Heal+	h Financial Systems	TERRE HAUTE RECTONAL	HOCDITAL		T- 1 d a		2552 10
	report is required by law (42 USC 1395g; 42	TERRE HAUTE REGIONAL	HUSPITAL	can nocult	in all intenim	eu of Form CMS-	2552-10
pavme	ents made since the beginning of the cost re	norting period being a	deemed overnav	ments (42	111 all 111ceriii	OMB NO. 0938-	
	TAL AND HOSPITAL HEALTH CARE COMPLEX COST R		Provider CCN		Period:	Worksheet S	.0030
	ETTLEMENT SUMMARY	LIONI CENTIFICATION	Provider CCN		From 09/01/2015	Parts I-III	
7.110 0	ETTERIENT SOMEWAY				To 08/31/2016	Date/Time Pre	epared:
						Date/Time Pre 1/26/2017 11:	15 am
	I - COST REPORT STATUS		and the same of th				
Provi	- E . J - recent officer to be				Date: 1/26/20	)17 Time: 11	1:15 am
use o		port					
	3.[0]If this is an amended repo 4.[F]Medicare Utilization. Ente		f times the pr for low.			ost report	
Contr		te Received:			R Date:		
use o		ntractor No.	+bis Dusyidas		ntractor's Vend		- 4
	(2) Settled without Audit 8.[1 (3) Settled with Audit 9.[1	N ]Final Report for t	tills Provider his Provider (	CCN TZ. [		nes reopened =	
	(4) Reopened	To that Report for a	iis i i ovidei e	CCIT	number of th	lles reopened =	0-9.
	(5) Amended						
	(3) Amerided						
PART :	II - CERTIFICATION						
MISRE	PRESENTATION OR FALSIFICATION OF ANY INFORMA	ATION CONTAINED IN THI	S COST REPORT	MAY BE PU	NISHABLE BY CRIM	MINAL, CIVIL AN	ND
ADMIN:	ISTRATIVE ACTION, FINE AND/OR IMPRISONMENT U	JNDER FEDERAL LAW. FL	RTHERMORE. IF	SERVICES	IDENTIFIED IN TH	ITS REPORT WERE	=
PROVI	DED OR PROCURED THROUGH THE PAYMENT DIRECTLY	Y OR INDIRECTLY OF A K	ICKBACK OR WE	RE OTHERWI	SE ILLEGAL. CRIM	MINAL. CIVIL AN	ND -
ADMIN:	ISTRATIVE ACTION, FINES AND/OR IMPRISONMENT	MAY RESULT.			, -, -, -, -, -, -, -, -, -, -,	,,	
	CERTIFICATION BY OFFICER OR ADMI	NISTRATOR OF PROVIDER	(S)				
	I HEREBY CERTIFY that I have read the abe electronically filed or manually submitt Expenses prepared by TERRE HAUTE REGIONAL and ending 08/31/2016 and to the best of complete and prepared from the books and except as noted. I further certify that health care services, and that the service laws and regulations.  Encryption Information ECR: Date: 1/26/2017 Time: 11:15 am 5.hkxn82bpz3tDzD5atzRxbtsn2600 GAZMgOR.w3n08MSPUMKOUtPK6DBVP. 7Zss1gkNYIOQne1V PI: Date: 1/26/2017 Time: 11:15 am N12iLMjxmFxWWLb1pSmPtN:1yUX7g0 McolPOCAWUGVHelGIIxJMDLOybm4yH FKtv00s1xvOPwwwR	ed cost report and the L HOSPITAL ( 150046 ) my knowledge and belivecords of the provic I am familiar with the ces identified in this (signed)	e Balance Shee for the cost ef, this repoler in accordate laws and recost report  Officer of the cost report	et and Stat reporting ort and sta unce with a egulations were provi	ement of Revenue period beginning tement are true pplicable instru regarding the pi ded in compliand rator of Provid	e and g 09/01/2015 , correct, uctions, rovision of ce with such	er
			Title XVI				
				Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
1 00	PART III - SETTLEMENT SUMMARY	<u> </u>			1		
1.00	Hospital	0	-71,485	45,540		2,615,346	1.00
2.00	Subprovider - IPF	0	33,867	-139		456,703	2.00
3.00	Subprovider - IRF	0	59,410	-115		144,989	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0	1		1	0	6 00

			Title	XVIII			
	[발문통통][발문학 - [발발발표] [발문학 발문학 - [발문학 발문학 - [발발학 발문학 - [발발학 발문학 - [발발학 - [발학학 - [발학 - [발학 - [발학 - [발학학 - [발학학 - [발학 - [발학학 - [발학 - [thetatententententententententententententent	Title V	Part A	Part B	HIT	Title XIX	
	[[발표하다] 그 교육 [] 이 그렇게 하고 하다는 이루스 [] 그리는 그 네	1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-71,485	45,540	0	2,615,346	1.00
2.00	Subprovider - IPF	0	33,867	-139		456,703	
3.00	Subprovider - IRF	0	59,410	-115		144.989	3.00
5.00	Swing bed - SNF	0	0	o		0	5.00
6.00	Swing bed - NF	0				0	6.00
12.00	CMHC I	o		o		0	12.00
200.00	Total	0	21,792	45,286	0	3,217,038	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. Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

Health Financia	al Systems	TERRE HAUTE REGIONA	L HOSPITAL	In Lie	u of Form CMS-2552-10
This report is	required by law (42 USC 139	95g; 42 CFR 413.20(b)). Fail	ure to report can re	esult in all interim	FORM APPROVED
payments made	since the beginning of the o	cost reporting period being	deemed overpayments	(42 USC 1395g).	OMB NO. 0938-0050
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX SUMMARY	COST REPORT CERTIFICATION	Provi der CCN: 1500	From 09/01/2015	Worksheet S Parts I-III Date/Time Prepared: 1/26/2017 11:15 am
PART I - COST	REPORT STATUS		<u> </u>	-	
Provi der	1. [ X ] Electronically file	d cost report		Date: 1/26/20	17 Time: 11:15 am
use only	2. [ ] Manually submitted	cost report			
		ed report enter the number on. Enter "F" for full or "L"		r resubmitted this c	ost report
Contractor use only	5. [ 1 ] Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended		this Provider CCN 1		

## 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 TERRE HAUTE REGIONAL HOSPITAL (150046) for the cost reporting period beginning 09/01/2015 and ending 08/31/2016 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	e
Date	

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-71, 485	45, 540	0	2, 615, 346	1.00
2.00	Subprovi der - IPF	0	33, 867	-139		456, 703	2.00
3.00	Subprovi der - IRF	0	59, 410	-115		144, 989	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	21, 792	45, 286	0	3, 217, 038	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.

From 09/01/2015 Part I Date/Time Prepared: 08/31/2016 1/25/2017 6:24 pm 3.00 4. 00 Hospital and Hospital Health Care Complex Address: Street: 3901 HOSPITAL LANE 1.00 PO Box: 1.00 TERRE HAUTE 2.00 Ci ty: State: IN Zip Code: 47802 County: VI GO 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Number Number Certi fi ed 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 Hospi tal TERRE HAUTE REGIONAL 150046 45460 07/01/1966 Ν Р 0 3.00 1 HOSPI TAI Р 4.00 Subprovider - IPF TERRE HAUTE PSYCHIATRIC 15S046 09/01/1991 0 45460 4 Ν 4.00 UNI T 5.00 Subprovider - IRF TERRE HAUTE REHAB UNIT 15T046 45460 5 09/01/2006 Ν Ρ 0 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF Swing Beds - NF 7.00 7.00 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14 00 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital-Based Health Clinic - FQHC 16.00 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From: To: 1.00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 09/01/2015 08/31/2016 20.00 21.00 Type of Control (see instructions) 21.00 4 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 Υ 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 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 in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν Ν 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 N 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 used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. Medi cai d Other In-State In-State Out-of 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 unpai d paid days el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 24.00 If this provider is an IPPS hospital, enter the 24.00 831 236 3, 139 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 60 35 0 0 25.00 244 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.

Health Financial Systems TERRE HAU	TE REGI	ONAL HOSPITAL		Ir	Lie	u of Form	m CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA				eriod: rom 09/01/		Workshe Part I		
			To			Date/Ti		
				Urban/Rur	al S	1/25/20 Date of		4 pm
26.00 Enter your standard geographic classification (not wa	na) sta	atus at the hen	inning of the	1. 00	1	2.0	0	26. 00
cost reporting period. Enter "1" for urban or "2" for	rural.		· ·		'			
27.00 Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or					1			27. 00
enter the effective date of the geographic reclassifi	cati on	in column 2.	•					25 22
35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	number	r or periods SC	H STATUS IN		0			35. 00
				Begi nni r 1. 00	ng:	Endi r 2. 0		
36.00 Enter applicable beginning and ending dates of SCH st	atus. S	Subscript line	36 for number	1.00		2.0	0	36. 00
of periods in excess of one and enter subsequent date 37.00 If this is a Medicare dependent hospital (MDH), enter		umber of period	s MDH status		0			37. 00
is in effect in the cost reporting period.		•			Ü			
37.01 Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for				N				37. 01
i nstructi ons)	,		•					20.00
38.00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of								38. 00
enter subsequent dates.				Y/N		1\Y	NI .	
				1. 00		2. 0	0	
39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii		,		N		N		39. 00
or "N" for no. Does the facility meet the mileage req	ui remer	nts in accordan	ce with 42					
CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes 40.00 Is this hospital subject to the HAC program reduction				N		N		40. 00
"N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.			es or "N" for					
no The Cordinal 2, Tor discharges on or after october 1.	(366 )	ristructrons)			V	XVIII	XIX	
Prospective Payment System (PPS)-Capital					1. 00	2.00	3. 00	
45.00 Does this facility qualify and receive Capital paymen	t for o	di sproporti onat	e share in acc	ordance	N	Y	N	45. 00
with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exce	ption f	for extraordi na	ry circumstano	es	N	l N	N	46. 00
pursuant to 42 CFR §412.348(f)? If yes, complete Wkst	. L, P1	t. III and Wkst	. L-1, Pt. I t	hrough				
Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300 PPS capi	tal? E	Enter "Y for ye	s or "N" for r	10.	N	N	N	47. 00
48.00 Is the facility electing full federal capital payment Teaching Hospitals	? Ente	er "Y" for yes	or "N" for no.		N	N	N	48. 00
56.00 Is this a hospital involved in training residents in	approve	ed GME programs	? Enter "Y" f	or yes	N			56. 00
or "N" for no. 57.00 If line 56 is yes, is this the first cost reporting p	eriod o	during which re	sidents in app	roved	N			57. 00
GME programs trained at this facility? Enter "Y" for	yes or	r"N" for no in	column 1. If	column 1				
is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y	", comp	olete Worksheet						
"N", complete Wkst. D, Parts III & IV and D-2, Pt. II 58.00 If line 56 is yes, did this facility elect cost reimb			ns' services a	ıs	N			58. 00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complet	te Wkst. D-5.		.5				
59.00 Are costs claimed on line 100 of Worksheet A? If yes 60.00 Are you claiming nursing school and/or allied health					N N			59. 00 60. 00
provider-operated criteria under §413.85? Enter "Y"				tions)		Di rect	CME	
	17 IV	TIVIE	DITECT GWE	INE		Direct	GIVIE	
61.00 Did your hospital receive FTE slots under ACA	1. 00 N	2. 00	3. 00	4.00	0.00	5.0		61. 00
section 5503? Enter "Y" for yes or "N" for no in	14				0.00		0.00	01.00
column 1. (see instructions) 61.01 Enter the average number of unweighted primary care		0.00	0. 00					61. 01
FTEs from the hospital's 3 most recent cost reports								
ending and submitted before March 23, 2010. (see instructions)								
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,		0.00	0.00					61. 02
and primary care FTEs added under section 5503 of								
ACA). (see instructions) 61.03 Enter the base line FTE count for primary care		0.00	0. 00					61. 03
and/or general surgery residents, which is used for								
determining compliance with the 75% test. (see instructions)								
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0. 00	0.00	)				61. 04
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		0.00	0.00	}				61. 05
primary care and/or general surgery FTE counts (line								
61.04 minus line 61.03). (see instructions)	1 1	ı l		I		I		

Health Financial Systems	TERRE HAU	TE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP					eriod: com 09/01/2015	Worksheet S-2 Part I	
				To			
		Y/N	I ME	Direct GME	IME	Direct GME	
		1. 00	2. 00	3. 00	4.00	5.00	
61.06 Enter the amount of ACA §5503 aw used for cap relief and/or FTEs care or general surgery. (see in	that are nonprimary		0.00	0.00			61. 06
	,	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1. 00	2. 00	3.00	4.00	
61.10 Of the FTEs in line 61.05, speci specialty, if any, and the numbe for each new program. (see instr column 1, the program name, enter program code, enter in column 3, unweighted count and enter in co FTE unweighted count.	er of FTE residents ductions) Enter in er in column 2, the the IME FTE				0. 00	0.00	61. 10
61.20 Of the FTEs in line 61.05, speci program specialty, if any, and tresidents for each expanded proginstructions) Enter in column 1, enter in column 2, the program c 3, the IME FTE unweighted count 4, direct GME FTE unweighted count	he number of FTE gram. (see the program name, code, enter in column and enter in column				0. 00	0. 00	61. 20
						1.00	
ACA Provisions Affecting the Hea							
62.00 Enter the number of FTE resident your hospital received HRSA PCRE	funding (see instruc	ctions)		, ,,,		0.00	62. 00
62.01 Enter the number of FTE resident during in this cost reporting per Teaching Hospitals that Claim Re	riod of HRSA THC prog	gram. (s	see instruction		your hospital	0.00	62. 01
63.00 Has your facility trained reside "Y" for yes or "N" for no in col	nts in nonprovider se	ettings	during this co		eriod? Enter	N	63. 00
1 TOT YES OF IN TOT HE THE COL	unin 1. 11 yes, compre	, te 11116	3 04-07. (366	Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
				Nonprovi der Si te	Hospi tal		
Section 5504 of the ACA Base Yea	nr FTE Residents in No	onprovi (	der Settings1	1.00 This base year	2.00 is your cost r	3.00 reporting	
period that begins on or after 5	luly 1, 2009 and befor	re June	30, 2010.	0. 00	0. 00		64. 00
in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	ber of unweighted nor tations occurring in number of unweighted our hospital. Enter in	n-priman all nor I non-pr n column	ry care nprovider rimary care n 3 the ratio				
	Program Name	Pro	ogram Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00		2. 00	3. 00	4.00	5.00	
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0.00	0.00	0. 000000	65. 00

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPI		TE REGIONAL HOSPITAL TA Provider	CCN: 150046 P	lr Period: From 09/01/ To 08/31/	2015	workshe Part I Date/Ti 1/25/20	et S-2 me Pre	pared:
				Unwei ghted FTEs Nonprovi der Si te	Unweigh FTEs i Hospita	n al	Ratio (c (col. 1 2)	col. 1/ + col. )	
	Section 5504 of the ACA Current	Year FTE Residents in	n Nonprovider Settin	1.00 gsEffective f	2.00 for cost re		3.C ng peric		
66. 00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00	D	0.00	0.	000000	66. 00
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweigh FTEs i Hospita	n	Ratio (d (col. 3 4)	+ col.	
(7.00		1.00	2.00	3. 00	4.00		5. C		
67. 00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00		0.00	U.		67.00
						1. 00	2.00	3.00	
	Inpatient Psychiatric Facility P						2.00	0.00	
	Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions) Inpatient Rehabilitation Facilit	e facility have an apefore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	oproved GME teaching 204? Enter "Y" for y lity train residents (D)? Enter "Y" for y	program in the yes or "N" for i s in a new teacl yes or "N" for i	most no. (see ni ng no.	Y N	N	0	70. 00
75. 00	Is this facility an Inpatient Re		y (IRF), or does it o	contain an IRF		Y			75. 00
76. 00	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	ember 15, 2004? Enter new teaching program for no. Column 3: It	r "Y" for yes ou m in accordance f column 2 is Y,	r "N" for with 42	N	N	0	76. 00
						-	1. C	)()	
	Long Term Care Hospital PPS Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no.				period? Er	nter	N N		80. 00 81. 00
	TEFRA Providers Is this a new hospital under 42 Did this facility establish a ne	w Other subprovider (	(excluded unit) under			no.	N		85. 00 86. 00
87. 00	\$413.40(f)(1)(ii)? Enter "Y" fo Is this hospital a "subclause (I for yes or "N" for no.			)(1)(B)(iv)(II) <sup>2</sup>	? Enter "Y'	'	N XI :		87. 00
					1. 00		2.0		
90. 00	Title V and XIX Services Does this facility have title V yes or "N" for no in the applica		hospital services? I	Enter "Y" for	N		Υ		90.00
91. 00	Is this hospital reimbursed for full or in part? Enter "Y" for y	title V and/or XIX th			N		N		91. 00
92. 00	Are title XIX NF patients occupy instructions) Enter "Y" for yes	ing title XVIII SNF b	oeds (dual certifica				N		92.00
	Does this facility operate an IC "Y" for yes or "N" for no in the	F/IID facility for pu applicable column.	urposes of title V an		N		N		93. 00
94. 00	Does title V or XIX reduce capit applicable column.	al cost? Enter "Y" fo	or yes, and "N" for i	no in the	N		N		94.00

Health Financial Systems TERRE HAUTE REC HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CCN: 150046 Pe	In eri od:	Li eu	of Form CMS- Worksheet S-2	
		Fi To	rom 09/01/2 o 08/31/2		Part I Date/Time Pro 1/25/2017 6:2	
		<u> </u>	V 1. 00		XI X 2. 00	1
95.00   If line 94 is "Y", enter the reduction percentage in the a 96.00   Does title V or XIX reduce operating cost? Enter "Y" for y			0. 00 N		0. 00 N	95. 00 96. 00
applicable column.  97.00 If line 96 is "Y", enter the reduction percentage in the a Rural Providers	pplicable colum	n.	0.00		0.00	97. 00
$105.00 \overline{\text{Does}}$ this hospital qualify as a critical access hospital ( $106.00 \overline{\text{lf}}$ this facility qualifies as a CAH, has it elected the al		hod of payment	N N			105. 00 106. 00
for outpatient services? (see instructions)  107.00  If this facility qualifies as a CAH, is it eligible for co training programs? Enter "Y" for yes or "N" for no in colu yes, the GME elimination is not made on Wkst. B, Pt. I, co reimbursed. If yes complete Wkst. D-2, Pt. II.	mn 1. (see inst	ructions) If	N			107. 00
108.00 s this a rural hospital qualifying for an exception to th CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N			108. 00
	Physi cal 1.00	0ccupational 2.00	Speech 3.00	1	Respiratory 4.00	-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N N	N N		N N	109. 00
					1.00	
110.00 Did this hospital participate in the Rural Community Hospi the current cost reporting period? Enter "Y" for yes or "N		on project (410	OA Demo)for		N T	110. 00
				1. 00	2.00 3.00	
Miscellaneous Cost Reporting Information  115.00 s this an all-inclusive rate provider? Enter "Y" for yes	or "N" for no i	n column 1 lf	column 1	N	0	115. 00
is yes, enter the method used (A, B, or E only) in column 3 either "93" percent for short term hospital or "98" percepsychiatric, rehabilitation and long term hospitals provid Pub. 15-1, chapter 22, §2208.1.	2. If column 2 i ent for long te	is "E", enter i rm care (includ	n column des			113.00
116.00 is this facility classified as a referral center? Enter "Y 117.00 is this facility legally-required to carry malpractice ins			N" for	N N		116. 00 117. 00
no.  118.00 Is the mal practice insurance a claims-made or occurrence p claim-made. Enter 2 if the policy is occurrence.	olicy? Enter 1	if the policy i	S	2		118. 00
perurin made. Effect 2 11 the portey 13 decurrence.		Premi ums	Losses		Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1. 00 282, 113	2.00	0	3. 00 896, 10	9 118. 01
			1 00		2.00	
118.02 Are malpractice premiums and paid losses reported in a cos Administrative and General? If yes, submit supporting sch and amounts contained therein.	t center other edule listing c	than the ost centers	1. 00 N		2.00	118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Ho §3121 and applicable amendments? (see instructions) Enter "N" for no. Is this a rural hospital with < 100 beds that Hold Harmless provision in ACA §3121 and applicable amendm Enter in column 2, "Y" for yes or "N" for no.	in column 1, "Y qualifies for t	" for yes or he Outpatient	N		N	119. 00 120. 00
121.00 Did this facility incur and report costs for high cost imp	lantable device	s charged to	Y			121. 00
patients? Enter "Y" for yes or "N" for no.					5. 00	
122.00 Does the cost report contain state health or similar taxes for no in column 1. If column 1 is "Y", enter in column 2			Y		3.00	122. 00
			Y		3.00	122. 00
for no in column 1. If column 1 is "Y", enter in column 2 where these taxes are included.  Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y"	the Worksheet A	line number	Y N		3.00	122. 00
for no in column 1. If column 1 is "Y", enter in column 2 where these taxes are included.  Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center.	the Worksheet A for yes and "N" enter the certi	for no. If			3.00	
for no in column 1. If column 1 is "Y", enter in column 2 where these taxes are included.  Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, e	for yes and "N" enter the certification.	for no. If			3. 00	125. 00
for no in column 1. If column 1 is "Y", enter in column 2 where these taxes are included. Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, in column 1 and termination date, if applicable, in column  127.00 If this is a Medicare certified heart transplant center, e in column 1 and termination date, if applicable, in column  128.00 If this is a Medicare certified liver transplant center, e	for yes and "N" enter the certification.  2. nter the certification.	for no. If fication date			3. 00	125. 00 126. 00
for no in column 1. If column 1 is "Y", enter in column 2 where these taxes are included.  Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, e in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, e in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified lung transplant center, en	for yes and "N" enter the certif. 2. nter the certif. 2. nter the certif. 2. nter the certif. 2.	for no. If fication date ication date			3. 00	125. 00 126. 00 127. 00
for no in column 1. If column 1 is "Y", enter in column 2 where these taxes are included.  Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, e in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, e in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified lung transplant center, en column 1 and termination date, if applicable, in column 2.  130.00 If this is a Medicare certified pancreas transplant center	for yes and "N" enter the certif 2. nter the certif 2. ter the certifi 2. ter the certifi 4. center the certifi 6. center the certifi 7. center the certifi 8. center the certifi 9.	for no. If fication date ication date ication date			3. 00	125. 00 126. 00 127. 00 128. 00
for no in column 1. If column 1 is "Y", enter in column 2 where these taxes are included.  Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, e in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, e in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified lung transplant center, en column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified lung transplant center, en column 1 and termination date, if applicable, in column 2.	for yes and "N" enter the certification.  ter the certification.  ter the certification.  ter the certification.	for no. If fication date ication date ication date cation date cation date in			3. 00	125. 00 126. 00 127. 00 128. 00 129. 00

IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX		Provi der C	CN: 150046			w of Form CMS Worksheet S- Part I Date/Time Pr 1/25/2017 6:	-2 repared:
					1. 00	2.00	$\dashv$
33.00 If this is a Medicare certified ot	her transplant center, er	nter the certific	ation date				133. 0
in column 1 and termination date, 34.00 If this is an organ procurement or and termination date, if applicabl	ganization (OPO), enter t		column 1				134. 0
All Providers	e, III corumii z.						
40.00 Are there any related organization chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column 1. It	f yes, and home o	office cost	s	Υ	44H070	140. 0
1.00		00	0113)		3. 00		
If this facility is part of a chai				name and	daddress	of the	
home office and enter the home off 41.00Name: HOSPITAL CORP. OF AMERICA	<u>Contractor name and Contractor's Name: Contractor's Name: Contractor's Name: Contractor's Name: Contractor (Contractor)</u>			tor's Nu	mhor, 1020	1	
41.00 Name: HOSPITAL CORP. OF AMERICA 42.00 Street: ONE PARK PLAZA	PO Box:	АПАВА	Contrac	tor S Nu	mber: 1030	ı	141.0
43. 00 Ci ty: NASHVI LLE	State: T	N	Zip Cod	e:	3720	3	143. 0
	·						
44.00 Are provider based physicians' cos	ts included in Werksheet	A2				1. 00 Y	144. 0
44. Dolnie pi ovi dei based pilysi ci alls COS	to Theraueu TH WOLKSHEEL	Λ:				Ť	144. 0
					1. 00	2. 00	
45.00 If costs for renal services are clinpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"	for yes or "N" for no ir lude Medicare utilization	n column 1. If co	olumn 1 is		Υ		145. 0
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	y changed from the previous column 1. (See CMS Pub.			f	N		146. 0
						1. 00	$\dashv$
47.00 Was there a change in the statisti	cal basis? Enter "Y" for	yes or "N" for r	10.			N	147. C
48.00 Was there a change in the order of		-				N	148. 0
49.00 Was there a change to the simplifi	ed cost finding method? E	Enter "Y" for yes Part A	or "N" fo Part B		itle V	N Title XIX	149. C
		1.00	2.00		3.00	4.00	$\dashv$
Does this facility contain a provi		n exemption from	the applic	ati on of	the lowe	r of costs	
or charges? Enter "Y" for yes or "	N" for no for each compoi			(See 42			455.6
55.00 Hospi tal 56.00 Subprovi der - TPF		N N	N N		N N	N N	155. 0 156. 0
57. 00 Subprovider - IRF		N N	N		N	N	157. 0
58. 00 SUBPROVI DER							158. 0
59. 00 SNF		N	N		N	N	159. 0
60.00HOME HEALTH AGENCY							14100
		N	N N		N N	N N	
		N	N N		N N	N N	
61. 00 CMHC		N					
61.00 CMHC  Multicampus			N		N	N 1. 00	160.0
61.00 CMHC  Multicampus  65.00 Is this hospital part of a Multica	impus hospital that has or		N	erent CB	N	N	
61.00 CMHC  Multicampus	mpus hospital that has or Name		N Ses in diff	erent CB	N	N 1. 00	161. C
Multicampus  65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.		ne or more campus	N ses in diff		N SAs?	N 1.00 N FTE/Campus 5.00	161. 0
61.00 CMHC  Multicampus  65.00 Is this hospital part of a Multica	Name	ne or more campus	N ses in diff	ip Code	N SAs? CBSA	N 1.00 N FTE/Campus 5.00	161. C
Multicampus 65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.  66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	Name	ne or more campus	N ses in diff	ip Code	N SAs? CBSA	N 1.00 N FTE/Campus 5.00 0.0	161. 0
Multicampus  65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.  66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	Name O	ne or more campus  County  1.00	ses in diff	i p Code 3.00	N SAs? CBSA	N 1.00 N FTE/Campus 5.00	161. 0
Multicampus 65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.  66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	Name 0  incentive in the Americ under \$1886(n)? Enter 'Usis "Y") and is a meaning the state of t	can Recovery and	Ses in diff    State   Z   2.00	ip Code 3.00	SAS? CBSA 4.00	N 1.00 N FTE/Campus 5.00 0.0	161. 0

Health Financial Systems	TERRE HAUTE REGIONAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDI	ENTIFICATION DATA	Provi der CCN: 150046	Peri od:	Worksheet S-2	
			From 09/01/2015		
			To 08/31/2016		
				1/25/2017 6: 2	4 pm
			Begi nni ng	Endi ng	
			1. 00	2.00	
				12/29/2014	170. 00
				1.00	
171.00 If line 167 is "Y", does this provider Medicare cost plans reported on Wkst. (see instructions)				N	171. 00

Heal th	Financial Systems TERRE HAUTE REG	IONAL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI	FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der		Peri od: From 09/01/2015	Worksheet S-2 Part II	2
				To 08/31/2016		
				Y/N	Date 0.2	4 piii
	To the second se			1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter Mm/dd/yyyy format.	N for all NO re	sponses. Ente	r all dates in t	the	
	COMPLETED BY ALL HOSPITALS					1
	Provider Organization and Operation					
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a	e beginning of column 2 (see	instructions)	N		1.00
	proper tring periods in jeep enter the date of the shange in	2. (333	Y/N	Date	V/I	
2.00	The the consider terminated markining to the Madisons I	D	1.00	2. 00	3. 00	2.00
2.00	Has the provider terminated participation in the Medicare I yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.00
3.00	Is the provider involved in business transactions, including	ng management	Y			3.00
	contracts, with individuals or entities (e.g., chain home					
	or medical supply companies) that are related to the provious officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other					
	relationships? (see instructions)		Y/N	Tymo	Do+o	_
			1.00	7ype 2. 00	Date 3.00	
	Financial Data and Reports					
4. 00	Column 1: Were the financial statements prepared by a Cer-Accountant? Column 2: If yes, enter "A" for Audited, "C"		N			4. 00
	or "R" for Reviewed. Submit complete copy or enter date available.					
	column 3. (see instructions) If no, see instructions.					
5. 00	Are the cost report total expenses and total revenues differentiation on the filed financial statements? If yes, submit reconstructions are the cost report total expenses and total revenues differentiations.		N			5.00
	THOSE OF THE TITES THATEFUL STATEMENTS. IT YES, SUMMET OF	concrit att on.		Y/N	Legal Oper.	
				1. 00	2. 00	
6. 00	Approved Educational Activities  Column 1: Are costs claimed for nursing school? Column 2:	If ves. is th	ne provider is	N		6.00
	the legal operator of the program?					
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved		l during the	N N		7. 00
0.00	cost reporting period? If yes, see instructions.	and/or renewed	r durring the	IN		0.00
9.00	Are costs claimed for Interns and Residents in an approved		al education	N		9. 00
10. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of		he current	N		10.00
10.00	cost reporting period? If yes, see instructions.	or renewed in t	ine current			10.00
11. 00	Are GME cost directly assigned to cost centers other than	I & Rin an App	proved	N		11. 00
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
					1.00	
12. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s see instruct	Long		Y	12. 00
13. 00	,			st reporting	N N	13. 00
	period? If yes, submit copy.					
14. 00	If line 12 is yes, were patient deductibles and/or co-paymone Bed Complement	ents waived? If	yes, see ins	tructi ons.	N	14. 00
15. 00	Did total beds available change from the prior cost report	ing period? If	yes, see inst	ructions.	N	15. 00
			t A		t B	
		Y/N 1.00	2.00	Y/N 3. 00	Date 4. 00	
	PS&R Data			1		
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N		N		16. 00
	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	Υ	12/01/2016	Υ	12/01/2016	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.					
	1 of materials in the year add that dott one.	I	I	1	1	1

OSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	ONAL HOSPITAL Provi der	CCN: 1	50046	Peri od:	u of Form CM: Worksheet S	
				From 09/01/2015 To 08/31/2016		
	Descr	ption		Y/N	1/25/2017 6 Y/N	: 24 pm
		)		1.00	3. 00	
0.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				N	N	20.0
, , , , , , , , , , , , , , , , , , , ,	Y/N	D	ate	Y/N	Date	
	1. 00	2	2. 00	3. 00	4. 00	
1.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N			N		21. 0
					1. 00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS F	OSPI TA	LS)			
Capital Related Cost			ĺ			
2.00 Have assets been relifed for Medicare purposes? If yes, see	instructions				N	22. (
3.00 Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		N	23. (			
4.00 Were new leases and/or amendments to existing leases entered lf yes, see instructions		Y	24. (			
5.00 Have there been new capitalized leases entered into during instructions.	tne cost repor	ting p	eri od?	rir yes, see	N	25. (
6.00 Were assets subject to Sec. 2314 of DEFRA acquired during this instructions.	e cost reporti	ng per	i od? I	f yes, see	N	26. (
7.00 Has the provider's capitalization policy changed during the copy.	cost reportir	g peri	od? If	yes, submit	N	27. (
8.00 Were new Loans, mortgage agreements or Letters of credit en period? If yes, see instructions.	tered into dur	ing th	e cost	reporti ng	N	28.
9.00 Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instru	eserve Fund)	N	29.			
D.00 Has existing debt been replaced prior to its scheduled matulinstructions.	, see	N	30.			
OD Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.  Purchased Services						31. (
2.00 Have changes or new agreements occurred in patient care ser- arrangements with suppliers of services? If yes, see instru- 3.00 If line 32 is yes, were the requirements of Sec. 2135.2 app	ctions.		•		N	32.
no, see instructions. Provider-Based Physicians						
4.00 Are services furnished at the provider facility under an ar If yes, see instructions.	· ·				Y	34.
5.00 If line 34 is yes, were there new agreements or amended eximply physicians during the cost reporting period? If yes, see in		its wit	h the	provi der-based	Υ	35.
The state of the s				Y/N	Date	
				1. 00	2. 00	
Home Office Costs						
6.00 Were home office costs claimed on the cost report?			cc: -	Y		36.0
7.00 If line 36 is yes, has a home office cost statement been pro-	epared by the	nome o	тті се?	Y		37. (
If yes, see instructions.  8.00 If line 36 is yes, was the fiscal year end of the home off			hat of	Y	12/31/2016	38. (
the provider? If yes, enter in column 2 the fiscal year end [If line 36 is yes, did the provider render services to othe see instructions.			If yes	, N		39.
0.00 If line 36 is yes, did the provider render services to the instructions.	home office?	If yes	s, see	N		40. (
		00			20	
Cost Depart Dranger Contact Information	1.	00		2.	00	
1.00 Cost Report Preparer Contact Information  Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	DARRELL CUNNI NGHAM					41. (
respectively.  2.00 Enter the employer/company name of the cost report	HCA					42. (
preparer.						

Heal th	Financial Systems	TERRE HAUTE	REGI ONAL	HOSPI TAL				In Lie	u of Form C	MS-2	552-10
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE		Provi der	CCN:		Peri	iod: m 09/01/2015	Worksheet Part II	S-2	
							To	08/31/2016	Date/Time		
									1/25/2017	6: 24	1 pm
				3.	00						
	Cost Report Preparer Contact Information										
41. 00	Enter the first name, last name and the t	itle/position	REIME	BURSEMENT I	MANAG	ER					41.00
	held by the cost report preparer in colum	ins 1, 2, and 3	3,								
	respecti vel y.										
42.00	Enter the employer/company name of the co	st report									42.00
	preparer.										
43.00	Enter the telephone number and email addr	ess of the cos	st								43.00
	report preparer in columns 1 and 2, respe	cti vel y.									

						00/31/2010	1/25/2017 6: 24	
							I/P Days / 0/P	
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	Component	Line Number	INO.	or beds	Avai I abl e	CALL HOULS	ii tie v	
		1.00		2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		142		0.00	0.00	1. 00
1.00	8 exclude Swing Bed, Observation Bed and	30.00		142	31, 7/2	0.00	U	1.00
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2 00								2 00
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO I RF Subprovi der							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7. 00	Total Adults and Peds. (exclude observation			142	51, 972	0. 00	0	7. 00
	beds) (see instructions)							
8. 00	INTENSIVE CARE UNIT	31. 00		18	6, 588	0. 00	0	8. 00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43.00					0	13.00
14.00	Total (see instructions)			160	58, 560	0.00	0	14.00
15.00	CAH vi si ts						ol	15.00
16.00	SUBPROVIDER - IPF	40. 00		19	6, 954		o	16. 00
17. 00	SUBPROVIDER - IRF	41. 00		12	·		0	17. 00
18. 00	SUBPROVI DER				.,		_	18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20. 00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )							23. 00
24. 00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC	99. 00					0	25. 00
26. 00		99.00					U	26. 00
26. 25	RURAL HEALTH CLINIC							26. 25
	FEDERALLY QUALIFIED HEALTH CENTER			101				
27. 00	Total (sum of lines 14-26)			191				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF							31. 00
32. 00	Labor & delivery days (see instructions)			0	0			32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33. 00

						1/25/2017 6: 2	4 pm
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	10, 985	1, 179	19, 282			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)	1 701	2 072				2 00
2. 00 3. 00	HMO and other (see instructions) HMO IPF Subprovider	1, 721 88	3, 073				2. 00 3. 00
4.00	HMO IRF Subprovider	17	244				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	1/	244				5. 00
6. 00	Hospital Adults & Peds. Swing Bed SNF	٩	0				6.00
7. 00	Total Adults and Peds. (exclude observation	10, 985	1, 179	19, 282			7.00
7.00	beds) (see instructions)	10, 703	1, 1/7	17, 202			7.00
8.00	INTENSIVE CARE UNIT	1, 767	0	3, 365			8.00
9. 00	CORONARY CARE UNIT	1,707	Ŭ.	0,000			9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00			0	563			13.00
14. 00	Total (see instructions)	12, 752	1, 179			577. 09	
15.00	CAH vi si ts	0	0	·	)		15. 00
16.00	SUBPROVI DER - I PF	1, 426	2, 903	6, 404	0.00	34. 11	16. 00
17.00	SUBPROVI DER - I RF	1, 143	95	1, 827	0.00	12. 01	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	` ,						23. 00
24. 00	HOSPI CE						24. 00
24. 10		0	0	79			24. 10
25. 00	CMHC - CMHC	0	0	C	0.00	0.00	
26. 00							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00			000	0.500	0.00	623. 21	
28. 00	1		928	2, 589			28. 00
29. 00		0		c			29. 00
30. 00 31. 00							30. 00 31. 00
32. 00		0		91			32.00
32. 00	Labor & delivery days (see instructions) Total ancillary labor & delivery room	١	66	91			32.00
32.01	outpatient days (see instructions)						32.01
33 00	LTCH non-covered days	o					33. 00
55.50	12.2 2010. 00 0030	١			T.	ı	, 50.00

Provi der CCN: 150046

	Time Prep 2017 6:24	
Full Time Discharges		
Equivalents   Component   Nonpaid   Title V   Title XVIII   Title XIX   Tota	I Al I	
	ents	
	. 00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 0 2,828 329	5, 481	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) 302 971		2. 00
3.00 HM0 IPF Subprovi der		3. 00
4. 00 HMO LRF Subprovider 14		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 12.00 OTHER SPECIAL CARE (SPECIFY)		11. 00 12. 00
13. 00 NURSERY		13. 00
14. 00   Total (see instructions)	5, 481	14. 00
15.00 CAH visits	0, 101	15. 00
16. 00 SUBPROVI DER - I PF 0. 00 0 179 0	953	16.00
17. 00 SUBPROVI DER - I RF 0. 00 0 84 5	134	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 23. 00 AMBULATORY SURGICAL CENTER (D. P.)		22. 00 23. 00
23. 00 AMBULATORY SURGICAL CENTER (D. P. ) 24. 00 HOSPICE		24. 00
24. 00 HOSPICE (non-distinct part)		24. 10
25. 00   CMHC - CMHC   0. 00		25. 00
26. 00 RURAL HEALTH CLINIC		26.00
26. 25 FEDERALLY QUALIFIED HEALTH CENTER		26. 25
27.00 Total (sum of lines 14-26) 0.00		27.00
28.00 Observation Bed Days		28. 00
29. 00 Ambul ance Tri ps		29. 00
30.00 Employee discount days (see instruction)		30.00
31.00 Employee discount days - IRF		31. 00
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room		32. 00 32. 01
outpatient days (see instructions)		JZ. U I
33. 00 LTCH non-covered days		33.00

Provider CCN: 150046

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3	
From 09/01/2015	Part II	
To 08/31/2016	Date/Time Prepared:	1/25/2017 6:24 pm

						00, 01, 2010	1/25/2017 6: 2	
		Worksheet A	Amount	Recl assi fi cati	Adj usted		Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Worksheet A-6)	(col.2 ± col. 3)	Salaries in col. 4	col. 5)	
		1. 00	2.00	3.00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA							1
1 00	SALARIES Total salaries (see	200. 00	2/ //0 012		2/ //0 012	1 201 255 00	20.10	1.00
1. 00	instructions)	200.00	36, 668, 812	0	36, 668, 812	1, 301, 255. 00	28. 18	1.00
2.00	Non-physician anesthetist Part		0	0	0	0.00	0.00	2. 00
0.00	A					0.00		0.00
3.00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3. 00
4.00	Physician-Part A -		0	0	0	0.00	0.00	4. 00
	Admi ni strati ve							
4. 01 5. 00	Physicians - Part A - Teaching Physician-Part B		0	1	0	0. 00 0. 00		
6.00	Non-physician-Part B		0	0	0	0.00		
7. 00	Interns & residents (in an	21. 00	0	O	Ō	0. 00	1	
	approved program)		_	_	_			
7. 01	Contracted interns and residents (in an approved		0	O	0	0. 00	0. 00	7. 01
	programs)							
8.00	Home office personnel		0	0	0	0.00		
9.00	SNF	44. 00	2 700 420	0	2 700 420	0.00		
10. 00	Excluded area salaries (see instructions)		3, 788, 439	0	3, 788, 439	140, 342. 00	26. 99	10.00
	OTHER WAGES & RELATED COSTS							1
11. 00	Contract labor: Direct Patient		2, 870, 143	0	2, 870, 143	41, 996. 00	68. 34	11. 00
12. 00	Care Contract Labor: Top Level		0	0	0	0. 00	0.00	12. 00
12.00	management and other		O		Ĭ	0.00	0.00	12.00
	management and administrative							
12 00	Services		240 500	0	240 500	2 010 75	172.24	12.00
13. 00	Contract Labor: Physician-Part A - Administrative		348, 589	0	348, 589	2, 010. 75	1/3. 30	13. 00
14. 00	Home office salaries &		7, 360, 976	0	7, 360, 976	172, 480. 00	42. 68	14. 00
45.00	wage-related costs					0.00		45.00
15. 00	Home office: Physician Part A - Administrative		U	0	U	0. 00	0. 00	15. 00
16.00	Home office and Contract		0	0	О	0.00	0.00	16. 00
	Physicians Part A - Teaching							
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		8, 573, 785	0	8, 573, 785			17. 00
17.00	instructions)		0, 373, 703		0, 373, 703			17.00
18. 00	Wage-related costs (other)		0	0	0			18. 00
19. 00	(see instructions) Excluded areas		987, 862	0	987, 862			19. 00
20. 00	Non-physician anesthetist Part		0 0	o o	0			20.00
	Α							
21. 00	Non-physician anesthetist Part B		0	0	0			21. 00
22. 00	Physician Part A -		0	0	О			22. 00
	Admi ni strati ve							
22. 01	Physician Part A - Teaching		0		0			22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		0	1	0			23. 00 24. 00
25. 00	Interns & residents (in an		0		0			25. 00
	approved program)							
26. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4. 00	122, 414	0	122, 414	3, 947. 00	31. 01	26. 00
27. 00	Administrative & General	5. 00	3, 622, 159			86, 306. 00		
28. 00	Administrative & General under		52, 856		52, 856	331.00	159. 69	28. 00
29. 00	contract (see inst.)	6. 00	0		0	0. 00	0.00	29. 00
30.00	Maintenance & Repairs Operation of Plant	7. 00	734, 200	0	734, 200	27, 757. 00	1	
31. 00	Laundry & Linen Service	8. 00	0	O	0	0.00		1
32.00	Housekeepi ng	9. 00	888, 157	0	888, 157	66, 673. 00		1
33. 00	Housekeeping under contract (see instructions)		0	0	0	0. 00	0. 00	33. 00
34. 00	Di etary	10. 00	661, 589	-216, 304	445, 285	35, 897. 00	12. 40	34.00
35. 00	Dietary under contract (see		226, 909		226, 909	2, 536. 00		1
24 00	instructions)	11 00	2	217 201	217 204	17 407 00	10.40	24 00
36. 00 37. 00	Cafeteria Maintenance of Personnel	11. 00 12. 00	0	216, 304	216, 304 0	17, 437. 00 0. 00		
38. 00	Nursing Administration	13. 00	463, 198	177, 164	640, 362	14, 053. 00		1
39. 00	Central Services and Supply	14. 00	0	0	0	0.00		
40. 00	Pharmacy	15. 00	0	0	0	0. 00	0.00	40. 00

Health Financial Systems	TI	ERRE HAUTE REG	In Lie	u of Form CMS-2	2552-10		
HOSPITAL WAGE INDEX INFORMATION			Provi der		Period: From 09/01/2015 To 08/31/2016	Worksheet S-3 15 Part II 16 Date/Time Prepared 1/25/2017 6:24 pm	
	Worksheet A Line Number	Reported	Reclassificati on of Salaries (from Worksheet A-6)	Sal ari es (col . 2 ± col .	Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
	1. 00	2.00	3. 00	3) 4.00	col . 4 5. 00	6. 00	
41.00 Medical Records & Medical Records Library	16. 00	60, 894		60, 89			41. 00
42.00 Social Service 43.00 Other General Service	17. 00 18. 00		0 0	1, 478, 97	0.00 3 51,163.00		42. 00 43. 00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION	Provi der CCN: 150046	Peri od: Worksheet S-3

	AL WAS THEEX THE STANKETON					From 09/01/2015 To 08/31/2016		
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2. 00	3.00	4.00	5. 00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		36, 948, 577	0	36, 948, 57	7 1, 304, 122. 00	28. 33	1.00
	instructions)							
2.00	Excluded area salaries (see		3, 788, 439	0	3, 788, 43	9 140, 342. 00	26. 99	2.00
	instructions)							
3.00	Subtotal salaries (line 1		33, 160, 138	0	33, 160, 13	8 1, 163, 780. 00	28. 49	3.00
	minus line 2)							
4.00	Subtotal other wages & related		10, 579, 708	0	10, 579, 70	8 216, 486. 75	48. 87	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		8, 573, 785	0	8, 573, 78	0.00	25. 86	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		52, 313, 631	0	52, 313, 63	1 1, 380, 266. 75	37. 90	6.00
7.00	Total overhead cost (see		8, 311, 349	0	8, 311, 34	9 309, 074. 00	26. 89	7.00
	instructions)							

Health Financial Systems	TERRE HAUTE REGIONAL H	HOSPI TAL		In Lieu	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	F	Provi der CCN:	150046	Peri od: From 09/01/2015	Worksheet S-3
					Date/Time Prepared:

	To 08/31/2016	Date/Time Prep 1/25/2017 6:24	pared: 4 pm
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	1, 280, 706	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)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	88, 536	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)	4, 817, 803	8. 00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	-601	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	33, 849	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	416, 560	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	105, 304	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
	TAXES		
	FICA-Employers Portion Only	2, 134, 776	
18.00	Medicare Taxes - Employers Portion Only	495, 438	18. 00
19.00	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	-10, 180	20. 00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		
	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	199, 456	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	9, 561, 647	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

llool +b	Financial Systems	TERRE HAUTE REG	NONAL HOCK	DITAL			ا ما	eu of Form CMS-2	DEE2 10
	Financial Systems AL CONTRACT LABOR AND BENEFIT COST	TERRE HAUTE REG		vi der	CCN: 1	50046	Peri od:	Worksheet S-3	2552-10
	The contribute English find Benefit Coope					000.0	From 09/01/2015		
							To 08/31/2016		
	· · · · · · · · · · · · · · · · · · ·							1/25/2017 6: 2	4 pm
	Cost Center Description						Contract Labor		
							1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost								
	Hospital and Hospital-Based Component Ident								
1. 00	Total facility's contract labor and benefit	t cost					2, 906, 358		1. 00
2.00	Hospi tal						2, 870, 143	8, 573, 785	2. 00
3.00	Subprovider - IPF						33, 289	453, 066	3. 00
4.00	Subprovi der - I RF						2, 926	210, 024	4.00
5.00	Subprovider - (Other)						0	0	5. 00
6.00	Swing Beds - SNF						0	0	6. 00
7.00	Swing Beds - NF						0	0	7. 00
8.00	Hospital-Based SNF								8. 00
9.00	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
	Hospital-Based Health Clinic FQHC								15. 00
	Hospi tal -Based-CMHC						0	0	16. 00
	Renal Dialysis						0	0	17. 00
18. 00	Other						0	324, 772	18. 00
	ı						Ţ.	'	•

Heal th	Financial Systems TERRE HAUTE REGIONAL I	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 150046	Peri od:	Worksheet S-10	)
				From 09/01/2015 To 08/31/2016		
					1/25/2017 6: 24	4 pm
					1. 00	
	Uncompensated and indigent care cost computation					
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided Medicaid (see instructions for each line)	led by li	ne 202 column	1 8)	0. 156249	1. 00
2.00	Net revenue from Medicaid				16, 300, 910	2. 00
3.00	Did you receive DSH or supplemental payments from Medicaid?				N 10,000,710	3. 00
4. 00	If line 3 is "yes", does line 2 include all DSH or supplemental p	avments	from Medicaio	l?	.,	4. 00
5. 00	If line 4 is "no", then enter DSH or supplemental payments from N	,			0	5. 00
6. 00	Medi cai d charges				143, 361, 773	6. 00
7.00	Medicaid cost (line 1 times line 6)				22, 400, 134	7. 00
8.00	Difference between net revenue and costs for Medicaid program (li	ne 7 min	us sum of lir	es 2 and 5; if	6, 099, 224	8. 00
	< zero then enter zero)					
	State Children's Health Insurance Program (SCHIP) (see instruction	ns for e	ach line)			
9.00	Net revenue from stand-alone SCHIP				0	9. 00
10. 00	Stand-alone SCHIP charges				0	
11. 00	Stand-alone SCHIP cost (line 1 times line 10)				0	
12. 00	Difference between net revenue and costs for stand-alone SCHIP (I	ine 11 m	inus line 9;	if < zero then	0	12. 00
	enter zero)	:				
13. 00	Other state or local government indigent care program (see instru Net revenue from state or local indigent care program (Not include				0	13. 00
14. 00	Charges for patients covered under state or local indigent care p				0	14. 00
14.00	10)	n ogram (	Not Theradea	TIT TITLES 0 01	0	14.00
15. 00	State or local indigent care program cost (line 1 times line 14)				0	15. 00
16. 00	Difference between net revenue and costs for state or local indic	ent care	program (lir	e 15 minus line	0	16.00
	13; if < zero then enter zero)					
	Uncompensated care (see instructions for each line)					
17. 00	Private grants, donations, or endowment income restricted to fund					17. 00
18. 00	Government grants, appropriations or transfers for support of hos				0	18. 00
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local 8, 12 and 16)	i ndi gent	care program	s (sum of lines	6, 099, 224	19. 00
	jo, 12 and 10)		Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
			1. 00	2. 00	3. 00	
20. 00	Total initial obligation of patients approved for charity care (a charges excluding non-reimbursable cost centers) for the entire f		1, 797, 1 <sup>-</sup>	165, 829	1, 962, 946	20. 00
21. 00	Cost of initial obligation of patients approved for charity care		280, 79	25, 911	306, 709	21. 00
21.00	times line 20)	(TITIC T	200, 7	25, 711	300, 707	21.00
22. 00	,		3, 3	2, 210	5, 587	22. 00
	Cost of charity care (line 21 minus line 22)		277, 42	•	301, 122	
	·					
24. 00	Does the amount in line 20 column 2 include charges for patient of	lave have	nd a Longth	of stay limit	1. 00 Y	24. 00
24.00	imposed on patients covered by Medicaid or other indigent care pr		nu a rengtii t	ii Stay IIIIII t	T	24.00
25. 00			ogram's Lengt	h of stav limit	3, 911	25. 00
26. 00			. J 5 . 0.19	j	5, 027, 433	
27. 00					525, 596	
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (line		s line 27)		4, 501, 837	
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt exper			28)	703, 408	
30. 00		,		•	1, 004, 530	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line	30)			7, 103, 754	
		•				

Heal th	Financial Systems	TERRE HAUTE REGIO	ONAL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (				Peri od:	Worksheet A	
					From 09/01/2015 Fo 08/31/2016		narod:
					10 00/31/2010	1/25/2017 6: 2	.4 pm
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	2. 00	3. 00	4. 00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT		2, 481, 788	2, 481, 788	199, 729	2, 681, 517	1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		2, 580, 501				1
3.00	00300 OTHER CAP REL COSTS		0	1	0		1
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	122, 414	7, 217, 347	7, 339, 76	1 114, 720	7, 454, 481	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	3, 622, 159	8, 971, 012				
7.00	00700 OPERATION OF PLANT	734, 200	2, 640, 637				
8.00	00800 LAUNDRY & LINEN SERVICE	0	497, 353				
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	888, 157	456, 223				
11. 00	01100 CAFETERI A	661, 589	1, 294, 199 0		-642, 138 638, 087		
13. 00	01300 NURSING ADMINISTRATION	463, 198	84, 985	1			
16. 00	01600 MEDI CAL RECORDS & LI BRARY	60, 894	1, 024, 121				
18. 00	01850 I NSERVI CE EDUCATI ON	1, 478, 973	155, 015				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	5, 997, 385	2, 754, 708	8, 752, 093	34, 721		
31. 00	03100 I NTENSI VE CARE UNI T	1, 930, 817	692, 473				
40. 00	04000 SUBPROVI DER - I PF	1, 737, 503	1, 144, 669				
41.00	04100 SUBPROVI DER – I RF	805, 441	110, 260				
43. 00	04300 NURSERY	177, 346	60, 163	237, 509	9 -34	237, 475	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	3, 075, 732	4, 311, 097	7, 386, 829	-33, 220	7, 353, 609	50.00
51. 00	05100 RECOVERY ROOM	574, 355	95, 070				1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	765, 272	544, 682	1			
53. 00	05300 ANESTHESI OLOGY	0	0 1 1, 002	1,007,70	0 0	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	966, 032	1, 574, 913	2, 540, 94	-267, 765	2, 273, 180	1
54. 01	05401 ULTRASOUND	141, 609	35, 787	177, 396	6 0	,	54. 01
54. 02	05402 MAMMOGRAPHY	161, 823	110, 300				
55. 00	05500 RADI OLOGY-THERAPEUTI C	589, 007	450, 158				
56.00	05600 RADI OI SOTOPE	221, 699	752, 979				1
57. 00 58. 00	05700   CT   SCAN   05800   MRI	491, 549	242, 610 109, 212				
59. 00	05900 CARDI AC CATHETERI ZATI ON	244, 298 517, 462	207, 607				1
60. 00	06000 LABORATORY	1, 205, 429	1, 608, 545				1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	62, 152	534, 967				
65. 00	06500 RESPI RATORY THERAPY	1, 026, 185	656, 820				
66.00	06600 PHYSI CAL THERAPY	1, 123, 703	272, 827		-1, 586	1, 394, 944	66. 00
69. 00	06900 ELECTROCARDI OLOGY	483, 814	311, 364	795, 178		792, 373	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	55, 025	38, 297				
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	334, 641	5, 613, 065				1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	1 100 500	6, 448, 632				
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 489, 580	7, 747, 480	l	_  _		1
	07400   RENAL DI ALYSI S   03020   LI THOTRI PSY	0	796, 533 162, 003			796, 533 162, 003	
76. 00	03330 ENDOSCOPY	331, 914	408, 378				
76. 01	03950 PRI SON CLI NI C	128, 644	29, 429				
	03951 WOUNDCARE	68, 596	601, 759				
	03952 OPI C	438, 578	136, 463	1			1
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	2, 246, 142	7, 902, 680	10, 148, 822	-123, 821	10, 025, 001	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS			1			
99.00	O9900   CMHC   SPECIAL PURPOSE COST CENTERS	0	0	)	0	0	99. 00
118. 00		35, 423, 317	73, 869, 111	109, 292, 428	1, 587	109, 294, 015	110 00
110.00	NONREI MBURSABLE COST CENTERS	35, 425, 317	73,007,111	107, 272, 420	1, 307	109, 294, 013	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	30, 184	23, 675	53, 859	9 0	53, 859	190. 00
	19100 RESEARCH	0	0	1	o o		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	1	0		192. 00
	19300 NONPALD WORKERS	0	0		0		193. 00
	07950 OCCUPATIONAL MEDICINE	984, 185	217, 599	1, 201, 78	-1, 587		
	07951 OTHER NONREIMBURSABLE COST CENTERS	0	0	0=	0		194. 01
	07952 SITTERS	231, 126	19, 931	1			
200.00	TOTAL (SUM OF LINES 118-199)	36, 668, 812	74, 130, 316	110, 799, 128	8 0	110, 799, 128	J∠UU. UU

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150046 Period:

Peri od: Worksheet A From 09/01/2015 To 08/31/2016 Date/Ti me Prepared:

1/25/2017 6: 24 pm

Cost Center Description Adjustments Net Expenses (See A-8) For Allocation 6.00 7.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 129, 363 2,810,880 1.00 00200 CAP REL COSTS-MVBLE EQUIP 13, 241 3, 515, 154 2.00 2.00 3.00 00300 OTHER CAP REL COSTS 3.00 00400 EMPLOYEE BENEFITS DEPARTMENT -244 012 7, 210, 469 4 00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 4, 432, 084 16, 607, 335 5.00 00700 OPERATION OF PLANT 7.00 10, 484 3, 382, 469 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 497, 353 8.00 00900 HOUSEKEEPI NG 1, 348, 422 9.00 20.143 9 00 10.00 01000 DI ETARY -76 1, 313, 574 10.00 11.00 01100 CAFETERI A -337, 255 300, 832 11.00 01300 NURSING ADMINISTRATION 13 00 -942 713, 947 13 00 16.00 01600 MEDICAL RECORDS & LIBRARY 42, 392 1, 124, 135 16.00 18.00 01850 INSERVICE EDUCATION -1, 469 1,628,178 18.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDIATRICS -706, 816 8,079,998 31.00 03100 INTENSIVE CARE UNIT -6, 723 2, 480, 570 31.00 04000 SUBPROVI DER - I PF 40.00 40.00 -770, 265 2, 110, 409 04100 SUBPROVIDER - IRF 41.00 913, 145 41.00 -213 04300 NURSERY 43.00 219 237, 694 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM -3, 419, 491 3, 934, 118 50.00 05100 RECOVERY ROOM 51.00 669, 410 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM -30.0771, 271, 703 52.00 53.00 05300 ANESTHESI OLOGY 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C -659, 231 1, 613, 949 54.00 05401 ULTRASOUND 54.01 177, 396 54 01 54.02 05402 MAMMOGRAPHY 270, 649 54.02 0 05500 RADI OLOGY-THERAPEUTI C 55.00 -1, 304 1,002,198 55.00 56.00 05600 RADI OI SOTOPE 974, 238 56.00 05700 CT SCAN 57.00 -1, 152 732, 970 57.00 58.00 05800 MRI -127 353, 383 58.00 05900 CARDIAC CATHETERIZATION 59.00 -107 724, 326 59.00 60 00 06000 LABORATORY 0 2, 698, 358 60 00 597, 119 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 0 62.00 06500 RESPIRATORY THERAPY -159, 440 1, 270, 286 65.00 65.00 66.00 06600 PHYSI CAL THERAPY -38.036 1, 356, 908 66.00 06900 ELECTROCARDI OLOGY 780, 836 69.00 -11, 537 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 77, 518 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT -366 5, 871, 840 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 6, 625, 391 72 00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 9, 223, 948 73.00 74.00 07400 RENAL DIALYSIS 0 796, 533 74.00 76.00 03020 LI THOTRI PSY 0 162,003 76.00 03330 ENDOSCOPY -77, 100 592.045 76 01 76 01 03950 PRISON CLINIC 76.02 156, 435 76.02 76.03 03951 WOUNDCARE -5.697 663, 812 76.03 03952 OPI C 532, 799 76.04 -40.769 76.04 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY -6, 767, 605 3, 257, 396 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 0 0 99 00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) -8, 631, 884 100, 662, 131 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 53, 788 190 00 191. 00 19100 RESEARCH 191.00 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 0 193. 00 19300 NONPALD WORKERS 0 0 193.00 194. 00 07950 OCCUPATIONAL MEDICINE -312, 330 887, 867 194. 00 194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS O 194. 01 194. 02 07952 SI TTERS -182 250, 875 194. 02 TOTAL (SUM OF LINES 118-199) 200.00 -8, 944, 467 101, 854, 661 200.00

Health Financial Systems RECLASSIFICATIONS Peri od: From 09/01/2015 To 08/31/2016 Date/Ti me Prepared: 1/25/2017 6: 24 pm Provi der CCN: 150046

					1/25/201	7 6:24 pm
		Increases		0.11		
	Cost Center	Li ne #	Sal ary	Other 5 00		
	2. 00 A - LEASES	3. 00	4. 00	5. 00		
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	183, 032		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	ō	906, 038		2. 00
3.00		0.00	O	0		3. 00
4.00		0.00	O	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7. 00		0.00	0	0		7. 00
8. 00		0.00	0	0		8. 00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11. 00 12. 00		0. 00 0. 00	0	0		11. 00 12. 00
13. 00		0.00	0	0		13. 00
14. 00		0.00	o	o		14. 00
15. 00		0.00	o	Ö		15. 00
16. 00		0.00	ō	Ō		16. 00
17. 00		0.00	O	0		17. 00
18.00		0.00	O	0		18. 00
19.00		0.00	0	0		19. 00
20.00		0.00	0	0		20. 00
21. 00		0.00	0	0		21. 00
22. 00		0.00	0	0		22. 00
23. 00		0.00	0	0		23. 00
24. 00		0.00	0	0		24. 00
25. 00 26. 00		0. 00 0. 00	0	0		25. 00 26. 00
27. 00		0.00	0	0		27. 00
28. 00		0.00	0	0		28. 00
29. 00		0.00	ő	Ö		29. 00
27.00	0 — — — — —		<del> </del>	1, 089, 070		27.00
	B - PROPERTY INSURANCE	·	- '	, ,		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	31, 310		1. 00
	0			31, 310		
	C - EXECUTIVE COMPENSATION					
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	117, 992		1. 00
2.00	NURSING ADMINISTRATION	<u>13.</u> 00	177, 164	13, 036		2. 00
	O CAFETERIA		177, 164	131, 028		
1. 00	D - CAFETERI A CAFETERI A	11. 00	216, 304	421, 783		1. 00
1.00	CAPETERIA		216, 304	421, 783		1.00
	E - MEDICAL SUPPLIES		210, 304	421, 703		
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	O	147, 513		1.00
	PATIENT			,		
2.00	DRUGS CHARGED TO PATIENTS	73. 00	o	36		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9. 00 10. 00		0. 00 0. 00	0	0		9. 00 10. 00
11. 00		0.00	0	0		11. 00
12. 00		0.00	0	o		12. 00
13. 00		0.00	0	Ö		13. 00
14. 00		0.00	o	Ö		14. 00
15. 00		0.00	ō	Ö		15. 00
				147, 549		
	F - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	147		1. 00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8. 00			0	<u>0</u>		8. 00
	G - IMPLANTABLE DEVICES		U	14/		
1. 00	I MPL. DEV. CHARGED TO	72.00	0	228, 447		1. 00
1. 50	PATI ENTS	,2.00	J	220, 447		1.00
2.00	INSERVICE EDUCATION	18. 00	О	270		2. 00
3.00		0.00	0	O		3. 00
		· · · · · · · · · · · · · · · · · · ·				· · · · · · · · · · · · · · · · · · ·

Health Financial Systems RECLASSIFICATIONS TERRE HAUTE REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 150046

					1/25/2017 6: 24 p	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0	1	7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		0.00
11. 00		0.00	0	0		1.00
12.00		0. 00	0	0		2.00
	0		0	228, 717	7	
	H - ER BEDHOLD					
1.00	ADULTS & PEDIATRICS	30.00	73, 170	39, 159	)	1.00
2.00	INTENSIVE CARE UNIT	<u>31.</u> 00	2, 210	<u>1, 1</u> 83		2.00
	0		75, 380	40, 342		
	I - LOST CHARGES					
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	1, 191		1. 00
	PATI ENT					
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6. 00
	0		0	1, 191		
	J - EQUIPMENT PROPERTY TAX					
1.00	CAP REL COSTS-MVBLE EQUIP			<u>14, 6</u> 13	3	1.00
	TOTALS		0	14, 613	3	
	L - MISPOSTED LEASE					
1.00	CAP REL COSTS-MVBLE EQUIP			<u>7</u> 61		1. 00
	TOTALS		0	761		
500.00	Grand Total: Increases		468, 848	2, 106, 511	500	00.00

