This report is	required by law (42 USC 1395g; 42 CFR 413.20(b)). Fai	lure to report can resul	t in all interim	FORM APPROVED
payments made	since the beginning of the cost reporting period being	deemed overpayments (42	2 USC 1395g).	OMB NO. 0938-0050
				EXPIRES 05-31-2019
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION SUMMARY	Provi der CCN: 15-0169	Peri od: From 01/01/2016 To 12/31/2016	
PART I - COST	REPORT STATUS			
Provi der	1. [ X ] Electronically filed cost report		Date: 5/30/20	17 Time: 10:03 am
use only	2. [ ] Manually submitted cost report			
	3. [ 0 ]If this is an amended report enter the number 4. [ F ]Medicare Utilization. Enter "F" for full or "L		esubmitted this co	ost report
Contractor use only	5. [ 1 ]Cost Report Status 6. Date Received:     (1) As Submitted 7. Contractor No.     (2) Settled without Audit 8. [ N ] Initial Report for     (3) Settled with Audit 9. [ N ] Final Report for     (4) Reopened     (5) Amended	11. Cor this Provider CCN 12. [		

## PART II - CERTIFICATION

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

## CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPITAL OF INDIANA, INC. (15-0169) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)	Officer or Administrator of Provider(s)
	Ti tl e

Date

			Title XVIII				
Cost Center Description		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-407, 499	-26, 757	0	0	1. 00
2.00	Subprovi der - IPF	0	850	1, 144		0	2. 00
3.00	Subprovi der - I RF	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	-406, 649	-25, 613	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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0169 Peri od: Worksheet S-2 From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/30/2017 8:54 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 7150 CLEARVISTA DRIVE 1.00 PO Box: 1.00 2.00 City: INDIANAPOLIS State: IN Zip Code: 46256 County: MARION 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 COMMUNITY HOSPITAL OF 150169 26900 02/25/2008 Ν Р Р 3.00 1 NDIANA, INC. Subprovider - IPF COMMUNITY MENTAL HEALTH Р 4.00 15S169 26900 4 01/01/2010 N 0 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2016 12/31/2016 20.00 21.00 Type of Control (see instructions) 21.00 2 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 γ N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Ν Υ 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result N N 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 3 Ν 23 00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" "N" fo<u>r no</u>. used in the prior cost reporting period? In column 2 for yes or In-State Out-of Medi cai d Other In-State Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days paid days el i gi bl e unpai d days unpai d 1.00 2.00 3.00 4.00 5. 00 6.00 1, 177 24.00 If this provider is an IPPS hospital, enter the 2. 748 17, 268 33 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2. out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

0.00

0.00

61.05

surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).
61.05 Enter the difference between the baseline primary

and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line

61.04 minus line 61.03). (see instructions)

FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

N

Ν

94.00

applicable column.

94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the

ealth Financial Systems COMMUNITY HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der Co		eri od:	Worksheet S	5-2
		To	rom 01/01/2016 12/31/2016		
	<u>'</u>	'	V	XI X	
E 00 If line 04 is "V" enter the reduction percentage in the env	nlicable colum	n	1. 00 0. 00	2. 00 0. 00	05.0
5.00 If line 94 is "Y", enter the reduction percentage in the app 6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			0. 00 N	N N	95. 0 96. 0
7.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers	plicable colum	n.	0. 00	0.00	97. 0
05.00 Does this hospital qualify as a critical access hospital (CA 06.00 If this facility qualifies as a CAH, has it elected the all-		hod of payment	N N		105. 0 106. 0
for outpatient services? (see instructions) 07.00  If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see inst	ructions) If	N		107. 0
08.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108. 0
	Physi cal 1.00	Occupational 2.00	Speech 3.00	Respirator 4.00	СУ
09.00 of this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		2.00 N	3. 00 N	4. 00 N	109. 0
				1.00	_
10.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N"		on project (410	A Demo)for	N N	110. 0
			1. (	00 2.00 3.0	00
Miscellaneous Cost Reporting Information	r "N" for no i	n column 1 If	column 1 N		115. 0
15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.	. If column 2 nt for long te	is "E", enter i rm care (includ	n column es		, 113.0
16.00  s this facility classified as a referral center? Enter "Y"					
17.00 s this facility legally-required to carry malpractice insur	-		N" for Y		•
17.00 ls this facility legally-required to carry malpractice insur no. 18.00 ls the malpractice insurance a claims-made or occurrence pol	rance? Enter "	Y" for yes or "	N" for Y		116. 0 117. 0 118. 0
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Health Financial Systems	COMMUNITY HOSPITAL (	OF INDIANA, IN	C.		In Lie	eu of Form CMS	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provi der CC	N: 15-0169			Worksheet S	-2
					1/01/2016 2/31/2016		ranarad:
				10 1	2/31/2010	5/30/2017 8:	
133.00 If this is a Medicare certified other	ar transplant center ent	or the certifi	cation da		1. 00	2.00	133. 00
in column 1 and termination date, if	f applicable, in column 2	er the certifi	Cation da				133.00
134.00 If this is an organ procurement orga	nnization (OPO), enter th		n column	1			134. 00
and termination date, if applicable,	in column 2.						
All Providers  140.00 Are there any related organization of	or home office costs as d	efined in CMS	Pub 15_1		Υ	1	140. 00
chapter 10? Enter "Y" for yes or "N"					•		1.10.00
are claimed, enter in column 2 the h			i ons)				
1.00 If this facility is part of a chain	2.00				3.00	of the	
home office and enter the home office				e name and	address	or the	
141. 00 Name: COMMUNITY HEALTH NETWORK	Contractor's Name: WIS			actor's Nu	mber: 0810	01	141. 00
		RVICES					
142.00 Street: 1500 NORTH RITTER AVENUE	PO Box:		7: 0:		4/01	10 2005	142. 00
143. 00 Ci ty: I NDI ANAPOLI S	State: IN		Zip Co	ode:	462	19-3095	143. 00
						1.00	
144.00 Are provider based physicians' costs	s included in Worksheet A	?				Y	144. 00
					1.00		
145.00 If costs for renal services are clai	mod on Wkst A Line 74	are the costs	for		1. 00 Y	2.00	145. 00
inpatient services only? Enter "Y" f				s	ı		145.00
no, does the dialysis facility inclu	ude Medicare utilization						
period? Enter "Y" for yes or "N" fo							
146.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in o				1.6	N		146. 00
yes, enter the approval date (mm/dd/		5-2, Chapter 4	10, 94020)	''			
lyes, enter the approval date (min/da/	yyyy) iii corumii 2.						
						1.00	
147.00 Was there a change in the statistica						N	147. 00
148.00 was there a change in the order of a 149.00 was there a change to the simplified				for no		N N	148. 00 149. 00
177. 00 mas there a change to the simplification	2 cost irriaring metriod. Eri	Part A	Part		itle V	Title XIX	117.00
		1. 00	2.00		3. 00	4. 00	
Does this facility contain a provide							
or charges? Enter "Y" for yes or "N" 155.00 Hospi tal	for no for each compone	N N	and Part N	B. (See 4.	2 CFR 9413 N	3. 13) N	155. 00
156. 00 Subprovider - IPF		N	N N		N	N N	156. 00
157.00 Subprovi der - IRF		N	N		N	N	157. 00
158. 00 SUBPROVI DER							158. 00
159. 00 SNF		N N	l N N		N N	N	159. 00
160.00 HOME HEALTH AGENCY 161.00 CMHC		IV	I N		N	N N	160. 00 161. 00
101. 00 011110					.,		101.00
h						1.00	
Multicampus 165.00ls this hospital part of a Multicamp	ous bosnital that has one	or more compl	icoc in di	fforont CE	25452	N	165. 00
Enter "Y" for yes or "N" for no.	ous nospi tai that has one	or more campo	ises III ui	i i ei eiit CL	)3A3 !	IN IN	103.00
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00	4. 00	5. 00	
166.00 If line 165 is yes, for each						0. (	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)							
						1.00	
Health Information Technology (HIT)							
167.00 ls this provider a meaningful user u						Y	167. 00
168.00 If this provider is a CAH (line 105			e 167 is "'	Y"), enter	the		0168.00
reasonable cost incurred for the HIT 168.01 If this provider is a CAH and is not			nualify:	for a hard	ishi n	}	168. 01
exception under §413.70(a)(6)(ii)? E					λοιιι P		100.01
169.00 If this provider is a meaningful use	er (line 167 is "Y") and				enter the	9.	99169. 00
transition factor. (see instructions	5)					1	
transition factor. (see instructions	5)						

Health Financial Systems	COMMUNITY HOSPITAL OF	FINDIANA, INC.	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provider CCN: 15-0169	Peri od:	Worksheet S-2	
			From 01/01/2016		
			To 12/31/2016	Date/Time Pre	
				5/30/2017 8:5	<u>4 am</u>
			Begi nni ng	Endi ng	
			1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR be	eginning date and ending da	te for the reporting	01/01/2015	12/31/2015	170. 00
period respectively (mm/dd/yyyy)					
			1. 00	2.00	
171.00 If line 167 is "Y", does this provi	der have any days for indi	viduals enrolled in	N	0	171. 00
section 1876 Medicare cost plans re					
"Y" for yes and "N" for no in colur	nn 1. If column 1 is yes, e	nter the number of section	n		
1876 Medicare days in column 2. (se	ee instructions)				

		PITAL OF INDIANA	, INC.	In Li	eu of Form CMS-	-2552-10
10SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi de	r CCN: 15-0169	Peri od: From 01/01/2016 To 12/31/2016		epared:
				Y/N	Date	
	5 1 1 1 1 5 1 V C 11 V50	. N.C. II. N		1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enmm/dd/yyyy format.  COMPLETED BY ALL HOSPITALS	ter N for all Nu	responses. En	ter all dates in	tne	
	Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior treporting period? If yes, enter the date of the change			s) N		1.00
			Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medic yes, enter in column 2 the date of termination and in voluntary or "I" for involuntary.	column 3, "V" fo	or			2.00
3. 00	Is the provider involved in business transactions, incontracts, with individuals or entities (e.g., chain hor medical supply companies) that are related to the pofficers, medical staff, management personnel, or membof directors through ownership, control, or family and relationships? (see instructions)	nome offices, dri provider or its pers of the board	ng			3. 00
			Y/N	Туре	Date	
			1.00	2. 00	3. 00	
1. 00	Financial Data and Reports  Column 1: Were the financial statements prepared by a Accountant? Column 2: If yes, enter "A" for Audited, or "R" for Reviewed. Submit complete copy or enter dat column 3. (see instructions) If no, see instructions.	"C" for Compile	c Y	A		4. 00
5. 00	Are the cost report total expenses and total revenues those on the filed financial statements? If yes, submi		n. N			5. 00
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
5. 00	Column 1: Are costs claimed for nursing school? Colum the legal operator of the program?	nn 2: If yes, is	s the provider	is N		6. 00
7. 00	Are costs claimed for Allied Health Programs? If "Y" s			Υ		7. 00
3. 00	Were nursing school and/or allied health programs appr cost reporting period? If yes, see instructions.		· ·			8.00
9. 00	Are costs claimed for Interns and Residents in an appr program in the current cost report? If yes, see instru	ıcti ons.				9.00
	Was an approved Intern and Resident GME program initial cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other t			Y N		10.00
11.00	Teaching Program on Worksheet A? If yes, see instructi		Approved	IN .	\/ /NI	11.00
					Y/N 1. 00	
	Bad Debts Is the provider seeking reimbursement for bad debts? I If line 12 is yes, did the provider's bad debt collect period? If yes, submit copy.			cost reporting	Y N	12. 00 13. 00
14. 00	If line 12 is yes, were patient deductibles and/or co- Bed Complement	payments waived	? If yes, see i	nstructi ons.	N	14. 00
15. 00	Did total beds available change from the prior cost re	porting period?	If yes, see in	structions.	N	15. 00
			Part A		rt B	
		Y/N	Date	Y/N	Date	
		1.00	2. 00	3. 00	4.00	

	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only?	N		N		16. 00
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 .(see					
	instructions)					
17.00	Was the cost report prepared using the PS&R Report for	Y	04/29/2014	Υ	04/29/2014	17. 00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.					

Heal th	Financial Systems COMMUNITY HOSPITAL	OF INDIANA, I	NC.	In Lie	eu of Form CMS	S-2552-10		
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet S Part II	-2 repared:		
			i pti on	Y/N	Y/N			
20.00	16 1: 1/ 17 :		0	1.00	3.00	20.00		
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00		
		Y/N	Date	Y/N	Date			
	In the second se	1.00	2.00	3. 00	4. 00	04.00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00		
					1.00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS I	HOSPI TALS)					
	Capital Related Cost				Г			
22. 00	Have assets been relifed for Medicare purposes? If yes, see			464		22. 00		
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	sais illade duri	ng the cost		23. 00		
24. 00	Were new leases and/or amendments to existing leases entere	ed into during	this cost rep	orting period?		24. 00		
25 00	If yes, see instructions	<b></b>	-+::10	16		25.00		
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repoi	ting periou?	ii yes, see		25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the	ne cost reporti	ng period? If	yes, see		26. 00		
27. 00	instructions. Has the provider's capitalization policy changed during the	a cost reporti	ng period2 lf	vas submit		27. 00		
27.00	copy.	c cost reportin	ig perrou: Tr	yes, subiii t				
00.00	Interest Expense							
28. 00	Were new loans, mortgage agreements or letters of credit er period? If yes, see instructions.	nterea into aui	ring the cost	reporting		28. 00		
29. 00	Did the provider have a funded depreciation account and/or		ebt Service Re	eserve Fund)		29. 00		
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu	ructions	dobt2 If you	500		30. 00		
30.00	instructions.	unity with new	debt: 11 yes,	366		30.00		
31. 00	Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes,	see		31. 00		
	instructions. Purchased Services							
32. 00	Have changes or new agreements occurred in patient care ser		ed through cor	itractual		32. 00		
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app		na to competit	ive hidding2 lf		33. 00		
33.00	no, see instructions.	orrea pertariii	ig to competit	ive brading: 11		33.00		
	Provi der-Based Physi ci ans							
34. 00	Are services furnished at the provider facility under an arlf yes, see instructions.	rrangement with	n provi der-bas	sed physi ci ans?		34. 00		
35. 00	If line 34 is yes, were there new agreements or amended exi	isting agreemen	nts with the p	rovi der-based		35. 00		
	physicians during the cost reporting period? If yes, see in	nstructions.	•	V/ (N)	D 1			
				Y/N 1. 00	2.00			
	Home Office Costs							
36.00	Were home office costs claimed on the cost report?					36. 00		
37. 00	If line 36 is yes, has a home office cost statement been pr	repared by the	home office?			37. 00		
38. 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fice different	from that of			38. 00		
20.00	the provider? If yes, enter in column 2 the fiscal year end					20.00		
39. 00	If line 36 is yes, did the provider render services to other see instructions.	er chain compoi	nents? If yes,			39. 00		
40. 00	If line 36 is yes, did the provider render services to the	er services to the home office? If yes, see						
	instructions.							
		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,	RONALD		HELMS		41. 00		
	respecti vel y.							
42. 00	Enter the employer/company name of the cost report	COMMUNITY HEAL	_TH NETWORK			42. 00		
43. 00	preparer. Enter the telephone number and email address of the cost	317-355-5501		RHELMS@ECOMMUN	ITY. COM	43. 00		
	report preparer in columns 1 and 2, respectively.							

Heal th	Financial Systems	COMMUNITY HOSPITAL	OF INDIANA,	I NC.		In Lieu	u of Form CMS-:	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMEN	T QUESTI ONNAI RE	Provi de	CCN: 15-0169	Peri		Worksheet S-2	
					To	n 01/01/2016 12/31/2016		pared: 4 am
				3. 00				
	Cost Report Preparer Contact Information	n						
41.00	Enter the first name, last name and the	title/position	REI MBURSEME	NT MANAGER				41. 00
	held by the cost report preparer in col	umns 1, 2, and 3,						
	respecti vel y.							
42.00	Enter the employer/company name of the	cost report						42.00
	preparer.							
43.00	Enter the telephone number and email ad	dress of the cost						43.00
	report preparer in columns 1 and 2, res	pecti vel y.						

Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC.
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN:

Provider CCN: 15-0169

In Lieu of Form CMS-2552-10

Period: Worksheet S-3

From 01/01/2016 Part I

To 12/31/2016 Date/Time Prepared: 5/30/2017 8:54 am

						'		5/30/2017 8: 54	4 am
i		·						I/P Days / O/P	
								Visits / Trips	
		Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		<b>'</b>	Line Number			Avai I abl e			
			1.00		2.00	3.00	4. 00	5. 00	
	1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		229	82, 812	0.00	0	1. 00
		8 exclude Swing Bed, Observation Bed and							
		Hospice days) (see instructions for col. 2							
		for the portion of LDP room available beds)							
	2.00	HMO and other (see instructions)							2.00
	3.00	HMO IPF Subprovider							3.00
	4.00	HMO IRF Subprovider							4.00
	5.00	Hospital Adults & Peds. Swing Bed SNF						l ol	5.00
	6.00	Hospital Adults & Peds. Swing Bed NF						ol	6.00
	7.00	Total Adults and Peds. (exclude observation			229	82, 812	0.00	l ol	7.00
		beds) (see instructions)				, ,			
	8.00	INTENSIVE CARE UNIT	31. 00		24	8, 784	0.00	o	8.00
	9.00	CORONARY CARE UNIT				·			9. 00
	10.00	BURN INTENSIVE CARE UNIT							10.00
	11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
	12. 00	NEONATAL INTENSIVE CARE UNIT	35. 00		42	15, 372	0.00	0	12.00
	13. 00	NURSERY	43. 00		12	10,072	0.00	Ö	13. 00
	14. 00	Total (see instructions)	43.00		295	106, 968	0.00		14. 00
	15. 00	CAH visits			273	100, 700	0.00	0	15. 00
	16. 00	SUBPROVI DER - I PF	40. 00		19	6, 954		0	16. 00
	17. 00	SUBPROVI DER - I RF	40.00		1.7	0, 754		l	17. 00
	18. 00	SUBPROVI DER							18. 00
	19. 00	SKILLED NURSING FACILITY							19. 00
	20. 00	NURSING FACILITY							20.00
	21. 00	OTHER LONG TERM CARE							21. 00
	22. 00								21.00
		HOME HEALTH AGENCY							23. 00
	23. 00	AMBULATORY SURGICAL CENTER (D. P.)							
	24. 00	HOSPICE	20.00						24. 00
	24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
	25. 00	CMHC - CMHC							25. 00
	26. 00	RURAL HEALTH CLINIC	00.00						26. 00
	26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
	27. 00	Total (sum of lines 14-26)			314			_	27. 00
	28. 00	Observation Bed Days						0	28. 00
	29. 00	Ambul ance Tri ps							29. 00
	30. 00	Employee discount days (see instruction)							30.00
	31.00	Employee discount days - IRF							31.00
	32.00	Labor & delivery days (see instructions)			0	(	)		32.00
	32. 01	Total ancillary labor & delivery room							32. 01
		outpatient days (see instructions)							
	33. 00	LTCH non-covered days							33. 00

 Heal th Financial
 Systems
 COMMUNITY HO

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

Provider CCN: 15-0169

Peri od: Worksheet S-3 From 01/01/2016 Part I To 12/31/2016 Date/Time Prepared: 5/30/2017 8:54 am

		1 (0 0	/ O /D )/: : 1	/ T :		5/30/2017 8: 5	4 am
		T/P Days	/ O/P Visits	/ Irips	Full Time E	-qui val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	·			Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	19, 005	2, 098	53, 157			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)	7 150	15 75/				2 00
2.00	HMO and other (see instructions)	7, 159	15, 756				2.00
3. 00 4. 00	HMO I PF Subprovi der	0	0				3.00
4. 00 5. 00	HMO I RF Subprovi der	0	O O	0			4. 00 5. 00
6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	۷	0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	19, 005	2, 098	53, 157	1		7.00
7.00	beds) (see instructions)	19,005	2, 090	55, 157			7.00
8. 00	INTENSIVE CARE UNIT	2, 134	0	5, 460	,		8.00
9. 00	CORONARY CARE UNIT	2, 101	J	0, 100			9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGI CAL INTENSI VE CARE UNI T						11.00
12. 00	NEONATAL INTENSIVE CARE UNIT	0	46	11, 195			12. 00
13. 00	NURSERY		3, 314	7, 426			13. 00
14. 00	Total (see instructions)	21, 139	5, 458	77, 238		1, 368. 31	14.00
15. 00	CAH visits	0	0	0		,	15. 00
16.00	SUBPROVI DER - I PF	1, 868	0	2, 501	0. 50	14. 20	16. 00
17.00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	0	0	434			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0.00	1
27. 00	Total (sum of lines 14-26)		_		4. 39	1, 382. 51	27. 00
28. 00	Observation Bed Days		0	7, 737			28. 00
29. 00	Ambul ance Tri ps	0		0.400			29. 00
30.00	Employee discount days (see instruction)			2, 122			30.00
31.00	Employee discount days - IRF		2.0	0			31.00
32. 00	Labor & delivery days (see instructions)	0	33	1, 142			32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)			0	'		32. 01
33 00	LTCH non-covered days	0					33. 00
33.00	TETOTI HOT COVELED days	١	I		1	l	1 33.00

 Heal th Financial
 Systems
 COMMUNITY HO

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

Provi der CCN: 15-0169

Peri od: Worksheet S-3
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared: 5/30/2017 8:54 am

						5/30/2017 8: 5	<u>4 am </u>
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	Component	Workers	TI LIC V	THE XVIII	II ti c xi x	Patients	
		11.00	12.00	13.00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	11100		0 4, 590		16, 256	1. 00
	8 exclude Swing Bed, Observation Bed and			1			
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			1, 422	2, 517		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	NEONATAL INTENSIVE CARE UNIT						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00		0 4, 590	195	16, 256	ı
15. 00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF	0. 00		0 193	0	272	16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00 24. 00	AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE						23. 00 24. 00
24. 00	HOSPICE (non-distinct part)						24. 00
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days	0.00					28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provi der CCN: 15-0169

| Peri od: | Worksheet S-3 | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared: | Part II | P

					T		Date/Time Pre 5/30/2017 8:5	4 am
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from	(col.2 ± col.	Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	Worksheet A-6) 3.00	3) 4. 00	<u>col . 4</u> 5. 00	6.00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200. 00	89, 078, 230	-447, 618	88, 630, 612	2, 875, 615. 00	30. 82	1.00
2. 00	instructions) Non-physician anesthetist Part		0			0.00	0.00	2. 00
3. 00	Non-physician anesthetist Part		0	0	0	0.00	0.00	3. 00
4. 00	Physician-Part A - Administrative		248, 982	0	248, 982	1, 992. 00	124. 99	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0 1, 565, 896	0		0. 00 31, 132. 00	•	
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0.00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	0	0	0	0.00	0.00	7. 00
7. 01	Contracted interns and residents (in an approved programs)		0	О	О	0.00	0.00	7. 01
8. 00	Home office and/or related organization personnel		0	0	0	0.00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 1, 570, 125	-5, 910	0 1, 564, 215	0. 00 51, 159. 00		
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient Care		1, 400, 456		.,,	14, 189. 00		
12. 00	Contract labor: Top level management and other management and administrative services		0	0	0	0. 00	0.00	12. 00
13. 00	Contract Labor: Physician-Part A - Administrative		3, 970, 567	0	3, 970, 567	28, 545. 00	139. 10	13. 00
14. 00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14. 00
14. 01 14. 02	Home office salaries Related organization salaries		25, 510, 628 0	0	25, 510, 628 0	660, 633. 00 0. 00		14. 01 14. 02
15. 00	Home office: Physician Part A - Administrative		0	O	0	0.00		15. 00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16. 00
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		28, 926, 075	0	28, 926, 075		1	17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)		0	0	0			18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		530, 283 0	0	,			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
22. 00	Physician Part A - Administrative		24, 548	0	24, 548			22. 00
22. 01	Physician Part A - Teaching		0	0				22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		368, 353	0	368, 353			23. 00 24. 00
25. 00	Interns & residents (in an approved program)		0	0	0			25. 00
25. 50 25. 51	Home office wage-related Related orgainzation		5, 415, 236 0	0	5, 415, 236 0			25. 50 25. 51
25. 52	wage-related Home office: Physician Part A - Administrative -		0	0	0			25. 52
25. 53	wage-related Home office & Contract Physicians Part A - Teaching -		0	0	0			25. 53
	wage-related OVERHEAD COSTS - DIRECT SALARIE	ES		<u> </u>				
	Employee Benefits Department	4. 00						26.00
21.00	Administrative & General	5. 00	5, 228, 444	0	5, 228, 444	150, 793. 00	y 34.67	27.00

| Peri od: | Worksheet S-3 | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared: | Part II | P Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0169

							5/30/2017 8: 5	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)		col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		7, 743, 996	0	7, 743, 996	74, 501. 00	103. 94	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00		0	0	0.00		29. 00
30.00	Operation of Plant	7. 00		0	2, 541, 614			30.00
31.00	Laundry & Linen Service	8. 00	0	0	0	0.00		
32.00	Housekeepi ng	9. 00	2, 271, 085	0	2, 271, 085	152, 568. 00	14. 89	32.00
33.00	Housekeeping under contract		419, 619	0	419, 619	9, 911. 00	42. 34	33.00
	(see instructions)							
34.00	1	10. 00	2, 158, 367	-1, 357, 188	801, 179	48, 098. 00	16. 66	34.00
35.00	Dietary under contract (see		0	0	0	0.00	0.00	35.00
	instructions)							
36. 00	Cafeteri a	11. 00	0	1, 357, 188	1, 357, 188	81, 478. 00	16. 66	36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13. 00	2, 139, 214	0	2, 139, 214	72, 485. 00	29. 51	38. 00
39.00	Central Services and Supply	14. 00	0	0	0	0.00	0.00	39. 00
40.00	Pharmacy	15. 00	4, 093, 877	0	4, 093, 877	101, 560. 00	40. 31	40.00
41.00	Medical Records & Medical	16. 00	289, 205	0	289, 205	7, 962. 00	36. 32	41.00
	Records Li brary							
42.00	Soci al Servi ce	17. 00	2, 037, 373	0	2, 037, 373	58, 816. 00	34. 64	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

Total overhead cost (see

instructions)

7.00

32.92

7.00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provi der CCN: 15-0169 Peri od: From 01/01/2016 To 12/31/2016 5/30/2017 8:54 am Average Hourly Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 95, 675, 949 -447, 618 95, 228, 331 2, 928, 895. 00 32. 51 1.00 instructions) 2.00 1, 570, 125 -5, 910 51, 159. 00 30. 58 2.00 Excluded area salaries (see 1, 564, 215 instructions) 3.00 Subtotal salaries (line 1 94, 105, 824 -441, 708 93, 664, 116 2, 877, 736. 00 32.55 3.00 minus line 2) 4.00 Subtotal other wages & related 30, 881, 651 30, 881, 651 703, 367. 00 43.91 4.00 costs (see inst.) Subtotal wage-related costs 5.00 34, 365, 859 C 34, 365, 859 0.00 36.69 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 159, 353, 334 -441, 708 158, 911, 626 3, 581, 103. 00 44 38

29, 100, 947

884, 014. 00

29, 100, 947

Health Financial Systems
HOSPITAL WAGE RELATED COSTS Provider CCN: 15-0169

		5/30/2017 8: 5	4 am
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	2, 483, 940	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	7, 085, 007	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	9, 055, 887	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8. 03	Heal th Insurance (Purchased)	0	8. 03
9. 00	Prescription Drug Plan	3, 431, 386	
10.00	Dental, Hearing and Vision Plan	149, 072	
11. 00	Life Insurance (If employee is owner or beneficiary)	45, 701	
12. 00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13. 00	Disability Insurance (If employee is owner or beneficiary)	766, 979	
14. 00	Long-Term Care Insurance (If employee is owner or beneficiary)	, 66, 7, 7	14. 00
15. 00	Workers' Compensation Insurance	172, 739	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	172, 737	16. 00
10.00	Non cumulative portion)	O	10.00
	TAXES		
17. 00		6, 564, 561	17. 00
18. 00	Medicare Taxes - Employers Portion Only	0, 00 1, 00 1	18.00
19. 00	Unemployment Insurance	0	19.00
	State or Federal Unemployment Taxes	0	20.00
20.00	OTHER	0	20.00
21 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
21.00	instructions))	O	21.00
22. 00	Day Care Cost and Allowances	0	22. 00
	Tui ti on Rei mbursement	93. 985	
	Total Wage Related cost (Sum of lines 1 -23)	29, 849, 257	
_ 1. 00	Part B - Other than Core Related Cost	27,017,207	2 1. 50
25 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00
20.00	Johney Wide Reduced Control (Street 1)	O <sub>1</sub>	25.00

Health Financial Systems	COMMUNITY HOSPITAL OF	I NDI ANA,	I NC.	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provi der	CCN: 15-0169	From 01/01/2016	Worksheet S-3 Part V Date/Time Prepared:

		0 12/31/2010	5/30/2017 8: 54						
	Cost Center Description	Contract Labor	Benefit Cost						
		1. 00	2. 00						
	PART V - Contract Labor and Benefit Cost								
Hospital and Hospital-Based Component Identification:									
1.00	Total facility's contract labor and benefit cost	1, 400, 456	29, 849, 257	1.00					
2.00	Hospi tal	1, 400, 456	29, 318, 975	2.00					
3.00	Subprovi der - I PF	0	306, 121	3.00					
4.00	Subprovi der - I RF			4. 00					
5.00	Subprovi der - (Other)	0	0	5.00					
6.00	Swing Beds - SNF	0	0	6.00					
7.00	Swing Beds - NF	0	0	7. 00					
8.00	Hospi tal -Based SNF			8. 00					
9.00	Hospi tal -Based NF			9. 00					
10.00	Hospi tal -Based OLTC			10.00					
11. 00	Hospi tal -Based HHA			11.00					
12.00	Separately Certified ASC			12.00					
13.00	Hospi tal -Based Hospi ce			13.00					
14.00	Hospital-Based Health Clinic RHC			14.00					
15. 00	Hospital-Based Health Clinic FQHC			15.00					
16. 00	Hospi tal -Based-CMHC			16.00					
17. 00	Renal Di al ysi s	0	0	17. 00					
18. 00	0ther	0	224, 161	18. 00					

USPLI	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 1		Period: From 01/01/2016	Worksheet S-1	
				To 12/31/2016	Date/Time Pre 5/30/2017 8:5	pare <u>4 am</u>
					1. 00	
	Uncompensated and indigent care cost computation					
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 d	ivided by line 2	202 column	8)	0. 232563	] 1.
	Medicaid (see instructions for each line)					
00	Net revenue from Medicaid				31, 977, 041	2.
00	Did you receive DSH or supplemental payments from Medicaid?				N	3.
00	If line 3 is "yes", does line 2 include all DSH or supplements		n Medicaid	?		4.
00	If line 4 is "no", then enter DSH or supplemental payments from	om Medicaid			0	5.
00	Medi cai d charges				224, 820, 174	
00	Medicaid cost (line 1 times line 6)				52, 284, 854	
00	Difference between net revenue and costs for Medicaid program	(line 7 minus s	sum of lin	es 2 and 5; if	20, 307, 813	8
	<pre>&lt; zero then enter zero) Children's Weelth Insurance Program (CMLP) (ass instructions to the contract of t</pre>	for each line)				
	Children's Health Insurance Program (CHIP) (see instructions	ror each fine)			0	١,
00	Net revenue from stand-alone CHIP				0	
00	Stand-alone CHIP charges				0	
00	Stand-alone CHIP cost (line 1 times line 10)	(line 11 minus	line O. i	f . zono +hon	0	1 1
UU	Difference between net revenue and costs for stand-alone CHIP enter zero)	(Tine II minus	Tine 9; I	i < zero then	U	'-
	Other state or local government indigent care program (see ins	structions for e	each Line)			1
00	Net revenue from state or local indigent care program (Not in			)	0	13
00	Charges for patients covered under state or local indigent cal				0	
	10)	pg (			_	'
00	State or local indigent care program cost (line 1 times line	14)			0	15
00	Difference between net revenue and costs for state or local in		ogram (lin	e 15 minus line	0	1
	13; if < zero then enter zero)					]
	Uncompensated care (see instructions for each line)					4
	Private grants, donations, or endowment income restricted to				0	1
00	Government grants, appropriations or transfers for support of				0	1
00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	al indigent care	programs	(sum of lines	20, 307, 813	19
		U	ni nsured	Insured	Total (col. 1	
		r	oati ents	pati ents	+ col . 2)	
	In		1. 00	2. 00	3. 00	
00			808, 00		2, 034, 638	
00	Cost of patients approved for charity care (line 1 times line	20)	187, 91	2 285, 270	473, 182	
00	Partial payment by patients approved for charity care		407.04	0	0	
00	Cost of charity care (line 21 minus line 22)		187, 91	2 285, 270	473, 182	23
					1. 00	
00	Does the amount in line 20 column 2 include charges for patient imposed on patients covered by Medicaid or other indigent care		a length o	f stay limit	N	24
იი	If line 24 is "yes," charges for patient days beyond an indig	gent care progra	am's Lenat	h of stav limit	0	25
	Total bad debt expense for the entire hospital complex (see in		o . o.igt		20, 104, 000	
00	Medicare bad debts for the entire hospital complex (see instru				333, 249	
00	Non-Medicare and non-reimbursable Medicare bad debt expense (	•	ne 27)		19, 770, 751	
. 00				28)	4, 597, 945	
	Cost of uncompensated care (line 23 column 3 plus line 29)			• •	5, 071, 127	

5, 071, 127 30. 00 25, 378, 940 31. 00

30.00 Cost of uncompensated care (line 23 column 3 plus line 29)
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

		IUNI TY HOSPI TAL OF				u of Form CMS-1	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC	F	Period: From 01/01/2016	Worksheet A	
				1	Γο 12/31/2016	Date/Time Pre 5/30/2017 8:5	
	Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Reclassi fi ed	4 4111
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +- col. 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		0		16, 682, 499	16, 682, 499	1.00
2. 00 3. 00	OO200   CAP REL COSTS-MVBLE EQUIP   OO300   OTHER CAP REL COSTS		0	(	11, 286, 419	11, 286, 419 0	2. 00 3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	178, 153	227, 430	405, 583	-98, 368	307, 215	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	5, 228, 444	109, 973, 694			97, 849, 660	5. 00
7.00	00700 OPERATION OF PLANT	2, 541, 614	6, 820, 040	9, 361, 654		9, 295, 925	7.00
8. 00 9. 00	OO800   LAUNDRY & LI NEN SERVI CE   OO900   HOUSEKEEPI NG	0 2, 271, 085	766, 698 1, 516, 321	766, 698 3, 787, 406		766, 612 3, 776, 005	8. 00 9. 00
10. 00	01000 DI ETARY	2, 158, 367	1, 014, 841	3, 173, 208		1, 158, 339	
11. 00	01100 CAFETERI A	0	O	(	1, 962, 212	1, 962, 212	1
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 139, 214	585, 075	2, 724, 289		2, 714, 287	
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	4, 093, 877	1, 037, 249 13, 774, 040	1, 037, 249 17, 867, 917		-639, 573 4, 428, 731	
16. 00	01600 MEDICAL RECORDS & LIBRARY	289, 205	186, 620	475, 825		475, 624	
17. 00	01700 SOCIAL SERVICE	2, 037, 373	802, 106	2, 839, 479	-125	2, 839, 354	
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	(	0	0	19.00
21. 00 22. 00	O2100   I &R SERVI CES-SALARY & FRINGES APPRVD   O2200   I &R SERVI CES-OTHER PRGM COSTS APPRVD		0	(		0	21. 00 22. 00
22.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	<u> </u>		<u> </u>		22.00
30. 00	03000 ADULTS & PEDI ATRI CS	28, 530, 160	23, 020, 426	51, 550, 586	-11, 340, 789	40, 209, 797	30. 00
31. 00	03100   INTENSIVE CARE UNIT	3, 619, 159	1, 664, 453			4, 827, 868	
35. 00 40. 00	02060   NEONATAL   INTENSIVE CARE UNIT   04000   SUBPROVIDER -   IPF	6, 026, 673 1, 003, 708	2, 272, 270 441, 780			8, 084, 001 1, 424, 994	
43. 00	04300 NURSERY	1,003,708	441, 780		2, 620, 759	2, 620, 759	•
	ANCILLARY SERVICE COST CENTERS	-1	-			_,, -	
50. 00	05000 OPERATING ROOM	4, 548, 512	30, 248, 111	34, 796, 623		12, 512, 742	
51. 00 52. 00	O5100   RECOVERY ROOM   O5200   DELIVERY ROOM & LABOR ROOM	1, 974, 851 354, 407	1, 068, 164 237, 589	3, 043, 015 591, 99 <i>6</i>		3, 006, 542 6, 560, 997	•
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 180, 007	2, 192, 170			4, 253, 262	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	364, 237	2, 326, 338			1, 263, 026	1
57. 00	05700 CT SCAN	768, 253	788, 045	1, 556, 298		1, 208, 997	
58. 00 59. 00	05800   MAGNETIC RESONANCE I MAGING (MRI)   05900   CARDIAC CATHETERIZATION	437, 936	2, 004, 959	2, 442, 895	5 –547, 053 -120, 621	1, 895, 842 -120, 612	1
60.00	06000 LABORATORY	208, 903	9, 090, 685	9, 299, 588		9, 254, 991	
64. 00	06400 I NTRAVENOUS THERAPY	275, 749	204, 475	480, 224		466, 480	1
65. 00	06500 RESPI RATORY THERAPY	2, 603, 600	1, 637, 132			3, 854, 202	
66.00	O6600   PHYSI CAL THERAPY   O6700   OCCUPATI ONAL THERAPY	4, 744, 860	2, 254, 685	6, 999, 545 (		4, 618, 695	
67. 00 68. 00	06800 SPEECH PATHOLOGY		0	(	1, 316, 317 253, 436	1, 316, 317 253, 436	
69. 00	06900 ELECTROCARDI OLOGY	72, 805	578, 122	650, 927	-12, 839	638, 088	ı
	07000 ELECTROENCEPHALOGRAPHY	912, 227	619, 801	1, 532, 028		1, 334, 193	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	12, 422, 228 11, 524, 803	12, 422, 228 11, 524, 803	
73. 00	07300 DRUGS CHARGED TO PATIENTS		0	(	13, 836, 233	13, 836, 233	
74. 00	07400 RENAL DIALYSIS	o	972, 419	972, 419		968, 867	
76. 00	03330 ENDOSCOPY	957, 009	1, 709, 171	2, 666, 180		1, 700, 326	
76. 06 76. 07	03954 I MAGI NG CENTER	1, 319, 121	3, 001, 391	4, 320, 512		3, 335, 131	
76.07	03955 BREAST DIAGNOSTIC CENTER OUTPATIENT SERVICE COST CENTERS	0	4, 773, 969	4, 773, 969	-60, 458	4, 713, 511	76. 07
90.00	09000 CLI NI C	0	0	(	0	0	90.00
90. 26	04975 SPINE CENTER	176, 899	48, 029			227, 982	
	09100 EMERGENCY	5, 495, 405	3, 212, 190	8, 707, 595	-194, 042	8, 513, 553	
92.00	O9200   OBSERVATION BEDS (NON-DISTINCT PART)   SPECIAL PURPOSE COST CENTERS						92.00
113.00	11300   I NTEREST EXPENSE		0	(	0	0	113. 00
	11400 UTILIZATION REVIEW - SNF	0	o	(			114. 00
118.00		88, 511, 813	231, 070, 497	319, 582, 310	48, 250	319, 630, 560	118. 00
190 00	NONREIMBURSABLE COST CENTERS   19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		O	(	0	0	190. 00
	19100 RESEARCH	o	o	(	o o		191.00
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	169, 058			169, 058	192. 00
	19300 NONPALD WORKERS	0	0	(	0		193.00
	07950  HOME OFFICE  07956  PAVILLIONS		17, 759	17, 759	9 2, 702		194. 00 194. 06
194.08	07958 OTHER NRCC	555, 197	1, 602, 570			2, 106, 815	
194. 10	07960 COMMUNITY REHAB HOSPITAL	11, 220	889	12, 109	9 0	12, 109	194. 10
200.00	TOTAL (SUM OF LINES 118-199)	89, 078, 230	232, 860, 773	321, 939, 003	3 0	321, 939, 003	200. 00

	Financial Systems COMM SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C		OF INDIANA, INC	Peri od:	u of Form CMS- Worksheet A	2552-10
				From 01/01/2016 To 12/31/2016	Date/Time Pre 5/30/2017 8:5	
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation			
		6. 00	7.00			
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLDG & FIXT	-3, 197, 447	13, 485, 052			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P	3, 143, 138	14, 429, 557			2.00
3. 00 4. 00	00300 OTHER CAP REL COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT	0 3, 869, 214	0 4, 176, 429			3. 00 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-40, 130, 495	57, 719, 165			5. 00
7. 00	00700 OPERATION OF PLANT	791, 970	10, 087, 895			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	766, 612			8. 00
9.00	00900 HOUSEKEEPI NG	-8, 754	3, 767, 251			9. 00
10.00	01000 DI ETARY	-19, 671	1, 138, 668			10.00
11.00	01100 CAFETERI A	-68, 248	1, 893, 964			11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	2, 976, 323 1, 054, 952	5, 690, 610 415, 379			13. 00 14. 00
15. 00	01500 PHARMACY	1,034, 432	4, 428, 731			15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	3, 032, 310	3, 507, 934			16. 00
17. 00	01700 SOCIAL SERVICE	0	2, 839, 354			17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	О			19. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	331, 366	331, 366			21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	579, 259	579, 259			22. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1 211 551	41 421 240			30.00
30.00	03100 INTENSIVE CARE UNIT	1, 211, 551 0	41, 421, 348 4, 827, 868			31.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	-217, 902	7, 866, 099			35. 00
40. 00	04000 SUBPROVI DER - I PF	-4, 000	1, 420, 994			40.00
43.00	04300 NURSERY	0	2, 620, 759			43. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	-517, 952	11, 994, 790			50.00
51.00	05100 RECOVERY ROOM	0	3, 006, 542			51.00
52. 00 54. 00	O5200   DELIVERY ROOM & LABOR ROOM   O5400   RADIOLOGY-DIAGNOSTIC	492, 136	6, 560, 997 4, 745, 398			52. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	472, 130	1, 263, 026			55. 00
57. 00	05700 CT SCAN	-588	1, 208, 409			57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	1, 895, 842			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	83, 578	-37, 034			59. 00
60.00	06000 LABORATORY	-1, 296, 418	7, 958, 573			60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	466, 480			64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	125	3, 854, 202			65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	-125 0	4, 618, 570 1, 316, 317			67.00
68. 00	06800 SPEECH PATHOLOGY	Ö	253, 436			68. 00
69. 00	06900 ELECTROCARDI OLOGY	31, 221	669, 309			69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	272, 233	1, 606, 426			70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12, 422, 228			71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	11, 524, 803			72. 00
	07300 DRUGS CHARGED TO PATIENTS	983, 268	14, 819, 501			73. 00 74. 00
76.00	07400 RENAL DI ALYSI S 03330 ENDOSCOPY	0	968, 867 1, 700, 326			76.00
	03954 I MAGING CENTER		3, 335, 131			76.06
76. 07	03955 BREAST DIAGNOSTIC CENTER	0	4, 713, 511			76. 07
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	0	0			90.00
90. 26	04975 SPI NE CENTER	0	227, 982			90. 26
	09100 EMERGENCY	-215, 839	8, 297, 714			91.00
92.00	09200  OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS					92. 00
113 00	11300   INTEREST EXPENSE	O	0			113. 00
	11400 UTILIZATION REVIEW - SNF	o	o			114. 00
118.00		-26, 824, 920	292, 805, 640			118. 00
	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190. 00
	19100 RESEARCH	0	0			191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	169, 058			192.00
	19300  NONPALD WORKERS   07950  HOME OFFICE		O			193. 00 194. 00
	07956 PAVI LLI ONS	0	20, 461			194.00
	307958 OTHER NRCC		2, 106, 815			194. 08
	07960 COMMUNITY REHAB HOSPITAL	O	12, 109			194. 10
200.00		-26, 824, 920	•			200. 00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 Provi der CCN: 15-0169 

					10 12/31/2016	Date/lime Prepared: 5/30/2017 8:54 am
		Increases				
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
	A - Labor and Delivery Salary	3.00	4.00	5.00		
1.00	NURSERY	43.00	1, 824, 708	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	5200	<u>4, 155, 9</u> 27	0		2. 00
	0		5, 980, 635	0		
1 00	B - Labor and Delivery Other NURSERY	43.00	0	796, 051		1 00
1. 00 2. 00	DELIVERY ROOM & LABOR ROOM	52. 00	0	1, 813, 074		1. 00 2. 00
2.00	TOTALS			2, 609, 125		2.00
	C - Chargeable Medical Supplie	es				
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	12, 422, 228		1.00
2. 00	PATI ENTS	0.00	o	0		2. 00
3.00		0.00	o	0		3.00
4. 00		0.00	Ö	Ö		4. 00
5.00		0.00	0	0		5. 00
6. 00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8. 00 9. 00		0. 00 0. 00	o	0		8. 00 9. 00
10. 00		0.00	o	0		10. 00
11. 00		0.00	O	0		11. 00
12.00		0.00	0	0		12. 00
13.00		0.00	0	0		13.00
14. 00 15. 00	1	0. 00 0. 00	0	0		14. 00 15. 00
16. 00		0.00	Ö	0		16. 00
17. 00		0.00	Ö	0		17. 00
18.00		0.00	0	0		18. 00
	0		0	12, 422, 228		
1. 00	D - Depreciation Expense CAP REL COSTS-MVBLE EQUIP	2. 00	0	12, 752, 244		1. 00
2.00	CAF REE COSTS-WVBEE EQUIF	0.00	o	12, 732, 244		2.00
3.00		0.00	Ö	Ö		3.00
4.00		0.00	О	0		4. 00
5.00		0.00	0	0		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	Ö	0		9. 00
10.00		0.00	O	0		10. 00
11. 00		0.00	0	0		11. 00
12.00		0.00	0	0		12. 00
13. 00 14. 00		0. 00 0. 00	0	0		13. 00 14. 00
15. 00		0.00	o	0		15. 00
16. 00		0.00	Ö	0		16. 00
17.00		0.00	O	0		17. 00
18. 00		0.00	0	0		18. 00
19. 00 20. 00		0. 00 0. 00	0	0		19. 00 20. 00
21. 00		0.00	0	0		21. 00
22. 00		0.00	O	0		22. 00
23. 00		0.00	0	0		23. 00
24. 00		0.00	0	0		24. 00
25. 00 26. 00		0. 00 0. 00	O	0		25. 00 26. 00
26.00		0.00	0	0		26.00
28. 00		0.00	Ö	Ö		28. 00
29. 00		0.00	o_	0		29. 00
			0	12, 752, 244		
1 00	E - Radiology Support Salary RADIOLOGY-THERAPEUTIC	EE 00	74 555			1 00
1. 00 2. 00	CT SCAN	55. 00 57. 00	74, 555 175, 971			1. 00 2. 00
3. 00	MAGNETIC RESONANCE I MAGING	58.00	48, 860			3.00
	(MRI )					
	5 0 11 1 0		299, 386	0		
1 00	F - Radiology Support Other	EF 00	Ol.	27 050		1 00
1. 00 2. 00	RADI OLOGY-THERAPEUTI C CT SCAN	55. 00 57. 00	0	27, 850 65, 734		1. 00 2. 00
3.00	MAGNETIC RESONANCE I MAGING	58. 00	0	18, 252		3.00
	(MRI )		]			3.00
			0	111, 836		1

Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-0169 Period: From 01/01/2016 To 12/31/2016 Date/Time Prepared: 5/30/2017 8: 54 am

Cost Century   Tree   Subseq   Other						5/30 5/30	0/2017 8: 54 am
Company   Comp							
A							
1.00			3.00	4.00	5.00		
1.00	1. 00		1.00	0	263, 784		1.00
IMPL DRY CHARGED TO		0 — — — — — —					
DATE   Section   DATE   DATE   Section   DATE							
2.00 3.00 4.00 4.00 4.00 4.00 4.00 4.00 4	1. 00		72.00	0	11, 524, 803		1.00
3.00   0.00   0.00   0   0   0   0   0	2.00	FATTENTS	0.00	o	0		2.00
5.00			1				
0.00					=		
7.00 8.00 9.00 9.00 9.00 9.00 9.00 9.00 9				- 1	٩		
8.00			1	l l	=		
10.00			1	- 1	-		
11.00	9.00		0.00	0	0		9. 00
12.00				•	-		
TOTALS					=		
1. Interest Expense	12.00	TOTALS — — — —					12.00
0		I - Interest Expense		-	, 52 . , 533		
J - Other Capit Ial Rental Reclass	1.00	CAP REL COSTS-BLDG & FIXT	1.00				1.00
1.00		O Char Conital Bontal Book		Ol	9, 598, 978		
2.00   GPERATION OF PLANT	1 00			ol	5, 353, 912		1 00
3.00 SPINE CENTER 90.26 0 3.054 4.00 6.00 7.00 0 0 30.763 4.40 7.00 1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				•			
5.00			1	•	3, 054		3. 00
6. 00 7. 00 8. 00 9. 00 9. 00 10. 00			1	•			
7. 00   0. 00   0. 00   0   0. 00   0.		PAVILLIONS		•			
8. 00 9. 00 10.			1	•			
10.00     0.00   0   0   0   11.00   12.00   13.00   13.00   14.00   13.00   14.00   15.00   15.00   15.00   16.00   16.00   16.00   16.00   17.00   16.00   17.00   16.00   17.00   18.00   19.00							
11.00     0.00   0   0   0   11.00   12.00   13.00   13.00   13.00   13.00   14.00   14.00   14.00   15.00   14.00   15.00   16.00   16.00   16.00   16.00   17.00   18.00   18.00   18.00   19.00   18.00   19.00					-		
12.00			1				
13.00			1				•
15.00					-		
16.00			1		0		
17. 00			1		-		
18.00			1				
19.00     19.00     20.00     20.00							
21.00   22.00   20.00   20.00   20.00   22.0							
22.00			1				
23. 00 24. 00 24. 00 25. 00 26. 00 27. 00  0					=		
24. 00 25. 00 26. 00 26. 00 27. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1			-		
26. 00 27. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					-		
27.00 0					l l		
CAP REL COSTS-BLDG & FIXT   1.00   0   6,819,737   0   1.00   CAP REL COSTS-BLDG & FIXT   1.00   0   6,819,737   0   1.00   CAFETERI A   11.00   1,357,188   0				~	-		
1.00   CAP REL COSTS-BLDG & FIXT   1.00   0   6,819,737   0   1.00   0   0   0   0   0   0   0   0   0	27.00		0.00	0			27.00
1.00		K - Depreciation by CC		<u> </u>	3, 400, 704		
L - Cafeteria Salary	1.00	CAP REL COSTS-BLDG & FIXT	1.00				1.00
1.00		O Cofoto: - C-L		0	6, 819, 737		
1.00   CAFETERI A	1 00		11 00	1 357 188			1 00
Note	1.00			1, 357, 188	— — <sub>0</sub>		1.00
1.00					<u> </u>		
1. 00 LABORATORY 60. 00 0 2, 386 1. 00 2. 00 3. 00 4. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00			0			1. 00
1. 00 LABORATORY		0		O	005, 024		
2.00   DRUGS CHARGED TO PATIENTS   73.00   0   13,836,233   2.00   3.00   4.00   5.00   6.00   6.00   6.00   7.00   8.00   9.00   10.00   0   0   0   11.00   11.00   12.00   13.00   0.00   0   0   0   0   0   11.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   10.00   10.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   10.00   10.00   13.00	1. 00	LABORATORY	60.00	ol	2, 386		1.00
4.00       0.00       0       0       0       4.00         5.00       0.00       0       0       0       5.00         6.00       0.00       0       0       0       6.00         7.00       0.00       0       0       0       7.00         8.00       0.00       0       0       0       8.00         9.00       0.00       0       0       9.00       10.00         10.00       0.00       0       0       11.00       11.00         12.00       0.00       0       0       0       12.00         13.00       0.00       0       0       0       13.00	2.00	DRUGS CHARGED TO PATIENTS	73. 00	1	13, 836, 233		2. 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     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				•			
6.00     0.00     0.00     0.00       7.00     0.00     0.00     0.00       8.00     0.00     0.00     0.00       9.00     0.00     0.00     0.00       10.00     0.00     0.00     0.00       11.00     0.00     0.00     0.00       12.00     0.00     0.00     0.00       13.00     0.00     0.00     0.00       13.00     0.00     0.00     0.00				•	0		
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					0		
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					٩		7. 00
10. 00     0     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				•	0		
11. 00     0.00     0     0     11. 00       12. 00     0.00     0     0     12. 00       13. 00     0.00     0     0     13. 00					0		
12. 00 13. 00 0. 00 0 0 12. 00 13. 00 13. 00				•	=		
13.00				- 1	-		
14.00     0.00       0     0       14.00	13.00		0.00	О	0		13. 00
	14. 00		0.00	0	0		14. 00

Health Financial Systems RECLASSIFICATIONS COMMUNITY HOSPITAL OF INDIANA, INC.

