS 0 31.00 03100 INTENSIVE CARE UNIT 0 43.00 04300 NURSERY 0							
9.00 I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 0 31.00 03100 I NTENSI VE CARE UNI T 0 31.00 43.00 04300 NURSERY 0 43.00							
30. 00 03000 ADULTS & PEDIATRICS 0 30. 00 31. 00 03100 INTENSIVE CARE UNIT 0 31. 00 43. 00 04300 NURSERY 0 43. 00							
31.00 03100 INTENSIVE CARE UNIT 0 31.00 43.00 43.00 04300 NURSERY 0 43.00 43.00	INPATIENT ROUTINE SERVICE COST CENT						
43. 00 04300 NURSERY 0 43. 00	30. 00 03000 ADULTS & PEDIATRICS	0					30.00
43. 00 04300 NURSERY 0 43. 00	31.00 03100 INTENSIVE CARE UNIT	0					31.00
		0					43.00
		0					

	Fr To	eriod: rom 01/01/2021 o 12/31/2021	Worksheet D Part IV	
Cost Center Description Non Physician Nursing Nu	1		Date/Time Pre	pared:
Cost Center Description Non Physician Nursing Nu		11	5/30/2022 2:5	<u>3 pm</u>
		Hospital Allied Health	PPS	
	5	Post-Stepdown	Arrieu nearth	
Cost Post-Stepdown	r ogr uni	Adjustments		
Adjustments		naj do tilon to		
1.00 2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS				
50. 00 05000 OPERATI NG ROOM 0 0	0	0	0	
51.00 05100 RECOVERY ROOM 0 0	0	0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY 0 0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0	0	0	0	54.00
54. 01 05401 ULTRASOUND 0 0	0	0	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0	0	0	0	55.00
56. 00 05600 RADI 0I SOTOPE 0 0	0	0	0	56.00
57. 00 05700 CT SCAN 0 0	0	0	0	57.00
58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0 0	0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0	0	0	0	59.00
60. 00 06000 LABORATORY 0 0	0	0	0	60.00
60. 01 06001 BLOOD LABORATORY 0 0	0	0	0	60.01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0	0	0	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0	0	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY 0 0	0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY 0 0	0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY 0 0	0	0	0	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 0 0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 0 0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 0 0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO 0	0	0	0	70.00
	0	0	0	71.00
	0	0		
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 74.00 07400 RENAL DI ALYSI S 0 0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS	0	0	0	74.00
90. 00 09000 CLINIC 0 0	0	0	0	90.00
90. 01 09001 WOUND/OSTOMY CLINIC 0 0	Ő	0	0	90.01
90. 02 09002 CTR ADVANCED HEART CARE 0 0	0	0	0	90.02
90. 03 09003 RADI ATI ON ONCOLOGY 0 0	0	0	0	90.03
90. 04 09004 MUNCIE CLINIC 0 0	0	0	0	90.04
90. 05 09005 ANTI COAGULATI ON CLINIC 0 0	0	0	0	90.05
90. 06 09006 PREGNANCY PLUS 0 0	0	0	0	90.06
90. 07 09007 0/P LAB 0 0	0	0	0	90.07
90. 08 09008 0/P LAB 0 0	0	0	0	90.08
90. 09 09009 FORTVILLE CLINIC 0 0	0	0	0	90.09
90. 10 09010 1030 S SCATTERFIELD (MEDCHECK) 0 0	0	0	0	90.10
90. 11 09011 DI ABETI C PLUS CLINIC 0 0	0	0	0	90.11
90. 12 09012 OTHER ONCOLOGY SERVICES 0 0	0	0	0	90.12
91.00 09100 EMERGENCY 0 0	0	0	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0	0		0	92.00
OTHER REIMBURSABLE COST CENTERS				
98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0	0	0		98.00
200.00 Total (lines 50 through 199) 0 0	0	0	0	200.00

	Financial Systems	COMMUNITY HOSP		01 45 0440		eu of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF GH COSTS	RVICE UTHER PAS	S Provider C	UN: 15-0113	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre	parad
					10 12/31/2021	5/30/2022 2:5	
				XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medical Education Cost	(sum of cols.	Outpatient Cost (sum o	(from Wkst. C,	to Charges (col. 5 ÷ col.	
		Education Cost	1, 2, 3, and 4)	cols. 2, 3,		7)	
				and 4)	0)	(see	
						instructions)	
		4.00	5.00	6.00	7.00	8.00	
	ANCI LLARY SERVI CE COST CENTERS	-	-	1		1	
50.00	05000 OPERATING ROOM	0	0		0 129, 657, 094		
51.00	05100 RECOVERY ROOM	0	0		0 0	0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 3, 912, 412		
53.00	05300 ANESTHESI OLOGY	0	0		0 0 0	0.000000	
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	0	0		0 14, 373, 552 0 9, 054, 868		
54.01	05500 RADI OLOGY - THERAPEUTI C	0			0 9, 054, 868 0 0	0.000000	
55.00 56.00	05500 RADI OLOGY - THERAPEUTIC	0			0 9, 291, 347	0.000000	
57.00	05700 CT SCAN	0			0 45, 903, 245	0.000000	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 16, 958, 533	0.000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 24, 714, 859	0.000000	•
60.00	06000 LABORATORY	0	0		0 60, 203, 573	0. 000000	
60.01	06001 BLOOD LABORATORY	0	0		0 0	0. 000000	•
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 2, 029, 835	0.000000	•
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0. 000000	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0. 000000	64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 13, 377, 691	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 9, 742, 332	0. 000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 1, 793, 187	0. 000000	•
68.00	06800 SPEECH PATHOLOGY	0	0		0 810, 970	0. 000000	•
69.00	06900 ELECTROCARDI OLOGY	0	0		0 14, 753, 302	0. 000000	•
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 4, 795, 798		•
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 17, 654, 707	0.000000	•
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 21, 756, 153	0.000000	
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0		0 65, 356, 032 0 813, 372	0.000000	
74.00	OUTPATIENT SERVICE COST CENTERS	0	0	1	0 813, 372	0.00000	74.00
90.00	09000 CLINIC	0	0		0 0	0.000000	90.00
90.01	09001 WOUND/OSTOMY CLINIC	0	0		0 7, 087, 719		
90.02	09002 CTR ADVANCED HEART CARE	0	0		0 455,009	0. 000000	
90.03	09003 RADI ATI ON ONCOLOGY	0	0		0 48, 607, 906	0. 000000	
90.04	09004 MUNCIE CLINIC	0	0		0 0	0.000000	•
90.05	09005 ANTI COAGULATI ON CLINIC	0	0		0 789, 432	0.000000	
90.06	09006 PREGNANCY PLUS	0	0		0 0	0. 000000	1
90.07	09007 0/P LAB	0	0		0 0	0. 000000	90.07
90.08	09008 0/P LAB	0	0		0 0	0.000000	90.08
90.09	09009 FORTVILLE CLINIC	0	0		0 0	0. 000000	90.09
90. 10	09010 1030 S SCATTERFIELD (MEDCHECK)	0	0		0 0	0.000000	
90.11	09011 DIABETIC PLUS CLINIC	0	0		0 237, 587	0.000000	•
90.12	09012 OTHER ONCOLOGY SERVICES	0	0		0 0	0.000000	•
91.00	09100 EMERGENCY	0	0		0 91, 274, 516		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 3, 466, 312	0.000000	92.00
00 00	OTHER REIMBURSABLE COST CENTERS 09850 OTHER REIMBURSABLE COST CENTERS		0	1	0	0,000000	98.00
98.00 200.00		0			0 0 0 618, 871, 343		98.00 200.00
200.00		0	ı 0	1	oro, o/1, 343	I	I∠00. 00

Health Financial Systems	COMMUNI TY HOSPI T				eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVI CE OTHER PASS	Provider CO	CN: 15-0113	Period: From 01/01/2021 To 12/31/2021		pared: 3 pm
		Title	XVIII	Hospi tal	PPS	-
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.	5	Costs (col.		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS	- -			- I	•	
50. 00 05000 OPERATI NG ROOM	0. 000000	11, 070, 937		0 17, 785, 271	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0	1	0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	17, 431		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	o l	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1,027,388		0 2, 066, 830	o o	
54. 01 05401 ULTRASOUND	0. 000000	495, 726		0 1, 341, 850		54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	177, 282		0 2, 144, 100		56.00
57. 00 05700 CT SCAN	0. 000000	2,887,298		0 7, 743, 569		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	562, 666		0 3, 563, 433		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	1, 499, 820		0 4, 905, 711		
60. 00 06000 LABORATORY	0. 000000	4, 352, 521		0 3, 208, 204		60,00
60. 01 06001 BLOOD LABORATORY	0. 000000	1,002,021		0 0,200,201	o o	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	325, 574		0 194, 153		62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 194, 130		
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0			-	
65. 00 06500 RESPIRATORY THERAPY	0. 000000	3, 033, 822		0 394, 238		65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	3, 033, 822		0 9,940		
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	268, 817		0 9, 940		67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	164, 699		0 2, 335		•
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	1, 389, 738		0 2, 474, 639		69.00
70. 00 07000 ELECTROEARDIOLOGI	0. 000000	293, 051		0 2, 474, 039	-	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 545, 470		0 2, 749, 699		71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	2, 540, 848				
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	8, 981, 807		0 2, 787, 276 0 10, 166, 122		
74.00 07400 RENAL DIALYSIS	0. 000000	222, 636		0 10, 100, 122		
OUTPATIENT SERVICE COST CENTERS	0.000000	222, 030			<u>/</u> 0	74.00
90. 00 09000 CLINIC	0.000000	0	1	0 0	0 0	90.00
90. 01 09001 WOUND/OSTOMY CLINIC	0. 000000	128, 707		0 2, 539, 271		
90. 02 09002 CTR ADVANCED HEART CARE	0. 000000	120, 707		0 2, 337, 271		90.01
90. 03 09003 RADIATION ONCOLOGY	0. 000000	356, 750		0 11, 418, 529		90.02
90. 04 09004 MUNCI E CLINIC	0. 000000	000,700		0 11, 410, 323	0 0	90.04
90. 05 09005 ANTI COAGULATI ON CLINIC	0. 000000	0		0 273, 848		90.05
90. 06 09006 PREGNANCY PLUS	0. 000000	0		0 273,040		90.06
90. 07 09007 0/P LAB	0. 000000	0			-	90.07
90. 08 09008 0/P LAB	0. 000000	0				90.08
90. 09 09009 FORTVI LLE CLI NI C	0. 000000	0		0 0	-	90.00
90. 10 09010 1030 S SCATTERFIELD (MEDCHECK)	0. 000000	0				
90. 11 09010 1030 3 SCATTERFIELD (MEDCHECK) 90. 11 09011 DIABETIC PLUS CLINIC	0. 000000	0		0 63	-	90.10
90. 12 09012 OTHER ONCOLOGY SERVICES	0. 000000	0		0 0	-	
		•		-		
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	0.000000	6, 422, 494 333, 492				
OTHER REIMBURSABLE COST CENTERS	0.000000	333, 492	1	0 1, 664, 223	0	72.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	98.00
200.00 Total (lines 50 through 199)	0.000000	48, 484, 262		0 88, 714, 660		200.00
	I I	10, 104, 202	I	SS, 714, 000	-1 U	1-00.00

					From 01/01/2021	Part V	
					To 12/31/2021	Date/Time Pre 5/30/2022 2:5	
		1	Title	XVIII	Hospi tal	PPS	
				Charges		Costs	L
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C, Part I, col. 9	inst.)	Services Subject To	Services Not Subject To		
		Fait I, COI. 9		Ded. & Coins	-		
				(see inst.)			
		1.00	2.00	3.00	4.00	5.00	
	LLARY SERVICE COST CENTERS						
	OO OPERATING ROOM	0. 157448	17, 785, 271		0 0		
	DO RECOVERY ROOM	0. 000000	0		0 0		
	DO DELIVERY ROOM & LABOR ROOM	0. 730642	0		0 0	0	
	00 ANESTHESI OLOGY	0. 000000	0		0 0	0	
	00 RADI OLOGY-DI AGNOSTI C	0. 327199	2,066,830		0 0	676, 265	
	01 ULTRASOUND	0. 117433	1, 341, 850		0 0	157, 577	
	00 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	
	DO RADI OI SOTOPE	0. 096921	2, 144, 100		0 0	207, 808	
	DO CT SCAN	0. 041970	7, 743, 569		0 0	324, 998	
	DO MAGNETIC RESONANCE IMAGING (MRI)	0. 138961	3, 563, 433		0 0	495, 178	
	00 CARDI AC CATHETERI ZATI ON	0. 092161	4, 905, 711		0 0	452, 115	
		0. 199142	3, 208, 204		0 0		
	DI BLOOD LABORATORY	0. 000000	0		0 0	0	
	00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 617576	194, 153		0 0		
	00 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	
	00 I NTRAVENOUS THERAPY 00 RESPI RATORY THERAPY	0.00000	0 204 220		0 0	124 545	
	00 PHYSI CAL THERAPY	0. 315913 0. 639893			0 0	124, 545	
	00 OCCUPATIONAL THERAPY	0. 839893	9, 940 9, 230		0 0	6, 361 3, 779	
	DO SPEECH PATHOLOGY	0. 409432			0 0	939	1
	DO ELECTROCARDI OLOGY	0. 223567	2, 335		0 0	553, 248	
	DO ELECTROENCEPHALOGRAPHY	0. 329616	615, 038		0 0	202, 726	
	DO MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 407220			· ·	1, 119, 732	
	DO I MPL. DEV. CHARGED TO PATIENTS	0. 471346	2, 787, 276		0 0	1, 313, 771	
	DO DRUGS CHARGED TO PATIENTS	0. 261342	10, 166, 122		0 30, 049		
	DO RENAL DI ALYSI S	0. 588444	0		0 0		
	PATIENT SERVICE COST CENTERS						
	DO CLINIC	0. 000000	0	I	0 0	0	90.00
0.01 0900	D1 WOUND/OSTOMY CLINIC	0. 395422	2, 539, 271		0 0	1, 004, 084	90.01
0. 02 0900	02 CTR ADVANCED HEART CARE	0. 714970	139, 466		0 0	99, 714	90.02
0.03 0900	3 RADIATION ONCOLOGY	0. 142413	11, 418, 529		0 0	1, 626, 147	90.03
0.04 0900	D4 MUNCIE CLINIC	0. 000000	0		0 0	0	90.04
0.05 0900	D5 ANTICOAGULATION CLINIC	0. 838225	273, 848		0 0	229, 546	90.05
	06 PREGNANCY PLUS	0. 000000	0		0 0	0	90.06
	07 0/P LAB	0. 000000	0		0 0	0	
	08 0/P LAB	0. 000000	0		0 0	0	
	09 FORTVILLE CLINIC	0. 000000	0		0 0	0	
	10 1030 S SCATTERFIELD (MEDCHECK)	0. 000000	0		0 0		
	1 DIABETIC PLUS CLINIC	2. 749969	63		0 0	173	
	2 OTHER ONCOLOGY SERVICES	0. 000000	0		0 0	0	
	00 EMERGENCY	0. 126532			0 0	1, 330, 816	
	00 OBSERVATION BEDS (NON-DISTINCT PART)	1. 106454	1, 664, 223		0 0	1, 841, 386	92.00
	R REIMBURSABLE COST CENTERS	0.000533	-	1	0 -	-	00.00
	50 OTHER REIMBURSABLE COST CENTERS	0. 000000			0 0	-	
00.00	Subtotal (see instructions)		88, 714, 660	4, 95	_	17, 986, 790	
01.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges Net Charges (line 200 - line 201)	1	88, 714, 660	4, 95			1