Health Financial Systems
RECLASSIFICATIONS In Lieu of Form CMS-2552-10 Provi der CCN: 150046

						1/25/2017	6:24 pm
		Decreases			1		
	Cost Center	Li ne #	Salary		Wkst. A-7 Ref.		
	A - LEASES	7. 00	8. 00	9. 00	10. 00		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	ol	3, 272	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	77, 657	10		2. 00
3. 00	OPERATION OF PLANT	7.00	0	2, 852	0		3. 00
4. 00	HOUSEKEEPI NG	9. 00	0	16, 101	o		4. 00
5. 00	DI ETARY	10. 00	o	4, 051	o		5. 00
6.00	NURSING ADMINISTRATION	13.00	0	23, 494	0		6. 00
7.00	MEDICAL RECORDS & LIBRARY	16. 00	0	3, 272	O		7. 00
8.00	INSERVICE EDUCATION	18. 00	O	4, 611	0		8. 00
9.00	ADULTS & PEDIATRICS	30.00	0	77, 086	0		9. 00
10.00	INTENSIVE CARE UNIT	31.00	0	138, 724	0		10. 00
11. 00	SUBPROVI DER - I PF	40. 00	0	1, 498	0		11. 00
12.00	SUBPROVI DER - I RF	41. 00	0	2, 343	0		12. 00
13. 00	OPERATING ROOM	50. 00	0	11, 970	0		13. 00
14. 00	DELIVERY ROOM & LABOR ROOM	52. 00	0	6, 886	0		14. 00
15. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	260, 494	0		15. 00
16.00	MAMMOGRAPHY	54. 02	0	1, 474	0		16.00
17. 00	RADI OLOGY-THERAPEUTI C	55.00	0	5, 051	0		17. 00
18.00	LABORATORY	60.00	U	114, 199	0		18. 00
19. 00 20. 00	RESPIRATORY THERAPY PHYSICAL THERAPY	65. 00 66. 00	0	194, 952 1, 473	0		19. 00 20. 00
21. 00	ELECTROENCEPHALOGRAPHY	70. 00	0	15, 804	0		21. 00
22. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	44, 601	0		22. 00
22.00	PATIENT	71.00	o o	44, 001	o o		22.00
23. 00	DRUGS CHARGED TO PATIENTS	73. 00	0	1, 473	o		23. 00
24. 00	ENDOSCOPY	76. 01	0	70, 326	0		24. 00
25. 00	PRISON CLINIC	76. 02	0	1, 473	0		25. 00
26. 00	WOUNDCARE	76. 03	0	440	0		26. 00
27.00	OPI C	76. 04	0	1, 473	0		27. 00
28. 00	OCCUPATIONAL MEDICINE	194.00	0	1, 580	0		28. 00
29.00	RADI OI SOTOPE	56. 00	0	440	0		29. 00
	0		0	1, 089, 070			
	B - PROPERTY INSURANCE						
1. 00	ADMI NI STRATI VE & GENERAL			31, 310	12		1. 00
	0		0	31, 310			_
1 00	C - EXECUTIVE COMPENSATION		177 1/4	121 020			1 00
1.00	ADMINISTRATIVE & GENERAL	5. 00 0. 00	177, 164	131, 028	0		1.00
2. 00			177, 164	0 131, 028	0		2. 00
	D - CAFETERIA		177, 104	131, 020			
1.00	DI ETARY	10.00	216, 304	421, 783	0		1.00
1.00	0		216, 304	421, 783	— — <del>-</del> -		1.00
	E - MEDICAL SUPPLIES		2.0,00.1	1217700			
1.00	ADULTS & PEDIATRICS	30.00	0	8	0		1. 00
2.00	INTENSIVE CARE UNIT	31.00	0	464	O		2. 00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	O	216	0		3. 00
4.00	OPERATING ROOM	50.00	0	15, 353	0		4. 00
5.00	RECOVERY ROOM	51.00	0	7	0		5. 00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	0	7, 271	0		6. 00
7. 00	CARDIAC CATHETERIZATION	59. 00	0	604	0		7. 00
8. 00	LABORATORY	60.00	0	1, 390	0		8. 00
9.00	RESPIRATORY THERAPY	65.00	0	58, 327	0		9. 00
10.00	ELECTROCARDI OLOGY	69.00	0	2, 797	0		10.00
11. 00	IMPL. DEV. CHARGED TO	72. 00	U	51, 688	0		11. 00
12. 00	PATIENTS PRISON CLINIC	76. 02	0	165	0		12. 00
13. 00	WOUNDCARE	76. 02 76. 03	o	392	0		13. 00
14. 00	EMERGENCY	91.00	0	8, 058	0		14. 00
15. 00	ENDOSCOPY	76. 01	0	809	o		15. 00
10.00	0		— — — <del>ў</del>	147, 549	— — —		10.00
	F - DRUGS	I		,			
1.00	ADULTS & PEDIATRICS	30.00	0	9	0		1. 00
2.00	MEDICAL SUPPLIES CHARGED TO	71. 00	О	35	0		2. 00
	PATI ENT						
3.00	EMERGENCY	91.00	0	41	0		3. 00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	o	4	0		4. 00
5. 00	LABORATORY	60.00	0	25	0		5. 00
6.00	ENDOSCOPY	76. 01	0	12	0		6. 00
7.00	WOUNDCARE	76. 03	0	14	0		7. 00
8. 00	OCCUPATI ONAL MEDI CI NE	1 <u>94.</u> 00		$\frac{7}{147}$	0		8. 00
	0		0	147			1

RECLASSI FI CATIONS

Provider CCN: 150046

Worksheet A-6 From 09/01/2015 08/31/2016 Date/Time Prepared:

1/25/2017 6:24 pm Decreases Cost Center 0ther Wkst. A-7 Ref. Li ne # Sal ary 10.00 6.00 7.00 8.00 9.00 G - IMPLANTABLE DEVICES ADULTS & PEDIATRICS 30.00 40 1.00 INTENSIVE CARE UNIT 0 2.00 31.00 0 17 2.00 0 3.00 NURSERY 43.00 34 3.00 OPERATING ROOM 4.00 50.00 5, 725 4.00 0 5.00 DELIVERY ROOM & LABOR ROOM 52.00 1,068 0 5.00 RECOVERY ROOM 0 6.00 51.00 6.00 RADI OLOGY-THERAPEUTI C 0 0 7.00 7.00 55.00 30, 612 8.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 179, 568 0 8.00 PATI ENT 9.00 ELECTROCARDI OLOGY 69.00 0 0 9.00 10.00 DRUGS CHARGED TO PATIENTS 73.00 0 11, 522 0 10.00 11.00 LABORATORY 60.00 0 0 11.00 12.00 PHYSICAL THERAPY 66.00 0 12.00 228, 717 H - ER BEDHOLD 1.00 **EMERGENCY** 91.00 75, 380 40, 342 0 1.00 2.00 0.00 0 2.00 75, 380 40, 342 I - LOST CHARGES 1.00 ADULTS & PEDIATRICS 30.00 465 0 1.00 2.00 INTENSIVE CARE UNIT 31.00 0 185 0 2.00 CARDIAC CATHETERIZATION 59.00 0 0 3.00 3.00 32 4.00 CT SCAN 57.00 0 37 0 4.00 5.00 DRUGS CHARGED TO PATIENTS 73.00 0 300 0 5.00 <u>50.</u>00 6.00 OPERATING ROOM 172 6.00 0 ō 1, 191 J - EQUIPMENT PROPERTY TAX 1.00 CAP REL COSTS-BLDG & FIXT 1.00 14, 613 13 1.00 TOTALS 14,613 L - MISPOSTED LEASE 1.00 ADMINISTRATIVE & GENERAL 5.00 761 10 1.00 TOTALS 761 500.00 Grand Total: Decreases 2, 106, 511 468, 848 500 00

Provi der CCN: 150046

				T	o 08/31/2016	Date/Time Pre	
						1/25/2017 6: 2	4 pm
			Б. 1	Acqui si ti ons	<b>.</b>	D: 1	
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances	2.00	2.00	4.00	Retirements	
	DADT I ANALYCIC OF CHANCEC IN CADITAL ACCE	1.00	2. 00	3. 00	4. 00	5. 00	
1 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		٥		0	0	1 00
1.00	Land	1, 262, 718	0	0	0	0	1.00
2.00	Land Improvements	3, 158, 371	0	0	0	0	2.00
3.00	Buildings and Fixtures	38, 638, 215	0	0	0	0	3.00
4.00	Building Improvements	7, 429, 901	335, 068		335, 068		4. 00
5.00	Fi xed Equi pment	26, 731, 459	327, 945		327, 945		5. 00
6.00	Movable Equipment	54, 005, 249	4, 125, 653	0	4, 125, 653	14, 699, 400	6. 00
7. 00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	131, 225, 913	4, 788, 666	0	4, 788, 666	14, 699, 400	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10. 00	Total (line 8 minus line 9)	131, 225, 913	4, 788, 666	0	4, 788, 666	14, 699, 400	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	1, 262, 718	0				1. 00
2.00	Land Improvements	3, 158, 371	0				2. 00
3.00	Buildings and Fixtures	38, 638, 215	0				3. 00
4.00	Building Improvements	7, 764, 969	0				4. 00
5.00	Fi xed Equipment	27, 059, 404	0				5. 00
6.00	Movable Equipment	43, 431, 502	0				6. 00
7. 00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	121, 315, 179	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	121, 315, 179	0				10. 00

Heal th	Financial Systems T	ERRE HAUTE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od:	Worksheet A-7	
					From 09/01/2015		
					To 08/31/2016	Date/Time Pre 1/25/2017 6: 2	
			SI	JMMARY OF CAPI	ΤΔΙ	172372017 0.2	4 pili
			30	JUNIARY OF CALL	IAL		
	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 WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	2, 363, 298	0		0	118, 490	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2, 456, 294	106, 667	17, 54	0	0	2. 00
3.00	Total (sum of lines 1-2)	4, 819, 592	106, 667	17, 54	0	118, 490	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	2, 481, 788				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2, 580, 501				2. 00
3.00	Total (sum of lines 1-2)	0	5, 062, 289				3. 00

Heal th	n Financial Systems T	ERRE HAUTE REG	IONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 09/01/2015 To 08/31/2016	Worksheet A-7 Part III Date/Time Pre 1/25/2017 6:24	pared:
		COM	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col 2)	•		
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI					2.22	
1.00	CAP REL COSTS-BLDG & FLXT	77, 883, 667	0	77, 883, 66	7 0. 641994	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	43, 431, 502		,,			2. 00
3.00	Total (sum of lines 1-2)	121, 315, 169		121, 315, 16			3. 00
		ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	f Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)		40.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	6. 00	7. 00	8. 00	9. 00	10. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	ENTERS		ı	0 2, 492, 661	183, 032	1. 00
2.00	CAP REL COSTS-BEDG & TTXT				0 2, 469, 535	·	2.00
3.00	Total (sum of lines 1-2)	0			0 4, 962, 196		3. 00
0.00		J	Sl	JMMARY OF CAPI		17 1707 170	0.00
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			,	,	) Capi tal -Relate	` ' '	
			,	·	d Costs (see	through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	1		1	_1		
1.00	CAP REL COSTS-BLDG & FIXT	0	,			2, 810, 880	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	17, 540		,		-, ,	2.00
3.00	Total (sum of lines 1-2)	17, 540	31, 310	118, 49	0 0	6, 326, 034	3. 00

Provi der CCN: 150046

				T i	08/31/2016	Date/Time Prep	
				Expense Classification on	Worksheet A	1/25/2017 6: 2	4 pm
				To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1. 00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FLXT	1.00	5.00	1. 00
	COSTS-BLDG & FLXT (chapter 2)						
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
	(chapter 2)						
4.00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5.00	Refunds and rebates of		0		0. 00	0	5. 00
	expenses (chapter 8)						
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6. 00
7. 00	Tel ephone services (pay		0		0. 00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	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 9, 285, 578-		0. 00	0	9. 00 10. 00
10.00	adjustment	A-0-2	- 7, 203, 370			J	10.00
11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	4, 784, 802			0	12. 00
12.00	transactions (chapter 10)		1, 701, 002			Ŭ	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		0		0. 00 0. 00	0	14. 00 15. 00
	and others		· ·				
16. 00	Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
	patients						
17. 00	Sale of drugs to other than		0		0. 00	0	17. 00
18. 00	patients Sale of medical records and		0		0. 00	0	18. 00
40.00	abstracts						40.00
19. 00	Nursing school (tuition, fees, books, etc.)		0		0. 00	0	19. 00
20.00	Vending machines		0		0. 00	0	20. 00
21. 00	Income from imposition of interest, finance or penalty		0		0. 00	0	21. 00
	charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments	1					
23. 00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of						
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of						
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
23.00	physicians' compensation		O	oost denter bereted	114.00		23.00
27.00	(chapter 21)		0	CAR DEL COCTO DI DO A FLYT	1 00		27.00
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	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00	0	
30. 00	Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68. 00		31. 00
50	pathology costs in excess of		O		55. 50		50
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0. 00	0	32. 00
JZ. UU	Depreciation and Interest		U		0.00		J2. UU
	X-RAY COPY	В		RADI OLOGY-DI AGNOSTI C	54. 00	0	
33. OT	CAFETERI A	В	-316, 991	CAFETERI A	11. 00	0	33. 01

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Peri od: Worksheet A-8 From 09/01/2015 Date/Time Prepared: Provi der CCN: 150046

				To	08/31/2016	Date/Time Pre 1/25/2017 6:2	
				Expense Classification on		172072017 0.2	, piii
				To/From Which the Amount is	to be Adjusted		
	Cook Cooker Bookinting	D: - (Cd (2)	A	0+ 0+	1: "	WI+ A 7 D-E	
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
33. 02	VENDI NG	В		CAFETERI A	11. 00	0	33. 02
33. 03	ED OTHER	В		INSERVICE EDUCATION	18. 00	0	
33. 04 33. 05	MEDICAL RECORDS SCRAP METAL	B B		MEDICAL RECORDS & LIBRARY ADMINISTRATIVE & GENERAL	16. 00 5. 00	0	33. 04 33. 05
33. 06	COMP REHAB	В		ELECTROCARDI OLOGY	69. 00	0	33.06
33. 07	INTEREST INCOME	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 07
33. 08	HOSPI CE	В		ADULTS & PEDIATRICS	30. 00	0	33. 08
33. 09 33. 10	UNCLAIMED PROPERTY WORKER'S COMP. PAID CLAIMS	B A		ADMINISTRATIVE & GENERAL EMPLOYEE BENEFITS DEPARTMENT	5. 00 4. 00	0	33. 09 33. 10
33. 10	WORKER'S COMP. PAID CLAIMS WORKER'S COMP INSURANCE	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 10
33. 12	PATIENT ACCOUNT INTEREST	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 12
33. 13	PATI ENT TELEPHONES	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 13
33. 14 33. 15	PATIENT TELEPHONES PATIENT TV' S	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33. 14 33. 15
33. 16	PATIENT TV'S	A		OPERATION OF PLANT	7. 00	0	33. 16
33. 17	CONSULTING 900-317	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 17
33. 18	ADMI N. TRAVEL 900-750	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 18
33. 19 33. 20	ADMIN. MEALS 900-764 MISC. XXX870	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33. 19 33. 20
33. 21	NONPATIENT GIFTS	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 21
33. 22	NONPATIENT GIFTS	A	-37, 113	ADMINISTRATIVE & GENERAL	5. 00	0	33. 22
33. 23	NONPATIENT GIFTS	A		INSERVICE EDUCATION	18.00	0	33. 23
33. 24 33. 25	NONPATIENT GIFTS PATIENT GIFTS	A A		EMERGENCY ADMINISTRATIVE & GENERAL	91. 00 5. 00	0	33. 24 33. 25
33. 26	SPOUSE TRAVEL	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 26
33. 27	ALCOHOL	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 27
33. 28	ALCOHOL	A		I NSERVI CE EDUCATI ON	18. 00	0	33. 28
33. 29 33. 30	ALCOHOL ALCOHOL	A A		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	0	33. 29 33. 30
33. 31	ALCOHOL	A		EMERGENCY	91.00	0	33. 31
33. 32	COUNTRY CLUB DUES	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 32
33. 33	PHYSICIAN RECRUITMENT	A		ADMINISTRATIVE & GENERAL	5.00	0	33. 33
33. 34 33. 35	PHYSICIAN RECRUITMENT NONALLOWABLES 900805	A A		DI ETARY ADMI NI STRATI VE & GENERAL	10. 00 5. 00	0	33. 34 33. 35
33. 36	CONTRI BUTI ONS	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 36
33. 37	PENALTI ES	A		OPERATION OF PLANT	7. 00	0	33. 37
33. 38	MED STAFF NONALLOWABLES 843971	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 38
33. 39 33. 40	POB DEPT. 858 MARKETING DEPT. 919718	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33. 39 33. 40
33. 41	PUBLIC RELATIONS DEPT. 920	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 41
33. 42	SALES DEPT. 965	A	-452	ADMINISTRATIVE & GENERAL	5. 00	0	33. 42
33. 43	LEGAL FEES	A	· ·	ADMINISTRATIVE & GENERAL	5.00	0	
33. 44 33. 45	CLINICAL RESEARCH CLINICAL RESEARCH	A A		RADI OLOGY-THERAPEUTI C OPI C	55. 00 76. 04	0	•
33. 46	CLINICAL RESEARCH	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	
33. 47	CRNA	A		OPERATING ROOM	50. 00	0	33. 47
33. 48	NURSE PRACTITIONER	A		OCCUPATIONAL MEDICINE INSERVICE EDUCATION	194.00	0	33. 48
33. 49 33. 50	NURSE PRACTITIONER LOBBYING DUES	A A		ADMINISTRATIVE & GENERAL	18. 00 5. 00	0	33. 49 33. 50
33. 51	MOB ACCOUNTING	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 51
33. 52	MOB ACCOUNTI NG	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 52
33. 53 33. 54	USEFUL LIFE ADJUSTMENT PHYSICIAN RECORDS STORAGE	A A		CAP REL COSTS-BLDG & FIXT OPERATION OF PLANT	1.00	9	33. 53 33. 54
33. 55	SOFTWARE AMORTIZATION	A		CAP REL COSTS-MVBLE EQUIP	7. 00 2. 00	9	33. 55
33. 56	ADVERTI SI NG	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 56
33. 57	ADVERTI SI NG	Α		RADI OLOGY-THERAPEUTI C	55.00	0	
33. 58	ADVERTI SI NG	A		OPI C	76. 04	0	33. 58
33. 59 33. 60	ADVERTI SI NG ADVERTI SI NG	A A		EMERGENCY GIFT, FLOWER, COFFEE SHOP &	91. 00 190. 00	0	33. 59 33. 60
55. 55			-71	CANTEEN CONTEL SHOP &	170.00		55. 55
33. 61			0		0.00	0	
33. 62 33. 63			0		0. 00 0. 00	0	
33. 64			0		0.00	0	1
33. 65			Ö		0. 00	Ö	33. 65
33. 66			0		0.00	0	•
33. 67 33. 68			0		0. 00 0. 00	0	
33. 68			0		0.00		1
	1	ı		1			

				Т	o 08/31/2016	Date/Time Pre 1/25/2017 6:2	
				Expense Classification on	Worksheet A	172372017 0.2	T PIII
				To/From Which the Amount is	to be Adiusted		
				To Troil Will ell the Amount 13	to be maj astea		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	0001 00tol	1.00	2. 00	3.00	4. 00	5. 00	
33. 70			0		0.00	0	33. 70
33. 71			0		0.00	0	1
33. 72			0		0.00	0	33. 72
33. 73			0		0.00	0	33. 73
33. 74			0		0.00	0	33. 74
33. 75			0		0.00	0	1
33. 76			0		0.00	0	33. 76
33. 77			0		0.00	0	33. 77
33. 78			0		0.00	0	33. 78
33. 79			0		0.00	0	1
33. 80			0		0.00	0	33. 80
33. 81			0		0.00	0	33. 81
33. 82			0		0.00	0	33. 82
33. 83			0		0.00	0	1
33. 84			0		0.00	0	33. 84
33. 85			0		0.00	0	33. 85
33. 86			0		0.00	0	33. 86
33. 87			0		0.00	0	1
33. 88			0		0.00	0	33. 88
33. 89			0		0.00	0	33. 89
33. 90			0		0.00	0	1
33. 91			0		0.00	0	1
33. 92			0		0.00	0	33. 92
33. 93			0		0.00	0	33. 93
33. 94			0		0.00	0	1
33. 95			0		0.00	0	1
33. 96			0		0.00	0	33. 96
33. 97			0		0.00	0	1
33. 98			0		0.00	0	1
33. 99			0		0.00	0	1
50. 00	TOTAL (sum of lines 1 thru 49)		-8, 944, 467		0.00	0	50.00
30.00	(Transfer to Worksheet A,		-0, 744, 407				30.00
	column 6, line 200.)						
(1) 5	i-ti			CMC Dub 1E 1			

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

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

  B. Amount Received if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provi der CCN: 150046 Peri od: Worksheet A-8-1 From 09/01/2015
To 08/31/2016 Date/Time Prepared: OFFICE COSTS

				To 08/31/2016	Date/Time Pre 1/25/2017 6:2	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	7 5
				Allowable Cost	Included in Wks. A, column	
					WKS. A, COLUMNI 5	
	1. 00	2.00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
1.00		ADMINISTRATIVE & GENERAL	HPG	94, 049	180, 961	1. 00
2.00		ADMINISTRATIVE & GENERAL	IT&S	1, 567, 982	1, 657, 186	2. 00
3. 00 4. 00		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	HOME OFFICE COST HOME OFFICE DIRECT COMP.	2, 172, 409 348, 108	7, 345, 733 0	3. 00 4. 00
4. 01		ADMINISTRATIVE & GENERAL	SSC	2, 501, 602	2, 501, 602	4. 00
4. 02	5. 00	ADMINISTRATIVE & GENERAL	SUPPLY CHAIN	1, 253, 182	1, 253, 182	4. 02
4. 03		ADMINISTRATIVE & GENERAL	PARALLON WORKFORCE SOLUTIONS	-2, 909 12, 019	-2, 909 12, 040	4. 03 4. 04
4. 04 4. 05	•	NURSING ADMINISTRATION MEDICAL RECORDS & LIBRARY	PARALLON WORKFORCE SOLUTIONS PARALLON WORKFORCE SOLUTIONS	12, 018 2, 744	12, 960 2, 959	4. 04
4. 06		ADULTS & PEDIATRICS	PARALLON WORKFORCE SOLUTIONS	912, 413	983, 946	4. 06
4. 07		INTENSIVE CARE UNIT	PARALLON WORKFORCE SOLUTIONS	85, 642	92, 356	4. 07
4. 08 4. 09	•	SUBPROVI DER – I PF SUBPROVI DER – I RF	PARALLON WORKFORCE SOLUTIONS PARALLON WORKFORCE SOLUTIONS	30, 869 2, 713	33, 289 2, 926	4. 08 4. 09
4. 10		NURSERY	PARALLON WORKFORCE SOLUTIONS	-2, 789	-3, 008	4. 10
4. 11		OPERATING ROOM	PARALLON WORKFORCE SOLUTIONS	475, 485	512, 763	4. 11
4. 12	•	DELIVERY ROOM & LABOR ROOM	PARALLON WORKFORCE SOLUTIONS	383, 642	413, 719	4. 12
4. 13 4. 14	58.00	CT SCAN MRI	PARALLON WORKFORCE SOLUTIONS PARALLON WORKFORCE SOLUTIONS	14, 693 1, 619	15, 845 1, 746	4. 13 4. 14
4. 15	•	CARDIAC CATHETERIZATION	PARALLON WORKFORCE SOLUTIONS	1, 360		4. 15
4. 16		RESPI RATORY THERAPY	PARALLON WORKFORCE SOLUTIONS	3, 066		4. 16
4. 17 4. 18	•	PHYSICAL THERAPY MEDICAL SUPPLIES CHARGED TO	PARALLON WORKFORCE SOLUTIONS PARALLON WORKFORCE SOLUTIONS	72, 863 4, 669	78, 575 5, 035	4. 17 4. 18
4. 19		EMERGENCY	PARALLON WORKFORCE SOLUTIONS	521, 717	562, 619	4. 19
4. 20		SITTERS	PARALLON WORKFORCE SOLUTIONS	2, 322	2, 504	4. 20
4. 21	•	ADMINISTRATIVE & GENERAL	PARALLON MARK-UP	0	729, 187	4. 21
4. 22 4. 23		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	PARALLON PAYROLL CAPITAL DIVISION IT&S	34, 530 1, 345, 866	34, 530 1, 345, 291	4. 22 4. 23
4. 24		MEDICAL RECORDS & LIBRARY	HI M	996, 761	949, 845	4. 24
4. 25		MEDICAL RECORDS & LIBRARY	I CD-10 FEES	31, 970	36, 256	4. 25
4. 26 4. 27		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	REVENUE INTEGRITY CREDENTIALING	136, 968 70, 730	136, 968 70, 730	4. 26 4. 27
4. 28		SUBPROVI DER - I PF	BEHAVI ORAL HEALTH	132, 035	171, 471	4. 28
4. 29	•	ADMINISTRATIVE & GENERAL	IT&S PARALLON	302, 486	302, 486	4. 29
4. 30 4. 31		MEDICAL RECORDS & LIBRARY EMPLOYEE BENEFITS DEPARTMENT	PREBILL DENIAL HCA HR SERVICES	25, 483 280, 831	24, 160 397, 951	4. 30 4. 31
4. 31	1	ADMINISTRATIVE & GENERAL	CALL CENTER	200, 031	69, 917	4. 31
4. 33		ADMINISTRATIVE & GENERAL	PHYSICIAN RECRUITING	0	80, 770	4. 33
4.34		ADMINISTRATIVE & GENERAL	MALPRACTI CE	64, 253	744, 485	4. 34
4. 35 4. 36		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	GENERAL LIABILITY INSURANCE PHYSICIAN SALES	0	7, 133 168, 822	4. 35 4. 36
4. 37		ADMINISTRATIVE & GENERAL	MARKETING ALLOCATIONS	Ö	129, 935	4. 37
4. 38		ADMINISTRATIVE & GENERAL	RI CHMOND FSC	160, 234	170, 220	4. 38
4. 39 4. 40	•	EMPLOYEE BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	RESTORATION PLAN EXP. SELF INS_POOLING ADJ.	0	180 67, 227	4. 39 4. 40
4. 41		ADMINISTRATIVE & GENERAL	INTERCOMPANY INTEREST	Ö		4. 41
4. 42		ADMINISTRATIVE & GENERAL	HOME OFFICE INTEREST	570, 231	0	4. 42
4. 43 4. 44	•	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	POB SPACE POB SPACE	96, 825 289	0	4. 43 4. 44
4. 45		ADMINISTRATIVE & GENERAL	POB SPACE	41, 546	l o	4. 45
4.46	7.00	OPERATION OF PLANT	POB SPACE	53, 865	О	4. 46
4. 47		HOUSEKEEPI NG	POB SPACE	16, 720	0	4. 47
4. 48 4. 49		CAP REL COSTS-BLDG & FIXT ADMINISTRATIVE & GENERAL	PAVILLION SPACE PAVILLION SPACE	77, 021 1, 478	0	4. 48 4. 49
4. 50		OPERATION OF PLANT	PAVILLION SPACE	24, 974	Ö	4. 50
4. 51		HOUSEKEEPI NG	PAVILLION SPACE	3, 423	0	4. 51
4. 52 4. 53	0.00			0	0	4. 52 4. 53
4. 53	0.00			0	0	4. 53
4.55	0.00			0	0	4. 55
5.00	TOTALS (sum of lines 1-4).			14, 927, 988	10, 143, 186	5. 00
	Transfer column 6, line 5 to Worksheet A-8, column 2,					
	line 12.					
* The	amounts on lines 1-4 (and sub	oscripts as appropriate) are	transferred in detail to Works	sheet A column	6 lines as	

<sup>\*</sup> 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.

Health Financial Systems	TERRE HAUTE F	REGI ONAL	HOSPI TAL		In Lie	u of Form CMS-2!	552-10
STATEMENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND H	HOME	Provi der	CCN: 150046	Peri od: From 09/01/2015	Worksheet A-8-	1
OFFICE COSTS						Date/Time Prep	
						1/25/2017 6: 24	pm
				Related Organ	nization(s) and/o	r Home Office	

Percentage of

Ownershi p

3.00

Percentage of

Ownershi p

5.00

Name

4.00

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	100. 00 PARALLON 100. 00	6. 00
7.00	В	54. 40 HPG   54. 40	7.00
8.00	В	100.00 HCl   100.00	8.00
9.00	В	100.00 CAPI TAL DI VI SI 0   100.00	9.00
10.00	В	100.00 WORKFORCE MGT. 100.00	10.00
10. 01	В	100.00 HCA   100.00	10. 01
10. 02	В	100.00 P0B   100.00	10. 02
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

Symbol (1)

1.00

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.

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

Name

2.00

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

	Net	Wkst. A-7 Ref.	1723/2017 6.2	ı piii
	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			4 00
1.00	-86, 912			1.00
2.00	-89, 204	1		2.00
3.00	-5, 173, 324			3. 00
4. 00 4. 01	348, 108			4. 00 4. 01
4. 01	0			4. 01
4. 03	0	1		4. 02
4. 04	-942			4. 04
4. 05	-215			4. 05
4. 06	-71, 533			4. 06
4.07	-6, 714			4. 07
4.08	-2, 420	1		4. 08
4.09	-213			4. 09
4. 10	219	0		4. 10
4. 11	-37, 278			4. 11
4. 12	-30, 077			4. 12
4. 13	-1, 152			4. 13
4. 14	-127			4. 14
4. 15	-107	1		4. 15
4. 16 4. 17	-240	1		4. 16 4. 17
4. 17 4. 18	-5, 712 -366	1		4. 17
4. 19	-40, 902			4. 19
4. 20	-182			4. 20
4. 21	-729, 187			4. 21
4. 22	0	1		4. 22
4. 23	575	0		4. 23
4. 24	46, 916			4. 24
4. 25	-4, 286			4. 25
4. 26	0			4. 26
4. 27	0	_		4. 27
4. 28	-39, 436	1		4. 28
4. 29 4. 30	1, 323			4. 29 4. 30
4. 30	-117, 120			4. 30
4. 32	-69, 917			4. 31
4. 33	-80, 770			4. 33
4. 34	-680, 232			4. 34
4. 35	-7, 133			4. 35
4. 36	-168, 822	0		4. 36
4.37	-129, 935	0		4. 37
4. 38	-9, 986			4. 38
4. 39	-180			4. 39
4. 40	-67, 227			4. 40
4. 41	11, 153, 140			4. 41
4.42	570, 231	0		4. 42
4.43	96, 825			4. 43
4. 44 4. 45	289 41, 546			4. 44 4. 45
4. 45	53, 865	0		4. 45
4. 47	16, 720			4. 47
4. 48	77, 021			4. 48
4. 49	1, 478			4. 49
4.50	24, 974	0		4. 50
4. 51	3, 423	0		4. 51
4.52	0	0		4. 52
4.53	0			4. 53
4. 54	0			4. 54
4. 55	0	0		4. 55
5.00	4, 784, 802			5. 00

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

Related Organization(s) and/or Home Office		
Type of Business		
6. 00		

Heal t	h Financial Systems	TERRE HAUTE	REGI ONAL	. HOSPI TAL		In Lie	u of Form CMS-	2552-10
STATI	EMENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND	HOME	Provi der CCN	: 150046	Peri od:	Worksheet A-8	3-1
OFFI(	CE COSTS					From 09/01/2015	D-+- /T: D	
						To 08/31/2016	Date/Time Pro 1/25/2017 6:2	
	Related Organization(s) and/or Home Office		·					
	Type of Business							
	6. 00							
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR	HOME OFF	I CE:				

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

reimbur	sement under title XVIII.	
6.00	MANAGEMENT	6. 00
7.00	PURCHASI NG	7.00
8.00	I NSURANCE	8.00
9.00	MANAGEMENT	9. 00
10.00	STAFFING	10.00
10. 01	HOSPITAL MGT.	10. 01
10. 02	PROFESSI ONAL BU	10. 02
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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provi der CCN: 150046

					1	To 08/31/2016	Date/Time Pre	epared:
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	14 pill
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1. 00	30.00	ADULTS & PEDIATRICS	604, 262	553, 024	51, 238	211, 500	274	1. 00
2.00	40. 00	SUBPROVIDER - IPF	728, 409	728, 409	0	181, 300	0	2. 00
3.00	50.00	OPERATING ROOM	446, 381	421, 955		246, 400	177	3. 00
4.00	54.00	RADI OLOGY-DI AGNOSTI C	658, 886	658, 886	0	271, 900	0	4. 00
5.00	65. 00	RESPI RATORY THERAPY	159, 200	159, 200	0	211, 500	0	5. 00
6.00	66. 00	PHYSI CAL THERAPY	73, 200	12, 900	60, 300	211, 500	402	6. 00
7.00	69. 00	ELECTROCARDI OLOGY	35, 925		35, 925	211, 500	240	7. 00
8.00	76. 01	ENDOSCOPY	77, 100	77, 100	0	246, 400	0	8. 00
9.00	76. 03	WOUNDCARE	24, 000	-3,000	27,000	211, 500	180	9. 00
10.00	76. 04	OPI C	88, 638	l c	88, 638	211, 500	474	10. 00
11. 00		EMERGENCY	6, 568, 231	6, 507, 169	61, 062	211, 500	264	11. 00
12.00	194. 00	OCCUPATIONAL MEDICINE	28, 800	28, 800	0	211, 500	0	12. 00
200.00	İ		9, 493, 032	9, 144, 443	348, 589		2, 011	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				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		ADULTS & PEDIATRICS	27, 861	1, 393				1. 00
2.00		SUBPROVIDER - IPF	0	C		_		
3.00		OPERATING ROOM	20, 968			0	· ·	
4.00		RADI OLOGY-DI AGNOSTI C	0	0	1	0	0	4. 00
5. 00		RESPI RATORY THERAPY	0		_	0	0	5. 00
6. 00		PHYSI CAL THERAPY	40, 876			ı	· ·	6. 00
7.00		ELECTROCARDI OLOGY	24, 404			0	0	7. 00
8.00		ENDOSCOPY	0	C	_	0	0	8. 00
9.00		WOUNDCARE	18, 303			0	0	9. 00
10.00	76. 04		48, 198	·		0	0	10. 00
11. 00		EMERGENCY	26, 844			0		11. 00
12.00	194. 00	OCCUPATIONAL MEDICINE	0	C	9	0		12. 00
200.00			207, 454				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	2.00	15. 00	16. 00	17. 00	18. 00		
1.00		ADULTS & PEDIATRICS	13.00			576, 401		1.00
2.00		SUBPROVI DER - I PF	0					2. 00
3.00		OPERATING ROOM	0		1			3. 00
4.00		RADI OLOGY-DI AGNOSTI C	0	20, 700	1	658, 886		4. 00
5. 00		RESPI RATORY THERAPY	0	1	1			5. 00
6. 00		PHYSI CAL THERAPY	0	40, 876	_	32, 324		6. 00
7. 00		ELECTROCARDI OLOGY		24, 404	1	11, 521		7. 00
8. 00		ENDOSCOPY		24, 404				8. 00
9. 00		WOUNDCARE	0		_	5, 697		9. 00
10.00	76. 04		0					10.00
11. 00		EMERGENCY	0					11. 00
12. 00		OCCUPATIONAL MEDICINE	0	,		28, 800		12. 00
200.00	.,		0		_			200.00
	'		'				'	'

| Peri od: | Worksheet B | From 09/01/2015 | Part | To 08/31/2016 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150046

				<del>'</del> T	08/31/2016	Date/Time Pre	
			CAPI TAL REI	LATED COSTS		1/25/2017 6: 2	4 pm
	Cost Contor Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMDLOVEE	Subtatal	
	Cost Center Description	for Cost	BLDG & FIXI	MARTE EGOLA	EMPLOYEE BENEFITS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A col. 7)					
		0	1.00	2.00	4. 00	4A	
	GENERAL SERVI CE COST CENTERS	0.010.000	0.040.000	ı			1 00
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	2, 810, 880 3, 515, 154		3, 515, 154			1. 00 2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT	7, 210, 469	l				4. 00
	00500 ADMINISTRATIVE & GENERAL	16, 607, 335	1			17, 716, 589	5. 00
	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	3, 382, 469 497, 353		1		4, 991, 491 559, 334	7. 00 8. 00
	00900 HOUSEKEEPI NG	1, 348, 422				1, 547, 547	9. 00
10. 00	01000 DI ETARY	1, 313, 574	l	56, 463	88, 653	1, 503, 469	1
	01100 CAFETERI A	300, 832	l	1		408, 468	
1	01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY	713, 947 1, 124, 135	l	1		858, 766 1, 236, 049	
1	01850 I NSERVI CE EDUCATI ON	1, 628, 178	l			2, 017, 746	1
	INPATIENT ROUTINE SERVICE COST CENTERS	0.070.000		1 (00 750		10.001.000	
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	8, 079, 998 2, 480, 570	1			10, 381, 938 3, 051, 469	1
	04000 SUBPROVI DER - I PF	2, 110, 409	l			2, 624, 298	
41. 00	04100 SUBPROVI DER - I RF	913, 145	88, 320	111, 364	160, 357	1, 273, 186	
	04300 NURSERY	237, 694	8, 083	10, 191	35, 308	291, 276	43. 00
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	3, 934, 118	195, 274	246, 225	612, 354	4, 987, 971	50.00
	05100 RECOVERY ROOM	669, 410	l			811, 328	1
	05200 DELIVERY ROOM & LABOR ROOM	1, 271, 703	1	1		1, 549, 775	
	05300  ANESTHESI OLOGY 05400  RADI OLOGY-DI AGNOSTI C	1, 613, 949	0 101, 171			0 2, 035, 018	53. 00 54. 00
	05401 ULTRASOUND	177, 396	l	l		212, 695	1
	05402 MAMMOGRAPHY	270, 649	1	1		329, 035	1
	05500 RADI OLOGY-THERAPEUTI C	1, 002, 198	l	1		1, 227, 586	1
	05600 RADI 0I SOTOPE 05700 CT SCAN	974, 238 732, 970	l			1, 031, 364 858, 875	56. 00 57. 00
	05800 MRI	353, 383	l	1		420, 225	1
	05900 CARDI AC CATHETERI ZATI ON	724, 326	l	1		867, 485	1
1	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	2, 698, 358 597, 119	l	1		3, 032, 030 615, 094	60. 00 62. 00
	06500 RESPIRATORY THERAPY	1, 270, 286	l	1		1, 503, 280	1
	06600 PHYSI CAL THERAPY	1, 356, 908				1, 818, 418	
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	780, 836	1	1		915, 527 107, 553	69.00
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	77, 518 5, 871, 840	l	1		6, 087, 090	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	6, 625, 391	0	1		6, 625, 391	72. 00
	07300 DRUGS CHARGED TO PATIENTS	9, 223, 948	l	1	296, 563	9, 567, 509	
1	07400 RENAL DI ALYSI S 03020 LI THOTRI PSY	796, 533 162, 003	i .	4, 608	0	804, 795 162, 003	1
	03330 ENDOSCOPY	592, 045		18, 792	66, 081	691, 821	
	03950 PRISON CLINIC	156, 435	l		25, 612	313, 325	
	03951 WOUNDCARE 03952 OPI C	663, 812 532, 799		1		707, 716 687, 068	
	OUTPATIENT SERVICE COST CENTERS	332, 177	27,013	37, 337	07, 317	087,008	70.04
	09100 EMERGENCY	3, 257, 396	79, 595	100, 362	432, 181	3, 869, 534	
	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
	OTHER REIMBURSABLE COST CENTERS 09900 CMHC	0	0	0	O	0	99. 00
	SPECIAL PURPOSE COST CENTERS						77.00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	100, 662, 131	2, 748, 000	3, 465, 007	7, 028, 141	100, 301, 137	118. 00
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	53, 788	4, 699	5, 925	6, 009	70 421	190. 00
	19100 RESEARCH	0	0	3, 723			191. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	o		192. 00
	19300 NONPALD WORKERS 07950 OCCUPATIONAL MEDICINE	0 887, 867	0 35, 071	0	0 195, 943	0 1, 163, 103	193.00
	07950 OCCUPATIONAL MEDICINE 07951 OTHER NONREIMBURSABLE COST CENTERS	007,867	23, 110	1			194. 00
194. 02	07952 SI TTERS	250, 875		1	_	296, 890	194. 02
200.00	Cross Foot Adjustments	]	_	_			200.00
201. 00 202. 00	Negative Cost Centers TOTAL (sum lines 118-201)	101, 854, 661	2, 810, 880	3, 515, 154	0 7, 276, 108		201. 00 202. 00
_02.00	,			3,510,104	, ,, 2, 3, 130	, 55 1, 551	,

Provider CCN: 150046

				1	0 08/31/2016	1/25/2017 6:2	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	, p
		& GENERAL	PLANT	LINEN SERVICE			
	OFNEDAL CERVILOE COCT OFNITERS	5. 00	7. 00	8. 00	9. 00	10. 00	
1. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS-BLDG & FIXT	T		I			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	17, 716, 589					5. 00
7.00	00700 OPERATION OF PLANT	1, 051, 038	6, 042, 529				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	117, 777	85, 055	762, 166			8. 00
9.00	00900 HOUSEKEEPI NG	325, 861	30, 602	55, 039	1, 959, 049		9. 00
10. 00	01000 DI ETARY	316, 579	138, 932	0	45, 922	2, 004, 902	10. 00
11. 00	01100 CAFETERI A	86, 009	88, 610	1		0	
13. 00	01300 NURSI NG ADMI NI STRATI ON	180, 827	23, 780		,	0	
16. 00	01600 MEDI CAL RECORDS & LI BRARY	260, 270	136, 938			0	1
18. 00	01850 I NSERVI CE EDUCATI ON	424, 869	130, 525	0	43, 143	0	18. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2, 186, 055	1, 500, 338	294, 095	495, 920	948, 068	30.00
31. 00	03100 INTENSIVE CARE UNIT	642, 536	255, 309	l	84, 389	56, 515	1
40. 00	04000 SUBPROVI DER - I PF	552, 588	230, 496	1		292, 185	1
41. 00	04100 SUBPROVI DER – I RF	268, 090	274, 021	1		121, 084	
43. 00	04300 NURSERY	61, 333	25, 077	1		0	
	ANCILLARY SERVICE COST CENTERS		·				1
50.00	05000 OPERATING ROOM	1, 050, 297	605, 857	62, 421	200, 258	0	50.00
51. 00	05100 RECOVERY ROOM	170, 838	37, 832		12, 505	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	326, 330	172, 512	11, 811	57, 022	0	
53. 00	05300 ANESTHESI OLOGY	0	0	· ·	- I	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	428, 506	313, 894			0	
54. 01	05401 ULTRASOUND	44, 786	9, 752		-,	0	
54. 02	05402 MAMMOGRAPHY	69, 284	35, 910	1	,	0	
55. 00 56. 00	05500   RADI OLOGY-THERAPEUTI C   05600   RADI OI SOTOPE	258, 488 217, 170	148, 372 17, 823	1		0	
57. 00	05700 CT SCAN	180, 850	38, 480	1	l ' '	0	
58. 00	05800 MRI	88, 485	24, 981	l ő	l ' '	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	182, 663	55, 078			0	
60. 00	06000 LABORATORY	638, 442	128, 555	1	l '	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	129, 518	7, 686	1	l	0	62. 00
65.00	06500 RESPI RATORY THERAPY	316, 540	39, 369	0	13, 013	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	382, 897	326, 312	13, 701	107, 858	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	192, 779	52, 652	5, 315	17, 403	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	22, 647	26, 182		8, 654	0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 281, 734	203, 954		67, 414	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 395, 082	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 014, 592	64, 494	1	,	0	
74. 00 76. 00	07400 RENAL DI ALYSI S 03020 LI THOTRI PSY	169, 462 34, 112	11, 337	0		0	
76. 00	03330 ENDOSCOPY	145, 674	46, 239	_	-	0	
76. 01	03950 PRI SON CLI NI C	65, 976	180, 150		59, 546	0	
76. 02	03951 WOUNDCARE	149, 021	41, 507			0	
76. 04	03952 OPI C	144, 673	91, 877			0	
	OUTPATIENT SERVICE COST CENTERS						ĺ
91.00	09100 EMERGENCY	814, 792	246, 950	84, 213	81, 626	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						
99. 00	09900 CMHC	0	0	0	0	0	99. 00
	SPECIAL PURPOSE COST CENTERS	17 000 170	5 0 4 7 4 0 0	7,0 4,4	1 004 545	1 117 050	
118. 00	<u> </u>	17, 389, 470	5, 847, 438	762, 166	1, 894, 565	1, 417, 852	1118.00
100.00	NONREIMBURSABLE COST CENTERS   19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	14 020	14 500	0	4, 819		190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	14, 828	14, 580	0	l '		191.00
	19200 PHYSICIANS' PRIVATE OFFICES		0	0	-		192. 00
	19300 NONPALD WORKERS		0	0	0		193. 00
	07950 OCCUPATI ONAL MEDI CI NE	244, 910	108, 811	0	35, 966		194. 00
	07951 OTHER NONREIMBURSABLE COST CENTERS	4, 866	71, 700		23, 699	587, 050	
	07952 SI TTERS	62, 515	0	0	0		194. 02
200.00							200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	17, 716, 589	6, 042, 529	762, 166	1, 959, 049	2, 004, 902	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150046 Peri od: Worksheet B From 09/01/2015 Part I To 08/31/2016 Date/Time Prepared:

CAPTERIA   MISSING   WITH CALE   SIGNIFICAL   SIGNIFICA						T	0 08/31/2016	Date/Time Pre 1/25/2017 6:2	
CENTERIA   NURSING   NUR							OTHER GENERAL	1/23/2017 0.2	4 piii
CENERAL SERVICE COST CENTERS									
Care			Cost Center Description	CAFETERI A				Subtotal	
CENERAL SERVICE COST CENTERS					ADMINISTRATION		EDUCATION		
1.00				11.00	13.00		18. 00	24. 00	
2.00									
0-0400   DIPLOYEE BENEFITS DEPARTMENT									•
5.00   00500  AUMINISTATIVE A CENERAL									•
0.0000   0.00000   0.0000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000000									•
9.00   00000   000000   000000   000000   00000   00000   000000									•
10.00   01000   DETARY									
11.00 0 1100 (AFETERIA   612,376   1.079,377   1.600,233   1.600,231   1.00   13.00									•
13.00   01300   MURSING ADMINISTRATION   8,094   1,779,327   1,680,233   1,680,233   16.00				410 274					•
1.00   01000   MEDI CAL RECORDS & LIBRARY   1,713   0   1,680,233   1,680,233   1,880,233   1,880,233   1,880,233   1,880,231   1,880,233   1,880,233   1,880,233   1,880,233   1,880,233   1,880,233   1,880,233   1,880,233   1,880,233   1,880,233   1,880,233   1,880,233   1,880,233   1,880,233   1,880,233   1,880,231   1,880,233   1,880,23									ł
IMPATIENT ROUTINE SERVICE COST CENTERS   133, 128   300, 327   61, 742   739, 803   17, 131, 414   30 0 0		1				1, 680, 233			•
0.000   0.3000   ADULTS & PEDIATRICS   133, 128   390, 327   61, 742   799, 803   17, 131, 414   30. 00   30. 00   0.4000   MINENSIVE CARE INIT   34, 256   99, 183   22, 242   194, 764   4, 503, 084   31. 00   40. 00   0.4000   SUBPROVIDER - I PF   41, 021   114, 521   59, 570   30. 360   4, 387, 554   40. 00   40. 00   40. 00   57, 793   41, 869   2, 137, 565   41. 00   41. 0	18. 00			29, 468	81, 313	0	2, 727, 064		18. 00
31.00   03100   INTENSIVE CARE UNIT   34, 256   98, 183   23, 242   194, 764   4, 503, 084   31 0.00   0400   034000   SUBPROVIDER   IPF   41, 021   114, 521   59, 507   360, 369   4, 387, 555   41 00 0   41.00   04100   SUBPROVIDER   IFF   14, 443   40, 001   5, 793   411, 869   2, 137, 565   41 00   41.00	20.00			122 120	200 227	/1 740	720 002	17 101 414	20.00
40.00   04000 SUBPROVI DER   IPF		1					l .		•
11.00   04100 SUBPROVIDER - IRF   14, 443   40, 001   5, 793   41, 869   2, 137, 565   41, 00   ANOLILARY SERVICE COST CENTERS   3,099   8,927   2, 146   16, 075   416, 222   43. 00   ANOLILARY SERVICE COST CENTERS   50. 00							l		•
## AMCILLARY SERVICE COST CENTERS  50.00   GOOD OPERATING ROMM   61, 985   0   223, 213   87, 849   7, 279, 851   50. 00   51.00   05100 PERATING ROMM   8, 301   0   31, 237   36, 261   1, 108, 302   51. 00   52.00   05200 DELVIERY ROM & LABOR ROOM   14, 909   41, 140   8, 499   53, 083   2, 235, 381   52. 00   53.00   05200 DELVIERY ROM & LABOR ROOM   14, 909   41, 140   0   0   0   0   0   53. 00   53.00   05300 ANESTHESI OLOGY   0   0   0   0   0   0   0   53. 00   54.01   05401 ULTRASOUND   2, 995   0   9, 720   14, 205   297, 376   54. 01   54.01   05401 ULTRASOUND   2, 995   0   9, 720   14, 205   297, 376   54. 01   55.00   05500 RADI OLOGY-THERAPEUTI C   9, 696   26, 754   42, 036   44, 859   1, 806, 833   55. 00   55.00   05500 RADI OLOGY-THERAPEUTI C   9, 696   26, 754   42, 036   44, 859   1, 806, 833   55. 00   57.00   05700 CT SCAM   10, 265   0   125, 369   33, 271   1, 259, 829   57. 00   59.00   05900 MRI   4.213   0   34, 870   4, 860   588, 891   58. 00   59.00   05900 MRI   4.213   0   34, 870   4, 860   588, 891   58. 00   59.00   05900 CARDI AC CATHETRIZATI ON   6, 503   17, 943   57, 675   23, 551   1, 229, 103   59. 00   60.00   06000 LABORATORY   31, 477   0   155, 709   37, 756   4, 076, 461   60. 00   60.00   06000 RESPIRATORY THERAPY   15, 569   53, 999   49, 050   62, 055   2, 056, 875   65. 00   60.00   06000 RESPIRATORY THERAPY   15, 958   0   18, 900   10, 900   2, 793, 949   66. 00   60.00   06000 RESPIRATORY THERAPY   15, 958   0   18, 900   10, 900   2, 793, 949   66. 00   60.00   06000 RESPIRATORY THERAPY   15, 958   0   18, 900   10, 10, 775, 317   62. 00   60.00   06000 LELECTROCARPILLORAPHY   1, 084   2, 991   4, 111   1, 869   175, 091   70. 00   70.00   07000 LELECTROCARPILLORAPHY   1, 084   2, 991   4, 111   1, 869   175, 091   70. 00   70.00   07000 LELECTROCARPILLORAPHY   1, 084   2, 991   4, 111   1, 869   175, 091   70. 00   70.00   07000 LELECTROCARPILLORAPHY   1, 084   2, 991   4, 111   1, 869   175, 091   70. 00   70.00   07000 DELECTROCARPILLORAPHY   1, 084   2,									
50.00	43.00			3, 099	8, 927	2, 146	16, 075	416, 222	43. 00
51.00	F0 00			(4.005		000 040	07.040	7 070 054	F0 00
1.00   05200   051/0									1
53.00   05300   ANSTHESI OLOGY   0   0   0   0   0   0   53.00   54.00   05400   RADIOLOGY-OI JACKOSTIC   25.998   0   38.219   29.532   3.011,048   54.00   54.01   05401   ULTRASOUND   2.995   0   9.720   14.205   297,376   54.01   54.02   05402   MAMDIGRAPHY   3.491   0   6.401   29.158   495.149   54.02   54.02   MAMDIGRAPHY   3.491   54.02   54.00   6.401   29.158   495.149   54.02   54.00   6.500   RADIOLOGY-THERAPEUTIC   9.696   26.754   42.036   44.859   1.806,833   55.00   57.00   05700   CT SCAN   10.265   0   125.369   33.271   1.259 829   57.00   6.500   MSDIO MRDIOLOGY-THERAPEUTIC   4.213   0   34.870   34.870   33.271   1.259 829   57.00   6.500   MSDIO MRDIOLOGY-THERAPEUTIC   4.213   0   34.870   34.870   33.271   1.259 829   57.00   6.500   MSDIO MRDIOLOGY-THERAPEUTIC   4.503   17.943   57.675   23.551   1.229   103   59.00   6.500   MSDIO MRDIOLOGY   31.477   31.475   37.5675   23.551   1.229   103   59.00   6.500   MSDIO LABORATORY   31.477   31.475   37.5675   23.551   1.229   103   59.00   6.500   MSDIO LABORATORY   4.050   4.		1							1
54.01   05401   ULTRASOUND   2,995   0   9,720   14,205   297,376   54.01				C , , o			l		1
54.02   OS402   MAMINGRAPHY   3, 491   0   6, 401   29, 158   485, 149   54, 02   55.00   OS500   RADI OLOFY-THERAPEUTIC   9, 696   26, 754   42, 036   44, 886   1, 806, 833   55.00   55.00   OS500   RADI OLOFY-THERAPEUTIC   9, 696   26, 754   42, 036   44, 886   1, 806, 833   55.00   56.00   OS500   RADI OLOFY-THERAPEUTIC   3, 249   0   32, 680   44, 860   1, 313, 037   56.00   58.00   OS500   CARDI ACC ATHETERIZATION   6, 550   31, 727   1, 1259   297   57.00   59.00   OS500   CARDI ACC CATHETERIZATION   6, 5503   17, 794   34, 870   4, 860   585, 891   58.00   60.00   OS500   OS500   CARDI ACC CATHETERIZATION   6, 5503   17, 794   37, 756   4, 076, 461   60.00   OS500   OS500   OS500   CARDI ACC CATHETERIZATION   71, 775   717   71, 775   717   71, 71, 71, 71, 71, 71, 71, 71, 71, 71,						38, 219	29, 532	3, 011, 048	54. 00
55 00   05500   RADIO LOCY-THERAPUTIC   9,696   26,754   42,036   44,859   1,806,833   55 00		1					l		1
56. 00   05600   RADIO I SOTOPE   3, 249   0   32, 680   4, 860   1, 313, 337   56. 00		1	i e e e e e e e e e e e e e e e e e e e				· · ·		•
10, 265   0   0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0,		1					l		ı
59.00   05900   CARDI AC CATHETERI ZATION   6.503   17,942   57,675   23,551   1,229   103   59,00							l		•
60.00   06000   06000   06000   06000   PACKED RED BLOOD CELL   1,510   0   165,709   37,756   4,076,461   60.00   62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   1,510   0   17,473   1,495   775,317   62.00   65.00   06500   RESPIRATORY THERAPY   19,569   53,999   49,050   62,055   2,056,875   65.00   66.00   06000   06000   019,905   2,793,949   66.00   06000   06000   019,905   2,793,949   66.00   06000   06000   019,005   2,793,949   66.00   060000   060000   060000   060000   060000   060000   060000   060000   0600000   06000000   0600000000	58. 00	05800	MRI				l		1
62.00   06200   MPINILE BLOOD & PACKED RED BLOOD CELL   1,510   0   17,473   1,495   775,317   62.00   65.00   06500   RESPIRATORY THERAPY   19,569   53,999   49,050   62,055   2,056,875   65.00   66.00   06600   PHYSI CAL THERAPY   15,958   0   18,900   109,905   2,793,949   66.00   67.00   06600   PHYSI CAL THERAPY   15,958   0   18,900   109,905   2,793,949   66.00   68.00   06600   PHYSI CAL THERAPY   15,958   0   18,900   109,905   2,793,949   66.00   69.00   06600   PHYSI CAL THERAPY   1,084   2,991   4,111   1,869   175,091   70.00   71.00   07000   ELECTROCHEDIALOGRAPHY   1,084   2,991   4,111   1,869   175,091   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   9,698   0   104,720   0   7,829,905   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   49,678   0   8,070,151   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   24,131   0   266,071   0   11,958,115   73.00   74.00   07400   RENAL DIALYSIS   0   0   0   14,656   0   1,003,997   74.00   76.01   03202   LITHOTRIPSY   0   0   0   3,404   0   199,519   76.00   76.02   03950   PRISON CLINIC   2,412   0   928   0   622,337   76.02   76.03   03951   MOUNDCARE   1,197   6,654   8,830   8,972   946,770   76.03   76.04   03952   DPIL OR LORENGE   1,197   6,654   8,830   8,972   946,770   76.03   76.04   03952   DPIL OR LORENGE   0   0   0   0   0   0   76.00   09200   DESERVATION BEDS (NON-DISTINCT PART   99,000   76.00   0900   DESERVATION BEDS (NON-DISTINCT PART   90,000   76.00   0900   DESERVATION BEDS (SUM OF LINES 1-117)   587,010   1,057,083   1,680,233   2,701,270   99,053,989   77.00   1900   0   0   0   0   0   0   0   0   78.00   1900   0   0   0   0   0   0   0   0   79.00   0900   DESERVATION BEDS (SUM OF LINES 1-117)   587,010   1,057,083   1,680,233   2,701,270   99,053,989   78.00   1900   0   0   0   0   0   0   0   0   0							l		1
65.00   06500   RESPI RATORY THERAPY   19, 569   53, 999   49, 050   62, 055   2, 056, 875   65.00   66.00   06600   PHYSI CAL THERAPY   15, 958   0   18, 900   109, 905   2, 793, 949   66. 00   67.00   06900   ELECTROCARDI OLLOGY   10, 832   29, 890   40, 563   25, 794   1, 290, 755   69. 00   67.00   07000   ELECTROCARDI OLLOGY   10, 832   29, 890   40, 563   25, 794   1, 290, 755   69. 00   67.00   07000   ELECTROCARDI OLLOGY   10, 832   29, 890   40, 563   25, 794   1, 290, 755   69. 00   67.00   07000   ELECTROCARDI OLLOGY   10, 832   29, 890   40, 563   25, 794   1, 290, 755   69. 00   67.00   07000   ELECTROCARDI OLLOGY   10, 832   29, 890   40, 563   25, 794   1, 290, 755   69. 00   67.00   07000   ELECTROCARDI OLLOGY   10, 832   29, 890   40, 563   25, 794   1, 290, 755   69. 00   67.00   07000   ELECTROCARDI OLLOGY   10, 832   29, 890   40, 563   25, 794   1, 290, 755   69. 00   67.00   07100   MEDICAL SUPPLIES   24, 131   0   0   0   49, 678   0   8, 070, 151   72. 00   67.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   14, 656   0   1, 003, 997   74. 00   67.00   07400   RENAL DI ALYSIS   0   0   0   14, 656   0   1, 003, 997   74. 00   67.01   07330   ENDOSCOPY   4, 643   0   20, 144   31, 208   954, 833   76. 01   67.01   07330   MOUNDCARE   2, 412   0   928   0   622, 337   76. 02   67.03   03951   WOUNDCARE   1, 197   6, 654   8, 830   8, 972   946, 770   76. 03   67.04   03952   DPI C   8, 573   23, 657   16, 330   0   1, 009, 397   76. 04   69.00   09000   CMRC   SPECIAL PURPOSE   0   0   0   0   0   69.00   09000   CMRC   SPECIAL PURPOSE   0   0   0   0   0   69.00   09000   CMRC   SPECIAL PURPOSE   0   0   0   0   0   69.00   09000   CMRC   SPECIAL PURPOSE   0   0   0   0   0   69.00   09000   CMRC   SPECIAL PURPOSE   0   0   0   0   0   0   69.00   19000   RESEARCH   0   0   0   0   0   0   0   69.00   19000   RESEARCH   0   0   0   0   0   0   0   69.00   19000   RESEARCH   0   0   0   0   0   0   0   69.00   19000   RESEARCH   0   0   0   0   0   0   0   69.00   19000   01900   01900		1	l e e e e e e e e e e e e e e e e e e e				l		1
66. 00   06600   PHYSICAL THERAPY   15,958   0   18,900   109,905   2,793,949   66. 00   06900   ELECTROCARDIOLOGY   10,832   29,890   40,563   25,794   1,290,755   69. 00   70. 00   70. 00   ELECTROENCEPHALOGRAPHY   1,084   2,991   4,111   1,869   175,091   70. 00   71. 0							I		•
69.00   06900   ELECTROCARDIOLOGY   10,832   29,890   40,563   25,794   1,290,755   69.00   70		1							1
71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   9,698   0   104,720   0   7,829,905   71.00   72.00   07200   MPL. DEV. CHARGED TO PATIENTS   0   0   49,678   0   8,070,151   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   24,131   0   266,071   0   11,958,115   73.00   74.00   CRNAL DI ALYSIS   0   0   0   14,656   0   1,003,997   74.00   76.00   03020   LITHOTRI PSY   0   0   0   0   3,404   0   199,519   76.00   76.01   03330   ENDOSCOPY   4,643   0   20,144   31,028   954,833   76.01   76.02   03950   PRI SON CLINI C   2,412   0   928   0   622,337   76.02   76.03   03951   WOUNDCARE   1,197   6,654   8,830   8,972   946,770   76.03   76.04   03952   OPI C   8,573   23,657   16,330   0   1,009,397   76.04   03952   OPI C   8,573   23,657   16,330   0   1,009,397   76.04   03952   OPI C   8,573   23,657   16,330   0   1,009,397   76.04   03952   OPI C   8,573   23,657   16,330   0   1,009,397   76.04   03952   OPI C   8,573   23,657   16,330   0   1,009,397   76.04   03952   OPI C   8,573   23,657   16,330   0   1,009,397   76.04   03952   OPI C   8,573   23,657   16,330   0   1,009,397   76.04   03952   OPI C   09000   0   0   0   0   0   0   0   0							l		1
72. 00   07200   MPL. DEV. CHARGED TO PATIENTS   0   0   49,678   0   8,070,151   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   24,131   0   266,071   0   11,958,115   73. 00   74. 00   07400   RENAL DIALYSIS   0   0   0   14,656   0   1,003,997   74. 00   76. 01   03320   LI THOTRI PSY   0   0   0   3,404   0   199,519   76. 00   76. 01   03330   RNDOSCOPY   4,643   0   20,144   31,028   954,833   76. 01   76. 02   03950   PRI SON CLINIC   2,412   0   928   0   622,337   76. 02   76. 03   03951   WOUNDCARE   1,197   6,654   8,830   8,972   946,770   76. 03   76. 04   03952   DPI C   0   8,573   23,657   16,330   0   1,009,397   76. 04   03952   DPI C   0   0   0   0   0   0   0   0   0					1		1, 869		•
73. 00   07300   DRUGS CHARGED TO PATIENTS   24, 131   0   266, 071   0   11, 958, 115   73. 00   74. 00   07400   RENAL DIALYSIS   0   0   0   14, 656   0   1, 003, 997   74. 00   76. 00   03020   LITHOTRI PSY   0   0   0   0   3, 404   0   199, 519   76. 00   76. 01   03330   ENDOSCOPY   4, 643   0   20, 144   31, 028   954, 833   76. 01   76. 02   03950   PRI SON CLINIC   2, 412   0   928   0   622, 337   76. 02   76. 03   03951   WOUNDCARE   1, 197   6, 654   8, 830   8, 972   946, 770   76. 03   76. 04   76. 04   76. 05   7				9, 698	1				1
74. 00 07400 RENAL DI ALYSI S 0 0 0 14,656 0 1,003,997 74. 00 76. 00 03020 LI THOTRI PSY 0 0 0 3,404 0 199,519 76. 00 76. 01 03300 ENDOSCOPY 4,643 0 20,144 31,028 954,833 76. 01 76. 02 03950 PRI SON CLINIC 2,412 0 928 0 622,337 76. 02 76. 03 03951 WOUNDCARE 1,197 6,564 8,830 8,972 946,770 76. 03 76. 04 03952 PDI C 8,573 23,657 16,330 0 1,009,397 76. 04 07950 DEMERGENCY 39,999 120,783 137,254 708,027 6,103,178 91. 00 09100 EMERGENCY 39,999 120,783 137,254 708,027 6,103,178 91. 00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART 0THER REI MBURSABLE COST CENTERS  118. 00 SUBTOTALS (SUM OF LINES 1-117) 587,010 1,057,083 1,680,233 2,701,270 99,053,989 118. 00 192. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 965 0 0 0 0 105,613 190.00 191. 00 19100 RESEARCH 0 0 0 0 0 0 0 0 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 191. 00 194. 01 07950 OCCUPATI ONAL MEDI CI NE 16,693 0 0 0 0 0 0 191. 00 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				24 121			_		1
76. 00   03020   LITHOTRIPSY   0   0   0   3, 404   0   199, 519   76. 00   76. 01   03330   ENDOSCOPY   4, 643   0   20, 144   31, 028   954, 833   76. 01   76. 02   03950   PRI SON CLINIC   2, 412   0   928   0   622, 337   76. 03   03951   WOUNDCARE   1, 197   6, 654   8, 830   8, 972   946, 770   76. 04   03952   OPL   8, 573   23, 657   16, 330   0   1, 009, 397   76. 04   03952   OPL   8, 573   23, 657   16, 330   0   1, 009, 397   76. 04   047   OPL   OPL   OPL   OPL   OPL   OPL   76. 05   OPL   OPL   OPL   OPL   OPL   OPL   OPL   76. 06   OPL   OPL   OPL   OPL   OPL   OPL   OPL   76. 07   OPL   OPL   OPL   OPL   OPL   OPL   OPL   OPL   76. 08   OPL   OPL   OPL   OPL   OPL   OPL   OPL   OPL   OPL   76. 09   OPL   OP				24, 131					1
76. 02 03950 PRI SON CLINIC 2, 412 0 928 0 622, 337 76. 02 76. 03 03951 WOUNDCARE 1, 197 6, 654 8, 830 8, 972 946, 770 76. 03 76. 04 03952 OPL		1		d	1		Ö		1
76. 03  03951 WOUNDCARE							31, 028		
76. 04 03952 OPI C OUTPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS 99. 00 09900 CMHC 09900 CMHC 09900 CMHC 0900 CM							ا		
91. 00   O9100   EMERGENCY   SPRINT SERVICE COST CENTERS   SPRINT									1
91. 00	70.04			0, 37 3	25, 057	10, 330		1,007,377	70.04
99. 00 OTHER REIMBURSABLE COST CENTERS  99. 00 OP900 CMHC SPECIAL PURPOSE COST CENTERS  118. 00 SUBTOTALS (SUM OF LINES 1-117) 587, 010 1, 057, 083 1, 680, 233 2, 701, 270 99, 053, 989 118. 00 NONREI MBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 965 0 0 0 0 105, 613 190. 00 191. 00 19100 RESEARCH 0 0 0 0 0 0 0 191. 00 192. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 0 0 0 192. 00 193. 00 19300 NONPAID WORKERS 0 0 0 0 0 0 0 193. 00 194. 00 07950 OCCUPATI ONAL MEDI CI NE 16, 693 0 0 0 21, 308 1, 590, 791 194. 00 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 710, 425 194. 01 194. 02 07952 SI TIERS 7, 708 22, 244 0 4, 486 393, 843 194. 02 200. 00 CCOSS Foot Adjustments 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	91.00			39, 999	120, 783	137, 254	708, 027	6, 103, 178	91. 00
99. 00   09900   CMHC   0   0   0   0   0   0   99. 00	92. 00								92. 00
SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1-117)   587,010   1,057,083   1,680,233   2,701,270   99,053,989   118.00	00 00					0	ا	0	00 00
118. 00   SUBTOTALS (SUM OF LINES 1-117)   587, 010   1, 057, 083   1, 680, 233   2, 701, 270   99, 053, 989   118. 00	77.00				,	0			77.00
190. 00       19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN       965       0       0       0       105, 613 190. 00         191. 00       19100 RESEARCH       0       0       0       0       0       191. 00         192. 00       19200 PHYSI CI ANS' PRI VATE OFFI CES       0       0       0       0       0       0       192. 00         193. 00       19300 NONPAI D WORKERS       0       0       0       0       0       193. 00         194. 00       07950 OCCUPATI ONAL MEDI CI NE       16, 693       0       0       21, 308       1, 590, 791       194. 00         194. 01       07951 OTHER NONREI MBURSABLE COST CENTERS       0       0       0       0       710, 425       194. 00         194. 02       07952 SI TTERS       7, 708       22, 244       0       4, 486       393, 843       194. 02         200. 00       0       0       0       0       0       0       0       0       0         201. 00       Negati ve Cost Centers       0	118. 00		SUBTOTALS (SUM OF LINES 1-117)	587, 010	1, 057, 083	1, 680, 233	2, 701, 270	99, 053, 989	118. 00
191. 00	400.00							105 (10	
192. 00				965	1		0		
193. 00 19300 NONPAID WORKERS 0 0 0 0 0 193. 00 194. 00 07950 OCCUPATIONAL MEDICINE 16, 693 0 0 21, 308 1, 590, 791 194. 00 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 710, 425 194. 01 194. 02 07952 SITTERS 7, 708 22, 244 0 4, 486 393, 843 194. 02 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 10. 00					1	0	l ől		
194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 710, 425 194. 01 194. 02 07952 SITTERS 7, 708 22, 244 0 4, 486 393, 843 194. 02 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 201. 00					o o	Ö	0		
194. 02 07952 SITTERS 7, 708 22, 244 0 4, 486 393, 843 194. 02 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 201. 00				16, 693	0	0	21, 308		
200.00       Cross Foot Adjustments       0 200.00         201.00       Negative Cost Centers       0 0 0		1		7 - 2	0	0	0		1
201.00   Negative Cost Centers   0   0   0   0   201.00				/, /08	22, 244	0	4, 486		
				(		0	0		
			, ,	612, 376	1, 079, 327	1, 680, 233			