Provider CCN: 15-0169 Peri od: Worksheet A-6 From 01/01/2016 To 12/31/2016 Date/Time Prepared:

					5/30/2017 8:5	54 am
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3.00	4.00	5. 00		
15.00		0.00	0	0		15. 00
16.00		0.00	0	0		16. 00
17.00		0.00	0	0		17. 00
18.00		0.00	0	0		18. 00
19.00		0.00	0	0		19. 00
20.00		0.00	0	0		20. 00
21.00		0.00	o	0		21.00
22.00		0.00	o	0		22. 00
23.00		0.00	o	0		23. 00
24.00		0.00	o	0		24. 00
25.00		0.00	o	0		25. 00
				13, 838, 619		1
	R - Therapy Salary					1
1.00	OCCUPATI ONAL THERAPY	67. 00	916, 716	0		1. 00
2.00	SPEECH PATHOLOGY	68. 00	176, 499	0		2. 00
	TOTALS		1, 093, 215	<sub>0</sub>		
	S - Therapy Other					
1.00	OCCUPATI ONAL THERAPY	67. 00		399, 601		1. 00
2.00	SPEECH PATHOLOGY	68. 00		76, 937		2. 00
			0	476, 538		
	T - STD BENEFIT RECLASS					
1.00	ADULTS & PEDIATRICS	30. 00	0	5, 092		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	67, 054		2. 00
3.00	ADULTS & PEDIATRICS	30.00	0	14, 487		3. 00
4.00	ADULTS & PEDIATRICS	30.00	0	11, 837		4. 00
5.00	ADULTS & PEDIATRICS	30.00	0	5, 844		5. 00
6.00	ADULTS & PEDIATRICS	30.00	0	16, 688		6. 00
7.00	ADULTS & PEDIATRICS	30. 00	0	48, 133		7. 00
8.00	ADULTS & PEDIATRICS	30.00	0	464		8. 00
9. 00	INTENSIVE CARE UNIT	31. 00	0	34, 945		9. 00
10. 00	NEONATAL INTENSIVE CARE UNIT	35. 00	0	70, 780		10.00
11. 00	SUBPROVI DER - I PF	40. 00	0	5, 910		11. 00
12.00	OPERATING ROOM	50. 00	0	9, 568		12. 00
13.00	OPERATING ROOM	50.00	0	28, 073		13. 00
14.00	RECOVERY ROOM	51. 00	0	10, 216		14. 00
15. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	3, 850		15. 00
16. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	1, 454		16. 00
17. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	5, 932		17. 00
18. 00	LABORATORY	60.00	0	3, 606		18. 00
19.00	I NTRAVENOUS THERAPY	64. 00	0	1, 423		19. 00
20.00	RESPI RATORY THERAPY	65. 00	0	13, 402		20. 00
21. 00	RESPI RATORY THERAPY	65. 00	0	1, 678		21. 00
22. 00	PHYSI CAL THERAPY	66. 00	0	2, 299		22. 00
23. 00	PHYSI CAL THERAPY	66. 00	0	20, 452		23. 00
24. 00	PHYSI CAL THERAPY	66. 00	0	3, 574		24. 00
25. 00	ELECTROCARDI OLOGY	69. 00	0	1, 765		25. 00
26. 00	ELECTROENCEPHALOGRAPHY	70. 00	0	315		26. 00
27. 00	ENDOSCOPY	76. 00	0	6, 560		27. 00
28. 00	I MAGING CENTER	76. 06	0	5, 628		28. 00
29. 00	I MAGI NG CENTER	76. 06	0	4, 554		29. 00
30.00	EMERGENCY	91.00	0	751		30.00
31.00	EMERGENCY	91.00	0	36, 722		31.00
32. 00	EMERGENCY	91.00	•	<u>4, 562</u>		32. 00
E00.00	TOTALS		0 700 404	447, 618		F00 00
500.00	Grand Total: Increases		8, 730, 424	76, 879, 298		500.00

Peri od: From 01/01/2016 To 12/31/2016 Date/Time Prepared: 5/30/2017 8:54 am

						5/30/2017 8:	
		Decreases					
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8. 00	9. 00	10. 00		
1. 00	A - Labor and Delivery Salary ADULTS & PEDIATRICS	30.00	5, 980, 635	0	0		1.00
2. 00	ABOLIS & LEDIATRICS	0.00	0, 700, 039	0			2. 00
	0 — — — — —		5, 980, 635	<u> </u>			
	B - Labor and Delivery Other						
1.00	ADULTS & PEDIATRICS	30.00	0	2, 609, 125			1. 00
2.00		0.00	0_	0	0		2. 00
	TOTALS		0	2, 609, 125			
1 00	C - Chargeable Medical Suppli		٥	70 420	٥		1 00
1. 00 2. 00	CENTRAL SERVICES & SUPPLY ADULTS & PEDIATRICS	14. 00 30. 00	0	78, 438 1, 153, 201	0		1. 00 2. 00
3.00	INTENSIVE CARE UNIT	31.00	0	240, 940	l .		3. 00
4. 00	NEONATAL INTENSIVE CARE UNIT	35.00	Ö	57, 276	- 1		4. 00
5. 00	OPERATING ROOM	50.00	o	8, 967, 137	o		5. 00
6.00	RECOVERY ROOM	51.00	0	76	О		6. 00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	0	22, 559			7. 00
8.00	RADI OLOGY-THERAPEUTI C	55. 00	0	726, 290			8. 00
9. 00	CT SCAN	57. 00	0	186, 712	l .		9. 00
10. 00	MAGNETIC RESONANCE I MAGING	58. 00	0	14, 722	0		10. 00
11. 00	(MRI) CARDIAC CATHETERIZATION	59.00	o	56, 876	o		11. 00
12.00	INTRAVENOUS THERAPY	64.00	0	5, 319	l 1		12. 00
13. 00	RESPIRATORY THERAPY	65.00	0	116, 393	l 1		13. 00
14. 00	ELECTROENCEPHALOGRAPHY	70.00	o	5	I		14. 00
15. 00	ENDOSCOPY	76.00	0	673, 395	0		15. 00
16.00	I MAGING CENTER	76.06	O	52, 747	0		16. 00
17. 00	BREAST DIAGNOSTIC CENTER	76. 07	0	213			17. 00
18. 00	EMERGENCY	91.00	•	6 <u>9, 9</u> 29			18. 00
	0		0	12, 422, 228			
1. 00	D - Depreciation Expense EMPLOYEE BENEFITS DEPARTMENT	4.00	ol	4, 737	9		1.00
2. 00	ADMINISTRATIVE & GENERAL	5.00	0	7, 294, 635	1		2. 00
3.00	OPERATION OF PLANT	7. 00	o	68, 431	ő		3. 00
4.00	HOUSEKEEPI NG	9.00	0	10, 343	0		4. 00
5.00	DI ETARY	10.00	0	51, 826	0		5. 00
6.00	NURSING ADMINISTRATION	13. 00	0	7, 899	I I		6. 00
7. 00	CENTRAL SERVICES & SUPPLY	14.00	0	83, 420	0		7. 00
8.00	PHARMACY	15.00	0	102, 990	l 1		8. 00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	1 205 000	l .		9. 00
10. 00 11. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	0	1, 305, 900 181, 136	l 1		10. 00 11. 00
12. 00	NEONATAL INTENSIVE CARE UNIT	35.00	0	144, 268			12. 00
13. 00	SUBPROVI DER - I PF	40. 00	o	15, 098	l 1		13. 00
14.00	OPERATING ROOM	50.00	0	722, 069	l 1		14. 00
15.00	RECOVERY ROOM	51.00	0	12, 079	O		15. 00
16.00	RADI OLOGY-DI AGNOSTI C	54.00	0	586, 571	0		16. 00
17. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	251, 924			17. 00
18.00	CT SCAN	57.00	0	258, 818			18. 00
19. 00	MAGNETIC RESONANCE IMAGING (MRI)	58. 00	0	512, 517	0		19. 00
20. 00	LABORATORY	60.00	o	7, 789	0		20. 00
21. 00	RESPIRATORY THERAPY	65. 00	o	195, 382			21. 00
22. 00	PHYSI CAL THERAPY	66.00	0	105, 324			22. 00
23.00	ELECTROCARDI OLOGY	69.00	0	9, 964	0		23. 00
24. 00	ELECTROENCEPHALOGRAPHY	70.00	0	90, 668			24. 00
25. 00	ENDOSCOPY	76. 00	0	271, 673	l 1		25. 00
26. 00	I MAGING CENTER	76.06	0	302, 071	0		26. 00
27. 00 28. 00	BREAST DIAGNOSTIC CENTER EMERGENCY	76. 07 91. 00	ol Ol	59, 731 79, 338			27. 00 28. 00
29. 00	PAVI LLI ONS	194. 06	0	15, 615			29. 00
27.00	0	174.00	— — — <del>ў</del>	12, 752, 244			27.00
	E - Radiology Support Salary	L		.=,			
1.00	RADI OLOGY-DI AGNOSTI C	54.00	299, 386				1. 00
2.00							2. 00
3.00	<u> </u>						3. 00
	F - Radiology Support Other		299, 386	0			$\dashv$
1.00	RADI OLOGY-DI AGNOSTI C	54.00	0	111, 836	0		1.00
2. 00	INDI GEOGI BIAGNOSTIC	0.00	0	111, 630	1		2. 00
3. 00		0.00	o	0	o		3. 00
				111, 836			
		·	,		·		

Heal th	Financial Systems	COMM	UNITY HOSPITAL	OF INDIANA, IN	NC.	In Lieu of Form CM	
RECLAS	SIFICATIONS			Provi der Co		Period: Worksheet A From 01/01/2016	1-6
						Γο 12/31/2016 Date/Time P	repared:
		Decreases				5/30/2017 8	3:54 am
	Cost Center	Li ne #	Sal ary	Other V	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10. 00		
4 00	G - Capital Insurance Costs	5 00		0/0 704		T	4 00
1. 00	ADMI NI STRATI VE & GENERAL	5.00	0	26 <u>3, 7</u> 84 263, 784	1 <u>4</u>		1. 00
	H - Implantable Device Reclas	LL SS	O <sub>1</sub>	203, 764			
1.00	ADULTS & PEDIATRICS	30.00	0	23, 976	0		1.00
2.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	1, 571	0	ł czaraczania w przez pr	2. 00
3.00	OPERATING ROOM	50.00	0	10, 758, 306	0	l .	3. 00
4. 00 5. 00	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	54. 00 55. 00	0	249 533, 830	0	l .	4. 00 5. 00
6. 00	MAGNETIC RESONANCE I MAGING	58.00	0	69	0	l .	6. 00
0.00	(MRI)	00.00	J	0,	9		0.00
7.00	CARDIAC CATHETERIZATION	59.00	0	63, 745	0		7. 00
8.00	INTRAVENOUS THERAPY	64.00	0	7, 679	0	l .	8. 00
9.00	RESPIRATORY THERAPY	65.00	0	41	0	l .	9. 00
10. 00 11. 00	PHYSICAL THERAPY I MAGING CENTER	66. 00 76. 06	0	2, 544 121, 463	0	l .	10. 00 11. 00
12. 00	EMERGENCY	91.00	0	11, 330	0	l .	12. 00
	TOTALS			11, 524, 803			
	I - Interest Expense			,			
1. 00	ADMI NI STRATI VE & GENERAL		•	9, 598, 978	1 <u>1</u>		1. 00
	U J - Other Capital Rental Recl	200	0	9, 598, 978			
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	93, 631	10		1.00
2.00	ADMI NI STRATI VE & GENERAL	5. 00	Ö	195, 026	0	l .	2. 00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	86	0		3. 00
4.00	HOUSEKEEPI NG	9.00	0	1, 058	0	l .	4. 00
5.00	DIETARY	10.00	0	831	0	l .	5. 00
6. 00 7. 00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13. 00 14. 00	0	2, 103 1, 509, 407	0	l .	6. 00 7. 00
8. 00	PHARMACY	15. 00	0	484, 796	0	l .	8. 00
9. 00	MEDICAL RECORDS & LIBRARY	16.00	0	173	0	l .	9. 00
10.00	SOCIAL SERVICE	17. 00	0	125	0		10.00
11. 00	ADULTS & PEDIATRICS	30.00	0	14, 666	0	1	11. 00
12.00	INTENSIVE CARE UNIT	31.00	0	712	0		12. 00
13. 00 14. 00	NEONATAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	35. 00 40. 00	0	514 346	0	l .	13. 00 14. 00
15. 00	OPERATING ROOM	50.00	o	1, 756, 412	0		15. 00
16. 00	RECOVERY ROOM	51.00	Ö	346	0	l .	16. 00
17.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 595	0		17. 00
18. 00	RADI OLOGY-THERAPEUTI C	55.00	0	726	0	l .	18. 00
19. 00	MAGNETIC RESONANCE IMAGING	58. 00	0	346	0		19. 00
20. 00	(MRI) LABORATORY	60.00	o	39, 194	0		20. 00
21. 00	INTRAVENOUS THERAPY	64.00	o	173	0	1	21. 00
22. 00	RESPIRATORY THERAPY	65.00	0	66, 054	0		22. 00
23. 00	PHYSI CAL THERAPY	66.00	0	701, 158	0	1	23. 00
24. 00	ELECTROENCEPHALOGRAPHY	70.00	0	106, 685	0	l .	24. 00
25. 00 26. 00	ENDOSCOPY I MAGI NG CENTER	76. 00 76. 06	0	1, 273 383, 624	0	l .	25. 00 26. 00
27. 00	OTHER NRCC	194. 08	0	47, 704	0	l .	27. 00
27.00	0	174.00	— — <del>ў</del>	5, 408, 764	<u> </u>		27.00
	K - Depreciation by CC						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	<u>6, 819, 7</u> 37	9		1. 00
	0		0	6, 819, 737			
1 00	L - Cafeteria Salary	10.00	1 257 100				1 00
1. 00	DI ETARY	10.00	1, 357, 188 1, 357, 188				1. 00
	M - Cafeteria Reclass	L	1, 337, 100	O <sub>I</sub>			
1.00	DI ETARY	10.00	0	605, 024	0		1. 00
	0		0	605, 024			
	Q - Drugs Charges to Pat		-1				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	55	0	i e	1.00
2. 00 3. 00	CENTRAL SERVICES & SUPPLY PHARMACY	14. 00 15. 00	0	5, 557 12, 851, 400	0	l .	2. 00 3. 00
4. 00	ADULTS & PEDIATRICS	30.00	o	253, 286	0	l .	4. 00
5. 00	INTENSIVE CARE UNIT	31.00	Ö	32, 956	0		5. 00
6.00	NEONATAL INTENSIVE CARE UNIT	35.00	О	11, 313	0	l .	6. 00
7.00	SUBPROVI DER - I PF	40.00	0	5, 050	0		7. 00
8.00	OPERATING ROOM	50.00	0	79, 957	0	l .	8. 00
9. 00 10. 00	RECOVERY ROOM RADIOLOGY-DIAGNOSTIC	51. 00 54. 00	0	23, 972 96, 719	0	l .	9. 00 10. 00
11. 00	RADI OLOGY-DI AGNOSTI C	55.00	0	96, 719 17, 184	0	l .	11. 00
12. 00	CT SCAN	57. 00	Ö	143, 476	0		12. 00
		'		'			· 

Provider COL 15-016  Period		Financial Systems	COMM	MUNITY HOSPITAL			In Lieu of Form CN Period: Worksheet	
Copt Curitor	NECEAS.	STITUATIONS			Trovider		From 01/01/2016	
Cost Genter								
C. 0.0   7.00   8.00   9.00   10.00   13.00   10.00   13.00   13.00   14.00   0   13.00   14.00   0   15.00								
13.00   MAGNETIC RESONANCE IMAGINS   58.00   0   86,511   0   13.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   15.00   RSSPIBATIORY THERAPY   64.00   0   8,660   0   15.00								
(ORI) 16. 00   INTRAVENOUS THERAPY	12 00							12.00
14.00	13.00		56.00	٥	00, 311			13.00
10.00   HYPSICAL THERAPY	14.00		64.00	0	573	(		14. 00
17.00   ELECTROCARDIOLOGY	15.00	RESPI RATORY THERAPY	65.00	0	8, 660	(		15. 00
18.00   ELECTROENCEPHIALOGRAPHY   70,00   0   4.77   0   18.00						`	1	1
19.00   REMAL DIALYSIS   74.00   0   3.552   0   19.00						(		
20.00   NIOSCOPY				٩		(		1
21.00   MAGING CENTER				-1		(		1
22.00   SREAST DIAGNOSTIC CENTER   76.07   0   64.208   0   22.00		l l		-1			) )	1
23.00   EMERGENCY		l l		٦				1
24. 00   PAVILLIONS				-1				1
25.00   OTHER NRCC				-1				1
R - Therapy Salary				0				1
1.00		0			13, 838, 619			
1.00						_		
TOTALS		PHYSICAL THERAPY		· · · · · · · · · · · · · · · · · · ·			- <b> </b>	1
S - Therapy Other PHYSICAL THERAPY	2.00	TOTALS					<u> </u>	2.00
1.00				1, 073, 213				
T - STD BENEFIT RECLASS   T - STD BENEFIT	1.00		66.00		476, 538			1. 00
T - STD BENEFIT RECIASS   1.00	2.00		4					2. 00
1. 0.0 ADULTS & PEDIATRICS 30.00 5.092 0 0 2.00 2. 0.0 ADULTS & PEDIATRICS 30.00 67.054 0 0 0 2.00 3. 0.0 ADULTS & PEDIATRICS 30.00 14.487 0 0 0 3.00 4. 0.0 ADULTS & PEDIATRICS 30.00 11.837 0 0 0 4.00 5. 0.0 ADULTS & PEDIATRICS 30.00 11.837 0 0 0 5.00 6. 0.0 ADULTS & PEDIATRICS 30.00 15.844 0 0 0 5.00 6. 0.0 ADULTS & PEDIATRICS 30.00 16.688 0 0 0 6.00 8. 0.0 ADULTS & PEDIATRICS 30.00 16.688 0 0 0 7.00 8. 0.0 ADULTS & PEDIATRICS 30.00 48.133 0 0 0 7.00 8. 0.0 ADULTS & PEDIATRICS 30.00 44.4 0 0 0 9 8.00 8. 0.0 ADULTS & PEDIATRICS 30.00 44.4 0 0 0 9 9.00 10. 0.0 NEONATAL INTENSIVE CARE UNIT 31.00 34.945 0 0 0 9.00 11. 0.0 SUBPROVIDER - IPF 40.00 5.910 0 0 11.00 11. 0.0 SUBPROVIDER - IPF 40.00 5.910 0 0 11.00 13. 0.0 OPERATING ROOM 50.00 28.073 0 0 12.00 13. 0.0 OPERATING ROOM 50.00 28.073 0 0 12.00 14. 0.0 RECOVERY ROOM 50.00 28.073 0 0 13.00 15. 0.0 RADIOLOGY-DIAGNOSTIC 54.00 3.850 0 0 0 12.00 17. 0.0 RADIOLOGY-DIAGNOSTIC 54.00 3.850 0 0 0 15.00 18. 0.0 LABORATIORY 60.00 3.606 0 0 18.00 19. 0.0 INTRAVENOUS THERAPY 66.00 3.606 0 0 19.00 19. 0.0 INTRAVENOUS THERAPY 66.00 2.299 0 0 0 19.00 10.00 PHYSICAL THERAPY 66.00 2.299 0 0 0 22.00 10.00 PHYSICAL THERAPY 66.00 2.299 0 0 0 22.00 10.00 PHYSICAL THERAPY 66.00 2.299 0 0 0 22.00 10.00 ELECTROCARDIOLOGY 69.00 1.765 0 0 0 22.00 10.00 EMERGENCY 76.00 6.562 0 0 0 28.00 10.00 EMERGENCY 91.00 36.722 0 0 0 29.00 10.00 EMERGENCY 91.00 36.722 0 0 0 29.00 10.00 EMERGENCY 91.00 36.722 0 0 0 29.00 10.00 EMERGENCY 91.00 44.562 0 0 0 29.00 10.00 EMERGENCY 91.00 44.561 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		T CTD DENIELT DECLACE		0	476, 538			
2. 00 ADULTS & PEDI ATRI CS 30. 00 67, 054 0 0 3.00 ADULTS & PEDI ATRI CS 30. 00 11, 487 0 0 0 3.00 ADULTS & PEDI ATRI CS 30. 00 11, 487 0 0 0 4.00 ADULTS & PEDI ATRI CS 30. 00 11, 487 0 0 0 5. 00 ADULTS & PEDI ATRI CS 30. 00 15, 844 0 0 0 5. 00 ADULTS & PEDI ATRI CS 30. 00 16, 688 0 0 0 6. 00 ADULTS & PEDI ATRI CS 30. 00 48, 133 0 0 0 7. 00 ADULTS & PEDI ATRI CS 30. 00 464 0 0 0 8. 00 0 9. 00 INTENSIVE CARE UNIT 31. 00 34, 945 0 0 9. 00 10. 00 ADULTS & PEDI ATRI CS 30. 00 464 0 0 0 9. 00 INTENSIVE CARE UNIT 31. 00 34, 945 0 0 0 9. 00 10. 00 ADULTS & PEDI ATRI CS 30. 00 464 0 0 0 9. 00 INTENSIVE CARE UNIT 31. 00 34, 945 0 0 0 10. 00 ADULTS & PEDI ATRI CS 30. 00 70, 780 0 0 0 10. 00 ADULTS & PEDI ATRI CS 30. 00 70, 780 0 0 0 10. 00 ADULTS & PEDI ATRI CS 70 ADULT	1 00		30 00	5 002	0	(		1 00
3.00 ADULTS & PEDI ATRI CS 3.00 ADULTS & PEDI ATRI CS 3.00 ADULTS & PEDI ATRI CS 3.00 11, 837 0 0 0 4.00 ADULTS & PEDI ATRI CS 3.00 15, 844 0 0 0 6.00 ADULTS & PEDI ATRI CS 3.00 16, 688 0 0 0 6.00 ADULTS & PEDI ATRI CS 3.00 0 16, 688 0 0 0 8.00 ADULTS & PEDI ATRI CS 3.00 0 48, 133 0 0 0 8.00 ADULTS & PEDI ATRI CS 3.00 0 464 0 0 0 8.00 ADULTS & PEDI ATRI CS 3.00 0 464 0 0 0 8.00 ADULTS & PEDI ATRI CS 3.00 0 464 0 0 0 0 8.00 ADULTS & PEDI ATRI CS 3.00 0 464 0 0 0 0 8.00 ADULTS & PEDI ATRI CS 3.00 0 464 0 0 0 0 0 0 1NTENSI VE CARE UNIT 31.00 34, 945 0 0 0 0 11.00 NEONATAL INTENSI VE CARE UNIT 35.00 70, 780 0 0 0 10.00 11.00 SUBPROVI DER - I PF 40.00 5, 910 0 0 11.00 12.00 OPERATI ING ROOM 50.00 9, 568 0 0 0 11.00 13.00 OPERATI ING ROOM 50.00 9, 568 0 0 0 11.00 14.00 RECOVERY ROOM 51.00 10, 216 0 0 14.00 16.00 RADI OLOGY-DI AGNOSTI C 54.00 1, 454 0 0 16.00 17.00 RADI OLOGY-DI AGNOSTI C 54.00 1, 454 0 0 16.00 18.00 LABORATORY 60.00 5, 932 0 0 17.00 18.00 LABORATORY 60.00 5, 932 0 0 0 18.00 19.00 INTRAVENOUS THERAPY 64.00 1, 423 0 0 19.00 19.00 INTRAVENOUS THERAPY 65.00 13, 402 0 0 19.00 20.00 RESPIRATORY THERAPY 66.00 2, 299 0 0 0 22.00 21.00 RESPIRATORY THERAPY 66.00 2.05 22.00 PHYSI CAL THERAPY 66.00 2.05 23.00 PHYSI CAL THERAPY 66.00 2.05 24.00 PHYSI CAL THERAPY 66.00 2.05 25.00 ELECTROCROID LOGY 69.00 1, 765 0 0 0 22.00 26.00 ELECTROCROID LOGY 69.00 1, 765 0 0 0 22.00 27.00 ENDOSCOPY 76.00 6.560 0 0 0 22.00 28.00 IMAGI NG CENTER 76.06 5, 628 0 0 0 22.00 29.00 IMAGI NG CENTER 76.06 5, 628 0 0 22.00 29.00 IMAGI NG CENTER 76.06 5, 628 0 0 29.00 30.00 EMERGENCY 91.00 36, 722 0 0 0 30.00 EMERGENCY 91.00 44, 7618		l l					- <b> </b>	1
4. 00 ADULTS & PEDI ATRICS 30. 00 11, 837 0 0 6		1					- <b> </b>	1
5.00 ADULTS & PEDIATRI CS 30.00 5.844 0 0 6.00 ADULTS & PEDIATRI CS 30.00 16.688 0 0 0 6.00 ADULTS & PEDIATRI CS 30.00 48, 133 0 0 0 7.00 8.00 ADULTS & PEDIATRI CS 30.00 484 133 0 0 0 7.00 8.00 ADULTS & PEDIATRI CS 30.00 464 0 0 0 8.00 9.00 INTENSI VE CARE UNIT 31.00 34, 945 0 0 9.00 11.00 NEONATAL INTENSI VE CARE UNIT 35.00 70, 780 0 0 10.00 11.00 SUBPROVI DER - I PF 40.00 5, 910 0 0 11.00 13.00 OPERATI ING ROOM 50.00 9, 568 0 0 12.00 14.00 RECOVERY ROOM 51.00 10, 216 0 0 14.00 15.00 RADI OLOGY-DI AGNOSTI C 54.00 3, 850 0 0 14.00 16.00 RADI OLOGY-DI AGNOSTI C 54.00 1, 454 0 0 0 17.00 18.00 LABORATORY 60.00 1, 44.00 1, 454 0 0 0 17.00 18.00 LABORATORY 60.00 3, 606 0 0 17.00 18.00 INTRAVENOUS THERAPY 65.00 1, 678 0 0 0 19.00 19.00 RESPIRATORY THERAPY 65.00 1, 678 0 0 0 22.00 22.00 RESPIRATORY THERAPY 66.00 20.452 0 0 0 22.00 23.00 PHYSI CAL THERAPY 66.00 20.452 0 0 0 22.00 24.00 PHYSI CAL THERAPY 66.00 20.452 0 0 0 22.00 25.00 ELECTROCARDI OLOGY 69.00 1, 765 0 0 25.00 26.00 ELECTROCARDI OLOGY 79.00 3, 574 0 0 22.00 27.00 RESPIRATORY THERAPY 66.00 20.452 0 0 0 22.00 28.00 PHYSI CAL THERAPY 66.00 20.452 0 0 0 22.00 29.00 PHYSI CAL THERAPY 66.00 3, 574 0 0 22.00 29.00 PHYSI CAL THERAPY 66.00 20.452 0 0 0 22.00 29.00 PHYSI CAL THERAPY 66.00 20.452 0 0 0 22.00 29.00 PHYSI CAL THERAPY 66.00 20.452 0 0 0 22.00 29.00 PHYSI CAL THERAPY 66.00 20.452 0 0 0 22.00 29.00 PHYSI CAL THERAPY 66.00 20.452 0 0 0 22.00 29.00 PHYSI CAL THERAPY 66.00 20.452 0 0 0 22.00 29.00 PHYSI CAL THERAPY 66.00 20.452 0 0 0 22.00 29.00 PHYSI CAL THERAPY 66.00 20.452 0 0 0 22.00 29.00 PHYSI CAL THERAPY 66.00 3.574 0 0 0 22.00 29.00 PHYSI CAL THERAPY 66.00 20.452 0 0 0 22.00 29.00 PHYSI CAL THERAPY 66.00 20.452 0 0 0 22.00 29.00 PHYSI CAL THERAPY 66.00 20.452 0 0 0 22.00 29.00 PHYSI CAL THERAPY 66.00 20.452 0 0 0 22.00 29.00 PHYSI CAL THERAPY 66.00 20.00 3.574 0 0 0 22.00 29.00 PHYSI CAL THERAPY 60.00 3.500 0 20.00 20.								1
7. 00 ADULTS & PEDI ATRI CS 30. 00 48, 133 0 0 0 8. 00 8. 00 10. 00 ADULTS & PEDI ATRI CS 30. 00 464 0 0 0 8. 00 10. 00 1	5.00	ADULTS & PEDIATRICS	30.00	5, 844	0	(		5. 00
8. 00   ADULTS & PEDI ATRI CS   30. 00   4.64   0   0   0   9. 00   1NTRNSI VE CARE UNI T   31. 00   34, 945   0   0   0   0   10. 00   11. 00   NEONATAL INTENSI VE CARE UNI T   35. 00   70, 780   0   0   0   11. 00   11. 00   SUBPROVI DER - IPF   40. 00   5, 910   0   0   11. 00   12. 00   OPERATI NG ROOM   50. 00   9, 568   0   0   0   13. 00   OPERATI NG ROOM   50. 00   28, 073   0   0   0   13. 00   OPERATI NG ROOM   51. 00   10, 216   0   0   14. 00   15. 00   RADI OLOGY-DI AGNOSTI C   54. 00   3, 850   0   0   0   15. 00   16. 00   16. 00   17. 00   RADI OLOGY-DI AGNOSTI C   54. 00   3, 850   0   0   17. 00   18. 00   19. 00   1NTRAVENOUS THERAPY   64. 00   3, 606   0   0   19. 00   1NTRAVENOUS THERAPY   65. 00   13, 402   0   0   22. 00   22. 00   22. 00   PHYSI CAL THERAPY   66. 00   2, 299   0   0   22. 00   22. 00   23. 00   PHYSI CAL THERAPY   66. 00   20, 452   0   0   22. 00   23. 00   PHYSI CAL THERAPY   66. 00   20, 452   0   0   22. 00   23. 00   24. 00   24. 00   25. 00   26. 00   27. 00   28. 00   27. 00   28. 00   27. 00   28. 00   27. 00   27. 00   28. 00   27. 00   28. 00   27. 00   28. 00   27. 00   28. 00   27. 00   27. 00   28. 00   27. 00   28. 00   27. 00   28. 00   27. 00   27. 00   28. 00   29. 00	6.00	ADULTS & PEDIATRICS	30.00	16, 688	0	(		6. 00
9.00   INTENSIVE CARE UNIT   31.00   34,945   0   0   0   10.00   NEONATAL INTENSIVE CARE UNIT   35.00   70,780   0   0   11.00   11.00   Subprovi DER - I PF   40.00   5,910   0   0   11.00   12.00   OPERATING ROOM   50.00   9,568   0   0   0   12.00   13.00   OPERATING ROOM   50.00   28,073   0   0   0   14.00   13.00   OPERATING ROOM   51.00   10,216   0   0   0   14.00   15.00   RADI OLOGY-DI AGNOSTI C   54.00   3,850   0   0   15.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   17.00   16.00   17.00   16.00   17.00   16.00   17.00   16.00   17.00   16.00   17.00   16.00   17.				48, 133		(		
10. 00   NEONATAL INTENSIVE CARE UNIT   35. 00   70, 780   0   0   10. 00     11. 00   SUBPROVIDER - IPF   40. 00   5, 910   0   0     12. 00   OPERATING ROOM   50. 00   9, 568   0   0   12. 00     13. 00   OPERATING ROOM   50. 00   28, 073   0   0   0   13. 00     14. 00   RECOVERY ROOM   51. 00   10, 216   0   0   0   14. 00     15. 00   RADI OLOGY-DI AGNOSTIC   54. 00   3, 850   0   0   15. 00     16. 00   RADI OLOGY-DI AGNOSTIC   54. 00   1, 454   0   0   0   16. 00     17. 00   RADI OLOGY-DI AGNOSTIC   54. 00   5, 932   0   0   17. 00     18. 00   LABORATORY   60. 00   3, 606   0   0   18. 00     19. 00   INTRAVENOUS THERAPY   64. 00   1, 423   0   0   19. 00     10. 01   INTRAVENOUS THERAPY   65. 00   13, 402   0   0   22. 00     21. 00   RESPI RATORY THERAPY   65. 00   1, 678   0   0   21. 00     22. 00   PHYSI CAL THERAPY   66. 00   2, 299   0   0   22. 00     23. 00   PHYSI CAL THERAPY   66. 00   2, 299   0   0   22. 00     24. 00   PHYSI CAL THERAPY   66. 00   3, 574   0   0     25. 00   ELECTROCARDI OLOGY   69. 00   1, 765   0   0     26. 00   ELECTROCARDI OLOGY   76. 00   6, 560   0     27. 00   ENDOSCOPY   76. 00   6, 560   0     28. 00   IMAGI NG CENTER   76. 06   5, 628   0   0     29. 00   IMAGI NG CENTER   76. 06   5, 628   0   0     20. 00   EMERGENCY   91. 00   751   0   0     20. 00   EMERGENCY   91. 00   36, 722   0   0     20. 00   EMERGENCY   91. 00   36, 722   0   0     20. 00   EMERGENCY   91. 00   36, 722   0   0     20. 00   EMERGENCY   91. 00   36, 722   0   0     20. 00   EMERGENCY   91. 00   36, 722   0   0     20. 00   EMERGENCY   91. 00   447, 618   0				1	-	I	1	
11. 00 SUBPROVI DER - I PF		l l					-	1
12. 00 OPERATI NG ROOM 50. 00 9, 568 0 0 0 12. 00 13. 00 OPERATI NG ROOM 50. 00 28, 073 0 0 0 13. 00 14. 00 RECOVERY ROOM 51. 00 10, 216 0 0 0 14. 00 15. 00 RADI OLOGY-DI AGNOSTI C 54. 00 3, 850 0 0 0 15. 00 16. 00 RADI OLOGY-DI AGNOSTI C 54. 00 1, 454 0 0 0 16. 00 17. 00 RADI OLOGY-DI AGNOSTI C 54. 00 1, 454 0 0 0 0 16. 00 17. 00 RADI OLOGY-DI AGNOSTI C 54. 00 1, 454 0 0 0 0 17. 00 18. 00 LABORATORY 60. 00 3, 606 0 0 0 18. 00 19. 00 INTRAVENOUS THERAPY 64. 00 1, 423 0 0 0 18. 00 20. 00 RESPI RATORY THERAPY 65. 00 13, 402 0 0 0 21. 00 21. 00 RESPI RATORY THERAPY 66. 00 2, 279 0 0 0 22. 00 22. 00 PHYSI CAL THERAPY 66. 00 2, 279 0 0 0 22. 00 23. 00 PHYSI CAL THERAPY 66. 00 3, 574 0 0 22. 00 24. 00 PHYSI CAL THERAPY 66. 00 3, 574 0 0 22. 00 24. 00 PHYSI CAL THERAPY 66. 00 3, 574 0 0 22. 00 25. 00 ELECTROCARDI OLOGY 69. 00 1, 765 0 0 25. 00 26. 00 ELECTROCARDI OLOGY 69. 00 1, 765 0 0 0 25. 00 26. 00 ELECTROCARDI OLOGY 76. 00 6, 560 0 0 27. 00 28. 00 IMAGI NG CENTER 76. 06 5, 628 0 0 0 29. 00 30. 00 EMERGENCY 91. 00 36, 722 0 0 0 32. 00 31. 00 EMERGENCY 91. 00 36, 722 0 0 0 32. 00 32. 00 EMERGENCY 91. 00 44, 562 0 0 0 32. 00 33. 00 EMERGENCY 91. 00 44, 562 0 0 0 33. 00 31. 00 EMERGENCY 91. 00 44, 562 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		l l					1	1
13. 00 OPERATING ROOM 50. 00 28,073 0 0 0 13. 00 14. 00 RECOVERY ROOM 51. 00 10, 216 0 0 14. 00 15. 00 RADI OLOGY-DI AGNOSTI C 54. 00 3, 850 0 0 15. 00 16. 00 RADI OLOGY-DI AGNOSTI C 54. 00 1, 454 0 0 0 16. 00 17. 00 RADI OLOGY-DI AGNOSTI C 54. 00 5, 932 0 0 0 17. 00 18. 00 LABORATORY 60. 00 3, 606 0 0 0 18. 00 19. 00 INTRAVENOUS THERAPY 64. 00 1, 423 0 0 0 19. 00 20. 00 RESPI RATORY THERAPY 65. 00 13, 402 0 0 0 19. 00 21. 00 RESPI RATORY THERAPY 65. 00 1, 678 0 0 0 22. 00 22. 00 PHYSI CAL THERAPY 66. 00 2, 299 0 0 0 22. 00 23. 00 PHYSI CAL THERAPY 66. 00 20, 452 0 0 0 22. 00 24. 00 PHYSI CAL THERAPY 66. 00 3, 574 0 0 0 22. 00 25. 00 ELECTROCARDI OLOGY 69. 00 1, 765 0 0 0 22. 00 26. 00 ELECTROCARDI OLOGY 69. 00 1, 765 0 0 0 22. 00 27. 00 ENDOSCOPY 76. 00 6, 560 0 0 0 22. 00 28. 00 IMAGI NG CENTER 76. 06 5, 628 0 0 0 22. 00 30. 00 EMERGENCY 91. 00 4, 562 0 0 0 32. 00 31. 00 EMERGENCY 91. 00 4, 562 0 0 0 32. 00 32. 00 EMERGENCY 91. 00 4, 562 0 0 0 32. 00 32. 00 EMERGENCY 91. 00 4, 562 0 0 0 32. 00 33. 00 EMERGENCY 91. 00 4, 562 0 0 0 33. 00 31. 00 EMERGENCY 91. 00 4, 562 0 0 0 32. 00 TOTAL'S						l		1
14. 00       RECOVERY ROOM       51. 00       10, 216       0       0       14. 00         15. 00       RADI OLOGY-DI AGNOSTI C       54. 00       3, 850       0       0       0       15. 00         16. 00       RADI OLOGY-DI AGNOSTI C       54. 00       5, 932       0       0       16. 00         17. 00       RADI OLOGY-DI AGNOSTI C       54. 00       5, 932       0       0       17. 00         18. 00       LABORATORY       60. 00       3, 606       0       0       0       18. 00         19. 00       INTRAVENOUS THERAPY       64. 00       1, 423       0       0       0       19. 00         20. 00       RESPI RATORY THERAPY       65. 00       13, 402       0       0       20. 00         21. 00       RESPI RATORY THERAPY       65. 00       1, 678       0       0       21. 00         22. 00       PHYSI CAL THERAPY       66. 00       2, 299       0       0       22. 00         23. 00       PHYSI CAL THERAPY       66. 00       20, 452       0       0       23. 00         24. 00       PHYSI CAL THERAPY       66. 00       3, 574       0       0       24. 00         25. 00       ELECTROCAR								1
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16. 00 RADI OLOGY-DI AGNOSTI C 54. 00 1, 454 0 0 0 18. 00 17. 00 RADI OLOGY-DI AGNOSTI C 54. 00 5, 932 0 0 0 17. 00 18. 00 LABORATORY 60. 00 3, 606 0 0 0 18. 00 19. 00 1NTRAVENOUS THERAPY 64. 00 1, 423 0 0 0 19. 00 1NTRAVENOUS THERAPY 65. 00 13, 402 0 0 0 20. 00 21. 00 RESPI RATORY THERAPY 65. 00 1, 678 0 0 0 21. 00 22. 00 PHYSI CAL THERAPY 66. 00 2, 299 0 0 0 22. 00 24. 00 PHYSI CAL THERAPY 66. 00 20. 452 0 0 0 23. 00 PHYSI CAL THERAPY 66. 00 3, 574 0 0 24. 00 PHYSI CAL THERAPY 66. 00 3, 574 0 0 24. 00 PHYSI CAL THERAPY 66. 00 3, 574 0 0 25. 00 ELECTROCARDI OLOGY 69. 00 1, 765 0 0 25. 00 26. 00 ELECTROCARDI OLOGY 69. 00 1, 765 0 0 0 25. 00 26. 00 ELECTROENCEPHALOGRAPHY 70. 00 315 0 0 26. 00 27. 00 ENDOSCOPY 76. 00 6, 560 0 0 27. 00 EMBGING CENTER 76. 06 5, 628 0 0 0 28. 00 1MAGI NG CENTER 76. 06 4, 554 0 0 0 29. 00 31. 00 EMERGENCY 91. 00 36, 722 0 0 0 32. 00 EMERGENCY 91. 00 36, 722 0 0 0 32. 00 EMERGENCY 91. 00 447, 618 0 0							- <b> </b>	1
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22. 00       PHYSI CAL THERAPY       66. 00       2, 299       0       0       22. 00         23. 00       PHYSI CAL THERAPY       66. 00       20, 452       0       0       0       23. 00         24. 00       PHYSI CAL THERAPY       66. 00       3, 574       0       0       0       24. 00         25. 00       ELECTROCARDI OLOGY       69. 00       1, 765       0       0       0       25. 00         26. 00       ELECTROENCEPHALOGRAPHY       70. 00       315       0       0       0       26. 00         27. 00       ENDOSCOPY       76. 00       6, 560       0       0       0       27. 00         28. 00       I MAGI NG CENTER       76. 06       5, 628       0       0       28. 00         29. 00       I MAGI NG CENTER       76. 06       4, 554       0       0       29. 00         30. 00       EMERGENCY       91. 00       751       0       0       30. 00         31. 00       EMERGENCY       91. 00       4, 562       0       0       0         32. 00       EMERGENCY       91. 00       4, 562       0       0       0	20.00	RESPI RATORY THERAPY	65.00	13, 402	0	(	)	20. 00
23. 00 PHYSI CAL THERAPY 66. 00 20, 452 0 0 0 24. 00 24. 00 PHYSI CAL THERAPY 66. 00 3, 574 0 0 0 25. 00 ELECTROCARDI OLOGY 69. 00 1, 765 0 0 26. 00 ELECTROENCEPHALOGRAPHY 70. 00 315 0 0 27. 00 ENDOSCOPY 76. 00 6, 560 0 0 28. 00 I MAGI NG CENTER 76. 06 5, 628 0 0 29. 00 I MAGI NG CENTER 76. 06 4, 554 0 0 30. 00 EMERGENCY 91. 00 751 0 0 31. 00 EMERGENCY 91. 00 36, 722 0 0 32. 00 EMERGENCY 91. 00 4, 562 0 0 32. 00 EMERGENCY 91. 00 4, 562 0 0 32. 00 EMERGENCY 91. 00 4, 562 0 0 32. 00 EMERGENCY 91. 00 4, 562 0 0 32. 00 EMERGENCY 91. 00 4, 562 0 0 32. 00 EMERGENCY 91. 00 4, 562 0 0 32. 00 EMERGENCY 91. 00 4, 562 0 0 33. 00 EMERGENCY 91. 00 4, 562 0 0 34. 00 EMERGENCY 91. 00 4, 562 0 0 35. 00 EMERGENCY 91. 00 4, 562 0 0 36. 00 0 0 37. 00 0 0 0 0 38. 00 0 0 0 0 39. 00 0 0 0 0 39. 00 0 0 0 0 30. 00 0 0 0 0 30. 00 0 0 0 0 0 30. 00 0 0 0 0 30. 00 0 0 0 0 0 30. 00 0 0 0 0 0 30. 00 0 0 0 0 0 30. 00 0 0 0 0 0 0 30. 00 0 0 0 0 0 0 30. 00 0 0 0 0 0 0 30. 00 0 0 0 0 0 0 0 30. 00 0 0 0 0 0 0 0 30. 00 0 0 0 0 0 0 0 30. 00 0 0 0 0 0 0 0 0 0 30. 00 0 0 0 0 0 0 0 0 0 0 30. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							•	
24. 00     PHYSI CAL THERAPY     66. 00     3, 574     0     0     24. 00       25. 00     ELECTROCARDI OLOGY     69. 00     1, 765     0     0     0     25. 00       26. 00     ELECTROENCEPHALOGRAPHY     70. 00     315     0     0     0     26. 00       27. 00     ENDOSCOPY     76. 00     6, 560     0     0     0     27. 00       28. 00     I MAGI NG CENTER     76. 06     5, 628     0     0     28. 00       29. 00     I MAGI NG CENTER     76. 06     4, 554     0     0     29. 00       30. 00     EMERGENCY     91. 00     751     0     0     30. 00       31. 00     EMERGENCY     91. 00     36, 722     0     0     31. 00       32. 00     EMERGENCY     91. 00     4, 562     0     0     32. 00							l .	
25. 00   ELECTROCARDI OLOGY   69. 00   1, 765   0   0   0   25. 00   26. 00   ELECTROENCEPHALOGRAPHY   70. 00   315   0   0   0   27. 00   ENDOSCOPY   76. 00   6, 560   0   0   0   28. 00   I MAGI NG CENTER   76. 06   5, 628   0   0   0   29. 00   I MAGI NG CENTER   76. 06   4, 554   0   0   30. 00   EMERGENCY   91. 00   751   0   0   31. 00   EMERGENCY   91. 00   36, 722   0   0   32. 00   EMERGENCY   91. 00   4, 562   0   0   30. 00   EMERGENCY   91. 00   4, 562   0   0   31. 00   EMERGENCY   91. 00   4, 562   0   0   32. 00   TOTALS   447, 618   0							l .	
26. 00   ELECTROENCEPHALOGRAPHY   70. 00   315   0   0   0   26. 00   27. 00   ENDOSCOPY   76. 00   6, 560   0   0   0   27. 00   28. 00   1 MAGI NG CENTER   76. 06   5, 628   0   0   0   28. 00   29. 00   1 MAGI NG CENTER   76. 06   4, 554   0   0   0   29. 00   30. 00   EMERGENCY   91. 00   751   0   0   0   31. 00   31. 00   EMERGENCY   91. 00   36, 722   0   0   0   31. 00   32. 00   EMERGENCY   91. 00   4, 562   0   0   0   32. 00   32. 00   32. 00   33. 00   34. 00   34. 00   34. 00   0   0   0   0   0   0   0   0   0							- <b> </b>	
27. 00     ENDOSCOPY     76. 00     6, 560     0     0     27. 00       28. 00     I MAGI NG CENTER     76. 06     5, 628     0     0     28. 00       29. 00     I MAGI NG CENTER     76. 06     4, 554     0     0     29. 00       30. 00     EMERGENCY     91. 00     751     0     0     30. 00       31. 00     EMERGENCY     91. 00     36, 722     0     0     31. 00       32. 00     EMERGENCY     91. 00     4, 562     0     0     32. 00       TOTALS     447, 618     0     0					0		•	
28. 00   IMAGING CENTER   76. 06   5, 628   0   0   0   28. 00   29. 00   IMAGING CENTER   76. 06   4, 554   0   0   0   0   0   0   0   0   0				1	0			1
29. 00     I MAGI NG CENTER     76. 06     4, 554     0     0       30. 00     EMERGENCY     91. 00     751     0     0       31. 00     EMERGENCY     91. 00     36, 722     0     0       32. 00     EMERGENCY     91. 00     4, 562     0     0       TOTALS     447, 618     0     0					0		á	1
30. 00   EMERGENCY   91. 00   751   0   0   0   30. 00   31. 00   31. 00   EMERGENCY   91. 00   36, 722   0   0   0   31. 00   32. 00   EMERGENCY   91. 00   4, 562   0   0   0   32. 00   0   0   0   0   0   0   0   0   0		1			0		ől	
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32. 00 EMERGENCY 91. 00 4, 562 0 0 32. 00 TOTALS 447, 618 0				1	0		1	
TOTALS 447, 618 0					0			
500.00   Grand Total: Decreases   9, 178, 042   76, 431, 680   500.00							_	
	500.00	Grand Total: Decreases		9, 178, 042	76, 431, 680			500. 00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0169 Peri od: Worksheet A-7 From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/30/2017 8:54 am Acqui si ti ons Begi nni ng Total Di sposal s and Purchases Donati on Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 2, 705, 851 0 1.00 0 2.00 Land Improvements 3, 158, 137 0 2.00 289, 284, 636 3.00 832, 089 3 00 Buildings and Fixtures 2, 794, 712 0 4.00 Building Improvements 1, 820, 702 1, 820, 702 0 4.00 5.00 Fixed Equipment 3, 118, 039 0 5.00 0 6.00 Movable Equipment 95, 025, 378 815, 598 815, 598 374, 398 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 396, 086, 753 2, 636, 300 2, 636, 300 1, 206, 487 8.00 9.00 Reconciling Items 0 9.00 1, 206, 487 Total (line 8 minus line 9) 10.00 396, 086, 753 2, 636, 300 0 2, 636, 300 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 2, 705, 851 0 1.00 2.00 Land Improvements 3, 158, 137 0 2.00 3.00 Buildings and Fixtures 288, 452, 547 0 3.00 0 4.00 Building Improvements 4, 615, 414 4.00 5.00 Fi xed Equipment 3, 118, 039 0 5.00 Movable Equipment 0 6.00 95, 466, 578 6.00 7. 00 7.00 HIT designated Assets 0

397, 516, 566

397, 516, 566

0

0

Health Financial Systems COM	MUNITY HOSPITAL	OF INDIANA,	I NC.	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 15-0169	Peri od:	Worksheet A-7	
				From 01/01/2016		
				To 12/31/2016	Date/Time Pre	pared:
					5/30/2017 8:5	<u>4 am</u>
	SUMMARY OF CAPITAL					
Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
				instructions)	instructions)	
	9. 00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	IN 2, LINES 1	and 2			
1.00 CAP REL COSTS-BLDG & FLXT	0		0	0 0	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0		o	0 0	0	2.00
3.00 Total (sum of lines 1-2)	0		o	0 0	0	3. 00
	SUMMARY O	F CAPITAL		<u> </u>		
Cost Center Description	Other	Total (1) (su	ım			
2222 2222. Bood 1 p t 1 d 11	Canital Dalata	, , ,				

2: 00 ON NEE 00010 MINDEE EQ011		J	· · · · · ·		٩	٠,	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	IN 2, LINES 1 a	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	Financial Systems COMM	UNITY HOSPITAL	OF INDIANA, IN	NC.	In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2016 Fo 12/31/2016	Date/Time Pre 5/30/2017 8:5	pared:
		COM	PUTATION OF RAT	TIOS	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 CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	295, 237, 485	l .	295, 237, 48!		l	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	98, 143, 417		98, 143, 41		0	2. 00
3.00 Total (sum of lines 1-2) 393, 380, 902 0 393, 380, 902 1.000000 0						3. 00	
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL							
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate	cols. 5			
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0	)	6, 819, 737	l e	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	) (	9, 075, 645		2. 00
3.00	Total (sum of lines 1-2)	0		)	15, 895, 382	5, 353, 912	3. 00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
				,	d Costs (see	through 14)	
					instructions)		
		11.00	12.00	13.00	14.00	15. 00	
	DADT III DECONCIIIATION OF CADITAL COSTS CE	MITER					I

6, 401, 531

0 6, 401, 531

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
CAP REL COSTS-BLDG & FIXT 6

0 0 0

0 0 0

263, 784

263, 784

13, 485, 052 1. 00 14, 429, 557 2. 00 27, 914, 609 3. 00

1.00

2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)

| Period: | Worksheet A-8 | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES COMMUNITY HOSPITAL OF INDIANA, INC.

Provider CCN: 15-0169

				To	12/31/2016		
				Expense Classification on	Worksheet A	5/30/2017 8: 54	4 alli
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2. 00	3.00	4. 00	5. 00	
1.00	Investment income - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
	COSTS-MVBLE EQUIP (chapter 2)						
3. 00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4.00	Trade, quantity, and time	В	-7, 745	ADMINISTRATIVE & GENERAL	5. 00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
3.00	expenses (chapter 8)		O		0.00	Ĭ	3. 00
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6. 00
7. 00	Tel ephone services (pay		0		0. 00	0	7. 00
	stations excluded) (chapter						
8. 00	21) Television and radio service		0		0. 00	0	8. 00
	(chapter 21)		_			_	
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -841, 342		0. 00	0	9. 00 10. 00
	adj ustment	7 0 2				Ĭ	10.00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12. 00	Related organization	A-8-1	-3, 149, 076			0	12. 00
40.00	transactions (chapter 10)				0.00		40.00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests		0		0. 00 0. 00	0	13. 00 14. 00
15. 00	Rental of quarters to employee		0		0. 00	0	15. 00
16. 00	and others Sale of medical and surgical		0		0. 00	0	16. 00
10.00	supplies to other than		· ·		0.00	J.	10.00
17. 00	patients Sale of drugs to other than		0		0. 00	0	17. 00
17.00	patients		0		0.00		17.00
18. 00	Sale of medical records and		0		0. 00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees,		0		0. 00	0	19. 00
00.00	books, etc.)				0.00		00.00
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0	20. 00 21. 00
	interest, finance or penalty						
22. 00	charges (chapter 21) Interest expense on Medicare		0		0. 00	0	22. 00
22.00	overpayments and borrowings to		· ·		0.00		22.00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
23.00	therapy costs in excess of	7 0 3	O	RESTRATORT THERATT	03.00		23.00
24.00	limitation (chapter 14)	A 0 2	0	DUVCLCAL THEDADY	// 00		24.00
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25 25	limitation (chapter 14)		=	NITH LIZATION SEVERY			25 22
25. 00	Utilization review - physicians' compensation		0	UTILIZATION REVIEW - SNF	114. 00		25. 00
	(chapter 21)						
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
29. 00	Physicians' assistant		0	NOW THE CLAW AND STILL THE	0.00	0	
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	Ω	SPEECH PATHOLOGY	68. 00		31. 00
500	pathology costs in excess of		O		55. 66		500
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0. 00	0	32. 00
JZ. UU	Depreciation and Interest		O		0.00		32.00
33.00	Mi sc Revenue	В		EMERGENCY	91.00	0	
33. 01	Mi sc Revenue	В	- 133, 086	EMPLOYEE BENEFITS DEPARTMENT	4. 00	ΟĮ	33. 01

ADJUSTMENTS TO EXPENSES Provider CCN: 15-0169 Peri od: Worksheet A-8 From 01/01/2016 To 12/31/2016 Date/Time Prepared: 5/30/2017 8:54 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 33.02 Misc Revenue -111, 539 ADMI NI STRATI VE & GENERAL 33. 02 В 5.00 -35, 375 OPERATION OF PLANT 33.03 Mi sc Revenue В 7.00 0 33.03 33. 04 Misc Revenue В -8, 754 HOUSEKEEPI NG 9.00 33.04 33.05 Misc Revenue В -19, 671 DI ETARY 10.00 33.05 -52, 610 NURSING ADMINISTRATION 33 06 Misc Revenue 13.00 ol 33 06 В -23, 360 ADULTS & PEDIATRICS 33.07 Mi sc Revenue В 30.00 33.07 33. 08 Misc Revenue В -45 NEONATAL INTENSIVE CARE UNIT 35.00 33.08 33.09 Mi sc Revenue В -202 OPERATING ROOM 50.00 ol 33.09 -113, 402 RADI OLOGY-DI AGNOSTI C Misc Revenue 33.10 В 54.00 33.10 33. 11 Misc Revenue В -1, 296, 418 LABORATORY 60.00 33.11 33. 12 Misc Revenue В -125 PHYSI CAL THERAPY 66.00 33.12 -27, 749 CAP REL COSTS-BLDG & FIXT 34 01 00 Non-Allow Interest Expense 1 00 11 34 01 Α 34.02 LOC Non-Allow Interest Expense Α -69, 400 CAP REL COSTS-BLDG & FIXT 1.00 11 34.02 34. 03 12A Non-Allow Interest Expense -2,550,274 CAP REL COSTS-BLDG & FIXT 1.00 11 34.03 Α -139, 657 CAP REL COSTS-BLDG & FIXT 12B Non-Allow Interest Expense 34.04 34.04 Α 1.00 11 50M BMO Non-Allow Interest 34.05 -248, 253 CAP REL COSTS-BLDG & FIXT Α 1.00 11 34.05 Expense 34.06 Non-Allow Debt Issuance Α -81, 276 ADMINI STRATI VE & GENERAL 5.00 Ω 34.06 Expense 34.07 16AB Non-Allow Interest -162, 114 CAP REL COSTS-BLDG & FIXT 1.00 11 34.07 Α Expense HAF Tax Offset 35.00 -17, 491, 081 ADMINI STRATI VE & GENERAL 5.00 35.00 0 Α Meals of Wheels Cost 0 36.00 Α -68, 248 CAFETERI A 11.00 36.00 -44,000 ADMINISTRATIVE & GENERAL 36. 01 Sponsorshi p Α 5.00 36.01 Nurse Practitioner Offset -217, 857 NEONATAL INTENSIVE CARE UNIT 35.00 36, 02 36.02 Α Cardiac Cath Expense 36.03 Α 83, 578 CARDI AC CATHETERI ZATI ON 59.00 36.03 TOTAL (sum of lines 1 thru 49) -26, 824, 920 50.00 50.00 (Transfer to Worksheet A, column 6, line 200.)

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

<sup>(2)</sup> Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 15-0169
Period:
From 01/01/2016
To 12/31/2016
Date/Time Prepared:
5/20/2017 8:54 am
5/20/2017 8:54 am

				10 12/31/2010	5/30/2017 8:5	
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:		I		T	
1. 00		I&R SERVICES-SALARY & FRINGE		331, 366		1. 00
2.00		I&R SERVICES-OTHER PRGM COST		579, 259		2. 00
3.00		ADMINISTRATIVE & GENERAL	7250 CLEARVI STA	212, 960		3. 00
3. 01	II	ELECTROENCEPHALOGRAPHY	7250 CLEARVI STA	109, 151		
4.00	l e	CAP REL COSTS-MVBLE EQUIP	CHNW - HOME OFFICE	3, 143, 138		4. 00
4. 01	l e	EMPLOYEE BENEFITS DEPARTMENT	CHNW - HOME OFFICE	4, 002, 300		4. 01
4.02	l e	ADMINISTRATIVE & GENERAL	CHNW - HOME OFFICE	41, 483, 898		4. 02
4.03	1	OPERATION OF PLANT	CHNW - HOME OFFICE	827, 345		4. 03
4.04		NURSING ADMINISTRATION	CHNW - HOME OFFICE	3, 028, 933	0	4. 04
4.05		CENTRAL SERVICES & SUPPLY	CHNW - HOME OFFICE	1, 054, 952	0	4. 05
4.06	16. 00	MEDICAL RECORDS & LIBRARY	CHNW - HOME OFFICE	3, 032, 310	0	4. 06
4.07	30.00	ADULTS & PEDIATRICS	CHNW - HOME OFFICE	1, 234, 911	0	4. 07
4.08	54.00	RADI OLOGY-DI AGNOSTI C	CHNW - HOME OFFICE	605, 538	0	4. 08
4.09	69. 00	ELECTROCARDI OLOGY	CHNW - HOME OFFICE	31, 221	0	4. 09
4. 10	70.00	ELECTROENCEPHALOGRAPHY	CHNW - HOME OFFICE	259, 987	0	4. 10
4. 11	73. 00	DRUGS CHARGED TO PATIENTS	CHNW - HOME OFFICE	983, 268	0	4. 11
5.00	TOTALS (sum of lines 1-4).			60, 920, 537	64, 069, 613	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.