ealth Financial Systems	COMMUNI TY HOSP				u of Form CMS-2	2552-1
PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-0113	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prep 5/30/2022 2:53	pared:
		Title	XVIII	Hospi tal	PPS	5 pili
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.					
	(see inst.)	(see inst.)				
ANCILLARY SERVICE COST CENTERS	6.00	7.00				
ANCI LLARY SERVICE COST CENTERS 0. 00 05000 OPERATING ROOM	0	0				50.00
1. 00 05100 RECOVERY ROOM	0	0				51.00
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
3. 00 05300 ANESTHESI OLOGY	0	0				53.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
4. 01 05401 ULTRASOUND	0	0				54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C		0				55.00
6. 00 05600 RADI 01 SOTOPE		0				56.00
7. 00 05700 CT SCAN		0				57.00
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
0. 00 06000 LABORATORY	0	0				60.00
0. 01 06001 BLOOD LABORATORY	0	0				60.0
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.0
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.0
4. 00 06400 I NTRAVENOUS THERAPY	0	0				64.00
5. 00 06500 RESPI RATORY THERAPY	0	0				65.00
6. 00 06600 PHYSI CAL THERAPY	0	0				66.00
7. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
8.00 06800 SPEECH PATHOLOGY	0	0				68.00
9.00 06900 ELECTROCARDI OLOGY	0	0				69.00
0.00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,017	0				71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
3.00 07300 DRUGS CHARGED TO PATIENTS	0	7, 853				73.00
4.00 07400 RENAL DIALYSIS	0	0				74.00
OUTPATIENT SERVICE COST CENTERS		·				
0. 00 09000 CLINIC	0	0				90.00
0.01 09001 WOUND/OSTOMY CLINIC	0	0				90.0
0. 02 09002 CTR ADVANCED HEART CARE	0	0				90.0
0. 03 09003 RADIATION ONCOLOGY	0	0				90.0
0.04 09004 MUNCIE CLINIC	0	0				90.0
0. 05 09005 ANTI COAGULATI ON CLINIC	0	0				90.0
0.06 09006 PREGNANCY PLUS	0	0				90.0
0.07 09007 0/P LAB	0	0				90.0
0.08 09008 0/P LAB	0	0				90.0
0. 09 09009 FORTVILLE CLINIC	0	0				90.0
0.10 09010 1030 S SCATTERFIELD (MEDCHECK)	0	0				90.10
0.11 09011 DIABETIC PLUS CLINIC	0	0	•			90. 1 ⁻
0. 12 09012 OTHER ONCOLOGY SERVICES	0	0				90.12
1.00 09100 EMERGENCY	0		•			91.00
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
OTHER REIMBURSABLE COST CENTERS		1	1			
8.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0				98.00
00.00 Subtotal (see instructions)	2, 017	7, 853			1	200.00
01.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
02.00 Net Charges (line 200 - line 201)	2,017	7, 853				202.00

Health Financial Systems	COMMUNI TY HOSP	ITAL ANDERSON		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS	Provider C		Period:	Worksheet D	
				From 01/01/2021	Part I	
				To 12/31/2021	Date/Time Pre 5/30/2022 2:5	pared:
		Titl	e XIX	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 & PEDIATRICS	1, 291, 163	0	1, 291, 16	3 22, 745	56.77	30.00
31.00 INTENSIVE CARE UNIT	370, 157		370, 15	7 4, 228	87.55	31.00
43.00 NURSERY	121, 681		121, 68	1 1, 389	87.60	43.00
200.00 Total (lines 30 through 199)	1, 783, 001		1, 783, 00	1 28, 362		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	568					30.00
31.00 INTENSIVE CARE UNIT	231					31.00
43.00 NURSERY	1, 316					43.00
200.00 Total (lines 30 through 199)	2, 115	167, 751				200.00

APPORTI UNM							
	IENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL CUSIS	Provider C	LN: 15-0113	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 5/30/2022 2:5	pared:
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col		column 4)	
		Part II, col.	8)	2)	-		
		26)					
		1.00	2.00	3.00	4.00	5.00	
	LLARY SERVICE COST CENTERS	1		1	- 1	1	
	DO OPERATING ROOM	1, 899, 778	129, 657, 094				
	DO RECOVERY ROOM	0	C	0.0000			
	DO DELIVERY ROOM & LABOR ROOM	119, 616	3, 912, 412			3, 815	
	DO ANESTHESI OLOGY	0	C	0.0000		0	
	DO RADI OLOGY-DI AGNOSTI C	409, 867	14, 373, 552				
	D1 ULTRASOUND	23, 124	9, 054, 868				
	DO RADI OLOGY-THERAPEUTI C	0	C	0.0000		0	
	DO RADI OI SOTOPE	111, 344	9, 291, 347				
	DO CT SCAN	71, 806	45, 903, 245			473	
	DO MAGNETIC RESONANCE IMAGING (MRI)	469, 446					
	DO CARDI AC CATHETERI ZATI ON	257, 690					59.00
	DO LABORATORY	481, 039					
	D1 BLOOD LABORATORY	0	-	0.0000		-	
	DO WHOLE BLOOD & PACKED RED BLOOD CELLS	36, 975					
	DO BLOOD STORING, PROCESSING & TRANS.	0	-	0.0000		-	
	DO I NTRAVENOUS THERAPY	0	-			-	
	DO RESPI RATORY THERAPY	102, 730		0.00767		2, 205	
	DO PHYSI CAL THERAPY	922, 630					
	DO OCCUPATI ONAL THERAPY	19, 996					
	DO SPEECH PATHOLOGY	8, 961	810, 970				1
	DO ELECTROCARDI OLOGY	332, 377	14, 753, 302			2, 246	
	DO ELECTROENCEPHALOGRAPHY	118, 327	4, 795, 798				
	DO MEDICAL SUPPLIES CHARGED TO PATIENTS	95, 153		0.00539		521	
	DO IMPL. DEV. CHARGED TO PATIENTS	135, 723					
	DO DRUGS CHARGED TO PATIENTS	438, 964					
	DO RENAL DI ALYSI S	4,032	813, 372	0.00495	57 58, 405	290	74.00
	PATIENT SERVICE COST CENTERS	0	0	0.0000		0	90.00
	DO CLINIC D1 WOUND/OSTOMY CLINIC	83, 803				0	90.00
	D2 CTR ADVANCED HEART CARE					0	
		22, 475					
	D3 RADIATION ONCOLOGY D4 MUNCIE CLINIC	842, 891	48, 607, 906				90.03 90.04
	D5 ANTICOAGULATION CLINIC	6, 547	789, 432	0.0000		-	
	D6 PREGNANCY PLUS	0, 547	/89, 432	0.00829			
	07 0/P LAB	0					
	0/P LAB	0		0.0000		-	
	D9 FORTVILLE CLINIC	0	, i i i i i i i i i i i i i i i i i i i				
	10 1030 S SCATTERFIELD (MEDCHECK)	0					
	11 DIABETIC PLUS CLINIC	20, 080		0. 00000 0. 08451		-	
	12 OTHER ONCOLOGY SERVICES	20, 080	237, 587	0.0845		-	1
	DO EMERGENCY	-				-	
	DO OBSERVATION BEDS (NON-DISTINCT PART)	277, 870 116, 996				2, 362 304	
72. UU 10920	ER REIMBURSABLE COST CENTERS	110,996	3, 400, 312	0.03375	9,021	1	92.00
		0		0.0000	0 00	0	98.00
98.00 0985	50 OTHER REIMBURSABLE COST CENTERS	n	0				

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE	OTHER PASS THROUGH COS			Period: From 01/01/2021 To 12/31/2021	Worksheet D Part III Date/Time Pre 5/30/2022 2:5	epared: 53 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown	-	Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTE	RS				•	
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
43. 00 04300 NURSERY	0	0		0 0	l o	43.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,		^		
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTE	RS					
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	22, 74	5 0.00	568	30.00
31.00 03100 INTENSIVE CARE UNIT		0	4, 22	8 0.00	231	31.00
43.00 04300 NURSERY		0	1, 38	9 0.00	1, 316	43.00
200.00 Total (lines 30 through 199)		0	28, 36			200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9,00					
INPATIENT ROUTINE SERVICE COST CENTE						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31.00 03100 I NTENSI VE CARE UNI T	0					31.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00
		1				

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	EVICE OTHER PASS	6 Provider CC	CN: 15-0113	Period: From 01/01/2021 To 12/31/2021		pared: 3 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
	0001	Adjustments		, laj do tillorito		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS		27.	2100	0,11	0.00	
50. 00 05000 OPERATING ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
53.00 05300 ANESTHESI OLOGY	0	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54. 01 05400 ULTRASOUND	0	0		0 0	0	54.00
	0	0		0 0	0	
	0	-		-	-	
56. 00 05600 RADI 0I SOTOPE		0		0	0	56.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0 0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0	0		0 0	0	90.00
90.01 09001 WOUND/OSTOMY CLINIC	0	0		0 0	0	90.01
90. 02 09002 CTR ADVANCED HEART CARE	0	0		0 0	0	90.02
90. 03 09003 RADIATION ONCOLOGY	0	0		0 0	0	90.03
90. 04 09004 MUNCIE CLINIC	0	0		0 0	0	90.04
90. 05 09005 ANTI COAGULATI ON CLINIC	0	0		0 0	0	90.05
90.06 09006 PREGNANCY PLUS	0	0		0 0	0	90.06
90. 07 09007 0/P LAB	0	0		0 0	0	90.07
90. 08 09008 0/P LAB	0	0		0 0	0	90.08
90. 09 09009 FORTVI LLE CLI NI C	0	0		0 0	0	90.09
90. 10 09010 1030 S SCATTERFIELD (MEDCHECK)	0	0		0 0	0	90.10
90. 11 09011 DI ABETI C PLUS CLINIC	0	0		0 0	0	
90. 12 09012 OTHER ONCOLOGY SERVICES	0	0		0 0	0	90.12
91. 00 09100 EMERGENCY	0	0		0 0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	0	
OTHER REIMBURSABLE COST CENTERS					0	72.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
200.00 Total (lines 50 through 199)	0	0		0 0		200.00
	ų v	ų		ч U	1 0	1-00.00

	Financial Systems	COMMUNITY HOSPI		N 45 0440		eu of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE H COSTS	RVICE OTHER PASS	S Provider C	CN: 15-0113	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre	pared:
						5/30/2022 2:5	
				e XIX	Hospi tal	PPS	
	Cost Center Description	All Other Medical	Total Cost (sum of cols.	Total Outpatient	(from Wkst. C,	Ratio of Cost to Charges	
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
		Luucation cost	4)	col s. 2, 3,	8)	7)	
			.,	and 4)	- /	(see	
						instructions)	
		4.00	5.00	6.00	7.00	8.00	
	ANCI LLARY SERVI CE COST CENTERS	-					
	05000 OPERATING ROOM	0	0		0 129, 657, 094		
	05100 RECOVERY ROOM	0	0		0 0	0.000000	
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 3, 912, 412		
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0 0 14, 373, 552	0.000000	
	05401 ULTRASOUND	0	0		0 9, 054, 868		
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 9,034,000	0.000000	•
56.00	05600 RADI OI SOTOPE	0	0		0 9, 291, 347	0.000000	
57.00	05700 CT SCAN	0	0		0 45, 903, 245	0.000000	•
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 16, 958, 533	0. 000000	•
	05900 CARDI AC CATHETERI ZATI ON	0	0		0 24, 714, 859	0. 000000	•
60.00	06000 LABORATORY	0	0		0 60, 203, 573	0. 000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0 0	0. 000000	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 2, 029, 835	0.000000	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0. 000000	•
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0.000000	•
65.00	06500 RESPI RATORY THERAPY	0	0		0 13, 377, 691	0.000000	•
66.00	06600 PHYSI CAL THERAPY	0	0		0 9, 742, 332	0.000000	•
	06700 OCCUPATI ONAL THERAPY	0	0		0 1, 793, 187	0.000000	•
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0		0 810, 970 0 14, 753, 302	0.000000	•
	07000 ELECTROCARDI OLOGY	0	0		0 14, 753, 302 0 4, 795, 798		•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 17, 654, 707	0.000000	•
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 21, 756, 153	0.000000	•
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 65, 356, 032		
	07400 RENAL DI ALYSI S	0	0		0 813, 372	0. 000000	
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 0	0.000000	90.00
	09001 WOUND/OSTOMY CLINIC	0	0		0 7, 087, 719	0.000000	90.01
	09002 CTR ADVANCED HEART CARE	0	0		0 455, 009	0. 000000	
	09003 RADIATION ONCOLOGY	0	0		0 48, 607, 906	0.000000	
	09004 MUNCIE CLINIC	0	0		0 0	0.000000	
	09005 ANTI COAGULATI ON CLINIC	0	0		0 789, 432	0. 000000	1
	09006 PREGNANCY PLUS	0	0		0 0	0.000000	1
	09007 0/P LAB	0	0		0 0	0.000000	1
	09008 0/P LAB	0	0		0 0	0.000000	•
	09009 FORTVILLE CLINIC 09010 1030 S SCATTERFIELD (MEDCHECK)	0	0			0.000000	•
	09011 DIABETIC PLUS CLINIC	0			0 237, 587	0.000000	
	09012 OTHER ONCOLOGY SERVICES	0			0 237, 587	0.000000	•
	09100 EMERGENCY	0	0		0 91, 274, 516		•
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 3, 466, 312	0.000000	•
	OTHER REIMBURSABLE COST CENTERS			L	.,		1
	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0. 000000	98.00

	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	COMMUNITY HOSPIT	Provider C	CN. 1E 0110	Peri od:	Worksheet D	2552-10
	H COSTS	VICE UTHER PASS	Provider C	UN: 15-0113	From 01/01/2021 To 12/31/2021	Part IV	
				e XIX	Hospi tal	PPS	<u>s pili</u>
	Cost Center Description	Outpatient	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	·····	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Throug	h 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 SERVICE COST CENTERS			1	-1		
50.00	05000 OPERATI NG ROOM	0. 000000	558, 553		0 0	-	
51.00	05100 RECOVERY ROOM	0. 000000	0		0 0		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	124, 784		0 0		
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0 0		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	82, 643		0 0	°	
54.01	05401 ULTRASOUND	0. 000000	46, 070		0 0	-	
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0		
56.00	05600 RADI OI SOTOPE	0. 000000	35, 755		0 0		
57.00	05700 CT SCAN	0. 000000	302, 677		0 0	-	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	82,006		0 0		
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	139, 172		0 0		
60.00		0. 000000	512, 275		0 0	-	
60.01	06001 BLOOD LABORATORY	0. 000000	0		0 0		
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	66, 718		0 0	° .	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0		
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	-	
65.00	06500 RESPI RATORY THERAPY	0. 000000	287, 181		0 0		
66.00	06600 PHYSI CAL THERAPY	0. 000000	20, 206		0 0		
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	15, 143		0 0		
68.00	06800 SPEECH PATHOLOGY	0. 000000	12,099		0 0	-	
69.00		0. 000000	99, 714		0 0	-	
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	19, 653		0 0		
71.00 72.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 000000	96, 602		5	° .	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	28, 396		-		
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	683, 773		0 0	-	
74.00	07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	0. 000000	58, 405		0 (<u> </u>	74.00
90.00	09000 CLINIC	0. 000000	0	1	0 0	0 0	90.00
90.00 90.01	09001 WOUND/OSTOMY CLINIC	0. 000000	13, 257		0 0		
90.01 90.02	09002 CTR ADVANCED HEART CARE	0. 000000	13, 237		0 0		
90.03	09003 RADIATION ONCOLOGY	0. 000000	28, 869		0 0		
90.04	09004 MUNCI E CLINIC	0. 000000	20,007		0 0		
90.05	09005 ANTI COAGULATI ON CLINIC	0. 000000	0		0 0		
90.06	09006 PREGNANCY PLUS	0. 000000	0		0 0		
90.07	09007 0/P LAB	0. 000000	0		0 0	-	
90.08	09008 0/P LAB	0. 000000	0		0 0		90.08
90.09	09009 FORTVILLE CLINIC	0. 000000	0		0 0	-	
90.10	09010 1030 S SCATTERFIELD (MEDCHECK)	0. 000000	0		0 0		
90.11	09011 DI ABETI C PLUS CLINI C	0. 000000	0		0 0	° .	
90.12	09012 OTHER ONCOLOGY SERVICES	0. 000000	0		0 0	° .	
91.00	09100 EMERGENCY	0. 000000	776, 115		0 0		1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	9, 021		0 0		
. 2. 00	OTHER REIMBURSABLE COST CENTERS	0.000000	2,021	1			1
00 00	09850 OTHER REI MBURSABLE COST CENTERS	0.000000	0		0 0	0 0	98.00
98.00							

