This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0113 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/25/2023 11:38 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/25/2023 Time: 11:38 am use only] Manually prepared cost report Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Initial Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPITAL ANDERSON (15-0113) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 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.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX					
		1	2	SI GNATURE STATEMENT				
1	Hol	ly Millard	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1			
2	Signatory Printed Name	Holly Millard			2			
3	Signatory Title	SVP OF FINANCE			3			
4	Date	(Dated when report is electronica			4			

			Title XVIII				
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	343, 343	-118, 263	0	0	1. 00
2.00	SUBPROVI DER - I PF	0	0	0		0	2. 00
3.00	SUBPROVI DER - I RF	0	0	0		0	3. 00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6. 00
200.00	TOTAL	0	343, 343	-118, 263	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems COMMUNITY HOSPITAL ANDERSON In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0113 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/25/2023 11:38 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1515 NORTH MADISON AVE 1.00 PO Box: 1.00 State: IN 2.00 City: ANDERSON Zip Code: 46011 County: MADISON 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)
V XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal COMMUNITY HOSPITAL 150113 26900 01/01/1966 Ν 3.00 ANDERSON Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22.01 Υ 22.01 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 a final UCP 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 22.03 N Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? 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, yes or "N" for no. 23 00 Which method is used to determine Medicaid days on lines 24 and/or 25 23 00 3 N below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

61. 20	column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0. 00	0. 00	61. 20		
	<u>J</u>	,			1. 00			
	100 0 1 1 100 10 10 10 10 10 10 10 10 10							
	ACA Provisions Affecting the Health Resources and Ser			1.6		, , , , ,		
62.00	Enter the number of FTE residents that your hospital		reporting peri	od for which	0.00	62. 00		
	your hospital received HRSA PCRE funding (see instruc							
62. 01	Enter the number of FTE residents that rotated from a			your hospital	0.00	62. 01		
	during in this cost reporting period of HRSA THC proc		s)					
	Teaching Hospitals that Claim Residents in Nonprovide							
63. 00	Has your facility trained residents in nonprovider se				N	63. 00		
	"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)							

Health Financial Systems	COMMUNI T	Y HOSPITAL ANDERSON		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA Provider CO		eriod: -om 01/01/2022) 12/31/2022	Worksheet S-2 Part I Date/Time Pre 5/25/2023 11:	pared:
		'	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1. 00	2.00	3.00	
Section 5504 of the ACA Base Yea period that begins on or after J			This base year	is your cost r	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to rosettings. Enter in column 2 the	64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio					64. 00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
	1.00	2. 00	3. 00	4.00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 Ratio (col. 1/	65.00
			FTEs Nonprovi der	FTEs in Hospital	(col. 1 + col. 2))	
			Si te	поѕрі таі	2))	
			1. 00	2.00	3.00	
Section 5504 of the ACA Current		n Nonprovider Setting	sEffective fo	r cost reporti	ng peri ods	
beginning on or after July 1, 20 66.00 Enter in column 1 the number of		ry caro rosidont	0.00	0. 25	0. 000000	66 00
FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00		0. 00000	00.00
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	
			FTEs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
			Si te		,,,	
	1.00	2.00	3. 00	4.00	5.00	.= -
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	0. 000000	67.00

	Financial Systems COMMUNITY HOSPITAL ANDERSON AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CC		eriod: rom 01/01/2	022 022	of Form Workshee Part I Date/Tin 5/25/202	et S-2 me Pre	pared:
					1. 0	0	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-490 For a cost reporting period beginning prior to October 1, 2022, did you ob MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Fina (August 10, 2022)?	tain permissio	n from your		N		68. 00
	(Magazi 10, 2022).			1. 00	2. 00	3. 00	
	Inpatient Psychiatric Facility PPS						
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it conta Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teachin recent cost report filed on or before November 15, 2004? Enter "Y" for ye 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for ye Column 3: If column 2 is Y, indicate which program year began during this (see instructions)	g program in t s or "N" for r in a new teach s or "N" for r	the most no. (see ni ng no.	N N	N	0	70. 00 71. 00
75 00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it co	ntain an IDE		N			75. 00
	subprovider? Enter "Y" for yes and "N" for no. 100 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						
					1. 0	0	
	Long Term Care Hospital PPS				N		
	D.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 1.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no. TEFRA Providers						80. 00 81. 00
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 16.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						85. 00 86. 00
87. 00	Is this hospital an extended neoplastic disease care hospital classified u 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	nder section			N		87. 00
	1 000 (d) (1) (d) 1 2 1 (d) 1 1 00 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Approved f Permanen Adjustmer (Y/N) 1.00	t	Number Appro Permar Adjustm	ved ent ents	
88. 00	Column 1: Is this hospital approved for a permanent adjustment to the TEFR amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete co 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.					0	88. 00
	por amin' El Error ena mambol en approtes por mantente daj de timorro.	Wkst. A Line No.		Date	Appro Permar Adjusti Amount Discha	ment ment Per irge	
89. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	1. 00	2.00		3. 0		89. 00
89.00	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the	0. 00				0	84.00
	TEFRA target amount per discharge.		V 1. 00		XI X		
0.5	Title V and XIX Services						0.5
	Does this facility have title V and/or XIX inpatient hospital services? En yes or "N" for no in the applicable column.		N N		Y N		90. 00 91. 00
	00 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see				N N		91.00
	instructions) Enter "Y" for yes or "N" for no in the applicable column.						
	3.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter N "Y" for yes or "N" for no in the applicable column.				N		93. 00
	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no applicable column.		N O OO		N O O	n	94. 00
	If line 94 is "Y", enter the reduction percentage in the applicable column Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no applicable column.		0. 00 N		0. 0 N	U	95. 00 96. 00
97. 00	If line 96 is "Y", enter the reduction percentage in the applicable column		0. 00		0. 0	0	97. 00

Health Financial Systems COMMUNITY HOSPI HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	^N· 15_∩112	In Lie Period:	u of Form CM Worksheet S	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		From 01/01/2022 To 12/31/2022	Part I	repared:
			V	XI X	
98.00 Does title V or XIX follow Medicare (title XVIII) for the in	nterns and res	idents post	1. 00 Y	2. 00 N	98. 00
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" i column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the re	for yes or "N"	for no in		Y	98. 01
C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti title XIX.	itle V, and in	column 2 for			
98.02 Does title V or XIX follow Medicare (title XVIII) for the cabed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes a for title V, and in column 2 for title XIX.			Y	Y	98. 02
98.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye for title V, and in column 2 for title XIX.			N	N	98. 03
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in		N	N	98. 04	
98.05 Does title V or XIX follow Medicare (title XVIII) and add bawkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in a	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in				98. 05
column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Y	98. 06
Rural Providers					
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all-	-inclusive met	hod of pavment	N N		105. 00 106. 00
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for contraining programs? Enter "Y" for yes or "N" for no in column	ost reimbursem	ent for I&R	N		107. 00
Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded IF	you train I&R: PF and/or IRF	s in an			
Enter "Y" for yes or "N" for no in column 2. (see instructi 108.00 is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche		N		108. 00
	Physi cal 1.00	0ccupati onal 2.00	Speech 3.00	Respirator 4.00	У
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 Hospital Demonstration) for the current cost reporting period? Enter 'complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.	"Y" for yes or	"N" for no. I	f yes,	1. 00 N	110.00
			1. 00	2.00	
111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this compared in the second of the FCHIP demonstration properties to continuous properties all that apply: "A" for Ambulance services; "B" for action for tele-health services.	ost reporting polumn 1 is Y, or rticipating in	period? Enter enter the column 2.	N		111. 00
112.00 Did this hospital participate in the Pennsylvania Rural Heal	Lth Model	1. 00 N	2. 00	3.00	112. 00
(PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If come "Y", enter in column 2, the date the hospital began participal demonstration. In column 3, enter the date the hospital coal	eporting olumn 1 is pating in the				112.00
participation in the demonstration, if applicable. 113.00 Did this hospital participate in the Community Health Access Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no.					113. 00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "G for short term hospital or "98" percent for long term care in psychiatric, rehabilitation and long term hospitals provider the definition in CMS Buth 15.1. about a 22, 52200.1	B, or E only) 93" percent (includes	N			0115.00
the definition in CMS Pub.15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y"	for yes or	N			116. 00
"N" for no.	,				
117.00 s this facility legally-required to carry malpractice insur	rance? Enter	Υ		1	117. 00

117. 00 118. 00

117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.

118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.

Health Financial Systems COMMUNITY HOSPITA	AL ANDERSON		In Lie	u of Form CN	IS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	N: 15-0113	Peri od:	Worksheet S	
			From 01/01/2022 To 12/31/2022	Part I Date/Time F	Prepared:
		Dromitumo	Langer	5/25/2023 1	11:38 am
		Premi ums	Losses	Insurance	
		1. 00	2.00	3. 00	
118.01 List amounts of malpractice premiums and paid losses:		962, 4			0 118. 01
			1.00	2.00	
118.02 Are mal practice premiums and paid losses reported in a cost of	enter other t	han the	1. 00 N	2.00	118. 02
Administrative and General? If yes, submit supporting schedu					
and amounts contained therein. 119.00D0 NOT USE THIS LINE					119. 00
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold	Harmless prov	ision in ACA	N N	N	120. 00
§3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua					
Hold Harmless provision in ACA §3121 and applicable amendments					
Enter in column 2, "Y" for yes or "N" for no.					101 00
121.00 Did this facility incur and report costs for high cost implan patients? Enter "Y" for yes or "N" for no.	table devices	cnarged to	Y		121. 00
122.00 Does the cost report contain healthcare related taxes as define					122. 00
Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.	is "Y", enter	in column 2			
123.00 Did the facility and/or its subproviders (if applicable) purc					123. 00
services, e.g., legal, accounting, tax preparation, bookkeepi	J. 1 J				
management/consulting services, from an unrelated organization for yes or "N" for no.	n? In corumn	i, enter i			
If column 1 is "Y", were the majority of the expenses, i.e.,					
professional services expenses, for services purchased from u located in a CBSA outside of the main hospital CBSA? In colum					
"N" for no.					
Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant cer	ntar2 Entar "	V" for yes	N		125. 00
and "N" for no. If yes, enter certification date(s) (mm/dd/yy		i ioi yes	14		123.00
126.00 If this is a Medicare-certified kidney transplant program, en	ter the certi	fication dat	е		126. 00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare-certified heart transplant program, ento	er the certif	ication date	,		127. 00
in column 1 and termination date, if applicable, in column 2.					100.00
128.00 f this is a Medicare-certified liver transplant program, ent- in column 1 and termination date, if applicable, in column 2.	er the certif	ication date	•		128. 00
129.00 If this is a Medicare-certified lung transplant program, enter	r the certifi	cation date			129. 00
in column 1 and termination date, if applicable, in column 2. 130.00 olf this is a Medicare-certified pancreas transplant program,	enter the cer	ti fi cati on			130. 00
date in column 1 and termination date, if applicable, in colu	mn 2.				100.00
131.00 If this is a Medicare-certified intestinal transplant program date in column 1 and termination date, if applicable, in column		erti fi cati on	1		131. 00
132.00 If this is a Medicare-certified islet transplant program, entitle		ication date			132. 00
in column 1 and termination date, if applicable, in column 2.					122.00
133.00 Removed and reserved 134.00 If this is a hospital-based organ procurement organization (0)	PO). enter th	e OPO number			133. 00 134. 00
in column 1 and termination date, if applicable, in column 2.					
All Providers 140.00 Are there any related organization or home office costs as de	fined in CMS	Pub 15-1	Y	HB0720	140. 00
chapter 10? Enter "Y" for yes or "N" for no in column 1. If y	es, and home	office costs		1.50720	1.10.00
are claimed, enter in column 2 the home office chain number. 1.00 2.00	(see instruct	i ons)	3.00		
If this facility is part of a chain organization, enter on li	nes 141 throu	ugh 143 the r		of the	
home office and enter the home office contractor name and con 141.00 Name: COMMUNITY HEALTH NETWORK Contractor's Name: WPS	tractor numbe		or's Number: 0810	\1	141 00
142.00 Street: 1500 NORTH RITTER AVE PO Box:		Contract	or s number: 0810	71	141. 00 142. 00
143.00 City: INDIANAPOLIS State: IN		Zi p Code	: 4621	9	143. 00
				1. 00	
144.00 Are provider based physicians' costs included in Worksheet A?				Y	144. 00
			1 00	2.00	
145.00 f costs for renal services are claimed on Wkst. A, line 74,	are the costs	for	1. 00 Y	2.00	145. 00
inpatient services only? Enter "Y" for yes or "N" for no in co	olumn 1. If c	olumn 1 is			
no, does the dialysis facility include Medicare utilization for period? Enter "Y" for yes or "N" for no in column 2.	or this cost	reporti ng			
146.00 Has the cost allocation methodology changed from the previous	ly filed cost	report?	N		146. 00
Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15	-2, chapter 4	0, §4020) If			
yes, enter the approval date (mm/dd/yyyy) in column 2.			I	I	I

Health Financial Systems			AL ANDERSON			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	1	Provi der CC	Provider CCN: 15-0113 Period: From 01/01/202 To 12/31/202				
							1. 00	
147.00 Was there a change in the statisti	cal basis? Enter "Y"	for yes	s or "N" for	no.			Y	147. 00
148.00 Was there a change in the order of							N	148. 00
149.00 Was there a change to the simplifi	ed cost finding metho	od? Ente	er "Y" for ye	s or "N" f	or no.		N	149. 00
			Part A	Part B	3	Title V	Title XIX	
			1.00	2.00		3.00	4. 00	
Does this facility contain a provi or charges? Enter "Y" for yes or '								
155. 00 Hospi tal	N TOT HO TOT Each Co	omponen	N N	and Part E	s. (See	N 42 CFR 9413	. 13) N	155. 00
156. 00 Subprovi der – TPF			N	N		N	N	156. 00
157. 00 Subprovi der - I RF			N	N		N	N	157. 00
158. 00 SUBPROVI DER								158. 00
159. 00 SNF			N	N		N	N	159. 00
160.00 HOME HEALTH AGENCY			N	N		N	N	160.00
161. 00 CMHC				N		N	N	161. 00
							1. 00	
Mul ti campus								
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that ha	as one o	or more campu	ses in dif	ferent	CBSAs?	N	165. 00
	Name		County		Zip Co		FTE/Campus	
	0		1. 00	2. 00	3.00	4.00	5. 00	
166.00 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)							0. 0	166. 00
							1. 00	-
Health Information Technology (HI	Γ) incentive in the Ar	meri can	Recovery and	d Reinvestm	nent A	ct	1.00	
167.00 Is this provider a meaningful user							Y	167. 00
168.00 If this provider is a CAH (line 10	05 is "Y") and is a me	eani ngfu	ul user (line	167 is "Y	'"), er	nter the		168. 00
reasonable cost incurred for the H								
168.01 If this provider is a CAH and is r						nardshi p		168. 01
exception under §413.70(a)(6)(ii)′ 169.00 f this provider is a meaningful u	user (line 167 is "Y")					, enter the	9.9	99169. 00
transition factor. (see instruction	ons)					D!!	F1:	
						Begi nni ng 1. 00	Endi ng 2. 00	+
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	peginning date and end	ding dat	te for the re	porting		1.00	2.00	170. 00
period respectivery (illiii/dd/yyyy)						1.00	2.00	
171.00 fline 167 is "Y", does this prov	i don havo any dave fe	or india	vi dual s. oprol	Lodin		1. 00 N	2. 00	0 171. 00
section 1876 Medicare cost plans in "Y" for yes and "N" for no in column 2. (s	reported on Wkst. S-3, umn 1. If column 1 is	Pt. I,	, line 2, col	. 6? Enter		IV		0171.00

Heal th	Financial Systems COMMUNITY HOSPI	TAL ANDERSON		In Lie	eu of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0113	Peri od:	Worksheet S-2	
				From 01/01/2022 To 12/31/2022		epared:
				Y/N	5/25/2023 11:	38 am
				1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE					
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	esponses. Ent	er all dates in	the	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					+
	Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the			N		1.00
	reporting period? If yes, enter the date of the change in c	orumn 2. (see	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2.00	Has the provider terminated participation in the Medicare P		N			2. 00
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	n 3, V Tor				
3.00	Is the provider involved in business transactions, includin	g management	N			3. 00
	contracts, with individuals or entities (e.g., chain home o					
	or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o					
	of directors through ownership, control, or family and othe					
	relationships? (see instructions)		V /N	Tumo	Doto	
			1.00	Type 2. 00	Date 3.00	
	Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Cert		Y	A	03/31/2021	4. 00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.	Trable III				
5.00	Are the cost report total expenses and total revenues diffe		N			5. 00
	those on the filed financial statements? If yes, submit rec	onciliation.		Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities				1	
6. 00	Column 1: Are costs claimed for a nursing program? Column the Legal operator of the program?	2: If yes, is	s the provide	r N		6. 00
7. 00						
8. 00	Were nursing programs and/or allied health programs approve	d and/or renew	ved during th	e N		8. 00
9. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	araduate medic	ral education	N		9. 00
7. 00	program in the current cost report? If yes, see instruction	14		7.00		
10.00	Was an approved Intern and Resident GME program initiated o	r renewed in t	he current	N		10.00
11. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I	& R in an Ann	proved	N		11.00
	Teaching Program on Worksheet A? If yes, see instructions.	a K III ali App	71 0 1 0 4			11.00
					Y/N	
	Bad Debts				1. 00	
12. 00	Is the provider seeking reimbursement for bad debts? If yes	, see instruct	i ons.		Υ	12. 00
13. 00	If line 12 is yes, did the provider's bad debt collection p	olicy change c	during this c	ost reporting	N	13. 00
14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura	nco amounte wa	nivod2 lf vos	500	N	14.00
14.00	instructions.	rice amounts wa	iiveu: ii yes	, see	IN	14.00
	Bed Complement					
15. 00	Did total beds available change from the prior cost reporti		yes, see ins t A		Y rt B	15. 00
		Y/N	Date	Y/N	Date	
		1. 00	2.00	3. 00	4. 00	
16. 00	Was the cost report prepared using the PS&R Report only?	N		N		14 00
16.00	If either column 1 or 3 is yes, enter the paid-through	IV		IN		16. 00
	date of the PS&R Report used in columns 2 and 4 .(see					
17. 00	instructions)	V	05 (02 (2022	V	05 (02 (2022	17.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Υ	05/02/2022	Y	05/02/2022	17. 00
	either column 1 or 3 is yes, enter the paid-through date		1			
10.00	in columns 2 and 4. (see instructions)	N		N		10.00
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	N		N		18. 00
	but are not included on the PS&R Report used to file this		1			
46	cost report? If yes, see instructions.					40 -
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19. 00
	information? If yes, see instructions.		1			
	·		-	•	-	-

Heal th	Financial Systems COMMUNITY HOSPI	ITAL ANDERSON		In Lie	u of Form CM	S-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	Provider CCN: 15-0113 Pe		Worksheet S Part II Date/Time P 5/25/2023 1	repared:
	<u> </u>	Descr	i pti on	Y/N	Y/N	
	1011 11 12 12 12 12 12 12 12 12 12 12 12 1		0	1.00	3. 00	00.00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00
		Y/N	Date	Y/N	Date	
	In	1.00	2.00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	HOSPI TALS)			
22.00	Capital Related Cost	l notruptions		I	N	22.00
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense		sale mado dur	ing the cost	N N	22. 00 23. 00
23.00	reporting period? If yes, see instructions.	due to apprais	sais illaue uui	ring the cost	IV	23.00
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	ed into during	this cost re	porting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	rting period?	If yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	ne cost reporti	ng period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportir	ng period? If	yes, submit	N	27. 00
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit er	ntered into dur	ing the cost	reporting	N	28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	N	29. 00			
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu	N	30. 00			
31. 00	instructions. Has debt been recalled before scheduled maturity without is	N	31. 00			
	instructions. Purchased Services					
32.00	Have changes or new agreements occurred in patient care ser	N	32. 00			
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app		ng to competi	tive bidding? If	N	33. 00
	no, see instructions. Provider-Based Physicians					
34. 00	Were services furnished at the provider facility under an a	arrangement wi	th provider-b	ased physicians?	N	34. 00
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi		nts with the	provi der-based	N	35. 00
	physicians during the cost reporting period? If yes, see in	ISTRUCTIONS.		Y/N	Date	
				1. 00	2. 00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	sonored by the	homo offico?	N N		36. 00 37. 00
37. 00	If yes, see instructions.	epared by the	nome office?	IN IN		37.00
38. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			N		38. 00
39. 00				, N		39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00
	Cost Report Preparer Contact Information	1.	00	2.	00	
41. 00		SHI RLEY		BI SHOP		41. 00
42. 00	respecti vel y.	COMMUNITY HEAL	TH NETWORK			42. 00
43. 00	preparer. Enter the telephone number and email address of the cost	317-355-4135		SBI SHOP@ECOMMUN	NI TY. COM	43. 00
	report preparer in columns 1 and 2, respectively.					

Heal th	Financial Systems COMMUNITY HOSP	PITAL ANDERSON	In Lie	In Lieu of Form CMS-2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCN: 15-0113	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Pre		
			10 12/31/2022	5/25/2023 11:	38 am	
		3.00				
	Cost Report Preparer Contact Information					
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	NETWORK DIRECTOR OF REIMBURSEMENT			41. 00	
42. 00	Enter the employer/company name of the cost report				42. 00	
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43. 00	

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | To 12/31/2

Component Worksheet A No. of Beds Bed Days Available Aline No. No. of Beds Bed Days Available Aline No. of Beds Al					'	0 12/31/2022	5/25/2023 11:	
Component								oo am
Component								
Line No.		Component	Worksheet A	No. of Beds	Bed Days			
PART I - STATISTICAL DATA 1.00 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LOP room available beds) 2.00 4.0					,			
PART I - STATISTICAL DATA 1.00			1. 00	2. 00	3.00	4. 00	5. 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 Hold and other (see instructions) 2.00 3.00 4.00 Hold IPF Subprovider 3.00 5.00 6.00 Hospital Adults & Peds. Swing Bed SNF 0.5 0.00 0.5 0.0		PART I - STATISTICAL DATA						
Hospice days) (see instructions for col. 2 for the portion of LIDP room avail able beds)	1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	111	40, 515	0.00	0	1. 00
For the portion of LDP room available beds) 2.00 3.00 3.00 4.0		8 exclude Swing Bed, Observation Bed and						
2.00 HMO and other (see instructions) 2.00 4.00 4.00 4.00 4.00 6.00 6.00 HMO IRF Subprovider 0 5.00 6.00		Hospice days) (see instructions for col. 2						
3.00 HMO IPF Subprovider		for the portion of LDP room available beds)						
4.00	2.00	HMO and other (see instructions)						2.00
5.00 Hospital Adults & Peds. Swing Bed NF	3.00	HMO IPF Subprovider						3.00
6.00 Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) Total Adults and Peds. (exclude observation beds) (see instructions) Total Adults and Peds. (exclude observation beds) (see instructions) Total Company Care Unit Total Company Car	4.00	HMO IRF Subprovider						4. 00
Total Adults and Peds. (exclude observation beds) (see instructions) 111	5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
Deds) (see instructions) 1	6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
8. 00	7.00	Total Adults and Peds. (exclude observation		111	40, 515	0.00	0	7. 00
9.00 10.00 BURN INTENSIVE CARE UNIT 11.00 SURROLGAL INTENSIVE CARE UNIT 11.00 SURSICAL INTENSIVE CARE UNIT 11.00 Total (see instructions) 12.00 Total (see instructions) 12.00 CAH visits 12.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 19.00 SKILLED NURSING FACILITY 19.00 NURSING FACILITY 20.00 NURSING FACILITY 20.00 HOME HEALTH AGENCY 21.00 HOME HEALTH AGENCY 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE (non-distinct part) 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 ROWAL INTENSIVE (See instruction) 30.00 Employee di scount days (see instruction) 31.00 Employee di scount days (see instructions) 32.01 Total ancillary labor & delivery como outpatient days (see instructions) 33.00 LTCH hon-covered days 33.01 LTCH non-covered days 33.01 LTCH site neutral days and discharges		beds) (see instructions)						
10.00 BURN INTENSIVE CARE UNIT	8.00	INTENSIVE CARE UNIT	31. 00	17	6, 205	0.00	0	8. 00
11. 00 SURGICAL INTENSIVE CARE UNIT 11. 00 12. 00 OTHER SPECIAL CARE (SPECIFY) 12. 00 13. 00 14. 00 Total (see instructions) 43. 00 128 46, 720 0. 00 0 14. 00 15. 00 CAH visits 0 15. 00 15. 00 16. 00 SUBPROVIDER - IPF 16. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER 18. 00 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 HOME HEALTH AGENCY 21. 00 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE (non-distinct part) 30. 00 24. 10 HOSPICE (non-distinct part) 30. 00 24. 10 HOSPICE (some standard of the standard	9.00	CORONARY CARE UNIT						9. 00
12.00 OTHER SPECIAL CARE (SPECIFY)								
13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 10 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 01 LTCH site neutral days and discharges	11. 00	SURGICAL INTENSIVE CARE UNIT						
14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 Observation Bed Days 29.00 Ambul ance Trips 30.00 Employee di scount days (see instruction) 31.00 Employee di scount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH site neutral days and discharges 128 46,720 0.00 0 14.00 0 15.00 0 15.00 0 17.00 17.00 18.00 0 17.00 20.00 17.00 18.00 0 18.00 0.00 19.00 0 19.00 0.00 0 19.00 0.00 0 19.00								
15. 00 CAH visits 16. 00 SUBPROVI DER - IPF 17. 00 SUBPROVI DER - IRF 18. 00 SUBPROVI DER 19. 00 SYILLED NURSI NG FACILITY 19. 00 SYILLED NURSI NG FACILITY 20. 00 NURSI NG FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 10 HOSPI CE 24. 10 HOSPI CE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Empl oyee discount days (see instruction) 31. 00 Empl oyee discount days (see instructions) 32. 01 Total (sum of ilary labor & delivery room outpatient days (see instructions) 31. 00 LTCH non-covered days 33. 00 LTCH non-covered days 33. 01 LTCH site neutral days and discharges	13.00	NURSERY	43. 00				0	
16. 00 SUBPROVIDER - IPF 16. 00 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER 18. 00 SUBPROVIDER 18. 00 19. 0	14.00	Total (see instructions)		128	46, 720	0.00	0	
17. 00 SUBPROVI DER - IRF 17. 00 18. 00 SUBPROVI DER 18. 00 SUBPROVI DER 19. 00 SKILLED NURSI NG FACILITY 19. 00 20. 00 NURSI NG FACILITY 20. 00 20. 00 21. 00 21. 00 21. 00 22. 00 HOME HEALTH AGENCY 22. 00 HOME HEALTH AGENCY 22. 00 24. 00 40. 00		· ·					0	
18.00 SUBPROVI DER 19.00 SKILLED NURSI NG FACILITY 20.00 NURSI NG FACILITY 20.00 PURSI PURSI NG FACILITY 20.00 PURSI NG FACILI		1						
19. 00 20. 00 19. 00 20. 00 19. 00 20. 00 21. 00 21. 00 21. 00 21. 00 22. 00 23. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 20. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 22. 00 23. 00 24. 00 24. 10 25. 00 26. 00 27. 00 28. 00 28. 00 29. 00 29. 00 20		i i						
20.00 NURSING FACILITY 20.00 21.00 21.00 22.00 22.00 22.00 23.00 24.00 24.00 25.00 24.00 25.00 24.00 25.		1						
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges								
22. 00 23. 00 24. 00 4MBULATORY SURGICAL CENTER (D. P.) 23. 00 24. 00 4MSPICE (non-distinct part) 25. 00 26. 00 RURAL HEALTH CLINIC 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 01 LTCH site neutral days and discharges		1						
23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.00 24.10 HOSPICE (non-distinct part) 30.00 25.00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 89.00 27.00 Total (sum of lines 14-26) 128 27.00 28.00 Observation Bed Days 29.00 Ambul ance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 31.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 30.00								
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34. 00 Temporary Expansion Covid-17 File Acute Care 30.00 0 0 0 0 34.00			30 00	_	,			
	34.00	Transportary Expansion Covid-17 The Acute Care	30.00	0		11	١	34.00

Health Financial Systems COMMUNIT

Provider CCN: 15-0113

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2022 | Part | | To 12/31/2022 | Date/Time Prepared: | 5/25/2023 | 11: 38 am

Component Title XVIII Title XIX Total All Payroll Payroll Payroll Title XVIII Title XIX Total All Payroll Payrol
PART I - STATISTICAL DATA
PART I - STATISTICAL DATA
PART I - STATISTICAL DATA 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 8, 336 4, 729 2.00 3.00 HMO IPF Subprovider 0 0 0 0 0 3.00 0 0 0 0 0 0 0 0 0
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see i nstructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 8, 336 4, 729 2.00 3.00 HMO IPF Subprovider 0 0 0 3.00 4.00 HMO IRF Subprovider 0 0 0 0 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 0 0 0 6.00
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)
Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 8,336 4,729 2.00 3.00 HMO IPF Subprovider 0 0 0 0 4.00 HMO IRF Subprovider 0 0 0 0 0 0 0 0 0 0
For the portion of LDP room available beds 2.00
2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 HM0 IRF Subprovider 6.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 899 1, 193 14.00 Total (see instructions) 8, 336 4, 729 0 0 0 0 3.00 4.00 0 6.00 7.00 0 6.00 7.00 0 7.
3.00 HM0 IPF Subprovider 4.00 HM0 IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 19.00 CAH visits 10.00 Surgical (see instructions) 11.00 CAH visits 10.00 Surgical (see instructions) 11.00 CAH visits 10.00 Surgical (see instructions) 10.00 Surgical (see instructions) 11.00 CAH visits 10.00 Surgical (see instructions) 11.00 Surgical (see instructions) 12.00 Surgical (see instructions) 13.00 Surgical (see instructions) 13.00 Surgical (see instructions) 14.00 Surgical (see instructions) 15.00
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5.00 Hospital Adults & Peds. Swing Bed SNF
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 897 124 3,475 8.00 CORONARY CARE UNIT 9.00 SURGICAL INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 899 1,193 13.00 NURSERY 899 1,193 13.00 Total (see instructions) 6,496 1,774 24,912 0.16 899.23 14.00 15.00 CAH visits
7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 899 1, 193 14.00 Total (see instructions) 6, 496 1, 774 24, 912 0.16 899. 23 14.00 15.00 CAH visits
B. 00
8.00 INTENSIVE CARE UNIT 897 124 3,475 8.00 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00
9.00 CORONARY CARE UNIT
10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 NURSERY 899 1,193 13.00 Total (see instructions) 6,496 1,774 24,912 0.16 899.23 14.00 15.00 CAH visits 0 0 0 0 0 15.00
11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 13.00 NURSERY 899 1,193 14.00 15.00 CAH visits 0 0 0 0 15.00 15.00 15.00 16.00 17
12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 12.00 13.00 14.774 24,912 0.16 899.23 14.00 15.00
13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 13.00 NURSERY 1, 193
14.00 Total (see instructions) 6,496 1,774 24,912 0.16 899.23 14.00 15.00 CAH visits 0 0 0 15.00
15. 00 CAH vi si ts 0 0 0 15. 00
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17. 00 SUBPROVIDER - I RF 17. 00
18.00 SUBPROVIDER 18.00
19.00 SKILLED NURSING FACILITY
20.00 NURSING FACILITY 20.00
21.00 OTHER LONG TERM CARE
22. 00 HOME HEALTH AGENCY
23. 00 AMBULATORY SURGI CAL CENTER (D. P.)
24. 00 HOSPI CE 24. 00
24. 10 HOSPICE (non-distinct part) 61 24. 10
25. 00 CMHC - CMHC 25. 00
26. 00 RURAL HEALTH CLINIC 26. 00
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0. 00 0. 00 26. 25
27.00 Total (sum of lines 14-26) 0.16 899.23 27.00
28.00 Observation Bed Days 355 2,334 28.00
29. 00 Ambul ance Tri ps 0 29. 00
30.00 Employee discount days (see instruction) 223 30.00
31.00 Employee discount days - IRF 0 31.00
32.00 Labor & delivery days (see instructions) 0 11 195 32.00
32.01 Total ancillary labor & delivery room 0 32.01
outpatient days (see instructions)
33.00 LTCH non-covered days 0 33.00
33.01 LTCH site neutral days and discharges 0 33.01
34.00 Temporary Expansi on COVID-19 PHE Acute Care 0 0 0 34.00

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | | To 12/31/2022 | Date/Time Prepared: Provider CCN: 15-0113

Full Time Discharges Component Full Time Equivalents Nonpaid Title V Title XVIII Title XIX Total All Pattlents Title V Title XVIII Title XIX Total All Pattlents Title XVIII Title XIX Total All Title XVIII Title XIX Total All Pattlents Title XVIII Title XIX Total All Pattlents Title XVIII Title XIX Total All Title XVIII Title XIX Total All Title XVIII Pattlents Title XVIII Title XIX Total All Title XVIII Title XVI					To	12/31/2022	Date/Time Prep 5/25/2023 11:3	
Equivalents Nonpaid Workers Title V Title XVIII Title XIX Patients Patients Nonpaid Workers Title V Title XVIII Title XIX Patients Pati			Full Time		Di sch	arges	372372023 11.	30 am
Morkers Morkers Patt ents			Equi val ents			3		
11.00 12.00 13.00 14.00 15.00		Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
PART I - STATISTICAL DATA								
1.00			11. 00	12. 00	13. 00	14. 00	15. 00	
8 exclude Swing Bed, Observation Bed and Hospic ed Jays) (see instructions for col. 2 for the portion of LDP room available beds) 1,514 1,210 2.00			1		1	.1		
Hospice days) (\$ee instructions for col. 2 for the portion of LDP room available beds)	1. 00			0	1, 470	169	5, 830	1. 00
For the portion of LDP room available beds)								
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4.00 HMO IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults & Peds. (exclude observation beds) (see instructions) 8.00 INTENSI VE CARE UNIT 9.00 CORONARY CARE UNIT 11.00 SURGICAL INTENSI VE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 15.00 CAH visits 16.00 Subprovider - IRF 18.00 Subprovider - IRF 19.00 SKILLED NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 OTHER SPECIAL CORE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D. P.) 24.00 HOSPICE (Chon-distinct part) 25.00 CMC - CMHC - CMHC 26.00 RURAL HEALTH CLINIC C 26.00 FEDERALLY QUALIFIED HEALTH CENTER 0.00 CAB SUBPROVILED HEALTH CENTER 0.00 CAB SUBPROVILED SURGICAL CENTER (D. P.) 26.00 RURAL HEALTH CLINIC C 26.00 RURAL HEALTH CLINIC C 26.00 FEDERALLY QUALIFIED HEALTH CENTER 0.00 CAB SUBPROVILED SURGICAL CENTER (D. P.) 26.00 RURAL HEALTH CLINIC C 26.00 FEDERALLY QUALIFIED HEALTH CENTER 0.00 CAB SUBPROVILED SURGICAL CENTER (D. P.) 26.00 RURAL HEALTH CLINIC C 26.00 FEDERALLY QUALIFIED HEALTH CENTER					1, 314	1, 210		
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8. 00 INTENSIVE CARE UNIT	7.00							7.00
9. 00 CORONARY CARE UNIT	8. 00							8. 00
10. 00 BURN INTENSIVE CARE UNIT 10. 00 11. 00 11. 00 12. 00 12. 00 13. 00 14. 00 15. 00 14. 00 15. 00 15. 00 16.								9. 00
12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER OSKILLED NURSING FACILITY 19.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D. P.) 16.00 CAH visits 16.00 SUBPROVIDER 17.00 OTHER LONG TERM CARE 22.00 CAMBULATORY SURGICAL CENTER (D. P.) 17.00 CAL visits 18.00 CAL vi								10. 00
13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 15.00 SUBPROVI DER - I PF 17.00 SUBPROVI DER - I RF 18.00 SUBPROVI DER 18.00 SKI LLED NURSI NG FACI LI TY 20.00 NURSI NG FACI LI TY 20.00 OTHER LONG TERM CARE 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGI CAL CENTER (D. P.) 24.00 HOSPI CE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 CMC - CMHC 26.00 FEDERALLY QUALIFIED HEALTH CENTER 13.00 14.00 15.00 16.00 17.470 169 5,830 14.00 15.00 16.00 17.470 169 5,830 14.00 15.00 16.00 17.470 169 5,830 14.00 15.00 16.00 17.470 169 17.00 18.00 19	11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
14.00 Total (see instructions) 0.00 0 1,470 169 5,830 14.00 15.00 15.00 CAH visits 15.00 16.00 SUBPROVIDER - I PF 16.00 17.00 SUBPROVIDER - I RF 17.00 SUBPROVIDER 18.00 SUBPROVIDER 18.00 SKILLED NURSING FACILITY 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 24.00 HOSPICE (non-distinct part) 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 25.00 CMHC - CMHC 26.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 0.00 26.25 EDERALLY QUALIFIED HEALTH CENTER 0.00 0	12.00	OTHER SPECIAL CARE (SPECIFY)	İ					12.00
15. 00 CAH visits 16. 00 SUBPROVIDER - I PF 16. 00 SUBPROVIDER - I RF 17. 00 SUBPROVIDER - I RF 18. 00 SUBPROVIDER 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 15. 00 16. 00 17. 00 18. 00 19.	13.00	NURSERY						13.00
16. 00 SUBPROVI DER - I PF 16. 00 17. 00 SUBPROVI DER - I RF 17. 00 18. 00 SUBPROVI DER 18. 00	14.00	Total (see instructions)	0.00	0	1, 470	169	5, 830	14.00
17. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER 18. 00 19. 00 SKI LLED NURSI NG FACI LI TY 19. 00 NURSI NG FACI LI TY 20. 00 OTHER LONG TERM CARE 21. 00 OTHER LALTH AGENCY 22. 00 HOME HEALTH AGENCY 22. 00 AMBULATORY SURGI CAL CENTER (D. P.) 23. 00 AMBULATORY SURGI CAL CENTER (D. P.) 24. 00 HOSPI CE 24. 00 HOSPI CE (non-distinct part) 24. 10 HOSPI CE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 RURAL HEALTH CLINI C 26. 00 RURAL HEALTH CLINI C 26. 26. 25	15. 00	CAH visits						15. 00
18. 00 19. 00 20. 00 21. 00 22. 00 24. 00 24. 00 24. 00 24. 00 24. 00 25. 00 26. 00 26. 25 26. 00 27. 00 28. 00 29		SUBPROVI DER - I PF						16. 00
19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 OTHER LONG TERM CARE 21. 00 OTHER LONG TERM CARE 21. 00 HOME HEALTH AGENCY 22. 00 AMBULATORY SURGICAL CENTER (D. P.) 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 23. 00 CMHC - CMHC 25. 00 CMHC - CMHC 25. 00 CMHC - CMHC 25. 00 FURAL HEALTH CLINIC 26. 00 CMRAL HEALTH CLINIC 26. 00 CMC - CMFC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0. 00		4						
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22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 RURAL HEALTH CLINIC 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0. 00		4						
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24. 10 HOSPICE (non-distinct part) 24. 10 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0. 00 24. 10 25. 00 26. 25								
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26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0. 00 26. 25								
			0.00					
28. 00 Observation Bed Days 28. 00		,	0.00		•			
29. 00 Ambul ance Tri ps 29. 00		,						
30.00 Employee discount days (see instruction)		•						
31. 00 Employee di scount days - IRF		, , , , , , , , , , , , , , , , , , , ,						
32.00 Labor & delivery days (see instructions)								
32.01 Total ancillary labor & delivery room 32.01		,				ļ		
outpatient days (see instructions)								-
33.00 LTCH non-covered days 0 33.00	33.00				0			33. 00
33.01 LTCH site neutral days and discharges 0 33.01					0			
34.00 Temporary Expansion COVID-19 PHE Acute Care 34.00	34. 00	Temporary Expansion COVID-19 PHE Acute Care				l		34. 00

Provider CCN: 15-0113

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 |

					'	o 12/31/2022	Date/lime Pre 5/25/2023 11:	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)		Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1.00	Total salaries (see	200. 00	71, 430, 647	-320, 220	71, 110, 427	1, 870, 505. 00	38. 02	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0	С	0.00	0. 00	2. 00
3.00	Non-physician anesthetist Part		0	0	C	0.00	0. 00	3. 00
4.00	Physician-Part A - Administrative		123, 053	0	123, 053	832.00	147. 90	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0 285, 976	0	1	0. 00 4, 026. 00		1
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	0	C	0.00	0.00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	0	0	C	0.00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved		0	О	С	0.00	0.00	7. 01
8.00	programs) Home office and/or related organization personnel		0	0	С	0.00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 757, 760	-2, 996	754, 764	0. 00 18, 621. 00		
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient Care		5, 707, 941	0	5, 707, 941	42, 459. 00	134. 43	11. 00
12. 00	Contract labor: Top level management and other management and administrative		0	0	C	0.00	0. 00	12. 00
13. 00	services Contract Labor: Physician-Part A - Administrative		1, 445, 229	0	1, 445, 229	19, 874. 00	72. 72	13. 00
14. 00	Home office and/or related organization salaries and		0	0	C	0.00	0.00	14. 00
14. 01	wage-related costs Home office salaries		0	О	C	0.00	0. 00	14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	1	0. 00 0. 00		1
16. 00	- Administrative Home office and Contract		0	0	(0.00		
16. 01	Physicians Part A - Teaching Home office Physicians Part A		0	0	C			16. 01
	- Teaching Home office contract		0	0	(16. 02
.0.02	Physicians Part A - Teaching WAGE-RELATED COSTS					0.00	0.00]
17. 00	Wage-related costs (core) (see instructions)		19, 332, 774	0	19, 332, 774			17. 00
18. 00	Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		198, 524 0	0	198, 524 C			19. 00 20. 00
21. 00	Non-physician anesthetist Part		0	0	C			21. 00
22. 00	Physician Part A - Administrative		10, 700	0	10, 700			22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0 51, 776		1	1		22. 01 23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	C)		24. 00 25. 00
25. 50	approved program) Home office wage-related		0	0	С			25. 50
25. 51	(core) Related organization		0	0	C			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative - wage-related (core)		0	0	C			25. 52

Provider CCN: 15-0113

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared:

					'	0 12/31/2022	5/25/2023 11:	
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE							
26. 00	Employee Benefits Department	4. 00	200, 611		200, 611	·		26. 00
27. 00	Administrative & General	5. 00	7, 051, 970					
28. 00	Administrative & General under		2, 805, 789	0	2, 805, 789	25, 767. 00	108. 89	28. 00
	contract (see inst.)		_	_	_			
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00		29. 00
30. 00	Operation of Plant	7. 00	3, 423, 318	-12, 848	3, 410, 470	· ·		
31. 00	Laundry & Linen Service	8. 00	0	0	0	0. 00		
32. 00	Housekeepi ng	9. 00	2, 330, 572	-15, 827	2, 314, 745	·		
33. 00	Housekeeping under contract		0	0	0	0.00	0. 00	33. 00
	(see instructions)							
34. 00	Di etary	10. 00	1, 852, 951	-1, 796, 889	56, 062	·		34.00
35. 00	Di etary under contract (see		0	0	0	0.00	0. 00	35. 00
	instructions)							
36. 00	Cafeteri a	11. 00	43, 082	1, 788, 887	1, 831, 969	·		36. 00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0.00		
38. 00	Nursing Administration	13. 00	1, 514, 066					
39. 00	Central Services and Supply	14. 00	333, 682			·		
40.00	Pharmacy	15. 00	2, 831, 285	-3, 157	2, 828, 128	·		
41. 00	Medical Records & Medical	16. 00	0	0	0	0.00	0.00	41. 00
	Records Library							
	Soci al Servi ce	17. 00	0	0	0	0. 00		42.00
43. 00	Other General Service	18. 00	0	0	0	0.00	0.00	43. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION COMMUNITY HOSPITAL ANDERSON Provider CCN: 15-0113

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2022 | Part III | To 12/31/2022 | Date/Time Prepared: | 5/25/2023 11: 38 am

		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		73, 950, 460	-320, 220	73, 630, 240	1, 892, 246. 00	38. 91	1.00
	instructions)							
2.00	Excluded area salaries (see		757, 760	-2, 996	754, 764	18, 621. 00	40. 53	2.00
	instructions)							
3.00	Subtotal salaries (line 1		73, 192, 700	-317, 224	72, 875, 476	1, 873, 625. 00	38. 90	3.00
	minus line 2)							
4.00	Subtotal other wages & related		7, 153, 170	0	7, 153, 170	62, 333. 00	114. 76	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		19, 343, 474	0	19, 343, 474	0.00	26. 54	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		99, 689, 344	-317, 224	99, 372, 120	1, 935, 958. 00	51. 33	6.00
7.00	Total overhead cost (see		22, 387, 326	-68, 835	22, 318, 491	637, 463. 00	35. 01	7.00
	instructions)							

	To 12/31/2022	Date/Time Pre 5/25/2023 11:	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	3, 026, 241	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	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	7, 286, 452	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	2, 721, 085	9. 00
10.00	Dental, Hearing and Vision Plan	74, 362	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	38, 984	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)	965, 398	
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15. 00	'Workers' Compensation Insurance	290, 462	15. 00
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumulative portion)		
	TAXES		
	FICA-Employers Portion Only	5, 183, 568	
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unemployment Insurance	0	19. 00
20. 00		0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	<pre>instructions))</pre>	_	
22. 00	Day Care Cost and Allowances	0	22. 00
23. 00	Tuition Reimbursement	7, 222	23. 00
24. 00	Total Wage Related cost (Sum of Lines 1 -23)	19, 593, 774	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0113	Peri od: Worksheet S-3 From 01/01/2022 Part V
		To 12/31/2022 Date/Time Prepared:

			0 12/31/2022	Date/lime Prep 5/25/2023 11:3	
	Cost Center Description		Contract Labor		30 G.III
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1. 00	Total facility's contract labor and benefit cost		5, 707, 941	19, 593, 774	1. 00
2.00	Hospi tal		5, 707, 941	19, 395, 250	2.00
3.00	SUBPROVIDER - IPF				3.00
4. 00	SUBPROVIDER - IRF				4.00
5.00	Subprovi der - (0ther)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00	SKILLED NURSING FACILITY				8.00
9.00	NURSING FACILITY				9.00
10.00	OTHER LONG TERM CARE I				10.00
11. 00	Hospi tal -Based HHA				11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I				12.00
13.00	Hospi tal -Based Hospi ce				13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15.00	Hospital-Based Health Clinic FQHC				15.00
16.00	Hospi tal -Based-CMHC				16.00
17. 00	RENAL DIALYSIS I		0	0	17.00
18. 00	0ther		0	198, 524	18. 00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Heal th	Financial Systems COMMUNITY HOSPITAL	ANDERSON	In Lie	eu of Form CMS-2	2552-10
Incompensated and Indigent care cost computation 1.00				Peri od:	Worksheet S-1	
1.00						narod:
Uncompensated and Indigent care cost computation 1.00 Cost to charge ratio (Worksheet C. Part I line 202 column 3 divided by line 202 column 8) 0.231494 1.00 Cost to charge ratio (Worksheet C. Part I line 202 column 3 divided by line 202 column 8) 0.231494 1.00 Modicald (See Instructions for each I ine) 2.00 Not revenue from Medicald 43.589.087 2.00 3.00 Did you receive DSH or supplemental payments From Medicald Y 3.00 1.00				10 12/31/2022		
1.00 Cost to charge ratio (Morkshet C, Part I line 202 column 3 divided by line 202 column 8) 0.231494 1.00 Medical di (see instructions for each line) 43,589.057 2.00 0.00					1.00	
Medicaid (see Instructions for each line) Medicaid 43,589,057 2.00		Uncompensated and indigent care cost computation				
Net revenue from Medical	1.00		vided by line 202 colum	nn 8)	0. 231494	1. 00
3.00 1 dy our receive DSN or supplemental payments from Medical of? Y 3.00 0.00 1 filine 3 is yes, does line 2 include all DSN and/or supplemental payments from Medical of? N 4.00 0.00					10.500.057	
1						1
1			al payments from Medic	rai d?	•	1
Medical d charges		1		Ja. 41		1
8.00	6.00	Medi cai d charges			171, 010, 859	6. 00
2 zero then enter zero		1				1
Children's Health Insurance Program (CHIP) (see instructions for each line)	8. 00		(line 7 minus sum of li	nes 2 and 5; if	1, 016, 516	8. 00
9.00 Net revenue from stand-al one CHIP 0 0.00		Children's Health Insurance Program (CHIP) (see instructions for	or each line)		L	1
11. 00 Stand-al one CHIP cost "(line 1 times line 10) 10. 00	9.00		,		0	9.00
12.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then 0 12.00	10. 00					
enter zero) Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 0 13.00						
Other state or local government indigent care program (See instructions for each Line) 13.00 13.00 13.00 14.00 15.	12. 00		line 11 minus line 9;	if < zero then	0	12.00
13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 0 13.00 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 0 14.00 15.00 State or local indigent care program cost (line 1 times line 14) 0 15.00 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 indigent care program (line 15 minus line 0 16.00 13. if < zero then enter zero) 0 16.00 13. if < zero then enter zero) 0 16.00 13. if < zero then enter zero) 0 16.00 13. if < zero then enter zero) 0 16.00 13. if < zero then enter zero) 0 16.00 14.00 13. if < zero then enter zero) 0 16.00 15.00 Forats, donations, or endowment income restricted to funding charity care 35, 271 17.00 15.00 Covernment grants, appropriations or transfers for support of hospital operations 0 18.00 18.00 15.00 State instructions for each line 0 1.00 2.00 3.00 15.00 2.00 3.00 2.00 3.00 15.00 2.00 3.00 2.00 3.00 15.00 2.00 3.00 2.00 3.00 15.00 2.00 3.00 2.00 3.00 15.00 2.00 3.00 2.00 3.00 15.00 2.00 3.00 2.00 3.00 15.00 2.00 3.00 2.00 3.00 15.00 2.00 3.00 2.00 3.00 15.00 2.00 3.00 2.00 3.00 15.00 2.00 3.00 2.00 3.00 15.00 2.00 3.00 2.00 3.00 15.00 2.00 3.00 2.00 3.00 15.00 2.00 3.00 3.00 2.00 3.00 15.00 2.00 3.00 3.00 2.00 3.00 15.00 2.00 3.00 3.00 3.00 15.00 2.00 3.00 3.00 3.00 3.00 15.00 2.00 3.00 3.00 3.00 3.00 15.00 2.00 3.00 3.00 3.00 3.00 3.00 3.00 15.00 2.00 3.00			ructions for each line	9)		1
10) 15. 00 State or local indigent care program cost (line 1 times line 14) 16. 00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16. 00 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17. 00 Private grants, donations, or endowment income restricted to funding charity care 35, 271 17. 00 18. 00 Government grants, appropriations or transfers for support of hospital operations 0 18. 00 19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 1, 016, 516 19. 00 19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 1, 016, 516 19. 00 19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 1, 016, 516 19. 00 19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 1, 016, 516 19. 00 19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 1, 016, 516 19. 00 19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 1, 016, 516 19. 00 19. 00 Total unreimbursed cost for Medicaid (cHIP and state and local indigent care programs (sum of lines 1, 016, 516 19. 00 19. 00 Charity care charges and uninsured discounts for the entire facility 4, 185, 810 1, 083, 730 5, 269, 540 20. 00 19. 00 Cost of patients approved for charity care and uninsured discounts (see 968, 990 1, 083, 730 2, 052, 632 23. 00 19. 00 Cost of patients approved for charity care and uninsured discounts (see 968, 990 1, 083, 730 2, 052, 632 23. 00 19. 00 Cost of charity care (line 21 minus line 22) 968, 902 1, 083, 730 2, 052, 632 23. 00 19. 00 Cost of charity care (line 21 minus line 22) 968, 902 1, 083, 730 2, 052, 632 23. 00 19. 00 Cost of charity care (line 21 minus line 22) 10. 00	13.00				0	13. 00
15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 35, 271 and 16) 18.00 Government grants, appropriations or transfers for support of hospital operations 0 18.00 Government grants, appropriations or transfers for support of hospital operations 1, 016, 516 19.00 and 16.00 grants, appropriations or transfers for support of hospital operations 1, 016, 516 19.00 and 16.00 grants appropriations or transfers for support of hospital operations 1, 016, 516 19.00 and 16.00 Government grants, appropriations or transfers for support of hospital operations 1, 016, 516 19.00 and 16.00 grants approved for the entire facility 1, 016, 516 19.00 and 16.00 grants approved for charity care each line) 10.00 Charity care charges and uninsured discounts for the entire facility 4, 185, 810 1, 083, 730 2, 052, 549, 540 (see instructions) 10.00 Cost of patients approved for charity care and uninsured discounts (see 968, 990 1, 083, 730 2, 052, 632 23.00 and 16.00 and	14. 00		e program (Not included	d in lines 6 or	0	14. 00
16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line or 13: if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 35, 271 17.00 20 18.00 19.00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 1,016, 516 19.00	15 00	1 /	1)			15 00
13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 35,271 17.00 18.00 Government grants, appropriations or transfers for support of hospital operations 0 18.00 18.00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 1,016,516 19.00 1.00 2.00 3.00				ne 15 minus line		
Instructions for each line) Private grants, donations, or endowment income restricted to funding charity care Sovernment grants, appropriations or transfers for support of hospital operations Total unrel mbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 1,016,516 19.00 1	10.00		go ca. o p. og. a (10.00
17. 00 Private grants, donations, or endowment income restricted to funding charity care 8. 00 Government grants, appropriations or transfers for support of hospital operations 19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines lines lines) 19. 00 Note of the patients lines li			P and state/local indi	gent care program	ms (see	
18.00 Government grants, appropriations or transfers for support of hospital operations 19.00 Total unrelimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 1, 016, 516 19.00 19	17. 00		unding charity care		35, 271	17. 00
8, 12 and 16) Uninsured patients patie		1	3			1
Uncompensated Care (see instructions for each line) Uncompensated Care (see instructions for each line) 20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see 968, 990 1, 083, 730 2, 052, 720 21.00 instructions) Payments received from patients for amounts previously written off as 88 0 88 22.00 charity care 23.00 Cost of charity care (line 21 minus line 22) 968, 902 1, 083, 730 2, 052, 632 23.00 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit N 24.00 imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 0, 40, 757, 27.00 care reimbursable bad debts for the entire hospital complex (see instructions) 9, 480, 920 26.00 27.01 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 9, 480, 920 25, 780 27.01 Medicare bad debt expense (see instructions) 9, 255, 140 28.00 29.00 Cost of non-Medicare bad debt expense (see instructions) 9, 255, 140 28.00 30.00 Cost of nunompensated care (line 23 column 3 plus line 29) 4, 274, 164 30.00	19. 00		indigent care program	ns (sum of lines	1, 016, 516	19. 00
Uncompensated Care (see instructions for each line) 20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22.00 Payments received from patients for amounts previously written off as a mount on line 20 column 2, include charges for patient days beyond a length of stay limit inposed on patients covered by Medicaid or other indigent care program? 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit inposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit in the charges for patient days beyond the indigent care program's length of stay limit in the charges for patient days beyond the indigent care program's length of stay limit in the charges for patient days beyond the indigent care program's length of stay limit in the charges for patient days beyond the indigent care program's length of stay limit in the charges for patient days beyond the indigent care program's length of stay limit in the charges for patient days beyond the indigent care program's length of stay limit in the charges for patient days beyond the indigent care program's length of stay limit in the charges for patient days beyond the indigent care program's length of stay limit in the charges for patient days beyond the indigent care program's length of stay limit in the charges for patient days beyond the indigent care program's length of stay limit in the charges for patient days beyond the indigent care program's length of stay limit in the charges for patient days beyond the indigent care program's length of stay limit in the charges for patient days beyond the indigent care program's length of stay limit in the charges for patient days beyond the indigent care program's length of stay limit in the charges for patient days beyon		10, 12 and 10)	Uni nsured	Insured	Total (col. 1	
Uncompensated Care (see instructions for each line) 20.00 Chari ty care charges and uninsured discounts for the entire facility (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 968, 990 1, 083, 730 2, 052, 720 21.00 instructions) 22.00 Payments received from patients for amounts previously written off as 88 0 88 22.00 charity care 23.00 Cost of charity care (line 21 minus line 22) 968, 902 1, 083, 730 2, 052, 632 23.00 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit to 10 total bad debt expense for the entire hospital complex (see instructions) 9, 480, 920 26.00 27.01 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 146, 757 27.00 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 9, 255, 140 28.00 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 9, 255, 140 30.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 4, 274, 164 30.00						
20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22.00 Payments received from patients for amounts previously written off as charity care 23.00 Cost of charity care (line 21 minus line 22) 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit to 25.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27.00 Medicare lallowable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29)		Uncompared Care (see instructions for each line)	1.00	2. 00	3.00	
(see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22.00 Payments received from patients for amounts previously written off as 88 0 88 22.00 charity care 23.00 Cost of charity care (line 21 minus line 22) 968,902 1,083,730 2,052,632 23.00 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 9, 480, 920 26.00 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 146, 757 27.00 28.00 Non-Medicare bad debt expense (see instructions) 9, 255, 140 28.00 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 2, 221, 532 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 4, 274, 164 30.00	20. 00		cility 4, 185, 8	310 1, 083, 730	5, 269, 540	20.00
instructions) Payments received from patients for amounts previously written off as 88 0 88 22.00 charity care 23.00 Cost of charity care (line 21 minus line 22) 968, 902 1,083,730 2,052,632 23.00 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 77.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 78.00 Non-Medicare bad debt expense (see instructions) 79.480,920 26.00 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29)		1 '				
22. 00 Payments received from patients for amounts previously written off as charity care 23. 00 Cost of charity care (line 21 minus line 22) 24. 00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25. 00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26. 00 Total bad debt expense for the entire hospital complex (see instructions) 27. 00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27. 01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28. 00 Non-Medicare bad debt expense (see instructions) 29. 00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 20. 00 Rodicare and non-reimbursable Medicare bad debt expense (see instructions) 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 20. 00 Rodicare and non-reimbursable Medicare bad debt expense (see instructions) 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29)	21. 00		ints (see 968,9	990 1, 083, 730	2, 052, 720	21. 00
charity care Cost of charity care (line 21 minus line 22) 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare allowable bad debts for the entire hospital complex (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29)	22 00		off as	88	88	22 00
24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 10.00 Dost of uncompensated care (line 23 column 3 plus line 29)	22.00	"	011 43			22.00
24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 24.00 Imposed a length of stay limit N 24.00 25.00 p, 480, 920 26.00 9, 480, 920 26.00 146, 757 27.00 127.01 28.00 Non-Medicare allowable bad debts for the entire hospital complex (see instructions) 9, 255, 140 28.00 2, 221, 532 29.00 4, 274, 164 30.00	23. 00	Cost of charity care (line 21 minus line 22)	968,	902 1, 083, 730	2, 052, 632	23. 00
24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29)					1.00	
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stay limit 26. 00 Total bad debt expense for the entire hospital complex (see instructions) 27. 00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27. 01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28. 00 Non-Medicare bad debt expense (see instructions) 29. 00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 29. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 30. 00 26. 00 27. 01 28. 00 29. 480, 920 26. 00 29. 480, 720 225, 780 27. 01 225, 780 27. 01 29. 00 29. 00 20. 00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 29. 00 20.		imposed on patients covered by Medicaid or other indigent care	program?	•		
27. 00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27. 01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28. 00 Non-Medicare bad debt expense (see instructions) 29. 00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 146, 757 27. 00 225, 780 27. 01 28. 00 29. 255, 140 28. 00 29. 221, 532 29. 00 4, 274, 164 30. 00		stay limit		-		
27. 01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28. 00 Non-Medicare bad debt expense (see instructions) 29. 00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 27. 01 28. 00 29. 00 20. 01 225, 780 27. 01 28. 00 29. 00 29. 00 20. 02 20. 02 20. 03 20. 00 2			,			1
28.00 Non-Medicare bad debt expense (see instructions) 9, 255, 140 28.00 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 2, 221, 532 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 4, 274, 164 30.00		,	,			•
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 2, 221, 532 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 4, 274, 164 30.00		, , ,	bee Thisti ucti uns)			1
30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 4, 274, 164 30.00			oense (see instructions	s)		1
	30.00	, , , , , , , , , , , , , , , , , , , ,	•			30. 00
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30) 5,290,680 31.00	31. 00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)		5, 290, 680	31.00

leal th	Financial Systems	COMMUNITY HOSPITAL	ANDERSON		In Lie	u of Form CMS-2	2552-1
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO		Peri od:	Worksheet A	
					From 01/01/2022 To 12/31/2022		
	0 1 0 1 5	0.1.	0.11	T	D 1 '6' 1'	5/25/2023 11:	38 am
	Cost Center Description	Sal ari es	0ther	lotal (col. l + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance	
				+ (01. 2)	Olis (See A-O)	(col. 3 +-	
						col . 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						1
	00100 CAP REL COSTS-BLDG & FIXT		0	9	2, 895, 938		
. 00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS		0	(6, 658, 591	6, 658, 591	2.0
	00400 EMPLOYEE BENEFITS DEPARTMENT	200, 611	36, 745	237, 350	0 6 -720	_	
	00500 ADMINISTRATIVE & GENERAL	7, 051, 970	63, 774, 713			69, 961, 746	
	00600 MAINTENANCE & REPAIRS	7,031,770	03, 774, 713	70, 020, 00	0	07, 701, 740	1
	00700 OPERATION OF PLANT	3, 423, 318	6, 507, 067	9, 930, 38	-1, 405, 097	8, 525, 288	1
	00800 LAUNDRY & LINEN SERVICE	0	0	(5	0	1 .
	00900 HOUSEKEEPI NG	2, 330, 572	1, 213, 624	3, 544, 196	6 -13, 519	3, 530, 677	9. (
0. 00	01000 DI ETARY	1, 852, 951	1, 808, 103	3, 661, 054	4 -3, 575, 483	85, 571	10. (
	01100 CAFETERI A	43, 082	68, 915	111, 99	7 3, 420, 701	3, 532, 698	11. (
	01200 MAINTENANCE OF PERSONNEL	0	0	(9	_	12. (
	01300 NURSING ADMINISTRATION	1, 514, 066	490, 045				
	01400 CENTRAL SERVI CES & SUPPLY	333, 682	-220, 691	112, 99			
	01500 PHARMACY	2, 831, 285	9, 601, 733				
	01600 MEDI CAL RECORDS & LI BRARY	0	19, 810	19, 810	0	,	
	01700 SOCIAL SERVICE	0	0	9) 0	0	1
	01900 NONPHYSI CI AN ANESTHETI STS	0	0		ال ال	0	19. (20. (
	02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0)	ال ال	1 0	21. (
	02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0) 0	1 0	22. (
	02300 PARAMED ED PRGM-(EMS)	0	0			0	1
. 00	INPATIENT ROUTINE SERVICE COST CENTERS		J	· ·			25. (
0. 00	03000 ADULTS & PEDIATRICS	17, 910, 791	9, 398, 536	27, 309, 32	7 -3, 347, 442	23, 961, 885	30.0
	03100 NTENSI VE CARE UNIT	3, 530, 463	3, 268, 505				
	04300 NURSERY	0	0	1	1, 077, 835		
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	6, 034, 005	17, 396, 720	23, 430, 72	5 -12, 454, 131	10, 976, 594	50.0
	05100 RECOVERY ROOM	0	0		0	0	51. (
	05200 DELIVERY ROOM & LABOR ROOM	0	0	(1, 581, 143	1, 581, 143	
	05300 ANESTHESI OLOGY	0	0	(0	0	
	05400 RADI OLOGY-DI AGNOSTI C	1, 884, 130	1, 402, 709				
	05401 ULTRASOUND	563, 927	209, 968	773, 89!	34, 660		
	05500 RADI OLOGY-THERAPEUTI C	217 400	475 200	700 700) 0	520,070	
	05600 RADI 01 S0T0PE 05700 CT SCAN	317, 499 730, 212	475, 290 740, 243				1
	05800 MAGNETIC RESONANCE IMAGING (MRI)	599, 759	1, 160, 718				
	05900 CARDI AC CATHETERI ZATI ON	738, 858	1, 564, 814				
	06000 LABORATORY	2, 780, 297	5, 397, 379			7, 920, 509	
	06001 BLOOD LABORATORY	0	0	0, .,,, 0,	0	0	1
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	220, 837	506, 227	727, 06	4 -2, 968	_	
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0		63.
	06400 I NTRAVENOUS THERAPY	0	0		ol ol	0	1
	06500 RESPI RATORY THERAPY	2, 348, 752	1, 131, 326	3, 480, 078	-101, 906	3, 378, 172	1
	06600 PHYSI CAL THERAPY	3, 283, 139	1, 987, 544				
	06700 OCCUPATIONAL THERAPY	0	O		521, 651		1
	06800 SPEECH PATHOLOGY	O	0		242, 948		1
	06900 ELECTROCARDI OLOGY	1, 074, 280	489, 885			1, 432, 711	
	07000 ELECTROENCEPHALOGRAPHY	525, 949	458, 756	1			1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		6, 280, 006		
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(7, 434, 234		
	07300 DRUGS CHARGED TO PATIENTS	0	0	007.00	8, 555, 276		
1. 00	07400 RENAL DI ALYSI S	0	337, 934	337, 93	4 -12, 645	325, 289	74.
	OUTPATIENT SERVICE COST CENTERS	٥	0		0	0	1 00 /
	09000 CLINIC 09001 WOUND/OSTOMY CLINIC	672, 777	1, 519, 554	2 102 22	1 -222, 023	1 070 209	
	09002 CTR ADVANCED HEART CARE	323, 611					
	09003 RADIATION ONCOLOGY	1, 872, 975	126, 818 3, 323, 156				1
	09004 MUNCI E CLINI C	1, 072, 973	3, 323, 130 0	5, 170, 13	0 -1,011,494		1
	09005 ANTI COAGULATI ON CLINIC	335, 821	110, 854	446, 67!	-	446, 675	1
	09006 PREGNANCY PLUS	0	0	110, 07	مُ ا	0	1
	09007 0/P LAB	o	0		o o	0	1
	09008 0/P LAB	ŏl	n			ő	1
	09009 FORTVILLE CLINIC	ol ol	29, 580	29, 580	-28, 980	_	1
	09010 1030 S SCATTERFIELD (MEDCHECK)	o	, 230]	o o	0	1
	09011 DI ABETI C PLUS CLINIC	375, 374	96, 870	472, 24	4 -2, 105	470, 139	1
	09012 OTHER ONCOLOGY SERVICES	O	0		o ' o	0	1
	09100 EMERGENCY	4, 967, 894	2, 368, 564	7, 336, 458	-274, 964	7, 061, 494	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)					1	92.0
2. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REI MBURSABLE COST CENTERS O9850 OTHER REI MBURSABLE COST CENTERS	0	0		0 0		98.0

Health Financial Systems	COMMUNITY HOSPIT	ANDEDSON		Inlie	u of Form CMS-	2552_10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O		Provi der Co	CN: 15-0113	Peri od:	Worksheet A	2332-10
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 11:	pared: 38 am
Cost Center Description	Sal ari es	Other	Total (col. + col. 2)	1 Reclassificati ons (See A-6)		
	1.00	2.00	3. 00	4. 00	5. 00	
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	70, 672, 887	136, 802, 014	207, 474, 90	1, 397, 331	208, 872, 232	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 00
190. 01 19001 WELLNESS CENTERS	658, 390	598, 898	1, 257, 28	-366, 423	890, 865	
190. 02 19002 EMPLOYED ORTHO MD	0	0		0 0		190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)	0	0		0		190. 03
190. 04 19004 SUMMIT CONV. (LTC)	0	0		0		190. 04
190. 05 19005 PARKVI EW CONV. (LTC)	0	0		0 0	-	190. 05
190. 06 19006 MONTI CELLO HSE.	0	88, 542	88, 54	-42, 500		190. 06
190. 07 19007 NH PARK PLACE (LTC)	0	0		0		190. 07
190. 08 19008 MADI SON PLACE OF ELWOOD (LTC)	0	0		0		190. 08
190. 09 19009 SPI NE SURGEON	0	0		0		190. 09
190. 10 19010 CLI NI CAL RESEARCH CENTER	0	0		0		190. 10
190. 11 19011 ONCOLOGI ST	U	0	20	0		190. 11
190. 12 19012 MEDI CAL INTERNI ST 190. 13 19013 RHEUMATOLOGY	0	281	28	0 0	-	190. 12
190. 13 19013 RHEUMATOLOGY 190. 14 19014 ROCK STEADY BOXING	99, 370	67, 829	167, 19	٥	144, 827	190. 13
190. 14 19014 ROCK STEADY BOXING 190. 15 19015 OTHER ONCOLOGY SERVICES	99, 370	07, 829	107, 19	-22, 372		190. 14
190. 13 19013 OTHER ONCOLOGY SERVICES	0	0		0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	2, 711, 818	2, 711, 8	18 -831, 378		
192. 01 19201 MUNCIE MD OFFICES	0	155, 805				192. 01
192. 02 19202 FOUNDATION	0	133, 603	155, 60	0 -130, 740		192. 02
192. 03 19203 SP0E	0	0				192. 02
192. 04 19204 HEALTHY HEART	0	0		0		192. 04
192. 05 19205 VACANT SPACE	0	0		0		192. 05
192. 07 19207 PARK PLACE CENTER	0	0		0		192. 07
192. 08 19208 RENTAL PROPERTY	0	0		0 0		192. 08
192. 09 19209 RESIDENTIAL PROPERTY (1430 N MADISON	ol	7, 100	7, 10	00 -3, 718		192. 09
192. 10 19210 1512 N MADI SON AVE	ol	0	,,	0 0		192. 10
200.00 TOTAL (SUM OF LINES 118 through 199)	71, 430, 647	140, 432, 287	211, 862, 93	0	211, 862, 934	200. 00

Provi der CCN: 15-0113

| Period: | Worksheet A | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: 5/25/2023 11: 38 am

					11: 38 am
	Cost Center Description		Net Expenses For Allocation	10,20,2020	111 00 0
		6.00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	0	2, 895, 938		1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	2, 811, 782	9, 470, 373		2. 00
3.00	00300 OTHER CAP REL COSTS	0	0		3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 184, 980	3, 421, 616		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-37, 479, 517	32, 482, 229		5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700 OPERATION OF PLANT	ol	8, 525, 288		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	o	0		8. 00
9.00	00900 HOUSEKEEPI NG	0	3, 530, 677		9. 00
10.00	01000 DI ETARY	0	85, 571		10.00
11. 00	01100 CAFETERI A	-1, 024, 558	2, 508, 140		11.00
12. 00	01200 MAINTENANCE OF PERSONNEL	1,024,330	2, 300, 140		12. 00
	01300 NURSI NG ADMI NI STRATI ON	2, 734, 506	4, 738, 173		13. 00
	01400 CENTRAL SERVICES & SUPPLY	803, 359	711, 471		14. 00
	01500 PHARMACY	003, 337	3, 827, 851		15. 00
	01600 MEDICAL RECORDS & LIBRARY	1, 076, 194	1, 096, 004		16. 00
	01700 SOCIAL SERVICE	1,070,194	1, 090, 004		17. 00
	01900 NONPHYSICIAN ANESTHETISTS		0		19.00
			0		
	02000 NURSI NG PROGRAM	14 101	14 101		20.00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	14, 101	14, 101		
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	29, 849	29, 849		22. 00
23. 00	O2300 PARAMED ED PRGM-(EMS)	0	0		23. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		04 040 040		
30.00	03000 ADULTS & PEDI ATRI CS	348, 164	24, 310, 049		30.00
31.00	03100 I NTENSI VE CARE UNI T	0	6, 342, 467		31.00
43. 00	04300 NURSERY	0	1, 077, 835		43. 00
	ANCI LLARY SERVI CE COST CENTERS				
50. 00	05000 OPERATI NG ROOM	-17, 928	10, 958, 666		50.00
51. 00	05100 RECOVERY ROOM	0	0		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 581, 143		52. 00
53. 00	05300 ANESTHESI OLOGY	0	0		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	115, 045	2, 562, 806		54.00
54. 01	05401 ULTRASOUND	0	808, 555		54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		55. 00
56. 00	05600 RADI 0I SOTOPE	0	530, 979		56. 00
57.00	05700 CT SCAN	0	1, 473, 654		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 341, 231		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	1, 179, 251		59. 00
60.00	06000 LABORATORY	-1, 687	7, 918, 822		60.00
60. 01	06001 BLOOD LABORATORY	0	0		60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	724, 096		62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		64.00
65.00	06500 RESPI RATORY THERAPY	-47, 358	3, 330, 814		65. 00
66.00	06600 PHYSI CAL THERAPY	0	3, 652, 647		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	521, 651		67.00
68.00	06800 SPEECH PATHOLOGY	0	242, 948		68. 00
69.00	06900 ELECTROCARDI OLOGY	0	1, 432, 711		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	913, 380		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6, 280, 006		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	O	7, 434, 234		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	8, 555, 276		73.00
74.00	07400 RENAL DIALYSIS	O	325, 289		74.00
	OUTPATIENT SERVICE COST CENTERS	-1			
90.00	09000 CLI NI C	0	0		90.00
90. 01	09001 WOUND/OSTOMY CLINIC	Ö	1, 970, 308		90. 01
	09002 CTR ADVANCED HEART CARE	-238, 618	210, 902		90. 02
90. 03	09003 RADIATION ONCOLOGY	-568, 140	3, 616, 497		90. 03
90. 04	09004 MUNCI E CLINI C	0	0,010,477		90. 04
90. 05	09005 ANTICOAGULATION CLINIC		446, 675		90. 05
90.06	09006 PREGNANCY PLUS		440, 075		90.06
90. 07	09007 0/P LAB		0		90. 07
90.07	09008 0/P LAB		0		90. 08
90.08	09009 FORTVI LLE CLI NI C		600		90.08
90. 10	09010 1030 S SCATTERFIELD (MEDCHECK)		000		90. 10
	09011 DIABETIC PLUS CLINIC	-932	469, 207		90. 10
90. 11	09011 OTHER ONCOLOGY SERVICES	-932	469, 207		90. 11
			-1		90. 12
91.00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART)	874, 516	7, 936, 010		
	10720010D3EKVATION BED3 (NUN-DISTINCI PAKI)				92. 00
92. 00					
	OTHER REIMBURSABLE COST CENTERS		~I		
	OTHER REI MBURSABLE COST CENTERS 09850 OTHER REI MBURSABLE COST CENTERS	0	0		98. 00
	OTHER REIMBURSABLE COST CENTERS 09850 OTHER REIMBURSABLE COST CENTERS SPECIAL PURPOSE COST CENTERS	-27, 386, 242	181, 485, 990		98. 00

Health FinancialSystemsCOMMUNITY FRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES COMMUNITY HOSPITAL ANDERSON In Lieu of Form CMS-2552-10

Provi der CCN: 15-0113

			5/25/2023 11: 38 am
Cost Center Description	Adjustments	Net Expenses	
		For Allocation	
	6. 00	7.00	
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1
190. 01 19001 WELLNESS CENTERS	0	890, 865	
190.02 19002 EMPLOYED ORTHO MD	0	0	190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)	0	0	190. 03
190. 04 19004 SUMMI T CONV. (LTC)	0	0	190. 04
190. 05 19005 PARKVI EW CONV. (LTC)	0	0	190. 05
190. 06 19006 MONTI CELLO HSE.	0	46, 042	
190. 07 19007 NH PARK PLACE (LTC)	0	0	190. 07
190. 08 19008 MADI SON PLACE OF ELWOOD (LTC)	0	0	190. 08
190. 09 19009 SPI NE SURGEON	0	0	190. 09
190. 10 19010 CLINI CAL RESEARCH CENTER	0	0	190. 10
190. 11 19011 ONCOLOGI ST	0	0	190. 11
190. 12 19012 MEDI CAL I NTERNI ST	0	281	
190. 13 19013 RHEUMATOLOGY	0	144 027	190. 13
190. 14 19014 ROCK STEADY BOXING	0	144, 827	
190. 15 19015 OTHER ONCOLOGY SERVICES 191. 00 19100 RESEARCH	0	١	190. 15
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	1, 880, 440	
192. 00 19200 PHTSICIANS PRIVATE OFFICES	0	24, 865	· ·
192. 02 19202 FOUNDATION	0	24, 603	192. 02
192. 03 19203 SP0E	0	0	192. 02
192. 04 19204 HEALTHY HEART	0		192.04
192. 05 19205 VACANT SPACE	0		192.05
192. 07 19207 PARK PLACE CENTER	0		192. 07
192. 08 19208 RENTAL PROPERTY	0		192. 08
192. 09 19209 RESIDENTIAL PROPERTY (1430 N MADISON	l 0	3, 382	
192. 10 19210 1512 N MADI SON AVE	0	0	192. 10
200.00 TOTAL (SUM OF LINES 118 through 199)	-27, 386, 242	184, 476, 692	·

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 Period: Worksheet A-6
From 01/01/2022
To 12/31/2022 Date/Time Prepared: 5/25/2023 11:38 am Provider CCN: 15-0113

					5/25/2023 1	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2.00 A - Chargeable Medical Suppli	3.00	4.00	5. 00		
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	7, 731		1.00
2.00	CENTRAL SERVICES & SUPPLY	14. 00	O	1		2. 00
3.00	MEDICAL SUPPLIES CHARGED TO	71.00	O	6, 280, 006		3. 00
	PATI ENTS					
4.00		0.00	0			4. 00
5. 00 6. 00		0. 00 0. 00	0			5. 00 6. 00
7. 00		0.00	0			7. 00
8. 00		0.00	Ö	1		8. 00
9.00		0.00	O			9. 00
10.00		0.00	0	0		10. 00
11. 00		0.00	0			11. 00
12.00		0.00	0			12.00
13. 00 14. 00		0. 00 0. 00	0			13. 00 14. 00
15. 00		0.00	0	1		15. 00
16. 00		0.00	Ö	1		16. 00
17. 00		0.00	O	1		17. 00
18. 00		0.00	O			18. 00
19. 00		0.00	0			19. 00
20.00		0.00	0			20.00
21. 00 22. 00		0. 00 0. 00	0			21. 00 22. 00
22.00	TOTALS — — — — —					22.00
	B - Implantable Device Reclas	SS		0,001,011		
1.00	IMPL. DEV. CHARGED TO	72.00	C	7, 434, 234		1.00
2 00	PATI ENTS	0.00				2.00
2. 00			0			2. 00
	C - Drugs Charges to Pat			77 10 17 20 1		
1.00	DRUGS CHARGED TO PATIENTS	73.00	C	8, 555, 276		1. 00
2.00		0.00	0			2. 00
3.00		0. 00 0. 00	0			3. 00
4. 00 5. 00		0.00		1		4. 00 5. 00
6. 00		0.00		1		6. 00
7. 00		0.00	0	1		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0			9. 00
10.00		0.00	0			10.00
11. 00		0.00	0			11.00
12. 00 13. 00		0. 00 0. 00	0			12. 00 13. 00
14. 00		0.00	Ö	1		14. 00
15. 00		0.00	O			15. 00
16.00		0.00	O			16. 00
17. 00		0.00				17. 00
18. 00		0.00	0			18. 00
19. 00 20. 00		0. 00 0. 00	0	1		19. 00 20. 00
21. 00		0.00	0	1		21.00
22. 00		0.00	O	1		22. 00
	TOTALS			8, 555, 276		
1 00	D - Depreciation Expense CAP REL COSTS-MVBLE EQUIP	2.00	0	(040 407		1 00
1. 00 2. 00	CAP REL COSTS-MVBLE EQUIP	2. 00 0. 00	0			1. 00 2. 00
3.00		0.00	0			3. 00
4. 00		0.00	0			4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0			6. 00
7.00		0.00	0			7. 00
8.00		0.00	0			8. 00
9. 00 10. 00		0. 00 0. 00		1		9. 00 10. 00
11. 00		0.00	0	1		11. 00
12. 00		0.00	0	1		12. 00
13.00		0.00	0			13. 00
14.00		0.00	0			14.00
15. 00		0.00	0			15. 00
16. 00 17. 00		0. 00 0. 00	0			16. 00 17. 00
18. 00		0.00	0			18. 00
19. 00	<u> </u>	0.00	O	0		19. 00

Heal th	Financial Systems		COMMUNITY HOSP	TAL ANDERSON		In Lie	u of Form CMS	-2552-10
	SI FI CATI ONS			Provider CCN:	15-0113	Peri od:	Worksheet A-	
						From 01/01/2022 To 12/31/2022	Date/Time Pr	
		Increases				<u> </u>	5/25/2023 11	: 38 am
	Cost Center	Li ne #	Sal ary	Other				
	2. 00	3. 00	4. 00	5. 00				
20. 00 21. 00		0. 00 0. 00	0	0				20. 00 21. 00
22. 00		0.00	0	0				22. 00
23. 00		0.00	o	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	О	0				28. 00
29. 00		0.00	0	0				29. 00
30. 00 31. 00		0. 00 0. 00	0	0				30. 00 31. 00
32. 00		0.00	o	Ö				32. 00
33.00		0.00	o	0				33. 00
34.00		0.00	0	0				34.00
35. 00 36. 00		0. 00 0. 00	0	0				35. 00 36. 00
00.00	TOTALS — — — —		0	6, 940, 407				00.00
1 00	F - Other Capital Rental	2 2 2	-1					1
1. 00 2. 00	CAP REL COSTS-MVBLE EQUIP	2. 00 0. 00	0	2, 461, 133 0				1. 00 2. 00
3.00		0.00	0	0				3. 00
4.00		0.00	О	0				4. 00
5.00		0.00	0	0				5. 00
6. 00 7. 00		0. 00 0. 00	0	0				6. 00 7. 00
8. 00		0.00	o	Ö				8. 00
9.00		0.00	o	0				9. 00
10. 00 11. 00		0.00	0	0				10.00
12.00		0. 00 0. 00	ol Ol	0				11. 00 12. 00
13. 00		0.00	Ö	0				13. 00
14. 00		0.00	0	0				14. 00
15. 00 16. 00		0. 00 0. 00	0	0				15. 00 16. 00
17. 00		0.00	•	0				17. 00
	TOTALS		0	2, 461, 133				
1. 00	G - Therapy Reclass OCCUPATIONAL THERAPY	67.00	396, 860	0				1.00
2. 00	SPEECH PATHOLOGY	68.00	184, 829	0				2. 00
3. 00	OCCUPATI ONAL THERAPY	67. 00	0	124, 791				3. 00
4.00	SPEECH PATHOLOGY	68.00	0	<u>58, 1</u> 19				4. 00
	TOTALS H - Labor and Delivery		581, 689	182, 910				-
1.00	NURSERY	43.00	757, 442	0				1. 00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1, 111, 139	0				2. 00
3.00	NURSERY	43.00	0	320, 393				3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0 1, 868, 581	47 <u>0, 004</u> 790, 397				4. 00
	I - Cafeteria		., 555, 551					
1.00	CAFETERI A	11.00	1, 788, 887	0				1. 00
2.00	CAFETERI A	1100	0 1, 788, 887	<u>1, 631, 814</u> 1, 631, 814				2. 00
	J - STD BENEFIT RECLASS		., 755, 557	., 551, 614				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	26, 572				1.00
2. 00 3. 00	OPERATION OF PLANT HOUSEKEEPING	7. 00 9. 00	0	12, 848 15, 827				2. 00 3. 00
4.00	DI ETARY	10.00	0	8, 002				4. 00
5. 00	NURSING ADMINISTRATION	13. 00	o	646				5. 00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	1, 783				6. 00
7. 00 8. 00	PHARMACY ADULTS & PEDIATRICS	15. 00 30. 00	0	3, 157 84, 213				7. 00 8. 00
9. 00	INTENSIVE CARE UNIT	31.00	0	2, 138				9. 00
10.00	OPERATING ROOM	50.00	ō	52, 148				10.00
11.00	RADI OLOGY-DI AGNOSTI C	54.00	0	9, 026				11. 00
12. 00 13. 00	LABORATORY WHOLE BLOOD & PACKED RED	60. 00 62. 00	0	5, 644 5, 753				12. 00 13. 00
13.00	BLOOD CELLS	02.00	ď	5, 755				13.00
14. 00	RESPIRATORY THERAPY	65.00	О	35, 900				14. 00
15.00	PHYSI CAL THERAPY	66.00	0	11, 793				15. 00
16. 00 17. 00	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	69. 00 70. 00	0	5, 746 3, 992				16. 00 17. 00
18. 00	WOUND/OSTOMY CLINIC	90. 01	О	436				18. 00
19. 00	RADIATION ONCOLOGY	90. 03	0	5, 777				19. 00

Heal th Financial Systems COMMUNITY HOSPITAL ANDERSON In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-0113 Period: From 01/01/2022 To 12/31/2022 Date/Time Prepared:

					To 12/31/20	022 Date/Time Prepared: 5/25/2023 11:38 am
		Increases				072072020 11.00 dill
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3.00	4.00	5. 00		
20. 00	EMERGENCY	91.00	0	25, 823		20.00
21.00	WELLNESS CENTERS	190.01		<u>2, 996</u>		21.00
	TOTALS		0	320, 220		
	K - Building Depreciation					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0_	<u>2, 742, 949</u>		1.00
	TOTALS		0	2, 742, 949		
	L - Capital Insurance Costs					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0_	15 <u>2, 9</u> 89		1.00
	TOTALS		0	152, 989		
	M - Radiology Support Staff					
1.00	ULTRASOUND	54. 01	42, 629	0		1.00
2.00	RADI OI SOTOPE	56.00	37, 396	0		2. 00
3.00	CT SCAN	57.00	215, 511	0		3.00
4. 00	MAGNETIC RESONANCE IMAGING (MRI)	58. 00	60, 275	0		4. 00
5.00	ULTRASOUND	54. 01	o	11, 620		5. 00
6. 00	RADI OI SOTOPE	56.00	o	10, 194		6. 00
7. 00	CT SCAN	57.00	o	58, 746		7. 00
8.00	MAGNETIC RESONANCE IMAGING	58.00	o	16, 430		8.00
	(MRI)			·		
	TOTALS	$ \top$	355, 811	96, 990		
500.00	Grand Total: Increases		4, 594, 968	37, 610, 863		500. 00

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

Peri od: From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/25/2023 11:38 am

COST CENTER Line # Salary Other Past, A 7, Ref.			Decreases				372372023 11	. 50 am
A. Chargesolate National Supplies 1.00 160 0 1.0		Cost Center		Sal ary	0ther	Wkst. A-7 Ref.		
1.00				8. 00	9. 00	10.00		
2.00 MUSHSING ANDA MISTIANT ON 15 00 0 1-88 0 2.2 00 4.00 ALD MISTIANT STREET 1.5 00 0 1.7 82 0 0 3.0 00 4.00 ALD MISTIANT STREET 1.5 00 0 1.5 12, 535 0 0 4.0 0 4.00 ALD MISTIANT STREET 1.5 00 0 0 0 1.5 12, 535 0 0 4.0 0 4.00 ALD MISTIANT STREET 1.5 00 0 0 0 1.5 12, 535 0 0 0 4.00 ALD MISTIANT STREET 1.5 00 0 0 0 1.5 12, 535 0 0 0 4.00 ALD MISTIANT STREET 1.5 00 0 0 0 1.5 12, 535 0 0 0 4.00 ALD MISTIANT STREET 1.5 00 0 0 0 1.5 12, 535 0 0 0 4.00 ALD MISTIANT STREET 1.5 00 0 0 0 0 4.00 ALD MISTIANT STREET 1.5 00 0 0 0 0 4.00 ALD MISTIANT STREET 1.5 00 0 0 0 0 4.00 ALD MISTIANT STREET 1.5 00 0 0 0 4.00 ALD MISTIANT STREET 1.5 00 0 0 0 4.00 ALD MISTIANT STREET 1.5 00 0 4.00 ALD MISTIANT STREET				_				
3.00 MARABATY 15.00 0 19,789 0 3.00 3				-				1
A.00		1		-				1
				-	·			1
OPERATING ROOM				-				1
7.00 RADIOLOGY-OLAGOSTIC 54.00 0 26.132 0 8.00 0 8.00 0 17.00 0 0 0 0 0 0 0 0 0		1	1	ŭ,				1
B.00 ULTRASQUIND		1		0				1
10.00 MAGNETIC RESONANCE IMACING 58.00 0 13.181 0 10.00 10.00 13.181 0 11.00 13.00 13.181 0 13.00 13.181 0 13.00 13.181 0 13.00 13.181 0 13.00 13.181 0 13.00		1	1	0				1
ORIT OC CATHETERIZATION SO , OC C 644,834 O 11.00	9.00	CT SCAN	57.00	0	154, 645	0		9. 00
11.00 CARDÍAC CATHETER ZATION	10.00		58. 00	0	13, 181	0		10.00
12.00 ABORNTORY 60.00 0 221 0 12.00 13.00 14		1` '		_		_		
13.00 OF SEPS HATGEY THERAPY 6.5.00 0 38,097 0 114.00 15.00 ELECTROCARD LOCKY 6.9.00 0 2.658 0 15.00 15.00 ELECTROCARD LOCKY 6.9.00 0 2.658 0 15.00 16.00 ELECTROCARD LOCKY 7.00 0 1 1.40 0 16.00 16.00 ELECTROCARD LOCKY 7.00 0 0 1.548 0 16.00 16.00 ELECTROCARD LOCKY 7.00 0 0 1.548 0 0 16.00 16.00 ELECTROCARD LOCKY 7.00 0 0 1.548 0 0 16.00 16.00 ELECTROCARD LOCKY 7.00 0 0 1.945 0 0 19.00 17.00 0 CTR ADVANCED BEART CARE 90.02 0 270 0 19.00 18.00 EMUNDOOSTOM CLINIC 90.00 0 19.45 0 0 270 0 19.00 18.00 EMUNDOOSTOM CLINIC 90.00 0 19.45 0 0 27		l l		0				1
14.00		1		0				1
15.00 ELECTROCARDIOLOGY		1		0	·			1
16.00 LLECTROENCEPHALOGRAPHY 70.00 0 1,545 0 16.00		1		0				1
17.00 RENAL DIALYSIS 74.00 0 12.500 0 17.00 18.00 MOUND/SOTRIWY CLINIC 90.01 0 220.173 0 18.00 19.00 CIR ADMANCED HEART CARE 90.02 0 210 0 19.00 21.00 REMARKED HEART CARE 90.02 0 210 0 19.00 21.00 REMARKED HEART CARE 90.02 0 210 0 210 0 21.00 REMARKED HEART CARE 90.02 0 210 0 210 0 21.00 REMARKED HEART CARE 90.02 0 212,828 0 210 22.00 CORE CARES CONTROL OF CAR		1		0				1
19.00 CTR ADVANCED HEART CARE		1		0				1
20.00 ABULATION ONCOLOGY 90.03 0 194, 506 0 21.00	18.00	WOUND/OSTOMY CLINIC	90. 01	0	205, 173	0		18. 00
21.00				0				1
22. 00				0				1
TOTALS		1		-				1
B - I mpl antable Device Rocciass 1.00 0	22. 00		190.01					22.00
1.00				Ü	6, 301, 544			-
Carrier Carr	1 00			0	7 142 829	0		1 00
TOTALS		1		-				1
C - Drugs Charges to Pat	2.00							2.00
2. 0.0 NURSING ADMINISTRATION 13. 00 0 66 0 3. 00 4. 0.0 PHARMACY 15. 00 0 242 0 3. 00 5. 0.0 AULTS & PEDIATRICS 30. 00 0 6. 6.38 0 5. 00 6. 0.0 INTENSIVE CARE UNIT 31. 00 0 1. 846 0 6. 00 7. 00 OPERATING ROOM 50. 00 0 1. 846 0 7. 00 8. 00 RADIOLOGY-DIACNOSTIC 54. 00 0 7. 424 0 8. 00 9. 00 LITASOUND 54. 01 0 6 0 9. 00 10. 00 RADIOLOGY-DIACNOSTIC 54. 00 0 7. 424 0 8. 00 10. 00 RADIOLOGY-DIACNOSTIC 54. 00 0 7. 424 0 9. 00 10. 00 TCSCAN 57. 00 0 15. 54 0 10. 00 12. 00 RADIOLOGY-DIACNOSTIC 56. 00 0 15. 479 0 11. 00 <tr< td=""><td></td><td></td><td><u>'</u></td><td></td><td>, ,</td><td>'</td><td></td><td>1</td></tr<>			<u>'</u>		, ,	'		1
3.00 CENTRAL SERVICES & SUPPLY 14.00 0 242 0 3.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 6.638 0 5.00 6.638 0 6.638 0 6.600 6.00 6.00 6.00 6.600 6.0	1.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 937	0		1. 00
A. DO		1		-				1
5.00 ADULTS & PEDIATRICS 30.00 0 6.638 0 6.00				-				1
6.00 INTENSIVE CARE UNIT 31.00 0 1.846 0 6.00 7.00 DePARTIN IN ROOM 50.00 0 16.594 0 7.00 8.00 RADI DLOGY-DI AGROSTI C 54.00 0 7.424 0 8.00 9.00 UTRASOLIND 54.01 0 6 0 9.00 11.00 RADI DLOGY-DI AGROSTI C 54.01 0 0 0 9.00 11.00 RADI DLOGY-DI AGROSTI C 54.01 0 0 0 9.00 11.00 CT SCAN 57.00 0 115.479 0 11.00 11.00 CT SCAN 57.00 0 15.4837 0 11.00 13.00 CARDI AC CATHETERI ZATI ON 59.00 0 6.701 0 13.00 14.00 RESPIRATORY THERAPY 65.00 0 15 0 14.00 16.00 ELECTROCARDI DLOGY 69.00 0 313 0 16.00 17.00 ELECTROCARDI DLOGY 69.00 0 313 0 16.00 18.00 RENAL DI ALYSIS 74.00 0 85 0 18.00 19.00 MOUND/OSTOMY CLI NI C 90.01 0 1.176 0 20.00 CTR ADVANCED HEART CARE 90.02 0 334 0 20.00 21.00 RADI ATION MOLOGOY 91.00 0 48 0 22.00 22.00 EMERGENCY 91.00 0 6.595 0 22.00 ADMINISTRATI ON 5.00 0 77.00 0 77.00 20.00 ADMINISTRATI ON 13.00 0 14.05, 081 0 0 20.00 ADMINISTRATI ON 13.00 0 14.05, 081 0 0 20.00 ADMINISTRATI ON 13.00 0 14.05, 081 0 0 20.00 ADMINISTRATI ON 13.00 0 14.05, 081 0 0 20.00 ADMINISTRATI ON 13.00 0 14.05, 081 0 0 20.00 ADMINISTRATI ON 13.00 0 14.05, 081 0 0 20.00 ADMINISTRATI ON 13.00 0 14.05, 081 0 0 20.00 ADMINISTRATI ON 13.00 0 14.05, 081 0 0 20.00 ADMINISTRATI ON 13.00 0 14.05, 081 0 0 20.00 ADMINISTRATI ON 13.00 0 14.05, 081 0 0 20.00 ADMINISTRATI ON 13.00 0 14.05, 081 0 0 20.00 ADMINISTRATI ON 13.00 0 14.05, 081 0 0 20.00 ADMINISTRATI ON 13.00 0 14.05, 081 0 0 20.00 ADMINISTRATI ON 13.00 0 14.05, 081 0 0 20.00 ADMINISTRATI ON 13.00 0 14.05, 081 0 0 20.00 ADMINISTRATI ON 13.00 0 14.05, 081 0 0 20.00 ADMINISTRATI ON 13.00 0 14.05, 081 0 0 20.00				0				1
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8. 00 RADI OLGY - DI AGNOSTI C 54. 00 0 7. 424 0 0 9. 00 0 1. TASOUND 54. 01 0 6 0 9. 00 0 1. TASOUND 54. 01 0 6 0 9. 00 0 1. 00 0 0 0 0 0 0 0 0 0		1	1	0				1
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12.00 MAGNETIC RESONANCE IMAGING (MRI) 12.00 154,837 0 12.00 13.00 13.00 14.00 RESPIRATORY THERAPY 65.00 0 15 0 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 15.00 14.00 15.00 15.00 14.00 15.00		1		0	220, 301			1
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13. 00 CARDIAC CATHETERIZATION 59, 00 0 6, 701 0 13. 00	12.00		58.00	0	54, 837	0		12. 00
14.00 RESPIRATORY THERAPY				_		_		
15.00 PHYSICAL THERAPY			· · · · · · · · · · · · · · · · · · ·	0				
16. 00		1	1	0				1
17. 00		1		0				1
18. 00 RENAL DI ALYSIS 74. 00 0 85 0 18. 00 19. 00 WOUND/OSTOMY CLINIC 90. 01 0 1, 176 0 20. 00 20. 00 CTR ADVANCED HEART CARE 90. 02 0 334 0 22. 00 21. 00 RADIATION ONCOLOGY 90. 03 0 48 0 22. 00 22. 00 EMERGENCY 91. 00 0 6, 098 0 0 22. 00 EMERGENCY 91. 00 0 8, 555, 276 D - Depreciation Expense 1. 00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 711, 609 0 2. 00 3. 00 OPERATION OF PLANT 7. 00 0 711, 609 0 3. 00 4. 00 HOUSEKEEPING 9. 00 0 3, 124 0 4. 00 5. 00 DI ETARY 10. 00 0 150, 942 0 5. 00 6. 00 NURSING ADMINISTRATION 13. 00 0 210 0 6. 00 7. 00 CENTRAL SERVICES & SUPPLY 14. 00 0 65, 875 0 7. 00 9. 00 ADULTS & PEDIATRICS 30. 00 169, 302 0 9. 00 10. 00 INTENSIVE CARE UNIT 31. 00 0 169, 302 0 9. 00 11. 00 OPERATION 50. 00 150, 00 169, 302 0 9. 00 11. 00 OPERATION 50. 00 10. 00 10. 00 10. 00 10. 00 11. 00 OPERATION 50. 00 10. 00 10. 00 10. 00 10. 00 11. 00 OPERATION 50. 00 0 169, 302 0 9. 00 10. 00 INTENSIVE CARE UNIT 31. 00 0 169, 302 0 9. 00 11. 00 OPERATION 50. 00 10. 00 10. 00 10. 00 10. 00 11. 00 OPERATION 50. 00 0 352, 721 0 11. 00 12. 00 RADIOLOGY-DI AGNOSTIC 54. 00 0 352, 721 0 12. 00 13. 00 ULTRASOUND 54. 01 0 2. 650 0 13. 00 14. 00 RADIOLOGY-DI AGNOSTIC 54. 00 0 352, 721 0 12. 00 15. 00 CT SCAN 57. 00 934 0 15. 00 16. 00 MACNETIC RESONANCE I MAGING 58. 00 114, 933 0 (MRI) 17. 00 CARDIAC CATHETERIZATION 59. 00 0 181, 481 0 17. 00				0				1
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22.00 EMERGENCY 91.00 0 6,098 0 22.00	20.00	CTR ADVANCED HEART CARE	90. 02	0				20. 00
TOTALS		RADIATION ONCOLOGY		0				1
D - Depreciation Expense 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 720 9 1.00	22. 00		<u> </u>	0				22. 00
1.00 EMPLOYEE BENEFITS DEPARTMENT				0	8, 555, 276			-
2. 00 ADMINISTRATIVE & GENERAL 5. 00 0 711, 609 0 2. 00 3. 00 OPERATION OF PLANT 7. 00 0 1, 405, 081 0 3. 00 4. 00 HOUSEKEEPING 9. 00 0 3, 124 0 4. 00 5. 00 DI ETARY 10. 00 150, 942 0 6. 00 NURSING ADMINISTRATION 13. 00 0 210 0 6. 00 7. 00 CENTRAL SERVICES & SUPPLY 14. 00 0 65, 875 0 7. 00 8. 00 PHARMACY 15. 00 0 6. 349 0 9. 00 8. 00 9. 00 ADULTS & PEDIATRICS 30. 00 0 169, 302 0 9. 00 10. 00 INTENSIVE CARE UNIT 31. 00 0 169, 302 0 9. 00 11. 00 OPERATING ROOM 50. 00 0 1, 092, 108 0 11. 00 12. 00 RADIOLOGY-DIAGNOSTIC 54. 00 0 352, 721 0 12. 00 13. 00 ULTRASOUND 54. 01 0 2, 650 0 13. 00 14. 00 RADIOLOGY-DIAGNOSTIC 56. 00 934 0 15. 00 16. 00 MAGNETIC RESONANCE IMAGING 58. 00 114, 933 0 (MRI) 17. 00 CARDIAC CATHETERIZATION 59. 00 181, 481 0 17. 00	1 00		4 00	0	720			1 00
3. 00 OPERATION OF PLANT 7. 00 9. 00 1, 405, 081 0 4. 00 4. 00 4. 00 5. 00 DIETARY 10. 00 10. 00 0 150, 942 0 5. 00 DIETARY 10. 00 13. 00 0 150, 942 0 6. 00 NURSING ADMINISTRATION 13. 00 0 210 0 6. 00 7. 00 CENTRAL SERVICES & SUPPLY 14. 00 0 65, 875 0 7. 00 8. 00 PHARMACY 15. 00 0 66, 349 0 8. 00 9. 00 ADULTS & PEDIATRICS 30. 00 0 169, 302 0 9. 00 10. 00 INTENSIVE CARE UNIT 31. 00 0 168, 915 0 10. 00 11. 00 OPERATING ROOM 50. 00 0 1, 092, 108 0 11. 00 OPERATING ROOM 50. 00 0 352, 721 0 12. 00 13. 00 ULTRASOUND 54. 01 0 2, 650 0 13. 00 14. 00 RADIOLOGY-DIAGNOSTIC 56. 00 0 89, 099 0 144. 00 RADIOLOGY-DIAGNOSTIC 56. 00 0 934 0 15. 00 15. 00 CT SCAN 57. 00 0 934 0 15. 00 16. 00 MAGNETIC RESONANCE I MAGING 58. 00 0 114, 933 0 17. 00 CARDIAC CATHETERIZATION 59. 00 0 181, 481 0 17. 00		1		-				1
4. 00 HOUSEKEEPING 9. 00 0 3, 124 0 5. 00 DI ETARY 10. 00 0 150, 942 0 5. 00 5. 00 6. 00 NURSI NG ADMI NI STRATI ON 13. 00 0 210 0 6. 00 7. 00 CENTRAL SERVI CES & SUPPLY 14. 00 0 65, 875 0 7. 00 8. 00 PHARMACY 15. 00 0 6. 349 0 8. 00 9. 00 ADULTS & PEDI ATRI CS 30. 00 0 10. 9. 00 10. 00 INTENSI VE CARE UNI T 31. 00 0 10. 00 10. 00 11. 00 0 11. 00 0 0 0		1						1
5. 00 DI ETARY 10. 00 0 150, 942 0 5. 00 6. 00 NURSI NG ADMI NI STRATI ON 13. 00 0 210 0 6. 00 7. 00 CENTRAL SERVI CES & SUPPLY 14. 00 0 65, 875 0 7. 00 8. 00 PHARMACY 15. 00 0 6, 349 0 8. 00 9. 00 ADULTS & PEDI ATRI CS 30. 00 0 169, 302 0 0 10. 00 INTENSI VE CARE UNI T 31. 00 0 108, 915 0 10. 00 11. 00 OPERATI NG ROOM 50. 00 0 1, 092, 108 0 11. 00 12. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 352, 721 0 12. 00 13. 00 ULTRASOUND 54. 01 0 2, 650 0 13. 00 14. 00 RADI OLOGY-DI AGNOSTI C 56. 00 0 89, 099 0 14. 00 15. 00 CT SCAN 57. 00 0 934 0 15. 00 16. 00 MAGNETI C RESONANCE I MAGI NG 58. 00 0 114, 933 0 16. 00 17. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 181, 481 0 17. 00 <		1		0				1
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8. 00 PHARMACY 15. 00 0 6, 349 0 9. 00 9. 00 10. 00 169, 302 0 9. 00 9. 00 10. 00 1 NTENSI VE CARE UNI T 31. 00 0 10. 00	6.00	NURSING ADMINISTRATION		0				6. 00
9. 00 ADULTS & PEDIATRICS 30. 00 0 169, 302 0 10. 00 INTENSIVE CARE UNIT 31. 00 0 108, 915 0 10. 00 11. 00 0 11. 00 0 0 12. 00 0 12. 00 0 12. 00 0 12. 00 0 12. 00 0 12. 00 0 12. 00 0 12. 00 0 12. 00 0 12. 00 0 12. 00 0 12. 00 0 12. 00 0 12. 00 0 12. 00 0 12. 00 0 12. 00 0 12. 00 0 12. 00 0 13. 00 0 12. 00 0 12. 00 0 13. 00 0 13. 00 0 13. 00 0 14. 00 RADI OI SOTOPE 56. 00 0 13. 00 14. 00 RADI OI SOTOPE 56. 00 0 13. 00 15. 00 0 15. 00 0 15. 00 0 15. 00 0 14. 00 0 15. 00 0 16. 00 0 14. 933 0 16. 00 0 17. 00 0 0 14. 933 0 16. 00 0 17. 00 0 0 17. 00 0 0 0 181, 481 0 0 17. 00 0 17. 00	7.00	CENTRAL SERVICES & SUPPLY		0				7. 00
10. 00 INTENSIVE CARE UNIT 31. 00 0 108, 915 0 10. 00 11. 00 OPERATING ROOM 50. 00 0 1, 092, 108 0 11. 00 12. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 352, 721 0 12. 00 13. 00 ULTRASOUND 54. 01 0 2, 650 0 13. 00 14. 00 RADI OI SOTOPE 56. 00 0 89, 099 0 14. 00 15. 00 CT SCAN 57. 00 0 934 0 15. 00 16. 00 MAGNETI C RESONANCE I MAGI NG 58. 00 0 114, 933 0 16. 00 (MRI) 17. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 181, 481 0 17. 00				0				1
11. 00 OPERATING ROOM 50. 00 1, 092, 108 0 11. 00 12. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 352, 721 0 12. 00 13. 00 ULTRASOUND 54. 01 0 2, 650 0 13. 00 14. 00 RADI OLOGY-DI AGNOSTI C 56. 00 0 13. 00 14. 00 RADI OLOGY-DI AGNOSTI C 54. 01 0 2, 650 0 13. 00 15. 00 CT SCAN 57. 00 0 89, 099 0 14. 00 16. 00 MAGNETI C RESONANCE I MAGI NG (MRI) 17. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 181, 481 0 17. 00				0				1
12. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 352, 721 0 12. 00 13. 00 ULTRASOUND 54. 01 0 2, 650 0 13. 00 14. 00 RADI OLOGY-DI AGNOSTI C 54. 01 0 2, 650 0 13. 00 15. 00 CT SCAN 57. 00 0 934 0 15. 00 16. 00 MAGNETI C RESONANCE I MAGI NG (MRI) 17. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 181, 481 0 17. 00				0				
13. 00 ULTRASOUND 54. 01 0 2, 650 0 13. 00 14. 00 RADI OI SOTOPE 56. 00 0 89, 099 0 14. 00 15. 00 CT SCAN 57. 00 0 934 0 15. 00 16. 00 MAGNETI C RESONANCE I MAGI NG (MRI) 114, 933 0 16. 00 17. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 181, 481 0 17. 00				0				1
14. 00 RADI OI SOTOPE 56. 00 0 89, 099 0 14. 00 15. 00 CT SCAN 57. 00 0 934 0 15. 00 16. 00 MAGNETI C RESONANCE I MAGI NG (MRI) 58. 00 0 114, 933 0 16. 00 17. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 181, 481 0 17. 00				0				1
15. 00 CT SCAN 57. 00 0 934 0 15. 00 16. 00 MAGNETIC RESONANCE I MAGI NG 58. 00 0 114, 933 0 16. 00 (MRI) 59. 00 0 181, 481 0 17. 00		1		0				1
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(MRI) 17. 00 CARDIAC CATHETERIZATION 59. 00 0 181, 481 0 17. 00				0				1
		(MRI)						
18. UU LABURATURY 60. 00 0 208, 384 0 18. 00			1	-				1
	18.00	LABUKA UKY	60.00	0	208, 384	0		18.00