			Related Organization(s) and	or Home Office			
Symbol (1)	Name	Percentage of	Name	Percentage of			
		Ownershi p		Ownershi p			
1. 00	2. 00	3. 00	4. 00	5. 00			
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							
		1.00 2.00	Symbol (1)   Name   Percentage of Ownership   1.00   2.00   3.00	Symbol (1)   Name   Percentage of Ownership   1.00   2.00   3.00   4.00	Ownershi p         Ownershi p           1.00         2.00         3.00         4.00         5.00		

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

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

6. 00	В	CHNW	100.00	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
100.00	G. Other (financial or	G			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
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

			5/30/2017	
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6. 00	7. 00		
			MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO			
1.00	331, 366			1. 00
2.00	579, 259			2. 00
3.00	20, 026			3. 00
3. 01	12, 246			3. 01
4.00	3, 143, 138			4. 00
4. 01	4, 002, 300			4. 01
4. 02	-22, 295, 876			4. 02
4. 03	827, 345			4. 03
4.04	3, 028, 933			4. 04
4. 05	1, 054, 952			4. 05
4.06	3, 032, 310			4. 06
4. 07	1, 234, 911			4. 07
4. 08	605, 538			4. 08
4. 09	31, 221			4. 09
4. 10	259, 987			4. 10
4. 11	983, 268			4. 11
5.00	-3, 149, 076			5. 00

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

1100 110 0	zoon postou to normanost m	cordinate transfer 2, the amount arrowable should be that eated the cordinate transfer the	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
-	B. INTERRELATIONSHIP TO RELAT	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
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Peri od: Worksheet A-8-2 From 01/01/2016 To 12/31/2016 Date/Time Prepared: Provider CCN: 15-0169

					-	Γο 12/31/201 <i>6</i>	Date/Time Pre 5/30/2017 8:5	
	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		AGGREGATE-ADMINISTRATIVE &	119, 004	119, 004	0	0	0	1. 00
0.00		GENERAL	4 000	4 000				0.00
2.00		AGGREGATE OPERATING POOM	4,000			0	0	2.00
3. 00 4. 00	50.00 AGGREGATE-OPERATING ROOM 57.00 AGGREGATE-CT SCAN		517, 750 588			0	0	3. 00 4. 00
4. 00 5. 00	91. OO AGGREGATE-CT SCAN		200, 000	•		0		
6.00	0.00	AGGREGATE-EMERGENCT	200,000	1		0	0	6.00
7. 00	0.00				_		0	7. 00
8. 00	0.00		0		0	0	0	8. 00
9. 00	0.00			0	0	١	0	9. 00
10. 00	0.00			0	0	١	0	10.00
200.00	0.00		841, 342	841, 342	0		0	
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	200.00
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00		AGGREGATE-ADMINISTRATIVE &	0	0	0	0	0	1. 00
2. 00		GENERAL AGGREGATE-SUBPROVIDER - IPF	0	0	0	0	0	2. 00
3.00				-	_	0	0	
4. 00	50.00 AGGREGATE-OPERATING ROOM 57.00 AGGREGATE-CT SCAN			1	_	0		
5.00	91. OO AGGREGATE - EMERGENCY				0		0	5. 00
6. 00	0.00	AGGREGATE EMERGENCT		0	0	١	l ő	
7. 00	0.00		0	0	0	0	0	7. 00
8. 00	0.00		0	0	0	0	Ö	8. 00
9. 00	0.00		0	Ō	0	Ö	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	0.00	14	1/ 00	47.00	10.00		
1. 00	1.00	2. 00 AGGREGATE-ADMINISTRATIVE &	15. 00	16. 00	17. 00	18. 00 119. 004		1. 00
1.00		GENERAL		0	0	119,004		1.00
2.00		AGGREGATE-SUBPROVI DER - I PF	0	0	0	4,000		2. 00
3.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	517, 750		3. 00
4.00	57. 00 AGGREGATE-CT SCAN		0	0	0	588		4. 00
5.00	91. 00 AGGREGATE-EMERGENCY		0	0	0	200, 000		5. 00
6.00	0.00		0	0	0	0		6. 00
7.00	0.00		0	0	0	0		7. 00
8.00	0. 00		0	0	0	0		8. 00
9.00	0. 00		0	0	0	0		9. 00
10.00	0. 00		0	0	0	0		10. 00
200.00			0	0	0	841, 342		200. 00

Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0169 Peri od: Worksheet B From 01/01/2016 To 12/31/2016 Part I Date/Time Prepared: 5/30/2017 8:54 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP EMPLOYEE Subtotal for Cost **BENEFITS** DEPARTMENT All ocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 1.00 13, 485, 052 13, 485, 052 1.00 2.00 14, 429, 557 14, 429, 557 2.00 4, 176, 429 57, 719, 165 27, 004 409, 726 4, 210, 860 248, 905 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 7, 427 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5, 669, 878 64, 047, 674 5.00

7.00   000000   000000		OO ADMINISTRATIVE & GENERAL	57, 719, 165	409, 726	5, 669, 878	248, 905	64, 047, 674	5. 00
0.000   0.0000   DISTERCEP NG			10, 087, 895	2, 023, 054	137, 956	120, 996	12, 369, 901	7. 00
10.00   01000   DETARY   1,138,685   161,354   30,167   30,161   2,283,052   10.00   10.00   10.00   2,287,052   11.00   11.00   11.00   0100   02,687,067   12.384					_	- 1		
11.00 0 1100 CAFETERIA   1,893,964   273,335   51,093   101,087   30   51,025,06   30.00   30.								
13 00 01300   MURSIN CAMINI STRATION   5, 690, 610   18, 803   12, 384   111, 839   5, 823, 636   13, 00   15, 00 01500   PHANMACY   4, 428, 731   145, 850   109, 448   174, 937   4, 938, 922   15, 00   15, 00 01500   PHANMACY   4, 428, 731   145, 850   109, 448   174, 937   4, 938, 922   15, 00   19, 00 01500   PHANMACY   2, 839, 838   21, 320   0   0   0   0   19, 00 01500   MORPHYSIC CAN RECIBER S LIBRARY   3, 873, 873   145, 850   0   0   0   0   19, 00 01500   MORPHYSIC CAN RESTHETISTS   2, 839, 838   21, 320   0   0   0   0   22, 00 01500   MORPHYSIC CAN RESTHETISTS   3, 93, 836   21, 320   0   0   0   0   22, 00 0200   148 SERVICES-SHALAY & FRINGES APPRVD   579, 259   0   0   0   0   579, 259   22 00   19, 10 0200   148 SERVICES-SERVICE COST CENTERS   41, 421, 3448   3, 973, 659   1, 786, 688   1, 065, 415   48, 247, 110   30, 00 03000 ADURTS & PEDIATRICS   41, 421, 3448   3, 973, 659   1, 786, 688   1, 065, 415   48, 247, 110   30, 00 03000 ADURTS & PEDIATRICS   41, 421, 3448   3, 973, 659   1, 786, 688   1, 065, 415   48, 247, 110   30, 00 03000 ADURTS & PEDIATRICS   41, 421, 3448   3, 973, 659   1, 786, 688   1, 065, 415   48, 247, 110   30, 00 03000 ADURTS & PEDIATRICS   41, 421, 3448   3, 973, 659   1, 786, 688   1, 065, 415   48, 247, 110   30, 00 03000 ADURTS & PEDIATRICS   41, 421, 3448   3, 973, 659   1, 786, 688   1, 065, 415   48, 247, 110   30, 00 03000 ADURTS & PEDIATRICS   41, 421, 3448   3, 973, 659   1, 786, 688   1, 065, 415   48, 247, 110   30, 00 03000 ADURTS & PEDIATRICS   41, 421, 3448   3, 973, 659   1, 786, 688   1, 065, 415   48, 247, 110   30, 00 03000 ADURTS & PEDIATRICS   41, 421, 3448   3, 973, 659   1, 786, 688   1, 065, 415   48, 247, 110   30, 00 03000 ADURTS & PEDIATRICS   41, 421, 448   3, 973, 659   1, 786, 688   1, 065, 415   48, 247, 110   30, 00 03000 ADURTS & PEDIATRICS   41, 421, 448   3, 973, 659   1, 786, 688   1, 065, 415   48, 247, 110   30, 00 03000 ADURTS & PEDIATRICS   41, 421, 421, 421, 421, 421, 421, 421,			1 1					
14 00 01400 CENTRAL SERVICES & SUPPLY 4, 415, 379 300, 567 130, 799 10, 486 134, 809 34, 498, 731 14, 00 1600 014600 MEDICAL RECORDS & LIBRARY 3, 507, 934 18, 269 44 113, 768 3, 540, 015 16, 00 1700 01700								
15.00   01500   PIAMBIACY   4, 428, 731   145, 850   109, 448   114, 873   4, 938, 922   15, 00   17.00   01700   SOCI AL SERVICE   2, 839, 354   21, 321   0   96, 991   2, 957, 666   17.00   17.0			1 1					
16.00   01-000   MEDI CAL RECORDS & LIBRARY   3, 507, 934   18, 269   4.4   13, 768   3, 540, 015   10, 00   170, 00			1			- 1		
17. 00 0 1700 (ONDPHYSICIAL SERVICE 2.839, 354 21, 321 0 0 9, 991 2.957, 666 17.00 17.00 17.00 (ONDPHYSICIAN AMESTHETISTS 3 0 0 0 0 0 331, 366 21 0 0 0 0 331, 366 21 0 0 0 0 331, 366 21 0 0 0 0 331, 366 21 0 0 0 0 331, 366 21 0 0 0 0 0 331, 366 21 0 0 0 0 0 331, 366 21 0 0 0 0 0 331, 366 21 0 0 0 0 0 331, 366 21 0 0 0 0 0 331, 366 21 0 0 0 0 0 331, 366 21 0 0 0 0 0 331, 366 21 0 0 0 0 0 331, 366 21 0 0 0 0 0 0 331, 366 21 0 0 0 0 0 0 331, 366 21 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		l	1					
19.00   1900   MORIPHYSICI AN AMESTHETI STS   0   0   0   0   331, 366   21.00   220   10   RS FERVICE-SCHIER PIRGE COSTS APPRVD   579, 259   0   0   0   0   579, 259   22.00			1					
21.00   02100  IAR SERVICES-SALARY & FRINCES APPRIVD   331, 366   21.00   0   0   0   331, 366   21.00   0   0   0   579, 259   22.00   0   0   579, 259   22.00   0   0   579, 259   22.00   0   0   579, 259   22.00   0   0   579, 259   22.00   0   0   0   579, 259   22.00   0   0   0   579, 259   22.00   0   0   0   0   0   0   0   0   0		l	0		-			
IMPATI ENT ROUTINE SERVICE COST CENTERS   41, 421, 348   3, 973, 659   1, 786, 688   1, 0.65, 415   48, 247, 110   30 00   310 00   30100   AULTS & PEDIDATRICS   41, 421, 348   3, 973, 659   1, 786, 688   1, 0.65, 415   48, 247, 110   30 00   310 00   30100   INTENSIVE CARE UNIT   4, 827, 886   881, 525   223, 8792   226, 189   228, 536   9, 171, 113   35 00   40 00   40000   SUBPROVIDER   IPP   1, 420, 994   139, 385   23, 671   47, 501   1, 631, 551   40 00   40 00   3000   MIRSTERY   2, 620, 759   437, 721   79, 557   68, 867   3, 224, 404   43, 00   4300   MIRSTERY   2, 620, 759   437, 721   79, 557   68, 867   3, 224, 404   43, 00   4300		l	331, 366			o	331, 366	
30.00			1	0	0	o		
31 00   03100   INTENSIVE CARE UNIT	INF	PATIENT ROUTINE SERVICE COST CENTERS						
15. 00   02060 NEONATAL INTENSIVE CARE UNIT   7, 866,099   795,289   226,189   228,354   9,171,112   35. 00		l	41, 421, 348	3, 973, 659	1, 786, 688	1, 065, 415		
40. 00   04000   NUBSERY   F   1, 420, 994   139, 385   23, 671   47, 501   1, 631, 551   40. 00			1					
MAINTELLARY SERVICE COST CENTERS			1					
ANCILLARY SERVICE COST CENTERS   1.1, 194, 1790   6.00, 352   1, 192, 385   214, 745   14, 002, 272   50. 00   51. 00   05100   05100   PECATIVE ROOM   3. 00.6, 542   331, 270   18, 938   92, 528   3. 450, 278   51. 00   52. 00   05200   0ELIVERY ROOM   6.560, 0.97   996, 938   111, 199   214, 719   7, 958, 853   52. 00   55. 00   05500   DELIVERY ROOM   6.560, 0.97   996, 938   111, 199   214, 719   7, 958, 853   52. 00   55. 00   05500   DELIVERY ROOM   6.560, 0.97   996, 938   111, 199   214, 719   7, 958, 853   52. 00   55. 00   05500   DELIVERY ROOM   6.500, 940   404, 051   20, 889   11, 888, 910   55. 00   5500   05500   CABDIO ARON THERAPPUTC   1.263, 026   200, 944   404, 051   20, 889   11, 888, 910   55. 00   5500   05500   MAINCHET CRESONANCE IMAGING (MRI )   1.895, 842   111, 523   800, 494   23, 174   22, 840, 033   58. 00   5900   0ASDMATORY   7.958, 573   1115, 471   12, 212   9, 773   80, 96, 029   60. 00   6000   ABDORATORY   7.958, 573   115, 471   12, 212   9, 773   80, 96, 029   60. 00   6000   CABDORATORY   7.958, 573   115, 471   12, 212   9, 773   80, 96, 029   60. 00   6000   CESPI NATORY HERAPPY   3.864, 202   124, 891   306, 328   132, 229   4.408, 650   65. 00   65600   RESPI NATORY HERAPPY   3.864, 202   124, 891   306, 328   132, 229   4.408, 650   66. 00   6600   PHYSI CAL THERAPY   4.618, 570   124, 891   306, 328   132, 229   4.408, 650   66. 00   6000   GEED TRADOR HERAPPY   1.316, 317   0   127, 084   172, 587   4.918, 241   66. 00   66. 00   6600   FHYSI CAL THERAPY   1.316, 317   0   127, 084   172, 587   4.918, 241   66. 00   68. 00   6800   SPEECH PATHOLOGY   253, 436   0   6.143   8.402   267, 981   68. 00   68. 00   6800   SPEECH PATHOLOGY   253, 436   0   6.143   8.402   267, 981   68. 00   69.			1					
50.00   050000   050000   050000   050000   050000   050000   050000   050000   050000   050000   0500000   0500000   0500000000			2, 620, 759	437, 721	79, 557	86, 867	3, 224, 904	43. 00
51 00   05100   RECOVERY ROOM   ALBOR ROOM   6, 560, 997   996, 938   181, 199   214, 719   7, 953, 853   52 00   5500   05500   DELY IVERY ROOM   ALBOR ROOM   6, 560, 997   996, 938   181, 199   214, 719   7, 953, 853   52 00   55, 00   05500   RADIOLOGY-PHEAPPUTC   1, 263, 026   200, 944   404, 051   20, 889   1, 888, 910   55, 00   05500   RADIOLOGY-PHEAPPUTC   1, 263, 026   200, 944   404, 051   20, 889   1, 888, 910   55, 00   05500   CARDIOLOGY-PHEAPPUTC   1, 263, 026   200, 944   404, 051   20, 889   1, 888, 910   55, 00   05500   CARDIOLAGY-PHEAPPUTC   1, 201, 84, 00   26, 884   427, 205   44, 951   1, 707, 149   57, 00   67, 67, 67, 67, 67, 67, 67, 67, 67, 67,			44 004 700	(00.050	4 400 005	04.4.745	44 000 070	F0 00
S2 00   05200   DELIVERY ROOM & LABOR ROOM   6, 560, 997   996, 938   181, 199   214, 779   7, 933, 853   52, 00   05500   RADI DOLGOY-THERAPEUTIC   4,745, 398   198, 179   136, 600   5, 963, 384   54, 00   057, 00   05700   CT SCAN   1, 208, 409   20, 944   404, 051   20, 889   1, 888, 910   55, 00   0570   OT SCAN   1, 208, 409   26, 584   404, 051   20, 889   1, 888, 910   57, 00   370, 00   570, 0		l						
54 00   05400   RADIOLOGY-DIAGNOSTIC   4,745,398   198,179   883,207   136,600   5,963,384   54.00   55.00   05500   RADIOLOGY-THERAPEUTIC   1,263.026   200,944   404,051   20,889   1.888,910   55.00   05500   CT SCAN   1,208,409   26,584   427,205   44,951   1,707,149   57.00   20,800   0800   MAGNETIC RESONANCE IMAGING (MRI)   1,895,842   111,523   40,000   23,174   2,840,033,58   20,000   0								
1.			1 1		· ·			
1, 208, 409   26, 584   427, 205   44, 951   1, 707, 149   57, 00   58, 00   05900   CARDITIC RESONANCE IMAGING (MRI)   1, 895, 842   111, 523   809, 494   23, 174   2, 840, 033   58, 00   59, 00   05900								
S8 00   OSBOO   MAGNETIC RESONANCE IMAGING (MRI)   1,895,842   111,523   809,494   23,174   2,840,033   58,00   50,00   0500   04000   CARDIAC CATHETERIZATION   7,958,573   115,471   12,212   9,773   8,006,029   0,00   0.00   0.6400   0.6400   INTRAVENIOUS THERAPY   4.66,480   141,731   12,212   9,773   8,006,029   0,00   0.6400   INTRAVENIOUS THERAPY   4.66,480   141,731   306,328   123,229   4.408,650   65.00   0.6500   RESPIRATORY THERAPY   4,618,570   0   127,084   172,587   4,918,241   66.00   0.6600   0.6600   MINTRAVENIOUS THERAPY   1,316,317   0   31,900   43,461   1,391,862   67.00   0.6700   0.00			1 1					
59.00   05900   CARDIAC CATHETERI ZATION   -37, 034   19, 642   0   0   -17, 392   59.00			1					
60.00   06000   LABORATORY   7,958,573   115,471   12,212   9,773   8,096,029   60.00		, ,	1 1					
64.00   06400   INTRAVENOUS THERAPY   4.66, 480   141, 731   0   13, 060   621, 271   64.00			1 1		-			
65.00   06500   RESPI RATORY THERAPY   3, 854, 202   124, 891   306, 328   123, 229   4, 408, 650   65, 00   66.00   06600   PHYSI CAL THERAPY   4, 618, 570   0   31, 904   43, 641   172, 587   4, 918, 241   66, 00   67.00   06700   0CCUPATI ONAL THERAPY   1, 316, 317   0   31, 904   43, 641   1, 391, 862   67, 00   68.00   06800   SPEECH PATHOLOGY   253, 436   0   6, 143   8, 402   267, 981   68, 00   69.00   06900   ELECTROCARDI OLOGY   1, 606, 426   30, 608   142, 153   43, 412   1, 822, 599   70, 00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   12, 422, 228   0   0   0   0   12, 422, 228   71, 70   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   11, 524, 803   0   0   0   0   11, 524, 803   72, 00   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   11, 524, 803   0   0   0   0   11, 524, 803   72, 00   73.00   07300   DRUGS CHARGED TO PATI ENTS   14, 819, 501   0   0   0   0   14, 819, 501   73, 00   74.00   07400   RENAL DI ALYSI S   968, 867   2, 384   0   0   0   971, 251   74, 00   76.00   03306   ENDOSCOPY   1, 700, 326   161, 087   425, 940   45, 247   2, 332, 600   76, 00   76.06   039954   IMAGI ING CENTER   3, 335, 131   0   469, 385   62, 313   3, 866, 829   76, 00   76.07   039955   RERAST DI AGNOSTIC CENTER   4, 713, 511   0   93, 649   0   4, 807, 160   76, 07   79.00   09000   CLI NI C   0   0   0   0   0   0   0   79.00   09000   00   00   00   00   0   0		l	1 1					
66. 00   06600   PNYSI CAL THERAPY		l e e e e e e e e e e e e e e e e e e e	1		_			
67.00   06700   05CUPATI ONAL THERAPY   1, 316, 317   0   31, 904   43, 641   1, 391, 862   67.00   68.00   06800   SPEECH PATHOLOGY   253, 436   0   6, 143   8, 402   267, 981   68.00   69.00   06900   ELECTROCARDI OLOGY   669, 309   0   15, 622   3, 382   688, 313   69.00   71.00   07000   ELECTROCARDI OLOGY   1, 606, 426   30, 608   142, 153   43, 412   1, 822, 599   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   12, 422, 228   0   0   0   0   12, 422, 228   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   11, 524, 803   0   0   0   0   14, 819, 501   73.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   14, 819, 501   0   0   0   0   14, 819, 501   73.00   74.00   07400   RENAL. DI ALYSI S   968, 867   2, 384   0   0   0   971, 251   74.00   76.00   03330   ENDOSCOPY   1, 700, 326   161, 087   425, 940   45, 247   2, 332, 600   76.00   76.07   03955   BREAST DI AGNOSTIC CENTER   4, 713, 511   0   93, 649   0   4, 807, 160   76.07   03955   BREAST DI AGNOSTIC CENTER   4, 713, 511   0   93, 649   0   4, 807, 160   76.00   09000   CLI NI C   0   0   0   0   0   0   76.01   09000   EMERGENCY   8, 297, 714   552, 600   178, 401   259, 613   9, 288, 328   91.00   76.02   09700   DEBERGENCY   SIPPLES   S		l e e e e e e e e e e e e e e e e e e e	1					
68.00   06800   SPEECH PATHOLOGY   253, 436   0   6, 143   8, 402   267, 981   68.00   69.00   06900   ELECTROCARDI OLOGY   669, 309   0   15, 622   3, 382   688, 313   69.00   70.00   07000   ELECTROCENCEPHALOGRAPHY   1, 606, 426   30, 608   142, 153   43, 412   1, 822, 599   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   12, 422, 228   0   0   0   0   12, 422, 228   71.00   72.00   07200   IMPL. DE DEV. CHARGED TO PATIENTS   11, 524, 803   0   0   0   0   11, 524, 803   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   14, 819, 501   0   0   0   0   14, 819, 501   73.00   74.00   07400   RENAL DI ALYSI S   968, 867   2, 384   0   0   0   0   14, 819, 501   74.00   76.00   03330   ENDOSCOPY   1, 700, 326   161, 087   425, 940   45, 247   2, 332, 600   76.00   76.07   03955   BREAST DI AGNOSTI C CENTER   3, 335, 131   0   469, 385   62, 313   3, 866, 829   76.00   76.07   03955   BREAST DI AGNOSTI C CENTER   4, 713, 511   0   93, 649   0   4, 807, 160   76.07   03955   BREAST DI AGNOSTI C CENTER   227, 982   0   4, 788   8, 421   241, 191   90.26   79.00   09000   CLI NI C   0   0   0   0   0   0   0   79.00   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   09000   09000   79.00   090				0	· ·			
70. 00   07000   ELECTROENCEPHALOGRAPHY   1, 606, 2426   30, 608   142, 153   43, 412   1, 822, 599   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   12, 422, 228   0   0   0   12, 422, 228   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   11, 524, 803   0   0   0   0   11, 524, 803   72. 00   73.00   07300   DRUGS CHARGED TO PATIENTS   14, 819, 501   0   0   0   0   14, 819, 501   73. 00   74. 00   07400   RENAL DI ALYSI S   968, 867   2, 384   0   0   0   971, 251   73. 00   76. 00   03330   ENDOSCOPY   1, 700, 326   161, 087   425, 940   45, 247   2, 332, 60   76. 00   76. 00   03330   ENDOSCOPY   1, 700, 326   161, 087   425, 940   45, 247   2, 332, 60   76. 06   76. 07	68. 00 068	300 SPEECH PATHOLOGY	253, 436	0			267, 981	68. 00
77. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   12, 422, 228   0   0   0   12, 422, 228   71. 00   72. 00   07200   MPL. DEV. CHARGED TO PATIENTS   11, 524, 803   0   0   0   11, 524, 803   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   14, 819, 501   0   0   0   14, 819, 501   73. 00   74. 00   07400   RENAL DI ALYSIS   968, 867   2, 384   0   0   971, 251   74. 00   76. 00   03330   ENDOSCOPY   1, 700, 326   161, 087   425, 940   45, 247   2, 332, 600   76. 06   03954   IMAGI NG CENTER   3, 335, 131   0   469, 385   62, 313   3, 866, 827   76. 06   76. 07   03955   BREAST DI AGNOSTIC CENTER   4, 713, 511   0   93, 649   0   4, 807, 160   76. 07   03955   BREAST DI AGNOSTIC CENTER   4, 713, 511   0   93, 649   0   4, 807, 160   76. 07   03955   SPINE CENTER   227, 982   0   4, 788   8, 421   241, 191   90. 26   91. 00   91000   EMERGENCY   8, 297, 714   552, 600   178, 401   259, 613   9, 288, 30   91. 00   92. 00   9200   09SERVATI ON BEDS (NON-DI STINCT PART)   SPECI AL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   114. 00   11400   UTI LI ZATI ON REVI EW - SNF   118. 00   119. 00   19100   19100   EMERGENCY   SUBTOTALS (SUM OF LINES 1-117)   292, 805, 640   13, 396, 127   14, 355, 582   4, 183, 895   292, 615, 775   118. 00   190. 00   191. 00   19100   19100   EMERGENCH   0   0   0   0   0   0   0   191. 00   191. 00   191. 00   1910	69. 00 069	POO ELECTROCARDI OLOGY	669, 309	0	15, 622	3, 382	688, 313	69. 00
72. 00   07200   MPL DEV. CHARGED TO PATIENTS   11, 524, 803   0   0   0   11, 524, 803   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   14, 819, 501   0   0   0   0   11, 524, 803   72. 00   73. 00   07400   RENAL DI ALYSIS   948, 867   2, 384   0   0   0   971, 251   74. 00   74. 00   07400   RENAL DI ALYSIS   948, 867   2, 384   0   0   0   971, 251   74. 00   76. 00   03330   ENDOSCOPY   1, 700, 326   161, 087   425, 940   45, 247   2, 332, 600   76. 00		000 ELECTROENCEPHALOGRAPHY	1, 606, 426	30, 608	142, 153	43, 412	1, 822, 599	70.00
73.00   07300   DRUGS CHARGED TO PATIENTS   14, 819, 501   0   0   14, 819, 501   73.00   74.00   7400   RENAL DIALYSIS   968, 867   2, 384   0   0   971, 251   74.00   76.00   03330   ENDOSCOPY   1, 700, 326   161, 087   425, 940   45, 247   2, 332, 600   76.00   76.00   76.00   3954   IMAGING CENTER   3, 335, 131   0   469, 385   62, 313   3, 866, 829   76.06   76.07			12, 422, 228	0	0	0	12, 422, 228	71. 00
74. 00 07400 RENAL DI ALYSI S 968, 867 2, 384 0 0 0 971, 251 74. 00 76. 00 0330 ENDOSCOPY 1, 700, 326 161, 087 425, 940 45, 247 2, 332, 600 76. 00 6 03954 I MAGI NG CENTER 3, 335, 131 0 469, 385 62, 313 3, 86, 829 76. 06 76. 07 000 03955 BREAST DI AGNOSTI C CENTER 4, 713, 511 0 93, 649 0 4, 807, 160 76. 07 000 09000 (CLI NI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0	0		72. 00
76. 00 03330   ENDOSCOPY			1		-	-1		
76. 06   03954   IMAGING CENTER   3, 335, 131   0   469, 385   62, 313   3, 866, 829   76. 06   76. 07   03955   BREAST DI LAGNOSTIC CENTER   4, 713, 511   0   93, 649   0   4, 807, 160   76. 07   00000   0   0   0   0   0   0   0		l	1			- 1		
76. 07 03955 BREAST DI AGNOSTIC CENTER 4, 713, 511 0 93, 649 0 4, 807, 160 76. 07 0UTPATIENT SERVICE COST CENTERS  90. 00 09000 CLI NI C 0 0 0 0 0 0 0 90. 00. 0			1					
90. 00   09000   CLI NI C   0   0   0   0   0   0   0   0   0			1	-				
90. 00			4, 713, 511	0	93, 649	0	4, 807, 160	76. 07
90. 26   04975   SPI NE CENTER   227, 982   0   4, 788   8, 421   241, 191   90. 26   91. 00   09100   EMERGENCY   8, 297, 714   552, 600   178, 401   259, 613   9, 288, 328   91. 00   92. 00   085ERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   09200   085ERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   09200   085ERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   09200   085ERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   09200   085ERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   09200   085ERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   09200   085ERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   09200   085ERVATI ON BEDS (NON-DI STI NCT PART)   113. 00   114. 00				ما		ما	0	00.00
91. 00			1		-		-	
92. 00				-				
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   113.00   114.00   11400   UTILIZATION REVIEW - SNF   114.00   114.00   SUBTOTALS (SUM OF LINES 1-117)   292,805,640   13,396,127   14,355,582   4,183,895   292,615,775   118.00   NONREI MBURSABLE COST CENTERS   0   76,510   0   0   76,510   190.00   191.00   19100   RESEARCH   0   0   0   0   0   0   0   191.00   192.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   169,058   0   0   0   0   0   169,058   192.00   193.00   19300   NONPAI D WORKERS   0   0   0   0   0   193.00   194.00   194.00   195.00   194.00   195			0, 277, 714	332, 000	170, 401	237, 013		
113. 00 114.00 115.00 115.00 116.00 1							U	72.00
114. 00 118. 00 119. 0								113 00
118. 00   SUBTOTALS (SUM OF LINES 1-117)   292,805,640   13,396,127   14,355,582   4,183,895   292,615,775   118. 00								
NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   76,510   0   0   0   76,510   190. 00	1		292, 805, 640	13, 396, 127	14, 355, 582	4. 183. 895		
190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   76, 510   0   0   76, 510   190. 00   191. 00   191. 00   19100   RESEARCH   0   0   0   0   0   191. 00   191. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   169, 058   0   0   0   0   169, 058   192. 00   193. 00   194. 00   0   0   0   0   0   0   193. 00   194. 00   0   0   0   0   0   0   0   194. 00				,,	,	.,,		
192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   169, 058   0   0   0   169, 058   192. 00   193. 00   193. 00   193. 00   194. 00   0   0   0   0   0   193. 00   194. 00			0	76, 510	0	0	76, 510	190. 00
193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00 194			0	1	0	o	0	191. 00
194. 00 07950 HOME OFFICE 0 0 0 0 0 194. 00 194. 06 07956 PAVILLIONS 20, 461 0 73, 975 0 94, 436 194. 06 194. 08 07958 OTHER NRCC 2, 106, 815 12, 415 0 26, 431 2, 145, 661 194. 08 194. 10 07960 COMMUNITY REHAB HOSPITAL 12, 109 0 534 12, 643 194. 10 200. 00 Cross Foot Adjustments 0 0 0 0 0 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00	192. 00 192	200 PHYSICIANS' PRIVATE OFFICES	169, 058	o	0	o	169, 058	192. 00
194. 06 07956 PAVI LLI ONS 20, 461 0 73, 975 0 94, 436 194. 06 194. 08 07958 OTHER NRCC 2, 106, 815 12, 415 0 26, 431 2, 145, 661 194. 08 194. 10 07960 COMMUNI TY REHAB HOSPI TAL 12, 109 0 534 12, 643 194. 10 200. 00 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 201. 00	193. 00 193	NONPALD WORKERS	0	0	0	0	0	193. 00
194. 08 07958 OTHER NRCC 2, 106, 815 12, 415 0 26, 431 2, 145, 661 194. 08 194. 10 07960 COMMUNITY REHAB HOSPITAL 12, 109 0 534 12, 643 194. 10 200. 00 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 201. 00	194. 00 079	P50 HOME OFFICE	0	0	0	0	0	194. 00
194.10 07960 COMMUNITY REHAB HOSPITAL 12,109 0 0 534 12,643 194.10 200.00 Cross Foot Adjustments 0 0 0 0 0 201.00				0	73, 975	0		
200.00   Cross Foot Adjustments   0 200.00   201.00   Negative Cost Centers   0 0 0 0 0 201.00		l	1 1	12, 415	0			
201.00   Negative Cost Centers   0 0 0 201.00			12, 109	0	0	534	12, 643	194. 10
202.00    101AL (Sum lines 118-201)   295, 114, 083  13, 485, 052  14, 429, 557  4, 210, 860  295, 114, 083 202.00		1 3	205 444 263	0	0	0 0 0 0 0		
	202.00	IUTAL (SUM TINES 178-207)	295, 114, 083	13, 485, 052	14, 429, 557	4, 210, 860	295, 114, 083	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2016 | Part I | To 12/31/2016 | Date/Time Prepared: 5/30/2017 8:54 am

					5/30/2017 8: 5	4 am
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5. 00	7. 00	8. 00	9. 00	10. 00	
GENERAL SERVICE COST CENTERS						
1.00   00100   CAP REL COSTS-BLDG & FLXT						1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00   00500 ADMINISTRATIVE & GENERAL	64, 047, 674					5.00
7.00   00700 OPERATION OF PLANT	3, 428, 467	15, 798, 368				7.00
8.00 00800 LAUNDRY & LINEN SERVICE	225, 409	66, 867	1, 105, 553			8. 00
9. 00 00900 HOUSEKEEPI NG	1, 108, 642	155, 323		5, 263, 945		9. 00
10. 00   01000 DI ETARY	379, 248	231, 208		78, 136	2, 056, 917	10.00
11. 00   01100   CAFETERI A	632, 761	391, 668		132, 364	0	11. 00
13. 00 01300 NURSING ADMINISTRATION	1, 614, 091	26, 944		9, 106	0	13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	234, 683	430, 690		145, 551	0	14. 00
15. 00 01500 PHARMACY	1, 368, 881	208, 991	0	70, 628	0	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	981, 158	26, 179		8, 847	0	16. 00
17. 00 01700 SOCI AL SERVI CE	819, 753	30, 551		10, 325	0	17. 00
	019, 733	30, 331		10, 323	0	17.00
	01 040	0		U		
21. 00   02100   1 &R SERVI CES-SALARY & FRINGES APPRVD	91, 842	0	0	0	0	21. 00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	160, 549	0	0	0	0	22. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1			
30. 00   03000   ADULTS & PEDI ATRI CS	13, 372, 289	5, 693, 951			1, 371, 218	30. 00
31.00 03100 INTENSIVE CARE UNIT	1, 708, 431	1, 263, 158			140, 844	31. 00
35.00  02060 NEONATAL INTENSIVE CARE UNIT	2, 541, 884	1, 139, 588			288, 782	35. 00
40. 00   04000   SUBPROVI DER - 1 PF	452, 204	199, 728	0	67, 498	64, 515	40.00
43. 00   04300   NURSERY	893, 821	627, 220	42, 259	211, 968	191, 558	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	3, 880, 898	860, 259	49, 164	290, 723	0	50.00
51.00 05100 RECOVERY ROOM	956, 286	474, 685	0	160, 419	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 204, 506	1, 428, 537	96, 253	482, 772	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 652, 823	283, 975		95, 969	0	54.00
55. 00   05500 RADI OLOGY-THERAPEUTI C	523, 534	287, 937			0	55. 00
57. 00   05700   CT   SCAN	473, 157	38, 093		12, 873	0	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	787, 149	159, 804		54, 006	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	28, 146		9, 512	0	59. 00
60. 00   06000   LABORATORY	2, 243, 912	165, 461		55, 917	0	60. 00
64. 00   06400   NTRAVENOUS THERAPY		203, 089		68, 634	0	64. 00
	172, 193				0	
65. 00 06500 RESPI RATORY THERAPY	1, 221, 910	178, 960		60, 479		65. 00
66. 00   06600   PHYSI CAL THERAPY	1, 363, 150	0	0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	385, 771	0	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	74, 274	0	0	0	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY	190, 774	0	0	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	505, 155	43, 859	0	14, 822	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 442, 970	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 194, 237	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 107, 403	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	269, 194	3, 416	0	1, 154	0	74.00
76. 00 03330 ENDOSCOPY	646, 508	230, 825	28, 552	78, 007	0	76.00
76.06 03954 I MAGI NG CENTER	1, 071, 738	0	0	o	0	76.06
76. 07 03955 BREAST DIAGNOSTIC CENTER	1, 332, 362	0	0	0	0	76. 07
OUTPATIENT SERVICE COST CENTERS	•		•			
90. 00 09000 CLI NI C	0	0	0	0	0	90. 00
90. 26   04975   SPI NE CENTER	66, 849	0	0	0	0	90. 26
91. 00   09100   EMERGENCY	2, 574, 372	791, 834	121, 048	267, 599	0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,0,1,0,2	,,,,,,,,,	121,010	20,,0,,	Ü	92. 00
SPECIAL PURPOSE COST CENTERS						72.00
113. 00 11300   NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW - SNF						114. 00
118.00   SUBTOTALS (SUM OF LINES 1-117)	42 255 220	15 470 044	1, 105, 553	5, 220, 883	2, 056, 917	
	63, 355, 238	15, 670, 946	1, 100, 555	3, 220, 663	2, 030, 917	116.00
NONREI MBURSABLE COST CENTERS	21 20/	100 (22	1 0	27.050		100 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	21, 206	109, 633		37, 050		190.00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	46, 856	0	0	0		192. 00
193. 00 19300 NONPAI D WORKERS	0	0	) O	0		193. 00
194.00 07950 HOME OFFICE	0	0	0	0		194. 00
194. 06 07956 PAVI LLI ONS	26, 174	0	0	0		194. 06
194. 08 07958 OTHER NRCC	594, 696	17, 789	0	6, 012		194. 08
194.10 07960 COMMUNITY REHAB HOSPITAL	3, 504	0	0	0	0	194. 10
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	o	0	201. 00
202.00 TOTAL (sum lines 118-201)	64, 047, 674	15, 798, 368	1, 105, 553	5, 263, 945		
	,		'	•		

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

Cost Center Description CAFETERI A NURSI NG CENTRAL **PHARMACY** MEDI CAL RECORDS & SERVICES & ADMI NI STRATI ON SUPPLY LI BRARY 11. 00 13.00 15.00 14.00 16,00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 3, 439, 795 11.00 01300 NURSING ADMINISTRATION 114, 988 13.00 7, 588, 765 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 1, 657, 659 14.00 3, 745 15.00 01500 PHARMACY 160, 984 6, 752, 151 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 13, 142 24 4, 569, 365 16.00 01700 SOCIAL SERVICE 91, 991 17.00 0 0 17.00 126 0 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 C 0 0 0 19.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 0 0 0 21.00 02200 & SERVICES-OTHER PRGM COSTS APPRVD 0 22.00 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 140, 027 3, 563, 330 54, 581 0 518, 844 30.00 03100 INTENSIVE CARE UNIT 544, 255 0 31.00 174, 125 8,973 73, 435 31.00 o 02060 NEONATAL INTENSIVE CARE UNIT 831, 786 8, 300 282, 364 35.00 35.00 266, 116 04000 SUBPROVIDER - IPF 45, 995 3, 206 0 18, 473 40.00 143, 766 40.00 04300 NURSERY 43.00 88, 705 277, 262 4, 121 0 36, 772 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 220 121 688 021 98 988 0 566 588 50 00 05100 RECOVERY ROOM 0 51.00 88,705 6,018 107, 693 51.00 05200 DELIVERY ROOM & LABOR ROOM 203, 694 636, 676 9, 386 0 78, 576 52.00 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 131, 415 C 4,747 0 137, 064 54.00 05500 RADI OLOGY-THERAPEUTI C 19.712 55.00 C 9, 110 87, 745 55.00 57.00 05700 CT SCAN 45, 995 0 380 241, 742 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 22, 998 0 2, 188 0 82, 061 58.00 05900 CARDIAC CATHETERIZATION 59 00 Ω 4 215 59 00 06000 LABORATORY 60.00 6,571 0 90, 345 386, 980 60.00 06400 INTRAVENOUS THERAPY 0 5, 097 64.00 13.142 205 64.00 65.00 06500 RESPIRATORY THERAPY 128, 130 4, 188 0 100, 563 65.00 06600 PHYSI CAL THERAPY 32, 854 66.00 Ω 4 185 94, 891 66 00 06700 OCCUPATIONAL THERAPY 67.00 39, 425 0 1,049 25, 345 67.00 06800 SPEECH PATHOLOGY 6, 571 0 68.00 202 7, 427 68.00 0 69.00 06900 ELECTROCARDI OLOGY 3, 285 20 29, 150 69.00 07000 ELECTROENCEPHALOGRAPHY 2 955 70 00 45, 995 43, 738 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 806, 599 0 290, 797 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 494, 750 146, 726 72.00 07300 DRUGS CHARGED TO PATIENTS 362, 714 73.00 0 0 6, 752, 151 73.00 C 07400 RENAL DIALYSIS 10, 698 74.00 0 0 142 0 74 00 76.00 03330 ENDOSCOPY 45, 995 0 6, 413 0 67, 769 76.00 76.06 03954 I MAGING CENTER 0 6, 210 0 199, 507 76.06 03955 BREAST DIAGNOSTIC CENTER 0 76.07 0 0 40, 469 76.07 253 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 0 0 90.00 2, 783 04975 SPINE CENTER 84 0 90. 26 90.26 09100 EMERGENCY 903, 669 91.00 289.114 22, 200 519, 139 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW - SNF 114.00 SUBTOTALS (SUM OF LINES 1-117) 3, 439, 795 7, 588, 765 1, 653, 693 6, 752, 151 4, 569, 365 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 191. 00 19100 RESEARCH 0 C 0 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 3, 432 0 0 192.00 0 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 0 194.00 07950 HOME OFFICE 01194.00 C 0 0 194. 06 07956 PAVI LLI ONS 0 216 0 194.06 194. 08 07958 OTHER NRCC 0 0 0 194. 08 0 318 0 194. 1007960 COMMUNITY REHAB HOSPITAL 0 0 194, 10 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118-201) 3, 439, 795 7, 588, 765 1, 657, 659 6, 752, 151 4, 569, 365 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: | 5/30/2017 8:54 am

Cost Centrar Person   Price   Cost Centrar Person   Price   Cost Centrar Person   Price   Cost Centrar Person   Price   Cost Centrar   Price							5/30/2017 8:5	4 am
MARTSHEISTS   Y.A. FRINCES   PROMOSTS					INTERNS &	RESI DENTS		
MARTSHEISTS   Y.A. FRINCES   PROMOSTS								
DEPERAL SERVICE COST CENTERS	Cost Center De	scription	SOCIAL SERVICE	NONPHYSI CI AN	SERVI CES-SALAR	SERVI CES-OTHER	Subtotal	
DEPERAL SERVICE COST CONTESS   17.00   19.00   21.00   22.00   24.00				ANESTHETI STS	Y & FRINGES	PRGM COSTS		
CHEMPAL SENVICE COST CENTERS   1.00   0.00			17. 00	19. 00		22.00	24.00	
1.00   1.00	GENERAL SERVICE COST	CENTERS			•	<u> </u>		
2.00								1 1 00
0.000   DIMINISTRATIVE & CEREBAL								
5.00   00000   DEBATTURE SECREPAN								1
7. 00   00   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   000000								1
8.00   0.0800  CAURIDATY & LI NEN SERVICE     2.0   0.000	1 1							1
9.00   0.0900   9.0SERCEPT NG								
10.00   0.000   ETARY	8.00  00800 LAUNDRY & LINE	N SERVICE						8. 00
11.00   01100  CAFETERIA   11.00   11.	9. 00   00900   HOUSEKEEPI NG							9. 00
11.00   01100  CAFETERIA   11.00   11.	10. 00   01000 DI ETARY							10.00
13.00   1300   NURSI NO. AMM IN STRATI ON								1
14.00   01400    PARSANCEY		STRATION						
15.00								1
16. 00   1000   MEDICAL RECORDS & LIBRARY	1 1	L3 & SUFFLI						1
17.00 01700 (NDR) SOCIAL SERVICE 3.910.412 0 12.00 0200 (NDR) NDR) NDR) NDR) NDR) NDR) NDR) NDR)		C 0 110040V						1
19.00   1900   NON-HYSICI AN AMESTHETISTS   0   423,206   739,808   21.00   22.00   22.00   IAS SEPU CES-CALARY & FRINCES APPRVD   0   423,206   739,808   21.00   22.00   22.00   IAS SEPU CES-COTIER PROBU COSTS APPRVD   0   423,206   739,808   21.00   22.00   IAS SEPU CES-COTIER PROBU COSTS APPRVD   0   0   0   0   0   0   0   0   0								
21.00			1					
22.00			0	0				19. 00
INPATI ENT ROUTINE SERVICE COST CENTERS   2, 606, 828	21. 00   02100   1 &R SERVICES-S	ALARY & FRINGES APPRVD	0		423, 208			21.00
INPATI ENT ROUTINE SERVICE COST CENTERS   2,606,828   0   122,431   214,022   79,398,295   30.00   30.00   30.00   AURTS & PEDIATRICS   2,606,828   0   122,431   214,022   79,398,295   30.00   30.00   30.00   AURTS & PEDIATRICS   267,759   0   0   0   0   10,845,862   31.00   31.00   30.00   AURTS & PEDIATRICS   267,759   0   0   0   0   15,406,204   35.00   30.	22. 00   02200   L&R SERVICES-0	THER PRGM COSTS APPRVD	0			739, 808		22. 00
30.00   30000   ADULTS & PEDIATRICS   2,606,828   0   122,431   214,022   79,382,795   30.00   30.00   30000   INTENSIVE CARE UNIT   549,004   0   0   0   0   10,845,822   31.00   35.00   20000   INTENSIVE CARE UNIT   549,004   0   0   0   0   10,845,822   31.00   35.00   30.00   30000   INTENSIVE CARE UNIT   549,004   0   0   0   0   15,406,204   35.00   36.201   32.802,017   40.00   36.201   32.802,017   32.000   36.201   32.000   36.201   32.000   36.201   32.000   36.201   32.000   36.201   32.000   36.201   32.000   36.201   32.000   36.201   32.000   36.201   32.000   36.201   32.000   36.201   32.000   36.201   32.000   36.201   32.000   32.201			'					1
31.00   03100   NATENIYE CARE UNIT   227,759   0   0   0   10,845,852   31.00   03.00   0300   NCONTATAL INTENIYE CARE UNIT   549,004   0   0   0   0   15,496,204   35.00   04000   NCONTATAL INTENIYE CARE UNIT   549,004   0   0   0   0   15,496,204   35.00   04000   NURSERY   364,172   0   0   0   0   0   5,902,762   43.00   04000   NURSERY   364,172   0   0   0   0   0   5,902,762   43.00   04000   NURSERY   364,172   0   0   0   0   0   0   5,902,762   43.00   04000   NURSERY   NOON   0   0   0   0   0   0   0   0   0			2 606 828	0	122 431	214 022	79 398 295	30.00
35. 00   02000 NEONATAL INTENSIVE CARE UNIT   549, 004   0   0   0   15, 496, 204   35. 00   043. 00   04300 NURSERY   364, 172   0   0   48, 201   2, 882, 047, 40. 00   04300 NURSERY   364, 172   0   0   48, 201   2, 882, 047, 40. 00   0   0   0   0   0   0   0   0				0	122, .01	211,022		1
40.00   04000   NUBSERY   10.00   12.00   15.962, 762   43.00   03.00   05.0				-		0		1
	1 1			-	· -	04.044		1
ANCILLARY SERVICE COST CENTERS   50.00   50.00   50.00   50.00   50.00   50.00   50.00   50.00   50.00   50.00   50.00   50.00   50.00   50.00   50.00   50.00   50.00   50.00   50.00   60.		I PF						1
50.00   050000   0FEATH NG ROOM   0   0   0   0   0   20, 657, 034   50.00   51.00   65100   RECOVERY ROOM   0   0   0   0   0   0   0   52.244, 084   51.00   52.00   05200   DELI YERY ROOM   8   15.00   0   0   0   0   0   0   0   13.094, 253   52.00   05500   RADI DLOGY-HIR RAPPUTI C   0   0   0   0   0   0   2, 941, 356   55.00   05500   RADI DLOGY-HIR RAPPUTI C   0   0   0   0   0   0   2, 941, 356   55.00   05500   RADI DLOGY-HIR RAPPUTI C   0   0   0   0   0   0   2, 941, 356   55.00   05500   RADI DLOGY-HIR RAPPUTI C   0   0   0   0   0   0   2, 941, 356   55.00   05500   RADI RADI RAPPORT C   RAPPORT			364, 172	0	0	0	5, 962, 762	43.00
51.00   05100   RECOVERY ROOM   0   0   0   0   5, 244, 084   51.00   52.00   05200   DELIVERY ROOM & LABOR ROOM   0   0   0   0   0   0   0   0   3, 335, 302   54.00   55.00   05500   DELIVERY ROOM & LABOR ROOM   0   0   0   0   0   0   0   0   0								
52.00   05200   DELYERY ROOM & LABOR ROOM   0 0 0 0 13, 094, 253   52.00	50. 00   05000   OPERATI NG ROOM		0	0	0	0	20, 657, 034	50.00
54 00   05400   RADI OLGOY-DI AGNOSTIC   0 0 0 0 0 8, 335, 032   54 0.00	51.00   05100 RECOVERY ROOM		0	0	0	0	5, 244, 084	51.00
54.00	52. 00 05200 DELIVERY ROOM	& LABOR ROOM	o	0	0	ol	13, 094, 253	52. 00
55.00   0.5500   RADIOLOGY-THERAPEUTIC   0 0 0 0 0 2,411,356   55.00   57.00   6570   CT SCAN   0 0 0 0 0 0, 2,519,389   57.00   58.00   0.5800   MAGNETIC RESONANCE IMAGING (MRI)   0 0 0 0 0 3,948,239   58.00   0.5800   MAGNETIC RESONANCE IMAGING (MRI)   0 0 0 0 0 0 2,44,81   59.00   0.59			0	0	0	0		1
57.00   05700   CT SCAN   0 0 0 0 0 0 2,519,399   57.00			0	0	ĺ			1
58. 00   OSBOO   MAGNETIC RESONANCE IMAGING (MRI)   0   0   0   0   3, 448, 239   58. 00   00   00   00   00   00   00   00	1 1	AI LOTT O	0	0	١			1
59.00   05900   CARDIAC CATHETERI ZATION   0   0   0   24, 481   59.00		ANCE IMACING (MDI)	0	0	0	0		1
60.00   0.0000   LABORATORY   0 0 0 0 0 0 1, 1, 045, 215   0.0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	U		1
64.00   04400   INTRAVENOUS THERAPY   0   0   0   0   0   1,083,631   64.00		ERIZATION	0	0	0	0		1
65.00   06500   RESPI RATORY THERAPY   0   0   0   5,784   10,111   6,429,216   66,00   69,00			0	0	0	0	11, 045, 215	60.00
66.00   06600   PMSI CAL THERAPY   0   0   5,784   10,111   6,429,216   66,00   67.00   06700   OCCUPATI ONAL THERAPY   0   0   0   0   0   0   68.00   06800   SPECEH PATHOLOGY   0   0   0   0   0   69.00   06800   SPECEH PATHOLOGY   0   0   0   69.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   71.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   72.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   74.00   07400   REVAIL DIALYSIS   0   0   0   0   75.00   07400   REVAIL DIALYSIS   0   0   0   0   76.00   03330   ENDOSCOPY   0   0   0   0   76.00   03330   ENDOSCOPY   0   0   0   0   76.00   03954   IMAGING CENTER   0   0   0   0   76.00   03955   BREAST DIAGNOSTIC CENTER   0   0   0   0   76.07   03955   BREAST DIAGNOSTIC CENTER   0   0   0   0   76.07   03955   BREAST DIAGNOSTIC CENTER   0   0   0   0   76.07   03955   SREAST DIAGNOSTIC CENTER   0   0   0   0   76.00   09000   CLINIC   0   0   0   0   76.00   09000   09000   09000   09000   09000   09000   76.00   09000   09000   09000   09000   09000   09000   09000   76.00   09000   09000   09000   09000   09000   09000   09000   09000   76.00   09000   0	64. 00   06400   I NTRAVENOUS TH	ERAPY	0	0	0	0	1, 083, 631	64. 00
67:00   06700	65. 00 06500 RESPIRATORY TH	ERAPY	0	0	0	0	6, 102, 880	65. 00
67:00   06700	66. 00 06600 PHYSI CAL THERA	PY	o	0	5. 784	10, 111	6, 429, 216	66.00
68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   356, 455   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   0   911, 542   69. 00   70. 00   07000   ELECTROCENCEPHALLOGRAPHY   0   0   0   0   0   0   2, 479, 123   70. 00   71. 00   07000   DELECTROCENCEPHALLOGRAPHY   0   0   0   0   0   0   16, 962, 594   71. 00   72. 00   07000   ELECTROCENCEPHALLOGRAPHY   0   0   0   0   0   16, 962, 594   71. 00   72. 00   07000   ELECTROCENCEPHALLOGRAPHY   0   0   0   0   0   15, 360, 516   72. 00   72. 00   07000   DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   26, 041, 769   73. 00   74. 00   07400   RENAL DIALYSIS   0   0   0   0   0   0   0   26, 041, 769   73. 00   74. 00   07400   RENAL DIALYSIS   0   0   0   0   0   0   0   3, 436, 669   76. 00   76. 00   03330   ENDOSCOPY   0   0   0   0   0   0   0   0   0			0	0	0	ا م		1
69.00   06900   ELECTROCARDI OLOGY   0 0 0 0 0 0 911,542   69.00			0	0	0	ام		1
70. 00 07000   ELECTROENCEPHALOGRAPHY	1 1		0	0	١			
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   16, 962, 594   71, 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   15, 360, 516   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   26, 041, 769   73. 00   74. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   1, 255, 855   74. 00   76. 00   03330   ENDOSCOPY   0   0   0   0   0   0   3, 436, 669   76. 00   76. 00   0   0   0   0   0   0   0   0   0			0	0	0	0		
72. 00   07200   MPL. DEV. CHARGED TO PATIENTS   0   0   0   0   26, 041, 765   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   26, 041, 76   73. 00   74. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   1.255, 855   74. 00   74. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   1.255, 855   74. 00   74. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   3. 436, 669   76. 00   76. 00   03330   ENDOSCOPY   0   0   0   0   0   0   0   0   0	1 1		0	0	0	0		1
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   26, 041, 769   73. 00   74. 00   07400   RENAL DIALYSIS   0   0   0   0   0   0   1, 255, 855   74. 00   76. 00   03330   ENDOSCOPY   0   0   0   0   0   0   3, 436, 669   76. 00   76. 00   03954   IMAGING CENTER   0   0   0   0   0   0   0   5, 144, 284   76. 06   76. 07   03955   BREAST DIAGNOSTIC CENTER   0   0   0   0   0   0   6, 180, 244   76. 07   03955   BREAST DIAGNOSTIC CENTER   0   0   0   0   0   0   0   0   0			0	0	0	0		1
74. 00   07400   RENAL DIALYSIS   0   0   0   0   0   1, 255, 855   74. 00   76. 00   0   0   33. 436, 669   76. 00   0   0   0   0   0   0   0   3. 436, 669   76. 00   0   0   0   0   0   0   0   0   0			0	0	0	0		1
76. 00 03330   ENDOSCOPY	1 1		0	0	0	0		
76. 06   03954   IMAGI NG CENTER   0   0   0   0   0   5, 144, 284   76. 06   76. 07   70. 07	74.00  07400 RENAL DIALYSIS		0	0	0	0	1, 255, 855	74. 00
76. 07   03955   BREAST DI AGNOSTIC CENTER   0   0   0   0   6, 180, 244   76. 07	76. 00 03330 ENDOSCOPY		0	0	0	0	3, 436, 669	76. 00
76. 07   03955   BREAST DI AGNOSTIC CENTER   0   0   0   0   6, 180, 244   76. 07	76.06 03954 I MAGI NG CENTER		0	0	0	O	5, 144, 284	76. 06
90. 00   09000   CLINIC   0 0 0 0 0 0 0 0 0 90.00			0	0	0	اه		1
90. 00			-1	-		-1	5,,	1
90. 26		JOST GENTERO	0	0	n	٥	0	90 00
91. 00	1 1		1	0		0		
92. 00   09200   0BSERVATI ON BEDS (NON-DI STINCT PART)   92. 00   SPECI AL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   114. 00   11400   UTI LI ZATI ON REVIEW - SNF   114. 00   SUBTOTALS (SUM OF LINES 1-117)   3, 910, 412   0   192, 804   337, 043   291, 115, 720   118. 00   NONREI MBURSABLE COST CENTERS   100, 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   244, 399   190. 00   191. 00   19100   RESEARCH   0   0   0   0   0   0   191. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   230, 404   402, 765   852, 515   192. 00   194. 00   00   00   00   00   00   194. 00   194			1	0	1/ 200	20 (40		
SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   113. 00   11400   UTI LI ZATI ON REVIEW - SNF   114. 00   11400   UTI LI ZATI ON REVIEW - SNF   114. 00   11400   SUBTOTALS (SUM OF LINES 1-117)   3, 910, 412   0   192, 804   337, 043   291, 115, 720   118. 00   118. 00   NONREI MBURSABLE COST CENTERS   0   0   0   0   0   244, 399   190. 00   191. 00   19100   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   0   191. 00   191. 00   19200   PHYSI CI ANS' PRI VATE OFFICES   0   0   0   0   0   0   193. 00   193. 00   19300   NONPAI D WORKERS   0   0   0   0   0   0   193. 00   194. 00   07950   HOME OFFICE   0   0   0   0   0   120, 826   194. 06   194. 08   07958   OTHER NRCC   0   0   0   0   0   2, 764, 476   194. 08   194. 10   07960   COMMUNI TY REHAB HOSPI TAL   0   0   0   0   0   0   0   0   0		DC (NON DICTINGT DADT)	U	Ü	10, 388	28, 649	14, 822, 340	
113. 00								92.00
114. 00 118. 00 119. 0								1
118. 00   SUBTOTALS (SUM OF LINES 1-117)   3,910,412   0   192,804   337,043   291,115,720   118. 00   190. 00   190. 00   190. 00   190. 00   190. 00   191. 00   191. 00   1910   RESEARCH   0   0   0   0   0   191. 00   191. 00   192. 00   192. 00   193								113. 00
NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   244, 399   190. 00   191. 00   19100   RESEARCH   0   0   0   0   0   0   191. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   230, 404   402, 765   852, 515   192. 00   193. 00   19300   NONRAI D WORKERS   0   0   0   0   0   0   193. 00   194. 00   07950   HOME OFFI CE   0   0   0   0   0   0   194. 00   194.	114.00 11400 UTILIZATION RE	VIEW - SNF						114. 00
NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   244, 399   190. 00   191. 00   19100   RESEARCH   0   0   0   0   0   0   191. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   230, 404   402, 765   852, 515   192. 00   193. 00   193.00   NONRAI D WORKERS   0   0   0   0   0   0   193. 00   194. 00   1	118.00 SUBTOTALS (SUM	OF LINES 1-117)	3, 910, 412	0	192, 804	337, 043	291, 115, 720	118. 00
190. 00       19000       GIFT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       0       244, 399       190. 00         191. 00       19100       RESEARCH       0       0       0       0       0       191. 00         192. 00       19200       PHYSI CI ANS' PRI VATE OFFI CES       0       0       230, 404       402, 765       852, 515       192. 00         193. 00       19300       NONPAI D WORKERS       0       0       0       0       0       193. 00         194. 00       07950       HOME OFFI CE       0       0       0       0       0       194. 00         194. 06       07956       PAVI LLI ONS       0       0       0       0       120, 826       194. 06         194. 08       07958       OTHER NRCC       0       0       0       0       2, 764, 476       194. 08         194. 10       07960       COMMUNI TY REHAB HOSPI TAL       0       0       0       0       16, 147       194. 10         200. 00       Negati ve Cost Centers       0       0       0       0       0       0       0       201. 00	NONREL MBURSABLE COST	CENTERS				, , , , , , ,	, , , , , ,	1
191. 00       19100       RESEARCH       0       0       0       0       191. 00         192. 00       19200       PHYSI CI ANS' PRI VATE OFFI CES       0       0       230, 404       402, 765       852, 515       192. 00         193. 00       19300       NONPAI D WORKERS       0       0       0       0       0       193. 00         194. 00       07950       HOME OFFI CE       0       0       0       0       0       194. 00         194. 08       07958       PAVI LLI ONS       0       0       0       0       120, 826       194. 06         194. 08       07958       OTHER NRCC       0       0       0       0       2, 764, 476       194. 08         194. 10       07960       COMMUNITY REHAB HOSPITAL       0       0       0       0       16, 147       194. 10         200. 00       Cross Foot Adjustments       0       0       0       0       0       0       201. 00			0	0	n	ام	244 300	190 00
192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES     0     0     230, 404   402, 765   852, 515   192. 00       193. 00   19300   NONPAI D WORKERS     0     0     0     0     0     193. 00       194. 00   07950   HOME OFFI CE     0     0     0     0     0     194. 00       194. 06   07956   PAVI LLI ONS     0     0     0     0     120, 826   194. 06       194. 08   07958   OTHER NRCC     0     0     0     0     2, 764, 476   194. 08       194. 10   07960   COMMUNI TY REHAB HOSPI TAL     0     0     0     0     0     16, 147   194. 10       200. 00   Cross Foot Adjustments     0     0     0     0     0     0     201. 00		COLLEGUE & CANTEEN	1	0	١			
193. 00   19300   NONPAI D WORKERS       0       0       0       0   193. 00         194. 00   07950   HOME   OFFI CE       0       0       0       0       194. 00         194. 06   07956   PAVI LLI ONS       0       0       0       0       120, 826   194. 06         194. 08   07958   OTHER   NRCC       0       0       0       0       2, 764, 476   194. 08         194. 10   07960   COMMUNI   TY   REHAB   HOSPI   TAL       0       0       0       0       0       16, 147   194. 10         200. 00   Cross   Foot   Adjustments       0       0       0       0       0       0       200. 00         201. 00   Negative   Cost   Centers       0 </td <td></td> <td>LVATE OFFICES</td> <td></td> <td>0</td> <td>220 404</td> <td>400 7/5</td> <td></td> <td></td>		LVATE OFFICES		0	220 404	400 7/5		
194. 00       07950       HOME OFFICE       0       0       0       0       194. 00         194. 06       07956       PAVI LLI ONS       0       0       0       0       120, 826       194. 06         194. 08       07958       OTHER NRCC       0       0       0       0       2, 764, 476       194. 08         194. 10       07960       COMMUNITY REHAB HOSPITAL       0       0       0       0       16, 147       194. 10         200. 00       Cross Foot Adjustments       0       0       0       0       0       200. 00         201. 00       Negative Cost Centers       0       0       0       0       0       201. 00			0	0	230, 404	402, 765		
194. 06     07956     PAVI LLI ONS     0     0     0     120, 826     194. 06       194. 08     07958     OTHER NRCC     0     0     0     0     2, 764, 476     194. 08       194. 10     07960     COMMUNI TY REHAB HOSPI TAL     0     0     0     0     16, 147     194. 10       200. 00     Cross Foot Adjustments     0     0     0     0     0     200. 00       201. 00     Negative Cost Centers     0     0     0     0     0     201. 00		5	0	0	0	이		
194. 08 07958     OTHER NRCC     0     0     0     2, 764, 476     194. 08       194. 10 07960     COMMUNITY REHAB HOSPITAL     0     0     0     0     16, 147     194. 10       200. 00     Cross Foot Adjustments     0     0     0     0     0     200. 00       201. 00     Negative Cost Centers     0     0     0     0     0     201. 00			0	0	0	0		1
194. 10 07960     COMMUNITY REHAB HOSPITAL     0     0     0     16, 147 194. 10       200. 00     Cross Foot Adjustments     0     0     0     0     200. 00       201. 00     Negative Cost Centers     0     0     0     0     0     201. 00	194. 06 07956  PAVI LLI ONS		0	0	0	0		
194. 10 07960     COMMUNITY REHAB HOSPITAL     0     0     0     16, 147 194. 10       200. 00     Cross Foot Adjustments     0     0     0     0     0     200. 00       201. 00     Negative Cost Centers     0     0     0     0     0     0     201. 00	194.08 07958 OTHER NRCC		0	0	0	ol	2, 764, 476	194. 08
200.00       Cross Foot Adjustments       0       0       0       0       200.00         201.00       Negative Cost Centers       0       0       0       0       0       0       0       201.00		B HOSPITAL	0	0	0	o		
201.00   Negative Cost Centers   0   0   0   0   201.00				0	l	ار		
			_	0				
202.00    101AL (Suiii 111165 110-201)   3, 410, 412  U  423, 208  /34, 808  245, 114, 083   202.00			2 010 410	0	422 200	720 000		
	202.00   TOTAL (SUM TIM	CS 110-ZUI)	3, 910, 412	0	<sub>1</sub> 423, 208	139, 808	∠ <del>7</del> 3, 114, U83	12U2. UU