Health Financial Systems

In Lieu of Form CMS-2552-10 TERRE HAUTE REGIONAL HOSPITAL COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150046 Peri od: Worksheet B From 09/01/2015 Part I Date/Time Prepared: 08/31/2016 1/25/2017 6:24 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adj ustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01850 INSERVICE EDUCATION 18.00 18.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 17, 131, 414 30.00 03100 INTENSIVE CARE UNIT 31.00 0 0 4, 503, 084 31.00 04000 SUBPROVIDER - IPF 4.387.554 40.00 40 00 04100 SUBPROVI DER - I RF 41.00 2, 137, 565 41.00 04300 NURSERY 416, 222 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 7, 279, 851 50 00 0000000000000000000000000000 05100 RECOVERY ROOM 51.00 1, 108, 302 51.00 05200 DELIVERY ROOM & LABOR ROOM 2, 235, 081 52.00 53.00 05300 ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 54 00 3, 011, 048 54 00 54.01 05401 ULTRASOUND 297, 376 54.01 05402 MAMMOGRAPHY 485, 149 54.02 54.02 05500 RADI OLOGY-THERAPEUTI C 1,806,833 55.00 55.00 05600 RADI OI SOTOPE 1, 313, 037 56.00 56.00 57.00 05700 CT SCAN 1, 259, 829 57.00 05800 MRI 58.00 585, 891 58.00 1, 229, 103 59.00 05900 CARDIAC CATHETERIZATION 59.00 06000 LABORATORY 60.00 4, 076, 461 60 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 775, 317 62.00 62.00 06500 RESPIRATORY THERAPY 2, 056, 875 65.00 65.00 06600 PHYSI CAL THERAPY 2, 793, 949 66.00 66,00 06900 ELECTROCARDI OLOGY 69.00 1, 290, 755 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 175, 091 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 7, 829, 905 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 8, 070, 151 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 11, 958, 115 73.00 74.00 07400 RENAL DIALYSIS 1,003,997 74.00 199, 519 03020 LI THOTRI PSY 76.00 76.00 03330 ENDOSCOPY 76. 01 954, 833 76.01 76. 02 03950 PRISON CLINIC 622, 337 76.02 0 03951 WOUNDCARE 946, 770 76.03 76.03 03952 OPI C 76.04 1,009,397 76.04 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 6, 103, 178 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 0 0 99.00 SPECIAL PURPOSE COST CENTERS 118 00 SUBTOTALS (SUM OF LINES 1-117) 0 99, 053, 989 118 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 105, 613 0 191. 00 19100 RESEARCH 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0000000 192 00 0 193. 00 19300 NONPALD WORKERS 193. 00 194.00 07950 OCCUPATIONAL MEDICINE 1, 590, 791 194.00 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 710, 425 194. 01 194. 02 07952 SI TTERS 393, 843 194. 02 200.00 Cross Foot Adjustments 200.00

C

101, 854, 661

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118-201)

201.00

202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150046

				10	08/31/2016	Date/IIme Pre   1/25/2017 6:2	
			CAPITAL RE	LATED COSTS			
Cost	Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
COST	center bescription	Assigned New	DLDG & TTXT	WVBLL LQUIF	Subtotal	BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs	1 00	2.00	24	4. 00	
GENERAL SER	VICE COST CENTERS	0	1.00	2. 00	2A	4.00	
	EL COSTS-BLDG & FIXT						1.00
	EL COSTS-MVBLE EQUIP						2. 00
	YEE BENEFITS DEPARTMENT	0	29, 032		65, 639	65, 639	4. 00
	ISTRATIVE & GENERAL TION OF PLANT	2, 012, 070	187, 261 647, 015		2, 435, 453 1, 462, 849	6, 187 1, 319	5. 00 7. 00
	RY & LINEN SERVICE		27, 414		61, 981	1, 317	8.00
9. 00 00900 HOUSE		o	9, 863		22, 300	1, 595	9. 00
10. 00 01000 DI ETAI		0	44, 779		101, 242	800	10. 00
11. 00   01100   CAFET		0	28, 560		64, 572	388	11.00
	NG ADMINISTRATION AL RECORDS & LIBRARY	75 11, 550	7, 664 44, 137		17, 403 111, 340	1, 150 109	13. 00 16. 00
	VICE EDUCATION	11, 550	42, 070		95, 116	2, 656	18.00
	OUTINE SERVICE COST CENTERS	<u> </u>	12/0/0	, 33, 313	707 1.10	2, 000	10.00
	S & PEDIATRICS	5, 657	483, 575		1, 098, 982	10, 903	30. 00
	SIVE CARE UNIT	531	82, 289		186, 580	3, 472	31.00
	OVIDER - IPF OVIDER - IRF	191 17	74, 291 88, 320		168, 157 199, 701	3, 121 1, 447	40. 00 41. 00
43. 00   04100 30BFK		-17	8, 083		18, 257	319	43.00
	ERVICE COST CENTERS		3, 33				
50. 00 05000 OPERA		2, 948	195, 274		444, 447	5, 524	50. 00
51. 00   05100   RECOVI		0	12, 194		27, 569	1, 032	51.00
52. 00   05200   DELI VI 53. 00   05300   ANESTI	ERY ROOM & LABOR ROOM	2, 379	55, 602		128, 091	1, 374 0	52. 00 53. 00
	LOGY-DI AGNOSTI C		101, 171	ή "	228, 740	1, 735	54.00
54. 01   05401   ULTRA		o	3, 143		7, 106	254	54. 01
54. 02 05402 MAMMO		0	11, 574		26, 168	291	54. 02
	LOGY-THERAPEUTI C	0	47, 822		108, 121	1, 058	55.00
56. 00   05600 RADI 0 57. 00   05700 CT SC		0 91	5, 745 12, 403		12, 988 28, 133	398 883	56. 00 57. 00
58. 00   05800 MRI	7.1.V	10	8, 052		18, 214	439	58.00
59. 00 05900 CARDI	AC CATHETERIZATION	8	17, 752		40, 144	929	59. 00
60. 00 06000 LABORA		0	41, 435		93, 681	2, 165	60.00
	BLOOD & PACKED RED BLOOD CELL	0	2, 477		5, 601	112	62.00
65. 00   06500 RESPI   66. 00   06600 PHYSI	RATORY THERAPY	19 452	12, 689 105, 174		28, 708 238, 242	1, 843 2, 018	65. 00 66. 00
	ROCARDI OLOGY	0	16, 970		38, 368	869	69.00
	ROENCEPHALOGRAPHY	o	8, 439		19, 080	99	70.00
	AL SUPPLIES CHARGED TO PATIENT	29	65, 737		148, 655	601	71. 00
	DEV. CHARGED TO PATIENTS	0	20. 70-	0	0	0	72.00
73. 00   07300 DRUGS 74. 00   07400 RENAL	CHARGED TO PATIENTS	0	20, 787 3, 654		46, 998 8, 262	2, 675 0	73. 00 74. 00
76. 00 03020 LI THO			3, 034		0, 202	0	76.00
76. 01 03330 ENDOS	COPY	o	14, 903	18, 792	33, 695	596	1
76. 02 03950 PRI S0I		0	58, 064		131, 278	231	1
76. 03   03951   WOUNDO	CARE	0	13, 378		30, 247	123	76. 03
	SERVICE COST CENTERS	l o	29, 613	37, 339	66, 952	788	76. 04
91. 00 09100 EMERGI		3, 235	79, 595	100, 362	183, 192	3, 899	91.00
	VATION BEDS (NON-DISTINCT PART				0		92. 00
	SURSABLE COST CENTERS						
99. 00 09900 CMHC	POSE COST CENTERS	0	C	0	0	0	99. 00
	TALS (SUM OF LINES 1-117)	2, 039, 245	2, 748, 000	3, 465, 007	8, 252, 252	63, 402	118 00
	ABLE COST CENTERS	2/00//2/0	27 7 107 000	0, 100, 007	0, 202, 202	307 102	
	FLOWER, COFFEE SHOP & CANTEEN	0	4, 699	5, 925	10, 624		190. 00
191. 00 19100 RESEAL		0	C	0	0		191.00
192. 00 19200 PHYSI ( 193. 00 19300 NONPA	CLANS' PRIVATE OFFICES	0	(		0		192. 00 193. 00
193. 00 19300 NONPA 194. 00 07950 OCCUPA		0	35, 071	44, 222	79, 293		193.00
	NONREIMBURSABLE COST CENTERS		23, 110		23, 110		194. 01
194. 02 07952 SI TTEI	RS	14	(	o	14		194. 02
	Foot Adjustments				0		200.00
1 1 9	ive Cost Centers (sum lines 118-201)	2, 039, 259	) 010 000	0 2 515 154	0 245 202	0 65, 639	201. 00
202. 00    TOTAL	(3uiii 111163 110-201)	2,037,239	2, 810, 880	3, 515, 154	8, 365, 293	00, 039	<sub>1</sub> 202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150046

COST CONTROL POSCRIPTION   ASSESSMENT   COST CONTROL   COST CONT							1/25/2017 6: 2	4 pm
1.00		Cost Center Description				HOUSEKEEPI NG		
RIN RMI. STRAYLEY COST CONTENS 1.00 000100 (APR REL COSTS-ADUBLE EQUIPER) 2.00 00000 (APR REL COSTS-ADUBLE EQUIPER) 3.00 000000 (AND REL COSTS-ADUBLE EQUIPER) 4.00 000000 (AND REL COSTS-ADUBLE) 5.00 00000 (AND REL COSTS-ADUBLE) 6.00 00000 (AND REL COSTS ADUBLE) 6.00 00000 (AND						0.00	10.00	
1.00		CENEDAL CEDVICE COCT CENTERS	5. 00	7.00	8.00	9. 00	10.00	
2,00	1 00		T		Ī			1 00
0.000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00							I	1
5.00   OSCOL AMBINISTRATIVE & CEMERAL   2, 441, 400   7.00   7.00   OTOO OPERATION OF PLANT   1.141, 918   1,609, 016   7.00							I	1
0.000   0.00			2 441 640				I	1
8. 00 00000   LANDRY & LINEN SERVICE   16, 231   22, 649   100, 861   84, 236   9. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.		1		1 600 016			I	1
9.00   09000   HOUSEKEEPI INC   44, 908   8, 149   7, 244   84, 236   9, 00   11.00   01000   DETARY   43, 629   36, 995   0   1, 295   14, 641   10. 00   11.00   01000   DETARY   35, 869   36, 464   0   1, 266   0   1, 266   16.00   16000   MESI NA JANINI STRATI ON   24, 921   0, 332   0   3.89   0   1. 209   16.00   01600   MESI NA JANINI STRATI ON   24, 921   0, 332   0   3.89   0   1. 209   17.00   03000   MESI NA JANINI STRATI ON   24, 921   0, 332   0   0, 388   0   13. 00   18.00   03000   ADULTS & PEDIATRI CS   301, 310   399, 514   88, 919   21, 323   87, 312   30, 00   18.00   03000   ADULTS & PEDIATRI CS   301, 310   399, 514   88, 919   21, 323   87, 312   30, 00   18.00   03000   ADULTS & PEDIATRI CS   301, 310   399, 514   88, 919   21, 323   87, 312   30, 00   18.00   03000   ADULTS & PEDIATRI CS   301, 310   399, 514   88, 919   21, 323   87, 312   30, 00   18.00   03000   ADULTS & PEDIATRI CS   301, 310   399, 514   88, 919   21, 323   87, 312   30, 00   18.00   03000   ADULTS & PEDIATRI CS   301, 310   399, 514   89, 919   21, 323   87, 312   30, 00   18.00   03000   ADULTS & PEDIATRI CS   301, 310   399, 514   89, 919   21, 323   87, 312   30, 00   18.00   03000   ADULTS & PEDIATRI CS   301, 310   399, 514   89, 919   21, 323   87, 312   30, 00   18.00   04000   SUBPROVIDER - 1 PF   76, 155   61, 377   4, 806   3, 276   26, 909   40, 00   18.00   04000   SUBPROVIDER - 1 PF   76, 155   61, 377   4, 806   3, 276   26, 909   40, 00   18.00   04300   BURSKY MARCHINE COIST CENTERS   84, 533   66, 718   0   350   0   18.00   05400   BURSKY MARCHINE COIST CENTERS   84, 533   66, 718   0   350   0   18.00   05400   BEDEVEY ROSM   24, 900   24, 400   25, 500   0   0   0   0   0   0   0   18.00   05400   BEDEVEY ROSM   24, 900   24, 400   24, 500   25, 500   0   0   0   0   0   0   0   0   0		1	1				I	1
10.00   01000   DIELARY			1			84 236	I	•
11.00 0 1100 (CAFETER A 1 1.093 23.995 0 1.299 0 1.100 1.200 0 110 01 1.00 16.00 01600 MISSI MA ADMINISTRATION 24.921 6.332 0 338 0 13.00 16.00 01600 MISSI MA ADMINISTRATION 24.921 6.332 0 338 0 13.00 16.00 01600 MISSI MA ERCORDS & LIBRARY 35.869 36.464 0 1.946 0 16.00 18.00 18.00 01850 MISSI MA ERCORDS & LIBRARY 58.853 34.756 0 19.00			1					•
13.00   01300 NURSING ADMINISTRATION   24, 921   6, 332   0   338   0   13, 00   10   00   10   00   010   00   010   01   00   01   00   01   00   01   00   01   01   00   01   00   01   01   00   01   00   01   01   00   01   01   00   01   01   00   01   01   00   01   01   00   01   01   00   01   00   01   01   00   01   00   01   01   00   01   00   01   01   00   01   00   01   00   01   01   00   01   01   00   01   01   00   01   0			1					•
10								1
18. 00		1 1					_	•
INPATI ENT BOUTINE SERVICE COST CENTERS   30,00   30,00   30,00   AURIS & PEDIDATRICS   30,1310   399,514   38,919   21,323   87,312   30,00   30,00   AURIS & PEDIDATRICS   30,01   31,00   31,00   AURIS & PEDIDATRICS   30,00   52,00   31,00   31,00   AURIS & PEDIDATRICS   30,00   52,00   31,00   41,00   31,00   AURIS & PEDIDATRICS   30,00   52,00   40,00   41,00   41,00   54,00		1 1	1				_	•
30 00   30000   ADULTS & PEDI ATRICS   301, 310   399, 514   38, 919   21, 323   87, 312   30, 00   310   00   3100   INTENSIVE CARE UNIT   88, 551   67, 984   8, 261   3, 679   5, 205   31, 00   40 00   04000   SUBPROVI DER - I PF   76, 155   61, 377   4, 806   3, 276   26, 909   40, 00   40 00   40 00   50   50   50   50	10.00		00,000	01,700	,	1,000		10.00
31.00   03100   INTENSIVE CARE UNIT	30. 00		301, 310	399, 514	38, 919	21, 323	87. 312	30.00
40.00   0.0000   SUBPROVIDER - I PF   76, 155   61, 377   4, 806   3, 276   26, 909   40, 00   41.00   0.4100   SUBPROVIDER - I RF   36, 947   72, 967   1, 125   3, 895   11, 151   41, 00   43.00   NARSERY   8, 453   6, 678   0   356   0   43.00   NARSERY   8, 453   6, 678   0   356   0   43.00   NARSERY   8, 451   0   50.00   50.		1 1	1					•
141.00   04100   SUBROVI DER - I RF   36, 947   72, 967   1, 125   3, 995   11, 151   41, 00   436, 00   430, 00   430, 00   430, 00   430, 00   430, 00   430, 00   430, 00   430, 00   430, 00   430, 00   430, 00   430, 00   430, 00   440, 00   538   0   51, 00   520, 00   5200   01, 00   020, 00   01, 00   0   0   0   0   0   0   0   0   0			1					1
ABOOD   MARSERY   ABOOD   AB			1					•
ANCIL LLARY SERVICE COST CENTERS		1 1	1					1
50.00								
55.00	50.00		144, 746	161, 329	8, 261	8, 611	0	50.00
S2.00   OS200   OS200   DELLYREY ROOM & LABOR ROOM	51.00	05100 RECOVERY ROOM					0	51.00
54.00   05400   RADI OLOCY-DI AGNOSTIC   59,054   83,584   4,900   4,461   0   54,00   54,01   5401   ULTRASOUND   6,672   0   5700   139   0   54,01   54,02   05402   MAMMOGRAPHY   9,548   9,562   0   510   0   55,00   055,00	52.00	05200 DELIVERY ROOM & LABOR ROOM	44, 973	45, 937	1, 563	2, 452	0	52. 00
54.01   05401   ULTRASQUIMD	53.00		1				0	53.00
54.02   05402   MAMINGRAPHY   0, 548   0, 562   0   510   0   54.02	54.00	05400 RADI OLOGY-DI AGNOSTI C	59, 054	83, 584	4, 900	4, 461	0	54.00
54. 02   05402   MAMINGRAPHY   9, 548   9, 562   0   510   0   54. 02	54. 01		1				0	54. 01
55. 00   05500   RADIO LOGY-THERAPEUTIC   35. 623   39. 509   0   2, 109   0   55. 50   55. 00   55.	54. 02	05402 MAMMOGRAPHY	1				0	1
56.00   05.00   05.00   RADIO I SOTOPE   29, 929   4,746   0   253   0,56,00		1					0	•
57.00   05700   CT SCAN   24, 924   10, 247   0   547   0   57, 00   58, 00   5800   MRI   12, 195   6, 652   0   355   0, 58, 00   59, 00   05900   CARDIAC CATHETERI ZATION   25, 174   14, 666   0   783   0, 59, 00   60, 00   06000   LABORATORY   87, 986   34, 232   0   1, 827   0   60, 00   62, 00   62, 00   62, 00   62, 00   62, 00   62, 00   62, 00   62, 00   62, 00   63, 00   64, 00   64, 00   64, 00   64, 00   64, 00   64, 00   64, 00   64, 00   64, 00   65, 00   66,		1 1	1				0	ı
58.00   05800   MR    12, 195   6, 652   0   355   0   58.00   59.00   05900   CARPI AC CATHETERI ZATI ON   25, 174   14, 666   0   783   0   59, 00   60.00   06000   LABORATORY   87, 966   34, 232   0   1, 827   0   60.00   62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   17, 849   2, 047   0   109   0   62.00   65.00   06500   RESPI RATORY THERAPY   43, 624   10, 483   0   550   0   65.00   66.00   06600   RESPI RATORY THERAPY   52, 769   86, 891   1, 813   4, 638   0   66.00   69.00   06900   ELECTROCARDI OLOGY   26, 568   14, 020   703   748   0   69, 00   70.00   07000   CELECTROCARDI OLOGY   3, 121   6, 972   0   372   0   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   176, 641   54, 309   9, 64   2, 899   0   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   192, 262   0   0   0   0   0   0   72.00   74.00   07400   RENAL DI ALYSIS   227, 640   17, 174   0   917   0   73.00   75.00   03020   LITHOTRI PSY   4, 701   0   0   0   0   0   0   0   76.01   03330   ENDOSCODY   20, 076   12, 312   0   657   0   76.00   76.03   03951   MOUNDCARE   20, 537   11, 052   1, 211   590   76.00   76.03   03951   MOUNDCARE   20, 537   11, 052   1, 211   590   76.00   76.04   03952   DPI C   19, 938   24, 465   907   1, 306   0   76.00   76.00   09900   MICL SERVICE COST CENTERS   11, 144   3, 510   0   0   0   76.00   09900   MICL SERVICE COST CENTERS   11, 10, 10, 10, 10, 10, 10, 10, 10, 10,			1				_	•
59,00   05900   CARDIAC CATHETER ZATION   25,174   14,666   0   783   0   59,00   60.00   60			1				_	•
60. 00   06000   LABORATORY   87, 986   34, 232   0   1, 827   0   60. 00   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   17, 849   2, 047   0   109   0   62. 00   65. 00   06500   RESPI RATORY THERAPY   43, 624   10, 483   0   560   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   52, 769   86, 891   1, 813   4, 638   0   66. 00   67. 00   07000   CELCTROCARDI OLOGY   26, 568   14, 020   703   748   0   69. 00   67. 00   07000   CELCTROENCEPHALOGRAPHY   3, 121   6, 972   0   372   0   70. 00   67. 00   07000   LELCTROENCEPHALOGRAPHY   3, 121   6, 972   0   372   0   70. 00   67. 00   07000   IMPL DEV. CHARGED TO PATIENTS   192, 262   0   0   0   0   0   0   67. 00   07000   IMPL DEV. CHARGED TO PATIENTS   192, 262   0   0   0   0   0   0   67. 00   07000   IMPL DEV. CHARGED TO PATIENTS   277, 640   17, 174   0   917   0   73. 00   67. 00   07000   IMPL DEV. CHARGED TO PATIENTS   273, 354   30, 019   0   161   0   74. 00   67. 00   03020   LITHOTRI PSY   4, 701   0   0   0   0   0   0   0   67. 00   03020   LITHOTRI PSY   4, 701   0   0   0   0   0   0   0   67. 00   03030   SUDUNDCARE   20, 20, 20   20, 20   20, 20   67. 0. 03   03951   WOUNDCARE   20, 20, 37   11, 052   1, 211   590   0   76. 03   67. 0. 04   03952   DPI CONDUNDCARE   20, 537   11, 052   1, 211   590   0   76. 03   67. 0. 04   03952   DPI CONDUNDCARE   20, 537   11, 052   1, 211   590   0   76. 03   67. 0. 09200   0985RVATI ON BEDS (NON-DISTINCT PART OTHER REI MBURSABLE COST CENTERS   19, 938   24, 465   907   1, 306   0   0   0   0   67. 00   09900   CMHC   000   0   0   0   0   0   0   0   0			1				_	1
62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   17, 849   2, 047   0   109   0   62.00   65.00   06500   RESPIRATORY THERRAPY   43, 624   10, 483   0   560   0650   66.00   06600   PHYSI CAL THERAPY   52, 769   86, 891   1, 813   4, 638   0   66.00   67.00   06900   ELECTROCARDIOLOGY   26, 568   14, 020   703   748   0   69.00   69.00   06900   ELECTROCENCEPHALOGRAPHY   3, 121   6, 972   0   372   0   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   176, 641   54, 309   9, 964   2, 899   0   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   192, 262   0   0   0   0   0   0   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   277, 640   17, 174   0   917   0   73.00   74.00   07400   RENAL DI ALYSIS   23, 354   3,019   0   161   0   74.00   76.01   03320   ELITHOTRI PSY   4, 701   0   0   0   0   0   0   76.01   03320   ENDOSCOPY   20, 076   12, 312   0   657   0   76.01   76.02   03950   PRI SON CLINIC   9, 902   47, 971   0   2, 560   0   76.02   76.03   03951   WOUNDCARE   20, 537   11, 052   1,211   590   0   76.03   76.04   03952   OPIC COST CENTERS   79.00   09200   OBSERVATION BEDS (NON-DISTINCT PART   70.00   70.00   70.00   70.00   71.00   09000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   2, 396, 558   1, 557, 068   100, 861   81, 464   130, 577   718.00   SUBTOTALS (SUM OF LINES   1-117)   2, 396, 558   1, 557, 068   100, 861   81, 464   130, 577   719.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   2, 396, 558   1, 557, 068   100, 861   81, 464   130, 577   719.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   2, 396, 558   1, 557, 068   100, 861   81, 464   130, 577   719.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   2, 396, 558   1, 557, 068   100, 861   81, 464   130, 577   719.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   2, 396, 558   1, 557, 068   100, 861   81, 464   130, 577   719.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   2, 396, 558   1, 557, 068   100, 861   81, 464   130, 577   719.00   19000   19000   19000   19000   19000   19000   19000   19			1				. 0	1
65.00   06500   RESPIRATORY THERAPY   52,769   86,891   1,813   4,638   0   65.00							. 0	1
66.00   06600   069000   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   069			1				_	•
69.00   06900   ELECTROCARDIOLOGY   26, 568   14, 020   7003   748   0   69, 00   700. 00   70		1 1					_	•
70.00   07000   ELECTROENCEPHALGGRAPHY   3, 121   6, 972   0   372   0   70.00     71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   176, 641   54, 309   9, 964   2, 899   0   71.00     72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   192, 262   0   0   0   0   0   0     73.00   07300   DRUGS CHARGED TO PATIENTS   277, 640   17, 174   0   917   0   73.00     74.00   07400   RENAL DI ALYSI S   23, 354   3, 019   0   0   161   0   74.00     76.01   03330   ENDOSCOPY   20, 076   12, 312   0   657   0   76.01     76.02   03950   PRISON CLINI C   9, 902   47, 971   0   2, 560   0   76.02     76.03   03951   WOUNDCARE   20, 537   11, 052   1, 211   590   0   76.03     76.04   03952   DPI C   0000   0   0   0   0   0     92.00   0900   DERREGENCY   112, 290   65, 758   11, 144   3, 510   0   91.00     92.00   0900   DERREGENCY   0, 300, 500   0   0   0   0   0     99.00   OBSERVATION BEDS (NON-DISTINCT PART   0   0, 00   0   0   0   0   0     99.00   OSPECIAL PURPOSE COST CENTERS   0   0   0   0   0   0   0   0     191.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   2, 344   3, 882   0   207   0   190.00     191.00   19000   RESEARCH   0   0   0   0   0   0   0   0   0     192.00   19000   RESEARCH   0   0   0   0   0   0   0   0   0     193.00   19300   NONPAID WORKERS   0   0   0   0   0   0   0   0     194.00   07950   OCCUPATIONAL MEDI CINE   33, 752   28, 974   0   1, 546   0   194.00     194.01   07951   OTHER NONREI MBURSABLE COST CENTERS   8, 615   0   0   0   0   0   0   0     201.00   Negative Cost Centers   0   0   0   0   0   0   0     201.00   Negative Cost Centers   0   0   0   0   0   0     201.00   Negative Cost Centers   0   0   0   0   0   0     201.00   Negative Cost Centers   0   0   0   0   0     201.00   0   Negative Cost Centers   0   0   0   0   0     201.00   0   0   0   0   0   0   0     201.00   0   0   0   0   0   0   0     201.00   0   0   0   0   0   0   0     201.00   0   0   0   0   0   0   0     201.00   0   0   0   0   0   0     201.00   0   0   0   0   0   0   0     201.00			1				-	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1 1	1				_	1
72. 00   07200   IMPL DEV CHARGED TO PATIENTS   192, 262   0   0   0   0   0   72. 00		1 1					_	•
73. 00   07300   RUISC CHARGED TO PATIENTS   277, 640   17, 174   0   917   0   73. 00     74. 00   07400   RENAL DI ALYSIS   23, 354   3, 019   0   161   0   74. 00     76. 00   03020   LITHOTRI PSY   4, 701   0   0   0   0   0   0     76. 01   03330   ENDOSCOPY   20, 076   12, 312   0   657   0   76. 01     76. 02   03950   PRI SON CLINIC   9, 092   47, 971   0   2, 560   0   76. 02     76. 03   03951   WOUNDCARE   20, 537   11, 052   1, 211   590   0   76. 03     76. 04   03952   OPI C   19, 938   24, 465   907   1, 306   0   76. 04     77. 00   0900   EMERGENCY   112, 290   65, 758   11, 144   3, 510   91. 00     78. 00   0900   OBSERVATI ON BEDS (NON-DI STINCT PART   0   0   0   0   0   0     79. 00   09900   CMHC   09900					·		-	1
74. 00 07400 RENAL DI ALYSIS 23,354 3,019 0 161 0 74. 00 76. 00 0320 LITHOTRI PSY 4,701 0 0 0 0 76. 00 76. 01 0330 ENDOSCOPY 20,076 12,312 0 657 0 76. 01 76. 02 03950 PRI SON CLI NI C 9,092 47,971 0 2,560 0 76. 02 76. 03 03951 WOUNDCARE 20,537 11,052 1,211 590 0 76. 03 76. 04 03952 PRI SON CLI NI C 19,938 24,465 907 1,306 0 76. 03 76. 04 09100 EMERGENCY 11,000 DIPLATI ENT SERVI CE COST CENTERS  91. 00 09100 EMERGENCY 112,290 65,758 11,144 3,510 0 91. 00 92. 00 09200 DISSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS  118. 00 SUBTOTALS (SUM OF LI NES 1-117) 2,396,558 1,557,068 100,861 81,464 130,577  119. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2,044 3,882 0 207 0 191. 00 191. 00 19100 RESEARCH 0 0 0 0 0 0 0 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 0 0 0 0 192. 00 193. 00 19300 NONPAID WORKERS 0 0 0 0 0 0 0 0 193. 00 194. 00 07950 COLOPATIONAL MEDI CI NE 33,752 28,974 0 1,546 0 194. 00 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 8,615 0 0 0 0 0 194. 02 200. 00 Cross Foot Adjustments 8,615 0 0 0 0 0 0 0 194. 02 200. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	_	· -	-	_	•
76. 00 03020 LITHOTRIPSY 4, 701 0 0 0 0 0 76. 00 76. 01 03330 ENDOSCOPY 20, 076 12, 312 0 657 0 76. 01 76. 02 03950 PRI SON CLI NI C 9, 092 47, 971 0 2, 560 0 76. 02 76. 03 03951 WOUNDCARE 20, 537 11, 052 1, 211 590 0 76. 03 76. 04 03952 OPI C 19, 938 24, 465 907 1, 306 0 76. 03 76. 04 03952 OPI C 19, 938 24, 465 907 1, 306 0 76. 03 76. 04 03952 OPI C 19, 938 24, 465 907 1, 306 0 76. 03 76. 04 03952 OPI C 19, 938 24, 465 907 1, 306 0 76. 03 76. 04 03952 OPI C 19, 938 24, 465 907 1, 306 0 76. 03 76. 04 03952 OPI C 19, 938 24, 465 907 1, 306 0 76. 03 76. 04 03952 OPI C 19, 938 24, 465 907 1, 306 0 76. 03 76. 04 03952 OPI C 19, 938 24, 465 907 1, 306 0 76. 03 76. 04 03952 OPI C 19, 938 24, 465 907 1, 306 0 76. 04 00000000000000000000000000000000000			1				_	1
76. 01 03330   ENDOSCOPY   20,076   12,312   0   657   0   76. 01   76. 02 03950   PRI SON CLINIC   9,092   47,971   0   2,560   0   76. 02   76. 03 03951   MOUNDCARE   20,537   11,052   1,211   590   0   76. 03   76. 04 03952   OPI C   19,938   24,465   907   1,306   0   76. 04   76. 04 03952   OPI C   19,938   24,465   907   1,306   0   76. 04   76. 04 03952   OPI C   19,938   24,465   907   1,306   0   76. 04   76. 04 03952   OPI C   19,938   24,465   907   1,306   0   76. 04   76. 04 03952   OPI C   19,938   24,465   907   1,306   0   76. 04   76. 04 03952   OPI C   12,904   112,290   65,758   11,144   3,510   0   91.00   76. 04 09200   OBSERVATI ON BEDS (NON-DISTINCT PART   92.00   76. 02 09200   OBSERVATI ON BEDS (NON-DISTINCT PART   92.00   76. 03 09900   OPI C   0   0   0   0   0   0   76. 04 09200   OPI C   0   0   0   0   0   76. 05 09200   OPI C   0   0   0   0   76. 06 09200   OPI C   0   0   0   0   76. 07 099.00   76. 09000   OPI C   0   0   0   0   76. 09000   OPI C   0   0   0   0   76. 09000   OPI C   0   76. 09000   0   76. 09000   0   76. 09000   0   76. 09000   0   76. 09000   0   76. 09000   0   76. 09000   0   76. 09000   0   76. 09000   0   76. 09000   0   76. 09000   0   76. 09000   0   76. 09000   0   76. 09000   0   76. 09000   0   76. 09000   0PI C   0   76. 09000   0   76. 09000   0   76. 09000   0   76. 09000   0PI C					1		_	•
76. 02		1 1	1	_	_	-		•
76. 03			1				_	1
76. 04 03952 OPI C 0UTPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS  99. 00 SPECIAL PURPOSE COST CENTERS  118. 00 SUBTOTALS (SUM OF LINES 1-117) 2, 396, 558 1, 557, 068 100, 861 81, 464 130, 577 118. 00 19100 RESEARCH 0 0 0 0 0 0 0 0 19100 RESEARCH 0 0 0 0 0 0 0 1910. 00 1910. 00 1910. 00 1910. 00 19200 PHYSI CIANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 0 1912. 00 193. 00 19300 NONPAID WORKERS 0 0 0 0 0 0 0 193. 00 194. 00 07950 OCCUPATIONAL MEDICINE 333, 752 28, 974 0 1, 546 0 194. 00 194. 00 07950 ITTERS  100. 00 100 Negative Cost Centers 8, 671 19, 092 0 1, 019 54, 064 194. 01 194. 00 207. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1	1				_	
OUTPATI ENT SERVI CE COST CENTERS   OPEN							_	1
91. 00	76. 04		19, 938	24, 400	907	1, 300	0	76.04
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   0   0   0   0   0   0   0   0   0	01 00		112 200	4E 7E0	11 144	2 E10	0	01 00
OTHER REIMBURSABLE COST CENTERS   O   O   O   O   O   O   O   O   O		1 1	112, 290	05, /58	11, 144	3, 510	ı	
99. 00   09900   CMHC   0   0   0   0   0   0   0   0   0	92.00							92.00
SPECIAL PURPOSE COST CENTERS   118.00   SUBTOTALS (SUM OF LINES 1-117)   2,396,558   1,557,068   100,861   81,464   130,577   118.00   NONREI MBURSABLE COST CENTERS   190.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   2,044   3,882   0   207   0   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   0   0   0   0   192.00   193.00   19300   NONPAI D WORKERS   0   0   0   0   0   0   193.00   194.00   07950   OCCUPATI ONAL MEDI CI NE   33,752   28,974   0   1,546   0   194.00   194.01   07951   OTHER NONREI MBURSABLE COST CENTERS   671   19,092   0   1,019   54,064   194.01   194.02   07952   SI TTERS   8,615   0   0   0   0   194.02   200.00   Cross Foot Adjustments   200.00   0   0   0   0   201.00	00.00					ما		00.00
118. 00   SUBTOTALS (SUM OF LINES 1-117)   2, 396, 558   1, 557, 068   100, 861   81, 464   130, 577   118. 00	99.00		0		0	U	0	99.00
NONRE   MBURSABLE   COST   CENTERS     190. 00   19000   GI FT,   FLOWER,   COFFEE   SHOP & CANTEEN   2, 044   3, 882   0   207   0   190. 00   191. 00   191. 00   19100   RESEARCH   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   19300   NONPAI D   WORKERS   0   0   0   0   0   0   193. 00   194. 00   07950   OCCUPATI ONAL   MEDI CI NE   33, 752   28, 974   0   1, 546   0   194. 01   194. 01   19751   OTHER   NONREI   MBURSABLE   COST   CENTERS   671   19, 092   0   1, 019   54, 064   194. 01   194. 02   07952   SI TTERS   8, 615   0   0   0   0   194. 02   200. 00   Cross   Foot   Adj ustments   200. 00   201. 00   Negati ve   Cost   Centers   0   0   0   0   0   201. 00   0   0   201. 00   0   0   0   0   0   0   0   0   0	110 00		2 20/ 550	1 557 0/0	100.0/1	01 4/4	120 577	110 00
190. 00       19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN       2,044       3,882       0       207       0       190. 00         191. 00       19100 RESEARCH       0       0       0       0       0       191. 00         192. 00       19200 PHYSI CI ANS' PRI VATE OFFI CES       0       0       0       0       0       0       192. 00         193. 00       19300 NONPAI D WORKERS       0       0       0       0       0       0       0       193. 00         194. 00       07950 OCCUPATI ONAL MEDI CI NE       33, 752       28, 974       0       1, 546       0       194. 00         194. 01       07951 OTHER NONREI MBURSABLE COST CENTERS       671       19, 092       0       1, 019       54, 064       194. 01         194. 02       07952 SI TTERS       8, 615       0       0       0       0       194. 02         200. 00       Cross Foot Adj ustments       0       0       0       0       0       0       201. 00	118.00		2, 396, 558	1, 557, 068	100, 861	81, 464	130, 577	118.00
191. 00   19100   RESEARCH   0 0 0 0 0 0 191. 00   192. 00   192. 00   192. 00   192. 00   192. 00   193. 00   194. 00   194. 01   194. 01   194. 02   194	400.00		0.044	2 000		207		400.00
192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   0   0   192. 00   193. 00   19300   NONPAI D WORKERS   0   0   0   0   193. 00   194. 00   07950   OCCUPATI ONAL MEDI CI NE   33, 752   28, 974   0   1, 546   0   194. 00   194. 01   07951   OTHER NONREI MBURSABLE COST CENTERS   671   19, 092   0   1, 019   54, 064   194. 01   194. 02   07952   SI TTERS   8, 615   0   0   0   0   194. 00   200. 00   Cross Foot Adjustments   0   0   0   0   0   201. 00   201. 00   Negati ve Cost Centers   0   0   0   0   0   201. 00								
193. 00   19300   NONPAI D WORKERS   0 0 0 0 0 193. 00   194. 00   194. 00   195. 00			0	0				
194. 00   07950   0CCUPATI ONAL MEDI CI NE   33,752   28,974   0   1,546   0   194. 00   194. 01   07951   07951   07951   07952   079			0	0	· -	0		
194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 671 19, 092 0 1, 019 54, 064 194. 01 194. 02 07952 SITTERS 8, 615 0 0 0 0 194. 02 200. 00 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 0 201. 00			0	0 00 0	_	. 0	_	
194. 02 07952 SITTERS     8,615     0     0     0     194. 02 200. 00       200. 00 201. 00     Cross Foot Adjustments Negative Cost Centers     0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>1</td></td<>								1
200.00       Cross Foot Adjustments       200.00         201.00       Negative Cost Centers       0       0       0       0       0       0       201.00					9	1, 019		1
201.00   Negative Cost Centers   0   0   0   0   201.00			8, 615	0	0	0	0	
		, ,					I	1
202.00			0	0	0	0		
	202. 00		2, 441, 640	1, 609, 016	100, 861	84, 236	184, 641	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS TERRE HAUTE REGIONAL HOSPITAL Provider CCN: 150046

					11	0 08/31/2016	Date/IIme Pre   1/25/2017 6:2	
						OTHER GENERAL	1 172072017 0.2	, p
		Coot Conton Decemintion	CAFETERI A	NUDCLNC	MEDICAL	SERVI CE	Culatatal	
		Cost Center Description	CAFETERIA	NURSI NG ADMI NI STRATI ON	MEDICAL RECORDS &	I NSERVI CE EDUCATI ON	Subtotal	
					LI BRARY			
	CENED	AL CEDIUCE COST CENTERS	11. 00	13. 00	16. 00	18. 00	24. 00	
1.00		AL SERVICE COST CENTERS  CAP REL COSTS-BLDG & FIXT						1.00
2.00	1	CAP REL COSTS-MVBLE EQUIP						2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 7. 00		ADMINISTRATIVE & GENERAL OPERATION OF PLANT						5. 00 7. 00
8.00	1	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPI NG						9. 00
10.00		DIETARY	404 //-					10.00
11. 00 13. 00		CAFETERIA NURSING ADMINISTRATION	101, 667 1, 344					11. 00 13. 00
16. 00		MEDICAL RECORDS & LIBRARY	284		186, 012			16. 00
18. 00	01850	INSERVICE EDUCATION	4, 892	3, 879		201, 707		18. 00
00.00		I ENT ROUTI NE SERVI CE COST CENTERS	00.404	10 (10		5 4 74 O	0.0/0.504	00.00
30. 00 31. 00	1	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	22, 104 5, 687			54, 718 14, 406	2, 060, 531 391, 029	1
40. 00	1	SUBPROVI DER - I PF	6, 810			26, 655	389, 315	
41.00	04100	SUBPROVI DER - I RF	2, 398			3, 097	335, 277	41. 00
43. 00		NURSERY	514	426	237	1, 189	36, 429	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	10, 291	0	24, 680	6, 498	814, 387	50.00
51.00		RECOVERY ROOM	1, 378		3, 454	2, 682	70, 271	51. 00
52. 00	1	DELIVERY ROOM & LABOR ROOM	2, 475	1	940	3, 926	233, 694	
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0 4 147	1	0	0 2, 184	0 393, 051	53. 00 54. 00
54. 00		ULTRASOUND	4, 167 497	1		1, 051	18, 891	54. 00
54. 02	1	MAMMOGRAPHY	580	1	708	2, 157	49, 524	
55. 00	1	RADI OLOGY-THERAPEUTI C	1, 610			3, 318	197, 272	
56. 00 57. 00		RADI OI SOTOPE CT SCAN	539 1, 704		3, 613 13, 862	359 2, 461	52, 825 82, 761	56. 00 57. 00
58. 00	05800		699		3, 855	359	42, 768	1
59. 00		CARDI AC CATHETERI ZATI ON	1, 080	1		1, 742	91, 751	
60.00	1	LABORATORY	5, 226			2, 793	246, 232	
62. 00 65. 00		WHOLE BLOOD & PACKED RED BLOOD CELL RESPIRATORY THERAPY	251 3, 249	1	, -	111 4, 590	28, 012 101, 056	
66. 00	1	PHYSI CAL THERAPY	2, 649		2, 090	8, 129	399, 239	
69. 00	06900	ELECTROCARDI OLOGY	1, 798			1, 908	90, 893	
70.00	1	ELECTROENCEPHALOGRAPHY	180			138	30, 560	
71. 00 72. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	1, 610	0	·	0	406, 258 197, 755	
73. 00	1	DRUGS CHARGED TO PATIENTS	4, 006	1	29, 651	o	379, 061	1
74.00		RENAL DIALYSIS	C	0	,	o	36, 416	1
76.00	1	LI THOTRI PSY	771	0		0	5, 077	1
76. 01 76. 02		ENDOSCOPY PRISON CLINIC	771 400			2, 295	72, 629 191, 635	
		WOUNDCARE	199			l .		76. 03
76. 04	03952		1, 423	1, 129	1, 805	0	118, 713	76. 04
91. 00		TIENT SERVICE COST CENTERS  EMERGENCY	6, 641	5, 762	15, 176	52, 369	459, 741	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART	0, 041	3, 702	13, 170	32, 307	437, 741	92.00
		REIMBURSABLE COST CENTERS						
99. 00	09900	CMHC AL PURPOSE COST CENTERS	C	0	0	0	0	99. 00
118.00		SUBTOTALS (SUM OF LINES 1-117)	97, 456	50, 427	186, 012	199, 799	8, 088, 969	118. 00
	NONRE	MBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH	160 0	1		0		190. 00 191. 00
		PHYSICIANS' PRIVATE OFFICES		0	0			191.00
		NONPALD WORKERS	C	o o	Ö	o		193. 00
		OCCUPATIONAL MEDICINE	2, 771	1	0	1, 576	149, 680	
		OTHER NONREIMBURSABLE COST CENTERS SITTERS	1, 280	0 1, 061	0	0 332	97, 956 11, 717	
200.00		Cross Foot Adjustments	1, 280	, 1,061		332	11, /1/	200. 00
201.00		Negative Cost Centers	C	0	0	О	0	201. 00
202.00	)	TOTAL (sum lines 118-201)	101, 667	51, 488	186, 012	201, 707	8, 365, 293	202. 00

TERRE HAUTE REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150046 Worksheet B Peri od: From 09/01/2015 To 08/31/2016 Part II Date/Time Prepared: 1/25/2017 6:24 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 26.00 25.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8. 00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 11. 00 01100 CAFETERIA 11.00 13. 00 01300 NURSI NG ADMI NI STRATI ON 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 18.00 01850 INSERVICE EDUCATION 18.00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 2,060,531 30.00 31 00 03100 INTENSIVE CARE UNIT 391 029 31 00

31.00	03100 INTENSIVE CARE UNIT	0	391, 029		31.00
40.00	04000 SUBPROVI DER - I PF	0	389, 315		40.00
41.00	04100 SUBPROVI DER – I RF	0	335, 277		41.00
43.00	04300 NURSERY	o	36, 429		43.00
A	NCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	814, 387		50.00
51.00	05100 RECOVERY ROOM	o	70, 271		51.00
52.00	D5200 DELIVERY ROOM & LABOR ROOM	l ol	233, 694		52. 00
	05300 ANESTHESI OLOGY	o	0	·	53. 00
	D5400 RADI OLOGY-DI AGNOSTI C	0	393, 051		54.00
	05401 ULTRASOUND	o	18, 891	1	54. 01
	05402 MAMMOGRAPHY		49, 524	i e	54. 02
	05500 RADI OLOGY-THERAPEUTI C		197, 272		55. 00
	05600 RADI OI SOTOPE		52, 825	i e	56. 00
	05700 CT SCAN		82, 761		57. 00
	05800 MRI		42, 768	l e e e e e e e e e e e e e e e e e e e	58. 00
	05900 CARDI AC CATHETERI ZATI ON		91, 751		59. 00
	06000 LABORATORY		246, 232		60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	28, 012		62.00
1	06500 RESPI RATORY THERAPY	0	101, 056		65. 00
	06600 PHYSI CAL THERAPY	0	399, 239		66.00
		0			
	06900 ELECTROCARDI OLOGY	0	90, 893		69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	30, 560		70.00
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	406, 258		71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	197, 755		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	379, 061		73. 00
	07400 RENAL DI ALYSI S	0	36, 416		74. 00
	03020 LI THOTRI PSY	0	5, 077		76. 00
	03330 ENDOSCOPY	0	72, 629		76. 01
	03950 PRISON CLINIC	0	191, 635		76. 02
	03951 WOUNDCARE	0	65, 916		76. 03
	03952 OPI C	0	118, 713		76. 04
	OUTPAȚIENT SERVICE COST CENTERS				
	09100 EMERGENCY	0	459, 741		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			92. 00
	OTHER REIMBURSABLE COST CENTERS				
99.00	09900 CMHC	0	0		99. 00
S	SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	8, 088, 969		118. 00
N	IONREI MBURSABLE COST CENTERS				
190.001	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16, 971		190. 00
191.001	19100 RESEARCH	0	0		191. 00
192.001	19200 PHYSICIANS' PRIVATE OFFICES	0	0		192. 00
193.001	19300 NONPALD WORKERS	o	0		193. 00
194.000	07950 OCCUPATIONAL MEDICINE	o	149, 680		194. 00
	07951 OTHER NONREIMBURSABLE COST CENTERS	o	97, 956		194. 01
	07952 SI TTERS	o	11, 717		194. 02
200.00	Cross Foot Adjustments	l o	0		200.00
201.00	Negative Cost Centers	ا	0	l .	201. 00
202.00	TOTAL (sum lines 118-201)	l o	8, 365, 293		202. 00
_02.00	1.1 (64 1.1.65 1.16 261)	۱	0,000,270		1-32.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 150046 Peri od: Worksheet B-1 From 09/01/2015 08/31/2016 Date/Time Prepared: 1/25/2017 6:24 pm CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE (SOUARE FEET) (SOUARE BENEFITS & GENERAL (ACCUM. COST) FOOTAGE) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 363 073 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 360, 088 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 3,750 3, 750 36, 546, 398 4.00 00500 ADMINISTRATIVE & GENERAL 3, 444, 995 84, 138, 072 5 00 24 188 24, 188 -17, 716, 589 5 00 7.00 00700 OPERATION OF PLANT 83, 573 83, 573 734, 200 4, 991, 491 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 3,541 3, 541 559, 334 8.00 0 00900 HOUSEKEEPI NG 1, 274 1, 274 888, 157 1, 547, 547 9.00 9.00 01000 DI ETARY 10.00 5.784 5. 784 445, 285 1, 503, 469 10 00 11.00 01100 CAFETERI A 3,689 3, 689 216, 304 0 408, 468 11.00 01300 NURSING ADMINISTRATION 990 990 640, 362 0 858, 766 13.00 13.00 01600 MEDICAL RECORDS & LIBRARY 5, 701 60, 894 0 1, 236, 049 16, 00 5.701 16, 00 01850 INSERVICE EDUCATION 18.00 5, 434 5, 434 1, 478, 973 2, 017, 746 18.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 62, 462 62, 462 6,070,555 0 10, 381, 938 30.00 0 3, 051, 469 03100 INTENSIVE CARE UNIT 1, 933, 027 31.00 10.629 10.629 31.00 40.00 04000 SUBPROVIDER - IPF 9.596 9.596 1, 737, 503 0 2, 624, 298 40 00 41.00 04100 SUBPROVIDER - IRF 11, 408 11, 408 805, 441 0 1, 273, 186 41.00 43.00 04300 NURSERY 1,044 1,044 177, 346 0 291, 276 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 25, 223 25, 223 3, 075, 732 4, 987, 971 50.00 1, 575 574, 355 05100 RECOVERY ROOM 1,575 0 811, 328 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 7, 182 7, 182 765, 272 0 1, 549, 775 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 13,068 13,068 966, 032 2, 035, 018 54.00 05401 ULTRASOUND 54.01 406 406 141,609 0 0 0 0 0 0 0 0 0 212, 695 54.01 54.02 05402 MAMMOGRAPHY 1, 495 1, 495 161, 823 329, 035 54.02 |05500| RADI OLOGY-THERAPEUTI C 55.00 6, 177 6, 177 589,007 1, 227, 586 55.00 05600 RADI 0I SOTOPE 742 221, 699 1, 031, 364 56, 00 742 56.00 57.00 05700 CT SCAN 1,602 1, 602 491, 549 858, 875 57.00 05800 MRI 244, 298 420, 225 58 00 1.040 1.040 58 00 59.00 05900 CARDI AC CATHETERI ZATI ON 2, 293 2, 293 517, 462 867, 485 59.00 06000 LABORATORY 60.00 5, 352 5, 352 1, 205, 429 3, 032, 030 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 320 320 62, 152 615, 094 62.00 06500 RESPIRATORY THERAPY 1, 503, 280 65.00 1,639 1, 639 1, 026, 185 65.00 66.00 06600 PHYSI CAL THERAPY 13,585 13, 585 1, 123, 703 1, 818, 418 66.00 69.00 06900 ELECTROCARDI OLOGY 2, 192 2, 192 483, 814 0 0 0 0 0 0 915, 527 69.00 07000 ELECTROENCEPHALOGRAPHY 1.090 1.090 55 025 70 00 107, 553 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 8, 491 8, 491 334, 641 6, 087, 090 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 6, 625, 391 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2,685 2, 685 1, 489, 580 9, 567, 509 73.00 07400 RENAL DIALYSIS 804, 795 74 00 74 00 472 472 C 76.00 03020 LI THOTRI PSY 162,003 76.00 03330 ENDOSCOPY 1, 925 1, 925 331, 914 691, 821 76.01 0 76.01 76.02 03950 PRISON CLINIC 7,500 7,500 128, 644 313, 325 76.02 03951 WOUNDCARE 03952 OPI C 1, 728 1, 728 68, 596 76.03 707, 716 76 03 76.04 3,825 3,825 438, 578 687, 068 76.04 OUTPATIENT SERVICE COST CENTERS 91.00 10, 281 91.00 09100 EMERGENCY 10, 281 2, 170, 762 0 3, 869, 534 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 0 0 0 0 0 99.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 354, 951 354, 951 35, 300, 903 -17, 716, 589 82, 584, 548 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 70, 421 190. 00 607 607 30. 184 191. 00 19100 RESEARCH 0 0 C 0 0 191.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192.00 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 0 194. 00 07950 OCCUPATIONAL MEDICINE 1, 163, 103 194. 00 4.530 4,530 984, 185 194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 2.985 23, 110 194. 01 231, 126 194. 02 07952 SI TTERS 296, 890 194. 02 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 201.00 202.00 Cost to be allocated (per Wkst. B, 2, 810, 880 3, 515, 154 7, 276, 108 17, 716, 589 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 7. 741914 9.761930 0.199092 0. 210566 203. 00 Cost to be allocated (per Wkst. B, 2, 441, 640 204. 00 204 00 65, 639 Part II)

Health Financial Systems TE	ERRE HAUTE REGI	ONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 09/01/2015	Worksheet B-1	
				o 08/31/2016	Date/Time Pre 1/25/2017 6:2	
	CAPITAL REL	LATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FEET)	FOOTAGE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	& GENERAL (ACCUM. COST)	
	1.00	2.00	4.00	5A	5. 00	
205.00 Unit cost multiplier (Wkst. B, Part			0. 001796		0. 029019	205. 00

near th	Financial Systems	TERRE HAUTE REG	IONAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der	F	Period: From 09/01/2015 To 08/31/2016	Worksheet B-1 Date/Time Pre 1/25/2017 6:2	pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (MANHOURS)	
		7. 00	8.00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						4
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	251, 562 3, 541 1, 274	12, 906				1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00
10. 00 11. 00 13. 00	01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	5, 784 3, 689 990	0	5, 784 3, 689 990	o	1, 063, 238 14, 053	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	5, 701	0	5, 701	0	2, 974	16.00
18. 00	01850 I NSERVI CE EDUCATI ON	5, 434	. 0	5, 434	I 0	51, 163	18.00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	62, 462	4, 980	62, 462	68, 276	231, 145	30.00
31. 00	03100 INTENSIVE CARE UNIT	10, 629				59, 477	1
40.00	04000 SUBPROVI DER - I PF	9, 596	615	9, 596	21, 042	71, 223	40.00
41.00	04100 SUBPROVI DER - I RF	11, 408	1			25, 077	1
43.00	04300 NURSERY	1, 044	. 0	1, 044	0	5, 380	43.00
FO 00	ANCILLARY SERVICE COST CENTERS    05000   OPERATING ROOM	25 222	1 057	25 222		107 (22	- 00
50. 00 51. 00	05100 RECOVERY ROOM	25, 223 1, 575				107, 622 14, 412	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	7, 182	1			25, 886	1
53. 00	05300 ANESTHESI OLOGY	, , , , , , , , , , , , , , , , , , ,	0	.,		0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	13, 068	627	13, 068	o o	43, 576	54.00
54. 01	05401 ULTRASOUND	406	1	406		5, 200	
54. 02	05402 MAMMOGRAPHY	1, 495	1	1, 495		6, 061	
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C	6, 177 742		-,		16, 834	
57. 00	05600 RADI OI SOTOPE 05700 CT SCAN	1, 602	1	742 1, 602		5, 641 17, 822	
58. 00	05800 MRI	1, 040	1	1, 040		7, 315	
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 293		2, 293		11, 290	1
60.00	06000 LABORATORY	5, 352		5, 352		54, 652	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELI		ł	320		2, 622	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 639 13, 585		1, 639 13, 585		33, 977 27, 707	
69. 00	06900 ELECTROCARDI OLOGY	2, 192	1			18, 807	
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 090	ł .	1, 090		1, 882	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	8, 491	1, 275	8, 491	0	16, 839	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	C	1	(	-	0	
	07300 DRUGS CHARGED TO PATIENTS	2, 685	1	2, 685		41, 898	
	07400 RENAL DI ALYSI S 03020 LI THOTRI PSY	472	1	472		0	74. 00 76. 00
	03330 ENDOSCOPY	1, 925	1	· `	1 1		76.0
76. 02	03950 PRI SON CLINIC	7, 500		7, 500		4, 187	
76. 03	03951 WOUNDCARE	1, 728	1			2, 078	
76. 04	03952 OPI C	3, 825	116	3, 825	5 0	14, 885	76. 04
91. 00	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	10, 281	1, 426	10, 281	ol	69, 449	91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1, 420	10, 201	٩	09, 449	92.00
72.00	OTHER REIMBURSABLE COST CENTERS		1				1 /2.00
99. 00	09900 CMHC	C	0	(	0	0	99.00
	SPECIAL PURPOSE COST CENTERS						4
118. 00		243, 440	12, 906	238, 625	102, 108	1, 019, 196	]118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	l 607	ı o	607	7 0	1 676	190. 00
	19100 RESEARCH	.   007	1	007			191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	C	0	C	o	0	192. 00
	19300 NONPALD WORKERS	C	0	C	0		193. 00
194.00	07950 OCCUPATIONAL MEDICINE	4, 530	0	4, 530		28, 983	
	07951 OTHER NONREIMBURSABLE COST CENTERS 07952 SITTERS	2, 985		2, 985	42, 277	13, 383	194. 0
200.00	I I		,		, 	13, 303	200. 00
201.00	Negative Cost Centers						201.00
202.00		6, 042, 529	762, 166	1, 959, 049	2, 004, 902	612, 376	202. 00
	Part I)   Unit cost multiplier (Wkst. B, Part	24. 020039	59. 055168	7. 939505	13. 885805	0. 575954	303 0
202 00		1, 609, 016	1	84, 236		0. 575954 101, 667	
203.00	TOSE TO BE ALTOCATED THE WKY B		100,001	1 01, 200	101,041	101, 007	1-01.00
203. 00 204. 00	Part II)						
	Part II)		7. 815047	0. 341386	1. 278810	0. 095620	205. 00