PPORTI ONME	ncial Systems NT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provider C	CN: 15-0113	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/30/2022 2:5	
		-	Titl	e XIX	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
		1.00	0.00	(see inst.)	(see inst.)	F 00	
ANCLL	LARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	OPERATING ROOM	0. 157448	0	1, 275, 24	17 0	0	50.00
	RECOVERY ROOM	0. 137448			0 0	0	
	DELIVERY ROOM & LABOR ROOM	0. 730642	-		0 0	0	
	ANESTHESI OLOGY	0. 000000			0 0	0	
	RADI OLOGY-DI AGNOSTI C			257 4	-		
		0. 327199				0	
		0. 117433				0	54.0
	RADI OLOGY-THERAPEUTI C	0.00000			0 0	0	
	RADI OI SOTOPE	0. 096921	0			0	56.0
	CT SCAN	0. 041970				0	
	MAGNETIC RESONANCE IMAGING (MRI)	0. 138961	0			0	
	CARDIAC CATHETERIZATION	0. 092161	0			0	
	LABORATORY	0. 199142	-			0	
	BLOOD LABORATORY	0. 000000			0 0	0	
	WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 617576				0	
	BLOOD STORING, PROCESSING & TRANS.	0. 000000	-		0 0	0	63.0
	INTRAVENOUS THERAPY	0. 000000			0 0	0	64.0
5.00 06500	RESPI RATORY THERAPY	0. 315913		34, 55	52 0	0	65.0
	PHYSI CAL THERAPY	0. 639893		81, 73	36 0	0	66.0
	OCCUPATIONAL THERAPY	0. 409452	-	2, 59	92 0	0	67.0
	SPEECH PATHOLOGY	0. 402238	0	7,74	19 0	0	68.0
	ELECTROCARDI OLOGY	0. 223567	0	100, 16	64 0	0	69.0
	ELECTROENCEPHALOGRAPHY	0. 329616	0	99, 93	39 0	0	70.0
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 407220		243, 41	12 0	0	71.0
	IMPL. DEV. CHARGED TO PATIENTS	0. 471346	0	55, 93	38 0	0	72.0
3.00 07300	DRUGS CHARGED TO PATIENTS	0. 261342				0	73.0
	RENAL DIALYSIS	0. 588444	0		0 0	0	74.0
	TIENT SERVICE COST CENTERS						
		0. 000000			0 0	0	
	WOUND/OSTOMY CLINIC	0. 395422				0	
	CTR ADVANCED HEART CARE	0. 714970				0	
	RADIATION ONCOLOGY	0. 142413		635, 40	01 0	0	
	MUNCIE CLINIC	0. 000000			0 0	0	
	ANTICOAGULATION CLINIC	0. 838225		6, 85	51 0	0	90.0
	PREGNANCY PLUS	0. 000000	0		0 0	0	90.0
	0/P LAB	0. 000000			0 0	0	
	0/P LAB	0. 000000			0 0	0	
09009 09009	FORTVILLE CLINIC	0. 000000	0		0 0	0	90.0
	1030 S SCATTERFIELD (MEDCHECK)	0. 000000	0		0 0	0	
09011 09011	DIABETIC PLUS CLINIC	2.749969	0	6, 36	55 0	0	90.1
09012 09012	OTHER ONCOLOGY SERVICES	0. 000000	0		0 0	0	90.1
1.00 09100	EMERGENCY	0. 126532	0	2, 978, 14	40 0	0	91.0
2.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	1. 106454	0	43, 14	13 0	0	92.0
	REIMBURSABLE COST CENTERS						1
	OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	98. C
00.00	Subtotal (see instructions)	1	0			0	200.0
01.00	Less PBP Clinic Lab. Services-Program	1			0 0		201. C
	Only Charges						
02.00	Net Charges (line 200 - line 201)	1	0	8, 845, 09	99 0		202.0

Heal th Financ	ial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-	-2552-10
APPORTI ONMENT	T OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC	CN: 15-0113	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre	oparodi
					10 12/31/2021	5/30/2022 2:5	
			Titl	e XIX	Hospi tal	PPS	
		Cos					
(Cost Center Description	Cost	Cost				
		Reimbursed Services	Reimbursed Services Not				
		Subject To	Subject To				
		Ded. & Coi ns.					
		(see inst.)	(see inst.)				
		6.00	7.00				
ANCI LL/	ARY SERVICE COST CENTERS						
	OPERATING ROOM	200, 785	0				50.00
	RECOVERY ROOM	0	0				51.00
	DELIVERY ROOM & LABOR ROOM	0	0				52.00
	ANESTHESI OLOGY	0	0				53.00
	RADI OLOGY-DI AGNOSTI C	84, 290	0				54.00
	ULTRASOUND	17, 134	0				54.01
	RADI OLOGY-THERAPEUTI C	0	0				55.00
	RADI OI SOTOPE	8, 665	0				56.00
	CT SCAN	41, 558	0				57.00
	MAGNETIC RESONANCE IMAGING (MRI)	37, 981	0				58.00
	CARDI AC CATHETERI ZATI ON LABORATORY	9, 203	0				59.00 60.00
	BLOOD LABORATORY	168, 580 0	0				60.00
	WHOLE BLOOD & PACKED RED BLOOD CELLS	22, 261	0				62.00
	BLOOD STORING, PROCESSING & TRANS.	22,201	0				63.00
	INTRAVENOUS THERAPY	0	0				64.00
	RESPIRATORY THERAPY	10, 915	0				65.00
	PHYSI CAL THERAPY	52, 302	o				66.00
	OCCUPATIONAL THERAPY	1,061	o				67.00
	SPEECH PATHOLOGY	3, 117	o				68.00
	ELECTROCARDI OLOGY	22, 393	o				69.00
70.00 07000 E	ELECTROENCEPHALOGRAPHY	32, 941	o				70.00
71.00 07100 N	MEDICAL SUPPLIES CHARGED TO PATIENTS	99, 122	o				71.00
72.00 07200 I	IMPL. DEV. CHARGED TO PATIENTS	26, 366	0				72.00
	DRUGS CHARGED TO PATIENTS	84, 471	0				73.00
	RENAL DIALYSIS	0	0				74.00
	I ENT SERVICE COST CENTERS						
90.00 09000 0		0	0				90.00
	WOUND/OSTOMY CLINIC	77, 902	0				90.01
	CTR ADVANCED HEART CARE	10, 570	0				90.02
1 1	RADIATION ONCOLOGY	90, 489	0				90.03
	MUNCIE CLINIC ANTICOAGULATION CLINIC	5, 743	0				90.04
	PREGNANCY PLUS	5,743	0				90.05
	0/P LAB	0	0				90.08
90.08 09008 0		0	0				90.07
	FORTVILLE CLINIC	0	0				90.09
	1030 S SCATTERFIELD (MEDCHECK)	0	0				90.10
	DIABETIC PLUS CLINIC	17, 504	0				90.11
	OTHER ONCOLOGY SERVICES	0	0				90.12
	EMERGENCY	376, 830	0				91.00
92.00 09200 0	OBSERVATION BEDS (NON-DISTINCT PART)	47, 736	0				92.00
	REIMBURSABLE COST CENTERS						
	OTHER REIMBURSABLE COST CENTERS	0	0				98.00
	Subtotal (see instructions)	1, 549, 919	0				200.00
	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	1, 549, 919	0				202.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0113	Period: From 01/01/2021	Worksheet D-1	
			To 12/31/2021	Date/Time Pre 5/30/2022 2:5	
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
00 00	Inpatient days (including private room days and swing-bed day			22, 745 22, 745	
00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		rivate room davs.	22, 745	
	do not complete this line.	5, 5, 5,		-	
00 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 21 of the cost	20, 684 0	4. 5.
00	reporting period	Join days) thi dugn beceilib	er st of the cost	0	5.
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	om davs) through December	- 31 of the cost	0	7.
00	reporting period	on days) through becember	ST OF the cost	0	'·
00	Total swing-bed NF type inpatient days (including private roo	om days) after December :	31 of the cost	0	8.
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Program (excluding	n swing-bed and	6, 068	9.
00	newborn days) (see instructions)	0 1	, ₀	0,000	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 21 of the cost reporting period (see instru	only (including private i	room days)	0	10.
. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11.
	December 31 of the cost reporting period (if calendar year, e	enter 0 on this line)	5 ,	-	
. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	IX only (including priva	te room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI	IX only (including priva	te room davs)	0	13
	after December 31 of the cost reporting period (if calendar v	year, enter O on this li	ne)	-	
. 00	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	14
. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces through December 31 (of the cost	0.00	17.
. 00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost	0.00	18.
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19.
	reporting period			0.00	
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of 1	the cost	0.00	20.
. 00	Total general inpatient routine service cost (see instruction	ns)		42, 326, 110	21.
. 00	Swing-bed cost applicable to SNF type services through Decemb	ber 31 of the cost repor	ting period (line	0	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	r 31 of the cost reporti	na period (line 6	0	23.
	x line 18)				
. 00	Swing-bed cost applicable to NF type services through December 7×1 (ine 19)	er 31 of the cost reporti	ng period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25
00	x line 20)			0	2
. 00 . 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 42, 326, 110	26. 27.
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(11116 21 111110 20)		12,020,110	
. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed cl	narges)	0	
. 00 . 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29 30
. 00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33
. 00	Average per diem private room charge differential (line 32 mi	inus line 33)(see instru	ctions)	0.00	
. 00	Average per diem private room cost differential (line 34 x li	ine 31)		0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)	and unit onto the state	66	0	36
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	TTERENTIAL (line	42, 326, 110	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.			1.0/0.00	
. 00 . 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 860. 90 11, 291, 941	
	Medically necessary private room cost applicable to the Progr	ram (line 14 x line 35)	I	0	40

OMPUTATION OF INPATIENT OPERATING	CUST		Provider C		eriod: rom 01/01/2021	Worksheet D-1	1
				T,		Date/Time Pre 5/30/2022 2:5	
				XVIII	Hospi tal	PPS	-
Cost Center Descriptio		Total npatient Costl	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	-	1.00	2.00	3.00	4.00	5.00	
2.00 NURSERY (title V & XIX only)	0	0	0.00	0	0) 42.
Intensive Care Type Inpatie	nt Hospital Units	0 450 740	4.000	0.007.44	4.4/7	0 (11 053	1 40
3.00 INTENSIVE CARE UNIT 4.00 CORONARY CARE UNIT		9, 459, 762	4, 228	2, 237. 41	1, 167	2, 611, 057	43.
5. 00 BURN INTENSIVE CARE UNIT							44.
5. 00 SURGICAL INTENSIVE CARE UNI	т						46.
7.00 OTHER SPECIAL CARE (SPECIFY)			<u> </u>			47.
Cost Center Descriptio	n					1.00	
3.00 Program inpatient ancillary	service cost (Wks		Line 200)			1.00 10,950,040) 48.
9.00 Total Program inpatient cos				ns)		24, 853, 038	
PASS THROUGH COST ADJUSTMEN		9 / 1					
0.00 Pass through costs applicab	le to Program inpa	tient routine :	services (from	Wkst. D, sum	of Parts I and	446, 651	I 50.
III) 1.00 Pass through costs applicab	le to Program inna	tiont ancillar	v sarvicas (fr	om Wkst D su	m of Parts II	499, 141	51.
and IV)			y Scivices (II	un mitor. D, Sul		+ 77, 141	JI.
2.00 Total Program excludable co						945, 792	
3.00 Total Program inpatient ope			lated, non-phy	sician anesthe	tist, and	23, 907, 246	53.
medical education costs (li TARGET AMOUNT AND LIMIT COM		2)				i	
4.00 Program di scharges						0	54.
5.00 Target amount per discharge						0.00	55.
5.00 Target amount (line 54 x li						0	
7.00 Difference between adjusted		ng cost and ta	rget amount (I	ine 56 minus l	ine 53)	0	
3.00 Bonus payment (see instruct 9.00 Lesser of lines 53/54 or 55		orting period	ending 1996 u	ndated and com	nounded by the	0.00	
market basket		bi tring period .			Sounded by the	0.00	/ J /.
0.00 Lesser of lines 53/54 or 55						0.00	
1.00 If line 53/54 is less than						0) 61.
which operating costs (line amount (line 56), otherwise			s (Tines 54 x	50), OF 1% OF	the target		
2.00 Relief payment (see instruc		lotr dotrono)				0	62.
3.00 Allowable Inpatient cost pl		nt (see instru	ctions)			0	63.
PROGRAM INPATIENT ROUTINE S 4.00 Medicare swing-bed SNF inpa		through Dooo	mbox 21 of the	aaat ranarti n	a popied (See	0	
4.00 Medicare swing-bed SNF inpa instructions)(title XVIII o		s through becei		cost reporting	j period (see		64.
5.00 Medicare swing-bed SNF inpa		s after Decemb	er 31 of the c	ost reporting	period (See	0	65.
instructions)(title XVIII o							
5.00 Total Medicare swing-bed SN	F inpatient routine	e costs (line)	64 plus line 6	5)(title XVIII	only). For	0	66.
CAH (see instructions) 7.00 Title V or XIX swing-bed NF	inpatient routine	costs through	December 31 o	f the cost rep	ortina period	0	67.
(line 12 x line 19)		0			0.1		
3.00 Title V or XIX swing-bed NF	inpatient routine	costs after D	ecember 31 of	the cost repor	ting period	0	68.
(line 13 x line 20) 2.00 Total title V or XIX swing-	had NE innationt r	outino costs (lino 67 - lino	60)		0	69.
PART III - SKILLED NURSING				,			07.
0.00 Skilled nursing facility/ot							70.
1.00 Adjusted general inpatient			ine 70 ÷ line	2)			71.
2.00 Program routine service cos			(line 14 v !!	no 25)			72.
3.00 Medically necessary private 4.00 Total Program general inpat				ne 30)		1	73.
5.00 Capital -related cost alloca			,	orksheet B, Pa	rt II, column	1	75.
26, line 45)	•						
5.00 Per diem capital -related co	•						76.
7.00 Program capital-related cos 3.00 Inpatient routine service c	•						77.
9.00 Aggregate charges to benefi	•		rovi der record	s)		1	79.
0.00 Total Program routine servi		• •		· .	s line 79)	1	80.
.00 Inpatient routine service of	•						81.
. 00 Inpatient routine service c	•						82.
8.00 Reasonable inpatient routin 4.00 Program inpatient ancillary			5)				83. 84.
5.00 Utilization review - physic			ns)			1	85.
5.00 Total Program inpatient ope							86.
DADT IV COMPUTATION OF OP	SERVATION BED DASS	THROUGH COST					
PART IV - COMPUTATION OF OB							
7.00 Total observation bed days 3.00 Adjusted general inpatient	(see instructions)		line 2)			2, 061 1, 860. 90	