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

			To 12/31/2016 Date/Time Prepare 5/30/2017 8:54	
Cost Center Description	Intern &	Total	373072017 0.34	aiii
	Residents Cost			
	& Post Stepdown			
	Adjustments			
OFWERN OFRIGOR OF STATERS	25.00	26. 00		
GENERAL SERVICE COST CENTERS  1.00 O0100 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
7. 00 00700 OPERATION OF PLANT				7.00
8. 00   00800   LAUNDRY & LI NEN SERVI CE 9. 00   00900   HOUSEKEEPI NG				8. 00 9. 00
10. 00 01000 DI ETARY				0.00
11. 00   01100   CAFETERI A				1. 00
13.00 01300 NURSING ADMINISTRATION				3. 00
14. 00   01400   CENTRAL SERVI CES & SUPPLY 15. 00   01500   PHARMACY				4. 00
16. 00   01600   MEDI CAL RECORDS & LI BRARY				5. 00 6. 00
17. 00 01700 SOCIAL SERVICE				7. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS			1	9. 00
21. 00   02100   1&R SERVI CES-SALARY & FRI NGES APPR				21. 00
22. 00   02200  I &R SERVI CES-OTHER PRGM COSTS APPR I NPATI ENT ROUTI NE SERVI CE COST CENTERS	RVD		2	22. 00
30. 00 03000 ADULTS & PEDIATRICS	-336, 453	79, 061, 842	3	80. 00
31. 00 03100 I NTENSI VE CARE UNI T	0	10, 845, 852		31. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	15, 496, 204		35. 00
40. 00   04000   SUBPROVI DER - I PF	-132, 462	2, 749, 585		10. 00 13. 00
43. 00 O4300 NURSERY  ANCI LLARY SERVI CE COST CENTERS	0	5, 962, 762	4	13.00
50. 00 05000 OPERATING ROOM	0	20, 657, 034	5	50.00
51.00 05100 RECOVERY ROOM	0	5, 244, 084		1. 00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0	13, 094, 253		2. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 55. 00   05500   RADI OLOGY-THERAPEUTI C	0	8, 335, 032 2, 941, 356		54. 00 55. 00
57. 00 05700 CT SCAN	O	2, 519, 389		7. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	3, 948, 239	5	8. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	24, 481		9. 00
60. 00   06000   LABORATORY 64. 00   06400   I NTRAVENOUS THERAPY	0	11, 045, 215 1, 083, 631		0. 00 4. 00
65. 00 06500 RESPIRATORY THERAPY		6, 102, 880		5.00
66. 00   06600   PHYSI CAL THERAPY	-15, 895	6, 413, 321		6. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 843, 452		7. 00
68. 00 06800 SPEECH PATHOLOGY	0	356, 455		8. 00
69. 00   06900   ELECTROCARDI OLOGY 70. 00   07000   ELECTROENCEPHALOGRAPHY	0	911, 542 2, 479, 123		9. 00 0. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN		16, 962, 594		1.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	15, 360, 516		2. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	26, 041, 769		3.00
74. 00   07400   RENAL DI ALYSI S 76. 00   03330   ENDOSCOPY	0	1, 255, 855		4. 00 6. 00
76. 00   03330  ENDOSCOPY 76. 06   03954   I MAGI NG CENTER		3, 436, 669 5, 144, 284		6.06
76. 07 03955 BREAST DIAGNOSTIC CENTER	Ö	6, 180, 244		6. 07
OUTPATIENT SERVICE COST CENTERS				
90. 00   09000   CLI NI C 90. 26   04975   SPI NE CENTER	0 0	0 310, 907		90. 00 90. 26
91. 00   09100   EMERGENCY	-45, 037	14, 777, 303		70. 20 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR		, ,		2. 00
SPECIAL PURPOSE COST CENTERS	, ,			
113. 00 11300   INTEREST EXPENSE				3. 00
114.00 11400 UTILIZATION REVIEW - SNF 118.00 SUBTOTALS (SUM OF LINES 1-117)	-529, 847	290, 585, 873		4. 00 8. 00
NONREI MBURSABLE COST CENTERS	-327,047	270, 303, 073		0.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEE	N O	244, 399		0. 00
191. 00 19100 RESEARCH	0	0		91. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 193.00 19300 NONPAID WORKERS	-633, 169	219, 346		92. 00 93. 00
193.00 19300 NONPALD WORKERS 194.00 07950 HOME OFFICE		0		73. 00 94. 00
194. 06 07956 PAVI LLI ONS		120, 826		94. 06
194. 08 07958 OTHER NRCC	0	2, 764, 476		94. 08
194. 10 07960 COMMUNITY REHAB HOSPITAL	0	16, 147		94. 10
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0	0		00. 00 01. 00
202. 00 TOTAL (sum lines 118-201)	-1, 163, 016	293, 951, 067		)2. 00
	, , , , , , , , , , , ,		1	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0169

Cost Content Description					Io	12/31/2016	Date/lime Pre 5/30/2017 8:5	
ASSIGNMENT   PRINCE FORT CENTERS   PRINCE FORT CENTERS   PRINCE FORT CENTERS   PRINCE FORT CENTERS				CAPI TAL REI	LATED COSTS			
ASSIGNMENT   PRINCE FORT CENTERS   PRINCE FORT CENTERS   PRINCE FORT CENTERS   PRINCE FORT CENTERS		Cost Center Description	Directly	RIDG & FLYT	MVRLE FOLLE	Subtotal	EMPLOYEE	
		cost center bescription		DEDG & TIXI	WVDLL LQOTT	Subtotal		
DESIGNATION STRATUP CORT CRITTERS   0   1.00   2.00   2A   4.00			Capi tal				DEPARTMENT	
CEREBAL SERVICE COST CENTERS				1 00	2.00	21	4.00	
2.00		GENERAL SERVICE COST CENTERS	0	1.00	2.00	ZN	4.00	
4.00 DODGO INFLOYME INFELLIS INFORMATION 0 277, 006 77, 477 34, 431 4, 431 4, 500 0000 0000 OPERATION OF PLANT 0 0 2,023, 054 137, 966 82 6,079, 010 0000 OPERATION OF PLANT 0 0 2,023, 054 137, 966 82 6,079, 010 2,000 0000 OPERATION OF PLANT 0 0 100, 996 16, 200 100, 010 000 DETARY 0 161, 354 30, 102 191, 1510 332 10.00 100, 01000 DETARY 0 161, 354 30, 102 191, 1510 332 10.00 110, 01000 DETARY 0 161, 354 30, 102 191, 1510 332 10.00 110, 01000 DETARY 0 161, 354 30, 102 191, 1510 332 10.00 110, 01000 DETARY 0 188, 800 12, 388 10.00 110, 01000 DETARY 0 188, 800 12, 388 10, 00 1000 DETARY 0 188, 800								1
5.00   0.000   ADMINISTRATIVE & GENERAL   0   400,724   5,669 878   6,079,001   2,034   5,00				27.004	7 407	24 424	24 424	1
0.0000   ORDING PERATION OF PERAMY   0   2,023,054   137,956   2,161,010   999   7,000   0.000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000000			0					
0.000   0.0000   DISTEREY NO.			O		1 1			•
10.00   01000   DETARY			0		1			•
11.00   01100  CAFETERIA   0   273, 335   51,079   324,428   528   11.00   13.00   1300   MIRSTING AMINISTRATION   0   130,889   431,385   30.00   14.00   CINTRAL SERVICES & SURPLY   0   300,567   130,736   431,355   50   14.00   14.00   CINTRAL SERVICES & SURPLY   0   18,800   14.6   68   315,298   15.00			0					1
13.00   01300   MURSINK AMIN INSTRATION   0   18, 803   12, 384   31, 187   812   13.00   15.00   01500   PHARMACY   0   145, 860   149, 448   315, 298   1, 593   15.00   15.00   01500   PHARMACY   0   145, 860   149, 448   315, 298   1, 593   15.00   17.00   01700   3001   AL SERVICE   0   12, 220   0   21, 321   179   170   17.00   01700   3001   AL SERVICE   0   21, 321   0   0   0   0   0   17.00   01700   3001   AL SERVICE   0   21, 321   0   0   0   0   0   0   17.00   01700   3001   AL SERVICE   0   0   0   0   0   0   0   0   0   17.00   01700   3001   AL SERVICE   SERVICE   0   0   0   0   0   0   0   0   0   17.00   01700   148 SERVICE   SERVICE   0   0   0   0   0   0   0   0   0   17.00   01700   148 SERVICE   SERV			0					•
15.00   01500   PIAMMACY   0   145, 850   109, 448   315, 298   1, 593   15, 00   170, 00   1700   0			ő		1			•
16.00   0.000   MEDICAL RECORDS & LIBRARY   0   18, 269   44   18, 313   113   10.00			0		1			•
17.00   01700   NORPHYSICIAL SERVICE   0   21, 321   0   21, 221   793   71, 700   10100   1000   0000   0   0   0   0			0		1			•
19.00   01900   MORPHYSICI AN AMESTHETISTS   0   0   0   0   0   0   22 100   2200   IAS SERVICES-SALARY & FRINCES APPRIVD   0   0   0   0   0   0   22 100   2200   IAS SERVICES-SCHER PROXICOSTS APPRIVD   0   0   0   0   0   0   22 100   22 00   IMPATILET ROUTINE SERVICE COST CENTERS   30.00   03000   ADULTS & PEDIATRICS   0   3,973,659   1,786,588   5,760,347   8,723   30.00   310,00			0		1			•
22.00			O		1			1
INPATI ENT ROUTINE SERVICE COST CENTERS   30 00 0   3, 973, 659   1, 786, 688   5, 760, 347   8, 726   30 00 0   310 00 0 00000 ADULTS & PEDIDATRICS   0   3, 973, 659   1, 786, 688   5, 760, 347   8, 726   30 00 0   310 00 0 00000 ROUNGTAL INTENSIVE CARE UNIT   0   759, 289   226, 187   1, 165, 517   1, 394   31 0.00   400 00 00000 ROUNGTAL INTENSIVE CARE UNIT   0   759, 289   226, 187   163, 056   388   40 00   40 00 0 0000 ROUNGTAL INTENSIVE CARE UNIT   0   749, 385   723, 671   163, 056   388   40 00   40 00 0 ROUNGTAL INTENSIVE CARE UNIT   3, 90   4			0		-	-	_	1
30.00   30000   ADULTS & PEDIATRICS   0   3.973,699   1,766,688   5,760,347   8,726   30.00   30.00   30.00   INTENSIVE CARE UNIT   0   881,525   283,992   1,165,517   1,394   31.00   33.00   30.00   INTENSIVE CARE UNIT   0   795,289   226,189   1,021,478   2,317   35.00   38	22. 00		0	0	0	0	0	22. 00
31.00   03100   INTENSIVE CARE UNIT   0   881,525   2283,992   1.165,517   1,394   31.00   04000   ROMATAL INTENSIVE CARE UNIT   0   795,289   226,187   1,021,478   2,317   35.00   04000   ROMATAL INTENSIVE CARE UNIT   0   795,289   226,187   163,056   388   40.00   04000   NURSERY   0   437,721   79,557   517,278   710   43.00   4300   04000   NURSERY   0   437,721   79,557   517,278   710   43.00   4300   04000   RECOVERY ROOM   0   600,352   1,192,385   1,792,737   1,755   50.00   05000   PERATI NG ROOM   0   331,270   18,938   350,208   764   51.00   05000   RECOVERY ROOM   0   341,727   18,938   350,208   764   51.00   05000   RECOVERY ROOM   0   341,727   18,938   350,208   764   51.00   05000   RECOVERY ROOM   0   400,400   400,400   171,755   52.00   05000   RECOVERY ROOM   0   400,400	30. 00		0	3, 973, 659	1. 786. 688	5, 760, 347	8. 726	30.00
40. 00   040000 SUBPERVY   EPF   0   139, 385   23, 671   163, 056   388   40. 00   43. 00			0					1
MAINTELARY SERVICE COST CENTERS			0		1			
ANCILLARY SERVICE COST CENTERS   1, 192, 385			0		1	·		ł
50.00   0500000   0500000   0500000   0500000   0500000   0500000   0500000   05000000   05000000   050000000   0500000000	43.00		ı y	437, 721	19, 557	317, 270	710	43.00
52.00   05200   DELIVERY ROOM & LABOR ROOM   0   996, 938   181, 199   1, 178, 137   1, 755   52.00     54.00   05400   RADI DICOSY-THERAPEUTIC   0   200, 944   404, 051   604, 995   171   55. 00     55.00   05500   RADI DICOSY-THERAPEUTIC   0   200, 944   404, 051   604, 995   171   55. 00     57.00   05700   CT SCAN   0   226, 584   404, 051   604, 995   171   55. 00     58.00   05800   MAGNETIC RESONANCE IMAGING (MRI)   0   111, 523   809, 494   921, 017   189   58. 00     59.00   05900   CARDI AC CATHETERI ZATI ON   0   119, 642   0   19, 642   0   19, 642   0     60.00   06000   LABORATORY   0   114, 731   12, 21   127, 683   80   60. 00     60.00   06000   INTRAVENOUS THERAPY   0   114, 731   12, 21   127, 683   80   60. 00     65.00   06500   PREST RATIORY THERAPY   0   124, 891   306, 328   431, 219   1, 007   65. 00     66.00   06500   PREST RATIORY THERAPY   0   124, 891   306, 328   431, 219   1, 007   65. 00     66.00   06500   PREST RATIORY THERAPY   0   0   0   127, 084   127, 084   1, 410   66. 00     66.00   06500   PREST RATIORY THERAPY   0   0   0   31, 904   31, 1904   315   67, 700     67.00   06700   0CUENATIONAL THERAPY   0   0   0   0   6, 143   6, 143   6, 143   69, 80     68.00   06900   DREST RATIOR THOLOGY   0   0   0   0   6, 143   6, 143   6, 143   6, 143     69.00   06900   DREST RATIOR THOLOGY   0   0   0   0   0   0   0   0     70.00   07000   DREST CENTRAL GRAPHY   0   30, 608   142, 153   172, 761   335   70, 90     70.00   07000   DREST CENTRAL GRAPHY   0   30, 608   142, 153   172, 761   335   70, 90     70.00   07000   DREST CENTRAL DIALYSIS   0   2, 84   0   2, 84   0   74, 90     70.00   07000   DREST CENTRAL DIALYSIS   0   2, 84   0   0   0   0   0   0   0     70.00   07000   DREST CENTRE   0   0   0   0   0   0   0   0   0	50.00		0	600, 352	1, 192, 385	1, 792, 737	1, 755	50. 00
54 00   05400   RADIOLOGY-DIAGNOSTIC   0   198, 179   883, 207   1,081, 386   1,116   54, 00   55, 00   05500   RADIOLOGY-THERAPEUTIC   0   200, 944   40, 051   604, 955   171   55, 00   05700   CT SCAN   0   26, 584   427, 205   453, 789   367   57, 00   68, 00   05800   MAGNETIC RESONANCE IMAGING (MRI )   0   111, 523   88, 00   494   921, 017   189   58, 00   60, 00   05900   CARDINATORY   0   115, 471   12, 212   127, 693   80   60, 00   6000   06000   LABORATORY   0   115, 471   12, 212   127, 693   80   60, 00   6000   LABORATORY   0   115, 471   12, 212   127, 693   80   60, 00   6000   LABORATORY   0   124, 891   306, 328   431, 219   1,007   65, 00   65, 00   05900   REPRIATORY THERAPY   0   124, 891   306, 328   431, 219   1,007   65, 00   66, 00			0					ł
55, 00   05500   RADIOLOGY-THERAPEUTIC   0   200, 944   404, 051   604, 995   171   55, 00   570   00   570   00   570   00   570   00   570   00   570   00   570   00   570   00   570   00   570   00   570   00   570   00   570   00   570   00   570   00   580   00   08600   MAGNETI C RESONANCE I MAGI NG (MRI )   0   111, 523   809, 494   921, 017   189   58, 00   590   00   00   00   00   19, 642   0   59, 00   00   00   00   00   00   00   00			0					•
57. 00   05700   CT SCAN   0   26, 584   427, 205   453, 789   367   57. 00   580. 00   05800   MAGNETIC RESONANCE IMAGING (MRI ) 0   111, 523   809, 494   921, 017   189   58. 00   05900			0					ł
59.00   05900   CARDIAC CATHETERI ZATION   0   19, 642   0   19, 642   0   059.00			0					•
60.00   06000   LABORATORY   0   115, 471   12, 212   127, 683   80   60.00   64.00   06400   INTRAVENDUS THERAPY   0   141, 731   0   141, 731   107   64.00   65.00   06500   RESPIRATORY THERAPY   0   124, 891   306, 328   431, 219   1, 007   65.00   66.00   06600   PHYSI CAL THERAPY   0   0   0   127, 084   127, 084   1, 410   66.00   66.00   06600   O6600   COLPATIONAL THERAPY   0   0   0   0   31, 904   31, 904   357   67.00   68.00   08600   SPECH PATHOLOGY   0   0   0   6, 143   6, 143   69   68.00   08600   SPECH PATHOLOGY   0   0   0   6, 143   6, 143   69   68.00   08600   SPECH PATHOLOGY   0   0   0   0   15, 622   15, 622   28   69, 00   00   000   00   0   0   0   0   0			0					•
64.00   06400   INTRAVENOUS THERAPY   0   141, 731   0,7   64.00			0					•
65.00   06500   RESPI RATORY THERAPY   0   124,891   306,328   431,219   1,007   65.00   66.00   06600   PHYSI CAL THERAPY   0   0   0   127,084   127,084   1,410   66.00   67.00   06700   0CCUPATI ONAL THERAPY   0   0   0   31,904   31,904   357   67.00   68.00   06800   SPEECH PATHOLOGY   0   0   0   6,143   6,143   69   68.00   69.00   06900   ELECTROCARDI OLLOGY   0   0   0   15,622   228   69.00   70.00   07000   CLECTROCARDI OLLOGY   0   0   0   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   72.00   07200   MPL   DEV   CHARGED TO PATI ENTS   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   74.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   75.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   76.00   03330   ENDOSCOPY   0   161,087   425,940   587,027   370   76.00   76.00   03954   IMAGI NG CENTER   0   0   0   469,385   509   76.00   76.01   03955   BREAST DI AGNOSTIC CENTER   0   0   93,649   93,649   0   76.07   76.01   03955   BREAST DI AGNOSTIC CENTERS   0   0   0   0   0   0   79.02   04975   SPI NE CENTER   0   0   0   4,788   4,788   69   90.26   79.03   04975   SPI NE CENTER   0   552,600   178,401   731,001   2,121   91.00   79.00   09000   CLLT NIC CENTERS   0   0   0   0   0   0   79.00   09100   EMERGENCY   0   552,600   178,401   731,001   2,121   91.00   79.00   09200   DSSERVATI ON BEDS (NON-DISTINCT PART)   0   13,396,127   14,355,582   27,751,709   34,211   79.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   0   79.01   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   79.01   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   79.01   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   79.01   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   79.01   19000   Cross Foot Adjustments   0   0   0   0   0   0   79.01   19000   Cross Foot Adjustments   0   0   0   0   0   79.01   19000   Cr			0					•
67.00   06700   05CUPATI ONAL THERAPY   0   0   0   31, 904   31, 904   35, 67.00   68.00   06800   SPEECH PATHOLOGY   0   0   0   6, 143   69, 48.00   69.00   06900   ELECTROCARDI OLOGY   0   0   0   15, 622   15, 622   28, 69.00   70.00   07000   ELECTROCARDI OLOGY   0   0   0   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   74.00   07400   RENAL DI ALYSIS   0   2, 384   0   2, 384   0   74.00   76.00   03300   ENDOSCOPY   0   161, 087   425, 940   587, 027   370   76.00   76.06   03954   IMAGI NS CENTER   0   0   0   93, 649   93, 649   0   76.07   03955   BREAST DI AGNOSTIC CENTER   0   0   93, 649   93, 649   0   76.07   04975   SPINE CENTER   0   0   0   0   0   70.00   09000   CLI NI C   0   0   0   0   0   70.00   09000   DEBERGENCY   0   552, 600   178, 401   731, 001   2, 121   91.00   70.01   09000   OFFICE SHOPE SHOP & CANTEEN   0   0   0   0   0   71.00   09000   OFFICE SHOP & CANTEEN   0   0   0   0   71.00   09000   OFFICE SHOPE SHOP & CANTEEN   0   0   0   0   0   71.00   09000   OFFICE SHOPE SHOP & CANTEEN   0   0   0   0   71.00   09000   OFFICE SHOPE SHOP & CANTEEN   0   0   0   0   71.00   09000   OFFICE SHOPE SHOP & CANTEEN   0   0   0   0   71.00   09000   OFFICE SHOPE SHOPE   0   0   0   0   71.00   09000   OFFICE SHOPE SHOPE & CONTERS   0   0   0   0   71.00   09000   OFFICE SHOPE SHOPE & CONTERS   0   0   0   0   71.00   09000   OFFICE SHOPE & O   0   0   0   0   71.00   09000   OFFICE SHOPE & CONTERS   0   0   0   0   71.00   09000   0   0   0   0   0   71.00   09000   0   0   0   0   0   0   71.00   09000   0   0   0   0   0   71.00   09000   0   0   0   0   0   71.00   09000   0   0   0   0   0   71.00   09000   0   0   0   0   0   71.00   0   0   0   0   0   71.00   09000   0   0   0   0   0   71.00   0   0   0   0   0   71.00   0   0   0   0   0   71.00   0   0   0   0   0   71.00   0   0   0   0	65.00		0		1			65. 00
68.00   66800   SPEECH PATHOLOGY   0   0   0   6, 143   6, 143   69   68.00   69.00   069000   ELECTROCRADI OLOGY   0   0   0   15, 622   15, 622   28   69.00   70.00   07000   ELECTROCREDI CHORDY   0   30, 608   142, 153   172, 761   355   70.00   71.00   07000   ELECTROCREDI CEPHALLOGRAPHY   0   30, 608   142, 153   172, 761   355   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   0   72.00   07200   IMPL. DE DV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   74.00   07400   RENAL DIALYSIS   0   2, 384   0   2, 384   0   74.00   76.00   03330   ENDOSCOPY   0   161, 087   425, 940   587, 027   370   76.00   76.00   03330   ENDOSCOPY   0   161, 087   425, 940   587, 027   370   76.00   76.07   03955   BREAST DIAGNOSTIC CENTER   0   0   469, 385   469, 385   509   76.00   76.07   03955   BREAST DIAGNOSTIC CENTER   0   0   0   93, 649   93, 649   0   76.07   76.07   03955   BREAST DIAGNOSTIC CENTER   0   0   0   0   0   0   0   79.00   09000   CLINIC   0   0   0   0   0   0   0   79.00   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   09000   09000   09000   79.00   090			0	0				•
69.00   06900   ELECTROCARDI OLOGY   0 0 0 15, 622   15, 622   28 69.00   70.00   07000   ELECTROENCEPHALOGRAPHY   0 30, 608   142, 153   172, 761   355   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0 0 0 0 0 0 0 0   72.00   07200   IMPL. BEV. CHARGED TO PATIENTS   0 0 0 0 0 0 0 0   73.00   07300   DRUGS CHARGED TO PATIENTS   0 0 0 0 0 0 0 0   74.00   07400   RENAL DI ALYSIS   0 0 2, 384   0 2, 384   0 74.00   76.00   03301   ENDOSCOPY   0 161, 087   425, 940   587, 027   370   76.06   03954   IMAGI NG CENTER   0 0 0   469, 385   469, 385   509   76.06   76.07   03955   BREAST DI AGNOSTIC CENTER   0 0 0   93, 649   93, 649   0   76.07   03955   BREAST DI AGNOSTIC CENTER   0 0 0   4, 788   4, 788   69   90. 26   76.07   03955   BREAST DI AGNOSTIC CENTER   0 0 0   4, 788   4, 788   69   90. 26   76.07   03950   DRENESCHICE COST CENTERS   0 0 0   4, 788   4, 788   69   90. 26   76.08   03950   DRENESCHICE COST CENTERS   0 0 0   4, 788   4, 788   69   90. 26   76.09   09000   CLINIC   0 0 0 0   4, 788   4, 788   69   90. 26   76.00   09000   DRENESCHICE COST CENTERS   0 0 0   73, 401   731, 001   2, 121   91.00   76.00   09000   05000   05000   05000   05000   05000   05000   76.00   09000   05000   05000   05000   05000   05000   76.00   070000   05000   05000   05000   05000   05000   76.00   070000   05000   05000   05000   05000   05000   76.00   070000   05000   05000   05000   05000   05000   76.00   070000   05000   05000   05000   05000   05000   76.00   070000   05000   05000   05000   05000   05000   76.00   070000   05000   05000   05000   05000   05000   76.00   070000   05000   05000   05000   05000   05000   76.00   070000   05000   05000   05000   05000   05000   76.00   05000   05000   05000   05000   05000   05000   76.00   05000   05000   05000   05000   05000   05000   76.00   05000   05000   05000   05000   05000   05000   76.00   05000   05000   05000   05000   05000   05000   76.00   05000   050000   050000   05000   05000   76.00   050000   050000   050000   050000   05000			0	0	1			•
70. 00   07000   ELECTROENCEPHALOGRAPHY   0   30, 608   142, 153   172, 761   355   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   72. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   73. 00   74. 00   07400   RENAL DIALYSIS   0   2, 384   0   2, 384   0   2, 384   0   74. 00   76. 00   03330   ENDOSCOPY   0   161, 087   425, 940   587, 027   370   76. 00   76. 00   03330   ENDOSCOPY   0   161, 087   425, 940   587, 027   370   76. 00   76.			0	0	1			•
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   73. 00   07400   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   74. 00   07400   RENAL DI ALYSIS   0   2,384   0   74. 00   76. 00   03330   ENDOSCOPY   0   161,087   425,940   587,027   370   76. 06   76. 07   03955   BREAST DI AGNOSTIC CENTER   0   0   0   469,385   469,385   509   76. 06   76. 07   03955   BREAST DI AGNOSTIC CENTER   0   0   0   93,649   0   76. 07   76. 07   03955   BREAST DI AGNOSTIC CENTER   0   0   0   0   0   0   76. 07   09000   CLI NI C   0   0   0   0   0   0   0   76. 08   04975   SPI NE CENTER   0   0   0   0   0   0   0   76. 09   09000   CLI NI C   0   0   0   0   0   0   0   77. 00   09100   DRERGENCY   0   552,600   178,401   731,001   2,121   91.00   78. 00   09100   DRERGENCY   0   552,600   178,401   731,001   2,121   91.00   79. 00   09000   DRERGENCY   0   552,600   178,401   731,001   2,121   91.00   79. 00   09100   DRERGENCY   0   13,396,127   14,355,582   27,751,709   34,211   118.00   79. 00   19000   OREA TENES   0   0   0   0   0   0   79. 00   09000   DRESCARCH   0   0   0   0   0   79. 00   09000   OREA TENES   0   0   0   0   79. 00   09000   OREA TENES   0   0   0   0   79. 00   09000   OREA TENES   0   0   0   0   79. 00   09000   OREA TENES   0   0   0   0   79. 00   09000   OREA TENES   0   0   79. 00   09000   OREA TENES   0   0   79.		07000 ELECTROENCEPHALOGRAPHY	0	30, 608	1			70. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   73. 00   74. 00   07400   07400   RENAL DIALYSIS   0   2,384   0   73. 00   74. 00   07400   07400   RENAL DIALYSIS   0   2,384   0   73. 00   76. 00   03330   ENDOSCOPY   0   161,087   425,940   587,027   370   76. 00   03954   IMAGING CENTER   0   0   0   469,385   469,385   509   76. 06   76. 07   03955   BREAST DIAGNOSTIC CENTER   0   0   0   93,649   93,649   0   76. 07   79. 00   09000   CLINIC   0   0   0   0   0   0   0   79. 20   09000   CLINIC   0   0   0   4,788   4,788   69   90. 26   79. 00   09100   EMERGENCY   0   552,600   178,401   731,001   2,121   79. 00   09000   OBSERVATION BEDS (NON-DISTINCT PART)   92. 00   79. 00   09000   OBSERVATION BEDS (NON-DISTINCT PART)   92. 00   79. 00   113.00   INTEREST EXPENSE   114. 00   79. 00   114.00   UTILIZATION REVIEW - SNF   114. 00   79. 00   19000   ORSESTANCH   0   0   0   0   0   0   79. 00   19000   ORSESTANCH   0   0   0   0   0   79. 00   19000   ORSESTANCH   0   0   0   0   0   79. 00   19000   ORSESTANCH   0   0   0   79. 00   19000   ORSESTANCH   0   0   0   0   79. 00   19000   ORSESTANCH   0   0   0   79. 00   09000   ORSESTANCH   0   0   0   79. 00   09000   ORSESTANCH   0   0   0   79. 00   09000   ORSESTANCH   0   0   79. 00   09000   ORSESTANCH   0   0   0   79. 00   09000   ORSESTANCH   0   0   79. 00   09000   ORSESTANCH   0   0			0	_	-	-	_	•
74. 00 07400 RENAL DIALYSIS 0 2, 384 0 2, 384 0 74. 00 76. 00 03330 ENDOSCOPY 0 161,087 425,940 587,027 370 76. 00 76. 00 03935 INDIAGNOSCOPY 0 161,087 425,940 587,027 370 76. 00 76. 07 03955 BREAST DIAGNOSTIC CENTER 0 0 0 469,385 469,385 509 76. 06 76. 07 03955 BREAST DIAGNOSTIC CENTER 0 0 0 93,649 93,649 0 76. 07 000 09000 CLI IN C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0				
76. 00 03330   ENDOSCOPY 0 161, 087 425, 940 587, 027 370 76. 00 76. 06 03954   IMAGING CENTER 0 0 0 469, 385 469, 385 509 76. 06 76. 07 03955   BREAST DI AGNOSTIC CENTER 0 0 0 93, 649 93, 649 0 76. 07  0UTPATI ENT SERVICE COST CENTERS  90. 00 09000   CLI NI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			o o	2, 384	1	J	Ĭ	•
76. 07 03955 BREAST DI AGNOSTIC CENTER 0 0 93,649 93,649 0 76. 07 00TPATIENT SERVICE COST CENTERS  90. 00 09000 CLIN IC 0 0 0 0 0 0 90. 00 90. 00 90. 26 91. 00 09100 EMERGENCY 0 552,600 178, 401 731,001 2, 121 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 92. 00 SPECI AL PURPOSE COST CENTERS  113. 00 11300 I INTEREST EXPENSE 113. 00 11400 UTI LI ZATI ON REVI EW - SNF 118. 00 SUBTOTALS (SUM OF LINES 1-117) 0 13, 396, 127 14, 355, 582 27, 751, 709 34, 211 18. 00 NONREI MBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 76, 510 0 76, 510 0 191. 00 192. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 192. 00 193. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 73, 975 73, 975 0 194. 06 194. 00 07950 HOME OFFI CE 0 0 0 0 73, 975 73, 975 0 194. 06 194. 00 07950 HOME OFFI CE 0 0 0 0 73, 975 73, 975 0 194. 08 194. 10 07960 COMMUNITY REHAB HOSPI TAL 0 0 0 0 0 0 12, 415 216 194. 08 194. 10 07960 COMMUNITY REHAB HOSPI TAL 0 0 0 0 0 0 0 194. 00 194. 10 07960 COMMUNITY REHAB HOSPI TAL 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0		425, 940	587, 027		
90. 00   09000   CLINIC   0   0   0   0   0   0   0   0   0		1	0		1			•
90. 00	76.07		J U	0	93, 049	93, 649	0	76.07
91. 00	90.00		0	0	0	0	0	90.00
92. 00   09200   0BSERVATI ON BEDS (NON-DI STINCT PART)   92. 00   92. 00   SPECI AL PURPOSE COST CENTERS   113. 00   11400   UTI LI ZATI ON REVIEW - SNF   114. 00   SUBTOTALS (SUM OF LI NES 1-117)   0   13, 396, 127   14, 355, 582   27, 751, 709   34, 211   18. 00   NONREI MBURSABLE COST CENTERS   118. 00   NONREI MBURSABLE COST CENTERS   119. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   191. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   0   0   0   192. 00   193. 00   19300   NONPAI D WORKERS   0   0   0   0   0   193. 00   194. 00			0	_	1			1
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   113.00   114.00   11400   UTILIZATION REVIEW - SNF   114.00   114.00   11400   UTILIZATION REVIEW - SNF   114.00   114.00   114.00   SUBTOTALS (SUM OF LINES 1-117)   0   13,396,127   14,355,582   27,751,709   34,211   118.00   118.00   119.			0	552, 600	178, 401		2, 121	
113. 00	92.00					U		92.00
118. 00   SUBTOTALS (SUM OF LINES 1-117)   0   13, 396, 127   14, 355, 582   27, 751, 709   34, 211   118. 00	113.00							113. 00
NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   76, 510   0   76, 510   0   190. 00   191. 00   191. 00   19100   RESEARCH   0   0   0   0   0   0   0   191. 00   192. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   0   0   0   0   192. 00   193. 00   193. 00   193. 00   193. 00   193. 00   194. 00   195. 00   0   0   0   0   0   0   194. 00   194. 00   194. 00   195. 00								1
190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   76, 510   0   190. 00   191. 00   19100   RESEARCH   0   0   0   0   0   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   0   0   193. 00   19300   NONPAI D WORKERS   0   0   0   0   194. 00   07950   HOME OFFI CE   0   0   0   194. 06   07956   PAVI LLI ONS   0   194. 06   194. 08   07958   OTHER NRCC   0   12, 415   0   194. 10   07960   COMMUNI TY REHAB HOSPI TAL   0   0   0   0   200. 00   Negative Cost Centers   0   0   0   0   201. 00   Negative Cost Centers   0   0   0   190. 00   0   0   0   191. 00   0   0   0   191. 00   0   0   191. 00   0   0   191. 00   0   0   191. 00   0   0   191. 00   0   0   191. 00   0   192. 00   0   0   193. 00   0   194. 00   0   194. 00   0   195. 00   0   195. 00   0   196. 00   0   197. 00   0   190. 00   0   191. 00   0   191. 00   0   191. 00   0   191. 00   0   192. 00   0   193. 00   194. 00   0   194. 00   195. 00   0   194. 00   195. 00   196. 00   197. 00   199. 00   199. 00   199. 00   199. 00   199. 00   199. 00   199. 00   199. 00   199. 00   199. 00   199. 00   199. 00   199. 00   190. 00   191. 00   191. 00   192. 00   193. 00   194. 00   194. 00   194. 00   195. 00   195. 00   196. 00   197. 00   199. 00   199. 00   199. 00   199. 00   199. 00   199. 00   199. 00   191. 00   191. 00   192. 00   193. 00   194. 00   194. 00   194. 00   194. 00   195. 00   196. 00   197. 00   199. 0	118. 00		0	13, 396, 127	14, 355, 582	27, 751, 709	34, 211	118. 00
191. 00       19100       RESEARCH       0       0       0       0       191. 00         192. 00       19200       PHYSI CI ANS' PRI VATE OFFI CES       0       0       0       0       0       192. 00         193. 00       19300       NONPAI D WORKERS       0       0       0       0       0       193. 00         194. 00       07950       HOME OFFI CE       0       0       0       0       0       194. 00         194. 06       07956       PAVI LLI ONS       0       0       73, 975       0       194. 06         194. 08       07958       OTHEN NRCC       0       12, 415       0       12, 415       216       194. 06         194. 10       07960       COMMUNI TY REHAB HOSPI TAL       0       0       0       0       4       194. 10         200. 00       Cross Foot Adj ustments       0       0       0       0       0       200. 00	190.00		0	76, 510	0	76, 510	0	190. 00
192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES	191.00	19100 RESEARCH	Ö			75,510		
194. 00     07950     HOME OFFICE     0     0     0     0     194. 00       194. 06     07956     PAVI LLI ONS     0     0     73, 975     73, 975     0     194. 06       194. 08     07958     OTHER NRCC     0     12, 415     0     12, 415     216 194. 08       194. 10     07960     COMMUNITY REHAB HOSPITAL     0     0     0     0     4 194. 10       200. 00     Cross Foot Adjustments     0     0     0     0     200. 00       201. 00     Negative Cost Centers     0     0     0     0     0			0	0	0	0	0	192. 00
194. 06 07956 PAVI LLI ONS 0 0 0 73, 975 73, 975 0 194. 06 194. 08 07958 OTHER NRCC 0 12, 415 0 12, 415 216 194. 08 194. 10 07960 COMMUNI TY REHAB HOSPI TAL 0 0 0 0 4 194. 10 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 201. 00			0	0	0	0		
194. 08 07958 OTHER NRCC 0 12, 415 0 12, 415 216 194. 08 194. 10 07960 COMMUNITY REHAB HOSPITAL 0 0 0 0 4 194. 10 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 201. 00				0	73. 975	73. 975		l .
200.00   Cross Foot Adjustments   0   200.00   201.00   Negative Cost Centers   0   0   0   201.00				12, 415			216	194. 08
201.00   Negative Cost Centers   0 0 0 201.00		1	0	0	0	0	4	194. 10
202. 00 TOTAL (sum lines 118-201) 0 13, 485, 052 14, 429, 557 27, 914, 609 34, 431 202. 00		, ,		0		0	_	
			0	13, 485. 052	14, 429, 557	27, 914, 609	34. 431	202.00
		·	·		·			

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared: 5/30/2017 8:54 am

Cost Center Description	0 11.00 0 13.00 0 14.00 0 15.00 0 16.00 0 17.00 0 19.00 0 21.00 0 22.00
GENERAL SERVICE COST CENTERS	2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 3 10. 00 0 11. 00 0 13. 00 14. 00 0 15. 00 0 16. 00 0 17. 00 0 19. 00 0 21. 00 0 22. 00
1.00	2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 3 10. 00 0 11. 00 0 13. 00 14. 00 0 15. 00 0 16. 00 0 17. 00 0 19. 00 0 21. 00 0 22. 00
2.00   00200   CAP REL COSTS-MVBLE EQUIP   4.00   00400   EMPLOYEE BENEFITS DEPARTMENT   5.00   00500   ADMI NI STRATI VE & GENERAL   6,081,638   7.00   00700   OPERATION OF PLANT   325,551   2,487,550   8.00   00800   LAUNDRY & LI NEN SERVI CE   21,404   10,529   78,598   9.00   00900   HOUSEKEEPI NG   105,271   24,457   0   255,223   10.00   01000   DI ETARY   36,012   36,405   0   3,788   268,0   11.00   01100   CAFETERI A   60,084   61,670   0   6,418	2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 3 10. 00 0 11. 00 0 13. 00 14. 00 0 15. 00 0 16. 00 0 17. 00 0 19. 00 0 21. 00 0 22. 00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT   5.00   00500   ADMINISTRATIVE & GENERAL   6,081,638   7.00   00700   OPERATION OF PLANT   325,551   2,487,550   8.00   00800   AUNDRY & LINEN SERVICE   21,404   10,529   78,598   9.00   00900   HOUSEKEEPING   105,271   24,457   0   255,223   10.00   01000   DIETARY   36,012   36,405   0   3,788   268,0   11.00   01100   CAFETERIA   60,084   61,670   0   6,418	4.00 5.00 7.00 8.00 9.00 3 10.00 0 11.00 0 13.00 14.00 0 15.00 0 16.00 0 17.00 0 19.00 0 21.00 0 22.00
5. 00     00500     ADMINISTRATIVE & GENERAL     6, 081, 638       7. 00     00700     OPERATION OF PLANT     325, 551     2, 487, 550       8. 00     00800     LAUNDRY & LINEN SERVICE     21, 404     10, 529     78, 598       9. 00     00900     HOUSEKEEPING     105, 271     24, 457     0     255, 223       10. 00     01000     DI ETARY     36, 012     36, 405     0     3, 788     268, 0       11. 00     01100     CAFETERIA     60, 084     61, 670     0     6, 418	5. 00 7. 00 8. 00 9. 00 3 10. 00 0 11. 00 0 13. 00 14. 00 0 15. 00 0 16. 00 0 17. 00 0 19. 00 0 21. 00 0 22. 00
7. 00   00700   OPERATI ON OF PLANT   325, 551   2, 487, 550   8. 00   00800   LAUNDRY & LI NEN SERVI CE   21, 404   10, 529   78, 598   9. 00   00900   HOUSEKEEPI NG   105, 271   24, 457   0   255, 223   10. 00   01000   DI ETARY   36, 012   36, 405   0   3, 788   268, 0   11. 00   01100   CAFETERI A   60, 084   61, 670   0   6, 418	7. 00 8. 00 9. 00 3 10. 00 0 11. 00 0 13. 00 0 14. 00 0 15. 00 0 16. 00 0 17. 00 0 19. 00 0 21. 00
9. 00   00900   HOUSEKEEPI NG   105, 271   24, 457   0 255, 223   10. 00   01000   DI ETARY   36, 012   36, 405   0 3, 788   268, 0	9.00 3 10.00 0 11.00 0 13.00 0 14.00 0 15.00 0 16.00 0 17.00 0 19.00 0 21.00 0 22.00
10. 00     01000 DI ETARY     36, 012     36, 405     0     3,788     268, 0       11. 00     01100 CAFETERI A     60, 084     61, 670     0     6,418	3 10.00 0 11.00 0 13.00 0 14.00 0 15.00 0 16.00 0 17.00 0 19.00 0 21.00 0 22.00
11. 00 01100 CAFETERI A 60, 084 61, 670 0 6, 418	0 11.00 0 13.00 0 14.00 0 15.00 0 16.00 0 17.00 0 19.00 0 21.00 0 22.00
	0 13.00 0 14.00 0 15.00 0 16.00 0 17.00 0 19.00 0 21.00 0 22.00
42 00 1042001NUDCING ADMINICEDATION 1 452 277 4 242 0 4 44	0 14.00 0 15.00 0 16.00 0 17.00 0 19.00 0 21.00 0 22.00
13. 00   01300   NURSI NG ADMI NI STRATI ON   153, 266   4, 242   0   441   14. 00   01400   CENTRAL SERVI CES & SUPPLY   22, 284   67, 815   0   7, 057	0 15. 00 0 16. 00 0 17. 00 0 19. 00 0 21. 00 0 22. 00
14. 00   01400   CENTRAL SERVI CES & SUPPLY   22, 284   67, 815   0   7, 057   15. 00   01500   PHARMACY   129, 983   32, 907   0   3, 424	0 16.00 0 17.00 0 19.00 0 21.00 0 22.00
16. 00   01600   MEDI CAL RECORDS & LI BRARY   93, 166   4, 122   0   429	0 17.00 0 19.00 0 21.00 0 22.00
17. 00   01700  SOCI AL SERVI CE   77, 840   4, 810   0   501	0 21.00 0 22.00
19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0	0 22.00
21.00   02100   1&R SERVI CES-SALARY & FRI NGES APPRVD   8,721   0   0   0	
22. 00   02200   1 &R SERVI CES-OTHER PRGM COSTS APPRVD   15, 245   0   0   0	20.00
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00   03000   ADULTS & PEDIATRICS   1, 269, 742   896, 548   40, 481   93, 300   178, 6 31. 00   03100   INTENSIVE CARE UNIT   162, 225   198, 892   5, 259   20, 697   18, 3	
31. 00   03100   I NTENSI VE CARE UNI T   162, 225   198, 892   5, 259   20, 697   18, 3   35. 00   02060   NEONATAL I NTENSI VE CARE UNI T   241, 365   179, 435   2, 285   18, 673   37, 6	•
40. 00   04000   SUBPROVI DER -   PF   42, 939   31, 448   0   3, 273   8, 4	•
43. 00   04300   NURSERY   84, 873   98, 760   3, 004   10, 277   24, 9	
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 OPERATI NG ROOM 368, 512 135, 453 3, 495 14, 096	0 50.00
51. 00   05100   RECOVERY ROOM   90, 804   74, 742   0   7, 778	0 51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM   209, 330   224, 932   6, 843   23, 407	0 52.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C   156, 944   44, 714   4, 668   4, 653   40, 713   40	0 54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0 55.00 0 57.00
57. 00   05700   CT SCAN	0 58.00
59. 00   05900   CARDI AC CATHETERI ZATI ON   0   4, 432   0   461	0 59.00
60. 00 06000 LABORATORY 213, 071 26, 053 0 2, 711	0 60.00
64. 00   06400   I NTRAVENOUS THERAPY   16, 351   31, 978   0   3, 328	0 64.00
65. 00   06500   RESPI RATORY THERAPY   116, 027   28, 178   0   2, 932	0 65.00
66. 00   06600   PHYSI CAL THERAPY   129, 438   0   0   0	0 66.00
67. 00   06700   0CCUPATI ONAL THERAPY   36, 631   0   0   0   0	0 67.00
68. 00   06800   SPEECH PATHOLOGY   7, 053   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   18, 115   0   0   0   0   0   0   0   0   0	0 68.00
69. 00   06900   ELECTROCARDI OLOGY   18, 115   0   0   0   70. 00   07000   ELECTROENCEPHALOGRAPHY   47, 967   6, 906   0   719	0 69.00
71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   326, 928   0   0	0 71.00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   303, 310   0   0   0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS 390,020 0 0 0	0 73.00
74. 00   07400   RENAL DI ALYSI S   25, 561   538   0   56	0 74.00
76. 00   03330   ENDOSCOPY   61, 389   36, 345   2, 030   3, 782	0 76.00
76. 06   03954   IMAGI NG CENTER   101, 767   0   0	0 76.06
76. 07   03955   BREAST DI AGNOSTI C CENTER   126, 515   0   0   0   0   0   0   0   0   0	0 76. 07
90. 00   09000  CLINI C   0   0   0	0 90.00
90. 26   04975   SPI NE CENTER	0 90.26
91. 00   09100   EMERGENCY   244, 450   124, 679   8, 606   12, 975	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	92. 00
SPECIAL PURPOSE COST CENTERS	
113. 00 11300   I NTEREST EXPENSE	113. 00
114. 00   11400   UTI LI ZATI ON REVI EW - SNF	114. 00
118. 00 SUBTOTALS (SUM OF LI NES 1-117) 6, 015, 887 2, 467, 487 78, 598 253, 136 268, 0 NONREI MBURSABLE COST CENTERS	3 118. 00
190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   2, 014   17, 262   0   1, 796	0 190. 00
191. 00 19100 RESEARCH 0 0 0 0	0 191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 4, 449 0 0 0	0 192. 00
193. 00 19300 NONPALD WORKERS 0 0 0 0	0 193. 00
194. 00 07950 HOME OFFICE 0 0 0 0	0 194. 00
194. 06 07956 PAVI LLI ONS 2, 485 0 0 0	0 194. 06
194. 08 07958 OTHER NRCC 56, 470 2, 801 0 291	0 194. 08
194. 10 07960 COMMUNI TY REHAB HOSPI TAL 333 0 0 0	0 194. 10
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 0 0	200. 00 0 201. 00
	3 202. 00
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Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0169