Provider CCN: 150046

				' '	1/25/2017 6:	
				OTHER GENERAL		
				SERVI CE		
	Cost Center Description	NURSI NG	MEDI CAL	I NSERVI CE		
		ADMI NI STRATI ON	RECORDS & LI BRARY	EDUCATION (TIME SPENT)		
		(DIRECT NRSING	(GROSS CHAR	(TIME SPENT)		
		HRS)	GES)			
		13.00	16. 00	18. 00		
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLDG & FIXT					1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMI NI STRATI VE & GENERAL					5.00
7. 00 8. 00	OO7OO   OPERATION OF PLANT   OO8OO   LAUNDRY & LINEN SERVICE					7. 00 8. 00
9. 00	00900 HOUSEKEEPING					9. 00
10. 00	01000 DI ETARY					10.00
	01100 CAFETERI A					11. 00
	01300 NURSING ADMINISTRATION	679, 124				13. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	633, 950, 480			16. 00
18.00	01850 I NSERVI CE EDUCATI ON	51, 163	0	7, 295		18. 00
	I NPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDI ATRI CS	245, 597	23, 298, 971	1, 979		30.00
	03100 I NTENSI VE CARE UNI T	61, 778	8, 770, 558			31.00
	04000   SUBPROVI DER   -     PF   04100   SUBPROVI DER   -       RF	72, 058 25, 169	22, 479, 135 2, 186, 183			40. 00 41. 00
	04300 NURSERY	5, 617	2, 166, 163 809, 710			43.00
43.00	ANCI LLARY SERVI CE COST CENTERS	3,017	007,710	1 43		- 43.00
50.00	05000 OPERATI NG ROOM	0	84, 231, 176	235		50.00
	05100 RECOVERY ROOM	0	11, 787, 427			51.00
	05200 DELIVERY ROOM & LABOR ROOM	25, 886	3, 207, 087	142		52.00
	05300 ANESTHESI OLOGY	0	0	0		53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	14, 422, 183			54.00
	05401 ULTRASOUND	0	3, 667, 814	38		54. 01
	05402 MAMMOGRAPHY	14 024	2, 415, 287	78		54. 02
55. 00 56. 00	05500  RADI OLOGY-THERAPEUTI C   05600  RADI OI SOTOPE	16, 834	15, 862, 669 12, 331, 906			55. 00 56. 00
57. 00	05700 CT SCAN	0	47, 309, 128			57. 00
	05800 MRI	0	13, 158, 459	1		58. 00
	05900 CARDI AC CATHETERI ZATI ON	11, 290	21, 764, 114	1		59. 00
60.00	06000 LABORATORY	0	62, 531, 829	101		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	6, 593, 461	4		62. 00
65. 00	06500 RESPI RATORY THERAPY	33, 977	18, 509, 531	166		65. 00
	06600 PHYSI CAL THERAPY	0	7, 131, 902			66. 00
	06900 ELECTROCARDI OLOGY	18, 807	15, 306, 627	69		69.00
	07000  ELECTROENCEPHALOGRAPHY   07100  MEDICAL SUPPLIES CHARGED TO PATIENT	1, 882	1, 551, 414			70. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	39, 517, 121 18, 746, 420			72.00
	07300 DRUGS CHARGED TO PATIENTS	o	100, 305, 684	ĺ		73. 00
	07400 RENAL DIALYSIS	o	5, 530, 574			74. 00
	03020 LI THOTRI PSY	0	1, 284, 350			76. 00
	03330 ENDOSCOPY	0	7, 601, 343			76. 01
76. 02	03950 PRISON CLINIC	0	350, 310	0		76. 02
	03951 WOUNDCARE	4, 187	3, 331, 924			76. 03
76. 04	03952 OPI C	14, 885	6, 162, 086	0		76. 04
01 00	OUTPATIENT SERVICE COST CENTERS	75 000	F1 704 007	1 004		01.00
	09100 EMERGENCY	75, 998	51, 794, 097	1, 894		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS					92. 00
99. 00	09900 CMHC	0	0	0		99. 00
77.00	SPECIAL PURPOSE COST CENTERS		J	<u> </u>		<b>-</b> //. 00
118. 00		665, 128	633, 950, 480	7, 226		118. 00
	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190. 00
	19100 RESEARCH	0	0			191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	·		192. 00
	19300 NONPAI D WORKERS	0	0	·		193. 00
	07950 OCCUPATI ONAL MEDI CI NE	0	0	57		194. 00
	07951 OTHER NONREIMBURSABLE COST CENTERS 07952 SITTERS	13, 996	0	0 12		194. 01 194. 02
200.00		13, 990	U	12		200.00
201.00	1					201. 00
		1 4 676 667	1 400 222	2, 727, 064		202. 00
	Cost to be allocated (per Wkst. B.	1, 079, 3271	1, 000, 233			
202.00	Cost to be allocated (per Wkst. B, Part I)	1, 079, 327	1, 680, 233	2, 727, 001		
202. 00 203. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	1. 589293	0. 002650	373. 826456		203. 00
202. 00	Part I) Unit cost multiplier (Wkst. B, Part I)			373. 826456		203. 00 204. 00

Health Financial Systems T	ERRE HAUTE REGI	ONAL HOSPITAL		In Li€	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od: From 09/01/2015	Worksheet B-1	
				To 08/31/2016		
			OTHER GENERA	L		
			SERVI CE			
Cost Center Description	NURSI NG	MEDI CAL	I NSERVI CE			
	ADMI NI STRATI ON	RECORDS &	EDUCATI ON			
		LI BRARY	(TIME SPENT)	)		
	(DIRECT NRSING	(GROSS CHAR				
	HRS)	GES)				
	13. 00	16. 00	18. 00			
205.00 Unit cost multiplier (Wkst. B, Part	0. 075815	0. 000293	27. 65003	34		205.00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15	0046 Period: Worksheet C From 09/01/2015 Part I
		To 08/31/2016 Date/Time Prepared

				Т	o 08/31/2016	Date/Time Pre 1/25/2017 6:2	pared: 4 nm
			Ti tl	e XVIII	Hospi tal	PPS	ı pııı
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	'	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	17, 131, 414		17, 131, 414		17, 154, 791	
	03100 INTENSIVE CARE UNIT	4, 503, 084		4, 503, 084		4, 503, 084	
1	04000 SUBPROVI DER - I PF	4, 387, 554		4, 387, 554		4, 387, 554	
1	04100 SUBPROVI DER - I RF	2, 137, 565		2, 137, 565		2, 137, 565	
	04300 NURSERY	416, 222		416, 222	0	416, 222	43. 00
	ANCILLARY SERVICE COST CENTERS	7 070 054	I	7 070 054		7 000 000	
	05000 OPERATING ROOM	7, 279, 851		7, 279, 851		7, 283, 309	50.00
	05100 RECOVERY ROOM	1, 108, 302		1, 108, 302		1, 108, 302	
	05200 DELIVERY ROOM & LABOR ROOM	2, 235, 081		2, 235, 081		2, 235, 081	
	05300 ANESTHESI OLOGY			0	٩	0	
	05400  RADI OLOGY-DI AGNOSTI C 05401  ULTRASOUND	3, 011, 048		3, 011, 048		3, 011, 048	
	05401 OLTRASOUND 05402 MAMMOGRAPHY	297, 376		297, 376 485, 149		297, 376 485, 149	
	05500 RADI OLOGY-THERAPEUTI C	485, 149 1, 806, 833		1, 806, 833		1, 806, 833	1
	05600 RADI OLOGT - THERAPEUTI C	1, 313, 037		1, 313, 037		1, 313, 037	
	05700 CT SCAN	1, 259, 829		1, 259, 829		1, 313, 037	
	05700 CT 3CAN 05800 MRI	585, 891		585, 891		585, 891	
	05900 CARDI AC CATHETERI ZATI ON	1, 229, 103		1, 229, 103		1, 229, 103	
	06000 LABORATORY	4, 076, 461		4, 076, 461		4, 076, 461	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	775, 317		775, 317		775, 317	
	06500 RESPIRATORY THERAPY	2, 056, 875	0			2, 056, 875	
	06600 PHYSI CAL THERAPY	2, 793, 949	0	2, 793, 949		2, 813, 373	1
	06900 ELECTROCARDI OLOGY	1, 290, 755	Ĭ	1, 290, 755		1, 302, 276	1
1	07000 ELECTROENCEPHALOGRAPHY	175, 091		175, 091		175, 091	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	7, 829, 905		7, 829, 905		7, 829, 905	
	07200 IMPL. DEV. CHARGED TO PATIENTS	8, 070, 151		8, 070, 151		8, 070, 151	
73. 00	07300 DRUGS CHARGED TO PATIENTS	11, 958, 115		11, 958, 115		11, 958, 115	73. 00
74. 00	07400 RENAL DIALYSIS	1, 003, 997		1, 003, 997	o	1, 003, 997	74. 00
76. 00	03020 LI THOTRI PSY	199, 519		199, 519	o	199, 519	76. 00
76. 01	03330 ENDOSCOPY	954, 833		954, 833	o	954, 833	76. 01
76. 02	03950 PRISON CLINIC	622, 337		622, 337	o	622, 337	76. 02
76. 03	03951 WOUNDCARE	946, 770		946, 770	8, 697	955, 467	76. 03
	03952 OPI C	1, 009, 397		1, 009, 397	40, 440	1, 049, 837	76. 04
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	6, 103, 178		6, 103, 178	34, 218	6, 137, 396	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 030, 708		2, 030, 708		2, 030, 708	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09900 CMHC	0		0		0	
200.00	Subtotal (see instructions)	101, 084, 697	0	, ,		101, 225, 832	
201. 00	Less Observation Beds	2, 030, 708		2, 030, 708		2, 030, 708	
202. 00	Total (see instructions)	99, 053, 989	0	99, 053, 989	141, 135	99, 195, 124	J202. 00

In Lieu of Form CMS-2552-10
Worksheet C
01/2015 Part I
01/2016 Date/Time Prepared:
1/25/2017 6:24 pm
tal PPS Peri od: From 09/01/2015 To 08/31/2016 Title XVIII Hospi tal

		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
		·	+ col. 7)	Rati o	Inpati ent	
			ĺ		Rati o	
	6.00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	20, 626, 812		20, 626, 812			30.00
31.00 03100 INTENSIVE CARE UNIT	8, 770, 558		8, 770, 558			31. 00
40. 00   04000   SUBPROVI DER - 1 PF	22, 479, 135		22, 479, 135			40. 00
41. 00   04100   SUBPROVI DER -   I RF	2, 186, 183		2, 186, 183			41. 00
43. 00   04300 NURSERY	809, 710		809, 710			43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	39, 340, 180	44, 890, 996	84, 231, 176	0. 086427	0. 000000	50. 00
51. 00   05100   RECOVERY   ROOM	4, 274, 893	7, 512, 534			0. 000000	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 079, 953	127, 134			0. 000000	52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	0,20,,00,	0. 000000	0. 000000	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 592, 832	9, 829, 351	14, 422, 183		0. 000000	54. 00
54. 01   05401   ULTRASOUND	869, 846	2, 797, 968	3, 667, 814		0. 000000	54. 01
54. 02 05402 MAMMOGRAPHY	4, 219	2, 411, 068			0. 000000	54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 216, 021	14, 646, 648	15, 862, 669		0. 000000	55. 00
56. 00   05600 RADI 01 SOTOPE	1, 155, 116	11, 176, 790			0. 000000	56. 00
57. 00   05700 CT SCAN	15, 789, 893	31, 519, 235	47, 309, 128		0. 000000	57. 00
58. 00   05800 MRI	3, 754, 489	9, 403, 970	13, 158, 459		0.000000	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	12, 541, 213	9, 222, 901	21, 764, 114		0.000000	59. 00
60. 00   06000  LABORATORY	30, 182, 797	32, 349, 032	62, 531, 829		0. 000000	60.00
					0. 000000	62.00
	5, 318, 870	1, 274, 591	6, 593, 461			
65. 00 06500 RESPIRATORY THERAPY	17, 433, 379	1, 076, 152			0. 000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	5, 048, 024	2, 083, 878			0. 000000	66. 00
69. 00 06900 ELECTROCARDI OLOGY	8, 229, 831	7, 076, 796	15, 306, 627		0. 000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	662, 544	888, 870	1, 551, 414		0. 000000	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	23, 955, 166	15, 561, 955			0. 000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	10, 174, 242	8, 572, 178			0. 000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	61, 483, 044	38, 822, 640			0.000000	73.00
74. 00   07400   RENAL DI ALYSI S	5, 453, 301	77, 273			0.000000	74.00
76. 00   03020   LI THOTRI PSY	0	1, 284, 350			0.000000	76. 00
76. 01   03330   ENDOSCOPY	2, 171, 660	5, 429, 683	7, 601, 343	0. 125614	0.000000	76. 01
76. 02   03950   PRI SON CLI NI C	1, 236	349, 074	350, 310	1. 776532	0.000000	76. 02
76. 03   03951   WOUNDCARE	58, 419	3, 273, 505	3, 331, 924	0. 284151	0.000000	76. 03
76. 04  03952 OPI C	74, 183	6, 087, 903	6, 162, 086	0. 163808	0.000000	76. 04
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	15, 138, 826	36, 655, 271	51, 794, 097	0. 117835	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	598, 366	2, 073, 793		0. 759950	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
99. 00 09900 CMHC	0	0	0			99. 00
200.00 Subtotal (see instructions)	327, 474, 941	306, 475, 539	633, 950, 480			200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	327, 474, 941	306, 475, 539	633, 950, 480			202. 00
	1 32.7, 7 1 1	2001 1101 007	, 500, 700, 100	1		

Health Financial Systems	TERRE HAUTE REGIONAL	HOSPI TAL		In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CC	N: 150046	Peri od: From 09/01/2015 To 08/31/2016	Worksheet C Part I Date/Time Prepared: 1/25/2017 6:24 pm

				1/25/2017 6: 24 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS	<u>,                                      </u>			
30. 00   03000   ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
40. 00   04000   SUBPROVI DER - 1 PF				40. 00
41. 00   04100   SUBPROVI DER - I RF				41.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATING ROOM	0. 086468			50.00
51.00   05100   RECOVERY ROOM	0. 094024			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 696919			52. 00
53. 00   05300   ANESTHESI OLOGY	0. 000000			53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 208779			54.00
54. 01   05401   ULTRASOUND	0. 081077			54. 01
54. 02   05402   MAMMOGRAPHY	0. 200866			54. 02
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 113905			55. 00
56. 00   05600   RADI 01 SOTOPE	0. 106475			56. 00
57. 00  05700 CT SCAN	0. 026630			57. 00
58. 00   05800   MRI	0. 044526			58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0. 056474			59.00
60. 00  06000 LABORATORY	0. 065190			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 117589			62. 00
65. 00   06500   RESPI RATORY THERAPY	0. 111125			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 394477			66. 00
69. 00  06900   ELECTROCARDI OLOGY	0. 085079			69. 00
70. 00   07000   ELECTROENCEPHALOGRAPHY	0. 112859			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 198140			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 430490			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 119217			73. 00
74. 00   07400   RENAL DI ALYSI S	0. 181536			74. 00
76. 00  03020  LI THOTRI PSY	0. 155346			76. 00
76. 01   03330   ENDOSCOPY	0. 125614			76. 01
76. 02   03950   PRI SON CLINI C	1. 776532			76. 02
76. 03   03951   WOUNDCARE	0. 286761			76. 03
76. 04 03952 OPI C	0. 170370			76. 04
OUTPATIENT SERVICE COST CENTERS				
91. 00   09100   EMERGENCY	0. 118496			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 759950			92. 00
OTHER REIMBURSABLE COST CENTERS				
99. 00 09900 CMHC				99. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAI	_	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi dei	CCN: 150046		Worksheet C
			From 09/01/2015 To 08/31/2016	Part     Date/Time Prepared:

				o 08/31/2016	Date/Time Pre	pared:
		Ti +	le XIX	Hospi tal	Cost	4 piii
		111	I E XIX	Costs	COST	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
cost center bescription	(from Wkst. B,	Adj.	Total Costs	Di sal I owance	TOTAL COSTS	
	Part I, col.	Auj .		Di Sai i Owance		
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS	17, 131, 414		17, 131, 414	23, 377	17, 154, 791	30.00
31. 00   03100   NTENSI VE CARE UNI T	4, 503, 084		4, 503, 084		4, 503, 084	
40. 00   04000   SUBPROVI DER -   1 PF	4, 387, 554	l e	4, 387, 554	I	4, 387, 554	
41. 00   04100   SUBPROVI DER -   1 FF	2, 137, 565	ł	2, 137, 565	I	2, 137, 565	
43. 00   04300   NURSERY	416, 222	ł	416, 222	I	416, 222	
ANCI LLARY SERVI CE COST CENTERS	410, 222		410, 222	<u>-                                    </u>	410, 222	43.00
50. 00 05000 OPERATING ROOM	7, 279, 851		7, 279, 851	3, 458	7, 283, 309	50.00
51. 00   05100   RECOVERY   ROOM	1, 108, 302		1, 108, 302		1, 108, 302	1
52. 00 05200 DELIVERY ROOM & LABOR ROOM	2, 235, 081		2, 235, 081		2, 235, 081	52. 00
53. 00   05300   ANESTHESI OLOGY	2, 233, 061		2, 233, 06	I I	2, 233, 061	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	3, 011, 048	l	3, 011, 048	ή	3, 011, 048	1
54. 01   05401   ULTRASOUND	297, 376		297, 376		297, 376	
54. 02   05402   MAMMOGRAPHY	485, 149		485, 149		485, 149	54. 01
55. 00   05500 RADI OLOGY-THERAPEUTI C	1, 806, 833		1, 806, 833		1, 806, 833	1
56. 00   05600 RADI 0I SOTOPE	1, 313, 037	l .	1, 313, 037		1, 313, 037	56. 00
57. 00   05700 CT   SCAN	1, 259, 829		1, 259, 829		1, 259, 829	
58. 00   05800   MRI						58.00
	585, 891		585, 891		585, 891 1, 229, 103	
59. 00   05900   CARDI AC   CATHETERI ZATI ON 60. 00   06000   LABORATORY	1, 229, 103		1, 229, 103	I		
	4, 076, 461		4, 076, 461	I	4, 076, 461	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	775, 317	l .	775, 317	I	775, 317	62.00
65. 00 06500 RESPIRATORY THERAPY	2, 056, 875		,		2, 056, 875	65. 00
66. 00 06600 PHYSI CAL THERAPY	2, 793, 949		2, 793, 949		2, 813, 373	66.00
69. 00 06900 ELECTROCARDI OLOGY	1, 290, 755		1, 290, 755		1, 302, 276	
70. 00 07000 ELECTROENCEPHALOGRAPHY	175, 091		175, 091		175, 091	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	7, 829, 905		7, 829, 905	I	7, 829, 905	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	8, 070, 151		8, 070, 151		8, 070, 151	
73. 00 07300 DRUGS CHARGED TO PATIENTS	11, 958, 115	ł	11, 958, 115	I	11, 958, 115	
74. 00   07400   RENAL DI ALYSI S	1, 003, 997	l e	1, 003, 997	I I	1, 003, 997	
76. 00   03020   LI THOTRI PSY	199, 519	l e	199, 519	I I	199, 519	
76. 01 03330 ENDOSCOPY	954, 833	ł	954, 833	I I	954, 833	
76. 02 03950 PRI SON CLINI C	622, 337		622, 337	I I	622, 337	76. 02
76. 03   03951   WOUNDCARE	946, 770		946, 770		955, 467	
76. 04 03952 0PI C	1, 009, 397		1, 009, 397	40, 440	1, 049, 837	76. 04
OUTPATIENT SERVICE COST CENTERS	/ 400 470	I	( 400 470	0.4.04.01	/ 407 00/	04.00
91. 00 09100 EMERGENCY	6, 103, 178	l e	6, 103, 178		6, 137, 396	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 030, 708		2, 030, 708	3	2, 030, 708	92.00
OTHER REIMBURSABLE COST CENTERS	1 -			\		00.00
99. 00 09900 CMHC	0	l	(104 004 (0		0	
200.00 Subtotal (see instructions)	101, 084, 697	l			101, 225, 832	
201. 00 Less Observation Beds	2, 030, 708	l .	2, 030, 708		2, 030, 708	
202.00   Total (see instructions)	99, 053, 989	0	99, 053, 989	9 141, 135	99, 195, 124	1202.00

Date/Time Prepared: 08/31/2016 1/25/2017 6:24 pm Title XIX Hospi tal Cost 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 20, 626, 812 30.00 30.00 03000 ADULTS & PEDIATRICS 20, 626, 812 31.00 03100 INTENSIVE CARE UNIT 8, 770, 558 8, 770, 558 31.00 22, 479, 135 04000 SUBPROVI DER - I PF 22, 479, 135 40.00 40.00 41.00 04100 SUBPROVI DER - I RF 2, 186, 183 2, 186, 183 41.00 04300 NURSERY 43.00 809, 710 809, 710 43.00 ANCILLARY SERVICE COST CENTERS 44, 890, 996 84, 231, 176 50 00 05000 OPERATING ROOM 39, 340, 180 0.086427 0.000000 50.00 05100 RECOVERY ROOM 7, 512, 534 4.274.893 11, 787, 427 0.094024 0.000000 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.696919 52 00 3, 079, 953 127, 134 3, 207, 087 0.000000 52 00 53.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 592, 832 9, 829, 351 14, 422, 183 0.208779 0.000000 54.00 0.081077 05401 ULTRASOUND 2, 797, 968 54.01 869, 846 3, 667, 814 0.000000 54.01 54.02 05402 MAMMOGRAPHY 4, 219 2, 411, 068 2, 415, 287 0.200866 0.000000 54.02 55.00 05500 RADI OLOGY-THERAPEUTI C 1, 216, 021 14, 646, 648 15, 862, 669 0.113905 0.000000 55.00 56.00 05600 RADI OI SOTOPE 1, 155, 116 11, 176, 790 12, 331, 906 0.106475 0.000000 56.00 15, 789, 893 05700 CT SCAN 31, 519, 235 47. 309, 128 57 00 0.026630 0.000000 57 00 58.00 05800 MRI 3, 754, 489 9, 403, 970 13, 158, 459 0.044526 0.000000 58.00 05900 CARDIAC CATHETERIZATION 12, 541, 213 9, 222, 901 21, 764, 114 0.056474 59.00 0.000000 59.00 06000 LABORATORY 30, 182, 797 32, 349, 032 0.000000 60.00 62, 531, 829 0.065190 60.00 1, 274, 591 6, 593, 461 0. 117589 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 5, 318, 870 0.000000 62.00 65.00 06500 RESPIRATORY THERAPY 17, 433, 379 1,076,152 18, 509, 531 0.111125 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 5, 048, 024 2, 083, 878 7, 131, 902 0.391754 0.000000 66.00 69 00 06900 ELECTROCARDI OLOGY 8, 229, 831 7, 076, 796 15, 306, 627 0.084327 0 000000 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 662, 544 888, 870 1, 551, 414 0.112859 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 23, 955, 166 15, 561, 955 39, 517, 121 0. 198140 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 10, 174, 242 8, 572, 178 18, 746, 420 0.430490 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 61, 483, 044 38, 822, 640 100, 305, 684 0.119217 0.000000 73.00 74.00 07400 RENAL DIALYSIS 5, 453, 301 77, 273 5, 530, 574 0.181536 0.000000 74.00 76.00 03020 LI THOTRI PSY 1, 284, 350 1, 284, 350 0.155346 0.000000 76.00 76 01 03330 ENDOSCOPY 2 171 660 5, 429, 683 7 601 343 0 125614 0.000000 76 01 03950 PRISON CLINIC 76.02 1, 236 349, 074 350, 310 1.776532 0.000000 76.02 76.03 03951 WOUNDCARE 58, 419 3, 273, 505 3, 331, 924 0. 284151 0.000000 76.03 03952 OPI C 6, 087, 903 76.04 74, 1<u>83</u> 6, 162, 086 0.163808 0.000000 76.04 OUTPATIENT SERVICE COST CENTERS 91.00 15, 138, 826 09100 EMERGENCY 36, 655, 271 51, 794, 097 0.117835 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 2, 672, 159 0.759950 0.000000 92.00 598, 366 2,073,793 92.00

327, 474, 941

327, 474, 941

306, 475, 539

306, 475, 539

633, 950, 480

633, 950, 480

99.00

200.00

201.00

202.00

OTHER REIMBURSABLE COST CENTERS

Less Observation Beds

Total (see instructions)

Subtotal (see instructions)

99. 00 09900 CMHC

200.00

201.00

202.00

Health Financial Systems	TERRE HAUTE REGIONAL	HOSPI TAL		In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CC	N: 150046	Peri od: From 09/01/2015 To 08/31/2016	Worksheet C Part I Date/Time Prepared: 1/25/2017 6:24 pm

				1/25/2017 6: 24 pm
		Title XIX	Hospi tal	Cost
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
40. 00   04000   SUBPROVI DER - I PF				40. 00
41. 00   04100   SUBPROVI DER - I RF				41. 00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50. 00
51.00   05100   RECOVERY ROOM	0. 000000			51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00   05300   ANESTHESI OLOGY	0. 000000			53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
54. 01  05401 ULTRASOUND	0. 000000			54. 01
54. 02   05402   MAMMOGRAPHY	0. 000000			54. 02
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
56. 00   05600   RADI 0I SOTOPE	0. 000000			56. 00
57. 00  05700 CT SCAN	0. 000000			57. 00
58. 00  05800 MRI	0. 000000			58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00  06000 LABORATORY	0. 000000			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			62. 00
65. 00  06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00  06600 PHYSI CAL THERAPY	0. 000000			66. 00
69. 00  06900 ELECTROCARDI OLOGY	0. 000000			69. 00
70. 00  07000  ELECTROENCEPHALOGRAPHY	0. 000000			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
74. 00   07400   RENAL DI ALYSI S	0. 000000			74. 00
76. 00  03020  LI THOTRI PSY	0. 000000			76. 00
76. 01   03330   ENDOSCOPY	0. 000000			76. 01
76. 02   03950   PRI SON CLI NI C	0. 000000			76. 02
76. 03   03951   WOUNDCARE	0. 000000			76. 03
76. 04 03952 OPI C	0. 000000			76. 04
OUTPATIENT SERVICE COST CENTERS				
91. 00   09100   EMERGENCY	0. 000000			91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS				
99. 00 09900 CMHC				99. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	TERRE HAUTE REGIONAL	. HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE CO	OST TO CHARGE RATIOS NET OF	Provi der CCN: 150046		Worksheet C
REDUCTIONS FOR MEDICALD ONLY			From 09/01/2015	Part II

NEDGO.	·· <del>·</del>			T	08/31/2016	Date/Time Prepared: 1/25/2017 6:24 pm	
			Ti t	le XIX	Hospi tal	Cost	4 рііі
	Cost Center Description	Total Cost		Operating Cost		Operating Cost	
	<b>'</b>	(Wkst. B, Part		Net of Capital	Reduction	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
			,	col . 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						1
	05000 OPERATING ROOM	7, 279, 851			0	_	00.00
	05100 RECOVERY ROOM	1, 108, 302			0	0	
	05200 DELIVERY ROOM & LABOR ROOM	2, 235, 081	233, 694	2, 001, 387	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54.00	05400  RADI OLOGY-DI AGNOSTI C	3, 011, 048	393, 051	2, 617, 997	0	0	54.00
54. 01	05401 ULTRASOUND	297, 376	18, 891	278, 485	0	0	54. 01
	05402 MAMMOGRAPHY	485, 149			0	0	54. 02
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 806, 833	197, 272	1, 609, 561	0	0	55. 00
56.00	05600  RADI 0I SOTOPE	1, 313, 037	52, 825	1, 260, 212	0	0	56. 00
57.00	05700 CT SCAN	1, 259, 829	82, 761	1, 177, 068	0	0	57. 00
58.00	05800  MRI	585, 891	42, 768	543, 123	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 229, 103	91, 751	1, 137, 352	0	0	59. 00
60.00	06000 LABORATORY	4, 076, 461	246, 232	3, 830, 229	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	775, 317	28, 012	747, 305	0	0	62. 00
65.00	06500 RESPI RATORY THERAPY	2, 056, 875	101, 056	1, 955, 819	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	2, 793, 949	399, 239	2, 394, 710	0	0	66. 00
69.00	06900 ELECTROCARDI OLOGY	1, 290, 755	90, 893	1, 199, 862	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	175, 091	30, 560	144, 531	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	7, 829, 905	406, 258	7, 423, 647	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	8, 070, 151	197, 755	7, 872, 396	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	11, 958, 115	379, 061	11, 579, 054	0	0	73. 00
74.00	07400 RENAL DIALYSIS	1, 003, 997	36, 416		0	0	74.00
76. 00	03020 LI THOTRI PSY	199, 519	5, 077	194, 442	0	0	76. 00
	03330 ENDOSCOPY	954, 833			0	0	1
76. 02	03950 PRI SON CLI NI C	622, 337			0	0	76. 02
	03951 WOUNDCARE	946, 770		·	0	l o	76. 03
	03952 OPI C	1, 009, 397			0	o o	76. 04
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	6, 103, 178	459, 741	5, 643, 437	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 030, 708	243, 916	1, 786, 792	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						1
99.00	09900 CMHC	0	0	0	0	0	99. 00
200.00	Subtotal (sum of lines 50 thru 199)	72, 508, 858	5, 120, 304	67, 388, 554	0	0	200. 00
201.00	Less Observation Beds	2, 030, 708	243, 916	1, 786, 792	0	0	201. 00
202.00	Total (line 200 minus line 201)	70, 478, 150	4, 876, 388	65, 601, 762	0	0	202. 00

Health Financial Systems	TERRE HAUTE REGIONAL	. HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST REDUCTIONS FOR MEDICALD ONLY	TO CHARGE RATIOS NET OF	Provi der CCN: 150046	From 09/01/2015	Worksheet C Part II Date/Time Prepared:

						1/25/2017 6:24 pm
			Ti t	le XIX	Hospi tal	Cost
	Cost Center Description	Cost Net of	Total Charges	Outpati ent		
		Capital and	(Worksheet C,			
		Operating Cost	Part I, column	Ratio (col.	6	
		Reducti on	8)	/ col . 7)		
		6.00	7. 00	8. 00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000  OPERATI NG ROOM	7, 279, 851	84, 231, 176	0. 08642	27	50.00
51.00	05100 RECOVERY ROOM	1, 108, 302	11, 787, 427	0. 09402	24	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 235, 081	3, 207, 087	0. 6969	19	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0. 00000	00	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 011, 048	14, 422, 183	0. 2087	79	54.00
54.01	05401 ULTRASOUND	297, 376	3, 667, 814	0. 0810	77	54. 01
54.02	05402 MAMMOGRAPHY	485, 149	2, 415, 287	0. 20086	56	54. 02
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 806, 833	15, 862, 669	0. 11390	05	55. 00
56.00	05600 RADI 0I SOTOPE	1, 313, 037	12, 331, 906	0. 1064	75	56. 00
57.00	05700 CT SCAN	1, 259, 829	47, 309, 128	0. 02663	30	57. 00
58.00	05800 MRI	585, 891			26	58. 00
	05900 CARDI AC CATHETERI ZATI ON	1, 229, 103				59. 00
60.00	06000 LABORATORY	4, 076, 461	62, 531, 829			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	775, 317				62.00
65.00	06500 RESPIRATORY THERAPY	2, 056, 875				65. 00
66. 00	06600 PHYSI CAL THERAPY	2, 793, 949				66. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 290, 755		l .		69.00
	07000 ELECTROENCEPHALOGRAPHY	175, 091	1, 551, 414			70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	7, 829, 905		l .		71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	8, 070, 151	18, 746, 420			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	11, 958, 115				73. 00
	07400 RENAL DIALYSIS	1, 003, 997				74. 00
76.00	03020 LI THOTRI PSY	199, 519				76. 00
	03330 ENDOSCOPY	954, 833				76. 01
	03950 PRI SON CLI NI C	622, 337				76. 02
	03951 WOUNDCARE	946, 770				76. 03
	03952 OPI C	1, 009, 397				76. 03
70.04	OUTPATIENT SERVICE COST CENTERS	1,007,377	0, 102, 000	0. 10300	50	70.04
91. 00	09100 EMERGENCY	6, 103, 178	51, 794, 097	0. 11783	35	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 030, 708				92.00
72.00	OTHER REIMBURSABLE COST CENTERS	2,030,700	2,072,137	0. 7577	<u>.</u>	72.00
99 00	09900 CMHC	0	0	0.0000	20	99. 00
200.00		72, 508, 858	ļ			200. 00
201.00	1 1	2, 030, 708		•		201.00
201.00		70, 478, 150		1		202.00
202.00	Trotal (Title 200 IIII lus Title 201)	10,470,150	1 3/9,0/0,082	I	I I	J202. 00

Heal th	Health Financial Systems TERRE HAUTE REGIONAL HOSPITAL In Lieu of Form CMS-2552-10							
APPORT	IONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Period: From 09/01/2015 To 08/31/2016		pared: 4 pm	
				e XVIII	Hospi tal	PPS		
	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col		Per Diem (col. 3 / col. 4)		
		26)		2)				
		1.00	2. 00	3.00	4. 00	5. 00		
	INPATIENT ROUTINE SERVICE COST CENTERS	_						
30. 00	ADULTS & PEDIATRICS	2, 060, 531		2, 060, 53		94. 21	30. 00	
31. 00	INTENSIVE CARE UNIT	391, 029		391, 02				
40.00	SUBPROVI DER - I PF	389, 315		389, 31				
41.00	SUBPROVI DER - I RF	335, 277		335, 27		183. 51	41. 00	
	NURSERY	36, 429		36, 42		64. 71		
200.00	Total (lines 30-199)	3, 212, 581		3, 212, 58	1 34, 030		200. 00	
	Cost Center Description	I npati ent	Inpati ent					
		Program days	Program					
			Capital Cost					
			(col. 5 x col.					
		/ 00	6) 7. 00					
	INPATIENT ROUTINE SERVICE COST CENTERS	6. 00	7.00					
30. 00	ADULTS & PEDIATRICS	10, 985	1, 034, 897				30. 00	
31. 00	INTENSIVE CARE UNIT	1, 767					31. 00	
40.00	SUBPROVI DER - I PF	1, 707					40.00	
	SUBPROVIDER - I RF	1, 143					41. 00	
	NURSERY	1, 143	204, 732	1			43.00	
	Total (lines 30-199)	15, 321		1			200. 00	

Hool +b	Financial Systems	ERRE HAUTE REG	LONAL	INT IDOU		la lie	u of Form CMS-2	DEE2 10
	Financial Systems T TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA					Period: From 09/01/2015 To 08/31/2016	Worksheet D Part II Date/Time Pre 1/25/2017 6:2	pared:
					e XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal			Ratio of Cos		Capital Costs	
				Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	1	•	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.		8)	2)			
		26)						
	1	1.00	2	. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	T			T			
50. 00	05000 OPERATING ROOM	814, 387	1	, 231, 176			174, 833	1
51. 00	05100 RECOVERY ROOM	70, 271	1	, 787, 427	•		11, 716	
		233, 694	1	, 207, 087			0	
53.00	05300 ANESTHESI OLOGY	0	1	0	0.0000		0	
	I I	393, 051	1	, 422, 183			-	
54. 01	05401 ULTRASOUND	18, 891	1	, 667, 814			2, 198	
	05402 MAMMOGRAPHY	49, 524	1	, 415, 287		•		54. 02
55. 00	05500 RADI OLOGY-THERAPEUTI C	197, 272	1	, 862, 669			6, 886	
56. 00	05600 RADI OI SOTOPE	52, 825		, 331, 906			· ·	
		82, 761	1	, 309, 128			13, 584	
	05800  MRI	42, 768	1	, 158, 459				
	05900 CARDI AC CATHETERI ZATI ON	91, 751		, 764, 114				
60.00	06000 LABORATORY	246, 232	1	, 531, 829				•
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	28, 012		, 593, 461				
65. 00	06500 RESPI RATORY THERAPY	101, 056		, 509, 531				
66. 00	06600 PHYSI CAL THERAPY	399, 239	1	, 131, 902			83, 049	
69. 00	06900 ELECTROCARDI OLOGY	90, 893		, 306, 627				
		30, 560		, 551, 414				
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	406, 258	39	, 517, 121	0. 01028	1 12, 471, 728		
	07200 I MPL. DEV. CHARGED TO PATIENTS	197, 755		, 746, 420		9 5, 672, 198	59, 836	72. 00
		379, 061		, 305, 684			115, 621	
		36, 416	1	, 530, 574			21, 343	
76. 00	03020 LI THOTRI PSY	5, 077	1	, 284, 350	0.00395	3 0	0	76. 00
76. 01	03330 ENDOSCOPY	72, 629		, 601, 343			11, 983	
	03950 PRI SON CLI NI C	191, 635		350, 310			0	
7/ 02	020E1 WOUNDCADE	/ - 01/	1 2	221 024	0 01070	2 40 505	000	7/00

65, 916 118, 713

459, 741

243, 916 5, 120, 304

3, 331, 924 6, 162, 086

51, 794, 097 2, 672, 159

579, 078, 082

6, 973, 980 380, 256 135, 943, 489

40, 595

54, 645

61, 901 91. 00 34, 710 92. 00 994, 932 200. 00

803

1, 053

76. 03

76. 04

0.019783

0. 019265

0.008876

0.091280

76. 02 03950 PRI SON CLINI C 76. 03 03951 WOUNDCARE 76. 04 03952 OPI C

OUTPATIENT SERVICE COST CENTERS
91. 00 O9100 EMERGENCY

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

Health Financial Systems T	ERRE HAUTE REG	IONAL	HOSPI TAL		In Li€	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS	Provi der	CCN: 150046	Peri od: From 09/01/2015 To 08/31/2016	Date/Time Pre 1/25/2017 6:2	
				e 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	1.00		. 00	3.00	4.00	3.00	
30. 00   03000   ADULTS & PEDI ATRI CS 31. 00   03100   I NTENSI VE CARE UNI T	C		0		0 0	0	30. 00 31. 00
40. 00   04000  SUBPROVI DER -   PF			0			0	40.00
41. 00   04100   SUBPROVI DER -   RF			0			0	
43. 00 04300 NURSERY		ó	0			0	
200.00 Total (lines 30-199)		ó	0		0	_	200.00
Cost Center Description	Total Patient Days		em (col. col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x		200. 00
	6.00	7	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00   03000   ADULTS & PEDI ATRI CS	21, 871		0.00				30. 00
31. 00 03100 INTENSIVE CARE UNIT	3, 365		0.00				31. 00
40. 00   04000   SUBPROVI DER - I PF	6, 404		0.00				40. 00
41. 00   04100   SUBPROVI DER -   RF	1, 827	1	0.00				41.00
43. 00 04300 NURSERY	563		0.00		0 0		43. 00
200.00   Total (lines 30-199)	34, 030	기		15, 32	21  0	1	200. 00

Health Financial Systems	TERRE HAUTE REGIONAL	. HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT / THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150046	Peri od: From 09/01/2015 To 08/31/2016	Worksheet D Part IV Date/Time Prepared: 1/25/2017 6:24 pm

				T	o 08/31/2016	Date/Time Pre 1/25/2017 6:2	
			Ti t	le XVIII	Hospi tal	PPS	4 рііі
	Cost Center Description	Non Physician		I Allied Health		Total Cost	
	'	Anestheti st			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1. 00	2.00	3. 00	4. 00	5. 00	
	ARY SERVICE COST CENTERS						
	OPERATING ROOM	0		0 0	0	0	00.00
	RECOVERY ROOM	0		ol c	0	0	51. 00
	DELIVERY ROOM & LABOR ROOM	0		ol c	0	0	52. 00
	ANESTHESI OLOGY	0		ol c	0	0	53. 00
	RADI OLOGY-DI AGNOSTI C	0		0	0	0	54.00
1 1	ULTRASOUND	0		0	0	0	54. 01
	MAMMOGRAPHY	0		0	0	0	54. 02
	RADI OLOGY-THERAPEUTI C	0		0	0	0	55. 00
56. 00   05600		0		0	0	0	56. 00
	CT SCAN	0		0	0	0	57. 00
58. 00   05800		0		0	0	0	58. 00
	CARDI AC CATHETERI ZATI ON	0		0	0	0	59. 00
	LABORATORY	0			0	0	60.00
	WHOLE BLOOD & PACKED RED BLOOD CELL	0			0	0	62.00
	RESPI RATORY THERAPY	0			0	0	65. 00
	PHYSI CAL THERAPY	0			0	0	66. 00
	ELECTROCARDI OLOGY	0			0	0	69.00
	ELECTROENCEPHALOGRAPHY	0			0	0	70.00
	MEDICAL SUPPLIES CHARGED TO PATIENT	0			0	0	71.00
	IMPL. DEV. CHARGED TO PATIENTS	0			0	0	72.00
	DRUGS CHARGED TO PATIENTS	0			0	0	73.00
	RENAL DI ALYSI S LI THOTRI PSY	0			0	0	74.00
		0			0	0	76. 00
	ENDOSCOPY PRISON CLINIC	0				0	76. 01
	WOUNDCARE	0			0	0	76. 02 76. 03
		0			0	0	
76. 04 03952 0	LENT SERVICE COST CENTERS	0		UJ C	, U	<u> </u>	76. 04
91. 00 09100 I		0		ol c		0	91. 00
	OBSERVATION BEDS (NON-DISTINCT PART					0	
1 1	Total (lines 50-199)						200.00
200.00	10tal (11165 30-177)	1	I	ν <sub>l</sub>	ή υ	ı	<sub>1</sub> 200.00

APPORT	Financial Systems T TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS	ERRE HAUTE REG	S Provi der	CCN: 150046	In Lie Period: From 09/01/2015 To 08/31/2016		pared:
				e XVIII	Hospi tal PPS		
	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)		Ratio of Cost	I npati ent Program Charges	
		6. 00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0					
51. 00	05100 RECOVERY ROOM	0					
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	-,,				52. 00
53.00	05300 ANESTHESI OLOGY	0	(	1			
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	14, 422, 183				1
54. 01	05401 ULTRASOUND	0	3, 667, 814				
54. 02	05402 MAMMOGRAPHY	0	2, 415, 287				
55.00	05500 RADI OLOGY-THERAPEUTI C	0					
56. 00	05600 RADI OI SOTOPE	0	,				
57. 00	05700 CT SCAN	0	47, 309, 128				57. 00
58. 00	05800 MRI	0					
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	, , , , ,				
60.00	06000 LABORATORY	0		1			1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	6, 593, 461				
65.00	06500 RESPI RATORY THERAPY	0	18, 509, 531				1
66.00	06600 PHYSI CAL THERAPY	0	.,				
69.00	06900 ELECTROCARDI OLOGY	0					
70.00	07000 ELECTROENCEPHALOGRAPHY	0	.,,	1			
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		1			1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0				5, 672, 198	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	,	1			1
74.00	07400 RENAL DIALYSIS	0	5, 530, 574				
76.00	03020 LI THOTRI PSY	0	1, 284, 350				
76. 01	03330 ENDOSCOPY		7, 601, 343				76. 01
76. 02	03950 PRI SON CLI NI C		350, 310				
76. 03	03951 WOUNDCARE 03952 OPI C		3, 331, 924				1
76. 04	OUTPATIENT SERVICE COST CENTERS		6, 162, 086	0.00000	ισ <sub>Ι</sub> υ. υυυυυυ	54, 645	76. 04

0

51, 794, 097 2, 672, 159 579, 078, 082

0.000000

0.000000

0.000000

0.000000

6, 973, 980 91. 00 380, 256 92. 00 135, 943, 489 200. 00

OUTPATIENT SERVICE COST CENTERS
91. 00 O9100 EMERGENCY

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

Health Financial Systems	TE	RRE HAUTE	REGI ONAL	HOSPI TAL		In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERV	I CE OTHER	PASS	Provi der CC	CN: 150046	Peri od: From 09/01/2015 To 08/31/2016	Worksheet D Part IV Date/Time Prepared:

			'	00/31/2010	1/25/2017 6:2	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Inpati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	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   OPERATING ROOM	0	13, 154, 700	0			50.00
51.00   05100   RECOVERY ROOM	0	1, 982, 755	0			51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	0			52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	0			53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	2, 230, 062	2 0			54.00
54. 01   05401   ULTRASOUND	0	559, 995	0			54. 01
54. 02   05402   MAMMOGRAPHY	0	167, 545	0			54. 02
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	8, 037, 166	0			55. 00
56. 00   05600   RADI 01 SOTOPE	0	4, 688, 428	0			56. 00
57.00   05700   CT   SCAN	0	9, 205, 263	0			57. 00
58. 00   05800   MRI	0	2, 693, 990	0			58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	0	4, 926, 491	0			59. 00
60. 00   06000   LABORATORY	0	6, 157, 367	0			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	424, 430	0			62. 00
65. 00 06500 RESPIRATORY THERAPY	0	217, 005	0			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	4, 730	0			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	2, 289, 592	2			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	229, 104	0			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	4, 944, 185	0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	3, 481, 160	0			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	13, 892, 847	0			73. 00
74.00 07400 RENAL DIALYSIS	o	36, 523	0			74. 00
76. 00   03020   LI THOTRI PSY	O	437, 406	0			76. 00
76. 01 03330 ENDOSCOPY	O	2, 069, 065	0			76. 01
76. 02 03950 PRI SON CLINI C	O	O	0			76. 02
76. 03   03951   WOUNDCARE	o	1, 355, 215	0			76. 03
76. 04   03952   0PI C	O	2, 429, 662	. 0			76. 04
OUTPATIENT SERVICE COST CENTERS	· '		•			
91. 00 09100 EMERGENCY	0	6, 424, 781	0			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	O	344, 236	0			92.00
200.00 Total (lines 50-199)	o	92, 383, 703	0			200. 00

Health Financial Systems		TERRE HAUTE REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE COST	Provi der CCN: 150046		Worksheet D
				From 09/01/2015	

				From 09/01/2015 To 08/31/2016	Part V Date/Time Pre 1/25/2017 6:2	
		Ti tl	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charg	ge PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see		Rei mbursed	(see inst.)	
	Worksheet C,	,	Servi ces	Services Not		
	Part I, col.	9	Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 08642				1, 136, 921	50. 00
51.00   05100   RECOVERY ROOM	0. 09402				186, 427	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM			1		0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 00000	l e	1		0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 2087	,	2	0	465, 590	54. 00
54. 01   05401   ULTRASOUND	0. 0810	77 559, 995	5 (	0	45, 403	54. 01
54. 02   05402   MAMMOGRAPHY	0. 2008	66 167, 545	5 (	0	33, 654	54. 02
55. 00   05500 RADI OLOGY-THERAPEUTI C	0. 11390	05 8, 037, 166		0	915, 473	55. 00
56. 00   05600 RADI OI SOTOPE	0. 1064	75 4, 688, 428	3	0	499, 200	56. 00
57.00 05700 CT SCAN	0. 02663			o	245, 136	57.00
58. 00   05800 MRI	0. 04452	26 2, 693, 990	) (	o	119, 953	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 0564	74 4, 926, 491		ol ol	278, 219	59. 00
60. 00   06000   LABORATORY	0. 06519	90 6, 157, 367	664	1 o	401, 399	60.00
62.00 06200 WHOLE BLOOD & PACKED RED B	LOOD CELL 0. 11758	39 424, 430		ol ol	49, 908	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 1111:	25 217, 005		ol ol	24, 115	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 3917!	54 4, 730		ol ol	1, 853	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 08432	27 2, 289, 592		ol ol	193, 074	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 1128!			ol ol	25, 856	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO	0. 1981 O. 1981	4, 944, 185	il (	ol ol	979, 641	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATI				ol	1, 498, 605	•
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 1192		•	133, 213	1, 656, 264	73. 00
74.00 07400 RENAL DIALYSIS	0. 1815				6, 630	ł
76. 00   03020 LI THOTRI PSY	0. 15534		l e	ol ol	67, 949	1
76. 01   03330 ENDOSCOPY	0. 1256			o	259, 904	76. 01
76. 02   03950   PRI SON   CLI NI C	1. 77653			o	0	76. 02
76. 03   03951   WOUNDCARE	0. 2841!			1	385, 086	76. 03
76. 04   03952   OPI C	0. 16380				397, 998	76. 04
OUTPATIENT SERVICE COST CENTERS	1 0. 1000	27 1277 002		,	07.17.70	70.0.
91. 00 09100 EMERGENCY	0. 1178;	35 6, 424, 781		0	757, 064	91.00
92. 00 09200 OBSERVATION BEDS (NON-DIST			l		261, 602	92.00
200.00 Subtotal (see instructions	l l	92, 383, 703	1	1		1
201.00 Less PBP Clinic Lab. Servi		72, 303, 703	002		10, 072, 724	201.00
Only Charges	oos i rogi aiii			1 4		201.00
202.00 Net Charges (line 200 +/-	Line 201)	92, 383, 703	664	133, 213	10, 892, 924	202 00
		, ,2,000,700	1 00	.,, 2.10	.0,0,2,721	1-32.00

Health Financial Systems	TERRE HAUTE REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 150046	Peri od: From 09/01/2015	Worksheet D Part V
			To 08/31/2016	Date/Time Prepared

				To 08/31/2016		epared:
		Ti +I	e XVIII	Hospi tal	1/25/2017 6:: PPS	24 pm
	Cos	sts	C XVIII	1103pi tai	113	
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	0				50.00
51.00   05100   RECOVERY ROOM	0	0				51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00   05300   ANESTHESI OLOGY	0	0				53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0				54.00
54. 01   05401   ULTRASOUND	0	0				54. 01
54. 02   05402 MAMMOGRAPHY	0	0				54. 02
55. 00   05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
56. 00   05600 RADI OI SOTOPE	0	0				56. 00
57. 00   05700 CT SCAN	0	0				57. 00
58. 00   05800   MRI	0	0				58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60. 00   06000   LABORATORY	43	0				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62. 00
65. 00 06500 RESPIRATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66. 00
69. 00   06900   ELECTROCARDI OLOGY	0	0				69. 00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0				70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	15, 881				73.00
74.00  07400   RENAL DIALYSIS	0	0				74.00
76. 00   03020   LI THOTRI PSY	0	0				76. 00
76. 01   03330   ENDOSCOPY	0	0				76. 01
76. 02   03950   PRI SON CLI NI C	0	0				76. 02
76. 03   03951   WOUNDCARE	0	-				76. 03
76. 04 03952 OPI C	0	0				76. 04
OUTPATIENT SERVICE COST CENTERS						
91. 00   09100   EMERGENCY	0					91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	-	ı			92. 00
200.00 Subtotal (see instructions)	43	15, 881				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges	40	15 004				200 00
202.00   Net Charges (line 200 +/- line 201)	43	15, 881	l			202. 00

Health Financial Systems	TERRE HAUTE REG	IONAL HOSPITAL		In lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA			CCN: 150046	Peri od:	Worksheet D	2002 .0
				From 09/01/2015	Part II	
		Component	t CCN: 15S046	To 08/31/2016	Date/Time Pre 1/25/2017 6:2	pared:
		Ti tl	e XVIII	Subprovi der -	PPS	т рііі
Cost Center Description	Capi tal	Total Charges	Dotio of Cos	IPF t Inpatient	Capital Costs	
cost center bescription		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,				column 4)	
	Part II, col.	8)	2)	. Charges	COT ullil 4)	
	26)	0)	2)			
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00 05000 OPERATING ROOM	814, 387	84, 231, 176	0.00966	8 0	0	50.00
51. 00   05100   RECOVERY   ROOM	70, 271				0	
52. 00   05200   DELI VERY ROOM & LABOR ROOM	233, 694				0	
53. 00   05300   ANESTHESI OLOGY	200,071		1		0	1
54. 00   05400   RADI OLOGY - DI AGNOSTI C	393, 051	_	1		595	
54. 01   05401   ULTRASOUND	18, 891				0	1
54. 02   05402 MAMMOGRAPHY	49, 524				0	1
55. 00   05500   RADI OLOGY-THERAPEUTI C	197, 272		1		0	
56. 00   05600 RADI 01 SOTOPE	52, 825				0	1
57. 00   05700 CT SCAN	82, 761				61	57.00
58. 00   05800 MRI	42, 768				56	1
59. 00   05900   CARDI AC   CATHETERI ZATI ON	91, 751				0	1
60. 00   06000   LABORATORY	246, 232		1		1, 927	
62. 00   06200   LABORATORY 62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL	28, 012				1, 927	1
65. 00 06500 RESPIRATORY THERAPY	1				290	
66. 00   06600   PHYSI CAL THERAPY	101, 056 399, 239				280	
69. 00   06900   ELECTROCARDI OLOGY	90, 893					1
70. 00   07000   ELECTROENCEPHALOGRAPHY	1				59 109	
71. 00   07100   BEECTROENCEPHALOGRAPHY 71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT	30, 560					
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	406, 258 197, 755				65 0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1				2, 119	
	379, 061				· ·	1
74. 00   07400   RENAL DI ALYSI S	36, 416		1		0	
76. 00   03020   LI THOTRI PSY	5, 077				0	
76. 01   03330   ENDOSCOPY	72, 629				0	
76. 02   03950   PRI SON CLI NI C	191, 635				0	76. 02
76. 03   03951   WOUNDCARE	65, 916				0	
76. 04 03952 OPI C	118, 713	6, 162, 086	0. 01926	5 0	0	76. 04
OUTPATIENT SERVICE COST CENTERS	450.744	F1 704 007	0.0000	202 224	0.540	01.00
91. 00 09100 EMERGENCY	459, 741				2, 513	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	4 074 200	_, -, -, -,	1		0 074	
200.00   Total (lines 50-199)	4, 876, 388	579, 078, 082	1	1, 489, 423	8,074	200. 00

	5	TERRE HALITE REAL	LONAL LIGGELTAL			6.5. 046	0550 40
APPORT	Financial Systems T TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS	FERRE HAUTE REGI RVICE OTHER PASS	S Provi der	CCN: 150046 t CCN: 15S046	Period: From 09/01/2015 To 08/31/2016		pared:
			Ti tl	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Non Physician Anesthetist Cost			Medical Education Cost	4)	
	T	1. 00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1				1	
50.00	05000 OPERATI NG ROOM	0	C		0 0		
51. 00 52. 00	O5100   RECOVERY ROOM   O5200   DELIVERY ROOM & LABOR ROOM	0			0 0	0	1
53. 00	05300 ANESTHESI OLOGY	0			0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0				0	
54. 01	05401 ULTRASOUND	0	Ĭ		0 0	Ö	
54. 02	05402 MAMMOGRAPHY	0	ĺ		o o	l ő	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0			0 0	0	55. 00
56.00	05600 RADI OI SOTOPE	0	C		0 0	0	56. 00
57.00	05700 CT SCAN	0	C		0 0	0	57. 00
58.00	05800 MRI	0	C		0 0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0	
60.00	06000 LABORATORY	0	C		0	0	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C		0 0	0	
65.00	06500 RESPI RATORY THERAPY	0	C	)	0	0	
66. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	0		2	0	0	
69. 00 70. 00	07000 ELECTROENCEPHALOGRAPHY	0			0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				0	
		0				0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	ĺ		0 0	0	1
74. 00	07400 RENAL DIALYSIS	0	Ċ		0 0	Ō	
76.00	03020 LI THOTRI PSY	0	C		0 0	0	76. 00
76. 01	03330 ENDOSCOPY	0	C		0 0	0	76. 01
76. 02	03950 PRI SON CLINI C	0	C		0 0	0	76. 02
76. 03	03951 WOUNDCARE	0	C		0	0	
76. 04	03952 OPI C	0	C	)	0 0	0	76. 04
01 00	OUTPATIENT SERVICE COST CENTERS				0 0		01 00
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0 0			0 0		1
200.00	,	0		l	0 0		200. 00
200.00	110001 (111103 30 177)	1	1	1	0	,	1200.00

Heelth Finensial Systems	TENNE HALITE NEC	LONAL HOSDITAL		مادها	u of Form CMS	2552 10
Health Financial Systems T APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	ERRE HAUTE REG	S Provi der		Period: From 09/01/2015 To 08/31/2016	u of Form CMS-2 Worksheet D Part IV Date/Time Pre 1/25/2017 6:2	pared:
		Ti tl	e XVIII	Subprovi der -	PPS	<u> </u>
Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	8)	to Charges (col. 5 ÷ col 7)	d Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
ANOULL ADV. CEDVI OF COCT CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
ANCI LLARY SERVICE COST CENTERS  50. 00 05000 OPERATING ROOM		04 221 177	0.00000	0 000000	0	FO 00
	0				0	
51. 00 05100 RECOVERY ROOM	0				0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	-,,			0	52.00
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C	0				0	53. 00 54. 00
	1	, .==,			21, 821	
54. 01   05401   ULTRASOUND 54. 02   05402   MAMMOGRAPHY	0				0	1
55. 00   05500   RADI OLOGY-THERAPEUTI C					0	55.00
56. 00   05600   RADI 0I SOTOPE			•		0	56.00
57. 00   05700 CT SCAN					35, 006	
58. 00   05800   MRI		,,	•		17, 192	
59. 00   05900 CARDI AC CATHETERI ZATI ON					17, 192	
60. 00   06000   LABORATORY		,			489, 243	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL					407, 243	
65. 00 06500 RESPIRATORY THERAPY					53, 065	
66. 00   06600 PHYSI CAL THERAPY			l .		4, 995	
69. 00 06900 ELECTROCARDI OLOGY					9, 889	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0				5, 541	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				6, 284	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0				0	1
73.00 07300 DRUGS CHARGED TO PATIENTS	0				560, 710	
74. 00 07400 RENAL DIALYSIS	0				0	1
76. 00 03020 LI THOTRI PSY	0				0	76. 00
76. 01 03330 ENDOSCOPY	0	7, 601, 343			0	1
76. 02 03950 PRI SON CLI NI C	0			0. 000000	0	76. 02
76. 03   03951   WOUNDCARE	0	3, 331, 924	0.00000	0. 000000	0	76. 03
76. 04 03952 OPI C	0	6, 162, 086	0. 00000	0. 000000	0	76. 04
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	51, 794, 097	0.00000	0. 000000	283, 091	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2, 672, 159	0. 00000	0. 000000	2, 586	92.00
200.00 Total (lines 50-199)	0	579, 078, 082			1, 489, 423	200. 00

Health Financial Systems	TERRE HAUTE REGIONAL	L HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150046	Peri od: From 09/01/2015	Worksheet D Part IV
Timoodii 66313		Component CCN: 15SO46	To 08/31/2016	Date/Time Prepared: 1/25/2017 6:24 pm
		Title XVIII	Subprovi der -	PPS

		11 11	e xviii	I PF	PPS
Cost Center Description	I npati ent	Outpati ent	Outpati ent	1111	
oost center bescription	Program	Program	Program		
	Pass-Through	Charges	Pass-Through		
	Costs (col. 8	g	Costs (col. 9		
	x col. 10)		x col. 12)		
	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM	0	0	(	D	50. 00
51.00   05100   RECOVERY ROOM	0	0	(		51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	(		52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	(	O .	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	(	O .	54. 00
54. 01   05401   ULTRASOUND	0	0	(	O .	54. 01
54. 02   05402   MAMMOGRAPHY	0	0	(		54. 02
55. 00   05500 RADI OLOGY-THERAPEUTI C	0	0			55. 00
56. 00   05600   RADI OI SOTOPE	0	0	(		56. 00
57. 00   05700   CT   SCAN	0	0	(		57. 00
58. 00   05800   MRI	0	0	(		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	O	0	(		59. 00
60. 00   06000   LABORATORY	o	1, 200			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	_   0	0			62.00
65. 00 06500 RESPIRATORY THERAPY	o	0			65. 00
66. 00 06600 PHYSI CAL THERAPY	o	0			66.00
69. 00 06900 ELECTROCARDI OLOGY	o	0			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	o	0			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	- l ol	0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	0			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	3, 166			73.00
74. 00 07400 RENAL DIALYSIS	o	0			74.00
76. 00 03020 LI THOTRI PSY	o	0			76. 00
76. 01 03330 ENDOSCOPY	o	0			76. 01
76. 02 03950 PRI SON CLINIC	o	0			76. 02
76. 03 03951 WOUNDCARE	o	0			76. 03
76. 04 03952 OPI C	ol	0			76. 04
OUTPATIENT SERVICE COST CENTERS				<u> </u>	
91. 00 09100 EMERGENCY	0	4, 539	(		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	- 0	0			92. 00
200.00 Total (lines 50-199)	O	8, 905	(		200. 00

APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 150046	Peri od:	Worksheet D	
			Component	CCN: 15SO46	From 09/01/2015 To 08/31/2016		pared: 4 pm
			Ti tl	e XVIII	Subprovi der – I PF	PPS	
				Charges	IPF	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	<b>'</b>		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	,	
		Part I, col. 9	ĺ	Subject To	Subject To		
		·		Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	0. 086427	0		0	0	
51. 00	05100 RECOVERY ROOM	0. 094024	0		0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 696919	ŀ		0	0	
53. 00	05300 ANESTHESI OLOGY	0. 000000	0		0	0	1 00.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 208779	0		0	0	
54. 01	05401 ULTRASOUND	0. 081077	0		0	0	
54. 02	05402 MAMMOGRAPHY	0. 200866	0		0	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 113905	0		0	0	
56. 00	05600 RADI OI SOTOPE	0. 106475	0		0	0	
57. 00	05700  CT SCAN	0. 026630	0		0	0	
58. 00	05800 MRI	0. 044526	0		0	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 056474	0		0	0	
60. 00	06000 LABORATORY	0. 065190			0	78	
52. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 117589	l .		0	0	
65. 00	06500 RESPI RATORY THERAPY	0. 111125	0		0	0	
66. 00	06600 PHYSI CAL THERAPY	0. 391754	0		0	0	
59. 00	06900 ELECTROCARDI OLOGY	0. 084327	0		0	0	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 112859	0		0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 198140	0		0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 430490	0		0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 119217	3, 166		0 3, 060	377	73. 00
74. 00	07400 RENAL DIALYSIS	0. 181536	0		0	0	74.00
76. 00	03020 LI THOTRI PSY	0. 155346	0		0	0	76. 00
76. 01	03330 ENDOSCOPY	0. 125614	0		0	0	76. 01
76. 02	03950 PRI SON CLINIC	1. 776532	0		0	0	76. 02
76. 03	03951 WOUNDCARE	0. 284151	0		0 0	0	76. 03
76. 04	03952 OPI C	0. 163808	0		0 0	0	76. 04
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	0. 117835			0 0	535	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 759950	l o		0 0	0	92.00

0. 759950

8, 905

8, 905

0 0 0

0

3, 060

3, 060

91. 00 92. 00

990 200. 00 201. 00

990 202. 00

0

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

200.00

201.00

202.00

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges

Net Charges (line 200 +/- line 201)