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2021	Worksheet D-1	
				To 12/31/2021	Date/Time Pre 5/30/2022 2:5	
		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	1, 291, 163	42, 326, 110	0.03050	5 3, 835, 315	116, 996	90.00
91.00 Nursing Program cost	0	42, 326, 110	0.00000	3, 835, 315	0	91.00
92.00 Allied health cost	0	42, 326, 110	0.00000	3, 835, 315	0	92.00
93.00 All other Medical Education	0	42, 326, 110	0.00000	3, 835, 315	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0113	Period: From 01/01/2021	Worksheet D-1	
			To 12/31/2021	Date/Time Pre 5/30/2022 2:5	
	Cost Center Description	Title XIX	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS	(c. oveluding nowhern)		22 745	1 1.
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-	bed and newborn days)		22, 745 22, 745	2.
00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ays). If you have only pr	rivate room days,	0	3
00 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	20, 684 0	
00	reporting period Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo			0	
00	reporting period Total swing-bed NF type inpatient days (including private roc	3.		0	
	reporting period (if calendar year, enter 0 on this line)	-		-	
00	Total inpatient days including private room days applicable t newborn days) (see instructions)	0 1 0		568	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		room days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		oom days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including privat	e room days)	0	12
00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)			0 1, 389	
	Nursery days (title V or XIX only)			1, 316	
00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 c	of the cost	0.00	17
00	reporting period Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instruction	ıs)		42, 409, 729	21
. 00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	per 31 of the cost report	ing period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	⁻ 31 of the cost reportir	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	er 31 of the cost reporti	ng period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	
	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			42, 409, 729	27
	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	
. 00 . 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)	~		0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00	
	Average per diem private room cost differential (line 34 x li			0.00	
	Private room cost differential adjustment (line 3 x line 35)	<i>`</i>		0	
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	fferential (line	42, 409, 729	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ILICTMENTS			
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ		1	1 044 57	2
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1,864.57	
	IFIOULAM VEHELAL THUALTELL TOULTHE SELVICE COST (TIME 9 X TIME	= 30/		1, 059, 076	39
	Medically necessary private room cost applicable to the Progr	cam (line 14 v line 2E)		0	40

OMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-	- <u>2552</u> 1
				From 01/01/2021 Fo 12/31/2021	Date/Time Pre	epare
		Title		Hospi tal	5/30/2022 2:5 PPS	53 pm
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
	Inpatient Costl		iem (col. 1		(col. 3 x col.	
	1.00	2.00	<u>col. 2)</u>	4.00	4)	
2.00 NURSERY (title V & XIX only)	1.00	2.00	3.00			3 42
Intensive Care Type Inpatient Hospita		1,007	17 1001 0	.,	1,700,010	
. 00 INTENSIVE CARE UNIT	9, 459, 762	4, 228	2, 237. 4	1 231	516, 842	
. 00 CORONARY CARE UNIT						44
0.00 BURN INTENSIVE CARE UNIT 0.00 SURGICAL INTENSIVE CARE UNIT						45
. 00 OTHER SPECIAL CARE (SPECIFY)						47
Cost Center Description						
.00 Program inpatient ancillary service c	oct (Wkst D 2 col 2	Lino 200)			1.00	2 48
.00 Total Program inpatient costs (sum of			s)		4, 453, 223	
PASS THROUGH COST ADJUSTMENTS			3)		μ 1 , 1 , 100, 220	1 1
.00 Pass through costs applicable to Prog	ram inpatient routine s	services (from	Wkst. D, sum	of Parts I and	167, 751	i 50
)				m of Doubo II	10 1/2	
.00 Pass through costs applicable to Prog and IV)	ram inpatient ancillary	/ services (tro	M WKST. D, SI	um of Parts II	40, 462	2 51
2.00 Total Program excludable cost (sum of	lines 50 and 51)				208, 213	3 52
3.00 Total Program inpatient operating cos	t excluding capital rel	ated, non-phys	ician anesthe	etist, and	4, 245, 010	
medical education costs (line 49 minu	s line 52)					-
. 00 Program di scharges					C	54
. 00 Target amount per discharge					0.00	
.00 Target amount (line 54 x line 55)					C	
.00 Difference between adjusted inpatient	operating cost and tar	get amount (li	ne 56 minus l	ine 53)	C	
. 00 Bonus payment (see instructions)		1. 100/			0	
.00 Lesser of lines 53/54 or 55 from the market basket	cost reporting period e	ending 1996, up	dated and cor	npounded by the	0.00	59
. 00 Lesser of lines 53/54 or 55 from pric	r year cost report, upo	lated by the ma	rket basket		0.00	0 60
.00 If line 53/54 is less than the lower					C	61
which operating costs (line 53) are l		s (lines 54 x 6	0), or 1% of	the target		
amount (line 56), otherwise enter zer 0.00 Relief payment (see instructions)	o (see instructions)				l c	62
6.00 Allowable Inpatient cost plus incenti	ve pavment (see instruc	ctions)				
PROGRAM INPATIENT ROUTINE SWING BED C	OST					
.00 Medicare swing-bed SNF inpatient rout	ine costs through Decem	nber 31 of the	cost reportin	ng period (See	C	64
instructions)(title XVIII only) 0.00 Medicare swing-bed SNF inpatient rout	ine costs after Decembe	or 31 of the co	st reporting	neriod (See	l c	65
instructions) (title XVIII only)	The costs after becembe		st reporting	period (See		
.00 Total Medicare swing-bed SNF inpatier	t routine costs (line 6	64 plus line 65)(title XVIII	only). For	C	66
CAH (see instructions)						
7.00 Title V or XIX swing-bed NF inpatient (line 12 x line 19)	routine costs through	December 31 of	the cost rep	porting period	C	67
8.00 Title V or XIX swing-bed NF inpatient	routine costs after De	ecember 31 of t	he cost repo	ting period	C	68
(line 13 x line 20)				5 1		
2.00 Total title V or XIX swing-bed NF inp					0	0 69
PART III - SKILLED NURSING FACILITY, 0.00 Skilled nursing facility/other nursing						70
.00 Adjusted general inpatient routine se	5 5		. ,			71
.00 Program routine service cost (line 9	x line 71)					72
. 00 Medically necessary private room cost			e 35)			73
.00 Total Program general inpatient routi .00 Capital-related cost allocated to inp			rkchoot P D	st II column		74
 Control Control C	attent foutthe service	CUSIS (ITUM WO	IKSHEEL D, Pa	art II, corumn		15
. 00 Per diem capital-related costs (line	75 ÷ line 2)					76
.00 Program capital-related costs (line 9	· ·					77
00 Inpatient routine service cost (line	-	ouldon noon-l-	`			78
00 Aggregate charges to beneficiaries fo 00 Total Program routine service costs f				is line 70)		80
.00 Inpatient routine service costs i	•	St rimitation		13 THE 77)		81
00 Inpatient routine service cost limita						82
.00 Reasonable inpatient routine service	costs (see instructions					83
. 00 Program inpatient ancillary services	•	>				84
.00 Utilization review - physician comper .00 Total Program inpatient operating cos						85
PART IV - COMPUTATION OF OBSERVATION		ough 00)				
7.00 Total observation bed days (see instr					2, 061	
3.00 Adjusted general inpatient routine co		line 2)			1, 864. 57	
0.00 Observation bed cost (line 87 x line					3, 842, 879	