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared: | 5/30/2017 8:54 am

Cost Center Description		NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	5/30/2017 8: 5 MEDI CAL RECORDS & LI BRARY	4 am
CENEDAL CEDIUCE COCT CENTEDO	11. 00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS	453, 128 15, 148 0 21, 207 1, 731 12, 118 0 0	205, 116 0 0 0	528, 512 1, 194 8 40 0 0	505, 606 0 0 0 0	117, 882 0 0 0 0	1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 17. 00 19. 00 21. 00
30. 00 03000 ADULTS & PEDI ATRI CS	150, 175		17, 402	0	13, 336	30.00
31. 00   03100   INTENSI VE CARE UNIT 35. 00   02060   NEONATAL   INTENSI VE CARE UNIT 40. 00   04000   SUBPROVI DER -   PF 43. 00   04300   NURSERY   ANCI LLARY SERVI CE COST CENTERS	22, 938 35, 056 6, 059 11, 685	22, 482 3, 886	2, 861 2, 646 1, 022 1, 314	0 0 0 0	1, 888 7, 258 475 945	31. 00 35. 00 40. 00 43. 00
	28. 997	18, 596	31, 560	O	14. 996	50. 00
50. 00   05000   OPERATING ROOM   51. 00   05100   RECOVERY ROOM   52. 00   05200   DELI VERY ROOM & LABOR ROOM   54. 00   05400   RADI OLOGY-DI AGNOSTI C   55. 00   05500   RADI OLOGY-DI AGNOSTI C   57. 00   05700   CT SCAN   58. 00   05800   MAGNETI C RESONANCE   MAGING (MRI )   59. 00   05900   CARDI AC CATHETERI ZATI ON   60. 00   06000   LABORATORY   64. 00   06400   INTRAVENOUS THERAPY   65. 00   06500   RESPI RATORY THERAPY   66. 00   06600   PHYSI CAL THERAPY   67. 00   06700   OCCUPATI ONAL THERAPY   68. 00   06800   SPEECH PATHOLOGY   69. 00   06900   ELECTROCARDI OLOGY   70. 00   07000   ELECTROCARDI OLOGY   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   73. 00   07300   DRUGS CHARGED TO PATI ENTS   74. 00   07400   RENAL DI ALYSI S   76. 00   03395   BREAST DI AGNOSTI C CENTER   00179ATI ENT SENVI CE COST CENTER   00179ATI ENT SENVI CE COST CENTER   001700   EMERGENCY   09200   OBSERVATI ON BEDS (NON-DI STINCT PART)   SPECI AL PURPOSE COST CENTERS   09200   OBSERVATI ON BEDS (NON-DI STINCT PART)   SPECI AL PURPOSE COST CENTERS   00100   00100   MERGENCY   00200   OBSERVATI ON BEDS (NON-DI STINCT PART)   SPECI AL PURPOSE COST CENTERS   00100   00100   MERGENCY   00200   OBSERVATI ON BEDS (NON-DI STINCT PART)   SPECI AL PURPOSE COST CENTERS   001000   00100   001000   00100   001000   001000   001000   001000   001000	28, 997 11, 685 26, 833 17, 311 2, 597 6, 059 3, 030 866 1, 731 16, 879 4, 328 5, 193 866 433 6, 059 0 0 6, 059 0 0 38, 085	17, 209 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31, 560 1, 919 2, 993 1, 513 2, 905 121 698 0 28, 804 65 1, 335 1, 334 335 64 6 942 257, 173 157, 738 0 45 2, 044 1, 980 81	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	14, 996 2, 768 2, 020 3, 523 2, 255 6, 214 2, 109 108 9, 947 131 2, 585 2, 439 651 191 749 1, 124 7, 475 3, 771 9, 323 275 1, 742 5, 128 1, 040	
113.00 11300 INTEREST EXPENSE 114.00 11400 UTILIZATION REVIEW - SNF 118.00 SUBTOTALS (SUM OF LINES 1-117)	453, 128	205, 116	527, 247	505, 606	117, 882	113. 00 114. 00 118. 00
NONREI MBURSABLE COST CENTERS   190.00   19100   GIFT, FLOWER, COFFEE SHOP & CANTEEN   191.00   19100   RESEARCH   192.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   193.00   19300   NONPAI D WORKERS   194.00   07950   HOME OFFI CE   194.06   07956   PAVI LLI ONS   194.08   07958   OTHER NRCC   194.10   07960   COMMUNI TY REHAB HOSPI TAL   200.00   Cross Foot Adjustments   Negative Cost Centers   202.00   TOTAL (sum lines 118-201)	0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 1, 094 0 0 69 102 0 0 528, 512	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	190. 00 191. 00 192. 00 193. 00 194. 00 194. 06 194. 08 194. 10 200. 00 201. 00 202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared: | 5/30/2017 8:54 am

						5/30/2017 8:5	<u>4 am</u>
				INTERNS &	RESI DENTS		
	Cost Center Description	SOCI AL SERVI CE		SERVI CES-SALAR		Subtotal	
			ANESTHETI STS	Y & FRINGES	PRGM COSTS		
051	WEDAL OFFICE OROT OFFITTED	17. 00	19. 00	21.00	22. 00	24. 00	
	NERAL SERVICE COST CENTERS						
	100 CAP REL COSTS-BLDG & FIXT						1.00
	200 CAP REL COSTS-MVBLE EQUIP						2.00
1	400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	500 ADMINISTRATIVE & GENERAL						5. 00
	700 OPERATION OF PLANT						7. 00
	800 LAUNDRY & LINEN SERVICE						8. 00
1	900 HOUSEKEEPI NG						9. 00
	000 DI ETARY						10. 00
1	100 CAFETERI A						11. 00
	300 NURSING ADMINISTRATION						13. 00
	400 CENTRAL SERVICES & SUPPLY						14. 00
	500 PHARMACY						15. 00
	600 MEDICAL RECORDS & LIBRARY						16. 00
	700 SOCI AL SERVI CE	117, 423					17. 00
1	900 NONPHYSICIAN ANESTHETISTS	0	C	1			19. 00
	100    &R SERVICES-SALARY & FRINGES APPRVD	0		8, 721			21. 00
	200 1&R SERVICES-OTHER PRGM COSTS APPRVD	0			15, 245		22. 00
	PATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDIATRICS	78, 279				8, 603, 329	1
	100 INTENSIVE CARE UNIT	8, 040				1, 622, 775	
35. 00   020	060 NEONATAL INTENSIVE CARE UNIT	16, 486				1, 587, 112	35. 00
	000 SUBPROVI DER - I PF	3, 683				264, 636	40.00
43.00 043	300 NURSERY	10, 935				772, 237	43.00
	CILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	0				2, 410, 197	50.00
	100 RECOVERY ROOM	0				540, 668	51.00
	200 DELIVERY ROOM & LABOR ROOM	0				1, 693, 459	52. 00
	400 RADI OLOGY-DI AGNOSTI C	0				1, 315, 828	54.00
55.00 055	500 RADI OLOGY-THERAPEUTI C	0				714, 617	55. 00
57.00 057	700 CT SCAN	0				518, 101	57. 00
58. 00   058	800 MAGNETIC RESONANCE IMAGING (MRI)	0				1, 029, 567	58. 00
59.00 059	900 CARDI AC CATHETERI ZATI ON	0				24, 643	59. 00
60.00 060	000 LABORATORY	0				409, 215	60.00
64. 00 064	400 INTRAVENOUS THERAPY	0				195, 422	64. 00
65.00 065	500 RESPI RATORY THERAPY	0				600, 162	65. 00
66.00 066	600 PHYSI CAL THERAPY	0				266, 033	66. 00
67. 00 067	700 OCCUPATI ONAL THERAPY	0				75, 071	67. 00
68. 00 068	800 SPEECH PATHOLOGY	0				14, 386	68. 00
69. 00 069	900 ELECTROCARDI OLOGY	0				34, 953	69. 00
70.00 070	000 ELECTROENCEPHALOGRAPHY	0				236, 833	70. 00
71.00 071	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0				591, 576	71. 00
72. 00   072	200 IMPL. DEV. CHARGED TO PATIENTS	0				464, 819	72.00
73. 00   073	300 DRUGS CHARGED TO PATIENTS	0				904, 949	73.00
74. 00   074	400 RENAL DIALYSIS	0				28, 859	74.00
	330 ENDOSCOPY	0				700, 788	
76. 06 039	954 IMAGING CENTER	0				578, 769	76. 06
76. 07 039	955 BREAST DIAGNOSTIC CENTER	0				221, 285	76. 07
רטס	TPATIENT SERVICE COST CENTERS						
	DOO CLI NI C	0				0	90. 00
90. 26 049	975 SPINE CENTER	0				11, 304	
91.00 091	100 EMERGENCY	0				1, 206, 764	91.00
92.00 092	200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
SPE	ECIAL PURPOSE COST CENTERS						
	300 INTEREST EXPENSE						113. 00
114. 00 114	400 UTILIZATION REVIEW - SNF						114. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	117, 423	C	0	0	27, 638, 357	118. 00
NON	NREIMBURSABLE COST CENTERS						
190. 00 190	OOO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				97, 582	190. 00
191. 00 191	100 RESEARCH	0				0	191. 00
192. 00 192	200 PHYSICIANS' PRIVATE OFFICES	0				5, 543	192. 00
193. 00 193	300 NONPALD WORKERS	0				0	193. 00
194. 00 079	950 HOME OFFICE	0					194. 00
	956 PAVI LLI ONS	0				76, 529	194. 06
	958 OTHER NRCC	0				72, 295	194. 08
	960 COMMUNITY REHAB HOSPITAL	0					194. 10
200.00	Cross Foot Adjustments		C	8, 721	15, 245		200.00
201.00	Negative Cost Centers	0	C	0	0	0	201. 00
202.00	TOTAL (sum lines 118-201)	117, 423	C	8, 721	15, 245	27, 914, 609	
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Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0169

				1		ate/lime Prepared: /30/2017 8:54 am
	Cost Center Description	Intern &	Total	<u>'</u>	,	00,201, 0101 4
		Residents Cost				
		& Post Stepdown				
		Adjustments				
		25. 00	26. 00			
	ENERAL SERVICE COST CENTERS	T				
1	0100 CAP REL COSTS-BLDG & FLXT					1.00
	0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT					2. 00 4. 00
	0500 ADMINISTRATIVE & GENERAL					5. 00
1	0700 OPERATION OF PLANT					7. 00
8.00 00	0800 LAUNDRY & LINEN SERVICE					8. 00
	0900 HOUSEKEEPI NG					9. 00
	1000 DI ETARY					10.00
	1100 CAFETERIA 1300 NURSING ADMINISTRATION					11. 00
	1400 CENTRAL SERVICES & SUPPLY					14. 00
	1500 PHARMACY					15. 00
	1600 MEDICAL RECORDS & LIBRARY					16. 00
17. 00 01	1700 SOCIAL SERVICE					17. 00
1	1900 NONPHYSICIAN ANESTHETISTS					19. 00
	2100 I &R SERVI CES-SALARY & FRINGES APPRVD					21.00
	2200 1&R SERVICES-OTHER PRGM COSTS APPRVD NPATIENT ROUTINE SERVICE COST CENTERS					22. 00
	3000 ADULTS & PEDIATRICS	O	8, 603, 329			30.00
1	3100 INTENSIVE CARE UNIT	Ö	1, 622, 775			31. 00
35. 00 02	2060 NEONATAL INTENSIVE CARE UNIT	0	1, 587, 112			35. 00
1	4000 SUBPROVI DER - I PF	0	264, 636			40. 00
	4300 NURSERY	0	772, 237			43. 00
	NCILLARY SERVICE COST CENTERS 5000 OPERATING ROOM	0	2, 410, 197			50.00
	5100 RECOVERY ROOM		540, 668			51. 00
1	5200 DELIVERY ROOM & LABOR ROOM	o	1, 693, 459			52. 00
54. 00 05	5400 RADI OLOGY-DI AGNOSTI C	0	1, 315, 828			54. 00
	5500 RADI OLOGY-THERAPEUTI C	0	714, 617			55. 00
	5700 CT SCAN	0	518, 101			57. 00
	5800 MAGNETIC RESONANCE IMAGING (MRI) 5900 CARDIAC CATHETERIZATION	0	1, 029, 567 24, 643			58. 00 59. 00
1	6000 LABORATORY		409, 215			60.00
1	6400 I NTRAVENOUS THERAPY	o	195, 422			64. 00
	6500 RESPI RATORY THERAPY	O	600, 162			65. 00
	6600 PHYSI CAL THERAPY	0	266, 033			66. 00
	6700 OCCUPATI ONAL THERAPY	0	75, 071			67. 00
	6800 SPEECH PATHOLOGY 6900 ELECTROCARDI OLOGY	0	14, 386			68. 00
1	7000 ELECTROCARDI OLOGY	0	34, 953 236, 833			69. 00 70. 00
1	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS		591, 576			71. 00
1	7200 I MPL. DEV. CHARGED TO PATIENTS	o	464, 819			72. 00
	7300 DRUGS CHARGED TO PATIENTS	0	904, 949			73. 00
	7400 RENAL DIALYSIS	0	28, 859			74. 00
1	3330 ENDOSCOPY	0	700, 788			76.00
	3954 IMAGING CENTER 3955 BREAST DIAGNOSTIC CENTER	0	578, 769 221, 285			76. 06 76. 07
	JTPATIENT SERVICE COST CENTERS	<u> </u>	221, 200			70.07
	9000 CLI NI C	0	0			90.00
90. 26 04	4975 SPINE CENTER	0	11, 304			90. 26
	9100 EMERGENCY	0	1, 206, 764			91. 00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0				92. 00
	PECIAL PURPOSE COST CENTERS 1300 INTEREST EXPENSE	Т				113. 00
	1400 UTILIZATION REVIEW - SNF					114.00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	o	27, 638, 357			118. 00
	ONREI MBURSABLE COST CENTERS	-\\\	,			
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	97, 582			190. 00
	9100 RESEARCH	0	0			191. 00
	9200 PHYSI CLANS' PRI VATE OFFI CES	0	5, 543			192. 00
	9300 NONPAID WORKERS 7950 HOME OFFICE	0	0			193. 00 194. 00
	7956 PAVI LLI ONS		76, 529			194. 00
	7958 OTHER NRCC		70, 327			194. 08
	7960 COMMUNITY REHAB HOSPITAL	o	337			194. 10
200.00	Cross Foot Adjustments	o	23, 966			200. 00
201.00	Negative Cost Centers	O	0			201. 00
202.00	TOTAL (sum lines 118-201)	0	27, 914, 609			202. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0169

					Τ̈́	o 12/31/2016		
			CAPITAL RE	L LATED COSTS			5/30/2017 8: 5	4 am
		Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		oost denter bescription		(DOLLAR VALUE)	BENEFITS	neconci i i ati on	& GENERAL	
					DEPARTMENT (GROSS		(ACCUM. COST)	
					SALARI ES)			
	GENER	AL SERVICE COST CENTERS	1. 00	2. 00	4.00	5A	5. 00	
1.00	00100	CAP REL COSTS-BLDG & FIXT	707, 123					1. 00
2. 00 4. 00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	1, 416	9, 203, 459 4, 737				2. 00 4. 00
5. 00	1	ADMINISTRATIVE & GENERAL	21, 485	1			231, 083, 801	5. 00
7.00	1	OPERATION OF PLANT	106, 084	1			12, 369, 901	7. 00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	2, 447 5, 684	1	1	_	813, 277 3, 999, 980	8. 00 9. 00
10.00	01000	DI ETARY	8, 461	19, 238	801, 179	0	1, 368, 325	10. 00
11. 00 13. 00		CAFETERIA NURSING ADMINISTRATION	14, 333 986	1			2, 283, 002 5, 823, 636	11. 00 13. 00
14.00	01400	CENTRAL SERVICES & SUPPLY	15, 761	83, 420	C	0	846, 735	14. 00
15. 00 16. 00		PHARMACY MEDICAL RECORDS & LIBRARY	7, 648 958	1			4, 938, 922 3, 540, 015	15. 00 16. 00
17. 00	01700	SOCIAL SERVICE	1, 118	ł			2, 957, 666	
19. 00 21. 00		NONPHYSICIAN ANESTHETISTS I &R SERVICES-SALARY & FRINGES APPRVD	0	0		_	221 244	19. 00 21. 00
21.00		I &R SERVICES-OTHER PRGM COSTS APPRVD		0			331, 366 579, 259	
20.00		I ENT ROUTINE SERVICE COST CENTERS	200.240	1 120 505	22 270 02/		40 247 110	20.00
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	208, 369 46, 225				48, 247, 110 6, 164, 015	
35. 00	02060	NEONATAL INTENSIVE CARE UNIT	41, 703	144, 268	5, 955, 893		9, 171, 113	35. 00
40. 00 43. 00		SUBPROVIDER - IPF NURSERY	7, 309 22, 953				1, 631, 551 3, 224, 904	40. 00 43. 00
	ANCI L	LARY SERVICE COST CENTERS					., .,	
50. 00 51. 00		OPERATING ROOM RECOVERY ROOM	31, 481 17, 371			0	14, 002, 272 3, 450, 278	50. 00 51. 00
52. 00	1	DELIVERY ROOM & LABOR ROOM	52, 277	•			7, 953, 853	
54.00	1	RADI OLOGY TUEDA PEUTLO	10, 392				5, 963, 384	1
55. 00 57. 00	1	RADI OLOGY-THERAPEUTI C CT SCAN	10, 537 1, 394	1			1, 888, 910 1, 707, 149	55. 00 57. 00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	5, 848	1	1		2, 840, 033	
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	1, 030 6, 055			,	0 8, 096, 029	59. 00 60. 00
64. 00	06400	INTRAVENOUS THERAPY	7, 432	. 0	274, 326	0	621, 271	64. 00
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	6, 549	195, 382 81, 057			4, 408, 650 4, 918, 241	65. 00 66. 00
67. 00	06700	OCCUPATI ONAL THERAPY	0	20, 349	916, 716	0	1, 391, 862	67. 00
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	3, 918 9, 964			267, 981 688, 313	•
70. 00		ELECTROENCEPHALOGRAPHY	1, 605	1			1, 822, 599	•
	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1				
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	1			11, 524, 803 14, 819, 501	
74.00		RENAL DI ALYSI S	125	l .	050.440	0	971, 251	
76. 00 76. 06	1	ENDOSCOPY I MAGING CENTER	8, 447				2, 332, 600 3, 866, 829	
76. 07	03955	BREAST DIAGNOSTIC CENTER	0	1		0	4, 807, 160	
90. 00		TIENT SERVICE COST CENTERS CLINIC		0		0	0	90. 00
90. 26	04975	SPINE CENTER	0	3, 054	176, 899	0	241, 191	90. 26
91. 00 92. 00	1	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	28, 977	113, 788	5, 453, 370	0	9, 288, 328	91. 00 92. 00
72.00		AL PURPOSE COST CENTERS						72.00
	1	INTEREST EXPENSE						113.00
118.00	1	UTILIZATION REVIEW - SNF SUBTOTALS (SUM OF LINES 1-117)	702, 460	9, 156, 276	87, 886, 042	-64, 030, 282		114. 00 118. 00
400.00		IMBURSABLE COST CENTERS	4 010				7/ 540	100 00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH	4, 012	0			76, 510 0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	O	C	0	169, 058	192. 00
		NONPALD WORKERS HOME OFFICE	0	0	0	0		193. 00 194. 00
194.06	07956	PAVI LLI ONS		47, 183		ő	94, 436	194. 06
		OTHER NRCC COMMUNITY REHAB HOSPITAL	651	0	,		2, 145, 661 12, 643	•
200.00		Cross Foot Adjustments		Ï	11, 220			200. 00
201.00		Negative Cost Centers						201. 00

Heal th Finar	ncial Systems COMM	MUNITY HOSPITAL	OF INDIANA, IN	IC.	In Lie	eu of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CC		Period: From 01/01/2016	Worksheet B-1	
				7	Го 12/31/2016	Date/Time Pre 5/30/2017 8:5	
		CAPITAL REI	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconci I i ati on		
		(SQUARE FEET)	(DOLLAR VALUE)			& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS			
				SALARI ES)			
		1.00	2.00	4.00	5A	5. 00	
202. 00	Cost to be allocated (per Wkst. B, Part I)	13, 485, 052	14, 429, 557	4, 210, 860	D	64, 047, 674	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	19. 070306	1. 567841	0. 047606	5	0. 277162	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)			34, 431	1	6, 081, 638	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0.000389	9	0. 026318	205. 00
I	1)	ı	l l		1	I	1

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

Peri od: Worksheet B-1 From 01/01/2016 To 12/31/2016 Date/Time Prepared:

				o 12/31/2016	Date/Time Pre 5/30/2017 8:5	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	4 alli
	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(TOTAL PATIENT DAYS)	(MEALS SERVED)	
	(SQUARE TEET)	LAUNDRY)		DATO)		
CENEDAL CEDALOE COCT CENTEDO	7. 00	8. 00	9. 00	10.00	11. 00	
1. 00 O0100 CAP REL COSTS -BLDG & FLXT						1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00   00500   ADMINISTRATIVE & GENERAL 7.00   00700   OPERATION OF PLANT	578, 138					5. 00 7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	2, 447	<b>+</b>				8. 00
9. 00   00900   HOUSEKEEPI NG	5, 684	0	570, 007			9. 00
10. 00   01000   DI ETARY	8, 461	0	8, 461			10.00
11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG   ADMI NI STRATI ON	14, 333 986	l .	14, 333 98 <i>6</i>		1, 047 35	11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	15, 761	Ö	15, 761		0	14. 00
15. 00   01500   PHARMACY	7, 648	l .	7, 648		49	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	958		958		4	16.00
17. 00   01700   SOCIAL SERVICE 19. 00   01900   NONPHYSICIAN ANESTHETISTS	1, 118		1, 118		28 0	17. 00 19. 00
21. 00 02100 I &R SERVI CES-SALARY & FRINGES APPRVD	Ö		d	-	0	21. 00
22.00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0	0		0	0	22. 00
30.00 O3000 ADULTS & PEDIATRICS	208, 369	120 042	208, 369	E2 1E7	347	30.00
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT	46, 225		46, 225		53	31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	41, 703	, , , , , ,			81	35. 00
40. 00   04000   SUBPROVI DER - 1 PF	7, 309		7, 309		14	40. 00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS	22, 953	10, 245	22, 953	7, 426	27	43. 00
50. 00   05000   OPERATING ROOM	31, 481	11, 919	31, 481	0	67	50.00
51. 00   05100   RECOVERY ROOM	17, 371	0			_	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	52, 277				62	52. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	10, 392	1			40	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C 57. 00   05700   CT   SCAN	10, 537 1, 394				6 14	55. 00 57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	5, 848		1		7	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 030	l .	1, 030		0	59. 00
60. 00   06000   LABORATORY	6, 055	l .	6, 055		2	60.00
64. 00   06400   I NTRAVENOUS THERAPY 65. 00   06500   RESPI RATORY THERAPY	7, 432 6, 549	l .	7, 432 6, 549		4 39	64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	0,017	Ö	0,017	Ö	10	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	C	0	12	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	2 1	68. 00 69. 00
69. 00   06900  ELECTROCARDI OLOGY 70. 00   07000  ELECTROENCEPHALOGRAPHY	0 1, 605		1, 605	_	14	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	l .	., 555		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS 74. 00   07400   RENAL DIALYSIS	125		125	0	0 0	73. 00 74. 00
74. 00   07400   RENAL BIALTSIS 76. 00   03330   ENDOSCOPY	8, 447				14	1
76. 06 03954 I MAGI NG CENTER	0					76. 06
76. 07 03955 BREAST DIAGNOSTIC CENTER	0	0	(	0	0	76. 07
90. 00 O9000 CLINIC	0	1		0	0	90.00
90. 26   04975   SPI NE CENTER				_	0	90. 26
91. 00 09100 EMERGENCY	28, 977	29, 346	28, 977	0	88	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS  113. 00 11300   INTEREST EXPENSE			Ι			113. 00
114. 00 11400 UTI LI ZATI ON REVI EW - SNF						114. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	573, 475	268, 023	565, 344	79, 739	1, 047	118. 00
NONREI MBURSABLE COST CENTERS	4.040	1	1 046			1400 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH	4, 012 0	l .	4, 012			190. 00 191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	Ö				192. 00
193. 00 19300 NONPALD WORKERS	0	0	C	0		193. 00
194. 00 07950 HOME OFFICE	0	0	0	0		194.00
194. 06 07956  PAVI LLI ONS 194. 08 07958  OTHER NRCC	0 651	0	651	0		194. 06 194. 08
194. 10 07938 OTHER NRCC 194. 10 07960 COMMUNITY REHAB HOSPITAL	001	0	051			194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	45 75					201. 00
202.00   Cost to be allocated (per Wkst. B, Part I)	15, 798, 368	1, 105, 553	5, 263, 945	2, 056, 917	3, 439, 795	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	27. 326292	4. 124844	9. 234878	25. 795621	3, 285. 382044	203. 00
			·	. '		

Heal th Finan	cial Systems COM	MUNITY HOSPITAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
COST ALLOCAT	TION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
		_			From 01/01/2016 Fo 12/31/2016		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE FEET)	(TOTAL PATIENT	(MEALS SERVED)	
		(SQUARE FEET)	(POUNDS OF		DAYS)		
			LAUNDRY)				
		7. 00	8. 00	9. 00	10.00	11. 00	
	Cost to be allocated (per Wkst. B, Part II)	2, 487, 550	78, 598	255, 223	268, 033	453, 128	204. 00
	Unit cost multiplier (Wkst. B, Part II)	4. 302692	0. 293251	0. 447754	3. 361379	432. 787011	205. 00

COST ALLO	OCATION - STATISTICAL BASIS		Provi der CC		eri od:	Worksheet B-1	
				T	rom 01/01/2016 o 12/31/2016	Date/Time Pre	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	5/30/2017 8:5 SOCIAL SERVICE	
	odst denter beserver on	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	SERVI SERVI SE	
		(5) 5507 11150	SUPPLY	REQUIS.)	LI BRARY	(TOTAL PATIENT	
		(DI RECT NURS. HRS. )	(COSTED REQUIS.)		(GROSS CHARGES)	DAYS)	
		13.00	14. 00	15. 00	16. 00	17. 00	
	NERAL SERVICE COST CENTERS						
	100 CAP REL COSTS-BLDG & FLXT						1.00
	200 CAP REL COSTS-MVBLE EQUIP 400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
1	500 ADMINISTRATIVE & GENERAL						5. 00
	700 OPERATION OF PLANT						7. 00
	800 LAUNDRY & LINEN SERVICE  900 HOUSEKEEPING						8. 00 9. 00
	000 DI ETARY						10.00
	100 CAFETERI A						11. 00
	300 NURSING ADMINISTRATION	739					13. 00
1	400 CENTRAL SERVICES & SUPPLY 500 PHARMACY	0	39, 279, 059 88, 740				14. 00 15. 00
	600 MEDICAL RECORDS & LIBRARY		562	13, 836, 234	1, 249, 494, 496		16. 00
1	700 SOCIAL SERVICE	o	2, 991	0	0	79, 739	
	900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	
	100 I &R SERVI CES-SALARY & FRINGES APPRVD	0	0	0	0	0	
	200 1&R SERVICES-OTHER PRGM COSTS APPRVD PATIENT ROUTINE SERVICE COST CENTERS	U_	U	0	0	0	22.00
	000 ADULTS & PEDIATRICS	347	1, 293, 336	0	141, 876, 816	53, 157	30.00
1	100 INTENSIVE CARE UNIT	53	212, 610				•
1	060 NEONATAL INTENSIVE CARE UNIT	81	196, 672			l	1
	000 SUBPROVIDER - IPF 300 NURSERY	14	75, 978 97, 653	0			1
	CILLARY SERVICE COST CENTERS	2.	7.7 000		107 0007 210	., .20	10.00
4	000 OPERATING ROOM	67	2, 345, 570			l e	
	100 RECOVERY ROOM	0	142, 599			l e	51.00
	200 DELIVERY ROOM & LABOR ROOM 400 RADIOLOGY-DIAGNOSTIC	62	222, 414 112, 479		21, 486, 482 37, 480, 031	0 1	52. 00 54. 00
4	500 RADI OLOGY-THERAPEUTI C	o	215, 872		23, 993, 734	Ö	55. 00
1	700 CT SCAN	0	9, 005	i e	66, 104, 005	i e	57. 00
	800 MAGNETIC RESONANCE IMAGING (MRI)	0	51, 846	0	22, 439, 431	l	58. 00 59. 00
	900 CARDI AC CATHETERI ZATI ON 000 LABORATORY		2, 140, 764		1, 152, 710 105, 819, 013	l	60.00
	400 I NTRAVENOUS THERAPY	Ö	4, 856		1, 393, 708	l	64.00
	500 RESPI RATORY THERAPY	0	99, 239	0	27, 498, 815	l	65. 00
	600 PHYSI CAL THERAPY 700 OCCUPATI ONAL THERAPY	0	99, 167	0	25, 947, 880	0	66. 00 67. 00
	800 SPEECH PATHOLOGY		24, 862 4, 787	0	6, 930, 547 2, 030, 866	1	68.00
	900 ELECTROCARDI OLOGY	o	471	0		l	69. 00
	000 ELECTROENCEPHALOGRAPHY	0	70, 019	0	11, 959, 981	0	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS 200 IMPL. DEV. CHARGED TO PATIENTS	0	19, 112, 742				
	300 DRUGS CHARGED TO PATIENTS		11, 723, 378 0				
	400 RENAL DIALYSIS	o	3, 360		2, 925, 252	0	74. 00
	330 ENDOSCOPY	0	151, 949		18, 531, 370	l e	76. 00
1	954 IMAGING CENTER 955 BREAST DIAGNOSTIC CENTER	0	147, 138 5, 997	0	54, 554, 929 11, 066, 146	l e	
	TPATIENT SERVICE COST CENTERS	ı o	5, 777	0	11, 000, 140	<u> </u>	70.07
	000 CLI NI C	0	0	0	0	0	90.00
	975 SPI NE CENTER	0	1, 979		·		
	100 EMERGENCY 200 OBSERVATION BEDS (NON-DISTINCT PART)	88	526, 036	0	141, 957, 638	0	91. 00 92. 00
	ECIAL PURPOSE COST CENTERS						72.00
113. 00 11	300 I NTEREST EXPENSE						113. 00
	400 UTI LI ZATI ON REVI EW - SNF	700	00 405 074	40.007.004	4 040 404 404	70 700	114.00
118. 00	SUBTOTALS (SUM OF LINES 1-117)   NREI MBURSABLE COST CENTERS	739	39, 185, 071	13, 836, 234	1, 249, 494, 496	19, 739	118. 00
	OOO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19	100 RESEARCH	0	0	0	0	0	191. 00
	200 PHYSI CI ANS' PRI VATE OFFI CES	0	81, 330		0		192.00
	300 NONPAID WORKERS 950 HOME OFFICE		0	0	0	l	193. 00 194. 00
	956 PAVI LLI ONS		5, 113	· -	0	l	194. 06
	958 OTHER NRCC	0	7, 545	0	0		194. 08
	960 COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194. 10
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
201.00	Cost to be allocated (per Wkst. B,	7, 588, 765	1, 657, 659	6, 752, 151	4, 569, 365	3, 910, 412	•
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	10, 268. 964817	0. 042202	0. 488005	0. 003657	49. 040143	203. 00

Heal th Finar	ncial Systems CC	MMUNITY HOSPITAL	OF INDIANA, IN	IC.	In Lie	eu of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					rom 01/01/2016 o 12/31/2016		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUIS.)	LI BRARY	(TOTAL PATIENT	
		(DI RECT NURS.	(COSTED		(GROSS	DAYS)	
		HRS. )	REQUIS.)		CHARGES)	·	
		13. 00	14.00	15.00	16.00	17. 00	
204.00	Cost to be allocated (per Wkst. B,	205, 116	528, 512	505, 606	117, 882	117, 423	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	277. 558863	0. 013455	0. 036542	0. 000094	1. 472592	205. 00
	11)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: From 01/01/2016 To 12/31/2016 Date/Time Prepared: 5/30/2017 8:54 am

			LUTERNO	DEOL DENTO	5/30/2017 8: 54	4 am
			INTERNS &	RESI DENTS		
	Cost Center Description	NONPHYSI CI AN	CEDVICES SALAD	SERVI CES-OTHER		
	cost center bescription	ANESTHETI STS	Y & FRINGES	PRGM COSTS		
				(ASSI GNED		
		(ASSI GNED	(ASSI GNED			
		TI ME) 19. 00	TI ME) 21.00	TI ME) 22. 00		
	GENERAL SERVICE COST CENTERS	17.00	21.00	22.00		
1.00	00100 CAP REL COSTS-BLDG & FLXT					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL					5. 00
7. 00	00700 OPERATION OF PLANT					7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00	00900 HOUSEKEEPI NG					9. 00
						1
10.00	01000 DI ETARY					10.00
11.00	01100 CAFETERI A					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON				•	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00	1					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY					16. 00
17. 00	1					17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	C				19. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD		439	1		21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD			439		22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS	C	127	127		30.00
31.00	03100 INTENSIVE CARE UNIT	C	0	i l		31. 00
35.00	02060 NEONATAL INTENSIVE CARE UNIT		0	o		35. 00
40.00	04000 SUBPROVI DER - I PF	C	50	50		40.00
43.00	04300 NURSERY	C	l .	1		43. 00
	ANCILLARY SERVICE COST CENTERS	-	-	-		
50. 00	05000 OPERATING ROOM	C	0	0		50.00
51. 00	05100 RECOVERY ROOM					51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM					52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C					54.00
55. 00				0		55. 00
	05500 RADI OLOGY-THERAPEUTI C					
57. 00	05700 CT SCAN					57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	C	0			58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0	0		59. 00
60.00	06000 LABORATORY	C	0	0		60.00
64. 00	06400 I NTRAVENOUS THERAPY		0	0		64. 00
65. 00	06500 RESPI RATORY THERAPY	C	0	0		65. 00
66. 00	06600 PHYSI CAL THERAPY	C	6	6		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	C	0	0		67. 00
68. 00	06800 SPEECH PATHOLOGY	C	0	0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	C	0	0		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	C	0	0		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0	0		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	C	0	0		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	C	0	0		73. 00
74.00	07400 RENAL DIALYSIS	C	0	0		74.00
76.00	03330 ENDOSCOPY	C	0	0		76.00
76.06	03954 I MAGING CENTER	C	0	0		76. 06
76. 07	03955 BREAST DIAGNOSTIC CENTER	C	0	0		76. 07
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	C	0	0		90.00
90. 26	04975 SPI NE CENTER	C	0	o		90. 26
	09100 EMERGENCY	l c	-			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
,2,00	SPECIAL PURPOSE COST CENTERS					/2.00
113 0	11300 INTEREST EXPENSE					113. 00
	11400 UTILIZATION REVIEW - SNF					114. 00
118. 00		0	200	200		118. 00
110.00	NONREI MBURSABLE COST CENTERS		200	200		110.00
100 0				J		100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C				190.00
	19100 RESEARCH	C	_		•	191. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	_ C	239	239		192.00
	19300 NONPALD WORKERS	C	0	0		193. 00
	07950 HOME OFFI CE	0	0	0		194. 00
	07956 PAVI LLI ONS	C	0	0		194. 06
	B 07958 OTHER NRCC	0	0	0		194. 08
	07960 COMMUNITY REHAB HOSPITAL	C	0	0		194. 10
200.00						200. 00
201.00	Negative Cost Centers				l	201. 00
202.00		C	423, 208	739, 808	l	202. 00
	Part I)					1
				'		

Health Financial Systems C	MMUNITY HOSPITAL	OF INDIANA, I	NC.	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
				From 01/01/2016	D 1 /T' D	
				To 12/31/2016	Date/Time Pre 5/30/2017 8:5	
		INTERNS &	RESI DENTS		7 37 307 2017 6. 3	4 aiii
			_			
Cost Center Description	NONPHYSI CI AN	SERVI CES-SALAF	SERVI CES-OTHE	R		
	ANESTHETI STS	Y & FRINGES	PRGM COSTS			
	(ASSI GNED	(ASSI GNED	(ASSI GNED			
	TIME)	TIME)	TIME)			
	19. 00	21.00	22. 00			
203.00 Unit cost multiplier (Wkst. B, Part	0.000000	964. 027335	1, 685. 21184	5		203. 00
204.00 Cost to be allocated (per Wkst. B,	(	8, 72	1 15, 24	5		204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	19. 865604	4 34. 72665	1		205. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0169 Peri od: Worksheet C From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/30/2017 8:54 am Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 79.061.842 79, 061, 842 79.061.842 03100 INTENSIVE CARE UNIT 10, 845, 852 10, 845, 852 0 10, 845, 852 31.00 31.00 02060 NEONATAL INTENSIVE CARE UNIT 0 35.00 15, 496, 204 15, 496, 204 15, 496, 204 35.00 04000 SUBPROVI DER - I PF 2.749.585 2, 749, 585 0 2, 749, 585 40.00 40.00 04300 NURSERY 5, 962, 762 5, 962, 762 43.00 5, 962, 762 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 20, 657, 034 20, 657, 034 20, 657, 034 50.00 0 05100 RECOVERY ROOM 5, 244, 084 5, 244, 084 5, 244, 084 51 00 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 13, 094, 253 13, 094, 253 13, 094, 253 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 8, 335, 032 8, 335, 032 0 0 0 8, 335, 032 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 2, 941, 356 2, 941, 356 2, 941, 356 55.00 2, 519, 389 05700 CT SCAN 2, 519, 389 57.00 2.519.389 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 3, 948, 239 3, 948, 239 3, 948, 239 58.00 05900 CARDIAC CATHETERIZATION 59.00 24, 481 24, 481 0 0 0 0 0 24, 481 59.00 06000 LABORATORY 11, 045, 215 11, 045, 215 11, 045, 215 60 00 60 00 64.00 06400 I NTRAVENOUS THERAPY 1,083,631 1, 083, 631 1, 083, 631 64.00 65.00 06500 RESPIRATORY THERAPY 6, 102, 880 6, 102, 880 6, 102, 880 65.00 66.00 06600 PHYSI CAL THERAPY 6, 413, 321 6, 413, 321 6, 413, 321 66.00 06700 OCCUPATIONAL THERAPY 0 1, 843, 452 1, 843, 452 67 00 67 00 1,843,452 68.00 06800 SPEECH PATHOLOGY 356, 455 356, 455 356, 455 68.00 69.00 06900 ELECTROCARDI OLOGY 911, 542 911, 542 0 0 0 0 0 0 911, 542 69.00 2, 479, 123 2, 479, 123 70 00 07000 ELECTROENCEPHALOGRAPHY 2 479 123 70 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 16, 962, 594 16, 962, 594 16, 962, 594 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 15, 360, 516 15, 360, 516 15, 360, 516 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 26, 041, 769 26, 041, 769 26, 041, 769 73.00 07400 RENAL DIALYSIS 1, 255, 855 74 00 1 255 855 1, 255, 855 74 00 76.00 03330 ENDOSCOPY 3, 436, 669 3, 436, 669 3, 436, 669 76.00 03954 I MAGING CENTER 5, 144, 284 5, 144, 284 0 5, 144, 284 76.06 76.06 6, 180, 244 76.07 03955 BREAST DIAGNOSTIC CENTER 6, 180, 244 6, 180, 244 76.07 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 0 04975 SPINE CENTER 310, 907 310, 907 0 310, 907 90.26 90.26 91.00 09100 EMERGENCY 14, 777, 303 14, 777, 303 ol 14, 777, 303 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 10, 045, 334 10, 045, 334 10, 045, 334 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVI EW - SNF 114.00 200.00 300, 631, 207 200. 00 Subtotal (see instructions) 300, 631, 207 0 300, 631, 207 0 10, 045, 334 201.00 Less Observation Beds 10, 045, 334 10, 045, 334 201. 00 202.00 Total (see instructions) 290, 585, 873 290, 585, 873 290, 585, 873 202. 00

202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0169 Peri od: Worksheet C From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/30/2017 8:54 am Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 130, 490, 333 130, 490, 333 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 20, 080, 585 20, 080, 585 31.00 02060 NEONATAL INTENSIVE CARE UNIT 35.00 77, 211, 825 77, 211, 825 35.00 04000 SUBPROVIDER - IPF 40.00 5.051.443 5, 051, 443 40.00 04300 NURSERY 43.00 10.055.218 10, 055, 218 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 109, 860, 207 45, 082, 223 154, 942, 430 0 133321 0.000000 50.00 05100 RECOVERY ROOM 29, 448, 429 17.344.791 12, 103, 638 0.178077 0.000000 51.00 51.00 21, 486, 482 0.000000 05200 DELIVERY ROOM & LABOR ROOM 52 00 21, 486, 482 0.609418 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 10, 809, 175 26, 670, 856 37, 480, 031 0. 222386 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 11, 456, 117 12, 537, 617 23, 993, 734 0.122589 0.000000 55.00 66, 104, 005 05700 CT SCAN 45, 401, 129 20, 702, 876 0.038113 0.000000 57.00 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 4, 688, 256 17, 751, 175 22, 439, 431 0.175951 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 1, 152, 710 1, 152, 710 0. 021238 0.000000 59.00 60.00 06000 LABORATORY 65, 279, 093 40, 539, 920 105, 819, 013 0. 104378 0.000000 60.00 |06400| I NTRAVENOUS THERAPY 0.777517 1, 237, 781 155, 927 1, 393, 708 64.00 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 25, 047, 803 2, 451, 012 27, 498, 815 0. 221932 0.000000 65.00 06600 PHYSI CAL THERAPY 5, 699, 583 20, 248, 297 25, 947, 880 0. 247162 0.000000 66.00 66.00 06700 OCCUPATIONAL THERAPY 4, 535, 903 2, 394, 644 6, 930, 547 0.265989 0.000000 67.00 67.00 06800 SPEECH PATHOLOGY 2, 030, 866 68.00 1, 358, 807 672, 059 0. 175519 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 6, 498, 249 1, 472, 858 7, 971, 107 0.114356 0.000000 69.00 11, 959, 981 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 132, 898 10, 827, 083 0. 207285 0.000000 70.00 79, 517, 803 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 58 724 225 20, 793, 578 0 213318 0.000000 71 00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 34, 502, 266 5, 619, 644 40, 121, 910 0.382846 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 70, 620, 811 28, 562, 657 99, 183, 468 0. 262562 0.000000 73.00 74.00 07400 RENAL DIALYSIS 2, 925, 252 2, 925, 252 0.429315 0.000000 74.00 03330 ENDOSCOPY 3, 957, 776 14, 573, 594 18, 531, 370 0.185451 76.00 0.000000 76.00 76.06 03954 I MAGING CENTER 301, 939 54, 252, 990 54, 554, 929 0.094295 0.000000 76.06 03955 BREAST DIAGNOSTIC CENTER 76.07 39, 985 11, 026, 161 11, 066, 146 0.558482 0.000000 76.07 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0.000000 90.00 90. 26 04975 SPINE CENTER 300 760, 624 760, 924 0.408591 0.000000 90. 26 91.00 09100 EMERGENCY 29, 018, 118 112, 939, 520 141, 957, 638 0.104097 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 9, 234, 951 11, 386, 483 0.882216 0.000000 92.00 92 00 2, 151, 532 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW - SNF 114.00 496, 072, 157 1, 249, 494, 496 200.00 753, 422, 339 200. 00 Subtotal (see instructions) 201.00 Less Observation Beds 201.00 202.00

753, 422, 339

496, 072, 157 1, 249, 494, 496

Total (see instructions)

			10 12/31/2010	5/30/2017 8:54 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT				35.00
40. 00   04000   SUBPROVI DER - I PF				40.00
43. 00   04300   NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 133321			50.00
51.00 05100 RECOVERY ROOM	0. 178077			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 609418			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 222386			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 122589			55. 00
57. 00 05700 CT SCAN	0. 038113			57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 175951			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 021238			59. 00
60. 00 06000 LABORATORY	0. 104378			60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 777517			64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 221932			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 247162			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 265989			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 175519			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 114356			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 207285			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 213318			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 382846			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 262562			73. 00
74.00 07400 RENAL DIALYSIS	0. 429315			74.00
76. 00 03330 ENDOSCOPY	0. 185451			76. 00
76. 06 03954 I MAGI NG CENTER	0. 094295			76. 06
76. 07 03955 BREAST DIAGNOSTIC CENTER	0. 558482			76. 07
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
90. 26   04975   SPI NE CENTER	0. 408591			90. 26
91. 00   09100   EMERGENCY	0. 104097			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 882216			92.00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300   NTEREST EXPENSE				113. 00
114.00 11400 UTILIZATION REVIEW - SNF				114. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
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COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0169 Peri od: Worksheet C From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/30/2017 8:54 am Title XIX Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30 00 03000 ADULTS & PEDIATRICS 79.061.842 79, 061, 842 79.061.842 03100 INTENSIVE CARE UNIT 10, 845, 852 10, 845, 852 0 10, 845, 852 31.00 31.00 02060 NEONATAL INTENSIVE CARE UNIT 0 35.00 15, 496, 204 15, 496, 204 15, 496, 204 35.00 04000 SUBPROVI DER - I PF 2.749.585 2, 749, 585 0 2, 749, 585 40.00 40.00 04300 NURSERY 5, 962, 762 5, 962, 762 43.00 5, 962, 762 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 20, 657, 034 20, 657, 034 20, 657, 034 50.00 0 05100 RECOVERY ROOM 5, 244, 084 5, 244, 084 5, 244, 084 51 00 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 13, 094, 253 13, 094, 253 13, 094, 253 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 8, 335, 032 8, 335, 032 0 0 0 8, 335, 032 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 2, 941, 356 2, 941, 356 2, 941, 356 55.00 2, 519, 389 05700 CT SCAN 2, 519, 389 57.00 2.519.389 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 3, 948, 239 3, 948, 239 3, 948, 239 58.00 05900 CARDIAC CATHETERIZATION 59.00 24, 481 24, 481 0 0 0 0 0 24, 481 59.00 06000 LABORATORY 11, 045, 215 11, 045, 215 11, 045, 215 60 00 60 00 64.00 06400 I NTRAVENOUS THERAPY 1,083,631 1, 083, 631 1, 083, 631 64.00 65.00 06500 RESPIRATORY THERAPY 6, 102, 880 6, 102, 880 6, 102, 880 65.00 66.00 06600 PHYSI CAL THERAPY 6, 413, 321 6, 413, 321 6, 413, 321 66.00 06700 OCCUPATIONAL THERAPY 0 1, 843, 452 1, 843, 452 67 00 67 00 1,843,452 68.00 06800 SPEECH PATHOLOGY 356, 455 356, 455 356, 455 68.00 06900 ELECTROCARDI OLOGY 69.00 911, 542 911, 542 0 0 0 0 0 0 911, 542 69.00 2, 479, 123 2, 479, 123 70 00 07000 ELECTROENCEPHALOGRAPHY 2 479 123 70 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 16, 962, 594 16, 962, 594 16, 962, 594 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 15, 360, 516 15, 360, 516 15, 360, 516 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 26, 041, 769 26, 041, 769 26, 041, 769 73.00 07400 RENAL DIALYSIS 1, 255, 855 74 00 1 255 855 1, 255, 855 74 00 76.00 03330 ENDOSCOPY 3, 436, 669 3, 436, 669 3, 436, 669 76.00 03954 I MAGING CENTER 5, 144, 284 5, 144, 284 0 5, 144, 284 76.06 76.06 6, 180, 244 76.07 03955 BREAST DIAGNOSTIC CENTER 6, 180, 244 6, 180, 244 76.07 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 0 04975 SPINE CENTER 310, 907 310, 907 0 310, 907 90.26 90.26 91.00 09100 EMERGENCY 14, 777, 303 14, 777, 303 ol 14, 777, 303 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 10, 045, 334 10, 045, 334 10, 045, 334 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVI EW - SNF 114.00 200.00 300, 631, 207 200. 00 Subtotal (see instructions) 300, 631, 207 0 300, 631, 207 0 10, 045, 334 201.00 Less Observation Beds 10, 045, 334 10, 045, 334 201. 00 202.00 Total (see instructions) 290, 585, 873 290, 585, 873 290, 585, 873 202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0169 Peri od: Worksheet C From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/30/2017 8:54 am Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 130, 490, 333 130, 490, 333 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 20, 080, 585 20, 080, 585 31.00 02060 NEONATAL INTENSIVE CARE UNIT 35.00 77, 211, 825 77, 211, 825 35.00 04000 SUBPROVIDER - IPF 40.00 5.051.443 5, 051, 443 40.00 04300 NURSERY 43.00 10.055.218 10, 055, 218 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 109, 860, 207 45, 082, 223 154, 942, 430 0 133321 0.000000 50.00 05100 RECOVERY ROOM 29, 448, 429 17.344.791 12, 103, 638 0.178077 0.000000 51.00 51.00 21, 486, 482 0.000000 05200 DELIVERY ROOM & LABOR ROOM 52 00 21, 486, 482 0.609418 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 10, 809, 175 26, 670, 856 37, 480, 031 0. 222386 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 11, 456, 117 12, 537, 617 23, 993, 734 0.122589 0.000000 55.00 66, 104, 005 05700 CT SCAN 45, 401, 129 20, 702, 876 0.038113 0.000000 57.00 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 4, 688, 256 17, 751, 175 22, 439, 431 0.175951 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 1, 152, 710 1, 152, 710 0. 021238 0.000000 59.00 60.00 06000 LABORATORY 65, 279, 093 40, 539, 920 105, 819, 013 0. 104378 0.000000 60.00 |06400| I NTRAVENOUS THERAPY 0.777517 1, 237, 781 155, 927 1, 393, 708 64.00 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 25, 047, 803 2, 451, 012 27, 498, 815 0. 221932 0.000000 65.00 06600 PHYSI CAL THERAPY 5, 699, 583 20, 248, 297 25, 947, 880 0. 247162 0.000000 66.00 66.00 06700 OCCUPATIONAL THERAPY 4, 535, 903 2, 394, 644 6, 930, 547 0.265989 0.000000 67.00 67.00 06800 SPEECH PATHOLOGY 2, 030, 866 68.00 1, 358, 807 672, 059 0. 175519 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 6, 498, 249 1, 472, 858 7, 971, 107 0.114356 0.000000 69.00 11, 959, 981 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 132, 898 10, 827, 083 0. 207285 0.000000 70.00 79, 517, 803 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 58 724 225 20, 793, 578 0 213318 0.000000 71 00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 34, 502, 266 5, 619, 644 40, 121, 910 0.382846 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 70, 620, 811 28, 562, 657 99, 183, 468 0. 262562 0.000000 73.00 74.00 07400 RENAL DIALYSIS 2, 925, 252 2, 925, 252 0.429315 0.000000 74.00 03330 ENDOSCOPY 3, 957, 776 14, 573, 594 18, 531, 370 0.185451 76.00 0.000000 76.00 76.06 03954 I MAGING CENTER 301, 939 54, 252, 990 54, 554, 929 0.094295 0.000000 76.06 03955 BREAST DIAGNOSTIC CENTER 76.07 39, 985 11, 026, 161 11, 066, 146 0.558482 0.000000 76.07 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0.000000 90.00 90. 26 04975 SPINE CENTER 300 760, 624 760, 924 0.408591 0.000000 90. 26 91.00 09100 EMERGENCY 29, 018, 118 112, 939, 520 141, 957, 638 0.104097 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 9, 234, 951 11, 386, 483 0.882216 0.000000 92.00 92 00 2, 151, 532 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW - SNF 114.00 496, 072, 157 1, 249, 494, 496 200.00 753, 422, 339 200. 00 Subtotal (see instructions) 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 753, 422, 339 496, 072, 157 1, 249, 494, 496 202.00