	Financial Systems T TONMENT OF MEDICAL. OTHER HEALTH SERVICES AND	ERRE HAUTE REG		- CCN: 150046	Peri od:	u of Form CMS- Worksheet D	2552-10
APPURI	TUNMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider	CCN: 150046	From 09/01/2015	Part V	
			Componer	nt CCN: 15SO46		Date/Time Pro 1/25/2017 6:2	epared: 24 pm
			Ti t	le XVIII	Subprovi der - I PF	PPS	
		Cos	sts			L	
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
	[	6. 00	7.00				
	ANCILLARY SERVICE COST CENTERS	1	1	al			
50.00	05000 OPERATI NG ROOM	0		0			50.00
51.00	05100 RECOVERY ROOM	0		0			51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		0			52. 00
53.00	05300 ANESTHESI OLOGY	0		0			53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		0			54.00
54. 01	05401 ULTRASOUND			0			54. 01
54. 02	05402   MAMMOGRAPHY   05500   RADI OLOGY-THERAPEUTI C						54. 02 55. 00
55. 00 56. 00	05600 RADI OLOGY - THERAPEUTI C						56.00
57. 00	05700 CT SCAN						57. 00
58. 00	05800 MRI			0			58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON						59.00
60.00	06000 LABORATORY			0			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL			0			62. 00
65.00	06500 RESPIRATORY THERAPY			0			65.00
66. 00	06600 PHYSI CAL THERAPY			0			66.00
	06900 ELECTROCARDI OLOGY			0			69.00
	07000 ELECTROENCEPHALOGRAPHY			o			70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT			o			71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS			o			72.00
	07300 DRUGS CHARGED TO PATIENTS		36	5			73. 00
	07400 RENAL DIALYSIS	0		o			74.00
76. 00	03020 LI THOTRI PSY			o			76. 00
76. 01	03330 ENDOSCOPY	0		o			76. 01
76. 02	03950 PRISON CLINIC	0		o			76. 02
76. 03	03951 WOUNDCARE	0		o			76. 03
76. 04	03952 OPI C	0		o			76. 04
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	0	l .	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		o			92.00

0 0 0

365

365

200.00

201. 00

202. 00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

200.00

201.00

202.00

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges
Net Charges (line 200 +/- line 201)

Health Financial Systems T	ERRE HAUTE REG	IONAL HOSPITAL		Inlie	u of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA			CCN: 150046	Peri od:	Worksheet D	2332-10
ATTORTION OF THE ATTENT ANOTEDIAN SERVICE GATTA	E 00010		t CCN: 15T046	From 09/01/2015 To 08/31/2016	Part II Date/Time Pre 1/25/2017 6:2	pared:
		Ti tl	e XVIII	Subprovider - IRF	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.			column 4)	
	Part II, col.	8)	2)			
	26)		ĺ			
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 O5000 OPERATING ROOM	814, 387	84, 231, 176	0. 00966	8 456	4	50.00
51. 00   05100   RECOVERY ROOM	70, 271	11, 787, 427	0.00596	2 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	233, 694	3, 207, 087	0. 07286	8 0	0	52.00
53. 00   05300   ANESTHESI OLOGY	0	O	0.00000	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	393, 051	14, 422, 183	0. 02725	38, 375	1, 046	54.00
54. 01   05401   ULTRASOUND	18, 891	3, 667, 814	0.00515		12	54. 01
54. 02 05402 MAMMOGRAPHY	49, 524				0	54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	197, 272		1	6 0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	52, 825				28	56.00
57. 00   05700 CT SCAN	82, 761				76	57. 00
58. 00   05800   MRI	42, 768	13, 158, 459	0.00325	0 8, 408	27	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	91, 751				35	
60. 00   06000   LABORATORY	246, 232				1, 064	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	28, 012				115	1
65. 00 06500 RESPIRATORY THERAPY	101, 056		1		520	65.00
66. 00   06600 PHYSI CAL THERAPY	399, 239		1		93, 605	66.00
69. 00 06900 ELECTROCARDI OLOGY	90, 893	15, 306, 627	0.00593		119	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	30, 560				113	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	406, 258			1 220, 698	2, 269	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	197, 755	18, 746, 420	0. 01054	.9	0	1
73.00 07300 DRUGS CHARGED TO PATIENTS	379, 061			9 775, 849	2, 932	73.00
74. 00 07400 RENAL DIALYSIS	36, 416	5, 530, 574	0. 00658	4 159, 790	1, 052	74.00
76. 00 03020 LI THOTRI PSY	5,077			3 0	0	76.00
76. 01   03330   ENDOSCOPY	72, 629			5 4, 545	43	76. 01
76. 02   03950   PRI SON CLI NI C	191, 635				0	
76. 03   03951   WOUNDCARE	65, 916				0	
76. 04   03952   OPI C	118, 713				0	1
OUTPATIENT SERVICE COST CENTERS		, ., ,				1
91. 00 09100 EMERGENCY	459, 741	51, 794, 097	0. 00887	6 3, 117	28	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		1	0 1, 518	0	92.00
200.00 Total (lines 50-199)	4, 876, 388	579, 078, 082		3, 363, 622	103, 088	200. 00

111 41-	Figure in Contains	FEDDE HALITE DECL	LONAL HOCDITAL		111-	of Farm CNC	2552 10
APPORT	Financial Systems T TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS	FERRE HAUTE REGI RVICE OTHER PASS	S Provi der	CCN: 150046 t CCN: 15T046	Period: From 09/01/2015 To 08/31/2016		pared:
			Ti tl	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Non Physician Anesthetist Cost			Medical Education Cost	4)	
	T	1. 00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1					
50.00	05000 OPERATI NG ROOM	0	C		0 0		
51. 00 52. 00	O5100   RECOVERY ROOM   O5200   DELIVERY ROOM & LABOR ROOM	0			0 0	0	1
53. 00	05300 ANESTHESI OLOGY	0			0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0				0	
54. 01	05401 ULTRASOUND	0	Ĭ		0 0	ő	
54. 02	05402 MAMMOGRAPHY	0	ĺ		o o	ő	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0			0 0	0	55. 00
56.00	05600 RADI OI SOTOPE	0	C		0 0	0	56. 00
57.00	05700 CT SCAN	0	C		0 0	0	57. 00
58.00	05800 MRI	0	C		0 0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	C	)	0 0	0	
60.00	06000 LABORATORY	0	C		0	0	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C		0 0	0	
65.00	06500 RESPI RATORY THERAPY	0	C	)	0	0	
66.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	0			0	0	
69. 00 70. 00	07000 ELECTROENCEPHALOGRAPHY	0			0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				0	
		0				0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	ĺ		0 0	o o	1
74. 00	07400 RENAL DIALYSIS	0	Ċ		0 0	ō	
76.00	03020 LI THOTRI PSY	0	C		0 0	0	76. 00
76. 01	03330 ENDOSCOPY	0	C		0 0	0	76. 01
76. 02	03950 PRI SON CLINI C	0	C		0 0	0	76. 02
76. 03	03951 WOUNDCARE	0	C		0	0	
76. 04	03952 OPI C	0	C	)	0 0	0	76. 04
01 00	OUTPATIENT SERVICE COST CENTERS	1 0			0 0	0	01 00
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0 0		1
200.00	,	0		l	0 0		200. 00
200.00	110001 (111103 30 177)	1	1	1	0	1	1200.00

Health Financial Systems	TERRE HAUTE REG	IONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provi der		Peri od:	Worksheet D	
THROUGH COSTS		Component		From 09/01/2015 To 08/31/2016	Part IV Date/Time Pre 1/25/2017 6:2	pared:
		Ti tl	e XVIII	Subprovi der - I RF	PPS	, p
Cost Center Description	Total	Total Charges	Ratio of Cos		I npati ent	
oust deliter bescription	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.			Charges	
	col . 2, 3 and	8)	7)	(col. 6 ÷ col.	3	
	4)	ŕ	,	7)		
	6. 00	7. 00	8. 00	9. 00	10. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM	0				456	
51.00   05100   RECOVERY ROOM	0				0	
52.00   05200   DELIVERY ROOM & LABOR ROOM	0				0	
53. 00   05300   ANESTHESI OLOGY	0				0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0				38, 375	
54. 01   05401   ULTRASOUND	0	3, 667, 814			2, 310	
54. 02   05402   MAMMOGRAPHY	0	_,,	1		0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0				0	
56. 00   05600   RADI 01 SOTOPE	0		1		6, 491	56.00
57. 00   05700   CT   SCAN	0				43, 420	
58. 00   05800   MRI 59. 00   05900   CARDI AC   CATHETERI ZATI ON	0		1		8, 408 8, 253	
60. 00   06000   CARDIAC CATHETERIZATION					8, 253 270, 139	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL					270, 139	
65. 00 06500 RESPIRATORY THERAPY		-,	1		95, 245	
66. 00   06600   PHYSI CAL THERAPY			1		1, 672, 148	
69. 00 06900 ELECTROCARDI OLOGY	Ö	.,			19, 982	
70. 00 07000 ELECTROENCEPHALOGRAPHY			1		5, 754	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		1		220, 698	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0				0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0				775, 849	
74. 00 07400 RENAL DIALYSIS	0	5, 530, 574	0.00000	0. 000000	159, 790	74.00
76. 00   03020 LI THOTRI PSY	0				0	
76. 01 03330 ENDOSCOPY	0	7, 601, 343			4, 545	76. 01
76. 02   03950   PRI SON CLINI C	0	350, 310			0	76. 02
76. 03   03951   WOUNDCARE	0	3, 331, 924			0	1
76. 04 03952 OPI C	0	6, 162, 086	0.00000	0. 000000	0	76. 04
OUTPATIENT SERVICE COST CENTERS						1
91. 00   09100   EMERGENCY	0				3, 117	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0. 000000	1, 518	
200.00   Total (lines 50-199)	0	579, 078, 082			3, 363, 622	200.00

Health Financial Systems	TERRE	HAUTE	REGI ONAL	HOSPI TAL		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY THROUGH COSTS	SERVI CE	OTHER	PASS	Provi der	CCN: 150046	Period: From 09/01/2015	Worksheet D
THROUGH COSTS				Component	CCN: 15TO46		Date/Time Prepared: 1/25/2017 6:24 pm
				Ti tl	e XVIII	Subprovi der - I RF	PPS

			Ti tl	e XVIII	Subprovi der  - I RF	PPS	
	Cost Center Description	Inpati ent	Outpati ent	Outpati ent			
	· · · · · · · · · · · · · · · · · · ·	Program	Program	Program			
		Pass-Through	Charges	Pass-Through	ı İ		
		Costs (col. 8	J	Costs (col.			
		x col. 10)		x col. 12)			
		11.00	12.00	13.00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	1	0		50.00
51.00	05100 RECOVERY ROOM	0	0	)	0		51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	)	0		52. 00
53.00	05300 ANESTHESI OLOGY	0	0	)	0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	)	0		54.00
54.01	05401 ULTRASOUND	0	0	)	0		54. 01
54.02	05402 MAMMOGRAPHY	0	0	)	0		54. 02
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	)	0		55. 00
56.00	05600 RADI OI SOTOPE	0	0	)	0		56. 00
57.00	05700 CT SCAN	0	0	)	0		57. 00
58.00	05800 MRI	0	0	)	0		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	)	0		59. 00
60.00	06000 LABORATORY	0	0	)	0		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	)	0		62. 00
65.00	06500 RESPI RATORY THERAPY	0	0	)	0		65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	)	0		66. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	)	0		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	)	0		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	)	0		71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	)	0		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1, 613		0		73. 00
74.00	07400 RENAL DIALYSIS	0	0	)	0		74. 00
76.00	03020 LI THOTRI PSY	0	0	)	0		76. 00
76. 01	03330 ENDOSCOPY	0	0	)	0		76. 01
76. 02	03950 PRI SON CLINIC	0	0	)	0		76. 02
76. 03	03951 WOUNDCARE	0	0	1	0		76. 03
76. 04	03952 OPI C	0	0	)	0		76. 04
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	0	0		0		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	)	0		92.00
200.00		0	1, 613		0		200. 00

	TERRE HAUTE REG				u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST		CCN: 150046 CCN: 15T046	Peri od: From 09/01/2015 To 08/31/2016		pared: 4 nm
		Ti tl	e XVIII	Subprovi der - I RF	PPS	т рііі
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9	'	Subject To	Subject To		
			Ded. & Coins			
	1.00	2.00	(see inst.)	(see inst.)	Г 00	
ANCILLARY SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
50. 00 05000 OPERATING ROOM	0. 086427	. 0		0 0	0	50.00
51. 00   05100   RECOVERY ROOM	0. 094024			0 0		51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 696919			0 0	0	52.00
53. 00   05300   ANESTHESI OLOGY	0. 000000	1		0 0	, o	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 208779	1		0 0	Ö	54.00
54. 01   05401   ULTRASOUND	0. 081077	1		0 0	o o	54. 01
54. 02   05402   MAMMOGRAPHY	0. 200866	•		0 0	,	54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 113905			0 0	0	55. 00
56. 00   05600 RADI 0I SOTOPE	0. 106475	ł .		0 0	Ō	56. 00
57. 00 05700 CT SCAN	0. 026630			0 0	0	57. 00
58. 00   05800 MRI	0. 044526	<b> </b>		0 0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 056474	. 0		0 0	0	59. 00
60. 00 06000 LABORATORY	0. 065190	0		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 117589	0		0 0	0	62. 00
65. 00 06500 RESPIRATORY THERAPY	0. 111125	0		0 0	0	65. 00
66. 00   06600 PHYSI CAL THERAPY	0. 391754	. 0		0 0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 084327	0		0 0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 112859	0		0 0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 198140			0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 430490	1		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 119217			0 1, 994	192	
74. 00   07400   RENAL DI ALYSI S	0. 181536	1		0	0	74. 00
76. 00   03020   LI THOTRI PSY	0. 155346	1		0	0	76. 00
76. 01 03330 ENDOSCOPY	0. 125614			0 0	0	76. 01
76. 02   03950   PRI SON CLINI C	1. 776532	ł		0	0	76. 02
76. 03   03951   WOUNDCARE	0. 284151	1		0 0	_	76. 03
76. 04 03952 OPI C	0. 163808	0		0 0	0	76. 04
OUTPATIENT SERVICE COST CENTERS	0.447005	_				01 00
91. 00   09100   EMERGENCY	0. 117835	1		0 0		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 759950	0	I	0 0	0	92.00

1, 613

1, 613

192 200. 00 201. 00

192 202. 00

0 0 0

0

1, 994

1, 994

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

200.00

201.00

202.00

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges

Net Charges (line 200 +/- line 201)

APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CCN: 150046 t CCN: 15T046	Peri od: From 09/01/2015 To 08/31/2016	Worksheet D Part V Date/Time Pre 1/25/2017 6:2	
			Ti t	e XVIII	Subprovi der - I RF	PPS	•
		Co	sts		1		
	Cost Center Description	Cost Reimbursed	Cost Reimbursed				
		Servi ces	Services Not Subject To				
		Subject To Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00	1			
	ANCILLARY SERVICE COST CENTERS	0.00	7100	1			
50.00	05000 OPERATING ROOM	C	)				50.00
51.00	05100 RECOVERY ROOM	C					51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	C					52.00
53.00	05300 ANESTHESI OLOGY	C	)				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	C	)				54.00
54. 01	05401 ULTRASOUND	C					54. 01
	05402 MAMMOGRAPHY	C					54. 02
	05500 RADI OLOGY-THERAPEUTI C						55. 00
56.00	05600  RADI OI SOTOPE   05700  CT SCAN						56.00
57. 00 58. 00	05800 MRI						57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON						59.00
60.00	06000 LABORATORY						60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL						62. 00
65. 00	06500 RESPIRATORY THERAPY						65.00
66. 00	06600 PHYSI CAL THERAPY	l c					66.00
69. 00	06900 ELECTROCARDI OLOGY	C					69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	C					70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	)				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	C					72. 00
	07300 DRUGS CHARGED TO PATIENTS	C	238				73.00
	07400 RENAL DI ALYSI S	C	l l				74. 00
76.00	03020 LI THOTRI PSY	C					76. 00
	03330 ENDOSCOPY						76. 01
	03950  PRI SON CLI NI C   03951  WOUNDCARE			ار			76. 02
	03952 OPLC		l .				76. 03 76. 04
70.04	OUTPATIENT SERVICE COST CENTERS		′1	4			1 70.04
91.00	09100 EMERGENCY						91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		l .	ol .			92. 00

0 0 0

0

238

238

92.00

200.00

201. 00

202. 00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

200.00

201.00

202.00

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges
Net Charges (line 200 +/- line 201)

Heal th	Financial Systems	TERRE HAUTE REG	IONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS		<u> </u>	Period: From 09/01/2015 Fo 08/31/2016	Worksheet D Part I Date/Time Pre 1/25/2017 6:2	
				le XIX	Hospi tal	Cost	
	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 & PEDI ATRI CS	2, 060, 531	0	2, 060, 53		94. 21	30. 00
31.00	INTENSIVE CARE UNIT	391, 029		391, 02		116. 20	31. 00
40.00	SUBPROVI DER - I PF	389, 315	0	389, 31	6, 404	60. 79	40. 00
41.00	SUBPROVI DER - I RF	335, 277	0	335, 27	7 1, 827	183. 51	41. 00
43.00	NURSERY	36, 429		36, 42	9 563	64. 71	43.00
200.00	Total (lines 30-199)	3, 212, 581		3, 212, 58	1 34, 030		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 & PEDI ATRI CS	1, 179	111, 074				30. 00
31.00	INTENSIVE CARE UNIT	0	0				31. 00
40.00	SUBPROVI DER - I PF	2, 903	176, 473				40. 00
41.00	SUBPROVI DER - I RF	95	17, 433				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30-199)	4, 177	304, 980				200. 00

Heal th	Financial Systems	TERRE HAUTE REG	IONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPOR	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der		Peri od: From 09/01/2015 To 08/31/2016	Worksheet D Part II Date/Time Pre 1/25/2017 6:2	pared: 4 pm
			Ti ·	tle XIX	Hospi tal	Cost	
	Cost Center Description	Capi tal		Ratio of Cos	t Inpatient	Capital Costs	
		Related Cost	(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	ANOLILIABIY OFBY OF COOT OFFITEDO	1.00	2. 00	3.00	4. 00	5. 00	
F0 00	ANCILLARY SERVICE COST CENTERS	044.007	04 004 47		7 000 007	/7.000	F0 00
50.00	05000 OPERATI NG ROOM	814, 387				67, 892	50.00
51.00	05100 RECOVERY ROOM	70, 271		1		4, 749	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	233, 694				118, 252	52.00
53. 00	05300 ANESTHESI OLOGY	0				0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	393, 051		1		18, 872	54.00
54. 01	05401 ULTRASOUND	18, 891		1		944	54. 01
54. 02	05402 MAMMOGRAPHY	49, 524		1		0	54. 02 55. 00
55. 00 56. 00	05500  RADI OLOGY-THERAPEUTI C   05600  RADI OI SOTOPE	197, 272 52, 825		1		1, 916 552	56.00
57. 00	05700 CT SCAN	82, 761		1		4, 657	57. 00
58. 00	05800 MRI	42, 768				2, 111	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	91, 751				6, 380	59.00
60.00	06000 LABORATORY	246, 232		1			60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	28, 012		1			62.00
65. 00	06500 RESPIRATORY THERAPY	101, 056		1		16, 409	65. 00
66. 00	06600 PHYSI CAL THERAPY	399, 239		1		14, 957	66. 00
69. 00	06900 ELECTROCARDI OLOGY	90, 893				•	
70. 00	07000 ELECTROEARDT GEOGT	30, 560		1		2, 141	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	406, 258		1		30, 503	71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	197, 755		1		17, 849	72.00
73. 00		379, 061	100, 305, 684	1		38, 037	73.00
73.00	OTOGO DINGGO GIANGED TO TATTENTO	3,7,001	100, 303, 00.	1 0.00377	, 10, 000, 402	30, 037	, 5. 00

36, 416

5, 077

72, 629

191, 635

65, 916 118, 713

459, 741

243, 916

5, 120, 304

5, 530, 574

1, 284, 350

7, 601, 343

3, 331, 924 6, 162, 086

51, 794, 097

579, 078, 082

2, 672, 159

350, 310

0.006584

0.003953

0.009555

0.547044

0. 019783

0.019265

0.008876

0. 091280

651, 842

302, 713

1, 236

10, 939

<u>7, 4</u>11

2, 326, 007

42, 990, 020

Ω

74.00

76. 00

76.01

76.02

76.03

143 76.04

0 92.00

20, 646 91. 00

401, 612 200. 00

4, 292

2, 892

676

216

74.00 07400 RENAL DIALYSIS

03950 PRISON CLINIC

OUTPATIENT SERVICE COST CENTERS

Total (lines 50-199)

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

76. 00 03020 LI THOTRI PSY

76. 01 03330 ENDOSCOPY

76. 03 03951 WOUNDCARE

91. 00 09100 EMERGENCY

76. 04 03952 OPI C

76.02

200.00

Health Financial Systems T	ERRE HAUTE REC	GIONAL HOSPITAL	-	In Li∈	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS		CCN: 150046	Peri od: From 09/01/2015 To 08/31/2016	Date/Time Pre 1/25/2017 6:2	pared: 4 pm
			tle XIX	Hospi tal	Cost	
Cost Center Description	Nursing School	Allied Health Cost	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	30. 00 31. 00
40. 00   04000   SUBPROVI DER -   PF				0	0	
41. 00   04100   SUBPROVI DER -   RF		o i	o l	0 0	o o	
43. 00   04300   NURSERY			o	0	Ō	43. 00
200.00 Total (lines 30-199)		0	0	0	0	200.00
Cost Center Description	Total Patient Days	Per Di em (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 0.00			
30. 00	21, 87 3, 36 6, 40 1, 82	0. 00 4 0. 00 7 0. 00	0 0 2, 90 0 9	0 0		30. 00 31. 00 40. 00 41. 00
43.00   04300   NURSERY 200.00   Total (lines 30-199)	563 34, 030	•	4, 17	0 77 0		43. 00 200. 00

Health Financial Systems	TERRE HAUTE REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150046	Peri od: From 09/01/2015 To 08/31/2016	Worksheet D Part IV Date/Time Prepared: 1/25/2017 6:24 pm

			'	0 00/31/2010	1/25/2017 6: 2	
			le XIX	Hospi tal	Cost	
Cost Center Description	Non Physician N	lursing School	Allied Health	All Other	Total Cost	
	Anesthetist	-		Medi cal	(sum of col 1	
	Cost			Education Cost		
					4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	0	0	0	0	50.00
51.00   05100   RECOVERY ROOM	0	0	0	0	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	C	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54. 00
54. 01   05401   ULTRASOUND	0	0	C	0	0	54. 01
54. 02   05402   MAMMOGRAPHY	0	0	C	0	0	54. 02
55. 00   05500 RADI OLOGY-THERAPEUTI C	0	0	C	0	0	55. 00
56. 00   05600   RADI 01 SOTOPE	0	0	C	0	0	56. 00
57. 00  05700 CT SCAN	0	0	C	0	0	57. 00
58. 00   05800   MRI	o	0	C	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	C	0	0	59. 00
60. 00   06000   LABORATORY	o	0	C	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	, c	0	0	62. 00
65. 00 06500 RESPIRATORY THERAPY	0	0	, c	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	l c	0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	d	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	d	O	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	d	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	d	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	0		0	0	73. 00
74.00 07400 RENAL DIALYSIS	o	0		0	0	74. 00
76. 00   03020 LI THOTRI PSY	0	0		0	0	76. 00
76. 01 03330 ENDOSCOPY	0	0		0	0	76. 01
76. 02 03950 PRI SON CLINI C	0	0	l d	0	0	76. 02
76. 03   03951   WOUNDCARE	0	0	i o	0	0	76. 03
76. 04   03952   0PI C	0	0	i o	0	0	76. 04
OUTPATIENT SERVICE COST CENTERS		<u>-</u>	-	-1		
91. 00 09100 EMERGENCY	O	0	C	0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	l c	0	0	92.00
200.00 Total (lines 50-199)	0	0	[ c	o	0	200. 00

APPORT	Financial Systems T TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS	ERRE HAUTE REG			In Lie Period: From 09/01/2015 To 08/31/2016		pared:
				le XIX	Hospi tal	Cost	
	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	to Charges	Ratio of Cost	Inpatient Program Charges	
		6.00	7.00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS	0.00	,	0.00	7. 00		
50.00	05000 OPERATING ROOM	0	84, 231, 176	0.00000	0. 000000	7, 022, 337	50.00
51.00	05100 RECOVERY ROOM	0	11, 787, 427	0.00000	0. 000000	796, 473	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	3, 207, 087	0.00000	0. 000000	1, 622, 822	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0.00000	0. 000000	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	14, 422, 183	0.00000	0. 000000	692, 464	54.00
54.01	05401 ULTRASOUND	0	3, 667, 814	0.00000	0. 000000	183, 370	54. 01
54.02	05402 MAMMOGRAPHY	0	2, 415, 287	0.00000	0. 000000	0	54. 02
55.00	05500 RADI OLOGY-THERAPEUTI C	0	15, 862, 669	0.00000	0.000000	154, 070	55.00
56.00	05600 RADI OI SOTOPE	0	12, 331, 906	0.00000			56. 00
57.00	05700 CT SCAN	0	47, 309, 128				
58. 00	05800 MRI	0	13, 158, 459				
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	,				
60.00	06000 LABORATORY	0	62, 531, 829				60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	6, 593, 461				
65.00	06500 RESPI RATORY THERAPY	0	18, 509, 531				
66. 00	06600 PHYSI CAL THERAPY	0	.,				66. 00
69. 00	06900 ELECTROCARDI OLOGY	0					
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1, 551, 414				
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	,	1			
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0					
73.00	07300 DRUGS CHARGED TO PATIENTS	0		1			
74. 00	07400 RENAL DI ALYSI S	0	5, 530, 574				
76. 00	03020 LI THOTRI PSY	0	1, 284, 350				
76. 01	03330 ENDOSCOPY	0	7, 601, 343				
76. 02	03950 PRI SON CLINI C	0	350, 310				
76. 03	03951 WOUNDCARE	0	3, 331, 924				
76. 04	03952 OPI C	0	6, 162, 086	0.00000	0. 000000	7, 411	76. 04
	OUTPATIENT SERVICE COST CENTERS						I

0

51, 794, 097 2, 672, 159 579, 078, 082

0.000000

0.000000

0.000000

0.000000

91.00

0 92.00

42, 990, 020 200. 00

2, 326, 007

OUTPATIENT SERVICE COST CENTERS
91. 00 O9100 EMERGENCY

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

Health Financial Systems	TERRE	HAUTE	REGI ONAL	HOSPI TAL		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE	OTHER	PASS	Provider CCN	I: 150046	Peri od: From 09/01/2015 To 08/31/2016	Worksheet D Part IV Date/Time Prepared:

				10 00/31/2010	1/25/2017 6:	
		Ti t	le XIX	Hospi tal	Cost	<u> </u>
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	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   OPERATING ROOM	0	C		0		50.00
51.00   05100   RECOVERY ROOM	0	C	)	0		51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	C		0		52. 00
53. 00   05300   ANESTHESI OLOGY	0	C	)	0		53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	C	)	0		54.00
54. 01   05401   ULTRASOUND	0	C		O		54. 01
54. 02   05402   MAMMOGRAPHY	0	C		O		54. 02
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	C		O		55. 00
56. 00   05600   RADI 0I SOTOPE	0	C		O		56. 00
57. 00  05700   CT   SCAN	0	C		O		57.00
58. 00   05800   MRI	0	C		O		58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0	C		O		59. 00
60. 00   06000   LABORATORY	0	C		O		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C		O		62. 00
65. 00 06500 RESPIRATORY THERAPY	0	C		0		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	C		O		66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C		O		70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		O		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		O		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		O		73. 00
74.00 07400 RENAL DIALYSIS	O	C		O		74. 00
76. 00   03020   LI THOTRI PSY	O	C		O		76. 00
76. 01   03330   ENDOSCOPY	O	C		o		76. 01
76. 02 03950 PRI SON CLINI C	0	C		o		76. 02
76. 03   03951   WOUNDCARE	0	C		o		76. 03
76. 04 03952 OPI C	O	C		0		76. 04
OUTPATIENT SERVICE COST CENTERS	· '		•	•		
91. 00 09100 EMERGENCY	0	C		O		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C		O		92.00
200.00 Total (lines 50-199)	0	C		C		200. 00

Health Financial Systems	TERRE HAUTE REGIONAL	HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 150046	Peri od: From 09/01/2015	Worksheet D Part V

08/31/2016 Date/Time Prepared: 1/25/2017 6: 24 pm Title XIX Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) 3.00 (see inst.) 1. 00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 086427 10, 232, 445 0 50.00 51.00 05100 RECOVERY ROOM 0.094024 0 1, 894, 553 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.696919 0 0 52 00 25, 448 52 00 0 0 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 208779 2, 716, 526 0 54.00 54.01 05401 ULTRASOUND 0.081077 0 0 661, 516 0 54.01 05402 MAMMOGRAPHY 0 0 54.02 0.200866 194, 477 0 54.02 55.00 05500 RADI OLOGY-THERAPEUTI C 0.113905 1, 039, 721 0 55.00 05600 RADI OI SOTOPE 0 0 56.00 0.106475 1, 206, 421 0 56.00 0 05700 CT SCAN 7. 083. 974 0.026630 0 57 00 57 00 0 58.00 05800 MRI 0.044526 0 1, 538, 404 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.056474 1, 062, 386 0 59.00 60.00 06000 LABORATORY 0.065190 8, 724, 862 60.00 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0.117589 195, 089 0 62.00 65.00 06500 RESPIRATORY THERAPY 0. 111125 0 419, 051 0 65.00 06600 PHYSI CAL THERAPY 0. 391754 454, 259 66.00 66.00 69.00 06900 ELECTROCARDI OLOGY 0.084327 0 0 1, 446, 941 69.00 0 0 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 0.112859 315, 195 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 198140 3, 248, 054 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.430490 72.00 72.00 1, 737, 451 0 07300 DRUGS CHARGED TO PATIENTS 0 6, 551, 167 73.00 0.119217 0 73.00 07400 RENAL DIALYSIS 0 0 74.00 0.181536 4.227 0 74 00 76.00 03020 LI THOTRI PSY 0.155346 0 240, 017 0 76.00 03330 ENDOSCOPY 76. 01 0. 125614 0 620, 855 76.01 03950 PRISON CLINIC 0 0 76.02 1.776532 0 76.02 03951 WOUNDCARE 0 76. 03 0.284151 0 343, 177 0 76.03 03952 OPI C 0.163808 376, 928 0 76.04 76.04 OUTPATIENT SERVICE COST CENTERS 12, 899, 548 91.00 91.00 09100 EMERGENCY 0.117835 0 0 0 Ol 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.759950 C 765, 822 0 92.00 Subtotal (see instructions) 0 0 200.00 200.00 0 65, 998, 514 Less PBP Clinic Lab. Services-Program 0 201.00 201.00 Only Charges

0

65, 998, 514

0 202.00

202.00

Net Charges (line 200 +/- line 201)

Health Financial Systems	TERRE HAUTE REGIONAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHE	ER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150046		Worksheet D
			From 09/01/2015	Part V

08/31/2016 Date/Time Prepared: 1/25/2017 6:24 pm To Title XIX Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 884, 360 50.00 51.00 05100 RECOVERY ROOM 178, 133 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 17, 735 52 00 05300 ANESTHESI OLOGY 53.00 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 567, 154 54.00 54. 01 05401 ULTRASOUND 53, 634 54.01 05402 MAMMOGRAPHY 39, 064 54.02 54.02 55.00 05500 RADI OLOGY-THERAPEUTI C 118, 429 55.00 05600 RADI OI SOTOPE 56.00 128, 454 56.00 05700 CT SCAN 57 00 188, 646 57 00 58.00 05800 MRI 68, 499 58.00 59.00 05900 CARDIAC CATHETERIZATION 59, 997 59.00 06000 LABORATORY 60.00 568, 774 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 22, 940 62.00 62.00 65.00 06500 RESPIRATORY THERAPY 46, 567 65.00 66.00 06600 PHYSI CAL THERAPY 177, 958 66.00 69.00 06900 ELECTROCARDI OLOGY 122, 016 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 35, 573 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 643, 569 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 747, 955 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 781, 010 73.00 74.00 07400 RENAL DIALYSIS 767 74 00 76.00 03020 LI THOTRI PSY 37, 286 76.00 03330 ENDOSCOPY 76. 01 77, 988 76.01 76.02 03950 PRISON CLINIC 0 76.02 03951 WOUNDCARE 97, 514 76.03 76.03 76.04 03952 OPI C 61,744 76.04 OUTPATIENT SERVICE COST CENTERS 0 91.00 09100 EMERGENCY 1, 520, 018 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 581, 986 92.00 0 200.00 Subtotal (see instructions) 7, 827, 770 200. 00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges Net Charges (line 200 +/- line 201) 0 202.00 7, 827, 770 202.00

Health Financial Systems T	ERRE HAUTE REG	IONAL HOSPITAL		In lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA			CCN: 150046	Peri od:	Worksheet D	2332 10
	55575		t CCN: 15SO46	From 09/01/2015 To 08/31/2016	Part II Date/Time Pre	pared:
		T: 4	le XIX	Subprovi der -	1/25/2017 6: 2	4 pm
		111	ie xix	I PF	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(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	814, 387				23	
51.00   05100   RECOVERY ROOM	70, 271				13	51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	233, 694	3, 207, 087			0	52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	0.00000	00	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	393, 051	14, 422, 183	0. 02725		966	54.00
54. 01   05401   ULTRASOUND	18, 891	3, 667, 814	0.00515	13, 396	69	54. 01
54. 02   05402   MAMMOGRAPHY	49, 524	2, 415, 287	0. 02050	04	0	54. 02
55. 00   05500   RADI OLOGY-THERAPEUTI C	197, 272	15, 862, 669	0. 01243	36 0	0	55. 00
56. 00   05600   RADI 0I SOTOPE	52, 825	12, 331, 906	0. 00428	34 0	0	56. 00
57. 00 05700 CT SCAN	82, 761	47, 309, 128	0. 00174	129, 084	226	57. 00
58. 00   05800   MRI	42, 768	13, 158, 459			27	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	91, 751	21, 764, 114	0.0042	16 0	0	59. 00
60. 00   06000   LABORATORY	246, 232		0. 00393		5, 020	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	28, 012		0. 00424	1, 678	7	62. 00
65. 00 06500 RESPIRATORY THERAPY	101, 056				226	65. 00
66. 00   06600 PHYSI CAL THERAPY	399, 239	7, 131, 902	0. 05597	79 3, 933	220	66.00
69. 00 06900 ELECTROCARDI OLOGY	90, 893	15, 306, 627	0.00593	38, 466	228	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	30, 560	1, 551, 414	0. 01969	98 5, 541	109	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	406, 258			16, 785	173	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	197, 755	18, 746, 420	0. 01054	1, 064, 479	11, 229	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	379, 061	100, 305, 684	0.00377	79 0	0	73. 00
74.00 07400 RENAL DIALYSIS	36, 416	5, 530, 574	0. 00658	34 0	0	74.00
76. 00   03020   LI THOTRI PSY	5, 077	1, 284, 350	0. 00395	53 0	0	76. 00
76. 01   03330   ENDOSCOPY	72, 629	7, 601, 343	0.00955	55 4, 545	43	76. 01
76. 02 03950 PRI SON CLINI C	191, 635	350, 310	0. 54704	14 0	0	76. 02
76. 03   03951   WOUNDCARE	65, 916	3, 331, 924	0. 01978	33 0	0	76. 03
76. 04 03952 OPI C	118, 713	6, 162, 086	0. 01926	55 0	0	76. 04
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	459, 741	51, 794, 097	0.00887	76 796, 530	7, 070	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			9, 917	0	92.00
200.00 Total (lines 50-199)	4, 876, 388	579, 078, 082		3, 448, 987	25, 649	200. 00

Heal th	Financial Systems T	ERRE HAUTE REG	IONAL HOSPITAL		In Li <i>e</i>	eu of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS		S Provider Component	CCN: 150046 t CCN: 15S046	Peri od: From 09/01/2015 To 08/31/2016	Worksheet D Part IV Date/Time Pre 1/25/2017 6:2	pared:
				le XIX	Subprovi der  - I PF	Cost	
	Cost Center Description	Anesthetist Cost	Nursing School		Medical Education Cost	4)	
	ANOLLI ADV. CEDVI OF COCT. CENTERS	1.00	2. 00	3.00	4. 00	5. 00	
FO 00	ANCI LLARY SERVI CE COST CENTERS			ı			F0 00
50. 00 51. 00	05000   OPERATI NG ROOM   05100   RECOVERY ROOM	0	-	1	0 0	_	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0				0	52.00
53. 00	05300 ANESTHESI OLOGY	0				0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0		,	0 0	ő	54.00
54. 01	05401 ULTRASOUND	0	Ö	,	0 0	ō	54. 01
54. 02	05402 MAMMOGRAPHY	0	O	1	0 0	0	54. 02
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	1	0 0	0	55. 00
56.00	05600  RADI 0I SOTOPE	0	0	)	0 0	0	56. 00
57.00	05700 CT SCAN	0	0	)	0	0	57. 00
58. 00	05800 MRI	0	0	)	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	1	0	0	59. 00
60.00	06000 LABORATORY	0	0	1	0 0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	62.00
65. 00	06500   RESPI RATORY   THERAPY   06600   PHYSI CAL   THERAPY	0			0	0	65.00
66. 00 69. 00	06900 ELECTROCARDI OLOGY	0			0	0	66. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0				0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		,	0 0	ő	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	i c	)	0 0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	)	0 0	0	74. 00
76.00	03020 LI THOTRI PSY	0	0	)	0 0	0	76. 00
76. 01	03330 ENDOSCOPY	0	0	)	0	0	76. 01
76. 02	03950 PRI SON CLI NI C	0	0	)	0	0	
76. 03	03951 WOUNDCARE	0	0	1	0	_	76. 03
76. 04	03952 OPI C	0	0	1	0 0	0	76. 04
91. 00	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	0		1	0 0	0	91, 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		1			
200.00	,			1	0 0		200.00
200.00	1 1 1 2 2 2 1 1 1 1 2 2 2 2 2 2 2 2 2 2	1	1	1	-1	1	1-30.00

Health Financial Systems T	ERRE HAUTE REG	IONAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	RVICE OTHER PAS		CCN: 150046 t CCN: 15S046	Period: From 09/01/2015 To 08/31/2016	Worksheet D Part IV	pared:
		Ti t	le XIX	Subprovi der  - I PF	Cost	
Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4) 6.00	8)		Ratio of Cost	Inpatient Program Charges	
ANCI LLARY SERVI CE COST CENTERS	6.00	7. 00	8.00	9.00	10.00	
50. 00   O5000   OPERATING ROOM	0	84, 231, 176	0.00000	0. 000000	2, 430	50.00
51. 00   05100   RECOVERY   ROOM					2, 430	
52. 00   05200   DELI VERY ROOM & LABOR ROOM					2, 123	52.00
53. 00   05300   ANESTHESI OLOGY			1		0	
54. 00   05400   RADI OLOGY - DI AGNOSTI C					35, 453	
54. 01   05401   ULTRASOUND					13, 396	
54. 02   05402   MAMMOGRAPHY					0	
55. 00 05500 RADI OLOGY-THERAPEUTI C			1		o o	55.00
56. 00   05600 RADI OI SOTOPE		,,	•		Ö	
57. 00 05700 CT SCAN					129, 084	
58. 00   05800   MRI			•		8, 408	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0				0	
60. 00 06000 LABORATORY	0		•		1, 274, 782	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0. 000000	1, 678	
65. 00 06500 RESPIRATORY THERAPY	0	18, 509, 531	0.00000	0. 000000	41, 437	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	7, 131, 902	0. 00000	0. 000000	3, 933	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	15, 306, 627	0.00000	0. 000000	38, 466	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	1, 551, 414	0.00000	0. 000000	5, 541	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	39, 517, 121	0.00000	0. 000000	16, 785	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	18, 746, 420	0.00000	0. 000000	1, 064, 479	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0				0	73. 00
74.00 07400 RENAL DIALYSIS	0	-,,			0	74. 00
76. 00   03020   LI THOTRI PSY	0	1, 284, 350	0.00000		0	76. 00
76. 01   03330   ENDOSCOPY	0	7,00.,010			4, 545	76. 01
76. 02   03950   PRI SON CLI NI C	0	1,			0	
76. 03   03951   WOUNDCARE	0		1		0	
76. 04 03952 OPI C	0	6, 162, 086	0.00000	0. 000000	0	76. 04
OUTPATIENT SERVICE COST CENTERS						
91. 00   09100   EMERGENCY	0		•			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0. 000000		92.00
200.00   Total (lines 50-199)	0	579, 078, 082	4		3, 448, 987	J200. 00

Health Financial Systems	TERRE	HAUTE	REGI ONAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE	OTHER	PASS	Provi der	CCN: 150046	Peri od: From 09/01/2015	Worksheet D	
THROUGH COSTS				Component	CCN: 15SO46	To 08/31/2016		
				Ti t	le XIX	Subprovi der -	Cost	<u>, biii </u>
Cost Contor Description	In	nati on	+ Out	tnati ont	Outpationt	I PF		

					IPF	
Cos	t Center Description	I npati ent	Outpati ent	Outpati ent		
		Program	Program	Program		
		Pass-Through	Charges	Pass-Through		
		Costs (col. 8		Costs (col. 9		
		x col. 10)		x col. 12)		
		11. 00	12.00	13. 00		
	SERVI CE COST CENTERS					
50. 00   05000 OPE	RATING ROOM	0	0	)		50.00
51. 00   05100 REC	OVERY ROOM	0	0	) (		51.00
52. 00   05200 DELI	IVERY ROOM & LABOR ROOM	0	0	)		52.00
53. 00   05300 ANES	STHESI OLOGY	0	0	) (		53.00
54. 00   05400 RADI	I OLOGY-DI AGNOSTI C	0	0	) (		54.00
54. 01   05401 ULTI	RASOUND	0	0	) (		54. 01
54. 02 05402 MAM	MOGRAPHY	0	0	) (		54. 02
55. 00   05500 RADI	I OLOGY-THERAPEUTI C	0	0	) (		55.00
56. 00   05600 RADI	I OI SOTOPE	0	0	) (		56.00
57.00 05700 CT S	SCAN	0	0	) (		57.00
58. 00   05800 MRI		0	0	) (		58.00
59. 00   05900 CARI	DIAC CATHETERIZATION	0	0	) (		59.00
60. 00 06000 LAB	ORATORY	0	0	) (		60.00
62. 00 06200 WHO	LE BLOOD & PACKED RED BLOOD CELL	0	0	) (		62.00
65. 00 06500 RESI	PI RATORY THERAPY	0	0	) (		65.00
66. 00 06600 PHYS	SI CAL THERAPY	0	0	) (		66.00
69. 00 06900 ELEC	CTROCARDI OLOGY	0	0	) (		69.00
70. 00 07000 ELEC	CTROENCEPHALOGRAPHY	0	0	) (		70.00
71. 00 07100 MEDI	ICAL SUPPLIES CHARGED TO PATIENT	0	0	) (		71.00
72. 00 07200 I MPI	L. DEV. CHARGED TO PATIENTS	0	0	) (		72. 00
73. 00 07300 DRU	GS CHARGED TO PATIENTS	0	0	) (		73. 00
74. 00 07400 RENA	AL DIALYSIS	0	0	) (		74. 00
76. 00   03020 LI TI	HOTRI PSY	0	0	) (		76. 00
76. 01 03330 END	OSCOPY STORY	0	0			76. 01
76. 02 03950 PRIS	SON CLINIC	0	0	) (		76. 02
76. 03   03951   WOU!	NDCARE	0	0	) (		76. 03
76. 04 03952 OPI (	C	0	0	(		76. 04
OUTPATI EN	T SERVICE COST CENTERS					
91. 00 09100 EMER	RGENCY	0	0		D	91. 00
92. 00 09200 OBSI	ERVATION BEDS (NON-DISTINCT PART	0	0			92.00
200. 00 Tota	al (lines 50-199)	0	0	(		200. 00

Health Financial Systems	TERRE HAUTE REG	IONAL HOSPITAL		In lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA			CCN: 150046	Peri od:	Worksheet D	2002 10
ALTONING OF THE ATTENDED THE SERVICE SHAFT	12 00010		t CCN: 15T046	From 09/01/2015 To 08/31/2016	Part II Date/Time Pre	nared·
		ooporrorr			1/25/2017 6: 2	
		Ti t	le XIX	Subprovi der – I RF	Cost	
Cost Center Description	Capi tal	Total Charges	Patio of Cos		Capital Costs	
Cost Center Description		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	9	9	column 4)	
	Part II, col.	8)	2)	. Charges	cordilli 4)	
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	11.00	2.00	0.00	00	0.00	
50. 00 05000 OPERATING ROOM	814, 387	84, 231, 176	0.00966	0 8	0	50.00
51. 00 05100 RECOVERY ROOM	70, 271			0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	233, 694				0	
53. 00   05300   ANESTHESI OLOGY	0		1		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	393, 051	14, 422, 183	1		274	54.00
54. 01   05401   ULTRASOUND	18, 891	1			6	1
54. 02 05402 MAMMOGRAPHY	49, 524				0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	197, 272		1		Ö	
56. 00   05600 RADI OI SOTOPE	52, 825				0	
57. 00   05700 CT   SCAN	82, 761				16	
58. 00   05800 MRI	42, 768		1		0	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	91, 751				0	1
60. 00   06000   LABORATORY	246, 232		1		232	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	28, 012				47	62.00
65. 00 06500 RESPIRATORY THERAPY	101, 056				348	
66. 00   06600 PHYSI CAL THERAPY	399, 239				25, 760	
69. 00   06900   ELECTROCARDI OLOGY	90, 893				43	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	30, 560		1		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	406, 258				181	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	197, 755				0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	379, 061		1		1, 105	1
74. 00 07400 RENAL DIALYSIS	36, 416				150	1
76. 00 03020 LI THOTRI PSY	5, 077		1		0	
76. 01 03330 ENDOSCOPY	72, 629				0	
76. 02   03950   PRI SON   CLI NI C	191, 635				0	
76. 03   03951   WOUNDCARE	65, 916				0	
76. 04 03952 0PI C	118, 713		1		0	
OUTPATIENT SERVICE COST CENTERS	110,713	0, 102, 000	0.01720	,5  0		70.04
91. 00 09100 EMERGENCY	459, 741	51, 794, 097	0.00887	'6 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		1		Ö	92.00
200.00 Total (lines 50-199)	4, 876, 388		1	954, 110	_	200. 00

APP0R1	Financial Systems T TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS	FERRE HAUTE REG RVICE OTHER PAS:	S Provi der	CCN: 150046 t CCN: 15T046	Peri od: From 09/01/2015		pared:
			Ti t	le XIX	Subprovi der  - I RF	Cost	
	Cost Center Description	Anesthetist Cost	Nursi ng School		h All Other Medical Education Cost	4)	
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCI LLARY SERVI CE COST CENTERS		1	1			
50. 00	05000 OPERATING ROOM	0		1	0 0	0	
51.00	05100 RECOVERY ROOM	0	C	1	0 0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			0	0	52.00
53.00	05300 ANESTHESI OLOGY	0			0	0	
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C	0			0	0	54. 00 54. 01
54. 01	05401 ULTRASOUND 05402 MAMMOGRAPHY	0			0	0	54.01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0			0	0	55. 00
56. 00	05600 RADI OLOGI - THERAPEUTI C	0				0	
57. 00	05700 CT SCAN					0	
58. 00	05800 MRI	0				0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0			0 0	Ö	1
60. 00	06000 LABORATORY	0	l c		0 0	0	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	ď	,	0 0	0	62.00
65. 00	06500 RESPIRATORY THERAPY	0	d	,	0 0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	d	)	0 0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0	c	1	0 0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	C	)	0 0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	C	1	0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	C	)	0	0	
74. 00	07400 RENAL DI ALYSI S	0	C		0	0	
76. 00	03020 LI THOTRI PSY	0	C	1	0	0	
76. 01	03330 ENDOSCOPY	0	C	1	0	0	
76. 02	03950 PRI SON CLI NI C	0		1	0	0	
76. 03	03951 WOUNDCARE	0			0 0	0	
76. 04	03952 OPI C	0	<u>C</u>	1	0 0	0	76. 04
01 00	OUTPATIENT SERVICE COST CENTERS O9100 EMERGENCY	1 0	C	1	0 0	0	91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	_	l .	0 0		
200.00	,		_	1	0 0		200. 00
200.00	1.023. (11100 00 177)	1	1	1	٥,	,	1-30.00

Heal th	Financial Systems	TERRE HAUTE REG	IONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	ERVICE OTHER PAS	S Provi der	CCN: 150046	Peri od:	Worksheet D	
THROUG	H COSTS		Componen	t CCN: 15TO46	From 09/01/2015 To 08/31/2016	Part IV Date/Time Pre 1/25/2017 6:2	pared:
			Ti 1	Te XIX	Subprovider -	Cost	, p
	Cost Center Description	Total	Total Charges	Patio of Cos		I npati ent	
	cost center bescription	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 .	onal goo	
		4)		'	7)		
		6.00	7.00	8.00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS			•	<u> </u>		
50.00	05000 OPERATING ROOM	0	84, 231, 176	0.00000	0. 000000	0	50.00
51.00	05100 RECOVERY ROOM	0	11, 787, 427	0.00000	0. 000000	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	3, 207, 087	0.00000		0	52.00
53. 00	05300 ANESTHESI OLOGY	0	(	0.00000	0. 000000	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	14, 422, 183	0. 00000	0. 000000	10, 066	54.00
54. 01	05401 ULTRASOUND	0	3, 667, 814			1, 218	54. 01
54. 02	05402 MAMMOGRAPHY	0	2, 415, 287			0	54. 02
55. 00	05500 RADI OLOGY-THERAPEUTI C	0				0	
56. 00	05600  RADI 0I SOTOPE	0		1		0	56.00
57. 00	05700  CT SCAN	0				9, 041	
58. 00	05800 MRI	0				0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0				0	59.00
60.00	06000 LABORATORY	0	,,			58, 817	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0				10, 966	
65. 00	06500 RESPI RATORY THERAPY	0		1		63, 731	
66. 00	06600 PHYSI CAL THERAPY	0	.,			460, 176	
69. 00	06900 ELECTROCARDI OLOGY	0				7, 232	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	.,,	1		17.57	
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS			1		17, 567 0	
72.00	07300 DRUGS CHARGED TO PATIENTS					292, 469	
74. 00	07400 RENAL DIALYSIS					292, 409	74.00
76.00	03020 LI THOTRI PSY			1		22, 627	
76. 00 76. 01	03330 ENDOSCOPY		.,,	1		0	
76. 02	03950 PRI SON CLI NI C		350, 310			0	
76. 02 76. 03	03951 WOUNDCARE					0	
	03952 OPI C					0	
. 5. 5 +	OUTPATIENT SERVICE COST CENTERS		0,102,000	. 0.00000	3. 555666		1 , 5. 57
91. 00	09100 EMERGENCY	0	51, 794, 097	0.00000	0. 000000	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	1
200.00					21 22 3000	954, 110	

Health Financial Systems	TERRE HAUTE I	REGI ONAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCI THROUGH COSTS	LLARY SERVICE OTHER I	PASS	Provi der	CCN: 150046	Peri od: From 09/01/2015	Worksheet D	
THROUGH COSTS			Component	CCN: 15T046	To 08/31/2016		
			Ti t	le XIX	Subprovi der -	Cost	
					I RF		
Cost Center Description	I npati ent	t Out	tpati ent	Outpati ent			

			I C AI A	IRF	0031	
Cost Center Description	Inpatient	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	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	0		0		50. 00
51.00   05100   RECOVERY ROOM	0	0		0		51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0		0		52. 00
53. 00   05300   ANESTHESI OLOGY	0	0		0		53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
54. 01  05401 ULTRASOUND	0	0		0		54. 01
54. 02   05402   MAMMOGRAPHY	0	0		0		54. 02
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	0		0		55. 00
56. 00   05600   RADI 0I SOTOPE	0	0		0		56. 00
57.00   05700   CT   SCAN	0	0		0		57. 00
58. 00   05800   MRI	0	0		0		58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	0		0		59. 00
60. 00   06000   LABORATORY	0	0		0		60.00
62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0		62. 00
65. 00   06500   RESPI RATORY THERAPY	0	0		0		65. 00
66. 00   06600 PHYSI CAL THERAPY	0	0		0		66. 00
69. 00   06900   ELECTROCARDI OLOGY	0	0		0		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0		70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0		73. 00
74. 00   07400   RENAL DI ALYSI S	0	0		0		74. 00
76. 00   03020   LI THOTRI PSY	0	0		0		76. 00
76. 01 03330 ENDOSCOPY	0	0		o		76. 01
76. 02   03950   PRI SON CLI NI C	0	0		o		76. 02
76. 03   03951   WOUNDCARE	0	0		o		76. 03
76. 04  03952 OPI C	o	Ō		o		76. 04
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	0	)	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	o	0		0		92. 00
200.00 Total (lines 50-199)	0	0		0		200. 00

	Financial Systems	TERRE HAUTE REGIONAL			u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 150046	Peri od: From 09/01/2015	Worksheet D-1	
				To 08/31/2016		
			T: +1 - V(// 1 1	11: +-1	1/25/2017 6: 2	4 pm
	Cost Center Description		Title XVIII	Hospi tal	PPS	
	oost conten beschiptron				1. 00	
	PART I - ALL PROVIDER COMPONENTS					
1 00	I NPATI ENT DAYS	and days and and an bad days			21 071	1 00
1. 00 2. 00	Inpatient days (including private rounding private roundi				21, 871 21, 871	•
3. 00	Private room days (excluding swing-b	ivate room days	21, 8/1			
3.00	do not complete this line.	ed and observation bed days	). It you have only pr	i vate i oom days,	O	3.00
4.00	Semi-private room days (excluding sw	ng-bed and observation bed	days)		19, 282	4.00
5.00	Total swing-bed SNF type inpatient d	ays (including private room	days) through Decembe	r 31 of the cost	0	5.00
	reporting period					
6. 00	Total swing-bed SNF type inpatient d		days) after December	31 of the cost	0	6.00
7. 00	reporting period (if calendar year, Total swing-bed NF type inpatient da		days) through December	21 of the cost	0	7.00
7.00	reporting period	ys (frictualing private room)	days) till odgir becelliber	31 OF THE COST	U	7.00
8. 00						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					9.00
	newborn days)				0	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)					10.00
11. 00						11.00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)					11.00
12.00						12.00
	through December 31 of the cost reporting period					
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)					13. 00
14 00	after December 31 of the cost report	ng period (if calendar yea	r, enter 0 on this lin	e)	0	14 00
14. 00 15. 00	Medically necessary private room days. Total nursery days (title V or XIX o		(excluding swing-bed	uays)	0	
16. 00	Nursery days (title V or XIX only)	'' y)			0	
10.00	SWING BED ADJUSTMENT					10.00
17. 00	Medicare rate for swing-bed SNF serv	ces applicable to services	through December 31 o	f the cost	0.00	17. 00
	reporting period		-			
18. 00	Medicare rate for swing-bed SNF serv	ces applicable to services	after December 31 of	the cost	0. 00	18. 00
10 00	reporting period	and applicable to complete	through Docombon 21 of	the cost	0.00	19.00
19. 00	Medicaid rate for swing-bed NF servi- reporting period	ces applicable to services	through becember 31 of	the cost	0. 00	19.00
20. 00	Medicald rate for swing-bed NF servi	ces applicable to services	after December 31 of t	he cost	0.00	20.00
	reporting period	эррин зами за одини за				
21.00	Total general inpatient routine serv	ce cost (see instructions)			17, 154, 791	21.00
22. 00	Swing-bed cost applicable to SNF type	e services through December	31 of the cost report	ing period (line	0	22. 00
22 00	5 x line 17)		1 -6		0	22.00
23. 00	Swing-bed cost applicable to SNF type x line 18)	e services after December 3	or the cost reportin	g period (iine 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type	services through December	31 of the cost reporti	na period (line	0	24.00
	7 x line 19)			3   1   2   (11.10	· ·	
25. 00	Swing-bed cost applicable to NF type	services after December 31	of the cost reporting	period (line 8	0	25. 00
	x line 20)					
26. 00	Total swing-bed cost (see instruction	•	! 01! !! 0/\		0	
27. 00	General inpatient routine service co PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	st net of swing-bed cost (I	ine 21 minus iine 26)		17, 154, 791	27. 00
28. 00	General inpatient routine service ch	arges (excluding swing-hed	and observation hed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing		0000. Valion bod on	300/	0	
30.00					0	

Inpatient days (including private room days, excluding swing-bed and needborn days)   17 you have enry private room days.   21,871   2,00	1.00	Impatrent days (including private room days and swing-bed days, excluding newborn)	21,8/1	1.00
do not complete this line.  4.00 Semi-private room days (excluding swing-bed and observation bed days)  5.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost  7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost  7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost  8.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost  9.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost  9.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost  10.00 Swing-bed SNF type inpatient days (including private room days) after December 31 of the cost  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including p	2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	21, 871	2. 00
3.6ml private room days (excluding swing-ded and observation bed days)   19, 282   4.00	3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
5.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of Potal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of reporting period (if calendar year, enter 0 on this line) 7.0 period swing-bed SNF type inpatient days (including private room days) brough December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Total soling-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 11.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and nexborn days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to titles V or XXI only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to titles V or XXI only (including private room days) 12.00 Swing-bed SNF type inpatient days applicable to titles V or XXI only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to titles V or XXI only (including private room days) 14.00 Medical type of the coet reporting period (if calendar year, enter 0 on this line) 15.00 Total nursery days (title V or XXI only) 16.00 Nursery days (title V or XXI only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including period (including private room days) 18.00 Medical drate for swing-bed NF services applicable to services through December 31 of the cost reporting period (line 0 22.00 NF period period (including period NF period NF period NF period NF period NF period NF period NF period		do not complete this line.		
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o. 00   Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost rotal swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if cal entary save, enter 0 on this I line)  10   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal entary save, enter 0 on this I line)  10   Total inpatient days including private room days) after December 31 of the cost reporting period (if cal entary save, enter 0 on this I line)  11   Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) are through December 31 of the cost reporting period (if cal entary save, enter 0 on this I line)  12   Total inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (if cal entary save, enter 0 on this line)  13   Total inpatient days applicable to titles V or XIX only (including private room days) after through December 31 of the cost reporting period (if called and enter 0 on this line)  14   Total inpatient days applicable to titles V or XIX only (including private room days) after through December 31 of the cost reporting period (if called and enter 0 on this line)  15   Total inpatient days applicable to titles V or XIX only (including private room days) and through December 31 of the cost reporting period (if called and enter 0 on this line)  16   Total inpatient days applicable to the Program (excluding swing-bed days)  17   Total inpatient days applicable to services through December 31 of the cost reporting period (including private room days)  18   Total inpatient days applicable to services through December 31 of the cost reporting period (including private room days)  19   Total inpatient days applicable to SF type services after December 31 of the cost reporting period (line 6 x line 3)  20   Total inpatient days applicable to NF t			-	
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newborn days)  10 00 Swing-bed SNT type inpatient days applicable to title XVIII only (including private room days)  11 00 through December 31 of the cost reporting period (see instructions)  12 00 Swing-bed SNT type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  13 00 Swing-bed NT type inpatient days applicable to titles V or XIX only (including private room days)  14 00 Swing-bed NT type inpatient days applicable to titles V or XIX only (including private room days)  15 00 Swing-bed NT type inpatient days applicable to titles V or XIX only (including private room days)  16 00 Swing-bed NT type inpatient days applicable to the Program (excluding swing-bed days)  17 00 Mcdically necessary private room days applicable to the Program (excluding swing-bed days)  18 00 Swing-bed Swing-bed SNT services applicable to services through December 31 of the cost of reporting period  18 00 Mcdicare rate for swing-bed SNT services applicable to services after December 31 of the cost of reporting period  19 00 Mcdicare rate for swing-bed SNT services applicable to services after December 31 of the cost of reporting period (including swing-bed swing-bed swing-bed swing-bed swing-bed swing-bed swing-bed SNT services applicable to services after December 31 of the cost of reporting period (line of reporting period swing-bed SNT services applicable to services after December 31 of the cost of reporting period (line of reporting period swing-bed SNT services applicable to services after December 31 of the cost of reporting period (line of reporting period swing-bed swing-bed SNT type services after December 31 of the cost reporting period (line of reporting period (line of reporting period (line of reporting period (line of reporting period (line of reporting period (line of reporting period (line of reporting period (line of reporting period (line of reporting period (line of reporting period (line of reporting p		reporting period (if calendar year, enter 0 on this line)		
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through December 31 of the cost reporting period  13.00 Mang-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Modically necessary private room days applicable to the Program (excluding swing-bed days)  15.00  16.00 Total nursery days (title V or XIX only)  16.00  17.00 Modically necessary private room days applicable to the Program (excluding swing-bed days)  17.00 Modically necessary private room days applicable to the Program (excluding swing-bed days)  18.00 Modical nursery days (title V or XIX only)  18.00 Modicare rate for swing-bed SNF services applicable to services through December 31 of the cost  18.00 Modicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19.00 Modical drate for swing-bed SNF services applicable to services after December 31 of the cost  19.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line solities)  19.00 Modical drate for swing-bed NF services after December 31 of the cost reporting period (line solities)  19.00 Modical drate for swing-bed cost (see instructions)  29.00 Modical drate for swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line solities)  29.00 Modical drate for swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line solities)  29.00 Modical drate for swing-bed cost (see instructions)  29.00 Modical drate for swing-bed cost (see instruct	12.00			12.00
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after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14. 00 Modically necessary private room days applicable to the Program (excluding swing-bed days)  0 14. 00  15. 00 Total nursery days (title V or XIX only)  0 16. 00  Norsery days (title V or XIX only)  0 16. 00  Norsery days (title V or XIX only)  0 16. 00  Norsery days (title V or XIX only)  17. 00  Norsery days (title V or XIX only)  18. 00  Note did care rate for swing-bed SNF services applicable to services through December 31 of the cost  19. 00  Norser days (title V or XIX only)  19. 00			_	
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16. 00 Nursery days (title V or XIX only)  17. 00 SWINS BED ADJUSTMENT  17. 00 Redicare rate for swing-bed SNF services applicable to services through December 31 of the cost percent of the dedicare rate for swing-bed SNF services applicable to services after December 31 of the cost percent of the dedicare rate for swing-bed SNF services applicable to services after December 31 of the cost percent of the dedicare rate for swing-bed NF services applicable to services after December 31 of the cost percent of the cost reporting period of the dedicare rate for swing-bed NF services applicable to services after December 31 of the cost percent of the cost reporting period of the cost reporting period of the cost reporting period of the cost reporting period of the cost reporting period of the cost spilicable to SNF type services through December 31 of the cost reporting period (line to the cost ine 17) of the cost applicable to SNF type services after December 31 of the cost reporting period (line to the cost cost cost (see instructions) to the cost reporting period (line to the cost reporting period (line to the cost cost cost cost cost cost cost cost	14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
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25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRI VATE ROOM DIFFERENTI AL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  Pri vate room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Ceneral inpatient routine service cost/charge ratio (line 27 + line 28)  Average private room per diem charge (line 29 + line 3)  Average per diem private room per diem charge (line 30 + line 4)  Average per diem private room cost differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 34 x line 31)  Ceneral inpatient routine service cost (line 34 x line 31)  Ceneral inpatient routine service cost (line 34 x line 31)  Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 37 minus line 36)  Private room cost differential adjustment (line 3 x line 35)  Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 37 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine	24.00		٥Į	24.00
26.00 Total swing-bed cost (see instructions) 0 26.00 Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 17, 154, 791 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28.00 Pri vate room charges (excluding swing-bed charges) 0 29.00 Semi-private room charges (excluding swing-bed charges) 0 29.00 Semi-private room charges (excluding swing-bed charges) 0 29.00 Average private room per diem charge (line 29 + line 3) 0.000 Average per vate room per diem charge (line 29 + line 3) 0.00 Average semi-private room per diem charge (line 30 + line 4) 0.00 33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 0.00 34.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 Average per diem private room cost differential (line 3 x line 35) 0.00 36.00 Private room cost differential (line 3 x line 35) 0.00 36.00 Private room cost differential (line 3 x line 35) 0.00 36.00 Private room cost differential (line 3 x line 35) 0.00 36.00 Average per diem private room cost differential (line 3 x line 35) 0.00 36.00 Private room cost differential (line 3 x line 35) 0.00 36.00 Average per diem private room cost differential (line 3 x line 35) 0.00 36.00 Average per diem private room cost differential (line 3 x line 35) 0.00 36.00 Average per diem private room cost differential (line 3 x line 35) 0.00 36.00 Average per diem private room cost differential (line 3 x line 35) 0.00 36.00 Average per diem private room cost differential (line 3 x line 35) 0.00 36.00 Average per diem private room cost differential (line 3 x line 35) 0.00 36.00 Average per diem private room cost differential (line 3 x line 35) 0.00 36.00 37.00 Average per diem private room cost differential (line 3 x line 35) 0.00 36.00 37.00 Average per diem private room cost differential (line 3 x line 35) 0.00 36.00 37.00 Average per diem private room cost differential (line 3 x line		, ,	_	
Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27.00 PRIVATE ROOM DIFFERNTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average per diem private room per diem charge (line 30 + line 4)  30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private	25.00		0	25.00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  17, 154, 791 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00 Average private room per diem charge (line 29 + line 3)  33. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  34. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  47. 00 Qeneral (line 14 x line 35)  48. 616, 195 39. 00  40. 00		· ·		
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30.00 Average private room per diem charge (line 29 ÷ line 3)  30.00 Average semi-private room per diem charge (line 30 ÷ line 4)  30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17, 154, 791)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00 29.00 29.00  0 29.00 29.00  0 29.00  0 29.00  0 29.00  0 20.00  0 20.00  0 31.00  0 0.000000000000000000000000000000	26. 00	Total swing-bed cost (see instructions)	0	26. 00
28. 00 29. 00 29. 00 30. 00 30. 00 30. 00 30. 00 31. 00 32. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 39. 00 30	27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	17, 154, 791	27. 00
28. 00 29. 00 29. 00 30. 00 30. 00 30. 00 30. 00 31. 00 32. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 39. 00 30		PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		
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30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17, 154, 791) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0.00 000000 31.00 0 0.00 32.00 0 0.00 33.00 0 0.00 33.00 0 0.00 33.00 0 0.00 33.00 0 0.00 35.00 0 0.00 35.00 0 0.00 35.00 0 0.00 35.00 0 36.00 0 37.00 36.00 0 37.00 36.00 0 37.00 36.00 0 37.00 36.00 0 37.00 36.00 0 37.00 37.00 37.00 0 38.00 37.00 37.00 0 38.00 37.00 37.00 0 38.00 37.00 37.00 37.00 0 38.00 37.00 37.00 37.00 37.00 0 38.00 37.			-	
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17, 154, 791)  37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  37.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 00 00 00 00 00 00 00 00 00 00 00 00			-	
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17, 154, 791) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0.00 32.00 0 0.00 33.00 0 0.00 34.00 0 35.00 0 0.00 35.00 0 0.00 36.00 0 0 36.00 0 0 36.00 0 0 36.00 0 0 36.00 0 0 36.00 0 0 36.00 0 0 36.00 0 0 36.00 0 0 36.00 0 0 36.00 0 0 36.00 0 0 36.00 0 0 36.00 0 0 36.00 0 0 36.00 0 0 36.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17, 154, 791)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Wedically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 33.00  0.00 34.00  37.00 35.00  17, 154, 791  37.00  17, 154, 791  37.00  38.00  39.00 Program general inpatient routine service cost per diem (see instructions)  8, 616, 195  9.00 40.00				
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17, 154, 791)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  784.36 38.00  Program general inpatient routine service cost (line 9 x line 38)  8,616,195 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17, 154, 791) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 35.00 17, 154, 791 37.00 37.00 38.00 9 8, 616, 195 9 9 00 9 00 00 00 00 00 00 00 00 00 00 00 00 00	33. 00			
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17, 154, 791) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 35.00 17, 154, 791 37.00 37.00 38.00 9 8, 616, 195 9 9 00 9 00 00 00 00 00 00 00 00 00 00 00 00 00	34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17, 154, 791 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  784.36 38.00  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	35.00			
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  784.36 38.00  Program general inpatient routine service cost (line 9 x line 38)  8,616,195 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		, , ,	0	
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  784.36 38.00 Program general inpatient routine service cost (line 9 x line 38)  8,616,195 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00			17 154 791	
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  784.36 38.00 Program general inpatient routine service cost (line 9 x line 38)  8,616,195 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37.00		17, 154, 771	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  784.36 38.00  Program general inpatient routine service cost (line 9 x line 38)  8,616,195 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00				
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  784.36 38.00 Program general inpatient routine service cost (line 9 x line 38)  8,616,195 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00				
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  8,616,195 39.00 40.00				
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				
	39. 00	Program general inpatient routine service cost (line 9 x line 38)	8, 616, 195	39. 00
	40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	ol	40.00
, 5 5 , 7 , 7 , 7 , 7 , 7 , 7 , 7 , 7 ,			8, 616, 195	