Health Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/30/2022 2:5	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 291, 163	42, 409, 729	0. 03044	5 3, 842, 879	116, 996	90.00
91.00 Nursing Program cost	0	42, 409, 729	0.00000	3, 842, 879	0	91.00
92.00 Allied health cost	0	42, 409, 729	0.00000	3, 842, 879	0	92.00
93.00 All other Medical Education	0	42, 409, 729	0.00000			93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider COK 15-0113 Period To Distruction (1/1/12) Period (1/1/12) Period (1/1/12) Worksheet D-3 (1/1/12) Worksheet D-3 (1/1/12) Cost Center Description If the XVIII Instruction (1/1/12) Instruction (1/1/12) Period (1/1/12) Period (1/	Health Financial Systems COMMUNITY HOSPITA	AL ANDERSON		In Lie	eu of Form CMS-	2552-10
To To T23/12021 Deterting Program Despit ant Program 0 Cost Center Description Ti Lie XVIII Tel 0 of Cost To Charges Program Program Program Program Program Cost Cos	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0113		Worksheet D-3	
Cost Center Description Figure 110 eXUI1 Hospit E1 Figure 110 eXUI1 Figure 110 eXUI1<					Date/Time Pre	nared
Cost Center Description Program Program Program 100 2.00 3.00 3.00 3.00 30.00 3000 ADULTS & PENTOR COST CENTERS 3.00 3.00 3.00 30.00 3000 ADULTS & PENTOR COST CENTERS 3.00 3.00 3.00 3.00 30.00 3000 ADULTS & PENTOR COST CENTERS 3.00 3.00 3.00 3.00 44.00 44.00 4.00<				10 12/31/2021		
To Charges Program Program Program Program Continuestical Continu		Title	e XVIII	Hospi tal		
Image: Charges Coling Charges Coling Coling 1000 1000 2.00 3.00 1.00 2.00 3.00 1000 1000 1000 1000 10.05 2.00 3.00 1000 1000 10.05 2.00 4.815.278 4.815.278 4.815.278 1000 0000 0000 1.743.077 1.743.077 50.00 50.00 51.00 52.00 62.00 1.743.07.28 13.61.60 54.00 51.00 650.00 RECOVERY ROM 0.0170.00 0.0170.00 1.743.07 50.00 55.00 50.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00	Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
Image: constraint of the service cost centers Image: constraint of the service cost centers Image: constraint of the service cost centers 0 0.0000 ADULTS & PEDIATRICS 30.00 50.00 50.0			To Charges	U U		
IMPATIENT RUUTINE SERVICE COST CENTERS 30.00 30.00 30.00 30.00 30000 ADULTS & PEDIATRICS 31.559,251 30.00 43.00 04300 NURSERV 4.845,878 43.00 43.00 04300 NURSERV 4.845,878 43.00 43.00 04300 NURSERV 4.845,878 43.00 43.01 06300 APENATESENCE COST CENTERS 0.157448 11.070.931 1.743,097 50.01 05300 ANESTIESI CLOW 0.000000 17.433 455,726 52.00 51.00 05300 ANESTIESI CLOW 0.000000 0 53.00 55.00 <t< td=""><td></td><td></td><td></td><td>Charges</td><td></td><td></td></t<>				Charges		
INPART ENT ROUT NE SERVICE COST CENTERS 30.00 0.00 30.00 31.00			1.00			
30. 00 03000 ADULTS & PEDLATRICS 13. 559, 251 30. 00 43. 00 03000 INTENSIVE CASE LINIT 4. 845, 876 43. 00 43. 00 03000 INTENSIVE CASE LINIT 4. 845, 876 43. 00 43. 00 03000 INTENSIVE CASE LINIT 4. 845, 876 43. 00 44. 00 05000 OPERATING ROM 0. 157448 11, 070, 937 1, 743, 997 50. 00 50. 00 05200 OPERATING ROM 0. 000000 0 51. 00 55. 00			1.00	2.00	3.00	
31.00 03100 NTERSIV © CARE UNIT 4, 845, 878 31.00 AND 04.300 UNSERY 43.00 AND 04.300 UNSERY 43.00 AND 04.300 UNSERY 0.000000 0 55.00 00 05000 OPERATING ROOM 0.000000 0 0 55.00 00 05000 DECOVERY ROOM 0.000000 0 0 55.00 00 05000 ALESTIESIOLOSY 0.000000 0 0 55.00 00 05000 ALESTIESIOLOSY 0.000000 0 0 55.00 00 05401 DUCY-DIAGNOSTIC 0.000000 0 0 55.00 00 05700 DETATING ROMANDIO 0.1177.33 495,726 55.00 010000 CHT-REAPPUTIC 0.000000 0 0.000000 177,729 17,183 55.00 0100000 CHT-REAPPUTIC 0.000000 0.000000 0 171,783 95.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00			1	12 550 251	1	20.00
43. 00 0.4300 NURSERY 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 50. 00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td>•</td></td<>						•
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52.00 05200 DELLIVERY ROWA & LABOR ROMM 0.730642 17.431 12.736 52.00 53.00 05300 MESTHES LOGY 0.8400 RADI LOGY - IN ARNOSTI C 0.827199 1.027.388 336.160 54.00 54.00 05500 RADI LOGY - IN ERAPEUTI C 0.0174731 495.726 58.215 54.01 55.00 05500 RADI LOGY - HERAPEUTI C 0.096921 177.22 17.182 50.00 50.00 05700 C T SCAN 0.096921 177.282 17.182 50.00 50.00 05600 LAROATI C C ATHETERI ZATI ON 0.199474 4.382,251 86.67.70 60.01 50.00 05600 LABORATORY 0.99921 17.756 325.574 220.166.770 60.01 60.00 060001 MICE BLODO B APACKD RED BLODO CELLS 0.617576 325.574 20.076.756 325.574 20.076.756 325.574 20.076.756 325.574 20.076.766 30.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00						•
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54. 01 05401 ULTRASOLIND 0.117433 4495, 726 58. 215 54. 01 55. 00 05500 RADI 0LOY-THERAPEUTI C 0.00000 0 0 55. 00 70. 00 05700 CT SCAN 0.041970 2.887, 298 121, 180 57. 00 70. 00 05700 CT SCAN 0.041970 2.887, 298 124, 180 57. 00 70. 00 05700 CARDI ACCATHETERIZATION 0.139961 552, 666 78, 189 58. 00 70. 00 05000 LABDRATORY 0.000000 0 0 60. 01 70. 00 06200 WHOLE BLODD & PACKED RED BLODD CELLS 0.617576 325, 574 201. 667 62. 00 70. 00 06400 INTRAVENOUS THERAPY 0.300983 385, 288 246, 434 66. 00 70. 00 06400 INTRAVENOUS THERAPY 0.409452 228. 817 110. 066 67. 00 70. 00 0700 CEEPI PATHOLOGY 0.422587 1.389, 738 338. 288 246, 43 66. 00 70. 00 0700 ELECTRORANT HERAPY 0.409452 2.540, 848 1.19, 619 72. 00 70. 00 0700 ELECTRORANT HERAPY 0.420248 1					336, 160	54.00
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57. 00 057.00 CT SCAN 0.041970 2, 887, 298 121, 180 57. 00 58. 00 05800 MARCH TIC RESONANCE IMAGING (MRI) 0.138961 562, 666 76, 849 58. 00 59. 00 05000 CADIN AC CATHETERI ZATI ON 0.092161 1,499, 820 138, 225 59. 00 60. 01 06000 LABORATORY 0.199142 4, 352, 521 866, 770 60. 00 60. 01 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.17576 3225, 574 201, 067 62. 00 63. 00 06300 BLOOD TARKENDRS, PROCESSING & TRANS. 0.000000 0 64. 00 65. 00 06500 PESPI RATORY THERAPY 0.3359913 333, 32, 295, 824 45. 00 66. 00 06600 PESPI RATORY THERAPY 0.439993 385, 288 246, 543 66. 00 67. 00 06000 CULL THERAPY 0.2329616 293, 511 10. 068, 700 71. 00 010400 CLL THERAPY 0.2329616 293, 51 96, 194 70. 00 72. 00 07200 ILECTROCACEPHALTHERAPY 0.2329616 293, 51 96, 59 <td>55. 00 05500 RADI OLOGY-THERAPEUTI C</td> <td></td> <td>0.00000</td> <td>0 0</td> <td>0</td> <td>55.00</td>	55. 00 05500 RADI OLOGY-THERAPEUTI C		0.00000	0 0	0	55.00
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59:00 059:00 CARDIAC CATHETERIZATION 0.092161 1.499.820 138.225 59.00 00:00 06000 LABORATORY 0.090000 0 0 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 00 0 0 0 00 00 00 00 00 00 00 0	57.00 05700 CT SCAN		0. 04197	2, 887, 298	121, 180	57.00
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60:01 BLOOD LABORATORY 0.000000 0 0 0.000000 0 0 0.000000 0 0 0.000000 0 0.00000 0 0 0	59. 00 05900 CARDI AC CATHETERI ZATI ON		0.09216	1, 499, 820	138, 225	59.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.617576 325.574 201.067 62.00 63.00 06400 INTRAVENOUS THERAPY 0.000000 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0.315913 3.033, 822 958, 424 65.00 66.00 06600 PHYSI CAL THERAPY 0.409452 268, 817 110.068 67.00 06.00 05000 SPECE THATURY THERAPY 0.409452 268, 817 110.068 67.00 06.00 06600 SPECE THATUOLOGY 0.409452 268, 817 110.068 67.00 07.00 DELECTROCARDIOLOGY 0.223567 1,389, 738 310.700 69.00 0.00 07000 ILECTROCARDE THATS 0.4071346 2,540, 848 1,197, 619 70.00 0.01 07000 REAL DIALYIS 0.588444 222, 636 131,009 74.00 0.020 ORMEL DLALYIS 0.000000 0 0 00.00 0.020 REAL DIALYIS			0. 19914	4, 352, 521	866, 770	60.00
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90.01 09001 WOUND/OSTOMY CLINIC 0.395422 128,707 50,894 90.01 90.02 09002 CTR ADVANCED HEART CARE 0.714970 0 0 90.02 90.03 09003 RADI ATI ON ONCOLOGY 0.142413 356,750 50,804 90.04 90.05 09004 MUNCI E CLINIC 0.000000 0 0 90.04 90.05 09005 ANTI COAGULATI ON CLINIC 0.838225 0 0 90.05 90.06 09006 PREGNANCY PLUS 0.000000 0 90.06 90.06 90.07 0/907 0/P LAB 0.000000 0 90.06 90.07 90.08 0/P LAB 0.000000 0 0 90.08 90.09 90.01 90.09 90.00 90.09 90.00 90.09 90.00 90.09 90.00 90.09 90.00 90.09 90.00 90.09 90.00 90.09 90.00 90.09 90.00 90.09 90.00 90.00 90.00 90.00 90.00 90.00 90.01 90.10 90.10 90.11 <t< td=""><td></td><td></td><td>0.0000</td><td>0</td><td>0</td><td>90 00</td></t<>			0.0000	0	0	90 00
90.02 09002 CTR ADVANCED HEART CARE 0.714970 0 0 90.02 90.03 09003 RADI ATI ON ONCOLOGY 0.142413 356, 750 50, 806 90.03 90.04 09004 MUNCI E CLINIC 0.00000 0 90.04 90.05 ANTI COAGULATI ON CLINIC 0.838225 0 90.05 90.06 09007 O/P LAB 0.00000 0 90.06 90.07 09007 O/P LAB 0.00000 0 90.08 90.09 90008 O/P LAB 0.000000 0 90.08 90.09 FORTVI LLE CLINIC 0.00000 0 90.09 90.09 FORTVI LLE CLINIC 0.00000 0 90.09 90.10 09010 1030 S SCATTERFIELD (MEDCHECK) 0.000000 0 90.10 90.11 09011 DI ABETI C PLUS CLINIC 0.000000 0 90.11 90.11 09010 EMERGENCY 0.126532 6, 422, 494 812, 651 91.00 91.00 09100 EMERGENCY 0.126532 6, 422, 494						•
90.03 09003 RADI ATI ON ONCOLOGY 0.142413 356,750 50,806 90.03 90.04 09004 MUNCI E CLINIC 0.00000 0 0 90.04 90.05 ANTI COAGULATION CLINIC 0.838225 0 0 90.05 90.06 09006 PREGNANCY PLUS 0.00000 0 90.06 90.07 09007 0/P LAB 0.00000 0 90.07 90.08 09008 0/P LAB 0.00000 0 90.08 90.09 90009 FORTVI LLE CLINIC 0.000000 0 90.09 90.10 09010 1030 S SCATTERFIELD (MEDCHECK) 0.000000 0 90.10 90.11 09011 DI ABETI C PLUS CLINIC 0.000000 0 90.12 91.10 09101 DI ABETI C PLUS CLINIC 0.126532 6,422,494 812,651 91.00 92.00 095ERVATION BEDS (NON-DI STINCT PART) 1.106454 333,492 368,994 92.00 92.00 0BSERVATION BEDS (COST CENTERS 0.000000 0 98.00 90.00 98.00 901.00<						•
90.04 09004 MUNCLE CLINIC 0.00000 0 0 90.04 90.05 ANTI COAGULATI ON CLINIC 0.838225 0 0 90.05 90.06 09006 PREGNANCY PLUS 0.000000 0 90.06 90.07 09007 0/P LAB 0.000000 0 90.07 90.08 09008 0/P LAB 0.000000 0 90.08 90.09 FORTVILLE CLINIC 0.000000 0 90.09 90.10 09009 FORTVILLE CLINIC 0.000000 0 90.09 90.11 09011 DI ABETI C PLUS CLINIC 0.000000 0 90.10 90.12 09112 OTHER ONCOLOGY SERVICES 0.000000 0 90.12 91.00 09100 EMERGENCY 0.126532 6, 422, 494 812, 651 91.00 92.00 092850 OTHER REI MBURSABLE COST CENTERS 0.000000 0 98.00 92.00 092850 OTHER REI MBURSABLE COST CENTERS 0.000000 0 98.00 90.01 Total (sum of Lines 50 through 94 and 96 through 98) 48, 484, 262 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
90.06 09006 PREGNANCY PLUS 0.00000 0 0 90.06 90.07 09007 0/P LAB 0.00000 0 0 90.07 90.08 09009 0/P LAB 0.00000 0 0 90.08 90.09 09009 FORTVILLE CLINIC 0.00000 0 0 90.09 90.10 09010 1030 S SCATTERFIELD (MEDCHECK) 0.000000 0 0 90.10 90.11 09011 DIABETIC PLUS CLINIC 2.749969 0 0 90.11 90.12 09102 OTHER ONCOLOGY SERVICES 0.000000 0 90.12 91.00 09100 EMERGENCY 0.126532 6, 422, 494 812, 651 91.00 92.00 0BSERVATION BEDS (NON-DI STINCT PART) 1.106454 333, 492 368, 994 92.00 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0.000000 0 0 98.00 908.00 Total (sum of lines 50 through 94 and 96 through 98) 48, 484, 262 10, 950, 040 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line						•
90.06 09006 PREGNANCY PLUS 0.00000 0 90.06 90.06 90.07 0/P LAB 0.00000 0 90.07 90.08 09009 0/P LAB 0.000000 0 90.07 90.08 90.09 90.09 90.07 0.000000 0 90.08 90.09 90.09 90.09 90.09 90.09 90.09 90.09 90.00 0 90.08 90.09 90.09 90.00 0 90.08 90.09 90.09 90.09 90.09 90.09 90.00 0 90.09 90.09 90.09 90.00 0 90.08 90.09 90.09 90.09 90.09 90.09 90.09 90.09 90.09 90.09 90.09 90.09 90.01 1030 S SCATTERFIELD (MEDCHECK) 90.09 90.00 90.01 90.00 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01<						•
90.07 0/9007 0/P LAB 0.00000 0 0 90.07 90.08 09008 0/P LAB 0.00000 0 0 90.08 90.09 9009 FORTVI LLE CLINIC 0.00000 0 90.09 90.10 09010 1030 S SCATTERFIELD (MEDCHECK) 0.000000 0 90.10 90.11 09011 104BETIC PLUS CLINIC 2.749969 0 0 90.12 90.12 09102 OTHER NOCOLOGY SERVICES 0.000000 0 90.12 90.12 91.00 09100 EMERGENCY 0.126532 6,422,494 812,651 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 1.106454 333,492 368,994 92.00 92.00 OBSERVATION BEDS COST CENTERS 0.000000 0 0 98.00 90.80 98.00 98.00 90.00000 0 0 98.00 90100 Total (sum of Lines 50 through 94 and 96 through 98) 0.000000 48, 484, 262 10, 950, 040 200.00 201.00						•
90.09 09009 FORTVI LLE CLINIC 0.00000 0 90.09 90.09 90.009 FORTVI LLE CLINIC 0.00000 0 90.09 90.009 90.000 0 90.09 90.000 0 90.09 90.00 90.00 0 90.09 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.01 90.01 104BETI C PLUS CLINIC 90.01 91.00 92.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00	90. 07 09007 0/P LAB		0.00000	0 0	0	90.07
90.10 09010 1030 S SCATTERFIELD (MEDCHECK) 0.000000 0 90.10 90.11 09011 DIABETIC PLUS CLINIC 2.749969 0 0 90.11 90.12 0912 OTHER ONCOLOGY SERVICES 0.000000 0 90.12 91.00 09100 EMERGENCY 0.126532 6,422,494 812,651 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 1.106454 333,492 368,994 92.00 OTHER REIMBURSABLE COST CENTERS 00.00000 0 0 0 98.00 0 0 98.00 200.00 User PBP Clinic Laboratory Services-Program only charges (line 61) 0 0 0 20.00	90. 08 09008 0/P LAB		0.00000	0 0	0	90.08
90.11 09011 DI ABETI C PLUS CLINIC 2.749969 0 0 90.11 90.12 09012 OTHER ONCOLOGY SERVICES 0.000000 0 90.12 91.00 09100 EMERGENCY 0.126532 6,422,494 812,651 91.00 92.00 09200 DBSERVATI ON BEDS (NON-DI STINCT PART) 1.106454 333,492 368,994 92.00 0THER REI MBURSABLE COST CENTERS 0.000000 0 0 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0.000000 0 98.00 98.00 200.00 10,950,040 200.00 200.00 200.00 201.00 201.00 201.00 201.00 0 0 0 200.00			0.00000	0 0	0	90.09
90.12 09012 OTHER ONCOLOGY SERVICES 0.000000 0 90.12 91.00 09100 EMERGENCY 0.126532 6,422,494 812,651 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.106454 333,492 368,994 92.00 0THER REI MBURSABLE COST CENTERS 0.000000 0 0 0 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 98.00 0 0 98.00 0 0 0 98.00 0 0 0 0 98.00 0 0 0 0 0 200.00 201.00 10,950,040 200.00 201.00 20					0	
91.00 09100 EMERGENCY 0.126532 6, 422, 494 812, 651 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 1.106454 333, 492 368, 994 92.00 0THER REIMBURSABLE COST CENTERS 0.000000 0 0 98.00 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0.000000 0 98.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 48, 484, 262 10, 950, 040 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 201.00			2.74996	09 0	0	
92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 1.106454 333,492 368,994 92.00 0THER REI MBURSABLE COST CENTERS 0.000000 0 98.00 98.00 98.00 09850 0THER REI MBURSABLE COST CENTERS 0.000000 0 98.00 98.00 200.00 10,950,040 200.00 200.00 201.00						
OTHER REIMBURSABLE COST CENTERS98.00098500THER REIMBURSABLE COST CENTERS0.000000098.00200.00Total (sum of lines 50 through 94 and 96 through 98)48,484,26210,950,040200.00201.00Less PBP Clinic Laboratory Services-Program only charges (line 61)0201.00			0. 12653	6, 422, 494		
98.00 09850 OTHER REI MBURSABLE COST CENTERS 0.000000 0 98.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 48, 484, 262 10, 950, 040 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 201.00			1. 10645	333, 492	368, 994	92.00
200. 00 Total (sum of lines 50 through 94 and 96 through 98) 48, 484, 262 10, 950, 040 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00			1		1	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00			0.00000			
		<i></i>		48, 484, 262	10, 950, 040	•
202. 00 Net charges (The 200 minus The 201) 48, 484, 262 202. 00		s (line 61)				
	202.00 Net charges (line 200 minus line 201)		1	48, 484, 262	[]	J202. 00

	nancial Systems COMMUNITY HOSPITA				u of Form CMS-2	
INPAILENT	ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0113	Period: From 01/01/2021	Worksheet D-3	
				To 12/31/2021	Date/Time Pre	pared:
					5/30/2022 2:5	
		Titl	e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
	ATIENT ROUTINE SERVICE COST CENTERS		1	1 007 017		
	000 ADULTS & PEDIATRICS			1, 907, 847		30.00
1	00 INTENSIVE CARE UNIT			568, 968		31.00
	300 NURSERY			149, 118		43.00
	I LLARY SERVICE COST CENTERS		0.4574		07.040	50.00
	DOO OPERATING ROOM		0. 1574			50.00
	00 RECOVERY ROOM		0.0000		01 170	51.00
	200 DELIVERY ROOM & LABOR ROOM		0.73064			52.00
	300 ANESTHESI OLOGY		0.0000		0	53.00
	IOO RADI OLOGY-DI AGNOSTI C IO1 ULTRASOUND		0. 3271			54.00
	500 RADI OLOGY-THERAPEUTI C		0. 11743		5, 410 0	54.01 55.00
	000 RADI OLOGI - I HERAPEUTI C					56.00
	700 CT SCAN		0. 09692 0. 0419		12, 703	57.00
	BOO MAGNETIC RESONANCE IMAGING (MRI)		0. 13890			57.00
	200 CARDIAC CATHETERIZATION		0. 13890		12, 826	59.00
	000 LABORATORY		0. 1991			60.00
	001 BLOOD LABORATORY		0. 00000		0 102,015	60.00
	200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 6175			
	BLOOD STORING, PROCESSING & TRANS.		0.0000		41,203	63.00
	100 INTRAVENOUS THERAPY		0.00000		0	64.00
	500 RESPIRATORY THERAPY		0. 3159		90, 724	65.00
	00 PHYSI CAL THERAPY		0. 63989			66.00
	700 OCCUPATI ONAL THERAPY		0. 40945			
	300 SPEECH PATHOLOGY		0. 40223			68.00
	200 ELECTROCARDI OLOGY		0. 22350			
	DOO ELECTROENCEPHALOGRAPHY		0. 3296			
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 40722			
1	200 I MPL. DEV. CHARGED TO PATIENTS		0. 47134			72.00
	BOO DRUGS CHARGED TO PATIENTS		0. 26134			73.00
	100 RENAL DI ALYSI S		0. 58844			
	PATIENT SERVICE COST CENTERS					1
	DOO CLINIC		0.0000	0 00	0	90.00
	001 WOUND/OSTOMY CLINIC		0. 39542		5, 242	90.01
	002 CTR ADVANCED HEART CARE		0. 7149		0	90.02
	NO3 RADIATION ONCOLOGY		0. 1424			90.03
90.04 090	DO4 MUNCIE CLINIC		0. 00000		0	90.04
	005 ANTI COAGULATI ON CLINIC		0. 83822		0	90.05
	006 PREGNANCY PLUS		0. 00000		0	90.06
	007 0/P LAB		0.0000		0	90.07
	008 0/P LAB		0.0000			90.08
	009 FORTVILLE CLINIC		0.0000		0	90.09
	10 1030 S SCATTERFIELD (MEDCHECK)		0.0000		0	90.10
	DII DIABETIC PLUS CLINIC		2.74996		0	90.11
	012 OTHER ONCOLOGY SERVICES		0.0000		0	90.12
	OO EMERGENCY		0. 12653		98, 203	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 1064			92.00
	IER REI MBURSABLE COST CENTERS]
	350 OTHER REIMBURSABLE COST CENTERS		0.0000	0 00	0	98.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			4, 099, 087	921, 992	
	Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201.00
201.00		- (201.00