Cost Center Description					10 12/31/2010	5/30/2017 8:54 a	am
INPATI ENT ROUTI NE SERVICE COST CENTERS   30.00   30000 ADULTS & PEDIATRICS   31.00				Title XIX	Hospi tal		
INPATI ENT ROUTI NE SERVICE COST CENTERS		Cost Center Description	PPS Inpatient				
INPATI ENT ROUTH NE SERVI CE COST CENTERS   30.00   30.00   DULTS & PEDI ATRIC S   31.00   31.00   DULTS & PEDI ATRIC S   31.00   31.00   INTERSI VE CARE UNIT   31.00   31.00   CARD AND AND AND AND AND AND AND AND AND AN							
30.00			11. 00				
31.00   03100   INTENSIVE CARE UNIT							
35. 00   2060   NEONATAL INTENSIVE CARE UNIT	30.00	03000 ADULTS & PEDI ATRI CS				30	0. 00
40. 00   4000   SUBPROVI DER - I PF   40. 00							
43. 00   04300   NURSERY						35	5. 00
ANCIL LLARY SERVICE COST CENTERS						40	0. 00
50.00	43.00					43	3.00
51.00   05100   RECOVERY ROOM   0.178077   51.00   05200   DELI VERY ROOM & LABOR ROOM   0.609418   52.00   05200   DELI VERY ROOM & LABOR ROOM   0.609418   52.00   05500   RADI DLOGY-DI AGNOSTIC   0.222386   54.00   05500   RADI DLOGY-DI AGNOSTIC   0.122589   55.00   05500   CADID DLOGY-THERAPEUTI C   0.122589   55.00   05500   CADID DLOGY-THERAPEUTI C   0.122589   55.00   05500   CADID DLOGY-THERAPEUTI C   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.00000000							
52. 00   05200   DELIVERY ROOM & LABOR ROOM   0. 609418   52. 00   05400   RADI OLOGY-DI AGNOSTIC   0. 222386   54. 00   05500   RADI OLLOGY-THERAPEUTI C   0. 122589   55. 00   05500   CT SCAN   0. 038113   57. 00   05700   CT SCAN   0. 038113   57. 00   05900   CARDI ALCOGY-THERAPEUTI C   0. 122589   55. 00   05900   MAGNETI C RESONANCE I MAGI NG (MRI )   0. 175951   58. 00   05900   CARDI AC CATHETERI ZATI ON   0. 021238   59. 00   06000   LABORATORY   0. 104378   60. 00   06000   LABORATORY   0. 104378   66. 00   06400   INTRAVENOUS THERAPY   0. 2717517   64. 00   06600   CABORATORY   0. 104378   66. 00   06600   CABORATORY   0. 104378   66. 00   06600   CABORATORY   0. 241162   0. 06500   PHYSI CAL THERAPY   0. 241162   0. 06500   PHYSI CAL THERAPY   0. 241162   0. 06500   PHYSI CAL THERAPY   0. 265989   67. 00   06900   ELECTROCARDI OLOGY   0. 175519   68. 00   06900   ELECTROCARDI OLOGY   0. 175519   68. 00   06900   ELECTROCARDI OLOGY   0. 174366   69. 00   07000   ELECTROCARDI OLOGY   0. 114356   69. 00   07000   ELECTROCARDI OLOGY   0. 114356   69. 00   07000   ELECTROCARDI OLOGY   0. 114356   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 262562   73. 00   07300   RUNLS DIALVEIS   0. 104378   74. 00   07400   RENAL DIALVEIS   0. 2429315   74. 00   07400   RENAL DIALVEIS   0. 429315   74. 00   07400   RENAL DIALVEIS   0. 249315   74. 00   07400   RENAL DI							
54. 00	51.00	05100 RECOVERY ROOM	0. 178077			51	1.00
55. 00   05500   RADIOLOCY-THERAPEUTI C   0. 122589   55. 00   05700   CT SCAN   0. 038113   57. 00   05700   CT SCAN   0. 038113   57. 00   05900   CARDI AC CATHETERI ZATI ON   0. 021238   59. 00   05900   CARDI AC CATHETERI ZATI ON   0. 021238   60. 00   06000   LABORATORY   0. 104378   66. 00   06000   LABORATORY   0. 217932   65. 00   06500   RESPI RATORY THERAPY   0. 247162   66. 00   0600   PHYSI CAL SUBJECT OF A COLUMN   0. 114356   0. 00000   06000   ELECTROCARDI OLOGY   0. 114356   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 000000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 0000000   0. 0000000   0. 0000000   0. 00000000	52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 609418			52	2.00
57. 00	54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 222386			54	4.00
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI )   0. 175951   58. 00   05900   CARDIAC CATHETERIZATION   0. 021238   59. 00   06000   LABORATORY   0. 104378   66. 00   06400   LABORATORY   0. 104378   66. 00   06400   CABORATORY   0. 104378   65. 00   06500   RESPIRATORY THERAPY   0. 221932   065. 00   06600   PHYSI CAL THERAPY   0. 221932   066. 00   06600   PHYSI CAL THERAPY   0. 247162   06. 00   06600   PHYSI CAL THERAPY   0. 247162   06. 00   06600   PHYSI CAL THERAPY   0. 247162   06. 00   06900   CELECTROCARDI OLOGY   0. 175519   069. 00   06900   ELECTROCARDI OLOGY   0. 114356   06. 00   07000   ELECTROCARDI OLOGY   0. 114356   06. 00   07000   ELECTROCARDI OLOGY   0. 114356   06. 00   07000   ELECTROCARDI OLOGY   0. 114356   07. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0. 213318   71. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 382846   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 382846   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 382846   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 382846   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 262562   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 429315   74. 00   07400   RENAL DIALYSIS   0. 429315   75. 00   07500   RENAL DIALYSIS   0. 558482   0. 0000000   09000   CLINIC   0. 0000000   09000   0000000000000000	55.00	05500 RADI OLOGY-THERAPEUTI C	0. 122589			55	5.00
59. 00     05900 CARDI AC CATHETERI ZATI ON     0.021238       60. 00     06000 LABORATORY     0.104378       64. 00     06400 INTRAVENOUS THERAPY     0.777517       65. 00     06500 RESPI RATORY THERAPY     0.221932       66. 00     06600 PHYSI CAL THERAPY     0.247162       67. 00     06700 0 OCCUPATI ONAL THERAPY     0.265989       68. 00     06800 SPEECH PATHOLOGY     0.175519       69. 00     06900 ELECTROCARDI OLOGY     0.114356       70. 00     07000 ELECTROCARDI OLOGY     0.114356       71. 00     07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS     0.213318       71. 00     07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS     0.382846       72. 00     07200 IMPL DEV. CHARGED TO PATIENTS     0.382846       73. 00     07300 DRUGS CHARGED TO PATIENTS     0.262562       74. 00     07400 RENAL DI ALYSI S     0.429315       76. 07     0.3955 RRAST DI AGNOSTI C CENTER     0.598482       90. 00     00TPATIENT SERVI CE COST CENTERS     76. 07       90. 26     0.4975 SPI NE CENTER     0.408591       90. 00     09000 CLI NI C     0.000000       09200 DESREVATI ON BEDS (NON-DISTINCT PART)     0.882216       9200 DOS SUBSTRANTION BEDS (NON-DISTINCT PART)     0.882216       113. 00     11300 INTEREST EXPENSE     114. 00	57.00	05700 CT SCAN	0. 038113			57	7. 00
59. 00     05900 CARDI AC CATHETERI ZATI ON     0.021238       60. 00     06000 LABORATORY     0.104378       64. 00     06400 INTRAVENOUS THERAPY     0.777517       65. 00     06500 RESPI RATORY THERAPY     0.221932       66. 00     06600 PHYSI CAL THERAPY     0.247162       67. 00     06700 0 OCCUPATI ONAL THERAPY     0.265989       68. 00     06800 SPEECH PATHOLOGY     0.175519       69. 00     06900 ELECTROCARDI OLOGY     0.114356       70. 00     07000 ELECTROCARDI OLOGY     0.114356       71. 00     07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS     0.213318       71. 00     07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS     0.382846       72. 00     07200 IMPL DEV. CHARGED TO PATIENTS     0.382846       73. 00     07300 DRUGS CHARGED TO PATIENTS     0.262562       74. 00     07400 RENAL DI ALYSI S     0.429315       76. 07     0.3955 RRAST DI AGNOSTI C CENTER     0.598482       90. 00     00TPATIENT SERVI CE COST CENTERS     76. 07       90. 26     0.4975 SPI NE CENTER     0.408591       90. 00     09000 CLI NI C     0.000000       09200 DESREVATI ON BEDS (NON-DISTINCT PART)     0.882216       9200 DOS SUBSTRANTION BEDS (NON-DISTINCT PART)     0.882216       113. 00     11300 INTEREST EXPENSE     114. 00	58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 175951			58	8. 00
64. 00   06400   INTRAVENOUS THERAPY   0.777517   65. 00   06500   RESPI RATORY THERAPY   0.221932   65. 00   06600   PHYSI CAL THERAPY   0.221932   65. 00   06700   0CCUPATI ONAL THERAPY   0.265989   67. 00   06700   0CCUPATI ONAL THERAPY   0.265989   67. 00   06700   0CCUPATI ONAL THERAPY   0.265989   67. 00   06800   SPECH PATHOLOGY   0.175519   68. 00   06900   ELECTROCARDI OLOGY   0.114356   69. 00   07000   ELECTROCARDI OLOGY   0.114356   0.207285   70. 00   07000   ELECTROCARDI OLOGY   0.27285   70. 00   07000   ELECTROCROCEPHALOGRAPHY   0.207285   70. 00   07000   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.382846   71. 00   07300   DRUGS CHARGED TO PATI ENTS   0.382846   72. 00   07300   DRUGS CHARGED TO PATI ENTS   0.382846   72. 00   07300   DRUGS CHARGED TO PATI ENTS   0.362562   73. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0.382846   74. 00   7400   RENAL DI ALYSIS   0.429315   74. 00   76. 00   03955   BREAT DI AGNOSTIC CENTER   0.558482   76. 00   03955   BREAST DI AGNOSTIC CENTER   0.558482   76. 00   09000   CLINIC   0.000000   09. 00   090000   090000   090000   090000   09000   090000   090000   090000   090000   090000   090000   090000   090000   090000000   0900000000			0. 021238			59	9. 00
65. 00   06500   RESPIRATORY THERAPY   0. 221932   65. 00   66. 00   06600   PHYSI CAL THERAPY   0. 247162   66. 00   66. 00   67. 00   6700   CCUPATI ONAL THERAPY   0. 265989   67. 00   6700   CCUPATI ONAL THERAPY   0. 265989   67. 00   68. 00   6800   SPECH PATHOLOGY   0. 175519   68. 00   69. 00   07000   ELECTROCARDI OLOGY   0. 114356   69. 00   07000   ELECTROCARDI OLOGY   0. 114356   69. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 213318   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 382846   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 382846   72. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 262562   73. 00   07400   REMAL DI ALYSI S   0. 429315   74. 00   07400   REMAL DI ALYSI S   0. 429315   74. 00   07400   REMAL DI ALYSI S   0. 429315   74. 00   07400   REMAL DI ALYSI S   0. 588482   76. 06   03951   MAGING CENTER   0. 094295   76. 00   03955   BREAST DI AGNOSTI C CENTER   0. 558482   76. 06   07000   0900   00000   00000   00000   000000   000000	60.00	06000 LABORATORY	0. 104378			60	0. 00
65. 00   06500   RESPIRATORY THERAPY   0. 221932   65. 00   66. 00   06600   PHYSI CAL THERAPY   0. 247162   66. 00   66. 00   67. 00   6700   CCUPATI ONAL THERAPY   0. 265989   67. 00   6700   CCUPATI ONAL THERAPY   0. 265989   67. 00   68. 00   6800   SPECH PATHOLOGY   0. 175519   68. 00   69. 00   07000   ELECTROCARDI OLOGY   0. 114356   69. 00   07000   ELECTROCARDI OLOGY   0. 114356   69. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 213318   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 382846   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 382846   72. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 262562   73. 00   07400   REMAL DI ALYSI S   0. 429315   74. 00   07400   REMAL DI ALYSI S   0. 429315   74. 00   07400   REMAL DI ALYSI S   0. 429315   74. 00   07400   REMAL DI ALYSI S   0. 588482   76. 06   03951   MAGING CENTER   0. 094295   76. 00   03955   BREAST DI AGNOSTI C CENTER   0. 558482   76. 06   07000   0900   00000   00000   00000   000000   000000	64.00	06400 I NTRAVENOUS THERAPY	0. 777517			64	4. 00
66. 00		1 1	1				
67. 00   06700   06700   0CCUPATI ONAL THERAPY   0. 265989   67. 00   68. 00   06800   SPECH PATHOLOGY   0. 175519   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0. 114356   69. 00   06900   ELECTROCARDI OLOGY   0. 114356   69. 00   07000   ELECTROENCEPHALOGRAPHY   0. 207285   70. 00   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0. 213318   71. 00   71. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 382846   72. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 262562   73. 00   07400   RENAL DI ALYSI S   0. 429315   74. 00   07400   RENAL DI ALYSI S   0. 429315   74. 00   07400   RENAL DI ALYSI S   0. 185451   76. 06   03954   IMAGI NG CENTER   0. 094295   76. 06   03955   BREAST DI AGNOSTI C CENTER   0. 558482   76. 07   00000   CLI NI C   0. 000000   0. 000000   0. 00000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000		1 1	1 1			•	
68. 00		1 1	1 1			•	
69. 00   06900   ELECTROCARDI OLOGY   0. 114356   70. 00   7000   ELECTROCARDI OLOGY   0. 207285   70. 00   7000   ELECTROCARDI OLOGRAPHY   0. 207285   70. 00   70. 00   70. 00   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 213318   71. 00   71. 0							
70. 00   07000   ELECTROENCEPHALOGRAPHY   0. 207285   70. 00   71. 00   71. 00   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0. 213318   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 382846   72. 00   72. 00   07300   DRUGS CHARGED TO PATIENTS   0. 262562   73. 00   74. 00   07400   RENAL DIALYSIS   0. 429315   74. 00   76. 00   03330   ENDOSCOPY   0. 185451   76. 00   76. 00   03954   IMAGI NG CENTER   0. 094295   76. 00   03955   BREAST DIAGNOSTIC CENTER   0. 558482   76. 00   001000   001000   001000   001000   001000   001000   001000   001000   001000   001000   0010000   0010000   0010000   0010000   00100000   00100000   00100000   001000000   001000000   0010000000   00100000000							
71. 00		l I	1 1			•	
72. 00 07200   IMPL. DEV. CHARGED TO PATIENTS		l I	1 1			•	
73. 00		1					
74. 00							
76. 00 03330 ENDOSCOPY 0. 185451 76. 06 76. 06 03954 I MAGING CENTER 0. 094295 76. 07 76. 07 03955 BREAST DI AGNOSTIC CENTER 0. 558482 76. 07 0UTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC 0. 0. 000000 90. 26 04975 SPINE CENTER 0. 408591 90. 26 91. 00 09100 EMERGENCY 0. 104097 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0. 882216 92. 00 SPECIAL PURPOSE COST CENTERS  113. 00 11300 I NTEREST EXPENSE 114. 00 114. 00 11400 UTILIZATION REVIEW - SNF 200. 00 Subtotal (see instructions) Less Observation Beds							
76. 06 03954   IMAGING CENTER 0. 094295 76. 07 76.							
76. 07  03955 BREAST DI AGNOSTI C CENTER  0. 558482  90. 00 09000 CLI NI C  90. 26 04975 SPI NE CENTER  91. 00 09100 EMERGENCY  92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)  SPECIAL PURPOSE COST CENTERS  113. 00 11300 INTEREST EXPENSE  114. 00 11400 UTI LI ZATI ON REVI EW - SNF  Subtotal (see instructions)  Less Observati on Beds  76. 07  90. 00  9			1 1				
OUTPATIENT SERVICE COST CENTERS   O. 000000						ı	
90. 00   09000   CLINIC   0. 000000   90. 00   90. 00   90. 00   90. 00   90. 00   90. 26   91. 00   91. 00   91. 00   92. 00   9			1 212212				
90. 26   04975   SPI NE CENTER   0. 408591   0. 104097   91. 00   92. 00   92.00   09200   085ERVATION BEDS (NON-DISTINCT PART)   0. 882216   92. 00   SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   114. 00   11400   UTILIZATION REVIEW - SNF   200. 00   Subtotal (see instructions)   Less Observation Beds   201. 00	90. 00		0.000000			90	0. 00
91. 00							
92. 00			1				
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   114.00   11400   UTILIZATION REVIEW - SNF   114.00   200.00   Subtotal (see instructions)   200.00   201.00   Less Observation Beds   201.00							
113. 00	00		1.0022.0			, , , , , , , , , , , , , , , , , , ,	
114.00	113.00					113	3. 00
200.00         Subtotal (see instructions)         200.00           201.00         Less Observation Beds         201.00						•	
201.00 Less Observation Beds 201.00		1					
		l I					

Heal th Financial Systems COMMUNITY HOSPIT CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY Provider CCN: 15-0169

						5/30/2017 8: 5	4 am
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cos	Capi tal	Operating Cost	
		(Wkst. B, Part				Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
				col . 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	20, 657, 034	2, 410, 197	18, 246, 83	7 0	0	50.00
51.00	05100 RECOVERY ROOM	5, 244, 084	540, 668	4, 703, 416	5 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	13, 094, 253	1, 693, 459	11, 400, 794	1 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 335, 032	1, 315, 828	7, 019, 204	1 0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	2, 941, 356	714, 617	2, 226, 739	9 0	0	55.00
57.00	05700 CT SCAN	2, 519, 389	518, 101	2, 001, 288	3 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 948, 239	1, 029, 567	2, 918, 672	2 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	24, 481	24, 643			0	59.00
60.00	06000 LABORATORY	11, 045, 215	409, 215		ol o	l ol	60.00
64.00	06400 I NTRAVENOUS THERAPY	1, 083, 631	195, 422			o	64.00
65.00	06500 RESPIRATORY THERAPY	6, 102, 880	600, 162			o	65.00
66. 00	06600 PHYSI CAL THERAPY	6, 413, 321	266, 033			0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 843, 452	75, 071			0	67. 00
68. 00	06800 SPEECH PATHOLOGY	356, 455	14, 386			0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	911, 542	34, 953			l ol	69. 00
	07000 ELECTROENCEPHALOGRAPHY	2, 479, 123	236, 833				70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 962, 594	591, 576			0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	15, 360, 516	464, 819			1	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	26, 041, 769	904, 949			l o	73. 00
	07400 RENAL DIALYSIS	1, 255, 855	28, 859			l o	74. 00
	03330 ENDOSCOPY	3, 436, 669	700, 788			0	76. 00
76. 06	03954 I MAGI NG CENTER	5, 144, 284	578, 769			· ·	76. 06
	03955 BREAST DIAGNOSTIC CENTER	6, 180, 244	221, 285				76. 07
70.07	OUTPATIENT SERVICE COST CENTERS	0, 100, 244	221, 203	3, 730, 73	<u> </u>	0	70.07
90 00	09000 CLINIC	0	0			0	90. 00
90. 26	04975 SPI NE CENTER	310, 907	11, 304			1	90. 26
91. 00	09100 EMERGENCY	14, 777, 303	1, 206, 764			1	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	10, 045, 334	1, 093, 113				92. 00
92.00	SPECIAL PURPOSE COST CENTERS	10, 043, 334	1,093,113	0, 932, 22	ı U	U	92.00
112 00	11300 I NTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW - SNF						114. 00
200.00		186, 514, 962	15, 881, 381	170, 633, 58 <sup>-</sup>			200. 00
200.00		10, 045, 334	1, 093, 113				200.00
201.00		176, 469, 628					201.00
202.00	Trotal (Trie 200 milius Trie 201)	170, 409, 028	14, 788, 268	161, 681, 360	ار	ا	202.00

Peri od: Worksheet C From 01/01/2016 Part II To 12/31/2016 Date/Ti me Prepared: 5/30/2017 8:54 am Provi der CCN: 15-0169 REDUCTIONS FOR MEDICALD ONLY

						5/30/2017 8: 5	4 am
				e XIX	Hospi tal	PPS	
	Cost Center Description		Total Charges				
		Capital and		Cost to Charge			
		Operating Cost					
		Reduction	8)	/ col. 7)			
		6. 00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	20, 657, 034					50.00
51.00	05100 RECOVERY ROOM	5, 244, 084	29, 448, 429				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	13, 094, 253					52. 00
54.00	05400  RADI OLOGY-DI AGNOSTI C	8, 335, 032					54.00
55.00	05500  RADI OLOGY-THERAPEUTI C	2, 941, 356	23, 993, 734				55. 00
57. 00	05700  CT SCAN	2, 519, 389	66, 104, 005				57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 948, 239	22, 439, 431	0. 175951			58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	24, 481	1, 152, 710				59. 00
60.00	06000 LABORATORY	11, 045, 215	105, 819, 013	0. 104378			60.00
64.00	06400 I NTRAVENOUS THERAPY	1, 083, 631	1, 393, 708	0. 777517			64.00
65.00	06500 RESPI RATORY THERAPY	6, 102, 880	27, 498, 815	0. 221932			65.00
66.00	06600 PHYSI CAL THERAPY	6, 413, 321	25, 947, 880	0. 247162			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 843, 452	6, 930, 547	0. 265989			67. 00
68.00	06800 SPEECH PATHOLOGY	356, 455	2, 030, 866	0. 175519			68. 00
69.00	06900 ELECTROCARDI OLOGY	911, 542	7, 971, 107	0. 114356			69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	2, 479, 123	11, 959, 981	0. 207285			70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 962, 594	79, 517, 803	0. 213318			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	15, 360, 516	40, 121, 910	0. 382846			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	26, 041, 769	99, 183, 468	0. 262562			73. 00
74.00	07400 RENAL DIALYSIS	1, 255, 855		0. 429315			74. 00
76.00	03330 ENDOSCOPY	3, 436, 669		0. 185451			76. 00
76.06	03954 I MAGI NG CENTER	5, 144, 284					76. 06
76. 07	03955 BREAST DIAGNOSTIC CENTER	6, 180, 244		0. 558482			76. 07
	OUTPATIENT SERVICE COST CENTERS			<u>'</u>			
90.00	09000 CLI NI C	0	0	0.000000			90.00
90. 26	04975 SPI NE CENTER	310, 907	760, 924				90. 26
91. 00	09100 EMERGENCY	14, 777, 303					91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	10, 045, 334	11, 386, 483				92.00
	SPECIAL PURPOSE COST CENTERS		,				1
113, 00	11300 I NTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW - SNF						114. 00
200.00		186, 514, 962	1, 006, 605, 092				200. 00
201.00	, ,	10, 045, 334					201. 00
202.00	1		1, 006, 605, 092				202. 00
202.00	1 1.010. (1110 200 11110 201)	1 170, 107, 020	., 500, 500, 672	ı	l .		1-32. 00

Health Financial Systems COM	MUNITY HOSPITAL	OF INDIANA, IN	NC.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C	<u> </u>	Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/30/2017 8:5	pared: 4 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	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	8, 603, 329	0	8, 603, 32	60, 894	141. 28	30. 00
31.00 INTENSIVE CARE UNIT	1, 622, 775		1, 622, 77	5, 460	297. 21	31. 00
35.00 NEONATAL INTENSIVE CARE UNIT	1, 587, 112		1, 587, 11:	11, 195	141. 77	35. 00
40. 00 SUBPROVI DER - I PF	264, 636	0	264, 63	5 2, 501	105.81	40. 00
43. 00 NURSERY	772, 237		772, 23	7, 426	103. 99	43.00
200.00 Total (lines 30-199)	12, 850, 089		12, 850, 08	9 87, 476		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	19, 005	2, 685, 026				30.00
31.00 INTENSIVE CARE UNIT	2, 134	634, 246				31.00
35.00 NEONATAL INTENSIVE CARE UNIT	0	0				35. 00
40. 00 SUBPROVI DER - I PF	1, 868	197, 653				40. 00
43. 00 NURSERY	0	1	1			43.00
200.00 Total (lines 30-199)	23, 007	3, 516, 925				200. 00

Health Financial Systems COMM	MUNITY HOSPITAL	OF INDIANA, IN	NC.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co		Period: From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	PPS	ı uıı
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	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 410, 197		•		634, 585	
51.00  05100   RECOVERY ROOM	540, 668		•		90, 578	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 693, 459				0	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 315, 828				147, 158	54. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C	714, 617				149, 157	55. 00
57. 00   05700   CT   SCAN	518, 101				64, 341	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 029, 567				94, 572	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	24, 643					
60. 00   06000   LABORATORY	409, 215					
64. 00   06400   I NTRAVENOUS THERAPY	195, 422			·	· ·	64. 00
65. 00 06500 RESPI RATORY THERAPY	600, 162	1 ' '			157, 062	
66. 00 06600 PHYSI CAL THERAPY	266, 033				27, 259	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	75, 071	1 ' '				
68. 00 06800 SPEECH PATHOLOGY	14, 386					
69. 00 06900 ELECTROCARDI OLOGY	34, 953				· ·	
70. 00  07000 ELECTROENCEPHALOGRAPHY	236, 833	11, 959, 981		·	7, 467	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	591, 576				99, 118	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	464, 819				168, 323	
73.00 07300 DRUGS CHARGED TO PATIENTS	904, 949					
74. 00   07400   RENAL DI ALYSI S	28, 859				16, 030	74. 00
76. 00   03330   ENDOSCOPY	700, 788		•		8, 669	76. 00
76. 06   03954   I MAGI NG CENTER	578, 769				182	76. 06
76. 07 03955 BREAST DIAGNOSTIC CENTER	221, 285	11, 066, 146	0. 01999	7 423	8	76. 07
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000   CLI NI C	0	1	0.00000		0	90.00
90. 26   04975   SPI NE CENTER	11, 304		•		0	90. 26
91. 00   09100   EMERGENCY	1, 206, 764		•		111, 446	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 093, 113					
200.00   Total (lines 50-199)	15, 881, 381	1, 006, 605, 092		175, 775, 632	2, 283, 437	200. 00

Health Financial Systems COMM	IUNITY HOSPITAL	OF INDIANA, IN	NC.	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	TS Provider C		Period: From 01/01/2016 To 12/31/2016		pared: 4 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Cost	All Other Medical Education Cos		Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00	2, 00	3, 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS 31. 00   03100   NTENSI VE CARE UNI T	0	0		0 0	0	
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0	0		Ö	0	
40. 00   04000   SUBPROVI DER -   PF	0	Ö	,	o o	0	
43. 00 04300 NURSERY	0	0		O	0	43.00
200.00 Total (lines 30-199)	0	0	)	o	0	200. 00
Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through		
				Cost (col. 7 x		
	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00   03000   ADULTS & PEDI ATRI CS	60, 894					30.00
31. 00 03100 I NTENSI VE CARE UNI T	5, 460	l .	, , ,			31.00
35. 00   02060   NEONATAL INTENSIVE CARE UNIT 40. 00   04000   SUBPROVIDER - IPF	11, 195	l .		0		35. 00
40. 00   04000  SUBPROVI DER - I PF 43. 00   04300  NURSERY	2, 501 7, 426	l .		0		40. 00 43. 00
200.00 Total (lines 30-199)	87, 476		23, 00	7 0		200. 00

Heal th Financial Systems COMMUNITY HOSPITAL OF APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS | Period: | Worksheet D | From 01/01/2016 | Part IV | To | 12/31/2016 | Date/Time Prepared: Provider CCN: 15-0169 THROUGH COSTS

			T	o 12/31/2016	Date/Time Pre 5/30/2017 8:5	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician I	Nursing School	Allied Health		Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost		
	1.00		0.00		4)	
ANOULL ADV. CEDVI OF COCT. CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS  50. 00   05000   OPERATI NG ROOM					0	F0 00
50. 00   05000   OPERATING ROOM 51. 00   05100   RECOVERY ROOM	0	0	0	U	0	50. 00 51. 00
1	١	0	0	U	0	51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM   54. 00   05400   RADI OLOGY-DI AGNOSTI C	١	0	0	U	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0	0	0	0	55. 00
57. 00   05700   CT   SCAN		0	0	0	0	57. 00
58. 00   05700   CT   SCAN   58. 00   05800   MAGNETI C   RESONANCE   MAGING (1	MPL)	0	0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	wiki )	0	0	0	0	59. 00
60. 00   06000   LABORATORY	l ől	0	0		0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	ا	0	0	٥	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	ام	0	0	٥	0	65. 00
66. 00   06600   PHYSI CAL THERAPY		0	0	Ö	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0	0	o	0	67. 00
68. 00 06800 SPEECH PATHOLOGY		0	0	ol	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	ol	0	0	ol	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	l	0	0	o	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO I	PATI ENTS 0	0	0	o	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIEN	rs o	0	0	o	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	0	0	o	0	73. 00
74.00 07400 RENAL DIALYSIS	o	0	0	o	0	74.00
76. 00 03330 ENDOSCOPY	o	0	0	o	0	76. 00
76.06 03954 I MAGING CENTER	o	0	0	o	0	76. 06
76. 07 03955 BREAST DIAGNOSTIC CENTER	0	0	0	0	0	76. 07
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000  CLI NI C	0	0	0	0	0	90.00
90. 26  04975   SPI NE CENTER	0	0	0	0	0	90. 26
91. 00   09100   EMERGENCY	0	0	0	0	0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTING	CT PART) 0	0	0	0	0	92. 00
200.00   Total (lines 50-199)	0	0	0	0	0	200. 00

Heal th	Financial Systems COMM	IUNI TY HOSPI TAL	OF INDIANA, II	NC.	In Lie	eu of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	VICE OTHER PAS	S Provider C		Period: From 01/01/2016 Fo 12/31/2016		
			Ti tl e	e XVIII	Hospi tal	PPS	4 (111)
	Cost Center Description	Total	Total Charges			Inpati ent	
		Outpati ent	(from Wkst. C,		Ratio of Cost		
		Cost (sum of		(col. 5 ÷ col		Charges	
		col. 2, 3 and	8)	7)	(col. 6 ÷ col.	Ŭ	
		4)	·		7)		
		6.00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	154, 942, 430				50.00
51.00	05100 RECOVERY ROOM	0	29, 448, 429	0.00000			51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	21, 486, 482				52. 00
54.00	05400  RADI OLOGY-DI AGNOSTI C	0	37, 480, 031				54.00
55.00	05500   RADI OLOGY-THERAPEUTI C	0	23, 993, 734				
57.00	05700  CT SCAN	0	66, 104, 005				57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	22, 439, 431				58. 00
59.00	05900   CARDI AC   CATHETERI ZATI ON	0	1, 152, 710				59. 00
60.00	06000 LABORATORY	0	,				
64.00	06400 I NTRAVENOUS THERAPY	0	.,				
65.00	06500 RESPI RATORY THERAPY	0	27, 498, 815	0.00000	0.000000	7, 196, 435	65. 00
66.00	06600 PHYSI CAL THERAPY	0	25, 947, 880				66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	6, 930, 547	0.00000	0.000000	1, 900, 238	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	2, 030, 866				
69. 00	06900 ELECTROCARDI OLOGY	0	7, 971, 107	0.00000	0. 000000	2, 928, 758	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	11, 959, 981				70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	79, 517, 803				71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	40, 121, 910	0.00000	0.000000		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	777 1007 100				
74.00	07400 RENAL DIALYSIS	0	2, 925, 252	0.00000	0.000000	1, 624, 887	74. 00
76.00	03330 ENDOSCOPY	0	,,				76. 00
76.06	03954 I MAGI NG CENTER	0					76. 06
76. 07	03955 BREAST DIAGNOSTIC CENTER	0	11, 066, 146	0.00000	0.000000	423	76. 07
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0					90. 00
90. 26	04975 SPI NE CENTER	0					90. 26
91.00	09100 EMERGENCY	0	141, 957, 638	0.00000			
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	,	1	0. 000000		
200.00	Total (lines 50-199)	0	1, 006, 605, 092			175, 775, 632	200. 00

THROUGH COSTS

					10 12/01/2010	5/30/2017 8: 5	
			Title	: XVIII	Hospi tal	PPS	
	Cost Center Description	Inpati ent	Outpati ent	Outpati ent			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Through	n		
		Costs (col. 8		Costs (col.	9		
		x col. 10)		x col. 12)			
		11. 00	12. 00	13. 00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	7, 864, 067		0		50.00
51. 00	05100 RECOVERY ROOM	0	1, 509, 413		0		51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	5, 028, 589	l .	0		54.00
55. 00	05500  RADI OLOGY-THERAPEUTI C	0	5, 785, 743	l .	0		55. 00
57.00	05700  CT SCAN	0	9, 293, 651		0		57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	3, 658, 296		0		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0		59. 00
60.00	06000 LABORATORY	0	7, 251, 197		0		60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0		64.00
65.00	06500 RESPI RATORY THERAPY	0	254, 222		0		65. 00
66.00	06600 PHYSI CAL THERAPY	0	62, 607		0		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	53, 877		0		67. 00
68.00	06800 SPEECH PATHOLOGY	0	12, 504		0		68. 00
69.00	06900 ELECTROCARDI OLOGY	o	269, 719		0		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	o	2, 374, 945		0		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	3, 340, 050		0		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	1, 817, 692		0		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	5, 564, 757		0		73. 00
74.00	07400 RENAL DIALYSIS	o	0		0		74. 00
76.00	03330 ENDOSCOPY	o	4, 370, 901		0		76. 00
76.06	03954 I MAGI NG CENTER	o	13, 148, 847		0		76. 06
76. 07	03955 BREAST DIAGNOSTIC CENTER	o	706, 190		0		76. 07
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	0	0		0		90. 00
90. 26	04975 SPI NE CENTER	0	3, 145		0		90. 26
91.00	09100 EMERGENCY	o	15, 299, 846		0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	2, 860, 051		0		92.00
200.00	Total (lines 50-199)	0	90, 530, 309		0		200. 00

Heal th	Financial Systems COMM	MUNITY HOSPITAL	OF INDIANA, IN	IC.	In Lie	eu of Form CMS-2	2552-10
APPOR <sup>-</sup>	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Co		Period: From 01/01/2016 Fo 12/31/2016	Worksheet D Part V Date/Time Pre 5/30/2017 8:5	pared: 4 am
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge Ratio From Worksheet C,	PPS Reimbursed Services (see inst.)	Cost Rei mbursed Servi ces	Cost Reimbursed Services Not	PPS Services (see inst.)	
		Part I, col. 9	ŕ	Subject To	Subject To		
				Ded. & Coins. (see inst.)	Ded. & Coins. (see inst.)		
		1. 00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
50.00	05000 OPERATING ROOM	0. 133321	7, 864, 067		0	1, 048, 445	50. 00
51.00	05100 RECOVERY ROOM	0. 178077			0	268, 792	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 609418	0		0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 222386	5, 028, 589		0	1, 118, 288	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 122589	5, 785, 743		0	709, 268	55. 00
57.00	05700 CT SCAN	0. 038113	9, 293, 651		0	354, 209	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 175951	3, 658, 296		0	643, 681	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 021238	0		0	0	59. 00
60.00	06000 LABORATORY	0. 104378	7, 251, 197	38	1 0	756, 865	60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 777517	0		0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 221932	254, 222		0	56, 420	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 247162	62, 607		0	15, 474	
67. 00	06700 OCCUPATI ONAL THERAPY	0. 265989			0	14, 331	
68. 00	06800 SPEECH PATHOLOGY	0. 175519			0	2, 195	
69. 00	06900 ELECTROCARDI OLOGY	0. 114356	269, 719		0	30, 844	69. 00

0. 207285

0. 213318

0. 382846

0. 262562

0. 429315

0. 185451

0.094295

0.558482

0.000000

0. 408591

0. 104097

0. 882216

2, 374, 945

3, 340, 050

1, 817, 692

5, 564, 757

4, 370, 901

13, 148, 847

15, 299, 846

2, 860, 051

90, 530, 309

90, 530, 309

706, 190

3, 145

0

0

0

0

163, 067

163, 067

163, 067

0

0

0

0

0

0

0

0

0

0

381

381

492, 290

712, 493

695, 896

810, 588

394, 394

1, 285

14, 942, 574 202. 00

1, 461, 094

1, 239, 871

1, 592, 668

2, 523, 183

14, 942, 574

70.00

71.00

72.00

73.00

74.00

76.00

76.06

76.07

90.00

90. 26

91.00

92.00

200.00

201.00

70. 00 07000 ELECTROENCEPHALOGRAPHY

07400 RENAL DIALYSIS

03954 I MAGING CENTER

04975 SPINE CENTER

Only Charges

09100 EMERGENCY

03330 ENDOSCOPY

09000 CLI NI C

71.00

72.00

73.00

74.00

76.00

76.06

76.07

90.00

90. 26

91.00

92.00

200.00

201.00

202.00

07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 +/- line 201)

Subtotal (see instructions)

07200 IMPL. DEV. CHARGED TO PATIENTS

07300 DRUGS CHARGED TO PATIENTS

03955 BREAST DIAGNOSTIC CENTER

OUTPATIENT SERVICE COST CENTERS

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0169 Peri od: Worksheet D From 01/01/2016 Part V 12/31/2016 Date/Time Prepared: 5/30/2017 8:54 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 0000000 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 55.00 57.00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 58.00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 06000 LABORATORY 0 60.00 60.00 06400 I NTRAVENOUS THERAPY 0 64 00 64.00 65.00 06500 RESPIRATORY THERAPY 0 65.00

40

40

42, 815

42, 815

92.00

200. 00

201. 00

202.00

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 +/- line 201)

Subtotal (see instructions)

Only Charges

92.00

200.00

201.00

202.00

MCRI F32 - 10. 5. 160. 2

Health Financial Systems COMM	MUNITY HOSPITAL	OE INDIANA IN	NC	In Lie	eu of Form CMS-2	2552 10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C		Peri od:	Worksheet D	2332-10
AFFORTIONWENT OF INFATIENT ANGIELART SERVICE CAFTTA	AL 00313	Frovider	CN. 15-0109	From 01/01/2016	Part II	
		· ·	CCN: 15-S169	To 12/31/2016	Date/Time Pre 5/30/2017 8:5	pared: 4 am
		Title	e XVIII	Subprovi der -	PPS	
				I PF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,	9	Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26) 1, 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	2, 410, 197	154, 942, 430	0. 01555	5 0	0	50.00
51. 00   05100   RECOVERY   ROOM	540, 668				0	51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	1, 693, 459					
54. 00   05400 RADI OLOGY-DI AGNOSTI C	1, 315, 828				817	
55. 00   05500   RADI OLOGY-THERAPEUTI C	714, 617				017	55.00
57. 00   05700   CT   SCAN	518, 101					
58. 00   05800 MAGNETI C RESONANCE I MAGING (MRI)	1, 029, 567				151	
59. 00   05900   CARDI AC CATHETERI ZATI ON	24, 643				0	
60. 00   06000   LABORATORY	409, 215					
64. 00 06400 I NTRAVENOUS THERAPY	195, 422					
65. 00 06500 RESPIRATORY THERAPY	600, 162		1			1
66. 00   06600 PHYSI CAL THERAPY	266, 033				732	
67. 00 06700 OCCUPATI ONAL THERAPY	75, 071					
68. 00 06800 SPEECH PATHOLOGY	14, 386	2, 030, 866	0. 00708			68. 00
69. 00 06900 ELECTROCARDI OLOGY	34, 953					69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	236, 833			2 10, 132	201	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	591, 576	79, 517, 803	0.00744	0 18, 437	137	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	464, 819	40, 121, 910	0. 01158	5 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	904, 949	99, 183, 468	0. 00912	4 375, 806	3, 429	73. 00
74. 00 07400 RENAL DIALYSIS	28, 859	2, 925, 252	0. 00986	5 0	0	74.00
76. 00   03330   ENDOSCOPY	700, 788	18, 531, 370	0. 03781	6 0	0	76. 00
76. 06   03954   I MAGI NG CENTER	578, 769	54, 554, 929	0. 01060	9 0	0	76. 06
76. 07 03955 BREAST DIAGNOSTIC CENTER	221, 285	11, 066, 146	0. 01999	7 0	0	76. 07
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	_				
90. 26   04975   SPI NE CENTER	11, 304				_	
91. 00   09100   EMERGENCY	1, 206, 764					91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				l	
200.00   Total (lines 50-199)	14, 788, 268	1, 006, 605, 092		1, 325, 846	13, 888	200.00

Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. In Lieu of Form CMS-						2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der C	CN: 15-0169	Peri od:	Worksheet D	
THROUGH COSTS			00N 4E 6440	From 01/01/2016	Part IV	
		Component	CCN: 15-S169	To 12/31/2016	Date/Time Pre 5/30/2017 8:5	pared: 4 am
		Title	xVIII	Subprovi der -	PPS	<del>1</del> uiii
		11 11 0		IPF	110	
Cost Center Description	Non Physician N	ursing School	Allied Healt		Total Cost	
	Anestheti st	Ü		Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	0	0		0	0	50.00
51.00   05100   RECOVERY ROOM	0	0		0	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0		0	0	
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	0		0 0	0	
57. 00  05700 CT SCAN	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
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	64. 00
65. 00 06500 RESPIRATORY 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	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	
74.00 07400 RENAL DIALYSIS	0	0		0	0	
76. 00   03330   ENDOSCOPY	0	0		0	0	
76. 06   03954   I MAGI NG CENTER	0	0		0	0	76. 06
76. 07 03955 BREAST DIAGNOSTIC CENTER	0	0		0 0	0	76. 07
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C	0	0	•	0		
90. 26   04975   SPI NE CENTER	0	0		0	0	
91. 00   09100   EMERGENCY	0	0		0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	0	
200.00   Total (lines 50-199)	0	0	1	0 0	0	200. 00

Usalah Firancial Custom	UNITY HOCDITAL	OF INDIANA IA	10	1-11-	£ F OMC :	2552 10
Health Financial Systems COMM APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	UNITY HOSPITAL			Peri od:	u of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS	VICE UTILK FAS	5 Frovider C		rom 01/01/2016	Part IV	
		'	CCN: 15-S169	To 12/31/2016	Date/Time Pre 5/30/2017 8:5	pared: 4 am
		Title	: XVIII	Subprovi der -	PPS	
	T	 		I PF		
Cost Center Description	Total	Total Charges	Ratio of Cost		I npati ent	
	Outpatient Cost (sum of	(from Wkst. C,	to Charges (col. 5 ÷ col.	Ratio of Cost to Charges	Program Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.	charges	
	4)	0)	')	7)		
	6. 00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
50. 00 05000 OPERATING ROOM	0	154, 942, 430	0.000000	0.000000	0	50.00
51. 00 05100 RECOVERY ROOM	0				0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0				0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	37, 480, 031		0. 000000	23, 280	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	23, 993, 734	0.000000	0. 000000	0	55. 00
57. 00  05700 CT SCAN	0	66, 104, 005	0. 000000	0. 000000	42, 096	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	22, 439, 431	0. 000000	0. 000000	3, 295	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	1, 152, 710	0.000000	0.000000	0	59. 00
60. 00  06000 LABORATORY	0				501, 090	
64. 00   06400   I NTRAVENOUS THERAPY	0	,			26, 878	
65. 00 06500 RESPI RATORY THERAPY	0				17, 942	
66. 00 06600 PHYSI CAL THERAPY	0				71, 361	
67. 00 06700 OCCUPATI ONAL THERAPY	0	6, 930, 547			49, 850	1
68. 00 06800 SPEECH PATHOLOGY	0	2, 030, 866			7, 243	1
69. 00 06900 ELECTROCARDI OLOGY	0	.,			9, 416	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0				10, 132	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0				18, 437	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0				0	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0				375, 806	1
74. 00   07400   RENAL DI ALYSI S 76. 00   03330   ENDOSCOPY	0	2, 925, 252			0	74. 00 76. 00
76. 00   03330   ENDOSCOPY 76. 06   03954   I MAGI NG CENTER	0	, ,			0	76.00
76. 07   03955   BREAST DI AGNOSTI C CENTER	0				0	76.06
OUTPATIENT SERVICE COST CENTERS	0	11,000,140	0.00000	0. 000000	0	76.07
90. 00 09000 CLINIC	0	0	0. 000000	0. 000000	0	90.00
90. 26   04975   SPI NE CENTER	0				0	90. 00
91. 00   09100   EMERGENCY	0	1			159, 941	1
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	0				9, 079	1
200.00 Total (lines 50-199)	0			0.000000	1, 325, 846	1
	1	1 ., 555, 555, 672	1	1	., 525, 616	,_ 50. 00

Health Financial Systems	COMMUNITY HOSPITAL O	F INDIANA, I	NC.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der C	CN: 15-0169	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2016	Part IV	
		Component	CCN: 15-S169	To 12/31/2016	Date/Time Pre	pared:
		· ·			5/30/2017 8: 5	4 am
		Ti tl e	e XVIII	Subprovi der -	PPS	
				IPF		
Cost Center Description	Inpatient	Outpati ent	Outpati ent			

			litle	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Inpati ent	Outpatient	Outpati ent			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Through	n		
		Costs (col. 8	Ü	Costs (col.	9		
		x col. 10)		x col. 12)			
		11. 00	12. 00	13. 00			
	CILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	0	0	)	0		50. 00
	100 RECOVERY ROOM	0	0	)	0		51.00
	200 DELIVERY ROOM & LABOR ROOM	0	0	)	0		52. 00
	400 RADI OLOGY-DI AGNOSTI C	0	0	)	0		54. 00
	500 RADI OLOGY-THERAPEUTI C	0	0	)	0		55. 00
	700 CT SCAN	0	0	)	0		57. 00
58. 00   05	800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	)	0		58. 00
59. 00   05	900 CARDI AC CATHETERI ZATI ON	0	0	)	0		59. 00
60.00 06	000 LABORATORY	0	0	)	0		60.00
64. 00   06	400 INTRAVENOUS THERAPY	0	0	)	0		64. 00
65. 00 06	500 RESPI RATORY THERAPY	0	0	)	0		65. 00
66. 00 06	600 PHYSI CAL THERAPY	0	0	)	0		66. 00
67. 00 06	700 OCCUPATI ONAL THERAPY	0	0	)	0		67. 00
68. 00 06	800 SPEECH PATHOLOGY	0	0	)	0		68. 00
69. 00 06	900 ELECTROCARDI OLOGY	0	0	)	0		69. 00
70. 00   07	000 ELECTROENCEPHALOGRAPHY	0	0	)	0		70. 00
71. 00   07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0		71. 00
72. 00   07	200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0		72. 00
73. 00   07	300 DRUGS CHARGED TO PATIENTS	0	0		0		73. 00
74. 00   07	400 RENAL DIALYSIS	0	0		0		74. 00
76. 00   03	330 ENDOSCOPY	0	0		0		76. 00
76. 06   03	954 I MAGING CENTER	0	0		0		76. 06
76. 07   03	955 BREAST DIAGNOSTIC CENTER	0	0		0		76. 07
OU <sup>-</sup>	TPATIENT SERVICE COST CENTERS						1
90. 00 09	000 CLI NI C	0	O		0		90.00
90. 26 04	975 SPINE CENTER	0	0		0		90. 26
91. 00 09	100 EMERGENCY	0	0		0		91. 00
92. 00 09:	200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0		92. 00
200.00	Total (lines 50-199)	0	0		0		200. 00

Health Financial Systems	COMMUNITY HOSPITAL OF	INDIANA, INC.	In Lieu	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0169	Period: From 01/01/2016	Worksheet D Part V

Component CCN: 15-S169 12/31/2016 Date/Time Prepared: To 5/30/2017 8:54 am Title XVIII Subprovi der -PPS Charges Costs Cost to Charge PPS Reimbursed Cost Center Description Cost PPS Services Cost Services (see Rei mbursed Ratio From Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 133321 0 50.00 51.00 05100 RECOVERY ROOM 0.178077 0 51.00 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 0.609418 52 00 0 52 00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 222386 0 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0. 122589 0 0 0 55.00 55.00 0 05700 CT SCAN 0 57.00 57.00 0.038113 0 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0. 175951 0 58.00 Ω 58.00 59.00 05900 CARDIAC CATHETERIZATION 0. 021238 0 0 0 59.00 60.00 06000 LABORATORY 0.104378 0 60.00 06400 I NTRAVENOUS THERAPY 0. 777517 0 0 64.00 64.00 0 06500 RESPIRATORY THERAPY 65.00 0. 221932 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 247162 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0. 265989 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 0.175519 0 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 0.114356 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.207285 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 213318 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.382846 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 262562 2, 956 0 73.00 07400 RENAL DIALYSIS 0 74.00 0. 429315 0 0 74.00 OI 76.00 03330 ENDOSCOPY 0. 185451 0 0 76.00 0 0 76.06 03954 I MAGING CENTER 0.094295 0 0 76.06 03955 BREAST DIAGNOSTIC CENTER 0. 558482 0 0 0 76.07 76.07 0 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 0.000000 09000 CLI NI C 0 0 04975 SPINE CENTER 90. 26 0.408591 0 0 0 0 90.26 09100 EMERGENCY 0. 104097 0 0 91.00 91.00 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 281 92.00 0.882216 0 0 Ω 0 0 200. 00 200.00 Subtotal (see instructions) 2, 956 1, 281 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges

o

2, 956

1, 281

0 202.00

202.00

Net Charges (line 200 +/- line 201)

Health Financial Systems COMM	UNI TY HOSPI TAL	OF INDIANA, II	NC.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Component	CN: 15-0169 CCN: 15-S169	From 01/01/2016 To 12/31/2016		
		Titl∈	e XVIII	Subprovi der - I PF	PPS	
	Cos	its				
Cost Center Description	Cost	Cost				

			Title	XVIII	Subprovi der - I PF	PPS	
		Cos	its				
	Cost Center Description	Cost	Cost				
	<b>'</b>	Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7. 00				
	CILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	0	0				50.00
	100 RECOVERY ROOM	0	0				51.00
	200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54.00 054	400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55. 00   05!	500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
57. 00 05	700 CT SCAN	0	0				57. 00
58. 00   058	800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58. 00
59. 00 059	900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60.00 060	000 LABORATORY	0	0				60.00
64. 00   064	400 INTRAVENOUS THERAPY	0	0				64.00
65. 00 06!	500 RESPI RATORY THERAPY	0	0				65.00
66. 00   066	600 PHYSI CAL THERAPY	0	0				66.00
67. 00 06 <sup>-</sup>	700 OCCUPATI ONAL THERAPY	0	0				67.00
68. 00   068	800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 069	900 ELECTROCARDI OLOGY	0	0				69. 00
70. 00   070	000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71. 00   07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. 00
72. 00   07:	200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73. 00   07:	300 DRUGS CHARGED TO PATIENTS	776	0				73. 00
74. 00   074	400 RENAL DIALYSIS	O	0				74. 00
76. 00   03:	330 ENDOSCOPY	O	0				76. 00
76. 06   039	954 I MAGI NG CENTER	O	0				76. 06
76. 07   039	955 BREAST DIAGNOSTIC CENTER	O	0				76. 07
	TPATIENT SERVICE COST CENTERS						
90.00 090	000 CLI NI C	0	0				90.00
90. 26 049	975 SPINE CENTER	0	0				90. 26
91. 00 09	100 EMERGENCY	0	0				91.00
92. 00 09:	200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 130				92.00
200. 00	Subtotal (see instructions)	776	1, 130				200. 00
201.00	Less PBP Clinic Lab. Services-Program	0					201. 00
	Only Charges						
202. 00	Net Charges (line 200 +/- line 201)	776	1, 130				202. 00

Health Financial Systems COM	MUNITY HOSPITAL	OF INDIANA, IN	NC.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider Co		Period: From 01/01/2016 To 12/31/2016	5/30/2017 8:5	pared: 4 am
			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	8, 603, 329		-,,			
31.00   INTENSIVE CARE UNIT	1, 622, 775		1, 622, 77	5, 460	297. 21	31.00
35.00 NEONATAL INTENSIVE CARE UNIT	1, 587, 112		1, 587, 11			35. 00
40. 00   SUBPROVI DER - I PF	264, 636	0	264, 63	6 2, 501	105. 81	40. 00
43. 00 NURSERY	772, 237		772, 23	7, 426	103. 99	43. 00
200.00 Total (lines 30-199)	12, 850, 089		12, 850, 08	9 87, 476		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	2, 098	296, 405				30. 00
31.00 INTENSIVE CARE UNIT	0	0	)			31.00
35. OO NEONATAL INTENSIVE CARE UNIT	46	6, 521				35. 00
40. 00 SUBPROVI DER - I PF	0	0	)			40.00
43. 00 NURSERY	3, 314	344, 623				43.00
200.00 Total (lines 30-199)	5, 458					200. 00
	•		•			•