	Financial Systems	TERRE HAUTE REGIO				eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der		Period: From 09/01/2015	Worksheet D-1	
					To 08/31/2016	Date/Time Pre	
			Ti tl	e XVIII	Hospi tal	1/25/2017 6: 24 PPS	4 piii
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	npatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	0	O	0.0	0 0	0	42. 00
43. 00	Intensive Care Type Inpatient Hospital Unit	4, 503, 084	3, 365	1, 338. 2	1 1, 767	2, 364, 617	43.00
44. 00	CORONARY CARE UNIT	4, 303, 004	3, 303	1, 330. 2	1,707	2, 304, 017	44. 00
45.00	BURN INTENSIVE CARE UNIT						45. 00
46. 00							46. 00
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
	<u> </u>					1. 00	
48. 00	Program inpatient ancillary service cost (W			,,,,,		17, 034, 280	
49.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(S	see instructio	ons)		28, 015, 092	49. 00
50.00	Pass through costs applicable to Program in	patient routine s	services (from	n Wkst. D, sum	of Parts I and	1, 240, 222	50.00
E1 00	Dags through seets applicable to Drogram in	notiont oncillor	, comilece (fr	om Wkot D o	um of Dosto II	004 022	F1 00
51. 00	Pass through costs applicable to Program in and IV)	patient anciliary	services (Tr	OM WKST. D, S	um or Parts II	994, 932	51.00
52. 00	Total Program excludable cost (sum of lines					2, 235, 154	52. 00
53. 00	Total Program inpatient operating cost excl		ated, non-phy	sician anesth	etist, and	25, 779, 938	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	54. 00
	Target amount per discharge					0.00	1
56. 00 57. 00							
58. 00							
59. 00	9.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						
60. 00							
61. 00	If line 53/54 is less than the lower of lin				the amount by	0.00	
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						
62 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)							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	instructions)(title XVIII only)	sts through becen	iber 31 of the	e cost reporti	ng period (see	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine co	sts after Decembe	er 31 of the c	ost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rout	ina costs (lina A	Mindus line A	5)(title XVII	l only) For	0	66. 00
00.00	CAH (see instructions)	The costs (The c	54 prus rine c	55)(title XVII	i oniy). Toi		00.00
67. 00	Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 c	of the cost re	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routi	ne costs after De	ecember 31 of	the cost repo	rting period	0	68. 00
00.00	(line 13 x line 20)	00010 4. 10. 50		3531 . 365	. cr.i.g por rod		00.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER Skilled nursing facility/other nursing faci						70. 00
71. 00	Adjusted general inpatient routine service	-					71. 00
72. 00	Program routine service cost (line 9 x line		(line 14 v li	no 25)			72.00
73. 00 74. 00	Medically necessary private room cost appli Total Program general inpatient routine ser						73.00
75. 00	Capital-related cost allocated to inpatient	•			art II, column		75. 00
7/ 00	26, line 45)	ino 2)					74 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ l Program capital-related costs (line 9 x lin						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 min	,					78. 00
79.00	Aggregate charges to beneficiaries for exce				us lino 70)		79.00
80.00	Total Program routine service costs for com Inpatient routine service cost per diem lim	•	ost iimitatior	ı (iine /8 min	us IIIIe /9)		80. 00 81. 00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82. 00	
83.00	Reasonable inpatient routine service costs	•	s)				83.00
84. 00 85. 00	Program inpatient ancillary services (see i Utilization review - physician compensation		15)				84. 00 85. 00
	Total Program inpatient operating costs (su						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PA	SS THROUGH COST					
87. 00 88. 00	Total observation bed days (see instruction Adjusted general inpatient routine cost per	•	line 2)			2, 589 784. 36	
	Observation bed cost (line 87 x line 88) (s	•	2)			2, 030, 708	
	,	,					•

Health Financial Systems	TERRE HAUTE REG	IONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 09/01/2015 To 08/31/2016	Date/Time Pre 1/25/2017 6:2	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	2, 060, 531	17, 154, 791	0. 12011	4 2, 030, 708	243, 916	90.00
91.00 Nursing School cost		17, 154, 791	0. 00000	2, 030, 708	0	91.00
92.00 Allied health cost		17, 154, 791	0. 00000	2, 030, 708	0	92.00
93.00 All other Medical Education		17, 154, 791	0. 00000	2, 030, 708	0	93.00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150046	Period: From 09/01/2015	Worksheet D-1
	Component CCN: 15SO46		
	Title XVIII	Subprovi der -	PPS

		TI LIE AVIII	I PF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			6, 404	1.00
2.00	Inpatient days (including private room days, excluding swing-be			6, 404	2.00
3. 00	Private room days (excluding swing-bed and observation bed days do not complete this line.	). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		6, 404	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room		31 of the cost	0	5. 00
	reporting period		11 -6 +1		
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after becember s	or the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private room	days) after December 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	the Program (excluding	swing-bed and	1, 426	9. 00
	newborn days)			.,	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instruction Swing-bed SNF type inpatient days applicable to title XVIII only		nom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enti-	er 0 on this line)	Join days) arter	٥	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00
10.00	through December 31 of the cost reporting period				12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar year			0	13. 00
14. 00	Medically necessary private room days applicable to the Program		, I	0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to services	through December 31 of	the cost	0.00	17. 00
17.00	reporting period	till odgir becelliber 31 of	the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of t	the cost	0.00	18. 00
10.00	reporting period			0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	inrough becember 31 of	the cost	0.00	19. 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	21 of the cost reporti	ng poriod (line	4, 387, 554 0	21. 00 22. 00
22.00	5 x line 17)	31 of the cost reporti	ng perrod (Trie	U	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3	l of the cost reporting	period (line 6	0	23. 00
0.4.00	x line 18)				04.00
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 10^{-5}$ x line 19)	31 of the cost reportir	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
	x line 20)				
26. 00	Total swing-bed cost (see instructions)	no 21 minuo lino 24)		0	
27. 00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ne 21 minus iine 20)		4, 387, 554	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3)	ine 28)		0. 000000 0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 minus	s line 33)(see instruct	i ons)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x line	31)		0.00	
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 and 27 minus line 36)	private room cost dif	rerential (line	4, 387, 554	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	MENTS			
38.00	Adjusted general inpatient routine service cost per diem (see i			685. 13	
39.00	Program general inpatient routine service cost (line 9 x line 3)			976, 995	
40. 00 41. 00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +	•		0 976, 995	40. 00 41. 00
55	1.2.2 25. dam gono. dapatt ont l'oditino doi vido dost (l'ille d') l		I	,,,,,,,,,	55

		ERRE HAUTE REGI		2011 150011		eu of Form CMS-2		
COMPUT	ATION OF INPATIENT OPERATING COST			F	Period: From 09/01/2015 Fo 08/31/2016	Worksheet D-1 Date/Time Pre		
			·	e XVIII	Subprovi der -	1/25/2017 6: 2 PPS		
					I PF			
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 - col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00	MUDCEDY (+; +l - V 0 VIV and a)	1.00	2. 00	3.00	4. 00	5. 00	42.00	
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0.00	0	0	42. 00	
43.00	INTENSIVE CARE UNIT	0	C	0.00	0	0		
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	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00	
40.00	Decree in the second control of the second c	-+ 0.21 2	11 200)			1. 00	40.00	
48. 00 49. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ons)		151, 081 1, 128, 076	1	
50.00	Pass through costs applicable to Program inpa	atient routine :	services (from	n Wkst. D, sum	of Parts I and	86, 687	50. 00	
51. 00	Pass through costs applicable to Program inpaged IVA	atient ancillar	y services (fr	om Wkst. D, su	ım of Parts II	8, 074	51. 00	
52. 00	and IV)  Total Program excludable cost (sum of lines!	50 and 51)				94, 761	52. 00	
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line !		lated, non-phy	ysician anesthe	etist, and	1, 033, 315	53. 00	
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00	
55.00	Target amount per discharge					0.00	•	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ng cost and ta	raet amount (I	ine 56 minus I	ine 53)	0 0		
58. 00	B. 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					0.00	•	
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target							61. 00	
amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions)							62. 00	
63.00 Allowable Inpatient cost plus incentive payment (see instructions)							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)	J		·		0	65. 00	
	instructions) (title XVIII only)							
66.00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)		•			0		
	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	-		•				
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)			,	ting period	0		
69.00	Total title V or XIX swing-bed NF inpatient of PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00	
70.00	Skilled nursing facility/other nursing facili	ty/ICF/IID rou	tine service d	cost (line 37)			70.00	
71. 00 72. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71. 00 72. 00	
73. 00	Medically necessary private room cost applica	able to Program	•	,			73. 00	
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient ( 26, line 45)	•			art II, column		74. 00 75. 00	
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00	
77. 00 78. 00							77. 00 78. 00	
79. 00							79. 00	
80.00	0.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00	
81. 00 82. 00							81. 00 82. 00	
83. 00	Reasonable inpatient routine service costs (	see instruction	•				83. 00	
84.00   Program inpatient ancillary services (see instructions) 85.00   Utilization review - physician compensation (see instructions)							84. 00 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)					l 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 T	ERRE HAUTE REC	ONAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der		Peri od:	Worksheet D-1	
c		Component	CCN: 15S046	From 09/01/2015 To 08/31/2016	Date/Time Pre 1/25/2017 6:2		
			Ti tl	e XVIII	Subprovi der -	PPS	
					I PF		
Cost Center Description	Cost	Rout	ine Cost	column 1 ÷	Total	Observati on	
		(from	line 21)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
	1. 00		2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST						
90.00 Capital -related cost	389, 31	5	4, 387, 554	0. 08873	2 0	0	90.00
91.00 Nursing School cost			4, 387, 554	0. 00000	0 0	0	91.00
92.00 Allied health cost		0	4, 387, 554	0. 00000	0 0	0	92.00
93.00 All other Medical Education		o	4, 387, 554	0. 00000	0	0	93. 00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	eu of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15004		Worksheet D-1
	Component CCN: 15TO	From 09/01/2015 To 08/31/2016	Date/Time Prepared: 1/25/2017 6:24 pm
	Title XVIII	Subprovi der -	PPS

DAME 1 - ALL PROVIDER COMPONENTS  1.00  INVESTIGATION  INVESTIGATI			Title XVIII	Subprovi der - I RF	PPS	
Inpatient days (including private room days and swing-bed days, excluding newborn)   1,827   1,00		Cost Center Description		1100	1.00	
IMPARTIENT DAYS   1.00   Impartient days (including private room days and swing-bed days, excluding newborn)   1.87   1.00   Impartient days (including private room days, excluding swing-bed and observation bed days)   1.90		PART I - ALL PROVIDER COMPONENTS			1. 00	
1,827   2.00   Inipatient days (including private room days, excluding swing-bed and newborn days)   1,827   2.00   2.0						
Private room days (excluding swing-bed and observation bed days)  4.00 Seel -private room days (excluding swing-bed and observation bed days)  5.00 reporting refronced by Sex (excluding swing-bed and observation bed days)  6.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (in Calledard year, enter 0 on this line)  7.00 Iotal swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (in Calledard year, enter 0 on this line)  9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (in Calledard year, enter 0 on this line)  10.00 Swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (in Calledard year, enter 0 on this line)  10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and individual year)  10.00 Swing-bed SNF type inpatient days applicable to the program (excluding swing-bed and individual year)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  13.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  14.00 Medically necessary private room days applica						
do not complete this line.  4. 00 Semi-private room days (excluding saing-bed and observation bed days) frough December 31 of the cost of 1011 saing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. 00 Total Impatient days line and the system of the cost reporting period (if calendar year, enter 0 on this line)  7. 00 Total Impatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8. 00 Total Impatient days including private room days) applicable to the Program (excluding swing-bed and newton days)  9. 00 Swing-bed SNF type inpatient days applicable to it it it XVIII only (including private room days) after December 31 of the cost reporting period (see instruction this line)  10. 00 Swing-bed SNF type inpatient days applicable to it it it it XVIII only (including private room days) after December 31 of the cost reporting period (see instruction)  12. 00 Swing-bed NF type inpatient days applicable to it it it is VIII only (including private room days)  13. 00 Swing-bed NF type inpatient days applicable to it it is VIII only (including private room days)  14. 00 Swing-bed NF type inpatient days applicable to it it is VIII only (including private room days)  15. 00 Swing-bed NF type inpatient days applicable to it it is VIII only (including private room days)  16. 00 Swing-bed NF type inpatient days applicable to services through December 31 of the cost reporting bed NF type inpatient days applicable to services through December 31 of the cost reporting period (including private room days)  17. 00 Swing-bed NF type inp				ivato room days		
Total 'swing-bed SNE' type inpatient days' (including private room days) after December 31 of the cost open comporting period (if calendar year, enter 0 on this line)  Total 'swing-bed NE' type inpatient days' (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total 'swing-bed NE' type inpatient days' (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total 'inpatient days' including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total 'inpatient days' including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Swing-bed SNE' type inpatient days applicable to the Program (excluding swing-bed and newborn days)  Swing-bed SNE' type inpatient days applicable to the title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Swing-bed SNE' type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Swing-bed SNE' type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Swing-bed SNE' type inpatient days applicable to titles V or XIX only (including private room days) at through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Swing-bed SNE' type inpatient days applicable to titles V or XIX only (including private room days)  Total nursery days (title V or XIX only)  SNE SED ADJUSTNENT  On Medicar rate for swing-bed SNE services applicable to services through December 31 of the cost reporting period (including swing-bed snew patients)  Medical days are applicable to SNE' type services applicable to services after December 31 of the	3.00		7. IT you have only pr	I vate 100m days,	O	3.00
reporting period (if callendar year, enter 0 on this line) 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.0						
6.00         Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)         7.00           7.00         Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)         0           8.00         Total inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)         0           9.00         Total inpatient days including private room days applicable to the Program (excluding swing-bed and neeborn days)         0           10.00         Swing-bed SNF type inpatient days applicable to title XVII only (including private room days)         0           11.00         Swing-bed SNF type inpatient days applicable to title XVII only (including private room days) after through becember 31 of the cost reporting period (if calendar year, enter 0 on this line)         0           12.00         Swing-bed MF type inpatient days applicable to titles V or XIX only (including private room days) after through becember 31 of the cost reporting period (if calendar year, enter 0 on this line)         0           13.00         Swing-bed MF type inpatient days applicable to titles V or XIX only (including private room days)         0         1           14.00         Buckery days (intitle V or XIX only (including private room days)         0         1         0           15.00         December 31 of the cost report	5. 00		days) through Decembe	r 31 of the cost	0	5. 00
reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed NF type inpatient days (including private room days) shrough December 31 of the cost proporting period (if calendar year, enter 0 on this line) 9. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost newborn days) including private room days) swing-bed and newborn days) including private room days papil cable to the Program (excluding swing-bed and newborn days) including private room days) including private room days) on through December 31 of the cost reporting period (if calendar year, enter 0 on this line) on the period private room days applicable to title XVIII only (including private room days) on 11.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) on 12.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) on 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) on 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) on 12.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) on 14.00 Medically necessary days (title V or XIX only) on 15.00 Swing-bed Cost applicable to Swing-bed Swing-bed cost reporting period (line 6 Swing-bed Cost applicable to Swing-bed Charges) On 20.00 Swing-bed Cost applicable to Ftype services af	6. 00		davs) after December	31 of the cost	0	6. 00
reporting period  8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 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 newborn days)  10. 00 Swing-bed SMb type inpatient days applicable to title XVIII only (including private room days)  11. 00 Swing-bed SMb type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) applicable to services after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) applicable to services after December 31 of the cost reporting period (including private room days) applicable to services after December 31 of the cost reporting period (including private room days) applicable to SW services after December 31 of the cost reporting period (line 6 x 1) including private room days applicable to SW services after December 31 of the cost reporting period (line 6 x 1) including private room days applicabl		reporting period (if calendar year, enter 0 on this line)	3 ,			
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar yeap; enter 0 on this line)	7. 00		days) through December	31 of the cost	0	7. 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 newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 12.00 Swing-bed NF type inpatient days applicable to title X or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to title X or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to title X or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to title X or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title Y or XIX only) 16.00 Narsery days (title Y or XIX only) 17.00 Narsery days (title Y or XIX only) 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medical d rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medical d rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medical d rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medical day applicable to SNF type services through December 31 of the cost reporting period (line 6 SNF type services through December 31 of the cost reporting period	8. 00	1	davs) after December 3	1 of the cost	0	8. 00
newborn days)  10.00 Sating-bed SNF type inpatient days applicable to title XVIII only (including private room days)  10.00 Sing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions)  12.00 Sing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  13.00 Sing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Sing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  15.00 Sing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  16.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  16.00 Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost or eporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost or eporting period  19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost or eporting period  19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost or eporting period  20.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost or eporting period (line 6 or eporting period (line 6 or eporting period (line 6 or eporting period (line 6 or eporting period (line 6 or eporting period (line 6 or eporting period (line 6 or eporting period (line 6 or eporting period (line 6 or eporting period (line 6 or eporting period (line 6 or eporting period (line 6 or eporting period (line 6 or eporting period (line 8 or eporting eporting eporting epopting epopti		reporting period (if calendar year, enter 0 on this line)				
10.00   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)   10.00   through December 31 of the cost reporting period (See instructions)   11.00   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after   12.00   Swing-bed NF type inpatient days applicable to title XVIII only (including private room days)   0   12.00   through December 31 of the cost reporting period (if calendar year, enter 0 on this line)   13.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   0   13.00   after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   15.00   Total nursery days (title V or XIX only)   0   15.00   Total nursery days (title V or XIX only)   0   15.00   Total nursery days (title V or XIX only)   0   16.00   SWING BED ADJUSTMENT   17.00   Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost   0.00   17.00   Total cost reporting period   17.00   Total cost	9. 00		the Program (excluding	swing-bed and	1, 143	9. 00
through December 31 of the cost reporting period (see instructions)  1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.01 Obsense 11 of the cost reporting period (if calendar year, enter 0 on this line)  1.02 Obsense 12 of the cost reporting period (if calendar year, enter 0 on this line)  1.03 Obsense 13 of the cost reporting period (if calendar year, enter 0 on this line)  1.04 Obsense 14 Obsense 15 of the cost reporting period (if calendar year, enter 0 on this line)  1.05 Obsense 15 Obsens	10. 00		v (including private r	oom days)	0	10. 00
December 31 of the cost reporting period (if cal endar year, enter 0 on this line)   12.00		through December 31 of the cost reporting period (see instruction	ons)	,		
12.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   0   12.00	11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only	y (including private r	oom days) after	0	11. 00
through December 31 of the cost reporting period after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  13.00 Swing-bed NT type inpatient days applicable to titles V or XIX only (including private room days)	12. 00			e room days)	0	12. 00
after December'31 of the cost reporting period (if calendar year, enter 0 on this line)  14. 00  15. 00  16. 10  16. 00  17. 00  18. 00  18. 00  18. 00  19. 0		through December 31 of the cost reporting period	3 ( 3 )	,		
14.00   Modically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   0   15.00   10.00   Nursery days (title V or XIX only)   0   15.00   15.00   15.00   Nursery days (title V or XIX only)   0   15.00   15.00   Nursery days (title V or XIX only)   15.00	13. 00				0	13. 00
15.00   Total nursery days (title V or XIX only)   0   15.00   16.00	14. 00				0	14. 00
SWING BED ADJUSTNENT  17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting period reporting period services after December 31 of the cost reporting period services after December 31 of the cost reporting period services applicable to services through December 31 of the cost reporting period services applicable to services through December 31 of the cost reporting period services applicable to services after December 31 of the cost reporting period services applicable to services after December 31 of the cost reporting period services applicable to services after December 31 of the cost reporting period services applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) sung-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) sung-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) sung-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19) sung-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19) sung-bed cost sung-bed cost sung-bed cost sung-bed cost sung-bed cost sung-bed cost sung-bed cost (see instructions) sung-bed cost sung-bed cost (see instructions) sung-bed cost (see instructions) sung-bed cost (see instructions) sung-bed cost (see instructions) sung-bed cost (see instructions) sung-bed cost (see instructions) sung-bed cost (see instructions) sung-bed cost (see instructions) sung-bed cost (see instructions) sung-bed cost (see instructions) sung-bed cost (see instructions) sung-bed charges) sung-bed charges) sung-bed charges) sung-bed charges) sung-bed charges) sung-bed charges) sung-bed charges sung-bed charges sung-bed charges sung-bed charges sung-bed charges sung-bed charges sung-bed charges sung-bed sung-bed sung-bed sung-bed sung-bed sung-bed sung-bed sung-bed sung-bed su					-	
17.00   Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost   0.00   17.00   18.00   18.00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost   0.00   18.00   19.0	16. 00				0	16. 00
reporting period  18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  20. 00 Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20. 00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21. 00 Total general inpatient routine service cost (see instructions)  22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  25. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 19)  26. 00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 General inpatient routine service cost net of swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  29. 00 Private room charges (excluding swing-bed charges)  20. 00 Oceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 28)  20. 00 Oceneral inpatient routine service cost (cline 22 minus line 28)  20. 00 Oceneral inpatient routine service cost charges (excluding swing-bed charges)  20. 00 Oceneral inpatient routine service cost charges (line 29 + line 3)  20. 00 Oceneral inpatient routine service cost cost period cost and private room cost differential (line 3 x line 4)  20. 00 Oceneral inpatient routine service cost period cost and private room cost differential (line 3 x line 31)  20. 00 Oceneral inpatient routine service cost period cost and private room cost differential (line 3 x line 31)  20. 00 Oc	17. 00		through December 31 o	f the cost	0.00	17. 00
reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions) 22.103 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 2 23.00 x line 18)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 2 24.00 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service cost generals (sculuding swing-bed and observation bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average period demonstrate for swing-bed cost (line 27 + line 28)  30.00 Average perivate room per diem charge (line 29 + line 3)  31.00 General inpatient routine service cost reporting period (line 2 minus line 23)  32.00 Average peridem private room cost differential (line 32 minus line 33) (see instructions)  33.00 Average peridem private room cost differential (line 34 x line 31)  34.00 Average peridem private room cost differential (line 34 x line 31)  35.00 Average peridem private room cost differential (line 34 x line 31)  36.00 Private room cost differential (line 34 x line 35)  37.00 Proyram general inpatient routine service cost per diem (see instructions)  38.00 Averag						
19.00   Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period   20.00   Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period   2, 137, 565   21.00   20.0	18. 00		after December 31 of	the cost	0.00	18. 00
20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 7 Total general inpatient routine service cost (see instructions) 2.100 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 18) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 20 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 2, 137, 565 27.00 PRI VATE ROOM DIFFERENTIAL ADUSTIMENT 200 20 Pri vate room charges (excluding swing-bed charges) 29.00 2	19. 00		through December 31 of	the cost	0. 00	19. 00
reporting period Total general inpatient routine service cost (see instructions)  2, 137,565  21, 00  22, 00  22, 137,565  21, 00  22, 00  23, 00  24, 00  25, 11ne 17)  24, 00  25, 00  24, 00  25, 00  26, 00  27, 00  27, 00  28, 00  29, 00  20, 00  20, 00  20, 00  20, 00  21, 10  24, 00  25, 00  26, 00  27, 00  27, 00  28, 00  29, 00  29, 00  20, 0	20.00		after December 21 of t	ho cost	0.00	20.00
22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27. 00 FRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Frivate room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charges ratio (line 27 ÷ line 28)  30. 00 Average private room per diem charge (line 29 ÷ line 3)  30. 00 Average per viate room per diem charge (line 30 ÷ line 4)  30. 00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  30. 00 Average per diem private room cost differential (line 32 minus line 33)  30. 00 Private room cost differential adjustment (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 32 minus line 33)  30. 00 Private room cost differential adjustment (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 32 minus line 36)  30. 00 Private room cost differential cost neckletal (line 32 minus line 36)  30. 00 Program general inpatient routine service cost per diem (see instructions)  30. 01 Average per diem private room cost differential (line 32 minus line 34)  30. 01 Average per diem private room cost differential (line 32 minus line 35)  30. 01 Average per diem private room cost differential (line 34 minus 4)  30. 02 Average per diem private room cost differential (line 34 minus 4)  30. 01 Average per diem private room cost differential (lin	20.00		arter becember 31 or t	THE COST	0.00	20.00
5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 v line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 line 20)  26.00 Total swing-bed cost (see instructions)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 * line 28)  32.00 Average private room per diem charge (line 29 * line 3)  33.00 Average semi-private room per diem charge (line 30 * line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 32 minus line 33)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost reto of swing-bed cost and private room cost differential (line 2, 137, 565)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)			24 6 11			
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 X line 19)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 137, 565)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 37 minus line 36)  30.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  31.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	22. 00		31 of the cost report	ing period (line	0	22.00
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7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 vine 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  34.00 Average per diem private room cost differential (line 32 minus line 33)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 137, 565)  37.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	24.00	1	21 of the cost reporti	ng poriod (Lino	0	24 00
x line 20)  26. 00  Total swing-bed cost (see instructions)  27. 00  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00  29. 00  Private room charges (excluding swing-bed and observation bed charges)  30. 00  Semi-private room charges (excluding swing-bed charges)  31. 00  General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00  Average private room per diem charge (line 29 ÷ line 3)  33. 00  Average semi-private room per diem charge (line 30 ÷ line 4)  Average per diem private room cost differential (line 34 x line 33)  Average per diem private room cost differential (line 34 x line 31)  35. 00  Average per diem private room cost differential (line 34 x line 35)  Average inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 137, 565)  Adjusted general inpatient routine service cost per diem (see instructions)  38. 00  Adjusted general inpatient routine service cost per diem (see instructions)  1, 169. 99  38. 00  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 26. 00  2, 137, 565  2, 700  26. 00  2, 137, 565  2, 700  2, 137, 565  2, 700  2, 137, 565  2, 700  2, 137, 565  2, 700  2, 137, 565  2, 700  2, 137, 565  2, 700  2, 137, 565  2, 700  2, 137, 565  2, 700  2, 137, 565  2, 700  2, 137, 565  2, 700  2, 137, 565  2, 700  2, 137, 565  2, 700  2, 137, 565  2, 700  2, 137, 565  2, 700  2, 137, 565  2, 700  2, 137, 565  2, 700  2, 100	24.00		or the cost reporti	ing perrod (Trile	O	24.00
26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRI VATE ROOM DIFFERNTI AL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Pri vate room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average pri vate room per diem charge (line 29 + line 3)  30.00 Average semi-private room per diem charge (line 30 + line 4)  30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem	25. 00		of the cost reporting	period (line 8	0	25. 00
27. 00  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00  General inpatient routine service charges (excluding swing-bed and observation bed charges)  9. 00  Private room charges (excluding swing-bed charges)  30. 00  Semi-private room charges (excluding swing-bed charges)  31. 00  General inpatient routine service cost/charge ratio (line 27 ± line 28)  32. 00  Average private room per diem charge (line 29 ± line 3)  33. 00  Average semi-private room per diem charge (line 30 ± line 4)  Average per diem private room charge differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  35. 00  Average per diem private room cost differential (line 34 x line 35)  Private room cost differential adjustment (line 3 x line 35)  This inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 ± line 28)  Adjusted general inpatient routine service cost per diem (see instructions)  1, 169.99  38. 00  Adjusted general inpatient routine service cost per diem (see instructions)  1, 169.99  38. 00  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00  40.00	26. 00	1			0	26. 00
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30.00 Average private room per diem charge (line 29 ÷ line 3)  30.00 Average semi-private room per diem charge (line 30 ÷ line 4)  30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 2, 137, 565)  30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 2, 137, 565)  30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 2, 137, 565)  30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 2, 137, 565)  30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 2, 137, 565)  30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 2, 137, 565)  30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 2, 137, 565)  30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 2, 137, 565)  30.00 Average per diem private room		General inpatient routine service cost net of swing-bed cost (II	ne 21 minus line 26)			
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 32.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 137, 565) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 30.00 30.00 30.00 30.00 30.00 32.	20.00				0	20.00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 137, 565) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			and observation bed cn	arges)		
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33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 137, 565)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		, ,	ine 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 137, 565)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 137, 565 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			s lino 22)(soo instruc	tions)		
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 137, 565 37.00 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  79.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 36.00 36.00 37.			, ,	ti ons)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 137, 565 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00 2, 137, 565 2, 137, 565 2, 137			01)		0.00	
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00			d private room cost di	fferential (line	2. 137. 565	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 169.99 38.00 Program general inpatient routine service cost (line 9 x line 38)  1, 337, 299 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	200	27 minus line 36)			_,,	200
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 169.99 39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  1, 169.99 39.00 40.00			TMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,337,299 39.00 40.00	38 NO				1 160 00	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			•			
41.00   Total Program general inpatient routine service cost (line 39 + line 40)   1,337,299   41.00	40.00	Medically necessary private room cost applicable to the Program	(line 14 x line 35)		0	40.00
	41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		1, 337, 299	41. 00

	<u> </u>	ERRE HAUTE REGION				u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCI Component CC	Fr	riod: om 09/01/2015 08/31/2016	Worksheet D-1 Date/Time Pre	narod:
			Ti tl e X		Subprovi der -	1/25/2017 6: 2	
					I RF		
	Cost Center Description	Total Inpatient CostIn		verage Per em (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	<u> </u>	<u> </u>	0.00	0	0	42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0	0.00	0	0	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
40.00	Drogram i proti est escillary corrigo cost (Wk	n+ D 2 and 2	Lina 200)			1. 00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			)		871, 606 2, 208, 905	
50.00	Pass through costs applicable to Program inp	atient routine se	rvices (from Wk	kst. D, sum o	f Parts I and	209, 752	50. 00
51. 00	Pass through costs applicable to Program inp	atient ancillary	services (from	Wkst. D, sum	of Parts II	103, 088	51. 00
52. 00	and IV)  Total Program excludable cost (sum of lines	50 and 51)				312, 840	52. 00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ted, non-physic	cian anesthet	ist, and	1, 896, 065	53. 00
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00	Target amount per discharge					0.00	55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and targ	et amount (line	s 56 minus li	ne 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ing cost and targ	et amount (Tine	2 30 minus 11	110 33)	0	58. 00
59. 00	2.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the						
60.00	market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60. 00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						0	61. 00
62. 00	amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions)						62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instruct	i ons)			0 0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decemb	er 31 of the co	ost reporting	period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after December	31 of the cost	t reporting p	eriod (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	plus line 65)(	(title XVIII	only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through D	ecember 31 of t	the cost repo	rting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin- (line 13 x line 20)	e costs after Dec	ember 31 of the	e cost report	ing period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						70. 00
71. 00	Adjusted general inpatient routine service c	1	e 70 ÷ line 2)	,			71. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	•	line 14 x line	35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv						74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)		osts (from Work	ksheet B, Par	t II, column		75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	. *					76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu	,					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp.			ine 78 minus	line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi	tati on		, 5 , 111 1143	,,		81. 00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (						82. 00 83. 00
84. 00	Program inpatient ancillary services (see in	· · · · · · · · · · · · · · · · · · ·					83.00
85. 00	Utilization review - physician compensation	(see instructions					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ugh 85)				86. 00
87. 00	Total observation bed days (see instructions	)				0	87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se		ine 2)				88. 00 89. 00
07.00	Tobact various bed cost (Time of A Time oo) (Se	o matructions)			ı	O	07.00

Health Financial Systems T	ERRE HAUTE F	REGI ONAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der		Peri od:	Worksheet D-1	
			Component	CCN: 15T046	From 09/01/2015 To 08/31/2016	Date/Time Pre 1/25/2017 6:2	
			Ti tl	e XVIII	Subprovider -	PPS	
					I RF	1	
Cost Center Description	Cost	Rou	tine Cost	column 1 ÷	Total	Observati on	
		(fro	m 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	335,	277	2, 137, 565	0. 15685	0	0	90.00
91.00 Nursing School cost		0	2, 137, 565	0. 00000	0 0	0	91.00
92.00 Allied health cost		0	2, 137, 565	0. 00000	0 0	0	92.00
93.00 All other Medical Education		0	2, 137, 565	0. 00000	0	0	93. 00

	Financial Systems	TERRE HAUTE REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CCN: 150046	Peri od: From 09/01/2015	Worksheet D-1	
				To 08/31/2016	Date/Time Pre 1/25/2017 6:2	pared:
			Title XIX	Hospi tal	Cost	piii
	Cost Center Description					
	PART I - ALL PROVIDER COMPONENTS				1. 00	
	INPATIENT DAYS					
1.00	Inpatient days (including private room days				21, 871	
2. 00 3. 00	Inpatient days (including private room days Private room days (excluding swing-bed and			ivato room days	21, 871 0	2. 00 3. 00
3.00	do not complete this line.	observation bed days	). If you have only pr	I vate 100iii days,	O	3.00
4.00	Semi-private room days (excluding swing-bed				19, 282	4. 00
5.00	Total swing-bed SNF type inpatient days (in	ncluding private room	days) through Decembe	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (in	ncluding private room	days) after December	31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter		days) arter becomber	or or the cost	ŭ	0.00
7. 00	Total swing-bed NF type inpatient days (in	cluding private room	days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (inc	cluding private room	days) after Necember 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter (		days) arter becember 5	To the cost	O	0.00
9. 00	Total inpatient days including private room		the Program (excluding	swing-bed and	1, 179	9. 00
10. 00	newborn days)	lo to titlo VVIII onl	v (i polydina privoto m	voom dovo)	0	10.00
10.00	Swing-bed SNF type inpatient days applicable through December 31 of the cost reporting			oom days)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable			oom days) after	0	11. 00
	December 31 of the cost reporting period (					40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12. 00	
13. 00	, , ,				0	13. 00
	after December 31 of the cost reporting per	riod (if calendar yea	r, enter O on this lin	e)		
14.00	Medically necessary private room days appli	icable to the Program	(excluding swing-bed	days)	0 563	
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)				0	
	SWI NG BED ADJUSTMENT					
17. 00	Medicare rate for swing-bed SNF services a	oplicable to services	through December 31 o	f the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services a	nnlicable to services	after December 31 of	the cost	0.00	18. 00
10.00	reporting period	opin cable to services	arter becomber 51 01	the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services app	plicable to services	through December 31 of	the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services app	nlicable to services	after December 31 of t	he cost	0.00	20.00
20.00	reporting period	pricable to services	arter becember 31 or t	THE COST	0.00	20.00
21. 00	Total general inpatient routine service cos				17, 131, 414	21. 00
22. 00	Swing-bed cost applicable to SNF type servi	ices through December	31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type servi	ices after December 3	1 of the cost reportin	a period (line 6	0	23. 00
20.00	x line 18)	rees arter becomber o	Tot the cost reportin	g period (iiie o	Ü	20.00
24. 00	Swing-bed cost applicable to NF type servi	ces through December	31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type servio	cos after December 21	of the cost reporting	ported (line 9	0	25. 00
25.00	x line 20)	ces ai tei beceiibei 31	of the cost reporting	perrou (Trile 8	O	25.00
26. 00	Total swing-bed cost (see instructions)				0	26. 00
27. 00	General inpatient routine service cost net	of swing-bed cost (I	ine 21 minus line 26)		17, 131, 414	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges	(excluding swing-hed	and observation had ob	arnes)	0	28. 00
29. 00	Private room charges (excluding swing-bed		ana observation bed en	ui gos)	0	29.00
30. 00	Semi-private room charges (excluding swing	-bed charges)			0	30. 00
31.00	General inpatient routine service cost/char		line 28)		0. 000000	
32.00	Average private room per diem charge (line Average semi-private room per diem charge				0.00	32. 00 33. 00

18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
10.00	reporting period	0.00	18.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
	reporting period		
20.00	Medical d rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	17, 131, 414	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
23. 00	5 x line 17) Swing had cost applicable to SNE type corvices after December 21 of the cost reporting period (line 4)	0	23. 00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	١	23.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
21.00	To x i ine 19)	ĭ	21.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	o	25. 00
	x line 20)		
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	17, 131, 414	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)	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)		32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)		33. 00
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		34.00
35. 00	Average per diem private room cost differential (line 34 x line 31)		
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	17, 131, 414	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	783. 29	38. 00
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)		
39. 00	, , , , , , , , , , , , , , , , , , , ,	923, 499	
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0 923, 499	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	923, 499	41.00

	Financial Systems TATION OF INPATIENT OPERATING COST	TERRE HAUTE REGI		CCN: 150046	In Lie Period:	w of Form CMS Worksheet D-	
COMI O	ATTOM OF THE ATTEMPORE OF ENATING COST		l i ovi dei	130040	From 09/01/2015		
					To 08/31/2016	Date/Time Pr 1/25/2017 6:	
				le XIX	Hospi tal	Cost	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col	
		Inpatient Cost	impatrent bays	col. 2)	<del>-</del>	4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	416, 222	563	739. 2	29 0		0 42.00
43. 00	Intensive Care Type Inpatient Hospital Unit INTENSIVE CARE UNIT	4, 503, 084	3, 365	1, 338. 2	21 0		0 43.00
44. 00	CORONARY CARE UNIT	4, 503, 084	3, 300	1, 330. 2		'	44.00
45. 00	1						45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (W	Vkst. D-3, col. 3	. line 200)			6, 057, 74	6 48.00
	Total Program inpatient costs (sum of lines			ns)		6, 981, 24	
	PASS THROUGH COST ADJUSTMENTS						
50. 00	Pass through costs applicable to Program in	npatient routine	services (from	ı Wkst. D, sum	of Parts I and	'	0 50.00
51. 00		nnatient ancillar	v services (fr	om Wkst D s	um of Parts II		51.00
01.00	and IV)	patront anorrrar	y services (ii	om wkot. b, c	idiii or Turto II		01.00
52. 00	Total Program excludable cost (sum of lines						52.00
53. 00	Total Program inpatient operating cost excl		lated, non-phy	sician anesth	etist, and	(	0 53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00	Program discharges						54.00
55. 00	Target amount per discharge					0.00	0 55.00
56. 00	,				==>		0 56.00
57. 00 58. 00	Difference between adjusted inpatient opera Bonus payment (see instructions)	iting cost and ta	rget amount (I	ine 56 minus	line 53)		0 57.00 0 58.00
59. 00	Lesser of lines 53/54 or 55 from the cost r	reporting period	endina 1996 u	indated and co	mpounded by the		0 59.00
07.00	market basket	oper tring period	onaring 1770, a	paaroa ana oc	podilaod by the	0.0	07.00
60.00	Lesser of lines 53/54 or 55 from prior year						0 60.00
61. 00						'	0 61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						
62.00 Relief payment (see instructions)					(	0 62.00	
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						(	0 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							0 (4 00
64. 00	instructions)(title XVIII only)	ists through bece	iliber 31 of the	cost reporti	ng period (see	'	0 64.00
65. 00	Medicare swing-bed SNF inpatient routine co	sts after Decemb	er 31 of the c	ost reporting	period (See		0 65.00
	instructions)(title XVIII only)			=> <			
66. 00	Total Medicare swing-bed SNF inpatient rout CAH (see instructions)	ine costs (line	64 plus line 6	5)(title XVII	I only). For	'	0 66.00
67. 00	Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 c	of the cost re	portina period		67. 00
	(line 12 x line 19)	9					
68. 00	Title V or XIX swing-bed NF inpatient routi	ne costs after D	ecember 31 of	the cost repo	orting period	(	0 68. 00
69 00	(line 13 x line 20)  Total title V or XLX swing-bed NF inpatient	routine costs (	line 67 ± line	68)			69.00
27. 00	PART III - SKILLED NURSING FACILITY, OTHER						<u> </u>
70. 00	Skilled nursing facility/other nursing faci	lity/ICF/IID rou	tine service c	ost (line 37)			70. 00
71.00	Adjusted general inpatient routine service		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost appli		(line 14 v li	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine ser						74.00
75. 00	Capital -related cost allocated to inpatient	•			art II, column		75. 00
<b>7</b> , 00	26, line 45)						7, 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ l Program capital-related costs (line 9 x lin	. *					76. 00 77. 00
78.00	,						78.00
79. 00	Aggregate charges to beneficiaries for exce	ess costs (from p	rovi der record	ls)			79. 00
	Total Program routine service costs for com	•	ost limitation	(line 78 mir	us line 79)		80.00
81.00	Inpatient routine service cost per diem lim		`				81.00
82. 00 83. 00	Inpatient routine service cost limitation (Reasonable inpatient routine service costs	•	* .				82. 00 83. 00
84. 00	Program inpatient ancillary services (see i	•	<u>-,</u>				84. 00
85. 00	Utilization review - physician compensation	n (see instruction					85. 00
86. 00			rough 85)				86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PA Total observation bed days (see instruction					2, 58	9 87. 00
87 00							
87. 00 88. 00	,		line 2)				9 88.00

Health Financial Systems T	ERRE HAUTE REG	IONAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 09/01/2015 To 08/31/2016	Date/Time Pre 1/25/2017 6:2	
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	2, 060, 531	17, 131, 414	0. 12027	8 2, 027, 938	243, 916	90. 00
91.00 Nursing School cost	0	17, 131, 414	0.00000	0 2, 027, 938	0	91.00
92.00 Allied health cost	0	17, 131, 414	0.00000	0 2, 027, 938	0	92.00
93.00 All other Medical Education	0	17, 131, 414	0. 00000	0 2, 027, 938	0	93. 00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150046	Peri od: From 09/01/2015	Worksheet D-1
	Component CCN: 15SO46	To 08/31/2016	Date/Time Prepared: 1/25/2017 6:24 pm
	Title XIX	Subprovi der -	Cost

		II tie xix	I PF	COST	
	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,			6, 404	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed Private room days (excluding swing-bed and observation bed days			6, 404	2. 00
3. 00	do not complete this line.	i. II you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		6, 404	4.00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December 3	21 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becember a	of the cost	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room of	days) through December	31 of the cost	0	7. 00
0 00	reporting period Total swing-bed NF type inpatient days (including private room o	lava) aftan Dagamban 21	l of the cost	0	0.00
8. 00	reporting period (if calendar year, enter 0 on this line)	ays) arter becember 31	i or the cost	U	8. 00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	2, 903	9. 00
10.00	newborn days)	. (!!!!!+		0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instruction		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only	(including private ro	oom days) after	0	11.00
10.00	December 31 of the cost reporting period (if calendar year, ent				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX of through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX (	only (including private	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year	-	, I		
14. 00 15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed o	days)	0 563	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 of	f the cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of t	the cost	0. 00	18. 00
	reporting period				
19. 00	Medicald rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0. 00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services a	after December 31 of th	ne cost	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	31 of the cost reporti	ng period (line	4, 387, 554 0	21. 00 22. 00
22.00	5 x line 17)	31 of the cost reporti	ng perrou (Trie	O	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3	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:	21 of the cost reportin	ng ported (Line	0	24. 00
24.00	7 x line 19)	or the cost reporting	ig perrou (irrie	O	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting $% \begin{center} cen$	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 (li	ne 21 minus line 26)		4, 387, 554	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed a	and observation bed cha	arges)	0	28. 00 29. 00
30.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ 1	ine 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 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 minus	c lino 22)(soo instruct	tions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line	, ,	11 0115)	0.00	
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 and	d private room cost dif	ferential (line	4, 387, 554	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	MENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i	nstructi ons)		685. 13	
39. 00	Program general inpatient routine service cost (line 9 x line 3)	•		1, 988, 932	
40. 00 41. 00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +	•		0 1, 988, 932	40. 00 41. 00
00	1.22. 1.23. dail gollo. d. 1.1.pd. 1.3.1. 1.0d. 1110 301 1100 3031 (11110 37 1		1	., 700, 702	00

		ERRE HAUTE REGION				u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCI Component CC	Fr	riod: om 09/01/2015 08/31/2016	Worksheet D-1 Date/Time Pre	pared:
			Title		Subprovi der -	1/25/2017 6: 2 Cost	
	Cost Center Description	Total		verage Per	IPF Program Days	Program Cost	
	cost center bescription	Inpatient Cost Inp			Trogram bays	(col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00	42.00
42.00	Intensive Care Type Inpatient Hospital Units	O O	Ol .	0.00	O <sub>I</sub>	0	42.00
43.00	INTENSIVE CARE UNIT	0	0	0. 00	0	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	1						46. 00
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
	·					1. 00	
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			)		669, 565 2, 658, 497	48. 00 49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inp.	atient routine se	rvices (from Wk	kst. D, sum o	f Parts I and	0	50. 00
51. 00		atient ancillary:	services (from	Wkst. D, sum	of Parts II	0	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	,		,		0	52. 00
53. 00	Total Program inpatient operating cost exclu	ding capital rela	ted, non-physic	cian anesthet	ist, and	0	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	
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 operat	ing cost and targ	et amount (line	e 56 minus li	ne 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting ported on	ding 1006 unds	ated and comm	ounded by the	0 0. 00	58. 00 59. 00
37.00	market basket	oor tring period em	urng 1770, upus	area ana comp	ounded by the	0.00	37.00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				e amount by	0.00	60. 00 61. 00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		(lines 54 x 60)	), or 1% of t	he target		
62.00	Relief payment (see instructions)		:>			0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mstruct	1 0115)			0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decemb	er 31 of the co	ost reporting	period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after December	31 of the cost	t reporting p	eriod (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 64	plus line 65)(	(title XVIII	only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through D	ecember 31 of t	the cost repo	rting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after Dec	ember 31 of the	e cost report	ing period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						70. 00
71.00	Adjusted general inpatient routine service c	ost per diem (line		,			71. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	•	line 14 x line	35)			72. 00 73. 00
74.00	Total Program general inpatient routine serv	ce costs (line 7	2 + line 73)	•			74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)		osts (from Work	ksheet B, Par	t II, column		75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78.00	Inpatient routine service cost (line 74 minu	,	ui dan naganda)				78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp			ine 78 minus	line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi	tati on	`		·		81. 00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (	,					82. 00 83. 00
84. 00	Program inpatient ancillary services (see in	structions)					84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	ug.1 00 <i>)</i>				
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		ine 2)			0 00	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (se		2)				89. 00

Heal th Fi	nancial Systems T	ERRE HAUTE REC	SI ONAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTAT	ION OF INPATIENT OPERATING COST			Provi der		Peri od:	Worksheet D-1	
						From 09/01/2015	D 1 (T' D	
				Component	CCN: 15S046	To 08/31/2016	Date/Time Pre	
				Ti t	le XIX	Subprovi der -	Cost	+ piii
					I C XIX	I PF	0031	
	Cost Center Description	Cost	Rout	ine Cost	column 1 ÷	Total	Observati on	
			(fron	n 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	
CO	OMPUTATION OF OBSERVATION BED PASS THROUGH (							
90. 00 Ca	api tal -rel ated cost	389, 31	5	4, 387, 554	0. 08873	2 0	0	90.00
91. 00 Nu	ursing School cost	(	)	4, 387, 554	0. 00000	0 0	0	91.00
92. 00 AI	lied health cost	(	)	4, 387, 554	0. 00000	0 0	0	92.00
93. 00 AI	I other Medical Education	(	0	4, 387, 554	0. 00000	0 0	0	93. 00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150046		Worksheet D-1
	Component CCN: 15TO4	From 09/01/2015 To 08/31/2016	Date/Time Prepared: 1/25/2017 6:24 pm
	Title XIX	Subprovi der -	Cost

		litle XIX	Subprovider -	Cost	
	Cost Center Description		110		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			1, 827	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed			1, 827	2.00
3. 00	Private room days (excluding swing-bed and observation bed days) do not complete this line.	). IT you have only pr	rivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		1, 827	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December	er 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room of	Mays) through December	31 of the cost	0	7. 00
	reporting period	3,			
8. 00	Total swing-bed NF type inpatient days (including private room (reporting period (if calendar year, enter 0 on this line)	days) after December 3	31 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	g swing-bed and	95	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instruction		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only	y (including private r	room days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, ento Swing-bed NF type inpatient days applicable to titles V or XIX of		ce room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX of	only (including privat	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar year	on, enter O on this lir	ne)		
14. 00 15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding Swing-bed	days)	0 563	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	3			17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	after December 31 of	the cost	0. 00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0. 00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services a reporting period	after December 31 of t	the cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions)			2, 137, 565	
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ line 17)	31 of the cost report	ing period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 3' x line 18)	l of the cost reportir	ng period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December :   7 x line 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
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 (I	ne 21 minus line 26)		2, 137, 565	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		, , , , , , , , , , , , , , , , , , ,		
	General inpatient routine service charges (excluding swing-bed a Private room charges (excluding swing-bed charges)	and observation bed ch	narges)	0	28. 00
29. 00 30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ 1	ine 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)			0.00	33. 00
34.00	Average per diem private room charge differential (line 32 minus	s line 33)(see instruc	ctions)	0. 00	34.00
35. 00	Average per diem private room cost differential (line 34 x line	31)		0.00	
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 and 27 minus line 36)	d private room cost di	fferential (line	2, 137, 565	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST				
38. 00	Adjusted general inpatient routine service cost per diem (see i	•		1, 169. 99	
39. 00	Program general inpatient routine service cost (line 9 x line 3)	-		111, 149	
40.00	Medically necessary private room cost applicable to the Program	` ,		0 111, 149	
41. 00	Total Program general inpatient routine service cost (line 39 +	1111E 4U)	l	111, 149	41.00

		ERRE HAUTE REGION				u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCM Component CC	Fr	eriod: com 09/01/2015 0 08/31/2016	Worksheet D-1 Date/Time Pre	pared:
			Title		Subprovider -	1/25/2017 6: 2 Cost	
	Cost Center Description	Total		verage Per	IRF Program Days	Program Cost	
	cost center bescription	Inpatient Cost In			110graiii bays	(col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00	5. 00	42.00
42.00	Intensive Care Type Inpatient Hospital Units	U U	O <sub>I</sub>	0.00	O	0	42.00
43.00	INTENSIVE CARE UNIT	0	0	0. 00	0	0	
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	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
	·					1. 00	
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines					238, 025 349, 174	
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inp.	atient routine se	rvices (from Wk	st. D, sum o	f Parts I and	0	50. 00
51. 00	Pass through costs applicable to Program inp.	atient ancillary	services (from	Wkst D sum	of Parts II	0	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	Ž	301 11 000 (11 0	mor by oun		0	52. 00
53. 00	Total Program inpatient operating cost exclu	,	ted, non-physic	ian anesthet	ist, and	0	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0. 00 0	55. 00 56. 00
57. 00	Difference between adjusted inpatient operat	ing cost and targ	et amount (line	e 56 minus li	ne 53)	0	57. 00
58.00			di 100/ d-			0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period en	arng 1996, upda	itea ana comp	ounded by the	0. 00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line				o amount by	0. 00 0	60. 00 61. 00
01.00	which operating costs (line 53) are less tha	n expected costs				0	01.00
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	nstructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instruct	ons)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decemb	er 31 of the co	st reporting	period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the cost	reporting p	eriod (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	plus line 65)(	title XVIII	only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through D	ecember 31 of t	he cost repo	rting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after Dec	ember 31 of the	cost report	ing period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (li	ne 67 + line 68	3)		0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						70. 00
71.00	Adjusted general inpatient routine service of			. (Trile 37)			70.00
72.00	Program routine service cost (line 9 x line		lino 14 v lino	25)			72.00
73. 00 74. 00	Medically necessary private room cost application. Total Program general inpatient routine serv			35)			73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service c	osts (from Work	sheet B, Par	t II, column		75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus	s line 77)					78. 00
79.00	Aggregate charges to beneficiaries for exces			ino 70 minus	lino 70)		79.00
80. 00 81. 00	Total Program routine service costs for comp. Inpatient routine service cost per diem limi		ı ıımı tatıON (I	THE /O III HUS	11110 /7)		80. 00 81. 00
82.00	Inpatient routine service cost limitation (I						82.00
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in						83. 00 84. 00
85. 00	Utilization review - physician compensation	(see instructions					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ugh 85)				86. 00
87. 00	Total observation bed days (see instructions	)				0	87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se		ne 2)				88. 00 89. 00
		,			!		

Health Financial Systems T	ERRE HAUTE RE	GI ONAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der		Peri od:	Worksheet D-1	
			Component	CCN: 15T046	From 09/01/2015 To 08/31/2016	Date/Time Prep 1/25/2017 6: 2	
			Ti ti	le XIX	Subprovi der  - I RF	Cost	
Cost Center Description	Cost		tine Cost m line 21)	col umn 1 ÷ col umn 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) 5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH C			2.00	3.00	4.00	5.00	
90.00 Capital -related cost	335, 2	77	2, 137, 565	0. 15685	0 0	0	90. 00
91.00 Nursing School cost		0	2, 137, 565	0.00000	0 0	0	91. 00
92.00 Allied health cost		0	2, 137, 565			0	92.00
93.00   All other Medical Education		O	2, 137, 565	0. 00000	0	0	93. 00

	nancial Systems	TERRE HAUTE REGIONAL HOSPITAL		In Li∈	eu of Form CMS-	2552-10
I NPATI ENT	T ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150046	Peri od:	Worksheet D-3	
				From 09/01/2015 To 08/31/2016		
		Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
			4.00	0.00	2)	
LNU	DATIENT DOUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
	PATIENT ROUTINE SERVICE COST CENTERS OOO ADULTS & PEDIATRICS			10, 321, 037		30. 00
	100 INTENSIVE CARE UNIT			4, 718, 532		31. 00
	000 SUBPROVI DER - I PF			4, 710, 332		40.00
	100 SUBPROVI DER - I RF					41. 00
	300 NURSERY					43. 00
	CILLARY SERVICE COST CENTERS					1
	000 OPERATING ROOM		0.0864	68 18, 083, 696	1, 563, 661	50.00
51.00 05	100 RECOVERY ROOM		0.0940	24 1, 965, 163	184, 772	51.00
	200 DELIVERY ROOM & LABOR ROOM		0. 6969	19 0	0	52.00
	300 ANESTHESI OLOGY		0.0000	00 0	0	53.00
54.00 05	400 RADI OLOGY-DI AGNOSTI C		0. 2087	79 2, 440, 979	509, 625	54.00
	401 ULTRASOUND		0. 0810		34, 598	
	402 MAMMOGRAPHY		0. 2008			1
	500 RADI OLOGY-THERAPEUTI C		0. 1139		63, 075	1
	600 RADI OI SOTOPE		0. 1064			1
	700 CT SCAN		0. 0266		206, 831	1
	800 MRI		0.0445			1
	900 CARDI AC CATHETERI ZATI ON		0.0564			1
	000 LABORATORY 200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 0651 0. 1175			1
	500 RESPIRATORY THERAPY		0.1173			1
	600 PHYSI CAL THERAPY		0. 1111			1
	900 ELECTROCARDI OLOGY		0. 0850			1
	000 ELECTROENCEPHALOGRAPHY		0. 0030			1
	100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1981			1
	200 I MPL. DEV. CHARGED TO PATIENTS		0. 4304			
	300 DRUGS CHARGED TO PATIENTS		0. 1192		3, 647, 516	1
	400 RENAL DI ALYSI S		0. 1815		588, 468	1
76. 00 03	020 LI THOTRI PSY		0. 1553	46 0	0	76. 00
76. 01 03	330 ENDOSCOPY		0. 1256	14 1, 254, 111	157, 534	76. 01
76. 02   03	950 PRISON CLINIC		1. 7765		0	76. 02
	951 WOUNDCARE		0. 2867	61 40, 595	11, 641	76. 03
76. 04 03			0. 1703	70 54, 645	9, 310	76. 04
	TPATIENT SERVICE COST CENTERS					
	100 EMERGENCY		0. 1184			1
	200 OBSERVATION BEDS (NON-DISTINCT PART		0. 7599			1
200. 00 201. 00	Total (sum of lines 50-94 and 96-98)	Orogram only charges (line (1)		135, 943, 489		200.00
/UT UU	THESS POPILITIES L'ADDITATORY SERVICES-H	riouram onivichardes (LINE 61)	1	i U	1	1/01 (10)

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

0 135, 943, 489

17, 034, 280 200. 00 201. 00 202. 00

201. 00 202. 00

NPATI EN	NT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od: From 09/01/2015	Worksheet D-3	
		Component		To 08/31/2016	Date/Time Pre 1/25/2017 6:2	
		Ti tl	e XVIII	Subprovider -	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2) 3. 00	_
1.1	NPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	3000 ADULTS & PEDIATRICS			0		30.
	3100 INTENSIVE CARE UNIT			0		31.
	4000 SUBPROVI DER - I PF			4, 939, 478		40.
	4100 SUBPROVI DER - I RF			0		41.
3.00 04	4300 NURSERY					43.
A۱	NCILLARY SERVICE COST CENTERS					
0.00 05	5000 OPERATING ROOM		0. 08646	0 8	0	50.
	5100 RECOVERY ROOM		0. 09402		0	51.
	5200 DELIVERY ROOM & LABOR ROOM		0. 69691		0	52.
	5300 ANESTHESI OLOGY		0.00000		0	
	5400 RADI OLOGY-DI AGNOSTI C		0. 20877		4, 556	
	5401 ULTRASOUND		0. 08107		0	
	5402 MAMMOGRAPHY		0. 20086		0	1
	5500  RADI OLOGY-THERAPEUTI C 5600  RADI OI SOTOPE		0. 11390 0. 10647		0	
	5700 CT SCAN		0. 10047		932	
	5800 MRI		0. 04452		765	1
	5900 CARDI AC CATHETERI ZATI ON		0. 05647		0	1
	6000 LABORATORY		0. 06519		31, 894	
2.00 06	6200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 11758		0	62.
5.00 06	6500 RESPI RATORY THERAPY		0. 11112	53, 065	5, 897	65.
6.00 06	6600 PHYSI CAL THERAPY		0. 39447	7 4, 995	1, 970	66.
	6900 ELECTROCARDI OLOGY		0. 08507	9, 889	841	
	7000 ELECTROENCEPHALOGRAPHY		0. 11285		625	1
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 19814		1, 245	1
	7200 IMPL. DEV. CHARGED TO PATIENTS		0. 43049		0	1
	7300 DRUGS CHARGED TO PATIENTS		0. 11921		66, 846	
	7400 RENAL DI ALYSI S		0. 18153		0	74.
	3020  LI THOTRI PSY 3330  ENDOSCOPY		0. 15534 0. 12561		0	1
	3330 PRI SON CLI NI C		1. 77653		0	
	3951 WOUNDCARE		0. 28676		0	76.
	3952 OPI C		0. 17037		0	
	UTPATIENT SERVICE COST CENTERS		3. 17037	<u> </u>	0	1 , 5.
	9100 EMERGENCY		0. 11849	283, 091	33, 545	91.
	9200 OBSERVATION BEDS (NON-DISTINCT PART		0. 75995		1, 965	
00.00	Total (sum of lines 50-94 and 96-98)			1, 489, 423	151, 081	
01.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.
02.00	Net Charges (line 200 minus line 201)		I	1, 489, 423		202.