Provider CCN: 15-0113

| Period: | Worksheet A-6 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: | 5/25/2023 | 11: 38 am

						5/25/2023 1	
		Decreases				ı	
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
10.00	6. 00	7. 00	8. 00	9. 00	10.00		10.00
19. 00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62. 00	0	2, 968	0		19. 00
20. 00	RESPIRATORY THERAPY	65. 00	o	63, 794	0		20. 00
21. 00	PHYSI CAL THERAPY	66.00	Ö	96, 520			21. 00
22. 00	ELECTROCARDI OLOGY	69.00	o	128, 483			22. 00
23. 00	ELECTROENCEPHALOGRAPHY	70.00	o	62, 860	-		23. 00
24. 00	WOUND/OSTOMY CLINIC	90. 01	O	15, 674			24. 00
25. 00	CTR ADVANCED HEART CARE	90. 02	O	365			25. 00
26.00	RADIATION ONCOLOGY	90. 03	o	816, 940	0		26. 00
27.00	FORTVILLE CLINIC	90. 09	o	2, 086	0		27. 00
28. 00	DIABETIC PLUS CLINIC	90. 11	0	2, 105	0		28. 00
29. 00	EMERGENCY	91. 00	0	55, 830	0		29. 00
30.00	WELLNESS CENTERS	190. 01	0	149, 676			30. 00
31. 00	MONTICELLO HSE.	190. 06	0	42, 500			31. 00
32. 00	ROCK STEADY BOXING	190. 14	0	2, 509			32. 00
33. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	823, 378			33. 00
34. 00	MUNCIE MD OFFICES	192. 01	0	1, 940			34. 00
35. 00	RESIDENTIAL PROPERTY (1430 N	192. 09	0	3, 718	0		35. 00
27 00	MADI SON	F 00		4 (24	0		24 00
36. 00	ADMI NI STRATI VE & GENERAL		— — o	<u>4, 624</u> 6, 940, 407			36. 00
	F - Other Capital Rental		U _I	0, 940, 407			
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	1, 509	10		1.00
2. 00	HOUSEKEEPI NG	9. 00	Ö	10, 395		l .	2. 00
3.00	DI ETARY	10. 00	o	3, 840		l .	3. 00
4. 00	CENTRAL SERVICES & SUPPLY	14. 00	o	152, 569			4. 00
5. 00	PHARMACY	15. 00	o	464, 011	0		5. 00
6. 00	INTENSIVE CARE UNIT	31. 00	O	212	0		6. 00
7.00	OPERATING ROOM	50.00	0	325, 426			7. 00
8.00	MAGNETIC RESONANCE IMAGING	58. 00	o	313, 000	0		8. 00
	(MRI)						
9.00	LABORATORY	60.00	0	48, 562			9. 00
10. 00	PHYSI CAL THERAPY	66. 00	0	756, 406			10.00
11. 00	ELECTROENCEPHALOGRAPHY	70. 00	0	6, 825			11. 00
12. 00	FORTVILLE CLINIC	90. 09	0	26, 894	0		12. 00
13.00	EMERGENCY	91.00	0	212	0		13.00
14.00	WELLNESS CENTERS	190. 01	0	194, 409			14. 00
15. 00	ROCK STEADY BOXING	190. 14	0	19, 863			15. 00
16.00	PHYSICIANS' PRIVATE OFFICES	192. 00 192. 01	0	8, 000 129, 000			16. 00 17. 00
17. 00	MUNCIE MD_OFFICES TOTALS	192.01	— — — 0				17.00
	G - Therapy Reclass		<u> </u>	2, 401, 133			
1.00	PHYSI CAL THERAPY	66.00	581, 689	0	0		1.00
2. 00		0.00	0	0	0	1	2. 00
3.00	PHYSI CAL THERAPY	66.00	O	182, 910		l .	3. 00
4.00		0.00	o	0	0		4. 00
	TOTALS		581, 689	182, 910			
	H - Labor and Delivery				1		
1. 00	ADULTS & PEDIATRICS	30. 00	1, 868, 581	0			1. 00
2.00		0.00	0	0	0	i e	2. 00
3.00	ADULTS & PEDIATRICS	30.00	0	790, 397		l .	3. 00
4. 00	TOTAL C — — — — —		0	0	0		4. 00
	TOTALS I - Cafeteria		1, 868, 581	790, 397			+
1.00	DI ETARY	10.00	1, 788, 887	0	0		1.00
2. 00	DI ETARY	10.00	1, 788, 887	<u>1, 631, 8</u> 14			2. 00
2.00	TOTALS		1, 788, 887	1, 631, 814			2.00
	J - STD BENEFIT RECLASS		.,,	.,	I.		
1.00	ADMINISTRATIVE & GENERAL	5. 00	26, 572	0	0		1.00
2.00	OPERATION OF PLANT	7. 00	12, 848	0	0		2. 00
3.00	HOUSEKEEPI NG	9. 00	15, 827	0	0		3. 00
4.00	DI ETARY	10. 00	8, 002	0	0		4. 00
5.00	NURSING ADMINISTRATION	13. 00	646	0	0		5. 00
6.00	CENTRAL SERVICES & SUPPLY	14. 00	1, 783	0	0		6. 00
7.00	PHARMACY	15. 00	3, 157	0	0		7. 00
8.00	ADULTS & PEDIATRICS	30.00	84, 213	0	0		8. 00
9.00	INTENSIVE CARE UNIT	31.00	2, 138	0	0		9.00
10.00	OPERATING ROOM	50.00	52, 148	0	0		10.00
11. 00	RADI OLOGY-DI AGNOSTI C	54. 00 60. 00	9, 026 5, 644	0	0		11. 00 12. 00
12. 00 13. 00	LABORATORY WHOLE BLOOD & PACKED RED	60. 00 62. 00	5, 644 5, 753	0	0		13. 00
13.00	BLOOD CELLS	02.00	5, 755	Ü			13.00
14. 00	RESPIRATORY THERAPY	65. 00	35, 900	0	0		14. 00
15. 00	PHYSI CAL THERAPY	66.00		0		1	15. 00
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Health Financial Systems RECLASSIFICATIONS COMMUNITY HOSPITAL ANDERSON In Lieu of Form CMS-2552-10 Provider CCN: 15-0113

| Peri od: | Worksheet A-6 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared:

						5/25/2023 11	
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
16.00	ELECTROCARDI OLOGY	69. 00	5, 746	0	0		16. 00
17.00	ELECTROENCEPHALOGRAPHY	70. 00	3, 992	0	0		17. 00
18.00	WOUND/OSTOMY CLINIC	90. 01	436	0	0		18. 00
19. 00	RADIATION ONCOLOGY	90. 03	5, 777	0	0		19. 00
20.00	EMERGENCY	91. 00	25, 823	0	0		20. 00
21.00	WELLNESS CENTERS	190. 01	2, 996	0	0)	21. 00
	TOTALS		320, 220	0			
	K - Building Depreciation						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2, 742, 949	9	<u>)</u>	1. 00
	TOTALS		0	2, 742, 949			
	L - Capital Insurance Costs						
1.00	ADMI NI STRATI VE & GENERAL	500	0_	15 <u>2, 9</u> 89		2	1. 00
	TOTALS		0	152, 989			_
	M - Radiology Support Staff						
1.00	RADI OLOGY-DI AGNOSTI C	54.00	355, 811	0	0		1. 00
2.00		0.00	0	0	0		2. 00
3.00		0.00	0	0	0		3. 00
4.00		0.00	0	0	0		4. 00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	0	96, 990	0		5. 00
6.00		0.00	0	0	0		6. 00
7.00		0.00	0	0	0		7. 00
8.00		0.00	0	0	0		8. 00
	TOTALS		355, 811	96, 990			
500.00	Grand Total: Decreases		4, 915, 188	37, 290, 643			500.00

				10	12/31/2022	5/25/2023 11:3	
				Acqui si ti ons		0,20,2020 111	JU 4
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES					
1.00	Land	6, 280, 153	0	0	0	12, 000	1. 00
2.00	Land Improvements	2, 007, 545	15, 632	0	15, 632	0	2. 00
3.00	Buildings and Fixtures	78, 186, 026	4, 560, 787	0	4, 560, 787	81, 431	3. 00
4.00	Building Improvements	2, 763, 325	0	0	0	0	4. 00
5.00	Fi xed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	79, 330, 674	3, 503, 811	0	3, 503, 811	316, 134	6. 00
7. 00	HIT designated Assets	0	0	0	0	0	7. 00
8. 00	Subtotal (sum of lines 1-7)	168, 567, 723	8, 080, 230	0	8, 080, 230	409, 565	
9. 00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	168, 567, 723	8, 080, 230	0	8, 080, 230	409, 565	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	6, 268, 153	0				1. 00
2.00	Land Improvements	2, 023, 177	0				2. 00
3.00	Buildings and Fixtures	82, 665, 382	0				3. 00
4.00	Building Improvements	2, 763, 325	0				4. 00
5.00	Fixed Equipment	0	0				5. 00
6.00	Movable Equipment	82, 518, 351	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	176, 238, 388	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	176, 238, 388	0				10.00

Heal th	n Financial Systems	COMMUNITY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-0113	Peri od: From 01/01/2022	Worksheet A-7 Part II	
					To 12/31/2022	Date/Time Pre	
					1 - 1	5/25/2023 11:	38 am
			St	JMMARY OF CAF	71 IAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
		0.00	10.00	11.00	instructions)		
	PART II - RECONCILIATION OF AMOUNTS FROM WORL	9.00	10.00	ind 2	12.00	13. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	NOTICE I A, COLUM	IN Z, LINES I A	iliu z			1. 00
2.00	CAP REL COSTS-BLDG & FTXT	0	0		0	0	
3. 00	Total (sum of lines 1-2)	0	0		0	0	2. 00 3. 00
3.00	Total (suil of Titles 1-2)	SUMMARY 0	E CADITAL	1	0 0	- 0	3.00
		SUIVIIVIARY	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	cost center bescription	Capi tal -Rel ate	, , ,				
		d Costs (see	through 14)				
		instructions)	tili ougii 14)				
		14. 00	15. 00	1			
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			ind 2			
1. 00	CAP REL COSTS-BLDG & FLXT	0	0	1			1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	0	١				2. 00
3. 00	Total (sum of lines 1-2)	0	l n				3. 00
2.00	1 (1	,	1		'	1 2.00

Heal th	n Financial Systems	COMMUNITY HOSP	ITAL ANDERSON		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2022 To 12/31/2022	Worksheet A-7 Part III Date/Time Prep 5/25/2023 11:3	
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				2)			
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FLXT	93, 720, 037	l .	93, 720, 03			1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	82, 518, 351	l .	82, 518, 35			2.00
3.00	Total (sum of lines 1-2)	176, 238, 388		176, 238, 38			3. 00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
		6.00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		1		0 740 040		
1.00	CAP REL COSTS-BLDG & FLXT	0	_)	0 2, 742, 949		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	_)	0 7, 009, 240		2.00
3.00	Total (sum of lines 1-2)	0	· · · · · · · · · · · · · · · · · · ·) 	0 9, 752, 189	2, 461, 133	3. 00
				JMMARY OF CAPI			
	Cost Center Description	Interest	Insurance (see			Total (2) (sum	
			instructions)	instructions)	Capi tal -Relate		
					d Costs (see	through 14)	
		11.00	10.00	10.00	instructions)	45.00	
	DART III DECONCILIATION OF CARLTAL COCTO O	11.00	12. 00	13. 00	14. 00	15. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CL CAP REL COSTS-BLDG & FIXT	ENTERS	152 000	1		2 005 020	1. 00
2.00	CAP REL COSTS-BLDG & FIXT	0	102,707	1	0 0	2, 895, 938 9, 470, 373	2. 00
3.00	Total (sum of lines 1-2)		_	l	0 0	12, 366, 311	
3.00	Total (Suiii Of Titles 1-2)	1	152, 989	1	O _I U	12, 300, 311	3.00

| Period: | Worksheet A-8 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Provi der CCN: 15-0113

Suppose Classor Floation on Recisions A \$7,27,003 11, 38, 86					To	12/31/2022		
Cost Centur Description Resist/Osis (2) Amount Cost Centur Line # Most A-7 Bof							3/23/2023 11.	oo alii
1.00 Investment Income - CAP REL 1.00 2.00 3.00 4.00 1.00 0 0.00 0 0.00 0 0.00 0					To/From Which the Amount is	to be Adjusted		
1.00 Investment Income - CAP REL 1.00 2.00 3.00 4.00 1.00 0 0.00 0 0.00 0 0.00 0								
1.00 Investment Income - CAP REL 1.00 2.00 3.00 4.00 1.00 0 0.00 0 0.00 0 0.00 0								
Treestment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1.00 0 1.00		Cost Center Description	• • • • • • • • • • • • • • • • • • • •					
Investment income - CAP REL OCAP REL COSTS-WBLE EQUIP 2.00 0 2.00 0 3.00 10 cestment income - other 0 0 0.00 0 3.00 0 3.00 0 5.00 0 5.00 0 6.	1. 00	II	1.00					1. 00
0.00 0.00 0.3 0.00 0.3 0.00 0.3 0.00 0.3 0.00 0.3 0.00 0.00 0.3 0.00 0.00 0.3 0.00	2. 00			0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
Chapter 2 OAMINISTRATIVE & GENERAL C. 0.0 0 4 0.0	2 00			0		0.00	0	2 00
discounts (chapter 8) 8		(chapter 2)		O				
Second	4. 00			0	ADMINISTRATIVE & GENERAL	5. 00	0	4. 00
Sental of provider space by 0 0.00 0.6.00 0.00 0.6.00 0.00 0.7.00 0.00 0.7.00 0.00	5. 00	Refunds and rebates of	В	-8, 217	ADMINISTRATIVE & GENERAL	5. 00	О	5. 00
Telephone services (pay stations excluded) (chapter 21) Stations excluded) (chapter 22) Stations excluded) (chapter 23) Stations excluded) (chapter 24) Stations exclu	6.00	Rental of provider space by		0		0. 00	0	6. 00
Stations excluded) (chapter 21)	7. 00			0		0. 00	0	7. 00
1.00 1.00 0.00								
Parking of (chapter 21) A-8-2 0 0.00 0.	8.00	Television and radio service		0		0. 00	0	8. 00
adjustment	9. 00			0		0. 00	0	9. 00
11.00 Sair of Scrap, waste, etc. (Chapter 23) 12.00 Related organization A-8-1 2,304,607 0 12.00 0 13.00 13.00 13.00 13.00 14.00 13.00 14.00 14.00 16.00 16.00 15.00 0 15.00 0 15.00 0 15.00 0 15.00 15.00 0 15.	10. 00		A-8-2	-235, 146			О	10. 00
12.00 Related organization 13.00 Laundry and I linen service 0 0 0 0 0 0 13.00	11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11. 00
13.00 Laundry and I linen service 0 0.00 0.13.00 15.00 1	12. 00		A-8-1	2, 304, 607			0	12. 00
14.00 Caffetria-employees and guests B -1,013,476CAFETERIA 11.00 0 14.00	12 00	1		0		0.00	0	12 00
and others		Cafeteria-employees and guests		-1, 013, 476	CAFETERI A			
16.00 Sale of medical and surgical supplies to other than patients 0 0.00 0 16.00	15. 00			0		0. 00	0	15. 00
patients	16. 00	Sale of medical and surgical		0		0. 00	0	16. 00
patients								
18.00 Sale of medical records and abstracts 19.00 abstracts 19.00 0	17. 00			0		0. 00	0	17. 00
19.00 Nursing and all lied health education (tuit tion, fees, books, etc.) 20.00 Vending machines 0 0.00 0.00 0.00 0.00 0.20.00	18. 00	Sale of medical records and	В	0	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
Dooks, etc.) Vending machines 0 Vending machines 0 0.00 0.	19. 00	Nursing and allied health		0		0. 00	0	19. 00
20.00 Vending machines 0 0.00 0.00 0.20.00								
interest, finance or penal ty charges (chapter 21) 22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		Vending machines		0				
Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments ORESPIRATORY THERAPY	21.00	interest, finance or penalty		U		0.00	o o	21.00
overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT COSTS-BLDG & FIXT 1.00 0 26.00 COSTS-BLDG & FIXT 1.00 0 27.00 CAP REL COSTS-BLDG & FIXT 1.00 0 27.00 CAP REL COSTS-MVBLE EQUIP 2.00 0 28.00 Non-physicians' assistant 0 0.00 0 29.00 29.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see instructions) 2.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 0 ADJULTS & PEDIATRICS 30.00 30.00 30.00 20.	22. 00			0		0.00	0	22. 00
23.00 Adj ustment for respiratory therapy costs in excess of limitation (chapter 14) Adj ustment for physical therapy costs in excess of limitation (chapter 14) Adj ustment for physical therapy costs in excess of limitation (chapter 14) Adj ustment for physical therapy costs in excess of limitation (chapter 14) A-8-3 OPHYSICAL THERAPY 66.00 24.00		overpayments and borrowings to				2.23		
1 imitation (chapter 14)	23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT								
limitation (chapter 14) Utilization review -	24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		limitation (chapter 14)		_				
(chapter 21) Depreciation - CAP REL COSTS-BLDG & FIXT 27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist A ONONPHYSICIAN ANESTHETISTS A ONONPHYSICIAN ANESTHETISTS Byon COSTS-BLDG & FIXT 1. 00 26. 00 27. 00 27. 00 27. 00 28. 00 29. 00 29. 00 29. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see instructions) 30. 09 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAP REL COSTS-BLDG & FIXT OCAP REL COSTS-BLDG & FIXT 1. 00 0 26. 00 0 27. 00 0 27. 00 0 28. 00 0 29. 00 0 29. 00 0 29. 00 0 30. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00			0	*** Cost Center Deleted ***	114. 00		25. 00
COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist A ONONPHYSICIAN ANESTHETISTS 19. 00 28. 00 Physicians' assistant Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) Adjustment for speech pathology costs in excess of limitation (chapter 14) A-8-3 OSPEECH PATHOLOGY CAP REL COSTS-MVBLE EQUIP 2. 00 O 27. 00 O 29. 00 O 30. 00 O 31. 00 O 32. 00 O 32. 00 O 0 0 0 0 0 O 0 0 0 0 O 0 0 0 0	26 00			0	CAD DEL COSTS_BLDG & FLYT	1 00	0	26 00
28. 00 COSTS-MVBLE EQUIP Non-physician Anesthetist A ONONPHYSICIAN ANESTHETISTS 19. 00 28. 00 29. 00 Physicians' assistant O OCCUPATIONAL THERAPY 67. 00 30. 00 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see instructions) A-8-3 OSPEECH PATHOLOGY Compathology costs in excess of limitation (chapter 14) A-8-3 OSPEECH PATHOLOGY Compathology costs in excess of limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest O O O O O 32. 00 OSPEECH PATHOLOGY O O O O 32. 00 OSPEECH PATHOLOGY O O O 32. 00 O O O 32. 00 OSPEECH PATHOLOGY O O 33. 00 O O 34. 00 O O 35. 00 O O 36. 00 O 37. 00 O 38. 00 O 39. 00 O 39. 00 O 39. 00 O 30. 00 O 3		COSTS-BLDG & FLXT						
29.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest	27. 00			0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
30.00 Adj ustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adj ustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adj ustment for Depreciation and Interest A-8-3 OCCUPATIONAL THERAPY 67.00 30.00			А	0	NONPHYSICIAN ANESTHETISTS		0	
limitation (chapter 14) Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest OADULTS & PEDIATRICS 30.00 30.99 OADULTS & PEDIATRICS 30.00 31.00 31.00 32.00		Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY		-	
instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest								
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest A-8-3 OSPEECH PATHOLOGY 68.00 31.00 O O O O O O O O O O O O O O O O O O	30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
I i mi tation (chapter 14) 32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest	31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest								
	32. 00	CAH HIT Adjustment for		0		0. 00	o	32. 00
	33. 00		В	-421, 383	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00

				T	o 12/31/2022	Date/Time Prep 5/25/2023 11:	
				Expense Classification on	Workshoot A	5/25/2023 11:	38 8111
				To/From Which the Amount is			
				TO/TTOM WITCH THE AMOUNT 13	to be Aujusteu		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4. 00	5. 00	
33. 01	Investment Income	В	-1, 930, 800	ADMINISTRATIVE & GENERAL	5. 00	9	33. 01
33. 02	Space Rental Income	В	-59, 200	ADMINISTRATIVE & GENERAL	5. 00	0	33. 02
33. 03	Space Rental Income	В	-568, 140	RADIATION ONCOLOGY	90. 03	0	33. 03
33. 04	Mi sc Revenue	В	-908, 185	ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
33. 05	Mi sc Revenue	В	-11, 082	CAFETERI A	11. 00	0	33. 05
33. 06	Mi sc Revenue	В	-17, 928	OPERATING ROOM	50.00	0	33. 06
33. 07	Mi sc Revenue	В	-1, 687	LABORATORY	60.00	0	33. 07
33. 08	Mi sc Revenue	В	0	MEDICAL RECORDS & LIBRARY	16. 00	0	33. 08
33. 09	Mi sc Revenue	В	0	OPERATING ROOM	50.00	0	33. 09
33. 10	Mi sc Revenue	В	0	LABORATORY	60.00	0	33. 10
34.00	HAF Tax Offset	A	-14, 379, 924	ADMINISTRATIVE & GENERAL	5. 00	0	34. 00
34. 01	Sponsorshi p	A	-477, 143	ADMINISTRATIVE & GENERAL	5. 00	0	34. 01
34. 02	Sponsorshi p	A	-932	DIABETIC PLUS CLINIC	90. 11	0	34. 02
34. 03	APP	A	-47, 358	RESPIRATORY THERAPY	65.00	0	34. 03
34.04	APP	A	-238, 618	CTR ADVANCED HEART CARE	90. 02	0	34. 04
34. 05	Hospitalist Loss	A	-3, 303, 275	ADMINISTRATIVE & GENERAL	5. 00	0	34. 05
34.06	Bad Debt	A	-8, 783, 020	ADMINISTRATIVE & GENERAL	5. 00		34. 06
36. 01	Non Allow Marketing	A	-109, 972	ADMINISTRATIVE & GENERAL	5. 00	0	36. 01
36. 02	EPIC Amortization	A	1, 392, 695	CAP REL COSTS-MVBLE EQUIP	2. 00	9	36. 02
36. 03	EPIC Amortization	A	1, 431, 942	ADMINISTRATIVE & GENERAL	5. 00	0	36. 03
50.00	TOTAL (sum of lines 1 thru 49)		-27, 386, 242				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

⁽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 OFFICE COSTS

Provider CCN: 15-0113

Worksheet A-8-1

From 01/01/2022 To 12/31/2022 Date/Time Prepared:

				10 12/31/2022	5/25/2023 11:3	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2.00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	1	I&R SERVICES-SALARY & FRINGE		14, 101	0	1.00
2.00	1	I &R SERVICES-OTHER PRGM. COS	RESI DENTS	29, 849	0	2.00
3.00	2. 00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	1, 419, 087	0	3.00
3. 01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	3, 184, 980	0	3. 01
3.02	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE	20, 453, 307	28, 836, 906	3. 02
3.03	13. 00	NURSING ADMINISTRATION	HOME OFFICE	2, 734, 506	0	3. 03
3.04	14.00	CENTRAL SERVICES & SUPPLY	HOME OFFICE	803, 359	0	3. 04
3.05	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	1, 076, 194	0	3. 05
3.06	30.00	ADULTS & PEDIATRICS	HOME OFFICE	348, 164	0	3.06
3.07	54.00	RADI OLOGY-DI AGNOSTI C	HOME OFFICE	115, 045	0	3. 07
4.00	5. 00	ADMINISTRATIVE & GENERAL	CPN MEDICAL DIRECTOR	88, 405	0	4.00
4.01	91.00	EMERGENCY	CPN CALL	874, 516	0	4. 01
5.00	TOTALS (sum of lines 1-4).			31, 141, 513	28, 836, 906	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

nas n	ot been posted to worksheet A,	cordinas i and/or 2, the amoun	it allowable 311	ioura de marcatea m corumn 4	or this part.		
				Related Organization(s) and/	or Home Office		
	Symbol (1)	Name	Percentage of	Name	Percentage of		
			Ownershi p		Ownershi p		
	1. 00	2.00	3. 00	4. 00	5. 00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

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

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

Heal th	Financial Syste	ems		COMMUNITY HOSPITA	L ANDERSON	In Lie	u of Form CMS-	2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED	ORGANIZATIONS AND HOME	Provider CCN: 15-0113	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS					From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 11:	
	Net	Wkst. A-7 Ref						
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6. 00	7. 00						
	A. COSTS INCURI	RED AND ADJUST	MENTS REC	DUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED (ORGANIZATIONS OR (CLAI MED	
	HOME OFFICE COS	STS:						
1.00	14, 101)					1.00
2.00	29, 849)					2. 00
3.00	1, 419, 087		9					3. 00
3. 01	3, 184, 980		o					3. 01
3.02	-8, 383, 599		o					3. 02
3. 03	2, 734, 506		ol					3. 03

3.04

3.05

3 06

3.07

4.00

4.01

5.00

5.00 2, 304, 607 The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

1100 110	zoon pootou to normanout //	cordinate i dilaret 27 the discourt difference of order a be find edited in cordinate for this parti-	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELATE	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00
7. 00
8.00
9.00
10.00
100.00

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

3.04

3.05

3.06

3.07

4.00

4.01

1, 076, 194

803, 359

348.164

115,045

88, 405

874, 516

0

0

0

Provider CCN: 15-0113

Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/25/2023 11: 38 am

							5/25/2023 11:	<u>38 am</u>
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1. 00		AGGREGATE-ADMINISTRATIVE &	235, 146					1. 00
1.00		GENERAL	255, 140	255, 140	0	0	j Y	1.00
2.00	0. 00		0	0	0	0	0	2. 00
3.00	0.00		0	0	0	0		3. 00
			0	1	0	0		
4.00	0. 00		0	0	_	0	0	4. 00
5.00	0. 00		0	0	0	0	0	5. 00
6.00	0. 00		0	0	0	0	0	6. 00
7.00	0. 00		0	0	0	0	0	7. 00
8. 00	0. 00		0	0	0	0	0	
9.00	0. 00		0	0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	10.00
200.00			235, 146	235, 146	0		l ol	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit		Memberships &	Component	of Malpractice	
		1 46.11.11.61	2	Li mi t	Continuing	Share of col.	Insurance	
					Educati on	12	11104141100	
	1. 00	2.00	8.00	9. 00	12. 00	13. 00	14. 00	
1. 00		AGGREGATE-ADMINISTRATIVE &	0.00					1. 00
1.00		GENERAL	Ĭ	Ĭ	J	J	j j	1.00
2.00	0. 00		l	0	0	0	0	2. 00
3.00	0.00		0	Ö		0	1 1	3. 00
4. 00	0.00			0				
5.00	0.00		0	0		0		5. 00
			0	1	_	0	-	
6. 00	0. 00		0	0	0	0	0	
7. 00	0. 00		0	0	0	0	0	7. 00
8.00	0. 00		0	0	0	0	0	8. 00
9. 00	0. 00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00	5. 00	AGGREGATE-ADMINISTRATIVE &	0	0	0	235, 146		1. 00
		GENERAL						
2.00	0. 00		0	0	0	0		2. 00
3.00	0. 00		0	0	0	0		3. 00
4. 00	0. 00		ا م	Ö		0		4. 00
5. 00	0.00		l	Ö		0		5. 00
6. 00	0.00		١	١	0	0		6. 00
7. 00	0.00			0		0		7. 00
8. 00	0.00			0	0	0		7. 00 8. 00
				1		0		
9.00	0.00			0		J		9. 00
10.00	0. 00		0] 0	0	0		10.00
200.00			0	0	0	235, 146		200. 00

| Period: | Worksheet B | From 01/01/2022 | Part | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0113

					o 12/31/2022		pared:
			CAPI TAL REI	ATED_COSTS		5/25/2023 11:	38 am
	Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7) 0	1. 00	2.00	4. 00	4A	
	GENERAL SERVICE COST CENTERS	Ü	1.00	2.00	1. 00	171	
1.00	00100 CAP REL COSTS-BLDG & FIXT	2, 895, 938					1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P	9, 470, 373		9, 470, 373			2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	3, 421, 616 32, 482, 229		1, 995, 799	-,,	34, 909, 756	4. 00 5. 00
6. 00	00600 MAI NTENANCE & REPAI RS	0	0,,,10	0	0	0 1, 70 7, 700	6. 00
7.00	00700 OPERATION OF PLANT	8, 525, 288	597, 055	636, 145	166, 015	9, 924, 503	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	15 000	0	0	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	3, 530, 677 85, 571	30, 836	15, 909 14, 097		3, 690, 099 102, 397	9. 00 10. 00
11. 00	01100 CAFETERI A	2, 508, 140	116, 822	51, 551		2, 765, 690	11. 00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	C	0	0	12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	4, 738, 173	32, 207	247		4, 844, 297	13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	711, 471 3, 827, 851	76, 500 34, 939			1, 045, 123 4, 553, 429	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 096, 004	37, 862		137,000	1, 133, 866	16.00
17. 00	01700 SOCIAL SERVICE	0	0	C	O	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	C	0	0	19. 00
20. 00 21. 00	02000 NURSI NG PROGRAM	14 101	0	0	0	14 101	20.00
21.00	02100 &R SERVICES-SALARY & FRINGES APPRVD 02200 &R SERVICES-OTHER PRGM. COSTS APPRVD	14, 101 29, 849) 0		0	14, 101 29, 849	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(EMS)	0	0	Ö	O	27, 317	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	24, 310, 049					30.00
31. 00 43. 00	03100 NTENSI VE CARE UNI T 04300 NURSERY	6, 342, 467 1, 077, 835	133, 989 98, 798			6, 775, 031 1, 221, 767	31. 00 43. 00
43.00	ANCILLARY SERVICE COST CENTERS	1,011,033	70, 770	0, 200	30, 071	1, 221, 707	43.00
50.00	05000 OPERATING ROOM	10, 958, 666	339, 307	1, 481, 716	291, 185	13, 070, 874	50. 00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	1, 581, 143	61, 491 0	12, 121	54, 088	1, 708, 843 0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 562, 806	32, 177	346, 925	73, 956	3, 015, 864	54. 00
54. 01	05401 ULTRASOUND	808, 555	11, 673	3, 671	29, 526	853, 425	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	105 000	0	0	55. 00
56. 00 57. 00	05600	530, 979 1, 473, 654	15, 151 59, 152			668, 736 1, 581, 640	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 341, 231	0	504, 337		1, 877, 697	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 179, 251	65, 714				59. 00
60.00	06000 LABORATORY	7, 918, 822	78, 365	300, 066	135, 065	8, 432, 318	60.00
60. 01 62. 00	06001 BLOOD LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	724, 096	8, 609	3, 492	10, 470	0 746, 667	60. 01 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	724,070	0,007	3, 472	10, 470	740,007	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	C	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	3, 330, 814	2, 520			3, 517, 757	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	3, 652, 647 521, 651	64, 172 12, 822	997, 829 3, 973		4, 845, 575 557, 764	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	242, 948				259, 763	68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 432, 711	146, 801	151, 188		1, 782, 714	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	913, 380	34, 808	81, 999	25, 408	1, 055, 595	70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	6, 280, 006 7, 434, 234	0		0	6, 280, 006 7, 434, 234	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	8, 555, 276	0		o	8, 555, 276	73.00
74. 00	07400 RENAL DIALYSIS	325, 289		C	0	325, 289	74.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC 09001 WOUND/OSTOMY CLINIC	0 1, 970, 308	0 54 017	C 753	_	0	90.00
90. 01 90. 02	09001 WOUND/0510MY CEINIC	210, 902	54, 817 0	5, 752 430		2, 063, 605 227, 085	90. 01 90. 02
90. 03	09003 RADI ATI ON ONCOLOGY	3, 616, 497	10, 867	542, 260		4, 260, 515	90. 03
90. 04	09004 MUNCIE CLINIC	0	0	C	0	0	90. 04
90. 05	09005 ANTI COAGULATI ON CLI NI C	446, 675	0	C	16, 347	463, 022	90.05
90. 06 90. 07	09006 PREGNANCY PLUS	0	0		0	0	90. 06 90. 07
90.08	09008 0/P LAB		Ö		o	0	90.07
90. 09	09009 FORTVILLE CLINIC	600	0	31, 647	0	32, 247	90. 09
90. 10	09010 1030 S SCATTERFIELD (MEDCHECK)	0	0	0 477	0	400.054	90. 10
90. 11 90. 12	09011 DI ABETI C PLUS CLINI C 09012 OTHER ONCOLOGY SERVI CES	469, 207 0	0	2, 477	18, 272 0	489, 956 0	90. 11 90. 12
91. 00	09100 EMERGENCY	7, 936, 010	125, 280	47, 979	240, 570	8, 349, 839	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	

Health Financial Systems	COMMUNITY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC		Peri od: From 01/01/2022 To 12/31/2022	Worksheet B Part I Date/Time Pre 5/25/2023 11:	epared:
		CAPI TAL REI	_ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1.00	2.00	4. 00	4A	
OTHER REIMBURSABLE COST CENTERS	,					
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	181, 485, 990	2, 839, 386	8, 704, 33	3, 415, 027	180, 626, 661	118. 00
NONREI MBURSABLE COST CENTERS				-1 -1		4
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
190. 01 19001 WELLNESS CENTERS	890, 865	8, 085	404, 89		1, 335, 743	1
190. 02 19002 EMPLOYED ORTHO MD	0	0		0 0		190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)	0	0		0		190. 03
190. 04 19004 SUMMI T CONV. (LTC)	0	0		0		190. 04
190. 05 19005 PARKVI EW CONV. (LTC)	0	0		0		190. 05
190. 06 19006 MONTI CELLO HSE.	46, 042	0		0		190.06
190. 07 19007 NH PARK PLACE (LTC)	0	0		0		190. 07
190.08 19008 MADISON PLACE OF ELWOOD (LTC)	0	0		0		190. 08
190. 09 19009 SPI NE SURGEON	0	0		0		190. 09
190. 10 19010 CLINI CAL RESEARCH CENTER	0	0		0		190. 10
190. 11 19011 ONCOLOGI ST	0	0		0		190. 11
190. 12 19012 MEDI CAL I NTERNI ST	281	0		0		190. 12
190. 13 19013 RHEUMATOLOGY	0	0		0 0		190. 13
190. 14 19014 ROCK STEADY BOXING	144, 827	0	26, 32		175, 989	1
190. 15 19015 OTHER ONCOLOGY SERVICES	0	0		0		190. 15
191. 00 19100 RESEARCH	1 000 440	0	102.00	0 0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 880, 440	48, 467	183, 02		2, 111, 933	
192. 01 19201 MUNCI E MD OFFICES	24, 865	0	151, 79		176, 661	
192. 02 19202 FOUNDATI ON	0	0		0 0		192. 02
192. 03 19203 SP0E	0	0				192. 03
192. 04 19204 HEALTHY HEART	0	0				192. 04
192. 05 19205 VACANT SPACE	0	0				192. 05
192. 07 19207 PARK PLACE CENTER	0	0				192. 07 192. 08
192. 08 19208 RENTAL PROPERTY (1430 N. MADLSON	١	0				
192. 09 19209 RESIDENTIAL PROPERTY (1430 N MADISON	3, 382	0				192. 09
192. 10 19210 1512 N MADI SON AVE	ا	0				192. 10
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		^				200. 00
	104 474 400	2 005 020	0 470 27	2 451 747	184, 476, 692	
202.00 TOTAL (sum lines 118 through 201)	184, 476, 692	2, 895, 938	9, 470, 37	3, 451, 767	184, 470, 692	1202.00

Provider CCN: 15-0113

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

5/25/2023 11:38 am Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL **REPAIRS PLANT** LINEN SERVICE 9.00 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 34, 909, 756 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7.00 2, 316, 439 12, 240, 942 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 861, 291 0 173, 228 4, 724, 618 9 00 10.00 01000 DI ETARY 23, 900 10.00 0 11.00 01100 CAFETERI A 645, 529 656, 274 256, 937 11.00 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 C 0 0 13.00 01300 NURSING ADMINISTRATION 1, 130, 688 180, 930 70,836 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 243, 938 429, 758 0 168, 254 14.00 0 01500 PHARMACY 1, 062, 798 15.00 196, 276 76, 844 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 264, 651 212, 699 83, 273 16.00 0 17.00 01700 SOCIAL SERVICE 0 C 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 0 19.00 0 02000 NURSI NG PROGRAM 20.00 0 0 20.00 0 0 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 21.00 3 291 C 0 0 21 00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 6, 967 22.00 0 22.00 23.00 02300 PARAMED ED PRGM-(EMS) 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 5, 997, 650 0 2, 420, 046 0 947, 469 30.00 31.00 03100 INTENSIVE CARE UNIT 1,581,333 752, 714 0 294, 694 31.00 04300 NURSERY 285, 168 555, 022 0 217, 296 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 050, 820 0 1, 906, 135 0 746, 269 50.00 05100 RECOVERY ROOM 51.00 0 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 398.854 0 52.00 345, 437 135, 242 52.00 05300 ANESTHESI OLOGY 0 53.00 C Ω 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 703, 921 180, 760 0 70, 769 54.00 54.01 05401 ULTRASOUND 199, 195 0 65, 576 0 25, 674 54.01 55 00 05500 RADI OLOGY-THERAPEUTI C 55 00 0 05600 RADI OI SOTOPE 56.00 156,087 C 85. 114 33, 323 56.00 05700 CT SCAN 369, 164 0 332, 299 0 57.00 57.00 130.098 0 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 438, 266 58.00 0 05900 CARDIAC CATHETERIZATION 59.00 341, 695 C 369, 165 144, 531 59 00 1, 968, 154 60.00 06000 LABORATORY 0 440, 234 0 172, 356 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 62 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 174 277 Ω 18, 934 48, 361 62 00 06300 BLOOD STORING, PROCESSING & TRANS 63.00 C 0 63.00 C 06400 INTRAVENOUS THERAPY 0 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 821,066 0 14, 157 0 5, 543 65.00 06600 PHYSI CAL THERAPY 1, 130, 986 Ω 360, 501 141, 139 66.00 66 00 67.00 06700 OCCUPATIONAL THERAPY 130, 185 72,032 28, 201 67.00 68.00 06800 SPEECH PATHOLOGY 60,630 33, 524 0 13, 125 68.00 06900 ELECTROCARDI OLOGY 416, 096 824, 689 0 69.00 322, 873 69.00 07000 ELECTROENCEPHALOGRAPHY 195, 540 70.00 246, 382 Ω 76, 556 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 465, 791 0 C 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 1, 735, 195 0 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 1.996.853 0 73.00 0 07400 RENAL DIALYSIS 74.00 75, 924 Ω 0 0 0 74 00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C C 90 00 09001 WOUND/OSTOMY CLINIC 481.658 307, 949 120, 565 90.01 90.01 0 0 90.02 09002 CTR ADVANCED HEART CARE 53.003 C Γ 0 90 02 09003 RADIATION ONCOLOGY 994, 430 0 23, 900 90.03 90.03 61,046 90.04 09004 MUNCIE CLINIC 0 90.04 90.05 09005 ANTICOAGULATION CLINIC 108.072 0 0 90.05 90.06 09006 PREGNANCY PLUS C 0 0 90.06 0 90.07 09007 0/P LAB 0 0 O 90.07 0 09008 0/P LAB 90.08 0 0 90.08 0 09009 FORTVILLE CLINIC 90 09 7.527 C 0 Λ 90.09 09010 1030 S SCATTERFIELD (MEDCHECK) 0 90.10 90.10 0 90. 11 09011 DIABETIC PLUS CLINIC 114, 359 0 0 90.11 0 09012 OTHER ONCOLOGY SERVICES 90.12 0 C 0 0 90.12 91.00 09100 EMERGENCY 1, 948, 903 703, 786 275, 539 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09850 OTHER REIMBURSABLE COST CENTERS 98.00 0 0 0 0 0 98.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 34, 011, 136 11, 923, 252 0 4, 600, 240 118. 00