58. 00	Health Financial Systems COM	MUNITY HOSPITAL	OF INDIANA, IN	NC.	In Lie	eu of Form CMS-	2552-10
Capital Related Cost (From Wkst. B, Part II, col.   Col.   Part III, col.   Pa	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS			From 01/01/2016 To 12/31/2016	Part II Date/Time Pre 5/30/2017 8:5	
Rel ated Cost   (From Wists, C,   to Charges   Column 4)   Part I, col.   20   2   20   3.00   4.00   5.00							
CFrom Wisst. B, Part I, col.   Col. 1 + col.   Col. 1 + col.   Col. 1 + col.   Col. 1 + col.   Col. may	Cost Center Description						
Part II, col. 260   2.00   3.00   4.00   5.00							
ANCILLARY SERVICE COST CENTERS					. Charges	column 4)	
NOTE			8)	2)			
ANCI LLARY SERVICE COST CENTERS							
50.00		1. 00	2.00	3.00	4. 00	5. 00	
51.00   05100   RECOVERY ROOM   540, 668   29, 448, 429   0.018360   156, 909   2, 881   51.00   05200   DELI VERY ROOM & LABOR ROOM   1, 693, 459   21, 486, 482   0.078815   362, 359   28, 559   52.00   05200   DELI VERY ROOM & LABOR ROOM   1, 693, 459   21, 486, 482   0.078815   362, 359   28, 559   52.00   05200   RADI OLOGY-DI AGNOSTI C   1, 315, 828   37, 480, 031   0.035107   337, 140   11,836   54.00   05400   RADI OLOGY-THERAPEUTI C   714, 617   23, 993, 734   0.029783   159, 371   4, 747   55.00   05700   CT SCAN   518, 101   66, 104, 005   0.007838   341,868   2, 680   57.00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   1, 029, 567   24, 493, 431   0.045882   97, 932   4, 493   58.00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   1, 029, 567   22, 439, 431   0.045882   97, 932   4, 493   58.00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   1, 029, 567   20, 439, 431   0.045882   97, 932   4, 493   58.00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   1, 029, 567   30, 431   0.003867   1, 521, 488   5, 884   60.00   06000   LABORATORY   409, 215   105, 819, 013   0.003867   1, 521, 488   5, 884   60.00   06000   LABORATORY   409, 215   105, 819, 013   0.003867   1, 521, 488   5, 884   60.00   06000   CARDI NAT THERAPY   409, 215   105, 819, 013   0.003867   1, 521, 488   5, 884   60.00   06000   CARDI NAT THERAPY   266, 033   25, 947, 880   0.010253   65, 639   673   66.00   06700   0CUPATI ONAL THERAPY   266, 033   25, 947, 880   0.010253   65, 639   673   66.00   06700   0CUPATI ONAL THERAPY   266, 033   25, 947, 880   0.010253   153, 744   1, 665   67.00   06700   0CUPATI ONAL THERAPY   326, 833   11, 959, 981   0.010832   153, 744   1, 665   67.00   07000   ELECTROCARDI OLOGY   34, 553   7, 971, 107   0.004385   122, 072   535   69.00   07000   ELECTROCARDI OLOGY   34, 553   7, 971, 107   0.004385   122, 072   535   69.00   07000   ELECTROCARDI OLOGY   34, 553   7, 971, 107   0.004385   122, 072   535   69.00   07000   0.004365   17, 747, 7572   15, 945   73.00   07300   07000   ELECTROCARD			I	1			
52.00   05200   DELIVERY ROOM & LABOR ROOM   1,693,459   21,486,482   0.078815   362,359   28,559   52.00   05400   RADIOLOGY-DIAGNOSTIC   1,315,828   37,480,031   0.035107   337,140   11,836   54.05   05500   RADIOLOGY-THERAPEUTIC   714,617   23,993,734   0.029783   159,371   4,747   55.00   05500   CARDIOLOGY-THERAPEUTIC   714,617   23,993,734   0.029783   159,371   4,747   55.00   05700   CT SCAN   518,101   66,104,005   0.007838   341,868   2,680   57.00   05900   CARDIA C CATHETERI ZATION   24,643   1,152,710   0.021378   0   0.5900   06900   CARDIA C CATHETERI ZATION   24,643   1,152,710   0.021378   0   0.5900   06000   LABORATORY   409,215   105,819,013   0.003867   1,521,488   5,884   60.00   06500   RESPIRATORY THERAPY   195,422   1,393,708   0.140217   24,591   3,448   64.00   06500   RESPIRATORY THERAPY   266,033   25,947,880   0.010253   65,639   673   66.00   06600   PHYSI CAL THERAPY   266,033   25,947,880   0.010253   65,639   673   66.00   06600   O6600   SPEECH PATHOLOGY   14,386   2,030,866   0.007084   67,117   475   68.00   06600   SPEECH PATHOLOGY   34,953   7,971,107   0.004385   122,072   535   69.00   06900   ELECTROCARDIO LOGY   34,953   7,971,107   0.004385   122,072   535   69.00   07000   ELECTROCARDIO LOGY   34,953   7,971,107   0.004385   122,072   535   69.00   07000   ELECTROCARDIO LOGY   34,953   7,971,107   0.004385   122,072   535   69.00   07000   ELECTROCARDIO LOGY   34,953   7,971,107   0.004385   122,072   535   69.00   07000   ELECTROCARDIO LOGY   34,953   7,971,107   0.004385   122,072   535   69.00   07000   ELECTROCARDIO LOGY   34,953   7,971,107   0.004385   122,072   535   69.00   07000   ELECTROCARDIO LOGY   34,953   7,971,107   0.004385   122,072   535   69.00   07000   ELECTROCARDIO LOGY   070,000							
54. 00   05400   RADI OLOGY-DI AGNOSTI C   1, 315, 828   37, 480, 031   0. 035107   337, 140   11, 836   54. 05   05500   RADI OLOGY-THERAPEUTI C   714, 617   23, 993, 734   0. 029783   159, 371   4, 747   55. 05   05700   CT SCAN   518, 101   66, 104, 005   0.007838   341, 868   2, 680   57. 00   05700   CT SCAN   518, 101   66, 104, 005   0.007838   341, 868   2, 680   57. 00   05900   CARDI AC CATHETERI ZATI ON   24, 643   1, 152, 710   0. 021378   0   0. 59. 00   0. 00000   CARDI AC CATHETERI ZATI ON   24, 643   1, 152, 710   0. 021378   0   0. 59. 00   0. 00000   CARDI AC CATHETERI ZATI ON   24, 643   1, 152, 710   0. 021378   0   0. 59. 00   0. 00000   CARDI AC CATHETERI ZATI ON   24, 643   1, 152, 710   0. 021378   0   0. 59. 00   0. 00000   CARDI AC CATHETERI ZATI ON   24, 643   1, 152, 710   0. 021378   0   0. 059. 00   0. 00000   CARDI AC CATHETERI ZATI ON   24, 643   1, 152, 710   0. 021378   0   0. 59. 00   0. 00000   CARDI AC CATHETERI ZATI ON   24, 643   1, 152, 710   0. 021378   0   0. 003867   1, 521, 488   5. 844   60. 00   0. 00000   CARDI AC CATHETERI ZATI ON   24, 643   1, 152, 710   0. 021378   0   0. 003867   1, 521, 488   5. 844   60. 00   0. 00000   CARDI AC CATHETERI ZATI ON   24, 643   1, 152, 710   0. 021378   0   0. 003867   1, 521, 488   5. 844   60. 00   0. 00000   CARDI AC CATHETERI ZATI ON   24, 643   1, 152, 710   0. 021378   0   0. 003867   1, 521, 488   5. 844   60. 00   0. 00000   0. 008600   CARDIA CATHETERI ZATI ON   24, 643   1, 152, 710   0. 021378   0. 0013862   1, 232, 411   26, 897   65. 00   0. 00000   0. 001282   1, 232, 411   26, 897   65. 00   0. 00000   0. 00000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 00000000		•		1			
55. 00   05500   RADI OLOGY-THERAPEUTI C   714, 617   23, 993, 734   0. 029783   159, 371   4, 747   55. 05   05700   05700   CT SCAN   518, 101   66, 104, 005   0. 007838   341, 868   2, 680   57. 0   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   1, 029, 567   22, 439, 431   0. 045882   97, 932   4, 493   58. 0   05900   CARDI AC CATHETERI ZATI ON   24, 643   1, 152, 710   0. 021378   0   0. 59. 0   0. 06000   LABORATORY   409, 215   105, 819, 013   0. 003867   1, 521, 488   5, 884   60. 0   0. 06000   LABORATORY   195, 422   1, 393, 708   0. 140217   24, 591   3, 448   64. 0   0. 06400   INTRAVENOUS THERAPY   600, 162   27, 498, 815   0. 021825   1, 232, 411   26, 897   65. 00   06500   RESPI RATORY THERAPY   600, 162   27, 498, 815   0. 021825   1, 232, 411   26, 897   65. 00   06600   PHYSI CAL THERAPY   75, 071   6, 930, 547   0. 010253   65, 639   673   66. 00   06600   PHYSI CAL THERAPY   75, 071   6, 930, 547   0. 010832   153, 744   1, 665   67. 0   0. 06900   ELECTROCARDI OLOGY   34, 953   7, 971, 107   0. 004385   122, 072   535   69. 0   0. 06900   ELECTROENCEPHALOGRAPHY   236, 833   11, 959, 981   0. 019802   22, 049   437   70. 0   0. 07000   ELECTROENCEPHALOGRAPHY   236, 833   11, 959, 981   0. 019802   22, 049   437   70. 0   0. 07000   ELECTROENCEPHALOGRAPHY   236, 833   11, 959, 981   0. 019802   22, 049   437   70. 0   0. 07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   591, 576   79, 517, 803   0. 007440   727, 831   5, 415   71. 0   72. 0   73. 00   0. 07300   DRUGS CHARGED TO PATI ENTS   904, 949   99, 183, 468   0. 009124   1, 747, 572   15, 945   73. 00   73. 00   0. 07300   DRUGS CHARGED TO PATI ENTS   904, 949   99, 183, 468   0. 009124   1, 747, 572   15, 945   73. 00   0. 003330   ENDOSCOPY   70, 788   18, 531, 370   0. 037816   21, 560   815   76. 00   0. 003330   ENDOSCOPY   70, 788   18, 531, 370   0. 037816   21, 560   815   76. 00   0. 000000   0   0. 000000   0   0							
57. 00   05700   CT SCAN   518, 101   66, 104, 005   0. 007838   341, 868   2, 680   57. 00   5800   MAGNETI C RESONANCE I MAGI NG (MRI )   1, 029, 567   22, 439, 431   0. 045882   97, 932   4, 493   58. 0   05900   CARDI AC CATHETERI ZATI ON   24, 643   1, 152, 710   0. 021378   0   0. 59. 00   05900   CARDI AC CATHETERI ZATI ON   24, 643   1, 152, 710   0. 021378   0   0. 59. 00   05900   CARDI AC CATHETERI ZATI ON   24, 643   1, 152, 710   0. 021378   0   0. 59. 00   05900   CARDI AC CATHETERI ZATI ON   24, 643   1, 152, 710   0. 021378   0   0. 003867   1, 521, 488   5, 884   60. 00   06400   INTRAVENOUS THERAPY   195, 422   1, 393, 708   0. 140217   24, 591   3, 448   64. 00   06400   PHYSI CAL THERAPY   600, 162   27, 498, 815   0. 021825   1, 232, 411   26, 897   65. 00   06500   RESPI RATORY THERAPY   75, 071   6, 930, 547   0. 010832   153, 744   1, 665   67. 00   06700   0CCUPATI ONAL THERAPY   75, 071   6, 930, 547   0. 010832   153, 744   1, 665   67. 00   06900   ELECTROCARDI OLOGY   34, 953   7, 971, 107   0. 004385   122, 072   535   69. 00   06900   ELECTROCARDI OLOGY   34, 953   7, 971, 107   0. 004385   122, 072   535   69. 00   07000   ELECTROCARDI OLOGY   34, 953   7, 971, 107   0. 004385   122, 072   535   69. 00   07000   ELECTROCARDI OLOGY   34, 953   7, 971, 803   0. 007440   727, 831   5, 415   71. 07100   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   591, 576   79, 517, 803   0. 007440   727, 831   5, 415   71. 07100   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   904, 949   99, 183, 468   0. 009124   1, 747, 572   15, 945   73. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   28, 859   2, 925, 252   0. 009865   17, 570   173   74. 076, 00   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000							
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1,029,567 22,439,431 0.045882 97,932 4,493 58.0   59. 00 05900 CARDIAC CATHETERIZATION 24,643 1,152,710 0.021378 0 0 59.0   60. 00 06000 LABORATORY 409,215 105,819,013 0.003867 1,521,488 5,884 60.0   60. 00 06400 INTRAVENOUS THERAPY 195,422 1,393,708 0.140217 24,591 3,448   64. 00 06500 RESPIRATORY THERAPY 600,162 27,498,815 0.021825 1,232,411 26,897 65.0   66. 00 06600 PHYSICAL THERAPY 266,033 25,947,880 0.010253 65,639 673 66.0   67. 00 06700 OCCUPATIONAL THERAPY 75,071 6,930,547 0.010832 153,744 1,665 67.0   68. 00 06800 SPEECH PATHOLOGY 14,386 2,030,866 0.007084 67,117 475 68.0   69. 00 06900 ELECTROCARDIOLOGY 34,953 7,971,107 0.004385 122,072 535 69.0   70. 00 07000 ELECTROCARDIOLOGY 34,953 11,959,981 0.019802 22,049 437 70.0   71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 591,576 79,517,803 0.007440 727,831 5,415 71.0   72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 591,576 79,517,803 0.007440 727,831 5,415 71.0   73. 00 07300 DRUGS CHARGED TO PATIENTS 904,949 99,183,468 0.009124 1,747,572 15,945 73.0   74. 00 07300 DRUGS CHARGED TO PATIENTS 904,949 99,183,468 0.009124 1,747,572 15,945 73.0   75. 00 03301 ENDOSCOPY 700,788 18,531,370 0.037816 21,560 815 76.0   03955 BREAST DIAGNOSTIC CENTER 578,769 54,554,929 0.010609 0 0 76.0   00100 DUTPATIENT SERVICE COST CENTER 221,285 11,066,146 0.019997 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		•		1			
59. 00   05900   CARDI AC CATHETERI ZATI ON   24, 643   1, 152, 710   0. 021378   0   0   59. 06   06   06   06000   LABORATORY   409, 215   105, 819, 013   0. 003867   1, 521, 488   5, 884   60. 06   06   06   06   06   06   06							
60. 00   06000   LABORATORY   409, 215   105, 819, 013   0.003867   1, 521, 488   5, 884   60. 00   60. 00   1NTRAVENOUS THERAPY   195, 422   1, 393, 708   0.140217   24, 591   3, 448   64. 00   65. 00   06500   RESPI RATORY THERAPY   600, 162   27, 498, 815   0.021825   1, 232, 411   26, 897   65. 00   06600   PHYSI CAL THERAPY   266, 033   25, 947, 880   0.010253   65, 639   673   66. 00   06700   0CCUPATI ONAL THERAPY   75, 071   6, 930, 547   0.010832   153, 744   1, 665   67. 00   06900   SPEECH PATHOLOGY   14, 386   2, 030, 866   0.007084   67, 117   475   68. 00   06900   ELECTROCARDI OLOGY   34, 953   7, 971, 107   0.004385   122, 072   535   69. 00   07000   ELECTROENCEPHALOGRAPHY   236, 833   11, 959, 981   0.019802   22, 049   437   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   591, 576   79, 517, 803   0.007440   727, 831   5, 415   71. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   904, 949   99, 183, 468   0.009124   1, 747, 572   15, 945   73. 00   07300   DRUGS CHARGED TO PATI ENTS   904, 949   99, 183, 468   0.009124   1, 747, 572   15, 945   73. 00   07400   RENAL DI ALYSIS   28, 859   2, 925, 252   0.009865   17, 570   173   74. 00   07400   RENAL DI ALYSIS   28, 859   2, 925, 252   0.009865   17, 570   173   74. 00   07400   RENAL DI ALYSIS   28, 859   2, 925, 252   0.009865   17, 570   173   74. 00   07400   07				l .			
64. 00 06400   INTRAVENOUS THERAPY		•				1	
65. 00 06500 RESPI RATORY THERAPY 600, 162 27, 498, 815 0. 021825 1, 232, 411 26, 897 65. 06 06 00 06600 PHYSI CAL THERAPY 266, 033 25, 947, 880 0. 010253 65, 639 673 66. 07 06 07 00 0CCUPATI ONAL THERAPY 75, 071 6, 930, 547 0. 010832 153, 744 1, 665 67. 07 08 06800 SPEECH PATHOLOGY 14, 386 2, 030, 866 0. 007084 67, 117 475 68. 07 06900 ELECTROCARDI OLOGY 34, 953 7, 971, 107 0. 004385 122, 072 535 69. 07 0. 00 07000 ELECTROENCEPHALOGRAPHY 236, 833 11, 959, 981 0. 019802 22, 049 437 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 591, 576 79, 517, 803 0. 007440 727, 831 5, 415 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 464, 819 40, 121, 910 0. 011585 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 904, 949 99, 183, 468 0. 009124 1, 747, 572 15, 945 73. 00 07300 DRUGS CHARGED TO PATI ENTS 904, 949 99, 183, 468 0. 009124 1, 747, 572 15, 945 73. 00 07400 RENAL DI ALYSI S 28, 859 2, 925, 252 0. 009865 17, 570 173 74. 00 07400 RENAL DI ALYSI S 28, 859 2, 925, 252 0. 009865 17, 570 173 74. 00 07400 RENAL DI ALYSI S 28, 859 2, 925, 252 0. 009865 17, 570 173 74. 00 07400 RENAL DI ALYSI S 28, 859 2, 925, 252 0. 009865 17, 570 173 74. 00 07400 RENAL DI ALYSI S 28, 859 2, 925, 252 0. 009865 17, 570 173 74. 00 07400 RENAL DI ALYSI S 28, 859 2, 925, 252 0. 009865 17, 570 173 74. 00 07400 RENAL DI ALYSI S 28, 859 2, 925, 252 0. 009865 17, 570 173 74. 00 07400 RENAL DI ALYSI S 28, 859 2, 925, 252 0. 009865 17, 570 0. 00 07400 RENAL DI ALYSI S 28, 859 2, 925, 252 0. 009865 17, 570 0. 00 07400 RENAL DI ALYSI S 28, 859 2, 925, 252 0. 009865 17, 570 0. 00 07400 RENAL DI ALYSI S 28, 859 2, 925, 252 0. 009865 17, 570 0. 00 07400 RENAL DI ALYSI S 28, 859 2, 925, 252 0. 009865 17, 570 0. 00 07400 RENAL DI ALYSI S 28, 859 2, 925, 252 0. 009865 17, 570 0. 00 07400 RENAL DI ALYSI S 28, 859 2, 925, 252 0. 009865 17, 570 0. 00 07400 RENAL DI ALYSI S 28, 859 2, 925, 252 0. 009865 17, 570 0. 00 07400 RENAL DI ALYSI S 28, 859 2, 925, 252 0. 009865 17, 570 0. 00 07400 RENAL DI ALYSI S 28, 859 2, 925, 252 0. 009865 17, 570 0. 00 00							
66. 00 06600 PHYSI CAL THERAPY 266, 033 25, 947, 880 0. 010253 65, 639 673 66. 0670 06700 0CCUPATI ONAL THERAPY 75, 071 6, 930, 547 0. 010832 153, 744 1, 665 67. 068. 00 06800 SPEECH PATHOLOGY 14, 386 2, 030, 866 0. 007084 67, 117 475 68. 069. 00 06900 ELECTROCARDI OLOGY 34, 953 7, 971, 107 0. 004385 122, 072 535 69. 070. 00 07000 ELECTROCEPHALOGRAPHY 236, 833 11, 959, 981 0. 019802 22, 049 437 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 591, 576 79, 517, 803 0. 007440 727, 831 5, 415 71. 072. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 464, 819 40, 121, 910 0. 011585 0 0 72. 073. 00 07300 DRUGS CHARGED TO PATI ENTS 904, 949 99, 183, 468 0. 009124 1, 747, 572 15, 945 73. 074. 00 07400 RENAL DI ALYSI S 28, 859 2, 925, 252 0. 009865 17, 570 173 74. 075. 00 03330 ENDOSCOPY 700, 788 18, 531, 370 0. 037816 21, 560 815 76. 00 03955 BREAST DI AGNOSTIC CENTER 221, 285 11, 066, 146 0. 019997 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		•					
67. 00		•					
68. 00							
69. 00					-		1
70. 00   07000   ELECTROENCEPHALOGRAPHY   236, 833   11, 959, 981   0. 019802   22, 049   437   70. 071. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   591, 576   79, 517, 803   0. 007440   727, 831   5, 415   71. 072. 00   07200   MPL. DEV. CHARGED TO PATI ENTS   464, 819   40, 121, 910   0. 011585   0   0   72. 073. 00   07300   DRUGS CHARGED TO PATI ENTS   904, 949   99, 183, 468   0. 009124   1, 747, 572   15, 945   73. 00   07400   RENAL DI ALYSI S   28, 859   2, 925, 252   0. 009865   17, 570   173   74. 00   07400   RENAL DI ALYSI S   28, 859   2, 925, 252   0. 009865   17, 570   173   74. 00   03330   ENDOSCOPY   700, 788   18, 531, 370   0. 037816   21, 560   815   76. 07   03955   BREAST DI AGNOSTI C CENTER   578, 769   54, 554, 929   0. 010609   0   0   0   0   0   0   0   0   0							
71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   591, 576   79, 517, 803   0.007440   727, 831   5, 415   71. 00   07200   MPL. DEV. CHARGED TO PATI ENTS   464, 819   40, 121, 910   0.011585   0   0   72. 00   07300   DRUGS CHARGED TO PATI ENTS   904, 949   99, 183, 468   0.009124   1, 747, 572   15, 945   73. 00   07400   RENAL DI ALYSI S   28, 859   2, 925, 252   0.009865   17, 570   173   74. 00   76. 00   0.03330   ENDOSCOPY   700, 788   18, 531, 370   0.037816   21, 560   815   76. 00   0.03954   IMAGI NG CENTER   578, 769   54, 554, 929   0.010609   0   0   76. 00   0.000000   0   0   0   0   0   0		•					
72. 00		•					
73. 00   07300   DRUGS CHARGED TO PATIENTS   904, 949   99, 183, 468   0.009124   1, 747, 572   15, 945   73. 00   74. 00   07400   RENAL DI ALYSI S   28, 859   2, 925, 252   0.009865   17, 570   173   74. 00   76. 00   0.03330   ENDOSCOPY   700, 788   18, 531, 370   0.037816   21, 560   815   76. 00   0.03951   IMAGI NG CENTER   578, 769   54, 554, 929   0.010609   0   0   0   76. 00   0.00000   0.000001   0.000001   0.0000000   0.0000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000						5, 415	
74. 00   07400   RENAL DI ALYSI S   28, 859   2, 925, 252   0.009865   17, 570   173   74. 075   76. 00   03330   ENDOSCOPY   700, 788   18, 531, 370   0.037816   21, 560   815   76. 075   76. 06   03954   IMAGI NG CENTER   578, 769   54, 554, 929   0.010609   0   0   0   0   0   0   0   0   0		•					
76. 00							
76. 06 03954 I MAGI NG CENTER 578, 769 54, 554, 929 0. 010609 0 0 76. 07 03955 BREAST DI AGNOSTI C CENTER 221, 285 11, 066, 146 0. 019997 0 0 76. 07 00 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0							
76. 07 03955 BREAST DI AGNOSTI C CENTER 221, 285 11, 066, 146 0.019997 0 0 0 76. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						815	
OUTPATIENT SERVICE COST CENTERS           90. 00         09000 CLINIC         0         0.000000         0         0.000000         0         0.000000           90. 26         04975 SPI NE CENTER         11, 304         760, 924         0.014856         0         0         0         90. 2           91. 00         09100 EMERGENCY         1, 206, 764         141, 957, 638         0.008501         417, 607         3, 550         91. 0           92. 00         09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)         1, 093, 113         11, 386, 483         0.096001         136, 994         13, 152         92. 0	76. 06   03954   I MAGI NG CENTER	578, 769	54, 554, 929			0	76. 06
90. 00   09000   CLI NI C   0   0   0   0   000000   0   0   90. 0   9		221, 285	11, 066, 146	0. 01999	7 0	0	76. 07
90. 26   04975   SPI NE CENTER							
91. 00   09100   EMERGENCY		_	_			0	
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   1,093,113   11,386,483   0.096001   136,994   13,152   92.0							90. 26
		1, 206, 764	141, 957, 638	0.00850			
200. 00   Total (Lines 50-199)   15, 881, 381   1, 006, 605, 092   8, 879, 278   152, 078   200. 0				1			
	200.00   Total (lines 50-199)	15, 881, 381	1, 006, 605, 092		8, 879, 278	152, 078	200. 00

Health Financial Systems COMM	MUNITY HOSPITAL	OF INDIANA, IN	NC.	In Li∈	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provider C		Period: From 01/01/2016 To 12/31/2016		pared: 4 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Cost	All Other Medical Education Cos		Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS 31. 00   03100   NTENSI VE CARE UNI T	0	0		0 0	0	
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	O		0	0	35. 00
40. 00   04000   SUBPROVI DER - 1 PF	0	0		0 0	0	40.00
43. 00   04300   NURSERY	0	0		0	0	43.00
200.00 Total (lines 30-199)	0	0		0	0	200.00
Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	9		
				Pass-Through Cost (col. 7 x		
	6.00	7. 00	8. 00	col . 8) 9.00		
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00		
30. 00 03000 ADULTS & PEDIATRICS	60, 894	0.00	2, 09	8 0		30.00
31. 00 03100 I NTENSI VE CARE UNIT	5, 460			0 0		31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	11, 195	0.00	4	6 0		35. 00
40. 00   04000   SUBPROVI DER - 1 PF	2, 501	0.00		0 0		40. 00
43. 00   04300   NURSERY	7, 426	0.00	3, 31	4 0		43.00
200.00   Total (lines 30-199)	87, 476		5, 45	8 0	ĺ	200. 00

Heal th Financial Systems COMMUNITY HOSPITAL OF APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS | Period: | Worksheet D | From 01/01/2016 | Part IV | To | 12/31/2016 | Date/Time Prepared: Provider CCN: 15-0169 THROUGH COSTS

					To 12/31/2016	Date/Time Pre 5/30/2017 8:5	
				e XIX	Hospi tal	PPS	
Со	st Center Description	Non Physician N	ursing School	Allied Health		Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost		
						4)	
	NV 050VI 05 000T 05VT500	1.00	2. 00	3. 00	4. 00	5. 00	
	RY SERVICE COST CENTERS						F0 00
	PERATI NG ROOM	0	0		0	0	50.00
	COVERY ROOM	0	0		0	0	51.00
1 1	LIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
	DI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
	DI OLOGY-THERAPEUTI C	0	0		0	0	55. 00
57. 00 05700 CT		0	0		0	0	57. 00
1 1	GNETIC RESONANCE IMAGING (MRI)	0	0		0	0	58. 00
	RDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
60. 00 06000 LA		0	0		0	0	60.00
1 1	TRAVENOUS THERAPY	0	0		0	0	64. 00
	SPI RATORY THERAPY	0	0		0	0	65. 00
	IYSI CAL THERAPY	0	0		0	0	66. 00
	CUPATIONAL THERAPY	0	0		0	0	67. 00
	PEECH PATHOLOGY	0	0		0	0	68. 00
	ECTROCARDI OLOGY	0	0		0	0	69. 00
	ECTROENCEPHALOGRAPHY	0	0		0	0	70. 00
	DICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
	IPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
	RUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
1 1	NAL DIALYSIS	0	0		0	0	74. 00
76. 00   03330 EN		0	0		0	0	76. 00
	IAGING CENTER	0	0		0	0	76. 06
	REAST DIAGNOSTIC CENTER	0	0		0	0	76. 07
	ENT SERVICE COST CENTERS						
90. 00 09000 CL		0	0		0	0	90. 00
	PINE CENTER	0	0		0	0	90. 26
91.00 09100 EM		0	0		0	0	91. 00
1 1	SERVATION BEDS (NON-DISTINCT PART)	0	0		0	0	92.00
200. 00 To	tal (lines 50-199)	0	0		0	0	200. 00

Hoalth F	Financial Systems COMM	UNITY HOSPITAL	OF INDIANA II	NC.	Inlie	u of Form CMS-2	2552_10
	ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER				Peri od:	Worksheet D	2332-10
THROUGH		VICE UTILK FAS.	3 Flovidei C		From 01/01/2016	Part IV	
TTIKOOGIT	00313				Γο 12/31/2016	Date/Time Pre 5/30/2017 8:5	pared:
						5/30/2017 8: 5	4 am
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total		Ratio of Cost		I npati ent	
		Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of		(col. 5 ÷ col.		Charges	
		col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4) 6. 00	7. 00	0.00	7) 9. 00	10.00	
ΙΔ	NCILLARY SERVICE COST CENTERS	6.00	7.00	8.00	9.00	10. 00	
	D5000 OPERATING ROOM	0	154, 942, 430	0. 00000	0.000000	1, 145, 454	50.00
	D5100 RECOVERY ROOM	0		1		156, 909	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	21, 486, 482			362, 359	
	05400 RADI OLOGY-DI AGNOSTI C	0	37, 480, 031			337, 140	
	05500 RADI OLOGY-THERAPEUTI C	0	23, 993, 734			159, 371	55.00
	05700 CT SCAN	0	66, 104, 005			341, 868	
	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0	22, 439, 431			97, 932	
	05900 CARDI AC CATHETERI ZATI ON	0	1, 152, 710			77, 732	59.00
	06000 LABORATORY	0	105, 819, 013			1, 521, 488	
	06400 I NTRAVENOUS THERAPY	0	1, 393, 708			24, 591	64.00
	06500 RESPI RATORY THERAPY	0	27, 498, 815			1, 232, 411	65. 00
	06600 PHYSI CAL THERAPY	0	25, 947, 880			65, 639	66.00
	06700 OCCUPATI ONAL THERAPY	0	6, 930, 547			153, 744	67. 00
	06800 SPEECH PATHOLOGY	0	2, 030, 866			67, 117	68.00
	06900 ELECTROCARDI OLOGY	0	7, 971, 107			122, 072	69.00
	07000 ELECTROENCEPHALOGRAPHY	o o				22, 049	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	79, 517, 803			727, 831	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	40, 121, 910			0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	99, 183, 468			1, 747, 572	73. 00
	07400 RENAL DIALYSIS	0	2, 925, 252			17, 570	74. 00
	03330 ENDOSCOPY	0	18, 531, 370			21, 560	1
76.06 0	03954 I MAGING CENTER	0	54, 554, 929	0. 00000	0. 000000	0	76. 06
76. 07 0	03955 BREAST DIAGNOSTIC CENTER	0	11, 066, 146	0. 00000	0. 000000	0	76. 07
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>					
90.00 0	09000 CLI NI C	0	C	0.00000	0.000000	0	90.00
90. 26 0	04975 SPI NE CENTER	0	760, 924	0.00000	0. 000000	0	90. 26
91.00 0	09100 EMERGENCY	0	141, 957, 638	0. 00000	0. 000000	417, 607	91.00
92.00 0	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	11, 386, 483	0. 00000	0. 000000	136, 994	92. 00
200.00	Total (lines 50-199)	0				8, 879, 278	200. 00
·			•	•	•		

THROUGH COSTS

Title XIX							5/30/2017 8:5	4 am
Program   Pass-Through   Costs (col   8 x col   10)   20 x col   12 x col			Ti tl	e XIX	H	lospi tal	PPS	
Pass-Through Costs (cot 9 x col 1 10)	Cost Center Description	I npati ent	Outpati ent	Outpati ent				
Costs (col. 8   x col. 10)   x col. 12			Program					
X COI . 10)   X COI . 12)   X COI . 12)   X COI . 12			Charges					
NACILLARY SERVICE COST CENTERS					9			
ANCILLARY SERVICE COST CENTERS								
50. 00   05000   OPERATI NG ROOM   0   0   0   0   0   51. 00		11. 00	12. 00	13. 00				
51. 00   05100   RECOVERY ROOM   0   0   0   0   0   52. 00   52. 00   05200   DELI VERY ROOM & LABOR ROOM   0   0   0   0   0   52. 00   54. 00   05400   RADI OLOGY-DI AGNOSTI C   0   0   0   0   0   55. 00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0   0   55. 00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0   57. 00   05700   CT SCAN   0   0   0   0   0   58. 00   05800   MAGNETI C RESONANCE   IMAGI NG (MRI )   0   0   0   0   59. 00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   0   60. 00   06000   LABORATORY   0   0   0   0   61. 00   06000   LABORATORY   0   0   0   0   62. 00   06400   NTRAVENOUS THERAPY   0   0   0   0   63. 00   06600   PHYSI CAL THERAPY   0   0   0   0   64. 00   06600   PHYSI CAL THERAPY   0   0   0   0   65. 00   06600   PHYSI CAL THERAPY   0   0   0   0   66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   67. 00   06700   OCCUPATI ONAL THERAPY   0   0   0   0   68. 00   06900   ELECTROCARDI OLOGY   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   74. 00   07400   RENAL DI ALYSIS   0   0   0   76. 06   03954   IMAGI NG CENTER   0   0   0   76. 06   03954   IMAGI NG CENTER   0   0   0   76. 06   03955   BREAST DI AGNOSTIC CENTER   0   0   0   79. 00   09000   CLIVIT CENTER   0   0   0   79. 00   09000   CLIVIT CENTER   0   0   0   79. 00   09000   00   00   00   79. 00   09000   00   00   00   79. 00   09000   00   00   00   79. 00   09000   00   00   00   79. 00   09000   00   00   00   79. 00   09000   00   00   00   79. 00   09000   00   00   00   79. 00   09000   00   00   00   79. 00   09000   00   00   00   79. 00   09000   00   00   00   79. 00   09000   00   00   79. 00   09000   00   00   00   79. 00   09000   00   00   00   79. 00   09000   00   00   79. 00   09000   00   00   79. 00   09000   00   00								
52. 00   05200   DELI VERY ROOM & LABOR ROOM   0   0   0   54. 00   54. 00   05400   RADI OLOGY-DI AGNOSTI C   0   0   0   0   55. 00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0   57. 00   05700   CT SCAN   0   0   0   0   58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   0   0   0   59. 00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   60. 00   06900   CARDI AC CATHETERI ZATI ON   0   0   0   60. 00   06000   LABORATORY   0   0   0   0   64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   65. 00   06500   RESPI RATORY THERAPY   0   0   0   0   66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   67. 00   06700   OCCUPATI ONAL THERAPY   0   0   0   68. 00   06800   SPEECH PATHOLOGY   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   71. 00   07000   ELECTROCARDI OLOGY   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   71. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   72. 00   07200   IRPL. DEV. CHARGED TO PATI ENTS   0   0   0   74. 00   07300   ROUS CHARGED TO PATI ENTS   0   0   0   75. 00   03395   IMAGI NC CENTER   0   0   0   76. 00   03395   RERAST DI AGNOSTI C CENTER   0   0   0   79. 00   09000   CLINI C   0   0   79. 20   09000   DERGENCY   0   0   79. 20   09000   DOSCOPY   0   0   79. 20   09000   DOSCOPY   0   0   79. 20   09000   DERGENCY   0   0   79. 20   09000   DERGENCY   0   0   79. 20   09000   DOSCOPY   0   0   79. 20   09000   DERGENCY   0		0	0	)	0			
54. 00		0	0	)	0			
55. 00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0   0   0   0   0   0	52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	1	0			52. 00
57. 00   05700   CT SCAN   0   0   0   0   0   58. 00   580. 00   MAGNETI C RESONANCE IMAGING (MRI)   0   0   0   0   0   58. 00   59. 00   05900   CARDIA C CATHETERI ZATI ON   0   0   0   0   0   0   0   0   0		0	0	1	0			
58. 00   05800   MAGNETIC RESONANCE IMAGING (MRI)   0   0   0   0   59. 00   59. 00   05900   CARDIJAC CATHETERIZATION   0   0   0   0   60. 00   06000   LABORATORY   0   0   0   0   64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   65. 00   06500   RESPI RATORY THERAPY   0   0   0   0   66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   67. 00   06700   OCCUPATI ONAL THERAPY   0   0   0   0   68. 00   06900   SPEECH PATHOLOGY   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   70. 00   07000   ELECTROCARDI OLOGY   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   74. 00   07400   RENAL DI ALYSIS   0   0   0   76. 00   03393   ENDOSCOPY   0   0   0   76. 00   03954   IMAGING CENTER   0   0   0   76. 00   03955   BREAST DI AGNOSTIC CENTER   0   0   90. 00   09100   CLINIC   0   0   90. 26   04975   SPI NE CENTER   0   0   0   90. 26   04975   SPI NE CENTER   0   0   0   90. 26   04975   SPI NE CENTER   0   0   0   91. 00   09100   DRERGENCY   0   0   0   92. 00   09200   OSSERVATI ON BEDS (NON-DISTINCT PART)   0   0   0   92. 00   09200   OSSERVATI ON BEDS (NON-DISTINCT PART)   0   0   0   92. 00   09200   OSSERVATI ON BEDS (NON-DISTINCT PART)   0   0   0   92. 00   09200   OSSERVATION BEDS (NON-DISTINCT PART)   0   0   0   92. 00   09200   OSSERVATION BEDS (NON-DISTINCT PART)   0   0   0   92. 00   09200   OSSERVATION BEDS (NON-DISTINCT PART)   0   0   0   92. 00   09200   OSSERVATION BEDS (NON-DISTINCT PART)   0   0   0   92. 00   09200   OSSERVATION BEDS (NON-DISTINCT PART)   0   0   0   92. 00   09200   OSSERVATION BEDS (NON-DISTINCT PART)   0   0   0   92. 00   09200   OSSERVATION BEDS (NON-DISTINCT PART)   0   0   0   92. 00   09200   OSSERVATION BEDS (NON-DISTINCT PART)   0   0   0   92. 00   09200   OSSERVATION BEDS (NON-DISTINCT PART)   0   0   0   92. 00   09200   OSSERVATION BEDS (NON-DISTINCT PART)   0   0   0   93. 00   09200   OS	55. 00   05500   RADI OLOGY-THERAPEUTI C	0	0		0			55. 00
59. 00 05900 CARDIAC CATHETERIZATION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	57. 00   05700   CT   SCAN	0	0	)	0			57. 00
60. 00 06000 LABORATORY 0 0 0 0 0 64. 00 64. 00 64. 00 1NTRAVENOUS THERAPY 0 0 0 0 0 64. 00 65. 00 66. 00 6	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	)	0			58. 00
64. 00	59. 00   05900 CARDI AC CATHETERI ZATI ON	0	0	)	0			59. 00
65. 00	60. 00   06000   LABORATORY	0	0	)	0			60.00
66. 00	64. 00 06400 I NTRAVENOUS THERAPY	0	0	)	0			64. 00
67. 00	65. 00 06500 RESPIRATORY THERAPY	0	0	)	0			65. 00
68. 00	66. 00 06600 PHYSI CAL THERAPY	O	0	1	0			66. 00
69. 00	67. 00 06700 OCCUPATI ONAL THERAPY	O	O	1	0			67. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 7000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 71.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 72.00 G7200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 73.00 GRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 GRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 GRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 GRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 GRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73.00 GRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 74.00 GRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 74.00 GRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 74.00 GRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	68. 00 06800 SPEECH PATHOLOGY	O	0	)	0			68. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 7000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 71.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 72.00 G7200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 73.00 GRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 GRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 GRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 GRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 GRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73.00 GRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 74.00 GRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 74.00 GRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 74.00 GRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	69. 00 06900 ELECTROCARDI OLOGY	o	0	)	0			69. 00
72. 00		o	0	)	0			70.00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   73. 00   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   0   0   0   0   0	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0	)	0			71.00
74. 00 07400 RENAL DIALYSIS 0 0 0 0 76.00 76. 00 03330 ENDOSCOPY 0 0 0 0 76. 00 76. 06 03954 I MAGING CENTER 0 0 0 0 76. 06 76. 07 03955 BREAST DIAGNOSTIC CENTER 0 0 0 0 76. 07  OUTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC 0 0 0 90. 00 90. 26 04975 SPINE CENTER 0 0 0 0 90. 26 91. 00 09100 EMERGENCY 0 0 0 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 9. 20	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	)	0			72. 00
74. 00 07400 RENAL DIALYSIS 0 0 0 0 76.00 76. 00 03330 ENDOSCOPY 0 0 0 0 76. 00 76. 06 03954 I MAGING CENTER 0 0 0 0 76. 06 76. 07 03955 BREAST DIAGNOSTIC CENTER 0 0 0 0 76. 07  OUTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC 0 0 0 90. 00 90. 26 04975 SPINE CENTER 0 0 0 0 90. 26 91. 00 09100 EMERGENCY 0 0 0 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 9. 20	73.00 07300 DRUGS CHARGED TO PATIENTS	l ol	0	)	0			73. 00
76. 00 03330 ENDOSCOPY 0 0 0 0 76. 00 76. 06 03954 I MAGI NG CENTER 0 0 0 0 76. 06 76. 07 03955 BREAST DI AGNOSTI C CENTER 0 0 0 0 0 76. 07  OUTPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 0 0 0 90. 26 90. 26 04975 SPI NE CENTER 0 0 0 0 90. 26 91. 00 09100 EMERGENCY 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 9. 20		o	0	)	0			74. 00
76. 06 03954 I MAGI NG CENTER 0 0 0 0 76. 06 76. 07 03955 BREAST DI AGNOSTI C CENTER 0 0 0 0 76. 07  OUTPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 0 0 0 90. 00		l ol	0	)	0			76. 00
76. 07 03955 BREAST DIAGNOSTIC CENTER 0 0 0 0 76. 07 0UTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC 0 0 0 90. 00 90. 26 04975 SPINE CENTER 0 0 0 0 0 90. 26 91. 00 09100 EMERGENCY 0 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92. 00		o	0	,	0			1
OUTPATIENT SERVICE COST CENTERS   90.00   0   0   0   0   0   0   0   0   0		o	0	,	0			76, 07
90. 00   09000   CLI NI C   0   0   0   90. 00   90. 26   91. 00   09100   EMERGENCY   0   0   0   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   0   0   0   0   92. 00   09200		1						
90. 26   04975   SPI NE CENTER   0 0 0 0 91.00   91.00   92.00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   0 0 0 0 92.00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		O	C		0			90.00
91. 00   09100   EMERGENCY   0   0   0   0   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   92. 00			0	,[	0			
92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   0   0   0   92. 00			0	,[	0			
			0	,[	0			
			0		0			

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0169 Peri od: Worksheet D From 01/01/2016 Part V 12/31/2016 Date/Time Prepared: 5/30/2017 8:54 am Title XIX Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 133321 562, 514 0 50.00 51.00 05100 RECOVERY ROOM 0.178077 0 47, 470 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0.609418 52 00 0 52 00 O 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 0. 222386 0 589, 701 0 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 122589 44, 974 0 55.00 57.00 05700 CT SCAN 0.038113 0 730, 514 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0.175951 132, 501 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.021238 0 59.00 06000 LABORATORY 60.00 0.104378 0 972, 473 0 60.00 06400 I NTRAVENOUS THERAPY 0 777517 0 64 00 0 64 00 C 65.00 06500 RESPIRATORY THERAPY 0. 221932 70, 931 0 65.00 06600 PHYSI CAL THERAPY 0. 247162 57, 277 0 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 0. 265989 27, 612 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 0.175519 29, 185 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.114356 0 22, 403 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0. 207285 37, 481 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 213318 0 197, 480 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72 00 0.382846 C 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 262562 366, 801 0 73.00 07400 RENAL DIALYSIS 0 74.00 74.00 0.429315 0 03330 ENDOSCOPY 76.00 0.185451 0 109, 291 0 76.00 03954 I MAGING CENTER Ω 76.06 0.094295 200, 229 Ω 76.06 03955 BREAST DIAGNOSTIC CENTER 76.07 0.558482 0 27, 645 0 76.07 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 0.000000 0 0 04975 SPINE CENTER 90. 26 0.408591 0 0 0 90. 26 91.00 09100 EMERGENCY 0.104097 3, 623, 565 0 0 0 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.882216 0 411, 820 0 92.00 200.00 Subtotal (see instructions) Λ 200. 00 8, 261, 867 0 Less PBP Clinic Lab. Services-Program 201.00 0 201.00 Only Charges 202.00 Net Charges (line 200 +/- line 201) 8, 261, 867 0 0 202. 00

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0169 Peri od: Worksheet D From 01/01/2016 Part V 12/31/2016 Date/Time Prepared: 5/30/2017 8:54 am Title XIX Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 74, 995 0 50.00 51.00 05100 RECOVERY ROOM 8, 453 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 131, 141 0 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 5, 513 55.00 57.00 05700 CT SCAN 27.842 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 23, 314 58.00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 06000 LABORATORY 0 60.00 101, 505 60.00 06400 I NTRAVENOUS THERAPY 0 64 00 64 00 65.00 06500 RESPIRATORY THERAPY 15, 742 0 65.00 66.00 06600 PHYSI CAL THERAPY 14, 157 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 7,344 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 5, 123 68.00 69.00 06900 ELECTROCARDI OLOGY 2,562 0 69.00 07000 ELECTROENCEPHALOGRAPHY 7,769 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 42, 126 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 96, 308 0 73.00 74.00 07400 RENAL DIALYSIS 0 0 74.00 03330 ENDOSCOPY 0 76.00 20.268 76.00 03954 I MAGING CENTER 76.06 18, 881 0 76.06 76. 07 03955 BREAST DIAGNOSTIC CENTER 15, 439 0 76.07 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 0 0 04975 SPINE CENTER 90. 26 0 0 90. 26 91.00 09100 EMERGENCY 377, 202 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 363, 314 92.00 200.00 Subtotal (see instructions) 1, 358, 998 0 200. 00 Less PBP Clinic Lab. Services-Program 201.00 201. 00 Only Charges

1, 358, 998

0

202.00

202.00

Net Charges (line 200 +/- line 201)

Health Financial Systems	COMMUNITY HOSPITAL OF	I NDI ANA,	I NC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der	CCN: 15-0169	Peri od: From 01/01/2016	Worksheet D-1	
					Date/Time Pre 5/30/2017 8:5	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description						
					4 00	

		Title XVIII	Hospi tal	5/30/2017 8: 5 PPS	4 am		
	Cost Center Description			1.00			
	PART I - ALL PROVIDER COMPONENTS			1.00			
	I NPATI ENT DAYS						
1. 00 2. 00	Inpatient days (including private room days and swing-bed days	60, 894 60, 894	1. 00 2. 00				
3.00							
	do not complete this line.	,-, , , ,			3. 00		
4.00	Semi-private room days (excluding swing-bed and observation be		04 0 11	53, 157	4. 00		
5.00	Total swing-bed SNF type inpatient days (including private rooreporting period	om days) through December	r 31 or the cost	0	5. 00		
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December 3	31 of the cost	0	6. 00		
	reporting period (if calendar year, enter 0 on this line)						
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	m days) through December	31 of the cost	0	7. 00		
8.00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00		
	reporting period (if calendar year, enter 0 on this line)						
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	19, 005	9. 00		
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom days)	0	10. 00		
	through December 31 of the cost reporting period (see instruc-		som days)	, and the second	10.00		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11. 00		
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00		
12.00	through December 31 of the cost reporting period	Comy (Therading private	c room days)		12.00		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00		
14. 00	after December 31 of the cost reporting period (if calendar you Medically necessary private room days applicable to the Progra			0	14. 00		
15. 00	Total nursery days (title V or XIX only)	diii (excrudring swring-bed t	uays)	0	15. 00		
16. 00	Nursery days (title V or XIX only)	0	16. 00				
	SWING BED ADJUSTMENT						
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost	0.00	17. 00		
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00		
	reporting period						
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	0. 00	19. 00				
20. 00	Medicald rate for swing-bed NF services applicable to services	0.00	20. 00				
	reporting period						
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		ng poriod (line	79, 061, 842 0	21. 00 22. 00		
22.00	5 x line 17)	si 31 of the cost reporti	riig perrou (Triie	0	22.00		
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00		
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	s 21 of the cost reportion	ng poriod (lino	0	24. 00		
24.00	7 x line 19)	31 of the cost reportin	ig perrod (Trile	0	24.00		
25. 00	Swing-bed cost applicable to NF type services after December :	31 of the cost reporting	period (line 8	0	25. 00		
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00		
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		79, 061, 842			
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	,		, ,			
	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)		28. 00		
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00		
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000			
32.00	Average private room per diem charge (line 29 ÷ line 3)			0. 00			
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	aug line 22) (eee inctrue	ti ana)	0.00			
34. 00 35. 00	Average per diem private room charge differential (line 32 mil Average per diem private room cost differential (line 34 x li		LI UIIS)	0. 00 0. 00	34. 00 35. 00		
36. 00	Private room cost differential adjustment (line 3 x line 35)	:= = '/		0.00	36. 00		
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	79, 061, 842	37. 00		
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY						
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS					
38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 298. 35	38. 00		
39.00	Program general inpatient routine service cost (line 9 x line			24, 675, 142	39.00		
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39			0 24, 675, 142	40.00		
41.00	Trotal Trogram general impatrent routine service cost (IIIIe 39	11116 40)		24,075,142	41.00		

		UNITY HOSPITAL (				u of Form CMS-:	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0169	Peri od: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Pre 5/30/2017 8:5	pared:
			Ti tl e	e XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	0	C	0. (	00 0		42. 00
	Intensive Care Type Inpatient Hospital Units						1
43. 00	INTENSIVE CARE UNIT	10, 845, 852	5, 460	1, 986.	42 2, 134	4, 239, 020	1
44.00	CORONARY CARE UNIT						44.00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46.00	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	15, 496, 204	11, 195	1, 384. :	21 0	0	46. 00 47. 00
47.00	Cost Center Description	15, 490, 204	11, 190	1, 304.	21  0	U	47.00
	oost content beschiptron					1.00	
48. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3,	line 200)			32, 655, 341	48. 00
	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS	<u> </u>		•		61, 569, 503	
50. 00	Pass through costs applicable to Program inpa	atient routine s	services (from	n Wkst. D, sur	m of Parts I and	3, 319, 272	50.00
51. 00	<pre>III) Pass through costs applicable to Program inpa and IV)</pre>	atient ancillary	/ services (fr	rom Wkst. D, s	sum of Parts II	2, 283, 437	51. 00
52. 00	Total Program excludable cost (sum of lines!	50 and 51)				5, 602, 709	52.00
53. 00	Total Program inpatient operating cost exclude		ated, non-phy	sician anesth	netist, and	55, 966, 794	
	medical education costs (line 49 minus line!						
	TARGET AMOUNT AND LIMIT COMPUTATION						4
54. 00	Program di scharges					0	
55.00	Target amount per discharge					0.00	1
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	0					
58. 00	Bonus payment (see instructions)	0					
59. 00	Lesser of lines 53/54 or 55 from the cost re		1				
	market basket						
60.00	Lesser of lines 53/54 or 55 from prior year	46	0.00	1			
61. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					0	61.00
	amount (line 56), otherwise enter zero (see i		S (TITIES 54 X	00), 01 1% 01	the target		
62.00	Relief payment (see instructions)					0	62. 00
	Allowable Inpatient cost plus incentive payme	ent (see instruc	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	nber 31 of the	e cost reporti	ng period (See	0	64. 00
/F 00	instructions)(title XVIII only)		04 6 11				/F 00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decembe	er 31 of the c	cost reportino	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	64 plus line 6	55)(title XVII	I only). For	0	66. 00
	CAH (see instructions)					_	
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 c	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient (	coutine costs (1	ine 67 ± line	. 68)		0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER NU						07.00
70.00	Skilled nursing facility/other nursing facili	ty/ICF/IID rout	ine service d	cost (line 37)	)		70. 00
71. 00	Adjusted general inpatient routine service co		ne 70 ÷ line	2)			71. 00
72.00	Program routine service cost (line 9 x line		/II	05)			72. 00
73.00	Medically necessary private room cost application of the program general inpatient routine services.						73.00
74. 00 75. 00	Capital-related cost allocated to inpatient	•			Part II column		74. 00 75. 00
, 5. 00	26, line 45)	Satisfic Service	COSES (TIOIL V	IOI KOINGEL D, I	art II, Corumii		73.00
76. 00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line						77. 00
78. 00	Inpatient routine service cost (line 74 minus						78. 00
79. 00	Aggregate charges to beneficiaries for excess			•			79. 00
80.00	Total Program routine service costs for compa		ost limitation	n (line 78 mir	nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi						81. 00 82. 00
82. 00 83. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (						82.00
JJ. UU	mode on a bit of the control of the	,,,, in the creation of the	- /			i	

Utilization review - physician compensation (see instructions)
Total Program inpatient operating costs (sum of lines 83 through 85)
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)
89.00 Observation bed cost (line 87 x line 88) (see instructions) 7, 737 87.00 1, 298. 35 88. 00 10, 045, 334 89. 00

84.00

85. 00

86.00

85.00

86.00

84.00 Program inpatient ancillary services (see instructions)

Health Financial Systems COMM	MUNITY HOSPITAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2016	Worksheet D-1	
				To 12/31/2016	Date/Time Prep 5/30/2017 8:5	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	8, 603, 329	79, 061, 842	0. 10881	8 10, 045, 334	1, 093, 113	90.00
91.00 Nursing School cost	0	79, 061, 842	0.00000	0 10, 045, 334	0	91.00
92.00 Allied health cost	0	79, 061, 842	0.00000	0 10, 045, 334	0	92.00
93.00 All other Medical Education	0	79, 061, 842	0. 00000	0 10, 045, 334	0	93. 00

Health Financial Systems	COMMUNITY HOSPITAL OF INDIANA, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0169	Peri od: From 01/01/2016	Worksheet D-1
	Component CCN: 15-S169	To 12/31/2016	Date/Time Prepared: 5/30/2017 8:54 am
	Title XVIII	Subprovi der -	PPS

		litie xviii	Subprovider -	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			2, 501	1. 00
2.00	Inpatient days (including private room days, excluding swing-			2, 501	2. 00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pr	rivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		2, 501	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	5. 00
	reporting period			_	
6. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
,, 00	reporting period	dayo, t oag becombe.	0. 0. 1 0001	· ·	7.00
8.00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	a the Dragram (avaludina	, owing bod and	1, 868	9. 00
9.00	newborn days)	o the Program (excruding	g Swifig-bed and	1,000	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	room days)	0	10. 00
	through December 31 of the cost reporting period (see instruc			_	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en		room days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI		re room days)	0	12. 00
	through December 31 of the cost reporting period	3 .			
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar you Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	am (exertaining swring bea	uays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWING BED ADJUSTMENT		6.11	2.22	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 d	or the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
40.00	reporting period		40.00		
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	0.00	19. 00		
20.00	Medicaid rate for swing-bed NF services applicable to services	0.00	20. 00		
04.00	reporting period	0.740.505	04 00		
21. 00 22. 00	Total general inpatient routine service cost (see instruction: Swing-bed cost applicable to SNF type services through December		ing period (line	2, 749, 585 0	
22.00	5 x line 17)	ci 31 di the cost report	ing period (ine	O	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23. 00
24. 00	X line 18)	r 21 of the cost reporti	ng poriod (line	0	24. 00
24.00	Swing-bed cost applicable to NF type services through December   7 x line 19)	i 31 of the cost reporti	ng perrod (Trile	U	24.00
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00
27.00	x line 20)			0	27.00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 2, 749, 585	26. 00 27. 00
27.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	(1116 21116 11116 20)		2/11/1000	27.00
	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)		28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)			0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	· lino 29)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	÷ 111le 20)		0. 000000	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	
34.00	Average per diem private room charge differential (line 32 min	nus line 33)(see instrud	ctions)	0.00	34. 00
35.00	Average per diem private room cost differential (line 34 x line	ne 31)		0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	fferential (line	0 2, 749, 585	36. 00 37. 00	
37.00	27 minus line 36)	ana private room cost di	Traientiai (TINE	2, 147, 505	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		<u>'</u>		
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 000 00	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 099. 39 2, 053, 661	
40. 00	Medically necessary private room cost applicable to the Program			2, 053, 001	
	Total Program general inpatient routine service cost (line 39			2, 053, 661	

	Financial Systems COMM ATION OF INPATIENT OPERATING COST	UNI TY HOSPI TAL		NC. CN: 15-0169	In Lie	eu of Form CMS-2 Worksheet D-1		
COMI OT	ATTOM OF THE ATTEM OF ENATING GOST			CCN: 15-S169	From 01/01/2016 To 12/31/2016	Date/Time Pre	pared:	
			Ti tl e	e XVIII	Subprovi der -	5/30/2017 8: 5 PPS	4 am	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
10.00	Indiana de la companya del companya de la companya del companya de la companya de	1.00	2.00	3.00	4.00	5. 00	10.00	
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0.	00 0	0	42.00	
43.00	INTENSIVE CARE UNIT	0	C	0.	00 0	0	43.00	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00	
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00	
47. 00	NEONATAL INTENSIVE CARE UNIT   Cost Center Description	0		0.	00 0	0	47. 00	
	·					1. 00		
48. 00 49. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines			ons)		247, 154 2, 300, 815	1	
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sui	m of Parts I and	197, 653	50.00	
51. 00	III) Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D,	sum of Parts II	13, 888	51.00	
52. 00	and IV) Total Program excludable cost (sum of lines!		- · · · · · · · · · · · · · · · · · · ·	•		211, 541		
53. 00	Total Program inpatient operating cost excluded medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	ding capital re	lated, non-phy	vsician anesti	hetist, and	2, 089, 274		
54. 00	Program di scharges					0	54. 00	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00	
57. 00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0		
58.00	58.00 Bonus payment (see instructions)							
59.00	59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket							
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target							60. 00 61. 00	
62. 00	0	62. 00						
63. 00	l	63. 00						
PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See							64. 00	
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the d	cost reportin	g period (See	0	65. 00	
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	55)(title XVI	II only). For	0	66. 00	
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 d	of the cost r	eporting period	0	67. 00	
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost rep	orting period	0	68. 00	
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	•				0	69. 00	
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili				)		70. 00	
71. 00	Adjusted general inpatient routine service co	ost per diem (I					71.00	
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)	,	(line 14 x li	ne 35)			72.00	
74.00	Total Program general inpatient routine servi	ce costs (line	72 + line 73)				74.00	
75. 00	Capital-related cost allocated to inpatient (26, line 45)	routine service	costs (from V	Norksheet B, I	Part II, column		75. 00	
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line	. *					76. 00 77. 00	
78.00	Inpatient routine service cost (line 74 minus						78. 00	
79. 00 80. 00	Aggregate charges to beneficiaries for excess				nue lino 70)		79. 00 80. 00	
80.00	Total Program routine service costs for compa Inpatient routine service cost per diem limi		ost iimitätiör	. (ιιι⊮ /Ծ MII	ius IIIle /9)		80.00	
82.00	Inpatient routine service cost limitation (li	ne 9 x line 81	* .				82.00	
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		S)				83.00	
85. 00	Utilization review - physician compensation		ns)				85. 00	
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00	
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					0	87. 00	
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			0.00	88. 00	
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89.00	

Health Financial Systems COMM	MUNITY HOSPITAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
		Component (		From 01/01/2016 To 12/31/2016		
		Title	XVIII	Subprovi der -	PPS	
				IPF		
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	264, 636	2, 749, 585	0. 09624	6 0	0	90. 00
91.00 Nursing School cost	0	2, 749, 585	0.00000	0	0	91. 00
92.00 Allied health cost	0	2, 749, 585	0.00000	0	0	92.00
93.00 All other Medical Education	0	2, 749, 585	0. 00000	0 0	0	93. 00

Health Financial Systems	COMMUNITY HOSPITAL OF	INDIANA, I	NC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider 0	CCN: 15-0169	Peri od: From 01/01/2016	Worksheet D-1	
				To 12/31/2016	Date/Time Pre 5/30/2017 8:5	pared: 4 am
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description						
					1. 00	
PART I _ ALL PROVIDER COMPONENTS						

		Title XIX	Hospi tal	PPS	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			60, 894	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-l Private room days (excluding swing-bed and observation bed day		vate room days	60, 894 0	2. 00 3. 00
0.00	do not complete this line.	,e, yeu nave em y p	lato i com dayo,		0.00
4.00	Semi-private room days (excluding swing-bed and observation be			53, 157	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roof reporting period	om days) through December	31 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December 3	1 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private roor reporting period	n days) through December :	31 of the cost	0	7. 00
8.00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 31	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days)	o the Program (excluding s	swing-bed and	2, 098	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instructions)		om days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, etc.)	nly (including private ro	om days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI: through December 31 of the cost reporting period		room days)	0	12. 00
13. 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. 00
14.00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)				15.00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			3, 314	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	the cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of t	ne cost	0.00	18. 00
19. 00	Medical d rate for swing-bed NF services applicable to services reporting period	0. 00	19. 00		
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of the	e cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions			79, 061, 842	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)	·		0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December $\mathbf{x}$ line 18)			0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	·		0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December (x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 79, 061, 842	26. 00 27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation had observed	rnes)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed char	ges)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33)(see instructi	ons)	0. 00 0. 00	33. 00 34. 00
35. 00	Average per diem private room cost differential (line 34 x li		0113)	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost dif	ferential (line	79, 061, 842	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1, 298. 35	38. 00
38.00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 298. 35 2, 723, 938	38.00
40. 00	Medically necessary private room cost applicable to the Progra			0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		2, 723, 938	41. 00

Heal th	Financial Systems COMM	IUNITY HOSPITAL	OF INDIANA II	NC.	In lie	eu of Form CMS-:	2552-10	
	ATION OF INPATIENT OPERATING COST	BIN IT HOSTITAL		CN: 15-0169	Period: From 01/01/2016	Worksheet D-1		
					To 12/31/2016			
			Ti tI	e XIX	Hospi tal	PPS	4 аш	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost		
		Inpatient Cost	Inpatient Days		÷	(col. 3 x col.		
		1.00		col . 2)		4)		
42.00	NUDCEDY (+; +l o V o VIV only)	1.00	2.00	3.00	4.00	5.00	12.00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	5, 962, 762	7, 426	0 802. 9	6 3, 314	2, 661, 009	42. 00	
43. 00	INTENSIVE CARE UNIT	10, 845, 852	5, 460	1, 986. 4	2 0	0	43. 00	
44. 00	CORONARY CARE UNIT	10,010,002	0, 100	1, 700. 1			44. 00	
45.00	BURN INTENSIVE CARE UNIT						45. 00	
46.00	SURGICAL INTENSIVE CARE UNIT						46. 00	
47. 00	NEONATAL INTENSIVE CARE UNIT	15, 496, 204	11, 195	1, 384. 2	1 46	63, 674	47. 00	
	Cost Center Description					1.00		
49.00	Program inpatient ancillary service cost (Wk	c+ D 2 col 2	line 200)			1. 00 1, 855, 100	48. 00	
48. 00 49. 00	Total Program inpatient costs (sum of lines			ns)		7, 303, 721	1	
47.00	PASS THROUGH COST ADJUSTMENTS	41 till odgir 40) (	see mstructro	) is j		7, 303, 721	47.00	
50.00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sum	of Parts I and	647, 549	50. 00	
51. 00	  Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	152, 078	51.00	
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				799, 627	52. 00	
53.00	Total Program inpatient operating cost exclu		lated, non-phy	sician anesth	etist, and	6, 504, 094	53. 00	
	medical education costs (line 49 minus line	52)						
E 4 00	TARGET AMOUNT AND LIMIT COMPUTATION						F.4.00	
54.00	Program di scharges					0.00		
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	1	
57. 00	, , , , , , , , , , , , , , , , , , ,							
58. 00								
59. 00	59.00 Lesser of Lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the							
	market basket							
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	1	
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less tha					0	61.00	
	amount (line 56), otherwise enter zero (see		S (TITIES 34 X	00), 01 1% 01	the target			
62. 00	Relief payment (see instructions)	111311 4011 0113)				0	62. 00	
63.00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0		
	PROGRAM INPATIENT ROUTINE SWING BED COST							
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost reporti	ng period (See	0	64. 00	
<b>(</b> F 00	instructions)(title XVIII only)	+£+ D	21 -6 +6				/F 00	
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 or the c	cost reporting	period (See	0	65. 00	
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	I only). For	0	66. 00	
	CAH (see instructions)			, (				
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31 c	of the cost re	porting period	0	67. 00	
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repo	rting period	0	68. 00	
	(line 13 x line 20)			•	0.			
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00	
70.00	PART III - SKILLED NURSING FACILITY, OTHER NI						70.00	
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service o	•		, ,			70.00	
72. 00	Program routine service cost (line 9 x line		THE 70 + TIME	2)			72.00	
73. 00	Medically necessary private room cost applications		(line 14 x li	ne 35)			73. 00	
74. 00	Total Program general inpatient routine serv						74. 00	
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from W	Vorksheet B, P	art II, column		75. 00	
	26, line 45)							
76. 00	Per diem capital-related costs (line 75 ÷ li	,					76. 00	
77. 00	Program capital -related costs (line 9 x line						77. 00	
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovi don rocoss	le)			78. 00 79. 00	
80.00	Total Program routine service costs for comp.				us line 79)		80.00	
81. 00	Inpatient routine service cost per diem limi			. (			81.00	
82. 00	Inpatient routine service cost limitation (		)				82. 00	
83 00	Reasonable inpatient routine service costs (	saa instruction	ie)			I	83.00	