IPATTE	NT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150046 CCN: 15T046	Peri od: From 09/01/2015 To 08/31/2016	Worksheet D-3  Date/Time Pre 1/25/2017 6:2	epare
		Ti tl	e XVIII	Subprovi der - I RF	PPS	. р
	Cost Center Description		Ratio of Cos To Charges	t Inpatient	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS		1			4
	D3000 ADULTS & PEDI ATRI CS			0		30.
	03100   INTENSIVE CARE UNIT			0		31.
	04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF			٥		40.
	04100 SUBPROVIDER - 1 RF			1, 361, 113		41.
	ANCI LLARY SERVI CE COST CENTERS					1 43.
	D5000 OPERATING ROOM		0. 0864	68 456	39	50.
	D5100 RECOVERY ROOM		0. 0940		0	1
2.00	D5200 DELIVERY ROOM & LABOR ROOM		0. 6969		0	52
8. OO	D5300 ANESTHESI OLOGY		0.0000	00 0	0	53
. 00	D5400 RADI OLOGY-DI AGNOSTI C		0. 2087	79 38, 375	8, 012	54
	D5401 ULTRASOUND		0. 0810		187	
	D5402 MAMMOGRAPHY		0. 2008		0	
- 1	D5500 RADI OLOGY-THERAPEUTI C		0. 1139		0	
	D5600 RADI OI SOTOPE		0. 1064	· ·	691	
	D5700  CT SCAN D5800  MRI		0. 0266 0. 0445		1, 156 374	
	D5900 CARDI AC CATHETERI ZATI ON		0.0445	· ·	466	
- 1	06000 LABORATORY		0.0364		17, 610	
	D6200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 1175	· ·	3, 189	
- 1	06500 RESPIRATORY THERAPY		0. 1111	·	10, 584	1
	06600 PHYSI CAL THERAPY		0. 3944	· ·	659, 624	
0.00	D6900 ELECTROCARDI OLOGY		0. 0850	79 19, 982	1, 700	69
0.00	D7000 ELECTROENCEPHALOGRAPHY		0. 1128	5, 754	649	70
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1981	·	43, 729	
	D7200 IMPL. DEV. CHARGED TO PATIENTS		0. 4304		0	
	D7300 DRUGS CHARGED TO PATIENTS		0. 1192	· ·	92, 494	
	07400 RENAL DI ALYSI S		0. 1815	·	29, 008	
	03020  LI THOTRI PSY 03330  ENDOSCOPY		0. 1553		0 571	
	03330  ENDOSCOPY 03950  PRI SON CLI NI C		0. 1256 1. 7765	·	5/1	
	D3950 PRI SON CETNIC D3951 WOUNDCARE		0. 2867		0	
	03952 OPI C		0. 2807		0	1
	DUTPATIENT SERVICE COST CENTERS		0. 1700	70	0	1 ′ °
	09100 EMERGENCY		0. 1184	96 3, 117	369	91
- 1	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 7599			
00.00	Total (sum of lines 50-94 and 96-98)			3, 363, 622	871, 606	200
1.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201
2.00	Net Charges (line 200 minus line 201)		1	3, 363, 622	1	202

Health Financial Systems TERRE HAUTE REGIONAL				eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150046	Peri od: From 09/01/2015	Worksheet D-3	
			To 08/31/2016	Date/Time Pre	nared.
			10 00/31/2010	1/25/2017 6: 2	4 pm
	Ti ·	tle XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	st Inpatient	Inpatient	
		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					
30. 00   03000   ADULTS & PEDI ATRI CS			3, 413, 183		30. 00
31. 00 03100 INTENSIVE CARE UNIT			1, 456, 857		31. 00
40. 00   04000   SUBPROVI DER - I PF			0		40.00
41. 00   04100   SUBPROVI DER -   RF			0		41. 00
43. 00   04300  NURSERY			500, 687		43. 00
ANCI LLARY SERVI CE COST CENTERS		0.00/4	07 7 000 007	1 (0/ 000	
50. 00   05000   0PERATI NG ROOM		0.0864		606, 920	
51. 00   05100   RECOVERY ROOM		0.0940			
52. 00   05200   DELI VERY ROOM & LABOR ROOM		0. 6969			
53. 00   05300   ANESTHESI OLOGY		0.0000		0	
54. 00   05400   RADI OLOGY - DI AGNOSTI C		0. 2087			
54. 01   05401   ULTRASOUND		0.0810			
54. 02   05402   MAMMOGRAPHY		0. 2008		0	
55. 00   05500   RADI OLOGY - THERAPEUTI C		0. 1139			
56. 00   05600   RADI 0I SOTOPE 57. 00   05700   CT   SCAN		0. 1064 0. 0266		13, 729 70, 905	
57. 00   05700   CT   SCAN 58. 00   05800   MRI		0.0266			
59. 00   05900   CARDI AC   CATHETERI ZATI ON		0.0564			1
60. 00   06000   LABORATORY		0.0651			
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL		0.0031			1
65. 00   06500   RESPI RATORY THERAPY		0. 1173			1
66. 00   06600   PHYSI CAL THERAPY		0. 3917		104, 672	
69. 00   06900   ELECTROCARDI OLOGY		0. 0843			
70. 00   07000   ELECTROENCEPHALOGRAPHY		0. 1128		12, 267	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1981			1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4304			1
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1192			
74. 00   07400   RENAL DI ALYSI S		0. 1815			
76. 00   03020   LI THOTRI PSY		0. 1553		0	
76. 01   03330   ENDOSCOPY		0. 1256			
76. 02 03950 PRI SON CLINI C		1. 7765	-		
76. 03   03951   WOUNDCARE		0. 2841			1
76. 04 03952 OPI C		0. 1638		1, 214	
OUTPATIENT SERVICE COST CENTERS		•	<u> </u>		
91. 00 09100 EMERGENCY		0. 1178	35 2, 326, 007	274, 085	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 7599	50 0	0	92.00
200.00 Total (sum of lines 50-94 and 96-98)		1	42, 990, 020	6, 057, 746	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)	1	0		201.00
202.00 Net Charges (line 200 minus line 201)			42, 990, 020		202. 00

NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150046	Period: From 09/01/2015	Worksheet D-3	3
		Component	CCN: 15SO46	To 08/31/2016	Date/Time Pre 1/25/2017 6:2	
		Ti t	le XIX	Subprovi der - I PF	Cost	. r p
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	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	
0. 00	03000 ADULTS & PEDIATRICS			0		30.
1. 00	03100   NTENSI VE CARE UNI T			0		31.
0.00	04000 SUBPROVI DER - I PF			10, 192, 851		40.
1.00	04100 SUBPROVI DER - I RF			0		41.
3. 00	04300 NURSERY			0		43.
	ANCILLARY SERVICE COST CENTERS					
0. 00	05000 OPERATING ROOM		0. 0864		l	
1. 00	05100 RECOVERY ROOM		0. 0940			
2. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 6969			1 .
3. 00	05300 ANESTHESI OLOGY		0.0000		0	
4.00	05400 RADI OLOGY-DI AGNOSTI C		0. 2087			
4. 01 4. 02	05401 ULTRASOUND		0.0810			1
4. 02 5. 00	05402   MAMMOGRAPHY   05500   RADI OLOGY - THERAPEUTI C		0. 2008 0. 1139		0	
6. 00	05600 RADI OLOGI - THERAPEUTI C		0.1139			
7. 00	05700 CT SCAN		0. 0266			
8. 00	05800 MRI		0. 0445			1
9. 00	05900 CARDI AC CATHETERI ZATI ON		0. 0564		0	
0. 00	06000 LABORATORY		0. 0651		83, 103	60.
2. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 1175			62.
5. 00	06500 RESPI RATORY THERAPY		0. 1111	25 41, 437	4, 605	65.
6. 00	06600 PHYSI CAL THERAPY		0. 3917	54 3, 933	1, 541	66.
9. 00	06900 ELECTROCARDI OLOGY		0. 0843			
0. 00	07000 ELECTROENCEPHALOGRAPHY		0. 1128		625	
1. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1981			
2. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 4304			
3. 00	07300 DRUGS CHARGED TO PATIENTS		0. 1192		0	
	07400 RENAL DI ALYSI S		0. 1815		0	
6. 00	03020 LI THOTRI PSY		0. 1553		0	
6. 01 6. 02	03330 ENDOSCOPY 03950 PRI SON CLI NI C		0. 1256 1. 7765		571 0	
6. 02	03951 WOUNDCARE		0. 2841			1
6. 04	03952 OPI C		0. 2641			1
J. J4	OUTPATIENT SERVICE COST CENTERS		0. 1030	00, 0	<u> </u>	1 ′ ′ ′
1. 00	09100 EMERGENCY		0. 1178	35 796, 530	93, 859	91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 7599			
00.00	,			3, 448, 987	669, 565	
01.00		s (line 61)		0		201.
02.00		. ,		3, 448, 987		202.

ATTENT AMOTEENAN SERVIN	CE COST APPORTIONMENT		CCN: 150046 CCN: 15T046	Peri od: From 09/01/2015 To 08/31/2016	Worksheet D-3 Date/Time Pre	pare
		Ti t	le XIX	Subprovi der - I RF	1/25/2017 6: 2 Cost	4 PIII
Cost Center D	escription		Ratio of Cos To Charges	Inpatient Program	Inpatient Program Costs (col. 1 x col. 2)	
			1. 00	2. 00	3. 00	
INPATIENT ROUTINE S			1			4
00 03000 ADULTS & PEDI				0		30.
00 03100 I NTENSI VE CAR				0		31.
00   04000   SUBPROVI DER - 00   04100   SUBPROVI DER -				0		40.
00 04300 NURSERY	IRF			379, 626 0		41.
ANCI LLARY SERVI CE C	OST CENTERS			<u> </u>		1 43
00 05000 OPERATING ROO			0. 0864	27 0	0	50.
00 05100 RECOVERY ROOM			0. 0940	24 0	0	51
00 05200 DELIVERY ROOM	& LABOR ROOM		0. 6969		0	52
00 05300 ANESTHESI OLOG	<b>(</b>		0.0000	00 0	0	53
00   05400   RADI OLOGY-DI A	GNOSTI C		0. 2087		2, 102	
01  05401   ULTRASOUND			0. 0810		99	
02 05402 MAMMOGRAPHY			0. 2008		0	
00 05500 RADI OLOGY-THE	RAPEUTI C		0. 1139		0	1
00   05600   RADI 0I SOTOPE			0. 1064		0	
00   05700   CT   SCAN   00   05800   MRI			0. 0266 0. 0445		241 0	
00 05900 CARDI AC CATHE	TERL ZATLON		0. 0564		0	
00 06000 LABORATORY	IEM ZATION		0. 0651		3, 834	
	PACKED RED BLOOD CELL		0. 1175		1, 289	
00 06500 RESPIRATORY T			0. 1111		7, 082	
00 06600 PHYSI CAL THER	APY		0. 3917		180, 276	66
00 06900 ELECTROCARDI 0	_OGY		0. 0843	27 7, 232	610	69
00 07000 ELECTROENCEPH			0. 1128		0	
	ES CHARGED TO PATIENT		0. 1981	· · · · · · · · · · · · · · · · · · ·	3, 481	
00 07200 I MPL. DEV. CH.			0. 4304		0	
00 07300 DRUGS CHARGED 00 07400 RENAL DI ALYSI			0. 1192		34, 867	
00   07400   RENAL DI ALYSI   00   03020   LI THOTRI PSY			0. 1815 0. 1553		4, 144 0	
01 03330 ENDOSCOPY			0. 1553		0	
02 03950 PRI SON CLINI C			1. 7765		0	1
03   03951   WOUNDCARE			0. 2841		0	
04 03952 OPI C			0. 1638		0	1
OUTPATIENT SERVICE	COST CENTERS			-		1
00 09100 EMERGENCY			0. 1178	35 0	0	91
	EDS (NON-DISTINCT PART		0. 7599	50 0	0	
	lines 50-94 and 96-98)			954, 110	238, 025	
I.00 Less PBP Clin	c Laboratory Services-Program only	, oborgoo (line (1)	I .	l ol		201

Health Financial Systems	TERRE HAUTE REGIONAL HO	OSPI TAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pr	rovider CCN: 150046	From 09/01/2015	Worksheet E Part A Date/Time Prepared: 1/25/2017 6:24 pm
		T' 11 \0.0111		DDC

			70 00,01,2010	1/25/2017 6: 2	4 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring	g prior to October 1 (s	see	0 1, 609, 704	1. 00 1. 01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurring	19, 913, 973	1. 02		
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI for	discharges occurring p	orior to October	0	1. 03
1.04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCl for October 1 (see instructions)	discharges occurring	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			810, 031 0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruction	ns)		0	2. 02
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost reporti	ng period (see instru	ctions)	0 152. 71	3. 00 4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most (	recent cost reporting	period ending on	0.00	5. 00
6. 00	or before 12/31/1996 (see instructions) FTE count for allopathic and osteopathic programs which meet the			0. 00	6. 00
7. 00	for new programs in accordance with 42 CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified und			0. 00	7. 00
7. 01	ACA Section 5503 reduction amount to the IME cap as specified unlf the cost report straddles July 1, 2011 then see instructions.	nder 42 CFR §412.105(f)		0.00	7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopathi affiliated programs in accordance with 42 CFR 413.75(b), 413.79(1998), and 67 FR 50069 (August 1, 2002).	c and osteopathic prog		0. 00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots the cost report straddles July 1, 2011, see instructions.	s under section 5503 or	f the ACA. If	0.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots under section 5506 of ACA. (see instructions)	s from a closed teachi	ng hospital	0.00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines instructions)	(8, 8,01 and 8,02) (9	see	0.00	9. 00
10. 00 11. 00	FTE count for allopathic and osteopathic programs in the current FTE count for residents in dental and podlatric programs.	t year from your record	ds	0.00	10. 00 11. 00
12. 00	Current year allowable FTE (see instructions)			0.00	ł
13.00	Total allowable FTE count for the prior year.			0. 00	
14. 00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ended on or after Sep	tember 30, 1997,	0.00	14. 00
15. 00	Sum of lines 12 through 14 divided by 3.				15. 00
16.00	Adjustment for residents in initial years of the program			0.00	16. 00 17. 00
17. 00 18. 00	Adjustment for residents displaced by program or hospital closur Adjusted rolling average FTE count	е		0.00	ł
19. 00	Current year resident to bed ratio (line 18 divided by line 4).			0. 000000	ł
20.00	Prior year resident to bed ratio (see instructions)			0.000000	
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21. 00
22. 00	IME payment adjustment (see instructions)			0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			0	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for Section Number of additional allopathic and osteopathic IME FTE residen	n 422 of the MMA t 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)	6.11			24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the low instructions)	ver 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)			0	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) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29. 00 29. 01
20.00	Disproportionate Share Adjustment	ant days (s !+	ti ono)	F /0	20.00
30. 00 31. 00	Percentage of SSI recipient patient days to Medicare Part A pati Percentage of Medicaid patient days (see instructions)	ent days (see Instruc	LI UIIS)	5. 68 18. 53	•
31.00	Sum of lines 30 and 31			24. 21	1
	Allowable disproportionate share percentage (see instructions)			9. 19	•
	Disproportionate share adjustment (see instructions)			494, 507	1
			'		

	Financial Systems TERRE HAUTE REGIONA	AL HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150046	Peri od: From 09/01/2015 To 08/31/2016	Date/Time Pre	
		Title XVIII	Hospi tal	1/25/2017 6: 24 PPS	4 pm
			Prior to 10/1	On/After 10/1	
	Uncompensated Care Adjustment		1.00	2. 00	
35. 00	Total uncompensated care amount (see instructions)		7, 647, 644, 885	6, 406, 145, 534	35. 00
35. 01	Factor 3 (see instructions)		0. 000115775	0. 000114159	35. 01
35. 02	Hospital uncompensated care payment (If line 34 is zero, ente (see instructions)	er zero on this line)	885, 405	731, 318	35. 02
35. 03	Pro rata share of the hospital uncompensated care payment amou	unt (see instructions)	72, 773	671, 374	35. 03
36. 00			744, 147		36. 00
40. 00	Additional payment for high percentage of ESRD beneficiary dis Total Medicare discharges on Worksheet S-3, Part I excluding d		gh 46) 0		40. 00
40.00	652, 682, 683, 684 and 685 (see instructions)	discharges for Mis-Dros			40.00
			Before 1/1	On/After 1/1	
41 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68	22 604 an 605 (coo	1.00	1. 01	41. 00
41.00	instructions)	55, 064 dii 065. (See			41.00
41. 01	Total ESRD Medicare covered and paid discharges excluding MS-D	DRGs 652, 682, 683, 684	0	0	41. 01
42. 00	an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not qualif	fy for adjustment)	0.00		42. 00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682			1	43. 00
	instructions)				
44. 00	Ratio of average length of stay to one week (line 43 divided b days)	by line 41 divided by /	0. 000000		44. 00
45. 00	Average weekly cost for dialysis treatments (see instructions)	)	0.00	0.00	45. 00
46. 00	Total additional payment (line 45 times line 44 times line 41.	01)	02 572 272		46. 00
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH, sm	nall rural hospitals	23, 572, 362		47. 00 48. 00
	only. (see instructions)		_		
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instructions)			23, 572, 362	49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and			1, 897, 100	1
51. 00 52. 00	Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, lin			0	51. 00 52. 00
53. 00	Nursing and Allied Health Managed Care payment	10 47 300 TH311 dot1 0H3).		Ö	53.00
54.00	Special add-on payments for new technologies				] 55.00
	1	-		6, 192	54.00
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69			6, 192 0	54. 00 55. 00
	1	uctions)	hrough 35).	6, 192	54.00
55. 00 56. 00 57. 00 58. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Cost of physicians' services in a teaching hospital (see intru Routine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. I	uctions) I, column 9, lines 30 t	hrough 35).	6, 192 0 0 0 0	54. 00 55. 00 56. 00 57. 00 58. 00
55. 00 56. 00 57. 00 58. 00 59. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Cost of physicians' services in a teaching hospital (see intru Routine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58)	uctions) I, column 9, lines 30 t	hrough 35).	6, 192 0 0 0 0 0 25, 475, 654	54. 00 55. 00 56. 00 57. 00 58. 00 59. 00
55. 00 56. 00 57. 00 58. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Cost of physicians' services in a teaching hospital (see intru Routine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. I	uctions) I, column 9, lines 30 t V, col. 11 line 200)	hrough 35).	6, 192 0 0 0 0	54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Cost of physicians' services in a teaching hospital (see intru Routine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments  Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries	uctions) I, column 9, lines 30 t V, col. 11 line 200)	hrough 35).	6, 192 0 0 0 0 25, 475, 654 10, 966 25, 464, 688 2, 346, 932	54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Cost of physicians' services in a teaching hospital (see intru Routine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries	uctions) I, column 9, lines 30 t V, col. 11 line 200)	hrough 35).	6, 192 0 0 0 0 25, 475, 654 10, 966 25, 464, 688 2, 346, 932 70, 287	54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Cost of physicians' services in a teaching hospital (see intru Routine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)	uctions) I, column 9, lines 30 t V, col. 11 line 200)	hrough 35).	6, 192 0 0 0 0 25, 475, 654 10, 966 25, 464, 688 2, 346, 932 70, 287 220, 202	54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Cost of physicians' services in a teaching hospital (see intru Routine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries	uctions) I, column 9, lines 30 t V, col. 11 line 200) line 60)	hrough 35).	6, 192 0 0 0 0 25, 475, 654 10, 966 25, 464, 688 2, 346, 932 70, 287	54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Cost of physicians' services in a teaching hospital (see intru Routine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments  Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) (line 61 plus line 65 minus lines 62 and 63)	uctions) I, column 9, lines 30 t V, col. 11 line 200) line 60)	<b>,</b>	6, 192 0 0 0 25, 475, 654 10, 966 25, 464, 688 2, 346, 932 70, 287 220, 202 143, 131 55, 959 23, 190, 600	54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Cost of physicians' services in a teaching hospital (see intru Routine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments  Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries  Coinsurance billed to program beneficiaries  Allowable bad debts (see instructions)  Adjusted reimbursable bad debts (see instructions)  Allowable bad debts for dual eligible beneficiaries (see instructional)  Credits received from manufacturers for replaced devices for a	uctions) I, column 9, lines 30 t V, col. 11 line 200)  line 60)  ructions)  applicable to MS-DRGs (s	ee instructions)	6, 192 0 0 0 25, 475, 654 10, 966 25, 464, 688 2, 346, 932 70, 287 220, 202 143, 131 55, 959 23, 190, 600	54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Cost of physicians' services in a teaching hospital (see intru Routine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. II Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	uctions) I, column 9, lines 30 t V, col. 11 line 200)  line 60)  ructions)  applicable to MS-DRGs (s	ee instructions)	6, 192 0 0 0 0 25, 475, 654 10, 966 25, 464, 688 2, 346, 932 70, 287 220, 202 143, 131 55, 959 23, 190, 600 0	54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 70. 00 70. 50	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Cost of physicians' services in a teaching hospital (see intru Routine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. II Total (sum of amounts on lines 49 through 58) Primary payer payments  Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries  Coinsurance billed to program beneficiaries  Allowable bad debts (see instructions)  Adjusted reimbursable bad debts (see instructions)  Allowable bad debts for dual eligible beneficiaries (see instructions)  Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	uctions) I, column 9, lines 30 t V, col. 11 line 200)  line 60)  ructions)  applicable to MS-DRGs (s	ee instructions)	6, 192 0 0 0 25, 475, 654 10, 966 25, 464, 688 2, 346, 932 70, 287 220, 202 143, 131 55, 959 23, 190, 600 0 0 0	54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Cost of physicians' services in a teaching hospital (see intru Routine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. II Total (sum of amounts on lines 49 through 58) Primary payer payments  Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries  Coinsurance billed to program beneficiaries  Allowable bad debts (see instructions)  Adjusted reimbursable bad debts (see instructions)  Allowable bad debts for dual eligible beneficiaries (see instructions)  Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  RURAL DEMONSTRATION PROJECT  SCH or MDH volume decrease adjustment	uctions) I, column 9, lines 30 t V, col. 11 line 200)  line 60)  ructions) applicable to MS-DRGs (s (For SCH see instruction	ee instructions)	6, 192 0 0 0 0 25, 475, 654 10, 966 25, 464, 688 2, 346, 932 70, 287 220, 202 143, 131 55, 959 23, 190, 600 0	54. 00 55. 00 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 50 70. 88
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 89 70. 90	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Cost of physicians' services in a teaching hospital (see intru Routine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. II Total (sum of amounts on lines 49 through 58) Primary payer payments  Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries  Coinsurance billed to program beneficiaries  Allowable bad debts (see instructions)  Adjusted reimbursable bad debts (see instructions)  Allowable bad debts for dual eligible beneficiaries (see instructions)  Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  RURAL DEMONSTRATION PROJECT  SCH or MDH volume decrease adjustment  Pioneer ACO demonstration payment adjustment amount (see instructions)	uctions) I, column 9, lines 30 t V, col. 11 line 200)  line 60)  ructions) applicable to MS-DRGs (s (For SCH see instruction	ee instructions)	6, 192 0 0 0 0 25, 475, 654 10, 966 25, 464, 688 2, 346, 932 70, 287 220, 202 143, 131 55, 959 23, 190, 600 0	54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 89 70. 90
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 62. 00 63. 00 64. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 88 70. 88 70. 90 70. 91	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Cost of physicians' services in a teaching hospital (see intru Routine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. II Total (sum of amounts on lines 49 through 58) Primary payer payments  Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries  Coinsurance billed to program beneficiaries  Allowable bad debts (see instructions)  Adjusted reimbursable bad debts (see instructions)  Allowable bad debts for dual eligible beneficiaries (see instructions)  Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  RURAL DEMONSTRATION PROJECT  SCH or MDH volume decrease adjustment  Pioneer ACO demonstration payment adjustment amount (see instructions)  HSP bonus payment HVBP adjustment amount (see instructions)	uctions) I, column 9, lines 30 t V, col. 11 line 200)  line 60)  ructions) applicable to MS-DRGs (s (For SCH see instruction	ee instructions)	6, 192 0 0 0 25, 475, 654 10, 966 25, 464, 688 2, 346, 932 70, 287 220, 202 143, 131 55, 959 23, 190, 600 0 0 0 0 0 0	54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 88 70. 88 70. 90 70. 91
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 88 70. 89 70. 91 70. 92	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Cost of physicians' services in a teaching hospital (see intru Routine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. II Total (sum of amounts on lines 49 through 58) Primary payer payments  Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries  Coinsurance billed to program beneficiaries  Allowable bad debts (see instructions)  Adjusted reimbursable bad debts (see instructions)  Allowable bad debts for dual eligible beneficiaries (see instructions)  Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  RURAL DEMONSTRATION PROJECT  SCH or MDH volume decrease adjustment  Pioneer ACO demonstration payment adjustment amount (see instructions)  HSP bonus payment HYRP adjustment amount (see instructions)  Bundled Model 1 discount amount (see instructions)	uctions) I, column 9, lines 30 t V, col. 11 line 200)  line 60)  ructions) applicable to MS-DRGs (s (For SCH see instruction	ee instructions)	6, 192 0 0 0 25, 475, 654 10, 966 25, 464, 688 2, 346, 932 70, 287 220, 202 143, 131 55, 959 23, 190, 600 0 0 0 0 0 0	54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 88 70. 89 70. 91 70. 92
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 88 70. 89 70. 91 70. 93 70. 93 70. 94	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Cost of physicians' services in a teaching hospital (see intru Routine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. II Total (sum of amounts on lines 49 through 58) Primary payer payments  Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries  Coinsurance billed to program beneficiaries  Allowable bad debts (see instructions)  Adjusted reimbursable bad debts (see instructions)  Allowable bad debts for dual eligible beneficiaries (see instructions)  Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  RURAL DEMONSTRATION PROJECT  SCH or MDH volume decrease adjustment  Pioneer ACO demonstration payment adjustment amount (see instructions)  HSP bonus payment HVBP adjustment amount (see instructions)	uctions) I, column 9, lines 30 t V, col. 11 line 200)  line 60)  ructions) applicable to MS-DRGs (s (For SCH see instruction	ee instructions)	6, 192 0 0 0 25, 475, 654 10, 966 25, 464, 688 2, 346, 932 70, 287 220, 202 143, 131 55, 959 23, 190, 600 0 0 0 0 0 0 0 0 0 0 0 0	54. 00 55. 00 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 88 70. 89 70. 90 70. 91 70. 92 70. 93

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150046	Peri od: From 09/01/2015 To 08/31/2016	Worksheet E Part A Date/Time Prep 1/25/2017 6:24	
		Ti tl	e XVIII	Hospi tal	PPS	
			FFY	/ (yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0		0	0	70. 96
	the corresponding federal year for the period prior to 10/1)					
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in			0	0	70. 97
70.00	the corresponding federal year for the period ending on or afte	r 10/1)				70.00
70. 98	Low Volume Payment-3				0	
70. 99	HAC adjustment amount (see instructions)	0 70)			0	70. 99
	Amount due provider (line 67 minus lines 68 plus/minus lines 69 Sequestration adjustment (see instructions)	& 70)			23, 018, 781	
	, ,				460, 376 22, 629, 890	
	Interim payments Tentative settlement (for contractor use only)				22, 629, 890	
	Balance due provider (Program) (line 71 minus lines 71.01, 72,	and 72)			-71, 485	
	Protested amounts (nonallowable cost report items) in accordance				301, 528	
73.00	CMS Pub. 15-2, chapter 1, §115.2	e wi tii			301, 320	75.00
	TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)					
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instr	uctions)			0	90.00
	Capital outlier from Wkst. L, Pt. I, line 2				0	
92. 00	Operating outlier reconciliation adjustment amount (see instruc	tions)			0	92.00
93. 00	Capital outlier reconciliation adjustment amount (see instruction	ons) ´			0	93.00
	The rate used to calculate the time value of money (see instruc				0.00	94.00
95. 00	Time value of money for operating expenses (see instructions)				0	95.00
96. 00	Time value of money for capital related expenses (see instructi	ons)			0	96.00
				Prior to 10/1	On/After 10/1	
				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					
	HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	
	HVBP adjustment amount for HSP bonus payment (see instructions)			0	0	102. 00
	HRR Adjustment for HSP Bonus Payment					
	HRR adjustment factor (see instructions)			0.0000	0. 0000	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	0	104. 0

Health Financial Systems	TERRE HAUTE REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150046	From 09/01/2015	Worksheet E Part B Date/Time Prepared: 1/25/2017 6:24 pm
		Title XVIII	Hospi tal	PPS

MART R. MEDICAL AND CHURCH SEAT THIS STEWLORS   1.00				To 08/31/2016	Date/Time Pre 1/25/2017 6:2	
MATERIAL AND OTHER HEAT IL SERVICES   1,500   1,500   1,500   1,000			Title XVIII	Hospi tal		
MATERIAL AND OTHER HEAT IL SERVICES   1,500   1,500   1,500   1,000					1 00	
Medical and other services relatured under OPPS (see instructions)   10,892,924   20,00   10,529,924   20,00   10,529,924   20,00   10,529,924   20,00   10,529,924   20,00   10,529,924   20,00   10,529,924   20,00   20,0		PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00   Description   1.00   2.00   1.00	1.00				15, 924	1.00
0.00   Cut   Inf   payment (see Instructions)   0.00   5.00   5.00   Enter the hospital of specific payment to cost ratio (see Instructions)   0.00   5.00		· ·				
Internation   Computation						1
Line 2 times line 5			:>			1
			ions)		l .	1
Transitional corridor payment (see instructions)   0   0.00					1	1
Ancillary service other pass through costs from Wisst. D. Pt. IV, col. 13, line 200					l	1
1.00   Total cost (sum of lines 1 and 10) (see instructions)   1.924   1.00	9.00		, col. 13, line 200		0	9. 00
COMPUTATION OF LESSER OF COST OR CHARGES   Reasonable charges   Reasonable charges   130, 877   12, 00   Ancil lary service charges (from Wkst. D-4, Pt. III., cal. 4, line 69)   133, 877   14, 00   130, 0	10.00				0	10. 00
Reasonable charges   133,877   12.00   Ancil Tarry service charges   133,877   12.00   Ancil Tarry service charges (sum of Filnes 12 and 13)   13.00	11. 00				15, 924	11. 00
12.00   Ancil larry service charges   133, 877   12.00   13.00   Organ acquisition charges (from Wist. D-4, Pt. III, col. 4, line 69)   13.00   13.0						1
13.00   organ acquisition charges (from West. D-4, Pt. III, col. 4, line 69)   13.3 877   14.00   Total reasonable charges (sum of lines 12 and 13)   13.8 877   14.00   Total reasonable charges (sum of lines 12 and 13)   15.00   Aggregate amount actually collected from patients   liable for payment for services on a charge basis   0   15.00   Aggregate amount actually collected 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   16.00   Amounts that would have been realized from patients   liable for payment for services on a chargebasis   0   15.00   16.00   16.00   Total customary charges (see instructions)   0.000000   17.00	12 00				133 877	12 00
14.00   Total reasonable charges (sum of lines 12 and 13)   13,877   14,00			e 69)			1
15.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   16.00   Amounts that would have been realized from patients liable for payment for services on a chargebasis   0   16.00   17.00			,		133, 877	1
16.00   Amounts that would have been realized from patients   I able for payment for services on a chargebasis   A blad band about payment been made in accordance with 42 CFR \$413.13(e)   Co.		Customary charges				]
had such payment been made in accordance with 42 CFR \$413.13(e)		, 00 0	-	0		
17.00	16. 00			n a chargebasis	0	16. 00
18.00   Total customery charges (see instructions)   13.3877   18.00   17.90	17 00				0 000000	17 00
19. 00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see   117, 953   19. 00   117, 953   19. 0						
Instructions		,	if line 18 exceeds li	ne 11) (see	1	1
instructions				, ,		
1.0   Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)   15,924   21.00   22.00   23.00   Cost of physicians' services in a teaching hospital (see instructions)   0.22.00   23.00   25.	20. 00		if line 11 exceeds li	ne 18) (see	0	20. 00
22.00   Interns and residents (see instructions)   0   22.00   23.00   23.00   25.00   50.00	21 00		instructions)		15 024	21 00
23.00   Cost of physicians' services in a teaching hospital (see instructions)   0.20.00   24.00   24.00   24.00   24.00   24.00   24.00   24.00   24.00   24.00   25.00   2		, ,	Tristi ucti ons)		l	1
24. 00   Total prospective payment (sum of lines 3, 4, 8 and 9)   10,580,162   24. 00		· · · · · · · · · · · · · · · · · · ·	ctions)			1
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)   2, 150, 079   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   27. 00   28. 00   29. 00   ESRD direct medical education payments (From Wkst. E-4, line 50)   0   28. 00   29. 00   28. 00   29. 00					10, 580, 162	1
26. 00         Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)         2, 150,079   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)         8, 446,007   27.00           28. 00         Direct graduate medical education payments (from Wkst. E-4, line 50)         0         28.00           30. 00         Subtotal (sum of lines 27 through 29)         8, 446,007   30.00         30.00           31. 00         Primary payer payments         1, 279   31.00         8, 444,728   32.00           32. 00         Subtotal (line 30 minus line 31)         8, 444,728   32.00         32.00           34. 00         AlLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)         33.00           34. 00         All owable bad debts (see instructions)         535, 241   34.00           35. 00         All owable bad debts (see instructions)         337, 413   36.00           36. 00         All owable bad debts for dual eligible beneficiaries (see instructions)         8, 792, 635   37.00           37. 00         Subtotal (see instructions)         8, 792, 635   37.00           39. 00         PS&R 13P OTHER         75, 399   39.00           39. 50         PS&R 13P OTHER         75, 399   39.00           39. 98         PECOVERY OF ACCELERATED DEPRECIATION		COMPUTATION OF REIMBURSEMENT SETTLEMENT				]
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)   1			0411			1
Instructions   Direct graduate medical education payments (from Wkst. E-4, line 50)   0   28. 00   29. 00   29. 00   28. 00   29. 00   28. 00   29. 00   29. 00   28. 00   29. 00   2		,		and 221 (soo		•
28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   ESRD direct medical education costs (from Wkst. E-4, line 36)   0   28.00   29.00   2	27.00		us the sum of filles 22	and 23] (See	8, 440, 007	27.00
30. 00   Subtotal (sum of lines 27 through 29)   8, 446, 007   31. 00   Primary payer payments   1, 279   31. 00   20. 00   Primary payer payments   8, 444, 728   32. 00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33. 00   Composite rate ESRD (from Wist. 1–5, line 11)   0   33. 00   34. 00   Allowable bad debts (see instructions)   535, 241   34. 00   34. 00   Allowable bad debts for dual eligible beneficiaries (see instructions)   377, 413   36. 00   37. 0	28. 00		e 50)		0	28. 00
31.00   Note	29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
32.00   Subtotal (ine 30 minus line 31)   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (From Wkst. I - 5, line 11)   0   33.00   34.00   All owable bad debts (see instructions)   535, 241   34.00   35.00   Adj used reimbursable bad debts (see instructions)   377, 413   36.00   All owable bad debts for dual eligible beneficiaries (see instructions)   377, 413   36.00   37, 413   36.00   All owable bad debts for dual eligible beneficiaries (see instructions)   8, 792, 635   37.00   Subtotal (see instructions)   8, 792, 635   37.00   Subtotal (see instructions)   8, 792, 635   37.00   Subtotal (see instructions)   75, 399   39.00   Sex 139 OTHER   75, 399   39.00   75, 399   39.00   75, 399   75,					1	1
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. I -5, line 11)   535, 241   34.00   34.00   All owable bad debts (see instructions)   347, 907   35.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   377, 413   36.00   37.00   38.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   8,792, 635   37.00   38.00   MSP-LCC reconciliation amount from PS&R   538, 240   38.00   39.00   PS&R 13P OTHER   75,399   39.00   95&R 13P OTHER   75,399   39.00   95&R 13P OTHER   75,399   39.50   97					1	1
33.00   Composite rate ESRD (from Wkst. I-5, line 11)   0   33.00   34.00   All owable bad debts (see instructions)   535, 241   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   377, 413   36.00   37.00   All owable bad debts for dual eligible beneficiaries (see instructions)   377, 413   36.00   37.00   Subtotal (see instructions)   8,792, 635   37.00   38.00   MSP-LCC reconciliation amount from PS&R   53   38.00   MSP-LCC reconciliation amount from PS&R   75,399   39.00   75,399   39.00   75,399	32.00		5)		8, 444, 728	32.00
34.00	33. 00		3)		0	33.00
36.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       377,413       36.00         37.00       Subtotal (see instructions)       8,792,635       37.00         38.00       MSP-LCC reconciliation amount from PS&R       53       38.00         39.00       PS&R 13P OTHER       75,399       39.00         39.50       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         40.01       Sequestration adjustment (see instructions)       8,867,981       40.00         40.01       Sequestration adjustment (see instructions)       177,360       40.01         41.00       Interim payments       8,645,081       41.00         42.00       Tentative settlement (for contractors use only)       0       42.00         43.00       Balance due provider/program (see instructions)       45,540       43.00         44.00       Fills.2       70       BE COMPLETED BY CONTRACTOR       0       90.00         91.00       Outlier reconciliation adjustment amount (see instructions)       0       90.00					535, 241	
37.00   Subtotal (see instructions)   8,792,635   37.00   38.00   MSP-LCC reconciliation amount from PS&R   53   38.00   39.00   75.399   39.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   0   39.50   39.98   39.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.99   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   40.00   Subtotal (see instructions)   177,360   40.00   Sequestration adjustment (see instructions)   177,360   40.00   1.00	35. 00	Adjusted reimbursable bad debts (see instructions)			347, 907	35. 00
38.00       MSP-LCC reconciliation amount from PS&R       53       38.00         39.00       PS&R 13P OTHER       75,399       39.00         39.50       Pioneer ACO demonstration payment adjustment (see instructions)       0       39.50         39.98       RECOVERY OF ACCELERATED DEPRECIATION       0       39.98         8. 867, 981       40.00       Subtotal (see instructions)       8,867,981       40.00         40.01       Subtotal (see instructions)       177,360       40.01         41.00       Interim payments       8,645,081       41.00         42.00       Tentative settlement (for contractors use only)       45,540       43.00         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,       0       45,540       43.00         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 (see instructions)       0       93.00			ctions)		l	•
39.00   PS&R 13P OTHER   75,399   39.00   39.50   Pi oneer 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)   8,867,981   40.00   A0.01   Sequestration adjustment (see instructions)   177,360   40.01   41.00   Interim payments   8,645,081   41.00   A2.00   Tentative settlement (for contractors use only)   0   42.00   43.00   Balance due provider/program (see instructions)   45,540   43.00   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   44.00   Final coultier amount (see instructions)   0   90.00   Outlier reconciliation adjustment amount (see instructions)   0   91.00   0   0   0   0   0   0   0   0   0		· · · · · · · · · · · · · · · · · · ·				
39.50   Pi oneer ACO demonstration payment adjustment (see instructions)   0   39.50						•
Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.98					l '	1
39. 99   RECOVERY OF ACCELERATED DEPRECIATION   0   39. 99				tions)		
40.01   Sequestration adjustment (see instructions)   177, 360   40.01   41.00   Interim payments   8,645,081   41.00   42.00   Tentative settlement (for contractors use only)   0   42.00   43.00   Bal ance due provider/program (see instructions)   45,540   43.00   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   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 (see instructions)   0   93.00   93.00   Time Value of Money (see instructions)   0   93.00	39. 99	RECOVERY OF ACCELERATED DEPRECIATION	`	,	0	
41.00   Interim payments   8,645,081   41.00   42.00   43.00   43.00   Balance due provider/program (see instructions)   45,540   43.00   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   44.00   15   15   15   15   15   15   15	40.00	Subtotal (see instructions)			8, 867, 981	40. 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, 0 44.00 \$\frac{115.2}{5115.2}\$  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 42.00 43.00 44.00 45.540 44.00 90.00 90.00 90.00 90.00 91.00 92.00 93.00		l '			1	1
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{115.2}{5115.2}\$  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 To Be COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  90.00 Outlier reconciliation adjustment amount (see instructions)  92.00 Time Value of Money (see instructions)  93.00 Time Value of Money (see instructions)						1
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 The rate used to calculate the Time Value of Money 0.00 92.00 Time Value of Money (see instructions) 0 93.00						1
\$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 outlier reconciliation adjustment amount (see instructions) 0 outlier reconciliation adjustment amount (see instructions) 0 pl.00 1 The rate used to calculate the Time Value of Money 1 me Value of Money (see instructions) 0 pl.00 1 me Value of Money (see instructions) 0 pl.00					l	1
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)  90.00 Outlier reconciliation adjustment amount (see instructions)  90.00 Outlier reconciliation adjustment amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 Outlier reconciliation adjustment amount (see instructions)  93.00 Outlier reconciliation adjustment amount (see instructions)  93.00 Outlier reconciliation adjustment amount (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  95.00 Outlier reconciliation adjustment amount (see instructions)  96.00 Outlier reconciliation adjustment amount (see instructions)  97.00 Outlier reconciliation adjustment amount (see instructions)	14.00	§115. 2	CIII ONIO I UD. 10-Z,	onaptor I,	l	14.00
90.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00		TO BE COMPLETED BY CONTRACTOR				]
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		Original outlier amount (see instructions)	<u> </u>			
93.00 Time Value of Money (see instructions) 0 93.00		1				
					l	•
71. 00   10tdi (3diii 01 111103 71 diid 70)					1	•
	, 1. 00	1.0.a. (0a 01 111100 /1 dild /0)		ļ		, , , , , ,

Health Financial Systems	TERRE HAUTE REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150046	Peri od: From 09/01/2015	Worksheet E
		Component CCN: 15SO46		
		Title XVIII	Subprovi der -	PPS

		Title XVIII	Subprovi der - I PF	PPS		
				1. 00		
	PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			365	1. 00	
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		990		
3.00	PPS payments			1, 412	3.00	
4. 00 5. 00	Outlier payment (see instructions) Enter the hospital specific payment to cost ratio (see instruct	ions)		0. 000	4. 00 5. 00	
6. 00	Line 2 times line 5	1 0113)		0.000	6. 00	
7.00	Sum of line 3 plus line 4 divided by line 6			0. 00	7. 00	
8.00	Transitional corridor payment (see instructions)	aal 12 lina 200		0	8. 00	
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV Organ acquisitions	, COI. 13, TTHE 200		0	9. 00 10. 00	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			365		
	COMPUTATION OF LESSER OF COST OR CHARGES					
12 00	Reasonable charges		ı	2 040	12. 00	
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		3,000	12.00	
14. 00	Total reasonable charges (sum of lines 12 and 13)	,		3, 060		
	Customary charges					
15. 00 16. 00	Aggregate amount actually collected from patients liable for pa Amounts that would have been realized from patients liable for			0		
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	payment for services of	ii a ciiai gebasi s	U	10.00	
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000		
18.00	Total customary charges (see instructions)	: £   ! 10   !	11) (	3, 060		
19. 00	Excess of customary charges over reasonable cost (complete only instructions)	IT TIME 18 exceeds IT	ne II) (see	2, 695	19. 00	
20.00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20. 00	
21 00	instructions)	i natruati ana)		2/5	21 00	
21. 00 22. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see Interns and residents (see instructions)	instructions)		365 0	21. 00 22. 00	
23. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23. 00	
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			1, 412	24. 00	
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT  Deductibles and coinsurance (for CAH, see instructions)			0	25. 00	
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)		154		
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl			1, 623	27. 00	
28. 00	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, lin</pre>	0. 50)		0	28. 00	
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	e 30)		0		
30.00	Subtotal (sum of lines 27 through 29)			1, 623	30. 00	
31.00	Primary payer payments			0		
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE:	3)		1, 623	32. 00	
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	3)		0	33. 00	
34.00	Allowable bad debts (see instructions)			0	34.00	
35. 00	Adjusted reimbursable bad debts (see instructions)	-+!>		0	35. 00	
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see instru Subtotal (see instructions)	Ctrons)		0 1, 623	36. 00 37. 00	
38. 00	MSP-LCC reconciliation amount from PS&R			0		
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0		
39. 50	Pi oneer ACO demonstration payment adjustment (see instructions)	d daylaga (aga i natrua	t: ana)	0	39. 50	
39. 98 39. 99	Partial or full credits received from manufacturers for replace RECOVERY OF ACCELERATED DEPRECIATION	a devices (see instruc	tions)	0	39. 98 39. 99	
40.00	Subtotal (see instructions)			1, 623		
40. 01	Sequestration adjustment (see instructions)			32		
41. 00 42. 00	Interim payments Tentative settlement (for contractors use only)			1, 730 0	41. 00 42. 00	
43. 00	Balance due provider/program (see instructions)			-139		
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0		
	§115. 2					
90. 00	TO BE COMPLETED BY CONTRACTOR  Original outlier amount (see instructions)			0	90. 00	
91.00	Outlier reconciliation adjustment amount (see instructions)			0		
92. 00	The rate used to calculate the Time Value of Money				92. 00	
93.00	Time Value of Money (see instructions)			0	93. 00 94. 00	
74. UU	Total (sum of lines 91 and 93)		I	U	74.00	

Health Financial Systems	TERRE HAUTE REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150046		Worksheet E
			From 09/01/2015	
		Component CCN: 15TO46	To 08/31/2016	Date/Time Prepared:
		•		1/25/2017 6: 24 pm
		Title XVIII	Subprovi der -	PPS
			LDE	

		Title XVIII	Subprovi der - I RF	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			238	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)	ons)		192	2.00
3. 00 4. 00	PPS payments Outlier payment (see instructions)			390 0	3. 00 4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0. 000	
6.00	Line 2 times line 5	,		0	6. 00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	
8. 00 9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV	col 13 line 200		0	8. 00 9. 00
10.00	Organ acquisitions	, cor. 13, frile 200		0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			238	
	COMPUTATION OF LESSER OF COST OR CHARGES				
12. 00	Reasonable charges Ancillary service charges			1, 994	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)			1, 994	14. 00
15 00	Customary charges			0	15 00
15. 00 16. 00	Aggregate amount actually collected from patients liable for pa Amounts that would have been realized from patients liable for			0	15. 00 16. 00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	payment for services (	on a onal gobasi s		10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
18. 00 19. 00	Total customary charges (see instructions)	if line 10 exceeds li	no 11) (coo	1, 994	
19.00	Excess of customary charges over reasonable cost (complete only instructions)	II IIIle to exceeds II	The TT) (See	1, 756	19.00
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20. 00
21. 00	<pre>instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH see</pre>	instructions)		238	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			390	24. 00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for			0	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plinstructions)	us the sum of lines 22	2 and 23] (see	628	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	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)			628	
31. 00 32. 00	Primary payer payments Subtotal (line 30 minus line 31)			0 628	31. 00 32. 00
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE:	5)		020	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	,		0	33. 00
34.00	Allowable bad debts (see instructions)			0	
35. 00 36. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instru	rtions)		0	35. 00 36. 00
37. 00	Subtotal (see instructions)	011 0113)		628	
38. 00	MSP-LCC reconciliation amount from PS&R			0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50 39. 98	Prioneer ACO demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replace	d devices (see instru	rtions)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	a devices (see institut	311 0113)	0	39. 99
40.00	Subtotal (see instructions)			628	
40. 01	Sequestration adjustment (see instructions)			13	
41. 00 42. 00	Interim payments Tentative settlement (for contractors use only)			730	41. 00 42. 00
43. 00	Balance due provider/program (see instructions)			-115	
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90. 00
	Outlier reconciliation adjustment amount (see instructions)			0	91. 00
92.00	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	
00	1 (		'	١	

| Period: | Worksheet E-1 | From 09/01/2015 | Part | To 08/31/2016 | Date/Time Prepared: | 1/25/2017 6:24 pm Health Financial Systems TERRE ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 150046

Inpatient Part A				20/11/1		1/25/2017 6: 24	4 pm
1.00					Hospi tal	PPS	
1.00   2.00   3.00   4.00   1.00   2.00   3.00   4.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   2.00   3.645,081   1.00   2.00   1.00   1.00   1.00   2.00   3.645,081   1.00   2.00   1.00   1.00   2.00   3.645,081   1.00   2.00   3.645,081   1.00   2.00   3			inpatien	t Part A	Par	T B	
1.00							
Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.			1.00				
Submitted for to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero   3.00   List separately each retroactive lump sum adjustment amount based on subsequent revision of the Interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider   3.01   ADJUSTMENTS TO PROVIDER   0   0   3.00				22, 629, 890	)		1. 00
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero the interim rate for the Cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	2.00			(	)	0	2. 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							
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  ADJUSTMENTS TO PROVIDER  ADJUSTMENTS TO PROVIDER  O	0.00						0.00
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00						3.00
payment. If none, write "NONE" or enter a zero. (1)							
Program to Provider   ADJUSTMENTS TO PROVIDER							
ADJUSTMENTS TO PROVIDER							
3.02 3.03 3.04 3.05 3.06 3.07 3.09 3.09 3.09 3.09 3.09 3.00 3.00 3.00	3. 01			(		0	3. 01
3.03 3.04 3.05 Provider to Program 3.50 3.51 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.5.39) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wrst. E or Wrst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR TO BE COMPLETED BY CONTRACTOR TENTATIVE TO PROGRAM  TENTATIVE TO PR							3. 02
3. 50					)	l	3. 03
3. 50	3. 04					o	3. 04
3. 50   ADJUSTMENTS TO PROGRAM	3.05					0	3. 05
3.51   3.52   3.53   0   0   0   3.55     3.53   0   0   0   0   3.55     3.54   0   0   0   0   3.55     3.55   0   0   0   0   3.55     3.54   0   0   0   0   3.55     3.55   0   0   0   0   3.55     3.59   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		Provider to Program			•		
3.52   3.53   3.54   3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   3.50-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   22,629,890   8,645,081   4.00   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   To BE COMPLETED BY CONTRACTOR	3.50	ADJUSTMENTS TO PROGRAM		(	)	0	3. 50
3.53   3.54   3.54   0   0   0   0   3.55	3.51			(	)	0	3. 51
3.54   3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   22,629,890   8,645,081   4.00   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR							3. 52
3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   3.99   3.99   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   22,629,890   8,645,081   4.00   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR						1 - 1	3. 53
3.50-3.98   Total interim payments (sum of lines 1, 2, and 3.99)   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   To BE COMPLETED BY CONTRACTOR							
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)   22,629,890   8,645,081   4.00	3. 99			(	)	0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   To BE COMPLETED BY CONTRACTOR						0 / 15 001	
appropriate   TO BE COMPLETED BY CONTRACTOR	4.00			22, 629, 890	)	8, 645, 081	4.00
TO BE COMPLÉTED BY CONTRACTOR   S. 00							
Solid   List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	5 00						5 00
Write "NONE" or enter a zero. (1)   Program to Provider	3.00						3. 00
Program to Provider							
5. 02   0					•		
Description   Description	5. 01	TENTATI VE TO PROVI DER		(	)	0	5. 01
Provider to Program	5.02			(	)	0	5. 02
TENTATI VE TO PROGRAM	5.03			(	)	0	5. 03
5.51 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  0 0 0 5.51 0 0 0 5.52 0 0 0 0 5.52 0 0 0 0 5.52 0 0 0 0 5.52 0 0 0 0 5.52 0 0 0 0 0 5.52 0 0 0 0 0 0 5.52 0 0 0 0 0 0 0 0 5.52 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
5. 52   0   0   5. 52   5. 99   Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00   Determined net settlement amount (balance due) based on the cost report. (1) 6. 01   SETTLEMENT TO PROVIDER   0   45, 540   6. 01   6. 02   SETTLEMENT TO PROGRAM   71, 485   0   6. 02   7. 00   Total Medicare program liability (see instructions)   22, 558, 405   8, 690, 621   7. 00      Contractor NPR Date (Mo/Day/Yr)   0   1. 00   2. 00		TENTATI VE TO PROGRAM					
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  0 1. 00 2. 00						- 1	
5. 50 - 5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  0 1. 00 2.00				· ·		- 1	
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr) 0 1.00 2.00	5. 99	,		(	)	0	5. 99
the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 71, 485 7. 00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr) 0 1. 00 2. 00		1: :: : : : : : : : : : : : : : : : : :					/ 00
6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 70 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr) 0 1. 00 2. 00	6.00	, ,					6.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1.00 2.00	6 01					45 540	6 01
7.00 Total Medicare program liability (see instructions)  22,558,405  Contractor Number (Mo/Day/Yr)  0 1.00 2.00							
Contractor NPR Date   Number (Mo/Day/Yr)   0   1.00   2.00						ı	
Number         (Mo/Day/Yr)           0         1.00         2.00	7.00	10 tal moderous program readility (see Histractions)		22, 330, 400			7.00
0 1.00 2.00							
8.00 Name of Contractor 8.00			(	)			
	8.00	Name of Contractor					8. 00

		Ti tl	e XVIII	Subprovi der - I PF	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4.00	
1.00	Total interim payments paid to provider		983, 043		1, 730	1. 00
2.00	Interim payments payable on individual bills, either		C		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider			T		
3. 01	ADJUSTMENTS TO PROVIDER		C		0	3. 01
3. 02			C		0	3. 02
3. 03 3. 04			[		0	3. 03 3. 04
3. 04						3. 04
3.03	Provider to Program				0	3. 03
3.50	ADJUSTMENTS TO PROGRAM		С		0	3. 50
3.51			C		0	3. 51
3.52			C		0	3. 52
3. 53			C		0	3. 53
3.54			C		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C		0	3. 99
4 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		002 042		1 720	4 00
4. 00	(transfer to Wkst. E or Wkst. E-3, line and column as		983, 043		1, 730	4. 00
	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)					
5. 01	Program to Provider TENTATIVE TO PROVIDER		С		0	5. 01
5. 01	TENTATIVE TO PROVIDER					5. 01
5. 02			Ö		l ol	5. 02
0.00	Provider to Program					0.00
5.50	TENTATI VE TO PROGRAM		C		0	5. 50
5. 51			C		0	5. 51
5. 52			C		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C		0	5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on					6. 00
6.00	the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		33, 867		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		00,007		139	6. 02
7.00	Total Medicare program liability (see instructions)		1, 016, 910		1, 591	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	Name of Contractor	(	)	1. 00	2. 00	0.00
8. 00	Name of Contractor			I	l l	8. 00

		11 11	e XVIII	Subprovider - IRF	PPS	
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider	1.00	1, 775, 775		730	1. 00
2.00	Interim payments payable on individual bills, either		1,,,0,,,0		0	2.00
2.00	submitted or to be submitted to the contractor for				Ĭ	2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0		l ol	3. 02
3.03			0		o	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3.51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		o	3. 53
3.54			0		0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 775, 775		730	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)					
E 04	Program to Provider					F 04
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03	Dravi dan ta Dragnam		0		U	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		0		0	5. 50
5. 51	TENTATIVE TO PROGRAW					5. 50
5. 52			0			5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0			5. 99
J. 77	5. 50-5. 98)					3. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		59, 410		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0 0		115	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 835, 185		615	7. 00
			., 555, 165	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	•	•		1	'	

Heal th	Financial Systems	TERRE HAUTE REGIONAL	HOSPI TAI	In lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	TERRE TIMOTE REGIONAL	Provider CCN: 150046	Peri od: From 09/01/2015 To 08/31/2016	Worksheet E-1 Part II	pared:
			Title XVIII	Hospi tal	PPS	
					1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDA					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECT					
1. 00	Total hospital discharges as defined in AA			14	5, 481	1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col.		2		12, 752	2. 00
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, c		_		1, 721	3. 00
4.00	Total inpatient days from S-3, Pt. I col.		2		22, 647	4. 00
5. 00	Total hospital charges from Wkst C, Pt. I,				633, 950, 480	5. 00
6. 00	Total hospital charity care charges from W				1, 962, 946	6. 00
7. 00	CAH only - The reasonable cost incurred fo	r the purchase of cer	tified HII technology	Wkst. S-2, Pt. I	0	7. 00
0.00	line 168	!+!>				0.00
8.00	Calculation of the HIT incentive payment (	-			0	8. 00
9.00	Sequestration adjustment amount (see instr				0	9. 00
10.00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)				0	10. 00
20.00	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS					20.00
	Initial/interim HIT payment adjustment (se	e instructions)			0	30.00
	Other Adjustment (specify)	-: l: 20 l:	- 21) ( !+	- \	0	31. 00
32.00	Balance due provider (line 8 (or line 10)	minus line 30 and line	e 31) (see Instruction	S)	0	32. 00

Health Financial Systems	TERRE HAUTE REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150046	From 09/01/2015	Worksheet E-3 Part I Date/Time Pre 1/25/2017 6:2	pared:
		Title XVIII	Hospi tal	PPS	

				1/25/2017 6: 2	4 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - MEDICARE PART A SERVICES - TEFRA				
1.00	Inpatient hospital services (see instructions)			0	1.00
2.00	Organ acquisition			0	2. 00
3.00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	3. 00
4.00	Subtotal (sum of lines 1 thru 3)			0	4. 00
5.00	Primary payer payments			0	5. 00
6.00	Subtotal (line 4 less line 5).			0	6. 00
7.00	Deducti bl es			0	7. 00
8.00	Subtotal (line 6 minus line 7)			0	8. 00
9.00	Coinsurance			0	9. 00
10.00	Subtotal (line 8 minus line 9)			0	10.00
11. 00	Allowable bad debts (exclude bad debts for professional service	s) (see instructions)		0	11. 00
12.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			0	12. 00
13.00	3	ctions)		0	13. 00
14. 00	,			0	14. 00
15. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 49)		0	15. 00
16. 00					16. 00
17. 00				0	
17. 50	,			0	17. 50
				0	
18. 00				0	18. 00
18. 01	Sequestration adjustment (see instructions)			0	18. 01
19. 00				0	19. 00
20.00	3,			0	20. 00
21. 00	Balance due provider/program (line 18 minus lines 18.01, 19, an	d 20)		0	21. 00
22. 00	Protested amounts (nonallowable cost report items) in accordanc §115.2	e with CMS Pub. 15-2, o	chapter 1,	0	22. 00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPI	TAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi	der CCN: 150046		Worksheet E-3
			From 09/01/2015	
	Compor	onent CCN: 15SO46	To 08/31/2016	Date/Time Prepared:
	·			1/25/2017 6: 24 pm
	Т	Title XVIII	Subprovi der -	PPS
			. LDE	