Provider CCN: 15-0113

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Ti me Prepared:

5/25/2023 11:38 am ADMINISTRATIVE MAINTENANCE & Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL REPAI RS PLANT LINEN SERVICE 5.00 6.00 7.00 8.00 9.00 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 01 19001 WELLNESS CENTERS 311, 770 0 45, 417 17, 781 190. 01 190. 02 19002 EMPLOYED ORTHO MD 0 190. 02 0 0 0 190. 03 19003 NORTHVI EW CONV. (LTC) 0 0 0 0 190. 03 190. 04 19004 SUMMIT CONV. (LTC) 0 0 0 0 190. 04 190. 05 19005 PARKVI EW CONV. (LTC) 0 0 190. 05 190. 06 19006 MONTI CELLO HSE. 190. 07 19007 NH PARK PLACE (LTC) 0 0 0 190.06 10, 746 0 0 190.07 0 0 190. 08 19008 MADI SON PLACE OF ELWOOD (LTC) 0 0 0 190. 08 190. 09 19009 SPI NE SURGEON 0 0 0 0 190. 09 190. 10 19010 CLINI CAL RESEARCH CENTER 0 0 190. 10 0 0 0 0 190. 11 190. 11 19011 ONCOLOGI ST 0 0 190. 12 19012 MEDICAL INTERNIST 66 0 0 190. 12 190. 13 19013 RHEUMATOLOGY 0 0 0 190. 13 0 0 0 190, 14 190. 14 19014 ROCK STEADY BOXING 41, 077 0 190. 15 19015 OTHER ONCOLOGY SERVICES 0 0 0 190. 15 191. 00 19100 RESEARCH 0 191. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 492, 938 0 106, 597 192. 00 272, 273 192. 01 19201 MUNCIE MD OFFICES 0 0 192. 01 41, 234 0 192. 02 19202 FOUNDATI ON 0 192. 02 192. 03 19203 SP0E 0 0 0 192. 03 0 192. 04 19204 HEALTHY HEART 0 0 0 192. 04 0 192.05 19205 VACANT SPACE 0 0 192. 05 192. 07 19207 PARK PLACE CENTER 0 0 0 0 192. 07 192. 08 19208 RENTAL PROPERTY 0 0 0 0 192. 08 192.09 19209 RESIDENTIAL PROPERTY (1430 N MADISON 0 0 0 192. 09 789 192. 10 19210 1512 N MADI SON AVE 0 C 0 0 192. 10 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 201.00 TOTAL (sum lines 118 through 201) 34, 909, 756 0 12, 240, 942 4, 724, 618 202. 00 202.00

Provider CCN: 15-0113

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

5/25/2023 11:38 am Cost Center Description DI ETARY CAFETERI A MAINTENANCE OF NURSI NG CENTRAL ADMI NI STRATI ON SERVICES & **PERSONNEL SUPPLY** 10.00 11.00 12.00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 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 126, 297 10 00 01100 CAFETERI A 11.00 4, 324, 430 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 0 12.00 152, 315 13.00 01300 NURSING ADMINISTRATION 0 6, 379, 066 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 39, 734 1, 926, 807 14.00 01500 PHARMACY 0 8, 508 15.00 185, 427 0 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 C 0 16.00 17.00 01700 SOCIAL SERVICE 0 0 17.00 0 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 0 19.00 19.00 0 02000 NURSING PROGRAM 0 20 00 C Λ 20 00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 0 21.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 0 0 22.00 0 0 22.00 02300 PARAMED ED PRGM-(EMS) 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 102, 632 1, 245, 015 0 3, 884, 616 120, 247 30.00 03100 INTENSIVE CARE UNIT 31.00 17,617 251, 651 0 785, 173 24, 386 31.00 43.00 04300 NURSERY 6,048 52, 979 0 5, 678 43 00 165, 654 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 543, 623 184, 538 50.00 496, 680 0 51.00 05100 RECOVERY ROOM 0 0 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 79, 469 0 8, 329 52.00 0 53.00 05300 ANESTHESI OLOGY 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 0 119, 203 0 8,728 54.00 54 01 05401 ULTRASOUND 33, 112 0 2.761 54 01 05500 RADI OLOGY-THERAPEUTI C 0 55.00 Ω 55.00 05600 RADI OI SOTOPE 0000 19, 867 0 0 688 56.00 56.00 57.00 05700 CT SCAN 66, 224 0 1,533 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 2, 171 58 00 46, 357 58 00 05900 CARDIAC CATHETERIZATION 0 59.00 52, 979 11,854 59.00 06000 LABORATORY 0 227, 037 60.00 271, 519 60.00 60.01 06001 BLOOD LABORATORY 000000000000 0 0 60.01 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62 00 19,867 36, 241 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 64.00 06400 INTRAVENOUS THERAPY 0 0 64.00 0 06500 RESPIRATORY THERAPY 139, 070 0 10, 512 65.00 65.00 0 06600 PHYSI CAL THERAPY 66.00 251, 651 3.806 66.00 67.00 06700 OCCUPATIONAL THERAPY 13, 245 0 0 0 0 239 67.00 68 00 06800 SPEECH PATHOLOGY 6, 622 111 68.00 06900 ELECTROCARDI OLOGY 92, 714 0 69.00 2.787 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 39, 734 2.809 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 535, 082 71.00 71.00 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS Ω 633, 440 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 C 0 0 73.00 74.00 07400 RENAL DIALYSIS 686 74.00 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 0 90.00 90.00 0 0 46, 357 0 90.01 09001 WOUND/OSTOMY CLINIC 0 11, 996 90.01 26, 490 09002 CTR ADVANCED HEART CARE 0 0 90.02 90.02 0000000 888 0 90.03 09003 RADIATION ONCOLOGY 0 90.03 132, 448 15, 236 90.04 09004 MUNCIE CLINIC 0 0 90.04 0 0 90.05 09005 ANTI COAGULATION CLINIC 26, 490 1,682 90.05 90.06 09006 PREGNANCY PLUS 0 90.06 0 0 0 90.07 09007 0/P LAB 0 90.07 Ω 0 09008 0/P LAB 0 90 08 C 0 90.08 90.09 09009 FORTVILLE CLINIC 0 90.09 0 09010 1030 S SCATTERFIELD (MEDCHECK) 90.10 0 0 0 90.10 90.11 09011 DIABETIC PLUS CLINIC 33, 112 0 740 90.11 09012 OTHER ONCOLOGY SERVICES 0 0 90.12 Ω 90.12 09100 EMERGENCY 384, 099 0 60, 967 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 98.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 126, 297 4, 324, 430 0 6, 379, 066 1, 923, 681 118. 00 118.00

TOTAL (sum lines 118 through 201)

Provider CCN: 15-0113

Period: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

6, 379, 066

1, 926, 807 202. 00

5/25/2023 11:38 am Cost Center Description DI ETARY CAFETERI A MAINTENANCE OF NURSI NG CENTRAL PERSONNEL ADMI NI STRATI ON SERVICES & **SUPPLY** 10.00 11.00 12.00 13.00 14.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 190. 01 19001 WELLNESS CENTERS 0 312 190. 01 0 190. 02 190. 02 19002 EMPLOYED ORTHO MD 0 0 190. 03 19003 NORTHVI EW CONV. (LTC) 0 190. 03 0 190. 04 19004 SUMMIT CONV. (LTC) 0 0 190. 04 190. 05 19005 PARKVIEW CONV. (LTC) 0 0 0 190. 05 190. 06 19006 MONTI CELLO HSE. 0 0 190.06 0 190. 07 19007 NH PARK PLACE (LTC) 0 190. 07 190. 08 19008 MADI SON PLACE OF ELWOOD (LTC) 0 0 0 190. 08 190. 09 19009 SPINE SURGEON 0 0 0 190. 09 01 0 190. 10 190. 10 19010 CLINICAL RESEARCH CENTER 0 190. 11 19011 ONCOLOGI ST 0 0 190. 11 190. 12 19012 MEDICAL INTERNIST 11 190. 12 OI 190. 13 19013 RHEUMATOLOGY 0 0 190. 13 190. 14 19014 ROCK STEADY BOXING 0 78 190. 14 190. 15 19015 OTHER ONCOLOGY SERVICES 0 190. 15 191. 00 19100 RESEARCH 0 0 0 191.00 2, 724 192. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192. 01 19201 MUNCIE MD OFFICES 0 0 192. 01 192. 02 19202 FOUNDATI ON 0 0 192. 02 192. 03 19203 SP0E 0 0 192. 03 OI 192. 04 19204 HEALTHY HEART 0 0 192. 04 192.05 19205 VACANT SPACE 0 0 192. 05 192. 07 19207 PARK PLACE CENTER 0 0 192. 07 0 0 192. 08 19208 RENTAL PROPERTY 0 192.08 0 192. 09 19209 RESIDENTIAL PROPERTY (1430 N MADISON 1 192. 09 C 0 0 192. 10 19210 1512 N MADI SON AVE 0 0 192. 10 200. 00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 0 201. 00

126, 297

4, 324, 430

202.00

Provider CCN: 15-0113

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

5/25/2023 11:38 am Cost Center Description **PHARMACY** MEDI CAL SOCIAL SERVICE NONPHYSICIAN NURSI NG RECORDS & **ANESTHETI STS PROGRAM** LI BRARY 15. 00 17.00 19. 00 20.00 16,00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 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 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 6,083,282 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 1,694,490 16.00 17.00 01700 SOCIAL SERVICE 0 17.00 0 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 19.00 0 0 02000 NURSING PROGRAM 0 20 00 C Λ 20.00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 C 21.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 0 0 22.00 22.00 02300 PARAMED ED PRGM-(EMS) 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 162, 463 0 0 0 30.00 03100 INTENSIVE CARE UNIT 0 31.00 36, 587 0 0 0 31.00 43.00 04300 NURSERY 0 6, 302 0 0 0 43 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 337, 541 0 0 50.00 0 51.00 05100 RECOVERY ROOM 0 0 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 9, 244 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 00000000 33, 650 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 54.00 54 01 05401 ULTRASOUND 22, 617 0 0 54 01 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 55.00 05600 RADI OI SOTOPE 19, 931 0 0 56.00 56.00 57.00 05700 CT SCAN 114, 815 0 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58 00 40.381 0 58 00 05900 CARDIAC CATHETERIZATION 0 59.00 57, 041 0 59.00 06000 LABORATORY 60.00 60.00 138, 825 0 60.01 06001 BLOOD LABORATORY 0 0 0 0 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62 00 4,639 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0000 0 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 33, 225 65.00 0 0 06600 PHYSI CAL THERAPY 66.00 22, 422 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 4, 352 0 0 67.00 68 00 06800 SPEECH PATHOLOGY 2, 032 68.00 0 06900 ELECTROCARDI OLOGY 0 36, 286 69.00 0 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 11, 756 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 42, 445 0 71.00 0 71.00 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 49, 571 0 72.00 07300 DRUGS CHARGED TO PATIENTS 6, 083, 282 0 73.00 132, 333 0 73.00 74.00 07400 RENAL DIALYSIS 2, 158 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 0 90.00 0 0 09001 WOUND/OSTOMY CLINIC 0 90.01 0 18, 713 0 0 90.01 09002 CTR ADVANCED HEART CARE 0 90.02 90.02 0000000 1, 114 0 0 0 0 0 0 0 90.03 09003 RADIATION ONCOLOGY 125, 176 0 90.03 0 90.04 09004 MUNCIE CLINIC 0 90.04 0 90.05 09005 ANTI COAGULATION CLINIC 2,675 0 90.05 90.06 09006 PREGNANCY PLUS 0 90.06 90.07 09007 0/P LAB 0 90.07 0 0 09008 0/P LAB 0 90 08 C 0 90.08 90.09 09009 FORTVILLE CLINIC 0 90.09 09010 1030 S SCATTERFIELD (MEDCHECK) 0 0 90.10 0 0 0 90.10 90.11 09011 DIABETIC PLUS CLINIC 569 0 0 90.11 09012 OTHER ONCOLOGY SERVICES 0 90.12 0 90.12 09100 EMERGENCY 225, 627 0 0 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 98.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 6, 083, 282 1, 694, 490 0 0 0 118. 00 118.00

TOTAL (sum lines 118 through 201)

Provider CCN: 15-0113

Peri od: Worksheet B From 01/01/2022 Part I

0 202. 00

12/31/2022 Date/Time Prepared: 5/25/2023 11:38 am Cost Center Description **PHARMACY** MEDI CAL SOCIAL SERVICE NONPHYSICIAN NURSI NG RECORDS & **ANESTHETI STS** PROGRAM LI BRARY 15. 00 17.00 19. 00 20.00 16, 00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0000000000000000000000000000000 190. 01 19001 WELLNESS CENTERS 0 0 190. 01 0 0 190. 02 190. 02 19002 EMPLOYED ORTHO MD 0 0 190. 03 19003 NORTHVI EW CONV. (LTC) 0 190. 03 0 190. 04 19004 SUMMIT CONV. (LTC) 0 190. 04 190. 05 19005 PARKVIEW CONV. (LTC) 0 0 0 190. 05 190. 06 19006 MONTI CELLO HSE. 0 0 190.06 0 190. 07 19007 NH PARK PLACE (LTC) 0 0 190. 07 190. 08 19008 MADI SON PLACE OF ELWOOD (LTC) 0 0 0 190. 08 190. 09 19009 SPINE SURGEON 0 0 0 190. 09 ol 0 190. 10 190. 10 19010 CLINICAL RESEARCH CENTER 0 190. 11 19011 ONCOLOGI ST 0 0 190. 11 190. 12 19012 MEDICAL INTERNIST 0 190. 12 0 190. 13 190. 13 19013 RHEUMATOLOGY 0 0 0 0 190. 14 19014 ROCK STEADY BOXING 0 0 190. 14 190. 15 19015 OTHER ONCOLOGY SERVICES 0 190. 15 191. 00 19100 RESEARCH 0 0 0 191.00 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192. 00 192. 01 19201 MUNCIE MD OFFICES 0 192. 01 192. 02 19202 FOUNDATI ON 0 192. 02 0 0 0 192. 03 19203 SP0E 0 192. 03 01 192. 04 19204 HEALTHY HEART 0 192. 04 192.05 19205 VACANT SPACE 0 0 192. 05 192. 07 19207 PARK PLACE CENTER 0 192. 07 0 0 0 192. 08 192. 08 19208 RENTAL PROPERTY 0 192. 09 19209 RESIDENTIAL PROPERTY (1430 N MADISON 0 0 192. 09 192. 10 19210 1512 N MADI SON AVE 0 192. 10 0 200. 00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 0 201.00

6, 083, 282

1, 694, 490

202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2022 | Part | | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | To Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0113

					lo	12/31/2022	Date/lime Pre 5/25/2023 11:	
		INTERNS &	RESI DENTS				072072020 11.	00 4111
	Cost Center Description	SERVI CES-SALAR Y & FRI NGES	SERVICES-OTHER PRGM. COSTS	PARAMED ED PRGM-(EMS)		Subtotal	Intern & Residents Cost & Post Stepdown	
							Adjustments	
	CENEDAL CEDALCE COCT CENTEDS	21. 00	22. 00	23. 00		24. 00	25. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT				_			1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP							2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT							4. 00
5.00	00500 ADMINISTRATIVE & GENERAL							5. 00
6.00	00600 MAINTENANCE & REPAIRS							6. 00
7.00	00700 OPERATION OF PLANT							7. 00
8.00	00800 LAUNDRY & LINEN SERVICE							8. 00
9.00	00900 HOUSEKEEPI NG							9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A							10. 00 11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL							12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON							13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY							14. 00
15.00	01500 PHARMACY							15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY							16.00
17. 00 19. 00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS							17. 00 19. 00
20. 00	02000 NURSI NG PROGRAM							20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	17, 392						21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD		36, 816					22. 00
23. 00	02300 PARAMED ED PRGM-(EMS)				0			23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					40 57/ /22		20.00
30. 00 31. 00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	0			0	40, 576, 633 10, 519, 186	l .	30. 00 31. 00
43. 00	04300 NURSERY	0	0		0	2, 515, 914	0	43. 00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	17, 392	1	1	0	21, 390, 688	1	50. 00
51.00	05100 RECOVERY ROOM	0	0		0	0 (05 440	0	51.00
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0		0	2, 685, 418	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	4, 132, 895	0	54. 00
54. 01	05401 ULTRASOUND	0	Ō		0	1, 202, 360	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55. 00
56.00	05600 RADI OI SOTOPE	0	0		0	983, 746		56. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	2, 595, 773 2, 404, 872	l e	57. 00 58. 00
59. 00	05900 CARDIAC CATHETERIZATION	0	0		0	2, 441, 217	0	59. 00
60.00	06000 LABORATORY	0	Ō		0	11, 650, 443	1	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	0	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	1, 048, 986	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0		63.00
65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0		0	4, 541, 330	· ·	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	Ö		0	6, 756, 080		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	806, 018	l	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	375, 807	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	3, 478, 159	l	69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	1, 628, 372	0	70.00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	8, 323, 324 9, 852, 440		71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	Ö		o	16, 767, 744		73. 00
74. 00	07400 RENAL DIALYSIS	0	0		0	404, 057	0	74. 00
	OUTPATIENT SERVICE COST CENTERS							
	09000 CLINIC	0	0		0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	l	90.00
90. 01 90. 02	O9001 WOUND/OSTOMY CLINIC O9002 CTR ADVANCED HEART CARE	0	0		0	3, 050, 843 308, 580	0 0	90. 01 90. 02
90. 03	09003 RADI ATI ON ONCOLOGY	0	Ö		0	5, 612, 751	Ö	90. 03
90. 04	09004 MUNCI E CLINI C	0	Ō		0	0	0	90. 04
90. 05	09005 ANTI COAGULATION CLINIC	0	0		0	601, 941	0	90. 05
90. 06	09006 PREGNANCY PLUS	0	0		0	0	0	90. 06
90. 07	09007 0/P LAB	0	0		0	0	0	90. 07
90. 08 90. 09	09008 0/P LAB 09009 FORTVI LLE CLI NI C	0			0	0 39, 774	0 0	90. 08 90. 09
	09010 1030 S SCATTERFIELD (MEDCHECK)	0			0	37, 774	0	90. 10
90. 11	09011 DI ABETI C PLUS CLINI C	0	Ö		0	638, 736	Ö	90. 11
	09012 OTHER ONCOLOGY SERVICES	0	0		0	0	0	90. 12
91.00	09100 EMERGENCY	0	0		0	11, 948, 760		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1	l	<u> </u>	- 1		0	92. 00

Health Financial Cystems	COMMUNITY HOSDI	TAL ANDEDCON		la li	ou of Form CMC 2552 10
Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS	COMMUNITY HOSPI	Provi der CC	CN: 15-0113	Period: From 01/01/2022 To 12/31/2022	
	INTERNS &	RESI DENTS			
Cost Center Description	SERVICES-SALAR Y & FRINGES	PRGM. COSTS	PARAMED ED PRGM-(EMS)		Intern & Residents Cost & Post Stepdown Adjustments
	21. 00	22. 00	23. 00	24.00	25. 00
OTHER REIMBURSABLE COST CENTERS		_1			
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0 98.00
SPECIAL PURPOSE COST CENTERS	17, 392	27 017		0 170 202 047	E4 200 110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	17, 392	36, 816		0 179, 282, 847	-54, 208 118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	ol		0 0	0 190. 00
190. 01 19001 WELLNESS CENTERS		ő		0 1, 711, 023	
190. 02 19002 EMPLOYED ORTHO MD	o	o		0 0	0 190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)	0	o		0 0	0 190. 03
190. 04 19004 SUMMIT CONV. (LTC)	o	o		0 0	0 190. 04
190. 05 19005 PARKVI EW CONV. (LTC)	0	o		0 0	0 190. 05
190. 06 19006 MONTI CELLO HSE.	O	o		0 56, 788	0 190. 06
190. 07 19007 NH PARK PLACE (LTC)	0	0		0 0	0 190. 07
190.08 19008 MADISON PLACE OF ELWOOD (LTC)	0	0		0 0	0 190. 08
190. 09 19009 SPI NE SURGEON	0	0		0 0	0 190. 09
190. 10 19010 CLINICAL RESEARCH CENTER	0	0		0 0	0 190. 10
190. 11 19011 ONCOLOGI ST	0	0		0 0	0 190. 11
190. 12 19012 MEDI CAL I NTERNI ST	0	0		0 358	
190. 13 19013 RHEUMATOLOGY	0	0		0 0	1 01.700
190. 14 19014 ROCK STEADY BOXING	0	0		0 217, 144	
190. 15 19015 OTHER ONCOLOGY SERVICES	0	0		0	0 190. 15
191. 00 19100 RESEARCH	0	0		0 2 986 465	0 191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	U		2, 700, 100	
192.01 19201 MUNCLE MD OFFICES 192.02 19202 FOUNDATION		0		0 217, 895	0 192. 01 0 192. 02
192. 02 19202 FOUNDATTON 192. 03 19203 SP0E		0			0 192.02
192. 03 19203 SPOE 192. 04 19204 HEALTHY HEART		0			0 192. 03
192. 05 19205 VACANT SPACE		0			0 192.04
192. 03 19203 VACANT SPACE 192. 07 19207 PARK PLACE CENTER		0			0 192. 03
192. 08 19208 RENTAL PROPERTY		0		0	0 192. 07
192.09 19209 RESIDENTIAL PROPERTY (1430 N MADISON		ol		0 4, 172	
192. 10 19210 1512 N MADI SON AVE		ol		0 ., 1, 2	0 192. 10
200.00 Cross Foot Adjustments		o		o c	0 200. 00
201.00 Negative Cost Centers	0	o		0	0 201. 00
	1				1

17, 392

36, 816

184, 476, 692

-54, 208 202. 00

202.00

Cross Foot Adjustments Negative Cost Centers TOTAL (sum lines 118 through 201)

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2022 | Part I | To 12/31/2022 | Date/Time Prepared: | 5/25/2023 | 11: 38 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0113

			5/25/2023 11	:38 am_
	Cost Center Description	Total		
		26. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FLXT			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL			5. 00
6.00	00600 MAI NTENANCE & REPAI RS			6. 00
7.00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9.00	00900 HOUSEKEEPI NG			9.00
10.00	01000 DI ETARY			10.00
11. 00	01100 CAFETERI A			11.00
12.00	01200 MAI NTENANCE OF PERSONNEL			12.00
13.00	01300 NURSI NG ADMI NI STRATI ON			13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY			14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY			16. 00
17. 00	01700 SOCIAL SERVICE			17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS			19.00
20. 00	02000 NURSI NG PROGRAM			20.00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD			21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD			22. 00
23. 00	02300 PARAMED ED PRGM-(EMS)			23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS			25.00
30. 00	03000 ADULTS & PEDIATRICS	40, 576, 633		30.00
31. 00	03100 NTENSIVE CARE UNIT	10, 519, 186		31.00
43. 00	04300 NURSERY	2, 515, 914		43. 00
10.00	ANCI LLARY SERVI CE COST CENTERS	2,010,714		1 10.00
50.00	05000 OPERATING ROOM	21, 336, 480		50.00
51. 00	05100 RECOVERY ROOM	0		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 685, 418		52. 00
53. 00	05300 ANESTHESI OLOGY	_,,		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 132, 895		54.00
54. 01	05401 ULTRASOUND	1, 202, 360		54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0		55. 00
56. 00	05600 RADI OI SOTOPE	983, 746		56. 00
57. 00	05700 CT SCAN	2, 595, 773		57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 404, 872		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 441, 217		59. 00
60.00	06000 LABORATORY	11, 650, 443		60. 00
60. 01	06001 BLOOD LABORATORY	0		60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 048, 986		62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		63. 00
64.00	06400 I NTRAVENOUS THERAPY	o		64. 00
65.00	06500 RESPI RATORY THERAPY	4, 541, 330		65. 00
66.00	06600 PHYSI CAL THERAPY	6, 756, 080		66. 00
67.00	06700 OCCUPATIONAL THERAPY	806, 018		67. 00
68.00	06800 SPEECH PATHOLOGY	375, 807		68. 00
69.00	06900 ELECTROCARDI OLOGY	3, 478, 159		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 628, 372		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 323, 324		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	9, 852, 440		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	16, 767, 744		73. 00
74.00		404, 057		74. 00
	OUTPATIENT SERVICE COST CENTERS			
90.00	1 1	0		90. 00
90. 01	09001 WOUND/OSTOMY CLINIC	3, 050, 843		90. 01
90. 02	09002 CTR ADVANCED HEART CARE	308, 580		90. 02
90. 03	09003 RADI ATI ON ONCOLOGY	5, 612, 751		90. 03
90. 04	09004 MUNCIE CLINIC	0		90. 04
90. 05	09005 ANTI COAGULATI ON CLINIC	601, 941		90. 05
90. 06	09006 PREGNANCY PLUS	0		90. 06
90. 07	09007 0/P LAB	0		90. 07
90. 08	09008 0/P LAB	0		90. 08
90. 09	09009 FORTVILLE CLINIC	39, 774		90. 09
90. 10	09010 1030 S SCATTERFIELD (MEDCHECK)	0		90. 10
90. 11	09011 DI ABETI C PLUS CLINI C	638, 736		90. 11
	09012 OTHER ONCOLOGY SERVICES	0		90. 12
91.00	09100 EMERGENCY	11, 948, 760		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92. 00
00.00	OTHER REIMBURSABLE COST CENTERS	5		1 00 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0		98. 00
110 0	SPECIAL PURPOSE COST CENTERS	170 000 (00		110 00
118.00	, ,	179, 228, 639		118. 00
100 00	NONREI MBURSABLE COST CENTERS			100 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190. 00

Heal th Financial Systems COMMUNITY HOSPITAL ANDERSON In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0113
From 01/01/2022
To 12/31/2022
Date/Time Prepared:

5/25/2023 11:38 am Cost Center Description Total 26. 00 190. 01 19001 WELLNESS CENTERS 1, 711, 023 190. 01 190. 02 19002 EMPLOYED ORTHO MD 190. 02 0 190. 03 19003 NORTHVI EW CONV. (LTC) 0 190. 03 190. 04 19004 SUMMIT CONV. (LTC) 0 190. 04 190.05 19005 PARKVIEW CONV. (LTC) 0 190. 05 190. 06 19006 MONTI CELLO HSE. 56, 788 190. 06 190.07 19007 NH PARK PLACE (LTC) 0 190. 07 190.08 19008 MADISON PLACE OF ELWOOD (LTC) 0 190. 08 190. 09 19009 SPINE SURGEON 0 190. 09 190. 10 19010 CLINICAL RESEARCH CENTER 0 190. 10 190. 11 19011 ONCOLOGI ST 0 190. 11 190. 12 19012 MEDICAL INTERNIST 358 190. 12 190. 13 19013 RHEUMATOLOGY 190. 13 0 190. 14 19014 ROCK STEADY BOXING 217, 144 190. 14 190. 15 19015 OTHER ONCOLOGY SERVICES 0 190. 15 191. 00 19100 RESEARCH 191. 00 0 2, 986, 465 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 00 192. 01 19201 MUNCIE MD OFFICES 217, 895 192. 01

0

0

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0

4, 172

184, 422, 484

192. 02

192. 03

192. 04

192. 05

192. 07

192. 08

192. 09

192. 10

200.00

201. 00

202. 00

192. 02 19202 FOUNDATION

192.04 19204 HEALTHY HEART

192. 07 19207 PARK PLACE CENTER

192. 10 19210 1512 N MADI SON AVE

192. 09 19209 RESIDENTIAL PROPERTY (1430 N MADISON

TOTAL (sum lines 118 through 201)

Cross Foot Adjustments

Negative Cost Centers

192. 08 19208 RENTAL PROPERTY

192. 05 19205 VACANT SPACE

192. 03 19203 SP0E

200.00

201.00

202.00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2022 | Part II |
| To | 12/31/2022 | Date/Time Prepared: | 5/25/2023 | 11:38 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0113

				10) 12/31/2022	5/25/2023 11:	
			CAPI TAL REI	LATED COSTS		7 0, 20, 2020	00 4
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		Related Costs					
	OFNEDAL CEDIUSE COCT SENTEDO	0	1. 00	2. 00	2A	4. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	30, 151		30, 151	30, 151	4.00
5. 00	00500 ADMINISTRATIVE & GENERAL		89, 746	1	2, 085, 545	2, 986	5. 00
6. 00	00600 MAI NTENANCE & REPAI RS	0	07, 740	1, 7,3, 7,7	2, 003, 343	2, 700	6. 00
7. 00	00700 OPERATION OF PLANT	0	597, 055	636, 145	1, 233, 200	1, 449	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8. 00
9.00	00900 HOUSEKEEPI NG	o	30, 836	15, 909	46, 745	984	9. 00
10.00	01000 DI ETARY	0	0	14, 097	14, 097	24	10. 00
11. 00	01100 CAFETERI A	0	116, 822	51, 551	168, 373	779	11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	32, 207	1	32, 454	643	13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0	76, 500 34, 939	1	317, 496 587, 910	141 1, 202	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	37, 862	1	37, 862	1, 202	16. 00
17. 00	01700 SOCI AL SERVI CE	o	0.,002	Ö	0	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20.00	02000 NURSI NG PROGRAM	o	0	0	0	0	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	- 1	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(EMS)	0	0	0	0	0	23. 00
30. 00	O3000 ADULTS & PEDIATRICS	0	430, 787	178, 836	609, 623	6, 793	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	133, 989		260, 812	1, 500	1
43. 00	04300 NURSERY		98, 798		107, 061	322	43. 00
	ANCILLARY SERVICE COST CENTERS	-1		5, 200		, , ,	
50.00	05000 OPERATING ROOM	0	339, 307	1, 481, 716	1, 821, 023	2, 542	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	61, 491	12, 121	73, 612	472	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	0	32, 177 11, 673		379, 102	646 258	54. 00 54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	11, 6/3	3, 671	15, 344	256	55. 00
56. 00	05600 RADI OI SOTOPE	0	15, 151	105, 330	120, 481	151	56. 00
57. 00	05700 CT SCAN	o	59, 152		61, 950	402	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	O	0	504, 337	504, 337	281	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	65, 714	183, 021	248, 735	314	59. 00
60.00	06000 LABORATORY	0	78, 365	300, 066	378, 431	1, 179	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	8, 609	3, 492	12, 101	91	62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0	0	O O	0	63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY		2, 520	71, 838	74, 358	983	1
66. 00	06600 PHYSI CAL THERAPY	Ö	64, 172		1, 062, 001	1, 143	ı
67. 00	06700 OCCUPATI ONAL THERAPY	0	12, 822	1	16, 795	169	67. 00
68.00	06800 SPEECH PATHOLOGY	0	5, 968	1, 850	7, 818	79	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	146, 801	151, 188	297, 989	454	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	34, 808	81, 999	116, 807	222	70. 00
	l i	0	0	0	0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 74. 00	l i	0	0		0	0	73. 00 74. 00
74.00	OUTPATIENT SERVICE COST CENTERS	ı o		<u> </u>	<u> </u>	0	74.00
90.00	09000 CLINIC	0	0	0	ol	0	90.00
90. 01	09001 WOUND/OSTOMY CLINIC	0	54, 817	5, 752	60, 569	286	90. 01
90. 02	09002 CTR ADVANCED HEART CARE	0	0	430	430	138	90. 02
90. 03	09003 RADIATION ONCOLOGY	0	10, 867	542, 260	553, 127	794	90. 03
90. 04	09004 MUNCIE CLINIC	0	0	0	0	0	90. 04
90. 05	09005 ANTI COAGULATI ON CLINI C	0	0	0	0	143	90. 05
90.06	09006 PREGNANCY PLUS	0	0	0	0	0	90.06
90. 07	09007	0	0	0	0	0	90. 07 90. 08
90. 08 90. 09	09009 FORTVILLE CLINIC		0	31, 647	31, 647	0	90.08
	09010 1030 S SCATTERFIELD (MEDCHECK)		0	31, 347	01,047	0	90. 10
		l ől	0	2, 477	2, 477	160	1
	09012 OTHER ONCOLOGY SERVICES	0	0	0	0	0	90. 12
	09100 EMERGENCY	0	125, 280	47, 979	173, 259	2, 100	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				o		92.00

	COMMUNITY HOCK	TAL ANDERSON			C.F. OHC	0550 40
Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	COMMUNITY HOSPI	Provider CC		Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Pre 5/25/2023 11:	pared:
		CAPI TAL REL	_ATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1. 00	2. 00	2A	4. 00	
OTHER REIMBURSABLE COST CENTERS			ı			
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98. 00
SPECIAL PURPOSE COST CENTERS	_			.1		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	2, 839, 386	8, 704, 33	6 11, 543, 722	29, 830	118. 00
NONREI MBURSABLE COST CENTERS	1			ما		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
190. 01 19001 WELLNESS CENTERS	0	8, 085	404, 89	0 412, 975		190. 01
190. 02 19002 EMPLOYED ORTHO MD	0	0		0		190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)	0	0		0		190. 03
190. 04 19004 SUMMI T CONV. (LTC)	0	0		0		190. 04
190. 05 19005 PARKVI EW CONV. (LTC)	0	0		0		190. 05
190. 06 19006 MONTI CELLO HSE.	0	0		0		190. 06
190. 07 19007 NH PARK PLACE (LTC)	0	0		0		190. 07
190. 08 19008 MADI SON PLACE OF ELWOOD (LTC)	0	0		0		190. 08
190. 09 19009 SPI NE SURGEON	0	0		0		190. 09
190. 10 19010 CLINI CAL RESEARCH CENTER	0	0		0		190. 10
190. 11 19011 ONCOLOGI ST	0	0		0		190. 11
190. 12 19012 MEDI CAL I NTERNI ST	0	0		0		190. 12
190. 13 19013 RHEUMATOLOGY	0	0		0 0		190. 13
190. 14 19014 ROCK STEADY BOXING	0	0	26, 32	5 26, 325		190. 14
190. 15 19015 OTHER ONCOLOGY SERVICES	0	0		0		190. 15
191. 00 19100 RESEARCH	0	10 1/7	400.00	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	48, 467	183, 02			192. 00
192. 01 19201 MUNCI E MD OFFICES	0	0	151, 79	6 151, 796		192. 01
192. 02 19202 FOUNDATI ON	0	0		0		192. 02
192. 03 19203 SPOE	0	0		0		192. 03
192. 04 19204 HEALTHY HEART	0	0		0		192. 04
192. 05 19205 VACANT SPACE	0	0		0		192. 05
192. 07 19207 PARK PLACE CENTER	0	0		0		192. 07
192. 08 19208 RENTAL PROPERTY (1430 N. MARI CON	0	0		0		192. 08
192. 09 19209 RESIDENTIAL PROPERTY (1430 N MADISON	0	0		0		192. 09
192. 10 19210 1512 N MADI SON AVE	0	O			0	192. 10
200.00 Cross Foot Adjustments				0		200. 00

2, 895, 938

12, 366, 311

9, 470, 373

0 201. 00 30, 151 202. 00

201.00 202.00 Negative Cost Centers TOTAL (sum lines 118 through 201)

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0113

Peri od: Worksheet B From 01/01/2022 Part II To 12/31/2022 Date/Time Prepared:

5/25/2023 11:38 am Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL REPAI RS **PLANT** LINEN SERVICE 9.00 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 2.088.531 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7.00 138, 586 1, 373, 235 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 118, 691 9.00 51, 529 0 19, 433 9 00 10.00 01000 DI ETARY 1,430 10.00 0 0 11.00 01100 CAFETERI A 38, 620 73,623 6, 455 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12 00 0 0 13.00 01300 NURSING ADMINISTRATION 67,646 20, 297 1,780 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14, 594 48, 212 0 4, 227 14.00 0 01500 PHARMACY 1, 930 15.00 63.584 22.019 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 15.833 23.861 2,092 16.00 17.00 01700 SOCIAL SERVICE C 0 0 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 19 00 0 0 0 19.00 02000 NURSI NG PROGRAM 20.00 0 0 20.00 0 0 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 197 C 0 0 21.00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 0 22.00 417 0 22.00 23.00 02300 PARAMED ED PRGM-(EMS) 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 358, 802 0 271, 494 0 23, 801 30.00 31.00 03100 INTENSIVE CARE UNIT 94.607 0 84, 442 0 7,403 31.00 17, 061 04300 NURSERY 0 62, 264 0 43.00 5, 459 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 182, 522 0 213, 837 0 18, 748 50.00 05100 RECOVERY ROOM 51.00 0 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 23.862 38.752 3.398 52.00 05300 ANESTHESI OLOGY 53.00 C \cap Ω 53.00 54.00 0 05400 RADI OLOGY-DI AGNOSTI C 42, 114 0 20, 278 1,778 54.00 54.01 05401 ULTRASOUND 11, 917 0 7, 357 0 645 54.01 55 00 05500 RADI OLOGY-THERAPEUTI C Ω 55 00 0 05600 RADI OI SOTOPE 56.00 9.338 0 9,548 837 56.00 05700 CT SCAN 22, 086 0 0 57.00 37, 279 3.268 57.00 0 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 26, 220 58.00 0 05900 CARDIAC CATHETERIZATION 59.00 20, 443 0 41.414 3,631 59.00 06000 LABORATORY 0 60.00 117, 749 0 49, 387 4, 330 60.00 60.01 06001 BLOOD LABORATORY 0 0 0 60.01 62 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS Ω 10 426 5 425 476 62 00 06300 BLOOD STORING, PROCESSING & TRANS 63.00 C C 63.00 Ω 06400 INTRAVENOUS THERAPY 64.00 0 64.00 65.00 06500 RESPIRATORY THERAPY 49, 122 0 1,588 0 139 65.00 06600 PHYSI CAL THERAPY 67.664 Ω 40 442 66.00 3.546 66.00 67.00 06700 OCCUPATIONAL THERAPY 7,789 8,081 708 67.00 68.00 06800 SPEECH PATHOLOGY 3,627 3, 761 0 330 68.00 06900 ELECTROCARDI OLOGY 92, 517 69.00 24.894 8.111 69.00 07000 ELECTROENCEPHALOGRAPHY 14.740 70.00 70.00 Ω 21, 936 1, 923 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 87,694 0 C 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 103,812 0 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 119.466 0 0 73.00 07400 RENAL DIALYSIS 74.00 4, 542 Ω 0 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0 n 90 00 09001 WOUND/OSTOMY CLINIC 28.816 0 3,029 90.01 90.01 0 34, 547 90.02 09002 CTR ADVANCED HEART CARE 3.171 Ω Γ Λ 90 02 09003 RADIATION ONCOLOGY 59, 494 90.03 90.03 6,848 0 0 0 600 90.04 09004 MUNCIE CLINIC 90.04 C 09005 ANTI COAGULATION CLINIC 90.05 6,466 0 0 0 90.05 90.06 09006 PREGNANCY PLUS C 0 0 90.06 0 90.07 09007 0/P LAB 0 0 0 0 90.07 09008 0/P LAB 90.08 0 0 90.08 0 0 09009 FORTVILLE CLINIC 90 09 450 C 0 0 90.09 09010 1030 S SCATTERFIELD (MEDCHECK) 90.10 0 90. 11 09011 DIABETIC PLUS CLINIC 6,842 0 0 90.11 0 09012 OTHER ONCOLOGY SERVICES 90.12 0 C 0 0 90.12 91.00 09100 EMERGENCY 116, 597 78, 953 6, 922 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09850 OTHER REIMBURSABLE COST CENTERS 98.00 98.00 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 034, 769 1, 337, 595 0 115, 566 118. 00

Provider CCN: 15-0113

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | T

				12/01/2022	5/25/2023 11:	
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5.00	6.00	7. 00	8. 00	9. 00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
190. 01 19001 WELLNESS CENTERS	18, 652	0	5, 095	0	447	190. 01
190.02 19002 EMPLOYED ORTHO MD	0	0	0	0	0	190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)	0	0	0	0	0	190. 03
190.04 19004 SUMMIT CONV. (LTC)	0	0	0	0	0	190. 04
190. 05 19005 PARKVI EW CONV. (LTC)	0	0	0	0	0	190. 05
190. 06 19006 MONTI CELLO HSE.	643	0	0	0	0	190. 06
190. 07 19007 NH PARK PLACE (LTC)	0	0	0	0	0	190. 07
190.08 19008 MADISON PLACE OF ELWOOD (LTC)	0	0	0	0	0	190. 08
190. 09 19009 SPI NE SURGEON	o	0	0	o	0	190. 09
190. 10 19010 CLINICAL RESEARCH CENTER	o	0	0	o	0	190. 10
190. 11 19011 ONCOLOGI ST	o	0	0	o	0	190. 11
190. 12 19012 MEDI CAL I NTERNI ST	4	0	0	o	0	190. 12
190. 13 19013 RHEUMATOLOGY	o	0	0	o	0	190. 13
190. 14 19014 ROCK STEADY BOXING	2, 458	0	0	o	0	190. 14
190. 15 19015 OTHER ONCOLOGY SERVICES	o	0	0	o	0	190. 15
191. 00 19100 RESEARCH	o	0	0	o	0	191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	29, 491	0	30, 545	o	2, 678	192. 00
192.01 19201 MUNCIE MD OFFICES	2, 467	0	0	o	0	192. 01
192. 02 19202 FOUNDATI ON	o	0	0	o	0	192. 02
192. 03 19203 SP0E	o	0	0	o	0	192. 03
192. 04 19204 HEALTHY HEART	o	0	0	o	0	192. 04
192. 05 19205 VACANT SPACE	o	0	0	o	0	192. 05
192. 07 19207 PARK PLACE CENTER	o	0	0	o	0	192. 07
192. 08 19208 RENTAL PROPERTY	o	0	0	o	0	192. 08
192.09 19209 RESIDENTIAL PROPERTY (1430 N MADISON	47	0	0	o	0	192. 09
192. 10 19210 1512 N MADI SON AVE	o	0	0	o	0	192. 10
200.00 Cross Foot Adjustments					I	200.00
201.00 Negative Cost Centers	o	0	0	o		201.00
202.00 TOTAL (sum lines 118 through 201)	2, 088, 531	0	1, 373, 235	o	118, 691	
				-1		•

Provider CCN: 15-0113

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2022 | Part II |
| To | 12/31/2022 | Date/Time Prepared: | 5/25/2023 | 11:38 am

				0 12/31/2022	5/25/2023 11:	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF		CENTRAL	
			PERSONNEL	ADMI NI STRATI ON	SERVI CES & SUPPLY	
	10.00	11. 00	12. 00	13.00	14. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6.00 00600 MAINTENANCE & REPAIRS						6. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	15, 551					10. 00
11. 00 01100 CAFETERI A	0	287, 850)			11. 00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0) C			12. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	10, 139	1	132, 959	007.045	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	2, 645	1		387, 315	14.00
15. 00 O1500 PHARMACY 16. 00 O1600 MEDI CAL RECORDS & LI BRARY	0	12, 343	C		1, 710 0	15. 00 16. 00
17. 00 01700 SOCIAL SERVICE	0	0			0	17. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	Ö	0		ol ol	0	19. 00
20. 00 02000 NURSI NG PROGRAM	o	0	i c	ol	0	20. 00
21.00 02100 L&R SERVICES-SALARY & FRINGES APPRVD	0	0	ol c	o	0	21. 00
22.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	C	o	0	22. 00
23. 00 02300 PARAMED ED PRGM-(EMS)	0	0) C	0	0	23. 00
I NPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS	12, 637	82, 873	l .		24, 171	30.00
31. 00 03100 NTENSIVE CARE UNIT	2, 169	16, 751			4, 902	31.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	745	3, 526	<u>C</u>	3, 453	1, 141	43. 00
50. 00 05000 OPERATING ROOM	0	33, 061		32, 174	37, 094	50. 00
51. 00 05100 RECOVERY ROOM	0	33, 001			0	51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	o	5, 290		_	1, 674	52. 00
53. 00 05300 ANESTHESI OLOGY	Ö	0	d	_	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	О	7, 935	c	o	1, 754	54.00
54. 01 05401 ULTRASOUND	0	2, 204	- c	o	555	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	C	0	0	55. 00
56. 00 05600 RADI OI SOTOPE	0	1, 322	1	_	138	56. 00
57. 00 05700 CT SCAN	0	4, 408	1	_	308	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	3, 086	1	_	436	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	3, 526	1		2, 383	59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	0	18, 073			45, 637 0	60. 00 60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1, 322	1		7, 285	62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	1, 322			7, 203	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	o	0	i c	ol ol	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0	9, 257		o	2, 113	65.00
66. 00 06600 PHYSI CAL THERAPY	0	16, 751	c	o	765	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	882	c c	0	48	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	441		0	22	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	6, 171	l .	0	560	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	2, 645	C	0	565	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			107, 558	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	_	127, 334 0	72. 00 73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	1	_	138	74.00
OUTPATIENT SERVICE COST CENTERS				., O	130	, 1. 00
90. 00 09000 CLINIC	0	0	C	0	0	90. 00
90. 01 09001 WOUND/OSTOMY CLINIC	0	3, 086	1		2, 411	90. 01
90.02 09002 CTR ADVANCED HEART CARE	0	1, 763	C	o	179	90. 02
90. 03 09003 RADI ATI ON ONCOLOGY	0	8, 816	d c	0	3, 063	90. 03
90. 04 09004 MUNCIE CLINIC	0	0	1	0	0	90. 04
90. 05 09005 ANTI COAGULATI ON CLINIC	0	1, 763	0	0	338	90. 05
90. 06 09006 PREGNANCY PLUS	0	0		0	0	90.06
90. 07 09007 0/P LAB	0	0			0	90. 07
90. 08 09008 0/P LAB 90. 09 09009 FORTVI LLE CLI NI C	0	0			0	90. 08 90. 09
90. 10 09010 1030 S SCATTERFIELD (MEDCHECK)	0	0			0	90. 09
90. 11 09011 DI ABETI C PLUS CLINI C	0	2, 204			149	90. 10
90. 12 09012 OTHER ONCOLOGY SERVICES	ol	2, 204		ol ol	0	90. 12
91. 00 09100 EMERGENCY	ol	25, 567	0	ol ol	12, 255	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	C	0	0	98. 00
SPECIAL PURPOSE COST CENTERS	45 55.1	007.055	I -	400 0=-1	201 15:	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	15, 551	287, 850	() C	132, 959	386, 686	118.00

ALLOCATION OF CAPITAL RELATED COSTS

TOTAL (sum lines 118 through 201)

Provider CCN: 15-0113

Peri od: Worksheet B From 01/01/2022 Part II To 12/31/2022 Date/Time Prepared:

0

132, 959

387, 315 202. 00

5/25/2023 11:38 am Cost Center Description DI ETARY CAFETERI A MAINTENANCE OF NURSI NG CENTRAL PERSONNEL ADMI NI STRATI ON SERVICES & **SUPPLY** 10.00 11.00 12.00 13.00 14.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 190. 01 19001 WELLNESS CENTERS 0 63 190. 01 0 190. 02 190. 02 19002 EMPLOYED ORTHO MD 0 0 190. 03 19003 NORTHVI EW CONV. (LTC) 0 190. 03 0 190. 04 19004 SUMMIT CONV. (LTC) 0 190. 04 190. 05 19005 PARKVIEW CONV. (LTC) 0 0 0 190. 05 190. 06 19006 MONTI CELLO HSE. 0 0 190.06 0 190. 07 19007 NH PARK PLACE (LTC) 0 190. 07 190. 08 19008 MADI SON PLACE OF ELWOOD (LTC) 0 0 0 190. 08 190. 09 19009 SPINE SURGEON 0 0 0 190. 09 ol 0 190. 10 190. 10 19010 CLINICAL RESEARCH CENTER 0 190. 11 19011 ONCOLOGI ST 0 0 190. 11 190. 12 19012 MEDICAL INTERNIST 2 190. 12 0 190. 13 190. 13 19013 RHEUMATOLOGY 0 0 190. 14 19014 ROCK STEADY BOXING 0 16 190. 14 190. 15 19015 OTHER ONCOLOGY SERVICES 0 190. 15 191. 00 19100 RESEARCH 0 0 0 191.00 0 548 192. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 01 19201 MUNCIE MD OFFICES 0 192. 01 192. 02 19202 FOUNDATI ON 0 0 192. 02 192. 03 19203 SP0E 0 0 192. 03 01 192. 04 19204 HEALTHY HEART 0 0 192. 04 192.05 19205 VACANT SPACE 0 0 192. 05 192. 07 19207 PARK PLACE CENTER 0 0 192. 07 0 0 192. 08 19208 RENTAL PROPERTY 0 192.08 0 192. 09 19209 RESIDENTIAL PROPERTY (1430 N MADISON 0 192. 09 C 0 192. 10 19210 1512 N MADI SON AVE 0 192. 10 200. 00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 0 201. 00