83.00

84.00 85. 00

84.00

85.00

83.00 Reasonable inpatient routine service costs (see instructions)

Health Financial Systems COMM	MUNITY HOSPITAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016	Date/Time Prep 5/30/2017 8:54	
		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	8, 603, 329	79, 061, 842	0. 10881	10, 045, 334	1, 093, 113	90.00
91.00 Nursing School cost	0	79, 061, 842	0.00000	10, 045, 334	0	91.00
92.00 Allied health cost	0	79, 061, 842	0.00000	10, 045, 334	0	92.00
93.00 All other Medical Education	0	79, 061, 842	0.00000	10, 045, 334	0	93. 00

Health Financial Systems	COMMUNITY HOSPITAL OF INDIAN	NA, INC.	In Lieu	ı of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi	der CCN: 15-0169	Peri od: From 01/01/2016	Worksheet D-3

INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	rovi der C	CN: 15-0169	Peri od:	Worksheet D-3	
				From 01/01/2016 To 12/31/2016	Date/Time Pre	nared·
				10 12/01/2010	5/30/2017 8:5	4 am
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
	[		1.00	2. 00	3. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	22.224.244		
	03000 ADULTS & PEDI ATRI CS			33, 006, 266		30.00
31. 00	03100 I NTENSI VE CARE UNI T			7, 847, 206		31.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT			0		35. 00
40.00	04000 SUBPROVI DER - I PF			0		40. 00
43. 00	04300 NURSERY					43. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS  05000 OPERATI NG ROOM		0 1222	21 40 707 221	F 420 002	F0 00
50.00			0. 1333		5, 438, 993	
51.00	05100 RECOVERY ROOM		0. 1780		l	
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 6094		0	52. 00
54.00	05400 RADI OLOGY -DI AGNOSTI C		0. 2223			
55.00	05500 RADI OLOGY-THERAPEUTI C		0. 1225			ı
57. 00	05700 CT SCAN		0. 0381			1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 1759			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 0212			59. 00
60.00	06000 LABORATORY		0. 1043			1
64. 00	06400 I NTRAVENOUS THERAPY		0. 7775	· ·		64.00
65.00	06500 RESPI RATORY THERAPY		0. 2219			1
66. 00	06600 PHYSI CAL THERAPY		0. 2471			1
67. 00	06700 OCCUPATIONAL THERAPY		0. 2659			1
68. 00	06800 SPEECH PATHOLOGY		0. 1755			1
69. 00	06900 ELECTROCARDI OLOGY		0. 1143			69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY		0. 2072			
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2133			
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 3828	· · ·		
	07300 DRUGS CHARGED TO PATIENTS		0. 2625	· · ·		
74.00	07400 RENAL DI ALYSI S		0. 4293		697, 588	1
76. 00	03330 ENDOSCOPY		0. 1854			1
76. 06	03954 I MAGI NG CENTER		0. 0942			
76. 07	03955 BREAST DI AGNOSTI C CENTER		0. 5584	82 423	236	76. 07
00.00	OUTPATIENT SERVICE COST CENTERS		0.0000	20		00.00
90.00	09000 CLINIC		0.0000			90.00
	04975 SPI NE CENTER		0. 4085		0	90. 26
91. 00	09100 EMERGENCY		0. 1040			1
	09200 OBSERVATI ON BEDS (NON-DISTINCT PART)		0. 8822			
200.00				175, 775, 632	1	1
201.00		iine 61)		0	l	201. 00
202.00	Net Charges (line 200 minus line 201)			175, 775, 632		202. 00

Health Financial Systems COMMUNITY HOSPITAL	OE INDIANA I	NC	In Lie	u of Form CMS-:	2552 10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0169	Peri od:	Worksheet D-3	
		CCN: 15-S169	From 01/01/2016 To 12/31/2016		pared:
	Title	e XVIII	Subprovi der -	PPS	T GIII
Cost Center Description		Ratio of Cos To Charges	_	Inpatient Program Costs (col. 1 x col. 2) 3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	3.00	
30. 00   03000   ADULTS & PEDI ATRI CS			0		30.00
31. 00   03100   I NTENSI VE CARE UNI T			o o		31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT			0		35.00
40. 00   04000   SUBPROVI DER - 1 PF			3, 763, 986		40.00
43. 00   04300   NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS					
50. 00   05000   OPERATI NG ROOM		0. 13332		0	
51. 00   05100   RECOVERY ROOM		0. 17807		0	
52. 00   O5200   DELIVERY ROOM & LABOR ROOM		0. 6094		0	
54. 00   05400   RADI OLOGY - DI AGNOSTI C		0. 22238			
55. 00   05500   RADI OLOGY-THERAPEUTI C 57. 00   05700   CT   SCAN		0. 12258 0. 0381		0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 0381		1, 604 580	
59. 00   05900 CARDI AC CATHETERI ZATI ON		0. 02123		0	
60. 00   06000   LABORATORY		0. 10437			
64. 00   06400   INTRAVENOUS THERAPY		0. 7775			
65. 00 06500 RESPIRATORY THERAPY		0. 22193		3, 982	
66. 00 06600 PHYSI CAL THERAPY		0. 24716		17, 638	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 26598	49, 850	13, 260	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 1755	7, 243	1, 271	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 11435	9, 416	1, 077	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 20728		2, 100	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 21331		3, 933	
72. 00 O7200 I MPL. DEV. CHARGED TO PATIENTS		0. 38284		0	
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 26256		'	
74. 00   07400   RENAL DI ALYSI S		0. 42931		0	
76. 00   03330   ENDOSCOPY		0. 18545		0	
76.06   03954   IMAGING CENTER 76.07   03955   BREAST DIAGNOSTIC CENTER		0. 09429 0. 55848		-	
OUTPATIENT SERVICE COST CENTERS		0. 55640	JZ <sub>1</sub> 0		/0.0/
90. 00 09000 CLINI C		0.00000	00	0	90.00
90. 26   04975   SPI NE CENTER		0. 40859		0	
91. 00   09100   EMERGENCY		0. 10409		16, 649	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 88221			92. 00
200 00 Total (sum of Lines 50-94 and 96-98)		1	1 325 846		

159, 941 9, 079 1, 325, 846

1, 325, 846

16, 649 91. 00 8, 010 92. 00 247, 154 200. 00

201. 00 202. 00

200.00

201.00 202.00 Total (sum of lines 50-94 and 96-98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net Charges (line 200 minus line 201)

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

Health Financial Systems	COMMUNITY HOSPITAL OF	INDIANA, II	NC.	In Li€	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C	CN: 15-0169	Peri od:	Worksheet D-3	
				From 01/01/2016 To 12/31/2016	Doto/Timo Dro	narod:
				To 12/31/2016	Date/Time Pre 5/30/2017 8:5	pareu: 4 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description			Ratio of Cos		Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			1.00	2. 00	3.00	
30. 00   03000   ADULTS & PEDIATRICS			1	2, 683, 711		30.00
31. 00 03100 I NTENSI VE CARE UNI T				663, 948		31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT				9, 681, 862		35. 00
40. 00   04000   SUBPROVI DER - I PF				7,001,002		40. 00
43. 00   04300   NURSERY				404, 502		43. 00
ANCI LLARY SERVI CE COST CENTERS				10.7.00	l	
50. 00 05000 OPERATING ROOM			0. 1333	21 1, 145, 454	152, 713	50.00
51.00   05100   RECOVERY ROOM			0. 1780	77 156, 909	27, 942	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM			0.6094	18 362, 359	220, 828	52. 00
54. 00   05400 RADI OLOGY-DI AGNOSTI C			0. 2223	86 337, 140	74, 975	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C			0. 1225	89 159, 371	19, 537	55. 00
57. 00 05700 CT SCAN			0. 0381	13 341, 868	13, 030	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)			0. 1759	51 97, 932	17, 231	58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON			0. 0212	38 0	0	59. 00
60. 00   06000   LABORATORY			0. 1043	78 1, 521, 488	158, 810	60.00
64.00 06400 INTRAVENOUS THERAPY			0. 7775	17 24, 591	19, 120	64.00
65. 00 06500 RESPIRATORY THERAPY			0. 2219	32 1, 232, 411	273, 511	65. 00
66. 00 06600 PHYSI CAL THERAPY			0. 2471	62 65, 639	16, 223	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY			0. 2659	89 153, 744	40, 894	67. 00
68.00 06800 SPEECH PATHOLOGY			0. 1755	19 67, 117	11, 780	68. 00
69. 00 06900 ELECTROCARDI OLOGY			0. 1143	56 122, 072	13, 960	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY			0. 2072		4, 570	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN	TS		0. 2133	18 727, 831	155, 259	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 3828		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 2625	62 1, 747, 572	458, 846	73.00
74.00   07400   RENAL DIALYSIS			0. 4293	15 17, 570	7, 543	74.00
76. 00   03330   ENDOSCOPY			0. 1854	51 21, 560	3, 998	76. 00
76.06 03954 I MAGING CENTER			0.0942	95 0	0	76. 06
76. 07 03955 BREAST DIAGNOSTIC CENTER			0. 5584	82 0	0	76. 07
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000   CLI NI C			0.0000		0	90.00
90. 26   04975   SPI NE CENTER			0. 4085		0	90. 26
91. 00   09100   EMERGENCY			0. 1040			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	,		0. 8822			
200.00 Total (sum of lines 50-94 and 96-9				8, 879, 278	1, 855, 100	1
201.00 Less PBP Clinic Laboratory Service		(line 61)		0		201. 00
202.00   Net Charges (line 200 minus line 2	01)			8, 879, 278		202. 00

Health Financial Systems	COMMUNITY HOSPITAL OF	INDIANA, INC.	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared:

			10 12/31/2016	Date/IIme Pre    5/30/2017 8:5	
	Title XVIII Hospital			PPS	
				1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				1 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurri instructions)	0 31, 109, 519	1. 00 1. 01		
1.02	DRG amounts other than outlier payments for discharges occurriinstructions)	ng on or after October	1 (see	9, 637, 475	1. 02
1.03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	or discharges occurring	orior to October	0	1. 03
1.04	DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	or discharges occurring	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			1, 287, 452	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructi	ons)		0	2. 02
3.00	Managed Care Simulated Payments	(113)		13, 669, 013	3.00
4. 00	Bed days available divided by number of days in the cost report Indirect Medical Education Adjustment	rting period (see instru	ctions)	269. 94	4. 00
5.00	FTE count for allopathic and osteopathic programs for the most 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 which meet if for new programs in accordance with 42 CFR 413.79(e)	the criteria for an add-	on to the cap	0.00	6. 00
7.00	MMA Section 422 reduction amount to the IME cap as specified ι	- ,		0.00	7. 00
7. 01	ACA Section 5503 reduction amount to the IME cap as specified If the cost report straddles July 1, 2011 then see instruction	ns.		0. 00	
8. 00	Adjustment (increase or decrease) to the FTE count for alloparaffiliated programs in accordance with 42 CFR 413.75(b), 413.71998), and 67 FR 50069 (August 1, 2002).			2. 95	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If				8. 01
8. 02	the cost report straddles July 1, 2011, see instructions.  The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see linstructions)				9. 00
10. 00 11. 00	FTE count for allopathic and osteopathic programs in the curre FTE count for residents in dental and podiatric programs.	ent year from your recor	ds	2. 22 2. 16	
	Current year allowable FTE (see instructions)				12.00
	Total allowable FTE count for the prior year.			2. 52	•
14. 00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ar ended on or after Sep	tember 30, 1997,	0. 87	
15. 00	Sum of lines 12 through 14 divided by 3.			2 59	15. 00
16. 00	Adjustment for residents in initial years of the program				16.00
17. 00	Adjustment for residents displaced by program or hospital clos	sure			17. 00
18.00	Adjusted rolling average FTE count			2. 59	18. 00
	Current year resident to bed ratio (line 18 divided by line 4)	).		0.009595	19. 00
20.00	Prior year resident to bed ratio (see instructions)			0.005730	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.005730	21. 00
22.00	IME payment adjustment (see instructions)			127, 457	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			42, 757	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for Secti Number of additional allopathic and osteopathic IME FTE reside	on 422 of the MMA ent cap slots under 42 Se	ec. 412.105	0.00	23. 00
	(f)(1)(iv)(C).				
24.00	IME FTE Resident Count Over Cap (see instructions)			-0. 73	1
25. 00	If the amount on line 24 is greater than -0-, then enter the linstructions)	lower of line 23 or line	24 (see	0.00	25. 00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26. 00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27. 00
28.00	IME add-on adjustment amount (see instructions)				28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)	)		0	28. 01
29. 00 29. 01	Total IME payment ( sum of lines 22 and 28)				29. 00 29. 01
-	Disproportionate Share Adjustment			42, 757	1
30.00	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	tions)	3. 12	30.00
	Percentage of Medicaid patient days (see instructions)		- /	26. 39	1
	, , , , , , , , , , , , , , , , , , , ,			29. 51	•
	Allowable disproportionate share percentage (see instructions)	)		13. 56	•
	Disproportionate share adjustment (see instructions)	•		1, 381, 324	
5 00	12. 2p. 2p. 1. 5.14 to 5.14. 5 day as this it (500 1115 ti dott 6115)		I	., 551, 524	

Health Financial Systems COMMUNI	TY HOSPITAL OF IN	IDI ANA, INC.	In Lie	u of Form CMS-2	2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pi	rovider CCN: 15-0169	Peri od: From 01/01/2016	Worksheet E Part A		
			To 12/31/2016	Date/Time Pre		
		Title XVIII	Hospi tal	5/30/2017 8: 5 PPS	4 am	
		THE AVITT	Prior to 10/1			
			1. 00	2. 00		
Uncompensated Care Adjustment	`		/ 40/ 445 504	E 077 400 447	05.00	
35.00 Total uncompensated care amount (see instruction 35.01 Factor 3 (see instructions)	ns)		6, 406, 145, 534 0. 000483842	5, 977, 483, 147	35. 00 35. 01	
35.01 Factor 3 (see instructions) 35.02 Hospital uncompensated care payment (If line 34)	Als zoro ontor	zoro on this line)	3, 099, 562	0. 000471897 2, 820, 755	35. 01 35. 02	
(see instructions)	4 IS Zei O, eiitei	zero on this rine)	3, 044, 302	2, 820, 733	33.02	
35.03 Pro rata share of the hospital uncompensated car	re payment amount	(see instructions)	2, 320, 437	710, 985	35. 03	
36.00 Total uncompensated care (sum of columns 1 and 2			3, 031, 422		36. 00	
Additional payment for high percentage of ESRD b						
40.00 Total Medicare discharges on Worksheet S-3, Part	t I excluding dis	charges for MS-DRGs	0		40. 00	
652, 682, 683, 684 and 685 (see instructions) 41.00 Total ESRD Medicare discharges excluding MS-DRGs	s 652 682 683	684 an 685 (see	0		41. 00	
instructions)	3 032, 002, 003,	004 an 005. (See	0		41.00	
41.01 Total ESRD Medicare covered and paid discharges	excluding MS-DRG	s 652, 682, 683, 684	1 0		41. 01	
an 685. (see instructions)						
3.00 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see 0					43. 00	
instructions) 44.00 Ratio of average length of stay to one week (lir	no 12 dividad by	lino 41 divided by 7	0. 000000		44. 00	
days)	ne 43 di vi ded by	Title 41 divided by 7	0.00000		44.00	
45.00 Average weekly cost for dialysis treatments (see	e instructions)		0.00		45.00	
46.00 Total additional payment (line 45 times line 44		)	0		46. 00	
47.00 Subtotal (see instructions)			46, 574, 649		47.00	
48.00 Hospital specific payments (to be completed by S	SCH and MDH, smal	l rural hospitals	0		48. 00	
only. (see instructions)				A		
				Amount 1.00		
49.00 Total payment for inpatient operating costs (see	e instructions)			46, 617, 406	49. 00	
50.00 Payment for inpatient program capital (from Wkst	,	t. II, as applicable)	ı	3, 647, 054	50.00	
51.00 Exception payment for inpatient program capital	(Wkst. L, Pt. II	I, see instructions)		0	51.00	
52.00 Direct graduate medical education payment (from	Wkst. E-4, line	49 see instructions).		84, 025	52.00	
53.00 Nursing and Allied Health Managed Care payment				0	53.00	
54.00 Special add-on payments for new technologies				0	54. 00 54. 01	
' 3	54.01   Islet isolation add-on payment					
55.00 Net organ acquisition cost (Wkst. D-4 Pt. III, c		:>		0	55. 00	
56.00 Cost of physicians' services in a teaching hospi	•		hrough 2E)	0	56. 00 57. 00	
57.00 Routine service other pass through costs (from W 58.00 Ancillary service other pass through costs from			.iii ougii 33).	0	57.00	
59.00 Total (sum of amounts on lines 49 through 58)	mot. D, It. IV,	551. IT ITHE 200)		50, 348, 485	59. 00	
60.00 Primary payer payments				10, 580	60.00	
61.00 Total amount payable for program beneficiaries (	(line 59 minus li	ne 60)		50, 337, 905	61. 00	
62.00 Deductibles billed to program beneficiaries		•		4, 010, 784	62.00	
63.00 Coinsurance billed to program beneficiaries				117, 208	63. 00	
64.00 Allowable bad debts (see instructions)				256, 049	64. 00	

Health Financial Systems COMMUNITY HOSPITAL O				eu of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0169	Peri od:	Worksheet E	
			From 01/01/2016 To 12/31/2016		norod.
			To 12/31/2016	Date/Time Prep 5/30/2017 8:54	pareu: 4 am
	Ti tl e	e XVIII	Hospi tal	PPS	<del>T</del> GIII
			(уууу)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter i	in column O		0	0	70. 96
the corresponding federal year for the period prior to 10/1)					
70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter i	in column O		0	0	70. 97
the corresponding federal year for the period ending on or a					
70. 98 Low Volume Payment-3				0	70. 98
70.99 HAC adjustment amount (see instructions)				117, 467	70. 99
71.00 Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			46, 155, 659	71. 00
71.01   Sequestration adjustment (see instructions)				923, 113	71. 01
72.00 Interim payments				45, 640, 045	72.00
73.00 Tentative settlement (for contractor use only)				0	73. 00
74.00 Balance due provider (Program) (line 71 minus lines 71.01, 72	2, and 73)			-407, 499	74.00
75.00 Protested amounts (nonallowable cost report items) in accorda	ance with			7, 383, 208	75. 00
CMS Pub. 15-2, chapter 1, §115.2					
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see ins	structions)			0	90. 00
91.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00 Operating outlier reconciliation adjustment amount (see insti				0	92.00
93.00 Capital outlier reconciliation adjustment amount (see instruc	ctions)			0	93. 00
94.00 The rate used to calculate the time value of money (see insti				0.00	
95.00 Time value of money for operating expenses (see instructions)	)			0	95. 00
96.00 Time value of money for capital related expenses (see instruc	ctions)			0	96. 00
				On/After 10/1	
			1. 00	2.00	

	1.00	2. 00	
HSP Bonus Payment Amount			
100.00 HSP bonus amount (see instructions)	0	0	100. 00
HVBP Adjustment for HSP Bonus Payment			
101.00 HVBP adjustment factor (see instructions)	0. 0000000000	0.0000000000	101. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102. 00
HRR Adjustment for HSP Bonus Payment			
103.00 HRR adjustment factor (see instructions)	0. 0000	0.0000	103. 00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

Health Financial Systems	COMMUNITY HOSPITAL OF	I NDI ANA,	INC.		In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der	CCN:	15-0169	From 01/01/2016	Worksheet E Part B Date/Time Prepared: 5/30/2017 8:54 am

			To 12/31/2016	Date/Time Pre 5/30/2017 8:5		
		Title XVIII	Hospi tal	PPS		
				1 00		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00		
1.00	Medical and other services (see instructions)			42, 855	1. 00	
2.00	Medical and other services reimbursed under OPPS (see instructions)	ti ons)		14, 942, 574	2. 00	
3.00	PPS payments			12, 180, 833	3. 00	
4.00	Outlier payment (see instructions)			25, 378	4. 00	
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0. 000	5. 00	
6. 00 7. 00	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6			0 0. 00	6. 00 7. 00	
8. 00	Transitional corridor payment (see instructions)			0.00	8.00	
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV. col. 13. Line 200		0	9.00	
10.00	Organ acquisitions	,		0	10.00	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			42, 855	11. 00	
	COMPUTATION OF LESSER OF COST OR CHARGES					
12 00	Reasonable charges			163, 448	12 00	
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 60)		163, 448	13. 00	
14. 00	Total reasonable charges (sum of lines 12 and 13)	1116 07)		163, 448		
00	Customary charges			1007 110		
15. 00	Aggregate amount actually collected from patients liable for p			0	15. 00	
16. 00	Amounts that would have been realized from patients liable for	. 3	n a chargebasis	0	16. 00	
47.00	had such payment been made in accordance with 42 CFR §413.13(6	e)		0.000000	47.00	
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 163, 448	17. 00 18. 00	
19. 00	Excess of customary charges over reasonable cost (complete only	vifline 18 exceeds li	ne 11) (see	120, 593		
17.00	instructions)	Ty TT TTHE TO EXCECUS TT	110 11) (300	120, 070	17.00	
20.00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds li	ne 18) (see	0	20. 00	
04.00	instructions)	40.055	04 00			
21. 00 22. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see Interns and residents (see instructions)	e instructions)		42, 855 0	21. 00 22. 00	
23. 00	Cost of physicians' services in a teaching hospital (see insti	ructions)		0	23. 00	
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)	401.01.0)		12, 206, 211		
	COMPUTATION OF REIMBÜRSEMENT SETTLEMENT					
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0 2, 604, 976	25. 00 26. 00	
26. 00						
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)    instructions	orus the sum of fines 22	and 23] (See	9, 644, 090	27. 00	
28. 00	Direct graduate medical education payments (from Wkst. E-4, Li	ne 50)		19, 713	28. 00	
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00	
30. 00	Subtotal (sum of lines 27 through 29)			9, 663, 803	30.00	
31. 00	Primary payer payments			4, 853	31.00	
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE)	res)		9, 658, 950	32. 00	
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		0	33. 00	
34. 00	Allowable bad debts (see instructions)			255, 326	34. 00	
35.00	Adjusted reimbursable bad debts (see instructions)			165, 962	35. 00	
36.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		212, 405		
37. 00	Subtotal (see instructions)			9, 824, 912		
38. 00	MSP-LCC reconciliation amount from PS&R			366		
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	=)		0	39. 00 39. 50	
39. 98	Partial or full credits received from manufacturers for replace		tions)	0	39. 98	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	sed devices (see Thati de	(10113)	0	39. 99	
40.00	Subtotal (see instructions)			9, 824, 546	40.00	
40. 01	Sequestration adjustment (see instructions)			196, 491	40. 01	
41. 00	Interim payments	9, 654, 812	41.00			
42. 00	Tentative settlement (for contractors use only)	0 253	42. 00 43. 00			
43.00						
44. 00	Protested amounts (nonallowable cost report items) in accordar §115.2	ICE WI LII CINS PUD. 15-2,	chapter I,	0	44. 00	
	TO BE COMPLETED BY CONTRACTOR					
90.00	Original outlier amount (see instructions)			0	90. 00	
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00	
92.00	The rate used to calculate the Time Value of Money			0.00	92.00	
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93. 00 94. 00	
74.00	Tiotal (Sail of Fillos / Gila /o)		'	O	74.00	

Health Financial Systems	COMMUNITY HOSPITAL OF	INDIANA, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169	Peri od: From 01/01/2016	Worksheet E
		Component CCN: 15-S169		
		Title XVIII	Subprovi der -	PPS

			Title XVIII	Subprovi der - I PF	PPS	
PART B - MEDICAL AND OTHER MEALTH SERVICES   1.00   Medical and other services (as fear instructions)   1,906   1.00						
Medical and other services (see Instructions)		PART R - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
PS payments   460   0.00	1.00				1, 906	1. 00
Outlier payment (see instructions)		· ·	tions)			
Enter the fixespital specific payment to cost ratio (see instructions)   0.000   5.00   5.00   1.000   1.000   1.000   7.00   5.00   7.00   5.00   7.00   5.00   7.00   5.00   7.00   5.00   7.00   5.00   7.00		1 . 3				
1		, , ,	ctions)			
1   1   1   2   2   2   2   2   2   2						
9,00						
0.00   Organ acquisitions   0.10.00   10.00   1.906		, , , , , , , , , , , , , , , , , , , ,	V col 12 line 200			
1.00   Total cost (sum of lines 1 and 10) (see instructions)			v, cor. 13, 111le 200			
Reasonable charges   4,237   12.00   Acid lary service charges   4,237   12.00   Acid lary service charges   4,237   12.00   13.00   13.00   13.00   14.00   14.00   14.00   15.00						
12.00   Ancil ilary service charges   1.20						
13.00   Organ acquisition charges (from West. D-4, Pt. III., col. 4, line 69)   0   13.00   Customary charges   4,237   14.00   Customary charges   15.00   Agregate amount actually collected from patients liable for payment for services on a charge basis   0   15.00   Amounts that would have been realized from patients liable for payment for services on a chargebasis   0   15.00   Amounts that would have been realized from patients liable for payment for services on a chargebasis   0   15.00   16.00   1	12 00				4 237	12 00
14. 00   Total reasonable charges (sum of lines 12 and 13)   12. 00   15. 00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   15. 00   16. 0			ne 69)			
15.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   15.00					4, 237	
16.00   Amounts that would have been realized from patients   I iable for payment for services on a chargebasis   had such payment been made in accordance with 14.2 CFR \$413.13(e)   0.000000   17.00   Natio of line 15 to line 16 (not to exceed 1.000000)   17.00   Natio of line 15 to line 16 (not to exceed 1.000000)   17.00   Natio of line 15 to line 16 (not to exceed 1.000000)   17.00   Natio of line 15 to line 16 (not to exceed 1.000000)   17.00   Natio of line 15 to line 16 (not to exceed 1.000000)   17.00   National Payments   National	45.00			<u> </u>		45.00
had such payment been made in accordance with 42 CFR \$413.13(e)						
18.00   Total customary charges (see Instructions)   2,231   18.00	10.00	· ·	1 3	ir a chargebasi s	ı "I	10.00
19.00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)   20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)   1,900   20.00						
Instructions			v if lime 10 evecede liv	no 11) (ooo		
20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20.00	19.00		y if line 18 exceeds iii	ne II) (see	2, 331	19.00
21.00   Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)   0.22.00   22.00   Cost of physicians' services in a teaching hospital (see instructions)   0.23.00   23.00   Cost of physicians' services in a teaching hospital (see instructions)   0.23.00   23.00   24.00   25.00	20.00	1	y if line 11 exceeds lin	ne 18) (see	ol	20. 00
22.00   Interns and residents (see Instructions)   0   22.00   23.00   23.00   20.00		1				
23. 00   Cost of physicians' services in a teaching hospital (see instructions)   0   23. 00			e instructions)			
COMPUTATION OF RELIMBURSEMENT SETTLEMENT   Computation			ructions)			
25. 00   Deductibles and coinsurance (For CAH, see instructions)   0   25. 00   Deductibles and coinsurance relating to amount on line 24 (For CAH, see instructions)   0   26. 00   27.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   0   28. 00   29. 00   29. 00   ESR0 direct medical education payments (From Wkst. E-4, line 50)   0   29. 00	24.00		, 		460	24. 00
26. 00         Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)         0         26. 00           27. 00         Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)         2. 366         27. 00           28. 00         Direct graduate medical education payments (from Wkst. E-4, line 50)         0         29. 00           29. 00         ESRD direct medical education costs (from Wkst. E-4, line 36)         0         29. 00           31. 00         Primary payer payments         0         31. 00           31. 00         Subtotal (line 30 minus line 31)         2, 366         32. 00           32. 00         ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)         0         31. 00           33. 00         Allowable bad debts (see instructions)         0         34. 00           34. 00         Allowable bad debts (see instructions)         0         35. 00           35. 00         Allowable bad debts for dual eligible beneficiaries (see instructions)         0         36. 00           36. 00         MSP-LCC reconciliation amount from PS&R         0         38. 00           39. 00         MSP-LCC reconciliation mount from mulfacturers for replaced devices (see instructions)         0         39. 50           39. 99         Partial or full credits r	25 00					25 00
27. 00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   0   28. 00		1	CAH. see instructions)			
28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   28.00   29.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   0   29.00   30.00   Subtotal (sum of lines 27 through 29)   2,366   30.00   31.00   7   7   7   7   7   7   7   7   7		,		and 23] (see		
29, 00   ESRD direct medical education costs (from Wkst. E-4, line 36)   0   29, 00   30, 00   Subtotal (sum of lines 27 through 29)   2, 366   30, 00   31, 00   7 mary payer payments   0   31, 00   20, 00	00.00		50)			00.00
30. 00   Subtotal (sum of lines 27 through 29)   2, 366   30. 00   31. 00   Primary payer payments   0   31. 00   31. 00   32. 00   Subtotal (line 30 minus line 31)   2, 366   32. 00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   32. 00   Composite rate ESRD (from Wist. I -5, line 11)   0   33. 00   34. 00   Allowable bad debts (see instructions)   0   34. 00   35. 00   36. 00   Allowable bad debts (see instructions)   0   36. 00   37. 00   38. 00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   36. 00   37. 00   38. 00   MSP-LCC reconciliation amount from PS&R   0   38. 00   39.			ne 50)			
32.00   Subtotal (line 30 minus line 31)   2,366   32.00						
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33. 00   Composite rate ESRD (from Wkst. I -5, line 11)   0   34. 00   34. 00   31. 00   35. 00   34. 00   34. 00   34. 00   34. 00   35. 00   35. 00   Adjusted reimbursable bad debts (see instructions)   0   35. 00   36. 00   36. 00   37. 00   38. 00   38. 00   38. 00   38. 00   38. 00   38. 00   MSP-LCC reconciliation amount from PS&R   0   38. 00   39. 00   39. 00   39. 00   39. 00   39. 00   39. 50   39. 00   39. 50   39. 00   39. 50   39						
33. 00   Composite rate ESRD (from Wkst. I-5, line 11)	32. 00		`CC\		2, 366	32. 00
34.00	33. 00	Composite rate FSRD (from Wkst. I-5. line 11)	,E3)		0	33. 00
36.00						
37.00   Subtotal (see instructions)   2,366   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.00   Pioneer ACO demonstration payment adjustment (see instructions)   0   39.50   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   40.00   Subtotal (see instructions)   2,366   40.00   40.01   Sequestration adjustment (see instructions)   2,366   40.00   41.00   Interim payments   1,175   41.00   42.00   43.00   Balance due provider/program (see instructions)   1,144   43.00   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   1,144   43.00   44.00   Comparison   1,145   41.00   41.00   Comparison   1,145   41.00   Comparison   1,145   41.00   41.00   Comparison   1,145   41.00   Comparison   1,1						
38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.90 Pioneer ACO demonstration payment adjustment (see instructions) 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Og 39.00 39.00 39.00 Og 39.00		, ,	ructions)			
39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.50   39.98   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   40.00   Subtotal (see instructions)   2,366   40.00   40.01   Sequestration adjustment (see instructions)   47   40.01   41.00   Interim payments   1,175   41.00   42.00   43.00   Bal ance due provider/program (see instructions)   1,144   43.00   44.00   Frotested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   44.00						
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions)  39. 98 RECOVERY OF ACCELERATED DEPRECIATION  40. 00 Subtotal (see instructions)  40. 01 Sequestration adjustment (see instructions)  41. 00 Interim payments  42. 00 Tentative settlement (for contractors use only)  43. 00 Balance due provider/program (see instructions)  44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 91. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					0	
39. 99   RECOVERY OF ACCELERATED DEPRECIATION   0   39. 99   40. 00   Subtotal (see instructions)   2, 366   40. 00   40. 01   Sequestration adjustment (see instructions)   47   40. 01   41. 00   42. 00   Tentative settlement (for contractors use only)   43. 00   Bal ance due provider/program (see instructions)   1, 144   43. 00   44. 00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0   44. 00   Fig. 15. 2   10   10   10   10   10   10   10						
40.00       Subtotal (see instructions)       2, 366       40.00         40.01       Sequestration adjustment (see instructions)       47       40.01         41.00       Interim payments       1, 175       41.00         42.00       Tentative settlement (for contractors use only)       0       42.00         43.00       Bal ance due provider/program (see instructions)       1, 144       43.00         44.00       Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2       0       44.00         90.00       Original outlier amount (see instructions)       0       90.00         91.00       Outlier reconciliation adjustment amount (see instructions)       0       91.00         92.00       The rate used to calculate the Time Value of Money       0.00       92.00         93.00       Time Value of Money (see instructions)       0       93.00		•	ced devices (see instruc	tions)		
41.00   Interim payments   1,175   41.00   42.00   Tentative settlement (for contractors use only)   0   42.00   43.00   Balance due provider/program (see instructions)   1,144   43.00   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   44.00						
42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)						
43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00   \$\frac{		00 Interim payments				
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$\frac{\f		• • • • • • • • • • • • • • • • • • • •				
TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)						
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 90.00 91.00 92.00 93.00 0 93.00						
91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 91.00  92.00  93.00 0 93.00	00.00					00.00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00 93.00		, ,				
		1				
94.00   IOTAI (SUM OT LINES 91 and 93)   0   94.00		1				
	94.00	Tiotal (Sum of lines 91 and 93)			O	94.00

Peri od:

Provider CCN: 15-0169 Worksheet E-1 From 01/01/2016 Part I 12/31/2016 Date/Time Prepared: 5/30/2017 8:54 am Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 45, 551, 045 9, 621, 812 1. 00 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 07/01/2016 89,000 07/01/2016 33,000 3.01 3.02 3.02 3.03 0 3.03 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 0 3.51 0 3.51 0 0 3.52 3.52 0 3.53 3.53 0 3.54 Ω Λ 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 89,000 33,000 3.99 3.50-3.98) 9, 654, 812 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 45, 640, 045 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 0 6.01 26, 757 6 02 SETTLEMENT TO PROGRAM 407, 499 6.02 7.00 Total Medicare program liability (see instructions) 45, 232, 546 9, 628, 055 7.00 Contractor NPR Date (Mo/Day/Yr) Number

0

1 00

2 00

8.00

8.00 Name of Contractor

Health Financial Systems COMMUNITY
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 15-0169 Component CCN: 15-S169

		Title	XVIII	Subprovider -	PPS	
		Inpatien	t Part A	Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1. 00 2. 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,		1, 591, 20	0	1, 175 0	1. 00 2. 00
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3.01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3.05				0	0	3. 05
	Provi der to Program		Γ	al		
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51 3. 52				0	0	3. 51 3. 52
3.52				0		3. 52
3. 54				o		3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			o	0	3. 99
3. 77	3. 50-3. 98)				Ĭ	3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 591, 20	0	1, 175	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5. 03				0	0	5. 03
F F0	Provi der to Program		I			F F0
5. 50 5. 51	TENTATIVE TO PROGRAM			0	0	5. 50 5. 51
5. 51				0		5. 51
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		5. 99
6. 00	5. 50-5. 98)  Determined net settlement amount (balance due) based on			O		6. 00
	the cost report. (1)		٥٢	0	1 144	
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		85	0	1, 144 0	6. 01 6. 02
6. 02 7. 00	Total Medicare program liability (see instructions)		1, 592, 05	-	2, 319	6. 02 7. 00
7.00	Tiotal medicale program framility (see Histructions)		1, 392, 03	Contractor	NPR Date	7.00
			)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		<i>.</i>	1.00	2.00	8. 00
5. 00	name of contractor			I	ı	0.00

Heal th	Financial Systems COMMUNITY HOSE	PITAL OF INDIANA, INC.	In Lie	u of Form CMS-2	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT  Provider CCN: 15-0169 From 01/01/2016 To 12/31/2016				
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REP				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALC			16, 256	
1. 00					
2.00					2. 00 3. 00
3.00	.00   Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lir	•		69, 812	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line			1, 249, 494, 496	5. 00
6.00	Total hospital charity care charges from Wkst. S-10, c			2, 034, 638	6. 00
7. 00	CAH only - The reasonable cost incurred for the purchalline 168	ase of certified HIT technology	Wkst. S-2, Pt. I	0	7. 00
8.00	Calculation of the HIT incentive payment (see instruct	tions)		0	8. 00
9.00	Sequestration adjustment amount (see instructions)			0	9. 00
10.00	Calculation of the HIT incentive payment after sequest	ration (see instructions)		0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instruction	ons)		0	30. 00
31.00	Other Adjustment (specify)			0	31.00
32 00	00 Relance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)				

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

0 30.00 0 31.00 0 32.00

Health Financial Systems	COMMUNITY HOSPITAL OF INDIANA, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0169	Peri od: From 01/01/2016	Worksheet E-3 Part II
	Component CCN: 15-S169	To 12/31/2016	Date/Time Prepared: 5/30/2017 8:54 am
	Title XVIII	Subprovi der -	PPS
		IPF	

	I PF			
		-	1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		11 00	
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		1, 783, 902	1.00
2.00	Net IPF PPS Outlier Payments		0	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before Novem 15, 2004. (see instructions)	ber	0. 00	4. 00
4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced program or hospital closure, that would not be counted without a temporary cap adjustment under CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4. 01
5. 00	New Teaching program adjustment. (see instructions)		0. 00	5. 00
6. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a	"new	0. 00	6. 00
7. 00	teaching program" (see instuctions) Current year's unweighted L&R FTE count for residents within the new program growth period of a	"new	0.00	7. 00
8. 00	teaching program" (see instuctions) Intern and resident count for IPF PPS medical education adjustment (see instructions)		0. 00	8. 00
9. 00	Average Daily Census (see instructions)		6. 833333	
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.		0. 000000	
11. 00	Teaching Adjustment (line 1 multiplied by line 10).		0.000000	11. 00
12. 00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		1, 783, 902	
13. 00	Nursing and Allied Health Managed Care payment (see instruction)		1, 703, 702	13. 00
	Organ acqui si ti on (DO NOT USE THIS LINE)		O	14. 00
15. 00	Cost of physicians' services in a teaching hospital (see instructions)		0	15. 00
16. 00	Subtotal (see instructions)		1, 783, 902	
	Primary payer payments		1, 763, 402	17. 00
18. 00	Subtotal (line 16 less line 17).		1, 783, 902	
	Deducti bl es		155, 708	
	Subtotal (line 18 minus line 19)		1, 628, 194	
21. 00	Coi nsurance		4, 508	
	Subtotal (line 20 minus line 21)		1, 623, 686	
23. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		1, 023, 080	
24. 00			855	
	, ,		90	
	Allowable bad debts for dual eligible beneficiaries (see instructions)			
26. 00	Subtotal (sum of lines 22 and 24)		1, 624, 541	
	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	
	Other pass through costs (see instructions)		0	
29. 00	Outlier payments reconciliation		0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	
30. 50	Pioneer ACC demonstration payment adjustment (see instructions)		0	
30. 99	Recovery of Accelerated Depreciation		0	30. 99
31.00	Total amount payable to the provider (see instructions)		1, 624, 541	
31. 01	Sequestration adjustment (see instructions)		32, 491	•
	Interim payments		1, 591, 200	
33.00	Tentative settlement (for contractor use only)		0	
34. 00 35. 00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		850 0	34. 00 35. 00
	TO BE COMPLETED BY CONTRACTOR			
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52. 00
	Time Value of Money (see instructions)	l		53.00

I RECT	Financial Systems COMMUNITY HOSPITAL OF GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der C		Peri od:	u of Form CMS-2 Worksheet E-4	
	L EDUCATION COSTS			From 01/01/2016 To 12/31/2016	Date/Time Pre	
		T: 41 -		11	5/30/2017 8: 5	4 am
		11116	XVIII	Hospi tal	PPS	
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
. 00	Unweighted resident FTE count for allopathic and osteopathic pending on or before December 31, 1996.	orograms for	cost reporti	ng periods	0. 00	1. (
. 00	Unweighted FTE resident cap add-on for new programs per 42 CFF	R 413.79(e)(	1) (see insti	ructions)	0. 00	2. (
00	Amount of reduction to Direct GME cap under section 422 of MM/				0. 00	1
01	Direct GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011)	with 42 CFR	8 §413.79 (m).	(see	0. 00	3. (
00	Adjustment (plus or minus) to the FTE cap for allopathic and (	osteopathi c	programs due	to a Medicare	2. 95	4.
	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		p9			
01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst	ructions for	cost reporti	ng peri ods	0. 00	4.
02	straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap slots	s (see inst	ructions for	cost reporting	0. 00	4.
. 02	periods straddling 7/1/2011)	3 (300 11131	ructions for	cost reporting	0.00	
00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus	us or minus	line 4 plus l	ines 4.01 and	2. 95	5.
00	4.02 plus applicable subscripts Unweighted resident FTE count for allopathic and osteopathic;	orograms for	the current	year from your	4. 39	6.
00	records (see instructions)	or ograms Tor	the current	year from your	4. 37	0.
. 00	Enter the lesser of line 5 or line 6				2. 95	7.
			Primary Card	e 0ther 2.00	<u>Total</u> 3. 00	
00	Weighted FTE count for physicians in an allopathic and osteopa	athi c	1. 00		2. 22	8.
	program for the current year.					_
00	If line 6 is less than 5 enter the amount from line 8, otherwimultiply line 8 times the result of line 5 divided by the amount		1.0	0. 45	1. 49	9.
	6.	ant on tine				
0. 00	Weighted dental and podiatric resident FTE count for the curre			2. 16		10.
0. 01	Unweighted dental and podiatric resident FTE count for the cu	rrent year		0.00		10.
2. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting	n vear (see	1. (			11. 12.
. 00	instructions)	y year (see	' '	1.02		12.
3. 00	Total weighted resident FTE count for the penultimate cost rep	porting	1. (	0.00		13.
4. 00	year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided	hv 3)	1. !	50 1.41		14.
5. 00	Adjustment for residents in initial years of new programs	by 3).	0.0			15.
5. 01	Unweighted adjustment for residents in initial years of new pr		0.0	0. 00		15.
. 00	Adjustment for residents displaced by program or hospital clos		0.0			16.
5. 01	Unweighted adjustment for residents displaced by program or holds	оѕрі таі	0.0	0.00		16.
7. 00			1. !	50 1.41		17.
3. 00	Per resident amount		89, 817.	·		18.
9. 00	Approved amount for resident costs		134, 7:	27 126, 643	261, 370	19.
					1. 00	
0. 00	Additional unweighted allopathic and osteopathic direct GME F	TE resident	cap slots red	ceived under 42	0. 00	20.
00	Sec. 413.79(c)(4)	a+: ana)			1 44	21
. 00	Direct GME FTE unweighted resident count over cap (see instructional Allowable additional direct GME FTE Resident Count (see instructional direct GME FTE Resident Count (see instructio				1. 44 0. 00	
. 00	Enter the locally adjustment national average per resident amo	,	structions)		0. 00	
	Multiply line 22 time line 23				0	1
. 00	Total direct GME amount (sum of lines 19 and 24)		Inpatient Pa	rt Managad cara	261, 370	25.
			A	rt Managed care		
			1.00	2. 00	3. 00	
00	COMPUTATION OF PROGRAM PATIENT LOAD		22.0	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7		١,,
. 00	Inpatient Days (see instructions) Total Inpatient Days (see instructions)		23, 00			26. 27.
. 00	Ratio of inpatient days to total inpatient days		0. 3132			28.
9. 00	Program direct GME amount		81, 80	64 25, 473		29.
0.00	Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount		l	3, 599	400 700	30.
	LINE LELLING AND CHIEFE LANGE AND HILL		1	1	103, 738	1.51

Hool +h	Financial Systems COMMUNITY HOSPITAL OF	LINDLANA LNC	In Lie	u of Form CMS-2	DEED 10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der CCN: 15-0169	Peri od:	Worksheet E-4	
	MEDICAL EDUCATION COSTS   From 01/01/2016   To 12/31/2016   E				pared: 4 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLI EDUCATION COSTS)	E XVIII ONLY (NURSING SC	HOOL AND PARAMEDI	CAL	
32. 00	Renal dialysis direct medical education costs (from Wkst. B, and 94)	Pt. I, sum of col. 20 an	d 23, lines 74	0	32. 00
33. 00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I. col. 8. sum of lines	74 and 94)	2, 925, 252	33. 00
34.00	Ratio of direct medical education costs to total charges (lin		ĺ	0.000000	
35.00	Medicare outpatient ESRD charges (see instructions)			0	35. 00
36.00	6.00   Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY			
	Part A Reasonable Cost				
37. 00				63, 870, 318	
38. 00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	39. 00
40.00	1 3 1 3 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1			10, 580	1
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minu	s line 40)		63, 859, 738	41.00
42.00	Part B Reasonable Cost Reasonable cost (see instructions)			14, 987, 335	1 42 00
	Primary payer payments (see instructions)			4, 853	•
44. 00	) ) ) ) )			14, 982, 482	
45. 00	Total reasonable cost (sum of lines 41 and 44)			78, 842, 220	•
46. 00	,	e 41 ÷ line 45)		0. 809969	
	Ratio of Part B reasonable cost to total reasonable cost (line			0. 190031	
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA				
48.00	Total program GME payment (line 31)			103, 738	48. 00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		84, 025	49. 00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instructions)		19, 713	50.00

Health Financial Systems

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

Provider CCN: 15-0169

Peri od: Worksheet G
From 01/01/2016
To 12/31/2016 Date/Time Prepared: 5/30/2017 8:54 am

Offi y)					5/30/2017 8:5	4 am
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2. 00	3. 00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3, 650	1	0	_	1.00
2.00	Temporary investments	0	0	0		2.00
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	702 520 421	0	0	0	3. 00 4. 00
5. 00	Other receivable	792, 528, 431 500	1	0	0	5.00
6. 00	Allowances for uncollectible notes and accounts receivable		1	0	0	6.00
7. 00	Inventory	4, 681, 697	1	0	0	7. 00
8.00	Prepai d expenses	0	o o	0	0	8.00
9.00	Other current assets	296, 029	0	0	0	9. 00
10.00	Due from other funds	0	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	611, 534, 617	0	0	0	11. 00
	FIXED ASSETS					
12. 00	Land	2, 705, 851		0	_	12.00
13.00	Land improvements	3, 158, 137		0		13.00
14. 00	Accumulated depreciation	201 702 022	0	0	1	14.00
15. 00 16. 00	Buildings	301, 703, 922	0	0	0	15. 00 16. 00
17. 00	Accumulated depreciation Leasehold improvements	1, 321, 040		0	0	17. 00
18. 00	Accumulated depreciation	1, 321, 040		0	0	18.00
19. 00	Fi xed equipment	102, 172, 275	1	0	l o	19.00
20. 00	Accumulated depreciation	0	o o	0	0	20.00
21. 00	Automobiles and trucks	0	0	0	0	21.00
22. 00	Accumulated depreciation	0	0	0	0	22. 00
23. 00	Maj or movable equipment	0	0	0	0	23. 00
24.00	Accumulated depreciation	-197, 851, 665	0	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26. 00	Accumulated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	21/ 270	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	316, 270		0	1	29.00
30. 00	Total fixed assets (sum of lines 12-29)  OTHER ASSETS	213, 525, 830	) 0	0	0	30. 00
31. 00	Investments	1	) 0	0	0	31.00
32. 00	Deposits on Leases			0		32.00
33. 00	Due from owners/officers	0		0	l o	33. 00
34.00	Other assets	91, 645, 315	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	91, 645, 315	1	0	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	916, 705, 762	2 0	0	0	36. 00
	CURRENT LI ABI LI TI ES					
37. 00	Accounts payable	507, 389	1	0	-	37. 00
38. 00	Salaries, wages, and fees payable	0	0	0	1	38. 00
39. 00	Payroll taxes payable	0	0	0	0	39. 00
40. 00	Notes and Loans payable (short term)	0	0	0	0	40.00
41. 00	Deferred income Accelerated payments	0	) U	0	0	41.00
42. 00 43. 00	Due to other funds	0		0	0	42. 00 43. 00
44. 00	Other current liabilities	3, 059, 173		0	0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44)	3, 566, 562		0		45. 00
10.00	LONG TERM LIABILITIES	0,000,002	-1	0		10.00
46. 00	Mortgage payable	1 0	0	0	0	46. 00
47.00	Notes payable	0	o	0		47. 00
48.00	Unsecured Loans	0	0	0	0	48. 00
49.00	Other long term liabilities	0	o	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3, 566, 562	2 0	0	0	51.00
	CAPI TAL ACCOUNTS					
52. 00	General fund balance	913, 139, 200	1			52. 00
53. 00	Specific purpose fund		0			53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0	0	56.00
57. 00 58. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	57. 00 58. 00
56.00	replacement, and expansion					30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	913, 139, 200	n	n	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	916, 705, 762	1	Ō	Ö	60.00
	59)					

16.00

17.00

18.00

19.00

0

STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-0169 Peri od: Worksheet G-1 From 01/01/2016 12/31/2016 Date/Time Prepared: 5/30/2017 8:54 am General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 811, 803, 459 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 101, 335, 741 2.00 3.00 Total (sum of line 1 and line 2) 913, 139, 200 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 913, 139, 200 11.00 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 00000 13.00 13.00 14.00 14.00 0 15.00 0 15.00 16.00 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 913, 139, 200 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 0 11.00 Subtotal (line 3 plus line 10) 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00

16.00

17.00

18.00

19.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

 
 Heal th Financial Systems
 COMMUNITY

 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES
 In Lieu of Form CMS-2552-10 Provider CCN: 15-0169 

		'	0 12/31/2010	5/30/2017 8:5	
	Cost Center Description	Inpatient	Outpati ent	Total	
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	139, 308, 889		139, 308, 889	1.00
2.00	SUBPROVI DER - I PF	5, 043, 178		5, 043, 178	2.00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	l c		0	5. 00
6.00	Swing bed - NF	l c		o	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8. 00	NURSING FACILITY				8. 00
9. 00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	144, 352, 067		144, 352, 067	
10.00	Intensive Care Type Inpatient Hospital Services	111,002,007		111/002/007	10.00
11. 00	INTENSIVE CARE UNIT	21, 290, 223		21, 290, 223	11. 00
12. 00	CORONARY CARE UNIT				12.00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGI CAL INTENSI VE CARE UNI T				14. 00
15. 00	NEONATAL INTENSIVE CARE UNIT	80, 556, 994		80, 556, 994	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of I			101, 847, 217	16. 00
10.00	11-15)	101, 047, 217		101, 047, 217	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	246, 199, 284		246, 199, 284	17. 00
18. 00	Ancillary services	501, 832, 385		1, 042, 500, 381	18. 00
19. 00	Outpatient services	301, 832, 303		1, 042, 300, 301	19. 00
20. 00	RURAL HEALTH CLINIC		l -	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22. 00	HOME HEALTH AGENCY		U	U	22.00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24. 00
25. 00					25. 00
26. 00	AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE				26.00
			0		
27. 00	OTHER (SPECIFY)	- Wi+ 740 021 //6	T40 ((7 00)	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst. 748, 031, 669	540, 667, 996	1, 288, 699, 665	28. 00
	G-3, line 1) PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		321, 939, 003		29. 00
30. 00	operating expenses (per wkst. A, corumn 3, inne 200)				30.00
31. 00					31. 00
31.00					32.00
33. 00					33. 00
34. 00					34.00
35. 00	T + 1 11111 ( C + 1 20 05)	C			35. 00
36.00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECIFY)				37. 00
38. 00		0			38. 00
39. 00		C			39. 00
40. 00					40. 00
41. 00					41. 00
42. 00	Total deductions (sum of lines 37-41)		0		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer	321, 939, 003		43. 00
	to Wkst. G-3, line 4)	l			

Health Financial Systems	COMMUNITY HOSPITAL OF INDIANA, INC.	In Lie	u of Form CMS-2552-10
STATEMENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0169	Peri od: From 01/01/2016 To 12/31/2016	Worksheet G-3  Date/Time Prepared: 5/30/2017 8:54 am

STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-0169	Period: From 01/01/2016	Worksheet G-3	
			To 12/31/2016		
				5/30/2017 8:5	4 am
1.00	T	202		1.00	1.00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			1, 288, 699, 665	•
2.00	Less contractual allowances and discounts on patients' account	īs —		867, 905, 533	•
3.00	Net patient revenues (line 1 minus line 2)			420, 794, 132	•
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line	13)		321, 939, 003	
5. 00	Net income from service to patients (line 3 minus line 4)			98, 855, 129	5. 00
,	OTHER I NCOME				,
6. 00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8. 00	Revenues from telephone and other miscellaneous communication	servi ces		0	8. 00
9. 00	Revenue from television and radio service			0	9. 00
10. 00	Purchase di scounts			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 guests			19, 671	14. 00
15. 00	Revenue from rental of living quarters			0	15. 00
16. 00		nan patients		0	16. 00
17. 00				0	17. 00
18. 00				0	18. 00
19. 00				0	19. 00
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23. 00	00 Governmental appropriations			0	23. 00
24.00				2, 460, 941	24. 00
25.00	0 Total other income (sum of lines 6-24)			2, 480, 612	25. 00
26.00	00 Total (line 5 plus line 25)			101, 335, 741	26. 00
27. 00	OTHER EXPENSES (SPECIFY)			0	27. 00
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)			101, 335, 741	29. 00

	lealth Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. In Lie					
CALCULATION OF CAPITAL PAYMENT		Prov	/ider CCN: 15-0169	Peri od: From 01/01/2016	Worksheet L Parts I-III	
				To 12/31/2016	Date/Time Pre	pared:
					5/30/2017 8:5	4 am
			Title XVIII	Hospi tal	PPS	
					1. 00	
	PART I - FULLY PROSPECTIVE METHOD	-				
	CAPITAL FEDERAL AMOUNT					
1.00	Capital DRG other than outlier				3, 275, 146	
1.01	Model 4 BPCI Capital DRG other than outlier				0	
2. 00 2. 01	Capital DRG outlier payments				158, 041 0	2. 00 2. 01
3. 00	Model 4 BPCI Capital DRG outlier payments  Total inpatient days divided by number of days in the cost reporting period (see instructions)				199. 66	
4. 00	Number of interns & residents (see instructions)				2. 59	
5. 00	· · · · · · · · · · · · · · · · · · ·				0. 37	
6. 00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)				12, 118	
7. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line				3. 12	7. 00
8. 00	30) (see instructions) Percentage of Medicaid patient days to total days (see	instruction	c)		26. 39	8.00
9. 00	Sum of lines 7 and 8	THIS ET GETT OFF	3)		29. 51	
10. 00	Allowable disproportionate share percentage (see instru	ictions)			6. 16	
11. 00	Disproportionate share adjustment (see instructions)				201, 749	11.00
12. 00	Total prospective capital payments (see instructions)				3, 647, 054	12. 00
					1. 00	
	PART II - PAYMENT UNDER REASONABLE COST					
1.00	Program inpatient routine capital cost (see instruction				0	
2. 00 3. 00	Program inpatient ancillary capital cost (see instruction Total inpatient program capital cost (line 1 plus line 1				0	
4. 00	Capital cost payment factor (see instructions)				0	4.00
5. 00	Total inpatient program capital cost (line 3 x line 4)				0	
					1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				1. 00	
1. 00	Program inpatient capital costs (see instructions)				0	1.00
2. 00	Program inpatient capital costs for extraordinary circumstances (see instructions)				0	
3.00	Net program inpatient capital costs (line 1 minus line 2)				0	3.00
4.00	Applicable exception percentage (see instructions)	_			0.00	
5.00	Capital cost for comparison to payments (line 3 x line				0	5.00
6.00	Percentage adjustment for extraordinary circumstances (			(line ()	0.00	
7. 00	Adjustment to capital minimum payment level for extraor	dinary circ	umstances (line 2 )	( II ne 6)	0	7. 00

0

0

0 12.00

0 13.00 0 14.00

0 15.00

0 16.00

0 17.00

9. 00 10. 00

11.00

9.00

12.00

13.00

14.00

Capital minimum payment level (line 5 plus line 7)

(if line 12 is negative, enter the amount on this line)

16.00 Current year operating and capital costs (see instructions)

17.00 Current year exception offset amount (see instructions)

Worksheet L, Part III, line 14)

Current year capital payments (from Part I, line 12, as applicable)

15.00 Current year allowable operating and capital payment (see instructions)

10.00 | Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)

Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)

Current year exception payment (if line 12 is positive, enter the amount on this line)

Carryover of accumulated capital minimum payment level over capital payment for the following period

11.00 | Carryover of accumulated capital minimum payment level over capital payment (from prior year