CALCUL	Financial Systems COMMUNITY HOSPITA ATION OF REIMBURSEMENT SETTLEMENT	AL ANDERSON Provider CCN: 15-0113	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Pre	2552-10 pared:
				5/30/2022 2:5	
		Title XVIII	Hospi tal	PPS	
				1.00	
1.00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0	1.00
1.00	DRG amounts other than outlier payments for discharges occurr	ing prior to October 1	(see	10, 498, 098	
1 00	instructions)		1 (4 242 204	1 00
1. 02	DRG amounts other than outlier payments for discharges occurr instructions)	ing on or after uctober	T (see	4, 242, 394	1. 02
1.03	DRG for federal specific operating payment for Model 4 BPCI f	or discharges occurring	prior to October	0	1.03
1.04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI f	or discharges occurring	on or after	0	1.04
1.04	October 1 (see instructions)	or discharges beedinning		0	1.04
2.00	Outlier payments for discharges. (see instructions)				2.00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instruct	i ons)		0	
2.02	Outlier payments for discharges occurring prior to October 1	-		592, 493	
2.04	Outlier payments for discharges occurring on or after October			171, 988	
3.00	Managed Care Simulated Payments			14, 807, 683	3.00
4.00	Bed days available divided by number of days in the cost repo	rting period (see instru	uctions)	118.35	4.00
5.00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the mos	t recent cost reporting	period ending on	0.00	5.00
5.00	or before 12/31/1996. (see instructions)	t recent cost reporting	period ending on	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet t	he criteria for an add-o	on to the cap for	0.00	6.00
7.00	new programs in accordance with 42 CFR 413.79(e)	under 12 CED \$112 105(f)	(1)(1)(1)(1)	0.00	7.00
7.00	MMA Section 422 reduction amount to the IME cap as specified ACA § 5503 reduction amount to the IME cap as specified under			0.00 0.00	
	cost report straddles July 1, 2011 then see instructions.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
8.00	Adjustment (increase or decrease) to the FTE count for allopa			0.00	8.00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.	79(c)(2)(iv), 64 FR 2634	10 (May 12,		
8.01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap sl	ots under § 5503 of the	ACA. If the cost	0.00	8.01
	report straddles July 1, 2011, see instructions.				
8. 02	The amount of increase if the hospital was awarded FTE cap sl	ots from a closed teachi	ng hospital	0.00	8. 02
9.00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin	es (8 8 01 and 8 02)	(see	0.00	9.00
	instructions)		(000	0.00	,
10.00	FTE count for allopathic and osteopathic programs in the curr	ent year from your recou	-ds	0.00	
11.00	FTE count for residents in dental and podiatric programs.			0.25	
12.00 13.00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.			0. 25 0. 00	
14.00	Total allowable FTE count for the penultimate year if that ye	ar ended on or after Se	otember 30, 1997,	0.16	1
	otherwise enter zero.				
15.00	Sum of lines 12 through 14 divided by 3.			0.14	
16.00	Adjustment for residents in initial years of the program	0.120			16.00
17.00 18.00	Adjustment for residents displaced by program or hospital clo Adjusted rolling average FTE count	sure		0.00 0.14	
	Current year resident to bed ratio (line 18 divided by line 4).		0.001183	
20. 00	Prior year resident to bed ratio (see instructions)	, ,		0. 000000	
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
22.00	IME payment adjustment (see instructions)			0	
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 42.	2 of the MMA		0	22.01
23.00	Number of additional allopathic and osteopathic IME FTE resid		CFR 412.105	0.00	23.00
	(f)(1)(iv)(C).				
24.00	IME FTE Resident Count Over Cap (see instructions)		24 (0.00	
25.00	If the amount on line 24 is greater than -O-, then enter the instructions)	Tower of Time 23 of Time	e 24 (See	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	
28.00	IME add-on adjustment amount (see instructions)	、 、		0	
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	1
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0	1)		0	
27.01	Disproportionate Share Adjustment	·/		0	/. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A p	atient days (see instruc	ctions)	2.66	30.00
31.00	Percentage of Medicaid patient days (see instructions)			25.84	
	Sum of Linco 20 and 21			28.50	32.00
32.00 33.00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions	`		12.73	

ALCUL	I Financial Systems COMMUNITY HOSP LATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0113	Peri od:	Worksheet E	
			From 01/01/2021 To 12/31/2021	Part A Date/Time Pre	nare
			10 12/31/2021	5/30/2022 2:53	3 pm
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
			1.00	2.00	
- 00	Uncompensated Care Adjustment		0.000.014.504	7 400 000 740	0.5
5.00			8, 290, 014, 521		
5.01	Factor 3 (see instructions)	nton zono on this line) (co	0. 000147153		35.
5.02	Hospital uncompensated care payment (If line 34 is zero, el instructions)	inter zero on this rine) (se	e 1, 219, 902	803, 373	35.
5. 03	Pro rata share of the hospital uncompensated care payment a	amount (see instructions)	912, 420	202, 494	35.
6.00	Total uncompensated care (sum of columns 1 and 2 on line 3	,	1, 114, 914		36.
0.00	Additional payment for high percentage of ESRD beneficiary				00.
0. 00	Total Medicare discharges (see instructions)		0		40.
1.00	Total ESRD Medicare discharges (see instructions)		0		41.
1. 01	Total ESRD Medicare covered and paid discharges (see instru	uctions)	0		41.
2.00	Divide line 41 by line 40 (if less than 10%, you do not qu	alify for adjustment)	0.00		42.
3.00	Total Medicare ESRD inpatient days (see instructions)		0		43.
4.00	Ratio of average length of stay to one week (line 43 divid	ed by line 41 divided by 7	0. 000000		44.
	days)				
5.00	Average weekly cost for dialysis treatments (see instruction	-	0.00		45.
6.00		41.01)	0		46.
7.00	Subtotal (see instructions)		17, 089, 003		47.
8.00	Hospital specific payments (to be completed by SCH and MDH	, small rural nospitals	0		48.
	only. (see instructions)			Amount	
				1.00	
9.00	Total payment for inpatient operating costs (see instruction	ons)		17, 089, 003	49
00 .C	Payment for inpatient program capital (from Wkst. L, Pt. I	and Pt. II, as applicable)		1, 198, 466	50
1. 00	Exception payment for inpatient program capital (Wkst. L,	Pt. III, see instructions)		0	51
2.00	Direct graduate medical education payment (from Wkst. E-4,	line 49 see instructions).		4, 755	
3.00	Nursing and Allied Health Managed Care payment			0	53
4.00				768, 134	54.
4.01	Islet isolation add-on payment			0	54.
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lin	-		0	55
6.00 7.00	Cost of physicians' services in a teaching hospital (see in Routine service other pass through costs (from Wkst. D, Pt		arough 25)	0	56 57
8.00	Ancillary service other pass through costs (from Wkst. D, Pt Ancillary service other pass through costs from Wkst. D, P		il ougil 35).	0	58
9.00	Total (sum of amounts on lines 49 through 58)			19, 060, 358	
0.00	3			23, 404	
1.00	Total amount payable for program beneficiaries (line 59 min	nus line 60)		19, 036, 954	
	Deductibles billed to program beneficiaries	<i>`</i>		1, 601, 048	
2.00	Coinsurance billed to program beneficiaries			35, 559	63
	Allowable bad debts (see instructions)			30, 306	64
3. 00				19, 699	65
3.00 4.00 5.00	5			11, 773	66
3.00 4.00 5.00 6.00	Allowable bad debts for dual eligible beneficiaries (see i	nstructions)			
3.00 4.00 5.00 6.00 7.00	Allowable bad debts for dual eligible beneficiaries (see i Subtotal (line 61 plus line 65 minus lines 62 and 63)			17, 420, 046	67
3.00 4.00 5.00 6.00 7.00 3.00	Allowable bad debts for dual eligible beneficiaries (see i Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	or applicable to MS-DRGs (s		0	67 68
3.00 4.00 5.00 6.00 7.00 8.00 9.00	Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96	or applicable to MS-DRGs (s		0	67 68 69
3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00	Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 90 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	or applicable to MS-DRGs (so 6).(For SCH see instruction	5)	0 0 0	67 68 69 70
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 0. 50	Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 90 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon	or applicable to MS-DRGs (so 6).(For SCH see instruction nstration) adjustment (see	5)	0 0 0	67 68 69 70 70
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 0. 50 0. 87	Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fr Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestration	or applicable to MS-DRGs (so 6).(For SCH see instruction nstration) adjustment (see on	5)	0 0 0 0	67 68 69 70 70 70
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 0. 50 0. 87 0. 88	Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fr Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only	or applicable to MS-DRGs (so 6).(For SCH see instruction: nstration) adjustment (see on)	5)	0 0 0	67 68 69 70 70 70 70
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 0. 50 0. 87 0. 88 0. 89	Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fi Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see in	or applicable to MS-DRGs (so 6).(For SCH see instruction: nstration) adjustment (see on) nstructions)	5)	0 0 0 0 0	67 68 69 70 70 70 70 70
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 0. 50 0. 87 0. 88 0. 89 0. 90	Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 90 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions)	or applicable to MS-DRGs (so 6).(For SCH see instruction: nstration) adjustment (see on) nstructions))	5)	0 0 0 0 0 0	67 68 70 70 70 70 70 70
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 0. 50 0. 87 0. 88 0. 89 0. 90 0. 91	Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (\$410A Demon Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	or applicable to MS-DRGs (so 6).(For SCH see instruction: nstration) adjustment (see on) nstructions))	5)	0 0 0 0 0 0 0	67 68 69 70 70 70 70 70 70 70
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 0.50 0.87 0.88 0.89 0.90 0.91 0.92 0.93	Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	or applicable to MS-DRGs (so 6).(For SCH see instruction: nstration) adjustment (see on) nstructions))	5)	0 0 0 0 0 0 0	67. 68. 69. 70. 70. 70. 70. 70. 70. 70. 70.
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 0. 50 0. 87 0. 88 0. 89 0. 90 0. 91	Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	or applicable to MS-DRGs (so 6).(For SCH see instruction: nstration) adjustment (see on) nstructions))	5)	0 0 0 0 0 0 0	67. 68. 69. 70. 70. 70. 70. 70. 70. 70. 70. 70.