15, 551

287, 850

202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0113

Peri od: Worksheet B From 01/01/2022 Part II To 12/31/2022 Date/Time Prepared:

5/25/2023 11:38 am Cost Center Description **PHARMACY** MEDI CAL SOCIAL SERVICE NONPHYSICIAN NURSI NG RECORDS & **ANESTHETISTS PROGRAM** LI BRARY 15. 00 17.00 19. 00 20.00 16,00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 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 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 690, 698 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 79,648 16.00 17.00 01700 SOCIAL SERVICE 0 17.00 0 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 02000 NURSING PROGRAM 0 0 Ω 20.00 20 00 C 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 C 21.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 0 0 22.00 22.00 02300 PARAMED ED PRGM-(EMS) 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 7,644 0 30.00 03100 INTENSIVE CARE UNIT 0 1, 722 31.00 0 31.00 0 43.00 04300 NURSERY 297 0 43 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 15, 799 50.00 0 0 51.00 05100 RECOVERY ROOM 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 435 52.00 53.00 05300 ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 0000000000000000000 0 54.00 1,583 54.00 0 54 01 05401 ULTRASOUND 1.064 54 01 0 |05500| RADI OLOGY-THERAPEUTI C 55.00 55.00 56.00 05600 RADI OI SOTOPE 938 0 56.00 57.00 05700 CT SCAN 5, 402 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1, 900 0 58 00 58 00 05900 CARDIAC CATHETERIZATION 0 59.00 2,684 59.00 06000 LABORATORY 60.00 6, 532 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62 00 218 62 00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 64.00 06400 INTRAVENOUS THERAPY 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 1.563 65.00 0 06600 PHYSI CAL THERAPY 66.00 1.055 66.00 67.00 06700 OCCUPATIONAL THERAPY 205 0 67.00 68 00 06800 SPEECH PATHOLOGY 96 68.00 06900 ELECTROCARDI OLOGY 0 1, 707 69.00 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 553 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 1, 997 71.00 71.00 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 332 72.00 0 07300 DRUGS CHARGED TO PATIENTS 690, 698 73.00 6, 227 73.00 74.00 07400 RENAL DIALYSIS 102 74.00 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 0 90.00 0 0 09001 WOUND/OSTOMY CLINIC 90.01 881 90.01 09002 CTR ADVANCED HEART CARE 0 90.02 90.02 00000000000 52 0 90. 03 09003 RADIATION ONCOLOGY 5, 890 90.03 0 90.04 09004 MUNCIE CLINIC 90.04 90.05 09005 ANTI COAGULATION CLINIC 126 90.05 90.06 09006 PREGNANCY PLUS 0 90.06 0 90.07 09007 0/P LAB 0 90.07 0 09008 0/P LAB 90 08 C 90 08 90.09 09009 FORTVILLE CLINIC 90.09 09010 1030 S SCATTERFIELD (MEDCHECK) 0 90.10 90.10 90.11 09011 DIABETIC PLUS CLINIC 27 0 90.11 0 09012 OTHER ONCOLOGY SERVICES 90.12 90.12 91.00 09100 EMERGENCY 10, 617 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 98.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 690, 698 79, 648 0 0 0 118. 00 118.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0113

			T	o 12/31/2022		
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	NURSI NG	
		RECORDS &		ANESTHETI STS	PROGRAM	
		LI BRARY				
	15. 00	16. 00	17. 00	19. 00	20. 00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190. 00
190. 01 19001 WELLNESS CENTERS	0	0	0			190. 01
190.02 19002 EMPLOYED ORTHO MD	0	0	0			190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)	0	0	0			190. 03
190.04 19004 SUMMIT CONV. (LTC)	0	0	0			190. 04
190.05 19005 PARKVI EW CONV. (LTC)	0	0	0			190. 05
190. 06 19006 MONTI CELLO HSE.	0	0	0			190. 06
190.07 19007 NH PARK PLACE (LTC)	0	0	0			190. 07
190.08 19008 MADISON PLACE OF ELWOOD (LTC)	0	0	0			190. 08
190. 09 19009 SPI NE SURGEON	0	0	0			190. 09
190. 10 19010 CLINICAL RESEARCH CENTER	0	0	0			190. 10
190. 11 19011 ONCOLOGI ST	0	0	0			190. 11
190. 12 19012 MEDI CAL I NTERNI ST	0	0	0			190. 12
190. 13 19013 RHEUMATOLOGY	0	0	0			190. 13
190. 14 19014 ROCK STEADY BOXING	0	0	0			190. 14
190. 15 19015 OTHER ONCOLOGY SERVICES	0	0	0			190. 15
191. 00 19100 RESEARCH	0	0	0			191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0			192. 00
192.01 19201 MUNCIE MD OFFICES	0	0	0			192. 01
192. 02 19202 FOUNDATI ON	0	0	0			192. 02
192. 03 19203 SP0E	0	0	0			192. 03
192.04 19204 HEALTHY HEART	0	0	0			192. 04
192.05 19205 VACANT SPACE	0	0	0			192. 05
192.07 19207 PARK PLACE CENTER	0	0	0			192. 07
192.08 19208 RENTAL PROPERTY	0	0	0			192. 08
192.09 19209 RESIDENTIAL PROPERTY (1430 N MADISON	0	0	0			192. 09
192.10 19210 1512 N MADISON AVE	0	0	0			192. 10
200.00 Cross Foot Adjustments				0		0 200. 00
201.00 Negative Cost Centers	0	0	0	0		0 201. 00
202.00 TOTAL (sum lines 118 through 201)	690, 698	79, 648	0	0		0 202. 00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | To 12/31 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0113

					To 12/31/2022	Date/Time Pre 5/25/2023 11:	
		INTERNS &	RESI DENTS			372372023 11.	30 aiii
		CEDIU OEC CALAD	CEDVI OFC. OTHER	DADAMED ED			
	Cost Center Description	Y & FRINGES	SERVICES-OTHER PRGM. COSTS	PARAMED ED PRGM-(EMS)	Subtotal	Intern & Residents Cost	
				(2		& Post	
						Stepdown	
		21. 00	22.00	23. 00	24.00	Adjustments 25.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	OO200 CAP REL COSTS-MVBLE EQUIP OO400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE						7. 00
8. 00 9. 00	00900 HOUSEKEEPING						8. 00 9. 00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
12. 00 13. 00	O1200 MAI NTENANCE OF PERSONNEL O1300 NURSI NG ADMI NI STRATI ON						12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE						16. 00 17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS						17.00
20. 00	02000 NURSI NG PROGRAM						20. 00
21.00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	197	44.7				21. 00
22. 00 23. 00	O2200 I &R SERVICES-OTHER PRGM. COSTS APPRVD O2300 PARAMED ED PRGM-(EMS)		417		0		22. 00 23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				0		25.00
30.00	03000 ADULTS & PEDIATRICS				1, 478, 805	1	30. 00
31.00	03100 I NTENSI VE CARE UNI T				490, 673		31.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS				201, 329	<u>/</u>	43. 00
50.00	05000 OPERATI NG ROOM				2, 356, 800	0	50. 00
51.00	05100 RECOVERY ROOM				(1	51.00
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY				147, 495	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C				455, 190	1	54. 00
54. 01	05401 ULTRASOUND				39, 344	1	54. 01
55. 00	O5500 RADI OLOGY-THERAPEUTI C				140.750	1	55. 00
56. 00 57. 00	05600				142, 753 135, 103	1	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)				536, 260	l .	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON				323, 130	1	59. 00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY				621, 318	1	60. 00 60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS				37, 344	1	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.				C		63. 00
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY				139, 123	ή	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY				1, 193, 367	1	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY				34, 677	0	67. 00
68. 00	06800 SPEECH PATHOLOGY				16, 174	1	68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY				432, 403 159, 391		69. 00 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				197, 249		71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS				233, 478	1	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS				816, 391 4, 782	1	73. 00 74. 00
74.00	OUTPATIENT SERVICE COST CENTERS				4, 702		74.00
90.00	09000 CLI NI C				C		90. 00
90. 01	09001 WOUND/OSTOMY CLINIC				133, 625	1	90. 01
90. 02	09002 CTR ADVANCED HEART CARE 09003 RADI ATI ON ONCOLOGY				5, 733 638, 632		90. 02 90. 03
	09004 MUNCI E CLI NI C				000,002	0	90. 04
90.05	09005 ANTI COAGULATI ON CLINI C				8, 836		90. 05
90. 06 90. 07	09006 PREGNANCY PLUS	1				0	90. 06 90. 07
	09007 07P LAB					0	90.07
90.09	09009 FORTVILLE CLINIC	1			32, 097		90. 09
90. 10	09010 1030 S SCATTERFIELD (MEDCHECK)				11 25	0	90. 10
	09011 DI ABETIC PLUS CLINIC 09012 OTHER ONCOLOGY SERVICES	1			11, 859	0	90. 11 90. 12
91.00	09100 EMERGENCY]			426, 270	1	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	<u> </u>		<u> </u>		0	92. 00

Heal th Financial Systems COMMUNITY HOSPITAL ANDERSON In Lieu of Form CMS-25: ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0113 Period: Worksheet B From 01/01/2022 Part II	
To 12/31/2022 Date/Time Prepa 5/25/2023 11: 38	am_
Cost Center Description SERVICES-SALAR SERVICES-OTHER Y & FRINGES PRGM. COSTS PRGM-(EMS) PRGM-(EMS) Subtotal Intern & Residents Cost & Post Stepdown Adjustments	
21. 00 22. 00 23. 00 24. 00 25. 00	
OTHER REI MBURSABLE COST CENTERS	
98. 00 O9850 OTHER REIMBURSABLE COST CENTERS 0 0 9	8.00
SPECIAL PURPOSE COST CENTERS	
	8. 00
NONREI MBURSABLE COST CENTERS	
	0. 00
	0. 01
	0. 02
	0. 03
	0. 04
	0. 05
	0. 06
	0. 00
	0. 08
	0. 08
	0. 09
	0. 10
	0. 11
	0. 12
	0. 13
	0. 15
	1.00
	2.00
	2. 01
	2. 02
	2. 03
	2. 04
	2. 05
	2. 07
	2. 08
	2. 09
	2. 10
	0. 00
	1. 00
202.00 TOTAL (sum lines 118 through 201) 197 417 0 12,366,311 0 20	2. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | 5/25/2023 11: 38 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOSPITAL ANDERSON

Provider CCN: 15-0113

			5/25/2023 11:	38 am
	Cost Center Description	Total		
		26. 00		
	GENERAL SERVICE COST CENTERS			4
1. 00	00100 CAP REL COSTS-BLDG & FIXT			1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL			5. 00
6. 00	00600 MAI NTENANCE & REPAI RS			6. 00
7.00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9.00	00900 HOUSEKEEPI NG			9.00
10.00	01000 DI ETARY			10.00
11.00	01100 CAFETERIA			11.00
12.00	01200 MAI NTENANCE OF PERSONNEL			12.00
13.00	01300 NURSI NG ADMI NI STRATI ON			13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY			14. 00
16. 00	01500 PHARMACY			15. 00 16. 00
17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE			17. 00
19.00	01900 NONPHYSI CLAN ANESTHETI STS			19.00
20. 00	02000 NURSI NG PROGRAM			20.00
21.00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD			21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD			22. 00
23. 00	02300 PARAMED ED PRGM-(EMS)			23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			7 25.00
30. 00		1, 478, 805		30.00
31. 00	03100 INTENSIVE CARE UNIT	490, 673		31.00
43. 00	04300 NURSERY	201, 329		43. 00
. 5. 55	ANCI LLARY SERVI CE COST CENTERS	201,027		1 .5. 55
50. 00		2, 356, 800		50.00
51. 00	05100 RECOVERY ROOM	0		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	147, 495		52. 00
53. 00	05300 ANESTHESI OLOGY	0		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	455, 190		54.00
54. 01	05401 ULTRASOUND	39, 344		54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	O		55. 00
56.00	05600 RADI OI SOTOPE	142, 753		56. 00
57.00	05700 CT SCAN	135, 103		57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	536, 260		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	323, 130		59. 00
60.00	06000 LABORATORY	621, 318		60. 00
60. 01	06001 BLOOD LABORATORY	0		60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	37, 344		62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0		64.00
65.00	06500 RESPI RATORY THERAPY	139, 123		65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 193, 367		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	34, 677		67. 00
68. 00	06800 SPEECH PATHOLOGY	16, 174		68. 00
69. 00	06900 ELECTROCARDI OLOGY	432, 403		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	159, 391		70. 00
	1 1	197, 249		71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	233, 478		72. 00
73. 00	I I	816, 391		73. 00
74. 00		4, 782		74. 00
00.00	OUTPATIENT SERVICE COST CENTERS			4 00 00
90.00	1	122 425		90.00
90. 01		133, 625		90. 01
90. 02	1	5, 733		90. 02
90. 03	+ +	638, 632		90. 03
90. 04 90. 05	1	0 026		90. 04 90. 05
90.05	+ +	8, 836		90.05
90.06	09000 PREGNANCY PLUS			90.06
90.07				90.07
90.08	09009 FORTVILLE CLINIC	32, 097		90.08
90. 09		32,097		90. 10
90. 10	09011 DIABETIC PLUS CLINIC	11, 859		90. 10
	09012 OTHER ONCOLOGY SERVICES	11,009		90. 11
91.00		426, 270		91. 00
92. 00		720, 270		92.00
, 2. 00	OTHER REIMBURSABLE COST CENTERS	<u> </u>		1 /2. 50
98 NN	09850 OTHER REIMBURSABLE COST CENTERS	0		98. 00
,0.00	SPECIAL PURPOSE COST CENTERS	0		1 /3. 50
118. 00		11, 449, 631		118. 00
	NONREI MBURSABLE COST CENTERS	., , , 551		1 50
190. N	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190. 00
	· · · · · · · · · · · · · · · · · · ·			

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOSPITAL ANDERSON Provider CCN: 15-0113

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | T

		5/25/2023 11:38 am
Cost Center Description	Total	
	26.00	
190. 01 19001 WELLNESS CENTERS	437, 511	190. 01
190.02 19002 EMPLOYED ORTHO MD	0	190. 02
190. 03 19003 NORTHVI EW CONV. (LTC)	0	190. 03
190.04 19004 SUMMIT CONV. (LTC)	0	190. 04
190.05 19005 PARKVIEW CONV. (LTC)	0	190. 05
190. 06 19006 MONTI CELLO HSE.	643	190. 06
190.07 19007 NH PARK PLACE (LTC)	0	190. 07
190.08 19008 MADISON PLACE OF ELWOOD (LTC)	0	190. 08
190. 09 19009 SPI NE SURGEON	0	190. 09
190. 10 19010 CLINICAL RESEARCH CENTER	0	190. 10
190. 11 19011 ONCOLOGI ST	0	190. 11
190. 12 19012 MEDI CAL I NTERNI ST	6	190. 12
190. 13 19013 RHEUMATOLOGY	0	190. 13
190. 14 19014 ROCK STEADY BOXING	28, 841	190. 14
190. 15 19015 OTHER ONCOLOGY SERVICES	0	190. 15
191. 00 19100 RESEARCH	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	294, 755	192. 00
192.01 19201 MUNCIE MD OFFICES	154, 263	192. 01
192. 02 19202 FOUNDATI ON	0	192. 02
192. 03 19203 SP0E	0	192. 03
192. 04 19204 HEALTHY HEART	0	192. 04
192. 05 19205 VACANT SPACE	0	192. 05
192.07 19207 PARK PLACE CENTER	0	192. 07
192. 08 19208 RENTAL PROPERTY	0	192. 08
192.09 19209 RESIDENTIAL PROPERTY (1430 N MADISON	47	192. 09
192.10 19210 1512 N MADISON AVE	0	192. 10
200.00 Cross Foot Adjustments	614	200.00
201.00 Negative Cost Centers	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	12, 366, 311	202. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Provider CCN: 15-0113

					1	o 12/31/2022	Date/Time Prep 5/25/2023 11:	
			CAPITAL RE	LATED COSTS			072072020 11.	oo aiii
		Cook Cooks December 1	DIDC & FLVT	MADLE FOLLID	EMDLOVEE	D!!!-+!	ADMINI CTDATIVE	
		Cost Center Description	BLDG & FLXT	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS	Reconciliation	ADMINISTRATIVE & GENERAL	
			(SGOTINE TEET)	(BOLLAN VALUE)	DEPARTMENT		(ACCUM. COST)	
					(GROSS			
			1.00	2.00	SALARI ES)	ΕΛ	F 00	
	GENER	AL SERVICE COST CENTERS	1.00	2.00	4. 00	5A	5. 00	
1.00		CAP REL COSTS-BLDG & FIXT	287, 283					1. 00
2.00		CAP REL COSTS-MVBLE EQUIP		8, 048, 154				2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT	2, 991	0	, ,		440 544 004	4. 00
5. 00 6. 00		ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	8, 903	1, 696, 081	7, 025, 398	-34, 909, 756	149, 566, 936	5. 00 6. 00
7. 00	1	OPERATION OF PLANT	59, 229	540, 611	3, 410, 470	0	9, 924, 503	7. 00
8.00		LAUNDRY & LINEN SERVICE	0	0	0	0	0	8. 00
9.00		HOUSEKEEPI NG	3, 059				3, 690, 099	9. 00
10. 00 11. 00		DI ETARY CAFETERI A	0 11, 589	11, 980 43, 809			102, 397 2, 765, 690	10. 00 11. 00
12. 00		MAINTENANCE OF PERSONNEL	11, 367	43, 809		0	2, 703, 040	12. 00
13. 00	1	NURSING ADMINISTRATION	3, 195	210	1, 513, 420	0	4, 844, 297	13. 00
14. 00		CENTRAL SERVICES & SUPPLY	7, 589				1, 045, 123	
15.00		PHARMACY	3, 466		2, 828, 128	0	4, 553, 429 1, 133, 866	
16. 00 17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	3, 756	0	0	0	1, 133, 800	16. 00 17. 00
19. 00		NONPHYSICIAN ANESTHETISTS	Ö	Ö	Ö	Ö	Ö	19. 00
20. 00		NURSI NG PROGRAM	0	0	0	0	0	20. 00
21. 00		I &R SERVI CES-SALARY & FRINGES APPRVD	0	0	0	0	14, 101	
22. 00 23. 00		I&R SERVICES-OTHER PRGM. COSTS APPRVD PARAMED ED PRGM-(EMS)	0	0	0 0		29, 849 0	22. 00 23. 00
23.00		I ENT ROUTINE SERVICE COST CENTERS		0		0	0	23.00
30. 00		ADULTS & PEDIATRICS	42, 735	151, 979	15, 957, 997	0		30. 00
31.00	1	INTENSIVE CARE UNIT	13, 292					
43. 00		NURSERY LARY SERVICE COST CENTERS	9, 801	7, 022	757, 442	0	1, 221, 767	43. 00
50. 00		OPERATING ROOM	33, 660	1, 259, 198	5, 981, 857	0	13, 070, 874	50. 00
51.00		RECOVERY ROOM	0	0	0		0	51. 00
52. 00		DELIVERY ROOM & LABOR ROOM	6, 100	10, 301	1, 111, 139	0	1, 708, 843	
53. 00 54. 00		ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0 3, 192	0 294, 825	0 1, 519, 293	0	0 3, 015, 864	53. 00 54. 00
54. 00		ULTRASOUND	1, 158		606, 556		853, 425	
55. 00	1	RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00		RADI OI SOTOPE	1, 503				668, 736	
57. 00 58. 00	1	CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	5, 868 0				1, 581, 640 1, 877, 697	
59. 00	1	CARDIAC CATHETERIZATION	6, 519				1, 463, 952	
60.00		LABORATORY	7, 774				8, 432, 318	
60. 01		BLOOD LABORATORY	0		0	0	0	60. 01
62. 00 63. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS BLOOD STORING, PROCESSING & TRANS.	854	2, 968	215, 084	0	746, 667 0	62. 00 63. 00
64. 00		INTRAVENOUS THERAPY		0	0	0	0	
65.00		RESPI RATORY THERAPY	250	61, 050	2, 312, 852	0	3, 517, 757	
66. 00	1	PHYSI CAL THERAPY	6, 366				4, 845, 575	
67. 00 68. 00	1	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	1, 272 592				557, 764 259, 763	
69. 00		ELECTROCARDI OLOGY	14, 563				1, 782, 714	
70.00		ELECTROENCEPHALOGRAPHY	3, 453				1, 055, 595	
71.00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	6, 280, 006	
72. 00 73. 00	1	IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0	0	0	7, 434, 234 8, 555, 276	
74.00	1	RENAL DIALYSIS		0		0	325, 289	74. 00
		TIENT SERVICE COST CENTERS	-	_	_	_		
90.00		CLI NI C	0				0	
90. 01 90. 02	1	WOUND/OSTOMY CLINIC CTR ADVANCED HEART CARE	5, 438				2, 063, 605	
90. 02		RADI ATI ON ONCOLOGY	1, 078	365 460, 826			227, 085 4, 260, 515	
90. 04		MUNCIE CLINIC	0	0	0	0	0	90. 04
90.05	1	ANTI COAGULATION CLINIC	0	0	335, 821	0	463, 022	90. 05
90.06	1	PREGNANCY PLUS	0	0	0	0	0	90.06
90. 07 90. 08		O/P LAB O/P LAB		0) 	0	0	90. 07 90. 08
90. 09		FORTVILLE CLINIC] 0	26, 894	Ö	Ö	32, 247	90. 09
90. 10	09010	1030 S SCATTERFIELD (MEDCHECK)	0	0	0	0	0	90. 10
90. 11	09011	DIABETIC PLUS CLINIC	0	2, 105	375, 374	0	489, 956	
90. 12 91. 00		OTHER ONCOLOGY SERVICES EMERGENCY	12, 428	40, 774	4, 942, 071	0	8, 349, 839	90. 12 91. 00
		OBSERVATION BEDS (NON-DISTINCT PART)	12, 720	10,774	., , , , , , , , , , , ,		3,317,337	92. 00

Health Financial Systems	COMMUNITY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CC	F	Period: From 01/01/2022 To 12/31/2022	Worksheet B-1 Date/Time Pre	pared:
	CAPITAL REL	ATED COSTS			5/25/2023 11:	38 am
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci I i ati on	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	1.00	2.00	4. 00	5A	5. 00	
OTHER REIMBURSABLE COST CENTERS						
98.00 O9850 OTHER REIMBURSABLE COST CENTERS	0	0	C	0	0	98. 00
SPECIAL PURPOSE COST CENTERS	004 (70	7 007 457	70 455 050	04.000.754	445 744 005	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	281, 673	7, 397, 157	70, 155, 052	-34, 909, 756	145, 716, 905	1118. 00
NONREI MBURSABLE COST CENTERS		0		0		100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.01 19001 WELLNESS CENTERS	0 802	244 005	· -			190. 00
190. 01 19001 WELLINESS CENTERS 190. 02 19002 EMPLOYED ORTHO MD	802	344, 085 0			1, 335, 743	190. 01
190. 02 19002 EMPLOTED ORTHO MD 190. 03 19003 NORTHVI EW CONV. (LTC)	0	0	·			190. 02
190. 04 19004 SUMMIT CONV. (LTC)	0	0				190. 03
190. 05 19005 PARKVI EW CONV. (LTC)	0	0				190. 04
190. 06 19006 MONTI CELLO HSE.	0	0				190. 06
190. 07 19007 NH PARK PLACE (LTC)	0	0	ĺ	0		190. 07
190. 08 19008 MADI SON PLACE OF ELWOOD (LTC)	0	0	ĺ	o o		190. 08
190. 09 19009 SPI NE SURGEON	0	0	ĺ	0		190. 09
190. 10 19010 CLINI CAL RESEARCH CENTER	0	0	ĺ	0		190. 10
190. 11 19011 ONCOLOGI ST	0	0	ĺ	o o		190. 11
190. 12 19012 MEDI CAL I NTERNI ST	0	0		0		190. 12
190. 13 19013 RHEUMATOLOGY	0	0	l d	0		190. 13
190. 14 19014 ROCK STEADY BOXING	0	22, 372	99, 370	0	175, 989	1
190. 15 19015 OTHER ONCOLOGY SERVICES	0	0				190. 15
191. 00 19100 RESEARCH	0	0	l c	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	4, 808	155, 540	l c	0	2, 111, 933	192. 00
192.01 19201 MUNCIE MD OFFICES	0	129, 000	l c	0	176, 661	192. 01
192. 02 19202 FOUNDATI ON	0	0	C	0	0	192. 02
192. 03 19203 SP0E	0	0	C	0	0	192. 03
192.04 19204 HEALTHY HEART	0	0	l c	0	0	192. 04
192. 05 19205 VACANT SPACE	0	0	C	0	0	192. 05
192.07 19207 PARK PLACE CENTER	0	0	C	0	0	192. 07
192.08 19208 RENTAL PROPERTY	0	0	C	0	0	192. 08
192.09 19209 RESIDENTIAL PROPERTY (1430 N MADISON	0	0	[c	0	3, 382	192. 09
192.10 19210 1512 N MADISON AVE	0	0	C	0	0	192. 10
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B.	2, 895, 938	9, 470, 373	3. 451. 767	'	34, 909, 756	202.00

2, 895, 938

10. 080436

9, 470, 373

1. 176714

3, 451, 767

0.048678

0.000425

30, 151

206. 00

207. 00

34, 909, 756 202. 00

0. 233406 203. 00 2, 088, 531 204. 00

0. 013964 205. 00

202.00

203.00

204.00

205.00

206.00

207.00

Part I)

Part II)

(per Wkst. B-2)

Parts III and IV)

11)

Cost to be allocated (per Wkst. B,

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

Unit cost multiplier (Wkst. B, Part I)

NAHE adjustment amount to be allocated

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0113

Period: Worksheet B-1 From 01/01/2022

12/31/2022 Date/Time Prepared: 5/25/2023 11:38 am Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY LINEN SERVICE (SQUARE FEET) (TOTAL PATIENT **REPALRS** PLANT (SQUARE FEET) (SQUARE FEET) (POUNDS OF DAYS) LAUNDRY) 7.00 10.00 6.00 9.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 0 7.00 7.00 216, 160 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 00000000000 3, 059 213, 101 9.00 01000 DI ETARY 24, 912 10.00 10.00 01100 CAFETERI A 0 11.00 11, 589 11, 589 Λ 11.00 01200 MAINTENANCE OF PERSONNEL 0 12.00 0 12.00 13.00 01300 NURSING ADMINISTRATION 3, 195 3, 195 0 13.00 01400 CENTRAL SERVICES & SUPPLY 7, 589 0 14.00 7.589 14.00 0 0 01500 PHARMACY 15.00 3, 466 3, 466 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 3, 756 3, 756 16.00 01700 SOCIAL SERVICE 17.00 С 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 19 00 0 19 00 Ω 0 0 20.00 02000 NURSING PROGRAM C 0 0 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 0 21.00 21.00 C 0 22.00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 0 0 0 22.00 0 02300 PARAMED ED PRGM-(EMS) 0 23 00 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 42, 735 0 42, 735 20, 244 30.00 03100 INTENSIVE CARE UNIT 0 0 31 00 13 292 13 292 3, 475 31.00 43.00 04300 NURSERY 0 9,801 0 9,801 1, 193 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 50.00 33,660 33,660 0 05100 RECOVERY ROOM 51 00 0 51 00 0 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 6, 100 6, 100 0 52.00 05300 ANESTHESI OLOGY 0000 0 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 3, 192 0 3, 192 0 54.00 54.01 0 05401 ULTRASOUND 1, 158 1, 158 0 54 01 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 05600 RADI OI SOTOPE 56.00 1.503 1.503 56.00 57.00 05700 CT SCAN 000000000000000000 5, 868 0 5, 868 57.00 0 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 6,519 6, 519 0 59.00 60.00 06000 LABORATORY 7,774 0 7,774 0 60.00 06001 BLOOD LABORATORY 0 60.01 60.01 0 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 854 854 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 250 250 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 6, 366 6, 366 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 1, 272 1, 272 67.00 06800 SPEECH PATHOLOGY 592 0 592 68.00 0 68.00 06900 ELECTROCARDI OLOGY 0 69 00 14, 563 14, 563 0 69.00 07000 ELECTROENCEPHALOGRAPHY 3, 453 70.00 70.00 3, 453 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS C 0 71.00 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 C 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS C 0 0 73.00 74.00 07400 RENAL DIALYSIS 0 0 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 Λ 90 00 90.01 09001 WOUND/OSTOMY CLINIC 0 5, 438 0 5, 438 0 90.01 09002 CTR ADVANCED HEART CARE 90.02 0000000000 0 90.02 09003 RADIATION ONCOLOGY 1.078 0 1.078 90.03 90.03 0 09004 MUNCIE CLINIC 0 90.04 0 0 90.04 0 90.05 09005 ANTI COAGULATION CLINIC 0 0 0 90.05 09006 PREGNANCY PLUS 0 90.06 0 0 0 90.06 0 90 07 09007 0/P LAB 0 90 07 Ω 0 0 09008 0/P LAB 0 90.08 0 90.08 09009 FORTVILLE CLINIC 0 0 90.09 90.09 90.10 09010 1030 S SCATTERFIELD (MEDCHECK) 0 0 0 90.10 09011 DIABETIC PLUS CLINIC 0 0 90 11 90 11 Ω 0 90.12 09012 OTHER ONCOLOGY SERVICES 0 0 0 0 90.12 09100 EMERGENCY 91.00 12, 428 12.428 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS

0

0

0

0

0 98.00

09850 OTHER REIMBURSABLE COST CENTERS

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS COMMUNITY HOSPITAL ANDERSON In Lieu of Form CMS-2552-10 Provider CCN: 15-0113 Peri od: From 01/01/2022 To 12/31/2022 Worksheet B-1 To 12/31/2022 Date/Time Prepared: 5/25/2023 11: 38 am

MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPING DI ETARY Cost Center Description

	cost center Description	REPAIRS (SQUARE FEET)	PLANT	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	(SQUARE FEET)	(TOTAL PATIENT DAYS)	
		6. 00	7. 00	8. 00	9. 00	10.00	
	AL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	210, 550	0	207, 491	24, 912	118. 00
	I MBURSABLE COST CENTERS		1 0	1			100.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0 802				190. 00
	WELLNESS CENTERS EMPLOYED ORTHO MD	0	0 802			l .	190. 01 190. 02
	NORTHVI EW CONV. (LTC)			0	_		190. 02
	SUMMIT CONV. (LTC)	0				l .	190. 03
	PARKVI EW CONV. (LTC)	0		0			190. 05
	MONTI CELLO HSE.	0	0	ő	0	l .	190. 06
	NH PARK PLACE (LTC)	0	Ö	Ō	_		190. 07
190. 08 19008	MADISON PLACE OF ELWOOD (LTC)	0	0	o	0	0	190. 08
190. 09 19009	SPI NE SURGEON	0	0	0	0	0	190. 09
190. 10 19010	CLINICAL RESEARCH CENTER	0	0	0	0	0	190. 10
190. 11 19011		0	0	0	0	0	190. 11
	MEDICAL INTERNIST	0	0	0	0		190. 12
	RHEUMATOLOGY	0	0	0	0		190. 13
	ROCK STEADY BOXING	0	0	0	0		190. 14
	OTHER ONCOLOGY SERVICES	0	0	0	0		190. 15
191. 00 19100	l .	0	0	0	4 000		191. 00
	PHYSICIANS' PRIVATE OFFICES	0	4, 808	0	4, 808		192. 00
	MUNCIE MD OFFICES	0	0	0	0		192. 01 192. 02
192. 02 19202 192. 03 19203		0		0	_		192. 02
	HEALTHY HEART						192. 03
	VACANT SPACE						192. 05
	PARK PLACE CENTER	0		0			192. 07
	RENTAL PROPERTY	0	0	o o	0		192. 08
	RESIDENTIAL PROPERTY (1430 N MADISON	0	0	o	0	0	192. 09
192. 10 19210	1512 N MADISON AVE	0	0	0	0	0	192. 10
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	12, 240, 942	0	4, 724, 618	126, 297	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	56. 629080	0. 000000	22. 170792	5. 069725	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	0	1, 373, 235				
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	6. 352864	0. 000000	0. 556971	0. 624237	205. 00
206. 00	NAHE adjustment amount to be allocated						206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Provider CCN: 15-0113

				To	12/31/2022	Date/Time Pre 5/25/2023 11:	
	Cost Center Description	CAFETERI A	MAINTENANCE OF PERSONNEL		CENTRAL SERVI CES &	PHARMACY	
		(ONSITE FTES)	(NUMBER	ADMI NI STRATI ON	SUPPLY	(COSTED REQUIS.)	
			HOUSED)	(DI RECT NURS.	(COSTED		
		11.00	12.00	HRS.) 13. 00	REQUIS.) 14.00	15. 00	
	GENERAL SERVICE COST CENTERS	11.00	12.00	13.00	14.00	13.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE						8. 00 9. 00
10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						10.00
11. 00	01100 CAFETERI A	653	:				11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	C		1			12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	23	1	641, 666	22 /12 01/		13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	28		0	22, 613, 916 99, 858		14. 00 15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	1	ol ol	6	0, 000, 210	16.00
17. 00	01700 SOCIAL SERVICE	C	C	0	0	0	17. 00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	C	C	0	0	0	19.00
20. 00 21. 00	02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRVD				0	0	20.00
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD		-	ol ol	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(EMS)	C) c	0	0	0	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	100	ıl	200 751	1 411 207		20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	188			1, 411, 287 286, 205	0	30.00
43. 00	04300 NURSERY	8			66, 641	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM	75	1	1 .00, 2, 2	2, 165, 842	0	1
51. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	12	•		97, 759	0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	C	1	o	0	Ö	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	18	C	0	102, 434	0	54. 00
54. 01	05401 ULTRASOUND	5			32, 406	0	54. 01
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	3			8, 079	0	55. 00 56. 00
57. 00	05700 CT SCAN	10	o c	O	17, 997	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	7	C	0	25, 480	0	58. 00
59. 00 60. 00	O5900 CARDI AC CATHETERI ZATI ON O6000 LABORATORY	8			139, 130 2, 664, 632	0	59. 00 60. 00
60. 01	06001 BLOOD LABORATORY	0			2, 004, 032	0	60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	3	c	0	425, 349	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	C	C	0	0	0	63.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	21			0 123, 373	0	64. 00 65. 00
66. 00		38		ol ol	44, 670	0	1
67. 00	06700 OCCUPATI ONAL THERAPY	2		0	2, 805	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	1	C	0	1, 306	0	68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	14			32, 708 32, 965	0	69. 00 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		Ö	o o	6, 280, 005	Ö	71.00
72. 00		C) c	0	7, 434, 234		72. 00
73. 00 74. 00		C			0 047	8, 635, 215 0	
74.00	OUTPATIENT SERVICE COST CENTERS		<u> </u>	n O	8, 047	0	74.00
90.00	09000 CLINIC	С	C	0	0	0	90.00
90. 01	09001 WOUND/OSTOMY CLINIC	7	C	0	140, 793	0	90. 01
90. 02 90. 03	09002 CTR ADVANCED HEART CARE	4			10, 427	0	90. 02 90. 03
90. 03	O9003 RADI ATI ON ONCOLOGY O9004 MUNCI E CLI NI C	20			178, 819 0	0	90.03
90. 05	09005 ANTI COAGULATION CLINIC	4	Ö	o o	19, 746	Ö	1
90. 06	09006 PREGNANCY PLUS	C) c	0	0	0	90. 06
90. 07	09007 0/P LAB 09008 0/P LAB	C			0	0	90. 07
90. 08 90. 09	09008 07P LAB				0	0	90. 08 90. 09
90. 10	09010 1030 S SCATTERFIELD (MEDCHECK)	i c	Ö	o	Ō	Ō	90. 10
90. 11	09011 DIABETIC PLUS CLINIC	5	i c	o	8, 680	0	90. 11
90. 12	1	C			715 540	0	90. 12
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	58		ή	715, 540	0	91. 00 92. 00
, 00	OTHER REIMBURSABLE COST CENTERS						
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	C	C	0	0	0	98. 00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-0113	Period: Worksheet R-1		

From 01/01/2022 12/31/2022 Date/Time Prepared: 5/25/2023 11:38 am Cost Center Description CAFETERI A MAINTENANCE OF NURSI NG CENTRAL **PHARMACY** (ONSITE FTES) PERSONNEL ADMI NI STRATI ON SERVICES & (COSTED (NUMBER SUPPLY REQUIS.) (DIRECT NURS HOUSED) (COSTED REQUIS.) HRS.) 12.00 15.00 11.00 13.00 14.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 653 0 641, 666 22, 577, 223 8, 635, 215 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190. 00 190. 01 19001 WELLNESS CENTERS 0 0 190. 01 0000000000000000000000000000 0 3,667 190. 02 19002 EMPLOYED ORTHO MD 0 0 0 190. 02 0 0 0 0 190. 03 190. 03 19003 NORTHVI EW CONV. (LTC) 0 0 190. 04 19004 SUMMIT CONV. (LTC) 0 0 0 190. 04 190. 05 19005 PARKVI EW CONV. (LTC) 0 0 190. 05 0 190. 06 19006 MONTI CELLO HSE. 0 0 190.06 190.07 19007 NH PARK PLACE (LTC) 0 0 0 190, 07 190. 08 19008 MADI SON PLACE OF ELWOOD (LTC) 0 190. 08 0 0 0 190. 09 190. 09 19009 SPI NE SURGEON 0 0 190. 10 19010 CLINI CAL RESEARCH CENTER 0 190, 10 Ω 0 190. 11 190. 11 19011 ONCOLOGI ST 0 0 190. 12 19012 MEDICAL INTERNIST 0 0 190. 12 128 190. 13 19013 RHEUMATOLOGY 0 0 190, 13 0 190. 14 19014 ROCK STEADY BOXING 910 0 190, 14 190. 15 19015 OTHER ONCOLOGY SERVICES 0 0 0 190. 15 191. 00 19100 RESEARCH 0 191.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192.00 Ω 31, 974 0 192. 01 19201 MUNCIE MD OFFICES 0 0 0 192. 01 192. 02 19202 FOUNDATI ON 0 192. 02 192. 03 19203 SP0E 0 0 192. 03 192.04 19204 HEALTHY HEART 0 192. 04 192.05 19205 VACANT SPACE 0 192. 05 192. 07 19207 PARK PLACE CENTER 0 0 192. 07 192. 08 19208 RENTAL PROPERTY 0 0 192. 08 192. 09 19209 RESIDENTIAL PROPERTY (1430 N MADISON 0 0 192, 09 14 192. 10 19210 1512 N MADI SON AVE 0 0 0 192. 10 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 201.00 6, 379, 066 6, 083, 282 202. 00 202.00 Cost to be allocated (per Wkst. B, 4, 324, 430 Ω 1, 926, 807 Part I) 6, 622. 404288 0.000000 9. 941412 0.085204 0. 704474 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, 287, 850 132, 959 387, 315 690, 698 204. 00 204.00 Part II) 0. 079986 205. 00 205.00 Unit cost multiplier (Wkst. B, Part 440. 811639 0.000000 0.207209 0.017127 II) 206.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D. 207.00 Parts III and IV)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Provider CCN: 15-0113

					Tc	12/31/2022	Date/Time Prep 5/25/2023 11:	
							INTERNS &	
		Cost Center Description	MEDI CAL	SOCIAL SERVICE	NONPHYSICI AN	NURSI NG	RESI DENTS SERVI CES-SALAR	
			RECORDS &	(TIME CDENT)	ANESTHETI STS	PROGRAM	Y & FRINGES	
			LI BRARY (GROSS	(TIME SPENT)	(ASSIGNED TIME)	(ASSI GNED TIME)	(ASSIGNED TIME)	
			CHARGES)		,			
	GENER	AL SERVICE COST CENTERS	16. 00	17. 00	19. 00	20. 00	21. 00	
1.00	00100	CAP REL COSTS-BLDG & FIXT						1. 00
2. 00 4. 00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT						2.00
5. 00		ADMINISTRATIVE & GENERAL						4. 00 5. 00
6.00	00600	MAINTENANCE & REPAIRS						6. 00
7. 00 8. 00	1	OPERATION OF PLANT						7. 00 8. 00
9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING						9. 00
10.00	1	DI ETARY						10. 00
11. 00 12. 00	1	CAFETERIA MAINTENANCE OF PERSONNEL						11. 00 12. 00
13. 00	1	NURSING ADMINISTRATION						13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY						14. 00
15. 00 16. 00		PHARMACY MEDI CAL RECORDS & LI BRARY	774, 227, 043					15. 00 16. 00
17. 00		SOCIAL SERVICE	0 174, 227, 043	О				17. 00
19. 00	1	NONPHYSICIAN ANESTHETISTS	0	0	0			19. 00
20. 00 21. 00	1	NURSING PROGRAM I&R SERVICES-SALARY & FRINGES APPRVD	0	0		0	1, 600	20. 00 21. 00
22. 00		I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	0			1,000	22. 00
23. 00		PARAMED ED PRGM-(EMS)	0	0				23. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	74, 217, 948	0	O	0	0	30. 00
31. 00		INTENSIVE CARE UNIT	16, 714, 115			0	0	31. 00
43. 00		NURSERY	2, 878, 806	0	0	0	0	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	154, 332, 359	0	O	0	1, 600	50. 00
51. 00	1	RECOVERY ROOM	0	ő		0	0	51. 00
52.00	1	DELIVERY ROOM & LABOR ROOM	4, 223, 099			0	0	52.00
53. 00 54. 00		ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	15, 372, 477	0	0	0	0	53. 00 54. 00
54. 01		ULTRASOUND	10, 332, 168	Ö	Ō	0	0	54. 01
55. 00	1	RADI OLOGY-THERAPEUTI C	0 104 044	0	0	0	0	55. 00
56. 00 57. 00	1	RADI OI SOTOPE CT SCAN	9, 104, 964 52, 450, 807		0	0	0	56. 00 57. 00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	18, 447, 380		0	0	0	58. 00
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	26, 057, 795 63, 419, 395		0	0	0	59. 00 60. 00
60. 00	1	BLOOD LABORATORY	03, 419, 393		0	0	0	60. 00
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 119, 438		0	0	0	62. 00
63. 00 64. 00		BLOOD STORING, PROCESSING & TRANS. INTRAVENOUS THERAPY	0	0	0	0	0	63. 00 64. 00
65. 00		RESPIRATORY THERAPY	15, 178, 332	Ö	0	0	0	65. 00
66. 00	06600	PHYSI CAL THERAPY	10, 242, 844		0	0	0	66. 00
67. 00 68. 00	1	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	1, 988, 071 928, 257	0	0	0	0	67. 00 68. 00
69. 00		ELECTROCARDI OLOGY	16, 576, 704	Ö	Ö	0	0	69. 00
70.00		ELECTROENCEPHALOGRAPHY	5, 370, 349		0	0	0	70.00
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	19, 390, 014 22, 645, 297		0	0	0	71. 00 72. 00
73. 00	1	DRUGS CHARGED TO PATIENTS	60, 453, 718		Ö	0	0	73. 00
74. 00		RENAL DIALYSIS	985, 907	0	0	0	0	74. 00
90. 00		TIENT SERVICE COST CENTERS CLINIC	0	0	O	0	0	90. 00
90. 01	09001	WOUND/OSTOMY CLINIC	8, 548, 622			0	0	90. 01
90. 02		CTR ADVANCED HEART CARE	508, 977	0	0	0	0	90. 02
90. 03 90. 04		RADIATION ONCOLOGY MUNCIE CLINIC	57, 184, 061 0			0	0	90. 03 90. 04
90. 05	1	ANTI COAGULATI ON CLINIC	1, 221, 951	Ō	Ō	0	0	90. 05
90.06		PREGNANCY PLUS	0	0	0	0	0	90.06
90. 07 90. 08		O/P LAB O/P LAB	0	0	0	0	0	90. 07 90. 08
90. 09	09009	FORTVILLE CLINIC	0	0	Ö	Ō	0	90. 09
90. 10 90. 11		1030 S SCATTERFIELD (MEDCHECK) DIABETIC PLUS CLINIC	259, 905	0	0	0	0	90. 10 90. 11
90. 11		OTHER ONCOLOGY SERVICES	239, 905	0	0	0	0	90. 11 90. 12
91.00	09100	EMERGENCY	103, 073, 283	0	0	0	0	91. 00
92. 00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		l				92. 00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lieu of Form CMS-2552-10		
COST ALLOCATION CTATICTICAL DACIC	Description CON 15 0112 Descri	I WI+ D 1		

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0113 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/25/2023 11:38 am INTERNS & **RESI DENTS** Cost Center Description MEDI CAL SOCIAL SERVICE NONPHYSI CI AN NURSI NG SERVI CES-SALAR Y & FRINGES RECORDS & **ANESTHETISTS PROGRAM** (TIME SPENT) (ASSI GNED (ASSI GNED (ASSI GNED LI BRARY (GROSS TIME) TIME) TIME) CHARGES) 17.00 19.00 20.00 21.00 16.00 OTHER REIMBURSABLE COST CENTERS 98 00 0 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 98 00 Ωl SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 774, 227, 043 0 0 0 1, 600 118. 00 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 190. 01 19001 WELLNESS CENTERS 0 0 0 0 190. 01 0 190. 02 19002 EMPLOYED ORTHO MD 00000000000000000000000000 0 0 0 190. 02 0 190. 03 19003 NORTHVI EW CONV. (LTC) 0 190 03 0 190. 04 19004 SUMMIT CONV. (LTC) 0 0 190. 04 190. 05 19005 PARKVI EW CONV. (LTC) 0 0 0 190. 05 190.06 19006 MONTI CELLO HSE. 0 0 0 190. 06 0 0 190. 07 190. 07 19007 NH PARK PLACE (LTC) 0 190. 08 19008 MADI SON PLACE OF ELWOOD (LTC) 0 0 0 190. 08 190. 09 19009 SPI NE SURGEON 0 190. 09 190. 10 19010 CLINICAL RESEARCH CENTER 0 0 0 190. 10 190. 11 19011 ONCOLOGI ST 0 0 0 190. 11 190. 12 19012 MEDI CAL INTERNI ST 0 190. 12 190. 13 19013 RHEUMATOLOGY 0 0 190. 13 190. 14 19014 ROCK STEADY BOXING 0 0 0 190, 14 0 0 190. 15 190. 15 19015 OTHER ONCOLOGY SERVICES 191. 00 19100 RESEARCH 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 192. 01 19201 MUNCIE MD OFFICES 0 0 0 192. 01 0 192. 02 19202 FOUNDATI ON 0 192. 02 192. 03 19203 SP0E 0 192. 03 192.04 19204 HEALTHY HEART 0 0 192. 04 192.05 19205 VACANT SPACE 0 0 192. 05 192. 07 19207 PARK PLACE CENTER 0 192. 07 192. 08 19208 RENTAL PROPERTY 0 0 192. 08 192.09 | 19209 | RESIDENTIAL PROPERTY (1430 N MADISON 0 0 192, 09 C 192. 10 19210 1512 N MADI SON AVE 0 0 192. 10 200.00 200. 00 Cross Foot Adjustments Negative Cost Centers 201.00 201. 00 17, 392 202. 00 202.00 Cost to be allocated (per Wkst. B, 1, 694, 490 0 0 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.002189 0.000000 0.000000 0.000000 10. 870000 203. 00 204.00 Cost to be allocated (per Wkst. B, 79,648 197 204. 00 Part II) 0.000000 205.00 Unit cost multiplier (Wkst. B, Part 0.000103 0.000000 0.000000 0. 123125 205. 00 II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 0.000000 207.00 Parts III and IV)

COMMUNITY HOSPITAL ANDERSON

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/25/2023 11: 38 am Provider CCN: 15-0113