Next Till - MEDICARE PART A SERVICES - IPF PPS   Next Till - MEDICARE PART A SERVICES - IPF PPS   Next Till - MEDICARE PART A SERVICES - IPF PPS   Next Till - MEDICARE PART A SERVICES - IPF PPS   Next Till - MEDICARE PART A SERVICES - IPF PPS   Next Till -		I PF		
New Teaching program adjustment (see instructions)   1.00, 10.00			1, 00	
2.00   Net IPF PPS Dutlier Payments   39,527   2.00   3.00   Net IPF PPS ED PPS ED Payments   0.30   3.00   Net IPF PPS ED PPS ED Payments   0.30   3.00   Net IPF PPS ED PPS ED Payments   0.00   3		PART II - MEDICARE PART A SERVICES - IPF PPS	1	
Net IPF PPS ECT Payments	1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1, 107, 169	1.00
Unweighted Intern and resident FTE count in the most recent cost report filed on or before November   15,004 (see Instructions)   2,004 (see Instructions)   2,004 (see Instructions)   2,004 (see Instructions)   2,006 (see Instructions)   3,007 (see Instructions)	2.00	Net IPF PPS Outlier Payments	89, 527	2. 00
15, 2004, (see instructions)	3.00	Net IPF PPS ECT Payments	0	3. 00
4.01   Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)   5.00   New Teaching program adjustment. (see instructions)   6.00   Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)   7.00   Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)   8.00   Intern and resident count for IPF PPS medical education adjustment (see instructions)   8.00   Intern and resident count for IPF PPS medical education adjustment (see instructions)   8.00   Intern and resident count for IPF PPS medical education adjustment (see instructions)   8.00   Intern and resident count for IPF PPS medical education adjustment (see instructions)   9.00   Captage Dail y Census (see instructions)   17.497268   9.00   0.0000000   17.400   0.000000   17.497268   9.00   0.000000   17.497268   9.00   0.000000   17.497268   9.00   0.000000   17.497268   9.00   0.000000   17.497268   9.00   0.000000   17.497268   9.00   0.000000   17.497268   9.00   0.000000   17.497268   9.00   0.0000000   17.497268   9.00   0.0000000   17.497268   9.00   0.0000000   17.497268   9.00   0.0000000000000000000000000000	4. 00		0.00	4. 00
Current year's unweighted FTE count of IRR excluding FTEs in the new program growth period of a "new teaching program" (see instructions)   0.00   7.00	4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42	0.00	4. 01
teaching program" (see instructions) 7.00 Current year's unwelghted I&R FIE count for residents within the new program growth period of a "new teaching program" (see instructions) 8.00 Intern and resident count for IPF PPS medical education adjustment (see instructions) 9.00 Average Dally Census (see instructions) 11, 497268 9,00 12,00 Teaching Adjustment Factor (((1 + (line B/line 9)) raised to the power of .5150 -1). 9.00 Old Teaching Adjustment factor (((1 + (line B/line 9)) raised to the power of .5150 -1). 9.00 Old Adjusted Net IPF PPS Payments (sum of Iines 1, 2, 3 and 11) 9.01 Old Adjusted Net IPF PPS Payments (sum of Iines 1, 2, 3 and 11) 9.02 Old Adjusted Net IPF PPS Payments (sum of Iines 1, 2, 3 and 11) 9.03 Old Nursing and Allied Health Managed Care payment (see instruction) 9.04 Organ acquisition (DO NOT USE THIS LINE) 9.05 Old Cost of physic lams' services in a teaching hospital (see instructions) 9.07 Old Porturn Py payer payments 9.08 Subtotal (line 16 less line 17). 9.09 Old Deductibles 9.00 Old Color (line 16 less line 17) 9.00 Old Color (line 16 less line 17) 9.00 Old Color (line 18 minus line 19) 9.00 Old Color (line 20 minus line 19) 9.00 Deductibles 9.01 Old Color (line 20 minus line 21) 9.00 Old Color (line 20 minus line 21) 9.00 Old Old Color (line 20 minus line 21) 9.00 Old Old Color (line 20 minus line 21) 9.00 Old Old Color (line 20 minus line 21) 9.00 Old Old Color (line 20 minus line 21) 9.00 Old Old Color (line 20 minus line 21) 9.00 Old Old Color (line 20 minus line 21) 9.00 Old Color (line 20 minus line 21) 9.00 Old Color (line 20 minus line 21) 9.00 Old Color (line 20 minus line 21) 9.00 Old Old Color (line 20 minus line 21) 9.00 Old Old Color (line 20 minus line 21) 9.00 Old Old Color (line 20 minus line 21) 9.00 Old Old Color (line 20 minus line 21) 9.00 Old Old Color (line 20 minus line 21) 9.00 Old Old Color (line 20 minus line 21) 9.00 Old Old Color (line 20 minus line 21) 9.00 Old Old Color (line 20 minus line 21) 9.00 Old Old Color (line 20 minus line 21) 9.00 Old Old Col	5.00	New Teaching program adjustment. (see instructions)	0.00	5. 00
2.00   Current year's unweighted IRR FTE count for residents within the new program growth period of a "new teaching program" (see instructions)   0.00   8.00	6. 00		0.00	6. 00
No.   Netron and resident count for IPF PPS medical education adjustment (see instructions)   1.00   8.00   8.00   No.	7. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0.00	7. 00
	8.00		0.00	8.00
10. 00   Teaching Adjustment Factor (((1 + (line B/line 9)) raised to the power of .5150 -1).   0.000000   10. 00   10				
11. 00   Teaching Adjustment (line 1 multiplied by line 10).   11. 00   12. 00   13. 00   13. 00   14. 00   14. 00   15. 00   1			1	
12.00			1	
13. 00   Nursing and Allied Health Managed Care payment (see instruction)   14. 00   0rgan acquisition (DD NOT USE THIS LINE)   14. 00   15. 00   0rgan acquisition (DD NOT USE THIS LINE)   14. 00   15. 00   0rgan acquisition (DD NOT USE THIS LINE)   11. 196, 696   16. 00   15. 00   0rgan acquisition (DD NOT USE THIS LINE)   1. 196, 696   16. 00   17. 00   0rgan acquisition (DD NOT USE THIS LINE)   1. 196, 696   16. 00   17. 00   0rgan acquisition (DD NOT USE THIS LINE)   1. 196, 696   18. 00   17. 00   0rgan acquisition (DD NOT USE THIS LINE)   1. 196, 696   18. 00   19. 00   0rgan acquisition (DD NOT USE THIS LINE)   1. 196, 696   18. 00   19. 00   0rgan acquisition (DD NOT USE THIS LINE)   1. 19. 00   1. 19. 00   0rgan acquisition (DD NOT USE THIS LINE)   1. 19. 00   1. 19. 00   0rgan acquisition (DD NOT USE THIS LINE)   1. 19. 00   1. 19. 00   0rgan acquisition (DD NOT USE THIS LINE)   1. 19. 00   1. 19. 00   0rgan acquisition (DD NOT USE THIS LINE)   1. 19. 00   1. 19. 00   0rgan acquisition (DD NOT USE THIS LINE)   1. 19. 00   1. 19. 00   0rgan acquisition (DD NOT Use This payments (PD NOT Use This payments (PD NOT Use This Line 19)   1. 19. 00   0rgan acquisition (DD NOT Use This Line 19)   1. 19. 00   0rgan acquisition (DD NOT Use This Line 19)   1. 19. 00   0rgan acquisition (DD NOT Use This Line 19)   1. 19. 0rgan acquisition (DD NOT Use This Line 19)   1. 19. 00   0rgan acquisition (DD NOT Use This Line 19)   1. 19. 00   0rgan acquisition (DD NOT Use This Line 19)   1. 19. 00   0rgan acquisition (DD NOT Use This Line 19)   1. 19. 0rgan acquisition (DD NOT Use This Line 19)   1. 19. 0rgan acquisition (DD NOT Use This Line 19)   1. 19. 0rgan acquisition (DD NOT Use This Line 19)   1. 19. 0rgan acquisition (DD NOT Use This Line 19)   1. 19. 0rgan acquisition (DD NOT Use This Line 19)   1. 19. 0rgan acquisition (DD NOT Use This Line 19)   1. 19. 0rgan acquisition (DD NOT Use This Line 19)   1. 19. 0rgan acquisition (DD NOT Use This Line 19)   1. 19. 0rgan acquisition (DD NOT Use This Line 19)   1. 19. 0			1	
14. 00   Organ acquisition (D0 NOT USE THIS LINE)   14. 00   Cost of physicians' services in a teaching hospital (see instructions)   0   15. 00   15. 00   17. 00   Primary payer payments   0   17. 00   17. 00   17. 00   Primary payer payments   0   17. 00   17. 00   Primary payer payments   0   17. 00   17. 00   Primary payer payments   0   17. 00   17. 00   17. 00   Primary payer payments   0   17. 00   17.				
15.00				
1, 196, 696   16, 000   1, 196, 696   16, 000   1, 196, 696   16, 000   1, 196, 696   18, 00   19, 000   1, 196, 696   18, 00   19, 00				
17. 00   Primary payer payments			1	
18. 00       Subtotal (line 16 less line 17).       1, 196, 696       18. 00         19. 00       Deductibles       148, 112       19. 00         21. 00       Subtotal (line 18 minus line 19)       1, 048, 584       20. 00         21. 00       Coinsurance       45, 479       21. 00         22. 00       Subtotal (line 20 minus line 21)       1, 003, 105       22. 00         24. 00       Adjusted reimbursable bad debts (exclude bad debts for professional services) (see instructions)       34, 558       24. 00         25. 00       All lowable bad debts for dual eligible beneficiaries (see instructions)       10, 983       25. 00         26. 00       Subtotal (sum of lines 22 and 24)       1, 037, 663       26. 00         27. 00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0       27. 00         28. 00       Other pass through costs (see instructions)       0       27. 00         29. 00       Other pass through costs (see instructions)       0       29. 00         30. 50       Other pass through costs (see instructions)       0       29. 00         30. 50       Other pass through costs (see instructions)       0       29. 00         30. 50       Other payments reconciliation       0       29. 00         30. 50				
19. 00     148, 112   19. 00   20. 00			1	
20.00   Subtotal (line 18 minus line 19)   1,048,584   20.00   21.00   Coinsurance   45,479   21.00   22.00   22.00   Subtotal (line 20 minus line 21)   1,003,105   22.00   23.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   53,166   23.00   24.00   Adjusted reimbursable bad debts for beneficiaries (see instructions)   34,558   24.00   25.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   10,983   25.00   26.00   Subtotal (sum of lines 22 and 24)   1,037,663   26.00   27.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0 27.00   28.00   29.0				
21.00   Coinsurance   45,479   21.00   22.00   Subtotal (line 20 minus line 21)   1,003,105   22.00   23.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   53,166   23.00   24.00   Adjusted reimbursable bad debts (see instructions)   34,558   24.00   25.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   10,983   25.00   25.00   Subtotal (sum of lines 22 and 24)   1,037,663   25.00   27.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0   27.00   28.00   Other pass through costs (see instructions)   0   28.00   0   28.00   0   29.00   0   0   0   0   0   0   0   0   0				
22.00   Subtotal (line 20 minus line 21)   1,003,105   22.00   23.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   53,166   23.00   24.00   Adjusted reimbursable bad debts (see instructions)   34,558   24.00   25.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   10,983   25.00   26.00   Subtotal (sum of lines 22 and 24)   1,037,663   26.00   27.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0   27.00   27				
23.00				
24.00       Adjusted reimbursable bad debts (see instructions)       34,558       24.00         25.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       10,983       25.00         26.00       Subtotal (sum of lines 22 and 24)       1,037,663       25.00         27.00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0       27.00         28.00       Other pass through costs (see instructions)       0       28.00         29.00       Outlier payments reconciliation       0       29.00         30.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       30.00         30.50       Pioneer ACO demonstration payment adjustment (see instructions)       0       30.00         30.99       Recovery of Accelerated Depreciation       0       30.99         31.01       Sequestration adjustment (see instructions)       1,037,663       31.00         32.00       Interim payments       20,753       33.100         33.00       Tentative settlement (for contractor use only)       0       33.00         34.00       Balance due provider/program (line 31 minus lines 31.01, 32 and 33)       33,867       34.00         35.00       To BE COMPLETED BY CONTRACTOR       89,527       50.00         50.00				
25. 00				
26.00 Subtotal (sum of lines 22 and 24)  27.00 Direct graduate medical education payments (from Wkst. E-4, line 49)  28.00 Other pass through costs (see instructions)  30.00 OUTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS				
27. 00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0       27. 00         28. 00       Other pass through costs (see instructions)       0       28. 00         29. 00       Outlier payments reconciliation       0       29. 00         30. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       30. 00         30. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0       30. 00         30. 99       Recovery of Accelerated Depreciation       0       30. 99         31. 00       Total amount payable to the provider (see instructions)       1, 037, 663       31. 00         32. 01       Interim payments       20, 753       31. 01         32. 00       Tentative settlement (for contractor use only)       0       33. 00         34. 00       Balance due provider/program (line 31 minus lines 31.01, 32 and 33)       33, 867       34. 00         35. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0       35. 00         51. 00       Original outlier amount from Worksheet E-3, Part II, line 2       89, 527       50. 00         51. 00       Outlier reconciliation adjustment amount (see instructions)       0       51. 00         52. 00       The rate used to calculate the Time Value of Mon		, , , , , , , , , , , , , , , , , , ,		
28.00 Other pass through costs (see instructions) 0 28.00 29.00 Outlier payments reconciliation 0 29.00 30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 30.00 30.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 30.50 30.99 Recovery of Accelerated Depreciation 0 30.99 31.00 Total amount payable to the provider (see instructions) 1,037,663 31.00 31.01 Sequestration adjustment (see instructions) 20,753 31.01 32.00 Interim payments 983,043 32.00 33.00 Tentative settlement (for contractor use only) 983,043 32.00 34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33) 33,867 34.00 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 \$\frac{\text{5115.2}}{\text{TO BE COMPLETED BY CONTRACTOR}} 0 01 interim payment from Worksheet E-3, Part II, line 2 0 01 ier reconciliation adjustment amount (see instructions) 0 51.00 52.00 The rate used to calculate the Time Value of Money 0.00 52.00	26. 00	Subtotal (sum of lines 22 and 24)	1, 037, 663	26. 00
29. 00       Outlier payments reconciliation       0       29. 00         30. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       30. 00         30. 50       Pi oneer ACO demonstration payment adjustment (see instructions)       0       30. 50         30. 99       Recovery of Accel erated Depreciation       0       30. 99         31. 00       Total amount payable to the provider (see instructions)       1, 037, 663       31. 00         31. 01       Sequestration adjustment (see instructions)       20, 753       31. 01         32. 00       Interim payments       983, 043       32. 00         33. 00       Tentative settlement (for contractor use only)       0       33. 00         34. 00       Balance due provider/program (line 31 minus lines 31.01, 32 and 33)       33, 867       34. 00         35. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0       35. 00         50. 00       Original outlier amount from Worksheet E-3, Part II, line 2       89, 527       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	27. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27. 00
30.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   30.00   30.50   30.50   9Pi oneer ACO demonstration payment adjustment (see instructions)   0   30.50   30.99   30.99   30.00   30.99   30.00   30.99   30.00   30.99   30.00   30.00   30.99   30.00   30.99   30.00	28. 00	Other pass through costs (see instructions)	0	28. 00
30.50   Pi oneer ACO demonstration payment adjustment (see instructions)   0   30.50   30.99   30.99   30.00   30.99   30.00   30.99   30.00   30.099   30.00   30.0	29. 00	Outlier payments reconciliation	0	29. 00
30.99   Recovery of Accelerated Depreciation   0   30.99   31.00   Total amount payable to the provider (see instructions)   1,037,663   31.00   31.01   Sequestration adjustment (see instructions)   20,753   31.01   32.00   Interim payments   983,043   32.00   33.00   Tentative settlement (for contractor use only)   0   33.00   34.00   Balance due provider/program (line 31 minus lines 31.01, 32 and 33)   33,867   34.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
31.00   Total amount payable to the provider (see instructions)   1,037,663   31.00   31.01   Sequestration adjustment (see instructions)   20,753   31.01   32.00   Interim payments   983,043   32.00   33.00   Tentative settlement (for contractor use only)   0   33.00   33.00   33.00   33.867   34.00   35.00   Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   35.00   The rate used to calculate the Time Value of Money   0.00   52.00   The rate used to calculate the Time Value of Money   0.00   52.00   0.00   0.00   52.00   0.00	30. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30. 50
31.01   Sequestration adjustment (see instructions)   20,753   31.01   32.00   Interim payments   983,043   32.00   33.00   Tentative settlement (for contractor use only)   0   33.00   33.00   34.00   Bal ance due provider/program (line 31 minus lines 31.01, 32 and 33)   33,867   34.00   Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   35.00   Silbs. 2   TO BE COMPLETED BY CONTRACTOR	30. 99	Recovery of Accelerated Depreciation	0	30. 99
32.00   Interim payments   983,043   32.00   33.00   Tentative settlement (for contractor use only)   0   33.00   34.00   Balance due provider/program (line 31 minus lines 31.01, 32 and 33)   33,867   34.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   35.00   Si15.2   TO BE COMPLETED BY CONTRACTOR   50.00   Original outlier amount from Worksheet E-3, Part II, line 2   89,527   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	31.00	Total amount payable to the provider (see instructions)	1, 037, 663	31. 00
32.00   Interim payments   983,043   32.00   33.00   Tentative settlement (for contractor use only)   0   33.00   34.00   Balance due provider/program (line 31 minus lines 31.01, 32 and 33)   33,867   34.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   35.00   Si15.2   TO BE COMPLETED BY CONTRACTOR   50.00   Original outlier amount from Worksheet E-3, Part II, line 2   89,527   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	31. 01			
33.00 Tentative settlement (for contractor use only)  34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33)  35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  50.00 Original outlier amount from Worksheet E-3, Part II, line 2  50.00 Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  33.00  33.00  33.00  33.00  33.00  33.00  34.00  35.00  35.00  50.00  50.00  50.00  50.00  50.00  50.00  50.00				
34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33)  33,867 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) and accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) and accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) and accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) and accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) and accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) and accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) and accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) and accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) and accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) and accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) and accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) and accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) and accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) and accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) and accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) and accordance with				
35.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$1.00 \$1.		· · · · · · · · · · · · · · · · · · ·	1	
50.00 Original outlier amount from Worksheet E-3, Part II, line 2 51.00 Outlier reconciliation adjustment amount (see instructions) 51.00 The rate used to calculate the Time Value of Money  89,527 50.00 51.00 52.00 The rate used to calculate the Time Value of Money		Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		35. 00
51.00 Outlier reconciliation adjustment amount (see instructions)  0 51.00 The rate used to calculate the Time Value of Money  0.00 52.00				
52.00 The rate used to calculate the Time Value of Money 0.00 52.00	50.00	Original outlier amount from Worksheet E-3, Part II, line 2	89, 527	50. 00
	51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
53.00   Time Value of Money (see instructions)   0   53.00	52.00	The rate used to calculate the Time Value of Money	0.00	52. 00
	53.00	Time Value of Money (see instructions)	0	53.00

Health Financial Systems	TERRE HAUTE REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150046	Peri od: From 09/01/2015	Worksheet E-3
	Component CCN: 15T046		
	Title XVIII	Subprovi der -	PPS
		I RF	

Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)   0.00   7.00			IRF				
No.   Net Federal PPS Payment (see instructions)   1.517,104   1.00   Net Federal PPS Payment (see instructions)   0.0448   2.00   1.							
Net Federal PPS Payment (see Instructions)   1,517,104   1.00		DIST. LL. MEDICINE DATA CEDITICE. LDC DEC					
Medicare SSI ratio (IRF PPS only) (see instructions)   10.448   2.00   10.01	1 00			1 517 104	1 00		
1,00     1   1,00     1,00							
0.00   Utilier Payments   266,793   4.00   5.00   United pixed intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)   5.00   S. 00   S.		, , , , ,					
Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to Nowmber 15, 2004 (see instructions)		1 '					
to November 15, 2004 (see instructions) c1 captured intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412, 424(d)(1)(iii)(F)(1) or (2) (see instructions) c2 captured year's unweighted FTE count of 18 Rexcluding FTEs in the new program growth period of a "new teaching program" (see instructions) c3 captured year's unweighted FTE count for lake Rexcluding FTEs in the new program growth period of a "new teaching program" (see instructions) c4 carrier year's unweighted FTE count for lake Rexcluding FTEs in the new program growth period of a "new teaching program" (see instructions) c1 counter year's unweighted FTE count for residents within the new program growth period of a "new teaching program" (see instructions) c1 countern and resident count for IRR PPS medical education adjustment (see instructions) c1 countern and resident count for IRR PPS medical education adjustment (see instructions) c1 countern and resident Factor (see instructions) c1 countern and resident Factor (see instructions) c1 countern and resident factor (see instructions) c1 countern and resident (see instructions) c1 countern and resident factor (see instructions) c1 countern and resident factor (see instructions) c1 countern and resident (see instructions) c1 countern and resident (see instructions) c1 countern and resident (see instructions) c1 countern and resident (see instructions) c1 countern and resident (see instructions) c1 countern and resident (see instructions) c1 countern and resident (see instructions) c1 countern and resident (see instructions) c1 countern and resident (see instructions) c1 countern and resident (see instructions) c1 countern and resident (see instructions) c1 countern and resident (see instructions) c1 countern and resident (see instructions) c1 countern and resident (see instructions) c1 countern and resident (see instructions) c2 countern and resident (see instructions) c2 countern and re			ding on or prior	·			
Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 (FR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)	5.00		aring on or prior	0.00	3.00		
program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CRR \$412.424(d)(1)(i)(i)(i)(i)(i)(i) (i) (i) (i) (i) (i)	5 01		e displaced by	0.00	5 01		
CFR §412.424(d)(1)(11)(F)(1) or (2) (see instructions)   0.00   6.00   0.00	5.01	]	,	0.00	3.01		
New Teaching program adjustment. (see instructions)   0.00 6.00			morre drider 12				
Courrent year's unweighted FTE count of IAR excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	6.00			0.00	6. 00		
teaching program" (see instructions)  0. 00 (Urrent year's unweighted 188 FTE count for residents within the new program growth period of a "new teaching program" (see instructions)  1. 00 (1.00 Average Dail ty Census (see instructions)  1. 00 Teaching Adjustment Factor (see instructions)  1. 00 Teaching Adjustment Factor (see instructions)  1. 01 Teaching Adjustment (see instructions)  1. 02 Teaching Adjustment (see instructions)  1. 03 Total PPS Payment (see instructions)  1. 04 Total PPS Payment (see instructions)  1. 05 Total PPS Payment (see instructions)  1. 06 Total PPS Payment (see instructions)  1. 07 Total PPS Payment (see instructions)  1. 08 Total PPS Payment (see instructions)  1. 08 Total PPS Payment (see instructions)  1. 08 Total PPS Payment (see instructions)  1. 09 Total PPS Payment (see instructions)  1. 00 Total PPS Payment (s	7. 00		eriod of a "new				
Current 'year's unweighted I&R FIE count for residents within the new program growth period of a "new teaching program" (see instructions)   0.00							
teaching program" (see instructions) 10.00 20.00	8.00	,	eriod of a "new	0.00	8. 00		
11.00   Teaching Adjustment Factor (see instructions)   0.000000   11.00   12.00   Teaching Adjustment (see instructions)   0.20.00   12.00	9.00			0.00	9. 00		
	10.00	Average Daily Census (see instructions)		4. 991803	10.00		
Total PPS Payment (see instructions)   1,887,212   13.00   14.00   Nursing and Allied Health Managed Care payments (see instruction)   14.00   15.00   15.00   16.00	11.00	Teaching Adjustment Factor (see instructions)		0.000000	11. 00		
14.00	12.00	Teaching Adjustment (see instructions)		0	12.00		
15.00   Organ acquisition (D0 NOT USE THIS LINE)   15.00   16.00   16.00   17.00   18.00   17.00   18.00   1	13.00	Total PPS Payment (see instructions)		1, 887, 212	13.00		
16.00   Cost of physicians' services in a teaching hospital (see instructions)   0   16.00   1,887,212   17.00   Subtotal (see instructions)   0   1,887,212   17.00   18.00   Primary payer payments   0   18.00   1,887,212   19.00   1,887,212   19.00   1,800	14.00	Nursing and Allied Health Managed Care payments (see instruction)		0	14.00		
17.00   Subtotal (see instructions)   1,887,212   17.00   18.00   Primary payer payments   1,887,212   19.00   18.00   19.00   20.00	15.00	Organ acquisition (DO NOT USE THIS LINE)			15.00		
18.00   Primary payer payments   0   18.00	16.00	Cost of physicians' services in a teaching hospital (see instructions)		0	16.00		
19.00   Subtotal (line 17 less line 18).   1,887,212   19.00   20.00   Deductibles   7,644   20.00   21.00   Subtotal (line 19 minus line 20)   1,879,568   21.00   22.00   Coinsurance   6,930   22.00   23.00   Subtotal (line 21 minus line 22)   1,872,638   23.00   Adjusted reimbursable bad debts (exclude bad debts for professional services) (see instructions)   0,25.00   Adjusted reimbursable bad debts (see instructions)   0,25.00   Adjusted reimbursable bad debts (see instructions)   0,25.00   Adjusted reimbursable bad debts (see instructions)   0,25.00   Adjusted reimbursable bad debts (see instructions)   0,25.00   Adjusted reimbursable bad debts (see instructions)   0,25.00   Adjusted reimbursable bad debts (see instructions)   0,25.00   Adjusted reimbursable bad debts (see instructions)   0,25.00   Adjusted reimbursable bad debts (see instructions)   0,25.00   Adjusted reimbursable bad debts (see instructions)   0,25.00   Adjusted reimbursable bad debts (see instructions)   0,25.00   Adjusted reimbursable bad debts (see instructions)   0,25.00   25.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0,28.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0,29.00	17.00	Subtotal (see instructions)		1, 887, 212	17.00		
Deductibles   7,644   20.00   20.00   Subtotal (line 19 minus line 20)   1,879,568   21.00   22.00   Coinsurance   6,930   22.00   Coinsurance   5.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   0   25.00   25.00   Allowable bad debts (see instructions)   0   25.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   26.00   27.00   Subtotal (sum of lines 23 and 25)   1,872,638   27.00   27.00   Subtotal (sum of lines 23 and 25)   1,872,638   27.00   27.00   Coinsurance   2	18.00	Pri mary payer payments		0	18.00		
Subtotal (line 19 minus line 20)	19.00	Subtotal (line 17 less line 18).		1, 887, 212	19.00		
Coinsurance	20.00	Deducti bl es		7, 644	20.00		
23. 00   Subtotal (line 21 minus line 22)   1,872,638   23. 00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   0   24. 00   24. 00   25. 00   Allowable bad debts (see instructions)   0   25. 00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   26. 00   27. 00   Subtotal (sum of lines 23 and 25)   1,872,638   27. 00   28. 00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0   28. 00   29. 00   00   00   00   00   00   00   00	21. 00	Subtotal (line 19 minus line 20)		1, 879, 568	21.00		
All owable bad debts (exclude bad debts for professional services) (see instructions)  All owable bad debts (see instructions)  All owable bad debts (see instructions)  All owable bad debts for dual eligible beneficiaries (see instructions)  Subtotal (sum of lines 23 and 25)  Busclet graduate medical education payments (from Wkst. E-4, line 49)  Direct graduate medical education payments (from Wkst. E-4, line 49)  Other pass through costs (see instructions)  Other pass through costs (see instructions)  Outlier payments reconciliation  Other ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  Pioneer ACO demonstration payment adjustment (see instructions)  Recovery of Accelerated Depreciation  Total amount payable to the provider (see instructions)  Sequestration adjustment (see instructions)  1, 872, 638  32. 00  Interim payments  Tentative settlement (for contractor use only)  Balance due provider/program (line 32 minus lines 32.01, 33, and 34)  Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 51.00  To BE COMPLETED BY CONTRACTOR  Original outlier amount from Wkst. E-3, Pt. III, line 4  Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  O. 00  Differ and used instructions  Occupance instructions  24. 00  25. 00  24. 00  25. 00  26. 00  28. 00  28. 00  28. 00  29. 00  2	22. 00	Coinsurance		6, 930	22. 00		
25. 00   Adjusted reimbursable bad debts (see instructions)   0   25. 00	23. 00			1, 872, 638	23. 00		
26. 00	24. 00						
27. 00   Subtotal (sum of lines 23 and 25)   1,872,638   27. 00   28. 00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0   28. 00   29. 00   0   0   0   0   0   0   0   0   0	25. 00	Adjusted reimbursable bad debts (see instructions)		0	25. 00		
Direct graduate medical education payments (from Wkst. E-4, line 49)   0   28.00	26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)					
29.00   Other pass through costs (see instructions)   0   29.00	27. 00			1, 872, 638			
30.00 Outlier payments reconciliation 0 30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 31.00 Sequestration payment adjustment (see instructions) 0 31.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 31.50 Sequestration adjustment (see instructions) 1,872,638 32.00 Total amount payable to the provider (see instructions) 1,872,638 32.00 Sequestration adjustment (see instructions) 37,453 32.01 Interim payments 1,775,775 33.00 Interim payments 1,775,775 33.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 Outlier reconciliation adjustment amount (see instructions) 0 51.00 The rate used to calculate the Time Value of Money 0.00 52.00	28. 00						
OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   31.00	29. 00	Other pass through costs (see instructions)			29. 00		
Recovery of Accelerated Depreciation Total amount payable to the provider (see instructions) Responsible to the provide	30. 00						
Recovery of Accelerated Depreciation 0 31.99 Total amount payable to the provider (see instructions) 1,872,638 32.00 Sequestration adjustment (see instructions) 37,453 32.01 Interim payments 1,775,775 33.00 Tentative settlement (for contractor use only) 0 34.00 Balance due provider/program (line 32 minus lines 32.01, 33, and 34) 59,410 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Total amount payable to the provider (see instructions) 32.01 Tentative settlement (for contractor use only) 59,410 35.00 Tentative settlement (for contractor use only) 59,410 35.00 Tentative settlement (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Total amount payable to the provider (see instructions) 50.00 Total amount payable to the provider (see instructions) 51.00 Tentative settlement (for contractor use only) 51.00 Tentative settlemen	31. 00						
Total amount payable to the provider (see instructions)  32.00 Sequestration adjustment (see instructions)  33.00 Interim payments  34.00 Tentative settlement (for contractor use only)  35.00 Balance due provider/program (line 32 minus lines 32.01, 33, and 34)  36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  36.00 Original outlier amount from Wkst. E-3, Pt. III, line 4  36.100 Outlier reconciliation adjustment amount (see instructions)  37, 453 32.00  37, 453 32.00  38.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  36.00 Outlier reconciliation adjustment amount (see instructions)  36.00 Outlier reconciliation adjustment amount (see instructions)  37, 453 32.00  32.00 Outlier reconciliation adjustment amount in accordance with CMS Pub. 15-2, chapter 1,  38.00 Outlier reconciliation adjustment amount (see instructions)  38.00 Outlier reconciliation adjustment amount (see instructions)  39.00 Outlier reconciliation adjustment amount (see instructions)  30.00 Outlier reconciliation adjustment amount (see instructions)	31. 50						
32. 01 Sequestration adjustment (see instructions) 37, 453 32. 01 Interim payments 31, 775, 775 33. 00 32. 01 Tentative settlement (for contractor use only) 38. 00 Balance due provider/program (line 32 minus lines 32.01, 33, and 34) 39. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36. 00 39. 00 Original outlier amount from Wkst. E-3, Pt. III, line 4 39. 00 Outlier reconciliation adjustment amount (see instructions) 30. 00 Outlier retounciliation adjustment amount (see instructions) 30. 00 Outlier retounciliation adjustment amount (see instructions) 30. 00 Outlier retounciliation adjustment amount (see instructions) 31. 00 Outlier retounciliation adjustment amount (see instructions) 31. 00 Outlier retounciliation adjustment amount (see instructions) 31. 00 Outlier retounciliation adjustment amount (see instructions) 32. 01 Outlier retounciliation adjustment amount (see instructions) 32. 01 Outlier retounciliation adjustment amount (see instructions) 32. 01 Outlier retounciliation adjustment amount (see instructions) 32. 01 Outlier retounciliation adjustment amount (see instructions) 33. 00 Outlier retounciliation adjustment amount (see instructions) 34. 00 Outlier retounciliation adjustment amount (see instructions)	31. 99			-			
1,775,775 33.00 Tentative settlement (for contractor use only) 36.00 Balance due provider/program (line 32 minus lines 32.01, 33, and 34) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  TO BE COMPLETED BY CONTRACTOR Original outlier amount from Wkst. E-3, Pt. III, line 4 Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money  1, 775, 775 33.00 34.00 54.00 55.00 56.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 Outlier reconciliation adjustment amount (see instructions) Oncomparison of the contractor use only) n the contractor use only on the contractor use only on the contractor use only on the contractor use on the contractor use on the contractor use on the contractor use on the contractor use on the contractor use on the contractor use on the contractor use on the contractor use on the contractor use on the contractor use on the contractor use on t	32. 00						
Tentative settlement (for contractor use only)  34.00 Balance due provider/program (line 32 minus lines 32.01, 33, and 34)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  TO BE COMPLETED BY CONTRACTOR  Original outlier amount from Wkst. E-3, Pt. III, line 4  Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  34.00 35.00 36.00  Tentative settlement (for contractor use only)  0 34.00 35.00 36.00 59,410 36.00 36.00  50.00	32. 01						
Balance due provider/program (line 32 minus lines 32.01, 33, and 34)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  TO BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4  Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  50.00 Balance due provider/program (line 32 minus lines 32.01, 33, and 34)  59, 410 35.00  36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  0 36.00  50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  §115. 2  TO BE COMPLETED BY CONTRACTOR  Outlier amount from Wkst. E-3, Pt. III, line 4  Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  36. 00  50. 00  50. 00  50. 00  50. 00  50. 00  50. 00	34. 00			-			
\$115.2 TO BE COMPLETED BY CONTRACTOR  Original outlier amount from Wkst. E-3, Pt. III, line 4  Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  \$115.2  \$266,793 50.00  \$51.00  \$51.00  \$52.00 The rate used to calculate the Time Value of Money  \$52.00 The rate used to calculate the Time Value of Money							
TO BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4  51.00 Outlier reconciliation adjustment amount (see instructions)  52.00 The rate used to calculate the Time Value of Money  53.00 The rate used to calculate the Time Value of Money  54.00 The rate used to calculate the Time Value of Money	36. 00		chapter 1,	0	36. 00		
50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money 50.00 The rate used to calculate the Time Value of Money 50.00 The rate used to calculate the Time Value of Money 50.00 The rate used to calculate the Time Value of Money							
51.00 Outlier reconciliation adjustment amount (see instructions)  0 51.00 The rate used to calculate the Time Value of Money  0.00 52.00							
52.00 The rate used to calculate the Time Value of Money 0.00 52.00	50.00			· ·			
		, , ,		-			
os. ou   it me value or money (see instructions)   0  53.00							
	ეკ. 00	Titile value of money (see instructions)		0	os. 00		

Heal th	Financial Systems	TERRE HAUTE REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150046	Peri od:	Worksheet E-3	
				From 09/01/2015		
				To 08/31/2016		oared:
					1/25/2017 6: 2	4 pm
			Title XIX	Hospi tal	Cost	
				I npati ent	Outpati ent	
				1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT -	ALL OTHER HEALTH SERV	ICES FOR TITLES V OR X	IX SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICE	S				
1.00	Inpatient hospital/SNF/NF services			6, 981, 245		1.00
2.00	Medical and other services				7, 827, 770	2.00
3.00	Organ acquisition (certified transplant ce	enters only)		0		3.00

		Inpatient	Outpati ent	
		1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	6, 981, 245		1.00
2.00	Medical and other services		7, 827, 770	2. 00
3.00	Organ acquisition (certified transplant centers only)	0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)	6, 981, 245	7, 827, 770	4.00
5.00	Inpatient primary payer payments	0	, . , .	5. 00
6.00	Outpatient primary payer payments		0	1
7. 00	Subtotal (line 4 less sum of lines 5 and 6)	6, 981, 245	7, 827, 770	1
7.00	COMPUTATION OF LESSER OF COST OR CHARGES	0, 701, 210	7,027,770	7.00
	Reasonable Charges			
8. 00	Routine service charges	ام		8.00
9. 00	Ancillary service charges	42, 990, 020	65, 998, 514	9.00
			05, 998, 514	1
10.00	Organ acquisition charges, net of revenue	0		10.00
11. 00	Incentive from target amount computation	0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)	42, 990, 020	65, 998, 514	12.00
	CUSTOMARY CHARGES			
13. 00	Amount actually collected from patients liable for payment for services on a charge	0	0	13. 00
	basis			
14. 00	Amounts that would have been realized from patients liable for payment for services on	0	0	14. 00
	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15. 00
16.00	Total customary charges (see instructions)	42, 990, 020	65, 998, 514	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds	36, 008, 775	58, 170, 744	17. 00
	line 4) (see instructions)			
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line	o	0	18. 00
	16) (see instructions)			
19.00	Interns and Residents (see instructions)	0	0	19.00
20. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)	6, 981, 245	7, 827, 770	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS provide		7,027,770	21.00
22. 00	Other than outlier payments	0	0	22. 00
23. 00	1 3	0	0	23.00
	Outlier payments	U	Ü	
	Program capital payments	0		24. 00
	Capital exception payments (see instructions)	0		25. 00
	Routine and Ancillary service other pass through costs	0	0	
	Subtotal (sum of lines 22 through 26)	0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)	0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)	6, 981, 245	7, 827, 770	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	6, 981, 245	7, 827, 770	31.00
32.00	Deducti bl es	O	0	32.00
33.00	Coinsurance	o	0	33.00
	Allowable bad debts (see instructions)	0	0	34.00
	Utilization review	0	-	35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	6, 981, 245	7, 827, 770	•
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0, 701, 243	7,027,770	37.00
	Subtotal (line 36 ± line 37)	6, 981, 245	-	
		0, 901, 243	7, 827, 770	39.00
	Direct graduate medical education payments (from Wkst. E-4)	( 001 045	7 007 770	
		6, 981, 245	7, 827, 770	1
41. 00	Interim payments	7, 139, 061	5, 054, 608	1
42. 00	Balance due provider/program (line 40 minus line 41)	-157, 816	2, 773, 162	1
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2			

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Health Financial Systems	TERRE HAUTE REGIONAL	HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150046		Worksheet E-3	
			From 09/01/2015	Part VII	
		Component CCN: 15SO46	To 08/31/2016	Date/Time Pre	pared:
		•		1/25/2017 6: 2	4 pm
		Title XIX	Subprovi der -	Cost	
			I PF		
			I npati ent	Outpati ent	
			4 00	0.00	

		I PF		
		I npati ent	Outpati ent	
		1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	2, 658, 497		1. 00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	2, 658, 497	0	4. 00
5.00	Inpatient primary payer payments	0		5. 00
6.00	Outpati ent pri mary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	2, 658, 497	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES	,		
	Reasonable Charges			İ
8.00	Routine service charges	0		8.00
9. 00	Ancillary service charges	3, 448, 987	0	9. 00
10.00	Organ acquisition charges, net of revenue	0	Ü	10.00
11. 00	Incentive from target amount computation	0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)	3, 448, 987	0	
12.00	CUSTOMARY CHARGES	3, 440, 707		12.00
13. 00	Amount actually collected from patients liable for payment for services on a charge	O	0	13.00
13.00	basis		O	13.00
14. 00	Amounts that would have been realized from patients liable for payment for services on	o	0	14. 00
14.00	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		O	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000	0. 000000	15 00
16. 00	Total customary charges (see instructions)	3. 448. 987	0.000000	16.00
17. 00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds	790, 490	0	
17.00	lline 4) (see instructions)	770, 470	U	17.00
18. 00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)	٥	U	10.00
19. 00	Interns and Residents (see instructions)	o	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)	2, 658, 497	0	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS provide			21.00
22. 00	Other than outlier payments	0	0	22. 00
23. 00	Outlier payments		0	23.00
24. 00	Program capital payments	0	O	24.00
25. 00	Capital exception payments (see instructions)	0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	26.00
27. 00	Subtotal (sum of lines 22 through 26)		0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29. 00	Titles V or XIX (sum of lines 21 and 27)	2, 658, 497	0	
29.00		2, 058, 497	0	29.00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	20.00
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	2, 658, 497	0	31.00
32. 00	Deducti bl es	0	0	32. 00
33. 00	Coi nsurance	0	0	33. 00
34. 00	Allowable bad debts (see instructions)	0	0	34.00
35. 00	Utilization review	0		35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	2, 658, 497	0	36. 00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37. 00
38. 00	Subtotal (line 36 ± line 37)	2, 658, 497	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)	0		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	2, 658, 497	0	40. 00
41. 00	Interim payments	2, 201, 794	0	41. 00
42.00	Balance due provider/program (line 40 minus line 41)	456, 703	0	42. 00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2			
		•		

Health Financial Systems	TERRE HAUTE REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150046	Peri od: From 09/01/2015	Worksheet E-3	
		Component CCN: 15T046			
		Title XIX	Subprovi der - I RF	Cost	·
			I npati ent	Outpati ent	
			1. 00	2. 00	
PART VII - CALCULATION OF REIMBURSEMENT - A		CES FOR TITLES V OR XI	IX SERVICES		

		I RF		
		I npati ent	Outpati ent	
		1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	349, 174		1. 00
2.00	Medical and other services		0	2. 00
3.00	Organ acquisition (certified transplant centers only)	0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)	349, 174	0	4. 00
5.00	Inpatient primary payer payments	0		5. 00
6.00	Outpatient primary payer payments		0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	349, 174	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routi ne servi ce charges	0		8. 00
9. 00	Ancillary service charges	954, 110	0	9. 00
10.00	Organ acquisition charges, net of revenue	70.7.10	<u> </u>	10. 00
11. 00	Incentive from target amount computation	0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)	954, 110	0	
12.00	CUSTOMARY CHARGES	701,110	J	12.00
13. 00	Amount actually collected from patients liable for payment for services on a charge	0	0	13. 00
10.00	basis		J	10.00
14. 00	Amounts that would have been realized from patients liable for payment for services on	0	0	14. 00
11.00	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	Ĭ	o o	11.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000	0. 000000	15 00
16. 00	Total customary charges (see instructions)	954, 110	0.000000	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds	604, 936	0	17. 00
17.00	line 4) (see instructions)	004, 730	O	17.00
18. 00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)	Ĭ	O	10.00
19. 00	Interns and Residents (see instructions)	0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instructions)	o o	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)	349, 174	0	21. 00
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS provide		0	21.00
22. 00	Other than outlier payments	0	0	22. 00
23. 00	Outlier payments	o	0	23. 00
24. 00	Program capital payments	0	O	24. 00
25. 00	Capital exception payments (see instructions)	0		25. 00
26. 00	Routine and Ancillary service other pass through costs	0	0	
27. 00	Subtotal (sum of lines 22 through 26)	0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)	0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)	349, 174	0	
29.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	349, 174	U	29.00
30. 00	Excess of reasonable cost (from line 18)	ام	0	30. 00
	· · · · · · · · · · · · · · · · · · ·	240 174	0	31. 00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	349, 174 0	-	
32.00	Deducti bl es	j	0	32. 00
33. 00	Coi nsurance	0	0	33. 00
34.00	Allowable bad debts (see instructions)	0	0	34. 00
35. 00	Utilization review	0		35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	349, 174	0	36. 00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37. 00
38. 00	Subtotal (line 36 ± line 37)	349, 174	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)	0		39. 00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)	349, 174	0	40. 00
41. 00	Interim payments	204, 185	0	41. 00
42.00	Balance due provider/program (line 40 minus line 41)	144, 989	0	
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2	l l		

Health Financial Systems TERRE HAUTE REGION.

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

Peri od: Worksheet G From 09/01/2015 To 08/31/2016 Date/Time Prepared: Provider CCN: 150046

			'	0 06/31/2010	1/25/2017 6: 2	
		General Fund	Speci fi c	Endowment Fund		
			Purpose Fund			
	I	1.00	2.00	3. 00	4. 00	
1 00	CURRENT ASSETS	-152	1 0	O	0	1 00
1. 00 2. 00	Cash on hand in banks Temporary investments	- 152			0	1. 00 2. 00
3.00	Notes receivable				0	3.00
4. 00	Accounts receivable	26, 219, 531	· -		0	4. 00
5. 00	Other receivable	19, 764		0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-9, 113, 208	0	0	0	6. 00
7.00	Inventory	6, 107, 506	0	0	0	7. 00
8.00	Prepai d expenses	428, 999		-	0	8. 00
9.00	Other current assets	0	-		0	9. 00
10.00	Due from other funds	1, 619			0	
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	23, 664, 059	0	0	0	11. 00
12. 00	Land	1, 262, 718	0	0	0	12. 00
13. 00	Land improvements	3, 158, 371			0	13. 00
14. 00	Accumulated depreciation	-3, 023, 197			0	14. 00
15. 00	Bui I di ngs	38, 638, 215	0	0	0	15. 00
16.00	Accumulated depreciation	-24, 840, 135	0	0	0	16. 00
17. 00	Leasehold improvements	7, 764, 970		0	0	17. 00
18. 00	Accumulated depreciation	-5, 456, 215			0	18. 00
19. 00	Fi xed equipment	27, 059, 404	•		0	19. 00
20. 00 21. 00	Accumulated depreciation	-18, 694, 904	0		0	20. 00 21. 00
21.00	Automobiles and trucks Accumulated depreciation	0		0	0	21.00
23. 00	Major movable equipment	38, 674, 454		0	0	23. 00
24. 00	Accumulated depreciation	-29, 821, 885		Ö	0	24. 00
25. 00	Mi nor equipment depreciable	4, 757, 047		0	0	25. 00
26.00	Accumulated depreciation	-2, 854, 497	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0		0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	2, 301, 055			0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	38, 925, 401	0	0	0	30. 00
31. 00	OTHER ASSETS Investments	2, 386, 484	0	0	0	31. 00
32. 00	Deposits on Leases	2, 300, 404			0	32.00
33. 00	Due from owners/officers	Ö	Ö		0	33. 00
34. 00	Other assets	3, 063, 197	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5, 449, 681	0	0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	68, 039, 141	0	0	0	36. 00
	CURRENT LIABILITIES	1		1		
37. 00	Accounts payable	5, 044, 751			0	37. 00
38. 00	Salaries, wages, and fees payable	3, 585, 499	1	0	0	38. 00
39. 00 40. 00	Payroll taxes payable Notes and loans payable (short term)	3, 129, 448 105, 677		0	0	39. 00 40. 00
41. 00	Deferred income	103,077	1	0	0	41. 00
42. 00	Accel erated payments	ĺ			, , , , , , , , , , , , , , , , , , ,	42. 00
43.00	Due to other funds	632	0	0	0	43.00
	Other current liabilities	0			0	
45.00	Total current liabilities (sum of lines 37 thru 44)	11, 866, 007	0	0	0	45. 00
	LONG TERM LIABILITIES	1	1			
46.00	Mortgage payable	0	0		0	
47. 00 48. 00	Notes payable Unsecured Loans	227, 510 -213, 063, 279	•		0	47. 00 48. 00
49. 00	Other long term liabilities	66, 434			0	49. 00
50. 00	Total long term liabilities (sum of lines 46 thru 49)	-212, 769, 335			0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	-200, 903, 328			0	51. 00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	268, 942, 469				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 57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			ا	0	56. 00 57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	replacement, and expansion					
59. 00	Total fund balances (sum of lines 52 thru 58)	268, 942, 469			0	
60. 00	Total liabilities and fund balances (sum of lines 51 and	68, 039, 141	0	0	0	60. 00
	[59]	I	I	l l		l

Provider CCN: 150046

					To 08/31/201	6 Date/Time Pre 1/25/2017 6:2	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	Pill
		1, 00	2.00	3.00	4. 00	5. 00	
1. 00	Fund balances at beginning of period	11.00	264, 455, 644			0	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		10, 871, 240	1			2.00
3.00	Total (sum of line 1 and line 2)		275, 326, 884			o	3. 00
4.00	ROUNDING	9			0	0	4. 00
5.00		o			0	0	5. 00
6.00		0			0	0	6. 00
7.00		0			0	0	7. 00
8.00		0			0	0	8. 00
9. 00		0			0	0	9. 00
10. 00	Total additions (sum of line 4-9)		9	1		0	10.00
11. 00	Subtotal (line 3 plus line 10)		275, 326, 893			0	11.00
12. 00	FEDERAL TAX LIABILITY ENTRY	6, 384, 424			0	0	12.00
13. 00		0			0	0	13. 00
14.00		0			0	0	14.00
15.00		0			0	0	15.00
16.00					0	0	16. 00 17. 00
17. 00 18. 00	Total deductions (sum of lines 12-17)	٩	6, 384, 424		U		18.00
19. 00	Fund balance at end of period per balance		268, 942, 469	1			19.00
19.00	sheet (line 11 minus line 18)		200, 742, 407			٩	19.00
		Endowment Fund	PI ant	Fund		'	
	T	6. 00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0	0		0		3.00
4. 00 5. 00	ROUNDI NG		0				4. 00 5. 00
6. 00			0				6.00
7. 00			0				7. 00
8. 00			0				8. 00
9. 00			0	1			9. 00
10.00	Total additions (sum of line 4-9)	o			О		10.00
11.00	Subtotal (line 3 plus line 10)	o			О		11. 00
12.00	FEDERAL TAX LIABILITY ENTRY		0	1			12. 00
13.00			0	)			13.00
14.00			0				14. 00
15. 00			0				15. 00
16. 00			0	1			16. 00
17. 00			0	1			17. 00
18. 00	Total deductions (sum of lines 12-17)	0			0		18. 00
19. 00	Fund balance at end of period per balance	0		1	0		19. 00
	sheet (line 11 minus line 18)			I			

| Peri od: | Worksheet G-2 | From 09/01/2015 | Parts | & II | To 08/31/2016 | Date/Time Prepared: Health Financial Systems TER STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 150046

			То	08/31/2016	Date/Time Prep 1/25/2017 6:24	
	Cost Center Description	Inpatient		Outpati ent	Total	, p
	'	1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal	21, 443, 4			21, 443, 475	1. 00
2.00	SUBPROVIDER - IPF	20, 479, 1			20, 479, 135	2. 00
3.00	SUBPROVI DER - I RF	2, 186, 1	183		2, 186, 183	3. 00
4.00	SUBPROVI DER					4. 00
5. 00	Swing bed - SNF		0		0	5. 00
6. 00	Swi ng bed - NF		0		0	6. 00
7.00	SKILLED NURSING FACILITY					7. 00
8.00	NURSI NG FACILITY					8. 00
9.00	OTHER LONG TERM CARE	44 100 -	700		44 100 702	9. 00
10. 00	Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services	44, 108, 7	93		44, 108, 793	10. 00
11. 00	INTENSIVE CARE UNIT	8, 770, 5	550	I	8, 770, 558	11. 00
12. 00	CORONARY CARE UNIT	0,770,3	556		6, 770, 556	12. 00
13. 00	BURN INTENSIVE CARE UNIT					13. 00
14. 00	SURGI CAL I NTENSI VE CARE UNI T					14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	8, 770, 5	558		8, 770, 558	16. 00
	11-15)	, , , , ,			2,	
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	52, 879, 3	351		52, 879, 351	17. 00
18.00	Ancillary services	257, 748, 4	145	272, 354, 820	530, 103, 265	18. 00
19.00	Outpatient services	15, 138, 8	326	36, 655, 271	51, 794, 097	19. 00
20.00	RURAL HEALTH CLINIC		0	0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00
22. 00	HOME HEALTH AGENCY					22. 00
23. 00	AMBULANCE SERVICES					23. 00
24. 00	CMHC			0	0	24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )					25. 00
26. 00	HOSPI CE					26. 00
27. 00	OTHER (SPECIFY)		0	0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wks	st. 325, 766, 6	522	309, 010, 091	634, 776, 713	28. 00
	G-3, line 1)					
29. 00	PART II - OPERATING EXPENSES  Operating expenses (per Wkst. A, column 3, line 200)			110, 799, 128		29. 00
30.00	GAIN/LOSS ON DISPOSAL	4, 7	755	110, 799, 120		30. 00
31. 00	ROUNDI NG	4, /	9			31. 00
32. 00	ROUNDING		0			32. 00
33. 00			0			33. 00
34. 00			0			34. 00
35. 00			0			35. 00
36. 00	Total additions (sum of lines 30-35)			4, 764		36. 00
37. 00	HITECH	4, 9	942	.,		37. 00
38. 00	ATHLETI C TRAINING	7, 9				38. 00
39.00	INTEREST INCOME	12, 8				39. 00
40.00	UNCLAIMED PROPERTY	3, 6				40.00
41.00	ROUNDI NG		1			41.00
42.00	Total deductions (sum of lines 37-41)			29, 336		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tran	nsfer		110, 774, 556		43.00
	to Wkst. G-3, line 4)			l		

Provider CCN: 150046   Port od: From 09/01/2015   From 09/01/2015   From 09/01/2015   From 09/01/2015   From 09/01/2015   From 09/01/2015   From 09/01/2015   From 09/01/2015   From 09/01/2015   From 09/01/2015   From 09/01/2015   From 09/01/2015   From 09/01/2015   From 09/01/2015   From 09/01/2015   From 09/01/2015   Date/Time Prepared: 1/25/2017 6: 24 pm	Health Financial Systems TERRE HAUTE REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
To		
1.00		1/2016 Date/Time Prepared:
1.00		
2.00   Less contractual allowances and discounts on patients' accounts   513,557,527   2.00     3.00   Net patient revenues (line 1 minus line 2)   121,219, 186   3.00     4.00   Less total operating expenses (from Wkst. G-2, Part II, line 43)   110,774,565   4.00     5.00   Net income from service to patients (line 3 minus line 4)   10,444,630     5.00   OTHER INCOME   10,444,630     6.00   Contributions, donations, bequests, etc   0   6.00     7.00   Income from investments   0   7.00     8.00   Revenue from television and radio service   0   8.00     9.00   Revenue from television and radio service   0   9.00     10.00   Purchase discounts   0   11.00     11.00   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   0   14.00     15.00   Revenue from sale of medical and surgical supplies to other than patients   0   15.00     16.00   Revenue from sale of medical and surgical supplies to other than patients   0   17.00     18.00   Revenue from sale of medical and surgical supplies to other than patients   0   19.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00   10.00   1		
3.00   Net patient revenues (line 1 minus line 2)   Less total operating expenses (from Wkst. 6-2, Part II, line 43)   110,774,556   4.00   Net income from service to patients (line 3 minus line 4)   10,444,630   10,444,630   5.00   Net income from service to patients (line 3 minus line 4)   10,444,630   5.00   Ontributions, donations, bequests, etc   0   6.00   Contributions, donations, bequests, etc   0   7.00   Net income from investments   0   7.00   Net income from investments   0   7.00   Newenue from television and radio service   0   9.00   Newenue from television and radio service   0   10.00   Newenue from television and radio service   0   10.00   Newenue from television and radio service   0   10.00   Newenue from meal sold to employees and guests   0   11.00   Newenue from meal sold to employees and guests   0   14.00   Newenue from meal sold to employees and guests   0   14.00   Newenue from sale of medical and surgical supplies to other than patients   0   15.00   Newenue from sale of drugs to other than patients   0   17.00   Newenue from sale of drugs to other than patients   0   17.00   Newenue from sale of medical records and abstracts   0   18.00   17.00   Newenue from gifts, flowers, coffee shops, and canteen   0   20.00   Newenue from gifts, flowers, coffee shops, and canteen   0   20.00   Newenue from gifts, flowers, coffee shops, and canteen   0   20.00   Newenue from gifts, flowers, coffee shops, and canteen   0   20.00   Newenue from gifts, flowers, coffee shops, and canteen   0   20.00   Newenue from gifts, flowers, coffee shops, and canteen   0   20.00   Newenue from gifts, flowers, coffee shops, and canteen   0   20.00   Newenue from gifts, flowers, coffee shops, and canteen   0   20.00   Newenue from gifts, flowers, coffee shops, and canteen   0   20.00   Newenue		
4.00   Less total operating expenses (from Wkst. G-2, Part II, line 43)   110, 774, 556   4.00   Net income from service to patients (line 3 minus line 4)   5.00   OTHER INCOME		
Net income from service to patients (line 3 minus line 4)		
OTHER INCOME         Contributions, donations, bequests, etc         6.00           7.00 Income from investments         0 7.00           8.00 Revenues from telephone and other miscellaneous communication services         0 8.00           9.00 Revenue from television and radio service         0 9.00           10.00 Purchase discounts         0 10.00           11.00 Parking lot receipts         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         0 14.00           15.00 Revenue from rental of living quarters         0 15.00           16.00 Revenue from sale of medical and surgical supplies to other than patients         0 16.00           17.00 Revenue from sale of medical records and abstracts         0 17.00           18.00 Revenue from sale of medical records and abstracts         0 17.00           19.00 Revenue from gifts, flowers, coffee shops, and canteen         0 20.00           21.00 Revenue from gifts, flowers, coffee shops, and canteen         0 22.00           22.00 Rental of vending machines         0 22.00           22.00 There Revenue in come (sum of lines 6-24)         426.610         24.00           25.00 Total other income (sum of lines 6-24)         10,871,240         26.00		
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 services         0         8.00           9.00         Revenue from television and radio service         0         9.00           10.00         Purchase discounts         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         0         14.00           15.00         Revenue from meals sold to employees and guests         0         14.00           16.00         Revenue from meals sold to employees and guests         0         15.00           16.00         Revenue from sale of medical and surgical supplies to other than patients         0         16.00           17.00         Revenue from sale of medical and surgical supplies to other than patients         0         16.00           19.00         Revenue from sale of medical records and abstracts         0         17.00 <tr< td=""><td></td><td>10, 444, 630 5. 00</td></tr<>		10, 444, 630 5. 00
7.00       Income from investments       0       7.00         8.00       Revenues from telephone and other miscellaneous communication services       0       8.00         9.00       Revenue from television and radio service       0       9.00         10.00       Purchase discounts       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       0       14.00         15.00       Revenue from sale of medical and surgical supplies to other than patients       0       15.00         16.00       Revenue from sale of fedical and surgical supplies to other than patients       0       17.00         18.00       Revenue from sale of fedical records and abstracts       0       17.00         18.00       Revenue from sale of textbooks, uniforms, etc.)       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         22.00       Governmental appropriations       0		
8.00       Revenues from telephone and other miscel laneous communication services       0       8.00         9.00       Revenue from television and radio service       0       9.00         10.00       Purchase discounts       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       0       14.00         15.00       Revenue from meals sold to employees and guests       0       14.00         15.00       Revenue from sale of medical and surgical supplies to other than patients       0       15.00         16.00       Revenue from sale of drugs to other than patients       0       17.00         18.00       Revenue from sale of medical records and abstracts       0       17.00         18.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00		
9.00       Revenue from television and radio service       0       9.00         10.00       Purchase discounts       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 laundry and linen service       0       13.00         14.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from laundry and linen service       0       14.00         15.00       Revenue from laundry and linen service       0       14.00         16.00       Revenue from meal's sold to employees and guests       0       14.00         15.00       Revenue from rental of living quarters       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of medical records and abstracts       0       17.00         18.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00		
10.00   Purchase discounts   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   0   14.00     15.00   Revenue from rental of living quarters   0   15.00     16.00   Revenue from sale of medical and surgical supplies to other than patients   0   16.00     17.00   Revenue from sale of medical records and abstracts   0   17.00     18.00   Revenue from sale of medical records and abstracts   0   18.00     19.00   Tuition (fees, sale of textbooks, uniforms, etc.)   0   19.00     10.00   Revenue from gifts, flowers, coffee shops, and canteen   0   20.00     10.00   Rental of vending machines   0   21.00     22.00   Rental of hospital space   0   23.00     23.00   Governmental appropriations   0   23.00     24.00   OTHER REVENUE   426,610   24.00     25.00   Total other income (sum of lines 6-24)   426,610   25.00     27.00   OTHER EXPENSES (SPECIFY)   0   27.00     28.00   Total other expenses (sum of line 27 and subscripts)   0   28.00		
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       0       14. 00         15. 00       Revenue from meals of living quarters       0       15. 00         16. 00       Revenue from sale of medical and surgical supplies to other than patients       0       16. 00         17. 00       Revenue from sale of medical records and abstracts       0       17. 00         18. 00       Revenue from sale of medical records and abstracts       0       18. 00         19. 00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19. 00         20. 00       Revenue from gifts, flowers, coffee shops, and canteen       0       20. 00         21. 00       Rental of vending machines       0       21. 00         22. 00       Rental of vending machines       0       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 00       THER REVENUE       426, 610       24. 00         25. 00       Total other income (sum of lines 6-24)       426, 610       25. 00		
12.00		
13.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from meals sold to employees and guests       0       14.00         15.00       Revenue from rental of living quarters       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of drugs to other than patients       0       17.00         18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER REVENUE       426,610       24.00         25.00       Total other income (sum of lines 6-24)       426,610       25.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00		
14.00       Revenue from meals sold to employees and guests       0       14.00         15.00       Revenue from rental of living quarters       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of drugs to other than patients       0       17.00         18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER REVENUE       426, 610       24.00         25.00       Total other income (sum of lines 6-24)       426, 610       25.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00		
15. 00       Revenue from rental of living quarters       0       15. 00         16. 00       Revenue from sale of medical and surgical supplies to other than patients       0       16. 00         17. 00       Revenue from sale of drugs to other than patients       0       17. 00         18. 00       Revenue from sale of medical records and abstracts       0       18. 00         19. 00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19. 00         20. 00       Revenue from gifts, flowers, coffee shops, and canteen       0       20. 00         21. 00       Rental of vending machines       0       21. 00         22. 00       Rental of hospital space       0       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 00       OTHER REVENUE       426, 610       24. 00         25. 00       Total other income (sum of lines 6-24)       426, 610       25. 00         27. 00       OTHER EXPENSES (SPECIFY)       10, 871, 240       26. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       27. 00		
16.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of drugs to other than patients       0       17.00         18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER REVENUE       426,610       24.00         25.00       Total other income (sum of lines 6-24)       426,610       25.00         26.00       Total (line 5 plus line 25)       10,871,240       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00		
17. 00       Revenue from sale of drugs to other than patients       0       17. 00         18. 00       Revenue from sale of medical records and abstracts       0       18. 00         19. 00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19. 00         20. 00       Revenue from gifts, flowers, coffee shops, and canteen       0       20. 00         21. 00       Rental of vending machines       0       21. 00         22. 00       Rental of hospital space       0       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 00       OTHER REVENUE       426, 610       24. 00         25. 00       Total other income (sum of lines 6-24)       426, 610       25. 00         26. 00       Total (line 5 plus line 25)       10, 871, 240       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00		
18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER REVENUE       426,610       24.00         25.00       Total other income (sum of lines 6-24)       426,610       25.00         26.00       Total (line 5 plus line 25)       10,871,240       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00		
19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER REVENUE       426,610       24.00         25.00       Total other income (sum of lines 6-24)       426,610       25.00         26.00       Total (line 5 plus line 25)       10,871,240       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00		
20. 00       Revenue from gifts, flowers, coffee shops, and canteen       0       20. 00         21. 00       Rental of vending machines       0       21. 00         22. 00       Rental of hospital space       0       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 00       OTHER REVENUE       426, 610       24. 00         25. 00       Total other income (sum of lines 6-24)       426, 610       25. 00         26. 00       Total (line 5 plus line 25)       10, 871, 240       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00		
21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER REVENUE       426,610       24.00         25.00       Total other income (sum of lines 6-24)       426,610       25.00         26.00       Total (line 5 plus line 25)       10,871,240       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00		
22. 00       Rental of hospital space       0       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 00       OTHER REVENUE       426, 610       24. 00         25. 00       Total other income (sum of lines 6-24)       426, 610       25. 00         26. 00       Total (line 5 plus line 25)       10, 871, 240       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00		
23.00       Governmental appropriations       0       23.00         24.00       OTHER REVENUE       426,610       24.00         25.00       Total other income (sum of lines 6-24)       426,610       25.00         26.00       Total (line 5 plus line 25)       10,871,240       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00	21.00   Rental of vending machines	0 21.00
24. 00       OTHER REVENUE       426, 610       24. 00         25. 00       Total other income (sum of lines 6-24)       426, 610       25. 00         26. 00       Total (line 5 plus line 25)       10, 871, 240       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00	22.00 Rental of hospital space	0 22.00
25. 00       Total other income (sum of lines 6-24)       426, 610       25. 00         26. 00       Total (line 5 plus line 25)       10, 871, 240       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0 27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0 28. 00	23.00 Governmental appropriations	0 23.00
26. 00       Total (line 5 plus line 25)       10, 871, 240       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0 27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0 28. 00	24. 00 OTHER REVENUE	426, 610 24. 00
27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00	25.00 Total other income (sum of lines 6-24)	426, 610 25. 00
28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00		10, 871, 240 26. 00
	27.00 OTHER EXPENSES (SPECIFY)	0 27.00
29.00   Net income (or loss) for the period (line 26 minus line 28)   10,871,240   29.00	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)	10, 871, 240 29. 00

	Financial Systems TERRE HAUTE REGIONAL	L <sub>_</sub> HOSPI TAL	In Lie	u of Form CMS-2	<u>2552-10</u>
CALCUL	ATION OF CAPITAL PAYMENT	Provi der CCN: 150046	Peri od: From 09/01/2015 To 08/31/2016	Worksheet L Parts I-III Date/Time Pre 1/25/2017 6:2	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				1
4 00	CAPITAL FEDERAL AMOUNT			4 740 044	4 00
1.00	Capital DRG other than outlier			1, 713, 341	1
1. 01 2. 00	Model 4 BPCI Capital DRG other than outlier Capital DRG outlier payments			0 97, 749	
2. 00	Model 4 BPCI Capital DRG outlier payments			97, 749	1
3. 00	Total inpatient days divided by number of days in the cost repo	orting period (see inst	ructions)	62. 13	
4. 00	Number of interns & residents (see instructions)	or tring period (see That	i de ti ons)	0.00	
5. 00	Indirect medical education percentage (see instructions)			0.00	
6.00	Indirect medical education adjustment (multiply line 5 by the s	sum of lines 1 and 1.01	, columns 1 and	0	
	1.01) (see instructions)				
7.00	Percentage of SSI recipient patient days to Medicare Part A pat	tient days (Worksheet E	, part A line	5. 68	7. 00
	30) (see instructions)			40.50	
8.00	Percentage of Medicaid patient days to total days (see instruct	tions)		18. 53	
9.00	Sum of lines 7 and 8			24. 21	
10. 00 11. 00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)				10. 00 11. 00
12. 00	Total prospective capital payments (see instructions)			1, 897, 100	
12.00	Total prospective capital payments (see Histractions)			1, 677, 100	12.00
	DADT II DAVMENT INDED DEACONADIE COCT			1. 00	
1. 00	PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions)			0	1.00
2. 00	Program inpatient ancillary capital cost (see instructions)			0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4. 00	Capital cost payment factor (see instructions)			0	
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1. 00	
1.00	Program inpatient capital costs (see instructions)			0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances	s (see instructions)		0	2. 00
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	3. 00
4.00	Applicable exception percentage (see instructions)			0.00	
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	
6.00	Percentage adjustment for extraordinary circumstances (see inst			0.00	
7.00	Adjustment to capital minimum payment level for extraordinary of	circumstances (line 2 x	(line 6)	0	
8. 00 9. 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applica	abl a)		0	
10.00	Current year capital payments (from Part 1, fine 12, as appired Current year comparison of capital minimum payment level to cap		less line 0)	0	
11. 00	Carryover of accumulated capital minimum payment level over cap			0	
11.00	Worksheet L, Part III, line 14)	s. ca. paymone (110m pri	J. J. G. 1		11.50
12.00	Net comparison of capital minimum payment level to capital paym	ments (line 10 plus lin	ie 11)	0	12. 00
13.00	Current year exception payment (if line 12 is positive, enter t			0	13. 00
14.00	Carryover of accumulated capital minimum payment level over cap	oital payment for the f	following period	0	14. 00
	(if line 12 is negative, enter the amount on this line)				
15.00	Current year allowable operating and capital payment (see instr	ructions)		0	
16.00				0	
17.00	Current year exception offset amount (see instructions)			0	17. 00