	Provider C	CN: 15-0113	In Lie Period:	Worksheet E	
			From 01/01/2021 To 12/31/2021	Part A Date/Time Pre 5/30/2022 2:5	
	Title	XVIII	Hospi tal	PPS	<u>.</u>
		FFY	(уууу)	Amount	
96 Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0	1.00	70
the corresponding federal year for the period prior to 10/1)					
97 Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period ending on or af			0	0	70
98 Low Volume Payment-3				0	70
99 HAC adjustment amount (see instructions)				52, 950	
00 Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			17, 308, 743	
01 Sequestration adjustment (see instructions)				0	
02 Demonstration payment adjustment amount after sequestration 03 Sequestration adjustment-PARHM pass-throughs				0	71 71
00 Interim payments				16, 917, 574	
01 Interim payments-PARHM				10, 917, 574	72
00 Tentative settlement (for contractor use only)				0	
01 Tentative settlement-PARHM (for contractor use only)				0	73
00 Balance due provider/program (line 71 minus lines 71.01, 71.0	2 72 and			391, 169	
73)	2, , 2, and			0,1,10,	
01 Balance due provider/program-PARHM (see instructions)					74
00 Protested amounts (nonallowable cost report items) in accorda	nce with			286, 369	75
CMS Pub. 15-2, chapter 1, §115.2					
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90
plus 2.04 (see instructions)					
00 Capital outlier from Wkst. L, Pt. I, line 2				0	91
00 Operating outlier reconciliation adjustment amount (see instr				0	92
00 Capital outlier reconciliation adjustment amount (see instruc 00 The rate used to calculate the time value of money (see instr				0.00	93
00 The rate used to calculate the time value of money (see instr 00 Time value of money for operating expenses (see instructions)				0.00	94
00 Time value of money for capital related expenses (see fist detrois)	tions)			0	
		1	Prior to 10/1		
			1.00	2.00	
HSP Bonus Payment Amount				0	1.00
. 00 HSP bonus amount (see instructions)			0	0	100
HVBP Adjustment for HSP Bonus Payment					
00 HV/PD adjustment factor (coo instructions)			0,000000000	0.000000000	1101
.00 HVBP adjustment factor (see instructions)	c)		0. 000000000	0.000000000	
.00 HVBP adjustment amount for HSP bonus payment (see instruction	s)		0.0000000000000000000000000000000000000		
.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment	s)		0	0	102
. 00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment . 00 HRR adjustment factor (see instructions)			0.0000	0.0000	102 103
 .00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment .00 HRR adjustment factor (see instructions) .00 HRR adjustment amount for HSP bonus payment (see instructions)	stment	0	0.0000	102 103
 .00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment .00 HRR adjustment factor (see instructions) .00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst) ration) Adju		0.0000	0.0000	102 103 104
 .00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment .00 HRR adjustment factor (see instructions) .00 HRR adjustment amount for HSP bonus payment (see instructions) ration) Adju		0.0000	0.0000	102 103 104
 .00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment .00 HRR adjustment factor (see instructions) .00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst .00 Is this the first year of the current 5-year demonstration pe) ration) Adju		0.0000	0.0000	102 103 104
 .00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment .00 HRR adjustment factor (see instructions) .00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 100 Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement .00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin) ration) Adju riod under t		0.0000	0.0000	10: 10: 10: 20(
 .00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment .00 HRR adjustment factor (see instructions) .00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 1s this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement .00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin .00 Medicare discharges (see instructions)) ration) Adju riod under t		0.0000	0.0000	102 102 104 200 207 202
 .00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment .00 HRR adjustment factor (see instructions) .00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst .00 Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement .00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin .00 Medicare discharges (see instructions) .00 Case-mix adjustment factor (see instructions)) ration) Adju riod under t e 49)	he 21st	0.0000	0.0000	10: 10: 10: 20: 20:
 .00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment .00 HRR adjustment factor (see instructions) .00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst .00 Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement .00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin .00 Medicare discharges (see instructions) .00 Case-mix adjustment factor (see instructions) .00 Computation of Demonstration Target Amount Limitation (N/A in) ration) Adju riod under t e 49)	he 21st	0.0000	0.0000	102 103 104 200 201 202
 .00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment .00 HRR adjustment factor (see instructions) .00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst .00 Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement .00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin .00 Medicare discharges (see instructions) .00 Case-mix adjustment factor (see instructions) .00 Case-mix adjustment factor (see instructions) .00 Case-mix adjustment factor (see instructions)) ration) Adju riod under t e 49)	he 21st	0.0000	0 0.0000 0	102 103 104 200 201 202 203
 .00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment .00 HRR adjustment factor (see instructions) .00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst .00 Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement .00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin .00 Medicare discharges (see instructions) .00 Case-mix adjustment factor (see instructions) .00 Computation of Demonstration Target Amount Limitation (N/A in period) .00 Medicare target amount) ration) Adju riod under t e 49)	he 21st	0.0000	0 0.0000 0	102 103 104 200 201 202 203
 .00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment .00 HRR adjustment factor (see instructions) .00 HRR adjustment factor (see instructions) .00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst .00 Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement .00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin .00 Medicare discharges (see instructions) .00 Case-mix adjustment factor (see instructions) .00 Case target amount .00 Medicare target amount .00 Medicare target amount .00 Kase-mix adjusted target amount (line 203 times line 204)) ration) Adju riod under t e 49)	he 21st	0.0000	0 0.0000 0	102 103 104 200 201 202 203 204 204
 .00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment .00 HRR adjustment factor (see instructions) .00 HRR adjustment factor (see instructions) .00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst .00 Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement .00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin .00 Medicare discharges (see instructions) .00 Case-mix adjustment factor (see instructions) .00 Case target amount .00 Medicare target amount .00 Medicare inpatient routine cost cap (line 202 times line 204) .00 Medicare inpatient routine cost cap (line 202 times line 205)) ration) Adju riod under t e 49)	he 21st	0.0000	0 0.0000 0	102
 .00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment .00 HRR adjustment factor (see instructions) .00 HRR adjustment factor (see instructions) .00 HRR adjustment for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 100 Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement .00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin 00 Medicare discharges (see instructions) .00 Case-mix adjustment factor (see instructions) .00 Case-mix adjustment factor (see instructions) .00 Medicare target amount .00 Medicare inpatient current 5-year target Amount Limitation (N/A in period) .00 Medicare inpatient routine cost cap (line 202 times line 204) .00 Medicare to Medicare Part A Inpatient Reimbursement) ration) Adju riod under t e 49) first year	he 21st	0.0000	0 0.0000 0	102 103 104 200 201 202 203 204 205 206
 .00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment .00 HRR adjustment factor (see instructions) .00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement .00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin 00 Medicare discharges (see instructions) .00 Gase-mix adjustment factor (see instructions) .00 Medicare target amount .00 Medicare target amount .00 Medicare inpatient routine cost cap (line 203 times line 204) .00 Medicare inpatient routine cost cap (line 202 times line 205) .00 Adjustment to Medicare Part A Inpatient Reimbursement .00 Program reimbursement under the §410A Demonstration (see instruction (see instruction)) ration) Adju riod under t e 49) first year ructions)	he 21st	0.0000	0 0.0000 0 :rati on	102 103 104 200 201 202 203 204 205 206 207
 .00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment factor (see instructions) .00 HRR adjustment factor (see instructions) .00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement .00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin 00 Medicare discharges (see instructions) .00 Case-mix adjustment factor (see instructions) .00 Case-mix adjustment factor (see instructions) .00 Medicare target amount .00 Medicare target amount .00 Medicare target amount .00 Medicare inpatient routine cost cap (line 202 times line 204) .00 Medicare Part A inpatient Reimbursement .00 Program reimbursement under the \$410A Demonstration (see instruction)) ration) Adju riod under t e 49) first year ructions)	he 21st	0.0000	0 0.0000 0	102 103 104 200 201 202 203 204 205 206 207 208
 .00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment .00 HRR adjustment factor (see instructions) .00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement .00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin 00 Medicare discharges (see instructions) .00 Gase-mix adjustment factor (see instructions) .00 Medicare target amount .00 Medicare target amount .00 Medicare inpatient routine cost cap (line 203 times line 204) .00 Medicare inpatient routine cost cap (line 202 times line 205) .00 Adjustment to Medicare Part A Inpatient Reimbursement .00 Program reimbursement under the §410A Demonstration (see instruction (see instruction)) ration) Adju riod under t e 49) first year ructions)	he 21st	0.0000	0.0000 0	102 103 104 200 201 202 203 204 205 206 207 208 207
 .00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment factor (see instructions) .00 HRR adjustment factor (see instructions) .00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 00 Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement .00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin 00 Medicare discharges (see instructions) .00 Case-mix adjustment factor (see instructions) .00 Case-mix adjustment factor (see instructions) .00 Medicare target amount .00 Medicare target amount .00 Case-mix adjusted target amount (line 203 times line 204) .00 Medicare inpatient on Medicare Part A Inpatient Reimbursement .00 Program reimbursement under the §410A Demonstration (see instructions) .00 Adjustment to Medicare IPPS payments (see instructions)) ration) Adju riod under t e 49) first year ructions)	he 21st	0.0000	0.0000 0	102 103 104 200 202 202 203 204 205 206 207 208 207 208 209 210
 .00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment .00 HRR adjustment factor (see instructions) .00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst .00 Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. .00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin .00 Medicare discharges (see instructions) .00 Case-mix adjustment factor (see instructions) .00 Case-mix adjustment factor (see instructions) .00 Medicare target amount .00 Medicare target amount .00 Medicare inpatient routine cost cap (line 203 times line 204) .00 Medicare Part A Inpatient Reimbursement .00 Program reimbursement under the §410A Demonstration (see instructions) .00 Program reimbursement under the Success (from Wkst. E, Pt. A, .00 Adjustment to Medicare IPPS payments (see instructions)) ration) Adju riod under t e 49) first year ructions)	he 21st	0.0000	0.0000 0	102 103 104 200 201 202 203 204 205 206
 .00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment .00 HRR adjustment factor (see instructions) .00 HRR adjustment factor (see instructions) .00 HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Rural Community Hospital Demonstration Project (§410A Demonst .00 Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement .00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin .00 Medicare discharges (see instructions) .00 Case-mix adjustment factor (see instructions) .00 Case-mix adjustment for the cost cap (line 203 times line 204) .00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement .00 Program reimbursement under the §410A Demonstration (see inst .00 Program to Medicare IPPS payments (see instructions) .00 Reserved for future use .00 Total adjustment to Medicare IPPS payments (see instructions)) ration) Adju riod under t e 49) first year ructions) line 59)	he 21st	0.0000	0.0000 0	102 103 104 200 202 202 203 204 205 206 207 208 207 208 209 210
 .00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment .00 HRR adjustment factor (see instructions) .00 HRR adjustment factor (see instructions) .00 HRR adjustment for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement .00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin 00 Medicare discharges (see instructions) .00 Case-mix adjustment factor (see instructions) .00 Case-mix adjustment factor (see instructions) .00 Case-mix adjusted target amount (line 203 times line 204) .00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement .00 Program reimbursement under the §410A Demonstration (see instructions) .00 Reserved for future use .00 Total adjustment to Medicare IPPS payments (see instructions)) ration) Adju riod under t e 49) first year ructions) line 59)	he 21st	0.0000	0 0.0000 0 :rati on	102 103 104 200 201 202 203 204 205 206 207 208 209 210 211

	Financial Systems COMMUNITY HOSPITA ATION OF REIMBURSEMENT SETTLEMENT	AL ANDERSON Provider CCN: 15-0113	Peri od:	worksheet E	2552-10
			From 01/01/2021 To 12/31/2021	Part B Date/Time Pre	
		Title XVIII	Hospi tal	5/30/2022 2: 5 PPS	3 pm
				1 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			9,870	
2.00 3.00	Medical and other services reimbursed under OPPS (see instruc OPPS payments	tions)		17, 986, 790 13, 222, 830	
4.00	Outlier payment (see instructions)			206, 999	4.00
4.01 5.00	Outlier reconciliation amount (see instructions)	ctionc)		0.000	4.01 5.00
5.00 6.00	Enter the hospital specific payment to cost ratio (see instru Line 2 times line 5	ctrons)		0.000	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	IV col 12 lino 200		0	
9.00 10.00	Organ acquisitions	TV, COL. 13, THE 200		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			9, 870	
	COMPUTATION OF LESSER OF COST OR CHARGES				
12.00	Reasonable charges Ancillary service charges			35, 002	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)			35, 002	14.00
15.00	Customary charges 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 fo			0	16.00
17 00	had such payment been made in accordance with 42 CFR §413.13(e)		0. 000000	17 00
17.00 18.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			35, 002	
19.00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see	25, 132	1
20. 00	instructions)	ly if line 11 exceeds li	no 19) (coo	0	20.00
20.00	Excess of reasonable cost over customary charges (complete on instructions)	i y i i i i exceeds i i	The To) (See	0	20.00
21.00	Lesser of cost or charges (see instructions)				21.00
22.00 23.00	Interns and residents (see instructions) 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)			13, 429, 829	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	```			
25.00 26.00	Deductibles and coinsurance amounts (for CAH, see instruction Deductibles and Coinsurance amounts relating to amount on lin	-	uctions)	991 2, 290, 903	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)		,	11, 147, 805	
	instructions)				
28.00 29.00	Direct graduate medical education payments (from Wkst. E-4, I ESRD direct medical education costs (from Wkst. E-4, line 36)	-		3, 445	
30.00	Subtotal (sum of lines 27 through 29)			11, 151, 250	•
31.00	Primary payer payments			7, 156	
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	(FS)		11, 144, 094	32.00
33.00	Composite rate ESRD (from Wkst. 1-5, line 11)	623)		0	33.00
34.00	Allowable bad debts (see instructions)			187, 617	
35.00 36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		121, 951 181, 726	35.00 36.00
37.00	Subtotal (see instructions)			11, 266, 045	
38.00	MSP-LCC reconciliation amount from PS&R			-101	
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	c)		0	39.00 39.50
39.90	Demonstration payment adjustment amount before sequestration	3)		0	
39. 98	Partial or full credits received from manufacturers for repla	ced devices (see instruc	tions)	0	39. 98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			11, 266, 146	40.00
40. 02	Demonstration payment adjustment amount after sequestration			0	1
40.03	Sequestration adjustment-PARHM pass-throughs			11 570 255	40.03
41.00 41.01	Interim payments Interim payments-PARHM			11, 579, 355	41.00
42.00	Tentative settlement (for contractors use only)			0	1
42.01	Tentative settlement-PARHM (for contractor use only)			010.000	42.01
43.00 43.01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			-313, 209	43.00 43.01
44.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	20, 659	1
					l
90 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
90.00 91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money			0.00	
93.00 94.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93.00 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CC	CN: 15-0113	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part I Date/Time Prep 5/30/2022 2:53	
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	тв	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		16, 917, 57	74 0	11, 579, 355 0	1. (2. (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					5.0
01	ADJUSTMENTS TO PROVIDER			0	0	3.0
02				0	0	3.0
03				0	0	3.
04 05				0	0	3. 3.
05	Provider to Program			0	0	3.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52				0	0	3.
53				0	0	3.
54				0	0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		16, 917, 57	74	11, 579, 355	4.
00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.
00	desk review. Al so show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.
01	TENTATI VE TO PROVI DER			0	0	5.
)2				0	0	5.
)3				0	0	5
	Provider to Program	1				_
0	TENTATI VE TO PROGRAM			0	0	5.
51 52				0	0	5. 5.
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
00	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		391, 16	59	0	6.
)2	SETTLEMENT TO PROGRAM		0, 1, 10	0	313, 209	6.
00	Total Medicare program liability (see instructions)		17, 308, 74	43	11, 266, 146	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
		-)	1.00	2.00	

Heal th	Financial Systems CO	IMUNI TY HOSPI TAL ANDERSON	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0113	Period: From 01/01/2021	Worksheet E-1 Part II	
			To 12/31/2021	Date/Time Pre 5/30/2022 2:5	
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD C				1
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION A				4
1.00	Total hospital discharges as defined in AARA §4				1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of		for cost		2.00
	reporting periods beginning on or after 10/01/2				
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6				3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8,		d plus for cost		4.00
	reporting periods beginning on or after 10/01/2				
5.00	Total hospital charges from Wkst C, Pt. I, col.				5.00
6.00	Total hospital charity care charges from Wkst.				6.00
7.00	CAH only - The reasonable cost incurred for the line 168	purchase of certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see i	nstructions)			8.00
9.00	Sequestration adjustment amount (see instruction	ns)			9.00
10.00	Calculation of the HIT incentive payment after	sequestration (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CA	4			
30.00	Initial/interim HIT payment adjustment (see ins	tructions)			30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus	line 30 and line 31) (see instruction	ns)		32.00

	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CC	CN: 15-0113	Period: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Pre	pared:
		Title	XVIII	Hospi tal	5/30/2022 2:5 PPS	3 pm
					1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
. 00	Unweighted resident FTE count for allopathic and osteopathic pr ending on or before December 31, 1996.	rograms for	cost reporti	ng periods	0.00	1.00
. 00	Unweighted FTE resident cap add-on for new programs per 42 CFR	413.79(e)(1) (see instr	ructions)	0.00	
. 00 . 01	Amount of reduction to Direct GME cap under section 422 of MMA Direct GME cap reduction amount under ACA §5503 in accordance w	with 42 CFR	8413 79 (m)	(see	0.00	
. 00	instructions for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and os		,		0.00	
. 01	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)) ACA Section 5503 increase to the Direct GME FTE Cap (see instru straddling 7/1/2011)	uctions for	cost reporti	ng periods	0.00	4.0
. 02	ACA Section 5506 number of additional direct GME FTE cap slots	(see inst	ructions for	cost reporting	0.00	4.0
5.00	periods straddling 7/1/2011) FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus 4.02 plus applicable subscripts	s or minus	line 4 plus l	ines 4.01 and	0.00	5.00
o. 00	Unweighted resident FTE count for allopathic and osteopathic pr records (see instructions)	rograms for	the current	year from your	0.00	
. 00	Enter the lesser of line 5 or line 6		Primary Care	e Other	0.00 Total	7.0
			1.00	2.00	3.00	
8. 00	Weighted FTE count for physicians in an allopathic and osteopat program for the current year.	thic	0.0	0.00	0.00	8.0
. 00	If line 6 is less than 5 enter the amount from line 8, otherwis multiply line 8 times the result of line 5 divided by the amour		0.0	0.00	0.00	9.0
0. 00	6. Weighted dental and podiatric resident FTE count for the currer	nt year		0. 25		10.0
0.01	Unweighted dental and podiatric resident FTE count for the curr	rent year		0.00		10.0
1.00 2.00	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting	vear (see	0. (0. (11.0
3.00	instructions) Total weighted resident FTE count for the penultimate cost repo		0. (13. 0
4.00	year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided b	ov 3).	0. (0. 14		14. (
5.00	Adjustment for residents in initial years of new programs		0.0			15.0
5.01	Unweighted adjustment for residents in initial years of new pro		0. (15.0
6. 00 6. 01	Adjustment for residents displaced by program or hospital closu Unweighted adjustment for residents displaced by program or hos closure		0. (0. (16. (16. (
7.00	Adjusted rolling average FTE count		0.0			17.0
8.00 9.00	Per resident amount Approved amount for resident costs		97, 625. 9	92 97, 625. 92 0 13, 668	13, 668	18.0
0.00	Additional unweighted allopathic and osteopathic direct GME FTE	- resident	cap slots red	ceived under 42	1.00	20.0
	Sec. 413.79(c)(4)					
1.00	Direct GME FTE unweighted resident count over cap (see instruct				0.00	
2.00 3.00	Allowable additional direct GME FTE Resident Count (see instruct Enter the locality adjustment national average per resident amount		nstructions)		0.00 0.00	
4.00	Multiply line 22 time line 23				0.00	
5.00	Total direct GME amount (sum of lines 19 and 24)				13, 668	25.0
			Inpatient Par A	rt Managed Care	Total	
			1.00	2.00	3.00	
6. 00	COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, 3.02, column 2)	line	7, 23	35 8, 159		26.0
7.00	Total Inpatient Days (see instructions)		25, 10			27.0
8.00	Ratio of inpatient days to total inpatient days		0. 2882			28.0
9.00	Program direct GME amount Percent reduction for MA DCME		3, 93		8, 381	29.0 29.0
9.01	Percent reduction for MA DGME Reduction for direct GME payments for Medicare Advantage			4.07 181	181	
	Net Program direct GME amount			.51	8, 200	