					5/25/2023 11:38 am
		I NTERNS &			
	Cost Center Description	RESI DENTS SERVI CES-OTHER	PARAMED ED		
	cost center bescriptron	PRGM. COSTS	PRGM-(EMS)		
		(ASSI GNED	(ASSI GNED		
		TIME)	TIME)		
	T	22.00	23. 00		
1 00	GENERAL SERVICE COST CENTERS			I	1.00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 00	00500 ADMINISTRATIVE & GENERAL				5. 00
6.00	00600 MAINTENANCE & REPAIRS				6. 00
7.00	00700 OPERATION OF PLANT				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE				8. 00
9.00	00900 HOUSEKEEPI NG				9.00
10.00	01000 DI ETARY				10.00
11. 00 12. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL				11. 00
13. 00	01300 NURSING ADMINISTRATION				13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY				14.00
15.00	01500 PHARMACY				15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY				16. 00
17. 00	01700 SOCIAL SERVICE				17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS				19.00
20. 00 21. 00	02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRVD				20.00
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	1, 600			22.00
23. 00	02300 PARAMED ED PRGM-(EMS)	1,000	0		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	,			
30.00	03000 ADULTS & PEDIATRICS	0	0		30.00
31. 00	03100 INTENSIVE CARE UNIT	0	0		31.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0		43. 00
50. 00	05000 OPERATING ROOM	1, 600	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 55. 00	05401 ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C	0	0		54. 01 55. 00
56. 00	05600 RADI OLOGI - ITIERAF LUTT C	0	0		56.00
57. 00	05700 CT SCAN	0	0	•	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		59. 00
60.00	06000 LABORATORY	0	0	•	60.00
60. 01 62. 00	06001 BLOOD LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	•	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64. 00	06400 I NTRAVENOUS THERAPY	O	0		64. 00
65.00	06500 RESPI RATORY THERAPY	0	0	•	65. 00
	06600 PHYSI CAL THERAPY	0	0		66. 00
	06700 OCCUPATI ONAL THERAPY	0	0		67. 00
68.00	06800 SPEECH PATHOLOGY	0	0		68. 00
69.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	0		69. 00 70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		73. 00
74. 00	07400 RENAL DIALYSIS	0	0		74. 00
00.00	OUTPATIENT SERVICE COST CENTERS		^		00.00
	09000 CLINIC 09001 WOUND/OSTOMY CLINIC		0		90.00
	09002 CTR ADVANCED HEART CARE	0	0		90.02
	09003 RADI ATI ON ONCOLOGY	0	0		90. 03
90. 04	09004 MUNCIE CLINIC	0	0		90. 04
90. 05	09005 ANTI COAGULATI ON CLI NI C	0	0		90. 05
90. 06	09006 PREGNANCY PLUS	0	0		90.06
90. 07	09007 0/P LAB	0	0		90.07
90. 08 90. 09	09008 0/P LAB 09009 FORTVILLE CLINIC	0	0		90. 08
	09010 1030 S SCATTERFIELD (MEDCHECK)		0		90.09
90. 11	09011 DI ABETI C PLUS CLINI C	O	0		90. 11
90. 12	09012 OTHER ONCOLOGY SERVICES	0	0		90. 12
	09100 EMERGENCY	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1 1		I	92.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS COMMUNITY HOSPITAL ANDERSON Provider CCN: 15-0113

				To 12/31/2022	Date/Time Prepared:
		I NTERNS & RESI DENTS			5/25/2023 11: 38 am
	Cost Center Description	SERVI CES-OTHER	PARAMED ED		
		PRGM. COSTS	PRGM-(EMS)		
		(ASSI GNED	(ASSI GNED		
		TIME)	TIME)	-	
071150	DELMBURGARUE GOOT OFFITTERS	22. 00	23. 00		
	REIMBURSABLE COST CENTERS			.I	
	OTHER REIMBURSABLE COST CENTERS	0	0)	98. 00
118. 00	AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	1, 600	0	1	118. 00
	IMBURSABLE COST CENTERS	1, 600		<u>'</u>	118.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0		190. 00
	WELLNESS CENTERS		0	1	190. 01
	EMPLOYED ORTHO MD	0	0		190. 02
	NORTHVI EW CONV. (LTC)		0	1	190. 03
	SUMMIT CONV. (LTC)	0	0	1	190. 04
	PARKVI EW CONV. (LTC)	o	0	1	190. 05
	MONTI CELLO HSE.	o	0	1	190. 06
	NH PARK PLACE (LTC)	o	0	•	190. 07
	MADISON PLACE OF ELWOOD (LTC)	o	0	1	190. 08
	SPI NE SURGEON	o	0		190. 09
190. 10 19010	CLINICAL RESEARCH CENTER	o	0		190. 10
190. 11 19011	ONCOLOGIST	O	0	o l	190. 11
190. 12 19012	MEDICAL INTERNIST	O	0	o l	190. 12
190. 13 19013	RHEUMATOLOGY	0	0	ol .	190. 13
190. 14 19014	ROCK STEADY BOXING	0	0	ol .	190. 14
190. 15 19015	OTHER ONCOLOGY SERVICES	O	0		190. 15
191. 00 19100	RESEARCH	0	0		191. 00
	PHYSICIANS' PRIVATE OFFICES	0	0		192. 00
192. 01 19201	MUNCIE MD OFFICES	0	0		192. 01
192. 02 19202	FOUNDATI ON	0	0		192. 02
192. 03 19203		0	0		192. 03
	HEALTHY HEART	0	0	1	192. 04
	VACANT SPACE	0	0	1	192. 05
	PARK PLACE CENTER	0	0	1	192. 07
	RENTAL PROPERTY	0	0	1	192. 08
	RESIDENTIAL PROPERTY (1430 N MADISON	0	0		192. 09
	1512 N MADI SON AVE	0	0		192. 10
200. 00	Cross Foot Adjustments				200. 00
201. 00	Negative Cost Centers		_		201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	36, 816	0		202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	23. 010000	0. 000000	•	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	417	0		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 260625	0. 000000		205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)		0		206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0. 000000		207. 00

| Period: | Worksheet C | From 01/01/2022 | Part | | Date/Time Prepared: | 5/25/2023 | 11:38 am

						5/25/2023 11:	38 am_
			Title	: XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	5551 5511tol. 25551. pt. 511	(from Wkst. B,	Adj.	1014. 00010	Di sal I owance	10141 00010	
		Part I, col.	riaj.		Di Sai i Gwance		
		26)					
			2.00	2.00	4.00	F 00	
	LABORT SAIT DOUTLAS OFFICE OF COST OFFITEDS	1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1		1			
30.00	03000 ADULTS & PEDI ATRI CS	40, 576, 633		40, 576, 63			30. 00
31. 00	03100 INTENSIVE CARE UNIT	10, 519, 186		10, 519, 18	6 0	10, 519, 186	31. 00
43.00	04300 NURSERY	2, 515, 914		2, 515, 91	4 0	2, 515, 914	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	21, 336, 480		21, 336, 48	0 0	21, 336, 480	50. 00
51.00	05100 RECOVERY ROOM	0			0 0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 685, 418		2, 685, 41			52. 00
53. 00	05300 ANESTHESI OLOGY	2,000,110			0 0		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 132, 895		4, 132, 89		l e	54. 00
54. 01	05401 ULTRASOUND	1, 202, 360		1, 202, 36			54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0			0		55. 00
56.00	05600 RADI 0I SOTOPE	983, 746		983, 74			56. 00
57. 00	05700 CT SCAN	2, 595, 773		2, 595, 77	3 0	2, 595, 773	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 404, 872		2, 404, 87	2 0	2, 404, 872	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 441, 217		2, 441, 21	7 0	2, 441, 217	59. 00
60.00	06000 LABORATORY	11, 650, 443		11, 650, 44			60.00
60. 01	06001 BLOOD LABORATORY	0			0 0		60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 048, 986		1, 048, 98			62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	1,040,700		1, 040, 70	0 0		63. 00
		0			-		
64.00	06400 NTRAVENOUS THERAPY	0			0		64. 00
65. 00	06500 RESPI RATORY THERAPY	4, 541, 330					65. 00
66.00	06600 PHYSI CAL THERAPY	6, 756, 080	0	-, ,		-, ,	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	806, 018	0	806, 01			67. 00
68. 00	06800 SPEECH PATHOLOGY	375, 807	0	375, 80	7 0	375, 807	68. 00
69. 00	06900 ELECTROCARDI OLOGY	3, 478, 159		3, 478, 15	9 0	3, 478, 159	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 628, 372		1, 628, 37	2 0	1, 628, 372	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 323, 324		8, 323, 32			71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	9, 852, 440		9, 852, 44			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	16, 767, 744		16, 767, 74			73. 00
74.00		404, 057		404, 05			74.00
74.00	07400 RENAL DI ALYSI S	404, 037		404, 03	7 0	404, 037	74.00
00.00	OUTPATIENT SERVICE COST CENTERS	1		I			00.00
90.00	09000 CLI NI C	0		l .	0 0	l e	90.00
90. 01	09001 WOUND/OSTOMY CLINIC	3, 050, 843		3, 050, 84			90. 01
90. 02	09002 CTR ADVANCED HEART CARE	308, 580		308, 58			90. 02
90. 03	09003 RADI ATI ON ONCOLOGY	5, 612, 751		5, 612, 75	1 0	5, 612, 751	90. 03
90.04	09004 MUNCIE CLINIC	0			0 0	0	90. 04
90.05	09005 ANTI COAGULATI ON CLINI C	601, 941		601, 94	1 0	601, 941	90. 05
90.06	09006 PREGNANCY PLUS	0			0 0		90. 06
90. 07	09007 0/P LAB	0			0 0		90. 07
90. 08	09008 0/P LAB	0			0 0		90. 08
		20 774		20.77	-	_	90.08
90. 09	09009 FORTVI LLE CLI NI C	39, 774		39, 77			
90. 10	09010 1030 S SCATTERFIELD (MEDCHECK)	0		l .	0		90. 10
90. 11	09011 DIABETIC PLUS CLINIC	638, 736		638, 73			90. 11
90. 12	09012 OTHER ONCOLOGY SERVICES	0			0		90. 12
91.00	09100 EMERGENCY	11, 948, 760		11, 948, 76	0 0	11, 948, 760	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 194, 618		4, 194, 61	8	4, 194, 618	92. 00
	OTHER REIMBURSABLE COST CENTERS						
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0			0 0	n	98. 00
200.00		183, 423, 257		l .		l e	
201.00		4, 194, 618		4, 194, 61		4, 194, 618	
202.00	1 1	179, 228, 639					
202.00	Total (see Histi detroils)	177,220,037	١	1 177, 220, 00	1	177, 220, 037	1202.00

Peri od: Worksheet C From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared: 5/25/2023 11:38 am

					5/25/2023 11:	<u>38 am</u>
		Title	: XVIII	Hospi tal	PPS	
		Charges		·		
Cost Center Description	Inpatient	Outpati ent	Total (col 6	Cost or Other	TEFRA	
oost denter bescription	Impatront	outputtent	+ col . 7)	Ratio	Inpatient	
			+ (01. 7)	Ratio	Ratio	
	4 00	7.00	0.00	9. 00		
LUBATIONT BOUTLING OFFICE OF CONT. OFFITEDO	6. 00	7. 00	8. 00	9.00	10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	69, 847, 431		69, 847, 431			30.00
31.00 03100 INTENSIVE CARE UNIT	16, 714, 115		16, 714, 115			31. 00
43. 00 04300 NURSERY	2, 878, 806		2, 878, 806			43.00
ANCILLARY SERVICE COST CENTERS						Ī
50. 00 05000 OPERATING ROOM	42, 127, 590	112, 204, 769	154, 332, 359	0. 138250	0.000000	50.00
51. 00 05100 RECOVERY ROOM	0	0	0	0. 000000	0.000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	4, 223, 099	0	4, 223, 099	0. 635888	0. 000000	
53. 00 05300 ANESTHESI OLOGY	4, 223, 077	0	4, 223, 077	0. 000000	0. 000000	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 367, 629	12, 004, 848	15 272 477	0. 268850	0. 000000	
54. 01 05401 ULTRASOUND	1, 548, 382	8, 783, 786	10, 332, 168	0. 116371	0. 000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0. 000000	0. 000000	
56. 00 05600 RADI 0I SOTOPE	476, 661	8, 628, 303	9, 104, 964	0. 108045	0.000000	56. 00
57. 00 05700 CT SCAN	11, 124, 272	41, 326, 535	52, 450, 807	0. 049490	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 208, 561	16, 238, 819	18, 447, 380	0. 130364	0.000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	10, 196, 311	15, 861, 484	26, 057, 795	0. 093685	0.000000	59. 00
60. 00 06000 LABORATORY	14, 057, 091	49, 362, 304	63, 419, 395	0. 183705	0.000000	60.00
60. 01 06001 BLOOD LABORATORY	11,007,071	17, 002, 001	00, 117, 070	0. 000000	0. 000000	60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 459, 902	659, 536	2, 119, 438	0. 494936	0. 000000	62.00
	1, 439, 902	009, 000	2, 119, 430			
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0. 000000	0. 000000	63. 00
64.00 06400 I NTRAVENOUS THERAPY	0	0	0	0. 000000	0. 000000	64. 00
65. 00 06500 RESPI RATORY THERAPY	12, 168, 761	3, 009, 571	15, 178, 332	0. 299198	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 198, 901	9, 043, 943		0. 659590	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	910, 645	1, 077, 426	1, 988, 071	0. 405427	0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	614, 003	314, 254	928, 257	0. 404852	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	4, 305, 272	12, 271, 432	16, 576, 704	0. 209822	0.000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 376, 155	3, 994, 194		0. 303215	0.000000	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 384, 846	13, 005, 168		0. 429258	0. 000000	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	7, 870, 724	14, 774, 573		0. 435077	0. 000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	25, 525, 606	34, 928, 112	60, 453, 718	0. 277365	0. 000000	
74. 00 07400 RENAL DI ALYSI S	985, 907	0	985, 907	0. 409833	0. 000000	74. 00
OUTPATIENT SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,					
90. 00 09000 CLI NI C	0	0		0. 000000	0.000000	
90. 01 09001 WOUND/OSTOMY CLINIC	390, 169	8, 158, 453	8, 548, 622	0. 356881	0.000000	90. 01
90. 02 09002 CTR ADVANCED HEART CARE	7, 122	501, 855	508, 977	0. 606275	0.000000	90. 02
90. 03 09003 RADIATION ONCOLOGY	1, 148, 827	56, 035, 234	57, 184, 061	0. 098152	0.000000	90. 03
90. 04 09004 MUNCIE CLINIC	ol	0	0	0.000000	0.000000	90. 04
90. 05 09005 ANTI COAGULATI ON CLINIC	1, 891	1, 220, 060	1, 221, 951	0. 492606	0. 000000	90. 05
90. 06 09006 PREGNANCY PLUS	1 ., 0, 1	., 220, 000	1,221,701	0. 000000	0. 000000	
90. 07 09007 0/P LAB		0	0	0. 000000	0. 000000	90. 07
	0	0	0			90.07
	0	0	0	0. 000000	0. 000000	
90. 09 09009 FORTVI LLE CLI NI C	0	0	0	0. 000000	0. 000000	90. 09
90. 10 09010 1030 S SCATTERFIELD (MEDCHECK)	0	0	0	0. 000000	0.000000	
90. 11 09011 DIABETIC PLUS CLINIC	468	259, 437	259, 905	2. 457575	0.000000	90. 11
90. 12 09012 OTHER ONCOLOGY SERVICES	0	0	0	0. 000000	0.000000	90. 12
91. 00 09100 EMERGENCY	23, 157, 834	79, 915, 449	103, 073, 283	0. 115925	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	787, 728	3, 582, 789		0. 959753	0.000000	
OTHER REIMBURSABLE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,	2,002,.07	., 0, 0, 017	2. 707.00	2. 000000	1
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	<u> </u>	0. 000000	0. 000000	98. 00
200.00 Subtotal (see instructions)	267, 064, 709	507, 162, 334	774, 227, 043	0.000000	0.000000	200. 00
	207,004,709	501, 102, 334	114, 221, 043			200.00
201.00 Less Observation Beds	0/7 0/4 700	FO7 1/2 224	774 007 040			
202.00 Total (see instructions)	267, 064, 709	507, 162, 334	774, 227, 043			202. 00

Heal th Financial Systems COMMUNITY HOSPITAL ANDERSON In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0113
Period: Worksheet C
From 01/01/2022 Part I
To 12/31/2022 Date/Time Prepared:

5/25/2023 11:38 am Title XVIII Hospi tal PPS PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 138250 50.00 51.00 05100 RECOVERY ROOM 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.635888 52.00 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 268850 54.00 05401 ULTRASOUND 54.01 0.116371 54 01 05500 RADI OLOGY-THERAPEUTI C 55.00 0.000000 55.00 56.00 05600 RADI OI SOTOPE 0. 108045 56.00 05700 CT SCAN 0.049490 57.00 57.00 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.130364 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.093685 59.00 06000 LABORATORY 0. 183705 60.00 60.00 06001 BLOOD LABORATORY 0.000000 60.01 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 494936 62.00 62 00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63.00 63.00 06400 I NTRAVENOUS THERAPY 64.00 0.000000 64.00 06500 RESPIRATORY THERAPY 0. 299198 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 0.659590 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.405427 67.00 06800 SPEECH PATHOLOGY 68.00 0. 404852 68.00 06900 ELECTROCARDI OLOGY 0. 209822 69 00 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.303215 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0. 429258 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.435077 07300 DRUGS CHARGED TO PATIENTS 73.00 0.277365 73.00 74.00 07400 RENAL DIALYSIS 0.409833 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 90.00 09001 WOUND/OSTOMY CLINIC 90.01 0. 356881 90.01 90.02 09002 CTR ADVANCED HEART CARE 0.606275 90.02 09003 RADIATION ONCOLOGY 90. 03 0.098152 90.03 90. 04 09004 MUNCIE CLINIC 0.000000 90.04 90.05 09005 ANTI COAGULATION CLINIC 0.492606 90.05 09006 PREGNANCY PLUS 0.000000 90.06 90.06 90.07 09007 0/P LAB 0.000000 90.07 09008 0/P LAB 90.08 0.000000 90.08 90.09 09009 FORTVILLE CLINIC 0.000000 90.09 90. 10 09010 1030 S SCATTERFIELD (MEDCHECK) 0.000000 90.10 09011 DIABETIC PLUS CLINIC 90 11 2 457575 90 11 90.12 09012 OTHER ONCOLOGY SERVICES 0.000000 90.12 91.00 09100 EMERGENCY 0. 115925 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 959753 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 98.00 200.00 Subtotal (see instructions) 200.00 Less Observation Beds 201. 00 201.00 202. 00 202.00 Total (see instructions)

Part I

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183, 477, 465 200. 00

179, 282, 847 202. 00

4, 194, 618 201. 00

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91 00

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638, 736

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183, 477, 465

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4, 194, 618

Date/Time Prepared: 12/31/2022 5/25/2023 11:38 am Title XIX Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 1.00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 40, 576, 633 40, 576, 633 40, 576, 633 10, 519, 186 03100 INTENSIVE CARE UNIT 10, 519, 186 10, 519, 186 0 31.00 31.00 43.00 04300 NURSERY 2, 515, 914 2, 515, 914 0 2, 515, 914 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 21, 390, 688 21, 390, 688 21, 390, 688 50.00 51.00 05100 RECOVERY ROOM 0 51.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 2, 685, 418 2, 685, 418 2, 685, 418 52.00 53 00 05300 ANESTHESI OLOGY Λ 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 132, 895 4, 132, 895 0 4, 132, 895 54.00 54.01 05401 ULTRASOUND 1, 202, 360 1, 202, 360 0 0 0 1, 202, 360 54.01 05500 RADI OLOGY-THERAPEUTI C 55.00 55.00 0 05600 RADI 0I SOTOPE 983, 746 983, 746 56,00 983, 746 56.00 57.00 05700 CT SCAN 2, 595, 773 2, 595, 773 2, 595, 773 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 2, 404, 872 58.00 2, 404, 872 2, 404, 872 0 0 0 58.00 05900 CARDIAC CATHETERIZATION 59 00 2 441 217 2 441 217 2 441 217 59 00 60.00 06000 LABORATORY 11, 650, 443 11, 650, 443 11, 650, 443 60.00 06001 BLOOD LABORATORY 60.01 60.01 C 0 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1,048,986 1, 048, 986 1, 048, 986 62.00 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63 00 0 0 0 63 00 0 64.00 06400 INTRAVENOUS THERAPY 0 0 0 64.00 06500 RESPIRATORY THERAPY 65.00 4, 541, 330 4, 541, 330 0 0 0 4, 541, 330 65.00 06600 PHYSI CAL THERAPY 6 756 080 Ω 6, 756, 080 6, 756, 080 66 00 66 00 06700 OCCUPATIONAL THERAPY 67.00 806, 018 806, 018 806, 018 67.00 06800 SPEECH PATHOLOGY 375, 807 375, 807 375, 807 68.00 68.00 06900 ELECTROCARDI OLOGY 69.00 3, 478, 159 3, 478, 159 0 3, 478, 159 69.00 07000 ELECTROENCEPHALOGRAPHY 70 00 1 628 372 1, 628, 372 1, 628, 372 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 8, 323, 324 8, 323, 324 8, 323, 324 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 9, 852, 440 0 9, 852, 440 72.00 9, 852, 440 72.00 0 16, 767, 744 73.00 07300 DRUGS CHARGED TO PATIENTS 16, 767, 744 16, 767, 744 73.00 07400 RENAL DIALYSIS 404, 057 <u>404, 0</u>57 74.00 404, 057 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 0 90.01 09001 WOUND/OSTOMY CLINIC 3, 050, 843 3, 050, 843 3, 050, 843 90.01 09002 CTR ADVANCED HEART CARE 90.02 308, 580 308, 580 308, 580 90 02 0 90.03 09003 RADIATION ONCOLOGY 5, 612, 751 5, 612, 751 5, 612, 751 90.03 90 04 09004 MUNCIE CLINIC 0 90 04 09005 ANTI COAGULATION CLINIC 601, 941 90.05 601.941 601, 941 90.05 09006 PREGNANCY PLUS 90.06 0 0 Λ 90.06 90.07 09007 0/P LAB 0 0 0 0 90.07 0 90.08 09008 0/P LAB 90.08 C Ω 09009 FORTVILLE CLINIC 90.09 39, 774 39, 774 39, 774 90.09

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90.12

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92.00

98.00

200.00

201.00

202.00

09010 1030 S SCATTERFIELD (MEDCHECK)

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Subtotal (see instructions)

09011 DIABETIC PLUS CLINIC

09100 EMERGENCY

09012 OTHER ONCOLOGY SERVICES

OTHER REIMBURSABLE COST CENTERS 09850 OTHER REIMBURSABLE COST CENTERS

Less Observation Beds

Total (see instructions)

							5/25/2023 11:	38 am
				Ti tl	e XIX	Hospi tal	PPS	
				Charges				
		Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
		·	·	·	+ col. 7)	Ratio	Inpati ent	
							Rati o	
			6.00	7.00	8. 00	9. 00	10.00	
	I NPAT	IENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	69, 847, 431		69, 847, 431			30. 00
31.00	03100	INTENSIVE CARE UNIT	16, 714, 115		16, 714, 115	i		31.00
43.00	04300	NURSERY	2, 878, 806		2, 878, 806	1		43.00
	ANCI L	LARY SERVICE COST CENTERS						
50.00		OPERATING ROOM	42, 127, 590	112, 204, 769	154, 332, 359	0. 138601	0.000000	50. 00
51. 00		RECOVERY ROOM	0	0	C	0.000000	0.000000	
52.00	05200	DELIVERY ROOM & LABOR ROOM	4, 223, 099	0	4, 223, 099	0. 635888	0.000000	52. 00
53.00	05300	ANESTHESI OLOGY	0	0	C	0.000000	0.000000	53. 00
54.00	05400	RADI OLOGY-DI AGNOSTI C	3, 367, 629	12, 004, 848	15, 372, 477	0. 268850	0.000000	54. 00
54. 01		ULTRASOUND	1, 548, 382	8, 783, 786	10, 332, 168		0.000000	
55. 00	05500	RADI OLOGY-THERAPEUTI C	0	0	C	0.000000	0.000000	
56.00		RADI OI SOTOPE	476, 661	8, 628, 303			0.000000	
57.00	05700	CT SCAN	11, 124, 272	41, 326, 535	52, 450, 807		0.000000	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2, 208, 561	16, 238, 819			0.000000	
59.00	05900	CARDI AC CATHETERI ZATI ON	10, 196, 311	15, 861, 484	26, 057, 795	0. 093685	0.000000	59. 00
60.00	06000	LABORATORY	14, 057, 091	49, 362, 304	63, 419, 395	0. 183705	0.000000	60.00
60. 01		BLOOD LABORATORY	0	0	C	0.000000	0.000000	
62.00		WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 459, 902	659, 536	2, 119, 438	0. 494936	0. 000000	62. 00
63.00		BLOOD STORING, PROCESSING & TRANS.	0	0	C	0.000000	0.000000	63. 00
64.00		INTRAVENOUS THERAPY	0	0	C		0.000000	64. 00
65.00	06500	RESPI RATORY THERAPY	12, 168, 761	3, 009, 571	15, 178, 332	0. 299198	0.000000	65. 00
66.00		PHYSI CAL THERAPY	1, 198, 901	9, 043, 943			0.000000	
67.00		OCCUPATI ONAL THERAPY	910, 645	1, 077, 426	1, 988, 071	0. 405427	0.000000	67. 00
68.00		SPEECH PATHOLOGY	614, 003	314, 254	928, 257	0. 404852	0.000000	68. 00
69. 00		ELECTROCARDI OLOGY	4, 305, 272	12, 271, 432	16, 576, 704	0. 209822	0.000000	
70.00	07000	ELECTROENCEPHALOGRAPHY	1, 376, 155	3, 994, 194	5, 370, 349	0. 303215	0.000000	70. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 384, 846	13, 005, 168	19, 390, 014	0. 429258	0.000000	71. 00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7, 870, 724	14, 774, 573			0.000000	
73.00	07300	DRUGS CHARGED TO PATIENTS	25, 525, 606	34, 928, 112	60, 453, 718	0. 277365	0.000000	73. 00
74.00	07400	RENAL DIALYSIS	985, 907	0	985, 907	0. 409833	0.000000	74. 00
	OUTPA	TIENT SERVICE COST CENTERS						
90.00		CLI NI C	0	0	C		0.000000	
90. 01		WOUND/OSTOMY CLINIC	390, 169	8, 158, 453			0.000000	
90. 02		CTR ADVANCED HEART CARE	7, 122	501, 855			0.000000	
90. 03		RADIATION ONCOLOGY	1, 148, 827	56, 035, 234	57, 184, 061	0. 098152	0.000000	
90. 04		MUNCIE CLINIC	0	0	C	0.000000	0.000000	
90. 05		ANTICOAGULATION CLINIC	1, 891	1, 220, 060	1, 221, 951		0.000000	
90. 06		PREGNANCY PLUS	0	0	C	0.000000	0.000000	
90. 07		O/P LAB	0	0	C		0.000000	
90. 08	09008	O/P LAB	0	0	C		0.000000	
90. 09	09009	FORTVILLE CLINIC	0	0	C		0.000000	
90. 10	09010	1030 S SCATTERFIELD (MEDCHECK)	0	0	C	0.000000	0.000000	90. 10
90. 11		DIABETIC PLUS CLINIC	468	259, 437	259, 905		0. 000000	
90. 12		OTHER ONCOLOGY SERVICES	0	0	[C	0. 000000	0. 000000	
91. 00		EMERGENCY	23, 157, 834	79, 915, 449			0. 000000	
92.00		OBSERVATION BEDS (NON-DISTINCT PART)	787, 728	3, 582, 789	4, 370, 517	0. 959753	0. 000000	92. 00
		REIMBURSABLE COST CENTERS						
98. 00		OTHER REIMBURSABLE COST CENTERS	0	0			0.000000	1
200.00		Subtotal (see instructions)	267, 064, 709	507, 162, 334	774, 227, 043			200. 00
201.00		Less Observation Beds						201. 00
202.00)	Total (see instructions)	267, 064, 709	507, 162, 334	774, 227, 043			202. 00

Heal th Financial Systems COMMUNITY HOSPITAL ANDERSON In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0113
Period: Worksheet C
From 01/01/2022 Part I
To 12/31/2022 Date/Time Prepared:

5/25/2023 11:38 am Title XIX Hospi tal PPS PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0. 138601 51.00 05100 RECOVERY ROOM 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.635888 52.00 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 268850 54.00 05401 ULTRASOUND 54.01 0.116371 54 01 05500 RADI OLOGY-THERAPEUTI C 55.00 0.000000 55.00 56.00 05600 RADI OI SOTOPE 0. 108045 56.00 05700 CT SCAN 0.049490 57.00 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.130364 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.093685 59.00 06000 LABORATORY 0. 183705 60.00 60.00 06001 BLOOD LABORATORY 0.000000 60.01 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 494936 62.00 62 00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63.00 63.00 06400 I NTRAVENOUS THERAPY 64.00 0.000000 64.00 06500 RESPIRATORY THERAPY 0. 299198 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 0.659590 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.405427 67.00 06800 SPEECH PATHOLOGY 68.00 0. 404852 68.00 06900 ELECTROCARDI OLOGY 0. 209822 69 00 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.303215 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0. 429258 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.435077 07300 DRUGS CHARGED TO PATIENTS 73.00 0.277365 73.00 74.00 07400 RENAL DIALYSIS 0.409833 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 90.00 09001 WOUND/OSTOMY CLINIC 90.01 0. 356881 90.01 90.02 09002 CTR ADVANCED HEART CARE 0.606275 90.02 09003 RADIATION ONCOLOGY 90. 03 0.098152 90.03 90. 04 09004 MUNCIE CLINIC 0.000000 90.04 90.05 09005 ANTI COAGULATION CLINIC 0.492606 90.05 09006 PREGNANCY PLUS 0.000000 90.06 90.06 90.07 09007 0/P LAB 0.000000 90.07 09008 0/P LAB 90.08 0.000000 90.08 90.09 09009 FORTVILLE CLINIC 0.000000 90.09 90. 10 09010 1030 S SCATTERFIELD (MEDCHECK) 0.000000 90.10 09011 DIABETIC PLUS CLINIC 90 11 2 457575 90 11 90.12 09012 OTHER ONCOLOGY SERVICES 0.000000 90.12 91.00 09100 EMERGENCY 0. 115925 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 959753 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 98.00 200.00 Subtotal (see instructions) 200.00 Less Observation Beds 201. 00 201.00 202. 00 202.00 Total (see instructions)

Heal th Financial Systems COMMUNITY HO CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY

						5/25/2023 11:	38 am_
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
	·	(Wkst. B, Part	(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						
50.00	05000 OPERATING ROOM	21, 390, 688	2, 356, 800	19, 033, 888	0	0	50.00
51. 00	05100 RECOVERY ROOM	0	_,,,	1			51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 685, 418	147, 495				52.00
53. 00	05300 ANESTHESI OLOGY	2,000,110	117, 170	2,007,720	0	_	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 132, 895	455, 190	3, 677, 705	_	_	54. 00
54. 01	05401 ULTRASOUND	1, 202, 360			_	_	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 202, 300	37, 344	1, 103, 010	0		55.00
56. 00	05600 RADI OLOGY-THERAPEUTI C	002 744	142 752	840, 993	_	_	56.00
		983, 746					
57. 00	05700 CT SCAN	2, 595, 773					57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 404, 872	1			_	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 441, 217	1			_	59. 00
60.00	06000 LABORATORY	11, 650, 443	1	1			60.00
60. 01	06001 BLOOD LABORATORY	0	0	1	_	_	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 048, 986	37, 344	1		_	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	_		63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	4, 541, 330	139, 123	4, 402, 207	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	6, 756, 080	1, 193, 367	5, 562, 713	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	806, 018	34, 677	771, 341	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	375, 807	16, 174	359, 633	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	3, 478, 159	432, 403	3, 045, 756	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 628, 372				0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 323, 324	1				71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	9, 852, 440					72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	16, 767, 744	1			_	73.00
74. 00	07400 RENAL DIALYSIS	404, 057	4, 782			_	74. 00
74.00	OUTPATIENT SERVICE COST CENTERS	404,037	4, 702	. 377, 213	0	0	74.00
90. 00	09000 CLINIC	1	0	0	0	0	90.00
90. 00	09001 WOUND/OSTOMY CLINIC	3, 050, 843	1		_	_	90.00
90. 01	09002 CTR ADVANCED HEART CARE	308, 580	1		0	l .	90.01
90. 02	09002 CTR ADVANCED HEART CARE	1			_	_	1
	i i	5, 612, 751	638, 632	1		_	90. 03
90. 04	09004 MUNCI E CLINI C	(04.044	0 001	0	_	_	90. 04
90. 05	09005 ANTI COAGULATI ON CLI NI C	601, 941	8, 836	1		_	90.05
90.06	09006 PREGNANCY PLUS	0	0	0			90.06
90. 07	09007 0/P LAB	0	0	0	0	_	90. 07
90. 08	09008 0/P LAB	0	0	0			90. 08
90. 09	09009 FORTVILLE CLINIC	39, 774	32, 097	7, 677			90. 09
90. 10	09010 1030 S SCATTERFIELD (MEDCHECK)	0	0	0	0	_	90. 10
90. 11	09011 DI ABETI C PLUS CLINIC	638, 736	11, 859	626, 877	0	0	90. 11
90. 12	09012 OTHER ONCOLOGY SERVICES	0	0	1	_		90. 12
91. 00	09100 EMERGENCY	11, 948, 760					91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 194, 618		4, 041, 745	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
200.00	Subtotal (sum of lines 50 thru 199)	129, 865, 732	9, 431, 697	120, 434, 035	0		200. 00
201.00	1 1 7	4, 194, 618				0	201. 00
202.00	1 1	125, 671, 114	1				202. 00
50	1 1				'	,	

Peri od: Worksheet C From 01/01/2022 Part II To 12/31/2022 Date/Time Prepared: 5/25/2023 11: 38 am REDUCTIONS FOR MEDICALD ONLY

Cost Center Description Cost Net of Capital and Charges Outpatient Capital and Cost Net of Cost to Charge Operating Cost Part I, column Ratio (col. 6	PPS
Capital and (Worksheet C, Cost to Charge	
Operating Cost Part I, column Ratio (col. 6	
Reduction 8) / col. 7)	
6.00 7.00 8.00	
ANCI LLARY SERVI CE COST CENTERS	
50. 00 05000 OPERATI NG ROOM 21, 390, 688 154, 332, 359 0. 138601	50.00
51. 00 05100 RECOVERY ROOM 0 0. 000000	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 2, 685, 418 4, 223, 099 0. 635888	52.00
53. 00 05300 ANESTHESI OLOGY 0 0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 4, 132, 895 15, 372, 477 0. 268850	54.00
54. 01 05401 ULTRASOUND	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0.000000	55. 00
56. 00 05600 RADI OI SOTOPE 983, 746 9, 104, 964 0. 108045	56.00
57. 00 05700 CT SCAN 2, 595, 773 52, 450, 807 0. 049490	57. 00
	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 2, 441, 217 26, 057, 795 0. 093685	59.00
60. 00 06000 LABORATORY	60.00
60. 01 06001 BLOOD LABORATORY 0 0. 000000	60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1, 048, 986 2, 119, 438 0. 494936	62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0. 000000	63. 00
64. 00 06400 I NTRAVENOUS THERAPY 0 0. 000000	64. 00
65. 00 06500 RESPI RATORY THERAPY 4, 541, 330 15, 178, 332 0. 299198	65.00
66. 00 06600 PHYSI CAL THERAPY 6, 756, 080 10, 242, 844 0. 659590	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 806, 018 1, 988, 071 0. 405427	67.00
68. 00 06800 SPEECH PATHOLOGY 375, 807 928, 257 0. 404852	68.00
69. 00 06900 ELECTROCARDI OLOGY 3, 478, 159 16, 576, 704 0. 209822	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 1, 628, 372 5, 370, 349 0. 303215	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 8, 323, 324 19, 390, 014 0. 429258	71. 00
72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 9, 852, 440 22, 645, 297 0. 435077	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 16, 767, 744 60, 453, 718 0. 277365	73. 00
74. 00 07400 RENAL DI ALYSI S 404, 057 985, 907 0. 409833	74.00
OUTPATIENT SERVICE COST CENTERS	74.00
90. 00 09000 CLI NI C 0 0 0. 000000	90.00
90. 01 09001 WOUND/OSTOMY CLINIC 3, 050, 843 8, 548, 622 0. 356881	90.00
	90.01
90. 03 09003 RADI ATI ON ONCOLOGY 5, 612, 751 57, 184, 061 0. 098152	90. 03
90. 04 09004 MUNCI E CLINI C	90. 04
90. 05 09005 ANTI COAGULATI ON CLINIC 601, 941 1, 221, 951 0. 492606	90. 05
90. 06 09006 PREGNANCY PLUS 0 0 0. 000000	90.06
90. 07 09007 0/P LAB 0 0 0. 000000	90. 07
90. 08 09008 0/P LAB 0 0 0. 000000	90. 08
90. 09 09009 FORTVI LLE CLINI C 39, 774 0 0. 000000	90. 09
90. 10 09010 1030 S SCATTERFIELD (MEDCHECK) 0 0. 000000	90. 10
90. 11 09011 DI ABETI C PLUS CLI NI C 638, 736 259, 905 2. 457575	90. 11
90. 12 09012 OTHER ONCOLOGY SERVICES 0 0 0. 000000	90. 12
91. 00 09100 EMERGENCY 11, 948, 760 103, 073, 283 0. 115925	91.00
92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 4, 194, 618 4, 370, 517 0. 959753	92.00
OTHER REIMBURSABLE COST CENTERS	
98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0.000000	98. 00
200.00 Subtotal (sum of lines 50 thru 199) 129,865,732 684,786,691	200.00
201. 00 Less Observation Beds 4, 194, 618 0	201. 00
202. 00 Total (line 200 minus line 201) 125, 671, 114 684, 786, 691	202.00
202.00 1004. (1110-200 million 1110-201) 120,071,114 004,700,071	1202.00

Health Financial Systems	COMMUNITY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10	
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Peri od:	Worksheet D		
				From 01/01/2022		narad.	
				To 12/31/2022	Date/Time Prepa 5/25/2023 11:38		
		Title	XVIII	Hospi tal	PPS		
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.		
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)		
	(from Wkst. B,		Related Cost		ĺ		
	Part II, col.		(col . 1 - col				
	26)		2)				
	1.00	2. 00	3.00	4. 00	5. 00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDIATRICS	1, 478, 805	0	1, 478, 80	5 22, 578	65. 50	30. 00	
31.00 INTENSIVE CARE UNIT	490, 673		490, 67	3, 475	141. 20	31.00	
43. 00 NURSERY	201, 329		201, 32	9 1, 193	168. 76	43.00	
200.00 Total (lines 30 through 199)	2, 170, 807		2, 170, 80	7 27, 246		200.00	
Cost Center Description	I npati ent	I npati ent					
	Program days	Program					
		Capital Cost					
		(col. 5 x col.					
		6)					
	6.00	7. 00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDIATRICS	5, 599	366, 735				30. 00	
31.00 INTENSIVE CARE UNIT	897	126, 656				31. 00	
43. 00 NURSERY	0	0				43. 00	
200.00 Total (lines 30 through 199)	6, 496	493, 391				200. 00	

Health Financial Systems	COMMUNITY HOSPITAL	L ANDERSON		In Lieu of Form CMS-2552-10
ADDODELONMENT OF LADATIENT	ANGLI LADV CEDVICE CADITAL COCTO	D: -I CON 1E 0112	D!I	Wasaliala a A. D

	COMMUNITY HUSP	I IAL ANDERSON		III LI E	u or Form CW3-2	2332-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider Co		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part II Date/Time Pre 5/25/2023 11:	pared:
		Ti tl e	: XVIII	Hospi tal	PPS	00 4111
Cost Center Description	Capi tal	Total Charges			Capital Costs	
oust deliter bescription	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col		column 4)	
	Part II, col.		7	. Charges	Corumii 4)	
	·	8)	2)			
	26)	2.00	2.00	4.00	F 00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3. 00	4. 00	5. 00	
50. 00 05000 OPERATING ROOM	2, 356, 800	154, 332, 359	0. 01527	1 12, 415, 732	189, 601	50.00
51. 00 05100 RECOVERY ROOM	2, 330, 800	154, 332, 357	0.00000		189,001	51.00
	1 47 405	4 000 000				
52. 00 05200 DELI VERY ROOM & LABOR ROOM	147, 495	4, 223, 099			0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0. 00000		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	455, 190					54. 00
54. 01 05401 ULTRASOUND	39, 344	10, 332, 168			1, 661	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.00000	0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	142, 753	9, 104, 964	0. 01567	9 168, 770	2, 646	56. 00
57. 00 05700 CT SCAN	135, 103	52, 450, 807	0. 00257	6 3, 200, 661	8, 245	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	536, 260				15, 666	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	323, 130					
60. 00 06000 LABORATORY	621, 318					
60. 01 06001 BLOOD LABORATORY	021, 310	03, 417, 373	0. 00000		0	60. 01
		2 110 120				
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	37, 344	2, 119, 438			6, 095	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 00000		01	63. 00
64.00 06400 I NTRAVENOUS THERAPY	0	0	0. 00000		0	64. 00
65. 00 06500 RESPI RATORY THERAPY	139, 123					65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 193, 367	10, 242, 844	0. 11650	7 453, 225	52, 804	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	34, 677	1, 988, 071	0. 01744	317, 364	5, 536	67. 00
68. 00 06800 SPEECH PATHOLOGY	16, 174	928, 257	0. 01742	4 187, 183	3, 261	68. 00
69. 00 06900 ELECTROCARDI OLOGY	432, 403	16, 576, 704	0. 02608	5 1, 370, 002	35, 737	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	159, 391	5, 370, 349	•			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	197, 249					
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	233, 478					
73. 00 07300 DRUGS CHARGED TO PATIENTS	816, 391	60, 453, 718				
74. 00 07400 RENAL DIALYSIS	4, 782					1
OUTPATIENT SERVICE COST CENTERS	4, 702	900, 907	0.00463	0 270, 040	1, 332	74.00
90. 00 09000 CLINIC	0		0.00000		0	90.00
90. 01 09001 WOUND/OSTOMY CLINIC	133, 625				2, 542	90.00
90. 02 09002 CTR ADVANCED HEART CARE	1				2, 542	90.01
	5, 733	· ·			-	
90. 03 09003 RADI ATI ON ONCOLOGY	638, 632	57, 184, 061	0. 01116		3, 867	
90. 04 09004 MUNCI E CLINI C	0	0	0.00000		0	90. 04
90. 05 09005 ANTI COAGULATI ON CLINI C	8, 836	1, 221, 951	0. 00723			90. 05
90. 06 09006 PREGNANCY PLUS	0	0	0. 00000		0	90. 06
90. 07 09007 0/P LAB	0	0	0.00000	0	0	90. 07
90. 08 09008 0/P LAB	0	0	0.00000	0	0	90. 08
90. 09 09009 FORTVILLE CLINIC	32, 097	0	0. 00000	0 0	0	90. 09
90. 10 09010 1030 S SCATTERFIELD (MEDCHECK)	0	l o	0. 00000	0	0	90. 10
90. 11 09011 DI ABETI C PLUS CLINI C	11, 859	259, 905			0	90. 11
90. 12 09012 OTHER ONCOLOGY SERVICES	11,037	207,700	0. 00000		0	90. 12
91. 00 09100 EMERGENCY	426, 270	103, 073, 283			-	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	152, 873					
OTHER REIMBURSABLE COST CENTERS	152,873	4,370,517	0.03497	o _l 350, 360	12, 255	92.00
	0		0.00000		0	00 00
		1	0.00000			
200.00 Total (lines 50 through 199)	9, 431, 697	684, 786, 691	I	50, 123, 552	651, 340	J200. 00

Health Financial Systems	COMMUNITY HOSPI	COMMUNITY HOSPITAL ANDERSON In Lieu of F				
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST	!		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part III Date/Time Pre 5/25/2023 11:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Post-Stepdown Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0 0	0 0 0 0	(0 0 0	0 0 0 0	30. 00 31. 00 43. 00 200. 00
Cost Center Description		Total Costs (sum of cols. 1 through 3, minus col. 4)	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5.00	6. 00	7. 00	8. 00	
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 NTENSIVE CARE UNIT 43.00 04300 NURSERY 200.00 Total (Lines 30 through 199)	0	0 0 0	22, 578 3, 479 1, 193 27, 246	0. 00 0. 00	5, 599 897 0 6, 496	30. 00 31. 00 43. 00 200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	Ü	27,210	-1	3, 170	233. 30
30.00 03000 ADULTS & PEDIATRICS 03100 O1000 O1000	0 0 0 0					30. 00 31. 00 43. 00 200. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet D
From 01/01/2022	Part IV
To 12/31/2022	Date/Time Prepared:
5/25/2023	11:38 am THROUGH COSTS

						'		5/25/2023 11:	38 am
				Title	XVIII		Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi	ng	Nursi ng		Allied Health	Allied Health	
		Anestheti st	Progra	am	Program		Post-Stepdown		
		Cost	Post-Ste	down			Adjustments		
			Adjustme	ents			· ·		
		1. 00	2A		2. 00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0		0		0	0	0	50.00
51.00	05100 RECOVERY ROOM	0		0		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0		0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0		0		0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		0		0	0	0	54.00
54. 01	05401 ULTRASOUND	0		0		0	0	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0		o		0	0	0	55. 00
56.00	05600 RADI OI SOTOPE	0		0		0	0	0	56. 00
57.00	05700 CT SCAN	0		o		0	0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		o		0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0		o		0	0	0	59. 00
60.00	06000 LABORATORY	0		o		0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0		o		0	0	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		o		0	0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		o		0	0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0		o		0	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0		o		0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0		o		0	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0		o		0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0		o		0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		o		0	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		o		0	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		o		0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		o		0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		o		0	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0		o		0	0	0	74. 00
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLI NI C	0		0		0	0	0	90.00
90. 01	09001 WOUND/OSTOMY CLINIC	0		o		0	0	0	90. 01
90. 02	09002 CTR ADVANCED HEART CARE	0		o		0	0	0	90. 02
90. 03	09003 RADIATION ONCOLOGY	0		o		0	0	0	90. 03
90.04	09004 MUNCIE CLINIC	0		o		0	0	0	90. 04
90. 05	09005 ANTICOAGULATION CLINIC	0		o		0	0	0	90. 05
90.06	09006 PREGNANCY PLUS	0		o		0	0	0	90. 06
90. 07	09007 0/P LAB	0		o		0	0	0	90. 07
90. 08	09008 0/P LAB	0		o		0	0	0	90. 08
90. 09	09009 FORTVILLE CLINIC	0		o		0	0	0	90. 09
90. 10	09010 1030 S SCATTERFIELD (MEDCHECK)	0		o		0	0	0	90. 10
90. 11	09011 DI ABETI C PLUS CLINIC	0		o		0	0	0	90. 11
90. 12	09012 OTHER ONCOLOGY SERVICES	0		o		0	0	0	90. 12
91.00	09100 EMERGENCY	0		o		0	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0		0	92.00
	OTHER REIMBURSABLE COST CENTERS	,							
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0		0		0	0	0	98. 00
200.00	Total (lines 50 through 199)	0		0		0	0	0	200. 00

| Peri od: | Worksheet D | From 01/01/2022 | Part IV | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | To 12/31/ Provider CCN: 15-0113 THROUGH COSTS

				0 12/31/2022	5/25/2023 11:3	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS		_	Γ .	154 000 050		
50. 00 05000 OPERATI NG ROOM	0	0	C		0. 000000	50.00
51. 00 05100 RECOVERY ROOM	0	1	C	_	0. 000000	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	C	4, 223, 099		52.00
53. 00 05300 ANESTHESI OLOGY	0	0		15 272 477	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	C		0.000000	54.00
54. 01 05401 ULTRASOUND	0	0	C	10, 332, 168		54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 104 044	0.000000	55. 00
56. 00 05600 RADI 0I SOTOPE 57. 00 05700 CT SCAN		0	_	7, 101, 701	0.000000	56. 00 57. 00
		0		,,	0. 000000 0. 000000	
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 59. 00 05900 CARDIAC CATHETERIZATION		0			0. 000000	58. 00 59. 00
60. 00 06000 LABORATORY		0			0. 000000	60.00
60. 00 06000 LABORATORY	0	0		,,	0. 000000	60. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0		ή		62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0		2, 119, 430	0.000000	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0			0.000000	64. 00
65. 00 06500 RESPIRATORY THERAPY	0	0		<u> </u>	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY		0			0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0			0. 000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0			0. 000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	ď	1	0. 000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	ď		0. 000000	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	d		0. 000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	d		0. 000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C		0. 000000	73. 00
74.00 07400 RENAL DIALYSIS	0	0	d		0. 000000	74. 00
OUTPATIENT SERVICE COST CENTERS		•				
90. 00 09000 CLI NI C	0	0	C	0	0.000000	90. 00
90.01 09001 WOUND/OSTOMY CLINIC	0	0	C	8, 548, 622	0.000000	90. 01
90.02 09002 CTR ADVANCED HEART CARE	0	0	C	508, 977	0.000000	90. 02
90. 03 09003 RADIATION ONCOLOGY	0	0	C	57, 184, 061	0.000000	90. 03
90. 04 09004 MUNCIE CLINIC	0	0	C	0	0.000000	90. 04
90. 05 09005 ANTI COAGULATI ON CLINIC	0	0	C	1, 221, 951	0.000000	90. 05
90. 06 09006 PREGNANCY PLUS	0	0	C	0	0.000000	90. 06
90. 07 09007 0/P LAB	0	0	C	0	0.000000	90. 07
90. 08 09008 0/P LAB	0	0	C	0	0.000000	90. 08
90. 09 09009 FORTVILLE CLINIC	0	0	C	0	0.000000	90. 09
90. 10 09010 1030 S SCATTERFIELD (MEDCHECK)	0	0	C	,	0. 000000	90. 10
90. 11 09011 DIABETIC PLUS CLINIC	0	0	C	259, 905	0. 000000	90. 11
90. 12 09012 OTHER ONCOLOGY SERVICES	0	0	C	, I	0. 000000	90. 12
91. 00 09100 EMERGENCY	0	0	C		0. 000000	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	C	4, 370, 517	0.000000	92. 00
OTHER REIMBURSABLE COST CENTERS					0	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	l e			0. 000000	98. 00
200.00 Total (lines 50 through 199)	0	0	C	684, 786, 691		200. 00

Health Financial Systems	COMMUNITY HOSPITA	L ANDERSON	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0113	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2022	Part IV

12/31/2022 Date/Time Prepared: 5/25/2023 11:38 am Title XVIII Hospi tal **PPS** Outpati ent Cost Center Description Outpati ent Inpatient I npati ent Outpati ent Program Ratio of Cost Program Program Program Pass-Through Pass-Through to Charges Charges Charges Costs (col. (col. 6 ÷ col Costs (col. x col. 12) 13.00 x col. 10) 7) 11. 00 9.00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 12, 415, 732 21, 261, 893 50.00 0 0 51.00 05100 RECOVERY ROOM 0.000000 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 52.00 0 52.00 05300 ANESTHESI OLOGY 0.000000 0 0 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 1, 902, 068 54.00 0.000000 1,013,110 54.00 0 54.01 05401 ULTRASOUND 0.000000 436, 088 0 1, 796, 217 0 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 05600 RADI OI SOTOPE 0.000000 168, 770 0 2. 020. 142 56 00 0 56 00 0 57.00 05700 CT SCAN 0.000000 3, 200, 661 9, 052, 908 0 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 538, 911 3, 667, 976 0 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 0.000000 2, 373, 968 3, 859, 266 0 59.00 06000 LABORATORY 3, 947, 008 0 0.000000 3, 219, 919 60 00 60 00 0 60.01 06001 BLOOD LABORATORY 0.000000 0 0 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 0.000000 345, 909 357, 961 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63 00 0.000000 0 63 00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 64.00 06500 RESPIRATORY THERAPY 0.000000 3, 183, 663 482, 704 0 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 0.000000 453, 225 12, 861 0 66.00 06700 OCCUPATIONAL THERAPY 0 67 00 0.000000 317, 364 9, 518 67 00 0 06800 SPEECH PATHOLOGY 0 68.00 0.000000 187, 183 1,692 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 1, 370, 002 2, 825, 183 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 376, 794 0 499, 924 0 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 1,878,670 2, 470, 808 71 00 71 00 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 2, 859, 153 2, 831, 381 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 6, 985, 406 0 9, 623, 534 0 73.00 73.00 07400 RENAL DIALYSIS 0 74.00 0.000000 278, 840 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 90.00 09001 WOUND/OSTOMY CLINIC 0 3, 259, 091 90.01 90.01 0.000000 162, 597 0 90.02 09002 CTR ADVANCED HEART CARE 0.000000 0 143.303 90.02 0 0 09003 RADIATION ONCOLOGY 90 03 90.03 0.000000 346, 261 14, 533, 230 Ω 09004 MUNCIE CLINIC 0.000000 90.04 90.04 09005 ANTI COAGULATION CLINIC 398, 242 90.05 0.000000 0 90.05 09006 PREGNANCY PLUS 0 90.06 90.06 0.000000 C 0 0 09007 0/P LAB 90.07 0.000000 0 0 0 90.07 90.08 09008 0/P LAB 0.000000 0 0 90.08 90.09 09009 FORTVILLE CLINIC 0.000000 0 90.09 0 90. 10 90.10 09010 1030 S SCATTERFIELD (MEDCHECK) 0.000000 0 Λ 90.11 09011 DIABETIC PLUS CLINIC 0.000000 0 330 0 90.11 90. 12 09012 OTHER ONCOLOGY SERVICES 0.000000 0 90.12 09100 EMERGENCY 0 91.00 6, 933, 877 91.00 0.000000 11, 143, 243 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 0.000000 350, 360 319, 084 0 92.00 OTHER REIMBURSABLE COST CENTERS 98 00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 0 0 98.00 0 95, 692, 478 Total (lines 50 through 199) 50, 123, 552 0 200.00 200.00

APPORT	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2022 Fo 12/31/2022		pared:
					12/01/2022	5/25/2023 11:	38 am
			Titl∈	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
		1.00	2.00	(see inst.)	(see inst.)	F 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2. 00	3.00	4. 00	5. 00	
50. 00	05000 OPERATING ROOM	0. 138250	21, 261, 893	:	0	2, 939, 457	50.00
51. 00	05100 RECOVERY ROOM	0. 000000			o o		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 635888	1	1		1	52. 00
53. 00	05300 ANESTHESI OLOGY	0. 000000	I		0	Ō	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 268850	•	3	0		54. 00
54. 01	05401 ULTRASOUND	0. 116371	1, 796, 217			209, 028	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000				0	55. 00
56. 00	05600 RADI OI SOTOPE	0. 108045			0	218, 266	1
57. 00	05700 CT SCAN	0. 049490		1	0	448, 028	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 130364	1	1	0	478, 172	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 093685	3, 859, 266		0	361, 555	59. 00
60.00	06000 LABORATORY	0. 183705	3, 219, 919	1, 31	6 0	591, 515	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000			0	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 494936	357, 961		0	177, 168	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 299198	482, 704	. (0	144, 424	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 659590	12, 861		0	8, 483	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 405427	9, 518	3	0	3, 859	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 404852		1	0	685	1
69. 00	06900 ELECTROCARDI OLOGY	0. 209822		1			1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 303215	•		-	151, 584	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 429258				1, 060, 614	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 435077			-	1, 231, 869	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS	0. 277365				2, 669, 232	1
74.00	07400 RENAL DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS	0. 409833	0	'	<u> </u>	0	74.00
90. 00	09000 CLINIC	0. 000000			0 0	0	90.00
90. 01	09001 WOUND/OSTOMY CLINIC	0. 356881	•				1
90. 02	09002 CTR ADVANCED HEART CARE	0. 606275				,	90. 02
90. 03	09003 RADI ATI ON ONCOLOGY	0. 098152	1				90. 03
90. 04	09004 MUNCIE CLINIC	0. 000000			0	0	90. 04
90. 05	09005 ANTI COAGULATI ON CLINIC	0. 492606	1	2	0	196, 176	1
90.06	09006 PREGNANCY PLUS	0. 000000	1	1	0	0	90. 06
90. 07	09007 0/P LAB	0. 000000	0		0	0	90. 07
90.08	09008 0/P LAB	0. 000000	0		0	0	90. 08
90.09	09009 FORTVILLE CLINIC	0. 000000	0		0	0	90. 09
90. 10	09010 1030 S SCATTERFIELD (MEDCHECK)	0. 000000	0)	0	0	90. 10
90. 11	09011 DI ABETI C PLUS CLINI C	2. 457575	330)	0	811	90. 11
	09012 OTHER ONCOLOGY SERVICES	0. 000000			0	l e	1
91. 00	09100 EMERGENCY	0. 115925			0		1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 959753	319, 084		0	306, 242	92.00
00.00	OTHER REIMBURSABLE COST CENTERS	0.000000			J -		00.00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	•		0	•	
200.00	, ,		95, 692, 478	4, 74!			1
201.00	Less PBP Clinic Lab. Services-Program Only Charges			1	0		201. 00
202.00			95, 692, 478	4, 74!	5 0	16, 269, 560	202 00
202.00	1 5 355 (1.1 200 11110 201)	1	, 5, 5, 2, 170	1 1,77	-,	1 .5,257,500	1-02.00

Health Financial Systems COMMUNITY HOSP APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST In Lieu of Form CMS-2552-10 COMMUNITY HOSPITAL ANDERSON Provider CCN: 15-0113

Peri od: Worksheet D
From 01/01/2022 Part V
To 12/31/2022 Date/Time Prepared: 5/25/2023 11: 38 am

			Ti +Lo	XVIII	Hospi tal	PPS	30 aiii
				- AVIII	Hospi tal	PP3	
			sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coi ns.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7.00				
	ICI LLARY SERVI CE COST CENTERS						
50.00 05	5000 OPERATING ROOM	0	0				50.00
51.00 05	5100 RECOVERY ROOM	0	0				51.00
	5200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
	3300 ANESTHESI OLOGY						53.00
	6400 RADI OLOGY-DI AGNOSTI C						54. 00
			-				
	0401 ULTRASOUND		0				54. 01
	5500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
56. 00 05	6600 RADI OI SOTOPE	0	0				56. 00
57.00 05	5700 CT SCAN	0	0				57. 00
58. 00 05	5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58. 00
	5900 CARDI AC CATHETERI ZATI ON		l .	•			59.00
	5000 LABORATORY	242					60.00
	5001 BLOOD LABORATORY	242	ł				
1		_					60. 01
	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1				62. 00
	300 BLOOD STORING, PROCESSING & TRANS.	0	0				63. 00
64. 00 06	400 INTRAVENOUS THERAPY	0	0				64.00
65.00 06	500 RESPI RATORY THERAPY	0	0				65. 00
66. 00 06	6600 PHYSI CAL THERAPY		0				66. 00
	700 OCCUPATI ONAL THERAPY		o				67.00
	8800 SPEECH PATHOLOGY		o o	1			68. 00
	900 ELECTROCARDI OLOGY		1				69. 00
			l .				
	000 ELECTROENCEPHALOGRAPHY	0	0				70. 00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 472	1				71. 00
	200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73.00 07	7300 DRUGS CHARGED TO PATIENTS	0	0				73. 00
	400 RENAL DIALYSIS	0	0				74. 00
	ITPATIENT SERVICE COST CENTERS						1
	2000 CLINIC	0	0				90.00
	2001 WOUND/OSTOMY CLINIC						90. 01
1	2002 CTR ADVANCED HEART CARE		1				90. 02
			1				
	2003 RADIATION ONCOLOGY		0				90. 03
	POO4 MUNCIE CLINIC	0	0				90. 04
90. 05 09	0005 ANTICOAGULATION CLINIC	0	0				90. 05
	POO6 PREGNANCY PLUS	0	0				90.06
90. 07 09	0007 0/P LAB	0	0				90. 07
	0008 0/P LAB		o o				90. 08
	2009 FORTVILLE CLINIC						90. 09
							90. 10
	2010 1030 S SCATTERFIELD (MEDCHECK)	0	1				
	PO11 DIABETIC PLUS CLINIC	0	0				90. 11
	012 OTHER ONCOLOGY SERVICES	0	0				90. 12
	2100 EMERGENCY	0	0				91. 00
92. 00 09	200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92. 00
	THER REIMBURSABLE COST CENTERS	•					1
	2850 OTHER REIMBURSABLE COST CENTERS	0	0				98. 00
200.00	Subtotal (see instructions)	1, 714	1				200. 00
201.00	Less PBP Clinic Lab. Services-Program	1,714	J				201. 00
201.00	Only Charges		Ί				201.00
202 20	, ,	1 744					202 00
202. 00	Net Charges (line 200 - line 201)	1, 714	. 0	I			202. 00

Health Financial Systems	COMMUNITY HOSPI	TAL ANDERSON		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2022 To 12/31/2022		narod:
				10 12/31/2022	5/25/2023 11:	38 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 478, 805		1 1, 1, 0, 00			
31.00 INTENSIVE CARE UNIT	490, 673	l e	490, 67	•		
43. 00 NURSERY	201, 329		201, 32	9 1, 193	168. 76	43. 00
200.00 Total (lines 30 through 199)	2, 170, 807		2, 170, 80	7 27, 246		200. 00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00 ADULTS & PEDIATRICS	751	49, 191				30.00
31.00 INTENSIVE CARE UNIT	124					31. 00
43. 00 NURSERY	899	151, 715				43.00
200.00 Total (lines 30 through 199)	1, 774	218, 415				200. 00

Health Financial Systems	COMMUNITY HOSP	ITAL ANDERSON		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0113	Peri od:	Worksheet D	
				From 01/01/2022	Part II	
				To 12/31/2022		
					5/25/2023 11:	38 am_
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			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	2, 356, 800	154, 332, 359	0. 01527	1 562, 944	8, 597	50.00
51. 00 05100 RECOVERY ROOM	0		0. 00000	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	147, 495	4, 223, 099			4, 148	52.00
53. 00 05300 ANESTHESI OLOGY	0	1,,	0.00000		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	455, 190	15, 372, 477	1		3, 343	
54. 01 05401 ULTRASOUND	39, 344	10, 332, 168	1		258	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	37, 344	10, 332, 100	0.00000		0	55.00
56. 00 05600 RADI OI SOTOPE	142 752	0 104 044	1		0	56.00
	142, 753					
57. 00 05700 CT SCAN	135, 103		l .		724	57. 00
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	536, 260				2, 032	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	323, 130				1, 517	59. 00
60. 00 06000 LABORATORY	621, 318	63, 419, 395				
60. 01 06001 BL00D LABORATORY	0	0	0.00000		0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	37, 344	2, 119, 438	0. 01762	.0 62, 159	1, 095	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000	0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.00000	0 0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	139, 123	15, 178, 332	0.00916	388, 249	3, 559	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 193, 367	10, 242, 844			2, 382	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	34, 677				253	
68. 00 06800 SPEECH PATHOLOGY	16, 174				408	68.00
69. 00 06900 ELECTROCARDI OLOGY	432, 403	16, 576, 704	1		2, 693	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	159, 391	5, 370, 349			494	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1				1, 350	71.00
	197, 249					
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	233, 478				759	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	816, 391	60, 453, 718			13, 817	73. 00
74. 00 07400 RENAL DI ALYSI S	4, 782	985, 907	0. 00485	35, 781	174	74. 00
OUTPATIENT SERVICE COST CENTERS		T	1			
90. 00 09000 CLI NI C	0		0. 00000		0	90. 00
90. 01 09001 WOUND/OSTOMY CLINIC	133, 625		1		313	
90. 02 09002 CTR ADVANCED HEART CARE	5, 733	508, 977	0. 01126	0	0	90. 02
90. 03 09003 RADI ATI ON ONCOLOGY	638, 632	57, 184, 061	0. 01116	51, 883	579	90. 03
90. 04 09004 MUNCIE CLINIC	0	0	0.00000	0 0	0	90. 04
90.05 09005 ANTICOAGULATION CLINIC	8, 836	1, 221, 951	0.00723	0	0	90. 05
90. 06 09006 PREGNANCY PLUS	0	0	0. 00000	0	0	90.06
90. 07 09007 0/P LAB	0	1 0	0. 00000	0	0	90. 07
90. 08 09008 0/P LAB	0		1		0	90. 08
90. 09 09009 FORTVILLE CLINIC	32, 097				ő	90. 09
90. 10 09010 1030 S SCATTERFIELD (MEDCHECK)	02,077		0. 00000		0	90. 10
90. 11 09011 DI ABETI C PLUS CLI NI C	11, 859	259, 905			0	90. 10
90. 12 09011 DTABETTC PLOS CLINIC 90. 12 09012 OTHER ONCOLOGY SERVICES	11,839	209, 900			0	90.11
	40/ 070	400 070 000	0.00000		-	
91. 00 09100 EMERGENCY	426, 270					91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	152, 873	4, 370, 517	0. 03497	8, 552	299	92. 00
OTHER REIMBURSABLE COST CENTERS			1	_		
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0				0	98. 00
200.00 Total (lines 50 through 199)	9, 431, 697	684, 786, 691	1	4, 599, 583	57, 186	200. 00

Health Financial Systems	COMMUNITY HOSPI	TAL ANDERSON		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST	S Provider CO		Period: From 01/01/2022 Fo 12/31/2022	Worksheet D Part III Date/Time Pre 5/25/2023 11:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Post-Stepdown Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0 0 0	0 0 0 0	(0 0 0 0 0 0	0 0 0	31. 00
Cost Center Description		Total Costs (sum of cols. 1 through 3, minus col. 4)	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5. 00	6. 00	7. 00	8. 00	
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 NURSERY 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0	0 0 0	22, 578 3, 479 1, 193 27, 240	0. 00 0. 00	124 899	
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00			-1		
30.00 03000 ADULTS & PEDIATRICS 31.00 04300 NURSERY Total (lines 30 through 199)	0 0 0 0					30. 00 31. 00 43. 00 200. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 01/01/2022 | Part IV | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | T Provider CCN: 15-0113 THROUGH COSTS

						10	12/31/2022	5/25/2023 11:	
			-	Title	XIX		Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng		Nursi ng	Α	Allied Health	Allied Health	
		Anestheti st	Program		Program	P	Post-Stepdown		
		Cost	Post-Stepd	own			Adjustments		
			Adjustmen	ts					
		1.00	2A		2. 00		3A	3. 00	
	ANCI LLARY SERVI CE COST CENTERS		1						
50. 00	05000 OPERATI NG 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		O		0	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0		O		0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		O		0	0	0	54.00
54. 01	05401 ULTRASOUND	0		O		0	0	0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0		O		0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0		O		0	0	0	56. 00
57. 00	05700 CT SCAN	0		O		0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0		0		0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		0		0	0	0	59. 00
60.00	06000 LABORATORY	0		0		0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0		O		0	0	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		O		0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		O		0	0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0		O		0	0	0	64. 00
65. 00	06500 RESPIRATORY THERAPY	0		O		0	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0		O		0	0	0	66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0		0		0	0	0	67. 00 68. 00
	I I	0		0		0	0	0	
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0		0		0	0	0	69. 00 70. 00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0		0	0	0	70.00
71.00	07200 I MPL. DEV. CHARGED TO PATTENTS	0				0	0	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0		0		0	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0		0		0	0	0	74.00
74.00	OUTPATIENT SERVICE COST CENTERS	0		<u> </u>		U	U	U	74.00
90. 00	09000 CLINI C	0		0		0	0	0	90.00
90. 01	09001 WOUND/OSTOMY CLINIC	0		o		O	0	0	90. 01
90. 02	09002 CTR ADVANCED HEART CARE	0		o		0	0	0	90. 02
90. 03	09003 RADIATION ONCOLOGY	0		o		0	0	0	90. 03
90. 04	09004 MUNCIE CLINIC	0		o		0	0	0	90. 04
90. 05	09005 ANTI COAGULATI ON CLINIC	0		o		0	0	0	90. 05
90.06	09006 PREGNANCY PLUS	0		o		0	0	0	90. 06
90. 07	09007 0/P LAB	0		o		0	0	0	90. 07
90. 08	09008 0/P LAB	0		o		0	0	0	90. 08
90. 09	09009 FORTVILLE CLINIC	0		o		0	0	0	90. 09
90. 10	09010 1030 S SCATTERFIELD (MEDCHECK)	0		o		0	0	0	90. 10
90. 11	09011 DI ABETI C PLUS CLINIC	0		o		0	0	0	90. 11
90. 12	09012 OTHER ONCOLOGY SERVICES	0		o		0	0	0	90. 12
91. 00	09100 EMERGENCY	0		0		0	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0		0	92. 00
	OTHER REIMBURSABLE COST CENTERS								
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0		0		0	0	0	98. 00
200.00	Total (lines 50 through 199)	0		0		0	0	0	200. 00

| Peri od: | Worksheet D | From 01/01/2022 | Part IV | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | To 12/31/ THROUGH COSTS

				0 12/31/2022	Date/lime Pre 5/25/2023 11:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
'	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	(154, 332, 359	0. 000000	50.00
51.00 05100 RECOVERY ROOM	0	0	(0	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	(4, 223, 099	0.000000	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	(0	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(15, 372, 477	0.000000	54.00
54. 01 05401 ULTRASOUND	0	0	(10, 332, 168	0.000000	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0.000000	55. 00
56. 00 05600 RADI OI SOTOPE	0	0		9, 104, 964	0.000000	56. 00
57. 00 05700 CT SCAN	0	0	(0. 000000	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(0. 000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0			0.000000	59. 00
60. 00 06000 LABORATORY	0	0			0. 000000	60.00
60. 01 06001 BLOOD LABORATORY	0	0	(0	0. 000000	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	Ö	0		2, 119, 438	0. 000000	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	ì	0 2,,	0. 000000	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		o o	0. 000000	64. 00
65. 00 06500 RESPIRATORY THERAPY	0	0		15, 178, 332	0. 000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0			0. 000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	Ō			0. 000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	Ō			0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		· ·	0. 000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0			0. 000000	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0. 000000	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0			0. 000000	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0			0. 000000	73.00
74. 00 07400 RENAL DIALYSIS	0	0			0. 000000	74.00
OUTPATIENT SERVICE COST CENTERS	0	U U		705, 707	0.000000	74.00
90. 00 09000 CLINIC	0	0		0	0. 000000	90.00
90. 01 09001 WOUND/OSTOMY CLINIC	0	0			0. 000000	90. 01
90. 02 09002 CTR ADVANCED HEART CARE	0	0			0. 000000	90. 02
90. 03 09003 RADI ATI ON ONCOLOGY	0	0		· ·	0. 000000	90. 03
90. 04 09004 MUNCI E CLI NI C		0			0.000000	90.03
	0	0		,	0.000000	90.04
90. 05 09005 ANTI COAGULATI ON CLINI C 90. 06 09006 PREGNANCY PLUS	0	0		.,,	0.000000	90.03
90. 07 09007 0/P LAB	0	0			0.000000	90.08
90. 07 09007 07P LAB 90. 08 09008 07P LAB	0	0			0. 000000	90.07
	0	0				•
90. 09 09009 FORTVILLE CLINIC	0	0			0.000000	90. 09
90. 10 09010 1030 S SCATTERFIELD (MEDCHECK)	0	0	(0 005	0.000000	90. 10
90. 11 09011 DI ABETI C PLUS CLI NI C	0	0	(0.000000	90. 11
90. 12 09012 OTHER ONCOLOGY SERVI CES	0	0	(0.000000	90. 12
91. 00 09100 EMERGENCY	0	0	(0.000000	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(4, 370, 517	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS	_			\	0.000000	00.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0		(0. 000000	98. 00
200.00 Total (lines 50 through 199)	0	0	(684, 786, 691		200. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 01/01/2022 | Part IV | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | T Provider CCN: 15-0113 THROUGH COSTS

				1	0 12/31/2022	5/25/2023 11:	
			Ti tl	e XIX	Hospi tal	PPS	
Cost Ce	nter Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8	· ·	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SER	VICE COST CENTERS	·					
50. 00 05000 OPERATI	NG ROOM	0. 000000	562, 944	0	0	0	50. 00
51. 00 05100 RECOVER	Y ROOM	0. 000000	0	0	0	0	51. 00
52. 00 05200 DELI VER	Y ROOM & LABOR ROOM	0. 000000	118, 754	0	0	0	52. 00
53. 00 05300 ANESTHE	SI OLOGY	0. 000000	0	0	0	0	53. 00
54. 00 05400 RADI OLO	GY-DI AGNOSTI C	0. 000000	112, 903	0	0	0	54. 00
54. 01 05401 ULTRAS0	UND	0. 000000	67, 782	0	0	0	54. 01
55. 00 05500 RADI OLO	GY-THERAPEUTI C	0. 000000	0	0	0	0	55. 00
56.00 05600 RADIOIS	OTOPE	0. 000000	0	0	0	0	56. 00
57.00 05700 CT SCAN		0. 000000	281, 167	0	0	0	57. 00
58. 00 05800 MAGNETI	C RESONANCE IMAGING (MRI)	0. 000000	69, 907	0	0	0	58. 00
59. 00 05900 CARDI AC	CATHETERI ZATI ON	0. 000000	122, 300	0	0	0	59. 00
60. 00 06000 LABORAT	ORY	0. 000000	540, 286	0	0	0	60.00
60. 01 06001 BL00D L	ABORATORY	0. 000000	0	0	0	0	60. 01
62. 00 06200 WHOLE B	LOOD & PACKED RED BLOOD CELLS	0. 000000	62, 159	0	0	0	62. 00
	TORING, PROCESSING & TRANS.	0. 000000	0	0	0	0	63. 00
64. 00 06400 NTRAVE		0. 000000	0	Ō	0	0	64. 00
65. 00 06500 RESPI RA		0. 000000	388, 249	Ō	0	0	65. 00
66. 00 06600 PHYSI CA		0. 000000	20, 445		0	0	66. 00
	I ONAL THERAPY	0. 000000	14, 507	0	0	0	67. 00
68. 00 06800 SPEECH		0. 000000	23, 444		0	0	68. 00
69. 00 06900 ELECTRO		0. 000000	103, 244	1	0	0	69. 00
	ENCEPHALOGRAPHY	0. 000000	16, 629		0	0	70.00
	SUPPLIES CHARGED TO PATIENTS	0. 000000	132, 698	1	0	0	71. 00
	EV. CHARGED TO PATIENTS	0. 000000	73, 602	1	0	0	72. 00
	HARGED TO PATIENTS	0. 000000	1, 023, 147	1	0	0	73. 00
74. 00 07400 RENAL D		0. 000000	35, 781	0	0	-	1
	RVICE COST CENTERS	0.000000	00,701		9		7 1. 00
90. 00 09000 CLI NI C		0. 000000	0	0	0	0	90.00
90. 01 09001 WOUND/0	STOMY CLINIC	0. 000000	20, 014	0	0	0	90. 01
90. 02 09002 CTR ADV	ANCED HEART CARE	0. 000000	. 0	0	0	0	90. 02
90. 03 09003 RADI ATI		0. 000000	51, 883	0	0	0	90. 03
90. 04 09004 MUNCI E		0. 000000	0	0	0	0	90. 04
	GULATION CLINIC	0. 000000	0	Ō	0	0	90. 05
90. 06 09006 PREGNAN		0. 000000	0	Ō	0	0	90.06
90. 07 09007 0/P LAB		0. 000000	0	Ō	0	0	90. 07
90. 08 09008 0/P LAB		0. 000000	0	1	0	0	90. 08
90. 09 09009 FORTVI L		0. 000000	0	1	0	0	90. 09
	SCATTERFIELD (MEDCHECK)	0. 000000	0	1	0	Ö	90. 10
	C PLUS CLINIC	0. 000000	0	_	0	0	90. 11
	NCOLOGY SERVICES	0. 000000	0	0	0	0	90. 12
91. 00 09100 EMERGEN		0. 000000	749, 186	1	0	0	91. 00
	TION BEDS (NON-DISTINCT PART)	0. 000000	8, 552	0	0	0	
	SABLE COST CENTERS	0.000000	0, 332		0		, ,2.00
	EIMBURSABLE COST CENTERS	0. 000000	0	0	0	0	98. 00
	lines 50 through 199)	3. 333000	4, 599, 583				200. 00
1.000		1 1	., 5, , , 500	'	·		

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0113 Peri od: Worksheet D From 01/01/2022 Part V Date/Time Prepared: 12/31/2022 5/25/2023 11:38 am Title XIX Hospi tal Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 138601 1, 591, 195 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 0 51.00 C 05200 DELIVERY ROOM & LABOR ROOM 52 00 0.635888 0 O 52 00 0 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 268850 317, 889 0 54.00 54.01 05401 ULTRASOUND 0.116371 0 216, 048 0 54 01 05500 RADI OLOGY-THERAPEUTI C 55.00 0.000000 0 0 55.00 56.00 05600 RADI OI SOTOPE 0. 108045 127, 691 0 56.00 57.00 05700 CT SCAN 0.049490 1,014,654 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 130364 303 091 58 00 58 00 0 59.00 05900 CARDIAC CATHETERIZATION 0.093685 453, 886 0 59.00 06000 LABORATORY 0.183705 954, 998 0 60.00 60.00 06001 BLOOD LABORATORY 0.000000 60.01 0 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62 00 0.494936 0 25, 818 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 0 63.00 C 06400 INTRAVENOUS THERAPY 0.000000 64.00 64.00 06500 RESPIRATORY THERAPY 0. 299198 0 65.00 47, 203 0 65.00 06600 PHYSI CAL THERAPY 0.659590 0 66.00 86, 320 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.405427 6,735 0 67.00 06800 SPEECH PATHOLOGY 5, 397 68.00 0.404852 68.00 06900 ELECTROCARDI OLOGY 69.00 0.209822 160.743 0 69.00 07000 ELECTROENCEPHALOGRAPHY 108, 434 70.00 0.303215 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 429258 0 339, 073 71.00 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.435077 138, 412 72.00 07300 DRUGS CHARGED TO PATIENTS 0 507, 644 73.00 0.277365 0 73.00 74.00 07400 RENAL DIALYSIS 0.409833 0 0 0 Ω 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 C 0 0 90.00 09001 WOUND/OSTOMY CLINIC 0 90 01 0.356881 90.01 0 156, 802 0 90.02 09002 CTR ADVANCED HEART CARE 0.606275 5, 978 0 90.02 09003 RADIATION ONCOLOGY 90.03 0.098152 1, 839, 751 0 0 0 0 0 0 0 0 0 O 90.03 09004 MUNCIE CLINIC 0.000000 90.04 90.04 C 0 09005 ANTI COAGULATION CLINIC 90.05 0.492606 7, 721 0 90.05 90.06 09006 PREGNANCY PLUS 0.000000 0 0 90.06 90.07 09007 0/P LAB 0.000000 90.07 0 09008 0/P LAB 90 08 0.000000 0 90 08 Λ 90.09 09009 FORTVILLE CLINIC 0.000000 0 0 90.09 90.10 09010 1030 S SCATTERFIELD (MEDCHECK) 0.000000 0 90.10 09011 DIABETIC PLUS CLINIC 0 90.11 90.11 2.457575 4.740 0 09012 OTHER ONCOLOGY SERVICES 90.12 0.000000 0 \cap 0 90.12 91.00 09100 EMERGENCY 0.115925 0 3, 198, 633 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.959753 0 121, 096 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 0 0 98.00 200.00 Subtotal (see instructions) 0 11, 739, 952 0 0 200.00

ol

0

11, 739, 952

201.00

0 202.00

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

Peri od: Worksheet D From 01/01/2022 Part V To 12/31/2022 Date/Time Prepared: 5/25/2023 11:38 am Provi der CCN: 15-0113

						5/25/2023 11: 3	38 am_
			Ti tl	e XIX	Hospi tal	PPS	
	·	Cos	sts		· · · · · · · · · · · · · · · · · · ·		
	Cost Center Description	Cost	Cost				
	oost ochter beschiptron	Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.					
		(see inst.)	(see inst.)				
		6.00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	220, 541	0				50.00
51. 00	05100 RECOVERY ROOM	0					51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		1			52.00
				1			
53.00	05300 ANESTHESI OLOGY	_		1			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	85, 464		•			54. 00
54. 01	05401 ULTRASOUND	25, 142		1			54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
56.00	05600 RADI OI SOTOPE	13, 796	0				56. 00
57.00	05700 CT SCAN	50, 215	0				57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	39, 512		1			58.00
59. 00	OFOOO CAPDIAC CATHETEDIZATION	42, 522		1			59.00
	05900 CARDI AC CATHETERI ZATI ON	1		1			•
60.00	06000 LABORATORY	175, 438		1			60.00
60. 01	06001 BLOOD LABORATORY	0	0				60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	12, 778	0				62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0				64.00
65. 00	06500 RESPI RATORY THERAPY	14, 123		1			65. 00
66. 00	06600 PHYSI CAL THERAPY						1
		56, 936					66.00
67. 00	06700 OCCUPATI ONAL THERAPY	2, 731	0				67. 00
68. 00	06800 SPEECH PATHOLOGY	2, 185	0				68. 00
69. 00	06900 ELECTROCARDI OLOGY	33, 727	0				69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	32, 879	0				70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	145, 550	l .				71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	60, 220		1			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1		1			73.00
	07300 DRUGS CHARGED TO PATTENTS	140, 803		1			
74. 00	07400 RENAL DIALYSIS	0	0				74. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0					90. 00
90. 01	09001 WOUND/OSTOMY CLINIC	55, 960	0				90. 01
90.02	09002 CTR ADVANCED HEART CARE	3, 624	0				90. 02
90. 03	09003 RADIATION ONCOLOGY	180, 575					90. 03
90. 04	09004 MUNCI E CLINI C	100,070	Ö	1			90. 04
		2 002		1			•
90.05	09005 ANTI COAGULATI ON CLI NI C	3, 803		1			90. 05
90. 06	09006 PREGNANCY PLUS	0					90. 06
90. 07	09007 0/P LAB	0	0				90. 07
90.08	09008 0/P LAB	0	0				90. 08
90.09	09009 FORTVILLE CLINIC	0	0				90. 09
90. 10	09010 1030 S SCATTERFIELD (MEDCHECK)	0	0				90. 10
90. 11	09011 DI ABETI C PLUS CLINI C	11, 649		1			90. 11
		11,049	0				•
90. 12	09012 OTHER ONCOLOGY SERVICES	070 000	_	1			90. 12
91. 00	09100 EMERGENCY	370, 802					91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	116, 222	0				92.00
	OTHER REIMBURSABLE COST CENTERS						
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0				98. 00
200.00		1, 897, 197	l .				200. 00
201.00		0					201. 00
201.00	Only Charges						
202 00		1, 897, 197	0				202 00
202.00	Net Charges (line 200 - line 201)	1,071,191	1	T			202. 00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0113	Peri od: From 01/01/2022	Worksheet D-1	
			Date/Time Pre 5/25/2023 11:	
	Title XVIII	Hospi tal	PPS	
Cost Center Description			•	

Private room days (excluding swing-bed and observation bed days). If you have only private room days. 0 3.00			Title XVIII	Hospi tal	PPS	30 alli
PART 1 - ALL PROVIDER COMPONENTS		Cost Center Description				
		DADT I ALL DDOVIDED COMPONENTS			1.00	
Inpattient days (Including private room days and saing-bed days, excluding newborn) 22,578 2.00 Inpattient days (excluding private room days, excluding saing-bed and newborn days) 22,578 2.00 Private room days, excluding saing-bed and observation bed days) 27,578 2.00 20,000 20						
Private room days (excluding swing-bed and observation bed days). If you have only private room days. 0 3.00	1.00		s, excluding newborn)		22, 578	1.00
do not complete this line. 4. 00 Semi-private room days (excluding swing-bed and observation bed days) 1. 10 Intal swing-bed SM 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 SM 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 MS type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8. 00 Total swing-bed MS type inpatient days (including private room days) ufter December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total swing-bed SM type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10. 00 Swing-bed SM type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SM type inpatient days applicable to title XVIII only (including private room days) 12. 00 Swing-bed SM type inpatient days applicable to title XVIII only (including private room days) 13. 00 Swing-bed SM type inpatient days applicable to title XVIII only (including private room days) 14. 00 Swing-bed SM type inpatient days applicable to title XVIII only (including private room days) 15. 00 Swing-bed SM type inpatient days applicable to title XVIII only (including private room days) 16. 00 Swing-bed SM type inpatient days applicable to title XVIII only (including private room days) 17. 00 Swing-bed SM type inpatient days applicable to title XVIII only (including private room days) 18. 00 Swing-bed SM type inpatient days applicable to title XVIII only (including private room days) 18. 00 Swing-bed SM type inpatient days applicable to title XVIII only (including private room days) 18. 00 Swing-bed SM type inpatient days applicable to title XVIII only (including private room days	2.00				22, 578	
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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 40, 576, 633 and 97.00) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 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		, , , , , , , , , , , , , , , , , , , ,				
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 20, 576, 633) 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 36.00 40, 576, 633 37.00 40, 576, 633 37.00 40, 576, 633 37.00 40, 576, 633 40				tions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 20, 576, 633 and 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 40.00		, , ,	ne 31)			1
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) 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)		, , , , , , , , , , , , , , , , , , ,	and private room cost di	fferential (line	-	
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) 1,797.18 38.00 10,062,411 39.00 40.00		27 minus line 36)			. 2, 3, 0, 000]
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,797.18 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) 1,797.18 38.00 10,062,411 39.00 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) 10,062,411 39.00 40.00	20.00				1 707 10	20.00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , , ,	•			1
		, ,	•			ı
		, , , , , , , , , , , , , , , , , , , ,	,			1

	Financial Systems ATION OF INPATIENT OPERATING COST	COMMUNITY HOSPI	TAL ANDERSON Provider CO	CN: 15-0113	In Lie	eu of Form CMS-2 Worksheet D-1	
20 01					From 01/01/2022 To 12/31/2022		pared:
	Cost Center Description	Total Inpatient Cost	Total	XVIII Average Per Diem (col. 1 col. 2)		PPS Program Cost (col. 3 x col. 4)	
42 00	NURSERY (title V & XIX only)	1.00	2. 00	3. 00	4. 00 00 0	5.00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	0	0	0.	00 0	0	42.00
43. 00 44. 00 45. 00 46. 00 47. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) Cost Center Description	10, 519, 186	3, 475	3, 027.	10 897	2, 715, 309	43. 00 44. 00 45. 00 46. 00 47. 00
						1.00	
48. 00 48. 01	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti			III line 10	column 1)	10, 597, 081	1
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.0	1)(see instruc	tions)	·	23, 374, 801	
50.00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, su	m of Parts I and	493, 391	50.00
51. 00	Pass through costs applicable to Program inp and IV)		y services (fr	om Wkst. D,	sum of Parts II	651, 340	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu	ding capital re	lated, non-phy	sician anest	hetist, and	1, 144, 731 22, 230, 070	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00	Program di scharges						54.00
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge						55. 00 55. 01
55. 02	Adjustment amount per discharge (contractor	use only)					55. 02
56.00	Target amount (line 54 x sum of lines 55, 55				50)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (i	ine 56 minus	line 53)	0	57. 00 58. 00
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repo	rting period	endi ng 1996,		59.00
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	m prior year c	ost report,	updated by the	0.00	60.00
61. 00	market basket) Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	ser of 50% of t	he amount by w	hich operati	ng costs (line	0	61. 00
62. 00	enter zero. (see instructions) Relief payment (see instructions)					l .	62.00
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST		,			0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	mber 31 of the	cost report	ing period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	er 31 of the c	ost reportin	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line 6	5)(title XVI	<pre>II only); for</pre>	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	0					67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)			·	orting period	0	
	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF/IID (ONLY		0	
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c)		70. 00 71. 00
71.00	Program routine service cost (line 9 x line	,	THE /U = TIME.	4)			71.00
73. 00	Medically necessary private room cost applic	able to Program		ne 35)			73. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•	,	orksheet B, I	Part II, column		74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
78.00	Inpatient routine service cost (line 74 minu		rovi don n '	6)			78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi						81. 00
	Inpatient routine service cost limitation (I		•				82.00
83. 00 84. 00	Reasonable inpatient routine service costs (s)				83. 00 84. 00
85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)				85.00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86.00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PASS					2.22:	07.00
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			2, 334 1, 797. 18	1
89. 00	Observation bed cost (line 87 x line 88) (se	•				4, 194, 618	1

Health Financial Systems	COMMUNITY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022		pared: 38 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 478, 805	40, 576, 633	0. 03644	5 4, 194, 618	152, 873	90.00
91.00 Nursing Program cost	0	40, 576, 633	0.00000	4, 194, 618	0	91.00
92.00 Allied health cost	0	40, 576, 633	0.00000	4, 194, 618	0	92.00
93.00 All other Medical Education	0	40, 576, 633	0.00000	4, 194, 618	0	93.00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0113	Peri od: From 01/01/2022	Worksheet D-1	
		To 12/31/2022	Date/Time Pre 5/25/2023 11:	
	Title XIX	Hospi tal	PPS	
Cost Center Description				
			1 00	

		Ti +Lo VIV	Hospi tal	5/25/2023 11: PPS	38 am
	Cost Center Description	Title XIX	Hospi tal	PPS	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
4 00	I NPATI ENT DAYS		-	00 570	4.00
1.00	Inpatient days (including private room days and swing-bed days			22, 578	
2. 00 3. 00	Inpatient days (including private room days, excluding swing-l Private room days (excluding swing-bed and observation bed day	<i>y</i> ,	vata room dave	22, 578 0	2. 00 3. 00
3.00	do not complete this line.	ys). IT you have only pri	vate room days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		20, 244	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period	3 7			
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private roor	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roor	m days) after December 3	l of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	arter becember 5	i or the cost	0	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	751	9. 00
	newborn days) (see instructions)	0			
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10.00
	through December 31 of the cost reporting period (see instruction)				44.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, en		oom days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Comy (Therearing private	2 1 00m days)	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this line	e)		
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	days)	0	14.00
15. 00	Total nursery days (title V or XIX only)			1, 193	
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			899	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	os through Docombor 21 of	tho cost	0.00	17. 00
17.00	reporting period	es through becember 31 of	the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of i	the cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period	6. 5 . 6.			
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of th	ne cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	=)		40, 576, 633	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		na period (line	40, 370, 033	
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
	x line 18)			_	
24. 00	Swing-bed cost applicable to NF type services through December	1 31 of the cost reporting	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	21 of the cost reporting	neriod (line 8	0	25. 00
25.00	x line 20)	or the cost reporting	perrou (irric o	0	23.00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		40, 576, 633	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	
29. 00	Private room charges (excluding swing-bed charges)			0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	Line 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	F 11116 20)		0.00000	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruct	tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x lin		,	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 a	and private room cost dit	ferential (line	40, 576, 633	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			1, 797. 18	38. 00
39. 00	Program general inpatient routine service cost per drem (see	•		1, 797. 16	
40. 00	Medically necessary private room cost applicable to the Program	•		0	40. 00
	Total Program general inpatient routine service cost (line 39	•		1, 349, 682	
			'		

	Financial Systems ATION OF INPATIENT OPERATING COST	COMMUNITY HOSET	TAL ANDERSON Provider CO	N: 15-0112	Period:	u of Form CMS-2 Worksheet D-1	
JOINIPUI	ATION OF INFATIENT OPERATING COST				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 11:	pared:
	0 10 1 0 11	T		e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost		col . 2)	÷	Program Cost (col. 3 x col. 4)	
10.00	ANDREDY (1) II WA WIYA I Y	1.00	2.00	3.00	4. 00	5. 00	10.0
12. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	2, 515, 914	1, 193	2, 108. 9	90 899	1, 895, 901	42.00
13. 00	INTENSIVE CARE UNIT	10, 519, 186	3, 475	3, 027.	10 124	375, 360	43.00
14. 00	CORONARY CARE UNIT						44.00
15. 00	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT						46.00
17. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
	cost center bescriptron					1. 00	
18. 00	Program inpatient ancillary service cost (W					1, 022, 737	48. 00
18. 01	Program inpatient cellular therapy acquisiti				column 1)	0	
19. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.0	1)(see instruc	tions)		4, 643, 680	49.0
50. 00	Pass through costs applicable to Program in	patient routine	services (from	Wkst D sum	of Parts L and	218, 415	50.00
, , , ,		od tront routino	30. 1. 333 (1. 3	mor. b, oun	. or rares r and	2.0,	00.0
51. 00	Pass through costs applicable to Program in	patient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	57, 186	51.00
3 00	and IV)	50 and 51)				275, 601	E2 0
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated, non-phy	sician anesth	netist, and	4. 368. 079	
	medical education costs (line 49 minus line					., 555, 577]
	TARGET AMOUNT AND LIMIT COMPUTATION						ļ
54. 00 55. 00	Program discharges Target amount per discharge					0	54. 0 55. 0
55. 00	Permanent adjustment amount per discharge						55.0
55. 02	Adjustment amount per discharge (contractor	use only)					55.0
6. 00	Target amount (line 54 x sum of lines 55, 55					0	
57. 00	Difference between adjusted inpatient operation	ting cost and ta	rget amount (I	ine 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line EE from	the cost rope	rting poriod	anding 1004	0	
9.00	updated and compounded by the market basket)		the cost repo	iting period	ending 1990,	0.00	59. 0
60.00	Expected costs (lesser of line 53 ÷ line 54,		m prior year c	ost report, ι	pdated by the	0. 00	60.0
51. 00	market basket) Continuous improvement bonus payment (if lir 55.01, or line 59, or line 60, enter the les					0	61. 0
52. 00	53) are less than expected costs (lines 54) enter zero. (see instructions) Relief payment (see instructions)	x 60), or 1 % of	the target am	ount (line 56	o), otherwise	0	62.0
3. 00	Allowable Inpatient cost plus incentive payr	ment (see instru	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	sts through Dece	mber 31 of the	cost reporti	ng period (See	0	64.0
5.00	Medicare swing-bed SNF inpatient routine cos	sts after Decemb	er 31 of the c	ost reporting	period (See	0	65.0
	instructions)(title XVIII only)						
6. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	l only); for	0	66.0
57. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routing	ne costs through	December 31 o	f the cost re	porting period	0	67.0
8. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	· ·				0	
59. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 0
70.00	Skilled nursing facility/other nursing facil						70.0
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine /U ÷ line	2)			71.0
73. 00	Medically necessary private room cost applic		(line 14 x li	ne 35)			73.0
74. 00	Total Program general inpatient routine serv	vice costs (line	72 + line 73)	ŕ			74.0
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from W	orksheet B, F	Part II, column		75. 0
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.0
77. 00	Program capital -related costs (line 9 x line						77.0
78. 00	Inpatient routine service cost (line 74 minu	us line 77)					78. 0
9.00	Aggregate charges to beneficiaries for exces			*	763		79.0
30. 00 31. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ust limitation	(IINe /8 mir	ius iine /9)		80.0
31.00	Inpatient routine service cost per drem from)				82.0
33. 00	Reasonable inpatient routine service costs						83. 0
34. 00	Program inpatient ancillary services (see in		`				84.0
35. 00 36. 00	Utilization review - physician compensation Total Program inpatient operating costs (sur						85. 0 86. 0
	PART IV - COMPUTATION OF OBSERVATION BED PAS		rough 65)				1 30.0
	Total observation bed days (see instructions					2, 334	87. 0
37. 00 38. 00	Adjusted general inpatient routine cost per	•				1, 797. 18	•

Health Financial Systems	COMMUNITY HOSPI	TAL ANDERSON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 11:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 478, 805	40, 576, 633	0. 03644	5 4, 194, 618	152, 873	90.00
91.00 Nursing Program cost	o	40, 576, 633	0.00000	4, 194, 618	0	91.00
92.00 Allied health cost	o	40, 576, 633	0.00000	4, 194, 618	0	92.00
93.00 All other Medical Education	0	40, 576, 633	0.00000	4, 194, 618	0	93. 00

	MUNITY HOSPITAL ANDERSON		In Lie	u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC		Peri od:	Worksheet D-3	
			From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 11:	
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
LAIDATI ENT. DOUTLAG CEDVA OF COCT. CENTEDO		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS			12 700 252		20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT			13, 798, 252		30.00
43. 00 04300 NURSERY			4, 043, 088		43.00
ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 O5000 OPERATING ROOM		0. 13825	12, 415, 732	1, 716, 475	50.00
51. 00 05100 RECOVERY ROOM		0. 00000		1, 710, 473	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 63588		Ö	52.00
53. 00 05300 ANESTHESI OLOGY		0. 00000		Ö	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 26885		272, 375	
54. 01 05401 ULTRASOUND		0. 11637		50, 748	1
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 00000		0	55. 00
56. 00 05600 RADI OI SOTOPE		0. 10804		18, 235	56. 00
57. 00 05700 CT SCAN		0. 04949	3, 200, 661	158, 401	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 13036	538, 911	70, 255	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 09368	2, 373, 968	222, 405	59. 00
60. 00 06000 LABORATORY		0. 18370	3, 947, 008	725, 085	60.00
60. 01 06001 BLOOD LABORATORY		0.00000	0 0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 49493	345, 909	171, 203	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000	0 0	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY		0.00000		0	64. 00
65. 00 06500 RESPI RATORY THERAPY		0. 29919		952, 546	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 65959		298, 943	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 40542		128, 668	1
68. 00 06800 SPEECH PATHOLOGY		0. 40485		75, 781	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 20982		287, 457	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 30321		114, 250	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 42925			1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 43507		1, 243, 952	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 27736			1
74. 00 O7400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS		0. 40983	278, 840	114, 278	74. 00
90. 00 09000 CLINIC		0. 00000	0	0	90.00
90. 01 09000 CLINIC 90. 01 09001 WOUND/OSTOMY CLINIC	1	0. 35688		58, 028	
90. 02 09002 CTR ADVANCED HEART CARE		0. 60627		0 36,028	90.01
90. 03 09003 RADI ATI ON ONCOLOGY		0. 00027		33, 986	
76. 66 G. GOOD MADE AT THE ON COLOUR	•	0.07013	340, 201	33, 700	70.03

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90. 04 09004 MUNCIE CLINIC

09007 0/P LAB

09008 0/P LAB

09005 ANTI COAGULATION CLINIC

09012 OTHER ONCOLOGY SERVICES

09010 1030 S SCATTERFIELD (MEDCHECK)
09011 DIABETIC PLUS CLINIC

09006 PREGNANCY PLUS

09009 FORTVILLE CLINIC

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Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-2	552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 1	From 01/01/2022	Date/Time Prep	
- <u></u>	Title XI	IX Hospital	5/25/2023 11: 3 PPS	88 am_
Cost Center Description	Rat	io of Cost Inpatient	Inpati ent	