Heal th	Financial Systems COMMUNITY F	IOSPI TA	L ANDERSON	In Lie	u of Form CMS-2	2552-10
DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRE	CT	Provider CCN: 15-0113	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS			From 01/01/2021 To 12/31/2021	Data /Tima Dra	oorod.
				To 12/31/2021	Date/Time Pre 5/30/2022 2:53	
			Title XVIII	Hospi tal	PPS	
					1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE	- TITLE	XVIII ONLY (NURSING PR	OGRAM AND PARAMED	OI CAL	
	EDUCATION COSTS)					
32.00	Renal dialysis direct medical education costs (from Wks	t. B, F	Pt. I, sum of col. 20 an	d 23, lines 74	0	32.00
	and 94)					
33.00	Renal dialysis and home dialysis total charges (Wkst. C			74 and 94)	813, 372	
34.00	Ratio of direct medical education costs to total charge	s (line	e 32 ÷ line 33)		0.00000	
35.00	Medicare outpatient ESRD charges (see instructions)				0	35.00
36.00	Medicare outpatient ESRD direct medical education costs				0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE	XVIII	ONLY			
	Part A Reasonable Cost				04.050.000	
37.00	Reasonable cost (see instructions)	(0)			24, 853, 038	
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, li				0	38.00
39.00	Cost of physicians' services in a teaching hospital (se	e insti	ructions)		0	39.00
40.00	Primary payer payments (see instructions)				23, 404	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 3 Part B Reasonable Cost	9 minus	s Tine 40)		24, 829, 634	41.00
42.00	Reasonable cost (see instructions)				17, 996, 660	42.00
42.00	Primary payer payments (see instructions)				7, 156	42.00 43.00
43.00	Total Part B reasonable cost (line 42 minus line 43)				17, 989, 504	
44.00	Total reasonable cost (sum of lines 41 and 44)				42, 819, 138	
45.00	Ratio of Part A reasonable cost to total reasonable cost	t (lind	$11 \div 1$ in (45)		0. 579872	
40.00		•	,		0. 420128	40.00
-7.00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A	<u>``</u>	,		0.420120	ч <i>1</i> .00
48.00					8, 200	48.00
	Part A Medicare GME payment (line 46 x 48) (title XVIII	onl v)	(see instructions)		4, 755	
	Part B Medicare GME payment (line 40 x 40) (title XVIII					50.00
00.00		J J)			5, 445	00.00

LANC	<u>Financial Systems</u> E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	CN: 15-0113	Period: From 01/01/2021	worksheet G	
nly)				To 12/31/2021	Date/Time Pre 5/30/2022 2:5	pare 3 pm
		General Fund	Specific Purpose Func		Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	336, 087		0 0	0	1 1
00	Temporary investments	0		0 0	0	2
00	Notes receivable	0		0 0	0	3
00	Accounts receivable	63, 869, 873		0 0	0	4
00	Other receivable	-37, 586, 192		0 0	0	5
00	Allowances for uncollectible notes and accounts receivable	3, 429, 146		0 0	0	6
00	Inventory	3, 680, 662		0 0	0	7
00	Prepaid expenses	71, 159		0 0	0	8
00	Other current assets	149, 093		0 0	0	9
. 00	Due from other funds	0		0 0	0	10
. 00	Total current assets (sum of lines 1-10)	33, 949, 828		0 0	0	11
	FIXED ASSETS			- (
. 00	Land	6, 280, 153		0 0	0	
. 00	Land improvements	2,007,545		0 0	0	13
. 00	Accumulated depreciation	0		0 0	0	14
	Buildings	78, 186, 026		0 0	0	15
. 00	Accumulated depreciation	0		0 0	0	16
. 00	Leasehold improvements	2, 763, 325		0 0	0	17
. 00	Accumulated depreciation	0		0 0	0	18
	Fixed equipment	78, 296, 815		0 0	0	19
0. 00	Accumulated depreciation			0 0	0	20
	Automobiles and trucks	1, 033, 859		0 0	0	21
	Accumulated depreciation			0 0	0	22
	Major movable equipment			0 0	0	23
	Accumulated depreciation Minor equipment depreciable	-115, 086, 776		0 0	0	24
	Accumulated depreciation			0 0	0	26
	HIT designated Assets			0 0	0	27
	Accumulated depreciation			0 0	0	
	Mi nor equi pment-nondepreci abl e			0 0	0	
	Total fixed assets (sum of lines 12-29)	53, 480, 947		0 0	0	
. 00	OTHER ASSETS	55, 460, 947		0 0	0	1 30
. 00	Investments	393, 175		0 0	0	31
2.00	Deposits on Leases	0,1,0		0 0	0	32
8.00	Due from owners/officers			0 0	0	33
. 00	Other assets	220, 078, 802		0 0	0	34
5.00	Total other assets (sum of lines 31-34)	220, 471, 977		0 0	0	35
b. 00	Total assets (sum of lines 11, 30, and 35)	307, 902, 752		0 0	0	
. 00	CURRENT LI ABI LI TI ES	007,702,702		0 0	Ŭ	1 00
00	Accounts payable	923, 864		0 0	0	37
3.00	Salaries, wages, and fees payable	0		0 0	0	38
0.00	Payroll taxes payable	0		0 0	0	
. 00	Notes and Loans payable (short term)	0		0 0	0	
	Deferred income	0		0 0	0	
	Accelerated payments	0				42
	Due to other funds	0		0 0	0	
	Other current liabilities	10, 365, 401		0 0	0	
	Total current liabilities (sum of lines 37 thru 44)	11, 289, 265		0 0	0	45
	LONG TERM LIABILITIES					
. 00	Mortgage payable	0		0 0	0	46
. 00	Notes payable	0		0 0	0	47
3. 00	Unsecured Loans	0		0 0	0	48
00 .	Other long term liabilities	3, 377, 036		0 0	0	49
0. 00	Total long term liabilities (sum of lines 46 thru 49)	3, 377, 036		0 0	0	50
. 00	Total liabilities (sum of lines 45 and 50)	14, 666, 301		0 0	0	51
	CAPI TAL ACCOUNTS	_	_			
. 00	General fund balance	293, 236, 451				52
. 00	Specific purpose fund			0		53
. 00	Donor created - endowment fund balance - restricted			0		54
5.00	Donor created - endowment fund balance - unrestricted			0		55
. 00	Governing body created - endowment fund balance			0		56
. 00	Plant fund balance - invested in plant				0	57
8. 00	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion					
0. 00	Total fund balances (sum of lines 52 thru 58)	293, 236, 451		0 0	0	
). 00	Total liabilities and fund balances (sum of lines 51 and	307, 902, 752		0 0	0	60

Heal th	Financial Systems	COMMUNI TY HOSPI	TAL ANDERSON			In Lie	u of Form CMS	-25	552-10
STATEN	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0113		eriod: com 01/01/2021 o 12/31/2021	Worksheet G- Date/Time Pr 5/30/2022 2:	ера	
		General	Fund	Speci al	Pui	rpose Fund	Endowment Fun	d	
								+	
1 00	Fund hal ansas at haginning of pariod	1.00	2.00	3.00		4.00	5.00		1 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)		287, 731, 700 5, 504, 751 293, 236, 451 0 293, 236, 451 0 293, 236, 451		0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0		0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 17.\ 00\\ 18.\ $
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		293, 236, 451			0			19.00
		Endowment Fund	PI ant	Fund					
		6.00	7.00	8.00					
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0 0		0				1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0	0 0 0 0 0 0		0 0 0 0				10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

	Financial Systems COMMUNITY HOSPIT IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	N: 15-0113	Peri od:	Worksheet G-2	2552-10
o mi Ei				From 01/01/2021 To 12/31/2021	Parts I & II	pared:
	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		35, 839, 1	39	35, 839, 139	
2.00	SUBPROVIDER - IPF					2.00
3.00 4.00	SUBPROVIDER - IRF					3.00
4.00 5.00	SUBPROVI DER Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY			0	0	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)		35, 839, 1	39	35, 839, 139	
	Intensive Care Type Inpatient Hospital Services		00700771		00,00,10,	1
11.00	INTENSIVE CARE UNIT		18, 388, 5	90	18, 388, 590	11.00
12.00	CORONARY CARE UNI T					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum o	flines	18, 388, 5	90	18, 388, 590	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 1	6)	54, 227, 7		54, 227, 729	
18.00	Ancillary services		187, 906, 8			
19.00	Outpatient services			0 0		
20.00	RURAL HEALTH CLINIC			0 0		
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	
22.00 23.00	HOME HEALTH AGENCY AMBULANCE SERVI CES					22.00
23.00	CMHC					23.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					24.00
26.00	HOSPICE					26.00
27.00	OTHER (SPECIFY)			0	0	
28.00	Total patient revenues (sum of lines 17-27)(transfer column	3 to Wkst	242, 134, 5	90 474, 114, 023		
20.00	G-3, line 1)		212/101/0	, , , , , , , , , , , , , , , , , , , ,	, 10, 210, 010	20.00
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			243, 891, 585		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECI FY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00	Tatal deductions (sum of lines 27 (1)			0		41.00
42.00 43.00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line -	(12) (transfor		243, 891, 585		42.00
4J. UU	to Wkst. G-3, line 4)	42) (LI dHSI eF		243, 871, 585	1	43.00

Heal th	Financial Systems	COMMUNI TY HOSPI TAI	_ ANDERSON	In Lie	u of Form CMS-2	2552-10
STATE	MENT OF REVENUES AND EXPENSES		Provider CCN: 15-0113	Peri od:	Worksheet G-3	
				From 01/01/2021 To 12/31/2021	Date/Time Pre	nared
				10 12/31/2021	5/30/2022 2:5	
					1.00	
1.00	Total patient revenues (from Wkst. G-2, Par				716, 248, 613	
2.00	Less contractual allowances and discounts o	n patients' account	S		510, 589, 116	2.00
3.00	Net patient revenues (line 1 minus line 2)				205, 659, 497	3.00
4.00	Less total operating expenses (from Wkst. G		3)		243, 891, 585	4.00
5.00	Net income from service to patients (line 3	minus line 4)			-38, 232, 088	5.00
(00	OTHER INCOME				142.240	(00
6.00 7.00	Contributions, donations, bequests, etc Income from investments				143, 240 34, 364, 371	6.00 7.00
7.00 8.00	Revenues from telephone and other miscellan	aque communication	convi coc		34, 364, 371	7.00 8.00
8.00 9.00	Revenue from tel evision and radio service		Services		0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13.00
14.00	Revenue from meals sold to employees and gu	lests			846, 641	14.00
15.00					0 10, 0 11	15.00
16.00		supplies to other th	nan patients		0	16.00
17.00					0	17.00
18.00					337, 381	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				2, 395, 202	22.00
23.00	Governmental appropriations				0	23.00
24.00	MI SC REVENUE				1, 068, 547	24.00
	COVI D-19 PHE Fundi ng				4, 581, 457	
25.00	. , ,				43, 736, 839	
26.00					5, 504, 751	
27.00					0	27.00
					0	28.00
29.00	Net income (or loss) for the period (line 2	6 minus line 28)			5, 504, 751	29.00

CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0113	Peri od:	Worksheet L	
			From 01/01/2021 To 12/31/2021	Parts I-III Date/Time Pre 5/30/2022 2:55	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT			1 117 000	
. 00	Capital DRG other than outlier			1, 117, 993	
. 01	Model 4 BPCI Capital DRG other than outlier			0	
2.00	Capital DRG outlier payments			13, 393 0	
2.01 3.00	Model 4 BPCI Capital DRG outlier payments	et reporting pariod (can inct	ructions)	69.21	2. 3.
1.00	Total inpatient days divided by number of days in the co Number of interns & residents (see instructions)	st reporting period (see thst	ructions)	09.21	
F. 00 5. 00	Indirect medical education percentage (see instructions)			0.14	
5.00	Indirect medical education percentage (see fistilicitors)		columns 1 and	671	6.
5.00	1.01) (see instructions)	y the sum of times I and 1.01		071	0.
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line				7.
	30) (see instructions)				
8.00	Percentage of Medicaid patient days to total days (see i	nstructions)		25.84	
00 .	Sum of lines 7 and 8			28.50	
	Allowable disproportionate share percentage (see instruc	tions)		5.94	
11.00	Disproportionate share adjustment (see instructions)			66, 409	
12.00	Total prospective capital payments (see instructions)			1, 198, 466	12.
				1.00	
	PART II - PAYMENT UNDER REASONABLE COST			1100	
1.00	Program inpatient routine capital cost (see instructions			0	1.
2.00	Program inpatient ancillary capital cost (see instructio	ins)		0	2.
3.00	Total inpatient program capital cost (line 1 plus line 2			0	3.
4.00	Capital cost payment factor (see instructions)			0	4.
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5.
				1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
. 00	Program inpatient capital costs (see instructions)			0	1 1.
2.00	Program inpatient capital costs for extraordinary circum	stances (see instructions)		0	2.
3.00	Net program inpatient capital costs (line 1 minus line 2			0	
4.00	Applicable exception percentage (see instructions)	, ,		0.00	
5.00	Capital cost for comparison to payments (line 3 x line 4			0	
5.00	Percentage adjustment for extraordinary circumstances (s			0.00	
. 00	Adjustment to capital minimum payment level for extraord		line 6)	0	7.
3.00	Capital minimum payment level (line 5 plus line 7)	•		0	8.
9.00	Current year capital payments (from Part I, line 12, as	appl i cabl e)		0	9.
0.00	Current year comparison of capital minimum payment level	to capital payments (line 8	less line 9)	0	10.
11.00	Carryover of accumulated capital minimum payment level o	ver capital payment (from pri	or year	0	11.
	Worksheet L, Part III, line 14)				
	Net comparison of capital minimum payment level to capit				12.
12 00	Current year averation normant (if line 12 is positive			0	1 1 2

- 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)
 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line)
 14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period 13.00 0 14.00 0 (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions)
 16.00 Current year operating and capital costs (see instructions)
 17.00 Current year exception offset amount (see instructions) 0 15.00 0 16.00 0 17.00