				To 12/31/2022	Date/Time Pre 5/25/2023 11:	
		Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
<u> </u>	NPATI ENT ROUTI NE SERVI CE COST CENTERS					
	D3000 ADULTS & PEDIATRICS			2, 570, 57	1	30. 00
	03100 INTENSIVE CARE UNIT			554, 568	1	31. 00
	04300 NURSERY			303, 722	2	43. 00
	ANCILLARY SERVICE COST CENTERS			510.01		
	D5000 OPERATING ROOM		0. 13860			50.00
	D5100 RECOVERY ROOM		0.00000		0	51.00
	D5200 DELIVERY ROOM & LABOR ROOM		0. 63588		1	
	D5300 ANESTHESI OLOGY		0.0000		0	53.00
	D5400 RADI OLOGY-DI AGNOSTI C		0. 2688!		1	1
	D5401 ULTRASOUND D5500 RADI OLOGY-THERAPEUTI C		0. 1163		1	54. 01 55. 00
	DSSOU RADI OLOGY - THERAPEUTT C DS600 RADI OI SOTOPE		0. 00000 0. 1080		0 0	56.00
	05700 CT SCAN		0. 10804			57.00
	D5800 MAGNETIC RESONANCE IMAGING (MRI)		0. 0494	·	1	58.00
59.00	D5900 CARDI AC CATHETERI ZATI ON		0. 13036	·	1	ł
	06000 LABORATORY		0. 18370			60.00
	06001 BLOOD LABORATORY		0. 00000			60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 49493			1
1	06300 BLOOD STORING, PROCESSING & TRANS.		0. 00000		0 0	63.00
- 1	06400 I NTRAVENOUS THERAPY		0.0000			64.00
- 1	06500 RESPIRATORY THERAPY		0. 2991			65.00
	06600 PHYSI CAL THERAPY		0. 65959	·	1	66.00
	06700 OCCUPATI ONAL THERAPY		0. 40542	·		67. 00
	06800 SPEECH PATHOLOGY		0. 4048!			68. 00
	D6900 ELECTROCARDI OLOGY		0. 2098			1
1	D7000 ELECTROENCEPHALOGRAPHY		0. 3032		1	•
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4292			1
1	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4350			
	D7300 DRUGS CHARGED TO PATIENTS		0. 2773			73. 00
74.00	D7400 RENAL DIALYSIS		0. 4098	35, 78 ⁻	1 14, 664	74. 00
C	DUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C		0.0000	00	0	90. 00
90. 01	09001 WOUND/OSTOMY CLINIC		0. 35688	20, 01	7, 143	90. 01
	09002 CTR ADVANCED HEART CARE		0. 6062		0	90. 02
	D9003 RADI ATI ON ONCOLOGY		0. 0981!			
1	D9004 MUNCIE CLINIC		0.0000		-	90. 04
	D9005 ANTI COAGULATI ON CLI NI C		0. 49260		0	90. 05
	09006 PREGNANCY PLUS		0. 00000		٥,	90. 06
	09007 0/P LAB		0. 00000		٥,	90. 07
	09008		0. 00000		٥,	90. 08
	D9009 FORTVILLE CLINIC		0.0000		٥ ا	90. 09
	09010 1030 S SCATTERFIELD (MEDCHECK)		0.0000		٥ ا	90. 10
	09011 DIABETIC PLUS CLINIC		2. 4575		٥ ا	90. 11
1	09012 OTHER ONCOLOGY SERVICES		0.00000		٥	90. 12
	D9100 EMERGENCY		0. 1159:			1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 9597	8, 552	2 8, 208	92. 00
	OTHER REI MBURSABLE COST CENTERS		0.0000	00 (1 1	98. 00
1	O9850 OTHER REIMBURSABLE COST CENTERS		0.0000		٥	
200. 00 201. 00	Total (sum of lines 50 through 94 and 96 through 98)	(Lino 61)		4, 599, 58	1, 022, 737	200. 00
201.00	Less PBP Clinic Laboratory Services-Program only charges Net charges (line 200 minus line 201)	(TITIE OI)		4, 599, 583	3	201.00
202.00	mor sharges (Title 200 millias Title 201)		I	7, 377, 30.	~1	1202.00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0113	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/25/2023 11:38 am
	T: +1 - \0.01 1	11	DDC

PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS 1.00 DRG amounts Other than Outlier Payments 1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 (see 10,164,916 1 instructions) 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see 3,720,380 1 instructions) 1.03 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 1.04 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions) 2.00 Outlier payments for discharges. (see instructions) 2.01 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.02 Outlier payment for discharges occurring prior to October 1 (see instructions) 2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.04 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.05 Outlier payments for discharges occurring prior to October 1 (see instructions) 3.00 Managed Care Simulated Payments 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 4.01 DRG for federal specific operating prior to October 1 (see instructions) 4.01 DRG for federal specific operating prior to October 1 (see instructions) 5.00 FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions) 5.01 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 6.26 Rural track programs FTE ap limitation adjustment after the cap-building window closed under \$127 of the CAA 2021 (see instructions) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.
1.00 DRG Amounts Other than Outlier Payments 1.01 DRG amounts other than Outlier payments for discharges occurring prior to October 1 (see 1.01 instructions) 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see 1.03 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 1.04 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0.1 October 1 (see instructions) 2.00 Outlier payments for discharges. (see instructions) 2.01 Outlier payments for discharges (see instructions) 2.02 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.04 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.05 Outlier payments for discharges occurring on or after October 1 (see instructions) 2.06 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Managed Care Simulated Payments 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 4.01 Indirect Medical Education Adjustment 5.00 FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996, (see instructions) 5.01 FTE cap adjustment for qualifing hospitals under \$131 of the CAA 2021 (see instructions) 6.00 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 6.26 Rural track program FTE cap limitation adjustment after the cap-building window closed under \$127 of the CAA 2021 (see instructions) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.
1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions) 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions) 1.03 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 1.04 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 tocober 1 (see instructions) 2.00 Outlier payments for discharges. (see instructions) 2.01 Outlier payments for discharges for Model 4 BPCI (see instructions) 2.02 Outlier payment for discharges occurring prior to October 1 (see instructions) 2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.05 Managed Care Simul ated Payments 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 5.00 TFE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions) 5.01 FTE cap adjustment for qualifing hospitals under \$131 of the CAA 2021 (see instructions) 6.06 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 6.26 Rural track program FTE cap limitation adjustment after the cap-building window closed under \$127 of the CAA 2021 (see instructions) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.
1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions) 1.03 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 1.04 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions) 2.00 Outlier payments for discharges. (see instructions) 2.01 Outlier payments for discharges for Model 4 BPCI (see instructions) 2.02 Outlier payment for discharges occurring prior to October 1 (see instructions) 2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 2.05 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Managed Care Simulated Payments 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 5.00 FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions) 5.01 FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) 5.02 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 6.26 Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) 7.01 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.
1.03 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 1.04 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions) 2.00 Outlier payments for discharges. (see instructions) 2.01 Outlier payment for discharges for Model 4 BPCI (see instructions) 2.02 Outlier payment for discharges for Model 4 BPCI (see instructions) 2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.05 Managed Care Simulated Payments 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 5.01 FTE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions) 5.01 FTE cap adjustment for qualifing hospitals under \$131 of the CAA 2021 (see instructions) 5.02 Rural track program FTE cap limitation adjustment after the cap-building window closed under \$127 of the CAA 2021 (see instructions) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(1) 7.01 ACA \$ 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.
October 1 (see instructions) 2.00 Outlier payments for discharges. (see instructions) 2.01 Outlier reconciliation amount 2.02 Outlier payment for discharges for Model 4 BPCI (see instructions) 2.03 Outlier payment for discharges occurring prior to October 1 (see instructions) 2.04 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.05 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Managed Care Simulated Payments 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 5.00 Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions) 5.01 FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) 6.02 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 6.26 Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) 7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.
2.01 Outlier reconciliation amount 2.02 Outlier payment for discharges for Model 4 BPCI (see instructions) 2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Managed Care Simulated Payments 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 4.00 Indirect Medical Education Adjustment 5.00 FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions) 5.01 FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) 6.00 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 6.26 Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) 7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.
2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Managed Care Simulated Payments 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 4.00 FTE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions) 5.01 FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) 6.00 FTE count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 6.26 Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) 7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.
2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Managed Care Simulated Payments 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 5.00 FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions) 5.01 FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) 6.00 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 6.26 Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) 7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.
3.00 Managed Care Simulated Payments 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 121.44 Indirect Medical Education Adjustment 5.00 FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions) 5.01 FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) 6.00 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 6.26 Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) 7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.
4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 121.44 Indirect Medical Education Adjustment 5.00 FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions) 5.01 FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) 6.00 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 6.26 Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) 7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.
Indirect Medical Education Adjustment 5.00 FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions) 5.01 FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) 6.00 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 6.26 Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) 7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.
or before 12/31/1996. (see instructions) 5.01 FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) 6.00 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 6.26 Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) 7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.
6.00 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 6.26 Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) 7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.
Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions) MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.
7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.
track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b)
and 87 FR 49075 (August 10, 2022) (see instructions) 8.00 Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for 0.00 8 affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,
1998), and 67 FR 50069 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost 0.00 8 report straddles July 1, 2011, see instructions.
8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital 0.00 8 under § 5506 of ACA. (see instructions)
8.21 The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see 0.00 8 instructions)
9.00 Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or 0.00 9 minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)
10.00 FTE count for allopathic and osteopathic programs in the current year from your records 11.00 FTE count for residents in dental and podiatric programs. 0.00 10
12.00 Current year allowable FTE (see instructions)
13.00 Total allowable FTE count for the prior year.
14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 0.00 14 otherwise enter zero.
15.00 Sum of lines 12 through 14 divided by 3. 0.14 15
16.00 Adjustment for residents in initial years of the program (see instructions) 0.00 16
17.00 Adjustment for residents displaced by program or hospital closure 0.00 17
18.00 Adjusted rolling average FTE count 19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.14 18
19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.001153 19 20.00 Prior year resident to bed ratio (see instructions) 0.002112 20
21.00 Enter the lesser of lines 19 or 20 (see instructions)
22.00 IME payment adjustment (see instructions) 8,748 22
22.01 IME payment adjustment - Managed Care (see instructions) 9,818 22 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA
23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23 (f)(1)(iv)(C).
24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25 0.00 25
26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 0.000000 26
27. 00 Time payments adjustment factor. (see instructions) 0.000000 27 28. 00 TIME add-on adjustment amount (see instructions) 0.28
28.01 IME add-on adjustment amount - Managed Care (see instructions)
29. 00 Total IME payment (sum of lines 22 and 28) 8,748 29
29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 9,818 29 Disproportionate Share Adjustment
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 3.46 30
31.00 Percentage of Medicaid patient days (see instructions) 25.72 31
32.00 Sum of Lines 30 and 31 29.18 32
33.00 Allowable disproportionate share percentage (see instructions) 34.00 Disproportionate share adjustment (see instructions) 13.29 33 461,339 34
401, 339 34

ncompensated Care Payment Adjustment otal uncompensated care amount (see instructions) actor 3 (see instructions) ospital UCP, including supplemental UCP (If line 34 is zero, see instructions) ror rata share of the hospital UCP, including supplemental UC otal UCP adjustment (sum of columns 1 and 2 on line 35.03) dditional payment for high percentage of ESRD beneficiary di otal Medicare discharges (see instructions) otal ESRD Medicare discharges (see instructions) otal ESRD Medicare covered and paid discharges (see instruct ivide line 41 by line 40 (if less than 10%, you do not quali otal Medicare ESRD inpatient days (see instructions) atio of average length of stay to one week (line 43 divided ays) verage weekly cost for dialysis treatments (see instructions otal additional payment (line 45 times line 44 times line 41 ubtotal (see instructions) ospital specific payments (to be completed by SCH and MDH, s nly. (see instructions)	CP (see instructions) scharges (lines 40 throustions) fy for adjustment) by line 41 divided by 7 s)	0. 000111704 803, 373 600, 879 816, 210	Date/Time Preps/5/25/2023 11:3 PPS On/After 10/1 2.00 6,874,403,459 0.000124273 854,301 215,331	38 a 35. 35. 35.
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ubtotal (see instructions) ospital specific payments (to be completed by SCH and MDH, s	ŕ	0	i I	45.
ospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	16, 259, 457		46. 47.
		10, 237, 437		48.
			Amount 1.00	
otal payment for inpatient operating costs (see instructions	s)		16, 269, 275	49.
ayment for inpatient program capital (from Wkst. L, Pt. I an			1, 132, 536	1
xception payment for inpatient program capital (Wkst. L, Pt.			0	1
irect graduate medical education payment (from Wkst. E-4, li	ne 49 see instructions).		5, 337	
ursing and Allied Health Managed Care payment pecial add-on payments for new technologies			0 320, 020	
slet isolation add-on payment			320, 020	1
et organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	59)		o	
ellular therapy acquisition cost (see instructions)	,		0	55.
ost of physicians' services in a teaching hospital (see intr			0	
outine service other pass through costs (from Wkst. D, Pt. I		hrough 35).	0	
	IV, col. 11 line 200)			
,				
	s line 60)		l	
oinsurance billed to program beneficiaries			6, 224	1
llowable bad debts (see instructions)			45, 140	64.
djusted reimbursable bad debts (see instructions)			29, 341	1
	tructions)		l	
	applicable to MS DDCs (s	oo instructions)		
			l :	
THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	(. 2. 23. 233 11131 4311 011	-,	Ö	
	tration) adjustment (see	instructions)	0	
95 respirator payment adjustment amount (see instructions)			0	
emonstration payment adjustment amount before sequestration			0	1
	tructions)			70. 70.
LODEEL ACO DEMONSTRALLON DAVMENT ANTHSTMENT AMOUNT (SEE LINST	ir ucti ons)			
, , , , , , , , , , , , , , , , , , , ,			1	1
SP bonus payment HVBP adjustment amount (see instructions)			ő	
, , , , , , , , , , , , , , , , , , , ,			o	1
SP bonus payment HVBP adjustment amount (see instructions) SP bonus payment HRR adjustment amount (see instructions)			, -,	70.
	otal (sum of amounts on lines 49 through 58) rimary payer payments otal amount payable for program beneficiaries (line 59 minus eductibles billed to program beneficiaries oinsurance billed to program beneficiaries oinsurance billed to program beneficiaries llowable bad debts (see instructions) djusted reimbursable bad debts (see instructions) llowable bad debts for dual eligible beneficiaries (see inst ubtotal (line 61 plus line 65 minus lines 62 and 63) redits received from manufacturers for replaced devices for utlier payments reconciliation (sum of lines 93, 95 and 96). THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) ural Community Hospital Demonstration Project (§410A Demonst 95 respirator payment adjustment amount (see instructions) emonstration payment adjustment amount before sequestration CH or MDH volume decrease adjustment (contractor use only) i oneer ACO demonstration payment adjustment amount (see instructions) SP bonus payment HVBP adjustment amount (see instructions)	rimary payer payments otal amount payable for program beneficiaries (line 59 minus line 60) eductibles billed to program beneficiaries oinsurance billed to program beneficiaries llowable bad debts (see instructions) djusted reimbursable bad debts (see instructions) llowable bad debts for dual eligible beneficiaries (see instructions) ubtotal (line 61 plus line 65 minus lines 62 and 63) redits received from manufacturers for replaced devices for applicable to MS-DRGs (soutlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instruction THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) ural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see 95 respirator payment adjustment amount (see instructions) emonstration payment adjustment amount before sequestration CH or MDH volume decrease adjustment (contractor use only) ioneer ACO demonstration payment adjustment amount (see instructions) SP bonus payment HVBP adjustment amount (see instructions) undled Model 1 discount amount (see instructions)	otal (Sum of amounts on lines 49 through 58) rimary payer payments otal amount payable for program beneficiaries (line 59 minus line 60) eductibles billed to program beneficiaries oinsurance billed to program beneficiaries llowable bad debts (see instructions) djusted reimbursable bad debts (see instructions) llowable bad debts for dual eligible beneficiaries (see instructions) ubtotal (line 61 plus line 65 minus lines 62 and 63) redits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) utlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) ural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions) 95 respirator payment adjustment amount (see instructions) emonstration payment adjustment amount before sequestration CH or MDH volume decrease adjustment (contractor use only) i oneer ACO demonstration payment adjustment amount (see instructions) SP bonus payment HRR adjustment amount (see instructions) undled Model 1 discount amount (see instructions)	total (sum of amounts on lines 49 through 58) rimary payer payments otal amount payable for program beneficiaries (line 59 minus line 60) eductibles billed to program beneficiaries oinsurance billed to program beneficiaries llowable bad debts (see instructions) djusted reimbursable bad debts (see instructions) llowable bad debts for dual eligible beneficiaries (see instructions) ubtotal (line 61 plus line 65 minus lines 62 and 63) redits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) utilier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) utilier payments (SEE INSTRUCTIONS) (SPECIFY) ural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions) 95 respirator payment adjustment amount (see instructions) emonstration payment adjustment amount (see instructions) conditions amount and the payment and the payment and the payment and the payment and pay

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON		In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0113	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Pre 5/25/2023 11::	
	Ti tl e	e XVIII	Hospi tal	PPS	
		FFY	(уууу)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)			0	0	70. 96
70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)			0	0	70. 97
70.98 Low Volume Payment-3				0	70. 98
70.99 HAC adjustment amount (see instructions)				127, 148	70. 99
71 00 Amount due provider (Line 67 minus Lines 69 plus/minus Lines 60 % 70)		i		15 027 6/10	71 00

	Low vorume adjustment for rederal fiscal year (yyyy) (Enter fit corumn o	· ·	I -	10.91
	the corresponding federal year for the period ending on or after 10/1)		_	
70. 98	3		0	
70. 99			127, 148	
71. 00			15, 837, 648	
71. 01			199, 554	71. 01
71. 02	Demonstration payment adjustment amount after sequestration		0	71. 02
71. 03	Sequestration adjustment-PARHM or CHART pass-throughs			71. 03
72.00	Interim payments		15, 294, 751	72.00
72. 01	Interim payments-PARHM or CHART			72. 01
73.00	Tentative settlement (for contractor use only)		0	73. 00
73. 01	, , , , , , , , , , , , , , , , , , , ,			73. 01
74. 00			343, 343	
, ,, ,,	73)		0.0,0.0	/ 00
74. 01	Balance due provider/program-PARHM or CHART (see instructions)			74. 01
75. 00	, , , , , , , , , , , , , , , , , , , ,		272, 637	
75.00	CMS Pub. 15-2, chapter 1, §115.2		272,037	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			1
90. 00	Operating outlier amount from Wkst. E, Pt. A, Iine 2, or sum of 2.03		0	90.00
70.00	plus 2.04 (see instructions)		l	70.00
01 00			0	91.00
	91.00 Capital outlier from Wkst. L, Pt. I, line 2		0	
	92.00 Operating outlier reconciliation adjustment amount (see instructions)		0	
	93.00 Capital outlier reconciliation adjustment amount (see instructions)		1	94.00
	94.00 The rate used to calculate the time value of money (see instructions)			
	95.00 Time value of money for operating expenses (see instructions)		0	
96.00	96.00 Time value of money for capital related expenses (see instructions)		0	96. 00
			On/After 10/1	
	UCD Desire Desired Assessed	1.00	2.00	
100.00	HSP Bonus Payment Amount	1. 00	2. 00	100.00
100.00	HSP bonus amount (see instructions)		2. 00	100. 00
	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment	1.00	2.00	
101.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)	1. 00	2. 00 0 0. 0000000000	101. 00
101.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions)	1.00	2. 00 0 0. 0000000000	
101. 00 102. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment	0.0000000000000000000000000000000000000	2.00 0.00000000000000000000000000000000	101. 00 102. 00
101. 00 102. 00 103. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)	0. 0000000000 0. 0000000000000000000000	2.00 0.0000000000 0.0000000000000000000	101. 00 102. 00 103. 00
101. 00 102. 00 103. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment	0.0000000000000000000000000000000000000	2.00 0.0000000000 0.0000000000000000000	101. 00 102. 00
101. 00 102. 00 103. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)	0. 0000000000 0. 0000000000000000000000	2.00 0.0000000000 0.0000000000000000000	101. 00 102. 00 103. 00
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101. 00 102. 00 103. 00 104. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment	0. 0000000000 0. 0000000000000000000000	2.00 0.0000000000 0.0000000000000000000	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st	0. 0000000000 0. 0000000000000000000000	2.00 0.0000000000 0.0000000000000000000	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.	0. 0000000000 0. 0000000000000000000000	2.00 0.0000000000 0.0000000000000000000	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	0. 0000000000 0. 0000000000000000000000	2.00 0.0000000000 0.0000000000000000000	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Dis this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)	0. 0000000000 0. 0000000000000000000000	2.00 0.0000000000 0.0000000000000000000	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions)	0. 0000000000 0. 0000000000 0	2.00 0.0000000000 0.0000 0.0000	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	0. 0000000000 0. 0000000000 0	2.00 0.0000000000 0.0000 0.0000	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curren	0. 0000000000 0. 0000000000 0	2.00 0.0000000000 0.0000 0.0000	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curren period) Medicare target amount	0. 0000000000 0. 0000000000 0	2.00 0.0000000000 0.0000 0.0000	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curren period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	0. 0000000000 0. 0000000000 0	2.00 0.0000000000 0.0000 0.0000	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curren period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	0. 0000000000 0. 0000000000 0	2.00 0.0000000000 0.0000 0.0000	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curren period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	0. 0000000000 0. 0000000000 0	2.00 0.0000000000 0.0000 0.0000	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curren period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	0. 0000000000 0. 0000000000 0	2.00 0.0000000000 0.0000 0.0000	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00

Health Financial Systems	COMMUNITY HOSPITAL ANDERSON	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0113	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/25/2023 11:38 am

		10 12/01/2022	5/25/2023 11:	
	Title XVIII	Hospi tal	PPS	
			1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		1, 714	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		16, 269, 560	2.00
3.00	OPPS payments		13, 390, 926	3.00
4.00	Outlier payment (see instructions)		195, 678	4. 00
4. 01	Outlier reconciliation amount (see instructions)		0 000	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0. 000 0	5. 00 6. 00
6. 00 7. 00	Line 2 times line 5		0.00	7.00
8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)		0.00	8.00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9. 00
10.00	Organ acqui si ti ons		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)		1, 714	11.00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES		1, 714	11.00
	Reasonable charges			
12. 00	Ancillary service charges		4 745	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13)		4, 745	14. 00
	Customary charges		.,,,,,,	
15. 00	Aggregate amount actually collected from patients liable for payment for services on a	a charge basis	0	15. 00
16.00	Amounts that would have been realized from patients liable for payment for services or		0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)	3		
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17. 00
18.00	Total customary charges (see instructions)		4, 745	18. 00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds lin	ne 11) (see	3, 031	19. 00
	instructions)			
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds lin	ne 18) (see	0	20. 00
	instructions)			
21. 00	Lesser of cost or charges (see instructions)		1, 714	
22. 00	Interns and residents (see instructions)		0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instructions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		13, 586, 604	24. 00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		404	25 00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	ictions)	686	
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instru	•	2, 513, 114	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22	and 23] (See	11, 074, 518	27. 00
28. 00	instructions) Direct graduate medical education payments (from Wkst. E-4, line 50)		3, 716	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)		3, 710	29.00
30. 00	Subtotal (sum of lines 27 through 29)		11, 078, 234	30.00
31. 00	Primary payer payments		11, 657	31.00
32. 00	Subtotal (line 30 minus line 31)		11, 066, 577	
	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	Allowable bad debts (see instructions)		180, 640	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		117, 416	35. 00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		156, 600	36. 00
37.00	Subtotal (see instructions)		11, 183, 993	37. 00
38. 00	MSP-LCC reconciliation amount from PS&R		-132	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)		0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration		0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced devices (see instruc-	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		0	39. 99
40. 00	Subtotal (see instructions)		11, 184, 125	40.00
40. 01	Sequestration adjustment (see instructions)		140, 920	40. 01
40. 02	Demonstration payment adjustment amount after sequestration		0	40. 02
40. 03	Sequestration adjustment-PARHM or CHART pass-throughs		11 1/1 1/0	40. 03
41. 00 41. 01	Interim payments		11, 161, 468	1
41.01	Interim payments-PARHM or CHART Tentative settlement (for contractors use only)		0	41. 01 42. 00
42. 00	Tentative settlement-PARHM or CHART (for contractor use only)		U	42. 00
43. 00	Balance due provider/program (see instructions)		-118, 263	43. 00
43. 01	Balance due provider/program-PARHM (see instructions)		-110, 203	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, or	chanter 1	4, 896	44. 00
77.00	§115. 2	Shapter 1,	4, 070	77.00
	TO BE COMPLETED BY CONTRACTOR			
90. 00	Original outlier amount (see instructions)		0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92. 00	The rate used to calculate the Time Value of Money		0.00	
93. 00	Time Value of Money (see instructions)		0	93. 00
94.00	Total (sum of lines 91 and 93)		0	94. 00

Health Financial Systems	COMMUNITY HOSPITAL	ANDERSON	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0113	Peri od:	Worksheet E	
			From 01/01/2022		
			To 12/31/2022	Date/Time Pre	epared:
				5/25/2023 11:	38 am_
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				C	200. 00

Health Financial Systems COMMU ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: Provider CCN: 15-0113

			'	0 12/31/2022	5/25/2023 11: 3	
		Title	XVIII	Hospi tal	PPS	
		I npati en	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		15, 294, 751		11, 161, 468	1. 00
2. 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		C		0	2. 00
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. 00
3. 01	ADJUSTMENTS TO PROVIDER		C		0	3. 01
3. 02			C		0	3. 02
3. 03			l c		0	3. 03
3.04					ol	3. 04
3. 05					ol	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		C		0	3.50
3.51			l c		o	3. 51
3.52			l c		o	3. 52
3.53			l c		o	3. 53
3.54			l c		o	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		l c		o	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		15, 294, 751		11, 161, 468	4. 00
1. 00	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		10, 271, 701		11, 101, 100	1. 00
	TO BE COMPLETED BY CONTRACTOR		l .			
5.00	List separately each tentative settlement payment after					5. 00
3.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3. 00
	Program to Provider		•			
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5.02			l c		o	5. 02
5.03			C		o	5. 03
	Provider to Program					
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. 01	the cost report. (1) SETTLEMENT TO PROVIDER		242 242		0	6. 01
			343, 343		-	
6. 02	SETTLEMENT TO PROGRAM		~		118, 263 11, 043, 205	6. 02 7. 00
7. 00	Total Medicare program liability (see instructions)		15, 638, 094		NPR Date	7.00
				Contractor Number	(Mo/Day/Yr)	
		- 1)	1. 00	2. 00	
8. 00	Name of Contractor			1.00	2.00	8. 00
5.00	name of contractor				·	5. 00

Heal th	Financial Systems COMMUNI	TY HOSPITAL ANDERSON	In Lie	u of Form CMS-	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0113 Period: Wor From 01/01/2022 Par				
			To 12/31/2022	Part II Date/Time Pre	
				5/25/2023 11:	38 am_
		Title XVIII	Hospi tal	PPS	
			_		
	TO BE COMPLETED BY CONTRACTOR FOR MONOTANDARD COST	DEDODE		1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST				4
1 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND C		4.4		4 00
1.00	Total hospital discharges as defined in AARA §4102	Trom WKST. S-3, Pt. I col. 15 line	14		1.00
2.00	Medicare days (see instructions)				2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. li	ne 2			3. 00
4.00	Total inpatient days (see instructions)				4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 I				5. 00
6. 00	Total hospital charity care charges from Wkst. S-10	·			6. 00
7. 00	CAH only - The reasonable cost incurred for the pur	chase of certified HII technology	Wkst. S-2, Pt. I		7. 00
0.00	line 168				0.00
8. 00	Calculation of the HIT incentive payment (see instr	uctions)			8. 00
9. 00	Sequestration adjustment amount (see instructions)				9. 00
10. 00	Calculation of the HIT incentive payment after sequ	estration (see instructions)			10. 00
	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH				4
	Initial/interim HIT payment adjustment (see instruc	ctions)			30. 00
	Other Adjustment (specify)		_		31. 00
32. 00	Balance due provider (line 8 (or line 10) minus lin	ne 30 and line 31) (see instruction	s)		32. 00

	Financial Systems COMMUNITY HOSPITA				eu of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der CO	CN: 15-0113	Peri od: From 01/01/2022	Worksheet E-4	
				To 12/31/2022	Date/Time Prep 5/25/2023 11:	
		Title	XVIII	Hospi tal	PPS	
					1.00	
1. 00	COMPUTATION OF TOTAL DIRECT GME AMOUNT Unweighted resident FTE count for allopathic and osteopathic	nrograms for	cost reporti	ng neriods	0.00	1. 00
	ending on or before December 31, 1996.	. 0	cost reporti	ing periods		
1. 01 2. 00	FTE cap adjustment under §131 of the CAA 2021 (see instruction Unweighted FTE resident cap add-on for new programs per 42 CFI		1) (see instr	ructions)	0. 00 0. 00	1. 01 2. 00
2. 26	Rural track program FTE cap limitation adjustment after the ca	. , ,	, .	,	0.00	2. 26
3. 00	the CAA 2021 (see instructions) Amount of reduction to Direct GME cap under section 422 of MM.	A			0.00	3. 00
3. 01	Direct GME cap reduction amount under ACA §5503 in accordance		§413.79 (m).	(see	0. 00	3. 01
3. 02	instructions for cost reporting periods straddling 7/1/2011) Adjustment (increase or decrease) to the hospital's rural transfer or transfe	ck FTE limit	ation(s) for	rural track		3. 02
	programs with a rural track Medicare GME affiliation agreemen					
4. 00	49075 (August 10, 2022) (see instructions) Adjustment (plus or minus) to the FTE cap for allopathic and	osteopathi c	programs due	to a Medicare	0.00	4. 00
4. 01	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f) ACA Section 5503 increase to the Direct GME FTE Cap (see insti		cost roporti	na nori odo	0.00	4. 01
4.01	straddling 7/1/2011)	i uctions for	cost reporti	ng perrous	0.00	4.01
4. 02	ACA Section 5506 number of additional direct GME FTE cap slot: periods straddling 7/1/2011)	s (see inst	ructions for	cost reporting	0.00	4. 02
4. 21	The amount of increase if the hospital was awarded FTE cap slo	ots under §1	26 of the CAA	A 2021 (see		4. 21
5. 00	instructions) FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus line			nus lines 3 and	0. 00	5. 00
6. 00	3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.27 Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your					6. 00
7. 00	records (see instructions) Enter the lesser of line 5 or line 6				0.00	7. 00
			Primary Care		Total	
8. 00	Weighted FTE count for physicians in an allopathic and osteopa	athi c	1.00	2. 00	3.00	8. 00
9. 00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw	i se	0.0	0.00	0.00	9. 00
	multiply line 8 times the result of line 5 divided by the amount	unt on line				
	6. For cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions.	, 2022, 01				
10.00	Weighted dental and podiatric resident FTE count for the curry			0. 16		10.00
10. 01 11. 00	Unweighted dental and podiatric resident FTE count for the cultotal weighted FTE count	rrent year	0. (0. 16 00		10. 01 11. 00
12. 00	Total weighted resident FTE count for the prior cost reporting	g year (see	0.0	0. 25		12. 00
13. 00	instructions) Total weighted resident FTE count for the penultimate cost re	porti ng	0.0	0. 00		13. 00
14. 00	year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	0. (0. 14		14. 00
15. 00	Adjustment for residents in initial years of new programs		0. (15. 00
15. 01 16. 00	Unweighted adjustment for residents in initial years of new p Adjustment for residents displaced by program or hospital close		0. (0. (15. 01 16. 00
16. 01	Unweighted adjustment for residents displaced by program or he		0. (16. 01
17. 00	closure Adjusted rolling average FTE count		0. (17. 00
18. 00 18. 01	Per resident amount Per resident amount under §131 of the CAA 2021		106, 207. 2	106, 207. 23		18. 00 18. 01
	Approved amount for resident costs			0 14, 869	14, 869	
					1. 00	
20. 00	Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)	TE resident	cap slots red	cei ved under 42	0.00	20. 00
21. 00	Direct GME FTE unweighted resident count over cap (see instru	,			0.00	
22. 00 23. 00	Allowable additional direct GME FTE Resident Count (see instruenter the locality adjustment national average per resident and		nstructions)			22. 00 23. 00
24.00	Multiply line 22 time line 23	mount (366 I	11311 4611 0113)		0	24.00
25. 00	Total direct GME amount (sum of lines 19 and 24)				14, 869	25. 00

	Financial Systems COMMUNITY HOSPITAL GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der C	CN: 15-0113	Peri od:	u of Form CMS-2 Worksheet E-4	
	L EDUCATION COSTS			From 01/01/2022	D-+- /T: D	
				To 12/31/2022	Date/Time Prep 5/25/2023 11:3	
		Title	: XVIII	Hospi tal	PPS	<u> </u>
			Inpatient Par	t Managed Care	Total	
			A			
	COMPUTATION OF PROCESM DATIENT LOAD		1.00	2. 00	3. 00	
26. 00	COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions) (Title XIX - see S-2 Part I)	V line	6, 49	96 8, 336		26. 00
20.00	3.02, column 2)	A, TITIE	0, 45	0, 330		20.00
27. 00	Total Inpatient Days (see instructions)		23, 9	23, 914		27. 00
28. 00	Ratio of inpatient days to total inpatient days		0. 27164			28. 00
29. 00	, , , , , , , , , , , , , , , , , , , ,		4, 03	5, 183	9, 222	29. 00
29. 01	Percent reduction for MA DGME			3. 26		29. 01
30.00	Reduction for direct GME payments for Medicare Advantage			169	169	30. 00
31.00	Net Program direct GME amount				9, 053	31.00
	DUDGOT WEDLOW SDUGATION COOTS FOR FORD COMPOSITE DATE. TITLE		/		1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE EDUCATION COSTS)	XVIII ONLY	(NURSING PRO	GRAM AND PARAMEL	OI CAL	
32. 00	Renal dialysis direct medical education costs (from Wkst. B, F and 94)	Pt. I, sum o	of col. 20 and	1 23, lines 74	0	32. 00
33. 00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I	l col 8 s	um of lines 7	'4 and 94)	985. 907	33. 00
34. 00	Ratio of direct medical education costs to total charges (line			4 dild 74)	0. 000000	
35. 00	j ,		,		0	35. 00
36.00	Medicare outpatient ESRD direct medical education costs (line	34 x line 3	5)		0	36. 00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY				
	Part A Reasonable Cost					
37. 00					23, 374, 801	
38. 00	Organ acquisition and HSCT acquisition costs (see instructions				0	38. 00
39.00	Cost of physicians' services in a teaching hospital (see instr Primary payer payments (see instructions)	ructions)			0 18, 593	39. 00 40. 00
41. 00	Total Part A reasonable cost (sum of lines 37 through 39 minus	s Lino 40)			23, 356, 208	
41.00	Part B Reasonable Cost	5 TTHE 40)			23, 330, 200	41.00
42 00	Reasonable cost (see instructions)				16, 271, 274	42. 00
43. 00	Primary payer payments (see instructions)				11, 657	
44. 00	, , , , , , , , , , , , , , , , , , , ,				16, 259, 617	
45.00	Total reasonable cost (sum of lines 41 and 44)				39, 615, 825	45. 00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line				0. 589568	46. 00
47. 00			45)		0. 410432	47. 00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAR	RT B				
	Total program GME payment (line 31)				9, 053	
49. 00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				5, 337	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instru	ictions)		3, /16	50.00

Heal th	Financial Systems COMMUNITY HOSPITA	AL ANDERSON	In Lie	u of Form CMS-2	552-10
				Worksheet E-5	
			From 01/01/2022 To 12/31/2022	Date/Time Prep 5/25/2023 11:3	oared: 88 am_
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instr	uctions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instruc	tions)		0	4.00
5.00 The rate used to calculate the time value of money (see instructions)			0.00	5.00	
6.00	Time value of money for operating expenses (see instructions)			0	6.00
7.00	Time value of money for capital related expenses (see instruc	tions)		0	7.00

Health Financial Systems

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

Provider CCN: 15-0113 Period: From 01/0

oni y)					5/25/2023 11:	
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	0.00	1.00	
1.00	Cash on hand in banks	860, 164	. (0	0	1.00
2.00	Temporary investments	0	0	-	0	
3. 00	Notes receivable	0		,	0	
4.00	Accounts receivable	76, 183, 475		0	0	1
5.00	Other recei vable	-52, 632, 986		0	0	
6. 00 7. 00	Allowances for uncollectible notes and accounts receivable	398, 680		0	0	
8. 00	Inventory Prepai d expenses	4, 059, 908 73, 582			0	
9. 00	Other current assets	447, 427			0	
10. 00	Due from other funds	117, 127		,	0	
11. 00	Total current assets (sum of lines 1-10)	29, 390, 250		-		
	FIXED ASSETS	, , , , , , , , , , , , , , , , , , , ,				
12.00	Land	6, 268, 153	(0	0	12. 00
13.00	Land improvements	2, 023, 177	' C	0	0	13. 00
14.00	Accumulated depreciation	0) (0	_	1
15. 00	Bui I di ngs	82, 665, 381	1	1	0	
16. 00	Accumulated depreciation	0		1	0	1
17. 00	Leasehold improvements	2, 763, 325		0	0	
18.00	Accumulated depreciation	01 404 403		0	0	
19. 00 20. 00	Fixed equipment Accumulated depreciation	81, 484, 492		0	0	
21. 00	Automobiles and trucks	1, 033, 859			0	
22. 00	Accumulated depreciation	1,033,039		1	0	
23. 00	Major movable equipment	0		1	0	
24. 00	Accumulated depreciation	-122, 085, 867	1	o o	Ö	
25. 00	Mi nor equipment depreciable	0		o o	0	
26.00	Accumulated depreciation	0) (0	0	26. 00
27.00	HIT designated Assets	0) (0	0	27. 00
28. 00	Accumul ated depreciation	0) (0	0	
29. 00	Mi nor equi pment-nondepreci abl e	0) (-	0	
30. 00	Total fixed assets (sum of lines 12-29)	54, 152, 520) (0	0	30.00
	OTHER ASSETS					
31.00	Investments	886, 187		-		
32. 00 33. 00	Deposits on leases Due from owners/officers	0		1	0	
34. 00	Other assets	282, 045, 419	1	1	0	1
35. 00	Total other assets (sum of lines 31-34)	282, 931, 606		,	0	1
36. 00	Total assets (sum of lines 11, 30, and 35)	366, 474, 376		,		1
	CURRENT LIABILITIES				_	
37.00	Accounts payable	911, 724	. (0	0	37. 00
38.00	Salaries, wages, and fees payable	0) (0	0	38. 00
39. 00	Payroll taxes payable	0) (0	0	39. 00
40.00	Notes and Loans payable (short term)	0) (0	0	
41. 00	Deferred income	0)	0	0	
42.00	Accel erated payments	0)			42. 00
43.00	Due to other funds	0 010 5/0		0	0	
44. 00	Other current liabilities	8, 818, 568		-	Ĭ	
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	9, 730, 292	:	0	0	45. 00
46. 00	Mortgage payable	0) (0	0	46. 00
47. 00	Notes payable			,	-	
48. 00	Unsecured Loans	0		-		
49. 00	Other long term liabilities	3, 585, 809		-	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	3, 585, 809		0		1
51.00	Total liabilities (sum of lines 45 and 50)	13, 316, 101		0	0	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	353, 158, 275	5			52. 00
53. 00	Specific purpose fund		C)		53. 00
54.00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0	_	56. 00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	353, 158, 275			0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	366, 474, 376			0	
	59)					
	· ·	•	•	1	•	•

Provider CCN: 15-0113

					10 12/31/2022	5/25/2023 11:	
		General	Fund	Speci al I	Purpose Fund	Endowment Fund	
		1.00	2.00	2.00	4.00	F 00	
1. 00	Fund balances at beginning of period	1.00	2. 00 353, 743, 749	3. 00	4. 00	5. 00	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-585, 472			1	2.00
3.00	Total (sum of line 1 and line 2)		353, 158, 277			,	3. 00
4.00	Additions (credit adjustments) (specify)	o	000, 100, 277		0	O	4. 00
5. 00	(, (, (, (, (o			0	0	5. 00
6.00		o			0	0	6. 00
7.00		O			0	0	7. 00
8.00		0			0	0	8. 00
9.00		0			0	0	
10.00	Total additions (sum of line 4-9)		0		C)	10. 00
11. 00	Subtotal (line 3 plus line 10)		353, 158, 277		C)	11. 00
12. 00	ROUNDI NG	2			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 17. 00		0			0	0	16. 00 17. 00
18.00	Total deductions (sum of lines 12-17)	٩	2				18.00
19. 00	Fund balance at end of period per balance		353, 158, 275				19. 00
17.00	sheet (line 11 minus line 18)		333, 130, 273			1	17.00
		Endowment Fund	PI ant	Fund			
		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)	O O	0		0		3.00
4. 00 5. 00	Additions (credit adjustments) (specify)		0				4. 00 5. 00
6.00			0				6.00
7. 00			0				7. 00
8. 00			0				8.00
9. 00			0				9. 00
10.00	Total additions (sum of line 4-9)	o			0		10.00
11. 00	Subtotal (line 3 plus line 10)	O			0		11. 00
12.00	ROUNDING		0				12. 00
13.00			0				13. 00
14.00			0				14.00
15.00			0				15. 00
16. 00			0				16. 00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 12-17)	0			0		18. 00
19. 00	Fund balance at end of period per balance	0			0		19. 00
	sheet (line 11 minus line 18)	ı l		I	1		l

Health Financial Systems CC STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0113

			10	12/31/2022	5/25/2023 11:3	
	Cost Center Description	Inpatient	Ot.	utpati ent	Total	JO alli
		1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal	42, 492, 0	583		42, 492, 683	1.00
2.00	SUBPROVI DER - I PF					2.00
3.00	SUBPROVI DER - I RF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF		0		0	5.00
6.00	Swing bed - NF		0		0	6.00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)	42, 492, (583		42, 492, 683	10.00
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT	16, 729, 9	996		16, 729, 996	
12. 00	CORONARY CARE UNIT					12. 00
13. 00	BURN INTENSIVE CARE UNIT					13.00
14. 00	SURGI CAL INTENSIVE CARE UNIT					14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of I	i nes 16, 729, 9	996		16, 729, 996	16. 00
	11-15)					
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	59, 222, (59, 222, 679	17. 00
18.00	Ancillary services	192, 257,	154 5	540, 421, 395	732, 678, 549	18. 00
19. 00	Outpatient services		0	0	0	19. 00
20. 00 21. 00	RURAL HEALTH CLINIC		0	0	0	20. 00 21. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		U	٩	۷	
23. 00	HOME HEALTH AGENCY AMBULANCE SERVICES					22. 00 23. 00
24. 00	CMHC					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 t	to Wkst. 251,479,8	333 F	540, 421, 395	791, 901, 228	
20.00	G-3, line 1)	231, 477,	,55	740, 421, 373	771, 701, 220	20.00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		2	211, 862, 934		29. 00
30. 00	ADD (SPECIFY)		0	,,		30.00
31. 00			0			31. 00
32.00			0			32.00
33.00			0			33.00
34.00			0			34.00
35.00			0			35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37. 00	DEDUCT (SPECIFY)		0			37.00
38. 00			0			38.00
39. 00			0			39. 00
40.00			0			40.00
41. 00			0			41.00
42. 00	Total deductions (sum of lines 37-41)			0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer	2	211, 862, 934		43.00
	to Wkst. G-3, line 4)				l	

	· · · · · · · · · · · · · · · · · · ·	COMMUNITY HOSPITAL ANDERSON		u of Form CMS-2	
STATE	MENT OF REVENUES AND EXPENSES	Provider CCN: 15-0113	Peri od: From 01/01/2022	Worksheet G-3	
			To 12/31/2022	Date/Time Pre 5/25/2023 11:	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part			791, 901, 228	
2.00	Less contractual allowances and discounts on	patients' accounts		577, 332, 022	
3.00	Net patient revenues (line 1 minus line 2)			214, 569, 206	
4.00	Less total operating expenses (from Wkst. G-2			211, 862, 934	4. 00
5.00	Net income from service to patients (line 3 r	ninus line 4)		2, 706, 272	5. 00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			538, 172	
7.00	Income from investments			-14, 407, 135	7. 00
8.00	Revenues from telephone and other miscellaneo	ous communication services		0	
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			8, 217	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 gues	sts		1, 013, 476	14. 00
15. 00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical sup	oplies to other than patients		0	16. 00
17.00	Revenue from sale of drugs to other than pati	ents		0	17. 00
18. 00	Revenue from sale of medical records and abst	cracts		0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, e	etc.)		0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, ar	nd canteen		0	20.00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			2, 498, 006	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	MI SC REVENUE			1, 384, 592	24. 00
24. 50	COVI D-19 PHE Fundi ng			5, 686, 550	24. 50
25.00	Total other income (sum of lines 6-24)			-3, 278, 122	25. 00
	Total (line 5 plus line 25)			571 OFA	26 00

-571, 850 26. 00

13, 622 27. 00 13, 622 28. 00 -585, 472 29. 00

26.00 Total (line 5 plus line 25)

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

Heal th	Financial Systems COMMUNITY HOSPIT	AL ANDERSON	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0113	Peri od: From 01/01/2022 To 12/31/2022	Date/Time Pre	
		Title XVIII	Hospi tal	5/25/2023 11: 3 PPS	38 am_
		I tile xviii	поѕрі таі	PP3	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			11.00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			1, 048, 665	1. 00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			19, 378	2. 00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00				66. 13	3. 00
4.00	· · · · · · · · · · · · · · · · · · ·			0. 14	4. 00
5.00	Indirect medical education percentage (see instructions)			0.06	5. 00
6. 00	Indirect medical education adjustment (multiply line 5 by the 1.01) (see instructions)			629	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)			3. 46	7. 00
8.00	Percentage of Medicaid patient days to total days (see instr	uctions)		25. 72	8. 00
9.00	Sum of lines 7 and 8			29. 18	
10.00	Allowable disproportionate share percentage (see instruction	s)		6. 09	
11.00	Disproportionate share adjustment (see instructions)			63, 864	
12. 00	Total prospective capital payments (see instructions)			1, 132, 536	12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			0	
1.00	Program inpatient routine capital cost (see instructions)				1.00
2 00					
2.00	Program inpatient ancillary capital cost (see instructions)			0	2. 00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	2. 00 3. 00
3. 00 4. 00	Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions)			0	2. 00 3. 00 4. 00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	2. 00 3. 00
3. 00 4. 00	Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	2. 00 3. 00 4. 00
3. 00 4. 00 5. 00	Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS			0 0 0 0	2. 00 3. 00 4. 00 5. 00
3. 00 4. 00 5. 00	Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)			1.00	2. 00 3. 00 4. 00 5. 00
3. 00 4. 00 5. 00 1. 00 2. 00	Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstand	ces (see instructions)		1.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00
3. 00 4. 00 5. 00 1. 00 2. 00 3. 00	Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan. Net program inpatient capital costs (line 1 minus line 2)	ces (see instructions)		1.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00
3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00	Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan. Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	ces (see instructions)		1.00 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00
1. 00 2. 00 3. 00 4. 00 5. 00	Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan. Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)			1.00 0 0 0 0 0 0 0.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00
3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstant Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions)	nstructions)	Line 6)	1.00 0 0 0 0 0 0 0 0.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan. Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary	nstructions)	line 6)	0 0 0 0 1.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan. Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7)	nstructions) y circumstances (line 2 x	line 6)	1.00 0 0 0 0 0 0 0 0.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan. Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl	nstructions) y circumstances (line 2 x icable)	ŕ	0 0 0 0 1.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan. Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see included adjustment to capital minimum payment level for extraordinary capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level over the carryover of accumulated capital minimum payment level over the carryover of accumulated capital minimum payment level over the carryover of accumulated capital minimum payment level over the capital minimum payment level over the carryover of accumulated capital minimum payment level over the carryover of accumulated capital minimum payment level over the capital minimum payment level over	nstructions) y circumstances (line 2 x icable) capital payments (line 8	less line 9)	0 0 0 0 1.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	nstructions) y circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri	less line 9) or year	0 0 0 0 1.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstant Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary capital minimum payment level for extraordinary capital minimum payment level for extraordinary capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appled current year comparison of capital minimum payment level over a correct of accumulated capital minimum payment level over a worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payments of capital minimum payment level to capital payments of capital minimum payment level to capital payments of capital minimum payment level to ca	nstructions) y circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri ayments (line 10 plus lir	less line 9) or year e 11)	0 0 0 0 0 0 0 0 0.00 0 0.00 0 0 0	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	nstructions) y circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri ayments (line 10 plus line r the amount on this line	less line 9) or year e 11)	0 0 0 0 1.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00

15.00 0 16.00 0 17.00

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

15.00 Current year allowable operating and capital payment (see instructions)
16.00 Current year operating and capital costs (see instructions)
17.00 Current year exception offset amount (see instructions)